Moses Laboratories

For Laboratory Results and/or Other Information 920-4695

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Bacteriology

904-2861

Clinical Pathology

Weiler Division

Antibiotic susceptibility Patterns

Commonly Isolated Bacteria

July 2016 - June 2017

(12 Months)

Moses Laboratories

Telephone

1. Data is shown for epidemiologic purposes; contact ID for questions about use of antifungals.

2. CLSI no longer recommends testing the following agents: Imipenem, piperacillin-tazobactam, and cephalosporins.

3. Voriconazole resistant and all other species are reported as if isolates came from both CSF and all other sterile sites. Susceptibility rates are higher for non-CSF sites because higher antibiotic concentrations can be reached.

4. For pneumococcal isolates from non-sterile sites (sputum), penicillin susceptibility rates are also reported separately for oral and parenteral formulations. The susceptibility rate is higher for parenteral than oral penicillin because higher concentrations are achieved when penicillin is given parenterally.

5. Pneumococcal susceptibility rates against penicillin and ceftriaxone from sterile sites are reported as if isolates came from both CSF and all other sterile sites. Susceptibility rates are also reported separately for oral and parenteral formulations. The susceptibility rate is higher for parenteral than oral penicillin because higher antibiotic concentrations are achieved when penicillin is given parenterally.

6. The susceptibility rates to vancomycin were all 100%.

All Montefiore Sterile Sites- Enterococcal Susceptibility

C. parapsilosis

C. albicans

C. tropicalis

C. glabrata

No susceptible category for voriconazole and amphotericin B.

No interpretive category for voriconazole and micafungin.

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## ANTIBIOTIC SUSCEPTIBILITY PATTERNS OF COMMONLY ISOLATED BACTERIA

### July 2016-June 2017 (12 months)

#### (Percent Susceptible)

### MOSES DIVISION

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<tr>
<th>No. tested (Mode)</th>
<th>AMK</th>
<th>GENT</th>
<th>TOBRA</th>
<th>AMPI</th>
<th>AMPI/SULB</th>
<th>AZTREO</th>
<th>CEFEPIME</th>
<th>CEFOTAXIN</th>
<th>CEFAZOLIN</th>
<th>CIPRO</th>
<th>MEROFENEM</th>
<th>PIP/TAZO</th>
<th>TMP/SMX</th>
<th>NITRO (Urines only)</th>
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<tr>
<td>Acinetobacter baumannii complex</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>Acinetobacter baumannii complex</td>
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<tr>
<td>Citrobacter freundii</td>
<td>41</td>
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<td>100</td>
<td>100</td>
<td>95</td>
<td>97</td>
<td>93</td>
<td>94</td>
<td>93</td>
<td>88</td>
<td>90</td>
<td>98</td>
<td>84</td>
<td></td>
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<tr>
<td>Citrobacter koseri</td>
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<td>80</td>
<td>100</td>
<td>100</td>
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<td>99</td>
<td>98</td>
<td>99</td>
<td>93</td>
<td>88</td>
<td>99</td>
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<tr>
<td>Enterobacter aerogenes</td>
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<td>58</td>
<td>100</td>
<td>100</td>
<td>98</td>
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<td>95</td>
<td>93</td>
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<tr>
<td>Enterobacter aerogenes</td>
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<td>174</td>
<td>100</td>
<td>100</td>
<td>95</td>
<td>93</td>
<td>94</td>
<td>90</td>
<td>95</td>
<td>92</td>
<td>73</td>
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<td>Escherichia coli</td>
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<td>87</td>
<td>36</td>
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<td>93</td>
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<tr>
<td>E. coli pyelitis</td>
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<td>Morganella morgani</td>
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<td>Serratia marcescens</td>
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<td>100</td>
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<td>98</td>
<td>98</td>
<td>98</td>
<td>91</td>
<td>97</td>
</tr>
<tr>
<td>Salmonella sp (not S. typh. all campuses)</td>
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<td>25</td>
<td>97</td>
<td>76</td>
<td>97</td>
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<td>82</td>
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<td>89</td>
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</tbody>
</table>

### Notes:

1. Minimum inhibitory concentrations (MIC) and interpretations are based on the CLSI standards and an advanced antibiotic expert system.

2. All staphylococci may rapidly develop resistance during prolonged therapy with penicillin. Use with staphylococci is not recommended for therapy of uncomplicated UTI due to E. coli, K. pneumoniae, P. mirabilis.

3. Percentages are not calculated for organisms with <10 isolates. For N of < 30 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, nafcilin, ampicillin-sulbactam, piperacillin-tazobactam, amoxicillin-clavulanic acid, cefazolin, cephalaxin, cefotan, ceftriaxone, cefepime, and meropenem (as well as other penicillins, cephalosporins, and carbapenems that are non-formulary).

5. MRSA isolates with reduced susceptibility to daptomycin have been detected at Montefiore Campuses.

6. Gentamicin should not be used as single agent and only for synergy for treatment of staphylococcal infections.

7. For urine isolates, cefazolin results predict results for the oral agents cefotaxim, ceftriaxim, cefpodoxim, cefozepim, cephalaxin, and loracarbef when used for therapy of uncomplicated UTI due to E. coli, K. pneumoniae, P. mirabilis.