

Urticaria and/or Angioedema Management Pathway (Adults)		
V2.0	Last reviewed: 19/01/2023	Review date: extended to 09/2026

Urticaria and Angioedema Primary Care Pathway (Adults)

Please use algorithms below to assess and manage patients with either urticaria +/- angioedema or angioedema in isolation

Refer to photographs on [Dermnet NZ](https://www.dermnetnz.org/) for photographs of urticaria and urticarial vasculitis.

What to tell patients

Most episodes of urticaria are not allergic. It is important to reassure patients with history not suggestive of allergy that this is the case to prevent them from needlessly trying to identify an allergic trigger.

Most cases of urticaria resolve spontaneously over time; how long is not predictable. Antihistamines mask symptoms but do not alter the natural history e.g. how long it will take before resolution.

Inducible (physical urticaria) may be life-long particularly dermographism and cholinergic urticaria.

More information and patient leaflets on urticaria and angioedema can be found on the [British Association of Dermatologists](https://www.britishtest.org/) and [Allergy UK](https://www.allergyuk.org/) websites.

Prescribing

[NICE](https://www.nice.org.uk/) and the [British Society of Allergy and Clinical Immunology \(BSACI\)](https://www.bsaci.org/) guidelines recommend higher than licensed doses of antihistamines. Patients should be advised not to drive if they do feel drowsy (drowsiness can occur at higher doses even if licensed doses were tolerated). Titrate up according to sedative side effects (which may occur at these doses in patients who tolerate licensed doses) and patient tolerance.

Medication	License	Recommended dose	Doses used in urticaria/angioedema												
Cetirizine	The relief of nasal and ocular symptoms of seasonal and perennial allergic rhinitis. The relief of symptoms of chronic idiopathic urticaria.	<u>Adults</u> : 10mg once daily (1 tablet)	Up to 20mg twice a day (off-label).												
Fexofenadine	The relief of symptoms associated with chronic idiopathic urticaria.	<u>Adults</u> : 120mg or 180mg once daily taken before a meal.	Up to 540mg daily as 360mg in the morning and 180mg in the evening (off-label).												
Tranexamic acid	Hereditary angioneurotic oedema.	Some patients are aware of the onset of illness; suitable treatment for these patients is intermittently 1g-1.5g two to three times daily for some days. Other patients are treated continuously at this dosage.	1g three times daily increased to 1.5g three times daily. Dose and dose interval reduced if eGFR <50ml/min (Table 1) or if serum creatinine is \geq 120micromol according to the SPC . <table border="1" data-bbox="917 1467 1500 1675"> <thead> <tr> <th>GFR (ml/min)</th> <th>Tranexamic acid oral dose</th> <th>Dose frequency</th> </tr> </thead> <tbody> <tr> <td>20 -50</td> <td>25 mg/kg</td> <td>12 hourly</td> </tr> <tr> <td>10 -20</td> <td>25 mg/kg</td> <td>12 to 24 hourly</td> </tr> <tr> <td><10</td> <td>12.5 mg/kg</td> <td>24 hourly</td> </tr> </tbody> </table>	GFR (ml/min)	Tranexamic acid oral dose	Dose frequency	20 -50	25 mg/kg	12 hourly	10 -20	25 mg/kg	12 to 24 hourly	<10	12.5 mg/kg	24 hourly
GFR (ml/min)	Tranexamic acid oral dose	Dose frequency													
20 -50	25 mg/kg	12 hourly													
10 -20	25 mg/kg	12 to 24 hourly													
<10	12.5 mg/kg	24 hourly													
Montelukast	The treatment of asthma as add-on therapy. In those asthmatic patients in whom montelukast is indicated in asthma, it can also provide symptomatic relief of seasonal allergic rhinitis.	The dosage for adults is one 10 mg tablet daily to be taken in the evening.	10mg at night.												

Urticaria and/or Angioedema Management Pathway (Adults)		
V2.0	Last reviewed: 19/01/2023	Review date: extended to 09/2026

Avoid sedating antihistamines.

