Table 8. Adult parenteral antimicrobial dosage guidelines

Antibiotic	Usual Dosages[a]
ANTIBACTERIAL AGENTS	
Penicillins	
ampicillin	1-2 g q4-6h
cloxacillin	2 g q4-6h
penicillin G	2-4 million units q4-6h
piperacillin-tazobactam	3.375-4.5 g q6h
meropenem	500 mg q6h
Cephalosporins	
cefazolin	1-2 g q8h
cefuroxime	0.75-1.5 g q8h
ceftriaxone	1-2 g q24h
ceftazidime	1-2 g q8h
Fluoroquinolones	
ciprofloxacin	400 mg q12h
levofloxacin	500-750 mg q24h
moxifloxacin	400 mg q24h
Macrolides	
azithromycin	500 mg q24h
Aminoglycosides	
gentamicin or tobramycin	80 mg q8h
Others	
clindamycin	600 mg q8h
cotrimoxazole (TMP-SMX)	10-20 mg/kg/day trimethoprim in divided doses q6-8h
metronidazole	500 mg q8h
vancomycin	1 g q12h or 15 mg/kg q12h
ANTIFUNGAL AGENTS	
amphotericin B	0.5-1 mg/kg q24h
fluconazole	100-400 mg q24h
caspofungin	70 mg load then 50 mg q24h
ANTIVIRAL AGENTS	
acyclovir	5-10 mg/kg/dose q8h
ganciclovir	5 mg/kg/dose q12h

[a] Based on normal renal function in a 70 kg patient.

Table 9. Parenteral to oral conversion suggestions

Parenteral Drug	Oral Therapy Options[a]
ANTIBACTERIAL AGENTS	
Penicillins	
ampicillin	amoxicillin
cloxacillin	cloxacillin or cephalexin
penicillin G	penicillin V
piperacillin-tazobactam	amoxicillin-clavulanate or cotrimoxazole (TMP-SMX) +/- metronidazole or ciprofloxacin +/- metronidazole
Cephalosporins	
cefazolin	cephalexin or cloxacillin
cefuroxime	cotrimoxazole or amoxicillin-clavulanate or azithromycin/clarithromycin
ceftriaxone	amoxicillin-clavulanate or cephalexin or ciprofloxacin/levofloxacin/moxifloxacin
ceftazidime	ciprofloxacin
Fluoroquinolones	
ciprofloxacin	ciprofloxacin
levofloxacin	levofloxacin
moxifloxacin	moxifloxacin
Macrolides	
azithromycin	azithromycin
Others	
clindamycin	cloxacillin +/- metronidazole or cephalexin +/- metronidazole or clindamycin
ANTIFUNGAL AGENTS	
fluconazole	fluconazole
ANTIVIRAL AGENTS	
acyclovir	acyclovir or valacyclovir

[a] Patients should be clinically stable, demonstrate clinical improvement, and be able to tolerate oral feeding and medications. Selection of oral therapy should be based on cultures and sensitivities. In absence of useful cultures, oral therapy may be selected based on potential pathogens, community- versus hospital-acquired infection, pharmacokinetics, spectrum of activity, and cost of each oral agent. Oral agents listed above represent those currently on the WRHA Formulary and does not represent all commercially available oral agents.

Table 10. Adult dosing recommendations in renal impairment[a]

