South East London
Adult Hyperhidrosis- treatment pathway for Primary Care

History and diagnosis.
Establish Primary[1] or Secondary

Secondary hyperhidrosis:

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

Primary hyperhidrosis:

1. Characterise[1]
   - Focal → craniofacial, axillary, palmoplantar
   - Generalised (more than one site but no underlying cause)
2. Calculate baseline HDSS[2]
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 advice[3] & support group (The Hyperhidrosis Support Group, and International Hyperhidrosis Society).

   c) **Prescribing options:**
   - Craniofacial hyperhidrosis – Consider a referral for a trial of **glycopyrrolate 2% w/w in cetomacrogol A cream** (BAD approved special). Apply to affected area once or twice daily,
   - Oral anticholinergics[4] (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 **Recommendation 077** 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

[4] See 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

[1] Diagnosis 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 Secondary Care
(Referrals from SEL Community Dermatology Services via e-RS only)

Generalised hyperhidrosis:
- Optimise systemics
- Combined approach

General Clinic:
1. Verify steps within Primary Care pathway have been taken and confirm diagnosis
2. Calculate baseline HDSS

Focal hyperhidrosis

Axillary

Botulinum toxin (Botox™), miraDry ® treatment, and iontophoresis for axillary hyperhidrosis are **not commissioned** by the SEL Integrated Care Board

These treatments are available through private providers including GSTT Private Patients found here https://www.guysandstthomas.nhs.uk/private-patients

*Note a trial of axillary pads for iontophoresis may be suitable for some patients (not offered by local NHS services)

Craniofacial

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

Palmoplantar

Iontophoresis (treatment delivered in all secondary care sites except Queen Elizabeth Hospital Woolwich):
1. Trial tap water iontophoresis x 7
2. Assess treatment efficacy (recalculate HDSS²). If stable and can purchase own machine provide information and training for home iontophoresis (*note can also buy axillary pads)

   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 continue glycopyrronium iontophoresis
7. If patient is stable and has purchased own machine, prescribe glycopyrronium 0.1% aqueous solution** via outpatient hospital prescription to enable continuation of glycopyrronium aqueous solution supply from the hospital for use at home.

** Note the 0.1% solution may be used as full strength or diluted with tap water to half strength 0.05% or quarter strength 0.025%. Patients will be stabilised on a strength, dose and frequency and be fully trained/ counselled before moving to home treatment.

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South East London Integrated Medicines Optimisation Committee (SEL IMOC). A partnership between NHS organisations in South East London Integrated Care System: NHS South East London (covering the boroughs of Bexley/Bromley/Greenwich/ Lambeth/Lewisham and Southwark) and GSTFT/KCH /SLaM/ Oxleas NHS Foundation Trusts and Lewisham & Greenwich NHS Trust