

## Guidelines for the treatment of Urticaria in Primary Care

### Note 1 Commonest underlying causes of urticaria

In most patients the cause of chronic urticaria is never established. In others, infections, drug eruptions, food reactions (urticaria 6-14 hours after ingestion) are incriminated rightly or wrongly. In an even smaller group urticaria is a symptom of an underlying systemic disease (thyroid disease, SLE, parasitic infestation, urticarial vasculitis, serum sickness, cryoglobulinaemia); these patients will almost certainly have other physical signs or symptoms.

### Note 2 Physical urticaria

Urticaria provoked by heat (sweating) cold, pressure, sunlight etc. These urticarias may be controlled by avoiding the provoking factor. Dermographism responds to regular antihistamines; other types do not. Refer for full investigation and advice on therapy.

### Note 3 Aspirin provocation

Salicylates and a range of other compounds (opiates, NSAIDs, codeine, vancomycin) may cause mast cell degranulation and hence urticaria. Ask specifically about provoking drugs. Consider referral for a tartrazine / benzoic acid / salicylate free diet in patients who notice that aspirin exacerbates their urticaria.

### Note 4 Role of RAST, patch prick test and oral challenge

Prick tests and RAST tests are not useful as a screening test of potential allergens in chronic urticaria. *Contact urticaria* is usually suggested by the history and can be confirmed by contact urticaria tests (different to patch tests). Patch tests (test for type 4 hypersensitivity) have no place in the investigation of urticaria (a type 1 reaction). Oral challenge is sometimes used, usually to reassure the patient or as an attempt to play for time.

### Note 5 Non-sedative v sedative antihistamines.

There is relatively little to choose between different antihistamines. Sedative/non-sedative choice depends on the need to avoid sedation. Combination H1 and H2 blockade is rarely helpful. Many antihistamines block histamine weals despite not preventing attacks; presumably because histamine is not the only mediator. Use continuous medication if attacks occur regularly. Use fast acting antihistamines (loratidine, fexofenadine) as required for sporadic attacks.

### Non sedative antihistamines

Drug	Minimum age for prescribing.	Adult dose ( see BNF 3.4.1 for children)		Notes
		Starting dose	Maximum dose	
Fexofenadine	12 years	120mg od	180mg od	Minimal sedation. Contraindicated in breast feeding.
Acrivastine	12 years	8mg tds	8mg tds	Avoid in renal impairment
Cetirizine	6 years	10mg od	10 mg od	Half dose in renal impairment
Desloratidine	12 years	5mg od	5mg od	Minimal sedation
Loratidine	2 years	10mg od	10mg od	Minimal sedation Drug interaction with: erythromycin, ketoconazole, cimetidine

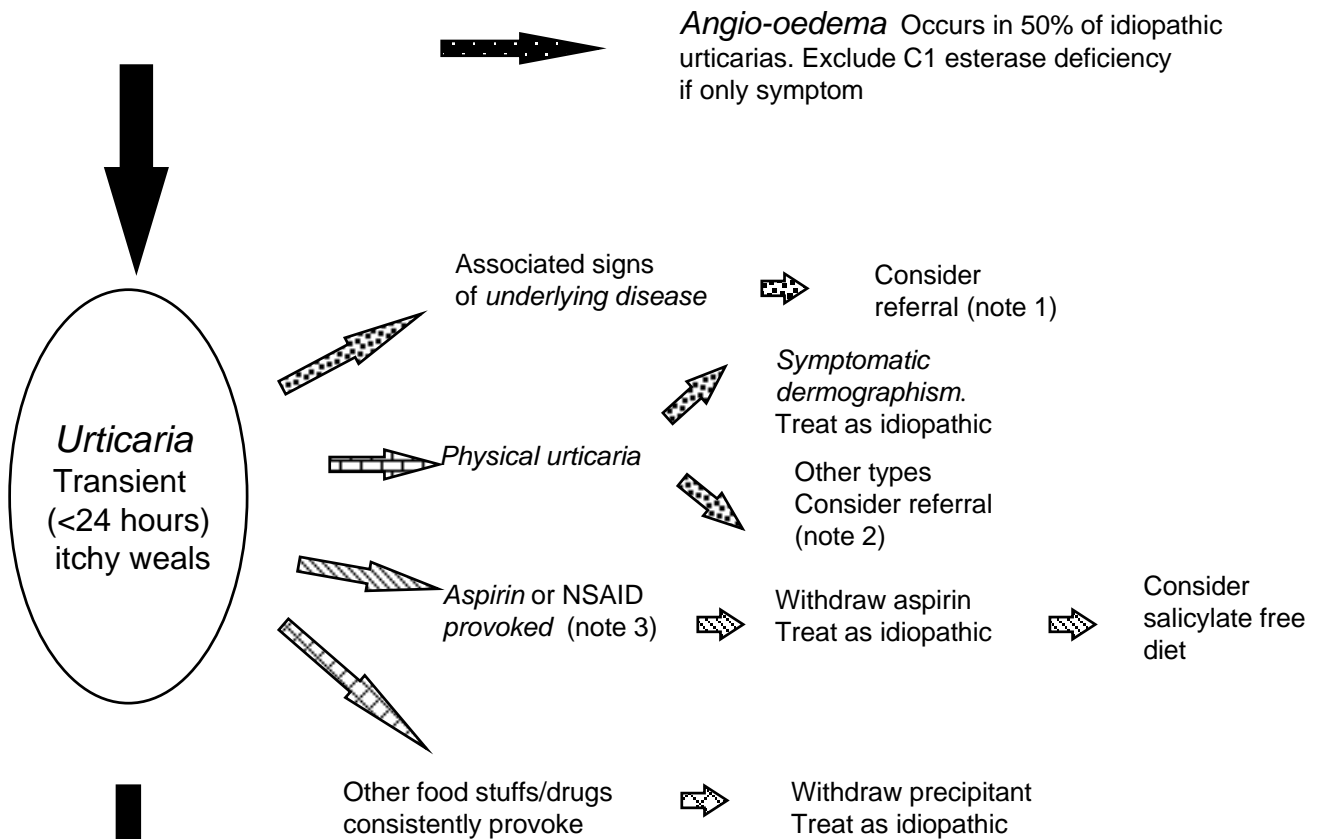
None recommended in pregnancy (see Data Sheets)

Update 17/5/00 Chemist & Druggist 26/4/97 interaction data

### Sedative antihistamines *Warn re: driving, alcohol, machinery.*

Drug	Minimum age for prescribing.	Adult dose ( see BNF 3.4.1 for children)		Notes
		Starting dose	Maximum dose	
Chlorpheniramine	1 year	4mg tds	24mg daily	Possible use in pregnancy - see Data sheet.
Promethazine	2 years	25mg on	50mg on	OK in pregnancy. Avoid last 4 weeks of pregnancy - see Data Sheet.
Hydroxyzine	6 months	25mg on	25mg qds	Do not use in pregnancy
Cyproheptadine	2 years	4mg tds	32mg daily	Possible use in pregnancy - see Data sheet.

# Management and referral guidelines for urticaria



*Idiopathic urticaria*  
The majority

## Management

Reassure - benign condition self limiting  
Explain - topical therapy not helpful  
Explain - skin testing not helpful (note 4)  
Prescribe antihistamine ( note 5)

No response after 3 agents

REFER

### **Key Standards in referral letter**

Treatment given - name /dose/duration of treatment  
Expectation from referral - diagnosis, reassurance/treatment/ advice