DERMATOLOGICA SINICA xxx (2017) 1–5

Contents lists available at ScienceDirect

Dermatologica Sinica

journal homepage: http://www.derm-sinica.com

ORIGINAL ARTICLE

Turkish dermatologists' approach for chronic spontaneous urticaria: A questionnaire based study

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ARTICLE INFO

Article history:
Received: Apr 17, 2017
Revised: Aug 9, 2017
Accepted: Sep 9, 2017

Only a part of this manuscript was presented as a poster at 25th EADV Congress 2016 Vienna.

Keywords:
Urticaria
Dermatologists
Therapeutics
Diagnosis
Guideline

ABSTRACT

Background/Objectives: Chronic spontaneous urticaria (CSU) is a common skin disorder which represents a challenge both for the patients and physicians. Guidelines and treatment algorithms have been created to help physicians to ease management. Our aim was to determine Turkish dermatologists' approach to CSU with regard to treatment, search for causative factors and use of instruments to assess the quality of life and severity of the disease.

Methods: This was a cross-sectional methodological study which was performed by delivery of a questionnaire including ten questions about the management of CSU.

Results: Analyses of 314 questionnaires revealed that the most common first-line treatments were non-sedating antihistamines in standard doses (65.6%), while second-line treatment was updosing antihistamines (59.9%) followed by addition of sedative-antihistamines (26.4%) and systemic steroids (19.1%). Third-line treatment option was omalizumab in 35% followed by systemic steroids. Twenty-two percent of the dermatologists referred the patients to a center experienced in urticaria. Most of them were performing laboratory testing for underlying causes including thyroid function tests, C-reactive protein, thyroid auto-antibodies, stool analyses, infection markers. Urticaria activity score and chronic urticaria quality of life questionnaire were used by 30 and 13%, respectively, while 56% were using none of the instruments.

Conclusion: Our study showed that the therapeutic management of Turkish dermatologists was parallel to the European Urticaria Guidelines. The high utility of omalizumab as a third line regimen improved patient care. Nevertheless there is a need for centers experienced in urticaria to refer antihistamine-resistant patients where third-line treatment options can not be implemented.

Introduction

Chronic spontaneous urticaria (CSU), is a skin disorder characterized by recurrent, transient and itchy wheals and/or angioedema present for more than 6 weeks, due to a known or unknown cause.[1] CSU has a point prevalence of 0.5–1% in the total population and can be seen in all age groups but the peak incidence is between 20 and 40 years of age.[2] The disease generally lasts for 1–5 years but

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http://dx.doi.org/10.1016/j.dsi.2017.09.002

Please cite this article in press as: Kocatürk E, et al., Turkish dermatologists' approach for chronic spontaneous urticaria: A questionnaire based study, Dermatologica Sinica (2017), http://dx.doi.org/10.1016/j.dsi.2017.09.002

can be prolonged in severe cases, cases associated with angioedema, combination with physical urticaria or with a positive autologous serum skin test.[2,3] Most often, the cause cannot be identified easily but about 45% of CSU patients have autoantibodies against their own IgE or IgE receptors that lead to spontaneous wheals on the skin.[1,3,4] On the basis of recent data, the European Urticaria Guidelines from the European Academy of Allergy and Immunology (EAACI/GA^{2}LEN/EDF/WAO) only recommend diagnostic laboratory tests limited to differential blood count, erythrocyte sedimentation rate (ESR) and C-reactive protein (CRP).[1] Additional diagnostic tests can be made according to the patients' history.[1] Curative treatment is not available for most of the patients since an underlying cause is rarely detected. Symptomatic treatment remains the mainstay of the therapy.[2]

Guidelines and treatment algorithms have been created to help the patients as well as their physicians.[2] EAACI/GA^{2}LEN/EDF/WAO guideline recommends using modern non-sedating H_1 antihistamines (nsAHs) for the first line treatment. If lesions persist after 2 weeks of treatment, increasing the dosage of modern nsAHs up to fourfold is recommended as the second line treatment. If lesions further persist for 1–4 weeks, the guidelines suggest to add omalizumab or cyclosporine-A (Cyc-A) or montelukast as third line treatments.[1,5–7]

In our study we investigated the Turkish dermatologists' approach to CSU patients; focusing on the medications prescribed as the first-line, second-line and third-line treatments, diagnostic testing for etiological factors and the scales used for activity and quality of life scoring.

Material and methods

A questionnaire including 10 questions was created to distribute to Turkish dermatology specialists in a national congress. It was also sent via e-mail to other dermatology specialists who could not attend to the congress. E-mail survey access was available for 2 months via SurveyMonkey.

