Candida auris (Candidozyma auris)

Clinical Overview and Long-Term Care Status Update — July 2026

Prepared for internal clinical reference. Synthesizes CDC surveillance data (through the 2022–2024 MMWR Surveillance Summary and 2025–2026 tracking updates), CDC clinical/laboratory guidance, and recent peer-reviewed literature. Sources are linked throughout and listed in full at the end.

1. Executive Summary

- **Cases keep rising, but growth is decelerating.** Confirmed clinical cases grew from 2,882 (2022) to 6,197–6,304 (2024) per finalized CDC surveillance; preliminary 2025 NNDSS data suggest roughly 7,000+ cases, similar to or slightly below 2024's preliminary count. Year-over-year growth has slowed from ~96% (2021→2022) to ~40% (2023→2024).
- **Geographic spread continues.** Invasive infections have now been reported in at least 39 states cumulatively, with active clinical transmission reported in 27+ states as of late 2025/2026; the West region carries the largest share of both clinical and screening cases.
- **Long-term care is directly implicated.** Long-term acute care hospitals (LTACHs) and ventilator-capable skilled nursing facilities (vSNFs) are high-risk, high-progression settings — LTACH-screened patients have the highest rate of progression from colonization to clinical infection (10.4%) of any facility type.
- **Resistance remains concentrated in azoles, not echinocandins.** Fluconazole resistance exceeds 95% nationally; amphotericin B resistance is ~15%; echinocandin resistance remains low (~1%) but is increasing, and pan-resistant isolates (resistant to all three classes) continue to be identified, including reported clusters.
- **Bottom line for LTC medical directors:** C. auris is now an endemic, entrenched pathogen in the U.S. post-acute care ecosystem, not an isolated outbreak organism. The operative issues are silent inter-facility transmission via colonized/undetected patients, diagnostic pitfalls in routine microbiology, environmental persistence that defeats standard disinfectants, and the need for sustained (often indefinite) precautions once a resident is identified as colonized.

2. Organism Overview

Candida auris is an emerging, often multidrug-resistant yeast first described in 2009 from an external ear infection in Japan (auris = "ear"). Retrospective analysis later identified U.S. isolates back to 2013, with the first prospectively recognized U.S. case in 2016. Genomic analysis shows near-simultaneous, independent emergence on at least three to five continents, producing genetically distinct clades (currently five to six recognized) rather than a single point-source outbreak — a pattern some researchers link to environmental/climate adaptation pressures that may have allowed a previously non-thermotolerant environmental fungus to adapt to human body temperature.

Taxonomic note: the name is changing

In 2024–2025, phylogenomic work reclassified C. auris into a new genus as Candidozyma auris, part of a broader restructuring of the Candida-related Metschnikowiaceae family. CDC, most clinical microbiology labs, and most clinical literature still use "Candida auris" as of mid-2026, and the two names are used interchangeably in practice; expect gradual transition in lab reports and the literature (e.g., "Candidozyma auris (formerly Candida auris)").

Why it is clinically distinct from other Candida species

- Frequently multidrug-resistant (azoles most commonly, sometimes amphotericin B and, less often, echinocandins), unlike most other Candida species.
- Persists on skin (colonization, especially axilla and groin) and in the healthcare environment for weeks to months — it survives routine hospital-grade disinfectants that rely solely on quaternary ammonium compounds.
- Transmits person-to-person and via contaminated surfaces/shared equipment in healthcare settings, behaving epidemiologically more like a multidrug-resistant bacterium (e.g., CRE, MRSA) than a typical Candida infection.
- Frequently misidentified by conventional laboratory identification methods as other, less concerning yeasts (see Section 4).
- Colonization can persist for months to indefinitely, creating a durable, often unrecognized reservoir that moves between facilities with the patient.

3. Current Epidemiologic Status (through 2026)

National case trends

Year	Clinical cases	Growth (YoY)	Screening (colonization) cases	Notes
2021	~1,470	—	—	Baseline pre-acceleration
2022	2,882	+95.9%	6,226	Sharp acceleration
2023	4,514–4,600*	+53.7%	~9,000*	39 states with invasive infections cumulatively
2024	6,197–6,304*	+39.9%	12,432	Growth decelerating but still rising
2025 (preliminary)	~7,000+	≈ flat to modest ↑	not yet finalized	27+ states reporting active clinical cases; final 2025 numbers pending CDC finalization

