HidraCare **Academy**

Module 4.01: International Consensus Document - Best practice in the management of hidradenitis suppurativa lesions

Summary:
This module focuses on the International Consensus Document on 'Best practice in the management of hidradenitis suppurativa lesions' (Journal of Wound Care, 2025)

Keywords:
Acne inversa, Verneuil's disease

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Module Overview

International Consensus Document – Best practice in the management of hidradenitis suppurativa lesions	
1. Introduction	• Overview of hidradenitis suppurativa
2. Presentation & Impact	• Pathophysiology, lesions & peri-lesional skin damage • Practical, psychological & socioeconomic impacts
3. Diagnosis, Assessment & Referral	• Diagnosis including identification & disease staging • Assessment including pain, infection, drainage & odor • Referral pathway
4. Medical & Pain Management	• The use of systemic & topical medications
5. Surgical Management	• The use of incision & drainage, deroofing, excisions
6. Lesional/ Wound Management	• Cleansing & debriding, exudate management and dressing retention solutions
7. Education	• The importance of improving disease awareness, understanding & multidisciplinary working among both professionals and patients
8. Conclusions	• Key best practice guidance & recommendations
9. Review Questions	• 10 questions to review your learning
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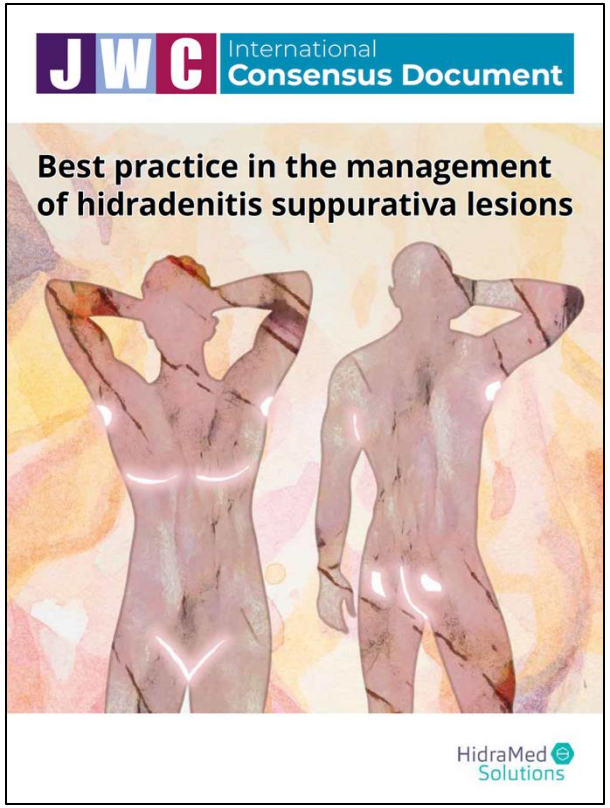
Introduction

- Hidradenitis suppurativa (HS) is a chronic inflammatory skin disease that is estimated to affect around **1%** of the population[1,2]

- HS presents as **extremely painful intertriginous skin lesions**, and this pain can be **exacerbated by skin damage from maceration or traumatic adhesive removal**.[3] HS lesions often become open and **discharge malodorous fluid**, which, if not contained, can stain clothes and bedsheets, causing stigma and embarrassment.

- Managing HS lesions is a daily challenge, requiring anti-inflammatory and analgesic medications, as well as **frequent dressing changes**. Consequently, HS is a debilitating disease that can have a devastating impact on a patient's practical, psychological and socioeconomic quality of life.

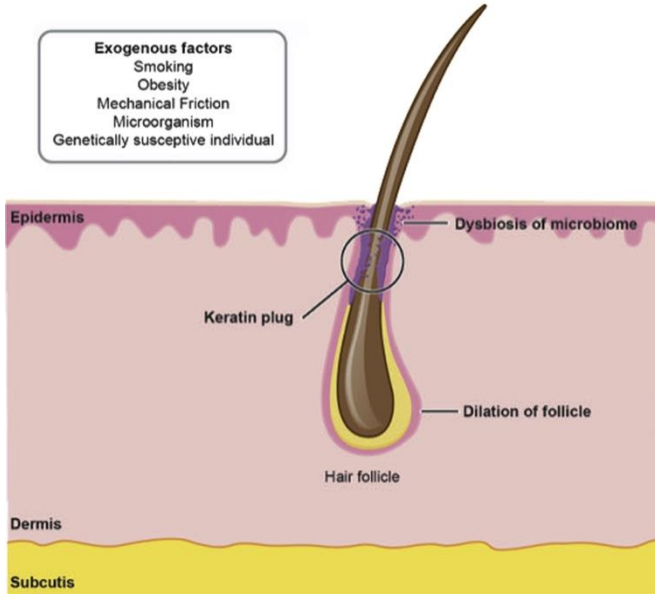


- There is a **lack of standardised guidelines**, protocols and pathways for the HS lesions, which often go under-recognised and misunderstood, and the **management of HS lesions can get lost** between the separate specialties of dermatology and wound care.

The Journal of Wound Care International Consensus Document is intended to address these gaps by providing best practice guidance on managing HS lesions.

Presentation - Pathophysiology

- The symptoms of HS arise from **chronic inflammation of the hair follicles**, but the exact aetiology of this disease process remains unclear.
- It has been proposed that a defect in the body's ability to clear keratin leads to the hyperkeratinisation and subsequent occlusion of the hair follicles, which then rupture and discharge their contents, including bacteria, into the dermis, initiating a substantial inflammatory response.[9]
- HS occurs in **women and men of all ages**, although it tends to **first present after puberty**. Prevalence data on sex and ethnicity is variable and inconclusive,[11] with some evidence for higher HS rates in women and people with dark skin tones.[4,12,13]



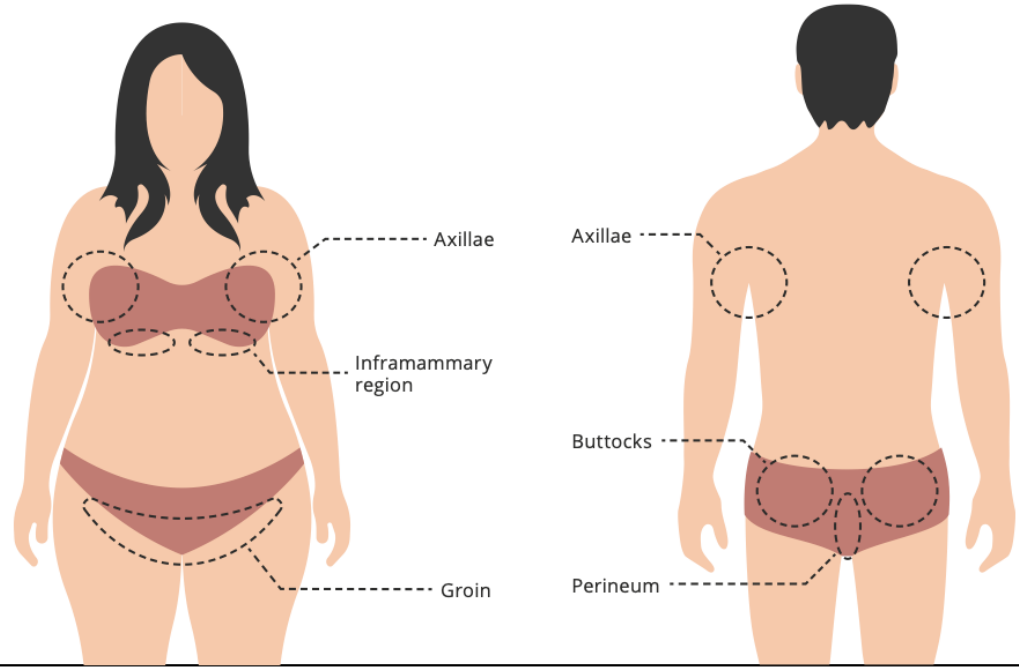
- Abscess formation and development of **sinus tracts and tunnelling** predispose to bacterial colonisation, biofilm formation and secondary infection, which exacerbate lesions and provoke chronic inflammation.[11,12]
- Although HS lesions may appear to be small on the surface, they are often associated with **deep tunnelling and heavy exudate production**, which are **challenging to treat**.

Consensus statement: HS is neither contagious nor linked to poor personal hygiene, even though these remain persistent and harmful misconceptions.

