

“Clinical efficacy of oral terbinafine, fluconazole and itraconazole in the treatment of tinea corporis”.

Abstract:

Context: Comparing terbinafine, fluconazole and itraconazole for its efficacy.

Aims: This study was aimed to assess the clinico-mycological efficacy of oral terbinafine, fluconazole and itraconazole in the treatment of tinea corporis in a tertiary care hospital.

Study Design: This is a randomised comparative study with a sample size of 60 patients.

Patients and Methods: Patients were enrolled after considering various inclusion and exclusion criteria into three groups. Group A (oral terbinafine 250mg daily for 2 weeks), group B (fluconazole 150mg once weekly for 4 weeks) and group C (itraconazole 200mg once daily for 2 weeks). Clinical assessment was performed weekly on the basis of physician global assessment grading the severity of pruritus, erythematic, vesicle and desquamation.

Statistical analysis used: Chi-square test was used to calculate the statistical significance between the pre and post interventional results.

Results: Of the 60 patients, 51 completed the study on comparison between the three groups terbinafine (n=15), itraconazole (n=18) and fluconazole (n=18), it was observed that terbinafine was more effective on pruritis (80%), erythema (40%) and desquamation (80%). Itraconazole showed effectiveness on vesicle (66.66%).

Conclusions: Terbinafine was better than itraconazole and fluconazole in relieving signs and symptoms during the study period.

Key-words: Desquamation, Erythema, Fluconazole, Itraconazole, Terbinafine, Tinea corporis.

Key Message: Efficacy studies play a very pivotal role in avoiding the resistance of the drugs among patients. According to this study, terbinafine was more effective than itraconazole and fluconazole in alleviating clinical signs and symptoms particularly pruritus, erythema and desquamation, whereas itraconazole was found effective in relieving vesicle.

Introduction:

Dermatophytosis represents a superficial infection of the keratinized layers of hair, nail and skin caused by dermatophytic fungi.

Topical agents such as clotrimazole are usually well tolerated and penetrate into the systemic circulation infrequently. However, they may not penetrate well into the keratin barrier, and thus may not provide optimal treatment for dermatophyte infections located within the keratin. Furthermore, they may induce irritant or allergic contact dermatitis, and repeated application to extensive areas of skin is not always practical for patients. For these reasons, a desirable alternative for the treatment of dermatophyte infections is an oral agent with proven efficacy and minimal toxicity.²

Dermatophytosis in India have received increasing attention in recent years from different parts of the country. So, this study was undertaken to evaluate the clinico-mycological efficacy of three drugs named fluconazole, itraconazole and terbinafine in treatment of tinea corporis and to evaluate the susceptibility of isolates to the three antifungal drugs.

Patients and Methods:

A randomised comparative study was conducted from August 2015 to March 2016, after ethical approval by local Ethics Committee. Sixty untreated patients of tinea corporis were selected. All the selected patients were >16 years of age with the diagnosis of tinea corporis confirmed by potassium hydroxide (KOH) or culture. Patients with extensive dermatophytosis³ (tinea corporis with cruris, pedis and onychomycosis) were excluded. Patients already on antifungal therapy (either topical or oral), 14 days of baseline were excluded. Patients who had used topical steroids were also excluded from the study. Pregnant women and patients with hepatic or renal disease were also not included. Patients were briefed about the nature of study and a written informed consent was obtained.

Study Design:

A detailed history was taken regarding duration and progress of lesion in past and demographic details including family history, age, and sex in a predesigned Performa. A complete dermatological examination was done to assess type of lesion, morphology and distribution was done along with general physical examination. Relevant systemic examination was done and the findings were recorded along with the vital examination of the patients. The affected area was first thoroughly cleaned with 70% alcohol to remove surface contaminants. After the alcohol dried, skin scraping was placed from the border of the active lesion using a microscopic slide, moving the slide perpendicular to the skin surface where another slide was kept along to collect the specimen sample. Specimen was collected on sterile paper.

Samples of the patients were subjected to necessary investigations which include KOH test, culture test.

KOH preparation: The specimen is placed on a clean sterilized glass slide, few drops of 20% KOH are added and then a cover slip is placed over it. The slide was left at room temperature for 24 hours. The specimen is examined under the microscope first under low power (10X) and then under high power (40X) for hyphae and arthrospores.

Culture: All the samples irrespective of KOH results were subjected to culture on Sabouraud dextrose agar (SDA) with chloramphenicol, and Sabouraud dextrose agar with chloramphenicol + cycloheximide. The specimen was inoculated on to this media and it was incubated at room temperature. They were examined every week for growth of colonies and were discarded after 4 weeks if there was no growth.

