**Talking Points for Allergists to Use When Being Interviewed by Local Media on COVID-19**

Remember to visit the [AAAAI COVID-19 resources page](https://education.aaaai.org/resources-for-a-i-clinicians/covid-19) where you can find patient articles, podcasts, infographics and more to help you prepare to speak with the media. For your convenience, we have also put together the below list of talking points.

**How to Tell the Difference Between COVID-19, Allergies, Influenza and the Common Cold**

* Reference the [AAAAI’s infographic](https://www.aaaai.org/Aaaai/media/MediaLibrary/Images/Promos/Coronavirus-Symptoms.pdf) and share it widely.
* This infographic is also [available in Spanish](https://www.aaaai.org/Aaaai/media/MediaLibrary/Images/Promos/Spanish-Coronavirus-Symptoms.pdf).

**Seeing Your Allergist**

* Many allergists are offering telemedicine visits. This will allow patients to meet or follow up with their allergist in a safe way. The allergist can then determine when it is safe to see and/or skin test patients.
* Some allergists are offering immunotherapy in office and should be contacted as to how that is being done in their office.

**Management of Asthma and Allergies During the Pollen Season and COVID-19**

* Current data (emphasis on current) indicates that it is safe to use nasal and inhaled corticosteroids in the management of asthma and allergic rhinitis during the pandemic.
* It is probably even more important to use these medications to prevent asthma exacerbations and poorly controlled rhinitis with sneezing and rhinorrhea.
* It is also okay to use systemic corticosteroids when indicated for asthma exacerbations.

**Asthma and COVID-19**

* There has been one report—a Centers for Disease Control and Prevention [Morbidity and Mortality Weekly Report from April 8](https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6915e3-H.pdf)—suggesting that asthma may increase the risk of hospitalization from COVID-19 in 18-49 year-old adults; however, this is based on a small number of patients. And in the opposite direction are data from several cities/countries with high COVID-19 infections where asthma was under-represented in those who died from COVID-19.
* It is important to stress that the numbers may change. There remain no data on non-hospitalized patients, so it’s not known if asthma is a risk for getting the virus or having more severe disease.
* Again, at this point, U.S. data suggests that asthma may be a risk factor for hospitalization with COVID-19, so it is important to emphasize asthma control with patients.
* Early reports of systemic corticosteroids being associated with death from COVID-19 are being extrapolated to include ALL steroids as being dangerous. However, patients with asthma should be counseled that their inhaled corticosteroids are safe and necessary to continue to use in order to prevent exacerbation.
* They should also be aware that systemic corticosteroids can and should be used to treat an asthma exacerbation, even if it is caused by COVID-19.
* Online discussion of nebulizers is causing confusion for some, as this is misconstrued to indicate that someone can catch COVID-19 from using a nebulizer.
* If patients require treatment with nebulized medications, such as albuterol or atrovent due to asthma, they should start treatment early and repeat until better.
* COVID-19 does not ‘live’ inside nebulizers. However, if the person with asthma who is receiving nebulized treatment has COVID-19, they could spread to others in close proximity due to the respiratory droplets created through the nebulizer.

**Food Allergies**

* Additional counseling may be needed for food allergy patients, especially with moving to grocery and restaurant pick-up service, since patients will not be able to pick and choose their favorites or query wait staff or chefs.
* Epinephrine should still be current and kept on hand.
* Oral immunotherapy patients should contact their allergist to discuss how to dose/maintain their immunotherapy.

**Cytokine Storm**

* Information is circulating online that patients with severe COVID-19 infection experience a cytokine storm.
* This is being extrapolated as some to infer that anyone with underlying ‘inflammation’, including allergic conditions, is at risk to experience this cytokine storm if they become ill with COVID-19.
* There is no evidence to suggest a patient’s allergic rhinitis, atopic dermatitis, chronic urticaria, food allergies, history of anaphylaxis, etc., places them at risk for severe outcomes should they become sick with COVID-19.

**Vaccine Development/COVID-19 Treatment**

* Concepts surrounding the need for clinical trials to demonstrate safety, efficacy, and dosing are challenging for many. Policy makers and medical professionals are making recommendations to skip these necessary steps and start using various treatments, including hydroxychloroquine, on a wide scale.
* It is important to explain the necessary steps involved in drug and vaccine discovery in an effort to help patients understand timeline, expectations, and why some early claims will not pan out (such as what has happened with hydroxychloroquine).
* It can help to explain the important difference between correlation and causation in simple terms and how this relates to the need for randomized controlled trials to demonstrate benefit of any treatment. Describing why personal anecdotes cannot be extrapolated to others is also helpful.

**Addressing False Medical Claims**

* Claims of supplements, vitamins, or foods that ‘boost immunity’ are rampant, including from medical professionals and large healthcare organizations.
* Specific COVID-19 treatments (all unproven) are being touted or sold, including essential oils, supplements, colloidal silver, Vitamin C, elderberry, homeopathy, and chiropractic adjustments.
* False claims of COVID-19 vaccines are being offered online.
* Common themes include extrapolation of laboratory/animal data from small studies, pseudoscientific explanations and anecdotal reports.
* Guide patients towards these simple fact-checking questions for any claim: What are the qualifications of the person making the claim? What does the body of evidence demonstrate for both benefits and risks? Is the person making the claim directly profiting from services or products? How can this apply to my specific situation, including factors pertaining to my medical history and possible interaction with medications or underlying conditions?