Presentation - Lesions

- HS is characterised by **recurrent inflammatory skin lesions**.
- These lesions most commonly occur in intertriginous areas, such as in the perineum or **buttocks** in men and in the **groin**, **armpits** (axillae) or **below the breasts** (inframammary region) in women (*Figure 1*), although they can occur almost anywhere on the body.[19]
- HS lesions are associated with **itching, discomfort and pain** directly caused by pro-inflammatory processes.
- Patients typically experience this pain in intense acute flares, which have been described as '***sharp and searing**, like being struck with a fireplace poker from the inside'.*[20]

Figure 1. Typical anatomical locations of hidradenitis suppurativa lesions



In addition to lesions and wounds, patients may refer to HS lesions as abscesses, bumps, boils, cysts and other terms

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Presentation - Lesions

- HS lesions have a variety of characteristic presentations, typically beginning with comedos, papules, pustules, nodules and plaques, before **progressing to abscesses, tunnels and ulcers** (*Figure 2*).[21] Lesions tend at first to be intact, without an opening onto the skin surface.

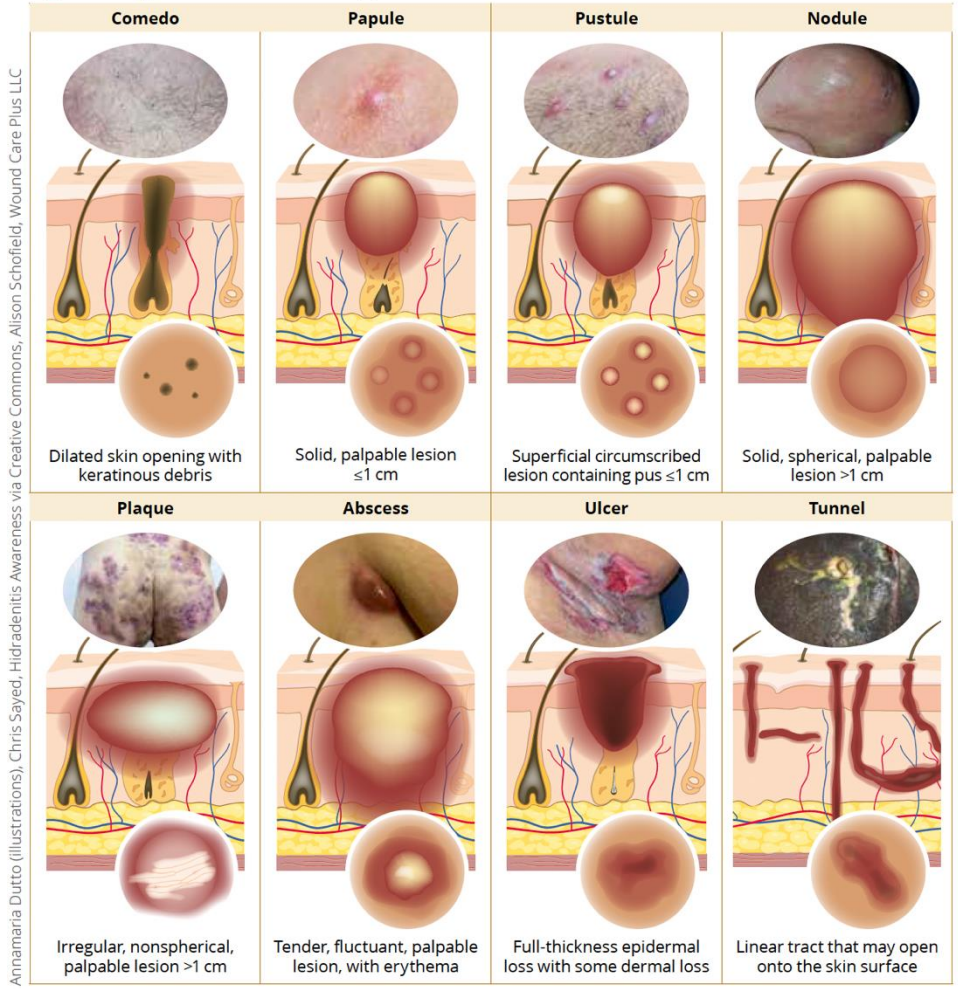
- As the disease progresses, abscesses and especially tunnels can **start to drain, producing copious amounts of liquid discharge** (exudate).

- These draining lesions can be especially **painful**[22] and **difficult to heal**.[23]

- **Draining lesions also tend to give off an unpleasant smell**, with this malodour occurring due to bacterial metabolism and the production of volatile fatty acids, and they are associated with **high exudate** and increased **bacterial burden**.[24,25]

Consensus statement: Advanced HS lesions may involve full-thickness loss of the epidermis and some of the dermis, either through ulceration, tunnelling or due to surgical deroofing or excision. These open lesions have wound-like characteristics, such as exudate production and a distinct bed and edge.

Figure 2. Types of hidradenitis suppurativa lesion[21]



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Presentation – Bacterial Burden

- Although HS is an **inflammatory disease and not caused by bacteria**, it can be exacerbated by a raised bacterial burden.
- Formation of abscess and tunnels increases bacterial burden and can lead to **biofilm formation**.[4,32]
- Biofilm is a **polymicrobial community** protected by a coating comprising extracellular polymeric substances, which, when well established, is associated with **wound chronicity**, being **resistant to topical antiseptics** and **systemic antibiotics**.[33]
- **Biofilm has been found in many HS skin samples**, particularly in **draining or open lesions**.[34] This biofilm can have a positive feedback with commensal bacteria, provoking and **exacerbating chronic inflammation**.
- Moreover, uncontrolled bacterial burden may result in **secondary infection**, resulting in increased pain, raised exudate levels and delayed healing.[35]

Presentation – Irritant Contact Dermatitis

- The skin around HS lesions is prone to damage from both **irritant contact dermatitis** and **medical adhesive-related skin injury** (MARSI).
- Irritant contact dermatitis is caused by **prolonged contact with exudate**, which contains high levels of corrosive proteolytic enzymes.[36]
- High exudate levels can overhydrate (**macerate**) the skin, particularly when combined with perspiration.[37]
- In HS, irritant contact dermatitis is **exacerbated by the typical location of lesions** in intertriginous areas, where skin folds impede air circulation and sweat evaporation, increasing maceration.[38]
- In skin folds, the **friction of delicate tissue rubbing** together **increases inflammation** and denudation.
- The resulting combination of corrosion, maceration and excoriation can lead to intense redness, itching and pain, as well as further **breakdown of the perilesional skin**, increased **risk of infection** and hospitalisation.[39]

Presentation – MARSI

- MARSI refers to **stripping, tearing or blistering** of the skin caused by frequent, traumatic **removal of medical adhesive products**, such as tapes and dressings.[40]
- MARSI can be **extremely painful** and may involve dermatitis, folliculitis and maceration.[40,41]
- In HS, the **high frequency of dressing changes** required to absorb the high levels of exudate can increase the risk and severity of MARSI.
- Moreover, MARSI can be exacerbated by using **adhesives to keep dressings securely in the intertriginous areas** where HS tends to occur.
- Consequently, patients often experience their most **severe episodes of HS-related pain during dressing changes**, leading to an expectation of pain during dressing changes.[42,43]
- Patients may also develop an allergy to adhesives used in dressings, leaving the skin vulnerable to allergic contact dermatitis.[44]

Consensus statement: The severity and frequency of irritant contact dermatitis and MARSI can be reduced with appropriate perilesional skin care and use of dressings and retention systems.

Impact – Practical

- HS is often a **debilitating** disease.
- Pain, scarring and bulky dressings can all **impede mobility**, with restricted movement potentially **hampering a patient's ability to perform daily tasks**, socialise, undertake sporting activities and form intimate relationships.
- **Highly exuding lesions** require wound dressings to absorb the exudate, which may be bulky, and the dressings need to be changed frequently as they become saturated.
- On average, people with HS change their dressings **2.8 times a day**, usually for around **6 months** of the year.[7] Many patients also report having to change underwear three times a day.[45]
- Failure to change dressings on time **risks leakage and staining** of bedclothes and garments, which can be a constant source of anxiety.

Impact – Practical

- The need for frequent dressing changes can make it difficult for patients to work, socialise or travel, potentially leading to **social isolation**.
- The association between HS flares and higher ambient temperatures can also discourage patients from going outside, especially in warmer places and at hotter times of the year.[46]
- The **unpredictable** disease course and risk of frequent or **unremitting relapses** can make it hard to plan any activity.
- Frequent and **time-consuming dressing changes**, alongside the need to wash stained garments and bedclothes and shop for appropriate clothes and dressings, significantly **burden the patient's time** available for other activities, such as work, social or family life.[7,45,47]
- HS can also affect a patient's choice of clothing, as they try to accommodate and disguise **bulky dressings**, as well as hide any stains. Female patients may also resort to wearing seamless pants, men's underwear or wireless bras for women with larger breasts, which can make them feel self-conscious and **affect self-esteem and body image**.