Pregnancy: Medication should be reviewed if planning, or in the event of pregnancy. Please refer to advice on oral anti-histamines in the following link: [Hayfever or allergic rhinitis: treatment during pregnancy – SPS - Specialist Pharmacy Service – The first stop for professional medicines advice](#)

Oral corticosteroids are effective but should be used for short courses only as tachyphylaxis (diminishing efficacy for the same dose) may occur and morbidity due to the side effects can be significant. There is no role for topical corticosteroids.

Patients who have had anaphylaxis (a life-threatening generalised allergic reaction that in 80% cases includes urticaria) should have adrenaline auto-injectors (AAI) prescribed unless there is a clear history that the reaction is due to medications. Patients require training in how and when to use an AAI. Supporting information can be found on the manufacturer’s website for the devices and Anaphylaxis UK website This should not be deferred until specialist review.

For diagnostic purposes urticaria is divided into two: **acute urticaria** includes any urticarial symptoms which are of less than 6 weeks duration whilst **chronic urticaria** is more or less daily urticaria for 6 weeks or more.

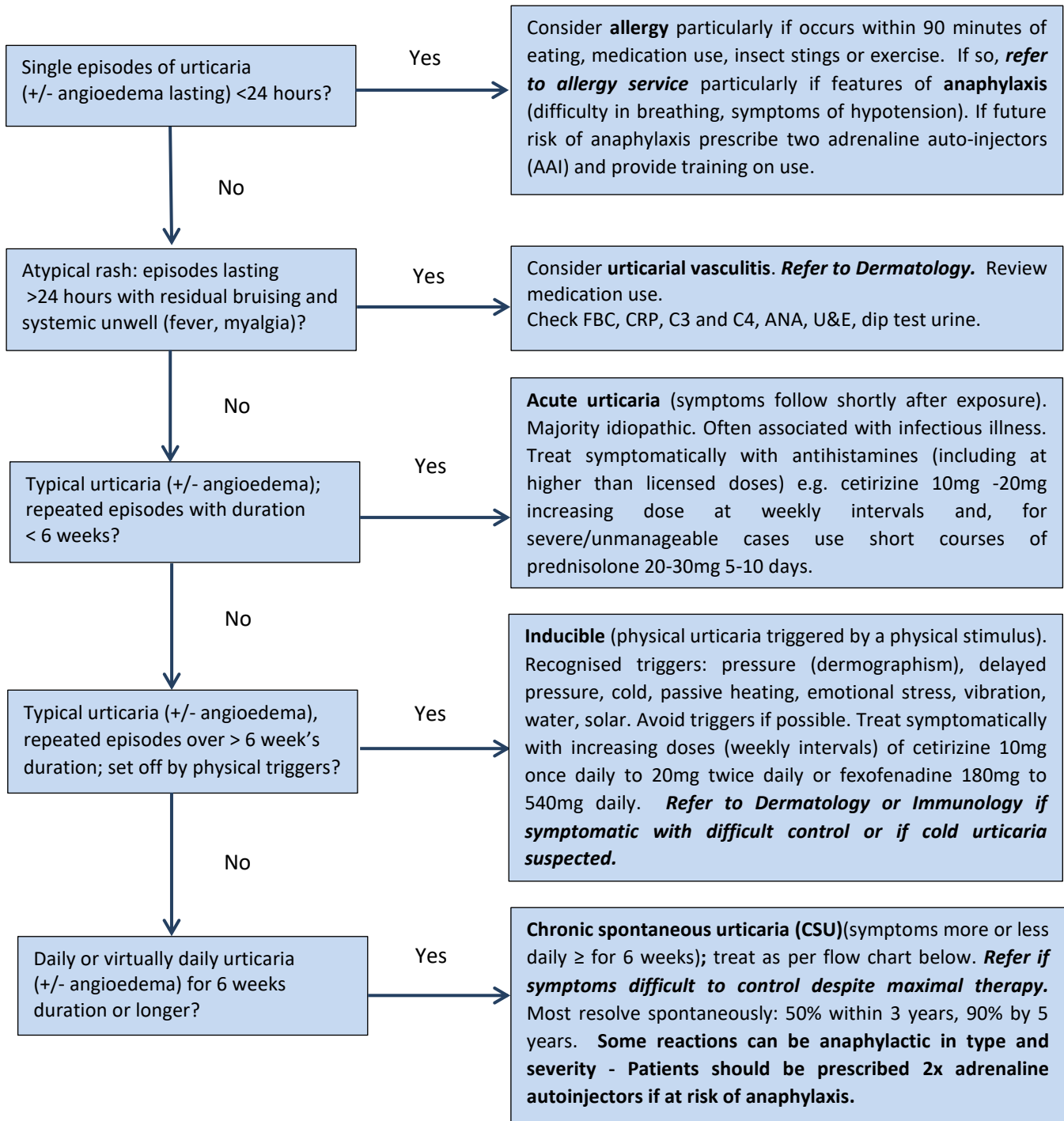
Acute urticaria will include urticaria happening in the context of an allergic reaction (in which case there will be a typical history of symptoms following shortly after exposure and often with other allergic symptoms), spontaneous (isolated) urticaria and urticaria associated with infections. Acute urticaria may evolve into chronic urticaria.