The questions related to demographic information included number of years in practice, affiliation and total number of CSU patients examined in a month. The questions related to the management of CSU consisted of the preferred medications as first, second and third line, time for second visit, the rationale for choosing the third-line treatment medications, the laboratory tests ordered for investigation of CSU etiology and tools that are used for the assessment of urticaria activity and quality of life impairment. All responders were requested to fill out the questionnaire completely. Uncompleted questionnaires were excluded from the study. No payment was made for the responders.

The rationale for making this questionnaire was to gather information and create a basis for the generation of Turkish urticaria guideline. The results of the survey were also used for this purpose.

Statistical analyses

The data obtained from surveys were recorded and reviewed by using MS-EXCELL. The data were first analyzed descriptively. Then explorative comparative statistical analyses comparing the different practicing years, working places, treatment modalities and usage of laboratory tests were performed.

Results

In total, 314 questionnaires were available for statistical analyses. Most of the responders (51.9%) have been practicing as a dermatology specialist for 5–20 years, followed by 26.4% practicing for 0–5 years and 21.7% practicing for over 20 years, respectively. The majority of the responders (30.3%) were working at university hospitals, while remaining 27.7% at the government hospitals, 24.2% at private hospitals and 17.8% at training and research hospitals, respectively. Most of the specialists (32.2%) examined 5–10 CSU patients per month.

Standard doses of non-sedating antihistamines (nsAHs) (65.6%) were the most common first treatment of choice, followed by combination of sedating and nsAHs (12.7%) and updosing of nsAHs(12.1%) (Table 1). Updosing of nsAHs (11 responders), combination of sedating and nsAHs (18 responders) and systemic steroids (2 responders) were the three most preferred first line treatments by the dermatologists working at private hospitals. Eleven responders from university hospitals also preferred high dose nsAHs as the first line treatment.

Majority of the dermatologists (50.3%) evaluated their patients 2 weeks after the first visit. If the lesions were refractory after the first-line treatment, most of the dermatologists (59.9%) preferred to upload nsAH treatment dosage, while 83 (26.4%) added sedative anti-histamines (sAHs) to the preexisting treatment and 70 (22.3%) preferred combination treatment of two different nsAHs as the second-line treatment, respectively (Table 2).

If the lesions still persisted despite the second-line treatment, the responders preferred omalizumab (35%), systemic steroids (22.9%), referral to centers experienced in urticaria (22%) and Cyc-A (11.1%) as the third line, respectively. The reported reasons for preferring omalizumab were due to its effectiveness, safety and its existence in the latest guidelines, respectively. The responders preferred systemic steroids at the second rank because of its effectiveness, fast action and its existence as a conventional treatment, respectively. The third most commonly preferred treatment Cyc-A was reported to be an effective, guideline recommended and fastly acting option, respectively. The responders that preferred omalizumab at the third line were working at university hospitals (66), training and research hospitals (32), private hospitals (8) and government hospitals (4). The responders that preferred systemic steroids as the second most common third line treatment were working at government hospitals (33), private hospitals (21), university hospitals (9) and training and research hospitals (9). Cyc-A, the third most common third line treatment, was preferred by the responders who were working at private hospitals (13), university hospitals (9), government hospitals (8) and training and research hospitals (5). Some of the responders referred patients to centers experienced in urticaria when they were refractory to second line treatments. These responders were working at government

Table 1 The preferred first line treatment options for CSU.

What is your first-line treatment option in CSU?	N	%
Standard dose non-sedating antihistamines	206	65,6%
Updosing of non-sedating antihistamines	38	12,1%
Combination of two non-sedating antihistamines	31	9,9%
Sedating antihistamines alone	3	1,0%
Combination of sedating and non-sedating antihistamines	40	12,7%
Leukotriene antagonists alone	0	0,0%
Non-sedating antihistamines and leukotriene antagonists	3	1,0%
Non-sedating antihistamines and H_2 blockers	4	1,3%
Non-sedating antihistamines + H_2 blockers + leukotriene antagonists	1	0,3%
Mast-cell stabilizers alone	0	0,0%
Mast cell stabilizers + non-sedating antihistamines	7	2,2%
Systemic steroids	4	1,3%
Pseudoallergen low diet	22	7,0%
Others	8	2,5%

Most of the dermatologists preferred standard dose antihistamines as the first line treatment of CSU. This was followed by combination of sAHs and nsAHs. Updosing of nsAHs, combination of two nsAHs and low pseudoallergen diet were the other commonly preferred first-line treatments.

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