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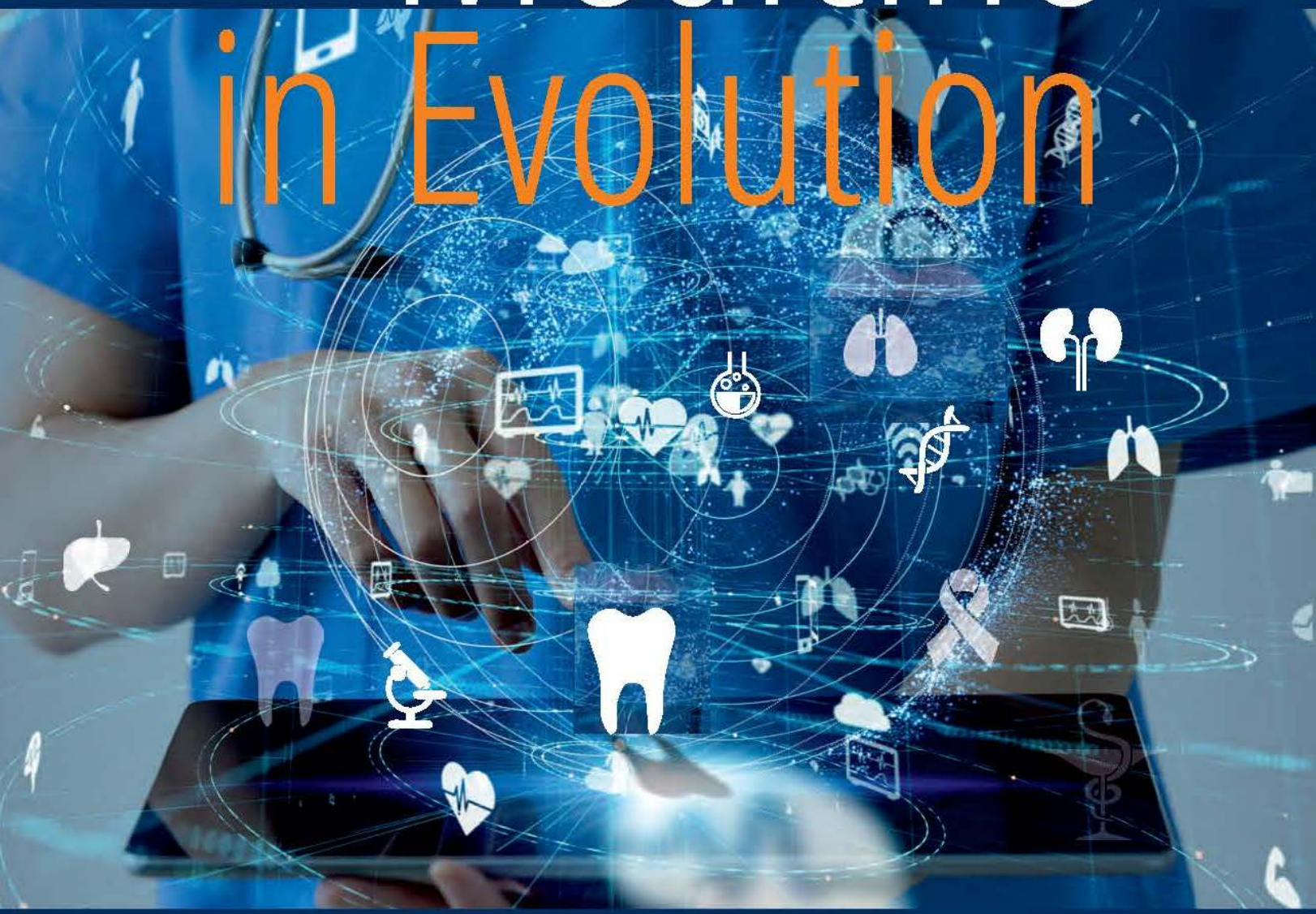

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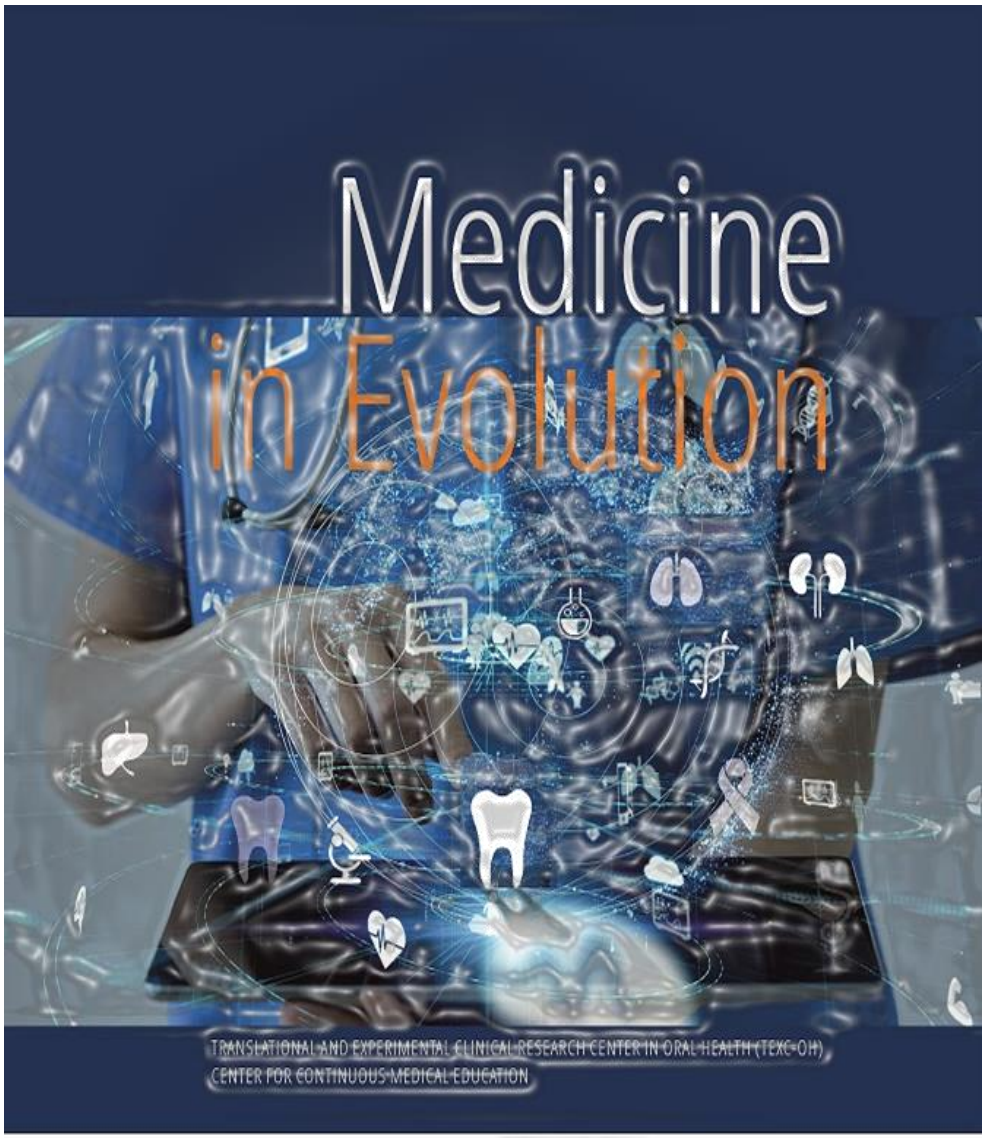

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National Conference of Infectious Diseases
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INTRODUCTION

We are pleased to present this ***Supplement to Volume XXXII, No. 1/2026*** *of the journal Medicine in Evolution, a special collection of scientific contributions dedicated to current challenges and advances in the field of infectious diseases, immunization, and antimicrobial therapies. This supplement brings together high-impact topics at the forefront of medical research and clinical practice.*

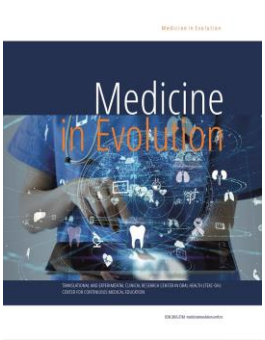
The thematic focus includes the persistent global challenge of HIV/AIDS, centered around a critical question: Can we stop the pandemic? Other articles explore the real-world difficulties encountered in the treatment of acute and chronic viral hepatitis, addressing both therapeutic barriers and innovative solutions. Vaccination is also prominently featured, with perspectives combining long-term experience and cutting-edge innovation. Furthermore, this supplement covers modern strategies in antibiotic, antiviral, and antifungal therapy, reflecting the ongoing need to combat resistance and improve therapeutic efficacy.

A dedicated ***Varia*** *section provides additional original contributions spanning a wide range of medical disciplines and interests.*

We gratefully acknowledge the leadership of ***Prof. Univ. Dr. Voichița Lăzureanu****, President of the Conference, whose commitment and expertise have been essential in curating this scientific endeavor. Our sincere appreciation also goes to* ***Prof. Univ. Dr. Adrian Streinu-Cercel****, Honorary President, whose remarkable contributions to infectious disease research and public health continue to inspire generations of medical professionals.*

We hope that this supplement will serve as a valuable resource for researchers, clinicians, and public health specialists, fostering dialogue and advancing knowledge in the pursuit of better health outcomes worldwide

Prof. Dr. Voichița Lăzureanu
Conference President



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ABSTRACTS

IMMUNOTHERAPY IN HIV INFECTION - CURRENT KNOWLEDGE AND FUTURE PERSPECTIVES

FLORENTINA DUMITRESCU[1,2]
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The AIDS epidemic has been a global public health issue for more than 40 years and has resulted in about 40 million deaths. Antiretroviral therapy (ART) transformed HIV infection from a fatal disease into a manageable chronic condition, prolonging survival and improving quality of life for people living with HIV. However, ART is not curative; immunotherapy in HIV infection represents a promising adjunct to ART, aiming to enhance host immune responses, control viral replication, and ultimately contribute to functional cure strategies. Unlike ART, which mainly directly targets viral enzymes, immunotherapeutic approaches focus on modulating the immune system to recognize and eliminate infected cells or to suppress viral persistence. Among the most advanced strategies are broadly neutralizing antibodies (bNAbs), which target conserved epitopes on the HIV envelope and have demonstrated the ability to transiently reduce viremia and delay viral rebound. Therapeutic vaccines are also under investigation, with the goal of inducing robust cellular and humoral immune responses capable of controlling infection in the absence of continuous ART. Additional approaches include immune checkpoint inhibitors to reverse T-cell exhaustion, cytokine therapies to enhance immune reconstitution, and cell-based therapies such as engineered T cells resistant to HIV infection. Strategies targeting viral latency, including "shock and kill" and "block and lock," are often combined with immunotherapy to address persistent reservoirs that remain a major barrier to cure. Despite significant progress, challenges such as viral diversity, immune escape, and limited durability of responses continue to hinder clinical success. Current evidence suggests that combination approaches integrating immunotherapy with ART and latency-targeting interventions may offer the greatest potential. Ongoing research is focused on improving efficacy, safety, and long-term outcomes, bringing the field closer to achieving sustained virologic remission or cure.

Keywords: HIV, antiretroviral therapy, immunotherapy

IMPLICATIONS OF BIOMARKERS IN THE MANAGEMENT OF SEPSIS

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Objectives

Sepsis remains one of the key challenges in acute care. Regardless the progress in early detection, the causative pathogen is still not identified in more than half of cases, often forcing clinicians to initiate broad spectrum empiric therapy. Globally, sepsis is estimated to account for approximatively 49 million cases each year an around 12 million deaths, underscoring its major public health impact. The accelerating spread of antimicrobial resistance further complicates management, narrowing effective treatment options and increasing the risk of an unfavorable outcomes in systemic infections scenarios.

Materials and Methods

Timely identification of sepsis is the central point for an effective management, due to early decisions regarding antimicrobial therapy, source control, and organ support often determine the clinical trajectory. Biomarkers can complement bedside assessment by providing rapid, objective signals of infection and host response, supporting earlier diagnosis, risk stratification, and more tailored therapeutic choices.

Results

Among currently available biomarkers at this moment, procalcitonin (PCT) remains one of the most clinically useful marker of bacterial infection, with higher levels frequently reported in Gram-negative bacteria sepsis. High elevated PCT and presepsin tend to cluster in septic shock and are more often seen in non-survivors than in survivors cohorts, suggesting potential prognostic relevance when interpreted within the clinical context.

