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CASE REPORT

Successful Treatment of *Kodamaea ohmeri* Bloodstream Infection with Voriconazole: A Case Report and Literature Review

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Abstract: *Kodamaea ohmeri* is an emerging opportunistic yeast pathogen frequently misidentified as *Candida*, posing significant diagnostic challenges. This report describes a case of *K. ohmeri* bloodstream infection in a 70-year-old female with poorly controlled diabetes following radical gastrectomy. Despite broad-spectrum antibacterial therapy for postoperative complications, she developed persistent fever. Blood cultures identified *K. ohmeri*, and antifungal susceptibility testing (AST) revealed a low voriconazole minimum inhibitory concentration (0.06 μg/mL), prompting targeted therapy that led to the clearance of fungemia and full clinical recovery. This case underscores the critical importance of rapid pathogen identification and AST-directed therapy in managing life-threatening *K. ohmeri* infections.

Keywords: *Kodamaea ohmeri*, bloodstream infection, voriconazole, antifungal, susceptibility testing, case report

Introduction

Kodamaea ohmeri (formerly known as *Pichia ohmeri* or *Yamadazyma ohmeri*) is an emerging opportunistic yeast pathogen[1,2] that is frequently misidentified as *Candida* due to phenotypic similarities,[3] creating substantial diagnostic hurdles. While it has been isolated from various environmental sources[4] and is used in food fermentation,[5,6] human infections are exclusively caused by *K. ohmeri*[7] among the *Kodamaea* species.[8–10] First identified in pleural effusion in 1984[11] and initially regarded as a contaminant, *K. ohmeri* has since been reported in cases of fungemia,[12–14] peritonitis,[15–20] endocarditis,[21–29] urinary tract infections,[30–32] pneumonia,[33,34] keratitis,[35,36] and skin infections,[2,33,37–42] primarily affecting immunocompromised individuals with a mortality rate as high as 50%.[7] The first case of septicemia was reported in China in 1994,[43] followed by a case in the United States in 1998,[44] with most cases occurring in Asia.[7]

Accurate identification of *K. ohmeri* is crucial for ensuring appropriate clinical management, as misidentification of this pathogen may result in delayed or suboptimal antifungal therapy. We herein report a case of a catheter-related bloodstream infection caused by *K. ohmeri* in a patient with gastric cancer and poorly controlled diabetes mellitus. The infection was successfully treated with voriconazole, guided by in vitro antifungal susceptibility testing (AST). Additionally, we review the pertinent literature to underscore the importance of rapid pathogen identification and targeted antifungal therapy in improving patient outcomes.

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Table 1 Key Laboratory Findings During the Patient's Hospitalization

Laboratory Findings	Reference Range	On Admission	POD 3	POD 10	POD 30	At Discharge
Temperature (°C)	36.1–37.2	36.8	38.3	39.0	37.5	36.5
Inflammatory markers						
WBC ($\times 10^9$/L)	3.50–9.50	4.72	8.86	8.25	14.35 ↑	5.02
CRP (mg/L)	< 10	–	> 200 ↑	> 200 ↑	105.67 ↑	9.18
PCT (ng/mL)	< 0.5	–	1.297 ↑	0.456	0.239	0.052
Fungal infection-related markers						
BDG (pg/mL)	< 80	-	-	-	< 10	-
GM (GMI)	< 0.5	-	-	0.19	0.57	-
Blood culture	Negative	-	-	Positive (*K. ohmeri*)	Negative	Negative
Liver function						
ALT (U/L)	7.0–40.0	18.9	136.5 ↑	41.7 ↑	26.2	17.1
AST (U/L)	13.0–35.0	19.5	122.9 ↑	45.5 ↑	47.4 ↑	19.2

Abbreviations: WBC, white blood cell count; CRP, C-reactive protein; PCT, procalcitonin; BDG, (1,3)-β-D-glucan; GM, galactomannan antigen; ALT, alanine aminotransferase; AST, aspartate aminotransferase; POD, postoperative day; ↑, above the reference range; –, not tested.

