
North American clinical practice guidelines for the medical management of hidradenitis suppurativa in special patient populations



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Background: Hidradenitis suppurativa (HS) affects different patient populations that require unique considerations in their management. However, no HS guidelines for these populations exist.

Objective: To provide evidence-based consensus recommendations for patients with HS in 7 special patient populations: (i) pregnancy, (ii) breastfeeding, (iii) pediatrics, (iv) malignancy, (v) tuberculosis infection, (vi) hepatitis B or C infection, and (vii) HIV disease.

Methods: Recommendations were developed using the Grading of Recommendations Assessment, Development, and Evaluation system to ascertain level of evidence and selected through a modified Delphi consensus process.

Results: One hundred eighteen expert consensus statements are provided for the management of patients with HS across these 7 special patient populations. (J Am Acad Dermatol 2025;92:825-52.)

Key words: antiandrogens; antibiotics; biologics; breastfeeding; comorbidity; guidelines; hepatitis B; hepatitis C; hidradenitis suppurativa; HIV; immunomodulators; immunosuppressive; malignancy; management; North America; pediatric; pregnancy; safety; therapy; tuberculosis.

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INTRODUCTION

Hidradenitis suppurativa (HS) is a chronic inflammatory skin condition affecting approximately 1% of individuals worldwide, and significantly impacts quality of life.¹ Managing HS is challenging due to limited high-quality evidence and scarce guidance for special patient populations often excluded from clinical trials. These guidelines offer expert consensus recommendations on the treatment of HS across 7 scenarios: (i) pregnancy, (ii) breastfeeding, (iii) pediatrics, (iv) malignancy, (v) tuberculosis (TB) infection, (vi) hepatitis B or C infection, and (vii) HIV disease.

METHODS

Recommendations were developed utilizing the Grading of Recommendations Assessment, Development, and Evaluation (Table I).^{2,3} An extended version of these guidelines, as well as detailed methodology described in Supplementary File 1, available via Mendeley at <https://data.mendeley.com/datasets/3twvcvwh33/1>.

RESULTS

Recommendations are summarized in Table II. Delphi round results are in Supplementary File 1, available via Mendeley at <https://data.mendeley.com/datasets/3twvcvwh33/1>. Collaborating with relevant specialists is essential for the safety of these approaches.

CAPSULE SUMMARY

- Managing hidradenitis suppurativa in special patient populations presents significant challenges due to the lack of direct evidence.
- These guidelines address the unique needs of diverse groups typically underrepresented in clinical trials, and highlight the importance of a multidisciplinary approach.

Pregnancy

Topical therapies. Data on topical antibiotics or antiseptic washes in pregnant HS patients are lacking. However, their mechanisms of action suggest minimal risks, allowing similar use to the general HS population.⁴ While 15% resorcinol is effective for HS, its safety during pregnancy is unconfirmed, with some studies

suggesting potential risks to fetal neurodevelopment.⁵⁻⁸

The 2016 Food and Drug Administration decision to remove triclosan from certain products due to thyroid hormone disruption concerns supports the recommendation to avoid triclosan washes during pregnancy.⁹⁻¹²

Supplements. Trials in non-HS pregnant patients show that zinc supplementation does not adversely affect maternal or neonatal out-

comes, though some studies were conducted in populations where zinc deficiency was presumed.¹³⁻¹⁷

Given that some evidence points to lower serum zinc levels in HS patients, these findings likely remain applicable.¹⁸

Intralesional steroids. There are no data on the safety of intralesional steroids in pregnant HS patients. Their use in acute, localized flares is based on expert opinion aligned with North American HS guidelines.¹⁹

Systemic antibiotics. Evidence from studies in non-HS patients suggests that cephalexin, azithromycin, and clindamycin are safe in pregnancy, with no

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are intended to assist physicians in clinical decision-making and are not a substitute for professional medical judgment. Clinical discretion should be exercised in all patient care decisions, taking into account individual patient circumstances.

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Abbreviations used:

ART:	antiretroviral therapy
BCG:	Bacille Calmette-Guérin
C5a:	Complement component 5a
GI:	gastrointestinal
HBV:	hepatitis B virus
HIV:	human immunodeficiency virus
HS:	hidradenitis suppurativa
IBD:	inflammatory bowel disease
ID:	infectious disease
IGRA:	Interferon-Gamma Release Assay
IL:	interleukin
OCP:	oral contraceptive pill
RCT:	randomized controlled trial
STI:	sexually transmitted infection
TB:	tuberculosis
TMP-SMX:	co-trimoxazole
TNF:	tumor necrosis factor
TST:	Tuberculin Skin Test

significant risks of congenital anomalies or preterm delivery.

Although moderate evidence supports the safety of clindamycin in pregnancy,²⁰ safety data on rifampin-clindamycin combination therapy in pregnancy are lacking.²¹⁻²³ Rifampin has historically been considered pregnancy Category C.²⁴ However, rifampin is endorsed by the Centers for Disease Control and Prevention and World Health Organization as first-line treatment for TB in pregnancy, supporting its safety.^{25,26} This combination may be used in select pregnant patients with severe HS.

Recommendations to avoid erythromycin, co-trimoxazole (TMP-SMX), metronidazole, dapsone, and doxycycline stem from potentially increased risks in pregnant patients with conditions other than HS. Furthermore, these antibiotics, apart from doxycycline, have very low evidence for use in HS.

Data on ertapenem in pregnancy are extremely limited.²⁷⁻²⁹ However, animal studies showed no teratogenic evidence, allowing consideration in select recalcitrant HS cases.³⁰

Anti-androgens. Metformin is considered safe in pregnancy based on a number of randomized controlled trials and cohort studies in pregnant patients with type 2 diabetes, gestational diabetes, or polycystic ovary syndrome.³¹⁻⁴⁵ In pregnant HS patients for whom anti-androgen therapy is appropriate, metformin is the anti-androgen of choice. Because of possible risks, particularly in later stages of pregnancy, avoiding oral contraceptive pills during pregnancy is recommended.⁴⁶⁻⁵³ However, inadvertent exposure early in pregnancy due to oral contraceptive pill failure is not likely to be associated with increased risk of congenital anomalies.⁵⁴⁻⁵⁸

Systemic immunomodulators. Prednisone may be considered for severe HS flares during pregnancy, using the minimal effective dose and duration.⁵⁹⁻⁶⁵ Cyclosporine use should be reserved for refractory cases, similar to its application in the general population.⁶⁶⁻⁶⁸

Biologics. No studies specifically address the safety of biologics in pregnant HS patients, but data from other conditions suggest no significant risks.^{19,69-97} Generally, patients with well-controlled HS on biologics should continue treatment throughout pregnancy.⁹⁴⁻⁹⁶ Certolizumab pegol, a pegylated IgG antibody with no FC portion, has been shown to have minimal placental transfer.⁹⁷ Its efficacy in HS is limited, but can be considered for those particularly concerned about in-utero biologic exposure.¹⁹ Timing of live vaccines for infants exposed to biologics in-utero should be managed with pediatric consultation.

