in various substances of day today use (including foods containing nickel) which could cause occult sensitivity in many individuals. These substances may have caused occult sensitivity in some of these patients of chronic urticaria as well in this study which were picked up on patch test. The study lacks comparison with age matched healthy controls from the same population which could have given patch test outcomes in that healthy population. Also the other potential causes of chronic urticaria like food, aero-allergens, auto-antibodies etc. were not looked for, investigated and ruled out. Neither there are details of how common allergen like nickel which is so ubiquitous, was avoided which caused remission in majority of his patch test positive patients. The possibility of spontaneous remission in some of these patients cannot be ruled out with certainty. There is no mention of controlled challenge/provocation test (possibly not done) which is important for confirmation. [3] Statistical analysis of data is also lacking to determine the statistical significance of the study results. There is no doubt that patch test is a safe, simple and inexpensive test, however its usefulness in etiological diagnosis of chronic urticaria seems to be of limited value so far.

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Authors' reply
Sir,
I thank Dr. Verma for his keen interest in my report and his valid comments. However, I would like to clarify some of the points:
1. The aim of this study was to see the role and relevance of patch testing in the etiological diagnoses of chronic urticaria, not to highlight the merits/demerits of ASST and other skin allergy tests; this article is very much clear on this point.
2. Table 1 has clearly mentioned the duration of chronic urticaria in all those 11 patients.
3. The scoring system you have mentioned is mostly suitable for hospital-based study where you can have sufficient time to monitor the patient's physical condition. In clinic-based study where you meet your patient for a short period of time, this type of scoring systems is difficult to use because a patient may/may not have attack of urticaria at the time of visiting the clinician. As mentioned in my article, my study was clinic based; moreover, my study included people from different strata-highly educated chemical engineer to illiterate cobbler. To avoid respondent's bias, I had to use the old, simple clinical method to assess the severity of itching: none-no itching; mild-itching that does not disturb night sleep; moderate-itching that disturbs night sleep more than occasionally but not continuously; severe-itching that disturbs night sleep continuously. I would like to inform you that 9 patients had moderate itching while the remaining 2 had severe itching in the study.

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Autologous serum skin test v/s autologous plasma skin test

Sir,
Chronic idiopathic urticaria (CIU) is a rather common skin disorder characterized by the recurrent eruption of short-lived wheals accompanied by redness and itching for at least 6 weeks.[1] In 25% to 60% of patients of chronic urticaria, the results of autologous serum skin test are positive.[1-4] About 30% to 50% of patients with chronic idiopathic urticaria have circulating histamine-releasing autoantibodies to the high-affinity IgE receptor Fc RI on basophils and mast cells or, less commonly, antibodies to IgE.[4] The term autoimmune urticaria is increasingly being accepted for this subgroup of patients. The autologous serum skin test (ASST) is currently
the best in vivo clinical test for detection of in vitro basophil histamine-releasing activity. One study reports that APST is positive in more patients with chronic urticaria than ASST.

The aim of the current study was to perform APST, i.e., investigate skin autoreactivity by using plasma anticoagulated with substances other than heparin, and compare it with ASST in patients with CIU.

Thirty consecutive consenting adult patients (male:female:13:17; age range, 18-60 years; mean age, 38.9 years; range of duration of urticaria, 2 months to 3 years) with CIU, seen at a private skin clinic in Navi Mumbai, India, were studied. CIU was diagnosed on the basis of the appearance of continuous or recurrent hives with or without angioedema for more than 6 weeks. Patients with physical urticaria were excluded. Pregnant and lactating mothers were excluded.

After antihistamine treatment (cetirizine 10 mg or fexofenadine 180 mg or hydroxyzine 25 mg daily in all cases) had been stopped for at least 3 days, all patients underwent intradermal testing with 0.05 ml of both sterile autologous serum (ASST) and plasma (APST), and saline as negative control. All patients underwent intradermal test with sodium citrate–anticoagulated plasma (0.125 mol/L of sodium citrate). Serum and plasma samples were centrifuged after 5 minutes at 2500 rpm for 5 minutes and immediately used for intradermal tests. For all intradermal tests (serum, plasma, and negative control), readings were taken at 30 minutes; only an unequivocal wheal-and-flare reaction with a wheel diameter of at least 1.5 mm greater than control was taken as a positive test result.

No patient reacted to the intradermal injection of saline. Altogether, 14 (46%) of 30 patients scored positive on ASST. Test with plasma also showed the same, 14 of 30, positive results. In 1 patient with severe urticaria, plasma-induced wheal was greater than serum-induced wheal by 3 mm. The wheel-and-flare area induced by autologous serum and plasma was equivalent in other 13 cases. Positive group had 4 males and 10 females. Duration of urticaria was more than 3 months in all positive cases.

A study from Italy showed that in patients with chronic idiopathic urticaria (CIU), plasma showed signs of thrombin generation and autologous plasma skin tests score positive in as many as 95% of cases. The extrinsic pathway of clotting cascade is activated in CIU. Disease severity is associated with the activation of the coagulation cascade. Others have confirmed the findings of the earlier studies, suggesting that systemic fibrinolysis may not be involved in chronic urticaria.

However, larger studies are required to confirm these findings and to decide whether plasma or serum should be used for the intradermal test.

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