

# SWL Treatment pathway for hyperhidrosis in primary care

## 1. Initial assessment

Determine if hyperhidrosis is primary (focal or generalised) or secondary (see below:)

- Pregnancy
- Anxiety
- Drug history (anticholinesterases, antidepressants, propranolol)
- Irregular periods (menopause)
- Palpitations and heat intolerance (thyrotoxicosis)
- Diabetes (autonomic neuropathy, hypoglycaemia)
- Nightsweats (haematological malignancy or TB)
- Weight loss (malignancy)
- Substance misuse (ETOH withdrawal, amphetamines)

Assessment of primary hyperhidrosis

- Assess site – e.g. axillary, palmo-plantar/ craniofacial if focal
- Assess impact on daily life - HDSS score

**Hyperhidrosis Disease Severity Scale (HDSS Score)**

Score	Description
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

If secondary –  
treat underlying  
cause

## 2. Lifestyle advice for primary hyperhidrosis

- Avoid known triggers (e.g. crowded rooms, caffeine, spicy foods etc.) where possible
- For axillary hyperhidrosis - avoid tight clothing and manmade fabrics, wear white clothing to minimise signs of sweating, consider armpit shields
- For plantar hyperhidrosis – moisture-wicking socks, changing socks twice daily, absorbent soles, absorbent foot powder e.g. Zeasorb dusting powder (OTC), avoid occlusive footwear, alternate pairs of shoes daily to allow them to dry out

## 3. Treatment of primary hyperhidrosis

Primary focal hyperhidrosis

Primary generalised hyperhidrosis

**Topical strong antiperspirants (20%-25% aluminium salts)**  
e.g. Driclor®; Anhydrol Forte®  
**Patient should be asked to purchase OTC\* (see NHSE self-care guidance)**

- Instructions for use: use at night on bone dry skin in a cool environment and wash off in the morning. For the first week it should be applied for 3 to 5 consecutive nights, then once or twice a week
  - If there is local irritation, manage with emollients, reduction in frequency of application or apply 1% hydrocortisone cream the morning after the treatment if necessary (also purchased OTC)

\*<https://www.england.nhs.uk/medicines/conditions-for-which-over-the-counter-items-should-not-routinely-be-prescribed/>

If successful after 1 month  
(reduction in HDSS from 3  
or 4 to 1 or 2) – continue  
and review any prescribed  
medications regularly

If not successful after one  
month

Oral anticholinergics:

- **Propantheline** 15mg three times a day, one hour before each meal, and 30mg at bedtime. May be increased up to 120mg per day.

*Anti-cholinergic should be taken one hour before the application of aluminium chloride, preventing sweating and irritation – need to counsel patients re: possible side effects e.g. constipation, blurred vision, dry mouth, photophobia, dry skin and urinary retention.*

**Contraindications:** significant bladder outflow obstruction, and gastro-intestinal obstruction.

**If NOT successful** after 1 month or treatment limiting side effects:

- **HDSS 1-2:** stop treatment and manage with life style advice and OTC topical treatments
- **HDSS 3-4:** refer to secondary care for consideration of botox injections if axillary/iontophoresis for focal disease or generalised disease unresponsive to above treatments. IFR application by specialist

Patient leaflet: <http://www.bad.org.uk/shared/get-file.ashx?id=93&itemtype=document>

NICE CKS: <https://cks.nice.org.uk/hyperhidrosis#!scenario>

The Hyperhidrosis Support Group: [www.hyperhidrosisuk.org](http://www.hyperhidrosisuk.org)