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Candida auris  
2018 Case Definition  
Candida auris  
2018 Case Definition  
NOTE:  
A surveillance case definition is a set of uniform criteria used to define a disease for public health surveillance. Surveillance case definitions enable public health officials to classify and count cases consistently across reporting jurisdictions. Surveillance case definitions are not intended to be used by healthcare providers for making a clinical diagnosis or determining how to meet an individual patient’s health needs.  
CSTE Position Statement(s)  
17-ID-03  
Subtype(s)  
Candida auris  
, clinical  
Candida auris  
, screening/surveillance  
Background  
Candida auris  
is an emerging multidrug-resistant (MDR) yeast that can cause invasive infections and is associated with high mortality.  
C. auris  
strains have been found to have elevated minimum inhibitory concentrations (MICs) to one of more of the three major classes of antifungals, with some resistant to all three classes, severely limiting treatment options. It can spread from patient to patient within healthcare settings and cause outbreaks, much like methicillin-resistant  
Staphylococcus aureus  
and multidrug-resistant  
Acinetobacter  
.  
C. auris  
requires specialized methods for identification and can be misidentified as other yeast (especially  
Candida haemulonii  
) by some testing methods (see CSTE position statement 17-ID-03, Appendix 1)  
1  
. Unlike  
C. auris  
, strains of  
C. haemulonii  
are typically unable to grow above 37°C; therefore,  
C. auris  
should be suspected when  
C. haemulonii  
is identified on culture of invasive body sites (e.g., blood) unless the method used can reliably detect  
C. auris  
.  
Known risk factors for  
C. auris  
infection are similar to those for invasive  
Candida  
infection in general, including central venous catheter use, recent surgery, diabetes, and recent broad-spectrum antibiotic or antifungal use. In the United States,  
C. auris  
has been observed predominantly among patients with extensive exposure to nursing homes and short-term and long-term acute care hospitals, and among patients who have invasive lines and tubes such as tracheostomy and gastrostomy tubes, Foley catheters, and central venous catheters. Patients who have received healthcare abroad, especially in  
countries with known  
C. auris  
transmission  
, may also be at risk for  
C. auris  
.  
C. auris  
is known to cause bloodstream infections, wound infections, and otitis, although it has also been cultured from bile, urine and the respiratory tract, which may involve colonization or infection.  
Clinical Description  
Clinical manifestation of  
C. auris  
infection depends upon the site of infection. Patients with  
C. auris  
bloodstream infection typically have sepsis and severe illness. Other invasive infections, such as intraabdominal candidiasis, and meningitis can also occur.  
C. auris  
has also been found to cause wound infections and otitis, and has been cultured from urine and respiratory specimens.  
C. auris  
has also been found to colonize the skin of asymptomatic people.  
Laboratory Criteria For Diagnosis  
Confirmatory laboratory evidence:  
Culture of  
C. auris  
from any body site, including blood, wound, skin, ear, urine, rectum, respiratory secretions, or other body fluids.  
Supportive laboratory evidence:  
Detection of  
C. haemulonii  
from urine, respiratory tract, or normally sterile site (e.g., blood) by a laboratory instrument not equipped to detect  
C. auris  
(i.e., not MALDI-TOF or ribosomal DNA sequencing as of February 2017) and isolate is not available for further testing. See the 2017 CSTE Position Statement, Appendix 1, for further details of performance characteristics of laboratory diagnostic tests.  
1  
C. auris  
cases should be stratified by  
blood  
versus  
non-blood clinical isolates  
.  
Epidemiologic Linkage  
Isolate from a person who is within same household, same healthcare facility, or in a healthcare facility that commonly shares patients with a facility, with another person with confirmatory laboratory evidence.  
Criteria to Distinguish a New Case from an Existing Case  
Count a clinical case only once even if a patient has a new event in the future (i.e., a new clinical isolate from a patient reported as a previous case would not be counted again). If a person previously had a suspect case, he or she may subsequently be counted as having a probable or confirmed case; the suspect case would be deleted. Similarly, if a person previously had a probable case, he or she may subsequently be counted as having a confirmed case; the probable case would be deleted.  
For colonization (screening/surveillance culture), count patient only once regardless of the interval between testing (assumes patient is always colonized).  
A person with a screening/surveillance case can later be categorized as having a clinical case (e.g., asymptomatic person with skin colonization who later develops invasive infection would be counted in both categories).  
A patient with a clinical case should not be counted as having a screening case thereafter (e.g., a patient with a known infection who later has skin colonization is not counted as having more than one case).  
Subtype(s) Case Definition  
Expand All  
Candida auris  
, clinical  
Case Classification  
Suspected  
Person with supportive laboratory evidence and no evidence of epidemiologic linkage.  
Probable  
Person with supportive laboratory evidence and evidence of epidemiologic linkage.  
Confirmed  
Person with confirmatory laboratory evidence. Specimen was collected for the purposes of diagnosing or treating disease in the normal course of care. This includes cultures of body sites reflecting invasive infection (e.g., blood, cerebrospinal fluid). Culture of wounds, urine, central venous catheter tips, and the respiratory tract would be classified as clinical cases unless the laboratory report indicates that the culture was performed as part of screening or surveillance and not in the normal course of care. Specimen source is  
NOT  
a screening/surveillance swab, such as skin (e.g., axilla, groin), external ear canal, nares, rectum, or stool.  
Candida auris  
, screening/surveillance  
Case Classification  
Confirmed  
Person with confirmatory laboratory evidence. Specimen was collected for the purpose of screening or surveillance. Specimen site is skin (e.g., axilla, groin), external ear canal, nares, rectum, stool, or other external body site. Cultures from other specimen sites, such as urine and respiratory cultures, collected specifically for screening or surveillance would be classified under this classification as well.  
References  
Council of State and Territorial Epidemiologists. Standardized case definition for  
Candida auris  
causing clinical infection and colonization in people. (17-ID-03) Atlanta, GA: Council of State and Territorial Epidemiologists; 2017.  
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National Notifiable Diseases Surveillance System (NNDSS)  
NNDSS receives and shares case data from state, local, and territorial health departments to help public health monitor, control, and prevent serious diseases.  
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