Characterization of women with a history of recurrent vulvovaginal candidosis.

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Characterization of women with a history of recurrent vulvovaginal candidosis

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Background. To characterize history, signs, and symptoms in women with a history of recurrent vulvovaginal candidosis (RVVC) and who had consulted with symptoms generally associated with the condition.

Methods. Eighty-three women with a history consistent with RVVC were interviewed regarding 32 parameters and 10 signs found at the clinical examination were noted. Candida cultures were made from the introitus and the posterior vaginal fornix.

Results. Only in a few of the 43 women with and the 40 without a positive yeast culture could any of the many etiological factors that have been associated with RVVC be traced. Only two factors differed between the groups, namely yogurt intake, which was reported by 28 (68%) and 38 (95%) women in these groups, respectively. Vaginal douching was performed by 10 (23%) women in the Candida-positive group and by 17 (42%) women in the Candida-negative group. Pruritis and burning occurred in 31 (72%) and 22 (51%) of culture-positive patients, which was less frequent than in the culture-negative group, i.e. reported by 19 (47%) and 9 (22%) patients, respectively (p = 0.022 and p = 0.007). Edema (p = 0.026) of the vulva as well as erythema (p = 0.019) and edema (p = 0.008) of the vaginal mucosa, caseous discharge (p = 0.016), were found more often in the Candida culture-positive cases.

Conclusions. History and results of clinical examination of patients with RVVC are not enough to distinguish those who are culture-positive from those who are culture-negative for Candida from the genital tract.

Key words: recurrent vulvovaginal candidosis; symptoms; signs; history; pathogenesis

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Accepted 18 February, 2002

Recurrent vulvovaginal candidosis (RVVC) is a common condition considered to affect 5–8% of all women, most often during reproductive age (1). Only in a small percentage of all RVVC cases, factors that have been associated with the condition, such as broad-spectrum antibiotic therapy, contraceptive use, pregnancy and uncontrolled diabetes mellitus, can be demonstrated (2). There have been a variety of proposals that one or more other factors can influence the rate of RVVC in a female population (3,4), but they have generally remained scientifically unproven (2).

Abbreviations:
RVVC: recurrent vulvovaginal candidosis; VVC: vulvovaginal candidosis.
made with a cohort without any history of VVC/RVVC or any such current problems. Extensive history taking, a pelvic examination and microbiological tests for Candida were performed. We also discuss the occurrence of some factors in our patients that have been regarded to trigger attacks of RVVC.

Materials and methods

Women with a history of RVVC

The 83 women studied had attended the outpatient department of the University maternity hospital No. 3, Kiev, Ukraine, from October 2000 to May 2001, because of current genital symptoms suggestive of VVC. The patients enrolled in the study had either been referred to the investigators by other gynecologists in the city or had consulted directly at the clinic. They had all a history assuming that they had had at least four attacks of VVC during the last year, i.e. they fulfilled the criteria for RVVC (2). The age range of the women studied was 17–42 years. The study group was divided into those who were Candida culture-positive (43 cases) and Candida culture-negative (40 cases) from the genital tract. The mean age of women of the Candida culture-positive and culture-negative group was 26.1 and 25.3 years, respectively.

The women enrolled in the study had given written consent for their participation. The study was approved by the institutional review board.

History taking

The women were asked for current symptoms and examined for any pathological genital signs; in all 16 parameters were noted. A structured interview, in all covering 32 possible etiological factors of RVVC, was performed. The patients had at least once, but generally several times, presented with a vaginal smear showing Candida morphotypes, i.e. blastoconidia and/or pseudohyphae.

Sampling and laboratory tests

Samples from the introitus and the posterior vaginal fornix were collected and cultured on Sabouraud (Beckton Dickinson®, Baltimore, Maryland USA) and chromogenic agar (CHROMagar, Paris, France). Indicator sticks measured the pH of vaginal secretions (Merck KGaA, Darmstadt, Germany).

