Surgical Indications and Continuity for Kids (SICK) ECHO 2018-2020
Pain in the Butt: Pilonidal Disease
5/16/2019
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Provided by the University of Wisconsin–Madison Interprofessional Continuing Education Partnership (ICEP)

Intended Audience:
Primary care physicians

Objectives:
As a result of this educational regularly scheduled series, learners will be able to:
1. Assess and correct physiological and psychological problems that may increase surgical risk for regional pediatric patients.
2. Give the patient and significant others complete learning and teaching guidelines regarding the surgery.
3. Instruct and demonstrate exercises that will benefit the pediatric patient postoperatively.
4. Plan for discharge and any projected changes in lifestyle due to the surgery.

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Pain in the Butt: Pilonidal disease

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Case Presentation

- 16 yo boy, otherwise healthy
- Chronic pain over tailbone
- Worsening over weeks to months
- Intermittent blood/mucoid drainage, small spots on underwear
- Afebrile
- Chronic annoyance

- PE: pits in the gluteal cleft, cephalad to a normal anus

Does this patient need surgery?

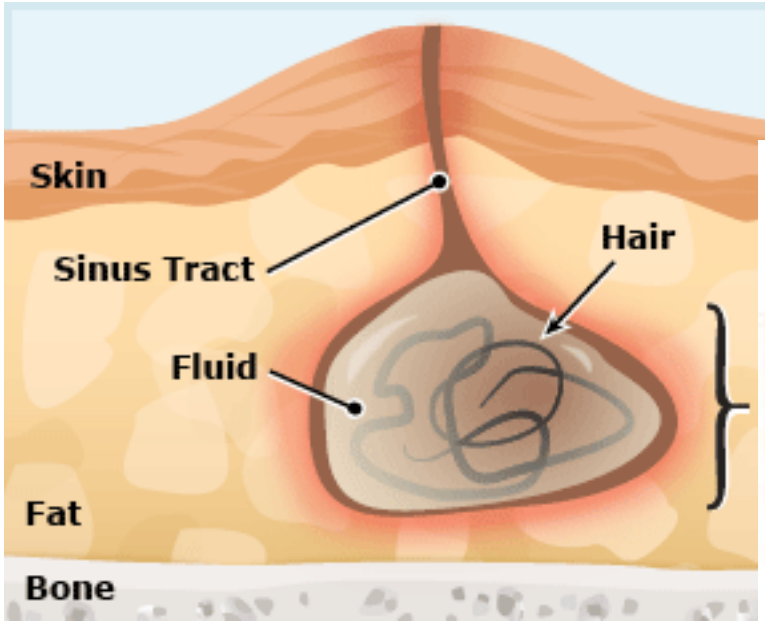
A. Yes, of course, cut out the cyst!

