

Chronic Urticaria in Children Clinical Guideline

V1.0

July 2026

Summary

Chronic urticaria: wheals $\pm$ angioedema, occurring daily (or near daily for > 6 weeks).

Potential aetiologies of chronic urticaria include:

- Spontaneous.
- Physical.
- Autoimmune.
- Vasculitis.
- Thyroid.
- Coeliac.
- (Drugs).
- Stress.
- Viral illness.

History/ Examination:

- Individual lesions lasting <24 hours.
- Urticaria with or without angioedema.
- Daily or near daily symptoms.
- Triggers e.g., cold, heat, minor trauma, dermatographism, (delayed) pressure.

Consider other causes e.g. IgA vasculitis if:

- Systemic illness; fevers, arthralgia, malaise.
- Lesions last >24 hours, painful, associated petechiae.

Investigations. Bloods:

- FBC (Full Blood Count).
- U and E's (Urine and Electrolyte's).
- LFT's (Liver Function Test) (liver autoantibodies if abnormal LFT's).
- TFT's (Thyroid Function Test).
- TTG (Tissue Transglutaminase).
- C3 and C4.
- Random glucose.
- Parasite/ bacterial/ viral infection testing only if suggested by history.
- Elimination diets are unlikely to be useful in chronic urticaria (if parent/ carer strongly feels this is food related- 1 month food diary).
- Investigations are typically negative in chronic spontaneous urticaria.

IgA (Immunoglobulin A) vasculitis:

Consider additional ANA and skin biopsy if vasculitis suspected (alongside the other suggested investigations.)

Management:

- Patient education; provide chronic spontaneous urticaria (CSU) information leaflet.
- Trigger identification/avoidance.
- NSAIDs (Non-steroidal anti-inflammatory drugs)/ aspirin should be avoided, as can worsen symptoms.
- Non-scented emollients may offer symptomatic relief.

First line- trial antihistamines:

- Loratadine.
- Cetirizine.
- If the first is unsuccessful, trial the other.
- May need up to 4 x usual daily dose (e.g. four times a day instead of once daily dose).
- If both loratadine and cetirizine are unsuccessful and >12 years old, can trial fexofenadine.
- Consider a 1 to 4 weeks trial of montelukast **alongside** antihistamine if antihistamine monotherapy unsuccessful.

If unresponsive to management consider other causes.

Allergy clinic referral:

- If above management is unsuccessful.
- If physical trigger (e.g. cold/water) with severe symptoms (to the point of feeling unwell e.g. syncope).
- Symptoms suggesting angioedema of airway.
- A suspicion of C1 esterase inhibitor deficiency (rare, plaques of angioedema, airway swelling, no urticaria, not itchy, may be family history).

Onward referral to Exeter paediatric urticaria clinic may be indicated in particularly severe presentations/with non-response to management.

Prior to referral:

- Maximise treatment as per guideline.
- Bloods.
- Discuss with local paediatric allergy clinic.

1. Aim/Purpose of this Guideline

This guideline is adapted from the British Society for Allergy and Clinical Immunology (BSACI) national guidance for chronic urticaria.

This guideline aims to assist general paediatricians reviewing children with chronic urticaria in outpatient general paediatric clinics. It covers up to the point of referral to specialist allergy clinics.

It aims to support clinicians in guiding history, examination, investigations into the cause of urticaria, management, and where appropriate, onward referral to local or regional specialist services.

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2. The Guidance

2.1. Introduction

Urticaria in children is most commonly seen as an *acute* presentation (i.e. commonly appearing within 1 hour of exposure to a trigger and resolving within 24 hours). Acute urticaria is often part of an allergic reaction, although can also be seen in response to a viral infection, lasting for days.

Chronic urticaria is defined as wheals and/or angioedema, occurring daily or near daily, over a course of at least 6 weeks.

Chronic spontaneous urticaria (CSU) occurs in the absence of a known trigger.

Chronic urticaria is unlikely to represent an allergic reaction.

2.2. Prognosis

CSU is rarely life-threatening, although its symptom burden may affect appearance, sleep, or daily living (e.g. if associated systemic symptoms). Missed education may also be seen where there is parental concern that the symptoms are secondary to infection or allergic reaction.

Chronic urticaria has a good prognosis, although often requires treatment over the course of years. It is usually responsive to antihistamines, as well as identification and avoidance of triggers.

Around a quarter of children will be disease-free by 3 years post-presentation, while most children presenting with chronic urticaria will be asymptomatic 7 years after presentation.

2.3. Aetiology

Chronic urticaria is associated with several different causes or triggers, and effective management is supported by identifying the aetiology in the individual presentation.