Breastfeeding

Systemic antibiotics. Limited human data support the safety of amoxicillin/clavulanic acid, macrolides, and metronidazole during breastfeeding.⁹⁸⁻¹⁰¹ Expert opinion supports amoxicillin/clavulanic acid for HS despite limited studies.¹⁰² Clindamycin is safe but may cause gastrointestinal effects in infants. Concerns about erythromycin include possible infantile hypertrophic pyloric stenosis, though findings are inconsistent.^{100,101,103,104} Metronidazole is deemed safe based on a cohort study showing no significant adverse effects in infants.⁹⁹ Rifampin and short-term doxycycline are considered safe based on limited data and expert opinion.¹⁰⁵⁻¹⁰⁷

Anti-androgens. Metformin is safe during breastfeeding and recommended for mild to moderate HS or as combination therapy, especially beneficial for those with metabolic comorbidities.^{19,108} Estrogen-containing contraceptives are safe and may be initiated 6-8 weeks postpartum to avoid impacting milk production.¹⁰⁹⁻¹¹¹

Systemic immunomodulators. Low-dose prednisone can be considered for severe, resistant HS, with a suggested 4-hour breastfeeding delay for doses ≥ 20 mg daily.¹¹²⁻¹¹⁴ Cyclosporine may be used following general HS guidelines.¹⁹

Biologics. Biologics, due to their large molecular size, are likely safe during breastfeeding with minimal transfer into breast milk.¹¹² Even if trace amounts are present, absorption by the infant's gastrointestinal tract is unlikely.¹¹²

Limited human data suggest no increased toxicity to infants breastfed by individuals on anti-tumor necrosis factors (TNFs), including infliximab, adalimumab and certolizumab.¹¹⁵⁻¹¹⁷ Safety data for anti-

Table I. Grading of recommendations, assessment, development, and evaluation

Evidence quality	Study types	Interpretation
High	• RCTs without important limitations • Overwhelming evidence from observational studies	Very confident that the true effect lies close to that of the estimate of the effect.
Moderate	• RCTs with important limitations • Exceptionally strong evidence from observational studies	Moderately confident in the effect estimate; the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.
Low	• RCTs with very important limitations • Observational studies	Confidence in the effect estimate is limited; the true effect may be substantially different from the estimate of the effect.
Very low	• Observational studies with important limitations • Case series	Very little confidence in the effect estimate; the true effect is likely to be substantially different from the estimate of the effect.
Recommendation strength*	Wording	Interpretation
Strong	"We recommend..."	Indicates the most appropriate action for most patients in the outlined population.
Conditional	"We suggest..."	Acknowledges the most appropriate action may vary according to clinical judgement and patient preferences.

RCT, Randomized controlled trial.

*Recommendation strength considers not only level of evidence, but also risks/benefits, resource stewardship, and patient factors. Therefore, a recommendation may be categorized as strong despite low/very low associated evidence, and vice versa.

IL-17s and ustekinumab in breastfeeding women are limited.¹¹³ This warrants careful consideration of potential risks and benefits before use if anti-TNFs are not feasible.

Pediatrics

Topical therapies. Recommendations for pediatric HS patients often rely on adult data and expert opinion.¹⁹ Clinical trials in acne have demonstrated the safe use of topical antibiotics, benzoyl peroxide, and retinoids for those aged 9 and older.¹¹⁸⁻¹²¹ Chlorhexidine is used safely in pediatric procedures.¹²² Concomitant antiseptic washes may help to mitigate antimicrobial resistance.^{123,124} Topical resorcinol has shown potential in limited pediatric HS cases.¹²⁵ Patients with mild HS may benefit from topical retinoids.¹¹⁸

Intralesional steroids. Data from adults support the use of intralesional corticosteroids for acute HS lesions.^{19,126,127} The patient's age and procedural tolerance should be considered, and appropriate pain management and distraction techniques should be used.

Systemic antibiotics. While doxycycline poses minimal risk of teeth staining in children below 8 years, its use requires caution.^{128,129} It is preferred over minocycline due to fewer severe side effects such as pseudotumor cerebri.¹³⁰ Limited evidence

supports the efficacy of rifampin plus clindamycin in pediatric HS.¹³¹

Anti-androgens. Most studies on the use of anti-androgens in pediatric patients were conducted in adolescents. Hormonal therapies are not recommended for premenarchal patients due to lack of evidence to support safety and efficacy before puberty, which could impact development and hormonal regulation.

Metformin, recommended for those showing signs of metabolic syndrome, is supported by safety data in overweight and obese adolescents.¹³²⁻¹³⁷ Spironolactone's safety in pediatric HS remains unclear,¹³⁸ and finasteride is reserved for refractory cases based on limited evidence.¹⁹

Systemic immunomodulators and biologics. Prednisone can be used for acute HS control while transitioning to long-term therapies.^{19,139,140} Cyclosporine is an option for refractory cases but ideally should be limited to less than a year.^{19,141,142} Isotretinoin is safe for acne in adolescents but requires strict adherence to pregnancy prevention.^{143,144} Based on expert opinion, isotretinoin may benefit pediatric patients with evidence of follicular occlusion or extensive comedonal disease.¹⁴⁵

Adalimumab is approved for HS patients aged 12 and up, with safety data extrapolated from other conditions.^{19,146-151} Infliximab, secukinumab, and ustekinumab are used in pediatric HS based on adult

Table II. Recommendations for the management of HS in special patient populations

No.	Recommendation	Recommendation strength	Evidence quality
Pregnancy			
Pregnancy: Topical therapies			
1.	In pregnant patients with HS who require topical antibiotics, we <i>suggest</i> using these agents with an approach similar to other HS patient populations.	Conditional	Very low
2.	In pregnant patients with HS who require topical therapy, we <i>suggest</i> avoiding resorcinol as evidence to support its safety is lacking.	Conditional	Very low
3.	In pregnant patients with HS who require antiseptic washes, we <i>suggest</i> avoiding triclosan as there may be an increased risk of endocrine-disrupting effects.	Conditional	Very low
4.	In pregnant patients with HS who require antiseptic washes, we <i>suggest</i> using chlorhexidine as it is unlikely to be associated with increased risks in pregnancy based on its mechanism of action.	Conditional	Very low
5.	In pregnant patients with HS who require antiseptic washes, we <i>suggest</i> using bleach baths as it is unlikely to be associated with increased risks in pregnancy based on its mechanism of action.	Conditional	Very low
6.	In pregnant patients with HS who require antiseptic washes, we <i>suggest</i> using zinc pyrithione as it is unlikely to be associated with increased risks in pregnancy based on its mechanism of action.	Conditional	Very low
Pregnancy: Supplements			
7.	In pregnant patients with HS who are seeking natural therapies, we <i>recommend</i> using zinc supplements as there is evidence it is safe for use in pregnancy.	Strong	Moderate
Pregnancy: Intralesional steroids			
8.	In pregnant patients with HS, we <i>suggest</i> using intralesional steroids for acute, localized flares.	Conditional	Very low
Pregnancy: Systemic antibiotics			
9.	In pregnant patients with HS who require systemic antibiotics, we <i>suggest</i> using oral cephalexin as there is evidence it is safe for use in pregnancy.	Conditional	Moderate
10.	In pregnant patients with HS who require systemic antibiotics, we <i>suggest</i> using oral azithromycin as there is evidence it is safe for use in pregnancy.	Conditional	Moderate
11.	In pregnant patients with HS who require systemic antibiotics, we <i>suggest</i> that oral rifampin and clindamycin combination can be used in select patients with severe disease. Oral clindamycin monotherapy may also be considered; however, the data are less robust to support its use as a monotherapy.	Conditional	Very low
12.	In pregnant patients with HS who require systemic antibiotics, we <i>suggest</i> using oral clindamycin as there is evidence it is safe for use in pregnancy.	Conditional	Moderate

