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ЕЖЕМЕСЯЧНЫЙ НАУЧНЫЙ ЖУРНАЛ

Медицинские новости Грузии

საქართველოს სამედიცინო სიახლენი

GEORGIAN MEDICAL NEWS

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GMN: Georgian Medical News is peer-reviewed, published monthly journal committed to promoting the science and art of medicine and the betterment of public health, published by the GMN Editorial Board since 1994. GMN carries original scientific articles on medicine, biology and pharmacy, which are of experimental, theoretical and practical character; publishes original research, reviews, commentaries, editorials, essays, medical news, and correspondence in English and Russian.

GMN is indexed in MEDLINE, SCOPUS, PubMed and VINITI Russian Academy of Sciences. The full text content is available through EBSCO databases.

GMN: Медицинские новости Грузии - ежемесячный рецензируемый научный журнал, издаётся Редакционной коллегией с 1994 года на русском и английском языках в целях поддержки медицинской науки и улучшения здравоохранения. В журнале публикуются оригинальные научные статьи в области медицины, биологии и фармации, статьи обзорного характера, научные сообщения, новости медицины и здравоохранения. Журнал индексируется в MEDLINE, отражён в базе данных SCOPUS, PubMed и ВИНИТИ РАН. Полнотекстовые статьи журнала доступны через БД EBSCO.

GMN: Georgian Medical News – საქართველოს სამედიცინო სიახლენი – არის ყოველთვიური სამეცნიერო სამედიცინო რეცენზირებადი ჟურნალი, გამოიცემა 1994 წლიდან, წარმოადგენს სარედაქციო კოლეგიისა და აშშ-ის მეცნიერების, განათლების, ინდუსტრიის, ხელოვნებისა და ბუნებისმეტყველების საერთაშორისო აკადემიის ერთობლივ გამოცემას. GMN-ში რუსულ და ინგლისურ ენებზე ქვეყნდება ექსპერიმენტული, თეორიული და პრაქტიკული ხასიათის ორიგინალური სამეცნიერო სტატიები მედიცინის, ბიოლოგიისა და ფარმაციის სფეროში, მიმოხილვითი ხასიათის სტატიები.

ჟურნალი ინდექსირებულია MEDLINE-ის საერთაშორისო სისტემაში, ასახულია SCOPUS-ის, PubMed-ის და ВИНИТИ РАН-ის მონაცემთა ბაზებში. სტატიების სრული ტექსტი ხელმისაწვდომია EBSCO-ს მონაცემთა ბაზებიდან.

WEBSITE

www.geomednews.com

К СВЕДЕНИЮ АВТОРОВ!

При направлении статьи в редакцию необходимо соблюдать следующие правила:

1. Статья должна быть представлена в двух экземплярах, на русском или английском языках, напечатанная через **полтора интервала на одной стороне стандартного листа с шириной левого поля в три сантиметра**. Используемый компьютерный шрифт для текста на русском и английском языках - **Times New Roman** (**Кириллица**), для текста на грузинском языке следует использовать **AcadNusx.** Размер шрифта - **12**. К рукописи, напечатанной на компьютере, должен быть приложен CD со статьей.

2. Размер статьи должен быть не менее десяти и не более двадцати страниц машинописи, включая указатель литературы и резюме на английском, русском и грузинском языках.

3. В статье должны быть освещены актуальность данного материала, методы и результаты исследования и их обсуждение.

При представлении в печать научных экспериментальных работ авторы должны указывать вид и количество экспериментальных животных, применявшиеся методы обезболивания и усыпления (в ходе острых опытов).

4. К статье должны быть приложены краткое (на полстраницы) резюме на английском, русском и грузинском языках (включающее следующие разделы: цель исследования, материал и методы, результаты и заключение) и список ключевых слов (key words).

5. Таблицы необходимо представлять в печатной форме. Фотокопии не принимаются. **Все цифровые, итоговые и процентные данные в таблицах должны соответствовать таковым в тексте статьи**. Таблицы и графики должны быть озаглавлены.

6. Фотографии должны быть контрастными, фотокопии с рентгенограмм - в позитивном изображении. Рисунки, чертежи и диаграммы следует озаглавить, пронумеровать и вставить в соответствующее место текста **в tiff формате**.

