EDITORIAL

URTICARIA – AS A PROBLEM

The distinction between the concepts of acute, chronic or recurrent urticaria do not seem to be clearly established, since the lesions occurring after the ingestion of a particular foodstuff are just as acute as those developing after exposure to cold or from rubbing which, nevertheless, are included in chronic forms.

The chronicity of urticarial reactions are taken into account when characteristic lesions persist for at least six weeks although, as already stated, included in the same concept are processes in which the lesions recur when certain well-defined stimuli (physical urticaria, thermic urticaria, allergens, foods, drugs, parasites) or other causes are present. Identification of these causes may be laborious and frequently leads to a provisional diagnosis of "chronic idiopathic urticaria" that is, of unknown cause (1). The frequency with which urticaria is accompanied by angioedema, which is sometimes the dominant lesion and which can even provoke severe situations, is well-known.

In an attempt to synthesize the various causes of urticarial reactions, several classifications have been formulated, although the criteria used do not always coincide. However, in practical terms, any one of these classifications is sufficient to understand the complexity of ethiological investigation, especially when the development of lesions cannot be related to a specific event (for example the intake of certain foods or drugs), contrary to what usually happens with the various types of physical or heat urticaria (2, 3).

In view of the above, it is always worth bearing in mind what could be called urticarial syndrome*, that is, a single cutaneous lesion produced by several causes versus the possibility that the cutaneous lesion is merely another* symptom *of other processes, usually highly important, such as the various vasculitis, complement factors deficiencies, autoimmune diseases (thyroiditis), neoplasias, or connective tissue diseases, among other less frequent diseases (4-6). For that reason, in each case the clinician needs to exhaust all the possible diagnoses before considering the "idiopathic" cause, without forgetting the possibility that the lesion might be a mere symptom of another, more serious, disease.*

In the present edition of Allergologia et Immunopathologia *several studies that investigate aspects of there problems are publised.*

Although doubts have been cast on the role of Helicobacter pylori *as a causative agent of urticaria in patients infected by this bacteria (7, 8) Gaig et al (9) consider* H. pylori *eradication beneficial in improving the symptoms of urticaria while other authors also observe*

improvement after H. pylori *eradication in patients with hereditary angioneurotic edema, although naturally the mechanism by which the microorganism intervenes in the process must be different because this disease is caused by deficiency of serum inhibitor of the activated first component of complement (10).*

For their part, Santaolalla et al (11) describe the characteristics of a series of twelve young patients studied in hospital with cold urticaria, three of which also suffer from other types of physical or thermal urticaria.

Lastly, Karakaya and Kalyonku review the relationship between asthma and metamizole intolerance in a group of 264 patients of which almost half presented urticaria (43%) or angioedema (45%) on taking the drug (12), this being an example of the not uncommon acute urticarial reactions caused by analgesics/antipyretics. Equally acute and sometimes severe are the reactions caused by sensitization to shellfish or molluscs, as González et al (13) describe in their presentation of a clinical case.

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