

Una iniciativa de:



ACADEMIA ESPAÑOLA
DE DERMATOLOGÍA
Y VENEREOLOGÍA



ACADEMIA ESPAÑOLA
DE DERMATOLOGÍA
Y VENEREOLOGÍA

Con el patrocinio de:



AEDV 35^a
edición

HIGHLIGHTS

Viena

30sep - 3oct
2026

AEDV 35ª edición

HIGHLIGHTS

Viena
30sep - 3oct
2026

ITS y otras enfermedades infecciosas

Daniel Vírseda González

Hospital Can Misses, Eivissa, Illes Balears

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Con el patrocinio de:



AEDV 35ª edición

HIGHLIGHTS

Viena
30sep - 3oct
2026

**NO TENGO CONFLICTOS
DE INTERÉS**

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AEDV 35ª edición

HIGHLIGHTS

Viena
30sep - 3oct
2026

**Un importante campo en crecimiento
que no debemos dejar atrás**

Una iniciativa de:



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UPDATES

Bacterial skin infections

🕒 Wednesday, 30 September • 14:15 - 15:45 CEST

📍 [Hall M](#)

UPDATES

STIs

🕒 Wednesday, 30 September • 14:15 - 15:45 CEST

📍 [Hall N](#)

UPDATES

STIs

🕒 Wednesday, 30 September • 16:00 - 17:30 CEST

📍 [Hall N](#)

UPDATES

Fungal skin infections

🕒 Thursday, 01 October • 08:30 - 10:00 CEST

📍 [Hall M](#)

UPDATES

Parasitic infestations and emerging viruses

🕒 Thursday, 01 October • 10:15 - 11:45 CEST

📍 [Hall M](#)

UPDATES

Genital diseases

🕒 Saturday, 03 October • 10:15 - 11:45 CEST

📍 [Hall M](#)

10:15 - 10:35 CEST

D4T10.2A

Urethritis



George Sorin Tiplica (Bucharest, Romania)

10:35 - 10:55 CEST

D4T10.2B

HPV associated genital diseases



Arne Vikström (Stockholm, Sweden)

☰ [Presentation description](#)

10:55 - 11:15 CEST

D4T10.2C

Vulvovaginal infections



Carmen Lisboa Silva (Porto, Portugal)

UPDATES

Managing skin diseases during pregnancy

🕒 Wednesday, 30 September • 16:00 - 17:30 CEST

📍 [Hall K](#)

16:40 - 17:00 CEST

D1T11.2C

STIs during pregnancy



Brigitte Stephan (Hamburg, Germany)

☰ [Presentation description](#)

FOCUS ON

Practical diagnostic and therapeutic algorithms

🕒 Thursday, 01 October • 10:15 - 11:45 CEST

📍 [Hall C](#)

10:55 - 11:15 CEST

D2T04.2C

European guidelines for the management of genital herpes



Usha Hartgill (Oslo, Norway)

UPDATES

Emergencies in dermatology

🕒 Saturday, 03 October • 08:30 - 10:00 CEST

📍 [Hall F2](#)

09:10 - 09:30 CEST

D4T06.1C

Soft tissue infections



Olivier Chosidow (Paris, France)

☰ [Presentation description](#)

UPDATES

Bacterial skin infections

🕒 Wednesday, 30 September • 14:15 - 15:45 CEST

📍 Hall M

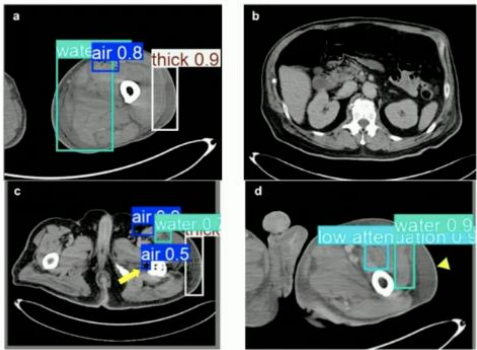
- **Thermal imaging:** infrared camera, now a smartphone accessory. Measures local skin hyperthermia. Non-invasive, bedside, a few seconds. **FLIR ONE Pro for iOS**



