II Jornada del Comité Español del Antibiograma (CoEsAnt)

Madrid, 12 de febrero de 2026

Antibiograma selectivo, ¿cómo, cuándo y por qué?

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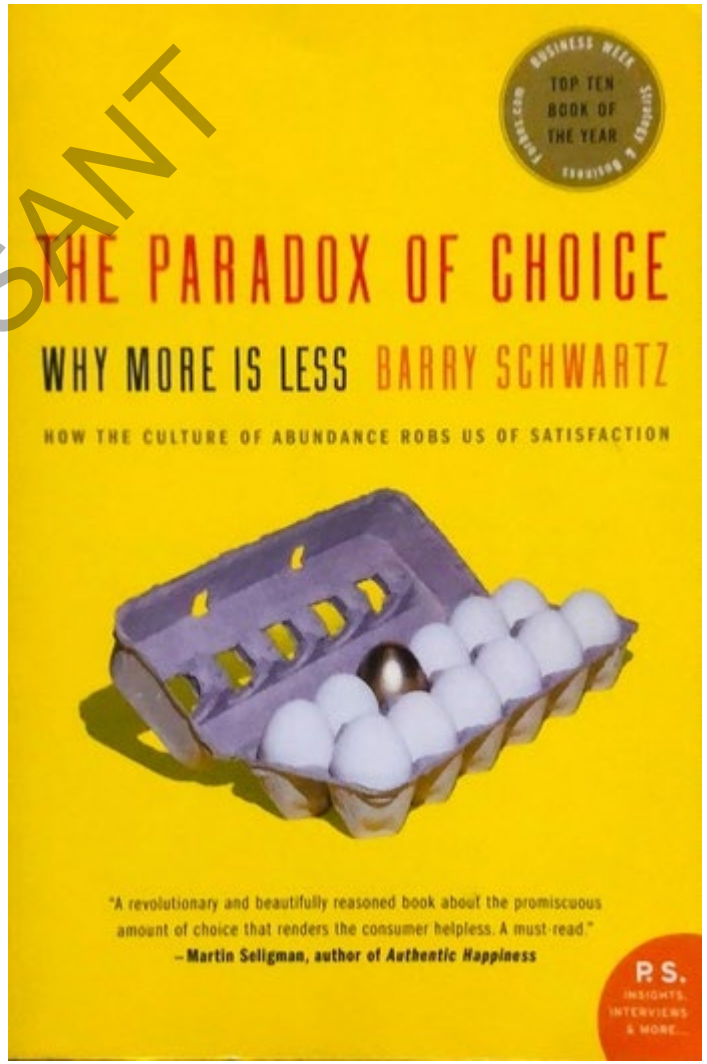
Conflictos de interés

- *Apoyo para formación (asistencia a congresos) por parte de MSD, Menarini, Shionogi.*

Barry Schwartz – “The Paradox of Choice”

“Cuantas más opciones tenemos, más difícil se vuelve elegir y menos satisfechos estamos con la decisión tomada.”



Objetivos

- Utilidad clínica del antibiograma
- Concepto de antibiograma selectivo
- ¿Cómo se realiza? ¿Criterios?
- ¿Cuándo debe aplicarse?
- ¿Por qué es una herramienta clave?

Utilidad clínica del antibiograma

- Permite elegir el tratamiento antibiótico más adecuado
- Permite la detección y control de resistencias
- Permite ajustar o desescalar tratamientos
- Contribuye al control de infecciones y vigilancia epidemiológica
- Mejora la seguridad y pronóstico del paciente
- Herramienta clave en programas PROA

Antibiograma selectivo "*Selective reporting*"

Estrategia de informe dirigido de antibióticos:

No se informa todo lo testado

Informe dirigido de los antibióticos disponibles:

Clínicamente adecuados
Recomendados como primera línea
Coherentes con la localización y el microorganismo

Priorizar antibióticos:

Eficaces
De menor espectro
Con mayor perfil de seguridad

Evitar inducir:

Uso innecesario de antibióticos de reserva
Confusión en la prescripción

Basado en:

Microorganismo identificado
Tipo de muestra y foco clínico
Patrones locales de resistencia
Guías EUCAST/CLSI/Otras
Políticas locales/nacionales de uso de antibióticos

Antibióticos alternativos si:

Resistencia a primera línea
Alergias documentadas
Infecciones graves o localizaciones especiales

No informar antibióticos:

Sin indicación clínica
Redundantes

Decisión consensuada

¿Cómo?

Criterios disponibles

COMITÉ	
EUCAST	No hay criterios específicos, si recomendaciones/indicaciones en diferentes documentos (https://www.eucast.org/)
CA-SFM	CA-SFM / EUCAST : Société Française de Microbiologie Ed ; 2025 v1.1 juillet 2025
COESANT-SEIMC	Recommendations of the Spanish Antibiogram Committee (COESANT) for selecting antimicrobial agents and concentrations for in vitro susceptibility studies using automated systems
CLSI	CLSI Performance Standards for Antimicrobial Susceptibility Testing. 35th ed. CLSI Supplement M100 Clinical and Laboratory Standards Institute; 2025. En 1972 el NCCLS acuña el término de "*Selective reporting*"

EUCAST

- Diversas indicaciones en documentos tipo “Expected phenotypes”, “Expert rules”, “Guidance documents”.

