IDBR 2025: Q and A

Day 1: Saturday, August 16, 2025

Question	Reply
can we give paxlovid for patients on tacrolimus	No. There is a substantial interaction. If it is rarely safe to hold the tacro for 7 days. In rare cases your pharmacist and transplant time might come up with a work around. These patients probably are the ones who merit the 3 day outpatient remdesivir regimen if you can arrange it.
Can you speak about Kleb oxytoca/raoultella and use of cephalosporins.	*(This question was answered live from the podium.)*
Citalopram rather Sertraline higher risk for serotonin syndrome?	Thought-provoking question. I'm not aware of a major difference in terms of propensity for serotonin syndrome, at least when combined with a weak inhibitor like linezolid.
Citalopram rather Sertraline higher risk for serotonin syndrome?	*(This question was answered live from the podium.)*
Could you comment on HBV vaccine non responsers	Great question. I've generally moved to giving Heplisav-B for prior non responders since response is generally higher. In the BEEHIVE study (Heplisav in people with HIV), it should 2 doses had high response rates, but response rates were even higher after 3 doses. So a 3rd dose can be an option.
Could you comment on HBV vaccine non responsers	Other options include double dose recombivax or energix
Did they drop the cochlear implant indication?	no, that is still an indication as is CSF leak - I assume you are referring to pneumococcal vaccination
Do we see aspergillus as commonly in immunosuppressed patients who aren't transplant? e.g. on mycophenolate for an auto-immune disease or similar	*(This question was answered live from the podium.)*
elderly patients with baseline encephalopathy and other risk factors to start with and started on cefepime and now cefepime being mentioned as a reason for encephalopathy — is there anyway we can differentiate or just dont use cefepime at all in such patient population	Tough situation. I'm not aware of a validated method to distinguish. I think, as you suggest, it would be best to avoid cefepime altogether.
For HBV and HIV co-infections can you elaborate on (1) whether tenofovir-based ART alone is sufficient or if FTC/3TC must absolutely be used in addition to tenofovir? And (2) in HIV patients with past HBV (core pos but also anti-HBs pos) do they also absolutely need a tenofovir backbone?	These are very good questions and I would also ask Dave Thomas who is the real hepatitis expert. Tenofovir alone has good anti HBV activity and tenofovir resistance is very rare. The formal recommendation is to use both but TDF alone probably works. The risk of reactivation HIV patients is who are core positive is not very high but a regimen with anti-HBV activity is recommended. I don't know if two drugs are absolutely needed, but if you do use 3TC alone and there is HBV reactivation there is a theoretical risk of 3TC resistance.
For HBV and HIV co-infections can you elaborate on (1) whether tenofovir-based ART alone is sufficient or if FTC/3TC must absolutely be used in addition to tenofovir? And (2) in HIV patients with past HBV (core pos but also anti-HBs pos) do they also absolutely need a tenofovir backbone?	*(This question was answered live from the podium.)*

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For previous presentation. How do you treat resistant aztreonam-avibactam and cefidetocol infections?	*(This question was answered live from the podium.)*
Good review-could you elaborate on efficay of cidfovir vs tecoviromat for treatment of mpox?	*(This question was answered live from the podium.)*
I'm not able to complete the day 1 evaluation. It says access denied. Anyone else having this issue? Can someone from the course pls assist? I'm attending virtually	Please call 301-818-6754 for assistance.
If a patient with a known organism (like the Candida) develops ecythma should they receive empiric pseudomonal coverage until PsA is ruled out or can it be attributed to their candidemia and call it a day ?	*(This question was answered live from the podium.)*
If patients are outside of the 5 day (Paxlovid) or 7 day (Remdesivir) window for COVID treatment but still symptomatic would you still initiate?	In a relatively immunocompetent patient, no. However, in patients who are not able to control viral replication because of B cell suppressive therapy or other severe immunosuppression most of us in ID would. The intensivists on the panel would not
In mPox, did tecovirimat fail due to late diagnosis? Thanks	It's possible but not likely. I think the investigators did there best to do exploratory analysis to see if this was the problem and could not identify a signal of better efficacy when started early.
In terms of drug interaction, compared to rifampin, how different is rifabutin in regards to drug interaction	In general, rifabutin has less DDI, because it induces less isoforms of CYP450. That said, as a rifamycin it is still problematic and worth a close look whenever you add it to someone's regimen.
Is erpatenem ok to use for ESBL producing organism causing osteomyelitis?	Thanks for the question. Unfortunately, I don't think we really know the answer. If the patient has an ESBL isolate susceptible to drugs like cipro, doxy, or TMP-SMX I would favor those. If you are going to use ertapenem I would suggest waiting until some debridement occurs and patient showing some improvement first. Thanks, Pranita
Is there ever an indication to add vanc to neutropenic fever treatment when there's concern for resistant strep? (Ie mucositis + Levofloxacin ppx)	*(This question was answered live from the podium.)*
Is there utility of using Toci or Bari in patients who are already intubated?	Yes, The studies of additional immunomodulators included critically ill patients
Levaquin neutropenia - in question - cefepime also has similar coverage including pseudo- then why not carbapenems instead of cefepime	Anti-pseudomonal b-lactam is recommended. The choice depends as well on your local antibiogram.
Neutropenia is the most common predisposing factor	*(This question was answered live from the podium.)*
No vaccine available in summer of 2020	*(This question was answered live from the podium.)*
Not sure how common this is done regarding question #2 giving empiric flu treatment. I feel we would be giving every immunosupressed patient empiric flu treatment during flu season which certainly not the case. Not sure if I am missing something here.	In reality, not every immunocompromised patient with fever gets empiric influenza therapy, but we also know that many patients hospitalized with influenza have delayed therapy or are not treated at all. It depends on your ability to get a rapid NAAT and the prevalence of flu.

