

MEETING GIVITI 2025

Candida Auris: sfide emergenti nella sanità italiana

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GIVITI

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Conflict of interest: none

Topic:

Candida Auris framework

ECDC notifications

Our experience

Spill-over effects

Review Article
***Candida auris* Infections**

Michail S. Lionakis, M.D., Sc.D., and Anuradha Chowdhary, M.D., Ph.D.

N Engl J Med
Volume 391(20):1924-1935
November 21, 2024



The NEW ENGLAND
JOURNAL of MEDICINE

Summary

- *C. auris*, a serious public health threat that may have emerged because of climate change, persists on human skin and inanimate objects, frequently causing difficult-to-control outbreaks in health care facilities.

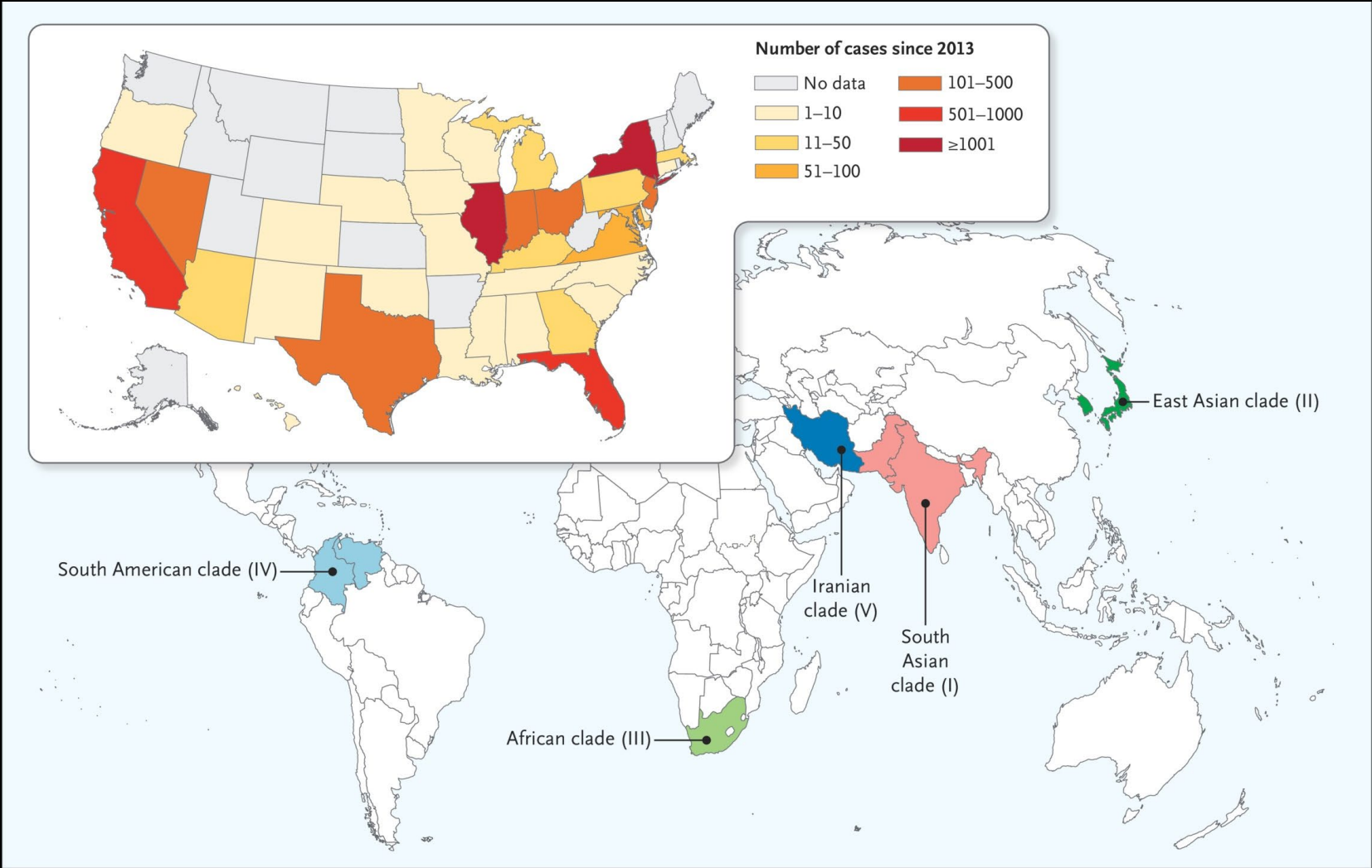


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Key points:

Since 2009, when it was first identified, *Candida auris* has rapidly spread across more than 45 countries in six continents; it has been subdivided into five clades with distinct geographic distributions.

Geographic Origins of Candida auris and Clinical Cases in the United States.



Lionakis MS, Chowdhary A. N Engl J Med2024;391:1924-1935

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Key points:

C. auris can be misidentified as other candida species on certain microbiologic tests.

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Key points:

C. auris persists for long periods on human skin and inanimate objects, frequently causing difficult-to-control outbreaks in health care facilities.

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Key points:

Skin colonization by *C. auris* is a risk factor for subsequent candidemia, which can develop in up to 25% of critically ill patients who are colonized with the fungus.

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Key points:

Most strains of *C. auris* are resistant to fluconazole, and some strains are resistant to all available classes of antifungal drugs.

