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Fluconazole for Thrush

Nystatin suspension availability has been spotty over the past few years. Its four times daily dosing and unpleasant taste also prevent it from winning popularity contests. Still, it's been the go-to drug for treating oral fungal (thrush) infections from *Candida* species (primarily *C. Albicans)* for years. Another antifungal, fluconazole, is an alternative worth considering. It is available as a 50 mg tablet and is dosed once daily for 7 – 14 days.

A fluconazole 10 mg/ml suspension is also available. It offers greater dosing flexibility and, potentially, improved efficacy. A review of 24 studies on oral candidiasis treatment published ten years ago in *J Clin Exp Dentistry* is still relevant today. Fluconazole in suspension form is preferred to tablets, as the liquid adheres well to the oral mucosa. The adhesive nature, combined with fluconazole's more pleasant taste relative to nystatin, translates to improved compliance and efficacy. Two dosage regimens are recommended: 5 ml (50 mg) p.o. daily for 7 to 14 days OR 5 ml of a diluted suspension (2 mg/ml) swished and swallowed three times daily for 10 days. The second regimen may be more advantageous, due to its prolonged oral contact time. Also, the lower total fluconazole dose reduces the likelihood of drug interactions.

Risk of thrush is elevated in the elderly. Weak immune systems, drying anticholinergic medications, poor oral hygiene, and dentures are primary contributors. Proper cleaning of the teeth, buccal cavity, tongue, and dentures must be included in both the treatment plan and day-to-day care. Dentures should be removed at night and soaked in chlorhexidine to kill any lingering fungus.

See Clearly and Sleep Peacefully with Melatonin

Benzodiazepines are a nuisance. They confuse and cause falls. Since they are Controlled Drugs, storage, administration, and tracking make them labour-intensive to work with. Adverse effects, ministry scrutiny, and excessive documentation have chipped away at their use. For these reasons, the popularity of melatonin as a sleeping aid has been increasing.

A recent review suggests melatonin may have another benefit: reduced risk of age-related macular degeneration (AMD). The macula is the vision center of the retina. A retrospective review published last year in *JAMA Ophthalmol.* found those aged 50 to 80 with a history of melatonin use were far less likely (65% risk reduction in the 70+ group) to develop AMD than melatonin-naïve individuals.

Don't Fall with Gabapentin

If gabapentin and duloxetine squared off in a "least falls" contest, who would be the winner? The answer – gabapentin! That's not what I would have guessed.

This was a retrospective study, but the number of subjects was substantial (57K) and it was relevant (all were 65+) to our population. These drugs were newly prescribed to treat postherpetic neuralgia, diabetic neuropathy, or fibromyalgia. Some of these patients had serious falls requiring hospital visits. Histories were reviewed for potential drug involvement. Were duloxetine or gabapentin initiated within the past 30, 90, or 180 days? At each time interval, there were twice as many fall-related hospital visits with duloxetine compared to gabapentin.

Most would guess the more sedating gabapentin would lose this contest. Gabapentin doses start low and increase slowly, while duloxetine starts at 30 mg and goes straight to 60. Perhaps slow and steady wins the race.

Prepared by Randy Goodman
Certified Geriatric Pharmacist