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On question 6, should VZV encephalitis be included in the differential diagnosis?	Yes it would also be in the differential diagnosis here.
Question 4- levaquin to cefepime- dont they have almost same coverage including for pseudo? Carbapenems in that situation?	*(This question was answered live from the podium.)*
Thanks for the talk. Can you comment on vaccinating routinely for HiB prior to eculizumab in previously vaccinated individuals?	I have not vaccinated for HiB in previously vax'ed adults. I couldn't find a recommendation for this. Thanks
That was a great talk! Have you come across ceftaroline associated eosinophilic pneumonia? (Just like you would see with Daptomycin). If we are unable to use Vancomycin or Linezolid.	Thank you for the compliment. I recall one case report a number of years ago of apparent ceftaroline-associated EP, but I don't remember seeing any since. I might have missed them, though, I admit that. In clinical practice I have never seen a case. The case report was in AJHP, I think. Thank you!
Thoughts on empiric double anti- coverage for febrile neutropenia? Eg. PipTazo + Tobra	As a standard neutropenic fever regimen/guidance we don't consider additional benefit with combination therapy anti-pseudomonal therapy.
What antibiotic you give for anthrax prophylaxis in pregnancy?	If mod/high risk exposure, then the recs are the same as if not pregnant
What antibiotic you give for anthrax prophylaxis in pregnancy?	meaning vaccine and abx (FQ)
What are the recommendations for previous erratic HPV vaccination? Eg. Dose 3 received after 9 months of dose 2. Repeat series altogether from scratch?	No need to repeat series. The timing is really to note minimal interval between doses. If received 3 doses total, then done
What do you do/recommend in regard to prophylaxis in solid organ cancer pts with prolonged severe neutropenia (>7 days) despite GCSF.	This response depends on a multitude of factors including: institutional-based decisions/protocols, location of patient (inpatient/outpatient), infection history, local antibiogram, as well as applied therapies for their solid tumor. The primary antimicrobial prophylaxis consideration would be bacterial prophylaxis - for this considerations would be akin to what we discussed (e.g. FQ therapy or 3rd gen oral cephs in those intolerant or with contraindications to FQ).
What is the recommendation regarding C diff prophylaxis in neutropenic patients? I've seen that there has been a trend of the oncologists using vancomycin prophylaxis.	There are studies that have evaluated this. Can send f/u references in this regard. However, this is not a standard of care and this is not something done in my practice. The exception where this might be considered is a patient with recent C. difficile infection receiving broad spectrum antibiotics
When these pts have such low plts/ refractory to plt transfusions- I often get pushback on removal of ports in BSI in the severely neutropenic MDS/AML patients. Do you have any organisms you'll salvage ports in these patients?	*(This question was answered live from the podium.)*

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When would you prefer mold active prophylaxis for these patients? Based on exposure only? Is this board relevant?	Which specific patients are you referring to? For example, with agents such as ibrutinib, particularly monotherapy, we do not apply mold active prophylaxis. however, in patients with AML / MDS receiving intensive induction therapy with prolonged (>7) and severe neutropenia (<500) mold-active azole is recommended. I suspect that the board would not ask specific questions about mold-active ppx guidance but focus on this as a pathogen and identifying infection in this at-rlsk population.
Where can we access the slides of the Livestream sessions so we can annotate while tuning in in real-time?	Slides can be accessed via EventScribe app in the App Store or Googly Play. Install app, search for 2025 IDBR, log in using your username (email address) and access key that was emailed to you from Eventscribe.com.
Why is cefepime always preferred to pipe/tazo for neutropenic fever? Is there a specific reason for that?	In attempt to minimize anaerobic coverage if not necessary required.
Why isn't the answer to to slide BR Day 1 slide #13 to check titers rather than go straight to vaccination?	*(This question was answered live from the podium.)*
Would Vabomere still be preferred if the KPC has high resistance to Meropenem?	Thanks - so yes. Even with high resistance to meropenem if the KPC-producing isolate is susceptible to meropenem-vaborbactam, I would use it. The vaborbactam is very good at inhibiting KPC enzymes so the meropenem MIC should decrease substantially with the combination.