Memo

To: ACS Clinicians and After-hours Physicians  
From: Kenneth I. Freedman, M.D., MBA, FASAM,  
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Infection Control Committee  
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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, **avoid treating asymptomatic (or minimally symptomatic) bacteriuria**, especially for patients with chronic indwelling Foley catheters and/or when UAs show 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) after obtaining the urine C&S; oral cephalaxin (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 **most** cases, **antibiotics should be discontinued** 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.**