RAPID RISK ASSESSMENT

Clusters of dermatophilosis in five EU/EEA countries in 2025–2026

17 June 2026

Summary

Dermatophilosis is a bacterial skin disease caused by *Dermatophilus congolensis,* a bacterium reported primarily in cattle, but also affecting other domestic and wild animals. So far, human infections have only been reported sporadically. Several clusters of genetically and epidemiologically linked cases predominantly affecting gay, bisexual and other men who have sex with men have been detected in four EU countries during the past six months. Cases have also been reported in Norway among individuals practicing martial arts, in 2025 and 2026. This indicates a possible shift in transmission dynamics, with human-to-human transmission through close physical contact being the most likely route. Indirect transmission via contaminated surfaces and fomites cannot be excluded at this stage.

This rapid risk assessment was produced to assess the current situation as *D. congolensis* infection is an unusual occurrence in humans. The target audience is public health authorities, community organisations and healthcare workers.

Epidemiological situation

Four EU countries (France, Germany, Spain, Sweden) have reported 70 cases of skin infections caused by *D. congolensis*, predominantly among gay, bisexual and other men who have sex with men who visited sex-in-premises venues (including adult spas) where close physical contact, including sexual contact, may have occurred. These venues can be defined as commercial establishments where men can socialise and engage in consensual sexual activity with other men if they choose to do so.

Most cases were diagnosed between December 2025 and June 2026. The clinical spectrum included papular, pustular or scaly, pruritic skin lesions, mainly in the genital and facial area, without systemic symptoms. All cases responded well to oral or topical antibiotics, with occasional self-limiting resolution. One EEA country (Norway) reported ten additional cases occurred linked to martial arts activities, with exposure taking place either in Norway (summer 2025) or during travel to Thailand (January 2026). In Austria, *D. congolensis* was identified in ten individuals in 2025 and seven by mid-2026 (mostly in men), based on data from two Vienna laboratories.

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Risk assessment

The overall risk of this event for the general population is assessed as very low, considering the very low probability of infection with *D. congolensis* and the very low impact due to the mild clinical course of the disease.

Among gay, bisexual and other men who have sex with men who have multiple sexual partners, the overall risk is assessed as low, given the low probability of infection – which reflects current evidence of human-to-human transmission, mainly through direct skin contact during sexual activity – and very low impact due to the mild clinical course of the disease.

The probability increases in gay, bisexual and other men who have sex with men who have multiple sexual partners and attend sex-in-premises venues. In this group, the probability of infection rises to moderate due to the current epidemiological evidence of exposure in these venues. Given the very low impact due to the mild clinical course of the disease, the overall risk is still low.

Recommendations

- Countries should continue epidemiological and microbiological investigations to better characterise transmission routes, risk factors and the extent of spread, and are encouraged to share results via EpiPulse.
- Perform whole genome sequencing (WGS) of all cases and environmental isolates to increase understanding of transmission routes and identify the original source. ECDC can provide support for WGS for countries without in-country capacity.
- Raise awareness among clinicians and laboratories to support timely recognition, testing, early access to treatment and reporting of cases.
- Implement targeted risk communication and prevention advice for gay, bisexual and other men who have sex with men, including messaging on dermatophilosis. The upcoming Pride season provides a strong communication opportunity.
- Collaborate with community-based organisations to reach these populations effectively and without generating stigma.
- Owners and operators of sex-in-premises venues should reinforce hygiene measures.

Epidemiological situation

Multi-country spread of *Dermatophilus congolensis* infection

Four EU countries (France, Germany, Spain, Sweden) have reported 70 cases of skin infections caused by *Dermatophilus congolensis,* predominantly, but not exclusively, among gay, bisexual and other men who have sex with men who visited sex-in-premises venues where close skin-to-skin sexual contact may occur. The majority of cases were diagnosed between December 2025 and June 2026. Ten cases have were also reported in Norway in 2025 and 2026, among individuals practicing martial arts, with exposure either in Norway or Thailand [1]. In Austria, a recent enquiry from two major clinical laboratories in Vienna identified *D. congolensis* in ten individuals in 2025 and seven by mid-2026 (six in men), suggesting a possible increase in 2026 (EpiPulse). No isolates were recovered, and data on sexual orientation or exposure settings were not collected.

