

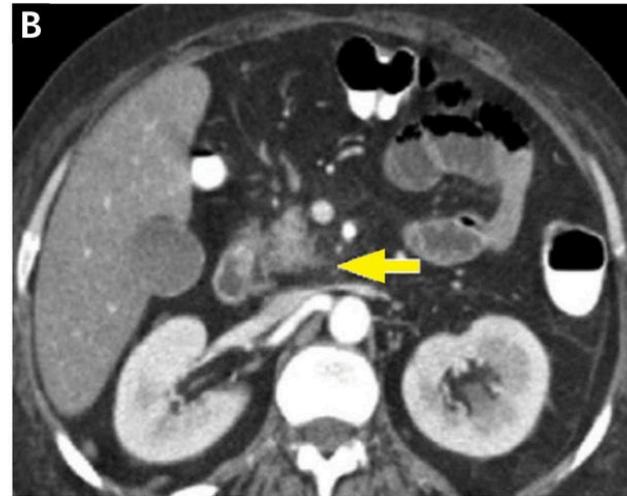
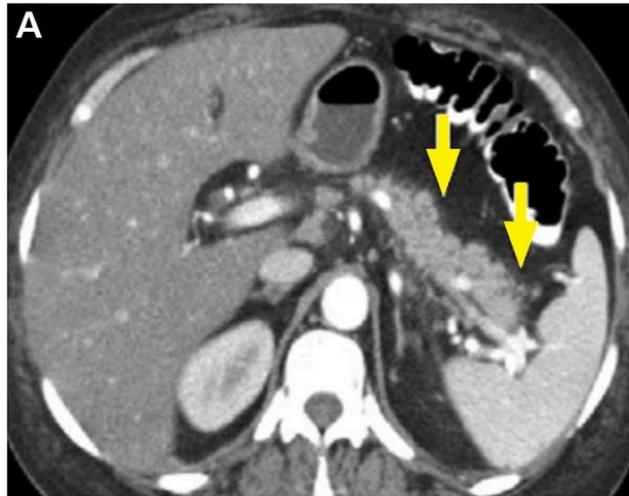
# *Candida auris* – two cases

Lucy S. Witt MD, MPH, MSc



# Case 1

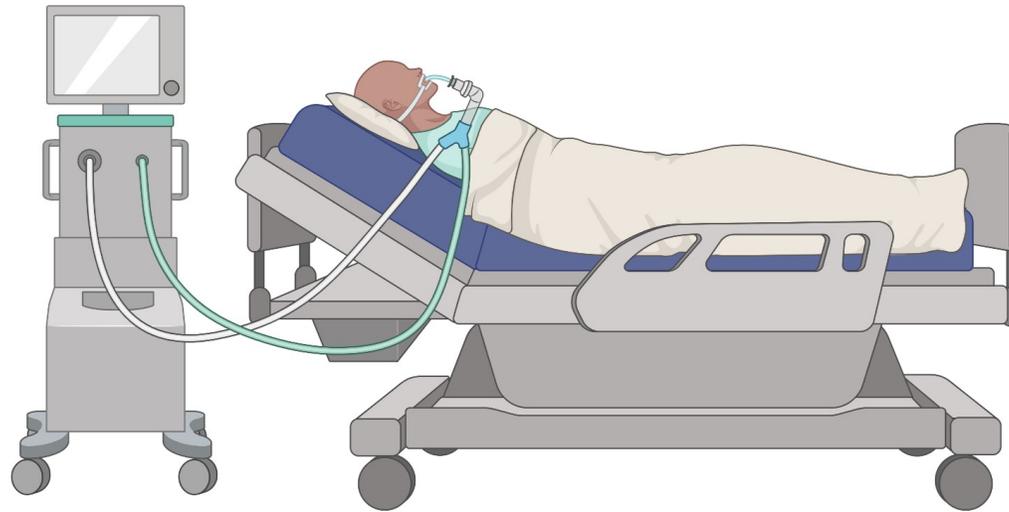
- 39M with past medical history of pancreatitis is admitted for a pancreatitis flare. He develops necrotizing pancreatitis with multiple abdominal abscesses



Tiffany Y. Chua et al. CCJM 2017;84:639-648

# Case 1

His hospital course is complicated by shock, respiratory failure, and kidney failure requiring continuous renal replacement therapy



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# Case 1

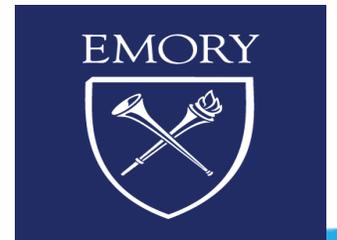
- He develops ESBL *E. coli* bacteremia followed by *Candida parapsilosis* fungemia and completes appropriate antimicrobial treatment for both these infections
- Interventional radiology is able to place drains in his abdominal abscesses

# Case 1



<https://www.capspharmacy.com/en/products-and-services/parenteral-nutrition.html>

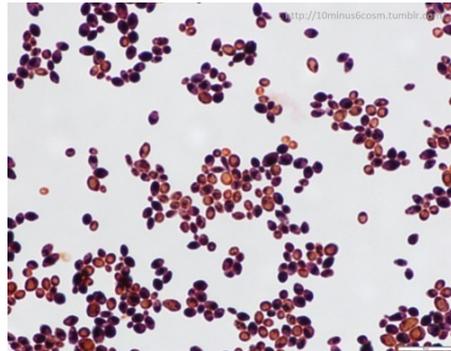
Due to his abdominal infections, he requires total parenteral nutrition (TPN) via a PICC line for nutrition throughout his hospitalization



# Case 1

- On day of planned discharge, the patient develops a new fever
- Blood cultures are collected and quickly turn positive

The initial gram stain shows yeast



Which is  
identified as  
*Candida auris*

# Case 1

## Antifungal susceptibility testing

Antifungal	MIC ( $\mu\text{g/mL}$ )
Amphotericin B	1
Echinocandin	0.12
Fluconazole	>256

# Case 1

- Infection prevention is notified, and he is placed in isolation with contact precautions



- Upon chart review, the infection preventionist notes that one of the **rooms** this patient had occupied had previously contained another patient with *C. auris* colonization.

# Case 1

- The patient received IV echinocandin treatment and cleared his fungemia within 48 hours.
- He completed four weeks of antifungal therapy and has not had a recurrent infection