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ORIGINAL RESEARCH

Criteria for Hidradenitis Suppurativa Competence Centers

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ABSTRACT

***Introduction*:** Hidradenitis suppurativa (HS) is a chronic, systemic, immune-mediated disease requiring multimodal care, which is crucial for raising awareness and advancing treatment. This project aimed to establish consensus among HS experts to define HS Competence Centers (HSCC) criteria using the Delphi consensus method.

***Methods*:** Overall, 22 global HS experts (3 patient representatives and 19 healthcare professionals [HCPs]) from 16 countries across 5 continents were invited to participate. Subsequently, a three-step Delphi polling was conducted among the HS experts from 20 May 2024 to 8 July 2024. A 50% agreement was required to reach consensus. Consensus levels included strong consensus (≥ 95%), consensus (≥ 75%), majority agreement (≥ 50%) and no majority agreement (< 50%).

***Results*:** In the prepolling step, 22 participants proposed 26 criteria. In step 1, 23 criteria were selected, of which 6 (23.1%) reached strong consensus, 11 (42.3%) reached consensus, and 6 (23.1%) majority agreement. The remaining 3 (11.5%) criteria proposed were rejected. In step 2, 13 of the 23 criteria (56.5%) were proposed for

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wording modifications. Of these, four (30.8%) retained initial wording and nine (69.2%) were modified. In step 3, 21 of the 23 criteria were identified as very important (91.3%), while 2 (8.7%) were considered less important. Among the 21 very important criteria, 2 (9.5%) reached strong consensus, i.e., essential, 12 (57.1%) reached consensus, and 7 (33.4%) had majority agreement. Overall, a set of 23 criteria (2 essential, 12 required—1st grade, 7 required—2nd grade, and 2 potential) was recommended to establish HSCC.

***Conclusions*:** This article reveals a consensus among an international group of HCPs and patients on a series of evidence-based criteria for HSCC. Standardized care, a hub and spoke model, multidisciplinary teams, specialized treatments, well-defined protocols, patient education, medical training, and robust referral systems were identified as essential/very important criteria for HSCC.

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Key Summary Points

Why carry out this study?

Criteria for defining hidradenitis suppurativa (HS) Competence Centers (HSCC) currently do not exist, although specialized and multidisciplinary care is crucial for raising disease awareness and advancing treatment in HS.

This is the is the first study to propose a set of criteria for defining and establishing HSCC on the basis of Delphi consensus method.

The study demonstrates consensus on a series of evidence-based criteria for HSCC among an international group of HS experts, including patient representatives and healthcare professionals.

What was learned from the study?

This study introduces a global framework to define and establish criteria for HSCC addressing unmet needs in HS care and supporting informed clinical decisions.

This provides a foundation for establishment of new HSCC worldwide.

INTRODUCTION

Hidradenitis suppurativa (HS) is a chronic, systemic, immune-mediated disease with an estimated global prevalence of up to 1% [1–6]. HS predominantly affects individuals aged 18–30 years, with nearly 10% of patients presenting the first symptom before the age of 18 years [6–9].

The clinical manifestations of HS include the presence of painful, deep-seated, recurrent inflammatory nodules that can develop into abscesses and tunnels, with suppuration and scarring of the folded skin [3, 10–12]. These manifestations have a negative impact on the quality of life (QoL) and psychological well-being of patients living with HS [13–16]. HS is also associated with various concomitant and secondary diseases, mostly metabolic syndromes, obesity, squamous cell carcinoma occasionally lymphoma, inflammatory bowel disease, spondyloarthropathy, and the risk of developing cardiovascular diseases [3, 17–20], which highlights the need for appropriate and timely evaluation of the patients by a multidisciplinary team of specialists.

Due to clinical complexities, early identification of HS remains challenging, where the average time from symptom onset to final diagnosis is nearly 7.2–10.2 years [21–23]. This long patient journey in HS is further aggravated by several unmet needs, including lack of awareness among patients and physicians, difficulties in accessing specialized clinics and experts, ineffective treatments, and delay in referrals, all of which lead to inadequate care [24, 25].

HS guidelines recommend a multidisciplinary approach for better outcomes in patients due to the multifactorial pathogenesis, heterogeneity in HS presentation, and associated comorbidities [3, 26–28]. Specialized centers are instrumental in catering to these needs, which include the availability of experts from different specialties along with comprehensive resources [29]. This makes specialized centers such as HS Competence Centers (HSCC) crucial in advancing care and raising disease awareness. However, there remains a lack of clear and established criteria for defining these HSCC.

