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### Reply to Lipsker et al. and Revuz on Hidradenitis Suppurativa Terminology: The Imaging Point of View

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#### Key Words

Hidradenitis suppurativa · Terminology · Imaging

I read with great interest the articles published by Lipsker et al. [1, 2] and Revuz [3] on hidradenitis suppurativa (HS) terminology. Indeed, it is valuable to have a common clinical terminology for HS. This can provide a tool for supporting the reproducibility of the outcomes, both in the clinical and research areas.

However, the clinical concepts of nodule, sinus, fistula or tunnel may be limited due to the lack of anatomical information on the deep part of these 3-dimensional structures. Moreover, these abnormalities present coordinates of spatial location that may not necessarily fit with the information provided by palpation.

On imaging, the definition of a nodule is volumetric and implies a usually round or oval-shaped structure with a different pattern of density from the surrounding tissue at all its borders. Size can be a matter for discussion but is commonly around 0.5–1 cm. This concept has been used for defining and monitoring lung or thyroid nodules for example on computed tomography and ultrasound [4–7].

Thus, the clinical dermatological description of a nodule may be more similar to a lump or bump. In our experience, working on ultrasound imaging, we actually do not see well-defined nodules when we study clinically named nodules in HS patients. Usually, these clinical nodules correspond to fluid collections or fistulous tracts with or without inflammatory signs (increased vascularity). The drainage openings are usually connected to fluid collections or fistulous tracts running underneath sometimes apparently normal skin in the vicinity. The cords frequently correspond to fistulous tracts with prominent fibrotic scarring; nevertheless, not all the palpable cords exactly match fistulae, and some of them can be just scarring. Besides that, there are nonpalpable fistulous tracts, hidden to the clinical examination, that run through the dermis and hypodermis sometimes for several centimeters, which do not open to the surface and just connect to the widened base of regional hair follicles or to other fistulous tracts.

Furthermore, the latter experience has been reported by researchers working in different countries [8, 9].

Therefore, considering the information and definitions of key subclinical anatomical lesions (pseudocyst, fluid collection, fistulous tract) in HS that have been described by imaging, particularly color Doppler ultrasound in the adult and pediatric population [8, 10], the initial clinical discordance between experts reported by Lipsker et al. [1] is not surprising. Moreover, the difficulty of achieving common definitions on just clinically based examinations or staging systems that could match the actual anatomical abnormalities with their exact spatial positioning and volumetric features is also to be expected.

Therefore, from the imaging point of view, the usage of an anatomically based common terminology in HS that could bring together the experience of a multispecialist team with clinicians, imaging professionals and pathologists may perhaps simplify the task in the future.

#### Disclosure Statement

The author has no conflicts of interest to disclose.

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