

Excluded: Procedure not routinely funded

Bedfordshire, Hertfordshire, West Essex, Luton and Milton Keynes Priorities Forum statement - adapted for Bedfordshire CCG

Number	51
Subject	The Management of Hyperhidrosis
Date of decision	October 2017
Date of review	October 2020

GUIDANCE

- Patients with localised hyperhidrosis (Hyperhidrosis Disease Severity Scale (HDSS) score of 1 -3) should be supported with self-management or primary care management. 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 recommended for self-management in patients with 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 for this indication) 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
- Botulinum toxin A should only be offered for patients with HDSS score of 4 AND all self-management (including iontophoresis for axillary and palmar/plantar hyperhidrosis) has been tried but not successful. Funding will be on a case by case basis only (prior approval or IFR)
- For those with hyperhidrosis in amputation stumps, HDSS should not be used to determine treatment in this cohort, and referral should be made after failure of conservative measures such as wicking socks tried by the orthotics department have failed if sweating is interfering with prosthetic fit or function. Funding will be on a case by case basis only (prior approval or IFR)

*Bedfordshire and Luton Joint Prescribing Committee has agreed that either oxybutynin immediate release or propantheline can be used as a first line oral anticholinergic. This recommendation has been supported by LCCG and BCCG Executive Teams.

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).¹ 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.

Diagnostic criteria for primary hyperhidrosis

- Focal visible excess sweating
- Present for at least 6 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

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

Lifestyle advice

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

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).

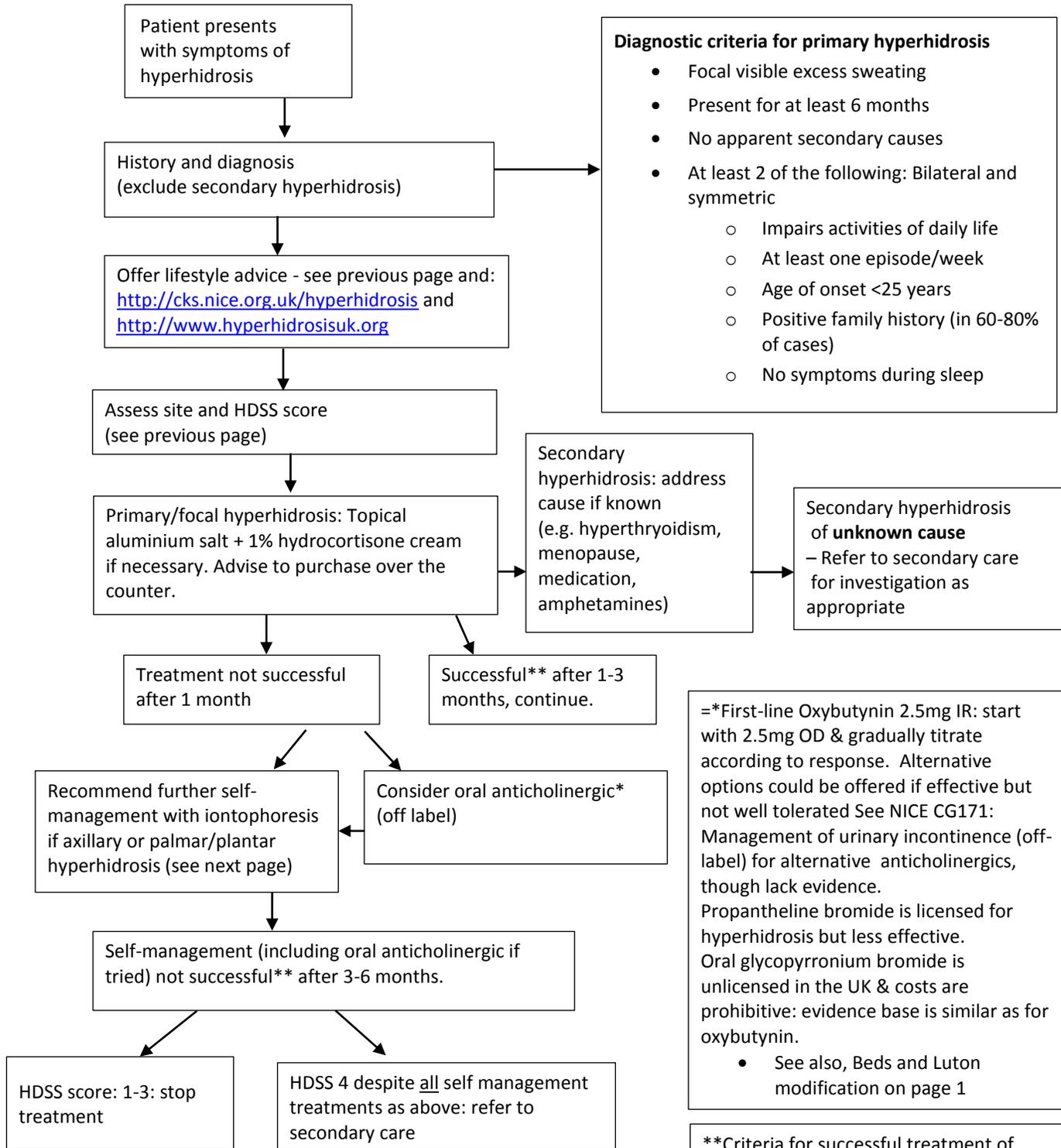
For people with amputation stump hyperhidrosis

