How not to discuss anticoagulation

Let’s begin with a toe curling qualitative study that analysed 37 clinical encounters between doctors in the US and patients about starting anticoagulants for atrial fibrillation. The quotes in the paper look more like excerpts from a Panorama investigation or a book called What not to say to patients: “[Anticoagulants] reduce your stroke rate from 10% a year down to 2%, and there are generally no side effects except that you bruise easier.” None of the encounters included a balanced discussion of benefits versus risks: “I am very uncomfortable not having you on [an anticoagulant] because you’re going to have a stroke.” The authors called this persuasive language, which roughly translates in everyday language to a guilt trip: “The whole idea is to prevent, God forbid, a stroke, okay? Because if a stroke happens we can’t do anything about it, but right now we can prevent it.” And then there’s the language used to bash warfarin, which only a few years ago was a lifesaving drug: “I’ll just tell this to you because somebody else will, and I don’t like saying this, but it’s true, it’s the main ingredient in rat poison.”

Deprescribing RAS inhibitors

A sure sign that a drug class has become part of the establishment is when they only make it into a major journal as part of a deprescribing study. An open-label randomised controlled trial of discontinuing renin-angiotensin system (RAS) inhibitors (angiotensin converting enzyme inhibitors and angiotensin receptor blockers) in people with an eGFR <30 mL/min/1.73 m² set out to explore suggestions that stopping RAS inhibitors may actually slow decline in renal function. It found no difference in clinically relevant decline over a three year follow-up period between continuing RAS inhibitors and discontinuing them. Although a small benefit from continuing RAS inhibitors may have been hidden by the small trial size (411 people), it at least suggests that stopping them in this group of patients is unlikely to lead to any sudden, clinically significant deterioration in renal function.

Reducing surgical site infections

A “robust benefit” from routinely changing gloves and instruments before abdominal wound closure leads the authors of a cluster randomised control trial published in the Lancet to suggest “that it should be widely implemented.” Hospitals where abdominal surgery is performed in seven low and middle income countries were assigned to either current practice or into surgical practice around the world.” Hospitals where abdominal surgery is performed in seven low and middle income countries were assigned to either current practice or for the whole scrub team to change gloves and instruments before abdominal wound closure. They found a 13% reduction in surgical site infections in the intervention group compared with usual care (P=0.0032), with rates of surgical site infection of 18.9% versus 16.0% respectively. They argue that the cost of this intervention is a fraction of the cost of managing resulting infections, and that the findings should apply to higher resource settings where surgical site infection rates from open abdominal surgery are similar.

SGLT2 inhibitors for chronic kidney disease

Drug trials don’t exactly make it easy for clinicians to convey the benefits and risks of treatments to patients. The EMPA-KIDNEY study reports positive findings for the sodium-glucose cotransporter 2 (SGLT2) inhibitor empagliflozin as a treatment to reduce progression of chronic kidney disease, but I’m not sure how I’d translate the findings to help a patient make an informed decision about taking them. In people with chronic kidney disease and an estimated glomerular filtration rate (eGFR) of at least 20 mL/min/1.73 m² but less than 45 mL/min/1.73 m², or an eGFR between 45 and 90 mL/min/1.73 m² with a urinary albumin to creatinine ratio (ACR) of at least 200, 16.9% of those taking a placebo daily for two years met the primary outcome of progression of kidney disease (sustained decrease in eGFR to under 10 mL/min/1.73 m² or by at least 40% from baseline, or death from renal causes) or death from cardiovascular causes. One of these outcomes occurred in 13.1% of those taking empagliflozin daily instead of placebo.
Continuous glucose monitoring for adults and children with diabetes: summary of updated NICE guidance

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Further information about the guidance, a list of members of the guideline development group, and the supporting evidence statements are in the full version on bmj.com.

Until this year, NICE had recommended technology for continuous glucose monitoring (CGM) for adults and children with type 1 diabetes in only a limited and defined population to ensure cost effectiveness, with capillary blood glucose fingerprick testing being the standard of care for most people with type 1 diabetes. New guidelines now recommend CGM should be offered to all adults and children living with type 1 diabetes.

