Hampshire and Isle of Wight Integrated Care Board Priorities Committee

Policy title	**Policy 68: Treatments for primary focal hyperhidrosis**
Policy position	**Criteria Based Access**
Date of issue	January 2023
Update	This policy will be updated as per 3-year cycle or in light of a substantial body of new evidence or new national guidance (e.g. NICE)

Hyperhidrosis describes sweating in excess of that required for normal body temperature regulation. Primary focal hyperhidrosis has no underlying cause, it most commonly affects the axillae (armpits), but may also involve the palms (palmar), soles (plantar), face, scalp, and groin.

The severity of hyperhidrosis can be measured using the Hyperhidrosis Severity Scale (HDSS). This 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.

The committee recommends that patients may trial oral antimuscarinic drugs if they continue to experience severe symptoms of hyperhidrosis (HDSS ≥ 3) despite optimal use of conservative management and self-care treatments for at least six weeks.

Conservative management and self-care treatments include:

- Avoiding triggers such as anxiety, stress, heat, exercise, smoking, alcohol, caffeine, chocolate, spicy or citrus food, hot food, or sweets
- For axillary hyperhidrosis: avoiding tight clothing and manmade fabrics, wearing white or black to minimise the signs of sweating and underarm pads for axillary hyperhidrosis.
- For plantar hyperhidrosis: wearing moisture wicking socks, absorbent soles, avoid occlusive footwear and alternate pairs of shoes
- The use of topical aluminium salt preparations such as 20% aluminium chloride hexahydrate antiperspirants (purchased over the counter)

Patients who have severe symptoms of hyperhidrosis (HDSS ≥ 3) despite at least a one-month trial of oral antimuscarinic drugs may be referred to secondary care for tap water iontophoresis or botulinum toxin A injections. Iontophoresis with glycopyrronium bromide is not recommended. The suitability of specific treatments depends on the locality of the symptoms. Botulinum toxin A injections may be repeated after a minimum of six months if a one-point reduction in HDSS is maintained.

Endoscopic Thoracic Sympathectomy for the upper limb should only be considered in patients suffering from severe and debilitating primary hyperhidrosis that has been refractory to other treatments. Patients should be counselled regarding the potential side effects of this operation.

The committee does not recommend the use of transcutaneous microwave ablation for the treatment of severe primarily axillary hyperhidrosis as the current evidence of safety and efficacy is deemed to be inadequate in quantity and quality by NICE.

References

NICE IPG601: Transcutaneous microwave ablation for severe primary axillary hyperhidrosis. https://www.nice.org.uk/guidance/ipg601

Coding

OPCS codes:

X85.1 Torsion dystonias and other involuntary movements drugs Band 1
S11.8 Other specified destruction of lesion of skin of other site & Y13.7 Microwave destruction of lesion of organ NOC
A752 – Excision of thoracic sympathetic nerve

ICD10 codes:

R61.0 – Localised hyperhidrosis

Version	**Date**	**Reason for change**
Version 1	March 2021 (Ratified by Board – July 2022)	This policy will be updated as per 3-year cycle

Exceptional circumstances may be considered where there is evidence of significant health impairment and there is also evidence of the intervention improving health status