IDBR 2025: Q and A
Day 3: Monday, August 18, 2025

Question	Reply	Submission Date	Submission Time
Is it possible for otic/ocular/Neurosyphilis to occur after adequate treatment and documented response after treatment for late latent syphilis?	Yes! 5% of patients treated for syphilis can progress to CNS complications!	08/18/2025	09:09:54
When suspecting neurosyphilis I typically just send CSF VDRL. Should I then be adding CSF treponemal tests on the front end because of the chance the VDRL may be falsely negative?	Only send for a CSF treponemal antibody test if CSF VDRL is nonreactive and there is no pleocytosis and if the CSF protein is mildly elevated. In that setting, it can be helpful to rule OUT neurosyphilis. Remember, you should not make a dx of neurosyphilis based on a reactive CSF treponemal antibody.	08/18/2025	09:12:59
For pts w/ cancer and at risk for neutropenia and may need HSV prophylaxis -- do you screen for HSV w/ glycoprotein G based type specific EIA? Or just go by history? What if hx is not clear, should you just start prophylaxis or would you test/screen? Thanks!	Usually, if they have a known history, just use it. Most of the time, the pre-transplant work-up will have the results of serological tests for HSV- so it tends to be known before the transplant.	08/18/2025	09:14:46
should we treat with extra 3 weeks of im pCN G after rx of neurosyphilis for a alate latent syphilis	Short answer is no. There are neither experimental nor clinical data to suggest that additional doses of BPG are needed after 10 days of IV penicillin. The ASTDA will be releasing a position statement soon advocating for not using additional doses. If it makes you feel better to do it, that's fine but all you need is 1 additional BPG dose after 10 days of PCN. Stay tuned for the ASTDA statement	08/18/2025	09:17:13
How would you treat bartonella henselae perivascular infection?	*(This question was answered live from the podium.)*	08/18/2025	09:31:34
Are there any useful questions to ask regarding pets (e.g., receipt of flea/tick ppx, presence of pet symptoms etc) ?	*(This question was answered live from the podium.)*	08/18/2025	09:39:51
On question 14, four days seems too soon for an incubation time for babesiosis? Thank you	Thank you for your questions. This stem comprised of four days of symptoms, which you are right would be too short. however, the incubation period[meaning acquisition to onset of symptoms] can be longer than the period of symptoms. For example, Lyme disease is 3-30 days typically from acquisition from a tick bite. For Babesia, that is 1-4 weeks. Also, the same tick doesn't necessarily need to transmit both if someone unknowingly had multiple Ixodes scapularis tick bites.	08/18/2025	09:58:43
Can nocardia infections cause false positive galactomannan?	*(This question was answered live from the podium.)*	08/18/2025	10:17:31
Melioidosis- option for bactrim if sulfa allergy?	*(This question was answered live from the podium.)*	08/18/2025	10:34:45
What is your approach to a TB patient, with radiographic and historical findings concerning for florid TB, who end up growing Norcardia species on one AFB culture? Would you assume contaminant if it doesn't appear again on subsequent AFB cultures while on RIPE?	*(This question was answered live from the podium.)*	08/18/2025	10:43:19
If there is a worry for LGV, can you send a chlamydia NAAT directly from a genital ulcer?	*(This question was answered live from the podium.)*	08/18/2025	10:51:35
Is pharyngeal gonorrhea the only element of triple screening that needs a test of cure?	*(This question was answered live from the podium.)*	08/18/2025	10:54:55
You mentioned about not needing to tx for Chl if Gon + and appropriate Chl testing is negative. Is this the same rec if they have a more extensive disease like PID? Do you still trust the testing? I had a PD dialysis pt w/ peritonitis w/ + peritoneal fluid for Gon and cervical NAAT + for Gon.	*(This question was answered live from the podium.)*	08/18/2025	10:55:23

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If one confirms septic arthritis with N. gonorrhea which will be treated longer IV antibiotic course, is there still a need to screen the other sites?	*(This question was answered live from the podium.)*	08/18/2025	11:01:10
is cefixime available in the US?	*(This question was answered live from the podium.)*	08/18/2025	11:02:52
treatment of Trich vaginalis in patients allergic to Metronidazole	*(This question was answered live from the podium.)*	08/18/2025	11:15:38