Parameter	Result
Optimal threshold	Max limb temperature 31.2 °C
Mean thermal gap	2.0 °C (33.2 vs 31.2 °C)
Thermal imaging	Se 93.5 % · Sp 38.4 % · NPV 87.8 %
ALT-70 alone	Se 98.8 % · Sp 22.0 %
Both combined	Se 91.7 % · Sp 53.9 %

• Novedades en técnicas diagnósticas

Dr. Romain Salle



- **Proof of concept on CT:** automated detection (YOLOv10) of 4 CT signs, 9001 images from 31 operated patients: **recall 74 %**
- Per sign recall: **fascial edema 92 %**; ectopic soft-tissue gas 76 %; fluid collection 68 %; absence of enhancement 66 %

• **Limitations: small single-centre retrospective CT series; no prospective validation**

=> Surgical exploration remains the gold standard

UPDATES

Fungal skin infections

🕒 Thursday, 01 October • 08:30 - 10:00 CEST

📍 Hall M

MENSAJES CLAVE

- Alta prevalencia (20-25%)
- Mayor en población con comorbilidades
- CONFIRMAR DIAGNÓSTICO ANTES DE TRATAR
 - Técnicas moleculares (PCR)
- Alta prevalencia hongos filamentosos no dermatofitos: 20%
- Tratamiento
 - Combinar métodos físicos (avulsión química, mecánica, TFD...) con antifúngicos

• Onicomycosis *Dr. Andrzej Jaworek*

TRATAMIENTO SISTÉMICO

- Aprobados: **terbinafina**, itraconazol, fluconazol
- Nuevas opciones: voriconazol, posaconazol, nuevos azoles

PREVENCIÓN RECAIDAS

- Control de fómites
- Tratamiento mantenimiento largo plazo

UPDATES

Fungal skin infections

Thursday, 01 October • 08:30 - 10:00 CEST

Hall M

Update en micosis superficiales y profundas Dr. Daciana Elena Branisteanu

TRICHOPHYTON INDOTINEAE

Received: 8 January 2026 | Accepted: 27 August 2026
DOI: 10.1111/jdv.70731

EA J EADV

CONSENSUS STATEMENT

**Consensus recommendations for *Trichophyton indotineae*:
A modified Delphi study**

Aditya K. Gupta^{1,2,3} | Mesbah Talukder^{3,4} | Ditte Marie L. Saunte^{5,6,7,8} |
Roderick James Hay^{8,9} | Michael Arabatzis^{8,10} | Avrom S. Caplan¹¹ | Eran Galili^{12,13} |
Eckart Haneke¹⁴ | Matilde Iorizzo¹⁵ | Riad Kassem^{12,13} | Ananta Khurana¹⁶ |
Shari R. Lipner¹⁷ | Anna Lyakhovitsky^{12,13} | Brian W. Morrison¹⁸ | Vincent Piguet^{1,2} |
Bianca Maria Piraccini¹⁹ | Carmen Rodríguez-Cerdeira^{20,21,22} | Avner Shemer^{12,13} |
Michela Starace^{23,24} | Olav Sundnes^{7,25,26} | Antonella Tosti¹⁸

Delphi Consensus on *Trichophyton indotineae* infections: Diagnosis & Management

Diagnosis

When to suspect: Terbinafine-resistant, recurrent dermatophytosis, history of travel to / residence in South Asia, widespread & extensive tinea, widespread lesions with several round/elliptic, well-circumscribed convex borders.

