Short Communication

New Indian Journal of Surgery
Volume 6 Number 3, July - September 2015
DOI : https://dx.doi.org/10.21088/nijs.0976.4747.6315.7

Hiradenitis Suppurativa

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A lady 45 years of age presented in the surgical OPD with chief complaints of multiple abscesses and draining sinuses in the perianal region for the past 6 months. She also complained of difficulty in walking and had associated constipation. The patient also gave history of similar lesions in the bilateral axillae which had healed with scarring on taking antibiotics from a private practitioner around 8-10 months ago. Patient did not report any history suggestive of tuberculosis, diabetes mellitus. On examination patient was well oriented in time, place and person. Her vitals were stable. Patient was pale and bilateral axillae had scarring. Local examination revealed multiple abscesses and pus draining sinuses present in the perianal region and bilateral gluteal region. No sulphur granules were noted in the pus. Skin excoriation was present and granulation tissue was present in certain regions. Digital rectal examination revealed decreased anal tone, multiple fistulae. Investigations showed that the patient was anemic and rest were in normal limit. MRI showed multiple sinuses and fistulae in the perianal region, communicating with the rectum.

Patient was treated with oral antibiotics (ciprofloxacin, augmentin) and repeated incisions and drainages. Subsequently a diverting colostomy was made in view of high perianal fistulae.

1. Two months after colostomy the gluteal regions had healed considerably.
2. Weeks later the patient presented with pus discharge and an abscess in the right axilla.

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Discussion

Hidradenitis suppurativa (HS) is a chronic, relapsing inflammatory disease of skin, characterized by recurrent draining sinuses and abscesses, predominantly in skin folds carrying terminal hairs and apocrine glands.

Hidradenitis suppurativa (from the Greek hidros, sweat and aden, glands), also known as acne inversa, was first described by Velpeau, a French physician in 1839, who reported a peculiar inflammation of the skin with the formation of superficial abscesses in the axillary, mammary and perianal areas [1].

The disease occurs where apocrine glandular tissue is found, but most commonly it affects the skin of the axillae and inguinoperineal regions [2]. Although may affect any area of the body surface.

Although the patho-physiology is understood poorly, it generally is believed that obstruction of the apocrine and/or follicular pores results in glandular dilatation and bacterial super-infection with subsequent gland rupture disseminating infection throughout the subcutaneous tissue plane [1]. Consequently, hidradenitis is associated with chronic painful abscesses, multiple odiferous draining sinus tracts, and chronic fibrosis with range-limiting scar formation [4]. Anogenital involvement most commonly affects the groins with extension to inguinal regions, mons pubis, inner thighs and sides of scrotum. The perineum, buttocks and perianal folds are often included. The sinuses can dissect deep into tissue, involving muscle, fascia and bowel forming a labyrinth of tracts in advanced cases [5]. Clinically, the disease often presents with tender subcutaneous nodules beginning around puberty. The nodules may spontaneously rupture or coalesce, forming painful, deep dermal abscesses. Eventually, fibrosis and the formation of extensive sinus tracts may result.

The abscesses tend to extend deeper into the subcutaneous tissue, developing inter-communicating sinus tracts, resulting in irregular hypertrophic scars [4]. In such a developed phase, antibiotics are usually ineffective alone and surgical treatment is required [3, 6, 7]. HS remains a challenging disease for both the patient and the physician. It is a chronic debilitating disease whose aetiology is still controversial.

Success of medical therapies, however, often is limited because of the indolent and recurrent nature of the disease. Operative excision of the involved follicles and inflammatory process is the only curative treatment [3, 4].

Excision and primary closure was used only for mild and moderate (Hurley stage I) axillary and inguinal disease, whereas wide local excision and split-thickness skin grafting or fasciocutaneous flap was the mainstay of treatment in patients with diffuse disease (Hurley stage II and III).

Hurley Staging System

Stage	Characteristics
I	Solitary or multiple isolated abscess formation without scarring or sinus tracts.
II	Recurrent abscesses, single or multiple widely separated lesions, with sinus tract formation.
III	Diffuse or broad involvement across a regional area with multiple interconnected sinus tracts and abscesses.

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