Infectious Diseases Board Review

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Disclosures & Acknowledgments

- Disclosures: No financial conflicts of interest to declare

- Acknowledgments: Slides adapted from Dr. Seth Cohen and Paul Pottinger

MEDICAL CONTENT CATEGORY	Target %
Allergy and Immunology	2%
Cardiovascular Disease	15%
Dermatology	3%
Endocrinology, Diabetes, and Metabolism	10%
Gastroenterology	10%
Hematology	4%
Infectious Disease	10%
Miscellaneous	1%
Nephrology and Urology	6%
Neurology	4%
Obstetrics and Gynecology	3%
Medical Oncology	6%
Ophthalmology	1%
Otolaryngology and Dental Medicine	1%
Psychiatry	3%
Pulmonary Disease	8%
Rheumatology and Orthopedics	10%
Geriatric Syndromes	3%
Total	**100%**

~20-22 Questions

https://www.abim.org/media/gdcb4plu/internal-medicine.pdf

SKIN AND SOFT TISSUE INFECTI					
Lymphadenitis and lymphangitis					
Diabetic foot infections					
Undifferentiated skin and sof					
CENTRAL NERVOUS SYSTEM					
Meningitis					
Brain abscess					
Encephalitis					
Epidural abscess					
Iatrogenic and postoperative					
Undifferentiated central nerv					
UPPER RESPIRATORY TRACT					
Acute and chronic sinusitis					
Otitis media and externa					
Mastoiditis					
Common cold					
Pharyngitis					
Epiglottitis					
Deep infections of head and					
Other upper respiratory tract					
SEXUALLY TRANSMITTED DISEASES AND INFECTIONS OF REPRODUCTIVE ORGANS *(<2% of exam)*					
Urethritis		MEDIUM	HIGH	MEDIUM	LOW
ENTERIC INFECTIONS *(<2% of exam)*					
Esophagitis (*Candida*, herpes simplex virus, cytomegalovirus)		MEDIUM	MEDIUM	MEDIUM	LOW
Gastroenteritis		HIGH	HIGH	MEDIUM	MEDIUM
Infections of the pancreas and pancreatic abscess	LF	MEDIUM	MEDIUM	MEDIUM	LOW
Bacterial peritonitis	LF	HIGH	HIGH	MEDIUM	MEDIUM
Intra-abdominal abscess other than liver and pancreas abscesses	LF	MEDIUM	MEDIUM	MEDIUM	LOW
ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) AND HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION *(<2% of exam)*					
Transmission and prevention of HIV	LF	HIGH	MEDIUM	MEDIUM	MEDIUM
Prevention of opportunistic infections	LF	MEDIUM	MEDIUM	MEDIUM	MEDIUM
Immune reconstitution inflammatory syndrome (IRIS)	LF	MEDIUM	MEDIUM	LOW	LOW
Neurologic complications of HIV infection	LF	MEDIUM	MEDIUM	LOW	LOW
Pulmonary complications of HIV infection	LF	MEDIUM	MEDIUM	MEDIUM	LOW
Gastrointestinal complications of HIV infection	LF	MEDIUM	MEDIUM	MEDIUM	LOW
Hematologic complications of HIV infection	LF	MEDIUM	MEDIUM	LOW	LOW
Oncologic complications of HIV infection	LF	MEDIUM	LOW	MEDIUM	LOW
Rheumatologic complications of HIV infection	LF	LOW	LOW	LOW	LOW
Cardio-metabolic complications of HIV therapy and infection	LF	MEDIUM	MEDIUM	MEDIUM	LOW
Oral complications of HIV infection	LF	MEDIUM	MEDIUM	LOW	LOW
Toxic shock syndrome	LF	HIGH	HIGH	MEDIUM	MEDIUM
Undifferentiated bacteremia and sepsis syndromes*		HIGH	HIGH	HIGH	MEDIUM

