Rounding@IOWA: Hidradenitis Suppurativa

[Upbeat theme music plays]

Transcript

Dr. Clancy

Welcome to Rounding@IOWA, a continuing medical education podcast developed by and for healthcare teams. I'm your host, Dr. Gerry Clancy, Professor of Psychiatry and Emergency Medicine and Senior Associate Dean for External Affairs here at the University of Iowa's Carver College of Medicine. Today, we will discuss guidance for clinicians in diagnosing and treating hidradenitis. First, we want our participants to cite and explain to patients the diagnosis of hidradenitis. Second, we want our participants to describe the mechanisms of disease and impairment from hidradenitis. And third, we want our participants to recognize trends in new pharmacological and surgical interventions for hidradenitis. Today, we have the great advantage of an expert on hidradenitis, Dr. Nicole Negbenebor. Dr. Negbenebor is a Clinical Assistant Professor of Dermatology at the University of Iowa. She is the director of the Skin of Color Clinic. She graduated from Brown University Medical School and then continued on at Brown University for dermatology residency. She came to the University of Iowa for Mohs Micrographic Surgery and Cutaneous Oncology Fellowship, and then stayed on as a professor here. Dr. Negbenebor, welcome to Rounding@IOWA.

Dr. Negbenebor

Thank you so much. I'm happy to be here.

Dr. Clancy

Well, again, thank you for joining us and thank you for the work you do. I've just provided our listeners your official titles and a summary of your training to get started and to let our listeners know a little bit more about you. Let's talk a little bit about how you were drawn to academic dermatology and specifically Mohs surgery.

Dr. Negbenebor

Yeah, that's a great question. So, you know, when I graduated dermatology residency, I was like, you know, I am not sure, you know, do I want to go into private practice or do I want to do academics? But I realized that at the core of who I am, I love learning. It's one of

my favorite things to do, and I wanted to be a part of the cutting edge in terms of what are some of the innovative things that we're doing in our specialty to figure out how to treat patients with all different types of diseases, particularly cutaneous disease. And I like the clinical trial aspects, the journal clubs, you know, you work with residents, you work with fellows, medical students. It's always this culture of learning and improving and, you know, gathering more information so that you can better treat people. And so that was one of the reasons why I ended up going into academics. The other question you asked was also, particularly for Mohs surgery, one of the things which we'll get more into, but one of the things that I felt was super important was the cutaneous oncology aspect of dermatology. We have the ability to diagnose and also treat patients who come in with skin cancer and also prevent it by counseling patients, you know, on wearing sunscreen and other sun protective behaviors. And for certain communities, a lot of communities don't even know that they can get skin cancer and don't even know how to prevent it. And so I saw that gap and I feel that Mohs surgery fills that gap in a very important and crucial way. The reason why I'm saying that we'll get into that later is because similar to our patients who have a lot of skin cancer burden and are in great need, patients with other conditions such as hidradenitis also have these gaps and needs that need to be filled by dermatology.

Dr. Clancy

That's a great answer. And hopefully that helps other people think about academic medicine as well. The same for me as far as why I'm in academic medicine, the vibrancy and variety, and then the forward-looking approach to academic medicine is just a great place to be. And I'm a little bit older than you, [laughter] but I can tell you that energy and enthusiasm continues on. So great that you see that early on in your career. In this work that you do, give us an idea of what a work week might look like for you, because academics has a lot of variety, so kind of paint out a typical week for you.

Dr. Negbenebor

I'm so glad we're talking about this because that's another reason why I was drawn to academics because of the variety and some of the more challenging cases that sometimes come into an academic center. And so on my Mondays, I'm at the VA hospital, do Mohs surgery and also, you know, some excisions as well. And then on Tuesdays in the mornings, I do a procedure clinic and then in the afternoons I do the skin of color clinic and also the director of the HS clinic, and also see patients with high-risk skin cancer. And then on Wednesdays, I do Mohs surgery, and then sometimes on Thursdays Mohs surgery, and then Fridays Mohs surgery at the university. So kind of three different places that.

