

CHRONIC URTICARIA

By J. Allen Meadows, MD

CHRONIC URTICARIA

There are two forms of urticaria (hives) and angioedema (swelling), one form is classified as acute, and the other is chronic. Acute urticaria and angioedema occur in as many as 25% of the population at some point in their life. These acute episodes often last no longer than a day, but may last as long as eight weeks. The cause of acute urticaria and angioedema is sometimes obvious to the patient, and occasionally it is due to a food or drug allergy. Chronic urticaria and angioedema is a far more perplexing problem. When urticaria or angioedema persist for longer than six to eight weeks, it is classified as chronic urticaria.

Chronic urticaria and angioedema results from swelling of the blood vessels near skin and immediately beneath the skin. This is accompanied by leakage of fluid from the blood vessels. The fluid produces swelling. Both dilation and the leakage of fluids is due to chemicals that are released into the skin. These chemicals are normally contained in cells in the body, mast cells, or attached to protein in the blood. In their normal form, contained in mast cells, they produce no damage. However, when they are released into the skin tissues immediately beneath the skin, the dilation and leakage occurs.

Chronic urticaria and angioedema usually are not caused by serious medical problems. In the overwhelming majority of patients, it poses no serious health problems. That is, it is usually not associated with any serious illness, and usually results in no medical complications; it should not shorten life or produce disability. Only rarely is chronic urticaria and angioedema associated with a more serious condition called anaphylaxis. Anaphylaxis is a life-threatening condition associated with shortness of breath, wheeze, vomiting, diarrhea, and other symptoms. Patients who have not previously experienced anaphylaxis are not likely to develop anaphylaxis.

Unfortunately, although this is usually not a life-threatening illness, physicians are usually unable to find a cause to the problem. As in almost every instance in which we do not know the cause of an illness, it is extremely difficult to cure a patient with chronic urticaria and angioedema. Because chronic urticaria is such a frustrating problem (in that we cannot find the cause), we must depend on treating symptoms. Symptom control is sometimes difficult and prescribed medications may cause significant side effects. Numerous drugs have been used to control chronic urticaria, but the main therapies used are antihistamines. In most instances, there is one final consolation. In almost all causes, the illness seems to subside spontaneously with time. Thus, even though we usually are not able to find a cause and might never cure the patient, in most instances, nature has a way of eliminating the problem. Thus, patients with chronic urticaria can expect to eventually obtain relief from this problem spontaneously. Unfortunately, we cannot predict when this will occur. As many as 50% of patients with urticaria will have resolution of symptoms within one to two years. Two-thirds are no longer having symptoms in ten years. Very few patients experience chronic urticaria for longer than 20 years. In the treatment of chronic urticaria, we will strike a balance between effectiveness, side effects, and cost.

At Alabama Allergy and Asthma Clinic, we see four to six new patients a week with urticaria and angioedema. Cause can be determined in less than 20% of the cases seen. The most common identifiable cause of chronic hives is thyroid disease, accounting for 5% to 14% of the total. Any endocrine infectious or autoimmune illness can trigger the hives. Recent research suggests that 40% to 60% of patients with chronic urticaria and angioedema have a specific condition for which there are no diagnostic tests. Perhaps, this explains why we find a specific cause in such a small percentage of patients. With this autoimmune condition, which will likely be called Kaplan's disease, people make autoantibodies to the allergy cells normally found in the skin, called mast cells. Those potential causes of urticaria are rare, and diagnostic tests are pursued only if clues in the history indicate a need for tests. Although many physicians and patients believe chronic urticaria is the result of an allergy to something like a food, only rarely is chronic urticaria a manifestation of an allergic condition. In patients with urticaria having lasted longer than two or three years, diagnostic tests are usually not recommended.

Treatments

1. Antihistamines (Zyrtec, Allegra, Tavist, Benadryl, hydroxyzine, ciproheptatine) - Classic H1 antihistamines are designed to counteract one of the main chemicals, histamine, believed responsible for the production of symptoms. In some patients, they are quite helpful. These drugs are quite safe. The only common side effect of antihistamines is drowsiness. However, there are several non-sedating antihistamines that may be effective in controlling symptoms without drowsiness.
2. Doxepin (Sinequan) - This is a unique, old, drug originally used as a tricyclic antidepressant. It is a very potent H1 antihistamine (25 times stronger than Benadryl) and H2 antihistamine (7 times stronger than Ranitidine). Doxepin causes particularly severe sedation, and patients may be unable to work for several days when it is first started. This is the most potent antihistamine available to treat urticaria.
3. H2 antihistamines (Zantac, ranitidine, Pepcid) - Although these agents are usually prescribed for stomach conditions, the skin also contains H2 receptors. H2 antihistamines are useful only in combination with classic antihistamines to help them work better.
4. Leukotriene modifiers (Singulair, Accolate) - These drugs work additively with antihistamines. They are less effective in controlling of hives when used alone. They are currently only approved for use in asthma and nasal allergies.
5. Oral Steroids (prednisone, methylprednisolone) - These are usually the most effective medications. Unfortunately, there are severe side effects associated with long-term use of steroids and, therefore, they are usually used for brief periods of time. Oral steroids can be administered safely for short periods during severe episodes, or during times at which the patient particularly needs to be clear, such as important social events, business meetings, the prom, etc.

6 Anti-hypertensives - Medications used to control hypertension (high blood pressure) can worsen or complicate hives. Patients with urticaria and angioedema should absolutely avoid ACE inhibitors (such as Vasotec and Zestril and many others) because of reports they may trigger serious, life threatening, episodes of angioedema. Beta-blockers (Metoprolol, Atenolol, Toprol & many others) should be relatively avoided since they compromise the effectiveness of some medicines prescribed to treat hives. The calcium channel blocker, Procardia, was shown in one study to be beneficial in relieving hives. Calcium channel blockers may be a good option in patients who have both chronic urticaria and hypertension.

7. Topical Agents - In some patients, steroid creams may relieve symptoms, although in most patients the area to be treated is too large to be practical. Zonalon (doxepin cream) can also be helpful if the area of hives is small. Zonalon Cream is significantly sedating.

8. Other Agents - Many other medications have been reported in medical literature to help some patients with hives, but are used less commonly. These include Procardia (as mentioned above) and colchicine (used in rheumatoid arthritis).