NHS
Dorset
Clinical Commissioning Group

# Policy statement - Management of hyperhidrosis

- Patients with localised mild-moderate hyperhidrosis (HDSS 1-2) should be treated in primary care and not referred to secondary care (see appendix 1 for severity scale).
- Patients with generalised hyperhidrosis should be referred to secondary care.
- Oxybutinin immediate release (IR) (off-label) should be prescribed in preference to glycopyrronium bromide (unlicensed). The level of evidence for oxybutynin IR and glycopyrronium bromide are of similar strength (weak). Propantheline bromide is the only oral anticholinergic licensed for hyperhidrosis in the UK but is considered to be less effective than oxybutynin or glycopyrronium. Prescribing of (unlicensed) glycopyrronium is not routinely commissioned and any prescribing should have been approved on an individual patient basis through the CCG's individual request process based on a patient's exceptionality.
- Endoscopic Thoracic Sympathectomy (ETS) is only commissioned following a multidisciplinary approach which supports it with both dermatology consultant and thoracic surgeon opinion. The evidence for benefit of this intervention is weak and there is significant risk of morbidity
- Tap-water iontophoresis is non-invasive and may be used for palmar, plantar and axillary hyperhidrosis. Axillary iontophoresis is effective in practice despite lack of published evidence (expert opinion). Costs are limited to activity costs for the initial treatment schedule.
- The evidence for using glycopyrronium bromide solution with iontophoresis is weak and costs in primary care are prohibitive. Where the use of glycopyrronium bromide solution with iontophoresis is being considered the supply of glycopyrronium bromide solution should remain with secondary care as a "red" drug.

**Introduction**

- 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.[2]
- 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 (see appendix 1).[3]

- This policy is broadly in line with a recent publication in the British Journal of Medicine[4] and the Clinical Knowledge Summary on hyperhidrosis[5]. However, the pathway is simplified by recommending GPs could initiate oral anticholinergic prior to referral into secondary care. A Cochrane review is in preparation; the contents of this review should be reconsidered following publication.[6]

**Notes about the pathway documents**

- In either pathway, **successful treatment** for hyperhidrosis can be defined as a reduction in HDSS from 3 or 4 to HDSS 1 or 2.
- For the primary care pathway, **treatment failure** can be defined as no change in HDSS score after 1 month of therapy or lack of tolerability for the treatment.
- For the secondary care pathway, **treatment failure** can be defined as no change in HDSS score after 4 weeks of therapy (3 months for surgery) or lack of tolerability for the treatment.
- With botulinum toxin A (BTX-A) injections, it is important to evaluate the treatment area: apparent failure may be due to a small area being missed. In this case, repeat treatment if the symptomatic area with a second round of BTX-A injections (at the same or higher dose) should be done before considering the treatment unsuccessful. If successful, repeat injections can be given when production of sweat is back to 50% of baseline, with a minimum treatment interval of 16 weeks. (This treatment is not available in Dorset)

## References


1. British Association of Dermatologists website. www.bad.org.uk. Accessed 06/06/2013
2. Walling HW, Swick BL. Treatment Options for Hyperhidrosis. Am J Clin Dermatol 2011; 12 (5): 1-11
3. Solish N et al. A comprehensive approach to the recognition, diagnosis, and severity-based treatment of focal hyperhidrosis: recommendations of the Canadian Hyperhidrosis Advisory Committee. Dermatol Surg 2007;33(8):908-23.. Available online: http://drypharmacistcom.ipage.com/uploads/2/9/5/9/2959076/chac_recommendations.pdf
4. Benson RA, Palin R, Holt PJE. Diagnosis and management of hyperhidrosis. BMJ 2013;347: f6800. Doi: 10.1136//bmj.f6800 [Epub]. Available online : http://www.bmj.com/content/347/bmj.f6800.pdf%2Bhtml
5. National Institute for Care and Excellence. NICE Clinical Knowledge Summary - Hyperhidrosis. Last updated July 2013. Available online: http://cks.nice.org.uk
6. Shams K, Rzany BJ, Prescott LE, Musekiwa A. Interventions for excessive sweating of unknown cause (Protocol). Cochrane Database of Systematic Reviews 2011. Available at: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD002953.pub2/ful