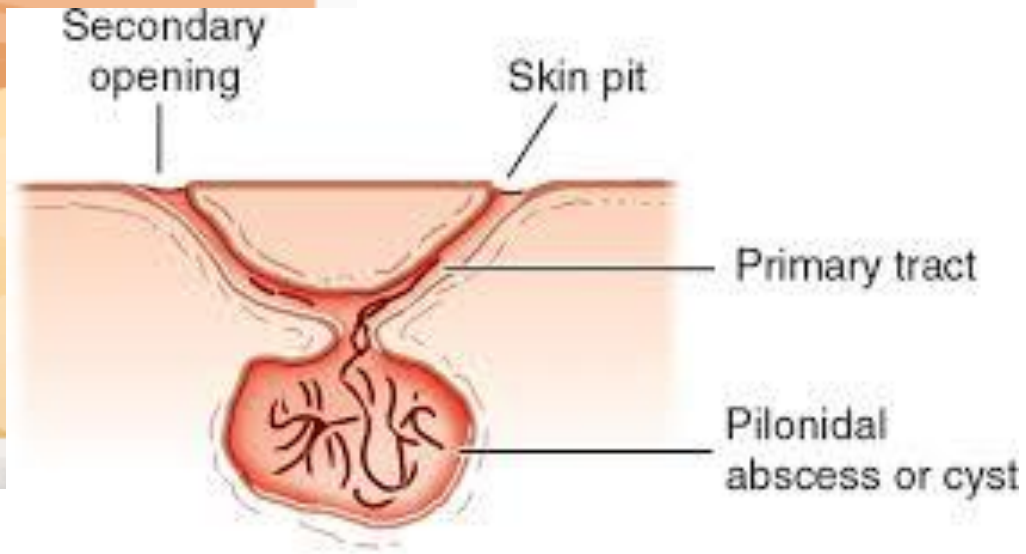
B. Hmmm, not so sure, probably…

C. NO surgery — I know just what to do for this!

What is pilonidal disease?

- NOT a true cyst!





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Pilonidal disease

- Herbert Mayo 1833 – hair-filled cyst over coccyx
- Hodge 1880 coined term “pilonidal”
  - Pilus = hair
  - Nidus = nest
- Aquired vs congenital?
  - WWII “Jeep seat”
  - 80,000 soldiers hospitalized
- Incidence 25 per 100,000
  - Age: teens to 30’s
  - M:F 2-4:1
  - Acute vs chronic 50:50

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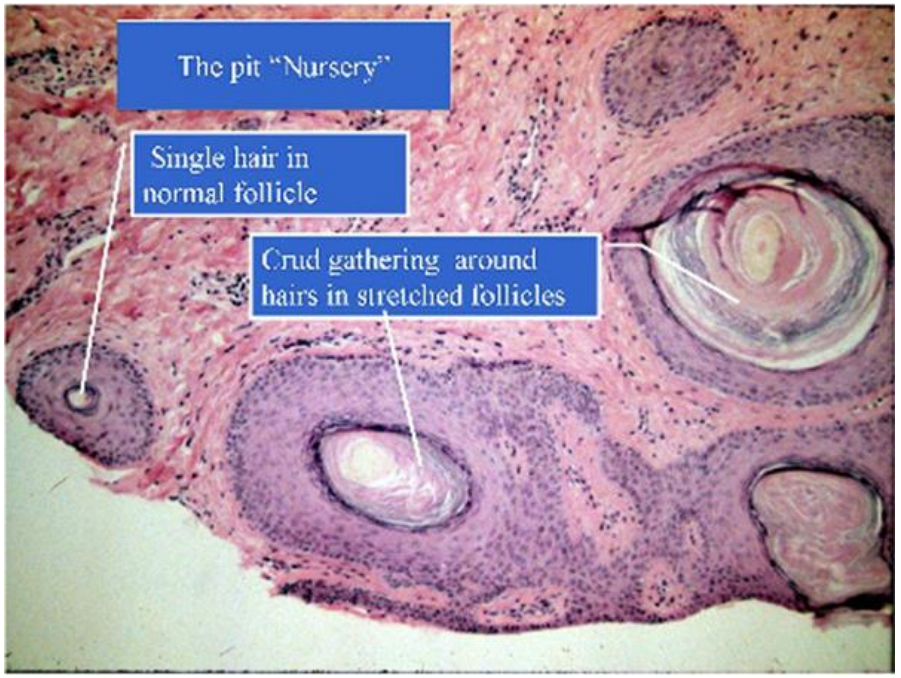
What causes pilonidal disease?

- Distorted/stretched/enlarged **hair follicle**
- Hair & debris get trapped
- Motion and pressure draws hair inward, burrows beneath the skin
- Epithelialized sinus forms
- Subcutaneous chronic foreign body reaction, inflammation, granulation tissue



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Risk factors

- Hirsutism – thick hair in gluteal cleft
- Post-pubertal
- Obesity
- Deep gluteal cleft
- Frequent trauma/pressure
  - Sedentary lifestyle
  - Prolonged sitting
  - Horseback riding
  - Motorcycles
- Family history