Case Presentation

A 70-year-old female with poorly controlled type 2 diabetes mellitus and hypertension was admitted to our hospital with a chief complaint of episodic upper abdominal dull pain for 40 days. She was diagnosed with adenocarcinoma of the gastric body. Initial laboratory findings on admission were within normal ranges (Table 1).

On December 17, 2023, the patient underwent a D2 lymphadenectomy with total gastrectomy. Three closed-suction drains (two intraperitoneal and one preperitoneal), a urinary catheter, and a nasoenteral feeding tube were placed during the surgery. Perioperative prophylactic cefuroxime was administered. Postoperatively, she developed severe complications, including anastomotic leakage, thoracic infection, respiratory failure, and septic shock with blood pressure dropping to 102/55 mmHg on postoperative day (POD) 4 (December 21). This critical condition necessitated emergency endotracheal intubation, mechanical ventilation, vasopressor support, and transfer to the Intensive Care Unit (ICU).

Despite broad-spectrum antibacterial therapy (imipenem-cilastatin, ornidazole, vancomycin, and amikacin), the patient developed persistent intermittent fever, with temperatures spiking to 39°C. Cultures of thoracic drainage and sputum yielded *Klebsiella pneumoniae* and *Acinetobacter baumannii*, confirming a polymicrobial infection. The persistence of fever despite this regimen raised suspicion of either drug-resistant bacteria or an unsuspected pathogen, prompting further investigation with blood cultures. On postoperative day 10 (December 27), yeast-like organisms were isolated from two sets of peripheral blood cultures. Based on the preliminary identification of *K. ohmeri* (99% probability; VITEK 2-Compact system with YST card) and antifungal susceptibility testing showing susceptibility to voriconazole (MIC ≤ 1 μg/mL), intravenous voriconazole (0.2 g every 12 hours) was administered.

Subcultures on Sabouraud dextrose agar showed creamy-white, wrinkled, yeast-like colonies (Figure 1a). Colonies on blood agar were small, grayish-white, with smooth surfaces and regular edges (Figure 1b). On chromogenic medium, colonies appeared initially dark green and turned pink with prolonged incubation (Figure 1c). Subsequent antifungal susceptibility testing using the YeastOne method confirmed high susceptibility[45] to voriconazole (MIC = 0.06 μg/mL), with a fluconazole MIC of 8 μg/mL (Table 2).

The patient's clinical condition improved gradually after initiating voriconazole. After a total course of 37 days of targeted antifungal therapy, which concluded on February 1, 2024, follow-up blood cultures and (1,3)-β-D-glucan test returned negative results (Table 1). The patient's overall condition stabilized, and she was successfully discharged on February 3, 2024 (POD 48). Following discharge, she was transferred to a secondary care facility for continued rehabilitation. Subsequent follow-up assessments indicated a favorable recovery.

Discussion

We conducted a search in the PubMed, Embase, Web of Science, and CNKI databases using the following keywords: ((*Kodamaea* OR *Pichia* OR *Yamadazyma*) AND *ohmeri*), to identify studies published in English before December 2024

