Opportunities for better outcomes in patients with hidradenitis suppurativa

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In this issue of the *JAAD*, a series of articles focus on advances and treatment gaps in the management of hidradenitis suppurativa. Orenstein et al[1] note an important gap in biologic prescription. They estimated the percentage of patients with HS who received a prescription for adalimumab or infliximab based on the number having active status in the database for at least 3 years who received more than 1 prescription for 1 of the 2 drugs during the 5-year period studied. They made a good faith effort to exclude those with *contraindications to* or *additional medical indications for* tumor necrosis factor-α—inhibitor therapy. Only approximately 18% of their patients had an established relationship with a dermatologist, and only 1.8% were treated with adalimumab or infliximab. While the study did not examine possible influence of access, surgical treatment, payer policy, or response to alternative medical therapy, the data suggest a significant gap in care for patients with a life-altering disease.

HS has a profound effect on quality of life, with a high percentage of patients experiencing anxiety and depression. A retrospective study of commercial, Medicare, and Medicaid claims data demonstrated high rates of emergency department visits and hospitalization among HS patients. The most frequently prescribed drugs included oral antibiotics and narcotics.[2] Extensive health care utilization and high rates of narcotic prescriptions suggest substantial opportunities to improve outcomes with more appropriate allocation of health care dollars toward disease-modifying therapies that do not promote addiction.

My own approach to the disease has evolved over time. Mild disease can respond to topical antiseptics, topical clindamycin, and intralesional corticosteroids. Disease flares show temporary improvement with oral antibiotic combinations, such as clindamycin with rifampin, along with flushing of sinus tracts with dilute triamcinolone suspension, but few patients will achieve sustained improvement with these regimens. Although agents such as spironolactone, dapsone, anakinra, and an increasingly wider range of biologics are useful, they seldom lead to complete cure in my experience. Moderate to severe disease responds best to surgical intervention in the form of extensive unroofing and curettage or excision of the entire region. American Academy of Dermatology treatment guidelines cite a high rate of patient satisfaction with deroofing techniques in which abscesses and interconnecting sinus tracts are probed, uncovered, and completely débrided, whereas simple incision and drainage is associated with an almost 100% recurrence rate.[3]

While surgery reigns supreme in our armamentarium, longitudinal data suggest that surgical intervention with adjunctive biologic therapy is superior to surgery alone.[4] I predict data will continue to support the combination of medical and surgical therapy as the standard of care. American Academy of Dermatology HS guidelines present an evidence-based treatment algorithm based on the best available evidence at the time of the review.[5] Evolving data suggest a role for biologics beyond those that target tumor necrosis factor, as well as other agents, such as spironolactone,[6] but surgical therapy remains the cornerstone of management.[7]

We have new promising options for mild to moderate disease, but the current best practice for severe HS is *extensive* surgical intervention together with medical therapy and avoidance of narcotics except for short-term postoperative analgesia. Patients with HS often become addicted to narcotics, and constricted pupils in a dimly lit room suggest the patient needs the help of a specialist in addiction medicine. HS is a complex and highly morbid

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disease associated with a high burden of depression, pain, and addiction. Earlier use of disease-modifying therapy has the potential to improve outcomes for this largely neglected disease.

REFERENCES

1. Orenstein LAV, Wright S, Strunk A, Garg A. Low prescription of tumor necrosis alpha inhibitors in hidradenitis suppurativa: a cross-sectional analysis. *J Am Acad Dermatol*. 2021;84(5):1399-1401.
2. Marvel J, Vlahiotis A, Sainski-Nguyen A, Willson R, Kimball A. Disease burden and cost of hidradenitis suppurativa: a retrospective examination of US administrative claims data. *BMJ Open*. 2019;9(9):e030579.
3. Alikhan A, Sayed C, Alavi A, et al. North American clinical management guidelines for hidradenitis suppurativa: a publication from the United States and Canadian Hidradenitis Suppurativa Foundations: part I: diagnosis, evaluation, and the use of complementary and procedural management. *J Am Acad Dermatol*. 2019;81(1):76-90.
4. Shanmugam VK, Mulani S, McNish S, Harris S, Buescher T, Amdur R. Longitudinal observational study of hidradenitis suppurativa: impact of surgical intervention with adjunctive biologic therapy. *Int J Dermatol*. 2018;57(1):62-69.
5. Alikhan A, Sayed C, Alavi A, et al. North American clinical management guidelines for hidradenitis suppurativa: a publication from the United States and Canadian Hidradenitis Suppurativa Foundations: part II: topical, intralesional, and systemic medical management. *J Am Acad Dermatol*. 2019;81(1):91-101.
6. Golbari NM, Porter ML, Kimball AB. Antiandrogen therapy with spironolactone for the treatment of hidradenitis suppurativa. *J Am Acad Dermatol*. 2019;80(1):114-119.
7. Wollina U, Brzezinski P, Koch A, Philipp-Dormston WG. Immunomodulatory drugs alone and adjuvant to surgery for hidradenitis suppurativa/acne inversa-A narrative review. *Dermatol Ther*. 2020:e13877. https://doi.org/10.1111/dth.13877.

Dermatology COVID registry: We need your help to answer critical questions about vaccine reactions

The Dermatology COVID-19 Registry is collecting data on cutaneous COVID-19 vaccine reactions.

The registry is supported by the American Academy of Dermatology and the International League of Dermatological Societies, and is available online through the AAD website at www.aad.org/covidregistry. Any health care worker can enter a case, data entry takes 5 to 7 minutes, and no patient-protected health information is required.

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Please enter any vaccine reactions you see into the registry.