В подписях к микрофотографиям следует указывать степень увеличения через окуляр или объектив и метод окраски или импрегнации срезов.

7. Фамилии отечественных авторов приводятся в оригинальной транскрипции.

8. При оформлении и направлении статей в журнал МНГ просим авторов соблюдать правила, изложенные в «Единых требованиях к рукописям, представляемым в биомедицинские журналы», принятых Международным комитетом редакторов медицинских журналов - http://www.spinesurgery.ru/files/publish.pdf и http://www.nlm.nih.gov/bsd/uniform_requirements.html
В конце каждой оригинальной статьи приводится библиографический список. В список литературы включаются все материалы, на которые имеются ссылки в тексте. Список составляется в алфавитном порядке и нумеруется. Литературный источник приводится на языке оригинала. В списке литературы сначала приводятся работы, написанные знаками грузинского алфавита, затем кириллицей и латиницей. Ссылки на цитируемые работы в тексте статьи даются в квадратных скобках в виде номера, соответствующего номеру данной работы в списке литературы. Большинство цитированных источников должны быть за последние 5-7 лет.

9. Для получения права на публикацию статья должна иметь от руководителя работы или учреждения визу и сопроводительное отношение, написанные или напечатанные на бланке и заверенные подписью и печатью.

10. В конце статьи должны быть подписи всех авторов, полностью приведены их фамилии, имена и отчества, указаны служебный и домашний номера телефонов и адреса или иные координаты. Количество авторов (соавторов) не должно превышать пяти человек.

11. Редакция оставляет за собой право сокращать и исправлять статьи. Корректура авторам не высылается, вся работа и сверка проводится по авторскому оригиналу.

12. Недопустимо направление в редакцию работ, представленных к печати в иных издательствах или опубликованных в других изданиях.

При нарушении указанных правил статьи не рассматриваются.

REQUIREMENTS

Please note, materials submitted to the Editorial Office Staff are supposed to meet the following requirements:

1. Articles must be provided with a double copy, in English or Russian languages and typed or compu-ter-printed on a single side of standard typing paper, with the left margin of **3** centimeters width, and **1.5** spacing between the lines, typeface - **Times New Roman** (**Cyrillic**), print size - **12** (referring to Georgian and Russian materials). With computer-printed texts please enclose a CD carrying the same file titled with Latin symbols.

2. Size of the article, including index and resume in English, Russian and Georgian languages must be at least 10 pages and not exceed the limit of 20 pages of typed or computer-printed text.

3. Submitted material must include a coverage of a topical subject, research methods, results, and review.

Authors of the scientific-research works must indicate the number of experimental biological species drawn in, list the employed methods of anesthetization and soporific means used during acute tests.

4. Articles must have a short (half page) abstract in English, Russian and Georgian (including the following sections: aim of study, material and methods, results and conclusions) and a list of key words.

5. Tables must be presented in an original typed or computer-printed form, instead of a photocopied version. **Numbers, totals, percentile data on the tables must coincide with those in the texts of the articles.** Tables and graphs must be headed.

6. Photographs are required to be contrasted and must be submitted with doubles. Please number each photograph with a pencil on its back, indicate author's name, title of the article (short version), and mark out its top and bottom parts. Drawings must be accurate, drafts and diagrams drawn in Indian ink (or black ink). Photocopies of the X-ray photographs must be presented in a positive image in **tiff format**.

Accurately numbered subtitles for each illustration must be listed on a separate sheet of paper. In the subtitles for the microphotographs please indicate the ocular and objective lens magnification power, method of coloring or impregnation of the microscopic sections (preparations).

7. Please indicate last names, first and middle initials of the native authors, present names and initials of the foreign authors in the transcription of the original language, enclose in parenthesis corresponding number under which the author is listed in the reference materials.

8. Please follow guidance offered to authors by The International Committee of Medical Journal Editors guidance in its Uniform Requirements for Manuscripts Submitted to Biomedical Journals publication available online at: http://www.nlm.nih.gov/bsd/uniform_requirements.html
http://www.icmje.org/urm_full.pdf
In GMN style for each work cited in the text, a bibliographic reference is given, and this is located at the end of the article under the title "References". All references cited in the text must be listed. The list of references should be arranged alphabetically and then numbered. References are numbered in the text [numbers in square brackets] and in the reference list and numbers are repeated throughout the text as needed. The bibliographic description is given in the language of publication (citations in Georgian script are followed by Cyrillic and Latin).