Combining Myxovirus resistance protein A (MxA) with C-reactive protein (CRP) may help differentiate viral from bacterial etiologies, a distinction that is increasingly important for antimicrobial stewardship. Heparin-binding protein (HBP) has also been associated with earlier recognition of sepsis, while IL-10 appears to track severity and has been linked with clinical scoring systems such as NEWS. Other suggested biomarkers that may add value in selected settings include adrenomedullin (proADM), sTREM-1, CD64, HMGB1, and monocyte distribution width (MDW). Emerging approaches also emphasize combining biomarkers with validated clinical scores, like integrating qSOFA with suPAR.

Conclusions

No single biomarker can replace clinical judgment in sepsis. Biomarker-informed strategies can meaningfully sharpen early decision-making strategies. The most useful biomarkers are those that are rapid, reproducible, and cost-effective, and that correlate with severity and also with the outcomes. Biomarkers support earlier recognition, improve risk stratification, and help clinicians align therapy more closely with the most likely etiology and trajectory of illness.

Keywords: sepsis; biomarkers; prognosis; evolution; antimicrobial stewardship

INFLUENZA IN INFANTS TOO YOUNG FOR VACCINATION – A PREVENTABLE THREAT?

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Background/Aims:

Influenza, highly contagious viral respiratory infection with potentially severe course, especially in vulnerable categories of the population (elderly, pregnant women, people with comorbidities, obese people, infants and young children), can be effectively prevented through vaccination. Infants under 6 months of age are not eligible for vaccination, so they can be protected against influenza only through non-specific measures, mainly isolation. The aim of this study was to evaluate some epidemiological and clinical-evolutionary aspects of influenza infection in this vulnerable age group.

Methods:

Retrospective, observational study on influenza cases in infants under 6 months old, confirmed by rapid antigen test, admitted to the Clinical Hospital of Pneumology and Infectious Diseases in Brasov, Romania, in 3 consecutive influenza seasons (2022-2023, 2023-2024, 2024-2025).

Results:

During the mentioned period, 666 patients with influenza were hospitalized, of which 62.16% were children. Of these, 22.46% were infants, 10.87% infants under 6 months of age and 6.67% newborns. Urban origin (64.44% of cases) and influenza A virus infections (60% of cases) dominated; the median duration of hospitalization was 5 days. Fever (93.33%) and cough (73.33%) were the most common clinical signs and 37.78% of patients also had diarrheal stools. Pulmonary involvement was frequent, represented by viral (46.67%) and bacterial (20%) pneumonia, along with bronchiolitis (20%) and laryngo-tracheo-bronchitis (8.89%). Respiratory coinfections were identified in 24.44% of patients, bacterial (Haemophilus influenzae, Streptococcus pneumoniae) and viral (respiratory syncytial virus, adenovirus), in varying proportions. The etiological treatment was represented by antivirals (Oseltamivir), applied in 95.56% of cases and antibiotics for bacterial superinfections in 75.56% of children. The evolution was favorable in 95.56% of cases, with clinical worsening in only 2 children.

Conclusions:

The study highlights the vulnerability of young infants, who cannot be vaccinated, to influenza infection, with risk of serious and complex forms of the disease. This situation can be prevented by vaccinating people around these children and by applying appropriate hygiene standards.

Keywords: influenza, infants, vaccination

HIV-ASSOCIATED MALIGNANCIES: CURRENT CHALLENGES

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Objectives: People living with HIV are experiencing increased life expectancy due to more effective and better-tolerated antiretroviral therapy, along with a reduced risk of opportunistic diseases. Although the overall incidence of AIDS-defining malignancies among HIV-infected individuals has declined, a recent increase in non-AIDS-defining malignancies has been observed in this population.

Materials and Methods: The aim of this study was to evaluate data from HIV-infected patients who developed malignant tumors and were followed in the Infectious Diseases II Department, Timişoara, between January 2017 and December 2025.

A retrospective analysis was performed, assessing demographic characteristics, types of malignant tumors, presenting symptoms, laboratory findings, pathological diagnosis, clinical stage, CD4 cell count, and HIV RNA levels at the time of diagnosis.

Results: A total of 834 HIV-infected patients were included in the analysis. Of these, 29 patients (3.4%) were identified as having various HIV-associated malignancies and were receiving antiretroviral therapy (ART) at the time of cancer diagnosis.

The age group most commonly affected was 20–40 years, accounting for 62% of cases.

Among all malignancies, AIDS-defining cancers represented 28%, while non-AIDS-defining cancers accounted for the majority of cases (72%).

Kaposi sarcoma was the most frequently encountered AIDS-defining malignancy, identified in 31% of patients (9 cases).

The three most common non-AIDS-defining malignancies were Hodgkin lymphoma (24%), followed by colon cancer and breast cancer, each accounting for 10.3% of cases.

At the time of tumor diagnosis, patients with AIDS-defining malignancies more frequently presented with low CD4 cell counts (<200 cells/μL), whereas those with non-AIDS-defining malignancies generally had preserved CD4 counts (>350 cells/μL).

Conclusion: In this analysis, non-AIDS-defining malignancies were more frequent than AIDS-defining malignancies, likely reflecting the increased survival of HIV-positive patients. These findings underscore the importance of improving long-term management strategies, particularly cancer screening programs, in this vulnerable population.

Keywords: AIDS-defining malignancies; HIV; non-AIDS-defining malignancies; non-Hodgkin lymphoma

CHALLENGES IN EARLY HIV CARE: MORTALITY, LATE PRESENTATION, AND NUTRITIONAL EVOLUTION UNDER ART

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Objectives:

To determine mortality and the cascade of care among newly diagnosed HIV cases during the first year after diagnosis; to identify demographic, epidemiological, and clinico-immunological characteristics, as well as the impact of antiretroviral therapy (ART) on nutritional status in the first year following HIV diagnosis.

Material and Methods:

A retrospective, observational, non-interventional cohort study was conducted in the Day Care Department in Galați. Newly diagnosed HIV/AIDS cases between 01.01.2018 and 31.12.2024 were included. Evaluation was performed at baseline and at 48 weeks after diagnosis, or until death or loss to follow-up. Data analysed included demographic characteristics, risk factors, disease stage, co-infections, nutritional status (BMI), ART regimens, and outcome parameters (CD4 count, viral suppression, retention in care).

Results:

A total of 112 people living with HIV (PLWH) were included. In 48-week, the rate of retention in care was 96.42%, and the survival rate was 84.25%. Most patients were male (67%), with a mean age of 37 years; 71.4% were smokers, 51% reported alcohol consumption, and 35% used recreational drugs. Upon diagnosis, 49% (55) met AIDS criteria (the revised CDC classification), 70% were late presenters, and 23% were very late presenters. The main co-infections were HBV (19%), syphilis (10%), and HCV (3%). At HIV diagnosis, 16% of PLWH were underweight, 64.3% had normal weight, 17% were overweight, and 2.7% were obese. No cases of diabetes were identified; however, lipid abnormalities were observed: 20% hypertriglyceridemia, 30.6% total hypercholesterolemia, 36% elevated LDL, and 51% low HDL. ART was initiated in 90% of cases, with 89% maintaining the same regimen at 48 weeks. By week 48, 81% achieved viral suppression, with a mean CD4 count gain of 212 ± 191 cells/mm³. Weight evolution under ART was variable, with a mean increase of 1.5 ± 1.9 kg in the first year, without significant differences between treatment regimens.

Conclusions:

Retention in care and access to ART meet WHO targets within the cascade of care; however, viral suppression rates need improvement. Late diagnosis remains a major issue, contributing to early mortality. Nutritional and metabolic monitoring are essential to improving quality of life, the goal of HIV management.

Keywords: people living with HIV (PLWH), cascade of care, antiretroviral therapy (ART), nutritional status

INVASIVE CANDIDIASIS: CURRENT PERSPECTIVES ON DIAGNOSIS AND TREATMENT

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Objectives:

Invasive candidiasis (IC) is a major cause of morbidity and mortality in critically ill and immunocompromised patients. Early diagnosis remains challenging, and antifungal resistance is an emerging concern. This aims to summarize current perspectives on the diagnosis and management of invasive candidiasis, based on recent international guidelines.

Material and Methods:

This work is based on a narrative overview of current international guidelines and recent literature, focusing on diagnostic strategies and therapeutic recommendations for invasive candidiasis.

Results and Conclusions:

Diagnosis relies on clinical suspicion and risk factor assessment, supported by laboratory methods. Blood cultures remain the reference standard but have limited sensitivity. Non-culture-based assays, such as β-D-glucan and molecular techniques, can facilitate earlier detection. Echinocandins are recommended as first-line therapy, with step-down to fluconazole in stable patients with susceptible isolates. Source control and antifungal stewardship are essential. The emergence of resistant species, including Candida glabrata and Candida auris, highlights the need for ongoing surveillance.

Keywords: invasive candidiasis; Candida spp.; echinocandins; diagnosis; antifungal therapy; guidelines

FAMILIAL CLUSTER OF CHIKUNGUNYA VIRUS INFECTION FOLLOWING TRAVEL TO AN ENDEMIC AREA

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Background Chikungunya is an emerging arboviral infection transmitted by Aedes mosquitoes, classically characterized by fever, rash, and arthralgia. In the context of increasing global mobility, imported cases frequently occur in clusters, particularly in areas with elevated epidemiological risk, and may be associated with atypical manifestations, including hematological and cutaneous involvement.

Case Presentation We report the case of a 38-year-old male patient, with no significant past medical history, who was admitted to our clinic with fever, rash, and arthralgia, with symptom onset shortly after returning from a trip to the Seychelles islands.

Clinical examination revealed a febrile patient presenting with arthralgia and an erythematous maculopapular rash involving the trunk and extremities. Additionally, a purpuric plaque was observed on the left calf, with subsequent extension to the contralateral side.

Laboratory investigations demonstrated moderate leukopenia (2080/mm3, lymphopenia 600/mm3 and thrombocytopenia 93000/mm3, and a mild inflammatory syndrome. Multiplex PCR testing for tropical pathogens was positive for Chikungunya virus. Initial Chikungunya IgM serology was negative but became positive on day 10 of illness.

The patient reported multiple mosquito bites during travel. Notably, his wife and father, who had been exposed in the same area, developed similar symptoms and also required hospitalization.

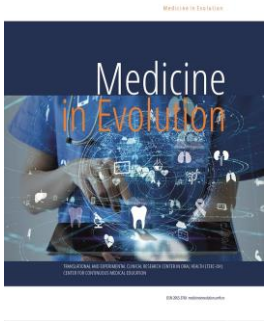
The clinical course under symptomatic treatment (antipyretics and analgesics) was favorable, with resolution of symptoms and improvement of laboratory parameters.

Conclusions This case highlights the importance of epidemiological context and molecular diagnostic methods in the early detection of Chikungunya virus infection, particularly in the initial phase when serology may be negative. It also underscores the variability of cutaneous manifestations, including purpuric lesions, as well as the risk of clustered transmission following shared exposure in endemic areas.

Pre-travel consultation remains essential for the prevention of potentially severe infections, especially in the setting of ongoing outbreaks, such as the one reported in the visited region, for which the CDC had issued a level 2 alert for Chikungunya.

Keywords: Chikungunya, purpuric rash, endemic area

SOLID ORGAN TRANSPLANTATION IN PEOPLE LIVING WITH HIV: FROM GLOBAL EVIDENCE TO REGIONAL REALITIES



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Background Solid organ transplantation in people living with HIV (PLH) has evolved into a standard and effective therapeutic option for carefully selected patients. In the modern ART era, both kidney and liver transplantation achieve favorable long-term patient and graft survival, particularly with the use of integrase inhibitors and, in HIV/HCV coinfection, direct-acting antivirals, which have significantly improved outcomes.

Results A recent meta-analysis confirms that kidney transplantation in PLH is feasible, although still associated with a higher risk of acute rejection and infections compared to HIV-negative recipients. Data from liver transplantation similarly show near-comparable long-term survival, especially in the post-DAA era. Importantly, transplantation from HIV-positive donors to HIV-positive recipients has proven safe and helps expand the donor pool.

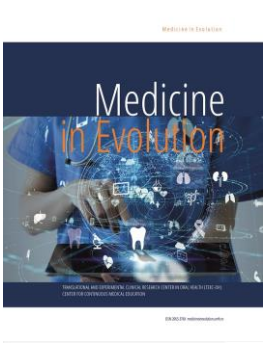
Findings from the latest studies on long-term outcomes further support these data, showing that overall patient survival is comparable between PLH and HIV-negative recipients, while acute rejection remains more frequent in PLH and represents a key determinant of graft outcomes.

In Central and Eastern Europe, access to transplantation remains uneven due to healthcare disparities and persistent stigma, limiting timely referral and eligibility. Notably, Romania has recently reported its first successful kidney transplant in a patient with HIV, highlighting. The first successful kidney transplant performed in a PLH in Romania demonstrated the growing regional capacity and the feasibility of the procedure under conditions of adequate virological control. However, it clearly highlighted that pharmacological management is the main determinant of post-transplant safety.