MEDIUM	LOW
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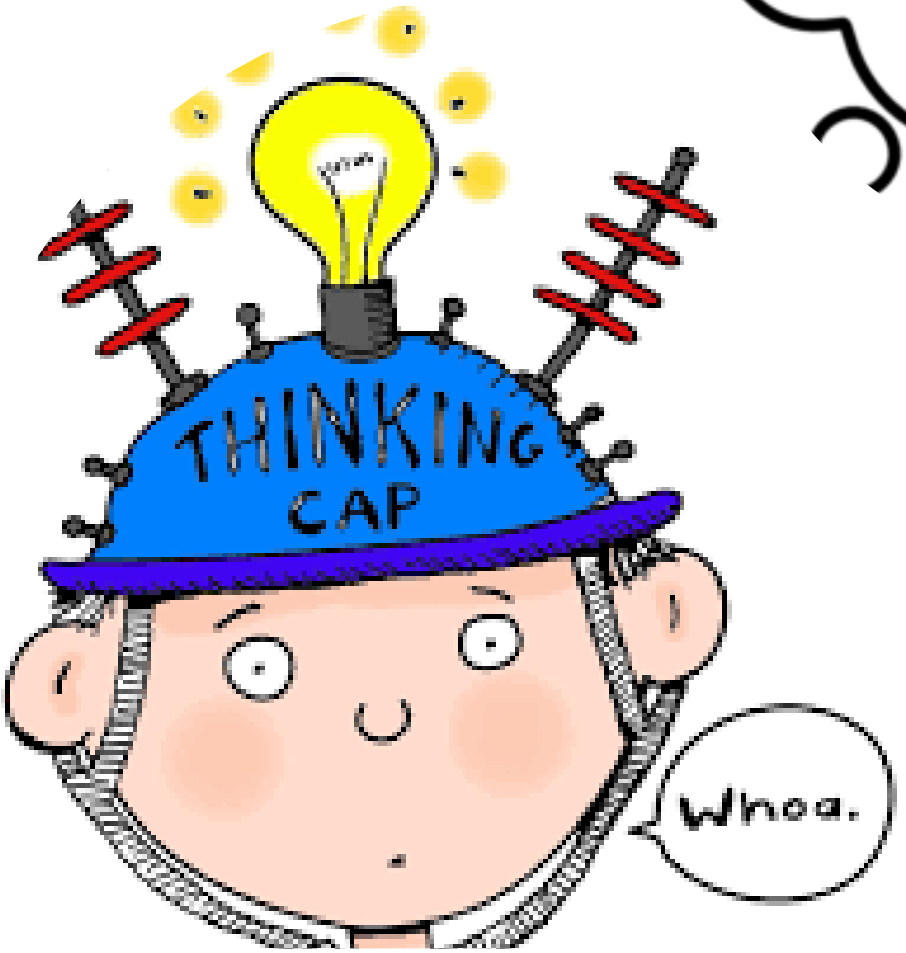
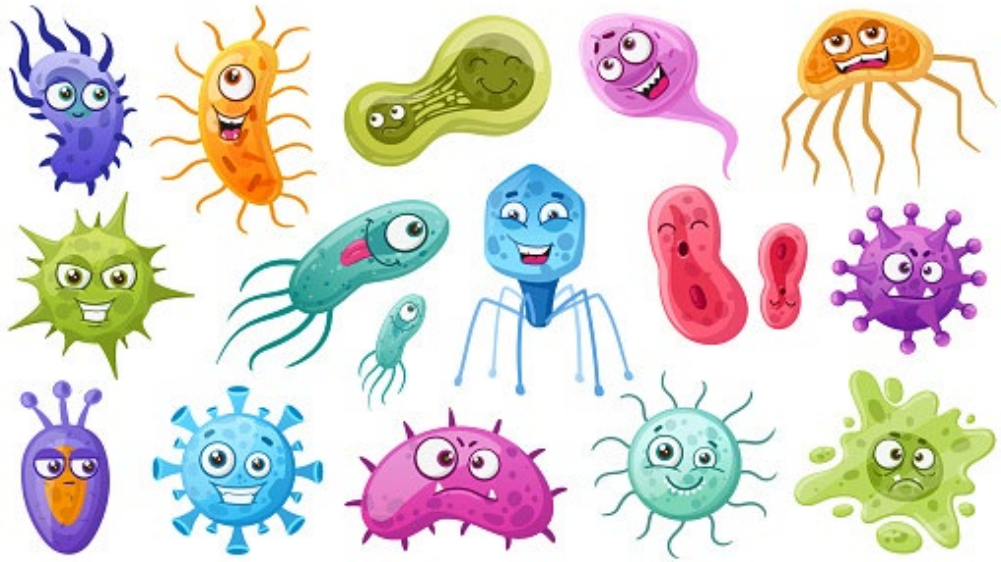
MEDIUM	MEDIUM

ID BOARD REVIEW

- Unusual bugs will be 1st order questions
  - *What's the diagnosis?*
- Common infections will get 2nd order questions
  - *How do you treat? Is there a special diagnostic test or association?*
- HIV: Focus on diagnosis, clinical manifestations
  - Management unlikely to be tested

Cases!





CASE 1

A 69-year-old man is evaluated in the preoperative clinic before undergoing transurethral resection of the prostate (TURP) for symptomatic benign prostatic hyperplasia. He reports no dysuria, urinary frequency, urgency, suprapubic pain, fever, or flank pain. His medical history includes hypertension and stage 3 chronic kidney disease.

As part of the preoperative evaluation, a urinalysis demonstrates positive nitrites and 15–20 white blood cells/high-power field. Urine culture grows >100,000 CFU/mL of Escherichia coli. His vital signs are normal, and physical examination is unremarkable.

What is the most appropriate next step in management?

A. No treatment is necessary because the patient has no urinary symptoms.
B. Begin culture-directed antibiotic therapy right before the planned procedure.
C. Repeat the urine culture after the procedure if urinary symptoms develop.
D. Delay the procedure indefinitely until the urine culture is sterile without antibiotics.
E. Start prophylactic antibiotics for a week prior to procedure and recheck urine culture for sterility

Answer:

What is the most appropriate next step in management?

A. No treatment is necessary because the patient has no urinary symptoms.
B. Begin culture-directed antibiotic therapy right before the planned procedure.
C. Repeat the urine culture after the procedure if urinary symptoms develop.
D. Delay the procedure indefinitely until the urine culture is sterile without antibiotics.
E. Start suppressive antibiotic for a week prior to procedure and recheck urine culture for sterility

Treat asymptomatic bacteriuria only in:

- Pregnant patients
- Patients undergoing endoscopic urologic procedures associated with mucosal trauma (e.g., TURP, transurethral bladder tumor resection, ureteroscopy with anticipated mucosal injury)

All other populations—including older adults, patients with diabetes, those with indwelling catheters, and most kidney transplant recipients—should **not** receive antibiotics for asymptomatic bacteriuria.

https://www.alamy.com/cute-funny-urine-analysis-character-vector-hand-drawn-cartoon-kawaii-character-simple-illustration-icon-isolated-on-white-background-so-glad-urine-my-life-quote-image477148166.html

CASE 2

A 74-year-old man presents with his second episode of Clostridioides difficile infection in the past 3 months. His initial episode occurred shortly after receiving clindamycin for cellulitis and was treated with a 10-day course of oral vancomycin, with complete resolution of symptoms. However, 2 weeks after finishing treatment, his diarrhea has returned. He is afebrile, hemodynamically stable, and tolerating oral intake. Stool testing is again positive for C. difficile toxin.