Clinical assessment: It was performed on the basis of global physician assessment by scoring the severity of pruritus, erythematic, vesicle and desquamation from 0 to 3 (3=severe, 2=moderate, 1=mild, 0=absent).

Diary for safety assessment: It was provided to the patients of all the three groups and patients were explained all the details about diary and trained to fill the diary. Patients were also provided with Patient Information Leaflet (PIL) in the language which was understandable to them.

First Visit

Patients were screened and thus allotted the Group of treatment.

Randomization

Patients were randomly assigned to three groups: Group 1, Group 2 and Group 3 through simple randomization method. All the patients of each group were prescribed same brands of one of terbinafine, fluconazole or itraconazole.

(I) GROUP A (Daily oral terbinafine)

In this group patients were given oral terbinafine (250 mg) daily at morning time after breakfast for 2 weeks.³

(II) GROUP B (Weekly oral fluconazole)

In this group patients were given oral fluconazole (150 mg) once weekly at morning time after breakfast for 4 weeks.³

(III) GROUP C (Daily oral itraconazole)

In this group patients were given oral itraconazole (200mg) once daily at morning time after breakfast for 2 weeks.³

Follow up and Evaluation

Patients were followed at 2nd and 3rd week wherein physical clinical assessment was performed in all their visits.

Statistical Analysis:

Once the data was collected, it coded and entered into Microsoft excel spreadsheet and analyzed. Fisher exact test was used for data analysis. P-value <0.05 was considered significant.

Results:

In the present study 60 patients with tinea corporis were enrolled. The results and observations were as below:

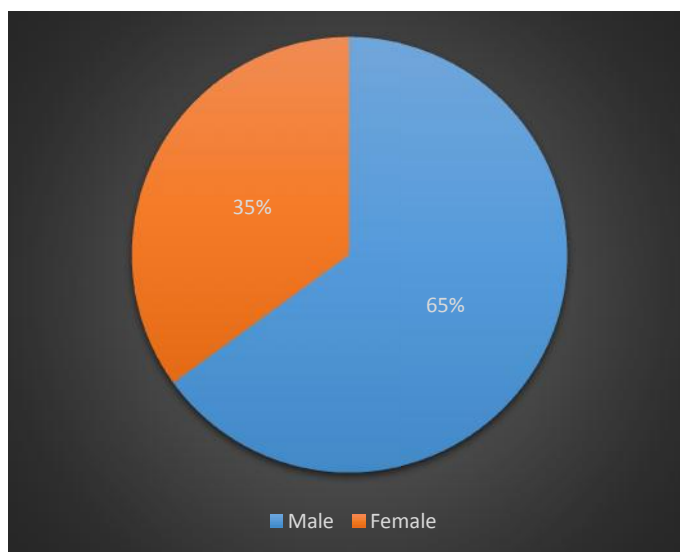


Figure 1: Sex Wise Distribution of patients

Our study showed that the Incidence of tinea corporis was high in males than females with the male to female ratio of 1.8:1.

