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Health Advisory

Update: Increase in *Candida auris* Cases in Philadelphia

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SUMMARY POINTS

- This advisory provides an update on the current epidemiology of *Candida auris, also known as Candidozyma auris,* in Philadelphia.
- Nationally, the number of *C. auris* cases has increased every year since the first case was reported in 2016.
- In the past two years, there has been a significant increase in the number of *C. auris* cases reported to the Philadelphia Department of Public Health (PDPH). A total of 103 *C. auris cases* were reported to the PDPH in 2024, and 221 cases in 2025, a 129% and 115% increase compared to the previous year, respectively.
- Since *C. auris* was first detected in Philadelphia in March 2020, a total of 511 cases have been reported to PDPH. Cases have been detected in acute care hospitals, long-term acute care hospitals (LTACHs), and ventilator-capable skilled nursing facilities (vSNFs), and include both colonized and clinically ill persons.
- PDPH is reminding healthcare facilities, providers, and laboratories to have heightened awareness for *C. auris* in patients and to implement appropriate infection control measures to prevent and contain transmission.
- Suspected or confirmed cases of *C. auris* identified in Philadelphia facilities or residents should be reported to PDPH at 215-685-6748.

EPIDEMIOLOGY OF *C. AURIS* IN PHILADELPHIA

The Philadelphia Department of Public Health (PDPH) is reminding healthcare facilities, providers, and laboratories to have heightened awareness for *C. auris* in patients and to take action to contain its spread.

In March 2020, the first confirmed case of *C. auris* in Pennsylvania was detected in a patient admitted to a Philadelphia short-term acute care hospital. Since then, a total of 511 *C. auris* cases have been reported to PDPH, including 204 clinical infection cases and 307 colonization cases.

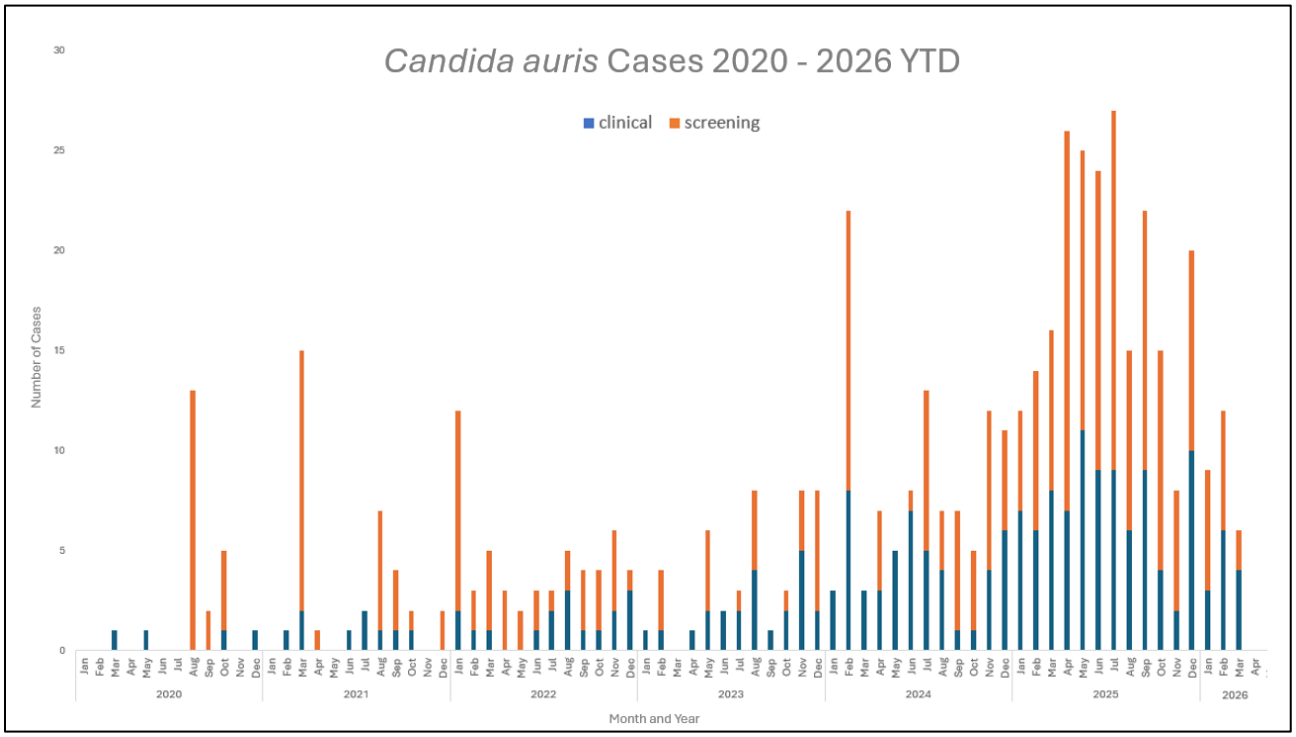

Figure 1. *C. auris* cases reported to the Philadelphia Department of Public Health, March 2020 – March 2026 (to date).