NICE has also recommended extending the use of intermittently scanned CGM (commonly referred to as “flash”) to adults with type 2 diabetes who take insulin therapy in certain circumstances in which they meet guidance criteria.

This article summarises these updated recommendations, published on 31 March 2022, referring to NICE guidance for type 1 diabetes in adults,1 diabetes (type 1 and type 2) in children and young people,2 and type 2 diabetes in adults.3

What you need to know

- The guideline update recommends real-time continuous glucose monitoring (CGM) and intermittently scanned CGM to a broader group of people than in previous recommendations, offering all people with type 1 diabetes access to this technology
- New recommendations for intermittently scanned CGM have been made aimed at a defined group of adults with type 2 diabetes who use insulin to manage their diabetes, particularly those who have recurrent or severe hypoglycaemia, impaired hypoglycaemia awareness, or a condition or disability that means they cannot self monitor their blood glucose levels and require input from carers
- The new guidance from NICE is likely to challenge short term funding from providers for glucose sensors, but cost effectiveness analyses within the guidance suggest that there are long term benefits to be gained from sensor use for patients with diabetes

The committee was strongly of the opinion that fear of hypoglycaemia was an important consideration

Recommendations

NICE recommendations are based on systematic reviews of best available evidence and explicit consideration of cost effectiveness. When minimal evidence is available, recommendations are based on the guideline committee’s experience and opinion of what constitutes good practice.

Evidence levels for the recommendations are in the full version of this article on bmj.com.

Adults with type 1 diabetes

The committee agreed that there was sufficient evidence in the key outcomes of haemoglobin A1c (HbA1c), time in range, and reduction in severe or nocturnal hypoglycaemia to demonstrate that both real-time CGM and intermittently scanned CGM provide clinical benefit over fingerpick self-monitoring of blood glucose in adults with type 1 diabetes.

No demonstrable benefit between real-time and intermittently scanned CGM was identified by the guideline committee given the quality and sample sizes of the evidence available for review. Available CGM technologies are evolving quickly with increasing overlap between real-time and intermittently scanned CGM, with features such as predictive alerts now added to both systems.

Health economic modelling found that, when the benefit of reduced fear of hypoglycaemia with CGM was included in the analysis, both technologies were cost effective for the full population of adults with type 1 diabetes compared with fingerpick self monitoring of blood glucose levels. The guideline committee were strongly of the opinion that fear of hypoglycaemia was an important...
People who need help from a healthcare professional to administer their insulin injections should also be offered intermittently scanned CGM
c
consideration for many people with type 1 diabetes, over and above the harms caused by the hypoglycaemic episodes themselves. Hypoglycaemia can seriously disrupt activities of daily living, and even be life threatening; fear of future episodes can lead to serious physical and psychological sequelae.
• Offer adults with type 1 diabetes a choice of real-time continuous glucose monitoring (CGM) or intermittently scanned CGM (commonly referred to as “flash”), based on their individual preferences, needs, characteristics, and the functionality of the devices available.
• When choosing a continuous glucose monitoring device:
  - Use shared decision making to identify the person’s needs and preferences, and offer them an appropriate device
  - If multiple devices meet their needs and preferences, offer the device with the lowest cost
• If a person cannot use or does not want real-time CGM or intermittently scanned CGM, offer capillary blood glucose monitoring.

Adults with type 2 diabetes
The guideline committee made new recommendations in this update aimed at people with type 2 diabetes using insulin to manage their diabetes if specific circumstances were met to ensure cost effectiveness. Approximately 2.8 million people in England have type 2 diabetes. There was no evidence of benefit for populations with type 2 diabetes not using insulin. The committee had to consider the potential additional cost associated with intermittently scanned CGM use in large numbers of adults with type 2 diabetes. In its resource impact analysis of the guideline recommendation, clinical experts on the NICE committee estimate that, of the eligible adults with type 2 diabetes (currently under 50,000 people), current uptake of intermittently scanned CGM is low at 5% but rising to 70% in five years’ time.

