OP-ED

Traffic Deaths Are Spiking in Black Communities. Here's How We Can Save Lives.

BY MONTANA WILLIAMS

If you live in Chicago, chances are you've heard about a traffic fatality in your neighborhood over the last year. If you're Black, the chances are even higher. A new report from the U.S. Department of Transportation (DOT) shows traffic deaths are up, and Black pedestrians, drivers, and passengers are being killed at a much higher rate on our nation's roads than other Americans. It's a cost Black communities cannot and should not have to pay.

While the City of Chicago is taking the problem of traffic fatalities seriously, there's more Congress and the federal government should be doing to stop the loss of life happening on our roads.

First, we need a serious investment in infrastructure in Black communities. One of the leading reasons Black people suffer such high rates of roadway injuries is because of a history of disinvestment in Black neighborhoods. City planners have left communities of color without the sidewalks, warning signs, and crosswalks other areas have.

Urban planners have also left minority communities to bear the brunt of traffic by running major highways through them. In Chicago, construction of the Eisenhower Expressway left historically black communities in the South Side cut off and less safe.

To reverse the damage done by these policies, it is vital to fully implement the investments in the recently passed Infrastructure Investment and Jobs Act which put the safety of local residents first. The bipartisan plan includes $5 billion for transportation safety, and Transportation Secretary Pete Buttigieg has committed $1 billion for the "Reconnecting Communities" plan to remove or modify expressways which have isolated and endangered Black and Brown communities.

While the infrastructure bill is a good first step, Congress shouldn't stop there. Making our roads safer will require a multi-pronged approach. To reduce traffic fatalities and increase road safety, lawmakers should work to advance testing for self-driving cars, or autonomous vehicles (AVs).

Research shows 90 percent of car crashes are caused by human error. By eliminating human error, AVs can reduce fatal accidents. Studies suggest putting AVs on the road now could save hundreds of thousands of lives over the long term.

The Autonomous Illinois Initiative has laid the framework for AV testing in the Chicago area, and aims to make Illinois a leader in autonomous vehicle transportation. But federal regulations limit manufacturers to testing just 2,500 autonomous vehicles at a time, meaning it could be many years before Chicago and the rest of the country sees their benefits.

Waiting longer to deploy autonomous vehicles is costing lives, and current regulations limit the industry's capacity to perfect this technology. Right now, Congress has the opportunity to ease these constraints by raising the cap on AV deployment more than thirtyfold, putting self-driving cars on the roads sooner.

Take all the traffic fatalities we've heard about over the past year and imagine for a moment if artificial intelligence had been behind the wheel instead of a speeding driver, or if roads had been designed to protect the lives of pedestrians. The results could have been different.

With DOT's new report on traffic fatalities, there's renewed national attention on making infrastructure in Black communities safer, and we should be using the moment to make investments and advance technologies that do so. To save lives, the Biden Administration must prioritize infrastructure investments in minority communities and update regulations on self-driving cars.

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NEWS

Most Blood Cancer Patients Benefit From a Third Dose of COVID-19 Vaccine

RYE BROOK, N.Y., PRNewswire -- While one in four blood cancer patients do not produce detectable antibodies after their first two doses of the COVID-19 vaccine, 43% of them will produce antibodies after a third dose, according to new data from The Leukemia & Lymphoma Society (LLS). For some patients with blood cancer, the third dose led to antibody levels seen in healthy adults. This was confirmed by measuring levels of detectable antibodies to the spike protein in SARS-CoV-2 before and after the third dose of the mRNA COVID-19 vaccines. Results from the study, the largest of its kind to date, also demonstrate that blood cancer patients who had at least some antibodies after the first two doses are likely to produce large amounts after the third vaccination.

"Our data shows a clear benefit of giving blood cancer patients three primary vaccine doses, but there is still a large portion of patients who will remain at risk even with the additional dose," says Lee Greenberger, Ph.D., LLS chief scientific officer. In this study, about 20% (139/699) of blood cancer patients still had no measurable COVID-19 antibodies after the third dose. The results, which were reported Saturday at the American Society of Hematology (ASH) Annual Meeting in Atlanta, are from the largest pool of blood cancer patients reported to date.

