Focal Hyperhidrosis

Effective Treatment With Intracutaneous Botulinum Toxin

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Objective: To evaluate the effect of intracutaneous injections of botulinum toxin type A on excessive focal hyperhidrosis.

Design: Therapeutic before-and-after trial over 4 months.

Setting: Neurological and dermatological university departments.

Patients: Eleven patients with excessive axillary, palmar, or plantar hyperhidrosis fulfilling the following criteria: (1) local and systemic drug therapy had failed to improve their symptoms; (2) the patients were severely disabled with respect to their occupation and social activities; and (3) a successful treatment by botulinum toxin would obviate the need for destructive surgical procedures.

Interventions: Three mouse units of botulinum toxin (Botox) per 4-cm² skin area was injected intracutaneously in 16 axillae, 8 palms, and 2 soles.

Main Outcome Measures: Reduction of hyperhidrosis as documented by the Minor iodine-starch test and gravimetical assessment of local spontaneous sweat production measured over 1 minute.

Results: In all patients, botulinum toxin completely abolished sweating in the injected areas (P<.001) within 3 to 7 days. No relevant adverse effects occurred and no clinical recurrence of hyperhidrosis was observed within the follow-up period of up to 5 months. Occasionally, subclinical reactivation of sweat gland function was observed 4 months after treatment.

Conclusions: Intracutaneous botulinum toxin seems preferable to any hitherto used conservative or surgical procedures and may become the therapy of choice in pathological focal hyperhidrosis.

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LOCALIZED idiopathic hyperhidrosis is a common disorder of sweating. The pathogenesis is unknown. The preferred sites of sweating are at the axillae, palms, and soles. In excessive cases, sweat runs down the trunk or drips from the hands and feet, a condition that is usually regarded as unacceptable in professional and private life. Profuse sweating leads to skin maceration, which may cause secondary infections.

Treatments include systemic anticholinergic drug therapy; topical application of acids, aldehydes, and metal salts, eg, aluminium chloride; and iontophoresis. If these measures prove ineffective, invasive or surgical treatments, such as sympathetic blockade, transaxillary sympathectomy, and excision or curettage of the most active sweating areas, are current alternatives. However, sweating tends to return some years after sympathectomy, and the procedure may be complicated by pneumothorax and severe compensatory hyperhidrosis in other parts of the body. Surgery of the axillary vault may produce excessive scar formation and focal paresthesias or anesthesia.

Botulinum toxin is a potent neurotoxin that blocks cholinergic nerve terminals. Earlier studies have shown its effect in reducing sweat production in normal volunteers. After our successful botulinum toxin treatment of excessive palmar hyperhidrosis in a single patient, we studied the therapeutic effects of botulinum toxin in patients with various types of focal sweating.

RESULTS

Intracutaneous injections of botulinum toxin abolished clinically disturbing hyperhidrosis in all patients. The treatment
PATIENTS AND METHODS

We treated 11 adult patients (10 women and 1 man; mean±SD age, 30.5±9.0 years) with pathological focal hyperhidrosis that was unresponsive to any prior topical or systemic drug therapy. The duration of hyperhidrosis was 10.8±6.0 (mean±SD) years. The hyperhidrosis was axillary alone in 7 patients, palmar alone in 2 patients, axillary and palmar in 1 patient, and palmar and plantar in 1 patient. All patients were severely disabled by occupational or social consequences of excessive sweating. In total, 16 axillae, 8 palms, and 2 soles were treated. A trial with botulinum toxin was offered before invasive procedures were performed. The results of neurological and dermatological examinations of all patients were unremarkable except for focal hyperhidrosis. The patients were instructed about the procedure and gave their written informed consent.

Before and 2, 4, 12, 16, and 20 weeks after the botulinum toxin injections, the area of hyperhidrosis was visualized by the Minor iodine-starch test (Figure 1). In this test, an iodine solution (2 g of iodine in 10 mL of castor oil and alcohol to 100 mL) is painted over the area of skin to be tested. After it has dried, fine rice or potato starch powder is applied. Sweat causes the mixture to turn dark blue.

