P1316
Poster Session V
Infections in transplant recipients

BREAK THROUGH CANDIDEMIA WITH CANDIDA PARAPSILOSIS DURING PROPHYLAXIS WITH MICAFUNGIN AFTER ALLOGENEIC HAEMATOPOIETIC STEM CELL TRANSPLANTATION – CUMULATIVE CASE REPORT

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Objectives

To systematically analyse breakthrough invasive infections with *C. parapsilosis* or *C. orthopsilosis* in patients undergoing allogeneic haematopoietic stem cell transplantation (HSCT) before and after the change of antifungal prophylaxis from the lipid formulation of amphotericin B (Abelcet®) to micafungin.

Methods

We performed a retrospective chart review from 1.10.2008 until 31.5.2013 in 640 patients undergoing an allogeneic HSCT in our institution. While primary antifungal prophylaxis was routinely undertaken using a lipid formulation of amphotericin B (Abelcet®) until October 2009, we started giving micafungin at a dosage of 50 or 100 mg in November 2009.

Results

During the observation period of four years and seven months, 640 adult patients received an allogeneic HSCT, while IC with *C. parapsilosis* or *C. orthopsilosis* was observed in ten patients, resulting in a cumulative incidence of 1.6 %. All breakthrough infections occurred during the period when micafungin (since November 2009) was used for primary antifungal prophylaxis.

The vast majority of patients (8/10) received an echinocandin (micafungin: n=7, caspofungin: n=1), while one patient was on liposomal amphotericin B (LAmB) and one patient did not receive any systemic antifungal medication at that timepoint, when IC was diagnosed. Anti-candida treatment was started immediately after receiving the results from the blood cultures with an antifugal drug with proven *in vitro* activity. In 9/10 patients clinical and microbiological success of the IC was observed after a maximum of seven days following initiation of targeted antifungal treatment (voriconazole: n=3, LAmB: n=5, caspofungin: n=1), while one patient died due to severe sepsis.

Conclusions

In summary, the occurrence of IC caused by *C. parapsilosis* seems to be a relevant, but manageable complication during antifungal prophylaxis with micafungin. Due to clinical suspicion early treatment with either an azole or liposomal amphothericin B as well as removal of catheters should be initiated.