







COVID-19 pandemic: Practical considerations on the organization of an allergy clinic—An EAACI/ARIA Position Paper

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Abbreviations: AAAAI, American Academy of Allergy, Asthma and Immunology; ACT, asthma control test; AD, atopic dermatitis; AIT, allergen immunotherapy; AR, allergic rhinitis; ARIA, Allergic Rhinitis and its Impact on Asthma; BAD, British Association of Dermatologists; BAL, bronchoalveolar lavages; BSL, biosafety level; COVID-19, coronavirus disease 2019; CRF, case report form; CRS, chronic rhinosinusitis; CRSwNP, chronic rhinosinusitis with nasal polyps; CRU, clinical research unit; DMZ, demilitarized zones; EAACI, European Academy of Allergy and Clinical Immunology; ECDC, European Centre for Disease Control; EHR, Electronic Health record; EMA, European Medicines Agency; ENT, ear, nose and throat; EPIT, epicutaneous immunotherapy; ERS, European Respiratory Society; ETFAD, Task Force on Atopic Dermatitis; FDA, Food and Drug Administration; FFP, filtering face-piece particles; GCP, good clinical practice; GDPR, General Data Protection Regulation; GINA, Global Initiative for Asthma; HCP, healthcare providers; ICS, inhaled corticosteroids; ICU, intensive care unit; IEC, institutional ethic committee; INCS, intranasal corticosteroids; IP, investigational product; IRB, institutional review board; ISOA, isolated onset of anosmia; IT, information technology; MDM, multidisciplinary meetings; OCS, oral corticosteroids; OIT, oral immunotherapy; PAPRs, powered air-purifying respirators; PBMC, peripheral blood mononuclear cells; PEF, peak expiratory flow; pMDI, pressurized metered-dose inhaler; SCIT, subcutaneous AIT; SCS, systemic corticosteroids; SLIT, sublingual AIT; SP, standard precautions; WHO, World Health Organization.

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Abstract

Background: The coronavirus disease 2019 (COVID-19) has evolved into a pandemic infectious disease transmitted by the severe acute respiratory syndrome coronavirus (SARS-CoV-2). Allergists and other healthcare providers (HCPs) in the field of allergies and associated airway diseases are on the front line, taking care of patients

potentially infected with SARS-CoV-2. Hence, strategies and practices to minimize risks of infection for both HCPs and treated patients have to be developed and followed by allergy clinics.

Method: The scientific information on COVID-19 was analysed by a literature search in MEDLINE, PubMed, the National and International Guidelines from the European Academy of Allergy and Clinical Immunology (EAACI), the Cochrane Library, and the internet.

Results: Based on the diagnostic and treatment standards developed by EAACI, on international information regarding COVID-19, on guidelines of the World Health Organization (WHO) and other international organizations, and on previous experience, a panel of experts including clinicians, psychologists, IT experts, and basic scientists along with EAACI and the “Allergic Rhinitis and its Impact on Asthma (ARIA)” initiative have developed recommendations for the optimal management of allergy clinics during the current COVID-19 pandemic. These recommendations are grouped into nine sections on different relevant aspects for the care of patients with allergies.

Conclusions: This international Position Paper provides recommendations on operational plans and procedures to maintain high standards in the daily clinical care of allergic patients while ensuring the necessary safety measures in the current COVID-19 pandemic.

KEYWORDS

allergen immunotherapy, allergy clinic, anaphylaxis, asthma, clinical trials, COVID-19, Position Paper, psychological impact, SARS-CoV-2

1 | INTRODUCTION

On March 11, 2020, the World Health Organization (WHO) declared the “*coronavirus disease 2019* (COVID-19)” as a pandemic viral disease. Since the first transmission dynamics reported in China,¹ the number of infected patients and fatalities have been increasing worldwide.² Typical symptoms of COVID-19 include general malaise, fever, respiratory problems and especially cough and shortness of breath. The clinical pattern differs somewhat from other airway diseases (Table 1).















Other symptoms include muscle and joint pain, sore throat, headache, nausea or vomiting, diarrhoea, nasal symptoms and especially smell and taste dysfunction. In about 80% of the registered cases, the disease shows a milder and transient course. However, in about 5% of patients, admission to the intensive care unit (ICU) is necessary due to hypoxaemia and extensive pneumonia, frequently resulting in respiratory failure due to severe acute respiratory syndrome, frequently accompanied by coagulopathy and pulmonary embolism and the involvement of other organs including kidney, heart and the central nervous system.^{2,4,5} Preventive measures have been implemented worldwide to adjust ambulatory health services and decrease direct patient contacts to a minimum. However, until now, there is no clear advice on how to manage allergic patients with co-morbid COVID-19

or non-SARS-CoV-2-infected allergic patients during the ongoing pandemic.⁶ The European Academy of Allergy and Clinical Immunology (EAACI), in alliance with the global initiative “Allergic Rhinitis and Its Impact on Asthma” (ARIA), has published several recommendations and assessments in the field of allergic diseases such as allergic rhinoconjunctivitis (ARC), allergic asthma and others⁷ regarding pharmacotherapy, allergen immunotherapy (AIT), biological treatment and others.^{5,8-18}

As allergists and other healthcare providers (HCPs) with a focus on allergic diseases frequently treat patients with manifestations of atopic disease in the upper and lower airways, they are on the front line in caring for patients potentially infected with SARS-CoV-2. As such, the clinical setting in an allergy outpatient clinic or hospital must ensure optimal care for the patients as well as sufficient prophylactic measures to minimize risks of infection for both the medical personnel and the patients requiring treatment, as reported in an academic allergy centre initiative.¹⁹ Therefore, clinical procedures in allergy clinics and outpatient practices must be optimized and standardized, within the contextual considerations regarding national regulations.²⁰

The aim of this Position Paper—prepared by EAACI in collaboration with ARIA—is to provide allergy clinics, specialized centres and practices with practical recommendations on measures for daily practice and optimal care for allergic patients during the current COVID-19 pandemic. These recommendations are grouped into nine sections (key

TABLE 1 Differences and similarities in the clinical pattern of COVID-19, common cold, flu, allergic rhinitis, chronic rhinosinusitis and allergic asthma (modified from³)

Symptoms	Coronavirus* (COVID-19) Symptoms range from mild to severe	Cold Gradual onset of symptoms	Flu Abrupt onset of symptoms	Seasonal allergies Abrupt onset of symptoms	Chronic rhinosinusitis	Allergic asthma
 Length of symptoms	7-25 days	Less than 14 days	7-14 days	Several weeks	Months	Several weeks or months (when caused by seasonal allergens) or persistent (when caused by perennial allergens)
 Cough	Common (usually dry)	Common (mild)	Common (usually dry)	Rare (usually dry unless it triggers asthma)	No	Common
 Shortness of breath	Sometimes	No**	No**	No**	No	Common
 Wheezing	Rare	No	Sometimes	Sometimes	No	Common
 Sneezing	No	Common	No	Common	Sometimes	No
 Runny or stuffy nose	Rare	Common	Sometimes	Common	Common	No
 Smell dysfunction	Common	Common	Common	Sometimes (in severe cases)	Common	Sometimes (in severe cases)
 Taste dysfunction	Common	Sometimes	Sometimes	Rare	Rare	Rare
 Sore throat	Sometimes	Common	Sometimes	Sometimes (usually mild)	Sometimes	No
 Fever	Common	Short fever period	Common	No	Common in acute exacerbations	No
 Feeling tired or weak	Sometimes	Sometimes	Common	Sometimes	Common	Sometimes
 Headaches	Sometimes	Rare	Common	Sometimes (related to sinus pain)	Common	No
 Body aches and pains	Sometimes	Common	Common	No	No	No
 Diarrhea	Sometimes	No	Sometimes for children	No	No	No

* Information is still evolving. ** Allergies, cold and flus can all trigger asthma, which can lead to shortness of breath.

Sources: Asthma and Allergy Foundation of America, World Health Organization, Centers for Disease Control and Prevention

TABLE 2 Key conclusions on the practical considerations on the organization of an allergy clinic during the current COVID-19 pandemic

Section	Key conclusions
COVID-19: general considerations for HCPs	Protective measures should be taken following the general recommendations from the European Centre for Disease Control and the World Health Organization, and current rules must comply with the national responsible government agencies.
COVID-19: clinical course in allergic patients	Viral infections, including infections with coronaviruses, are associated with aggravation of allergies such as asthma exacerbations. Limited knowledge is available on the differences in the course of COVID-19 infection in allergic compared with nonallergic patients, and further clinical evidence is needed.
Care of allergic patients: preclinical setting and triage of patients	Many clinics and medical offices already use remote healthcare tools to triage and manage patients outside the consultation hours and as part of usual practice. These measures can ideally be used to prioritize and triage allergic patients on the basis of the severity of the allergic disease, the need for in-person consultation and the differentiation of allergic symptoms from clinical symptoms of COVID-19.
Challenges and chances of information technology (IT)	Digital health solutions, especially the use of telemedicine, have been previously proposed as a useful tool to provide medical advice remotely when physical presence is impossible or should be limited to a strict minimum, such as in the current COVID-19 pandemic. However, certain limitations of this technology need to be considered and special emphasis should be placed on data security and data protection.
Clinical setting	General hygiene rules should be followed, especially in the preclinical and clinical setting. The entrance, which is the first point of contact, patient traffic and the triage of allergic patients should be organized to minimize the risks of viral infection. Moreover, the organization of staff should be optimized and regular training of procedures should be provided. Any physical contact with the patient should be minimized, and effective preventive measures carried out for any further examination and diagnostic.
Specific considerations in diagnostic procedures in allergic patients	Specific considerations in a clinical setting are necessary for the diagnostic procedures of different allergic diseases during the current pandemic. As SARS-CoV-2 spreads primarily through respiratory aerosols, airways but also other allergy-related organs are affected, and preventive measures should be ensured. These comprise ENT examinations (including endoscopy), bronchoscopy, nasal or bronchial allergen provocation tests, tissue sampling, lung function tests, skin testing, blood sample collection, drug provocation tests, oral food challenges and oesophageal examinations.
Specific considerations in the management of different allergic diseases	Though avoidance measures during the COVID-19 pandemic are similar in different allergic diseases, specific aspects should also be followed with optimal care for allergic rhinoconjunctivitis, asthma, atopic dermatitis, chronic rhinosinusitis, drug allergy, food allergy, urticaria and venom allergy. Different recommendations can be provided for patients with suspected SARS-CoV-2 infection or diagnosed COVID-19 disease versus noninfected individuals or patients having recovered from COVID-19 infection. After recovery from COVID-19, allergy care has to be resumed, but an interdisciplinary consultation is recommended before any further diagnostic or therapeutic procedure.
Socio-psychological considerations for allergic patients and optimal care during and after the pandemic	Socio-psychological mechanisms play a major role in terms of symptom development, symptom exacerbation and perception in allergic patients. Besides, the general population is highly sensitive to the perception of people showing respiratory symptoms during the COVID-19 pandemic. This increases the risk of stigmatization of patients with allergies, further enhancing the psychosocial stress of patients. Therefore, optimal medical and psychological care for patients with allergies during the COVID-19 pandemic is essential.
Considerations for performing non-COVID-19-related clinical trials	Clinical trials to combat the COVID-19 pandemic currently have top priority. However, a number of non-COVID-19 trials are also essential and should be continued if they can be conducted in a safe manner. Safety measures and new guidelines need to be established for participants, and research/laboratory staff dealing with non-COVID-19-related clinical trials, to ensure the continuation of essential and critical non-COVID-19 trials.

conclusions in Table 2) as elaborated by experts including clinicians, psychologists, information technology (IT) experts and basic scientists in the field of allergy. These recommendations are conditional and should be adapted regularly on the basis of evolving clinical evidence.

