

Material and Methods

Data were retrospectively collected (post hoc evaluation) from our 2 former studies [2, 7] investigating primary hyperhidrosis and quality of life in affected individuals in Sweden. The first study [2] was a cross-sectional population survey in Sweden that investigated 1,353 random individuals (18–60 years old) with the aim to describe the prevalence of primary hyperhidrosis and the quality of life impairments for those affected by the disease. A validated hyperhidrosis survey, together with the SF-36 and HDSS, was sent to all individuals, and they were asked to return the coded questionnaires within 1 week.

In the second study [7], we investigated the effect of primary hyperhidrosis on mental and physical health, depression, anxiety, and alcohol consumption. One hundred and fourteen patients diagnosed with axillary, palmar and plantar hyperhidrosis participated by answering questionnaires regarding hyperhidrosis symptoms (HDSS), a visual analogue scale, the Hospital Anxiety and Depression Scale, the Alcohol Use Disorder Identification Test, and the SF-36 before and 2 weeks after treatment with botulinum toxin. The information collected from our 2 previous studies included sex, age, age of onset, sites of hyperhidrosis, family history, SF-36 and HDSS. All data regarding hyperhidrosis occurring in other localisations than the axillary and palmar regions were collected from our cross-sectional population study.

A total of 188 cases with primary hyperhidrosis were available from both studies and were reviewed post hoc. None of the individuals included had received any treatment other than topical remedies. Individuals who had reported only 1 site of their body as their most problematic area of sweating were included ($n = 160/188$) while individuals with multifocal primary hyperhidrosis were excluded ($n = 28/188$).

Statistics

Descriptive statistics was used for background characteristics. Continuous variables were expressed as mean \pm standard deviation. Differences in mean scores were tested by the t test, and the χ^2 test was used for analysis of comparison between the participants. For both tests, a significance level of 0.1% was chosen. Microsoft Office 2013 was used for designing tables. IBM SPSS Statistics version 20 was used for calculations and data analysis.

Ethical Considerations

Voluntary participation and informed consent were ensured by a cover letter which included the purpose, background, method, use and safe-keeping of the data, sponsoring organization and confidentiality measures. Also, information about the research group and how to get into contact with them was added. Patients who participated in the research by visiting the Department of Dermatology and Venereology at Umeå University Hospital were asked to revise the cover letter and give their written consent for their participation in conjunction with their treatment. Individuals surveyed via post gave their consent by answering the survey. All surveys were coded, and only the research group had access to the survey material. Approval for the study was given by the Ethical Review Board at Umeå University (No. 2010-199-31M).