Underlying Disease May Drive Neuropathic Itch

BY BETSY BATES
Los Angeles Bureau

SANTA BARBARA, Calif. — When a patient comes to you with neuropathic pruritus, the most important thing to do is listen, not just look. If you see anything on the skin at all, it will be a vague, after-the-fact sign such as erythema or lichenification. It may be hard for a busy physician to do, but the key to making the diagnosis of neuropathic itch is to “sit there and listen to the patient,” said Timothy G. Berger, M.D., professor of clinical dermatology at the University of California, San Francisco, during the annual meeting of the California Society of Dermatology and Dermatologic Surgery.

The patient’s history and description of the sensation contain the clue as to whether the itch is central (multiple sclerosis, polymorphous light eruption); peripheral (brachioradial pruritus, notalgia paresthetica, postherpetic neuralgia, and possibly anogenital pruritus); or cutaneous (lichen simplex, and, in Dr. Berger’s opinion, prurigo nodularis).

Although neuropathic pruritus is notoriously difficult to treat, Dr. Berger offered suggestions for specific conditions:

- **Notalgia paresthetica.** This itch occurs lateral to the central spine, often just below the scapula. Research has established an anatomical correlation between the lower scapula. Patients may enter your office with what Dr. Berger calls “the ice pack sign,” carrying ice to apply to their arms or upper torso in desperate, “nothing else works.” The itch associated with this condition can be severe and potentially debilitating and primarily impacts fair-skinned, affluent, middle-aged people, especially women, he said. Even this severe itch develops in patients with chronic sun damage. The specific trigger is sun exposure late in the summer. The timing of itch onset (late versus early summer) distinguishes brachioradial pruritus from polymorphous light eruption (PMLE).

  - The differential diagnosis should include PMLE, cervical spine disease with nerve entrapment, and even in a hypertensive patient. Once those conditions are ruled out, ice packs provide relief, but there are other effective treatments as well, including avoiding sun exposure and wearing protective clothing, using topical steroids or capsaicin, and lidocaine patches (for localized disease); applying an Unna’s boot medicated gauze bandage to interrupt central sensitization; and prescribing drugs such as gabapentin, doxepin (Sinequan), mirtazapine (Remeron), or paroxetine (Paxil), and in severe cases, thalidomide.

  - Physical therapy, according to Dr. Berger. “These patients will get better with physical therapy, acupuncure, spinal manipulation, and TENS [transcutaneous electrical nerve stimulation],” he said.

- **Anogenital pruritus.** Chronic pruritus of the scrotum, labia majora, and perianal skin that is unrelieved by anti-inflammatories, antifungals, or topical hydrocortisone will indicate other causes for pruritus. Pramoxine (hydrocortisone-based) cream, or imidazole.

  - Another option is a novel therapy pioneered by gastroenterologists in Israel (Gut 2003;52:132-6). These researchers identified the dose at which topical capsaicin could be applied to the anogenital region without inducing burning—0.09%/—and found that two-thirds of their patients were able to tolerate it, with an 80% response rate and 55% reduction in pruritus.

  - Although the formulation the Israeli physicians used is not available in the United States, Reliable Rexall Compounding Pharmacy in San Francisco can mix hydrocortisone cream base www.reliablerexall.com; 415-664-8800. (Dr. Berger has no financial interest in this product.)

- **Prurigo nodularis.** Dr. Berger noted that sensory neural receptors for touch, temperature, pain, and itch are more numerous and the nerves are enlarged in lesions of prurigo nodularis, that mast cells and eosinophils are prolific in these areas of neural hyperplasia, and that these cytokines may be stimulating nerve growth. “My hypothesis is that prurigo nodularis is a subset of the central nervous system,” he said, induced in predisposed patients by rubbing and scratching. Superpotent steroids with occlusion, intralesional triamcinolone acetonide (Kenalog), capsaicin 0.76%-0.3% every 2-3 days, 100-200 mg daily are all potential therapies.

  - “Thalidomide has moved up on my list,” Dr. Berger said. “In this situation, we are talking about potential to make patients who have been miserable forever and ever much better.” Unfortunately, patients with prurigo nodularis are more susceptible than others to neurotoxicity associated with thalidomide, so he prescribes it according to an aggressive protocol that involves a neurologic evaluation at baseline and frequent nerve conduction studies, he said.

  - “Usually you buy them a few years, but sometimes the patient ends up with neuropathy and [you have to back down],” he said.

Skin Disorders Commonly Are Seen With Varicose Veins

BY BETSY BATES
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SANTA BARBARA, Calif. — Severe pruritus may be the first presenting sign of cancer, which most typically turns out to be Hodgkin’s disease, Timothy G. Berger, M.D., said at the annual meeting of the California Society of Dermatology and Dermatologic Surgery. But the question that always arises is when to suspect cancer and not one of the many neuropathic causes of itch on normal-appearing skin.

When do you work up a patient when there’s nothing to see? “The reason all of us are totally paranoid is that you can’t do a CT scan on every patient with itch,” said Dr. Berger, professor of clinical dermatology at the University of California, San Francisco.

Will you have to treat the patient conservatively, but to schedule repeat visits if traditional therapies fail to relieve longstanding idiopathic itch? He is most concerned, he said, when the itching is “disproportionately severe.” In such a case, he orders tests of liver function, iron and lactate hydrogenase levels, and endocrine function. Dr. Berger described a patient with a history of severe itch whose sedimentation rate and lactate hydrogenase levels were normal, but who had a CDA count of 140 cells/µL, despite a negative HIV test.

He referred the patient to an oncologist to evaluate a bulge in the groin that the patient thought was a hernia, but proved to be a low-grade T-cell lymphoma.

When patients are undergoing radiation or chemotheraphy treatments for Hodgkin’s disease but continue to suffer from severe pruritus, Dr. Berger recommends adding corticosteroids; cimetidine (200 mg, four times daily); or mitrazapine (7.5-15 mg each night) posibly in combination with paroxetine (20-40 mg each night). Patients with solid tumors can also experience severe pruritus, and his advice is to “pick from the bag” of effective therapies, including paroxetine (5-20 mg nightly), mirtazapine (7-15 mg nightly), a combination of paroxetine and mirtazapine, or thalidomide (100 mg nightly).

Pruritus is a problem as a third to half of patients with the myeloproliferative disorder polychromat heraemia vera as well, Dr. Berger said. For the vast majority of patients, the itch associated with this disease is aquagenic, occurring for 4-120 minutes after bathing.

The standard treatment has been aspirin (81-300 mg/day); however, a recent survey of patients suggests that a good second choice is paroxetine (20 mg every other day). Other Studies do not show the same antipruritic effect in polychromat heraemia vera patients, he said.

—Damian McNamara