Primary Care Guidance: URTICARIA IN CHILDREN

Healthier Together
Local advice and support to help manage and improve the health and wellbeing of babies, children, and young people

NHS

Is this urticaria?

- Urticaria is caused by release of histamine (+/- chemical mediators) from mast cells and may mimic an allergic reaction, **but is often unrelated to allergy and rarely needs referral**
- Food, environmental allergens, medication and venom may cause acute urticaria but they are very rarely causes of recurrent urticaria
- Do not advise routine dietary exclusion if no obvious trigger identified

URTICARIA = HIVES - itchy raised skin rash known as hives or wheals, round or ring-shaped, may join together. Wheals typically disappear spontaneously within 24 hours without a trace.
ANGIOEDEMA = SWELLING - swelling deep to the skin. Usually affects eyelids, lips or inside the mouth but may occur anywhere. May take longer to clear and can be painful.
Patients may present with URTICARIA alone OR be associated WITH ANGIOEDEMA

YES

MILD	MODERATE	SEVERE
Single episode OR **Recurrent episodes lasting < 6 weeks** Usually self limiting with no obvious trigger **Most common cause is viral urticaria** Does not require any treatment or investigations	1. **Isolated Angio-oedema WITHOUT Hives** **2. Urticarial vasculitis** – prolonged, tender wheals lasting more than 24 hours which resolve with bruising **3. Chronic urticaria: Frequent, regular or daily symptoms** **Lasting > 6 weeks with no obvious trigger AND on STEP 3 of TREATMENT FLOW CHART** Usually no obvious trigger identified Physical triggers e.g. temperature, hot/cold water, pressure, or friction may be reported **4. Suspected food or drug allergy:** close temporal relationship (up to 1 hour) and reproducible symptoms on ingestion/exposure	Any evidence of **severe reaction/anaphylaxis** – check ABC symptoms. - **Airway** - hoarse voice/cry, persistent cough, stridor, excessive drooling, difficulty swallowing, swollen tongue - **Breathing** – wheeze, cyanosis, breathlessness/increased work of breathing - **Circulation and consciousness** - pale, floppy, dizzy, unusually and profoundly sleepy, loss of consciousness, tachycardia, hypotension

Symptoms of itching and rash bothering patient

NO

- Explanation & reassurance
- Safety net advice & patient information leaflet
- Non-sedating antihistamine as required. **STEP 1**

YES

Move to **STEP 2**
Steroids – Do not routinely give oral Prednisolone, a single dose can be tried in those not responding to **STEP 3**. (No need for discussion with Paediatrics for single dose)

NO IMPROVEMENT IN 6 WEEKS DESPITE **STEP 3**

Refer to secondary care

1.Isolated angioedema, vasculitic lesions (urticarial vasculitis/HSP) or uncertainty discuss with Paediatric Advice line
2. Chronic urticaria or suspected allergy refer to Paediatric outpatients

999

Adrenaline and 999

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STEP 1 – AS REQUIRED ANTIHISTAMINE

- **Non-sedating antihistamine e.g. Cetirizine or Loratadine as required**
- **Use standard dose** as per BNFc
- Avoid Chlorphenamine due to risk of drowsiness

Standard Cetirizine Dose:
1 year – 250 microgram/kg x BD
2-5 Year – 2.5mg x BD
5-11 Year – 5mg x BD
12-17 Year – 10mg x OD

STEP 2 – REGULAR ANTIHISTAMINE

- **Non-sedating antihistamine e.g. Cetirizine, Loratadine, Fexofenadine**
- **Regular daily standard dose** as per BNFc
- Safe to give additional PRN doses if required for breakthrough symptoms
- Consider trial of stopping/weaning treatment every 3-6 months if symptoms controlled with no breakthrough
- Safe to continue regular daily antihistamine if symptoms persist

STEP 3 – HIGH DOSE REGULAR ANTIHISTAMINE

- **Consider trial of alternative antihistamine e.g. Fexofenadine**
- **Increase dose up to 4x standard dose** as per BSACI guideline for Management of Chronic urticaria – Chronic Urticaria and Angioedema – BSACI
- Consider trial of stopping/weaning treatment every 3-6 months if symptoms controlled with no breakthrough
- Safe to continue high dose regular daily antihistamine if symptoms persist

