



LABORATORY ALLIANCE
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**2024
OUTPATIENT
Antibiogram**

St. Joseph's Hospital Health Center

Data Are Percent Susceptible

January 2023 – December 2023

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Indication	No Antibiotic Allergies	Penicillin allergy – rash	Penicillin allergy – a hylaxis	Comments
Acute Sinusitis ¹ (Symptoms lasting 4-12 weeks)	Amoxicillin-clavulanic acid 875mg PO BID x5-7 days	Doxycycline hyclate tablets mg PO BID x5- days	Doxycycline hyclate tablets 0mg PO BID x5-7 d s	Use antibiotics when: <ul style="list-style-type: none"> Onset with persistent symptoms (purulent mucus) lasting >10 days and not improving Onset with severe symptoms for at least 3-4 days (high fever >39°C/102°F, purulent nasal discharge) Viral symptoms that appear to improve but then suddenly worsen around days 5-6 ("double sickening") Non-pharmacologic recommendations: 1. Saline nasal irrigations 2. Intranasal corticosteroids (if hx allergic rhinitis) No topical or oral decongestants or antihistamines are recommended
Pharyngitis ² Group A Streptococcus	Penicillin VK 500 mg PO BID x10 days or Amoxicillin 500mg PO BID x10 days	Cephalexin 500 mg PO BID x10 days	Clindamycin 300mg PO TID x10 days or Azithromycin 500 mg PO daily x1, 250 mg PO daily x4 days	Non pharmacologic recommendations: 1. APAP 2. NSAID
Bronchitis Acute	Routine antibiotic treatment for uncomplicated bronchitis is NOT recommended, regardless of duration of cough			
Pneumonia ³ (patients with comorbidities: chronic heart, lung, liver, or renal disease, diabetes, alcoholism, malignancy, or asplenia)	Cefuroxime axetil 500 mg PO BID x 5-7 days + Azithromycin 500mg x1 day, 250mg/day x 4 days or Amoxicillin-clavulanic acid 875mg PO BID x 5-7 days + Azithromycin 500mg x1 day, 250mg/day x 4 days	Cefuroxime axetil 500 mg PO BID x 5-7 days + Azithromycin 500mg x1 day, 250mg/day x 4 days	Levofloxacin 750 mg PO daily x5 days	Non-pharmacologic recommendations: 1. Oral hydration.
Uncomplicated ⁴ cystitis (well-controlled DM/elderly)	Creatinine clearance >30 ml/min Nitrofurantoin (Macrobid) 100 mg PO BID x5 days Or TMP-SMX 1 DS PO BID x3 days (lower sensitivity rate) Or Creatinine clearance <30 ml/min Cephalexin capsules 500 mg PO q8h x7 days	Creatinine clearance >30 ml/min Nitrofurantoin (Macrobid) 100 mg PO BID x5 days or TMP-SMX 1 DS PO BID x3 days (lower sensitivity rate) Or Creatinine clearance <30 ml/min Cephalexin capsules 500mg PO q8h x7 days	Creatinine clearance >30 ml/min Nitrofurantoin (Macrobid) 100mg PO BID x5 days or TMP-SMX 1 DS PO BID x3 days (lower sensitivity rate) or Creatinine clearance <30 ml/min, >10 ml/min Fosfomycin 3g PO x1	Non pharmacologic recommendations: Oral hydration If Pyridium is used, should only be used for 48 hours.
Uncomplicated ⁴ pyelonephritis Based on resistance rates and allergies, may need a dose of ceftriaxone or aminoglycoside in office	Ciprofloxacin 500 mg PO BID x7 days or Levofloxacin 750 mg PO daily x5 days or TMP-SMX DS PO BID x 14 days or Amoxicillin-clavulanic acid 500 mg/125 mg PO BID x10-14 days	Ciprofloxacin 500 mg PO BID x7 days or Levofloxacin 750 mg PO daily x5 days or TMP-SMX DS PO BID x14 days or Cefdinir 300mg PO BID x 10-14 days	Ciprofloxacin 500 mg PO BID x7 days or Levofloxacin 750 mg PO daily x5 days or TMP-SMX DS PO BID x14 days	
Purulent Cellulitis ⁵	TMP-SMX DS 1-2 PO BID x5 days (consider higher dose in obesity)	Sulfa allergy: Doxycycline hyclate tabs 100 mg PO BID x5 days	Sulfa/doxy allergy: Linezolid 600mg po q 12h x5 days	Antibiotics may not be needed with adequate I/D and no signs of systemic symptoms (SIRS).
Nonpurulent Cellulitis ⁵	Cephalexin capsules ⁶ < 60kg – 500mg PO 4 times daily 60-80kg – 1g PO 3 times daily >80kg – 1g PO 4 times daily Or Dicloxacillin 500mg PO 4 times/day X 5 days	Cephalixin capsules < 60kg – 500mg PO 4 times daily 60-80kg – 1g PO 3 times daily >80kg – 1g PO 4 times daily X 5 days	Linezolid 600mg PO q 12h	Non pharmacologic recommendations: Elevation of affected area Examine interdigital toe spaces and treat with topical antifungals if indicated.

References

1. Chow AW et al. Clin Infect Dis 2012;54(8):e72-112.
2. Shulman ST et al. Clin Infect Dis 2012;55(10):e86-102.
3. Metlay JP et al. Am J Respir Crit Care Med 2019;200:e45-e67.
4. Gupta K et al. Clin Infect Dis 2011;52(5):e103-120.
5. Stevens DL et al. Clin Infect Dis 2014;59(2):e-10-52.
6. Pallin DJ et al. Clin Infect Dis 2013;56(12):1754-62.

