Selective Reporting of Antibiogram Results

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Critical functions of clinical microbiology laboratory in the management of bacterial infections

- Isolation of the causative agent
- Correct identification
- Correct antimicrobial susceptibility testing (AST)
Clinically Relevant Reporting of AST Results

- Timely and effective communication of AST results is crucial.
- Laboratories play a critical role in directing the appropriate use of antibiotics.
- Development of clinically relevant policies and procedures that ensure that appropriate effective guidance is provided by the laboratory.

= role of the clinical microbiology in antimicrobial stewardship
How can the microbiology laboratory contribute to the antimicrobial stewardship?

- Preanalytical phase
- Analytical phase
- Post analytical phase
How can the microbiology laboratory contribute to the antimicrobial stewardship?

- **Preanalytical phase**

Specimen quality assessment

Rejection of inappropriate specimens → No AST for colonization or contamination

↑ epithelial cells, ↓ leukocytes
Low quality sputum specimen

↓ epithelial cells, ↑ leukocytes
High quality sputum specimen
How can the microbiology laboratory contribute to the antimicrobial stewardship?

• Analytical phase

Antimicrobial susceptibility testing

- Performance of AST only for clinically relevant specimens (when a pathogen is isolated)
- Analysis of AST results according to expert rules
  (Ampicillin susceptible Klebsiella pneumoniae)
- Detection of resistance mechanisms
  (Testing of D-zone phenomenon for group B streptococci for intrapartum prophylaxis)
How can the microbiology laboratory contribute to the antimicrobial stewardship?

• Post analytical phase
  - Selective reporting of AST results
  - Communication with physicians
  - Surveillance
  - Cumulative antibiogram to guide empirical treatment decisions
Role of selective reporting in antimicrobial stewardship

IDSA-SHEA Guideline

“We suggest selective and cascade reporting of antibiotics over reporting of all tested antibiotics.”

The goal of the clinical microbiology laboratory is to create a report which will direct the clinician to use the least toxic, most cost-effective and most clinically effective agent that is available.

This is accomplished by using clinically relevant testing approaches and selective reporting of AST results

= reporting susceptibility results for a limited number of antibiotics instead of all tested antibiotics.

E.g., routinely releasing linezolid results only when enterococci are nonsusceptible to ampicillin and vancomycin.
Selective reporting of AST results

- improves the clinical relevance of the reports produced
- minimizes the selection of multiresistant strains by avoiding the use of broad spectrum agents when narrow spectrum option is susceptible
Selective reporting of AST results

- improves the clinical relevance of the reports produced

Factors considered:
- site of infection/specimen source
- age of the patient
- pregnancy
Selective Reporting - Site of Infection

E.g., cerebrospinal fluid samples (meningitis)

Table 1B. (Continued)

<table>
<thead>
<tr>
<th>&quot;Warning&quot;: The following antimicrobial agents should not be routinely reported for bacteria isolated from CSF that are included in this document. These antimicrobial agents are not the drugs of choice and may not be effective for treating CSF infections caused by these organisms (i.e., the bacteria included in Tables 2A through 2J):</th>
</tr>
</thead>
<tbody>
<tr>
<td>agents administered by oral route only.</td>
</tr>
<tr>
<td>1st- and 2nd-generation cephalosporins and cephamycins</td>
</tr>
<tr>
<td>clindamycin</td>
</tr>
<tr>
<td>macrolides</td>
</tr>
<tr>
<td>tetracyclines</td>
</tr>
<tr>
<td>fluoroquinolones</td>
</tr>
</tbody>
</table>

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Selective Reporting - Site of Infection

- Macrolides
- Clindamycin
- Chloramphenicol
  Should not be reported for bacteria isolated from urinary tract infections.

- Daptomycin
  Should not be reported for bacteria isolated from lower respiratory tract infections.