Dr. Clancy

Excellent.

Dr. Negbenebor

Yeah. [laughter]

Dr. Clancy

And I imagine you have students in residence and fellows with you kind of all the time.

Dr. Negbenebor

You know, it's a mix, actually. It's a mix. And so, you know, sometimes at the VA, we'll have you know, residents and fellows, definitely at the university, and then sometimes at our satellite clinic at Iowa River Landing.

Dr. Clancy

Yeah, great, great. And you direct the Skin of Color Clinic. How did that get started? How long has that been around? And tell us a little bit about that.

Dr. Negbenebor

Yes, so one of my mentors, Dr. Nkanyezi Ferguson, she used to be here. Fantastic, fantastic mentor. And, you know, she ran the Skin of Color Clinic and she also did Mohs surgery. And I was like, oh my goodness, if you can see her, you can be her, you know, because I really hadn't seen a lot of people who were doing that. And, you know, she left, she went to University of Missouri where she's now the director of Mohs surgery. And when I started here as an attending, then I restarted the Skin of Color Clinic. And ever since then, it has been a great time. Yep.

Dr. Clancy

Great. Great, well, we're glad you're here. We're glad that you're doing the work that you're doing.

Dr. Negbenebor

Thank you.

Dr. Clancy

Let's start into understanding hidradenitis suppurativa. Is that how I would say it correctly?

Dr. Negbenebor

Excellent, excellent.

Dr. Clancy

All right, I'm not gonna say it too often. Can you describe some of the basics of this complex disease and then we can get even further into it. But let's just talk about kind of when we're introducing this concept to patients and to general practitioners, what is this diagnosis?

Dr. Negbenebor

Yes, yes. So this is a chronic inflammatory, think about it almost as an autoimmune condition. And when patients find out, there's usually a delay of almost six years before they find out what they have. And a lot of people are misdiagnosed, undertreated. And, you know, sometimes are made to feel that it's more a condition of cleanliness rather than, you know, inflammation, you know, coming from inside the body. And, you know, that's why a lot of patients, you know, have these comorbidities of, you know, anxiety and depression because they sometimes seek care from the healthcare system and they are told that there's nothing that can be done. And so, you know, when I have a patient who comes in and they've had these recurrent boils, recurrent areas or cysts, like more than two within six months, they probably need to start thinking about, does this patient have hydradenitis, especially if there's scarring, if there's tunnels, then especially in the intertriginous areas, then need to start thinking, does this patient have hidradenitis?

Dr. Clancy

You know, I did my dermatology clerkship here at the University of Iowa in the late 80s with Mary Stone, but I don't remember learning about or seeing hidradenitis. Kind of give us a timeline of how this diagnosis has become at least more considered and, you know, where were we 10 or 20 years ago as far as even seeing it on the horizon?

Dr. Negbenebor

Yes, we were in the dark.

Dr. Clancy

Yeah.

Dr. Negbenebor

We were in the dark because [laughter] you know, it was originally cited as being very rare, but now that we have more options for treatment, then I think it also helps. And also we're

better at diagnosing it. Let me say that. And so I think you have seen a higher incidence of patients now being diagnosed with hidradenitis. In addition to that, more people are realizing that, you know, dermatology also has other tools to treat it. So, you know, we're seeing more people but, you know, for a long time, I've had patients tell me that I originally—in their words—I originally came to dermatology ten years ago, and I was told there was nothing that could be done for me at all. And so they're like, so why would I come back and see a dermatologist? And then so by the time they come back, you know, it's pretty severe and widespread. And so, you know, they say it's about 1% of the population has hidradenitis, but I think it's probably more than that, honestly.

Dr. Clancy

Yeah. And is it a diagnosis by biopsy or is it really a combination of history and you know it when you see it? Tell me how you come up with this is hidradenitis.