Impact – Psychological

- Intense pain and inability to live a normal life can have a **severe impact on mental wellbeing**.[48,49]
- This impact is exacerbated by **scarring, odour and staining**, which may provoke feelings of embarrassment, guilt and stigmatisation, affecting social confidence, body image and sexual function.[50]
- Consequently, HS is associated with increased prevalence of **anxiety, depression** and other psychiatric conditions.[22,51,52]
- This psychological impact does not seem to be linked with disease severity, and **even mild HS** can have a profound **negative effect** on a patient's mental wellbeing.[53]
- The psychosocial and quality-of-life impacts of HS are **greater than other skin conditions**, such as atopic dermatitis and psoriasis.[54,55]
- The **lifelong duration** of HS is especially daunting and can trigger feelings of hopelessness and despair. This, combined with significant morbidity, major quality-of-life impairment and lack of effective treatment, has led both clinicians and patients to describe HS as a **'heartsink' condition**.[48,56,57]

Consensus statement: Ineffective or bulky dressings that impede movement, show through clothing or are liable to leak are likely to undermine patient confidence, dignity and mental wellbeing.

Impact – Socioeconomic

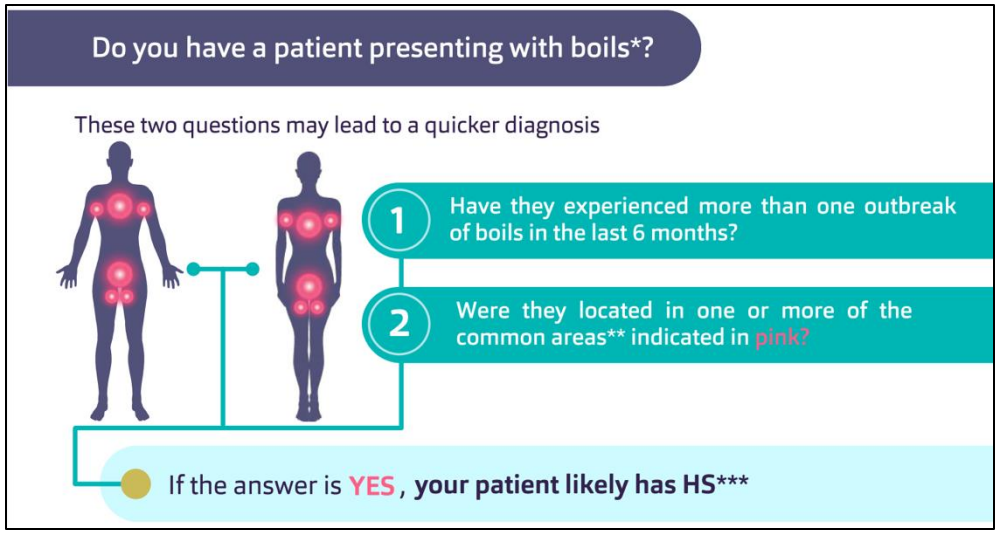
- Uncontrolled HS can have a notable **negative economic impact on patients, health systems and wider society**.[50,58-60]
- The **pain and exudate** associated with HS can prevent patients from working effectively or at all, requiring them to take frequent sick days or even leave employment entirely, with the **severe socioeconomic consequences** that entails.
- On average, patients with HS in employment are absent from work for **34 days a year** due to hospital appointments, emergency admissions or periods of hospitalisation.[58]
- Consequently, HS is linked to **higher unemployment and disability rates**, lower-income jobs and slower income growth, as well as less paid leave and a higher risk of leaving the workforce.[30,58]
- Health services often must bear the economic burden of **frequent dressing changes**, as well as the higher administrative burden and **treatment costs** associated with undiagnosed, late presenting or uncontrolled cases of HS.

Consensus statement: Uncontrolled exudate and malodour contribute to stigma and social isolation, which can keep patients from going to work and thus risk their economic security. Early diagnosis and prompt appropriate treatment of HS should reduce the economic burden of unnecessary emergency admissions and hospitalisations.

Diagnosis

HS is clinically diagnosed according to three key criteria:[28]

- Classic **lesional presentation** (comedos, papules, pustules, nodules and plaques, before progressing to abscesses, ulcers and tunnels)
- Classic **lesional distribution** (axillae, inframammary region, groin, perineum or buttocks)
- Chronicity and recurrence (**occurrence of more than two lesions within 6 months**[4,12,32])



A differential diagnosis can be made against other dermatological conditions that involve skin lesions with nodules, abscesses or tunnels (Figure 4).

There is minimal need for extensive workup with laboratory testing, biopsy or routine cultures to diagnose HS, as there is limited evidence that these are associated with specific and consistent HS markers.[4,27,63]

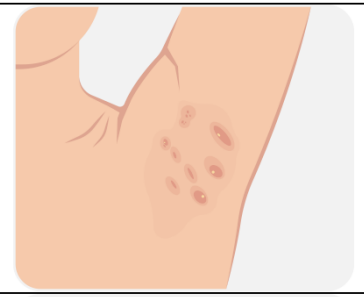
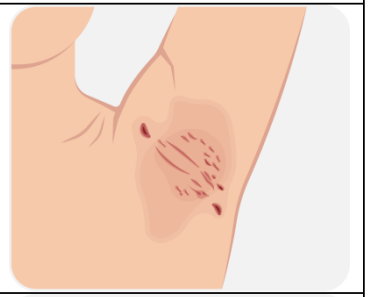
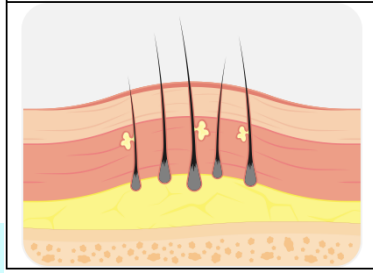
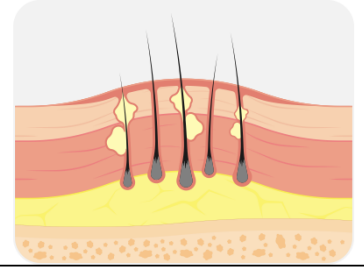
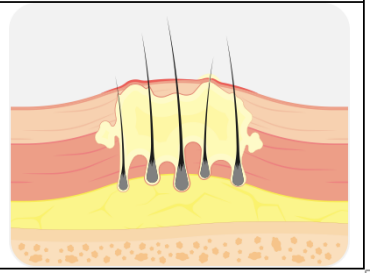
Diagnosis

- Early diagnosis of HS is imperative to make **appropriate referrals, initiate treatment** and steer the best possible course through a difficult disease.
- Untreated HS is liable to **progress in severity**, leading to worse pain and a greater risk of tunnels, scarring, skin folds and reduced mobility.
- However, patients with HS symptoms **may delay presenting** to a clinician for several reasons, such as embarrassment, potential stigmatisation and concern that the minor symptoms in the initial stages do not warrant professional advice.[64]
- When patients do seek care, they are most likely to present to a primary care provider, who may not be able to make the correct diagnosis. In primary care, **awareness and understanding of HS may be limited** by a lack of focus on this disease in pre-registration education or on-the-job primary-care training.
- Therefore, **HS is prone to frequent and repeated misdiagnosis**, and consequent delays in correct diagnosis and appropriate treatment are common,[65] with an **average diagnostic delay of 7–10 years**.[66] This can allow the disease to progress and irreversibly damage areas of skin. Such delays can cause patients to distrust and disengage from the healthcare system.[65,67,68]

Assessment - Disease

- The physical presentation of HS should be **staged** to guide appropriate interventions.
- HS severity is often classified using the **Hurley Staging System** (*Figure 5*).[82]
- Other staging tools are available,[83,84] including the Sartorius Score[85] and the dynamic, if relatively undifferentiated, International Hidradenitis Suppurativa Severity Score (IHS4).[86]
- These assessments often use presence of tunnels as a marker of disease activity and severity.[24,25]

Figure 5. Hurley Staging System for hidradenitis suppurativa classification[82]

Stage 1	Stage 2	Stage 3
Abscess formation, single or multiple, without tunnels and scar formation	Recurrent abscesses with tunnel formation and scar formation, single or multiple, widely separated lesions	Diffuse or near-diffuse involvement or multiple interconnected abscesses and tunnels across the entire area
		
		

Consensus statement:

HS assessments should always involve a grading tool based on the number, type and distribution of lesions. Complementary assessment tools for exudate, malodour, pain and/or quality of life need only be used where clinically useful.

