Background: Though autoimmune phenomena have been regularly associated with chronic urticaria in adults, data in children are sparse.

Aim: To describe our experience with children and adolescents with chronic urticaria and autoimmunity.

Methods and Results: Of 187 patients referred for evaluation of chronic urticaria during a 7.5 year period, eight (4.3%), all females aged 7–17 years, had increased levels of antithyroid antibody, either antithyroid peroxidase antibody (n = 4, >75 IU/ml), antithyroglobulin antibody (n = 2, >150 IU/ml), or both (n = 2). The duration of urticaria was four months to seven years. Five patients were euthyroid, one of whom was found to have increased antithyroid antibody levels five years after onset of the urticaria. One patient was diagnosed with Hashimoto thyroiditis three years before the urticaria, and was receiving treatment with thyroxine. Two other hypothyroid patients were diagnosed during the initial work up for urticaria (thyroxine 9.2 pmol/l, thyroid stimulating hormone (TSH) 40.2 mIU/l) and five years after onset of the urticaria (thyroxine 1.4 pmol/l, TSH 10.3 mIU/l). Both were treated with thyroxine but neither had remission of the urticaria. Five patients had a low positive titre of antinuclear antibodies.

Conclusion: Children with chronic urticaria should be screened periodically for thyroxine, TSH, and antithyroid antibodies, as thyroid autoimmunity and hypothyroidism may appear several years after onset of the urticaria.
1.6% in 6283 girls. Jakšić and colleagues reported a prevalence of thyroid autoimmunity in the 10–11 to 18 year age group, Rallison and colleagues reported a prevalence in males, whereas a 1.27% prevalence of autoimmune thyroiditis in 4819 children, and Marwaha and colleagues reported an 11 year old girl who had chronic urticaria with thyroid autoimmunity.

The association of chronic urticaria with autoimmune thyroid disease has frequently been reported in adults. The prevalence in adult series ranges from 14% to 33%.

Most cases of chronic urticaria in children are idiopathic. Physical stimuli, infections, and stress comprise the majority of identified causative factors. Most cases of chronic urticaria in children are idiopathic. The prevalence of thyroid autoimmunity in children has been reported to be higher than the prevalence reported to date for age matched children: in two population based studies of the 10–11 to 18 year age group, Rallison and colleagues reported a 1.27% prevalence of autoimmune thyroiditis in 4819 children, and Marwaha and colleagues found a prevalence of 1.6% in 6283 girls. Jakšić and colleagues found a prevalence of 0.35% in 5462 school age children.

DISCUSSION

The association of chronic urticaria with autoimmune thyroid disease has frequently been reported in adults. The prevalence in adult series ranges from 14% to 33%.

The prevalence of thyroid autoimmunity in our study was 5.4%. This is in accordance with findings of a higher prevalence of thyroid autoimmunity in women in cross sectional studies. Other investigators also showed that the association of chronic urticaria with thyroid autoimmunity is more common in females.

Our literature review yielded no large series of thyroid autoimmunity in chronic urticaria in children, although several case reports have been published. Dreyfus and colleagues described a 9 year old boy with chronic urticaria and antithyroid microsomal antibodies who had prolonged remission with thyroxine treatment. Levine and colleagues reported an 11 year old girl who had chronic urticaria with antithyroid antibodies, who was also found to have coeliac disease. Her family history revealed chronic urticaria and thyroid autoimmunity in three generations on the maternal side. In another report of two children, aged 15 and 13 years, with chronic urticaria, one child also had type 1 diabetes, increased levels of antithyroglobulin antibodies, and low titre of ANA; the other later developed systemic juvenile rheumatoid arthritis. He also had a positive family history of autoimmune disorders, such as thyroid disease, type 1 diabetes, and coeliac disease.

Similar to the patients reported by Levine and colleagues and Dalal and colleagues, four of our patients had a positive family history of autoimmune diseases, and five had positive titres of ANA, with low C3 levels in two. However, none, except patient 4, had any clinical or laboratory evidence of autoimmune disease other than the thyroid autoimmunity. Patient 4, whose brother had type 1 diabetes, also had increased levels of anti-GAD antibodies, but repeated oral glucose tolerance tests during the subsequent two years of follow up were consistently normal. It is known that type 1 diabetes may coexist with other endocrine diseases and that organ

### Table 1
Clinical features of eight girls with chronic urticaria and positive thyroid autoantibodies taken from a cohort of 187 children and adolescents with chronic urticaria

<table>
<thead>
<tr>
<th>Patient no.</th>
<th>Sex/age at presentation (y)</th>
<th>Duration of urticaria</th>
<th>Family history</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>F/10</td>
<td>9 mh</td>
<td>JRA (sister)</td>
</tr>
<tr>
<td>2</td>
<td>F/15</td>
<td>4 mh</td>
<td>Hypothyroidism (father)</td>
</tr>
<tr>
<td>3</td>
<td>F/17</td>
<td>5 mh</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>F/13.5</td>
<td>6 y</td>
<td>Type 1 diabetes (brother)</td>
</tr>
<tr>
<td>5</td>
<td>F/7</td>
<td>7 y</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>F/11</td>
<td>3 y</td>
<td>Hashimoto thyroiditis (mother)</td>
</tr>
<tr>
<td>7</td>
<td>F/8</td>
<td>6 mh</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>F/11</td>
<td>2 y</td>
<td></td>
</tr>
</tbody>
</table>

### Table 2
Laboratory test results from eight girls with chronic urticaria and thyroid autoimmunity, taken from a cohort of 187 patients

