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Correspondence

An academic allergy unit during COVID-19 pandemic in Italy



To the Editor:

Recently, Codispoti et al¹ delineated the clinical and academic challenges that the coronavirus disease 2019 (COVID-19) pandemic raised at their Division of Allergy and Immunology. They rapidly coordinated a lot of stressful changes in established practices to meet academic and health care needs. Besides congratulating the authors for their promptness, we here share our experience in getting across the COVID-19 pandemic in our Allergy Clinic, at Humanitas Research Hospital in Milan, where the epidemic first started in Italy.

First, programmed checks only for severe and poorly controlled allergic disease were carried out on outpatients, who were instructed to come at a set time and to maintain social distancing. To reduce the risk of in-hospital spread of the infection, COVID-19 and COVID-19-free zones were created. Checkpoints were created at the COVID-19-free-zone entrance to detect patients with fever (>37.5°C) and to screen for symptoms of active infection and/or contact with COVID-19-positive individuals. When the risk was considered low, patients were provided with protective surgical masks and sanitized to access the hospital.

Conversely, mild-to-moderate well-controlled patients were transitioned to a digital medicine service including phone, video, and email consults.

The administration of biologicals was managed as follows. Omalizumab and benralizumab were self-administered at home. A service for drug home delivery was activated. Conversely, patients not able to self-administer the drug came to the center. Mepolizumab was diluted and administered by the attending physician on site. When patients lived far from our center, the Severe Asthma Network in Italy² was used to identify a local near-home center for in-site administration.

Clinical research has been threatened by the COVID-19 pandemic. New recruitments in ongoing clinical trials have been temporarily suspended. Nonetheless, we are now faced with the need for online trial visits. Sponsors were consulted on a near-daily basis to reassess follow-up visit schedules and amend protocol requirements to facilitate online visits. When possible, the investigation product home delivery service and digital medicine service were used to obtain scheduled questionnaires and monitor drug administration.

Academic activities were rescheduled, and only online interactive platforms were used to keep educational programs ongoing.

Finally, we underline that we preferentially prescribe sublingual immunotherapy (SLIT) for airborne allergens. This allowed us not to suspend SLIT because a very efficient drug home delivery service was used by our pharmacy. This has proved to be a fruitful advantage of SLIT over subcutaneous immunotherapy, in allowing our patients to adhere to allergen immunotherapy. As reported in a recent article,³ allergen immunotherapy should be temporarily discontinued during an active infection and this further adds value to SLIT because this practice is more malleable than subcutaneous immunotherapy.

In a technology-based society, modern health care systems can raise to the COVID-19 challenge by maximizing the potential of telemedicine to address the clinical needs of patients affected by chronic diseases. The COVID-19 pandemic will have a profound impact on modern medicine and is reshaping the patient-physician relationship. Which long-term effects will this produce on issues such as health care system sustainability, patients' adherence, big-data medicine, other big epidemics of our times, and physician burnout?

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Reply



To the Editor:

As the coronavirus disease 2019 pandemic is expanding globally, sharing experiences and strategies in different programs is an essential way to communicate and empower the global allergy/immunology community. The correspondence by Malipiero et al¹ on our recent article² in the *Journal* is a great example of such communications and is well appreciated.

This commentary shows how telemedicine has helped programs across the world to overcome the otherwise debilitating gap of communication between patients and physicians. In our division, although all faculty and fellows were trained emergently to perform virtual medicine, it took a few weeks to troubleshoot and maximize the potential of these modalities. These experiences suggest that training on the optimal use of virtual visits and telemedicine should be added to the educational curriculum of training programs and annual meetings on a regular basis. In this day and age, technology is an