Letters

COMMENT & RESPONSE

Moving Toward Minimally Invasive Treatments and Better Risk Characterization for Pilonidal Disease

To the Editor We read the excellent article by Gil et al[1] in which they reviewed the management of pilonidal disease. However, they did not include laying open (unroofing) and curettage under local anesthesia (LOCULA) as an option in the management of pilonidal disease.[2] Unlike wide excision, LOCULA entails only deroofing of the sinus and partial trimming of edges. Therefore, the resultant wound is quite small, the procedure can be done under local anesthesia, the patient can be discharged from the hospital after 1 to 2 hours of the procedure, and the patient can resume normal daily activities in 3- to 5 days.[2-4] LOCULA is easy to learn and perform and can be repeated in case of a recurrence.

In a large proportional meta-analysis (n = 1445), the recurrence rate was 4.47% and the complication rate was only 1.44%.[2] We have performed LOCULA in 170 patients with follow-up available for up to 12 years with a recurrence rate of 1.9%.[3] It was also possible to successfully perform this procedure in all simple and complex cases (recurrent cases and cases with associated abscesses).[3]

Among all the factors responsible for pilonidal disease, the only modifiable factors are hairs and excessive sweating in the intergluteal cleft.[3] The flap procedures (Karydakis flap, Limberg flap, Bascom cleft lift, etc) flatten the contour of the buttocks and neutralize the impact of these 2 factors.[1] However, the buttock-contour flattening is cosmetically inferior, irreversible, and not preferred by patients.[5] In LOCULA, these 2 modifiable factors are not neutralized, and it is pertinent to instruct patients to take care of these 2 risk factors postoperatively to avoid recurrence (by regularly cleaning hairs and neutralizing effect of sweating by applying talcum powder to the gluteal cleft to keep it dry).[3] Per our experience, by neutralizing the 2 risk factors (hairs and sweating), the recurrence after simple LOCULA is minimal.[3,4]

Pilonidal disease does not involve malignant neoplasms. Therefore, wide excision is unwarranted and perhaps leads to overtreatment.[3] Pilonidal disease is perhaps an ordinary abscess at an unusual location, ie, intergluteal cleft, where the hairs and sweating lead to unusually high recurrence rate. Therefore, pilonidal disease can be treated like an ordinary abscess (deroofing plus curettage) provided modifiable risk factors (hairs and sweating) are postoperatively taken care of.[3,4] In patients who are unwilling to clean hairs for long period after surgery and do not mind disadvantages (cosmetically inferior and irreversibility) of buttock-contour flattening procedures, only those patients are the ideal candidates for flap procedures.[5]

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