Continued

Table II. Cont'd

No.	Recommendation	Recommendation strength	Evidence quality
13.	In pregnant patients with HS who require systemic antibiotics, we <i>suggest</i> avoiding oral metronidazole as there may be an increased risk of low birthweight and neuroblastoma.	Conditional	Low
14.	In pregnant patients with HS who require systemic antibiotics, we <i>suggest</i> avoiding oral co-trimoxazole (trimethoprim/sulfamethoxazole) as there may be an increased risk of preterm birth, low birthweight, and kernicterus.	Conditional	Low
15.	In pregnant patients with HS who require systemic antibiotics, we <i>suggest</i> avoiding oral dapsone as there may be an increased risk of preterm birth, low birthweight, and hemolysis.	Conditional	Very Low
16.	In pregnant patients with HS who require systemic antibiotics, we <i>recommend</i> avoiding oral doxycycline as there may be an increased risk of congenital anomalies, potential binding of the medication in fetal bones, and tooth discoloration.	Strong	Low
17.	In pregnant patients with HS who require systemic antibiotics, we <i>recommend</i> avoiding oral erythromycin as there may be an increased risk of adverse outcomes including elevated liver enzymes.	Strong	Low
Pregnancy: Anti-androgens			
18.	In pregnant patients with HS who require anti-androgens, we <i>recommend</i> using metformin as there is evidence it is safe for use in pregnancy.	Strong	Moderate
Pregnancy: Systemic immunomodulators and biologics			
19.	In pregnant patients with HS who require systemic immunomodulators, we <i>suggest</i> using prednisone only for acute, widespread flares.	Conditional	Low
20.	In pregnant patients with HS who require systemic immunomodulators, we <i>suggest</i> limiting use of cyclosporine to select treatment-refractory cases.	Conditional	Very low
21.	In patients with HS who are considering pregnancy while on biologics, we <i>recommend</i> providing counselling regarding the use of biologics during pregnancy.	Strong	Very low
22.	In patients with HS who are planning pregnancy while well-controlled on biologics, we <i>recommend</i> continuing biologic therapy throughout the pregnancy.	Strong	Very low
23.	In neonates with in-utero biologic exposure from maternal HS management, we <i>recommend</i> consulting with their pediatrician about the timing of administering live vaccines.	Strong	Very low
24.	In pregnant patients with HS who require biologics, we <i>recommend</i> using adalimumab.	Strong	Moderate
25.	In pregnant patients with HS who require biologics, we <i>suggest</i> using infliximab with an approach similar to other HS patient populations.	Conditional	Low

26.	In pregnant patients with HS who require biologics, we <i>suggest</i> using secukinumab with an approach similar to other HS patient populations.	Conditional	Very low
27.	In select patients with HS who are planning pregnancy and require biologics, we <i>suggest</i> using certolizumab as an alternative biologic if they have a compelling reason to be concerned about in-utero biologic exposure.	Conditional	Very low
Breastfeeding			
Breastfeeding: Systemic antibiotics			
28.	In breastfeeding patients with HS who require systemic antibiotics, we <i>suggest</i> using oral rifampin with an approach similar to other HS patient populations.	Conditional	Very low
29.	In breastfeeding patients with HS who require systemic antibiotics, we <i>suggest</i> exercising caution when using oral clindamycin as it may increase the risk of GI side effects in the infant.	Conditional	Very low
30.	In breastfeeding patients with HS who require systemic antibiotics, we <i>suggest</i> using oral amoxicillin/clavulanic acid.	Conditional	Low
31.	In breastfeeding patients with HS who require systemic antibiotics, we <i>suggest</i> using oral erythromycin.	Conditional	Low
32.	In breastfeeding patients with HS who require systemic antibiotics, we <i>suggest</i> using oral azithromycin.	Conditional	Low
33.	In breastfeeding patients with HS who require systemic antibiotics, we <i>suggest</i> using oral metronidazole.	Conditional	Low
34.	In breastfeeding patients with HS who require systemic antibiotics, we <i>recommend</i> limiting the use of oral doxycycline; if no suitable alternative antibiotic is available, oral doxycycline use should be limited to <3 weeks and without repeating courses.	Strong	Very low
Breastfeeding: Anti-androgens			
35.	In breastfeeding patients with HS who require anti-androgens, we <i>suggest</i> using metformin as there is evidence it is safe for use in breastfeeding.	Conditional	Moderate
36.	In breastfeeding patients with HS who require anti-androgens, we <i>suggest</i> using oral contraceptives especially when contraception is desired.	Conditional	Moderate
Breastfeeding: Systemic immunomodulators and biologics			
37.	In breastfeeding patients with HS who require systemic immunomodulators, we <i>suggest</i> using prednisone <20 mg daily only in acute, widespread flares; if a dose of ≥20 mg daily is required, patients should wait at least 4 h prior to breastfeeding.	Conditional	Very low
38.	In breastfeeding patients with HS who require systemic immunomodulators, we <i>suggest</i> limiting the use of cyclosporine to select treatment-refractory cases.	Conditional	Very low

Continued

Table II. Cont'd

No.	Recommendation	Recommendation strength	Evidence quality
39.	In breastfeeding patients with HS who require biologics, we <i>suggest</i> that biologics are likely safe to use during breastfeeding based on pharmacokinetics, as these are large proteins not well-absorbed by the GI tract, with very little medication passing into breast milk.	Conditional	Very low
40.	In breastfeeding patients with HS who require biologics, we <i>recommend</i> using adalimumab.	Strong	Moderate
41.	In breastfeeding patients with HS who require biologics, we <i>suggest</i> using infliximab with an approach similar to other HS patient populations.	Conditional	Moderate
42.	In breastfeeding patients with HS who benefitted from certolizumab during pregnancy, we <i>suggest</i> continuing certolizumab in select cases only, as efficacy data in HS is limited.	Conditional	Low
43.	In breastfeeding patients with HS who require biologics, we <i>suggest</i> exercising caution when using anti-IL-17s given minimal available data.	Conditional	Very low
44.	In breastfeeding patients with HS who require biologics, we <i>suggest</i> exercising caution when using ustekinumab given minimal available data.	Conditional	Moderate
Pediatrics			
Pediatrics: Topical therapies			
45.	In pediatric patients with HS who require topical antibiotics, we <i>suggest</i> using concomitant antiseptic washes to decrease bacterial resistance.	Conditional	Very low
46.	In pediatric patients with HS who require topical antibiotics, we <i>suggest</i> using these agents with an approach similar to other HS patient populations.	Conditional	Very low
47.	In pediatric patients with HS who require antiseptic washes, we <i>suggest</i> using these agents with an approach similar to other HS patient populations.	Conditional	Very low
48.	In pediatric patients with HS who require topical keratolytics, we <i>suggest</i> using topical retinoids in select cases.	Conditional	Very low
49.	In pediatric patients with HS who require topical keratolytics, we <i>suggest</i> using topical resorcinol in select cases.	Conditional	Very low