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Selective Reporting – Age of the patient

- Fluoroquinolones
- Tetracycline

Should not be reported for infants and young children
FDA category C and D agents should be avoided if safer options from category A and B are available:

- Fluoroquinolones (C)
- Vancomycin (C)
- Linezolid (C)
- Chloramphenicol (C)
- Clarithromycin (C)
- Telithromycin (C)
- Imipenem (C)
- Amikacin (C- D)
- Gentamicin (C - D)
- Tetracycline (D)
- Tigecycline (D)
Selective reporting of AST results

- improves the appropriateness of prescriptions

In a randomized study for urinary tract infections:

randomly assigned residents to an intervention group received AST results for 2–4 antibiotics, control group received full-length AST results for all 25 antibiotics tested.

The increase in appropriateness of antibiotic prescription with the use of selective reporting ranged from 7% to 41%, depending upon the clinical scenario.

Selective reporting of AST results

- improves the clinical relevance of the reports produced

- minimizes the selection of multiresistant strains by avoiding the use of broad spectrum agents when narrow spectrum option is susceptible
Selective reporting of AST results

- minimizes the selection of multiresistant strains by avoiding the use of broad spectrum agents when narrow spectrum option is susceptible

Ciprofloxacin susceptibility for all Enterobacteriaceae regardless of susceptibility to other agents is reported.

Intervention (selective reporting of ciprofloxacin results)

The suppression of ciprofloxacin susceptibility to Enterobacteriaceae when there is lack of resistance to the antibiotics on the Gram-negative panel.

Outcome

Selective reporting was associated with an immediate and sustained reduction in ciprofloxacin usage and statistically significant improvement in E. coli susceptibility to ciprofloxacin.

A controlled before–after study of modified reporting of urine cultures from noncatheterized medical and surgical inpatients during January/June 2013 (Baseline period) and February/July 2013 (Intervention period)

**Baseline period** - All urine cultures from noncatheterized inpatients from study wards were processed as usual in the microbiology laboratory

**Intervention period** - Positive results from noncatheterized specimens were no longer reported automatically. Instead, the following message was posted to the electronic medical record: «The majority of positive urine cultures from inpatients without an indwelling urinary catheter represent asymptomatic bacteriuria. If you strongly suspect that your patient has developed a urinary tract infection, please call the microbiology laboratory»
The rate of antimicrobial therapy for ASB during the baseline period was 48% among noncatheterized inpatients and 42% among catheterized inpatients.

Following introduction of modified reporting, treatment of ASB among noncatheterized inpatients decreased to 12% for an absolute risk reduction of 36% (P = .002).

The treatment rates among catheterized controls remained 41% during the intervention period, significantly above those of noncatheterized inpatients (P = .01).
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Table 2. Outcomes Before and After Implementation of Modified Urine Culture Reporting of Noncatheterized Medical and Surgical Inpatients

<table>
<thead>
<tr>
<th>Outcome measure</th>
<th>Baseline</th>
<th></th>
<th></th>
<th>Intervention</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Noncatheterized</td>
<td>Catheterized</td>
<td>Noncatheterized</td>
<td>Catheterized</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ASB treatment rate</td>
<td>15/31 (48)</td>
<td>11/26 (42)</td>
<td>4/33 (12)</td>
<td>18/44 (41)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process measures</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total cultures reported</td>
<td>37/37 (100)</td>
<td>28/28 (100)</td>
<td>5/37 (14)</td>
<td>49/49 (100)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Labeling accuracy</td>
<td>35/37 (95)</td>
<td>25/28 (89)</td>
<td>37/37 (100)</td>
<td>41/49 (84)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unintended consequences</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calls to laboratory</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>5/37 (14)</td>
<td>1/49 (2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Untreated UTI</td>
<td>1/37 (3)</td>
<td>1/28 (4)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sepsis</td>
<td>0 (0)</td>
<td>1/28 (4)</td>
<td>0 (0)</td>
<td>1/49 (2)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Data are presented as No. (%).
Abbreviations: ASB, asymptomatic bacteriuria; UTI, urinary tract infection.
### Table 1A. Suggested Groupings of Antimicrobial Agents Approved by the US Food and Drug Administration for Clinical Use That Should Be Considered for Testing and Reporting on Nonfastidious Organisms by Microbiology Laboratories in the United States