Conclusion Kidney and liver transplantation in PLH now offer outcomes close to the general population, but success depends on controlling rejection, optimizing ART, and improving access particularly in Central and Eastern Europe.Transplantation in PLH has moved from exception to standard of care. The future depends on equity of access and optimized management.

Keywords: Solid organ transplantation, PLH, kidney transplantation, liver transplantation

THE EVOLUTION OF TREATMENT OUTCOMES IN HIV LATE PRESENTER CASES



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Introduction: The human immunodeficiency virus is a public health concern due to the estimated 38.4 million HIV-positive individuals worldwide. It is the cause of acquired immunodeficiency syndrome. HIV infection causes and exacerbates many opportunistic infections, including tuberculosis (5.8% of new cases are among people living with HIV), cryptococcosis (prevalence of 4.4% in HIV-positive patients), Kaposi's sarcoma (24,500 new cases worldwide were attributable to HIV), and progressive multifocal leukoencephalopathy (prevalence of 4% in HIV-positive patients).

Material and methods: We conducted a retrospective clinical study of HIV/AIDS patients who were admitted to the "St. Parascheva" Clinical Hospital of Infectious Diseases in Iasi, Romania's northeastern area. To highlight the comorbidities of HIV/AIDS cases, we monitored the viro-immunological status in relation to patients' symptomatology. The investigation was conducted between January 1, 2016, and December 30, 2025.

Results: Of the 1,810 patients currently in the evidence, the Iasi Regional HIV/AIDS Center for clinical and viroimmunological investigation, 60.48% had an HIV infection diagnosis, and 39.52% had symptoms associated with AIDS. Men had a higher rate of HIV infection (59.81%). Mycobacterium TB infections (139 cases), Kaposi's sarcoma (12 cases), Cryptococcus neoformans infections (10 cases), and progressive multifocal leukoencephalopathy (10 cases) were the most prevalent AIDS-related illnesses. The most used antiretroviral regimens were based on integrase inhibitors and Nucleoside Reverse Transcriptase Inhibitors.

Conclusion: Managing HIV-related complications is fundamental to improving patient longevity and treatment success. Future efforts to improve the quality of life and prognosis for seropositive patients must focus on a multidisciplinary care model that addresses comorbidities through robust collaboration among medical specialties.

Keywords: HIV infection, opportunistic infections, pulmonary tuberculosis, Kaposi's sarcoma

CARBAPENEM-RESISTANT KLEBSIELLA PNEUMONIAE: A PREDICTOR OF ADVERSE CLINICAL OUTCOMES

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Objectives: Carbapenem-resistant Klebsiella pneumoniae(CRKP) has emerged as a major nosocomial threat because it is strongly linked to healthcare exposure, limited treatment options, and severe outcomes. We assessed determinants of colonisation, progression to CRE-associated sepsis, antimicrobial resistance patterns, and clinical outcomes among hospitalised adults with K. pneumoniae isolates.

Materials and methods: We performed a retrospective single-centre cohort analysis of consecutive adult admissions (January–July 2025) with at least one microbiologically confirmed K. pneumoniae isolate (clinical samples and/or surveillance rectal swabs). Isolates were classified as carbapenem-susceptible (CSKP), carbapenem-resistant (CRKP),ESBL-producing, or carbapenemase-producing (CAP-KP). Antimicrobial susceptibility testing was performed using routine EUCAST-based methods; carbapenemase detection was performed phenotypically, with selective molecular confirmation. Associations between clinical variables and resistance phenotypes were explored using group comparisons, correlation analysis, and multivariable logistic regression.

Results and conclusions: The cohort included 143 patients (56.0% male). Current colonisation was documented in 71/143 (49.7%), and colonisation within the previous three months in 47/143 (32.9%). CRE-associated sepsis occurred in 34/143 (23.8%) and was most frequent in CAP-KP (19/48, 39.6%; $p < 0.001$). Compared with CSKP/ESBL ($n = 62$), carbapenem-resistant phenotypes (CRKP/CAP-KP, $n = 81$) were significantly associated with current carriage (67.5% vs. 27.4%; OR 5.51), sepsis (36.3% vs. 8.1%; OR 6.52), ICU admission (77.5% vs. 43.5%; OR 4.46), prior antibiotic exposure within three months (65.0% vs. 37.1%; OR 3.15), non-active initial therapy (51.3% vs. 22.6%; OR 3.60), and delayed active therapy >72 h (40.0% vs. 22.6%; OR 2.28). In multivariable analysis, current colonisation (aOR 5.21), CRE-associated sepsis (aOR 6.33), ICU admission (aOR 4.12), invasive devices (aOR 3.74), recent hospitalisation ≤30 days (aOR 3.26), antibiotic exposure <3 months (aOR 2.89), and age ≥65 years (aOR 2.41) were independently associated with antimicrobial resistance. Overall in-hospital mortality was 10/143 (7.0%) and was higher in CRKP/CAP-KP than CSKP/ESBL (11.3% vs. 1.6%; $p = 0.02$).

In this high-risk hospital cohort, carbapenem resistance in K. pneumoniae was closely linked to colonisation status, ICU exposure, invasive devices, recent healthcare contact, and delayed effective therapy, with a measurable impact on sepsis and mortality. Strengthened surveillance, risk-adapted empirical strategies, and earlier initiation of active therapy are essential to mitigate CRKP burden.

Keywords: Klebsiella pneumoniae; carbapenem resistance; CRE colonisation; sepsis; ICU; antimicrobial stewardship; delayed active therapy; carbapenemase-producing Enterobacterales

EVALUATION OF THE VIROLOGICAL RESPONSE TO BULEVIRTIDE THERAPY IN A REAL-WORLD COHORT OF PATIENTS WITH CHRONIC HEPATITIS B + D

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Background and Aims

Chronic hepatitis D remains a severe disease associated with rapid progression and limited therapeutic options. The aim of this study was to evaluate the virological efficacy and safety profile of therapy in a real-world cohort of patients with chronic HBV + HDV infection.

Methods

Observational, single-center study conducted in an Infectious Diseases office in Craiova between 01.11.2025 and 31.03.2026, including 13 adult patients diagnosed with chronic hepatitis B + D, treated with bulevirtide ± nucleos(t)ide analogues.

Results

The cohort included 13 patients, aged 36–83 years. At baseline, all patients had detectable HDV RNA, and 10/13 (76.9%) presented moderate cytolysis. At week 48, 12/13 patients (92.3%) achieved virological response, while 7 patients (53.8%) showed normalization of transaminase levels. No adverse events were reported during treatment.

Conclusions

In this real-world cohort, bulevirtide therapy was associated with a high rate of virological response at week 48 and a favorable safety profile.

Keywords: Bulevirtide; Chronic hepatitis B + D; HDV RNA

RARE CAUSES OF BACTERIAL MENINGOENCEPHALITIS – BEYOND MOLECULAR BIOLOGY TECHNIQUES

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Introduction: Meningoencephalitis is a severe inflammatory condition of the central nervous system that constitutes a medical emergency, carrying a high risk of severe neurological complications and death in the absence of early, appropriate treatment. CSF PCR techniques represent a direct, rapid, and sensitive method for diagnosing the most common causative agents, but what happens when we are faced with pathogens much less commonly implicated in CNS infections? Below, we present a series of cases illustrating the importance of identifying the cause of bacterial meningitis for selecting the correct antibiotic treatment.

Contents:

1. A 76-year-old patient, admitted with a diagnosis of skin-origin sepsis caused by Staphylococcus aureus MSSA, underwent a lumbar puncture due to neurological symptoms and meningeal syndrome and was diagnosed with staphylococcal meningitis resulting from hematogenous spread; antibiotic therapy was switched to oxacillin.

2. A 42-year-old patient, recently discharged from the orthopedic department, was admitted to our department and diagnosed with meningoencephalitis caused by Streptococcus salivarius based on CSF cultures, most likely secondary to spinal anesthesia, with a slow but favorable course, though with persistent neurological sequelae and neurogenic bladder.

3. A 19-year-old female patient is transferred to our department for cerebral abscesses, with a positive bacteriological result from a cerebral puncture-biopsy for Streptococcus intermedius, most likely originating from orthodontic material, with a slow but favorable course under Ceftriaxone, but complicated by the onset of focal seizures and neurological deficits (partially corrected).

4. A 61-year-old female from a rural area, with a history of URTI 2 weeks prior, was admitted with a diagnosis of acute meningitis. Pharyngeal swab and CSF bacterial cultures were positive for Streptococcus equi, and a history of direct contact with horses and other domestic animals was confirmed. The course was complicated by the development of frontal cerebral empyema.

5. A 73-year-old patient, chronic alcohol user, is admitted for febrile syndrome and neurological symptoms (diplopia, vertigo), with a blood culture positive for Listeria monocytogenes. A lumbar puncture is performed, confirming decapitated meningoencephalitis, with negative multiplex PCR and bacterial cultures following antibiotic therapy. He is weaned off IV Ampicillin with a favorable outcome.

6. A 42-year-old patient with a recent history of fishing is admitted for acute febrile myoarthralgic syndrome. Leptospirosis is suspected and later confirmed by IgM serology; the patient develops severe headache, for which a lumbar puncture is performed, revealing findings suggestive of leptospirotic meningitis.

Conclusions: Multiplex PCR techniques on CSF are rapid and simple methods for determining the cause of meningoencephalitis; however, when dealing with specific causative agents (in an appropriate clinical and epidemiological context), traditional diagnostic methods (culture, serology, brain biopsy) are the ones that confirm the suspicion and allow for the de-escalation of antibiotic therapy.

HIV BEYOND CONTROLLING VIRAL LOAD: EVALUATION OF CARDIOVASCULAR RISK AND SUBCLINICAL MYOCARDIAL DISFUNCTION

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National Institute for Infectious Diseases "Prof. Dr. Matei Bals" Bucharest

Background and Objectives: The introduction of antiretroviral therapy (ART) has significantly increased life expectancy in people living with HIV. However, they face a growing burden of cardiovascular disease (CVD), driven not only by traditional risk factors but also by HIV and ART related specific mechanisms. In this study we aimed to assess the risk of CVD in our cohort of HIV-infected patients and to assess the need for lipid-lowering therapy according to current guidelines. The secondary objective was to assess the patient characteristics associated with subclinical left ventricular dysfunction, using the speckle tracking echocardiography (STE) in HIV-infected patients on ART.

Materials and Methods: We conducted a cross-sectional study including HIV-infected patients in our tertiary care HIV department in 2025. We collected demographic, clinical, and cardiovascular data, along with ART history and laboratory parameters.

In a secondary analysis, we evaluated subclinical myocardial function using STE, considering a normal global longitudinal strain (GLS) as values above −18 in a population of 30 patients on ART without clinically manifest CVD. STE was performed in 2019. A comparative analysis was subsequently performed to identify factors associated with subclinical myocardial dysfunction.

Results: A total of 241 patients on ART were included, of whom 169 (70%) were male, median age was 44 (37, 52) years. The median duration since diagnosis was 11 (8, 16.5) years, with a median CD4 nadir of 140 (40, 305) cells/mm³; 191 (80.3%) patients had undetectable viremia. Disease stages were distributed as follows: 58 (24.3%), 44 (18.4%), 137 (57.3%) in stage A, B and C respectively. Regarding ART regimens, the third agent consisted of an integrase inhibitor in 176 (75%), a non-nucleoside reverse transcriptase inhibitor in 55 (23%), and a protease inhibitor (PI) in 5 (2%) of patients. CVD risk factors included smoking in 91 (63.2%) patients, dyslipidemia in 144 (66%), hypertension in 61 (25.3%), obesity in 45 (20%), diabetes mellitus in 12 (5.2%), and a personal or family history of CVD in 35 (14.7%). Lipid-lowering, antihypertensive, and antiplatelet therapies were prescribed in 43 (19%), 31 (13.5%), and 10 (7.7%) patients respectively, while 162 (67%) met criteria for statin therapy according to the latest ESC recommendations (HIV infection in patients older than 40 years).

STE analysis was performed in 30 patients, revealing normal GLS values in 18 (60%) and abnormal values in 12 (40%). Comparative STE analysis indicated that subclinical myocardial dysfunction was more frequent in male sex (83% vs 78%, p=0.7), patients older than 40 years (41% vs 11%, p=0.05), patients with longer duration of HIV infection (6 vs 4.5 years, p=0.8), extended exposure to PIs (60 vs 48 months, p=0.4), and the use of PIs as the third ART agent (75% vs 50%, p=0.2).

