IDBR 2025: Q and A

Day 1: Sunday, August 17, 2025

Question	Reply	Submission Date	Submission Time
What's a good age range to suspect neutrophilic dysfunction in a question?	*(This question was answered live from the podium.)*	08/17/2025	09:27:07
Since S aureus infections are super common and we see Infective endocarditis with metastatic infections at various sites, when should severe S aureus infection raise suspicion for CGD? when do you initiate immune workup?	*(This question was answered live from the podium.)*	08/17/2025	09:27:45
Can you comment on non-chemotherapy-associated febrile neutropenia? Aka patients with chronic neutropenia (either genetic or induced by drugs other than chemo) who develop fever ? Do they need same management ?	*(This question was answered live from the podium.)*	08/17/2025	09:28:27
Can you explain why the answer to q1 is not A (check IgG subclasses as well as vaccine titers?)	*(This question was answered live from the podium.)*	08/17/2025	09:29:08
FQ also cause retinal detachment and with dysglycemia, do you recommend it against using them in Diabetics and/ or use them with caution?	*(This question was answered live from the podium.)*	08/17/2025	10:04:30
what is a pregnancy risk with macrolides? We use it for chlamydia in these pts.	*(This question was answered live from the podium.)*	08/17/2025	10:18:01
As vancomycin is a time killer not a concentration dependent killer, why loading is needed?	vanco has both time- and concentration-dependent killing activity;	08/17/2025	10:58:58
What is your preferred antibiotic for its antitoxin properties with respect to linezolid vs clindamycin?	Personally, I use linezolid more though many feel that there are more and ? better data with clindamycin; don't think you'll be asked to choose one over the other	08/17/2025	11:00:49
What are your thoughts on the practice of using IV daptomycin for staph related PJI's as opposed to cirpofloxacin/rifampin?	both are reasonable; choice depends on patient factors	08/17/2025	11:01:38
Is the Oritavancin warning against Osteomyelitis an artifact of study design I.e. missed osteomyelitis at the outset?	Could be though the cases were pretty impressive; not aware of more or recent data, unfortunately	08/17/2025	11:02:22
Dalbavancin is weekly or biweekly dosed for soft tissue infection for exam?	either ok - the 2 dose regimen requires coming back on day 8 so many prefer the single 1500mg dalvavancin IV dose	08/17/2025	11:03:07
Is omadacycline typically active against doxycycline resistant MRSA?	yes, omada is typically active; it was designed to bypass common tetracycline resistance mechanisms, including ribosomal protection, efflux. For serious MRSA serious infection, I would recommend checking omada MIC	08/17/2025	11:06:38
What is the efficacy of minocycline against ESBL infections?	may be a consideration for step down based on in vitro testing (would not use without MICs)	08/17/2025	11:13:50
How often should one monitor ekg while on fluoroquinolones when treating osteomyelitis?	Not sure there is a definite answer - I would obtain baseline and at regular intervals after 2 weeks, more often if + more risk factors	08/17/2025	11:14:39
Can you comment on thrombocytopenia risk with linezolid vs tedizolid? Is it really lower with tedizolid/can you use it longer before cytopenias develop?	This is controversial..risk MAY be lower with tedizolid but we've seen examples occurring relatively early in therapy	08/17/2025	11:15:41
Do you have any thoughts about cross-reactive allergic response to Daptomycin and Dalbavancin if a pt has a true Vanco allergy (not Redman/Redperson)? Do you use these meds of there is a true Vanco allergy? Thanks	No real data that I'm aware of, we take on a case-by-case basis	08/17/2025	11:16:42
can we use doxy with breast feeding	FDA data shows that doxy gets into breast milk but says short term (<3 weeks) may be ok; suggest alternative and peds consult	08/17/2025	11:22:01
Great point about prostate penetration - oral fosfomycin gets in very well.	good prostate penetration: quinolones, TMP/SMX, oral fosfomycin	08/17/2025	11:23:28

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Same Q for Chagas - any role for pre-immunosuppression screening?	Good question. I've had lots of conversations with people about this question over the years. Many transplant centers screen for chronic indeterminate Chagas disease prior to bone marrow or solid organ transplantation. If someone has positive antibody testing to Chagas disease, the general recommendation is not to pre-treat but rather to monitor for Chagas reactivation by serial PCR testing of the blood. This service is provided by the CDC. Basically one does pretty frequent testing (weekly I think for the few few months after transplant) initially, and then decrease to less frequent (biweekly, then monthly) for the next few months. Patients are started on treatmen if they become PCR positive in the blood for Chagas.	08/17/2025	12:00:20