<table>
<thead>
<tr>
<th>Patient no.</th>
<th>TSH (mIU/l)</th>
<th>Thyroxine (pmol/l)</th>
<th>Anti-TPO (IU/ml)</th>
<th>Anti-Tg (IU/ml)</th>
<th>ANA</th>
<th>Anti-DNA</th>
<th>C3 (mg/dl)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>40.2</td>
<td>9.2</td>
<td>132.9</td>
<td>35.7</td>
<td>Negative</td>
<td>ND</td>
<td>ND</td>
</tr>
<tr>
<td>2</td>
<td>3.07</td>
<td>12.2</td>
<td>105</td>
<td>14</td>
<td>Negative</td>
<td>ND</td>
<td>113</td>
</tr>
<tr>
<td>3</td>
<td>1.25</td>
<td>13.6</td>
<td>26</td>
<td>296</td>
<td>Negative</td>
<td>ND</td>
<td>125</td>
</tr>
<tr>
<td>4†</td>
<td>0.90</td>
<td>17</td>
<td>245</td>
<td>133</td>
<td>1.160</td>
<td>16%</td>
<td>72</td>
</tr>
<tr>
<td>5§</td>
<td>10.3</td>
<td>14</td>
<td>870</td>
<td>1605</td>
<td>1.80</td>
<td>10%</td>
<td>87</td>
</tr>
<tr>
<td>6§</td>
<td>0.85</td>
<td>15.7</td>
<td>1076</td>
<td>56</td>
<td>1.40</td>
<td>ND</td>
<td>106</td>
</tr>
<tr>
<td>7</td>
<td>2</td>
<td>20</td>
<td>248</td>
<td>599</td>
<td>1.40</td>
<td>ND</td>
<td>116</td>
</tr>
<tr>
<td>8</td>
<td>3.2</td>
<td>15.4</td>
<td>70</td>
<td>333</td>
<td>1.160</td>
<td>12%</td>
<td>143</td>
</tr>
</tbody>
</table>

| Normal range | 0.4–4 | 10.5–25.7 | <75 | <150 | <20% | 125±25 |

**Note:**
- Tg, thyroglobulin; ND, not done.
- Increased levels of antithyroid antibodies and TSH detected during the initial work up.
- Increased levels of antithyroid antibodies detected five years after onset of urticaria; this patient also had increased levels of anti-GAD antibodies.
- Increased levels of antithyroid antibodies and TSH detected five years after onset of urticaria.
- Hashimoto thyroiditis diagnosed three years prior to chronic urticaria. On thyroxine treatment at evaluation.
Specific antibodies are a frequent occurrence in these patients.12 Jaeger and colleagues13 found that type 1 diabetes associated antibodies and antithyroid antibodies were significantly more frequent in first degree relatives of patient with type 1 diabetes than in healthy controls.

Three of our patients (nos 1, 5, 6) were hypothyroid. Patient 1 was diagnosed during the work up for chronic urticaria; patient 6, three years prior to the appearance of the urticaria; and patient 5, five years after the appearance of the urticaria. In one additional patient (no. 4), antithyroid antibodies were detected only five years after the appearance of the urticaria. These findings may indicate that the thyroid autoimmunity in chronic urticaria is an evolving process and may be manifested before, concomitant with, or several years after the appearance of the urticaria. They may also explain the low prevalence of thyroid autoimmunity in our series compared to adults.

Adolescent patients with chronic urticaria may be diagnosed with thyroid autoimmunity only as young adults.

The mechanism whereby thyroid autoimmunity is associated with urticaria is poorly understood. The antithyroid IgG antibodies may not be directly involved in the mast cell degranulation and pathogenesis of the chronic urticaria, but only serve as indicators of autoimmunity. Skin biopsy specimens from patients with chronic urticaria, with or without Hashimoto thyroiditis, were indistinguishable by light microscopy, and no immune complex deposition was observed.14 Several researchers have observed serum histamine releasing activity in a subgroup of adult patients with chronic urticaria which was attributable to an IgG autoantibody directed against the alpha chain of the high affinity IgE receptor (FcεRı) of the mast cells or, less commonly, against IgE itself.15 In addition, clustering of thyroid antimicrosomal antibodies was found in patients with a positive autologous serum test, indicating the presence of functional histamine releasing autoantibodies.16 In a series of patients with chronic urticaria only patients with chronic urticaria and Hashimoto thyroiditis had anti-FcεRI antibodies in their sera that could induce degranulation of normal basophils.17 These antibodies have not been investigated systematically in children with chronic urticaria. Greaves1 found that three of seven tested patients aged 13–16 years had functional anti-FcεRI antibodies.

None of the three hypothyroid patients treated with thyrroxine had a remission of the urticaria, in contrast to the 9 year old euthyroid patient reported by Dreyfus and colleagues, and the euthyroid and hypothyroid patients in the series of Rumbyrt and colleagues18 and Gaig and colleagues.19 Moreover, patient 6 developed urticaria while on treatment with thyrroxine (table 2). Although we have treated only hypothyroid children, our experience does not support the use of thyrroxine treatment in euthyroid patients with chronic urticaria.

Euthyroid patients with a positive anti-TPO antibody have an appreciable risk of progression to hypothyroidism.20 Annual reassessment of thyroid function in patients with chronic urticaria and increased antithyroid titres is recommended.21 However, our experience shows that the thyroid autoimmunity may appear several years after the onset of chronic urticaria, emphasising the importance of follow up and periodic blood tests for thyrroxine/TSH and antithyroid antibodies in children with chronic urticaria. Whether children and adolescents with chronic urticaria and thyroid autoimmunity belong to the subgroup of chronic urticaria patients with autoimmune mast cell disease is still to be determined.

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