

Cold Urticaria and Delayed Pressure Urticaria in the Same Patient

Sir,

The association of different clinical types of physical urticaria in the same patient has been previously reported; however, the concurrent presence of delayed pressure urticaria and cold urticaria in the same patient is rare (1).

CASE REPORT

A 44-year-old woman presented us with a long history of swellings and itching which developed spontaneously 3–4 h after pressure; peak erythema, pain and swelling occurred 7–10 h after stimulus. The history revealed that affected areas were often refractory to the development of new lesions for 24–48 h. The areas most commonly affected were the extremities, trunk and buttock, with the face and lips slightly less commonly involved. The patient reported that the lesions were most often induced by standing, walking, or sitting on a hard surface, or by performing manual activities. In addition, our patient reported that for the past 3 years she had also developed wealing after exposure to cold (ice, cold water and cold environment). Local symptoms were redness, itching, wheals, or oedema on the cold-exposure skin; systemic symptoms were absent. Despite attempts to avoid pressure and cold exposure, the patient suffered from recurrent urticaria; her practitioner prescribed oral antihistamines (astemizole 10 mg daily for 5 weeks: cetirizine 10 mg daily and loratadine 10 mg daily for 4 and 5 weeks, respectively) and systemic steroids (prednisolone 40 mg daily for 3 weeks and, subsequently 20 mg daily for 10 days; deflazacort 30 mg daily for 3 weeks), with poor benefit. There was no family or personal history of atopy, or family history of cold urticaria. Routine haematologic and biochemical screening tests, including full blood count, erythrocyte sedimentation rate, antinuclear antibody, rheuma test, Waaler-Rose, cryoglobulins, cryofibrinogen, cryoagglutinins, circulating immune complexes, thyroid antibodies, complement C3, C4, C1 esterase inhibitor, hepatitis A, B, C, syphilis and infectious mononucleosis serology, Phadiatop and PRIST tests were all negative or within normal range.

Pressure testing was performed by suspending an 8-kg weight over the forearm for 8 min; swelling, pruritus and painful sensation developed 4 h later in the test-site skin. The application of an ice-cube to the forearm for 5 min produced a weal with pruritus on the contact area. After physical examination and clinical test results a diagnosis of concomitant delayed pressure urticaria and primary acquired cold urticaria was made. The patient was prescribed oxatomide (30 mg twice daily for 5 weeks), but without improvement; subsequently treatment with dapsone 100 mg daily and cyproheptadine 40 mg three times daily was started, which led to considerable improvement, the patient being completely asymptomatic after 1 month of treatment. Unfortunately, upon stopping dapsone and cyproheptadine therapy, the condition recurred and the patient refused an additional course of these drugs. The patient was finally prescribed cinnarizine 75 mg twice daily. After 2 months of treatment the patient improved, and the drug was reduced to 75 mg once daily.

After another 2 months of therapy, the patient referred that there was no reaction to pressure and/or cold stimulus, and with amelioration of symptoms, treatment was stopped. Both disorders disappeared simultaneously, and a follow-up was performed with monthly intervals of the clinical course for 7 months (from October to April); during this period no relapse was observed.

It is uncertain if the patient's improvement is due to the treatment or to other unknown factors.

REFERENCE

1. Lawlor F, Kobza-Black A, Greaves MW. Delayed pressure urticaria, cold urticaria and chronic urticaria. *Br J Dermatol* 1988; 119 (Suppl 33): 91.

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