Gluteal and Perianal Hidradenitis Suppurativa

Surgical Treatment by Wide Excision

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PURPOSE: Hidradenitis suppurativa is a chronic inflammatory disease of the skin and subcutaneous tissue. Extensive gluteal and perianal disease represents a challenge presentation. The aim of this study was to present results of management of extensive hidradenitis suppurativa in gluteal, perineal, and inguinal areas. METHODS: From January 1980 to May 2000, 56 patients underwent treatment of hidradenitis suppurativa in gluteal, perineal, and inguinal areas through wide excision; 52 (93 percent) were male and 36 (64 percent) were white. Mean age was 40 years. We evaluated distribution of disease, associated conditions, use of diverting colostomy, management of operative wounds, time to complete healing, complications, and recurrence. RESULTS: Twenty-one (37.6 percent) and 17 (30.6 percent) patients had gluteal and perineal disease, respectively. Squamous-cell carcinoma and Crohn’s disease were observed in one patient each. Wide surgical excision was performed in all. Healing by second intention was the choice in 32 (57.1 percent) patients, and 24 (42.9 percent) patients underwent delayed skin-grafting. Diverting colostomy was used in 23 (41 percent) patients. Mean time for complete healing in the nongrafted group was 10 (range, 7–17) weeks and in the skin graft group was 6 (range, 3–9) weeks. New resection was performed in five (8.9 percent) patients. Partial graft loss rate was 37.5 percent and recurrence was observed in only one (1.8 percent) patient. CONCLUSION: Significant morbidity derives from extensive gluteal and perineal hidradenitis suppurativa caused by the disease extension and large wounds that result from surgical treatment. Wide surgical excision is the treatment of choice and leads to cure. Skin-grafting and healing by second intention lead to effective wound healing. [Key words: Hidradenitis suppurativa; Skin graft; Apocrine glands; Abscess; Wound healing; Harmonic scalpel]


Hidradenitis suppurativa (HS) is a chronic and recurrent inflammatory disease of the skin and subcutaneous cellular tissue, areas of the body where apocrine sweat glands are present. Regions most commonly affected are the axillae, perineum, gluteal, and inframammary area. Extensive gluteal and perianal HS is a relevant nosocomial problem, because it leads to intense suffering that results in physical, psychological, familiar, and professional disturbance.

Surgical treatment is usually required, demanding radical extensive resection and may include the need of a temporary stoma. A multidisciplinary team is often required for appropriate care and long hospital stay and disability after discharge must be expected. When treatment is not performed in a radical way or when patients are not closely followed until definitive healing, recurrences are frequent.

The current study was undertaken to present our experience with management of 56 consecutive patients with extensive HS in gluteal, perineal, and inguinal areas.

PATIENTS AND METHODS

Patients

Patients with HS located in the perineal, inguinal, and gluteal areas, treated in the Colorectal Unit of the Gastroenterology Department at the University of São Paulo Medical School between January 1980 and May 2000 were reviewed. Extensive HS was defined as bilateral gluteal or perineal disease, because unilateral gluteal and perineal or unilateral gluteal and inguinal disease was present.

Clinical data regarding gender, age, race, time of disease onset, location of the lesions, associated diseases, surgical treatment, time until complete healing, early and late operative complications, and recurrence rates were evaluated. Diagnosis of HS was based on clinical features and in all cases was confirmed by pathologic examination of the resected tissue. Serum levels of testosterone and androgens were measured in 21 (37.5 percent) patients.

Methods

Radical surgical excision under general or spinal anesthesia was performed in all patients. Patients

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were operated in lithotomy, jackknife, or prone position. Operative technique included complete excision of the whole diseased skin and subcutaneous fatty tissue down to the muscular fascia under careful hemostasia. Excision was accomplished using cold blade, electrocautery, or harmonic scalpel. Lateral margins were taken up to healthy skin. Testicular tunics were also excised when needed because of extension of suppurative process and, as a rule, preservation of perianal skin was always attempted because there are no apocrine sweat glands in the close perianal area and in the anodermal region. When small satellite lesions were present, primary closure was always attempted. Secondary intention healing was used for larger lesions and delayed (after 2 or 3 weeks) skin grafting was preferentially used when extensive disease was present. Grafts were usually obtained from dorsal area of the thighs.

Patients were seen weekly until complete wound healing, thereafter, monthly for three months and subsequently every four months thereafter until a year was completed. Recurrence was assessed by clinical signs and symptoms observed in the early postoperative period and later follow-up.

RESULTS

Fifty-six patients were enrolled in the study. Fifty-two (93 percent) patients were male, and 36 (64 percent) were white. Mean age was 40 (range, 18–69) years. Duration of symptoms before first treatment varied between four months and 35 years, with an average of 7.2 years. Distribution of patients according to location and gender is presented in Table 1 and illustrated in Figure 1.

Serum levels of testosterone, hydroxyprogesterone, and dehydroepiandrosterone were normal in the 21 patients undergoing such studies. Associated conditions were observed in 20 (35.7 percent) patients (Table 2). Squamous-cell carcinoma was observed in only one (1.8 percent) patient with a large gluteal lesion. This 36-year-old male patient underwent multiple surgical interventions. Adjuvant radiotherapy and chemotherapy was also delivered with no success. He died after 18 months with disseminated disease.

In 32 (57.1 percent) patients, the resultant wound was left to heal by second intention. In 24 (42.9 percent) patients, skin grafting was performed for wound closure within two or three weeks after excision when signs of sepsis were no longer observed (Fig. 2). Diverting colostomy was used in 23 (41 percent) patients because of extensive and complex lesions involving perianal margins. There were no complications related to the stoma construction or reversal, which was performed after complete wound healing.

Mean time of follow-up was 12 months (range, 4 months to 6 years). Time for complete wound healing for patients treated by excision and second intention healing varied proportionally to the extent and degree of infection of the unroofed area, with a mean of ten weeks (range, 7–17 weeks). In the patients treated by excision and skin grafting, the time until complete

<table>
<thead>
<tr>
<th>Location</th>
<th>Male</th>
<th>Female</th>
<th>No. Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gluteal</td>
<td>19 (33.9)</td>
<td>2 (3.6)</td>
<td>21 (37.6)</td>
</tr>
<tr>
<td>Perineal</td>
<td>15 (26.8)</td>
<td>2 (3.6)</td>
<td>17 (30.3)</td>
</tr>
<tr>
<td>Gluteal and perineal</td>
<td>15 (26.8)</td>
<td>—</td>
<td>15 (26.8)</td>
</tr>
<tr>
<td>Gluteal and inguinal</td>
<td>3 (5.3)</td>
<td>—</td>
<td>3 (5.3)</td>
</tr>
<tr>
<td>Total</td>
<td>52 (92.8)</td>
<td>4 (7.2)</td>
<td>56 (100)</td>
</tr>
</tbody>
</table>

Figures are given as n (%).