Drug	Creatinine Clearance (CrCL) in mL/min[b] (suggested dosage adjustment based on normal dose)			
Penicillins				
ampicillin	> 30 (q6h)	10-30 (q6-12h)	< 10 (q12h)	
cloxacillin	NO CHANGE NECESSARY			
penicillin	> 50 (q4-6h)	10-50 (q6-8h)	< 10 (20-50% of usual dose)[a]	
piperacillin-tazobactam	> 40 (q6h)	20-40 (q8h)	< 20 (q12h)	
Carbapenems				
meropenem	> 50 (q6h)	30-49 (q8h)	10-29 (q12h)	< 10 (q24h)
Cephalosporins				
cefazolin	> 50 (q8h)	10-50 (q12h)	< 10 (q24h)	
cefuroxime	> 20 (q8h)	10-20 (q12h)	< 10 (q24h)	
ceftriaxone	NO CHANGE NECESSARY			
ceftazidime	> 50 (q8h)	30-50 (q12h)	10-30 (q24h)	< 10 (50% q24-48h)
Aminoglycosides[c]				
gentamicin/ tobramycin/ amikacin	Contact the Pharmacist at your facility for dosing assistance			
Fluoroquinolones				
ciprofloxacin	> 30 (q12h)	< 30 (q24h)		
levofloxacin (e.g. CAP)	> 50 (q24h)	20-49 (500 mg load, then 50% q24h)	10-19 (500 mg load, then 50% q48h)	
moxifloxacin	NO CHANGE NECESSARY			
Macrolides				
azithromycin	NO CHANGE NECESSARY			
Antifungal Agents				
fluconazole	> 50 (q24h)	20-50 (50% q24h)	< 20 (25% of usual dose q24h)	
caspofungin	NO CHANGE NECESSARY			
Antiviral Agents				
acyclovir	> 50 (q8h)	25-50 (q12h)	10-25 (q24h)	< 10 (50% q24h)
ganciclovir (induction doses)	50-69 2.5 mg/kg q12h	25-49 2.5 mg/kg q24h	10-25 1.25 mg/kg q24h	< 10 1.25 mg/kg 3x/wk
Miscellaneous				
clindamycin	NO CHANGE NECESSARY			
metronidazole	NO CHANGE NECESSARY			
cotrimoxazole (TMP-SMX)	> 25 (q6-8h)	15-25 (50% q6-8h)	< 15 (2.5-5 mg/kg, generally not recommended)[a]	
vancomycin[c]	Contact the Pharmacist at your facility for dosing assistance			

[a] Suggested dosages – for individualized dosage modifications or more information contact the Pharmacy Department at your facility.

[b] To estimate creatinine clearance (CrCL) (mL/min) use the following calculation normalized for a 72 kilogram person.
CrCL male = $\frac{(140\text{-age}) \times 88.4}{S_{Cr}\ (\mu moles/L)}$ CrCL female = 0.85 x CrCL male

[c] Monitor serum concentrations.

Table 11. Antimicrobial Restrictions at St. Boniface Hospital (revised 2017)

Antimicrobial (alphabetical order)	Status[a]	Exception Criteria	Criteria For Use[b]
Acyclovir IV	Consultation		
Amphotericin B Liposomal	Consultation		**Yes**
Caspofungin	Consultation		**Yes**
Ceftazidime	Consultation	Hemodialysis (HSC or SBH) or Peritoneal (SBH)	
Ertapenem	Consultation (CIVP[c] only)		
Fluconazole IV	Consultation		
Ganciclovir IV	Consultation	under protocol	
Linezolid	Consultation		**Yes**
Meropenem	Consultation		
Piperacillin-Tazobactam	Consultation		
Daptomycin	Consultation		**Yes**
Voriconazole	Consultation		**Yes**

[a] Consultation or verbal approval should be obtained from the Infectious Diseases consult service.

[b] Reviewed by the WRHA Antimicrobial Pharmacotherapy Subcommittee November 2014. Criteria for use may be obtained from a WRHA Pharmacy Department.

[c] CIVP = Community IV Program

Clindamycin use requires Infectious Diseases approval at St. Boniface Hospital.

Hôpital St-Boniface Hospital

St. Boniface Hospital Antibiogram for 2026

(Based on data from 2025)

Provided by:
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DISCLAIMERS

This guide is provided as an educational resource for physicians and other healthcare professionals caring for patients at the St. Boniface Hospital. The authors of the guide have made every effort to ensure that the information contained in it was accurate at the time of publication. Users of the guide are encouraged to consult other references to confirm the information presented in it. The authors are not responsible for errors, omissions, inaccuracies, or the continued completeness of the information contained in the guide. The information in the guide should not be used or relied upon to replace the skill and professional judgment required to determine appropriate patient care and treatment. Also, the guide is not intended to replace or to be used as a substitute for the complete prescribing information prepared by each pharmaceutical manufacturer for their anti-infective agents. Because of possible changes in anti-infective indications, changes in dosage information, differences in patients' responses to therapy, newly described toxicities, drug-drug interactions, and other items of importance, reference to complete prescribing information is recommended before any of the anti-infective agents described in the guide are used.

HOW TO USE THE ANTIBIOGRAM PORTION OF THE GUIDE (Tables 1-6)

- The information presented in the antibiogram is intended only to guide initial empiric anti-infective agent therapy at the St. Boniface Hospital.
- Initial broad-spectrum empiric therapy should be focused to the most appropriate narrow-spectrum agent(s) based on the laboratory identification of pathogen(s) and known susceptibility patterns/results, if the situation permits.
- Consideration should be given to equally efficacious but less expensive anti-infective agents for empiric therapy or when streamlining of therapy is desired, if the situation permits.

