

There was no playbook for HS care. There is one now.

The important thing about where the field is today is that HS is becoming a disease the community can treat, not something only specialty clinics know how to manage.

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■ GUIDELINE TEXT ■ CLINICIAN SERIES ■ FROM THE HS FOUNDATION

WHAT IT TOOK TO BUILD A PRACTICE

When I finished my dermatology training at UNC in 2013, HS was at the top of the list of diseases I did not feel ready to treat well. There were no FDA-approved therapies. There were very few experts across the country. And there was not much of anywhere to send patients who needed real help.

Infliximab, the biologic that has become one of the most commonly used off-label therapies for HS, was not something dermatologists were trained to coordinate. For patients who needed the drug and had nowhere else to get it, we had to learn to run the therapy ourselves. Surgery was harder. HS surgery was not part of dermatology residency training, and I would send patients out and get them back untreated.

HOW FAR THE FIELD HAS COME

When I started giving talks about HS surgery, I would sometimes find one or two people in a big room who had done surgery for HS themselves. Today, when I give the same talks, at least half of the room raises a hand. That is a measure of how the field has changed.

The comparison that comes to mind is psoriasis twenty-five years ago. It was a specialist disease because general dermatologists did not have the tools or the confidence to manage it. HS is not there yet, but it is on the same trajectory. As recently as a decade ago, dermatologists could reasonably say they did not have the tools to treat HS well. That excuse no longer exists.

WHAT THE GUIDELINE SUPPORTS ON EACH SIDE

MEDICAL

Four strong recommendations

Adalimumab, bimekizumab, infliximab and secukinumab, for moderate to severe HS.

PROCEDURAL

Conditional recommendations in favor

Deroofing, incision and drainage, local and regional excision, laser hair removal, botulinum toxin and intralesional triamcinolone acetonide.

FROM THE HS FOUNDATION

Dr. Sayed's argument is that these two columns are one treatment plan rather than a choice. The guideline recommends across both and does not sequence them.

THE MEDICATION AND SURGERY BALANCE

The clinical point I most want other dermatologists to understand is that medication and surgery are complementary, and for most patients with meaningful disease, neither alone is enough.

Medications can control inflammation, prevent new lesions from forming, and reduce pain and drainage. For most patients with the scarring and tunneling that develops over time, medications hit a limit. That scarring is a physical remodeling of the skin. It does not reverse with a drug. The disease quiets down, but specific areas keep flaring in the same spots. Patients often know exactly where these areas are. They can point to them.

Surgery addresses that physical remodeling, but surgery alone is not the answer either. If all we do is cut out active areas, the disease reappears somewhere else and the patient ends up in an endless cycle of procedures. Having surgery all the time is not much better than having HS all the time.

THE PIPELINE OVER THE NEXT FIVE TO SEVEN YEARS

New oral options are coming, including JAK inhibitors, which is meaningful because HS currently has no approved oral therapies. Additional biologics in mechanism classes we already use are going to expand the bench, and even similar mechanisms sometimes give better responses in patients who did not respond to what came before. Earlier-stage work on other pathways, including IL-1 inhibition, is showing promising signals and still needs phase three data.

THE LIVE-UPDATE PROCESS, AND WHY IT MATTERS

Focused updates will be driven by two events: phase three data that establishes strong evidence for a therapy, and FDA approvals that make a drug available for prescribing. Larger revisions on the standard five-year cycle will incorporate the accumulated smaller findings in between. Without it, the document would be dated within eighteen months of publication.

FROM THE HS FOUNDATION

The guideline's own Research Gaps section names the same problem from the other side: high-quality evidence is lacking to inform the optimal timing and sequencing of interventions, including integration of medical, procedural, surgical and wound care approaches. See piece 10 of the clinician series.

WHAT DETERMINES WHETHER THEY WORK

The guidelines are the most complete picture of HS care the field has ever produced. Whether they change patient outcomes will depend on what happens next: whether the clinicians who need them can find them, understand them, and put them into practice. That is the work still ahead of us.