Given the significant impact that this condition can have on the rehabilitation and ongoing function of this patient cohort, the recommendation is that access to botox injections is considered in the hyperhidrosis pathway for those who suffer from residual limb hyperhidrosis affecting prosthetic limb function or fit. Although the evidence around it is weak, what does exist seems to suggest a good effect and the procedure has had its safety demonstrated in treatment of hyperhidrosis in other areas. Topical measures may still be considered but the possibility of skin reactions (although very low-quality evidence covered here – expert opinion only) should be taken into account and monitored closely, with a low threshold for discontinuing treatment. Basic measures such as wicking socks can be provided by the prosthetics and orthotics services prior to onward referral, and further management should take a multidisciplinary approach. Additionally, the HDSS should not be used to determine treatment in this cohort, and referral should be made after failure of conservative measures such as wicking socks tried by the orthotics department have failed if sweating is interfering with prosthetic fit or function.

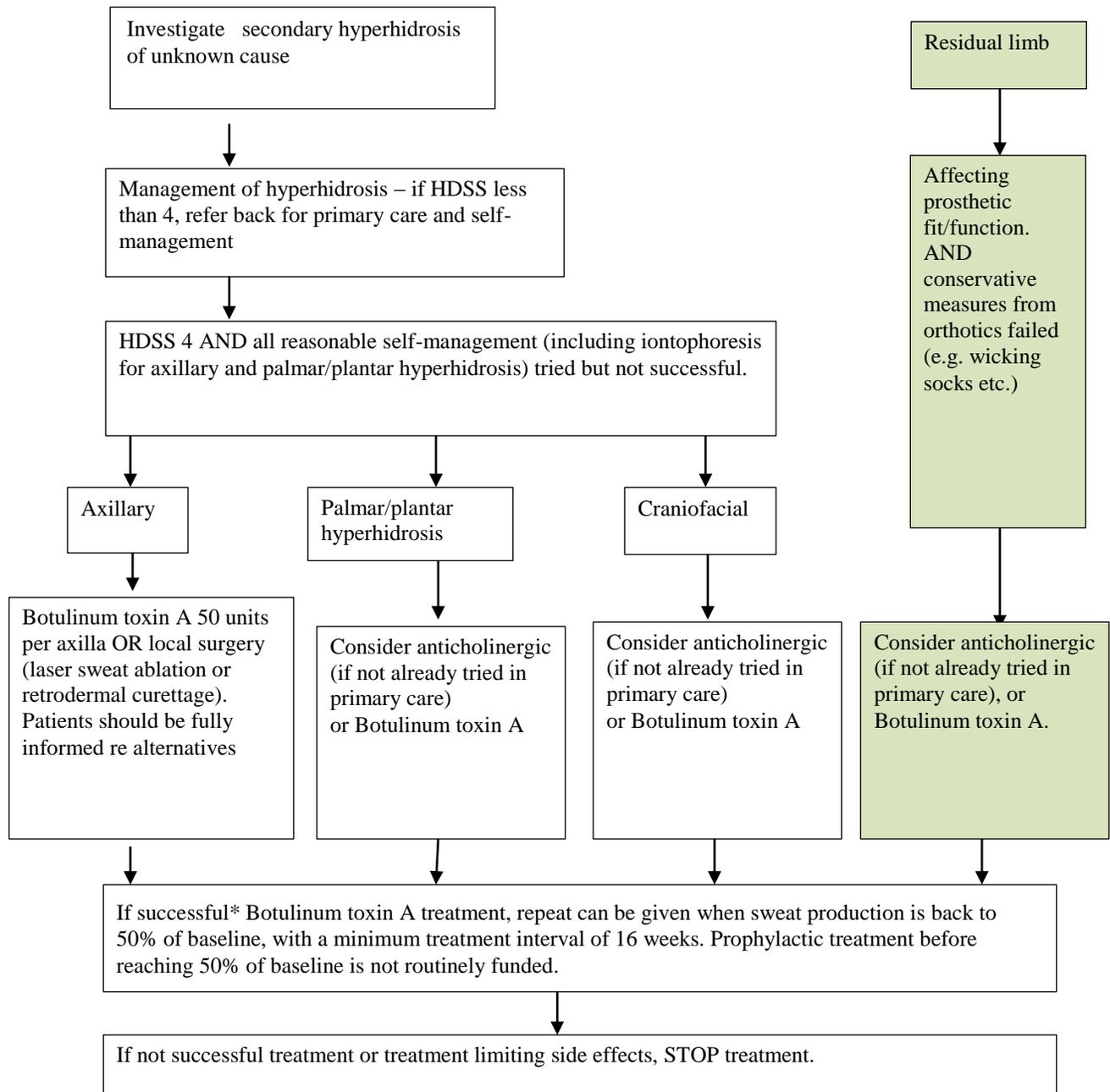
Practitioners must collect auditable information. Funding will be on a case by case basis via IFR/prior approval.

Human Rights and Equality Legislation has been considered in the formation of this guidance

Annex 1: Treatment for Focal Hyperhidrosis in Primary Care



Annex 2: Treatment for 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).
 In residual limb: Improved reported fit/function of prosthesis due to reduction in sweating.