Defining and establishing criteria for these centers is essential to address unmet needs in HS care and inform public health decision makers. These requirements may include, but are not limited to, elements such as standardized care, early and accurate diagnosis, standardized treatment protocols, continuous medical education for healthcare professionals (HCPs), and awareness programmes for patients.

This consensus article aims to address the lack of clarity in the definition of the elements constituting HSCC, which, in turn, would be instrumental in the establishment of optimal standardized care with new HSCC worldwide.

METHODS

Delphi Consensus Method and Participants

A total of 22 participants, including 19 HCPs and 3 patient representatives from 16 countries across 5 continents, were invited to contribute and support the development of the criteria for HSCCs. A three-step Delphi polling procedure was conducted worldwide from 20 May 2024 to 8 July 2024 to establish the HSCC criteria (Fig. 1). HCPs were identified as dermatologists with experience in managing patients with HS, while patient representatives were identified through patient associations or dermatologists specialized in HS (Table 1).

Delphi Polling Steps

In the prepolling step, the topic drivers (A.V. Marzano and C.C. Zouboulis) proposed a set of criteria to the experts, requesting additions or deletions. The first Delphi polling step was conducted to decide on the proposed criteria (26 May 2024 to 12 June 2024). The second step, focusing on the wording of the criteria in the case of proposed alternatives, took place from 13 June 2024 to 29 June 2024. The third step, assessing the consensus and significance level of the criteria, was conducted from 30 June to 8 July 2024.

Definition of Consensus

A 50% agreement was required for consensus. Consensus levels were defined as follows: strong consensus (≥95%), consensus (≥75%), majority agreement (≥50%), and no majority agreement (<50%).

Ethical Approval

This study did not require any patient information; hence no ethical review or approval was required. All the involved dermatologists who were part of the consensus gave their approval for the study to be published and were involved in the writing and/or revision of the manuscript.

RESULTS

Participants

All 22 participants agreed to participate to contribute each of the 3 rounds of the Delphi method, achieving a 0% attrition rate.

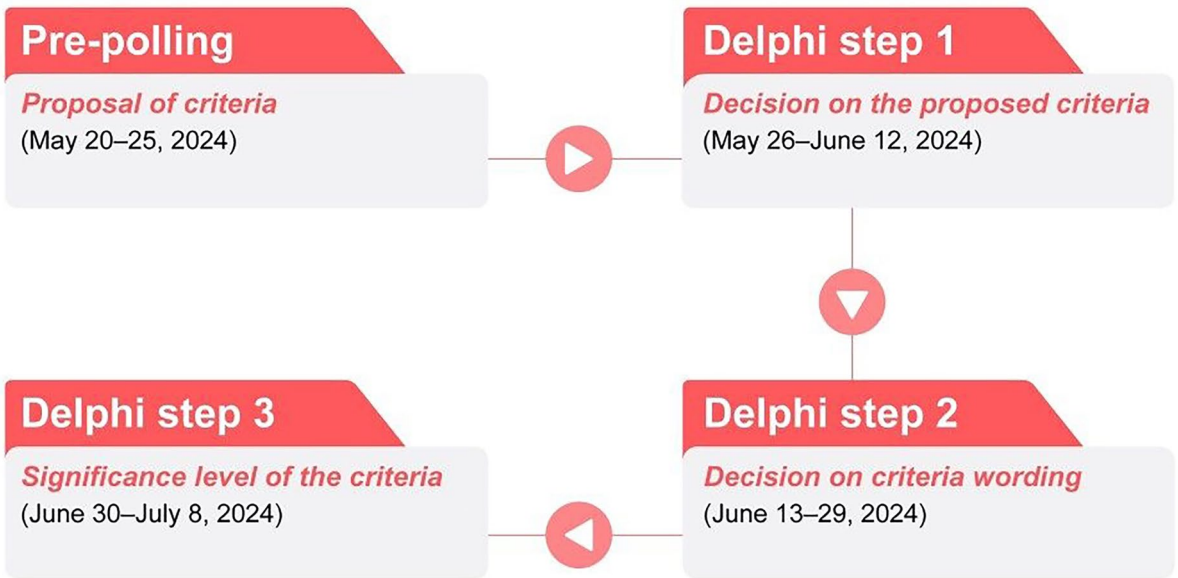

Fig. 1 Flowchart depicting the steps of the Delphi consensus method for the HSCC criteria

