INTRODUCTION

• In-Training Examinations (ITE) are used by many subspecialties to record knowledge gaps necessary for board preparation. ITE are used in graduate medical education to provide an assessment of each trainee’s progress against national averages.

• ITE scores correlate with pass rates on initial certification exams in psychiatry, internal medicine, neurology and infectious diseases1-4.

• Preparation for board certification during fellowship includes a combination of clinical experience and educational conferences, such as: case conference, journal club and grand rounds.

• We set out to improve our ITE scores, and introduced a new conference using active learning strategies and focused on providing additional exposure to ID topics not covered in our standard didactic core conferences.

METHODS

• In the 2009 academic year, we created a new joint faculty and fellow interactive board review (BR) conference.

• The format was case-based, bi-monthly, with a minimum of 4 questions, prepared by faculty and fellows who typically derive questions from missed objectives from prior ITEs.

• Faculty and fellows answer projected questions anonymously utilizing an audience response system (Turning Point®). The facilitator first calls on fellows, then faculty, to share their responses and rationale to build shared knowledge.

• Besides factual knowledge, attendees share information on prior case experiences, test taking and question writing strategies.

• Subsequently, the presenter has discussion slides which briefly discusses the topic that he/she has presented and the relevant information that is high yield for board exams.

RESULTS

Example

52 year old male with DM, COPD, is seen a day after returning from New Zealand (NZ) and Australia. He did a lot of hiking in NZ and northern Australia where it was rainy. He started feeling unwell during the return trip. He complains of 3 days of fevers, chills, productive cough, and pleurisy. A bipolar gram negative rod is seen on sputum Gram Stain.

Which of the following is the most likely causative organism?
1. Klebsiella pneumoniae
2. Burkholderia mallei
3. Pseudomonas aeruginosa
4. Burkholderia pseudomallei

Burkholderia pseudomallei (Meliodosis)
• Bipolar gram negative rod on Gram Stain
• Endemic in Thailand/Australia
• Chest X-ray: diffuse nodular infiltrates in upper lobes quickly coalescing to cavities.
• Can cause skin lesions, prostatitis, septic arthritis, osteomyelitis
• Patients with cystic fibrosis should be warned before traveling to endemic areas

Treatment
• Intrinsically resistant to PCN, AMP, 1st and 2nd gen cephalosporins, gentamicin, tobramycin, streptomycin. Usually resistant to fluoroquinolones
• Treatment is ceftazadime or meropenem or imipenem for 2 weeks followed by:
  - Eradication therapy for 12-20 weeks with TMP/SMX or doxycycline to prevent relapse
  - Failure is higher in severe disease

REFERENCES


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