Safety of Cyclooxygenase 2 Inhibitors and Increased Leukotriene Synthesis in Chronic Idiopathic Urticaria With Sensitivity to Nonsteroidal Anti-inflammatory Drugs

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Background: Nonsteroidal anti-inflammatory drugs (NSAIDs) exacerbate various forms of urticaria by a nonallergic mechanism involving inhibition of cyclooxygenases.

Objectives: To assess safety of cyclooxygenase inhibitors in patients with chronic idiopathic urticaria (CIU) and NSAID sensitivity and to evaluate a role of cysteinyl leukotriene metabolism and mast cell activation in sensitivity to NSAIDs in CIU.

Design: Aspirin challenge test followed by randomized, prospective, double-blind, placebo-controlled crossover trial with cyclooxygenase 2 inhibitors.

Setting: Tertiary referral center of a university hospital.

Patients: Thirty-six patients with CIU.

Interventions: Aspirin challenge test (up to 500 mg); randomized trial with rofecoxib (up to 37.5 mg) and celecoxib (up to 300 mg) in aspirin-sensitive patients. After completion of the trial, 7 patients received naproxen sodium (500 mg) as a positive control.

Main Outcome Measures: Standardized skin examination, skin biopsy with mast cell count, urinary levels of leukotriene E4 (LTE4), and serum levels of mast cell tryptase.

Results: Aspirin induced skin eruption in 18 patients. Rofecoxib or celecoxib did not elicit skin eruption in any of the aspirin-sensitive patients. Patients with CIU had higher urinary excretion of LTE4 than healthy control subjects. Basal urinary levels of LTE4 and serum mast cell tryptase were increased in aspirin-sensitive compared with aspirin-tolerant patients. Severity and duration of aspirin-induced urticaria showed a positive correlation with urinary LTE4 excretion. Naproxen precipitated urticaria in 5 of 7 aspirin-sensitive patients and caused further increase in urinary LTE4.

Conclusions: Cyclooxygenase 2 inhibitors do not induce urticaria in patients with CIU sensitive to NSAIDs. Sensitivity to NSAIDs in CIU is associated with overproduction of cysteinyl leukotrienes and mast cell activation and most likely depends on inhibition of cyclooxygenase 1.

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largely inferred from studies of an analogous, well-defined clinical syndrome of aspirin-induced asthma, which affects about 10% of adult asthmatic patients. Both syndromes affect middle-aged individuals, with a female preponderance. Sensitivity to NSAIDs is present in only a subset of patients with asthma and CIU. It is well established that in aspirin-induced asthma the mechanism of sensitivity involves inhibition of COX. The biochemical level, aspirin-induced asthma is characterized by overproduction of cysteinyl leukotrienes and increased urinary excretion of leukotriene E4 (LTEn). Nasal biopsy specimens from aspirin-sensitive patients with asthma contain elevated numbers of leukocytes expressing the cysteinyl leukotriene 1 receptor, expression of which is down-regulated after desensitization to aspirin. Consistently, leukotriene receptor antagonists improve asthma in aspirin-intolerant patients. Analogously, NSAID sensitivity in chronic urticaria is ameliorated by cysteinyl leukotriene receptor inhibitors, but leukotriene metabolism in aspirin-sensitive CIU has not been studied.

Recent reports demonstrated that selective inhibitors of COX-2 (coxibs) can be safely used in patients with aspirin-sensitive asthma, implicating inhibition of COX-1 as the principal mechanism triggering asthma attacks by NSAIDs. Several studies, performed without strict subtyping of a rash or confirmation of NSAID sensitivity by a drug challenge test, suggested better tolerability of selective COX-2 inhibitors in patients with a history of cutaneous eruptions induced by aspirin.

The goal of this study was to assess the safety of COX-2 inhibitors in patients with NSAID-exacerbated CIU and to correlate NSAID sensitivity with changes in leukotriene metabolism and mast cell activation. We conducted a double-blind, placebo-controlled, oral drug challenge study investigating the effects of the COX-2 inhibitors rofecoxib and celecoxib in patients with NSAID-sensitive CIU confirmed by aspirin challenge test.

