Answer to Dermacase *continued from* **page 1023**

3. Hidradenitis suppurativa

Hidradenitis suppurativa (HS) (or acne inversa) is a chronic, recurrent, inflammatory disease characterized by painful subcutaneous nodules affecting primarily the axillae, the perineum, and the inframammary fold.[1] The tender nodules often present at puberty and might spontaneously rupture or coalesce to form deep, painful dermal abscesses; subsequent hypertrophic scarring and dermal contractures often occur.[1] As a result of the location of the lesions and the chronic nature of HS, quality of life is severely affected.[2,3]

Typically, HS develops in the second or third decades of life; onset after menopause is rare.[1] There is a higher prevalence of HS in women, but men can have more severe HS, with lesions found in atypical locations[2]; overall prevalence is estimated at 1%.[4] There is no clear racial predilection.[1]

Hidradenitis suppurativa is understood to be a disease of follicular occlusion. Although the exact pathogenesis of HS is unknown, links to tobacco use, infection, genetics, and impaired immunity have been suggested.[5]

In addition to subcutaneous nodules, double comedones and ulcerations of the skin have also been described as features of HS.[1] Double comedones might be precursors of HS lesions in young children.[5] Common presenting complaints include burning, pruritus, local warmth, hyperhidrosis, and pain.

Diagnosis and treatment

Diagnosis of HS is made clinically, but the presence of the following 4 features can help to establish the diagnosis: 1) more than a single inflamed lesion, 2) chronic course, with new and recurrent lesions, 3) bilateral lesions, and 4) lesions located primarily in the milk line.[1] The differential diagnosis includes carbuncles, erysipelas, pilonidal cysts, and Crohn disease.[3] Carbuncles occur more commonly on the nape of the neck and back, and have greater incidences in those with poor hygiene and diabetes. They usually heal without treatment within 2 weeks.[6] Erysipelas is a specific, superficial cutaneous cellulitis characterized by a raised border and affecting primarily the legs, with associated constitutional symptoms.[6] Pilonidal cysts can be seen with HS, but they are typically found at the coccyx near the gluteal cleft. Antibiotic treatment is not necessary unless comorbid cellulitis is suspected.[6] Crohn disease might also be associated with HS; however, there is often a history of gastrointestinal signs and symptoms and primary involvement of the perianal region.[6] A thorough histology can help distinguish HS from its differential diagnoses in cases of greater uncertainty.[1]

Treatment of HS is medical or surgical, with antibiotics being the mainstay of initial therapy, particularly for acute lesions.[1,3] Use of topical 1% to 2% clindamycin twice daily for a minimum of 3 months is typical.[1] Topical clindamycin and oral tetracycline provide comparable benefits.[7] Continuation of treatment beyond 3 months reduces inflammatory nodules and abscesses.[7] Retinoids have not been found to be routinely effective, although a trial of isotretinoin can be considered.[8] Hormone therapy (eg, 5 mg of finasteride daily), particularly in women, has been used with good results.[9] Improvement has also been reported with combination use of ethinyloestradiol (50 mg) with cyproterone acetate (50 mg) or norgestrel (500 mg).[1] Spironolactone has been used anecdotally and found to be helpful.[3] Tumour necrosis factor–α inhibitors (including infliximab, etanercept, and adalimumab) have been found effective in severe HS refractory to antibiotic treatment[10]; further studies comparing tumour necrosis factor–α inhibitors with antibiotics are required. Abscesses that are fluctuating, full of liquid, and that do not respond to antibiotic therapy can be incised and drained to provide an immediate analgesic effect.[3] Packing of the wound might not be needed if the abscess is not deep or does not drain spontaneously.[3] Carbon dioxide laser therapy might also be considered for mild to moderate HS, with tissue ablation up to the subcutaneous plane.[11] Avoidance of tight-fitting clothing, smoking cessation, stress management, weight loss, and use of nonnarcotic analgesics are beneficial aspects of general treatment. For severe or intractable HS, surgery is the most effective treatment, particularly for the perianal and axillary areas.[1,3] Recurrence rates are lower, with more extensive tissue removal, where flaps or split-thickness skin grafts are used for wound closure.[1] Wide excision of lesions is most effective, followed by local excision; least effective is incision and drainage only.[1] For extremely severe HS, wide excision of all affected tissues and underlying sinus tracts is the best treatment option.

Ms Li is a third-year medical student at the University of Toronto in Ontario. **Dr Barankin** is a dermatologist practising in Toronto and Medical Director of the Toronto Dermatology Centre.

Competing interests
None declared

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