**Figures vary slightly by source (CDC tracking page vs. finalized MMWR Surveillance Summary vs. preliminary NNDSS weekly data) because of reporting lag and revision; the trend direction and deceleration pattern are consistent across all sources.*

Where cases are occurring

- **By region:** West ~28–36% of cases, Midwest ~19–21%, Southeast ~19–20%, with regional distribution relatively stable 2022–2024.
- **By facility type (clinical cases):** acute care hospitals 76.6%, LTACHs 17.8%, remainder in other settings.
- **By facility type (screening/colonization detection):** a notable shift has occurred — acute care hospital detection rose from 24.7% (2022) to 50.7% (2024) of all screening detections, while the LTACH share fell from 56.1% to 35.7%, reflecting expanded admission screening in acute care rather than a true drop in LTACH burden.
- **By specimen type (clinical cases):** urine 31.5%, blood 30.2% — bloodstream isolates are the most consequential given associated mortality.

- **Demographics:** 87.8% of clinical cases and 90% of screening-positive patients are age 45 or older; ~60% are male — consistent with a population of older, multimorbid, healthcare-exposed patients typical of LTC/post-acute care.

Colonization → clinical infection: the number that matters most for LTC

A CDC analysis of 21,195 U.S. patients with a positive colonization screen (2016–2023) found that only 6.9% went on to develop clinical infection (2.8% specifically bloodstream infection) — but progression risk varied sharply by the facility where colonization was first detected:

Facility type at colonization detection	Progression to clinical infection	Comment
LTACH	10.4%	Highest-risk setting
Acute care hospital	5.9%	
Ventilator-capable SNF (vSNF)	5.2%	Directly relevant to LTC
Non-ventilator LTC/SNF	2.7%	Lower but non-zero
West region (any facility)	13.6%	Geographic risk modifier

Median time from a positive screen to a bloodstream infection was 58 days — meaning a resident who screens positive (or is known-colonized on transfer) remains at meaningful risk for infection well after the index detection, reinforcing the need for sustained precautions rather than time-limited ones.

Resistance profile (CDC Antimicrobial Resistance Laboratory Network, 8,033 isolates, 2022–2023)

Antifungal class	Resistance rate	Comment
Fluconazole (azole)	>95% (as high as 83–95%+ regionally)	Essentially universal — azoles are not useful empirically
Amphotericin B	~15%	Meaningful minority resistant
Echinocandins	~1%	Still low — supports first-line status
Pan-resistant (all 3 classes)	<1%	Rare but reported, including clustered transmission of resistant strains

Bottom line: echinocandin resistance and pan-resistance remain uncommon but are trending upward, and documented person-to-person spread of resistant isolates means local antibiograms and facility-level trends matter — a fully pan-resistant infection currently has no reliable antifungal option.

4. Diagnosis

Identification pitfalls — why routine labs miss it

Standard biochemical/phenotypic identification platforms (e.g., older VITEK 2, API 20C AUX, BD Phoenix) frequently misidentify C. auris as other, less concerning organisms — most often Candida haemulonii, C. duobushaemulonii, C. famata, or Rhodotorula glutinis — because these methods were not built with C. auris in their reference databases. Any lab report of these "look-alike" species, especially from an older adult with healthcare exposure, should prompt confirmatory testing.

- **MALDI-TOF mass spectrometry:** accurate and rapid, but only with an updated, C. auris-inclusive reference library (both Bruker and bioMérieux have released updated/expanded libraries); older or non-updated libraries will still misidentify it.
- **Molecular methods (PCR, sequencing):** ITS or D1-D2 region sequencing gives definitive identification; targeted real-time PCR assays are increasingly used for both clinical specimens and colonization screening because they are faster than culture (hours vs. days) and are used by CDC's AR Lab Network.
- **CHROMagar Candida Plus:** a chromogenic agar that produces a characteristic pale blue colony with a blue halo for C. auris, useful as an inexpensive, rapid presumptive screening tool (especially for surveillance/screening swabs), but positive results still require confirmatory MALDI-TOF or molecular testing.
- **Definitive confirmation:** send unusual/ambiguous yeast isolates, or any isolate presumptively identified as C. auris or a look-alike species, to a state public health lab or CDC's Antimicrobial Resistance Laboratory Network (AR Lab Network) for confirmation and antifungal susceptibility testing.