2 | COVID-19: GENERAL CONSIDERATIONS FOR HCPs

Viral respiratory infections such as COVID-19 are most often transmitted by direct contact with the virus from the nose, mouth or coughed/sneezed in droplets from an infected individual.^{2,21} Hand-to-hand contact, inhaling particles from the air after an infected

person has coughed or sneezed and touching an infected surface are also common transmission mechanisms. Recommendations for allergic patients—just as for all subjects—include thorough handwashing with soap and water, frequent use of hand sanitizers, avoidance of people with cold-like symptoms and taking prescribed medications to optimally control upper and/or lower airway disease.

Patients with a suspected or confirmed diagnosis of COVID-19 should wear a face mask²² and be treated and examined in an individual room with the door closed. Ideally, an isolation room should be used and equipped with technical measures to protect against airborne infectious agents.^{2,21}

HCPs are at risk of contracting COVID-19, primarily through droplet spread, with the droplets containing a high reservoir of viral

load.²³ If any procedures involving the airway are strictly necessary for COVID-19-positive patients, it must be ensured that staff are supplied with the necessary personal protective equipment in order to avoid infection and possible fatalities. Filtering face-piece (FFP2/FFP3) masks, full eye protection or PAPRs (powered, air-purifying respirators) and further measures are recommended.²⁴

In accordance with WHO²⁵ and the European Centre for Disease Control (ECDC²⁶), the following preventive measures are recommended:

- keep a distance of at least 1.5-2 m from other people (social distancing)
- promote compliance with general hygiene measures such as regular hand disinfection (using an effective disinfectant)/handwashing for at least 30 seconds, avoid touching your face and mucous membranes with your hands
- minimize social contacts (social distancing)
- limit direct patient contacts to a strict minimum
- wear personal protective clothing
- encourage regular surface disinfection, especially door handles, etc.

2.1 | Conclusions

Protective measures should be taken following the general recommendations from the European Centre for Disease Control and the World Health Organization, and current rules must comply with the national responsible government agencies.

3 | COVID-19: CLINICAL COURSE IN ALLERGIC PATIENTS

Coronaviruses, just like the common cold viruses, may be associated with aggravation of asthma exacerbations²⁷ by stimulation of type 2 immune response-associated cytokine production in infected epithelial cells.²⁸ Allergic diseases might predispose to viral infections or a deferred viral clearance due to delayed and deficient production of the innate type I and type III interferons and/or deficient epithelial barrier function.^{29,30}

Until now, limited knowledge has been available on the differences in the course of COVID-19 infections in allergic compared with nonallergic patients. Three studies from Wuhan reported allergic diseases (asthma, allergic rhinitis, atopic dermatitis, urticaria or drug hypersensitivity) as co-morbidities of COVID-19 patients.^{5,8,31} In a study from Lombardy including over 1500 patients, 13% of COVID-19 patients admitted to intensive care had asthma.⁴ In none of these studies, a prolonged or aggravated disease course was reported for patients with allergic disease compared with the included nonallergic cases. In COVID-19 patients from the Seattle area, 3 out of 24 patients developed severe respiratory failure after systemic

glucocorticoid treatment due to asthma exacerbation.³² In the United States, higher asthma rates were found in COVID-19-hospitalized adult patients, especially those between 18 and 49 years. However, no information was available as to whether the asthma was caused by allergies.³³ A recent preliminary report suggested modulation of ACE-2 receptor levels by type 2 inflammation, which might shed new light on the role of type 2 immunity in SARS-CoV-2 infections and the COVID-19 disease course.³⁴ Without any doubt, more scientific evidence is needed to answer the question as to whether allergic diseases or the treatment of allergic diseases might predispose patients to COVID-19 development and disease course.

3.1 | Conclusions

Viral infections, including infections with coronaviruses, are associated with aggravation of allergies such as asthma exacerbations. Limited knowledge is available on the differences in the course of COVID-19 infection in allergic compared with nonallergic patients, and further clinical evidence is needed.

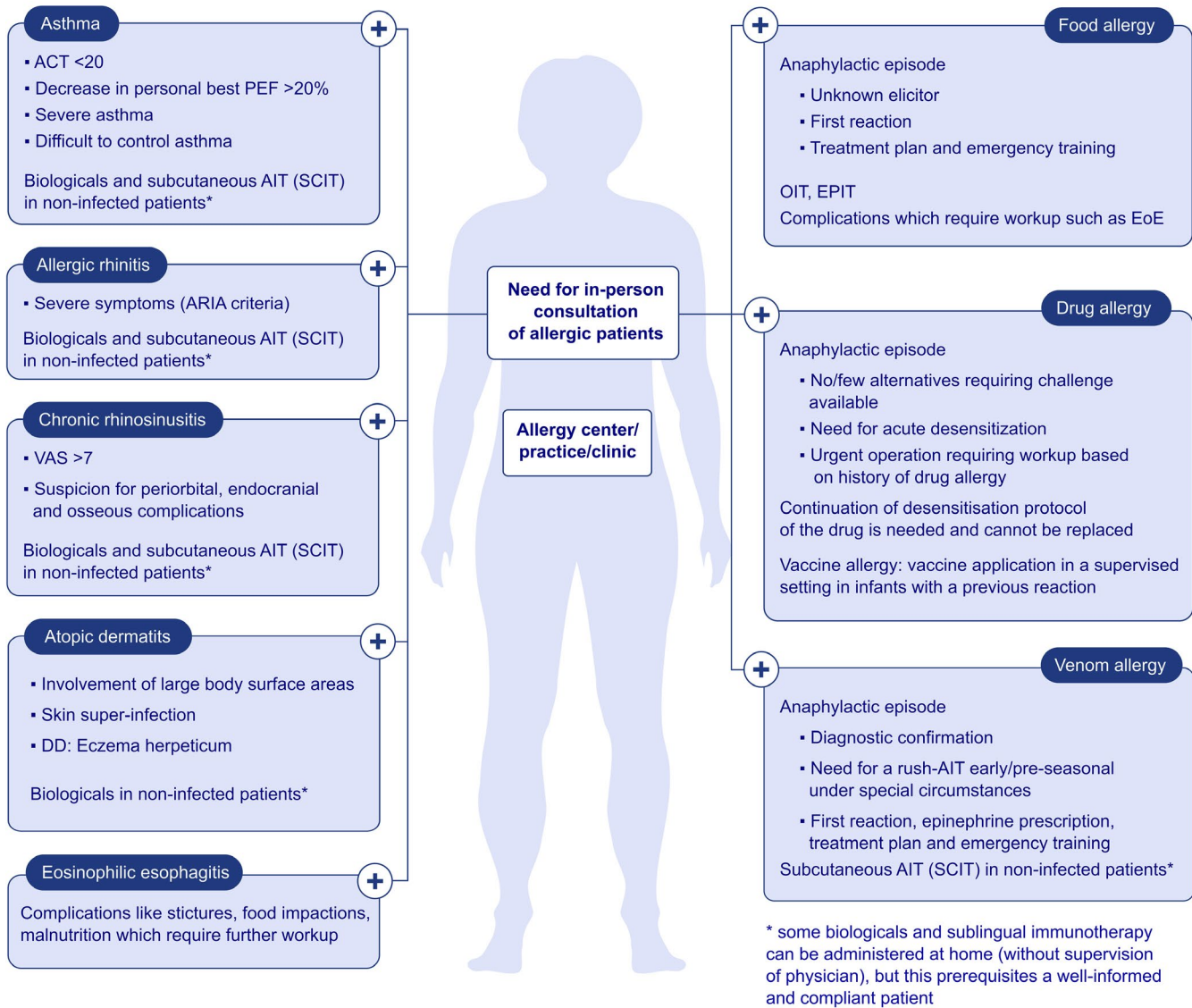
4 | CARE OF ALLERGIC PATIENTS: PRECLINICAL SETTING AND TRIAGE OF PATIENTS

Provision of the appropriate level of necessary medical care for patients with allergic diseases and asthma needs to be based on the following principles:

1. Delay elective ambulatory provider visits
 - a. Assess the patient's ability and resources to engage in home monitoring
 - b. Select the patients needing direct consultation via proper screening protocols
 - c. Reschedule any nonessential procedures that might impact on the safety of the patient and the HCP (eg, lung function testing, airway samplings, rhinoscopy, surgery, drug/food/venom provocation tests)
2. Implement remote healthcare tools

Many clinics and medical offices already use these remote healthcare tools to triage and manage patients outside the consultation hours and as part of usual practice. However, there are several core procedures that need to be taken into account. Primarily, sufficient numbers of healthcare providers (HCPs) should be identified to conduct telephone and telehealth interactions with patients to identify COVID-19 symptoms. They should be assigned and followed by proper advice on the basis of the differentiation of COVID-19 symptoms from those due to the common cold, flu, allergic rhinitis, chronic rhinosinusitis and allergic asthma (Table 1). For this purpose, telemedicine is a useful instrument, but should be provided by a dedicated HCP^{35,36} strictly following the general

Pre-assessment for likelihood of COVID-19 → Triage accordingly

**Relevant for all diseases**

- Consider severe psychological disturbance due to symptoms: evidence for socio-psychological impairment and suicide risk (section "Socio-psychological considerations for allergic patients and optimal care during and after the pandemic")
- Evidence for incorrect usage of prescribed medication and non-adherence, which requires in-person training
- These recommendations are primarily for patients with severe clinical phenotypes who do not have the capacity to interact in a virtual setting

FIGURE 1 Proposed criteria for in-person consultation of allergic patients. These recommendations should be considered as general guidelines that always need to be adapted to suit the needs of individual patients, the capabilities of the facility itself and must comply with the relevant and current rules from the responsibility government agency. ACT, asthma control test; AD, atopic dermatitis; ARIA, Allergic Rhinitis and its Impact on Asthma; AR, allergic rhinitis; CRS, chronic rhinosinusitis; EOE, eosinophilic esophagitis; EPIT, epicutaneous immunotherapy; PEF, peak expiratory flow; OIT, oral immunotherapy; SCIT, subcutaneous AIT

prerequisites of information technology (Section 5). The triage of urgent cases is highly important to determine those needing in-person consultation and diagnostic procedures and those who can be managed effectively via telemedicine or scheduled for later

dates. However, this important triage should not be undertaken by a medically untrained call centre operator. Individual demands for allergy testing need to be evaluated by experienced nurses or doctors with dedicated skills in taking an allergological history.³⁶ The

technique of documenting allergological history in telemedicine follows generally accepted principles of medical conversation. Standardized and validated questionnaires for quantifying symptoms can complement the analysis of the history, be prefilled by the patient before telemedicine consultation, document the collected data and facilitate computer-assisted evaluation.³⁷ Patients with a clear need for in-person consultation in the allergy clinic (Figure 1) should be identified, triaged to the clinic and instructed on the procedures to be followed in the clinic.