SUGGESTED CRITERIA FOR IV TO ORAL ANTIBIOTIC CONVERSION IN ADULTS

- Clinical improvement of infectious signs and symptoms (e.g., temperature defervescence, decreased white blood cell count).
- Patient is clinically stable (excludes patients in the intensive care unit, patients with febrile neutropenia, or patients with life threatening infections).
- Patient can tolerate oral feeding and medications (bowel sounds, no diarrhea/nausea/vomiting).
- For rapid step-down, choose agents with high bioavailability (e.g., clindamycin, cotrimoxazole (TMP-SMX), fluoroquinolones).
- If anti-infective agent susceptibilities are known, anti-infective therapy should be tailored based on available data.

Table 1. In vitro activity of selected anti-infective agents tested against Gram-negative bacilli[a]

Organism (number tested): January through August 2025	Percent Susceptible																
= Not tested, not routinely reported, or not recommended	Ampicillin	Amoxicillin-Clavulanate	Piperacillin-Tazobactam	Cefazolin	Cephalexin[b]	Cefuroxime	Ceftriaxone	Ceftazidime	Ertapenem	Meropenem	Gentamicin	Tobramycin	Ciprofloxacin	Trimethoprim-Sulfamethoxazole	Nitrofurantoin[c]
Citrobacter spp. (37)			84				78	76	100	100	89	92	81	89	95
Enterobacter cloacae complex (67)			75				72	70	94	99	94	90	85	81	30
Escherichia coli (178) systemic	47	82	95	59			79	84	100	100	88	88	58	72	
Escherichia coli (671) urine	49	83	96	68	n.d.		82	87	100	100	91	92	58	73	96
Haemophilus influenzae (103)[e]	80	n.d.				n.d.								75	
Klebsiella aerogenes (53)			77				70	75	94	100	100	98	92	98	17
Klebsiella pneumoniae (221)		81	88	73	n.d.		79	80	97	97	90	88	72	74	25
Klebsiella/Raoultella spp. (64)[e]		86	91	16			86	97	97	98	98	97	89	91	86
Morganella morganii (36)			100				94	83	100	100	94	97	75	89	
Proteus mirabilis (84)	80	96	100	n.d.	n.d.		98	100	100	100	95	94	90	79	
Pseudomonas aeruginosa (275)			89					89		92		99	86		
Serratia marcescens (58)			100				97	100	100	100	100	100	97	100	
Stenotrophomonas maltophilia (36)														100	

[a] Isolates tested and reported are from all sources combined, with the exception of *Escherichia coli* (subdivided into systemic isolates and urine isolates); isolates were collected from Jan to Aug, 2025 with the exception of *Klebsiella aerogenes*, *Serratia marcescens*, and *Stenotrophomonas maltophilia* (collected from Jan 2024 to Aug 2025); data compiled according to the recommendations of the Clinical and Laboratory Standards Institute (CLSI) in their document M39, 5th ed. (2022).
[b] Cephalexin is only indicated for the treatment of uncomplicated lower urinary tract infections.
[c] Nitrofurantoin is only indicated for acute cystitis.
[d] *H. influenzae* data obtained from isolates tested at Health Sciences Centre, Jan to Dec, 2025. Only 88 isolates were tested for Trimethoprim-Sulfamethoxazole. Data from adult and pediatric patients.
[e] The current laboratory identification system is unable to differentiate *Klebsiella oxytoca* from *Raoultella* spp.
n.d. = no data – absence of data for certain drug-organism combinations reflects limitations of the testing method currently used by Shared Health Clinical Microbiology laboratories.

Table 2. In vitro activity of selected anti-infective agents tested against Gram-positive cocci[a]

Organism (number tested): January through August 2025	Percent Susceptible														
= Not tested, not routinely reported, or not recommended	Penicillin	Ampicillin	Oxacillin[b]	Vancomycin	Daptomycin	High-Level Gentamicin[c]	High-Level Streptomycin[c]	Erythromycin[d]	Clindamycin	Trimethoprim-Sulfamethoxazole	Rifampin[e]	Linezolid	Doxycycline	Levofloxacin	Nitrofurantoin[f]
Enterococcus faecalis (58)		98		100	n.d.	80	93					97			100
Enterococcus faecium (47)		6		19	n.d.	56	87					96			n.d.
Enterococcus spp. (276)		89		99	n.d.	70	84					n.d.			88
Staphylococcus aureus (1210)			65	100	100			52	74	98	100	100	98		100
Staphylococcus epidermidis (116)			50	100	100			43	67	78	98	100	90		100
Staphylococcus lugdunensis (174)			95	100	100			89	90	99	99	100	98		100
Streptococcus pyogenes (100)[g] (Group A *Streptococcus*)	100			100					82					99	
Streptococcus agalactiae (148)[h] (Group B *Streptococcus*)	100			100					64						