Which of the following is the most appropriate next step in management?

A. Start oral metronidazole
B. Repeat oral vancomycin with a taper this time
C. Start oral fidaxomicin
D. Administer fecal microbiota transplantation
E. Start intravenous vancomycin

Answer:

Which of the following is the most appropriate next step in management?

A. Start oral metronidazole
B. Repeat oral vancomycin with a taper this time
C. Start oral fidaxomicin
D. Administer fecal microbiota transplantation
E. Start intravenous vancomycin

Treatment of Recurrent C. Diff

- IDSA Guidelines now recommend **oral fidaxomicin** as the preferred choice for **first recurrence**, as it reduces the risk of further recurrence compared to vancomycin.
- If cost-prohibitive, can do oral vancomycin again and consider adding a taper.
- Only use metronidazole in IV form and in combo w/ PO Vanc for severe disease
- For >2 recurrences, can consider fecal microbiota products such as traditional FMT or new rectal suspension(Rebyota) or oral capsule (Vowst)

CASE 3

A 66-year-old man presents with 1 week of fevers, abdominal pain, and diarrhea. He is 6 months s/p liver transplant for cirrhosis 2/2 alcohol use. He had one recent episode of rejection treated with high dose steroids. He is EBV-positive, HSV-2 positive, CMV R-/D+.

- PMH: ESLD complications pre-transplant, recurrent genital herpes
- Meds: Tacrolimus, prednisone 20mg daily, TMP-SMX DS daily, omeprazole, acyclovir 400mg BID

CASE 3

- Physical Exam: T 38.2, HR 96, BP 118/74, non-toxic in appearance, mild mid-epigastric tenderness without rebound
- Labs: WBC 2.6, Hct 42, Plt 86k, electrolytes normal. Blood CMV PCR negative.
- Micro: Stool O&P negative, C diff PCR negative, stool culture negative.
- Colonoscopy shows inflammation and multiple well demarcated ulcerations in the proximal colon, biopsies pending.

Which one of the following is the next best step?

A. Start ganciclovir

B. Start foscarnet

C. Start ciprofloxacin + metronidazole

D. Start acyclovir

E. Start steroids

Answer:

Which one of the following is the next best step?

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E. Start steroids

CMV After Transplant

- Buzz words: rejection, high dose steroids, D+/R-
- Spectrum of disease
  - Asymptomatic viremia
  - CMV syndrome (60%): fevers, fatigue, leukopenia, CMV viremia
  - Tissue invasive disease: GI, hepatitis, pneumonia (usually post-lung transplant)
- Disease usually occurs within 1st 6 months post-op (or after heavy immunosuppression)

CMV After Transplant

- Diagnosis: CMV PCR, may be negative in GI disease

- Treatment: Ganciclovir or valganciclovir
  - Side effects: leukopenia/neutropenia
  - Second line agents: Cidofovir or foscarnet

Serum CMV PCR may be negative in CMV colitis, treat CMV with ganciclovir or valganciclovir, D+/R- should be a red flag

CASE 4

A 28-year-old man presents to establish primary care. He has sex with men and reports three sexual partners in the past 6 months. He uses condoms inconsistently. He was treated for rectal gonorrhea 4 months ago. He has no history of HIV infection and feels well.

Laboratory studies:

- HIV antigen/antibody test: Negative
- HIV RNA: Negative
- Serum creatinine: Normal
- Hepatitis B surface antigen: Negative
- Hepatitis B surface antibody: Positive
- Hepatitis C antibody: Negative

CASE 4

Which of the following is the most appropriate next step?

A. Begin bictegravir/emtricitabine/tenofovir immediately

B. Prescribe daily emtricitabine-tenofovir disoproxil fumarate

C. Prescribe dolutegravir plus lamivudine

D. Repeat HIV testing in 6 months before initiating prophylaxis

E. Administer post-exposure prophylaxis

Answer:

Which of the following is the most appropriate next step?

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HIV Pre-Exposure Prophylaxis (PrEP)

- **Two drug tenofovir disoproxil fumarate-emtricitabine** is drug of choice
  - Alternative: tenofovir alafenamide-emtricitabine, but not receptive vaginal sex
- Use should be considered in MSM, serodiscordant couples (if one partner has a detectable viral load), PWID, etc.
- Document negative HIV Ag/Ab test and normal Cr before use
- **Check HBV status** (tenofovir and emtricitabine effective against hep B)

HIV Post-Exposure Prophylaxis (PEP)

- Can be used for occupational or non-occupational exposures
- Start as soon as possible after exposure, **must start within 72 hours**
- Treat for **28 days** (4 weeks)
- **Use a three-drug regimen**
  - Tenofovir disoproxil fumarate-emtricitabine + raltegravir or dolutegravir

HIV Testing

Screening

Test all adults at least once with a 4th generation HIV Ag/Ab assay

Diagnosis

Typically done with a 4th generation HIV Ag/Ab assay

If concerned for **acute HIV, obtain HIV-1 RNA (viral load)**

If 4th generation HIV Ag/Ab assay is positive, this is verified with a HIV-1/2 differentiation assay

Initial Labs

Once a diagnosis is confirmed, obtain a CD4 cell count and HIV-1 RNA

Opportunistic Infections

- Pneumocystis pneumonia
  - Subacute, dyspnea, dry cough, +/- fever; often chest radiograph shows bilateral infiltrates
- Cryptococcal meningitis
  - High ICP needs to be managed, often with serial LPs; treat with liposomal amphotericin B
- Toxoplasmosis encephalitis
  - Typically with CD4 < 100; MRI brain shows ring-enhancing lesions
- Disseminated MAC
  - Typically with CD4 < 50; fevers, sweats, LAD, cytopenias; dx with AFB blood cultures
- Candida esophagitis – treat with fluconazole; endoscopy if no response
- Cytomegalovirus retinitis – treat with ganciclovir or valganciclovir
- Kaposi Sarcoma – caused by HHV8, treat with ART

CASE 5

A 22-year-old woman wakes up to find a bat flying around her room. She denies being bitten, and her parents cannot find evidence of a bite. The bat flies away.

