

Congenital Candidiasis

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Abstract: *Intrauterine candidal infection is a rare condition. But it can occur through transplacental route or by ascending infection from the vagina. Skin lesions, which may be present at birth, are characterized by erythema, moist erosions and vesiculopustules with erythematous base. The diagnosis is confirmed by identification and isolation of Candidia albicans with KOH preparation and culture of the material obtained from active lesions. We are reporting a case of intrauterine candidal infection in a term neonate from Udaiyarpuram TK, in Tamil Nadu, India.*

Keywords: Candidiasis, congenital, pustular eruptions, Amphotericin B, neonate

1. Clinical Report

A full term, 3.250 kg female infant was born by cesarean section to a 26 year old, gravida 2 mother with no risk factors. The neonate had APGAR scores of 6 and 7 at 1 minute and 5 minutes respectively. On examination, the neonate had multiple erosions all over the Lt side of chest, Lt axilla, posterior aspect of the neck.[Figure 1] She also had a single hyperpigmented plaque with pustules studded over the plaque[Figure 2]. Post inflammatory hypopigmentation was note over the Rt side of lower back. The neonate also had cleft palate [Figure 3] The neonate was admitted in NICU, was started on IV antibiotics. KOH mount from the scrapping showed yeast and pseudohyphae. The culture from the scrapping grew Candidia albicans. The neonate was started on topical antifungals. The neonate responded to treatment and the lesions gradually disappeared.[Figure 4].



Figure 2



Figure 1



Figure 3

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Figure 4

cutaneous candidiasis – a rare disease of the neonate. *Acta Paediatr.* 2004;93:996-9

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2. Discussion

CC is a very rare condition which presents at birth or within first 6-7 days after birth and generally represents maternal chorioamnionitis occurring either from birth canal as an ascending infection or as transplacental infection.[1]. Ascending infection may occur either from subclinical rupture of membranes or even through or even through intact membranes resulting in whitish plaques on the membranes and umbilical cord along with skin lesions, described as ‘white dots on the placenta and red dots on the baby’.[2]. Ascending infection was more likely the pathogenesis in our case. Various risk factors like <27 weeks of gestation, wt <1000 gms, Intrauterine devices, cervical invasive procedures and extensive instrumentation have been reported [3].

Diagnosis is established by KOH mount of skin lesions showing budding yeasts and pseudohyphae and culture revealing candidial growth. Blood, urine and CSF culture should be obtained if there is a clinical suspicion of systemic infection. Treatment includes topical and systemic antifungal therapy.[4] Amphotericin B in the first line agent given at a dose of 0.5-1 mg/kg/day. [5]

CC is a very rare and it needs to be differentiated from various other causes of generalized maculopapular or pustular lesions at birth in order to avoid complications. Early recognition and prompt diagnosis will help in the successful management of the new born.

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