For milder forms, patients should be offered alternative solutions whenever possible to avoid any unnecessary risks associated with a real-life consultation, for example shipping electronic inhalation monitoring devices, peak-flow metres and providing prescriptions for medication (see section "clinical setting"). In particular, allergic patients with mild symptoms regularly attending the outpatient clinic should be instructed to continue their medication as prescribed (inhaled corticosteroids (ICS), intranasal corticosteroids (INCS), AIT and biologicals targeting the T2 immune response). Whenever possible, on-site administration in clinics for sublingual AIT and biologicals should be replaced by (self)-administration at home with close monitoring, and sufficient supplies of medication should be provided. Local community organizations and health services could be engaged to assist patients who are treated at home and who may need support services in order to ensure optimal care. In some cases, trained clinic nurses can assist by telephone. Additionally, these patients should be well-instructed regarding proper prevention measures for allergen exposure control, for example using peak-flow measurements or apps,³⁸⁻⁴⁰ and food avoidance⁴¹ (especially with online ordering and shipping where no individual selection of food is feasible). They should also be motivated to notify their HCPs in the case of exacerbation or deterioration of symptoms which cannot be appropriately managed at home.

4.1 | Conclusions

Many clinics and medical offices already use these remote healthcare tools to triage and manage patients outside the consultation hours and as part of usual practices. These measures can ideally be used to prioritize and triage allergic patients on the basis of the severity of the allergic disease, the need for in-person consultation and the differentiation of allergic symptoms from clinical symptoms of COVID-19.

5 | CHALLENGES AND CHANCES OF INFORMATION TECHNOLOGY (IT)

Combining the need for regular consultations and the highest degree of protection for both patients with allergic conditions and healthcare workers is a significant challenge in the current pandemic. Digital health solutions, especially the use of telemedicine, have been previously proposed as a useful tool to provide medical advice remotely when physical presence is impossible.^{36,42-44} These

technologies are now significantly gaining momentum.⁴⁵ However, certain limitations need to be considered.

As such, electronic health records (EHRs) have now been adopted by most major healthcare organizations. They facilitate remote access and offer greater flexibility than paper-based medical records, a factor that is particularly important during the major clinic restructuring that is occurring during the current COVID-19 pandemic. Here, we discuss some of the online tools and apps that can aid researchers, clinicians and other healthcare staff in working with each other (team communications) and with patients (clinical encounters) while working at different locations.

5.1 | Cybersecurity

Every Internet connection to other communication partners also involves a certain risk. Normally, clinical and company IT networks are secured from external networks—for example the Internet—by a complex security infrastructure such as firewalls, separate security zones (DMZ = demilitarized zones), web content filters, intrusion detection systems and virus scanners. These systems protect internal clinical networks and also protect from hacker attacks and insecure processes from the Internet.

If a videoconferencing system has security gaps, the "own network" can become compromised, up to the installation of malware. A few weeks ago, the US Federal Bureau of Investigation (FBI) issued a warning on the security gaps in videoconferencing systems.⁴⁶ Security gaps were discovered in the popular communication platform ZOOM ("Zoom vulnerability would have allowed hackers to eavesdrop on calls"⁴⁷). The use of dedicated computers only for this purpose - operated in a separately secured DMZ - is recommended for videoconferencing.

5.2 | Data protection and legal regulations

The use of messenger and/or video services in the healthcare sector is particularly worrying from a data protection perspective. It is a classic area handling particularly "sensitive" and protected data. The processing of healthcare data is even prohibited for the time being according to Art. 9 Para. (a) of the General Data Protection Regulation (GDPR).⁴⁸ Exceptions to this may be for data processing, insofar as processing is necessary for medical diagnostics, care or treatment in the health or social field. Exceptions may be possible according to Art. 9 Para. (b) of the GDPR.⁴⁸

In this context, it should be noted that:

- When using videoconferencing apps, the terms and conditions and privacy policies of the providers must be observed.
- Usage should be conducted in compliance with institution-specific policies and country-specific laws.
- Most of these apps prohibit commercial use of the service without a separate agreement. This may call into question the lawful use of these apps for healthcare communications.

- If the user agrees to the terms and conditions of the apps, he/she often grants the manufacturers of the apps the rights of use of the transferred data, images, etc. When transmitting personal data, this means a violation of the basic data protection regulation and, if applicable, of medical confidentiality, since unauthorized third parties have access to these data.⁴⁹

5.3 | Team communication

Commonly used team communication applications include Microsoft Teams,⁵⁰ Zoom,⁵¹ Box,⁵² WhatsApp⁵³ and Slack⁵⁴ (Table 3). However, these services should not be used for talking about sensitive health data of identifiable persons, but only for team organizational matters.

Easy accessibility, reliability, videoconferencing, private messaging, creation of distinct channels for relevant discussion and privacy are all important considerations. There exist popular tools that enable online videoconferencing, screen sharing, chats and file sharing. Only the apps approved by the hospitals' legal department should be used. They can be used for small teams or for larger and more formal meetings, such as weekly unit meetings covering inpatient activity

and consultations with relevant educational background. Postclinic multidisciplinary meetings (MDM) remain achievable and desirable to ensure that best practice standards are met and can be hosted on "Teams." Another popular tool is "Box," where private health information can be stored and the password encrypted. Folders and documents can be shared, and different levels of access can be provided. Document versions can be managed and archived in an easily accessible and convenient manner. There are also a number of cell phone apps that can be used to communicate with smaller groups. In addition to individually-owned cell phones, additional cell phones can be shared by members of nursing and administration staff. Office phones can be forwarded to these "hot" phones. Call forwarding between cell phones should be utilized based on a roster for receiving incoming calls.

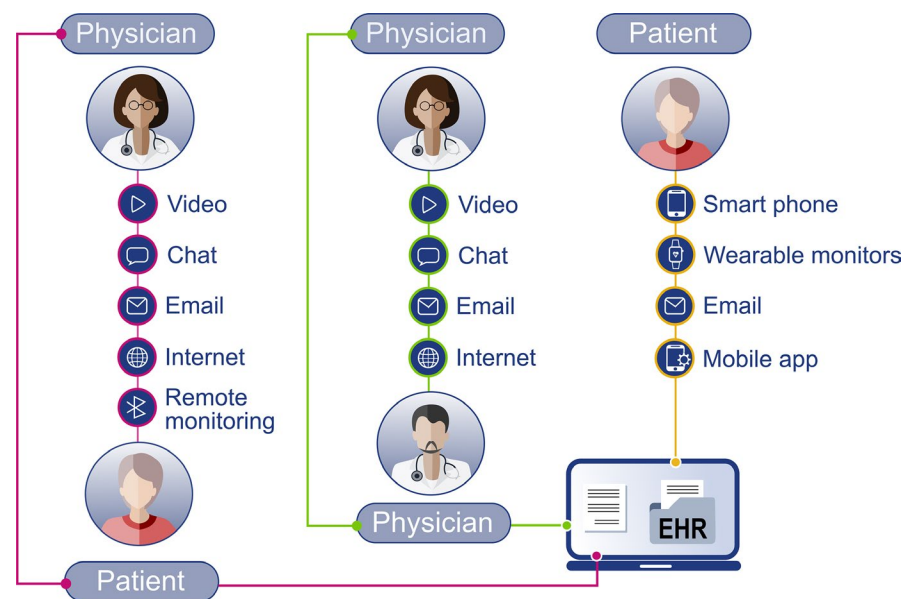
Many of these tools allow the generation of distinct channels to capture relevant discussions and to ensure patient follow-up. These can include clinic-specific channels to capture the logistics of billing, scheduling, rebooking and deferring patients, as well as patient-specific channels to capture follow-up required by nurses and doctors. For all channels, the ability to "tag" staff and reply to comments can be utilized.

TABLE 3 Commonly used team communication applications

Communication Activity	Technology
Team communications	Microsoft Teams, Zoom, Box, WhatsApp, Slack
Educational forums	Zoom, Microsoft Teams
Patient encounters/communication	Telephone, messenger services ^a , secure email, Telemedicine (Amwell, Doctor on Demand, Healthtap, MDLive, Teladoc, Zocdoc, Video visits via EHR and others)
Research/quality initiatives	REDCap, Box, R markdown

^aThe use of these services for patient communication is only lawful in the case of very well-informed written consent of the patient who must be aware of any risks.

FIGURE 2 Remote communication between the HCP and the patient. EHR, electronic health record



5.4 | Clinical encounters

Virtual doctor consultations as an alternative to on-site clinical encounters are increasing amid the coronavirus pandemic. Patient communications can take place via telephone, telemedicine/video, secure email and texting apps (Figure 2).

Video visits with a virtual care environment within the EHR platform are also being offered.⁵⁵ It is recommended that an approved, certified procedure should be used for the patient-related video consultation. These are subject to the respective legal regulations in the individual countries. It is important that the patient should be informed and should give his/her consent for the video consultation. This must be documented in order to have legal security in the case of complaint by the patient. Furthermore, it is important to have a direct "peer-to-peer" connection between the doctor's video workplace and the patient's workplace in order to prevent unauthorized third parties from recording the video stream. Corresponding security aspects must be taken into account (see also "cybersecurity").

5.5 | Conclusions

Digital health solutions, especially the use of telemedicine, have been previously proposed as a useful tool to provide medical advice remotely when physical presence is impossible or should be limited to a strict minimum, such as in the current COVID-19 pandemic. However, certain limitations of this technology need to be considered and special emphasis should be placed on data security and data protection.

6 | CLINICAL SETTING

6.1 | Public transport to and from a COVID-19 hospital

Transportation to and from the hospital should follow common healthcare recommendations. Public transport should have clear signs that it is going to the COVID-19 specialty hospital. At the final stop, the bus should be thoroughly disinfected. The driver's seat should be protected by a transparent plastic wall, and the patients should be at least 2 metres away.⁵⁶ The front door of the bus should not open for passengers; only the middle and back doors should be used.

6.2 | General hygiene rules

SARS-CoV-2 is an enveloped virus, which means it is susceptible to common hard-surface disinfectants such as soap and alcohol. Hand sanitizers should be provided in every patient room (ideally both inside and outside), in other patient care and common areas, and at all entrances to the building. Sinks should be well-stocked with soap and paper towels. High-touch surfaces,

such as door handles, need to be regularly cleaned with hospital grade-approved disinfectant solutions or diluted bleach.

