



CLINICAL GUIDELINES QUICK REFERENCE

Hidradenitis Suppurativa Clinical Guidelines

Hidradenitis Suppurativa Foundation and American Academy of Dermatology, 2026. First published in the Journal of the American Academy of Dermatology.

- 4 strong recommendations, all biologics
- 2 good practice statements, treated as strong
- 37 recommendations across 10 therapy categories
- Plus the therapies where evidence generation is needed

HS GUIDELINE FINDER · HOWTOTREATHS.COM

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START HERE

Reading the recommendations

STRENGTH OF SUPPORT

STRONGEST SUPPORT

STRONGEST CAUTION

STRENGTH TELLS YOU WHAT TO DO

Strong benefits clearly outweigh risks; applies to most patients in most circumstances

Good practice imperative to practice based on strong sentiment for the need, in spite of an absence of direct data; treated as a strong recommendation

Conditional benefits closely balanced with risks; applies to most patients, but the right action may differ with the clinical situation or patient values

No recommendation evaluated; evidence insufficient to advise for or against. An area where evidence generation is needed, not a recommendation against use

CERTAINTY TELLS YOU ABOUT THE EVIDENCE

Moderate true effect likely close to the estimate

Low confidence limited; true effect may differ substantially

Very low estimate very uncertain

THE DISTINCTION THAT MATTERS

Certainty reflects confidence in the underlying data, **not a treatment's clinical utility**. Many established HS treatments rest on observational studies, case series and small trials, and ratings are not adjusted for clinical familiarity. Treat strength of recommendation as the primary directive and certainty as context.

ALSO STATED UP FRONT

Multimodal care effective management addresses chronic disease and acute flares together

Screen for comorbidities interdisciplinary care should address medical and psychiatric comorbidity

Severity documentation recommendations for moderate to severe disease are not a requirement to document severity with a specific measure before treating

Terminology tunnels is preferred over sinus tracts or fistulas

RECOMMENDED FOR USE

What the guideline supports

TOPICAL

Topical clindamycin 1% **CONDITIONAL, FOR** low

Topical resorcinol 10-15% **CONDITIONAL, FOR** low

Topical ruxolitinib 1.5% cream **CONDITIONAL, FOR** low

SYSTEMIC ANTIBIOTICS

Doxycycline **CONDITIONAL, FOR** very low

Tetracycline **CONDITIONAL, FOR** very low

Clindamycin with rifampin **CONDITIONAL, FOR** very low

Ertapenem moderate to severe, refractory; bridge therapy **CONDITIONAL, FOR** very low

HORMONE THERAPY

Spirolonactone **CONDITIONAL, FOR** very low

BIOLOGICS

Adalimumab mod-severe **STRONG, FOR** moderate

Bimekizumab mod-severe **STRONG, FOR** moderate

Infliximab mod-severe **STRONG, FOR** low

Secukinumab mod-severe **STRONG, FOR** moderate

Adalimumab continued perioperatively continue through surgery **CONDITIONAL, FOR** low

OTHER SYSTEMIC

Upadacitinib mod-severe **CONDITIONAL, FOR** low

Short-term systemic corticosteroids mod-severe, short course only **CONDITIONAL, FOR** very low

PROCEDURAL

Deroofing recurrent or persistent lesions **CONDITIONAL, FOR** very low

Incision and drainage acutely painful abscesses **CONDITIONAL, FOR** very low

Lesional and regional excision persistent or recurrent lesions **CONDITIONAL, FOR** very low

Laser hair removal **CONDITIONAL, FOR** very low

Botulinum toxin **CONDITIONAL, FOR** very low

Intralesional triamcinolone acetone acutely painful lesions **CONDITIONAL, FOR** very low

Adjunctive hyperbaric oxygen therapy adjunctive to systemic antibiotics **CONDITIONAL, FOR** very low

