Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Evidence Based Intervention

Hyperhidrosis

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Policy: Hyperhidrosis

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).
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).

The diagnostic criteria for primary hyperhidrosis are:

- 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

The severity of hyperhidrosis symptoms should be assessed using the Hyperhidrosis Disease Severity Scale (HDSS). This is easy to use and validated against other questionnaires. The HDSS asks patients to rate the severity of their hyperhidrosis as one of the following:

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

A score of 1 or 2 indicated mild or moderate hyperhidrosis, a score of 3 or 4 indicates severe hyperhidrosis.

Recommendation

Patients with localised hyperhidrosis should be supported in primary care to trial self-management. The first stage of this is lifestyle advice, including:

All patients:

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

For patients 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 patient 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 patients 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).

If lifestyle advice has not been successful, then patients should trial topical aluminium salt preparations for 1 month. 1% hydrocortisone cream may be useful for patients who experience adverse reactions from these products. These are available over the counter and should not be prescribed.

Patients with axillary, plantar or palmar hyperhidrosis may gain benefit from iontophoresis. Iontophoresis devices are available for patients to buy if they wish to continue self-management techniques.

If patients do not achieve a 1-point reduction in HDSS with self-management then an oral anticholinergic may be considered. If patients continue to have severe (HDSS = 4) symptoms of hyperhidrosis following a 3-6 month trial of oral anticholinergic medication then they may be referred to secondary care for the consideration of botulinum toxin injections, laser sweat ablation or retrodermal curettage. Endoscopic thoracic sympathectomy (ETS) is not normally funded.

If secondary care treatment approved and successful (HDSS of 1 or 2 after 4 weeks for botulinum toxin or after 4 months for surgery) it may be repeated when HDSS scores increase by 1 point, with a minimum treatment interval of 16 weeks.
Patients with generalised hyperhidrosis should be referred to secondary care if addressing the cause of hyperhidrosis is not effective, or if the cause is not known.

Patients with amputation stump hyperhidrosis which is affecting prosthetic fit and function which has not been resolved with basic measures such as wicking socks should be referred to secondary care for consideration of botulinum toxin injections. Topical measures may still be considered but the possibility of skin reactions should be taken into account and monitored closely, with a low threshold for discontinuing treatment. The HDSS should not be used to determine treatment in this patient group.
Detailed recommendations are found in the pathways in the Annexes at the end of this policy.

Clinical coding: OPCS codes:
S532 – Injection of therapeutic substance into skin
A752 – Excision of thoracic sympathetic nerve
A759 – Unspecified excision of sympathetic nerve
ICD10 codes:
R61 – Hyperhidrosis
R610 – Localised hyperhidrosis
R611 – Generalised hyperhidrosis
R619 – Hyperhidrosis (unspecified)

Key words: Hyperhidrosis, Botulinum toxin, iontophoresis, sweating

Patients who are not eligible for treatment under this policy may be considered on an individual basis where their GP or consultant believes exceptional circumstances exist that warrant deviation from the rule of this policy. Individual cases will be reviewed as per the ICB policy.

Rationale

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.

Endoscopic Thoracic Sympathectomy is not normally funded due to a significant risk of complications.

Patients 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.
NOTE:

- This policy will be reviewed in the light of new evidence or new national guidance, eg, from NICE.
- Where a patient does not meet the policy criteria or the intervention is not normally funded by the NHS, an application for clinical exceptionality can be considered via the Individual Funding Request (IFR) Policy and Process.

References:

British Medical Journal Best Practice Guideline: Hyperhidrosis – Symptoms, diagnosis and treatment (2020). https://bestpractice.bmj.com/topics/en-gb/856

NICE Clinical knowledge Summary – Hyperhidrosis (2018). https://cks.nice.org.uk/topics/hyperhidrosis/

NICE Interventional Procedure Guidance 487: Endoscopic thoracic sympathectomy for primary hyperhidrosis of the upper limb (2014). https://www.nice.org.uk/guidance/ipg487/chapter/1-Recommendations

Glossary:

Iontophoresis – A treatment where a small electric current is passed through water, aiming to shut down the sweat glands temporarily
Endoscopic Thoracic Sympathectomy – A surgical procedure dividing appropriate parts of the sympathetic chain beside the vertebral column
Axillary hyperhidrosis – Hyperhidrosis affecting the armpits
Plantar hyperhidrosis – Hyperhidrosis affecting the soles of the feet
Palmar hyperhidrosis – Hyperhidrosis affecting the palms
Craniofacial hyperhidrosis – Hyperhidrosis affecting the forehead

Change History:

Version	Date	Reviewer(s)	Revision Description
V1.1	November 2023	M Skerry	Remove reference to CCG

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