Pediatrics: Intralesional steroids

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|-----|---|-------------|----------|
| 50. | In pediatric patients with HS, we <i>suggest</i> using intralesional steroids for acute, localized flares, taking into consideration the patient's age and procedural tolerance. Appropriate pain management and distraction techniques should be used. | Conditional | Very low |
|-----|---|-------------|----------|

Pediatrics: Systemic antibiotics

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|-----|---|-------------|----------|
| 51. | In pediatric patients with HS who require systemic antibiotics, we <i>recommend</i> using oral doxycycline for patients 8 years and older. | Strong | Moderate |
| 52. | In pediatric patients with HS who require systemic antibiotics, we <i>suggest</i> using oral minocycline for patients 8 y and older with doxycycline intolerance. | Conditional | Very low |
| 53. | In pediatric patients with HS who require systemic antibiotics, we <i>suggest</i> using combination therapy with oral rifampin and clindamycin. | Conditional | Low |

Pediatrics: Anti-androgens

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|-----|--|-------------|----------|
| 54. | In adolescent female patients with HS who require anti-androgens, we <i>suggest</i> using spironolactone. | Conditional | Very low |
| 55. | In adolescent female patients with HS who require anti-androgens, we <i>suggest</i> using combined oral contraceptives. | Conditional | Very low |
| 56. | In pediatric patients with HS who require anti-androgens, we <i>suggest</i> using finasteride in select cases particularly in male patients. | Conditional | Very low |
| 57. | In pediatric patients with HS who require anti-androgens, we <i>suggest</i> using metformin especially in cases of insulin resistance. | Conditional | Moderate |

Pediatrics: Systemic immunomodulators and biologics

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|-----|---|-------------|----------|
| 58. | In pediatric patients with HS who require systemic immunomodulators, we <i>suggest</i> using prednisone for acute, widespread flares. | Conditional | Very low |
| 59. | In pediatric patients with HS who require systemic immunomodulators, we <i>suggest</i> limiting the use of cyclosporine to select treatment-refractory cases. | Conditional | Very low |
| 60. | In pediatric patients with HS who require systemic immunomodulators, we <i>suggest</i> using oral isotretinoin only in patients with concomitant moderate-to-severe acne. | Conditional | Low |
| 61. | In pediatric patients with HS who require biologics, we <i>recommend</i> using adalimumab for patients 12 y and older. | Strong | High |
| 62. | In pediatric patients with HS who require biologics, we <i>suggest</i> using adalimumab for patients aged 2-11. | Conditional | Moderate |
| 63. | In pediatric patients with HS who require biologics, we <i>suggest</i> using infliximab for patients 6 y and older. | Conditional | Moderate |
| 64. | In pediatric patients with HS who require biologics, we <i>suggest</i> using secukinumab for patients 6 y and older. | Conditional | Moderate |

Continued

Table II. Cont'd

No.	Recommendation	Recommendation strength	Evidence quality
65.	In pediatric patients with HS who require biologics, we <i>suggest</i> using ustekinumab for patients 6 y and older.	Conditional	Moderate
Malignancy			
Malignancy: Intralesional steroids			
66.	In patients with HS who have a history of malignancy, we <i>suggest</i> using intralesional steroids for acute, localized flares.	Conditional	Very low
Malignancy: Systemic antibiotics			
67.	In patients with a history of malignancy who require systemic antibiotics for HS, we <i>recommend</i> using oral doxycycline as there is evidence it is safe.	Strong	Moderate
68.	In patients with a history of malignancy who require systemic antibiotics for HS, we <i>suggest</i> using oral tetracycline as there is evidence it is safe.	Conditional	Moderate
69.	In patients with a history of malignancy who require systemic antibiotics for HS, we <i>suggest</i> using oral minocycline as there is evidence it is safe.	Conditional	Low
70.	In patients with a history of malignancy who require systemic antibiotics for HS, we <i>suggest</i> using oral moxifloxacin as there is evidence it is safe, with monitoring for QT prolongation from drug–drug interactions with certain chemotherapy agents.	Conditional	Moderate
71.	In patients with a history of malignancy who require systemic antibiotics for HS, we <i>suggest</i> using oral clindamycin as there is evidence it is safe, with monitoring for severe diarrhea and <i>C. difficile</i> colitis.	Conditional	Low
72.	In patients with a history of malignancy who require systemic antibiotics for HS, we <i>suggest</i> using oral dapsone as it is unlikely to be associated with increased risks in this patient population based on its mechanism of action.	Conditional	Very low
73.	In patients with a history of malignancy who require systemic antibiotics for HS, we <i>suggest</i> using IV ertapenem for severe, recalcitrant cases as there is evidence it is safe.	Conditional	Moderate
Malignancy: Anti-androgens			
74.	In patients with a history of malignancy who require anti-androgens for HS, we <i>recommend</i> using metformin due to evidence of safety and potential survival benefit in certain malignancies.	Strong	Moderate
75.	In patients with a history of malignancy who require anti-androgens for HS, we <i>suggest</i> using spironolactone as there is evidence it is safe.	Conditional	Low
76.	In patients with a history of malignancy who require anti-androgens for HS, we <i>suggest</i> using oral contraceptives as there is evidence they are safe.	Conditional	Low
77.	In patients with a history of malignancy who require anti-androgens for HS, we <i>suggest</i> using finasteride, as there is evidence it is safe.	Conditional	Moderate

Malignancy: Systemic

immunomodulators and biologics

78.	When considering immunosuppressive medications or biologics for HS patients in the setting of malignancy, we <i>recommend</i> the physician consult with the patient's oncologist and take into account activity of HS, patient's age, characteristics of the previous cancer (organ, stage, histologic type, and prognosis), the time since completion of cancer treatment, and the individual carcinogenic effects of immunosuppressants. The physician should utilize a shared therapeutic decision-making approach to reach an informed decision, respecting the patient's preference.	Strong	Very Low
79.	In patients with a history of malignancy who require systemic immunomodulators for HS, we <i>suggest</i> using prednisone for acute, widespread flares.	Conditional	Low
80.	In patients with a history of malignancy who require systemic immunomodulators for HS, we <i>suggest</i> that methotrexate can be used as an adjunct treatment to prevent anti-TNF antibody formation if indicated, as exposure does not increase risk of recurrent malignancy.	Conditional	Moderate
81.	In patients with a history of malignancy who require systemic immunomodulators for HS, we <i>suggest</i> using oral retinoids with an approach similar to other HS patient populations, as exposure does not increase risk of recurrent malignancy.	Conditional	Moderate
82.	In patients with a history of malignancy in remission for over 5 y who require biologics for HS, we <i>suggest</i> considering anti-TNFs especially in non-high-risk malignancies.	Conditional	Moderate
83.	In patients with a history of malignancy in the last 5 y who require biologics for HS, we <i>suggest</i> considering secukinumab based on the currently available, albeit limited, evidence.	Conditional	Low
84.	In patients with a history of malignancy in the last 5 y who require biologics for HS, we <i>suggest</i> considering ustekinumab based on the currently available, albeit limited, evidence.	Conditional	Low

