

Abstract Book 2024

34th Congress of the European Society of Clinical Microbiology and Infectious Diseases

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: ESCMID

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Table of Contents

4	Welcome Address		ď	
6	ESCMID Global Programme Commitee		ď	
7	Abstract Reviewers		ď	
13	Abstract Categories		ď	
15	Abstracts		ď	
	15	1. Viral infection & disease (incl COVID-19)	ď	
	647	2. Bacterial infection & disease	ď	
	1365	3. Bacterial susceptibility & resistance	ď	
	2085	4. Diagnostic microbiology	ď	
	2442	5. New antibacterial agents, PK/PD & Stewardship	ď	
	3017	6. Fungal infection & disease	ď	
	3298	7. Parasitic diseases & global health	ď	
	3470	8. Healthcare-associated infections, infection prevention & control	ď	
	3844	9. Experimental microbiology, microbial pathogenesis & biofilms	ď	
	4080 10. Immunology, immune compromise & vaccinology		ď	
	4291	<u>11. Other</u>	ď	
	4390	12. Case reports and case series (n<10)	ď	
	4733	13. Late breakers	ď	
837	837 ESCMID Global 2024 Abstract Authors			

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ESCMID Global 2024 Abstract Programme -

Note from the Directors

The ESCMID Global 2024 congress (34th ECCMID) was held from April 27-30 in Barcelona, Spain. This year, the congress attracted a remarkable number of registrants, over 18,000 professionals from across the globe, a testament to its growing influence and importance.

Central to the success of ESCMID Global 2024 was its Abstract Programme and the outstanding response to the call for abstracts, which underscored the event's role as a premier platform for sharing cutting-edge research and innovations.

ESCMID Global 2024 received 7,887 abstract submissions, a new record compared to the 6,368 abstracts in 2023 and 4,800 abstracts in 2022. Additionally, 7% (587 of the submissions) were late-breaker abstracts, representing a 50% increase compared to 2023. This increase in submissions clearly indicates the importance of ESCMID Global as a leading stage for disseminating knowledge in infectious diseases and clinical microbiology.

The abstracts were submitted from 127 different countries. In addition to established contributions from European countries such as Spain, Italy, France, Germany, and the Netherlands, we received a significant contribution to submissions from non-European countries like the United States, India, and China, among the Top 10 presenting countries. Notably, 15% of all abstracts were received from low- and middle-income countries.

With 89% regular and 11% case abstracts, the abstracts submitted covered a wide array of topics. The number of submissions increased across all categories compared to last year. Particularly notable were the substantial increases in submissions related to healthcare-associated infections and infection prevention and control (+40%), bacterial infections and diseases (+30%), and bacterial susceptibility and resistance (+15%). Furthermore, there was a 30% increase in submissions of case reports and case-series, with the best contributions selected for the clinical case sessions and the Clinical Grand Round.

The overall acceptance rate was 66%. Out of the total submissions, 937 abstracts (18%) were selected for oral presentation, and 4,267 abstracts were selected as paper posters.

The breadth and quality of the research presented are the cornerstones of the congress' scientific exchange and educational merit. As we look forward, the insights and discoveries shared at this year's congress will undoubtedly inspire further advancements and contribute to improved patient care and public health worldwide.

We extend our sincere gratitude to all abstract submitters, whose contributions have greatly enhanced the congress value, to over a thousand dedicated abstract reviewers for their unwavering effort and commitment, and to our Programme Committee members, who supported us in creating such a rich and diverse programme. Their hard work ensures that ESCMID Global remains a beacon of excellence in the scientific community.

We are very proud to be able to share all accepted abstracts of ESCMID Global 2024.

Giulia De Angelis ESCMID Global Associate Director



Jacob Moran-GiladESCMID Global
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About ESCMID Global Abstract Book

We are pleased to present the abstract book for ESCMID Global 2024, held in Barcelona, Spain, 27-30 April 2024. This book is a collection of 4890 abstracts presented during the congress, whether delivered as oral presentations or uploaded to the ESCMID ePoster repository per Congress guidelines. Abstracts are organised into 12 cat-egories, representing the main research topics covered by the congress. Poster abstracts are fur-ther organised by subcategories, providing a more granular subdivision of all topics.