What is the next best course of action?

A. Initiate immediate PEP
B. Test her for rabies antibody
C. Try to capture the bat and send it for testing
D. Reassurance with close observation

Answer:

What is the next best course of action?

A. Initiate immediate PEP
B. Test her for rabies antibody
C. Try to capture the bat and send it for testing
D. Reassurance with close observation

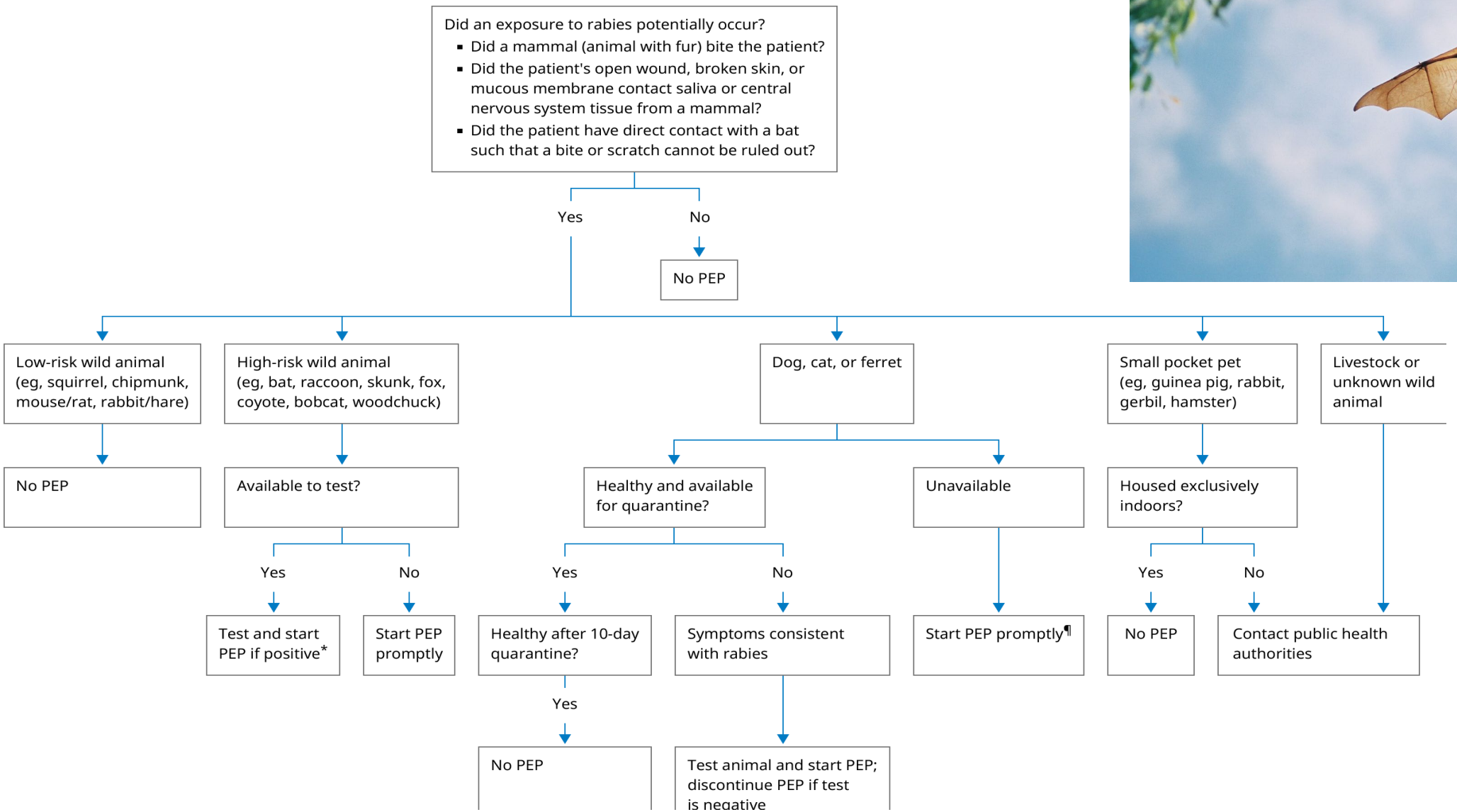
Canadian boy, 11, dies of rabies after waking to bat on his face

1 July 2026

Share Save Add as preferred on Google

Sareen Habeshian

Rabies Prevention



Case 6

A 35-year-old woman with no significant past medical history presents with fever, fatigue, and a new onset of right-sided heart failure. She recently came back from a 3-month trek through South America and recalls getting a few mosquito bites. Since coming back, she had an appointment with the dentist for a cleaning and then a dental procedure, but that was over two weeks ago. Blood cultures grow *Viridans streptococci*, and an echocardiogram reveals a vegetation on the tricuspid valve. What is the most likely risk factor for the development of infective endocarditis in this patient?

