

Antibiotic Susceptibility Patterns of Commonly Isolated Bacteria
July 2024 – June 2025 (12 months)

WAKEFIELD

NOTES

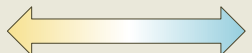
1. Minimum inhibitory concentrations (MIC) and interpretations are based on the CLSI standards and an advanced antibiotic expert system.
2. Percentages are not calculated for organisms with <10 isolates. For *N* of < 30 isolates, results may not be statistically relevant. Interpret with caution.

KEY

Text color:

- > 10% increase in susceptibility from previous year
- > 10% decline in susceptibility from previous year

Box color:intrinsic resistance

Less susceptibleMore susceptible

	AMPI		AMPI/SULB		AZTREO		CEFAZOL		CEFEPM		CEFOXTN		CEFTRIAX		CIPROFLX		GENT		MERO		NITRO (urine only)		PIP/TAZO		TOBRA		TMP/SMX	
	<i>N</i>	% S	<i>N</i>	% S	<i>N</i>	% S	<i>N</i>	% S	<i>N</i>	% S	<i>N</i>	% S	<i>N</i>	% S	<i>N</i>	% S	<i>N</i>	% S	<i>N</i>	% S	<i>N</i>	% S	<i>N</i>	% S	<i>N</i>	% S	<i>N</i>	% S
<i>Acinetobacter baumannii</i> complex			47	45					47	26			47	13	47	17	47	30	47	19			43	16	47	55	47	34
<i>Citrobacter freundii</i> ²			8	2	8	2			8	2			8	2	8	2	8	2	8	2	5	2	8	2	8	2	8	2
<i>Citrobacter koseri</i> ²			19	89	19	95	19	89	19	95	19	95	19	95	19	100	19	100	19	100	8	2	19	89	19	100	19	100
<i>Enterobacter cloacae</i>					32	81			33	91			33	73	33	76	33	100	33	97	16	50 ²	33	79	33	100	33	85
<i>Escherichia coli</i>	451	40	451	46	451	77	451	62	451	77	451	73	451	75	451	53	451	84	451	100	348	98	451	75	451	81	451	62
<i>Klebsiella (Enterobacter) aerogenes</i> ²					15	80			15	93			15	73	15	100	15	100	15	100	9	2	15	73	15	100	15	100
<i>Klebsiella oxytoca</i> ²			13	15	13	69	13	8	13	69	13	69	13	69	13	85	13	92	13	92	5	2	13	62	13	85	13	77
<i>Klebsiella pneumoniae</i>			176	51	176	68	176	57	176	68	175	66	176	66	176	67	176	91	176	96	108	56	176	61	176	85	176	70
<i>Morganella morganii</i> ²			28	21	27	96			28	96	28	64	28	93	28	61	28	89	28	100			28	93	28	96	28	68
<i>Proteus mirabilis</i>	111	51	111	68	111	83	111	1	109	86	111	82	111	83	111	53	111	66					111	84	111	77	111	74
<i>Providencia stuartii</i> ²			22	9	22	73			22	64	22	59	22	64	22	14			22	95			22	73			22	77
<i>Serratia marcescens</i>					41	68			41	93			41	63	41	63	41	88	41	98			41	63	41	68	35	94

	AMIK		AZTREO		CEFEPIME		CIPROFLX		GENT		MERO		PIP/TAZO	
	<i>N</i>	% S	<i>N</i>	% S	<i>N</i>	% S	<i>N</i>	% S	<i>N</i>	% S	<i>N</i>	% S	<i>N</i>	% S
<i>Pseudomonas aeruginosa</i>	103	100	208	73	209	86	209	81	209	96	209	81	209	74

	CEFTAZDM		LEVOFLX		MINO		TMP/SMX	
	<i>N</i>	% S	<i>N</i>	% S	<i>N</i>	% S	<i>N</i>	% S
<i>Stenotrophomonas maltophilia</i>	30	27	30	63	30	93	30	100

ENTEROCOCCUS Urine* Wakefield	AMPI		LEVOFLX		NITRO		TETRACYC		VANC	
	<i>N</i>	% S	<i>N</i>	% S	<i>N</i>	% S	<i>N</i>	% S	<i>N</i>	% S
<i>Enterococcus faecalis</i>	54	98	53	66	54	100	54	22	54	85
<i>Enterococcus faecium</i> ²	12	8	12	0	4	25	12	0	12	33
*Urine cultures with 10 ⁵ 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.										

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

STREPTOCOCCUS PNEUMONIAE All Campuses 2024-2025		Sterile Site				Non-Sterile Site			
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 suceptibility 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.

STAPHYLOCOCCUS ^A	CLINDA		OXA / CEF		GENT ^D		PEN G		TETRACYC		TMP/SMX		VANC	
	<i>N</i>	% S	<i>N</i>	% S	<i>N</i>	% S	<i>N</i>	% S	<i>N</i>	% S	<i>N</i>	% S	<i>N</i>	% S
<i>S. aureus</i> (MSSA)	231	69	231	100	231	95	231	0	231	94	231	96	231	100
<i>S. aureus</i> (MRSA) ^B	194	84	194	0	194	93	194	0	194	69	194	86	194	100
<i>S. epidermidis</i>	73	59	73	49	73	88	73	0	74	78			74	100
<i>S. haemolyticus</i> ²	12	50	12	42	12	58	12	0	12	58			12	100
<i>S. lugdunensis</i> ²	22	82	22	91	22	100	22	0	22	100	8		22	100

A. All staphylococci may rapidly develop resistance during prolonged therapy with quinolones. Use with staphylococci is not recommended.

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

C. 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, cephalexin, cefotetan, ceftriaxone, cefepime, and meropenem (as well as other penicillins, cephalosporins, and carbapenems that are non-formulary).

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

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

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
Enterococcus faecalis		139	99	139	67	139	77	139	99	139	87	139	92
Enterococcus faecium		96	10	94	95	95	86	96	98	95	60	94	36
A. For <i>E. faecalis</i> , 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	<i>C. albicans</i>					<i>C. parapsilosis</i> ²					<i>C. tropicalis</i> ²					<i>C. glabrata</i>					<i>C. auris</i> ^{A,2}		
	<i>N</i>	<i>S</i>	<i>SDD</i>	<i>I</i>	<i>R</i>	<i>N</i>	<i>S</i>	<i>SDD</i>	<i>I</i>	<i>R</i>	<i>N</i>	<i>S</i>	<i>SDD</i>	<i>I</i>	<i>R</i>	<i>N</i>	<i>S</i>	<i>SDD</i>	<i>I</i>	<i>R</i>	<i>N</i>	<i>S</i>	<i>R</i>
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.