Reprinted from www.antimicrobe.org

Table 6. Therapies of Choice for Invasive Candidiasis*

C. albicans: Fluconazole

C. tropicalis: Fluconazole

C. parapsilosis: Fluconazole

C. glabrata: Caspofungin

C. krusei: Caspofungin (IV); voriconazole (PO)

C. lusitaniae: Fluconazole

Species unknown: Caspofungin

Neutropenia: An amphotericin B preparation or caspofungin until neutrophil recovery, then as above.

Febrile neutropenia without proven candidiasis: Caspofungin

Meningitis: Caspofungin should probably be avoided—see text

*These guidelines apply principally to candidemia but can in general be extrapolated to renal, urinary, ocular, cardiac, pericardial, suppurative vascular (phlebitis), peritoneal, gallbladder, pancreatic, skeletal (osteomyelitis), joint (arthritis), meningeal, and pulmonary candidiasis. Unfortunately, the amount of data in these other settings is limited and there is usually no obvious best choice of therapy. The only other general guidelines are (a) durable cure of infected devices is very difficult to achieve without device removal (although infection can often be suppressed—see for example the section entitled "Candida Endocarditis, Pericarditis, and Suppurative Phlebitis") and (b) an agent that penetrates well is needed for protected spaces (the eye and brain—see those sections for details). Helpful anecdotes are found in the chapter sections that discuss individual disease forms.

When following these general guidelines, remember also that (a) Candida is not the only yeast to cause invasive fungal infections (be especially alert for cryptococcosis and histoplasmosis), (b) there can be mechanical and pharmacological factors that drive failure or breakthrough (see the section entitled "Persistent and Breakthrough Disease"), and (c) catheters and other potentially infected prosthetic devices usually need to be removed (see sections entitled "Management of Catheters" and "*Candida* Endocarditis, Pericarditis, and Suppurative Phlebitis").