

Antibiotic Susceptibility Patterns of Commonly Isolated Bacteria

July 2024 – June 2025 (12 months)

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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 susceptible More susceptible

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	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			38	66					38	50			38	32	38	47	37	70	37	54			36	47	38	84	38	61
<i>Citrobacter freundii</i> ²					18	61			18	89					18	78	18	100	18	100	11	91	18	72	18	100	18	89
<i>Citrobacter koseri</i>			32	94	32	97	32	84	32	97	32	91	32	97	32	94	32	100	32	100	23 ²	65	32	94	32	97	32	100
<i>Enterobacter cloacae</i>					69	67			69	80			69	64	69	84	69	97	69	100	40	30	69	72	69	94	69	78
<i>Escherichia coli</i>	709	39	709	43	707	79	709	64	709	80	709	77	709	79	708	58	709	85	709	99	572	97	709	77	707	83	709	65
<i>Klebsiella (Enterobacter) aerogenes</i> ²					27	59			27	96			27	56	27	96	27	100	27	100	14	43	27	44	27	100	27	96
<i>Klebsiella oxytoca</i>			31	52	31	84	31	45	31	84	31	84	31	84	31	84	31	87	31	97	18 ²	83	31	77	31	87	31	81
<i>Klebsiella pneumoniae</i>			253	62	253	77	253	67	253	78	253	71	253	76	252	73	253	92	253	96	158	54	253	70	253	89	253	75
<i>Morganella morganii</i>			30	17	30	93			30	100	30	80	30	83	30	53	30	87	30	100			30	97	30	80	30	53
<i>Proteus mirabilis</i>	150	78	150	89	150	95	150	1	150	97	150	94	150	95	150	72	150	71					150	95	150	80	150	78
<i>Providencia stuartii</i> ²			21	5	21	95			21	81	21	90	21	86	21	24			21	95			21	67			21	76
<i>Serratia marcescens</i> ²					26	88			26	96			26	88	26	81	26	96	26	100			26	88	26	58	21	95

	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>	134	99	225	74	228	90	229	84	227	94	230	89	230	79

	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> ²	26	31	26	65	26	81	26	100

<i>ENTEROCOCCUS</i> Urine* Weiler	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>	200	100	198	78	200	100	200	26	200	93
<i>Enterococcus faecium</i>	49	4	49	8	19	0	49	10	48	46
*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

<i>STREPTOCOCCUS PNEUMONIAE</i> All Campuses 2024-2025		Sterile Site				Non-Sterile Site			
		<i>N</i>	<i>S</i>	<i>I</i>	<i>R</i>	<i>N</i>	<i>S</i>	<i>I</i>	<i>R</i>
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.

<i>STAPHYLOCOCCUS</i> ^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)	163	77	163	100	163	98	163	0	163	93	163	94	163	100
<i>S. aureus</i> (MRSA) ^B	145	77	145	0	145	94	145	0	145	67	145	79	145	100
<i>S. epidermidis</i>	87	53	86	49	88	83	86	0	84	76			86	100
<i>S. haemolyticus</i> ²	14	7	14	21	14	58	14	0	14	71			12	100
<i>S. lugdunensis</i> ²	19	84	19	84	19	100	19	0	19	89	14	100	19	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

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

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.

<i>CANDIDA</i> 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.