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Differential Diagnosis

- Sacral dimple:
  - NOT a pilonidal
  - NOT a risk factor for pilonidal formation
  - Consider tethered cord
- Peri-anal abscess
  - Closer to anus
- Hidradenitis/folliculitis
  - Skin pustules
- Peri-anal Crohn's disease
  - Fistula/abscess
  - Fissure
  - Skin tags

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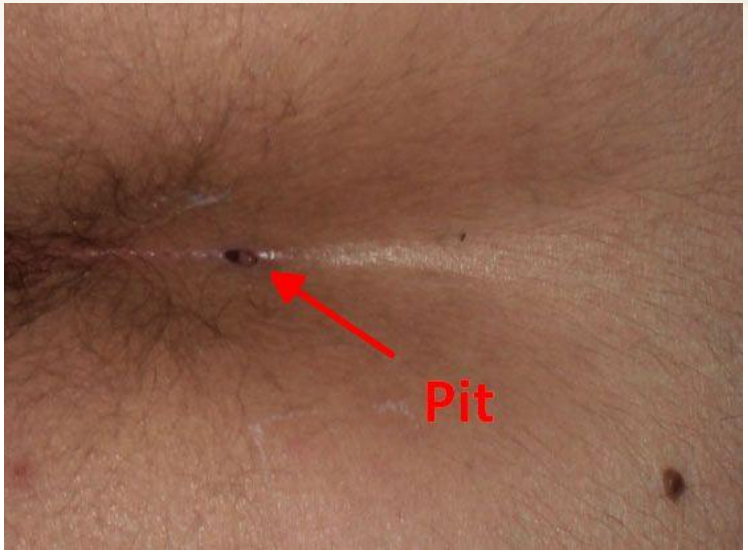
Diagnosis



- **Clinical**: H&P
- Pits = pilonidal disease
  - Midline gluteal cleft
  - Several cm cephalad to anus
- Anus normal
  - Digital rectal exam can help distinguish from Crohn's
- Imaging usually not needed
  - U/S can confirm presence of fluid collection/abscess

Treatment options: chronic

MEDICAL TREATMENTS: **Successful 20-50%**

1. **Hygiene**
   - Sitz baths/hand shower BID
   - Vertical scrubbing
2. **Hair removal**
   - Pull out of pits
   - Shaving (weekly)
   - Depilatories (Nair)
   - Laser hair removal
3. **Modifiable risk factors**
   - Weight loss
   - Activities
4. **Antibiotics?**
   - Not clearly beneficial unless cellulitis

Acute presentation

- 16 yo boy, otherwise healthy
- Severe pain over tailbone
- Worsening over days to ~1week
- Can’t sit, missing school
- +/- fevers
- +/- drainage

- PE:

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What is the next step in management?

A. Start medical management: hygiene & hair removal
B. Medical management + antibiotics will take care of this
C. Incision and drainage
D. Prescribe opioids for pain control
E. Refer to surgeon for excision

Management: acute

- **I&D Please!**
  - **Packing for ~48 hrs**
  - **Sitz baths**
- +/- Antibiotics
- **MEDICAL management**
  - **Hygiene**
  - **Hair removal**
  - **Risk factors**
- **Do not excise acutely**

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Surgical treatment

- Many creative inventions
- COMPLICATIONS 20-50%
  - Recurrence
  - Wound infection
  - Wound dehiscence
  - Chronic non-healing wounds
- Reserved for failure of medical management
- NOT for asymptomatic pits

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Surgical options

1. Wide local excision
   - Leave wound open – packing, wound vac
   - Midline closure
   - Off-midline flaps

2. Minimally-invasive pit excision & debridement
   - “Pit-picking”
   - Gips procedure

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Wide local excision: midline

