

REVIEW ARTICLE

Pilot study of mobile phone technology in allergic rhinitis in European countries: the MASK-rhinitis study

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Abstract

Background: The use of Apps running on smartphones and tablets profoundly affects medicine. The MASK-rhinitis (MACVIA-ARIA Sentinel Network for allergic rhinitis) App (*Allergy Diary*) assesses allergic rhinitis symptoms, disease control and impact on patients' lives. It is freely available in 20 countries (iOS and Android platforms).

Aims: To assess in a pilot study whether (i) *Allergy Diary* users were able to properly provide baseline characteristics (ii) simple phenotypic characteristics based upon data captured by the *Allergy Diary* could be identified and (iii) information gathered by this study could suggest novel research questions.

Methods: The *Allergy Diary* users were classified into six groups according to the baseline data that they entered into the App: (i) asymptomatic; (ii) nasal symptoms excluding rhinorrhea; (iii) rhinorrhea; (iv) rhinorrhea plus 1–2 nasal/ocular symptoms; (v) rhinorrhea plus ≥ 3 nasal/ocular symptoms; and (vi) rhinorrhea plus all nasal/ocular symptoms.

Results: By 1 June 2016, 3260 users had registered with the *Allergy Diary* and 2710 had completed the baseline questionnaire. Troublesome symptoms were found mainly in the users with the most symptoms. Around 50% of users with troublesome rhinitis and/or ocular symptoms suffered work impairment. Sleep was impaired by troublesome symptoms and nasal obstruction.

Conclusions: This is the first App (iOS and Android) to have tested for allergic rhinitis and conjunctivitis. A simple questionnaire administered by cell phones enables the identification of phenotypic differences between *a priori* defined rhinitis groups. The results suggest novel concepts and research questions in allergic rhinitis that may not be identified using classical methods.

Survey questionnaires are important tools in clinical practice and epidemiology. The use of information and communications technology (ICT) or health information technology (HIT), such as apps running on consumer smart devices (i.e. smartphones and tablets), is becoming increasingly popular and has the potential to profoundly affect health care (1). Novel app-based collaborative systems can have an important role in gathering information quickly and improving

coverage and accessibility of prevention and treatment (2). Classical tools are being replaced by newer smartphone technologies, providing individual measures across larger populations. However, variation in the mode of delivering a survey questionnaire may affect the quality of the responses collected, and data equivalence between survey questionnaires and apps is lacking (3). There are potential biases when using apps, as the information gathered is usually simple and less complete than when using lengthy questionnaires. Furthermore, the interpretation of studies on health effects is hindered by uncertainties in the exposure assessment (4). Implementing ICT innovations may also have disruptive consequences, so it is important to test applicability in each individual situation. In most instances, studies using ICT tools may have a selection bias as the phenotypic characteristics of the population are poorly known and the study may not be representative of the general population. Thus, the

Abbreviations

AHA, Active and Healthy Ageing; AIT, specific immunotherapy; AR, allergic rhinitis; ARIA, Allergic Rhinitis and its Impact on Asthma; EIP, European Innovation Partnership; HIT, health information technology; ICT, information and communications technology; MACVIA, Contre les MALadies Chroniques pour un Vieillessement Actif; MASK, MACVIA-ARIA Sentinel Network; NAR, nonallergic rhinitis; VAS, visual analogue scale.

information provided by questionnaires and apps is almost certainly not identical, but may provide complementary information for understanding unmet needs of diseases. Moreover, ICT tools may allow the proposal of novel concepts and research questions.

Several unmet needs have been identified in allergic rhinitis (AR). These include optimal AR control, multimorbidities, stratification of patients, promotion of multidisciplinary teams within integrated care pathways, endorsing innovation in clinical trials and encouraging patient empowerment (5, 6). Similar unmet needs have also been found in nonallergic rhinitis (NAR) (7, 8). In addition, NAR endotypes and phenotypes (9) need to be further evaluated to better understand pathophysiology, diagnosis and management (7).

