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HS Care Covered

A quick guide to the new European S2k guidelines (2024)

The much-anticipated **European S2k guidelines** have recently been published, redefining the approach to treating hidradenitis suppurativa (HS). Reflecting an almost complete overhaul of knowledge in HS treatment, the guidelines include a new classification and updated medical and surgical management algorithms.[1]

Click here to read the full guidelines

or scan the QR code

Key updates

HS can be classified into two phenotypes depending on the degree of detectable inflammation:[1]

Active (inflammatory) – potentially responsive to medical treatment

Inactive (predominantly non-inflammatory) – irreversibly damaged tissue, requiring surgical intervention

Each phenotype can be further categorised using key scores to assess severity to guide appropriate treatment:[1]

International Hidradenitis Suppurativa Severity Scoring System (IHS4) for active (inflammatory) HS

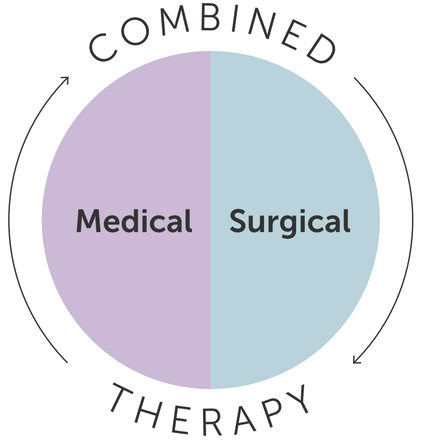
Hurley staging for inactive (non-inflammatory) HS

Management of HS by phenotype

The new classification enables more tailored treatment approaches, as phenotype and severity of HS lesions guide treatment decisions.[1]

Phenotype	Inflammatory	Non-inflammatory
Disease activity	**Active**	**Inactive**
Severity scoring system	**IHS4**	**Hurley**
Management	**Medical**	**Surgical**

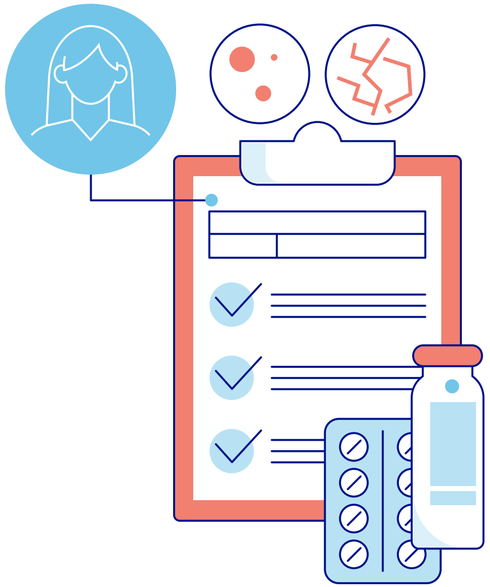
However, the combination of a medical therapy to reduce inflammation with a surgical procedure to remove irreversible tissue damage is currently considered a holistic therapeutic approach.[1]



Medical treatment of active HS

Treatment objectives include:[1]

- Reducing disease severity
- Intervening within the 'window of opportunity' to optimise outcomes[2,3]
- Adjusting treatment based on inflammatory activity and quality of life (e.g. monitor at 12 weeks of treatment)



1. Calculate IHS4 score to assess HS severity and define treatment plan[4]

Number of lesions	Points
Nodule	1
Abscess	2
Draining tunnel (fistulae/sinuses)	4

Total score	IHS4 severity
≤3	Mild
4–10	Moderate
≥11	Severe

2. Select a treatment option

To manage inflammation, treatment plans may involve a single medication or a combination of different therapies. These should be tailored to your patient's individual needs.[1]

Refer to the algorithm and full local prescribing information when assessing the suitability of treatment options for each individual patient.

