Rachel is a 33 years old married lady who came to the minor illness clinic describing symptoms of vaginal discharge which she has been experiencing for the past three months. Initially, she noticed a 'yeasty' smell, but more recently she has been concerned about a very thick vaginal discharge and intense itching and inflammation around her labia. She has become increasingly anxious about her symptoms and has requested professional advice. She has not tried any OTC treatments as she was unsure of the diagnosis and felt that it would improve without intervention.

Further information was gathered by taking a more detailed history. This included enquiring about abdominal pain, fever, recent antibiotics, if she was pregnant, if the symptoms changed around her menstrual cycle or if she has experienced any irregular bleeding (Johnson et al, 2006). No additional symptoms were established. Although her symptoms were typical of a candidal infection (Simon et al, 2002), it was necessary to examine her genitalia and take a high vaginal swab (HVS) for microscopy, culture and sensitivity. This was to ensure that she received the correct treatment, as she had not previously experienced a candidia infection before. The possibility that she had a candidal infection and the reason for requiring an examination and HVS were discussed. Rachel agreed and consented to the procedure. She was reassured to hear that many women are affected by yeast infections during their lifetime. (NHS Direct 2006, Bandolier 2005). The door was locked to ensure there were no interruptions and a screen was used around the couch to provide extra privacy. Her internal genitalia were examined using a speculum where a profuse, white, thick discharge was evident in patches around the cervix and on the vaginal walls. A HVS was taken from the lateral vaginal wall and sent for testing. The external genitalia also showed vulval redness and swelling. Following this examination Rachel was diagnosed as having vaginal thrush.

Rachel required an anti-fungal drug to treat the candidal infection, which can either be administered orally or vaginally (Johnson et al 2006). The National Guideline on the Management of Vulvovaginal Candidiasis (2002) indicates that all topical and oral azole therapies give an 80-95% cure rate in acute vulvo-vaginal candidiasis in non-pregnant women. The choice of treatment was offered to Rachel and she requested the pessary. A stat dose of clotrimazole 500mg was prescribed in a pessary form and she was advised to insert it into her vagina at night (Appendix1). A prescription was provided as the cost was slightly less than buying it OTC. She was also advised to buy some miconazole/hydrocortisone ointment OTC for the external inflammation and itching. This would be cheaper for her to buy from the pharmacy than to pay prescription charges. Watson et al (2000) compared the effectiveness between oral and intra-vaginal anti-fungal treatment of uncomplicated vulvovaginal candidiasis and found no differences. They recommend that the decision should consider: safety, cost and treatment preference. These issues were considered when prescribing treatment for Rachel.

Rachel was given some general advice, which included avoiding local irritants such as perfumed soaps and tight fitting synthetic clothing such as tights and cotton pants. She was concerned that the infection may be sexually transmitted so vaginal thrush was

explained and discussed. Vaginal thrush is a yeast infection caused by one or more species of candida, which are often present in the vagina. The growth of candida is normally kept under control by the presence of normal bacteria and the immune system. Symptoms usually occur when the immune system is compromised or the normal bacteria are destroyed, causing candida in the vagina to multiply (NHS Direct, 2006). It was also explained that as her husband was asymptomatic it would not be necessary to treat him. The National Guideline on the Management of Vulvovaginal Candidiasis (2002) found no evidence to support treatment of sexual partners if they have no symptoms. Rachel was advised that her symptoms should resolve within a week and if they did not then she should return for a follow up appointment.

In order to evaluate this case study effectively it was necessary to make telephone contact with Rachel, as she did not return for an appointment. She was contacted two weeks after the initial appointment and reported that the treatment had worked successfully within a few days and she had been free from symptoms since. She made reference to the miconazole/hydrocortisone ointment as she found it beneficial for alleviating the external inflammation and itching. However, she did ask advice about vaginal thrush which indicated that she did not retain much of the information discussed during her appointment. Verbal advice was provided about the reoccurrence of thrush and methods to help prevent it from reoccurring. Bandolier (2005) suggest that 1 in 10 women who experience thrush can go on to develop recurrent candidiasis. Rachel was also reminded about preventative methods such as: washing the vagina with water only and avoiding perfumed soaps, vaginal deodorants or douching, changing tampons frequently, wearing cotton underwear and avoiding tights.

This situation has highlighted that patients would benefit from having written information to take home with them. As a result patients are now offered a current evidence-based information leaflet by the Department of Health (Prodigy 2006), which are easily available from the computer system in the clinical rooms (Appendix 2). This will provide the patient with relevant up-to-date advice, which can be taken away and used for future reference.

On reflection, the consultation and outcome were successful. Rachel stated that initially she felt embarrassed by her symptoms but was made to feel comfortable knowing that she had privacy during the examination. She was also reassured to hear that she had a common problem that was easily managed. Chapple et al (2000) emphasize the importance of reassuring women that thrush is a common problem, which is often easily treated. They also identify the significance of informing women how to prevent thrush and the therapies available to them. Watson et al (2000) recognize the advantage of immediate treatment and symptom relief to the patient, by having the opportunity to buy necessary medicines from a pharmacy. The diagnosis of vaginal thrush was confirmed by microbiological diagnosis. This may have been useful if the treatment had not been effective and appropriate medication could have been used to treat Rachel. Pulse (2005) identifies that a pH measurement of vaginal secretions may help differentiate between vaginal thrush and bacterial vaginosis. This is a good suggestion as bacterial vaginosis is often a cause of vaginal discharge although it has very different symptoms to thrush.

The follow-up method highlighted areas for improvement. The current method relied greatly on the patients' ability to assess their own health and return if necessary, which some patients find difficult. It has been identified that the review method should be based on patient individuality and ability and confirmed at the initial appointment. A telephone consultation would be beneficial for some, whereas a face-to-face appointment would be the most appropriate option for others. It was extremely beneficial to evaluate and reflect upon the consultation and the telephone interview with Rachel as the outcome may not have been known.

Vaginal thrush is an embarrassing and uncomfortable problem for the majority of women who experience it. By providing patients with the correct treatment and an information leaflet they would have a great advantage to help resolve the infection promptly and take steps to help prevent it from re-occurring in the future.

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