

The Nationwide Epidemiology of Patients Treated for Hidradenitis Suppurativa by a Dermatologist in the Faroe Islands

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Hidradenitis suppurativa (HS) is a chronic inflammatory skin disease (1). Patients develop painful suppurating nodules and/or abscesses, always located in the axillary, inguinal, peri-genital, and perineal regions. The disease can progress and lead to scarring and the formation of tunnels (2). Studies have shown a correlation with the severity of HS and obesity and smoking (3). The diagnostic delay in HS diagnosis is 7.2 years globally (4). The diagnostic delay results in delayed treatment initiation.

The worldwide prevalence of HS has been estimated to be 0.0003–4% (4). The prevalence of HS in the Faroe Islands is unknown. This study was undertaken to estimate the population-based prevalence of HS, and to describe the epidemiology of HS patients in the Faroe Islands.

MATERIALS AND METHODS

The study was conducted as a retrospective registry-based study including HS patients registered in the Telemedicine patient records system (Danish Telemedicine, Copenhagen, Denmark) from the dermatological outpatient clinic, Landssjukrahusid, Tórshavn, Faroe Islands during a period from 2007–2022. Patients registered in the Telemedicine system are referred from general practitioners. We included demographic information, HS-specific data, and treatment-related data. In cases where no Hurley stage was recorded and photos of the lesions were available, the Hurley stage was identified by (DB & DMS) using the Hurley classification. The predefined data were extracted into an Excel spreadsheet by two investigators (AB & DB) separately for quality control. The prevalence of HS in the Faroe Islands was calculated based on a total population of 48,865 persons (data from 2020) (5).

RESULTS

A total of 45 individuals were diagnosed with HS. The prevalence of HS in the Faroe Islands is therefore 0.9% (45/48,865; CI 0.69–1.2). The majority (78%) of the HS patients were women. The median age at first contact was 33 years (IQR 25–46). Sixteen (36%) individuals were currently smoking. The mean $\pm$ standard deviation BMI of the HS population was 34.1 ± 4.48 . Areas of the skin affected indicated the axilla and the groin as the most common areas. Most patients (84%) were affected in multiple anatomical areas. Twenty-three (51%) medical records had data regarding a diagnostic delay, which was calculated to be a median of 10 years (IQR 5–25).

Twenty-one (47%) of the patients had received treatment before diagnosis. The most common past treatment

Table I. Demographic data, clinical data, and treatment (n=45)

Sex, n (%)		
Male	10 (22)	
Female	35 (78)	
Age at first contact in years, median (IQR)	33 (25–46)	
Smoker, n (%)		
Yes	16 (36)	
No	4 (9)	
Ex-smoker	3 (7)	
Not assessed	22 (49)	
Hurley stage, n (%)		
I	11 (24)	
II	29 (64)	
III	2 (4)	
Not assessed	3 (7)	
Body mass index, mean (SD)	34.1 (4.48)	
Not assessed	32 (71)	
Anatomic location – areas affected, n (%)		
Groin	36 (80)	
Axil	30 (66)	
Mamma	14 (31)	
Pubis	12 (26)	
Abdomen	8 (17)	
Nates	7 (15)	
Anus	6 (13)	
Genitalia	4 (8)	
Other	3 (6)	
Patients with more than one affected area (%)	38 (84)	
Diagnostic delay, years, median (IQR)	10 (5–25)	
Not assessed, n (%)	22 (49)	
	Patients, n (%)	Drug
<i>Treatment before diagnosis</i>		
Yes	21 (47)	Antibiotics
No	24 (53)	Tetracycline (systemic)
		Antibiotics (not specified)
		Fucidin (topical)
		Clindamycin (systemic)
		Erythromycin (systemic)
		Clindamycin (topical)
		Disinfectants
		Chlorhexidine gluconate (topical)
		Other
		Azelaic acid (topical)
		Contraceptive pill (systemic)
<i>Treatment after diagnosis – topical</i>		
Yes	44 (97)	Antibiotics/combined antibiotics
No	1 (2)	Clindamycin
		Benzoyl peroxide/clindamycin
		Clindamycin/tretinoin
		Disinfectants
		Chlorhexidine gluconate
		Other
		Azelaic acid
		Resorcinol
		Triamcinolone acetonide
		Hydrocortisone
<i>Treatment after diagnosis – systemic</i>		
Yes	35 (78)	Antibiotics
No	10 (22)	Tetracycline
		Combination of rifampicin & clindamycin
		Doxycycline
		Amoxicillin/clavulanic acid
		Roxithromycin
		Other
		Metformin
		Dapsone
		Adalimumab
		Acitretin
		Contraceptive pill
<i>Overall number of shifts in systemic treatment, n (%)</i>		
Median (IQR)	1 (0–1)	
Shift	18 (40)	
No shift	7 (16)	
Not on systemic treatment	11 (24)	
Lost to follow-up	9 (20)	
<i>Surgical treatment after diagnosis, n (%)</i>		Patients, n (%)
Yes: 6 (13)	Surgical procedure	
No: 39 (87)	CO ²	4 (9)
	Deroofing	2 (4)
	ID/excision	2 (4)

IQR: interquartile range; SD: standard deviation; ID: incision and drainage. *Administered to n of patients (%). Some patients had multiple treatments.

for HS was systemic antibiotic therapy. All patients, except one, had been treated with a topical treatment after diagnosis. The majority (78%) had received systemic treatment after diagnosis, with systemic antibiotics being the most common. Tetracyclines (doxycycline and tetracycline) represented 60% of the patients being treated with antibiotics. See **Table I** for more information.

DISCUSSION

Our study has several limitations that need to be considered. First, selection bias might be present in our cohort as only patients referred to a dermatologist by a general practitioner are included in this study. Patients with mild HS might not consult a general practitioner or the consulted practitioner might not refer them to a dermatologist. Second, the medical records were lacking essential data such as BMI and smoking for multiple patients. BMI was not assessed in 32 (71%) of the patients, and data on smoking were lacking in 22 (49%) records. The lack of data prohibited us from correctly characterizing all HS patients. However, a strength of our study is that the results represent all patients in the Faroe Islands seen by a dermatologist and registered under the diagnosis of HS.

Finally, this study is the first prevalence study to be undertaken on the population of the Faroe Islands. The prevalence of HS in the Faroe Islands is an important tool to create awareness of the disease, with the goal of reducing the diagnostic delay and initiate treatment.

Conflict of interest disclosures: DB: UCB Nordic paid for EADV Congress 2022 participation. GBEJ has received honoraria from AbbVie, Chemocentryx, Coloplast, Incyte, Inflarx, Novartis, Pierre Fabre, and UCB for participation on advisory boards, and grants from Abbvie, Astra-Zeneca, Inflarx, Janssen-Cilag, Leo Pharma, Novartis, Regeneron, and Sanofi for participation as an investigator, and received speaker honoraria from AbbVie, Boehringer-Ingelheim, Galderma, and MSD. He has also received unrestricted departmental grants from Abbvie, Leo Pharma, and Novartis. DMLS reports personal fees from UCB, AbbVie, Janssen, Jamjoom Pharma, and Sanofi, grants and personal fees from Abbvie, Leo Pharma, Pfizer, and Novartis outside the submitted work.

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