Cambridgeshire & Peterborough Integrated Care System

NHS Cambridgeshire & Peterborough

Lower Clinical Priority Policy

Management of Hyperhidrosis

Policy

This policy is assigned static status. This policy applies indefinitely, unless or until new evidence likely to have a material effect on the policy becomes available.

Treatment of primary hyperhidrosis with botulinum toxin injections will only be funded if the following criteria are met:

- The patient has documented medical complications due to hyperhidrosis, i.e. skin maceration with secondary skin infections; AND
- Documentation that the patient has failed a six month trial of conservative management, including the use of topical aluminium chloride or extra strength antiperspirants:
  - First line: Aluminium Chloride Hexahydrate 20% (over the counter)
  - Second line: Oxybutynin 2.5-5mg twice daily (off-label/unlicensed) (ICB Formulary)

For patients who are exceptional to the criteria or in whom Botulinum toxin injections fail or is contraindicated, surgical excision of sweat glands may be considered if the policy criteria are met. For these patients, clinicians need to apply to the Exceptional Cases Panel for approval of funding completing the funding request form.

It is the responsibility of referring and treating clinicians to ensure compliance with this policy.

No treatments for secondary hyperhidrosis will be funded (the underlying cause should be treated).

The following treatments for hyperhidrosis will not be funded:

- Iontophoresis
- Surgical sympathectomy
- Laser surgery
- Transcutaneous microwave ablation

Background

Hyperhidrosis is a condition of excessive sweating, in excess of the body's normal response for the regulation of body temperature. Hyperhidrosis may be primary or secondary and affect the whole body (generalised) or specific parts (focal). Primary hyperhidrosis is usually focal and can affect the armpits (axillary), hands, feet and face.

Conventional treatment involves the use of topical medication, such as aluminium chloride at 10-15% or higher concentration. On the failure of topical treatment, further management can involve systematic medications (as specific in the formulary), iontophoresis, botulinum toxin and surgical procedures.

Iontophoresis is a treatment that involves the transport of ions through the skin by a current. The mode of action remains unclear (see references 1-2) but one hypothesis suggests that charged ions driven into the skin by the current inhibit the function of sweat glands (see reference 2).

Botulinum toxin A therapy is a temporary treatment where the medication is delivered into the affected area by multiple intradermal injections. It temporarily blocks the chemical (acetylcholine) that innervate the sweat glands preventing the glands from producing sweat. Treatment lasts between 6-9 months.

Surgical procedures include sweat gland excision (primarily for axillary hyperhidrosis) and sympathectomy. Sweat gland excision is a minor surgery that can be under local anaesthetic. It aims to remove the maximum amount of sweat glands possible while maintaining the aesthetic appearance and mobility of the arm (see reference 3). Sympathectomy is a surgical procedure performed under a general anaesthesia that involves dividing the sympathetic nerves that lie along the sympathetic chain beside the vertebral column which stops the production of sweat (see reference 5).

Transcutaneous microwave ablation (see reference 4) is done under local anaesthesia using a machine with a handpiece that emits microwaves with the intention of ablating the sweat glands. Patients typically have a second treatment session to attain the maximum benefit.

Smoking

Patients who smoke should be advised to attempt to stop smoking - see stop smoking policy.

Rationale and Evidence

There is evidence that botulinum toxin is an effective treatment for primarily axillary hyperhidrosis (see references 5-10). The evidence for the use of iontophoresis (see reference 11) is low quality and patient compliance has been reported to be poor (see reference 12). Evidence for sympathectomy surgery is also low quality with a high risk of compensatory hyperhidrosis and serious complications (see references 12 and 14). A meta-analysis of nine trials of thoracic sympathectomy for palmar hyperhidrosis with pre and post-operative quality of life measurements found significant improvement in quality of life post-operatively, not dependent on number of segments on which the procedure was performed (subgroup analysis – see reference 15). Case series show beneficial short and longer-term outcomes for surgical excision of sweat glands (see references 12-14). Although it was not shown to be more effective than botulinum toxin injections (see reference 16), this procedure has been recommended in cases of severe refractory hyperhidrosis (see reference 12). Evidence on the safety and efficacy of transcutaneous microwave ablation for severe primary axillary hyperhidrosis is inadequate in quantity and quality, as determined by NICE. Therefore, this procedure should only be used with special arrangements for clinical governance, consent and audit or research (see reference 4).

Estimated Number of People Affected

It is considered that primary focal hyperhidrosis affects between 1% and 3% of the population (see reference 17).

Priority

Low priority treatment.

Glossary

Acetylcholine:	An acetic acid, organic compound, secreted in the sweat.
Axillary Hyperhidrosis:	Excessive sweating from the armpit.

