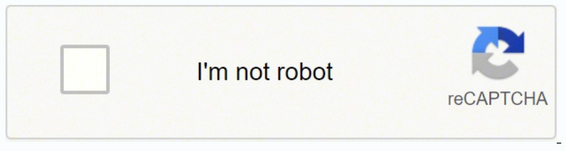

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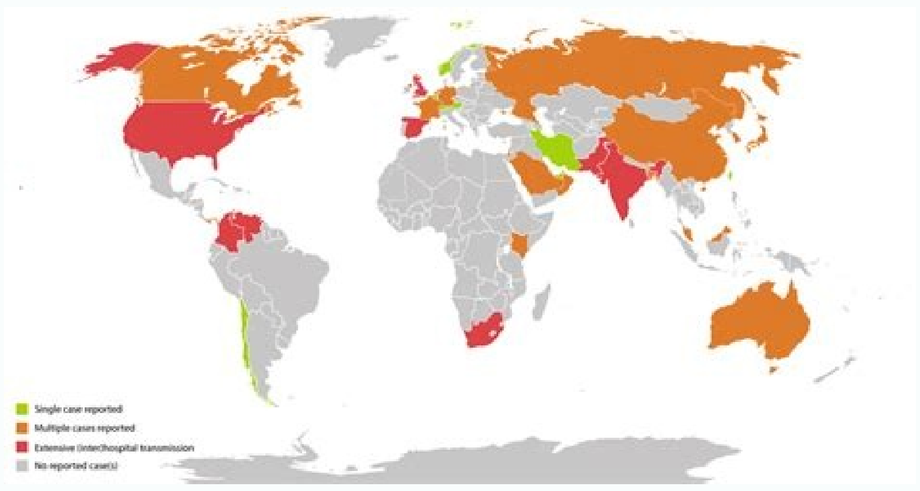
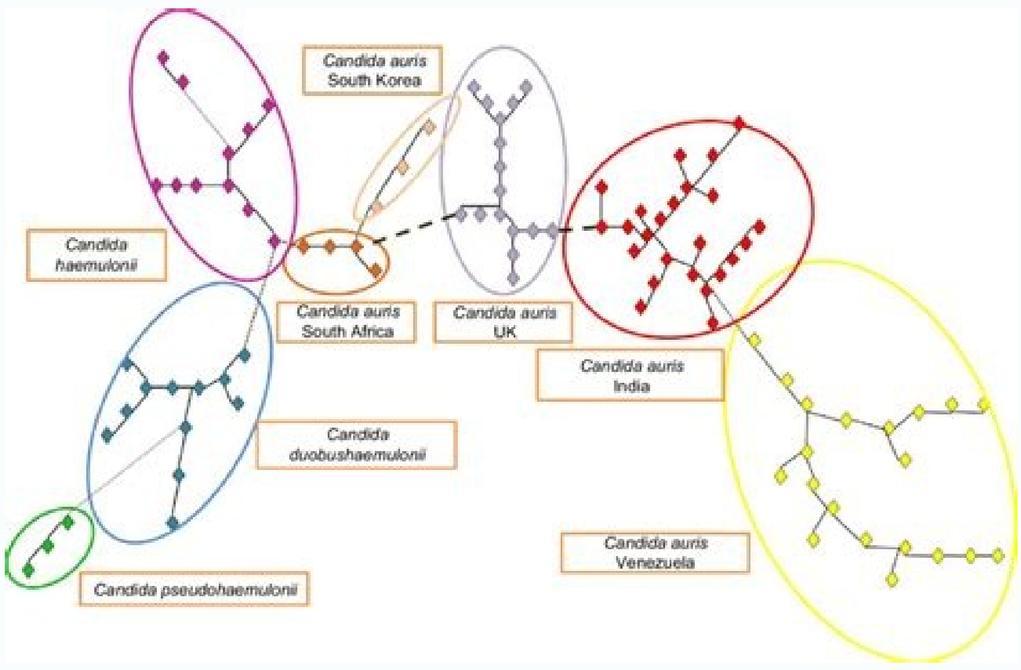
Candida auris guidelines south africa





