

## CANDIDEMIA

Yeast isolated in the blood should not be considered a contaminant.  
Formal ID consultation is required at Jefferson Highway for all patients with candidemia and has been associated with reduced morbidity and mortality.

Patients with candidemia should have the following completed:

- ❖ Determine the primary and any potential secondary foci of infection
- ❖ Eliminate or debride the foci of infection as early as possible
- ❖ Remove all intravascular catheters, if possible
- ❖ Draw repeat blood cultures every 48 hours until clearance of candidemia is documented
- ❖ Obtain a ophthalmologic exam to rule out endophthalmitis before discharge
- ❖ Duration of therapy:
  - » No evidence of metastatic complications: 2 weeks from first negative blood culture
  - » Patients with metastatic complications (e.g. endophthalmitis, endocarditis): obtain an ID consultation to determine the length of therapy

EMPIRIC THERAPY
<ul style="list-style-type: none"> <li>❖ Empiric antifungal coverage (x 72-96 hours) may be considered while awaiting cultures for patients with at least 3 of the following risk factors:               <ul style="list-style-type: none"> <li>» Indwelling central catheters</li> <li>» Receiving parenteral nutrition (TPN)</li> <li>» Recent surgery involving the GI tract or abdominal cavity</li> <li>» Neutropenia</li> <li>» Use of broad spectrum antimicrobials for &gt;96 hours with continued hemodynamic instability</li> <li>» Use of immunosuppressive agents</li> <li>» Colonized with <i>Candida</i> spp. at multiple non-sterile sites</li> </ul> </li> <li>❖ First line               <ul style="list-style-type: none"> <li>» Critically-ill patients: Micafungin 100mg IV q24h</li> <li>» Prolonged azole exposure in the last 90 days: Micafungin 100mg IV q24h</li> <li>» Fluconazole 800mg IV/PO x 1 dose, then 400mg q24h</li> </ul> </li> </ul>

DEFINITIVE THERAPY		
Species	First line	Alternative therapy (if susceptible)
<i>Candida albicans</i> <i>Candida dubliniensis</i> <i>Candida tropicalis</i> <i>Candida lusitanae</i> <i>Candida parapsilosis</i> <i>Candida guilliermondii</i>	Fluconazole 400mg (6mg/kg) IV/PO q24h <sup>a</sup>  If hemodynamically unstable, may consider Micafungin 100mg IV q24h	Micafungin 100mg IV q24h ( <i>C. parapsilosis</i> and <i>C. guilliermondii</i> may be less susceptible)  Liposomal amphotericin 3mg/kg IV q24h ( <i>C. lusitanae</i> considered resistant)
<i>Candida glabrata</i>	Micafungin 100mg IV q24h  If fluconazole susceptible: Fluconazole 800mg (12mg/kg) IV/PO q24h <sup>a</sup>	Voriconazole 6mg/kg IV/PO q12hx 2 doses, then 4mg/kg IV/PO q12h  Liposomal amphotericin 3mg/kg IV q24h
<i>Candida krusei</i>	Voriconazole 6mg/kg IV/PO q12h x 2 doses, then 4mg/kg IV/PO q12h  Micafungin 100mg IV q24h	Liposomal amphotericin 3mg/kg IV q24h

<sup>a</sup> Higher doses may be required for obese patients.

### References

1. Pappas PG, Kauffman CA, Andes D, et al. Clinical practice guidelines for the management of candidiasis: 2016 update by the Infectious Diseases Society of America. *Clin Infect Dis* 2016; 62: e1-50.
2. Garnacho-Montero J, Diaz-Martín A, García-Cabrera E, et al. Risk factors for fluconazole-resistant candidemia. *Antimicrob Agents Chemother*. 2010 Aug;54(8):3149-54.
3. Wenzel RP. Nosocomial candidemia: risk factors and attributable mortality. *Clin Infect Dis*. 1995 Jun;20(6):1531-4.
4. Safdar N, Slattey WR, Knasinski V, et al. Predictors and outcomes of candiduria in renal transplant recipients. *Clin Infect Dis*. 2005 May 15;40(10):1413-21.
5. Rex JH, Bennett JE, Sugar AM, et al. A randomized trial comparing fluconazole with amphotericin B for the treatment of candidemia in patients without neutropenia. Candidemia Study Group and the National Institute. *N Engl J Med* 1994; 331:1325-30.