DERMATOLOGY	
Procedure/Condition	**Criteria** ■ Black – criteria required to be met prior to referral. ■ Blue – criteria to be met prior to procedure
Hyperhidrosis **Secondary** ⇨	Prior to referral to secondary care, the following steps should be taken to manage hyperhidrosis: • Investigate and treat any underlying cause of the hyperhidrosis • Provide lifestyle advice modification • Advise the patient to use over-the-counter topical aluminium chloride • Consideration should be given to managing any underlying anxiety which may be worsening clinical presentation • Offer systemic treatment with anticholinergics if topical treatment is **not successful after 1 month**: - ➢ Propantheline – dose as per BNF (licensed) ➢ Oxybutynin – 2.5mg daily, titrate up by 2.5mg weekly, max 10mg daily (off –licence) Referral for iontophoresis should be considered for **palmar-plantar hyperhidrosis** when the above conservative measures have not proven to be successful. Intradermal botulinum toxin type A is preferred for **axillary and craniofacial hyperhidrosis** Intradermal botulinum toxin type A may be considered every 6 months for axillary hyperhidrosis when: – positive colour change is observed on a starch iodine test Local sweat gland excision may be considered for axillary hyperhidrosis where the patient has not responded to botulinum toxin type A OR cannot tolerate repeated intradermal injections. Endoscopic thoracic sympathectomy (ETS) (NICE IPG 487) is not routinely commissioned; funding should be sought via a business case submission to the CCG. Additionally, there is high potential for compensatory sweating.
Base Evidence	NICE Clinical Knowledge Summaries: Hyperhidrosis – management (last updated May 2018) – accessed online at www.cks.nice.org.uk NICE Evidence Summary (ES10): Hyperhidrosis: oxybutynin (last updated March 2017).Accessed online at https://www.nice.org.uk/advice/es10/chapter/evidence-review#evidence-review BMJ Best Practice – Hyperhidrosis (last updatedMarch 2018) – accessed on 07/01/20, https://bestpractice.bmj.com/topics/en-gb/856/pdf/856.pdf
OPCS code(s):	**S532** (with **X851** and **Z492**, to indicate botulinum administration), **S041, A752, A762, A782, A772, A792** plus the following ICD-10 codes **R61.0** (localised hyperhidrosis) **R61.1** (generalised hyperhidrosis) **R61.9** (hyperhidrosis unspecified)

Version No	Date	Changes
3.3	July 2018	New policy addition
3.4	October 2019	Addition of 'This procedure requires prior approval. Prior approval must be sought through Blueteq.' as requested by contracting.
4.0	January 2020	Removal of 'This procedure requires prior approval. Prior approval must be sought through Blueteq'; removal of clonidine as a systemic treatment option; removal of drug doses/frequency for propantheline, which have been replaced with references to the BNF.

Hyperhydrosis management pathway in primary care

Palmar – plantar | **Axillary** | **Craniofacial**

1. Investigate any underlying causes of the sweating
(eg thyrotoxicosis, phaeochromocytoma, recreational drug use, endocrine disorders, tuberculosis, carcinoma)

2. Give tailored lifestyle advice

- Wear moisture wicking socks and change twice daily
- Apply absorbent foot powder twice daily
- Avoid occlusive footwear (eg boots
- Alternate footwear on a daily basis to allow drying out

- Use a commercial deodorant
- Avoid tight clothing and manmade fabrics .
- Wear white or black fabrics to minimise visible sweat marks; dress shields are also available to protect expensive/ delicate fabrics

Avoid food and drink triggers known to make symptoms worse (eg spicy, sour, hot foods, alcohol)

3. Treat with topical aluminium chloride

Patient should be advised to purchase topical aluminium chloride over the counter, and apply at night, avoiding the eyes. A short course of hydrocortisone 1% may be used if skin irritation occurs.

4 (a) Consider trial of an anticholinergic if no improvement after 1 month of $AlCl_3$

Propantheline (dose as per BNF) licensed for use in hyperhidrosis. Oxybutynin (2.5mg daily, titrate up by 2.5mg weekly, max 10mg daily) may be used off-licence if propantheline contraindicated or not tolerated.

Discontinue if no benefit seen **after 1 month.**

4 (b) Consider trialling cognitive behavioural therapy (CBT) if anxiety exacerbates symptoms

Note that antidepressants (SSRIs) may potential worsen hyperhidrosis, as may propranolol.

Other medications which can cause hyperhidrosis as a side effect include pilocarpine, opioids, insulin, cholinesterase inhibitors (donepezil, rivastigmine, galantamine)

5. Refer to dermatology

Iontophoresis preferred treatment

Intradermal botulinum toxin A (every 6/12) is preferred treatment

6. Offer adjunctive short-term/ prn treatment with oral anticholinergics

(palmar only): Application for funding for ETS (endoscopic thorascopic sympathectomy) will be required – **NICE IPG 487**. Note high morbidity/ relapse

Referral may be needed for local sweat gland excision

Application for funding for ETS (endoscopic thorascopic sympathectomy) will be required – **NICE IPG 487**. Note high morbidity/ relapse of symptoms