Botulinum Toxin Therapy:	A preparation of protein which when injected in small doses blocks the nerves which supply the eccrine glands (sweat glands), preventing them from producing sweat. This treatment is often referred to as 'Botox'.
Contraindication:	A factor that renders the administration of a drug or the carrying out of a medical procedure inadvisable, e.g. a previous allergic reaction to penicillin is a contraindication to the future use of that drug.
Excision:	Removal of any structure from the body.
Hyperhidrosis:	Excessive sweating, typically localised to the armpits (axilla), palms, soles or face.
Iontophoresis:	A medical device is used to pass a mild electrical current through water and through the skin's surface.
OTC:	Available over the counter.
Skin Maceration:	Softening of the skins due to continual soaking in sweat.
Sympathectomy:	The sympathetic nerve (nerve that runs deep in the chest, along the spine) is cut or clamped to prevent nerve signals from passing through it.

References

1. Wang L, Hilliges M, Gajecki M, Marcusson J A, Johansson O. No change in skin innervation in patients with palmar hyperhidrosis treated with tap-water iontophoresis. The British journal of dermatology. 1994; 131 (5): 742-743.
2. Thomas L, Fatah S, Carmichael A J. Tap water iontophoresis may be ineffective for axillary hyperhidrosis. Clinical and experimental dermatology. 2015; 40 (3): 337-338.
3. National institute for health and care excellence. Interventional procedures guidance [IPG487]: Endoscopic thoracic sympathectomy for primary hyperhidrosis of the upper limb (2014). Nice.org.uk/guidance/ipg487/chapter/1-recommendations [accessed 03/12/2020].
4. National institute for health and care excellence. Interventional procedures guidance [ipg601]: transcutaneous microwave ablation for severe primary axillary hyperhidrosis (2017). Transcutaneous microwave ablation for severe primary axillary hyperhidrosis [accessed 03/12/2020].
5. Lowe N, et al. The place of botulinum toxin type A in the treatment of focal hyperhidrosis. British journal of dermatology 2004; 151, 1115-1122.
6. Rezende R M, Luz F B. Surgical treatment of axillary hyperhidrosis by suction-curettage of sweat glands. Anais brasileiros de dermatologia. 2014; 89(6): 940-954.
7. National institute of health and care excellence. Clinical knowledge summary: management of hyperhidrosis (age from 12 years onwards) cks.nice.org.uk/hyperhidrosis#!scenario. 2013.
8. Naumann M, Lowe N. Botulinum toxin type A in treatment of bilateral primary axillary hyperhidrosis: randomised, parallel group, double blind placebo controlled trial. British medical journal 2001: 323: 1-4.
9. Naumann M, et al. Botulinum toxin type A is a safe and effective treatment for axillary hyperhidrosis over 16 months: a prospective study. Archives dermatology 2003: 139: 731-6.
10. Naumann M, Janovic J. Safety of botulinum toxin type A: a systematic review and meta-analysis. Current medical research and opinion. 2004 20(7) 981-990.
11. Dahl J C, Glent-Madsen L. Treatment of hyperhidrosis manuum by tap water iontophoresis. Acta dermato-venereologica. 1989; 69 (4): 346-348.
12. Ozcan D, Gulec A T. Compliance with tap water iontophoresis in patients with palmoplantar hyperhidrosis. Journal of cutaneous medicine and surgery. 2014; 18(2): 109-113.
13. Deng B, Tan Q Y, Jiang Y G, et al. Optimisation of sympathectomy to treat palmar hyperhidrosis: the systematic review and meta-analysis of studies published during the past decade. Surgical endoscopy. 2011; 25 (6): 1893-1901.
14. Neves S, Uchoa P C, Wolosker N, et al. Long-term comparison of video-assisted thoracic sympathectomy and clinical observation for the treatment of palmar hyperhidrosis in children younger than 14. Paediatric dermatology. 2012; 29 (5): 575-579.
15. Wei Y, Xu ZD, Li H. Quality of life after thoracic sympathectomy for palmar hyperhidrosis: a meta-analysis. Gen thorac Cardiovasc surg. 2020 Aug; 69(8): 746-753. Doi: 10. 1007/s11748-020-01376-5. Epub 2020 May 10. PMID: 32390086.
16. Solish N, Bertucci V, Dansereau A, et al. A comprehensive approach to the recognition, diagnosis, and severity-based treatment of focal hyperhidrosis: recommendations of the Canadian Hyperhidrosis Advisory Committee. Dermatologic surgery: official publication for American Society for Dermatologic Surgery. 2007; 33(8): 908-923.
17. Moraites E, Vaughn O A, Hill S. Incidence and prevalence of hyperhidrosis. Dermatologic clinics. Oct 2014; 32 (4): 457-465.

Policy effective from:	Policy adopted by NHS C&P (ICB) 1 July 2022 Reviewed policy ratified by QPF 23/09/22 Reviewed policy approved by JCPEG 14/09/22 Reviewed policy approved by CPF 06/09/22 Policy developed by C&P Public Health Team
Policy to be reviewed:	September 2025
Policy reference:	Hyperhidrosis Oct 22 V9