Lesions should be assessed for uncharacteristic, sudden worsening or change in appearance or distribution, including notably high pain,redness (erythema) and firmness (induration), as these inflammation indicate potential infection alongside the underlying inflammatory disease process.

Assessment – Drainage & Odor

- Malodour and exudate can be assessed with the Hidradenitis Suppurativa Odor and Drainage Scale, which assesses the **usual and worst extent of exudate** in specific locations, as well as the effect of malodour and exudate on wellbeing (*Appendix 1*).[87]
- Draining tunnels are an **important marker of disease activity** in HS and both odor and drainage have a significant impact on a patient's quality of life.
- A **significant correlation** was demonstrated between the **HODS score and patient quality-of-life**. [87]
- The HODS tool asks the patient to rate both their **'usual' amount of drainage** and their **'worst' amount** over the last week, by body location. There are also questions about the level of odor and the impact of both drainage and odor on the patient.

Hidradenitis suppurativa Odor and Drainage Scale[87]

In the past 7 days...		
Usual amount of drainage by area	Head and neck	☐ None (1) ☐ Mild (2) ☐ Moderate (3) ☐ Severe (4) ☐ Very severe (5)
	Armpits	☐ None (1) ☐ Mild (2) ☐ Moderate (3) ☐ Severe (4) ☐ Very severe (5)
	Trunk	☐ None (1) ☐ Mild (2) ☐ Moderate (3) ☐ Severe (4) ☐ Very severe (5)
	Groin	☐ None (1) ☐ Mild (2) ☐ Moderate (3) ☐ Severe (4) ☐ Very severe (5)
	Buttocks	☐ None (1) ☐ Mild (2) ☐ Moderate (3) ☐ Severe (4) ☐ Very severe (5)
	Genital perianal area	☐ None (1) ☐ Mild (2) ☐ Moderate (3) ☐ Severe (4) ☐ Very severe (5)
	Other area	☐ None (1) ☐ Mild (2) ☐ Moderate (3) ☐ Severe (4) ☐ Very severe (5)
Worst amount of drainage by area	Head and neck	☐ None (1) ☐ Mild (2) ☐ Moderate (3) ☐ Severe (4) ☐ Very severe (5)
	Armpits	☐ None (1) ☐ Mild (2) ☐ Moderate (3) ☐ Severe (4) ☐ Very severe (5)
	Trunk	☐ None (1) ☐ Mild (2) ☐ Moderate (3) ☐ Severe (4) ☐ Very severe (5)
	Groin	☐ None (1) ☐ Mild (2) ☐ Moderate (3) ☐ Severe (4) ☐ Very severe (5)
	Buttocks	☐ None (1) ☐ Mild (2) ☐ Moderate (3) ☐ Severe (4) ☐ Very severe (5)
	Genital perianal area	☐ None (1) ☐ Mild (2) ☐ Moderate (3) ☐ Severe (4) ☐ Very severe (5)
	Other area	☐ None (1) ☐ Mild (2) ☐ Moderate (3) ☐ Severe (4) ☐ Very severe (5)
I felt embarrassed about the drainage		☐ Never (1) ☐ Rarely (2) ☐ Sometimes (3) ☐ Often (4) ☐ Always (5)
The drainage interfered with my sex life		☐ Never (1) ☐ Rarely (2) ☐ Sometimes (3) ☐ Often (4) ☐ Always (5)
The drainage made me select specific clothes		☐ Never (1) ☐ Rarely (2) ☐ Sometimes (3) ☐ Often (4) ☐ Always (5)
I felt embarrassed about the odour		☐ Never (1) ☐ Rarely (2) ☐ Sometimes (3) ☐ Often (4) ☐ Always (5)
The odour interfered with my sex life		☐ Never (1) ☐ Rarely (2) ☐ Sometimes (3) ☐ Often (4) ☐ Always (5)
The typical odour I perceived coming from areas affected by hidradenitis suppurativa		☐ None (1) ☐ Slight (2) ☐ Moderate (3) ☐ Strong (4) ☐ Very strong (5)

Assessment - Pain

- Pain intensity can be measured on a **scale of 1–10 with self-reported assessment** scales, such as the Numeric Rating Scale (*Appendix 2*), **Visual Analogue Scale**[88] and Wong-Baker FACES Scale[89]. Standalone use of such unidimensional scales can be useful for assessing acute pain.[90]
- However, holistic management of **chronic pain** benefits from multidimensional pain assessment encompassing not only intensity but also type and triggers, alongside functional and sociopsychological assessment.[4,31,90]
- Patients with HS can experience nociceptive pain, usually secondary to **potential tissue damage**, and **neuropathic pain**, usually due to nerve damage, both of which can be exacerbated by **procedural pain**. Pain type can be assessed with descriptors, such as 'aching', 'throbbing' and 'sharp', which commonly indicate nociceptive pain, compared with 'shooting', 'stabbing' or 'burning', which are associated with neuropathic pain.[91]
- Pain triggers can be determined by comparing the timing of pain onset with potential triggers, such as inflammation or infection, as well as asking patients whether relief occurs **spontaneously or due to surgical drainage**.
- Multidimensional pain assessment tools include the Brief Pain Inventory[92] and the Short-Form McGill Pain Questionnaire (*Appendix 3*).[93] The most appropriate pain assessment tool should be selected based on local protocols, as well as the individual patient's needs and capacity for self-assessment.

Numerical Rating Scale[88]

1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Short-Form McGill Pain Questionnaire[93]

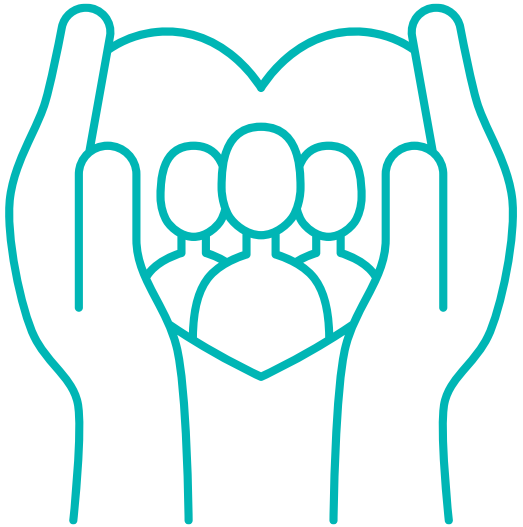
Sensory dimension	Affective dimension
☐ Throbbing	☐ Tiring/exhausting
☐ Shooting	☐ Sickening
☐ Stabbing	☐ Fearful
☐ Sharp	☐ Punishing/cruel
☐ Cramping	
☐ Gnawing	
☐ Hot/burning	
☐ Aching	
☐ Heavy	
☐ Tender	
☐ Splitting	

Assessment - Infection

- Guidance on the identification, assessment and management of local and system wound infection has been produced by the **International Wound Infection Institute**.[35]
- It outlines the **signs and symptoms** of each stage in the infection continuum, which ranges from contamination, through to local wound infection, to systemic infection.
- Technical innovation means that suspected infection can be assessed at the point of care with imaging technologies, although these are not yet widely available.[94]
- Fluorescence imaging can ascertain the bacterial load once chronic inhibitory bacterial load reaches 10^4 or beyond.[95] Near-infrared spectroscopy can confirm or rule out a potential inflammatory process when using the total haemoglobin image (*Figure 6*). NIRS can be used to see tunnels below the skin in some patients.

Consensus statement: Lesions should be assessed for uncharacteristic, sudden worsening or change in appearance or distribution, including notably high pain, redness (erythema) and firmness (induration), as these indicate potential infection alongside the underlying inflammatory disease process.