A) Bite from an insect on her trip
B) Use of intravenous drugs
C) Congenital heart disease
D) History of recent dental procedure

Answer:

What is the most likely risk factor for the development of infective endocarditis in this patient?

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B) Use of intravenous drugs
C) Congenital heart disease
D) History of recent dental procedure

Dental Health and IE

- Dental procedures can be a risk factor for bacteremia with specific oral bacteria.
- Although poor oral hygiene and periodontal disease is more highly correlated with bacteremia than dental procedures.
- Viridans strep can be more indolent (unlike Staph), so not unreasonable that dental procedure occurred >2wks ago.

Bacteria Associated with Dental Disease
Viridans group Strep
Nutritionally variant streptococci
Abiotrophia defectiva
Granulicatella sp
Gemella sp
HACEK organisms

Endocarditis prophylaxis: Less is more

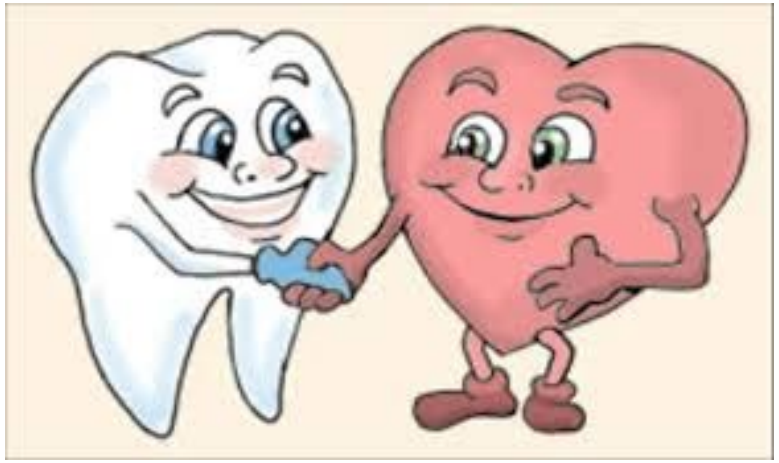
AT-RISK

- Any prosthetic valve or graft
- Any history of IE
- Heart transplant with valvulopathy
- Unrepaired or strictly palliated **cyanotic** heart disease
- Successfully repaired congenital defect within 6 months of repair
- Unsuccessfully repaired congenital defect (persistent leak, shunt)

&

ELIGIBLE PROCEDURE

- Manipulation of the gingiva or peri-apical region of the tooth
- Incision of the respiratory tract mucosa (tonsillectomy, transbronchial biopsy)



Prophylactic regimens

- One dose 30-60 minutes before procedure (1-2 hours after if missed)
  - Most patients: **Amoxicillin 2g**
  - Unable to take PO: Ampicillin 2g or cefazolin 1g or ceftriaxone 1g
  - PCN allergy: Cephalexin 2g or clindamycin 600mg or Azithromycin 500mg

Lasagna or Endocarditis?

CASE 7

A 22-year-old man undergoes high dose induction chemotherapy for AML. He is treated empirically with ceftazidime and vancomycin for febrile neutropenia but all cultures remain negative. Three weeks into his course, while still on antibiotics, he develops fever, cough, and pleuritic chest pain.

Chest CT is obtained.

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CASE 7

Based on the most likely etiology of this patient's pulmonary infiltrate, which one of the following would be the best empiric therapy?

A. Fluconazole
B. Amphotericin B
C. TMP-SMX
D. Meropenem
E. Voriconazole

Answer

Based on the most likely etiology of this patient's pulmonary infiltrate, which one of the following would be the best empiric therapy?

A. Fluconazole
B. Amphotericin B
C. TMP-SMX
D. Meropenem
E. Voriconazole

Aspergillus

- Buzz words: halo or air crescent sign on CT, prolonged neutropenia, acute angle branching
- Spectrum of disease
  - Non-invasive: ABPA, aspergilloma
  - Invasive: Pneumonia, sinusitis, disseminated disease
- Diagnosis: serum galactomannan may be helpful if positive, but poor NPV; biopsy or histopathology is definitive
- Treatment: Voriconazole

Halo or air crescent sign in patient with prolonged neutropenia is most likely invasive aspergillus and should be treated with voriconazole

CASE 8

A 74-year-old woman is admitted to the hospital with a painful vesicular rash involving the left side of her face. The lesions do not cross the midline. She has hypertension and osteoarthritis but is otherwise healthy. She is not receiving immunosuppressive therapy.

Which of the following is the most appropriate infection prevention recommendation?

A. Place the patient on contact precautions until all lesions have crusted.
B. Place the patient on airborne and contact precautions until all lesions have crusted.
C. Place the patient on droplet precautions until antiviral therapy is completed.
D. Place the patient on standard precautions only.

Answer

Which of the following is the most appropriate infection prevention recommendation?

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B. Place the patient on airborne and contact precautions until all lesions have crusted.
C. Place the patient on droplet precautions until antiviral therapy is completed.
D. Place the patient on standard precautions only.

Herpes zoster precautions

- **Localized herpes zoster in an immunocompetent patient:**
  - Standard – If it's one dermatome and the area is coverable
  - Contact – If one dermatome but not coverable (i.e. face, eye, etc)

- **Disseminated herpes zoster** or **localized herpes zoster in an immunocompromised patient:**
  - Airborne and contact precautions until all lesions have crusted because of the risk of airborne spread of varicella-zoster virus.