Table 1 Demographics of participants in the Delphi consensus method to establish the HSCC criteria

Total participants (*N* = 22)	
By countries	**Dermatologists** *N* = 19 (86.4%)
USA	4 (21.1%)
Germany	2 (10.5%)
Italy	1 (5.3%)
Australia	1 (5.3%)
Brazil	1 (5.3%)
Canada	1 (5.3%)
Chile	1 (5.3%)
China	1 (5.3%)
France	1 (5.3%)
Japan	1 (5.3%)
The Netherlands	1 (5.3%)
Norway	1 (5.3%)
Singapore	1 (5.3%)
Spain	1 (5.3%)
UK	1 (5.3%)
By countries	**Patient representatives** *N* = 3 (13.6%)
Germany	1 (33.3%)
Ireland	1 (33.3%)
Italy	1 (33.3%)

The data are presented as *n* (%)

HSCC Hidradenitis Suppurativa Competence Center

Delphi Consensus Method for the Development of the HSCC Criteria

Decision on the Proposed Criteria

During the prepolling step of the Delphi method, 26 proposed criteria were collected from 22 participants. These proposals were then introduced to the first Delphi polling step, resulting in the selection of 23 criteria. Among these, 6 (23.1%) criteria achieved strong consensus, 11 (42.3%) reached consensus, and 6 (23.1%) had majority agreement. The remaining three (11.5%) criteria proposed were rejected.

Decision on Criteria Wording

In the second Delphi polling step, 10 (43.5%) of the 23 criteria had no changes, while 13 (56.5%) were proposed for wording modifications. Of these, four retained initial wording (30.8%) and nine were modified (69.2%).

Significance Level of the Criteria

In the third Delphi polling step, 21 (91.3%) of the 23 criteria were identified as very important, while 2 (8.7%) were considered less important. Among the 21 very important criteria, 2 (9.5%) reached strong consensus, i.e., essential, 12 (57.1%) reached consensus, and 7 (33.4%) were very important with majority agreement.

HSCC Criteria

The complete Delphi method revealed a set of 23 criteria to establish HSCC. Overall, 2 essential criteria, 12 required—1st grade criteria, 7 required—2nd grade criteria, and 2 potential criteria were identified (Table 2). It is noteworthy that all the criteria categorized as required—2nd grade and potential received majority of agreement among the participants.

The essential criteria highlight that HS competence centers should offer diagnosis and medical treatment according to published guidelines, best clinical practices, and scientific evidence. Another essential criterion is that HSCC should use a "hub and spoke" model, where primary healthcare providers refer patients for specialized care, ensuring coordinated and comprehensive treatment regardless of the patient's location.

The required—1st grade criteria emphasized that HSCC should consist of a multidisciplinary team, including a dermatosurgeon or a dedicated HS surgeon and a senior dermatologist coordinating the center. They should implement urgent protocols for managing acute flares and complications and provide continuous medical education, wound care management, and referral for disease comorbidities. The multidisciplinary team should also include knowledge of imaging techniques, and standardized medical photography should be used for HS monitoring. HSCC should facilitate multidisciplinary meetings for optimized treatment plans, offer patient education resources and access to specialized surgical treatments, and use standardized templates for medical reports and forms to collect patient history and outcomes.

The required—2nd grade criteria underscored that HSCC should offer adequate referral to patient advocacy and support groups, promote lifestyle interventions, and demonstrate dedication to clinical trials and research. They should regularly publish or contribute to multicenter publications, be part of an International Collaboration Network, and develop global partnerships.

DISCUSSION

This study proposes a set of 23 defined criteria to establish HSCC on the basis of a Delphi consensus method by a group of HS experts across the world, including both HCPs and patient representatives. This initiative offers a robust standardized framework for global clinical practice and research in the field of HS.

Despite the availability of practice guidelines for diagnosis, treatment [27, 28], and emerging therapies in HS [30, 31], the outcomes in HS are still not satisfactory. Due to the complex pathways involved in the disease pathogenesis, heterogeneous clinical presentation, and associated comorbidities, effective management of HS requires a multidisciplinary approach that integrates multiple modalities including medical, surgical, and psychosocial therapies, as well as addressing associated comorbidities to achieve better outcomes [18, 27]. HSCC can facilitate this multidisciplinary approach and improve the diagnostic and therapeutic process, resulting in better standard of care and health outcomes [29].