People who have recurrent or severe hypoglycaemic events were identified by the committee as one of the groups most likely to benefit from intermittently scanned CGM, as were people who use insulin and have a condition or disability that restricts their ability to self monitor their blood glucose levels. This is because having access to intermittently scanned CGM means they might reduce their reliance on others to monitor their diabetes, potentially increasing their independence.

People advised to self measure their capillary blood glucose levels eight or more times a day should also be offered intermittently scanned CGM on cost equivalence grounds in line with funding requirements announced in NHS England’s previous flash glucose monitoring statement. This statement outlined arrangements for people with type 1 diabetes who need intensive monitoring and people with type 1 diabetes unable to routinely self monitor blood glucose due to disability where intermittently scanned CGM funding might be considered for adults with diabetes before this year’s publication of the NICE guidance. Although the NHS England statement specifically referred to people with type 1 diabetes, the committee felt this criterion was also important for people with type 2 diabetes who might have to monitor their blood glucose levels multiple times a day.

People who need help from a care worker or other healthcare professional to administer their insulin injections should also be offered intermittently scanned CGM, even if they use only once daily insulin injections. Intermittently scanned CGM will help care workers to assess a person’s blood glucose levels quickly, with the systems’ inbuilt alarms able to provide warning to carers when action might be required to treat a person’s high or low glucose levels. For people who have multiple home care visits each day, a historical record of blood glucose levels could be obtained at each visit to provide additional information to any point of care test. This will give carers greater confidence in making adjustments to the insulin treatment and reduce the risk of hypoglycaemic events between home visits. It might also reduce the number of hospital admissions for this group.

• Offer intermittently scanned CGM to adults with type 2 diabetes on multiple daily insulin injections if any of the following apply:
  - They have recurrent or severe hypoglycaemia
  - They have impaired hypoglycaemia awareness
  - They have a condition or disability (including a learning disability or cognitive impairment) that means they cannot self monitor their blood glucose by capillary blood glucose monitoring but could use an intermittently scanned CGM device (or have it scanned for them)
  - They would otherwise be advised to self measure at least eight times a day.

• Offer intermittently scanned CGM to adults with insulin-treated type 2 diabetes who would otherwise need help from a care worker or healthcare professional to monitor their blood glucose.

• Consider real-time CGM as an alternative to intermittently scanned CGM for adults with insulin-treated type 2 diabetes if it is available for the same or lower cost.

• If a person is offered real-time CGM or intermittently scanned CGM but cannot or does not want to use any of these devices, offer capillary blood glucose monitoring.

Children and young people with type 1 diabetes
The evidence for the guideline update showed that real-time CGM leads to a decrease in HbA1c and an increase in time in range in children and young people with type 1 diabetes, supporting the guideline committee’s experience in clinical practice. The continuous nature of real-time CGM alongside the option of connecting readings to the phone or device of a parent or carer to allow tracking of glucose levels in a family member were considered to be particularly important components for the technology use in children and young people. As the evidence showed similar benefits of real-time CGM in children and young people as for adults, the committee extrapolated the cost effectiveness results from adult health economic modelling and concluded that real-time CGM was cost effective in children and young people with type 1 diabetes.

Intermittently scanned CGM was not found to have a clinically meaningful effect on any of the outcomes that were looked at in the evidence review. In the committee’s experience, the sporadic nature of intermittently scanned CGM can reduce adherence to its use in children and young people. The clinical benefits of intermittently scanned CGM seen in the adult population were not found in children and young people. The committee
therefore agreed that the cost effectiveness findings for intermittently scanned CGM could not be extrapolated from adult data, and so they could not conclude that intermittently scanned CGM is a cost effective technology for children and young people with type 1 diabetes. They agreed that intermittently scanned CGM should be restricted to children and young people who are unable or do not want to use real-time CGM and would prefer to use intermittently scanned CGM. In March 2022, intermittently scanned CGM was licensed for children aged 4 years and over.

