Emergence of *non albicans* Candida in a tertiary care hospital of north India

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Abstract

**Introduction**: Over past few years, a dramatic increase in the incidence of infections caused by *Candida* species is seen, which has been attributed to increased number of immunocompromised patients, widespread use of broad spectrum antibiotics, long term use of corticosteroids and immunosuppressive drugs, prolonged hospital stay and use of advanced life support systems

**Aims and Objectives**: To determine the incidence of *Candida* infections among patients admitted to a tertiary care teaching hospital of north India, characterise *Candida* isolates upto to specie level and also to evaluate presence of any drug resistance among these strains.

**Material and Methods**: Present study was a hospital based prospective study carried out in the Department of Microbiology, of a tertiary care hospital in north India, over a period of one year from June 2016 to May 2017. For all *Candida* isolates obtained from various clinical samples, identification to the species level and anti-fungal susceptibility testing was done by automated Vitek 2 compact system (Biomerieux). Results were interpreted as per CLSI guidelines.

**Results**: A shift of trends from *Candida albicans* to *non albicans Candida* was observed as out of total 56 isolates, the number of *Candida albicans* isolates was 16 (28.6%) and *non-albicans Candida* was 40 (72.4%). Anti-fungal susceptibility test results showed high susceptibility to Voriconazole and Amphotericin B. Only 5.35% (3/56) of *Candida* isolates showed resistance.

**Conclusions**: Since *non albicans Candida* has emerged as an important nosocomial pathogen and these species are intrinsically resistant to some of the commonly used anti fungal drugs so anti-fungal susceptibility should be routinely performed to improve the treatment outcomes, for the benefit of the patient.

**Keywords**: *Candida albicans*, Shift, *non albicans Candida*, Anti fungal susceptibility testing.

Introduction

*Candida* is a component of commensal flora of human body and at the same time an important nosocomial pathogen, especially in critically ill and immunocompromised patients.¹,² Over past few years there has been a dramatic increase in the incidence of infections caused by *Candida* species making them the fourth leading cause of blood steam infections in USA and sixth among hospital acquired infections.³,⁴ This rise has been attributed to increased number of immunocompromised patients, widespread use of broad spectrum antibiotics, long term use of corticosteroids and immunosuppressive drugs, prolonged hospital stay and use of advanced life support systems.⁵

Contrary to the previous trends where *Candida albicans* used be predominant specie causing invasive candidiasis, a shift towards *non albicans Candida* has been observed recently besides association with higher mortality and morbidity.⁶,⁸ This shift in epidemiology has been linked to increased use of azoles.⁷,⁹,¹⁰

Since *Candida* can cause opportunistic infections in both immunocompromised as well as immunocompetent persons, we undertook a study to determine the incidence of *Candida* infections among patients admitted to a tertiary care teaching hospital of north India, to characterise *Candida* isolates upto to specie level in order to know any shift from *Candida albicans* to *non albicans Candida* and also to evaluate presence of any drug resistance among these strains.

Materials and Methods

Ours was a hospital based prospective study carried out in the Department of Microbiology of a tertiary care hospital in north India over a period of one year from June 2016 to May 2017.

From various clinical samples (Blood, urine, pus, urinary catheter tips, fluids etc) processed in Microbiology lab for routine diagnostic work up, 56 consecutive (non repeat) candida isolates obtained were included in the study. Relevant clinical history was also taken.

The processing of the clinical specimens was done as per standard microbiological techniques.¹¹ For blood steam infections, blood culture bottles were incubated in BacT alert 3D system (Biomerieux) and samples shown positive by the system were subcultured on blood agar and Sabouraud’s dextrose agar (SDA).

For other clinical samples also, candida isolates obtained on blood agar culture plates were subcultured on SDA for further processing. The growth obtained on SDA was characterised by colony morphology, Gram staining, Germ tube formation and identification to the species level and anti-fungal susceptibility testing was done by automated Vitek 2 compact system (Biomerieux) as per manufactures instructions, using yeast identification and anti fungal susceptibility cards. Results were interpreted as per CLSI guidelines.

Statistical analysis

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Statistical analysis was done using SPSS version 17.0 software and MS excel 2007.

**Results and observation**

In our study candida isolates obtained from 56 cases, that fulfilled the diagnostic criteria for candidiasis, were included and further processed for species identification and anti-fungal susceptibility testing with VITEK 2 Compact system (Biomerieux).

The results showed predominance of males, with male to female ratio is 1.4:1

Preponderance of *non albicans Candida* over *Candida albicans* was also observed as out of total 56 isolates, the number of *Candida albicans* isolates was 16 (28.6%) and *non-albicans Candida* was 40 (72.4%).

Among *non albicans Candida*, *Candida tropicalis* was the predominant species 27 (48.21%) followed by *Candida utilis* 9 (16.09%), *Candida gullermondii* 2 (3.57%), *Candida parapsilosis* 1 (1.78%), *Candida pelliculosa* 1 (1.78%). (Table 1, Fig 1)

The largest number of candida isolates was obtained from blood cultures (28) followed by urine cultures (14), Foley’s catheter tip cultures (13) and others (1). *Candida tropicalis* was the predominant species among blood and urine cultures isolates whereas *Candida albicans* was the predominant species in foley catheter tip culture isolates.

Most common predisposing factors were prior antibiotics use in 52 (92.85%) and hospital stay of more than two weeks in 50 (89.28%) cases. Other associated risk factors were indwelling catheter, diabetes, surgery, low birth weight in case of neonates (Table 2, Fig 2).