Assessment – Quality of Life



- Holistic impact on quality of life can be measured with the disease-specific Hidradenitis Suppurativa **Quality of Life Score** (*Appendix 4*)[96] or the general Dermatology Life Quality Index.[97]

- The impact of **open lesions** could also be assessed with the Wound-QoL questionnaire.[98]

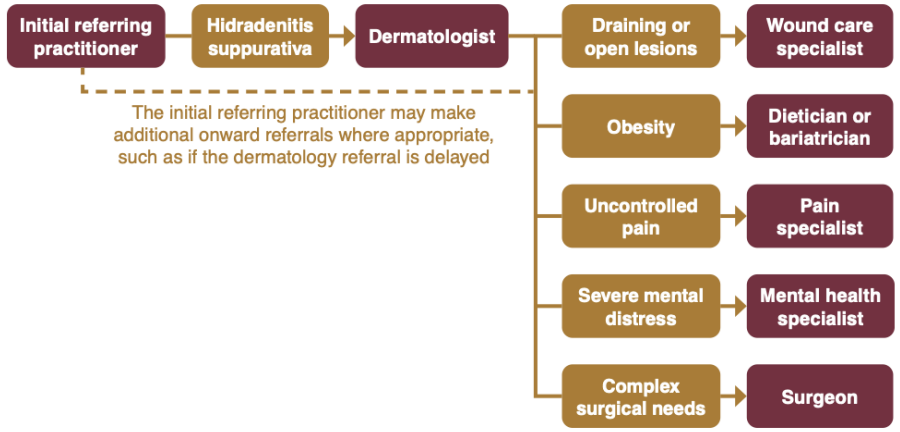
Hidradenitis Suppurativa Quality of Life Score

In the past 7 days...						
Symptoms	Pain	☐ None (0)	☐ Some (1)	☐ Moderate (2)	☐ High (3)	☐ Extreme (4)
	Itch	☐ None (0)	☐ Some (1)	☐ Moderate (2)	☐ High (3)	☐ Extreme (4)
	Drainage	☐ None (0)	☐ Some (1)	☐ Moderate (2)	☐ High (3)	☐ Extreme (4)
	Odour	☐ None (0)	☐ Some (1)	☐ Moderate (2)	☐ High (3)	☐ Extreme (4)
Psychosocial impact	Embarrassment	☐ None (0)	☐ Some (1)	☐ Moderate (2)	☐ High (3)	☐ Extreme (4)
	Low mood or depression	☐ None (0)	☐ Some (1)	☐ Moderate (2)	☐ High (3)	☐ Extreme (4)
	Anxiety or nervousness	☐ None (0)	☐ Some (1)	☐ Moderate (2)	☐ High (3)	☐ Extreme (4)
	Sexual desire	☐ None (0)	☐ Some (1)	☐ Moderate (2)	☐ High (3)	☐ Extreme (4)
Activities	Choice of clothes	☐ None (0)	☐ Some (1)	☐ Moderate (2)	☐ High (3)	☐ Extreme (4)
	Sexual activities	☐ None (0)	☐ Some (1)	☐ Moderate (2)	☐ High (3)	☐ Extreme (4)
	Sleeping	☐ None (0)	☐ Some (1)	☐ Moderate (2)	☐ High (3)	☐ Extreme (4)
	Getting dressed	☐ None (0)	☐ Some (1)	☐ Moderate (2)	☐ High (3)	☐ Extreme (4)
	Concentration	☐ None (0)	☐ Some (1)	☐ Moderate (2)	☐ High (3)	☐ Extreme (4)
	Exercising	☐ None (0)	☐ Some (1)	☐ Moderate (2)	☐ High (3)	☐ Extreme (4)
	Washing yourself	☐ None (0)	☐ Some (1)	☐ Moderate (2)	☐ High (3)	☐ Extreme (4)
	Walking (not for exercise)	☐ None (0)	☐ Some (1)	☐ Moderate (2)	☐ High (3)	☐ Extreme (4)
	Ability to work or study	☐ None (0)	☐ Some (1)	☐ Moderate (2)	☐ High (3)	☐ Extreme (4)

Referral

- In many countries including the US, there is no clear established referral pathways for patients presenting with HS. This consensus document aims to **establish an effective referral pathway** for HS (*Figure 7*).
- As standard practice, all patients presenting with suspected or diagnosed HS should be **promptly referred to a dermatologist**, even if at an early stage.
- Ideally, patients should be referred to a dermatologist with specialist expertise in treating HS.
- **Prompt referral to wound care** is particularly important for providing immediate symptom relief, especially in HS involving draining or ulcerous lesions with uncontrolled pain, exudate and malodour. Wound care is often needed when patients are waiting for systemic therapies to become available or take effect.

Figure 7. Suggested referral pathway for hidradenitis suppurativa



Consensus statement: Early access can facilitate disease modification in areas that matter most to patients, such as pain, exudate and malodour, contributing to more effective overall disease management with better long-term outcomes.

Wound care is also required following deroofing or excision, where patients will require a weekly review. Referral to wound care specialist can be beneficial for patients needing more effective dressings for draining or open lesions, or to manage irritant contact dermatitis or MARSI. Patients with HS should have prompt access to specialist wound care wherever possible, even if this can be more challenging in some settings, including remote locations.[99,100]

Medical Management

- HS is generally managed with an appropriate combination of **anti-inflammatory** (e.g., biologic), **antibiotic** and **analgesic** medications, as well as optimisation of risk factors (such as obesity). Treatment should be tailored to the challenges of specific presentations and based on patient preferences.
- Various medications can be used to **suppress the inflammatory disease processes** underlying HS and so reduce the severity of symptoms such as pain, swelling and erythema, as well as infection and suppuration (*Table 1*).
- Treating the root cause of inflammation can **slow the disease** process and encourage **longer periods of remission**.
- Systemic medications used to reduce inflammation in HS include antibiotics[101,102] and corticosteroids,[103] as well as **immunomodulating biologics**, including the tumor necrosis factor inhibitor adalimumab and the interleukin-17 inhibitors secukinumab and bimekizumab.[101,103-109]

Table 1. Anti-inflammatory medications used in hidradenitis suppurativa

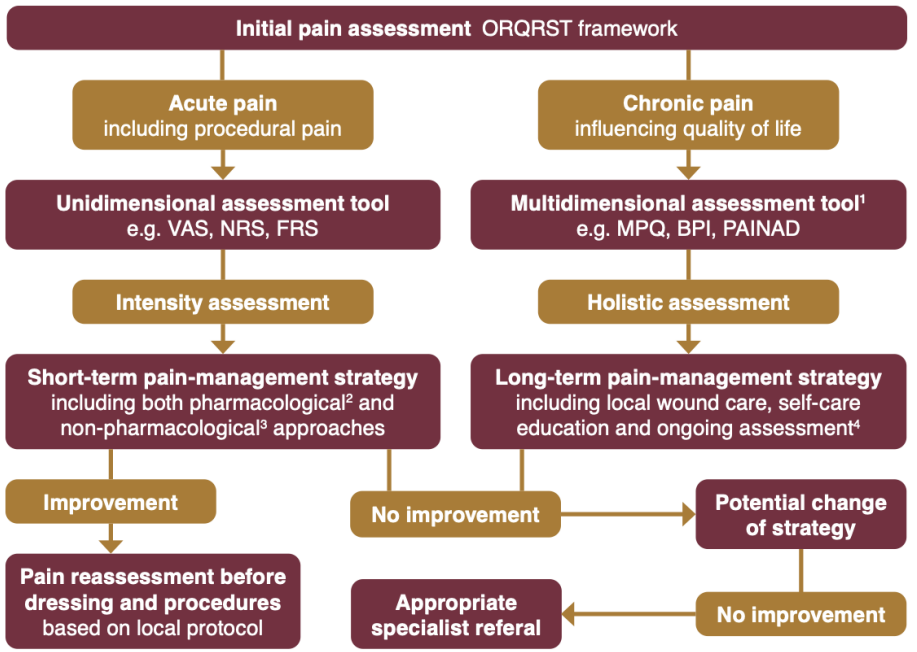
Route	Type	Examples
Systemic	Systemic antibiotics	Amoxicillin clavulanate, clindamycin, clindamycin + rifampin, dapsone, doxycycline, ertapenem, metronidazole, minocycline, trimethoprim + sulfamethoxazole
	Systemic corticosteroids	Betamethasone, prednisone
	Immunomodulators (biologics)	Adalimumab, secukinumab, bimekizumab
	Glucagon-like peptide-1 agonists	Metformin
	Retinoids	Acitretin
Topical	Topical antibiotics	Clindamycin 1%, metronidazole
	Topical corticosteroids	Triamcinolone acetonide
	Antimicrobial keratolytics	Resorcinol 15%

Consensus statement: When prescribing antibiotics, it is important to adhere to antimicrobial stewardship principles and local antibiotic prescribing guidelines, based on local surveillance data, to reduce the risk of multidrug resistance and adverse events.