Dr. Negbenebor

Yes, yes. So for a lot of patients, by the time they come to the specialty clinic, they usually have a sense themselves from reading, especially because, you know, there's not a lot of resources. out there in the past, they find communities online and say like, oh, I think I have this. Oh yeah, I think I have this. And so usually if the patient has kind of like more than those two boils, you know, like within the six months, especially in their intertriginous areas or the tunneling, the scarring, then I'm thinking this is not just a cyst. There are times where patients will have a different presentation of some of the lesions. And so you may need to do a biopsy to rule out Crohn's disease, which can also not only be comorbid with, you know, HS and or hidradenitis in patients, but it can be mistaken for that. And so that could be a different. Yeah. So sometimes we rule that out. And then I've had patients come in where they can tell verbatim, you know, the history that they've had. They they noticed that it got better with, you know, certain anti-inflammatories and then it came back when they came right off of it. It's usually a clinical diagnosis, but definitely combined with the history that helps.

Dr. Clancy

And you've mentioned this, but are there particular regions of the body that almost always are affected? Is it always the axillae? Is it always the inguinal areas? And beyond those, what are other areas that, I mean, is it even non-intertriginous areas as well?

Dr. Negbenebor

Yes, yes. So the most common areas are underneath the breasts, the axillary areas, the buttocks, groin, inguinal areas. But I have seen patients come for excisions who were

originally diagnosed with just having a cyst, and then they had sinus tracts and scarring behind their ears. And then I'm, you know, then you ask the questions like, oh, you have, you know, quite extensive, you know, cyst and tunnels behind your ears. Do you have it in other places like such your, such as your groin? And then they'll be like, yes, I do. Nobody's ever asked me about that. And then you're putting the pieces together to find out exactly, does this patient have hidradenitis? It's not an isolated lesion. It's the multiplicity of the lesions that are going on in the body.

Dr. Clancy

And, you know, you talked a little bit about Crohn's. What are some of the other things you want to make sure you also consider when you have a presentation like that? What's your differential look like?

Dr. Negbenebor

Yes. Yes. So I have actually had some patients come in who not only had HS but also had pyoderma gangrenosum. So you might want to also think about that, depending on how the lesion looks. There are also sometimes people can have a folliculitis. And sometimes in the early stages, it can be a little bit hard to tell. Is this just a folliculitis versus a more chronic inflammatory condition? So kind of assessing the history and getting at that and also seeing the presence of scars and tunneling, all that kind of other stuff, you shouldn't really have that with folliculitis. That shouldn't be something that happens. And then also the very isolated nature of it and the widespread certain areas. And then other things that it could be, of course, infection, you have to rule that kind of stuff out. Even very rarely, but sometimes you could even have like sarcoidosis. It's kind of like the great mimicker, but that shouldn't be really high up on that list. But those are some other things that you would think about too.

Dr. Clancy

And is there a most common wrong diagnosis for these patients? Is there, you said sometimes these patients are told there's just nothing you can do, but do they also go down a different pathway that the wrong treatment for the wrong diagnosis? What's kind of on the top of the list as far as some of the wrong diagnoses that they get first, second, third time around?

Dr. Negbenebor

Yes, yes. I think most commonly patients will say that they have sought care and they were told that they had cellulitis, or that they had a very extreme infection and needed to go on IV vancomycin. I've also had patients say that they had necrotizing fasciitis and needed to

be taken to surgery when actually they had HS. And so usually, which, you know, I think in some scenarios it makes sense. You want to rule out, you know, some of the things that would cause some of the most harm, you know, at first, but it's usually that these patients have a very exuberant infection, and that they need to be on big gun antibiotics.

Dr. Clancy

Yeah. And you do direct the skin of color clinic. Tell us a little bit about the impact of skin of color that may add to the mis- or underdiagnosing as well.

Dr. Negbenebor

Yes. Yes. So it's interesting in terms of the epidemiology, hidradenitis most often affects women and it also most often affects people of color. They've also shown some correlations too with sociodemographics as well. But in the fact that they're doing more of this research, they have also found that here are lesions that can show up and be less erythematous, because erythema may show up completely differently in patients with darker skin tones and may be more violaceous or may be more hyperpigmented. And just because there's not that very strong red or pink color doesn't mean that inflammation is not occurring currently in that area.