<table>
<thead>
<tr>
<th>GROUP A PRIMARY TEST AND REPORT</th>
<th>Enterobacteriaceae</th>
<th>Pseudomonas aeruginosa</th>
<th>Staphylococcus spp.</th>
<th>Enterococcus spp.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amoxicillin&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cefuroxime</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cefoxitin&lt;sup&gt;b&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cefotaxime&lt;sup&gt;c&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ceftazidime&lt;sup&gt;d&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gentamicin&lt;sup&gt;e&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tobramycin&lt;sup&gt;f&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gentamicin&lt;sup&gt;g&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Piperacillin-tazobactam</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clindamycin&lt;sup&gt;h&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Oxacillin&lt;sup&gt;i&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cefotaxime&lt;sup&gt;j&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Oxacillin&lt;sup&gt;k&lt;/sup&gt; (surrogate test for oxacillin)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Panicillin&lt;sup&gt;l&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trimethoprim-sulfamethoxazole</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### GROUP B OPTIONAL PRIMARY TEST REPORT SELECTIVELY

<table>
<thead>
<tr>
<th>Enterobacteriaceae</th>
<th>Pseudomonas aeruginosa</th>
<th>Staphylococcus spp.</th>
<th>Enterococcus spp.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amikacin&lt;sup&gt;c&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amoxicillin-clavulanate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ampicillin-sulbactam</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cefepime&lt;sup&gt;j&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ceftazidime&lt;sup&gt;d&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cefoxitin&lt;sup&gt;b&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cefotaxime&lt;sup&gt;c&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ciprofloxacin&lt;sup&gt;c&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Levofloxacin&lt;sup&gt;c&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doripenem</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Erlapenem</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Imipenem</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meropenem</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trimethoprim-sulfamethoxazole&lt;sup&gt;c&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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http://em100.edaptivedocs.info/Login.aspx
The purpose of selective antibiotic reporting is to preserve the clinical utility of broad-spectrum or newer agents when an isolate is susceptible to narrower spectrum agents.
The purpose of selective antibiotic reporting is to preserve the clinical utility of broad-spectrum or newer agents when an isolate is susceptible to narrower spectrum agents.

CLSI, M100-S27, 2017
http://em100.edaptivedocs.info/Login.aspx
CLSI’s cascade (selective) reporting algorithm

<table>
<thead>
<tr>
<th>GROUP A PRIMARY TEST AND REPORT</th>
<th>GROUP B OPTIONAL PRIMAR TEST REPORT SELECTIVELY</th>
<th>GROUP C SUPPLEMENTAL REPORT SELECTIVELY</th>
<th>GROUP U SUPPLEMENTAL FOR URINE ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enterobacteriaceae</td>
<td>Amikacin&lt;sup&gt;f&lt;/sup&gt;</td>
<td>Aztreonam</td>
<td>1&lt;sup&gt;2&lt;/sup&gt;Cefazolin (surrogate test for uncomplicated UTI)</td>
</tr>
<tr>
<td></td>
<td>Amoxicillin-clavulanate</td>
<td>Ceftazidime</td>
<td>Fosfomycin&lt;sup&gt;g&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>Ampicillin-sulbactam</td>
<td>Ceftaroline</td>
<td>Nitrofurantoin</td>
</tr>
<tr>
<td></td>
<td>Ceftolozane-lazobactam</td>
<td>Chlormphenicol&lt;sup&gt;b,c&lt;/sup&gt;</td>
<td>Sulfisoxazole</td>
</tr>
<tr>
<td></td>
<td>Piperacillin-lazobactam</td>
<td>Tetracycline&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Trimethoprim</td>
</tr>
</tbody>
</table>

<sup>a</sup>Piperacillin-lazobactam
<sup>b</sup>Chloramphenicol
<sup>c</sup>Tetracycline
<sup>d</sup>Cefepime
<sup>e</sup>Cefotaxime
<sup>f</sup>Cefuroxime
<sup>g</sup>Fosfomycin

CLSI, M100-S27, 2017
http://em100.edaptivedocs.info/Login.aspx
# Selective Reporting - Site of Infection

## Meningitis / *Escherichia coli*

### Group A

1\textsuperscript{st} generation cephalosporins  
**Do not report if susceptible**