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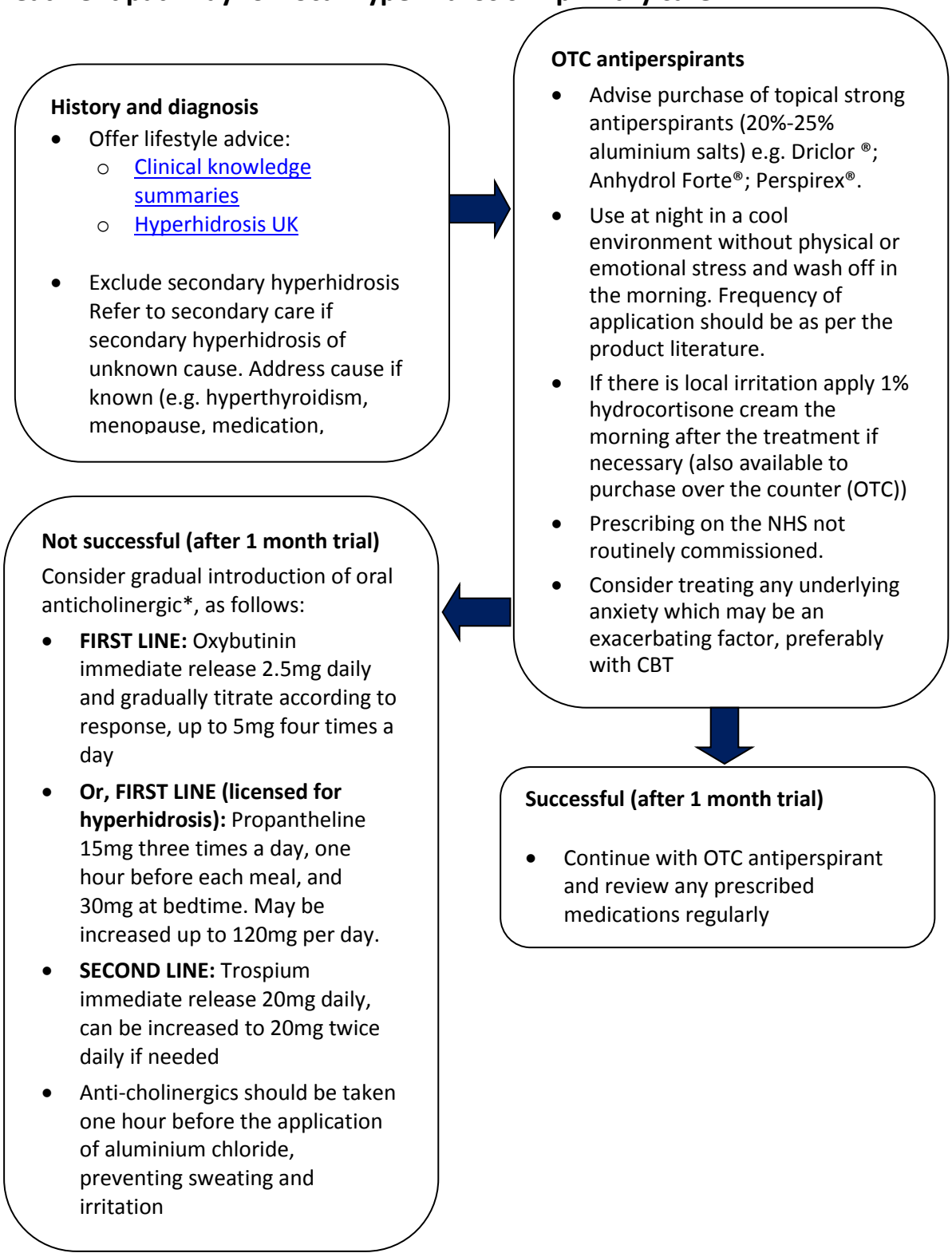
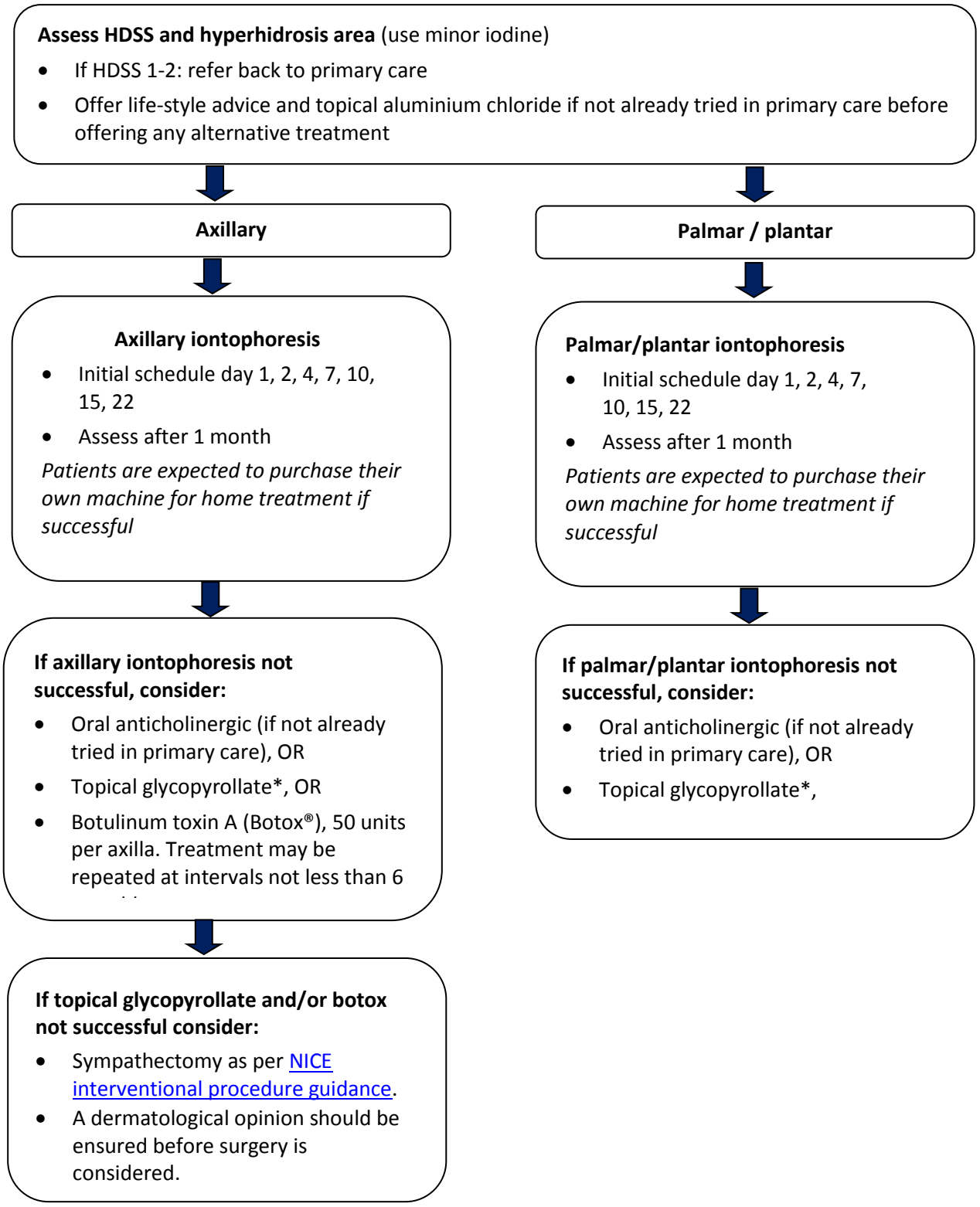
## Treatment pathway for focal hyperhidrosis in primary care