Dr. Clancy

Got it.

Dr. Negbenebor

That the skin tone, I would say, is the most often. Yep. Yep. And then when you go online, despite the sociodemographics of the disease, you may go online and only see photos in lighter skin tone. So it doesn't necessarily match for your learning what is actually happening. So it can lead to a greater misdiagnosis.

Dr. Clancy

And not an uncommon issue for many of the dermatologic diseases, I imagine.

Dr. Negbenebor

Yes, lupus, skin cancer. Oh, yeah, skin cancer. Yep.

Dr. Clancy

Yep, it's chronic disease, it's inflammatory with sometimes infection on top of it, a lot of scarring. What do you see as far as impairment and disability from this?

Dr. Negbenebor

Yes, there are a lot of patients because of the nodules that are or abscesses that are draining in constantly needing to do wound care, that it's very difficult for them to, you know, hold their arms up for a long period of time, or even working in a space where they have to be pretty social and have a lot of people-to-people interaction in the public. They don't want people to assume that they're having an infection or that something's wrong. And so, you know, there was a company, I think it's called Hydrowear, and they came out with specific clothing for hidradenitis patients so that they can more freely, you know, be out in public without worrying about some of the draining and other stuff that's a little bit more absorbent. Even thinking about the cost of wound care supplies, like constantly having to do these gauze pads and tape and does it stick and all this other stuff. And then if it's on the buttock area, sitting down for long periods of time can also trigger, you know aggravate it, especially with friction, and I'm not even talking about relationships, how that may, you know, affect people's quality of life. And then if people are always assuming you have an infection, how that affects how you see yourself. I mean, I'm talking about every aspect hidradenitis can affect people's lives.

Dr. Clancy

I can see the social impact. And, you know, there's the medical impact. There is the physical impairment impact. There is the social impact. There's the isolation impact, I imagine as well. And so, and then probably discrimination as well.

Dr. Negbenebor

Yes. And we actually have a lot of patients who do request FMLA and disability because when they have these flares, the pain sometimes is so great that it makes them unable to go to work.

Dr. Clancy

Sure, absolutely. Yeah. So for us to be able to talk about treatment, we first need to understand the pathology, the pathophysiology of it. Can you tell us what's happening really at that molecular and cellular level for this disease? You know, and I know there's a lot of diseases. We don't know everything, but at least what's our understanding so far as far as what's going on.

Dr. Negbenebor

Yeah, we're gathering more and more information every month, which is great. But, you know, usually what we say is that it kind of starts at the follicle level. There's, you know, a

comedone. And usually these patients also have something called a double-ended comedone. But you have this inflammatory process, which then, you know, creates the scarring, that long standing inflammation. Now, why does it go to certain intertrigenous areas? That's a question. You know, that's a... And I've also seen it where some patients don't have it just on their intertrigenous areas. And then why do people have it advance from the groin to the axillary areas and then some people never have it advanced from the groin to the axillary areas. But basically it attacks that immune system pathway, which then kind of offsets it into this chronic area where patients are constantly having this kind of like cycle where you have the hair follicle, then you have the inflammatory process, and then also having some of that bacteria that some people are saying plays a role in further causing the inflammation. And but not a true infection, you know, to the point of, you know, being pathogenic, but.

Dr. Clancy

And the primary issue.

Dr. Negbenebor

Exactly. Exactly. And then on the other side, there's the hormonal component. So, you know, we said this is a complex disease. You know, it is because there's a hormonal component because some people have triggers that are worse, you know, around certain times in their menstrual cycle. And, you know, particularly if they are in pregnancy, all this kind of other stuff. And so you'll see a wax and wane with the changes in hormones as well. And so that that kind of also guides some of our treatments. But yeah, yeah.