### Group B

2\textsuperscript{nd} generation cephalosporins  
Fluoroquinolones  
**Do not report if susceptible**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Group A</th>
<th>Group B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ampicillin(c)</td>
<td></td>
<td>Amoxicillin-clavulanate</td>
</tr>
<tr>
<td>Cefazolin(d)</td>
<td></td>
<td>Ampicillin-sulbactam</td>
</tr>
<tr>
<td>Gentamicin(e)</td>
<td></td>
<td>Cefotaxime(c,d) or ceftriaxone(c,d)</td>
</tr>
<tr>
<td>Tobramycin(g)</td>
<td></td>
<td>Ciprofloxacin(c)</td>
</tr>
<tr>
<td>Cefuroxime</td>
<td></td>
<td>Levofloxacin(c)</td>
</tr>
<tr>
<td>Cefepime</td>
<td></td>
<td>Doripenem</td>
</tr>
<tr>
<td>Cefotetan</td>
<td></td>
<td>Ertopenem</td>
</tr>
<tr>
<td>Cefoxitin</td>
<td></td>
<td>Imipenem</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Meropenem</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Trimethoprim-sulfamethoxazole(c)</td>
</tr>
</tbody>
</table>

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ESCMID Online Lecture Library
Selective Reporting - Site of Infection

Urinary tract infection /Staphylococcus spp.

**Group A**
- Macrolides
- Clindamycin

Do not report if susceptible

<table>
<thead>
<tr>
<th>Staphylococcus spp.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Azithromycin(^b) or</td>
</tr>
<tr>
<td>clarithromycin(^b) or</td>
</tr>
<tr>
<td>erythromycin(^b)</td>
</tr>
<tr>
<td>Clindamycin(^b)</td>
</tr>
<tr>
<td>(*,†,‡) Oxacillin(^i,k)</td>
</tr>
<tr>
<td>(†) Cefoxitin(^i,k)</td>
</tr>
<tr>
<td>(surrogate test for oxacillin)</td>
</tr>
<tr>
<td>Penicillin(^i)</td>
</tr>
<tr>
<td>Trimethoprim-sulfamethoxazole</td>
</tr>
<tr>
<td>Ceftriaxone(^h)</td>
</tr>
<tr>
<td>(*) Daptomycin(^i)</td>
</tr>
<tr>
<td>Linezolid</td>
</tr>
<tr>
<td>Tedizolid(^h)</td>
</tr>
<tr>
<td>Doxycycline</td>
</tr>
<tr>
<td>Minocycline(^b)</td>
</tr>
<tr>
<td>Tetracycline(^b)</td>
</tr>
<tr>
<td>(*) Vancomycin</td>
</tr>
<tr>
<td>Rifampin(^g)</td>
</tr>
</tbody>
</table>
Selective Reporting

When to report results in group B?

- Primary agent in the same class is resistant
- Patient has reported allergy to one or more of the primary agents
- Always reported on specific sites/sources of infection (i.e., a 3rd generation cephalosporin for cerebrospinal fluid isolates)
- Failure of primary therapy
- Polymicrobial or disseminated infection involving multiple body sites

Epidemiologic aid to infection control / surveillance
→ store in the laboratory (preferably in LIS), share the results with the infection control committee
Selective Reporting

Basic principles

- Ensure reporting is in line with local guidance on the use of antimicrobial agents.
- Report all clinically relevant resistances for significant pathogens.
  
  \[Escherichia\; coli\; vs.\; vancomycin\]  \[NDM-1\; positive\; Proteus\; mirabilis\; vs.\; colistin\]

- Report results for relevant antimicrobial agents that the requestor has stated are in use, unless clinically inappropriate.

  \[Stenotrophomonas\; maltophilia\; vs.\; carbapenems,\; aminoglycosides\]
Basic principles (continued)

- Whenever possible, always include a susceptibility result for a non-beta-lactam agent, so there’s always a treatment option for those with penicillin allergy.

  [Group A Streptococcus vs. penicillin]

- Whenever possible and appropriate include results for antimicrobial agents that can be given orally.

