

All MMC Sites

1. Minimum inhibitory concentrations (MIC) and interpretations are based on the CLSI standards and an advanced antibiotic expert system.
2. Percentages are not calculated for organisms with <10 isolates. For *N* of < 30 isolates, results may not be statistically relevant. Interpret with caution.

Less susceptible More susceptible

Text color: • > 10% increase in susceptibility from previous year • > 10% decline in susceptibility from previous year

	AMPI		CEFTRIAX		CIPROFLX		TMP/SMX	
	N	% S	N	% S	N	% S	N	% S
Salmonella species (all inpatient isolates) ²	29	97	18	94	29	62	29	100

	PEN		CEFTRIAX		VANC	
	N	% S	N	% S	N	% S
viridans <i>Streptococcus</i> (sterile sites)	66	77	68	99	68	100

STREPTOCOCCUS PNEUMONIAE All Campuses 2024-2025		Sterile Site				Non-Sterile Site			
		N	S	I	R	N	S	I	R
PENICILLIN ^{A,B}	Meningitis	44	68		32				
	Non-CNS	44	91	9	0				
	Parenteral					75	84	8	8
	Oral					75	49	19	32
CEFTRIAXONE ^A	Meningitis	44	93	5	2	75	91	1	8
	Non-CNS	44	98	2	0	75	92	8	0
LEVOFLOXACIN		47	98	0	2	77	99	0	1
TRIMETH/SULFA ^C						76	66	11	24

A. 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 higher for non-CSF sites because higher antibiotic concentrations can be reached.

B. 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.

C. Pneumococci from sterile sites are not tested against erythromycin and trimethoprim-sulfamethoxazole because those antimicrobials generally should be used only for pneumococcal respiratory infections.

ENTEROCOCCUS Sterile Sites All Campuses 2024-2025		AMPI		DAPTO ^A		GENT SYN ^B		LINEZD		STREP SYN ^B		VANC	
		N	% S	N	% S	N	% S	N	% S	N	% S	N	% S
<i>Enterococcus faecalis</i>		139	99	139	67	139	77	139	99	139	87	139	92
<i>Enterococcus faecium</i>		96	10	94	95	95	86	96	98	95	60	94	36

A. For *E. faecalis*, daptomycin is not recommended due to cost and the availability of an agent with a narrower spectrum of activity (i.e. ampicillin/amoxicillin).

B. Susceptibility indicates synergy with penicillin, ampicillin, piperacillin-tazobactam, and vancomycin.

CANDIDA All Campuses 2024-2025	C. albicans					C. parapsilosis ²					C. tropicalis ²					C. glabrata					C. auris ^{A,2}		
	N	S	SDD	I	R	N	S	SDD	I	R	N	S	SDD	I	R	N	S	SDD	I	R	N	S	R
Fluconazole	87	95	2		2	18	89	11		0	22	41	45		14	41		93		7	19	11	89
Voriconazole	87	98		1	1	18	100		0	0	22	41		55	5								
Micafungin	49	98		0	2	12	17		0	83	18	94		0	6	39	100		0	0	19	100	0
Amphotericin B																					19	47	53

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

A. Breakpoints for *C. auris* have not been established by CLSI. Breakpoints used here are defined by the CDC and are based on those established for closely related *Candida* species and on expert opinion.