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Characterising Baseline Assessments from an Implementation Science Study to Improve the Diagnosis and Management of Patients with Hidradenitis Suppurativa

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INTRODUCTION

- Hidradenitis suppurativa (HS) is a chronic, inflammatory skin disease that significantly impacts patients' quality of life and imposes a substantial disease burden, especially when diagnosis or treatment is delayed.[1]
- Patients with HS often experience delays in diagnosis of up to 7 to 10 years, with at least 3 misdiagnoses.[2-4] This is mainly due to the lack of recognition of HS across various medical specialties, especially among those initially encountering HS cases.[5,6]
- Implementation of objective assessments of HS symptoms and disease severity into clinical practice may help increase the HS diagnostic detection rate across healthcare professional (HCP) specialties.
- HELyx is an ongoing, implementation science study designed to evaluate the effectiveness and feasibility of implementing an online training (HS care package) on HS, including diagnostic screening for HCPs involved in HS diagnosis and management.[7]

OBJECTIVE

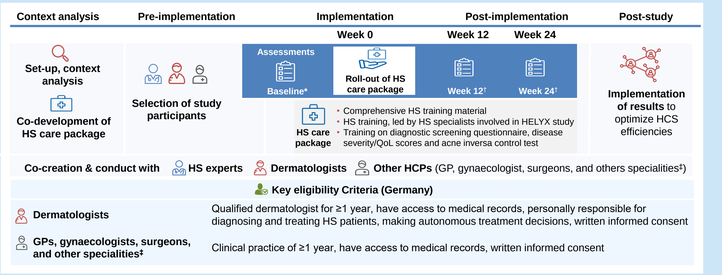
- To report interim baseline survey data, including the characterisation of diagnostic screening tools utilised, from the HELyx study in Germany

METHODS

Study overview

- HELyx is a hybrid effectiveness-implementation study being conducted in Germany, the United Arab Emirates and Spain, and employs a pre-post design involving HCPs.
- The implementation study performed in Germany includes dermatologists and non-dermatologists (GPs, gynaecologists, surgeons, and others).
- The study is designed by Novartis and guided by the Consolidated Framework for Implementation Research (CFIR) (**Figure 1**).
- Baseline assessments are conducted prior to implementation of the HS care package. After the implementation, assessments are conducted at weeks 12 and 24.
- At baseline, participating HCPs self-completed an online quantitative survey that collected information on their current management of HS and usage of diagnostic screening tools, disease severity scores and patient-reported outcomes in routine clinical practice.

Figure 1. Study Design of HELyx in Germany

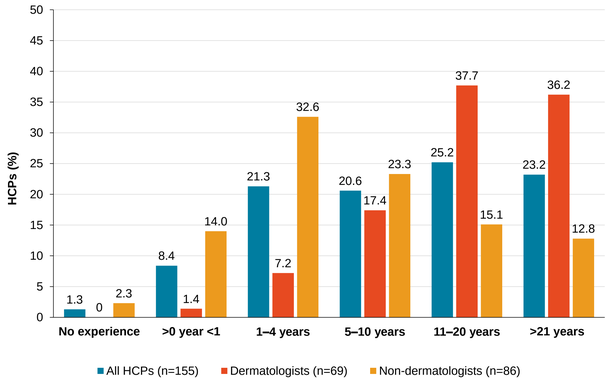


*Assessments include: Usage of diagnostic screening questionnaire, referral rate of suspected and confirmed HS patients, usage of scores for disease severity, quality of life, and evaluation of therapy, attitude of HCPs towards HS care package and perception of impact on their clinical practice.
†Same questionnaire as baseline, as well as questions regarding their views on the potential success of wider implementation of the HS care package and barriers and factors that may influence wider implementation. HCPs will also be asked about their perspectives on potential improvements in HS patient management.
‡Other specialties include: general practitioner internist, internal medicine, internal medicine general practitioner.
GP, General Practitioner; HCP, healthcare professional; HCS, healthcare strategy; HS, hidradenitis suppurativa; QoL, quality of life

RESULTS

- In total, 155 HCPs completed the baseline analysis of the HELyx study (dermatologists n=69, non-dermatologists n=86 [GPs n=19, gynaecologists n=54, surgeons n=4, and other specialties n=9]).
- In terms of HCP experience with HS patients, dermatologists had longer experience compared to non-dermatologists (**Figure 2**).

