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PILONIDAL SINUS.

This general guide is designed to provide background information to the operation that you will shortly undergo. It aims to supplement verbal discussion, to answer common questions and to be readily available as an *aide memoir*. It cannot cover in detail every aspect of your individual operation and may not deal with some areas that are of particular concern to you. These can be dealt with individually.

You should feel free to ask about any aspect of your care. All your questions will be answered fully, honestly and in as much detail as you wish. In the heat of the moment it is easy for questions that you intended to ask to slip from your mind. You should note on paper any questions that you may have.

Further information is available at the web site above. This site also provides links to other sites that may provide additional information.

What is a pilonidal sinus?

Although pilonidal sinus can occur anywhere, the natal cleft is by far the most common position. This document only refers to pilonidal sinuses in the natal cleft.

A pilonidal sinus is the pit visible in the skin. Hairs gather in this pit and this may result in a thickened, tender lump or an abscess that has to be drained as an urgent operation.

The cause of pilonidal sinuses has been a matter of controversy for many years. It is now generally accepted that this is an acquired condition and results from hairs being shed and 'ground' into the skin by the rubbing actions of the buttocks. Typical features are that sufferers are under 40 years, male, have dark hair, are hirsute on the back and/or buttocks, and have a Mediterranean background.

How are pilonidal sinuses treated?

If the pits are very small, have not been infected and have caused minimal symptoms a non-operative strategy can be adopted. The risk of a non-operative approach is that an infection is always possible. Once an infection has occurred the pits are 'seeded' with bacteria and further infections are almost certain.

The best operative strategy has been debated for many years. Over 100 different operative techniques have been described which clearly demonstrates that none have gained general acceptance. Currently two techniques appear to have a better track record than others

The first technique is that described by Bascom. This involves a small incision about 1 – 2 cm lateral to the natal cleft that is then extended down into the cavity. The pits themselves are then cored out. Patients go home the same or next day and can return to normal activities when pain permits (usually a few days later). Minimal dressings are required, just a bath or shower in which water runs over and into the open wounds. This is a minimal technique and is useful when patients present with an abscess, or if the pilonidal sinus is small.

The second technique is that described by Karydakakis. This involves a much longer incision, also about 1 – 2 cm lateral to the natal cleft. The pits and the surrounding skin are excised and flaps are then created. The wound is then closed in layers over a drain. It is a good operation for extensive pilonidal disease, but is a more major operation and up to 10% of wounds break down in total or in part. If this occurs the sutures have to be removed and the wound dressed daily until healed. This normally takes at least six weeks.

The management of complex or recurrent disease has to be individualised. It may require the use of flaps.

Pain relief.

Proper pain relief is very important for both holistic and physiological reasons. Your post-operative recovery will be slower if you do not have adequate pain relief. Patients often have an understandable reluctance to take pain relieving drugs. This is a mistake and may increase post-operative complications. The principle that underlies all methods of pain relief is that the drugs work best if you anticipate the pain. A small quantity of the drug taken regularly (even if pain free at that time) will work better than waiting for the pain to occur and then taking a larger dose.

After a couple of days adequate pain relief can normally be achieved by oral medication. Regular Panadol, regardless of whether you have pain or not, is the foundation on which other medications are given. You should use this to provide background pain relief for a week after your operation. Additional, stronger painkillers and/or anti-inflammatory drugs can then be taken on top of the Panadol for break through pain. Many strong painkilling medications contain morphine, codeine or a derivative of these drugs. One of the side effects of these drugs is constipation.

The wound, dressing and stitches.

All the original dressings should be removed no later than the third day. These dressings will tolerate a shower or a splash in a bath. A light dressing to protect the wound from clothes *etc* may be worn. The skin stitches will be under the skin and do not have to be removed.

The first two days.

This will depend on the operation you had.

If the wound was sutured closed you need to remain in bed for 48 hours, other than for visits to the bathroom. The wound will be closed with stitches that are under the skin. They will be absorbed and do not need to be removed. Steristrips will be placed over the incision, and on top of that a plaster. In some cases a compression dressing may be placed over the plaster.

The compression dressing (if used) can be removed the day after surgery. The plaster will tolerate a shower or a quick splash in a bath, but do not soak it. The plaster that is on the wound when you leave the hospital should be removed no later than 48 hours after the surgery and the steristrips no later than four days after the surgery. If they become dirty or start to fall off before that they can be removed. Thus by 96 hours all the original dressings should have been removed. The incision will be covered by new cells and can then be left open.