In both 2024 and 2025, there was a significant increase in the number of *C. auris* cases reported to PDPH (Figure 1). A total of 103 *C. auris* cases were reported in 2024 and 221 in 2025, representing increases of 129% and 115% compared to the previous year,

respectively. The increased volume may be partially explained by increased *C. auris* screening capacity in Philadelphia healthcare facilities, including admission screening programs in some high-risk facilities and hospital units, but that is not the only underlying cause. Clinical infection cases have increased as well, by 117% in 2024 and by 74% in 2025, demonstrating that the observed increases are not solely driven by increased detections of *C. auris* colonization but reflect an overall increase in *C. auris* prevalence among patients seeking care at Philadelphia healthcare facilities.

Cases have been detected at acute care hospitals, long-term acute care hospitals (LTACHs), and ventilator-capable skilled nursing facilities (vSNFs), in both colonized and clinically ill persons. *C. auris* has been detected in all LTACHs and vSNFs serving high-risk patients in the Philadelphia metropolitan area, and many of these facilities have experienced further transmission.

This HAN provides recommendations for Philadelphia healthcare facilities, providers, and laboratories for planning purposes in facilities where *C. auris* has not yet been identified, and for containment measures in facilities where cases have been detected.

C. AURIS CASE COUNTS: WHAT IS A CASE?

There are two types of *C. auris* cases: clinical and colonization. A clinical case occurs when a positive *C. auris* specimen is collected for the purpose of diagnosing or treating disease in the normal course of care. A colonization case occurs when a positive *C. auris* specimen is collected for screening or surveillance. Colonization cases are identified in people without symptoms. Colonization and infection can both lead to transmission of *C. auris*.

The CDC provides public health departments with standards for case counting, and also uses the same method to report cases on its own website. According to CDC guidance, a person who is colonized with *C. auris* counts as a colonization case only once. Likewise, a person with a *C. auris* clinical infection counts as a clinical case only once. However, if a person is first identified as a colonization case and later develops a *C. auris* clinical infection, these should be counted as two independent events: a colonization case and a clinical case. The reverse is not true: if a person is first identified as a clinical case of *C. auris* and later is found to be colonized, the colonization does not count as a new case.

C. AURIS BACKGROUND

C. auris is an emerging fungus that presents a serious global health threat for the following reasons:

- It is often multidrug-resistant, meaning that it is resistant to multiple antifungal drugs commonly used to treat *Candida* infections, resulting in significant morbidity and mortality in affected patients. Some strains are resistant to all three available antifungal classes.
- Both patients who are colonized and patients who are infected spread *C. auris* onto surfaces around them and to other patients.
- *C. auris* persists on surfaces for many months and is not killed by many common disinfectants.
- It spreads easily in healthcare settings and can cause outbreaks, particularly in vSNFs and LTACHs. For this reason, it is important to quickly identify *C. auris* so that healthcare facilities can take appropriate precautions to stop its spread.

C. auris infection has been identified in many body sites, including the bloodstream, urine, respiratory tract, and wounds. According to the CDC, the estimated crude mortality rate was 34% among patients hospitalized with *C. auris* infection in the U.S. in 2017-2022, and 47% among patients with bloodstream infection.[1]

A person's level of colonization may vary over time, leading to intermittent positive and negative results if testing is repeated. For this reason, testing for clearance is not recommended, and there is no established criteria for resolution of colonization. *C. auris* is also persistent in the environment and will survive many disinfectants routinely used in healthcare facilities.

Risk Factors

Persons who have recently spent time in hospitals and long-term care facilities, particularly vSNFs and LTACHs, and have invasive devices (e.g., mechanical ventilation or tracheostomy, feeding tubes, and central venous catheters) or extensive wounds, are at the highest risk for *C. auris* infection. As with other *Candida* infections, risk factors include recent surgery, diabetes, and use of broad-spectrum antibiotics or antifungals. Infections have primarily been found in adult patients of all ages, with only a limited number of pediatric cases reported nationally.