Chronic urticaria includes inducible (physical urticaria) and chronic spontaneous urticaria (the majority of which is thought to be autoimmune in aetiology). Inducible urticaria may co-exist with chronic spontaneous urticaria (particularly pressure urticaria).

Angioedema can co-exist with both acute and chronic urticaria or can occur in isolation. When it occurs with urticaria it is likely mast cell driven and should respond to antihistamines. **Isolated angioedema** can be mast cell driven or due to bradykinins; if the latter, it will not improve with antihistamines.

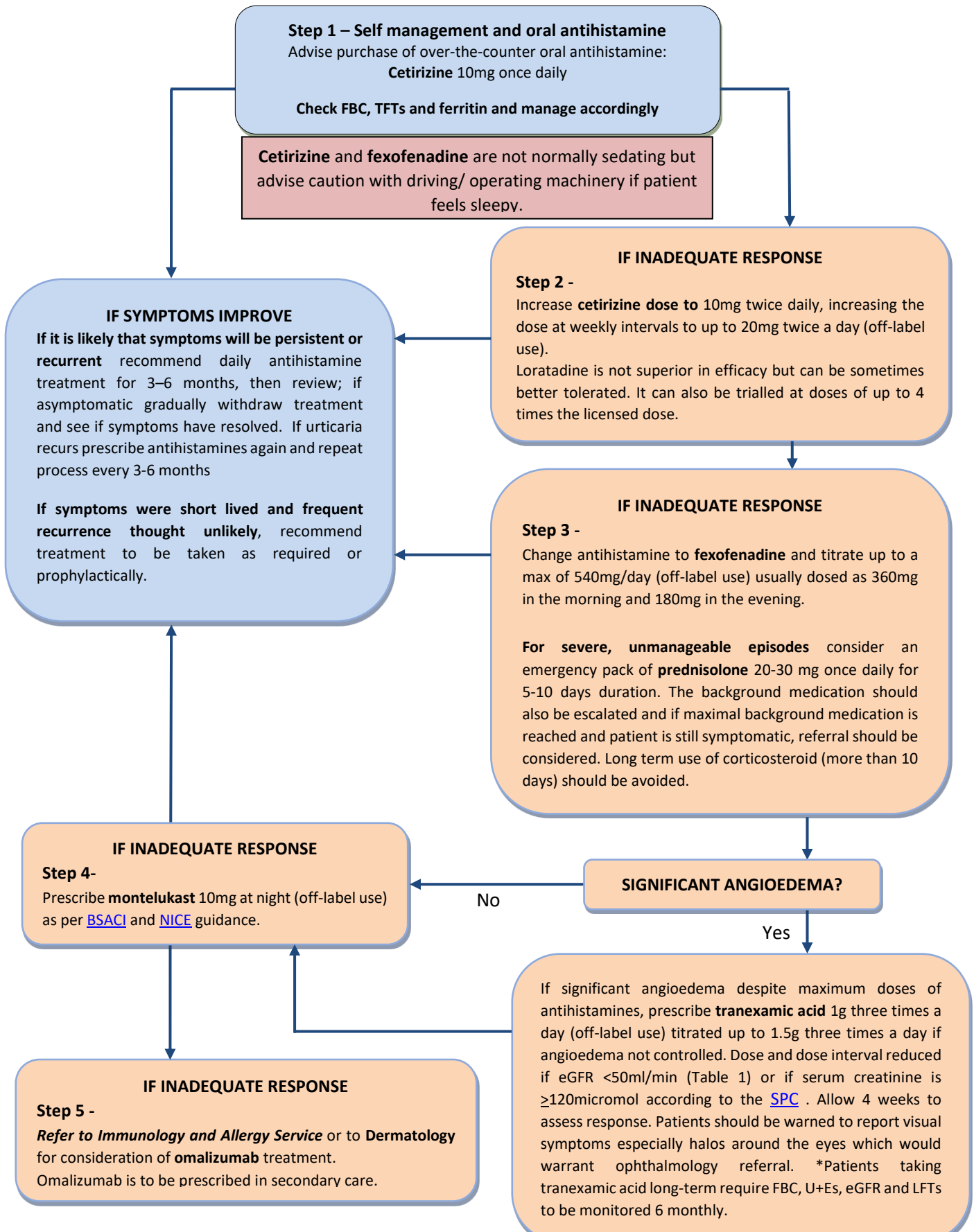
Angioedema can be caused by medication such as nonsteroidal anti-inflammatory drugs (NSAIDs), angiotensin-converting enzyme (ACE) inhibitors, angiotensin receptor blockers (ARBs), antiplatelets, factor Xa inhibitors and statins. Clinicians should consider stopping or changing the medication, however this may require specialist advice prior to making any amendments to a patient’s regimen.

