WHAT YOU MIGHT HAVE MISSED AT THE IUSTI CONGRESS

This is what you need to know about HS, hidradenitis suppurativa, a condition with recurring inflammatory nodules and abscesses.

At the AbbVie Symposium on September 1st, dermatologist Caitriona Ryan, St Vincent's University Hospital, Dublin, Ireland, gave a presentation on the topic:

"Hidradenitis Suppurativa - What do I need to know about this hidden disease?"

Hidradenitis suppurativa (HS) is a common chronic inflammatory disease that manifests on the skin as recurrent inflammatory nodules and abscesses. HS has a devastating impact on quality of life: depression, anxiety, isolation due to fear of stigmatization and significant sexual distress are reported by patients with HS. One of the most burdensome symptom is pain, usually linked to the deep seated inflammatory nodules.

Clinical presentation

HS is characterized by painful recurrent nodules, foul-smelling abscesses, fistulas, and hypertrophic scars, primarily in the axillary, groin, perianal, and inframammary areas.

Epidemiology

HS is not a rare disease; the estimated patient reported prevalence is ≤1–4% in European studies. The typical onset of the disease is in early 20s. There is considerable lag in diagnosis time and the average diagnose delay is 12 years. Early diagnosis is crucial for the management of the burden of HS.
The role of smoking and obesity is not known to be causal, but the high incidence of these factors in people with HS suggests that modifying these factors is reasonable as an adjuvant therapy.
HS is not contagious nor does poor hygiene cause hidradenitis suppurativa.

Goals of patient care:

Diagnose early, educate HCPs and patients and manage the disease and comorbidities with maximum treatment effectiveness. Early recognition and treatment may prevent irreversible changes and scarring.

Diagnosis of hidradenitis suppurativa is made clinically; biopsies are not routine

Establishing a diagnosis relies on 3 main features of HS:

1. Typical lesions: deep-seated nodules (blind boils) and/or fibrosis
2. Typical anatomical location: axillae and inguinocrural regions - Symmetrical lesions suggest systemic disease instead of local infection
3. Relapses and chronicity

Classification and severity assessment

HS disease severity can be assessed by e.g. Hurley staging where the scarring of the lesions is evaluated as a marker of the disease extent and progression. Newer severity classifications also take into consideration the presence of inflammation as a marker of active, more severe disease.

Medical therapy

A range of treatment options are available for HS. Preferred treatments for HS are conventional systemic therapy (tetracycline, topical clindamycin, combination of clindamycin and rifampicin, acitretin) and biologic therapy (adalimumab - registered; infliximab - off label) as well as surgery. The largest clinical study data on treatment of HS disease has been obtained from patients on adalimumab treatment. Antibiotics are, however, still first line in the treatment of HS**.** Every patient should be provided with adjuvant therapy such as pain management, treatment of super infections, weight loss and tobacco abstinence.

Often HS management requires a multidisciplinary team. This team should always consist of at least one dermatologist.

REFERENCES

1. Jemec G. Hidradenitis Suppurativa. N Engl J Med, 2012; 366:158– 164.
2. Zouboulis et al. 2015. European S1 guideline for the treatment of hidradenitis suppurativa/acne inversa. J Eur Acad Dermatol Venereol. 2015; 29:619-644.
3. Zouboulis CC. Adalimumab for the treatment of hidradenitis suppurativa/acne inversa. Expert Review of Clinical Immunology, 2016;12:10:1015– 1026.