Review

The Management of Urinary Tract Infections during the COVID-19 Pandemic: What Do We Need to Know?

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Abstract: The landscape of management of urinary tract infections (UTI) is changing rapidly. The COVID-19 pandemic draws our attention to the SARS-CoV-2 management with a subsequent reduced attention on bacterial infections. The COVID-19 diffusion containing procedures, such as use of facemasks and handwashing, have reduced spreading of bacteria and bacterial lung infections. However, a brief analysis of UTI management during the COVID-19 pandemic reveals that the pandemic has changed our management of UTI in a way that violates the principles of antimicrobial stewardship. We therefore remind all urologists and other physicians who manage patients affected by UTI about the importance of continued adherence to antimicrobial stewardship principles during the COVID-19 pandemic.

Keywords: SARS-CoV-2; COVID-19; urinary tract infections; antimicrobial stewardship; antibiotic resistances

1. Background and Aims

Since 2020, SARS-COV-2 infections have had a high impact on national and international healthcare systems and caused more than 5,100,000 deaths worldwide [1,2]. In the last 2 years, significant health resources have been used on development of medical drugs and vaccines in the war against SARS-COV2 disease (COVID-19). COVID-19 diffusion containing measures, such as facemasks and handwashing, have reduced the spread of all viruses and bacteria, with a subsequent reduction of bacterial-related lung infections [3]. However, the prevalence of urinary tract infections was not reduced by these preventive measures, and it is still necessary to maintain high level of adherence to antimicrobial stewardship in everyday clinical practice. During the COVID-19 pandemic, it became important to reduce the number of hospitalizations to prevent the spread of SARS-CoV-2 infection. For this reason, antimicrobial treatment is now prescribed earlier, and broad-spectrum antibiotics has been more frequently used in patients with suspected UTI in order to avoid severe infections and hospitalizations. Recently, Bendala Estrada et al. demonstrated in a multicenter, retrospective study, that the overall percentage of bacterial co-infection among patients with COVID-19 was low, but the use of antibiotics was high [4]. Moreover, the
recent International Severe Acute Respiratory and Emerging Infections Consortium (IS-ARIC) report demonstrated that 62% of patients with COVID-19 had received antimicrobial therapy, even though the prevalence of bacterial infections in COVID-19 has been low [5]. This is the background for the present work and the reason for discussing the role of UTI management during the COVID-19 pandemic. The aim of this Editor’s perspective is to give a brief narrative review of the management of UTIs during the COVID-19 pandemic, in order to provide the readers with some navigation points in everyday clinical practice.

2. Materials and Methods

Search of Evidence

Our objective is to give an update on UTI management during the COVID-19 pandemic, focusing on changes in practice that have an impact on antimicrobial stewardship. A literature search was performed in Embase, MEDLINE, Web of Science, and Google Scholar databases for relevant publications by using the following terms: “urinary tract infections” AND/OR “antimicrobial stewardship” AND (“SARS-CoV-2” OR “COVID-19”). Two authors (TC and CT) reviewed all selected articles independently. Any disagreements among reviewers were resolved through discussion and consensus. All references cited in relevant articles were also reviewed and analyzed. EndNote software was used to analyze all references (https://endnote.com/, accessed on 12 December 2021). The filters used included English language and humans. Even if this search was planned for a narrative review, our search was performed in line with the Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) and the recommendations of the European Association of Urology Guidelines (EAU) office for conducting systematic reviews and meta-analyses [6,7]. Our search identified 320 articles of potential interest. After the first screening round, 23 articles were considered eligible for inclusion (Table 1). The detailed selection process of the included studies is displayed in Figure 1.

Table 1. The summary of all studies included in this narrative review. Abbreviations used: ARDS = Adult Respiratory Distress Syndrome; CAUTI = Catheter associated urinary tract infections; and PE = Pulmonary Embolism.

