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Hidradenitis suppurativa diagnosis and management in primary care:

not just recurrent boils

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BACKGROUND

Hidradenitis suppurativa (HS) is characterised by inflamed skin lesions and scars that occur in apocrine-gland-bearing areas including axillae, inframammary folds, and groin, with a chronic course including flares.[1] It is associated with an average diagnostic delay of 7.2 years and has a Western population prevalence of approximately 1%–2%.[2,3] HS affects young to middle-aged adults and is more common in women. It is 2–3 times more common in people with skin of colour especially those of African American descent.[2] HS significantly impacts general health and quality of life. A recent cross-sectional survey of GPs found that, while patients were largely managed appropriately, there was suboptimal management of pain, psychosocial aspects, and comorbidity screening.[4] The current article aims to address this educational need.

WHY IS THE DIAGNOSIS OF HIDRADENITIS SUPPURATIVA IN PRIMARY CARE SO IMPORTANT?

Historically, HS was poorly recognised and under-researched. Patients are often treated sub-optimally and comorbidities are not managed. Practitioners in primary care can both diagnose and treat early disease. They can address comorbidities, support lifestyle changes, and offer psychological support.

WHAT ARE THE IMPORTANT ELEMENTS IN THE PATIENT'S HISTORY AND EXAMINATION?

Three main elements need to be considered in a diagnosis of HS:

- skin changes:
  - deep-seated painful nodules, abscesses, tunnelling, double-ended comedones, tombstone scarring, and rope-like scars may exist (Figure 1);
- locations of lesions:
  - for example, the axilla, groin, chest, abdominal fold, and perineum; and

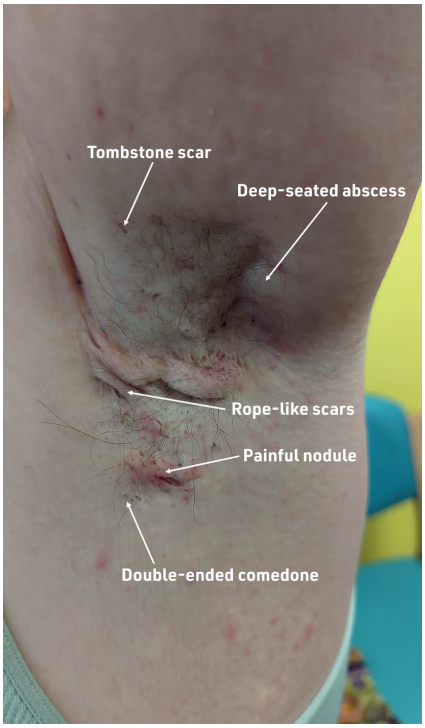


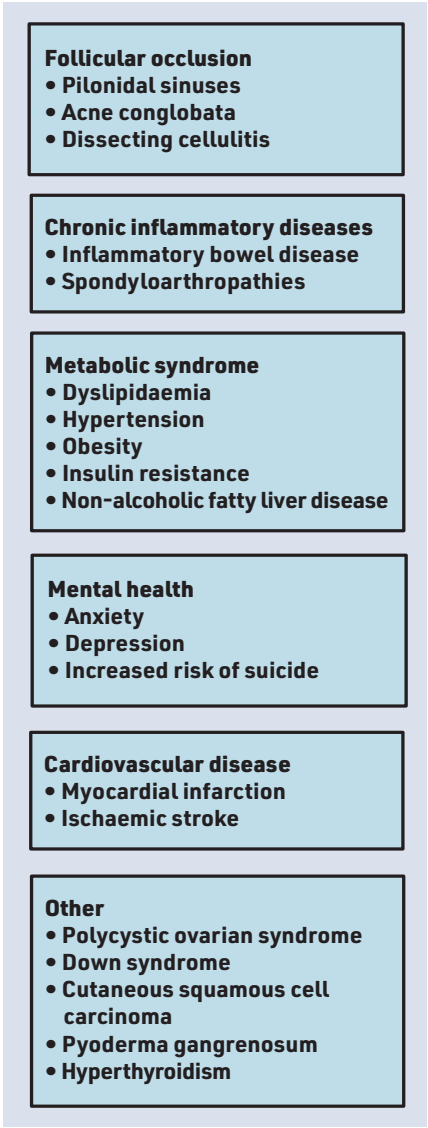
Figure 1. Examples of lesions in hidradenitis suppurativa.