- The order in which the laboratory reports susceptibility results is important, as prescribers tend to choose the first listed.

- Inform clinicians that susceptibility results for further antimicrobial agents may be available.

  → encourage clinicians for communication!
Testing Groups and Selective Reporting

– **A** (Primary test and report)
– **B** (Optional primary test, report selectively)
– **C** (Supplemental, report selectively)
– **U** (Supplemental, for urine only)

– No antimicrobial agent groupings, no rules for selective reporting
EUCAST Approach

Antimicrobial susceptibility testing
  Performance of AST
  Categorization of results according to breakpoints (S/I/R)


Detection of specific resistance mechanisms

Giske CG, Martinez-Martinez L, Cantón R et al. EUCAST guidelines for detection of resistance mechanisms and specific resistances of clinical and/or epidemiological importance. Version 2.0, March 2017 (draft document)

Implementation of expert rules
  Intrinsic resistances
  Unexpected phenotypes (usually resistance)
  Interpretive rules

AST guidelines used in UK NEQAS External Quality Assurance
(630-750 participants per year from a total of 40 countries)
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 on behalf of the EUCIC-ESGAP-EUCAST Selective Reporting Working Group 1


Cross-sectional survey conducted in 36 European countries
Selective reporting of antibiotic susceptibility test results in European countries: an ESCMID cross-sectional survey

Highlights

Nearly all respondents (34/36; 94%) perceived selective reporting as useful

Limited implementation of selective reporting of AST results
• Widely implemented 11/36 (31%)
  Belgium, Croatia, Czech Republic, Denmark, Ireland, Netherlands, Slovakia, Slovenia, Sweden, Turkey, United Kingdom
• Partially implemented 4/36 (11%)
• Limited to local initiatives or is not adopted 21/36 (58%)

Endorsed as standard of care by health authorities
- only in 3 countries: Ireland, Turkey, United Kingdom

Several barriers to implementation were reported

- lack of guidelines
- poor system support
- insufficient resources
- lack of professionals’ capability

**Conclusion:** selective reporting of AST results is poorly implemented in Europe and is applied with a huge heterogeneity of practices
The organisation of selective reporting and the degree of implementation in different clinical situations varied significantly.

The most common uses are urinary tract infections (UTIs), skin and soft-tissue infections, pharyngitis and, less frequently, lower respiratory tract infections.

The choice of reported and withheld antibiotics is also quite variable.

Selective Reporting of AST Results

Selective reporting requires good communication between laboratories and clinicians.

- microbiologist should receive relevant and reliable clinical information (patient’s age, sex, diagnosis, drug allergies, pregnancy, etc.) to perform selective reporting

- clinicians need to be aware that they can obtain hidden results if needed, without delay for severe infections
Carbapenem-resistant *K. pneumoniae* in Europe (EARS-Net and CAESAR), 2015

**Level B data:** The data provide an indication of the resistance patterns present in clinical settings in the country, but the proportion of resistance should be interpreted with care. Improvements are needed to attain a more valid assessment of the magnitude and trends of AMR in the country. For more information about levels of evidence, see section 5.2. Levels of evidence are only provided for CAESAR countries and areas.

**EARS-Net countries:** Austria, Belgium, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, United Kingdom.

**CAESAR countries and areas:** Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Georgia, Kazakhstan, Kyrgyzstan, Montenegro, Republic of Moldova, Russian Federation, Serbia, Switzerland, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine, Uzbekistan and Kosovo (in accordance with United Nations Security Council resolution 1244(1999)).

Due to different antibiotic formularies, varied resistance rates for particular pathogens and treatment guidelines in place, it seems irrational to develop a “recommended list of antimicrobials for testing and selective reporting“ that will not be implementable in each country.

For Europe, it might be feasible to publish the principles of selective reporting by an international initiative, considering the current European treatment guidelines and the EUCAST breakpoint table, to address the need to improve awareness, and provide a valuable resource that can be endorsed by health authorities and adapted according to their own conditions.
The key philosophy:

Only report results that are “need to know,” not “nice to know.”
Thank you for your attention.