D. congolensis is a Gram-positive bacterium that primarily causes exudative dermatitis in animals. Human infection is considered rare and has historically been associated with contact with infected animals or contaminated environments. In humans, the infection typically presents as a mild, localised cutaneous disease characterised by papules, pustules, crusted lesions, or folliculitis-like eruptions, and is usually not associated with systemic illness. The reported lesions in the current clusters were generally mild, with complete recovery following oral and/or topical antibiotic treatment, and occasional self-limiting resolution.

EU countries

France

On 11 May 2026, France reported 25 cases of folliculitis caused by *D. congolensis* in EpiPulse among gay, bisexual and other men who have sex with men, diagnosed between December 2025 and May 2026 in the Lyon municipality. Lesions included erythematous papules, sometimes pustular or scaly, with variable itching, and no mucosal involvement or systemic symptoms [2]. Affected areas of the body were predominantly the genital area and perioral region, the trunk, legs, and less frequently anal margins. Whole-genome sequencing from eight patients showed closely related strains (1–5 Single Nucleotide Polymorphism (SNP) differences across >94% of the genome).

As of 1 June 2026, France has reported a total of 40 cases diagnosed across eight cities, predominantly among gay, bisexual and other men who have sex with men who reported a history of exposure in adult saunas. Reported exposure occurred in venues located in France and abroad, including one sauna in Lyon, two in Paris, one in Bordeaux, one in Barcelona, one in Lausanne and one in Palermo. No contact with a diseased animal has been identified. One individual who was a confirmed case did not identify as a man who has sex with men and visited a leisure sauna without reporting sexual contact.

Among 27 patients in Lyon with available data, all were cisgender men who have sex with men, with a median age of 49 years (interquartile range [IQR]: 41.5–59.5). Four were receiving HIV treatment and 18 were on HIV pre-exposure prophylaxis (PrEP). Lesion co-infections (*Staphylococcus aureus, Staphylococcus lugdunensis*) were reported in 10 patients. Twenty-two reported visiting an adult sauna prior to symptom onset, and five reported sexual contact with men without sauna exposure. The modelled median incubation period was 5.85 days, with 80% of cases occurring between 3.75 and 13.5 days (range: 2–22 days). All cases were successfully treated with amoxicillin or pristinamycin, with or without local antiseptic care, and rapid improvement was observed after two to three days and all recovered completely.

Germany

As of 1 June 2026, 17 cases of *D. congolensis* infection have been identified, predominantly among men living in the federal states of Berlin and adjacent Brandenburg (two cases), with symptom onset between December 2025 and May 2026. Lesions included pustules, scaling rash, and itchiness, predominantly localised in the genital area, torso, face and legs. Among cases with available information, successful treatment regimens included topical treatment with fusidic acid (eight cases), treatment with doxycycline (one case), local antiseptic washes (one case), or a combination of doxycycline and antiseptic washes (one case). For one case, recovery without treatment was reported. One case was in a person living with HIV receiving antiretroviral therapy, and four in individuals receiving PrEP. Of 11 people interviewed, ten self-identified as gay, bisexual and other men who have sex with men. Ten individuals also reported attending saunas during the incubation period (six saunas in four German cities and one sauna in Barcelona; five of the German saunas were sex-in-premises venues restricted to men). Eight of the ten individuals reported sexual contact in saunas. No animal exposure or additional epidemiological links were identified.

Spain

Nine cases of *D. congolensis* infection were identified among gay, bisexual and other men who have sex with men in Barcelona, between December 2025 and March 2026 [3]. Lesions included papules, vesicles, pustules, scabs, nodules, or scaly lesions, typically affecting multiple sites, most commonly the genitals, thighs, groin, and beard area. All cases recovered without complications following antibiotic treatment (mainly cefadroxil or cloxacillin). Among the individuals, four were on HIV treatment, three on HIV PrEP, and four had concomitant STIs. All nine individuals reported visiting venues for sexual encounters in Barcelona or other cities in Europe in the week before symptom onset, including saunas (eight individuals) and a sex club (one individual); none reported animal contact or recent travel to tropical regions. Whole-genome sequencing showed nearly indistinguishable isolates (0–4 SNPs). As of 1 June 2026, five additional cases are under investigation in Spain, outside Catalonia: three linked to sexual contact among gay, bisexual and other men who have sex with men (April – May 2026; two involving sauna attendance), one linked to zoonotic exposure during travel to Thailand for tourism (July 2025), and one with unknown transmission (August 2025).

