

**Management of Hyperhidrosis**

**Version:**  
0.2

**Implementation date:**  
19 February 2018

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June 2018

**Review date:**  
November 2018

**Category:**  
Dependent on procedure:

- **Endoscopic Thoracic Sympathectomy – ETS** – Not Routinely Funded
- **Iontophoresis Machine** – Not Routinely Funded
- **Laser Sweat Ablation or Retrodermal Curettage** – Restricted
- **Management of Hyperhidrosis with Botulinum Toxin A** – Restricted

**Background**

Multiple localised and systemic therapies are available for the management of hyperhidrosis. The purpose of this document is to provide an evidence based and cost-effective treatment pathway for primary and secondary care. Hyperhidrosis is a disorder of excessive sweating beyond what is required for thermoregulation.

The condition may be localised (also referred to as primary or focal hyperhidrosis) or secondary to medication or a medical condition (generalised hyperhidrosis). The most important issue in directing therapy for hyperhidrosis is to differentiate between primary and secondary hyperhidrosis and between subtypes of primary hyperhidrosis (i.e. palmar, plantar, axillary, or craniofacial – the areas with a high density of eccrine sweat glands).

A complex dysfunction of the innervation of sweat glands via the sympathetic nervous system is likely to play a role in the pathophysiology of hyperhidrosis. Primary hyperhidrosis increases the risk of cutaneous infection and has a significant psychosocial burden and a negative impact on quality of life.

As there is no standardised definition of ‘excessive sweating’, clinicians base their diagnoses in part on measures to estimate how hyperhidrosis affects a patient’s quality of life. The Hyperhidrosis Disease Severity Scale (HDSS) should be used as this is easy to use and validated against other questionnaires.

The recommendations in this policy are broadly in line with a recent publication in the British Medical Journal and the Clinical Knowledge Summary on hyperhidrosis. However, the pathway is simplified by recommending GPs could initiate treatment with an oral anticholinergic prior to referral into secondary care.

Detailed recommendations are found in the pathways in the Annexes at the end of this policy and also refer to the MKCCG formulary - <http://www.formularymk.nhs.uk/>.

**Guidance**

- Patients with localised hyperhidrosis (Hyperhidrosis Disease Severity Scale (HDSS) score of 1 -3) should be treated in primary care. Patients with generalised hyperhidrosis should be referred to secondary care.
- Appropriate self-management including over the counter medications and tap water iontophoresis should be tried before other measures are considered.
- Tap-water iontophoresis is non-invasive and should be offered for palmar, plantar and axillary hyperhidrosis. Axillary iontophoresis may be effective in practice despite lack of published evidence (expert opinion). Iontophoresis with glycopyrronium bromide is not recommended as the level of evidence for adding glycopyrronium bromide solution is weak and would not be cost-effective.
- Oxybutynin immediate release (IR, off-label) should be prescribed in preference to glycopyrronium bromide (unlicensed) or propantheline bromide (less effective). The level of evidence for oxybutynin IR and glycopyrronium bromide are of similar strength (weak).
- Endoscopic Thoracic Sympathectomy (ETS) should no longer be offered due to weak evidence and a significant risk of morbidity.
- Ablation surgery of the axillae should be offered as an alternative to botulinum toxin A in specialised centres.

### **Diagnostic criteria for primary hyperhidrosis**

- Focal visible excess sweating
- Present for at least 3 months
- No apparent secondary causes
- At least 2 of the following: Bilateral and symmetric
  - Impairs activities of daily life
  - At least one episode/week
  - Age of onset <25 years
  - Positive family history (in 60-80% of cases)
  - No symptoms during sleep

### **Lifestyle advice**

- Modify behaviour to avoid identified triggers (such as crowded rooms, caffeine, or spicy foods), where possible.

### **Conservative Treatment:**

#### **For people with primary axillary hyperhidrosis:**

- Use a commercial antiperspirant (as opposed to a deodorant) frequently.
- Avoid tight clothing and manmade fabrics.
- Wear white (as opposed to blue) shirts or black clothing to minimize the signs of sweating.
- Consider using dress shields (also known as armpit or sweat shields) to absorb excess sweat and protect delicate or expensive clothing. These can be obtained via the internet or the Hyperhidrosis Support Group.

#### **For people with primary plantar hyperhidrosis:**

- Wear moisture-wicking socks, changing them at least twice daily.
- Use absorbent soles, and use absorbent foot powder twice daily.
- Avoid occlusive footwear (such as boots or sports shoes; wear leather shoes).
- Alternate pairs of shoes on a daily basis to allow them to dry out fully before wearing them again.

#### **For people with primary craniofacial hyperhidrosis:**

- Avoid food and drink triggers where possible, if they exacerbate symptoms (including caffeinated products, chocolate, spicy or sour foods, hot foods, alcohol, foods or drinks containing citric acid, or sweets).