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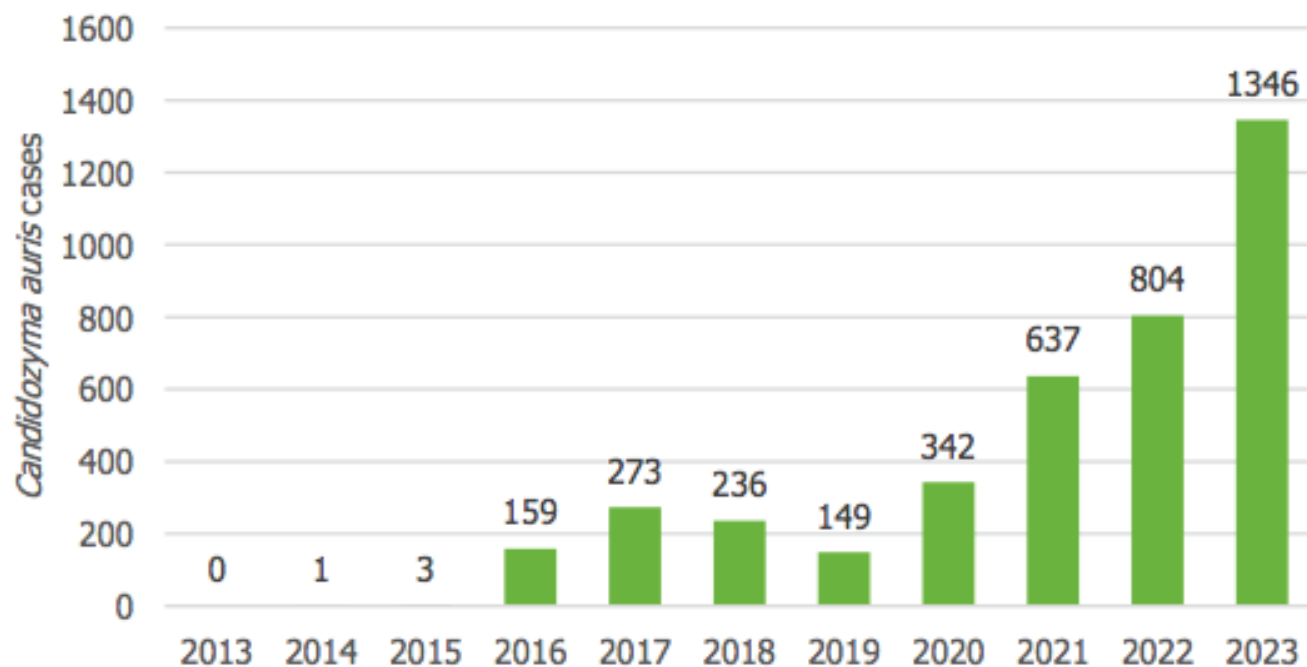
SURVEILLANCE AND MONITORING

Survey on the epidemiological situation, laboratory capacity and preparedness for *Candidozyma (Candida) auris*, 2024

11 September 2025

Recent distinct *C. auris* outbreaks were reported by three countries (Cyprus, France and Germany) while four countries (Greece, Italy, Romania and Spain) reported that it was no longer possible to distinguish specific outbreaks in a situation of regional endemicity.

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Figure 1. Reported cases of *Candidozyma auris*, EU/EEA, 2013-2023*

*Italy reported an additional 62 cases which could not be allocated to a specific year.

