Local wound care and topical management of hidradenitis suppurativa

Afsaneh Alavi, MD, MSc,[a] and Robert S. Kirsner, MD, PhD[b,c]
Toronto, Ontario, Canada, and Miami, Florida

Hidradenitis suppurativa (HS) is a chronic, recurrent, debilitating disease predominantly involving apocrine gland–bearing skin. The folliculoinfundibular dysfunction and an aberrant cutaneous immune response to commensal bacteria are recognized as potential contributors. Topical antibiotics, such as clindamycin, and keratolytic agents have been used in the management of early stages of HS. Proper wound care is a key part of management, particularly in patients with advanced HS. The evidence for the optimal topical therapy or optimal local wound care is limited. As such, a multidisciplinary approach is necessary to address all aspects of HS, including topical therapy, systemic therapy, and proper wound care. The focus of this paper is to review the evidence for the topical management and local wound care strategies in patients with HS. (J Am Acad Dermatol 2015;73:S55-61.)

Key words: clindamycin; hidradenitis suppurativa; NPWT; resorcinol; retinoid; topical treatments.

INTRODUCTION

Patients with hidradenitis suppurativa (HS) suffer the dilemma of living with a chronic, recurrent draining wound.[1] The smell, exudate, pain, and the need for frequent dressing changes all significantly affect their activities of daily living.[2]

Despite the enigmatic etiology of HS, the folliculoinfundibular dysfunction and an aberrant cutaneous immune response to commensal bacteria are known as the main contributors. HS requires a multidisciplinary team approach to address associated comorbidities and offer effective medical and surgical treatments. In this paper, we focus on topical care.

THE ROLE OF TOPICAL THERAPY

HS is divided into 3 stages according to the Hurley classification system. Topical antibiotic and topical keratolytic agents have been used as adjunctive therapies in the management of patients with mild HS (Hurley stage I or abscess formation without sinus tracts), based on the possible pathogenesis of occlusion of follicles and the role of bacteria.[3] The European guideline in the management of HS recommended topical clindamycin as first-line therapy for patients with Hurley stage I HS.[4]

In 1 study from the United Kingdom, antiseptics were used routinely (in 88% of cases), and topical antibiotics were used by 67% of patients with HS.[4] There are, however, few controlled trials studying the role of topical antibiotics as therapy for HS. One study, a small randomized, controlled trial (RCT), found topical administration of clindamycin reduced abscess, nodule, and pustule formation.[5] The exact mechanism by which topical clindamycin works is not entirely apparent because it has antimicrobial effects, reduces free fatty acids in the surface lipids, and suppresses leukocyte chemotaxis. In addition, although not studied in RCTs, topical resorcinol and topical retinoids also have been used in limited cases.[4,6] Table I summarizes the evidence for the role of topical therapy in patients with HS.

LOCAL WOUND CARE

Cleansers

Local hygiene may be an important factor to suppress the potential triggers of an aberrant immune response and to prevent secondary infection.

From the Department of Medicine (Dermatology),[a] University of Toronto, and the Departments of Dermatology[b] and Cutaneous Surgery,[c] University of Miami.

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Correspondence to: Afsaneh Alavi, MD, MSc, Department of Medicine (Dermatology), Women's College Hospital (main bldg), Wound Care Center, 76 Grenville St, 10th fl, Toronto, ON M5S 1B2, Canada. E-mail: afsaneh.alavi@utoronto.ca.

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The use of antiseptics and topical antibacterial agents may decrease the bacterial colonization.

The selection of appropriate wound cleansers may be helpful. Standard wound cleansing calls for the use of agents with low cytotoxicity including sterile water and isotonic normal saline. However, some suggest, in spite of any robust evidence, the use of antiseptic wash in patients with HS. The risk of contact dermatitis with frequent use needs to be weighed.

CAPSULE SUMMARY

- Long-term efficacy and safety data are limited or nonexistent for topical treatments for hidradenitis suppurativa.
- Topical antibiotics and keratolytics have been used to treat hidradenitis suppurativa–associated wounds.
- Proper wound care must fit the clinical circumstances for each patient, such that the treatment improves quality of life.

Antiseptics

Bacteria are thought to contribute to the pathogenesis of HS. The microbiome of HS, however, is complicated by the fact that cultures from the lesions are frequently sterile. In addition, antibiotics do not play a curative role in the management of HS. Lapins et al[9] found various colonized pathogens in severe HS, including Gram-positive and -negative bacteria. Antiseptics, therefore, may potentially play a role in the management of these patients. The use of antiseptics, such as silver and iodine, has been beneficial in critically colonized wounds.

Dressings

Proper dressings for patients with HS depend on the location of the lesions, the extent of the disease, the morphology of the lesions—for example, whether they are ulcers, tunneling sinuses, or abscesses—the amount of exudate, wound smell, dressing cost, and availability (Fig 1). In the presence of cavity and tunneling, the dressings should be adequate for packing to fill the cavities and absorb the fluids. By contrast, with superficial lesions, plain absorptive dressings can be applied (Fig 2). Depending on the amount of exudate, the choice of the dressings varies from superabsorbent dressings to foams to hydrofibers to calcium alginates. A dressing needs to stay in place to avoid friction and be in proper shape for a curved location, such as folds (Fig 3). Atraumatic adhesives—for example, silicone and nonadherent wound contact layers—limit skin damage by diminished trauma and minimize pain at dressing changes.

Wide surgical excision is often performed in patients with advanced HS. For that reason, local wound care is critical to heal postsurgical skin defects in patients with HS. The management of HS postsurgical wounds would be similar to other postsurgical wounds. For wounds not closed primarily and of significant depth, negative pressure wound therapy has been initiated therapeutically for a variety of postsurgical wounds including those that present in patients with HS.[10-12] Negative pressure wound therapy increases oxygen tension, decreases bacterial load, stimulates cellular activity, and promotes granulation tissue. It also prepares the wound bed for grafting. Table II lists the current evidence for the use of dressings in these patients.

In conclusion, the data in regard to local wound care in patients with HS remain limited. There is a need for RCTs that examine different types of dressings and topical medications. Because proper wound care improves the quality of life of patients with HS, there is a need to fully address this aspect of patient management in a research setting.

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