Government of **Western Australia**
South Metropolitan Health Service
Fiona Stanley Fremantle Hospitals Group

Dermatology pre-referral guidelines – Urticaria

Fiona Stanley Hospital Dermatology

Disclaimer

These guidelines have been produced to guide clinical decision making for General Practitioners (GPs) and referring non-GP Specialists. They are not strict protocols. Clinical common-sense should be applied at all times. These clinical guidelines should never be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of each patient. Clinicians should also consider the local skill level available and their local area policies before following any guideline.

Introduction

Urticaria, or hives, is a common disorder with a lifetime prevalence of ~ 20% in the generalpopulation. It presents with intensely pruritic, erythematous plaques that are transient – usually appearing and enlarging over the course of minutes to hours and then disappearing within 24 hours. Urticarial lesions are typically not painful (rather itchy) and they resolve without leaving residual bruising on the skin, unless there is trauma from scratching. Fixed non-scaly urticarial plaques may represent other diagnoses, such as erythema multiforme. Urticaria never causes mucous membrane erosion. Urticaria may be accompanied by angioedema, which is swelling deeper in the skin.

Urticaria is commonly categorized by its chronicity:

- Acute Urticaria – urticaria is considered acute when it has been present for less than 6 weeks. More than two-thirds of cases of new -onset urticaria will resolve within this timeframe, and often resolution is within one to three weeks.
- Chronic Urticaria – urticaria is considered chronic when it is recurrent, with signs and symptoms occurring most days of the week, for 6 weeks or longer.

A trigger for urticaria, such as infections (especially common in children), drug, food ingestion, or insect sting, may be identifiable in patients with new-onset urticaria – although no specific cause is found in many cases, particularly when the condition persists for weeks or months.

Pre-referral investigations

- Urticaria is diagnosed clinically based on a detailed history and physical examination confirming the presence of characteristic skin lesions. Lesions (or photographs of the patient's lesions) should be visualized directly to make the diagnosis with certainty since the term "hives" is used non-specifically by patients. If there are no active lesions at the time of evaluation, stroking the skin may be able to reproduce an urticarial response and help establish the diagnosis (dermatographism). However, the absence of this response does not exclude urticaria
- For most patients with new-onset urticaria, laboratory tests are not helpful. Two-thirds of cases will resolve spontaneously without any long-term sequelae.

Pre-referral management

General measures

- Patient counselling and reassurance. Most new-onset urticaria is an extremely common condition that is typically benign and self-limited. Most patients improve within 2-3 weeks, even when there is no clear identifiable trigger.
- Non-itchy cases of urticaria do not need treatment.
- Avoid physical triggers for urticaria, including tight clothing/straps, rubbing/scratching, hot showers, etc.
- Avoid mast-cell activating medications (including Aspirin, NSAIDs and Opioids) and alcohol.

- A menthol-containing emollient used as often as is needed can be cooling on the skin and can help relieve itch (eg, 1% Menthol in Sorbolene cream).

Specific measures

- Start a second generation, non-sedating H1 antihistamine (eg, cetirizine, loratadine, fexofenadine) at standard dosing. Advise patients they can double or triple the dose if necessary. Doses up to four times the standard have been studied in chronic urticaria in adult populations and have been shown to be safe and well tolerated. H1 antihistamine treatment should continue until the lesions completely resolve. Once no new lesions have appeared for a day or two, patients may taper down and stop the antihistamines. If patients continue to have recurrent episodes of urticaria most days of the week for 6 weeks, they are likely developing chronic urticaria and referral to dermatology (as per below) should be considered.
- A burst of Prednisolone can be considered in patients who have persistent symptoms or prominent angioedema after several days of regularly administered H1 antihistamines.
    - For adults: Prednisolone 30-60mg daily, with tapering over 5-7 days
    - For children: Prednisolone 0.5-1mg/kg/day (maximum 60mg daily), with tapering over 5-7 days

Other treatments may be used at the hospital

- Laboratory evaluation is considered in patients who have features suggestive of urticarial vasculitis, aa treatable infection, or an underlying systemic disorder.
- Chronic urticaria typically requires treatment with second generation, non-sedating H1 antihistamine (high-dose therapy) +/- addition of the following therapies:
    - First generation, sedating H1 antihistamine (at bedtime).
    - H2 antihistamine (eg, Famotidine).
    - Montelukast.
    - Biologic agents: Omalizumab, Dupilumab.
    - Other systemic agents: Cyclosporine, Methotrexate, Mycophenolate.
    - nbUVB phototherapy.

When to refer

- Chronic urticaria (> 6-weeks) which is not adequately managed with high-dose anti-histamines.
- Chronic urticaria associated with signs or symptoms suggestive of a systemic disorder: unintentional weight loss, unexplained fever, arthralgias or arthritis, lymphadenopathy.
- Clinical suspicion of urticarial vasculitis – lesions are typically long lasting (>24 hours), painful, or leave residual bruising.
- Isolated angioedema.
- As outlined above, if there is suspicion for an IgE-mediated allergic cause, referral should be made directly to Immunology.

Essential information to include in your referral

- Duration of symptoms.
- Triggers for urticaria.
- Presence of angioedema.
- Presence of fever or systemic symptoms.
- Medication/immunisation history.
- Treatments patient has trialled.

References

- Paller and Mancini – Hurwitz Clinical Pediatric Dermatology: A Textbook of Skin Disorders of Childhood and Adolescence (6th edution). Elsevier, 2022.
- Therapeutic Guidelines (2022). Therapeutic Guidelines- Urticaria. (Accessed: August 13, 2025).
- UpToDate (2025) New-onset urticaria (hives). (Accessed: August 13, 2025).
- UpToDate (2025) Chronic spontaneous urticaria. (Accessed: August 13, 2025).

Useful patient resources

1. Hives (urticaria) - Australasian Society of Clinical Immunology and Allergy (ASCIA) - ASCIA
2. Urticaria (Hives): a complete overview — DermNet - Dermnet NZ
3. ACD A-Z of Skin - Urticaria - Australasian College of Dermatologists
4. spd_hives_color_web.pdf - Society of Pediatric Dermatology

This document can be made available in alternative formats on request.

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