Fact Sheet

Information for Referrers: Chronic Urticaria

Chronic urticaria (CU) is defined by the presence of urticaria (wheals, hives) on most days of the week, for longer than six weeks. Angioedema occurs in about 40 percent of patients with CU and usually affects the lips, cheeks, periorbital areas, extremities, and genitals (seldom the tongue, throat or airway). In many cases, the underlying cause is autoimmunity (autoantibodies to the mast cell IgE receptor). Food allergy is almost never the cause.

Chronic urticaria can cause marked distress because it is physically uncomfortable, waxes and wanes unpredictably, and may interfere with work/school and sleep.

When to refer CU patients:

- Where CU is not controlled by antihistamines or has persisted for more than 6 months.
- Where there is concern patients are undertaking inappropriate dietary restrictions.
- Where angioedema has involved the oropharyngeal or laryngeal areas.
- Any features that might suggest an autoimmune or inflammatory disorder.
- Where there are features to suggest urticarial vasculitis (lesions lasting >24 hours, burning rather than itching, residual bruising).
- Where prednisolone has been needed repeatedly to control symptoms.

Reassurance

Patients with CU are often frustrated, and reassurance is an important component of successful management. There are three important concepts to relay to patients:

- CU is usually transient, and 50 percent of patients undergo remission within one year.
- While **acute** urticaria may be a manifestation of allergy and may be associated with anaphylaxis, chronic urticaria is a different disorder that is usually not allergic in origin and is not dangerous.
- The symptoms of CU can be successfully managed in the majority of patients.

Avoidance of exacerbating factors

Whilst no external cause can be found in most people affected by CU, the following factors may aggravate CU in some patients and if so, should be avoided:

- Physical factors such as heat, exercise, tight clothing or pressure on the skin.
- NSAIDs, alcohol, spicy food.

Investigations

Allergy testing is seldom informative in chronic urticaria, but may be used to rule out allergy and inappropriate dietary restrictions. There is no test for mast cell autoantibodies. Rarely, an associated autoimmune disease or occult infection may be found.

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TREATMENT

The first line of treatment to control symptoms is antihistamines.

- Non-sedating antihistamines (NSAH) at standard dose- cetirizine, desloratidine or fexofenadine recommended.
- NSAH can be used at 2X, 3X or 4X standard dose.
- Combination H1/H2- add ranitidine 150mg bd to NSAH.
- Add montelukast 10mg daily.

  (ranitidine and montelukast may or may not add incremental benefit)

Short courses of prednisolone (50mg, taper over 6-10 days) may be required for major flare-ups.

Dietary manipulations- IgE-mediated food allergy is almost never the cause of chronic urticaria. Food intolerance may sometimes be a cause or aggravating factor for chronic urticaria, but elimination diets should only be undertaken under the supervision of a specialist or dietitian.

NOTE: If after a period of time the urticaria remits, the patient does not need to be reviewed in the Immunology Clinic and should ring and cancel their appointment.

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For more information

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