- Offer real-time CGM to all children and young people with type 1 diabetes, alongside education to support children and young people and their families and carers to use it. Offer a choice of real-time CGM device based on their individual preferences, needs, characteristics, and the functionality of the devices available.
- Offer intermittently scanned CGM (commonly referred to as “flash”) to children and young people with type 1 diabetes aged 4 years and over who are unable to use real-time CGM or who express a clear preference for intermittently scanned CGM.
- When choosing a continuous glucose monitoring device:
  - Use shared decision making to identify the child or young person’s needs and preferences and offer them an appropriate device
  - If multiple devices meet their needs and preferences, offer the device with the lowest cost.
- If a child or young person cannot use or does not want real-time CGM or intermittently scanned CGM, offer capillary blood glucose monitoring.
- If the child or young person is not using their CGM device at least 70% of the time:
  - Ask if they are having problems with their device
  - Look at ways to address any problems or concerns to improve their use of the device, including further education and emotional and psychological support.

CGM should be provided by a team with expertise as part of supporting people to self-manage

Education, support, and monitoring
In making its recommendations on the availability and use of CGM in patient populations, the committee felt it was important to emphasise the support, education, and equity of access required for patients that should be available from clinical services implementing the guidance.

- CGM should be provided by a team with expertise in its use, as part of supporting people to self-manage their diabetes. Ensure CGM is part of the education provided to adults and children with diabetes.
- Advise adults and children and young people with type 1 diabetes who are using CGM that they will still need to take capillary blood glucose measurements (although they can do this less often). Explain that is because:
  - They will need to use capillary blood glucose measurements to check the accuracy of their CGM device
  - They will need capillary blood glucose monitoring as a back-up (for example, when their blood glucose levels are changing quickly or if the device stops working).
- Provide them with enough test strips to take capillary blood glucose measurements as needed.
- Monitor and review the person’s use of CGM as part of reviewing their diabetes care plan. Look at ways to address any problems or concerns to improve their use of the device, including further education and emotional and psychological support.
- Commissioners, providers, and healthcare professionals should address inequalities in CGM access and uptake by:
  - Monitoring who is using CGM
  - Identifying groups who are eligible but who have a lower uptake
  - Making plans to engage with these groups to encourage them to consider CGM.
**EASILY MISSED?**

**Hidradenitis suppurativa**

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A man in his 20s presents to primary care with a painful boil in the buttock area. He describes having had more than six painful nodules in the groin and buttock areas over the past five years that have been managed with short courses of antibiotics. He is a smoker and recalls that his mother may have had similar symptoms when she was younger. The lesions have affected his mental health and his relationship with his partner. On examination, the patient’s body mass index is 22; he has a tender inflamed nodule on the right buttock and rope-like scarring on the left groin.

**What is hidradenitis suppurativa?**

Hidradenitis suppurativa is a chronic, painful inflammatory skin disease with a relapsing and remitting course. It presents with inflamed nodules, abscesses, and skin tunnels that cause rope-like scarring (thick fibrotic plaques) in severe cases and affects flexural areas including the axillae, breasts, groin, perineum, and buttocks.1

**Patients with the greatest delay in diagnosis have more severe disease which is related to the development of scarring**

**How common is it?**

Epidemiology is difficult to confirm because misdiagnosis and late diagnosis are common. A multicentre retrospective cross-sectional study in Canada showed that only 18% of cases are diagnosed in the first year, and only 40% after five years from disease onset.2 UK survey data suggest that the reported average age at disease onset is 21.8 years, but patients first enter hospital settings at the age of 38.3-4

Population based clinical practice research of diagnosed and undiagnosed cases suggests a prevalence of 0.77% (95% confidence 0.76 to 0.78) or, when including probable cases, 1.19% (9.18 to 1.20) in the UK.1 A systematic review with meta-regression analysis in the US, Australia, Scandinavian countries, and all western European countries showed 0.40% prevalence.4 A 2021 systematic review of 39 race-specific prevalence studies suggests that hidradenitis suppurativa is most prevalent in the African American population, followed by white people, and is lowest in the Hispanic and Latino populations.7

