



Focus on Interdisciplinarity – Better Together: EAACI 2025

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ASTHMA is an inflammatory airway disease with a high prevalence in many parts of the world. It is characterised by variable airway obstruction in response to different triggers, and is shaped by an interplay of host and environmental factors.

Interdisciplinarity in clinical medicine refers to co-operating with clinical colleagues outside of one's own field of expertise, especially when investigating and treating patients with disease involvement in different organ systems. Presentations from the 2025 European Academy of Allergy and Clinical Immunology (EAACI) Congress showcased these concepts.

ASTHMA PHYSICIANS AND OTORHINOLARYNGOLOGISTS CAN, DO, AND SHOULD COLLABORATE TO IMPROVE OUTCOMES FOR PATIENTS WITH GLOBAL AIRWAYS DISEASE

Thanks to the groundbreaking work of our colleagues in clinical and basic immunology over the last decades, we have gained a much more detailed understanding of the pathophysiology driving airway diseases. The similarities of the airway epithelium in the upper and lower respiratory tract have led to a 'systems thinking' approach, where asthma is no longer seen as a disease of the lungs only. The concept of 'global', or 'united' airways has gained traction in the clinical community.

THERAPEUTIC INNOVATIONS HAVE TRANSFORMED CLINICAL CARE

The advent of monoclonal antibodies targeting specific steps in the inflammatory cascade has enabled us to treat and help a group of patients with severe inflammatory pathology and involvement in both the upper and lower airways.

Compounds such as mepolizumab, dupilumab, and tezepelumab have proven efficacy in both chronic rhinosinusitis with nasal polyps (CRSwNP), and Type 2 high asthma. Numerous presenters at the EAACI gathering reported on data from both pivotal studies¹⁻⁵ and real world evidence.⁶⁻¹³ Interestingly, the latter does not infrequently seem to outperform clinical studies in terms of long-term and sustained efficacy. Access to these medications and the rules for their use (including reimbursement) vary from country to country, even within Europe.

COMORBIDITIES REQUIRE COOPERATION: HOW, AND WITH WHOM?

The rate of comorbidity between severe eosinophilic asthma and CRSwNP is high, estimated at between 50–70%.^{14–16} The patient journey in the healthcare system can vary substantially. The traditional model of care has, hitherto, usually involved a lead physician trying to coordinate care by means of referrals to other disciplines and collecting their input, often leading to time delays in the process of patient phenotyping and endotyping in order to help choose the best way forward.

“**The rate of comorbidity between severe eosinophilic asthma and CRSwNP is high, estimated at between 50–70%**”

Philippe Gevaert, Professor in Rhinology and Allergy, Ghent University, Belgium, stressed the importance of having friendly collegial relations with his ear, nose, and throat colleagues. In some geographical areas, multidisciplinary conferences are established to discuss and determine whether patients potentially qualify for treatment with biologicals.

AN EXAMPLE OF INTERDISCIPLINARITY IN ACTION FROM SCANDINAVIA

A pilot project that took place at Lund University Hospital, Sweden, was presented in poster format at the EAACI Congress 2025.¹⁷ In this project, the authors established joint interdisciplinary clinics with both ear, nose, and throat, and asthma physicians in the same consultation room with the individual patient. This was done in order to achieve a holistic assessment and directly discuss the available therapeutic options with the patient, which, in many cases, was biological therapy targeted at both the upper and lower airways. In other cases, it was decided to initially optimise local treatment, whilst others were listed for functional endoscopic sinus surgery as a next step. Patients were selected for this interdisciplinary clinic from both specialities.

The close physical proximity in Lund, well-established collegial relations, and support of clinical leadership enabled this attempt to transform care. Of note, the challenges encountered during this pilot were a lack of clinic space and time.

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By implementing the joint interdisciplinary clinic, the time to decision regarding definitive management was shortened, and both patient and clinician satisfaction were high. The institution of such interdisciplinary clinics for a select population of patients was deemed well worth the institutional energy spent. Similar clinics in other locations can likely be established by interested clinicians familiar with their local circumstances. Several other examples of this exist in the Nordic countries.

CLOSING REMARKS

In this era of precision medicine, with an ever-growing armamentarium of therapeutic options, we are well-advised to seek improved collaboration with adjoining disciplines in the interest of our patients.

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