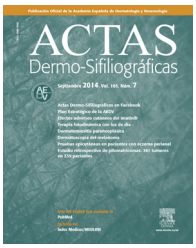
Actas Dermosifiliogr. 2015;106(9):716–724

ACTAS Dermo-Sifiliográficas

Full English text available at www.actasdermo.org



REVIEW

Update on Hidradenitis Suppurative (Part II): Treatment☆

A. Martorell,[a,*] F.J. García,[b] D. Jiménez-Gallo,[c] J.C. Pascual,[d] J. Pereyra-Rodríguez,[e] L. Salgado,[f] E. Vilarrasa[g]

[a] *Servicio de Dermatología, Hospital de Manises, Valencia, Spain*
[b] *Servicio de Dermatología, Hospital Universitario del Sureste, Arganda del Rey, Madrid, Spain*
[c] *Unidad de Gestión Clínica de Dermatología, Hospital Universitario Puerta del Mar , Cádiz, Spain*
[d] *Hospital General de Alicante, Alicante, Spain*
[e] *Hospital Virgen del Rocío, Sevilla, Spain*
[f] *Complejo Hospitalario de Pontevedra, Pontevedra, Spain*
[g] *Hospital de Santa Creu i Sant Pau, Barcelona, Spain*

Received 4 May 2015; accepted 30 June 2015
Available online 9 October 2015

KEYWORDS
Hidradenitis suppurativa;
Acne inversa;
Surgery;
Biologic therapy;
Systemic treatment;
Adalimumab

Abstract Although hidradenitis suppurativa is a common and serious skin condition, its treatment is not well established. It is now accepted that the moderate and severe forms of the disease are associated with marked systemic inflammation. The goal of treatment in hidradenitis suppurative is therefore to achieve systemic control of inflammation. In some cases, surgery may also be necessary to reduce the severity of the manifestations of cutaneous inflammation. Recent advances in our understanding of hidradenitis suppurativa have been accompanied by the emergence of novel approaches to its treatment, including the use of certain biologic drugs. Several clinical trials have been undertaken to test the effects of biologics (mainly adalimumab) in this setting. In this review, we analyze the different treatments available for hidradenitis suppurativa.

PALABRAS CLAVE
Hidradenitis supurativa;
Acné inversa;
Cirugía;

Actualización en hidradenitis supurativa (II): aspectos terapéuticos

Resumen A pesar de la importancia y de la gravedad de la hidradenitis supurativa, el tratamiento de esta enfermedad no se encuentra bien definido. Hoy en día, la hidradenitis es considerada una enfermedad cutánea que principalmente en las formas moderadas y severas

☆ Please cite this article as: Martorell A, García FJ, Jiménez-Gallo D, Pascual JC, Pereyra-Rodríguez J, Salgado L, et al. Actualización en hidradenitis supurativa (II): aspectos terapéuticos. Actas Dermosifiliogr. 2015;106:716–724.

* Corresponding author.
E-mail address: antmarto@hotmail.com (A. Martorell).

Terapia biológica;
Terapia sistémica;
Adalimumab

se asocia a un marcado componente inflamatorio sistémico. Por lo tanto, el tratamiento de esta enfermedad irá enfocado hacia un manejo sistémico del control de la inflamación, que ocasionalmente irá acompañado de la intervención quirúrgica para reducir la carga de inflamación localizada en la piel.

Los recientes avances en el conocimiento de la enfermedad se han acompañado de novedades terapéuticas, especialmente representadas por el desarrollo de ensayos clínicos de determinadas terapias biológicas, principalmente adalimumab, orientados al tratamiento específico de esta enfermedad.

En la presente revisión se pretende analizar las diferentes alternativas terapéuticas existentes en el manejo de la hidradenitis supurativa.

Introduction

Hidradenitis suppurativa (HS) is currently considered an inflammatory disease of the pilosebaceous follicle with an underlying immune system imbalance that affects genetically predisposed individuals. The course of disease can be modified by exogenous triggers or aggravating factors.[1,2]

The association between HS and autoimmune and autoinflammatory diseases, such as pyoderma gangrenosum and Crohn disease (Fig. 1),[1] together with clinical and laboratory findings, supports the existence of an immune system imbalance and consequently suggests inadequate control of the inflammatory response around hair follicles in intertriginous areas.

HS represents a true therapeutic challenge, with dermatologists responsible for taking decisions regarding patients' treatment needs.

General Measures

Numerous general measures can be taken to reduce situations that trigger flares, including tobacco cessation, weight reduction, control of cardiovascular risk factors, avoidance of the use of irritants in affected areas, and hair removal using lasers rather than razors.[1] These measures should be complemented by adequate psychological support, which in some cases will need to be intensified.

Local Treatment

The main noninvasive local treatment for localized Hurley stage I or mild stage II lesions is topical clindamycin 0.1% applied every 12 hours.[1–3] In one clinical trial, oral tetracycline administered at 500 mg/12 h did not show superior results to topical treatment with clindamycin.[4] Topical resorcinol 15% has also proven to be effective in reducing the pain and duration of inflammatory lesions in patients with Hurley stage I or II lesions.[1–3] Intralesional corticosteroids are the most common invasive local treatment and the most widely used drug is slow-release triamcinolone acetonide (depot preparation 40 mg/mL). Triamcinolone acetonide injections result in the remission of inflammatory nodules within 48 to 72 hours in patients with acute local lesions.[1]

First-Line Systemic/Biologic Therapies

First-line treatments for HS are treatments supported by high levels of evidence and favorable results.

Systemic Treatments

Combined Treatment With Oral Clindamycin and Oral Rifampicin

The combined use of clindamycin 300 mg/12 h and rifampicin 300 mg/12 h for 10 weeks is one of the most common treatments used to induce remission in patients with HS, regardless of disease severity (Hurley stage I, II, or III).[1] The beneficial effects of this combination of antibiotics have been confirmed by all series published to date, including a report of 116 patients.[5,6] The therapeutic effect is attributable to the anti-inflammatory properties of the 2 drugs and probably also to their ability to destroy the biofilm mentioned in the first part of this review article. The combination is well tolerated, as the most common adverse effects are gastrointestinal discomfort and diarrhea (generally mild).[1]

Other antibiotics used to treat HS are doxycycline, minocycline, and rifampicin associated with moxifloxacin and/or metronidazole, with variable response.[1–3]

Oral Acitretin

The use of acitretin in the treatment of HS is justified by the involvement of psoriasiform hyperplasia in the etiology and pathogenesis of the disease. In a recent study (2014), Matusiak et al.[7] reported on the efficacy of acitretin (mean [SD] dose, 0.56 [0.08] mg/kg/d) in 17 patients with HS. Nine of the patients completed the 9 months of treatment, and 8 (47%) achieved a reduction of 50% from baseline in the Hidradenitis Suppurativa Severity Index. The authors concluded that acitretin appears to be a promising option for the management of HS, although they cautioned that its use might be limited by the high doses required.

Isotretinoin has not proven to be effective in HS, probably because it primarily causes atrophy of hypertrophic sebaceous glands, which are seen in juvenile acne, but not in HS.[1,7]