

# Pilonidal Patient Hand-Out

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## **PILONIDAL DISEASE**

Pilonidal Disease is a misunderstood entity in the medical community, which often leads to overzealous treatment. Many times this will lead to a problem which is far worse than the initial Pilonidal Disease - that of an open, weeping, midline wound that remains unhealed or at best takes many months to heal by secondary intention requiring daily packing and other care.

The misunderstanding came about because it was believed that Pilonidal Disease was possibly a congenital process and a true cyst because of the hair that has been found in the diseased tissues. However, it has now been ascertained that Pilonidal Disease is not a cyst at all but is nothing more than an abscess caused by bacteria entering the subcutaneous tissues through diseased hair follicles in the midline of the cleft between the buttocks. These follicles become enlarged due to midline vacuum and pulling forces. They are identified in asymptomatic patients by a pinhead-sized opening often called a "pit." Sometimes individuals will have multiple pits in the midline of which they are totally unaware. Bacteria can then enter through the pits into the subcutaneous tissue creating an infection and often abscess formation. Many times hair shafts are sucked down into the subcutaneous tissue through these pits.

Because of the mistaken belief that this disease was a true cyst, surgeons have often attempted to "cure" it by wide excision and either attempt to close the wound in the midline, which type of incision is notorious for not healing well, or leave the wound open to heal by secondary intention, a very prolonged process. The patient was then left with a far more serious situation than with which he began.

Knowing that Pilonidal Disease therefore is nothing more than a subcutaneous abscess, which began because of midline pit formation, a rational method of treatment can be formulated. In most instances conservative treatment can be utilized to control the process rather than immediately attempting to cure it by surgical excision. This makes sense in that Pilonidal Disease is rarely seen after the age of thirty and therefore will resolve itself if it can be controlled until that time.

In asymptomatic individuals that are found to have small midline pits, nothing should be done except to educate them to use good hygiene by thoroughly cleaning and drying after each shower or bath and wiping after a bowel movement forward rather than backward. If bacteria can be kept from gathering about the opening of the pits then infection is unlikely to ensue. Also, they should

avoid traumatizing the area with such activities as bicycle riding, or excessive and improper sitting (not sitting straight) that keeps the pits open and also allows more bacteria to accumulate in the area. If the process becomes symptomatic with an acute abscess formation, nothing more should be done than to incise and drain the abscess, placing the incision away from the midline, pulling any hair protruding from the pits, and putting the patient on antibiotics and sitz baths.

Shaving the area seems to be very beneficial. Occasionally, silver nitrate or phenol can be used to eliminate granulation tissue to help close the abscess cavity and, if present, fistula tracts. Also, the opening of the fistula may need to be debrided to allow better access for treatment. When the patient again becomes asymptomatic the use of good hygiene will often prevent another episode to occur.

If the process becomes a repeated one in spite of good hygiene, and a fistula is not present, a simple operation of excising and closing the small midline pits, and cleaning out the abscess cavity through a lateral incision will many times be curative. This can be done with a local anesthetic and in an office surgery setting. If a fistula is present it should be opened full length and allowed to heal by secondary intention with daily packing and the base occasionally treated with silver nitrate. If the process fails to resolve after doing the above or if the patient has had previous surgery that has failed and has been left with a chronically open wound, an operation known as a Cleft Lift Procedure is recommended. This procedure obliterates the deep cleft, which allowed the process to develop and the non-healing to occur. It also creates an environment where the disease will not recur. The incision for this Cleft-Lift operation falls not in the midline but to the side. This can generally be done as an outpatient procedure.

In summary, one should try to control rather than cure this disease in its early stages. If this is not successful then the two above mentioned surgical procedures are far more successful in eradicating the problem than the more radical excisional approaches which often times lead to prolonged healing.

# ALGORITHM FOR TREATING PILONIDAL DISEASE

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