Hidradenitis Suppurativa

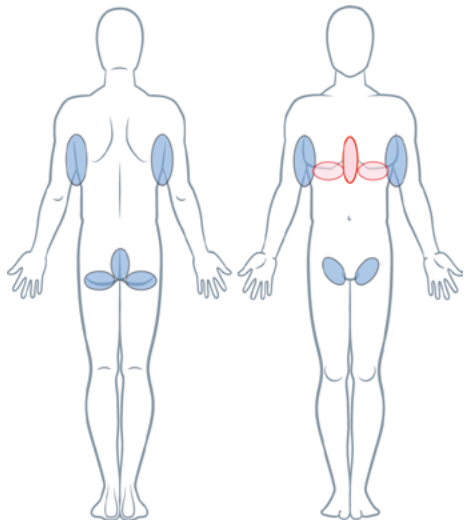
Hidradenitis Suppurativa – Primary Care Treatment Pathway

What is Hidradenitis Suppurativa (HS)?

- HS is a persistent inflammatory skin disorder, of unknown cause. It cannot be cured
- It is characterized by inflammatory nodules that wax and wane and recur at specific sites of the body
- Nodules can be painful and discharge non-purulent or purulent fluid. Continuing disease leads to sinus formation, chronic discharge, malodour & pain, and scarring, which may affect joint movement
- HS can have devastating effects on socio-economic function, mental health, and quality of life
- Timely diagnosis and treatment can improve symptoms and reduce long-term morbidity
- Peak incidence is from adolescence to 40s. Pre-pubertal or above 50s presentation is uncommon. Skin of colour patients may have more severe disease

How to Recognise HS

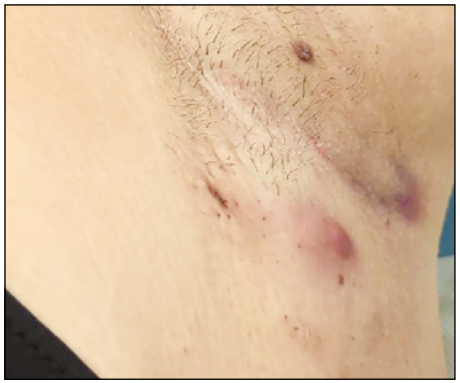
- HS is recognized clinically by the characteristic lesions, which consist of comedones, papules, nodules, abscesses, ulcers, sinus tracts and scars
- Consider the diagnosis if more than 2 abscesses develop in a flexural site during the last 6 months
- Atypical sites affected are the back, scalp (dissecting cellulitis of the scalp), behind the ears, and intergluteal cleft (pilonidal disease). HS can be associated with severe acne (acne conglobata)
- Flares can be triggered by stress, menstruation, heat, sweat, friction between body surfaces and pregnancy



Common locations of lesions
(red areas highlighted in females)

Staging: Mild

0-1 abscesses or +/-1-5 nodules. ≥1 abscesses without scar or sinus formation



Staging: Moderate

2-5 abscesses or more than 10 nodules. ≥1 recurrent abscesses with associated sinus tract/ scar formation

Staging: Severe

More than 5 abscesses +/- sinus tract formation. Multiple abscesses, interconnected sinus tracts and extensive scarring

Photographs courtesy of Dr Hannah Wainman and Dr Emma McMullen. Please see the PCDS website for more photographs and especially in skin of colour

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Associations

- Metabolic syndrome and obesity
- Cardiovascular disease (CVD)
- Type 2 diabetes
- Inflammatory bowel disease
- Inflammatory spondyloarthritis
- Body dysmorphia
- Depression, anxiety, social isolation, stigma and suicide
- Substance misuse.
- Decreased productivity and affected work

Complications

- Spreading infection and sepsis
- Scars and contractures
- Lymphoedema
- Squamous cell carcinoma (SCC), especially in men, over 50, with buttock disease
- Mortality from increased CVD risk and suicide risk

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PCDS PRIMARY CARE DERMATOLOGY SOCIETY

