

When should the diagnosis 'contact urticaria' be used?

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Summary

In the dermatological literature, the term 'contact urticaria syndrome' is often used with patients presenting no symptoms of contact urticaria, but symptoms of adjacent mucous membranes evolving to a systemic allergic reaction. Contact urticaria refers to a wheal and flare reaction following external contact with a causative substance. Its use should be restricted to skin: a skin reaction after direct skin contact.

Key words: conjunctivitis; contact urticaria; eye drop.

The title of a recent case report in this journal was 'Contact urticaria syndrome caused by sulfamethoxazole sodium contained in eye drops' (1). However, the authors did not describe any symptoms of contact urticaria: the patient first developed conjunctival congestion, lacrimation, eye pruritus, sneezing, and nasal discharge, that is, acute conjunctivitis or rhinoconjunctivitis, immediately after applying sulfamethoxazole eye drops, and later, after reapplication, the same symptoms reappeared, together with throat swelling, dyspnoea, generalized urticaria, and abdominal pain. Generalized urticaria in this case was a manifestation of a systemic allergic reaction, that is, anaphylaxis, as she did not apply the eye drops to the skin. Contact urticaria could have developed around the eyes, for example in the eyelids and on the face, but no such symptoms were reported at any stage. Even if the patient had had local urticaria on the face, allergic conjunctivitis would have been the primary disease, as percutaneous systemic absorption would have been quantitatively insignificant as compared with systemic absorption through mucous membranes of the eyes and the nose.

Generalized urticaria is a common symptom in anaphylaxis (in 80% of cases) (2), but not all such cases should be called 'contact urticaria syndrome' as though all anaphylactic reactions with skin manifestations are attributable to skin contact. The diagnosis of contact urticaria should be restricted to situations in which

patients have wheals, usually repetitively, at the site of the skin contact with a causative agent. True contact urticaria can evolve to generalized urticaria and even anaphylaxis, but, in my experience, this happens very rarely. Anaphylaxis usually requires exposure via the gastrointestinal tract (food allergy or drug reactions), intracutaneously/subcutaneously (insect sting reactions), or intravenously (drug reactions). Immediate IgE-mediated allergy manifests in different organs, depending on the exposure route: allergic conjunctivitis results from eye exposure, allergic rhinitis results from nasal exposure, allergic asthma results from respiratory exposure, allergic gastrointestinal symptoms result from indigestion, and contact urticaria results from skin exposure. Systemic allergic reactions can affect several of these organs after exposure of any of these organs. Do we really need entities such as 'contact urticaria syndrome'? If the answer is affirmative, should we not also use 'allergic conjunctivitis syndrome', which would be a more appropriate title for this case report? Anaphylaxis is anaphylaxis irrespective of the route of sensitization and location of primary symptoms.

This comment is not intended to specifically address the authors of the recent case report, because they are only the latest example of a long tradition in the dermatological literature, but future authors and reviewers of *Contact Dermatitis*, who can change the present policy and use the nomenclature in a logical way.

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