9. To obtain the rights of publication articles must be accompanied by a visa from the project instructor or the establishment, where the work has been performed, and a reference letter, both written or typed on a special signed form, certified by a stamp or a seal.

10. Articles must be signed by all of the authors at the end, and they must be provided with a list of full names, office and home phone numbers and addresses or other non-office locations where the authors could be reached. The number of the authors (co-authors) must not exceed the limit of 5 people.

11. Editorial Staff reserves the rights to cut down in size and correct the articles. Proof-sheets are not sent out to the authors. The entire editorial and collation work is performed according to the author's original text.

12. Sending in the works that have already been assigned to the press by other Editorial Staffs or have been printed by other publishers is not permissible.

Articles that Fail to Meet the Aforementioned Requirements are not Assigned to be Reviewed.

ავტორთა საყურადღებოდ!

რედაქციაში სტატიის წარმოდგენისას საჭიროა დავიცვათ შემდეგი წესები:

1. სტატია უნდა წარმოადგინოთ 2 ცალად, რუსულ ან ინგლისურ ენებზე,დაბეჭდილი სტანდარტული ფურცლის 1 გვერდზე, 3 სმ სიგანის მარცხენა ველისა და სტრიქონებს შორის 1,5 ინტერვალის დაცვით. გამოყენებული კომპიუტერული შრიფტი რუსულ და ინგლისურენოვან ტექსტებში - **Times New Roman (Кириллица)**, ხოლო ქართულენოვან ტექსტში საჭიროა გამოვიყენოთ **AcadNusx.** შრიფტის ზომა – 12. სტატიას თან უნდა ახლდეს CD სტატიით.

2. სტატიის მოცულობა არ უნდა შეადგენდეს 10 გვერდზე ნაკლებს და 20 გვერდზე მეტს ლიტერატურის სიის და რეზიუმეების (ინგლისურ, რუსულ და ქართულ ენებზე) ჩათვლით.

3. სტატიაში საჭიროა გაშუქდეს: საკითხის აქტუალობა; კვლევის მიზანი; საკვლევი მასალა და გამოყენებული მეთოდები; მიღებული შედეგები და მათი განსჯა. ექსპერიმენტული ხასიათის სტატიების წარმოდგენისას ავტორებმა უნდა მიუთითონ საექსპერიმენტო ცხოველების სახეობა და რაოდენობა; გაუტკივარებისა და დაძინების მეთოდები (მწვავე ცდების პირობებში).

4. სტატიას თან უნდა ახლდეს რეზიუმე ინგლისურ, რუსულ და ქართულ ენებზე არანაკლებ ნახევარი გვერდის მოცულობისა (სათაურის, ავტორების, დაწესებულების მითითებით და უნდა შეიცავდეს შემდეგ განყოფილებებს: მიზანი, მასალა და მეთოდები, შედეგები და დასკვნები; ტექსტუალური ნაწილი არ უნდა იყოს 15 სტრიქონზე ნაკლები) და საკვანძო სიტყვების ჩამონათვალი (key words).

5. ცხრილები საჭიროა წარმოადგინოთ ნაბეჭდი სახით. ყველა ციფრული, შემაჯამებელი და პროცენტული მონაცემები უნდა შეესაბამებოდეს ტექსტში მოყვანილს.

6. ფოტოსურათები უნდა იყოს კონტრასტული; სურათები, ნახაზები, დიაგრამები - დასათაურებული, დანომრილი და სათანადო ადგილას ჩასმული. რენტგენოგრამების ფოტოასლები წარმოადგინეთ პოზიტიური გამოსახულებით **tiff** ფორმატში. მიკროფოტოსურათების წარწერებში საჭიროა მიუთითოთ ოკულარის ან ობიექტივის საშუალებით გადიდების ხარისხი, ანათალების შეღებვის ან იმპრეგნაციის მეთოდი და აღნიშნოთ სურათის ზედა და ქვედა ნაწილები.

7. სამამულო ავტორების გვარები სტატიაში აღინიშნება ინიციალების თანდართვით, უცხოურისა – უცხოური ტრანსკრიპციით.

