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Key Approaches to Pain Management in Hidradenitis Suppurativa

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Introduction

Many patients living with hidradenitis suppurativa (HS) experience a significant impairment in their quality of life. One of the most prominent symptoms in these patients is pain, which makes a major contribution to their overall distress. Despite its impact, pain control has been shown to be an unmet need for many patients.[1] Pain has physical, psychological and social impacts.[2] When poorly controlled, pain can lead to increased visits to emergency departments, a higher likelihood of self-medication, and generally poor disease control.[3,4] This review provides a clinical approach for managing pain in patients with HS.

Validating Pain

Assessing pain in patients with HS can be done efficiently during a consultation. A simple and effective tool is the Pain Numeric Rating Scale, which allows clinicians to assess the level of pain experienced on a scale from 0 to 10.[5,6] For example, you might ask, "In the last 7 days, how severe has your HS-related pain been, on a scale of 1–10, with 10 being the worst?" If you prefer, the question can be tailored to focus on the most recent HS flare. This short inquiry not only provides valuable insight into the patient's experience but also creates a bond of trust. It signals to the patient that you are a professional who understands the impact of HS on their quality of life, and that it is a priority for you.

Qualifying Pain

Pain in HS is multifaceted and can vary in its nature and duration[7] (nociceptive, neuropathic, nociplastic) or temporality (acute versus chronic). Nociceptive pain is typically acute and is caused by inflammatory tissue damage.

Neuropathic pain, experienced by 30% of HS patients,[8,9] is defined as pain initiated or

caused by a primary lesion or dysfunction in the central and/or peripheral nervous system. Patients often describe it as "shooting", "itchy", "blinding", 'stinging' or "burning". Some patients may also report pruritus, which should be carefully distinguished from pruritus induced directly by skin damage, such as irritant intertrigo, since the treatment approaches differ.

Nociplastic pain, also known as central sensitization, involves heightened sensitivity of the pain perception pathway within the central nervous system to stimuli that are normally at subthreshold.[10]

In terms of temporality, acute pain is often intense and closely associated with disease flares. Chronic pain, defined as lasting 12 weeks or more, frequently involves a combination of pain types (e.g., nociceptive and neuropathic).

Treating Pain

A variety of treatment options have been described for controlling the different types of pain experienced by patients with HS.[11] For practical purposes, this discussion focuses on the options I regularly use. However, if you are seeking more options, I encourage you to consult the article by Surapaneni et al.[11]

General Rules for Pain Management in HS

Effective pain control in HS begins with optimal disease management. Optimizing medical treatment is important for pain control. Indeed, a patient with fewer inflammatory lesions will experience less pain. However, clinical studies have shown that even after 12 to 16 weeks of therapy, many patients continue to report moderate pain, emphasizing the need for targeted pain treatment alongside disease control. When pain is caused by an abscess, the immediate priority should be incision and drainage. For patients experiencing pain from a few isolated lesions, intralesional triamcinolone acetonide, at concentrations ranging from 10 to 40 mg/ml, can be beneficial.

Managing Acute Nociceptive Pain

Pain management in HS should follow a stepwise approach based on the severity of symptoms. Step 1 describes mild pain, rated between 1 and 3 out of 10 on the pain scale, and treatment includes acetaminophen at a dose of 500 mg, taken as two tablets orally every 6 hours. Topical therapies such as diclofenac gel (e.g., Voltaren® Emulgel Extra-Strength) and lidocaine 4% or 5% cream (e.g., DeepRelief®, Dr Numb®) can provide localized relief. Non-pharmacological options such as heat or cold therapy, applied for 10 to 15 minutes, or menthol-based products (e.g., DeepRelief®), may also be beneficial.

Step 2 describes moderate pain, rated between 4 and 7 out of 10, requires additional therapeutic options. Nonsteroidal anti-inflammatory drugs (NSAIDs), such as naproxen (500 mg twice daily) or celecoxib (100 mg twice daily) can be introduced. A short course of oral corticosteroids such as prednisone (25 mg daily for 7 days) may be considered, ideally alongside a proton-pump inhibitor.

Step 3 describes severe pain, rated between 8 and 10 out of 10. Consider adding stronger analgesics. The options include tramadol (50 to 100 mg every 4 to 6 hours as needed) or oxycodone (5 mg every 4 to 6 hours as needed). These medications should be used cautiously. To minimize risk, you should always aim for the minimum effective dose and the shortest duration of treatment (**Table 1**).

Managing Chronic Pain

Chronic pain in HS often requires a multimodal approach. Pharmacologic treatments commonly include antidepressants and antiepileptics. Treatment with these drugs should be discussed with the family doctor, if possible. Psychotherapy, local wound care, and physiotherapy can also be provided.

