HS

Autoinflammatory,
and not your fault.

References

1.Goldburg SR, Strober BE, Payette MJ. Hidradenitis suppurativa: Epidemiology, clinical presentation, and pathogenesis. J Am Acad Dermatol. 2020 May;82(5):1045-1058. doi: 10.1016/j.jaad.2019.08.090. Epub 2019 Oct 9. PMID: 31604104.

2. Zouboulis CC, Desai N, Emtestam L, Hunger RE, Ioannides D, Juhász I, Lapins J, Matusiak L, Prens EP, Revuz J, Schneider-Burrus S, Szepietowski JC, van der Zee HH, Jemec GB. European S1 guideline for the treatment of hidradenitis suppurativa/acne inversa. J Eur Acad Dermatol Venereol. 2015 Apr;29(4):619-44. doi: 10.1111/jdv.12966. Epub 2015 Jan 30. PMID: 25640693.

3. Oakley A, Hidradenitis suppurativa: severity assessment [internet]. New Zealand: Dermnet; 2015 [cited 2021, Dec 6]. Available from: https://dermnetnz.org/topics/hidradenitis-suppurativa-severity-assessment

4. Zouboulis CC, Bechara FG, Dickinson-Blok JL, et al. Hidradenitis suppurativa/acne inversa: a practical framework for treatment optimization - systematic review and recommendations from the HS ALLIANCE working group. J Eur Acad Dermatol Venereol. 2019 Jan;33(1):19-31. doi: 10.1111/jdv.15233. Epub 2018 Oct 23. PMID: 30176066; PMCID: PMC6587546.

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 Jul;81(1):91-101. doi: 10.1016/j.jaad.2019.02.068. Epub 2019 Mar 11. PMID: 30872149.

6. Nguyen TV, Damiani G, Orenstein LAV, et al. Hidradenitis suppurativa: an update on epidemiology, phenotypes, diagnosis, pathogenesis, comorbidities and quality of life. J Eur Acad Dermatol Venereol. 2021 Jan;35(1):50-61. doi: 10.1111/jdv.16677. Epub 2020 Jul 16. PMID: 32460374.

7. Calao M, Wilson JL, Spelman L, Billot L, Rubel D, Watts AD, Jemec GBE. Hidradenitis Suppurativa (HS) prevalence, demographics and management pathways in Australia: A population-based cross-sectional study. PLoS One. 2018 Jul 24;13(7):e0200683. doi: 10.1371/journal.pone.0200683. PMID: 30040827; PMCID: PMC6057625.

8. Jfri AH, O'Brien EA, Litvinov IV, Alavi A, Netchiporouk E. Hidradenitis Suppurativa: Comprehensive Review of Predisposing Genetic Mutations and Changes. J Cutan Med Surg. 2019 Sep/Oct;23(5):519-527. doi: 10.1177/1203475419852049. Epub 2019 Jun 6. PMID: 31167568.

HS Facts

Patients experience a significant **delay to diagnosis** ranging from an average of **7 to 10 years**.(6)

The prevalence of HS in Australia is estimated to be **0.7%**(7)

It is estimated **30-40%** of patients report a **family history** of HS.(8)

HS is associated with several other conditions, including: polycystic ovarian syndrome, inflammatory bowel disease, metabolic syndrome, diabetes mellitus type 2 and depression.(6)

HS can have a **significant impact on mental health** and quality of life.(6)

Disclaimer: information in this brochure is based on personal experience treating HS patients. This is an interpretation of the literature and is not intended to be definitive or include all treatments previously reported. This is what we have found works in our clinical practice.

Hidradenitis Suppurativa

Patient education and treatment guide

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What is HS ? [1,2]

A chronic autoinflammatory skin condition.
Immune system malfunctioning.

CLINICAL SIGNS:

Nodules, abscesses, sinus tracts, fistulas and scars. Common sites: axilla, groin and buttock.

WHAT CAUSES HS?

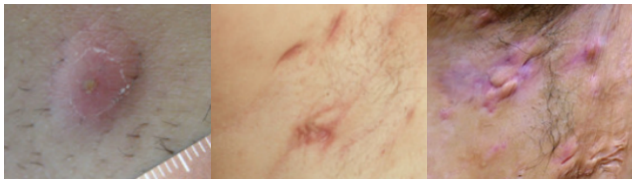
Research is ongoing, what we know so far: hair follicle becomes blocked with keratin -> inflammation, increased pro-inflammatory cytokines (e.g. IL-1, IL-17, TNFalpha) -> follicle ruptures -> chronic inflammation causing sinus tracts, abscess and cyst.

RISK FACTORS:

- smoking - 13 times increased risk(2)
- genetics
- hormone changes
- obesity - 4 times increased risk(2)

STAGING[3]

HS Hurley classification



I: Mild
Isolated abscess

II: Moderate
Scarring and sinus tracts, some normal skin.

III: Severe
Diffuse scarring and sinus tracts

Treatment [2,4,5]

Your HS treatment my consist of a number of different branches

PREVENTION OF NEW HS LESIONS

- ☐ Washes: phisohex or chlorhexidine, daily.
- ☐ 1% clindamycin lotion: apply daily to affected HS areas, after shower.
- ☐ Lifestyle changes: smoking cessation and healthy body weight.

WHEN YOU DEVELOP A NEW NODULE

- ☐ Resorcinol 15% in emollient base: a peeling/drying agent. Apply to new nodules 1-2 times a day.

WOUND CARE

For discharging sinus tracts or nodules: simple absorbent dressings, eg: sanitary napkins, gauze, combine. Avoid adhesive dressings and tapes.

ORAL MEDICATIONS

Antibiotics (anti-inflammatory action)

- ☐ Doxycycline: daily (at breakfast) for 3-4 months

Hormonal blockers:

- ☐ Spironolactone
- ☐ Oral contraceptive pill
- ☐ Metformin

INTRALESIONAL CORTICOSTEROID INJECTIONS

- ☐ Steroid solution (e.g. kenacort A10) injected into an inflamed HS lesion.

BIOLOGICS

- ☐ An injection that targets inflammatory markers that drive HS, e.g TNF, IL-1, IL-17. For moderate to severe HS that is not responding to other treatments.

SURGERY

- ☐ Deroofing: definitive treatment for painful recurrent nodules, fistulas or sinus tracts. Healing from the base up, leaves a scar.

Learn more about what is HS by watching our video, scan QR code

Scan the below QR code to learn more about HS deroofing surgery

For support, email Australia's first HS support group, HS Support Australia: HSaustralia@yahoo.com