One-Year Prevalence of Candida dubliniensis in a Dutch University Hospital

With reference to a recently published article by Polacheck et al. (9) reporting the isolation of Candida dubliniensis from non-human immunodeficiency virus (HIV)-infected patients in an Israeli hospital, we would like to add our data from a single center in The Netherlands. Since we described the occurrence of candidemia due to C. dubliniensis in non-HIV-infected patients (4), we prospectively studied the prevalence of C. dubliniensis during the year 1999 in our 1,000-bed tertiary-care university hospital. All germ-tube-positive yeasts isolated from various clinical specimens submitted to the diagnostic laboratory were further examined. Germ-tube-positive yeasts were suspected to be C. dubliniensis when there was no growth at 45°C, no assimilation of xylose, and no elaboration of β-glucosidase and when microscopic morphology showed abundant chlamydompospore formation on rice-cream agar (8, 10, 12). Molecular typing with RPO2 (4, 5) was used to confirm the phenotypic identification as C. dubliniensis. In 1999, a total of 3,848 yeast isolates were cultured from various clinical samples not typic identification as C. dubliniensis


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although *C. dubliniensis* was originally thought to be mainly associated with the oral cavity of HIV-infected and AIDS patients (3, 6, 8, 13–16), several recent studies have shown that it is more prevalent in HIV-negative individuals than perhaps originally thought (2, 5, 7–9, 15, 17). Our recent paper on the recovery of *C. dubliniensis* from HIV-negative patients in Israel added to this body of data and also provided the first report of the recovery of *C. dubliniensis* from the Middle East (12). Several studies have reported that *C. dubliniensis* is found as a commensal organism in HIV-negative individuals and that it can also cause overt oral and nonoral infection in this group (3, 5, 8, 9, 11, 15, 17). Our laboratory reported the first authenticated blood culture isolate of *C. dubliniensis* in 1998 from an HIV-negative patient (11). Since then, seven other cases of *C. dubliniensis* fungemia (six in HIV-negative individuals) have been reported from Europe (7) and North America (2) in patients with severe underlying medical conditions.

Because *C. dubliniensis* and its close relative *Candida albicans* share many phenotypic characteristics in common, many isolates of *C. dubliniensis* have been misidentified as *C. albicans* (3, 8–10, 13–16). This situation has been remedied to a large extent by the recent development of methods for discriminating between the two species 1, 4, 10, 11, 13, 15; I. F. Salkin, W. R. Pruitt, A. A. Padhye, D. Sullivan, D. Coleman, and D. H. Pincus, Letter, J. Clin. Microbiol. 36:1467, 1998). Therefore, we agree with Dr. Meis and colleagues that efforts must be made to correctly identify germ-tube-positive yeast isolates, especially since the majority of blood culture isolates of *C. dubliniensis* (seven of eight) reported to date have been recovered from HIV-negative individuals.

REFERENCES


