

Sudomotor effects of hyperhidrosis or anhidrosis (increased or absent sweating) may impact on temperature regulation, which is a common problem.

Hyperhidrosis may be compensatory for loss of sweating in another area, or may be the initial phase before progression to anhidrosis.

Aldrete found an 80% incidence of 'profuse diaphoresis' and 42% nocturnal diaphoresis. The Global survey reported 63% of respondents with increased sweating.

Excessive sweating (hyperhidrosis or diaphoresis) occurs when the sympathetic nervous system is running on overdrive.

This seems to be a common problem in arachnoiditis, and is probably in part due to direct effects on the sympathetic chain, which runs alongside the spine, and also partly due to the chronic stress of unremitting pain.

A further reason might be that arachnoiditis patients can experience intermittent low grade fevers and the sweating (especially at night) might be related to this.

Note that sweating can occur regardless of environmental temperature (even in the cold) or emotional state; *cold sweats* are often quite profuse.

Couto de Silva et al ([\[1\]](#)) described a case of arachnoiditis featuring body temperature disturbances and diaphoresis. T

he patient had "aberrant skin temperature and sweating" in different parts of the body.

Causes:

1. Primary = essential = idiopathic: cause unknown
2. Secondary: to conditions such as hyperthyroidism (overactive thyroid); menopausal

Primary hyperhidrosis is much more common in the general population than secondary: it usually starts in childhood or adolescence and persists throughout adult life.

Locations include the face, armpits, palms and soles of the feet. It can be a highly distressing condition. Scalp/facial sweating may also be associated with blushing; axillary (armpit) sweating can lead to telltale staining on clothes and a rapidly developing strong body odour which can make socialising difficult.

Primary hyperhidrosis occurs in up to 1% of the population.

Secondary hyperhidrosis in arachnoiditis:

Heat intolerance seems to be a related problem: in Aldrete's survey, 91% of respondents experienced this (in the Global survey the figure was 58%).

Low grade fever occurred in 70% (28% in Global survey).
Clearly this is a common problem.

Spinal cord injury patients may suffer from non-thermoregulatory reflex sweating, which is due to unchecked spinal cord activity.

Sweating is a function, which allows body temperature to be maintained, but in these patients, reflexive sweating occurs. It is often precipitated by stimuli such as emptying the bladder or bowel.

Compensatory sweating may occur if there is an area in which sweating is lost. Anhydrosis (absence of sweating) may occur in certain circumstances, including sympathectomy (see below).

Hyperhidrosis (excessive sweating) may also be a prelude to loss of sweating.

There is a peculiar condition called gustatory sweating (Frey's syndrome) which occurs in the face when salivary gland activity is stimulated by food.

An uncommon problem may be facial pain, loss of sweating on one side of the face and change in size of one pupil (Horner's syndrome). There are also isolated reports of Adie's tonic pupil.

Swelling (oedema) of the limbs (as in reflex sympathetic dystrophy RSD) is seen in some patients. However, it is difficult to assess whether this is a direct effect of arachnoiditis or a side effect of treatments such as intraspinal opiates (see below).

[\[1\]](#) Couto de Silva JM, Couto de Silva JM Jr., Antonio Aldrete J *Anesth Analg* 2001 Dec; 93(6): 1578-9 Body temperature and diaphoresis disturbances in a patient with arachnoiditis.