SUPPORTIVE

Routine pain assessment **GOOD PRACTICE, FOR**

Supportive pain management **CONDITIONAL, FOR** very low

Tobacco cessation in patients who use tobacco **CONDITIONAL, FOR** very low

COMPLEMENTARY

Adjunctive oral zinc clinician-guided **CONDITIONAL, FOR** very low

Vitamin D repletion if insufficient or deficient **CONDITIONAL, FOR** very low

RECOMMENDED AGAINST

What not to use

Acitretin	CONDITIONAL, AGAINST	very low
Isotretinoin	CONDITIONAL, AGAINST	very low
Etanercept	CONDITIONAL, AGAINST	very low
Guselkumab	CONDITIONAL, AGAINST	low
Risankizumab	CONDITIONAL, AGAINST	low
Vilobelimab	CONDITIONAL, AGAINST	low
Methotrexate	may still be used for anti-drug antibodies with TNF inhibitors	
	CONDITIONAL, AGAINST	very low
Azathioprine	may still be used for anti-drug antibodies with TNF inhibitors	
	CONDITIONAL, AGAINST	very low
Avacopan	CONDITIONAL, AGAINST	low
Radiotherapy	in pediatric and adolescent patients	
	GOOD PRACTICE, AGAINST	

RESEARCH GAPS

The workgroup searched the literature for all available therapeutic interventions for HS. For these, the evidence was insufficient to advise either way. **These are areas where evidence generation is needed, not recommendations against use.**

Topical therapies. Benzoyl peroxide, Chlorhexidine, Topical antiseptics

Systemic antibiotics. Amoxicillin-clavulanate, Clindamycin monotherapy, Dalbavancin, Dapsone, Linezolid, Metronidazole, rifampin plus moxifloxacin, Ofloxacin plus clindamycin

Hormonal therapies. Combination oral contraceptive pills, Finasteride, Metformin

Biologics. Anakinra, Ixekizumab, Spesolimab, Ustekinumab

Systemic therapies. Apremilast, Brepocitinib, Colchicine, Cyclosporine, Hydroxychloroquine, Roflumilast

Procedural interventions. Cryotherapy, Intense pulsed light, Intralesional photodynamic therapy, Microwave ablation, Photodynamic therapy, Radiofrequency, Radiotherapy in adults, Sclerotherapy

Wound care. Specific wound care regimens

Weight reduction. Bariatric surgery, GLP-1 and GLP-1/GIP receptor agonists

Diet. Dairy-free diet, Intermittent fasting, Mediterranean diet, Yeast exclusion diet

Complementary and alternative medicine. Myo-inositol, liposomal magnesium and folic acid supplement, Staphage lysate

DEVELOPED BY

A joint workgroup of **15 members** convened by the Hidradenitis Suppurativa Foundation and the American Academy of Dermatology, co-chaired by **Haley B. Naik, MD, MHSc** (UCSF) and **Craig N. Burkhart, MD, MSBS, MPH**. Members: Howa Yeung (Emory), Lindsay Frazer-Green (AAD), Steven D. Daveluy (Wayne State), Amit Garg (Northwell), Amy J. McMichael (Wake Forest), Christopher J. Sayed (UNC Chapel Hill), George K. Hightower (UC San Diego), Ginette Okoye (Howard), Kelly Keeler (AAD), Lauren A. V. Orenstein (Emory), Melanie Plotke (AAD), Melissa Shive (UC Irvine), Peggy A. Wu (UC Davis). Funded by the HS Foundation and the AAD. Members with a relevant conflict recused themselves from discussion and drafting of recommendations in that topic area. Disclosures are published with the guideline.

Adherence to these guidelines will not ensure successful treatment in every situation, and they do not set a standard of care or exclude other reasonable methods. The ultimate judgment on any specific therapy rests with the clinician and patient in light of the individual circumstances. Disclaimer paraphrased; the published version carries the AAD wording verbatim.

DOSING AND MONITORING

Topical, antibiotic, hormonal

THERAPY	DOSE	MONITORING
Topical clindamycin 1% <i>Topical antibiotic</i>	1% lotion, gel or solution twice daily to affected skin.	No routine monitoring
Topical resorcinol 10-15% <i>Topical keratolytic</i>	Over the counter; requires compounding. 10-15% cream once to twice daily to affected skin.	No routine monitoring
Topical ruxolitinib 1.5% cream <i>Topical JAK1/JAK2 inhibitor</i>	1.5% cream twice daily to affected skin. Do not exceed 60 g/week or 100 g per 2 weeks.	BOXED WARNING No routine labs per label; CBC as indicated; periodic skin exams for NMSC
Doxycycline <i>Tetracycline antibiotic</i>	100 mg by mouth twice daily for 12 weeks.	No routine monitoring
Tetracycline <i>Tetracycline antibiotic</i>	500 mg by mouth twice daily for 12 weeks.	No routine monitoring
Clindamycin with rifampin <i>Combination systemic antibiotics</i>	Clindamycin 300 mg and rifampin 300 mg, both by mouth twice daily for 12 weeks.	No routine labs for a 12-week course. Rifampin is a potent CYP3A4 inducer: review all concomitant meds
Ertapenem <i>Carbapenem antibiotic</i>	1 g intravenously daily for six or more weeks via PICC.	Baseline renal function, CBC, LFTs. Periodic renal function; adjust if CrCl 30 or less. Watch PICC site
Spironolactone <i>Anti-androgen</i>	50-200 mg by mouth daily.	BOXED WARNING Baseline K+ and creatinine; eGFR if renally impaired or on ACEi/ARB. K+ not needed in healthy patients