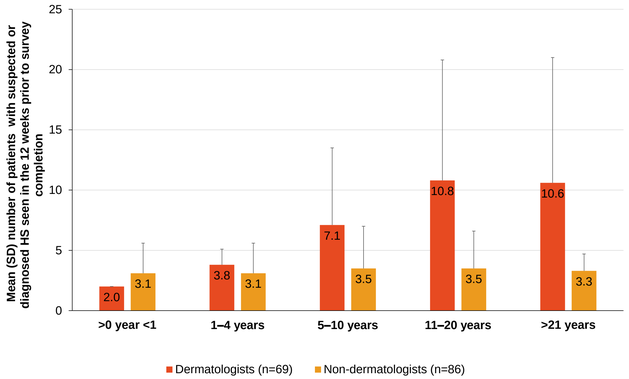
Figure 2. HCP experience with HS patients, and by dermatologists and non-dermatologists



HCPs, healthcare professionals.

- Overall, 45.2% (n=70) of HCPs were based in urban city centres (62.3% [n=43] dermatologists vs 31.4% [n=27] non-dermatologists), while a further 32.3% (n=50) were based in urban-rural (town centres, town suburbs) (20.3% [n=14] dermatologists vs. 41.9% [n=36] non-dermatologists) and 21.9% (n=34) in rural villages (15.9% [n=11] dermatologists vs. 26.7% [n=23] non-dermatologists).
- Of the non-dermatologists, most gynaecologists were based in urban city centres (37.0%, n=20) or urban-rural areas (46.3%, n=25), while half of the GPs were based in rural villages (52.6% [n=10] vs urban-rural areas 26.3% [n=5] and urban city centres 21.1% [n=4]).
- In the 12 weeks prior to survey completion, the mean±SD number of patients with suspected or diagnosed HS seen by dermatologists was 9.4±9.3, while 3.2±2.7 were seen by non-dermatologists.
- Compared to non-dermatologists, the average number (mean±SD) of patients with suspected or diagnosed HS seen by a dermatologist in the 12 weeks prior to survey completion was higher, with greater years of reported HS experience. Whereas, years of experience did not influence the number (mean±SD) of patients with suspected or diagnosed HS seen by a non-dermatologist (**Figure 3**).

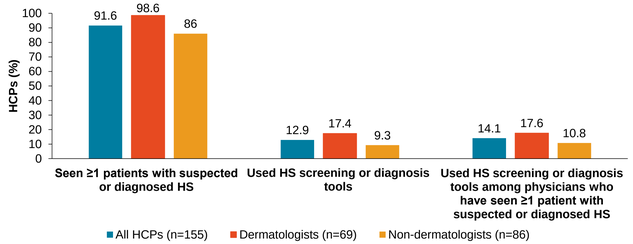
Figure 3. Mean (SD) number of patients with suspected or diagnosed HS seen by dermatologists and non-dermatologists in the 12 weeks prior to baseline survey completion, by years of HCP experience



HS, hidradenitis suppurativa

- Overall, 91.6% (n=142) of HCPs saw ≥1 patient with suspected or diagnosed HS in the 12 weeks prior to baseline survey completion, and the frequency was higher in dermatologists (98.6% [n=68]) than non-dermatologists (86.0% [n=74]).
- Overall, 12.9% (n=20) of HCPs used an HS diagnostic screening tool in the 12 weeks prior to baseline survey completion (17.4% [n=12] dermatologists vs 9.3% [n=8] non-dermatologists) (**Figure 4**).
- Among HCPs who saw ≥1 patient with suspected or diagnosed HS in the 12 weeks prior to baseline survey completion, only 14.1% (n=20) reported using an HS diagnostic screening tool, (17.6% [n=12] dermatologist vs 10.8% [n=8] non-dermatologist, all gynaecologists).

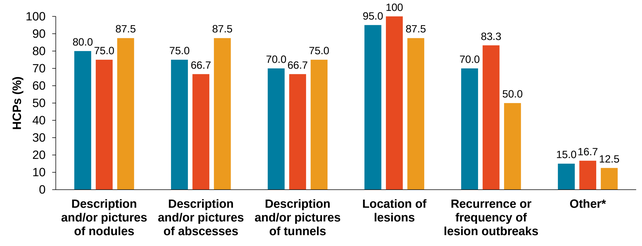
Figure 4. Use of diagnostic screening tools by HCP



HCPs, healthcare professionals.

