An update on hidradenitis suppurativa

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GPs need to be able to recognise hidradenitis suppurativa, which is one of the most distressing dermatological conditions.

Hidradenitis suppurativa (HS) is a chronic condition characterised by recurrent nodules or abscesses, sinus tract formation and scarring.[1] It occurs in areas with apocrine glands. The three most commonly affected sites are the axillae (Figures 1a and b), inguinal region and perianal/perineal region (Figures 2a and b). Other affected sites include the mammary and inframammary area, buttock, pubic region, chest, scalp, retroauricular area and eyelid.

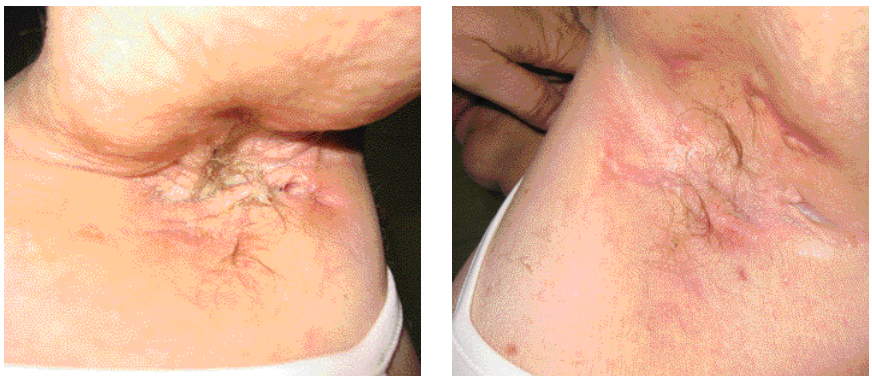
The aetiology of HS is unclear but may be due to follicular occlusion with secondary involvement of apocrine glands. Genetic and hormonal factors are probably involved. Although antibiotics are commonly used in treatment, the role of bacteria in the condition is controversial. Pus from lesions is often sterile, but affected areas can be secondarily infected with bacteria such as coagulase negative staphylococci.

HS has a female preponderance – the ratio of affected women to men is about three to one.[2] HS occurs after puberty, with peak incidences in the second and third decades. It is associated with obesity and smoking. HS is common in the community, with prevalence estimated at 1:300.[3] Men tend to present later than women, probably because of embarrassment. Inguinoperineal disease is also more common in men than in women.

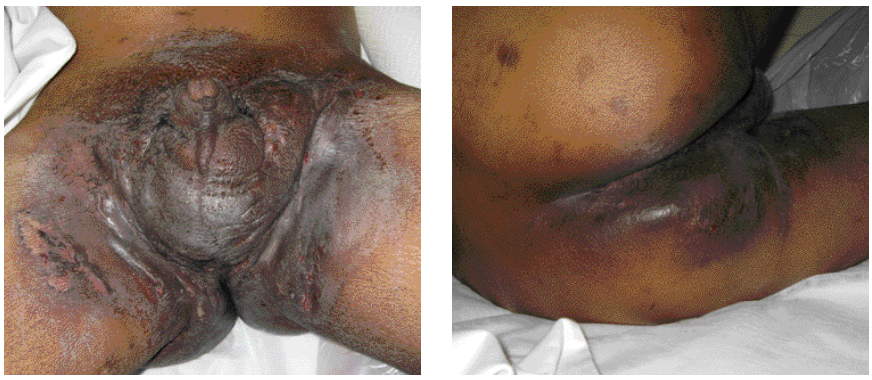
The role of GPs

GPs are often the first point of contact for patients suffering from HS, and it is important that the condition is recognised in order to ensure appropriate referral. HS can present in different sites with recurrent nodules or abscesses and patients have often had inflammatory lesions incised and drained on multiple occasions.

HS can be extremely debilitating. The recurrent painful abscesses and malodorous discharge may result in depression, social isolation and failed relationships. A recent quality of life study concluded that HS is one of the most distressing dermatological conditions.[4]



Figures 1a (left) and b (right). HS of the axillae: discharging sinus, macrocomedones and scarring.



Figures 2a (left) and b (right). Severe HS affecting the groin and perineal region.

