### Antimicrobial Susceptibilities of Selected Pathogens, 2003

<table>
<thead>
<tr>
<th>Pathogen</th>
<th>Number of Isolates Tested</th>
<th>% Susceptible</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staphylococcus aureus</strong></td>
<td>100</td>
<td>97</td>
</tr>
<tr>
<td><strong>Escherichia coli</strong></td>
<td>99</td>
<td>100</td>
</tr>
<tr>
<td><strong>Neisseria gonorrhoeae</strong></td>
<td>172</td>
<td>100</td>
</tr>
<tr>
<td><strong>Haemophilus influenzae</strong></td>
<td>84</td>
<td>100</td>
</tr>
<tr>
<td><strong>Streptococcus pneumoniae</strong></td>
<td>567</td>
<td>88</td>
</tr>
<tr>
<td><strong>Salmonella enterica (non-typhoidal)</strong></td>
<td>562</td>
<td>100</td>
</tr>
<tr>
<td><strong>Shigella flexneri</strong></td>
<td>8</td>
<td>100</td>
</tr>
<tr>
<td><strong>E. coli</strong></td>
<td>40</td>
<td>99</td>
</tr>
</tbody>
</table>

#### Trends, Comments and Other Pathogens

1. **Campylobacter spp.**
   - Ciprofloxacin susceptibility was determined for all isolates (n=578). Only 37% of isolates from patients returning from foreign travel were susceptible to quinolones. Susceptibilities were determined using 2003 NCCLS breakpoints for Enterobacteriaceae. Susceptibility for erythromycin was based on an MIC ≤ 4 µg/ml.

2. **Salmonella enterica (non-typhoidal)**
   - Antimicrobial treatment for enteric salmonellosis generally is not recommended.

3. **Neisseria gonorrhoeae**
   - The 145 isolates tested comprised approximately 5% of total gonococcal cases reported in 2003. All isolates were susceptible to ciprofloxacin and 97% were susceptible to trovafloxacin.
   - Five isolates (3%) had decreased susceptibility to amoxicillin provided for this agent.
   - Among 216 isolates tested through another surveillance system (AISP), 5 isolates were resistant to ciprofloxacin.

4. **Neisseria meningitidis**
   - Prospective CDC breakpoints: MIC of 0.06 µg/ml considered susceptible, MIC of 0.12 - 0.5 µg/ml considered "less susceptible" for penicillin.
   - In 2003, 1 isolate had an MIC of 0.12 and 1 had an MIC of 0.25 µg/ml for penicillin.

5. **Group B Streptococcus (GBS)**
   - All (2002) early-onset infants, 94% (15/16) of late-onset infants, 75% (24/32) of maternal, and 87% (233/268) of invasive, non-infant, non-maternal GBS case isolates were susceptible. 94% (32/35) of infant and maternal case isolates were susceptible to clindamycin and 79% (30/38) were susceptible to erythromycin.
   - All 289 isolates had an MIC of 0.5 µg/ml or less.

6. **Streptococcus pneumoniae**
   - The 567 isolates tested comprised approximately 35% of total pneumococcal cases reported in 2003. All isolates were susceptible to ciprofloxacin.
   - Five isolates (3%) had decreased susceptibility to penicillin.
   - Among 216 isolates tested through another surveillance system (AISP), 5 isolates were resistant to ciprofloxacin.

7. **Haemophilus influenzae**
   - Although 35% of the isolates were ampicillin-resistant, 100% were susceptible to amoxicillin-clavulanate, which contains a β-lactamase inhibitor.
   - All ampicillin-resistant isolates produced β-lactamase.

8. **Klebsiella pneumoniae**
   - National guidelines recommend initial four-drug therapy for TBD disease, including at least 1 drug that inhibits carbapenemase production.
   - All 57 isolates tested were susceptible to carbapenems.

9. **Methicillin-resistant Staphylococcus aureus (MRSA)**
   - Of 200 community-associated MRSA isolates tested in 2003 (2003 results pending), 79% were susceptible to ciprofloxacin. 86% were susceptible to clindamycin. 41% were susceptible to erythromycin. 88% were susceptible to gentamicin. 95% were susceptible to trimethoprim/sulfamethoxazole. 100% were susceptible to rifampin. 95% were susceptible to tetracycline. 100% were susceptible to linezolid.
   - None of the 57 isolates resistant to clindamycin were resistant to clindamycin.

10. **Acinetobacter baumannii**
    - All 57 isolates tested were susceptible to erythromycin using provisional CDC breakpoints.

**Antimicrobial treatment for E. coli O157:H7 infection is not recommended.**
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2003

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To Report a Case:
Fill out a Minnesota Department of Health case report form and mail to the above address. For diseases that require immediate reporting, or for questions about reporting, call the Acute Disease Investigation and Control Section at: 612-676-5414 or 877-676-5414 or fax form to 612-676-5743.

To Send an Isolate to MDH:
If you are sending an isolate by U.S. mail, use regulatory compliant transport packaging and send to the above address. If you are using a courier, use transport packaging appropriate for the specific courier and send to: 17 Delaware Street SE, Minneapolis, MN 55414. To request pre-paid transport labels (both mail and courier) and packaging, or for other assistance, call the Public Health Laboratory Specimen Handling Unit at: 612-676-5386.

The MDH Antibiogram is available on the MDH web site (http://www.health.state.mn.us). Laminated copies can be ordered from Antibiograms, Minnesota Dept. of Health, Acute Disease Investigation and Control Section, 717 Delaware St. SE, Minneapolis, MN 55414.