Sweden

As of 15 June 2026, four cases of *D. congolensis* infection were identified in Sweden among gay, bisexual and other men who have sex with men attending a sexual health clinic in Stockholm, all of whom were receiving HIV PrEP. None reported animal contact, but all had recent exposure to sex-in-premises venues. Two individuals likely contracted the infection in Sweden (diagnosed in March and June 2026; one had visited a spa), one in Japan (April 2026) and one in Spain (May 2026). For one case with available exposure information, the rash appeared one day after visiting a sex club. Lesions were reported in the genital and perianal regions, as well as on the lower abdomen and flanks. None experienced systemic illness, and no secondary cases were identified. Symptoms resolved rapidly following treatment with doxycycline (two cases) or amoxicillin (one case).

EEA countries

Norway

An outbreak with eight dermatophilosis cases was reported in Trondheim in August 2025 among members of a martial arts club [1]. In addition, in January 2026, two individuals who recently travelled to Thailand developed skin infections after attending martial arts training sessions; one case was laboratory-confirmed with *D. congolensis.* Participants from several European countries attended the same training sessions in Thailand.

Whole genome sequence analysis

Whole genome sequence data from 16 publicly available *D. congolensis* isolates was analysed by ECDC using the SNP-based tool *Snippy* [4]. This included nine French and seven Spanish human isolates from 2025-2026 (including one duplicate French isolate) [2,3]. As background data, isolates from cattle (40 isolated in Saint Kitts and Nevis in 2019 and one in DRC in 1956) were also analysed [3].

The seven Spanish isolates and four French isolates were indistinguishable in the SNP analysis. The remaining five French isolates differed from this cluster by 1-5 SNPs. The 41 background isolates from cattle differed significantly from these human isolates (in the scale of thousands of SNPs). These microbiological findings suggest that the cases are linked while ~~of~~ the non-human origin of the pathogen remains unrevealed. The phylogenetic tree including the French and Spanish isolates is shown in the Technical Annex.

ECDC risk assessment for the EU/EEA

This risk assessment has been developed based on the data available at the time of publication and follows the ECDC rapid risk assessment methodology, where the overall risk is determined by a combination of the probability of infection and the impact of disease [5].

The risk of dermatophilosis by *D. congolensis* to different population groups in the EU/EEA is assessed below.

Table 1. Risk assessed for different population groups in the EU/EEA

	General EU/EEA population	Gay, bisexual, and other men who have sex with men who have multiple sexual partners	Gay, bisexual, and other men who have sex with men who have multiple sexual partners and attend sex-in-premises venues
Probability	Very low	Low	Moderate
Impact	Very low	Very low	Very low
Overall risk	**Very low**	**Low**	**Low**

General population

Given the lack of evidence for widespread community transmission, transmission through casual social contact, or sustained household spread, the probability of further spread of *D. congolensis* to the general population in EU/EEA countries in the coming months is assessed as very low. The impact on the general population is very low, with cases reported as mild, treatable, and not associated with severe outcomes to date. resulting in a very low overall risk for this population. However, the individual risk may be higher for very young children, pregnant women, older adults, and immunocompromised individuals among close contacts of cases, due to the potentially greater impact of disease in these groups. Evidence is currently insufficient to clearly define increased risk in these groups.

Gay, bisexual and other men who have sex with men who have multiple sexual partners

The current outbreak is predominantly affecting gay, bisexual and other men who have sex with men. Skin-to-skin contact appears to be the main route of infection; although indirect transmission via contaminated surfaces and fomites cannot be excluded [6]. Lesions have predominantly affected areas exposed during sexual contact (e.g. genital region, face, and trunk), mirroring patterns observed in sexually transmitted dermatophytosis [7-9].

Outbreaks of other sexually transmitted infections among gay, bisexual and men who have sex with men have previously been linked to international travel and large social or mass gathering events (e.g. Pride festivals) [10-13]. Several such events take place across Europe during the summer months and may contribute to further transmission of *D. congolensis*.

