Practice Guidelines

Pilonidal Disease Management: Guidelines from the ASCRS

Key Points for Practice

- Pilonidal disease without abscess is best managed by frequent shaving or hair removal; adding local application of phenol can resolve disease and prevent recurrence.
- Fibrin glue application can be used alone or with surgical excision to treat chronic pilonidal disease without abscess and reduce recurrence.
- Abscesses should be treated with incision and drainage or surgical excision.

From the *AFP* Editors

Pilonidal disease is a reaction to hair in the gluteal cleft, in which unattached hairs injure or pierce the skin, resulting in a foreign body reaction. The condition, which has an annual incidence of about 70,000, can lead to midline pits or secondary infection. Signs and symptoms include cysts or sinus with drainage, subcutaneous tracts, or abscesses. The American Society of Colon and Rectal Surgeons (ASCRS) has released a clinical practice guideline to provide physicians with diagnosis and treatment options.

Diagnosis

The differential diagnosis includes hidradenitis suppurativa, infected skin furuncles, Crohn disease, and perianal fistula. Most patients with pilonidal disease will present with midline pits in the gluteal cleft, although they also may have surrounding cellulitis or abscess. Patients with chronic disease will most often present with chronic draining sinus disease in the intergluteal fold. The physical examination for suspected pilonidal disease should involve an anal examination to rule out fistula.

Treatment

In patients with confirmed pilonidal disease without an abscess, hair removal from the gluteal cleft via shaving or laser epilation is a key treatment. The optimal frequency of shaving is unclear, but the ASCRS recommends at least weekly. It should be noted that a local anesthetic and more than one treatment session may be needed when opting for laser epilation.

Local application of phenol also is an effective treatment option; it has been shown to resolve the condition in at least 67% of patients and prevent recurrences in at least 80%. Fewer than 15% of patients experience minor complications. Typically one to four treatments of hair removal, cyst curettage, and phenol application into the cyst and tracts can result in complete resolution of the condition.

Those with chronic disease, but without an abscess, can be treated with fibrin glue alone or in conjunction with surgical excision to prevent recurrence. Despite a lack of high-quality evidence for the best nonoperative approach, the main goal of any method is to achieve complete hair and debris removal to resolve the chronic low-grade inflammation.

Whether it is an initial or recurring occurence, first-line treatment of acute pilonidal disease with abscess is incision and drainage. This option is successful in 60% of patients with primary disease, with 40% requiring an additional procedure. Up to 40% of patients treated with incision

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This series is coordinated by Sumi Sexton, MD, editor-in-chief.

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and drainage will have a recurrence because of inadequate management of debris, epithelialization, granulation tissue, and sinus tracts.

Excision and primary closure or healing by secondary intention, including marsupialization, are primary therapy options for chronic pilonidal disease with sinuses. Although primary closure has been shown to have faster healing and less time off work than healing by secondary intention, recurrence rates are slightly higher. Flap-based approaches (e.g., rhomboid, Limberg, Karydakis, cleft-lift) can be used for patients with complex or recurrent disease who require a wide excision. Minimally invasive approaches assisted by endoscopy or video are additional options, but often these require the use of specific equipment and physician proficiency in using the technique. Small studies have not shown an advantage to antibiotics before or after surgery.

There is little evidence to guide treatment for recurrent disease. Surgical approaches should be selected based on whether there is an acute abscess or chronic disease and surgeon expertise. When treating patients for a recurrence, physicians should exclude other etiologies, including inflammatory bowel disease, immunosuppression, and cutaneous neoplasms.

Guideline source: American Society of Colon and Rectal Surgeons

Evidence rating system used? Yes

Systematic literature search described? Yes

Guideline developed by participants without relevant financial ties to industry? Yes

Recommendations based on patient-oriented outcomes? Yes

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