South East London Adult Hyperhidrosis - treatment pathway for *Primary Care*

History and diagnosis
Establish Primary or Secondary

Secondary hyperhidrosis:
1. Treat underlying cause
2. Refer to appropriate speciality
3. Manage symptoms with topical treatments

1. Characterise[1] primary hyperhidrosis
   - Generalised
   - Focal → palmoplantar, axillary, craniofacial
2. Calculate baseline HDSS [2]
3. **Management:**

a) Self-care:
- High-strength antiperspirants e.g. aluminium salts (Driclor® or Anhydrol Forte®)
- General advice[3] and support group (The Hyperhidrosis Support Group at www.hyperhidrosisuk.org The International Hyperhidrosis Society at www.sweathelp.org)

b) Prescribing options:
- Craniofacial hyperhidrosis- Trial **glycopyrrolate 2% w/w in cetomacrogol A cream** (BAD approved special). Apply to affected area twice daily.
- Oral anticholinergics (generalised but can be used in focal[4])
  1. **First line:** Oxybutynin immediate release 2.5mg daily up to 5mg three times a day
  2. **Second line options,** where there are intolerable adverse effects or inefficacy of oxybutynin IR – consider either:

(i) oxybutynin modified release 5-10mg daily or
(ii) Propantheline 15mg three times a day and 30mg at night (maximum total daily dose 120mg)

Also see SEL Area Prescribing Committee **Recommendation 077** for further information.

4. Recalculate HDSS post **1 month** of each treatment trial - aim for reduction of HDSS to 1 or 2

c) 5. Refer to secondary care (**dermatology**) if HDSS 3 or 4 despite above measures. **NOTE for focal hyperhidrosis- earlier consideration may be given for referral to dermatology for a trial of tap water iontophoresis.**

[4] See NICE hyperhidrosis evidence summary
http://www.nice.org.uk/advice/es10/chapter/key-points
Anti-muscarinic adverse effects: constipation, dry mouth, nausea, confusion, dizziness, headache, somnolence, blurred vision, urinary retention, flushing and dry skin
Anticholinergic burden: Many medicines have anticholinergic activity as a secondary pharmacological effect (e.g. some any psychotics, antidepressants, furosemide, some antiepileptics), and the additive cholinergic burden should be considered if intending to use oxybutynin or propanthaline in patients taking other agents with anticholinergic activity.

[1] Diagnosis of 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); Stops during sleep

[2] Hyperhidrosis 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

[3] Advice for primary focal hyperhidrosis:
Recommend the following lifestyle measures: Modify behaviour to avoid triggers (crowded rooms, caffeine, or spicy foods)
Primary axillary hyperhidrosis: Use a commercial antiperspirant frequently; avoid tight clothing and manmade fabrics; wear white shirts or black clothing to minimise the signs of sweating; consider using dress shields to absorb sweat and protect clothing
Primary plantar hyperhidrosis: Wear moisture-wicking socks, changed twice daily; use absorbent soles and use foot powder twice daily; avoid occlusive footwear
Alternate pairs of shoes on a daily basis
Primary craniofacial hyperhidrosis: Avoid food and drink triggers (caffeine, chocolate, spicy or sour foods, hot foods, alcohol, citric acid or sweets)

South East London Adult Hyperhidrosis treatment pathway - Secondary Care

General Clinic:
1. Verify above steps taken and confirm diagnosis
2. Calculate baseline HDSS

Generalised hyperhidrosis:
- Optimise systemics
- Combined approach

Focal hyperhidrosis:

Axillary

Day Surgery Laser Unit (DSLU) referral *(via EPR)*
- Funding for treatment of axillary hyperhidrosis with botulinum toxin (Botox™ licensed, 50 units in each axillae) as per SEL Treatment Access Policy criteria if:
  - Severe (HDSS 3 or 4)
  - Failed 6 month trial of conservative management including topical aluminium chloride or extra strength antiperspirant, general measures[3]
- Further treatments, at intervals of no less than 16 weeks, will only be commissioned provided at least a 2 point reduction on HDSS score can be shown during the 4 months following initial treatment.
- This pathway will be subject to audit and monitoring requirements.
- NOTE: Indications for botulinum toxin other than axillary hyperhidrosis require IFR funding approval

Palmoplantar

Iontophoresis pathway on Dermatology Day Centre (via EPR):
1. Trial tap water iontophoresis x 7
2. Assess treatment efficacy. If stable and has purchased own machine provide information and training for home iontophoresis.

   If symptoms remain uncontrolled:
3. Consider combined prescription with systemic anticholinergic
4. Offer glycopyrronium iontophoresis x 2
5. Recalculate HDSS to demonstrate efficacy
6. If efficacy demonstrated, to continue glycopyrronium iontophoresis
7. If patient is stable and has purchased own machine, prescribe glycopyrronium 0.1% aqueous solution via outpatient prescription (submission of B* notification form to commissioners required) to enable continuation of glycopyrronium supply from the hospital for use at home.

Craniofacial

Glycopyrrolate 2% w/w in cetomacrogol A cream (BAD approved special). Apply to affected area up to a maximum of twice daily.

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