**Candida krusei:** biology, epidemiology, pathogenicity and clinical manifestations of an emerging pathogen

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Summary. Early reports of *Candida krusei* in man describe the organism as a transient, infrequent isolate of minor clinical significance inhabiting the mucosal surfaces. More recently it has emerged as a notable pathogen with a spectrum of clinical manifestations such as fungaemia, endophthalmitis, arthritis and endocarditis, most of which usually occur in compromised patient groups in a nosocomial setting. The advent of human immunodeficiency virus infection and the widespread use of the newer triazole fluconazole to suppress fungal infections in these patients have contributed to a significant increase in *C. krusei* infection, particularly because of the high incidence of resistance of the yeast to this drug. Experimental studies have generally shown *C. krusei* to be less virulent than *C. albicans* in terms of its adherence to both epithelial and prosthetic surfaces, proteolytic potential and production of phospholipases. Furthermore, it would seem that *C. krusei* is significantly different from other medically important *Candida* spp. in its structural and metabolic features, and exhibits different behaviour patterns towards host defences, adding credence to the belief that it should be re-assigned taxonomically. An increased awareness of the pathogenic potential of this yeast coupled with the newer molecular biological approaches to its study may facilitate the continued exploration of the epidemiology and pathogenesis of *C. krusei* infections.

Introduction

There are nearly 150 asporogenous yeast species presently classified in the genus *Candida*. Of these, *C. albicans*, *C. tropicalis* and *C. glabrata* comprise > 80% of clinical *Candida* isolates while others such as *C. krusei*, *C. parapsilosis*, *C. guilliermondii* and *C. kefyr* are isolated sporadically and are thought to be less virulent. Nonetheless, their importance as medically important fungi has been recognised from the early twentieth century and recent data indicate that > 30% of nosocomial candida infections are due to species other than *C. albicans*.

The yeasts belonging to the genus *Candida* were first discovered by Langenbeck in 1839 from buccal aphthae in a patient with typhus, but the suggestion that *C. krusei* may cause disease in man was proposed by Castellani more than 75 years later. Since then, this organism has been generally recognised as a commensal in warm-blooded animals with very low pathogenicity and virulence. However, there has been a remarkable increase in the reports of *C. krusei* as a human pathogen during the last two to three decades. For instance, from 1960 onwards, > 65 articles have been published implicating *C. krusei* as an aetiological agent in human disease. Although this may be due partly to increased awareness of the organism and improvements in laboratory identification methods, there is little doubt that a true increase in the numbers of *C. krusei* infections has occurred during this period. This review emphasises the features that distinguish *C. krusei* from other members of the genus, its pathogenicity, epidemiology and clinical manifestations.

Biology

In contrast to a majority of other *Candida* spp. which are ovoid in shape, the cells of *C. krusei* are generally elongated and have the appearance of "long grain rice" (fig. 1), a feature which they share with *C. kefyr* (formerly *C. pseudotropicalis*) amongst clinically important *Candida* spp. *C. krusei* (Castellani Berkhout) measures 2-2.5-6 x 4.3-15.2 μm, with wide variations in the length and the breadth of the isolates (fig. 1). Variation in colony morphology of *C. krusei* has also been observed.
The ultrastructure of *C. krusei* has been described in one article. This study indicated a multilayered cell wall comprising six layers and a few intracytoplasmic organelles such as small vesicles, lipid droplets, ribosomes and groups of dense intra-cytoplasmic granules, probably glycogen. The multilayered cell wall consisted of an outer irregular coat of flocculent material, an electron-dense zone, a granular layer, a less granular layer, a thin layer of dense granules and another sparsely granular layer outside the trilaminar cell membrane. The outer layer of flocculent material appears in abundance in some isolates as extracellular extensions linking the individual cells, especially during growth of colonies on solid media (fig. 1c).

The α-D-mannan of the cell wall of *Candida* spp. is an important constituent of its structure as it acts as a major antigen. The mannan usually has a (1-6)-linked main backbone with side chains containing (1-2) or (1-3) linkages, or both. Although Nishikawa *et al.* are of the opinion that *C. krusei* cell-wall mannans are
Candida krusei: an emerging pathogen

Table I. The frequencies of oral isolation of *C. krusei* and *C. albicans* from various patient populations

<table>
<thead>
<tr>
<th>Date</th>
<th>Reference</th>
<th>Patient group</th>
<th>Sampling technique</th>
<th>C. krusei (%)</th>
<th>C. albicans (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1962</td>
<td>Mackenzie27</td>
<td>Hospital patients</td>
<td>Swabs</td>
<td>2-4</td>
<td>65-9</td>
</tr>
<tr>
<td>1962</td>
<td>Stenderup and Pederson28</td>
<td>Hospital patients</td>
<td>Swabs</td>
<td>1-1</td>
<td>75-6</td>
</tr>
<tr>
<td>1968</td>
<td>Mahgoub29</td>
<td>Children (oral thrush)</td>
<td>Swabs</td>
<td>4-0</td>
<td>44-0</td>
</tr>
<tr>
<td>1969</td>
<td>Pederson30</td>
<td>Obstetric patients</td>
<td>Not stated</td>
<td>0-5</td>
<td>79-2</td>
</tr>
<tr>
<td>1969</td>
<td>Grodzka31</td>
<td>Dental patients</td>
<td>Smears</td>
<td>2-8</td>
<td>61-1</td>
</tr>
<tr>
<td>1974</td>
<td>Olsen32</td>
<td>Denture stomatitis</td>
<td>Imprint and smears</td>
<td>2-3</td>
<td>54-7</td>
</tr>
<tr>
<td>1974</td>
<td>Milne33</td>
<td>Respiratory infections</td>
<td>Not stated</td>
<td>2-1</td>
<td>80-1</td>
</tr>
<tr>
<td>1975</td>
<td>Budtz-Jørgensen et al.34</td>
<td>Genitain patients</td>
<td>Swabs</td>
<td>1-7</td>
<td>65-9</td>
</tr>
<tr>
<td>1978</td>
<td>Odds et al.35</td>
<td>Diabetic patients</td>
<td>Mouth wash</td>
<td>5-4</td>
<td>73-9</td>
</tr>
<tr>
<td>1979</td>
<td>Coudert et al.36</td>
<td>Psychiatric patients</td>
<td>Not stated</td>
<td>3-0</td>
<td>33-3</td>
</tr>
<tr>
<td>1979</td>
<td>Shipman37</td>
<td>Cancer patients</td>
<td>Saliva</td>
<td>3-1</td>
<td>84-4</td>
</tr>
<tr>
<td>1981</td>
<td>Martin et al.38</td>
<td>Oral cancer</td>
<td>Swabs</td>
<td>1-9</td>
<td>65-8</td>
</tr>
<tr>
<td>1982</td>
<td>Staib et al.39</td>
<td>Denture stomatitis</td>
<td>Not stated</td>
<td>3-1</td>
<td>62-5</td>
</tr>
<tr>
<td>1983</td>
<td>Martin and Wilkinson40</td>
<td>School children</td>
<td>Swab</td>
<td>+</td>
<td>71-0</td>
</tr>
<tr>
<td>1984</td>
<td>MacFarlane41</td>
<td>Sjorgen's patients</td>
<td>Swab</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>1985</td>
<td>Wright et al.42</td>
<td>Denture wearers</td>
<td>Imprint cultures</td>
<td>6-1</td>
<td>46-9</td>
</tr>
<tr>
<td>1987</td>
<td>Fisher et al.43</td>
<td>Diabetic patients</td>
<td>Oral rinse</td>
<td>2-8</td>
<td>89-0</td>
</tr>
<tr>
<td>1989</td>
<td>Samaranayake et al.44</td>
<td>Burning mouth syndrome</td>
<td>Oral rinse</td>
<td>+</td>
<td>+</td>
</tr>
</tbody>
</table>

