Autoimmune Testing Helps Guide Urticaria Tx

BY BETSY BATES
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SCOTTSDALE, ARIZ. — Autoimmune testing may not be perfectly sensitive, but it can help to guide therapeutic decisions regarding patients with severe, recalcitrant chronic idiopathic urticaria.

By simple definition, chronic idiopathic urticaria is characterized by the appearance of transitory, pruritic wheals that occur on a daily basis for a period of at least 6 weeks, but in reality, we know that many of our patients have disease lasting months to years,” Dr. Diane R. Baker said at the annual meeting of the Noah Worcester Dermatological Society.

“It can be very resistant to treatment and has an impact on quality of life that is similar to what we see in our severe atopic dermatitis patients,” said Dr. Baker, a dermatologist in private practice in Portland, Ore., and former president of the American Academy of Dermatology.

Research conducted in the past 10-15 years has ushered in a new era of understanding about the etiology of chronic idiopathic urticaria. It is now known that approximately 40% of patients demonstrate autoimmune dysfunction.

These patients often have other autoimmune diseases and demonstrate a reduced histamine release from the basophils. Dr. Baker advised using this new information to one’s advantage in clinical practice by inquiring about a chronic urticaria patient’s personal or family history of autoimmune disease, conducting autologous serum skin testing (ASST), and/or ordering test results of abnormalities in patients with autoimmune chronic idiopathic dysfunction.

For example, results do not correlate with basophilic dysfunction, which improves considerably when patients go into remission, whether or not they have a positive autoantibody test.

Nonetheless, the two-pronged approach to identifying autoimmunity may have clinical relevance as important preliminary information, Dr. Baker said.

“I think a positive ASST or demonstration of the presence of functional autoantibodies helps support your decision about whether to put a patient on something more than an antihistamine, [such as] an immunomodulatory treatment,” she said.

In her experience, patients with positive results in either test seem to have more severe and resistant disease that requires higher than usual doses of antihistamines, often in conjunction with systemic corticosteroids or immunomodulatory agents such as methotrexate or cyclosporine.

Case reports generally guide this immunomodulatory therapy, although in one randomized, double-blind study cyclosporine added to an antihistamine produced marked improvement in two-thirds of 99 patients (J. Am. Acad. Dermatol. 2006;55:705-9).

Results of this test sometimes correlate well with ex vivo autoantibody testing for functional (histamine-releasing) anti-FcεRI autoantibody. A positive result, read at 15 and 30 minutes, comprises a skin reaction at the serum site that is 1.5 mm greater than any reaction at the saline control site and more than 90% larger than the histamine response.

The reaction in a patient with autologous chronic idiopathic urticaria is “across-the-room positive,” she said.

The tests may draw an incomplete picture of abnormalities in patients with autoimmune chronic idiopathic dysfunction. For example, results do not necessarily rule out autoimmunity as a basis for urticaria, she said.

She noted that in her experience, patients with disease lasting months to years, “but in reality, we know that many of our patients have disease lasting months to years,” Dr. Diane R. Baker said at the annual meeting of the Noah Worcester Dermatological Society.

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