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THE CONTAGION COURIER

Official Newsletter of the Nebraska ID Society

Introduction

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PRESIDENT, NEBRASKA INFECTIOUS DISEASES SOCIETY

On a recent Monday afternoon I found myself shopping for groceries. It is a mundane task, except when I am on the candy aisle, and notable only because having a clinic on Monday afternoons means that I should not have been in the store. Unfortunately, the majority of patients scheduled with me that day elected to skip their appointments. As clinic slots can be hard to find, especially as we head into the summer travel season, I pulled data on my 2025 schedule to see if themes existed for individuals who did not present for their appointments. The numbers were so clear I did not have to consult my wife (she has a degree in biostatistics) to identify a theme. Over 90% of my no-show encounters were related to exposures: either perinatal exposures or exposures to reportable diseases out in the community. While Infectious Diseases clinicians play a key role in these patients' care, primary care providers, school nurses, OBGYNs, and the health departments are all integral to their care and interactions with the health system. As we face worsening trends in STIs, including perinatal exposure, measles, tuberculosis, and other pathogens, I worry about all the at-risk patients not receiving the healthcare and guidance that they need, especially in a world of limited healthcare resources. Increasing our engagement with other practice groups remains vital to improving outcomes, and NIDS plays a significant role in fostering these relationships. Given the One Health theme of this year's annual meeting, and the ongoing efforts of the Ask-the-Expert series, I encourage all members of NIDS to reach to their colleagues in the practice groups with which they interact so that providers from non ID-fields can learn about NIDS and the role of our members within the healthcare system, so we can continue to identify areas in which we can partner to better improve patient outcomes.

This issue:

Announcements

Upcoming Events

ASK THE EXPERT

CONGENITAL SYPHILIS
ARHTUR CHANG, MD
7/22/25 1200-1300
REGISTRATION DETAILS TO COME

2025 NEBRASKA ANTIMICROBIAL STEWARDSHIP SUMMIT

FRIDAY 5/30/25
MORE DETAILS HERE

NIDS ANNUAL MEETING

8/15/25
HENRY DOORLY ZOO
REGISTRATION DETAILS TO FOLLOW

Member Spotlight

DAVID K WARREN, MD, MPH
CHIEF, DIVISION OF INFECTIOUS DISEASES
UNIVERSITY OF NEBRASKA MEDICAL CENTER

WHAT BROUGHT YOU TO NEBRASKA?

I came to Nebraska for the opportunity to lead an excellent ID Division at UNMC/Nebraska Medicine. There are many strengths of the program, including faculty who are recognized leaders in HIV care, infection prevention, antimicrobial stewardship, immunocompromised ID, and biopreparedness, just to name a few. The Division has developed innovative programs around remote care of ID patients and supporting infection prevention and antimicrobial stewardship in rural areas of the state, which have served as models nationally.

GIVEN THE CHALLENGES FACED BY THE FIELD OF INFECTIOUS DISEASES, HOW DO YOU PLAN ON LEADING YOUR DIVISION TO ADDRESS THESE CHANGES?

There are many challenges that face infectious diseases specialists today – a loss of trust in public health by the public, misinformation about infectious diseases on social media, and an unstable funding environment for biomedical research and programs which support the care of vulnerable individuals. This is in the face of increasing antimicrobial resistance and the re-emergence of vaccine-preventable diseases, such as measles. It is easy to become discouraged. My plan for the Division is to continue to "lead by example" by providing excellent care to the patients that we serve, particularly patients who from groups that are marginalized in society. I will support the research and educational missions that are core to the Division. Infectious Diseases specialists have always been advocates, but in the current environment, it is needed more than ever. I want to encourage the faculty to educate their patients, the public, and policymakers on evidence-based treatment and prevention strategies for infectious diseases. If we are silent, there are many individuals who will fill the void with misinformation.

WHAT WOULD YOU LIKE TO SEE NIDS DO TO HELP SUPPORT INFECTIOUS DISEASES WORK IN THE STATE OF NEBRASKA?

I would like to see NIDS take an active role in education and outreach to the public and policymakers in Nebraska. Having a dialogue with these groups, addressing their concerns and informing them about the risks of infectious diseases and what is needed to treat and prevent them, is critical to rebuilding the trust that has been lost in the time since the COVID-19 pandemic.

WHAT IS A FUN FACT ABOUT YOURSELF?

