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Pilonidal Sinus - A Case Report

Prashanth K[1], Veena P[2]

[1]Associate Professor, Department of Shalyatantra, Sri Dharmasthala Manjunatheshwara College of Ayurveda and Hospital, Kuthpady, Udupi, Karnataka, India.

[2]Post Graduate Scholar, Department of Shalyatantra, Sri Dharmasthala Manjunatheshwara College of Ayurveda and Hospital, Kuthpady, Udupi, Karnataka, India.

ABSTRACT

Pilonidal sinus is an acquired condition with significant morbidity and patient discomfort. The incidence of the disease is calculated to be 26 per 100,000 people. It has a male predominance with a ratio of 3:1. There are several methods to treat pilonidal sinus, but the recurrence rate is more. This apparently minor condition can present the surgeon with major challenges. Many of the standard surgical procedures are associated with a significant risk both of delayed healing and of recurrent disease. Location of the disease is in the natal cleft with midline positioning of the lesion associated with moisture and abundant hair poses greater threat to effective management. According to *Ayurveda* it can be correlated to *Salyaja Nadi Vrana*. Even though the disease is *Kricchrasadhya*, it is managed through *Patana* (surgery) followed by *Shodhana* and *Ropana* treatment. We report a 38 year old male patient presented with pus discharge from cleft of the buttock. Excision was done followed by diathermy and wound is treated with *Jathyadi Taila* dressing. Disease healed well with no recurrence in the 4months follow up period.

Key words: *Excision, Kricchrasadhya, Pilonidal sinus, Salyaja Nadi Vrana, Case Report*

INTRODUCTION

Pilonidal sinus means nest of hairs in Greek. The term 'pilonidal sinus' describes a condition found in the natal cleft overlying the coccyx, consisting of one or more, usually non infected, midline openings, which communicate with a fibrous track lined by granulation tissue and containing hair lying loosely within the lumen. A common affliction among the military, it has been referred to as 'jeep disease'. Although acquired theories of development are better accepted than the more historical congenital theories, exact mechanisms of development are speculative. Interdigital pilonidal sinus is an occupational disease of hairdressers, the hair within the interdigital cleft or clefts being from the customers. Pilonidal sinuses of the axilla and umbilicus have also been reported.[1] Types of hair, force of hair insertion into subcutaneous tissue and vulnerability of the skin are the three factors which cause pilonidal sinus.[2] It is having male preponderance 74% due to male sex hormone effect, hairy body, more sweat. The disease commonly occurs in young 20-29 years who are having active pilosebaceous glands. Men with dark and stiff hairs are prone to this disease. The initial pathology is of one, or more, tiny deep midline pits in the natal cleft which connect with a granulation tissue lined cavity, lying in the subcutaneous fat and containing loose hairs. Recurrent infections occur in this cavity which later extends under apparently normal skin, both in natal cleft and laterally into one or both buttocks. Minor infections may settle on antibiotics but if an abscess develops it will discharge

Address for correspondence:
Dr. Veena P
Post Graduate Scholar, Department of Shalyatantra, Sri Dharmasthala Manjunatheshwara College of Ayurveda and Hospital, Kuthpady, Udupi, Karnataka, India.
E-mail: veenapsugunan@gmail.com

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or require drainage. However, the underlying disease remains and repeated episodes of infection are likely.[3]

If left untreated the disease will lead to complications like abscess formation, recurrent inflammation, recurrence of the sinus and very rarely malignant change may occur. Chronic pilonidal sinus can cause occasionally sacral osteomyelitis, necrotising fasciitis and rarely meningitis.[4] The causes of high recurrence rate (20%) are improper removal of hair, overlooking of existing diverticulum, entry of new tuft of hairs and breakage of scar.[5] The treatment options for pilonidal sinus are many as the disease is notorious for its recurrence.

Case Report

Presenting Complaints

A 38-year old male patient visited OPD of Shalyatantra at SDM Ayurveda Hospital, Udupi with a history of pus discharge from the cleft of the buttock associated with intermittent pain since 6 months. Weight of the patient is 70.5 kg. The patient had no significant past medical history and family history.