Conclusions: A considerable proportion of HIV-infected patients exhibit multiple cardiovascular risk factors, and many meet criteria for statin therapy based on updated ESC recommendations. Speckle-tracking echocardiography represents a valuable adjunctive tool for the early detection of subclinical myocardial dysfunction in this population. These findings underscore the importance of cardiovascular risk assessment and an individualized approach when selecting or modifying antiretroviral regimens.

Keywords: HIV infection, antiretroviral therapy, cardiovascular risk, speckle tracking

THERAPEUTIC MANAGEMENT OF ACUTE SPONDYLODISCITIS: CLINICAL EXPERIENCE FROM A MOINESTI INFECTIOUS DISEASES DEPARTMENT

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Moinesti Municipal Emergency Clinical Hospital

Introduction

The present study aims to highlight several important general and specific aspects regarding the therapeutic management of acute spondylodiscitis, taking into account both national and international treatment protocols, as well as the clinical experience of the attending physician.

Materials and Methods

This study represents a retrospective analysis of cases diagnosed and treated in the Infectious Diseases Department of the Municipal Emergency Clinical Hospital Moineşti between 2022 and 2026.

A total of 20 patients were included in the analysis. Two cases are presented in detail, one diagnosed in 2022 and another in 2025.

In all cases, antibiotic therapy was administered for a minimum duration of 8 weeks, either during hospitalization or as oral outpatient treatment. Imaging follow-up was performed at monthly intervals, and antibiotic therapy was discontinued only after radiological remission of the lesions was documented.

One of the 20 patients presented with significant comorbidities, including chronic liver failure, ascites, dilated cardiomyopathy, anemia, and lower limb edema. The patient was admitted with a severe motor deficit, lesions involving all lumbar vertebral levels, psoas abscesses, and septic status. After a slight initial improvement following three weeks of treatment, the patient developed clinical decompensation secondary to underlying chronic cardiac, pulmonary, and hepatic disease, which ultimately resulted in death.

The remaining 19 patients completed treatment successfully. Management included dual antibiotic therapy, combined with probiotic therapy (oral Enterol or Enterolactis formulations), gastric protection with agents other than proton pump inhibitors (omeprazole/pantoprazole), hepatoprotective agents, vitamin supplementation, anti-inflammatory medication, muscle relaxants from the diazepam class administered intramuscularly, physiotherapy, and spinal immobilization. Immobilization was recommended in patients presenting with severe pain or risk of vertebral instability. Chronic treatments were continued or adjusted as clinically indicated.

Antibiotic dosing was individualized based on creatinine clearance, hepatic function, and antibiotic tissue penetration. Inflammatory markers, as well as renal and hepatic function, were closely monitored every 48–72 hours in hospitalized patients and every 14 days in those receiving outpatient oral therapy. Imaging follow-up was performed monthly using contrast-enhanced magnetic resonance imaging (MRI).

After completion of treatment and documented recovery, clinical and laboratory follow-up evaluations were conducted at 1 month, 6 months, and 1 year.

Results and Conclusions

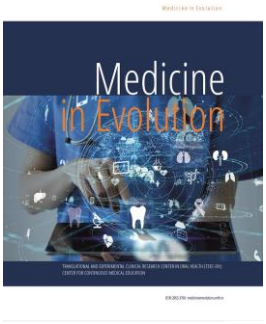
The overall mortality rate among the 20 patients was 5%.

In 95% of cases, the clinical outcome was favorable, with no relapses observed after completion of therapy.

The incidence of Clostridioides difficile pseudomembranous colitis was 0%.

Appropriate selection and combination of dual antibiotic therapy are essential, and antibiotic dosages should be adjusted according to bone tissue penetration and antibiogram results when the etiological agent is identified, even if empirical therapy was initiated initially.

MICROBIOTA – IMPLICATIONS IN INFECTIOUS PATHOLOGY



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Introduction:

Understanding the interactions between microorganisms, between microorganisms and the host, as well as the structural and compositional changes of the microbiota resulting from the inflammatory response, opens new therapeutic and behavioral directions.

Material and Method:

Published studies investigating changes in the gut microbiota and their role in the pathophysiology of infectious diseases were analyzed, using keywords such as dysbiosis and infection on specialized scientific platforms (PubMed, Google Scholar, Scopus).

Results:

The microbiota contributes to the regulation of immune mechanisms by inhibiting microbial colonization, through competitive mechanisms, and by stimulating the immune response. Pathogens can induce dysbiosis, promoting the progression of the underlying disease by blocking defense mechanisms. Advances in scientific research have demonstrated that the microbiota may influence susceptibility to infection – we will present the latest data from the literature regarding cutaneous streptococcal infections (erysipelas), diabetic foot, Lyme disease, recurrent candidiasis, and HIV infection.

Conclusions:

A detailed analysis of microbiota alterations in patients with infectious and communicable diseases may represent a starting point for identifying medical barriers that limit the implementation of effective therapeutic measures, with the aim of providing higher-quality patient care.

Keywords: microbiome, infection, dysbiosis, analysis

OPPORTUNISTIC INFECTION IN AN HIV LATE PRESENTER – A "FORGOTTEN" DISEASE OR A THERAPEUTIC CHALLENGE?

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Introduction: In the era of effective therapies and rapid testing, opportunistic infections in HIV late presenters remain a major therapeutic challenge. In this context, cerebral toxoplasmosis emerges as a severe and difficult-to-manage condition, substantially impacting prognosis and quality of life, leading to complex neurological presentations and requiring prompt, multidisciplinary therapeutic management.

Materials and methods: We present the clinical case of a 52-year-old female social worker, with no significant medical history, from an urban area, who presented to the Emergency Department of Vulcan complaining of headache, fever, vertigo, marked asthenia, followed by a syncopal episode and acute respiratory failure. During hospitalization at Vulcan Hospital (09.03–17.03.2026) she underwent clinical, laboratory and imaging evaluations and was tested for HIV, with a positive result. Persistence of symptoms and neurological deterioration prompted transfer to our clinic on 17.03.2026.

Results: At Victor Babeș Hospital (17.03–30.03.2026) the patient underwent clinical and laboratory evaluation, with severe immunosuppression: CD4 = 18 cells/µL and HIV-1 RNA = 741,310 copies/mL. Serological tests for opportunistic infections were performed. Chest radiography showed diffuse interstitial pneumonia. Because of persistent neurological symptoms, brain MRI with contrast was performed and demonstrated multiple supra- and infratentorial lesions with central necrosis and perilesional edema, predominantly in the left occipital white matter – findings suggestive of atypical cerebral toxoplasmosis. Clinical course was unfavorable, resulting in the patient's death despite initiation of specific therapy.

Conclusions: This case illustrates the consequences of delayed diagnosis in an HIV patient, resulting in fatal outcome despite specific therapy. Lack of insurance and limited access to early testing increase the risk of late presentation and opportunistic complications such as cerebral toxoplasmosis. Development and expansion of free testing centers and community medical outreach caravans are essential, as early detection substantially reduces morbidity and mortality.

Keywords: cerebral toxoplasmosis, HIV, opportunistic infections, brain MRI

Q FEVER – A DIAGNOSTIC PITFALL IN PROLONGED FEBRILE SYNDROMES

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Objectives:

Diagnostic challenges of a low-frequency zoonosis- Q fever. In Romania, this condition is likely underdiagnosed due to nonspecific symptomatology and limited number of reported cases. Recent data suggest an increasing trend in diagnosed cases over the past decade, particularly among patients aged 55–64 years.

Materials and methods

Retrospective analysis of a clinical case demonstrating the progression and features of Coxiella Burnetii infection.

Results

A 63-year-old female patient presented on the sixth day of illness for evaluation of a prolonged febrile syndrome, associated with chills, profuse sweating, and a persistent irritative cough. She had multiple prior visits to emergency services due to the recurrence of the previously described clinical picture. Clinical, laboratory, and imaging investigations revealed a nonspecific inflammatory syndrome and a diffuse bilateral interstitial pattern on chest imaging, in the context of prior treatment with oral Amoxicillin/ Clavulanic Acid.

To clarify the complex differential diagnosis, additional imaging investigations were performed, including chest CT. Definitive diagnosis was established through serological testing, which revealed the presence of anti-Coxiella Burnetii Ig M antibodies with increasing titers over time. The patient was treated with doxycycline according to protocol, resulting in symptom remission.

This case underscores the importance of follow-up for early diagnosis and reduction of the risk of complications, including hepatic and cardiac involvement – particularly valvular endocarditis and osteomyelitis.

Conclusions

The case highlights the necessity of integrating epidemiological data, clinical manifestations, and paraclinical investigations, emphasizing the diagnostic challenges of Coxiella Burnetii infection. A thorough differential diagnosis and a systematic clinical approach are crucial for the early identification of Q fever cases and the prevention of potential complications.

Keywords: Coxiella Burnetii, Q fever, febrile syndrom

POSTER SESSION

NECROTIZING FASCITIS – A SEVERE MEDICAL AND SURGICAL EMERGENCY

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Objectives: A medical and surgical emergency, necrotizing fasciitis is a polymicrobial infection with a high mortality rate. It is characterized by the development of tissue necrosis in the soft tissues and fascia due to the release of toxins and enzymes, which lead to tissue ischemia and vascular occlusion. Three types of fasciitis have been identified, as follows: type I polymicrobial, type II caused by Streptococcus pyogenes ± SAH, and type III caused by the Vibrio species.

Material and methods: We present two cases of necrotizing fasciitis admitted between 2024 and 2025 in Infectious Diseases Clinic, caused by skin ulcerations.

Results and conclusions: The first case was an 82-year-old diabetic patient with a varicose ulcer on the left calf who was admitted to the Emergency Department of the Academic Emergency Hospital Sibiu due to high fever and a patch of erythema on the left calf, with hemorrhagic and bullous changes. Bacteriological samples taken from the ulcerations and blood cultures isolated Escherichia coli with susceptibility to the antibiotics tested. Paraclinically, a marked inflammatory syndrome was observed, with procalcitonin levels of 44.21 ng/mL and deterioration of renal function; the patient's condition gradually worsened, leading to death within 48 hours of admission. The second case involved a 65-year-old female patient with diabetes and Alzheimer's disease, referred from the Psychiatric Hospital. She presented with fever, hemodynamic instability, and ulcerations on her calves and foot soles, some of which had developed into bullous or necrotic-hemorrhagic lesions. Bacteriological samples of the ulcerations and blood cultures revealed Staphylococcus aureus (MRSA), MLSBI, and Streptococcus pyogenes. The skin lesions evolved unfavorably, with the areas of necrosis spreading to the lower extremities and new areas appearing on the nasal pyramid. The patient developed multiple organ failure and died after 25 days of hospitalization.

Consequently, the complexity of cases of necrotizing fasciitis and their fulminant evolution highlight the importance of multidisciplinary team management.

Keywords: necrotizing fasciitis, Streptococcus pyogenes, SAH, E. coli, exitus

LYMPH NODE AND PULMONARY TUBERCULOSIS – DIAGNOSTIC CHALLENGES IN AN HIV-INFECTED PATIENT

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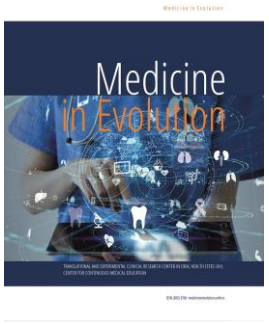
Case presentation. We present the case of an 11-year-old female patient, diagnosed with HIV infection in 2014, born to an HIV-positive mother with an unmonitored pregnancy (with antiretroviral treatment interrupted during pregnancy). She was brought in February 2026 to the Emergency Department of the "Victor Babeş" Hospital in Craiova for painful bilateral parotid tumor formations, bilateral laterocervical lymphadenopathy, bilateral otalgia, dysphagia, dysphonia, and occasional cough.

Biological investigations are performed (CD4 = 230 cells/mm³, HIV viral load = 7,277 copies/mL, PPD skin test – negative, sputum microbiological examination for Mycobacterium tuberculosis – negative) along with imaging studies: a computed tomography (CT) scan of the neck reveals circumferential thickening at the level of the nasopharynx and oropharynx with narrowing of the lumen, enlarged parotid glands with heterogeneous structure and contrast enhancement, multiple intralesional hypodense, non-enhancing areas with fluid and parafluid densities, as well as submental and bilateral submandibular lymphadenopathy. A chest CT scan identifies disseminated nodular, round-to-oval lesions in both lung fields, some with fluid densities, the largest located in the right upper lobe, as well as bilateral homogeneous axillary lymphadenopathy and subcentimetric mediastinal lymph nodes. The patient is transferred to the Pediatric Surgery and Orthopedics Clinic of the County Emergency Clinical Hospital Craiova, where a biopsy is performed on the left laterocervical lymph node conglomerate. Histopathological examination of the resected specimen reveals a microscopic structure with a cystic wall lined by non-keratinized stratified squamous epithelium, with lymphocytic infiltration, suggestive of a lymphoepithelial cyst. Although the histopathological findings were not suggestive of lymph node tuberculosis, initiation of anti-tuberculous therapy was decided, with antiretroviral therapy (ART) started two weeks after the anti-tuberculous treatment. The patient's clinical course was favorable.

