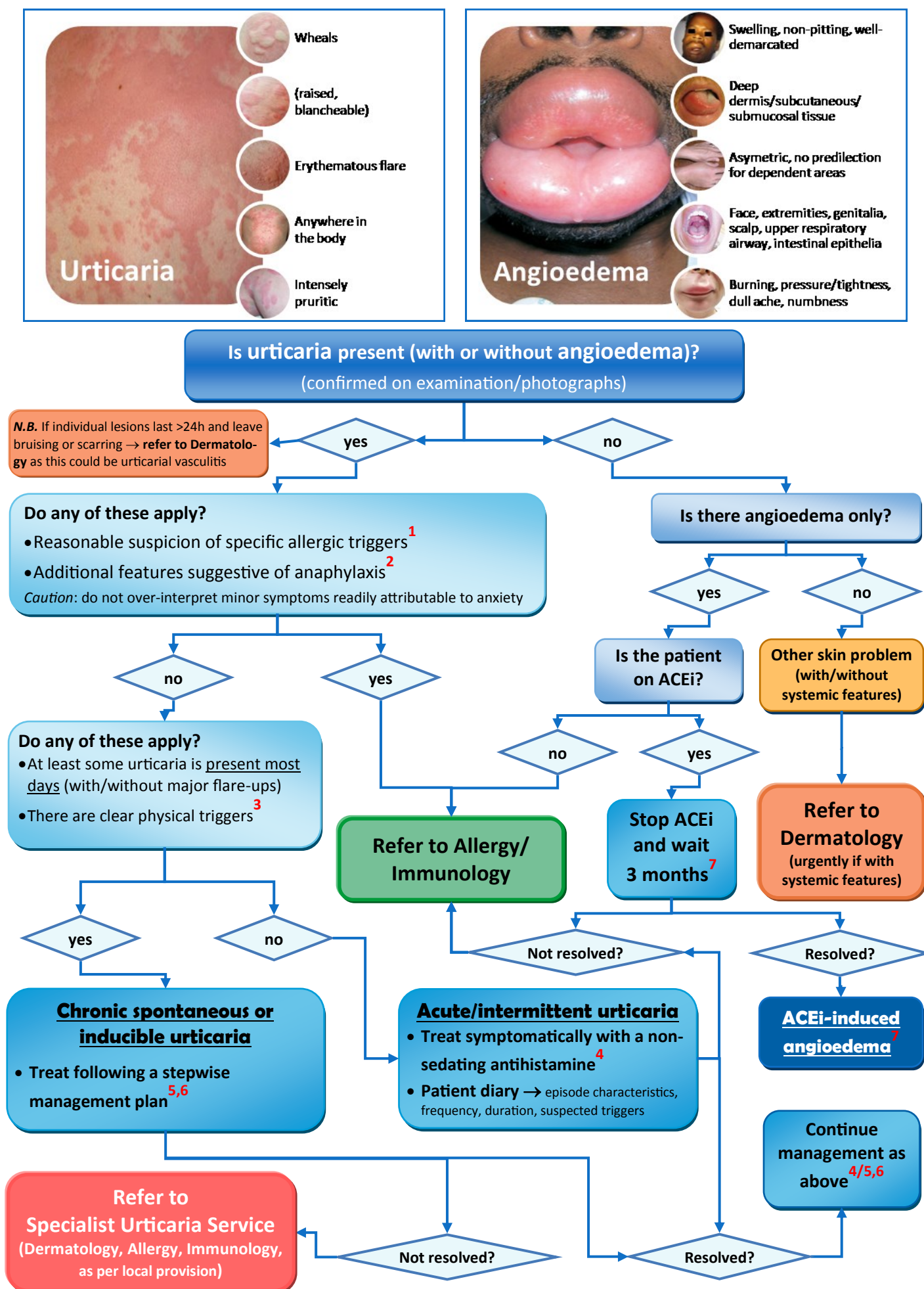


# URTICARIA

## Referral and Management Pathway for Primary Care



# NOTES

## Note 1

### Reasonable suspicion of specific allergic triggers for urticaria

- Usually single (or multiple cross-reactive) suspected culprit(s); e.g. nuts; penicillins, etc.
- Onset of urticaria/angioedema within 2 hours of exposure (usually less)
- Consistent association between exposure to suspected culprit(s) and onset of episodes (*i.e.* urticaria/angioedema occur *only* when exposed and upon *every* exposure)

