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Testimony in favor of LD 1927 by Sydney R. Sewall, MD MPH (Hallowell)

Sen Carney, Rep. Kuhn and member of the Judiciary Committee:

I write as a representative of the Maine Chapter of the American Academy of Pediatrics, an organization of over 300 child health practitioners from all corners of the state. While improvements in asthma care over the years have greatly reduced the number and duration of hospitalizations for this condition in children, the burden of disease remains high. If the degree of exposure to an environmental trigger is great enough, even the best interventions may not be able to control symptoms.

I personally have 4+ decades of experience treating children in the Central Maine area -- which included extensive work managing kids with asthma and allergies. I have a vivid memory of one school aged boy who was generally in good control for years -- managed in conjunction with the allergy specialists from Portland. He had significant asthma, but by then (late 90's) we were using inhaled steroids with great success, and the family was conscientious at using all the tools. One winter, his situation deteriorated -- he had a persistent cough and had increasing inability to play hard without wheezing. Over time, he began requiring admissions for oxygen support and needed oral steroids chronically to be comfortable. While the family had allergy proofed the home years prior, we wondered about his school. While past testing had determined it had adequate air quality, repeat testing that spring revealed mold counts that were off the chart -- and the school actually was shut down. Children were moved to other buildings -- and he was MUCH improved -- back to his prior baseline.

In kids without asthma, symptoms of mold exposure can mimic relatively benign but annoying infections -- like having a prolonged cold with chronic runny nose and cough, perhaps with associated itchy eyes. Among children with asthma, the literature suggests that up to 50% have some degree of mold sensitivity as a trigger for attacks. Most will not get as sick as my patient but may need to increase the use of their expensive inhalers to stay out of trouble. Their exertional capacity will also be limited, interfering with sports and play. In more severe cases, they end up in the ER or hospitalized.

Water penetration or plumbing leaks leading to persistent moisture is the cause of indoor mold accumulation. At times, but not always, a musty odor is the tipoff. Since there are no specific measuring techniques that define an abnormal air mold level, we still need to rely on common sense for evaluating housing -- inspections for visible mold accumulation remain the most practical approach. Studies looking to see whether measures addressing visible mold exposure in children with asthma improve lung function have yielded positive results. The interventions that were successful included chemical removal of mold, improving ventilation, and indoor moisture mitigation.

Kids deserve to live in safe housing. We already address other exposures that impair child health -- lead, arsenic, and more recently PFAS. I believe mold should be added to the list. It has a definite role causing a spectrum of respiratory complaints that are easily prevented through remediation. I urge you to vote "ought to pass" on LD 1927.

Sincerely,

Sydney R. Sewall, MD MPH
Hallowell