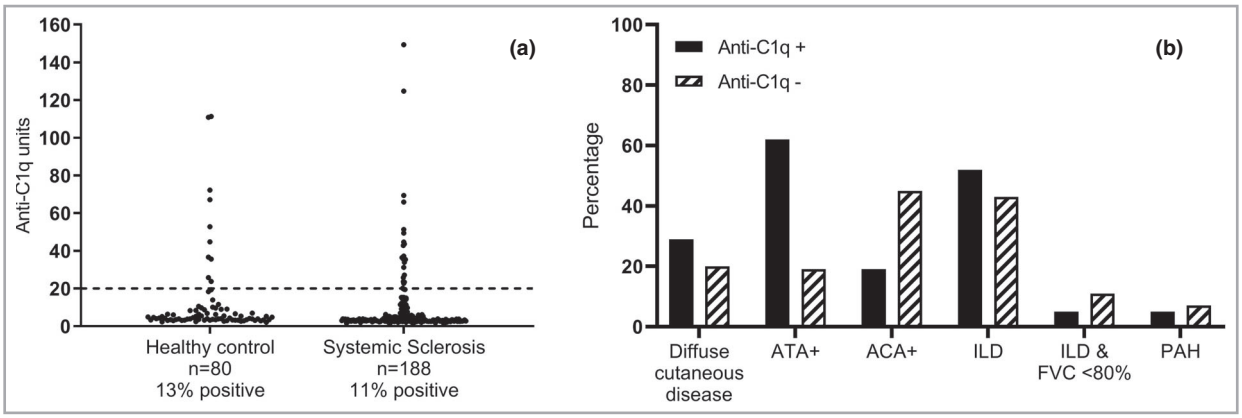

Figure 1 Anti-C1q in systemic sclerosis. (a) Anti-C1q autoantibodies in healthy controls and patients with systemic sclerosis, with the cutoff for positivity (20 units) indicated by the dotted line. (b) Percentage of diffuse cutaneous disease, presence of anti-topoisomerase antibodies (ATA) and anti-centromere antibodies (ACA), interstitial lung disease (ILD), clinically relevant ILD and pulmonary arterial hypertension (PAH) within anti-C1q-positive and anti-C1q-negative patients. FVC, forced vital capacity.

$P < 0{\cdot}001$), while there was no significant difference for ACA. Moreover, anti-C1q autoantibodies were found at a higher frequency in male than in female patients (nine of 39, 23% vs. 12 of 149, 8%; $P = 0{\cdot}008$).

The original study into anti-C1q autoantibodies in SSc found significantly more pulmonary fibrosis (55% vs. 28·8%) and more diffuse cutaneous SSc in anti-C1q-positive than anti-C1q-negative patients.[5] These findings suggested more severe disease in anti-C1q-positive patients. While in the present study ILD was found to be somewhat enriched in anti-C1q-positive patients (11 of 21, 52% in anti-C1q-positive patients vs. 71 of 167, 43% in anti-C1q-negative patients), this finding held no statistical significance. When investigating clinically relevant ILD (combined with FVC < 80%), the prevalence was even lower in anti-C1q-positive patients, and the same holds true for PAH. Furthermore, the observed association of anti-C1q with ATA, which is already reported to associate with lung complications, would detract from any added value of anti-C1q in SSc diagnostics. We therefore conclude that the presence of anti-C1q autoantibodies in our Dutch cohort is not correlated with SSc-related lung conditions. The aforementioned differences could be related to nonidentical patient populations in the respective studies. Compared with Liaskos *et al.*,[5] the current study includes a higher number of patients with SSc and a higher prevalence of ILD, but lower percentages of patients with diffuse cutaneous SSc and PAH. Nonetheless, the present study does not support a prognostic value for anti-C1q autoantibodies in SSc or its related lung conditions.