Physical urticaria – the wheals/angioedema is triggered by physical causes. In particular, cold exposure or water exposure are seen as triggers of chronic urticaria, although physical causes can include:

- Hot or cold water (aquagenic).
- Cold or heat.
- Sun (solar).
- Delayed pressure (e.g. sitting, lying, tight clothing).
- Minor trauma (e.g. dermatographism).
- Urticarial vasculitis – caused by IgA vasculitis (previously called Henoch-Schonlein purpura).
- Autoimmune.
- Thyroid – there is some association between autoimmune thyroid conditions and chronic urticaria, although the onset of urticaria often does not coincide with onset of thyroid issues. Urticaria sometimes improves (but not always) with thyroid replacement (i.e. thyroxine) in these cases.
- Coeliac – where there is chronic urticaria in context of coeliac disease, gluten avoidance may improve symptoms.
- Spontaneous – no trigger identified.
- Stress.
- Viral illness.

2.4. Presentation

Chronic spontaneous urticaria (CSU) can present as early as 2 years old, although it is more common in older children. It is however, more commonly seen in adults than children.

50 to 80% of children presenting with chronic spontaneous urticaria also have associated angioedema.

2.5. History and examination

There may be associated triggers for the chronic urticaria – such as cold (e.g. cold-water exposure), pressure (e.g. sitting/lying, tight clothing), dermatographism.

It is important to assess for signs of systemic illness (fevers, arthralgia, malaise etc.) in presentations of chronic urticaria, as the presence of these are more likely to be associated with urticarial vasculitis.

Consider the nature of the lesions, and the nature of their progression.

Lesions which persist for more than 24 hours, which are painful, or which fade to petechiae should increase suspicion for vasculitis.

The timing and distribution of lesions can also suggest the trigger(s)- for example, lesions which appear after cold water swimming may suggest cold or aquagenic urticaria, or lesions which appear at night may be associated with pressure from lying in bed.

Children are less likely to be on medications which are associated with chronic spontaneous urticaria, but a history of angiotensin converting enzyme (ACE)-inhibitor, NSAID (non-steroidal anti-inflammatory drugs), or aspirin use are common causes of chronic urticaria in adults.

2.6. Investigations

A thorough history or examination may be sufficient to make a clinical diagnosis of chronic spontaneous urticaria. Blood tests are often only useful when there is consideration of other potential causes for the symptoms (such as coeliac, vasculitis, thyroid).

In chronic spontaneous urticaria, investigations are typically negative.

Bloods are suggested in cases which present with:

- 6 or more weeks of daily or near-daily symptoms OR;
- Angioedema presenting without urticaria (important to rule out hereditary angioedema) OR;
- Severe cases.

Suggested bloods include:

- Full blood count.

- Liver function tests (with subsequent viral hepatitis screen if transaminases are abnormal).
- Renal function.
- Random glucose.
- TSH (Thyroid Stimulating Hormone) (consider thyroid autoantibodies if abnormal).
- TTG (Tissue Transglutaminase)(IgA (Immunoglobulin A) will automatically be included when TTG is requested).
- C3 and C4 (in cases of persistent angioedema/urticaria. If C4 is abnormal, testing C1 inhibitor is indicated).
- Skin testing and/or elimination diets are rarely of diagnostic benefit as chronic urticaria is unlikely to be caused by an allergic reaction.

If a parent/carer is particularly concerned about food being a trigger for episodes, without a specific food identified, they should be advised to keep a food diary for 1 month. Please note that patients with chronic spontaneous urticaria may develop hives following exposure to irritant foods, such as citrus fruits, tomatoes, spices. If there is true concern that the episodes are being triggered by particular foods, please discuss with the Paediatric Allergy team. Please be aware that there is currently a long wait for routine allergy clinic appointments if a referral is needed.

Testing for viral, bacterial, or parasitic infections as a potential trigger is only recommended if indicated by the clinical history.

2.7. Initial presentation suggestive of IgA vasculitis

Features such as systemic illness (fever, arthralgia, malaise), presence of petechiae, lesions that persist beyond 24 hours should prompt consideration of vasculitis as a potential cause for the child's symptoms.

Other causes (such as vasculitis) should be considered if chronic urticaria fails to respond to treatment.

If vasculitis is suspected, additional investigations, including ANA testing and skin biopsy should be considered.

2.8. Management

Management usually involves a combination of medication and avoidance of known triggers.

Non-fragranced emollients may also provide symptomatic relief for itch.

NSAIDs and aspirin should be avoided in chronic urticaria, as their use can exacerbate symptoms.

1st line – non sedating antihistamines. If one non-sedating antihistamine is unsuccessful, the child should be trialled on the other(s):

- Cetirizine (from 1 year old onwards, available as a syrup).
- Loratadine (from 2 years old onwards, available as a syrup).
- Fexofenadine – can be trialled in children aged 12 and up if neither loratadine nor cetirizine are successful in managing symptoms.
- Up to 4 times the usual daily dose of antihistamine may be needed to effectively manage symptoms (for example, in a 12-year-old, the usual dose of loratadine is 10mg OD, but they may need up to 10mg QDS to manage symptoms).

If the child's symptoms are unresponsive to treatment, this should increase suspicion for other causes of chronic urticaria e.g. vasculitis.