There are specialized centers in Europe and the USA with typical features proposed for HSCCs that provide high-volume, high-quality medical and surgical assistance to patients with HS in need [32–34]. Rudimental guides for initiating HS specialty clinics caring specific patient groups have been suggested in the USA [35, 36]. However, there is still a global shortage of such healthcare centers for HS.

In this study, a set of criteria to define and establish HSCC was established using the Delphi consensus method among a group of global HS

Table 2 Criteria for HSCC

	Criteria final evaluation	Significance level	Consensus level
A. 1st level: essential			
	A HS competence center should offer diagnosis and medical treatment according to published guidelines, good clinical practice, and scientific evidence	Very important	Strong consensus
2	HS competence centers should operate on a "hub and spoke" model where frontline HCP refer patients for specialized care. This approach enables a streamlined coordination of advanced diagnostics and treatments, facilitating comprehensive care and ensuring that patients receive expert services regardless of their location	Very important	Strong consensus
B. 2nd level: required—1st grade			
3	A HS competence center (hub) should consist of a multidisciplinary team	Very important	Consensus
4	The multidisciplinary team should include a core comprising a dermatosurgeon or dedicated/HS interested surgeon	Very important	Consensus
5	A HS competence center should implement urgent outpatient and inpatient protocols for managing acute flares and complications associated with the disease, in the outpatient/inpatient settings or at the emergency department, on the basis of severity	Very important	Consensus
6	A HS competence center should provide continuous medical education, with ongoing education programs for HCP to stay updated with the latest research and treatment methodologies	Very important	Consensus
7	A HS competence center should provide wound care management	Very important	Consensus
8	A HS competence center should offer referral and appropriate management for all potential disease comorbidities	Very important	Consensus
9	In case of multidisciplinary care need, a HS competence center should have the option of multidisciplinary meetings, where multiple specialists discuss the development of optimized treatment plans	Very important	Consensus
10	A HS competence center should offer patient education resources, such as comprehensive materials and programs to educate patients about their condition and management strategies (including all treatments/procedures provided by the HS unit itself)	Very important	Consensus
11	A HS competence center should offer access for targeted specialized surgical treatment (e.g., drainage, deroofing, LASER, IPL + RF) and LASER-assisted hair removal	Very important	Consensus
12	A HS competence center should use standardized templates for medical reports, including scoring systems	Very important	Consensus
13	A HS competence center should have standardized forms to collect patient history and patient reported outcomes	Very important	Consensus

Table 2 continued

Criteria final evaluation	Significance level	Consensus level
14 The multidisciplinary team should include a senior dermatologist coordinating the whole center	Very important	Consensus
C. 3rd level: required—2nd grade		
15 A HS competence center should offer adequate referral to patient advocacy and support groups to empower patients and enable them to connect with peer support and advocacy networks	Very important	Majority agreement
16 A HS competence center should actively promote interventions for lifestyle modification	Very important	Majority agreement
17 A HS competence center should have providers and staff demonstrating dedication to clinical trials and/or clinical research focused on advancing the understanding and/or treatment of HS	Very important	Majority agreement
18 A HS competence center should regularly publish or contribute in multicenter publications on HS	Very important	Majority agreement
19 A HS competence center should be part of an International Collaboration Network (HS Registry) and develop partnerships with other centers worldwide to share knowledge and coordinate on global studies	Very important	Majority agreement
20 The multidisciplinary team should include a core comprising imaging techniques	Very important	Majority agreement
21 A HS competence center should use standardized medical photography for HS monitoring	Very important	Majority agreement
D. 4th level: potential		
22 A HS competence center should have telemedicine capabilities	Less important	Majority agreement
23 A HS competence center should perform or have the possibility to cooperate in basic HS research	Less important	Majority agreement

Consensus level is defined as strong consensus: ≥ 95%; consensus: ≥ 75%; majority agreement: ≥ 50%; no majority agreement: < 50%

HCP healthcare professional, *HS* hidradenitis suppurativa, *HSCC* Hidradenitis Suppurativa Competence Center, *IPL + RF* intense pulsed light and radiofrequency, *LASER* light amplification by stimulated emission of radiation

experts. The top two essential requirements that should be present to define a HS clinic as a HSCC were as follows: (a) diagnosis and medical treatment according to published guidelines, good clinical practice, and scientific evidence and (b) a hub and spoke model for regional organization and referral. Various other criteria such as availability of sophisticated techniques, multidisciplinary team, early and accurate diagnosis, robust referral system, standardized treatment protocols, continuous medical education for HCPs, and awareness programs for patients have also been identified to facilitate and define the HSCC.

