Chronic Inducible Urticaria (CIndU) versus Chronic Spontaneous Urticaria (CSU): Can new names and new updated information improve our care for patients with urticaria?

Kiat Ruxrungtham

Due to the advanced changes in the field of chronic inducible urticaria, in this month, the EAACI/GA(2) LEN/EDF/UNEV consensus recommendations have published their 2016 updated and revised version on chronic inducible urticaria (CIndU).[1] The aim is to improve the diagnosis and management of patients with CIndU. Their 2009 version used an old and familiar term "physical urticaria".[2]

Classification of chronic inducible urticaria?

The new definition, in fact, makes it more clear by classifying chronic urticaria (patients who have had urticaria for 6 weeks or more) into chronic spontaneous (CSU) versus chronic inducible urticaria (CIndU) (Figure 1). In this new classification, CSU includes spontaneous appearance of urticaria/angioedema due to either known or unknown causes. They then classified CIndU into 2 subgroups: Physical versus non-physical CIndU (Figure 1). Physical CIndU includes: symptomatic dermographism/urticaria factitia, cold urticaria, delayed pressure urticaria, solar urticaria, vibratory angioedema, and heat urticaria, whereas non-physical CIndU includes cholinergic urticaria, contact urticaria, and aquagenic urticaria. Aside from obtaining thorough medical history of the patient with chronic urticarial, the definite diagnosis for CIndU also requires provocation testing. In general, the underlying causes of CIndU are not known. Specific provocations have been standardized and recommended to help identify a specific triggering/inducing factor for avoidance.

From Department of Medicine, Faculty of Medicine, Chulalongkorn University, Payathai Road, Pathumwan, Bangkok, Thailand 10330
E-mail: rkiatchula@gmail.com

Would this new chronic inducible urticaria classification be helpful in practice?

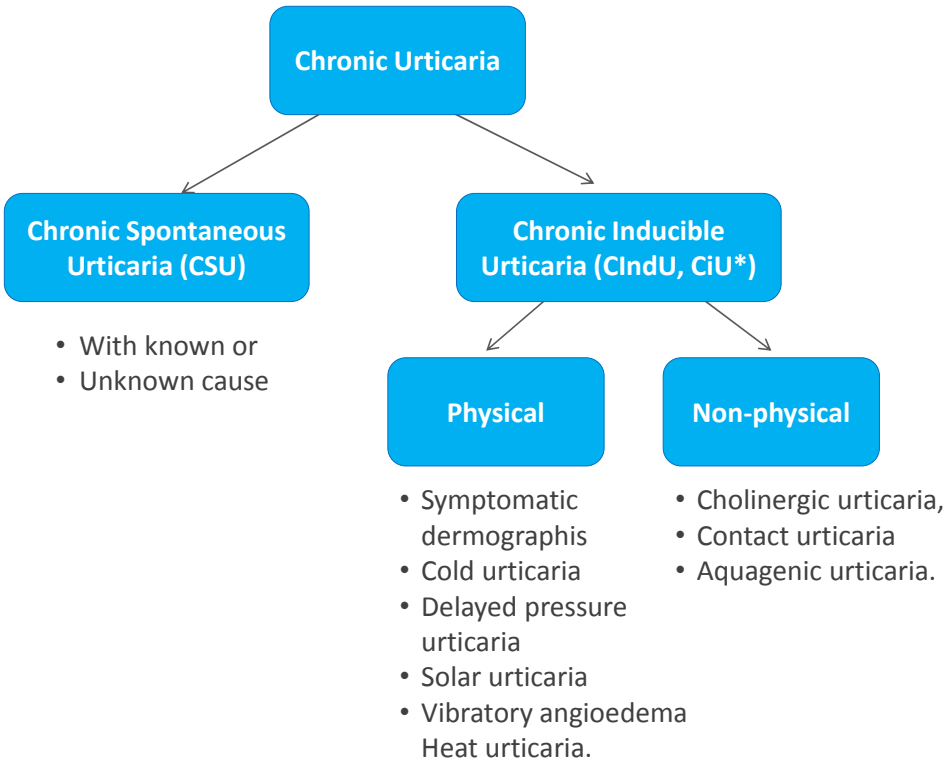
Overall, the classification of chronic urticaria into spontaneous and inducible types is very useful. There are some overlapping clinical settings between CSU and CIndU, i.e., patients with CSU with identified inducible factor(s) such as dermatographism (very common among CSU). This phenomenon may be indicative of hyperresponsiveness of the skin to the non-specific stimulants. Interestingly, the term "hyperresponsiveness" has been widely considered as a core pathophysiology of allergic airway diseases, both rhinitis and asthma, for decades, but so far has not been appreciated in pathophysiology and management of urticaria and atopic dermatitis.

