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I am the Allergist for Peter and Matthew Avoletta. I urge this committee to **reject HJ NO. 6**, a resolution of the Claims Commissioner to dismiss the claims of Joanne, Peter and Matthew Avoletta, and instead, order the relief requested.

I am a Board certified physician, who has known this family for 10 years. I also have treated other children who attended the Torrington Public Schools. Like several other buildings in this state, the Torrington public schools have been plagued with mold and poor indoor air quality due to repeated water incursion from faulty design and maintenance. As a result, several children and teachers have become ill.

When Peter Avoletta attended the Torrington Public Schools, I diagnosed him as having moderate to severe symptoms associated with allergic rhinitis, sinusitis and asthma. He continues to recover from prolonged mold exposure to which he was subjected while attending Torrington Middle School and later Torrington High School.

I also diagnosed his brother, Matthew with symptoms associated with allergic rhinitis, sinusitis and asthma secondary to indoor mold exposure. I saw firsthand the ill effects that Peter suffered while attending the Torrington Public Schools and I recommended that both Peter and Matthew not continue to attend those schools in order to prevent further harm to their physical health. I also was in contact with their allergist, Dr. Randolph, who concurred that continued attendance of these disabled children in the Torrington Public Schools was medically contraindicated.

The Avoletta parents followed my recommendations and the recommendations of their other allergist and kept the children from continued attendance at those schools to prevent further detrimental health effects.

I have been in constant contact with the Avoletta family through these many years watching as they tried to obtain a safe placement for their children. Unfortunately, the Torrington School District, along with other State officials, ignored my recommendations and continued to try to get the children to attend the unsafe school buildings. When this failed they fought the parents from obtaining just compensation.

For me to watch this travesty of justice, knowing the harmful effects that moldy buildings have on children and adults, and after fighting with other parents to obtain passage of the Indoor Air Quality Act that was supposed to make sure that all public school districts provide a healthy and safe environment for all children, I am not happy. This legislature took an important step in addressing the problem of moldy school buildings when it adopted the Indoor Air Quality Act. Unfortunately, the provisions of that act have not been adequately enforced by the State. There are many other children

who go to school every day in unsafe school buildings and who are continuing to be harmed, just as the Avoletta children were.

I feel that the State has an obligation to make sure that all children receive an appropriate education in a safe school setting. When it fails to enforce these statutory obligations, those who are harmed should be compensated.

The Avolettas should not be penalized for seeking relief from the Attorney General and the State Education Department before filing a claim with the Claims Commissioner. They followed my direction and the direction of various other state officials. When children are harmed because of the improper actions of the State, the State should be made to compensate for the harm it has done.

Please overturn the Claims Commissioner's decision and order compensation to the Avoletta children. This decision will show that the legislature is serious about the statutes that it adopts. Good indoor air quality and a safe school setting is very important for all school children.

Sincerely,


John Santilli MD

H.J No. 6 - Judiciary Committee

March 3, 21010 - Avoletta vs. CT State Dept. of Education.

Cover page for Dr. John Santilli's (10) page report to be entered for the record and considered as per his request.

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December 10, 2009

Re: Matthew Avoletta

DOB: 3/1/1992

To Whom It May Concern:

This letter summarizes my review of the medical history of Matthew Avoletta. My conclusions are based upon my experiences as a board certified allergist with a private practice for the past 35 years. I also have numerous publications in peer-reviewed medical journals including research on the health effects of mold exposure.

In recent years, the medical community has developed a very clear position on exposure to indoor mold and damp environments, which the NIOSH has summarized on their web site. Health problems associated with excessive damp conditions and mold, specifically allergies and asthma are discussed on their web site:

“Allergic responses like those to pollen or animal dander are the most common types of health problems related to mold. Typical symptoms include sneezing; irritation of the nose, mouth, or throat; nasal stuffiness and runny nose; and red, itchy or watery eyes. Inhaling or touching mold or mold spores can cause a person who was not previously allergic to mold to become allergic to mold. For people with known allergies, molds can trigger asthma symptoms such as shortness of breath, wheezing, or cough. Irritation can also occur in non-allergenic (non-sensitized) people. Additionally, scientific studies indicate that exposure to molds in the workplace can make pre-existing asthma worse. Recent NIOSH investigations document that some damp buildings are associated with developing new asthma

Asthma is a form of lung disease in which the airways develop inflammation and bronchospasm (reversible narrowing) in response to sensitizing or irritating exposure. Affected individuals can experience episodes of shortness of breath, cough, chest tightness, and wheezing. These symptoms occur after exposure to nonspecific irritating substances in the air or after exposure to substances to which an individual is allergic. Medical testing typically reveals evidence of bronchial hyper-responsiveness such as an abnormal methacholine challenge test or reversible airways obstruction on spirometry (a test of lung function). It is important for affected individuals to have a comprehensive asthma treatment plan and regular follow-up with their physician. Early diagnosis and removal from the impacted damp office environment can cure asthma caused by workplace exposures.

