IDBR 2026: Q and A
Day 2: Sunday, August 23, 2026

Question	Reply	Submission Date	Submission Time
While awaiting IV artesunate to arrive, what would be the initial treatment choice in severe malaria?	Good question. I mentioned it in my talk but just to reiterate: I think every ID physician should figure out how they would treat severe malaria (including how they'd obtain artesunate) before a case comes in. Travel is very common and lethality and morbidity of severe malaria increases with delays in therapy. That stated, if you find yourself in this situation, the typical advice is to administer an oral antimalarial while awaiting artesunate. Ideally this would be artemether/lumefantrine (Co-artem). Atovaquone/proguanil (Malarone) would also be an option. If the patient can't be given po, then this could be given by NG tube. IV quinidine is no longer readily available but I could see cases in which this could also be an option if you had access to it (need to monitor qt). I would definitely call the malaria treatment hotline which CDC staffs 24/7. Would reach out to them for any case of malaria where you have any treatment questions.	08/23/2026	10:32:35
What is considered new world and what is old world?	Americas = New World. Everywhere else = Old World.	08/23/2026	10:34:31
We cannot find any Mefloquine. So what is 2nd choice for pregnancy prophy?	For areas with chloroquine resistance at this time only Mefloquine is recommended. If you can't get it then clearly very careful mosquito avoidance. Feel free to reach out to me by email and I can try to help you locate mefloquine for pregnant travelers.	08/23/2026	10:37:35
Does the CDC still perform Leish species identification?	Good question. I'm not sure if they care currently doing this. If you have issues finding a lab that does species identification by PCR reach out to me by email and I can help you locate one. I typically use WRAIR (Walter Reed Army Institute of Research) but this is not available for patients outside the department of defense.	08/23/2026	10:40:32
Why not meropenem rather than imipenem with its increased seizure risk?	*(This question was answered live from the podium.)*	08/23/2026	10:42:05
How fast does an epidural abscess appear in an IVDU use? And how fast does it progress to radicular pain and paresthesias, and then stages 3/4 of paralysis. What time frame of back pain to not think this is an epidural abscess?	*(This question was answered live from the podium.)*	08/23/2026	10:51:50
Question for Dr. Tunkel from Gisela Macphail in Zoom Chat: How do you know when the patient with epidural or brain abscess has had enough duration of antibiotic? The MRI changes lag the clinical improvement. Duration of therapy? How to determine the end point?	*(This question was answered live from the podium.)*	08/23/2026	11:34:40
Is there a way to leave a question on a screen when options appear?	*(This question was answered live from the podium.)*	08/23/2026	12:47:58
If the person has G6pd deficiency what do you use for p.vivax/ovale?	In individuals that are G6PD deficient, CDC recommends consideration of weekly chloroquine prophylaxis for a year after iniital treatment with chloroquine or artemether/lumefantrine. Note that some malaria experts recommend an altered regimen in which primaquine at a different dose is given once a week for 8 weeks rather than daily for two weeks, with monitoring for development of hemolysis, however, this is not in the CDC guidelines.	08/23/2026	13:21:52

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Should we expect a question on Guinea worm?	It's hard to guess exactly what the boards will cover. Guinea worm (dracunculiasis) is very uncommon (just a handful of cases per year...about 10 in all of 2025), but it still persists and is something that could potentially be asked. I cover it briefly in the Even More Worms talk which is available in the online materials.	08/23/2026	13:24:56
Can you have breakthrough rabies after post exposure prophy with rabies immunoglobulin plus vaccine?	*(This question was answered live from the podium.)*	08/23/2026	13:26:20
Can you please specify in the talk you mentioned that you need to quantify microfilaria with serology if you want to treat loa loa?	Serology does not quantify the microfilaria burden in the blood. I was rushing at the very end and it's possible I tripped over my words. A positive filaria serology is helpful in cases of suspect Loa loa as it can help make a presumptive diagnosis in the right clinical setting (for example someone with peripheral eosinophilia and Calabar swellings). All patients with Loa loa need to have microfilaria levels quantified before treatment with DEC. A common approach for microfilaria quantification in the blood is by filtering a known quantity of blood (for example, 1 ml) through a filter , removing the filter paper and staining it, and then counting the number of microfilariae on the filter.	08/23/2026	13:29:01
