Best of en Infectiologie 2025
Infections fongiques

SPILF 23 mars 2026

François Danion

MCU-PH Maladies Infectieuses

CHU de Strasbourg

Liens d’intérêts

- Gilead Sciences, Pfizer, Bristol Myers Squibb, Astrazeneca, Mundipharma

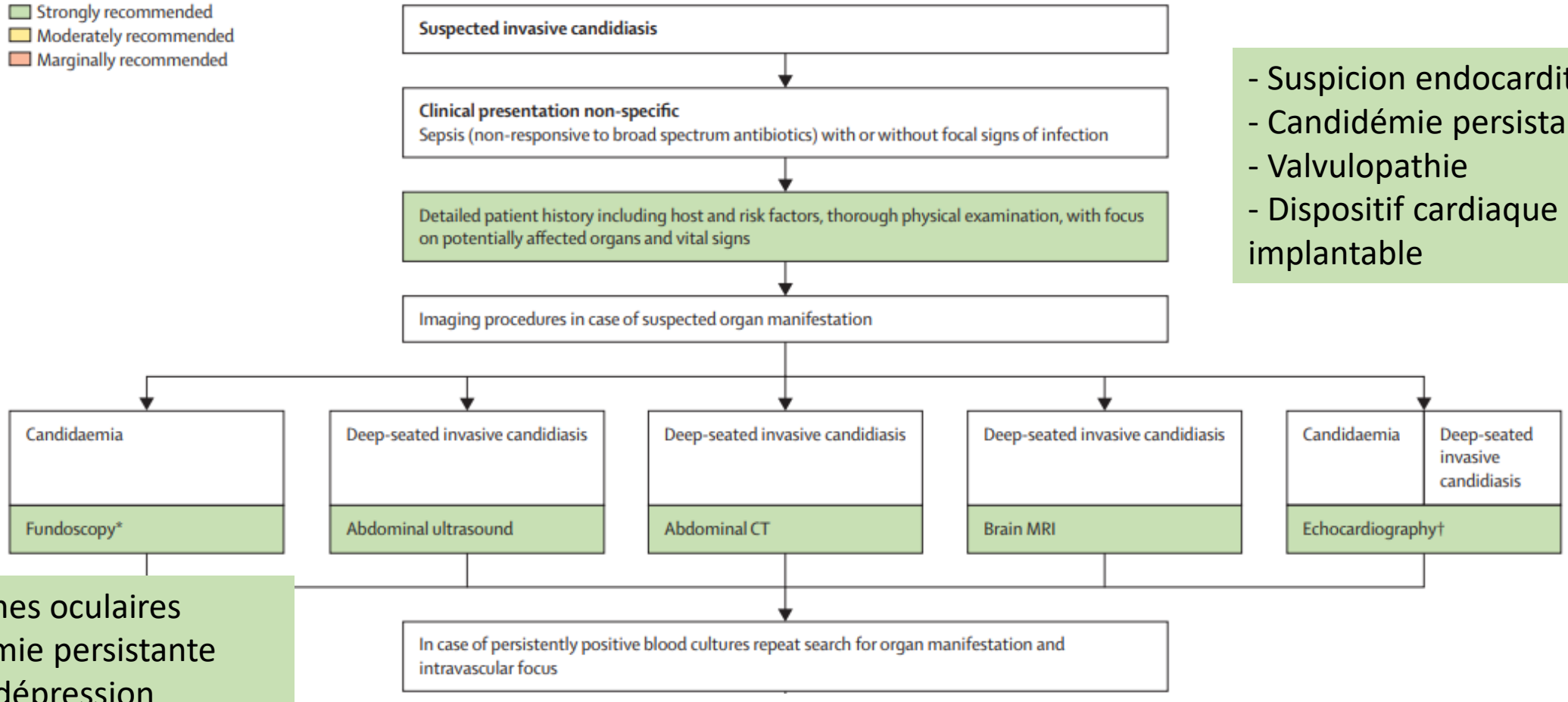
Plan

- Infections à levures
- Infections à filamenteux
- Pneumocystose
- Nouvelles molécules antifongiques

Infections à levures

Global guideline for the diagnosis and management of candidiasis: an initiative of the ECMM in cooperation with ISHAM and ASM

Oliver A Cornely, Rosanne Sprute, Matteo Bassetti, Sharon C-A Chen, Andreas H Groll, Oliver Kurzai, Cornelia Lass-Flörl, Luis Ostrosky-Zeichner, Riina Rautemaa-Richardson, Gunturu Revathi, Maria E Santolaya, P Lewis White, Ana Alastruey-Izquierdo, Maiken C Arendrup, John Baddley,



- Suspicion endocardite
- Candidémie persistante
- Valvulopathie
- Dispositif cardiaque implantable

- Symptômes oculaires
- Candidémie persistante
- Immunodépression
- Ceux qui ne peuvent verbaliser

Cornely O, Lancet ID 2025

Global guideline for the diagnosis and management of candidiasis: an initiative of the ECMM in cooperation with ISHAM and ASM

