Antibiotic Susceptibility Patterns of Commonly Isolated Bacteria
July 2023 – June 2024 (12 months)
All MMC Sites

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.

Box color: Intrinsic Resistance 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]	27	93	7	[2]	26	73	27	96

	PEN		CEFTRIAX		VANC	
	N	% S	*N*	% S	*N*	% S
viridans *Streptococcus* (sterile sites)	57	70	62	97	60	98

STREPTOCOCCUS PNEUMONIAE All Campuses 2023-2024		Sterile Site				Non-Sterile Site			
		N	S	I	R	*N*	S	I	R
PENICILLIN[A,B]	Meningitis	*52*	**62**		**38**				
	Non-CNS	*52*	98	0	2				
	Parenteral					*65*	91	6	3
	Oral					*65*	**62**	15	23
CEFTRIAXONE[A]	Meningitis	*53*	98	2	0	*65*	95	2	3
	Non-CNS	*53*	100	0	0	*65*	97	0	3
LEVOFLOXACIN		*60*	96	2	2	*72*	94	3	3
TRIMETH/SULFA[C]						*71*	76	8	15

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.

ENTEROCOCCUS **Sterile Sites** All Campuses 2023-2024	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	*143*	100	*143*	85	*143*	76	*143*	99	*143*	85	*143*	93
Enterococcus faecium	*93*	11	*92*	96	*92*	89	*93*	98	*92*	59	*93*	31

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 2023-2024	*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	*88*	93	2		3	*23*	87	9		13	*12*	**42**	**33**		**25**	*56*		**82**		**18**	*21*	5	95
Voriconazole	*88*	93		3	3	*23*	91		9	0	*12*	**42**		**58**	0								
Micafungin	5	[2]		[2]	[2]	*6*	[2]		[2]	[2]	*3*	[2]		[2]	[2]	*56*	96		0	4	*20*	100	0
Amphotericin B																					*20*	90	10

*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.