Women without any history or current symptoms suggestive of VVC/RVVC

A group of 136 women without any history of any current complaints suggesting either VVC or RVVC were interviewed using the same questionnaire as in the above-mentioned women with a history of RVVC. No gynecologic examination or laboratory tests were made in this group of women. The age range in this cohort was also 17–42 years (mean age 25.2 years).

Statistics

Data were analyzed by means of the SPSS (LDC, Lund) 10.0 statistical software, and the χ² and Fisher’s exact test. A p-value < 0.05 was considered significant.

Results

History

Table I shows anamnestic data in the two groups of symptomatic patients with and without a confirmed genital Candida infection and in the healthy comparison group. Women with RVVC reported a history of gynecologic diseases more frequently than women in the healthy comparison group.

Table II shows the history in the two symptomatic groups. Only two factors differed between the groups, namely yogurt intake, which was reported by 28 (68%) and 38 (95%) women in these groups, respectively. Vaginal douching was performed by 10 (23%) women in the Candida-positive group and by 17 (42%) women in the Candida-negative group. The corresponding figures in the comparison group of healthy women were 128 (94%) and 17 (12%), respectively.

Parameters concerning partner relations and contraception use in the three study groups are shown in Table III. In those with a positive yeast culture, intercourse for the first time had taken place at a mean of 4.5 years (range 0.5–17) before enrollment in the study. In the culture-negative group, the corresponding figure was 3.6 years (range 0.5–17) ago.

When asked whether the patients believed that the onset of their ‘RVVC problems’ had occurred in conjunction with any specific event, the following most frequent answers were obtained: during or shortly after a course of antibiotic therapy (7 cases), during pregnancy (4 cases), and shortly after having intercourse for the first time (4 cases). The corresponding figures in the culture-negative group were four, seven, and four, respectively. Only single patients in each of the groups believed that their problems started after an experience of severe stress or during a period of particularly warm or humid weather. Also, other uncommon proposals were onset after wearing too tight clothes, after iatrogenic measures or because they had suffered...
### Table I. Characterization of Candida culture-positive and culture-negative women with a history of recurrent vulvovaginal candidosis (RVVC) and who had consulted because of a new attack of the condition as well as a comparison group of women with no history of complaints consistent with a genital Candida infection

<table>
<thead>
<tr>
<th>Parameters studied</th>
<th>Candida culture-</th>
<th>Control group (n = 136)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>positive (n = 43)</td>
<td>negative (n = 40)</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>26.1</td>
<td>25.3</td>
<td>25.2</td>
</tr>
<tr>
<td>Gravidity</td>
<td>1.6</td>
<td>1.1</td>
<td>0.8</td>
</tr>
<tr>
<td>Parity</td>
<td>0.6</td>
<td>0.35</td>
<td>0.3</td>
</tr>
<tr>
<td>Prior sexually transmitted infection(s)</td>
<td>11 (28%)</td>
<td>11 (27%)</td>
<td>0</td>
</tr>
<tr>
<td>Allergy</td>
<td>9 (21%)</td>
<td>14 (35%)</td>
<td>25 (18%)</td>
</tr>
<tr>
<td>Gynecologic disease(s)</td>
<td>19 (44%)</td>
<td>12 (30%)</td>
<td>4 (3%)</td>
</tr>
<tr>
<td>Socio-economic situation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>severe</td>
<td>4 (9%)</td>
<td>3 (7%)</td>
<td>n.e.</td>
</tr>
<tr>
<td>satisfactory</td>
<td>23 (54%)</td>
<td>18 (45%)</td>
<td>n.e.</td>
</tr>
<tr>
<td>good</td>
<td>16 (37%)</td>
<td>19 (48%)</td>
<td>n.e.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n.e.: not estimated.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Table II. Some factors proposed in the literature that trigger attacks of RVVC in the Candida culture-positive and culture-negative cases studied and in the controls with no history or current symptoms suggestive of a genital Candida infection