- A total of 7.2% (67/928) of patients with suspected or diagnosed HS were screened with an HS diagnostic screening tool by HCPs in the 12 weeks prior to baseline survey completion. Of these, 8.0% (52/652) of patients saw a dermatologist vs 5.4% (15/276) a non-dermatologist (all gynaecologists).
- Both dermatologists and non-dermatologists who used an HS diagnostic screening tool in the 12 weeks prior to baseline survey completion mainly sought information on location of lesions (95.0% [n=19]) and description or images of nodules (80.0% [n=16]), abscesses (75.0% [n=15]), or tunnels (70.0% [n=14]) (**Figure 5**).

Figure 5. Information sought from HS diagnostic screening tools by HCPs using these tools



*Other information provided by HS screening and diagnosis tools include Dermatology Life Quality Index (DLQI), Hurley grade, sonography, and International Hidradenitis Suppurativa Severity Score System (IHS4). HCPs, healthcare professionals.

CONCLUSIONS

- Approximately 70% of HCPs had ≥5 years of experience managing patients with HS; dermatologists had longer experience than non-dermatologists (91.3% vs 51.2%).
- Most patients with suspected or diagnosed HS visited HCPs in urban city centre settings; experienced dermatologists saw more patients than inexperienced dermatologists and experienced/inexperienced non-dermatologists.
- Only 12.9% of HCPs reported using an HS diagnostic screening tool, and only 7.2% of patients with suspected or diagnosed HS were screened for HS using an HS diagnostic screening tool.

Disclosures

P-AB has received consulting fees from Novartis, AbbVie, Pfizer, and UCB; payment or honoraria from Novartis and AbbVie; support for attending meetings or travel from Novartis; and served on a Data Safety Monitoring Board or Advisory Board for Novartis. **JI** has acted as a consultant and/or advisory board member for Abbvie, Novartis, UCB, ChemoCentryx, Boehringer Ingelheim, Insmed, Viela Bio, MoonLake, Union Therapeutics, and Kymera Therapeutics; he also receives an editorial stipend from the British Journal of Dermatology as Editor-in-Chief and an author honorarium from UpToDate and is co-copyright holder of HiSQoL and Investigator and Patient Global Assessment instruments for HS. **JI's** department receives royalties from the DLQI and related instruments. **GK** is or has acted as a speaker and/or advisory board member for honoraria from AbbVie, Abbott, Actelion Pharmaceuticals, Amgen, Basilea Pharmaceutica, Bayer, Biogen IDEC, Boehringer, Bristol Myers Squibb, Celgene, Hexal, Janssen-Cilag, LEO Pharma, Lilly, MSD, Mylan, Novartis, Parexel, Pfizer, Sanofi, Sharpe and Dohme, Takeda and UCB. **BMG** has received disease-related consultancy/advisory board honoraria from Novartis and UCB**. MR** has received financial support for lectures, consultations and/or research studies from the following companies: AbbVie, Almirall, Bristol Myers Squib, ConvaTec, Lilly, Janssen Cilag, KLOX Technologies, Novartis, Paul Hartmann, Sanofi Genzyme and Urgo. **FGB** has received honoraria for participation in advisory boards, in clinical trials, and/or as a speaker for AbbVie Inc., AbbVie Deutschland GmbH & Co. KG, Boehringer Ingelheim Pharma GmbH & Co. KG, Celltrion, Incyte Corporation, Mölnlycke, Moonlake Immunotherapeutics, Novartis Pharma GmbH, UCB, and Janssen-Cilag GmbH. **MB, YG, BH, MZ, BMH, MF, EQ-F** and **CR** are stakeholders and/or employees of Novartis Pharma. **AM** has received honoraria and/or travel grants and/or has acted as an advisory board member for Novartis, AbbVie, Janssen Cilag, UCB, Lilly, LEO Pharma, L'Oreal, Sanofi, Boehringer Ingelheim, Almirall, Bristol Myers Squib and Amgen. He has also worked as a principal investigator in clinical trials supported by AbbVie, UCB, Jansen, Bristol Myers Squibb, Lilly, Galderma, Sanofi, and Novartis. **P-AB, JI, BMG, MR, and AM** have received honoraria for their participation in the global HS Implementation Science working group.

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