## Note 2

### Additional features suggestive of anaphylaxis

- Significant mucosal angioedema (visible tongue swelling, upper airway obstruction)
- Bronchospasm
- Syncope

## Note 3

### Inducible urticarias - physical and other triggers

- Pressure/trauma → **dermatographism, delayed pressure urticaria**
- Cold → **cold urticaria**
- Heat → **heat urticaria**
- Vibration → **vibratory urticaria/angioedema**
- Sunlight → **solar urticaria** (consider more common differential diagnosis of polymorphic light eruption)
- Increased body temperature/exercise/sweating → **cholinergic urticaria**
- Contact with allergens (e.g. animal dander, grass pollen, latex, etc.) → **contact urticaria**

## Note 4

### Treatment of acute/intermittent urticaria and angioedema

- Treat symptomatically - when required until full resolution of urticaria and angioedema
- Use a **non-sedating antihistamine**, 2 tablets at the first sign of symptoms and continue with 1 or 2 tablets once or twice daily until resolution:
  - **cetirizine 10mg** - cost-effective 1st line: available OTC
  - **loratadine 10mg** - cost-effective alternative; available OTC
  - **fexofenadine 180mg** - suitable alternative if the above do not lead to symptom resolution
- Review patient diary and:
  - implement allergen avoidance measures (e.g. foods/drugs), if appropriate
- Consider referral/discussion with Allergy/Immunology if allergy strongly suspected

# NOTES Continued

## Note 5

### Information on chronic spontaneous urticaria and angioedema (CSU) and chronic inducible urticarias (CIndU)

- Chronic urticaria and angioedema is defined by the presence of swellings and/or wheals, usually on most days of the week, for a duration of longer than 6 weeks
- In most cases, the pathogenesis is incompletely understood
  - An exogenous aetiology can be identified in only about 10% of patients.
  - In the majority of patients, **this is not an allergic condition**; rather, it is *spontaneous* and thought to be due to a mast cell activation disorder
  - Although not thought to be causative, there may be factors that exacerbate the condition, such as physical stimuli, stress, infection or ingestion of aspirin and other non-steroidal anti-inflammatory drugs (NSAIDs); as an example, patients may notice worsening of their symptoms following a hot shower, although in general, their symptoms wax and wane independent of any triggers
  - In most cases of chronic spontaneous urticaria and angioedema, without clinical signs or symptoms of an underlying disease, routine laboratory tests are normal
- Chronic spontaneous urticaria and angioedema is a self-limiting condition: ~50% of patients will have complete resolution after 6 months; ~70% after 3 years; ~90% after 5 years; ~92% after 25 years
- Management is symptomatic: antihistamines are effective in the vast majority of patients; other drugs may be considered if required
- See also the **BSACI Primary Care Guideline on Management of Chronic Urticaria and Angioedema** at: <http://www.guidelines.co.uk/bsaci/urticaria>

## Note 6

### Stepwise management plan for chronic spontaneous urticaria and angioedema (CSU), and chronic inducible urticarias (CIndU) - as per European and British guidelines<sup>Refs 1-3</sup>