Conclusions: In the context of HIV infection, severe immunosuppression may lead to false-negative results in tuberculosis-specific diagnostic tests. Nevertheless, the favorable clinical evolution under specific anti-tuberculous therapy supports the importance of early treatment initiation in cases with high suspicion, even in the absence of laboratory confirmation, highlighting the essential role of clinical judgment in the management of these patients.

Keywords: HIV, antiretroviral therapy, tuberculosis

CHEST PAIN ASSOCIATED WITH FEVER – PNEUMONIA OR ATYPICAL SEPSIS?



BOSOANCA CRISTINA ANA-MARIA[1], LAZUREANU ELENA-VOICHIȚA[1,2], NOVACESCU TALIDA[1,2], HERLO ALEXANDRA[1,2], GRADIȘTEAN IOANA[2], SAIZU ANDRA[1,2], BRINDESCU LAURA[1], MARINESCU ADELINA-RALUCA[1,2]

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Objectives: Clinically, severe infections can have polymorphic presentations, with multisystemic involvement and rapid progression to complications. The aim of this paper is to highlight the clinical, imaging, and evolutionary particularities of a case of acute pyelonephritis complicated by retroperitoneal extension and pleuro-pulmonary involvement.

Materials and methods: We present the case of a 73-year-old male patient, admitted to our clinic within the Victor Babeș Clinical Hospital of Infectious Diseases and Pneumophthisiology Timișoara, between 27.02-06.03.2026. The patient, with no known significant past medical history, presented with a febrile syndrome associated with chest pain, chills, sweating, and fatigue, symptoms that had appeared approximately 2 days prior.

Upon admission, the patient was hemodynamically stable, with a relatively good general condition and peripheral oxygen saturation within normal limits (BP=124/64 mmHg, HR=88 bpm, SpO2=96% on room air), without cough or obvious respiratory symptoms.

The clinical examination revealed vesicular breath sounds present, but abolished in the left hemithorax. The patient had an asthenic constitution and negative costovertebral angle tenderness (Giordano's sign) bilaterally.

Biologically, a marked inflammatory syndrome was highlighted, characterized by leukocytosis with neutrophilia and elevated values of C-reactive protein and procalcitonin.

To identify the infectious focus, multiple imaging investigations were performed. The chest X-ray revealed a right perihilar and infrahilar opacity associated with increased interstitial markings, in addition to a left the pleural effusion. The abdominal ultrasound examination revealed kidneys with a lobulated contour bilaterally, and in the right kidney, an irregular cystic formation of approximately 1.5 cm with calcified content (without posterior acoustic shadowing) was identified, located in the mid-renal cortex. Given these findings, a Uro-CT scan was indicated, which revealed the presence of a left staghorn calculus, associated with multiple foci of acute pyelonephritis complicated by multiloculated abscesses (renal, retroperitoneal, and within the psoas muscle), as well as bilateral pleural fluid collections, significantly larger on the left side with compressive atelectasis.

Broad-spectrum antibiotic therapy and supportive treatment were initiated, with an initially favorable evolution, the patient being subsequently transferred to the urology clinic for surgical treatment.

Results and conclusion: The case illustrates a severe infection of renal origin complicated by loco-regional and systemic extension. The particularity of the case consists in the extensive dissemination of the infection, with a discrepancy between the biological severity and the clinical status, highlighting the importance of early diagnosis and multidisciplinary management.

Keywords: sepsis, acute pyelonephritis, staghorn calculus, retroperitoneal abscess, pleural effusion

PLASMODIUM VIVAX MALARIA: HOW MANY RELAPSES ARE TOO MANY?

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Introduction: Malaria is an infectious parasitic disease caused by protozoa of the genus Plasmodium, transmitted to humans through the bite of female Anopheles mosquitoes, requiring rapid diagnosis and antimalarial treatment initiated as early as possible to prevent progression to severe forms. Plasmodium vivax produces latent forms in the liver called hypnozoites, which can reactivate long after the acute episode, causing relapses of malaria in the absence of secondary prophylaxis.

Abstract: We present the case of a 42-year-old male air traffic controller with no personal medical history and no previous history of malaria, who returned from a 3-week trip that included Qatar (Doha) – Indonesia (Sorong, Waisai, Denpasar) – Philippines (El Nido, Cebu), without prior antimalarial chemoprophylaxis, and who reported multiple mosquito bites during the trip.

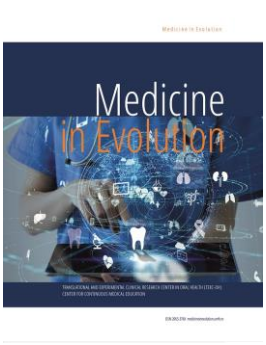
In December 2024, he was initially diagnosed with a mixed form of malaria, a co-infection of Plasmodium falciparum and Plasmodium vivax. Following the acute episode, which resolved with specific medication, G6PD enzyme activity was measured, and treatment with Primaquine was initiated for the prevention of relapses with Plasmodium vivax.

About one month later, he experienced a relapse of P. vivax (January 2025). Subsequently, two months later, he experienced a second relapse of P. vivax (March 2025), and after approximately four months, he developed a third relapse. All relapse episodes were managed with antimalarial treatment during the acute phase (Atovaquone/Proguanil and Doxycycline), with negative parasitological examinations of peripheral blood smears at discharge, followed by a 2-week course of Primaquine after each episode.

Throughout this period, the patient did not travel abroad, ruling out the possibility of reinfection with another Plasmodium vivax. Distinguishing between relapse and recrudescence remains difficult for some episodes of malaria caused by this species in the absence of molecular genotyping techniques.

Conclusions: Primaquine is the first-line antimalarial drug for the prevention of Plasmodium vivax relapses. Efficacy is not 100% and depends on the total cumulative dose, hepatic metabolism, susceptibility profile, and treatment adherence. Tafenoquine is a new treatment option for relapses, designed to address poor adherence to primaquine regimens through single-dose administration.

FROM VESICOURETERAL REFLUX TO SEPSIS - CASE PRESENTATION



BRÎNDESCU LAURA-ANAMARIA[1], LĂZUREANU ELENA-VOICHIȚA[1,2], SAIZU ANDRA[1,2], BOSOANCĂ CRISTINA ANA-MARIA[1], NOVĂCESCU TALIDA[1,2], HERLO ALEXANDRA[1,2], FLORUNCUȚ ANDREEA[1,2], GRĂDIȘTEAN IOANA[2], MĂCIUCEANU COSMIN[1], MARINESCU ADELINA-RALUCA[1,2]

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Objectives: Urinary tract infections in infants can rapidly progress to severe forms, including Sepsis, especially in the presence of underlying urological abnormalities. The purpose of this presentation is to highlight the importance of early evaluation and diagnosis, as well as prompt initiation of treatment, in order to prevent long-term complications.

Materials and Methods: We present the case of an 11-month-old infant admitted to Louis Țurcanu Children's Hospital in August 2025, with the diagnosis of Sepsis of unknown origin. The patient presented to the emergency department with digestive symptoms and high fever (40.1°C) and was subsequently hospitalized in our clinic between the 8th and 15th of December 2025.

Upon admission, the infant had a slightly altered general condition, decreased appetite, and mildly congested pharynx. Accelerated intestinal transit with loose stools without blood or mucus was noted.

Urination was present in diapers, with normal micturition.

Biological findings: marked inflammatory syndrome (CRP = 227.94 mg/L), leukocytosis with neutrophilia.

Secondary infectious foci (ENT, pulmonary, digestive) were excluded. Urinalysis and urine culture were difficult to obtain due to lack of patient cooperation, but were eventually collected on the third day after the initiation of antibiotic treatment. Abdominal ultrasound revealed ureterohydronephrosis.

Under the instituted antibiotic treatment, the patient's evolution was favorable. The patient was discharged after 7 days, with recommendation for a Pediatric Nephrology consultation, following which a voiding cystography was performed and bilateral vesicoureteral reflux was diagnosed.

Results and Conclusions: The presented case highlights an undiagnosed urological abnormality, namely vesicoureteral reflux, which favored the occurrence of recurrent urinary infections and progression to sepsis. Vesicoureteral reflux leads to retrograde urine flow, promoting bacterial colonization and renal inflammation. In the absence of identifying urinary tract abnormalities, imaging evaluation and initiation of therapeutic and prophylactic measures are essential, as recurrent episodes can lead to renal damage and even systemic complications.

Keywords: sepsis, vesicoureteral reflux, ureterohydronephrosis, infant

THE IMPORTANCE OF ANAMNESIS IN DIFFERENTIAL DIAGNOSIS: AN EMERGING INFECTION DURING THE INFLUENZA SEASON

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Objectives: Malaria remains a major health challenge, with Plasmodium falciparum accounting for most severe cases and deaths worldwide. Ongoing challenges, including antimalarial drug resistance and shifting epidemiology, highlight the importance of early diagnosis and timely initiation of appropriate therapy.

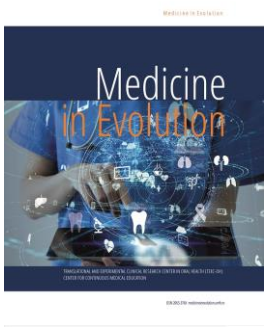
Material and methods: We report the case of a 32-year-old male, a native of Cameroon residing in Romania for the past 3 years, with no underlying health conditions, who received the influenza vaccine one day prior to the onset of symptoms, presented to our clinic with high fever, chills, headache, myalgias and nausea. He had traveled to his home country two weeks prior, without antimalarial chemoprophylaxis, with symptom onset on the last day of travel. An initial clinical diagnosis of presumed influenza with bacterial superinfection was made by the general practitioner, and home treatment with oseltamivir and azithromycin was prescribed. Due to persistent symptoms, he presented to our clinic two days later. Blood tests revealed lymphopenia, hyperbilirubinemia, mild thrombocytopenia and a marked inflammatory syndrome. A rapid diagnostic test was positive for Plasmodium falciparum-specific HRP2 antigen and negative for malarial pLDH antigen; however, peripheral blood smear and thick drop examinations were negative for parasitic elements on initial assessment. Repeat testing the following day confirmed Plasmodium falciparum on peripheral smear and thick drop, with a parasitemia of 0.01%. Dengue IgG was positive at admission, consistent with prior infection; subsequent serology showed Zika IgM-to-IgG seroconversion, while IgM positivity for Dengue and Chikungunya was likely due to cross-reactivity and was not confirmed on follow-up.

Results: The patient received antimalarial therapy with atovaquone/proguanil (250 mg/100 mg) 4 tablets once daily for 4 days along with oral doxycycline 100 mg twice daily for 7 days administered for its adjunctive effect and potential to enhance antimalarial efficacy. The patient had a favorable clinical outcome, with resolutions of symptoms, accompanied by improvement in inflammatory markers and persistent resolution of parasitemia. Mild neutropenia persisted even at 1-month follow-up, and a hematology consultation was recommended.

Conclusions: Symptom overlap during the influenza season may cause diagnostic confusion and result in misdiagnosis, particularly in regions without autochthonous malaria. Therefore, a detailed patient history, including travel history, is essential to avoid delays in establishing the correct diagnosis and initiating targeted etiological treatment. Furthermore, appropriate antimalarial chemoprophylaxis prior to travel to endemic areas remains crucial for prevention.

Keywords: Plasmodium falciparum, malaria, arbovirus infections, travel-related infection

PERSISTENT CEREBRAL TOXOPLASMOSIS IN A LATE-PRESENTER HIV PATIENT: LIMITS OF THERAPEUTIC RESPONSE



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Introduction: Cerebral toxoplasmosis is a frequent opportunistic infection in people living with human immunodeficiency virus (HIV), usually caused by the reactivation of a latent infection with the protozoon Toxoplasma gondii.

Objectives: To emphasize the risk of a prolonged course of cerebral toxoplasmosis in a severely immunocompromised patient, despite adequate treatment.

Material & Methods: Case report.

