Alder Hey Children's NHS
NHS Foundation Trust

Reference Number: FOIAH2425/585
From: Commercial

Date: 20 January 2025

Subject: Guidelines on the treatment of Chronic Spontaneous Urticaria (CSU)

Q1 Does Alder Hey Children's NHS Foundation Trust have any local treatment guidelines, pathways or protocols for the treatment of Chronic Spontaneous Urticaria (CSU)? Yes/No
If Yes, please provide a copy.

A1 Yes, see attached - *Assessment and Management of Chronic Spontaneous Urticaria and Angioedema Guideline*

Alder Hey Children's NHS Foundation Trust

Assessment and Management of Chronic Spontaneous Urticaria and Angioedema Guideline

Assessment

Chronic Urticaria / angioedema (CU) is defined as almost daily presence of hives (weals or nettle rash) for at least 6 weeks without obvious cause. Symptoms include short lived wheals (<24hr), itching and erythema. It is thought to affect 0.1-3% of children in the UK. Urticaria may occur alone in about 50% of cases, urticaria with angioedema in 40%, and angioedema without weals in 10%. Children who present with CU are frequently investigated unnecessarily.

Intermittent urticaria refers to recurrent hives for >6 weeks but with periods entirely free from urticaria. If it is impacting on QoL it may also be treated using this algorithm. Most are spontaneous, with no identifiable trigger, but physical factors such as pressure or cold exposure are some of the most commonly diagnosed precipitating factors.

Questions when considering an 'allergic' cause?

- Could it be related to any drugs the patient has taken (ACE inhibitor / aspirin / NSAID)?
- Does it occur only and reproducibly within 60 min (usually within 20 min) of eating a particular food? Exceptions meat and crustaceans (such as prawn).
- Does it occur only if a particular food (e.g. wheat) has been eaten followed by exercise?
- Does it occur after contact with an allergen to which the patient is sensitized (animals, grass, food, latex, etc.)?

Is there a vasculitic process?

- Are the episodes of urticaria / angioedema persistent rather than evanescent and self-limiting?
- Do individual lesions last more than 24 h?
- Are the urticarial lesions tender and painful rather than itchy?
- Does the skin show evidence of residual petechial haemorrhage, purpura or bruising?
- Does the patient have any symptoms and signs of underlying disease, e.g. fever, significant malaise, arthralgia, hypertension, and blood or protein in urine?

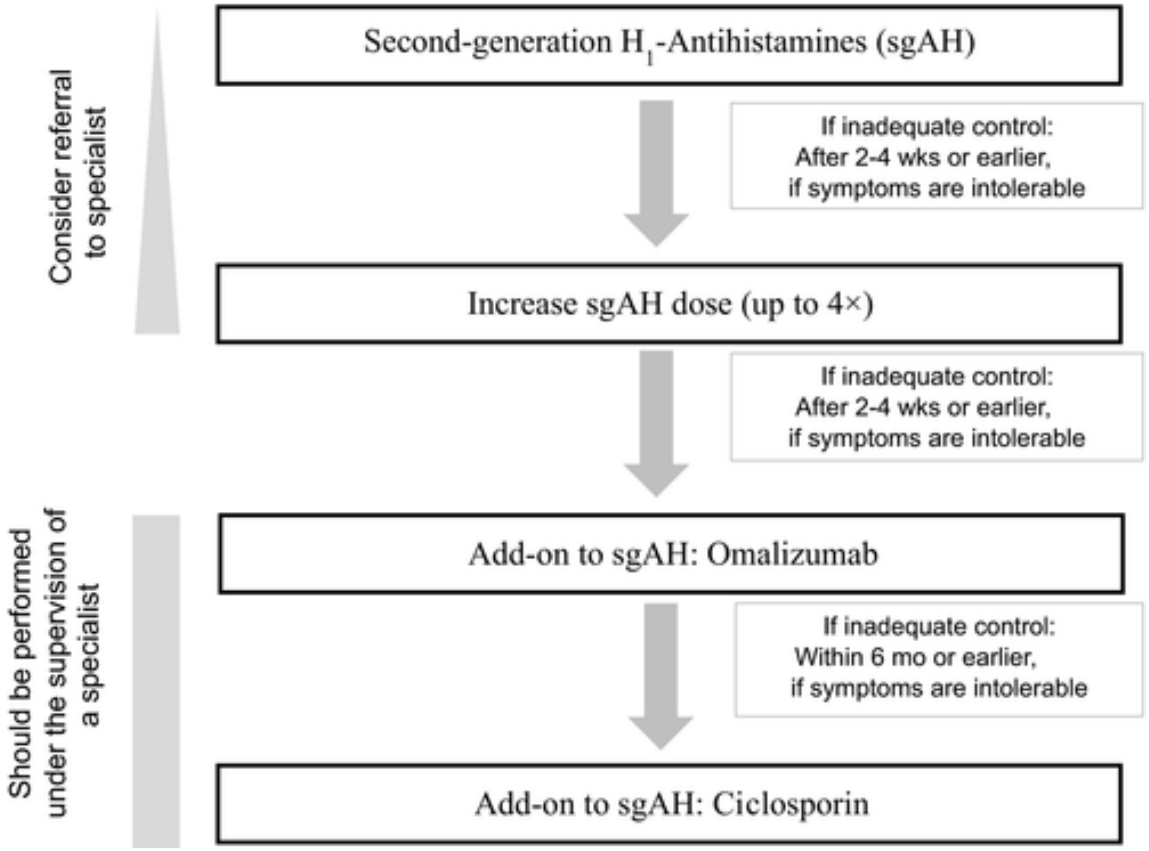
Investigations

No investigations are routinely indicated and should only be performed if there is a specific indication. The exception is complement C4 and C1inh, if a patient presents with angioedema without urticaria.

