Pediatric Hidradenitis Suppurativa with Concomitant Bipolar Disorder: An Underrepresented Population

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Dear Editor,

We applaud Tzur Bitan et al. [1] for their population-based, matched controlled study appraising the association between hidradenitis suppurativa (HS) and bipolar disorder (BD). This study found that the proportion of BD in HS patients was 7 times greater than in controls. These findings were statistically significant ($p < 0.001$) for those in age groups 30–49 years and 50–69 years [1]. However, there is a missed opportunity of significant data in the exclusion of 1,370 patients under the age of 18 years or over the age of 90 years. Here, we highlight the pediatric HS population as an opportunity to improve long-term amelioration in comorbidities and provide data demonstrating the necessity of screening for psychiatric comorbidities in this vulnerable population.

HS has an average delay in diagnosis of 5–14 years [2] due in part to management via numerous specialties and varied approaches to HS recognition and treatment. Early diagnosis is paramount in the HS pediatric population given the severity of the psychosocial and quality of life impacts. Additionally, prompt initiation of therapy can reduce the risk of progression to debilitating end-stage disease. In adults, early lesions of HS are often misdiagnosed as recurrent furunculosis, or folliculitis [3]. In pe-

diatrics, the clinical presentation is more severe, often presenting with complications, such as infection, lymphedema, and fistulization, resulting in misdiagnosis and delay in both HS and BD management [4].

BD often presents differently in pediatric versus adult populations, leading to a diagnostic challenge. Children typically present with high rates of rapid mood cycling and often meet symptom criteria for disruptive behavior disorders [5]. Combined with emotional immaturity and comorbid diagnoses, such as attention deficit hyperactivity disorder, differentiating BD in children and adolescents from other behavioral/psychiatric conditions can be even more difficult [6]. The delay in diagnosis and treatment for BD patients is on average 10 years, with untreated years compounding a lower likelihood of recovery [7]. In one study, 60% of BD patients reported onset of mood symptoms before the age of 20 years; whereas other studies report that 70% of patients experienced mood symptoms before age 18 years [6–8]. An earlier onset of symptoms is associated with a more severe disease course, as well as increased likelihood of anxiety disorders, substance abuse, and suicide attempts [8].

Psychiatric disorders in pediatric HS patients are significantly understudied, despite maintaining significant dis-

ease burden [4]. Tzur Bitan et al. [1] found BD in the 18–29 years HS age group ($n = 1$) to be statistically insignificant ($p = 0.83$). However, the low sample size used for this study is unlikely to provide the power required to detect a statistical association between HS and BD in their youngest reported age group. Shavit et al. [9] provide the only cross-sectional study that comments on the association between HS and BD in the pediatric population, showing that 13/3,207 pediatric HS patients (0.4%) had BD ($p = 0.06$).

Overall, there are too few cases of concomitant HS and BD reported in the literature to provide substantial claims. Dermatologists should exercise increased awareness of these underdiagnosed conditions and consider screening pediatric HS patients for concomitant psychiatric diagnoses, including BD, as a means to provide a patient-centered approach to this population.

Key Message

Hidradenitis suppurativa and bipolar disorder patients are underdiagnosed and underrepresented in dermatologic literature.

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