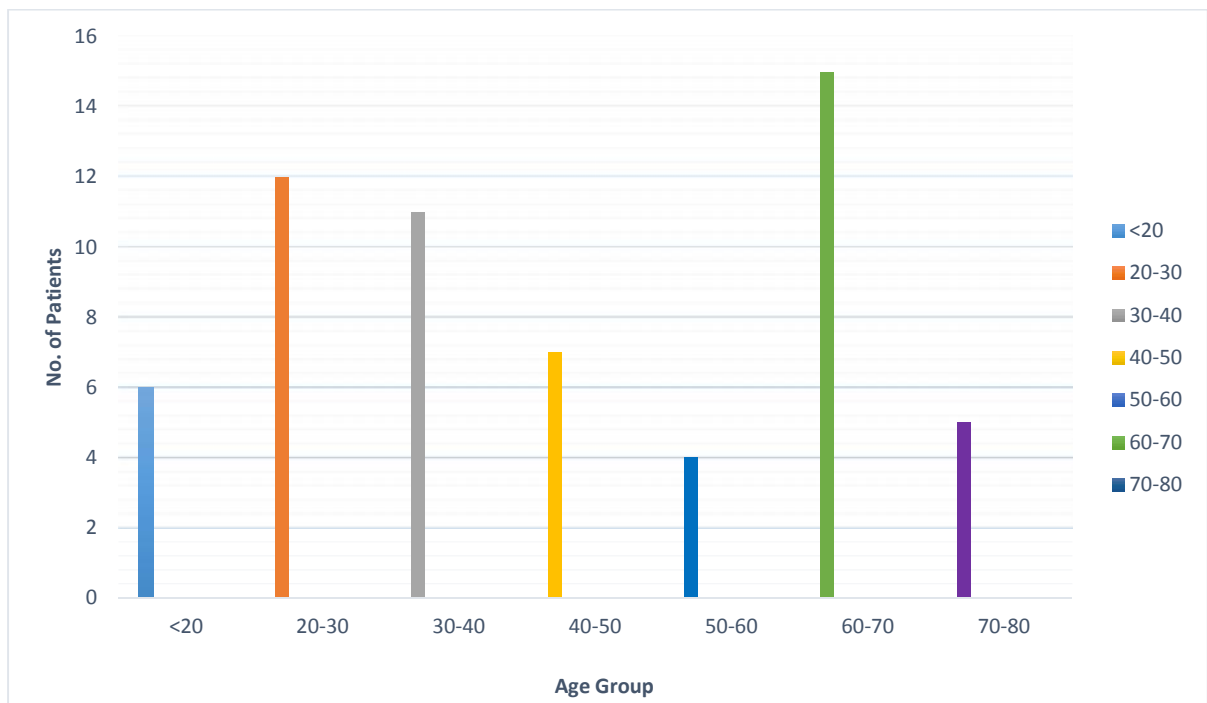


Figure 2: Commonly involved age group in the study

In the study, most common age group with tinea Corporis patients was 60-70 years comprised of 23.33%. The Distribution of other age groups is shown in figure 2.

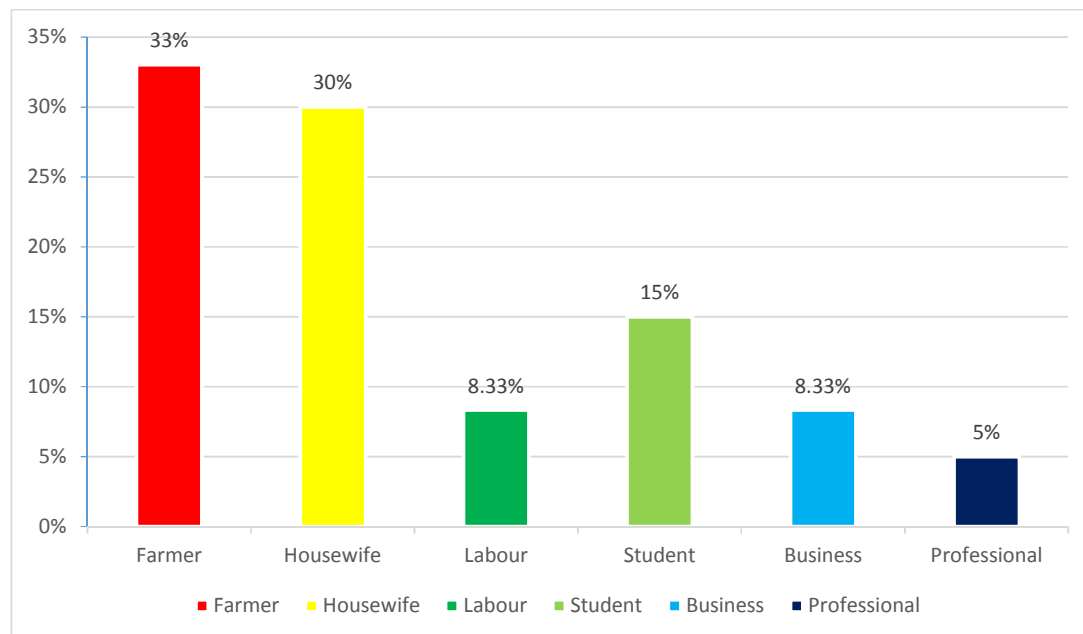


Figure 3: Occupation of the of the patients

In this study most of the patients were farmers (33%) followed by housewives (30%). The occupation of other patients is shown in figure 3.