Among antidepressants, amitriptyline, a tricyclic antidepressant (TCA), can be started at 10–25 mg daily, with a maximum dose of 150 mg daily. Venlafaxine, a serotoninnorepinephrine reuptake inhibitor (SNRI)

Pain Severity	Medication	Dose
Mild (1–3/10)	Acetaminophen	500 mg (2 tablets) every 6 hours
	Diclofenac gel (e.g., Voltaren®, Emulgel Extra-Strength®)	Topical application as directed
	Lidocaine 4% or 5% cream	Topical application as needed
	Heat or cold therapy	Apply for 10–15 minutes
	Menthol-based products (e.g., DeepRelief®)	Apply as directed
Moderate (4–7/10)	Naproxen	500 mg twice daily
	Celecoxib	100 mg twice daily
	Prednisone (short course)	25 mg daily for 7 days *with concomitant proton-pump inhibitor
Severe (8–10/10)	Tramadol	50–100 mg every 4–6 hours as needed
	Oxycodone	5 mg every 4–6 hours as needed

Table 1. Management of Acute Nociceptive Pain in Hidradenitis Suppurativa (HS); *courtesy of Helene Veillette, MD.*

Medication Type	Medication	Dose
Antidepressants	Amitriptyline	Start 10–25 mg daily; max 150 mg daily
	Venlafaxine	Start 37.5–75 mg daily; increase 75 mg/week to max 225 mg
Antiepileptics	Gabapentin	Start 100–300 mg daily; max 3600 mg/day
	Pregabalin	Start 75 mg twice daily; increase 75 mg every 2–4 weeks to max 600 mg/day

Table 2. Management of Chronic Pain in Hidradenitis Suppurativa (HS); *courtesy of Helene Veillette, MD, FRCPC.*

can be started at an initial dose of 37.5–75 mg daily, with gradual increases of 75 mg per week as tolerated, to a maximum of 225 mg daily. For antiepileptic options, gabapentin can be started at 100–300 mg daily, to a maximum of 3600 mg per day. Pregabalin is another choice, typically started at 75 mg twice daily, with dose increases of 75 mg every 2–4 weeks, to a maximum of 600 mg daily (**Table 2**).

Pregnant Women

For the pregnant patient, it is essential to assess the risk-benefit ratio and aim for using minimum effective doses. Certain drugs are recognized for their safety during pregnancy. These include acetaminophen, venlafaxine, amitriptyline, gabapentin, and pregabalin.[12] Procedural interventions may also be appropriate, such as the incision-drainage technique, intralesional injections with triamcinolone, and deroofing procedures may also be considered.[13,14]

Some medications require caution during specific stages of pregnancy. For example, naproxen should be discontinued at 30 weeks of gestation, and tramadol should not be used during the first trimester of pregnancy.[12]

Perioperative Pain

Clinical experience acquired over the years, supported by a number of studies,[15-17] has shown that combining different treatment strategies, both medical and surgical, can increase the probability of achieving therapeutic success in HS. Surgical techniques such as incision and drainage, deroofing, and both local and wide excisions can be performed to enhance treatment outcomes.