CASE 9

A 34-year-old otherwise healthy woman is evaluated for fever, myalgias, and diarrhea. Four days ago, she underwent surgery with placement of saline breast implants bilaterally.

- Exam: T 40.2, SBP 70, HR 120. Appears sick. Has a diffuse erythematous blanching rash. Surgical incisions look clear.
- Labs: WBC 13.6 (30% bands), plt 65K, creatinine 2.3, pregnancy test negative.
- Multiple cultures obtained, IV fluids and appropriate antibiotics are begun, and the patient is admitted to the ICU.

CASE 9

After resuscitation, which one of the following is the most appropriate next step?

A. Abdominal CT scan
B. Vaginal ultrasound
C. Start micafungin
D. Serum antibody test
E. Surgical consultation for removal of breast implants

Answer

After resuscitation, which one of the following is the most appropriate next step?

A. Abdominal CT scan
B. Vaginal ultrasound
C. Start micafungin
D. Serum antibody test
E. Surgical consultation for removal of breast implants

Staph Toxic Shock

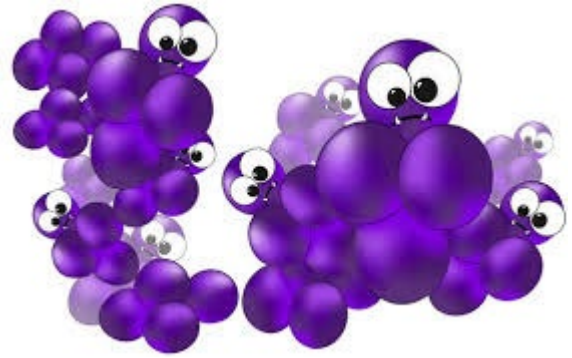
Two forms

- Menstrual: associated with hyper absorbent tampons
- Non-menstrual: associated with surgical procedures, cutaneous infection and post partum (or post abortion)
  - Wound will often appear benign but still require exploration
  - Since toxin mediated, may not appear to have much inflammation

Symptoms

- Fever, rash, and shock (by definition)
- Diarrhea, myalgias, and/or vomiting in >90%, conjunctival hyperemia common

Staph Toxic Shock



- Diagnosis
  - Labs: high WBC with bands, renal failure, thrombocytopenia, transaminitis
  - Blood cultures often negative (as opposed to group A strep toxic shock)
- Treatment
  - **Clindamycin to inhibit toxin production** +MRSA coverage (vancomycin) or MSSA coverage (nafcillin or cefazolin) **or linezolid**
  - Prompt surgical consultation
  - Consider IVIG in severe cases (more common in GAS toxic shock)

Septic shock + rash after surgery with negative blood cultures or benign appearing wound = staph toxic shock

Strep Toxic Shock

- MUCH higher mortality than in Staph TSS
- Majority are from invasive NSTI (in contrast to Staph)
- Can also cause post-surgical disease
- Majority are bacteremic (in contrast to < 5% in Staph)
- Rash is less common

Case 10

A 75-year-old man is hospitalized with 2 weeks of fever and malaise, and 72 hours of progressive delirium. History-taking is limited. Review of the medical record suggests that he has not been seen by a doctor for over 8 years. Blood cultures are positive for S. Bovis and TTE is negative but TEE reveals an aortic valve vegetation. At the completion of treatment, what additional step should be taken?

A) Make a dental appt
B) De-colonization with mupirocin and chlorhexidine bath
C) Chronic suppressive antibiotics
D) Colonoscopy
E) Repeat TEE

Answer

At the completion of treatment, what additional step should be taken?

A) Make a dental appt
B) De-colonization with mupirocin and chlorhexidine bath
C) Chronic suppressive antibiotics
D) Colonoscopy
E) Repeat TEE

ID recommends a colonoscopy

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Association Between Bacteremia From Specific Microbes and Subsequent Diagnosis of Colorectal Cancer

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Association of Blood Stream Infections and Probability of Underlying Colon Cancer

- **Clostridium septicum (HR 17.1)**
- Gemella morbillorum (HR 15.2)
- Fusobacterium nucleatum (HR 6.89)
- **Streptococcus bovis/gallolyticus (HR 5.73)**
- Bacteroides fragilis (HR 3.85)
- Peptostreptococcus species (HR 3.06)
- Clostridium perfringens (HR 2.29)

CASE 11

A 60-year-old man presents with progressive SOB and fevers x 2 weeks.

- PMH: Diabetes, CAD
- Social history: Lives in Phoenix, AZ
- Exam notable for tachycardia with bilateral crackles, no wheezing
- Labs notable for WBC of 14 with 15% eosinophilis
- Chest radiograph: Bilateral infiltrates

CASE 11

Which one of the following organisms is the most likely etiology of his symptoms?