Transmen on testosterone who have receptive vaginal/anal sex should undergo trichomonas screening/treatment as you would for cis-women?	*(This question was answered live from the podium.)*	08/18/2025	11:21:03
is there an option for paromomycin in R to Metronidazole in Trich?How do we test for R inTrich? Tx	*(This question was answered live from the podium.)*	08/18/2025	11:21:31
Can you comment on CTX 500 mg vs 1 g for N gonorrhoeae treatment	*(This question was answered live from the podium.)*	08/18/2025	11:30:56
Many oncological GYN are vaccinating or asking ID to vaccinate for HPV in pts with genital CIN3 and HPV.	*(This question was answered live from the podium.)*	08/18/2025	11:37:00
how would you manage a female patient with trichomoniasis on long term disulfiram to prevent alcoholism recurrence?	*(This question was answered live from the podium.)*	08/18/2025	11:40:25
Does DOXY PEP 100 mg work	*(This question was answered live from the podium.)*	08/18/2025	11:40:30
very difficult to get cefixime when prescribed	*(This question was answered live from the podium.)*	08/18/2025	11:45:57
why cant the reason be because the stains are negative?	*(This question was answered live from the podium.)*	08/18/2025	12:33:31
Re: TB. What if infants or pregnant family members? Would you still discharge immediately?	*(This question was answered live from the podium.)*	08/18/2025	12:34:28
Why not contact isolation?	I'm sorry but I'm not sure what this is referring to. Perhaps measles? Measles is airborne.	08/18/2025	13:10:44
Which oral abx do you use for DGI after first dose of ceftriaxone?	It depends on what the culture susceptibility testing demonstrates: You could use cefixime or a fluoroquinolone if the organism is susceptible. For DGI, treat with IV ceftriaxone until clinical improvement- usually 48-72 hours. Continue IV therapy if the patient has endocarditis or meningitis.	08/18/2025	13:12:48
If multiplex NAAT isn't commercially available, how does one distinguish between Chlamydia serotypes? Culture?	You can't distinguish between the two serogroups if multiplex PCR is not available. You go by symptoms; if the patient has severe proctitis, assume it is LGV and treat for 3 weeks. It's the only way!	08/18/2025	13:14:23
Regarding cryptococcus, is the reason why the correct answer is LP because the concern is elevated ICP driving the loss of vision? Wouldn’t you also want to use flucytosine in the patient’s management, but starting that is less important than LPs?	*(This question was answered live from the podium.)*	08/18/2025	14:19:29
Any advantage to doing a serum antigen for histo/blastow vs urine	the serum test has no advantage	08/18/2025	15:03:22
ophthalmologists now resisting coming for eye exam in candidiasis citing their literature of low yield	vitiritis occurs in 1-5% and requires intravitreal therapy. Waiting for symptoms is too late.	08/18/2025	15:11:32
Treatment options for cryptococcal meningitis after amphotericin b/flucytosine stage when patients qtc is >500? Isovuconazole?	there are no data on isavconazole for crypto so I would use fluconazole and watch the QTc	08/18/2025	15:14:26

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Do all extrapulmonary tuberculosis patients have to be ruled out first for pulmonary tuberculosis as well with isolation, smears and nucleic acid amp tests?	All people with extrapulmonary TB should be evaluated for concomitant pulmonary TB. Typically this includes smears, cultures, and, if available NAATs. Whether or not isolation is recommend depends on the circumstance and manifestations -- although almost always a hospitalized patient should be isolated until pulmonary TB is excluded with a reasonable certainty.	08/18/2025	16:08:22
Would you recommedn routine AFB blood culture in a patient with advanced pulmonary TB?	Yes, especially in an immunocompromised patient.	08/18/2025	16:08:59
Does MTB pcr same sensitivity and specificity if done on BAL or tissue biopsies?	Complicated question, since bacillary burden is often very low in tissue. But analytical sensitivity should be similar in BAL and tissues.	08/18/2025	16:09:52
For Dr Dorman. Are there countries of origin from which a relatively young patient with latent TB requiring treatment requires a special or combination drug regimen in the absence of known drug resistant TB exposure?	No, in the absence of known exposure to drug-R TB, one would administer 3HP, 3RIF, or 3HR. Even in areas with relatively high rates of drug resistant TB, drug susceptible TB is more common.	08/18/2025	16:11:05
