Connecticut Valley Hospital

Memo

To: ACS Clinicians and After-hours Physicians

From: Kenneth I. Freedman, M.D., MBA, FASAM,
Medical Director, Ambulatory Care Services and Chair,
Infection Control Committee
Laurie Wassil, RN, CIC,
Infection Control Practitioner and
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Date: 2/6/06

Re: Antibiotic Resistance

Attached are Antimicrobial Susceptibility Profiles from CVH isolates from 2005 and 2004. The prevalence of MRSA (methicillin-resistant *Staph. Aureus*) has exploded! Upon examination, you will also notice the marked drop of the susceptibility of E. coli to SXT (91% —> 67%), CIP (94% —> 70%), and LEV (94% —> 70%). The susceptibility of E. coli to CFZ only decreased from 100% to 93%.

These findings were discussed with the Middlesex Hospital Infectious Disease specialists, who advised:

1) Whenever possible, **<u>avoid</u> treating asymptomatic (or minimally symptomatic) bacteriuria, especially for patients with chronic indwelling Foley catheters and/or when UAs shows few WBCs;**

2) Whenever possible, await the urinary isolate sensitivities before deciding what antibiotic to use;

3) When empiric therapy is necessary (e.g., the patient is febrile), give oral amoxicillin and one dose of IM Gentamicin (2 mgs/kg) <u>after</u> obtaining the urine C&S; oral cephalexin (Keflex) is also reasonable for empiric therapy of mild UTIs;

4) Consider using nitrofurantoin (Macrodantin) for uncomplicated UTIs in patients with normal renal function who are allergic to beta-lactams and sulfa.

5) In <u>most</u> cases, antibiotics should be <u>discontinued</u> if culture shows less than 100,000 colonies per ml, or if more than two organisms grow.

We will be asking the PNT Committee to restrict quinolones (e.g., ciprofloxacin, levoquin, and others) for the next 6-12 months.

Remember that *Staph. aureus* in the urine means *Staph. aureus* in the blood until proven otherwise.

Contact the Infection Control Practitioners with any questions.

cc: Barbara Forgit, RN, CNA, MPA, Director of ACS
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