A recent study, based on participant surveys and focus groups involving adult patients with HS, underscored the necessity for enhanced medical management and supportive care

throughout the disease course. The study demonstrated the advantages of a virtual format for research, discussion, clinical engagement, and interdisciplinary collaboration in managing HS [37]. Another study used a co-creation approach (expert meetings and mixed-model Delphi method) and identified categories for establishing centers of excellence in HS in Brazil. These included onboarding and welcoming, infrastructure and procedures, infusion therapy, flows and referrals, staffing, disease management, metrics during diagnosis and treatment, awareness and advocacy, research, and education [38].

Standardized criteria in HS care help HCPs develop effective HSCC. Establishing these criteria ensures that centers provide consistent, high-quality care on the basis of best practices and current guidelines and reducing variability in treatment outcomes. Centers can implement standardized protocols so that all patients receive optimal care following the latest research. Meeting specific standards improves patient outcomes through accurate diagnosis, effective treatment, and ongoing management [39]. The multicenter, prospective, randomized EsmAiL trial, including more than 500 patients with HS receiving either standard of care or an intervention according to a trial-specific, multimodal concept, demonstrated that standardized, structured, and multidisciplinary treatment markedly improved the course of HS as well as patient satisfaction [32].

A hub and spoke regional organization for referral, with periodic information sharing and cooperation with general practitioners and dermatologists, serves a key purpose in the effective, long-term management of HS cases. The hub and spoke model, with the possible integration of telemedicine, has been implemented in many fields, including psoriasis and other dermatological conditions [40, 41], leading to more efficient use of resources while enhancing the quality of patient care.

HS is associated with several comorbidities, including metabolic syndrome, obesity, inflammatory bowel disease, squamous cell carcinoma, axial spondylarthritis, and mood disorders, as well as an increased risk of cardiovascular disease [42–44]. Comorbidities should be screened for and managed through appropriate referrals [45, 46]. Hence, an early, multifaceted, comprehensive multidisciplinary approach is required to address all aspects of care and achieve an adequate response. An integrated multidisciplinary care model for HS is associated with high patient satisfaction and trust [34].

A hierarchical structure for HS-dedicated multidisciplinary units has been proposed by an Italian group, with an operational core, consisting of a dermatologist, plastic surgeon (or a general surgeon), radiologist (or one healthcare professional [HCP] expert in ultrasound) [47], and nurse/wound care specialist, as well as various consultants [48]. A randomized trial investigating the effectiveness of interdisciplinary combined dermatology–gastroenterology–rheumatology clinical care compared with usual care (patients attending disease-specific department only) in patients with immune-mediated inflammatory diseases, including HS, is currently ongoing [49].

Comprehensive care requires a well-defined referral and counter-referral flow that includes various actionable specialties involved, such as nutritionists, psychologists, social workers, stoma therapy nurses, wound care specialists, and different medical specialists (general practitioner, endocrinologist, gastroenterologist, proctologist, surgeon, urologist, cardiologist, rheumatologist, gynecologist, and sports medicine physician).

Prompt referral of suspected cases through a network of general practitioners and dermatologists is crucial, supported by evidence of a "window of opportunity" in the disease course and the benefit of timely treatment [50–53]. Constant co-operation with general practitioners and local dermatologists will be instrumental in effectively managing routine, HS-related medical needs of lower severity cases.

HS is primarily diagnosed on the basis of clinical criteria including the appearance and location of lesions along with disease history [54]. However, imaging techniques can provide additional information to physicians for an in-depth evaluation of clinical manifestations, providing insights for surgical planning and therapeutic decisions [47, 55]. While ultrasound imaging is the most well-characterized and widely used technique, magnetic resonance has a role in

severe, deep anogenital HS lesions. Newer applications such as medical infrared thermography have the potential to assist in preoperative and intraoperative surgical excision of HS lesions [56, 57].

A set of recommendations has been proposed to optimize patient care within specialized HS clinics, offering tangible improvements in efficiency through both educational and organizational measures [58]. These include differential referral strategies based on severity so that patients with clinically mild-to-moderate HS are managed in general dermatology clinics over time, while patients with severe HS are referred to a specialized outpatient service consisting of a team with at least two dermatologists.

