Bronchiolitis is 1 of the most common causes of pediatric hospitalization and accounts for >$1.7 billion in hospital charges annually. The history of management of bronchiolitis in infants is a study in the reduction of unnecessary resources. Early in treating this disease, routine testing and ineffective therapies were common. Many of us recall the days of ubiquitous chest radiography, complete blood cell counts, albuterol, racemic epinephrine, and steroids. Many recall average lengths of stay of 5 days rather than perhaps 2.5 now. We have not entirely gotten away from that history. Although data show a lack of efficacy of these therapies and guidelines have reduced use, overtesting and overuse of interventions remain common. And we continue to employ new therapies before evidence demonstrates efficacy. For example, the use of high-flow nasal cannula has not been shown to impact length of stay or any resource use other than use of high-flow nasal cannula, yet we continue to broadly adopt it in the United States without robust evidence demonstrating benefit.

Although there have been considerable efforts to improve cost-effective care in the diagnosis and treatment of bronchiolitis through research and quality improvement, less attention has been paid to the costs of infection-control practices in hospitalized bronchiolitis patients. Many institutions have guidelines that require patients with bronchiolitis to be roomed with others who share the same causative pathogen, as assayed by respiratory viral pathogen (RVP) testing, on the basis of the logic that rooming patients with bronchiolitis who are infected with different viruses risks cross-infection. The cost of routine RVP testing is not insignificant, and it has been demonstrated that RVP testing lacks clinical value. Furthermore, cohorting presents significant logistic challenges, and there are no firm safety data supporting the need for this practice. Simplification of these cohorting practices has been shown to decrease unnecessary viral testing and reduce cost. Accordingly, cohorting patients with bronchiolitis on the basis of viral pathogen is an important source of potentially unnecessary hospital expenditure and effort and may increase emergency department wait time and delay hospital throughput.

In some cases, for instance, among adults with influenza, cohorting has been shown to be an effective manner of reducing nosocomial infection; however, to our knowledge, this has never been assessed in infants with bronchiolitis before.

In this issue of Hospital Pediatrics, Bekhof et al study this widespread belief that rooming patients with bronchiolitis caused by different viruses increases the probability of hospital-acquired infections (HAIs). In their prospective cohort study, they examined the hospital courses of 218 children admitted for acute bronchiolitis infection. RVP testing was performed, and all bronchiolitis patients were roomed at least 1.5 m apart with up to
testing, from both a pathophysiological and empirical perspective, seeks to mitigate an extremely low-incidence, low-level risk. That said, even with this evidence, we expect that many institutions will be reluctant to change their bronchiolitis cohorting policies. This is because it generally seems difficult to remove practices that are deemed safety enhancing (regardless of reality) because of parental pressures to keep their children away from others with other viruses and because of habit. That said, reluctance should not justify inaction. Routine practice to cohort patients on the basis of a test with questionable clinical relevance contradicts the basic principle of value-based medicine that treatment and policies should strive to optimize both quality of care and cost. It introduces waste from the under- and overuse of hospital resources (empty beds and needless provider and administrator shuffling of patients), increases direct costs from RVP testing expenses, and as found by Bekhof et al,9 has no effect on quality. Policy change should be seriously considered.

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