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REPLY

We thank Dr Jean-Nicolas Cornu and colleagues[1] for their comments regarding our article entitled "Factors influencing the incidence and remission of urinary incontinence after hysterectomy"[2] published in the *American Journal of Obstetrics and Gynecology*.

Our study showed that hysterectomy clearly influenced urinary incontinence (UI), as one fifth of the women experienced a change in their continence status post-hysterectomy. Vaginal delivery, obesity, and daily urge symptoms without incontinence prior to surgery increased de novo UI and had a negative influence on the rate of remission of UI after hysterectomy, which in turn influenced patients' satisfaction with surgery. De novo UI is a negative consequence of hysterectomy and remission of UI can be seen to be a positive development. Both are of importance when counselling patients contemplating a hysterectomy.

The study focused on the presence of UI and not the type of UI. We are well aware of the differences between types of incontinence and in this respect there was no "confusion" on our part. For our patients the occurrence of urinary leakage irrespective of whether it is of stress urinary type or of urge type is a highly disturbing issue.

Both stress UI and urge UI are common in women, however the relative proportions of these 2 types of incontinence do vary with age.[3] The prime aim of our study was to describe the incidence and remission of UI in women undergoing hysterectomy. In addition we studied possible factors influencing the incidence and remission rates of UI. One of the factors included in the logistic regression was the experience of daily urinary urge prior to hysterectomy in women without incontinence. Dr Cornu and colleagues correctly pointed out this could also have been expressed as overactive bladder without UI prior to surgery. Our study indicated that these women had a greater risk of incontinence following surgery, which is important knowledge for doctors and patients when considering a hysterectomy.

It would have been of interest to know to what extent antimuscarinic medication was being used but this information was not available in the data base.

In conclusion, because we analyzed UI alone without separation into stress UI or urge UI, we do not consider the analyses "blurred," as our specific aim was to study the influence of hysterectomy on the incidence and remission of UI, which was clearly presented. ■

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Comment on treatment for recurrent vulvovaginal candidiasis

TO THE EDITORS: With great interest we read the article "Recurrent vulvovaginal candidiasis" of Jack D. Sobel.[1] The author presents oral and topical treatment strategies for recurrent vulvovaginal candidiasis. Therapy with oral fluconazole starts with an initial "induction therapy" and is followed by a maintenance phase, wherein the drug is given at certain intervals.[2,3]

Although a systematic review confirms the advantage of the use of weekly fluconazole for 6 months,[2] we missed the emphasis on the advantages of another, more individualized and patient-centered regimen that is common in Europe.[3] In this regimen, the total dose of fluconazole is more individualized to the outcomes ("ReCiDiF" regimen).[3]