Chronic Spontaneous Urticaria and Angioedema

This guide is intended to provide advice on the recognition and non-specialist management of Chronic Spontaneous Urticaria and Angioedema (CSU&A).

- CSU&A is common (life time prevalence rate of 1-2% of the general population).
- Causes frequent, recurrent urticarial rashes +/- angioedema, with no obvious trigger.
- Is not allergic condition, hence, there is no role for allergy tests.
- Is a benign condition which does not progress to anaphylaxis (but avoid ACEi).

Diagnosis:

CSU&A is diagnosed primarily by history. Urticaria and angioedema can occur simultaneously or separately.

It is important to differentiate this condition from IgE-mediated allergic reactions, where release of histamine is triggered by specific, reproducible and recognised triggers, eg food, drugs, stings.

Such differentiation is usually clear from the history; the following are features suggestive of CSU&A:

- Frequent symptoms (on most days of the week for six weeks or more).
- More than 50% of patients sometimes wake up with symptoms.
- Protracted symptoms (lasting >24hours), however individual lesions last less than 24 hours, and resolve without bruising or scarring.
- No discernible pattern to symptom onset, eg, not always within 1 hour of food.
- No specific triggers linked to every episode of symptoms.
- Exacerbated during infection, stress, Asprin & NSAIDS, opiates, alcohol, and hormonal changes.

Demonstration of dermographism on examination indicates physical urticaria, which commonly co-exists with CSU&A. When present, dermographism is very helpful proof to the patient of the non-allergic nature of the condition. Absence of dermographism does not exclude spontaneous urticaria.

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Investigation:

There is no laboratory test to confirm this diagnosis.

CSU&A can be associated with autoimmune thyroid disease, and TFTs may be performed. Chronic infection can make CSU&A more difficult to manage. In particular dental +/- sinus infections should be appropriately evaluated.

Natural History:

CSU&A has a high rate of spontaneous remission; 50% of patients settle within 12 months without intervention. Half of the remainder will remit within 3-5 years, but for some patients CSU&A may be a long term condition.

Patients who have gone into remission may relapse, particularly during stressful life events.

Treatment:

The mainstay of treatment is regular, long-acting non-sedating antihistamine (Cetirizine, Loratidine, Desloratadine, Levocetirizine, Fexofenadine, Bilastine, etc). High doses may be required to achieve control. There is significant individual variation in response and side effect profile, so if one agent is ineffective, switch to an alternative.

These medications are licensed for once daily use, however, there is good safety data for more frequent dosing and their use up to 4 times the licensed dose is recommended in some guidelines. Side effects may be less evident using double doses of 2 different, unrelated agents.

ACEi should be stopped as they can exacerbate angioedema of any cause. If ACEi are prescribed for hypertension, consider a calcium channel blocker. If blockade of the Renin-Angiotensin axis is essential (renal protection & heart failure) an ARBs is acceptable, although associated with a 10% risk of angioedema in this group.

The following treatment can be initiated in primary care; each step should be tried for at least 1 month:

1. Single agent non-sedating antihistamine used regularly eg Cetirizine 10mg, with extra doses as required for breakthrough symptoms.
2. Double dosing +/- additional agent to achieve complete symptoms control.
3. If ineffective, consider referral. Trial of other antihistamines may be useful

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4. Montelukast 10mg nocte may be helpful, as adjuvant therapy, particularly in the NSAID sensitive group.

When symptoms have been controlled for several months; consider weaning antihistamines by reducing one dose of one tablet every 6-8 weeks. If symptoms recur, go back to the last treatment dose, which successfully controlled symptoms. Even after discontinuing regular antihistamines, symptoms may recur particularly during infections or periods of stress. Therefore, the patient should carry a card of antihistamines in their wallet and treat any breakthrough symptoms immediately.
In the event of relapse, patients should go straight back on to the treatment which controlled symptoms, without gradually up dosing.

Referral:

Refer to the Specialist Immunology and Allergy Clinic if;

- If not adequately controlled and symptoms remain troublesome despite treatment above.
- If the patient has had symptoms suggestive of anaphylaxis (airway compromise, severe bronchospasm or hypotension) in the past.

Angioedema

Angioedema without urticaria can be histamine mediated in which case it should respond to antihistamines. If this is the case the same advice as for CSU&A applies.
Angioedema without urticaria which does not respond to antihistamines may be bradykinin mediated. The following steps should be taken:

- Stop ACEi (if patient on one) – if symptoms persist 3-4 months after the ACEi has been stopped manage as above.
- Blood tests for Complement C4 level. If low, request C1inhibitor if available and refer to Immunology and Allergy Clinic with enclosing the results.

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