clinical presentation, microbiology, host factors, and response to therapy, VVC can be classified as either uncomplicated or complicated (Box 4). Approximately 10%–20% of women will have complicated VVC, requiring special diagnostic and therapeutic considerations.

Uncomplicated Vulvovaginal Candidiasis

Diagnostic Considerations

A diagnosis of *Candida* vaginitis is clinically indicated by the presence of external dysuria and vulvar pruritus, pain, swelling, and redness. Signs include vulvar edema, fissures, excoriations, and thick curdy vaginal discharge. Most healthy women with uncomplicated VVC have no identifiable precipitating factors. The diagnosis can be made in a woman who has signs and symptoms of vaginitis when either a wet preparation (saline, 10% KOH) of vaginal discharge demonstrates budding yeasts, hyphae, or pseudohyphae, or a culture or other test yields a positive result for a yeast species. *Candida* vaginitis is associated with normal vaginal pH (<4.5). Use of 10% KOH in wet preparations improves the visualization of yeast and mycelia by disrupting cellular material that might obscure the yeast or pseudohyphae. Examination of a wet mount with KOH preparation should be performed for all women with symptoms or signs of VVC, and women with a positive result should be treated. For those with negative wet mounts but existing signs or symptoms, vaginal cultures for *Candida* should be considered. If *Candida* cultures cannot be performed for these women, empiric treatment can be considered. Identifying *Candida* by culture in the absence of symptoms or signs is not an indication for treatment because approximately 10%–20% of women harbor *Candida* species and other yeasts in the vagina. The majority of PCR tests for yeast are not FDA cleared, and providers who use these tests should be familiar with the performance characteristics of the specific test used. Yeast culture, which can identify a broad group of pathogenic yeasts, remains the reference standard for diagnosis.

BOX 4. Classification of vulvovaginal candidiasis

Uncomplicated vulvovaginal candidiasis (VVC)

- Sporadic or infrequent VVC
  and
- Mild-to-moderate VVC
  and
- Likely to be *Candida albicans*
  and
- Nonimmunocompromised women

Complicated VVC

- Recurrent VVC (three or more episodes of symptomatic VVC in <1 year)
  or
- Severe VVC
  or
- Non–*albicans* candidiasis
  or
- Women with diabetes, immunocompromising conditions (e.g., HIV infection), underlying immunodeficiency, or immunosuppressive therapy (e.g., corticosteroids)

Source: Sobel JD, Faro S, Force RW, et al. Vulvovaginal candidiasis: epidemiologic, diagnostic, and therapeutic considerations. Am J Obstet Gynecol 1998;178:203–11.

Treatment

Short-course topical formulations (i.e., single dose and regimens of 1–3 days) effectively treat uncomplicated VVC. Treatment with azoles results in relief of symptoms and negative cultures in 80%–90% of patients who complete therapy.

Recommended Regimens for Vulvovaginal Candidiasis

Over-the-Counter Intravaginal Agents
Clotrimazole 1% cream 5 g intravaginally daily for 7–14 days
or
Clotrimazole 2% cream 5 g intravaginally daily for 3 days
or
Miconazole 2% cream 5 g intravaginally daily for 7 days
or
Miconazole 4% cream 5 g intravaginally daily for 3 days
or
Miconazole 100 mg vaginal suppository one suppository daily for 7 days
or
Miconazole 200 mg vaginal suppository one suppository for 3 days
or
Miconazole 1,200 mg vaginal suppository one suppository for 1 day
or
Tioconazole 6.5% ointment 5 g intravaginally in a single application

Prescription Intravaginal Agents
Butoconazole 2% cream (single-dose bioadhesive product) 5 g intravaginally in a single application
or
Terconazole 0.4% cream 5 g intravaginally daily for 7 days
or
Terconazole 0.8% cream 5 g intravaginally daily for 3 days
or
Terconazole 80 mg vaginal suppository one suppository daily for 3 days

Oral Agent
Fluconazole 150 mg orally in a single dose

The creams and suppositories in these regimens are oil based and might weaken latex condoms and diaphragms. Patients should refer to condom product labeling for further information. Even women who have previously received a diagnosis of VVC by a clinician are not necessarily more likely to be able to diagnose themselves; therefore, any woman whose symptoms persist after using an over-the-counter preparation or who has a recurrence of symptoms <2 months