Dr. Clancy

You know, this cycle of autoimmune and inflammation and secondary infection, I mean, we've seen it time and time again in in medicine now, but, you know, a lot of people don't really talk through what's happening with COVID. COVID is a virus that sets off your inflammatory process, your lungs fill with fluid, and then comes the secondary infection. But it's that interplay of virus causing inflammation that then sets up the most deadly part of COVID, which is actually the secondary infection. So around and round we go. So you've got to be able to understand those layers of pathology, layers of pathology, layers of interaction. It's not just a simple thing that's happening here.

Dr. Negbenebor

No.

Dr. Clancy

And heart disease as well. You know, we have heart disease as an interplay of inflammation as well.

Dr. Negbenebor

Yes.

Dr. Clancy

So no one should be surprised by this, that this is a complicated interplay.

[laughter]

Dr. Negbenebor

It is. And I feel like sometimes, you know, in the past people would say like, oh, is it just because people are obese? Or is it because people are smoking? Potentially, potentially that could trigger, you know, some flares, but that's not the end all be all reason why patients are developing this and why they continue to progress in the disease. Because we have patients who were never obese, never smoked, and they still develop this disease. So there's a lot more going on. I didn't even talk about the genetic components, but yeah, there's a lot.

Dr. Clancy

Sure, sure, sure. So when you look at kind of the risk factors and some people who, you know, kind of almost retrospectively, you look back and say, yeah, those are the risk factors. And sometimes those risk factors help you with the diagnosis. What do you look for as far as what could be some of the risk factors?

Dr. Negbenebor

Yeah, so . . .

Dr. Clancy

In getting it starting. And then we'll talk about risk factors as far as making it-

Dr. Negbenebor

Worse.

Dr. Clancy

Flare, yes.

Dr. Negbenebor

Yes, yes, yes, yes. In terms of a starting, you know, the genetic component, you know, they've looked at and they've been able to look at HS or hidradenitis tissue banks and find that, you know, there are some genes that are more likely to cause, you know, hidradenitis. They've also done a study that I recently read about. And if they started people early on oral contraceptives, then they were less likely to develop hidradenitis later on in their lives. So there's a lot of different things that are kind of potentially at play here as to why certain people develop hidradenitis suppurativa. But we just honestly need more research to figure out why is it, you know, even across demographics, why is that happening?

Dr. Clancy

Yeah. And, you know, once the diagnosis is made, what do you, what do you tell a patient, hey, you know, avoid doing this. You mentioned smoking a little bit, but are there, you know does heat make it worse? Does sweating make it worse? What are the things that really can light it up?

Dr. Negbenebor

Yes, I know we're not talking about treatment right now, but you know, sweating can definitely make it worse and that's why we sometimes do Botox injections to decrease sweating so that it's exactly, it's not, you know, at least atrophy and, you know, the glands and then so they're not being as triggered as much. And then in addition to that, other things is that some patients have told me that they felt that certain foods actually triggered their flares.

Dr. Clancy

Sure. There’s a whole field.

Dr. Negbenebor

There’s a whole field you know. [laughter]

Dr. Clancy

Inflammatory foods and biomes—absolutely.

Dr. Negbenebor

You know that. So I've had some patients keep food diaries and they have felt that when they became gluten free, that it was less likely to be severe. Some patients have felt that when they eliminated milk, that it was less likely to be severe. Again, that really depends on, you know, the individual patient and their experience.

Dr. Clancy

So you've done a great job taking the psychiatrist and getting him to at least understand the basics of this. [laughter] Is that, so I understand that this is, you know, inflammatory and autoimmune and infection and scarring all kind of going in this cycle. So how do you get started in treating? What are your first steps as far as treating maybe that overlying infection and then treating the inflammation and the autoimmune aspects? And you know, we talked about layers. So what are your first what are your first steps when somebody comes and it's unfortunately, you know, they've got a pretty severe case? What do you do first?