Treatment plans are created and disseminated to local referring providers. In addition, prompt in-house management of patients requiring small procedures, including laser-assisted deroofing, is suggested to shorten lead-time delays. These experts also advocate for the use of patient intake forms and electronic medical record templates to facilitate history-taking and standardize documentation, as well as educational videos on specific HS procedures and post-surgical wound care to assist in answering commonly asked questions [58].

Establishing the criteria for these centers can improve access to specialized care for patients who might otherwise have extended waiting periods for appointments with delays in diagnosis and treatment. Defining and establishing these criteria will also allow for benchmarking with other centers, fostering a culture of continuous improvement and excellence in HS care.

Strengths and Limitations

The strength of this project was the global distribution of the participating experts, thus supporting the generalizability of the study results. All participants, including both HCPs and patient representatives, provided comprehensive responses across all three rounds, minimizing attrition bias and reflecting a strong commitment to advancing care in HS. This engagement also highlighted the shared willingness among HCPs and patients to support the establishment of competence centers aimed at improving outcomes for individuals living with HS.

While the physician sample size was modest, it included experts from diverse global regions, offering a breadth of perspectives relevant to the study objectives. The uneven patient sample reflected the low geographical awareness distribution of the disease. These factors are consistent with the current landscape of HS and do not detract from the relevance of the insights generated.

Although this article provides comprehensive criteria for establishing HSCC on the basis of input from global experts, including both HCPs and patient representatives, the recommendations may need region-specific adaptation to ensure local relevance and feasibility. In particular, low- and middle-income countries may face substantial challenges, including shortages of specialist clinicians, limited access to specialized diagnostic resources, and fragmented healthcare systems, which could delay HS diagnosis and impede timely multidisciplinary management. As the expert panel did not include HCPs and patient representatives from low-income countries; inclusion of these perspectives might have provided valuable insights into the feasibility, adaptability, and accessibility of HSCCs in resource-constrained settings.

CONCLUSIONS

The findings of this study propose a series of evidence-based requirements for HSCCs. Ongoing research initiatives continue to identify several opportunities to improve care and optimize disease management for patients with HS. Timely diagnosis and early treatment initiation remain critical in symptom control, modifying disease progression, and eventually improving the QoL of patients with HS. HSCCs have the potential to offer comprehensive and effective care, addressing the multifaceted challenges associated with HS and contribution to better health outcomes for the patients.

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Data Availability. The data that support the findings of this study are available from the corresponding author upon reasonable request.

Declarations

Conflict of Interest. Angelo V Marzano reports consultancy/advisory boards' disease-relevant honoraria from AbbVie, Boehringer-Ingelheim, Bristol-Myers Squibb, Incyte, Johnson & Johnson, L'Oréal, LEO Pharma, Novartis Pharma, Pfizer, Sanofi and UCB Pharma. Falk G Bechara received honoraria for participation in advisory boards in clinical trials and/or as a speaker from AbbVie Inc., AbbVie Deutschland GmbH & Co. KG, Acelyrin, Beiersdorf, Boehringer-Ingelheim Pharma GmbH & Co. KG, Celltrion, Dr. Wolff, Incyte Corporation, Janssen-Cilag GmbH, Johnson & Johnson, Merck, Mölnlycke, MoonLake Immunotherapeutics, Novartis Pharma GmbH, Sanofi, Sitala and UCB Pharma. Vivian Y Shi is an Editorial Board member of Dermatology and Therapy. Vivian Y Shi was not involved in the selection of peer reviewers for the manuscript