In approximately 15% of asthmatics, the illness may have been caused, or made worse, by workplace exposures. Some occupational exposures are well known risks for asthma development (e.g., western red cedar; isocyanates). Indoor environment research has

identified evidence of an association between damp buildings and asthma symptoms in individuals with pre-existing asthma. There is also new evidence of an association between damp buildings and new-onset asthma. In an individual with new-onset asthma or worsening of stable pre-existing asthma, measurements of lung function made several times a day at work and at home over several weeks may reveal a pattern of changing lung function that suggests a workplace cause.

For individuals with new-onset asthma or worsening of stable pre-existing asthma that is suspected to be related to the indoor environment, controlling or eliminating the sources of indoor contaminants, along with optimal medical treatment, may lead to symptoms of improvement or resolution.”[1]

A recent review of student asthma rates and environmental audits of school buildings suggests that schools with poor indoor air quality have higher-than-average rates of asthma. Many Boston Public School (BPS) children and staff are learning and working in poor indoor environmental conditions that not only can exacerbate asthma, but also lead to other problems ranging from allergies and sinus infections to adverse academic performance. The Boston Urban Asthma Coalition (BUAC) conducted a preliminary analysis of 2004-05 childhood asthma rates for BPS students and compared them to the 2004-05 environmental audits of the top 10 schools with environmental problems. This analysis suggests that schools with the highest rates of leaks, mold, and pest infestations also have higher-than-average asthma rates for children. [2]

Matthew Avoletta Medical History

Matthew was initially seen in my office in July 2003. His mother reported that his symptoms, which included itchy eyes, sinus pain, headaches, post nasal drip, nasal congestion, cough, wheeze and shortness of breath, fatigue and difficulty concentrating began while attending the Torrington Elementary School and visiting the Middle School. Both schools had experienced water intrusion that lead to mold growth and contamination. Matthew always felt better when he was away from school on weekends and summer vacation.

Matthew reports: “I felt sick with eye problems, sore throats, fatigue and trouble breathing from kindergarten through fifth grade. I was absent for many school days or attending school while ill for fear of missing too much work. I had frequent visits to the Pediatrician and needed many different medications.

During fourth and fifth grade I performed in a band concert at the Torrington Middle School. On both occasions as well as on separate trips to the school I became ill. I would feel better once I was away from the school. I was advised by Dr. Santilli and Dr. Randolph not to attend Torrington Middle or High School until they were remediated and deemed safe. Since I could not attend the Torrington schools per the advice of his physicians, I chose the Chase Collegiate School in Waterbury. The Waterbury school had no problem with indoor air quality.

I enjoy sports and competing in athletic events, something I knew I would have to sacrifice at the small private Waterbury School. I also had to make new friends who lived a considerable distance away from his Torrington home. Although these sacrifices were hard to make I knew regaining my health was more important.

Since attending my new school, Chase Collegiate, I have seen a positive change in my overall health. I usually feel better and my ability to concentrate and do my school work has noticeably improved. I need an occasional allergy medication and recently restarted immunotherapy which

was very effective in the past. I once again able to participate in sports without needing my bronchodilator.

Currently I still experience periodic allergy symptoms, especially if exposed to molds. When I develop allergy symptoms such as fatigue, eye symptoms, runny nose, cough or chest tightness, my school work suffers. I sometimes find it difficult to focus and concentrate on my school work or pay attention. I feels very frustrated when I have an allergy flare-up since it so negatively affects my life."

Test Results

His physical exam on initial visit was unremarkable. His nares appeared pale and boggy, chest was clear. His blood work from July 2003 showed a low IgA and 12 pneumococcal antibody panel (1/12).

Matthew was RAST positive to the molds: *Alternaria*, *Aspergillus fumigatus* and *Penicillium*. He was also allergic to cat dander, dust mites, dog dander, tree and grass pollen, ragweed, corn, egg white, wheat, soy and peanut.