Dr. Negbenebor

Yes, yes. So one of the kind of first rungs in the ladder is that we usually start with topical clindamycin lotion, which not only helps with some of that kind of microbial aspect, but also for the anti-inflammatory aspect, too, that antibiotics have. That's true. And we also pair it with Hibiclens wash as well to kind of just really cleanse, you know, the area in those multiple areas when patients are, you know, showering on a daily basis. In addition to that, we also have patients consider oral doxycycline, or you can do minocycline. This could be at 100 milligrams twice a day. It can also be at a submicrobial dose, which we also use for inflammatory conditions such as rosacea and also some alopecias. But that could be like a 50 milligrams daily or 50 milligrams, you know, twice a day. It's really sometimes getting more at that inflammatory aspect rather than like an infectious aspect. We also, on a more of a kind of procedural aspect at getting at that, they have shown that using laser hair removal helps to decrease some amounts of bacteria in some of the areas that the laser actually hits and destroys. So that's more of the procedural aspect of that.

Dr. Clancy

Kind of taking the molecules out of it.

Dr. Negbenebor

Literally.

Dr. Clancy

Yeah, yeah, yeah, I get it. And is there a particular, you know, set of organisms that's usually the top players? Is it staph, is it strep, or is it just everything?

Dr. Negbenebor

Yes. And then, you know, usually in acne, we also talk about cutibacterium, which is kind of like a funny name, but also something to consider. Yeah.

Dr. Clancy

So now kind of going after the inflammation and the autoimmune aspects, what about some of the biologics, Nicole? Are they effective?

Dr. Negbenebor

Yes, they're very effective. And as quickly as possible, try to get patients on these biologics to prevent them from progressing. Sometimes when we wait ‘til they're early stage three or extremely severe, have all of the scarring, the anti-inflammatory medications are not going to take away the scars. They're going to take away some of the inflammatory nodules that then become scars. So if you can get ahead of the scarring process, even better. And you you know, I always tell patients when we're starting them on biologics, you know, one of our goals is to decrease your pain, decrease the draining, because that's what matters to patients. You know, it's not just the disease burden that I'm talking about. It's on my day-to-day, what am I feeling that's affecting my quality of life? And it's usually that draining and that pain. And there's all different classes of biologics, TNF alpha inhibitors, IL-17, IL-23. I mean, they’re coming out with more and more. Even JAK inhibitors as well. That's kind of a newer medication. And sometimes we will combine multiple pathways for immunosuppression to improve disease for these patients and even increase the dose at a higher level than psoriasis to help these patients as well.

Dr. Clancy

And is it unfortunately a battle with insurance companies and prior authorization, or they usually recognize that these are highly effective?

Dr. Negbenebor

You would not believe the battle.

Dr. Clancy

Wow.

Dr. Negbenebor

You would not believe the battle. And if you go on and look at Iowa Medicaid, there are very specific qualifications that they want patients to have before getting approved for biologics and to maintain them on biologics. And sometimes this can include greater than a certain number of actively draining nodules. And yeah, so, and sometimes what people want is that they have failed oral rifampin and oral clindamycin before they will go on a biologic medication. So there's a lot of steps there.

Dr. Clancy

Unfortunate, unfortunate. Well, you're an accomplished surgeon. Let's talk about where surgery comes in and microsurgery as you do. Let's talk about that as helpful and when is it indicated? When do you jump to that?

Dr. Negbenebor

So I have had some patients come in and they had one consistently draining lesion in the groin or one consistently draining lesion in the right axilla. And I always tell them it's very important to stay on your medications in addition to surgery. Surgery works well with medical management as well. But if they have that one area that is consistently bothering them, then surgery is a great and viable option to remove that spot. And literally you are reducing their inflammatory burden, surface area. And for a lot of these patients, these areas do not come back in that area. It doesn't prevent, you know, progression. That's why they need to stay on medical management. And it came out with a paper and they showed that patients who had biologics plus surgery had a better quality of life and also felt that their condition was doing better as well.

Dr. Clancy

Great. And are there times when it becomes more than just the nodule? Is it, you know, a major surgery on them on both axillae, or there's some times when you just say, we've got to get all of this out of here and essentially take it from the infection and inflammation to scar? Is that kind of the goal is to turn it into scar with surgery?

