

"Double Time" Surgical Technique for Treatment of Pilonidalis Cyst: First Results

Giampaolo Perri¹

¹ Department of Surgery and Translational Medicine, University of Florence, Italy

Received: 13 December 2013 Accepted: 3 January 2014 Published: 15 January 2014

Abstract

There are many surgical operations for the treatment of pilonidalis cyst. The results are controversial and surgical infections as recurrences are common complications. We suggest a new surgical technique consists in two operating times: the first ("dirty") of cyst exeresis and the second ("clean") of direct suture. The first results on 82 patients show only 7.3

Index terms— pilonidal cyst, surgical treatment of pilonidal cyst, sinus pilonidalis.

1 I.

Background ilonidal sinus (PS) is a common, chronic, benign disease of young adulthood that is encountered more commonly in males than in females. PS is not a major surgical challenge. However, considering the gender and age group it mainly affects, it is a serious condition that can cause significant loss of work and school in every community. The objectives for treating PS disease are minimal tissue loss, minimal postoperative morbidity, rapid return to daily activities and work, acceptable cosmetic results, minimal recurrence rate, and low cost. Although many surgical and nonsurgical techniques have been reported, no ideal treatment that provides all of these positive results is known.

2 II.

3 Materials and methods

We perform the operation in spinal anaesthesia or local anaesthesia only if the cyst is not complicated. Our surgical technique consists in two times:

1. Cyst excision 2. Suture of the wound For the moment 1 (Fig. ??), we create a first surgical field, and the instrumentalist prepares a specill, a syring containing methylene blue with atraumatic needle, two surgical clamps, two Kocher clamps, normal incisor and electric coagulator. The phases are:

? Disinfection of the skin and preparation of surgical field in the area around the cyst Author ? ? ? : Department of Surgery and Translational Medicine, University of Florence, Italy. e-mail: giamperri@hotmail.it

? Research of eventual fistulas and studying of the cyst with the specill ? Injection of 0,2-0,5 cc of methylene blue

? Incision of the skin and dermis with cutting incisor around the cyst. ? Completing the incision till the presacral fascia, taking away all the cyst with at least 0,5 cm margin from the cyst. ? Disinfection of the wound ? For the moment 2 (Fig. ??), the instrumentalist prepares a gloves change for all the operators and all the necessary for hemostasis and suture. The phases are: ?

4 Results

We have treated 82 patients (68 males, 14 females, median age: 17y.o.). Follow-up lasts 6 months. Only 6 patients (7,3%; all males) presented with partial deiscence of the suture and need re-opening of the wound and healing for second intention. Another patient presents a mild infection of the wound, solved by medications. No recurrences were observed in this patients.

5 IV. Discussion

This technique has found on two bases: the first is to avoid intraoperative contamination, the second to reduce bacterial postoperative colonization.

Intraoperative contamination is the cause of postoperative infection and re-opening of the wound: with this technique, we don't use the same instruments that we have used for cyst asportation.

Considering recurrences, We think that the main reason for that is the incomplete exeresis of the cyst: so, we always search for presacral fascia, and eventually, other areas coloured with methylene blue.

We suggest to use always specill and methylene blue in order to have a whole overview of the pathology and to perform the most radical exeresis.

Furthermore, this technique is tension-free and it is important in order to avoid deiscence of the suture due to excessive tension of the margins.

Fixed medications in this area just let bacteria to grow on that causing infections, so, in this method, the medication are changed every day and the bacterial load is reduced using disinfecting soap and steridrol.

V.

6 Conclusion

The described technique is safe and simple to learn, but it needs the active cooperation of the patient in postoperative course with the advantage of low rate of wound opening, infection and recurrence. Further studies are needed to confirm the results.¹



Figure 1:

¹© 2014 Global Journals Inc. (US)

-
- 60 [Hosseini et al. (2013)] , M Hosseini , A Heidari , B Jafarnejad , Indian , Surg . 2013 Oct.
- 61 [Karaca et al. (2013)] *Comparison of Limberg flap and excision and primary closure of pilonidal sinus disease,*
62 *in terms of quality of life and complications*, A S Karaca , R Ali , M Capar , S Karaca , Korean Surg , Soc .
63 2013 Nov.
- 64 [Comparison of the three surgical flap techniques in pilonidal sinus surgery. Sit M (2013)] *Comparison of the*
65 *three surgical flap techniques in pilonidal sinus surgery. Sit M*, (Aktas G, Yilmaz EE) 2013 Dec.
- 66 [Comparison of Three Surgical Methods in Treatment of Patients with Pilonidal Sinus: Modified Excision and Repair/Wide Excision
67 ‘Comparison of Three Surgical Methods in Treatment of Patients with Pilonidal Sinus: Modified Excision
68 and Repair/Wide Excision/Wide Excision and Flap in RASOUL’. *OMID and SADR Hospitals*, 2004-2007.
- 69 [Altintoprak et al. (2014)] ‘review of pilonidal sinus patients with early discharge after limberg flap procedure’.
70 F Altintoprak , K Gundogdu , T Ergonenc , E Dikicier , G Cakmak , F Celebi . *Int Surg* 2014 Jan-Feb.