

## **PRIMARY FOCAL HYPERHIDROSIS – MANAGEMENT GUIDELINES**

The diagnosis of primary focal hyperhidrosis can be made when focal, visible, excessive sweating occurs in at least one of the following sites: axillae, palms, soles, or craniofacial region, and:

- Has lasted at least 6 months, and
- Has no apparent cause, and
- Has at least two of the following characteristics:
  - Bilateral and relatively symmetrical
  - Impairs daily activities
  - Frequency of at least one episode per week
  - Onset before 25 years of age
  - Positive family history
  - Cessation of local sweating during sleep.
- If symptoms have lasted less than 6 months or onset is at 25 years of age or older, primary focal hyperhidrosis remains a likely diagnosis if other criteria are met, but extra care should be taken to exclude an underlying cause such as obesity, diabetes, thyrotoxicosis, alcoholism, chronic infection and drugs such as antidepressants.
- If the presentation is characteristic of primary focal hyperhidrosis and there is no evidence of an underlying cause, no laboratory tests are needed.

### **Management**

Managing patient expectations is important. Give links to patients for further information (see links below). Patients should be advised that anxiety and heat will make the sweating worse.

### **PALMS AND SOLES**

#### ***PRIMARY CARE MANAGEMENT***

##### **1) Aluminium chloride**

Preparations such as Anhydrol forte can be used. If it proves ineffective its effect can be enhanced by the wearing of polythene gloves overnight or the use of cling film. Reduced frequency of application and the use of hydrocortisone cream can improve tolerability and success.

##### **2) Antimuscarinic drugs**

Propantheline 15mg bd increasing to a maximum of 30mg qds can be used but side effects including a dry mouth and blurred vision limit the dosage and effectiveness. Glaucoma is a contraindication. Other Antimuscarinic drugs such as Oxybutynin (5mg od-tds) and Glycopyrrolate (topical powder or tabs – Robinul 2mg od-tds - may have to be ordered in by pharmacist) are not licensed for treatment of hyperhidrosis but are preferred by some patients.

#### ***SECONDARY CARE MANAGEMENT***

##### **3) Iontophoresis**

Using tap-water can be highly effective. The mechanism is uncertain and the effect lasts from a few days to a few weeks. If an initial course of treatments at hospital is successful, patients can buy a unit for treatment at home.

##### **4) Surgery**

For disabling palmar hyperhidrosis some surgeons undertake endoscopic transthoracic sympathectomy if all else has failed. Although effective, a significant number of patients develop compensatory hyperhidrosis elsewhere which can be even more distressing. Careful pre-op counselling is essential.

## **AXILLARY**

### **PRIMARY CARE MANAGEMENT**

#### **1) General Measures**

Medical treatments should not be considered unless the patient has used strong proprietary antiperspirants and general measures regarding loose cotton clothing preferably coloured white or black.

#### **2) Topical Aluminium Chloride Application**

Anhydrol forte or driclor can be applied to **dry** skin at night. It is important to avoid bathing beforehand, shaving the axilla or applying over an excessive area of skin. Use is often limited by irritation but attention to these details, reduced frequency of application and the use of hydrocortisone cream can improve tolerability and success.

#### **3) Antimuscarinic Drugs**

This can be tried, but side effects of dry mouth and blurred vision often mean these are not tolerated.

### **SECONDARY CARE MANAGEMENT**

#### **3) Iontophoresis**

Using tap-water and axillary pads can be effective although less effective than for palms and soles.

#### **4) Botulinum Toxin (BOTOX)**

This is licensed for use for axillary hyperhidrosis by injection. Patients receive multiple (approx 20) injections to the affected area. It permanently blocks the nerve endings but loses effectiveness as more nerve endings appear with in a few months. The effect lasts 4-6 months, but many patients find that the recurrent sweating is not as bad and they cope better with it. It is unusual for patients to need more than 2-3 courses.

#### **5) Surgery**

Surgical excision or curettage of the vault of the axilla is sometimes performed but can result in significant scarring.

### **Triage**

<b>Primary Idiopathic Hyperhidrosis</b>	<b>Axillary</b>	<b>Palms and soles</b>
1 <sup>st</sup> line treatment in primary care	Aluminium chloride +/- 1% hydrocortisone	Aluminium chloride +/- 1% hydrocortisone
2 <sup>nd</sup> line (consider) in primary care	Propranolol 15mg BD to 30mg QDS	Propranolol 15mg BD to 30mg QDS
Refer to GPwSI if above ineffective	Consider for Botox	Consider for Iontophoresis
Refer direct to secondary care only if patient has had first course of treatment already (patient will be more likely to self refer than return to GP for new referral).	Botox	Iontophoresis

### **PATIENT INFORMATION**

[www.bad.org.uk](http://www.bad.org.uk)

Patient leaflet on hyperhidrosis

[www.hyperhidrosisuk.org](http://www.hyperhidrosisuk.org)

Website of Hyperhidrosis Support Group

[www.sweathelp.org](http://www.sweathelp.org)

Website of International Hyperhidrosis Society