Each abstract underwent a peer-review process, and evaluated by at least three reviewers belonging to our esteemed panel of over 1000 expert reviewers. The average number of reviews per ab-stract was ~5. This year, the cut-off score for acceptance and inclusion in congress materials was 3.53 out of a maximum score of 6 points. Our esteemed panel of over 1000 reviewers consisted of ESCMID Global faculty who participated in the congress as a speaker or chair in the last five years and who, with expertise and diligence, have ensured the high quality of the selected abstracts.

The abstracts included in this book remain unedited, with no alterations made to the text or figures, ensuring that the original contributions of the authors are preserved. Authors provided their consent to publish their abstracts during submission. The responsibility for the content presented, its quality and originality and abstract authorship is with abstract submitters. ESCMID does not assume responsibility for abstract content. For more information please refer to the ESCMID Global Abstract Guidelines.

We extend our deepest gratitude to the contributors and reviewers for their invaluable efforts, which have not only enriched this abstract book but have also been the cornerstone of this congress' success. Your dedication and expertise have ensured that high quality research is presented at ESCMID Global. We hope this abstract book serves as a valuable resource and reference, and a testament to your outstanding contributions.

Sincerely, ESCMID Office



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Fuehrer, Hans-Peter, Austria G da Silva, Ronni A, Singapore Gaia, Valeria, Switzerland Galan Ladero, Maria Angeles, Spain Galani, Irene, Greece Gales, Ana, Brazil Garau, Javier, Spain Garcia, Pilar, Spain Garcia Vidal, Carolina, Spain García-Cobos, Silvia, Spain García-Contreras, Rodolfo, Mexico Gaskell, Katherine, United Kingdom Gatermann, Sören G., Germany Geerlings, Suzanne, Netherlands Georghiou, Sophia, Switzerland Gerding, Dale N., United States Ghanem-Zoubi, Nesrin, Israel Ghoshal, Ujjala, India Giacobbe, Daniele Roberto, Italy Giamarellos-Bourboulis, Evangelos, Greece Giamarellou, Helen, Greece Giani, Tommaso, Italy Giannella, Maddalena, Italy Giannitsioti, Efthymia, Greece Giske, Christian, Sweden Gits-Muselli, Maud, France Gkrania-Klotsas, Erossyni, United Kingdom Glasner, Corinna, Netherlands Glocker, Erik, Germany Gniadkowski, Marek, Poland Gobbi, Federico Giovanni, Italy Goering, Richard V., United States Goldenberg, Simon, United Kingdom Gomez Junyent, Joan, Spain Gomperts-Boneca, Ivo, France González Gutiérrez, Jessica, Spain Gonzalez-Candelas, Fernando, Spain Goodman, Anna, United Kingdom Gopalakrishnan, Ramachandran, India Goto, Michihiko, United States Gottlieb, Thomas, Australia Gow, Neil A. R., United Kingdom Goyal, Sagar, United States Green, Stefan, United States Grobusch, Martin P., Netherlands Groll, Andreas H., Germany Grossi, Paolo Antonio, Italy Grosso, Filipa, Portugal Gruell, Henning, Germany Grüner, Beate, Germany Grupel, Daniel, Israel Gudiol, Carlota, Spain Guery, Benoit, Switzerland Guglielmetti, Lorenzo, France Guinea, Jesus, Spain Gür, Deniz, Turkey Gutierrez Pimentel, Maria Eugenia, Panama Gutierrez-Gutierrez, Belen, Spain Gyssens, Inge C., Netherlands Haeusler, Gabrielle, Australia Haeussler, Susanne, Germany



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Abstract Categories and Subcategories

