MSH + UHN ASP ANTIMICROBIAL STEWARDSHIP PROGRAM

Candidemia (Yeast)

EMPIRIC CHOICE

In non-neutropenic patients: fluconazole 800 mg IV/PO once daily
- If recent azole use or hemodynamically unstable, consider using an echinocandin

In neutropenic patients: amphotericin B liposomal 3 mg/kg IV once daily or an echinocandin

DURATION

Repeat blood cultures to be drawn at 48 hours after first cultures, and then at day 3 and day 7 after 1st dose of antifungal therapy

Treat for at least 2 weeks from first negative blood culture UNLESS:
- Ongoing symptoms attributable to candidemia or evidence of metastatic complications (e.g., candida retinitis)

TOP FIVE ORGANISMS

C. albicans
C. glabrata
C. parapsilosis
C. tropicalis
C. krusei

CURRENT RESISTANCE ISSUES

Echinocandins are NOT recommended for treatment of *C. parapsilosis* due to higher MIC's

C. glabrata should be empirically treated with echinocandin pending susceptibilities

IMMUNOCOMPROMISED HOST CONSIDERATION

Amphotericin B liposomal 3 mg/kg IV once daily

Fluconazole if less critically ill and no recent azole exposure

Duration: 2 weeks after resolution of neutropenia and last positive blood culture (and resolution of signs and symptoms of infection)

Febrile patient with hematologic malignancy recovering from neutropenia at risk for hepato-splenic (chronic disseminated) candidiasis - a different treatment strategy is required

Elevated liver enzymes within the first week of therapy is unlikely due to fluconazole-associated toxicity

ADDITIONAL DIAGNOSTIC AND THERAPEUTIC COMMENTS

ID consultation is strongly recommended (ID is notified of blood cultures growing Candida at most institutions)

Remove all intravascular devices, replace at different site if possible

Ophthalmology assessment required to rule out ophthalmic disease within 1 week of therapy (or after count recovery in neutropenic patient)

REFERENCES

1. Pappas et al. 2009. Candidiasis. Clin Inf Dis 48:503
2. Disseminated candidemia. 2013. Sanford Guide. Antimicrobial Therapy, Inc. Sperryville, VA.