ANNEX 5: URTICARIA

Acute Urticaria

Hoverbox 1a

Clinical History

1. Time of onset of disease

2. Duration, frequency, shape, size and distribution of wheals

3. Associated angio-oedema

4. Associated systemic symptoms (bone/joint pain, fever, abdominal cramps)

5. Occurrence in relation to daytime, weekends, menstrual cycle, holidays and foreign travel.

6. Previous or current allergies, infections, internal/autoimmune diseases, gastric/intestinal problems or other disorders

Past and social

7. Social and occupational history, leisure activities. menstrual cycle,

8. Previous episodes and response to therapy including dosage and duration

9. Previous diagnostic procedures/results

10. Family and personal history regarding wheals and angioedema (for suspected hereditary Angioedema, Refer)

Causality/triggers

11. Occurrence in relation to foods or drugs (eg, NSAIDs, ACE inhibitors, penicillin) occurring within an acute time frame

12. Occurrence in relation to infections, stress

13.Induction by physical agents or exercise

Examination

14. Whole body exam: if painful (but obviously not infectious) or non blanching consider urticarial vasculitis and refer. Examine photographs if these are offered

Hoverbox 1b

The vast majority of acute urticaria cannot be explained although there is a clear temporal relationship with certain triggers, in particular infections. (COVID)

Urticaria is one of the most common skin manifestations reported in patients with COVID19; these manifestations precede the classical COVID19 symptoms in over 50% of cases. (1)

Symptoms may be exacerbated or continued as a result of heat, stress,
alcohol and taking concomitant NSAIDs.

The most important aspect of care is reassurance with a clear indication to return if symptoms escalate or continue beyond 6 weeks.

Examination of any photos which patients may bring may be helpful.

Hoverbox 1c

Second generation, non-sedating antihistamines are the preferred treatment. First generation antihistamines should not be used unless unavoidable. There is no benefit of mixing different antihistamines, H2 antagonists (e.g. Ranitidine) and anti-leucotriens (LTRAs) have no role. It is recommended to avoid the use of corticosteroid.

Hoverbox 1d

No investigations are indicated.
Patients expect investigations and should be informed that they are contraindicated as they are very rarely abnormal and maybe misleading.
The patient should be strongly reassured that this is the case.

Hoverbox 2

Urticarial vasculitis is often described as burning/painful. Lesions are tender. They remain fixed in one location. It requires specialist referral Urticarial Vasculitis can be associated with Infection, e.g. with hepatitis B/C or streptococcus; drugs, e.g. penicillins, allopurinol, quinolones or carbamazepine; autoimmune diseases such as Sjögren syndrome; immunoglobin disorders such as immunoglobulin A and immunoglobulin M monoclonal gammopathies; leukaemia and internal cancers. (2)

Hoverbox 3

It May be hereditary (familial) or acquired. Non resolving angio-oedema requires specialist referral.

Note: hereditary angioedema does not respond to adrenalin.

ACE-inhibitor induced angioedema may occur ANYTIME after initiation

1. Urticaria and COVID-19: A review - Algaadi - - Dermatologic Therapy - Wiley Online Library [Internet]. [cited 2020 Nov 11]. Available from: https://onlinelibrary.wiley.com/doi/10.1111/dth.14290

2. Davis MDP, Brewer JD. Urticarial vasculitis and hypocomplementemic urticarial vasculitis syndrome. Immunol Allergy Clin North Am. 2004 May;24(2):183–213, vi.

Chronic Urticaria

Hoverbox 4

Second generation, non-sedating antihistamines are the preferred treatment. First generation antihistamines should not be used unless unavoidable. There is no benefit of mixing different antihistamines. H2 antagonists (e.g. Ranitidine) and LTRAs have no role. It's recommended to avoid the use of corticosteroids.

The administration of loratadine and cetirizine in standard doses may be considered safe in pregnancy; loratadine is the H1 antihistamine of choice in all phases of pregnancy.

For children, second-generation, non-sedating H1-antihistamines are recommended as first-line therapy, with a weight-adjusted dosing.(3)

Hoverbox 5

Guidelines on management of urticaria recommend up dosing of non-sedating antihistamines up to 4 times the standard dose in patients who do not respond satisfactorily to the standard doses.

Hoverbox 6

The use of an app allows patients to record symptoms and take photos. They also incorporate disease activity questionnaires (e.g.Urticaria activity score (UAS) Dermatology quality of life index (DLQI)).These help to build up a picture over time allowing objective estimation of the frequency, extent and severity of the disease as well as assisting in diagnosis and identifying suspected triggers. They assist in assessing disease severity and persistence and response to therapy e.g. SymTrac Hives, My Hives Diary.

3. Wedi B, Wieczorek D, Raap U, Kapp A. Urticaria. J Dtsch Dermatol Ges J Ger Soc Dermatol JDDG. 2014Nov;12(11):997–1007; quiz 1008–9.

4. Gotua M, Kulumbegov B, Chanturidze N, Devidze M, Lomidze N, Rukhadze M. ASSOCIATION BETWEENURTICARIA AND INFECTIONS (REVIEW). Georgian Med News. 2019 Mar;(288):97–101.