Rhinitis Outcomes Questionnaire

We administered the Rhinitis Outcomes Questionnaire (ROQ) to assess the patient's symptoms [3]. This standardized and validated symptom questionnaire has a maximum score of 130 and a minimum score of 0. The survey considers allergic rhinitis symptoms, asthma-related symptoms and overall quality of life symptoms. The higher the score, the more allergic symptoms a patient has. It evaluates a patient's symptoms before their exposure, at the height of the exposure and after the exposure has ended.

The ROQ was adapted from a previous questionnaire by the members of the Rhinitis Committee of the American College of Allergy, Asthma, and Immunology, and modified to include input from the College's Executive Committee. The questionnaire is divided into five parts. The first part evaluates global symptoms, and the second, third, and fourth parts comprise specific symptoms of the nose, eyes, and chest. Each symptom question was scored on a Likert scale from 0 to 5 indicating the level of involvement (0 = none; 1 = minimal; 2 = mild; 3 = moderate; 4 = severe; and 5 = very severe). The fifth component of the evaluation collected a symptom-specific medical treatment history by frequency counts, including hospitalization, emergency room visits, sinus surgery, antibiotics, and other medication use.

This questionnaire was validated using relevant statistical methods of assessing the validity, reliability, and responsiveness of the ROQ, relying on a validation process that has been used successfully on different instruments. Four types of validity were used as criteria for evaluating the quality of this instrument: 1) content validity; 2) statistical validity; 3) construct validity; and 4) predictive validity. Additionally, the reliability of the scale used to score symptom responses and the overall responsiveness of the questionnaire were evaluated. The results of the statistical validation were published in the peer reviewed allergy journal *The Annals of Allergy, Asthma & Immunology*.

Peer review is a scholarly process used in the publication of manuscripts. Publishers use peer review to select and to screen submissions. The process also subjects an author's work or ideas to the scrutiny of one or more others who are experts in the field and forces authors to meet the standards of their discipline and thus achieve scientific objectivity. Scientific journals observe this convention universally.

Matthew Avoletta's ROQ results

Matthew scored 0 prior to attending the Torrington Schools and 100 (severe symptoms) at his worst while attending the Torrington Schools in 2003. As of July 2008 he had a score of 7 (minimal symptoms). Currently when exposed to mold his score increased to 66 (moderate to severe symptoms). He experiences fatigue, headaches, eye symptoms and asthma.

Cognitive Questionnaire

There is a growing body of evidence in the scientific literature supporting the relationship between allergic symptoms and cognitive impairment and depression. A 2007 study evaluated over 5800 residents of eight European cities and found that dampness and mold in homes were associated with depression [4]. A 2004 consensus report found that uncontrolled allergic rhinitis symptoms can diminish cognitive functioning in school children [5]. Furthermore, allergic rhinitis caused by seasonal exposure to ragweed is associated with decrements in vigilance and speed and efficiency across several cognitive domains. [6,7]

A recent study: "Sleep, Quality Of Life, And Productivity Impact Of Nasal Symptoms In The United States: Findings From The Burden Of Rhinitis In America Survey" concluded that Rhinitis is a common chronic condition that has been shown in observational and interventional studies to have a substantial impact on the sufferer. This study was performed to describe the impact of symptoms of allergic rhinitis (AR) on sleep, quality of life, and productivity in a U.S. population. A cohort of AR sufferers and non-AR sufferers was assembled by screening a representative sample of 15,000 households with a self-administered questionnaire in January 2004. A subsample of respondents received a detailed follow-up questionnaire in the May/June pollen season. Of the 7024 individuals with complete data, 3831 met the case definition of AR sufferer; 3193 were non-AR sufferers. Overall, AR sufferers had consistently poorer average scores on the sleep, quality of life, cognition, and productivity scales compared with non-AR sufferers. Subjects with AR symptoms had more sleep impairment (51.2) compared with subjects with non-AR symptoms and those with no symptoms (59.8 and 63.3, respectively). Only 3.6% of subjects with AR symptoms experienced 100% sleep adequacy compared with 11.7% of subjects with non-AR symptoms and 19.2% of subjects with no symptoms. Quality of life and cognition scores were worse in subjects with AR symptoms compared with subjects with non-AR or no symptoms. Work and school productivity was significantly reduced in subjects with AR symptoms in the past 4 weeks compared with subjects with no symptoms ($p < 0.05$). **Individuals who suffer from AR symptoms experience a substantial burden on their ability to sleep, quality of life, cognitive function, and school/workplace productivity. [8]**

We administer the Cognitive Questionnaire (CQ) [9] to assess a patient's cognitive symptoms on the same timeline as the ROQ. This cognitive symptom questionnaire has a maximum score of 120 and a minimum score of 0. The higher the score, the more cognitive problems a patient has. It evaluates a patient's symptoms before their exposure, at the height of the exposure and after the exposure has ended.

