

From: **Kansas Department of Health and Environment – Division of Public Health**

To: Healthcare Providers and Local Health Departments

RE: First case of *Candida auris* detected in Kansas

Background

Candida auris is an emerging antimicrobial-resistant yeast that was first identified in 2009 in Asia and began spreading in the United States in 2015. It can cause severe infections and spreads easily between hospitalized patients and nursing home residents. *C. auris* is often multidrug-resistant and some strains are resistant to all three major classes of antifungal medications. In 2019, CDC declared *C. auris* as one of the urgent (highest level) antimicrobial resistance threats in the United States. It is still rare in the United States, but cases have been increasing nationwide with 8,131 *C. auris* cases (clinical and screening cases) detected in the US in 2022 as compared to 323 in 2018. In July 2024, the Kansas Department of Health and Environment (KDHE) was notified of a clinical case of *C. auris* in a non-Kansas resident admitted to a Kansas hospital. After screening potential health care contacts, one additional person has tested positive. KDHE is issuing this health alert to ensure that health care personnel are aware the transmission dynamics, risk factors, diagnostic challenges and treatment recommendations for *C. auris*.

***Candida auris* Transmission and Clinical Risk Factors**

C. auris can spread easily in health care facilities through contact with contaminated surfaces (e.g., bedrails, bedside tables), shared mobile medical equipment (e.g., glucometers, ultrasound machines) or the hands or clothing of health care personnel. It can also persist on patients and surfaces for long periods of time. Also, many commonly used hospital grade disinfectants are not effective against it. These factors can lead to outbreaks in health care settings. Those at highest risk of getting a *C. auris* infection already have underlying clinical risk factors such as weakened immune system, being on mechanical ventilation, presence of indwelling medical devices, receiving complex or high acuity medical care, frequent or long health care stays and/or colonization or infection with other multidrug-resistant organisms. Healthy people usually do not get *C. auris* infections.

Epidemiological Risk Factors and Risk Mitigation Strategies

Patients who have received health care outside the U.S., or within the parts of the U.S. with high burden of *C. auris*, are at higher risk for *C. auris* colonization and/or infection. Similarly, patients with current or previous health care encounters at any facility with currently suspected or confirmed *C. auris* transmission will also be at higher risk for colonization and/or infection, especially those with underlying clinical risk factors described above. Therefore, all health care facilities must remain vigilant for the following high-risk indicators of *C. auris* patients:

- History of an overnight stay in a health care facility outside of the United States within the previous 12 months, **OR**
- History of ambulatory surgery or hemodialysis performed outside of the United States within the previous 12 months, **OR**
- History of an overnight stay within the previous 12 months in a hospital or skilled nursing facility in any of the states with high burden of *C. auris* such as California, Nevada, Texas, Illinois, Florida and New York. (For most up to date information refer to the [CDC *C. auris* tracking data](#)), **OR**
- Patients that are a roommate or close contact to a known *C. auris* positive patient in a health care setting, **OR**
- Patients from health care facilities with high prevalence or ongoing transmission of *C. auris*.

Upon identification of any of the epidemiological risk factors, health care facilities can mitigate risk of *C. auris* transmission with following considerations:

- Use the appropriate level of transmission-based precautions (based on setting) while *C. auris* colonization and/or infection is being ruled out, **AND**
- Conduct admission screening (bilateral axilla and groin swab) for *C. auris* when patients (especially those with clinical risk factors) are identified to have any of the epidemiological risk factors, **AND**
- Conduct widespread (point prevalence) screening based on intra-facility risk, if *C. auris* is detected, **AND**
- Ensure disinfectants used are effective against *C. auris* ([EPA List P](#)).
 - If a List P disinfectant is not immediately available, use disinfectants found on [EPA List K](#).
- [Report](#) suspected and confirmed *C. auris* within four hours to KDHE 877-427-7317.
- Communicate *C. auris* status, including recommended transmission-based precautions, to the receiving unit or facility before transfer. Consider using the following [form](#).

It should be noted that decisions regarding admission or discharge of a patient should be **based on clinical criteria and the ability of the facility to provide care – not on the presence or absence of infection or colonization with *C. auris***.

Health care facilities can reach out to the KDHE Healthcare-Associated Infections and Antimicrobial Resistance (HAI/AR) Section for assistance with screening and to request a free assessment of their infection prevention and control strategies (Infection Control Assessment and Response ICAR) to make sure their protocols are in alignment with current recommendations. Email: kdhe.HAIAR@ks.gov.

Diagnostic Challenges and Reporting Requirements

C. auris can be misidentified as a number of different organisms when using traditional phenotypic methods for yeast identification such as VITEK 2 YST, API 20C, BD Phoenix yeast identification system, and MicroScan. A detailed algorithm for when to suspect *C. auris* based on identification methods are available at this [link](#). Additional information regarding identification of *C. auris* and diagnostic challenges can be found at this [link](#).

Report suspected and confirmed cases of infection and colonization to KDHE immediately. Laboratory specimens should be forwarded to Kansas Health and Environmental Laboratories (KHEL) if positive for *C. auris*, if misidentification is suspected, or if laboratory does not have the ability to perform species identification on *Candida* isolates growing from a sterile body site.

***Candida auris* Treatment**

In the United States, about 90% of *C. auris* isolates have been resistant to fluconazole, and about 30% have been resistant to amphotericin B. Most strains of *C. auris* in the US (> 98%) have been susceptible to echinocandins, although echinocandin or pan-resistant cases do exist. Consultation with an infectious disease specialist is highly recommended when caring for patients with *C. auris* infection. It is important to note that even after treatment for invasive infections, patients generally remain colonized with *C. auris* for long periods, and perhaps indefinitely. Therefore, all recommended [infection prevention and control measures](#) should be followed for both *C. auris* infection and colonization. **It is not recommended** to treat colonization of *C. auris*, treatment is generally only indicated if clinical disease is present.

For more information on this or other HAI and AR issues please contact: kdhe.HAIAR@ks.gov.