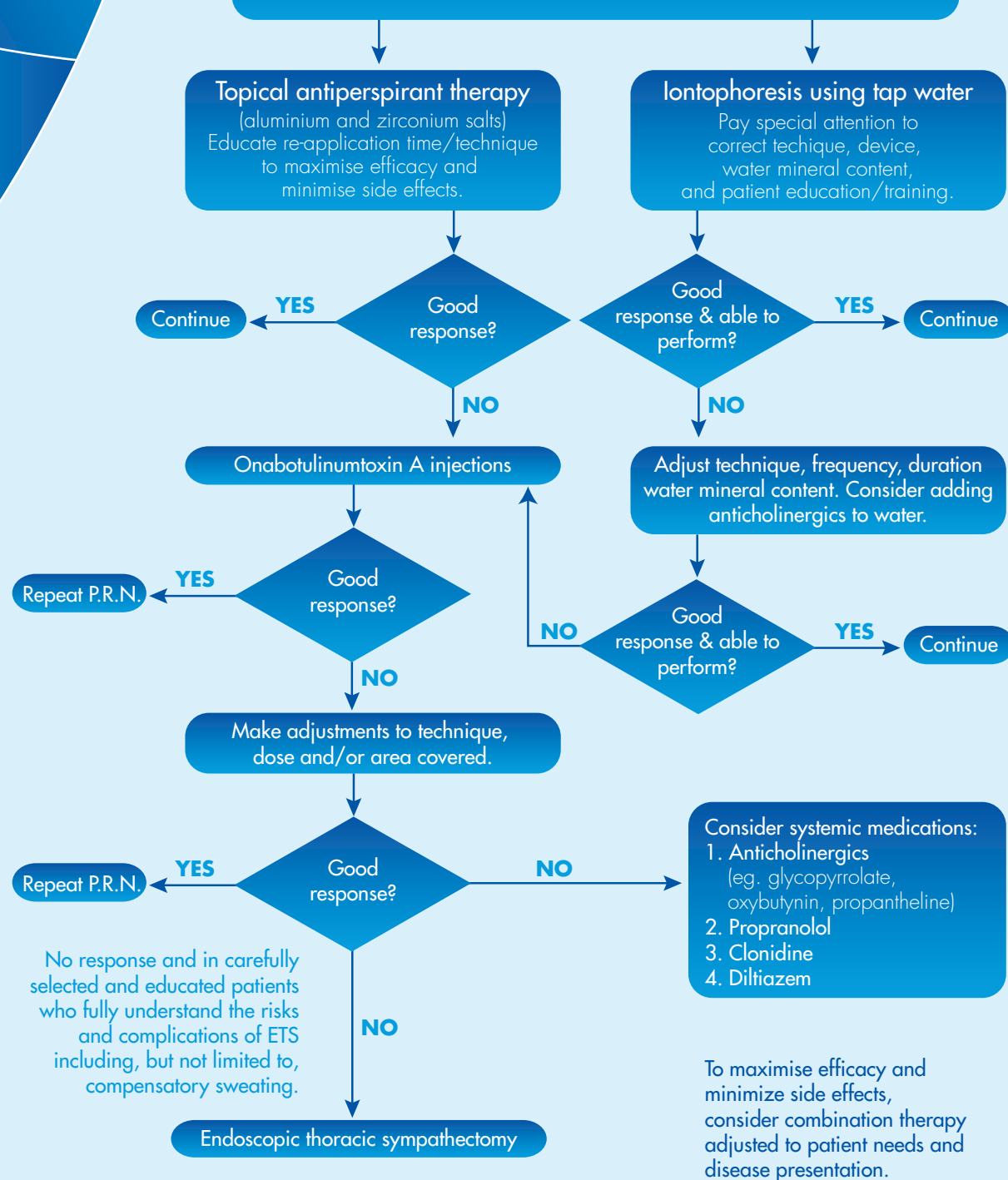


Primary Palmar Hyperhidrosis



BOTOX Treatment is now available under Specialist PBS listing for the management of severe underarm sweating.

- Patients entitled to 3 treatments per annum
- Botox lasts on average 6.1 months
- Costing to patients equivalent to \$2 per day



Sweat Free Clinic

Westside Dermatology
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sweatfree CLINICS

Specialist management for hyperhidrosis

Westside Dermatology in conjunction
with Queensland Vascular Group



cases are idiopathic, however the condition maybe secondary to drugs, neurological disorders or systemic diseases.

The Sweat Free Clinic is Australia's first multidisciplinary specialist clinic

Sweat Free Clinic is comprised of dermatologists, vascular surgeons and specialist nurse practitioners who manage all aspects of excessive sweating.

Over the next 6 months we will cover management options for plantar, axillary, generalized, and facial hyperhidrosis. This first

issue discusses the management options for sweaty palms, or palmar hyperhidrosis.

HOW COMMON IS HYPERHIDROSIS?