Smart devices and Internet-based applications are already used in rhinitis and may help to meet some of the unmet needs (10–16). MASK-rhinitis (MACVIA-ARIA Sentinel Network for allergic rhinitis), an ICT system centred around the patient (5, 17), is one of the implementation tools of the B3 Action Plan of the European Innovation Partnership on Active and Healthy Ageing (EIP on AHA) (18, 19). A mobile phone app (*Allergy Diary*) central to MASK-rhinitis belongs to the Région Occitanie (France). App users are asked to complete a short demographic questionnaire, thus providing baseline characteristics of their disease, and to use the touch screen to provide a daily visual analogue scale (VAS) score-based assessment of AR control. The *Allergy Diary* has been launched in 20 countries (5, 17).

Aims

At the onset of the project, it was proposed that a first analysis would be carried out after the enrolment of 3000 users. On 1 June 2016, information on baseline characteristics was made available for the first 3260 users of the MASK-rhinitis survey in Europe. The aims of this cross-sectional pilot study were to assess whether (i) *Allergy Diary* users were able to provide baseline characteristics, (ii) simple phenotypic characteristics based upon data captured by the *Allergy Diary* could be identified, and (iii) information gathered by this pilot study might generate novel concepts and research questions.

Methods

Users

All consecutive users from 1 August 2015 to 1 June 2016 were included in the study. Some of the demographic characteristics (age, sex, country and language) were recorded. The App was used by those who found it via the Internet, Apple store, Google Play or elsewhere. A few of the users were clinic patients who were asked by their physicians to use it. However, due to the anonymization of data that was requested in some of the countries, no specific information was gathered. None of the users were enrolled in a clinical study as we aimed to have a real-life assessment. There was no pan-European promotional campaign. Several approaches were proposed in the different countries such as (i) an e-mail

to members of the University Hospital of Montpellier (France) during the pollen season informing them of MASK; (ii) an observational study in Spain; (iii) the involvement of the Allergy societies in Germany, Portugal and Italy; and (iv) press releases and information to allergists during the EAACI meeting.

Allergy diary

The app collects the following data: (i) information on the AR symptoms experienced (nasal and ocular), (ii) disease type (intermittent/persistent), (iii) how symptoms impact users' lives and (iv) type(s) of AR treatment used (Table 1; Appendix). Geolocalized users assess their daily symptom control using the touch screen functionality on their smart phone to click on three consecutive VAS (i.e. general, nasal and ocular symptoms). Mobile phone messaging facilitates the management of AR, providing prompts to assess disease control, to take medication, and to visit a healthcare provider, if appropriate. The system was initially deployed in 15 countries and in 15 languages (translated and back-translated, culturally adapted and legally compliant). It is now also available in Australia, Brazil, Canada, Mexico and Switzerland.

Ethics

The Terms of Use, translated into all languages and customized according to the country's legislation, allow the use of the results for research purposes. The example of the UK terms of use is given in Appendix S1.

The data are anonymized except for the geolocalized data which are never totally anonymous. The European Commission's Article 29 Working Party stated that geolocation information is personal data (http://ec.europa.eu/newsroom/just/item-detail.cfm?item_id=50083) and that information can only be collected, shared or stored with people's express consent. This is the case for MASK, as users agree to geolocation in the terms of use of the App. Moreover, geolocation is optional given that the user can allow it or not on his/her cell phone and that it can be removed at any time. The problem of privacy due to geolocation was examined by the lawyers of each of the countries in which MASK has been launched and it was found to be in accordance with the existing laws. Moreover, geolocation is not used in the data mining process, nor is the phone IP.

An IRB approval was not required.

Outcomes

In this study, VAS measurements were not considered. Only the type and number of nasal/ocular symptoms were assessed to classify the users (Table 1; Appendix S2).

Classification of users

The clinical differentiation between AR and NAR may be difficult. Symptoms may differ depending on allergen sensitivity and exposure, as well as ethnicity, cultural differences,