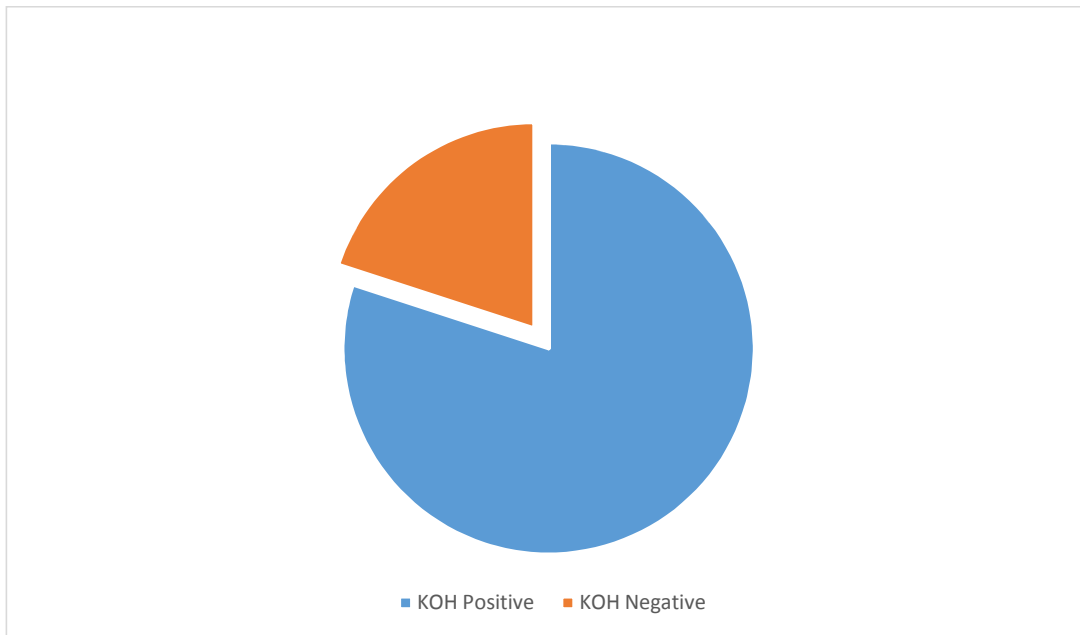


Figure 4: KOH Status of Clinical samples

In this study KOH examination for fungus was positive in 48% of the cases and negative for 52% cases.

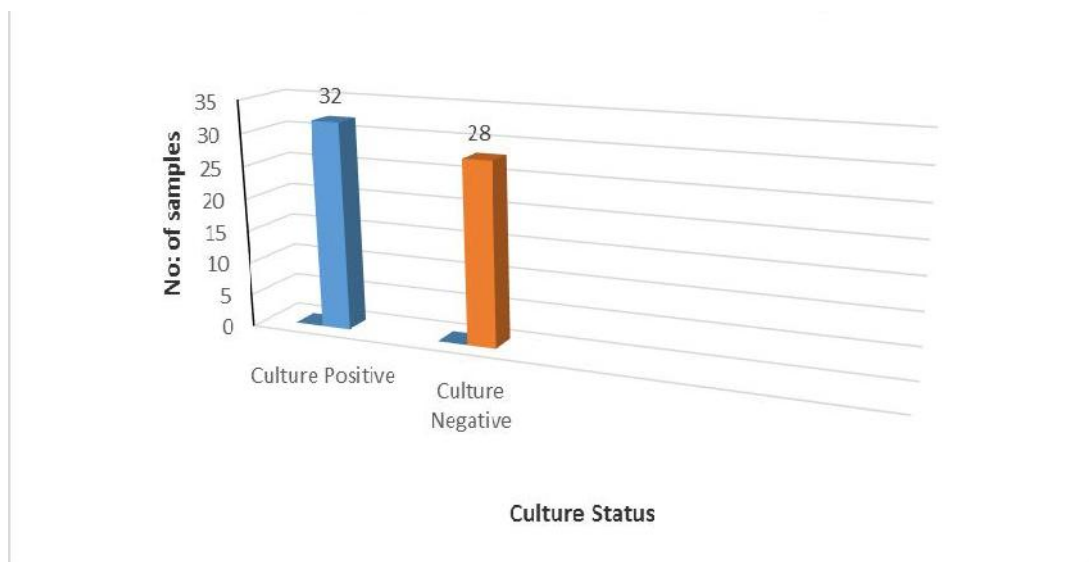


Figure 5: Culture Status of Clinical samples

Culture positivity for fungus in the study was 53.33%.

Out of 60 patients, 51 patients completed the study whereas 9 patients were lost to follow up. In terbinafine group, 5 patients were lost to follow up, whereas in itraconazole and fluconazole groups, 2 patients each were lost to follow up. Among the total 51 patients

enrolled in the study 15 patients were in the group of terbinafine and 18 each in itraconazole and fluconazole groups.