[a] Isolates tested and reported are from all sources (surveillance isolates excluded) with the exception of *Enterococcus faecalis* and *Enterococcus faecium* (systemic isolates only), Jan to Aug, 2025; data compiled according to the recommendations of the Clinical and Laboratory Standards Institute (CLSI) in their document M39, 5th ed. (2022).
[b] Oxacillin accurately predicts the activity of all semi-synthetic penicillins, including cloxacillin, beta-lactam/beta-lactamase inhibitor combinations, cephalosporins, and carbapenems for *Staphylococcus aureus* and coagulase-negative staphylococci.
[c] Susceptibility to high-level gentamicin or high-level streptomycin indicates that these agents can be used in combination with a cell wall active agent (e.g., ampicillin or vancomycin) for synergy. Gentamicin and streptomycin should never be used alone as treatment for *Enterococcus faecalis*, *Enterococcus faecium*, or *Enterococcus* spp.
[d] Erythromycin activity predicts the activity of azithromycin and clarithromycin for staphylococci and streptococci.
[e] Rifampin should NOT be used alone as treatment for infection.
[f] Nitrofurantoin is indicated for acute cystitis only.
[g] *Streptococcus pyogenes* isolates were obtained from wound and sterile site specimens submitted to Shared Health Clinical Microbiology laboratories between January and December, 2023.
[h] *Streptococcus agalactiae* isolates were obtained from vaginal/rectal swabs submitted for Group B *Streptococcus* detection to the Health Sciences Centre, St. Boniface Hospital, and Westman Laboratory in 2022.
n.d. = no data – absence of data for certain drug-organism combinations reflects limitations of the testing method currently used by Shared Health Clinical Microbiology laboratories.

Table 3. In vitro activity of selected anti-infective agents tested against *Streptococcus pneumoniae*[a]

Infection Type (number tested)	Percent Susceptible							
= Not tested, not routinely reported, or not recommended	Penicillin (oral)	Penicillin (intravenous)	Ceftriaxone	Vancomycin	Levofloxacin	Clarithromycin	Doxycycline	Trimethoprim-Sulfamethoxazole
Systemic Isolates (Blood + CSF)[b]								
Meningitis (257)		79	96	100				84
Non-Meningitis infection (257)	79	99	100	100	100	n.d.	n.d.	84
Respiratory Isolates[c]								
Non-Meningitis infection (136)	81	97	100	100	100	73	79	82

[a] For *Streptococcus pneumoniae*, different susceptibility breakpoints for penicillin and ceftriaxone exist depending on whether meningitis or a non-meningitis infection is being treated [CLSI, M100, 35th edition]. For penicillin, when treating a non-meningitis infection different breakpoints exist for oral and intravenous dosing. For non-meningitis infections, susceptibility to oral penicillin predicts susceptibility to amoxicillin. Oral agents are not appropriate for the treatment of bacterial meningitis.
[b] Systemic isolates were obtained from the Health Sciences Centre (HSC) and St. Boniface Hospital (SBH) clinical microbiology laboratories between January and December, 2025. CSF = cerebrospinal fluid.
[c] Respiratory isolates were obtained from patients evaluated at hospitals across Canada (2020 to 2023) as part of the CANWARD Study.
n.d. = no data.

Table 4. In vitro activity of selected anti-infective agents tested against Methicillin-Susceptible and Methicillin-Resistant *Staphylococcus aureus* isolates[a]

Organism (number tested)	Percent Susceptible							
= Not tested, not routinely reported, or not recommended	Oxacillin[b]	Vancomycin	Trimethoprim-Sulfamethoxazole	Erythromycin	Clindamycin	Doxycycline	Linezolid	Daptomycin
Methicillin-Susceptible *Staphylococcus aureus* (794)	100		99	65	73	99		
Methicillin-Resistant *Staphylococcus aureus* (436)	0	100	96	29	78	95	100	100

[a] Isolates tested and reported are from all sources (surveillance isolates excluded), Jan to Aug, 2025; data compiled according to the recommendations of the Clinical and Laboratory Standards Institute (CLSI) in their document M39, 5th ed. (2022).
[b] Oxacillin accurately predicts the activity of all semi-synthetic penicillins, including cloxacillin, beta-lactam/beta-lactamase inhibitor combinations, cephalosporins, and carbapenems for *Staphylococcus aureus*.