<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Setting</th>
<th>Type of Study</th>
<th>Aim of Study</th>
<th>Sample Size</th>
<th>Median Age (IQR)</th>
<th>Gender</th>
<th>Most Important Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wang Z et al. [8]</td>
<td>2020</td>
<td>Hospital (China)</td>
<td>Retrospective</td>
<td>Clinical features of COVID19 infection</td>
<td>69</td>
<td>42 (35–62)</td>
<td>Male 46%</td>
<td>Female 54% COVID-19 symptoms: Fever (87%), cough (55%), fatigue (42%), SpO2 &lt; 90% (20%)</td>
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<tr>
<td>Wu C et al. [9]</td>
<td>2020</td>
<td>Hospital (China)</td>
<td>Retrospective</td>
<td>Risk factors associated with ARDS and death</td>
<td>201</td>
<td>51 (43–60)</td>
<td>Male 63.7%</td>
<td>Female 36.3% Older age is associated with greater risk of ARDS (41.8%) and death (52.4%)</td>
</tr>
<tr>
<td>Wan S et al. [10]</td>
<td>2020</td>
<td>Hospital (China, North-east)-Chongqing</td>
<td>Retrospective</td>
<td>Clinical features of COVID-19 infection</td>
<td>135</td>
<td>47 (36–55)</td>
<td>Male: 53.3%</td>
<td>Female: 46.7% COVID-19 symptoms: Fever (88.9%), cough (76.5%), fatigue (32.5%)</td>
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<td>Author</td>
<td>Year</td>
<td>Setting</td>
<td>Type of Study</td>
<td>Aim of Study</td>
<td>Sample Size</td>
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<tr>
<td>Lansbury et al.</td>
<td>2020</td>
<td>Hospital (China, Europe, USA)</td>
<td>Retrospective</td>
<td>Clinical features of COVID-19 infection</td>
<td>2590 (22 studies included)</td>
<td>47 (36–55)</td>
<td>Male 53.3% Female 46.7%</td>
<td>Bacterial co-infections: 7% Common pathogens: <em>Mycoplasma pneumonia</em>, <em>Pseudomonas aeruginosa</em>, <em>Haemophilus influenzae</em> Routine use of antibiotics should be avoided</td>
</tr>
<tr>
<td>Rawson et al.</td>
<td>2020</td>
<td>China, USA, Saudi Arabia, Taiwan, South Korea, Canada, Hong Kong</td>
<td>Systematic review</td>
<td>Evaluation of patients with concomitant bacterial and fungal co-infection in patients with COVID-19</td>
<td>2010 patients (18 studies included)</td>
<td>-</td>
<td>-</td>
<td>COVID-19 positive: 8% No COVID-19: 11% 72% of the overall cohort received wide-spectrum antimicrobial therapy</td>
</tr>
<tr>
<td>Bardi T et al.</td>
<td>2021</td>
<td>Single-centre; Case-control study (Spain, Europe)</td>
<td>Retrospective</td>
<td>Evaluation of ICU-acquired infections in COVID-19 patients</td>
<td>140</td>
<td>61 (57–67)</td>
<td>Male 77% Female 33%</td>
<td>HAUTI Incidence: 47%; Primary (31%); catheter-related (25%); pneumonia (23%); trachobronchitis (10%); UTI (8%) with 60% of risk of septic shock</td>
</tr>
<tr>
<td>Karaba SM et al.</td>
<td>2020</td>
<td>Hospitals, Multicentric (USA)</td>
<td>Retrospective</td>
<td>Incidence of bacterial respiratory and non-respiratory co-infections</td>
<td>1016</td>
<td>62 (48–74)</td>
<td>Male 54% Female 46%</td>
<td>Bacterial respiratory: 1.2%; Bacterial pneumonia: 1.1% UTI: 3%</td>
</tr>
<tr>
<td>Van Laethem J et al.</td>
<td>2021</td>
<td>Hospital, single center (Belgium)</td>
<td>Retrospective</td>
<td>Quantitative/Qualitative evaluation of UTI in COVID-19 ward</td>
<td>622</td>
<td>63</td>
<td>Male 58% Female 42%</td>
<td>UTI Incidence 13% 12% of UTI subgroup under antibiotic therapy 61% overdiagnosis rate (unnecessary therapy)</td>
</tr>
<tr>
<td>Langford BJ et al.</td>
<td>2020</td>
<td>Hospitals, Multicentric (China, USA, Europe)</td>
<td>Systematic review and meta-analysis</td>
<td>Prevalence of bacterial co-infection (admission) and secondary infection (during hospitalization) in COVID-19 wards</td>
<td>3338</td>
<td>24 included studies</td>
<td>2–71</td>
<td>Low incidence of bacterial co-infection in COVID-19 wards (6.9%) but 71.9% of patients received antimicrobial therapy</td>
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<tr>
<td>Author</td>
<td>Year</td>
<td>Setting</td>
<td>Type of Study</td>
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<tr>
<td>Lai J et al. [18]</td>