+ , no quantitative data.

C. krusei is a genus of asexual yeasts.8 C. krusei is very closely related to a sexual species,18 and a sexual form—termed *Issatchenkia orientalis*—has been proposed for the organism.19

**Growth and metabolism**

*C. krusei* grows at a maximum temperature of 43–45°C. Although most of the medically important *Candida* spp. require biotin for growth and some have additional vitamin requirements, only *C. krusei* can grow in vitamin-free media.9 *C. krusei* assimilates and ferments only glucose out of a large panel of carbohydrates.19,20 The only other yeast sometimes isolated from medical specimens which reacts similarly is *C. pintolopesii*.19 However, of the medically important *Candida* spp., *C. krusei* is perhaps the only species which grows on Sabouraud’s dextrose agar as spreading colonies with a matt or a rough whitish yellow surface, in contrast to the convex colonies of other *Candida* spp. This characteristic, together with its “long grain rice” appearance on microscopy, helps the definitive identification of the species.21

A complex variety of fatty acids has been demonstrated as metabolites when *C. krusei* is grown in culture media containing lactose,22 it is also able to produce acetoin.23 It also produces a number of short-chain carboxylic acids when cultured in saliva supplemented with glucose; these include acetate, pyruvate, succinate, propionate, formate and lactate.24 The biological role of these, if any, is as yet unknown.

**Epidemiology**

Compared to the medically important *Candida* spp., *C. krusei* has been isolated from a large variety of
natural habitats such as the atmosphere, fruits, sewage, silage, soil, foods (including dairy and meat products, pickles, sugar and syrup-based products), wines and beer.\(^{10}\) Hence it is widely distributed in nature and considered to be a facultative saprophyte.\(^{10}\) It is also found in chickens and seagulls.\(^{8}\)

Generally, \(C.\) \(k r u s e i\) is considered to be a transient commensal in man and has been isolated only infrequently from the mucosal surfaces of various patient groups and as a mucosal inhabitant in healthy individuals.\(^{8}\) In his comprehensive review of the literature on oral carriage of \(C.\) \(a l b i c a n s\), Odds\(^{6}\) concluded that \(C.\) \(k r u s e i\) is the fifth most dominant species, with \(C.\) \(a l b i c a n s\), \(C.\) \(g l a b r a t a\), \(C.\) \(t r o p i c a l i s\) and \(C.\) \(p a r a p s i l o s i s\) preceding it. In one large study, the most common yeast combinations isolated from oral samples comprised \(C.\) \(a l b i c a n s\) with one or more of the following: \(C.\) \(k r u s e i\), \(C.\) \(t r o p i c a l i s\) or \(C.\) \(g l a b r a t a.\)\(^{26}\)

### Pathogenicity

#### Virulence factors

\(C.\) \(a l b i c a n s\) spp. have several virulence attributes. Some of these include adherence to host surfaces, production

### Table II. The frequencies of isolation of \(C.\) \(k r u s e i\) and \(C.\) \(a l b i c a n s\) from the gastrointestinal tract of various patient populations

<table>
<thead>
<tr>
<th>Date</th>
<th>Reference</th>
<th>Patient group</th>
<th>Sampling technique</th>
<th>(C.) (k r u s e i) (%)</th>
<th>(C.) (a l b i c a n s) (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1968</td>
<td>Schonebeck(^{43})</td>
<td>With or without gastric diseases</td>
<td>Aspirated by catheter</td>
<td>0.9</td>
<td>52.6</td>
</tr>
<tr>
<td>1968</td>
<td>Bernhardt(^{44})</td>
<td>Not stated</td>
<td>Not stated</td>
<td>3.7</td>
<td>53.1</td>
</tr>
<tr>
<td>1969</td>
<td>Cohen et al.(^{47})</td>
<td>Normal adults</td>
<td>Aspirates from small intestine</td>
<td>2.9</td>
<td>71.4</td>
</tr>
<tr>
<td>1974</td>
<td>Brooks et al.(^{48})</td>
<td>Pre-vagotomy and post-vagotomy</td>
<td>Aspiration</td>
<td>10.3</td>
<td>79.5</td>
</tr>
<tr>
<td>1980</td>
<td>Gordon et al.(^{49})</td>
<td>Chronic lymphocytic leukaemic patient with intra-abdominal abscess</td>
<td>Pus samples</td>
<td>+</td>
<td>—</td>
</tr>
<tr>
<td>1985</td>
<td>Di Febo(^{50})</td>
<td>Gastric ulcer</td>
<td>Biopsies of lesion border</td>
<td>2.6</td>
<td>47.5</td>
</tr>
</tbody>
</table>

+ : no quantitative data.