8. სტატიას თან უნდა ახლდეს ავტორის მიერ გამოყენებული სამამულო და უცხოური შრომების ბიბლიოგრაფიული სია (ბოლო 5-8 წლის სიღრმით). ანბანური წყობით წარმოდგენილ ბიბლიოგრაფიულ სიაში მიუთითეთ ჯერ სამამულო, შემდეგ უცხოელი ავტორები (გვარი, ინიციალები, სტატიის სათაური, ჟურნალის დასახელება, გამოცემის ადგილი, წელი, ჟურნალის №, პირველი და ბოლო გვერდები). მონოგრაფიის შემთხვევაში მიუთითეთ გამოცემის წელი, ადგილი და გვერდების საერთო რაოდენობა. ტექსტში კვადრატულ ფჩხილებში უნდა მიუთითოთ ავტორის შესაბამისი N ლიტერატურის სიის მიხედვით. მიზანშეწონილია, რომ ციტირებული წყაროების უმეტესი ნაწილი იყოს 5-6 წლის სიღრმის.

9. სტატიას თან უნდა ახლდეს: ა) დაწესებულების ან სამეცნიერო ხელმძღვანელის წარდგინება, დამოწმებული ხელმოწერითა და ბეჭდით; ბ) დარგის სპეციალისტის დამოწმებული რეცენზია, რომელშიც მითითებული იქნება საკითხის აქტუალობა, მასალის საკმაობა, მეთოდის სანდოობა, შედეგების სამეცნიერო-პრაქტიკული მნიშვნელობა.

10. სტატიის ბოლოს საჭიროა ყველა ავტორის ხელმოწერა, რომელთა რაოდენობა არ უნდა აღემატებოდეს 5-ს.

11. რედაქცია იტოვებს უფლებას შეასწოროს სტატია. ტექსტზე მუშაობა და შეჯერება ხდება საავტორო ორიგინალის მიხედვით.

12. დაუშვებელია რედაქციაში ისეთი სტატიის წარდგენა, რომელიც დასაბეჭდად წარდგენილი იყო სხვა რედაქციაში ან გამოქვეყნებული იყო სხვა გამოცემებში.

აღნიშნული წესების დარღვევის შემთხვევაში სტატიები არ განიხილება.

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OCULAR MANIFESTATIONS IN A PATIENT WITH HIDRADENITIS SUPPURATIVA: A CASE STUDY

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Abstract.

Background: Patients with chronic inflammatory skin disease called hidradenitis suppurativa (HS), which can also produce systemic comorbidities, show ocular symptoms. Although HS has dermatological roots, if left untreated it can cause major ocular issues like dry eye syndrome and corneal neovascularization, therefore affecting eyesight.

Case description: Our patient, a 19-year-old man with corneal neovascularization, scarring, bilateral dry eye disease, uncontrolled HS, and other medical disorders, after a year of therapy with adalimumab failed to sufficiently control the illness, secukinumab (300 mg monthly) and concomitant oral doxycycline (100 mg twice daily) were prescribed to reduce inflammation and prevent subsequent infections. As shown by ophthalmologic findings, bilateral corneal neovascularization, stromal infiltrates, and chronic inflammation helped to explain ocular discomfort and reduced quality of life. Both eyes maintained visual acuity at 6/6 even though corneal scarring could cause future damage.

Management and treatment: A multidisciplinary team under management of the patient comprised ophthalmology and dermatology doctors. Using continuous systemic treatment, management of HS flares and ocular inflammation is the ocular treatment included Tobradex, Lumify, artificial tears; more modern treatments like anti-VEGF therapy were under consideration for cases of progressive neovascularization.

Conclusion: As this case shows, a multidisciplinary approach is absolutely essential when tackling HS including the eyes. Early diagnosis and tailored treatment plans allow one to improve patient outcomes, maintain visual function, and minimize repercussions. More study is needed to better grasp the pathophysiology of HS-related ocular problems and create more sensible treatment plans.

Key words. Ocular Manifestations, bilateral dry eye disease, Hidradenitis Suppurativa.

Introduction.