<td>2020</td>
<td>Hospitals, multicentric (China)</td>
<td>Cross-sectional survey</td>
<td>Mental evaluation of health-care workers</td>
<td>1257</td>
<td>60.8%</td>
<td>Nurses 39.2% Physicians</td>
<td>High psychological burden. Depression, anxiety, distress more pronounced in nurse staff during the pandemic</td>
</tr>
<tr>
<td>Han J et al. [21]</td>
<td>2020</td>
<td>Letter to the editor</td>
<td>-</td>
<td>The role of procalcitonin for identifying bacterial co-infection in COVID-19 patients</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Procalcitonin may represent a negative prognostic factor (clinical deterioration) in patients admitted to COVID-19 wards</td>
</tr>
<tr>
<td>Muller et al. [22]</td>
<td>2000</td>
<td>Prospective multicentric study (Europe, USA)</td>
<td>Role of calcitonin precursors in predicting septic shock</td>
<td>101 ICU patients</td>
<td>59 (23–86)</td>
<td>Male: 60% Female: 40%</td>
<td>Calcitonin precursors are sensitive markers of sepsis compared to serum C-reactive and interleukins</td>
<td></td>
</tr>
<tr>
<td>Author</td>
<td>Year</td>
<td>Setting</td>
<td>Type of Study</td>
<td>Aim of Study</td>
<td>Sample Size</td>
<td>Median Age (IQR)</td>
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<tr>
<td>Suleyman G et al.</td>
<td>2021</td>
<td>Hospitals, USA (Abstract)</td>
<td>Retrospective–cross sectional study (USA) (Abstract)</td>
<td>Impact of COVID-19 on catheter-associated urinary tract infections (CAUTIs)</td>
<td>877</td>
<td>-</td>
<td>-</td>
<td>2019: Respiratory (21%); Urinary (54%); GI (3%); Skin (31%)–2020 Respiratory (13%); Urinary (57%); GI (4%); Skin 34% Decrease in number of infectious diseases treated with antibiotics due to lockdown restrictions</td>
</tr>
<tr>
<td>Van de Pol AC</td>
<td>2021</td>
<td>JGPN (Julius General Practitioners’ Network) registry 2019–2020</td>
<td>Care-based observational cohort study</td>
<td>Evaluation of number of infectious disease episodes, complications, and antibiotic prescription rates</td>
<td>2019: 27,263 2020: 37,604 (consultations)</td>
<td>-</td>
<td>-</td>
<td>- Careful clinical observation before antimicrobial treatment 27% treated for a UTI. Treatment of UTI associated with poor functional recovery and consequently of questionable utility</td>
</tr>
<tr>
<td>Reyes R et al.</td>
<td>2020</td>
<td>Editorial comment</td>
<td>Editorial comment</td>
<td>The impact of urinary tract infection in the era of COVID-19</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>- Increase of the frequency of UTIs with a mean age of 85.3 years (range not reported) Male: 29% Female: 71%</td>
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<tr>
<td>Dasgupta M et al.</td>
<td>2017</td>
<td>Hospital, Canada</td>
<td>Prospective cohort study</td>
<td>Determination of asymptomatic UTI treatment rate in older medically ill delirious patients</td>
<td>343</td>
<td>85.3 (range not reported)</td>
<td>Male: 29% Female: 71%</td>
<td>- Increased safety of healthcare workers associated with reduction of SSI</td>
</tr>
<tr>
<td>Antonello VS et al.</td>
<td>2021</td>
<td>Hospital, Brazil, Maternity Unit</td>
<td>Retrospective analysis</td>
<td>Consumption of personal protective equipment and products (PPEP) and frequency of surgical site infection among non-COVID 19 patients</td>
<td>Not reported</td>
<td>Not described</td>
<td>Not described</td>
<td>- COVID-19 caused a hypercoagulability state with increased risk of DIC (Disseminated intravascular coagulation)</td>
</tr>
<tr>
<td>Jue S et al.</td>
<td>2020</td>
<td>Editorial comment</td>
<td>Editorial comment</td>
<td>Thromboprophylaxis guidelines in COVID-19 patients</td>
<td>-</td>
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</tr>
<tr>
<td>Manne BK et al.</td>
<td>2020</td>
<td>Hospital, Single center (USA)</td>
<td>Retrospective series</td>
<td>Pathway analysis of COVID-19 infection on platelets</td>
<td>49.9</td>
<td>Male: 53% Female: 47%</td>
<td>-</td>
<td>COVID-19 increases platelet hyperreactivity</td>
</tr>
</tbody>
</table>
3. Evidence and Recommendations

