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.

Table 2B-1. Zone Diameter and MIC Breakpoints for *Pseudomonas aeruginosa*

Testing Conditions	
Medium:	Disk diffusion: MHA Broth dilution: CAMHB; iron-depleted CAMHB for cefiderocol (see Appendix H, section H1)[1] Agar dilution: MHA
Inoculum:	Broth culture method or colony suspension, equivalent to a 0.5 McFarland standard; positive blood culture broth for select antimicrobial agents with disk diffusion (see general comment [6])
Incubation:	35°C ± 2°C; ambient air Disk diffusion: 16–18 hours Dilution methods: 16–20 hours

QC Recommendations

Refer to the following:

- **Tables 4A-1, 4A-2, 5A-1, and 5A-2 that list acceptable QC ranges applicable for each method**
- **Appendix I to develop a QC plan**

When a commercial test system is used for antimicrobial susceptibility testing, refer to the manufacturer's instructions for QC **strains** and QC ranges.

Refer to Tables 3B, 3C, 3E, 3F-1, and 3F-3 for additional testing recommendations, reporting suggestions, and QC.

General Comments

(1) Refer to Table 1B-1 for antimicrobial agents that should be considered for testing and reporting by microbiology laboratories.

(2) For disk diffusion, test a maximum of 12 disks on a 150-mm plate and no more than 6 disks on a 100-mm plate; disks should be placed no less than 24 mm apart, center to center (see CLSI M02[2]). Each zone diameter should be clearly measurable; overlapping zones prevent accurate measurement. Measure the diameter of the zones of complete inhibition (as judged by the unaided eye), including the diameter of the disk (see CLSI M02QG[3]). Hold the Petri plate a few inches above a black background illuminated with reflected light. The zone margin should be considered the area showing no obvious, visible growth that can be detected with the unaided eye. Ignore faint growth of tiny colonies that can be detected only with a magnifying lens at the edge of the zone of inhibited growth.

(3) The susceptibility of *P. aeruginosa* isolated from patients with cystic fibrosis can be reliably determined by disk diffusion or dilution methods but may need extended incubation for up to 24 hours before reporting as susceptible.

(4) *P. aeruginosa* may develop resistance during therapy with all antimicrobial agents. Therefore, isolates that are initially susceptible may become resistant within a few days after initiation of therapy. Testing of repeat isolates may be warranted.

(5) An intermediate (I) with a ^ in Tables 2 indicates agents that have the potential to concentrate in the urine. The I^ is for informational use only. The decision to report I^ is best made by each laboratory based on institution-specific guidelines and in consultation with appropriate medical personnel.

Table 2B-1. *Pseudomonas aeruginosa* (Continued)

(6) Positive blood culture broth can be used as the inoculum for direct disk diffusion testing of select antimicrobial agents against *P. aeruginosa* (using methods described in Table 3F-1 and applying breakpoints in Table 3F-3). For antimicrobial agents not listed in Table 3F-3 for *P. aeruginosa*, CLSI has not yet evaluated this direct disk diffusion method.

NOTE: Information in boldface type is new or modified since the previous edition.