<table>
<thead>
<tr>
<th>Parameters</th>
<th>Candida culture-</th>
<th>Control group (n = 136)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>positive (n = 43)</td>
<td>negative (n = 40)</td>
<td></td>
</tr>
<tr>
<td>Antibiotic use last month</td>
<td>7 (16%)</td>
<td>5 (12%)</td>
<td>0</td>
</tr>
<tr>
<td>Wear of synthetic underwear</td>
<td>22 (51%)</td>
<td>22 (55%)</td>
<td>46 (34%)</td>
</tr>
<tr>
<td>Wear of tight clothes</td>
<td>26 (60%)</td>
<td>26 (65%)</td>
<td>65 (48%)</td>
</tr>
<tr>
<td>Washing underwear at ’=60°C</td>
<td>4 (9%)</td>
<td>6 (15%)</td>
<td>39 (29%)</td>
</tr>
<tr>
<td>Habit of vaginal douching</td>
<td>10 (23%)</td>
<td>17 (42%)</td>
<td>17 (12%)</td>
</tr>
<tr>
<td>Taking a hot bath</td>
<td>22 (51%)</td>
<td>19 (47%)</td>
<td>56 (41%)</td>
</tr>
<tr>
<td>Tampon user</td>
<td>16 (37%)</td>
<td>20 (50%)</td>
<td>38 (28%)</td>
</tr>
<tr>
<td>Panty-liner user</td>
<td>17 (40%)</td>
<td>21 (52%)</td>
<td>58 (43%)</td>
</tr>
<tr>
<td>Smoker</td>
<td>17 (40%)</td>
<td>11 (27%)</td>
<td>39 (29%)</td>
</tr>
<tr>
<td>Intake of a lot of sweets</td>
<td>17 (40%)</td>
<td>22 (55%)</td>
<td>111 (82%)</td>
</tr>
<tr>
<td>Yogurt consumer</td>
<td>28 (65%)</td>
<td>38 (95%)</td>
<td>128 (94%)</td>
</tr>
</tbody>
</table>

### Table III. Sexual practice and contraceptive use in the patients with a history of RVVC and in the healthy comparison group

<table>
<thead>
<tr>
<th>Parameters</th>
<th>Candida culture-</th>
<th>Control group (n = 136)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>positive (n = 43)</td>
<td>negative (n = 40)</td>
<td></td>
</tr>
<tr>
<td>Sexual debut at ’=17years</td>
<td>16 (37%)</td>
<td>8 (20%)</td>
<td>35 (26.%)</td>
</tr>
<tr>
<td>Mean age at sexual debut</td>
<td>18.1</td>
<td>18.8</td>
<td>19.3</td>
</tr>
<tr>
<td>Oral sex, regularly</td>
<td>23 (53%)</td>
<td>26 (62%)</td>
<td>36 (26%)</td>
</tr>
<tr>
<td>Anal sex, regularly</td>
<td>5 (12%)</td>
<td>10 (23%)</td>
<td>2 (1%)</td>
</tr>
<tr>
<td>Masturbate, regularly</td>
<td>7 (16%)</td>
<td>8 (20%)</td>
<td>10 (7%)</td>
</tr>
<tr>
<td>Sex during menstruation</td>
<td>7 (16%)</td>
<td>13 (32%)</td>
<td>20 (15%)</td>
</tr>
<tr>
<td>Mean no. of life-time partners</td>
<td>2.9</td>
<td>4.1</td>
<td>3</td>
</tr>
<tr>
<td>Oral contraception user</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>estrogen content high (&gt;35mg)</td>
<td>3 (7%)</td>
<td>1 (2%)</td>
<td>3 (2%)</td>
</tr>
<tr>
<td>medium (’=35mg &gt; 20mg)</td>
<td>1 (2%)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>low (’= 20 mg)</td>
<td>1 (2%)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>gestagen</td>
<td>1 (2%)</td>
<td>1 (2%)</td>
<td>2 (1%)</td>
</tr>
<tr>
<td>Spermicide user</td>
<td>1 (2%)</td>
<td>27 (67%)</td>
<td>61 (45%)</td>
</tr>
<tr>
<td>Partner condom user</td>
<td>19 (44%)</td>
<td>3 (2%)</td>
<td>0.633</td>
</tr>
<tr>
<td>IUD (non-hormonal releasing)</td>
<td>1 (2%)</td>
<td>0</td>
<td>3 (2%)</td>
</tr>
</tbody>
</table>
Table IV. Symptoms in the *Candida* culture-positive and culture-negative cases with a history of recurrent vulvovaginal candidosis (VVC)