Matthew Avoletta's CQ results

Matthew score 77 (moderate to severe symptoms) while in the Torrington Schools and 57 (moderate to severe symptoms) when exposed to molds (currently).

Allergy prevention

Guidelines published by the German Society for Allergology and Clinical Immunology (DGAKI), in cooperation with the Society of German Allergologists (ADA), the German Society for Pediatric and Adolescent Medicine (DGKJ), the German Society of Dermatology (DDG) and the German Society of Pediatric Allergology (GPA) are summarized here:

“The further increase of allergies in industrialized countries demands evidence-based measures of primary prevention. The recommendations as published in the guideline of 2004 were updated and consented on the basis of a systematic literature search. Evidence from the period February 2003-May 2008 was searched in the electronic databases Cochrane and MEDLINE as well as in reference lists of recent reviews and by contacting experts. The retrieved citations were screened for relevance first by title and abstract and in a second step as full paper. Levels of evidence were assigned to each included study and the methodological quality of the studies was assessed as high or low. Finally the revised recommendations were formally consented (nominal group process) by representatives of relevant societies and organizations including a self-help group. Of originally 4556 hits, 217 studies (4 Cochrane Reviews, 14 meta-analyses, 19 randomized controlled trials, 135 cohort and 45 case-control studies) were included and critically appraised.

Grossly unchanged remained the recommendations on **avoiding environmental tobacco smoke**, breast-feeding over 4 months (alternatively hypoallergenic formulas for children at risk), **avoiding a mold-promoting indoor climate**, vaccination according to current recommendations, and avoidance of furry pets (especially cats) in children at risk.

The recommendation on reducing the house dust mite allergen exposure as a measure of primary prevention was omitted and the impact of a delayed introduction of supplementary food was reduced. New recommendations were adopted concerning fish consumption (during pregnancy / breast-feeding and as supplementary food in the first year), avoidance of overweight, and reducing the exposure to indoor and outdoor air pollutants. The revision of this guideline on a profound evidence basis led to (1) a confirmation of existing recommendations, (2) substantial revisions, and (3) new recommendations. Thereby it is possible to give evidence-based and up-to-date recommendations on primary prevention of allergies.”[10]

Mold Exposure and Public Health

Mold exposure clearly has a negative impact on health, particularly in atopic patients. The mold exposure at an elementary school in Connecticut caused more than 85 of the students, teachers and staff to suffer from various symptoms ranging from headaches, post-nasal drip, wheezing, skin rashes, and recurrent sinus infections. Several teachers continue to experience health issues even though their exposure ended over two years ago [11,12].

Our public schools were the first buildings to be diagnosed with poor indoor air quality, in large part because parents will go to great lengths to advocate for their children's health. Through their efforts, many schools have been successfully remediated or replaced. Public schools are not the only buildings with poor indoor air quality. A recently published medical evaluation of occupants of a water-damaged office building confirms that occupancy of this building was associated with the onset and worsening of respiratory conditions, confirmed by objective medical tests. These conditions include adult-onset asthma and hypersensitivity pneumonitis, an inflammation of the lung caused by the body's immune reaction to small air-borne particles such as mold. [13]

The EPA states that "Molds can trigger asthma episodes in sensitive individuals with asthma. People with asthma should avoid contact with or exposure to molds." 1 "Some people are sensitive to molds. For these people, exposure to molds can cause symptoms such as nasal stuffiness, eye irritation, wheezing, or skin irritation. Some people, such as those with serious allergies to molds, may have more severe reactions. Severe reactions may occur among workers exposed to large amounts of molds in occupational settings, such as farmers working around moldy hay. Severe reactions may include fever and shortness of breath. Some people with chronic lung illnesses, such as obstructive lung disease, may develop mold infections in their lungs." [14]

The National Institutes of Health also recognizes the negative health impact of mold and their web site links to the EPA web site. [15] Molds produce mycotoxins under certain circumstances. Many symptoms and human health effects attributed to inhalation of mycotoxins have been reported. These symptoms and effects include mucus membrane irritation, skin rash, nausea, immune system suppression, acute or chronic liver damage, acute or chronic central nervous damage, endocrine effects, and cancer. It is clearly prudent to avoid molds and mycotoxins.