DIAGNOSIS OF TYPE OF URTICARIA

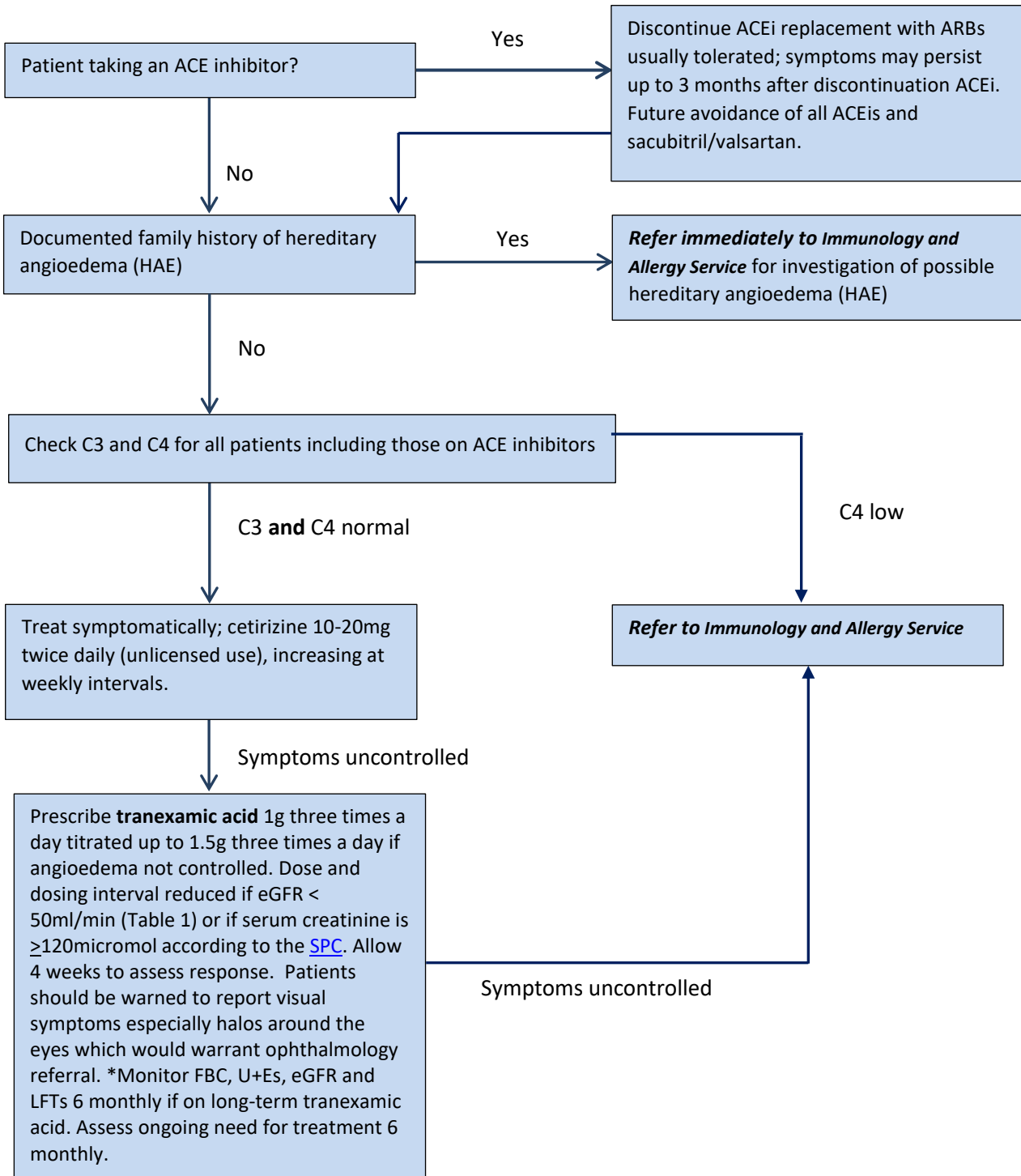


FOR PATIENTS WITH CHRONIC SPONTANEOUS URTICARIA (CSU)

+/- ANGIOEDEMA SYMPTOMS REQUIRING TREATMENT:



MANAGEMENT OF ISOLATED ANGIOEDEMA



Patients who are asymptomatic on therapy should gradually reduce treatment to see whether there has been resolution (as is often the case). When symptoms are infrequent it is suggested that a period twice the longest interval between previous episodes should pass before assuming resolution.

Frequency and severity of episodes may influence whether treatment is given prophylactically and discussion with patients who have infrequent symptoms should include the use of treatment on an as required basis versus treating for very many asymptomatic days to prevent symptoms on one day.

Urticaria and/or Angioedema Management Pathway (Adults)

Nottinghamshire Area Prescribing Committee

V2.0	Last reviewed: 19/01/2023	Review date: extended to 09/2026
------	------------------------------	-------------------------------------

Version Control - Urticaria and/or Angioedema Management Pathway (Adults)

Version	Author(s)	Date	Changes
1.0	Irina Varlan, Medicines Optimisation Interface Pharmacist	June 2019	
2.0	Bhavika Lad, Medicines Optimisation Pharmacist, Nottingham and Nottinghamshire ICB	January 2023	<ul style="list-style-type: none"> • Guideline title changed from Urticaria Primary Care Pathway to Urticaria and Angioedema Primary Care Pathway (Adults). • Advice on drowsiness at tolerated doses and clarity around unlicensed doses. • Guidance on antihistamine use in pregnancy. • Supply of Adrenaline Autoinjectors to those at risk of anaphylaxis and signposting for instructions of use. • Potential causes of angioedema updated • C3 and C4 to be checked for all patient's angioedema pathway. Dose change for the treatment of isolated angioedema when C3 and C4 are normal • Tranexamic acid – ophthalmology counselling included dose reduction in eGFR<50ml/min and monitoring guidance for long term use