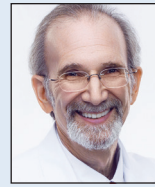




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## Hidradenitis Suppurativa

### THE PRESENTATION

Severe long-standing hidradenitis suppurativa (Hurley stage III) with architectural changes, ropy scarring, granulation tissue, and purulent discharge in the axilla of a 35-year-old Black man (A) and a 42-year-old Hispanic woman with a light skin tone (B).



Photographs courtesy of Richard P. Usatine, MD.

Hidradenitis suppurativa (HS) is a chronic inflammatory condition of the follicular epithelium that most commonly is found in the axillae and buttocks, as well as the inguinal, perianal, and submammary areas. It is characterized by firm and tender chronic nodules, abscesses complicated by sinus tracts, fistulae, and scarring thought to be related to follicular occlusion. Double-open comedones also may be seen.

The Hurley staging system is widely used to characterize the extent of disease in HS patients:

- Stage I (mild): nodule(s) and abscess(es) without sinus tracts (tunnels) or scarring;
- Stage II (moderate): recurrent nodule(s) and abscess(es) with a limited number of sinus tracts (tunnels) and/or scarring; and
- Stage III (severe): multiple or extensive sinus tracts (tunnels), abscesses, and/or scarring across the entire area.

### Epidemiology

Hidradenitis suppurativa is most common in adults and African American patients. It has a prevalence of 1.3% in African Americans.<sup>1</sup> When it occurs in children, it generally develops after the onset of puberty. The incidence is higher in females as well as individuals with a history of smoking and obesity (a higher body mass index).<sup>2-5</sup>

### Key clinical features in people with darker skin tones

The erythema associated with HS may be difficult to see in darker skin tones, but violaceous, dark brown, and gray lesions may be present. When active HS lesions subside, intense hyperpigmentation may be left behind, and in some skin tones a pink or violaceous lesion may be apparent.

### Worth noting

Hidradenitis suppurativa is disfiguring and has a negative impact on quality of life, including social relationships. Mental health support and screening tools are useful. Pain also is a common

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concern and may warrant referral to a pain specialist.<sup>6</sup> In early disease, HS lesions can be misdiagnosed as an infection that recurs in the same location.

Treatments for HS include oral antibiotics (ie, tetracyclines, rifampin, clindamycin), topical antibiotics, immunosuppressing biologics, metformin, and spironolactone.<sup>7</sup> Surgical interventions may be considered earlier in HS management and vary based on the location and severity of the lesions.<sup>8</sup>

Patients with HS are at risk for developing squamous cell carcinoma in scars even many years later<sup>9</sup>; therefore, patients should perform skin checks and be referred to a dermatologist. Squamous cell carcinoma is most commonly found on the buttocks of men with HS and has a poor prognosis.

## Health disparity highlight

Although those of African American and African descent have the highest rates of HS,<sup>1</sup> the clinical trials for adalimumab (the only biologic approved for HS) enrolled a low number of Black patients.

Thirty HS comorbidities have been identified. Garg et al<sup>10</sup> recommended that dermatologists perform examinations for comorbid conditions involving the skin and conduct a simple review of systems for extracutaneous comorbidities. Access to medical care is essential, and health care system barriers affect the ability of some patients to receive adequate continuity of care.

The diagnosis of HS often is delayed due to lack of HS knowledge about the condition in the medical community at large and delayed presentation to a dermatologist.

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