- duration:
  - lesions are *chronic* with regular *relapses*, often at previous sites, and at least two lesions in the last 6 months.[5]

Disease severity is stratified according to the Hurley criteria, with stage one being defined as inflammatory lesions (single or multiple) without skin tunnels or scars. Stage two sees recurrent abscesses with skin tunnels, scarring, and single or multiple lesions separated by normal skin. Stage three has diffuse or almost diffuse involvement of affected areas with widespread inflammatory lesions and multiple interconnecting skin tunnels.[6]

Other factors that may support a diagnosis but are not pathognomonic include family history, which is present in 40% of patients,[7]

Figure 2. Diseases associated with hidradenitis suppurativa: cutaneous squamous cell carcinoma is linked to longstanding perianal HS in particular.



and recurrent inflammatory lesions elsewhere including pilonidal sinuses, acne conglobata (severe nodulocystic acne), and dissecting cellulitis (pustules and nodules on the scalp).

WHICH INVESTIGATIONS ARE MOST USEFUL IN PRIMARY CARE?

There is no specific investigation to diagnose HS. Investigations should be centred around the associated comorbidities (Figure 2). Screening blood tests should include full blood count, renal profile, liver function tests, fasting lipid profile, HbA1c, and vitamin D. Faecal calprotectin should be considered in patients with any associated symptoms of inflammatory bowel disease or isolated perianal disease where cutaneous Crohn disease would be in the differential diagnosis.

Routine bacterial cultures are not indicated and should be reserved for patients in whom a secondary infection is suspected.

WHAT TREATMENTS CAN BE STARTED IN PRIMARY CARE?

Treatments for HS can be started in primary care. Even in mild disease the pain, odour, drainage, and disfigurement can profoundly affect quality of life. Treatment aims to reduce the formation of new lesions, the symptoms and severity of existing lesions, and psychological morbidity.

Education and support should be provided, explaining to the patient that this is a chronic inflammatory condition and not related to poor hygiene, nor is it contagious. Discussion with the patient about the disease's impact on their quality of life and screening for depression is imperative.

Advice regarding wound care and dressings can help the patient to feel more confident, reduce pain from abrasion, and reduce odour. It is important to ensure that a plentiful supply of the chosen dressings are provided and that it is understood that dressings aim to control symptoms and not to heal the areas. Dressings should be highly absorbent and where possible adhesive dressings should be avoided to prevent irritation. Dressings can be held in place by garments. Where adhesive dressings are needed, a silicone-based dressing should be used and a barrier film should be applied before the dressing to reduce the risk of a medical adhesive-related skin injury (MARSI).

The pain from HS lesions can be profound. It is important to discuss this with the patient and provide appropriate analgesia as a GP would for other chronic pain conditions. The involvement of local pain clinics and a multidisciplinary approach are often required.

Monitoring for comorbidities should be carried out and annual screening is recommended for cardiovascular disease, obesity, tobacco and alcohol use, psychological disorders, inflammatory bowel disease, and inflammatory arthropathies. Support should be offered for smoking cessation and weight loss.

For mild disease where no tunnelling or scarring is present, topical clindamycin can be commenced and should be applied twice daily to areas that are prone to recurrent flares. If this is ineffective or if more severe disease is present, treatment should be stepped up to an oral tetracycline (for example, doxycycline 100 mg twice daily or lymecycline 408 mg once daily increasing to twice daily if there is a lack of response after

12 weeks or in obesity). Tetracyclines in HS can be used long term, but an annual full blood count and renal and liver function are recommended. Other options to consider include metformin, which can be used off-licence to help with insulin and insulin-like growth factor, which both may contribute to HS. The dose should be titrated over a few weeks aiming for a dose of 1500 mg per day in divided doses and can be combined with a tetracycline or given separately.[8]

WHAT SUPPORT IS AVAILABLE FOR PATIENTS?

In the UK the HS Trust offers support through its Facebook page (https://www.facebook.com/groups/hstrust/). The international groups offering support include:

- HS Connect (https://www.hsconnect.org/);
- Hope for HS (https://hopeforhs.org/); and
- HS Foundation (https://www.hs-foundation.org/).

WHEN SHOULD A PATIENT BE REFERRED TO SECONDARY CARE?

Criteria for referral to secondary care include:

1. Patients who fail to gain control of their symptoms with the therapies already suggested;
2. Severe disease (Hurley stage 3) present at diagnosis or multiple areas involved, numerous nodules, and tunnelling;
3. Significant impact on their quality of life; and
4. When the diagnosis is in question and further assessment is required.

Many centres now have a multidisciplinary approach including dermatologists, surgeons, clinical psychologists, microbiologists, weight management services, pain teams, and tissue viability services. Here patients can be offered multifaceted support and have pharmacological treatments escalated. Potential options include 12-week courses of rifampicin and clindamycin, dapsone, acitretin (in males and non-fertile females), and adalimumab. Specialist surgeons are often involved in a multidisciplinary approach and either local deroofing of individual tunnels, or extensive excision of affected areas, may be offered.

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Ethical approval

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Provenance

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Competing interests

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Patient consent

The patient gave consent for publication of this article and its images.

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