and urinary colonization with *Candida glabrata*. Several weeks later, a lower urinary tract fungal infection developed, with pyuria, gross hematuria, and intravesical fungus ball on ultrasonography. Caspofungin was initiated, together with urinary catheterization and continuous bladder irrigation. Despite adequate antifungal treatment, the patient developed chills and fever, with sustained fungemia.

Fundoscopy, peritoneal fluid analysis, and transesophageal echocardiography were all normal. Kidney lesions identified by positron-emission tomography and computed tomography led to an emergency left nephrectomy (Figure 1). Further evolution was excellent, with no recurrence of fungemia, permitting caspofungin to be discontinued 2 weeks later.

Candiduria is a common finding, and predisposing factors include female sex, diabetes mellitus, prior surgical procedures, antibiotic use, total parenteral nutrition, and urinary catheterization (1). Candiduria most likely reflects colonization of the bladder, the perineum, or the indwelling urinary catheter (2). The association of fever, inflammatory syndrome, or pyuria should raise suspicion of a urinary tract infection, which can lead to candidal dissemination (3), especially when the upper urinary tract is involved. Infection ascending to the upper urinary tract is a rare complication of candiduria, which occurs almost exclusively in the presence of urinary obstruction and stasis; it is often complicated by local suppurative

***Candida glabrata* Renal Abscesses in a Peritoneal Dialysis Patient**

Editor:

We report the case of a 56-year-old diabetic woman on peritoneal dialysis for 21 months who developed candiduria with unexpected renal abscesses and candidemia.

Initial bilateral femoroplasty was complicated by postoperative wound infection, *Clostridium difficile* colitis, denutrition (treated with parenteral nutrition),

Figure 1 — Imaging by (A) positron-emission tomography and (B) computed tomography revealed abscesses (thin arrows) in the left kidney, with homolateral ureterohydronephrosis (large arrow). There was no evidence of urolithiasis nor extrinsic compression. (C) Macroscopic examination of the kidney confirmed the presence of multiple cortical abscesses (thin arrows) and of suppurative material in the calyx (large arrow) and in the ureter. Culture of the abscess content was positive for *Candida glabrata*.

disease, resulting in pyonephrosis or perinephric abscess (4). Accumulation of yeast filaments in the urinary tract, with fungus ball formation and ureteral obstruction, is not unusual.

Physicians should be aware of the potential threat of dissemination of urinary candidiasis in patients with signs of urinary tract infection, and obstruction should be rapidly ruled out, even in end-stage renal disease patients.

DISCLOSURES

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