1. Viral infection & disease (incl COVID-19)

- 1a. HIV/AIDS (incl diagnostics & epidemiology, anti-retroviral drugs, vaccines, treatment & susceptibility/resistance)
- 1b. Viral hepatitis (incl diagnostics & epidemiology, antiviral drugs, vaccines, treatment & susceptibility/resistance)
- 1c. Influenza and respiratory viruses (incl diagnostics & epidemiology, antiviral drugs, vaccines, treatment & susceptibility/resistance)
- 1d. Herpesviruses (incl diagnostics & epidemiology, antiviral drugs, treatment & susceptibility/resistance, excl clinical studies in immunocompromised hosts)
- 1e. Emerging/re-emerging, vector-borne and zoonotic viral diseases (other than COVID)
- 1f. Diagnostic virology (other than respiratory viruses, herpesviruses, hepatitis & HIV)
- 1g. Viral epidemiology general, prevalence studies, molecular and genomic epidemiology (other than respiratory viruses, herpesviruses, hepatitis & HIV)
- 1h. Antiviral drugs, treatment, susceptibility/resistance (other than respiratory viruses, herpesviruses, hepatitis & HIV)
- 1i. Basic and applied virology (incl in vitro and in vivo models, novel methods)
- 1j. COVID-19 (incl virology, epidemiology, evolution, immune response, diagnosis, treatment, vaccination, prevention, response and societal impact)

2. Bacterial infection & disease

- 2a. Tuberculosis and other mycobacterial infections (incl epidemiology, clinical, diagnostics, antimycobacterial drugs, susceptibility testing, treatment & prevention)
- 2b. Severe sepsis, bacteraemia & endocarditis (incl epidemiology, diagnosis, host bio-markers, treatment and outcome prediction)
- · 2c. Community-acquired respiratory infections (incl epidemiology, clinical features, imaging, treatment & prevention)
- 2d. Community-acquired abdominal/gastrointestinal, urinary tract & genital infections (incl epidemiology, clinical, imaging, treatment & prevention)
- 2e. Community acquired skin, soft tissue, bone & joint infections (incl epidemiology, clinical, imaging, treatment & prevention, excl prostheses)
- 2f. Community acquired nervous system and other multi-system bacterial infections (incl epidemiology, clinical, imaging, treatment & prevention)
- 2g. Zoonotic bacterial infections (incl foodborne, waterborne and vector-borne pathogens, veterinary microbiology and One Health aspects, excl AMR)
- 2h. Other intracellular or rare bacteria

3. Bacterial susceptibility & resistance

- 3a. Resistance surveillance & epidemiology: MRSA, VRE & other Gram-positives
- 3b. Resistance surveillance & epidemiology: Gram-negatives
- · 3c. Susceptibility testing methods (incl assay validation, phenotypic assays and comparative studies, excl TB)
- 3d. Resistance mechanisms (incl in vitro and in vivo studies, mobile elements, excl TB)
- 3e. Resistance detection/prediction approaches (rapid and/or molecular assays, resistome analysis, inference methods)
- 3f. Clinical outcome of resistant infections (retrospective and prospective studies, excl clinical trials of new drugs)
- 3g. Spread of resistance (incl carriage, reservoirs, ecology, models, excl nosocomial transmission)
- 3h. Policy aspects of AMR (incl societal impact, economics, mitigation)

4. Diagnostic microbiology

- 4a. Diagnostic bacteriology (incl culture based, traditional and general microbiology, serology, excl AST methods)
- 4b. Laboratory management (incl automation, data management, QC/QA, regulatory aspects)
- 4c. MALDI-TOF and other proteomic methods
- 4d. Molecular diagnostics (incl POCT and syndromic testing)
- 4e. Strain typing and surveillance (incl molecular, genomic and other advanced methods)
- 4f. Whole genome sequencing (incl pathogen characterisation, diagnostics, excl typing)
- 4g. Microbiome studies (incl clinical and diagnostic studies, One Health aspects)
- 4h. Clinical metagenomics
- 4i. Bioinformatics tools & pipelines
- · 4j. Other novel diagnostic technologies

5. New antibacterial agents, PK/PD & Stewardship

- 5a. Mechanisms of action & spectrum, new compounds, preclinical data & basic pharmacology (incl drug design, investigational and non-traditional therapeutics)
- 5b. Pharmacokinetics/pharmacodynamics of antibacterial drugs & therapeutic drug monitoring (incl lab methods, models, in vitro and in vivo studies)
- 5c. New or repurposed antibacterial agents: clinical studies and randomised trials
- 5d. Antimicrobial stewardship and prescribing (incl interventions, monitoring, impact, decision-support/prediction tools, behavioural aspects)
- 5e. Safety, hypersensitivity and adverse effects of treatment
- 5f. Pharmacoepidemiology / pharmacoeconomics (incl cost-effectiveness, modelling, data tools)