Tuberculosis

Tuberculosis: Systemic antibiotics

85.	In patients with HS who require treatment for latent TB, we <i>recommend</i> using a 4-mo course of oral rifampin.	Strong	Moderate
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Continued

Table II. Cont'd

No.	Recommendation	Recommendation strength	Evidence quality
Tuberculosis: Anti-androgens			
86.	In patients that are high risk for active TB who require anti-androgens for HS, we <i>recommend</i> using metformin as it is associated with a reduced risk of TB infection.	Strong	Moderate
Tuberculosis: Systemic immunomodulators and biologics			
87.	In patients with HS who require glucocorticoids, we <i>recommend</i> annual screening for latent TB if the dose exceeds 15 mg prednisone equivalent daily for at least 4 wks.	Strong	Low
88.	In patients with HS who require biologics, we <i>recommend</i> screening for TB prior to initiation. Screening can be performed with TST and/or IGRA, but in endemic regions with high percentages of BCG vaccination, IGRA may improve sensitivity and specificity.	Strong	Moderate
89.	In patients at high risk for active TB who require biologics for HS, we <i>suggest</i> considering non—anti-TNF biologic classes and being cautious when using anti-TNFs.	Conditional	Low
90.	In patients with latent TB not at high risk for active TB who require anti-TNFs for HS, we <i>suggest</i> starting prophylactic antibiotics at least 1 mo before biologic initiation.	Conditional	Moderate
91.	In patients with latent TB at high risk for active TB and/or are from endemic areas who require anti-TNFs for HS, we <i>suggest</i> completing prophylactic antibiotics prior to biologic initiation.	Conditional	Low
92.	In patients with active TB who require biologics for HS, we <i>suggest</i> completing TB treatment with resolution of symptoms before biologic (re)initiation and considering non—anti-TNF biologic classes.	Conditional	Very low
93.	In patients with latent TB who require biologics for HS, we <i>suggest</i> treating the latent TB concomitantly with anti-IL-17s or anti-IL-12/23s.	Conditional	Very low
Hepatitis B & C			
Hepatitis B and C: Systemic antibiotics			
94.	In patients with chronic hepatitis B or C who require systemic antibiotics for HS, we <i>suggest</i> using oral ciprofloxacin especially if there is evidence of cirrhosis, as it appears to be safe, and may be associated with improved survival and reduced risk of spontaneous bacterial peritonitis.	Conditional	Low

95.	In patients with chronic hepatitis B or C who require systemic antibiotics for HS, we <i>suggest</i> using oral co-trimoxazole (trimethoprim/sulfamethoxazole) especially if there is evidence of cirrhosis, as it appears to be safe, and may be associated with reduced risk of spontaneous bacterial peritonitis.	Conditional	Low
96.	In patients with chronic hepatitis B or C who require systemic antibiotics for HS, we <i>suggest</i> using oral doxycycline with an approach similar to other HS patient populations.	Conditional	Very low
97.	In patients with chronic hepatitis B or C who require systemic antibiotics for HS, we <i>suggest</i> caution when using oral rifampin due to the potential risk of hepatotoxicity.	Conditional	Very low
Hepatitis B and C: Anti-androgens			
98.	In patients with chronic hepatitis B or C without cirrhosis who require anti-androgens for HS, we <i>suggest</i> using these agents with an approach similar to other HS patient populations regardless of hepatitis B or C exposure status.	Strong	Very low
99.	In patients with cirrhosis who require anti-androgens for HS, we <i>suggest</i> exercising caution when using metformin as there may be an increased risk of metabolic acidosis and ascites.	Conditional	Moderate
Hepatitis B and C: Systemic immunomodulators and biologics			
100.	In patients with HS who require immunosuppressants or biologics, we <i>recommend</i> screening for hepatitis B and C prior to treatment initiation.	Strong	Very low
101.	In HBsAg-positive patients who require immunosuppressants or biologics for HS, we <i>recommend</i> coordinating care with a hepatologist.	Strong	Very low
102.	In HBcAb-positive, HBsAg-negative patients who require immunosuppressants or biologics for HS, we <i>recommend</i> monitoring ALT, HBsAg, and HBV DNA every 3-6 mo and starting anti-HBV therapy if reactivation occurs.	Strong	Very low
103.	In hepatitis C infected patients who require immunosuppressants or biologics for HS, we <i>recommend</i> referring to hepatology for consideration of treatment prior to initiating the immunosuppressant or biologic.	Strong	Very low
104.	In HBsAg-positive patients who require high-dose prednisone (>20 mg) for HS, we <i>recommend</i> anti-HBV prophylaxis prior to starting prednisone therapy.	Strong	Moderate

Continued

Table II. Cont'd

No.	Recommendation	Recommendation strength	Evidence quality
105.	In patients with a history of hepatitis B or C infection who require systemic immunomodulators for HS, we <i>recommend</i> avoiding methotrexate if there is evidence of hepatic impairment regardless of serological status.	Strong	Very low
HIV			
HIV: Systemic antibiotics			
106.	In patients with HS and HIV positivity who require systemic antibiotics, we <i>suggest</i> using oral doxycycline due to its added prophylactic benefit against bacterial STIs in this patient population.	Conditional	Moderate
107.	In patients with HS and HIV positivity who require systemic antibiotics, we <i>recommend</i> exercising caution in using oral rifampin due to the potential for drug interactions with certain HIV therapies.	Strong	Moderate
108.	In patients with HS and HIV positivity who require systemic antibiotics, we <i>suggest</i> using oral dapsone due to its added prophylactic benefit against <i>Pneumocystis jirovecii</i> pneumonia, a common opportunistic infection in individuals with HIV.	Conditional	Moderate
109.	In patients with HS and HIV positivity who require systemic antibiotics, we <i>suggest</i> using oral co-trimoxazole (trimethoprim/sulfamethoxazole) due to its added benefit of lowering mortality and infection rates in this patient population.	Conditional	Moderate
HIV: Anti-androgens			
110.	In patients with HS and HIV positivity who require anti-androgens, we <i>suggest</i> considering non-metformin anti-androgens with an approach similar to other HS patient populations.	Conditional	Very low
111.	In patients with HS and HIV positivity who require anti-androgens, we <i>suggest</i> using metformin especially in patients that are overweight and/or have metabolic syndrome.	Conditional	Moderate
HIV: Systemic immunomodulators and biologics			
112.	In patients with HS who require immunosuppressives or biologics, we <i>recommend</i> screening for HIV prior to treatment initiation.	Strong	Very low
113.	In patients with HS and HIV positivity who require systemic immunomodulators or biologics, we <i>recommend</i> coordinating care with an ID specialist and taking into account factors such as HIV control (viral load, CD4 count) and potential for drug interactions.	Strong	Very low

