Congress Interviews

We spoke to two recent Past Presidents of EAACI about their Presidential terms, their current contributions to the academy, and the progress in their areas of expertise.

Prof Dr. Hab. Ioana Agache

Transylvania University, Brasov, Romania
EAACI Past-President (2017–2019)
EAACI Research & Outreach Committee Secretary

Q1 You are the most recent Past-President of EAACI. What led you to take up such a role, and what were your proudest moments during your term?

I joined EAACI as a junior member some decades ago and I witnessed the academy grow into the most influential scientific organisation in the field of allergy, asthma, and clinical immunology worldwide. I believe that if you have the spirit, empathy, and belief, and you empower peers with similar energy and ideas, together we can accomplish anything that we put our collective minds to. During my presidency, the academy continued to grow in a sustainable way, continuing to build on the traditional EAACI values. However, we have expanded considerably the research and innovation portfolio, the communication and educational tools, and the stakeholder network.

Q2 One of your many contributions to EAACI is being the current Secretary for the Research & Outreach Committee. Please could you tell us about your role and the aims of the committee.

Firstly, the EAACI Research and Outreach Committee (ROC) support allergy, asthma, and clinical immunology research through the coordination and support of the research community. A platform for in-depth knowledge exchange between basic scientists will provide a continuously updated database with the available experimental models with specific benefits, limitations, costs, and availability, and will facilitate research recommendations on allergic disease models with alignment between research centres on standard operating procedures and data quality. Secondly, it will support high-quality and reproducible data by leveraging resources into a joint information exchange

network whilst boosting first-class experimental research through multicentre collaborations and strengthening the validity of the experimental medicine results. This approach will lead to more efficient use of resources and a more significant reduction in the numbers of animals used, thereby enhancing the ethical standards and translational capacity of experimental research. Finally, the EAACI ROC will deliver new forms of translation of key research findings, to better meet the needs of clinicians and more quickly develop precision approaches to improve and cure allergic disease and asthma.

Q3 You were the Project Co-Chair of the newly published EAACI Guidelines on the use of biologicals for severe asthma. What was the rationale for putting these guidelines together, and what are the key take-home messages?

Severe asthma imposes a significant burden on patients, families, and healthcare systems. Management is difficult because of disease heterogeneity, comorbidities, complexity in care pathways, and differences between national or regional healthcare systems. Better understanding of the mechanisms has enabled a stratified approach to the management of severe asthma, supporting the use of targeted treatments with biologicals. However, there are still many issues that require further clarification. These include selection of a certain biological (because they all target almost the same disease phenotype), the definition of response, strategies to enhance the response rate, the duration of treatment, and its cost-effectiveness. The EAACI Guidelines on the use of biologicals in severe asthma follow the Grading of Recommendations, Assessment, Development, and Evaluations (GRADE) approach in formulating recommendations for each product and each outcome. In addition, a management algorithm for the use of biologicals in the clinic is proposed, together with future approaches and research priorities.

Q4 What is the best approach for clinicians to take to ensure they are keeping up to date with the latest guidelines and that they are incorporating them into their day-to-day practice?

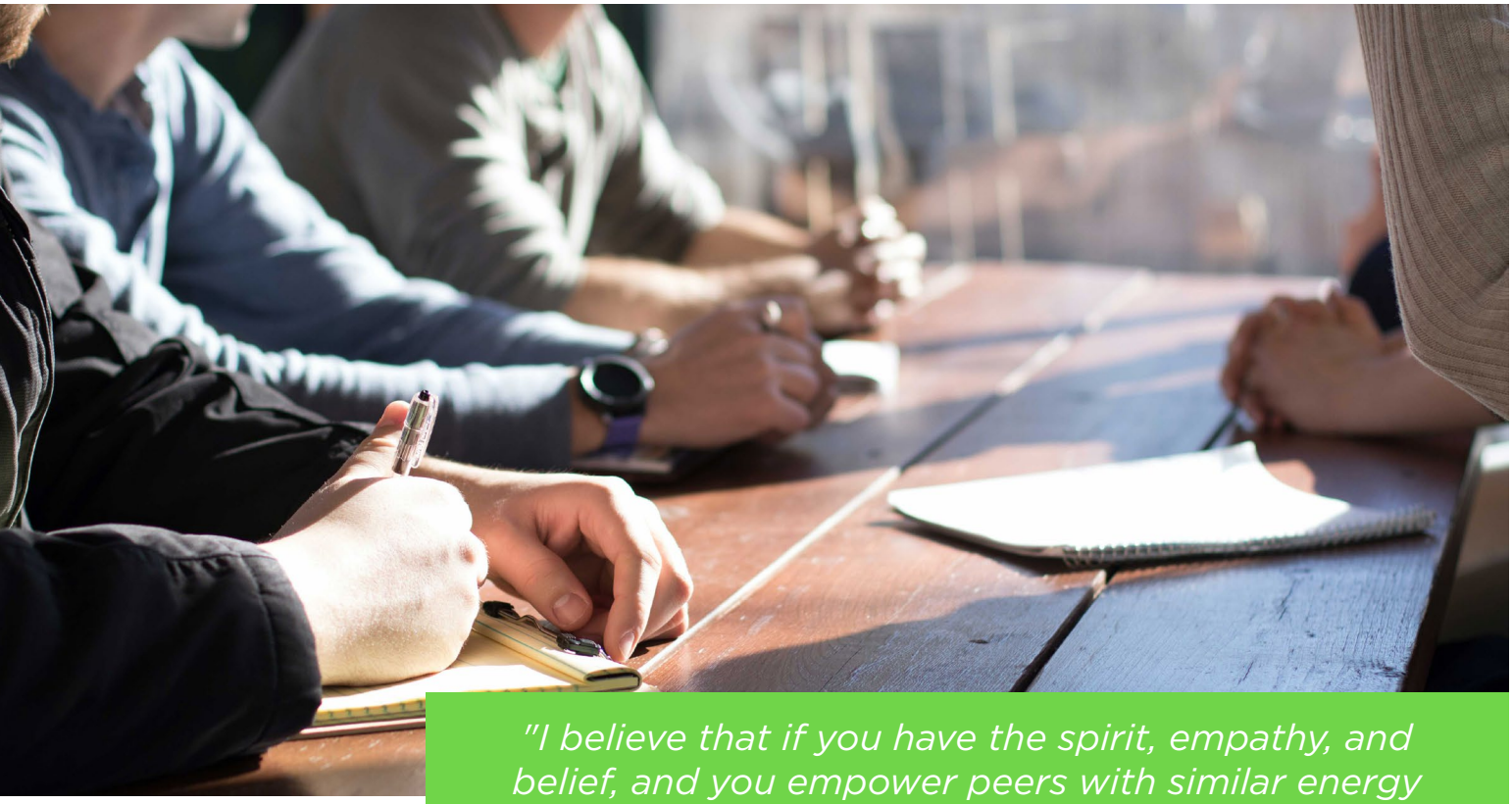
It starts with a switch from drug-oriented to patient-oriented research and with involvement from the very beginning of all stakeholders in the guidelines' development process. Then, the recommendations should be clear, concise, and meaningful for the clinician. Last but not least, flexibility with adaptation according the local environment (e.g., resource-constraint settings, cultural beliefs, local policies) should guide the implementation of the recommendations.