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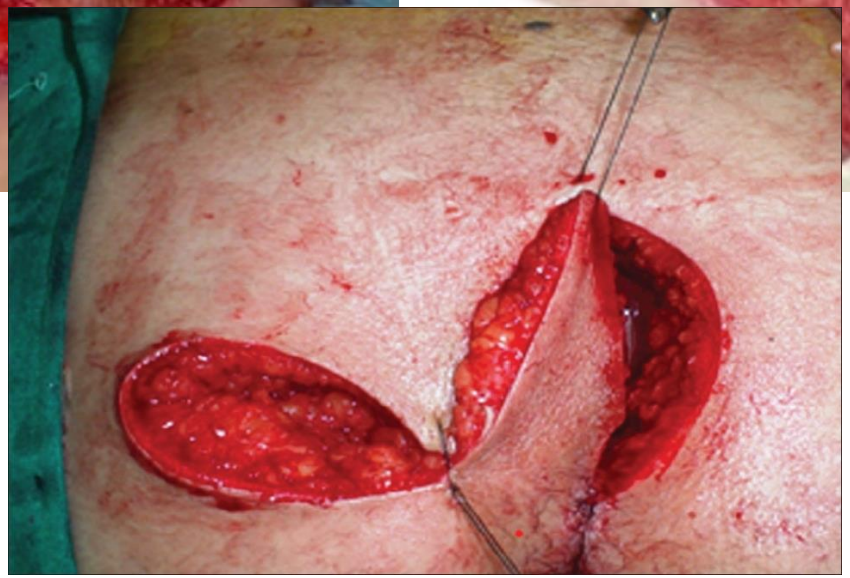
Wide local excision: midline + flap



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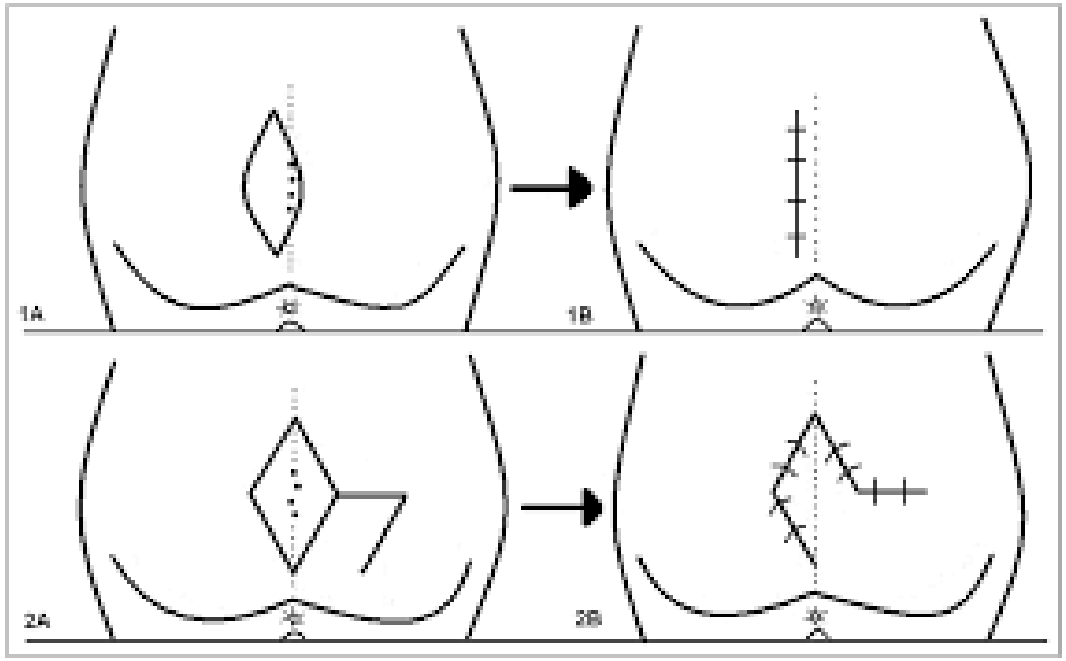
Wide local excision: off-midline + flap



A. Karydakis (off-midline)
B. Limberg flap (rhomboid)

- Bascom cleft-lift

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Minimally-invasive approach

- Just cut out the pits + debride cavity
- Can be office procedure w/ local anesthetic
- Now first-line surgical approach

