

HS is a systemic disease

Nearly every organ system can be related to inflammation in HS independently. The evidence base has to reflect that.

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■ GUIDELINE TEXT ■ CLINICIAN SERIES ■ FROM THE HS FOUNDATION

WHAT CHANGED, AND HOW

For a long time, HS was thought of primarily as a chronic skin disease. Dermatologists caring for HS patients recognized that these patients were also carrying a substantial burden of other medical conditions, but there was no way to systematically prove it. The patient populations were too small, the data too scattered, and the observations too anecdotal to move beyond individual clinical impression.

That began to change about a decade ago. When Big Data analytics platforms became capable of combining large HS patient populations with granular clinical information, we could finally make observations that were meaningful clinically and biologically. Nearly every organ system in the body can be related to inflammation in HS independently. The pattern is consistent enough, and independent enough of other risk factors, to reframe what HS is.

WHAT THIS MEANS FOR CLINICIANS

The immediate implication is that treatment strategy has to take a patient's comorbidity profile into account. The therapies we consider for HS interact with the other medical issues a patient is carrying, and choosing the right approach requires understanding the full picture of their health.

There is a second implication that is less obvious and may matter more. The dermatologist is not going to be the central figure managing every comorbid condition. But the dermatologist is often the clinician who has the earliest, clearest view of that patient's overall inflammatory burden. That puts us in a position to advocate with primary care and with other specialists for early identification of conditions that can be mitigated before they become chronic and disabling.

Interdisciplinary HS management should screen for and address medical and psychiatric comorbidities that contribute to HS burden. Treatment selection should consider comorbidities.

JOINT AAD AND HSF GUIDELINES, RECOMMENDATIONS

WHAT THIS MEANS FOR PAYERS

Conditions like obesity, metabolic disease, diabetes, and cardiovascular disease are not academic categories. When they go unrecognized and unmitigated, they lead to serious chronic health problems, disability, higher utilization of care, and in some cases increased mortality. Managing HS well is upstream of a set of conditions that carry significant systemic cost. Payers looking at the direct cost of HS therapies in isolation are looking at only part of the ledger.

WHY THE EVIDENCE BASE IS HARDER TO BUILD THAN IT LOOKS

The core problem is that we do not yet measure response to HS treatment in a way that fully works for everyone involved. The measurement should be meaningful to patients, reliable for investigators, and defensible for regulators.

The primary instrument currently used in HS clinical trials, the HiSCR, has real limitations on all three fronts. It does not capture response on draining tunnels, which are among the most symptomatic lesions a patient can have. A HiSCR 50 response, which sounds like an improvement on paper, often does not correspond to the patient feeling meaningfully better.

The instrument also asks investigators to do something intrinsically difficult. Counting individual inflammatory lesions accurately, and doing that consistently across visits and across raters, is a task human beings are imperfect at.

The consequence is that drugs with strong translational premise and strong phase 2 data can still fail in phase 3. It is close to a coin flip whether a good drug for HS makes it through. That should not be the case.

WHAT THE GUIDELINE SAYS ABOUT THIS GAP

Use of validated objective and patient-reported outcome measures remains essential, including development of tools sensitive to mild disease, where evidence is sparse, and tools that adequately capture tunnel burden.

JOINT AAD AND HSF GUIDELINES, RESEARCH GAPS

THREE FRONTS THE FIELD IS WORKING ON

Digital tools that help investigators apply the current framework more accurately. New measurement instruments designed to better capture what matters to patients while meeting regulatory rigor. And lessons learned from every trial, whether it succeeds or fails.

WHERE THE GUIDELINES FIT

The measurement framework used in trials informs the level of evidence assigned to each therapy. The therapies backed by that evidence are what the guidelines synthesize. The patient's individual comorbidity profile then informs which of those therapies makes sense for the person in front of us. Each element depends on the others.