SURVEILLANCE AND MONITORING

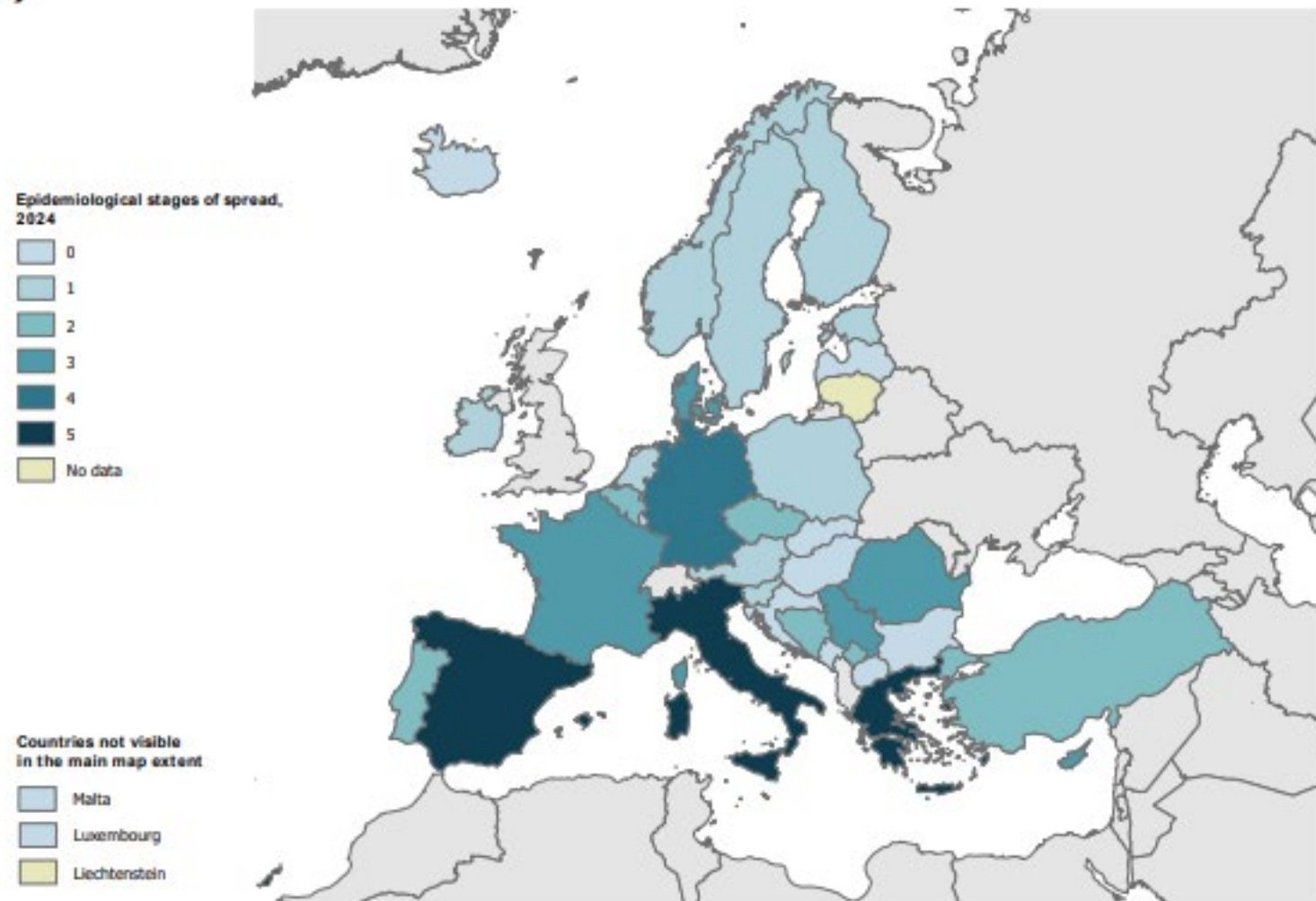
Survey on the epidemiological situation, laboratory capacity and preparedness for *Candidozyma (Candida) auris*, 2024

11 September 2025



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Table 1. Reported cases of *Candidozyma auris* infection and carriage, by European country, 2013-2023

Country	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2013 - 2023
Austria	0	0	0	0	0	1	0	2	1	1	2	7
Belgium	0	0	0	1	0	0	3	0	1	3	6	14
Bulgaria	0	0	0	0	0	0	0	0	0	0	0	0
Croatia	0	0	0	0	0	0	0	0	0	0	0	0
Cyprus	0	0	0	0	0	0	0	0	0	0	13	13
Czechia	0	0	0	0	0	0	0	0	1	1	1	3
Denmark	0	0	0	0	0	0	0	0	2	2	1	5
Estonia	0	0	0	0	0	0	0	0	0	0	1	1
Finland	0	0	0	0	0	0	0	0	1	2	2	5
France ^a	0	1	1	1	1	0	3	3	5	7	10	32
Germany	0	0	2	1	6	2	3	5	12	12	77	120
Greece	0	0	0	0	0	0	3	13	58	327	451	852
Hungary	0	0	0	0	0	0	0	0	0	0	0	0
Iceland	0	0	0	0	0	0	0	0	0	0	0	0
Ireland	0	0	0	0	0	0	0	0	0	0	0	0
Italy	0	0	0	0	0	0	0	57	221	42	330	712 ^b
Lithuania	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Luxembourg	0	0	0	0	0	0	0	0	0	0	0	0
Malta	0	0	0	0	0	0	0	0	0	0	0	0
The Netherlands	0	0	0	0	0	2	1	1	1	2	6	13
Norway	0	0	0	1	0	1	0	0	2	3	6	13
Poland	NA	NA	NA	NA	NA	NA	1	0	0	0	0	1
Portugal	0	0	0	0	0	0	0	0	0	0	4	4
Romania	0	0	0	0	0	0	0	0	0	147	257	404
Slovakia	0	0	0	0	0	0	0	0	0	0	0	0
Slovenia	0	0	0	0	0	0	0	0	0	0	1	1
Spain	0	0	0	155	266	230	135	260	331	253	177	1 807
Sweden	NA	NA	NA	NA	NA	NA	0	1	1	2	1	5
EU/EEA	0	1	3	159	273	236	149	342	637	804	1 346	4 012
Bosnia and Herzegovina	0	0	0	0	0	0	0	0	0	0	1	1
Kosovo	0	0	0	0	0	0	0	0	0	0	6	6
Montenegro	0	0	0	0	0	0	0	0	0	0	0	0
North Macedonia	0	0	0	0	0	0	0	0	0	0	0	0
Serbia	0	0	0	0	0	0	0	0	0	0	0	0
Türkiye	0	0	0	0	0	0	0	14	45	25	30	114
Survey total	0	1	3	159	273	236	149	356	682	829	1 383	4 133

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The period between a documented first case in the country and regional endemicity according to the ECDC staging system has been between five and seven years for Greece, Italy and Spain, showing how rapidly *C. auris* can spread through hospital networks. This rapid dissemination of *C. auris* is of serious concern and points to a high risk for continued *C. auris* spread throughout European healthcare systems

