Outpatient Antibiogram
January 1 – December 31,2019

TRICORE REFERENCE LABORATORIES

Non-Urine Isolates

Gram Positive Isolates

	# of Isolates	Azithromycin (Erythromycin)	Tetracycline (Doxycycline)	Moxifloxacin	Trimethoprim-Sulfamethoxazole	Clindamycin	Ampicillin-Sulbactam	Cephalexin	Minocycline	Linezolid
Staphylococcus aureus	796	49.1%	94.0%	73.3%	97.2%	85.8%	63.6%	63.6%	99.0%	100.0%
Staphylococcus aureus (MRSA)	291	13.4%	94.5%	44.8%	95.5%	86.6%			97.9%	100.0%
Staphylococcus aureus (MSSA)	509	69.5%	93.7%	89.7%	98.2%	85.3%	99.8%	100.0%	99.6%	100.0%

Mild Skin and Soft Tissue Infections	IDSA Guidelines Empiric Recommendations[C]
Nonpurulent (necrotizing infection/cellulitis/erysipelas) – Without systemic signs	Penicillin VK (for streptococci alone); OR Cephalexin or Dicloxacillin (for staphylococcus aureus); OR Clindamycin, sulfamethoxazole-trimethoprim or doxycycline (for MRSA)
Purulent (furuncle/carbuncle/abscess) - Without systemic signs	Incision and drainage

Isolates included in this antibiogram are from non-specialty outpatient clinics throughout New Mexico. Black shaded antibiotics have no coverage. Gray shaded antibiotics are <50% susceptible or Not Tested. Antibiotics included represent oral formulations available. Susceptibilities in green for oral treatment options are greater than or equal to 80%.

(A) Mandell LA, et al. IDSA/ATS. 2007;44 Suppl 2:S27-S63.

(B) With a high rate of local macrolide resistance (>25%), consider the following agents: β-lactam (e.g., high-dose amoxicillin or amoxicillin-clavulanate) + macrolide (azithromycin) OR doxycycline. Respiratory fluoroquinolones (e.g., moxifloxacin, levofloxacin) may be used as an alternative option.[A] Fluoroqinolone use is a risk factor for developing *Clostridium difficile*-associated diarrhea. (Deshpande A, et al. J Antimicrob Chemother. 2013;68:1951-61.)

(C) Stevens DL, et al. Clin Infect Dis. 2014;59:e10-e52.