https://www.eucast.org/

ScienceDirect

International Journal of Antimicrobial Agents
Volume 49, Issue 2, February 2017, Pages 162-166

Selective reporting of antibiotic susceptibility test results in European countries: an ESCMID cross-sectional survey

Céline Pulcini [a b], Gianpiero Tebano [a], Nico T. Mutters [c], Evelina Tacconelli [d e], Emmanuelle Cambau [f g], Gunnar Kahlmeter [h], Vincent Jarlier [i j]
EUCIC-ESGAP-EUCAST Selective Reporting Working Group[1]

- **Objetivo del estudio**: Identificar dónde y cómo se implementa el informe selectivo de resultados AST en Europa, evaluando su impacto en la prescripción de antibióticos.
- **Metodología**: Se realizó una encuesta transversal en línea entre representantes nacionales de ECCMID y EUCAST en Europa e Israel. De los 38 países invitados, 36 participaron.
- **Resultados**:
  - El informe selectivo de AST se implementó en 11 de los 36 países participantes.
  - La implementación varía según el tipo de hospital y el entorno (hospitalario o ambulatorio).
  - Los resultados sugieren que el informe selectivo puede influir en la prescripción de antibióticos, promoviendo un uso más racional y reduciendo la resistencia antimicrobiana.

- **Barreras identificadas:**
  - Falta de recursos suficientes.
  - Resistencia por parte de los profesionales.
  - Necesidad de más evidencia sobre los beneficios del informe selectivo.
- **Recomendaciones:**
- Se destaca la importancia de implementar estrategias de informe selectivo para mejorar el uso de antibióticos.
- Se sugiere la necesidad de más investigación para evaluar el impacto de estas estrategias en la resistencia antimicrobiana y en la práctica clínica.

Contents lists available at ScienceDirect

Clinical Microbiology and Infection

journal homepage: www.clinicalmicrobiologyandinfection.com

Commentary

Selective reporting of antibiotic susceptibility testing results: less is more

Gunnar Kahlmeter [1,2], Nathalie Thilly [3,4], Céline Pulcini [3,5,*]

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- Estudio observacional en Canadá (2014–2017) con 113.780 adultos,
- Demuestra que los antibióticos que aparecen como “sensibles” en el informe influyen fuertemente en la prescripción.
- Los médicos tienen **tres veces más probabilidad** de prescribir un antibiótico si aparece como sensible.
- Informar un antibiótico aumenta su prescripción (OR 1,23).
- El estudio solo incluye pacientes >65 años, lo que limita su generalización.

Clinical Microbiology and Infection 27 (2021) 568–575

Contents lists available at ScienceDirect

Clinical Microbiology and Infection

journal homepage: www.clinicalmicrobiologyandinfection.com

Original article

Antibiotic susceptibility reporting and association with antibiotic prescribing: a cohort study

Bradley J. Langford [1,*], Nick Daneman [2], Christina Diong [3], Alex Marchand-Austin [3], Kwaku Adomako [4], Arezou Saedi [4], Kevin L. Schwartz [5], Jennie Johnstone [6], Derek R. MacFadden [7], Larissa M. Matukas [8], Samir N. Patel [9], Gary Garber [10], Kevin A. Brown [5]

- **La notificación selectiva busca:**
- Reducir tratamientos innecesarios → mediante la estrategia de “**no reporting**”, especialmente útil en bacteriurias asintomáticas.
- Favorecer prescripciones adecuadas → mostrando solo antibióticos de primera línea para guiar al prescriptor.
- El informe selectivo actúa como un **nudge** (empujón conductual).

EUCAST

Contents lists available at ScienceDirect

Clinical Microbiology and Infection

journal homepage: www.clinicalmicrobiologyandinfection.com

Commentary

Selective reporting of antibiotic susceptibility testing results: less is more

Gunnar Kahlmeter [1,2], Nathalie Thilly [3,4], Céline Pulcini [3,5,*]

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[4] Université de Lorraine, CHRU-Nancy, Département Méthodologie, Promotion et Investigation, Nancy, France
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What is the potential role of ESCMID and EUCAST?

On several occasions over the last 10 years, it has been discussed whether EUCAST could take responsibility for trying to harmonize European reporting panels regarding both how many and which antibiotics to report, as well as for developing models for selective testing and/or reporting. For many reasons, this has so far been declined. Testing and reporting traditions differ widely between countries and indeed individual laboratories. Apart from tradition, antibiotic resistance and availability as well as antibiotic costs differ between countries. What seems like a rational model in one country may be considered impossible in another. At this point in time, the best we can hope to achieve is the development of some general principles. This report, and the science we refer to, will help gradually build a platform for this. The European Society for Clinical Microbiology (ESCMID) and the European Committee on Antimicrobial Susceptibility Testing (EUCAST) should be able to take the initiative.

CA-SFM

5. 2. *Pseudomonas* spp.

Détermination de la CMI (par microdilution selon la norme ISO 20776-1 ; pour la fosfomycine, la méthode de référence est la dilution en milieu gélosé). Milieu de culture : bouillon Mueller-Hinton ajusté en cations (conditions spécifiques pour le céfidérocol). Inoculum : 5×10^5 UFC/mL. Incubation : aérobiose, 35 ± 2 °C, 20 ± 4 h. Lecture : en l'absence d'indication particulière, la CMI correspond à la concentration la plus faible pour laquelle la croissance bactérienne n'est plus visible.	**Méthode par diffusion en milieu gélosé.** Milieu : gélose Mueller-Hinton. Inoculum : 0,5 McFarland. Incubation : aérobiose, 35 ± 2 °C, 20 ± 4 h.
Contrôle de qualité : *Pseudomonas aeruginosa* ATCC 27853. Pour les antibiotiques qui ne sont pas contrôlés par cette souche, voir le chapitre 1.3 Contrôle de qualité (tableau 4).	