Same Q for Chagas - any role for pre-immunosuppression screening?	I don't think this is typically done prior to other immunosuppression indications.	08/17/2025	12:00:55
If visceral leishmania can reactivate with TNF α inhibitors, any role for pre-immunosuppression screening? If yes with PCR, serology?	There are no general recommendations to screen for Leishmania prior to immune suppression. There are 2009 bone marrow transplant/ID society recs for parasitology screening and they mention this could be a concern but screening generally not done. There is also a group in Barcelona that does report that they screen for Leish IgG. In 2016 they published a screening approach for parasitic infections prior to bone marrow transplant. The parasites they screen for are Strongyloides, Schisto (which shouldn't worsen with transplant), Toxo, T. Cruzi, and Leish. The reference is Am J Trop Med Hyg 95(6)2016 pp1463-8. That said I don't think most groups screen for Leish prior to immune suppression.	08/17/2025	12:09:06
For leishmania detected prior to transplant or reactivated/acquired after transplant, want to clarify if all those patients are treated regardless of severity of presentation?	all active VL should def be treated. maybe you were asking something else? Feel free to email/call me if you want to talk more about pre-screening for parasitic infections prior to immune suppression. It's an interesting topic	08/17/2025	12:10:42
Wouldn't "medical leeches" be grown in a sterile environment?	hello Dr. Kuruppu! I didn't talk about leeches but my understanding is that even medical leeches carry certain bacteria (such as Aeromonas) in their intestinal tracts.	08/17/2025	12:12:18
With P. vivax having very low prevalence in Africa, in large part due to the Duffy antigen, could one safely rule out P. vivax as the answer on a board question if the stem involves a patient returning from Africa with suspected malaria or appropriate prophylaxis for patient going to Africa?	Ah...that would be nice. However, while P vivax has low endemicity in much of Africa, certain areas have P vivax (including areas of East Africa and Madagascar). in West and Central Africa rates of P vivax are very low but not zero.	08/17/2025	12:14:04
Malaria: we have had no mefloquine since early 2024. So we use atov/proguanil	I haven't prescribed mefloquine in a few eyars, but I thought it was still available. I just checked and it looks it's still available. Maybe I'm missing something? I agree that it seems reasonable that if mefloquine is not available then one can have a discussion with a patient regarding the risks/benefits of going with atov/proguanil. As I mentioned, it's gen not recommended more b/c of lack of experience with it than a known strong teratogenic risk.	08/17/2025	12:17:35
What is the duration for clinda in addition to beta lactam therapy in nec fasc	*(This question was answered live from the podium.)*	08/17/2025	12:24:12

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"For leishmania detected prior to transplant or reactivated/acquired after transplant, want to clarify if all those patients are treated regardless of severity of presentation?" I meant CHAGAS not leishmania	*(This question was answered live from the podium.)*	08/17/2025	12:26:11
Can you comment on the treatment of Chagas infected pregnant women's babies after birth?	*(This question was answered live from the podium.)*	08/17/2025	12:45:35
what about switching to Levaquin	*(This question was answered live from the podium.)*	08/17/2025	13:05:54
what about switching to levaquin for mycoplasma	*(This question was answered live from the podium.)*	08/17/2025	13:07:12
For question #19 -- can't rifaximin interact with his plavix leading to inc risk for bleeding? Thanks	*(This question was answered live from the podium.)*	08/17/2025	13:16:39
Is post artesunate hemolysis a contraindication to future artesunate use?	*(This question was answered live from the podium.)*	08/17/2025	13:23:58
Daptomycin is not ideal for epidural abscess and vertebral OM as well ? correct	*(This question was answered live from the podium.)*	08/17/2025	13:33:28
EHEC, especially O157:H7 has a very low infectious dose as well as Shigella and person-person spread occurs. It's more likely Shigellosis because of the mucous and fever	*(This question was answered live from the podium.)*	08/17/2025	13:52:52