Results and conclusions: We present the case of a 50-year-old man with no significant past medical history with complaints of severe headache and pain in the left lower limb associated with sensory-motor deficit and gait disturbance of 3-week duration and progressively worsening. Physical exam reveals cachexia and monoplegia of the left lower limb with hypotonia, diminished deep tendon reflexes and tactile hypoesthesia. Brain imaging raises the possibility of cerebral toxoplasmosis, leading to a positive HIV-1 serology test and referral to our clinic. Laboratory data includes repeat serology and Western Blot positive for HIV-1, with a viral load of 77 100 copies/mL, CD4 lymphocyte count of 60/mm3, serum T. gondii IgM negative and IgG positive. A lumbar puncture is performed and analysis of extracted cerebrospinal fluid (CSF) shows proteinorachia of 86 mg/dL, HIV viral load of 104 600 copies/mL and polymerase chain reaction (PCR) positive for T. gondii DNA. The patient is classified as category C3. Other causes of cerebral lesions are considered: JC virus, cytomegalovirus and Mycobacterium tuberculosis PCR from CSF are negative. Antimicrobial treatment is initiated with trimethoprim-sulfamethoxazole (CTX) 80/400 mg tablets taken orally, two tablets thrice daily and clindamycin 600 mg capsules, one capsule four times a day. On the 11th day of admission, antiretroviral therapy with bictegravir/emtricitabine/tenofovir alafenamide is initiated. In this severely immunocompromised patient, the cerebral lesions had a slow regression, requiring a prolonged curative treatment of seven months. The patient is followed-up clinically and with contrast magnetic resonance imaging (MRI) at one, two, three, five and twelve months after discharge, with persistance of lesions one year after. Despite the persistance of imaging findings, after five months of antimicrobial treatment the neurologic deficits are completely resolved, walking is possible with ease and the CD4 lymphocyte count is 229/mm3. Lumbar puncture and CSF analysis are repeated, with PCR negative for T. gondii DNA. This prompts withdrawal of clindamycin and continuation of CTX for another two months, after which the dose is reduced to one tablet a day as prophylaxis. Afterwards, the patient's clinical course is favorable and the virological response is towards constant improvement. A year after discharge, contrast MRI reveals the persistance of multiple cortical and subcortical cerebral lesions located in the frontal, parietal and occipital lobes bilaterally, more numerous on the right, some with minimal calcifications, with two lesions enhanced by contrast: one located parasagittally on the right displaying fine, annular enhancement, the other located subcortically on the right with dimensions smaller than one millimeter. Usually, the cerebral lesions of toxoplasmosis quickly regress with antiparasitic treatment, but in severely immunocompromised patients the therapeutic response may be delayed or incomplete.

Keywords: cerebral toxoplasmosis, HIV infection, trimethoprim-sulfamethoxazole, clindamycin

ACTINOMYCOSIS AFTER RECTAL CANCER THERAPY: A CHALLENGING DIAGNOSTIC DILEMMA

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Objective: To identify the classical and particular features of actinomycosis in infectious diseases practice.

Material and Methods: Case report complemented by a review of the medical literature.

Results: We present the case of a 56-year-old patient with no significant past medical history, who presented with prolonged diarrheal syndrome associated with bloating. The tumor marker CEA was slightly elevated (2.84 ng/mL; upper normal limit 2.5 ng/mL). Following investigations, the patient was diagnosed histopathologically with rectal adenocarcinoma, stage cT3aN2M0. The patient underwent neoadjuvant radiochemotherapy followed by abdominoperineal resection with left iliac end colostomy. At postoperative follow-up, a tumor mass was palpated, and exploratory laparoscopy with adhesiolysis and cytoblock sampling was performed. Histopathological examination revealed amorphous eosinophilic material, inflammatory infiltrate without suspicious atypia, ulcerations of the rectal wall, abscesses, and transmural necrosis extending to the presacral fascia, as well as fibrous tissue containing Actinomyces colonies, without evidence of malignancy. The patient received specific antibiotic therapy for actinomycosis for 6 months, with favorable clinical evolution. Tests for Clostridioides difficile were negative, although the patient continued to present with soft stools. Follow-up imaging revealed a mixed collection with a fluid–parafluid level and gadolinium-enhancing walls, located in the rectal resection site, showing dimensional regression and suggestive of an abscess, which had not been previously identified. This finding requires surgical and oncological reevaluation, as well as consideration of prolonging antibiotic therapy. According to data from the medical literature, Actinomyces spp. are anaerobic or microaerophilic bacilli with slow growth, which are commensals of the oral cavity, gastrointestinal tract, and genital tract. They may become pathogenic following disruption and invasion of the mucosal barrier, leading to granulomatous inflammation, abscesses, fistulas, and pseudotumoral masses with a tendency for local invasion, often presenting with progressive and nonspecific clinical manifestations. Infection with Actinomyces spp. has no proven oncogenic potential; however, it can mimic a tumor mass, coexist with a neoplasm, or complicate it, as is possible in the present case, requiring prolonged antibiotic therapy and careful monitoring. Both rectal neoplasia and radio- and chemotherapy may promote the pathogenicity of actinomycetes.

Conclusions: Actinomyces spp. infection is rare, but a high index of clinical suspicion in oncologic patients is essential for prognosis.

Keywords: Actinomyces spp., rectal neoplasm, diarrhea

COULD PROBIOTICS BE THE MISSING PIECE IN CLOSTRIDIOIDES DIFFICILE INFECTION RECOVERY?

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Objectives: Clostridioides difficile infection (CDI) causes profound gut microbiome disruption that frequently persists beyond clinical resolution. Multi-strain probiotics have been proposed as adjunctive tools to support post-antibiotic microbiome rehabilitation, yet their impact on gut microbial composition in CDI convalescence remains poorly characterized.

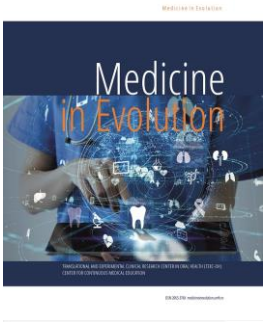
Material and Methods: Five adults with mild-to-moderate inaugural CDI were enrolled in a prospective pilot study in the Infectious Diseases II Clinic of "Victor Babeș" Clinical Hospital Timișoara, Romania, after completing standard antibiotic therapy (oral vancomycin 10–14 days). Following clinical resolution, all participants received a 30-day course of a 10-strain probiotic formulation, alongside general high-fiber dietary recommendations. Stool samples collected before (Day 0) and after supplementation (Day 30) were analysed via 16S rRNA gene sequencing, with inferred functional profiling and targeted screening for yeasts and enteric protozoa.

Results: At baseline, all patients exhibited severe dysbiosis, characterized by reduced microbial diversity, Actinobacteria depletion and Proteobacteria expansion. Following supplementation, four of five patients showed increased microbial diversity and partial dysbiosis indices improvement. Recovery trajectories were heterogeneous, with variable modifications of gut microbiome parameters. No CDI recurrences were observed at 30-day follow-up.

Conclusions: Multi-strain probiotic supplementation may support microbiome recovery during CDI convalescence. Because of limitations such as the small sample size (n=5), lack of a control group, inability to track followed dietary advice, the study's findings require extensive research to distinguish probiotic-specific effects from spontaneous post-antibiotic recovery.

Keywords: Clostridioides difficile infection; gut microbial diversity; multi-strain probiotic; 16S rRNA gene sequencing

ACUTE MENINGITIS WITH CLEAR CEREBROSPINAL FLUID – DIAGNOSTIC AND MANAGEMENT CHALLENGES



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Introduction: Meningitis represents a severe acute condition, considered a medical emergency, predominantly of infectious etiology, which can occasionally follow a fulminant course leading to death. Early diagnosis and the prompt initiation of appropriate etiologic therapy are essential for reducing mortality rates.

Objectives: Presentation of a clinical case of acute meningitis with clear cerebrospinal fluid (CSF) that raised etiological diagnosis and treatment challenges.

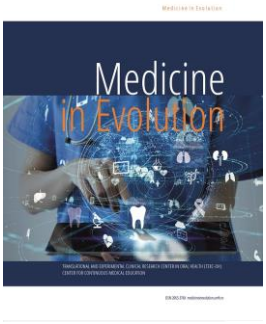
Material and methods: Analysis of medical information obtained from the medical record and the electronic database of the "Dr. Victor Babes" Clinical Hospital of Infectious Diseases and Pneumophthisiology, Craiova.

Results: A young 28-year-old male patient, British citizen, presented on March 26, 2026, to the Infectious Diseases Clinic - Adults 1 of our hospital, exhibiting fever, chills, emesis, photophobia, and headache. The epidemiological history evidenced that the patient had recently returned from his home country (England), raising initial suspicion of meningococcal meningitis, as he had traveled from an area with known outbreaks. Physical examination revealed a conscious, febrile patient with no visible skin rash (petechiae/purpura), but with a positive meningeal syndrome. Laboratory findings showed mildly elevated inflammatory markers. A head CT scan was performed, showing no structural abnormalities that would contraindicate a lumbar puncture. The lumbar puncture revealed clear CSF under slight hypertension, with a pleocytosis of 168 cells/mm³, the CSF smear showed no detectable microorganisms, 98% lymphocytes, 2% neutrophils, and protein levels were mildly elevated. CSF cultures and GeneXpert for Mycobacterium tuberculosis were negative. An Upper Respiratory PCR Panel was performed with detected Enterovirus. Following pathogenic and symptomatic treatment, the clinical progression was favorable. The patient requested discharge 48 hours after admission and declined a follow-up lumbar puncture for a CSF PCR panel (the kit was unavailable at the time of the initial procedure).

Conclusions: Cases of acute meningitis with clear CSF present significant challenges for positive and differential diagnosis, particularly in the current context of ongoing meningococcal meningitis in Europe.

Keywords: Meningitis, etiology, virus, CSF

NON-AIDS-DEFINING MALIGNANCY IN AN HIV-INFECTED PATIENT



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Introduction: With the widespread use of antiretroviral therapy, the life expectancy of HIV-positive patients has significantly improved, leading to an increased incidence of non-AIDS-defining malignancies, which have become an important cause of morbidity and mortality in this population.

Objectives: Presenting a case of an HIV-infected patient with low-grade appendiceal mucinous neoplasm, highlighting the importance of a multidisciplinary approach.

Material and methods: Assessment of clinical and paraclinical findings in a 36-year-old patient with HIV infection and low-grade appendiceal mucinous neoplasm, from Craiova Regional Centre.

Results: The patient was diagnosed with HIV infection in early childhood (parenteral transmission of HIV), with favorable clinical and immunovirological evolution under antiretroviral treatment. In January 2026, the patient was admitted in our clinic with a 4-day history of abdominal pain, abdominal distension, and loss of appetite. Physical examination revealed a distended abdomen and a palpable, firm, slightly mobile, non-tender mass located in the right flank/subcostal region. No peripheral lymphadenopathy was noted. Laboratory investigations showed normal hematological parameters and mild inflammatory syndrome (CRP 7.9 mg/L). Renal and liver function tests were within normal limits. Immunovirological evaluation revealed a CD4 count of 523 cells/mm³ and an undetectable HIV viral load. Abdominal ultrasound identified a well-defined, non-homogeneous tumor formation in the right subcostal region, without clear involvement of adjacent organs. CT imaging confirmed the presence of a large retroperitoneal mass. Subsequently, in January 2026, the patient was admitted to the Surgery Department, where complete surgical excision of the tumor was performed.

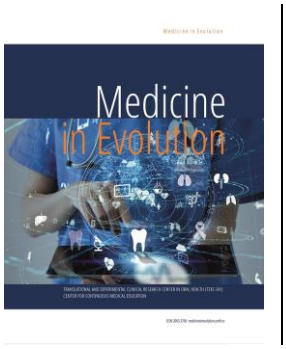
Histopathological examination of the resected specimen revealed a mucin-rich lesion with low cellularity, composed of mucinous epithelium without significant atypia, associated with microcalcifications and chronic inflammatory changes. Fragments consistent with appendiceal wall were identified, with focal invasion of acellular mucin into the muscular layer.

The final diagnosis was low-grade appendiceal mucinous neoplasm (LAMN), a tumor with intermediate malignant potential, staged as pTis. Following surgery, the patient was referred to the Oncology Department for further management and initiation of specific oncological therapy.

Conclusions: Careful multidisciplinary follow-up of HIV-infected patients, even in the context of effective virological control, is essential for the early detection of additional or unrelated pathologies.

Keywords: HIV, multidisciplinary, neoplasm

THE SILENT ENDEMIC: NAVIGATING THE TAXONOMIC SHIFT AND CLINICAL REALITIES OF CANDIDOZYMA (CANDIDA) AURIS IN ROMANIAN HOSPITALS



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Objectives: As of 2025, the pathogen formerly known as Candida auris—recently reclassified as Candidozyma auris—has transitioned from an emerging threat to an endemic pathogen within several European healthcare networks, including Romania. The primary objective of this study is to synthesize current epidemiological data and clinical challenges associated with this organism to provide an evidence-based "Readiness Protocol" for Romanian infectious disease units. This review aims to highlight diagnostic pitfalls, analyze regional resistance patterns, and establish clear criteria for proactive screening to prevent nosocomial outbreaks.