Initial & Holistic Assessment

- Assess and record affected sites
- Assess pain and how it is managed
- Assess effects on quality of life (DLQI)
- Assess for smoking and record BMI and blood pressure
- Assess for co-morbidities (CVD, metabolic syndrome, diabetes)
- Check for any GI and joint symptoms
- Assess mental health
- Assess psychosocial/sexual function
- Smear history
- Consider contraception especially if on treatment
- Signpost to smoking cessation services
- Weight management advice and services
- Referral/self-referral to IAPT or where available psychodermatology
- Social prescribing, where appropriate

Acute Flare Management

- For infective flares with tense and fluctuant abscess formation consider referring for incision and drainage to relieve pain. In systemic upset/sepsis, intravenous antibiotics may be required
- For flares that do not require drainage, consider flucloxacillin 1000mg QDS for 10-14 days (or clarithromycin 500mg bd)

Chronic Disease Management

- All patients should be prescribed topical antiseptics (e.g. Octenisan®) to reduce bacterial load and break biofilms
- Ensure regular medication review and assess disease severity, DLQI, and medication concordance
- Aim is to improve disease and control symptoms; not cure
- 1st line treatment: For mild HS, consider topical clindamycin bd, else, prescribe oral doxycycline 200mg od; both initially for 3 months. Aim for reduction in flares and improved disease control. If topical therapy does not control, swap to oral doxycycline. Do not prescribe oral tetracyclines in less than 12 years of age
- In pregnancy, consider topical clindamycin bd for 3 months and review. Carefully balance the benefits and risks of oral macrolide antibiotics, if needed (2nd and 3rd trimester only)
- If improved, consider treatment break but restart treatment after 2 or more flares
- If no or minimal response, or rapid flare after stopping antibiotics, commence 2nd line treatment and consider referral: oral rifampicin 300mg bd and clindamycin 300mg bd for 12 weeks, and continue clindamycin 300mg bd if helpful, further 12 weeks. Warn of orange colour to body fluids and urine; FBC & LFTs to be checked pre-treatment, 4 and 12 weeks (rare risk of hepatoxicity); check for drug interactions and warn reduced contraceptive efficacy
- In patients with PCOS and/or pre-menstrual flares, consider spironolactone (max. 100mg od; off-license), Yasmin or equivalent. Metformin (500-1500mg; off-license) may help patients with PCOS and metabolic syndrome
- Ensure appropriate analgesia is prescribed and available
- Encourage healthy lifestyle. Reduce friction: loose-fitting clothes, swimming as exercise; avoid high calorie foods/dairy intake; avoid shaving hair & irritating perfumes and deodorants. Topical clindamycin/metronidazole, octenisan can help malodour

When To Refer

- Severe psychological impact
- No improvement following adequate first line treatment (mild-moderate disease; refer whilst instituting second-line treatment)
- Severe disease (refer whilst instituting first line treatment)
- Diagnostic uncertainty
- Pregnancy
- Scarring

Dressing Advice

- Patients may need multiple dressings for differing needs and preferences
- Absorbent, low adhesive, foam and gentle border dressing – reduce friction. Hydrocolloid (e.g. DuoDerm extra thin) and Hydrogel (e.g. Actiform Cool) are useful in the presence of minimal-mild exudate.
- Shape of dressing – shapewear (Hidrawear) garments are available and prescribable and can keep dressings in place e.g. KerraFoam or Allevyn Gentle Border (moderate to high exudate areas)
- Charcoal dressings may help with odour (Odolock, Carbonet) in non-affected areas
- **Consider referral to local tissue viability for expert wound care**
- For surgical wounds, avoid packing and aim to cover with appropriate dressing e.g. absorbent dressings

Secondary Care Options

- 3rd line treatments: Acitretin, dapsone
- Biologics
- Intralesional steroids
- May be applicable for certain situations: isotretinoin, methotrexate, ciclosporin
- Ertapenem or other antibiotics
- Surgery, e.g. de-roofing and wide excision
- (Where available) laser hair removal and/or botulinum toxin injections

Practical Advice and Resources for all Patients

- Advise on pre-payment certificate
- The HS Support Network (UK and Ireland) – patient support group (FaceBook®)
- Hidradenitis Suppuritiva Trust – patient support group (UK; FaceBook®)
- HS-foundation.org (US site)

Please note this guidance is the views of the contributors and does not consider costs of treatments

A grant from Novartis enabled the development of this pathway. The company had no input or influence on the content