How did we get here

Event background

Italy reported a healthcare-associated outbreak of *C. auris* occurring in the region of Liguria with at least 277 cases in eight healthcare facilities. The first *C. auris* case was detected in one hospital (hospital A) in July 2019 and, since then, subsequent cases have been sporadically reported in the same hospital. In February 2020, *C. auris* was detected in an intensive care unit (ICU) dedicated to the treatment of patients with severe COVID-19 in hospital A. A subsequent increase in case numbers was observed throughout 2020 and 2021. Whole genome sequencing of *C. auris* isolates from 10 of the early cases from hospital A in 2019 and 2020 showed that the isolates belonged to the Southern Asian clade



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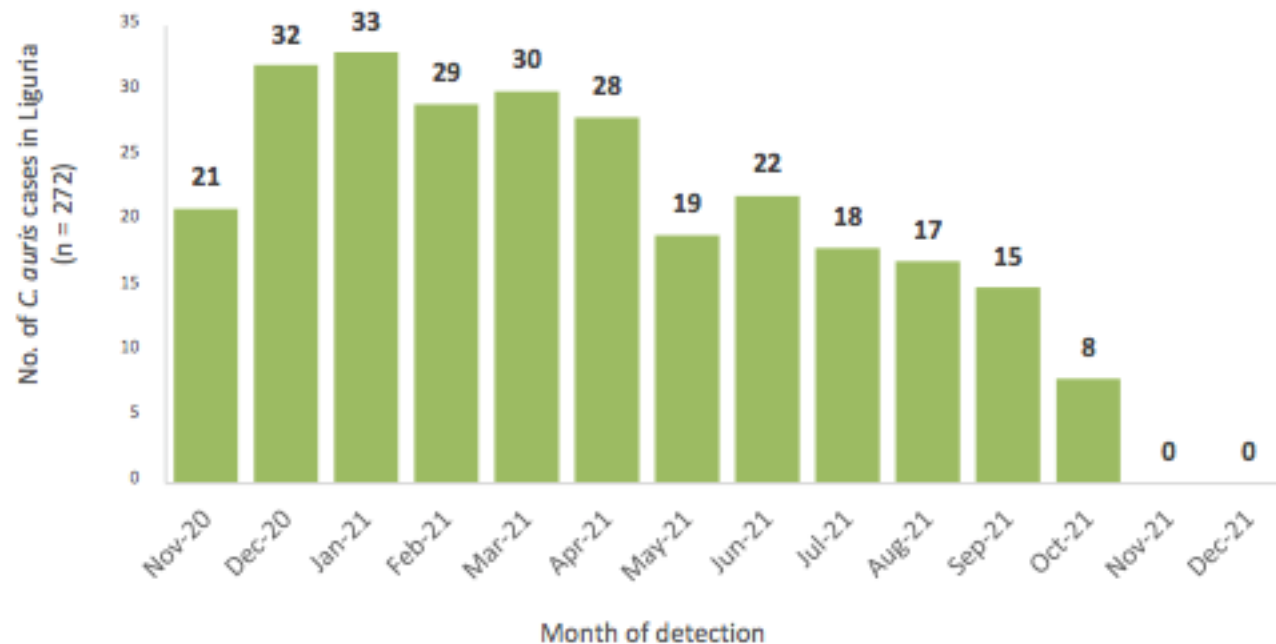


In June 2020, the Ministry of Health, in coordination with the National Institute of Health (ISS), published a Circular Letter including a case definition; recommendations for identification of *C. auris* isolates and management of cases, infection prevention and control measures, surveillance and notification; and information for cases and healthcare staff. In March 2021, another Circular Letter followed, with an update of *C. auris* epidemiology and a reminder regarding adequate laboratory identification and antifungal susceptibility testing, as well as prompt notification of cases.

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***Candida auris* outbreak in healthcare facilities in northern Italy, 2019-2021**

21 February 2022

Figure 1. Epidemiological curve of *C. auris* cases in Liguria, northern Italy, from November 2020 to December 2021 (n = 272*)

* Source: Italian Ministry of Health. Only cases with known date of diagnosis are included.

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RAPID RISK ASSESSMENT

***Candida auris* outbreak in healthcare facilities in northern Italy, 2019-2021**

21 February 2022

Control measures taken at the national level after receipt of the report from the Liguria region included the publication of a short update on the national and global epidemiological situation with a reminder on best practices for the management of *C. auris* cases and the need for national notification, as well as a request to neighbouring regions for detailed reports on *C. auris* cases in the same period. In response, the region of Emilia-Romagna notified 11 cases of *C. auris* with the first case recorded in December 2020. No replies from Lombardy, Piedmont or Tuscany had been received at the time of this assessment. One case of a *C. auris* bloodstream infection had been detected in Rome as of November 2019