### DESIGN OF THE STUDY

The experimental protocol is summarized in Table 1. All patients received placebo on day 1 of the study. On day 2 they were challenged with increasing doses of aspirin up to the cumulative dose of 500 mg.

Patients with positive aspirin challenge test results entered a randomized, double-blind, placebo-controlled, crossover trial with rofecoxib and celecoxib. This design was chosen to assess potential differences between the drugs. The challenge with these drugs was performed on days 8 and 15. As a positive control, after completion of the trial, aspirin-sensitive patients agreed to receive naproxen sodium (300 mg), a structurally dissimilar non-selective NSAID. All drugs and placebo had identical appearance.

### ASSESSMENT OF SEVERITY OF SKIN ERUPTION

To standardize the assessment of severity of the skin eruption, a modified Psoriasis Area and Severity Index (PASI) was used. For the assessment of urticaria, itching replaced desquamation in the index. Thus, we determined the degree of itching, erythema, and infiltration, expressed as a percentage of involvement of the 4 main body areas: head, trunk, upper extremity, and lower extremity. Each variable was assessed on a scale of 0 to 4, with 0 indicating no involvement and 4, severe involvement. Calculated PASI scores range from 0 to 72. We considered a PASI greater than 10 as indicating a severe reaction. The PASI was determined by an experienced dermatologist at the time of appearance of skin lesions and 2, 4, and 6 hours after the drug challenge.

### SKIN BIOPSY

One 4-mm punch biopsy was performed from the clinically most prominent lesion in 16 patients. Multiple formalin-fixed, paraffin-embedded sections were stained with hematoxylin-eosin and examined by one of us, an American Board of Pathology–
certified dermatopathologist (A.Z.). The number of mast cells per square millimeter of tissue section was counted after immunohistochemical staining with mast cell tryptase monoclonal antibodies (DAKO, Carpinteria, Calif) by means of a peroxidase-labeled streptavidin-biotin–based detection kit (DAKO). At least forty 0.11-mm² microscopic fields at ×400 magnification were counted in each biopsy specimen. The average ± SD number of mast cells in the field was 11 ± 8 (range, 0-37; total, 772 fields counted).

MEASUREMENTS OF URINARY LTE₄ AND SERUM TRYPOTASE

In patients with positive challenge test results, urine samples were collected at baseline, at the time of appearance of the first skin symptoms (time 0), and then 2, 4, and 6 hours later. In nonresponders, the urine samples were collected at baseline, at the end of aspirin dosing (ie, when a cumulative dose of 500 mg was reached [time 0]), and then 2, 4, and 6 hours later. Urine samples were stored in 50-mL aliquots at −70°C. The LTE₄ was measured in unpurified samples by direct enzyme immunoassay (enzyme-linked immunosorbent assay; Cayman Chemical, Ann Arbor, Mich). Measurements were made at the same time in duplicates with the use of the same kit. The results were expressed in picograms per milligram of creatinine. Serum tryptase was measured by fluoroenzyme immunoassay (UniCAP 100 Tryptase system; Pharmacia Diagnostics, Uppsala, Sweden) and expressed in micrograms per liter.

AUXILIARY LABORATORY TESTS

Blood was drawn at baseline and then at 2, 4, and 6 hours to measure the number of peripheral eosinophils. Vital signs and forced expiratory volume in 1 second were recorded every 15 minutes until 6 hours after the last dose of a drug.

STATISTICAL ANALYSIS

Statistical evaluation was carried out with STATISTICA software (StatSoft, Inc, Tulsa, Okla). Summary statistics were expressed as mean ± SD for symmetric distributed data and median and 25th and 75th percentiles for nonsymmetric (skewed) distributed data. A multiway analysis of variance model was used when needed as variance stabilizing transformation. Logarithmic transformation was used when a dose of aspirin and serum mast cell tryptase levels were significantly higher in patients with CIU than in healthy controls. The LTE₄ and serum mast cell tryptase levels were significantly higher in the patients with positive results of aspirin challenge test than in nonresponders. The increased LTE₄ levels were recorded in all 5 samplings of urine collected before drug challenge tests or administration of placebo. For patients with CIU, the results of the other 4 LTE₄ estimations were as follows: 403 (234-771), 608 (221-1058), 348 (245-564), and 451 (202-882) pg/mg of creatinine.