Hidradenitis suppurativa is most common in women of childbearing age, with a female to male ratio of 3:1. A study of the Finnish population found that almost 77% of participants were smokers and 50% had a body mass index more than 30.8

**Why is it missed?**

Diagnosis is clinical; there is no diagnostic test. It is commonly misdiagnosed and diagnosed late, and the average delay in diagnosis from symptom onset ranges from 7.2 to 13.7 years,5-11 typically with longer delays for women (odds ratio 1.87) and patients with more severe disease (odds ratio 1.85-2.35). Data from surveys and retrospective studies suggest that first physician visits occur between 2.3 to 12 years after symptom onset,6,9 perhaps due to embarrassment and stigma,9-11 but this alone does not explain the prolonged diagnosis times. Patients present to quite disparate specialties (including general practice, emergency medicine, gynaecology, surgery, and dermatology), and are likely to have seen three to five clinicians before receiving a diagnosis of hidradenitis suppurativa.8,11

Around 55% of patients are diagnosed after referral to dermatology.6,10 In a cohort of Finnish patients, 54% had received no other diagnosis before hidradenitis suppurativa was diagnosed, while the other cases were misdiagnosed as abscesses, folliculitis, furunculosis, acne, ingrown hair, sweat gland abcess, hair follicle inflammation, and pilonidal cyst (nodule appearances are very similar in these conditions).8 The relapsing and remitting nature of hidradenitis suppurativa compounds the problem and causes fragmented care. Many cases are treated with short courses of antibiotics (7-14 days usually), which is ineffective in the long term and does not prevent recurrence.13

**HOW PATIENTS WERE INVOLVED IN THE CREATION OF THIS ARTICLE**

C Harris, a patient partner, is coauthor of the article. She provided a patient perspective. She also suggested including the risk of squamous cell carcinoma, which was a concern that several patients had voiced to her. Her experience with hidradenitis suppurativa highlights the importance of early diagnosis and intervention.

**WHAT YOU NEED TO KNOW**

- Ask about recurrent patterns and typical sites of boil outbreaks to avoid misdiagnosis, as earlier initiation of treatment reduces disease burden
- Screen for cardiovascular disease risk factors, mental illness, and the effect on quality of life
- Refer to dermatology when patients have severe disease or when mild to moderate disease has not responded to first line treatment with tetracyclines in primary care

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Why does it matter?

An observational study found that patients with the greatest delay in diagnosis have more severe disease which is related to the development of scarring. More severe disease and delayed diagnosis are associated with disease onset at an earlier age. Severe disease is associated with increased risk of comorbidities (box 1), specifically mental illness and suicide, musculoskeletal disease, and cardiovascular disease. There have also been a few case reports of squamous cell carcinoma arising in patients with long term hidradenitis suppurativa scarring.

With time, pain changes from nociceptive pain (triggered by painful stimuli) to neuropathic (chronic) pain. Neuropathic pain is increased with disease duration, is associated with more severe pain and more severe disease, requires more pain medication, and is more challenging to treat. Patients are at increased risk for substance use disorder, possibly in an attempt to self medicate.

Impact on employment, average income, and career progression is well documented and the results replicated in different countries. Global unemployment rates are 25–36%, compared with 6% in the general population. Up to 15% of patients are unable to work because of disability, which also affects socioeconomic status and quality of life.

In the US, healthcare costs have been shown to be similar to costs for psoriasis, but expenditure distribution differs—in psoriasis, patients’ main expenditure is on medical treatments; for hidradenitis suppurativa it is on emergency department visits and surgical interventions, suggesting poorly managed disease and often unnecessary costs. Globally, around one in five patients with hidradenitis suppurativa have visited an emergency department, and in Portugal one in five patients have been hospitalised for problems related to their condition more than once over a five year period. Many emergency surgery procedures for acute lesions (such as incision and drainage of inflamed nodules) represent missed opportunities in primary care or dermatology settings to initiate medical control of underlying inflammation, which could have been done at less cost and with less patient discomfort.

