TRANSCRIPT

S6E1: Clinical Cases in Hidradenitis Suppurativa

Dr Laxmi Iyengar: Welcome to *Spot Diagnosis*. My name is Dr Laxmi Iyengar, and I'm a research and education fellow at the Skin Health Institute, a world-renowned centre of skin excellence located in Melbourne, Australia.

I begin today by acknowledging the Wurundjeri people of the Eastern Kulin Nation, traditional custodians of the land on which we record this podcast and pay my respects to their elders past and present. I extend that respect to Aboriginal and Torres Strait Islander peoples listening today.

I would like to welcome my co-host, Associate Professor Alvin Chong. Our regular listeners will know that Alvin is a consultant dermatologist at St. Vincent's Hospital and Head of Transplant Dermatology at the Skin Health Institute.

Associate Professor Alvin Chong: Thank you, Laxmi. It's a pleasure to be here.

Laxmi: Alvin, today I would like to revisit a topic that we have explored previously, Hidradenitis Suppurativa, otherwise known as HS. In Season 3, Episode 3, we discussed the pathogenesis of HS in detail. Today, I would like to focus our discussion on the management of clinical cases.

Alvin: Thanks Laxmi, I can't stress enough how difficult HS is to manage. This is a disease that, while it doesn't kill anyone, causes great morbidity in many of the sufferers. In fact, some years ago, while I was at St. Vincent's, we did a presentation for the medical unit there, and it was entitled, "Hidradenitis Suppurativa, is this the worst dermatological disease?" After that presentation, I think quite a lot of our medical colleagues were quite horrified at how difficult and how tricky it is to manage. Today, we are very grateful to have with us another guest. That's Dr Diana Norris. Diana is a consultant dermatologist at St. Vincent's Hospital and the Skin Health Institute in the Advanced Targeted Therapeutics Clinic. Diana has a special interest in HS and is part of the HS Clinic at St. Vincent's Hospital, Melbourne. Welcome, Diana.

Dr Diana Norris: Thank you so much for having me.

Laxmi: Thanks for being here, Diana, and talking to us. Can we start with the basics? What is HS?

Diana: HS is a chronic inflammatory skin condition of the pilosebaceous unit. It's mostly seen in the armpits, groin, and around the buttocks, but it can be more widespread. HS is typically characterised by nodules and abscesses, which can progress to sinus tracts or tunnels and eventually lead to scarring. These nodules and abscesses are persistent and recurrent in their nature.

Laxmi: How does it present usually?

Diana: The onset of HS is usually around puberty, although it can present later in life. HS is three times more common in females. As mentioned, it's usually seen in areas of skin friction, such as armpits, groin, and underneath the breasts. HS patients are often told they have recurrent boils or cysts. A common story is that they have seen many different doctors or have many presentations to an emergency department before eventually reaching a diagnosis.

Alvin: That's right Diana, in fact, I see quite a lot of patients that have had multiple presentations to emergencies to have their boils and abscesses lanced before the penny drops. This is a chronic problem. A question our listeners may have is, how do you actually tell the difference between simple folliculitis and HS?

Diana: Folliculitis is infection of the hair follicle. Here in Melbourne, this is most often caused by commensal skin bacteria. If we are looking at folliculitis on the skin, we'd notice polymorphic pustules and papules, each of which is located on the hair follicle. Although HS is also a follicular unit issue, it isn't primarily caused by infection. HS is autoinflammatory in nature. That means there's pro-inflammatory cytokines within the pilosebaceous unit, which are contributing to the nodules. If I were to swab an area of folliculitis and send for microscopy, culture, and sensitivity, I'd likely get a result, usually positive for Staphylococcus aureus. If I swabbed an HS lesion, however, I usually get a negative result because there's no infectious etiology. A tip that I find for differentiating HS from other skin conditions, like folliculitis, is to look for the double comedones. This is two blackheads right next to each other. You won't see this in folliculitis or any other skin condition.

Laxmi: Thanks for that tip, Diana. Our listeners will find that really helpful. What are some complications of HS?

