NHS
Central London
Clinical Commissioning Group

Angioedema

General points

Urticaria and angioedema are closely related, share many causes and treatments and can coexist

They are both manifestations of mast cell degranulation in superficial or deep skin layers respectively

Patient information

- Angioedema here

CLINICAL FEATURES

- Angioedema refers to oedema of the skin and / or mucosal surfaces with or without urticaria
- Fatalaties can occur if the airway is compromised
- Swelling lasts for 1-3 days
- GI swelling can cause colicky abdominal pain

CAUSES

- Idiopathic – often in response to emotional stress
- drug induced e.g. ACE inhibitors, foodstuffs
- inherited = hereditary angioedema (autosomal dominant C1 esterase inhibitor deficiency) causing complement mediated mast cell degranulation
    - check complement levels
    - more likely if patient suffers abdominal symptoms

MANAGEMENT

- Reassure the patient that urticaria is benign and usually self-limiting, give information sheet and use www.allergyuk.org
- Minimise any identifiable triggers as outlined above
- The mainstay of treatment is long-acting, non-sedating antihistamines (H1 blockers), often at higher doses than usual e.g.
    - cetirizine once a day and increased up to 10mg qds which can be used long term

- If unsuccessful or side-effects try another antihistamine e.g. loratadine, desloratadine, fexofenadine, levocetirizine, +/- sedating antihistamine if sleep disturbed (piriton) . Up to 2 to 3 x normal dose if necessary
- Add H2 blocking anti-histamine e.g. ranitidine or
- Try H1 blocker and montelukast
- There is relatively little to choose between different antihistamines but individuals may vary in their response to different agents
- Use continuous medication if attacks occur regularly

Pregnancy – use piriton

Referral criteria (to immunologist)

- Anaphylaxis i.e. involvement of airway, breathing or circulation
- Hereditary angioedema suspected