6.3 | Entrance to the clinic

A hospital should have only two entrances for the patients: one for emergencies and one for nonemergencies. The emergency entrance should have full patient isolation equipment. The triage doctor should immediately determine the need for full isolation of the patient. Patients who present with an acute respiratory illness and require hospital admission should be tested for SARS-CoV-2 RNA expression by RT-PCR on admission and placed in isolation until the results are ready.⁵⁷ Health care, cleaning and kitchen staff should all use a separate entrance. The entrance should be near the dressing rooms with two doors. At the nonemergency entrance to the hospital, masks and gloves should be provided for anyone who enters and it should be obligatory to wear these items. Visitors should be actively discouraged from entering the hospital if possible and in line with local recommendations. Outpatients should be pre-assessed and triaged accordingly (see Section 4). Patients should wear a surgical mask and gloves, and perform strict and repeated hand hygiene. A separate toilet/bathroom/commode should be used for virus RNA RT-PCR-positive patients.

6.4 | Staff organization

In order to reduce the risk of the healthcare workers becoming infected, which would result in service disruption, new forms of staff deployment need to be elaborated. The personnel in the triage area should wear a FFP2/3 mask as well as a face shield, goggles, gown, gloves and closed shoes.

A two-team approach has been adopted in many large hospital-based departments with no or minimal contact between the two teams. A popular method involves:

1. "Team 1": inpatient COVID-19 deployment including consultant, senior registrar and junior medical officer. Several such groups could form a roster depending on unit and hospital size.
2. "Team 2": outpatient allergy/asthma/immunology predominantly operating a virtual call centre approach and ideally remotely operating in staff homes.

A designated deputy head of department and subleads for allergy/asthma/immunology provide a backup framework for key personnel in the case of staff infection requiring substantial self-isolation and resulting in workforce disruption. In COVID-19 patient-overloaded clinics, day and night shifts can be decreased to 6 hours in order to avoid extreme fatigue and thus reduce the risk of HCP errors and infection. Moreover, there is an urgent need for staff training resources and mechanisms to ensure a constant re-training of the most important policies. This regular training has to involve all of the staff members.

6.5 | Patient organization

Any service that does not require a diagnostic or on-site therapeutic procedure should be undertaken via telemedicine consultation.⁵⁸

For regular nonacute care: only patients requiring a timely diagnostic or therapeutic procedure should be seen in the hospital. A history of identifying potentially infected contacts, recent travel and early symptoms such as anosmia and dysgeusia^{59,60} should be obtained from all patients before any in-person consultation in the clinical setting.⁶¹ There is now ample evidence that COVID-19 may be contagious before the onset of the classical symptoms of cough and high fever.⁸ Therefore, identifying the early symptoms of COVID-19 is of particular importance and is a health system priority. Recently, a probable association between COVID-19 and altered olfactory and gustatory function has been reported by several groups, often as the presenting symptom.^{60,62} To evaluate whether this could be a first symptom of COVID-19 can be particularly challenging when treating allergic and rhinosinusitis patients.

Establishing COVID-19-free zones in the hospital includes a strict screening protocol to ensure that patients who are entering the clinic are not infected by COVID-19.

Patients who have indications of potential COVID-19 infection (classical COVID-19 symptoms, fever, but also anosmia, and/or recent contact with a COVID-19-positive subject) should not be admitted to these areas.⁶³ These patients should be guided to the COVID-19 clinic for further screening evaluation.

To decrease the density of patients, the waiting area should be separated from the treatment area and the number of appointments reduced. Appointments should be scheduled with ample time intervals and online consulting services should be available whenever possible.⁶⁴

Precise appointment times are particularly important during the COVID-19 pandemic as this can greatly reduce patient-patient and patient-HCP hospital-acquired cross-infections. Also, precise appointments can ensure that patients stay in the hospital for a minimum amount of time and that the medical staff are fully prepared with personal protective equipment. Moreover, the patient should be admitted to a consulting room with good ventilation, and, at the same time, there should not be more than one patient in the waiting area for visiting or for postimmunotherapy observation.

6.6 | In the consultation room

All physical contact with the patient should be limited to a strict minimum. When caring for a patient with suspected COVID-19, staff are recommended to wear a gown, gloves and either an FFP/FFP2 (or local equivalent) respirator plus face shield and goggles, or a powered air-purifying respirator. However, in hospital areas outside potential SARS-CoV-2-contaminated zones, there is conflicting advice on the necessary level of personal protective equipment (even when available), and evidence-based recommendations are scarce. Gloves and face masks²² may be considered for use near entrances and in

common areas. Personal protective equipment should be available at the entrance of patient rooms and in other areas where patient care is provided. Signs at the entrance of patient rooms should clearly indicate the level of personal protective equipment required.

Diagnostic procedures involving upper airway manipulation such as anterior rhinoscopy and, even more, nasal endoscopy, or nasal provocation, should be considered as high risk of viral transmission. These procedures should therefore be limited to patients with an urgent need of examination during the initial phase of the COVID-19 outbreak. For further details, see nasal endoscopy during COVID-19.²⁴

6.7 | Conclusions

General hygiene rules should be followed, especially in the pre-clinical and clinical setting. The entrance, which is the first point of contact, patient traffic and the triage of allergic patients should be organized to minimize the risks of viral infection. Moreover, the organization of staff should be optimized and regular training of procedures should be provided. Any physical contact with the patient should be minimized, and effective preventive measures carried out for any further examination and diagnostic.

7 | SPECIFIC CONSIDERATIONS IN DIAGNOSTIC PROCEDURES IN ALLERGIC PATIENTS

The following sections overview the specific considerations for diagnostic procedures in different allergic diseases in a clinical setting during the current pandemic. The indication and the urgency for these tests should be taken into account and can be confirmed, for example, by an initial visit performed via telemedicine. Contraindications for skin tests, provocation tests and lung function tests can be clarified, and this can help to avoid unnecessary in-person consultations with patients during the COVID-19 pandemic.

7.1 | ENT examination, nasal provocation testing and sampling procedures

SARS-CoV-2 spreads primarily through respiratory aerosols, and higher viral loads have been detected in nasal swabs compared with other locations.⁶⁵ Thus, rhinoscopy, nasal endoscopy, nasal provocation testing, smell and taste testing and samplings are high-risk procedures. Nasal provocation tests should be avoided, whereas rhinoscopy, endoscopy and nasal samplings should be limited to patients with an urgent need for examination.⁶⁴ A tower with camera, screen and light source can maximize the examiner-patient distance during endoscopy.²⁴ The use of anaesthetic spray can be replaced by a soaked pledget, thus avoiding virus atomization.²⁴ The examiner should wear the adequate personal protective equipment

recommended for HCPs: FFP2 or FFP3 face mask, goggles or disposable face shield covering the front and sides of the face, clean gloves and clean isolation gown.⁶⁶

7.2 | Lung function testing, bronchoprovocation tests and lower airway sampling

Aerosols can be generated during spirometry, bronchoprovocation testing, fractionated exhaled nitric oxide (FeNO) measurement and other lower airway sampling procedures.⁶⁷⁻⁶⁹ Therefore, routine lung function testing and related procedures should be generally suspended during the current pandemic. In cases of extreme need, the personnel should use personal protective equipment and follow the other safety measures as described above.^{66,70}

7.3 | Skin testing and blood sample collection for diagnostic use

Skin testing should be generally suspended during the current pandemic. Nevertheless, exceptions can be considered after a careful/proper risk-benefit assessment or may be replaced by laboratory tests. When collecting biological samples or conducting skin testing, the personnel must use the recommended personal protective equipment⁶⁶ and also follow the standard precautions (SP) when handling clinical specimens, all of which may contain potentially infectious materials.⁷¹ In this case, a laboratory gown and a single-use waterproof apron may replace the isolation gown.^{72,73} After collection, samples should be placed in a leakproof primary container and inserted into watertight secondary packaging with absorbent material. This package should be placed in a rigid outer packaging with appropriate labelling.⁷⁴ Sample processing should be performed following biosafety level 2 (BLS-2) practices, the current standard in clinical laboratories. Aerosols can originate from centrifugation, pipetting, vortexing, mixing, decanting liquids, loading and spilling samples or cleaning up spills. Therefore, these procedures should be performed inside a biological safety cabinet and using centrifuge safety cups and sealed rotors.⁷¹ Work surfaces and equipment should be appropriately decontaminated and laboratory waste should be handled as biohazardous agents.⁷⁵ The inactivation of serum samples suspected to be contaminated with SARS-CoV-2 should be carried out by following the procedure recommended by WHO for serum samples for ELISA-based analysis.⁷⁶

7.4 | Sample collection for research use

Research procedures involving virus isolation and propagation in cell culture should be conducted in a BSL-3 laboratory.⁷⁷ The appropriate minimum containment measures for research procedures other than virus propagation (eg, flow cytometry) are currently unclear. The addition of a virus-neutralizing agent to research samples might be considered to ensure safe processing under BSL-2 conditions.⁷⁷

7.5 | Drug provocation tests

Cough, sneezing or rhinorrhoea may occur during drug provocation tests.^{78,79} Therefore, these procedures should not be generally conducted during the current pandemic.⁷⁹ Nevertheless, exceptions can be considered after a proper risk-benefit assessment. Examples of these include chemotherapy in oncologic patients, perioperative drugs or radiocontrast media in subjects needing urgent procedures, or antibiotics in infected individuals without any alternative effective drug.^{80,81}

7.6 | Oral food challenges and oesophageal examination

Oral food challenge may induce respiratory symptoms with aerosol-generating potential, together with vomiting and diarrhoea.⁸² Importantly, the virus can persist in gastrointestinal fluids for a longer period than in the respiratory specimens.⁸³ Therefore, oral food challenges should be avoided during the current pandemic, as they lack urgency.⁸⁴ The diagnosis of eosinophilic oesophagitis requires a gastroscopy-guided oesophageal biopsy.⁸⁵ The performance of a gastroscopy is not recommended during the current pandemic, due to the possible persistence of virus in biological fluids.⁸⁶ In the case of extreme need (eg, frequent food impaction), a proper risk-benefit assessment should be conducted.⁸⁷

7.7 | Conclusions

Specific considerations in a clinical setting are necessary for the diagnostic procedures of different allergic diseases during the current pandemic. As SARS-CoV-2 spreads primarily through respiratory aerosols, airways but also other allergy-related organs are affected, and preventive measures should be ensured. These comprise ENT examinations (including endoscopy), bronchoscopy, nasal or bronchial allergen provocation tests, tissue sampling, lung function tests, skin testing, blood sample collection, drug provocation tests, oral food challenges and oesophageal examinations.

8 | SPECIFIC CONSIDERATIONS IN THE MANAGEMENT OF DIFFERENT ALLERGIC DISEASES

8.1 | General treatment recommendations for selected allergic diseases during COVID-19

According to WHO, patients at risk of or with diagnosed COVID-19 should continue their treatment for any other disease (this includes allergic disease) in line with current guidelines. Special consideration should be given to the interference of drugs with COVID-19 or vice versa.²⁵ It is generally recommended that patients should have a supply of medication for at least a 14-day quarantine. Where more

stringent or lengthy measures of isolation are enforced, consideration must be given to availability of medicines and potential substitutes for current treatments, if particular medications cannot be obtained. Patients should have an action plan to ensure that these issues are covered.