Hyperhidrosis is a common condition that afflicts 3% of the population. The most commonly involved areas include the hands, feet, axillae, and face. The majority of hyperhidrosis

WHAT INVESTIGATIONS ARE NEEDED FOR PALMAR HYPERHIDROSIS?

In most patients this condition is primary and idiopathic, and no investigations are needed. Primary hyperhidrosis typically has an onset before puberty, is bilateral and symmetrical, and does not occur during sleep. It is often focal, and involves areas such as the hands, feet, underarms or face. Secondary hyperhidrosis is usually asymmetrical, of late onset, and often generalized.

Non-surgical options for the Management of Palmar Hyperhidrosis

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Background

Primary palmar hyperhidrosis usually presents in late childhood and is most often bilateral and symmetrical. Sweat production ranges from mild to very severe. Palmar hyperhidrosis can affect schooling, and work, and has a significant impact on relationships and self-confidence.

Treatment options

II Avoidance of triggers

Decreasing trigger factors for sweating, including caffeine and energy drinks can improve mild palmar hyperhidrosis, however has little impact on severe cases.

II Antiperspirants

Driclor or Aluminium Chloride Hexahydrate 20% is first line management and can be successful in mild cases of palmar hyperhidrosis. This should be

applied on a nightly basis and washed off in the morning. The rate-limiting factor is skin irritation. This over the counter topical should always be applied to dry skin. Ask patients to use a hairdryer on 'cool' settings to evaporate sweat prior to application.

II Tablets

Anticholinergics such as Propanthelene Bromide can reduce palmar, plantar and axillary sweating. Start patients on 15mg nocte, increase as tolerated to a maximum of 45 mg per day. Anticholinergic side effects such as sedation can be seen in up to 80% of cases, however if tolerated, oral medication can be considered as second line management. A combination of Driclor and anticholinergics can reduce sweating to an acceptable level in one third of palmar hyperhidrosis patients.

II Iontophoresis

This procedure is conducted in clinic and involves passing of an ionized substance through intact skin. The most common medium is tap water, however compounded solutions

can be ionized. Sweat production is reduced via dysfunction of the eccrine gland. Iontophoresis is considered to be third line therapy failing topical and oral medications. It can be effective in up to 70% of palmar-plantar hyperhidrosis.

II Creams

Failing iontophoresis I usually compound creams or wipes containing Glycopyrrrolate. Once again, as per anticholinergics, systemic side-effects limits the use.

II Botox injections

The use of Botulinumtoxin A has been approved by the PBS for the management of severe axillary hyperhidrosis not responding to Driclor, however BOTOX can be used off label for palmar hyperhidrosis. In this setting I use this treatment as the last resort prior to the consideration of surgery. Unlike its use in the axillary vault, side effects such as transient muscle weakness can be seen, additionally efficacy is limited to 3-4 months in this area, compared to 6-7 months for axillary sweating. Non-PBS listing also adds costs to the patient.



Endoscopic Thoracic Sympathectomy for Palmar Hyperhidrosis

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In many cases, symptoms of palmar hyperhidrosis are relatively mild and are well controlled without the need for surgery. In more severe cases or after failure of medical therapy, patients are often considered for minimally-invasive endoscopic thoracic sympathectomy (ETS). The aim is to reduce the sympathetic outflow the palms whilst preserving other sympathetic nerve functions.

This is achieved through 2 small intercostal incisions beneath the armpit for endoscopic access to the chest cavity. Unilateral lung deflation is performed under general anaesthesia, to facilitate exposure of the sympathetic chain on each side. For palmar hyperhidrosis, the aim is the interruption of the T3 ganglion only by direct division of the chain. This will prevent sympathetic signals to the hands to reduce sweating, whilst minimising the likelihood of

compensatory hyperhidrosis in other regions of the body, which is a risk particularly with higher T2 ganglion transection. The lung is reinflated over a drain tube, which is removed on the first post-operative morning prior to discharge home.

ETS is a very well-tolerated procedure which carries a success rate for eliminating palmar hyperhidrosis of over 90%. The main risk to be considered is the chance of 'compensatory hyperhidrosis' which may occur in 25-50% of cases. As expected, not all sympathetic outflow can be eliminated, and compensatory sweating particularly in the chest and abdomen can occur. Usually this is mild, well-tolerated, and much less severe than the palmar sweating the procedure was originally performed for. Indeed most patients who develop this

find it much less debilitating than the palmar symptoms prior to treatment. Provided patients are well informed through a comprehensive pre-operative discussion about expectations, this risk is not a major concern. Other risks include small pneumothoraces which spontaneously resolve, bleeding, infection and Horner's syndrome. This last risk can be caused by interruption of the T1 (Stellate) ganglion and is therefore a very rare occurrence.

There is usually minimal pain aside from some transient generalised chest discomfort and surgical site pain. These both rapidly subside. Patients can expect to be in hospital for 1 night after the procedure, and usually return to work duties, schooling and regular activities within a few days.

Referrals to:

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