If you unmask TB after starting ART -- do you hold ART, start TB tx and restart ART based on CD4 (ie: 2 vs 8 wks)? Or continue ART and add TB tx and monitor?	Continue ART, add TB treatment, and monitor.	08/18/2025	16:11:29
Concerning TB DDIs, if the HIV patient is on Bictarvy would we then stop their treatment and switch them to a Dolutegravir based treatment?	yes, typically I change the person to a DTG-based regimen.	08/18/2025	16:12:04
In question #2, what would you do? Stop INH?	Would temporarily hold all TB drugs, then do a challenge: rifampin plus ethambutol first, then add INH -- if tolerates this then assume that hepatotoxicity is due to PZA, and treat for a total of 9 months (cannot do 6-month treatment without PZA).	08/18/2025	16:13:12
Does 9 mon duration also hold same for immunosuppressed pt with abd TB?	yes, would use treatment duration of 9 months in this instance.	08/18/2025	16:13:35
I feel like I have seen more people have a positive MTB PCR + neg culture than the other way around. Given the different sensitivities of the tests (culture > PCR), why is that?	Depends on the specific circumstances, but it may be due to excessive "decontamination" causing cultures to be false neg.	08/18/2025	16:14:47
We might have missed this online, but can you summarize the reliable labs for Lyme?	For most cases, serology using FDA validated STTT or MTTT B burgdorferi antibodies are the tests of choice assuming you are not looking at early Lyme disease and erythema migrans (which if you are uncertain, can watch the rash for expansion or do acute/convalescent serology). PCR has a limited role in clinical practice. I feel it doesn't need to be used at all, but some use it on synovial fluid, the only fluid that is reasonable to test but is not an FDA validated assay, and mostly is done as a CLIA test by single labs.	08/18/2025	16:21:11
I may have heard it incorrectly, that we don’t treat erythema migrans with cephalosporins? I’m from Wisconsin and Cefuroxime is given if unable to give Doxycycline or Amoxicillin.	Regarding Lyme disease, 1st generation cephalosporins are ineffective. However, second generation (e.g., cefuroxime) and third gen {ceftriaxone} do work. Strange stuff that cephalexin fails against Borrelia.	08/18/2025	16:22:28
Are these cases of Lyme in North Carolina confirmed to be autochthonous, or could these people have traveled to more endemic areas?	Cases definitely acquired now in the western part of NC, in the Appalachians.	08/18/2025	16:22:59

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Dr. Auwaerter stated Rickettsia rickettsii doesn't cause an eschar, but the subgroup that causes Pacific Coast Tick fever does (slide 26). Could you clarify?	Why some diseases form eschar is not clear versus others. RMSF is not an eschar forming infection from the initial tick bite. Now, the Rickettsia 364D now proposed to be R rickettsii subsp californica you would think wouldn't generate an eschar, but it may not be the pathogen as much as the type of tick causing the bite, or a combination of the two at the site of acquisition. Good question, but would stick with what I mentioned for ABIM purposes.	08/18/2025	16:27:59
your Q had MSSA do we decolonize everyone in the ICU/ pre surgery for MSSA as well?	*(This question was answered live from the podium.)*	08/18/2025	17:13:35
Is there a similar benefit to decolonize those pts colonized with MSSA? Or just benefit if they have MRSA? Should family memebers/household contacts also do empiric decolonization?	*(This question was answered live from the podium.)*	08/18/2025	17:15:48
In a patient with pneumonia admitted- under eval including rule out TB- if sputumTBPCR is negative though AFB smears and cx are still pending- can we DC airborne isolation ?	*(This question was answered live from the podium.)*	08/18/2025	17:19:54
Is lead pipe rigidity with both NMS and malignant hyperthermia? It's listed under NMS on slide and then the chart listed it for malignant hyperthermia or is this a typo	*(This question was answered live from the podium.)*	08/18/2025	17:38:27
Is there any benefit of checking sputum for eosinophils if you suspect Dapto eosin PNA but are unable to get a bronch? Thanks!	*(This question was answered live from the podium.)*	08/18/2025	17:52:30
Surgical site infection - colorectal surgery- prophylaxis- is it single dose like perioperative or give for few days prior to surgery?	Goal is the have the highest concentration at the time of incision, so dose 60-120 minutes before (depending on the specific antimicrobial used)	08/18/2025	18:03:53