Is there a cutoff for degree of eosinophilia that is seen during these hemlith diseases?	Eosinophilia is typically defined as an absolute eosinophil count in the blood of greater than 500 cells per microliter. Eosinophilia, when present, is helpful to get someone thinking about helminths, but many helminth infections do not have eosinophilia. A key driver of eosinophilia in helminth infection is how much tissue invasion is occurring by the worm. For example, in ascaris, it's common to see peripheral eosinophilia in the context of Loeffler's syndrome when the larvae are migrating through the lungs, but uncommon when adult worms are residing in the intestinal tract (where they don't really invade the tissue). Hookworms, which always have some tissue invasion, have a higher frequency of causing eosinophilia. Bottom line: presence of eosinophilia is helpful in getting one to think about helminths, but lack of eosinophilia does not rule out worm infection.	08/23/2026	13:33:37
anti-NMDAR Encephalitis can reoccur ? would you recommend prophylactic oopherectomy if no teratomas found on imaging ?	*(This question was answered live from the podium.)*	08/23/2026	13:34:07
What do you actually biopsy in nuchal for rabies?	*(This question was answered live from the podium.)*	08/23/2026	13:37:56
Is an ophthalmological exam (fundoscopic exam) required before we treat neurocysticerosis requiring steroids with praziquantel and albendazole? Somebody mentioned at work that breakdown products as it's treated can cause blindness if there is ophthalmological involvement. Have you seen that?	Yes...fundoscopic exam is recommended for cysticercosis prior to medical treatment for exactly the reasons you mentioned. A colleague of mine had a case but I have not personally been in charge of the care of a patient with an intraocular cysticercus.	08/23/2026	13:39:02
What do you actually biopsy when you say nuchal biopsy in rabies	You take a section of skin 5-6 mm in diameter from the posterior region of the neck at the hairline. Biopsy must contain a minimum of 10 hair follicles and be of sufficient depth to include the cutaneous nerves at the base of the follicle.	08/23/2026	13:44:03
For patients with both HSV and VZV positive PCR CSF found to have positive HSV PCR over 1 month later, what is the likelihood of initial crossreactivity between HSV/VZV PCR?	not sure of the answer, but I would suspect there is not cross reactivity.	08/23/2026	13:44:57

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Any evidence for IVIG or other therapies for West Nile Transverse Myelitis?	Interesting question. Not sure it would treat the WNV, but I would use standard therapies for transverse myelitis.	08/23/2026	13:46:52
Could you help contrast HSV encephalitis from acyclovir toxicity vs nadar	For acyclovir toxicity, I would say that patients would develop symptoms of confusion, hallucinations, tremors and agitation within about 3 days of starting the medication. May be more likely in the elderly and those with renal insufficiency or those with volume depletion. For herpes encephalitis vs nmdar, it would depend of CSF diagnostic studies for each entity.	08/23/2026	13:52:07
Any comment on scedosporium and near drowning	Scedo is certainly on the list of organisms that can cause infection after near-drowning. It will much more likely to be present in stagnant, contaminated water rather than rivers, clean ponds/lakes, or the ocean.	08/23/2026	14:16:29
What do you mean by grossly contaminated for water in drowning? What antibiotics would you reach for?	Grossly contaminated water will capture long-standing stagnant water, sewage, or bodies of water that captures sewage or agricultural runoff (either by design or after a natural disaster). An antipseudomonal will be your go-to to cover Gram negative organisms. The Wilderness Medicine Society still recommends against prophy antimicrobials for this circumstance but it's generally accepted. For the board exam I would expect the patient to have developed symptoms consistent with pneumonia and a good description of the water source.	08/23/2026	14:23:40
For HSV or vzv encephalitis any data to favor transition from IV to oral after 5-7 days of iv acyclovir?	Tradionally for CNS infections, this is all parenteral therapy.	08/23/2026	15:00:56
The Chagas question is confusing as some would think that two tests are already positive.	It's two different serological tests using two different methods due to false positive rates.	08/23/2026	15:01:48
Would a patient's HSV CSF PCR have to become negative to consider autoimmune encephalitis? Also, how long do we expect HSV PCR to remain positive in CSF after initial diagnosis?	Typically HSV PCR turns negative within 7-10 days of acyclovir therapy. It would be negative typically when autoimmune encephalitis develops.	08/23/2026	15:03:15
Does a negative HSV blood serology eliminate the possibility of HSV encephalitis (for those unable to get an LP or to have it repeated 7d later)	False negative serologies do occur in 12-30% depending on the kit used, for latent infections especially if antiviral therapy is given during primary infection or patient is immunosupppressed.	08/23/2026	15:06:32
Can you please comment on hospital diagnostic stewardship for stool culture/multiplex PCR?	*(This question was answered live from the podium.)*	08/23/2026	15:16:17
In question 6 is cystoisospora not a concern?	*(This question was answered live from the podium.)*	08/23/2026	15:16:28