Laboratory identification of dermatophytes: KOH direct microscopy, fungal culture, PCR

Specific confirmation of *T. indotineae*: PCR with species-level discrimination, Internal transcribed spacer (ITS) sequencing

Antifungal susceptibility testing (AFST): Molecular testing (Squalene epoxidase sequencing)

Superficial fungal infections

Terbinafine resistance/ treatment failure (1st line)
Itraconazole continuous therapy: 100–200 mg/day x 6–8 weeks, or longer

Maintenance therapy
No consensus

Relapse
Itraconazole continuous therapy: 400 mg/day x 6–8 weeks, or longer
[Consensus threshold not reached (68.4%); threshold ≥ 70%]

Itraconazole failure
Posaconazole 300 mg/day x 4–12 weeks

Topical therapy

- T. indotineae* infections are best managed with oral antifungals plus topical adjunctive therapy.
- Luliconazole 1% cream [reached consensus threshold ≥ 70%].
- Other options: ciclopirox 1% cream/lotion/gel (63.2%), clotrimazole 1% cream (57.9%), ketoconazole 2% cream (57.9%), ketoconazole 2% shampoo (42.1%) [These options did not reach consensus threshold ≥ 70%].

Toenail onychomycosis

Partial terbinafine resistance (1st line)
Itraconazole 200 mg/day for 12–16 weeks

Complete terbinafine resistance/ treatment failure (1st line)
Itraconazole 400 mg/day for 12–16 weeks, or longer

Maintenance therapy
No consensus

Relapse
Itraconazole continuous therapy: 400 mg/day x 6–8 weeks, or longer
[Consensus threshold not reached (68.4%); threshold ≥ 70%]

Itraconazole failure
Posaconazole 300 mg/day x 4–12 weeks

Monitoring

Itraconazole TDM requirement
Hepatic impairment (consensus 70.0%), critically ill patients (50.0%)

Posaconazole TDM requirement
Hepatic impairment (68.4%), renal impairment (52.6%), critically ill patients (68.4%)

Special *

Pediatric patients
Itraconazole 5 mg/kg once daily for 2–4 months

Pregnancy
Clotrimazole 1% cream

Hepatic impairment
Dose reduction, LFT, Specialist involvement

Renal impairment
Dose reduction, RFT, Specialist involvement

Hygiene

Household members
Asymptomatic but are at higher risk of contact due to comorbidities (e.g., partners, diabetes)

- Screening and monitoring for early signs of infection
- Educate on hygiene measures and limit close contact with infected individuals
- Encourage laundering of clothing, bedding, socks and shoes at high temperatures

UPDATES

Parasitic infestations and emerging viruses

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📍 Hall M

- Leishmania cutánea
- Dr. Soner Uzun

EA CONGRESS 2026

JUST PUBLISHED

55 J EADV

DOI: 10.1111/ced.7071

SYSTEMATIC REVIEW

Systemic treatment of cutaneous leishmaniasis: A systematic review and meta-analysis

Maximilian Egg¹ | Dennis Wienand² | Lucie Harpain¹ | Marie-Luise Brunner-Kovarik¹ | Julia Walochnik³ | Markus Wiesmueller¹ | Amélie Hampel¹ | Tibor Spath¹ | Lukas Trnka¹ | Judit Simon^{2,4} | Alessandra Handisurya¹

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³Institute of Specific Prophylaxis and Tropical Medicine, Center for Pathophysiology, Infectiology and Immunology, Vienna, Austria