Although the risk of transmission within a healthcare facility increases with length of stay, documented transmission has occurred during exposure periods as short as four hours.[2-3]

Most new cases of *C. auris* in the U.S. are not linked to international exposure and are domestically acquired.

Drug resistance

Reports of echinocandin- or pan-resistant *C. auris* cases in the United States are increasing. Nationally, multiple outbreaks of highly resistant *C. auris* have involved people with overlapping healthcare exposures and without previous exposure to antifungal treatment, suggesting transmission of these strains is occurring.

Diagnosis
A *C. auris* diagnosis can often be missed if the laboratory does not further speciate *Candida* detected in clinical specimens. *C. auris* can also be misidentified as several different organisms, particularly *Candida haemulonii*, when using traditional phenotypic methods for yeast identification. The CDC has an algorithm to identify *C. auris* based on phenotypic laboratory methods and for initial species identification. For more information, please see the Laboratory Information for *C. auris*.

Treatment
CDC does not recommend treatment of *C. auris* identified from noninvasive sites (such as respiratory tract, urine, and skin colonization) when there is no evidence of infection. Similar to recommendations for other *Candida* species, treatment is generally only indicated if clinical disease is present. Patients who become colonized with *C. auris* are at risk of developing invasive *C. auris* infections. More information about how to prevent colonization from progressing into infection is available from the CDC.

INFECTION PREVENTION AND CONTROL FOR *C. AURIS*

Infection control measures should be used for all patients with *C. auris*, whether infected or colonized, and regardless of the specimen source. Transmission-based precautions should not be discontinued when treatment for an infection ends but should be continued for the duration of the patient's stay in a healthcare facility and implemented for any future healthcare stays.

The primary infection control measures for prevention of *C. auris* transmission in healthcare settings are:

- **Adherence to hand hygiene**. Alcohol-based hand sanitizer (ABHS) is effective against *C. auris* and is the preferred method for routine hand hygiene.
- **Appropriate use of transmission-based precautions**. Patients colonized or infected with *C. auris* in hospitals should be managed using contact precautions. For long-term nursing home residents, discuss options for implementing contact precautions or enhanced barrier precautions with your PDPH point of contact.
- **Cleaning and disinfecting the patient care environment and reusable equipment with an effective disinfectant**. Using an EPA-registered disinfectant with a kill claim against *C. auris* (List P) is critical, as *C. auris* can persist on surfaces in healthcare settings. If these products are not available, an EPA-registered hospital-grade disinfectant effective against *Clostridioides difficile* spores (List K) can be used.
- **Inter-facility communication about a patient's *C. auris* status** when a patient is transferred to another healthcare facility. Patients with a pending colonization specimen should be placed on preemptive contact precautions upon transfer to the receiving facility. PDPH has a transfer letter that can accompany a patient positive for *C. auris* upon transfer.
- **Screening contacts of newly identified case patients** to identify *C. auris* colonization.
- **Laboratory surveillance** of clinical specimens to detect additional cases.

Additional information can be obtained on the CDC's Infection Control Guidance: *Candida auris* page.

COLONIZATION SCREENING

All healthcare facilities and providers in Philadelphia should consider colonization screening in the following situations:

- Targeted screening of high-risk patients:
  - Healthcare contacts of those with newly identified *C. auris* infection or colonization;
  - Patients who are on a mechanical ventilator or have a tracheostomy and reside in or are transferred from an LTACH or a SNF with the capability to care for residents on ventilators;
  - Patients infected or colonized with carbapenemase-producing carbapenem-resistant Enterobacterales (CP-CRE), as co-colonization of *C. auris* with these organisms has been observed, especially in those with more than one risk factor
- Periodic preemptive *C. auris* point prevalence surveys are recommended in high-risk facilities and units. Discuss options with your PDPH point of contact.
- Admission screenings in high-risk facilities and units can help with early detection of colonized patients and inform implementation of transmission-based precautions. Early detection is key to preventing transmission. Discuss screening options with your PDPH point of contact.

Patients should be placed on preemptive contact precautions while awaiting test results if they are at high risk of being colonized with *C. auris* based on healthcare and risk factor history.

