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Cholinergic urticaria pdf

This article needs editing to comply with Wikipedia's Style Manual. In particular, it has problems with the lack of use of MEDMOS. Please help improve it if you can. -July 2018) (Learn how and when to remove this template message) Cholinergic urticariaCU on the volral aspect of the forearmSpecialtyDermatology Cholinergic urticaria (CU) is a type of physical urticaria (or hive) that occurs when a person sweats[1] or their body temperature of the nucleus increases. [2] Symptoms of Cholinergic urticaria usually represent a number of small, short-lived hives, but can also include sweat inflammation (wheals) and pain that develops usually in response to exercise, bathing, staying in a heated environment, or emotional stress. [3] [4] Although symptoms resolve rapidly, usually within 1 hour, cholinergic urticaria can significantly impair quality of life, especially in relation to sports activities. [5] Causes sweat hypersensitivity Acquired anhidrosis and/or hypohydrosis (idiopathic opioid inhibitors cholinesterase inhibitors Subtypes Sweat hypersensitivity This subtype of CU refers to those who are hypersensitive to their own sweat. Diagnosis Diagnosis is given by injecting autologous (own) sweat into the skin. [6] The features of the Hive are observed to coincide with sweating points of sweating. [7] Patophysiology Tanaka et al. Found that sweat hyper-sensitivity CU and atropic dermatitis seems to be almost the same, and therefore, sweat-induced histamine release from basophiles can also mediate a certain IgE for sweat in atropic dermatitis, as well as CU. [7] Treatment Suggested first-line treatment: Rapid desensitization protocol using autologous sweat. [6] Non-pharmacological treatment: Forced sweating by overheating of the body (hot bath or exercise) used daily can reduce symptoms through exhaustion of inflammatory mediators. [8] This non-pharmacological treatment is contraindicated in those with CU as a result of hypohydrosis (see below). Antihistamines are the most commonly prescribed first-line treatment of conventional urticaria, but its effectiveness in the treatment of CU is quite limited in most cases. [1] Some research suggests that first-generation antihistamines with anticholinergic properties such as diphenhydramine are most successful in the treatment of CU. Mixed-success treatment (e) : omalizumab (anti-IgE therapy),[9][10] danazol (synthetic androgen), [11] propranolol (beta blocker),[12][13] zileuton (antileukotriene). Acquired anhidrosis and/or hypohydrosis This subtype of CU applies to those who have abnormally reduced sweating. Diagnosis Sweat is easily visualized by a current indicator such as diaodinated starch or sodium alizarine sulfonate. They both go through a dramatic discoloration when moistened with sweat. The thermal power test of sweat evaluates the body's response to thermal stimulus by inducing sweating through the use of a hot box/ room, thermal blanket or exercise. The failure of the current indicator on the discoloration during thermogalacial sweat testing may indicate anhidrosis and/or hypohydrosis (see Minor test). [14] Skin biopsy can detect cellular infiltrations in sweat glands or ducts. [7] Features Severe heat intolerance (e.g. nausea, dizziness, and headache), and tingling, pricking, pinchy or burning pain across the entire body to hot environments or prolonged exercise that improve after cooling the body. It occurs in the absence of any causal skin, metabolic or neurological disorders. [15] The diagram visualizes the overflow of acetylcholine into adjacent mast cells. Pathophysiology [16] Whey, hypohydrosis and pain as if due to low levels of expression of acetylcholinesterase (AChE) and cholinergic receptors, males 3 (CHRM3) in epithelial cells of the eccrine gland. Elevated expression levels of CCL2/MCP-1, CCL5/RANTES and CCL17/TARC resulting in chemoattracted CD4+ and CD8+ T cell populations in the surrounding area may be responsible for performing a downmodulatory effect on the expressions AChE and CHRM3. Corticosteroid inhibits expressions CCL2/MCP-1, CCL5/RANTES and CCL17/TARC. This further supports the idea of CCL2/MCP-1, CCL5/RANTES and CCL17/TARC playing a key role. First-line treatment: HIRAs are the first line of therapy for CholU patients, but many patients show only a mild to moderate response to standard doses of H1RA. It has been reported that the addition of H2RA is effective in patients with refractory CholU who did not respond to H1RA dosing. Other studies have shown the efficacy of scopolamine butylbromide (an anticholinergic agent); combinations of propranolol (β2-adrenergic blocker), antihistamines and montelukasta; treatment and injection with botulinum toxin. [17] Non-pharmacological treatment: In the absence of sweat, cold water sprays and wet towels can be used to increase heat loss from the skin. Switching to cooler or air-conditioned environments when needed can also reduce discomfort. In case of severe hyperthermia (body temperature >105 °F/41 °C), drastic measures such as immersion in ice-cold water are needed to prevent irreversible brain damage. [18] Idiopathically unknown or unclassified at this time. This represents those who do not fall into any of the above categories. Prevalence Although overall research is limited, various studies show that CU is relatively common in populations with prevalence rates reportedly ranging from 5% to 20% (depending on locale, race and age). [19] [20] [21] The condition is more common in young adults, with prevalence appearing to peak in adults aged 26-28 (up to 20%). [19] The vast majority of cases appear to be mild and proportionally few individuals seek medical attention in relation to the condition. The history of Kolinergic urticaria was first described by Duke[22] in 1924 as urticaria caloricarica. The term Kolinergic stems from findings that hives similar to those of CU may be using cholinergic agonists (e.g. See also Miliaria Exercise-induced anaphylaxis Idiopathic pure co-engine failure Hypohidrosis Fabry disease Aquagenic urticaria References ^ a b Nakamizo, S.; Egawa, G.; Miyachi, Y.; Kabashima, K. (2012). Cholinergic urticaria: Categorization based on pathogenesis and its treatment options. *Journal of the European Academy of Dermatology and Venerology*. 26 (1): 114–116. doi:10.1111/j.1468-3083.2011.04017.x. PMID 21371134. ^ Schwartz, Robert. Cholinergic Urticaria. *Medscape*. Date: 31 March 2018 ^ Moore-Robinson, M.; Warin, R.P. (1968). 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