Telemedicine visits cannot replace all personal consultations, notably those mandatory for the administration of subcutaneous allergen immunotherapy (SCIT). Nevertheless, prior to the consultation, questions identifying actual contraindications can be clarified by a telemedicine consultation. Many of the biologics used for the treatment of allergic diseases (eg, omalizumab, benralizumab, mepolizumab and dupilumab) are registered for self-application if the patients are adequately trained in the injection technique and in the assessment and management of allergic side effects. During telemedicine visits, injection techniques may be rechecked, and patients' questions answered regarding their treatment. Peak-flow protocols can be discussed during a telemedicine visit, and treatments can be adapted.

In general, patients can be instructed on allergen avoidance measures and treatment modalities. They can show the drugs they have at home and can be instructed on the use and especially on the application techniques of inhalers and topical nasal sprays. Patients suffering from anaphylaxis may be trained to use adrenaline auto-injectors for self-administration; this improves safety and may also improve the patient's quality of life.

As a general rule, patients with severe allergic disease who are on biologicals and have a SARS-CoV-2 infection should pause the biologicals. Proper management and background controller treatment (topical steroids or other controller medications as recommended by current guidelines) should be continued as prescribed. If resolution of the disease is established (eg, via a negative SARS-CoV-2 test) at a minimum of 2 weeks postonset/positive testing, the re-administration of the biological should be re-initiated.⁹

8.2 | Avoidance measures

Importantly, self-identified and physician-diagnosed (via skin prick test, blood test, provocation testing) triggers of asthma exacerbation and allergies (seasonal, food allergies, etc.) need to be understood for each patient. Targeted messages to patients who have a known allergen sensitivity may be a meaningful way of connecting with patients during a time of limited in-person clinic visits (eg, reminder alerts that the spring season has arrived). Educational outreach messages or televisits can include instructions on allergen avoidance, indoor air purifiers and proper medication use (eg, reviewing the appropriate use of inhalers with spacers). Food scarcity during pandemic operations may adversely impact food-allergic families, and strategies for planning and stocking safe foods should be discussed. Medication supply should also be addressed in conversations with patients to plan for adequate controller and rescue medication with the possibility of substituting or switching medications as needed.

8.3 | COVID-19 in the light of different allergic diseases

The following section overviews recommendations for selected allergic diseases (Table 4).

8.4 | Atopic dermatitis

Atopic dermatitis is one of the most common skin disorders. The lifetime prevalence varies between 0.2% and 25% worldwide, the most affected area being the northern part of Europe.⁹⁰ The disease most often starts in early childhood and persists into adult life in up to 50% of affected patients.⁹¹ Co-morbidities with other atopic diseases including asthma, allergic rhinitis and food allergy are common.⁹² Most with mild-to-moderate atopic dermatitis can be controlled on topical treatment. However, in the severe cases, systemic immune-modulating treatments including immunosuppressive therapy are needed.⁹³ Conventional systemic immunosuppressive treatment, such as cyclosporine, may interact with the human body's defence mechanisms against viral disease, while dupilumab, which is registered in many countries for the treatment of moderate-to-severe atopic dermatitis, selectively interferes with type 2 inflammation and is in general not considered to increase the risk of viral infections.

It is well known that viral and bacterial infection may complicate and exacerbate atopic dermatitis including infections with *Staphylococcus aureus* (impetigo), poxvirus (molluscum contagiosum) and herpes simplex virus (eczema herpeticum).⁹² Severe and untreated atopic dermatitis is a known risk factor for disseminated viral skin disease.⁹⁴

In the current SARS-CoV-2 pandemic, the European Task Force on Atopic Dermatitis (ETFAD) recommends the continuity of all immune-modulating treatment since exacerbations of underlying diseases can have a large negative impact on the patient's immunity.³⁰ However, patients at risk are advised to strictly follow the recommendations issued by the local health authorities in each European country.³⁰ The British Association of Dermatologists (BAD) has addressed potential issues regarding the COVID-19 infection of patients undergoing immune-modulating treatment.⁹⁵ Other countries will follow. A thorough hygienic procedure is recommended with handwashing and disinfectants. Nonirritant soap substitutes should be used following the same instructions as those for regular soap. Moisturizers should be applied afterwards. In the case of COVID-19-infected atopic dermatitis patients, interdisciplinary risk assessment should be carried out, and, in accordance with current guidelines on active infections and systemic therapy, the immune-modulating therapy may or may not be paused afterwards.³⁰ If systemic treatment is paused, it is important to optimize the topical treatment. Furthermore, if the paused systemic treatment also has an effect on co-morbidity such as asthma, then the co-morbidity also has to be treated by other drugs. According to a letter from Italy regarding 245 patients on therapy with dupilumab, only two

TABLE 4 Key recommendations from recently published EAACI/ARIA statements

Disease	Recommendations for COVID-19–diagnosed individuals or for cases with suspected SARS-CoV-2 infection	Recommendations for noninfected individuals during the COVID-19 pandemic or for patients having recovered from COVID-19 infection
Allergic rhinoconjunctivitis ^{10,88}	Continue INCS Continue second-generation H1 antihistamines Stop SCIT until resolution of the disease is established Stop SLIT until resolution of the disease is established Biologicals ^a	Continue INCS Continue second-generation H1 antihistamines Continue SCIT and SLIT Consider supplying patient with a sufficient amount of SLIT medication for home self-administration (for a 14-day quarantine at least) Biologicals ^a
Asthma ¹³	For severe attacks, a pressurized metered-dose inhaler (pMDI) via a spacer is the preferred treatment instead of nebulizers While a patient is being treated for a severe asthma attack, his/her maintenance inhaled asthma treatment should be continued (at home and at hospital) For <i>acute asthma attacks</i> , patients should take a <i>short course</i> of oral corticosteroids (if instructed in their asthma action plan or by their healthcare provider), to prevent serious consequences. Additional treatment should be based on the individual patient and on the underlying disease. Biologicals ^a	Continue all inhaled medication, including ICS (containing therapies), as prescribed by the physician and in line with the personal asthma action plan. If needed, OCS should be continued at the lowest possible dose in patients at risk of severe attacks/exacerbations. Routine <i>spirometry</i> testing should be suspended to reduce the risk of viral transmission, and, if absolutely necessary, adequate infection control measures should be taken. Biologicals ^a
Atopic dermatitis	Continue topical treatment Systemic immune-modulating therapy may be paused based on interdisciplinary risk assessment. Optimize the topical treatment after pausing systemic treatment. Biologicals ^a	Continue topical treatment Continue systemic immune-modulating treatment Biologicals ^a
Chronic rhinosinusitis ¹¹	Like in other upper airway viral infections (common cold or flu), the loss of smell is a frequent symptom in COVID-19 patients. But a sudden and severe loss of smell (anosmia) and/or taste may also be present in COVID-19 patients who are otherwise asymptomatic ^{59,62} Surgery for CRS should be avoided unless patients are proven COVID-19–negative Patients with CRS should continue to use their INCS Biologicals ^a	Anosmia in COVID-19 patients often improves within 14 days Patients with CRS should continue using their INCS Biologicals ^a
Drug allergy ⁸⁹	Quick and accurate diagnostic and therapeutic decisions are mandatory in the case of DHRs induced by COVID-19 drugs	Severe allergic reactions must be treated immediately. Diagnostic testing may be urgently indicated in the case of suspicion of allergic reaction to highly necessary drugs. When validated and reliable, in vitro testing may be preferred for diagnosis. If not immediately required, drug allergy diagnostic must be postponed until the pandemic is locally under control, and alternative drugs should be used until then.
Food allergy	Severe allergic reactions must be treated immediately. Diagnostic testing should be postponed. In vitro diagnostic tests can be preferred for diagnosis in severe anaphylaxis cases. Strict avoidance measures must be taken, and an adrenaline autoinjector must be carried. OIT or EPIT: adapt dosing as indicated in the dosing plan and in coordination with the treating physician.	Severe allergic reactions must be treated immediately. Diagnostic testing should be postponed. In vitro diagnostic tests can be preferred for diagnosis in severe anaphylaxis cases. Strict avoidance measures must be taken and an adrenaline autoinjector carried. Continue OIT or EPIT
Urticaria	Continue second-generation H1 antihistamines. Systemic immune-modulating therapy may be paused based on interdisciplinary risk assessment. Biologicals ^a	Continue second-generation H1 antihistamines. Continue systemic immune-modulating treatment. Biologicals ^a

(Continues)

TABLE 4 (Continued)

Disease	Recommendations for COVID-19-diagnosed individuals or for cases with suspected SARS-CoV-2 infection	Recommendations for noninfected individuals during the COVID-19 pandemic or for patients having recovered from COVID-19 infection
Venom allergy	Severe allergic reactions must be treated immediately. Diagnostic testing is postponed. Strict avoidance measures must be taken and an adrenaline autoinjector carried. Stop SCIT until resolution of the disease is established.	Mastocytosis and grade 3 or 4 anaphylaxis patients need to be diagnosed and venom IT initiated. Strict avoidance measures must be taken and an adrenaline autoinjector carried. Continue SCIT.
Biologicals ^a	<p>Stop until resolution of the disease is established (eg, via a negative SARS-CoV-2 test in connection with clinical recovery), but for a minimum of 2 weeks from onset/positive testing.</p> <p>Ensure re-administration after recovery</p>	Continue the application of biologicals—if possible as home self-administration

Note: These recommendations are conditional and should be adapted regularly on the basis of more clinical data.

^aRecommendation applies for biologicals in the context of all diseases⁹

Abbreviations: EPIT, epicutaneous immunotherapy; CRS, chronic rhinosinusitis; INCS, intranasal corticosteroids; OCS, oral corticosteroids, OIT, oral immunotherapy; SCIT, subcutaneous immunotherapy; SLIT, sublingual immunotherapy

developed COVID-19.⁹⁶ An abnormal course of COVID-19 was not observed in these 2 patients. More clinical data are needed for this specific treatment.

8.5 | Urticaria

Urticaria is characterized by the development of wheals (hives), angio-oedema or both.⁹⁷ Acute urticaria is defined as the occurrence of wheals, angio-oedema or both for less than 6 weeks. Chronic urticaria is defined as wheals, angio-oedema or both for 6 weeks or more.⁹⁷ Viral infection has been found as a potential trigger—and sometimes as the main aetiological agent—in causing acute or chronic urticaria.⁹⁸

In Italy, 88 patients with COVID-19 were studied by a group of dermatologists. 20% developed cutaneous symptoms including erythematous rash and urticaria. It was concluded that the skin manifestations related to the COVID-19 infection are similar to those occurring during common viral infections.⁹⁹ In France, among 103 out- and inpatients with confirmed COVID-19 infection, two had urticaria.¹⁰⁰ In a study from China, 1.4% of the COVID-19 patients reported an underlying urticaria. However, skin symptoms during the infection were not described.⁵ The manifestation of urticaria could appear before the onset of fever or respiratory symptoms.¹⁰¹

As a consequence of these observations, the manifestation of acute urticaria could be an indication to test for SARS-CoV-2. According to the guidelines, second-generation H1 antihistamines are the base of urticaria treatment⁹⁷ and should be continued during the pandemic. If urticaria cannot be controlled on antihistamines in a 4-fold dose, omalizumab is recommended as an add-on treatment. Omalizumab is registered for self-administration after patients have received training on the injection technique and on the assessment of allergic side effects. Only

the first two injections need to be administered in hospital, due to the risk of anaphylaxis. Therefore, especially during the COVID pandemic, treatment at home is favourable. By telemedical visits, the efficacy of the treatment can be evaluated and patients' questions regarding their treatment may be reviewed. This is currently recommended by the BAD.⁹⁵ As for all COVID-19-infected patients, interdisciplinary risk assessment should be performed, and, in accordance with current guidelines on active infections and systemic therapy, the immune-modulating therapy may or may not be paused afterwards.