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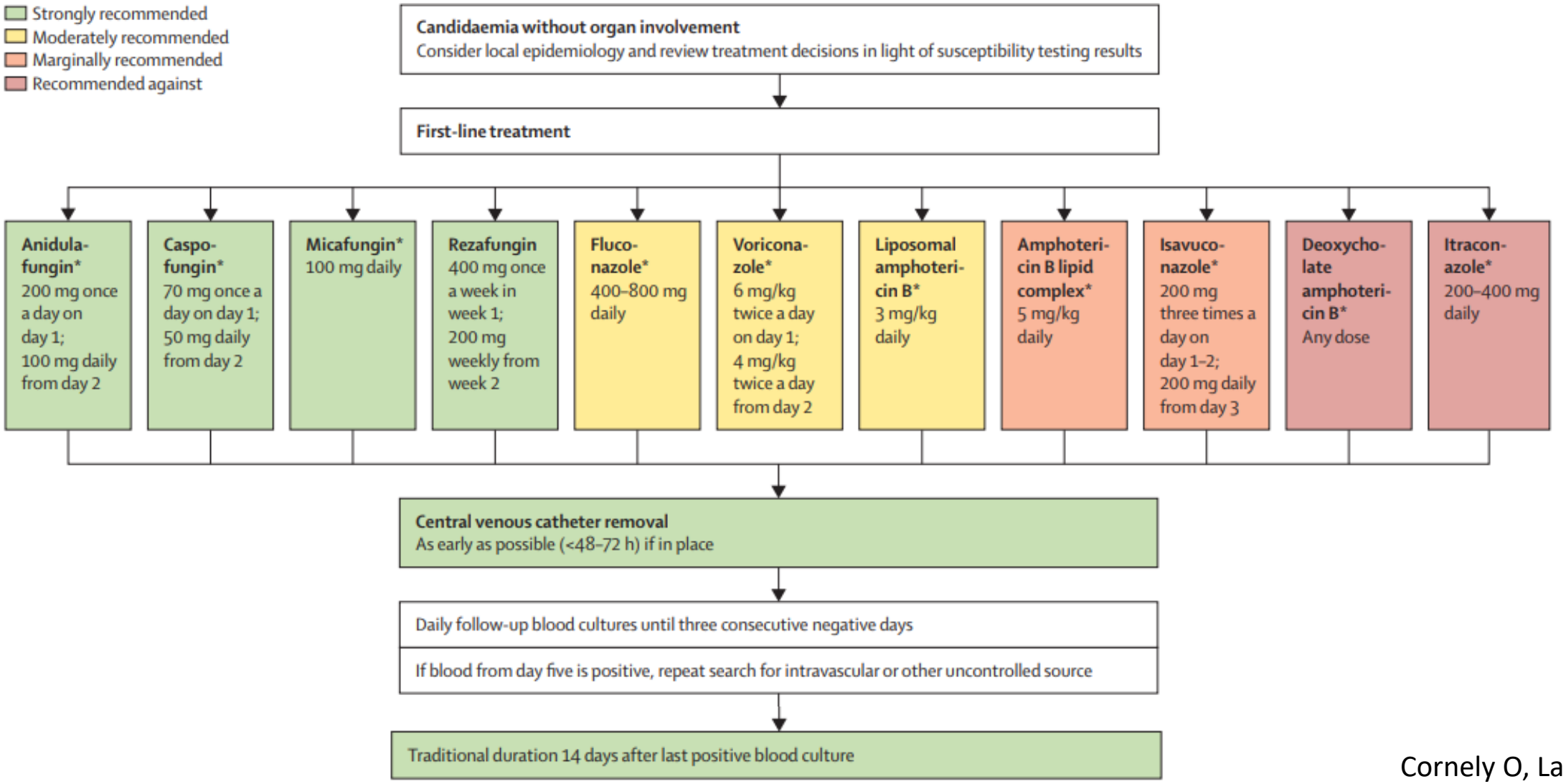
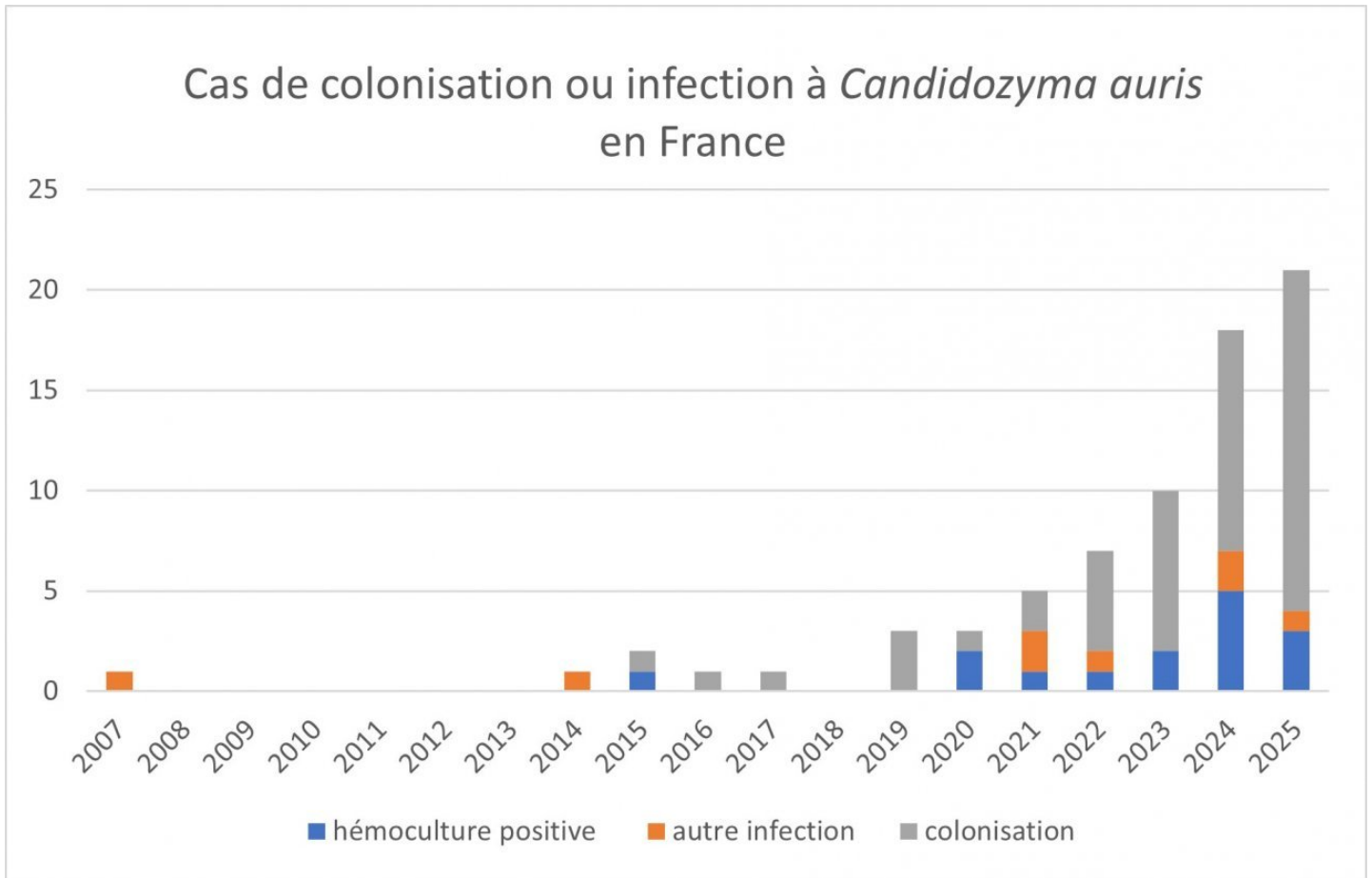


Cornely O, Lancet ID 2025

RAPPORT ANNUEL D'ACTIVITE 2025

Année d'exercice 2024

CNR Mycoses invasives et antifongiques



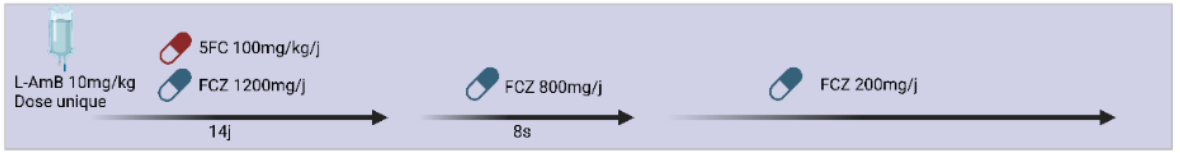
Données CNRMA, rapport 2025

JAMA Network Open

Original Investigation | Infectious Diseases

Single-Dose Liposomal Amphotericin Plus Fluconazole and Flucytosine for Cryptococcal Meningitis at a US Public Hospital

Devin Clark, MD; Javier Barranco-Trabi, MD; Irene Goo, MD, MPH; Maria Chyz, MD; Grace Manchala, MD; Kusha Davar, MD, MBA, MS; Sarah Freling, MD; Noah Wald-Dickler, MD; Rachel Baden, MD; Brad Spellberg, MD



Applicabilité du protocole Ambition chez les PvVIH dans les pays à fortes ressources ?

