Urticaria Pathway

Management – Primary Care and Community Setting

IS IT URTICARIA/ANGIOEDEMA?

URTICARIA = HIVES – itchy raised skin rash known as hives or wheals, round or ring-shaped, may join together. Wheals typically disappear of their own accord within 24 hours without a trace

ANGIOEDEMA = SWELLING – swelling deep to the skin. Usually affects eyelids, lips or inside the mouth but may occur anywhere. May take longer to clear and can be painful. May be associated with abdominal or joint pain.

Patients may present with URTICARIA alone OR be associated with ANGIOEDEMA. **Most episodes of urticaria are NTO allergic and do not require referral to allergy clinic or any further investigations**

NO → **Consider other causes of rash**

Consider Dermatology Referral

YES ↓

ACUTE URTICARIA

Single episode OR Recurrent episodes.
Lasting < 6 weeks AND no red flag features

- Usually self-limiting with no obvious trigger. Most common cause if viral urticaria.
- Does not require any treatment or investigations

Management
- Explanation and reassurance
- Safety netting advice and patient information leaflet.
- Non-sedating antihistamine as required

CHRONIC URTICARIA

Frequent, regular or daily symptoms.
Lasting > 6 weeks with no obvious trigger.

- Usually, no obvious trigger identified
- Physical triggers e.g. temperature, hot/cold water, pressure, or friction may be reported.
- NSAIDS/opioids may also be a trigger

Management
- Non-sedating antihistamine (see page 2 Flow Chart).
- Ensure patient is taking an over-the-counter daily multivitamin containing iron and vitamin D.

Patients with good disease control do not need referral or further investigations

RED FLAGS/CRITERIA FOR REFERRAL

Symptoms of ANAPHYLAXIS – PHONE 999
- Isolated angioedema without hives

- **Airway** – hoarse voice, stridor, swollen tongue, difficulty swallowing.
- **Breathing** – difficult breathing, persistent cough, wheeze.
- **Conscious level** – dizziness, pale or floppy, collapse

Refer or Discuss with Secondary Care if
- History suggestive of anaphylaxis
- Suspected food or drug allergy (see page 3)
- Chronic Urticaria not responding to Step 3 of treatment flow chart OR if significant anxiety.
- Urticarial Vasculitis – prolonged, tender wheals which resolve with bruising – refer to Dermatology.

Urticaria Pathway – Antihistamine Flow Chart

Management – Primary Care and Community Setting

STEP 1 – AS REQUIRED ANTIHISTAMINE

- **Non-sedating antihistamine e.g. Cetirizine or Loratadine as required**
- **Use standard dose** as per BNFc
- Avoid Chlorphenamine due to risk of drowsiness

STEP 2 – REGULAR ANTIHISTAMINE

- **Non-sedating antihistamine e.g. Cetirizine, Loratadine, Fexofenadine**
- **Regular daily stand dose** as per BNFc
- Safe to give additional PRN doses if required for breakthrough symptoms
- Consider trial of stopping/weaning treatment every 3-6 months if symptoms controlled with no breakthrough.
- Safe to continue regular daily antihistamine if symptoms persist.

STEP 3 – HIGH DOSE REGUALR ANTIHISTAMINE

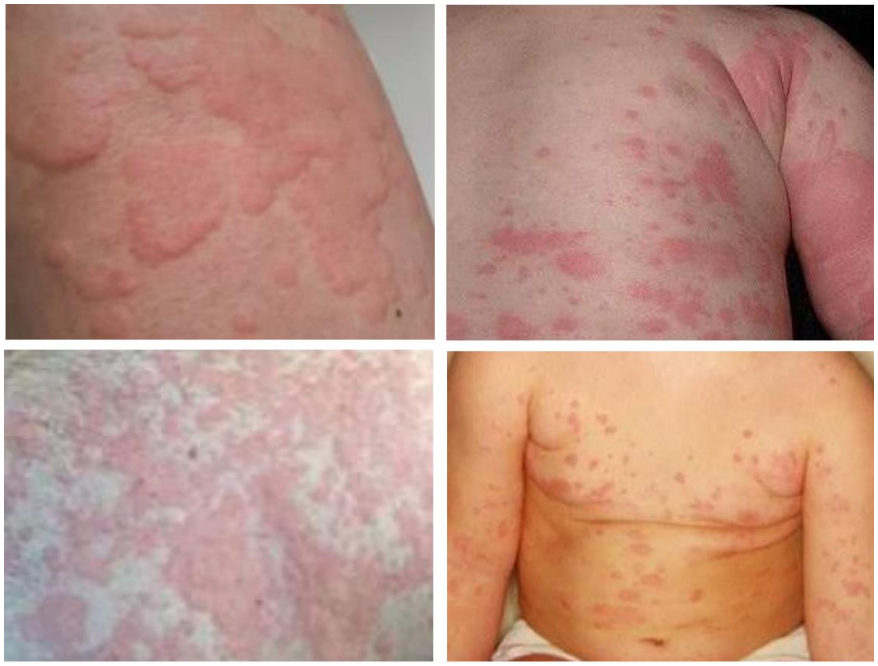
- **Consider trial of alternative antihistamine e.g. Fexofenadine.**
- **Increase dose up to 4x standard dose** as per BSACI guideline for management of Chronic Urticaria – Chronic Urticaria and Angioedema – BSACI
- Consider trial of stopping/weaning treatment every 3-6 months if symptoms controlled with no breakthrough
- Safe to continue high dose regular daily antihistamine if symptoms persist.

Urticaria Pathway – More Information

Management – Primary Care and Community Setting

- Urticaria is caused by release of histamine (+/- chemical mediators) from mast cells and may mimic an allergic reaction but is not necessarily due to allergy.
- Food, environmental allergens, medication and venom may cause acute urticaria but they are very rarely causes of recurrent urticaria.
- Consider food allergy if close temporal relationship (up to 1 hour) and reproducible symptoms on ingestion/exposure - refer to allergy clinic
- Do not advise routine dietary exclusion if no obvious trigger identified.
- For isolated angioedema consider differential diagnosis – nephrotic syndrome (discuss with General Paediatrics) or hereditary angioedema (refer Allergy).
- For vasculitic lesions consider differential diagnosis – HSP (discuss with General Paediatrics) or vasculitic urticaria (refer Dermatology)

URTICARIA



ANGIOEDEMA