Leukotriene antagonists

The leukotrienes are important products of mast cell activation and degranulation. Inhibition of these mediators may play a useful role in the management of chronic urticaria. With the advent of the leukotriene receptor antagonists, there is the opportunity for exploring this possibility. Results of clinical trials are awaited.

Other drugs

A variety of other drugs have been tried in resistant cases. Small studies have been published regarding the use of calcium antagonists and thyroxine in those with thyroid autoimmunity. Hydroxychloroquine and dapsone have also been used in occasional cases but in general, none of these drugs has been dramatically effective and all have significant potential adverse effects.

Immunomodulatory drugs

In patients identified as having autoimmune urticaria, initial treatment is the same as for any other urticaria, commencing with an adequate trial of antihistamines. However, patients with autoimmune urticaria tend to be more severely affected and less responsive to simple drugs. When the condition is causing marked disruption, other strategies may be considered. Reports of success with plasmapheresis and immunoglobulin infusions have been published, but this treatment should be regarded as experimental. A placebo-controlled trial of cyclosporin has had impressive results.[4] None of these treatments cures the condition, but they may be preferable to prolonged steroid use.

Corticosteroids

When rapid control of urticaria is needed, a short tapering course of steroids may be used, but in any other situation their role is limited. If prednisolone is to be used, it is advisable to give a moderate starting dose, e.g. 0.5 mg/kg (20–25 mg) for a few days before tapering slowly over a 10 day period.

Invariably, prolonged use of steroids leads to numerous adverse effects and severe rebound in urticaria when withdrawal is attempted.

REFERENCES

1. Greaves M. Chronic urticaria. J Allergy Clin Immunol 2000;105:664-72.
2. Greene SL, Reed CE, Schroeter AL. Double-blind crossover study comparing doxepin with diphenhydramine for the treatment of chronic urticaria. J Am Acad Dermatol 1985;12:669-75. (Randomised trial)
3. Bleehen SS, Thomas SE, Greaves MW, Newton J, Kennedy CT, Hindley F, et al. Cimetidine and chlorpheniramine in the treatment of chronic idiopathic urticaria: a multi-centre randomized double-blind study. Br J Dermatol 1987;117:81-8. (Randomised trial)
4. Grattan CE, O'Donnell BF, Francis DM, Niimi N, Barlow RJ, Seed PT, et al. Randomized double-blind study of cyclosporin in chronic 'idiopathic' urticaria. Br J Dermatol 2000;143:365-72. (Randomised trial)

Self-test questions

The following statements are either true or false (answers on page 131)

9. H_2 antagonists are ineffective in urticaria as there are no H_2 receptors in the skin.
10. Hepatitis C is a cause of urticarial vasculitis.

Facilitators file

The National Prescribing Service (NPS) has provided funds to divisions of general practice to employ facilitators. These facilitators visit general practitioners to discuss common prescribing problems. During their visits the facilitators are finding some interesting issues. *Australian Prescriber* is planning to publish some of these findings from time to time.

Combination antihypertensives

If a patient's blood pressure cannot be controlled by lifestyle changes drug treatment is needed. Therapeutic guidelines recommend starting treatment with one drug and adjusting the dose.[1] The NPS facilitators have, however, discovered that many patients are being started on fixed dose combination products.

The Drug Utilisation Sub-committee of the Pharmaceutical Benefits Advisory Committee has also found evidence that combination products are being used as first-line therapy. A review of new prescriptions for a product containing irbesartan and hydrochlorothiazide found that 17% of patients had not previously been prescribed an angiotensin receptor antagonist, an ACE inhibitor or a diuretic. Approximately 16% of patients who were prescribed a combination containing fosinopril and hydrochlorothiazide had not previously taken an ACE inhibitor, an angiotensin receptor antagonist or a diuretic.

Although some patients will need more than one drug to control their hypertension, it is best practice to start with a single product. Even some cases of severe hypertension can be managed with a single drug. Patients who do need two drugs may need doses which differ from those found in combination products. The fixed doses in these products make it difficult to titrate the dose to achieve optimum control of each patient's blood pressure.

REFERENCE

1. Writing Group for Therapeutic Guidelines: Cardiovascular. Therapeutic Guidelines: Cardiovascular. 3rd ed. Melbourne: Therapeutic Guidelines Ltd.; 1999.