

Correspondence and Reply

Real-life experience of an allergy and clinical immunology department in a Portuguese reference COVID-19 hospital

We read with great interest the article by Shaker et al,¹ which suggests a COVID-19 pandemic contingency strategy for Allergy and Immunology (AI) Clinics. Although this guidance is invaluable, in Portugal, the first cases were reported, national state of emergency was declared, and lockdown measures were imposed in March.² Such events had a tremendous impact on our AI Department, which is based at an academic hospital and the COVID-19 reference for northern Portugal, the initial national epidemic's epicenter.² By sharing our real-life experience during the first 8 weeks of COVID-19 (Table I), we now hope to complement available guidance, empowering others on strategies for a similar crisis.

Nonurgent activity was suspended, and outpatient appointments were mainly converted to phone consultations, relying on remote access to electronic health records, as well as an online prescribing system that allows prescription fulfillment using e-mail/SMS.

We restricted nonscheduled care to urticaria and hereditary angioedema exacerbations. Respiratory complaints were redirected to COVID-19 dedicated emergency department. A new e-mail box was created to answer patient requests and concerns, which were mainly related to heightened risk of infection, treatment safety of nasal/inhaled steroids, and prescription renewal.

Telework was authorized for medical staff with high-risk comorbidities. Others volunteered to participate in COVID-19 activities, on top of AI activity. The Infectious Diseases Department devised a homecare program for nonsevere cases to reduce admissions. Physicians would call to communicate a positive SARS-CoV-2 result and educate on isolation measures, with follow-up evaluations at every 24-72 hours, according to patient condition. Other responsibilities were to identify patients in need of in-hospital evaluations and psychological or social support and to initiate recovery protocol. The experience at the outpatient clinic and specific training in respiratory diseases made allergists particularly qualified to monitor patients on homecare, which soon became our focus.

Allergen immunotherapy initiations were postponed, and sublingual treatments (inhalant, latex, or Pru p 3) kept at home. Transfer of inhalant immunotherapy injections to primary care units was encouraged. Maintenance venom immunotherapy (VIT) was secured, considering its lifesaving potential. VIT ultra-rush initiations, drug, and food challenges, as well as uposing of oral tolerance inductions, were postponed, averting prolonged in-hospital stay and allergic reactions. Antineoplastic desensitizations were warranted as essential care.

Implementation of a self-injection program for omalizumab, benralizumab, and mepolizumab was accelerated. We switched to prefilled syringes/autoinjectors, designed self-administration training protocols and information leaflets, and encouraged all patients to enter the program.

Training programs were suspended. Residents were highly involved in the COVID-19 efforts and un-postponed clinical activity. Participation in digital congresses was safeguarded.

The uncertainties on how to prioritize service shutdown and patient care¹ and the lack of guidelines³ were very real and led us to heavily rely on creativity, open-mindedness, and shared decision-making.

Despite its dire effects,^{2,4,5} COVID-19 created an opportunity to expedite projects and rethink the role of digital tools,^{1,3} which proved to be a powerful resource, enabling the safe delivery of quality care. The intense participation in COVID-19 offered a sense of usefulness and companionship during uncertain times. Those were the ultimate silver linings of this crisis.

The authors wish to recognize the dedicated work of all staff members, who not only allowed for the results here presented but also provided unprecedented and high-quality care to our allergic as well as COVID-19 patients during a time of great uncertainties.

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TABLE I. Summary of decisions and production during lockdown and resume of regular activities

Activity	Decision during lockdown	n performed/n canceled [†]
Medical appointments		
First visits	Case-by-case decision according to apparent severity but primarily canceled	219 [‡] /365
Subsequent visits	Maintained. Conversion to phone consultation whenever possible	1881 [§] /13
Allergen immunotherapy		
SCIT initiation	Suspended	0/29
SCIT maintenance	Suspended; patients were encouraged to maintain regular schedule at their primary care units	17/604
VIT initiation	Suspended	
VIT maintenance	Predominantly maintained after risk-benefit assessment with patients	87/9
Food allergy		
Skin prick-prick tests	Suspended	0/28
Food challenges	Suspended	0/62
Oral tolerance induction	Suspended	0/2
Drug allergy		
Drug skin tests/challenges	Suspended	0/188
Rapid drug desensitization	Maintained for antineoplastic drugs	16/16
Other procedures		
Lung function tests*	Suspended	0/1040
Inhalants skin prick tests	Suspended	0/530
Biological drugs	Maintained; conversion to self-administration whenever possible	29/46
Urgent care		
Urgent consultation	Restricted to mucocutaneous symptoms	
Inpatient consultations	Maintained with PPE	
ER consultations	Maintained with PPE	
Medical staff		
Social distancing	Converted all staff meetings and intermediate communications into digital meetings via phone calls, WhatsApp, or e-mail Communication with patients via phone calls, WhatsApp, or e-mail Electronic prescriptions	
Participation in COVID-19 activities	Voluntary participation: monitoring patients under homecare as part of a broader multispecialty team (that performed around 11,000 consults), COVID-19 dedicated ward, and ED shifts	
Scientific activity		
Research	Suspended and/or redirected to COVID-19	
Continuous education	In-person meetings suspended. Participation in digital meetings encouraged	
Training programs	Globally suspended	

ED, Emergency department; ER, emergency room; PPE, personal protective equipment; SCIT, subcutaneous immunotherapy; VIT, venom immunotherapy.

*Includes spirometry with and without bronchodilation, impulse oscillometry, methacholine challenge test, fractional exhaled nitric oxide.

[†]Includes data from March 16 to May 11.

[‡]In-person appointments: 124 (57%).

[§]In-person appointments: 43 (2.3%).

^{||}Adhered to self-administration program/patients under biological therapy.