Diana: Most of the complications I see really stem from the two main issues that are experienced by HS patients, which are pain and discharge. Although infection isn't the primary cause of HS, I do at times see secondary infection as a result of this constant discharge. Comorbidities such as diabetes often come into play. If the discharge is prolonged and constant, patients can get anemia of chronic disease. Scarring is, unfortunately, quite commonly seen, and this can lead to restricted movements. Other complications in more severe cases include squamous cell carcinoma, and lymphoedema, both of which occur as a result of long-term chronic inflammation. This is usually seen in perianal HS. Perhaps the worst complication of HS is the psychological effects and the social isolation, which are a big issue in many chronic diseases, but really a huge problem in HS.

Laxmi: The psychosocial burden of HS is something that I often see as a GP. I was wondering if you could elaborate on that a bit further, please.

Diana: Nodules and abscesses are often tender, so pain is a really big factor for HS patients. Sometimes I see patients in so much pain from their HS that they can't sit, they can't lift their arms, and they can't do their regular jobs. This leads to time off work and then eventually financial stress. The other huge issue is discharge, which can be malodorous and cause a lot of distress. Managing discharge with pads or gauze is really difficult. They might need to change many times a

day, which can be really disruptive and embarrassing within the workplace. Dressings are also often really expensive. Seeking and maintaining relationships can be difficult for everyone, but having a condition like HS makes this even harder. Feelings of embarrassment, shame are very common, and HS patients often find themselves really isolated. Sexual dysfunction is also common. Luckily, we've got lots of online support groups, and I always encourage my patients just to have a look at these in case they find them useful.

Alvin: Yes, I think we've all seen terrible, terrible cases of HS where patients are unable to hold on jobs, unable to hold on relationships, and essentially their lives are almost wrecked by it. Tell me, Diana, what are the principles of managing HS?

Diana: Let's start with some general principles which apply to all patients with HS, regardless of severity. Number one, avoid friction, heat, and occlusive clothing. Bike shorts and tight gym gear are a common culprit. If your patient comes to their visit in their active wear, it's worth mentioning that this might be exacerbating their HS. Number two, weight loss in overweight and obese patients is useful. I don't like to make a big point of this during my initial consult, but rather I just point it out as a likely contributing factor. Similarly, smoking is known to exacerbate the condition, and I'll point this out to any HS patients that I see. Number three, antiseptic washes are a must. These should be applied daily to affected areas. Good options include pHisohex Wash or Chlorhexidine 2%. These can sometimes be short-stocked within pharmacies, so if you can't find them, look for Triclosan 1%, which is the same as pHisohex, or Microshield Skin Cleanser, which is Chlorhexidine 2%.

Laxmi: Diana, are there any topical treatments?

Diana: Yes, there are. This includes treatment like Clindamycin lotion or Resorcinol cream. These can be applied once or twice a day to any new or existing nodules.

Laxmi: What is Resorcinol?

Diana: Good question. Resorcinol is a drawing agent, so the aim really is to pull any of the discharge out to the surface of the skin and give the patient a rapid response and some relief. Resorcinol comes at a strength of 15%, and it needs to be made up at a compounding pharmacy. It can be quite expensive, so it won't suit everyone. It also has a rather short shelf life, which can be difficult for our rural patients. For some, it's a real game changer, though, when the effect of drying out the nodules provides rapid relief. If you want to try it for your patients, a script would read resorcinol 15% in stabilised emollient, apply BD to nodules.

Laxmi: How about oral treatments?

Diana: Oral treatments include oral antibiotics, such as Doxycycline or Erythromycin. I would typically prescribe Doxycycline at a dose of 100 milligrams daily. This should be taken in the morning with food. Erythromycin dosing is 400 milligrams BD. I would always warn patients of the potential for GI side effects with erythromycin. Aside from oral antibiotics, we can use antiandrogens, such as Spironolactone, or the combined oral contraceptive pill. Spironolactone

dosing usually starts at 50 milligrams in my patients. If they have no side effects, after two weeks, I'll ask them to increase to 100 milligrams daily. This can be a useful adjunct in patients who have cyclical flares. Metformin and Acitretin are less commonly used but are sometimes added, particularly in patients with relevant comorbidities.