114.	In patients with HS and HIV positivity who require systemic immunomodulators, we suggest that prednisone can be used cautiously for acute, widespread flares.	Conditional	Moderate
115.	In patients with HS and HIV positivity who require biologics, we suggest that adalimumab can be used cautiously based on currently available, albeit limited evidence.	Conditional	Low
116.	In patients with HS and HIV positivity who require biologics, we suggest that infliximab can be used cautiously based on currently available, albeit limited evidence.	Conditional	Low
117.	In patients with HS and HIV positivity who require biologics, we suggest that anti-IL-17s can be used if the HIV infection is well controlled.	Conditional	Very low
118.	In patients with HS and HIV positivity who require biologics, we suggest that ustekinumab can be used if the HIV infection is well controlled.	Conditional	Very low

GI, Gastrointestinal; HBV, hepatitis B virus; HS, hidradenitis suppurativa; ID, infectious disease; IGRA, interferon- γ release assay; IL, interleukin; STI, sexually transmitted infection; TNF, tumor necrosis factor; TST, tuberculin skin test.

HS guidelines and limited case series.^{19,152-157} Safety data from trials in other inflammatory conditions support their use; however, caution is advised particularly regarding anti-IL-17s in patients with a personal or family history of inflammatory bowel disease (IBD).¹⁵⁸

Malignancy

Intralesional steroids. While specific data are lacking, intralesional steroids are conditionally recommended for acute HS flares due to their favorable safety profile inferred from their mechanism of action.

Systemic antibiotics. Evidence is sparse for the safety and efficacy of systemic antibiotics in malignancy-associated HS. Studies suggest tetracyclines are safe based on their use in epidermal growth factor receptor inhibitor-induced eruptions, and antibiotics like moxifloxacin, clindamycin amoxicillin-clavulanate, and IV ertapenem, are deemed safe for cancer-related infections.¹⁵⁹⁻¹⁷¹

Anti-androgens. Studies indicate a generally safe profile for anti-androgens in certain cancers, with metformin showing survival benefits in solid tumors,¹⁷²⁻¹⁸² although effects on prostate and pancreatic cancers are unclear.^{173,183} Finasteride and spironolactone have not shown increased cancer recurrence risks.¹⁸⁴⁻¹⁸⁸

Systemic immunomodulators. HS treatment in patients with a history of malignancy should consider patient demographics and cancer characteristics.¹⁸⁹ European guidelines for IBD and cancer suggest delaying immunosuppressive therapy post-cancer treatment by 2 or 5 years for intermediate- or high-recurrence risk cancers.¹⁹⁰

Prednisone is used in some chemotherapy regimens, although prolonged use may lead to worse oncologic outcomes.^{191,192} Short prednisone courses may be used for severe HS flares.

Methotrexate and retinoids have limited efficacy data for HS, but have not been shown to increase new or recurrent malignancy.^{189,193-198} Methotrexate may be adjunctively used to prevent anti-TNF antibody formation if needed.

Biologics. Numerous studies indicate that anti-TNFs do not increase the risk of most new or recurrent malignancies.^{189,193,194,199-205} However, anti-TNFs have been linked with increased incidence of melanoma, and should be used with caution in patients with a melanoma history.²⁰⁶⁻²¹² Among 42 patients with malignancy history treated with secukinumab, no cancer progression or recurrence was reported; however, 3 patients developed new malignancies unrelated to their previous cancer.²¹³ Ustekinumab, although it is not a first-line treatment

for HS, is not associated with increase in new or recurrent malignancy in multiple IBD cohorts.^{204,214}

Tuberculosis

Systemic antibiotics. Multiple studies show a 4-month rifampin course (10 mg/kg/day, max dose 600 mg) is as effective as a 9-month isoniazid course for latent TB, with superior treatment completion, lower cost, and safety.²¹⁵⁻²²³ Given the established safety and efficacy of rifampin in combination with clindamycin for treating HS, its use is recommended for HS patients with latent TB.

Anti-androgens. Metformin reduces TB risk by 50% to 75% in diabetic patients,²²⁴⁻²²⁸ with its protective effect lessening with age.^{224,225} It is the preferred anti-androgen for HS patients at high risk for TB, such as those with close contacts, recent immigrants from high-incidence areas, and intravenous drug users.²²⁹

Systemic immunomodulators and biologics. Glucocorticoid therapy increases TB risk in a dose-dependent manner,²³⁰⁻²³² particularly when used with immunosuppressants or anti-TNFs.²³¹ Annual latent TB screening is advised for patients with rheumatic disease on long-term glucocorticoids.²³²

Anti-TNFs are linked with latent TB reactivation risk.^{233,234} Prior to biologic initiation, all patients should undergo TB screening with interferon- γ release assays and/or Tuberculin Skin Test. Bacille Calmette-Guérin vaccinated or immunocompromised patients may benefit from interferon- γ release assays due to Tuberculin Skin Test limitations.²³⁵⁻²³⁷ Immunosuppressed patients may require dual testing.^{235,238}

Treating latent TB can lower active TB risk in rheumatologic cohorts on anti-TNFs.^{239,240} For patients with latent TB at high risk for reactivation, non-TNF therapies should be considered for HS treatment. If anti-TNFs are required in these high-risk individuals, it may be prudent to complete TB treatment prior to biologic initiation. For patients with latent TB at low risk for reactivation, initiating treatment at least 1 month prior to anti-TNF initiation may be acceptable.^{234,240} Based on expert opinion, active TB cases should complete antibacterial treatment and symptom resolution prior to biologic re-initiation. Consideration may be given to re-initiating with a non-TNF biologic where possible.

Secukinumab and ustekinumab show no increased risk of latent TB reactivation in multiple cohort studies.²⁴¹⁻²⁴³ Isoniazid with ustekinumab is safe for latent TB.²⁴³ Therefore, we suggest treating latent TB concomitantly in HS patients on anti-IL-17s or anti-IL-12/23s.

Hepatitis B/C

Systemic antibiotics. There are no specific data on systemic antibiotic use for HS in the context of hepatitis B/C. Ciprofloxacin and TMP-SMX demonstrated favorable safety profiles in this patient population, with additional benefits like survival improvement and reduced incidence of spontaneous bacterial peritonitis, respectively.^{244,245} Caution is recommended with rifampin, due to hepatotoxicity risk in patients with hepatitis B/C based on data from retrospective studies.^{246,247} The recommendation to use doxycycline in this context relies on expert opinion due to a lack of studies.