- Étude monocentrique, Los Angeles General Medical Center, 80% des patients couverts par Medicaid, 5% non assurés
- Pré-cohorte : 26 patients en 2020-2022 vs cohorte ambition : 34 patients en 2022-2024

- Critère de jugement : survie à 90 jours sans rechute ni EI sévère
  - 70% dans le groupe Ambition vs 35% dans le groupe contrôle (p=0,001)

  - EI : 21% dans le groupe Ambition vs 62% dans le groupe contrôle
  - Pas de différence en terme de mortalité

Généralisation du protocole Ambition pour la cryptococcose neuroméningée chez les PvVIH ?

Clark et al., JAMA open network, 2025

Clin Infect Dis. 2025 May 16:ciaf237. doi: 10.1093/cid/ciaf237. Online ahead of print.

Histoplasma antigenuria prevalence in patients with advanced HIV disease in Côte d'Ivoire: a prospective trial ancillary study

Aude Sturny-Leclère [1], Ugo Françoise [2 3 4], Anani D Badjé [5 6], Dea Garcia-Hermoso [1], Cyrielle Aka [7], Hervé Menan [7], Delphine Gabillard [8], Conrad K Muzoora [9], Maryline Bonnet [10], François-Xavier Blanc [11], Olivier Lortholary [1 12], Alexandre Alanio [1 13], Antoine A Adenis [2 3 4], Didier Laureillard [14], Fanny Lanternier [1 12]

Prévalence de l'histoplasmose en Afrique Sub Saharienne ?

- Etude STATIS : VIH CD4<100/mm^3 nouvellement diagnostiqué en Côte d'Ivoire : tous traités par ARV, randomisation traitement antiBK systématique vs si diagnostic

- Dépistage systématique par antigénurie histoplasma (EIA) :
  - 68/240 : 24% = prévalence de la tuberculose !
  - Présentation clinique variable

- 35,7% des patients décédés à S48 avaient un AgU + vs 22% chez les survivants
  - IMC, CD4, Hb et pla plus élevés chez les patients survivants
  - 30% de décès sans cause établie : parmi eux, 50% d'AgU positif

L'AgU est associé à une sur-mortalité chez les PvVIH mais son impact dépend probablement du degré d'immunodépression

Sturny-Lecère *et al.*, CID, 2025

Infections à filamenteux

Clinical Infectious Diseases
MAJOR ARTICLE

Empirical Antifungal Treatment of Critically Ill Patients With Influenza-Associated Acute Respiratory Distress Syndrome: A Propensity Score Weighted Observational Study

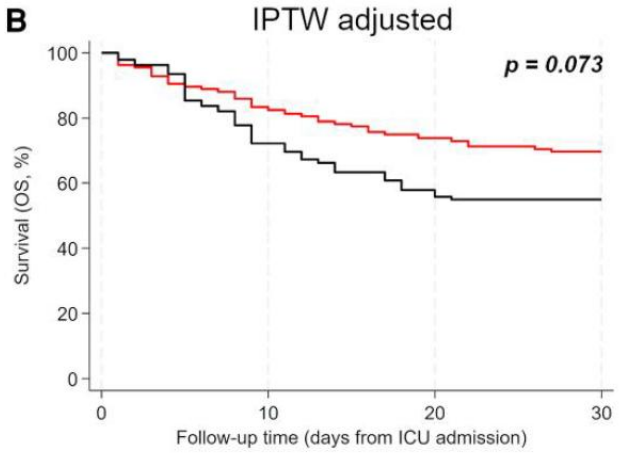
Stefan Hatzl,[1,2,3,4] Lisa Kriegl,[4,5] Christina Geiger,[5] Caroline Wilhelmer,[1] Alexander C. Reisinger,[1] Markus Keldorfer,[6] Julia Auinger,[1] Gernot Schilcher,[7] Florian Krammer,[2,3,8,9] Philipp Eller,[1] and Robert Krause[4,5]

Intérêt d'une prophylaxie anti-aspergillaire chez les patients présentant une grippe grave en USI ?

- Étude observationnelle multicentrique, 172 patients admis en USI pour un SDRA grippal
  - 35% prophylaxie anti-aspergillaire (94% par posaconazole IV) dans les 24h suivant l'admission

- Diagnostic de IAPA : 24 patients, 2 jours après l'admission en USI en médiane
  - 20 dans le groupe non traité vs 4 dans le groupe traité
  - Incidence à 30 j : 20,4 % vs 7,7 % (p=0,001) (utilisation d'un score de propension)
  - Pas d'impact sur la mortalité

Dont 3 diagnostiqués à J1 et J2



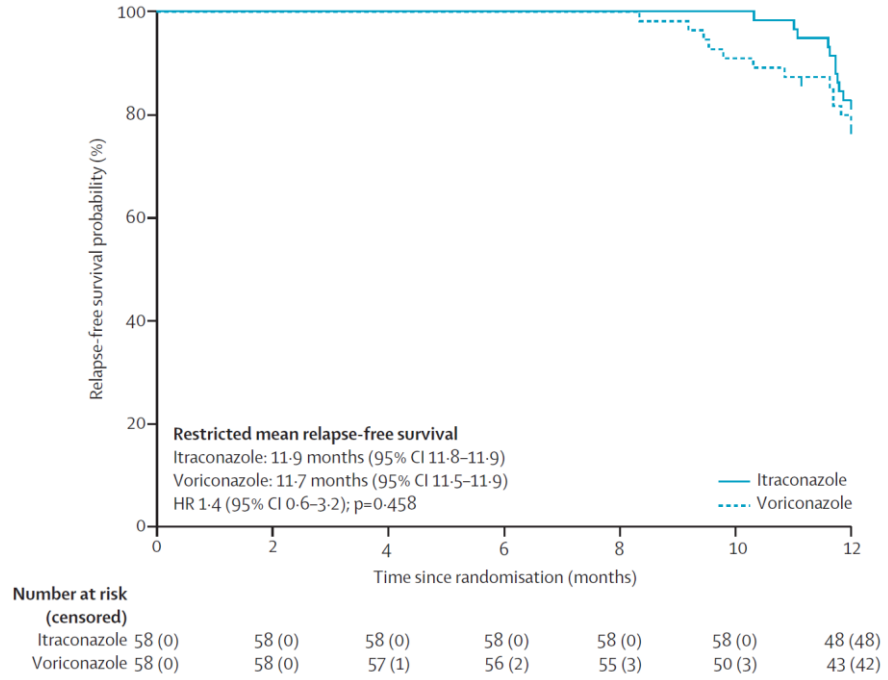
Hatzl et al. CID, 2025

Oral itraconazole versus oral voriconazole for treatment-naive patients with chronic pulmonary aspergillosis in India (VICTOR-CPA trial): a single-centre, open-label, randomised, controlled, superiority trial