Alvin: We've had a lot of advances in biologic treatments in medical conditions, and HS is one of these conditions. Maybe, Diana, you can take us through what can be prescribed for HS in terms of biologic treatments.

Diana: Sure. At the moment, the only Medicare-funded option we have is Adalimumab. We prescribe this to our patients after they fulfill specific criteria. Given the area of HS is broad and still being explored. There are a number of different targets that may be potential treatment options in the future. There's a lot of different biologic agents that are currently being trialed. The ones that we particularly have our eye on and may come into play over the next few years include the IL-17 agent Secukinumab. We're hoping to get this drug made available over the next few months.

Alvin: Surgical things, can they be done for HS?

Diana: Absolutely. The main treatment in regard to surgical procedures for HS is deroofing. This is our number one gold standard treatment, and we get really good outcomes from it. There's a large number of dermatologists that are able to do this procedure under local anesthetic, locally in their rooms, or through the public hospital system in particular services. Larger cases will be done by our plastic surgery colleagues, occasionally under local anesthetic, or larger cases under general.

Alvin: What about the cystic lesions? Can steroid injections be used sometimes?

Diana: Yes, and I find this a really useful trick for tender, problematic nodules as they come up. I like to use strengths between 10 to 40 milligrams per mil. The strength that I use really depends on the location. We need to be careful of atrophy in areas such as the groin, the axilla and in our younger patients who have less subcutaneous tissue. This is what directs me as to which strength to use. I'll apply a small amount directly into the center of the nodule itself and advise the patient that, fingers crossed, you'll have some rapid relief, and best case scenario, the nodule won't come back. Of course, there's a chance that it could recur, so I make sure that they're aware that there's a chance they'll be back in my rooms for a repeat injection down the track.

Alvin: Diana, how do you feel about these newer agents for weight loss, like GLP-1 receptor agonists? Do they have a place in HS?

Diana: Reducing weight loss is part of our general measures and general principles that, as I said, apply to all patients with HS. If they need some pharmaceutical help in their weight loss journey, I'm all for that. I would refer them on to our local Endocrinologist or link them in with one if they don't have one to discuss that further. Some of the general practitioners are also very well equipped to do this. On a case-by-case basis, I'll direct them to get further assistance from that perspective.

Alvin: *Ever wondered what the Skin Health Institute does? At the Skin Health Institute based in Melbourne, we aim to improve skin health for all our patients, and the research we conduct shapes clinical treatment and practice. We provide over 30,000 patient treatments each year, and also deliver exceptional education programs for dermatologists, registrars, and healthcare workers. We provide specialist training for visiting international medical graduates, workshops to upskill GPs and medical students, and public education programs aimed at improving skin health in the community. The Institute also conducts clinical trials and research projects that are published and presented internationally. We make substantial contributions to the worldwide clinical care and management of skin diseases, skin cancer, and melanoma, and are recognized globally for our medical research. We have multiple clinics for GPs to directly refer patients to. GPs can complete our online referral form available on our website at skinhealthinstitute.org.au/patientreferrals, or email referrals to referrals@skinhealthinstitute.org.au.*

Laxmi: I might take the liberty to discuss some recent encounters I've had with patients with both of you, which has sparked my interest in this topic for discussion today. The first is a case of a 23-year-old female. She's a non-smoker, and there are no other comorbidities. She presented to me for initial review with what she described as recurrent pimples in her groin area. Diana, can you please discuss your suggested approach to managing a patient with mild HS presenting in this way?

Diana: First, I would need to establish from history and examination that I'm confident with giving this young patient the diagnosis of HS. It can be a lot to digest. She has come in thinking she has a few stubborn pimples, and you'll be telling her that she has a chronic condition. This can be a really difficult conversation. An early referral to a dermatologist for diagnosis is always welcome. If you're going to proceed with the conversation, tell her all about HS and print out some trusted information for her to go home and read. I always do this, as we all know that sometimes our Google searches can lead you astray. I usually use the dermnet.nz handout, as I find this reads really well. I'd also make a point of telling her that she will see a range of severity in the images that she comes across online. Don't be spooked. She has early or mild HS, and this doesn't mean that she will progress to the more severe disease. Going through the general measures that we've already spoken about comes next. Avoiding tight clothing, avoid friction, and occlusive fabrics. Does she ride her bike as a regular means of transport, or is she a recreational cyclist? Wearing loose-fitting shorts where possible is useful, but please encourage your patient to keep on exercising, both for her mental health and her fitness. Does she use a form of hair removal in this area, and how does this affect her HS? If she's open-minded and a good candidate for laser hair removal, I have found it to be very useful in minimising nodules in some patients.

