Epidemiological Alert
Dermatophilosis by *Dermatophilus congolensis*

9 July 2026

Considering the identification of cases of dermatophilosis caused by *Dermatophilus congolensis* in people with no history of contact with animals, in particular in men who have sex with men, suggesting the possibility of a new route of transmission for this disease (human-to-human transmission through sexual contact), associated with a possible new species of *Dermatophilus*, the Pan American Health Organization / World Health Organization (PAHO/WHO) shares updated technical guidance to support Member States in laboratory preparation and diagnosis, infection prevention and control measures, and clinical case management.

Situation summary at the global level

Between December 2025 and June 2026, some clusters of skin diseases caused by *D. congolensis* have been identified in European countries in situations without a history of contact with animals in Germany (n= 17), Austria (n= 17), Spain (n= 14), France (n= 40), Norway (n= 10) and Sweden (n= 4). Most of these outbreaks have been associated with possible human-to-human transmission through sexual contact, predominantly in men who have sex with men, especially in individuals who report attendance at dedicated establishments for sexual encounters. Consequently, human-to-human transmission through close contact represents the relevant mechanism in this context. The cases reported in Norway were related to participation in martial arts activities, suggesting that sustained close physical contact constitutes a significant risk factor *(2)*.

Dermatophilosis (ICD-11 1C4Y) - Other Specified Bacterial Diseases

Dermatophilosis is a skin disease caused by *Dermatophilus congolensis*, a facultative, Gram-positive anaerobic actinobacterium that mainly affects cattle or other domestic and wild animals. Infections in humans have been described sporadically, associated with zoonotic exposure to livestock, wild animals, or contaminated environments *(1)*.

The clinical picture reported as of the date of publication of this alert consists of mild and localized skin lesions, such as papules, pustules and vesicles, squamous lesions or folliculitis, which mainly affect the genital, perianal, inguinal and facial area, as well as the thighs and trunk. Most cases did not present systemic symptoms and responded positively to topical treatments or oral antibiotics, presenting complete improvement and recovery without sequelae *(2, 3)*.

Whole genome sequencing (WGS) was performed on 16 publicly available isolates from patients in France (n= 9 isolates) and Spain (n= 7 isolates). The results showed a close genetic relationship between the isolates from both countries, with single nucleotide polymorphism (SNP) distances of 0 to 4 between pairs. Phylogenetic comparisons were also carried out

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between these isolates and publicly available genomes of *Dermatophilus congolensis* as the biological reference strain for this bacterium, DSM 44180 from the Democratic Republic of the Congo *(3)*. These comparisons showed that the study isolates formed a differentiated cluster, clearly separated from the zoonotic strains previously described, with a minimum distance of 20,410 SNPs from the nearest reference genome, while compared to the reference strain it was 58.7%, also below the 70% threshold established for species delimitation. These findings indicate that the isolates analyzed are genetically distinct from the *D. congolensis* strains described to date and are consistent with the possible identification of a new species within the genus *Dermatophilus*, which will require additional taxonomic characterization for its formal definition *(3)*.

Public health implications

The epidemiological and genomic information from the European outbreaks described suggests a possible change in transmission patterns, and points to close physical contact as the most likely route of transmission. However, the possibility of indirect transmission through contaminated surfaces, fomites or shared textiles, such as what has been documented between animals *(3, 4),* cannot be excluded for the time being.

This situation could imply a higher risk of exposure in certain practices that involve close physical contact, such as contact sports or sexual intercourse in environments with high humidity, such as saunas or bathhouses *(3, 4)*.

Situation summary in the Americas Region

In the Americas Region, dermatophilosis is mainly described as a disease of cattle, sheep, goats, and other domestic and wild mammals *(5)*. In humans, published reports have been sporadic, including four cases described in Brazil, associated with zoonotic exposure *(6)*. While available information suggests that human infection has historically been infrequent, recent events reported in Europe highlight the importance of strengthening integrated surveillance under a One Health approach.

The current risk situation in the Americas Region could be considered low, due to the absence of reported cases of dermatophilosis related to transmission through close contact or sexual contact. However, the holding of mass gatherings in the region during these months could generate conditions that favor greater close physical interaction, therefore maintaining continuous surveillance of the epidemiological situation is recommended.

Due to the identification of these unusual outbreaks of dermatophilosis in Europe, it is recommended that health authorities raise awareness and train health professionals and laboratories to, after clinical suspicion and sampling, facilitate microbiological confirmation and genomic characterization.

Guidance for Member States

The aim of this Epidemiological Alert is to provide Member States with updated guidance on the timely detection, notification, laboratory diagnosis, infection prevention and control, risk communication, and clinical management of suspected or confirmed cases of human dermatophilosis caused by *Dermatophilus congolensis*, in the context of recent outbreaks reported in several countries in Europe.