Also, in 10 patients, the hyperhidrosis was quantified gravimetrically before and 2 weeks after the botulinum toxin injections by measurement of spontaneous sweat secretion according to the protocol of Reinauer et al. Briefly, the respective hyperhidrotic area was blotted dry and then brought into contact with copy paper (Xerox) for 1 minute. The amount of sweat secreted during this collection period was then determined as weight increase.

Intracutaneous injection of botulinum toxin was highly effective in abolishing focal hyperhidrosis. Except for a few self-experiments in volunteers and a recent case report from this group, to our knowledge there are no reports in the literature on the efficacy of botulinum toxin injections on various excessive focal sweating disorders, such as axillary, palmar, or plantar hyperhidrosis.

Long-term studies of disorders with muscular hyperactivity, such as dystonia or spasticity, indicate that the duration of botulinum toxin action at the neuromuscular junction is about 3 months on average. Botulinum toxin applied to sweat glands appears to have a longer-lasting clinical effect. In gustatory sweating, which frequently occurs after posttraumatic misdirection of the regenerating parasympathetic fibers to the sweat glands, botulinum toxin treatment abolished sweating for more than 12 months. This finding is in agreement with our experience in a large group of patients with gustatory sweating in whom a single injection had an anhidritic effect that lasted at least 6 months. In the present study,
no clinical recurrence was observed within 16 weeks after injection, although at that time a clinically inapparent slight sweat production could be visualized by the Minor test in 3 patients, all of whom were reinjected 20 weeks after the first treatment.

At present, it is unclear why the action of botulinum toxin in the autonomic synapses of sweat glands lasts much longer than in the neuromuscular synapses. There are 2 mechanisms limiting the duration of synaptic action of botulinum toxin. First, botulinum toxin type A acts by cleaving a protein (SNAP-25) involved in the fusion of acetylcholine-containing vesicles with the plasma membrane. The rate of resynthesis of SNAP-25 could be higher in neuromuscular synapses than in cholinergic sympathetic nerve endings. Second, at the neuromuscular junction, botulinum toxin application is followed by axonal sprouting and consecutive reinnervation of muscle fibers. To date, it is unknown whether sprouting also occurs in sympathetic nerve endings after the administration of botulinum toxin. Longer denervation effects are also seen when botulinum toxin is injected into partially reinnervated tissue, as in gustatory sweating or hemifacial spasm. There is, however, no evidence for a preexisting denervation or reinnervation of sweat glands in idiopathic hyperhidrosis.

While the action of botulinum toxin on motor nerve terminals, with subsequent atrophy of muscle fibers, has been investigated extensively, little is known about the effect of botulinum toxin on autonomic nerve fibers and their end organs. Based on our histological findings, nerve fiber degeneration and sweat gland atrophy do not appear to be major components of botulinum tox injection. Even in hereditary autonomic neuropathy with anhidrosis, the morphological appearance of sweat glands
was normal. However, the long-term effects of botulinum toxin on sweat glands remain to be established.

Interestingly, patients with axillary sweating did not notice a significant reduction of unpleasant odor after botulinum toxin injection, despite a marked decline of sweat production. This observation can be explained by the different transmitters involved in the innervation of eccrine and apocrine sweat glands. Sweat-producing eccrine sweat glands are innervated by cholinergic sympathetic nerve fibers, which are blocked by botulinum toxin. Apocrine sweat glands, however, are supplied by adrenergic sympathetic nerve fibers, which remain unaffected by botulinum toxin.

An optimal effect that lasts for at least 4 months without adverse effects holds promise that this novel therapy may become the treatment of choice for focal hyperhidrosis that is unresponsive to any other local or systemic drug therapy. The botulinum toxin (Botox) that we used in our study is currently being evaluated as an orphan drug in the United States. In particular, it has not been sufficiently tested in pregnancy. Therefore, at this stage, it must not be given to women of childbearing age without contraception, to pregnant women, or to women during the lactation period.

In conclusion, intracutaneous administration of botulinum toxin is a novel, safe, and simple treatment for many patients with focal hyperhidrosis. It carries the potential to replace current invasive surgical procedures.

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REFERENCES