- Provide information on CSU and /or CIndU (can co-exist), including natural history and management plan → detailed below + patient information leaflet from British Association of Dermatologists available at <http://www.bad.org.uk/for-the-public/patient-information-leaflets/urticaria-and-angioedema>
- Management is symptomatic: antihistamines are effective in the vast majority of patients; other drugs may be considered if required
- Provide advice on control of inducible urticaria, if applicable and practicable; e.g. exposure to cold, heat, trauma (loose-fitting clothes), etc.
- Treatment is based on the frequency and severity of symptoms following a **stepwise plan**, below:
  - If episodes are relatively mild/infrequent (as per patient perception), consider taking a **non-sedating antihistamine (e.g. cetirizine/loratadine/fexofenadine)** on an as-needed basis as per Note 4
  - If episodes are more severe/frequent, consider regular treatment; start with 1 tablet a day, which can be incrementally increased up to 4 tablets per day (e.g. 2 tablets twice daily); leave periods of 1-4 weeks between each incremental step
  - If symptoms remain inadequately controlled despite the above, addition of **montelukast** 10mg daily may provide additional benefit; similarly, addition of **ranitidine** 150 mg twice daily may be tried
  - Once complete control is achieved, remain on corresponding step for ~3-6 months before considering stepping down in a similar stepwise fashion, starting with ranitidine (if used), followed by montelukast (if used), and then by gradual reduction of the non-sedating antihistamine; attempt medication changes every 4-6 weeks
  - If at any stage urticaria/angioedema recur, go back to the previous step that provided complete control and re-attempt stepping down ~3-6 months later. Recurrence of symptoms with decreasing treatment is not, in itself, a reason for referral
- Advise patient to seek immediate medical assistance if there is angioedema associated with breathing compromise
- Occasional and brief courses of oral **prednisolone** (e.g. 20 - 40 mg daily for 3 days) may be used to control severe episodes. If there is apparent steroid dependency consider referral
- Please refer if patient remains uncontrolled despite maximum treatment as per the plan above, when we will consider other strategies

## NOTES Continued

### Note 7

#### ACE inhibitor-induced angioedema

- ACE inhibitors (ACEi) are a common cause of drug-induced angioedema → ~1% of recipients
- It can occur with any ACEi and is not related to dose
- In >50% of cases, angioedema occurs during the first week of exposure, although it may occur any time during the course of therapy, from hours after starting to years of stable therapy
- Patients commonly present with swelling of the lips, tongue, upper airway (pharynx, larynx, and subglottic area) or face; another (less common) presentation is episodic abdominal pain and diarrhoea due to intestinal angioedema
  - Urticaria and itching are notably absent
  - Early signs of laryngeal oedema may include hoarseness of the throat and inspiratory stridor, which may progress to airway obstruction in up to 10% of cases. Rare cases of fatalities due to massive tongue swelling and asphyxiation have been reported.
- The diagnosis of ACEi-induced angioedema is clinical, based upon the presence of angioedema in a characteristic anatomic site, without itching or urticaria, in a patient taking ACEi; there are no definitive tests to identify those at risk or diagnose this condition
- The management of ACEi-induced angioedema is **discontinuation of the culprit drug and strict avoidance of all ACEi**
- Episodes of angioedema may persist for 3-6 months or more after this (though usually reduction of frequency and severity is observed shortly after); if episodes persist after this period, other causes must be investigated
- Angioedema associated with angiotensin receptor blockers (ARBs) has been occasionally reported and hence their use in individuals with ACEi-induced angioedema has been questioned but is not contra-indicated
- Antihistamines, glucocorticoids, and adrenaline are usually considered ineffective or minimally effective in treating ACEi-induced angioedema
- Angioedema episodes tend to resolve spontaneously, but urgent in-hospital attention is required if the airway is threatened

### Specialist Services provided by:

- **Greater Manchester**
  - Salford Royal NHS Foundation Trust
  - Allergy Centre, Wythenshawe Hospital, Manchester University NHS Foundation Trust
  - Immunology and Allergy Service, Manchester Royal Infirmary, Manchester University NHS Foundation Trust
- **Liverpool**
  - Royal Liverpool and Broadgreen University Hospitals NHS Trust
- **Lancashire**
  - Lancashire Teaching Hospitals NHS Foundation Trust

### Based on:

- Zuberbier T, Aberer W, Asero R et al. The EAACI/GA2LEN/EDF/WAO Guideline for the definition, classification, diagnosis, and management of urticaria: the 2013 revision and update. *Allergy* 2014;69(7):e1-29; EAACI—European Academy of Allergy and Clinical Immunology
- BSACI Primary Care Guideline—Management of chronic urticaria and angioedema: <http://www.guidelines.co.uk/bsaci/urticaria>
- Powell R, Leech S, Till S et al. BSACI Guideline for the management of chronic urticaria and angioedema. *Clin Exp Allergy* 2015;45:547-65
- Patient information leaflet from British Association of Dermatologists (BAD) available at <http://www.bad.org.uk/for-the-public/patient-information-leaflets/urticaria-and-angioedema>; multiple languages available