RESEARCH

Candida auris in South Africa, 2012–2016

Nelesh P. Govender, Rindidzani E. Magobo, Ruth Mpembe, Mabatho Mhlanga, Phelly Matlapeng, Craig Corcoran, Chetna Govind, Warren Lowman, Marthinus Senekal, Juno Thomas

To determine the epidemiology of *Candida auris* in South Africa, we reviewed data from public- and private-sector diagnostic laboratories that reported confirmed and probable cases of invasive disease and colonization for October 2012–November 2016. We defined a case as a first isolation of *C. auris* from any specimen from a person of any age admitted to any healthcare facility in South Africa. We defined probable cases as cases where the diagnostic laboratory had used a nonconfirmatory biochemical identification method and *C. haemulonii* was cultured. We analyzed 1,692 cases; 93% were from private-sector healthcare facilities, and 92% of cases from known locations were from Gauteng Province. Of cases with available data, 29% were invasive infections. The number of cases increased from 18 (October 2012–November 2013) to 861 (October 2015–November 2016). Our results show a large increase in *C. auris* cases during the study period, centered on private hospitals in Gauteng Province.

The earliest reported case of infection with the yeast *Candida auris* in South Africa occurred in 2009; however, the pathogen was initially misidentified as *Candida haemulonii* (a closely related yeast), and *C. auris* was only confirmed retrospectively in 2014, when 4 other cases of *C. auris* candidemia were described in South Africa (*1*). Since descriptions in Southeast Asia in 2009, cases of *C. auris* have been reported from many countries on 6 continents (Asia, Africa, South America, Europe, North America, and most recently Oceania) (*2*).

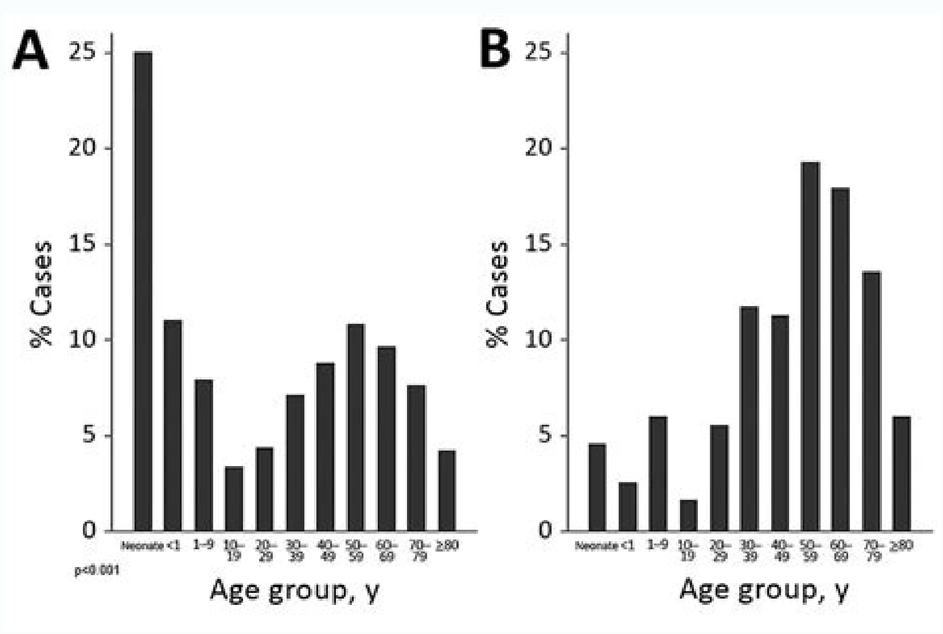
C. auris has been associated with large healthcare-associated outbreaks because of its ability to be transmitted person-to-person by direct contact, form biofilms, persist in the hospital environment on surfaces and on shared equipment, and resist chemical disinfection by certain products (*3*–*5*). Over the past 9 years, cases of *C. auris* have been detected at many hospitals in South Africa, causing large outbreaks at some facilities, and this pathogen now accounts for >1 of every 10 cases of candidemia (*6*). South Africa has a unique *C. auris* clade separated from Asian, Southeast Asian, and South American clades by tens of thousands of single-nucleotide polymorphisms, consistent with the hypothesis that *C. auris* emerged independently in Africa and simultaneously on several other continents (*7*). However, the prevalence and geographic extent of *C. auris* disease is likely underestimated, especially in low- and middle-income countries in Africa, because conventional laboratory methods misidentify the fungus and relatively few resource-limited countries have the capacity for identification by mass spectrometric or molecular methods (*8*). South Africa has an established national surveillance infrastructure for infectious diseases, including those caused by antimicrobial drug–resistant pathogens, that is based on a large network of well-equipped diagnostic pathology laboratories. In light of an emerging epidemic of *C. auris* infections among hospitalized patients in parts of South Africa, we sought to describe the national epidemiology of laboratory-confirmed cases during 2012–2016.