Table 1: Comparison of changes in proportion with pruritus

BASELINE VISIT				
DRUGS	GRADE			TOTAL PATIENTS(n)
	3	4		
FLUCONAZOLE	8 (44.44%)	10 (55.55%)		18
TERBINAFINE	9 (60%)	6 (40%)		15
ITRACONAZOLE	8 (44.44%)	10 (55.55)		18
	p=0.091			

VISIT 2				
DRUGS	GRADE			TOTAL PATIENTS(n)
	2	3	4	
FLUCONAZOLE	3 (16.66%)	12 (66.66)	3 (16.66)	18
TERBINAFINE	8 (53.33%)	7 (46.66%)	0	15
ITRACONAZOLE	4 (22.22%)	13 (72.22%)	1 5.55%)	18
TOTAL	p=0.599			

VISIT 3				
DRUGS	GRADE			TOTAL PATIENTS(n)
	1	2	3	
FLUCONAZOLE	0	9 (50%)	9 (50%)	18
TERBINAFINE	12 (80%)	3 (20%)	0	15
ITRACONAZOLE	4 (22.22%)	9 (50%)	5 (27.77%)	18
TOTAL	16	21	14	51
	p=0.001			

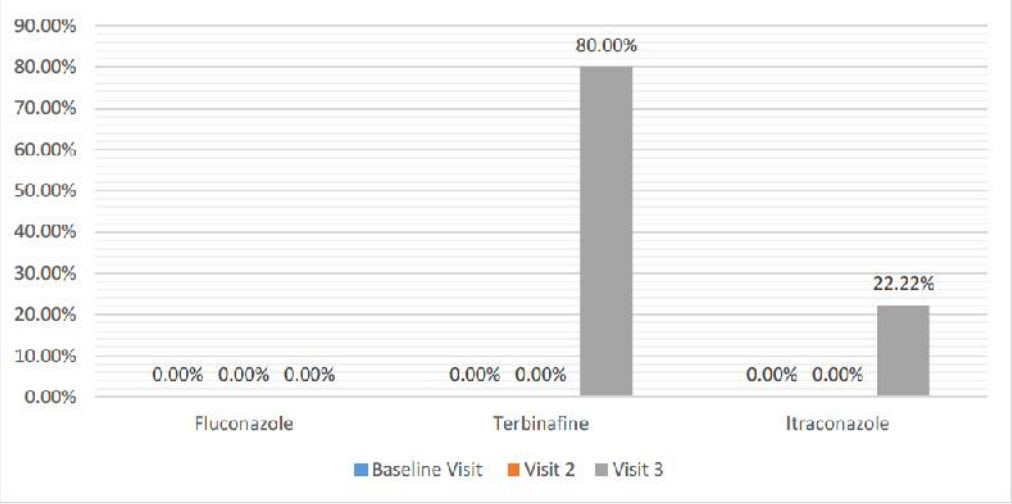


Figure 6: Comparison of changes in proportion with pruritus

Terbinafine was very effective in curing pruritus.

Table 2: Comparison of changes in proportion with erythema

BASELINE VISIT					
DRUGS	GRADE				TOTAL PATIENTS(n)
	1	2	3	4	
FLUCONAZOLE	1 (5.55%)	4 (22.22%)	10(55.55%)	3(16.66%)	18
TERBINAFINE	2(13.33%)	2 (13.33%)	7 (46.66%)	4 (26.22%)	15
ITRACONAZOLE	2(11.11%)	1(5.55%)	12(66.66%)	3(16.66%)	18
	p=0.765				

VISIT 2				
DRUGS	GRADE			TOTAL PATIENTS(n)
	1	2	3	
FLUCONAZOLE	2 (11.11%)	5 (27.7%)	11 (61.11%)	18
TERBINAFINE	4 (26.66%)	6(40%)	5(33.33%)	15
ITRACONAZOLE	2(11.11%)	13(72.22%)	3(16.66%)	18
	p=0.035			

VISIT 3				
DRUGS	GRADE			TOTAL PATIENTS(n)
	1	2	3	
FLUCONAZOLE	8 (44.44%)	8 (44.44%)	4 (22.22%)	18
TERBINAFINE	8 (53.33%)	6 (40%)	1 (6.66%)	15
ITRACONAZOLE	6 (33.33%)	11(61.11%)	1 (5.55%)	18
	p=0.435			

