

MEDPAGE TODAY'S
KevinMD.com
Social media's leading physician voice

Be an Upstander, Not a Bystander

By Aasna Shaukat, MD, MPH

I am a female immigrant gastroenterologist from Pakistan, practicing in Minneapolis. Having lived in this country for 22 years and married to a white man, I generally feel that I fit in pretty well. A couple weeks ago at work, I walked into a procedure room and introduced myself to a 66-year-old white male on whom I was about to perform a procedure. There were three other people in the room—a nurse and two techs. I explained the procedure in my usual cheerful voice and asked, “Do you have any questions?” like I always do at the consent process.

The patient said, “Yes, I do. Where’s your burqa?” I was quite taken aback and wondered if I misheard.

Me: “I’m sorry. What did you say?”

Patient: “I said, where’s your burqa?”

Me, confused: “Sir, why would I have a burqa?”

Patient: “Don’t women like you wear one to cover themselves?”

Me (more confused): “What do you mean women like me?”

Patient: “Well, aren’t you from Pakistan or Afghanistan? Aren’t you Muslim?” I was at a loss for words and desperately wanted to end the conversation.”

Me: “Let’s not talk about me but about your procedure. Any questions about the procedure?”

The patient replied, “no,” and we went ahead with the procedure and the rest of the day.

The incident bothered me all day and the following many days. I couldn’t quite put a finger on what it was and brushed it aside and stopped thinking about it. In the wake of recent events, it dawned upon me that it wasn’t the patient’s comments that bothered me. It was the fact that no one standing in the room witnessing the conversation stepped in. Not during the conversation, and not after. Considering I’ve worked with my colleagues every day and in the same place for the last 12 years, I felt strangely betrayed.

Stories like this happen every day and are sadly more common than we realize. There will always be racist, insensitive, inappropriate comments by people across life. It’s how we react to them that will shape our lives. Most individuals have asked how they can help. Well, start by being an upstander and not a bystander. That will mean the world to us people of color and immigrants.

And let’s start teaching and training students in medical school, nursing, and technical schools how to identify and stand up to inappropriate comments. It may take us a few generations to make seismic changes, but we must start now.

Aasna Shaukat, MD, MPH is a gastroenterologist and can be reached on Twitter at @aasmashaukatmd.



Bermuda Grass-Induced Allergic Rhinitis in a Colder Climate



Contributor
Anne K. Ellis, MD, MSc, FRCPC
Clinician Scientist
Kingston General Health Research Institute
Director
Allergy Research Unit/
Environmental Exposure Unit
Kingston Health Sciences Centre
Professor
Department of Medicine
Department of Biomedical and Molecular Sciences
Queen’s University
Chair
Division of Allergy & Immunology
James H. Day Chair in Allergic Diseases and Allergy Research
Faculty of Health Sciences
Kingston, Ontario, Canada

Although it was traditionally thought to have low exposure rates outside of tropical and subtropical areas, Bermuda grass pollen has been shown by researchers to have high positive sensitization rates in different areas of Canada. “We tested study participants for Bermuda grass as part of a cross-border collaboration with another allergy research group in Texas, and we were surprised to see how many Canadians were sensitized to this non-native grass,” notes Anne K. Ellis, MD, MSc, FRCPC. Such sensitization may result from previous time spent in regions where the grass type is abundant or from a cross-reactive mechanism to local grass pollens. However, with sensitization not necessarily resulting in allergic rhinitis (AR) symptoms when exposed to Bermuda grass pollen, Dr. Ellis and colleagues sought to determine if Bermuda grass allergen extract could provoke AR symptoms in Canadian participants who were sensitized to Bermuda grass using the Allergic Rhinitis-Clinical Investigator Collaborative nasal allergen challenge (NAC). “We wanted to see if these study participants who had a positive skin test to Bermuda grass actually had evidence of clinical allergy/disease,” Dr. Ellis adds.

Getting to the Root Cause

For a study published in the *Annals of Allergy, Asthma & Immunology*, adults aged 18–65 who were sensitized to Bermuda grass or nonallergic completed a titrated allergen challenge during a screening visit, during which total nasal symptom score (TNSS) and peak nasal inspiratory flow (PNIF) were collected prior to allergen exposure. Those who were sensitized to Bermuda grass but did not have a hypersensitive response received a series of increasing concentrations of Bermuda grass pollen extract, with TNSS and PNIF measured 10 minutes after each. Upon reaching qualifying criteria (TNSS >8 and PNIF fall >50%), the titrated challenge was stopped and the last dilution of extract was deemed the qualifying concentration.