Vaccines stimulate production of anti-spike antibodies, which can block entry of the COVID-19 virus into human cells. Having these antibodies appears to offer protection from getting sick or having severe disease. However, for many blood cancer patients, their antibody levels may not be as strong as those in fully vaccinated, healthy adults – making them more susceptible to a COVID-19 breakthrough infection.

The data reported by LLS are from the LLS National Patient Registry, which has been tracking COVID-19 vaccine response among more than 11,000 blood cancer patients since February 2021. LLS previously reported findings from first and second dose vaccination, as well as a smaller study with third vaccination in near real-time, to help blood cancer patients and their oncologists make informed decisions about vaccines and other measures they can take to avoid infection.

The larger pool of data in the current study, from 699 patients, provides more robust information about how the third COVID-19 mRNA dose works in patients with all types of blood cancer. The study does not include information about response to Johnson & Johnson vaccines.

The study was weighted to include more patients with blood cancers that deplete the immune system's B-cells, which are responsible for making antibodies. Patients with these types of cancer, including chronic lymphocytic leukemia, diffuse large B-cell lymphomas, follicular lymphomas, marginal zone lymphomas, mantle cell lymphomas, and Waldenstrom's Macroglobulinemia, are less likely to develop antibodies. In patients that failed to make antibodies to the initial vaccination, the antibody response after the third vaccination ranged from 0%-48%.

In contrast, the remaining participants had myeloid forms of leukemia, Hodgkin's lymphoma and multiple myeloma, all of which tend to respond more favorably to initial vaccinations as well as the third vaccination. Detectable antibody rates in these patients ranged from 75% to 100%.

Some cancer treatments blunt vaccine response, but one might actually boost it

B-cell depleting treatments, including Bruton tyrosine kinase (BTK) inhibitors and anti-CD20 antibody treatments, are essential for treating certain types of cancer but they blunt immune response either while patients are on therapy, or in the case of anti-CD20 antibody, even many months after the therapy is completed. Among chronic lymphocytic leukemia patients (320 in this study), who are commonly treated with these therapies, 65% who had no therapy for the previous two years produced antibodies to the third vaccine. However, among those who received BTK inhibitors and anti-CD20 antibody treatments within the last two years, just 23% to 41% produced third-dose antibodies.

In this study, some of the patient who were treated with IVIG infusion had unusually high levels of antibodies after a third vaccine dose, including some who were made no detectable antibodies after the first two doses. While the researchers cannot rule out that the large increase in antibodies was due solely to the third vaccine, IVIG infusions are likely to play a role.

Blood cancer patients should follow the CDC vaccination recommendations. But because they may not get optimal vaccine protection, they should continue to wear masks, social distance, avoid poorly ventilated and crowded spaces, and encourage those around them to get vaccinated to avoid infection.

Blood cancer patients should also alert their oncologist immediately if they come in contact with someone who has COVID-19 or if they test positive for the virus. Antibody therapy can help reduce the risk of getting sick or having serious complications from COVID-19, but treatment must start as soon after exposure as possible. In addition, FDA this week authorized a new monoclonal antibody cocktail that can be used to prevent COVID-19 in in immunocompromised patients who do not mount an adequate antibody response to vaccination.

The current study includes 699 patients enrolled in the LLS National Patient Registry who had a third COVID-19 vaccination between June and September 2021. Seventy-five percent of the patients in the study had forms of cancer known to blunt immune response to COVID-19 vaccines and to COVID-19 infection.

The median patient age was 68 years; 55% were female and 95% identified as white. In accordance with CDC recommendations, most patients received the same vaccine (Pfizer-BioNTech or Moderna) for their third dose as they did for the first two. The study does not include information about response to the Johnson & Johnson vaccine because nearly all of the patients in the registry received Moderna or Pfizer vaccines.