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continued

Table. Differential diagnoses for HS

- Carbuncles
- Lymphadenitis
- Infected sebaceous cysts
- Infections: tuberculosis, actinomycosis, cat-scratch disease, lymphogranuloma venereum
- Vegetative and pustular perineal lesions of inflammatory bowel disease

Diagnosis

There is no specific test for HS. Clinical features include tender subcutaneous nodules or abscesses (0.5 to 1.5 cm diameter) and comedones in the areas mentioned above. The lesions can resolve or they can progress, resulting in discharge of malodorous purulent or seropurulent material onto the skin. In mild cases, spontaneous remission may occur. In moderate to severe cases, new lesions develop in adjacent areas and lead to chronic inflammation, sinus formation and scarring (Figures 1a and b); other sites may subsequently become involved. Sinuses can dissect into tissues involving muscle, bowel and fascia, forming a labyrinth of tracts. Patients with perianal involvement should be investigated with colonoscopy because discharging sinuses in this region may be a manifestation of Crohn's disease.

Differential diagnoses for HS are listed in the Table.

Follicular occlusion tetrad

The follicular occlusion tetrad consists of HS, acne conglobata, dissecting cellulitis of the scalp and pilonidal sinus. Some patients with HS have a combination of these other conditions.

Treatment

To date, there have been no large randomised controlled trials of treatment options for HS. General measures that may be helpful include weight loss in obese patients and smoking cessation. Obesity is unlikely to be causal but is probably an exacerbating factor. Smoking may cause altered chemotaxis of polymorphic neutrophils, which possibly play a role in the aetiology of HS.

Medical management

Topical antibiotics

Topical clindamycin 1% (ClindaTech, Dalacin T, Zindaclin) is useful for patients who have mild HS. In a small randomised placebo-controlled trial, topical clindamycin 1% was shown to be significantly more effective than placebo, based on number of abscesses, inflammatory nodules and pustules, as well as a patient self-assessment score of overall progress.[5]

Systemic antibiotics

The spectrum of antibiotics used to treat acne are often employed for HS – these include minocycline (Akamin, Minomycin), 100 mg daily, and doxycycline, 100 mg daily. High dose oral clindamycin (Cleocin, Dalacin C), 300 mg twice daily, may be effective for patients who have mild to moderate HS. Disease relapse can occur following the discontinuation of treatment. Intravenous antibiotics may be necessary for flares or secondary infection; swabs from abscesses may be useful in guiding the choice of antibiotic.

Hormonal therapies

The antiandrogen cyproterone acetate with ethinyloestradiol (Brenda-35 ED, Diane-35 ED, Estelle-35 ED, Juliet-35 ED) is a treatment option for women affected by HS.[6] High dose cyproterone acetate (50 to 100 mg) has been used with some success in studies of HS patients, and may be taken in combination with the OCP on days 5 to 14 of the menstrual cycle.[7]

Retinoids

Treatment with oral isotretinoin may be commenced by a dermatologist for patients with moderate HS.

One study reported that about 20% of patients treated with isotretinoin achieved resolution by six months, with another 20% showing marked improvement.[8] Patients with milder disease seem to respond best. Approximately 16% of patients maintained improvement at follow-up (mean follow-up period, five years).

Acitretin (Neotigason), another retinoid, may be used for male patients.

Immunosuppression

Oral prednisolone is sometimes used for flares but cessation of treatment often results in disease recurrence. Systemic corticosteroids have several serious side effects and should not be used to treat patients with HS in the long term. High dose immunosuppression has been effective in a patient with severe HS following renal transplantation when oral tacrolimus and mycophenolate mofetil were commenced.

Increasingly, the role of biological therapies is being reported for treatment-resistant or severe HS. Infliximab[9] and adalimumab (Humira)[10] have been shown to be useful in severe cases.

Surgery

In acute situations, incision and drainage procedures are often performed but these invariably lead to disease recurrence. Excision of affected areas is advisable for moderate to severe HS.[2] Excision with primary closure is sometimes used for localised disease but is more likely to result in recurrence, probably because of compromised margins or wide distribution of apocrine glands. Wide excision with grafting or healing by secondary intention is less likely to result in recurrence and may be curative.

Unfortunately, the average time between the onset of symptoms and surgery is long: approximately seven years.[11] Early referral to plastic surgeons is important for patients who have either severe HS

or disease that is resistant to medical treatment. Nonetheless, there are disadvantages associated with the surgical approach – these include:

- recurrence in the treated site
- development of HS in previously unaffected areas
- worsening of HS in areas where it was previously mild
- cost and morbidity associated with surgery
- reduced range of movement
- scarring.

Conclusion

HS can be a debilitating condition that is difficult to treat. Its impact on a patient's quality of life is significant. Mild or moderate disease may respond to medical management, but moderate to severe disease warrants surgical management. For patients with moderate or severe HS, early recognition and collaboration between the GP, dermatologist and plastic surgeon are vital to achieve control of the disease. MT

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