A cumulative single-dose NAC (sum of all allergen dilutions received at screening) was completed at a follow-up visit 21 to 28 days later. TNSS and PNIF were then recorded at 15 minutes, 30 minutes, 1 hour, and hourly until 12 hours after the NAC. Patient-reported symptoms were also collected at 24 hours post-NAC. Symptoms of postnasal drip, nasal congestion and/or stuffiness, nasal itching, sneezing, itchy and/or watery eyes, red and/or burning eyes, and itchy ears, palate and/or throat were self-rated by each participant on a 0–3 point scale.

Significant Differences in Sensitized Vs Nonallergic Participants

Among participants who completed the screening titrated allergen challenge, Bermuda grass wheal size, peak TNSS, and PNIF fall were all

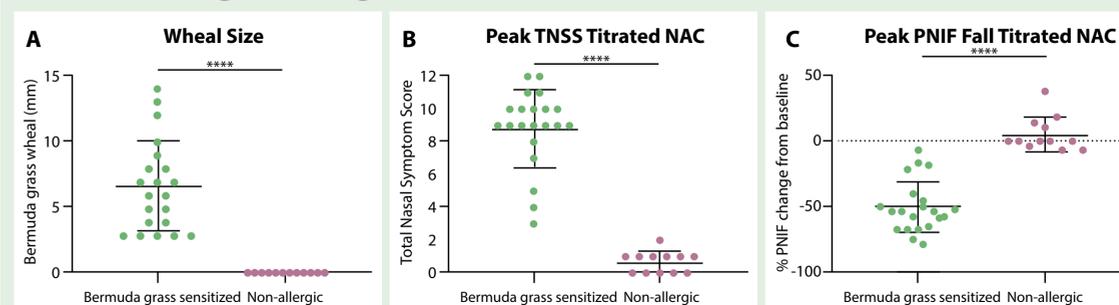
significantly greater in sensitized participants than in controls without allergy (Figure). Among sensitized participants, 90% achieved a clearly positive allergic response, according to European Academy of Allergy and Clinical Immunology guidelines, by reaching a TNSS of at least 5 when challenged, while 71% met the predetermined qualifying criteria. All sensitized patients who completed the screening visit also had positive skin prick test results for Timothy grass pollen extract.

During the NAC visit, when compared with nonallergic controls, those with Bermuda grass allergy had significantly greater mean TNSS at 15 minutes, 30 minutes, 1 hour, 2 hours, and 3 hours post-allergen challenge; significantly elevated TRSS at the same time points as well as at 4 hours; significantly greater Total Ocular Symptom Score at 15 minutes, 30 minutes, 1 hour, and 2 hours; and significantly greater mean PNIF fall at 15 minutes and 30 minutes.

Cross-Reactivity With Pasture Grasses?

“Participants with Bermuda grass sensitization do develop subjective and objective signs and symptoms following an NAC,” adds Dr. Ellis. “We believe, that due to the high degree of Bermuda grass sensitization seen and the lack of participants ever having lived in southern US, that patients have a higher degree of cross-reactivity to Bermuda grass if they are allergic to pasture grasses (eg, Rye, Orchard, Kentucky, Timothy) than previously believed, and treating these patients with standardized sublingual immunotherapy tablets that target pasture grasses should indeed be effective. I hope to conduct a pilot study to confirm this theory.” ■

Figure Titrated Allergen Challenge Results



Bermuda grass-sensitized participants expressed symptoms consistent with those with allergic rhinitis during titrated allergen challenge. The Bermuda grass wheal size data (A) for sensitized (n ¼ 21) and without allergy (n ¼ 12) participants were collected during the screening visit. Mean wheal size was significantly greater in Bermuda grass-sensitized participants than nonallergic controls (P < .0001, Mann-Whitney U test). Bermuda grass-sensitized participants also had significantly elevated peak total nasal symptom score (TNSS) than nonallergic participants (P < .0001, Mann-Whitney U test) (B). Likewise, the percent peak nasal inspiratory flow (PNIF) fall was significantly greater in Bermuda grass-sensitized participants than in nonallergic controls (P < .0001, Mann-Whitney U test) (C). NAC, nasal allergen challenge.

Source: Rawls M, et al. *Ann Allergy Asthma Immunol*. 2020;124(6):608–615.

Medical Economics

SMARTER BUSINESS. BETTER PATIENT CARE.

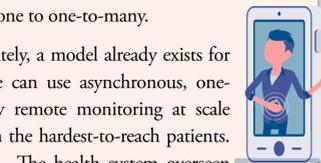
Why We Need a One-to-Many Telehealth Model of Care

This article was originally published in *Medical Economics* and is written by Jon Bloom, MD.

