

Combined Technique in the Management of Complex Pilonidal Disease

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Dear Editor,

Pilonidal sinus of the sacrococcygeal region most commonly occurs in young people. The exact pathophysiology of the disease is unclear. However, hair plays the central role in the formation of the sinus and the infection. Wide local excision was the traditional method of treatment (1).

Nowadays, there are many treatment options, ranging from non-operative treatments (shaving and hygiene) to surgical treatments (2).

With regards to the surgical management of pilonidal disease, we are faced with several problems, such as the variation of pilonidal disease from simple to complex cases, which include abscess or multiple fistulas, poor healing of the excision site, presence of hair, as a foreign body, in the pocket, long periods of sick leave and incomplete healing of the site of surgery (3).

In cases of complicated pilonidal disease, management remains a challenge and is controversial. Multiple methods, such as complete excision and secondary healing, complete excision and simple or partial closure, or excision and flap closure have been recommended. Other methods, such as rhomboid flap, Z plasty, the Karydak procedure, Bascom's cleft lift procedure, V-Y plasty, gluteus maximus myocutaneous flap and skin grafting are the options for the treatment of complex pilonidal disease (4, 5). In cases of disease complicated with abscess, there is no definite procedure for management (5, 6).

In this article and accompanying video, we present a novel technique, employed, to the best of our knowledge, for the first time in the management of complicated pilonidal disease with abscess. The patient was a 32-year-old man, who presented for the first time with pilonidal disease and a large abscess, via a long fistula tract, at the superior part of the cyst. The operation was done under general anesthesia in the prone Jackknife position. The operative area was shaved, just before the operation, and

prepared with povidone-iodine. The design of rhomboid flap was mapped on the skin before the operation. At first, the pilonidal cyst was excised, done to the presacral fascia in the midline and laterally to the fascia of gluteus maximus muscle.

The rhomboid flap was raised on the gluteus maximus muscle, in a standard fashion. Complete mobilization is essential to prevent tension. The defect was closed with flap and repair was done in two layers, the deep layer was closed by monocryl 2-0 and the skin with nylon 3-0. Closed suction drain was inserted below the flap to prevent any hematoma or collection. Then, the abscess cavity and the accompanying fistula tract were excised completely. After irrigation, partial closure of the tract was done. The patient was followed weekly in the outpatient clinic. Complete healing of the abscess cavity was achieved within 10 weeks post operation.

There are many options for the treatment of complicated pilonidal cyst and abscess. The combined method of drainage and rhomboid flap is a suitable choice for this complicated disease.

Authors' Contributions

Idea and design: Seyed Vahid Hosseini, writing and editing: Alimohamamad Bananzadeh.

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