

BACKGROUND AND HYPOTHESIS

 Cirrhosis has been identified as a risk factor for the development of candidemia, which is associated with high mortality rates.

 Although the current literature describes poor outcomes in cirrhotic patients with invasive candidiasis, factors contributing to worse outcomes are not well known.

• We aim to better understand the factors contributing to worse outcomes in cirrhotic patients with candidemia.

METHODS

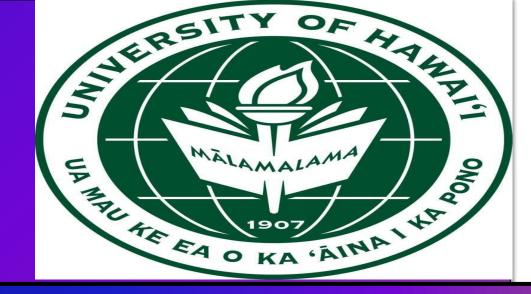
• Data were extracted from the National Inpat Sample (NIS) database from 2016-2019.

• Using the ICD-10-CM codes, patients diagnosed with candidemia were identified.

• Baseline demographic data, comorbidities, in hospital mortality, hospital charges, and hospital length of stay (LOS) were extracted and compared based on the presence or absence a concurrent diagnosis of cirrhosis.

• Statistical analyses were done using t-test a Chi-squared analysis. A multivariate analysis the mortality odds ratio (OR) was calculated to adjust for possible confounders.

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| | TABLE 1 UNIVARIATE AND MULTIVARIATE ANALYSIS OF POTENTIAL FACTORS AFFECTING IN-HOSPITAL MORTALITY IN PATIENTS WITH CHOLANGITIS UNDERWENT ERCP | | | |
| | Variable | adjusted OR (CI 95%) | P-value | A tot 2,65 |
| | Cirrhosis | 2.43 (1.94-3.02) | < 0.01 | Ther 319, |
| e | Age >= 65 | 1.47 (1.3-1.65) | < 0.01 | days Cirrh thos |
| | Female | 0.9 (0.81-1) | 0.06 | More cong with |
| | Non-White | 1.4 (1.26-1.57) | 0.02 | In pa hepa |
| atient | Alcoholism | 1.55 (1.22-1.96) | < 0.01 | (OR increased) Other hepa |
| | Diabetes mellitus | 0.65 (0.58-0.73) | < 0.01 | perit vario |
| , in- pital | Hypertension | 0.78 (0.69-0.87) | < 0.01 | A co cano in th |
| ce of and | Congestive heart failure | 1.71 (1.53-1.92) | < 0.01 | and prac the i |
| s for to | Obesity (BMI > 30) | 0.84 (0.72-0.99) | 0.04 | Mod unde in di avoi |



SULTS

otal of 49,130 patients diagnosed with candidemia, and 650 of them had a concurrent diagnosis of cirrhosis.

ere was no difference in the cost of hospitalization (\$9,472 vs. \$315,338; p = 0.86) or the LOS (21.6 vs 21.7 ys; p = 0.91).

Thotic patients had a higher in-hospital mortality than ose without cirrhosis (OR 2.43, CI 1.94-3.02; p = 0.01).

preover, age >65, non-white race, alcoholism, and ngestive heart failure were independently associated th a higher in-hospital mortality (Table 1).

patients with cirrhosis and candidemia, the presence of patic failure (OR 2.4, CI 1.63-3.53; p = 0.00) and ascites R 1.64, CI 1.11-2.45; p = 0.01) were associated with creased mortality.

her comorbidities such as hepatorenal syndrome, patopulmonary syndrome, spontaneous bacterial ritonitis, hepatocellular carcinoma, and esophageal rices did not have an association.

NCLUSIONS AND RECOMMENDATIONS

co-diagnosis of cirrhosis during hospitalization for ndidemia may indicate a poor prognosis, especially those with associated hepatic failure and ascites, d thus a careful clinical judgement should be acticed given the nature of cirrhosis may complicate e management of infection.

odifiable risk factors such as alcoholism and derlying socioeconomic factors may play key roles disease outcomes and should be addressed to oid excessively poor healthcare outcomes.