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Candida culture-positive (n = 43)</th>
<th>Candida culture-negative (n = 40)</th>
<th>p-value</th>
<th>OR</th>
<th>CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vulvovaginal irritation</td>
<td>22 (51%)</td>
<td>9 (22%)</td>
<td>0.007</td>
<td>3.6</td>
<td>1.4–9.4</td>
</tr>
<tr>
<td>Unpleasant odor</td>
<td>9 (21%)</td>
<td>10 (25%)</td>
<td>0.659</td>
<td>0.8</td>
<td>0.3–2.2</td>
</tr>
<tr>
<td>Dyspareunia</td>
<td>19 (44%)</td>
<td>14 (35%)</td>
<td>0.393</td>
<td>1.5</td>
<td>0.6–3.6</td>
</tr>
<tr>
<td>Dysuria burning at micturation</td>
<td>22 (51%)</td>
<td>9 (22%)</td>
<td>0.007</td>
<td>3.6</td>
<td>1.4–9.4</td>
</tr>
<tr>
<td>Intestinal diarrhea</td>
<td>2 (5%)</td>
<td>3 (7%)</td>
<td>0.668</td>
<td>0.6</td>
<td>0.1–3.8</td>
</tr>
</tbody>
</table>

Table V. Character of the vaginal discharge in the *Candida* culture-positive and culture-negative cases with a history of RVVC

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Candida culture-positive (n = 43)</th>
<th>Candida culture-negative (n = 40)</th>
<th>p-value</th>
<th>OR</th>
<th>CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mucosus</td>
<td>10 (23%)</td>
<td>18 (45%)</td>
<td>0.036</td>
<td>0.4</td>
<td>0.1–1.0</td>
</tr>
<tr>
<td>Caseous</td>
<td>23 (53%)</td>
<td>11 (27%)</td>
<td>0.016</td>
<td>3.0</td>
<td>1.2–7.6</td>
</tr>
<tr>
<td>Aqueous</td>
<td>2 (5%)</td>
<td>1 (2%)</td>
<td>0.527</td>
<td>1.9</td>
<td>0.2–21.8</td>
</tr>
<tr>
<td>Foamy</td>
<td>1 (2%)</td>
<td>1 (2%)</td>
<td>0.735</td>
<td>0.9</td>
<td>0.1–15.4</td>
</tr>
<tr>
<td>White</td>
<td>41 (95%)</td>
<td>38 (95%)</td>
<td>0.941</td>
<td>1.1</td>
<td>0.1–8.0</td>
</tr>
<tr>
<td>Yellow</td>
<td>2 (5%)</td>
<td>2 (5%)</td>
<td>0.668</td>
<td>0.6</td>
<td>0.1–3.8</td>
</tr>
<tr>
<td>Gray</td>
<td>0</td>
<td>0</td>
<td>0.281</td>
<td>0.3</td>
<td>0.03–3.0</td>
</tr>
</tbody>
</table>

Symptoms

Itching, an irritating feeling in the vulva and dysuria, occurred significantly more often in those with than without a positive *Candida* culture (Table IV). Otherwise, there were no statistical differences between the patients with regard to the symptoms registered.

