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Amelioration of long-term hidradenitis suppurativa by treating the patient with the dopamine agonist cabergoline

Abstract

Hidradenitis Suppurativa (HS) is an autoimmune condition that presents with painful oozing nodules that favor the inguinal and axillary areas, but can be present in other areas. It is more annoying than lethal, but it can disrupt quality of life. There is no effective standard therapy. Immune suppressors sometimes work, but they may cause the risk of significant adverse event events e.g., infection, or cancer. The condition itself does make patients more susceptible to cutaneous squamous cell carcinoma in the affected area. The case described here clearly shows a very good response to a very benign type of treatment, and that is cabergoline, a dopamine agonist which acts to decrease cellular permeability, and thus may inhibit infusion of toxic elements into the dermis, thus correcting the etiology of the problem similar to its action in effectively treating a large number of chronic refractory conditions. Hopefully this case report will influence other clinicians to try it on patients with HS and report their experience.

Keywords: Hidradenitis Suppurativa; Increased Cellular Permeability Syndrome; Dopamine Agonist; Cabergoline.

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Introduction

Hidradenitis Suppurativa (HS) is a chronic inflammatory disease that is not fully understood. Patients often present with deep painful nodules in the auxiliary, inguinal, genito anal or inframammary areas that can progress to abscesses or drainage tunnels in the skin [1]. These lesions often last an average of 7 to 15 days, but can persist for weeks or months [2]. The pathophysiology of HS is still being studied. Multiple hypotheses have been presented, including involvement of the innate immune system, B and T cell mechanisms, lifestyle factors, and genetic factors [1,2]. Pre-menstrual flares and pregnancy related associations have also been reported suggesting endocrine involvement in female patients [3].

The prevalence of this disease varies from 0.05% to 4.1% and more commonly affects females [2]. There have also been connections drawn between HS and metabolic syndrome, inflammatory arthritis, inflammatory bowel disease, and autoimmune diseases, such as systemic lupus erythematosus.

Diagnostic standards for HS require the presence of inflammatory painful skin lesions, occurring in one or more common sites associated with HS, and chronic or recurrent inflammation [2]. Due to the complexity of the disease treatment options vary among different pharmaceutical therapies and surgical options. Current drug therapies include topical antiseptics, topical antibiotics, intralesional steroid injections, hormonal therapies, and therapies targeting TNF and IL-17 specifically for moderate to severe disease [1]. Surgical

intervention often consists of incision and drainage techniques as well as ablative laser use [2]. Lifestyle modifications have also been suggested such as weight loss, smoking cessation, and avoidance of friction or irritating products on the skin [1].

There are many dermatologic conditions that have been successfully treated with dopamine agonists, especially dextroamphetamine sulfate [4-15]. Though local factors may determine the exact pathological presentation, the main initiating event may well be increased cellular permeability leading to the infusion of normally precluded unwanted elements into various tissues leading to a cellular immune inflammatory response [16]. According to the hypothesis, the permeability defect may co-exist in other organ systems leading to an association with non-dermatologic maladies [17,18]. The reason for using dopamine agonists is based on the effect of dopamine on decreasing cellular permeability and thus eliminating irritants crossing the mucosal barrier [17,19].

Though most of the successful cases have been treated with the dopamine agonist dextroamphetamine sulfate, some cases have been treated with the dopamine agonist cabergoline e.g., for dysmenorrhea, headaches, stomatodynia, and carpal tunnel syndrome [20-24]. A case is reported where HS was ameliorated by treatment with cabergoline.

Case report

The patient originally sought our opinion to help her conceive with primary infertility of 3 years duration. She was found to have Diminished Oocyte Reserve (DOR) with a serum anti-mullerian hormone level of 0.592 ng/ml. She was aged 30 and she had dysmenorrhea, but her only premenstrual symptom was a backache starting several days before her menses.

Her past history was positive otherwise for a 13-year history of HS. Her episodes consisting of painful plus oozing nodules occurred mainly in the inguinal and genito-anal area (80% of the time) but sometimes also included the axillae (20% of the time). The episodes were frequent and lasted several weeks at a time so that she would never have more than a month without these lesions.

Treatment with various antibiotics did not help nor did treatment with spironolactone 200 mg per day. Her serum androgen levels were not elevated with the serum Testosterone (T) was only 8 ng/dl (normal 13 to 71 according to LabCorp), a serum free T of 0.7 pg/nl (nl= 0.0 to 4.2), a serum dehydroepiandrosterone sulfate level of 60.5 µg/dl (84.8-378.0).

On initial examination, she had inflammatory nodules bilateral in the inguinal region that were red and oozing pus. This is despite being on adalimumab for almost one year.

She stated that in her opinion adalimumab did not ameliorate either the intensity of the outbreak or the frequency. The nodules had been present now for 3 weeks and were progressively worsening. The last episode ended at 5 weeks previously.

She was starting on cabergoline for two purposes. One purpose was to help prevent immune rejection of the fetus by reducing probable excessive cellular immunity leading to immune destruction of the embryo. This was probably the reason for the DOR [25]. We advised her that dopamine agonists can improve fecundity, especially in women with DOR [26,27]. This treatment would also likely ameliorate the premenstrual backaches [28,29].

Secondly, we advised her that we suspect that dopamine agonist therapy may improve the HS based on our experience of helping several unreported cases treated with dextroamphetamine sulfate. We would have initiated treatment with dextroamphetamine sulfate, except there is a law in New Jersey, the state where she lives, and the home of one of our offices, that precludes off-label use of a drug with a class II narcotic restriction.

Since she saw no improvement with 0.5 mg cabergoline twice a day. (But no side effects) we increased the dosage to 0.5 mg 3 times per week. Within one week there was 100% disappearance of the lesions. It has now been six months without a return of her HS. The longest remission she has had in 13 years was two months. For personal reasons she decided to defer attempts to conceive.

Discussion/Conclusion

It is not clear why such a safe drug like dextroamphetamine sulfate, which is non-addicting in the dosage used, has a class II narcotic restriction. Lately, even in states without the strange law of New Jersey restricting the prescription of amphetamines only for on label use e.g., attention deficit hyperactivity disorder, or depression.

For some reason in these authors' opinions, they have made physicians and pharmacist paranoid about writing or filling the prescription. Thus, when we see some of the same conditions helped by a dopamine agonist with no restriction e.g., cabergoline, we will report it. In general, we do not find cabergoline as effective as dextroamphetamine sulfate, but possibly it could be from using dosages meant for galactorrhea or prolactinoma that are lower dosages. Nevertheless, we have some evidence that another dopamine agonist, carbidopa-levodopa in low dosages of 10/100 twice daily, may be at effective as dextroamphetamine [30].

It is hoped that this reported case will encourage other physicians to try dopamine agonists not just for HS, but other chronic autoimmune conditions and publish their experiences whether positive or negative.

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