Philadelphia healthcare facilities and providers should contact PDPH to discuss public health resources for *C. auris* screening. Public health laboratory resources are available to perform colonization screening using a validated detection method for composite axillary/groin swabs. Facilities should also consider ways to increase capacity for *C. auris* screening, including developing their own laboratory capacity or working with reference laboratories that offer this testing.

CONTAINMENT RESPONSE FOR *C. AURIS*

C. auris resources are available at Philadelphia Department of Public Health - *Candida auris* Toolkit.

A single case of *C. auris* (infection or colonization) requires a robust containment response. PDPH will conduct outreach to healthcare facilities and clinical laboratories with cases, epidemiologic links to case patients, or with patients at high risk of *C. auris*.

Healthcare Facilities and Providers
Healthcare facilities should implement the following containment measures:

- Develop and maintain *C. auris* policies to ensure measures are in place should a patient with *C. auris* be detected in, or transferred to, the facility.
- Maintain vigilance for clinical illness that could be consistent with *C. auris*, particularly in patients at higher risk.
- Evaluate surveillance protocols with the laboratory to ensure prompt notification to the infection prevention and control program when *C. auris* is detected or suspected.
- Deliver education to staff and providers about *C. auris* and the infection prevention and control measures necessary to contain it. Resources are available on CDC's Infection Control Guidance: *Candida auris* page.
    - Educational in-services must include an emphasis on hand hygiene. Alcohol-based hand sanitizer is effective against *C. auris* and is the preferred method for cleaning hands when they are not visibly soiled. If hands are visibly soiled, wash with soap and water.
- Facilities that have not previously had *C. auris* cases should contact PDPH prior to admitting a patient known or suspected of being colonized or infected with *C. auris*.
- Report to PDPH when a patient colonized or infected with *C. auris* will be transferred from your facility to another facility; this allows public health to work with the receiving facility to provide education and ensure they are prepared to implement appropriate infection prevention and control measures.
- Review environmental cleaning practices for effectiveness against *C. auris*. Use of an EPA-registered hospital-grade disinfectant with a kill claim against *C. auris* (List P) is critical as *C. auris* can persist on surfaces in healthcare settings. If none of these products are available, an EPA-registered hospital-grade disinfectant effective against Clostridioides difficile spores (List K) can be used.
- Increase audits for hand hygiene, personal protective equipment (PPE) and environmental cleaning on units with *C. auris* positive patients. Re-educate healthcare personnel through an in-service or retraining if audits demonstrate low adherence to recommended infection prevention and control practices.

Clinical Laboratories
Clinical laboratories should implement methods to detect *C. auris* as outlined below:

- Use the CDC's Laboratory Information for *C. auris* and algorithm to identify *C. auris* based on the available phenotypic laboratory method and initial species identification.
- If your laboratory does not have methodologies required to speciate *C. auris*, talk with PDPH to evaluate the utility of forwarding isolates suspicious for *C. auris* for further testing at commercial or public health laboratories that can perform *C. auris* identification. Please do not forward isolates to the PDPH laboratory, PA Bureau of Laboratories (PA BOL), or the Maryland Regional Antimicrobial Resistance Laboratory Network (MD-ARLN) without PDPH approval.
- If possible, perform speciation for all yeast isolates from an inpatient in a healthcare facility (acute care hospital, LTACH, or SNF), including from both normally sterile and nonsterile body sites. This activity may be particularly useful in healthcare facilities that have already identified *C. auris* within their patient population.

Reporting
Healthcare facilities, providers, and laboratories with **suspected or confirmed cases of *C. auris* (infection or colonization), should report them to PDPH at 215-685-6748**. *C. auris* became nationally notifiable and a reportable condition in Philadelphia in 2018.

References

1. Benedict, K., Forsberg, K., Gold, J., Baggs, J., & Lyman, M. (2023). *Candida auris*–Associated Hospitalizations, United States, 2017–2022. Emerging Infectious Diseases, 29(7), 1485-1487. https://doi.org/10.3201/eid2907.230540.
2. Public Health England. *Candidozyma auris*: guidance for acute healthcare settings - 21 August 2025.
3. Schelenz S, Hagen F, Rhodes JL, Abdolrasouli A, Chowdhary A, Hall A, et al. First hospital outbreak of the globally emerging *Candida auris* in a European hospital. Antimicrob Resist Infect Control. 2016;5:35. Available from: https://aricjournal.biomedcentral.com/articles/10.1186/s13756-016-0132-5