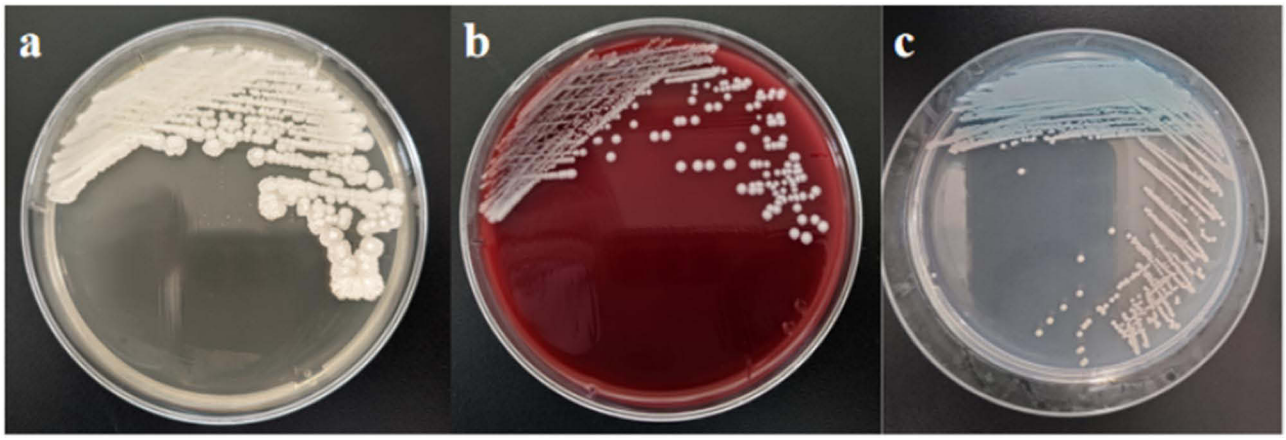

Figure 1 Colonial morphology of the isolated strain cultured on different media. (**a**) Sabouraud dextrose agar (35 °C, 48 h): creamy-white, yeast-like, wrinkled colonies; (**b**) Blood agar (35 °C, 5% CO_2, 48 h): small, grayish-white, variable-sized colonies with smooth surfaces and regular edges, showing no hemolysis and a fermentative odor; (**c**) Chromogenic medium (35 °C, 48 h): smooth, moist, yeast-like colonies, initially dark green and turning pink with prolonged incubation.

(Supplementary Figure 1). This search identified 70 studies encompassing 90 sporadic cases[1–3,11,14–43,47–80] and two outbreaks of *K. ohmeri* infection[45,81] (Supplementary Tables 1 and 2). This case successfully demonstrates the management of a life-threatening *K. ohmeri* bloodstream infection in a high-risk patient following radical gastrectomy, providing key insights into the management of this rare fungal pathogen. The patient's persistent fever despite broad-spectrum antibacterial therapy is a classic presentation necessitating high clinical suspicion for unusual fungal pathogens in immunocompromised hosts with breached barrier integrity. *K. ohmeri*, an emerging opportunistic yeast, is often misidentified as *Candida* species by conventional phenotypic methods,[3,10] representing a primary challenge for timely diagnosis and appropriate therapy.

The cornerstone of the successful outcome in this case was the adherence to the principle of "precision microbiology": antifungal therapy guided by susceptibility testing following rapid pathogen identification. The accurate species-level identification achieved via the VITEK 2 system was pivotal. Subsequent antifungal susceptibility testing (AST), performed according to the standardized broth microdilution method of CLSI M60,[46] revealed high in vitro susceptibility to voriconazole (MIC = 0.06 μg/mL). This finding is consistent with most previous reports, establishing voriconazole as the most potent azole against *K. ohmeri*.[10,54,61] Of critical importance, large-scale studies (Supplementary Table 2) have demonstrated that voriconazole exhibits consistently low MICs against this pathogen (MIC_{50}: 0.06 μg/mL; MIC_{90}: 1 μg/mL),[2,30] which strongly

Table 2 Antifungal Susceptibility Profile of the *K. ohmeri* Blood Isolate as Determined by VITEK 2-Compact and YeastOne Methods

Antifungal Agent (MIC, μg/mL)	VITEK 2-Compact Result	YeastOne Method Result
Voriconazole	≤ 1	0.06
Fluconazole	≤ 8	8
Itraconazole	≤ 0.125	0.12
Amphotericin B	≤ 1	0.25
5-Flucytosine	≤ 4	0.06
Posaconazole	-	0.03
Anidulafungin	-	0.12
Micafungin	-	0.03
Caspofungin	-	0.06

Notes: Susceptibility interpretations for the YeastOne method are based on the Clinical and Laboratory Standards Institute (CLSI) M60 guideline.[46] The VITEK 2-Compact system provides MIC ranges, while the YeastOne method yields specific MIC values.
Abbreviations: MIC, minimum inhibitory concentration; -, not tested.

