The first doctor an HS patient sees is usually not a dermatologist

Care begins at the frontline encounter, and so does the delay. Closing the diagnostic gap means doing the work there.

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GUIDELINE TEXT · CLINICIAN SERIES · FROM THE HS FOUNDATION

WHERE HS CARE ACTUALLY BEGINS

FIRST CONTACT
More than 80% of patients
Patients with HS first present to a clinician who is not a dermatologist. Primary care. OB/GYN. Urgent care. The emergency department.

THE COST OF THAT
A seven to ten year delay
That is where care begins, and where the delay to diagnosis begins with it.

WHERE THE WORK GOES
The frontline encounter
The place HS care most often goes wrong first, and so the place the field has to fix if it means to close the gap.

THE PATTERN, REPEATED

A patient walks into an urgent care or primary care office with a single painful lesion. The clinician sees an abscess, drains it, prescribes an antibiotic, and sends the patient home. The lesion improves. Six months later the patient comes back with another one. Then again. If the pattern is caught, the patient is eventually referred to dermatology. If it is not caught, they cycle through the system for years.

ONE QUESTION THAT COULD CHANGE IT

The gap in that pattern is not treatment. It is history. When a patient presents with what looks like a recurring skin infection, the question that would identify HS in most cases is a single line: has this happened before, and where?

Research suggests that asking whether a patient has had more than one boil in the armpit, groin, under the breast, or in the buttocks over the last six months identifies HS with roughly 90 to 98 percent probability.

My own view is that we can simplify further. Anyone who has had more than one boil in their life should be seen by a dermatologist. If it is not HS, we can identify what it is. If it is HS, we can start the work of managing it decades earlier than we do today.

WHAT FRONTLINE CARE CAN DO WHILE PATIENTS WAIT

Primary care and other non-dermatology clinicians have a set of medications in their existing wheelhouse that can help HS. Antibiotics. Spironolactone. Metformin. Finasteride. These are drugs a primary care physician is already comfortable prescribing. There is no reason a patient with an HS diagnosis should sit for three months without treatment when their primary care physician is capable of starting a first-line therapy while they wait.

FROM THE HS FOUNDATION
Two of those four sit differently in the guideline. It conditionally recommends systemic antibiotics and spironolactone. It finds insufficient evidence to make a recommendation on metformin or on finasteride. Dr. Daveluy's view here is his own. See piece 04 of the clinician series for what the guideline supports.

The upcoming guidelines will make it easier to identify which of those therapies are supported by evidence for which patients. They give a non-specialist clinician a defensible reference to point to when they start a therapy: this is recommended, here is the evidence, I am not improvising.

ONCE A PATIENT REACHES DERMATOLOGY

Medications, including biologics, can control inflammation and prevent new lesions from forming. They do not typically resolve the draining tunnels that develop in later-stage disease. Those need surgery. The dermatologist has to be the quarterback, keeping biologics running through surgical intervention and coordinating with a surgeon who understands why that matters.

THE QUESTION HE WOULD ADD TO EVERY VISIT

HS is a stressful disease. Dermatologists often do not ask about the mental health impact, and patients often do not know they can raise it. One practice I would encourage: what will you do when your HS is under control that you cannot do now? It sets a goal. It surfaces what the patient is trying to get back to.

THE COVERAGE ARGUMENT HE MAKES

There are therapies with strong evidence in HS that are not adequately covered because they read to a payer as cosmetic. Laser hair removal is the clearest example. A course of laser hair removal for an HS patient costs roughly $4,800. A year of biologic therapy costs approximately $40,000. If the laser treatment prevents the need for a biologic, the savings compound over the life of the patient.

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