

Inducible laryngeal obstruction, COVID-19 and asthma

In this issue of the journal, Haines and colleagues have compared and contrasted the triggers that patients report for inducible laryngeal obstruction and asthma.¹ Diagnoses were made with flexible laryngoscopy.² They describe mechanical factors, such as talking, shouting and swallowing, as being more common in the inducible laryngeal obstruction group compared to the asthma one. This contrasted with environmental factors, such as pollen/flowers and damp air, which were more common in the asthma group. These observations may be helpful in differentiating between inducible laryngeal obstruction and asthma. This ought to be helpful in improving patient management by correctly employing strategies for inducible laryngeal obstruction and asthma in the right patients. This is especially important given with flexible laryngoscopy being less available during the pandemic. This issue is addressed by a UK consensus statement on the diagnosis of inducible laryngeal, which can also be found in the December issue.

DunnGalvin and colleagues have examined the strategies that patients with peanut allergy use to cope with and manage their

allergy and how this impacts on their and their caregivers' quality of life.³ This is important given the challenges of predicting allergic reactions.⁴ The group took a qualitative approach in a study across eight European countries in school-age children ($n = 24$), teenagers ($n = 39$) and caregivers ($n = 44$). They have developed a conceptual model incorporating coping and control (Figure 1). These were driven by the fear of peanut allergy with the associated emotional, social, relationship and work issues.

Lastly, Wang and colleagues have looked at the association between COVID-19 and asthma in a systematic review and meta-analysis.⁵ They found 14 publications with data from 17,694 participants. All were rated as being of high quality. Their meta-analysis showed that developing severe COVID-19 disease was not associated with an increased risk of having asthma compared to non-severe COVID-19 (odds ratio 1.36, 95% CI: 0.79-2.34; $I^2 = 77\%$). Asthma was also not associated with a greater mortality with COVID-19 (1.03, 0.55-1.93, 76%). Reassuring, although the confidence intervals are relatively wide.

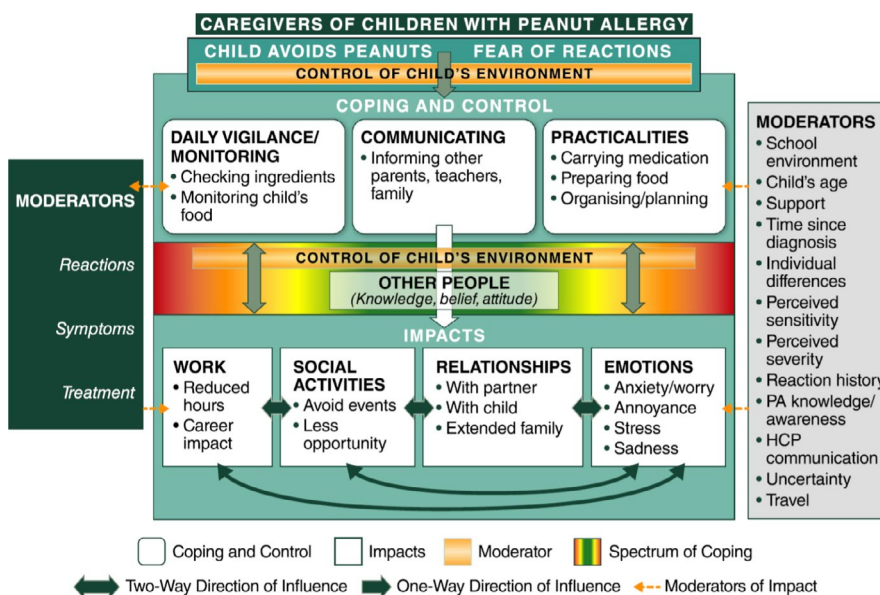


FIGURE 1 Conceptual model of the impact of peanut allergy on caregivers. See Figure 4, DunnGalvin (page 1244) for further details

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The cover image is based on the Original Article-Clinical Allergy APPEAL-2: A pan-European qualitative study to explore the burden of peanut-allergic children, teenagers and their caregivers by Audrey DunnGalvin et al., <https://doi.org/10.1111/cea.13719>

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