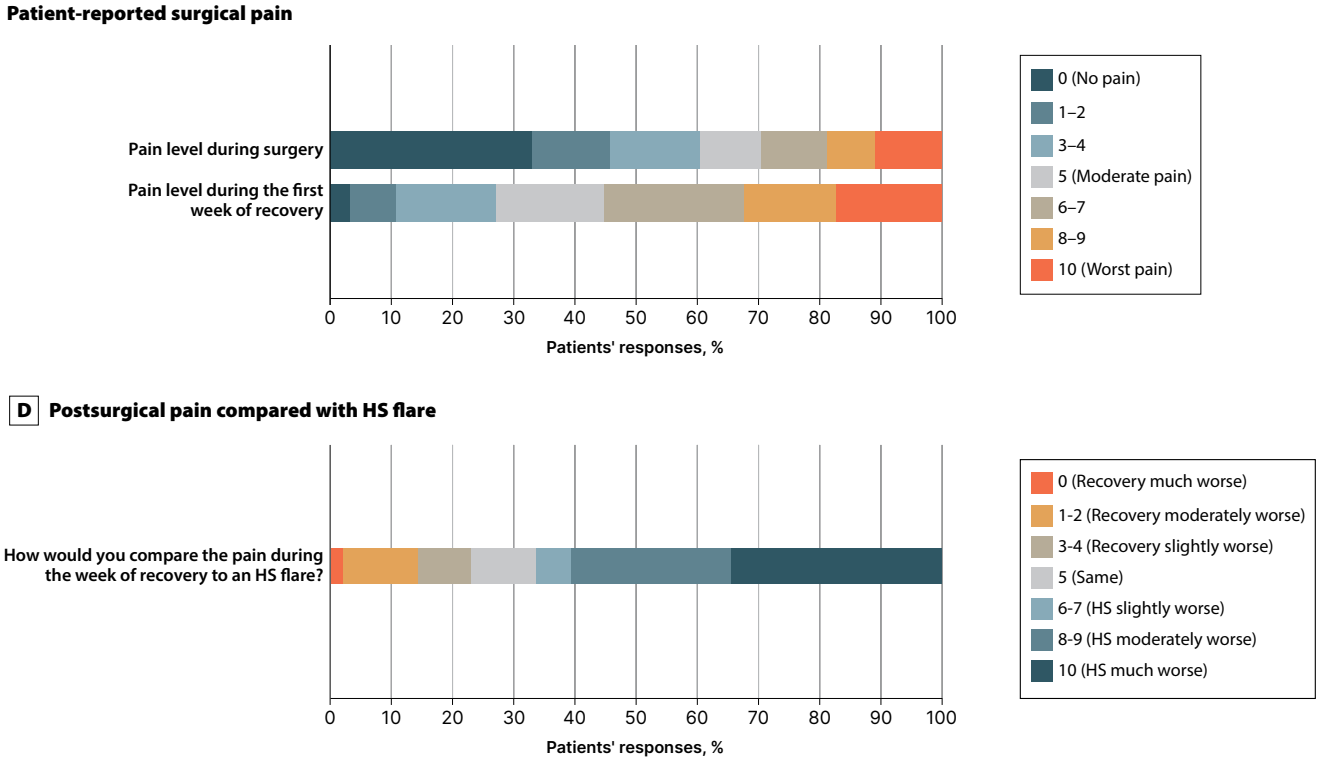

Figure 1. Patient reported surgical pain, and postsurgical pain compared with an HS flare; *adapted from Ravi, S et al, 2022.*[18]

Unfortunately for HS patients, the injection of anesthetics is particularly painful, especially in body folds, which are the typical location of HS lesions. This increased sensitivity makes it all the more important to minimize procedural pain during these surgical interventions.

Incision and drainage is a procedure designed to relieve the pain caused by a lesion, usually an abscess (see above). However, many patients with HS have had distressing experiences with this procedure in the past and remained traumatized because of the absence of anesthesia. Patients show excellent tolerance to incision and drainage if the procedure is performed under local anesthetic. Effective pain control can be achieved with a very superficial injection of anesthetic, creating a small, anesthetized zone just above the abscess cavity. Once this zone is anesthetized, a 4- or 6-mm punch can be used to incise the abscess in a manner that is much more tolerable for the patient.

Another simple surgical procedure to treat a recurrent lesion is deroofing. This procedure has demonstrated strong clinical efficacy and a high level of patient satisfaction. In a study[18] that included 78 patients and 194 roofing procedures, over 60% of patients described deroofing as painless or only slightly painful. However, during the first postoperative week, over 50% of patients experienced pain rated between 6 and 10 out of 10. Despite this, 65% of patients mentioned that the pain associated with an HS flare was more severe than the discomfort experienced after surgery (**Figure 1**).

Several strategies can help reduce the patient's pain when performing deroofing.[19] Administering a dose of analgesic, such as acetaminophen, ibuprofen, diclofenac, or celecoxib either shortly before or just after the procedure can help reduce pain during the first 24 hours postoperatively. For some patients, particularly those undergoing procedures in the inguinal and

perineal regions, the preoperative application of a topical anesthetic such as lidocaine/prilocaine cream (EMLA®) could be effective in reducing the pain. While study results are mixed, my experience is that some patients benefit from this technique.

It has been shown that preoperative anxiety is predictive of greater postoperative pain and even chronic pain. Creating a calm and reassuring environment, by ensuring patient comfort, offering distractions, or playing music can help reduce anxiety. For patients who are particularly anxious, a low dose of an anxiolytic may be considered (e.g., lorazepam 1 mg taken orally one hour before the procedure).

Inhaled methoxyflurane (Penthrox®) can also be useful for short-term relief of moderate to severe acute pain that is associated with trauma or interventional medical procedures. It is intended for use in conscious adult patients.[20] However, it is not recommended for patients under 18 years of age or for use during pregnancy.

It is important to bear in mind that in some care settings, patients are not allowed to bring their own medications. As the clinician, it is your responsibility to verify institutional policies and ensure that there are no contraindications to these treatments for the patient. In addition, for procedures involving sedation or significant discomfort, make sure that the patient has someone to accompany them home safely.

There are several practical techniques that can help reduce the pain associated with local anesthetic injections.[21] As with many routine clinical procedures you perform daily, using a small-gauge needle and injecting the anesthetic slowly will promote patient comfort. While some studies have explored whether the angle of needle insertion affects pain perception during anesthesia, findings remain inconclusive, and no clear consensus has been established.

Postoperative pain is an acute nociceptive pain. If the patient has no contraindications, they should be discharged with a prescription for acetaminophen 1 g orally every 6 hours and naproxen 500 mg orally twice daily as needed (you can refer to “Acute nociceptive pain” section above).

Conclusion

In summary, the pain experienced by patients with HS is an important issue that needs to be addressed in the context of a comprehensive management plan. Asking patients about their pain can be done quickly during an appointment and offers valuable insights into the patient’s experience. Unfortunately, few studies have focused on pain management in HS. However, the knowledge acquired from other diseases enables us to improve patients’ experience. Considering the anxiety and pain experienced during HS surgery and in the days that follow helps improve the patient’s overall experience. By identifying the medications you are comfortable using, and applying them thoughtfully, you can better support your patients and optimize their quality of life.

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