Table 1 Questions on symptoms and impact of symptoms

Q1: I have rhinitis: Yes/No
Q2: I have asthma: Yes/No
Q3: My symptoms (tick)
<ul style="list-style-type: none"> ● Runny nose ● Itchy nose ● Sneezing ● Congestion (blocked nose) ● Red eyes ● Itchy eyes ● Watery eyes
Q4: How they affect me: My symptoms (tick)
<ul style="list-style-type: none"> ● Affect my sleep ● Restrict my daily activities ● Restrict my participation in school or work ● Are troublesome
Q5: Medications
Q6: Are you currently receiving immunotherapy (a small dose of the thing you are allergic to, usually taken as an injection or placed under your tongue)? Yes/No
If YES to Q6 (Q7 and Q8)
Q7: What allergy is this?
<ul style="list-style-type: none"> ● Grass pollen ● Parietaria pollen ● Birch pollen ● Other pollen ● Dust mite ● Animal ● Cypress tree pollen ● Don't know ● Add allergy
Q8: How do you receive your treatment?
<ul style="list-style-type: none"> ● Injection ● Tablet under the tongue ● Drops under the tongue ● Spray under the tongue ● Other

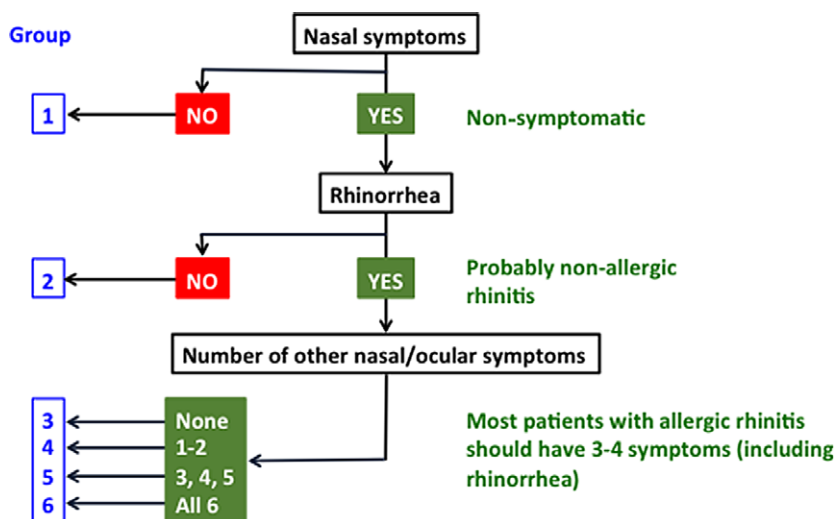
age, sex and other environmental risk factors. In the ARIA report, the major symptom differentiating AR and NAR was proposed to be rhinorrhea (20), although this may also exist in NAR (7, 8). Rhinorrhea is thought to be more severe in patients with pollen allergy than in those with mite allergy. However, it appears that the vast majority of mite allergic patients present rhinorrhea during nasal challenge (21) (K. C. Bergmann, personal communication) or during clinical trials (22, 23). Thus, in general, 'sneezers' and 'runners' may be ascribed to AR, whereas 'blockers' may be ascribed to NAR (24, 25). Patients suffering from AR usually present with all four of the cardinal nasal symptoms at a variable level (i.e. nasal obstruction, rhinorrhea, sneezing and pruritus) (26–29) and often also suffer from conjunctivitis (30, 31).

As a working hypothesis, we proposed to classify symptomatic participants according to rhinorrhea as an entry criterion (Fig. S1).

We then used the McDALL results, which indicated that multimorbidity is associated with more severe disease (32, 33). We hypothesized that users with many nasal and ocular symptoms have a more severe disease (34). Moreover, ocular symptoms are associated with severe AR (34, 35).

Users were classified into six groups: (i) asymptomatic; (ii) nasal symptoms excluding rhinorrhea; (iii) rhinorrhea; (iv) rhinorrhea plus 1–2 nasal/ocular symptoms; (v) rhinorrhea plus 3–5 nasal/ocular symptoms; and (vi) rhinorrhea plus all 6 nasal/ocular symptoms (Fig. 1).

The pharmacologic treatment received by the users was not considered due to the large diversity in this relatively small sample and also because VAS scores for a given level of AR severity are not impacted by medications (36). On the other hand, as there was no information on the effect of allergen-specific immunotherapy (AIT) on work, daily activity or sleep, we compared users who reported AIT with those who reported no AIT.

**Figure 1** Classification of users.

Biases

There are potential measurement biases when using apps, as the information collected is usually restricted and less complete than when using lengthy paper or web-based questionnaires. Furthermore, the interpretation of studies on health effects is hindered by uncertainties in the exposure assessment of pollutants or allergens (4). However, this study was not designed to compare questionnaires with apps. A bias might be introduced given that the app users might be a selected subset of all patients which is not representative. Higher education or specific age ranges might apply. The study was not meant to be representative of the general population.

