RSV bronchiolitis season 2021 has arrived, so be prepared!

Bronchiolitis is the most common cause for hospital admissions for young children. Predominantly, the causative agent is respiratory syncytial virus (RSV), which is transmitted similarly to SARS-CoV-2. The emergence of the COVID-19 pandemic led to non-pharmaceutical interventions (NPIs) to reduce the spread of the virus, including handwashing and social distancing. We took the opportunity to see how NPIs have impacted on RSV. We reviewed data retrospectively from children admitted to the Children’s Hospital for Wales (CHfW) between 1 October and 31 March from 2015 to 2021. Further details can be seen in our report.1

Over the five preceding winters to the 2020/2021 season, a total of 2922 patients presented with bronchiolitis after exclusion criteria was applied, with 1307 infants admitted to the hospital with bronchiolitis (44.7%). A total of 1214 swabs were taken and there was an average of 115 RSV positive swabs per season. In comparison, for the 2020/2021 seasons, 39 presented with bronchiolitis, with 22 admitted (56.4%). Thirty-two of the 39 patients had swabs; 59% were positive for rhinovirus and none for RSV. Table 1 outlines the number of presentations to the CHfW.

Our findings demonstrate a significant drop in the number of patients with bronchiolitis in 2020/2021, and no RSV cases were identified. The most significant drop in the number of patients presenting was in 2020/2021 compared to the previous winter in Wales, aligning with our data to reduce the spread of the virus, including handwashing and social distancing. We took the opportunity to see how NPIs have impacted on RSV. We reviewed data retrospectively from children admitted to the Children’s Hospital for Wales (CHfW) between 1 October and 31 March from 2015 to 2021. Further details can be seen in our report.1

There were concerns that as NPI measures are relaxed and as a return to normality begins, an epidemic in RSV bronchiolitis would emerge. In Australia, as a result of their NPIs, there were similar reductions in RSV cases initially. However, as restrictions were eased in New South Wales, there was a surge in RSV bronchiolitis lasting 3 months, during a time of the year which is atypical for them.2 Similar patterns have been noted in New York.3

Public Health England predicted a surge in the UK, estimating that RSV bronchiolitis cases would cause an epidemic this year, which will see cases rise from mid-August, and that there will be a 20%–50% increase in the number of RSV cases.4 In Wales, we have seen, as demonstrated in figure 1, a re-emergence of RSV bronchiolitis cases at a rapid rate that is out of sync with the usual seasonal pattern.5

Our data and data from other countries suggest, as predicted that with the easing of NPIs, an out of season epidemic of RSV bronchiolitis is beginning. Appropriate resource allocation and preparation is needed now, with changes in departments needed akin to how we prepared for the surges in COVID-19 infections. This should include redeployment of clinical staff to manage the increased numbers of patients, up-to-date training on bronchiolitis guidelines, including use of high-flow oxygen on acute paediatric wards,6 and public health advice to reinforce the importance of NPI practices such as handwashing to reduce the spread of RSV.

Farsi Hussain,1,2 Sarah Kotecha,2 Martin Oliver Edwards,3

1 Children’s Hospital for Wales, University Hospital of Wales, Cardiff, UK
2 General Paediatrics, Children’s Hospital for Wales, Cardiff, UK
3 Child Health, Cardiff University, School of Medicine, Cardiff, UK

Correspondence to Dr Farsi Hussain, Children’s Hospital for Wales, University Hospital of Wales, Cardiff CF14 4XW, UK; Hussainf7@cardiff.ac.uk

Twitter Martin Oliver Edwards @DrMartinEdwards

Contributors MOE was involved in the planning and design, and supervised the data collection and helped to draft the first manuscript and all subsequent versions. FH wrote the draft manuscript and helped to collect and analyse the data, and agreed all subsequent versions. SK helped to conduct the study by reviewing all versions of the manuscript and checking for data accuracy.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Not required.

Ethics approval Ethics permission was deemed unnecessary, as this was a retrospective study of seasonally collected, anonymised clinical data. No direct patient data were used.

Provenance and peer review Not commissioned; internally peer reviewed.

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Table 1 Table demonstrating number of patients presenting and admitted to a tertiary centre paediatric hospital from October 2015 to March 2021

<table>
<thead>
<tr>
<th>Year</th>
<th>Total number of patients presenting</th>
<th>Number of patients excluded</th>
<th>Total number of patients included</th>
<th>Total number of patients admitted</th>
<th>Mean length of overall admission (days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015–2016</td>
<td>509</td>
<td>325/509 (63.6%)</td>
<td>184/706 (93.7%)</td>
<td>216/477 (45.3%)</td>
<td>2.88</td>
</tr>
<tr>
<td>2016–2017</td>
<td>613</td>
<td>408/613 (66.5%)</td>
<td>205/736 (93.5%)</td>
<td>257/573 (42.9%)</td>
<td>3.86</td>
</tr>
<tr>
<td>2017–2018</td>
<td>746</td>
<td>135/746 (18.1%)</td>
<td>611/746 (81.9%)</td>
<td>262/811 (44.9%)</td>
<td>3.17</td>
</tr>
<tr>
<td>2018–2019</td>
<td>693</td>
<td>151/693 (21.8%)</td>
<td>542/693 (78.2%)</td>
<td>230/542 (42.4%)</td>
<td>2.80</td>
</tr>
<tr>
<td>2019–2020</td>
<td>759</td>
<td>40/759 (5.3%)</td>
<td>719/759 (94.7%)</td>
<td>342/719 (47.6%)</td>
<td>3.60</td>
</tr>
<tr>
<td>2020–2021</td>
<td>47</td>
<td>8/47 (17%)</td>
<td>40/47 (81.9%)</td>
<td>151/47 (32%)</td>
<td>1.14</td>
</tr>
</tbody>
</table>

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To cite Hussain F, Kotecha S, Edwards MO. Arch Dis Child 2021;106:e51.
Accepted 31 July 2021
Published Online First 19 August 2021
Arch Dis Child 2021;106:e51.
doi:10.1136/archdischild-2021-322835

ORCID iDs
Faris Hussain http://orcid.org/0000-0002-7840-6815
Martin Oliver Edwards http://orcid.org/0000-0002-7243-7039

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