key points

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Hidradenitis suppurativa is a chronic inflammatory skin disease which can develop from puberty onwards, with painful, deep-seated inflamed lesions at characteristic sites. A prevalence of 1-4% has been reported in studies of European populations, and a higher prevalence in those of African-American and mixed race ethnicity. Figures from a UK GP database show that 75% of people diagnosed with hidradenitis suppurativa are women. Patients are mostly of working age with an average age of 36 years at diagnosis.

It is much more common in smokers. There is also a clear link with obesity, and a relationship between increase in BMI and worsening severity of hidradenitis suppurativa in women. Up to 40% of patients are aware of a family history of the condition. Underlying mechanisms causing the disease are still unclear, but evidence suggests that the inflammatory process is driven by an abnormal immunological response, along with follicular occlusion and hormonal factors. Patients have a significant increase in the risk of myocardial infarction, stroke, diabetes mellitus and metabolic syndrome, and the risk of sudden cardiac death is twice that of population controls.

Patients complain of recurring painful boils in one or more of the typical areas. In women the most common areas affected are under the arms, under the breasts, in the groin, medial thighs, or suprapubic area and in men the armpits, buttocks and perianal area. The diagnosis is made clinically, in the presence of typical skin lesions at characteristic sites. Hidradenitis suppurativa is diagnosed on history and clinical appearance.

Specific treatment for hidradenitis suppurativa is determined by the severity on clinical assessment. In mild disease, where there is no skin scarring, topical treatment with 1% clindamycin lotion twice daily for three months may be as effective as oral tetracyclines. If systemic treatment is preferred, or in patients with more frequent flares, either lymecycline 408 mg or doxycycline 100 mg once or twice daily for three months is advised. Washing with topical antiseptics such as chlorhexidine 4% lotion or benzalkonium chloride may delay the development of bacterial resistance. At 12 weeks, if there is a good treatment response the therapy should be continued for at least a further three months, if not referral to dermatology services should be made.

If patients have advanced disease at presentation (Hurley stage III) with extensive sinus tract formation throughout one or more areas, an early referral to secondary care is likely to be appropriate, as management of these patients is often complex, involving both medical and surgical interventions. In secondary care oral clindamycin and rifampicin may be used in severe or resistant cases. Other options include dapsone and metformin. Adalimumab, a biologic drug, is now licensed and approved by NICE for specialist use in moderate to severe hidradenitis suppurativa where standard therapies have failed to produce adequate disease control.