**Hyperhidrosis Disease Severity Scale (HDSS)**

<b>Subjective Score</b>	<b>Clinical Interpretation</b>
My sweating is never noticeable and never interferes with my daily activities	1 – mild
My sweating is tolerable but sometimes interferes with my daily activities	2 – moderate
My sweating is barely tolerable and frequently interferes with my daily activities	3 – severe
My sweating is intolerable and always interferes with my daily activities	4 - severe

**Procedure Codes**

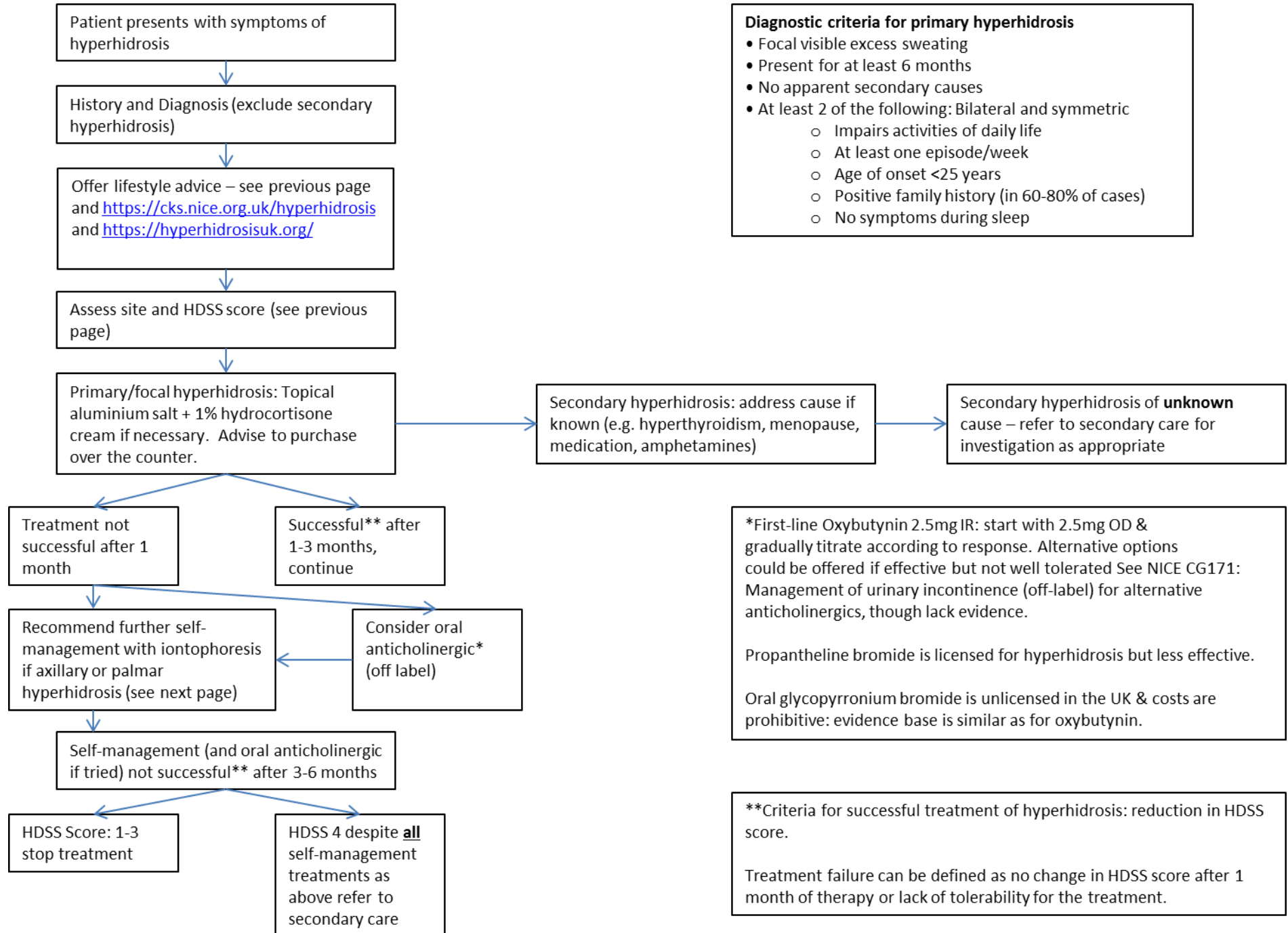
A752	Excision of thoracic sympathetic nerve
A762	Chemical destruction of thoracic sympathetic nerve
A772	Cryotherapy to thoracic sympathetic nerve
A782	Radiofrequency controlled thermal destruction of thoracic sympathetic nerve
A792	Destruction of thoracic sympathetic nerve NEC
S041	Excision of sweat gland bearing skin of axilla
S042	Excision of sweat gland bearing skin of groin
S043	Excision of sweat gland bearing skin NEC

