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Rare case report of neonatal sepsis due to *Kodameae ohmeri* in super specialty tertiary care center in Mumbai, India.

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Epidemiology of fungal pathogens is changing with time, with emergence of new species and increased virulence and resistance to antifungal agents in existing pathogens. Clinical spectrum of diseases caused by fungus is expanding due to multiple reasons. One such emerging fungus is *Kodameae ohmeri*[1]. Of late, a number of case reports are reported due to same causing fatality unless identified and reported[2,3]. We describe a rare case report of neonatal sepsis due to *Kodameae ohmeri*. A term female baby was born by normal vaginal delivery and cried immediately after birth. No active resuscitation was required. Her Apgar score was 8. She developed respiratory distress day two onwards which was progressive in nature. She was treated with Injection ceftriaxone and sodium bicarbonate and shifted to the neonatal intensive care unit for further management. Due to respiratory distress baby was intubated same day, fluid bolus was given and mechanical ventilation started. Ionotropic support (Dobutamine) started along with other supportive treatments. Intravenous antibiotics were escalated to piperacillin-tazobactam and amikacin. Baby was extubated after 48h, that is, on day 3. However, immediately after extubation distress worsened, baby developed features of sepsis, for which she was re-intubated and ventilated again. Blood culture was sent in BacT/Alert FP Plus bottle after re-intubation, which showed budding yeast cells, was immediately informed to the neonatologist and the baby was started on IV Fluconazole. The yeast cell was identified as *Kodameae ohmeri* by Chrome agar Candida (HiMedia, Mumbai, India) and VITEK2YST card (BioMerieux® Marcy l' Etiole -France). A second blood culture was sent on day 4, which also grew *Kodameae ohmeri*. The isolate was intermediately sensitive to Fluconazole (MIC=4) and sensitive to Amphotericin B (MIC=0.25), Flucytosine(MIC=1), Caspofungin (MIC=0.25) and Voriconazole (MIC=0.25). Intravenous Amphotericin B was started on day 5 and continued for 21 days and the baby responded well. A repeat blood culture showed no growth. Baby was discharged. Mother's high vaginal swab also grew budding yeast cells, which was later identified as the same, confirming that probably baby got the infection during parturition. We sincerely acknowledge Dr Arunaloke Chakrabarty from Division of Mycology, Department of Microbiology, Post Graduate Institute of Medical Education and Research, Chandigarh for molecular confirmation of the two isolates. To conclude, correct identification up to species level, interpreting the significance as a pathogen along with antifungal susceptibility results is necessary for best clinical outcome.

Biography

Dhruv Mamtora has completed his MBBS in 2010 from Lokmanya Tilak Municipal Medical College, Mumbai. He also has completed his MD in Medical Microbiology from Government Medical College, Miraj, Maharashtra in year 2013. He has completed Diploma in Hospital Administration and is also certified infection control practitioner. He is currently Head of Microbiology and Infection control at S. L. Raheja Hospital, a 154 bedded multispecialty hospital and center of excellence for diabetes and oncology. He has published papers in journals and has been serving as editor and reviewer for journals. He has organized conferences on systemic approach on infection control in January 2018. He is also faculty for multiple conferences at regional, national and international level. He is also media subject expert on infection control, microbiology, antimicrobials and outbreaks. He is also heading few of projects of which some of importance is national survey on infection control, point of care testing devices in infection control and on antimicrobial stewardship programs.

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