Pain Management

- **Minimising pain is essential to HS management**. Anti-inflammatory medications can control the inflammatory disease processes that underly pain, while **appropriate dressing use** can reduce pain resulting from irritant contact dermatitis and MARSI.[115]
- However, patients often also require analgesic medication, especially for acute pain. If these first-line treatments fail, patients can be prescribed opioids, but only for the shortest period necessary.[22,117]
- Pain is rated by patients as the most important symptom of HS,[22] but it is often **overlooked and undertreated.**
- Pain management should also be collaborative, with referral to pain specialists and for psychological therapies, as appropriate.[4,119]
- A multimodal, holistic and **multidisciplinary pain-management strategy** can be guided by a decision aid from the European Wound Management Association (*Figure 8*).

Figure 8. Decision aid to support the holistic management of wound-related pain



Notes

[1] Multidimensional assessment should include history of previous effective pain-management strategies

[2] Pharmacological approaches should follow the WHO Analgesic Ladder and may include psycho-pharmaceuticals for chronic pain.

[3] Non-pharmacological approaches may include distraction, warmth/cold application, aromatherapy, exercise and/or positioning.

[4] A long-term strategy should be developed and agreed with the individual and consider their holistic (bio-psycho-social) needs, such as age, maturity, cognitive function and experience with pain and previous care.

BPI=Brief Pain Inventory; FRS=Faces Pain Scale; PAINAD= Pain Assessment in Advanced Dementia; MPQ=McGill Pain Questionnaire; NRS=Numerical Rating Scale; ORQRST=Onset, Provocation, Quality, Radiation, Severity and Time; VAS=Visual Assessment Scale; WHO=World Health Organization

Surgical Management

Several surgical interventions can be used to manage moderate-to-severe HS where anti-inflammatory medication has not been sufficient to reduce the size of the lesions (*Figure 9*). The choice of intervention should be based on disease location, severity and presence of tunnels, as well as the relative advantages and disadvantages of the procedures:[122]

- **Incision and drainage** are indicated for painful abscesses and involve cutting into the abscess to drain the pus. This can provide rapid pain relief, although it is unlikely to resolve the underlying chronic disease activity.[123]

- **Deroofing** is indicated for simple tunnels or recurrent inflammatory nodules, and it involves the removal of all or most skin overlying a lesion to expose the underlying abscesses and tunnels, while leaving the bed of the exposed area intact. Deroofing decreases pain, shortens healing times and can be locally curative.

- **Lesional/regional excision** is typically indicated for interconnected tunnels and scarring, such as that seen in stage 3 HS, or lesions that recur after deroofing. It involves the removal of either the tissue around a single lesion (lesional excision) or a larger area containing multiple lesions (regional excision).[126] However, lesional/regional excision carries risks of infection, delayed healing and skin contractures.[27]

Figure 9. Surgical interventions for hidradenitis suppurativa lesions

Incision and drainage	Deroofing	Regional excision
		
Christopher Sayed	Science Photo Library	Abigail Chaffin

Consensus statement: Surgical management of HS lesions is not a standalone solution, and it must be integrated as an adjunctive part of a holistic care strategy, alongside anti-inflammatory medication and pain management and wound care

Lesional Management – Cleansing & Debriding

In people with HS, the skin of the intertriginous areas should be **regularly cleansed** as part of a standard skincare routine to minimise the potential ingress and spread of bacteria to reduce inflammation and avoid tissue breakdown.

This is **particularly important in draining or open lesions**, where the bed, edges and surrounding skin should be cleansed at every dressing change to reduce bacterial burden and consequent pain and malodour.

In HS, cleansing should generally be performed with a non-cytotoxic antiseptic (and potentially anti-inflammatory) solution, such as polyhexanide, octenidine or hypochlorous acid, with the addition of a surfactant. These solutions can **decrease bacterial burden and disrupt biofilm** better than sterile water and normal saline.[127,128]

Consensus statement:

- **Patients should be advised that daily showering in warm potable water is acceptable and that dressings should be removed before showering.**
- **Patients should be informed that cleansing may increase pain. If cleansing is painful, this can be reduced by warming the cleansing solution to room temperature (or slightly warmer) and applying topical analgesics, as required.[61,137]**
- **The cleansing solution should be applied gently using a soft cleansing cloth or monofilament pad to minimise friction.**
- **In open or deroofed HS lesions, the pad used for cleansing can also be used to gently debride any devitalised tissue (slough or necrotic tissue) and debris from the lesion bed, edges and surrounding skin.[132] This aims to remove pro-inflammatory cytokines and proteases, reduce bacterial burden and disrupt biofilm formation, thereby reducing pain and inflammation.[122,138] If this causes short-term acute pain, patients should be offered an appropriate analgesic and permitted to refuse or stop at any time.[132] More aggressive forms of debridement are generally not appropriate for HS lesions.[138]**

Lesional Management – Exudate Management

Draining and open lesions typically produce **exudate** and thus should be covered with an **appropriate dressing** to absorb the exudate, protect against contamination and optimise the healing environment, as well as to minimise malodour and the risk of irritant contact dermatitis and MARSI.

Consensus statement:

- **Patients should be provided with appropriate dedicated dressings wherever possible. Non-specialist absorbent products, such as incontinence pads and diapers, are likely to be less effective, comfortable and easy to retain, presenting a greater risk of leakage and embarrassment.**
- **To ensure patient-centred care, dressing choice should be guided by a thorough patient assessment, including discussing their personal circumstances, preferences and previous experiences of dressing use.**
- **Patients' dressing needs should be regularly re-evaluated and their treatment plan adjusted, as required, to optimise care costs and clinical outcomes. Care plans should specify who is responsible for ongoing management, re-evaluation and prescription needs.**

Table 2. Dressing options for exudate management

Dressing type	Indication	Fluid retention	Considerations
Non-adherent contact layer	Low or managed exudate	No capacity	• Material (e.g., silicone) allows atraumatic removal • Usually requires separate means of securement (e.g., adhesive secondary dressing, bandage or tubular bandage) • Suitable where exudate is primarily managed by a secondary dressing (e.g. superabsorbent)
Foam	Low-to-moderate exudate	Limited capacity	• Available in adhesive or non-adherent (atraumatic) variants
Gelling fibre	Moderate-to-high exudate	Moderate capacity	• Conformable to lesion bed • Maintains a moist healing environment • Encourages autolytic debridement • Potential to stick to wounds and impede changes
Superabsorbent	High-to-very-high exudate	High capacity	• This will help protect the surrounding skin from irritant contact dermatitis

Lesional Management – Exudate Management

Intact lesions generally do not require dressing, but if they painful they can be dressed with a non-adherent **contact layer** or **foam dressing** to cushion against pressure and minimise pain.

Draining or open HS lesions require dressings that can absorb and retain the copious amount of exudate produced. Its absorbency will also need to be sufficient to protect perilesional skin from exudate, which can cause maceration and irritant contact dermatitis, increasing the risk of further damage and infection.[37]

It is important to retain a relatively **moist lesional environment** when using superabsorbent dressings, as an optimum state of hydration facilitates cell migration, release of growth-factors and autolytic debridement.[140,141]

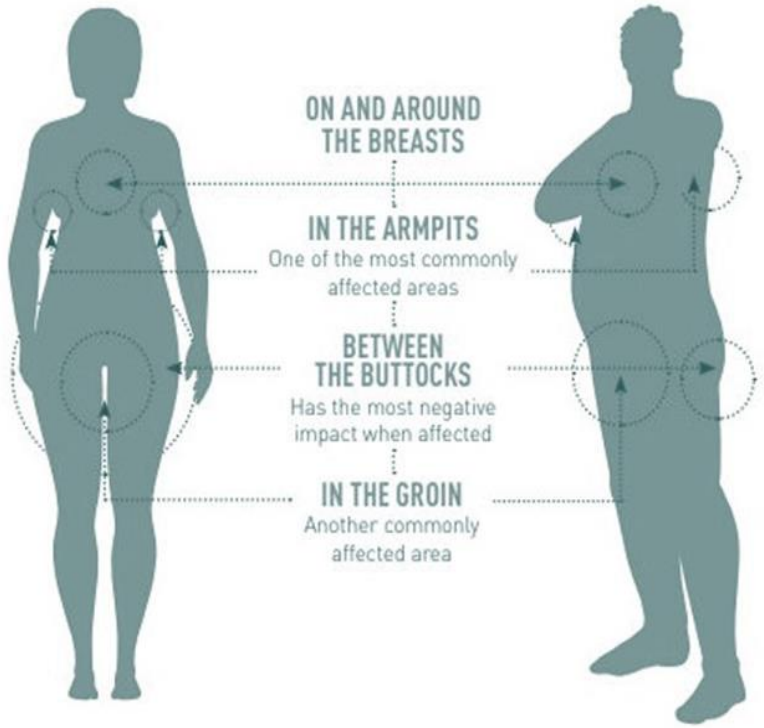
Superabsorbent dressings, which contain a blend of cellulose and fluid-retaining superabsorbent polymers to absorb and retain large volumes of fluid, are appropriate for **high exudate levels** and have been shown to sequester bacteria and pro-inflammatory cytokines.[139]