Ospedale Niguarda

Sistema Socio Sanitario



Regione
Lombardia

OUTBREAK CANDIDA AURIS

08/07/2025



Overview casi

Pz.	DATA	REPARTO CERTO/SOSPETTO DI POSITIVIZZAZIONE	TRASFERIMENTO IN REPARTO CON RISCONTRO DI SUCCESSIVE POSITIVITA'	ESITO	REPARTO ATTUALE DI RICOVERO
1	set-22	NEURORIA	NA	DIMESSO	NA
2	nov-22	NEURORIA	NA	DECESSO	NA
3	feb-23	CENTRO USTIONI	NA	DECESSO	NA
4	apr-23	NEURORIA GENNAIO 23	NA	DECESSO	NA
5	ago-23	NEURORIA GIUGNO 23	NA	DIMESSO	NA
6	ott-23	NEURORIA A SETTEMBRE 23 POI SUBINTENSIVA E NEUROLOGIA	SUBINTENSIVA	DECESSO	NA
7	ott-23	CONTATTO DEL CASO 7 IN SUBINTENSIVA	NA	DIMESSO	NA
8	set-24	SUBINTENSIVA	TERAPIA INTENSIVA	DECESSO	NA
9	nov-24	TERAPIA INTENSIVA1	NA	DECESSO	NA
10	gen-25	TERAPIA INTENSIVA1	NA	DIMESSO	NA
11	feb-25	TERAPIA INTENSIVA 1	NA	RICOVERATO	RIABILITAZIONE E NEURO
12	feb-25	TERAPIA INTENSIVA 1	NA	DECEDUTA	NA

Aggiornata all'08/07/2025

13	feb-25	SUBINT	NA	DIMESSO	MALATTIE INFETTIVE
14	feb-25	SUBINT (CONTATTO DEL CASO 13)	NA	DIMESSO	MALATTIE INFETTIVE
15	apr-25	TERAPIA INTENSIVA 1	NA	DIMESSO	NA
16	apr-25	UCC	NA	DECEDUTO	UCC
17	apr-25	TERAPIA INTENSIVA 1	NA	DIMESSO	NA
18	apr-25	TERAPIA INTENSIVA 1	NA	DIMESSO	EMATOLOGIA
19	apr-25	SUBINTENSIVA	SUBINTENSIVA	RICOVERATO	CHIRURGIA PLASTICA
20	mag-25	TERAPIA INTENSIVA 1	NA	RICOVERATO	MEDICINA D1
21	mag-25	TIN	NA	DIMESSO	TIN
22	mag-25	SUBINTENSIVA	TERAPIA INTENSIVA	RICOVERATO	TRAUMA TEAM
23	mag-25	TERAPIA INTENSIVA 1	NA	RICOVERATO	MEDICINA D1
24	giu-25	SUB	TERAPIA INTENSIVA	RICOVERATO	SAR1
25	giu-25	TERAPIA INTENSIVA 1	NA	RICOVERATO	SAR1

Pz.	DATA	REPARTO CERTO/SOSPETTO DI POSITIVIZZAZIONE	TRASFERIMENTO IN REPARTO CON RISCONTRO DI SUCCESSIVE POSITIVITA'	ESITO	REPARTO ATTUALE DI RICOVERO
1	set-22	NEURORIA	NA	DIMESSO	NA
2	nov-22	NEURORIA	NA	DECESSO	NA
3	feb-23	CENTRO USTIONI	NA	DECESSO	NA
4	apr-23	NEURORIA GENNAIO 23	NA	DECESSO	NA
5	ago-23	NEURORIA GIUGNO 23	NA	DIMESSO	NA
6	ott-23	NEURORIA A SETTEMBRE 23 POI SUBINTENSIVA E NEUROLOGIA	SUBINTENSIVA	DECESSO	NA
7	ott-23	CONTATTO DEL CASO 7 IN SUBINTENSIVA	NA	DIMESSO	NA
8	set-24	SUBINTENSIVA	TERAPIA INTENSIVA	DECESSO	NA
9	nov-24	TERAPIA INTENSIVA1	NA	DECESSO	NA
10	gen-25	TERAPIA INTENSIVA1	NA	DIMESSO	NA
11	feb-25	TERAPIA INTENSIVA 1	NA	RICOVERATO	RIABILITAZIONE NEURO
12	feb-25	TERAPIA INTENSIVA 1	NA	DECEDEUTA	NA

INIZIO TAMPONI MOLECOLARI					
13	feb-25	SUBINT	NA	DIMESSO	MALATTIE INFETTIVE
14	feb-25	(CONTATTO DEL	NA	DIMESSO	MALATTIE INFETTIVE
15	apr-25	INTENSIVA 1	NA	DIMESSO	NA
16	apr-25	UCC	NA	DECEBUTO	UCC
17	apr-25	INTENSIVA 1	NA	DIMESSO	NA
18	apr-25	INTENSIVA 1	NA	DIMESSO	EMATOLOGIA
19	apr-25	SUBINTENSIVA	SUBINTENSIVA	RICOVERATO	CHIRURGIA PLASTICA
20	mag-25	INTENSIVA 1	NA	RICOVERATO	MEDICINA DI
21	mag-25	TIN	NA	DIMESSO	TIN
22	mag-25	SUBINTENSIVA	TERAPIA INTENSIVA	RICOVERATO	TRAUMA TEAM
23	mag-25	INTENSIVA 1	NA	DECEBUTO	MEDICINA DI
24	giu-25	SUB	TERAPIA INTENSIVA	RICOVERATO	RIABILITAZIONE
25	giu-25	INTENSIVA 1	NA	DIMESSO	DIMESSO AL BEDDZA
26	lug-25	SUB	NA	RICOVERATO	ORTOPEDIA
27	lug-25	SUB	NA	DIMESSO	EMATOLOGIA
28	set-25	TERAPIA INTENSIVA 1	NA	DIMESSO	CCU
29	set-25	TERAPIA	NA	DIMESSO	TRAUMA TEAM
30	set-25	INTENSIVA 1	NA	RICOVERATO	SARI