Anti-androgens. In patients without cirrhosis, those with hepatitis B/C can be managed similarly to HS patients without these conditions. Metformin shows no increased risks for hepatocellular carcinoma or viral clearance issues,²⁴⁸⁻²⁵⁸ but caution is advised in cirrhotic patients due to potential risk of metabolic acidosis and ascites.^{252,253}

Two studies found that oral contraceptive pill use did not increase risk of adverse events in patients with hepatitis B/C.^{259,260}

Systemic immunomodulators and biologics. Guidelines on immunosuppressants or biologics in comorbid HS and hepatitis B/C are extrapolated from non-HS studies.²⁶¹⁻²⁸⁷ Before starting these therapies, all patients should be screened for hepatitis B and C. HBsAg-positive patients should consult with a hepatologist due to high HBV reactivation risks. HBcAb-positive, HBsAg-negative patients should have ongoing monitoring, and anti-HBV therapy initiated upon reactivation signs.^{261-265,271-287}

Hepatology consultation should be considered for patients with hepatitis C for potential curative therapy. In patients with chronic viral hepatitis and psoriasis, methotrexate didn't increase cirrhosis risk.²⁷⁰ None of the included studies assessed the safety of methotrexate in hepatitis B/C and existing hepatic impairment. Given its contraindications in hepatic impairment, adjunct methotrexate is best avoided in HS patients with existing liver issues, regardless of hepatitis status.

HIV

Systemic antibiotics. There are no specific safety data for systemic antibiotics in HS patients with HIV. Recommendations are derived from RCTs focused on preventing HIV-related co-infections. Doxycycline reduces syphilis incidence,²⁸⁸ while TMP-SMX offers mortality benefits and reduces severe bacterial infections in those on antiretroviral therapy (ART).^{289,290} TMP-SMX is also the preferred prophylaxis for *Pneumocystis jirovecii* pneumonia,

with dapsone as an alternative.^{291,292} Caution is recommended with rifampin due to potential ART interactions and risk of transaminitis and hyperbilirubinemia.^{293,294}

Anti-androgens. Metformin is safe for HIV-positive patients with metabolic syndrome and diabetes.²⁹⁵⁻³⁰⁰ There are no specific studies on finasteride and spironolactone in this population, but their use can follow general HS guidelines since no significant ART interactions have been reported.^{301,302}

Systemic immunomodulators and biologics. Guidelines for immunosuppressants and biologics in this population draw on HIV studies involving these drugs for non-HS conditions. HIV screening is essential before starting these therapies to avoid increased risk of opportunistic infections. Consultation with an infectious disease specialist is advisable to coordinate care.

Short courses of prednisone are generally safe and do not affect viral load or CD4+ counts in patients with HIV on ART.^{303,304} It is suggested that adalimumab and infliximab be used cautiously in this group.³⁰⁵ No data on anti-IL-17 and anti-IL-12/23 biologics in HIV are available. These agents should be considered only in well-controlled HIV cases.

EMERGING THERAPIES

As of this publication, adalimumab, secukinumab, and bimekizumab are approved in some jurisdictions for managing HS.³⁰⁶⁻³⁰⁸ Several other targets like Janus kinase, Complement component 5a, and various interleukins are under development.³⁰⁹⁻³¹⁶ These emerging treatments could provide new management options and improve HS outcomes, including for those in special populations.

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Conflicts of interest

Dr Alhusayen has received personal fees from Abbvie, Bausch health, Boehringer Ingelheim, Fresenius kabi, Janssen, Novartis, Pfizer, Sandoz, and UCB; investigator fees from Abbvie, Bausch health, Incyte, and Janssen outside the submitted work. Dr Alavi has served as a board member of HSF; consulted and received institutional fees for Admirall, BI, Incyte, InflarX, leo, Novartis, UCB; received principal investigator fees for BI and Processa. Dr Alikhan has been on an advisory board for Novartis. Dr Aleshin has received consulting fees from Santa Ana Bio

and Abbvie; served on advisory board for Novartis; received research funding from UCB. Dr Bahashwan has received honoraria from Janssen. Dr Daveluy has been a speaker, researcher, and consultant for Abbvie, UCB, Novartis; Researcher: Pfizer, Sanofi, and Regeneron. Dr Goldfarb has participated in clinical trials with Abbvie, Pfizer, Chemocentryx, and Incyte and served on advisory boards and consulted for Novartis, Boehringer Ingelheim and Sonoma Biotherapeutics; receives research support from Novartis and DeepX Health. Dr Garg is an advisor for AbbVie, Boehringer Ingelheim, Incyte, Insmed, Novartis, Pfizer, Sonoma Biotherapeutics, UCB, Union Therapeutics, and receives honoraria. Dr Gulliver has received grants/research support from AbbVie, Amgen, Eli Lilly, Novartis, and Pfizer; received honoraria for ad boards/invited talks/consultation from AbbVie, Actelion, Amgen, Arylide, Bausch Health, Boehringer, Celgene, Cipher, Eli Lilly, Galderma, Janssen, LEO Pharma, Merck, Novartis, PeerVoice, Pfizer, Sanofi-Genzyme, Tribute, UCB, Sun Pharma, and Valeant; has received clinical trial study fees from AbbVie, Asana Biosciences, Astellas, Boehringer-Ingelheim, Celgene, Corrona/National Psoriasis Foundation, Devonian, Eli Lilly, Galapagos, Galderma, Janssen, LEO Pharma, Novartis, Pfizer, Regeneron, Sun Pharma, and UCB. Dr Jaleel is an investigator for UCB and Eli Lilly; reports consulting for Eli Lilly and Chemocentryx and receives honoraria; has received funds from Pfizer and UCB for research fellow support; received funds from Dermatology Foundation, Skin of Color Society, Duke Strong Start Physician Scientist Award, and NIH K12; and is a board member for Skin of Color Society. Dr B. Kimball has received honoraria or consulting fees from Abbvie, Alumis, Bayer, Boehringer Ingelheim, Eli Lilly, Evoximmune, Innovaderm, Janssen, Novartis, Moonlake, Pfizer, Priovant, Sanofi, Sonoma Bio, Target RWE, UCB, Union Therapeutics; is on the board of directors of Admirall. Institution has received grants from Abbvie, Admirx, Anaplys Bio, Aristea, Bristol Myers Squibb, Eli Lilly, Incyte, Janssen, Moonlake, Novartis, Pfizer, Prometheus, Sanofi, Sonoma Bio, and UCB. Dr G. Kirchhof has received advisory board/consulting fees from AbbVie, Amgen, Arcutis, Bausch, Eli Lilly, Incyte, Janssen, LEO Pharma, Novartis, Pfizer, Recordati, Sanofi-Genzyme, Therakos, UCB Biopharma; speaker's bureau/honoraria from AbbVie, Amgen, Arcutis, Bausch, Eli Lilly, Incyte, Janssen, LEO Pharma, Novartis, Pfizer, Recordati, Sanofi-Genzyme, and UCB. Dr Kirby is an employee of Incyte Corporation; is on the advisory board for AbbVie, Incyte, Novartis, UCB; is a consultant for AbbVie, Alumis, DermTech, Guidepoint, Incyte, Insmed, Janssen, Moonlake, Novartis, and UCB. Dr Lev-Tov is a founder, owns stock, and has a podcast for LearnSkin.com; has consulted for Insmed, NextScience, Novartis, Pfizer, UCB, and Vomaris; is a clinical trialist for Incyte, Medline, Molnlycke, Moonlake, Novartis, Pfizer, Sigvaris, Tissue Tech, and UCB; receives research grant support from Essity, Next Science, Sigvaris, and Vomaris. Dr A. Lowes has served on the advisory boards for Abbvie, InflaRx, Janssen, Novartis, UCB, Viela Bio; consulted for Admirall,