Consensus statement:

- **An appropriately absorbent dressing should increase the wear time of a dressing, in turn decreasing the frequency of dressing changes and the associated time and financial burdens.**
- **An optimal dressing system needs to balance the increased retention capacity of thick padded dressings with the potential for such bulky dressings to be cumbersome and significantly limit mobility and range of movement.**

Lesional Management – Exudate Management

- Dressings need to be a suitable shape and size to cover the **difficult anatomical sites** of HS lesions.[47,142] For example, a typical 10x10cm square wound dressing may not be suitable.
- An ideal HS dressing should be flexible enough to conform to skin folds and other concave surfaces, especially as they move. A flexible dressing should also **maximise the patient's range of movement**.
- Likewise, a dressing may need to be larger than the visible open lesion, covering the entire area affected, both visible and subcutaneous, including satellite lesions and underlying tunnels.
- As patients with HS also often change their own dressings, their dressings should ideally be **easy to self-apply, adjust and remove**.[47]
- Dressings are also key to **managing malodour**. A sufficiently absorbent dressing should lock away the microbes that cause malodour along with the exudate. Persistent malodour can be managed with dedicated anti-odour dressings.[143] Antimicrobial dressings can also help with malodour.[144]



Lesional Management – Exudate Management

- The historical practice of **packing drained or deroofed abscesses and tunnels is not recommended**, because it is associated with **increased pain, anxiety and healing times** and has no significant impact on long-term resolution or recurrence of abscesses and tunnels.[123,146-148]

Consensus statement: Draining or deroofed abscesses should be covered with a contact layer to minimise MARSI and a soft, absorbent dressing to manage exudate.

- **Postoperative** wounds following extensive deroofing or excision where there are large volumes of exudate or delayed healing may be treated with **negative pressure wound therapy** (NPWT).[149,150]

Lesional Management – Dressings & Retention

- Dressings used on HS lesion **must stay in place securely** to prevent slippage, leakage and consequent staining, malodour and embarrassment. However, effective retention can be a challenge in the intertriginous areas affected by HS, which are generally **hairy**, affected by **heat and perspiration** and subject to frequent **movement and flexion.**
- One solution to keeping dressings in place is to use strong adhesives. However, **strong adhesives increase the risk of MARSI**, even if changed less frequently, and especially if the dressing has dried out and adhered to the wound bed.[153,154]
- Therefore, to prevent painful dressing changes, it is preferable to avoid strongly adhesive dressings and tapes, as well as dry, woven gauze dressings that shed fibres and adhere to the lesional wound.[6]
- MARSI is best avoided by using non-adherent or low-adherent dressings, such as those made of soft silicone or cohesive materials.[6,47] However, non-adherent or low-adherent dressings **can easily become displaced** or bunched, leading to **leakage** and **irritant contact dermatitis**.[47]
- Some patients with HS use **bandages, netting or low-adherent tape** to keep dressings in place and avoid strong adhesives, thereby minimising the risk of MARSI. However, these solutions are **not ideal**. Bandages or netting can be **awkward to apply** in the intertriginous areas, especially as most patients with HS change their own dressings. Low-adherent tape can be **bulky and visible**, causing additional **discomfort and embarrassment**.

Lesional Management – Dressing Retention Systems

Figure 10. Hidrawear dressing retention system

The Hidrawear dressing retention system with **SecureLock Technology™** (*Figure 10 and Box 3*) was developed with the challenges of **lesions & wounds caused by HS in difficult-to-dress areas** of the body in mind.

SecureLock Technology™ is specifically designed to minimise the risks of both irritant contact dermatitis and MARSI in HS.[7]

Consensus statement:

- **The potential of non-adhesive dressings and baselayers to minimise the risk of MARSI and dressing-change frequency could prove cost-effective, as well as improve the patient's comfort and quality of life.**
- **Therefore, where possible, HS patients with open lesions should have access to treatment including non-adhesive securement systems especially designed for HS.**

Box 3. Hidrawear dressing retention system with SecureLock Technology

The system has three components:

- A flexible, discreet and breathable baselayer
- A soft superabsorbent dressing to absorb moderate-to-heavy exudate or a super-soft foam dressing to absorb low-to-moderate exudate
- An external SecureLock Technology™ fastener device to hold dressings securely and attach them to the skin without using adhesives.

This combination of components can give patients confidence that their dressings are secure and unlikely to leak, while avoiding the pain and skin damage associated with repeated use of adhesives. The design is intended to be easy for patients to apply, to facilitate self-care. The baselayers include crop tops, T-shirts and briefs that cover the axillae and inframammary, perineal and anogenital regions most affected by HS. They are designed to look like regular clothing and come in various sizes for both men and women.

A pilot study of Hidrawear in 15 women with HS reported the following impacts on quality of life over a 21-day period:[7]

- Improved Dermatology Life Quality Index score (mean 19.3 to 4.53), including the ability to work and study, perform everyday tasks and form personal and sexual relationships
- Less dressing-related pain according to the Visual Assessment Scale (mean 5.5/10 to 0.8/10)
- Discontinuation of analgesia before dressing change (n=5/15 to n=0/15)
- Greater body confidence and confidence in the dressing system
- Increased comfort
- Easier application, adjustment and removal than traditional baselayers
- Less time spent managing wounds.[7]

Patients also reported less stretching, contorting and need for additional equipment, such as a mirror, to apply their dressings. The study concluded that a dressing system tailored to the needs of patients with HS can significantly reduce pain and improve many aspects of quality of life.[7]

Lesional Management – Reimbursement

Most US private, commercial or state-funded public-assistance insurance policies cover advanced wound dressings, although insufficient coverage and the cost of policy deductibles may restrict access in some cases.

Furthermore, decision-making may vary according to differences between states' access to and the purchase cost of products and treatments.[156,157]

Referrals to wound care specialists can be beneficial in increasing patient access to wound-care supplies. Any prescriber can prescribe wound care dressings, but wound care clinics may have the advantage of routinely documenting the necessary information to demonstrate medical necessity.[158]

Box 2. Reimbursement requirements for dressings for hidradenitis suppurativa in the US

• Full-thickness, ulcerous or deroofed lesion
• Moderate-to-high exudate volume
• Documented debridement (autolytic, enzymatic or mechanical) of the lesion bed
• Documented size and location of lesion
• Compliance with ordering requirements and restrictions
• Dressing covered by the insurance company or accessible from a third-party supplier
• Billable ICD-10 diagnosis codes:
  ○ L98.499 for non-pressure chronic ulcer of the skin of other sites with unspecified severity
  ○ L98.419 for non-pressure chronic ulcer of the buttocks or skin with unspecified severity)
  ○ L73.2. for hidradenitis suppurativa (official specific principal diagnosis)

Internationally, health systems differ in how dressings are funded. In the UK, dressings are generally available through wound-care formularies, where the choice of products is dictated by procurement processes and product costs.

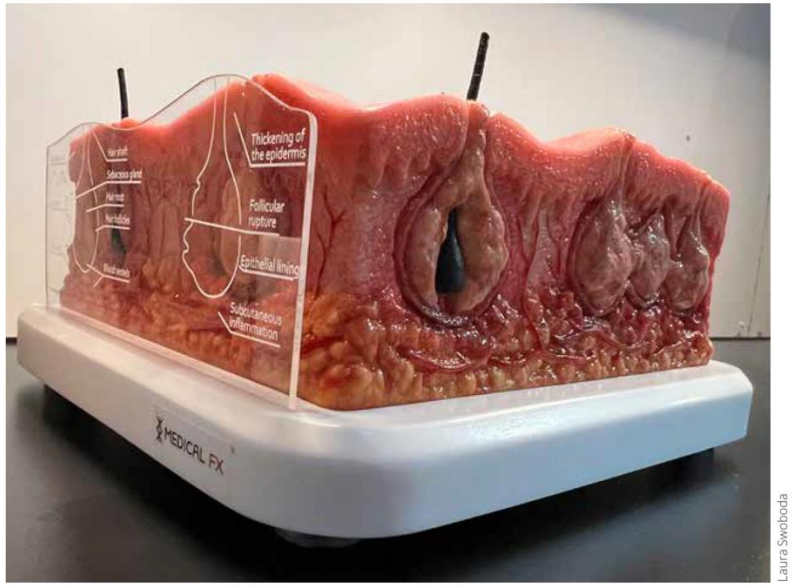
Coding requirements can be complex, and HS does not feature in assessment templates for wound care, so, for example, in primary care HS is likely to be coded as an 'abscess'.