Active (inflammatory) HS

Mild IHS4 ≤3	**Moderate** IHS4 4–10	**Severe** IHS4 ≥11
Should be recommended • Tetracyclines p.o. — 1st line **May be considered** • Clindamycin 2x300 mg/d p.o. — 1st line • Acitretin 0.25-0.50 mg/kg/d p.o. — 3rd line: Scarring folliculitis • Hormonal antiandrogens — 3rd line: Females with hyperandrogenism/PCOS • Metformin p.o. — 3rd line: Metabolic syndrome, diabetes mellitus		
May be considered • Clindamycin 1% gel/lotion/cream — 1st line • Resorcinol 15% peel 2x/d — 1st line • Intralesional triamcinolone 10-40 mg/ml — 1st line • Zinc gluconate 90 mg/d p.o. — 2nd line • PDT — 3rd line • Dapsone 25–200 mg/d p.o. — 3rd line		**May be considered** Ertapenem 1 g/d i.v. — 3rd line
	Should be recommended • Adalimumab 40 mg/week or 80 mg/every 2 weeks s,c. — 2nd line • Secukinumab 300 mg every 2 or 4 weeks s.c. — 2nd line • Bimekizumab 320 mg every 2 weeks s.c. for 16 weeks and every 4 weeks s.c. thereafter — 2nd line **Could be recommended** • Clindamycin 2x300 mg/d / Rifampicin 2x300 mg/d p.o. — 1st line • Infliximab 5 mg/kg every 8 weeks i.v. — 3rd line **May be considered** • Clindamycin 3x600 mg/d over 5 days i.v. — 1st line • Adalimumab biosimilars — 3rd line • Brodalumab 210 mg/every 2 weeks s.c. — 3rd line • Povorcitinib 15-180 mg/d p.o. — 3rd line • Upadacitinib 15 mg/d over 4 weeks p.o. — 3rd line • Spesolimab 1200 mg/every 2 weeks s.c. — 3rd line • Ustekinumab 45 mg/week s.c. (in patients with body weight >100 kg, 90 mg s.c.) at weeks 0, 4, 16 and 28 — 3rd line • Anakinra 100 mg/d s.c. — 3rd line • Biologics/other agent combination — 3rd line • Ciclosporine 2–6 mg/kg/d — Reserve	

Adjuvant treatment

Should be recommended
Cessation of smoking

Could be recommended
Weight reduction

May be considered
Psychological intervention, certain systemic analgesics

g/d, grams per day; i.v., intravenous; mg, milligram; mg/d, milligrams per day; mg/kg/d, milligrams per kilogram per day; PCOS, polycystic ovary syndrome; p.o., orally; s.c., subcutaneous.

View full guidelines

for more information on possible treatment considerations to control flares

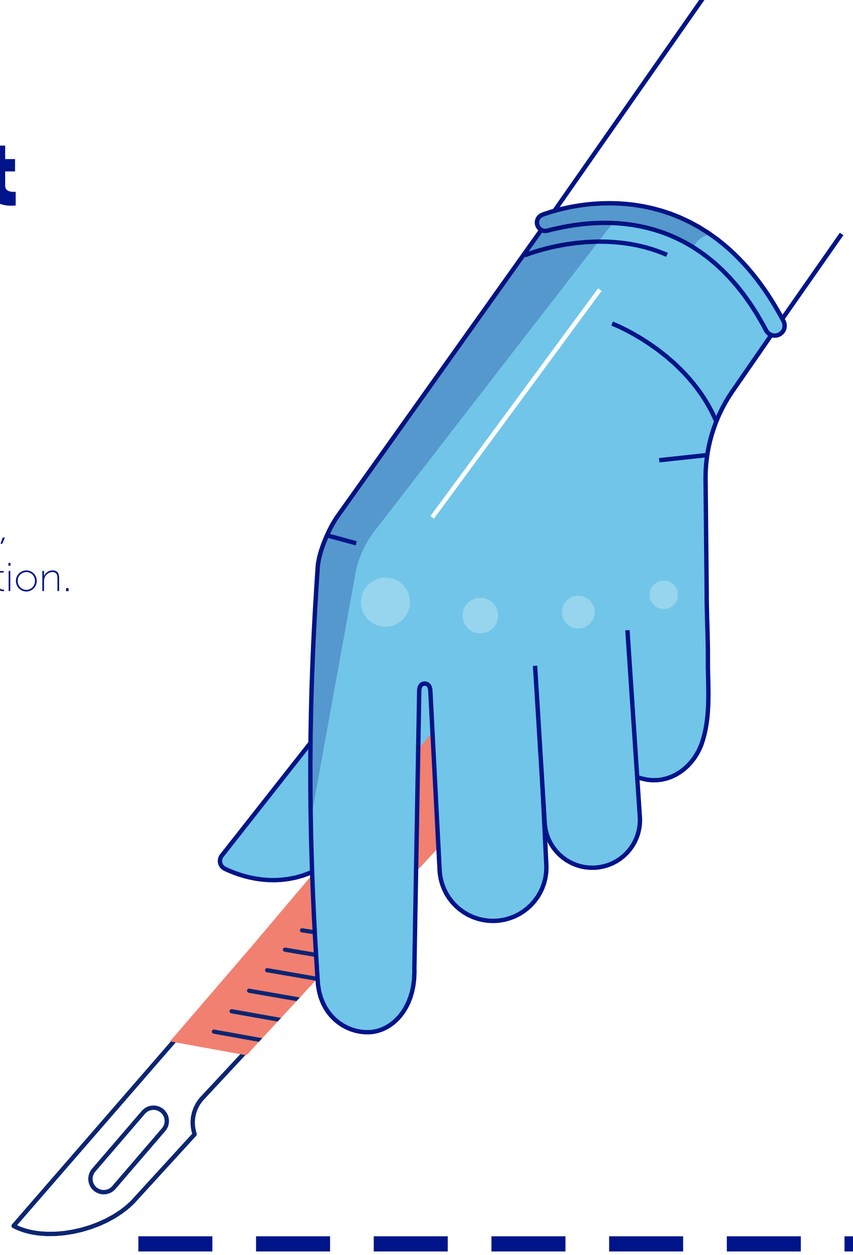
Print for reference

Surgical management of inactive HS

The level of irreversible tissue damage, often present in tunnels and scarring, is assessed by Hurley staging, which will indicate specific types of surgical intervention.