Finally, I'd talk her through using a daily over-the-counter wash such as pHisohex as part of a preventative approach. I would give her a prescription for clindamycin lotion or resorcinol to apply to the nodules. Before you finish this consult, make a time to follow up and review her progress. I often give patients an indication as to what's coming next. I'd say something like, "If this hasn't helped significantly, by the time I see you next, we will probably add in a tablet to help move things along."

Laxmi: I would like to discuss another case with you, a slightly more complicated case than the previous one. This patient is a 32-year-old female with recurrent HS in her axilla and her groin, with small sinus tract formation and scarring. She's on the combined oral contraceptive pill and has also been prescribed intermittent oral Doxycycline for a few weeks at a time for flares.

Diana: Just like the previous case, I would start by taking a full history and examining the patient to check that I'm happy with the diagnosis. Aspects of her history I'd be particularly interested in are whether she takes pain relief or has needed time off work for her HS. Does she flare around the time of her menstrual period? I'd also check her understanding of the condition. What does she already know about HS, and has she actually been given this diagnosis? You'd be surprised at how many patients I see that have been referred for HS but despite having this on their referral, they haven't had anyone sit down and talk to them about what it actually means. General measures always come next. I go through each and everyone with all patients regardless of severity. I'd check what wash she uses daily and which topical agent she is applying to the nodules. However, this patient has scarring and sinus tract formation, so really she needs oral therapy. Antibiotics for just a few weeks is insufficient for HS.

Just a reminder, HS isn't infectious in nature. It's an inflammatory issue. When we use antibiotics for HS, we're aiming for their anti-inflammatory effect, which means we need to use them for longer courses. I'd put this patient on three to four months of oral doxycycline at a dose of 100 milligrams daily. Let her know it might take a few weeks to start to work. In the meantime, she needs to be diligent with topical therapies and keep in mind all the general measures. She might have some tender nodules that are suitable for intralesional triamcinolone, and if this is the case, I'd do this for her today to give her some rapid relief.

Alvin: Can we now turn our attention to a patient with severe HS? This is actually a brief summary of one of the patients that I've managed at St. Vincent's. A 30-year-old female who has battled over 10 years of severe HS involving the gluteal area and the groin with interconnected cystic nodules. She's constantly discharging malodorous fluid. She has deep-seated sinus tracts. Her HS was so severe that she can't sit down without leaving a pool of discharge. She can't hold on a job. She's depressed kind of relationship. Essentially, I think this lady's life is completely dominated by her HS. All we have done, this was years ago, was give her regular antibiotics. It wasn't really enough. What would you do with a case like this, Diana?

Diana: Alvin, this is a really tricky case. Given her severe disease and quality of life disturbance, she's ideally managed in a hospital setting with multidisciplinary team involvement. There are so many aspects here that need addressing, from pain management to her psychosocial state to her wound management and dressings. I could go on and on. It's really easy to feel overwhelmed as a doctor facing a patient with HS for the first time. Let's just take it all back to basics. Is the diagnosis correct? There are conditions, for example, cutaneous Crohn's, that can mimic HS that I would really need to exclude with your patient. A detailed history, some investigations, or potentially referring to our gastroenterology colleagues might be necessary here.

Next, what does the patient know about their condition? What's their main problem from their perspective? My main goal today on this first encounter with this patient would not be necessarily to fix their skin but to start to understand the person and their needs. I'll cut straight to medical management.

My first thought in treatment modalities here is biologic therapy. Adalimumab is our only funded agent at this stage. I would start working the patient up towards the use of this medication. This includes blood screening, chest X-ray, and assessing their background vaccination status. Hopefully, we'll have other biologic agents available soon. There's also lots of great trials on the go. Here's my chance to throw a little shout-out to the clinical trials team at Skin Health Institute. There's three great HS trials running at the moment. I always think about them when I hear about tricky patients.