Abstract Categories and Subcategories

6. Fungal infection & disease

- 6a. Fungal disease epidemiology
- 6b. Diagnostic mycology (incl traditional, molecular and other methods)
- 6c. Antifungal susceptibility testing & resistance (incl surveillance, mechanisms)
- 6d. Antifungal drugs & treatment (incl pre-clinical studies and clinical trials)
- 6e. Basic mycology (incl in vitro and in vivo studies, pathogenesis, virulence, mycobiome)

7. Parasitic diseases & global health

- 7a. Parasitic disease epidemiology
- 7b. Diagnostic parasitology (incl traditional, molecular and other methods)
- 7c. Antiparasitic susceptibility & drug resistance (incl surveillance, mechasnism)
- 7d. Antiparasitic drugs & treatment (incl pre-clinical studies and clinical trials)
- · 7e. Travel medicine, migrant and refugee health
- 7f. Food & water safety, environmental health, vector epidemiology
- · 7g. Global and public health & health security (incl policy-making, climate change, biosafety/biosecurity)
- 7h. Infections in low-resource settings (incl epidemiology, burden, health infrastructure, health disparities and vulnerable populations)

8. Healthcare-associated infections, infection prevention & control

- 8a. Intravascular catheter-related infections (incl epidemiology, prevention)
- 8b. Other foreign-body and implant-associated infections (incl PJI)
- · 8c. Surgical site infections
- 8d. Healthcare-associated pneumonia (incl VAP)
- · 8e. Hospital epidemiology, transmission, surveillance & screening (incl hospital environment)
- 8f. Other healthcare associated infections (incl CDI, hospital outbreaks)
- 8g. Infection control interventions and trials (incl microbiota transplantation)
- 8h. Disinfection & biocides
- 8i. Healthcare workers and infection prevention (incl vaccination, protective equipment, behavioural aspects, training and practices)

9. Experimental microbiology, microbial pathogenesis & biofilms

- 9a. Microbial pathogenesis & virulence
- 9b. Host-pathogen interaction (incl basic microbiome studies, animal models)
- 9c. Pre-clinical biofilm studies
- 9d. Experimental and cellular microbiology
- 9e. Basic science studies using Omics (in vitro and in vivo)

10. Immunology, immune compromise & vaccinology

- 10a. Host genetics: susceptibility to infection & primary immunodeficiency
- 10b. Infections in immunocompromised hosts (incl epidemiology, clinical features, diagnosis, treatment, excl fungal infections)
- 10c. General vaccinology (incl in vitro and in vivo studies, policy, social aspects)
- 10d. Antiviral vaccines (excl influenza, respiratory and bloodborne viruses and COVID-19)
- 10e. Antibacterial vaccines
- 10f. Other preventive modalities (incl new vaccine technologies, antibody-based treatments)
- 10g. Immune response to infection (incl in vitro, animal and human studies, laboratory assessment of immunity and response, excl sepsis biomarkers)

11. Other

- 11a. Professional affairs and career development
- 11b. Publishing, ethics, other academic affairs
- 11c. Medical education for CM/ID
- 11d. Digital health and infection (incl AI, data mining, informatics)
- 11e. Diversity and equality
- 11f. Advocacy and role of patients

12. Case reports and case series (n<10)

- 12a. Viral infections
- 12b. Bacterial infections
- 12c. Fungal infections
- 12d. Parasitic infections
- 12e. Other unusual clinical situations

13. Late Breakers



Important Addresses

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Urine brilliance: urine TB LAM's role in challenging AIDS cases from LMIC's perspective

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Background

The identification of reliable markers for active tuberculosis (TB) diagnosis is pivotal, especially in challenging scenarios, particularly in low- and middle-income countries (LMICs), where co-infections, notably among individuals with AIDS, pose significant diagnostic challenges. Lipoarabinomannan (LAM), an immunogenic virulence factor released from metabolically active or degrading mycobacteria, presents a promising avenue for overcoming these hurdles. In this study, we present a case series that underscores the intricacies of TB diagnosis, specifically focusing on individuals co-infected with AIDS in LMICs.

