What has changed in the UK management of hidradenitis suppurativa from 2014 to 2019?

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Dear Editor,

A previous survey demonstrated the management of hidradenitis suppurativa (HS) in the UK in 2014[1] and subsequently, in 2018, the first UK guidelines for the management of HS were published.[2] We recently repeated the survey to evaluate whether there has been a change in the management of HS influenced by the guidelines and new HS treatment evidence.

The data were collected via an online survey that was accessible to members of the British Association of Dermatologists (BAD) between the 1st of November and 15th of December 2019. The total number of respondents was 54 in the 2019 survey and 134 in the 2014 survey of whom the majority were consultants (77.8% and 65.7% respectively). Approximately 75% of the participants in our 2019 survey see 1-5 new HS cases monthly with nearly 45% having more than 12 HS patients under their care.

The guidelines recommend using a topical antiseptic or antibiotic in mild to moderate HS. The frequency of prescribing a topical antiseptic remained the same (approximately 87%) while the frequency of prescribing a topical antibiotic increased in the 2019 survey from 67% to 79%.

Participants were asked to rank the top ten most frequently prescribed treatments for moderate to severe HS. Figure 1 compares the results of the 2014 and 2019 surveys. The guidelines recommend that tetracyclines or a combination of clindamycin and rifampicin be used to manage moderate to severe HS as first-line therapy. Tetracyclines were the most frequently prescribed first-line therapy, chosen by 44% of respondents, followed by the combination of clindamycin and rifampicin which was prescribed by 35% as first-line therapy and 44% as second-line therapy. In the 2014 survey, 75% of respondents prescribed tetracyclines and 12% gave clindamycin and rifampicin as first-line therapy. The majority (88%) prescribed clindamycin and rifampicin for 10-12 weeks as recommended by the guidelines while only 4 respondents prescribed longer courses of 26 weeks or more.

The BAD guidelines recommend that adalimumab followed by infliximab may be used when oral antibiotics, dapsone and acitretin (male patients or infertile females) therapy fails. In the 2019 survey adalimumab was the second most prescribed therapy (83%) followed by infliximab (30%). In contrast, in the 2014 survey, infliximab was the most commonly prescribed biologic followed by adalimumab and ustekinumab (46%, 27%, and 9% respectively). Ciclosporin which was ranked 6th (34%) in the 2014 survey did not rank in the top 10 interventions in the 2019 survey, prescribed by only 13% of respondents this time.

Antiandrogen therapies for HS, namely metformin and spironolactone, have shown benefit in several retrospective case series.[3,4] Approximately 52% and 28% of the respondents selected metformin and spironolactone in their top 10 therapies for HS, compared to 13% and 12% respectively in 2014.

Based on case series evidence, the BAD guidelines recommend avoidance of isotretinoin for HS in the absence of acne. Compared to 2014, the proportion of respondents prescribing isotretinoin for HS has nearly halved, from 62% to 35%, and isotretinoin has dropped from fourth to ninth choice.

There is still much debate about what constitutes a flare in HS and how to manage acute, painful lesions. Survey participants were asked what they recommend to manage an acute painful abscess. The most common responses in 2019 were oral and IV antibiotics (32%) and incision and drainage (30%) followed by deroofing surgery (15%) and intralesional triamcinolone (11%). Only a few respondents recommended oral steroids (4%) or analgesia as monotherapy (4%). In the previous survey, incision and drainage was the commonest acute intervention (45%).

Several studies have highlighted the increased prevalence of cardiovascular disease[5] and mental health problems [6,7] in people with HS. The BAD guidelines recommend that all patients should be screened annually for cardiovascular risk factors and depression and approximately one-quarter of

our respondents in 2019 (24.5%) were carrying out screening in their practice. This question was not included in the 2014 survey and so any change cannot be quantified.

While the 2019 survey targeted a similar population to the 2014 survey, there were fewer respondents in 2019 and it is likely that individuals differed between the two surveys, which is a limitation when comparing the results of the surveys.

