

Letters

Pilonidal disease: How do we clean this up?

I would like to comment on the article 'Pilonidal disease practice points: An update' (*AJGP*, March 2019).¹ There is no accepted terminology, classification or treatment for pilonidal disease. Pilonidal disease affects the natal cleft; the umbilicus is the next most common site. Hair associated with pilonidal disease comes from the head, back and buttocks.

There are three pathogenesis hypotheses. Stelzner's 'retention dermatopathy' was described by Karydakos 16 years previously as 'friction forces the hair – leading with the root end – to insert into the skin' (translated from Katharevousa Greek).² The Bascom idea is completely different – a stretched hair follicle sucks in debris so 'hair is a secondary invader'.³ Doll postulates short cut hair fragments after a haircut insert in the natal cleft.⁴

The natural history of pilonidal disease is unknown, but hair is almost always present. The authors' statement that pilonidal disease resolves after the fourth decade is unreferenced. 'Reassurance and hygiene' do not prevent the development of symptoms.

Unless it resolves quickly with broad spectrum oral antibiotics, pilonidal abscess requires off-midline drainage. Only half recur within five years,⁵ so not every patient requires definitive surgery following their first drainage.

Laying open/deroofing/marsupialisation are not often performed in Australia because of prolonged wound healing and the risk of an unhealed wound that can occur in a quarter of patients (after some procedures). Wide excision with healing by secondary intent is occasionally performed.

The authors confused two procedures described by the late John Bascom. Bascom 1 (or pit picking) refers to limited excision of each midline sinus. Endoscopic pilonidal sinus treatment

is an extension of this idea. Five-year recurrence following these procedures exceeds 15%.⁵

Bascom 2 (also called cleft lift) represents Bascom's modification of the Karydakos flap. Both have a 10-year recurrence of 3%:⁵ the lowest of any procedure (not 15% as quoted). This high success rate is attributed to flattening of the natal cleft and a scar that is completely away from the midline. There is no 'debridement' during the Karydakos flap.

Other commonly performed flaps (eg Limberg, keystone, step-ladder, Z-plasty) result in a scar that crosses the midline at least once, resulting in a higher recurrence rate.⁵

When treating a patient with poor hygiene with a purulent natal cleft, we need to stop blaming him. Surgery remains the only curative option. Patients rank disease recurrence as the most important outcome measure. Excision plus off-midline closure using the Bascom cleft lift or Karydakos flap allows surgeons to meet patient expectations.

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References

1. Choy KT, Srinath H. Pilonidal disease practice points: An update. *Aust J Gen Pract* 2019;48(3):116–18.
2. Karydakos GE. Hair insertion (pilonidal sinus). *Hellenic Armed Forces Med Rev* 1968;2:273–85.
3. Stelzner F. Causes of pilonidal sinus and pyoderma fistulans sinifica. *Langenbecks Arch Chir* 1984;362(2):105–18. [German.]
4. Doll D, Wilhelm D, Ommer A, et al. Immediate cut hair translocation to the intergluteal fold in the hairdressers shop – Another link to pilonidal sinus disease. *Pilonidal Sinus Journal* 2019;5(1).
5. Stauffer VK, Luedi MM, Kauf P, et al. Common surgical procedures in pilonidal sinus disease: A meta-analysis, merged data analysis, and comprehensive study on recurrence. *Sci Rep* 2018; 8(3058):1–28. doi: 10.1038/s41598-018-20143-4.

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