Antimicrobial Agent	Disk Content	Interpretive Categories and Zone Diameter Breakpoints, nearest whole mm			Interpretive Categories and MIC Breakpoints, µg/mL			Comments
		S	I	R	S	I	R	
PENICILLINS								
Piperacillin*	100 µg	≥ 22	18–21^	≤ 17	≤ 16	32^	≥ 64	
β-LACTAM COMBINATION AGENTS								
(7) Organisms that test susceptible to the β-lactam agent alone are also considered susceptible to the β-lactam combination agent. However, organisms that test susceptible to the β-lactam combination agent cannot be assumed to be susceptible to the β-lactam agent alone. Similarly, organisms that test intermediate or resistant to the β-lactam agent alone may be susceptible to the β-lactam combination agent.								
Piperacillin-tazobactam	100/10 µg	≥ 22	18–21	≤ 17	≤ 16/4	32/4	≥ 64/4	**(8)** Breakpoints for intermediate are only to provide a buffer zone to prevent small uncontrolled technical factors from causing major discrepancies in interpretation.
Ceftazidime-avibactam	30/20 µg	≥ 21	–	≤ 20	≤ 8/4	–	≥ 16/4	
Ceftolozane-tazobactam	30/10 µg	≥ 21	17–20^	≤ 16	≤ 4/4	8/4^	≥ 16/4	
Imipenem-relebactam	10/25 µg	≥ 23	20–22^	≤ 19	≤ 2/4	4/4^	≥ 8/4	
Ticarcillin-clavulanate*	75/10 µg	≥ 24	16–23^	≤ 15	≤ 16/2	32/2–64/2^	≥ 128/2	
CEPHEMS (PARENTERAL) (Including cephalosporins I, II, III, and IV. Please refer to Glossary I.)								
Ceftazidime	30 µg	≥ 18	15–17^	≤ 14	≤ 8	16^	≥ 32	
Cefepime	30 µg	≥ 18	15–17^	≤ 14	≤ 8	16^	≥ 32	

Table 2B-1. *Pseudomonas aeruginosa* (Continued)

Antimicrobial Agent	Disk Content	Interpretive Categories and Zone Diameter Breakpoints, nearest whole mm			Interpretive Categories and MIC Breakpoints, µg/mL			Comments
		S	I	R	S	I	R	
CEPHEMS (PARENTERAL) (Including cephalosporins I, II, III, and IV. Please refer to Glossary I.) (Continued)								
Cefiderocol	30 µg	≥ 18	13–17^	≤ 12	≤ 4	8^	≥ 16	**(9)** The accuracy and reproducibility of cefiderocol testing results by disk diffusion and broth microdilution are markedly affected by iron concentration and inoculum preparation and may vary by disk and media manufacturer. Depending on the type of variance observed, false-resistant or false-susceptible results may occur. Testing subsequent isolates is encouraged. Discussion with prescribers and antimicrobial stewardship members regarding the potential for inaccuracies is recommended.
MONOBACTAMS								
Aztreonam	30 µg	≥ 22	16–21^	≤ 15	≤ 8	16^	≥ 32	
CARBAPENEMS								
Doripenem*	10 µg	≥ 19	16–18^	≤ 15	≤ 2	4^	≥ 8	
Imipenem	10 µg	≥ 19	16–18^	≤ 15	≤ 2	4^	≥ 8	
Meropenem	10 µg	≥ 19	16–18^	≤ 15	≤ 2	4^	≥ 8	

Table 2B-1. *Pseudomonas aeruginosa* (Continued)

Antimicrobial Agent	Disk Content	Interpretive Categories and Zone Diameter Breakpoints, nearest whole mm			Interpretive Categories and MIC Breakpoints, µg/mL			Comments
		S	I	R	S	I	R	
LIPOPEPTIDES								
(10) WARNING: Clinical and PK/PD data demonstrate colistin and polymyxin B have limited clinical efficacy, even if an intermediate result is obtained. Alternative agents are strongly preferred. Colistin and polymyxin B should be used in combination with one or more active antimicrobial agents. Consultation with an infectious diseases specialist is recommended.								
Colistin or polymyxin B*	– –	– –	– –	– –	– –	≤ 2 ≤ 2	≥ 4 ≥ 4	**(11)** Colistin (methanesulfonate) should be given with a loading dose and maximum renally adjusted doses (see international consensus guidelines[4]). **(12)** Polymyxin B should be given with a loading dose and maximum recommended doses (see international consensus guidelines[4]). **(13)** When colistin or polymyxin B is given systemically, neither is likely to be effective for pneumonia. **(14)** For colistin, broth microdilution, CBDE, and CAT MIC methods are acceptable. For polymyxin B, broth microdilution is the only approved method. Disk diffusion and gradient diffusion methods should not be performed (see Table 3E).
AMINOGLYCOSIDES								
(15) Breakpoints for tobramycin and amikacin are based on population distributions of various species, PK/PD target attainment analyses with an end point of net bacterial stasis, and limited clinical data. Clinical outcomes data for aminoglycosides as monotherapy for systemic infections are limited and have resulted in worse treatment outcomes (for infections outside of the urinary tract) compared with other therapies. Combination therapy for most indications other than UTIs should be considered. Consultation with an infectious diseases specialist is recommended.								
Tobramycin	10 µg	≥ 19	13–18^	≤ 12	≤ 1	2^	≥ 4	**(16)** Tobramycin does not predict susceptibility to gentamicin.
Amikacin (U)[a]	30 µg	≥ 17	15–16^	≤ 14	≤ 16	32^	≥ 64	
Netilmicin*	30 µg	≥ 15	13–14^	≤ 12	≤ 8	16^	≥ 32	
FLUOROQUINOLONES								
Ciprofloxacin	5 µg	≥ 25	19–24^	≤ 18	≤ 0.5	1^	≥ 2	
Levofloxacin	5 µg	≥ 22	15–21^	≤ 14	≤ 1	2^	≥ 4	