Most reported cases in this outbreak have been mild. Only one individual had systemic symptoms, and none required hospitalisation or experienced complications. Patients responded well to short courses of commonly used antibiotics, or topical antibiotic treatment [2,3,14], with antimicrobial susceptibility testing showing broad sensitivity across several antibiotic classes, indicating that standard oral treatments are effective. Sporadically, even a self-limiting recovery has been reported. Among cases in France, Germany and Spain were individuals living with HIV and receiving ART who have fully recovered. Since HIV prevalence is higher among gay, bisexual and men who have sex with men than in the general population, more evidence is needed to assess risks in immunocompromised individuals. However, most people living with HIV in the EU/EEA (approximately 70%) are on antiretroviral therapy and are not severely immunocompromised [15].

The probability of *D. congolensis* infection among gay, bisexual, and other men who have sex with men who have multiple sexual partners is assessed as low, but higher than in the general population due to interconnected sexual networks. The impact among this population is assessed as very low, as reported infections have generally been mild and treatable, with no severe outcomes documented to date.

Gay, bisexual and other men who have sex with men who have multiple sexual partners and attend sex-in-premises venues

Attendance at sex-in-premises venues, especially adult saunas, and engaging in sexual contact were frequently reported among cases. Some infections occurred shortly after these visits (median six to seven days) and the humid conditions found in saunas and spas could favour the release and environmental persistence of infective *Dermatophilus* zoospores [16,17]. Sequencing data indicate that cases from different countries are genetically similar or even indistinguishable, suggesting they may be interconnected. However, further analysis with additional data, including results from ongoing epidemiological investigations and genomic analyses in countries reporting cases, will help to better understand transmission dynamics, considering the limited number of cases and incomplete information.

The probability of *D. congolensis* infection among gay, bisexual and other men who have sex with men who have multiple sexual partners and attend sex-in-premises venues is assessed as moderate with a very low impact.

ECDC recommendations

Managing cases

There are currently no formal clinical guidelines for the management of human infections with *D. congolensis* in Europe. The infection should be considered in patients presenting with compatible skin lesions, particularly in areas exposed to close skin-to-skin contact during sexual activity, including individuals reporting attendance at sex-in-premises venues. Diagnosis can be confirmed by laboratory testing of lesion samples (e.g. microscopy, culture, or molecular methods). For differential diagnosis, please see the Technical Annex.

Reported cases in the EU/EEA have responded well to short courses of antibiotics (e.g. amoxicillin, cefadroxil, cloxacillin, and doxycycline) or topical treatment with antibiotic ointment, with rapid clinical improvement and complete recovery, including among people living with HIV [2,3]. Although most infections have been mild, localised and self-limiting, treatment of confirmed cases is recommended as it may reduce onward transmission.

Strict isolation is not required because adopting simple hygiene practices can prevent further transmission. Patients should be advised to avoid close or intimate contact and to abstain from sexual activity until lesions have fully resolved. While condom use remains important for prevention of HIV and other STIs, it does not prevent transmission of *D. congolensis*, which occurs through direct contact with affected skin. General hygiene measures are recommended, including avoiding sharing personal items (e.g. towels, clothing, bedding), maintaining good hand and body hygiene, and covering active lesions where feasible.

As a precaution, people with skin lesions should avoid close contact with pets and livestock and follow general hygiene measures. Veterinarians should be consulted if animals develop compatible skin lesions.

Managing contacts

Close contacts primarily include sexual partners, and potentially, household contacts, however, no transmission to non-sexual contacts has been documented in the current clusters. Contact tracing should follow established STI partner notification practices [18].

While there have been no cases of severe disease among immunocompromised patients, identifying immunocompromised contacts is relevant to ensure prompt treatment and to acquire more evidence of possible risk factors for disease severity in this population.

Contacts should be advised to self-monitor for skin lesions for a period of 14 days after last exposure and seek medical assessment if symptoms develop. Contacts developing symptoms should be clinically evaluated, tested where appropriate, and treated if infection is confirmed. They should avoid close skin-to-skin contact with others, including sexual activity, until lesions have resolved. It should be emphasised that condoms alone do not provide protection against transmission of *D. congolensis*, as infection occurs through skin-to-skin contact. General hygiene measures should also be advised.