A. Pneumococcus
B. *Coccididiodes immitis*
C. Influenza
D. *Pneumocystis jirovecii*
E. *Aspergillus fumigatus*

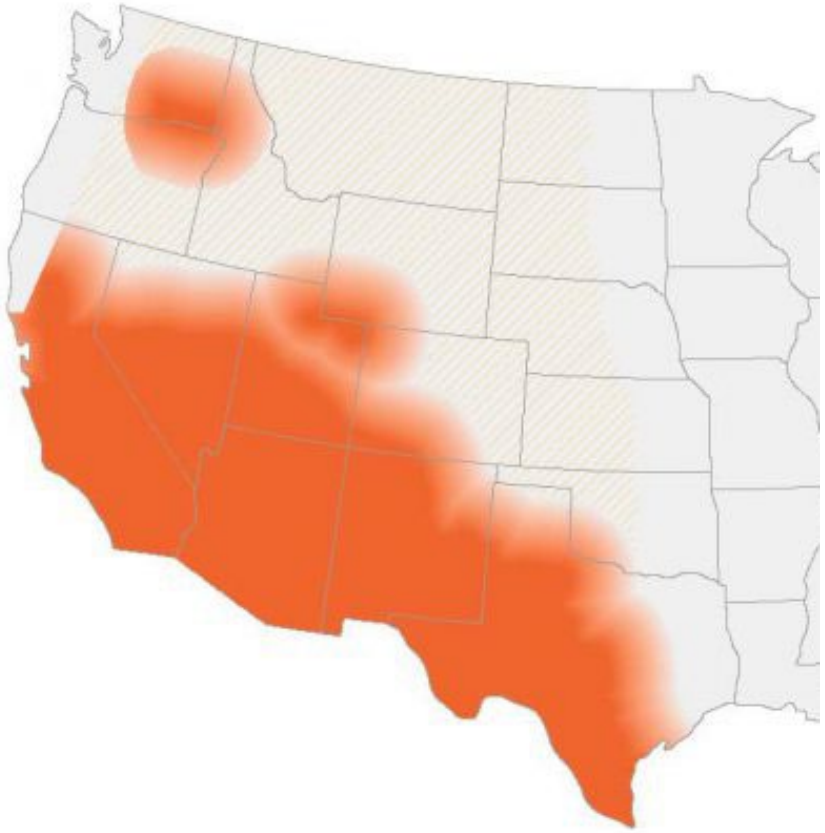
Answer

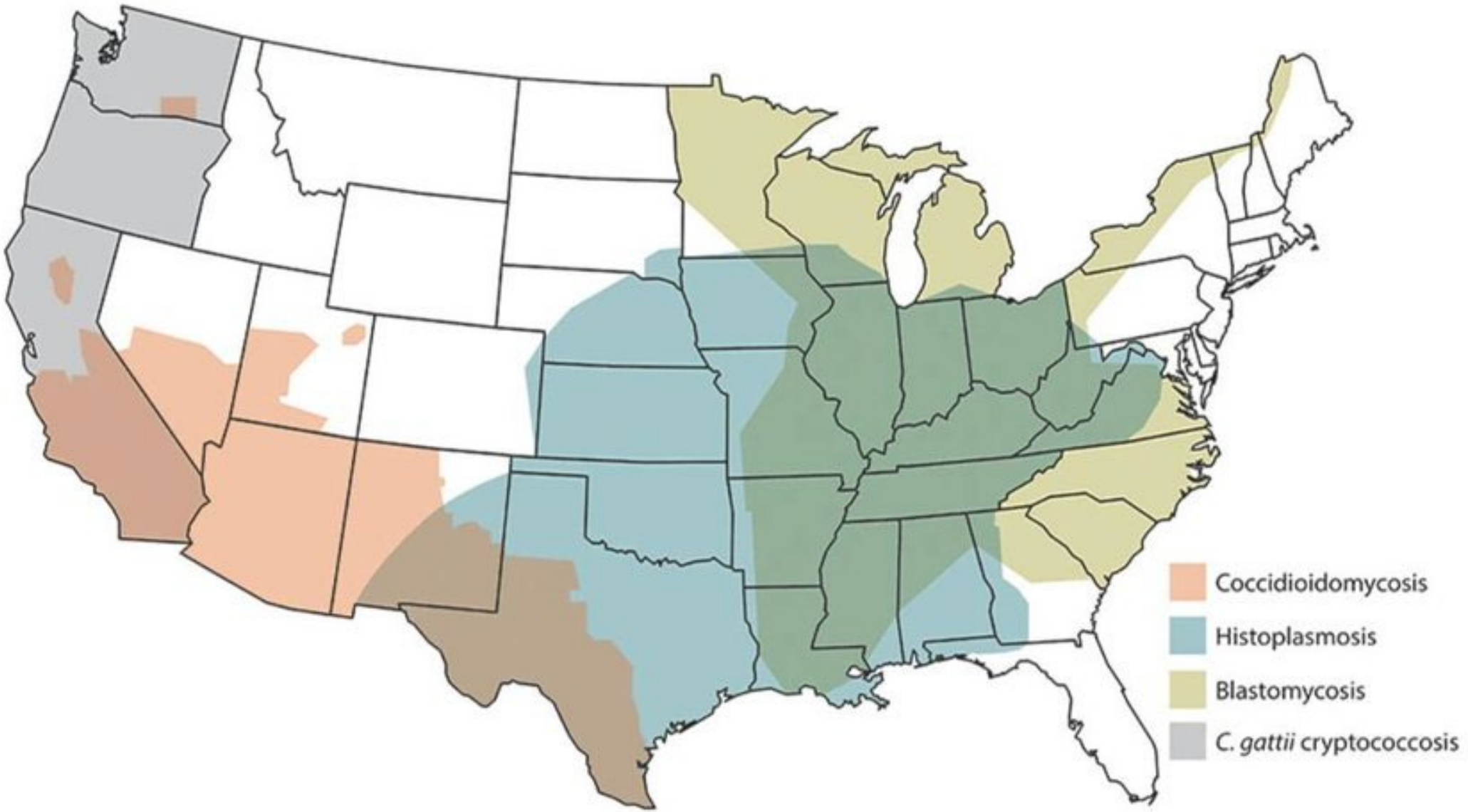
Which one of the following organisms is the most likely etiology of his symptoms?