Inderpaul Singh Sehgal, Ritesh Agarwal, Sahajal Dhooria, Kuruswamy Thurai Prasad, Valliappan Muthu, Ashutosh Nath Aggarwal, Shivaprakash M Rudramurthy, Mandeep Garg, Arunaloke Chakrabarti

- Etude prospective randomisée mono-centrique ouverte de supériorité
- Itraconazole 200 mgx2/j versus voriconazole, 6 mois
- CDJ: réponse favorable à 6 mois (incluant stabilité)

	Itraconazole (n=58)	Voriconazole (n=58)	p value
Participants with any treatment-related adverse event	20 (34%)	32 (55%)	0·025
Constipation	1 (2%)	1 (2%)	1·0
Anorexia	0	3 (5%)	0·079
Malaise	5 (9%)	6 (10%)	0·75
Myalgia	0	1 (2%)	0·32
Drying of lips	0	2 (3%)	0·15
Skin rash	1 (2%)	3 (5%)	0·31
Hyperpigmentation	1 (2%)	7 (12%)	0·028
Transient transaminitis	5 (9%)	20 (34%)	<0·0001
Gastritis	1 (2%)	2 (3%)	0·56
Weight loss	1 (2%)	0	0·32
Mucositis	1 (2%)	9 (16%)	0·0080
Sleep disturbances	1 (2%)	5 (9%)	0·094
Eye pain	1 (2%)	0	0·32
Visual hallucination	1 (2%)	2 (3%)	0·56



	Itraconazole (n=58)	Voriconazole (n=58)	ARR (95% CI)	p value*
Primary outcome				
Favourable response at 6 months	39 (67%)	40 (69%)	−0·02 (−0·2 to 0·15)	0·84
Clinical response	..	..	..	0·63
Stable	19 (33%)	16 (28%)	0·05 (−0·11 to 0·21)	..
Improvement	37 (64%)	38 (66%)	−0·02 (−0·19 to 0·15)	..
Worsening	2 (3%)	4 (7%)	−0·03 (−0·13 to 0·06)	..
Radiological response	..	..	..	0·61
Stable	28/58 (48%)	23/56 (41%)	0·07 (−0·11 to 0·24)	..
Partial improvement	12/58 (21%)	13/56 (23%)	−0·03 (−0·18 to 0·13)	..
Improvement	2/58 (3%)	5/56 (9%)	−0·05 (−0·16 to 0·04)	..
Worsening	16/58 (28%)	15/56 (27%)	0·01 (−0·15 to 0·17)	..

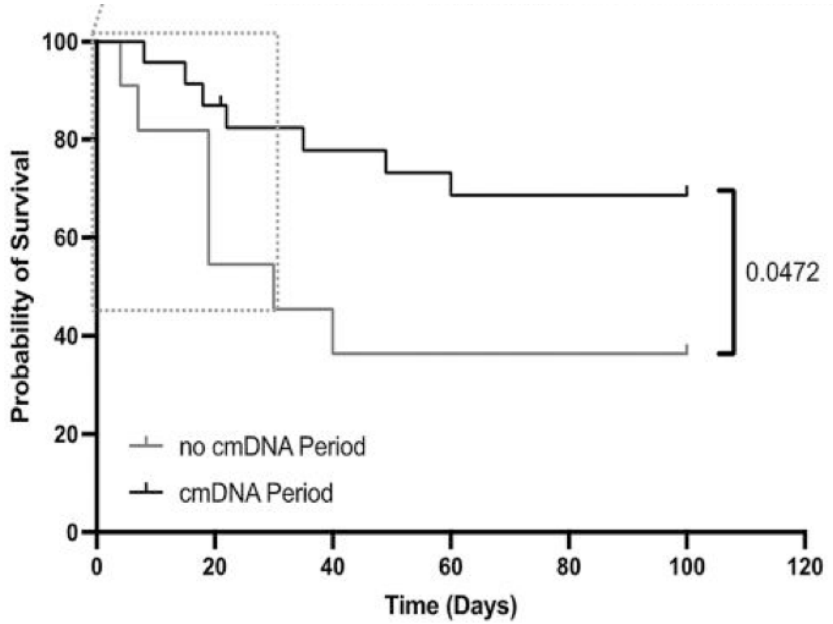
Seghal, Lancet Infect Dis 2025

Weekly Screening of Circulating *Mucorales* DNA and Early Treatment in Severely Burned Patients Improves Survival: Real-Life Bi-center Experience in France

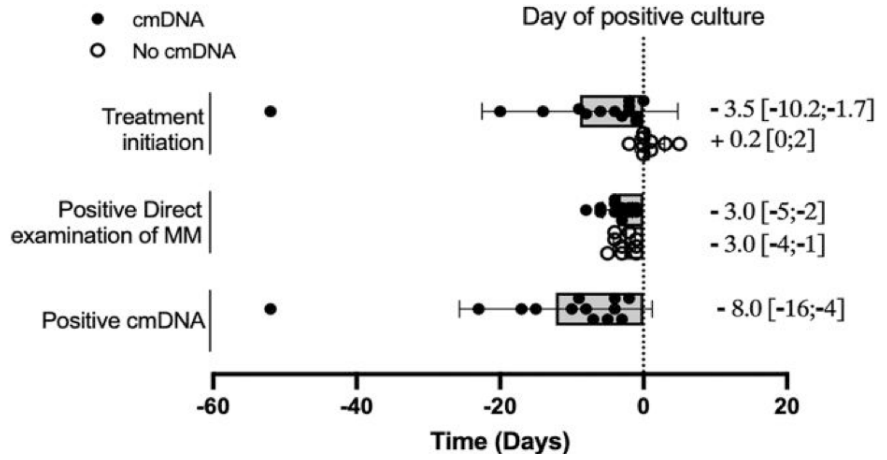
Emmanuel Faure,[1,2] Camille Cordier,[3,4] Hugo Delacoste,[1] Mathieu Jeanne,[5,6,7] François Dépret,[8,9,10] Samia Hamane,[11] Fanny Vuotto,[1] Mahdi Ouafi,[3] Marjorie Cornu,[3,4] Emmanuel Dudoignon,[8,9,10] Sarah Dellière,[11,12,a] and Alexandre Alanio[11,13,a]