I don't quite understand the answer to question 24 - the pregnant patient with possible Chagas. The stem says the blood bank did a test which was followed by a positive confirmatory test. Is that not considered 2 tests?	You are correct. The stem included that she had already had a confirmatory test, making it a confusing question. Teaching point remains the same but the stem should not have had that in it...the teacing point was that a positive Chagas serology should always be confirmed with a 2nd test obtained with a different platform.	08/23/2026	15:18:42
Q24 mentined in the stem that a confirmatory test was done	The stem included that she had already had a confirmatory test, making it a confusing question. Teaching point remains the same... a positive Chagas serology should always be confirmed with a 2nd test obtained with a different platform.	08/23/2026	15:20:45
Question from Zoom chat for Dr. Platts-Mills from M297941: how long after administration of oral typhoid vaccine should you avoid antibiotics?	I believe that the standard advice is no antibiotics until 3 days after the last dose!	08/23/2026	15:40:46
In typhoid fever, refs from the 90's in UpToDate describe diarrhea more than constipation. (Gasem Trop Geogr Med. 1995;47(4):164. Gotuzzo Arch Intern Med. 1991;151(2):381.) Is this still true?	In adults, certainly constipation is more common. If those references are in children, diarrhea can be more common, and possibly in immunocompromised patients as well.	08/23/2026	15:42:22
I thought Babesia had a longer incubation period?	*(This question was answered live from the podium.)*	08/23/2026	16:43:38

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What is likely to give a false positive MTT test in patient who does not have clinical signs or symptoms to suggest Lyme disease? How often do you see other Borrelia species produce + MTT?	So in a high endemic region, a positive is highly likely to be a true positive and series testing MTTT have found >99% specificity. However, if moving to low endemic region without exposure elsewhere, then there is a 100% false positive rate. Regarding other Borrelia spp., it may cross-react with B. mayonii, and European genospecies as well as tick-borne relapsing fever Borrelia.	08/23/2026	17:04:42
Are there any commerically available tests to diagnose European Lyme disease in a traveler other than the Mayo European Lyme test? Will MTT test be positive in European Lyme and if so which strains?	Generally not, although the components of some MTTT kits can be positive because of conserved antigens.	08/23/2026	17:05:41
Are the cases in florida coast counties of Lyme people who live in Florida half the year (snowbirds) or are they locally acquired?	Babesia can have a longer incubation period, typically 1-4 weeks. the issue is that co-infections may not come from a single tick bite but two or more.	08/23/2026	17:07:54
Are the cases in florida coast counties of Lyme people who live in Florida half the year (snowbirds) or are they locally acquired?	Florida Department of Health determined that almost all cases were imported into the state (acquired elsewhere) when I worked with them about 10 years ago. There are a handful of acquired cases without exposure, but these are often based on serology not EM rash, or may have been STARI, so unclear they truly represent B. burgdorferi.	08/23/2026	17:09:28
Just a comment - doxycycline is also the recommended first-line treatment for RMSF during pregnancy (in addition to children).	So for HME and RMSF short courses of doxycycline are recommended by CDC. Chloramphenicol has higher maternal fetal risks. HGA can receive rifampin	08/23/2026	17:12:08
For cryptococcus skin lesions, is a biopsy diagnostic?	*(This question was answered live from the podium.)*	08/23/2026	17:15:38
I have young man who is healthy with pulmo cocci and large cavitary lesion in lung. He is pretty asymptomatic now but lesion getting bigger. Treatment has not been helpful. Do I need to just send him for resection or ok to wait?	*(This question was answered live from the podium.)*	08/23/2026	17:20:34
Do all candidemias require a TTE?	*(This question was answered live from the podium.)*	08/23/2026	17:35:10
If you have hiv POS pt with T cell low 200s. Had crypto meningitis. Treated and did well. Still have very very high crypto titer in blood. Over 1:200. Still on fluconazole and has been retapped and csf was normal. Is there any reason to follow the titer? patient feels well.	*(This question was answered live from the podium.)*	08/23/2026	17:40:38
For candidemia do we always need an ophthalmology consult? Or only if it's persistent	*(This question was answered live from the podium.)*	08/23/2026	17:43:02
Isn't there an older candidemia guideline that recommends an Ophtho consult that was published by IDSA?	*(This question was answered live from the podium.)*	08/23/2026	17:52:45
For RIME/MIRM, is there any guideline for abx course beyond what is expected for a M. Pneumoniae pneumonia or is this managed with immunomodulation?	Extended antibiotics are not likely helpful. This is usually inflammatory at this stage, and leave it to dermatology to guide.	08/23/2026	18:28:38