

Commentary

Recurrent Vulvovaginitis and Immune System (RVVC)

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DESCRIPTION

The recurrent vulvovaginitis candidiasis (RVVC) is determined by symptoms of itching, burning and viscous mucus secretion and white with the appearance of fissures, vulvar redness and folliculitis satellites the femoral region extremely bother and appear for more than three semi-annual or episodes over six episodes per year. The diagnostic identification is by means of clinical symptoms and swab and culture required by the Obstetrician and Gynecologists. Patients who have such diagnosis has a significant loss of quality of life social (social retraction) and sexual (pain when intercourse). Still, sets up as a gateway to other more pathogenic bacteria commonly increasing the level of emotional stress and revealing a reduction or failure of the cellular immune system. Currently, the main form of treatment are antifungal medications, gynaecological care, treatment of partner sites and use of appropriate symptomatic or change lingerie, but anything do you work in the immune pathophysiology. In this way, through the recognition of local cell deficiency for candida, therapeutic success obtained and in preventing new occurrences, having a full satisfaction of the patients who opted for bi-monthly administration of betaglucana+ betaglucoronidase associated with the OID (oidiomicina), subcutaneously, repeated 8 times. After and, if necessary, carry out a dose every six months, four times for long-term clinical remission. In total cases the outcomes were success. Immunological aspects & discussions: The immune defense against candida sp. is, primarily, if not entirely, by cellular. Many women have antibodies against candida, but these do not offer protection and many women with defects on average by immunity cells have high prevalence of candida vaginitis. Recent evidence

indicates that the morphogenesis of Candida albicans could also be under the regulation of the natural immune system: PGE-2, a product of the macrophages showed stimulate the formation of hyphae from spores of C albicans, while the IFN-gamma, a product of T lymphocytes, has been shown to inhibit the formation of hyphae from C albicans, even in the presence of PGE-2. The betaendorphin is a neuropeptide produced by the anterior pituitary gland, especially under conditions of stress and physical exercises. Recent evidence suggests that beta-endorphin may also act as an immunomodulator. Both T lymphocytes as macrophages have membrane receptors for beta-endorphins. The beta-endorphin and the macrophage induce the production of PGE-2 and inhibit the synthesis of IFN-gamma. Due to incidence of candida vaginitis be more common in the luteal phase, just before menstruation, was examined on the cellular immune response against candida during each week of the menstrual cycle and the ability in each phase to induce germination of spores of Candida studies show that during the luteal phase, progesterone levels (25 ng/ml) inhibited the proliferation of Candida-induced lymphocytes in more than 50% of women, compared with women of lower progesterone levels (0.15 ng/ml) and that kept the proliferation of lymphocytes. Estrogen levels not promoted inhibition of Candida-induced lymphocytes or in luteal phase or in the proliferative phase of the menstrual cycle as well, women with high levels of progesterone in which macrophages present high sensitivity to immunosuppression induced by this hormone, may have greater susceptibility to candida vaginitis of repetition.

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