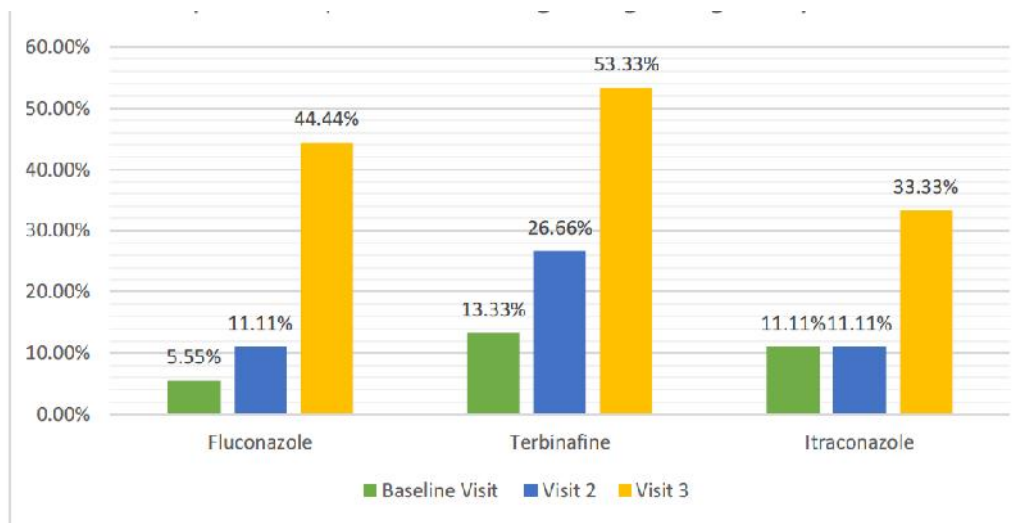


Figure 7: Comparison of changes in proportion with erythema

Terbinafine was effective in curing erythema.

Table 3: Comparison of changes in proportion with vesicles (we have not come across any patients with pustules)

BASELINE VISIT					
DRUGS	GRADE				TOTAL PATIENTS(n)
	1	2	3	4	
FLUCONAZOLE	3 (16.66%)	9(50%)	5(27.77%)	1(5.55%)	18
TERBINAFINE	7(46.66%)	5(33.33%)	3(20%)	0	15
ITRACONAZOLE	2(11.11%)	9(50%)	7(38.88%)	0	18
	p=0.221				

VISIT 2				
DRUGS	GRADE			TOTAL PATIENTS(n)
	1	2	3	
FLUCONAZOLE	8(44.44%)	7(38.88%)	3(16.66%)	18
TERBINAFINE	12(80%)	3(20%)	0	15
ITRACONAZOLE	7(38.88%)	10(55.55%)	1(5.55%)	18
	p=0.075			

VISIT 3			
DRUGS	GRADE		TOTAL PATIENTS(n)
	1	2	
FLUCONAZOLE	13(72.22%)	5(27.77%)	18
TERBINAFINE	15(100%)	0	15
ITRACONAZOLE	14(77.77%)	4(22.22%)	18
	p=0.072		

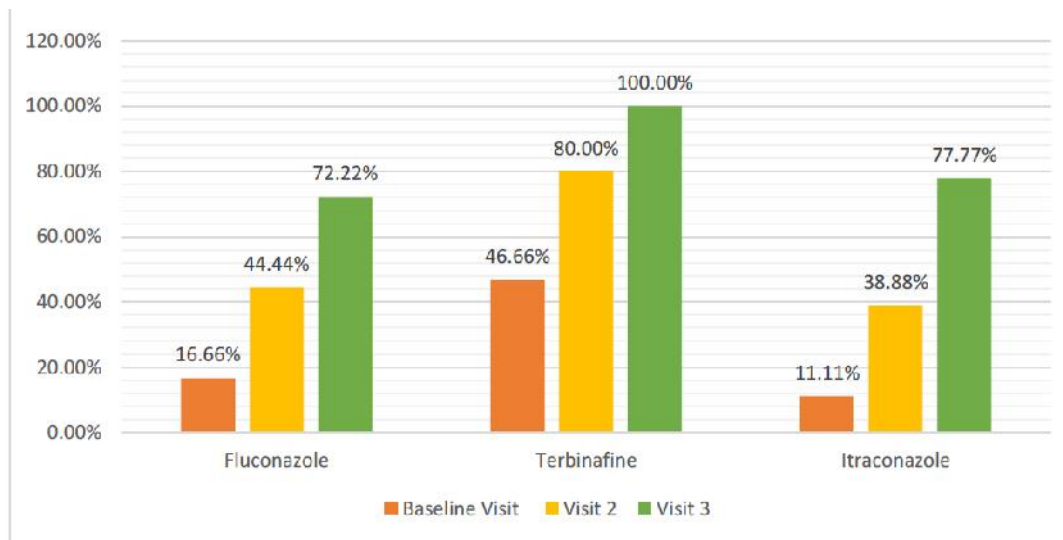


Figure 8: Comparison of changes in proportion with vesicles

Itraconazole was effective in curing vesicle.