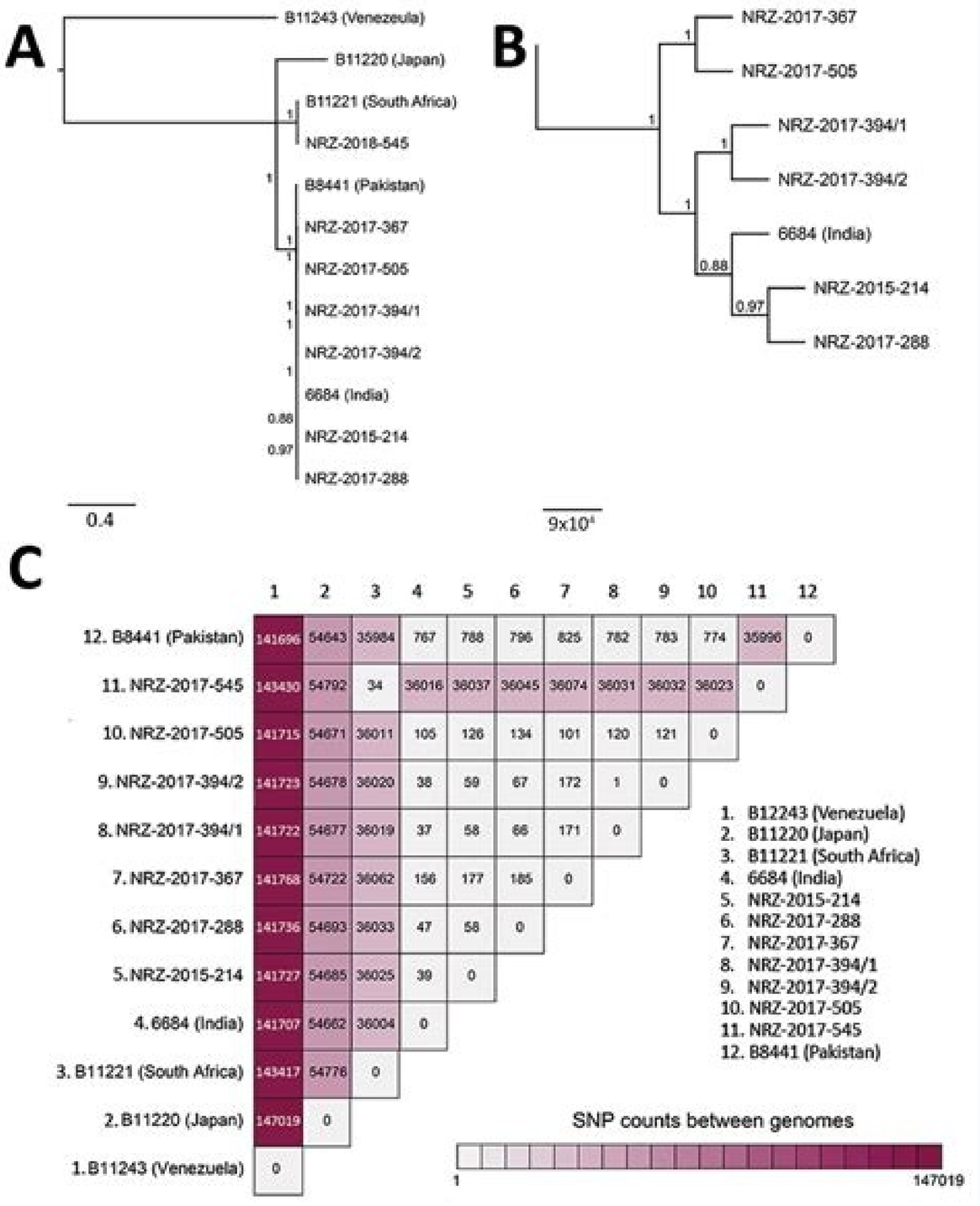
Materials and Methods

We conducted national laboratory-based surveillance for *C. auris* retrospectively over a period of >4 years, from the earliest known reports of cases in South Africa in October 2012 through November 2016 (*1*). We defined a case as a first isolation of *C. auris* from any specimen from a patient of any age admitted to any South Africa healthcare facility. We also included probable cases in which the diagnostic laboratory had used a nonconfirmatory biochemical identification method such as Vitek-2 YST (bioMérieux, Marcy l'Etoile, France) and *C. haemulonii* was cultured. The National Health Laboratory Service (NHLS) provides diagnostic pathology services to the public sector, serving ≈83% of the population of South Africa, and has >60 mostly hospital-based laboratories offering tests for fungal identification. We performed species-level identification for *Candida* at NHLS laboratories using several platforms during the surveillance

Author affiliations: National Institute for Communicable Diseases, a division of the National Health Laboratory Service, Johannesburg, South Africa (N.P. Govender, R.E. Magobo, R. Mpembe, M. Mhlanga, P. Matlapeng, J. Thomas); University of the Witwatersrand, Johannesburg (N.P. Govender, R.E. Magobo, W. Lowman); Ampath Laboratories, Pretoria, South Africa (C. Corcoran); Lancet Laboratories, Durban, South Africa (C. Govind); Vermaak and Partners Pathologists, Johannesburg/Cape Town, South Africa (W. Lowman); Pathcare Pathologists, Johannesburg (M. Senekal)

