Chronic spontaneous urticaria: pathogenesis and treatment considerations / Allen P. Kaplan

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ABSTRACT
The treatment of chronic spontaneous urticaria begins with antihistamines; however, the dose required typically exceeds that recommended for allergic rhinitis. Second-generation, relatively non-sedating H₁receptor blockers are typically employed up to 4 times a day. Firstgeneration antihistamines, such as hydroxyzine or diphenhydramine (Atarax or Benadryl), were employed similarly in the past. Should high dose antihistamines fail to control symptoms (at least 50%), omalizumab at 300 mg/month is the next step. This is effective in 70% of antihistamine refractory patients. H₂receptor blockers and leukotriene antagonists are no longer recommended; they add little and the literature does not support significant efficacy. For those patients who are unresponsive to both antihistamines and omalizumab, cyclosporine is recommended next. This is similarly effective in 65%-70% of patients; however, care is needed regarding possible side effects on blood pressure and renal function. Corticosteroids should not be employed chronically due to cumulative toxicity that is dose and time dependent. Brief courses of steroid e.g., 3 to 10 days can be employed for severe exacerbations, but should be an infrequent occurrence. Finally, other agents, such as dapsone or sulfasalazine, can be tried for those patients unresponsive to antihistamines, omalizumab, and cyclosporine.