Table 4: Comparison of changes in proportion with Desquamation

BASELINE VISIT					
DRUGS	GRADE				TOTAL PATIENTS(n)
	1	2	3	4	
FLUCONAZOLE	1(5.55%)	5(27.77%)	10(55.55%)	2(11.11%)	18
TERBINAFINE	1(6.66%)	3(20%)	11(73.33%)	0	15
ITRACONAZOLE	1(5.55%)	8(44.44%)	8(44.44%)	1(5.55%)	18
	p=0.498				

VISIT 2				
DRUGS	GRADE			TOTAL PATIENTS(n)
	1	2	3	
FLUCONAZOLE	1(5.55%)	15(83.33%)	2(11.11%)	18
TERBINAFINE	4(26.66%)	10(66.66%)	1(6.66%)	15
ITRACONAZOLE	8(44.44%)	8(44.44%)	2(11.11%)	18
	p=0.066			

VISIT 3				
DRUGS	GRADE			TOTAL PATIENTS(n)
	1	2	3	
FLUCONAZOLE	10(55.55%)	6(33.33%)	2(11.11%)	18
TERBINAFINE	13(86.66%)	2(13.33%)	0	15
ITRACONAZOLE	12(66.66%)	6(33.33%)	0	18
	p=0.276			

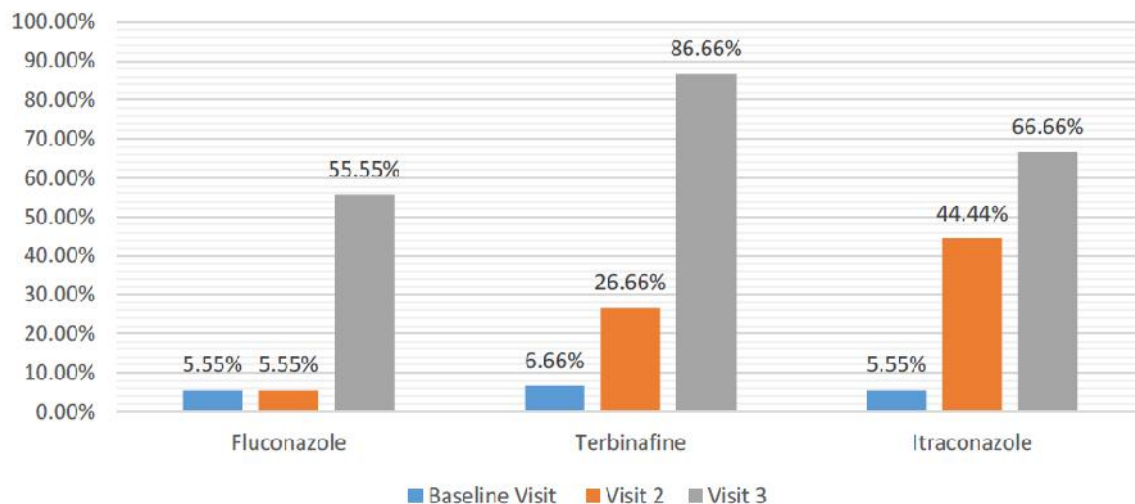


Figure 9: Comparison of changes in proportion with Desquamation

Terbinafine showed effective clinical improvement in G-A from 6.66% in baseline visit to 86.66% in V-3 with overall effectiveness of 80%.

Discussion:

Considering the facts the present study was conducted to know the clinical efficacy of three antifungal drugs i.e., terbinafine, itraconazole and fluconazole with respect to understanding the disease pattern which thereby relates to clinical efficacy of the above drugs.

In the present study males were more affected. Almost two third patients (65%) were males with a male to female ratio of 1.85:1.

There was lesser variation in the male to female ratio among most of the previous studies. In a study conducted by Kumar et al in 2013, male to female ratio was 1.36:1.⁴ In contrast, Bindu et al in 2002, had reported a wide variation in distribution of the disease in both the genders with a male to female ratio 2.06:1.

Overall the previous studies and present study observed male population is commonly greater which may be due to the increased sweating and active workload outdoors.

In this study maximum age group patients belonged to the age 61-70yrs old (25%) with next common age groups from 21-30yrs old (23.33%).

A study by Roopa and Biradar in 2012 encountered maximum number of cases in the age group 31-40yrs (47.27%) followed by 21-30yrs (29.09%). This is in contrast to our study where maximum number of patients was in the age group 61-70yrs. It may be due to the higher incidence of dermatophytes in those patients proportional to the hygienic conditions, amount of sebum production and decreased immunity with old age.³

Occupation distribution among the patients in the study was widely varied with maximum number of patients being farmers (33.33%) followed by housewives (30%) to a lesser extent of students (15%). Overall present study observed farmers being subjected to this disease is on higher incidence which may be due to outdoor activity and excessive sweating to that of housewives because all the female patients were housewives and prevalence may be due to wet conditions or humidity.⁷ In the present study maximum cases were noted from September to November (65%) with peak in the month of November. The higher incidence is during or post rainy days which may be due to humidity or moisture.