DOI: https://doi.org/10.3201/eid2411.180368





'Cause © The iniquity will be abundant, the love of many will be cold (Matthew 24:12). Brethren, do we not see and live this sad portion of Scripture? Yes, sir. Exclusive: Elizabeth Lee Vliet, M.D., shows the connection with the Obama era rationing care for 50-plus people Note: Dr. Vliet is a member of the Association of American Doctors and Surgeons, AAPSonline. com In a shocking departure from traditional hospital policies, admission to a hospital has become like returning to prison. Prisoners in American prisons have more visitation rights than COVID patients in American hospitals. A family member, a professional psychologist with a career focus on trauma victims, said that in many hospitals COVID patients are treated less well than animals. "The recordings of Mayo Clinic-Scottsdale and Banner Health System were issued by a lawyer from the Legal Advisory Council of Truth for the Health Foundation, a public charity association in Arizona. Managers discussed coordinated efforts to limit fluids and nutrition for patients with hospitalised COVID and to suppress all visits for patients with COVID. Hospital doctors of the COVID protocol must follow, on a block through the United States, it seems to be the implementation of the 2009-2010 "Complete Lives System" developed by Dr. Ezekiel Emanuel for the rationing of medica l care for people of over 50's age. Dr. Zeke Emanuel, who was White House health policy advisor to President Obama and invited President Joe Biden about COVID-19, said in his classic 2009 Lancet: the complete life system produces a priority curve on which individuals of age between the fifteen and the 40 years have more substantial, while the younger and older get the opportunities that are mitigated. "Actual" means rationing, rationing, Or denied medical assistance that commonly leads to premature death. In 2021, doctors, nurses, lawyers, defenders of patients and journalists reported serious hospital abuses, negligence of patients and denial of intravenous fluids vital and basic drugs to Covid patients hospitalized in the United States. The Complete Lives protocol apparently derived from 1990 of the United Kingdom National Health Service "Liverpool Pathway", which in fact constituted euthanasia. Now let's see her malicious manifestation in the Covid protocol. Age-based rationing is taking place every day in the Covid units of our hospitals, since the vast majority of Covid patients are over 50 years old, the age in which Emanuel states that a life is "complete" and not The use of medical resources is worth. The Complete Lives System and the Covid Protocol are both routes that lead to premature suffering and death, mainly the oldest Americans. They reach the government's goal to reduce Medicare costs. At the same time, hospitals earn extra million indexible with extra incentive payments for Covid patients during their tortured path towards death, while they are chemically and physically retained and isolated from families, shepherds, priests and rabbis. The heartbreaking story of Veronica Wolski, a supporter note of the freedom of Chicago, has been widely publicized. Once admitted to the hospital called Ironically Resurrection Hospital, in Veronica, Remdesivir was given, which had repeatedly refused, denied adequate basic medical assistance that could have save his life and did not allow him to be accessed to his family , at the priest or to the health proxy. A Veronica was prevented from leaving the hospital when she and the lawyers of her asked her release. His own Health has been removed from hospital security. Veronica died alone as a medical prisoner in a Catholic hospital, denying even a priest at the end of her life. Life. Human rights violations in hospital, including violations of the Geneva Conventions established after World War II to prevent prisoner abuse, occur daily throughout the United States. Patients are forced to take rapidly approved drugs such as Remdesivir, despite the known risks of kidney and liver failure, and to be placed on ventilators, both of which involve incentive payments and create huge profits for hospitals. Patients are denied adequate fluids and nutrition, as well as vitamins, inhaled and intravenous corticosteroids, antibiotics, antivirals and adequate doses of â~~ (anticoagulants). Patients suffer inhuman isolation with the use of chemical and physical restrictions, in violation of current patient protection guidelines. Hospitals use law enforcement to deny access to hospital bases for family and supporters. Patients and their supporters were denied information about the benefits of early treatments and denied access to such treatment. Autopsies confirmed that many patients died due to inadequate doses of standard anticoagulation, even after family members went to court to request therapeutic doses to help save