It should also be noted that the previous commonly used term "chronic idiopathic urticaria (CIU)" will no longer be used in the most recent guideline. It is not clear which short acronym should be used in common settings when etiology cannot be identified in a patient with chronic spontaneous urticaria. In clinical practice, a short acronym is useful. Therefore, in such setting, I would propose a term called "chronic idiopathic spontaneous urticaria or CISU" (Figure 1).

In addition, physical versus non-physical subclassification of CIndU may not be practical nor useful for general practitioners and may create confusion. One may consider to simply list all subtypes under CIndU without further subclassification. Last but not least, CIndU –is not a friendly acronym, so should CiU be considered as Chronic inducible urticaria?

Are the new updated recommendations useful for general practitioners to manage patients with CIndU (or CiU)?

This updated version is based on evidence-based grading for what treatment should be used for different subtypes of CIndU. For example, the first-line of management is to avoid the identified or



*CiU is a proposed simple acronym of chronic inducible urticaria by author

Figure 1. New classification of chronic urticaria from the EAACI/GA(2) LEN/EDF/UNEV consensus recommendations 2016

possible inducing factor(s) and use non-sedating H1-antihistamine. This recommendation is based on evidence level A which is the best practice for all, except for patients with delayed pressure urticaria which the evidence is at level B, and for vibratory angioedema, the evidence is at level C. Another example is increasing the dosage of non-sedating H1-antihistamine for cold urticarial has level A evidence support but lower strength of evidence for the treatment of other subtypes. Other alternative treatment options, such as omalizumab and cyclosporine, in general are recommended based on the strength of evidence at level B or below.

Research gaps and more work needs to be done in CIndU (CiU)

There are very few studies on CIndU or CiU particularly in Asia and the Pacific Region.[2-7] Most studies are clinic- or hospital-based enrollment, which are not representative of the general prevalence and natural history of the diseases. This is likely due to the fact that the field of chronic urticaria is not listed as a high priority for most public research funding agencies, therefore there is lack of well-designed, larger scale multicentered, multinational study to address the prevalence, incidence, and the treatment efficacy for CIndU or CiU. It is important to at least have such a great consortium for EAACI/GA(2) LEN/EDF/UNEV to take the lead and work together to give us the best state-of-the-art review and identify gaps to further guide investigations to improve future treatment of these common skin disorders.

References

1. Magerl M, Altrichter S, Borzova E, Gimenez-Arnau A, Grattan CEH, Lawlor F, et al. The definition, diagnostic testing, and management of chronic inducible urticarias – The EAACI/GA2LEN/EDF/UNEV consensus recommendations 2016 update and revision. Allergy. 2016;71: 780–802.
2. Silpa-archa N, Kulthanan K, Pinkaew S. Physical urticaria: prevalence, type and natural course in a tropical country. J Eur Acad Dermatol Venereol. 2011;25:1194-9.
3. Zhong H, Song Z, Chen W, Li H, He L, Gao T, et al. Chronic urticaria in Chinese population: a hospital-based multicenter epidemiological study. Allergy. 2014;69:359-64.
4. Silpa-Archa N, Wongpraparut C, Leenutaphong V. Analysis of solar urticaria in Thai patients. Asian Pac J Allergy Immunol. 2016;34:146-52.

5. Pezzolo E, Peroni A, Gisondi P, Girolomoni G. Heat urticaria: a revision of published cases with an update on classification and management. Br J Dermatol. 2016 Mar 12. doi: 10.1111/bjd. 14543. [Epub ahead of print]
6. Komarow HD, Eisch AR, Young M, Nelson C, Metcalfe DD. Solar Urticaria. J Allergy Clin Immunol Pract. 2015;3:789-90.
7. Chuamanochan M, Kulthanan K, Tuchinda P, Chularojanamontri L, Nuchkull P. Clinical features of chronic urticaria in aging population. Asian Pac J Allergy Immunol. 2016 Mar 20. doi: 10.12932/AP0708. [Epub ahead of print]