Environmental persistence and disinfection

Evidence on environmental control of *D. congolensis* in human settings is limited. Precautionary measures may therefore be considered based on the organism's characteristics and established hygiene practices in shared venues [19].

In sex-in-premises venues where close skin-to-skin sexual contact may occur this may include routine cleaning and disinfection of high-touch and skin-contact surfaces, particularly in humid areas, using standard broad-spectrum disinfectants according to manufacturer instructions. Measures to reduce moisture accumulation, including adequate ventilation, drying of shared surfaces, and regular laundering of reusable textiles, may also be effective.

Raising awareness among venue staff and sexual health services can support early detection and reinforce hygiene measures while transmission routes remain under investigation.

Healthcare settings and diagnostic laboratories

Awareness of *D. congolensis* infection should be raised among clinicians (e.g. dermatologists, sexual health clinicians, general practitioners) and laboratory staff in healthcare settings, as cases may be under-recognised due to non-specific presentations. Authorities could consider developing specific communication materials to support this activity. Laboratories should ensure appropriate diagnostic testing is performed on lesion samples. Further details on differential diagnosis and recommended laboratory methods and specimen handling are provided in the Technical Annex.

Risk communication and community engagement

Encouraging protective action among individuals and groups planning to visit sex-in-premises venues where close skin-to-skin sexual contact may occur (particularly facilities with hot and humid conditions such as adult saunas) is essential to reduce the transmission of this outbreak as epidemiological and microbiological data collected until now point to transmission within these networks. These protective actions include maintaining good personal hygiene, avoiding sharing items such as towels or razors, and seeking prompt medical advice for any rashes or skin infections. To reach the intended audiences effectively and listen to their concerns without generating stigma, public health authorities should actively work with community-based organisations and stakeholders and leverage the trust they have to deliver targeted risk communication messages through channels widely used by the intended audience [20].

This messaging should provide clear, non-judgemental information that focuses on the specific behaviour that reduces the risk of infection and transmission rather than on personal identity, while encouraging individuals to seek prompt medical advice for the diagnosis and treatment of any suspected rashes or skin infections.

The upcoming Pride season presents a strong opportunity for communication and community engagement on *D. congolensis.*

Other recommendations

ECDC recommends that countries continue epidemiological and microbiology investigations to better characterise transmission routes and the extent of spread and share results via EpiPulse. Countries are encouraged to share genome assemblies or accession numbers via EpiPulse; raw sequence reads can also be shared through the ECDC SFTP site. ECDC can provide support for genomic sequencing through ECDC laboratory contractor for countries without in-country capacity.

Limitations

This assessment is undertaken based on facts known to ECDC at the time of publication and has several key limitations. In particular, there are many scientific uncertainties and knowledge gaps regarding human *D. congolensis*, including:

- Human infection with *D. congolensis* has been rare and typically associated with animal exposure. The current clusters are unusual and may indicate an emerging transmission pattern; however, conclusions are based on preliminary data from ongoing investigations and remain subject to revision.
- Human-to-human transmission is not well characterised; heterogeneous and limited exposure data prevent a thorough assessment of transmission routes, risk factors, and key epidemiological parameters.
- The rate of mutations typically seen for *D. congolensis* is not well known and no clear thresholds for sequence-based analysis can be set to verify transmission chains.
- The duration of infectiousness in humans is unknown. Evidence on environmental persistence derives mainly from animal studies, and its relevance for human transmission is uncertain.

- Data on incubation period, asymptomatic infection, and severity across populations are limited, particularly among immunocompromised individuals.
- Low clinical awareness, the often mild, non-specific clinical presentation, the fact that *D. congolensis* is not a notifiable infection in most settings, may lead to under-detection and uncertainty regarding the true extent of transmission.
- The risk of anthropo-zoonotic (human-to-animal) transmission of *D. congolensis* in the EU/EEA, including spillover to pets, has not been documented.

External reviewers

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Technical Annex

Disease background and diagnostic techniques

Dermatophilosis is a bacterial skin infection caused by *Dermatophilus congolensis*, a Gram-positive, filamentous actinomycete. The pathogen primarily affects livestock and other animals, particularly cattle, sheep, and goats, where it causes exudative dermatitis [6]. Human infection are considered rare and have traditionally been associated with direct contact with infected animals or contaminated environments. Human cases associated with travel to regions with high prevalence of animal infections have been reported [21,22].