lives. Doctors and nurses put their careers, licenses, livelihoods, and even their lives at risk as they speak boldly to give their patients and the public life-saving information. A fellow ICU doctor posted this on social media recently: just finished a ten-night period in intensive care. Patient repression and obvious nastiness have taken on a whole new level within our healthcare colleagues. How can we NOT spiral towards the towards despair when this behavior Ã¨ allowed and is normalized?? Ã ÷ ÂÂÂÂwere thrown into a Ã ˜ Ô Ô ÔÂ~~ÔÂ ÂÂ Make fun of patients and families for not being VÃ ®d Ã¨ the cool thing now. Ã ÷ Â ÂÂÂ d;t mind taking of COVID patients. But this hateful vibe permeated my world Ã¨ what is going to end my career if not [stop]. Welcome to the brave new world of government medical care directed by obedient and profit-oriented hospital executives eager to distribute incentive payments for the follow-up of the "COVID protocol. EDITOR note: Last year, America's doctors, nurses, and paramedics were celebrated as front-line heroes battling a new, fearsome pandemic. Today, under Joe Biden, tens of thousands of these same heroes are denounced as rebels, conspiracy theorists, extremists, and potential terrorists. Along with a huge number of police officers, firefighters, border police officers, Navy SEALs, pilots, air traffic controllers and countless other truly essential Americans, they are all considered so dangerous to deserve resolution, their professional and personal lives turned upside down due to their decision not to be injected with experimental COVID vaccines. Biden's tyrannical mandate threatens to cripple the company american â from the forces of order to the airlines to the commercial supply chains to the hospitals. Is already happening. But the good news is that a large number of âheroes of yesterday are now fighting â courageously and courageously. entire epic showdown was presented as never before in the sensational October issue of the WND monthly Whistleblower magazine, titled "THE GREAT AMERICAN BULGE: âWe won't conform!â COVID-19 power grabs ignites the bold new era of national challenge." source How can I be saved? MARANATHA! Please come to the Lord Jesus¹! Page 2 How can I be saved? MARANATHA! Brethren, our WordPress does not allow most people to comment on messages. This has been happening since dissatisfaction has come to the site and placed me. We're working to fix this. Thank you for your patience. BRETHREN, I WANT YOU TO MAKE SURE HOW LONG WOMEN ARE. women. The protocol is mentioned in this article from Australia. From mail.google.com review started 11/03/2011Review Ended 11/22/2021Purilde 11/22/2021Sume Â © copyright 2021died et al. This is an open access articulated under the terms of the Attribution CreativeCommons license CC-BY 4.0., Which allows the use of non-restrictions, distribution and reproduction in any means, provided that the author and the original source are credited . Niim Research, National Institute of Supplementary Medicine, Melbourne, Aus 2. Health and Nutrition, University of Torrens, Melbourne, Aus 3. Discipline of General Practice, Adelaide University, Adelaide, Aus 4. Gold Coast Clinic, National Institute of Supplementary Medicine , Gold Coast, Aus 5. Nim Clinic, National Institute of Supplementary Medicine, Melbourne, Auscrisponding Author: Karin Ried, Karinried@nim.com.au Abstract BackgroundCovid-19 is a global pandemic. Treatment with hydroxichlorochin (HCQ), zinc and azithromycin (AZM), also known as a Zelenko protocol, and intravenous treatment (IV) Vitamin C (IVC) showed encouraging results in a large number of studies all over the world. Furthermore, vitamin D levels are an important system of symptoms gravity in patients with Covid-19. Objectives Our multicenter, randomized and label-label study has aimed at evaluating the effectiveness of HCQ, AZM and Zincwith or without IVC in patients hospitalized with COVID-19 in reducing the gravity of the symptom and duration of death and duration. Methods Hospitalized patients with Covid-19 in seven participating hospitals in Turkey were projected for admissibility and assigned randomly to receive HCQ, AZM and Zinc (Group 1) or HCQ, AZM, Zinc Plus IV Vitamin C Treatment (group 2) For 14 days. Patients also received non-feasight levels of vitamin D3.The studio is on the Australian and New Zealand clinical trial register ACTRN12620000557932 and has been the Australian Therapeutic Goods Administration (TGA). Results The study included 237 patients hospitalized with COVID-19 of etÃ between 22 and 99 years (meco: 63.3 Â± 15.7 years). Almost all patients were deficient in vitamin D (97%), 55% were severely deficient in vitamin D (Â±25 nmol/L) and 42% were deficient in vitamin D (Â±50 nmol/L); 3% had insufficient levels of vitamin D (Â±75 nmol/L), and none had optimal levels of vitamin D. Among patients, 73% had comorbidit, including diabetes (35%), heart disease (36%), and lung disease (34%). All except one patient (99.6%; n = 236/237) treated with HCQ, AZM and zinc with or without high dose of fully recovered vitamin C (IVC). Additional IVC therapy contributed significantly to faster recovery (15 days vs. 45 days until discharge; p = 0.0069). Side effects such as diarrhea, nausea and vomiting, reported by 15%-27% of patients, were mild to moderate and transient. No cardiac side effects were observed. Low vitamin D levels were significantly correlated with higher probability admission to the unit ICU and a longer hospital stay.