Repeating the 2014 survey demonstrates that HS care has evolved in the UK during the last 5 years, with greater access to adalimumab, less isotretinoin use and evidence of holistic care with screening for associated diseases. A national clinical audit based on the audit standards set in the guidelines has just been completed and the results will help in further dissemination of the BAD recommendations. Several challenges remain, such as management of an acute flare and development of surgical options.

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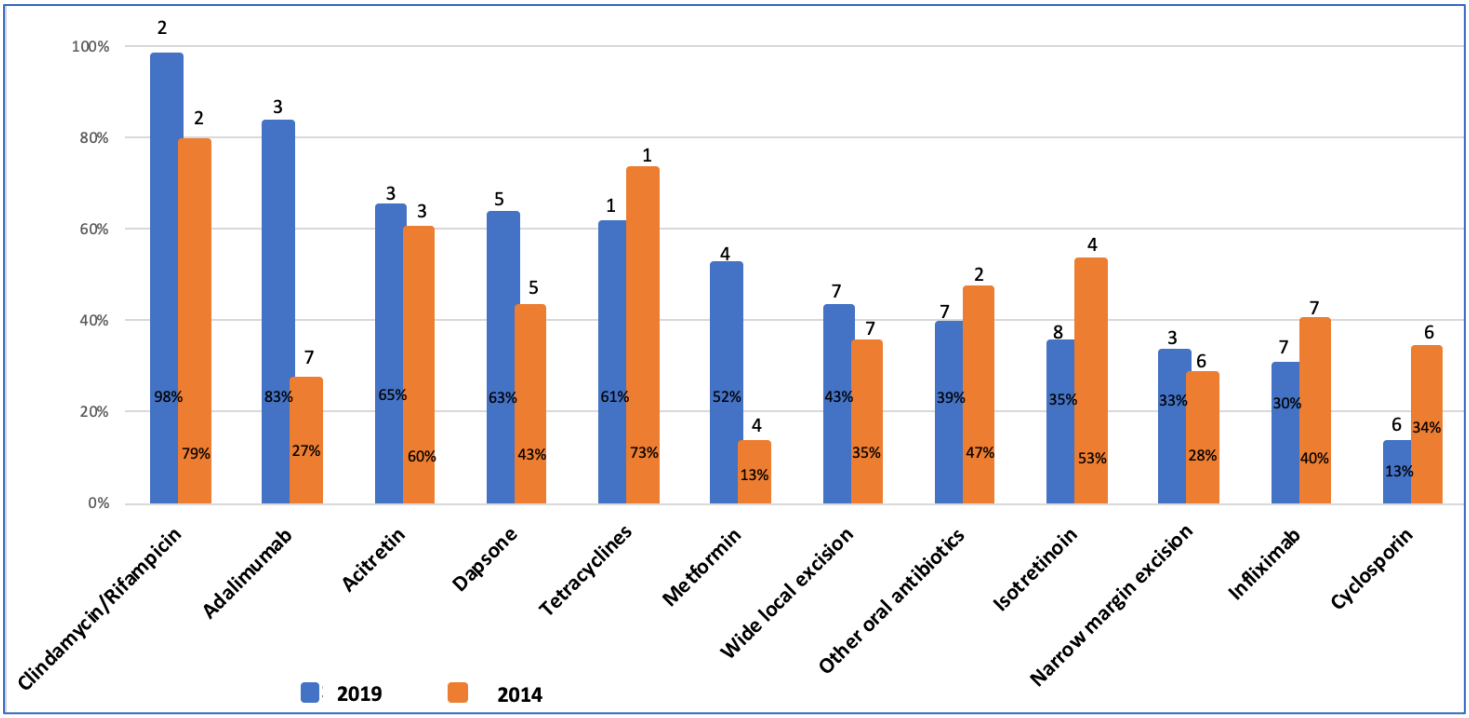

Fig 1. A chart showing the top 10 most common interventions for moderate to severe HS in the UK in 2014 and 2019. The numbers above the bars indicate the mode for the distribution of the ranking for each intervention.