A. Pneumococcus
B. *Coccididiodes immitis*
C. Influenza
D. *Pneumocystis jirovecii*
E. *Aspergillus fumigatus*

Coccidioidomycosis

- Pulmonary infiltrates and eosinophilia
- Buzz words: Southwest (including W Texas, CA, Mexico)
- Symptoms
  - Valley fever (subacute): fever, cough, arthralgias, E nodosum
  - Many extra pulmonary manifestations including osteomyelitis and meningitis and dissemination
- Epi: More severe disease pregnancy, and immunocompromised




Coccidioidomycosis
Histoplasmosis
Blastomycosis
C. gattii cryptococcosis

Rare Pneumonia Associations

Birds = *Chlamydia psittaci*

Horses + immunocompromise = *Rhodococcus equi*

Air conditioning, fountains = *Legionella pneumophila*

- Legionella urine Ag only for *L. pneumophila* serotype 1

Rodent droppings, cabin = Hantavirus

Rabbits = *Francisella tularensis*

Farm or parturient animals = *Coxiella burnetii*

Case 12

27-year-old previously healthy man presents to the ED with 12 hours of severe headache, fever, nausea, and confusion. His roommate reports he has been increasingly lethargic and complained of neck stiffness that morning.

On exam he is disoriented and has his neck resists bending forward.

What antibiotics would you use?

A. Vancomycin + Cefepime +Flagyl
B. Ampicillin-Sulbactam
C. Vancomycin + Ceftriaxone
D. Piperacillin-Tazobactam
E. Vancomycin + Ceftriaxone + Ampicillin

Answer

What antibiotics would you use?

A. Vancomycin + Cefepime +Flagyl
B. Ampicillin-Sulbactam
C. Vancomycin + Ceftriaxone
D. Piperacillin-Tazobactam
E. Vancomycin + Ceftriaxone + Ampicillin

But why Vancomycin?

Rare slight resistance to CTX only matters in CNS (less drug gets in)

Double cover S pneumo until we know sensis

Organism (% susceptible)	Maximum # of isolates tested			Cefazolin [a]			Ceftriaxone		
	H	ML	NW	H	ML	NW	H	ML	NW
MSSA [a]	1137	743	389	100	100	100			
MRSA (HMC 42%, ML 32%, NW 43%)	827	347	293						
Staphylococcus epidermidis [g]	268	228	41						
Staphylococcus lugdunensis [g]	39	36	50						
Streptococcus pneumoniae [h,i]	63								
without meningitis							100		
with meningitis							98		

Meningitis Empiric Coverage Summary

Bacterial coverage = Vancomycin + Ceftriaxone (2g q12h!!)

Add ampicillin if: immunocompromised or >50 or pregnant

Upgrade to Cefepime + flagyl for post-surgical

CNS Infections Pearls

- Enterovirus most common cause of viral meningitis
- Dexamethasone with first abx dose if suspect pneumococcal meningitis
- Subacute/chronic meningitis: TB, fungal, or parasitic
- **Freshwater exposure in summertime: think amebic cause**
- Aseptic meningitis: can be due to NSAIDs, antibiotics, or IVIG
- Health-care associated: Staph and GNRs, vancomycin + cefepime/mero empirically
- Brain abscess: vancomycin + ceftriaxone + metronidazole empirically
- Epidural abscess: MRI to diagnose, often Staph, drain + abx for 6 weeks

Additional ID Pearls

Toxoplasmosis

Coxiella

Bartonella

Dies
(nonspecific)

Tularemia

Bites you then dies

Rabies

Plague

SSTI Pearls

- Erysipelas/Cellulitis = usually Strep, tx with cephalexin or cefazolin
- Abscess = MSSA or MRSA, drain, use TMP-SMX or vanc empirically
- NSTI = empiric GP and GN coverage (vanc + pip-tazo + anti-toxin (clindamycin)), debridement
- *Vibrio vulnificus* = need to add doxycycline to empiric regimen
- Animal bites = often use amoxicillin-clavulanate empirically
- Diabetic foot infection = usually polymicrobial, if probe to bone likely have osteomyelitis (get x-ray, if need additional testing get MRI)

Viral Hepatitis Pearls

Hepatitis A

- Fecal oral transmission, abrupt onset, high aminotransferases
- Dx with hep A IgM, Tx supportive

Hepatitis B

- Review hepatitis serologies
- Treatment is only for certain criteria and/or if HIV as well
- Use tenofovir
- Screening criteria differs from hep C: if cirrhosis, fam hx of HCC, and certain populations
- PEP = if no previous vaccine, use hep B vaccine + HBIG

Hepatitis C

- Do NOT study hep C treatment – DAAs are effective
- Hep C can be silent for years – screen all baby boomers
- Screen patients with cirrhosis for HCC

Hepatic Infection Pearls

- Liver abscess
  - Abx alone if < 3 cm, need drainage + abx if bigger
- Cholecystitis
  - Empiric 3rd gen cephalosporin + metronidazole or piperacillin-tazobactam
  - Cholecystectomy before discharge
- Cholangitis
  - Empiric 3rd gen cephalosporin + metronidazole or piperacillin-tazobactam
  - Call GI for ERCP removal of stone

Micro:

- Often polymicrobial
- GNRs
- Enterococcus

Infections that DO NOT require abx

Asymptomatic bacteriuria or funguria
Hot tub folliculitis
URIs
Bronchitis (but beware pertussis)
Acute sinusitis < 10 days
In general, if things sound allergic, stable, viral, do not antibiose

Answer Key

1 – B	9 – E
2 – C	10 – D
3 – A	11 – B
4 – B	12 – C
5 – A	
6 – D	
7 – E	
8 - A	

Thank you!

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