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Managing Chronic Spontaneous Urticaria in Everyday Practice

Announcer:
You're listening to *On the Frontlines of Chronic Spontaneous Urticaria* on ReachMD. Here's your host, Dr. Charles Turck.

Dr. Turck:
You're listening to *On the Frontlines of Chronic Spontaneous Urticaria* on ReachMD, and I'm Dr. Charles Turck. Joining me today to discuss real-world management of chronic spontaneous urticaria, or CSU for short, is Dr. Jenny Murase. She's the Director of Medical Consultative Dermatology for the Palo Alto Foundation Medical Group and an Associate Clinical Professor at the University of California, San Francisco. Dr. Murase, welcome to the program.

Dr. Murase:
Thank you so much for having me.

Dr. Turck:
So, for context, Dr. Murase, how do you approach the initial evaluation and diagnosis of CSU, and what helps you distinguish it from other forms of urticaria?

Dr. Murase:
So chronic spontaneous urticaria is a condition that I think we see relatively commonly in our clinic. And it really is a sign that the patient has a significant mast cell load, and that the mast cells are degranulating and releasing histamine. And we can detect this clinically when we take a tongue blade in clinic and do X marks the spot on their back, and the skin welts up in response to the pressure. And that's a situation where we know that medications can help urticaria, such as antihistamines or different systemic agents that we have now available. They'll help the patient.

They definitely also have to have itch for this diagnosis as well, which we can assess through asking the NRS—the Numerical Rating Scales. So, on a scale of zero to 10, if 10 is a very significant itch, where's your itch on that scale today, in the past twenty-four hours? To be chronic, it has to be greater than six weeks.

And then you want to also ask about triggers, because if there are triggers such as heat or cold, then we start to think of urticaria associated with physical stimuli, like cholinergic urticaria or cold-induced urticaria. And then that is different than CSU, which tends to be idiopathic, meaning we really don't know what the underlying cause is in most cases that come in.

Dr. Turck:
Now, once CSU is diagnosed, how do you typically approach treatment, and what signals tell you that it's time to escalate therapy?

Dr. Murase:
I will take an approach where, essentially, I am taking therapies that are low risk and very well-tolerated—antihistamine pills like fexofenadine or loratadine, cetirizine, diphenhydramine, hydroxyzine, et cetera—and adding pills, for example, in the morning, midday, or evening, and stacking them to see if I can get the mast cells to quiet and stop degranulating.

And if I have a patient on upwards of four, five, or six antihistamine pills, and they are not responding and they're still quite itchy, then that's when I start to discuss the possibility of introducing a systemic agent as well.

I think it's very much based on the patient's itch score, their experience with the urticaria, and how much it's impacting their life. Are they able to sleep at night? Is it distracting from activities during the day? Is it affecting their functions of daily living enough to warrant a

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systemic therapy?

Dr. Turck:
I was wondering if you had anything else to share as far as the next steps that you take when you go through treatment sequencing or selection.

Dr. Murase:
So we have therapies that have been introduced over the past decade that have been particularly helpful because they are not immunosuppressive, and they really focus just on the allergic arm of the immune system. For example, omalizumab was introduced, and initially, that was a wonderful therapy in the sense that there was minimal immunosuppression. And it worked quite well in cases where the patient had failed antihistamine.

We also had the introduction of dupilumab, which is, I think, a particularly good agent if the patient falls within atopic diathesis. So if they do have asthma, allergies, hay fever, chronic rhinosinusitis with or without nasal polyps, atopic dermatitis, eosinophilic esophagitis, or food allergies—these Th2-driven inflammatory diseases—oftentimes dupilumab will help with the urticaria and these other conditions as well.

And then, most recently, we have remibrutinib, which is a pill that can be taken by mouth. And the safety profile for these three therapeutics is quite good and very reassuring for patients. And so I think that they all provide a great alternative to the antihistamines alone, when stacked antihistamines are not controlling the patient's pruritus.

Dr. Turck:
For those just tuning in, you're listening to *On the Frontlines of Chronic Spontaneous Urticaria* on ReachMD. I'm Dr. Charles Turck, and I'm speaking with Dr. Jenny Murase about key aspects of the treatment of chronic spontaneous urticaria, or CSU.

So, Dr. Murase, we know that adherence can be a challenge in CSU. So what strategies have you found effective in improving patients' adherence to therapies?

Dr. Murase:
It's important to set a framework for the patient so they understand why adherence is so important. So the way that I explain it to the patient is that the mast cell is essentially like a firecracker. It's covered in these packets of histamine, and when it explodes and degranulates, it releases the histamine, and then the membrane becomes very twitchy. And it stays twitchy for three months, so it's very easy for it to degranulate again.

