Acne Inversa (Hurley Clinical Stage II):
Case Report

ACNE INVERSA (HURLEY - ZAAWANSOWANIE KLINICZNE II’):
OPIS PRZYPADKU

Anca Chiriac¹, Liliana Foia², Tudor Pinteala³, Anca E. Chiriac⁴

¹CMI Dermatology-Iasi, Romania
²Univ.of Medicine Gr T Popa, Biochemistry Department, Iasi-Romania
³Imperial College of London, UK
⁴Univ.of Medicine Gr T Popa Iasi-Romania

Corresponding author: Anca Chiriac, MD PhD ancachiriac@yahoo.com

Abstract
We present a case of acne inversa Hurley clinical stage II, to a 28 year-old patient non-obese, smoker, with a long history of firm nodules, large abscesses and sinous tracts, small scars, distributed in the axillary, groin, perianal and inframammary areas, associated with lesions on the face. Any therapeutic schemas (antibiotics, Isotretinoin orally, Dapsone, UVB, cryotherapy) was unsuccesfully and we sent the patient to Surgery Department for wide excisions.

Streszczenie
Prezentujemy przypadek trądziku odwróconego w II etapie zaaawansowania klinicznego Hurley, u 28-letniego pacjenta bez otyłości, palącego papierosy, z długą historią guzków, dużych ropni, przetok, małych blizn, zlokalizowanych w dołach pachowych, w pachwinach, w okolicy odbytu i w obszarach poniżej pępka, związane ze zmianami na twarzy. Wszelkie schematy terapeutyczne (antybiotyki, Isotretynoina doustna, dapsone, UVB, krioterapia) był nieskuteczne, w związku z tym wysłaliśmy pacjenta do Oddziału Chirurgii celem opracowania chirurgicznego.

Key words: acne inversa; Isotretinoin; Dapsone; UVB; surgery
Słowa klucze: trądzik odwrócony; Isotretynoina; Dapson, UVB; chirurgia

Introduction
Hidradenitis suppurativa (from the Greek hidros = sweat and aden = glands) is a chronic follicular occlusive disease involving the intertriginous skin of the axillary, groin, perianal, and inframammary regions.

<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Name of the disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Velpeau - surgeon from</td>
<td>1839</td>
<td>first description: axillaray, submamary and perianal abscesses</td>
</tr>
<tr>
<td>Paris</td>
<td></td>
<td>first name: hidrosadenite phlegmonoeuse</td>
</tr>
<tr>
<td>Verneuil -Paris</td>
<td>1854</td>
<td>first pathogenic mechanism: inflammation of sweat glands</td>
</tr>
<tr>
<td>Schiefferdecker</td>
<td>1922</td>
<td>association acne-appocrine sweat glands</td>
</tr>
<tr>
<td>Pilsburry</td>
<td>1956</td>
<td>acne triad: hidradenitis suppurativa+acne conglobata+perifoliculitis capitis ascendens</td>
</tr>
<tr>
<td></td>
<td></td>
<td>and the cause: follicular occlusion</td>
</tr>
<tr>
<td>Plewig-Kligman</td>
<td>1975</td>
<td>acne tetrad: acne triad+pilonidal sinus</td>
</tr>
<tr>
<td>Plewig-Steger</td>
<td>1989</td>
<td>introduced the term: acne inversa (term accepted today all the world)</td>
</tr>
<tr>
<td>Recent studies</td>
<td>2000</td>
<td>genetic disease?</td>
</tr>
</tbody>
</table>

Table 1. History of the disease
Acne inversa has a typical clinical picture: cutaneous and subcutaneous nodular inflammation, fistulae with malodorous secretion and scarring. It affects men and women, with an incidence between 1-4 %, with a peak in the second and third decade of life, with unknown pathogenesis but with well documented trigger factors: smoking (unclear mechanism), obesity (by maceration and occlusion in the body folds through follicular hyperkeratosis), positive family history and lately genetic backgrounds.

Acne inversa is today regarded as an inflammatory disease of terminal hair follicules and not a disease of appocrine glands [1] that can explain the influence of androgens in the course of the disease, its absence before puberty and some therapeutic results with anti-androgen, although the hormonal levels in all patients are within normal limits [2].

**Case report and Conclusion**

A 28 year-old patient non-obese, smoker, presented in our department, with a long history of firm nodules, large abscesses and sinous tracts, small scars, distributed in the axillary, groin, perianal and infraumbilical areas, associated with lesions on the face. No fever, but pains and pruritus and an important impairment of the quality of life (Fig.1,2).

All the lab parameters were within normal limits, including androgen level.

Based on clinical aspects: (recurrent abscesses with tract formation and cicatrisation, multiple widely separated lesions with bilateral distribution on specific areas) and on chronicity of the lesions, we established the diagnosis of acne inversa Hurley clinical stage II.

We started immediatly Isotretinoin 20 mg/day increased after 2 months to 40 mg/day with a slight positive evolution in the first weeks of treatment, but with an aggressive relapse 3 months later, we stopped the medication after 10 months.

Based on the cultures performed from the axillary and anogenital regions which found Staphylococcus aureus, we introduced antibiotic therapy: Azythromycine, Ciprofloxacine and Oxacilline, but with no improvement. The next step was the treatment with Dapsone 50 mg/day, which was also discontinued after two months, for the absence of any therapeutical answer.

Strictly on the lesions, on small areas, we performed cryotherapy interrupted because of pains and later UVB 311 nm with no results.

So we are in front of a patient with a long history of acne inversa, not responding to treatment after one year of trying different therapeutical approaches.

Patient refused any other conservative therapy (such as TNF alfa antagonists or Methotrexat) and decided to accept the surgical treatment: wide excision of lesions in healthy tissue (lateral and deep safety margins). We sent him to the Surgery Department.

The particularity of this case was our fail of therapy and finally the decision to send the patient to Surgery.

**REFERENCES:**

ACNE INVERSA (HURLEY CLINICAL STAGE II): CASE REPORT

Anca Chiriac, Liliana Foia, Tudor Pinteala, Anca E. Chiriac

Prof. Uwe Wollina

Acne inversa also known as hidradenitis suppurativa is a chronic disease with great burden for patients. There has been much debate about terms and contents. From the histopathologic point of view, hidradenitis is a misnomer but as with other misnomers in medicine it is still in use. Although smoking and obesity are major known risk factors, stopping smoking after onset of disease does not alter the course so much. Treatment can be a challenge. Drug therapy often does not make a point. Only in early stages there is a temporary release. The more advanced the disease the greater the need for surgery. This has been very nicely shown by the contribution of Anca Chiriac et al. from Romania, who tried to cope with the disease by a broad armamentarium of drugs and procedures.

The paper also demonstrates that dermatologic surgery needs to be more developed in Europe. If we as dermatologists want to deal with the more severe dermatoses we have to establish a curriculum in dermatologic surgery. There is a number of very successful societies worldwide like the American Society for Dermatologic Surgery, the British Society for Dermatologic Surgery, the Indian Society for Dermatologic Surgery or the Polish Society for Dermatologic Surgery just to name a few. It would be an interesting idea to develop some standards for education and procedures in Europe.

Department of Dermatology and Allergology, Academic Teaching Hospital Dresden-Friedrichstadt, Dresden, Germany

Correspondence:
E-mail: uwollina@googlemail.com