Pathway for the Management of Hyperhidrosis

Introduction

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).[1] The most important issue in directing therapy for hyperhidrosis is to differentiate between generalised and localised and between subtypes of localised 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. Localised hyperhidrosis increases the risk of cutaneous infection and has a significant psychosocial burden and a negative impact on quality of life.[2]

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 (see appendix 1).[3]

This policy is broadly in line with a recent publication in the British Journal of Medicine[4] and the Clinical Knowledge Summary on hyperhidrosis[5]. However, the pathway is simplified by recommending GPs could initiate oral anticholinergic and iontophoresis prior to referral into secondary care. A Cochrane review is in preparation; the contents of this review should be reconsidered following publication.[6]

- Patients with localised hyperhidrosis should be treated in primary care and not referred to secondary care.
- Patients with generalised hyperhidrosis may be referred to secondary care.
- Oxybutinin (off-label) / glycopyrronium bromide (off-label). The level of evidence for oxybutynin and glycopyrronium bromide is of similar strength (weak). Propantheline bromide is the only oral anticholinergic licensed for hyperhidrosis in the UK but is considered to be less effective than oxybutynin or glycopyrronium.
- Endoscopic Thoracic Sympathectomy (ETS) is not commissioned due to weak evidence and significant risk of morbidity
- Tap-water iontophoresis is non-invasive and is appropriate for axillary, palmar, plantar and cranofacial hyperhidrosis. Costs are limited to activity costs for the initial treatment schedule.
- Iontophoresis with glycopyrronium bromide is not commissioned as the level of evidence for adding glycopyrronium bromide solution is weak and costs in primary care is prohibitive. It is not appropriate for ongoing prescriptions to originate from secondary care as patients could be discharged from the service after a successful trial of iontophoresis.

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[1] British Association of Dermatologists website. www.bad.org.uk. Accessed 06/06/2013
[2] Walling HW, Swick BL. Treatment Options for Hyperhidrosis. Am J Clin Dermatol 2011; 12 (5): 1-11
[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
[4] Benson RA, Palin R, Holt PJE. Diagnosis and management of hyperhidrosis. BMJ 2013;347: f6800. Doi: 10.1136//bmj.f6800 [Epub]. Available online : http://www.bmj.com/content/347/bmj.f6800.pdf%2Bhtml
[5] National Institute for Care and Excellence. NICE Clinical Knowledge Summary - Hyperhidrosis. Last updated July 2013. Available online: http://cks.nice.org.uk
[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: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD002953.pub2/full

NHS
Mid Essex Locality

History and diagnosis

Determine if secondary hyperhidrosis and address cause if known (e.g. hyperthyroidism, menopause, medication, amphetamines)
Offer lifestyle advice: http://cks.nice.org.uk/hyperhidrosis and http://www.hyperhidrosisuk.org/self-help.html.
Assess site to determine whether hyperhidrosis is local (axillary, palmar, plantar or craniofacial) or general
Determine HDSS score (see appendix 1) and treat if score is > 2

GENERALISED HYPERHIDROSIS

Gradual introduction of oral anticholinergic

- Oxybutinin Modified Release 5mg daily - up to 5mg four times a day
- Trospium Immediate Release 20mg daily - up to 20mg twice daily
- Propantheline 15mg three times a day, one hour before each meal, and 30mg at bedtime. May be increased up to 120mg per day.

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Partial success / some localised issues still present after at least 1 month – Iontophoresis recommended as **add-on** treatment

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Iontophoresis
(initial schedule day 1, 2, 4, 7, 10, 15, 22)
Assess after 1 month
Patients are expected to purchase their own machine for home treatment

LOCALISED HYPERHIDROSIS

Advise purchase of topical strong antiperspirants (20%-25% aluminium salts) e.g. Driclor ®; Anhydrol Forte®
Use at night in a cool environment without physical or emotional stress and wash off in the morning. For the first week it should be applied for 3 to 5 consecutive nights, then once or twice a week

If there is local irritation apply 1% hydrocortisone cream the morning after the treatment if necessary (also available to purchase over the counter (OTC)

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Not successful after at least 1 month – Recommend Iontophoresis

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Iontophoresis
(initial schedule day 1, 2, 4, 7, 10, 15, 22)
Assess after 1 month
Patients are expected to purchase their own machine for home treatment

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Not successful after at least 1 month – Refer to Secondary Care Dermatology clinic

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**Botulinum toxin A (Botox®)
Treatment may be repeated at intervals not less than 6 monthly

Successful treatment for hyperhidrosis can be defined as a reduction in HDSS from 3 or 4 to HDSS 1 or 2. Treatment failure can be defined as no change in HDSS score after 1 month of therapy or lack of tolerability for the treatment.

* There is no product available in the UK that is licensed for palmar or plantar hyperhidrosis other than axillary hyperhidrosis. Products are not interchangeable. Centres are advised to consult the latest information available from the manufacturers of the licensed products in the UK.

With botulinum toxin A injections, it is important to evaluate the treatment area: apparent failure may be due to a small area being missed. In this case, repeat treatment if the symptomatic area with a second round of botulinum toxin A injections (at the same or higher dose) should be done before considering the treatment unsuccessful. If successful, repeat injections can be given when production of sweat is back to 50% of baseline, with a minimum treatment interval of 6 months.

** Individual prior approval required for funding.

Appendix 1

Diagnosis of localised hyperhidrosis:

1. Focal visible excess sweating
2. Present for at least 6 months
3. No apparent secondary causes
4. 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)
   - Stops during sleep

Hyperhidrosis Disease Severity Scale (HDSS)

Subjective Score	Clinical interpretation
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

From:
Solish N, Benohanian A, Kowalski JW, Canadian Dermatology Study Group on Health-Related Quality of Life in Primary Axillary Hyperhidrosis. Prospective open-label study of botulinum toxin type A in patients with axillary hyperhidrosis: effects on functional impairment and quality of life. Dermatol Surg 2005; 31: 405-13.

Document reference	HyperhidrosisPAT201601v2.0final
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Approved by	Mid-Essex Area Prescribing Committee
Date approved	Jan 2016
Next review date	Jan 2018

Previous version	Key changes
Management of hyperhidrosis - version1.0	Document management added. Removal of glycopyrronium. Addition on Oxybutynin Modified Release. Pathway updated to reflect current practice.