Epidemiological surveillance and research

Member States should encourage the identification, confirmation, and reporting of suspected cases or clusters of cases of *D. congolensis*, in order to conduct microbiological and epidemiological investigations to better understand the extent of the outbreak, transmission routes, incubation period, risk factors, and potential environmental sources. Because *D. congolensis* infections are rare and not reported in all settings, the actual number of cases may be higher than currently reported *(7)*.

Since *D. congolensis* is a zoonotic pathogen, surveillance of this situation requires the One Health approach, which integrates human, animal, and environmental health, particularly to detect changes in transmission patterns.

Laboratory diagnosis

Laboratory confirmation should be sought in cases with lesions consistent with dermatophilosis, particularly when associated with a known outbreak, a site identified as at risk, contact sports or travel-related exposures. Diagnostic specimens should be collected before starting antibiotic treatment *(8, 9)*.

Samples recommended for laboratory diagnosis include smears of pustules, vesicles, scabs, bedsores, or exudative lesions. Microscopic examination by Gram stain may reveal gram-positive coccoid or filamentous forms with the characteristic pattern of branched filaments. *Dermatophilus congolensis* grows on blood agar incubated at 37 °C in an atmosphere with 5–10% CO_2. The colonies are characterized by being β-hemolytic, grayish-white, raised, wrinkled, and adherent *(10)*.

Laboratory confirmation can be performed by molecular methods, including polymerase chain reaction (PCR) tests targeting the 16S rRNA gene or specific assays based on the alkaline ceramidase gene, described as a highly specific marker for *Dermatophilus congolensis*. Amplicon sequencing is a complementary method for confirming identification when this analytical capability is available. Detection of *D. congolensis* in clinical laboratories can be challenging due to its low frequency in humans, limited diagnostic experience, and the need for molecular methods for confirmation. Currently, there are no standardized methodologies or recommendations for antimicrobial susceptibility testing, and no cut-off points for the interpretation of results. Therefore, it is recommended that suspected cases and isolates obtained be sent to National Reference Laboratories for microbiological confirmation and molecular or genomic characterization *(8, 9)*.

For more detailed genomic characterization, whole genome sequencing (WGS) of strains isolated from human, animal, and environmental samples is recommended to identify epidemiological links between cases or outbreaks, assess the magnitude of transmission, and contribute to the identification of potential sources or origins of infection *(3, 4)*.

Infection Prevention and Control Measures

The available evidence suggests that transmission occurs mainly by direct contact with skin lesions. Although indirect transmission through shared surfaces, fomites or textiles cannot be completely ruled out, the risk appears to be lower. Consequently, isolation measures are not required for clinically stable patients; however, it is recommended to maintain adequate personal hygiene measures and avoid direct contact of the lesions with other people until the symptoms disappear *(2-4)*.

In places where sexual encounters are held and there is the possibility of close skin-to-skin contact, it is recommended to reinforce environmental hygiene measures by regularly cleaning and disinfecting high-contact surfaces and those that come into direct contact with the skin, particularly in humid spaces. The use of broad-spectrum disinfectants, along with measures to reduce ambient humidity including adequate ventilation, drying of shared surfaces, and regular washing of textiles, can contribute to reducing the risk of exposure and transmission of the agent *(2)*.

Strengthening the application of standard precautions in all health care settings is recommended. In addition, precautions should be implemented to prevent transmission by contact during the care of patients with suspected or confirmed diagnosis of dermatophilosis, including the use of personal protective equipment (PPE) according to the risk of exposure and strict compliance with hand hygiene. Likewise, aim to use, when possible, disposable material for patient care and ensure adequate cleaning and disinfection of reusable equipment, instruments, and textiles, in accordance with the procedures established in each institution *(3, 4)*.

Case Management

Evidence on human infection with *Dermatophilus congolensis* remains limited; therefore, the recommendations presented in this alert are based on information available at the time of publication.

Reported outbreak-linked cases in Europe have generally presented with localized papules causing pruritus, pustules, vesicles, crusty lesions, nodules, scaly lesions, or folliculitis-like rashes. The lesions have most frequently affected the genital, perianal, inguinal, facial, thighs, and trunk areas. Systemic symptoms (fever and vomiting) have been described very infrequently *(2-4)*.

There are currently no clinical guidelines for the treatment of *Dermatophilus congolensis* infection in humans. Therapeutic treatment should be based on disease severity, distribution of skin lesions, comorbidities, differential diagnoses, culture results, and antimicrobial susceptibility *(2-4)*.

Reported cases have responded well to oral beta-lactam treatments, such as amoxicillin, cefadroxil, cloxacillin, doxycycline, or topical antibiotic treatment, with rapid improvement and complete recovery in most documented cases *(2-4)*.

Concomitant screening of other sexually transmitted infections is recommended and to treat them if present, is recommended.

Risk Communication

Risk communication should be clear, objective and nonjudgmental, focusing on behaviors and contexts that may increase exposure. Public health authorities should work together with community-based organizations, sexual health services, business owners and managers, contact sports clubs, and event organizers to disseminate evidence-based preventive information and encourage seeking prompt care in the presence of rashes or skin lesions consistent with dermatophilosis *(11)*.

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