3.1. Evidence

3.1.1. The Prevalence of Bacterial Co-Infections in COVID-19

Several studies demonstrated empiric use of antibiotics in a majority of patients with COVID-19 in a hospital setting [8,9]. The high use of antibiotics in COVID-19 patients is probably due to increased levels of blood inflammatory markers of bacterial infection, such as raised procalcitonin and C-reactive protein, in patients with COVID-19. However, most of these patients did not have a microbiologically proven bacterial co-infection [10]. According to a recent systematic review performed on 3834 hospitalized patients with COVID-19, the overall pooled proportion of patients who had laboratory-confirmed bacterial co-infections, was 7% [11]. Rawson et al. reported a similar finding of 8% prevalence of bacterial/fungal co-infection during hospital admission [12]. The same authors reported wide use of broad-spectrum antibiotics, despite paucity of evidence for bacterial co-infections and lack of antimicrobial stewardship considerations [12]. Based on the reviewed papers, we estimate the prevalence of bacterial co-infection to be less than 10% in hospitalized patients with COVID-19.

3.1.2. The Prevalence of UTI Co-Infections in COVID-19

The prevalence of urinary tract co-infections in patients affected by COVID-19 has not been investigated explicitly. The majority of the reviewed reports focused on pneumological co-infections. However, the prevalence of UTI co-infections in patients with COVID-19 can be extrapolated from some of the reviewed studies. Firstly, Bardi et al. reported the prevalence of UTI of 8% in 140 patients admitted to the intensive care unit, most of which were catheter-associated urinary tract infections [13]. Moreover, Karaba et al. reported a prevalence of 3% in 1016 patients admitted to five hospitals in the US [14]. A recent paper concluded that in more than 60% of patients hospitalized with COVID-19 and urinary tract co-infections, the UTIs were probably over-diagnoses [15]. Hence, the true prevalence of UTI associated to COVID-19 seems to be very low.