Dr. Negbenebor

Yes, yes. Destroy those tunnels, destroy those tracks. And I would say often by the time we are seeing patients for surgery, we probably are doing a pretty extensive excision.

Dr. Clancy

Got it, got it.

Dr. Negbenebor

Yep, yep. And there are other things too beyond excisions where we also do intralesional Kenalog injections to the actual spot if they're having an acute flare. Also, we do something called de-roofing where you just take off the top layer of the actual tunnel and curette the base so that that will scar over and not fill up again.

Dr. Clancy

Makes sense?

Dr. Negbenebor

Yeah.

Dr. Clancy

There's re-architecture happening, redesigning. Yep, I get it.

Dr. Negbenebor

Yep.

Dr. Clancy

What do you see as far as future trends, as far as being able to diagnosis and future trends as far as treatment? You know, you mentioned a little bit that the biologics are just opening up so many doors. You think we'll be better off five years from now than where we are right now with what you see coming down the pipeline.

Dr. Negbenebor

1,000%.

Dr. Clancy

Great.

Dr. Negbenebor

1,000% we are going to be even better because there are more and more companies and researchers looking at hidradenitis. I think psoriasis has been extremely progressive in the treatments, and now we can present so many options to patients with psoriasis. that they never could, you know, see a plaque again, right? Yeah. And be helped with their psoriatic arthritis. Hidradenitis is years back from the point where we are from psoriasis, but it will get there.

Dr. Clancy

Great.

Dr. Negbenebor

And that's true for eczema as well. You know, there are other things coming down the pipeline. We're also doing clinical trials here too in the dermatology department, so if you have a patient who's interested, particularly for intralesional treatments directly into the lesions, I mean, there's just so much going on that, you know, it's an exciting time for hidradenitis.

Dr. Clancy

Great, great. Well, and hopeful for patients, you know—

Dr. Negbenoebor

Yes.

Dr. Clancy

For patients that have been, you know, the treatments work pretty well, but boy, they hope for more. And you see a bright future for this, which is great.

Dr. Negbenebor

Yes. I mean, I've had patients crying in clinic saying, I never thought that somebody would be able to do something for me or offer me anything. Yeah.

Dr. Clancy

Yeah. Great. Well, you know, you've been a fantastic expert here and really been able to provide us with, again, just so much understanding on the layers and understanding on the layers of treatment. What are some of the take home points you'd like to leave with our listeners as we finish up?

Dr. Negbenebor

One of the things that comes to my mind is that hidradenitis and other chronic conditions, it definitely affects people on multiple levels. And, you know, I think part of the complexity that comes with a complex autoimmune disease is how many different facets of a patient's life that can be changed once they find out they have this diagnosis and then once they kind of unify things. When we have somebody come to the clinic and for the first time they're being diagnosed with this, and then we're setting them up and then we're telling them all the things that they could potentially develop from this that are associated with it. You may have depression, you may have anxiety, you need to have a community and stuff like that. You're kind of the focal point for bringing together their care. And I think in medicine, the more that we can work together as a multidisciplinary team to get people the best help that they can, then the better off we are in terms of improving people's lives. And that's working with psychiatry, that's working with the pain clinic, because a lot of these patients have chronic pain, which is another condition, right in addition to that. OB/GYN, urology. When I tell you, like, it's the burn unit, you know, it's been fantastic having other colleagues that we can refer to to work together to treat patients.

Dr. Clancy

You're so right. These highly complex diseases, if you have the team in place, it can make such a difference. You know, you think cancer, you think about burns, and now we think about hidradenitis as well. And, you know, it takes that team to really be comprehensive in what we do. So that's a great point. Well, to our expert, Dr. Nicole Negbenebor, thank you for joining us on Rounding@IOWA and for the work you've done in helping us understand hidradenitis and what we can do for these patients. For our listeners, you can access instructions for CME and CEUs within our show notes, and we hope you'll join us again for another session of Rounding@IOWA.