8.6 | Food allergy

Many reactions to foods are mild-to-moderate and can be self-managed by the patient, given the availability of an up-to-date action plan and adequate rescue medication. During periods of isolation, it is vital that children and adults with food allergy have access to suitable foods according to their dietary recommendations.¹⁰² Patients with a history of severe anaphylactic reaction urgently need an emergency health card providing information on the diagnosis, eliciting (causative) allergens and necessary treatment in the case of a severe reaction and/or an unexpected hospital admission due to COVID-19.¹⁰³ Oral (OIT) and epicutaneous immunotherapy (EPIT) for food allergy should follow the general rules of EAACI/ARIA for AIT during the COVID-19 pandemic (description in subchapter "allergic rhinoconjunctivitis").

8.7 | Venom allergy

In the case of an anaphylactic reaction due to an actual insect sting, patients should be treated according to the guidelines.

Especially in high-risk patients (eg, high risk of subsequent stings, patient suffering from mastocytosis, patient with grade 3 or 4 anaphylaxis), the diagnosis of insect venom allergy must be proved urgently. Venom immunotherapy should be initiated without any delay in order to prevent severe reactions in the case of further future stings.¹⁰⁴ The treatment should follow the general rules of EAACI/ARIA for AIT during COVID-19 pandemic (description in subchapter "allergic rhinoconjunctivitis"). Patients must be informed of avoidance strategies and provided with drugs for self-administration. Adrenaline autoinjectors must be prescribed, and patients must be trained to use these devices. Prior to the initiation of venom immunotherapy, contraindications and requirements for treatment can be discussed with the patient in a telemedicine consultation.

8.8 | Drug allergy

Severe allergic reactions to drugs must be treated immediately. Diagnostic testing may be urgently indicated in the case of a suspicion of allergic reaction to highly necessary drugs. This may be the case for example in patients suffering from reactions to antibiotics which may be necessary for treating bacterial superinfection in COVID-19 pneumonia. In the case of an immediate need for treatment with a drug that is suspected to be responsible for immediate type systemic reactions, drug desensitization or temporary tolerance induction is an option. This is a therapeutic procedure with the aim to induce a temporary state of unresponsiveness to a drug in a patient with confirmed immediate type reaction. During drug desensitization, respiratory and gastrointestinal symptoms occur commonly^{105,106}, with a subsequent risk of spreading infectious aerosols. Therefore, the decision to conduct the procedure during the current pandemic must consider both the expected benefits obtained from the drug administration, as well as the potential risks of severe reaction and spread of infection.⁸⁹ Absolute indications for desensitization/tolerance induction may include chemotherapeutic agents in oncologic patients, aspirin in subjects with ischaemic diseases and antibiotics in infected individuals when no effective alternative is available.¹⁰⁷

8.9 | Chronic rhinosinusitis

Chronic rhinosinusitis (CRS) affects approximately 12% of the general population worldwide and is regarded as a chronic airway disease that, according to WHO recommendations, may be a risk factor for COVID-19 patients.^{6,11} The inflammatory changes affecting the nasal and paranasal mucous membranes in CRS with nasal polyps (CRSwNP) are, in most cases, of the type 2 (T2) inflammation endotype. They are typically associated with epithelial damage and tissue destruction,¹⁰⁸ which can promote viral infections.¹⁰⁹ Asthma often co-exists with CRSwNP, and it is known that deterioration in the control of CRSwNP can promote asthma exacerbations.¹⁰⁹

Symptoms of nasal obstruction, rhinorrhoea, facial pressure and smell dysfunction regularly occur in CRS. Recently, a number of reports have been indicating that a sudden and severe (anosmia) isolated onset of loss of smell (ISOA) and/or loss of taste may also be present in COVID-19 patients who are otherwise asymptomatic. This is considered a marker symptom in screening for SARS-CoV-2 infection,^{62,110,111} but may also interfere with loss of smell in CRS.¹¹ CRS is treated with intranasal corticosteroids (INCS), systemic corticosteroids or specific T2 endotype-driven anti-inflammatory therapies according to the severity of disease.¹¹² INCS remain the standard treatment for CRS in the COVID-19 pandemic and also for patients with SARS-CoV-2 infection.¹¹ Surgical treatments should be reduced to a minimum, and surgery preserved only for patients with local complications and those for whom no other treatment options exist. Systemic corticosteroids should be avoided. Treatment of severe uncontrolled CRSwNP patients¹¹² with biologicals can be continued with careful monitoring in non-infected patients. However, it should be temporarily discontinued in patients having tested positive for SARS-CoV-2 (RT-PCR), until recovery. We suggest that physicians assess the risks vs. benefits in low-risk patients before initiating biologics therapy on a case-by-case basis. However, it should not be initiated in high-risk patients.^{9,11}

8.10 | Allergic rhinoconjunctivitis

There have been reports that topical applied "corticosteroid preparations" may increase the risk of developing COVID-19 or may cause a more severe course of the disease. This opinion massively unsettled numerous patients suffering from allergic rhinitis (AR), CRS or asthma. A current Position Paper by ARIA and EAACI on AR treatment⁸⁸ states that INCS is the therapeutic standard for the treatment of AR, regardless of symptoms and inflammation, thus avoiding mucosal damage. In approved doses (see package leaflet), INCS do not increase the risk of infections in patients with SARS-CoV-2, nor do they trigger a more severe course of COVID-19 disease.⁸⁸ Reducing allergic mucosal inflammation by INCS may even shorten the duration and decrease the severity of symptoms in upper respiratory tract virus infections of AR patients,¹¹³ but seems not to have any marked effects on the common cold symptoms of patients without AR. Therefore, it is recommended that patients with AR should continue to regularly use their INCS at the individually-prescribed dose. Hence, it is not advised that they change or stop their treatment without consulting their doctor.⁸⁸ Discontinuation of INCS may worsen AR symptoms with increased secretion and sneezing which may promote viral droplet transmission from SARS-CoV-2-infected patients to healthy individuals.⁸⁸ In addition, worsening of AR can trigger an exacerbation of asthma,⁸⁸ which is regarded by WHO as a risk factor for severe COVID-19 courses. Systemic glucocorticosteroids in general have several adverse effects if given long term.¹¹⁴ For AR, they should be used with even more caution during the current COVID-19

pandemic and only when no therapeutic alternatives are available⁸⁸ because of a potential temporary immunosuppression and a possible increased risk of contracting a SARS-CoV-2 infection or progression to severe disease.¹¹⁴

Allergen immunotherapy (AIT) is the only disease-modifying treatment option for patients with allergic diseases and it is administered through the subcutaneous (SCIT) or sublingual route (SLIT).^{115,116} During the current pandemic, special considerations should be introduced for the management of AIT.^{10,117} All in-person consultations may be preceded and prepared by a telemedicine visit, during which information is obtained on the patient's health status and possible contraindications for AIT. Since SLIT is self-administered at home during the maintenance phase, telemedicine visits may be helpful for advising patients and increasing their adherence to treatment.

In noninfected individuals during the COVID-19 pandemic or in patients having recovered from COVID-19 infection, it is recommended to continue SCIT in potentially life-threatening allergies, such as venom allergy.¹⁰ The possibility of expanding injection intervals in the continuation phase should be evaluated and may be beneficial. SLIT should also be continued, and the patient must be supplied with sufficient medication.

For both application routes, a continuation of AIT is possible in principle under the following prerequisites¹⁰: (a) asymptomatic patients without suspicion of SARS-CoV-2 infection and/or contact with SARS-CoV-2-positive individuals, (b) patients with a negative test result (RT-PCR), (c) patients after an adequate quarantine or (iv) patients with detection of serum IgG to SARS-CoV-2 without virus-specific IgM. In COVID-19-diagnosed cases (positive RT-PCR), in patients suspected of SARS-CoV-2 infection, or in symptomatic patients with exposure or contact to SARS-CoV-2-positive individuals, EAACI recommends interrupting SCIT and SLIT until recovery.¹⁰

If AIT is stopped due to signs of a potential SARS-CoV-2 infection (such as fever, cough, dyspnoea), or due to other signs of ill health, or due to local restrictions on clinic operations, it should be resumed after recovery but with proper dosage adjustment and under medical supervision when appropriate. To maintain social distancing procedures in the clinic, the following methods could be considered: stretching out the interval of IT or organizing different clinic hours to limit the number of patients attending for IT.^{10,20}

8.11 | Asthma

To date, there is very little information available on patients with asthma who have COVID-19. In general, viruses, including rhinoviruses and respiratory syncytial viruses, have been shown to induce asthma episodes or exacerbations.^{118,119} Mounting evidence implicates that particular viral pathogens, namely the human rhinovirus and respiratory syncytial virus, are among the most likely culprits in asthma inception.¹¹⁹ Bacterial infections and colonization have

also been associated with exacerbation and recurrent wheeze, an effect that may be independent, or a cofactor with viruses. In addition, certain individuals may have a genetic predisposition towards viral-induced wheezing and the development of asthma.¹¹⁹ Whether this also applies to SARS-CoV-2 infection remains to be seen. Interestingly, according to initial reports, allergic airway disease including asthma did not appear to be a risk factor for COVID-19 or for a severe clinical course.^{5,8,120} However, more recent reports from the United States show asthma as an underlying condition in 13%–27% of patients hospitalized with COVID-19, within the COVID-NET hospitals.³³ Additionally, immunocompromised patients—including the elderly, those with diabetes mellitus or those on (systemic) corticosteroids in conjunction with the underlying immune disorders—may be at an increased risk of being infected and more severely affected by SARS-CoV-2.^{5,121}

Optimal disease control is the first defence against respiratory triggers including infections in patients with inflammatory airway disease such as allergic rhinitis and asthma. Inhaled maintenance therapy with bronchodilators and ICS should not be stopped during the COVID-19 pandemic.¹³ The termination of inhaled treatment may in fact imply an increased risk for asthma symptom worsening and acute asthma exacerbations. Furthermore, the risk of asthma deteriorating in a threatening manner and necessitating (otherwise unscheduled) doctor visits or hospital stays—potentially responsible for contact with COVID-19 patients—is far more dangerous for asthmatic patients than a possible increased risk of SARS-CoV-2 infection due to a theoretic local immunodepression induced by ICS. Given the lack of current evidence that ICS negatively affects the COVID-19 outcome, experts and professional societies within the respiratory and allergy field—including the Global Initiative for Asthma (GINA), the American Academy of Allergy, Asthma and Immunology (AAAAI), the European Respiratory Society (ERS) and EAACI—all stress the importance of disease control, especially since many countries are now entering the spring pollen season.¹³ Apart from the generally applicable avoidance measures issued by the governments, the societies recommend that patients continue to take their corticosteroid-containing controller medications and other controllers (including biologicals), as detailed in their personal asthma plan and that they should seek medical help if disease control deteriorates.^{88,122–125} This applies both for adults and children with chronic inflammatory airway disease and with COVID-19 or a suspicion of having the infection. Contact with healthcare providers should be digital as much as possible.