In humans, dermatophilosis typically presents as localised cutaneous disease characterised by papules, pustules, crusted lesions, or folliculitis-like eruptions [2,3]. Lesions most commonly affect exposed skin or sites of inoculation and are generally not associated with severe systemic illness. (For images of the lesions please see [2,3])

Diagnosis is based on microbiological examination of lesion samples, including culture and identification of *D. congolensis* by methods such as MALDI-TOF mass spectrometry. Microscopy may demonstrate characteristic branching Gram-positive filaments with transverse septation ('tram-track' appearance). Differential diagnoses include staphylococcal folliculitis, sexually transmitted dermatophytosis, *Klebsiella aerogenes* folliculitis, secondary syphilis, mpox, and molluscum contagiosum [2].

The infection is generally responsive to antimicrobial therapy. Successful treatment has been reported with beta-lactams (e.g. amoxicillin, cefadroxil, cloxacillin) and doxycycline, typically resulting in complete clinical resolution. Antimicrobial susceptibility testing performed on isolates from a recent European cluster demonstrated susceptibility to a broad range of antibiotics, including beta-lactams, tetracyclines, macrolides, trimethoprim-sulfamethoxazole, linezolid, and amikacin [3]. However, in *D. congolensis* isolates from animals, reduced susceptibility or resistance to commonly used antibiotics has been reported, including tetracyclines, macrolides, and aminoglycosides [6].

The clinical course is usually benign, with lesions resolving following treatment and few reported complications. Reinfection may occur following repeated exposure [2].

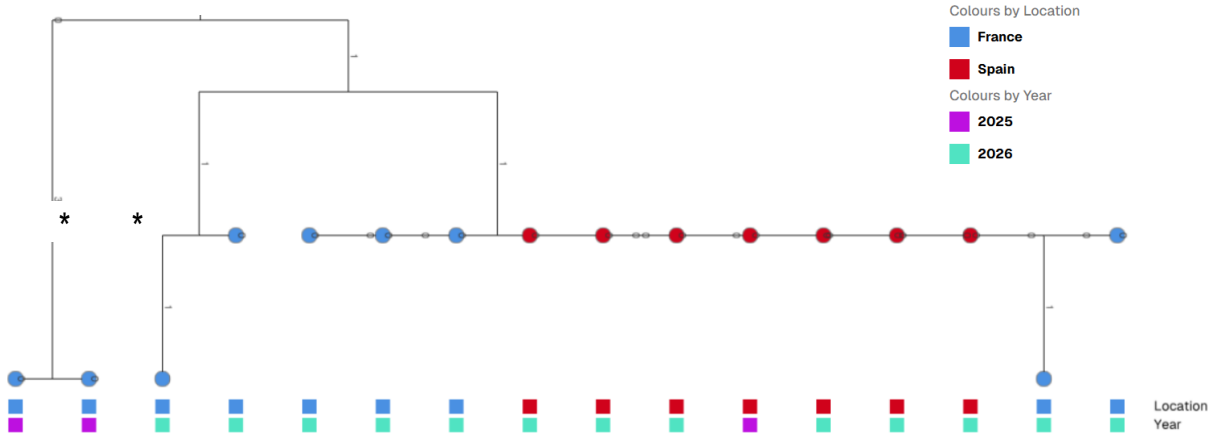
Animal data indicate that *D. congolensis* can persist for prolonged periods in dried scabs and crusts, with zoospores remaining viable for 12 months or longer [23]. Moisture can trigger zoospore release, facilitating transmission through direct contact with lesions or indirectly via contaminated surfaces and environmental materials. The duration of persistence, colonisation, and infectiousness in untreated humans, particularly on the scalp, remains unknown.

Methodology

Information was summarised from country comments in EpiPulse, peer-review publications [2,3], media articles, and noted from a teleconference convened by ECDC on 1 June 2026 with experts from France, Germany, Spain and Sweden.

Whole genome sequence analysis

Figure 1. Maximum likelihood tree of 16 human *D. congolensis* isolates showing numbers of differing SNPs, 2025-2026, as of 9 June 2026.



**Two isolates deriving from the same case*