⁴Department of Psychiatry, University of Oxford, Warneford Hospital, Oxford, UK

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Abstract Cutaneous leishmaniasis (CL) is increasingly reported in previously non-endemic European countries. Although often self-limiting or amenable to topical therapy, systemic treatment is indicated in specific situations. Evidence guiding systemic therapies remains limited and heterogeneous. **Objectives:** This systematic review and meta-analysis aimed to synthesize available evidence on systemic treatment regimens for CL. **Methods:** MEDLINE/PubMed and Embase were searched for clinically and/or parasitologically confirmed CL receiving systemic monotherapy with meglumine antimoniate (MA), miltefosine, azoles, pentamidine, or liposomal amphotericin B (L-AmB) until February 2026. Primary outcome was clinical cure assessed 2–7.5 months after treatment initiation. Pooled cure rates were estimated using random-effects meta-analysis. Subgroup analyses were performed for Old World (OWCL) and New World (NWCL) CL and by *Leishmania* species. **Results:** Eighty-three studies comprising 96 treatment arms and 4603 patients with OWCL and NWCL were included. Overall, study quality was moderate (per JBI checklist). MA, long regarded as standard of care in many countries, had a pooled cure rate of 59% (95% CI 52%–66%). Higher rates were observed with L-AmB (77%; 95% CI 56%–90%), followed by miltefosine (75%; 95% CI 69%–81%), itraconazole (70%; 95% CI 65%–76%), and fluconazole (62%; 95% CI 16%–93%). Lower rates were obtained with pentamidine (55%; 95% CI 42%–67%) and ketoconazole (36%; 95% CI 7%–82%). Species- and region-specific sub-analyses indicated miltefosine highly effective for OWCL (particularly *L. major*) and NWCL (*L. braziliensis*, *L. guyanensis*, *L. panamensis*). Head-to-head comparisons of miltefosine and MA showed no statistically significant difference. L-AmB was similarly effective in NWCL (particularly *L. braziliensis*), with lack of evidence for other species. **Conclusions:** Systemic treatment options for CL show variable efficacy. Despite the promising cure rates for miltefosine and L-AmB, comparative evidence remains insufficient to support therapy recommendations. Confirmation in adequately powered, high-quality RCTs, ideally stratified by species, is warranted to strengthen the evidence base.

Last-minute evidence update:
«systemic treatment of CL»

What does this meta-analysis add?

83 studies • 96 treatment arms • 4,603 patients

Pooled cure rates were variable

L-AmB	77%
Miltefosine	75%
Meglumine antimoniate	59%
Pentamidine	55%

Main message: systemic treatment response differs by region and species; comparative evidence is still insufficient for firm recommendations

UPDATES

Parasitic infestations and emerging viruses

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📍 [Hall M](#)

- Mpox *Dr. Alba Catalá*

MENSAJES CLAVE

- Mucositis (proctitis) principal complicación
 - Analgesia intensa + pauta corta corticoides
- Tecovirimat retirado de la UE por no evidencia clara en ensayos clínicos
 - Buenos resultados personales en pacientes inmunosuprimidos, gestantes y lesiones oculares
- Estudio multicéntrico retrospectivo español comparando clado Ib vs Ii
 - 48 casos
 - Mayor tasa hospitalización y uso tecovirimat (10% vs 0%)

UPDATES

STIs

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📍 [Hall N](#)

Trichophyton mentagrophytes VII

- HSH
- Alta afectación folicular
- Area facial, genital, glútea, inguinal
- Tratamiento: terbinafina oral 8-12 semanas

- ITS emergentes *Dr. Alba Catalá*



UPDATES

STIs

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📍 [Hall N](#)

Dermatophilus congolensis

- Transmisión contacto (deporte, sauna)
- Area facial, tronco, genital, glútea
- Tres fases
 - Papulovesicular → Pustulonodular → Descamativa
- Tratamiento
 - Autorresolutiva
 - Tópicos: fusídico
 - Oral: amoxicilina, cefadroxilo, doxiciclina

- ITS emergentes *Dr. Alba Catalá*



UPDATES

STIs

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📍 [Hall N](#)

Klebsiella aerogenes clon ST117

- Alta transmisión por sauna o jacuzzi
- Folliculitis limitada al área facial resistente a varios antibióticos
- Dx: notificar sospecha al laboratorio
- Tratamiento: isotretinoína