There was a statistically significant correlation between the baseline urinary levels of LTE₄ and the maximal intensity of skin eruption expressed as PASI (Figure 1) and duration of the rash (Pearson r = 0.64; P < .04; not shown).

There was no correlation between a dose of aspirin and the number of eosinophils in the peripheral blood or the intensity or duration of the skin reaction. Figure 2 shows the time course of urinary levels of LTE₄ during aspirin challenge in patients with CIU. There was a trend to further increase in LTE₄ levels after aspirin challenge in aspirin-sensitive patients. How-
ever, the differences did not reach statistical significance in the entire cohort or in subgroups with mild (PASI ≤10) or severe (PASI >10) skin reaction.

DOUBLE-BLIND, RANDOMIZED, CROSSOVER TRIAL WITH ROFECOXIB AND CELECOXIB

None of the 18 patients with positive aspirin challenge test results developed a skin reaction during challenge with placebo, rofecoxib (up to 37.5 mg), or celecoxib (up to 300 mg). There were no significant changes in LTE4 levels during challenge test with rofecoxib or celecoxib.

CHALLENGE WITH NAPROXEN

To exclude desensitization to NSAIDs, 7 aspirin-sensitive patients received naproxen sodium (500 mg) after completion of the trial with coxibs. Three patients with strong reactions to aspirin (PASI, 24.3±14.7) developed strong reactions to naproxen (PASI, 17.5±4.0). Two patients with weaker responses to aspirin (PASI, 11.8±7.3) developed mild urticaria (PASI, 4 and 8). No skin eruption was observed in the remaining 2 patients. Naproxen induced a significant increase in urinary LTE4 levels 2 hours after appearance of the urticaria (Figure 3).

SKIN BIOPSY RESULTS

Urticaria was diagnosed histologically in 12 of 16 skin biopsy specimens. Biopsy specimens from 2 patients with annular lesions showed a more complex pattern with a component of interstitial granulomatous reaction previously described in association with drugs.38 In 1 patient, a mild perivascular mononuclear infiltrate was present. Surprisingly, but without obvious explanation, the biopsy specimen in 1 patient demonstrated pauci-inflammatory interstitial mucinosis. Tissue sections contained 99±22 mast cell tryptase-positive cells per 1 mm². The number of mast cells did not correlate with intensity of skin eruption (PASI) or serum mast cell tryptase levels (Spearman r =0.38, P>.14).

COMMENT

Our study confirms high prevalence of NSAID sensitivity in CIU. Patients with CIU are often denied this class of medications because of fear of untoward reactions to NSAIDs. Our findings demonstrated lack of cross-reactivity between aspirin and 2 COX-2 inhibitors, rofecoxib and celecoxib. These findings are in line with recent reports that showed good tolerability of coxibs in patients with clinical history of NSAID-induced skin eruptions33,34 and NSAID-induced asthma,39-42 with the exception of one study35 that found 3% and 33.3% cross-reactivity with rofecoxib and celecoxib, respectively, in patients with NSAID-sensitive skin eruptions. The reasons for discrepancy in estimated cross-reactivity rates to coxibs in this study and our results are not easy to understand, but they may be due to different study popu-
lations or challenge protocols. In comparison, our study had a very uniform patient population, restricted to individuals with strictly defined CIU and positive results of aspirin challenge test.

In addition to clinical implications, our findings shed new light on the mechanisms involved in NSAID sensitivity in CIU. Lack of reaction to local injections of lysine-aspargin is consistent with a nonimmunologic mechanism of aspirin-induced rashes. Aspirin and older NSAIDs are nonselective inhibitors of COXs. The lack of cross-reactivity with coxibs strongly suggests inhibition of COX-1 as the principal mechanism involved in aspirin-induced exacerbation of CIU. However, possible involvement of a recently discovered third isoform of COXs, COX-3, or other yet undiscovered COXs cannot be excluded. Differential selectivity toward inhibition of COX-1 may also explain the results with naproxen, which induced urticaria in 5 of 7 patients with positive results of aspirin challenge test. Naproxen is a nonselective COX inhibitor, but with lower potency toward COX-1 than aspirin.

