Correspondence

A survey of the treatment and management of patients with severe chronic spontaneous urticaria

doi: 10.1111/ced.13778

Chronic spontaneous urticaria (CSU) is characterized by the recurrent appearance of weals, angio-oedema or both, occurring at least twice weekly for longer than 6 weeks.[1] It is often managed with antihistamines, but occasionally requires other systemic agents in recalcitrant cases.

A cross-sectional survey was conducted by means of an internet-based survey tool (Typeform; https://www.typeform.com). Participating consultants with a specialist interest in urticaria were identified through the specialist registers of the British Society of Allergy and Clinical Immunology (BSACI), the Improving Quality in Allergy Services (IQAS) Group and the British Association of Dermatologists (BAD), and invited to take part.

The survey content was based on current CSU treatment guidelines from EAACI/GA2LEN/EDF/WAO[1] and the British Society for Allergy and Clinical Immunology (BSACI).[2] The EAACI/GA2LEN/EDF/WAO guidelines are a joint initiative of the Dermatology Section of the European Academy of Allergy and Clinical Immunology (EAACI), the Global Allergy and Asthma European Network (GA2LEN) (a European Union-funded network of excellence), the European Dermatology Forum (EDF), and the World Allergy Organization (WAO). To standardize responses, all participants were presented with a case of recalcitrant CSU (failed on maximum dose of nonsedating antihistamines and montelukast), requiring alternative systemic treatment. Questions covered usage of systemic treatments, routine disease severity assessments, adherence to treatment guidelines and perceived barriers to prescribing.

Responses (Table 1) were received from 19 UK consultants (26 surveys sent; completion rate 73%), 15 of whom had > 10 years' experience in the treatment of CSU. The majority were allergy (58%) and dermatology consultants (37%). Of the 19 consultants, 56% provide a dedicated urticaria service, 37% treat both adult and paediatric patients, and the majority (79%) use systemic medications other than antihistamines and montelukast. Omalizumab and ciclosporin were the most commonly used first-line agents (47% and 27% respectively) (Fig. 1). The majority (84%) of consultants use validated measures to assess disease severity, including the weekly Urticaria

Table 1 Summary of survey results.

Parameter	Response, % (*n*)
Section 1: Demographics	
Country of work	
United Kingdom	100% (19)
Hospital grade	
Consultant	100% (19)
Specialty	
Allergy	58% (11)
Dermatology	37% (7)
Immunology	5% (1)
Caseload	
Adult only	42% (8)
Both adult and paediatric	37% (7)
Paediatric only	21% (4)
Number of years in specialty	
> 20	53% (10)
10–20	26% (5)
< 10	21% (4)
Section 2: Use of systemic medications	
Do you use systemic medication for the management of chronic urticaria?	
Yes	79% (15)
No	21% (4)
First-line treatments?	
Omalizumab	47% (7)
Ciclosporin	28% (4)
Other	20% (3)
Dapsone	7% (1)
Second-line treatments?	
Omalizumab	40% (6)
Ciclosporin	33% (5)
Mycophenolate mofetil	13% (2)
Other	13% (2)
Third-line treatments?	
Other	27% (4)
Dapsone	20% (3)
Ciclosporin	13% (2)
Methotrexate	13% (2)
Mycophenolate mofetil	13% (2)
If you use any of the listed treatments in children, which ones do you use?	
Ciclosporin	80% (4)
Omalizumab	80% (4)
Azathioprine	60% (3)
Dapsone	60% (3)
Mycophenolate mofetil	60% (3)
Methotrexate	20% (1)
Section 3: Use of standardized measures	
Do you use standardized measures when assessing disease?	
Yes	84% (16)
No	16% (3)

Table 1. continued

Parameter	Response, % (*n*)
Physician Global Assessment	
Most of the time	63% (10)
Sometimes	13% (2)
Never	25% (4)
Patient Global Assessment	
Most of the time	44% (7)
Sometimes	25% (4)
Rarely	6% (1)
Never	25% (4)
UAS-7	
Most of the time	63% (10)
Sometimes	38% (6)
In-clinic UAS	
Most of the time	25% (4)
Sometimes	13% (2)
Rarely	19% (3)
Never	44% (7)
Angio-oedema Activity Score	
Sometimes	44% (7)
Rarely	25% (4)
Never	31% (5)
Itch severity score	
Most of the time	13% (2)
Sometimes	19% (3)
Rarely	31% (5)
Never	38% (6)
Weekly number of hives score	
Most of the time	13% (2)
Sometimes	25% (4)
Rarely	19% (3)
Never	44% (7)
DLQI	
Most of the time	38% (6)
Sometimes	25% (4)
Rarely	25% (4)
Never	13% (2)
CU-Q2oL	
Sometimes	25% (4)
Rarely	25% (4)
Never	50% (8)
AE-QoL	
Sometimes	6% (1)
Rarely	31% (5)
Never	63% (10)
Section 4: Use of guidelines and perceived barriers	
Do you use guidelines to direct your management of urticaria?	
Yes	89% (17)
No	11% (2)
Which guidelines do you refer to?	
EACCI/GA(2)LEN/EDF/WAO	50% (8)
Other	38% (6)
Local guidelines	13% (2)
Support services for patients	
Access to nursing support	89% (16)
Access to inpatient facilities	61% (11)
Dedicated urticaria service	56% (10)
Nurse prescribers	28% (5)
Main perceived barriers to prescribing systemic medications	
Cost	
Side effects of treatments	
Views expressed by patient or family	
Long-term toxicity	

AE-QoL, Angioedema Quality of Life Questionnaire; CU-Q2oL, Chronic Urticaria Quality of Life Questionnaire EACCI/GA(2)LEN/EDF/WAO, European Academy of Allergy and Clinical Immunology, Global Allergy and Asthma European Network. European Dermatology Forum and World Allergy Organization; DLQI, Dermatology Life Quality Index; UAS7, weekly Urticaria Activity Score.