• ITS emergentes *Dr. Alba Catalá*

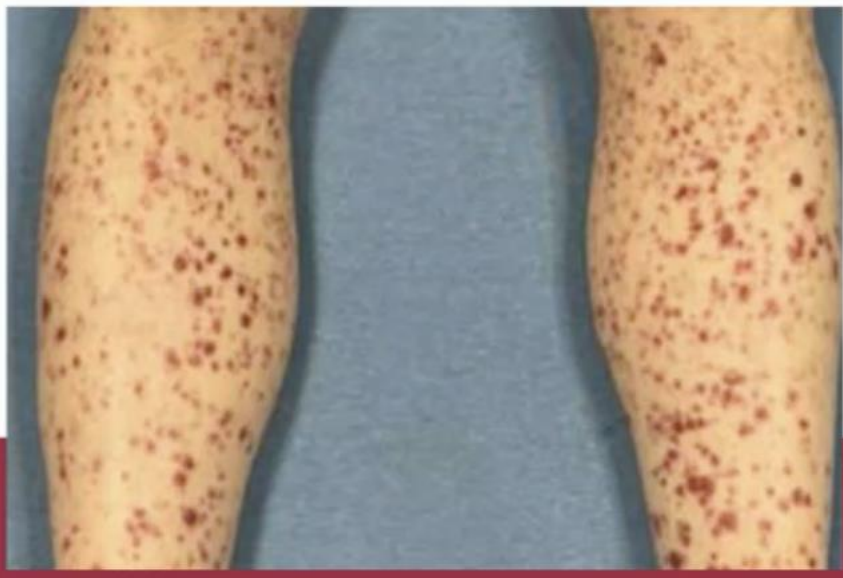


UPDATES

STIs

🕒 Wednesday, 30 September • 16:00 - 17:30 CEST

📍 Hall N



**PENSAR EN ITS
como causa de
vasculitis
(sífilis,
gonococo)**

UPDATES

STIs

🕒 Wednesday, 30 September • 16:00 - 17:30 CEST

📍 Hall N

NO TODA ÚLCERA GENITAL ES SÍFILIS o VHS

DIAGNÓSTICO DIFERENCIAL

- LGV
- Patógenos infrecuentes: chancroide, donovanosis
- Nuevos patógenos: Mpox, Strp. Pyogenes, MRSA
- Dermatitis inflamatorias: EFM, liquen plano genital, úlcera vulvar aguda

UPDATES

STIs

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- Update en VPH *Dr. Suzana Ljubojevic Hadzavdic*

MENSAJES CLAVE

- Beta-VPH pueden contribuir a desarrollar carcinomas cutáneos
- Emplear dermatoscopia +/- TCA para objetivar lesiones pequeñas
- Imiquimod puede ser una opción en lesiones premalignas (HSIL) para evitar cirugía
- No clara evidencia de utilidad de vacunación tras HSIL (VIVA trial 2026), no clara utilidad en el tratamiento de lesiones recalcitrantes
 - Útil en casos seleccionados
 - Reducción de reinfecciones

UPDATES

Bacterial skin infections

🕒 Wednesday, 30 September • 14:15 - 15:45 CEST

📍 [Hall M](#)

- Novedades en antibioterapia sistémica
Dr. Mario Fabri

NUEVOS ANTIBIÓTICOS en ITS

- GONORREA
 - Gepotidacina: altas tasas curación en uretra (92,6%), menor en faringe (78%)
 - Zodifloxacino: altas tasas curación en uretra (90%), no estudio en reservorio extracutáneo
- SÍFILIS
 - Linezolid: clara inferioridad frente a estándar actual

CONCLUSIONES FINALES

- La patología infecciosa y las ITS forman parte de nuestra práctica diaria como dermatólogos
 - Incluirlas siempre en el diagnóstico diferencial
- Buscar siempre el diagnóstico microbiológico, evitando tratamientos empíricos que puedan favorecer resistencias
- Necesidad real de nuevos antimicrobianos
 - Cuidar que la prescripción sea adecuada en indicación, dosis y duración

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HIGHLIGHTS

Viena

30sep - 3oct
2026

La Academia Española de Dermatología y Venereología expresa su agradecimiento al patrocinador UCB, por su especial apoyo y contribución con la actividad formativa Highlights 2026.

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GRACIAS