Table 2B-1. *Pseudomonas aeruginosa* (Continued)

Antimicrobial Agent	Disk Content	Interpretive Categories and Zone Diameter Breakpoints, nearest whole mm			Interpretive Categories and MIC Breakpoints, µg/mL			Comments
		S	I	R	S	I	R	
FLUOROQUINOLONES (Continued)								
Lomefloxacin* (U)[a]	10 µg	≥ 22	19–21^	≤ 18	≤ 2	4^	≥ 8	
Norfloxacin* (U)[a]	10 µg	≥ 17	13–16	≤ 12	≤ 4	8	≥ 16	
Ofloxacin*	5 µg	≥ 16	13–15^	≤ 12	≤ 2	4^	≥ 8	
Gatifloxacin*	5 µg	≥ 18	15–17^	≤ 14	≤ 2	4^	≥ 8	

Abbreviations: CAMHB, cation-adjusted Mueller-Hinton broth; CAT, colistin agar test; CBDE, colistin broth disk elution; I, intermediate; MHA, Mueller-Hinton agar; MIC, minimal inhibitory concentration; PK/PD, pharmacokinetic/pharmacodynamic; QC, quality control; R, resistant; S, susceptible; U, urine; UTI, urinary tract infection.
Symbols: ^, designation for agents that have the potential to concentrate in the urine; *, designation for "Other" agents that are not included in Tables 1 but have established clinical breakpoints.

Footnote

a. Report only on organisms isolated from the urinary tract.

References for Table 2B-1

1 Hackel MA, Tsuji M, Yamano Y, Echols R, Karlowsky JA, Sahm DF. Reproducibility of broth microdilution MICs for the novel siderophore cephalosporin, cefiderocol, determined using iron-depleted cation-adjusted Mueller-Hinton broth. *Diagn Microbiol Infect Dis.* 2019;94(4):321-325. doi:10.1016/j.diagmicrobio.2019.03.003

2 CLSI. *Performance Standards for Antimicrobial Disk Susceptibility Tests.* 14th ed. CLSI standard M02. Clinical and Laboratory Standards Institute; 2024.

3 CLSI. *M02 Disk Diffusion Reading Guide.* 2nd ed. CLSI quick guide M02-Ed14-QG. Clinical and Laboratory Standards Institute; 2024.

4 Tsuji BT, Pogue JM, Zavascki AP, et al. International consensus guidelines for the optimal use of the polymyxins: endorsed by the American College of Clinical Pharmacy (ACCP), European Society of Clinical Microbiology and Infectious Diseases (ESCMID), Infectious Diseases Society of America (IDSA), International Society for Anti-Infective Pharmacology (ISAP), Society of Critical Care Medicine (SCCM), and Society of Infectious Diseases Pharmacists (SIDP). *Pharmacotherapy.* 2019;39(1):10-39. doi:10.1002/phar.2209