Case Report

Kodamaea (Pichia) ohmeri fungaemia in a premature neonate

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Kodamaea ohmeri is a yeast that rarely causes human infections. The first case of K. ohmeri fungaemia in a premature neonate is reported; it was successfully treated with liposomal amphotericin B. Biochemical identification of the yeast was performed by Vitek II and API and was confirmed by rRNA gene sequencing. K. ohmeri as a human pathogenic yeast is uncommon to hospitalized neonates and immunocompromised individuals.

Introduction

Kodamaea ohmeri is a rare clinical isolate that has recently become known to cause various human infections. This yeast, previously known as Pichia ohmeri and Yamadazyma ohmeri (Yamada et al., 1995), is commonly used in the food industry for its fermentation properties in pickles (Kurtzman, 1998). K. ohmeri has been implicated in causing fungaemia (Bergman et al., 1998; Matute et al., 2000; Hitomi et al., 2002; Shin et al., 2003; Han et al., 2004), peritonitis (Choy & Wong, 2000), endocarditis (João et al., 2002; Reina & Larone, 2002), funguira (Puerto et al., 2002) and wound infection (Han et al., 2004). We report the first case of K. ohmeri fungaemia in a premature neonate successfully treated with liposomal amphotericin B.

Case report

A newborn baby, one of quadruplets, was delivered in October 2004 to a 26-year-old mother in the 25th week of gestation due to spontaneous rupture of membranes and premature labour pains. The baby was a low birth weight female (680 g). She was intubated because of a low APGAR score, and work up for sepsis was done and antimicrobial therapy with gentamicin and penicillin was initiated. The therapy was continued for one more week and then discontinued. On the 8th week the baby was doing well and after 89 days post-birth she weighed 1710 g and was breathing without a ventilator.

Blood cultures were performed using the Bactec automated culturing system (BD Diagnostic Systems) and paediatric bottle (Shannon Industrial Estate, Ireland). Identification of the yeast isolate was carried out through biochemical profiles with Vitek II and API ID 32C (bioMérieux). Sequence analysis of the 5·8S rRNA was performed to confirm the biochemical identification. Analysis methods were performed as previously mentioned (Han et al., 2004).

Blood cultures were performed on the 13th day of life showed a yeast-like organism. Based on this finding, amphotericin B was started (0·7 mg o.d.). In the following week, four successive blood cultures were positive for the yeast. The organism was tentatively identified as K. ohmeri by biochemical methods. The Antifungal Etest (Solna; Sweden) was used to determine susceptibility of the yeast; it was shown to be susceptible to amphotericin B (MIC, 0·064 μg ml⁻¹) and flucytosine (MIC, <0·002 μg ml⁻¹), but dose-dependently susceptible to itraconazole (MIC, 0·25 μg ml⁻¹) and fluconazole (MIC, 32 μg ml⁻¹). The dosage of amphotericin B was increased to 0·9 mg o.d. and fluconazole was started initially with 10 mg, which was later tapered to 5 mg. The yeast still grew in blood cultures on the 30th day of life. Amphotericin B was replaced by liposomal amphotericin B at 5 mg o.d. Three successive blood cultures during 3 weeks were negative for yeast growth. The antifungal therapy was continued for one more week and then discontinued. On the 8th week the baby was doing well and after 89 days post-birth she weighed 1710 g and was breathing without a ventilator.
Antifungal susceptibility data are available for five strains of K. ohmeri (MIC = 0.2–1 μg ml⁻¹), as was our K. ohmeri strain (0.064 μg ml⁻¹). Our patient did not respond to empiric treatment with fluconazole (in vitro dose-dependent susceptibility to this strain ≥ 32 μg ml⁻¹). Regular amphotericin B was not effective either as appeared from the positive successive blood culture results; however, the patient responded to liposomal amphotericin B. Noteworthy, of the 11 reported cases so far, eight patients recovered and three died.

The study case represents a hospital-acquired infection. Disseminated candidiasis is the most common nosocomial fungal infection, and Candida albicans has been reported to account for most cases of invasive candidiasis (Emori & Gaynes, 1993; Pfaffer, 1995). However, recent reports have also suggested emergence of infections caused by non-C. albicans Candida species (Wingard, 1995). In addition, less common pathogenic yeasts such as Trichosporon and Malassezia spp. have been reported with increased frequency as causes of nosocomial infections, especially in NICU patients (Fridkin & Jarvis, 1996). Although reports on emerging fungal pathogens fail to include K. ohmeri as a human pathogenic yeast, based on the recent series of case reports (Table 1) and this case report it could be considered an uncommon pathogen for premature neonates.

### References