Case(s) description

Our primary objective is to elucidate the diagnostic potential of urine LAM, strategically addressing challenges posed by atypical presentations and co-existing infections, particularly in the context of AIDS within LMICs. Several cases demonstrate the probability of TB, indicated through clinical presentation, where urine TB lipoarabinomannan (LAM) testing yielded positive results. One notable case involves prolonged undetected genitourinary tuberculosis spanning multiple years, emphasizing the difficulty of early diagnosis. Another case pertains to an AIDS patient initially suspected of CNS lymphoma, with a negative TB workup; however, the subsequent discovery of progressive TB occurred towards the end of the patient's life, aligning with the availability of TB LAM testing at our centre. Additionally, an AIDS patient diagnosed with cryptococcal meningitis tested positive for TB LAM, revealing the diagnostic challenges of concurrent infections. A comprehensive CT thorax-abdomen-pelvis revealed multiple lymphadenopathies, responding favourably to antituberculosis treatment. The last case involves an elderly lady with talaromy-cosis co-infected with TB, substantiated by ancillary investigations.

Discussion

Recognizing the imperative to avoid missing TB diagnoses in this vulnerable population, particularly in LMICs, we underscore the significance of urine TB LAM testing. Positive outcomes from LAM testing emphasize its potential for detecting TB amidst the backdrop of concurrent opportunistic infections in AIDS individuals within LMICs. The exploration of innovative methods, such as urine LAM testing, emerges as a crucial strategy to mitigate the risk of overlooking TB in this complex clinical context, ultimately enhancing health outcomes for individuals living with HIV in resource-limited settings.

References

Huerga H, et al. (2019) Diagnostic value of the urine lipoarabinomannanassay in HIV-positive, ambulatory patients with CD4 below 200 cells/µl in 2 low-resource settings: A prospective observational study. PLoS Med 16(4): e1002792.

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A unique case of Listeria monocytogenes superinfection of tuberculous lymphadenitis

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Background

Lymphadenitis due to Listeria monocytogenes (LM) is rarely described. We present a case of lymphadenitis due to LM and Mycobacterium tuberculosis (MTB), which, to our knowledge, has never been described.

Case(s) description

A 59-year-old woman from Mexico, with a history of recurrent otitis, presented to the Emergency Department with a 2-week history of erythematous and painful swelling in the right retromandibular site (Figure 1). Admission blood samples showed mild neutrophilia, raised C-reactive protein (74 mg/l, normal value <5 mg/l) and hyperglycemia (402 mg/dL). Ultrasound of the right neck showed multiple hypoechoic, enlarged lymph nodes from which a subcutaneous large hypoechoic collection originated, via a fistula (Figure 2). The infectious disease specialist performed an ultrasound-guided needle aspiration of the collection (Figure 3) and the drained material tested positive at the nucleic acid amplification test for MTB (acid-fast bacilli smear microscopy was negative and, later, culture became positive). Three induced sputum and bronchoalveolar lavage fluid had negative nucleic acid amplification test, smear, and culture. The HIV test was negative. A standard quadruple antitubercular treatment, including rifampicin, isoniazid, ethambutol, and pyrazinamide, was started. LM also grew in the culture of the drained material. Therefore trimethoprim/sulfamethoxazole was added for 10 days with improvement of the local inflammation in the right retromandibular site.

Discussion

Tuberculous lymphadenitis is one of the most common extrapulmonary manifestations of tuberculosis. Bacterial superinfection of tuberculous lymphadenitis has been rarely reported. Overall, only 19 cases of LM-associated lymphadenitis have been reported. The most frequent predisposing condition of LM-associated lymphadenitis is diabetes mellitus, as in our patient in whom a new diagnosis of diabetes was made. Coinfection of MTB and LM infection has only been reported twice^{2,3}, but at sites other than lymph nodes. An ultrasound-guided needle aspiration performed promptly by an infectious disease specialist, with a careful selection of tests to be sent, may be relevant to correctly and quickly frame the aetiology of a lymphadenomegaly.

