Introduction:
Candida score (CS) is used to identify patients with invasive candidiasis in the ICU, but its clinical use has not become widespread. Our objective was to evaluate the clinical significance of CS in a mixed population of ICU patients.

Methods:
This was a prospective observational study of critically ill patients who had Candida species growth during their stay in any of six different ICUs of a tertiary-care center. Two intensivists classified patients as having Candida colonization or invasive candidiasis according to predefined criteria. CS was calculated for each patient on the day of Candida species growth as follows: 1 point for parenteral nutrition + 1 point for surgery + 1 point for multifocal Candida colonization + 2 points for severe sepsis. The Receiver Operating Characteristic (ROC) curve was plotted to assess CS ability to discriminate between invasive candidiasis and Candida colonization.

Results:
CS was 1.6±0.9 in patients with Candida colonization (N=261) and 2.4±0.9 in those with invasive candidiasis (N=120) (p<0.001). However, only 38.7% of invasive candidiasis cases had CS≥3 (compared with 8.0% of Candida colonization cases; p<0.001). The ROC curve (Figure 1) showed that CS had fair ability to discriminate between invasive candidiasis and Candida colonization (area under the curve 0.71, 95% confidence interval 0.65 to 0.77; p<0.001). In patients with invasive candidiasis, CS was similar in hospital survivors and nonsurvivors (2.2±0.9 and 2.5±0.8, respectively; p=0.13). CS did not discriminate between survivors and nonsurvivors (area under the ROC curve 0.61, 95% confidence interval 0.46 to 0.75; p<0.15).

Conclusion:
CS was higher in patients with invasive candidiasis than those with Candida Colonization. However, its ability to discriminate between these patients was only fair. CS was not associated with hospital mortality.
ROC curve for Candida score discriminating between invasive candidiasis and Candida colonization.

Diagonal segments are produced by ties.