Funguria
Relatively common
Organisms
- Candida albicans 50%
- Candida glabrata 10 – 15%
- Others 35 – 40%

Risk factors
- Diabetes
- Immunosuppression
- Indwelling urethral catheters
- Antibiotics
- Hospitalisation

Presentation
**Asymptomatic**
- Dysuria and storage LUTS invasive LUT infection
- Fever loin pain and chills invasive UUT infection
- Obstruction fungal bezoar

Diagnosis
Numbers of cfu/ml undefined – **any positive urine culture should be evaluated**
- Presence or absence of pyuria irrelevant

Management

![Flowchart](image-url)
Majority of patients with asymptomatic funguria do not require antibiotic therapy: ~ 75% patients clear fungus following catheter change, cessation of antibiotics and attention to glucosuria. Other considerations:

(i) Persistent funguria with normal upper tracts
   a) Intravesical Rx
      50mg amphotericin B in 1L water via three-way catheter over 24 hours (IVAC 40 ml/h)
   b) Oral Rx
      Fluconazole 200mg/day for first day; 100mg day thereafter for 14 days. SE N+V, abdo pain and diarrhoea

(ii) Renal and disseminated candidiasis
    a) Intravenous fluconazole or amphotericin B
       APB a/w significant SE when given IV – chills, rigors, fever, bone marrow toxicity

(iii) Fungal bezoar
    a) Nephrostomy and irrigation with antifungals
    b) Percutaneous removal (Amplatz sheath)
    c) Nephrectomy