¹ Unfortunately, a 70-year-old patient with heart and lung disease Ã died after 17 days in intensive care and 22 days in hospital. Its vitamin D level was 6 nmol/L upon admission (i.e.¨, seriously deficient). Conclusions Our study suggests that the treatment protocol of HCQ, AZM and zinc with or without vitamin C Ã¨ safe and effective in the treatment of COVID-19, with high dose vitamin C IV which leads to a significantly faster recovery¹. important, our study confirms vitamin D deficiency to be a high risk factor of severe COVID-19 disease and hospitalization, the 97% of the patient co-ordinate of our study being vitamin D deficient, the 55% of these is severely vitamin D deficient, and no one has optimal levels. Future trials should evaluate treatment with a high dose combination D3 in addition to HCQ, AZM and zinc and high doses of vitamin C by intravenous route. Categories: Infectious diseases, Therapeutic, Integrated/Complementary vitamin d, Vitamin c by intravenous route, Zinc, Hydroxychlorokine, covid-19 treatment Introduction Acute Respiratory Syndrome Severe coronavirus 2 (SARS-CoV-2), or COVID-19, has affected millions of people around the world. COVID-19 was first reported by the World Health Organisation in December 2019 and was declared a global pandemic in March 2020. Exploring potentially beneficial therapies for COVID-19 has been a public health emergency. SARS-CoV-2 enters the cells by binding to the ACE2 receptor. Higher blood levels of ACE2 reflect the spread from the myocardium and pulmonary epithelium and identify patients who are vulnerable to the development of potentially fatal complications. At the beginning of the pandemic, the combination of hydroxychloroquine (HCQ), azithromycin (AZM) and zinc, also known as Zelenko protocol, had shown great promise in the treatment of COVID-19 [1,2]. In vitro, chloroquine increases the endosomal pH needed for the virus to fuse with the cells and interfere with the glycosylation of the V-2 cell SARS-Co-receptors, which block viral infection [3,4]. Investigators conducted a test on the time of addition, which showed that chloroquine is effective both in the entry and subsequent stages of SARS-CoV-2 infection in cells. Hydroxychloroquine has a higher in vitro potency than SARS-CoV-2 and, thanks to its enhanced safety profile, can be administered at higher doses than chloroquine [5]. In October 2021, a meta-analysis of over 290 studies worldwide that involved more than 412 000 patients has HCQ has significantly reduced morbidity and mortality in patients with COVID-19. In particular, when HCQ is used in early treatment, a meta-analysis of 32 studies involving more than 54,6 000 patients HCQ to improve symptoms and prevent the death of 64% -75% (all premature treatment studies (n = 32): RR, 0,36 (0,29-0.46), P 3 g daily or experimental antivirals; (4) a history of fever (e.g. night sweats and chills) and/or acute respiratory infections (e.g. cough, shortness of breath and sore throat) lasting more than seven days; (5) calculated creatinine clearance of 500 ms) 24 hours after the initial dose of studies, severe ventricular arrhythmia (including ventricular fibrillation) or sudden deathin the hospital, and one of the following adverse events in the first ten days after enrollment: diarrhea, grade 2o higher; upper; grade 2 or higher; and vomiting, grade 2 or greater (appendages). Fattive Design FeatureSle Studio was overseen by the steering committee composed of Chief Investigators (TB, KR and AS) Andinvestigators at Recruited Sites. Independent Data Security Monitoring Committees (DSMC) at Hospitals participants monitored the progress and safety of the test treatment and had to make recommendations on whether to continue, modify or discontinue the test for safety or ethical reasons. Sample Size calculation of phase 1, the required sample size is n = 100 in each intervention arm to have a statistical power of 80% to detect a relative risk reduction (€€€ of 30% in the proportion that progresses to the death of mechanical ventilation, compared to standard care and assuming a standard of care risk of progression of 30%. Sincethe participants were hospitalized, we assumed the minimum loss (

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