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supports its use as a first-line therapeutic agent. In contrast, the fluconazole MIC of 8 μg/mL observed in our case, classified as "Susceptible-Dose Dependent" (SDD) per CLSI M60 guidelines,[46] is at the upper limit of this category. This value aligns with the higher MICs frequently reported for fluconazole (MIC_{50}: 8 μg/mL; MIC_{90}: 32 μg/mL),[33,54,56] a pattern suggesting potential resistance or diminished clinical efficacy. Indeed, cases of clinical failure have been reported despite an SDD classification. This collective evidence underscores the superior potency and predicted therapeutic reliability of voriconazole for deep-seated infections compared to fluconazole. The timely initiation of voriconazole, directed by these AST results, was therefore crucial for clearing the fungemia and exemplifies the critical shift from empirical to targeted antifungal management.

The pathogenesis in this patient illustrates the cumulative effect of specific risk factors. The combination of radical gastrectomy, anastomotic leakage, indwelling central venous catheters, and poorly controlled diabetes created a "perfect storm" of immune dysregulation and mucosal barrier breakdown, significantly facilitating the translocation and invasion of *K. ohmeri*.[7,33,82] This pathophysiology aligns with the high incidence of *K. ohmeri* infections reported in surgical and critically ill patients.[15,18,74] Furthermore, the management of central venous catheters upon diagnosis of fungemia is an important measure for eradicating the source of infection and improving outcomes[48] (Supplementary Table 1).

We acknowledge that the generalizability of a single case report is limited. However, its value lies in delineating a successful diagnostic and therapeutic pathway for a rare pathogen. It is noteworthy that the absence of official Clinical and Laboratory Standards Institute (CLSI) or European Committee on Antimicrobial Susceptibility Testing (EUCAST) breakpoints specifically for *K. ohmeri* remains a limitation in the field, often necessitating interpretation based on criteria for related species or epidemiological cut-off values.[46] This case also suggests that deep-seated infections may require an adequate dose and a sufficient duration of therapy. The successful 37-day course of antifungal treatment in this patient indicates that the treatment duration should be individualized and guided by clinical and microbiological response.

Conclusions

In summary, this case reaffirms the role of *K. ohmeri* as an emerging opportunistic pathogen in immunocompromised patients. It highlights the critical need for early species-level identification and AST-guided therapy to ensure favorable outcomes. The clinical response to voriconazole observed here, consistent with most published reports, supports its use as a first-line therapeutic option for susceptible isolates. Future work should focus on establishing standardized AST interpretive criteria for this organism and refining treatment guidelines through the accumulation of additional clinical and susceptibility data.

Abbreviations

AST, antifungal susceptibility testing; MIC, minimum inhibitory concentration; POD, postoperative day; ICU, intensive care unit; SDD, susceptible-dose dependent; CLSI, Clinical and Laboratory Standards Institute; EUCAST, European Committee on Antimicrobial Susceptibility Testing.

Data Sharing Statement

This study is a case report integrated with a literature review. No new datasets were generated; all cited data sources are publicly available in the referenced publications.

Ethics Approval and Informed Consent

Ethical approval for this case report and for the publication of the case details was granted by the Ethics Review Committee of Huai'an First People's Hospital Affiliated to Nanjing Medical University (Approval No: KY2024-068-01).

Consent for Publication

Written informed consent was obtained from the patient for the publication of this case report.

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Author Contributions

All authors made a significant contribution to the work reported, whether that is in the conception, study design, execution, acquisition of data, analysis and interpretation, or in all these areas; took part in drafting, revising or critically reviewing the article; gave final approval of the version to be published; have agreed on the journal to which the article has been submitted; and agree to be accountable for all aspects of work. The specific contributions are as follows: LG, NL and WZ designed the studies. LG, KL, WH, LY, SS, QX and LL collected clinical information. WH, XJ and SP performed drug susceptibility testing. QL, SP, CL and CT contributed reagents or analysis tools. LG, KL, WH, JH, WZ and NL wrote and revised the manuscript.

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Disclosure

The authors report no conflict of interest concerning the materials or methods used in this study or the findings specified in this paper.

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