Updosing of antihistamines to improve control of chronic urticaria

Sir,

Nonsedating antihistamines are recommended as first line treatment for patients with urticaria. The current European Academy of Allergology and Clinical Immunology/Global Allergy and Asthma European Network/European Dermatology Forum (EAACI/GA²LEN/EDF) guidelines call for updosing of nonsedating antihistamines (up to four times the standard dose) in urticaria patients who do not respond satisfactorily to the standard doses.[1] There are a few studies to assess the efficacy of such a recommendation.

Twenty patients (12 females and eight males, age group 20-60 years, mean age 27.2 years) with chronic urticaria for at least six weeks and pruritus, wheal score of more than two were enrolled after an informed written consent. The exclusion criteria included physical urticaria, urticarial vasculitis, pregnant or lactating women, gastritis, a history of sensitivity to aspirin or NSAIDs and a history of aggravation of symptoms by pressure. Routine investigations like complete blood count, blood sugar, thyroid stimulating hormone (TSH) and urine examination were done to rule out infections before starting therapy. All 20 patients had chronic idiopathic urticaria of duration ranging from three months to two years (mean duration 14.8 months).

After a one-day washout without treatment we graded symptoms using the Urticaria activity score (UAS). The UAS consisted of the sum of the wheal number score and the itch severity score.[2] The wheal numbers were graded from 0 to 3 as follows: 0-<10 small wheals (diameter, <3 cm); 1-10 to 50 small wheals or <10 large wheals (diameter, >3 cm); 2->50 small wheals or 10 to 50 large wheals; and 3 - almost the whole body is covered. The severity of the itching was graded from 0 to 3 (0, none; 1, mild; 2, moderate; and 3, severe).

Sedation was graded from 0 to 3 (0, none; 1, mild; 2, moderate; and 3, severe). We recorded UAS at zero two and four weeks to monitor urticaria. All patients were started with levocetirizine 5 mg tablet at bed time. Patients were reviewed at weekly intervals of four weeks. For symptomatic patients, the dose of levocetirizine was doubled to two tablets at bed time at the end of one week and four tablets in two divided doses at the end of two weeks.

Investigations revealed microcytic anemia in two patients and raised thyroid stimulating hormone (TSH) in one patient. Average UAS was 4.5 at 0 weeks which came down to 2.2 at one week.

At the end of one week, eight patients out of 20 were symptomatic. We doubled the dose to 10 mg of levocetirizine at bedtime. At two weeks UAS was 1.2. At the end of two weeks two out of eight patients were symptomatic whose dose was doubled to 10 mg of Levocetirizine twice a day. At the end of four weeks UAS came down to less than 1.

Sedation was recorded as 0, mild or moderate or severe. One patient with 20 mg of levocetirizine complained of sedation, which was mild and one patient with 10 mg of levocetirizine complained of sedation which was also mild in nature. Twelve, six and two patients became symptom-free when administered 5, 10 and 20 mg levocetirizine respectively.

In a recent study, Levocetirizine 5 mg was significantly more efficacious than desloratadine 5 mg in the treatment of chronic idiopathic urticaria symptoms.[3] Another recent study from Germany showed that desloratadine at standard and high doses significantly improved objective signs of acquired cold urticaria

provoked by cold exposure. Desloratadine at four times the standard dose significantly reduced acquired cold urticaria lesion severity versus 5 mg of desloratadine without an increase in adverse events.[4]

The EAACI/GA²LEN recommendation of using nonsedating H 1 antihistamines up to four fold above the recommended doses appears to be effective with mild sedation. The current approach of adding another antihistamine may be changed to updosing the same antihistamine for desirable results. Further studies are required to validate this observation.

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DOI: 10.4103/0378-6323.58684 - **PMID:** 20061736

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