Management and General Prescribing Principles

NICE, EAACI and the British Society of Allergy and Clinical Immunology (BSACI) guidelines recommend higher than licensed doses of antihistamines. Patients should be informed that there is no cure but that the treatments can be effective in suppressing symptoms. Only non-sedating antihistamines should be used.

Continuous daily treatment is more effective than on a rescue basis flare. If patients experience side effects including drowsiness, the dosage should be modified, or the antihistamine changed. Prescribing more than one antihistamine at a time is not recommended. This is less effective than increasing the dose of a single antihistamine and may increase the risk of side effects.



Medication	**License**	**Recommended doses**	**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	1year 250microgram/kg BD 2-5 years 2.5mg BD 6-11 years 5mg BD 12-17 years 10mg OD	 Up to 10mg twice a day Up to 20mg twice a day Up to 20mg twice a day
Loratadine	Symptomatic relief of allergy such as hay fever, chronic idiopathic urticaria	2-11 years (body weight 31 kg) 5 mg OD 2-11 years (body weight> 31 kg) 10 mg OD 2-17 years 10mg OD	Up to 10mg twice daily Up to 20mg twice daily Up to 20 mg twice daily
Fexofenadine	The relief of symptoms associated with chronic idiopathic urticaria.	12-17 years 180mg OD 6-11 years 30mg BD	Up to 540mg daily as 360mg in the morning and 180mg in the evening Up to 240mg daily (120mg BD)
Tranexamic acid	Hereditary angioedema.	Some patients are aware of the onset of illness; suitable treatment for these patients is intermittently 15-25mg/kg (maximum1g-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.
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.	6 months--5years 4mg OD 6-14 years 5mg OD 15-17 years 10mg OD	

Prognosis

Parents need reassurance that this is not a severe disease and that it remits over time. A quarter of children with chronic spontaneous urticaria are disease-free 3 years after presentation, and 96% are asymptomatic after 7 years. Children with physical urticaria should be advised to avoid triggers and the condition usually regresses spontaneously after 2–3 years.

Referral

Referral should be considered for:

- Children with troublesome symptoms of rash and/or swelling despite treatments with non-sedating antihistamines including increased doses after a prolonged period of time.
- Any systemic features to suggest anaphylaxis
- If there is diagnostic uncertainty
- Children with angioedema alone

References

The EAACI/GA2 LEN/EDF/WAO Guideline for the definition, classification, diagnosis and management of urticaria: the 2013 revision and update. T. Zuberbier, W. Aberer, R. Asero et al. Allergy. 2018;73: 1393-1414

BASCI guideline for the management of chronic urticaria and angioedema, R.J. Powell, S.C Leech, S. Till, P.A.J Huber, S.M. Nasser and T.Clark Clinical and Experimental Allergy, 2015, 45, 547-585

Omalizumab for previously treated chronic spontaneous urticaria, Technology appraisal guidance [TA339] Published: 08 June 2015

Assessment and Management of Chronic Spontaneous Urticaria and Angioedema Guideline	
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Date ratified:	15/10/2021
Name of originator/author:	James Mwenechanya, Consultant Allergist
Name of responsible committee:	Allergy Team
Key search words:	Urticaria, allergy, antihistamine, levocetirizine, fexofenadine, montelukast, ranitidine, UAS, hive, wheal, rash, erythema, allergen, prednisolone, angioedema
Date issued:	September 2022 (minor update)
Review date:	October 2024

Version Control Table				
Version	**Date**	**Author**	**Status**	**Comment**
3.1	September 2022	James Mwenechanya, Consultant Allergist	Current	Maximum doses updated for Cetirizine
3	October 2021	James Mwenechanya, Consultant Allergist	Archived	Re-written and title updated
Guidelines on Management of Chronic Urticaria in Childhood				
2	January 2020	Nasim Mahmood, Consultant Paediatrician, Aideen Byrne, Consultant Allergist	Archived	6 month extension. Executive approved.
1	September 2012	Nasim Mahmood, Consultant Paediatrician, Aideen Byrne, Consultant Allergist	Archived	

Review & Amendment Log Record of changes made to guideline – Version 3.1			
Section Number	**Page Number**	**Change/s made**	**Reason for change**
Medication	3	Maximum doses updated for Cetirizine	Correction

Review & Amendment Log Record of changes made to guideline since last approved version			
Section Number	**Page Number**	**Change/s made**	**Reason for change**
All	All	Completely re-written	Out of date