**Evidence****References**

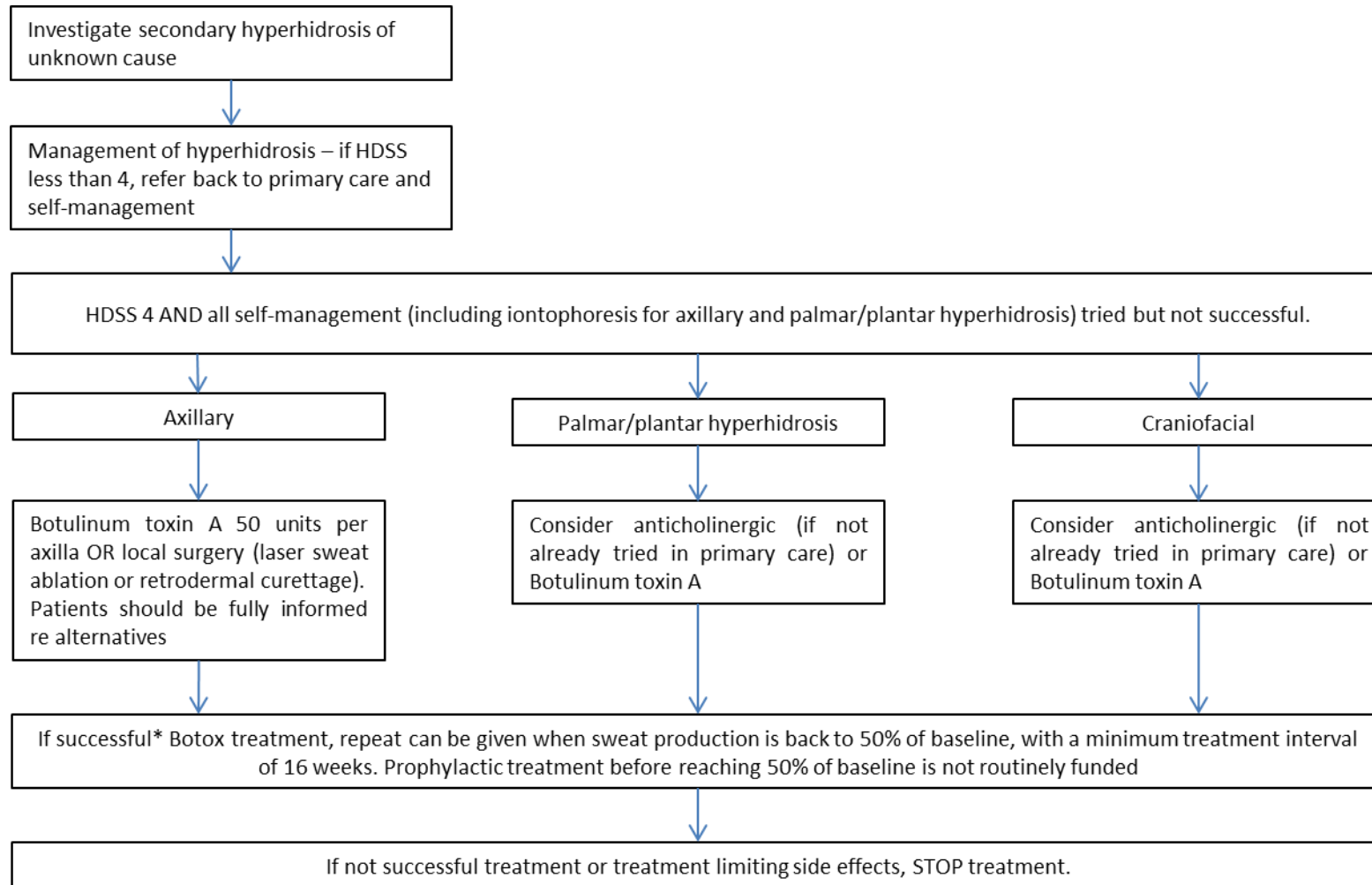
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3. Solish N et al. A comprehensive approach to the recognition, diagnosis, and severity-based treatment of focal hyperhidrosis: recommendations of the Canadian Hyperhidrosis Advisory Committee. Dermatol Surg 2007;33(8):908-23. Available online: [http://drypharmacistcom.ipage.com/uploads/2/9/5/9/2959076/chac\\_recommendations.pdf](http://drypharmacistcom.ipage.com/uploads/2/9/5/9/2959076/chac_recommendations.pdf)
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|  | <p>5. NICE Clinical Knowledge Summary - Hyperhidrosis. Last updated July 2013. Available online: <a href="http://cks.nice.org.uk">http://cks.nice.org.uk</a></p> <p>6. Shams K, Rzany BJ, Prescott LE, Musekiwa A. Interventions for excessive sweating of unknown cause (Protocol). Cochrane Database of Systematic Reviews 2011. Available at: <a href="http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD002953.pub2/full">http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD002953.pub2/full</a></p> |
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## Annex 1: Treatment of Focal Hyperhidrosis in Primary Care



## Annex 2: Treatment of Focal Hyperhidrosis in Secondary Care



\*Criteria for successful treatment of hyperhidrosis: reduction in HDSS score from 4 to 1-2 after 4 weeks of therapy (3 months for surgery).