And so, classically, when we've treated chronic spontaneous urticaria over the years, if it truly is a state where it's been chronic, we want the patients to stay on for a good three months. So, for example, they may take one antihistamine pill and they're still developing urticaria. Then they're taking two a day, let's say, and a week later, they're still having issues. Then they take three a day. And let's say that at three, the skin is quiet, they're no longer itching, and their skin is no longer welting up. So we want to stay on those three pills a day for a full three months before we taper off by one pill a week, and that's because of the way that the mast cell functions.

So if they have that in the back of their mind, that they have to keep the mast cell quiet, then a lot of times, adherence to the therapy improves. It is very difficult to take pills every day, particularly if you're not taking any other medications. And so I understand why, oftentimes, patients do not want to control with multiple pills of antihistamine a day, and they may prefer a shot once a month or a shot every other week instead of having to take multiple pills every day to keep their skin quiet. I can appreciate why it would be hard to have this regimen, where you're having to take multiple pills throughout the day.

And so I think that adherence to therapy relates more to us as clinicians speaking to the patient and trying to figure out what treatment regimen works with their lifestyle and what they can and cannot accommodate during the course of the day, and then developing a treatment regimen that allows them to adhere to the therapy.

Dr. Turck:
Now this gets at a little bit of what you were just talking about, but CSU can certainly impact quality of life significantly. So how do you address the emotional and day-to-day burden of the disease when communicating with patients and assessing outcomes?

Dr. Murase:
I think it's important to demonstrate that you get it as a provider. If you have not yourself been through a condition that itches to the degree that CSU can itch, at least demonstrate that you understand the impact.

So I'll make statements that refer to the data. For example, itch in terms of impact and quality of life is like having cystic fibrosis or having a kidney transplant? That's how much itch can affect quality of life. Or, for adults with urticaria, there are data to suggest that it's

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the same as having severe coronary artery disease.

So, I'll say, “Saying, ‘Don't itch,’ is like saying, ‘Don't breathe,’ right?” And the patients says, "Oh my gosh, I could not agree more. It's so miserable." And when you make statements that show that you get how much this is impacting them, it means a lot, because itch is invisible. And the onus is on us as providers to really do that itch assessment.

I see 30 to 35 patients a day. Almost all of my patients are itch and rash patients, because I've accumulated so many complex patients over the years. And I understand what it's like to be busy and really pressured on the front lines as a medical dermatologist.

But you can use your staff to ask simple questions. The itch intake in our clinic is, first, asking the NRS—so zero to 10, what's the worst itch in the past 24 hours? And then, does it distract from activities during the day? Because that's going to bring you to about a five to seven out of 10. And then does it wake you up at night? Because that's going to bring you to about an eight to 10 out of 10. And those simple questions can be asked by the staff using the staff's time and then are visible to the provider immediately before going into the office visit. You're going do something completely different for a chronic spontaneous urticaria patient who has an NRS of nine versus an NRS of one, right? It's going to completely change what you do, and the only way that you make that visible to you as a provider is through asking those questions.

I think that really is fundamentally what we need to do to get that quality-of-life impact, so that we have a sense for what we need to prescribe for the patient.

Dr. Turck:
Now, before we wrap up our program, Dr. Murase, what key takeaways would you like to leave with our audience about managing CSU in real-world practice?

Dr. Murase:
Oftentimes, we don't have a particular etiology that we can point to to indicate why their mast cells are degranulating and why the patient is experiencing the episode of chronic spontaneous urticaria.

I still think that it's good to ask if they have started to consume herbal therapies, protein drinks, licorice, sport drinks, and things like that, because tartrazine dyes they can cause the mast cells to degranulate more. I've had, over the years, when I think back—because I've done about 7,000 consults for my group—those times that I've been able to identify potential triggers. It would be in cases where they had those yellow, red, and orange dyes in their food or drink. So ask about those types of consumption of tartrazine dyes.

They might have a chronic infection. For example, I might do an ASO titer to look for strep. They might have symptoms of chronic sinusitis or chronic urinary tract infections, prostatitis, frequent yeast infections. Allergists will commonly ask for symptoms related to H. pylori, a gallbladder infection. So if you can find a nidus of infection, that is something that is helpful to screen for. The diagnostic tests are limited, but it's still good to ask those screening questions.

And I really think that if providers do not have their staff asking an NRS for the itch and rash patients that are coming through clinic, that is a very easy thing to implement in practice to really change our patients' lives. When I think back to the consults that I've done where the patients were the most desperate and really besides themselves, they were suffering with their skin disease, and oftentimes they were itching severely and did not have much to see on their skin. And that's really the patient that we do the best service to if we initiate those itch intakes and the itch questions so that we can capture that patient population and make sure that they're on the therapy that they need to be on to be comfortable in their own skin.

Dr. Turck:
Great comment for us to think on as we come to the end of today's program, and I want to thank my guest, Dr. Jenny Murase, for sharing her insights into how we can more effectively manage chronic spontaneous urticaria. Dr. Murase, thanks so much for being here today.

Dr. Murase:
My pleasure. Thank you for having me.

Announcer:
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