Pilonidal Cyst Patient Education

Diagnosis

Pilonidal cyst (pilo-nidal = “nest of hair”) is a common condition that arises in the midline buttock cleft skin. Although the exact etiology is not clear, it almost always involves the hair becoming embedded into the skin, where it acts as a foreign body causing a chronic inflammatory reaction and cyst formation. When the skin heals over it, characteristic small pits in the midline buttock cleft skin are formed. The condition can be manifest as a cyst or as a sinus tract by which the cyst drains through the adjacent skin. It affects men and women, and usually occurs in younger persons (ages 15-35).

Pilonidal disease may cause a variety of symptoms:

- Inflammation causing swelling and pain. This may be directly under the pits in the skin, or some distance away.
- Abscess that may drain spontaneously or may require incision & drainage, because an abscess has formed under or slightly to one side of the pits in the skin.
- Sinus formation, with one or more sites of drainage found at a distance from the underlying cyst. These can develop in any direction, but usually are postero-lateral. [If the site of sinus drainage is perianal, it may be confused with fistula in ano, and vice-versa.]
- Bleeding, from granulation tissue within the cyst cavity.

Treatment:

Treatment always involves surgical excision or debridement of the underlying chronic inflammatory, hair bearing cyst. Treatment must also include removal of hair from the surrounding skin. The single most important measure to prevent recurrence of pilonidal disease is shaving or removal of hair from the buttock cleft area and keeping it free of hair for 6-12 months after the wound is healed.

There is disagreement over whether the wound that results from excision of a pilonidal cyst should be closed primarily or left to heal by secondary intention. The lowest rate of recurrence is achieved by 1) excision of the abnormal tissue, 2) healing by secondary intention, and 3) prevention of recurrence by keeping all hair in the area shaved for at least 6-12 months after the wound is healed.

Healing by secondary intention has gotten a poor reputation in the past because the wound management was poor, and led to slow, painful healing. Proper wound management, using shower irrigation of the wound and plain cotton gauze dressings moistened with tap water and changed three times a day, is associated with a period of disability of 2-10 days (depending of the size of the wound), and achieves full healing within 5-8 weeks.

Antibiotic therapy may temporize, but rarely is effective in resolving a pilonidal abscess. Pilonidal abscess may drain spontaneously, but usually doesn’t. Definitive operation is best done when the cyst is not acutely inflamed.

If the patient presents with an abscess, incision and drainage should be carried out first, with the incision placed as close to the midline as feasible while still achieving good drainage. This makes subsequent excisional surgery easier, and leaves a smaller wound to heal, because the site at which the abscess is drained frequently becomes the exit site for a sinus tract, which must be excised as well.

The moist gauze packing placed at the time of I&D can be removed in two days. No additional packing is needed, only outer dressings. I&D is simply a temporizing maneuver to allow the inflammation to subside prior to definitive excision, which should be done when the inflammation and swelling has subsided, usually in 3-6 weeks.