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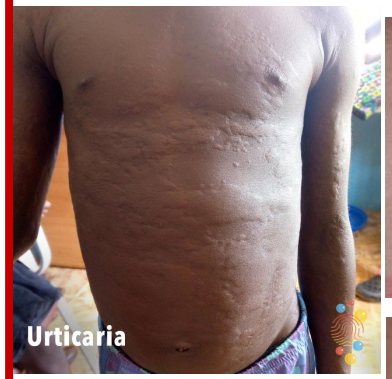
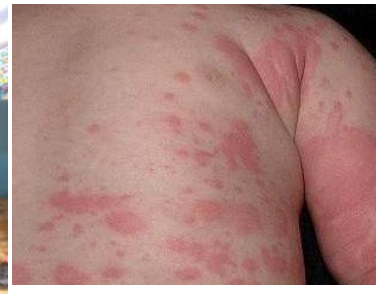
MORE INFORMATION:

- Urticaria is caused by release of histamine (+/- chemical mediators) from mast cells and may mimic an allergic reaction, but is not necessarily due to allergy
- Food, environmental allergens, medication and venom may cause acute urticaria but they are very rarely causes of recurrent urticaria
- Consider food allergy if close temporal relationship (up to 1 hour) and reproducible symptoms on ingestion/exposure
- Do not advise routine dietary exclusion if no obvious trigger identified
- For isolated angioedema consider differential diagnosis – nephrotic syndrome or hereditary angioedema
- For vasculitic lesions consider differential diagnosis – HSP or vasculitic urticaria

Urticaria





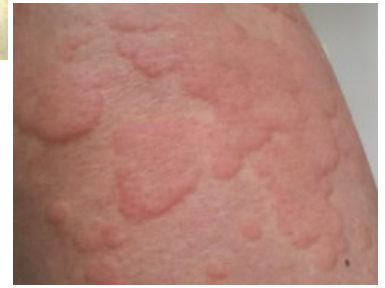
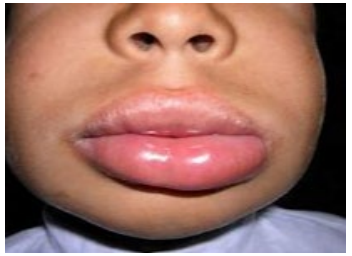
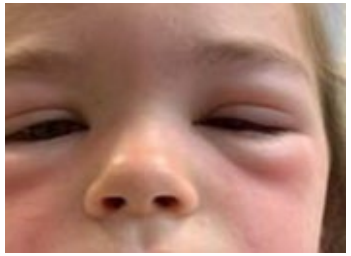
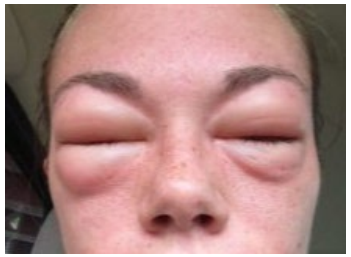


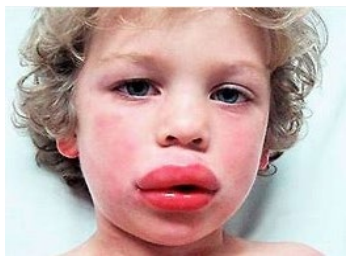
Photo credit
Skin Deep

Angiodema









Urticarial vasculitis

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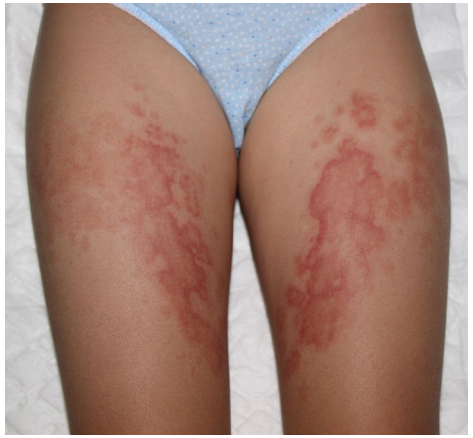

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This document was arrived at after careful consideration of the evidence available including but not exclusively NICE, SIGN, EBM data and NHS evidence, as applicable. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. The guidance does not, however, override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient in consultation with the patient and / or carer. April 2024 Review Date April 2027