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Event: Case of *Klebsiella aerogenes* ST177 folliculitis in England

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Incident Response Plan (IRP) Level:	Routine
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Distribution:	Please see page 4 for information with regards to the distribution instructions for this Briefing Note.

Summary:

Recent reports from Europe and the United States have described recurrent facial folliculitis caused by *Klebsiella aerogenes* among gay, bisexual and other men who have sex with men (GBMSM). Genomic investigations have identified a highly related lineage, suggesting a single genetic clone is circulating internationally. A confirmed case has recently been identified in England.

Commonly used β-lactam antibiotics, such as co-amoxiclav, are not reliable treatment options for *K. aerogenes*. Treatment should be guided by antibiotic susceptibility testing.

Although transmission may occur through intimate contact within GBMSM sexual networks, direct evidence of sexual transmission remains limited and alternative routes, including communal environmental exposures, cannot currently be excluded.

There is currently no evidence of a wider public health impact in England. Increased awareness among sexual health, dermatology, microbiology and infectious diseases clinicians may improve case recognition and understanding of this emerging condition.

Background and Interpretation:

Klebsiella aerogenes (formerly *Enterobacter aerogenes*) is a Gram-negative Enterobacterales species that commonly colonises the gastrointestinal tract and is usually associated with healthcare-associated infections. It is an uncommon cause of community-acquired skin and soft tissue infection.

Since 2024, reports from France, Belgium and North America have described a distinctive syndrome of recurrent facial folliculitis affecting GBMSM. A case series published in 2026 described 17 cases across several countries, with genomic analyses showing that isolates belong to ST117 or a closely related lineage. This suggests that cases have spread internationally through connected transmission networks.

To date, all reported cases have occurred among GBMSM. Many affected individuals reported recent STIs, HIV pre-exposure prophylaxis (PrEP) use, attendance at sex-associated venues, or use of communal facilities such as hot tubs, saunas and gyms. Although the epidemiology suggests possible spread through sexual networks, there is currently no definitive evidence that the infection is sexually transmitted and exposure from shared environments cannot be ruled out.

Clinical presentations are consistent, with follicular papules, pustules and occasionally painful nodules confined to the face, particularly the beard area. Diagnosis is often delayed because the condition can be mistaken for more common causes of folliculitis. Relapses are frequent and symptoms may persist for months or years. Systemic illness has not been reported. Diagnosis can be established by routine bacterial culture of pustular lesions, with *K. aerogenes* readily identified by standard microbiological methods, including MALDI-ToF.

A confirmed case has now been identified in England in a gay man with recurrent facial folliculitis. Genomic analysis identified the ST117 lineage. This is the same strain seen in international cases, but the isolate appears to be more resistant to antibiotics than those previously reported. In addition to its intrinsic chromosomal AmpC β-lactamase, the isolate carries the ESBL gene *bla*CTX-M-27, and resistance determinants affecting several other antimicrobial classes. Phenotypically, it was resistant to co-trimoxazole and chloramphenicol, and 'Susceptible, Increased exposure' to ciprofloxacin, leaving extremely limited oral treatment options (see EUCAST definitions of susceptibility testing categories).

Although current evidence does not indicate a substantial public health risk, the condition may be present but under-recognised in the UK. Clinicians should consider microbiological investigation in patients presenting with compatible recurrent facial folliculitis, and treatment should be guided by the results of antimicrobial susceptibility testing.

Implications and Recommendations for UKHSA Regions:

- Ensure Health Protection Teams are aware of emerging reports of *K. aerogenes* facial folliculitis among GBMSM and the confirmed case in England.
- Liaise with sexual health, dermatology, microbiology and infectious diseases colleagues if additional cases or clusters are identified.
- Support reporting of confirmed cases through established local and national surveillance mechanisms.
- Maintain a proportionate response given the absence of evidence for severe disease, invasive infection or substantial wider public health impact.
- Escalate concerns regarding clusters, unusual epidemiological links, severe disease or antimicrobial resistance patterns through established UKHSA routes.

Implications and Recommendations for UKHSA sites and services:

Laboratories:

- Be aware that *K. aerogenes* may be an emerging cause of recurrent facial folliculitis in GBMSM.
- Ensure isolates from compatible lesions are identified to species level and antibiotic susceptibility testing performed.

