A non responsive skin infection

Or is it?

Clayton Golledge, BSc (Med), MB, BS, MRCGP, FRCPA, FACTM, DTM&H, is Consultant in Clinical Microbiology and Infectious Diseases at the Western Australian Centre for Pathology and Medical Research, Western Australia.

A 22 year old woman comes to see you in frustration because no other doctor has been able to help her. She has had chronic infection of her axilla and perineal area for the past 18 months and has had no real help from repeated courses of tetracyclines, cephalaxin, amoxycillin and fluoroaxilin. She has tried a number of different topical treatments including chlorohexidine, muplacin and sodium fusidate with little response.

On examination she has obvious suppuration in both axillae and around the perineum. She is also quite obese and somewhat hirsute but otherwise the physical examination is normal.

Questions 1

What is this condition and what is its aetiology and pathogenesis?

Question 2

Is microbiological sampling likely to be of value?

Question 3

What conditions are associated with this disease?

Question 4

What is the differential diagnosis?

Question 5

How should she be managed in both the short and long term?

Answers

Answer 1

This condition is known as hidradenitis suppurativa (HS). It is a chronic, suppurative inflammatory disease affecting apocrine gland bearing areas, chiefly the axilla and perineum. It is best considered a disorder of terminal follicular epithelium within apocrine gland bearing skin. No immunological abnormality has been demonstrated among sufferers of HS.

Answer 2

Swabbing is usually of little or no value as bacterial involvement of HS is secondary to the disease process. The flora is not constant and may change unpredictably. Various bacteria may be isolated including staphylococci, streptococci, Gram negative rods and anaerobes.

Answer 3

HS is more common in women with a peak onset between 11 and 30. It is associated in many cases with an increase in androgen levels. It is also more common in obese patients.

Answer 4

The physician should suspect HS in any pubertal or adult patient with a tender abscess-like process in an apocrine gland bearing area. It should be differentiated from furunculosis, granulomatous disease, infected epidermoid cysts and actinomycosis. With predominant perineal or inguinal involvement granuloma inguinale and lymphogranuloma venereum should be considered. Crohn's disease should be excluded with perianal disease.

Answer 5

Surgery with wide excision down to soft normal tissue is the mainstay of treatment but many patients may have symptomatic relief with a long term course of antibiotics. In the author's practice clindamycin (300-450 mg tds) has shown sustained benefit and may need to be continued for several months. Relapse after cessation, however, is almost inevitable. Anti-androgen therapy with cyproterone acetate and ethinyloestradiol (Diane 35) may be of benefit in certain cases. Isotretinoin (Roaccutane) has been associated with equivocal results. Antiseptics and topical antibiotics have little or no role in the treatment of HS.