Bicentrique
- APHP Saint Louis CTB
- CHU de Lille CTB

2 périodes
-**NocmDNA** = pas de PCR sérique mucorales
-**cmDNA** = PCR sérique 2/semaine si TBSA>15%
37 Mucormycoses sur 711
TBSA médian 60%



TBSA ≥ 30% Gain en survie à M3 : 63,6% vs 30,4%



Délai diagnostic réduit de 8 jours

Faure, Clin Infect Dis 2025

Pneumocystose

Adjunctive corticosteroids in non-AIDS patients with severe *Pneumocystis jirovecii* pneumonia (PIC): a multicentre, double-blind, randomised controlled trial

Virginie Lemiale, Matthieu Resche-Rigon, Yoann Zerbib, Djamel Mokart, Nicolas De Prost, Florent Wallet, Pierre Perez, Achille Kouatchet, Laurent Argaud, Maxens Decavèle, Frédéric Pène, Amelie Seguin, Bruno Megarbane, Laure Calvet, Muriel Picard, Guillaume Rigault, Eric Mariotte, Lila Bouadma, Igor Theodose, Fabienne Tamion, Kada Klouche, Gwenhael Colin, Martine Nyunga, Anne-Sophie Moreau, Elie Azoulay

- Essai multicentrique randomisé 27 hôpitaux en France, 2017-2024
- Pneumocystose HIV- avec insuffisance respiratoire aigue: Pao2 <60 mmHg ou 3L o2
- Methylprednisolone IV 30 mgx2/j J1-5, 30 mg/j J6-12, 20 mg/j J13-21
- Mortalité toute cause à 28 jours

	Placebo group (n=111)	Corticosteroid group (n=107)
Age, years	67 (59–73)	67 (60–73)
Sex		
Male	67 (60%)	59 (55%)
Female	44 (40%)	48 (45%)
Charlson Comorbidity Index	5 (4–7)	5 (3–7)
Cause of immunosuppression		
Haematological malignancy	38 (34%)	44 (41%)
Allogeneic stem-cell transplantation	7 (15%)	10 (19%)
Solid malignancy	27 (24%)	23 (21%)
Solid-organ transplantation	24 (22%)	22 (21%)
Primary immune deficiency	3 (3%)	2 (2%)
Immunosuppressive treatment*	68 (61%)	63 (59%)
Previous corticosteroid treatment†	55 (50%)	51 (48%)
Dose, mg per day	10 (5–20)‡	15 (10–40)‡
Pneumocystis jirovecii pneumonia prophylaxis	19 (17%)	30 (28%)

Lemiale, Lancet Respir Med 2025

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	Placebo group (n=111)	Corticosteroid group (n=107)	Mean difference (95% CI)	p value
Primary endpoint				
All-cause 28-day mortality	36 (32·4%; 23·9 to 42·0)	23 (21·5%; 14·1 to 30·5)	10·9% (–0·9 to 22·5)	0·069
Secondary endpoints				
Mortality in the ICU*†‡	39 (30·8%; 22·1 to 39·6)	25 (22·8%; 14·6 to 31·0)	8·1% (–3·9 to 20)	0·079
Mortality in hospital‡	43 (31·5%; 22·9 to 40·2)	26 (21·5%; 13·7 to 29·3)	10·0% (–1·6 to 21·7)	0·028
All-cause 90-day mortality*	48 (43·2%; 33·2 to 51·8)	30 (28·0%; 19·0 to 36·1)	15·2% (2·7 to 27·8)	0·022
Invasive ventilation*‡§	18 (26·1%; 15·6 to 36·5)	6 (10·1%; 2·3 to 17·7)	16·5% (3·5 to 29·5)	0·020
Adverse events				
Admission to ICU after randomisation*¶	0	1 (16·7%)	–16·7% (–58·3 to 39·6)	0·31
Respiratory worsening*‖	101 (91·0%; 84·1 to 95·6)	88 (82·2%; 74·7 to 89·0)	8·7% (–0·3 to 18·2)	0·057
All secondary infections (pulmonary and non-pulmonary)*‡	38 (34·2%; 25·4 to 43·1)	25 (23·4%; 15·3 to 31·4)	14·7% (2·4 to 27·0)	0·055
Pulmonary infection*‡	27 (24·3%; 16·3 to 32·3)	15 (14·0%; 7·4 to 20·6)	11·7% (0·5 to 22·9)	0·050
Non-pulmonary infection*‡	23 (20·7%; 13·1 to 28·3)	15 (14·0%; 7·4 to 20·6)	10·3% (0·6 to 20·5)	0·13
Insulin needs*	25 (22·5%; 15·1 to 31·4)	33 (30·8%; 22·3 to 40·5)	–8·3% (–20·0 to 3·5)	0·16
Median length of stay in ICU, days†	18 (12 to 40)	11 (8 to 15)	..	..
Median length of stay in hospital, days	37 (28 to 71)	28 (24 to 36)	..	..
Ventilatory-free days at day 28	19·0 (0·0 to 28·0)	25·0 (0·0 to 28·0)	..	..

Lemiale, Lancet Respir Med 2025

Nouvelles molécules

Olorofim for the treatment of invasive fungal diseases in patients with few or no therapeutic options: a single-arm, open-label, phase 2b study

Johan A Maertens, George R Thompson III, Andrej Spec, Fariba M Donovan, Sarah P Hammond, Anke H W Bruns, Galia Rahav, Shmuel Shoham, Royce Johnson, Bart Rijnders, Joanna Schaenman, Martin Hoenigl, C Orla Morrissey, Sanjay R Mehta, Christopher H Heath, Philipp Koehler, David L Paterson, Monica A Slavin, Jesus Fortún, M Hong Nguyen, Thomas F Patterson, Olga Uspenskaya, Frank L Van de Veerdonk, Paul E Verweij, Mickael Aoun, Aspasia Georgala, Barbara D Alexander, Methee Chayakulkeeree, Varun Mehra, Marisa H Miceli, Monica K Sikka, Amparo Solé, Thomas J Walsh, Jose Maria Aguado, Steven M Holland, Mohamed Moussa, Riina Rautemaa-Richardson, Rohit Bazaz, Stefan Schwartz, Stephen R Walsh, Markus Plate, Dana Yehudai-Ofir, Roger J Brüggemann, Oliver A Cornely, Luis Ostrosky-Zeichner, Jose A Vazquez, P Lewis White, Karen Cornelissen, Geoffrey G Ross, Lesley Fitton, Aaron Dane, Daniela Zinzi, John H Rex, Sharon C-A Chen

- Olorofim: nouvel AF oral orotomide, inhibe la synthèse des pyrimidines
- Essai phase 2b, ouvert, simple bras
- *Aspergillus*, *L. prolificans*, *Scedosporium*, autres, avec peu ou pas d'autres options AF
- 90 mg x2/j (après dose de charge 150 mg x2/j) 3 mois
- End point: réponse globale à 42 jours

