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Urinary antigen testing for respiratory infection during COVID-19: The microbiologist as a diagnostic steward—Tom Williams*, Luke Blagdon Snell*, Jonathan Edgeworth*, Geraldine O’Hara (GUY’s and St Thomas’ NHS Foundation Trust, London, United Kingdom, King’s College London, London, United Kingdom)

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Abstract
The use of antimicrobials in the management of community-acquired COVID-19 is commonplace but evidence for coinfection with common bacterial pathogens to justify their use is lacking. We undertook a retrospective review of all respiratory cultures, blood cultures and urinary antigen tests in COVID-19 patients looking for co-infection with Streptococcus pneumoniae and Legionella pneumophila, and specifically to judge the utility of urinary antigen testing. 2,674 GSTT patients were included who had a positive RT-PCR test for SARS-CoV-2 performed at GSTT between 03-March-2020 and 31-Jan-2021 and who had at least one other microbiology sample for review.

Reviewing respiratory cultures (n = 2224) and blood cultures (n = 5557), Streptococcus pneumoniae was cultured in five respiratory samples from five (5/2674, 0.2%) patients. A pneumococcal urinary antigen test was performed on one of these patients and was negative.

316 pneumococcal urinary antigen tests were performed, with only two (0.3%) positive tests, neither of which had Streptococcus pneumoniae isolated by respiratory or blood culture. All 351 legionella urinary antigen tests were negative. The total cost for processing these urinary antigen tests is estimated at around £30,000. A lower proportion of patients had pneumococcal urinary antigen testing in the second wave (125/1600, 8%) compared to the first wave (178/1074, 17%; χ² p < 0.01), after new guidelines were introduced to recommend against their use.

We found little evidence of coinfection with Streptococcus pneumoniae or Legionella pneumophila in our cohort. Our data does not support routine urinary antigen testing in community-acquired COVID-19. Infection specialists have a role in diagnostic stewardship to prevent unnecessary testing.

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Nasal washes vs nasopharyngeal swabs for the detection of respiratory pathogens—Matthew Flynn (Queen Elisabeth University Hospital, Glasgow, United Kingdom)

Abstract
Background: Respiratory virus testing is frustrated by low sensitivity, estimated as low as 70%. One cause for this may be the method of sampling used. The question of which method of sampling yields pathogens with optimal sensitivity between nasopharyngeal swabs, nasal washes and aspirates was answered systematically, using new methodology for rapid reviews.

Methods: Cochrane interim guidance for conducting rapid reviews and the PRISMA protocol for combination of metanalysis and narrative synthesis. The study used the QUADAS-2 tool for risk of bias Revman and Rayyan QCRI software, and was registered with PROSPERO. Sensitivities were compared head-to-head against a consensus standard of positivity by either method as the gold standard. Insufficient, cross sectional and anatomical site-pooling methodologies were excluded.

Results: Of 13 eligible studies, 9 included infants, 6 included children under the age of 16 and 4 included adults. 8 had ‘high’ risk of bias, and 5 had ‘high’ applicability concerns. There were no statistical differences in pooled sensitivities between collection methods for 8 different viruses, and neither with use of PCR, immunofluorescence nor culture. In one study, Influenza H1N1 favoured nasopharyngeal swabs, with aspirates having 93.3% of the sensitivity of swabs (p > 0.001).

Conclusions: The chain of sampling, from anatomical site to laboratory results, features different potential foci along which sensitivity may be lost. A moderate body of evidence exists that use of a different sampling method between swabs and aspirates will not yield more respiratory pathogens. A new rapid reviews protocol helped answer this question in a 3 month period.

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Is there a role for inpatient influenza vaccination programmes?—Johanna Kellett Wright.*, Rajeka Lazarus,* (North Bristol NHS Trust, Bristol, United Kingdom, University Hospitals of Bristol and Weston, Bristol, United Kingdom)

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Abstract
Introduction: Patients with chronic liver disease have much higher mortality associated with influenza compared to other risk groups (1). Influenza vaccine uptake is much lower in adults with chronic liver disease (37.3%) compared to adults aged over 65 (72.4%) or other risk groups (44.9%) (2).

Hospital-based interventions for inpatients have been shown to increase uptake (3).

Vaccination records of patients admitted to a Hepatology ward were reviewed retrospectively to understand what proportion were eligible but did not receive annual influenza vaccine through current services.

Methods: Data was collected for inpatients 26th September 2020 to 29th November 2020. GP records were used to check vaccination status within the window 01/09/2020 to 28/02/2021. Patients not registered with a local GP or deceased were excluded. We compared the rates of vaccination between at risk groups.

Results: 134 were eligible for influenza vaccination and inclusion. 95 (70.9%) were not immunised at the time of admission. 36 (29.1%) went on to be immunised in the same influenza season, leaving 59 (44.0%) of individuals not receiving a vaccine at all.

Discussion: Vaccination rates are below the 75% target. Most patients, who were eligible at the time of admission, never received an influenza vaccination. An inpatient influenza vaccination programme could utilise this missed opportunity to increase vaccine uptake.

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Implementing Opt-Out HIV screening in the ambulatory assessment unit: A quality improvement project—Josh Morton, Alex Bunn, Martine Altidor, Samed Mils, Sarah Evans, Monique Andersson, Mridula Rajwani (Oxford University Hospitals NHS Foundation Trust, Oxford, United Kingdom)

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Abstract
Patients infected with HIV benefit from early diagnosis, allowing initiation of highly effective treatment to reduce the risk of complications and onward infection. Current NICE guidelines recommend routine screening in all individuals accessing healthcare where the population prevalence