In the present study *Trichophyton mentagrophytes* (40.62%) was most common isolate followed by *T. rubrum* (34.37%). Study conducted by Surendran et al from Mysore found that *T. rubrum* was chief isolate organism (55.5%) followed by *T. mentagrophytes* (33.3%). Neetu J et al conducted a study in Jaipur reported *T. rubrum* (22.22%) followed by *T. mentagrophytes* (15.55%) which also relates to other studies conducted in India and other countries. Isolation rate of the distribution of different dermatophytes varies with geographical area and the course of time leading to change in the spectrum of dermatophytic isolates.⁸

Change in pruritus was seen at the end of treatment phase with the comparison on the grades from baseline to visit 3 (V-3). It was noted that there were no patients with grade 1 (G-A 1) at baseline visit and visit 2 (V-2). Whereas in V-3 there were 0% of patients treated with Fluconazole, 80% of patients treated with terbinafine and 22.22% patients treated with itraconazole. Therefore it is significant that terbinafine was very effective in curing pruritus.

At the end of treatment phase the proportion of erythema was effectively cured to G-A from 13.33% in baseline visit to 53.33% in V-3 with effectiveness by 40% in terbinafine group followed by fluconazole 38.89% and itraconazole 20% effectiveness. Thus terbinafine is effective in curing erythema.

At the baseline visit vesicle in the itraconazole group 11.11% of patients were at G-A which was significantly increased to 77.77% with an effectiveness of 66.66% to that of terbinafine group which showed 53.34% and fluconazole 55.6% increase in resolution in G-A. Thus our study showing itraconazole is effective in curing vesicle.

Comparison of effectiveness in G-1 for desquamation terbinafine showed effective clinical improvement in G-A from 6.66% in baseline visit to 86.66% in V-3 with overall effectiveness of 80%.

A study by Deval et al⁹ in 2014 reported that there was no significant difference in between terbinafine (79%) and itraconazole (82%) in terms of clinical cure (>70%).⁹ Furthermore, a study conducted by Arca et al¹⁰ reported a clinical evaluation, where endpoint of the follow-up period, the clinical cure rates were 81.3% (13/16) in the terbinafine group, 77.8% (14/18) in the itraconazole group, and 37.5% (6/16) in the fluconazole group.

Hence the studies show that terbinafine being more effective followed by itraconazole and fluconazole.

What's known: Topical agents may not penetrate well into the keratin barrier, and thus may not provide optimal treatment for dermatophyte infections located within the keratin. A desirable alternative for the treatment of dermatophyte infections is an oral agent with proven efficacy and minimal toxicity.

What's new: Our study correlated the differential grading of pruritus, erythema, vesicle and desquamation. As per our knowledge no direct comparison of terbinafine, itraconazole and fluconazole was studied for tinea corporis with respect to pruritus, erythema, vesicle and desquamation.

Limitations: This study involved small sample size where the study can have a larger sample size if conducted for a longer duration which may also have more number of dermatophyte isolates which may have been studied for the efficacy of the drugs.

Conclusion: The result of this study indicates that terbinafine is better than itraconazole and fluconazole in relieving signs and symptoms during the study period, whereas itraconazole was found effective in relieving vesicle. Fluconazole is seen to be least effective in relieving the symptoms. None of the patients complained any contact dermatitis or adverse reaction to the drug suggesting excellent safety and tolerability of terbinafine, itraconazole and fluconazole.

Recommendations

Comparison of added antifungals agents can be included in further studies for better safety and efficacy of various drugs. Subjects with multiple clinical diagnosis of tinea can be included in further studies. Comparison of oral and topical antifungals can be studied with respect to relapse of the infection.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity.

Ethical approval

Ethical approval for the study was obtained from the KLE University's Ethics Committee. (Ref No: KLEUCOP/337/2015-16)

Acknowledgments

Authors contributed equally in the development of the manuscript.

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Nil.

Conflicts of interest

There are no conflicts of interest.

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Photograph 1: Tinea corporis with irregular border, erythema and desquamation at baseline visit



Photograph 2: Tinea corporis with erythema and desquamation at baseline visit



Photograph 3: Tinea Corporis with reduced erythema and desquamation after 2 weeks of terbinafine therapy