Liste standard		Liste complémentaire	
Amikacine	[...]	Aztréonam-avibactam	Imipénème-relebactam
Aztréonam	Imipénème	Céfidérocol	Lévofloxacine
Céfépime	Méropénème	Ceftazidime-avibactam	Méropénème-vaborbactam
Ceftazidime	Pipéracilline	Colistine	Ticarcilline (dépistage)
Ceftolozane-tazobactam	Pipéracilline-tazobactam	Fosfomycine	Ticarcilline-acide clavulanique
Ciprofloxacine	Tobramycine		

COESANT-SEIMC

Enferm Infecc Microbiol Clin. 2020;38(4):182–187

ELSEVIER

Enfermedades Infecciosas y Microbiología Clínica

www.elsevier.es/eimc

Review article

Recommendations of the Spanish Antibiogram Committee (COESANT) for selecting antimicrobial agents and concentrations for *in vitro* susceptibility studies using automated systems

Rafael Cantón[a,b,*], Antonio Oliver[b,c], Juan Ignacio Alós[d], Natividad de Benito[e], Germán Bou[b,f], José Campos[b,g], Jorge Calvo[b,h], Andrés Canut[i], Javier Castillo[j], Emilia Cercenado[k], Maria Ángeles Domínguez[b,l], Felipe Fernández-Cuenca[b,m], Jesús Guinea[k], Nieves Larrosa[b,n], Josefina Liñares[b,o], Lorena López-Cerero[b,m], Antonio López-Navas[o], Francesc Marco[b,p], Beatriz Mirelis[q], Miguel Ángel Moreno-Romo[r], María Isabel Morosini[a,b], Ferran Navarro[q], Jesús Oteo[b,g], Álvaro Pascual[b,m], Emilio Pérez-Trallero[s], María Pérez-Vázquez[b,g], Alex Soriano[t], Carmen Torres[u], Jordi Vila[b,p], Luis Martínez-Martínez[b,w]

Table 1
Categories used for the inclusion of the antimicrobial agents in susceptibility testing panels for automated systems.

Categories	Definitions
A	Antimicrobials that must be routinely studied and reported. They are relevant for both clinical purpose and for the process of interpretive reading of the antibiogram
B	Antimicrobials that must be routinely studied but selectively reported. They are useful for the process of interpretive reading of the antibiogram and should be selectively reported according to the type of patient, type of infection or the inferred resistance mechanism
C	Antimicrobials that should be selectively studied and reported according to the type of patient, type of infection or to the inferred resistance mechanism
D	Antimicrobials that are recommended to be routinely studied and reported in urine isolates
E	Antimicrobials that should be studied but not reported. They are useful for the detection of antimicrobial resistance mechanisms, application of an expert rule or as surrogate markers of the susceptibility testing result of other antimicrobials

TABLE S2. Antibiotics and concentrations recommended for the susceptibility testing of *Pseudomonas* spp.

Antimicrobial agent		Concentrations (mg/L)	Category	Comments
β-lactams	Ticarcillin	8-**16**-**32**-64	E	Breakpoints are based on high dose therapy. Not currently used in the clinical setting but useful for the inference of resistance mechanisms such as acquired β-lactamases and/or efflux pump overexpression. ECOFF has not yet been defined.
	Piperacillin	4-**8**-**16**-**32**-64	C	Breakpoints are based on high dose therapy.
	Piperacillin-tazobactam	4/4-**8**/4-**16**/4-**32**/4-64/4	A	Breakpoints are based on high dose therapy. For susceptibility testing purposes, the concentration of tazobactam is fixed at 4 mg/L.
	Ceftazidime	1-**2**-**4**-**8**-**16**-32	A	Breakpoints are based on high dose therapy.
	Cefepime	1-**2**-**4**-**8**-**16**-32	A	Breakpoints are based on high dose therapy.
	Ceftolozane-tazobactam	0.25/4-0.5/4-**1**/4-**2**/4-**4**/4-**8**/4-16/4	C	Useful for the detection of resistance mechanisms, particularly acquired β-lactamases. For susceptibility testing purposes, the concentration of tazobactam is fixed at 4 mg/L.
	Ceftazidime-avibactam	0.5/4-1/4-**2**/4-**4**/4-**8**/4-**16**/4-32/4	C	ECOFF has not yet been defined. Useful for the detection of resistance mechanisms, particularly acquired β-lactamases.
	Aztreonam	**1**-**2**-**4**-**8**-**16**-32	A	Breakpoints are based on high dose therapy. Useful for the detection of resistance mechanisms such as acquired MBLs.
	Imipenem	0.5-**1**-**2**-**4**-**8**-16	A	Breakpoints are based on high dose therapy.
	Meropenem	0.25-0.5-**1**-**2**-**4**-**8**-16	A	
	Meropenem-vaborbactam	**0.125**-**0.25**-**0.5**-**1**-**2**-4-8-16	C	ECOFF has not yet been defined. For susceptibility testing purposes, the concentration of vaborbactam is fixed at 8 mg/L.
Aminoglycosides	Gentamicin	**2**-**4**-**8**	A	Breakpoints are based on once daily administration of high dose therapy.
	Tobramycin	**1**-**2**-**4**-**8**	A	
	Amikacin	2-4-**8**-**16**-**32**	A	
Fluoroquinolones	Ciprofloxacin	0.125-**0.25**-**0.5**-**1**-**2**-4	A	Breakpoints are based on high dose therapy.
	Levofloxacin	0.25-0.5-**1**-**2**-**4**-**8**	C	Breakpoints are based on high dose therapy.
Others	Fosfomycin	16-**32**-**64**-**128**-256	C, D	Breakpoints are not defined. Infections caused by wild type isolates (ECOFF 128 mg/L) have been treated with combinations of fosfomycin and other agents.
	Colistin	0.5-1-**2**-**4**-**8**	B	