Box 1 | Conditions associated with hidradenitis suppurativa

- Metabolic syndrome
- Type 2 diabetes
- Hyperlipidaemia
- Hypertension
- Acne vulgaris
- Pilonidal sinus
- Psoriasis
- Inflammatory arthritis
- Polycystic ovarian syndrome
- Crohn’s disease
- Cardiovascular disease
- Anxiety
- Depression

Box 2 | Hurley staging for hidradenitis suppurativa

Hurley staging classifies the worst affected area based on whether there are single or multiple lesions and the presence of skin tunnels (figure): 

**Stage I**—Abscess formation, single or multiple, without sinus tracts or cicatrisation (wound healing to form scar tissue)

**Stage II**—Recurrent abscesses with tract formation and cicatrisation, single or multiple, widely separated lesions

**Stage III**—Diffuse or near diffuse involvement, or multiple interconnected tracts and abscesses across the entire area.

Hurley staging is useful to assess baseline severity, but, as it is based on scarring, patients are likely to remain in their severity category unless they have surgery.

The British Association of Dermatologists (BAD) guidelines state that a triad of “typical lesions, in characteristic locations, with a recurrent pattern” is required for diagnosis. Specifically, two typical lesions (defined as inflamed nodules or abscesses) in typical locations (armpits, submammary, abdominal fold, groin, genital, neck, or perianal areas) over six months or a history of at least five such lesions over a lifetime. The number of surgery sites can also indicate disease severity.

Consider asking patients with typical lesions about outbreaks of boils during the past six months, including how many boils were present and their location.

Where practicable, use patient reported clinical scoring measures to assess pain, discharge, and use of wound dressings; anxiety and depression; and overall effect on quality of life and employment.

Hurley staging is the most commonly used scoring system and recommended by BAD for assessing disease severity at baseline (box 2). An observational study found that patients with the greatest delay in diagnosis have more severe disease which is related to the development of scarring. More severe disease and delayed diagnosis are associated with disease onset at an earlier age. Severe disease is associated with increased risk of comorbidities (box 1), specifically mental illness and suicide, musculoskeletal disease, and cardiovascular disease.

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Consider asking patients with typical lesions about outbreaks of boils during the past six months, including how many boils were present and their location.

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Hurley staging is the most commonly used scoring system and recommended by BAD for assessing disease severity at baseline (box 2).
• How do you assess patients presenting with recurring boils or abscesses?
• When a patient presents with scarring, what other symptoms or signs might point towards a diagnosis of hidradenitis suppurativa?

Box 3 | Summary of treatments for hidradenitis suppurativa

Primary care management (for mild to moderate hidradenitis suppurativa, Hurley stage I and II)
- Topical clindamycin 1%
- Chlorhexidine gluconate 4% topical solution
- Tetracyclines (doxycycline 100 mg, lymecycline 408 mg; doubling the dose is permitted)
- Dermatology referral for patients with moderate hidradenitis suppurativa and inadequate response to tetracyclines after 3 months or with severe hidradenitis suppurativa

Secondary care medical management (for moderate to severe hidradenitis suppurativa, Hurley stage II and III)
- Clindamycin and rifampicin combination
- Dapsone
- Acitretin
- Adalimumab
- Infliximab

Surgical treatment
- Incision and drainage
- Limited excision
- Deroofing surgery—a tissue saving electrosurgical procedure in which the roof of the nodule, abscess, or skin tunnel is removed. A probe is used to assess the extent of skin tunnelling
- Wide local excision

*Adalimumab is the only licensed therapy for hidradenitis suppurativa in the UK, reflecting the higher quality of evidence for its use. However, its cost and the potential caveats common to biologics mean that the National Institute for Health and Care Excellence (NICE) recommends it only for moderate disease (Hurley stage II) when first line treatments have failed and for severe (Hurley Stage III) disease.

A PATIENT’S PERSPECTIVE

It took several years for my diagnosis; in part, due to my GP not being aware of HS [hidradenitis suppurativa], and assuming that the lumps and bumps and open wounds were due to my weight.

Eventually, I researched my symptoms on the internet and discovered information on HS, which I then presented to my GP, who referred me to a dermatologist, who immediately confirmed I had HS. What is interesting, is that, about five years prior to my diagnosis, I had discovered several lumps in my left breast, which had scared me.

