Chronic urticaria, hidradenitis suppurativa,

rosacea: skin as an expression terrain

The skin as an immune organ

The skin is one of the most densely mast cell-populated organs — particularly the superficial and peri-vascular dermis. In the PMCHS terrain, these cutaneous mast cells are chronically activated, producing persistent dermatological presentations that are too often treated in silos, without their common mechanism being recognised. Chronic urticaria, hidradenitis suppurativa and rosacea share a common denominator: local mast cell activation amplified by stress, hormones and certain foods.

Chronic spontaneous urticaria

Chronic spontaneous urticaria (CSU) — defined by urticarial lesions evolving for more than six weeks without classically identifiable trigger — is in the vast majority of cases of mast cell origin. Histamine released by dermal mast cells causes the characteristic vasodilation, oedema and pruritus. In the PMCHS terrain, CSU often resists standard antihistamine doses because the root cause — programmed mast cell hyperreactivity — is not addressed.

“ Urticaria that recurs despite antihistamines, without identified allergen, is a sign of an underlying mast cell terrain to explore. ”

Hidradenitis suppurativa (HS)

Hidradenitis suppurativa is a chronic inflammatory disease of the pilo-sebaceous follicles in friction zones (armpits, groin, under the breasts). Mast cells play a central role in its initiation and perpetuation: they activate follicular keratinocytes and maintain the cycle of inflammation → occlusion → abscess. The hormonal component is major — flares are frequently correlated with the menstrual cycle and oestrogenic variations, consistent with the ERalpha/GPR30 → mast cell degranulation loop described in the PMCHS framework.

HS patients statistically present a high rate of PMCHS-compatible comorbidities: PCOS, lipedema, digestive disorders, anxiety — suggesting a common terrain rather than independent pathologies.

Rosacea

Rosacea is characterised by cutaneous vascular hyperreactivity (flushing, persistent erythema, couperose) and peri-follicular inflammation. Dermal mast cells play an established role in its pathophysiology: they release vasoactive mediators (histamine, VEGF, PAF) that maintain vascular dilation and the inflammatory response. The classic triggers of rosacea — heat, alcohol, spices, stress, red wine — are also classic mast cell triggers.

In the PMCHS terrain, rosacea fits naturally into the spectrum of cutaneous manifestations of systemic mast cell hyperreactivity: it frequently coexists with urticaria, food reactions and digestive symptoms.

What this means in practice

- **Keep a skin diary**: note flares and preceding events (meals, stress, cycle, medications). The pattern reveals personal triggers.
- A **low-histamine and low-liberator diet** can significantly reduce the frequency and intensity of flares.
- **Mast cell stabilisation** (quercetin, luteolin, H1 antihistamines) addresses the root cause rather than symptoms.
- For hidradenitis, discuss with your dermatologist a **complete hormonal workup** (oestrogens, progesterone, free testosterone) and correlation with the menstrual cycle.

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