### Table III. The frequencies of isolation of \(C.\) \(k r u s e i\) and \(C.\) \(a l b i c a n s\) from various patient populations with and without symptoms of vaginitis

<table>
<thead>
<tr>
<th>Date</th>
<th>Reference</th>
<th>Patient group</th>
<th>Sampling technique</th>
<th>(C.) (k r u s e i) (%)</th>
<th>(C.) (a l b i c a n s) (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asymptomatic women</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1962</td>
<td>Stenderup and Pederson(^{51})</td>
<td>Hospital patients</td>
<td>Not stated</td>
<td>5.6</td>
<td>55.6</td>
</tr>
<tr>
<td>1963</td>
<td>Sonck and Somersalo(^{51})</td>
<td>Diabetic girls</td>
<td>Swabs</td>
<td>9.7</td>
<td>55.4</td>
</tr>
<tr>
<td>1963</td>
<td>Kearns and Gray(^{52})</td>
<td>Gynaecology</td>
<td>Not stated</td>
<td>3.2</td>
<td>77.7</td>
</tr>
<tr>
<td>1964</td>
<td>Hurley and Morris(^{53})</td>
<td>Obstetrics</td>
<td>Not stated</td>
<td>5.4</td>
<td>54.9</td>
</tr>
<tr>
<td>1966</td>
<td>Timonen et al.(^{55})</td>
<td>Gynaecology</td>
<td>Smear</td>
<td>4.9</td>
<td>37.6</td>
</tr>
<tr>
<td>1967</td>
<td>Mahgoub(^{59})</td>
<td>Pregnant women</td>
<td>Swabs</td>
<td>4.7</td>
<td>60.9</td>
</tr>
<tr>
<td>1979</td>
<td>Kinnipperbergen et al.(^{56})</td>
<td>Gynaecology</td>
<td>Not stated</td>
<td>4.8</td>
<td>76.9</td>
</tr>
<tr>
<td>1981</td>
<td>Bergamashi et al.(^{57})</td>
<td>Asymptomatic</td>
<td>Smear</td>
<td>11.7</td>
<td>83.3</td>
</tr>
<tr>
<td>1983</td>
<td>Schönheyder et al.(^{58})</td>
<td>Pregnant women</td>
<td>Swabs</td>
<td>3.0</td>
<td>64.0</td>
</tr>
<tr>
<td>1984</td>
<td>Mendling and Schnell(^{59})</td>
<td>Pregnant women</td>
<td>Not stated</td>
<td>2.7</td>
<td>73.6</td>
</tr>
<tr>
<td>1986</td>
<td>Mondello et al.(^{60})</td>
<td>Asymptomatic</td>
<td>Swabs</td>
<td>7.6</td>
<td>34.8</td>
</tr>
<tr>
<td>1986</td>
<td>Guaschino et al.(^{61})</td>
<td>Pregnant women</td>
<td>Swabs</td>
<td>5.0</td>
<td>66.3</td>
</tr>
</tbody>
</table>

| Symptomatic women |
| 1972  | Thierry et al.\(^{62}\)     | Vaginal candidosis                     | Swabs              | 12.5                      | 77.2                      |
| 1972  | Proost et al.\(^{63}\)      | Vaginal candidosis                     | Swabs              | 0.7                       | 93.4                      |
| 1972  | Peeters et al.\(^{64}\)     | Vaginal candidosis                     | Swabs              | 1.9                       | 81.5                      |
| 1973  | Hurley et al.\(^{65}\)      | Pregnant women                         | Charcoal swabs     | 0.4                       | 90.4                      |
| 1975  | Sparks et al.\(^{66}\)      | Obstetrics                             | Swabs              | 4.0                       | 86.0                      |
| 1985  | Horowicz et al.\(^{57}\)    | Gynaecology                            | Vaginal specimens  | 0.6                       | 67.9                      |
| 1986  | Brecker et al.\(^{68}\)     | Gynaecology                            | Not stated         | 2.2                       | 92.6                      |
| 1986  | Mondello et al.\(^{69}\)    | Gynaecology                            | Swabs              | 16.1                      | 29.0                      |
| 1987  | Saz and Del Palacio\(^{99}\) | Gynaecology                            | Not stated         | 1.7                       | 91.7                      |
| 1989  | Porra et al.\(^{70}\)       | Gynaecology                            | Not stated         | 11.4                      | 56.8                      |
| 1989  | Gugnani et al.\(^{71}\)     | Pregnant women                         | Not stated         | 5.4                       | 92.2                      |
of phospholipases and proteinases and formation of hyphae, which help evasion of the host immune defences. Unlike the more pathogenic C. albicans, relatively few studies have been conducted to determine the virulence potential of C. krusei in man and laboratory animals. An early investigation by Hurley and Stanley compared the cytopathic effect of C. krusei and other Candida spp. in cell cultures. C. krusei, C. kefyr and C. parapsilosis destroyed cultured mouse renal epithelial cells in 48–72 h, whereas the relatively more pathogenic C. albicans, C. tropicalis and C. stellatoidea (now re-assigned as C. albicans) induced degenerative changes rapidly, and totally destroyed the cultures in a much shorter period of 24 h.

Howlett determined the pathogenicity of C. krusei with an in-vitro organ culture system comprising the dorsal tongue mucosa of neonatal Sprague Dawley rats. In the tissues infected with C. krusei, the fungus grew in both the yeast and mycelial phases, but generally showed less invasiveness than C. albicans or C. tropicalis. C. albicans produced extensive epithelial invasion, penetrating all the layers of the epithelium, but C. krusei did not penetrate the stratum corneum, although a heavy growth of the yeast was observed on the superficial epithelium. However, a scanty growth of C. krusei into the connective tissues was observed at the explant edges. Similar results were also obtained for two other Candida spp.—C. parapsilosis and C. guilliermondii.

Although adhesion to host surfaces is an essential prerequisite for colonisation and subsequent invasion, very few workers have investigated the adhesion of C. krusei to host epithelial cells. In one early study by King et al., where the in-vitro adhesion of C. krusei and other Candida spp. to buccal epithelial cells (BEC) was compared, it was observed that the adhesion of C. krusei was far less than that of C. albicans. Indeed, C. krusei failed to adhere to BEC whereas the other species tested—C. tropicalis, C. parapsilosis, C. guilliermondii and C. kefyr—adhered but demonstrated lower values than C. albicans. In another investigation, Ray et al. investigated the adhesion of five Candida spp.; C. albicans and C. stellatoidea exhibited marked adhesion to BEC whereas C. tropicalis, C. parapsilosis, C. guilliermondii and C. krusei showed little or no adhesion. However, all these studies were conducted with only one or two isolates of C. krusei and hence it is not possible to conclude whether intra-species differences exist amongst different Candida spp.

Two recent investigations have employed a larger number of C. krusei isolates to evaluate the adhesion of the fungus to several surfaces. One of these, by Tobgi, revealed that seven C. krusei isolates had the lowest affinity to BEC when compared with a number of other Candida spp. that adhered to oral epithelial cells in the following hierarchical order: C. albicans, C. tropicalis, C. parapsilosis, C. glabrata, C. guilliermondii and C. krusei. In a second study with five isolates each of C. krusei and C. albicans, all C. krusei isolates were c. 15 times less adhesive than the C. albicans isolates.