3.1.3. Antibiotic Prescriptions and Antimicrobial Stewardship Considerations in COVID-19

In a study addressing both outpatients and hospitalized patients, the prevalence of bacterial co-infections in COVID-19 positive patients was 3.5% in outpatients and 14.3% in hospitalized patients, respectively [16]. Over-prescription of antibiotics in COVID-19 positive patients can increase selective pressure for development of antimicrobial resistance and collateral damage, such as Clostridium difficile infections [17]. As highlighted by Huttner et al., the over-prescribing of antibiotics may be due to lowered adherence to international guidelines on the use of antibiotics. The authors emphasize that physicians involved in the
management of COVID-19 positive patients have a high workload and show high levels of stress [18,19]. Furthermore, the higher rate of telemedicine within primary care, secondary care, and outpatient services also increased the number of antimicrobial prescriptions due to safety-netting and reduced access to laboratory diagnostics [17]. On the other hand, reduced access to pharmacies has limited the number of self-administered antibiotics, but rare antimicrobial stewardship initiatives within local healthcare environments have reduced the awareness of correct use of antibiotics during the pandemic [17,20]. The net effect of these COVID-19 related changes in clinical practice is an increased number of antibiotic prescriptions. Finally, as economic and health care resources were allocated to controlling the SARS-CoV-2 pandemic, our attention to antimicrobial resistance and antimicrobial stewardship diminished [20]. Huttner BD et al. now ask healthcare professionals to assess the impact of the COVID pandemic on antibiotic usage and resistance in all settings (community, nursing homes, and hospitals) [19]. However, the jury is still out in regards the impact of the COVID pandemic on antimicrobial stewardship programs and long-term rates of antimicrobial resistance [17].

3.2. Recommendations

3.2.1. The COVID-19 Pandemic: An Excellent Reminder of Antimicrobial Stewardship Principles

It might be said that the COVID-19 pandemic made us forget the need for antimicrobial stewardship in clinical practice, both in community as well as in the hospital setting. Although we still lack data about the long-term effects of COVID-19 on antimicrobial resistance, it is time to remind ourselves that antibiotic stewardship principles must be adhered to in order to avoid not only direct long-term effects of COVID-19, but also serious collateral damages on global health [19]. Several authors underline the importance of sticking to international guidelines in the management of urinary tract infections.

3.2.2. Think Twice before Prescribing Antimicrobials to COVID-19 Positive Patients!

As bacterial co-infections in COVID-19 patients are relatively rare (<10%) [13–15], prescription of antibiotics in COVID-19 patients should be avoided in patients without signs and/or symptoms related to bacterial infections [19]. Serum biomarkers, such as C-reactive protein and/or procalcitonin may play a role in the decision-making process before antibiotic prescription, but further investigations are required [15,19]. The white blood cells (WBC) count is generally considered as an index for bacterial infection, but its specificity in patients with SARS-CoV2 infection is low due to its vulnerability to several factors, such as the presence of inflammatory status or asymptomatic bacteriuria that could increase the level of WBCs. On the other hand, procalcitonin seems to be a useful marker to discriminate between SARS-CoV2 and bacterial infection. Hann J et al. highlighted that a non-elevated procalcitonin level on admission to a healthcare center predicts the absence of bacterial co-infection. Procalcitonin might therefore facilitate implementation of antibiotic stewardship principles [21]. The ability of procalcitonin to discriminate between viral infection alone and viral infection with bacterial co-infection is due to the fact that viral infections are associated with high production of interferon-γ by macrophages, which inhibits TNF-α in the immune response [22].

3.2.3. Asymptomatic Bacteriuria Is Not a Risk Factor for Future Complications in COVID-19 Patients

Asymptomatic bacteriuria is generally over-treated in COVID-19 positive hospitalized patients [15]. This is due to the erroneous assumption that asymptomatic bacteriuria increases the risk of complications in COVID-19 positive patients, which often get indwelling urinary catheters during hospitalization with SARS-CoV-2 [15]. According to Geehan Suleymant al., the COVID-19 pandemic did not have a negative impact on CAUTI rates, even though the rate of indwelling urinary catheters increased [23]. Another aspect to take into account is that during the first wave of pandemic, the number of infectious disease episodes treated with antibiotics decreased, without evidence for an increase in complica-
tions [24]. This is an indirect demonstration of a general over-diagnosis and overtreatment of infectious diseases, resulting in overuse of antibiotics.

Delirium is not generally considered a “systemic sign of infection”, but it should be taken into account in elderly patients. Decision about antibiotic treatment is complex and challenging in patients with bacteriuria and delirium in connection with SARS-CoV-2 infection [25]. Some authors suggest avoiding treatment for these patients, as no studies have shown benefit from antibiotic treatment in elderly patients with asymptomatic bacteriuria and delirium [25]. In a study performed before the COVID-19 pandemic, Dasgupta reported a significant further functional loss in patients who received antibiotics, compared with those who did not [26].

