

higher- and lower-starting-dose protocol patients, 98.4% discharged with an aspirin prescription were still taking aspirin at 1 month, indicating low rates of long-term hypersensitivity-related adverse events.

Our study shows that higher-starting-dose protocols (challenge or challenge-desensitization) for aspirin allergic patients with CAD without a history of anaphylaxis can be as safe and effective as lower-starting-dose protocols. Our center showed success in a large number of patients with ACS, in most cases before cardiac revascularization, without an increase in adverse cardiovascular outcomes. There was a high median and cumulative aspirin dose at reaction for all protocols, providing further evidence that low starting doses are unnecessary. Our findings support our center's trend of replacing lower-starting-dose with higher-starting-dose protocols, achieving aspirin's antiplatelet effect more quickly.

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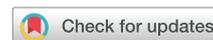
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## Unexpected and unintended cure of habit cough by proxy



In 1966, Dr Bernie Berman, a Boston allergist, described 6 children with a chronic cough that could be stopped by “the art of suggestion.” Dr Berman called this a habit cough.<sup>1</sup> This disorder has been repeatedly described, sometimes with different terms but with the same description of the characteristic sound of the cough, barking or honking, and the absence of the cough once asleep.<sup>2–8</sup> The frequency of habit cough diagnoses was reported at the rates of 7 per year at the University of Iowa<sup>6</sup> and 9 per year at the Brompton Hospital in London England.<sup>7</sup> A median age for children with the diagnosis was 10 years at both institutions.<sup>8</sup> Treatment at the University of Iowa consisted of suggestion therapy. In 1991, I described 9 patients who were successfully treated with suggestion therapy. Seven who could be contacted, even years later, had sustained benefit. Subsequently, I reviewed our experience with 140 children seen from 1995 to 2014. Among 85 of those children who were coughing when seen in the clinic, cessation of cough with suggestion therapy was successful in 81. In this letter, I present some unexpected and unintended additional observations related to this disorder.

In early February 2019, I received an e-mail from the father of a 12-year-old girl with a 3-month history of a repetitive daily cough that was absent once asleep. His online search for help led to me. He and his daughter were at a location 3000 miles from me. Her pediatric pulmonologist was prescribing inhaled corticosteroids, which were providing no benefit. Because she met the criteria for habit cough, I undertook, for the first time, delivering my usual suggestion therapy<sup>9</sup> via Skype. Cessation of cough occurred within 15 minutes. The girl's father recorded the procedure and created a website ([www.habitcough.com](http://www.habitcough.com)) that contained his daughter's history and an audiovisual recording.

The full video was also placed on YouTube (<https://www.youtube.com/watch?v=jnQUvD8QdJ0&t=670s>).

Although the outcome of this patient's treatment via Skype was a satisfying experience, an unexpected and unintended effect of the video was subsequently reported to me. I received unsought e-mails from the parents of 3 children and 2 adults, indicating that watching the young girl respond to suggestion therapy in the video resulted in cessation of their chronic cough.

The first of individuals these reached me in early April 2019. The mother of a 10-year-old boy described her previously healthy son who developed a dry hacking cough “that has not stopped, except at night when he's asleep” after a viral illness 2 months earlier. His pediatrician prescribed steroids, azithromycin, 3 different antihistamines, montelukast (Singulair), amoxicillin and clavulanate (Augmentin), albuterol and beclomethasone (QVAR), benzonatate (Tessalon Perles), dextromethorphan (Robitussin DM), and honey, with no benefit. Chest radiography and laboratory tests provided no diagnosis. The mother, a pediatric nurse, had seen the video at [www.habitcough.com](http://www.habitcough.com) and asked her son to sit by her and watch the video. The mother indicated that “he immediately identified with [the patient]; he jumped right into it and stopped coughing.” An e-mail more than a month later indicated that the previous coughing was still no longer present.

In May 2019, a mother of an 8-year-old girl sent me an e-mail describing her daughter as having a bad cold several months earlier that was followed by 2 months of a persistent daily cough characteristic of the habit cough. Her physician obtained chest radiography and prescribed “asthma and allergy medications” without benefit. A pulmonologist told her daughter to “take some ice water when you feel the cough coming on.” None of the measures were of benefit. Searching for help on the internet, the mother found the video on YouTube. While the 2 of them watched the suggestion therapy procedure on the video, her daughter commented excitedly, “I can hold the cough back.” This

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was followed by cessation of coughing. Mother stated, “THE COUGHING STOPPED! Like turning off a switch.” A subsequent e-mail from the mother reported that the cough was still gone 4 days later.

