

## Pilonidal Disease

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### PILONIDAL SINUSES, CYSTS, ABSCESSES: WHAT COLLEGE STUDENTS NEED TO KNOW

The presence of pilonidal sinuses, cysts, and/or abscesses is likely the reason you are reading this document. Broadly stated, you have pilonidal disease, which means over time a **pilonidal sinus** (a short tunnel or tract) has formed in the intergluteal cleft (or "crack") between your buttocks (butt cheeks). The sinus is filled with hair giving rise to the Latin name "pilonidal" which literally means "nest of hairs." When the pressures of prolonged sitting and traction on the skin stretch these sinuses, they become large and elongated and grow to a cavity with hair and unhealthy tissue. This structure is then called a **pilonidal cyst**. Often these cavities will cause discomfort, drain and cause an odor. They can even become contaminated with bacteria, giving rise to a painful **pilonidal abscess**. These are often what bring students in to seek medical help.

#### *Who Can Acquire Pilonidal Disease?*

The onset of pilonidal disease is rare before puberty and after the age of 40, with rates of 26 cases per 100,000 persons. It is commonly seen in males more frequently than females, probably due to their "hairy" nature. The following are considered risk factors that may predispose you to pilonidal disease:

- ◆ Male sex
- ◆ Caucasian race
- ◆ Family predisposition (parent or sibling had pilonidal disease)
- ◆ Obesity
- ◆ Sedentary lifestyle
- ◆ Occupation requiring prolonged sitting (especially with slouching posture)
- ◆ Local hirsutism (hairy buttocks)
- ◆ Poor hygiene
- ◆ Increased sweat activity

#### *What are the Signs and Symptoms of Pilonidal Disease?*

Initially the symptoms may be difficult to detect without assistance as **pilonidal sinuses** present only as small "pits or pores" in the intergluteal cleft and are hard to see. With a **pilonidal cyst** or early **pilonidal abscess** there may be tenderness in the buttocks, sacral or tail bone area after sitting in class or sitting at the computer for long periods. Sometimes a fall to the butt during sports will bring a student in for evaluation. In a few cases, the cyst may start to erode the overlying skin and a "sore" on or near the intergluteal cleft will appear but never heal. Some students may develop a progressively enlarging mass in the intergluteal cleft and on one side of the buttocks that is red, warm, firm, and exquisitely tender and makes walking difficult. The site may drain foul-smelling pus. Some students may even have a low-grade fever. These symptoms indicate a florid **pilonidal abscess**.

#### MEDICATIONS

As mentioned above, no medications will cure this condition. Anaerobic bacteria predominate over aerobic bacteria in **pilonidal abscesses**, with *Bacteroides* and *Enterococci* species being the most common, although aerobic organisms such as *Staphylococci* are present too. Antibiotics and pain medications are often used as adjuncts to incision and drainage of acute pilonidal abscesses.

#### SURGICAL EXCISION: OFFICE PROCEDURE OR MINOR SURGERY

This is curative. If a small sinus and cyst are present, an excision can be performed in our SHC treatment room under a local anesthetic. If you have a large lesion, you will be referred to a local general surgeon for an elective procedure.

In the case of a painful pilonidal abscess, an urgent incision and drainage under a local anesthetic is usually performed to bring about pain relief. These are done at SHC, but many students have these performed at local emergency rooms as they sometimes occur when SHC is closed. We often assume care for them or make referrals

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for students after the abscesses have been "opened up."

It is important to note that these abscesses still need to have excisions of the cyst cavities and sinus tracts that caused them, and the emergency rooms rarely will remove them when draining your abscess for pain relief. Usually emergency rooms will refer you to a local surgeon for follow up care. If SHC incises and drains a small abscess, we will attempt to debride it for complete cure; but if it is too large, we will also refer you to a local surgeon for excision of all diseased area of your tissue.

## WOUND CARE: HEALING FROM MINOR ON MAJOR PILONIDAL DISEASE SURGERY

Your pilonidal wound may be small, 1 inch in length and depth, to as large as 5-6 inches long and 3-4 inches deep. The size of your wound will dictate the duration of your wound care. Some wounds take a month to heal; whereas, others can take the entire semester to heal. We will assist you in dressing changes and supplies and educate you on their use and when to use them. Your participation by caring for the area and following all instructions is very important for proper healing.

We understand the prolonged time, inconvenience, and maybe embarrassment you must endure with daily wound care until you are healed. We ask that you are honest with us and tell us your problems, what you are or are not doing. If you cannot reach the wound or apply something, tell the nurse your problem. Change the dressings as directed. Clean the wound as directed.

The following are some concepts to remember with post-operative care:

- Remember, proper sitting posture. No sacral sitting or slouching! It puts pressure on the healing tissue and restricts blood flow. For up to 18 months after the skin has healed, the tensile strength of the scar has not returned to normal and will be subject to tearing or splitting.
- Sit no longer than 50 minutes before a 10-minute "butt-breather".
- For some patients, we will recommend a foam pad be used at home and even carried to class to sit on for comfort.
- Meticulous personal hygiene is of utmost importance. It is critically important that the wound be kept clean. Between dressing changes you may take a shower or even submerge the wound in your own private bath water. It is best to shower. Let warm water, with or without soap, run down your back, in and over the wound to rinse it out. Water from the shower head should not hit the wound bed directly. Pat the outside

of the wound dry before reapplying your dressings. Bathing DAILY is a must! It is important that you clean yourself adequately after bowel movements. Purchase flushable moist wipes (i.e. Scott's® Moist Towelettes) at a pharmacy or grocery to facilitate cleanliness of the anal area. Change your underwear everyday.

- We encourage high protein diets to facilitate wound healing. Smoking will slow wound healing. Poorly controlled diabetes slows healing.
- Periodically we will trim hair from the wound area to keep these from becoming "foreign bodies" in the wound bed which will inhibit wound healing.

## *What are Complications of Wound Healing?*

All chronic wounds open to air will have small amounts of bacteria in them, but the body can handle them and heal with them being present. If redness, heat, colored drainage, and wound tenderness develops where there once was none, wound infection is likely. Sometimes portions of the wound will heal at faster rates than others, called hypergranulation or epithelialization. Your nurses will look for this. If the surface heals faster than the deep portion, we may perform some simple techniques to slow the process to enable more even wound healing. Sometimes your fresh scar will split or tear from shearing or traction forces from sitting. Again, your nurse will talk you through your process as we know you can't see the area well.

## *Will I Get One of These Again?*

Recurrence is usually caused by one of two reasons: failure to identify one or more sinuses at the initial "curative" procedure, or usually due to secondary infection caused by residual hair or debris that was not removed from the initial "curative" excision and debridement procedure. 1-6% of people who have excisions of sinuses, cysts and/or abscesses will have recurrences.