Treatment of severe asthma with biologicals should also be continued.⁹ A discontinuation of biologicals can lead to a worsening of the underlying disease, which in turn could have a negative impact on the course of a COVID-19 infection.⁹ Virus-related asthma exacerbations occur less frequently or are less severe under biologicals, as demonstrated for omalizumab, but not in the context of COVID-19.^{126,127} However, when authorized by international regulatory bodies (eg, the European Medicines Agency (EMA) and the US Food

and Drug Administration (FDA)), self-administration should always be advised in order to reduce exposure to high-risk environments such as hospitals and primary care settings.

In the absence of biological therapy, patients would have to be switched to therapy with systemic glucocorticosteroids, especially those with severe asthma. This can have negative effects on the immune defence against SARS-CoV-2. In a study performed on patients from the Seattle area, severe respiratory failure was observed in 3 of 24 COVID-19 patients after systemic glucocorticoid treatment due to asthma exacerbation.³²

8.12 | Post-COVID-19 routine care

For patients who have recovered from moderate-to-severe COVID-19 infection, particular attention should focus on lung, kidney, cardiac and liver recovery before re-instituting usual medications¹²⁸⁻¹³¹ (Figure 3). Some patients infected with SARS-CoV-2 have a severe systemic inflammatory response, with marked elevation in CRP, D-dimer and ESR in addition to multi-organ dysfunction. Patients may have participated in COVID-19 clinical trials, and it is important to note which medication was potentially administered (see section "Considerations for

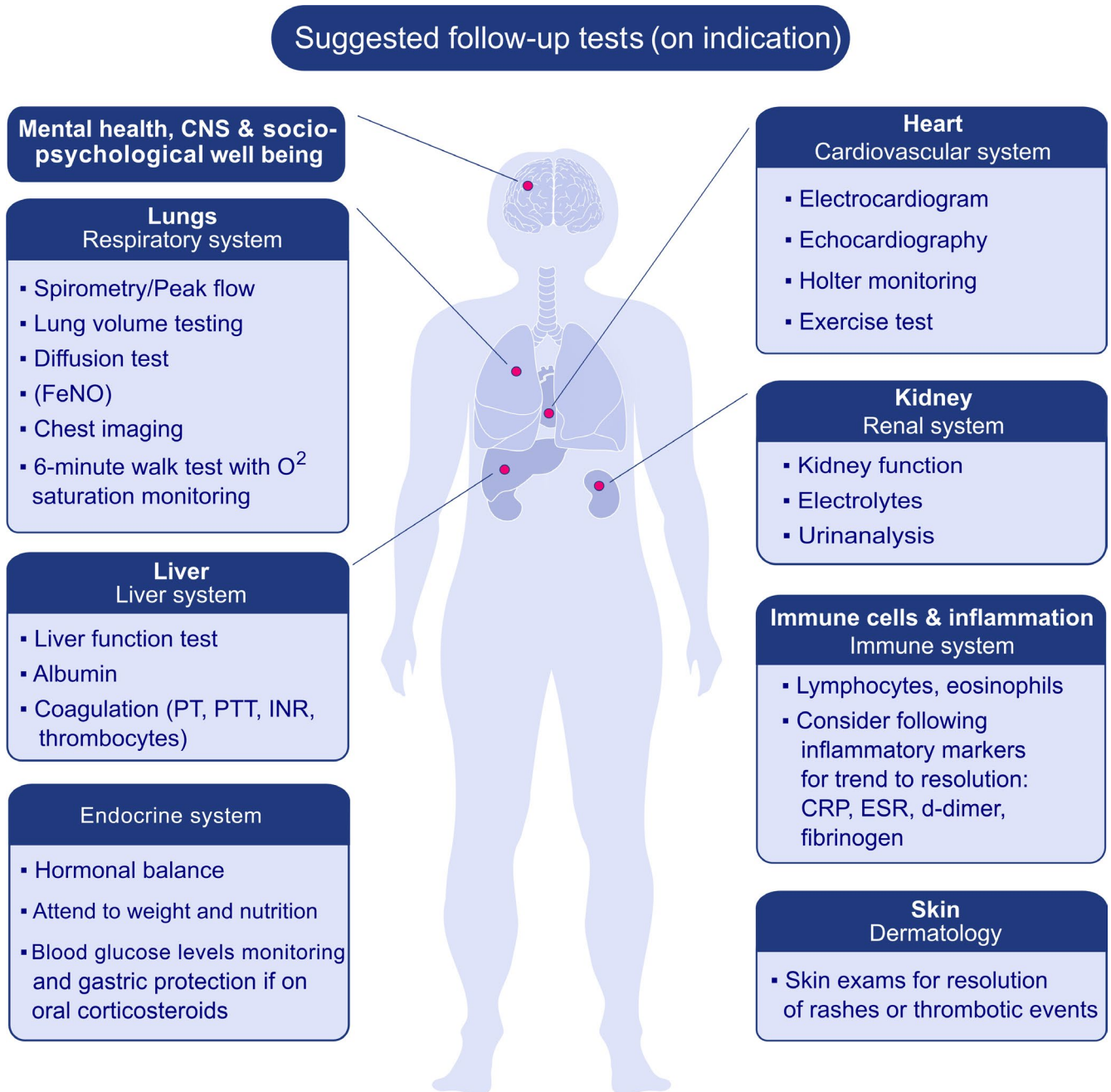


FIGURE 3 General diagnostic measures in post-COVID-19 routine care. The decision on the diagnostic tests or additional laboratories before restarting allergy care should be based on individual patients and/or interdisciplinary consultation.

performing clinical trials"). When resuming allergy care, clinical judgement should determine whether additional laboratories (complete blood count, liver function test, kidney function) or lung function testing are necessary before restarting the treatment of allergic diseases. This decision should be based on a multidisciplinary consultation. In some cases, a close follow-up to assess pulmonary rehabilitation may be warranted.

8.13 | Conclusions

Though avoidance measures during the COVID-19 pandemic are similar in different allergic diseases, specific aspects should also be followed with optimal care for allergic rhinoconjunctivitis, asthma, atopic dermatitis, chronic rhinosinusitis, drug allergy, food allergy, urticaria and venom allergy. Different recommendations can be provided for patients with suspected SARS-CoV-2 infection or diagnosed COVID-19 disease versus noninfected individuals or patients having recovered from COVID-19 infection.

After recovery from COVID-19, allergy care has to be resumed, but an interdisciplinary consultation is recommended before any further diagnostic or therapeutic procedure.

9 | SOCIO-PSYCHOLOGICAL CONSIDERATIONS FOR ALLERGIC PATIENTS AND OPTIMAL CARE DURING AND AFTER THE PANDEMIC

Allergic responses are affected by psychological factors such as stress and anxiety and can be modulated by interventions other than conventional drug therapy.¹³² These psychological mechanisms play a role in terms of symptom development, symptom exacerbation and perception.^{133,134} The reactions of other people to patients showing allergic respiratory symptoms during the COVID-19 pandemic are amplified. These reactions, along with the governmental regulations (eg, social distancing) for dealing with the pandemic, induce further stigmatization and thus enhance psychosocial stress for allergic patients.

Symptom development and symptom perception are only partially caused by the biological mechanisms of the allergy, and many patients report bodily symptoms that are mainly developed via psychological effects (nocebo effects). Relevant psychological mechanisms for symptom development include negative expectations, increased self-observation of somatic reactions, catastrophizing of perceived symptom (dysfunctional appraisal), fears and negative affect.¹³⁵ For many patients (and sometimes even for their physician), the reported symptoms are a conglomerate of potential allergic symptoms, potential symptoms of COVID-19 and correlates of concern that are almost impossible to disentangle. These nocebo symptoms can account for up to 80% of patients with medical conditions.¹³⁶

During the COVID-19 pandemic, the general population is highly sensitive to the perception of people showing respiratory symptoms. This increases the risk of stigmatization of patients with

allergies, further increasing the psychosocial stress of the patients. The neuroendocrine and immunological consequences of stress exposure are in turn able to amplify the development of allergic symptoms.^{133,137} Negative effects on the willingness to expose oneself to those contacts (eg, at work, in private social networks) are further potential consequences with negative impact on health conditions. This is even more problematic, because social contact and social support can dampen negative stress effects and reduce disease symptoms.¹³⁸ Several recommendations to improve medical care for patients with allergies during the COVID-19 pandemic can be given (Table 5).

9.1 | Conclusions

Socio-psychological mechanisms play a major role in terms of symptom development, symptom exacerbation and perception in allergic patients. Besides, the general population is highly sensitive to the perception of people showing respiratory symptoms during the COVID-19 pandemic. This increases the risk of stigmatization of patients with allergies, further enhancing the psychosocial stress of patients. Therefore, optimal medical and psychological care for patients with allergies during the COVID-19 pandemic is essential.

10 | CONSIDERATIONS FOR PERFORMING NON-COVID-19-RELATED CLINICAL TRIALS

For safety and feasibility reasons, many of the ongoing non-COVID-19-related clinical trials have been suspended during the current COVID-19 pandemic, as recommended by guidance from the US Food and Drug Agency as well as the European Medicines

TABLE 5 Improving medical care for patients with allergies during the COVID-19 pandemic

Manage the increased potential for the development of nocebo symptoms: patients should be informed about the potential detrimental effects of nocebo mechanisms, such as increased self-observation or negative expectations. Patients should be encouraged to work against them and to disentangle stress effects from symptoms of clinical conditions

Despite public encouragement for social distancing and increased social stigmatization in the public, patients should be encouraged to maintain an active social network employing the available communication channels. Social support is a crucial factor for improving health in general.

Encourage patients to do regular physical exercise. Regular physical activities induce anti-inflammatory responses.

An empathetic, reliable and predictable doctor-patient relationship guarantees patient compliance with medical recommendations and also lowers nocebo effects

Encourage engagement in stress reduction activities such as relaxation techniques, mindfulness and yoga

Agency.^{139,140} While it is imperative that clinical trials on COVID-19 be prioritized and quickly implemented following local regulatory policies and fulfilling highest quality standards,^{141,142} it is also critical that other essential clinical research programmes, such as those involving study drugs or clinical assessments, should continue safely as much as possible. However, the social distancing measures put into place by different governments (eg, close-down of clinical units and public transportation) complicate the implementation of certain protocol-related procedures, scheduled visits or hospital/clinic procurement of study medication. Nevertheless, with proper adjustments, some studies can be continued safely without loss of data integrity. In the following, we discuss safety and regulatory measures as well as logistical issues that should be taken into consideration when amending non-COVID-19-related clinical trial protocols during the COVID-19 pandemic (Table 6).

Immediate contact is indicated with all involved parties—sponsor, institutional review board (IRB), institutional ethics committee (IEC), participants, investigators and staff—as well as with all enrolled participants, to inform them of the changes related to the pandemic. All immediate actions should take place as long as the pandemic-related policies are in place and documented. Otherwise, conventional amendments are required.