I'd involve other specialties as soon as possible. If the patient's open to this, of course, given the deep sinus tracks and the extent of the disease, it's very likely that we'll need the assistance of our surgical colleagues, and linking her in early would be best. The pain service at the hospital might also be needed. Finally, I do wonder if this patient is adequately supported in the community by a GP who knows them well and is able to advocate for them where needed.

Laxmi: I really like the way you explain that. When would you recommend a referral for specialty care?

Diana: I like to involve as many people and as many practitioners as possible from the very first consultation. HS is such a tricky condition to manage. The more help a patient can access, the better. GPs really are perfectly placed to coordinate holistic care, particularly with the assistance of a team care arrangement or a GP management plan. They are my first contact point. If a patient doesn't have a nominated GP, helping them find one is on my agenda from their very first visit. I'd love to see more GP management plans created on the basis of HS. GPs are really well versed with these plans, but for any derms listening who may be less familiar, this is a plan created by our GPs that allocates subsidised visits to nominated allied health professionals that are considered beneficial in managing a patient's chronic disease. Options that would benefit lots of our HS patients include nutritionists, physiotherapy, social work, and psychologists. For the GPs out there, it's surprisingly difficult to access these very helpful services within a public hospital. You would be surprised and shocked. We really need your help out there in the community. In terms of medical specialties, I'll refer to endocrinologists if my patients have features of polycystic ovarian syndrome or issues with weight management. I'll refer to plastic surgery for larger surgical cases. Pain management services if simple analgesia is inadequate. At times, gastroenterologists or general physicians.

Alvin: Do you have any pearls of wisdom for our listeners regarding HS and myths as well?

Diana: Yes. It's important to remember that by the time these patients appear in your consulting room, they've often experienced a long journey of pain, embarrassment, and sometimes misdiagnosis. Give them the time and the forum to recount and share their experience and talk

about it in their own words. I find this can be really therapeutic in itself. I try my best not to talk at all or interrupt. After they have shared their story, I usually start with some rapid-fire facts. Some examples that I use, include, "This is not caused by poor hygiene. This isn't caused by anything you've done wrong or anything that you haven't done. It is not contagious. It is not your fault. It is an awful problem. While this isn't curable yet, there's lots of ways to minimise it. My goal is to manage this to the point where you don't even notice it in your everyday life. There's lots of research happening in this area and new treatments being trialed. I'm really optimistic there'll be new treatment options in the next few years that could be real game changers. I'll keep you up to date on anything new that comes along that might suit you."

Laxmi: If there's one thing that I'm going to take away from today's episode, it's that HS is inflammatory, not infectious in nature. Thank you so much for that discussion today.

Alvin: Also, I want to point out how holistic your approach is, Diana. I'm so impressed that you deal with the whole patient rather than just dealing with a small aspect of their disease. Thank you for highlighting this as a way of treating chronic disease.

Diana: Thanks, Alvin.

Laxmi: That concludes today's episode on HS and I personally hope that our listeners learned a lot from today's discussion. I hope that the spot diagnosis community will be able to recognise and treat HS and escalate care if required. Please also refer to the HS episode in Season 3, Episode 3 for further information on the topic.

Diana, thank you for being here and sharing your expertise. It was a pleasure to have you on *Spot Diagnosis*. Alvin, thank you also for sharing your insights. We would like to thank the education team at the Skin Health Institute and Balloon Tree Productions.

Remember, these podcasts are not meant to replace medical advice. If you have a skin condition that requires attention, we strongly encourage you to see your medical practitioner. For listeners who want more information on this subject, a transcript of this episode and links to other resources can be found on our website, spotdiagnosis.org.au. That's spotdiagnosis.org.au. Please share *Spot Diagnosis* with your friends and colleagues. Rate and review us. Let us know what you think. We would really appreciate your feedback and any suggestions. Also, please note that *Spot Diagnosis* is eligible for RACGP and ACRRM CPD.

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