Increased urinary LTE4 levels indicate increased global cysteinyl leukotriene production in CIU. Urinary LTE4 levels were invariably elevated when measured on 5 occasions during the period of 2 weeks as compared with levels in healthy controls. The LTE4 levels correlated with the intensity and duration of the reaction to aspirin. In addition, urinary LTE4 levels showed a trend to further rise after aspirin administration. In a group of 7 patients challenged with naproxen, further increase in LTE4 level above the baseline reached statistical significance. These results point to cysteinyl leukotrienes as major effector molecules in CIU and mediators of NSAID sensitivity. This suggestion is corroborated by recent reports showing that leukotriene receptor inhibitors block aspirin-induced urticaria and improve CIU.

Mast cells are the most likely source of increased leukotriene production in CIU. They are the target of pathogenic anti-FceRI antibodies. They are also the key cells in urticaria and a known source of leukotrienes. A role of mast cell activation in NSAID sensitivity in CIU is supported by our findings of elevated serum levels of mast cell tryptase, a specific mast cell–derived protein marker, in patients with aspirin sensitivity. There was no correlation between the number of mast cells in skin biopsy specimens and the intensity of skin eruption or serum mast cell tryptase levels. These results support the notion that increased activation of mast cells rather than their increased number is responsible for elevated levels of mast cell tryptase. However, we could not compare the number of mast cells in patients with positive aspirin challenge test with those in nonresponders or healthy subjects, as skin biopsies were not performed in the latter 2 groups.

Further mechanistic studies are obviously needed to elucidate likely complex regulatory relationships between biochemical pathways involved in NSAID sensitivity in CIU. However, interpretation of our data in the context of current understanding of a role of prostaglandins and leukotrienes in inflammation and pathomechanism of CIU allows us to suggest a plausible scenario (Figure 4). Our study links increased production of cysteinyl leukotrienes in CIU with mast cell activation, which is probably induced by anti-FceRI receptor antibodies or other triggers of urticaria. However, we can only speculate about the COX inhibition–sensitive mechanisms. It is logical to propose that inhibition of COX-1 by nonselective NSAIDs results in removal of the inhibitory effect of COX-1–derived metabolite or metabolites on mast cells and other inflammatory cells, thus unmasking activating mechanisms that lead to exacerbation of urticarial reaction. Prostaglandins E2 and D2, known inhibitors of mast cell, neutrophil, eosinophil, and endothelial cell activation via their cyclic adenosine monophosphate stimulatory effect, are possible molecules involved. Unfortunately, we were not able to assess global production of prostaglandins in our study, as their urinary levels reflect mostly local production by the kidney. In this context, it is interesting that circulating histamine-releasing serum factors, similar to those in patients with CIU, have been detected in most patients with intolerance to multiple NSAIDs but not by COX-2 selective coxibs, implicating involvement of COX-1. Activation of other cell types (eosinophils, neutrophils) participating in urticarial reaction in response to mast cell–derived mediators may also be affected by NSAIDs in a similar manner.

Figure 4. Proposed mechanisms involved in nonsteroidal anti-inflammatory drug (NSAID) sensitivity in chronic idiopathic urticaria. Our study suggests that chronic idiopathic urticaria is associated with in vivo activation of mast cells and increased synthesis of cysteinyl leukotriene (cys-LT). Activating mechanisms may include Fc receptor activation. Mast cell activation is under negative influence of cyclooxygenase (COX)-1–dependent prostaglandins (PG) such as prostaglandins E2 and D2, generated from arachidonic acid (AA), which are known to inhibit mast cell activation via cyclic adenosine monophosphate (cAMP)–dependent mechanism. Synthesis of inhibitory prostaglandins is blocked by nonselective NSAIDs but not by COX-2 selective coxibs, implicating involvement of COX-1. Activation of other cell types (eosinophils, neutrophils) participating in urticarial reaction in response to mast cell–derived mediators may also be affected by NSAIDs in a similar manner.
increased levels of mast cell tryptase consistent with mast cell activation. Eruptions induced by NSAIDs can be triggered by removal of COX-1–dependent prostaglandins, but further studies are needed to assess the potential role of newly discovered COX-3 or perhaps yet undiscovered isoforms of COX.

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