Montefiore Medical Center
WEILER DIVISION
Prepared by
Division of Microbiology
Department of Pathology
and
The Antibiotic Stewardship Program
Division of Infectious Diseases/Pharmacy

Antibiotic Susceptibility Patterns
of Commonly Isolated Bacteria

July 2016 - June 2017
(12 Months)

All test information is available on the Pathology Website under
Test Compendium

Moses Laboratories
Telephone
For Laboratory Results and/or Other Information
920-4695

Director, Microbiology
Michael H. Levy, Sc.D.
920-4189

Associate Director
Wendy A. Szymczak, Ph.D.
920-4585

Laboratory Manager, Microbiology
Philip Gallinella, M.S.
920-4188

Supervisor, Mycology/Mycobacteriology
Hilset Pabel, B.S.

Supervisor, Bacteriology
Myra Intal, B.S.

Supervisor, Parasitology/Serology
Rachana Thakor, M.S.

Supervisor Nights/Weekends
Zulma Figeroa, M.S.

Micro Supervisor Test Page
917-956-3012

Micro Fax
718-655-0859

Site Director, Clinical Pathology
Adam Cole, MD
904-2861

STAT Gram Stain Results of Test
Performed at Einstein Hospital
904-3425

(Notes: STAT Gram Stain requires
penicillin, ampicillin, piperacillin-tazobactam, and
vancomycin.)

1. Data is shown for epidemiologic purposes; contact ID for questions about use of antifungals.
2.  CLSI no longer recommends testing
C. glabrata
C. tropicalis
C. parapsilosis
C. albicans
3. Voriconazole resistant and all
species
4. Antibiotics not recommended due to cost and tolerability. Obtain
Infectious Disease consult as needed.
5. In vitro synergy indicates
synergistic activity with
penicillin, ampicillin, piperacillin-tazobactam, and
vancomycin.
6. Enterococcal cultures with 100,000 colonies of enterococci as a single organism have a
routine susceptibility test. Infectious Diseases generally recommends susceptibility
testing when patients do not respond to empiric therapy.

Montefiore Medical Center
WEILER DIVISION
Prepared by
Division of Microbiology
Department of Pathology
and
The Antibiotic Stewardship Program
Division of Infectious Diseases/Pharmacy

Antibiotic Susceptibility Patterns
of Commonly Isolated Bacteria

July 2016 - June 2017
(12 Months)
### Antibiotic Susceptibility Patterns of Commonly Isolated Bacteria

**July 2016 - June 2017 (12 Months)**

**(Percent Susceptible)**

#### Roller Division

<table>
<thead>
<tr>
<th>No. tested (Mode)</th>
<th>AMP</th>
<th>REN</th>
<th>TBM</th>
<th>CIP</th>
<th>TAB</th>
<th>AF</th>
<th>FE</th>
<th>EFK</th>
<th>CEMPA</th>
<th>CPT</th>
<th>TMM</th>
<th>SMX</th>
<th>TMZ</th>
<th>NITRO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stenotrophomonas maltophilia</strong></td>
<td>54</td>
<td>32</td>
<td>100</td>
<td>54</td>
<td>32</td>
<td>100</td>
<td>54</td>
<td>32</td>
<td>100</td>
<td>54</td>
<td>32</td>
<td>100</td>
<td>54</td>
<td>32</td>
</tr>
<tr>
<td><strong>Enterobacter cloacae</strong></td>
<td>12</td>
<td>28</td>
<td>96</td>
<td>12</td>
<td>28</td>
<td>96</td>
<td>12</td>
<td>28</td>
<td>96</td>
<td>12</td>
<td>28</td>
<td>96</td>
<td>12</td>
<td>28</td>
</tr>
<tr>
<td><strong>Citrobacter koseri</strong></td>
<td>39</td>
<td>42</td>
<td>100</td>
<td>39</td>
<td>42</td>
<td>100</td>
<td>39</td>
<td>42</td>
<td>100</td>
<td>39</td>
<td>42</td>
<td>100</td>
<td>39</td>
<td>42</td>
</tr>
<tr>
<td><strong>Acinetobacter baumannii</strong> complex</td>
<td>24</td>
<td>35</td>
<td>100</td>
<td>24</td>
<td>35</td>
<td>100</td>
<td>24</td>
<td>35</td>
<td>100</td>
<td>24</td>
<td>35</td>
<td>100</td>
<td>24</td>
<td>35</td>
</tr>
<tr>
<td><strong>Klebsiella</strong></td>
<td>24</td>
<td>27</td>
<td>100</td>
<td>24</td>
<td>27</td>
<td>100</td>
<td>24</td>
<td>27</td>
<td>100</td>
<td>24</td>
<td>27</td>
<td>100</td>
<td>24</td>
<td>27</td>
</tr>
<tr>
<td><strong>Escherichia coli</strong></td>
<td>38</td>
<td>34</td>
<td>100</td>
<td>38</td>
<td>34</td>
<td>100</td>
<td>38</td>
<td>34</td>
<td>100</td>
<td>38</td>
<td>34</td>
<td>100</td>
<td>38</td>
<td>34</td>
</tr>
<tr>
<td><strong>Proteus mirabilis</strong></td>
<td>12</td>
<td>12</td>
<td>100</td>
<td>12</td>
<td>12</td>
<td>100</td>
<td>12</td>
<td>12</td>
<td>100</td>
<td>12</td>
<td>12</td>
<td>100</td>
<td>12</td>
<td>12</td>
</tr>
</tbody>
</table>

#### Notes:

1. All stipulated concentrations (MIC) and interpretations are based on the CLSI standards and an advanced antibiotic expert system.
2. We do not recommend use without caution.
3. Penicillin-resistant staphylococci are also resistant to >10 isolates. For N of >10 isolates, results may not be statistically relevant. Interpret with caution.
4. Oxacillin-resistant staphylococci are also resistant to all penicillins, cephalosporins, and carbapenems. Oxacillin-susceptible staphylococci are also susceptible to dicloxacillin, nafcillin, ampicillin-sulbactam, piperacillin-tazobactam, amoxicillin-clavulanic acid, cefazolin, cephalaxin, cefadroxil, cefuroxime, cephalexin, and meropenem (as well as other penicillins, cephalosporins, and carbapenems that are non formulants).
5. MRSA isolates with reduced susceptibility to dicloxacillin have been detected at Memorial campuses.
6. Gentamicin should not be used as sole agent and only for synergy for treatment of staphylococcal infections.

**Methodology:**

- All susceptibility tests were performed using the agar dilution method on Mueller-Hinton II agar. Nalidixic acid and ciprofloxacin discs were used for susceptibility testing of Enterobacteriaceae and Pseudomonas aeruginosa, respectively.
- For urine isolates, cefazolin results predict results for the oral agents cefaclor, cephalexin, cefprozil, cefuroxime, cephalexin, and meropenem (as well as other penicillins, cephalosporins, and carbapenems that are non-formulants).
- Identification of organisms was performed using the BIOLOG system.