3.2.4. Antimicrobial Prophylaxis before Urological Procedures and Surgery in COVID-19 Positive Patients

The COVID-19 pandemic deferred the majority of scheduled urological surgical interventions, especially in the first wave of the pandemic. Only urgent and emergency surgical interventions were performed. In the opinion of the present panel, patients with COVID-19 who are supposed to undergo surgical procedures should get standard antimicrobial prophylaxis in line with international guidelines, even though there are no clinical trials supporting this recommendation. Recently, Antonello Vs et al. demonstrated a significant decrease (49%) in surgical site infection during the COVID-19 pandemic in comparison with a pre-COVID period. The authors highlight the importance of increased use of personal protective equipment and products in the operating theater [27].

3.2.5. Urosepsis and COVID-19

A possible alteration induced by SARS-CoV-2 in blood coagulation was addressed by Jue Js et al. [28]. Other reports demonstrated significant changes in platelet gene expression and function in COVID-19 patients and highlighted the role of SARS-CoV-2 in platelet activation and aggregation, resulting in thrombosis and coagulopathy [29]. On the basis of these observations, Cai et al. reported an increased risk of pulmonary embolism in a small cohort of patients with urosepsis and speculated that the findings are due to enhanced stimulation of thrombo-inflammatory mechanisms by the bacterial infection in association with the increased platelet activation due to SARS-CoV-2 co-infection [30]. Even though further studies are required to confirm these considerations, a higher level of attention is required in patients with urosepsis and COVID-19 infections as regards the risk of thromboembolism.

3.3. Limitations

This study, even if supported by a rigorous methodology according to the international guidelines [31], has a few limitations to take into account. Firstly, the lack of adequate data about the outpatients setting. Most included studies were performed in the hospital setting. The impact on COVID-19 pandemic in outpatients should be evaluated in depth, by using future studies in order to understand its impact on antimicrobial stewardship. Finally, the lack of data about the impact of COVID-19 pandemic on the healthcare systems costs for UTI management.

4. Conclusions and Final Remarks

In order to maintain a high adherence to antimicrobial stewardship principles, the management of UTIs in the COVID-19 pandemic should be based on the following considerations:

• Avoid using antibiotics in COVID-19 patients without any sign and/or symptoms related to bacterial infections.
• The presence of fever in the absence of symptoms related to UTIs is not an indication for the use of antibiotics.
• In case of symptoms related to UTIs, empirical antimicrobial treatment in accordance with international guidelines is the most appropriate practice.
• Asymptomatic bacteriuria is not a risk factor in patients affected by COVID-19 infection. The management of asymptomatic bacteriuria should also be in line with international guidelines, but elderly patients with bacteriuria and delirium require meticulous evaluation and continuous attention to a less harmful approach than antibiotic treatment.
• The care of COVID-19 patients is more difficult than for patients in a standard hospital setting. Isolation procedures might increase the use of urinary catheters and cause higher prevalence of catheter associated UTI and hospital acquired UTIs. The indications for catheterization in patients affected by COVID-19 requires careful considerations.
• Patients affected by COVID-19 have the same risk as non-COVID-19 patients to develop infectious complications after urological procedures. There is no evidence to deviate from international guidelines on antimicrobial prophylaxis before urological surgical procedures.
• Before prescription of antibiotic therapy, physicians must consider all possible collateral damages caused by antibiotics.
• It is urgently required to change current practice of preemptive broad-spectrum antibiotic prescription in COVID-19 patients. We must pay more attention to available evidence and the principles of antimicrobial stewardship!
• Please don’t forget to consider the patient’s quality of life in association with antimicrobial stewardship in everyday clinical practice! [32].

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22. Muller, B.; Becker, K.L.; Schächinger, H.; Rickenbacher, P.R.; Huber, P.R.; Zimmerli, W.; Ritz, R. Calcitonin precursors are reliable markers of sepsis in a medical intensive care unit. *Crit. Care Med.* 2000, 28, 977–983. [CrossRef]