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Guidelines for the management of chronic spontaneous urticaria: recommendations supported by the Centre of Evidence of the French Society of Dermatology

DOI: 10.1111/bjd.20415

Dear Editor, Chronic spontaneous urticaria (CSU) is an inflammatory disease characterized by spontaneous weals or angio-oedema for more than 6 weeks. The natural history

of the disease is resolution within several months or years, and treatment is necessary to limit flares, reduce pruritus and improve quality of life (QoL). Numerous medical drugs are available, all having suspensive effects on CSU. International guidelines from the EAACI/GA^{2}LEN/EDF/UNEV were published in 2018,[1] but practice remains heterogeneous, especially for CSU refractory to H_1 antihistamines and regarding states' official drug approval and reimbursement policies.

The Centre of Evidence of the French Society of Dermatology formulated recommendations on treatments for CSU based on evidence from the literature and on consensus expert opinion.[2] Firstly, a multidisciplinary working group, composed of eight health professionals including a biostatistician, with no conflicts of interest regarding the pharmaceutical industry, performed systematic reviews of all interventions, except for alternative treatments. The French National Health Authority performed the research of articles, including any therapeutic prospective study published between 2000 and 2017 found on MEDLINE, Embase, CENTRAL, LILACS and PsycINFO. Articles on diets and paediatric populations were included from 1995 because they were much fewer in number. Articles on H_1 and H_2 antihistamines were included after the inclusion periods of the systematic reviews from the Cochrane Collaboration, which were thus updated.[3,4]

The working group analysed the studies (two persons independently for each intervention) by describing the effect estimates, biases and harms, then graded the level of evidence (from D – no direct research evidence, to A – several multicentric double-blinded studies with concordant positive results and acceptable risks) after reaching unanimous consensus.[5] The comments from the eight experts who were secondarily interviewed were incorporated into the recommendations, then the synthesis was submitted to a multidisciplinary panel of 28 reviewers, including health providers and patients, who scored each recommendation from 1 to 9.

The main points from the recommendations are as follows.

(i) A second-generation H_1 antihistamine at a single dose is the recommended first-line treatment for CSU.[3] There is no evidence to favour one drug over another. Some H_1 antihistamines should be avoided in individuals who present a known increase in QT interval or those on enzymatic inhibitors.

(ii) In case of treatment insufficiency, the working group recommends a rapid increase in dosage (1 week to 2 months) until quadruple dosage of H_1 antihistamines, as a second-line treatment.[3]

(iii) The working group does not recommend the adjunction of H_2 antihistamines or montelukast to H_1 antihistamines in CSU, owing to the lack of demonstrated efficacy.[4]

(iv) No studies assessed the efficacy or safety of systemic steroids in CSU. The working group does not currently recommend using them.

(v) As a third-line treatment, in case of decreased QoL of individuals linked to refractory CSU, the working group recommends the adjunction of omalizumab (300 mg every 4 weeks)[6] or ciclosporin (4–5 mg kg^{-1} per day during a 6-month period) to H_1 antihistamines.

