

Hidradenitis suppurativa: New drugs, old challenges



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Advances in pharmacologic therapy offer new hope to patients with hidradenitis suppurativa, and a pair of articles in the new “Controversies” section of the *Journal of the American Academy of Dermatology (JAAD)* examines the question of whether we have entered an age in which medical therapy can replace surgery in the treatment of this debilitating disease.

Recent guidelines are available to lead physicians through the dizzying array of agents reported to be effective in this setting,¹ and effective agents can be divided into groups by mechanism of action. Drugs that target neutrophils, including doxycycline, dapson, anakinra, and canakinumab, can reduce pain and inflammatory symptoms.^{2,3} Agents that target tumor necrosis factor- α have also shown efficacy. The approval of adalimumab added a valuable agent to our armamentarium, and high-dose infliximab regimens represent a new treatment paradigm with very good response in some patients.⁴ When efficacy is lost to neutralizing antibodies, some evidence suggests that adjuvant therapy with methotrexate can restore response.⁵ Ustekinumab has shown efficacy and agents that target either Th17 or interleukin 23 are being studied, with promising preliminary results. It is likely that a wide range of biologics will obtain labeled indications for the treatment of hidradenitis suppurativa. Antiandrogens such as spironolactone at doses of 50 to 75 mg daily have been shown to improve the course of disease, but higher doses were not shown to improve responsiveness in 1 key study.⁶ Additional studies should address the question of whether higher doses or combination therapy can improve outcomes. Apremilast can improve specific disease measures, but an overall effect on quality of life has been more difficult to demonstrate.⁷ Oral zinc plus niacinamide has been used,⁸ but long-term pharmacologic doses of zinc compete with copper absorption and can produce a serious hyperchromic anemia. Short courses of antibiotics that target anaerobic bacteria can be

beneficial but emergence of resistance complicates longer courses of treatment.

Physical interventions, including flushing of sinus tracts with normal saline, flushing with triamcinolone suspension, and injection of triamcinolone into sterile abscesses, can reduce pain and inflammation, but for persistent and severe disease, surgical intervention remains the definitive treatment. Localized areas of disease lend themselves to simple excision. For extensive disease, wide excision must include every interconnected sinus tract to avoid recurrence. Secondary intention healing, grafting, and flap closure may be necessary. Unroofing of sinus tracts with curettage to remove all diseased tissue can be extremely effective with less morbidity, but just as with excision, the procedure must address the full extent of interconnected sinus tracts.

I would like to take this opportunity to thank our authors for their willingness to argue each side of this controversy, knowing full well that the answer lies somewhere in the middle. My approach to the disease has evolved during the years, with greater emphasis on pharmacologic therapy. But for severe disease, surgical treatment reigns supreme and can produce durable improvement in quality of life. We hope you enjoy the new “Controversies” section in *JAAD* and invite suggestions for other medical topics that lend themselves to debate.

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Funding sources: None.

Conflicts of interest: None disclosed.

Reprints not available from the author.

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J Am Acad Dermatol 2020;83:733-4.

0190-9622/\$36.00

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<https://doi.org/10.1016/j.jaad.2020.05.031>

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