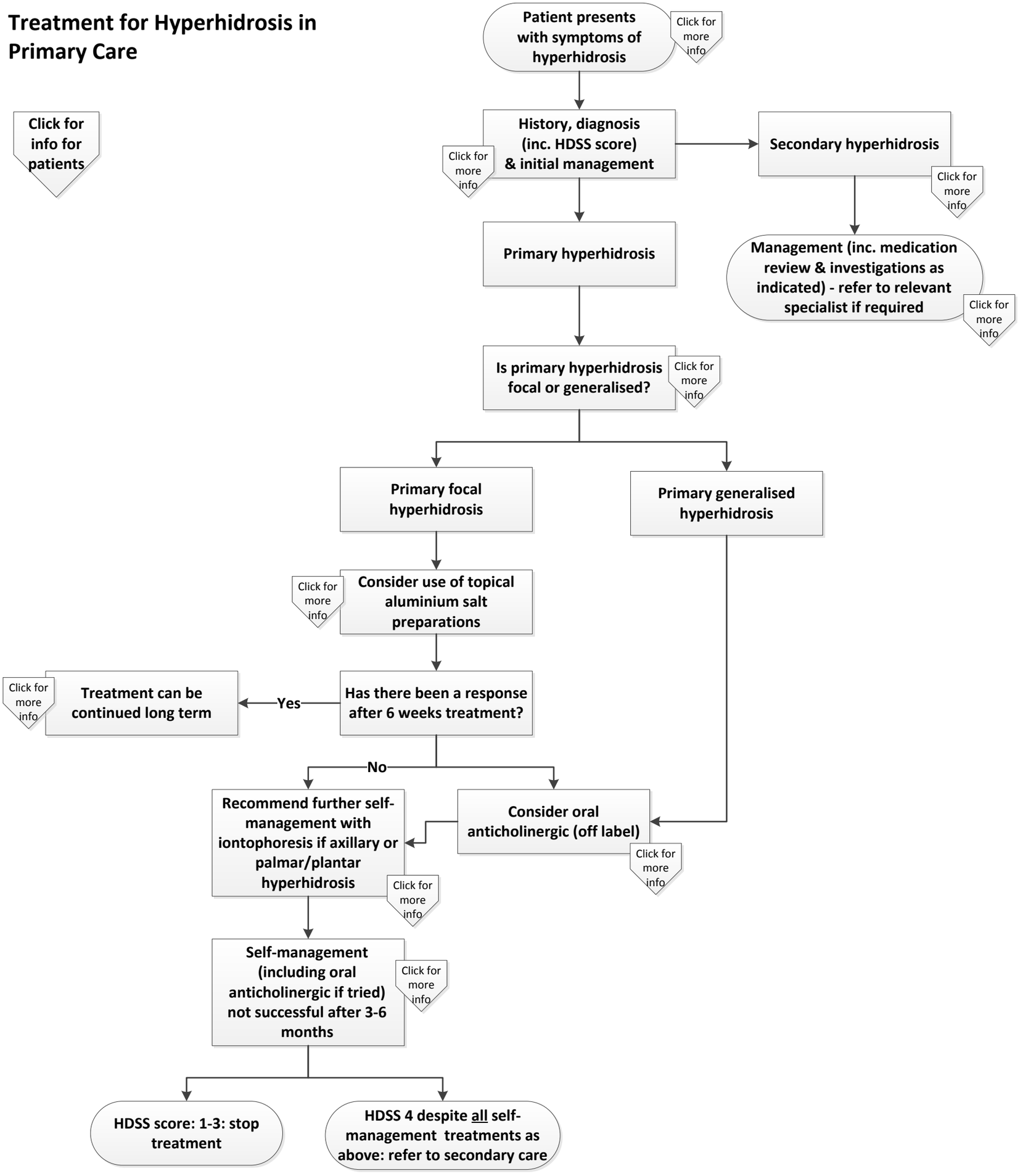
Treatment for Hyperhidrosis in Primary Care



Back to pathway

Patient presents with symptoms of hyperhidrosis

Hyperhidrosis describes sweating in excess of normal body temperature regulation.

(NB - Bromhidrosis describes unpleasant body odour, which may be associated with hyperhidrosis)

Back to pathway

History, diagnosis (including HDSS score) & initial management

1) The patient should be assessed to determine whether their hyperhidrosis is primary (idiopathic) or secondary (underlying cause(s) identified or suspected through clinical judgement).

NB - "if presentation is characteristic of primary focal hyperhidrosis and there is no evidence of an underlying cause, no laboratory tests are required"

History and examination to include can be found here: https://cks.nice.org.uk/hyperhidrosis#!diagnosisAdditional

2) Determine HDSS (Hyperhidrosis Disease Severity Scale) score

Subjective score

- 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

https://www.sweathelp.org/pdf/HDSS.pdf

3) Offer lifestyle advice (i.e. avoid identified triggers)

Nice/CKS Hyperhidrosis: https://cks.nice.org.uk/hyperhidrosis#!scenario

Hyperhidrosis UK: https://hyperhidrosisuk.org/treatment-options/self-help/

Back to pathway

Secondary hyperhidrosis

This is categorised (as for primary) into focal and generalised.
Both of these secondary types have an underlying cause.

