

False Treatment Technique for Pilonidal Sinus Disease

Pilonidal Sinüs Tedavisinde Yanlış Yöntem Seçimi

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Özet

Sakrokoksigeal pilonidal sinüs hastalığının (SPH) ideal tedavisinde hastalara en az zarar veren, nüks oranı düşük ve en kısa zamanda normal çalışma gücüne dönmesini sağlayan yöntemler tercih edilmelidir. Bu olgumuzda, bir ay önce eksizyon ve primer onarım yöntemi ile tedavi edilmiş ancak kısa sürede enfeksiyon ve yara açılması ile başvuran bir olguyu sunduk. Yirmiüç yaşında erkek hasta, 10 gündür devam eden intergluteal akıntı ve ağrı şikâyetleri ile acil servise başvurdu. Hastaya bir ay önce dış bir merkezde pilonidal sinüs tanısı ile eksizyon ve primer onarım uygulandı. Hastanın muayenesinde; intergluteal alanda enfekte, sütürleri açılmış ve cilt altında geniş bir boşluk saptandı. Bizim yaptığımız ikinci operasyonda; cilt altı boşlukları ve açılmış yarayı içine alan modifiye eşkenar dörtgen şeklinde eksizyon ve sağ taraftan hazırlanan cilt flebi ile primer onarım uygulandı. Hasta postoperatif 3. gün taburcu edildi ve postoperatif 5.günde dergi çekildi. Hasta postoperatif 20. günde herhangi bir komplikasyon olmadan tamamen iyileşti. Olgumuz benzersiz ya da nadir değildir. Ancak, biz SPH tedavisi için en uygun yöntemin ülkemizdeki tüm cerrahlar tarafından bilinmesi ve uygulanması gerektiğini düşünüyoruz.

Anahtar kelimeler: Pilonidal sinüs, tedavi yöntemi

Abstract

The ideal therapy for sacrococcygeal pilonidal disease (SPD) would be a prompt cure that allowed patients to return quickly to normal activity, with minimal morbidity and a low risk of complications. We report the case operated with excision and primer suture for SPD a month ago had infected and decomposed wound. A 23-year-old male patient was admitted to the emergency room with complaints of intergluteal discharge and pain that last for 10 days. Surgery which was excision and primer suture was applied him in other health center for SPD a month ago. There was infected and decomposed wound and a large cavity under sutured skin on intergluteal area. In the second operation, we excised decomposed wound including cavities and skin as modified equilateral quadrangle shape, a right flap was prepared and rotated to left side for primer suture. Patient was discharged on postoperative 3th day and drain was getting out on postoperative 5th day. Patient recovered completely without any complication on postoperative 20th day. Our case is no not only unique but also rare. However, we think that the most appropriate method for treatment of SPD should be known and applied by all surgeons in our country.

Key words: Pilonidal sinus disease, treatment technique

INTRODUCTION

Sacrococcygeal pilonidal disease (SPD) is a well recognized source of a common surgical problem affecting primarily white men between puberty and their early thirties (1). Incidence of SPD was found %8.8 in The Turkish soldiers (2). The ideal therapy would be a prompt cure that allowed patients to return quickly to normal activity, with minimal morbidity and a low risk of complications. Rationale of treatment requires eradication of the sinus tract; complete healing of the overlying skin and prevention of recurrence. Therefore; various noninvasive (3) and surgical methods (simple incision and drainage, lying open, marsupialization, excision and primary closure, or rhomboid excision and Limberg flap) have been performed for treatment (4-6). We report the case operated with excision and primer suture for SPD a month ago had infected and decomposed wound.

CASE

A 23-year-old male patient was admitted to the emergency room with complaints of intergluteal discharge and pain that last for 10 days. Surgery which was excision and primer suture was applied him in other health center for SPD a month ago. There is no any disease in the past and family history. Regarding vital signs, blood pressure was 115/76 mmHg, pulse rate was 82 times/minute, body temperature was 37°C. On

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physical examination, lung and heart sounds were normal. Additionally, there was infected and decomposed wound and a large cavity under sutured skin in the intergluteal area. Antibiotic and anti-inflammatory drugs were given as oral along one week. After medical treatment, patient was prepared for the second surgery.

In the second operation, we excised decomposed wound including cavities and skin as modified equilateral quadrangle shape. After bleeding control, a right flap was prepared and rotated to left side for primer suture (Modified Limberg Flap). Flap was fixed to subcutaneous fascia with a 2/0 vicryl and skin was sutured with a 2/0 nylon after a drain that can be done negative pressure was inserted to subcutaneous cavity from left side. Patient was discharged on postoperative 3th day and drain was getting out on postoperative 5th day. All sutures were taken away on postoperative 10th day and patient recovered completely without any complication on postoperative 20th day (Figure 2).

DISCUSSION

There is a classification which is defined by Tezel for SPD (Table) (7). According to this classification, he recommended Bascom procedure in type IV and V SPD. Healing by secondary intention after wide excision takes longer to achieve but has lower recurrence (8). Spivak et al showed that complete healing was fastest in the excision and primary

closure group, despite a 14% postoperative wound infection rate, in comparison to open excision without closure (9). Wide excision and primary closure was used in our case. Patient had complications which were intergluteal discharge, pain and decomposed wound after one month from surgery. We applied modified Limberg flap in the second operation after antibiotherapy. Because, other studies showed that the Limberg flap gave superior results to deep tension suturing. Treatment of pilonidal sinus by primary closure with a transposed rhomboid flap compared with deep suturing in prospective randomized clinical trials (10-12). Additionally, Bascom procedure in type IV and V SPD or V-Y flaps for recurrent and complicated PSD could be applied. Recurrence rate was determined as % 4 after Karydakís' technique in a trial (13). From the most of studies, it is apparent that various methods are being tried and no one method is universally acceptable. A questionnaire was done by Colak et al (14) responded by surgeons in our country, excision and flap reconstruction is first preference treatment method (%64) for SPD. Therefore, we applied the same method for this case, also.

In conclusion, our case is no not only unique but also rare. However, we think that the most appropriate method for treatment of SPD should be known and applied by all surgeons in our country. But, this ideal has yet to be demonstrably reached.

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Figure 2. All sutures were taken away on postoperative 10th day and patient recovered completely without any complication on postoperative 20th day

Table. Tezel's classification for sacrococcygeal pilonidal disease

Type I	Asymptomatic pit(s) without a history of abscess and/or drainage. The pits are almost always within the navicular area and require no surgical therapy. We recommend local hair removal and good personal hygiene.
Type II	Acute pilonidal abscess. The treatment is always drainage using with a lateral incision. Type II SPD usually requires further surgical treatment after acute symptoms resolve.
Type III	Pit(s) within the navicular area with a history of abscess and/or previous drainage. We prefer the Bascom procedure for patients with type III SPD.
Type IV	Extensive disease where one or more sinus opening lies outside the navicular area. Such patients usually have a history of multiple abscess formation and drainages without definitive pilonidal surgery. The surgical treatment of choice in these patients is the Bascom procedure combined with separate excision of pits outside the navicular area.
Type V	Recurrent pilonidal sinus following any surgical treatment. We recommend again the Bascom procedure in such patients.