Persistent hives, or chronic urticaria, can be challenging to diagnose, treat, and manage. This condition is also somewhat common—I see it often at Miami Children’s Hospital. Persistent hives are distinctive from an acute presentation because they typically last 6 weeks or longer. They are not only frustrating for physicians—the etiology is identified in only a minority of affected children, but this disease can significantly impair quality of life for patients and their families.

Infections are a common cause of persistent hives. Other conditions to consider in your differential diagnosis include drug and food allergies, physical urticaria (caused by exposure to heat or cold), autoimmune disease, erythema multiforme minor, and dermatographism. Dermatographism is a condition in which stroking or scratching the skin with a dull instrument causes a raised welt, or wheal, to appear because of increased mast cell activation. The skin generally appears pale in the center with a red flare on either side. A physical allergy causes this type of urticaria.

In conjunction with the physical examination, review all medications taken in the last 6 weeks, including but not limited to new agents. Also ask the patient and parents about the type of foods the child consumed within the last several weeks with regularity. A long-acting antihistamine, with 24-hour coverage, can be helpful. For some children with persistent hives, you may need to think outside the box and prescribe both a short-acting and long-acting antihistamine. The short-acting agent can be used to control an acute presentation while the long-acting drug provides maintenance.

If the condition improves with antihistamines and the hives are not interfering with quality of life or sleep, then you should feel comfortable treating the child. If antihistamine therapy is not helpful, the lesions are interfering with lifestyle or sleep, or the patient complains of swelling, it is appropriate to refer the child to a specialist for additional workup. Swelling is often a presenting sign with chronic urticaria, and typically it is generalized or affects the hands or face.

If you decide to order laboratory testing prior to a specialist referral, a complete blood count, an erythrocyte sedimentation rate assay, a liver function test, and thyroid studies can be helpful. But you also can simply refer the patient to an allergist or immunologist, and we can order the testing.

In contrast, a food-specific immunoglobulin G test is not helpful for the assessment of a child with persistent hives. This laboratory assay should not be ordered because it only adds to the cost of the diagnosis without aiding in the clinical diagnosis. If you are fortunate and can identify the cause of the chronic urticaria—which only occurs in 5%-20% of cases—it calls for dietary avoidance. This is another aspect where persistent hives differ from an acute presentation, because the etiology of an acute condition is more frequently found and subsequently may be avoided by the child.

Also educate the patient that persistent hives can be daily or episodic. Again, if the patient is lucky, the lesions resolve in less than 1 year. However, inform the patient that—in some cases—the hives can persist for several years.

Dr. Hernandez-Trujillo is director of the division of allergy and immunology at Miami Children’s Hospital. Dr. Hernandez-Trujillo disclosed that she has been a spokesperson for Schering-Plough Corp., which is now part of Merck & Co. To comment, e-mail her at pdnews@elsevier.com.