Interventi effettuati per il contenimento del cluster

- Sorveglianza con tamponi cutanei in tutte le aree critiche a partire da dicembre 2024
- Da febbraio 2025 tamponi molecolari
- Isolamento dei casi
- Tracciamento e isolamento dei contatti
- Chiusura accettazioni in SAR1 dal 17/02 al 24/03
- Interventi straordinari di sanificazione:
 - - marzo 2025 in SAR1: risanamenti nelle stanze utilizzate dai casi e cloro 5000 + perossido di idrogeno in tutti i locali
 - - giugno 2025 in subintensiva con chiusura della sub
- Task force regionale
- Riunioni giornaliere
- Sopralluoghi



SORVEGLIANZA IN CORSO

- TAMPONI CUTANEI MOLECOLARI (1 UNICO TAMPONE DA SFREGARE SU ASCELLA DX E SX E SU INGUINE DX E SX) ALL'INGRESSO E OGNI SETTIMANA IN TUTTE LE AREE CRITICHE DI NIGUARDA:
 - TERAPIA INTENSIVA 1 (3 VOLTE A SETTIMANA)
 - SUBINTENSIVA (3 VOLTE A SETTIMANA)
 - NEURORINIMAZIONE
 - SAR2
 - SAR3
 - UCC
 - TIN
- SORVEGLIANZA SU PAZIENTI PRECEDENTEMENTE OSPEDALIZZATI E CHE PROVENGONO DA ZONE A RISCHIO (ES LIGURIA, UK, BALCANI)



GESTIONE DEL CASO

- ISOLAMENTO STRUTTURALE E PRECAUZIONI DA CONTATTO
- PROTOCOLLO SPECIFICO DI SANIFICAZIONE:
 - 4 PASSAGGI/DIE (DI CUI UNO CON CLORO 5000 PPM)
 - PEROSSIDO AL TERMINE DELLA DEGENZA
- DEDICARE TUTTO IL MATERIALE E BUTTARE TUTTO AL TERMINE DEL RICOVERO (LA CARTELLA DEVE RIMANERE PULITA!)



SANIFICAZIONE ATTREZZATURE

- GIOCLOR 5000 PPM PER MATERIALI RESISTENTI: TEMPO DI CONTATTO 15 MINUTI
- LC ACT PER MATERIALI SENSIBILI (ES. SONDA ECOGRAFIA): TEMPO DI CONTATTO 15 MINUTI



GESTIONE DEI CONTATTI

- STESSA STANZA/OPEN SPACE
 - ISOLAMENTO **FUNZIONALE** E PRECAUZIONI DA CONTATTO PER 15 GIORNI
 - SORVEGLIANZA CON TAMPONI MOLECOLARI CUTANEI: T0, T48, T7, T14, T21, T 28
 - SE DIMISSIONI PRIMA DEL TERMINE DELLA SORVEGLIANZA PROSEGUIRE NELLA STRUTTURA ACCETTANTE/CON ATS SE AL DOMICILIO
 - AUMENTARE LIVELLO DI RISCHIO AD ALTO PER LE PULIZIE



PAZIENTI PROVENIENTI DA SAR1

- ISOLAMENTO FUNZIONALE PER 14 GIORNI
- TAMPONI CUTANEI MOLECOLARI DI
SORVEGLIANZA A T0, T48h, T7, T14, T21, T 28
- Non sono contatti in senso stretto, ma provengono da un reparto a rischio

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Regione Lombardia - Giunta
DIREZIONE GENERALE WELFARE
PREVENZIONE

Piazza Città di Lombardia n.1
20124 Milano
Tel 02 6765.1

welfare@pec.regione.lombardia.it

GESTIONE DEL CASO

- Provvedere all'implementazione delle precauzioni aggiuntive da contatto, con isolamento strutturale in stanza singola/box per tutta la durata della degenza. In presenza di più casi è possibile procedere con l'isolamento in coorte. Non gestire i casi in isolamento funzionale.
- Prevedere l'allestimento di carrelli dedicati con materiale monouso per la stanza singola/box di degenza e, al momento del trasferimento o della dimissione del paziente, smaltire ogni residuo di materiale inutilizzato e procedere con la sanificazione accurata del carrello (vedi paragrafo Gestione ambientale).

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Regione Lombardia - Giunta
DIREZIONE GENERALE WELFARE
PREVENZIONE

Piazza Città di Lombardia n.1
20124 Milano
Tel 02 6765.1

welfare@pec.regione.lombardia.it

GESTIONE DEL CASO

- Prevedere in ogni caso una assistenza con personale dedicato e auspicabilmente con rapporto infermieristico/assistenziale di 1:1 (l'operatore individuato dovrà effettuare l'assistenza esclusivamente sul caso per tutta la durata del turno), in particolare nei setting di cure intensive.

