A Letter in Response to "Diagnosing Catheter-Associated Urinary Tract Infection in Critically ill Patients: Do the Guidelines Help?"

Sir,

I read with interest the review article by Saran *et al*.[1] where the authors have suggested an approach to catheter-associated urinary tract infection (CAUTI) in catheterized patients with fever in Intensive Care Units (ICUs). The Centers for Disease Control and Prevention-National Health Safety Network (CDC-NHSN) CAUTI definition excluded *Candida* as a valid causative organism based on several factors: "*Candida* is a rare cause of UTI but urinary catheter colonization is common in some patient populations; treatment of candiduria is not associated with clinical benefit; and the inclusion of *Candida* in the definition may encourage inappropriate antifungal prescribing."[2] It is also to be emphasized that the CDC-NHSN CAUTI definitions are primarily for surveillance purposes only, whereas the definitions of Infectious Diseases Society of America (IDSA) are largely concerned with diagnosis as well as patient management. In this context, I would like to make the following modifications to the suggested managerial approach for CAUTI in ICU settings.

i. In Figure 2, under risk factors, total parenteral nutrition can be added for medical ICU and specific risk factors such as anastomic leakage, surgery of the large bowel, and necrotizing pancreatitis can be added for surgical ICU to the rsik factors already described in the risk factor in article by Saran *et al*. Similarly, for neonatal ICUs, the risk factors are different and may not be under the purview of the present review
ii. In Figure 2, under urine culture/sensitivity, it is recommended by the IDSA to remove the indwelling catheter and insert a new one (if still clinically indicated), with the urine specimen to be collected from the freshly placed catheter, before initiation of antibiotics/antifungal therapy for symptomatic infection.[3] This measure mitigates the effect of biofilms formed on the lumen of the catheter and hitherto contamination of urine specimen with microorganisms of the biofilm
iii. Candida score and/or Candida Colonization Index is not practiced in many ICUs. Furthermore, the predictive values of these scores are not validated for every ICU setting.[4] Putting these into algorithm will put extra burden on laboratories as well as patients.

And finally, disregarding *Candida* as a causative agent of

CAUTI in hospitals/centers who follow CDC-NHSN CAUTI definitions will not only have its implications on CLABSI rates, but also put the onus on *Candida auris* surveillance in India.[5,6]

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Conflicts of interest

There are no conflicts of interest.

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