In low viremia and unable to test for resistance but u suspect resistance - do u switch to alteranate resistance therapy?	Often just reducing immunosuppression will allow the CMV to fade away, with low level viremia/DNAemia. We tend to try to overtreat those. I would usually not switch therapies in that setting, but try to reduce immunosuppression. You could try maribavir, if needed, but that's a very $$ choice.	08/17/2025	14:46:34
Hello, have you used Cytogam in conjunction with ganciclovir or vanganciclovir life long for CMV treatment/prevention in any patient with NK defect and history of treated lymphoma. The patient I see lost his left eye to CMV retinitis and has controlled CMV retinitis in the right eye. Thanks!	Those are very challenging cases. I worry about resistance developing, which could be devastating. It's reasonable to consider CMV IG in that setting. Feel free to email me if you want to discuss further. I have a very similar case. Camille Kotton, ckotton@mgh.harvard.edu	08/17/2025	14:48:31
For HCWs: Is a hepBs Ab titer of >10 without documentation of hep B vaccination a dependable evidence of immunity (with hepB c Ab negative)? Thanks!	yes it technically is especially if there is also anti core indicating prior infection. if not and the titer is low, i would vaccinate and repeat a titer to see if there is an anamnestic response	08/17/2025	15:19:22
fulminant and relapsing HAV are more common in chronic HBV and HCV patients? What about in HIV esp untreated?	HIV infection doesn't appear to markedly affect the severity of acute hepatitis but it does increase the risk of accumulation of fibrosis, even quickly	08/17/2025	15:20:26
Question -4 - Bloody diarrhea- though travel and stem points to salmonella- wont u wait for studies since bloody diarrhea?	Hi Lavanya, with progression to dysentery (abdominal pain, blood, mucus), Shigella and Campylobacter would be much more likely than Salmonella. You are right that the threshold for treatment of Salmonella is higher, but here empiric therapy for dysentery is warranted!	08/17/2025	16:30:03
any pointers as to why/which shellfish lead to paralytic shellfish poising?	HI -- it looks like it is mostly mussels, oysters, clams and scallops -- because these shellfish feed on the algal blooms that generate the toxin!! Glad you asked -- now I know!!	08/17/2025	16:31:17
Are there studies suggesting that treating Campylobacter if symptoms present > 72 h is of any benefit? Note, dx often not made before that.	I might add that I think prolonged duration is sometimes included as an indication to treat, rather than a reason not to!	08/17/2025	16:33:00

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Can you comment on role of gallbladder as salmonella reservoir?	Jack was absolutely right to highlight the role of gallstones -- not surprisingly biofilms are involved. Thanks for the question -- James	08/17/2025	16:35:25
How about treatment in chronic hep B and use of monoclonal AB for other illnesses, ie UC or Crohns? Do we follow the same GL for treatment of Hep B?	generally those are moderate risk treatments that may require prevention if cirrhosis, pos sAg, etc. I would look each one up unless sure. AASLD has guidelines online	08/17/2025	17:18:17
Can you comment on the use of quant HBsurface Ag. When to dot i, is it useful to check together with DNAWhen to do HDV atb? Baseline only or repeated? Thank you	great question. i ran out of time or would have covered it. I do it on baseline in everyone but not in guidelines yet. it will determine whether new bepi med will work when it is apprroved in 2026	08/17/2025	17:19:36
Is that high viral load immune tolerant hep b a risk for transmission? Could that be a reason to treat?	it would be a reason to treat and I have some young persons who want to be sexually active who have told me they want to be treated even if not in guidelines. i do. but feeling is that since treatment is indefinite that it isn't worth risk to young persons to be on treatment for decades adn vaccine is the main way to prevent transmission	08/17/2025	17:21:18
I just want to be sure I understand please: For decompensated cirrhosis options are longer duration Sof/Vel or Sof/Vel + ribavarin?	correct. either 24 weeks (vs 12) or use RBV for shorter	08/17/2025	17:22:22
In practice (and to ease insurance approval) wouldn’t it be more cost effective to hold atorvastatin and then treat with glecaprevir/pivrentasvir as opposed to using an alternative regimen that may require a more prolonged course of therapy 12 wk (vs 8 wk with GP)?	yes, definitely a good solution. I hold statin when I cannot get an alternative regimen approved. but dont try to guess what the cost actually is. 12 weeks of sof vel can be cheaper than 8 weeks of gp. just depends on the 'deal'	08/17/2025	17:24:44
