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Transient hair loss in patients with chronic spontaneous urticaria treated with omalizumab

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Summary
Omalizumab (anti-IgE) is used as add-on therapy for antihistamine refractory chronic urticaria patients. The most commonly reported adverse effects were headache, arthralgia, upper respiratory infections, fatigue, nausea and injection-site reactions. However, lately a few cases of hair loss have been reported. We describe a case of transient hair loss in a young female patient after initiating treatment with omalizumab. Despite this side effect, the patient continued with omalizumab treatment for 10 months with good effect.

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Dear Editor,
We read with interest the recent case report by Konstantinou et al. (1) published in your journal about the use of omalizumab in three female patients with chronic spontaneous urticaria (CSU) who reported transient hair loss. In the case report by Konstantinou et al. (1) all three patients had previously been treated with non-sedating antihistamines, ranitidine and montelukast without any symptom relief. Furthermore, all of the patients were also treated with at least one short course of prednisolone due to severe angioedema and pruritus in the last four weeks before initiating treatment with omalizumab. Two of the female patients had no other known significant illnesses, whereas one of the patients was known with Hashimoto’s thyroiditis since the past 12 months. All three patients reported transient hair loss after initiating treatment with omalizumab, however only one of the patients (with Hashimoto’s thyroiditis) had visible alopecia areata. None of the patients discontinued their treatment.

Transient hair loss is not a commonly reported side effect of omalizumab. In the following we describe a similar case of a female patient from our dermatology department, who was treated with omalizumab and also experienced transient hair loss. The patient was a 27-year-old woman with a three week history of urticaria who was referred to our department in June 2015. At the time of the referral, she had abdominal pain and she reported a recent urinary tract infection, eye infection and orolabial herpes infection. Urine and routine blood tests were normal aside from CRP, which was elevated to 53 mg/l (normal < 10mg/l). The patient suffered from diffuse urticaria and swelling, primarily of her palms, soles and around her eyes. She was treated with non-sedating antihistamines four times daily as well as 50 mg prednisolone daily for three days with some symptomatic relief. However, a few days later her symptoms worsened and she was re-hospitalized. Routine blood tests showed elevation of CRP to 33 mg/l and leukocytes to 10.7 x 10⁹/l (normal 3.5-8.8 x 10⁹/l). Chest X-ray, throat culture and
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The use of omalizumab in patients with chronic spontaneous urticaria (CSU) is uncertain, as the patient described by Konstantinou et al. (1) with visible alopecia areata also had Hashimoto's thyroiditis, which is commonly associated with hair loss (3). Likewise, the hair loss in our case could have been caused by urticaria itself or the infectious diseases prior to urticaria. Also, our patient, and the cases described by Konstantinou et al. (1) were all treated with prednisolone, which has also been associated with hair loss. Furthermore, it is worth noting that hair loss is not a reported adverse effect in clinical phase trials of CSU and omalizumab. The most commonly reported adverse effects were headache, arthralgia, upper respiratory infections, fatigue, nausea and injection-site reactions (4-6). We conclude that hair loss may have multiple causes and that these must be accommodated in the explanation of the possible association between omalizumab use and hair loss in patients with urticaria.

References