In a related clinical study where the adhesion of C. krusei and C. albicans isolates to BEC from healthy individuals and bone marrow transplant patients were compared, the adhesion of C. albicans to the latter cells was three-fold lower than to the control cells, although adhesion of C. krusei remained the same. This may possibly reflect a selective colonisation process which may operate in these patients, possibly due to drug therapy (see section on C. krusei and antifungal agents), and may explain to some extent the frequent isolation of C. krusei from the mouth in compromised patient groups.

A few workers have examined the adherence of C. krusei to non-biological surfaces. Tobgi, for instance, found that the adhesion of C. krusei to denture acrylic strips was the lowest in comparison with several other Candida spp.—including C. albicans. Other studies examining the relative adherence of different Candida spp. to acrylic have confirmed these findings. However, a recent study, with 20 isolates of C. krusei, demonstrated that the adhesion of the latter to acrylic is significantly greater than that of C. albicans. Although the variations in these results from different centres could be attributable to differences in the isolates, techniques and culture media, it is fair to conclude that C. krusei is more adherent to inert surfaces than to buccal epithelial cells.

Cell-surface hydrophobicity is considered to play a critical role in the initial events leading to colonisation of host surfaces by Candida spp. and this property, together with adherence, may have clinical implications in fungal infections related to plastic devices such as implants and catheters. Klotz et al. have ranked the hydrophobicity of different Candida spp. by measurement of adherence to an aqueous-hydrocarbon two-phase system. The two C. krusei strains they studied were more hydrophobic than C. albicans, C. tropicalis, C. kefyr, C. parapsilosis, C. glabrata or C. lipolytica isolates. Others have also found C. krusei to be more highly hydrophobic than the key, medically important Candida spp. Recently, we examined the cell surface hydrophobicity of 20 oral isolates of C. krusei with the aforementioned biphasic assay system and found the hydrophobicity of the latter to be five-fold greater than that of a panel of C. albicans (Y. H. Samaranayake, unpublished data). Minagi et al. also observed the cell surface hydrophobicity of C. krusei to be similar to that of C. glabrata and C. tropicalis but greater than that of either C. albicans or C. parapsilosis. A significant positive correlation has been reported between the adherence of Candida spp. to acrylic surfaces and their cell surface hydrophobicity. However, when saliva-coated acrylic plates were used, the cell surface hydrophobicity as well as the adherence of C. krusei to acrylic was significantly decreased. Therefore, it would seem that, of the medically important Candida spp., C. krusei is endowed with a greater ability to colonise
inert surfaces such as implants and catheters by virtue of its cell surface hydrophobicity.

Once attached to an inert substrate, and if left undisturbed and provided with adequate nutrition, organisms multiply and colonise surfaces with resultant formation of thin pellicles or biofilms. This phenomenon of biofilm formation by microbes on implant materials (such as urinary catheters, prosthetic heart valves, cardiac pacemakers, silicone voice prostheses, endotracheal tubes and cerebrospinal fluid shunts) has received considerable attention in the last decade as there appears to be a direct relationship between the ability of an organism to form a biofilm and its pathogenicity. In a recent study, Hawser and Douglas demonstrated, with an in-vitro model, that the biofilm formation on the surface of different catheter materials varied among Candida spp., and also correlated to some extent with pathogenicity. Thus, less pathogenic species such as C. parapsilosis, C. pseudotropicalis (now C. kefyr) and C. glabrata produced significantly less biofilm than the more pathogenic C. albicans. Remarkably though, of the Candida spp. examined, C. krusei produced the most extensive biofilm on the surfaces of polyvinyl chloride catheter disks irrespective of the growth medium, which either suppressed or promoted extracellular polysaccharide formation. One reason for this may be the dual attributes of very high cell surface hydrophobicity and adherence of C. krusei to inert plastic surfaces compared with other species (see above) which may have facilitated biofilm development.

The ability to produce hydrolytic enzymes such as phospholipases and proteinases is considered a putative virulence factor of Candida spp. However, C. krusei, in contrast to species such as C. albicans, does not possess the ability to produce either of these enzymes.

From the foregoing review of the virulence attributes of C. krusei, it is evident that the organism is relatively less virulent than the commonly pathogenic Candida spp. such as C. albicans. The following section will further elucidate the relative vulnerability of C. krusei to host defence mechanisms.

Host defence factors

There are few studies on the effect of host defence factors on C. krusei. These mainly relate to the effect of constituents of biological fluids such as lysozyme and lactoferrin. Both are non-immune defence factors

Fig. 2. Scanning electronmicrographs of: a, control; b, apo-lactoferrin-treated C. krusei isolates. Note the bleb-like surface changes and irregular cell surface of the apo-lactoferrin-treated cells. Magnification × 10000. (From reference 94, with permission.)
Fig. 3. The fungicidal activity of lysozyme (2 μg/ml) for different candidal isolates. The higher the Fly value the more sensitive the isolate is to lysozyme. Note the very high susceptibility of *C. krusei* to lysozyme when compared with the other species. (From reference 96, with permission.)

present in human external secretions (e.g., saliva, milk, tears), mucosal surfaces and secondary granules of polymorphonuclear leucocytes. Lactoferrin is highly bactericidal in nature and this activity is a direct result of iron sequestration and deprivation of this element that is essential for bacterial growth. Lactoferrin may also interact directly with bacteria, altering their permeability. Valenti et al. were the first to examine the effect of iron-free lactoferrin on a single isolate of *C. krusei* and they reported no inhibition of growth or adsorption of lactoferrin on to the fungal cell surface. However, a recent study indicated varying degrees of susceptibility to lactoferrin amongst *C. albicans* and *C. krusei* isolates. The authors demonstrated that *C. krusei* was almost 50% more sensitive to iron-free lactoferrin than *C. albicans* and, furthermore, they noted cell surface changes such as bleb-like structures and efflux of cellular protein into the test medium due to lactoferrin activity, implying that cell death may be a direct consequence of permeability changes (fig. 2).

The inhibitory effects of lysozyme on *C. krusei* and several other *Candida* spp. were first demonstrated by Kamaya. Similar studies have been conducted by Tobgi et al. comparing the antifungal activity of lysozyme against a battery of *Candida* spp. They showed that the *Candida* spp. were susceptible to lysozyme in the following order: *C. krusei* > *C. parapsilosis* > *C. tropicalis* > *C. guilliermondii* > *C. albicans* > *C. glabrata*, the latter being the most resistant to lysozyme (fig. 3). Furthermore, *C. krusei* pre-incubated in sucrose-supplemented media becomes highly sensitive to the killing effect of lysozyme in comparison to *C. albicans*. As it is known that *C. albicans* produces an extracellular floccular layer during growth in sucrose-supplemented media, the increased sensitivity of *C. krusei* to lysozyme under these conditions appears to be due to the absence of such extracellular material. These data tend to confirm the observations of Kogan et al. that the cell wall structure of *C. krusei* differs significantly from that of *C. albicans* (see above) while indicating that biological fluids such as saliva may exert a selective colonisation pressure on different *Candida* spp., thereby suppressing the growth of more susceptible species such as *C. krusei*.