- Where *K. aerogenes* is isolated from facial folliculitis, laboratories should retain the isolate and arrange referral to the UKHSA Antimicrobial Resistance and Healthcare Associated Infections (AMRHAI) Reference Unit for whole-genome sequencing and lineage assignment to determine whether they belong to the emerging ST117-associated clade and to monitor antimicrobial resistance determinants.

Field Services and surveillance teams:

- Continue monitoring UK and international reports of *K. aerogenes* folliculitis.
- Review emerging evidence regarding transmission pathways, reservoirs, antimicrobial resistance and genomic epidemiology.
- Work with microbiology and specialist clinical networks to improve recognition and reporting of cases.

Implications and Recommendations for NHS:

Front-line clinicians:

- Consider *K. aerogenes* in GBMSM presenting with recurrent facial folliculitis, particularly where lesions involve the beard, moustache, chin or cheeks and have failed to respond to conventional acne or anti-staphylococcal therapies.
- Obtain bacterial swabs from pustular lesions before commencing additional antimicrobial treatment where clinically appropriate.
- Recognise that reported cases frequently relapse following apparently successful treatment and may persist for months or years.
- Seek advice from microbiology, dermatology or infectious disease specialists for persistent, recurrent or treatment-refractory disease.
- Continue routine STI testing, HIV prevention interventions and broader sexual health promotion activities where indicated.

NHS laboratories:

- Process specimens using routine bacteriological methods and identify isolates to species level where clinically relevant.
- Perform antimicrobial susceptibility testing in accordance with standard laboratory practice.
- Refer *K. aerogenes* isolates from confirmed cases of facial folliculitis to the UKHSA AMRHAI Reference Unit for whole-genome sequencing. This service is provided free-of-charge.

Implications and recommendations for Local Authorities:

- Maintain awareness of emerging reports of *K. aerogenes* folliculitis among GBMSM and any future updates from UKHSA.
- Support dissemination of clinical awareness messages through existing sexual health, public health and healthcare provider networks where appropriate.
- Work with commissioned sexual health services to ensure clinicians are aware of the reported clinical presentations, potential epidemiological risk factors and current recommendations for microbiological investigation.
- Encourage reporting of unusual clusters or increases in presentations of recurrent facial folliculitis.
- Continue to support established sexual health promotion programmes and access to sexual health services.

References or Sources of information:

Klebsiella aerogenes-related facial folliculitis in men having sex with men: A hypothetical new STI? - Bérot - 2025 - Journal of the European Academy of Dermatology and Venereology - Wiley Online Library

Eurosurveillance | Klebsiella aerogenes ST117 causing folliculitis in men having sex with men, Belgium, February 2025

Recurrent Facial Folliculitis Caused by Klebsiella aerogenes Sequence Type 117 in Men who Have Sex with Men - Volume 32, Number 7—July 2026 - Emerging Infectious Diseases journal - CDC

Instructions for Cascade:

Briefing Notes are routinely cascaded to the below groups:

- UKHSA Private Office Groups who cascade onwards within Groups
- UKHSA Health Protection in Regions:
  UKHSA Field Services
  UKHSA Health Protection Teams including UKHSA Regional Deputy Directors
  Deputy Directors in Regions Directorate
- UKHSA Lab Management Teams
- UKHSA Regional Communications
- Generic inbox for each of the Devolved Administrations
- Inboxes for each of the Crown Dependencies
- UKHSA UKOT Programme SPOC
- DHSC CMO (*excluding internal UKHSA briefing notes*)
- OHID Regional Directors of Public Health
- National NHSE Emergency Preparedness, Resilience and Response (EPRR)
- NHSE National Operations Centre
- **Devolved Administrations** to cascade to Medical Directors and other DA teams as appropriate to their local arrangements.
- **Crown Dependencies** to cascade to teams as appropriate to local arrangements.
- **UKHSA Regional Deputy Directors** to cascade to Directors of Public Health
- **UKHSA microbiologists** to cascade to non-UKHSA labs (NHS labs and private)
- **UKHSA microbiologists** to cascade to NHS Trust infection leads
- **NHS labs/NHS infection leads/NHS microbiologists/NHS infectious disease specialists** to cascade to Dermatology departments
- Royal College of Emergency Medicine - president@rcem.ac.uk
- Royal College of General Practitioners - Chair-RCGP@rcgp.org.uk
- Royal College of Pathologists - president@rcpath.org
- Royal College of Physicians - sarah.clarke@rcp.ac.uk
- Faculty of Sexual and Reproductive Healthcare - president@fsrh.org