Table 5. In vitro activity of selected anti-infective agents tested against anaerobic isolates collected from hospitals in Winnipeg[a]

Organism (number tested)	Percent Susceptible					
= Not tested, not routinely reported, or not recommended	Penicillin	Amoxicillin-Clavulanate	Piperacillin-Tazobactam	Clindamycin[b]	Metronidazole	Meropenem
Bacteroides fragilis (51)		n.d.	n.d.	62	100	98
Clostridium perfringens (30)	97	n.d.	n.d.	64	100	

[a] Bloodstream isolates obtained from the Health Sciences Centre (HSC) and St. Boniface Hospital (SBH) clinical microbiology laboratories between Jan 2024 and Dec 2025; data compiled according to the recommendations of the Clinical and Laboratory Standards Institute (CLSI) in their document M39, 5th ed. (2022).
[b] For clindamycin, only 45 *Bacteroides fragilis* isolates and 25 *Clostridium perfringens* isolates were tested. Please use discretion when interpreting clindamycin susceptibility versus *Clostridium perfringens* due to the small number of isolates tested.
n.d. = no data – absence of data for certain drug-organism combinations reflects limitations of the testing method currently used by Shared Health Clinical Microbiology laboratories.

Table 6. In vitro activity of selected anti-fungal agents tested against *Candida* species collected from hospitals in Winnipeg[a, b]

Organism (number tested)	Percent Susceptible		
	Fluconazole[c]	Voriconazole	Micafungin
Candida albicans (33)	100	100	100
Candida glabrata (39)	97	n.d.	97

[a] Data obtained by testing a random sample of *C. albicans* isolates from Health Sciences Centre and St. Boniface Hospital, collected between Jan 2017 and Dec 2018. Susceptibility interpretations are based on updated CLSI breakpoints (M27M44, 3rd Edition). Isolates tested and reported are from blood only.
[b] Data obtained by testing *C. glabrata* isolates from Shared Heath Clinical Microbiology laboratories, collected between Jan and Dec 2025. Susceptibility interpretations are based on updated CLSI breakpoints (M27M44, 3rd Edition). Isolates tested and reported are from blood only.
[c] For fluconazole, there is only a susceptible-dose dependent (SDD) breakpoint for *C. glabrata*. The percentage of *C. glabrata* isolates that tested SDD to fluconazole was 97%. Susceptibility of SDD isolates to fluconazole is dependent on achieving the maximum blood level possible (i.e., should use the maximum dosage regimen). Consultation with infectious diseases is recommended for further guidance.
n.d. = breakpoints have not been defined for voriconazole versus *C. glabrata*.

Table 7. Adult oral antimicrobial dosage guidelines

Antibiotic	Usual Dosages	Cost ($) per day[a]
ANTIBACTERIAL AGENTS		
Penicillins		
amoxicillin	500 mg tid	0.50
amoxicillin-clavulanate	500 mg tid or 875 mg bid	1.20
cloxacillin	500 mg qid	1.70
penicillin V	300 mg qid	0.30
Cephalosporins		
cephalexin	500 mg qid	0.75
Macrolides		
azithromycin	250–500 mg daily	1.00–2.00
clarithromycin	250–500 mg bid	0.90–1.80
Fluoroquinolones		
ciprofloxacin	250–750 mg bid	1.00–2.00
levofloxacin	500–750 mg daily	3.60–7.00
moxifloxacin	400 mg daily	1.60
Others		
clindamycin	450–600 mg tid	2.30–3.10
cotrimoxazole (TMP-SMX)	1 DS (double strength) tab bid	0.25
doxycycline	100 mg bid	1.00
nitrofurantoin (Macrobid®)	100 mg bid	1.00
metronidazole	500 mg tid	0.90
ANTIFUNGAL AGENTS		
fluconazole	100–400 mg daily	2.45–9.80
itraconazole	200–400 mg daily	8.85–17.70
ANTIVIRAL AGENTS		
acyclovir	200–800 mg 5x/day	1.90–9.40
valacyclovir	1 g tid	4.00

[a] Approximate cost per inpatient day excluding dispensing costs as of December 2024 based on the Manitoba Drug Interchangeability Formulary and Manufacturer's List Prices. Prices have been rounded.