

SUPPLEMENTARY FILE

Urticaria Voices: Dermatologists' and allergists' perspectives of chronic urticaria care and its treatment in China

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SUPPLEMENTARY METHODS

Pilot testing and refinement

A qualitative pilot was conducted to eliminate any ambiguities in the wording of the main survey questions, ensure that no relevant topics were omitted, and assess the length of the main survey. It also aimed to confirm that the questions were presented in a logical order, that appropriate answers could be provided and, where applicable, that suitable response lists were included, and that the survey could be completed within approximately 40 minutes. Participants in the pilot phase were recruited using the same method and criteria as the main phase of data collection. Responses collected during the pilot interviews were not included in the data analyses.

The pilot phase consisted of 2 computer-assisted telephone interviews with 2 Chinese physicians (1x dermatologist, 1x allergist). The length of the pilot interviews was set at 1 hour to allow for a detailed discussion between the participant and interviewer. All pilot interviews were conducted in local language (i.e., Chinese) and were audio recorded whilst the interviewer took notes. Following the pilot interviews, the initial draft survey for physicians were mildly adapted.

Table S1. Physician Inclusion Criteria and Verification Methods

Inclusion Criterion	Verification Method
Physician practicing in China	Self-reported country and region of practice
Primary specialty in Allergology/Allergy-Immunology or Dermatology	Self-reported primary specialty; only these specialties were eligible
Involved in autonomous treatment and prescribing decisions for patients with chronic urticaria	Self-reported prescribing responsibility; physicians answering "Yes" were eligible
Managed at least one patient with chronic urticaria during the previous 4 weeks	Self-reported number of CSU, CIndU, and mixed CSU+CIndU patients seen in the last 4 weeks; total >0 required
Able to prescribe all guideline-recommended treatment classes for chronic urticaria, including biologics (e.g., omalizumab)	Self-reported prescribing authority; physicians answering "Yes" were eligible
Provided informed consent and agreed to participate	Electronic consent obtained before survey initiation
CSU: Chronic Spontaneous Urticaria; CIndU: Chronic Inducible Urticaria	

Table S2. Key modifications to the global Urticaria Voices questionnaire for the China study

Domain	Global study item	China-adapted item	Rationale
Geographic classification	Country identification without detailed subnational guidance.	Physicians selected one of six Chinese regions, with a linked table identifying the provinces included in each region.	To support consistent regional classification and reduce uncertainty about the allocation of provinces to Chinese geographic regions.
Physician eligibility and specialty	“Family Doctor / Family Practice” was included as a specialty option.	Revised to “Primary care physician / GP/Family Doctor” and retained as a screen-out category; allergology and dermatology remained the eligible specialties.	To align the screener with the organization of specialist chronic urticaria care in China while preserving a recognizable category for ineligible primary-care respondents.
Diagnostic and treatment challenges	Open-ended question asking physicians to describe common challenges.	Closed multiple-response item covering self-medication, referral delays, unnecessary testing, limited provider awareness, trigger identification, adherence, disease unpredictability, and quality-of-life impact.	To standardize responses, reduce respondent burden, and permit quantitative comparison of challenges physicians across and disease types
Additional supportive care	Referral for psychological support/counselling or insomnia clinic/sleep therapy.	Added “Traditional Chinese Physical Therapy,” with examples of massage and acupuncture.	To capture a locally relevant form of supportive care recommended during China adaptation
Current treatment patterns	Options focused on antihistamines, omalizumab, ciclosporin, corticosteroids, immunosuppressants and antidepressants, and “other” categories.	Items distinguished monotherapy and combination therapy and explicitly included Traditional Chinese Medicine, glycyrrhizin, and Lei-Gong-Teng (Tripterygium), including Lei-Gong-Teng monotherapy.	To capture real-world Chinese prescribing patterns and specific locally relevant medicines.
Treatment satisfaction	Satisfaction was assessed for standard pharmacological classes and individual treatments.	The list was aligned with the revised China treatment-pattern items and included Traditional Chinese Medicine, glycyrrhizin, and Lei-Gong-Teng.	To ensure that satisfaction data corresponded to the therapies measured in the China-specific treatment-pattern questions.
Sleep burden	Sleep impact was not part of the original global study objective; the initial adaptation contained preliminary sleep questions.	A dedicated sleep module asked whether physicians discuss sleep, the percentage of patients reporting sleep problems, the frequency of specific sleep-related effects, and corresponding estimates for uncontrolled CSU and CINDU.	To address a new China study objective concerning the impact of chronic urticaria on sleep and to characterize sleep burden by disease type and control
Shared decision-making	The patient was listed as a potential final treatment decision-maker.	The response was expanded to “the patient and/or the family makes the final treatment decision.”	To reflect the potential involvement of family members in treatment decisions in the Chinese context.

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