Treatment pathway for hyperhidrosis in primary care

St George's University Hospitals NHS Foundation Trust
Wandsworth CCG
NHS Merton Clinical Commissioning Group

1. Initial assessment

Determine if hyperhidrosis is primary (focal or generalised) or secondary (see below :)

- Pregnancy
- Anxiety
- Drug history (anticholinesterases, antidepressants, propranolol)
- Irregular periods (menopause)
- Palpitations and heat intolerance (thyrotoxicosis)
- Diabetes (autonomic neuropathy, hypoglycaemia)
- Nightsweats (haematological malignancy or TB)
- Weight loss (malignancy)
- Substance misuse (ETOH withdrawal, amphetamines)

If secondary – treat underlying cause

Assessment of primary hyperhidrosis

- Assess site – e.g. axillary, palmo-plantar/ craniofacial if focal
- Assess impact on daily life - HDSS score (Hyperhydrosis Disease Severity Scale)

Score	Description
1	My sweating is never noticeable and never interferes with my daily activities
2	My sweating is tolerable but sometimes interferes with my daily activities
3	My sweating is barely tolerable and frequently interferes with my daily activities
4	My sweating is intolerable and always interferes with my daily activities

2. Lifestyle advice for primary hyperhidrosis

- Avoid known triggers (e.g. crowded rooms, caffeine, spicy foods etc.) where possible
- For axillary hyperhidrosis - avoid tight clothing and manmade fabrics, wear white clothing to minimise signs of sweating, consider armpit shields
- For plantar hyperhidrosis – moisture-wicking socks, changing socks twice daily, absorbent soles, absorbent foot powder e.g. Zeasorb®dusting powder (to be purchased OTC)*, avoid occlusive footwear, alternate pairs of shoes daily to allow them to dry out

3. Treatment of Primary HyperHidrosis

Primary focal hyperhidrosis

Topical strong antiperspirants (20%-25% aluminium salts) e.g. Driclor ®; Anhydrol Forte®

Patient should be asked to purchase OTC* (see NHSE self-care guidance)

- Instructions for use: use at night in a cool environment 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 for 1 month
  - If there is local irritation, manage with emollients, reduction in frequency of application or apply 1% hydrocortisone cream the morning after the treatment if necessary (also purchased OTC)

*https://www.england.nhs.uk/medicines/conditions-for-which-over-the-counter-items-should-not-routinely-be-prescribed/

If successful after 1 month (reduction in **HDSS from 3or 4 to 1 or 2**) – continue and review any prescribed medications regularly

If not successful after one month

Primary generalised hyperhidrosis

Oral anticholinergics:

- Propantheline 15mg three times a day, one hour before each meal, and 30mg at bedtime. May be increased up to 120mg per day.

Anti-cholinergic should be taken one hour before the application of aluminium chloride, preventing sweating and irritation – need to counsel patients re: possible side effects e.g. constipation, blurred vision, dry mouth, photophobia, dry skin and urinary retention. Contraindications: significant bladder outflow obstruction, and gastro-intestinal

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

- **HDSS 1-2**: stop treatment and manage with life style advice and OTC topical treatments
- **HDSS 3-4:** refer to secondary care for consideration of botox injections/iontophoresis for focal disease or generalised disease unresponsive to above treatments. IFR application by specialist.

Patient leaflet: http://www.bad.org.uk/shared/get-file.ashx?id=93&itemtype=document
NICE CKS: https://cks.nice.org.uk/hyperhidrosis#!scenario
The Hyperhidrosis Support Group: www.hyperhidrosisuk.org

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