Signs

The amount and the color of the vaginal discharge in the two groups with different culture results did not differ (p > 0.05), although a caseous discharge was more common in the culture-positive group (p = 0.016) (Table V). Edema of the vulva (p = 0.026), erythema (p = 0.019) and edema (p = 0.008) of the vaginal mucosa were, however, more common in the culture-positive group (Table VI).

Discussion

Obviously, there is an age-related physiological influence of sex hormones on the prevalence of RVVC, including the hormonal changes occurring during pregnancy (8).

However, in only 6% of our cases, first onset of symptoms suggestive of an attack of VVC had occurred during pregnancy. RVVC is uncommon before menarche and less common after than before menopause, although an increased prevalence is seen in women given hormone replacement therapy. The period in life we choose to study represented most of the reproductive age, i.e. we enrolled women 17–42 years of age.

Early start of sexual life has been regarded as a predisposing factor for RVVC (9). However, the mean age for first intercourse in our *Candida* culture-positive group (18.1 years) did not differ from that of the culture-negative women (18.8 years). Neither did it differ from the mean age (19.3 years) in the healthy comparison group.

Use of high estrogen-containing oral contraceptives has by some authors been found to trigger attacks of RVVC (10,11), while others have not found colonization by *Candida* to be more common in such users than non-users (12). In the present study, only a few used ‘the pill’, i.e. five (12%) of the culture-positive and only one (2.5%) of the culture-negative women. Spermicides were not used by more than one patient in each of the two groups from which *Candida* cultures had been from a hormonal disorder. Twenty-six of the *Candida* culture-positive (50%) and 22 (55%) of the culture-negative patients could not associate the onset of RVVC to any specific event.

Table VI. Signs in the *Candida* culture-positive and culture-negative cases with a history of recurrent VVC

<table>
<thead>
<tr>
<th>Signs</th>
<th>Candida culture-positive (n = 43)</th>
<th>Candida culture-negative (n = 40)</th>
<th>p-value</th>
<th>OR</th>
<th>CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perianal area normal findings</td>
<td>26 (60%)</td>
<td>29 (72%)</td>
<td>0.247</td>
<td>0.6</td>
<td>0.2–1.5</td>
</tr>
<tr>
<td>Erythema</td>
<td>16 (37%)</td>
<td>10 (25%)</td>
<td>0.231</td>
<td>1.8</td>
<td>0.7–4.8</td>
</tr>
<tr>
<td>Edema</td>
<td>4 (9%)</td>
<td>0</td>
<td>0.117</td>
<td>2.0</td>
<td>1.6–2.6</td>
</tr>
<tr>
<td>Dermatitis</td>
<td>3 (7%)</td>
<td>1 (2%)</td>
<td>0.617</td>
<td>2.9</td>
<td>0.3–29.3</td>
</tr>
<tr>
<td>Scratches</td>
<td>3 (7%)</td>
<td>0</td>
<td>0.242</td>
<td>2.0</td>
<td>1.6–2.5</td>
</tr>
<tr>
<td>Vulva normal findings</td>
<td>26 (60%)</td>
<td>29 (50%)</td>
<td>0.338</td>
<td>1.5</td>
<td>0.8–33.7</td>
</tr>
<tr>
<td>Erythema</td>
<td>17 (40%)</td>
<td>19 (47%)</td>
<td>0.464</td>
<td>0.7</td>
<td>0.3–1.7</td>
</tr>
<tr>
<td>Edema</td>
<td>6 (14%)</td>
<td>0</td>
<td>0.026</td>
<td>2.1</td>
<td>1.7–2.6</td>
</tr>
<tr>
<td>Fissures</td>
<td>3 (7%)</td>
<td>0</td>
<td>0.242</td>
<td>2.0</td>
<td>1.6–2.5</td>
</tr>
<tr>
<td>Vagina normal mucosa</td>
<td>9 (21%)</td>
<td>18 (40%)</td>
<td>0.019</td>
<td>0.3</td>
<td>0.1–0.8</td>
</tr>
<tr>
<td>Erythema</td>
<td>34 (79%)</td>
<td>22 (55%)</td>
<td>0.019</td>
<td>3.1</td>
<td>1.2–8.1</td>
</tr>
<tr>
<td>Edema</td>
<td>7 (16%)</td>
<td>0</td>
<td>0.008</td>
<td>2.1</td>
<td>1.7–2.7</td>
</tr>
</tbody>
</table>
made. None utilized a diaphragm, which is still an
other contraceptive method that has been associ-
ated with RVVC (13–15).