Size of the study

In this exploratory pilot study, all registered users were included to obtain the best possible estimates for the specified time window.

Statistical methods

The proportion of patients experiencing troublesome symptoms and impairment (i.e. work/school, daily activities and sleep) was described for each of the six symptom groups of the full data set. This aspect was further explored for subgroups suffering from particular symptoms potentially associated with impairment, that is ocular symptoms or nasal obstruction.

The effect of AIT was also analysed. Users were classified into two groups according to AIT status: (i) No AIT (i.e. 'No' to Q6) and (ii) AIT (i.e. 'Yes' to Q6 and responses to Q7 and Q8). Users with a 'Yes' to Q6 and no response to Q7 and/or Q8 were excluded from the AIT analysis.

The statistical analysis used chi-square analysis.

Results

Users

Among the 3260 registered users, 550 did not complete the questionnaire and 2710 files were analysable with reported symptoms and treatments in 20 countries (Table S1). Users included 1165 women (43%) and 1545 men (57%), with a

mean age of 33 ± 6.6 years. Eight countries had more than 100 users and, in some countries, numbers were low. The percentage of users who provided data ranged from 68.4% (UK) to 95.2% (the Netherlands).

AIT use (Q6) was reported by 264 users of which 15 did not respond to Q7 and/or Q8 and were excluded from further analyses (Fig. S2). The number of AIT users was too low to allow complete analyses. However, in group 3 (rhinitis with no other symptom), there was a greater number of users with AIT than without (Fig. S3).

Main results

Users who did not report 'rhinitis' (Q1) did not report any nasal symptom (Q3) and only 5% of them reported ocular symptoms. The impact of the disease (troublesome symptoms, sleep, work or school, daily activities) in the different groups was estimated in the full data set (Table 2). Users with no reported nasal and ocular symptoms (Group 1) rarely had any troublesome symptoms or impairment. Those with symptoms but without rhinitis (Group 2) often had troublesome symptoms (76%) but few experienced impairment of work or school and daily activities. In general, the proportion of patients reporting troublesome symptoms and impairment increased as the number of symptoms in addition to rhinitis increased.

The impact of the disease on each of the six symptom groups in those who did not report AIT was similar to that in the full data set and is shown in the Supporting information (Table S2).

Asthma

Table 3 presents results for asthma reporting. More users without rhinitis did not respond to the asthma question. There was no significant difference between the different groups in reported asthma.

Impact of individual symptoms on impairment

In subjects with rhinitis, the impact of individual symptoms on impairment is shown in Table 4. Impairment at work/school and of daily activities is associated with troublesome symptoms, nasal obstruction and ocular symptoms. On

Table 2 Impairment in users of the full data set ($N = 2710$)

Group	Symptom		N	Troublesome symptoms	Impairment			
	Rhinitis	Any other symptom			Work or school	Daily activities	Sleep	Any
1	No	No	283	20 (7%)	5 (2%)	11 (4%)	11 (4%)	18 (6%)
1†	No	Yes	39	23 (59%)	6 (15%)	5 (13%)	8 (21%)	15 (38%)
2	No	Yes	614	467 (76%)	118 (19%)	170 (28%)	210 (34%)	319 (52%)
3	Yes	None	87	23 (26%)	8 (9%)	17 (20%)	36 (41%)	55 (63%)
4	Yes	1 or 2	366	258 (70%)*	68 (19%)*	100 (27%)	95 (26%)	188 (51%)
5	Yes	3, 4 or 5	870	728 (84%)**	256 (29%)**	394 (45%)*	342 (39%)**	585 (67%)
6	Yes	All (6)	451	398 (88%)	220 (49%)**	284 (63%)**	233 (52%)**	365 (81%)

Chi-square test: $P < 0.01$ group 4 vs 3*; group 5 vs 4**; group 6 vs 5***.

†Subjects who answered "no rhinitis" Q1.

