# Candidemia

## Common Pathogens

*C. albicans*
*C. tropicalis*
*C. parapsilosis*
*C. glabrata*
*C. lusitaniae*
*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 Ill, 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

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|---|---|
| *C. albicans*<br>*C. tropicalis*<br>*C. parapsilosis*<br>*C. lusitaniae* | **PO/IV** Fluconazole 400 mg q24h |
| *C. krusei* | **IV** Caspofungin(R) 50 mg q24h |
| *C. glabrata* | **IV** Caspofungin(R) 50 mg q24h<br>*If fluconazole sensitive:*<br>**PO/IV** Fluconazole 400 mg q24h<br>*If dose-dependent fluconazole-sensitive:*<br>**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

- 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
- 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