

Outpatient Primary Care Management and Referral Guidelines
San Antonio Military Medical Center and Wilford Hall Ambulatory Surgical Center
Allergy and Immunology Service

Urticaria/Angioedema

Definition:

Urticaria – an intensely pruritic, erythematous, and evanescent rash characterized by a wheal and flare. A single urticaria or hive lesion should last <24 hours, although new hives can develop at other sites.

Angioedema – self-limited localized swelling from extravasation of fluid due to loss of vascular integrity; a “deeper” form of hive/urticaria. Angioedema may last several days to the deeper nature.

Urticaria and angioedema may occur together or in isolation.

History

- Identification of at least one of the above symptoms
- Attempt to determine a trigger if possible including food, drug, insect sting
 - o Trigger must be consistent (urticaria/angioedema must occur with EVERY encounter)
 - o Trigger must be chronologically consistent (urticaria/angioedema occur within 30-60 minutes of encountering the trigger)
 - o Urticaria/angioedema should not be occurring when the patient is NOT encountering the suspected trigger
- If no identifiable trigger is determined, patient likely fits into “idiopathic” category which can be further subdivided into acute or chronic
 - o Acute urticaria/angioedema (<6 weeks)
 - Most often secondary to acute infection (may even be subclinical)
 - Stress is another common cause
 - o Chronic urticaria/angioedema (≥6 weeks)
 - NOT an allergic process; consider an immune stimulating process (chronic illness/disease, hormonal imbalance, etc)
 - Rare causes
 - Urticarial vasculitis – bruising/scarring from rashes, systemic autoimmune symptoms present
 - Mastocytosis – overabundance of ‘mast’ cells (cells that contain histamine); bruising from rashes often present and systemic anaphylaxis often described in conjunction
 - Hereditary angioedema – urticaria is NEVER present; family history of unexplained swelling elicited
 - Frequently NO cause is found

Examination/Evaluation

- Presence of erythematous and evanescent rash characterized by a wheal and flare (or photographic evidence)
- Presence of angioedema (or photographic evidence)

Management

- If trigger identified: see drug, food, or venom management guidelines
- If no trigger identified
 - o Can start with regular age based dosing of non-sedating antihistamine
 - o If symptoms not resolving, then increase dose of non-sedating antihistamines (up to 4 times the FDA recommended dosing for allergic rhinitis)
 - Pediatrics 6 months – 2 years: Cetirizine 5 mg BID
 - Pediatrics 2-5 years: Cetirizine 10 mg BID
 - Pediatrics \geq 6 years: Cetirizine 10-20 mg BID
 - Adults: Cetirizine 20 mg BID
 - o Addition of H2 antihistamine blockers: Ranitidine 150 mg BID
 - o Addition of sedating antihistamine (hydroxyzine, diphenhydramine) as needed for breakthrough symptoms
 - o AVOID systemic steroids whenever possible due to risk of rebound after cessation of steroids; if steroids are needed, then a 2 week course with taper is recommended

Indications for referral

- If trigger identified: see drug, food, or venom management guidelines
- If no trigger identified and symptoms lasting \geq 6 weeks (chronic)
- Acute idiopathic urticaria is NOT an indication for referral since the vast majority resolve spontaneously and no additional testing/treatment will be performed other than what is listed above

There are very few consults that warrant ASAP or Urgent status. If this is entered by the referring provider, it will be downgraded to Routine unless that provider calls and directly speaks with an allergist either at SAMMC or WHASC and it is confirmed as an urgent consult.