	Invasive aspergillosis*† (n=101)	Invasive lomentosporiosis† (n=26)	Invasive scedosporiosis (n=22)	Other olorofim-susceptible fungi‡ (n=12)	Coccidioidomycosis (n=41)	Total§ (n=202)
Site of infection||						
Lung and/or sinonasal	89 (88%)	13 (50%)	8 (36%)	7 (58%)	8 (20%)	125 (62%)
CNS	12 (12%)	1 (4%)	3 (14%)	..	32 (78%)	48 (24%)
Bone and/or joint	5 (5%)	12 (46%)	7 (32%)	3 (25%)	7 (17%)	34 (17%)
Other extrapulmonary site**	8 (8%)	6 (23%)	13 (59%)	4 (33%)	8 (20%)	39 (19%)
Disseminated††	18 (18%)	8 (31%)	8 (36%)	3 (25%)	13 (32%)	50 (25%)
Reason for few or no treatment options						
Failure of available therapy	51 (50%)	9 (35%)	10 (45%)	6 (50%)	34 (83%)	110 (54%)
Known or predicted resistance to all licensed agents	23 (23%)	15 (58%)	5 (23%)	5 (42%)	2 (5%)	50 (25%)
Intolerance to available therapy	18 (18%)	1 (4%)	5 (23%)	1 (8%)	4 (10%)	29 (14%)
Inability to manage drug–drug interactions	6 (6%)	..	1 (5%)	..	..	7 (3%)
Inability to attain therapeutic levels	1 (1%)	1 (4%)	..	..	..	2 (1%)
Intravenous-only therapy produced a response but unable to switch to an azole	2 (2%)	..	..	..	..	2 (1%)
Other	..	..	1 (5%)‡‡	..	1 (2%)§§	2 (1%)

75 jours entre IFI et OLO
Durée médiane ttt: 73 j
Extension 114 p: 361 j

Maertens, Lancet Infect Dis 2025

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	Successful global response rate: stable classified as failure*		Successful global response rate: stable classified as success†		All-cause mortality	
	Day 42	Day 84	Day 42	Day 84	Day 42	Day 84
Overall (n=202)	58 (28·7%, 22·6–35·5)	55 (27·2%, 21·2–33·9)	152 (75·2%, 68·7–81·0)	128 (63·4%, 56·3–70·0)	24 (11·9%, 7·8–17·2)	33 (16·3%, 11·5–22·2)
Aspergillus spp‡ (n=101)	35 (34·7%, 25·5–44·8)	34 (33·7%, 24·6–43·8)	65 (64·4%, 54·2–73·6)	55 (54·5%, 44·2–64·4)	19 (18·8%, 11·7–27·8)	26 (25·7%, 17·6–35·4)
Lomentospora prolificans‡ (n=26)	11 (42·3%, 23·4–63·1)	11 (42·3%, 23·4–63·1)	20 (76·9%, 56·4–91·0)	19 (73·1%, 52·2–88·4)	3 (11·5%, 2·4–30·2)	3 (11·5%, 2·4–30·2)
Scedosporium spp (n=22)	8 (36·4%, 17·2–59·3)	5 (22·7%, 7·9–45·4)	19 (86·4%, 65·1–97·1)	13 (59·1%, 36·4–79·3)	2 (9·1%, 1·1–29·2)	3 (13·6%, 2·9–34·9)
Other olorofim-susceptible fungi§ (n=12)	4 (33·3%, 9·9–65·1)	5 (41·7%, 15·2–72·3)	9 (75·0%, 42·8–94·5)	6 (50·0%, 21·1–78·9)	0 (0·0%, 0·0–26·5)	1 (8·3%, 0·2–38·5)
Coccidioides spp¶ (n=41)	0 (0·0%, 0·0–8·6)	0 (0·0%, 0·0–8·6)	39 (95·1%, 83·5–99·4)	35 (85·4%, 70·8–94·4)	0 (0·0%, 0·0–8·6)	0 (0·0%, 0·0–8·6)

Maertens, Lancet Infect Dis 2025

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	Adverse event (n=203)	Related adverse event (n=203)	Serious adverse event (n=203)	Related serious adverse event (n=203)	Fatal (n=203)
Infections or infestations	127 (63%)	3 (1%)	65 (32%)	1 (0%)	16 (8%)
Gastrointestinal	107 (53%)	20 (10%)	8 (4%)	2 (1%)	1 (0%)
Investigations	87 (43%)	33 (16%)	15 (7%)	5 (2%)	0 (0%)
Nervous system	79 (39%)	5 (2%)	24 (12%)	0 (0%)	4 (2%)
General	76 (37%)	3 (1%)	12 (6%)	0 (0%)	0 (0%)
Musculoskeletal	68 (33%)	2 (1%)	6 (3%)	0 (0%)	0 (0%)
Respiratory	67 (33%)	0 (0%)	27 (13%)	0 (0%)	12 (6%)
Metabolism	60 (30%)	3 (1%)	6 (3%)	1 (0%)	0 (0%)
Blood and lymphatic system	47 (23%)	1 (0%)	5 (2%)	0 (0%)	1 (0%)
Skin	47 (23%)	3 (1%)	1 (0%)	0 (0%)	0 (0%)
Vascular	47 (23%)	0 (0%)	5 (2%)	0 (0%)	1 (0%)
Injury	47 (23%)	0 (0%)	11 (5%)	0 (0%)	0 (0%)
Cardiac	36 (18%)	2 (1%)	14 (7%)	1 (0%)	1 (0%)
Renal and urinary	35 (17%)	1 (0%)	5 (2%)	1 (0%)	0 (0%)
Eye	32 (16%)	4 (2%)	4 (2%)	0 (0%)	0 (0%)
Psychiatric	31 (15%)	2 (1%)	1 (0%)	0 (0%)	0 (0%)
Neoplasms	22 (11%)	0 (0%)	16 (8%)	0 (0%)	12 (6%)
Immune disorders	14 (7%)	0 (0%)	2 (1%)	0 (0%)	1 (0%)
Hepatobiliary	12 (6%)	1 (0%)	1 (0%)	1 (0%)	0 (0%)
Ear and labyrinth	10 (5%)	2 (1%)	1 (0%)	0 (0%)	0 (0%)
Reproductive system	8 (4%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Surgical and medical procedures	4 (2%)	0 (0%)	3 (1%)	0 (0%)	0 (0%)
Endocrine	1 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)

All treatment-emergent adverse events reported during the study are summarised regardless of causality using standard System Organ Class and Preferred Terminology categories (see also appendix pp 19–20).