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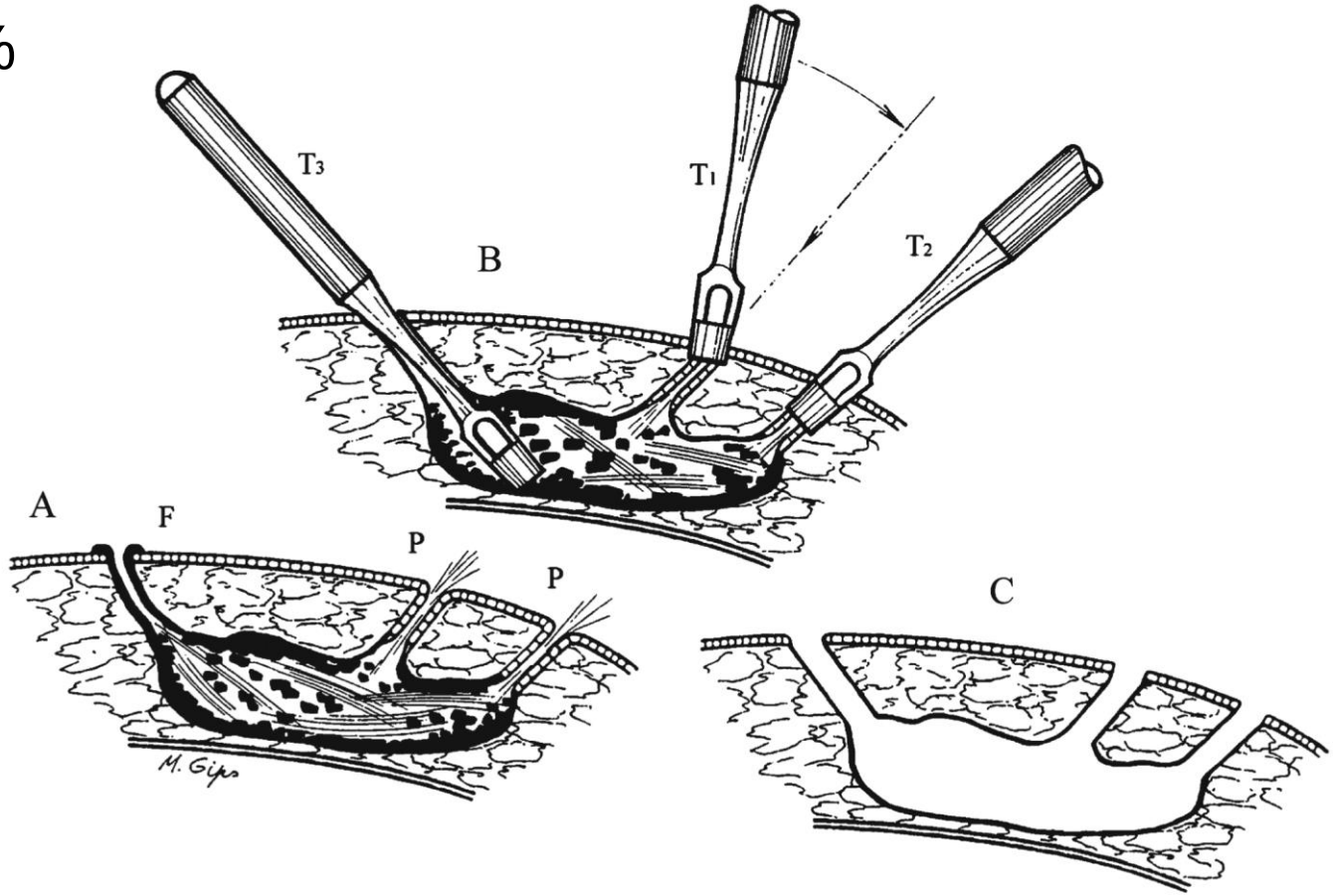
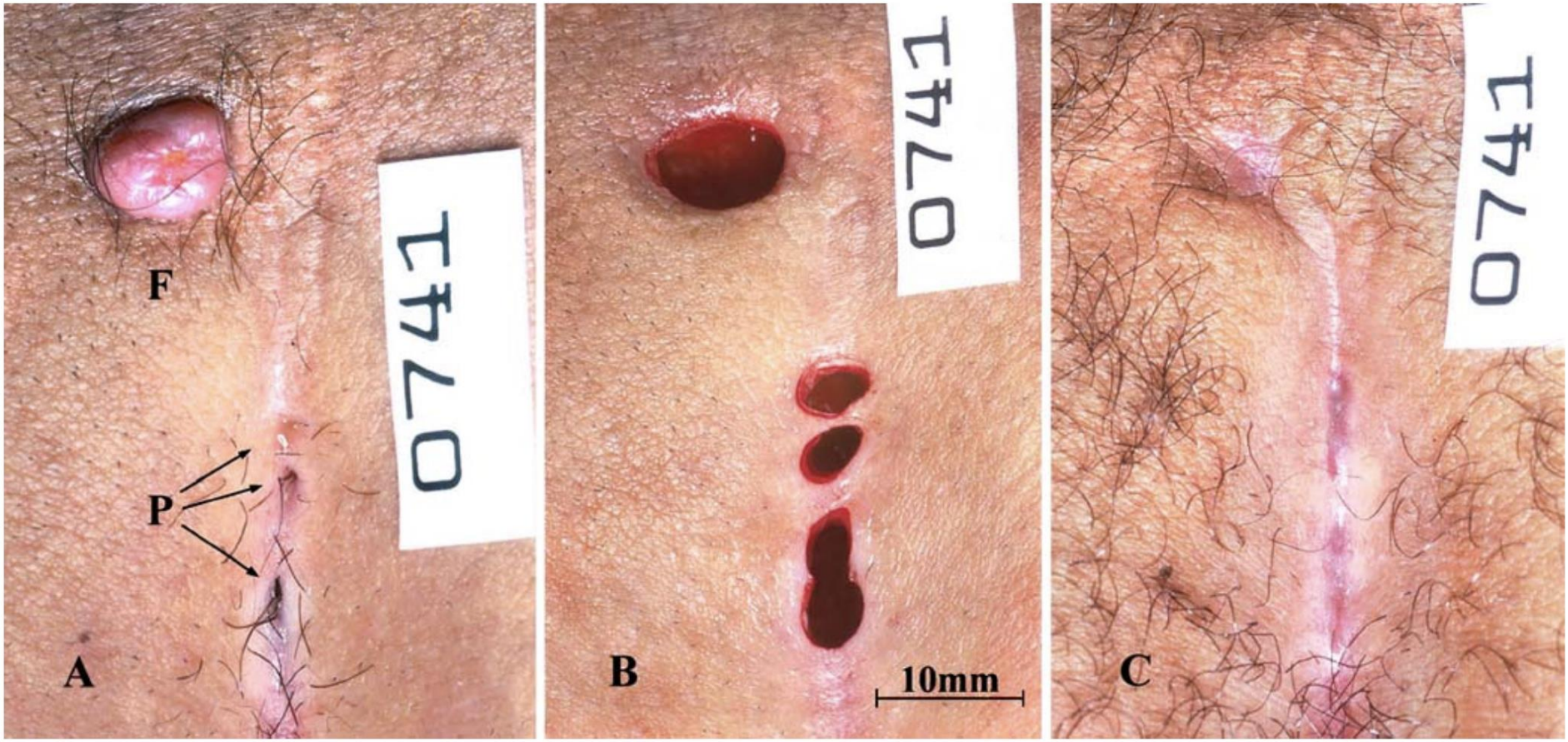
Moshe Gips procedure (2008)

Recurrence (1358 patients):

- 1-year 6%
- 10-year 16%



Moshe Gips procedure



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Thank you!

Questions?

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