I arranged for a mammogram to check these lumps through my work (I work in the NHS, and screening services were part of my remit)—I was told that my breast was full of cysts, which were benign, but something I should look out for.

This was actually my HS.

The impact of the delay in diagnosis was the loss of two relationships, as I struggled with body image, shame due to the open wounds, scarring, and limited mobility.

I also hid my condition from family and friends for a long time as I was embarrassed.

The emotional and psychological impact hurt more than the physical pain of the condition itself.

Patients are at increased risk for substance use disorder, possibly in an attempt to self medicate

How is hidradenitis suppurativa managed?

Box 3 summarises treatments available for hidradenitis suppurativa. Holistic care is appropriate at all stages. Offer lifestyle advice, analgesia, wound care, and, where appropriate, support for mental health, smoking cessation, and weight loss. Also screen for depression, anxiety, and cardiovascular risk factors.

There is limited and poor quality evidence to support most of the recommended medical treatments. Limited evidence confirms the authors’ clinical opinion that prolonged courses of topical clindamycin 1% and oral tetracycline-type antibiotics (most commonly doxycycline, with lymecycline and minocycline also used) can cause modest reductions in flare frequency and severity in patients with mild to moderate hidradenitis suppurativa (prescribed off-licence in the UK). If the treatment is effective and there are no flares for one year, a treatment break can be tried.

If flares are not controlled and scarring is occurring, consider referral to dermatology or to a hidradenitis suppurativa multidisciplinary team for access to second line medical therapies such as adalimumab. BAD guidelines recommend planned surgery on persistent localised disease or wide excision of disease uncontrolled by systemic therapy.

SEARCH STRATEGY

Google scholar was first used with search terms related to “hidradenitis suppurativa.” We then used more specific search criteria such as hidradenitis suppurativa and “prevalence,” “race,” “comorbidities,” “socioeconomic,” “delayed diagnosis,” “hospitalization,” “diagnosis,” “management,” “guidelines,” “review.” Preference was given to recent publications with the most up to date evidence and relevance to the article.
The study

The review was based on 26 articles about attitudes towards managing osteoarthritis. The studies were carried out in primary care and community settings in high income countries around the world. In all, they included 557 people with osteoarthritis and 199 professionals (mostly GPs, nurses, and physiotherapists, but some studies included mixed professional groups such as rheumatologists, surgeons, alternative medicine practitioners, and occupational therapists).

What did this study do?

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What did it find?

This research highlights areas in which people with osteoarthritis have different priorities and concerns to the professionals providing their care. The authors’ recommendations could promote trust and empathy in interactions and lead to more shared understanding, and better quality of life for patients.

Why is this important?

The review found that professionals:

- Were concerned that people with osteoarthritis had unrealistic expectations of treatment and did not always follow their advice to lose weight or exercise
- Saw self-management as a key goal, although many GPs felt unqualified to advise on exercises
- Thought that education on osteoarthritis was important but they did not always prioritise it
- Were frustrated that people sometimes mentioned relevant problems related to osteoarthritis too late in a time-limited consultation for them to take meaningful action.

Why was this study needed?

This study examined priorities and concerns in the management of osteoarthritis. It focused on areas in which people with the condition held different views from healthcare professionals. This allowed the authors to make recommendations to improve interactions.

What's next?

The researchers have developed a brief intervention for practitioners to enhance empathic and optimistic communication. It focuses on verbal and non-verbal communication within primary care. They are evaluating this training.

Competing interests: The BMJ has judged that there are no disqualifying financial ties to commercial companies.

Further details of other interests, disclaimers, and permissions can be found on bmj.com

Cite this as: BMJ 2022;379:o2234
A man in his 30s was referred to the dermatology clinic with a 15 year history of skin plaque psoriasis, which had been diagnosed clinically. He had no medical conditions, no history of smoking or alcohol misuse, and his family history was unremarkable. He had received topical steroid treatment intermittently for his psoriasis. Physical examination showed thick scaly erythematous plaques on the scalp, back, elbows, and lower legs. The patient had no joint pains or nail changes. A skin biopsy confirmed the diagnosis of moderate plaque psoriasis.