Hidradenitis suppurativa (HS) is a chronic, recurrent inflammatory skin disorder that primarily affects areas rich in apocrine glands, such as the axillae, groin, and buttocks. The symptoms of the condition are painful, deep-seated abscesses, sinus tracts, and scarring causing major morbidity and poor quality of life. The relevant lesions could show up as pustules, nodules, papules, or fistulas. Though common in other autoimmune diseases, ocular comorbidities in HS are not well known [1]. HS is mostly observed on the skin, it is now known to have systemic effects that can include metabolic syndrome, Crohn's disease, and most importantly, ocular disorders including dry eye, corneal neovascularization, and corneal scarring [2]. When the immune system is disrupted and inflammation all across the body, a condition known as hydradenitis suppurativa (HS). Though exact frequency of keratopathy and keratitis is unknown, research indicates that HS is linked to more common eye disorders [3,4] claim that the deregulation of the immune system more especially, in the tumor necrosis factor (TNF) pathway is thought to be a pathogenetic component for HS. For this reason, moderate to severe cases are being treated with biologic drugs like tumor necrosis factor (TNF) inhibitors and interleukin (IL)-17 inhibitors. Although the role of the ocular system in HS patients is still quite poorly investigated, it is becoming evident that systematic inflammation linked with HS might have severe ocular symptoms. Untreated ocular conditions include dry eye syndrome, and corneal neovascularization could cause these patients to lose their vision permanently [5]. Moreover, the management of different eye diseases requires a multidisciplinary approach including ophthalmologic and dermatological therapy. This method treats disease-related skin and ocular problems as well. Here, we observe the need of coordinated therapy methods in the complex clinical situation of a 19-year-old man with untreated HS and concomitant ocular symptoms.

Previous cohort studies (Lee et al. & Saygın et al.) [6,7] shown that HS and inflammatory eye diseases were both present; anterior uveitis was the most often occurring eye symptom in both groups. The most often occurring problems in HS patients were episcleritis, optic neuritis, and keratitis [6]. After 62 patients with HS were discovered to have 4 incidences of interstitial keratitis Bergeron and Stone [8], a case report first proposed the relationship between HS and corneal disease in 1967. Two following case studies of HS patients responding favorably to immunotherapy using adalimumab noted bilateral interstitial keratitis [9]. Earlier case studies of male patients with HS point to peripheral ulcerative keratitis Dallalzadeh et al. [10], in addition to non-ulcerating corneal inflammation as a possible association. There is a need to clarify it since the relationship to interstitial keratitis was not important and confusing elements were not completely addressed. There was no interstitial keratitis but a notably higher rate of keratitis in the HS group. Furthermore, a recent study and meta-analysis revealed that psoriasis and HS coexist together and share an inflammatory mechanism [1]. Given Lee et al. [11] found an enhanced incidence of keratopathy in psoriasis patients, we infer that HS patients may also have an elevated risk of keratopathy.

Case description.

A male patient with a history of hidradenitis suppurativa (HS), 19 years old, is scheduled for a follow-up visit with dermatologists and ophthalmologists. For a year the patient had been receiving systemic treatment for HS using adalimumab (Humira). Their illness management was inadequate; hence they were recently transferred to secukinumab (300 mg monthly). The patient was also provided oral doxycycline, 100 mg twice daily, for two months to lower inflammation and prevent more infections. The patient suffers from HS, dry eye

syndrome, bilateral corneal neovascularization, and other visual issues aggravating the eyes. Ocular results are corneal scarring and chronic inflammation. The patient's symptoms, which are influencing their daily activities, need a thorough approach.

Medical History:

The patient has a history of bilateral dry eye disease, corneal neovascularization, corneal scarring, and uncontrolled hidradenitis suppurativa. Visual acuity on ophthalmic examination was 6/6 in the right eye and 6/6p in the left. The right eye's intraocular pressure was 14 mmHg, whereas the left eye's was 17 mmHg. Evaluation of the anterior segment showed that both eyes had a normal punctal opening and lacrimal system, with no periorbital edema, erythema, or abnormalities of the eyelids. A slit-lamp examination revealed corneal neovascularization, two little patches of deep subepithelial stromal infiltrates, and a papillary reaction in the conjunctiva of both eyes. The results of the posterior region showed a blunt macular reflex, normal vascular, and a flat and connected retina. There were no indications of disc atrophy or edema, and the optic nerves showed a normal cup-to-disc ratio. The patient was diagnosed with bilat-eral dry eye syndrome, corneal neovascularization (Figure 1), corneal scarring (Figure 2), and hidradenitis suppurativa (uncontrolled) based on these findings.