Essential non-COVID-19-related research can be continued safely during the COVID-19 pandemic while maintaining data integrity with appropriate amendments to the protocols. These adjustments should take into consideration modern technological communication tools (between hospital staff and patients), IP delivery, appropriate laboratory safety guidelines, proper data source (case report form (CRF)), statistical analysis plans and regulatory documentation (Figure 4).

TABLE 6 General consideration when amending non-COVID-19-related clinical trial protocols during the COVID-19 pandemic

Provide written and oral instructions on disease symptoms and signs and for the prevention of disease spread

Study participants, research and laboratory staff may need to monitor their temperature and check for symptoms and signs of the pandemic during participation in the trial and if entering the clinical research unit/workplace

Study participants, research and laboratory staff should frequently wash their hands with disinfectants, wear PPE (eg, laboratory garments, gloves, face masks, eye protection) and clean work surfaces and equipment with appropriate disinfectants

Consider which visits can be conducted via remote solutions (phone check-ups, teleconsulting and monitoring)³⁶

Provide specific instructions on clinical trial unit procedures, particularly those that generate aerosols/droplets (eg, sputum and nasal fluid collection, nasal and bronchial provocation testing). All isolations of peripheral blood mononuclear cells (PBMC) and bronchoalveolar lavages (BAL) should be performed in a BSL-2 bench. For centrifugation steps, the use of closed beakers should be mandatory

Provide specific instructions for the collecting, handling and processing/testing of specimens from clinical trial participants

10.1 | Participant interactions

In conducting non-COVID-19-related trials (eg, in apparently noninfected individuals), the safety and well-being of the participants and hospital/research staff during physical interactions and specimen handling should be considered and risks evaluated. When possible and appropriate, remote options for participant visits using telemedicine or video consulting may facilitate the conduct of the clinical trial. Contact scripts to standardize messages are recommended. In general, these scripts do not require approval during lockdown. Study procedures that generate aerosols or droplets, such as spirometry or nebulization of agents or medication, may require special considerations on how to perform similar assessments safely or may need to be reconsidered. Staffing considerations should include the minimal essential personnel required to carry out study visits, and staff should be cross-trained and added to Delegation of Authority logs, as appropriate.

10.2 | Regulatory guidance

Regulatory aspects of protocol amendments need to be considered.^{139,140} Changes to protocols after Institutional Review Board (IRB) approval are only allowed without prior approval in cases where there is a need to eliminate immediate hazards for the participants. Regulations allow protocol adjustments for participant safety and minimization of risks for data integrity in line with good clinical practice (GCP). In the light of the COVID-19 pandemic, certain study visits or procedures may need to be paused or redesigned. This could facilitate ongoing research while maintaining safety, and also allow time for evaluating the benefits of continuing investigational products for enrolled participants versus the disadvantages (harm incurred) of discontinuing. New strategies for safety assessments, monitoring and data collection should be considered. Proper and detailed documentation of updates to procedures and operations is critical, and protocol amendments should be communicated to research staff, participants, sponsors and regulatory agencies as soon as possible. Changes that may impact efficacy assessments, data management and/or statistical analysis plans should be discussed, when necessary, with the appropriate EMA-/FDA-division review. Records of all deferred procedures need to be kept and documented.

10.3 | Investigational product

Depending on the clinical trial, adjustments to investigational product (IP) administration may be possible with the use of telemedicine. These decisions must involve conversations with protocol chairs, sponsors, medical monitors and regulatory authorities as applicable. If participants are not able to go to the clinical research unit (CRU), other options to continue IP intake include curbside dispensing or direct shipping of pharmaceuticals. The research pharmacy staff should ensure that all local and federal regulations are followed with

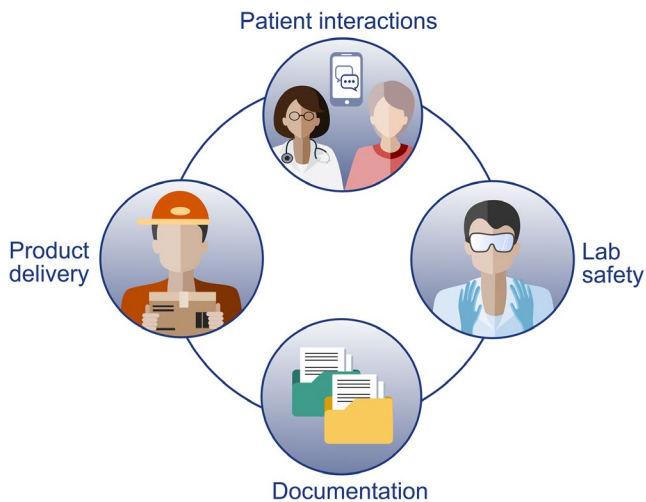


FIGURE 4 Ensuring data integrity in non-COVID-19-related research

regard to the documentation and transport of study medication. In parallel, any necessary rescue medications should be provided to study participants and documented with prior communication to relevant parties. Further guidance for the investigational product should be followed (Table 7).

10.4 | Laboratory safety and precautions

Laboratory staff should follow standard precautions (SP) when handling clinical specimens, all of which may contain potentially infectious materials (see also Section 6)⁷¹. SP include hand hygiene and the use of PPE, such as laboratory coats or gowns, gloves and eye protection. All new arriving samples can be potentially infected. Isolations have to be performed with closed centrifuge beakers which have to be loaded and unloaded in a biosafety cabinet. Materials should be carried in aerosol tight transport boxes. The usage of BSL-2 benches for all arriving patient materials is mandatory

TABLE 7 General considerations on investigational products when performing a non-COVID-19-related clinical trial during the COVID-19 pandemic

Treatment initiation and dose increases only performed in clinic; levels maintained at a stable dosage (eg, for oral immunotherapy) when clinic visits not possible

Training of at-home administration of biologics and injectables, where applicable⁹

Ensuring participants maintain adequate IP supply to continue at-home dosing as needed without disclosing identity via research pharmacy (direct-to-participant shipments or curbside dispensing)

Ensuring integrity between pharmacy and participant in the case of shipping (secure chain of custody and monitoring of storage conditions in transit)

Necessary rescue medication provision with written instructions and emergency phone numbers

during and after the pandemic. Handling of open vessels may only be performed inside of class II biosafety cabinets.

Antibody tests and procedures that utilize samples that are formaldehyde-fixed or virus-inactivated, or those that concentrate viruses (via precipitation or membrane filtration), may be performed in a BSL-2 laboratory. BSL-3 facilities and procedures are recommended for virus isolation in cell culture, initial characterization of viral agents recovered in cultures of SARS-CoV-2 specimens, and virus-neutralizing antibody assays (Table 8). All work surfaces and equipment should be decontaminated with appropriate disinfectants.

10.5 | Conclusion

Clinical trials to combat the COVID-19 pandemic currently have top priority. However, a number of non-COVID-19 trials are also essential and should be continued if they can be conducted in a safe manner. Safety measures and new guidelines need to be established for participants and research/laboratory staff dealing with non-COVID-19-related clinical trials, to ensure the continuation of essential and critical non-COVID-19 trials.

11 | DISCUSSION

In view of the ongoing and emerging novel coronavirus (COVID-19) pandemic spreading worldwide,² the safety and well-being of our patients, personnel and colleagues globally are of primary importance. EAACI and ARIA are closely monitoring the situation. They recommend aligning any diagnostic and treatment operations with guidance from WHO²⁵ and ECDC,²⁶ in accordance with all applicable national/regional/local government and public health authority requirements.

Allergists and other healthcare providers (HCPs) in the field of allergies and associated airway diseases are on the front line in taking care of patients potentially infected with SARS-CoV-2. Hence, strategies and practices to minimize risks of infection of both HCPs and the treated patients have to be developed and followed by allergy clinics.²⁰ This is especially important in high-risk patients for the course of the SARS-CoV-2 infection, for example in the elderly or in those with co-morbidities.

If patients are diagnosed with COVID-19 or are suspected to have COVID-19, they should follow the local area treatment and quarantine guidance. In general, most medications should be continued.^{10,88} Patients may be unable to attend clinic visits, have examinations and/or receive prescriptions. E-Health and telemedicine can assess the value of specialized treatments, provide education for self-management without the risk of infection⁴⁴ and triage patients for urgent in-person consultations. Examples for the latter are diagnostic testing in drug allergy in the case of suspicion of allergic reaction to highly necessary drugs⁸⁹ or the application of medication (eg, SCIT or biologics) through a HCP.

TABLE 8 Laboratory procedures that may require different biosafety level precautions⁷¹

Biosafety level 2 (BSL-2) precautions	Biosafety level 3 (BSL-3) precautions
Flow cytometry of formaldehyde-fixed specimens	Procedures with human or animal primary specimens to intentionally concentrate or isolate SARS-CoV-2 for research purposes (eg, ultracentrifugation of a sample)
Cell sorting with FACS Sorter has to be performed in the closed tube system. If a plate sort is necessary, the aerosol protection has to be used	Culturing specimens (eg, propagated virus)
Assays with virus-inactivated specimens	Preparatory work for in vivo activities
Concentration of samples prior to inactivation	Processing a culture (eg, propagated or cultivated) known to contain SARS-CoV-2 for packaging and distribution to laboratories
Sample preparation for nucleic acid extraction, flow cytometry analysis, molecular testing of nucleic acids	Preparing inoculum, inoculating animals and collecting specimens from experimentally infected animals
Antigen and antibody assays	Virus neutralization tests for blocking activity against SARS-CoV-2 (with live virus)

Clinic staff should keep in contact with the patient, preferably through telephone calls or videoconferences, to maintain awareness of their status in the case of symptom exacerbations. Dispensing a sufficient amount of medication is a way of enabling the patient to self-treat. In treatment with biologicals, the decision to continue or discontinue a treatment should be made on a case-by-case basis by the attending physician, since the safety and efficacy of the mentioned biologicals in COVID-19 patients are currently unknown.⁹ Besides, psychological care for patients with allergies during the COVID-19 pandemic is essential.

Non-COVID trials may be able to be continued according to regional regulations. However, special emphasis should continue to be placed on the safety of the participants and research/laboratory staff. The same safety precautions used in clinical routine for aerosol-generating procedures and handling of samples should also be applied in the non-COVID trials.

12 | CONCLUSION

According to current WHO and ECDC guidelines, patients at risk or with diagnosed COVID-19 should continue to be treated for all other diseases in line with current guidelines, if there are no interferences of treatment with COVID-19 or vice versa. Preparedness of the allergy clinic, specialized centre or practice is imperative in order to cope with COVID-19 correctly. The recommendations in this Position Paper are conditional since there is a paucity of data.

They should be revised regularly with new incoming information on COVID-19.

As doctors, scientists and specialist societies, we are required to observe our patients, to provide optimal advice and treatment based on the current state of medical knowledge, and to inform them accordingly when new evidence is available, making it possible to adapt the therapies. EAACI has a prevailing requirement to protect the safety and welfare of our patients, allergists and staff and is working diligently to ensure responses to new recommendations as quickly as possible.

CONFLICT OF INTEREST

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