Antifungal susceptibility test results showed high susceptibility to Voriconazole and Amphotericic B. Only 5.35% (3/56) of Candida isolates showed resistance (Table 3).

**Table 1: Distribution of Candida isolates obtained from various clinical specimens (n=56)**

| Clinical Specimen | Candida albicans | Candida tropicalis | Candida utilis | Candida gullermondii | Candida parapsilosis | Candida pelliculosa | Total |
|-------------------|------------------|--------------------|---------------|---------------------|---------------------|---------------------|-------|
| Blood             | 3 (10.7%)        | 14 (50%)           | 9 (32.14%)    | 1 (3.57%)           | 0                   | 1                   | 28    |
| Urine             | 4 (28.57%)       | 10 (71.42%)        | 0             | 0                   | 0                   | 0                   | 14    |
| Foley Catheter tip | 9 (69.23%)      | 3 (23.07%)         | 0             | 0                   | 1                   | 0                   | 13    |
| Others (Pus, Fluid) | 0              | 0                  | 0             | 1 (100%)            | 0                   | 0                   | 1     |
| Total             | 16 (28.57%)      | 27 (48.21%)        | 9 (16%)       | 2 (3.57%)           | 1                   | 1                   | 56    |

**Fig. 1: Specie wise distribution of Candida isolates**

| Predisposing factors | Number of patients |
|----------------------|--------------------|
| Low birth-weight neonates | 13(23.21%) |
| Age more than 50yrs | 20(35.71%) |
| Hospital stay > 2 weeks | 50(89.28%) |
| Prior antibiotic usage | 52(92.85%) |
| H/O Diabetes mellitus | 5(8.92%) |
| Prior surgery | 4(7.14%) |
| Indwelling catheter | 40(71.42%) |
Discussion

The current prospective analytical study over a period of one year reveals preponderance of non albicans Candida over Candida albicans which has been highlighted by similar other studies from different parts of the world.9,12,13

In our study, out of 56 Candida isolates recovered from various clinical specimens, 16 (28.6%) were Candida albicans and 40 (71.4%) were non albicans Candida which is in concordance with another study by Sachin C et al that also showed higher incidence of non albicans Candida (63.3%) over Candida albicans (36.7%).14 This shift toward non albicans Candida has been attributed to wide spread use of azoles. A study published by Oberoi K Jaswinder et al, they found a statistically significant relation between fluconazole use and increase in the isolation of non albicans species.15 However in our study the most common isolated species was Candida tropicalis and it showed 96% sensitivity to fluconazole. We also observed 9 cases of candidemia due to Candida utilis in newborn patients admitted to NICU over a period of 3 months during this study. All of these were low birth weight premature babies who were critically ill and were on multi drug therapy. Similar cases of candidemia by Candida utilis have been reported by Gric A L et al and Shivadasan J et al, in neonates.16,17

In sample wise distribution of Candida isolates, a predominance of blood isolates seen as follows. Blood isolates 28 (50%), urine isolates 14 (25%), Foley’s catheter tip isolates13 (23.21%) and 1 isolate from drainage fluid (1.7%). Out of 651 positive blood cultures, 28 (4.3%) were positive for Candida species. A lot of variation in prevalence of Candidemia has been reported in different parts of India. Xess et al from AIIMS, New Delhi has reported a prevalence rate of 6% where as another New Delhi based study reported 18% prevalence rate.18,20

Higher number of isolates from blood compared to other samples in our a study may be due to more use of invasive devices or may be because most of the patients were critically ill and were on broad spectrum antibiotic therapy.

It is also observed that the maximum number of Candida isolates were recovered from the patients admitted to different critical care units of the hospital.

**Table 3: Anti-fungal susceptibility results**

| Candida sp   | Fluconazole | Voriconazole | Caspofungin | Micafungin | Amphotericin B | Flucytocine |
|--------------|-------------|--------------|-------------|------------|----------------|-------------|
|              | S           | R            | S           | S          | S              | R           | S           | R          | S           | R            |
| C. albicans  | 16 (100%)   | 0            | 16 (100%)   | 0          | 16 (100%)     | 0           | 16 (100%)   | 0          | 16 (100%)   | 0            |
| (16)         |             |              |             |            |                |             |             |            |             |              |
| C. tropicalis| 25 (96.3%)  | 2 (3.7%)     | 27 (100%)   | 0          | 26 (96.3%)    | 1 (3.7%)    | 27 (100%)   | 0          | 27 (100%)   | 0            |
| (27)         |             |              |             |            |                |             |             |            |             |              |
| C. utilis    | 9 (100%)    | 0            | 9 (100%)    | 0          | 9 (100%)      | 0           | 9 (100%)    | 0          | 9 (100%)    | 0            |
| (9)          |             |              |             |            |                |             |             |            |             |              |
| C. guillermondii| 2 (100%) | 0            | 2 (100%)    | 0          | 2 (100%)      | 0           | 2 (100%)    | 0          | 2 (100%)    | 0            |
| (2)          |             |              |             |            |                |             |             |            |             |              |
| C. parapsilosis| 1 (100%) | 0            | 1 (100%)    | 0          | 1 (100%)      | 0           | 1 (100%)    | 0          | 1 (100%)    | 0            |
| (1)          |             |              |             |            |                |             |             |            |             |              |
| C. pelliculosis| 1 (100%) | 0            | 1 (100%)    | 0          | 1 (100%)      | 0           | 1 (100%)    | 0          | 1 (100%)    | 0            |
| (1)          |             |              |             |            |                |             |             |            |             |              |

**Fig. 2**
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