nor any of the subsequent editorial decisions. Vivian Y Shi is on the board of directors for the Hidradenitis Suppurativa Foundation (HSF), an advisor for the National Eczema Association, is a stock shareholder of Learn Health and 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, Dermavant, Boehringer-Ingelheim, Almirall, Alumis, Aristea Therapeutics, Menlo Therapeutics, Dermira, Burt's Bees, Galderma, Kiniksa, UCB, Ceraclere, Bain Capital, Target-PharmaSolutions, Castle Bioscience, Altus Lab/cQuell, MYOR, Polyfins Technology, GpSkin and Skin Actives Scientific. Antonio Martorell is a member of the European Hidradenitis Suppurativa Foundation and has acted as a consultant, advisory board member and investigator for and has received honoraria from, Incyte, Novartis, AbbVie, Pfizer, Johnson & Johnson, UCB Pharma, Lilly, LEO Pharma, L'Oréal, Sanofi, Sandoz, Galderma Legit Health and Amgen. Jennifer L Hsiao is an Editor-in-Chief of Dermatology and Therapy. Jennifer L Hsiao was not involved in the selection of peer reviewers for the manuscript nor any of the subsequent editorial decisions. Jennifer L Hsiao is on the board of directors for the Hidradenitis Suppurativa Foundation and has served as an advisor, investigator and/or speaker for AbbVie, Aclaris, Boehringer Ingelheim, Galderma, Incyte, Novartis, Sanofi Regeneron and UCB Pharma. Hessel H Van der Zee has received honoraria as speaker or as member of an advisory board for UCB Pharma, Novartis, AbbVie, Incyte, Sanofi, InflaRX and Insmed. Axel P Villani reports consulting fees from Janssen-Cilag; payment or honoraria from AbbVie, Almirall, BMS, Janssen-Cilag, LEO Pharma, Eli Lilly, MSD, Novartis and UCB Pharma; and support for attending meetings or travel from Janssen-Cilag and UCB Pharma. Afsaneh Alavi serves as the board member of the Hidradenitis Suppurativa Foundation, received grants from the NIH, HSF, La Roche-Posay, serves as the chair of Independent Data Monitoring: InflaRX, Almirall, Zura Bio and a consultant for AbbVie, Almirall, Avalo, BI, Cantargia, InflaRx, Incyte, LEO Pharma, Sanofi, Navigator, Novartis and UCB Pharma and as an investigator for BI and Processa. John R Ingram is a consultant and/or advisory board member for AbbVie, Boehringer Ingelheim, Cantargia, ChemoCentryx, Citryll, Elasmogen, Engitix, Incyte, Indero, Insmed, Kymera Therapeutics, MoonLake Immunotherapeutics, Novartis, UCB Pharma, UNION Therapeutics and Viela Bio; received stipend as immediate past-Editor-in-Chief of the *British Journal of Dermatology* and an author honorarium from UpToDate and is a co-copyright holder of HiSQOL and Investigator and Patient Global Assessment instruments for HS. His department receives income from copyright of the Dermatology Life Quality Instrument (DLQI) and related instruments. Christopher J Sayed is a speaker for AbbVie, UCB Pharma and Novartis; has consulted for AbbVie, AstraZeneca, Novartis, InflaRx, UCB, Incyte, Sanofi, Navigator Medicines, Sonoma Biotherapeutics and Alumis; is an investigator for AbbVie, AstraZeneca, Novartis, InflaRx, UCB, Incyte and ChemoCentryx; has received grant funding from AbbVie; and is on the board of the HS Foundation, an unpaid position. Thrasyvoulos Tzellos reports consultancy/advisory boards/speaker fees from AbbVie, Novartis, Boehringer-Ingelheim, MSD and UCB Pharma. He is the treasurer of the EHSF e.V. Nisha Suyien Chandran has received fees for participation in advisory boards from fees from AbbVie, Johnson & Johnson, Sanofi, Pfizer, Novartis, L'Oréal and DKSH for participation in advisory boards; investigator fees for clinical trials from AbbVie, Novartis, Amgen, Sanofi and Boehringer-Ingelheim; and speaker honoraria from Galderma, Johnson & Johnson, Janssen, LEO Pharma, Lion Corporation, Sanofi and Pfizer. Qiang Ju None to declare. Ichiro Kurokawa is an Editorial Board member of Dermatology and Therapy. Ichiro Kurokawa was not involved in the selection of peer reviewers for the manuscript nor any of the subsequent editorial decisions. John W Frew has conducted advisory work for Janssen, Boehringer Ingelheim, Pfizer, Kyowa Kirin, LEO Pharma, Regeneron, ChemoCentryx, AbbVie, Azora, Novartis and UCB; has participated in trials for Pfizer, UCB, Boehringer-Ingelheim, Eli Lilly, CSL and Azora; and has received research support from Ortho Dermatologics, Sun Pharma, LEO Pharma, UCB and La Roche-Posay. Wayne

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Ethical Approval. This study did not require any patient information; hence no ethical review or approval was required. All the involved dermatologists who were part of the consensus gave their approval for the study to be published and were involved in the writing and/or revision of the manuscript.

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