SUMMARY

One in five individuals will suffer from hives at some point during his or her lifetime. These individuals usually look to their family doctor for help. As such, patients presenting with hives will be a common occurrence in the primary care setting. Clinicians will need to develop an approach that determines treatment needs based on triggers, duration, and underlying cause. If medications are recommended, these need to provide symptom relief; however, not intolerable side effects. Short-lived episodes are generally amenable to antihistamines, though chronic urticaria requires a skilled approach. Recognition of underlying causes requires diligence, but may suggest a need for modifiers of systemic autoimmune diseases. Research efforts continue to yield information on mechanisms of pathophysiology.

Key Words: Angioedema; anti-IgE receptor antibody; autoimmune thyroid disease; chronic idiopathic urticaria; histamine-releasing factors; hives; mast cell; physical urticaria.

INTRODUCTION

Patients exhibiting hives and associated soft tissue swelling are common in the outpatient setting. These complaints brought to the primary care physician generally will result in a diagnosis of urticaria and angioedema. The patients refer to the urticaria and angioedema by various descriptive terms, such as hives, welts, or an itchy rash. Indeed, the lesions that are described by patients with a variety of terms can have a diverse appearance. Categorically, urticarial lesions are pruritic and have a center portion that is elevated. The elevated center is often surrounded by an erythematous halo. This prototypical lesion morphologically has a central wheal with a surrounding flare. However, the configuration of the lesions can be quite different, with some lesions typically being
round and circumscribed, whereas others can be serpiginous or diffuse. Characteristically, the lesions should blanch with pressure, and they generally resolve within 24 h, leaving no residual change to the skin. Lesions that do not blanch, do not result in pigmentation or scarring of the skin, or are not pruritic should be assessed for other dermatological processes or vasculitis.

Swelling of the subcutaneous tissue, or angioedema, commonly accompanies urticaria. This swelling generally results from the same pathophysiology. However, the actual process is occurring deeper in the tissue. As a result, the erythema that is seen surrounding superficial lesions is not observed, although the swelling can be visualized. Angioedema generally occurs on the extremities and digits as well as areas of the head, neck, face, and, in males, genitalia. Patients often describe it as being painful in comparison to urticaria, which is described as itchy.

A primary care physician will see many patients with urticaria and angioedema, which affect up to 15–20% of the general population, more commonly women. The majority of outbreaks are acute and self-limiting. Less than 10% of urticarial eruptions will become a chronic process. When urticarial lesions develop, they are associated with angioedema in as many as 50% of cases. Approximately 10% of the cases have only angioedema in the absence of urticaria, and the remaining 40% have solely urticaria.

Acute urticaria is a daily problem that primary care physicians handle frequently and effectively. The etiology is often elusive. However, its acute and self-limited character limits morbidity. Chronic urticaria and angioedema tend to be a much more vexing problem, often disabling and interfering with the patient’s quality of life (Fig. 1).

Recently, research suggests an autoimmune etiology for a subpopulation of those with chronic urticaria and angioedema, which could result in different approaches to the treatment of these patients.

**Fig. 1.** Chronic urticaria, which can affect quality of life on a daily basis.