I love hiking. I am a day hiker but would love to try longer hikes. Some of my favorite hikes have been the "Oh-Be-Joyful" trail in the Gunnison National Forest in Colorado, and Johnston Canyon Trail in Banff National Park. Since I arrived in Nebraska in January, I have hiked several trails around Omaha with my wife and our black and tan coonhound, Reggie. I am looking forward to exploring the Sandhills.

Notable Recent Articles

KARI NEEMANN, MD

APPENDICECTOMY VERSUS ANTIBIOTICS FOR ACUTE UNCOMPLICATED APPENDICITIS IN CHILDREN: AN OPEN-LABEL, INTERNATIONAL, MULTICENTRE, RANDOMISED, NON-INFERIORITY TRIAL.

ST PETER SD, ET AL. LANCET. 2025 JAN 18;405(10474):233-240.
DOI: 10.1016/S0140-6736(24)02420-6.

This international, multicenter, open-label, randomized, non-inferiority trial compared appendectomy with antibiotic therapy in children with acute uncomplicated appendicitis. The study aimed to determine whether antibiotic management was non-inferior to surgery, using a 20% non-inferiority margin based on treatment success rates.

The trial enrolled 936 children aged 5 to 16 years with simple appendicitis. Participants were randomized 1:1 to either undergo standard appendectomy or receive a 10-day course of antibiotics, with at least 48 hours of intravenous therapy followed by oral antibiotics. The primary outcome was treatment failure within 1 year of randomization, defined as additional procedures related to appendicitis requiring general anesthesia.

Results showed that 66% of children in the antibiotic group avoided surgery within the 12-month follow-up period, while 34% experienced treatment failure, requiring appendectomy due to recurrent appendicitis or worsening symptoms. In contrast, the appendectomy group had a 100% success rate in definitively treating appendicitis, though 27 (7%) had normal pathology and 1 (<1%) had surgical complication. The difference in treatment success rates between the two groups was −26.7% (90% CI: 22.4 to 30.9), exceeding the predefined 20% non-inferiority margin and thus failing to demonstrate non-inferiority of antibiotics compared to surgery.

Secondary outcomes revealed that children in the appendectomy group had shorter initial hospital stays (1.0 days [IQR 0.76-1.68] vs 1.25 days [IQR 0.92-2.09], p=<0.0001), but longer convalescence regarding return to school when compared to the antibiotic group (4 days [IQR 2-5] vs 1 day [IQR 1-3], p=<0.0001). Among those who initially responded to antibiotics, the cumulative risk of recurrence was highest in the first few months but decreased over time.

While this study confirms that antibiotics can be a feasible alternative to surgery in certain cases, it highlights the trade-off between avoiding immediate surgery and the increased risk of recurrence. Shared decision-making remains crucial, as families must balance the benefits of non-operative management with the possibility of future appendicitis episodes. These findings suggest that while antibiotics may be a reasonable first-line option for some children, appendectomy remains the definitive treatment with a higher overall success rate.

Notable Recent Articles

DAVID QUIMBY, MD

OUTCOMES ASSOCIATED WITH ASYMPTOMATIC BACTERIURIA MANAGEMENT IN ELDERLY PATIENTS HOSPITALIZED WITH GROUND-LEVEL FALL

EVERITT KA, ET AL. ASHE. 2025. DOI: 10.1016/S0140-6736(24)02420-6.

There are published recommendations about the lack of need to treat asymptomatic bacteriuria in elderly patients with various presentations. Despite this, however, urine is often checked and treated when these patients present to clinic or acute care facilities. This study looked at 292 patients > 65 y/o who were admitted to the hospital with no urinary symptoms but who had sustained a ground-level fall. Roughly one third received antibiotics for abnormal UA without symptoms c/w UTI. There was no difference in all-cause readmission rates or UTI-related readmission rates, all-cause mortality, or subsequent bacteremia with index urine culture organism between the two groups. However, one of the treated patients was readmitted due to AKI associated with trimethoprim-sulfamethoxazole and one patient developed C.difficile infection following meropenem received for the asymptomatic bacteriuria. With two episodes of clear harm and no outcomes benefit to treatment of asymptomatic bacteriuria in the population of older patients presenting with ground-level fall, there is further evidence that urine should not be checked and treated in this population. This study can provide further ammunition for those attempting to curtail inappropriate testing and treatment of asymptomatic bacteriuria.