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Clinical Pearls

Clinical Pearls will help prepare residents for the future by providing them with pearls about what they should know about a specific subject area by the time they complete their residency.

Hidradenitis suppurativa

By Jennifer Hsiao, MD, FAAD

1. **Don't forget about "non-classic" presentations of HS.**
   The mean delay to diagnosis for patients with HS is 10 years.[1] Dermatologists can help reduce that delay in diagnosis by having HS high on our radar for any patient who presents with a nodule or abscess in an intertriginous region. Consider checking typical HS-affected sites (axilla, groin, inframammary region, etc.) for clues such as open comedones and background scarring in all patients who report a history of recurrent nodules or abscesses. In addition, keeping in mind that HS can present in any area of the body with hair follicles is helpful to help diagnose patients who may have HS lesions in "non-classic" anatomic areas such as behind the ears, and on the neck, trunk, arms, or legs. Though research in the U.S. suggests that female patients are disproportionately affected, HS can affect people of all backgrounds, and some of the most severe cases of HS that we see in clinic are male patients with advanced gluteal disease. Another tip is to consider screening all your acne patients for HS given the high prevalence of acne among patients with HS, and many patients may not bring up HS symptoms on their own. You could be the one to uncover a diagnosis of HS early and help that patient get treatment sooner rather than later!

2. **Treat early.**
   Breakthroughs in new therapies for HS have shifted the treatment paradigm for HS away from endless cycles of antibiotics and incision and drainages (I&Ds) and toward timely initiation of long-term immunomodulators such as biologics.[2,3] We now have two FDA-approved biologic treatments for HS: adalimumab and secukinumab, and several in the therapeutic pipeline. Don't wait until patients have extensive tunnels and scarring before initiating a biologic. Earlier initiation of a biologic may help mitigate disease progression and prevent further irreversible tissue damage.[4] Just like how we aim to start patients on isotretinoin before there is acne scarring, we should be discussing biologics as a treatment option for patients with HS who have disease recalcitrant to traditional therapies such as topicals, oral antibiotics, and hormonal/metabolic treatments, even if there is no scar or tunnel present yet.

3. **Utilize combination treatment strategies for HS.**
   A multimodal approach to HS management is often needed to optimize care. As an example, for a female patient with moderate-to-severe HS, their baseline treatment regimen may consist of an immunomodulator such as a biologic, as well as spironolactone and/or metformin, a topical wash such as chlorhexidine, an oral antibiotic such as amoxicillin/clavulanate (Augmentin) to use prn flare, and deroofing procedures for persistent/fixed HS lesions.

4. **HS procedures: You can do it!**
   Procedural management is an important cornerstone of HS care. Though many therapeutic advances have been made in recent years in terms of medical treatments, our medications are currently not able to resolve HS tunnels, so surgical procedures are needed in these cases. All dermatologists have the skillset to perform HS deroofings or HS excisions. If you can cut out a BCC, you can cut out an HS tunnel. There is high patient satisfaction from these procedures.[5] One great way to learn more about HS procedures is to attend the HS Academy, which is an annual winter conference that is planned by the HS Foundation and specifically designed to equip dermatology residents with the knowledge and skills to provide top-notch HS medical and surgical care (www.hs-foundation.org/events). One procedural tip is to use a 4-6 mm punch tool instead of an 11 blade when performing an I&D on an HS abscess. This helps prevent the HS abscess from recurring by allowing it to continue draining over the next few days. Inject your anesthetic slowly and ensure adequate anesthesia prior to incising to maximize patient comfort. And remember, do NOT pack HS abscesses after draining them, it is so painful for the patient and is not necessary! DR

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