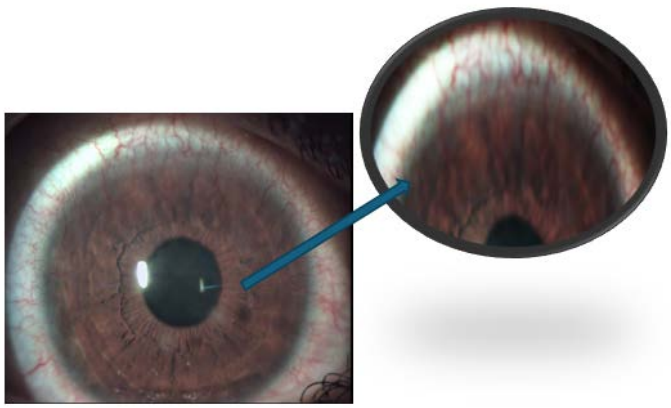

Figure 1. *The patient was diagnosed with bilateral dry eye syndrome, corneal neovascularization.*

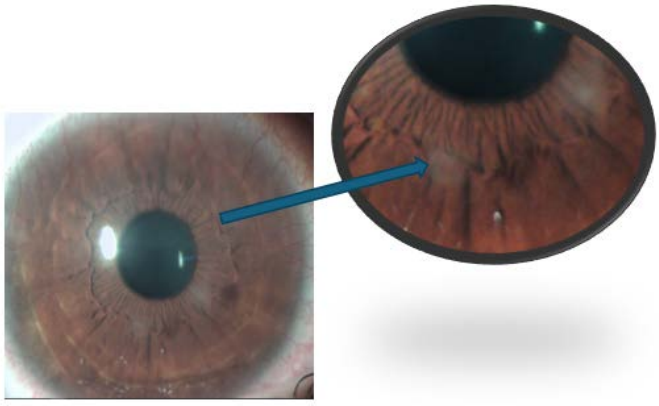

Figure 2. *Corneal scarring.*

Diagnosis:

- Hidradenitis Suppurativa (uncontrolled).
- Dry Eye Syndrome (bilateral).
- Corneal Neovascularization (bilateral).
- Corneal Scarring (bilateral).

Treatment Plan:

- Hidradenitis Suppurativa.
- Continue secukinumab (300 mg monthly).
- Start oral doxycycline (100 mg twice daily) for two months to reduce inflammation and control secondary infection.
- If no improvement after two months, consider escalating therapy with oral isotretinoin and increase secukinumab to 300 mg every two weeks.

Dry Eye Syndrome:

- Continue treatment with Tobradex (QPM) and Lumify (BID).
- Consider adding artificial tears and cyclosporine A ophthalmic emulsion (Restasis) if symptoms persist.
- Corneal Neovascularization and Scarring:
- Regular slit-lamp evaluations to monitor progression.
- If vision is significantly affected, consider anti-VEGF injections or corneal cross-linking to address neovascularization and improve corneal integrity.

Follow-Up:

- The patient will visit one more two months to have another assessment of the effectiveness of the doxycycline and secukinumab. The course of HS will decide whether starting oral isotretinoin is advisable. Ophthalmologic follow-ups will help to monitor the corneal neovascularization and subepithelial stromal infiltrates.

Discussion.

The mental and physical effects of hidradenitis suppurativa (HS) are severe since the hallmarks of the disorder recurring abscesses and scarring can create stigma and handicaps down the road [12]. Ocular symptoms and other related comorbidities have lately attracted increasing attention in HS treatment, hence changing the emphasis from dermatologic treatments long the basis of the condition to the systemic character of the illness. A previous study by Saygın et al. [7] indicates that, in the framework of HS, uveitis is the most often occurring sign of inflammatory ocular diseases (IED). Of the cases cited in these articles, just 23.5% (15 cases) and 5.0% (14) developed keratitis.

Case investigations of HS patients have revealed numerous types of IED in addition to keratoconjunctivitis sicca [13], phlyctenular keratoconjunctivitis [14], interstitial keratitis [9], and peripheral ulcerative keratitis [10].

