Candidemia

Common Pathogens

- C. albicans
- C. tropicalis
- C. parapsilosis
- C. glabrata
- C. Iusitaniae
- C. krusei

Empiric Therapy

PO/IV Fluconazole 800 mg loading dose, then 400 mg q24h

Alternative therapy:

IV Caspofungin_(R) 70 mg loading dose, then 50 mg q24h

If high risk for non-albicans candida (i.e. neutropenic, critically III, non-neutropenic on azole prophylaxis)

IV Caspofungin (R) 70 mg loading dose, then 50 mg q24h

Alternative therapy:

IV Liposomal Amphotericin_(R) B 3 – 5 mg/kg q24h

Pathogen-Directed Therapy

C. albicans

C. tropicalis

PO/IV Fluconazole 400 mg q24h

C. parapsilosis C. lusitaniae

C. krusei IV Caspofungin(R) 50 mg q24h

IV Caspofungin_(R) 50 mg q24h

If fluconazole sensitive:

C. glabrata

PO/IV Fluconazole 400 mg q24h

If dose-dependent fluconazole-sensitive:

PO/IV Fluconazole 800 mg q24h

Usual Duration of Therapy

14 days after first negative repeat blood cultures and resolution of candidemia-attributed symptoms Longer if evidence of metastatic complications (e.g. candida retinitis, endophthalmitis)

Clinical Considerations

- Ø Repeat blood cultures every 48 hours until clearance achieved
- All patients should have an ophthalmology assessment within 1 week of diagnosis to look for evidence of endophthalmitis
- Ø Remove all intravascular devices (e.g. central intravenous catheters) if possible; replace only if necessary
- © Echinocandins have poor CNS, GU and ocular penetration; where candidemia involves these organ systems, an Infectious Disease consultation is strongly suggested

(R) – This antimicrobial agent is restricted; Refer to Osler's antimicrobial restriction policies for more information



The information contained in these pages is intended for use by William Osler Health System staff. Clinical recommendations serve to guide therapeutic decision making, and should be used in conjunction with clinical assessment. Clinical content found in these documents have been reviewed & approved by the Antimicrobial Subcommittee.