Table 3: **Treatment-emergent adverse events by System Organ Class that occurred in more than 2% of the safety analysis set during the main or extended treatment phases**

Effets indésirables hépatiques :
45 (22%) dont 20 (10%) liés au ttt
=>Modification de dose 14 (7%)
=>Arrêt du traitement 6 (3%)

Maertens, Lancet Infect Dis 2025

Compassionate Use of Olorofim for Invasive Mold Infections: A Nationwide Observational Study in France

V. Esnault,[1] C. Godet,[2,3] D. Garcia-Hermoso,[4] A. Charmillon,[5] P. Parize,[6] C. Bonnal,[7] A. Debourgogne,[8,9] F. Morio,[10] M.-E. Bougnoux,[11,12] E. Dannaoui,[11,13] A. P. Bellanger,[14] J.-P. Gangneux,[15,16] B. Sendid,[17] E. Cardot,[18] C. Melenotte,[6] C. Rouzaud,[6] A. Lefort,[19] S. Colin de Verdiere,[20] O. Brugiere,[20] M. Tetart,[21,22] E. Eschapasse,[23] A. Berceanu,[24] P. Tattevin,[25] R. Levy,[26] E. Faure,[27] and F. Lanternier[4,6]

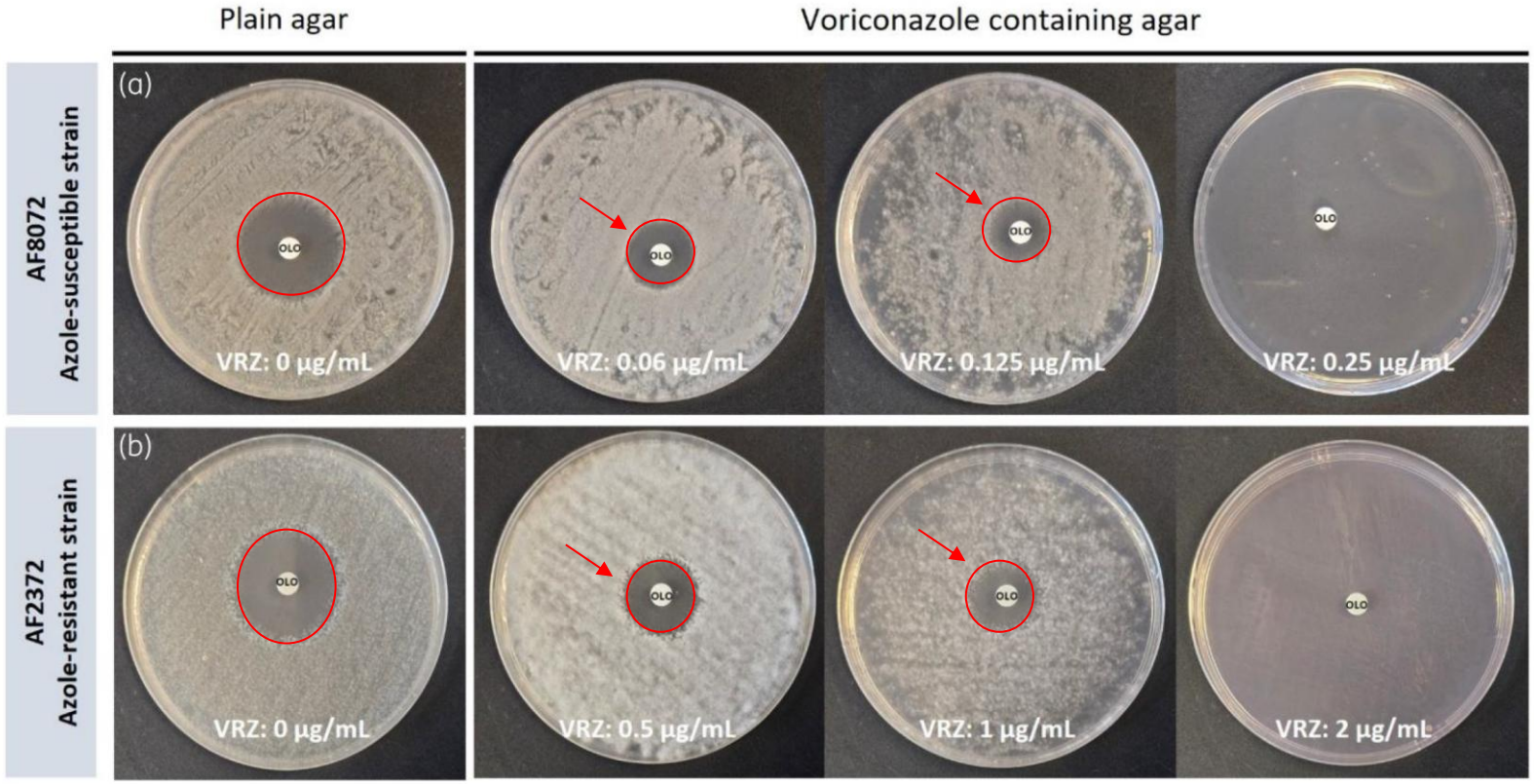
- Etude rétrospective, utilisation compassionnelle pour IFI avec option thérapeutique limitée
- Janvier 2020-31 décembre 2023
- 17 patients (PID n=4, SOT n=5)
- Durée AF préalable: 9 mois
- Localisations: 15/17 poumon, 4/17 SNC; 5/17 disséminées
- Espèces (n=23): *Aspergillus* (14/23), *Microascus* (3), *Scedosporium* (3), autres (3)
- Mortalité 3 mois: 29,4%
- Réponse clinique : réponse globale 5 (33%), réponse partielle 7 (47%), échec 3 (20%)
- Bonne tolérance

Esnault, OFID 2025

Antagonistic *in vitro* interaction between olorofim and voriconazole against *Aspergillus fumigatus*

Illan Laloum [1,2], Anne-Laure Bidaud[2], Elise Recalt [2], Patrick Schwarz [3], Marie-Elisabeth Bougnoux [1,2] and Eric Dannaoui [1,2,4]*

- 32 isolats cliniques: 27 VCZ-S et 5 VCZ-R
- Détermination des CMI du VCZ, olorofim et combinaison
- Par 2 techniques (checkerboard et analyse de surface)



Antagonisme 56 à 75% des isolats
100% antagonismes pour les souches azolés-R
Variabilité en fonction de la concentration de VCZ

Laloum, J Antimicrob Chemother 2025

Clinical Infectious Diseases
MAJOR ARTICLE
IDSA OXFORD

Fosmanogepix for the Treatment of Invasive Mold Diseases Caused by *Aspergillus* Species and Rare Molds: A Phase 2, Open-Label Study (AEGIS)

Michael R. Hodges,[1,2] Margaret Tawadrous,[3,a] Oliver A. Cornely,[4,5,6] George R. Thompson III[7] Monica A. Slavin,[8] Johan A. Maertens,[9,10] Sanjeet S. Dadwal,[11] Galia Rahav,[12] Susan Hazel,[13,14] Mary Almas,[15] Abhijeet Jakate,[16] and Rienk Pypstra[3,a]