Table 3 Reporting of asthma

Population with informed symptoms (n = 2710)				
Group	N	Asthma (yes)	No asthma	NA
1	322	107 (33.2%)	135 (41.9%)	74 (22.9%)
2	614	202 (32.9%)	339 (55.2%)	60 (10%)
3	87	62 (71.3%)	17 (19.5%)	7 (8.0%)
4	366	105 (28.7%)	208 (56.8%)	47 (12.8%)
5	870	259 (29.8%)	521 (60.0%)	72 (8.3%)
6	451	157 (34.8%)	244 (54.1%)	42 (9.3%)

the other hand, sleep is similar and is high in all groups (Fig. 2).

Discussion

In this pilot study, it is suggested that (i) the *Allergy Diary* users were able to complete the baseline characteristics in 20 countries using 15 languages; (ii) a simple questionnaire administered by cell phones on either iOS or Android platforms allows the identification of phenotypic differences between *a priori* defined rhinitis groups; (iii) a simplistic approach using six categories can be used and (iv) although the sample size is relatively limited, information gathered suggested novel concepts and research questions on AIT or the impact of AR symptoms on work.

Strengths and limitations

The strengths of the mobile technology are obvious. However, there is a need to use appropriate questions, and results should be confirmed by pilot studies. The mobile technology of MASK-rhinitis uses epidemiological methodology stating a hypothesis, collects and analyses data to test the hypothesis, and reaches conclusions about the hypothesis. Moreover, it can also be applied to an unbiased exploratory hypothesis generating investigation purposes.

Smart devices and Internet-based applications are already used in rhinitis (10–15), but the hypotheses raised in the present study have never been assessed.

There are potential biases when using apps as there is necessarily a selection bias: those who use these instruments are likely to be young and well educated. Also, the information gathered is usually restricted and phenotypes less characterized

than when using questionnaires. In the present study, we collected country, language, age, sex and date of entry of information. The response rate was high and most baseline questions were answered by users, suggesting that the *Allergy Diary* is simple and user friendly. However, we did not apply satisfaction or usability questionnaires. Moreover, we did not check accuracy or the time taken to complete the self-administered survey. None of the studies included in a recent meta-analysis assessed how elements of user interaction design, survey questionnaire design and intervention design might influence mode effects (3). Our observations cannot offer any insight into these important questions. Future larger scale studies will permit assessments to address these elements and their interactions.

Additional biases may be introduced by the countries with high versus low numbers of participants, but this will be tested further to the enrolment of more users.

Interpretation of the results and generalizability

Users of the *Allergy Diary* were apparently able to complete the baseline characteristics. It was found that a few questions should be added (current and/or past asthma, current and/or past AIT). The question on asthma did not appear to be discriminative among the asymptomatic and symptomatic groups and should be re-evaluated.

The period of study was winter and spring, suggesting that the relevant allergens were indoor allergens (e.g. house dust mites, animal dander) and pollens.

For the classification of rhinitis, simple phenotypic characteristics based on the information collected by the App could be identified. Rhinorrhea was used as the first discriminating symptom of the algorithm. It appears that users with rhinorrhea had increasing work or daily impairment associated with the increasing number of concomitant symptoms. This finding has not been previously reported and needs to be confirmed in other studies. However, it is in line with the MeDALL results proposing that multimorbidity is associated with severity of allergic diseases (33). The impact of asthma on the severity of AR needs more investigations as it is likely that the questionnaire was not informative enough. A refined version is currently being tested.

In the present study, nasal obstruction and ocular symptoms were associated with impaired work productivity. Although ocular symptoms are the most bothersome symptoms of AR (34, 35), their relationship with work has not

Table 4 Impact of individual symptoms on impairment in subjects with rhinorrhea

			Impairment		
			Work or school	Daily activities	Sleep
Subjects with rhinorrhea (N = 1774)					
Troublesome symptoms	Yes	N = 1407	483 (34%)**	659 (47%)**	603 (43%)**
	No	N = 367	69 (19%)	136 (37%)	103 (28%)
Nasal obstruction	Yes	N = 1274	467 (37%)***	635 (50%)***	591 (46%)**
	No	N = 500	85 (17%)	160 (32%)	115 (23%)
Ocular symptoms	Yes	N = 1324	461 (35%)***	659 (50%)***	541 (41%) NS
	No	N = 450	91 (20%)	136 (30%)	165 (37%)

Chi-square test: ** $P < 0.01$; *** $P < 0.001$; NS: not significant.