Secondary **focal** hyperhidrosis affects certain body areas (e.g. armpits, hands, feet):

- causes include:
  - gustatory sweating (i.e. chewing, after eating or seeing food)
  - neurological disorders (e.g. spinal injuries or neuropathies)

Secondary **generalised** hyperhidrosis can be due to a number of underlying conditions/disorders:

- *infective*:
  - acute viral/bacterial infections;
  - chronic infections (tuberculosis, malaria, brucellosis)
- *drugs*:
  - alcohol
  - cocaine
  - heroin (including withdrawal)
  - ciprofloxacin
  - aciclovir
  - esomeprazole
  - sertraline
  - other antidepressants
- *endocrine*:
  - diabetes
  - hyperthyroidism
  - menopause
  - pregnancy
  - carcinoid syndrome
  - hyperpituitarism
  - pheochromocytoma
  - acromegaly
- *neurological*:
  - stroke
  - spinal cord injuries
  - gustatory sweating post-parotidectomy
  - Parkinson's disease
- *other*:
  - lymphoma and other myeloproliferative disorders
  - congestive heart failure
  - anxiety
  - obesity

Back to pathway

Is primary hyperhidrosis focal or generalised?

Primary **focal** hyperhidrosis may affect the axillae, palms, soles, scalp, or limb stump. It has no underlying cause.

Do symptoms fit diagnostic criteria for primary focal hyperhidrosis?

- Focal visible excess sweating
  - Occurs in at least one of the following sites: axillae, palms, soles, or craniofacial region, *and*
  - Present for at least 6 months, *and*
  - No apparent secondary causes, *and*
  - 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

Primary **generalised** hyperhidrosis affects the entire body; and has no underlying cause
(**NB** - ensure you have excluded potential *secondary* causes; see "Secondary Hyperhidrosis")

Back to pathway

Not successful after 1 month or treatment limiting side-effects

NOT successful after 1 month or treatment limiting side-effects:

- HDSS 1-2: stop treatment
- HDSS 3-4: refer to secondary care

Back to pathway

Management (inc. medication review & investigations as indicated) - refer to relevant specialist if required

If clinical judgement leads to suspected cause for secondary hyperhidrosis, manage as appropriate:
i.e. review medications, arrange relevant investigations and refer (if required) to relevant specialist.

e.g. if obesity is the likely cause, manage as per Obesity pathway.

Baseline investigations may include:

- Full blood count.
- Erythrocyte sedimentation rate and/or C-reactive protein.
- Urea and electrolytes.
- Liver function tests.
- HbA1c.
- Thyroid function tests.
- Tests for HIV or tuberculosis, if indicated — see the CKS topics on HIV infection and AIDS and Tuberculosis for more information.
- Blood film for malarial parasites, if indicated — see the CKS topic on Malaria for more information.
- Chest X-ray.

Back to pathway

Consider use of topical aluminium salt preparations

Advise on the use of topical aluminium salt preparations for symptom relief.

- Recommend the use of 20% aluminium chloride hexahydrate preparations such as roll-on antiperspirants and sprays, which are available over-the-counter.
- Advise on the correct application technique:
  - Apply at night just before sleep to skin of the axillae, feet, or hands which has been carefully dried (avoiding the eyes, mucous membranes, and broken skin).
  - Wash the product off in the morning.
  - Apply every 1–2 days as tolerated, until symptoms improve. Following this, use as required, which may be up to every 6 weeks.
  - Avoid shaving the area and using hair removal products within 12 hours of application, and do not bathe immediately before use.
  - For craniofacial hyperhidrosis, consider soaking lotion pads for application to the face (off-label use).

If skin irritation occurs with the application of topical aluminium salt preparations:

- Advise on the use of topical emollients and soap substitutes.
- Advise the person to reduce the frequency of topical aluminium salt application until symptoms resolve.
- Consider prescribing a mildly-potent topical corticosteroid in addition, such as hydrocortisone 1% cream to be applied once daily for up to two weeks.
  - See the CKS topic on Corticosteroids - topical (skin), nose, and eyes for more information

Back to pathway

Treatment can be continued long term

Criteria for successful treatment of hyperhidrosis: reduction in HDSS score.

Treatment failure can be defined as no change in HDSS score after 1 month of therapy or lack of tolerability for the treatment

Back to pathway

Consider oral anticholinergic (off label)

First-line Oxybutynin 2.5mg IR: start with 2.5mg OD & gradually titrate according to response. Alternative options could be offered if effective but not well tolerated See NICE CG171: Management of urinary incontinence (off-label) for alternative anticholinergics, though lack evidence.

Propantheline bromide is licensed for hyperhidrosis but less effective.

Oral glycopyrronium bromide is unlicensed in the UK & costs are prohibitive: evidence base is similar as for oxybutynin.

Back to pathway

Self-management (including oral anticholinergic if tried) not successful after 3-6 months

Criteria for successful treatment of hyperhidrosis: reduction in HDSS score.

Treatment failure can be defined as no change in HDSS score after 1 month of therapy or lack of tolerability for the treatment

Back to pathway

Recommend further self-management with iontophoresis if axillary or palmar/plantar hyperhidrosis

Patients are expected to purchase their own machine for home treatment (there are companies with money-back guarantees if product unsuccessful)

Back to pathway

Information for patients

Support for suffers can be found here: http://www.hyperhidrosisuk.org/