What is Urticaria?

Urticaria consists of itchy, elevated skin lesions with an erythematous base, also described as “hives”. The lesions tend to move around and on resolution the skin looks completely normal. A single lesion lasts less than 24 hours.

Urticaria is due to temporary leaking of plasma into the dermis. If the pathologic process affects subcutaneous tissues then angioedema results, which most commonly involves the face but can also affect the trunk, genitalia and mucous membranes.

Urticaria is a very common problem, with up to 25% of people having an episode of urticaria at some time. Most often this is acute (urticaria goes on for less than 6 weeks), but it can also be chronic (>6 weeks).

What Causes Urticaria?

There are many possible causes that should be explored on history, considering the possible exposures and timing of exposure with respect to urticaria. These include:

- Medications including antibiotics or NSAID
- Infections including viruses and bacteria
- Urticaria is a common feature of food allergic reactions. Food allergic reactions usually occur within a short time of taking the food (often within minutes and almost always within 4 hours). Food allergy is often apparent after the first exposure to a food and rarely occurs once a food has been well tolerated for a period of time
- Insect stings from bees and wasps
- Physical triggers may include pressure, cold, exercise and rarely water
- Contact with plants / substances that may result in contact dermatitis (e.g. resulting in Rhus dermatitis from Japanese Wax Tree)
- Systemic diseases such as autoimmune, connective tissue and lymphoproliferative disorders.

Very frequently there is no apparent trigger and the urticaria is idiopathic.
Physical Examination

On physical examination there are erythematous raised skin lesions (wheals or welts). These can be:

- Localised or widespread
- Well circumscribed but often coalescent
- Intensely itchy
- Of variable size from pinpoint to large
- The lesions are polymorphic individual lesions and last less than 24 hours
- Observe for dyspnoea or dysphagia for the first few hours after onset of urticaria

Physical examination should also be directed at detecting possible causes if none is apparent on history, with review of lymph nodes, eyes, joints, throat, neck, ears, lungs, heart, and abdomen (looking for signs of possible connective tissue disorders, thyroid disease, lymphoreticular neoplasms).

Urticaria may be a component of anaphylaxis. If there is any respiratory or cardiovascular involvement (persistent cough, wheezing, dyspnea, dysphonia etc) refer to the anaphylaxis guideline.

Urticaria is not a feature of C1 Inhibitor deficiency. If there is recurrent angioedema without urticaria then evaluation for C1 Inhibitor deficiency is indicated (C4 and C1 inhibitor levels).

Differential Diagnosis

- Erythema multiforme: the lesions in EM are not itchy and individual lesions are fixed rather than transient. Target lesions are the hallmark and mucosal involvement may be present.
- Vasculitis (e.g. Henoch Schonlein purpura)
- Mastocytosis
- Flushing

Investigations

Investigations are not usually indicated for acute urticaria unless there is an apparent trigger on history that needs to be confirmed (e.g. food or insect allergy), or the history or physical signs are suggestive of an underlying disorder.

Chronic urticaria is most often idiopathic and investigation will depend on whether there are any features on history and examination suggestive of a possible underlying cause.
UTRICARIA

Allergy Testing

Routine allergy testing is not indicated in the context of urticaria unless a specific trigger is likely on history. This should be discussed with the family as it is a common misconception that allergy testing will be useful to find the cause.

Management

The management of urticaria consists of:

- Exclusion of identifiable triggers.
- Symptomatic relief with antihistamine. For acute urticaria treatment duration will depend on the situation (e.g. if due to a new food allergy treatment for one day may be sufficient, but if urticaria is a feature of an intercurrent illness treatment for the duration of the illness may be needed).
- Treatment for chronic urticaria should focus on symptom control. Regular non-sedating antihistamines should be given to control the urticaria. Attempts to discontinue the antihistamine should be made every 2-4 weeks to determine whether the urticaria has resolved.
- Explanation and reassurance.

Indications for Specialist Referral

- Referral to general paediatrics should be made if there is bruising of urticarial lesions or if there are systemic features. These may indicate urticarial vasculitis or a manifestation of another disease process.
- Referral to general paediatrics if there is a specific trigger (e.g. food, latex, venom) on history.
- Referral to paediatric allergy if the urticaria is a component of anaphylaxis.
- Referral to general paediatrics or paediatric allergy for patients with chronic urticaria (>6 weeks) that is difficult to control.

References


This is available on line at::