A number of other behavior-related factors have
been assumed, but hardly proven to trigger RVVC
(2). These factors include a high frequency of in-
tercourse and multiple partners as well as oral and
anal sex (9,13,17,18). However, we did not find
such sexual practice to differ between the women
in our study who were and were not found to harb-
or Candida (19). Unproven triggering factors of
RVVC include wearing of tight-fitting clothes and
of synthetic underwear (12) and wearing under-
wear washed at a temperature unable to kill Can-
dida organisms (20). Certain hygiene procedures
have also been considered to be associated with
genital Candida infections, including vaginal
douching. The latter was a significantly more com-
mon practice (with water) among our Candida cul-
ture-negative than culture-positive women (Table
II).

There is firm evidence that poor glucemic con-
tral in diabetes mellitus patients can trigger RVVC
attacks (21). Goswami and co-authors (22) found
a higher prevalence rate of VVC in diabetic women
(46%) than in healthy controls (23%) (p = 0.025).
None of our patients had, however, diabetes mel-
itus. Overweight is associated with diabetes and
with Candida skin infections (2). Only one of our
patients with a history of RVVC was obese. Intake
of rapid carbohydrates is believed to be able to in-
duce new attacks of RVVC (21,22). However, avail-
able data are inconsistent regarding the impact of
certain diets on RVVC (2).

There are a number of hypotheses that immune
pathogenetic mechanisms can explain RVVC, e.g.
inability of the cell-mediated immune system to ef-
effectively limit growth of Candida (23). The current
study did not, however, allow valuation of the im-
portance of an immune dysfunction in our pa-
ients, but the severely impaired cellular immunity
in advanced AIDS cases is associated with both
general and vaginal Candida infections.

VVC/RVVC are not useful early markers of HIV
infection (24); HIV-infections had not been diag-
nosed in any of our patients.

Recurrences of VVC have been blamed on thera-
peutic failure due to antifungal resistance (25). Re-
cently, we described a new resistance mechanism in
one of the drugs often used to treat RVVC cases,
i.e. fluconazole. There is an efflux of the drug in
fluconazole-resistant Candida strains (26). How-
ever, in our study population fluconazole had only
been used by a few of our patients.

The high rate, e.g. 52%, of negative Candida cul-
tures in our patients with a history of RVVC, and
who had symptoms and signs that could have sug-
gested that they had a current genital infection,
points to the difficulty in identifying ‘true’ RVVC
cases. That is, to track down such ‘RVVC’ pa-
tients, who really have a genital infection by Can-
dida. The use of yeast culture and patient-close di-
nostic tests for the detection of Candida cell
morphotypes, i.e. of blastoconidia and/or pseudohyphae, in wet mount or stained vaginal
and/or introital smears [as we have reported else-
where (16)], may also help to identify Candida-in-
fected persons. Thus, it is essential to stress that a
microbiologic diagnosis is necessary to identify
those cases that have a Candida infection that one
generally associated with the condition among pa-
tients with a history of RVVC and who consult
with symptoms and signs. Episodes believed to
represent RVVC must be classified as ‘idiopathic’
cases, as factors that have been associated with
RVVC can only be demonstrated in a minority of
them.

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