Colonization screening (surveillance testing)

- **Specimen:** a single composite swab of bilateral axillae and groin (the preferred, validated body sites for detecting colonization).
- **Method:** culture (with selective/enrichment broth) or PCR; PCR gives faster turnaround and is preferred for point prevalence surveys and outbreak response.
- **Who to screen:** patients/residents with an epidemiologic link to a known case (roommate, shared unit/care area, shared equipment), patients transferring from or with recent stays in high-acuity post-acute settings (LTACHs, vSNFs), and patients with prolonged healthcare exposure, mechanical ventilation, or indwelling devices.
- **When:** on admission (new-introduction detection), periodically during stay (point prevalence surveys, generally preferred over narrow targeted screening), and at transfer/discharge so receiving facilities are informed.
- **Susceptibility testing:** CLSI clinical breakpoints are not fully established for all drug classes; CDC provides tentative breakpoints (e.g., fluconazole ≥32 µg/mL, amphotericin B ≥2 µg/mL, anidulafungin/micafungin ≥4 µg/mL, caspofungin ≥2 µg/mL) used to guide therapy pending formal breakpoints.

5. Treatment

General principle

CDC is explicit that antifungal treatment is indicated only for clinical infection — colonized, asymptomatic patients should not be treated. Overuse of antifungals in colonized residents drives resistance without benefiting the patient.

First-line therapy

Population	Agent / dose	Notes
Adults & children ≥2 months	Echinocandin: anidulafungin 200 mg IV × 1, then 100 mg IV daily; caspofungin 70 mg IV × 1, then 50 mg IV daily; micafungin 100 mg IV daily	Echinocandins remain first-line given ~1% resistance

Population	Agent / dose	Notes
Neonates/infants <2 months	Amphotericin B deoxycholate 1 mg/kg IV daily	Preferred in this age group; caspofungin 25 mg/m²/day or micafungin 10 mg/kg/day are alternatives
Echinocandin failure or confirmed resistance	Liposomal amphotericin B 5 mg/kg IV daily	Consider if no clinical improvement after ~5 days of echinocandin therapy, or if susceptibility testing confirms resistance

Source control matters: remove or exchange indwelling catheters/lines where feasible, as with any candidemia.

Emerging / next-generation agents

- **Rezafungin:** FDA-approved (2023) second-generation echinocandin with a long half-life enabling once-weekly IV dosing; active across all recognized C. auris clades; FKS-mutation-mediated echinocandin cross-resistance remains a theoretical concern.
- **Fosmanogepix:** first-in-class Gwt1 inhibitor (novel mechanism, no cross-resistance with existing classes) in clinical development; small early trials show strong in vitro activity against pan-resistant isolates and promising (89% 30-day survival in a 9-patient candidemia cohort) but very preliminary clinical data.
- **Ibrexafungerp:** oral glucan synthase inhibitor (different binding site than echinocandins); FDA-approved for vulvovaginal candidiasis, with encouraging but limited data in invasive C. auris infection (7/8 candidemia patients surviving in one small series); investigational for invasive disease.
- **Combination therapy:** emerging in vitro data suggest synergy between echinocandins and triazoles (isavuconazole showing the strongest synergy) for difficult or resistant cases; this remains investigational rather than standard of care.

6. Infection Prevention & Control — Long-Term Care Focus

Precautions

- **Acute care / LTACH:** Contact Precautions (gown and gloves, proper donning/doffing) for the duration of the admission.
- **Nursing homes / custodial LTC:** either Contact Precautions or Enhanced Barrier Precautions may be used depending on state/local health department guidance and the resident's care needs (e.g., wound care, device use, or high-contact care favor Enhanced Barrier Precautions at minimum).
- **Duration:** because colonization can persist for many months — possibly indefinitely — precautions are generally maintained for the duration of the stay rather than discontinued after a fixed interval or a single negative screen.
- **Hand hygiene:** alcohol-based hand rub is acceptable when hands are not visibly soiled; soap and water is required when there is visible soiling.
- **Room placement:** single rooms preferred; when cohorting is necessary, maintain at least 3 feet of separation, use privacy curtains, and change PPE between residents in a shared room.

Environmental cleaning — a key LTC operational gap

- Standard disinfectants that rely solely on quaternary ammonium compounds are NOT effective against C. auris; facilities must use EPA-registered disinfectants with a specific C. auris claim (EPA "List P").

- Daily cleaning plus terminal cleaning at discharge/transfer is required; shared equipment (glucometers, BP cuffs, ventilator components, lifts, wheelchairs) must be cleaned/disinfected between residents or dedicated to the colonized resident.
- This is frequently an under-resourced gap in LTC settings relative to acute care — confirming that housekeeping/EVS has access to and is using List P products (not just standard quat-based cleaners) is a practical, high-yield check for medical directors and infection preventionists.