Efficacité du fosmanogepix pour le traitement d'infection à champignons filamenteux résistants ou rares

- inhibiteur de l'enzyme Gwt1
- Efficacité dans les candidémies et candidoses invasives dont *C.auris* dans 2 études de phase II
- 20 patients d'hématologie, avec options thérapeutiques limitées (résistance, contre-indication, intolérance ou échec du traitement de référence)

Fungal pathogen isolates tested by JMI Labs, n[b]	7
Aspergillus fumigatus	2
Aspergillus flavus	1
Fusarium solani	1
Lomentospora prolificans	1
Mucor circinelloides	1
Candida albicans	1

diagnostic par GM ou PCR *Aspergillus* pour les autres patients

Site of IMD, n (%)	
Other[a]	3 (15)
Pulmonary	16 (80)
Sinuses	1 (5)

Hodges et al., CID, 2025

Clinical Infectious Diseases
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Michael R. Hodges,[1,2] Margaret Tawadrous,[3,a] Oliver A. Cornely,[4,5,6] George R. Thompson III[7] Monica A. Slavin,[8] Johan A. Maertens,[9,10] Sanjeet S. Dadwal,[11] Galia Rahav,[12] Susan Hazel,[13,14] Mary Almas,[15] Abhijeet Jakate,[16] and Rienk Pypstra[3,a]

Efficacité

Efficacy Endpoints	FMGX Cohort N = 20
Primary: Day 42 All-Cause Mortality, n (%); 80% CI	5 (25); 12.7–41.5
Secondary: DRC assessed global response at EOST/ET	
Treatment success, n (%); 80% CI	8 (40); 24.9–56.7
Complete response, n (%)	4 (20)
Partial response, n (%)	4 (20)
Stable disease, n (%)	2 (10%)
Treatment failure, n (%)	10 (50)
Progression of disease, n (%)	6 (30)
Death, n (%)	4 (20)

Tolérance

Safety Parameters	FMGX Cohort N = 21
Overall safety summary, n (%)	
Number of TEAEs	258
Participants with TEAEs	21 (100)
Serious TEAEs	13 (61.9)
Grade 3 or 4 TEAEs	11 (52.4)
Grade 5 TEAEs	6 (28.6)

Évènements indésirables les plus fréquents :

- nausée (52%), vomissement (33%), diarrhée (24%)
- adaptation de la posologie (800mg en 1 prise -> 400mgx2/j) permettant d'améliorer la tolerance

Hodges et al., CID, 2025

Clinical Infectious Diseases
MAJOR ARTICLE
IDSA OXFORD

Fungal Meningitis in US Patients Who Received Epidural Anesthesia in Matamoros, Mexico

Dallas J. Smith,[1] Elizabeth Misas,[1] Jeremy A. W. Gold,[1] Nicole Evert,[2] Thi Dang,[2] Emilie Prot,[2] Simone Godwin,[3] JulieAnna Rivas,[4] Jessica Pearson,[5] Lori Koenecke,[6] Nirma D. Bustamante,[7] Maria Julia Marinissen,[8] Gabriel Garcia Rodriquez,[9] Irma López-Martínez,[10] Caitlyn Lutfy,[1] Samantha Williams,[1] Axel A. Vazquez Deida,[11,12] Katrina M. Byrd,[7,11] Julian A. Villalba,[13] Sarah Reagan-Steiner,[13] Lindsay Parnell,[1] Lalitha Gade,[1] Romney M. Humphries,[14] Nathan P. Wiederhold,[15] Charles Y. Chiu,[16] Joshua A. Lieberman,[17] Anastasia P. Litvintseva,[1] Tom Chiller,[1] and Luis Ostrosky-Zeichner[18]; for the Fungal Meningitis Response Team

- Épidémie de méningite à *fusarium solani* à la suite d'une anesthésie épidurale chez 24 patients
- Mortalité : 50%
- 7 patients traités par fosmanogepix (mortalité 1/7 vs 8/11 amphoB ou voriconazole)

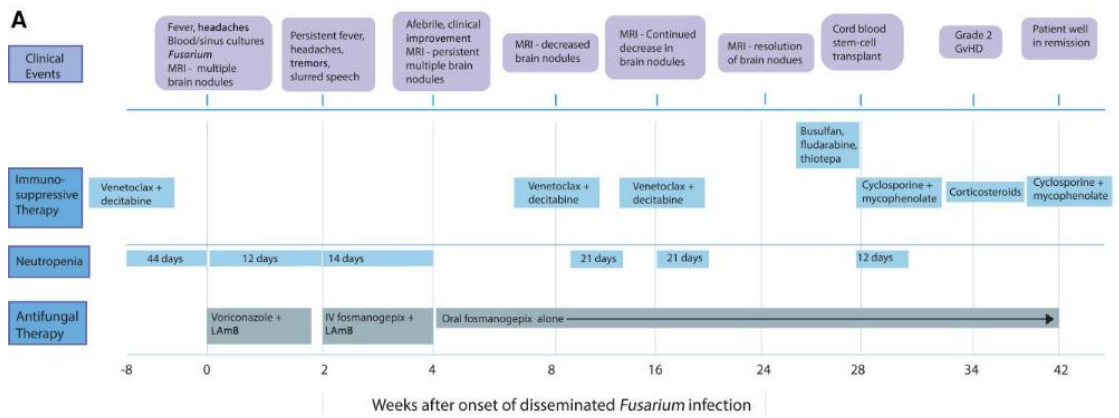
Smith et al. CID, 2025

Fosmanogepix Therapy of Disseminated *Fusarium* Infection

Clinical Infectious Diseases
BRIEF REPORT

Drew J. Winston,[1] Patricia A. Young,[1] Haran T. Schlamm,[2] and Gary J. Schiller[1]

- Traitement d'un patient ayant une infection disséminée avec atteinte cérébrale à fusarium dans un contexte de leucémie aigue myéloïde



Winston et al. CID, 2023

Conclusions

Infections à levures

- Échinocandines en 1ere ligne
- Augmentation du nombre d'infection/colonisation à *C. auris* en France
- Généralisation du protocole Ambition pour les PvVIH

Pneumocystose hypoxémiante VIH-

- Methylprednisolone IV diminue la mortalité, non significatif sur le CJP

Filamenteux :

- PCR mucorales 2x/semaine en screening chez les brulés, améliore la mortalité
- Aspergillose pulmonaire chronique: Pas de supériorité du VCZ par rapport à l'ITZ et moins bonne tolérance

Nouveaux antifongiques :

- Olorofim: nouvel classe AF, spectre large, données d'efficacité, tolérance hépatique, antagonisme *in vitro* voriconazole et olorofim
- Fosmanogepix : prometteur pour les filamenteux avec peu d'options thérapeutiques tels que *fusarium* (sauf Mucorales), tolérance digestive médiocre