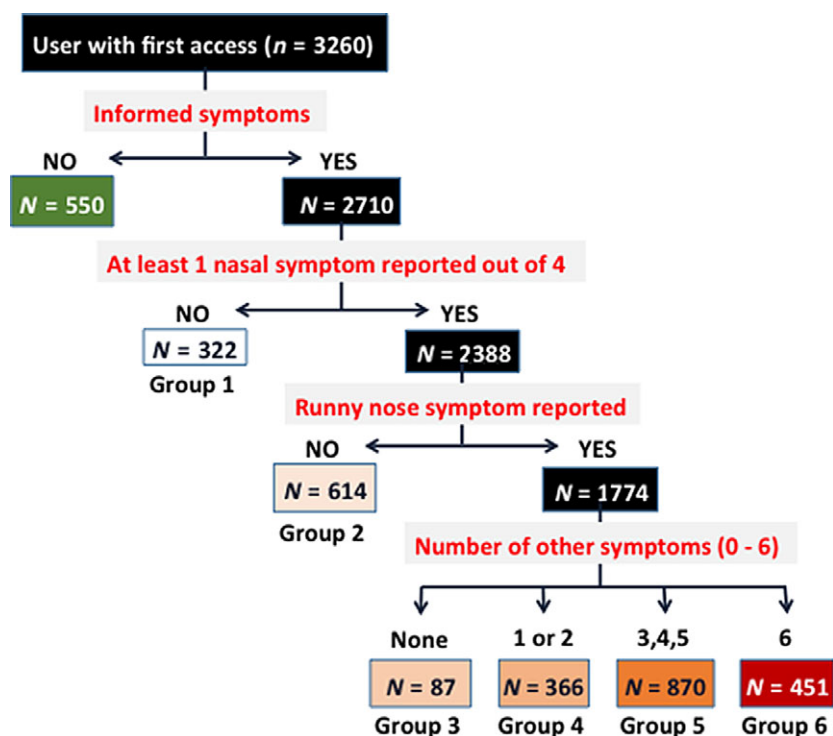


Figure 2 Distribution of the users.

been fully understood. These findings need to be confirmed using appropriate tests such as the Work Productivity and Activity questionnaire (WPAI-AS (37)) and EuroQuol (38), both of which are now embedded in the App.

The severity of symptoms (troublesome symptoms) was associated with an impairment of work productivity, daily activities and sleep. However, ocular symptoms were not associated with sleep impairment.

Interesting findings have been observed for AIT. A higher AIT ratio for Group 3 only suggests a positive impact of AIT on AR management with a reduction in occurrence of other nasal symptoms, although causation cannot be implied in the current study. The number of subjects is low and does not allow any firm conclusion. However, as for pharmacotherapy, treatment does not affect the reporting of impairment by symptomatic subjects.

The mobile technology is available in 15 European countries as well as in Australia, Brazil, Canada, Mexico and Switzerland.

This study shows how data collected via mobile technologies can provide different insights compared to the traditional conduct of research. Information gathered by this pilot study may suggest novel concepts and research questions enabling large studies that collect real-time data on people's location, environment, health and stratification (39).

Author contributions

The following authors participated in the translation, cultural adaptation and country dissemination of the App: J. Bousquet,

D. P. Caimmi, A. Bedbrook, M. Bewick, P. W. Hellings, P. Devillier, S. Arnavielhe, C. Bachert, K. C. Bergmann, G. W. Canonica, N. H. Chavannes, A. A. Cruz, R. Dahl, P. Demoly, A. Finkwagner, J. Fonseca, N. Guldemond, T. Haahntela, B. Hellqvist-Dahl, J. Just, T. Keil, L. Klimek, M. L. Kowalski, M. Kuitunen, P. Kuna, V. Kvedariene, D. Laune, A. M. Pereira, P. Carreiro-Martins, E. Melén, M. Morais-Almeida, J. Mullol, A. Muraro, R. Murray, L. Nogueira-Silva, N. G. Papadopoulos, G. Passalacqua, F. Portejoie, D. Price, D. Ryan, B. Samolinski, A. Sheikh, V. Siroux, O. Spranger, A. Todo Bom, P. V. Tomazic, A. Valero, E. Valovirta, A. Valiulis, O. VandenPlas, M. Wickman, and T. Zuberbier; G. De Vries and M. van Eerd developed the App; E. Mathieu-Dupas analysed the results; S. van der Meulen was the lawyer. Upon submission of a manuscript all co-authors should also be registered with correct e-mail addresses.