Samaranayake et al. examined the fungicidal effect of murine bronchial lavage fluid to determine whether respiratory secretions could protect the surfaces of the lower respiratory tract. Of the five different *Candida* spp. examined, *C. albicans* was the most sensitive, whereas *C. krusei* and *C. glabrata* were highly resistant to the activity of bronchial lavage fluid.

After exposure to a primary barrage of anti-candidal
importance of phagocytosis in host defence against
Although several investigators have reported the
release micro-assay and measurement of colony
ing of C. guilliermondii and C. parapsilosis were killed by poly-
morphonuclear and bone marrow cells more rapidly
(1 h) than C. albicans, C. tropicalis and C. viswanathi
(4 h). Moreover, the effector to target cell ratio was
significantly higher for the latter species. Another
interesting observation was that C. krusei, C. guilliermondii and C. parapsilosis were more vulnerable
to peritoneal resident macrophages and spleen cells, in
particular, whereas C. albicans and C. tropicalis were
not affected even in mice immunodepressed with
cyclophosphamide. A few other workers have shown a
similar hierarchy of resistance to intracellular killing of
different Candida spp. by macrophages. In a
cytotoxic colorimetric assay, Borg et al. demonstrated
that C. krusei, C. guilliermondii, C. parapsilosis and C. glabrata were associated with a lower degree of
cytotoxicity than C. albicans and C. tropicalis.
In another report, in an in-vitro phagocytosis assay with
rat peritoneal macrophages, phagocytic indices
obtained for C. krusei and C. viswanathi were signific-
antly lower than those for C. albicans and C. tropicalis.

In animal studies, Bistoni et al. tested the relative
pathogenicity of C. albicans, C. krusei, C. parapsilosis,
C. tropicalis and C. viswanathi in normal and
cyclophosphamide-immunodepressed mice. In normal
mice, only C. albicans, C. tropicalis and C. viswanathi
were pathogenic on intravenous challenge, with
increased virulence after cyclophosphamide treat-
ment; the mice were consistently resistant to challenge
with C. krusei, C. guilliermondii and C. parapsilosis,
despite increasing doses of cyclophosphamide.
Although the foregoing data are limited, a consensus
view that C. krusei is highly vulnerable to immuno-
effector cells, when compared with C. albicans, appears
to be emerging.

Despite the limited information available on the
pathogenic attributes of C. krusei and its host inter-
actions, it can be concluded that in both these aspects,
C. krusei appears to be a feeble pathogen when
compared with other Candida spp., especially C. albicans. Hence, the predominant motive force in its
conversion from commensalism to parasitism is likely
to be related to the host within which it may lie
dormant and cause disease in the event of complete or
partial failure of host antimicrobial defences. The next
section is an account of clinical manifestations that C. krusei may cause in hosts with such compromised
defences.

Clinical manifestations
Systemic infections

In parallel with the increase in superficial candida
infections, there has been a surge in the incidence of
systemic candida infections in recent years. This has
been related to several predisposing factors, including
the use of immunosuppressive drugs, prolonged
broad-spectrum antibiotic therapy, indwelling intra-
vascular catheters, extensive periods of treatment in
intensive care units and the pandemic of human
immunodeficiency virus (HIV) infection.
Although C. albicans and C. tropicalis infections have
predominated in these patient populations, the emer-
gence of the less virulent C. krusei as a systemic
pathogen has been described in a number of patients
with compromised host resistance.

In one of the earliest studies in which C. krusei was
implicated as a systemic pathogen, Young et al. described 70 patients with fungal infections from the
National Cancer Institute (Bethesda, MD, USA)
during the decade beginning 1962. Of these, 28 patients
had C. albicans- and one had C. krusei-associated
disseminated fungal disease; the rest of the infections
were other mycoses. C. krusei was observed histologi-
cally in one or more visceral organs that were not
considered to be the original portal of entry of the fungus. This is perhaps the earliest documentation of
C. krusei fungaemia and systemic infection.

A prospective investigation of surgical and autopsy
specimens submitted to the Mycology Laboratory of
the Veterans Administration Centre in Wisconsin,
USA, from 1963 to 1973 was undertaken by Rose and
Varkey to study patients with possible deep fungal
infections. Of 123 such patients, 55 (44.7 %) infections
were caused by Candida spp. and 28 (22.8 %) by
Aspergillus spp. There were 44 patients during the first
5 years and 79 during the second period—an increased
number which was related primarily to the marked
increase in deep-seated candida infections. The major
aetiological agent of the 55 patients with candida
infection was C. albicans. Of the 46 patients with
positive blood cultures, C. albicans was isolated from
33 patients, C. parapsilosis from four, C. krusei from
two, C. tropicalis from two and C. guilliermondii from
one patient. The main underlying diseases among the
55 patients were general surgery, aspiration pneu-
monia and cerebral sclerosis, although they did not
describe the condition of the patient with C. krusei
infection.

Disseminated candidosis was seen in 39 patients
who attended the Presbyterian-University Hospital,
USA between 1963 and 1975. These investigators
observed a six-fold increase in the incidence of dis-
seminated candidosis during the last 4 years compared
C. parapsilosis (tropicalis) patient) and solid tumour (two patients). They have followed. Horn 1982, of which seven were due to C. krusei in comparison to 53 with C. albicans, 29 C. tropicalis, 26 C. glabrata, 16 C. parapsilosis and one with C. kefyr (formerly C. pseudotropicalis) fungaemia. The underlying diseases for the C. krusei fungaemias were leukaemia (one patient) and solid tumour (two patients). They surmised that the most important predisposing factors in these patients were intravenous catheters, chemotherapy, neutropenia and antibiotic administration; diabetes mellitus, adrenocorticosteroid treatment and radiation therapy accounted to a lesser degree. In comparison to patients with infections due to other Candida spp. who had multiple positive sites for the respective organisms, all three C. krusei fungaemia patients had only one positive site for the yeast other than the blood cultures and in all cases this was their respiratory tract, as the yeasts were isolated from sputum. Although all three patients with C. krusei fungaemia died, it was difficult to attribute death to the fungaemia. These early studies tended to suggest that C. krusei is not merely an innocuous commensal but has the potential to cause serious infection in patients with underlying immunosuppressive disease.

