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Why Itch Matters in Chronic Spontaneous Urticaria

Announcer:

You're listening to *On the Frontlines of Chronic Spontaneous Urticaria* on ReachMD. Here's your host, Dr. Steve Jackson.

Dr. Jackson:

You're listening to *On the Frontlines of Chronic Spontaneous Urticaria* on ReachMD. I'm Dr. Steve Jackson, and joining me to discuss the significance of itch in chronic spontaneous urticaria is Dr. Nicholas K. Mollanazar. He's a dermatologist and an Assistant Professor of Clinical Dermatology at the University of Pennsylvania Perelman School of Medicine. Dr. Mollanazar, welcome to the program.

Dr. Mollanazar:

Thanks for having me. Happy to be here.

Dr. Jackson:

Dr. Mollanazar, what do we know about itch in the context of CSU, and what mechanisms are understood to drive it?

Dr. Mollanazar:

One of the most important things to appreciate about CSU is that itch is not a secondary complaint. It's a hallmark feature of the disease. At a basic level, it is closely tied to mast cell activation and the release of mediators that drive both the wheals and the sensory experience of itching.

But the more complete way to think about it is as more of a neuroimmune process. There is a meaningful crosstalk between immune activity and itch signaling pathways, which means the patient's experience is shaped by more than what we can see on the skin. That broader framework helps us understand CSU not simply as a disorder of visible hives, but as a condition of which itch itself is central to the biology and burden of the disease.

Originally, we thought that this was largely a histamine-mediated process, but we now know that there is this neuroimmune crosstalk that is driving the itching sensation. We believe that, likely, IL-4, 13, and maybe even 31 play a role, as well as histamine, in the mast cell activation process.

Dr. Jackson:

And with that in mind, how does itch contribute to the overall disease burden in patients with CSU? And how does it affect their daily functioning?

Dr. Mollanazar:

When we talk about disease burden in CSU, itch is a major part of the story. It can disrupt sleep, affect mental health, undermine work productivity, and make ordinary social interactions much harder. Over time, that often translates into fatigue, irritability, and a very real decline in quality of life.

And I think one of the key clinical points is that this burden can be underestimated if we focus too narrowly on lesion count or what the skin looks like in a brief office visit. For many patients, the lived burden of CSU is driven as much by relentless itch as by the wheals themselves.

Dr. Jackson:

So when you're evaluating patients, how do you assess itch in a meaningful way? And what tools or approaches help capture its true impact for you?

Dr. Mollanazar:

In practice, itch assessment has to go beyond a quick yes-or-no question. Patient-reported outcome tools, including measures like the UAS7 and dedicated itch severity scales can help us quantify symptom intensity and track change over time. I particularly find an NRS for itch symptoms to be the most helpful—where zero is no itch, ten is the worst itch ever—and asking patients to rate their itch from that scale of zero to ten, on average, gives you a good sense of where they're living in terms of itch intensity.

But equally important is asking open-ended questions. How is the patient sleeping? How often is itch interrupting the day? Is it affecting concentration, mood, or routine activities? Those answers often reveal the true burden of disease. I would also emphasize that the trend over time is often more informative than a single measurement, because CSU can fluctuate, and what matters most is whether we are moving towards a durable control.

The best itch assessment combines structured tools with a real understanding of how the symptoms are affecting daily life.

Dr. Jackson:

For those just tuning in, you're listening to *On the Frontlines of Chronic Spontaneous Urticaria* on ReachMD. I'm Dr. Steve Jackson, and I'm speaking with Dr. Nicholas K. Mollanazar about the clinical significance of itch in chronic spontaneous urticaria.

Dr. Mollanazar, let's shift gears now and talk about management. How does itch severity factor into current treatment goals and definitions of disease control in this?

Dr. Mollanazar:

Historically, clinicians may have emphasized wheal reduction for CSU, but the field is increasingly recognizing that itch control is a core treatment goal in CSU, as well. From a patient standpoint, relief from itching is often the outcome that matters most. So when we talk about disease control, we are really talking about complete symptom control or at least minimal disease activity, not simply an improvement in how the skin looks.

That shift is important, because it brings clinical goals into closer alignment with patient expectations and with what actually determines day-to-day functioning. Successful CSU management is increasingly defined by itch control, not simply by counting fewer hives.

Dr. Jackson:

You know, I don't think a lot of people can appreciate how bad pruritus can be in people and how devastating it can be.

Dr. Mollanazar:

Oh, I totally agree. When you talk about chronic itch in general or chronic pruritus in general—this isn't just relevant to CSU but looking at chronic pruritus as a whole category—that's itch lasting longer than six weeks. When you question patients and assess their quality-of-life impacts, and you compare it to other standardized metrics, we actually can show that patients suffering from chronic pruritus have the same amount of negative quality-of-life changes as those with chronic pain, which was kind of shocking, because we all know that chronic pain patients really suffer. It really impacts their lives. And to find that chronic itch patients suffer just as much, if not more, was actually shocking when it first came out.

Dr. Jackson:

Now, as newer therapies emerge, how are we seeing itch specifically addressed as a treatment endpoint or a marker of response?

Dr. Mollanazar:

As newer therapies emerge, itch is being treated much more explicitly as an endpoint in its own right. Clinical trials are increasingly incorporating itch-specific measures, which reflects a broader recognition that symptom relief is clinically meaningful. In many cases, rapid improvement in itch can serve as an early signal that a therapy is working, sometimes even before the full visible skin response is apparent.

That is especially relevant as biologics and other targeted therapies appear to moderate itch pathways more directly, allowing us to think about treatment response in a more patient-centered way. In the modern CSU landscape, itch is not just a symptom to note; it is a marker of meaningful treatment response.

Dr. Jackson:

And before we wrap up, Dr. Mollanazar, do you have any final thoughts that you'd like to leave with our audience?

Dr. Mollanazar:

If I had to leave the audience with one takeaway, it would be that itch should be treated as a central feature of CSU, not a secondary one. It shapes disease burden, affects quality of life, influences how we define control, and increasingly matters in how we evaluate

treatment success. The more seriously we take itch as both a clinical symptom and a therapeutic target, the better we can align our care with the realities patients are living with every day. To truly manage CSU well, we have to treat itch as one of the disease's most important outcomes.

Dr. Jackson:

And that is a great way to round out this discussion. I want to thank my guest, Dr. Nicholas K. Mollanazar, for joining me to discuss how itch shapes disease burden and treatment goals in chronic spontaneous urticaria. Dr. Mollanazar, thanks so much for being here today.

Dr. Mollanazar:

Thank you for having me.

Announcer:

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