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Regione Lombardia - Giunta
DIREZIONE GENERALE WELFARE
PREVENZIONE

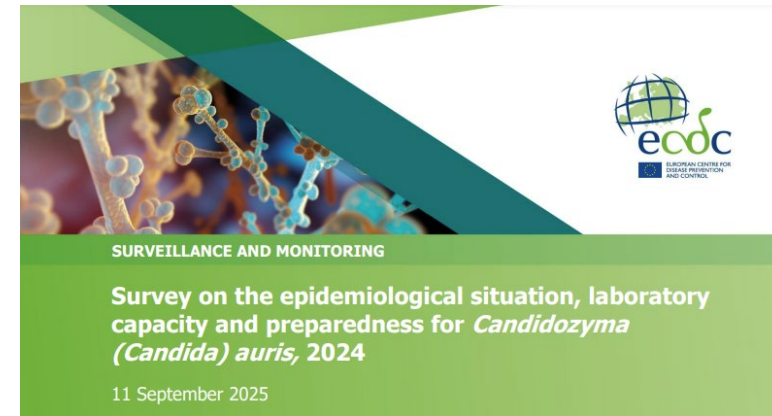
Piazza Città di Lombardia n.1
20124 Milano
Tel 02 6765.1

welfare@pec.regione.lombardia.it

L'operatore individuato dovrà inoltre vigilare sull'applicazione delle misure di IPC da parte di tutti gli eventuali altri operatori necessari per la gestione clinico-assistenziale del caso. Si raccomanda alla Direzione Sanitaria di garantire le condizioni organizzative di reparto necessarie per tale gestione.

- Prevedere il raggruppamento, per quanto possibile, di tutte le attività clinico-assistenziali sul paziente onde evitare accessi frequenti alla stanza singola/box di degenza e aumentare così il rischio di diffusione del microrganismo.

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Preparedness

Country	Mandatory notification	Mycology reference laboratory / reference function	Provision of reference testing to hospital laboratories	Guidance for laboratory testing	Guidance for clinical management	Guidance for infection control	National surveillance system
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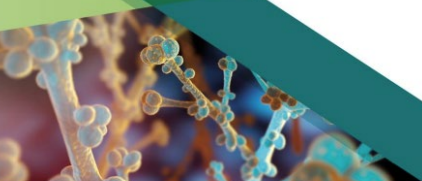


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Country	Mandatory notification	Mycology reference laboratory / reference function	Provision of reference testing to hospital laboratories	Guidance for laboratory testing	Guidance for clinical management	Guidance for infection control	National surveillance system
Austria	N	Y	Y	Y	N	Y	N
Belgium	Y	Y	Y	Y	Y	Y	Y
Bulgaria	N	Y	N	Y	Y	N	N
Croatia	N	Y	N	N	N	N	Y ^a
Cyprus	N	N	N	N	N	N	N
Czechia	N	Y	Y	Y	N	N	Y ^a
Denmark	Y	Y	Y	Y	Y	Y	Y ^b
Estonia	N	N	N	Y	N	N	N
Finland	N	Y	Y	Y	N	Y	Y ^c
France	N	Y	Y	Y	N	N	Y ^c
Germany	Y	Y	Y	Y	Y	Y	Y ^d
Greece	N	Y	Y	Y	Y	Y	Y ^c
Hungary	N	Y	Y	N	N	N	N
Iceland	Y	Y	Y	Y	N	N	Y ^c
Ireland	Y	N	N	N	N	N	Y ^c
Italy	Y	Y	Y	Y	Y	Y	Y ^b

Italy	Y	Y	Y	Y	Y	Y	Y	Y ^b
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Lithuania	N	Y	Y	Y	N	N	N
Luxembourg	Y	Y	Y	N	N	N	Y ^e
Malta	N	Y	N	N	Y	Y	NA
Netherlands	N	Y	Y	Y	N	Y	Y ^f
Norway	Y	Y	Y	Y	Y	N	Y ^b
Poland	Y	N	N	Y	N	N	Y ^g
Portugal	N	Y	Y	N	N	N	N
Romania	N	Y	N	Y	Y	Y	N
Slovakia	N	N	N	Y	N	Y	N
Slovenia	N	Y	Y	Y	Y	Y	N
Spain	N	Y	Y	Y	N	Y	N
Sweden	N	Y	Y	N	N	N	Y ^c
Bosnia and Herzegovina	N	Y	Y	N	N	N	N
Kosovo	N	Y	N	Y	N	Y	N
Montenegro	N	N	N	N	N	N	N
North Macedonia	N	N	N	N	N	N	N
Serbia	N	Y	Y	Y	N	N	Y ^h
Türkiye	N	Y	Y	Y	N	N	N
Total	9	29	23	24	11	15	17



SURVEILLANCE AND MONITORING

Survey on the epidemiological situation, laboratory capacity and preparedness for *Candidozyma (Candida) auris*, 2024

11 September 2025

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Key points:

Mortality Invasive candidiasis has a mortality rate of up to 30-40%, even in patients receiving antifungal treatment .There is currently limited information on the case-fatality rate specifically for invasive *C. auris* infections due to the small number of patients included in published case series or outbreak descriptions. A study published in 2013 reported case-fatality rates of 33% for all patients with *C. auris* bloodstream infections and of 57% for the subgroup of patients admitted to ICUs, but these rates might be attributable to the severity of underlying diseases in these patients .