Treatment objectives include:[1]

- Reducing disease severity
- Removing irreversibly damaged tissue



Inactive (non-inflammatory) HS

Hurley stage I	Hurley stage II	Hurley stage III
May be considered • Hair removal in typical HS areas by light sources (LASER, IPL)		
	Should be recommended • Incision and drainage • Deroofing • Excision of localised solitary draining tunnels	
	Should be recommended • Wide excision • Post-surgical secondary intention healing • Immediate or delayed skin grafting after HS surgery • Continuation of adalimumab treatment during surgery **Could be recommended** • Carbon dioxide LASER therapy • Post-surgical primary closure in certain anatomical regions • Skin grafting complemented with negative pressure wound therapy **May be considered** • Diode and alexandrite LASER treatment • Reconstruction with flap plasty	
Adjuvant treatment	**Should be recommended** Cessation of smoking	**Could be recommended** Weight reduction **May be considered** Psychological intervention, certain systemic analgesics

Incision and drainage is a minor procedure appropriate to relieve pain; however, further medical and surgical therapies will be needed to effectively treat your patient.[1]

IPL, intense pulsed light.

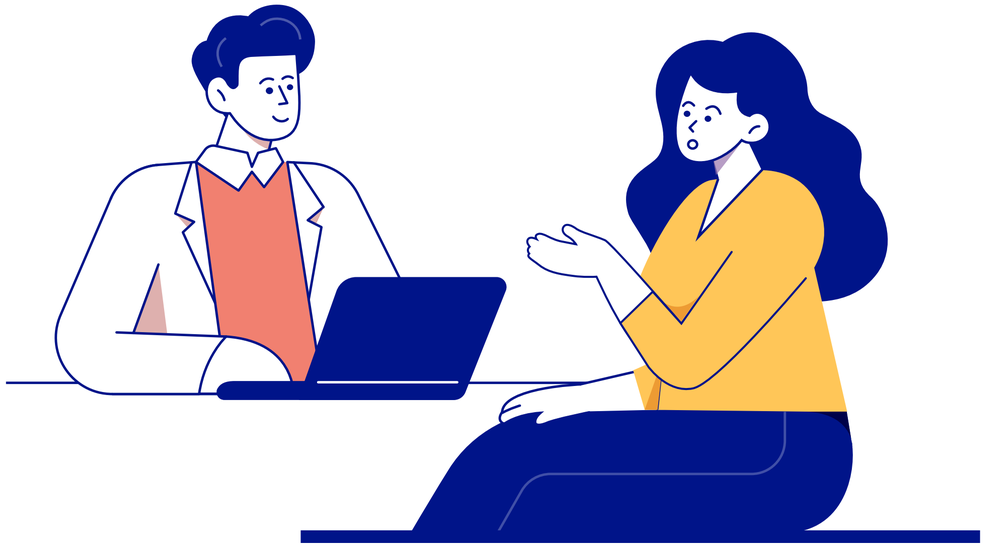
Ertapenem may be considered for downstaging prior to surgery[1]

Key considerations for choice of wound dressing:[1]

- Extent of involvement
- Morphology of lesions
- Volume of exudate (if high, consider negative pressure wound therapy)
- Cost of the product
- Availability of the dressing
- Location of lesion
- Any need for antimicrobials

Print for reference

Adjuvant treatment and lifestyle management



Treating HS is a collaborative effort and involves various specialists to address the condition and its associated comorbidities (including pain, anxiety, depression and obesity).[5] Consider the following management approaches:[1]

Should be recommended

Smoking cessation

Could be recommended

Weight reduction

May be considered

Psychological intervention

Specific systemic analgesics

Other considerations

Tetracyclines should not be administered to pregnant women or children <9 years of age due to risk of discolouration of permanent teeth. There are no formal studies or guidelines available on the use of resorcinol in pregnancy. Care should be taken if high-dose systemic corticosteroids are taken during pregnancy due to the potential risk of neonatal adrenal suppression. Dapsone is not teratogenic but should be avoided during breast feeding.[1]

References

1. Zouboulis CC, et al. J Eur Acad Dermatol Venereol. 2024. doi: 10.1111/jdv.20472. [Epub ahead of print].
2. Ocker L, et al. J Clin Med. 2022;11(23):7240.
3. Marzano AV et al. Br J Dermatol. 2021;184:133–140.
4. Zouboulis CC, et al. Br J Dermatol. 2017;177(5):1401–1409.
5. Garg A, et al. J Am Acad Dermatol. 2022;86(5):1092–1101.

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