Professional Education

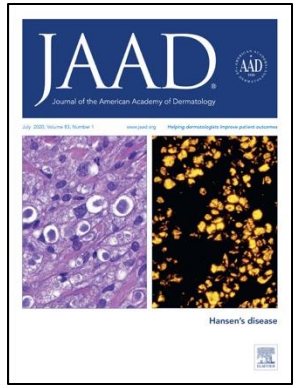
- Raising **awareness and understanding of HS among primary-care providers**, such as GPs, nurse practitioners and emergency department staff, is imperative to promote timely diagnosis, referral and treatment.
- Primary-care providers should be educated on the **signs and symptoms** of HS, **the appropriate referral pathway** and the basics of **initial treatment**.
- Professional and public education should also aim to **dispel misunderstandings about the cause of HS** and encourage empathy and compassion for what patients endure.[159]
- For dermatologists, wound care specialists and surgeons**, more in-depth education** on HS management will increase the number of specialists with the baseline level of confidence, competence and expertise to care for this difficult disease.
- Multidisciplinary education that shares knowledge between **dermatology and wound care** should help bridge the gap between specialties.

Consensus statement: HS is a challenging and complex disease, and effective diagnosis and management require sufficient awareness and understanding among health professionals.

Figure 12. Educational model of hidradenitis suppurativa lesions



Laura Swoboda



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Patient Education

The fact that diagnosis and treatment of HS are often incorrect or delayed suggests a **lack of awareness about the disease among patients and professionals**.

Patients with HS should be **thoroughly educated** on all relevant aspects of the disease (*Box 4*).

Box 4. Key points for patient education

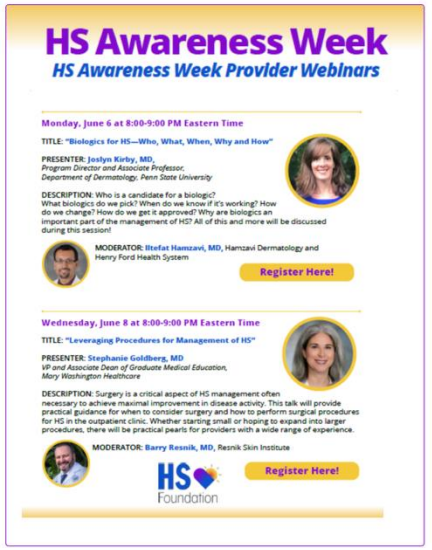
- Cause and symptoms of HS, including that HS is not contagious or due to poor hygiene
- Lifestyle modification, including smoking cessation and weight loss
- Anti-inflammatory medications
- Pain management and analgesics
- Surgical options
- Cleansing solutions and techniques
- Management of lesions
- Dressing and dressing-retention options
- Dressing changing technique, including hand hygiene
- Range of motion exercises that can be performed during dressing changes
- When and where to get help during a new flare
- Details of support groups

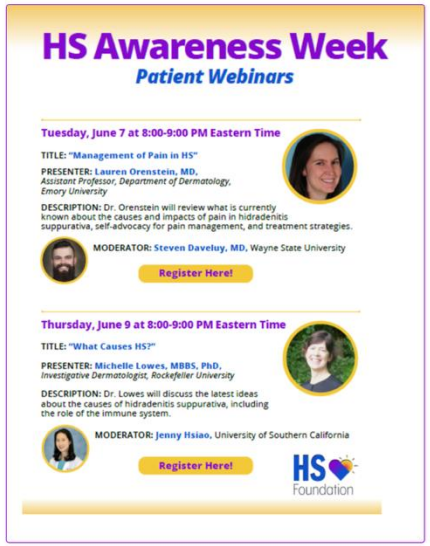
Consensus statement:

Patient education should aim to dispel the common myths that HS is contagious and linked to poor hygiene, which can lead to self-blame and reluctance to seek treatment among patients.

Patient Education

- Patients experiencing acute flares of HS typically have to **self-manage their lesions** daily, and research suggests that patients would like their dermatologists to spend more time counselling them on the management of acute flares and lesions.[62]
- Dermatologists have also recognised the need for more patient education on caring for their lesions, including **use of dressings and skin cleansing.**[7]
- Education should aim to help patients develop a long-term management plan and **empower self-care**.
- However, it should also ensure that patients understand the potential for inpatient admissions and know when to seek professional advice, to minimise the risk of the disease progressing untreated and reaching a crisis point.[163]





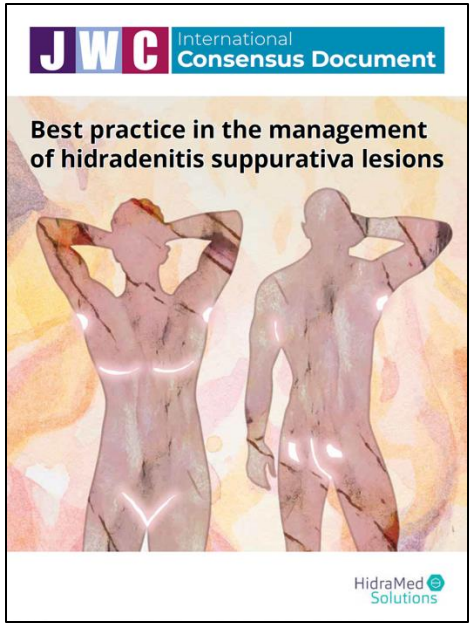
Consensus statement:

While patients with chronic conditions can become expert in self-management, those with HS should not be left to navigate a pervasive and debilitating disease alone. Ongoing professional support is essential to educate and advocate for patients, as well as to facilitate access to – and informed decisions about – appropriate treatments. Patient education should be delivered with a combination of specialist consultations and multimedia materials, including information leaflets, educational videos and website signposting.

Conclusions

HS is a painful and debilitating skin disease that has a huge impact on a patient's quality of life. HS lesions are intensely painful and, when open, produce high levels of exudate and malodour. However, while HS is typically lifelong and cannot be fully cured, appropriate support can help patients navigate the disease, manage its symptoms and minimise their impact on quality of life. This international consensus document offers guidance on diagnosing and managing HS lesions, based on the best available evidence and expert opinion.

- It emphasises the importance of **prompt recognition, diagnosis and referral of HS** to initiate timely treatment, prevent deterioration and improve outcomes.
- It also provides best-practice guidance for **managing lesions** according to a patient's specific presentation.
- A **holistic treatment** strategy should include **anti-inflammatory** medication and **antiseptic cleansing**, along with any appropriate lifestyle modifications, analgesics and surgical interventions.
- **Lesional pain, exudate and malodour** are typically the **main drivers of poor quality of life in HS** and thus require prompt and effective relief. This can be achieved by prioritising access to **specialist wound care** for lesional management, including antimicrobial cleansing and absorptive dressing, as well as interventions to resolve irritant contact dermatitis and MARSI.



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Reflective Questions

1. What is the prevalence of hidradenitis suppurativa, how does it typically present and how is it diagnosed?
2. List the anatomical locations where HS lesions most commonly occur?
3. Describe some of the challenges for both the healthcare professional and the patient caused by HS lesions?
4. Which assessment tool demonstrated a significant correlation between drainage & odour and impaired quality of life?
5. A critical piece of guidance from the best practice document is around the referral pathway – what are the challenges currently and describe the recommended pathway?
6. List some of the medical specialties needed to provide best practice care for HS patients?
7. What are the three surgical management procedures used for HS lesions?
8. What are some of the key challenges when dressing HS lesions?
9. List some of the main recommendations the best practice document makes about dressing selection?
10. Give some examples of the key points that patient education should address?

References

Journal of Wound Care International Consensus Document, ‘Best practice in the management of hidradenitis suppurativa lesions’ (Journal of Wound Care, Vol 34, No 6, Sup B, June 2025). For full references please refer to the full document.

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