Key points:

Findings from an outbreak in the US showed that, among patients with blood isolates of *C. auris*, the 30-day mortality rate was 39% and the 90-day mortality rate was 58% . In the UK outbreak, no fatality could be directly attributed to *C. auris* infection [12,38]. The mortality rate of *C. auris* bloodstream infections in neonates has been reported to be as high as 57%, but with decreasing rates in older children . However, as invasive *Candida* infections often occur in severely ill patients with multiple comorbidities, attributable mortality is difficult to determine

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Progetto PROSAFE

Popolazione complessiva (17 TI) - Anni 2020, 2021, 2022, 2023, 2024
Caratteristiche della popolazione all'ammissione - Pazienti candida auris

Pazienti (N): 20

Sesso	N	%
Maschio	13	65.0
Femmina	7	35.0
Missing	0	

Età (anni)	N	%
17-45	0	0.0
46-65	14	70.0
66-75	5	25.0
>75	1	5.0
Missing	0	
Media	61.0	
DS	7.6	

Degenza pre TI (giorni)	
Media	28.8
DS	50.1
Mediana	10.5
Q1 – Q3	1 – 31.5
Missing	0

Provenienza	N	%
Stesso ospedale	11	55.0
Altro ospedale	9	45.0
RSA/lungodegenza	0	0.0
Territorio	0	0.0
Missing	0	

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Esito TI	N	%
Deceduti	5	26.3
Trasferito nello stesso ospedale	13	68.4
Trasferito ad altro ospedale	1	5.3
Dimesso a casa	0	0.0
Dim. in cond. preterminali	0	0.0
Missing	1	

Trasferito a (N=14)	N	%
Reparto	9	64.3
Altra TI	2	14.3
Terapia subintensiva	0	0.0
Riabilitazione	1	7.1
Day hospital o RSA/lungodegenza	2	14.3
Missing	0	

Mortalità ospedaliera *	N	%
Vivi	10	58.8
Deceduti	7	41.2
Missing	2	

Timing mortalità osp. * (N=7)	N	%
In TI	5	71.4
Entro 24 ore post-TI	0	0.0
24-47 ore post-TI	0	0.0
48-71 ore post-TI	0	0.0
72-95 ore post-TI	0	0.0
Oltre 95 ore post-TI	2	28.6
Missing	0	

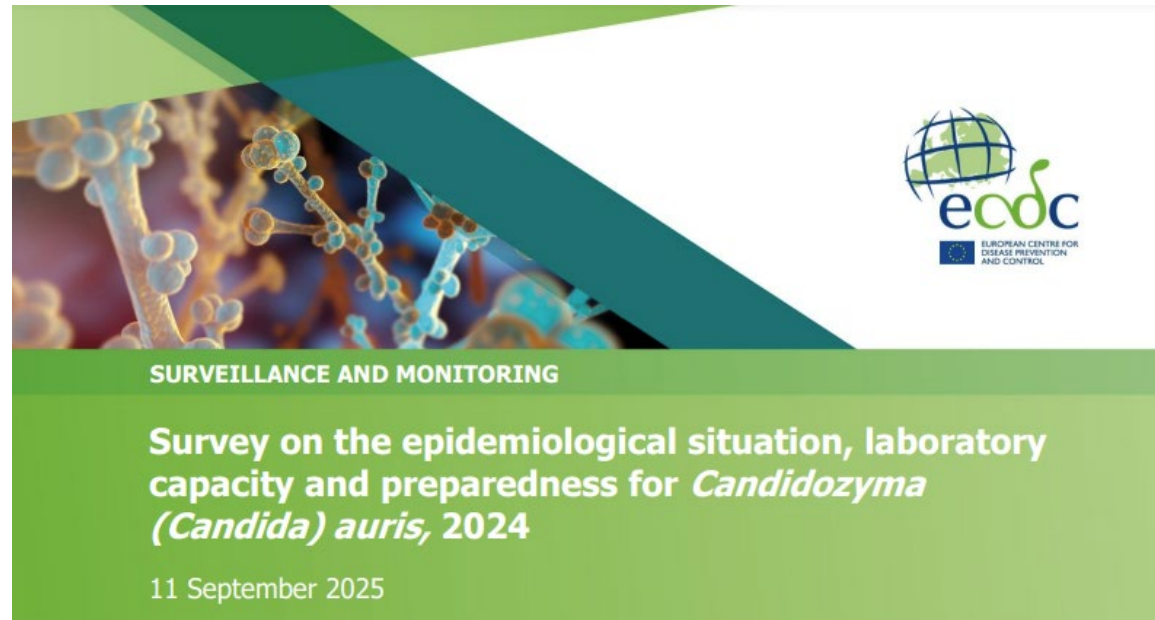
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Conclusions

However, there are also examples from EU/EEA countries where transmission of *C. auris* was successfully controlled and further spread prevented

Gaps in national preparedness for *C. auris* were still evident in the *C. auris* survey 2024.

National efforts for early detection and rapid implementation of IPC measures to contain or delay further spread of *C. auris* can still mitigate the impact on hospitalised patients in Europe.



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Spill-over effects:

Burden of C. Auris (not mortality but difficult to eradicate)

Knowledge (cultural approach, treatment, etc)

Preparedness (lab, equipment, logistic)

Innocent observer CIO

It is not an impossible mission