One thing the COVID-19 pandemic has made clear is that telemedicine is a public health necessity. However, real-time, or synchronous, telemedicine isn’t sustainable or scalable. We’re already seeing synchronous telemedicine practiced on a small scale put a strain on our healthcare system during COVID-19.

For telemedicine to work at scale, it must also have a one-to-many component. In this model, data can be remotely gathered and consistently monitored over time and then used for timely and targeted communication between patients and providers. This allows care to scale from one-to-one to one-to-many.

Fortunately, a model already exists for how we can use asynchronous, one-to-many remote monitoring at scale for even the hardest-to-reach patients.



The health system overseen by the VA is now successfully using asynchronous telehealth right now to ensure patients who cannot or should not visit a VA facility are still able to get the frequent care they need from a distance.

One such example is the effort to remotely monitor veterans at risk for diabetic amputations. Veterans place their feet on the Podometrics SmartMat for just 20 seconds a day in their home, and the temperature data captured is automatically sent to a care management team to monitor. When early signs of issues are detected, patients and providers are notified so clinical action can be taken quickly, helping to prevent more serious complications.

Such large-scale preventive care could not be achieved through synchronous, one-to-one telemedicine. There simply are not enough doctors available to check in with every patient for even 1 minute every day. However, remote asynchronous systems can gather data over time to help prioritize synchronous telemedicine, ensuring patients receive the care they need when it matters most.

A key takeaway of the current pandemic has been the importance of telehealth; however, for it to be sustainable, we need a combination of synchronous and asynchronous patient monitoring tools that allow for targeted communication. We should expect more healthcare providers to incorporate this kind of model to offer access at scale and save lives. ■

To read the unabridged version, visit www.medicaleconomics.com.

In Case You Missed It

Allergy-Related Diagnoses Tied to Irritable Bowel Syndrome

Asthma and food hypersensitivity (FH) at age 12 years are associated with an increased risk for irritable bowel syndrome (IBS) at age 16 years, according to a study presented at United European Gastroenterology Week Virtual 2020, held Oct. 11 to 13. Researchers examined the association between allergy-related diseases during childhood and IBS at age 16 years in a population-based birth cohort study. Data were included from 2,770 adolescents with complete follow-up at age 16. At 16 years of age, the prevalence of IBS was 6.4%. Compared with adolescents without IBS, those with IBS had an increased prevalence of asthma at 12 and 16 years, eczema at 16 years, and FH at 12 and 16 years. In crude analyses and after adjustment for sex, asthma and FH at 12 years were associated with an increased risk for IBS at 16 years. Asthma at ages 1 to 2 and eczema at ages 1 to 2, 4, and 8 were associated with increased IBS risk at age 16, although the associations were not statistically significant. Significant associations were seen for asthma, eczema, and FH with concurrent IBS at age 16; only the associations between asthma and FH remained significant after adjustment for sex. “The associations found in this study suggest there’s a shared pathophysiology between common allergy-related diseases and adolescent irritable bowel syndrome,” said the presenting author.

Allergy & Asthma Network Announces National Trusted Messengers Project to Address Health Inequities

As part of Respiratory Care Week, Allergy & Asthma Network (AAN) and partners launched Not One More Life Trusted Messengers, a holistic project built on trust to address health inequities, increase access to important health information and screenings for people of color and improve long-term health outcomes, especially for those with respiratory conditions. The project mobilizes leaders from the community, health advocacy, and pharmaceutical organizations to drive community engagement, expand healthcare access and accelerate digital innovation in order to correct disparities in health that go well beyond COVID-19. In addition to easy access to testing, the Trusted Messengers project also includes a follow-up intervention program, which includes 16 weeks of digital check-ins to help patients move from their initial screening through the continuum of care. Using predictive analytics and weather trends to identify future COVID-19 hot spots, Trusted Messengers will expand to additional cities in the coming year, partnering with trusted local leaders to reach communities with valuable health information and increase access to screenings for those who are at greater risk from COVID-19. “Interconnected systemic inequities – such as housing, job types, levels of education, etc. – negatively impact the health of people of color,” said Tonya Winders, CEO of AAN. “There is an urgent need to act fast and act now, but the work we have to do to correct disparities in health goes well beyond COVID-19. It takes time to change systems, so in addition to taking action now, we must commit to long-term approaches that result in meaningful impact and the reduction of disparities.” ■



We’ve masked our posters with
ANTIMICROBIAL COATING

We are in this together