In our study, we found that patients with HS had a higher risk of developing keratitis and keratopathy. Some systemic conditions associated with HS, as reported in previous studies, have also been linked to previous diseases, further supporting this association [1,9,15].

Dry eye syndrome (DES) is commonly observed in patients with systemic inflammatory conditions, including HS, due to the inflammatory mediators affecting the lacrimal glands and conjunctiva [16]. In this patient, dry eye symptoms have contributed to significant discomfort and visual impairment.

The management of DES typically includes anti-inflammatory treatments such as corticosteroid eye drops, cyclosporine A ophthalmic emulsion (Restasis), and lubricating artificial tears. The use of Tobradex and Lumify in this patient has been a prudent step in managing the ocular inflammation, but additional therapies may be needed if symptoms persist [17].

Since HS is a chronic illness, it is imperative to regularly check and manage dry eye symptoms to prevent severe eye damage. Due to continuous ocular inflammation and ischemia, another HS effect known as corneal neovascularization (CNV) creates new blood vessels into the once avascular cornea. Systemic inflammatory illnesses, including HS, hasten this process starting from an increase in vascular endothelial growth factor (VEGF). From CNV over time vision loss, corneal scarring, and other issues can arise [18]. Given scarring and bilateral corneal neovascularization already observed, it is imperative to constantly monitor this patient and seek therapies to stop any more loss of vision function. As per previous published literature, Adalimumab did not adequately control the patient's HS, hence secukinumab—a monoclonal antibody targeted at interleukin-17A—was administered. Secukinumab has shown promise in treating moderate to severe HS since it can alter the inflammatory cascade and lower the frequency of flare-ups. Regarding ocular involvement, secukinumab's capacity to lower systemic inflammation could perhaps also help to relieve ocular problems. Should the patient show no progress after two months, further therapeutic choices such oral isotretinoin could be investigated [19]. Secukinumab, an IL -17 inhibitor, has been evaluated in SUNSHINE and SUNRISE phase 3 clinical trials for HS and have shown better outcomes observed in severe cases when administered every 2 weeks. The efficacy was sustained through 52 weeks showing improvements in abscess count, inflammatory nodules and pain reduction [20-23]. Also in our study, oral doxycycline has been advised to assist reduce the inflammation in the patient's eyes and prevent secondary infections, which can strike those with HS and accompany the skin lesions. Antibiotics like doxycycline can help control the inflammatory nature of HS, particularly in cases when an infection is suspected or already present. Dealing with HS that has acquired eye issues calls for a multimodal strategy. In this way, combining both ophthalmologic and dermatological treatment have shown good patient outcomes by properly managing both the skin and ocular problems. Regular dermatological and ophthalmological follow-up visits are absolutely essential to monitor the evolution of HS and the state of the neovascularization and scarring in the cornea. Furthermore, if eyesight is seriously compromised, more complicated treatments such anti-VEFG therapy or corneal cross-linking can be needed to solve the eye problems [15].

Conclusion.

This case study shows the difficult problems related to the therapy of hidradenitis suppurativa (HS) and its obvious ocular symptoms in a young patient. This emphasizes even more the requirement of multidisciplinary approaches offering treatment considering the dermatologic and ophthalmologic aspects of the illness. The mix of corneal neovascularization, scarring, and dry eye condition of this patient emphasizes the systemic consequences of HS and the need of customized treatment approaches. Avoiding irreversible repercussions like vision loss, which can significantly affect the patient's quality of life, depends on quick and efficient treatment. Combining targeted ophthalmologic treatment with systemic drugs, including secukinumab, which seeks to alter inflammatory pathways, shows the value of tailored therapeutic programs. To keep visual function in cases of progressive ocular damage, sophisticated treatments includ-ing corneal cross-linking and anti-VEGF therapy could be required. This case study also emphasizes the significance of spotting systematic diseases like HS early and controlling them aggressively to lower their effect on general health. Regular follow-up visits and cooperation among dermatologists, ophthalmol-ogists, and other pertinent experts let one monitor the evolution of a condition and modify treatment.

Ultimately, this case illustrates how holistically treating HS and associated comorbidities will improve patient outcomes. More research is required to build evidence-based guidelines for integrated management and to better grasp the processes generating ocular involvement in HS.

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