Management Guideline for Spontaneous Urticaria ± Angioedema in Adults

**DIAGNOSIS**
- Individual itchy urticarial wheals (hives) last no more than 24 hours. They fade to leave normal skin.
- Acute eczema may simulate urticaria in the early stages, but urticaria does not scale, blister or weep as it resolves.
- Wheals, which are painful, persist for more than 24-48 hours and fade to leave bruising may indicate urticarial vasculitis or other dermatoses.
- Chronic urticaria implies duration for more than 6 weeks. The severity fluctuates.
- Some patients may have associated angioedema: may last up 48-72 hours
- Most cases are idiopathic, but up to 50% have an autoimmune background.
- Remits spontaneously in 12-24 months in many patients (~50%).

**MANAGEMENT**
- Reassure patients that the condition is usually not serious and is very unlikely to be an allergy. Typically allergic reactions manifest immediately or within 20-30 minutes of contact with the suspected precipitant and resolve within 1-2 days.
- Allergy testing for urticaria i.e. skin prick / specific IgE testing is usually not helpful.
- Rule out underlying infection, infestation or drug reaction by taking a detailed history.
- Treat with anti-histamines. Reassure that prolonged treatment with long-acting non-sedating anti-histamines is not harmful. See OCCC OTC policy statement.
- Non-sedating anti-histamines (e.g. cetirizine 10mg once daily, loratadine 10mg once daily, or fexofenadine 180mg once daily) are the mainstay of treatment and may be used for prolonged periods.
- First generation anti-histamines e.g. chlorphenamine, hydroxyzine should be avoided if possible especially long-term in view risk of sedation, psychomotor impairment and REM sleep disturbance.
- If not controlled within 1-2 weeks then titrate the dose up every week until to four times higher than the licensed dose e.g. loratadine or cetirizine 10-20mg once to twice daily or fexofenadine 180-360mg once to twice daily.
- If this is ineffective consider trying another agent of the same class or try adding montelukast 10mg at night [off-license].
- Adding ranitidine 150mg twice daily can occasionally be beneficial but there is no strong evidence for its use so it should not be used routinely [off-license].
- Prednisolone 30-40mg daily can be prescribed for 3-10 days for rescue but AVOID long-term use.
- Patients should avoid or take care with drugs containing salicylates, NSAIDs and opiates, which can aggravate or exacerbate urticaria.
- Paracetamol can be used safely.
- ACE inhibitors should be avoided or stopped in those with a background of angioedema especially in those with angioedema alone without urticaria.
- Provide patients with information - a patient information leaflet can be obtained at the British Association of Dermatologists. http://www.bad.org.uk/for-the-public/patient-information-leaflets

**Chronic urticaria**
- Patients with chronic urticaria should not be referred for allergy testing (prick testing or patch testing).
- Routine investigations are usually normal in chronic urticaria and are not necessary if the symptoms respond to anti-histamines.
- A FBC, ESR, CRP, TFT, thyroid peroxidase antibodies and urinalysis may be useful.
- If GI symptoms consider TTG antibodies ± exclusion of H pylori infection.
### Angio-oedema
- Complement levels (C3 / C4) should be measured in patients with angioedema especially if this is the predominant picture.
- A normal C4 virtually excludes C1 inhibitor deficiency, which is a rare cause of angioedema.
- If spontaneous angioedema alone, check the drug history: if on an ACE inhibitor STOP; milder episodes may arise for 6-12 weeks after discontinuation; angiotensin 2 antagonists (ARBs) can be used after this time, although <10% can develop angioedema. [Campo et al. Angioedema induced by angiotensin-converting enzyme inhibitors. 2013. Curr Opin All Clin Immunol; 337-44]

### REFER Email Advice
- Diagnostic difficulty - If the diagnosis is in doubt or for re-assurance consider email advice: oxon.dermatologyadvice@nhs.net

### REFER ONLY Consultant
- Patients whose urticaria is difficult to control with anti-histamines despite up to fourfold higher than the licensed doses of cetirizine, loratadine or fexofenadine 180mg ± montelukast 10mg at night or have unusual urticaria e.g. long lasting lesions >24-48 hours with bruising.
- Tranexamic acid can be used in treatment resistant angioedema – usually secondary care decision
- Check investigations as above.
- Secondary care therapeutic options may include omalizumab and/or ciclosporin.
- Ask patient to start monitoring urticaria activity i.e. UAS7 using the Symtrac Hives app.

### Summary

- **First line:**
  - Long-acting non-sedating anti-histamine (NSAH)
  - Eg Cetirizine or Loratadine 10mg od or Fexofenadine 180 od
  - If symptoms are uncontrolled after 1-2 weeks

- **Second line:**
  - Increase dose of anti-histamine (NSAH) every 1-2 weeks up to 4x
  - Eg Cetirizine or Loratadine 10-20mg od-bd or Fexofenadine 180-360 od-bd
  - If symptoms are uncontrolled after 1-4 weeks

- **Third line:**
  - Add in Montelukast 10mg od ± Ranitidine 150mg bd
  - Start using Symtrac Hives app to monitor symptoms
  - Refer for systemic treatment i.e SC Omalizumab or oral Ciclosporin
  - Avoid systemic steroids except Prednisolone 30-40mg od for 1-2 weeks

### ADDITIONAL INFORMATION
- Prescribing traffic lights: [http://www.oxfordshireformulary.nhs.uk/](http://www.oxfordshireformulary.nhs.uk/)
- See guidelines:
  - The EAACI Guideline for the definition, classification, diagnosis, and management of urticaria: the 2013 revision and update: [http://www.ga2len.net/PDF/Guideline.pdf](http://www.ga2len.net/PDF/Guideline.pdf)