REFLECTIONS

On Itch in an Algiatrist

We physicians call it pruritus, and we prescribe pills, lotions, ointments, and creams. We patients call it itching, and we scratch and scratch and scratch. Chronic itch may have a low profile as a medical problem, but it can totally disrupt the life of a patient. At its mildest, chronic itch is just an irritation, but at its worst, chronic itch can be disabling and all consuming. I wrote this essay based on my personal experience as a patient with chronic itch due to cholestatic liver disease coupled with my professional experience as a physician who has been treating patients with chronic pain for 25 years. I do not mean to suggest generalizing from my specifics, but now that I am feeling well, I felt it worthwhile to share some of my experiences from both sides of the exam table.

The neurobiological and clinical similarities between chronic itch and chronic pain are striking, and are just recently being well appreciated. Like chronic pain, in addition to being a symptom of a disease, itch can become the disease itself. Itch-related illness and chronic pain share aspects of anatomy and neurophysiology, have similar biopsychosocial issues, and require many of the same treatments. The model algiatrists used to treat patients with chronic pain can readily be applied to patients with chronic itch, especially with respect to medication management, rehabilitation, and the need for regular physician and other support.

As a physician, I had not thought much about chronic itch and certainly never considered how disabling it can be. As a patient, there were times when I thought of nothing else. Itch became my focus. I read all I could find about itch. In part to find some relief, and in part to distract myself I worked out a clinical classification based on my own different types of itches. I experimented with all sorts of things trying to itch less, and tried to avoid those things that make me itch more. I visited Websites. I scratched myself raw. My wife learned to rub and scratch my skin with just the right amount of counter-stimulation to soothe my itch without leaving scars. I consulted specialists. I tried to force myself to stop scratching. I hoped I might get better. I feared this was as good as it was going to get.

There are several significant consequences to chronic itch. The most obvious is excoriation of the skin, bleeding, and even infection. The scratch reflex is very powerful and hard to resist, and I continued to scratch even though I knew I might damage my skin. I just could not stop myself. However, the symptom that impaired me the most was loss of sleep because my itch was often much worse at night. It may have just been the rhythm of the itch. It may have been the quiet of the night. The sleep deprivation left me somnolent and fatigued the next day, which when coupled with the fatigue inherent to the underlying liver disease, just exacerbated my impairment. I fully appreciated the potential for psychological changes, especially depression, helplessness, and hopelessness.

There are several formal classifications of itch with a good deal of overlap. There is itch due to pathology of the skin. There is itch that is neurogenic, in which there is no disease of the skin. This form of itch may be at least partially due to circulating “pruritogens.” There is itch due to problems or lesions of the peripheral or central nervous systems. However, although these classifications serve the research and other professional communities, they do little to describe a patient’s experience.

I observed five distinct types of patterns to my itch. Type I chronic itch was localized to areas where there were skin lesions—itch due to pathology of the skin. I still get this in small areas of psoriasis. Interestingly, the intensity of the psoriatic itch was greatly magnified during my illness. Type II itch felt very neurogenic, with elements of both central and peripheral nervous system sensitization. There was a generalized hypersensitivity of my skin, which is referred to as allokinesis. When my skin was touched anywhere and in any way, the sensation of touch was magnified greatly. Light touch set off itching. Hot water felt much hotter, especially in my feet and hands. At times I had a generalized feeling of total body paresthesia,
usually worse in my feet and hands, which felt like an itch form of peripheral neuropathy.

Type III chronic itch was diffuse with no skin lesions, and was my most common itch pattern. The itch moved around quickly from place to place, a pattern I now think of as “fleeting itch.” One area itched, I scratched it, there was relief; but immediately another itch somewhere else took its place. The worst itch was in my feet and hands. The most unusual sites of itch were my external ear canals and eyes, and no area was spared except my teeth. There did not seem to be any relationship between one area that itched and where the itch traveled next. A subset of Type III itch is even more irritating—an itch that initially improves with scratching, but then gets worse and worse the more I scratched. This is referred to as scratch-induced itch.

Type IV was an itch so deep that I could not seem to reach it no matter how hard I dug in with my nails or fingertips. Within seconds to minutes, this itch grew in intensity and became very painful. The worst Type IV itch I had was in my feet, but I also experienced it in my hands. When this type of itch was active, I scratched hard and applied deep pressure to the point of pain. Although this hurt, at the same time it provided some relief of the itch.

Finally, Type V chronic itch was just plain painful, although it was definitely an itch. This painful itch felt like peripheral neuropathy. It had a dysesthetic much more than aching quality, had a stocking greater than glove distribution, and there was true allodynia. For me this pain came on suddenly and without precipitant or warning. I rubbed, paced, and scratched. Nothing helped, but then, after a few minutes, it would fade to Type IV and then finally eased.

The treatment of chronic itch is multi-factorial. Of course the first priority is to treat the underlying cause of the itch when possible. Medications that have been used successfully for symptom control and are quite familiar to pain specialists and include antihistamines, SSRIs, doxepin, gabapentin, butorphanol, opioid antagonists, and rifampin, among others. Localized itches might respond to capsaicin or TENS. Physical modalities, rehabilitation, and psychotherapy may be useful. Often there is the need for trial and retrial to find the best regimen for an individual patient.

Activity often helped my itch even though it seemed like the last thing I wanted to do. My itch was markedly reduced and sometimes even gone when I was walking or bicycling. Distractions helped as well. A good book or movie sometimes took my mind off of the itch, even as I unconsciously scratched. Physical modalities can alter the itch. Clothing can impact itching, particularly, in my experience, Type I itch. Soft cloth, such as well worn cotton, silk, and soft artificial fabrics, were better than harsh materials.

I originally wrote this essay as a distraction from my itching. But as I read more about itch, I became more interested in it as a clinical problem. As I wrote, I recognized an opportunity to expand the role of the algiatrist into an equally challenging and rewarding clinical problem—chronic itch. But if we do incorporate the treatment of chronic itch into our pain practices, I do not want us to be called pruritiatrists.

Jerome Schofferman, MD
SpineCare Medical Group
San Francisco Spine Institute
Daly City, California

Readings