# PERIANAL FORM OF SUPPURATIVE HIDRADENITIS

By

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SUMMARY

A 48-year-old worker with perianal form of suppurative hidradenitis is reported. Laboratory tests excluded a mycotic, tuberculous or other specific process. After repeated therapy with widespectrum antibiotics in combination with autovaccine a substantial improvement was noted. The inflammatory nodules after previous colliquation and formation of fistulas healed with depressed scars. Only where surgical incisions had been made two slightly dischrging sinuses remained.

Suppurative hidradenitis is not suitable for surgical treatment. Long-term application of wide-spectrum antibiotics possibly in combination with peroral corticoids yields the best results The authors point to the possibility of a malignant development in persistent cases.

The disease was first described in 1839 by Velpeau as an independent clinical entity occuring in the axillary, mammary, inguinal, genital and perianal region (Brunsting).

The early symtoms are characterized by red, slightly painful nodules with subsequent colliquation and formation of fistulas which may heal after a longer period by depressed scars. The cause of the disease is not known.

## REPORT OF A CASE

Patient V. S. 48 years old worker. Family and personal history insignificant. Present illness: In 1968 formation of an inflammatory nodule in the left gluteal region which healed spontaneously. After several weeks further nodules were formed on both gluteal rigions in the proximity of the anal opening. After colliquation of some of the nodules communicating abscesses with fistulas were formed. Examined by a surgeon who incised two abscesses and reconmended tetracycline 1g daily for 20 days. A partial improvement ensued for about two weeks. Then a relapse with original localization, pain and temperature about 38 C. The patient was admitted to the IInd Dermatological Clinic in Prague.

## FINDINGS UP ON ADMISSION

In both gluteal regions numerous inglammatory nodules localized mostly about the anus which was partly constricted. The nodules are either firm, relatively well defined against the surroundings, or soft with multiple fistulas producing yellowish pus. Skin over the inflammatory infiltrations is dark red. Laboratory data.-Blood WR negative, FW5/45, urinalysis normal, complete blood count normal.

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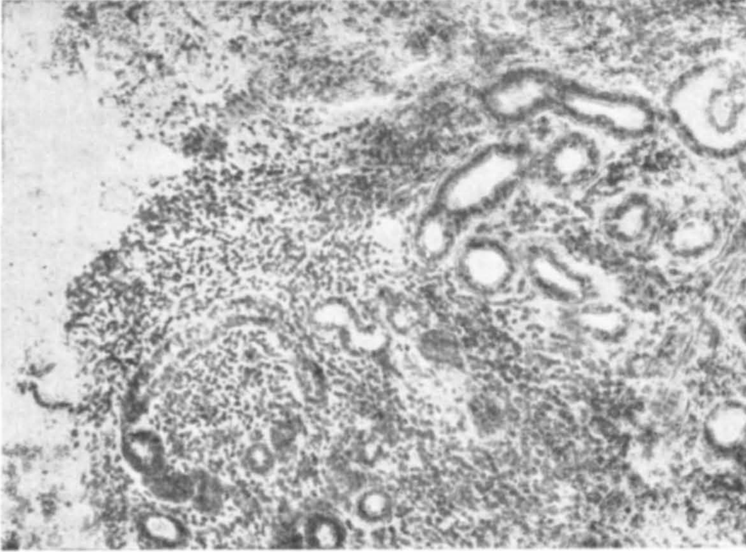
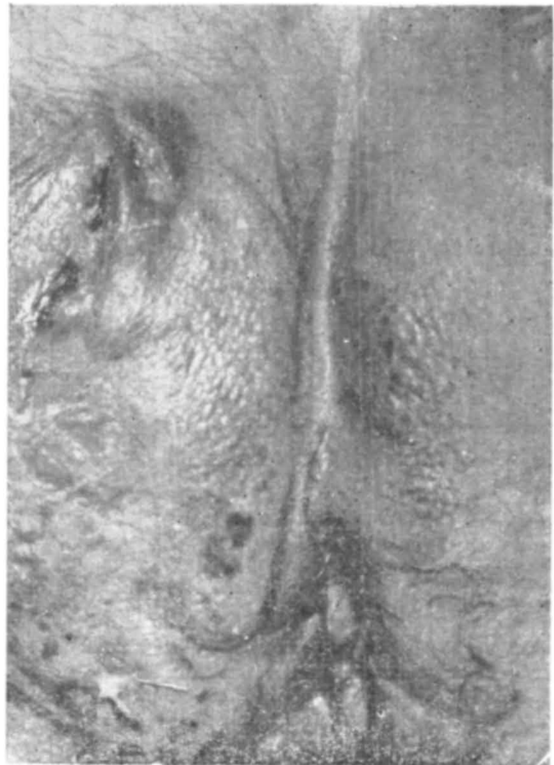
Bacteriological test of the pus : Staphylococcus pyogenes, Staphylococcus epidermidis. Sensitivity to antibiotics : Penicillin+, chloramphenicol + ,spiramycine +++ ,vancomycin +++, lincomycin +++, rovamycin +++, novamycin+++. Bacteriological examination for Mycobacterium tuberculosis and mycological examination for actinomycosis negative. Utilization of glucose: normal.



