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Pilonidals: Distilled wisdom

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Introduction

Pilonidal abscesses, the infrequent problem that usually responds well to conventional treatments, can become troubling[1-8].
When we surgeons have operated four times yet the wound fails to heal despite three years of trying hyperbaric oxygen, vacuum packs and daily dressings from wound care centers, we surgeons take notice and look for better answers[9-17]. Meantime, for a young victim, life is on hold.
To write of these problems I draw on fifty years of attending to more than 700 pilonidals and watching literature.
I will be brief, it is enough to know two mantras: *Pick All Pits!* and *Stay Out of The Ditch!*

Pick All Pits!

The first mantra warns the surgeon, with regard to vast majority of problems, that pits start bigger problems. Pits are stretched hair follicles that inject bacteria into fat. The holes are shaped as funnels and are lined with slick epidermis so the holes will never heal until the 2-4 mm long funnel of epidermis is gone. Pits are easily removed under local in the office. Funnels left behind grow new abscesses, grow recurrences.
According to a research by Gips et al. on 1,358 patients[18], 85% of patients with primary disease, never before operated, can have their problem solved permanently with removal of a few grams of tissue. Biopsy trephines offer a neat trick and pit excision with the tip of a pointed scalpel gives the same results. The following abstract inspires confidence that early removal of tiny bits of tissue will control most pilonidal disease and prevent spectacular problems. The illustrations that accompany this paper, and its bibliography are worth looking up. The article teaches less is better. Wide excision of blocks of fat down to periosteum, an outmoded treatment, now seems equivalent to treating a pimple on the chin by cutting off the patient's head!
How does one treat failures of the above, the 15% of pilonidals that make trouble after simple care? Also, what of the patients burdened by massive failures of repeated surgeries? The mantra, *Pick All Pits!*, is useless for both groups as all pits have departed earlier, but check to be sure.

Stay Out Of The Ditch!

An entirely different mantra is called for, i.e. *Stay Out Of The Ditch!* As you read on, purge prior concepts from your mind and prepare to write on a clear memory slate.
Those who have experience with pilonidal disease know disease involves a cleft. At the same time, likely you are not aware the cleft is the *cause of the disease*. I'll try to defend the statement.
Let's look more closely. Prepare yourself for a shock! Follow each step. Stand the patient. Mark skin where it turns into the cleft, changes from buttock skin to cleft lining. These "rim trails", similar to lines painted on the edge of a canyon, warn of the edge of danger. Let the patient lie face down. You see no sign of pilonidal disease *until* you spread the cleft. Then you may see a 6 cm long trough filled

with granulation tissue. You think you have seen the disease but you are *wrong*.
What you often see is a part of a closed abscess, shaped like a bathtub, the base and sidewalls, lined with loose granulation tissue. But, needing a *closed* cavity to explain its persistence, where is the *roof* of the cavity? Here is nature's trick. The roof is in your hands! You have just, as you spread the cleft, split and destroyed the roof.

Release the pull. The cleft walls clap together. The walls seal the roof. By release you have converted the tub into a closed chronic abscess cavity! The cleft walls will form a tight roof, 24/7, until the next office appointment. Then the roof will be ripped open as the cleft is next spread! Though difficult to visualize, this sealed space, created by the closure of the roof, seems the essence of pilonidal disease. The rubbing cleft walls seal the depths, prevent drainage of pus, prevent access of air to anaerobic bacteria that destroy tissue. Measurements of pressure under the rubbing cleft walls show walls make as tight a seal as a zip loc on a plastic bag or screwing a metal cap on a jar.

That explains why plastic surgery may fail. The surgeon may, with a Limberg or Z-plasty, or even a cleft lift, adequately shift tissue into the cleft to make the majority of the cleft shallow. However, at the distal end of the repair a tight cleft remains. Worse, a suture line may lie in the bottom of the small residual tight cleft, a sure recipe for failure.
The solution lies with suturing left fat against right fat before closing skin until there extends, to near anus and free of stitches, a blunt and ventilated cleft bottom. Then watch the rim trails that warn of danger and close skin safely, outside them, in air.
Patients and doctors can join the principles of off-midline treatment through the website of the Pilonidal Support Alliance (www.pilonidal.org), which keeps a freely accessible directory of surgeons worldwide familiar with off-midline repairs. As with laparoscopic surgery for gallstones, patients themselves may become the best advocates of off-midline surgical treatment.

Remember: *Pick All Pits! Stay Out Of the Ditch!*

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