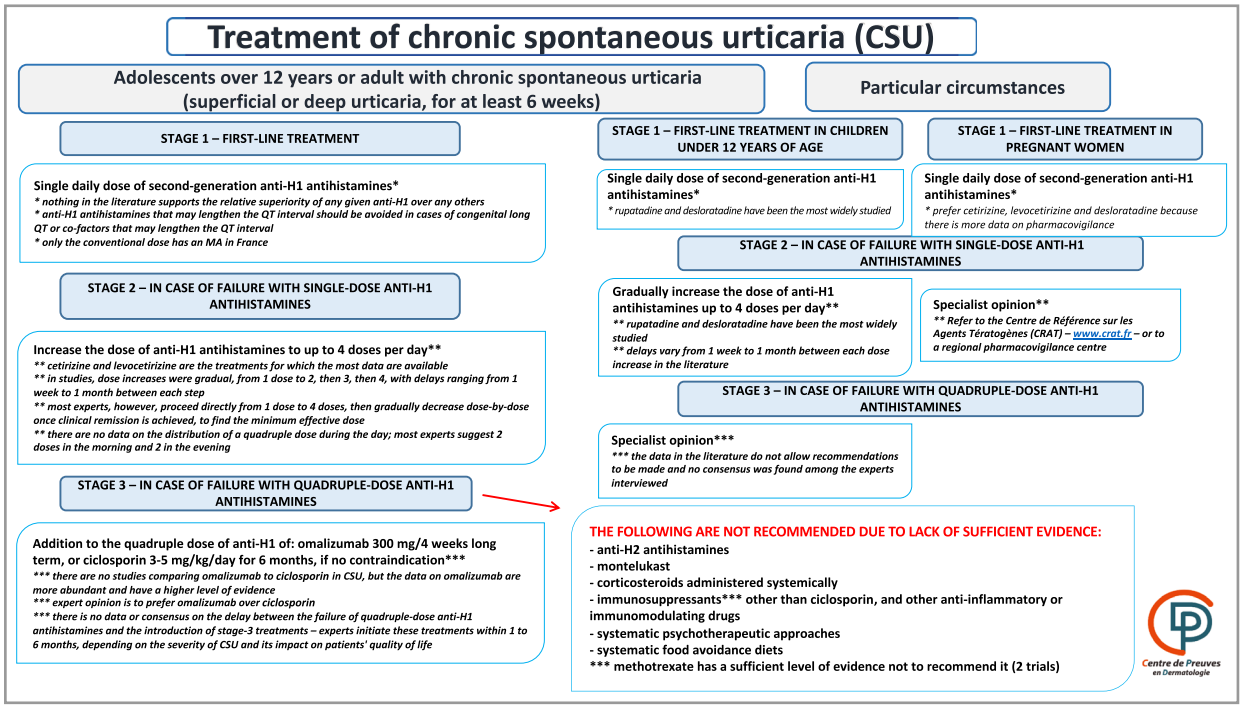

Figure 1 French guidelines for chronic spontaneous urticaria: treatment algorithm. MA, marketing authorization.

Randomized controlled trials have shown that omalizumab is more effective than placebo, with good short-term tolerance. No head-to-head trials have compared omalizumab and ciclosporin.

(vi) There is no evidence to indicate the optimal delay between the failure of quadruple dosage of H_1 antihistamines and initiation of omalizumab or ciclosporin; this would likely depend on the QoL of patients and the severity of the CSU.

(vii) Isolated studies of hydroxychloroquine, dapsone, sulfasalazine, high-dose vitamin D, phototherapy and miltefosine for CSU have been published, but the working group does not recommend them because the data are too sparse.

(viii) The working group does not recommend systematic food exclusion diets because of no evidence of benefit for individuals with CSU.[7] No prospective studies have been published to date on therapeutic education programmes and psychotherapy in CSU.

(ix) For children < 12 years old with CSU, single-dose H_1 antihistamines can be used. The working group recommends favouring rupatadine and desloratadine in case of dosage escalation because more data are available than for other drugs. There is a real lack of evidence for third-line treatments in paediatric populations.[8]

(x) During pregnancy and breastfeeding, a single dose of cetirizine, levocetirizine or desloratadine is preferred because more safety data for these H_1 antihistamines are available. In case of refractory CSU, a specialized consultation is required.

In conclusion, several drugs are considered effective for CSU. The impact on QoL should guide any therapeutic escalation. There is a need for randomized controlled trials (i) comparing omalizumab to immunosuppressive drugs, (ii) in paediatric individuals with CSU, and (iii) evaluating the usefulness of systemic steroids.

On behalf of the French Center of Evidence, these data led to a practical decision-making algorithm (Figure 1) and are included on a dedicated website to provide an easy-to-use tool with a fast step-by-step navigation according to clinical situations (https://reco.sfdermato.org/en/guidelines-chronic-spontaneous-urticaria).

Further methodological information is available upon direct request.

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Real-world drug survival of guselkumab, ixekizumab and secukinumab for psoriasis

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Dear Editor, Guselkumab is an interleukin (IL)-23 inhibitor approved for moderate-to-severe plaque psoriasis. It has demonstrated safety and efficacy in phase III clinical trials.[1–3] However, there are scarce data regarding its drug survival in clinical practice.