Material and Methods: A comprehensive literature review was performed using PubMed, Google Scholar, and the European Centre for Disease Prevention and Control (ECDC) databases, focusing on reports from 2022–2026. Data synthesis included the analysis of over 800 documented cases in Romania, focusing on the performance of automated biochemical identification systems (e.g., VITEK 2), antimicrobial susceptibility testing (AST) trends, and the efficacy of various environmental decontamination strategies. International guidelines from the WHO and CDC were adapted to the local healthcare infrastructure.

Results: The analysis reveals that Candidozyma auris is frequently misidentified by conventional laboratory methods as Candida haemulonii, C. famata, or C. sake, leading to delayed isolation and inappropriate therapy. In the Romanian landscape, the pathogen exhibits high-level resistance to fluconazole (>90%) and increasing resistance to amphotericin B (~40%). Romania is currently among the few EU nations with confirmed regional endemicity, with case numbers rising significantly since 2022. Unlike other Candida species, it demonstrates significant environmental persistence through biofilm formation, surviving on dry surfaces for over 14 days and resisting standard quaternary ammonium-based disinfectants. Mortality rates for invasive candidaemia in high-risk ICU cohorts remain alarmingly high, ranging between 30% and 60%. Genomic surveillance indicates that Clade I (South Asian) and Clade III (African) are the dominant lineages in Romania, both associated with high multidrug-resistance profiles, also these clades are particularly associated with large-scale hospital outbreaks.

Conclusions: Clinical vigilance is the cornerstone of managing this "Houdini of Fungi". It is no longer a question of if the pathogen will be encountered, but where it is currently circulating undetected. Successful management requires a three-pronged approach: 1) Proactive screening of high-risk patients via axilla and groin swabs; 2) Integration of MALDI-TOF MS for definitive identification; and 3) Implementation of strict contact precautions with chlorine-based environmental cleaning and first-line empiric use of echinocandins. This protocol serves as a critical roadmap for clinicians to intercept the pathogen before it establishes a permanent reservoir in the hospital environment.

Keywords: Candidozyma auris, Candida auris, Antimicrobial Resistance, Nosocomial Infection, Clinical Protocol, Romania

ERYTHEMA NODOSUM: A RARE CLINICAL MANIFESTATION OF BARTONELLA HENSELAE INFECTION

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Objectives: To identify the frequency of erythema nodosum associated with Bartonella henselae infection.

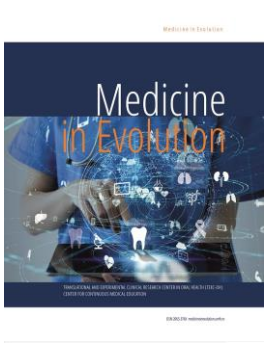
Material and Methods: Case report and review of the medical literature.

Results: A 39-year-old female patient, with no declared comorbidities, was clinically diagnosed with right axillary lymphadenitis, interpreted in an epidemiological context as cat scratch disease, with favorable evolution following doxycycline treatment. Over the next three weeks, the patient progressively developed fever, arthralgia, and painful, indurated, bilateral erythematous nodular lesions, predominantly on the lower limbs, characteristic of erythema nodosum (EN). HIV, hepatitis B, hepatitis C, syphilis, and pregnancy were excluded. The differential diagnosis considered and ruled out other causes of EN, including streptococcal and tuberculous infections, Mycoplasma pneumoniae, Yersinia enterocolitica, Campylobacter spp., Salmonella spp., fungal infections, drug-induced reactions, paraneoplastic syndromes, sarcoidosis, and Behçet's disease. Positive serology with elevated titers for Bartonella henselae (IgM >1/20; IgG 1/4096), suggestive of the convalescent phase, supports a causal relationship with EN. The clinical outcome was favorable following 21 days of clarithromycin therapy and corticosteroid treatment. According to the medical literature, Bartonella henselae are Gram-negative, intracellular bacteria responsible for a zoonosis with a wide clinical spectrum, ranging from asymptomatic infection to severe disease and death. Clinical manifestations may include fever, hepatitis, serositis, endocarditis, lymphadenopathy, uveitis, neuritis, as well as various dermatological manifestations. Erythema nodosum represents an inflammatory cutaneous reaction frequently associated with infections, but rarely reported in this etiological context. The frequency of EN following Bartonella henselae infection ranges between 0.4% and 3%, representing less than 1–3% of all EN cases. In the case series of the Clinical Hospital of Infectious Diseases Galaţi over the past 20 years, this is the only confirmed case with this association. Bartonella henselae exhibits endothelial tropism, explaining the systemic inflammatory response; however, vascular manifestations are the result of immune complex-mediated reactions rather than direct skin infection. Other rare dermatological manifestations of bartonellosis include purpura, vasculitis, maculopapular rash, urticaria, erythema marginatum, erythema multiforme, granuloma annulare, and angioproliferative granulomatous reactions.

Conclusions: Erythema nodosum is a rare clinical manifestation of Bartonella henselae infection. The etiological diagnosis is based on correlating clinical and epidemiological context and excluding other causes, requiring confirmation by laboratory testing.

Keywords: erythema nodosum, lymphadenitis, Bartonella henselae

CHALLENGES IN THE MANAGEMENT OF A RECURRENT CULTURE-NEGATIVE PROSTHETIC VALVE ENDOCARDITIS



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Objectives: Culture-negative prosthetic valve endocarditis accounts for a significant number of infectious endocarditis cases, and due to the inability to detect the etiological agent, it poses a great diagnostic and therapeutic challenge. The primary objective of this case report is to highlight those difficulties, focusing on two distinct episodes of clinical endocarditis, on a mechanical aortic valve prothesis, occurring in a young male patient, with a history of invasive dental procedures.

Material and methods: We present the case of a 40-years-old male patient, with a long-standing history of cardiovascular disease including a mechanical aortic valve replacement, at 15-years-old, mitral and tricuspid regurgitation and chronic anticoagulation therapy with Aenocumarol. Clinical data and laboratory findings including transthoracic and transesophageal echocardiographies and multiple sets of aerobic and anaerobic blood-cultures were collected during two separate admissions in April 2025 and January 2026, at the Infectious diseases Clinic, Mureş County Clinical Hospital.

Results: For the first admission the patient presented with a prolonged subfebrile state lasting for 3-4 months, following multiple dental extractions. The initial laboratory tests showed mild neutrophilia, elevated transaminases and LDH: 335U/L, with negative inflammatory markers and a blood-culture positive for Coagulase-negative Staphylococcus, interpreted as skin flora contamination. The echocardiography revealed a valvular mass on the posterior leaflet of the prosthetic aortic valve. The initial antibiotic treatment was Oxacillin and Gentamicin for 7 days, followed by Amoxicillin/Clavulanate for14 day, which led to clinical resolution.

The second episode occurred within a year, and the patient was readmitted with a similar subfebrile syndrome. Once again, despite active symptoms the inflammatory markers were mildly elevated (CRP: 7mg/L, HSR: 8mm/h) and 4 sets of blood-cultures remained negative. The transesophageal echocardiography was positive. The risk of MDR organisms was reevaluated and Vancomycin in association with Ceftriaxone was administered for 24 days. The patient was discharged in an improved general state and ecochardiographic resolution of the valvular mass.

Conclusions: This case demonstrates that even with negative blood-cultures, in a young patient with a mechanical aortic prothesis where dental procedures are the presumed entry point aggressive empirical antibiotic therapy is justified. The identification of the valvular mass on echocardiography was the key diagnostic element, in the absence of a microbiological confirmation. Tailoring the empirical antibiotic therapy to the clinical context, including MDR coverage with Vancomycin, led to favorable outcome with the resolution of the valvular mass without surgical intervention. Our case reinforces the importance of the multidisciplinary approach in infectious endocarditis, in both treatment and follow-up.

Keywords: prosthetic valve endocarditis, recurrent endocarditis, culture negative endocarditis

PERSISTENT KLEBSIELLA PNEUMONIAE BACTEREMIA DESPITE ADEQUATE ANTIBIOTIC THERAPY: THE ROLE OF HEPATIC ABSCESS DRAINAGE

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Objectives: To emphasize the crucial role of hepatic abscess drainage in achieving resolution of persistent Klebsiella pneumoniae bacteremia despite adequate antibiotic therapy.

Material and Methods: The case of a patient with persistent Klebsiella pneumoniae bacteremia and hepatic abscess despite adequate antibiotic therapy.

Results and Conclusions: A 47-year-old male is admitted with a 4-day history of nausea, vomiting and asthenia, followed by chills, undocumented fever and right upper quadrant abdominal pain. Due to associated bowel-transit arrest, an abdominal contrast-enhanced CT scan was performed, which ruled out intestinal obstruction and revealed a right hepatic lobe abscess measuring 45/42 mm. Laboratory evaluation showed severe inflammatory response (CRP 366mg/L, fibrinogen 1065 mg/dL) associated with hepatic cytolysis, cholestasis, coagulation abnormalities and lactic acidosis. The initial blood culture was positive for Klebsiella pneumoniae.

Therefore, the case was interpreted as severe sepsis due to Klebsiella pneumoniae with multiple system organ failure (MSOF) and empirical broad-spectrum antibiotic therapy with piperacillin-tazobactam was initiated. At admission, the patient also presented respiratory failure that worsened and persisted during hospitalization. Consequently, a pulmonary CT was performed, which revealed severe pneumonia with ground-glass opacities suggestive for acute respiratory distress syndrome (ARDS).

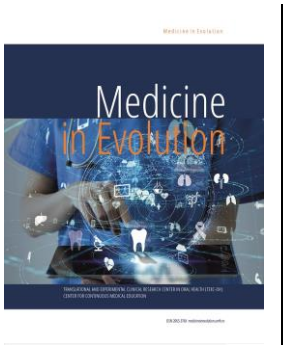
Despite the initiation of targeted intravenous antibiotic therapy with piperacillin-tazobactam for 4 days and then ampicillin-sulbactam, based on antimicrobial susceptibility testing that revealed a multi-sensitive pathogen, persistent Klebsiella pneumoniae bacteremia was documented by four more positive blood cultures, although a progressive decrease in inflammatory markers was observed on serial measurements.

Ultrasound-guided percutaneous drainage of the hepatic abscess was performed after 7 days of admission, and Klebsiella pneumoniae was isolated from the drained fluid as well, confirming the abscess as the source of infection. Following effective source control, the patient showed rapid clinical improvement, normalization of inflammatory markers and clearance of bacteremia.

This case highlights that effective source control through timely abscess drainage is essential for definitive resolution of persistent Klebsiella pneumoniae bacteremia, as appropriate antibiotic therapy alone may be insufficient for complete eradication in the absence of adequate source control.

Keywords: Klebsiella pneumoniae, persistent bacteremia, hepatic abscess, ultrasound-guided drainage, source control

SEPTIC COMPLICATIONS ASSOCIATED WITH SALMONELLA ENTERICA INFECTION: A CASE REPORT



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Objectives: Salmonella spp. is a Gram-negative bacillus and an etiological agent considered a global health problem, especially in developing countries. The main source of infection is contaminated food. The typical clinical presentation includes acute diarrheal disease or systemic infection, but extraintestinal manifestations such as involvement of the central nervous system, cardiovascular and respiratory systems, musculoskeletal system, hepatobiliary system, or genitourinary system are also observed, although less frequently.

Materials and methods: We present a case of periprosthetic infection of the left knee, associated with a soft-tissue abscess of the right hand, in a patient admitted initially to the Internal Medicine ward of the Cisnadie City Hospital for febrile gastroenteritis.

Results and conclusions: A 74-year-old patient with a history of total left knee arthroplasty in 2015, due to decompensated gonarthrosis with pain and functional impairment, underwent reoperation for prosthesis removal and spacer placement one year later because of a periprosthetic infection, followed by revision arthroplasty in 2018. At the end of September 2025, he was admitted to the Orthopedic Clinic with purulent discharge emerging through a fistula in the left knee and swelling of the right hand, which was fluctuating after venipuncture. Biologically, there was a significant inflammatory response, azotemia, and hepatocytolysis. Bacteriological tests from both infection sites identified Salmonella enterica, which remained sensitive to ampicillin, ceftazidime, ciprofloxacin, and sulfamethoxazole/trimethoprim. The patient's history was reviewed, noting the recent episode of diarrhea, and the decision was made to expand investigations to include blood and stool cultures. In addition to antibiotic therapy, the attending orthopedic surgeon decided to use a vacuum-assisted technique for abscess drainage. After 40 days of hospitalization and considering the favorable clinical course, healing of the right hand abscess, and decreased fistula discharge from the left lower limb, the patient was discharged with a prescription for suppressive antibiotic therapy.