Bold numbers indicate the minimum number of concentrations that are recommended to be included in the study of susceptibility testing to address the objectives explained in the text. Underlined numbers indicate the ECOFF values, when lacking is due to the absence of definition of this value by EUCAST. Greyed numbers indicate clinical categories: light grey corresponds to concentrations within intermediate (I) category and dark grey corresponds to concentrations within resistant (R) category. MBL: metallo-β-lactamases

Criterios disponibles-CLSI

C. Test/Report Tiers and Additional Designations

Antimicrobial Agent Test and Report Tiers and Additional Considerations for Agents Listed in Tables 1

Tier	Definition	Test	Report[a]	Additional Testing and Reporting Considerations
1	Antimicrobial agents that are appropriate for routine, primary testing and reporting	Routine	Routine	
2	Antimicrobial agents that are appropriate for routine, primary testing but may be reported following cascade reporting rules established at each institution	Routine	Cascade	• Report following cascade reporting rules due to resistance to agent(s) in Tier 1. • May be reported routinely based on institution-specific guidelines.
3	Antimicrobial agents that are appropriate for routine, primary testing in institutions that serve patients at high risk for MDROs but should only be reported following cascade reporting rules established at each institution[b]	Routine or by request	Cascade	Test routinely based on institution-specific guidelines or by clinician request and report following cascade reporting rules due to resistance to agent(s) in Tiers 1 and 2.
4	Antimicrobial agents that may warrant testing and reporting by clinician request if antimicrobial agents in other tiers are not optimal because of various factors	By request	By request	• Test and report by clinician request due to: – Unavailability of preferred drug for clinical use – Patient underlying condition, including allergies – Unusual susceptibility profile of the organism, including resistance to agents in Tiers 1, 2, and 3 – Polymicrobial infection • May also warrant testing as an epidemiological aid (eg, testing ceftazidime for Enterobacterales to indicate potential ESBL production; see Table 3A).
Urine only	Antimicrobial agents designated by a "(U)" in Tables 2 should be reported only on organisms isolated from the urinary tract.	Routine	Report as appropriate	Agents in Tiers 1, 2, and 3 may also be reported on urine isolates, as appropriate, following the testing and reporting guidance for the respective tiers.

Abbreviations: ESBL, extended-spectrum β-lactamase; MDRO, multidrug-resistant organism; UTI, urinary tract infection.

Criterios disponibles-CLSI

Antimicrobial Agent Test and Report Designations and Additional Considerations for Agents Not Listed in Tables 1

Designation	Definition	Test	Report[a]	Additional Testing and Reporting Considerations
Other	Antimicrobial agents with established clinical breakpoints designated by an * in Tables 2 that are generally not candidates for testing and reporting in the United States	By request	By request	• Test and report only by clinician request and only following consultation with the antimicrobial stewardship team and other relevant institutional stakeholders to ensure appropriateness of the request. • Agents with an "Other" designation may not reflect current consensus recommendations for first-choice and alternative drugs for the specific organism or organism group.
Inv.	Antimicrobial agents that are investigational for the organism group designated by "Inv." in Tables 2 have not yet been approved by the FDA for use in the United States.	By request	By request	Test and report only by clinician request and only following consultation with the antimicrobial stewardship team and other relevant institutional stakeholders to ensure appropriateness of the request. These agents would likely be clinically available for compassionate use only.

Abbreviations: FDA, US Food and Drug Administration; UTI, urinary tract infection.

Footnote

a. Antimicrobial agents should be reported selectively, as appropriate (eg, because it is effective in treating uncomplicated UTIs only, nitrofurantoin would be reported only on isolates from urine).

D. Selective and Cascade Reporting

Each laboratory should consider developing selective and/or cascade reporting rules in consultation with the antimicrobial stewardship team and other relevant institutional stakeholders. Selective and cascade reporting is done to encourage appropriate antimicrobial agent use. The positioning of drugs in Tables 1A through 1J can be used to guide development of selective and/or cascade reporting rules.

Selective reporting involves reporting results for specific antimicrobial agents based on defined criteria unrelated to results obtained from antimicrobial susceptibility testing (AST) (eg, organism identification, body site, clinical setting, or patient demographics). For example, nitrofurantoin would be reported only on isolates from urine because it is effective in treating uncomplicated urinary tract infections only. Daptomycin is not reported for isolates recovered from the lower respiratory tract because it interacts with pulmonary surfactant, resulting in inhibition of antibacterial activity. First- and second-generation cephalosporins are not reported on *Salmonella* spp. because of their ineffectiveness in treating patients with *Salmonella* infections.