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Conflict of interest

Dr. Devillier reports personal fees from Astra Zeneca, personal fees from Stallergenes, personal fees from ALK, personal fees from Meda Pharma, personal fees from GlaxoSmith Kline, personal fees from Menarini, grants and personal fees from Yslab, outside the submitted work; Dr. BACHERT reports other from MEDA, outside the submitted work; Dr. Cruz reports grants, personal fees and other from GlaxoSmithKline, personal fees from MEDA Pharma, other from Sanofi-Aventis, other from Merck, Sharp and Dohme, personal fees from Boehringer Ingelheim, personal fees from Novartis, personal fees from Eurofarma, outside the submitted work; Dr. Just reports grants from Novartis, personal fees from ALK-Abello, personal fees from Stallergenes -Green, personal fees from Astra, personal fees from Thermofischer, outside the submitted work; Dr. Klimek reports grants from ALK-Abelló, Denmark; Allergopharma, Germany; Bionorica, Germany; Biomay, Austria, Boehringer Ingelheim, Germany, Circassia, USA; Stallergenes, France; HAL, Netherlands; Allergy Therapeutics/Bencard, Great Britain/Germany; Hartington, Spain; Lofarma, Italy; MEDA, Sweden; Novartis, Switzerland, Leti, Spain; ROXALL, Germany; GlaxoSmithKline (GSK), Great Britain; Cytos, Switzerland; Curalogic, Denmark, outside the submitted work; Dr. Kuna reports personal fees from Adamed, personal fees from Boehringer Ingelheim, personal fees from AstraZeneca, personal fees from Chiesi, personal fees from FAES, personal fees from Berlin Chemie, personal fees from Novartis, personal fees from Polpharma, personal fees from Allergopharma, outside the submitted work; Dr. Mullol reports grants and personal fees from ALK-Abelló, Boehringer-Ingelheim, Crucell, FAES, GSK, Genentech, Hartington Pharmaceuticals, MEDA Pharma, Menarini, MSD, Novartis, Genentech-Roche, Sanofi-Genzyme, UCB Pharchim, Uriach Group, ALK-Abelló, Boehringer-Ingelheim, Crucell, FAES, GSK, Genentech, Hartington Pharmaceuticals, MEDA Pharma, Menarini, MSD, Novartis, Genentech-Roche, Sanofi-Genzyme, UCB Pharchim, Uriach Group, outside the submitted work; Dr. Price reports other from Aerocrine, Almirall, Amgen Inc., AstraZeneca plc, Boehringer Ingelheim, Chiesi, Meda, Mundipharma, Napp, Novartis International AG and Teva, other from Almirall, Amgen Inc., AstraZeneca plc, Boehringer Ingelheim, Chiesi, GlaxoSmithKline plc, Meda, Mundipharma, Napp, Novartis International AG, Pfizer, Inc., and Teva, grants from UK National Health Service, British Lung Foundation, Aerocrine, AKL Ltd, Almirall, AstraZeneca plc, Boehringer Ingelheim, Chiesi, Eli Lilly, GlaxoSmithKline plc, Meda, Merck & Co., Inc., Mundipharma, Napp, Novartis International AG, Orion, Pfizer, Inc., Respiratory Effectiveness Group, Takeda, Teva, and Zentiva, other from Almirall, AstraZeneca plc, Boehringer

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Supporting Information

Additional Supporting Information may be found in the online version of this article:

Figure S1 ARIA classification of rhinoconjunctivitis symptoms.

Figure S2 Distribution of the users according to AIT.

Figure S3 Stratification of symptomatic users depending on AIT (Q6 + Q7 + Q8: Table 1).

Table S1 Countries of users who informed symptoms.

Table S2 Impairment in users who did not report AIT ($N = 2446$).

Appendix S1 Terms of use for the UK.

Appendix S2 Cell phone screens.

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