Adding salt to the bath will not help heal the wound and may make your skin dry and tight. After washing the wound it should be padded rather than rubbed dry. You should not soak the wound or swim for at least ten days. If the incision is a bit sensitive you can cover it with a new plaster, but it should be left open at night.

A major concern to patients is that they will strain the wound and that it will rupture. With today's suture materials this is very unlikely. On the very few occasions that a wound does rupture it will be before you leave hospital. This would require an operation to repair the rupture. Once you have gone home a rupture is almost unheard of. If you 'over do it' the worst that will happen is that the wound will be very sore.

Wounds progress through several stages of healing. You may experience:-

- unusual tingling, numbness or itching sensations.
- a slightly hard or 'lumpy' feeling as new tissues form.
- pulling around the stitches or staples as the wound heals.

This is normal. Do not pull at any scabs as they act as a natural dressing and protect the new skin underneath. They will fall off when no longer required. You should seek help if any of the following occur:-

- the wound pain increases
- the wound becomes more reddened or swollen
- there is any discharge from the wound

If the wound was left open you may be able to go home the day after surgery. You will need to bath or shower at least once per day. The requirements for different patients vary and you will be given specific advice. A district nurse may need to visit you.

In either case you will need to return for review in 7 – 10 days

Work.

This depends on many factors, including your occupation, age and general health. You will definitely require two weeks off work, but some may require another two weeks.

Shaving in the post-operative period.

The importance of this cannot be over estimated.

The cause of the pilonidal sinus is the growth of hair as described above. At the time of surgery the hair around the buttocks will be shaved. In the post-operative period the hairs will grow back. If the area is not kept hair free, the newly grown hairs will rub on the wound and cause it to break down, or prevent healing if there has been a breakdown. The importance of keeping the skin around the scar hair free for at least three months after the surgery cannot be overstated. It is an essential part of the treatment. Ideally this will be done at home. Failing that, patients will need to return to the rooms every two weeks.

Surgical trainees.

Some patients may have part of their anterior resection undertaken by a surgical trainee. A trainee performing an anterior resection is normally, but not always, under the direct supervision of the consultant. It is important that, as part of their training, trainees gain independent experience whilst consultant cover is still immediately available. There is a substantial body of surgical literature that shows the outcome of operations undertaken by properly supervised trainees is no worse than those performed by the consultant. This literature specifically includes anterior resections.

What can go wrong?

You will be undergoing a minor operation. Occasionally minor operations are complicated by adverse events. The single greatest concern is either wound infection, or partial or complete breakdown of the wound. This is much higher for pilonidal surgery than for the equivalent surgery elsewhere. This is due to the position of the wound.

The table below summarises the complications associated with pilonidal surgery. If you want further information, please return for a further consultation so these can be discussed prior to the surgery.

Risk	What happens	What may be done (options)
<i>General complications that may occur after any surgery</i>		
Post-operative bleeding	Blood leaks into the drain	<ol style="list-style-type: none"> usually pressure only stops the bleeding blood transfusion re-operation
Wound infection	An infection, including the development of pus, occurs in the wound	Antibiotics started at the time of surgery. Drainage of any pus is required, and this may require another operation
Wound dehiscence	The wound opens up	Daily dressings until healed
Bladder may not empty	It is not possible to pass urine. As the bladder gets full, the patient gets uncomfortable.	The catheter is re-inserted and removed a few days later. Normally this solves the problem. Sometimes a catheter is required for 2-3 weeks. In men, prostate surgery may be required.
<i>What increases the risk of surgery</i>		
	<i>Examples</i>	<i>Why is the risk increased</i>
Medical illness	Pre-existing general medical conditions such as endocrine disorders, heart attacks or strokes <i>etc.</i>	As far as possible pre-existing medical problems will be corrected prior to surgery
Previous surgery		Scarred tissue is normally of poor quality and does not heal well
Obesity	All risks increased	<ol style="list-style-type: none"> poor quality tissue poor mobilisation leading to increased risk of DVT, chest infection poor blood supply so the risk of wound or anastomotic failure is much increased extra strain on the wound, heart <i>etc</i>
Drugs	Examples include steroids, aspirin, blood thinning agents	Normally because they increase the risk of bleeding, infection or decrease the quality of wound healing
Diabetes		<ol style="list-style-type: none"> ability to combat infection reduced poor blood supply slow healing
Smoking		Increased risk of infection.