Criterios disponibles-CLSI

Table 1B-1
Pseudomonas aeruginosa
CLSI M02 and CLSI M07

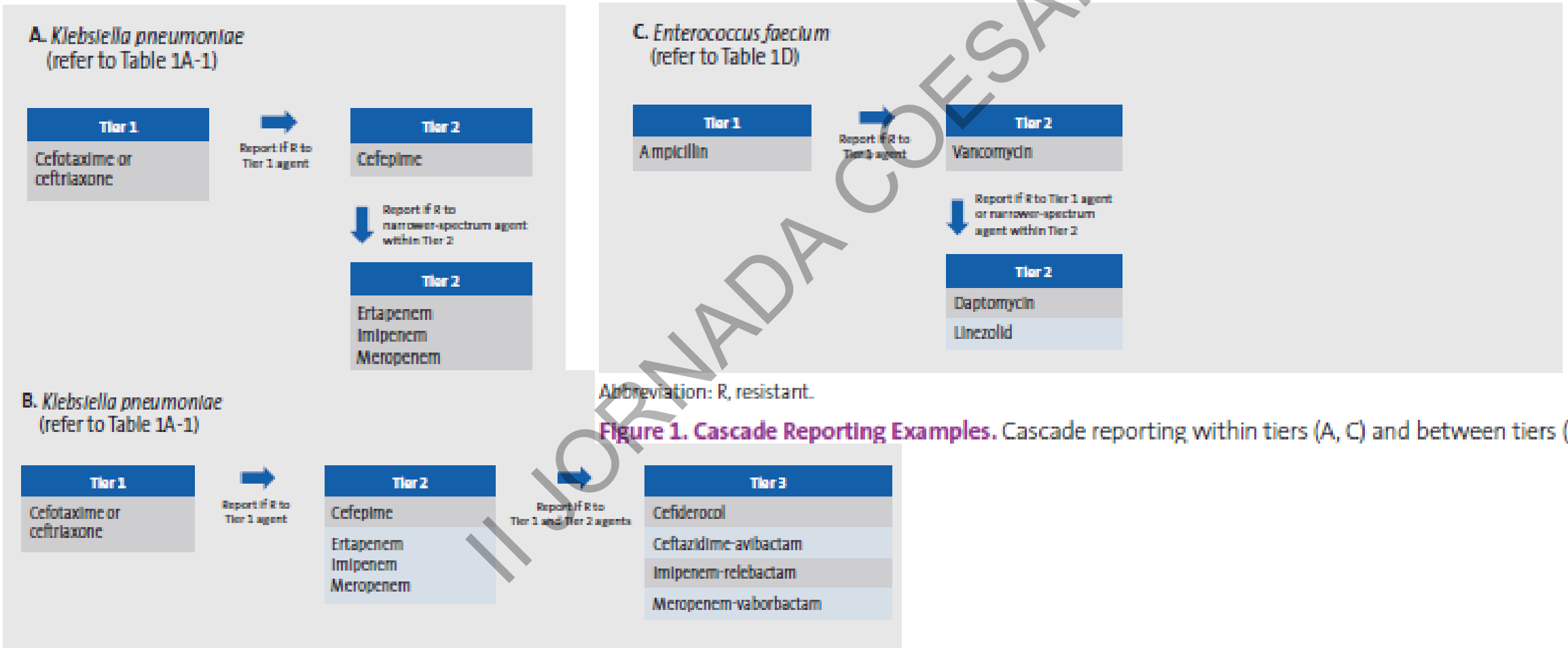
Table 1B-1. *Pseudomonas aeruginosa*

Tier 1: Antimicrobial agents that are appropriate for routine, primary testing and reporting	Tier 2: Antimicrobial agents that are appropriate for routine, primary testing but may be reported following cascade reporting rules established at each institution	Tier 3: Antimicrobial agents that are appropriate for routine, primary testing in institutions that serve patients at high risk for MDROs but should only be reported following cascade reporting rules established at each institution	Tier 4: Antimicrobial agents that may warrant testing and reporting by clinician request if antimicrobial agents in other tiers are not optimal because of various factors
Ceftazidime	Imipenem Meropenem	Cefiderocol	
Cefepime		Ceftazidime-avibactam	
Piperacillin-tazobactam		Ceftolozane-tazobactam	
		Imipenem-relebactam	
Tobramycin			
Ciprofloxacin Levofloxacin			
			Aztreonam
Urine Only			
	Amikacin		

Abbreviation: MDRO, multidrug-resistant organism.

CLSI M100-Ed35

CLSI Informe en “cascada”



Abbreviation: R, resistant.