Since the realisation of the importance of C. krusei fungaemia in compromised patients, other studies have followed. Horn et al. 1982 reported 200 episodes of fungaemia in 188 patients in the Memorial Sloan Kettering Cancer Institute, USA, between 1978 and 1982, of which seven were due to C. krusei in comparison with 89 patients with C. albicans fungaemia. Whereas most episodes of C. krusei fungaemia occurred in patients with leukaemia, lymphoma or aplastic anaemia, most episodes of C. parapsilosis and C. glabrata fungaemia occurred in patients with solid tumour or non-neoplastic diseases; C. albicans fungaemias were evenly distributed between patients with haematological and non-haematological malignancies. It was also noted that other factors such as neutropenia, chemotherapy, broad-spectrum parenteral antibiotics and oral nystatin therapy tended to precede C. krusei or C. tropicalis fungaemia.

Arguably, the landmark study that confirmed the importance of C. krusei fungaemia in compromised patients was that of Merz et al. 1989. They evaluated a total of 868 patients admitted to the Oncology Centre of the Johns Hopkins Medical Institution, Baltimore MD, USA (1977-1985) and receiving time sequential chemotherapy for haematological malignancies or bone marrow transplantation, to determine the role of C. krusei in systemic candidosis. The patients received chemotherapy that induced a period of profound granulocytopenia (< 100/mm³) of at least 2 weeks, a condition conducive to candida infection. They were variably given platelet, blood and leucocyte transfusions and antibiotics, and urine, stool, rectal swabs and throat swabs were examined for fungal growth. The two criteria used to delineate C. krusei systemic infection in this population were isolation of the yeast from two or more blood cultures collected within a 72-h period during granulocytopenia, and isolation of the organism and evidence of candidosis from histopathological findings from tissues taken at biopsy or autopsy.

C. krusei was isolated from a total of 108 (12.4%) patients during this 9-year study. However, only 46 of them had persistent colonisation and the number of patients colonised each year with C. krusei ranged from eight to 21. The gastrointestinal tract was most frequently colonised (73%) followed by the upper respiratory tract (39%) and the urinary tract (6%). Seven of the patients died within 1 month of C. krusei sepsis; systemic candidosis was seen in four patients on whom autopsies were performed.

Finally, there is a single case report of disseminated C. krusei fungaemia in a 23-year-old male patient who had acute lymphosarcoma. 1983 The patient was diagnosed as having disseminated candidosis and treated with amphotericin B. A few days later C. krusei was grown from blood and faecal cultures. After recovering completely the patient died 2 months later; post-mortem examination did not reveal any evidence of disseminated candidosis.

A series of reports on C. krusei fungaemia in patients who are on the newer triazole antifungal agent, fluconazole, has appeared. This has wide therapeutic and clinical implications, as discussed in the penultimate section of this review.

Ocular infections

The most important ocular manifestation of C. krusei infection to date has been endophthalmitis. Previous citations on candidal endophthalmitis have largely been related to infections with C. albicans 1984, 1985.
although other species such as *C. tropicalis*, *C. parapsilosis*, *C. glabrata* and *C. guilliermondii* have been reported sporadically to be associated with haematogenous endophthalmitis.  

There are three case reports of *C. krusei* endophthalmitis. The first describes *C. krusei* fungaemia together with endophthalmitis in a 70-year-old man who was admitted for elective abdominoperineal resection for a recurrent rectal adenocarcinoma. After surgery, total parenteral nutrition through a peripheral intravenous catheter was administered. The patient developed high fever 15 days after surgery and blood cultures yielded *C. krusei*. Endophthalmitis in the left eye due to *C. krusei* was diagnosed and the patient recovered after receiving intravenous amphotericin B.

In the second case, a 69-year-old man with acute myeloid leukaemia was found to have endophthalmitis due to *C. krusei*. The patient initially experienced recurrent fever despite negative culture, although he was persistently neutropenic. At this stage, piperacillin, gentamicin and induction chemotherapy was administered. Blood cultures on the 20th day of hospitalisation yielded *C. krusei*. Endophthalmitis of the left eye due to *C. krusei* was diagnosed and the patient recovered after receiving intravenous amphotericin B.

A third case report of endophthalmitis due to *C. krusei* was in a man with acute myeloid leukaemia who was on induction chemotherapy. The patient became neutropenic, developed fever on day 20 and 2 days later several cutaneous lesions were observed. Two blood cultures obtained from a peripheral vein on day 20 and 2 days later several cutaneous lesions were observed. Two blood cultures obtained from a peripheral vein on day 20 were positive for *C. krusei*. In spite of treatment with liposomal amphotericin B, the fever persisted and on day 32 the patient developed candidal endophthalmitis. He subsequently recovered from endophthalmitis, but several months later experienced a relapse of leukaemia and died. Autopsy results revealed no sign of candidal infection.

A corneal ulcer due to *C. krusei* has also been described in another report. A 45-year-old female farmer complained of pain, redness, swelling and lacrimation in the left eye. Prior to the isolation of the aetiological agent the patient was given penicillin, oxytetracycline eye ointment and atropine drops and chloramphenicol. The condition deteriorated with swelling and diminution of vision and 10 days later fungal cultures were positive for *C. krusei*. The patient recovered her vision after topical and intravenous amphotericin B therapy. Interestingly, in animal experiments, the *C. krusei* isolate produced endophthalmitis in three compromised albino rabbits. Infection developed in all eyes that were tested within 24-72 h after inoculation.

**Miscellaneous infections**

Arthritis due to *Candida* spp. is uncommon and the involvement of *C. krusei* as a causative agent is extremely rare. There has been a report of arthritis caused by *C. krusei* in a heroin addict who had leukaemia and was neutropenic. The 41-year-old patient was undergoing cytotoxic drug therapy for relapse of acute myelogenous leukaemia. Following chemotherapy, he became neutropenic and was in an isolation chamber without prophylactic antibiotic or antifungal therapy. On the 10th day of hospitalisation, *C. krusei* was grown from five sputum cultures and a urine culture. However, blood cultures were negative for fungi. Fever persisted and on the 21st day swelling and tenderness of the right knee occurred and synovial fluid obtained by arthrocentesis revealed *C. krusei*. On the 27th day in hospital, after *C. krusei* was grown from the second aspirate, intravenous amphotericin B was started. On the 29th hospital day the patient was discharged to receive amphotericin B intravenously three times weekly as an outpatient. After cessation of the antifungal therapy, swelling and tenderness of the right knee recurred. Amphotericin therapy was re-instituted and after 3 months there was no clinical evidence of arthritis. Arthritis in this case was possibly a consequence of haematogenous spread, as the patient was colonised in the respiratory tract and the urinary tract with *C. krusei*. It is noteworthy that arthritis caused by *C. albicans* is more common as haematogenous joint invasion complicating disseminated candidosis, although it is more often polyarticular than mono-articular.

