Reply to Anglemyer et al.

We fully agree with Anglemyer et al. that the SARS-CoV2 pandemic has and will continue to influence the epidemiology and evolution of respiratory infections globally. The exemplary data provided by Anglemyer et al. for respiratory syncytial virus (RSV) may also be reflective of potential developments for influenza, pertussis and pneumococcal epidemiology, for example concerning the low levels of influenza infections during recent influenza seasons [1,2]. With potential alleviation of social restrictions as well as SARS-CoV2 becoming seasonal, seasonal peaks in respiratory infections’ burden might be expected, including possible respiratory co-infections. Scarcity of hospital capacity, as exemplified currently by SARS-CoV2 in various countries, will pose serious challenges and optimized measures are required to prevent and control such outbreaks.

In addition to development of novel and improved respiratory vaccines, test-guided antiviral and other antimicrobial therapies and enhanced use of existing vaccines in vulnerable groups seem crucial to minimize the effects of winter infectious disease birdems. For example, high coverage rates of influenza vaccines and use of best options, such as high-dose formulations for older adults, are warranted [3]. The EU-project VITAL (Vaccines and Infectious disease in the Ageing Populations, No 806776) aims to improve vaccines, vaccination programs and other interventions for vulnerable adult groups, notably to avoid future seasonal peaks in respiratory infections, associated burdens and potential strains on hospital capacities [4].
References