Figure 1. Cascade Reporting Examples. Cascade reporting within tiers (A, C) and between tiers (A, B, and C)

CLSI *Performance Standards for Antimicrobial Susceptibility Testing*. 35th ed. CLSI Supplement M100 Clinical and Laboratory Standards Institute; 2025

AMERICAN SOCIETY FOR MICROBIOLOGY | Journal of Clinical Microbiology

Check for updates

Clinical Microbiology | Minireview

Guiding antimicrobial stewardship through thoughtful antimicrobial susceptibility testing and reporting strategies: an updated approach in 2023

Virginia M. Pierce,[1] Tanaya Bhowmick,[2] Patricia J. Simner[3,4]

Explicación detallada de los cambios en las tablas CLSI M100 Ed 33 (2023)

Ejemplos de implantación según instituciones

Antibiograma selectivo

EN FUNCIÓN DEL MICROORGANISMO

Resistencias adquiridas
Resistencias intrínsecas

Inf. polimicrobianas

Epidemiología local

EN FUNCIÓN DEL TIPO DE INFECCIÓN

Tratamientos de primera línea

Ajuste a guías locales/nacionales

EN FUNCION DEL ANTIBIÓTICO

Parámetros PK/PD
Daptomicina no en foco pulmonar

Antisépticos urinarios solo en foco urinario (nitrofurantoina)

Antibióticos uso exclusivo oral no en infecciones graves (p.ej meningitis)

Disponibilidad, posicionamiento

EN FUNCION DEL PACIENTE

Datos demográficos (edad, sexo, ambulante, ingresado)

Datos clínicos (alergias, insuficiencia renal, etc)

La implementación de este enfoque debe ser un proceso multidisciplinar, involucrando a Microbiólogos, equipos PROA y otros profesionales involucrados en la prescripción de antibióticos

Incluir comentarios explicativos al informe del antibiograma selectivo

Ejemplo informe selectivo y en cascada, Enterobacterales, pacientes ingresados

Enterobacterales no BLEE, no AMPC	Enterobacterales BLEE	Enterobacterales AMPC
Amoxicilina-clavulánico	Amoxicilina-clavulánico (informar siempre si es R, informar S previa comprobación en foco urinario)	Amoxicilina-clavulánico (informar R)
Piperacilina-tazobactam	Piperacilina-tazobactam (informar siempre si es R, informar S previa comprobación en foco urinario)	Piperacilina-tazobactam (informar siempre si es R, a petición clínica informar S previa comprobación)
Cefotaxima	Cefotaxima (informar R)	Cefepime
	Ertapenem	Ertapenem
	(Meropenem)	Meropenem
Ciprofloxacino	Ciprofloxacino	Ciprofloxacino
Gentamicina	Gentamicina	Gentamicina
Tobramicina	Tobramicina	Tobramicina
(Amikacina)	(Amikacina)	(Amikacina)
Trimetroprim-sulfametoxazol	Trimetroprim-sulfametoxazol	Trimetroprim-sulfametoxazol

Comentarios al microorganismo:

BLEE:

Cepa BLEE (Beta-Lactamasa Espectro Extendido) multi-resistente a betalactámicos.

El tratamiento con amoxicilina-clavulánico o piperacilina-tazobactam puede conducir a fracaso terapéutico excepto en infecciones de origen urinario siempre que muestren sensibilidad in vitro.

AMPC:

La cepa aislada posee betalactamasa tipo AmpC. No es aconsejable utilizar amoxicilina-clavulánico o cefalosporinas de 1ª a 3ª generación para el tratamiento de esta infección.

¿Cuándo?

J Antimicrob Chemother 2022; **77**: 3064–3068
https://doi.org/10.1093/jac/dkac279 Advance Access publication 17 August 2022

Journal of Antimicrobial Chemotherapy

Establishment of RCPA national guidelines for selective reporting of antimicrobials: processes, challenges and measuring the impact

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Received 14 February 2022; accepted 27 July 2022

Graham *et al* 2022 J Antimicrob Chemother Oct 28;77(11):3064-3068

Expert Review of Anti-infective Therapy

ISSN: 1478-7210 (Print) 1744-8336 (Online) Journal homepage: https://www.tandfonline.com/loi/ierz20

Selective reporting of antibiotic susceptibility testing results: a promising antibiotic stewardship tool

Gianpiero Tebano, Yosra Mouelhi, Veronica Zanichelli, Alexandre Charmillon, Sébastien Fougnot, Alain Lozniewski, Nathalie Thilly & Céline Pulcini

Tebano *et al 2020 Expert Review of Anti-infective Therapy*, 18 (3), pp.251-262.

¿Cuándo implantar el antibiograma selectivo?

Escenarios prioritarios (rápido impacto y bajo riesgo)

- Microorganismos sensibles a antibióticos de primera línea
- Infecciones no graves y estandarizadas con guías de tratamiento claras (p. ej., ITU comunitaria): mayor evidencia y mejores resultados iniciales.
- Centros con alto consumo de antibióticos de amplio espectro (piperacilina-tazobactam, cefepime, quinolonas, carbapenems), alta presión selectiva de resistencias, *C. difficile*.
- Entornos con recursos PROA limitados: la automatización en LIS permite un "nudge" de bajo coste operativo frente a auditorías/actuaciones PROA.

Escenarios complicados

- Bacteriemias / UCI / pacientes complejos
- En estos casos es posible, pero requieren reglas adaptadas y acceso al informe completo del antibiograma
- Ausencia de recursos técnicos, ausencia de guías de tratamiento

Tebano *et al* 2020; Graham et al 2022

Limitaciones y precauciones

- Necesidad de protocolos claros
- Revisión periódica según epidemiología local
- Comunicación fluida con los clínicos
- Disponibilidad/accesibilidad al antibiograma complete
- Imprescindible disponer de recursos técnicos para automatizar al máximo la selección

¿Por qué?