*Alternative anticholinergic options could be offered if effective but not well tolerated (see NICE CG171: Management of urinary incontinence (off-label) for alternative anticholinergics) though evidence is lacking. For more information about licensing status and doses of oral anticholinergic options, refer to appendix 2.

Glycopyrronium bromide is unlicensed in the UK and costs are prohibitive; evidence base is similar as for oxybutynin. Prescribing of glycopyrronium bromide is not supported unless there are exceptional clinical circumstances and existing patients should be assessed and switched whenever possible.

## Treatment pathway for hyperhidrosis in secondary care (HDSS 3-4 only)




***Topical glycopyrollate is recognised by BAD as an option for treating hyperhidrosis.

## Appendix 1: Diagnosis of primary hyperhidrosis

## Symptoms and signs

- 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

## 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 |

Taken From:

*Solish N, Benohanian A, Kowalski JW, Canadian Dermatology Study Group on Health-Related Quality of Life in Primary Axillary Hyperhidrosis. Prospective open-label study of botulinum toxin type A in patients with axillary hyperhidrosis: effects on functional impairment and quality of life. Dermatol Surg 2005; 31: 405-13.*

## Appendix 2

**INFORMATION ABOUT ORAL ANTICHOLINERGICS**

| Choice | Licensing status | Formulary status | Dose | Cost per month[1] |
|---|---|---|---|---|
| **FIRST LINE:** Oxybutinin immediate release | Not licensed for hyperhidrosis (use for this indication will be 'off-label') | Green | 2.5mg daily and gradually titrate according to response up to 5mg four times a day | £1.03 - £4.94 |
| **FIRST LINE (LICENSED OPTION):** Propantheline | Licensed for hyperhidrosis | Green | 15mg three times a day one hour before each meal and 30mg at bedtime. May be increased up to 120mg per day. | £26 - £41.48 |
| **SECOND LINE:** Trospium immediate release | Not licensed for hyperhidrosis (use for this indication will be 'off-label') | Green | 20mg daily can be increased to 20mg twice daily if needed | £12.38 - £24.75 |

1. Drug Tariff Sept 2015