Clinical vignette

Hidradenitis suppurativa

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Hidradenitis suppurativa is a chronic, recurrent, indolent, suppurative and cicatricial disease of apocrine gland-bearing skin. The apocrine sweat-glands are largely confined to the axillae, anogenital area and female breast. Patients with hidradenitis may present to specialists in genitourinary medicine who must therefore be aware of the condition.

The onset of the disease is rare before puberty (when the apocrine glands reach full development) or after 40 years of age.[1] There is no racial or sexual variation in incidence although axillary disease is more prevalent in females and anogenital disease in males. It occurs worldwide but more commonly in the tropics.[2]

The disease results from occlusion of apocrine ducts by keratin with resulting dilatation of the glands and secondary bacterial infection. Suppuration is followed by ulceration of the overlying skin. Healing is by fibrosis. The histology is diagnostic in early disease with keratinous occlusion of individual ducts and leucocytes and groups of cocci in the distended glands and surrounding skin. In late disease histology is non-specific showing only chronic inflammation and fibrosis. The cause of the disease process is unknown.[2] Observations that some women show improvement during and deterioration after pregnancy and that others suffer premenstrual or menstrual exacerbations suggest hormonal factors.[1] Local trauma from shaving or tight clothing and the application of depilatories or deodorants have been implicated in the initiation of disease.[2] However, one study demonstrated no significant differences in these practices between patients with hidradenitis and normal controls.[3]

Clinically the earliest lesion is a tender, abscess-like swelling in an apocrine area. This ruptures and drains to the overlying skin before healing by fibrosis. Subsequent lesions develop in the same and/or different sites. As the disease becomes chronic, extensive scarring and sinus formation occurs.[2] In decreasing frequency the disease may involve: the axillae, the anogenital area (including the upper thighs, buttocks, pubic and inguinal areas), the breasts, the back of the neck, the apocrine glands of the eyelids (the glands of Moll), heterotopic glands on the abdomen or back.[4,5] There is often a history of acne and patients, especially females, are frequently obese.

Complications include restricted movement or lymphoedema in a limb due to extensive cicatrisation, anal and urethral fistulae, a chronic cicatrising folliculitis of the scalp,[2] development of squamous carcinoma (in 3·2% of a series of 125 patients with perianal disease).[4]

Hidradenitis should be considered when there is an abscess-like lesion in an apocrine area. Early lesions may resemble an infected sebaceous or Bartholin's cyst, lymphadenitis, a furuncle or a pilonidal sinus.[6] As additional lesions develop the diagnosis becomes apparent to a clinician aware of the condition. Other sinus-producing diseases need to be considered in the differential diagnosis of an advanced case: tuberculosis, actinomycosis, Crohn's disease, lymphogranuloma venereum, granuloma inguinale, cat-scratch disease, tularaemia, nocardiosis.[6]

Early lesions are treated with antibiotics guided by the culture of any discharging fluid. Incision of lesions to obtain fluid should be avoided to minimise sinus-formation. Erythromycin and metronidazole are reasonable blind therapy.[1] Local use of compresses, antiseptics and antibiotics may be helpful in an acute episode and prophylactically. Intralesional or systemic corticosteroids may speed resolution.[2]

Surgery is indicated in advanced disease. Diseased tissue can be marsupialised and destroyed by curettage or diathermy. Extensive disease may require wide excision and skin-grafting.[1,5]

Early recognition of hidradenitis is important as with appropriate therapy the prognosis is excellent whereas if the diagnosis is delayed the disease may progress despite treatment resulting in severe morbidity.

1 Roberts SOB, Highet AS. Bacterial infections. In: Rook A, Wilkinson DS, Ebling FJG, Champion RH, Burton JL, eds. *Textbook of Dermatology*. 4th ed. Oxford: Blackwell Scientific Publications, 1986.
2 Hurley HJ. Apocrine glands. In: Fitzpatrick TB, Eisen AZ, Wolff K, Freedberg IM, Austen KF, eds. *Dermatology in General Medicine*. 3rd ed. New York: McGraw-Hill Inc, 1987.
3 Morgan WP, Leicester G. The role of depilation and deodorants in hidradenitis suppurativa. *Arch Dermatol* 1982;**118**:101–2.
4 Jackman RJ. Hidradenitis suppurativa: diagnosis and surgical management of perianal manifestations. *Proc R Soc Med* 1959;**52(suppl)**:110–2.
5 Hurley HJ. Hidradenitis suppurativa. In: Demis DJ, ed. *Clinical Dermatology*. 14th revision. Philadelphia: Harper and Row, 1987.
6 Moschella SL. Hidradenitis suppurativa—complications resulting in death. *JAMA* 1966;**198**:1:201–3.

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