World Health Organization

The World Health Organization (WHO) conducted a comprehensive review and evaluation of scientific evidence on the health effects of indoor air pollution and the factors that contribute to the growth of indoor microbial agents. According to WHO, problems of indoor air quality are important risk factors for human health in low, middle and high income countries. Indoor health is important because humans spend a good amount of time in buildings. Microbial pollution occurs when there is sufficient moisture available for mold and bacterial growth. Exposure to these contaminants is associated with respiratory symptoms, allergies, asthma and immunological reactions. There is clinical evidence that exposure to mold and other dampness-related microbial agents increases the risks of rare conditions such as hypersensitivity pneumonitis, allergic alveolitis, chronic rhinosinusitis and allergic fungal sinusitis. Evidence supports the occurrence of diverse inflammatory responses after exposure to microorganisms from damp buildings.

On the basis of the study by WHO, these guidelines were formulated to improve air quality:

1. Persistent dampness and microbial growth on interior surfaces and building structures should be avoided or minimized
2. Presence of condensation on surfaces or structures, visible mold growth, moldy odor or history of water leaks or damage are indicators of dampness and microbial growth and should be addressed
3. Mold and dampness-related problems should be prevented or remediated as soon as they occur
4. Management of moisture by controlling temperature and maintaining adequate ventilation to avoid excess humidity, condensation on surfaces and excess moisture in materials
5. Building owners are responsible for providing a healthy workplace or living environment free of excess moisture or mold by ensuring proper construction and maintenance of the building [16]

Scientific Literature

Fungi are able to invade into human tissue and can cause inflammatory reactions, especially in immuno-compromised individuals. [17] Current research has shown substantial evidence that exposure to fungi contributes to the development and severity of asthma, allergic rhinitis and atopic dermatitis in sensitized individuals. It has also demonstrated the relationship between

increased spore counts in an environment and the presence of allergic symptoms. [18] A study of children between the ages of 8 and 18 found that asthma symptom scores increased by 10% to 30% for every 1000 spores/m³ increase in the environment. [19]

Abstracts of Recently Published Studies (2008-2009)

1. Identification of mold and dampness-associated respiratory morbidity in 2 schools: comparison of questionnaire survey responses to national data. (2008)

Background: Dampness and mold problems are frequently encountered in schools. Approximately one third of US public schools require extensive repairs or need at least 1 building replaced. This study illustrates how national data can be used to identify building-related health risks in school employees and students.

Methods: School employees (n = 309) in 2 elementary schools (schools A and B) with dampness and mold problems completed standardized questionnaires. Responses were compared with participant responses from the 3rd National Health and Nutrition Examination Survey and were indirectly standardized for gender, age, smoking status, and (for school B) race. Uncontrolled comparisons were made to responses from a study of office workers, as well as between responses from school employees in different sections of the school buildings designated by decade of construction.

Results: Employees from both schools had excess work-related throat and lower respiratory symptoms, as well as eye, nasal, sinus, and wheezing symptoms. School B employees also had excess physician-diagnosed asthma and work-related fatigue, headache, and skin irritation. Employees in sections of the school buildings that were categorized as having greater dampness and mold contamination had more frequent upper and lower respiratory symptoms than employees working in other building sections.

Conclusions: This non-costly type of analysis of indoor air quality complaints can be used to motivate and prioritize building remediation in public schools where funds for building remediation are usually limited.[20]

2. Occupational Rhinitis In Damp And Moldy Workplaces (2008)

Background: Numerous studies confirm the association between exposure to indoor air dampness and molds and different health outcomes. Of these, upper respiratory tract problems are the most commonly reported work-related symptoms in damp indoor environments.[21]

The aim of this study was to describe a clinically investigated patient series with occupational rhinitis induced by molds.

Methods: Nasal provocation test (NPT) with commercial fungal allergens was performed in 369 patients during 1995-2004 at the Finnish Institute of Occupational Health. Of these, 60 (16%) were positive. In addition to positive NPT, the diagnosis of occupational rhinitis was based on verified exposure to molds, work-related nasal symptoms, and clinical investigations. We wanted to review the patient files of these 60 patients retrospectively, and 56 patients gave their informed consent.

