South East London Adult Hyperhidrosis- treatment pathway for <u>Primary Care</u>



History and diagnosis. Establish Primary¹ or Secondary

Secondary hyperhidrosis:

- 1. Treat underlying cause
- Refer to appropriate speciality
 Manage symptoms with topical treatments

Primary hyperhidrosis:

- 1. Characterise¹

 - Generalised (more than one site but no underlying cause)
- 2. Calculate baseline HDSS²
- 3. Management:
 - a) Self-care:
 - High-strength antiperspirants e.g. aluminium salts (Driclor® or Anhydrol Forte®)- Buy OTC, apply to dry skin, build up duration from 30 mins x3 /week to daily (overnight) as tolerated; trial for at least 6 weeks.
 - b) General advice³ & support group (The <u>Hyperhidrosis Support Group</u>, and <u>International</u> <u>Hyperhidrosis Society</u>).
 - c) Prescribing options:
 - Craniofacial hyperhidrosis Consider a referral for a trial of glycopyrrolate 2% w/w in cetomacrogol A cream (<u>BAD approved special</u>). Apply to affected area once or twice daily,
 - Oral anticholinergics⁴ (primary generalised hyperhidrosis but can be used in focal)
 - **1. First line:** Oxybutynin immediate release 2.5mg daily, build up to 5mg three times a day (off label)
 - 2. Second line: where there are intolerable adverse effects or inefficacy of oxybutynin IR consider either:
 - (i) Oxybutynin modified release 5-10mg daily (Off label) or

(ii) Propantheline 15mg three times a day and 30mg at night (maximum total daily dose 120mg) 4. Recalculate HDSS post 1 month of each treatment trial - aim for reduction of HDSS to 1 or 2. If successful continue, review regularly. Also see SEL IMOC <u>Recommendation 077</u> for further information

5. If HDSS 3 or 4 despite above measures refer to Community Dermatology Service. NB: for focal hyperhidrosis - earlier consideration may be given for referral to Dermatology for a trial of tap water iontophoresis

⁴See NICE hyperhidrosis evidence summary

Monitor for anti-muscarinic adverse effects and consider anticholinergic burden: Many medicines have anticholinergic activity as a secondary pharmacological effect (e.g. some psychotics, antidepressants, furosemide, some antiepileptics); the additive cholinergic burden should be considered if intending to use

¹Diagnosis of primary hyperhidrosis

- Usually 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)

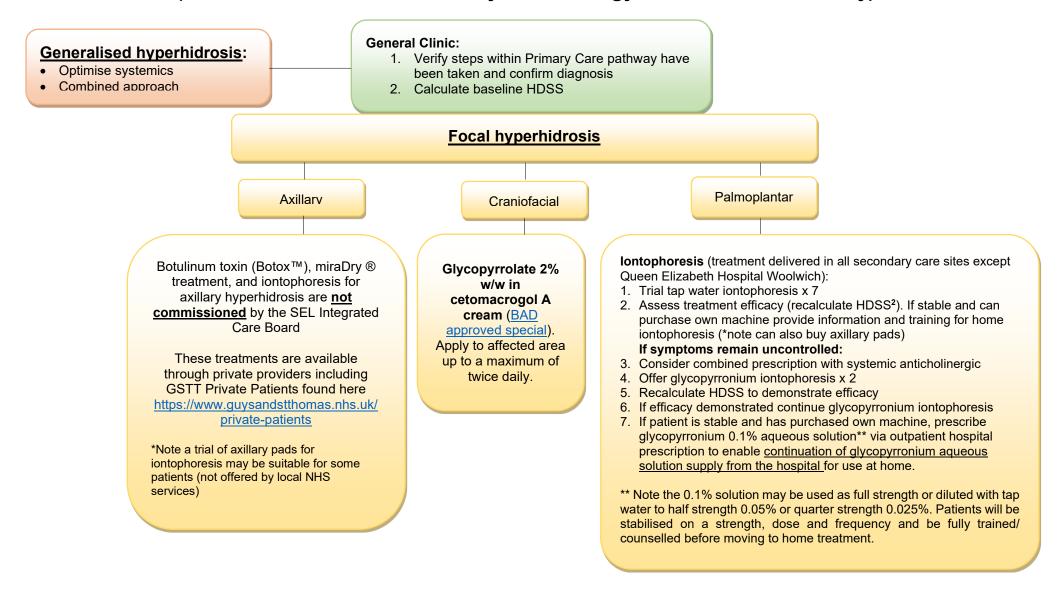
Subjective	Score	Clinical Interpretation
My sweating is never noticeable and never interferes with my daily activities	1	Mild
My sweating is tolerable but sometimes interferes with my daily activities	2	Moderate
My sweating is barely tolerable and frequently interferes with my daily activities	3	Severe
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 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 for <u>Secondary Care</u> (Referrals from SEL Community Dermatology Services via e-RS only)



Original Approval Date: August 2018 Last reviewed and updated: June 2023 Review date: June 2025 or sooner if indicated Not to be used for commercial or marketing purposes. Strictly for use within the NHS

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