This case emphasizes the importance of obtaining a thorough medical history from the patient, especially when there are significant concerns about the infection's source, to rule out other potential causes. Once the etiological diagnosis is established, surgical management is combined with antibiotic therapy.

Keywords: abscess, periprosthetic infection, septic arthritis, Salmonella enterica

STAGE IV DIFFUSE LARGE B-CELL LYMPHOMA AS THE FIRST CLINICAL PRESENTATION OF LATE-DIAGNOSED HIV INFECTION

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Introduction: Human immunodeficiency virus infection remains a major public health concern, especially when diagnosed late, in advanced stages of immunosuppression. Severe CD4 depletion increases the risk of opportunistic infections and aggressive malignancies, including diffuse large B-cell lymphoma, one of the most important HIV-associated lymphoproliferative disorders.

Material and Method: We present the case of a 56-year-old patient newly diagnosed with advanced HIV infection, stage C3, with severe immunosuppression, CD4 count of 17 cells/µL, and HIV viral load of 640,000 copies/mL. The patient initially presented with a large right axillary/pectoral lymph node mass, associated with fever, weight loss, altered general condition, and marked hepatomegaly. HIV infection and the lymphoproliferative disease were diagnosed within a short interval, while investigations were performed in parallel. Lymph node biopsy, together with histopathological and immunohistochemical assessment, confirmed stage IV diffuse large B-cell non-Hodgkin lymphoma with secondary hepatic involvement.

Results: Antiretroviral therapy with Bictegravir/Emtricitabine/Tenofovir Alafenamide was initiated, along with anti-infective and supportive treatment. The patient subsequently started chemotherapy, initially with an R-CVP regimen, followed by R-CHOP. After the third chemotherapy session, the clinical course was complicated by significant weight loss, memory impairment, gait disturbance, dysarthria, and bradylalia. Brain MRI revealed lesions suggestive of secondary lymphomatous involvement. Given the profound immunosuppression, progressive multifocal leukoencephalopathy was also considered, but JC virus testing ruled out this diagnosis.

Conclusions: This case illustrates the severe consequences of late HIV diagnosis, which may become clinically apparent through aggressive lymphoproliferative malignancy with systemic and neurological involvement. The association between advanced HIV infection and diffuse large B-cell lymphoma requires rapid multidisciplinary management. Neurological manifestations in severely immunocompromised patients remain diagnostically challenging, as lymphoma-related cerebral lesions and opportunistic central nervous system infections may overlap clinically and radiologically. Early HIV screening is essential to prevent advanced disease and reduce associated morbidity and mortality.

Keywords: HIV, AIDS, non-Hodgkin lymphoma, severe immunosuppression, cerebral involvement

KAWASAKI DISEASE IN A CHILD INITIALLY MANAGED AS SCARLET FEVER: DIAGNOSTIC OVERLAP AND CLINICAL CHALLENGES

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OBJECTIVES: Kawasaki disease (KD) is an acute systemic vasculitis of childhood with potential coronary artery involvement. We aimed to highlight the diagnostic challenge in differentiating Scarlet fever from Kawasaki disease in children, emphasizing the possibility of clinical overlap and the importance of early recognition of the vasculitic features.

MATERIALS AND METHODS: We report the case of a 4-year-and-11-month-old girl without significant past medical history, admitted for fever (with a four days onset) and cutaneous rash.

RESULTS: The initial clinical presentation consisted of high-grade fever and a maculopapular rash with scarlatiniform features, accompanied by a white coated tongue with peripheral erythema and early desquamation, leading to an initial diagnosis of scarlet fever and initiation of antibiotic therapy (Penicillin G 400 000 IU twice daily).

Persistent fever and progression of the pruritic maculopapular rash were followed by the development of cracked hemorrhagic lips, strawberry tongue, and bilateral non-exudative conjunctivitis, raising suspicion for Kawasaki disease. We excluded IgE-mediated allergy, Mycoplasma infection, Epstein–Barr virus infection, Toxoplasmosis, Rickettsial infections, Measles, and HIV infection.

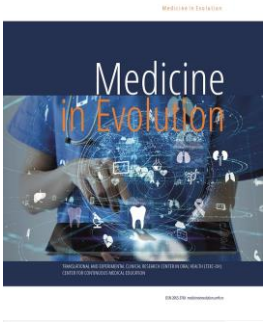
Laboratory findings revealed a significant inflammatory syndrome, with C-reactive protein elevated up to 127 mg/L, procalcitonin of 1,9 ng/ml and neutrophilic leukocytosis, while microbiological testing for Streptococcus pyogenes was negative. Echocardiography revealed normal cardiac function without coronary aneurysms, but with periarterial coronary hyperechogenicity suggestive of early inflammatory involvement.

Intravenous immunoglobulin (Intratect 50g/L solutin for infusion, 7,5g/day) was administered, with an initial infusion rate of 3 mL over the firsth 30 minutes, increased to 3.5 over the subsequent 30 minutes, and than to 6.5 mL/hour for a total of 3 days. This was combined with oral aspirin at a dose of 50 mg/kg/day, divided into 4 doses and intravenous corticosteroid therapy with hydrocortisone hemisuccinate at 40 mg four times daily, resulting in marked improvement of inflammatory markers and rapid fever resolution.

CONCLUSIONS: Kawasaki disease may closely mimic scarlet fever in the early stages, and clinical overlap can significantly complicate the diagnosis. Persistent fever despite appropriate antibiotic therapy and the development of bilarteral painless bulbar conjunctival injection without exudate, erythematous mouth and pharynx with strawberry tongue or red, cracked lips, polymorphous exanthem (morbilliform, maculopapular or sarlatiniform), swelling of the hands and feet with erythema of the palms and soles and cervical lymphadenopathy (>1,5 cm in diameter) should raise suspicion for vasculitis. Early echocardiographic assessment and rapid IVIg administration are essential to prevent coronary complications and improve outcomes.

Keywords: Kawasaki disease; Scarlet fever; immunoglobulins

INCIDENTAL HIV DIAGNOSIS IN NEUROLOGICAL DISORDERS: THERAPEUTIC LIMITATIONS IN ADVANCED STAGES



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Objectives:

HIV infection remains a significant public health concern, associated not only with progressive immunodeficiency but also with direct neurological dysfunction. HIV-associated encephalopathy represents a severe complication of advanced disease, and its early diagnosis is often difficult due to a nonspecific clinical onset.

Materials and Methods:

We present the case of a 49-year-old woman, initially admitted to the Psychiatry Clinic for a depressive episode, for which multiple therapeutic approaches had been tried over the past two years. She was recently diagnosed with HIV infection and subsequently transferred to the Infectious Diseases Clinic II. Investigations revealed severe immunosuppression (CD4 = 14 cells/µl, HIV RNA = 208,000 IU/ml), and the patient was classified as stage C3. Brain imaging findings were suggestive of HIV-associated encephalopathy. Her clinical course was marked by progressive neurological decline, ultimately requiring transfer to the ICU.

Results and Conclusions:

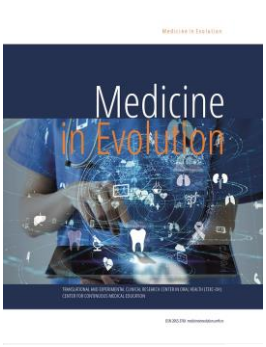
At admission, the patient showed significant neurological impairment, including bradylalia, bradypsychia, and right eyelid ptosis. A comprehensive treatment approach was initiated, including antibiotics, antifungal therapy, corticosteroids, diuretics, hemostatic agents, fluid and electrolyte replacement and transfusion support. Antiretroviral therapy with Bictegravir/Emtricitabine/Tenofovir alafenamide (50 mg/200 mg/25 mg) was started. The initial evolution showed a slow but noticeable improvement, followed by progressive neurological deterioration. On day 19, the patient became obtunded (GCS = 10) and was transferred to the ICU. Shortly thereafter, she developed cardiac arrest due to severe bradycardia, with no response to resuscitation efforts.

Conclusion:

Early diagnosis of HIV infection, along with timely neurological evaluation, is essential. Although prompt initiation of antiretroviral therapy may positively influence the course of the disease, the prognosis remains poor in patients with severe immunosuppression and advanced neurological involvement.

Keywords: HIV infection, HIV-associated encephalopathy, neurocognitive disorders, antiretroviral treatment

PRE-EXPOSURE PROPHYLAXIS (PrEP): USE AND ACCEPTABILITY AMONG GBMSM IN TIMIŞOARA



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Introduction:

Pre-exposure prophylaxis (PrEP) is an effective method for preventing HIV infection. In Romania, access to PrEP is limited, being available mainly in a few centers in cities such as Cluj-Napoca and Bucharest, which may influence the level of use.

Purpose:

To assess the level of knowledge, use, and interest in PrEP among gay, bisexual, and other men who have sex with men (GBMSM) accessing testing and prevention services.

Materials and Methods:

A descriptive observational study based on a questionnaire administered to GBMSM beneficiaries of Checkpoint ARAS Timişoara during 2025. A total of 332 unique respondents were included, all reporting at least one unprotected sexual contact in the past year. Levels of awareness regarding PrEP, its use, and reasons for non-use were analyzed.

Results:

Out of the 332 respondents, 227 (68.4%) reported having heard about PrEP. Among them, only 23 (10.1%) had used PrEP, while 202 (89.0%) had not used this prevention method.

Among those who had not used PrEP, 100 (49.5%) expressed interest in starting prophylaxis. The main reasons for non-use included the perception of low risk of infection (in the context of condom use), associated costs, limited access to specialized services, as well as reluctance regarding the need for regular medical monitoring.

Conclusions:

Although the level of awareness regarding PrEP is relatively high among GBMSM with risk behavior, the rate of use remains low. The significant interest in initiating PrEP highlights an important potential for expansion, but barriers related to cost and access limit its implementation. The development of dedicated local services could significantly improve PrEP accessibility and uptake.

Keywords: PrEP, GBMSM

THE IMPACT OF METABOLIC AND GENDER FACTORS ON BONE AGING IN ROMANIAN HIV PATIENTS

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Objective: Increased longevity among people living with HIV has brought new clinical challenges to the forefront. Loss of bone mineral density represents a major comorbidity, increasing the risk of fragility fractures at unexpectedly young ages. The study analyzed the prevalence and predictors of bone demineralization in a current cohort of HIV-positive patients from the Infectious Diseases Clinic of the "Victor Babes" Hospital in Timisoara. A cross-sectional analysis was performed on 180 subjects (41.86 ± 12.69 years) under stable antiretroviral treatment. Bone integrity assessment was performed by osteodensitometry (DXA) (gold standard), supplemented by body composition analysis through bioelectrical impedance (BIA) and monitoring of the serum lipid profile.

Material and method: The data indicate a marked prevalence of skeletal mass deficit (58.3%), with an osteoporosis incidence of 10% at an atypically low mean age (45.7 years). Statistical analysis revealed significant correlations between bone degradation and clinical history of AIDS, active smoking, and hypertriglyceridemia. A critical indicator was observed in the female population: patients with osteoporosis presented a precarious immunological status, with substantially lower CD4+ values (268.4 ± 180.5 cells/mL) compared to the group with optimal bone mineral density.

Results: The analysis revealed a marked prevalence of skeletal mass deficit, affecting 58.3% of the cohort, with 10% of participants already diagnosed with osteoporosis at a mean age of only 45.7 years. Statistical modeling identified significant correlations between bone degradation and a clinical history of AIDS, active smoking, and hypertriglyceridemia. A critical gender-specific indicator emerged among the female population, where those with osteoporosis exhibited a precarious immunological status – evidenced by substantially lower CD4+ counts (268.4±180.5cells/mL) compared to those with optimal bone density. Furthermore, while Body Mass Index (BMI) offered limited predictive value, bone mass determination via BIA proved to be a highly effective tool for identifying subclinical depletion.

Conclusions: These findings confirm an accelerated skeletal aging phenotype in PLWH, driven by a synergy of immunological history, metabolic dysregulation, and lifestyle factors. To mitigate the long-term burden of fragility fractures, we propose routine DXA and BIA screening starting at age 40, or earlier upon clinical milestones such as incomplete immune recovery or TDF/PI exposure. Transitioning toward a multidisciplinary management model that prioritizes early detection and aggressive risk-factor modification is essential for enhancing the quality of life in the aging HIV-positive population.

Keywords: HIV; osteopenia; osteoporosis; premature senescence; bone mineral density; demineralization; bioimpedance; skeletal health.