PAIN IS A RECOMMENDATION, NOT AN AFTERTHOUGHT

Ask every patient about pain as part of clinical assessment. 61% report moderate to severe pain and stigma limits disclosure. Severity: NRS, VAS, Wong-Baker FACES. Severity plus impact: Brief Pain Inventory. Chronic pain: Graded Chronic Pain Scale Revised. Character: painDETECT, Central Sensitization Inventory, McGill Pain Questionnaire.

Acute pain: compresses, topical lidocaine, acetaminophen, NSAIDs, intralesional triamcinolone acetonide, I&D, short-term systemic corticosteroids; opioids only if refractory, immediate-release, lowest effective dose, limited duration.

Chronic pain: SNRIs, tricyclics, gabapentin, pregabalin, psychotherapy, wound care.

DOSING AND MONITORING

Biologics and other systemics

BEFORE STARTING A BIOLOGIC OR JAK INHIBITOR

TB screening by TST or IGRA, with chest radiograph for secukinumab and upadacitinib. Hepatitis B panel, hepatitis C antibody and HIV screening for the TNF inhibitors. CBC and hepatic profile. Fasting lipids for upadacitinib. Then annual TB screening and vigilance for serious infection. Below: **standard screening**.

THERAPY	DOSE	MONITORING
Adalimumab <i>TNF inhibitor</i>	Adults and adolescents 12 years and older, 60 kg or more: 160 mg subcutaneously day 1 (or 80 mg on days 1 and 2), then 80 mg on day 15, then 40 mg weekly or 80 mg every 2 weeks from day 29. Adolescents 12 years and older, 30 to under 60 kg: 80 mg day 1, then 40 mg every 2 weeks from day 8.	BOXED WARNING Standard screening. Monitor HBV carriers for reactivation
Bimekizumab <i>IL-17A/F inhibitor</i>	Loading: 320 mg subcutaneously every 2 weeks from week 0 through 16. Maintenance: 320 mg every 4 weeks thereafter.	Standard screening. Periodic LFTs on treatment
Infliximab <i>TNF inhibitor</i>	Loading: 5-10 mg/kg intravenously at weeks 0, 2 and 6. Maintenance: every 4 to 8 weeks thereafter.	BOXED WARNING Standard screening. Stop if jaundice or LFTs 5x ULN
Secukinumab <i>IL-17A inhibitor</i>	Adults, loading: 300 mg subcutaneously weekly at weeks 0, 1, 2, 3 and 4. Maintenance: 300 mg every 4 weeks, may escalate to every 2 weeks for adequate response. Adolescents 12 years and older: 150 mg (30 to under 90 kg) or 300 mg (90 kg or more) on the same schedule.	Standard screening with chest radiograph
Upadacitinib <i>JAK1 inhibitor</i>	Adults and adolescents 12 to 64 years: 30 mg by mouth daily. Adults 65 and older: 15 mg by mouth daily.	BOXED WARNING Standard screening with chest radiograph. Fasting lipids at 12 weeks
Short-term systemic corticosteroids <i>Systemic corticosteroid</i>	Prednisone 40-60 mg by mouth daily with a taper over 1 to 2 weeks.	Blood glucose, especially in diabetes or prediabetes

ON STEP THERAPY

Step therapy, requiring a patient to work through insurer-designated treatments before a physician-prescribed therapy is covered, is stated to **lack evidence of clinical benefit** and to be associated with treatment delays, reduced access to guideline-concordant care, and worse clinical outcomes. The Cost section addresses the same issue economically.