TDF is so cheap and TAF is $1500/month with tons of paperwork. Can you clarify if you saying to never use TDF anymore at all?	TDF., TAF and ETV are all first line and I will use any if insurance requires. but all things being equal I prefer TAF over TDF bc of less bone and renal complications	08/17/2025	17:28:09
Is the drop in hospital incidence of cdiff and concomitant rise in community rates due to the fact that hospitals are discouraging testing hence patients may go home and get readmitted and immediately tested?	*(This question was answered live from the podium.)*	08/17/2025	17:44:06
Do you treat the third recurrence first before the FMT or other biological treatment?	*(This question was answered live from the podium.)*	08/17/2025	17:55:12
Can you comment on preemptive therapy?	*(This question was answered live from the podium.)*	08/17/2025	17:55:47
Any recommendations for checking baseline ecg before fidaxomicin use?	No. FDX is not well absorbed. Retrospective studies have not found a signal for cardiac effects of FDX.	08/17/2025	18:18:09
Isn't all the work in HP being done by GI.? Why should ID care, we have enough infections to take care of	The ABIM wants you to know about this infection. So do I!	08/17/2025	18:18:34
Along with antimicrobial resistance, is H. pylori eradication affected by differences in PPI metabolism due to CYP2C19 polymorphisms? If so, is this something the exam might ask about?	Yes this is a clinically-relevant issue but I think human genotyping is not yet recommended widely and probably not on the boards. For next year I will check and see if there is reason to add to my slides. Someday this testing might be recommended but not yet. THANKS for your question!	08/17/2025	18:21:03
What's the alternative agent for a patient who is intolerant to azithromycin and clarithromycin? do we have options	There are many recommended treatments for Hp that do not include macrolides. the tables in my slides show some good examples.	08/17/2025	18:22:13

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If H pylori is only sensitive to tetracycline by Mayo Clinic sensitivity testing (patient was treated by GI 4-5 times) is there any hope for a regimen to treat this or only recommend yearly EGD? Thanks!	Hard to comment on this here with out more info, and unlikely to be on boards. There are some good reviews on salvage therapy for Hp that have some creative thoughts. Collaboration with GI and, as you note, regular follow up might help. Sometimes we are out of options.	08/17/2025	18:23:55
For Strongy we routinely screen in new HIV diagnoses. Do you support this practice? In reference to your slide of it doesn't reactivate in HIV	I'm always a fan of screening for Strongyloides :) Usually I recommend screening everyone who is at risk at least once (immigrants, long-term travelers). If someone has a new dx of HIV but never was in a Strongy endemic area the benefit of screening is probably low, but I am not against it. Note that when AIDS was initially defined with a list of AIDS-defining illnesses, Strongyloides was on the list. Everyone thought that Strongy hyperinfection would occur all the time in AIDS patients. But it doesn't. We don't know exactly why but it's probalby because granulocyte populations (especially eosinophilis) retain their numbers and function in HIV, and those cells are likely more important than T cells in controlling worm infections. Strongyloides was removed at some point from the list of AIDS_defining diagnoses.	08/17/2025	18:40:05
For E granulosus, albendazole is currently back order in Canada. What alternatives would you recommend? Mebendazole alone? Mebendazole + praziquantel? Praziquantel alone?	That's tough. Praziquantel has some efficacy. Mebendazole has poor systemic absorption, so likely wouldn't be too effective. I'm not sure what the right answer is here. That's a difficult issue.	08/17/2025	18:40:56
Can you elaborate on E granulosus vs multilocularis in terms of presentation?	i didn't comment on it in this talk due to time. I think I do talk about it in one or two slides in the online worms talk. Basically, granulosus is much more prevalent. multilocularis is acquired by exposure to feces of foxes (and other similra animals). Radiographically multilocularis cysts present with borders that are not well defined...the parasite is penetrating into surrounding tissue. Clincially, multilocularis is more lethal and more difficult to treat. It behaves like a tumor and can metastasize to other places in the body. Treatment is usually very long term.	08/17/2025	18:43:06
Even if the neurocysticercosis is calcified and old on imaging with no symptoms - still indicated to treat?	If all the cysts are calcified then there's no indication to treat with anthelmintics. Often though a person will have some that are calcified and others that are still active.	08/17/2025	18:43:45