Candidal endocarditis is a frequent occurrence among intravenous drug abusers. In one survey Odds estimated that one-fifth of candidal endocarditis occurs in the latter group. *C. albicans* and *C. parapsilosis* accounted for the vast majority of reported cases, but 3-7% of 163 cases in the latter survey were due to *C. krusei*. The detailed clinical features of these case reports are sparse. Rubinstein et al. described a case of *C. krusei* endocarditis in a 36-year-old male heroin addict who had fever and heart failure. Although the patient was treated with intravenous amphotericin B he subsequently died. Autopsy examination revealed myocardial abscesses, aortic vegetation and septic emboli due to *C. krusei*.

Renal candidosis is usually seen in patients with pre-existing renal pathology and diabetes is the most common single underlying condition. Candida infection is usually obstructive, with fungal material often referred to as "fungus balls" collecting in the renal pelvis. As in the case of other candida infections, *C. albicans* is the most common species implicated in renal candidosis and *C. krusei* infection is still a rarity. In a review of 74 cases of renal candida infection, 86% were caused by *C. albicans* and 2.7% by *C. krusei*. A case report by Thomalla et al. represents a rare involvement of *C. krusei* leading to the ureteral obstruction. An immunosuppressed 29-year-old
woman presented with renal dysfunction. On cysto-
scopic examination, an erythematous papillary lesion
involving the ureteral orifice was observed; histo-
logical examination of a biopsy sample revealed
chronic inflammation and oedema and C. krusei
was isolated on culture. The patient was given intravenous
miconazole and bladder irrigation with amphotericin
B. The infection proved to be very difficult to eradicate
but resolved eventually after 11 weeks of combination
therapy with ketoconazole, amphotericin B and
flucytosine.

Antifungal agents
The most widely used antifungal agents are the
polyenes and the azoles, which include the imidazoles
and the newer triazoles. As it is beyond the scope of
this review to dwell in detail on the antifungal
sensitivity patterns of C. krusei and their clinical
implications, we provide for reference purposes, in
table IV, the relative MICs of various antifungal
agents against C. krusei and C. albicans. However,
because of the generally expressed concerns of the
emergence of fluconazole-resistant C. krusei isolates,
some aspects related to this problem are discussed
below.

Although fluconazole MICs for individual C. krusei
isolates have been reported as elevated by some
authors, only one group has directly compared the
MICS for C. krusei with those of other Candida spp.,
and they too report higher MICs for C. krusei than for
other species. This issue has been further compounded
by the discordant correlation of in-vitro testing with
outcome in vivo (for a recent review see Rex et al.,). For
theazole derivatives, especially, the outcome of
the in-vitro susceptibility tests depends on the methods
and media used and also on other variables such as the
endpoint definition, inoculum size, inoculum
preparation, incubation conditions and the nutritional
requirement of the fungus. Another key problem in
interpreting antifungal susceptibility test results is
the partial inhibition of growth with azoles. Accord-
ing to Odds et al., the activity of fluconazole against
Candida spp. in vitro appears to be the hardest
to determine meaningfully, being heavily dependent
on the culture medium used. Hence, future workers
need to review the available data by means of a
standardised assay method such as the National
Committee for Clinical Laboratory Standards (NCCLS)
reference method for MIC determination.

Notwithstanding these reservations, there is an
emerging consensus that C. krusei isolates demonstrate
a high level of resistance to fluconazole—widely used
in the empirical treatment of patients with immuno-
deficiencies, especially HIV-infected individuals. The
clinical implications of this problem are discussed in
some detail below.

Table IV. Sensitivities of C. krusei and C. albicans to antifungal agents

<table>
<thead>
<tr>
<th>Name of antifungal</th>
<th>Yeast</th>
<th>Number of isolates</th>
<th>MIC range (µg/ml)</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amphotericin B</td>
<td>C. krusei</td>
<td>133</td>
<td>0-05–&gt; 6-25</td>
<td>Athar and Winner, Bergan and Vangdal, Hamilton-Miller, Hopfer and Groeschel, King et al., Oblack et al., Potel and Arndt, Seidenfeld et al., Tortorano et al.</td>
</tr>
<tr>
<td>Nystatin</td>
<td>C. albicans</td>
<td>2318</td>
<td>0-05–4</td>
<td>McGinness and Rinaldi</td>
</tr>
<tr>
<td></td>
<td>C. krusei</td>
<td>105</td>
<td>0-5–25</td>
<td>Athar and Winner, Bergan and Vangdal, Potel and Arndt</td>
</tr>
<tr>
<td>Clotrimazole</td>
<td>C. albicans</td>
<td>1642</td>
<td>0-78–&gt; 100</td>
<td>McGinness and Rinaldi</td>
</tr>
<tr>
<td></td>
<td>C. krusei</td>
<td>37</td>
<td>&lt; 0-5–1</td>
<td>Akgun and Akst, Bergan and Vangdal, Hamilton-Miller, Jacob et al., Potel and Arndt, Saubolle and Hoepnich, Shadomy et al.</td>
</tr>
<tr>
<td>Econazole</td>
<td>C. albicans</td>
<td>1200</td>
<td>0-01–50</td>
<td>McGinness and Rinaldi</td>
</tr>
<tr>
<td></td>
<td>C. krusei</td>
<td>34</td>
<td>0-125–12-5</td>
<td>Bergan and Vangdal, Potel and Arndt, Schar et al.</td>
</tr>
<tr>
<td>Ketoconazole</td>
<td>C. albicans</td>
<td>283</td>
<td>0-016–25</td>
<td>McGinness and Rinaldi</td>
</tr>
<tr>
<td></td>
<td>C. krusei</td>
<td>37</td>
<td>0-1–10</td>
<td>Bergan and Vangdal, Drouhet and Dupont, Moody et al., Odds et al., Van Cutsem</td>
</tr>
<tr>
<td>Miconazole</td>
<td>C. albicans</td>
<td>976</td>
<td>0-01–&gt; 100</td>
<td>McGinness and Rinaldi</td>
</tr>
<tr>
<td></td>
<td>C. krusei</td>
<td>40</td>
<td>&lt; 0-063–6-25</td>
<td>Bergan and Vangdal, Moody et al., Potel and Arndt, Schar et al.</td>
</tr>
<tr>
<td>Fluconazole</td>
<td>C. albicans</td>
<td>1815</td>
<td>0-016–100</td>
<td>McGinness and Rinaldi</td>
</tr>
<tr>
<td></td>
<td>C. krusei</td>
<td>7</td>
<td>0-019–100</td>
<td>Arzeni et al., Fisher et al., Morace et al., Wingard et al.</td>
</tr>
<tr>
<td>Itraconazole</td>
<td>C. albicans</td>
<td>75</td>
<td>0-019–20</td>
<td>McGinness and Rinaldi</td>
</tr>
<tr>
<td></td>
<td>C. krusei</td>
<td>7</td>
<td>0-009–5</td>
<td>Arzeni et al.</td>
</tr>
<tr>
<td>5-Flurocytosine</td>
<td>C. krusei</td>
<td>85</td>
<td>0-063–128</td>
<td>McGinness and Rinaldi</td>
</tr>
<tr>
<td></td>
<td>C. albicans</td>
<td>1474</td>
<td>0-1–&gt; 25</td>
<td>Bergan and Vangdal, Drouhet et al., Hamilton-Miller, Hopfer et al., Marks et al., Pawlik and Barylak, Potel and Arndt, Speller and Davies, Tortorano et al.</td>
</tr>
<tr>
<td>Pimaricin</td>
<td>C. albicans</td>
<td>4382</td>
<td>0-016–&gt; 100</td>
<td>McGinness and Rinaldi</td>
</tr>
<tr>
<td></td>
<td>C. krusei</td>
<td>30</td>
<td>1-4</td>
<td>Potel and Arndt</td>
</tr>
<tr>
<td></td>
<td>C. albicans</td>
<td>289</td>
<td>1–100</td>
<td>McGinness and Rinaldi</td>
</tr>
</tbody>
</table>
C. krusei and fluconazole therapy

