Allergologia et immunopathologia
Sociedad Española de Inmunología Clínica, Alergología y Asma Pediátrica
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CORRESPONDENCE

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RE: Cold-induced urticaria and development of anaphylaxis

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Received: 28 June 2024; Accepted 29 July 2024
Available online: 1 September 2024

KEYWORDS
Cold-induced urticaria;
anaphylaxis;
chronic urticaria;
inducible urticaria

Dear Editor,

I have read the article titled, "Cold-induced anaphylaxis triggered by drinking cold water" by Alrafiaah et al. with great interest.[1] Ideally, this article should have discussed some aspects of the types of chronic urticaria,, but this has not been done. This makes it difficult to understand the purpose of the article. It would be helpful for the reader if these issues were discussed and clarified.

First: Although it is said that a trigger, e.g., cold should be looked for in a patient with chronic spontaneous urticaria (CSU), the coexistence of CSU and chronic inducible urticaria (CIndU) and the frequency of their coexistence, etc., have not been discussed in the article. For instance, of the 708 patients with CSU, 247 (35%) were found to have comorbid CIndU in a study.[2]

Second: In addition to CSU, this patient seemed to have cold urticaria and dermographism. Could the ice cube test be inaccurate in a patient with dermographism? Because, although the figure shows more skin signs of dermographism, there is no image showing a positive ice cube test. The coexistence of these three conditions and their effects on each other has never been mentioned or discussed in the article.[3]

Third: In this pediatric patient who also had CSU, no laboratory tests and no known serum tests for chronic cold urticaria were performed. Also, no further or detailed investigations were performed for the differential diagnosis of the patient.

Cold urticaria is described by the development of urticaria, usually superficial and/or angioedema reaction, following cold contact. It is more commonly seen in young women. Although the pathogenesis is unknown, the diagnosis is dependent on history and ice cube tests.[4,5] Cold urticaria can be categorized as acquired and familial disorders with

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https://doi.org/10.15586/aei.v52i5.1167

autosomal dominant inheritance. Idiopathic cold urticaria is the most frequent type, but cryopathy should also be investigated.

There is no adequate investigation as to whether this case is idiopathic or familial, or regarding its cause. In this case, no family history was given, and the presence of an acquired cause was not explored. Again, due to the age of the patient, the possibility of infections such as EBV, mycoplasma, hepatitis B, toxoplasmosis, or stings by ants/bees should have been discussed.[4-12]

Minor points: Although the patient had anaphylaxis and was in the emergency room for 2 hours, no epinephrine was administered. Instead, an epinephrine autoinjector was prescribed when sending the patient home as an accepted practice.[1] It is clear from the author's country of origin, as is the case in many other countries, that epinephrine is not only under-prescribed but also under-administered in the emergency department.

Conclusion: I would like to thank the authors for this high-quality case report and its results. This raises physicians' awareness of cold urticaria, a type of chronic inducible urticaria, and the possibility of anaphylaxis due to it.

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