Screening in the LTC/post-acute pipeline

- Prioritize screening for residents transferring from or with recent stays in LTACHs or vSNFs (the highest-risk source facilities), residents with an epidemiologic link to a known case, and residents with mechanical ventilation, tracheostomy, indwelling devices, or chronic wounds.
- Point prevalence surveys (screening an entire unit or facility at one time) are preferred over narrow, symptom-triggered screening because most colonized residents are asymptomatic and would otherwise be missed.
- Interfacility communication is critical: when transferring a known colonized or infected resident, proactively notify the receiving facility (many states now require this; CDC promotes standardized interfacility transfer forms noting MDRO status).

7. Clinical Concerns & Key Takeaways for Medical Directors

- **It is now endemic, not exotic.** With cases in a majority of states and a large, growing, mostly-asymptomatic colonized reservoir moving through post-acute care, any LTC facility — not just those with a known outbreak — should have a low threshold to consider C. auris in a resident with risk factors and an unusual or non-resolving yeast isolate.
- **Diagnostic vigilance is the first defense.** Any culture report of C. haemulonii, C. duobushaemulonii, C. famata, or Rhodotorula in a resident with healthcare exposure should trigger a call to the lab about confirmatory MALDI-TOF/molecular testing — routine identification platforms can miss C. auris entirely.
- **Mortality is substantial when infection is invasive.** Bloodstream infection carries historically cited mortality in the 30–60% (up to ~72% in some cohorts) range, though this is heavily confounded by the burden of comorbidity typical of the affected population (advanced age, mechanical ventilation, indwelling devices, multimorbidity) — the organism amplifies risk in an already-fragile population rather than acting in isolation.
- **Antifungal stewardship matters.** Treat infection, not colonization; use echinocandins first-line; reserve amphotericin B and investigational agents for confirmed resistance or clinical failure, both to protect the patient from unnecessary toxicity and to slow the emergence of resistance.
- **Environmental and PPE burden is real and ongoing.** Because colonization can persist indefinitely, facilities should plan for sustained (not short-term) precautions, EPA List P disinfectant procurement, and staff PPE compliance as a standing operational commitment for identified residents, not a time-limited outbreak response.
- **Reporting requirements vary by state.** Many states have made C. auris colonization and infection reportable conditions; confirm current state and local health department requirements, as these continue to evolve.
- **Watch the resistance trend, not just the case count.** Echinocandin resistance and pan-resistance remain low nationally but are increasing and have been associated with documented transmission clusters — a facility identifying an echinocandin-resistant isolate should treat this as a higher-priority infection control event and coordinate with public health authorities.

Sources

All figures and recommendations above are drawn from the following sources (accessed July 2026):

- CDC — Tracking C. auris (national case statistics)
- CDC MMWR — Surveillance for Candida auris, United States, 2022–2024
- CDC — Candida auris Testing by the Antimicrobial Resistance Laboratory Network, 2022–2023 (Emerging Infectious Diseases)
- CIDRAP — CDC study highlights substantial antifungal resistance in Candida auris
- CDC — Progression from Candida auris Colonization Screening to Clinical Case Status, United States, 2016–2023 (Emerging Infectious Diseases)
- CDC — Clinical Treatment of C. auris Infections
- CDC — Antifungal Susceptibility Testing for C. auris
- CDC — Infection Control Guidance: Candida auris
- CDC — Screening Recommendations for Healthcare Facilities
- CDC — Guidance for Detection of C. auris Colonization
- CDC — Identification of C. auris (laboratory guidance)
- Diagnostic Approaches for Candida auris: Screening, Identification, and Susceptibility Testing (PMC, 2025 review)
- Utility of CHROMagar Candida Plus for presumptive identification of Candida auris (PMC)
- Improvement of a MALDI-TOF database for reliable identification of Candidozyma auris (Microbiology Spectrum)
- Contagion Live — Unlocking New Defenses: The Changing Landscape of Candida (Candidozyma) auris Management
- Beyond candidiasis: should infections caused by Candidozyma auris be renamed? (Journal of Clinical Microbiology)
- Candidozyma auris (formerly Candida auris): resistant, long lasting, and everywhere (ScienceDirect)
- The Hill — Superbug hits 27 states: Here's where the deadly fungus is spreading (2026)
- Virginia Dept. of Health — Candida auris Infection Prevention in Long-Term Care Facilities
- California Department of Public Health — Candida auris Quicksheet