Histological picture of sulpurative hidradenitis.



Sulpurative hidradenitis in perianal region.

Pathological–Epidermis is irregularly extended without further changes. The whole corium down to subcutaneous region is edematous and penetrated by dense lymphoplasmocellular and polynuclear infiltrate, more especially perivascularly and in the region of the apocrine glands. The infiltration is penetrated by numerous bands of scarring tela fibrosa and by fistulas with hemorrhagic content. The changes described exclude a specific process and fall within chronic, nonspecific affections of skin adnexa, probably the apocrine glands.

*Fistulography.*– Gluteal regions show extensive infiltrations with multiple open and closed sinuses The rectal wall is not perforated.

*Urological Examination.*– Mild increase in size of prostate gland X–ray of heart, lung and spinal cord.– Finding on heart and lungs corresponding to age Slight spondylosis of the lower part of cervical spine, sinistroconvex scoliosis of thoracic spine. No other pathological changes of spine could be demonstrated.

*Therapy.*– Streptomycin 20 g. Procain penicillin G 12 million units. Rovamycin 35 g. Rimifon, PAS, Potassium iodide, local permanganate 2 sitz baths, *solux,*, antiphlogistics.

After the therapy most of the nodules were substantially reduced in size. Secretion from fistulas stopped and they healed by depressed scars with the exception of those surgically treated. The patient was referred to ambulatory dermatological care. Recommendation for prolonged and repeated treatment with wide–spectrum antibiotics according to established sensitivity in combination with an autovaccine. During check at the IInd Dermatological Clinic after 6 months only two secreting fistulas were apparent – the ones previously treated surgically. The patient had no sujective complaints.

## COMMENT

Perianal localization of suppurative hydradenitis occurs rather rarely. Inflammatory nodules with discharging fistulas in the rectal region are usually considered as a tubercular or deep mycotic process. The lack of success of existing therapy and negative results of histological and mycological examination should lead the physician to further diagnostic considerations.

With the present patient we also suspected first a tuberculous or mycotic disease.

Brunsting on the basis of histological studies (demonstrated that hidradenitis suppurativa, acne conglobata and cellulitis dissecans possess some features in common: a functional glandular hyperplasia of the apocrine gland and of the pilosebaceous apparatus, formation of double comedones, occlusion of the follicular duct and bacterial invasion.

Shelley and Cahn consider as the primary cause of suppurative hidradenitis the closing of the apocrine gland duct with keratinous plug with subsequent rupture of the wall. Microorganism trapped in the closed glandular ducts then readily penetrate into the surrounding dermis.

Lever doubts that suppurative hidradenitis should be a merely bacterial affair. He points out the clinical experience with peroral administration of corticosteroids which affect rather favourably its course and duration. He is of the opinion that the disease is due to a reaction between an antigen and antibody with

subsequent decomposition of the affected tissue. The mentioned secretion might represent according to Lever the antigenic substance.

Mckenna et al. found with 7 patients affected by this disease a reduced ability of glucose utilization. They tested the effect of riboflavin applied in low peroral doses with fine result.

In present patient we examined the blood sugar curve after administration of glucose. No disturbance of sugar utilization was found here.

Some authors maintain that prolonged suppurative hidradenitis may result in malignant changes. Donsky et al. describe the formation of spinocellular carcinoma on the basis of suppurative hidradenitis which persisted for 23 years. In spite of the fact that clinical changes pointed to the possibility of malignant turn only the eighth histological examination bore out the clinical suspicion.

## CONCLUSION

The perianal form of suppurative hidradenitis is frequently diagnosed incorrectly. The clinical symptoms often remind of skin tuberculosis or actinomycosis and lymphogranuloma venereum. With the present patient the original view was also one of tuberculosis.

A histological, serological, bacteriological and mycological examination is essential for recognizing the disease. Donsky's case indicates that if a malignant reversal is suspected the histological examination must be repeated several times if necessary.

Suppurative hidradenitis is in our experience not suitable for surgical treatment with the exception of persistent cases where a radical surgical incision with subsequent plastic finish might come into consideration. Most authors agree with the view that long-term application of broad spectrum antibiotics possibly in combination with peroral corticosteroids will yield the best results.

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