A routine oral examination revealed an asymptomatic reddish area on the tongue, 15 mm in diameter, where the filiform papillae were absent (figure, dotted arrow), and branching fissures on the dorsum of the tongue (figure, black arrows). The patient had been unaware of the tongue lesions.

1 What are the differential diagnoses?
2 What is the diagnosis?
3 What are the underlying conditions that are associated with this diagnosis?

Submitted by Mitsuhito Ota
Patient consent obtained
Cite this as: BMJ 2022;379:e071453

CASE REVIEW
Glossal lesions in a patient with psoriasis

Lesions on the dorsum of the tongue (dotted arrow showing absence of filiform papillae, black arrows showing branching fissures)
MINERVA

Post-traumatic ectopic nail-like structure
A man in his 50s presented with an asymptomatic nail-like structure of 3 mm diameter just below his left thumb nail (figure). While discussing his history, he reported trauma with a jigsaw (power tool, not puzzle) nearly three decades ago, when the moving blade injured the nail matrix zone. Although wound repair was successful, the patient developed unusual asymptomatic tissue growth at the site of the injury several months later. Ectopic nail (onychoheterotopia) describes the growth of a nail plate in a location other than the normal nail unit, which can be congenital or associated with trauma. Management of ectopic nail ranges from observation to excision and is guided by the appearance of the nail, symptom severity, and functional impairment.

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Patient consent obtained.
Cite this as: BMJ 2022;379:e072014

Social prescribing
England’s Office for Health Improvement and Disparities is keen to promote social prescribing—an initiative in which health professionals can refer people to non-clinical services (often provided by voluntary sector organisations) with the aim of improving mental health and wellbeing. Interventions include volunteering, arts activities, group learning, gardening, and sporting activities.
Minerva likes the idea of non-pharmacological interventions, but a systematic review warns that few of these schemes have been properly evaluated and there’s no robust evidence about their effectiveness (www.gov.uk/government/publications/social-prescribing-applying-all-our-health/social-prescribing-applying-all-our-health; BMJ Open doi:10.1136/bmjopen-2021-060214).

Prenatal exposure to anaesthesia
Although non-obstetric surgery and anaesthesia are best avoided during pregnancy, it looks as if any risk to the fetus is low. Among 130 children aged 2-18 whose mothers had needed surgery while pregnant, psychosocial problems, learning disorders, and psychiatric diagnoses were no commoner than in an unexposed control group of children born to women of the same age and parity (Association of Anaesthetists doi:10.1111/anae.15884).

A systematic review warns there’s no robust evidence on non-pharmacological interventions

Complications of central catheters
Complications from peripherally inserted central catheters were common in a retrospective study of 3000 adult cancer patients. Around one in seven experienced problems, including bloodstream infection, deep vein thrombosis, pulmonary embolism, and catheter occlusion. Complication rates across the 50 hospitals in the study varied widely, indicating potential for improvement (Cancer doi:10.1002/cncr.34410).

Low carbohydrate diets
A diet containing less than 40 g of carbohydrate a day leads to a small reduction in haemoglobin A1c concentrations, according to a randomised trial in adults with starting levels in the range 6.0% to 6.9%. Participants allocated to a low carbohydrate diet also lost weight and reduced their blood pressure. Whether they were able to sustain the diet after the 6 month trial ended isn’t clear (JAMA Network Open doi:10.1001/jamanetworkopen.2022.38645).

Sleep duration
Whitehall II is a venerable longitudinal study that has followed 10 000 people, all originally employed in the London offices of the British civil service, since 1985. Its latest finding is that short sleep duration (self-reports of ≤5 hours a night) was associated with a small increase in the risk of onset of a first disease and subsequent multimorbidity. Long sleep duration (≥9 hours a night) was also associated with multimorbidity (PLOS Med doi:10.1371/journal.pmed.1004109).

Cite this as: BMJ 2022;379:o2638