

Referral and co-management

The guideline gives no referral guidance. This piece assembles what it does support, and where the handoffs actually fall.

■ GUIDELINE TEXT ■ CLINICIAN SERIES ■ FROM THE HS FOUNDATION

WHAT THE GUIDELINE ASKS FOR

Effective HS management addresses both chronic HS disease and acute HS flares, often requiring multimodal strategies including systemic, procedural, and supportive therapies. Interdisciplinary HS management should screen for and address medical and psychiatric comorbidities that contribute to HS burden.

JOINT AAD AND HSF GUIDELINES, RECOMMENDATIONS

WHEN TO REFER

WHAT DR. NAIK DESCRIBES

Signs that prompt a systemic conversation

Scarring, tunnel development, excruciating sustained pain, impaired quality of life and limited function. Her clinical observations, not criteria. She writes that no clear definition of moderate HS exists. See piece 02.

WHAT IS ON THE OTHER SIDE

Four strong recommendations

Adalimumab, bimekizumab, infliximab and secukinumab carry the guideline's only strong recommendations, all for moderate to severe HS.

WHAT DOES NOT GATE IT

No severity score is required

The guideline states that recommendations for moderate to severe HS should not be read as requirements to document severity with specific measures before patients access treatment.

WHAT TO KEEP DOING WHILE THE PATIENT WAITS

The guideline describes no sequence and no wait. The items below are guideline-supported care, ordered by the Foundation.

- **What the guideline supports.** Topical and oral options, with the doses and cautions it reports. See piece 04.
- **Pain.** Routine pain assessment is a good practice statement, and supportive pain management is a recommendation in its own right. See piece 03.
- **Comorbidities.** The guideline asks for screening as part of interdisciplinary management. See piece 05.
- **What to send on.** What has been tried, what was started, and where the pain sits.

WHAT TO PUT IN THE REFERRAL

The guideline does not address referral. Every row below is a guideline-supported element of care, assembled here by the Foundation for a handoff.

WHAT TO INCLUDE	WHY IT IS WORTH SENDING
What the presentation looks like now	The four strong recommendations are written for moderate to severe HS, which the guideline does not define.
What has already been tried, and for how long	The guideline conditionally recommends several topical and oral therapies. Naming what has been used prevents a restart of the same sequence.
The pain assessment, and which tool you used	The guideline names the Numeric Rating Scale, Visual Analog Scale, Wong-Baker FACES, Brief Pain Inventory and GCPS-r among its validated options.
Comorbidities screened, and what you found	Treatment selection should consider comorbidities, so this changes what the specialist can reach for.

THE ADVOCACY ROLE DR. GARG DESCRIBES

Dr. Amit Garg, Secretary of the HS Foundation, writes that the dermatologist is often the clinician with the earliest, clearest view of a patient's overall inflammatory burden. That is a reason to advocate with primary care and other specialists for early identification of conditions that can be mitigated before they become chronic and disabling. The dermatologist is not going to be the central figure managing every comorbid condition. That is not the model.

GARG, HS IS A SYSTEMIC DISEASE, HOWTOTREATHS

FROM THE HS FOUNDATION

The guideline names dermatology, primary care, pain medicine, psychiatry, psychology, palliative care and wound care as specialties to consider for refractory pain. It says nothing else about referral, in either direction. Reading that list as a sign that referral in HS runs more than one way is ours.

WHAT CO-MANAGEMENT LOOKS LIKE ON THE OTHER SIDE

Dr. Christopher Sayed, Vice President of the HS Foundation, describes medication and surgery as complementary rather than alternatives. Medication controls inflammation and prevents new lesions. It reaches a limit at the scarring and tunneling that develops over time, because that scarring is a physical remodeling of the skin. Surgery addresses the remodeling. Surgery alone leads to an endless cycle of procedures. Most patients with meaningful disease need both.

SAYED, THERE WAS NO PLAYBOOK FOR HS CARE, HOWTOTREATHS

Dr. Sayed also describes how far capacity has come. When he began giving talks on HS surgery, one or two people in a large room had done it. Today at least half the room raises a hand. He compares HS to psoriasis twenty-five years ago: a specialist disease until the therapies and the training caught up, and he describes HS as becoming a disease the community can treat rather than one only specialty clinics manage.

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