Clinical Microbiology and Infection 29 (2023) 897–903

Contents lists available at ScienceDirect

Clinical Microbiology and Infection

journal homepage: www.clinicalmicrobiologyandinfection.com

Original article

Impact of selective reporting of antib
for urinary tract infections in the ou
controlled before-after intervention

Maïa Simon [1, 2, *], Sébastien Fougnot [3], Patrice
Nathalie Thilly [1, 2, †], Céline Pulcini [1, 5, †] on beha
Committee

[1)] Université de Lorraine, Laboratoire APEMAC, Nancy, France
[2)] Centre Hospitalier Régional Universitaire de Nancy, Département Méthodolog
[3)] Laboratoire ATOUTBIO, Nancy, France
[4)] Laboratoire BIOGROUP, Metz, France
[5)] Centre Hospitalier Régional Universitaire de Nancy, Centre régional en antibio

Available on
ScienceD
www.sciencedi

Original article

Antibiotic guidelines coupled with selective reporting of antibi

C. Michelangeli [a,b], D. Girard-Lamoulere [c], A. Assi [d], M. Della Guardia [d], P.-M. Roge

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Munting et al.
Antimicrobial Resistance & Infection Control (2022) 11:165
https://doi.org/10.1186/s13756-022-01203-x

Antimicrobial Resistance and Infection Control

RESEARCH Open Access

Impact of selective reporting of antibiotic susceptibility testing results on meropenem prescriptions for the treatment of *Pseudomonas aeruginosa* infections after 2020 EUCAST criteria update: an observational study in a university hospital

Aline Munting[1,4*], José Damas[1], Benjamin Viala[2,4], Guy Prod'hom[3], Benoit Guery[1] and Laurence Senn[1,4]

RESEARCH ARTICLE

ting of Antimicrobial Susceptibility
:t on Antimicrobial Resistance
hcare Safety Network, April 2020

Amy Webb,[a,b] Virgie Fields,[a,b] Laura Blum,[a,b] Malissa Mojica,[a,b]

JAC-Antimicrobial Resistance

c susceptibility testing results for urine
cultures: feasibility and acceptability by general practitioners and laboratory professionals in France

Gaëlle Le Dref[1]†, Maïa Simon[1,2]†, Aurélie Bocquier[1], Sébastien Fougnot[3], Joëlle Kivits[1], Alain Duda[3], Céline Pulcini[1,4], and Nathalie Thilly[1,2]* on behalf of the ANTIBIO-ciblés Scientific Committee‡

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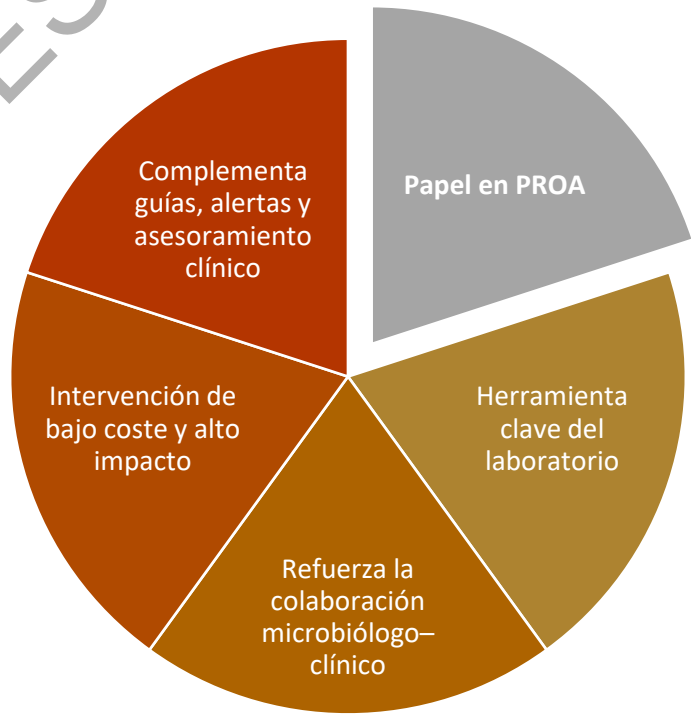
Efectos del antibiograma selectivo

Mejora la **adecuación del tratamiento antibiótico**

Reduce el uso de antibióticos de amplio espectro

Disminuye la presión selectiva y la resistencia

Facilita la interpretación clínica del informe



Tebano *et al* 2020; Graham et al 2022

Journal of Clinical Microbiology

| Clinical Microbiology | Point-Counterpoint

Point-Counterpoint: Cascade reporting—useful tool to support antimicrobial stewardship, or dangerously misleading

Joseph L. Kuti,[1] Joseph D. Lutgring,[2] Patricia J. Simner,[3,4] Samia N. Naccache,[5] Emily L. Heil[6]

Aspecto	Pros (POINT)	Contras (COUNTERPOINT)
Uso antibiótico	Reduce uso de antibióticos de amplio espectro y mejora prescripciones.	Riesgo de asumir sensibilidades no informadas
Resistencias	Puede mejorar perfiles de sensibilidad.	Sesgo en datos de resistencia locales y nacionales.
Resultados clínicos	Sin aumento de mortalidad ni fracaso clínico.	Puede faltar información en infecciones polimicrobianas.
Implementación	Fácil, automatizable y coste-efectiva.	Reglas complejas y carga al laboratorio.
Formación clínica	Nudge efectivo hacia espectros estrechos.	No promueve aprendizaje sostenido.
Regulación e HªCª	Integrable en algoritmos automáticos.	Riesgo de incumplimiento normativo.
Vigilancia epidemiológica	Refuerza stewardship local.	Distorsiona antibiogramas y datos de resistencias.