In June 2019, I received an e-mail from the father of a 9-year-old boy with a history of motor and vocal tics who had a persistent repetitive chronic dry cough. The father indicated that the cough occurred several times per minute and was not present when asleep. When watching the video, the boy first stated, “It’s different than mine,” but then associated what he was observing with his own condition and found he could suppress the cough. The cough was still gone the following day.

I also received e-mails from 2 adult women, 58 and 68 years old. They both indicated that watching the 30-minute video and following along with the dialogue resulted in cessation of their chronic cough. One of the women stated, “I listened to the video and concentrated. It really works.” The other woman commented, “It’s amazing; mind over matter?”

Habit cough causes considerable morbidity, including well-intentioned iatrogenesis, unneeded testing, unnecessary medication, and even hospitalization.<sup>9</sup> Several variations of suggestion are well documented as curative for habit cough.<sup>1,4,5,8</sup> The current unanticipated and unintended observations reported in 3 children and 2 adults demonstrate further the amenability of habit cough to suggestion. The clinical characteristics of habit cough are sufficiently distinct that the diagnosis can be made by the typical history of a repetitive harsh, barking, or honking cough, occurring up to several times per minute, that is

absent once asleep. No testing is needed for diagnosis, and no medications are needed for treatment. Knowledge and skillful interaction with the patient are the tools for diagnosing and treating this disorder.

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## The practical clinical relevance of rhinitis classification in children with asthma outcomes of the “Control’Asma” study



Asthma and rhinitis may share pathogenic mechanisms, and extensive investigation has been devoted to exploring their reciprocal impact. A recent prospective study investigated the prevalence of rhinitis and its phenotypes, symptom severity, and medication use in 619 children with asthma.<sup>1</sup> Rhinitis was found to be a common asthma comorbidity (93.5%) and was refractory to standard rhinitis medications. Perennial allergic rhinitis with seasonal exacerbation caused by poly-allergy was common (34.2%), mostly severe, and often associated with difficult-to-control asthma. In line with previous evidence,<sup>2,3</sup> the study concluded that poly-allergy should be considered a significant risk factor for poor control of asthma.

The Italian Society of Paediatric Allergy and Immunology recently established a Study Group (“Control’Asma”) to evaluate asthma control in children managed in clinical practice. In this context, the group considers rhinitis a comorbidity worthy of investigation. We therefore conducted a study aimed at evaluating the prevalence and impact of rhinitis and its phenotypes on asthma outcomes in a large group of children with asthma.

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Author’s contribution: MAT, MD, GM, and GC designed the study, GC wrote the manuscript.

We enrolled and visited 333 children across 10 Italian paediatric allergy centers. Information was gathered about asthma duration, asthma control levels, and asthma severity grade according to the Global Initiative for Asthma (GINA) guidelines.<sup>4</sup> Emergency department admissions, absences from school, current use of medications, including inhaled and oral corticosteroids, were also reported, and also body mass index (BMI) assessment, lung function testing, fractional exhaled nitric oxide (FeNO) measurement, and children’s asthma control test score (c-ACT). Children self-administered the children asthma control test (c-ACT) questionnaire. The Review Ethics Committees approved the study procedure, and written informed consent was obtained from the parents of all children. Clinical data were recorded on an electronic case report form approved for this study.

Demographic and clinical characteristics are described using means with standard deviation for normally distributed continuous data (eg, age), medians with lower and upper quartiles for not normally distributed data (eg, FeNO levels), and absolute frequency and percentages for categorical data (eg, frequency of male subjects). The normality of distribution was assessed by Shapiro-Wilk W test. Normally distributed quantitative data were analyzed using analysis of variance (ANOVA) followed by a Sheffè post hoc test, and non-normally distributed quantitative data using a Kruskal-Wallis test followed by Bonferroni’s correction. Comparison of frequency distributions was made by means of the  $\chi^2$  test or Fisher’s exact test in case of expected frequencies less than 5, followed by Bonferroni’s correction. Statistical significance was set