BSN medical, Incyte, Janssen, Kymera, Phoenixis, and XBiotech. Dr Lara-Corrales has received grants/research support from Abbvie, Clementia, Eli Lilly, Timber, Arcutis, EB Medical Research Foundation, EB Research Partnership, Physicians Services Incorporated (PSI) Foundation, SkIN Canada, La Roche Posse, Sanofi Genzyme, Regeneron, Mayne Pharma, Bristol Myers, and Alexion; has received honoraria or consultation fees from Sanofi Genzyme, Abeona, Avicanna, Ipsen, Novartis, Eli Lilly, Union Chimique Belge's (UCB) and Abbvie; participated in company sponsored speaker's bureau for Sanofi Genzyme, Abbvie, Eli Lilly, Novartis, Alexion; is a board member of DeBRA Canada, Camp Liberte and Children International Summer Villages (CISV). Dr Micheletti has received consulting fees from Vertex and research funding from Acelyrin, Amgen, Boehringer-Ingelheim, Cabaletta Bio, and InflaRx, all outside the submitted work; he is also a Section Editor for JAMA Dermatology. Dr Okun has consulted for AbbVie, Azora Therapeutics, Bluefin Biomedicine, Boehringer Ingelheim, Incyte, Novartis, Phoenixis, Regeneron, and Vyne Therapeutics. Dr Orenstein has received consulting fees from UCB and Novartis; has received grant support from Pfizer; is an Associate Editor for Dermatology; is a board member of the Hidradenitis Suppurativa Foundation. Dr Poelman has received grant support from UCB, Pfizer, Amgen; consulting fees from Abbvie, Novartis, UCB, Sandoz, Bausch health, Incyte, Janssen; is an investigator for clinical trials for Abbvie, Incyte, Moonlake, BioJamp; is president of the Canadian Hidradenitis Suppurativa Foundation. Dr Piguet has received grants from AbbVie, Bausch Health, Celgene, Eli Lilly, Incyte, Janssen, LEO Pharma, L'Oréal, Novartis, Organon, Pfizer, Sandoz, Sanofi, and Bristol Myers Squibb; received payment or honoraria for speaking engagement from Sanofi; participated on an advisory board for LEO Pharma, Novartis, Sanofi, and Union Therapeutics; received equipment donation from L'Oréal. Dr Porter has received consulting fees from Novartis, Janssen, UCB, Pfizer, Trifecta Clinical, Alumis, Incyte, Abbvie, Eli Lilly, Sanofi, Sonoma Biotherapeutics, and Prometheus Laboratories; her institution has received grants from Anaptysbio, Novartis, UCB, Pfizer, Janssen Pharmaceuticals, Abbvie, Incyte, Eli Lilly, Regeneron, Moonlake Therapeutics, Sonoma Biotherapeutics, Sanofi, Bristol-Myers-Squibb, Oasis Pharmaceuticals, Bayer, and Prometheus Laboratories. Dr Resnik: Speaker's Bureau, Abbvie, Novartis. Board member, Hidradenitis Suppurativa Foundation. Dr Sibbald has received honoraria from Abbvie, Leo Pharma, Novartis, Incyte, Pfizer, and Sanofi; grant support from Pfizer. Dr Shi is on the board of directors for the Hidradenitis Suppurativa Foundation (HSF); is an advisor for the National Eczema Association; is a stock shareholder of Learn Health; has served as an advisory board member, investigator, speaker, and/or received research funding from Sanofi Genzyme, Regeneron, AbbVie, Genentech, Eli Lilly, Novartis, SUN Pharma, LEO Pharma, Pfizer, Incyte, Boehringer Ingelheim, Almirall, Alumis, Aristeia Therapeutics, Menlo Therapeutics, Dermira, Burt's Bees, Galderma, Kiniksa,

UCB, Bain Capital, Target-PharmaSolutions, Altus Lab/cQuell, MYOR, Polyfins Technology, GpSkin and Skin Actives Scientific. Dr Sayed is an investigator for AbbVie, ChemoCentryx, Incyte, InflaRx, Novartis and UCB Pharma; has received consultancy fees from AbbVie, Alumis, Astrazeneca, InflaRx, Sandoz, Incyte, Logical Images, Sanofi, Sonoma Biotherapeutics, and UCB Pharma; is a speaker for AbbVie and Novartis; is the secretary of the HS Foundation and member of the European HS Foundation. Dr Wong is a consultant for Abbvie, Amgen, Bausch Health, BioJamp, Boehringer Ingelheim, Bristol Meyers Squibb, Celltrion, Eli-Lilly, Galderma, Janssen, Johnson & Johnson, Leo Pharma, Novartis, Pfizer, Sanofi, Sun Pharma, and UCB; has received speaker fees from Abbvie, Eli-Lilly, Leo Pharma, Novartis, Pfizer and UCB; is a board member for the Canadian HS Foundation. Dr Zaenglein has received research grants from Abbvie, Galderma, Dermavant, Incyte, Palvella; has received consulting fees from UCB, Ortho Dermatologics, and Dermavant; is an Editor-in-Chief of Pediatric Dermatology. Dr Veillette has received honoraria for presentations for AbbVie, BioJAMP, Celltrion, Janssen, Novartis, Sanofi, Bausch Health, Pfizer, Boehringer-Ingelheim, Incyte, and UCB; has received consulting fees from Abbvie, Bausch Health, BioJAMP, Celltrion, Eli Lilly, Galderma, LEO Pharma, Janssen, Novartis, Sandoz, Pfizer, Sanofi, Sun Pharma, UCB, and Boehringer-Ingelheim; is an investigator for Sanofi, AnaptysBio, Boehringer-Ingelheim, Abbvie, Amgen, Bausch, Merck, Pfizer, and Incyte; is a board member of the Canadian HS Foundation. Dr L. Hsiao is on the Board of Directors for the Hidradenitis Suppurativa Foundation; has consulted for AbbVie, Aclaris, Boehringer Ingelheim, Incyte, Novartis, and UCB; is a speaker for AbbVie, Novartis, Sanofi Regeneron, UCB; is an investigator for Amgen, Boehringer Ingelheim, and Incyte. Dr B. Naik has received grant support from AbbVie; received consulting fees from 23andme, Abbvie, Aristeia Therapeutics, Nimbus Therapeutics, Medscape, Sonoma Biotherapeutics, DAVA Oncology, Boehringer Ingelheim, UCB, and Novartis; received investigator fees from Pfizer; holds shares in Radera, Inc; is an Associate Editor for JAMA Dermatology and a board member of the Hidradenitis Suppurativa Foundation. Drs Lenczowski, Lam, and Author Dienes have no conflicts of interest to declare.

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