In cases where non-sedating antihistamine monotherapy is unsuccessful (after trialling all appropriate options), a 1 to 4-week trial of montelukast alongside antihistamine therapy can be considered. Montelukast monotherapy has a poor efficacy in managing symptoms.

Montelukast has been found to be more effective in delayed-pressure urticaria.

A short course of oral corticosteroids could be considered in specific circumstances. A 3 to 5 day course is sufficient to provide some initial symptom relief while introducing other management(s). It should be noted that in inducible urticaria that has had no response to antihistamine therapy, steroids have a poor efficacy. Steroids should not be considered for long-term use in chronic urticaria.

Tranexamic acid may be useful in cases of isolated angioedema without urticaria. A maximum dose of 15 to 25 mg/kg (maximum 1.5g) 2 to 3 times per day is recommended.

2.9. Onward referral

Where the above first-line management options have been unsuccessful, onward referral to the RCHT paediatric allergy clinic may be of benefit.

In cases with a physical trigger and particularly severe symptoms (i.e. to the point of feeling unwell, e.g. syncope), a referral to the allergy clinic is indicated.

Onward referral to Royal Devon and Exeter's paediatric urticaria clinic may be indicated to consider treatment options not currently available at RCHT. These may include Anti-IgE (e.g. omalizumab) in children aged >7 years old, or ciclosporin.

Before making the referral, please ensure the following are done:

- Treatment has been maximised as per guidelines.
- Bloods.
- Discussion with the local paediatric allergy team prior to referral.

2.10. Further resources:

Resources for parents should be provided.

- Allergy UK CSU webpage:
<https://www.allergyuk.org/resources/chronic-spontaneous-urticaria/>
<https://www.allergyuk.org/resources/csu/>
- Allergy UK CSU Printable Leaflet <https://www.allergyuk.org/wp-content/uploads/2024/09/Chronic-Spontaneous-Urticaria-v2.pdf>.
- British Association of Dermatologists Printable Leaflet on Urticaria and Angioedema <https://www.bad.org.uk/pils/urticaria-and-angioedema>.
- BSACI guidance on chronic urticaria, from which this guideline is adapted https://www.bsaci.org/wp-content/uploads/2020/01/Urticaria_Angioedema2015-1.pdf.

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Referrals of chronic urticaria to paediatric allergy team should reduce – we will record any cases that are referred to us and review whether this is following this guidance.
Lead	Paediatric Allergy Team, RCHT.
Tool	Case reviews.
Frequency	Quarterly.
Reporting arrangements	Chronic urticaria Referrals and cases - Discussion at paediatric Allergy MDT. Minutes will be shared with management and with paediatric allergy team. Updates re referrals will be shared with the general paediatric team. Documentation in MDT minutes.
Acting on recommendations and Lead(s)	Paediatric Allergy team will action if change needed
Change in practice and lessons to be shared	To share with wider team as needed

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the [Equality Diversity And Inclusion Policy](#) or the [Equality and Diversity website](#).

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Chronic Urticaria in Children Clinical Guideline V1.0
This document replaces (exact title of previous version):	New Document
Date Issued/Approved:	June 2026
Date Valid From:	July 2026
Date Valid To:	July 2029
Directorate/Department responsible (author/owner):	Dr Megan Rayner, Foundation Year 2 Doctor and Dr Kathryn Thomas, Paediatric Consultant, Paediatric Allergy Team, RCHT.
Contact details:	01872 252949
Brief summary of contents:	Flowchart and guideline to support assessment, investigation and management of urticaria in children (Paediatric).
Suggested Keywords:	Urticaria, paediatric, children.
Target Audience:	RCHT: Yes CFT: Yes CIOB ICB: No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Paediatric Audit and Guidelines Meeting
Manager confirming approval processes:	Catherine Rule
Name of Governance Lead confirming consultation and ratification:	Michael Cross
Links to key external standards:	BSACI Urticaria Paper – linked within document.
Related Documents:	See reference section.

Information Category	Detailed Information
Training Need Identified?	No – this guideline is to support general paediatric team in management of these cases. Change to RMS triaging will be needed – to be shared across the paediatric RMS triage team.
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical/Paediatrics/Common Childhood Infections and Presentations

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
May 2026	V1.0	Initial issue.	Megan Rayner, F2. Kathryn Thomas, Consultant Paediatrician (Allergy)

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust [The Policy on Policies \(Development and Management of Knowledge Procedural and Web Documents Policy\)](#). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Quality and Equality Impact Assessment (QEIA) Form

The QEIA process allows RCHT to monitor the impact of changes to its policies and services, ensuring that nobody is unduly disadvantaged.

Please ensure you have completed a Quality and Equality Impact Assessment (QEIA) using this link to complete the form:

[E11 QEIA Policy](#)

For guidance, please see the [QEIA Essentials – Quick Reference Guide](#) or contact as required below:

Equality, Diversity and Inclusion guidance, please contact: rcht.inclusion@nhs.net

Quality Governance guidance, please contact Jillian Tozer: jillian.tozer3@nhs.net