Mensajes clave

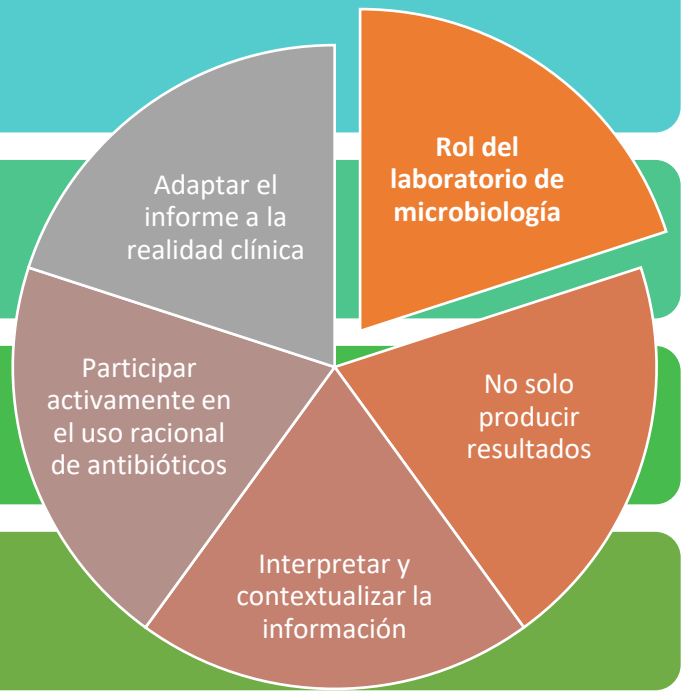
El antibiograma selectivo **no oculta información**, la optimiza

Es una **herramienta clínica**, no solo técnica

Contribuye a **mejorar resultados** y **frenar resistencias**

Importante **herramienta PROA**

Rol del Microbiólogo



MENÚ DEL DÍA 22,50 €

Primeros platos sueltos 9,00 € - Segundos platos ssueltos 12,00 €

PARA EMPEZAR...

CALIENTES

- BERENJENAS RELLENAS DE SETAS Y GAMBAS 13,50 €
- GAMBONES RELLENOS DE FOIE Y CARNE 14,00 €
- CALAMARES A LA ANDALUZA 13,00 €
- CHIPIRONES A LA PLANCHA 13,00 €
- CARACOLES GUISADOS A LA LLAUNA 14,00 €
- MEJILLONES DEL PRAT CON ROMESCO 12,50 €
- ALTE HALLOÚGUESTÀ 14,00 €

FRÍOS

- ENSALADA CESAR 11,50 €
- ENSALADA TEMPLADA DE GULAS Y GAMBAS 12,50 €
- PASTEL DE CABRILLA 11,00 €
- MOJETE MURCIANO 11,00 €
- VITELLO TONNATO 13,50 €
- ENTRECOT DE CERDO, 14 ,3,50 €
- CARPACCIO DE BÚEY 12,50 €

PARA CONTINUAR....

- BACALAO CON SALSA DE CEPS
- LOMO DE ORZA CON GUARNICIÓN
- COLITA DE MERLUZA AL ORIO
- ESPAGUETIS A LA CREMA 11,001,50 €
- ENTRECOT DE CERDO A LA BRASA €
- PLANCHA PARRILLADA
- PEZ ESPADA A LA PLANCHA
- MASETA DE CANANAA LA DONOSTIBRRA
- COSTILLA DE CORDERO A LA BRASA
- CODILLO AL HORNO CON SALSA DE MIEL

MENÚ DEL DÍA 14,50 €

Primeros platos sueltos 6,00 € - Segundos platos ssueltos 7,00 €

PARA EMPEZAR..

- GALEONES DE FOIE
- ENSALADA CESAR 11,50 €
- ENSALADA DE ATÚN 11,00 €
- ESPAGUETIS A LA MARINERA 13,00 €
- ENTRECOT DE CERDO A LA BRASA €
- PLANCHA PARRILLADA 13,50 €
- PEZ ESPADA A LA PLANCHA

PARA CONTINUAR..

- ENTRECOT DE CERDO A LA BRASA 11,50 €
- COLITA DE MERLUZA AL ORÍO 11,50 €
- COSTILLA DE CORDERO A LA BRASA 13,50 €
- CODILLO AL HORNO CON MIEL 13,60 €
- HUEVA A LA MARINERA 1271,50 €
- PASTEL DE CORDERO LECIEAL Y SETAS 12,50 €
- PEZ ESPADA A LA PLANCHA 13,3,50 €

POSTRE DE LA CASA, HELADO O FRUTA • AGUA, VINO D O. TURMELLO INCLUIDO

Miércoles, 26 de marzo de 2025

Primeros platos a elegir

Sopa de cocido con relleno
Arroz con costillas
Revolconas con torreznos y huevo
Crema de judías pintas con arroz

Segundos platos a elegir

Garbanzos y viandas del cocido
Fajitas de carne con salsa picante
Traseros de pollo al cava con patatas fritas
Bocaditos de bacalao rebozado con pisto de verduras

Postre a elegir

Falso tiramisú de azahar
Arroz con chocolate
Multipostre del día
Torrijas sobre natillas

ción de pan, vino de la casa, gaseosa y agua (Loc
ación de pan y botella pequeña de agua (Recoger