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LETTER TO THE EDITOR

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The Management of Acute and Chronic Urticaria

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Dear Editor,

The updated version of the international guideline for urticaria covers the definition and classification of urticaria and outlines expert-guided and evidence-based diagnostic and therapeutic approaches for the different subtypes of urticaria (1). We would like to share our opinions about the management of acute and chronic urticaria, and the algorithm of transition from acute urticaria treatment to chronic urticarial treatment.

The point we want to emphasize is how to administer the 2nd generation antihistamine (AH) doses increased in the first step in the treatment of chronic urticaria (2x dose increase: 1x2 or 2x1; 3x dose increase 1x3 or 3x1 or 1x2 in the morning and 1x1 in the evening; 4x dose increase: 4x1 or 1x4 or 2x2). Considering the previous studies on dose increase in chronic urticaria, a 1x2 dose schedule can be used for a 2x dose increase, and a 2x2 dose schedule can be used for a four-fold dose increase (2-6). On the other hand, we think that the AH administration using a time interval may not affect the treatment management much due to the long-acting nature of 2nd generation AHs, although it is speculative. A 1x2 or 2x2 dose increase seems to be a more appropriate approach for ease of administration and to increase patient drug compliance, although it is speculative since there is no study on this subject.

Another issue that draws our attention is the timing of increasing the dose of 2nd generation AH in the 1st step. It has been reported that although four-fold AH increase is achieved in a time interval of >7-28 days if the urticaria control test (UCT) result is <12, the next step, omalizumab, can be started (1). However, we think that it should be emphasized that this timing may vary according to the individual and that the implementation of urticaria action plans by personalizing the treatment should be emphasized. In this sense, we wanted to share with you the urticaria action plan that we applied in our clinic (Figure 1). In recent years, the concept of "there is no disease, there are patients" has come to the fore and personalized treatments have begun to be implemented, with the planning of treatment management with precision medicine coming to the fore in all chronic disease groups. In this sense, we think that clinical and biological markers showing resistance to AHs in chronic urticaria or potential biomarkers that may show the possibility of resistance to treatments such as omalizumab and cyclosporine should now be actively used in the chronic urticaria treatment algorithm (7). We are aware that this update and revision of the international guideline for urticaria had been developed following the methods recommended by Cochrane and the Grading of Recommendations Assessment, Development and Evaluation (GRADE) working group. However, we hope that the next consensus report will place more emphasis on the importance of individualized management of therapy using clinical and biological markers in chronic urticaria.

Conflict of Interest

Gülden Paçacı Çetin reports congress travel support and speaker fees from GlaxoSmithKline. İnsu Yılmaz reports advisory board, speaker fees, and congress travel support from Novartis, GlaxoSmithKline, and Chiesi. Murat Türk reports congress travel support from Novartis. Bahar Arslan declares no conflict of interest.

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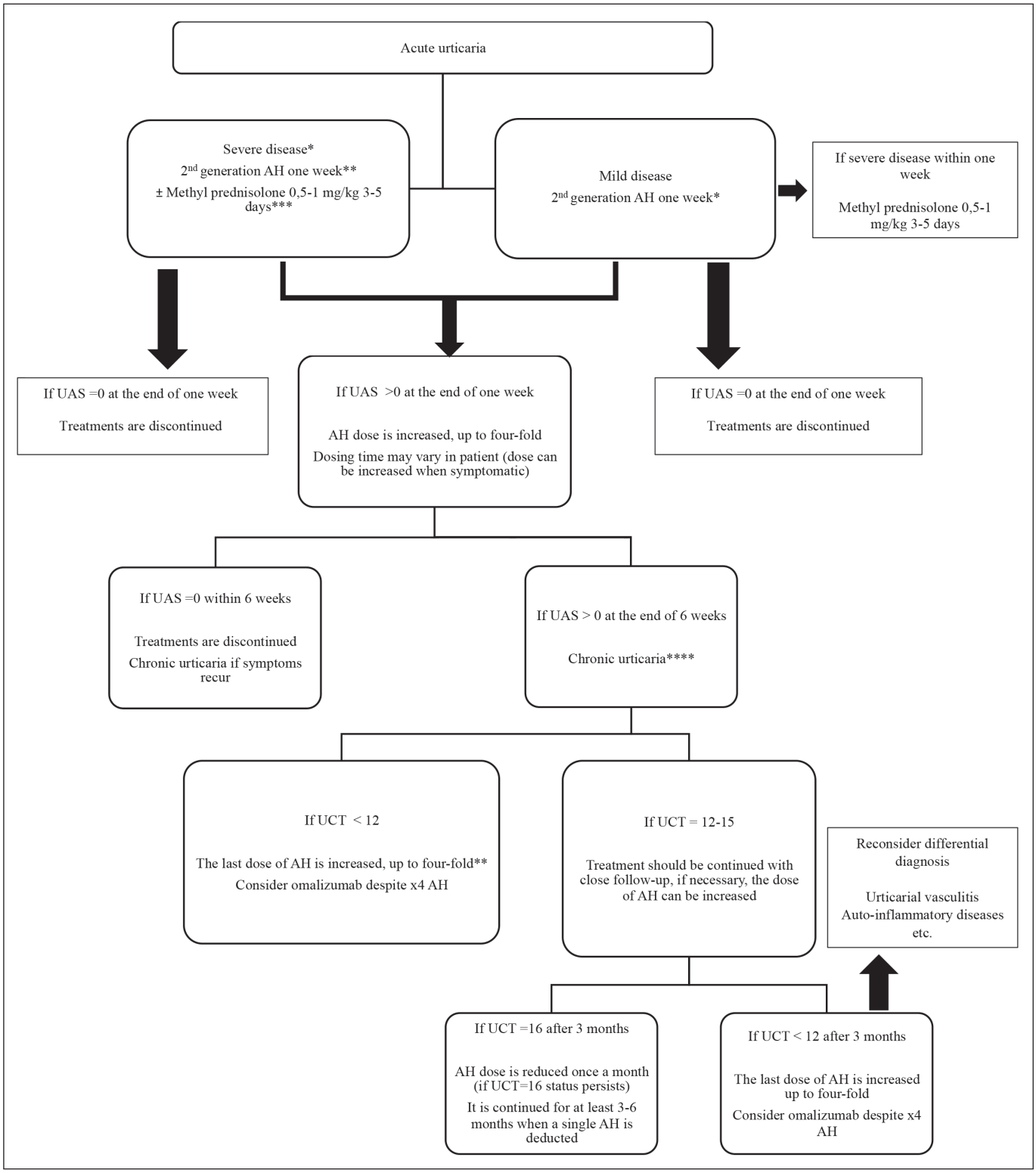

Figure 1. The algorithm of transition from acute urticaria treatment to chronic urticaria treatment.

We define severe disease as UAS >4 (this definition is an unvalidated expert opinion), ** May be combined with montelukast if there is a history of allergic asthma, allergic rhinitis, nasal polyp, NSAID triggers, * If gastric protective agent is planned, H2-receptor antagonists may be preferred instead of PPIs, **** Step 1 and Step 2 treatment.*

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