Table 1. Trends in Antibiotic Susceptibility of Nosocomial Isolates and Selected Antimicrobials: 2002 to 2006*

		Susceptible Isolates/Total Isolates (*n* and %)			
Isolate	Period	Amoxicillin-Clavulanic Acid	Amikacin	Ciprofloxacin	Ofloxacin
Escherichia coli	2002 to 2005	18/24 (75)	7/10 (70)	11/26 (42)	12/26 (46)
	2005 to 2006	3/4 (75)	2/3 (67)	1/5 (20)	4/5 (80)
Klebsiella	2002 to 2005	8/9 (89)	4/6 (67)	2/8 (25)	5/8 (63)
	2005 to 2006	12/14 (86)	10/14 (71)	7/14 (50)	10/14 (71)
Proteus	2002 to 2005	0/3 (0)	2/3 (67)	1/4 (25)	3/4 (75)
	2005 to 2006	1/1 (100)	0/1 (0)	0/1 (0)	0/1 (0)
Pseudomonas	2002 to 2005	2/8 (25)	2/6 (33)	5/9 (56)	7/9 (77)
	2005 to 2006	0/2 (0)	2/2 (100)	1/2 (50)	1/2 (50)
Cumulative	2002 to 2005	28/44 (64)	15/25 (60)	19/47 (40)	27/47 (57)
	2005 to 2006	16/21 (76)	14/20 (70)	9/22 (22)	15/22 (68)

* Data were analyzed for changes in susceptibility rate with Fisher's exact test and chi-square test for linear trends. None of the differences (except ciprofloxacin) were significant at $P \leq .05$.

Table 2. Trends in Broader-Spectrum Antibiotics of Nosocomial Isolates: 2005 to 2007*

		Susceptible Isolates/Total (*n* and %)			
Isolate	Period	Aztreonam	Meropenem	Piperacillin-Tazobactam	Cefepime
Escherichia coli	2005 to 2006	3/5 (60)	4/4 (100)	5/5 (100)	1/4 (25)
	2006 to 2007	2/5 (40)	5/5 (100)	4/5 (80)	1/5 (20)
Klebsiella	2005 to 2006	10/14 (41)	14/14 (100)	13/14 (93)	8/14 (57)
	2006 to 2007	6/16 (27)	12/16 (77)	14/16 (88)	5/15 (33)
Proteus	2005 to 2006	0/1 (0)	1/1 (100)	1/1 (100)	1/1 (100)
	2006 to 2007	2/2 (100)	2/2 (100)	2/2 (100)	2/2 (100)
Pseudomonas	2005 to 2006	2/2 (100)	2/2 (100)	2/2 (100)	2/2 (100)
	2006 to 2007	4/8 (80)	4/5 (80)	5/5 (100)	2/5 (40)
Cumulative	2005 to 2006	15/22 (68)	21/21 (100)	21/22 (95)	12/21 (57)
	2006 to 2007	14/28 (50)	23/28 (82)	25/28 (89)	10/27 (37)

* Data were analyzed for changes in susceptibility rate with Fisher's exact test and chi-square test for linear trends. None of the differences were significant at $P \leq .05$.

The author responds:

Local susceptibility testing and production of an antibiogram of the local community is ideal to guide initial empirical therapy and therapy for patients who fail initial antibiotic treatment, while awaiting in vitro susceptibility results. A locally produced antibiogram of local organisms is the most useful because it better reflects the organisms and resistance patterns in the population served than can national guidelines. Each hospital and hospital unit has different resistance patterns, and clinicians who are aware of the local patterns are more likely to choose the best empirical antibiotic, and to pick more appropriate antibiotics if the initial antibiotics fail.

In rural areas with limited resources the knowledge of local resistance patterns may be important because less expensive antibiotics may be effective if resistance to those agents is locally uncommon. Only knowledge of the local antibiotic resistance patterns will permit those choices to be made safely. Important changes in local resistance patterns, detected via surveillance, will guide shifts to antibiotics that will remain effective and inexpensive for the population served.

Robert E Siegel MD
Intensive Care Unit
James J Peters Veterans Affairs
Medical Center
Bronx, New York

The author reports no conflicts of interest related to the content of this letter.