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Candida auris  
2019 Case Definition  
Candida auris  
2019 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)  
18-ID-05  
Subtype(s)  
Candida auris  
, colonization/screening  
Candida auris  
, clinical  
Background  
Candida auris (C. auris)  
is an emerging multidrug-resistant yeast that can cause invasive infections and is associated with high mortality. Some strains of  
C. auris  
are resistant to the three major classes of antifungals, severely limiting treatment options.  
C. auris  
can spread in healthcare settings and cause outbreaks.  
C. auris  
can colonize patients’ skin and other body sites, perhaps indefinitely, and colonization poses a risk both for invasive infection and transmission.  
C. auris  
persists in the healthcare environment for weeks, and certain routinely used disinfectants in healthcare settings are not effective against the organism. Recent investigations have demonstrated that one-third to half of all patients on a given unit, especially in a long-term care setting, can become colonized with  
C. auris  
within weeks of an index patient entering the facility. Outbreaks of  
C. auris  
in many parts of the world have been very difficult to control, sometimes requiring closure of hospital units and intensive public health interventions. In some countries with unchecked transmission of  
C. auris  
, it has become a leading cause of  
Candida  
infections, signaling a rapid change in the epidemiology of  
Candida  
infections.  
In the United States,  
C. auris  
has been predominantly identified among patients with extensive exposure to ventilator units at skilled nursing facilities and long-term acute care hospitals, and those who have received healthcare in countries with extensive  
C. auris  
transmission. Other risk factors for  
C. auris  
infection are similar to those for invasive infection with other  
Candida  
species and include central venous catheter use, and recent broad-spectrum antibiotic or antifungal use.  
Commonly used yeast identification methods often misidentify  
C. auris  
as other yeasts (especially  
Candida haemulonii  
) (  
Appendix 1  
contains a list of fungal species commonly reported in place of  
C. auris  
by different laboratory identification methods).  
C. auris  
should be suspected when  
C. haemulonii  
(especially when isolated from an invasive site) or other organisms listed in  
Appendix 1  
are identified by a yeast identification method that cannot accurately identify  
C. auris  
.  
As of April 2018, over 700 patients with  
C. auris  
infection or colonization have been identified in the United States. Most cases have occurred in New York City, New Jersey, and the Chicago area.  
C. auris  
has only recently emerged in the United States, with cases primarily occurring after mid-2015. Given the recent emergence and limited geographic extent of cases, there is an opportunity to control the spread of  
C. auris  
before it becomes more widespread in the United States.  
Control requires timely detection of the organism and adherence to recommended infection control practices, which includes proper hand hygiene, contact precautions, thorough environmental disinfection, contact tracing, and public health notification and action to prevent transmission within a healthcare facility and in the region.  
Laboratory Criteria For Diagnosis  
Confirmatory laboratory evidence:  
Detection of  
C. auris  
from any body site using either culture or a culture independent diagnostic test (CIDT) (e.g., Polymerase Chain Reaction [PCR]).  
Presumptive laboratory evidence:  
Detection of  
C. haemulonii  
from any body site using a yeast identification method that is not able to detect  
C. auris  
(see  
CSTE position statement 18-ID-05, Appendix 1  
),  
AND  
either the isolate/specimen is not available for further testing, or the isolate/specimen has not yet undergone further testing.  
(Note: When additional test results are available, case re-classification may occur, including making this a non-case.)  
Epidemiologic Linkage  
Person resided within the same household with another person with confirmatory or presumptive laboratory evidence of  
C. auris  
infection or colonization.  
OR  
Person received care within the same healthcare facility as another person with confirmatory or presumptive laboratory evidence of  
C. auris  
infection or colonization.\*  
OR  
Person received care in a healthcare facility that commonly shares patients with another facility that had a patient with confirmatory or presumptive laboratory evidence of  
C. auris  
infection or colonization.\*  
OR  
Person had an overnight stay in a healthcare facility in the previous one year in a foreign country with documented  
C. auris  
transmission (  
https://www.cdc.gov/fungal/candida-auris/tracking-c-auris.html  
).  
\*Note: the person with confirmatory or presumptive laboratory evidence of  
C. auris  
and potentially exposed individuals do not need to be present in a health care facility for any overlapping time period. Any case occurring in a facility with a confirmed or probable case identified in the prior 12 months would be considered epidemiologically linked.  
Criteria to Distinguish a New Case from an Existing Case  
A person with a clinical case should not be counted as a colonization/screening case  
thereafter (e.g., patient with known infection who later has colonization of skin is not  
counted as more than one case).  
A person with a colonization/screening case can be later categorized as a clinical case  
(e.g., patient with positive screening swab who later develops bloodstream infection would  
be counted in both categories).  
Subtype(s) Case Definition  
Expand All  
Candida auris  
, colonization/screening  
Case Classification  
Probable  
Person with presumptive laboratory evidence from a swab collected for the purpose of screening for  
C. auris  
colonization regardless of site swabbed. Typical colonization/screening specimen sites are skin (e.g., axilla, groin), nares, rectum, or other external body sites. Swabs from wound or draining ear are considered clinical.  
Confirmed  
Person with confirmatory laboratory evidence from a swab collected for the purpose of screening for  
C. auris  
colonization regardless of site swabbed. Typical colonization/screening specimen sites are skin (e.g., axilla, groin), nares, rectum, or other external body sites. Swabs from wound or draining ear are considered clinical.  
Candida auris  
, clinical  
Case Classification  
Suspected  
Person with presumptive laboratory evidence from a clinical specimen collected for the purpose of diagnosing or treating disease in the normal course of care and no evidence of epidemiologic linkage. A clinical specimen includes specimens from sites reflecting invasive infection (e.g., blood, cerebrospinal fluid) and specimens from non-invasive sites such as wounds, urine, and the respiratory tract, where presence of  
C. auris  
may simply represent colonization and not true infection.  
Probable  
Person with presumptive laboratory evidence from a clinical specimen collected for the purpose of diagnosing or treating disease in the normal course of care and evidence of epidemiologic linkage. A clinical specimen includes specimens from sites reflecting invasive infection (e.g., blood, cerebrospinal fluid) and specimens from non-invasive sites such as wounds, urine, and the respiratory tract, where presence of  
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may simply represent colonization and not true infection.  
Confirmed  
Person with confirmatory laboratory evidence from a clinical specimen collected for the purpose of diagnosing or treating disease in the normal course of care. This includes specimens from sites reflecting invasive infection (e.g., blood, cerebrospinal fluid) and specimens from non-invasive sites such as wounds, urine, and the respiratory tract, where presence of  
C. auris  
may simply represent colonization and not true infection.  
Comments  
Candida auris  
, clinical: Public Health jurisdiction may consider stratifying clinical cases as invasive vs non-invasive.  
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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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