Results: The mean age of the patients was 43.7 years (SD +/- 9.5). Fifty (89.3%) patients were women. In 23% of the patients, IgE-mediated allergy to molds could be established.

Atopy significantly increased IgE sensitization to molds (OR, 10.3 [95% CI, 2.0-52.5]). The most common mold to induce occupational rhinitis was *Aspergillus fumigatus*. Exposure time was over 5 years in 63% of the patients. Association between the IgE sensitization to molds and exposure level was statistically significant (Fisher's exact test, $p = .046$).

Conclusion: This is the first clinically investigated series on occupational rhinitis in relation to a moldy environment. Based on our findings, we conclude that molds growing in conjunction with moisture damages can induce occupational rhinitis. IgE-mediated allergy to molds was not common. Atopy and significant exposure level increased IgE sensitization to molds. [21]

3. Remodeling Of The Lower And Upper Airways (2009)

Background: Remodeling is defined as modeling again or differently, as reconstructing. Remodeling is a critical aspect of wound repair in all organs; it represents a dynamic process that associates the production and degradation of matrix in reaction to inflammation. This leads to normal reconstruction or a pathologic process. **Asthma is a chronic inflammatory disease associated with abnormal airways remodeling.** In allergic rhinitis, another chronic inflammatory disease, remodeling is still poorly understood. Even though inflammation is similar in allergic rhinitis and asthma, the pathologic extent of nasal remodeling, as well as its clinical consequences, might be different from those in bronchi.

Conclusion: Remodeling occurs less in upper airways compared to lower airways; it is apparent, however, that the structure of the rhinitic nose is not normal. [22]

Additional Health Concerns

Exposure to allergens creates allergic inflammation in Matthew. This inflammation means that VOC exposure may aggravate his condition. VOCs are emitted by a wide array of products numbering in the thousands. Examples include: paints and lacquers, cleaning supplies, pesticides, building material and furnishings, office equipment such as copier and printers and fuels made of organic chemicals. Paper product contamination is of particular concern in buildings with a VOC problem or water contamination. This information can be validated by accessing the website: www.epa.gov/iaq/voc.html. This allergic inflammation is associated with asthma, hepatitis, fibrosis, interstitial pulmonary fibrosis, scleroderma and Hodgkin's disease.

Estimated Costs of Treatment

Treatment for allergic rhinitis and asthma usually involves three to four visits to an allergist a year which cost around \$150 per visit and immunotherapy anywhere from 20 to 100+ times per year at a cost of \$100 per visit. Costs to treat symptoms can be estimated as follows:

Non-drowsy antihistamines: \$1200 per year
Steroid nasal sprays: \$1400 per year
Asthma control medication: \$2000 per year
Immunotherapy: \$5600 per year

Estimated Total Cost per year: \$10,200

Medical treatment that will be needed for the next five to ten years. I have found that patients exposed to high levels of indoor mold for a long period of time generally improve after three to five years of treatment and/or medication to control their symptoms. However, re-exposure to even moderate levels of mold in an indoor environment can cause symptoms to worsen.

Conclusion

Matthew Avoletta suffers from symptoms associated with allergic rhinitis, sinusitis and asthma secondary to indoor mold exposure at Torrington Elementary and Middle Schools.

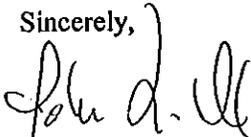
According to his mother there is documentation of roof leaks at Torrington High School from April 2005 through April 2008. All leaks occurred in various locations in the school. Wet ceiling tiles, puddles and wet walls were also observed.

These conditions would be detrimental to Matthew's health since he was advised to avoid any building with water intrusion. Water intrusion leads to mold growth and contamination indoors unless immediate measures are taken to remediate all wet areas. However, in Matthew's case he has been previously sensitized to molds and should avoid all buildings with water damage.

I am of the opinion, within a reasonable degree of medical probability, that the damp environment as validated by the CDC and NIOSH [3] has caused his allergic, cognitive and respiratory problems.

Also, given his medical history and ROQ score when in the school building and confirmation of mold contamination in the Torrington Schools, I conclude within a reasonable degree of medical certainty that the mold in his school environment had a negative impact on his health.

Sincerely,



John Santilli, MD FAAAI FCAAAI

Chief of Allergy Dept of Medicine
St Vincent's Medical Center Bridgeport CT
Chairman Committee on Public Health
CT State Medical Society

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