Choice of Antimicrobial Therapy

A. Empiric Therapy:

Prior to receiving specific susceptibility results, drugs to which organisms are greater than 80% susceptible are generally considered good choices, although patient history, site of infection, and specific pharmacologic properties as they apply to the particular patient must be taken into account.

B. Therapeutic Therapy:

The drug of choice for treatment of an infection is usually the most active drug against the pathogenic organism or the organism most likely to cause infection. Choice of drugs should be modified by site of infection and patient's clinical status regarding allergy, renal function, immune status or pregnancy.

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Laboratory Alliance of CNY-St. Joseph's Hosp Health CTR Outpatient Antibioqram:
 Prepared by: Russell Rawling, MS Microbiology Manager

(Data are % susceptible)

Organism Display	Number of Isolates*	Ampicillin	Amoxicillin/clavulanate	Ampicillin/sulbactam	Piperacillin/tazobactam!!	Cefazolin**	Cefoxitin	Cefepime	Ceftazidime	Ceftriaxone	Cefiderocol	Ertapenem	Meropenem	Ciprofloxacin	Levofloxacin	Gentamicin++	Tobramycin	Amikacin##	Tetracycline (Doxycycline)	Minocycline	Trimethoprim / sulfamethoxazole (Bactrim)	Nitrofurantoin	Clindamycin	Erythromycin	Azithromycin	Oxacillin+	Penicillin	Vancomycin	Rifampin++	Daptomycin!	Linezolid	
ESCHERICHIA COLI	1148	58	87	ND	97/97	91	95	95	95	95	ND	100	100	82	79	93	94	100	80	ND	82	97										
KLEBSIELLA PNEUMONIAE	209	0	89	ND	91/96	73	91	82	81	82	ND	99	99	82	75	93	93	100	76	ND	82	35										
PROTEUS MIRABILIS	111	83	100	ND	100/100	78	91	97	97	95	ND	79	98	74	73	96	95	100	0	ND	82	0										
ENTEROBACTER CLOACAE COMPLEX	90	0	0	ND	80/84	0	0	97	77	75	ND	93	96	88	84	95	95	100	82	ND	86	44										
SERRATIA MARCESCENS	79	0	0	ND	95/96	0	0	100	100	98	ND	100	100	91	85	100	96	100	19	ND	100	0										
KLEBSIELLA OXYTOCA	56	0	94	ND	96/98	62	91	96	96	96	ND	100	100	95	94	99	99	100	86	ND	98	100										
MORGANELLA MORGANI	38	0	0	ND	98/100	0	53	100	78	84	ND	100	100	73	73	100	100	100	49	ND	80	0										
CITROBACTER KOSERI	32	0	16	ND	94/97	89	90	100	94	94	ND	100	100	100	100	100	100	100	100	ND	100	100										
PSEUDOMONAS AERUGINOSA	194	NI	NI	NI	96	NI	NI	96	96	NI	ND	NI	92	79	69	NI	100	99	NI	NI	NI	NI										
BETA STREP GRP A- BLOOD & SOFT TISSUE	48	100								100					96				83				87	85			100	100			100	
BETA STREP GRP B- BLOOD & SOFT TISSUE	126	100								100					97				0			37	28			100	100			100		
ENTEROCOCCUS SP., VSE	156	84												68	69				50							83	100		71	99		
ENTEROCOCCUS SP., VRE	15	17												5	5				0			25						0		ND	97	
STAPH. AUREUS, MSSA	406													92	93	100			94		93	100	74	65	99		100	100	100	100		
STAPH. AUREUS, MRSA	279													22	23	100			80		75	100	62	12	0		100	99	100	100		
STAPH. SPECIES, COAG.NEG	110													74	76	97			75		74	99	50	36	47		100	98	100	100		
ACINETOBACT BAUMANII COMM WIDE	112		81		49			65	47				56	40	44	73	97					52										
STENOTROPH MALTOPHILIA COMM WIDE	312										100				76					100	99											
HAEM INFLUENZAE COMM WIDE	121	60	100							98			100		100				79		60											
STREP PNEUMONIAE COMM WIDE	109									96					100				80		86		87	67	67	#99	100				100	

* Note: isolates from all sources; urine, blood, respiratory, wound, etc.

** For uncomplicated UIT's, Cefazolin MIC results less than or equal to 16 mcg/ml predict susceptibility of the following oral cephalosporins: cefactor, cefdinir, cefpodoxime, ceftazidime, cefuroxime and cephalexin.

+ Oxacillin susceptible Staph are also susceptible to other penicillinase resistant penicillins, betalactam/betalactamase inhibitor combinations, cepheps, and carbapenems FDA approved to treat Staph infections.

++ Gentamicin and Rifampin may be used in combination with other drugs against Staph isolates.

! Data is only for Enterococcus faecalis.

!! Pip/Taz data for ENTERICS: 1st % is Susceptible (<=8/4) and 2nd % is Susceptible plus Susceptible Dose Dependent (<=16/4)

99% were in the intermediate or susceptible range indicating many could be treated for pneumonia with appropriate dosing of an IV penicillin.

Amikacin is only indicated for P aeruginosa from urine specimens.

NI= drug not active

ND = No data

The percentage in red are greater than or equal to 80% susceptibility, potentially useful for empiric therapy.