Fluconazole is highly active against several pathogens that cause systemic mycoses.\(^{156}\) It is a triazole with a low mol. wt and unique pharmacokinetics—good water solubility, weak protein binding, long half-life and high level of cerebrospinal fluid penetration. It is well absorbed after oral administration and has been effective in treating both superficial\(^{157}\) and systemic candida infections.\(^{158}\) It has emerged as the drug of choice for prophylaxis of oropharyngeal and systemic candidosis\(^{159}\) in HIV-infected patients. Despite the initial claims of the efficacy of fluconazole in candida infections in general, studies in animals and man have now demonstrated both prophylactic and therapeutic failure of fluconazole against C. krusei.\(^{160,163,164}\) Furthermore, it is possible that the increase in colonisation and infection of human patients by C. krusei has been documented in the last few years is partly attributable to the widespread use of this drug as a prophylactic antifungal agent.

Immediately after the approval of its use in early 1990, fluconazole was used as a prophylactic antifungal agent in recipients of heart and bone marrow transplants.\(^{160,169}\) In one study conducted by Goodman et al.\(^{169}\) patients receiving bone marrow transplants were randomly assigned to receive fluconazole (400 mg daily) or placebo. By the end of the treatment period 28 of 177 patients in the placebo group developed systemic fungal infections, two of which were due to C. krusei. In comparison, five of 179 patients who received fluconazole developed systemic fungal infections of which three were due to C. krusei. This study demonstrated that although fluconazole prevents infection with most pathogenic Candida spp. it does not eradicate C. krusei.

In another retrospective study of 463 bone marrow transplant and leukaemia patients, there was a seven-fold greater incidence of blood stream or visceral infection with C. krusei in 84 patients who received fluconazole prophylaxis than in 355 patients who received other modes of prophylaxis, including amphotericin B, miconazole and ketoconazole, or no prophylaxis.\(^{160}\) The foregoing observations suggest that the prophylactic use of fluconazole in immunocompromised patients, while decreasing the frequency of fungal infection caused by C. albicans and C. tropicalis may also promote the emergence of resistant pathogens such as C. krusei.

Several other reports have documented the development of resistant strains of Candida spp. after the use of fluconazole as a prophylactic agent or as primary therapy for superficial candidosis.\(^{166-168}\) A recent study by Casasnovas et al.\(^{162}\) also strongly supports these reports and suggests that fluconazole is not the ideal antifungal agent for preventing C. krusei infections. The author observed a high incidence (11%) of C. krusei septicemia in patients with neutropenia who received fluconazole. Goodman et al.\(^{169}\) also concluded that fluconazole can be administered effectively to reduce the incidence of systemic mycoses in severely immunosuppressed patients, although they noted a tendency towards increased isolation of C. krusei during therapy and more episodes of candidaemia due to C. krusei in patients who received this drug.

Other case reports of failure of fluconazole therapy include the following. Roder et al.\(^{161}\) described consistent growth of C. krusei from at least six blood cultures of a patient during treatment with fluconazole, suggesting that this agent was ineffective against C. krusei. In another report reaffirming the failure of C. krusei infection to respond to therapy with fluconazole, Akova et al.\(^{163}\) quoted three immunosuppressed patients who developed oropharyngeal C. krusei infection with ulceration after fluconazole treatment. Furthermore, the development of C. krusei sepsis in an HIV-infected patient during fluconazole treatment was described by Stellbrink et al.\(^{171}\)

Taken together, these data strongly indicate that the administration of fluconazole, especially in low doses, as a prophylactic antifungal agent in immunocompromised patients may result in the emergence of resistant C. krusei strains. Hence, controlled clinical trials of prophylactic and therapeutic use of triazoles for disseminated candidosis appear to be warranted before their widespread recommendation as a primary therapeutic agent. Furthermore, it should now be mandatory to identify Candida isolates to species level whenever fluconazole is to be used for treatment of systemic mycoses.

Conclusions

The biology, epidemiology, pathogenicity and clinical manifestations of C. krusei have been reviewed. The available data indicate that C. krusei is significantly different from other medically important Candida spp. in its structural and metabolic features and that it exhibits different behaviour patterns towards host defences, thus adding credence to the belief that it should be taxonomically re-assigned. Experimental studies have generally shown that C. krusei is less virulent than C. albicans in terms of its adherence to epithelial and prosthetic surfaces, proteolytic potential and production of phospholipases.

Early reports described this organism as a sporadic isolate of minor clinical significance, but more recently it has emerged as an important nosocomial pathogen. The most common clinical manifestation of C. krusei is disseminated fungaemia in compromised patients, especially leukaemia patients. The advent of HIV infection and the widespread use of the newer triazole fluconazole to suppress fungal infections in these individuals have contributed to a significant increase in C. krusei infection, particularly because of the high incidence of resistance of the yeast to this drug. Other focal infections due to C. krusei include endophthalmitis, arthritis and endocarditis, which are usually
related to invasive procedures superimposed on a compromised host defence system. Thus the epithet “an emerging pathogen” could justifiably be given to this yeast, not least because of a putative increasing incidence of *C. krusei* infection, due partly to the HIV pandemic. An increased awareness of the pathogenic potential of this yeast coupled with the newer molecular biological approaches to its study should enhance our understanding of the epidemiology and pathogenicity of this important nosocomial pathogen.

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