Q5 Earlier this year it was announced that EAACI is launching a research platform. What content will this platform host, and how will it facilitate collaboration?

The knowledge exchange platform will facilitate basic and clinical research career development by expanding the funding opportunities for EAACI fellowships, develop educational and training programmes on cutting-edge research methodologies, facilitate access of EAACI members to research funding opportunities, and inform public policy on research priorities in allergic diseases and asthma via public engagement and outreach activities. Finally, the ROC aims to build an infrastructure that will monitor, analyse, and interpret science and research data to identify trends, barriers and opportunities, as well as strategic imperatives, forecast needs, and directions. In addition, this infrastructure will identify, collect, analyse, and disseminate data related to academic allergy and clinical immunology (funding, pipeline) and provide periodic public policy recommendations on behalf of EAACI.

Q6 As a response to the COVID-19 outbreak, EAACI 2020 will now take place virtually. Do you think this will encourage EAACI to host more virtual events in the future?

Not necessarily. I believe that we should keep a balance between live and virtual events in order to ensure direct networking and communication, whilst outreaching remotely to those who cannot attend in person. Whether through personal mobile devices or sophisticated virtual meeting suites, technology is revolutionising the way meeting content is communicated, both in and out of the meeting room. Not only are people outside the room drawn in, but those within the room have access to a heightened degree of interaction. Hybrid meetings are already a



"I believe that if you have the spirit, empathy, and belief, and you empower peers with similar energy and ideas, together we can accomplish anything that we put our collective minds to."

tradition and we will continue on that path.

Q7

COVID-19 is not only impacting clinicians, but also scientific researchers. What impacts will the COVID-19 pandemic have on the course and direction of your research, or the field of asthma in general?

I saw recently a very interesting headline: "The confrontation between the pandemics and the chronic disease." Both healthcare professionals and patients with asthma were caught in the middle and we all had to adapt fast to ensure optimal care for asthma whilst coping with the pandemic's harsh restrictions, meant to ensure safety at a population level. So, we switched as many patients as possible to telemedicine and ensured direct consultations for all those in need, including diagnosis of new cases. The overall goal was to ensure optimal asthma control and accessibility to proper care, either in person or virtually. As for research, it never stopped, because patients with asthma are in urgent need of new medications, although we had to adjust here as well and postpone all unnecessary evaluations until the restrictions are lifted. The major lesson learned is that we have to invest more in the near future in strengthening both the European Union and the national competence in health. Hopefully, more funding will be allocated for medical research, innovation, and quality care for chronic diseases.

Q8

One of your research focusses is asthma phenotypes and endotypes. In your opinion, what have been the most influential developments in this field over the recent years?

The management of severe asthma evolved from the bulk approach to stratified management based on disease phenotypes. However, the burden of the disease did not improve as expected. This is particularly due to the fact that phenotypes do not necessarily relate to or give insights into the underlying pathogenetic mechanisms which are described by the disease endotypes. Based on the major immune-inflammatory pathways involved, Type-2 high, Type-2 low, and mixed endotypes are described for severe asthma, with several shared pathogenetic pathways such as genetic and epigenetic, metabolic, neurogenic, and remodelling subtypes. The concept of multidimensional endotyping as an unbiased approach to severe asthma and precision immunology are new tools facilitating the shift from the stratified to the precision medicine approach.