Activity Score (UAS-7, 63%), the Physician Global Assessment (63%), the Patient Global Assessment (44%) and the Dermatology Quality of Life Index (DLQI) (38%). Guidelines are used by 89% to direct their management of CSU, with 50% using the EAACI/GA2LEN/EDF/WAO guideline,[1] compared with 31% primarily using the BSACI guideline.[2] The main perceived barriers to prescribing systemic medications were potential adverse effects (AEs) (32% strongly agreed), potential long-term toxicity (26% strongly agreed), cost of treatment (42% strongly agreed), and views expressed by the patient and their family (37% agreed).

Our findings show variance between dermatology, allergy and immunology consultants with regard to the prescribing of systemic agents in CSU (Fig. 2). Our findings suggest that allergists are more likely to prescribe omalizumab as first-line treatment, whereas dermatologists more commonly prescribe ciclosporin, which is not in keeping with National Institute for Care Excellence guidance.[3]

Drug-related AEs are the main perceived barrier for clinicians to prescribe systemic medications. Other barriers to prescribing are the cost of medications. The list price for omalizumab 300 mg monthly for 12 months is £6150,[4] excluding the cost of post-injection observations required in a secondary care setting, whereas ciclosporin (in generic formulation) costs £2660 for 12 months (300 mg/day; 4 mg/kg/day for a patient weighing 75 kg),[4] excluding the cost of renal function and blood-pressure monitoring. The main limitation to our survey was the number of respondents, as we chose to focus on consultant physicians with a specialist interest in urticaria.

In summary, our UK survey highlights the differences in management of CSU between dermatologists and other specialists, resulting in variation in the care provided for patients with CSU. Although national and international treatment guidelines now recommend omalizumab as a

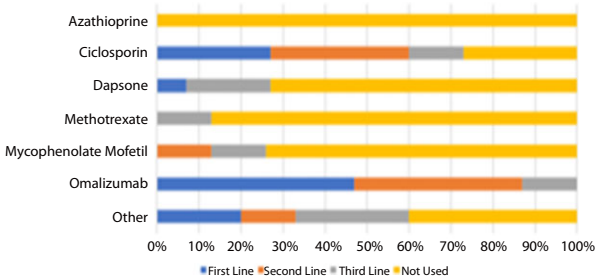

Figure 1 First-, second- and third-line systemic drug selection.

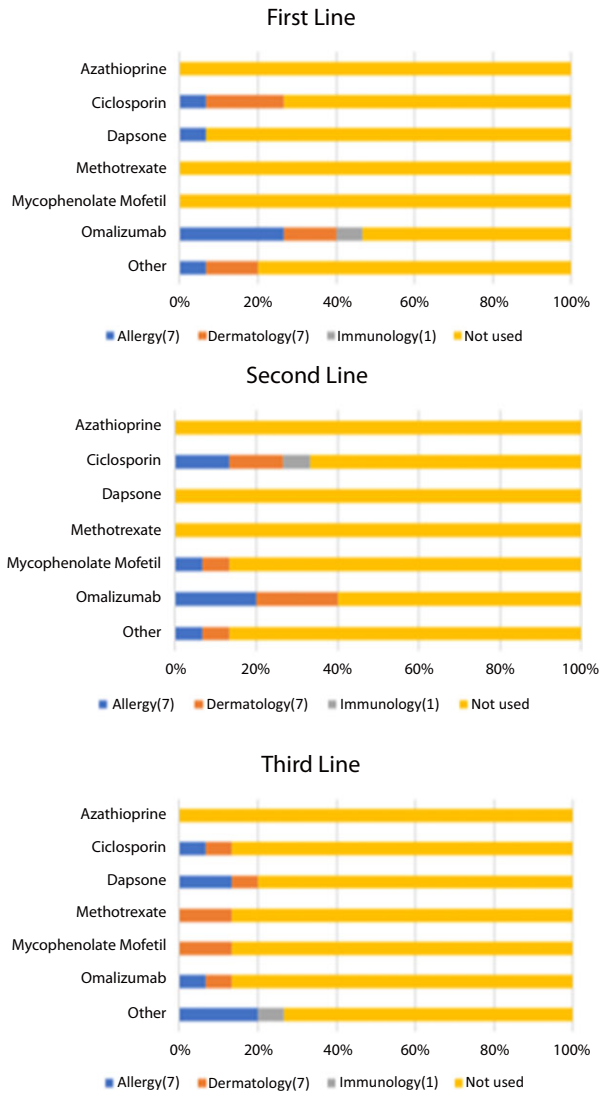

Figure 2 First-, second- and third-line systemic drug selection by specialty.

first-line agent for severe CSU not responding to antihistamine and montelukast treatment, these guidelines are based on placebo-controlled studies. The current lack of head-to-head comparisons between conventional systemic and biologic therapies may explain some of the variation in treatment approaches we observed, and highlights the need for further research in this area, including a comprehensive health economics evalation.[3,5]

Acknowledgement

The UK DCTN is grateful to the British Association of Dermatologists and the University of Nottingham for financial support of the Network.

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Conflict of interest: the authors declare that they have no conflicts of interest.

JRI and CF are on the editorial board of the British Journal of Dermatology, *which is owned by the same society as* Clinical and Experimental Dermatology.

Accepted for publication 25 April 2018

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