Clinical findings and diagnostic assessments

Systemic examinations were unremarkable. Local examination on the natal cleft region showed a secondary sinus 2cm away from the midline with tuft of hair seen in the opening of the sinus. Purulent discharge was present. On palpation, indurations and tenderness was present with no local rise in temperature. Delicate Probing revealed the tract directed towards the primary sinus in the midline.

The whole tract with overlying skin was surgically excised under local anaesthesia.

Treatment given - Surgical Excision

With a prior appropriate skin preparation, procedure was done in jack knife position. The buttocks strapped apart by adhesive tapes. Methylene blue was injected to find all ramifications. Probing done through secondary sinus and an elliptical incision was made around the tract. Incision deepened to include the whole tract with diverticulae along with tuft of hair and is excised. Floor of the wound curetted with Volkmann spoon followed by saline wash. Haemostatis secured with diathermy. *Jatyadi Taila* soaked bandage placed with T bandage. Daily dressing followed to facilitate secondary healing.

Intravenous antibiotics given for 3days, followed by *Kaishora Guggulu* DS 1TID, *Gandhaka Rasayana* DS 1TID, *Swadista Virechana Choorna* 50g + *Yashada Bhasma* 1g 1 tsp HS internally for 1 week. Follow up was done for 4 months and no recurrence was observed.

Discussion

Pilonidal sinus may present as a simple sinus with single midline opening or may present as a complex disease with one or more secondary tracts. Often the secondary tracts are directed cranially away from the midline openings. Rarely, pilonidal abscess bursts open in perianal region mimicking a fistula-in-ano creating diagnostic problems to surgeons.

Although medications temporarily palliate the disease, surgery is the primary treatment for pilonidal sinus. Due to varied presentations and higher risk of recurrence many surgical procedures are advocated for this disease. Among them Bascom technique, Rhomboid limberg flap, Karydakis, Z plasty and Marsupialization are carried out in the recent years. Each of these surgical technique would have merits and demerits. Hence, appropriate surgical technique should be chosen based on the presentation of the disease. Excision of the sinus and leaving the wound open to heal with secondary intention is a good old technique that was carried out in this patient as the secondary sinus was just about 2cm from the primary midline sinus. Both the openings with the intervening tract could easily be included during excision. Prior injection of methylene blue would also help in clearing the diverticule if present. Further, curetting the floor and diligent use of diathermy adds to the same purpose of effective clearance of the tract along with control of bleeding. Leaving the wound open to granulate usually takes 8-10 weeks to heal completely. This procedure is far simpler and more reliable than any form of primary closure with reference to recurrence, probably due to effective removal of the

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remnants of the tracts and complete secondary healing resulting in a broad hairless scar. Following the complete healing of the wound it is important to maintain hygiene of the area and periodic shaving of the surrounding area for a period of atleast 6 months to prevent recurrence.

From an *Ayurveda* standpoint, the disease matches the description of *Nadivrana*, explained in *Sushrutha Samhita*. A detailed description of the disease is documented in the text along with its surgical treatment. As the tract is impregnated with the tuft of human hair acting as foreign body (*Shalya*), it is diagnosed as *Shalyaja Nadi Vrana*. *Sushruta* emphasised excision of the tract along with the foreign body as the main treatment followed by management of the wound (*Vrana*) which is no different from what is practised in the current surgery.

Further emphasis on removal of hair that interfere healing of any ulcer is described in *Shashti Upakrama* of *Sushruta Samhita*. Surgical instruments like *Kshura* (razor), *Karthari* (scissors) and *Samdamsha* (forceps) are recommended for removal of hair according to the presentation of the ulcer.

Conclusion

Pilonidal sinus is a disease often seen in adult males. Complete excision of the lesion and allowing secondary healing of the wound has helped in achieving cure of the disease without recurrence during a follow-up of 4 months. The disadvantage of this procedure is prolonged healing time and requirement of periodical dressing until wound heals.

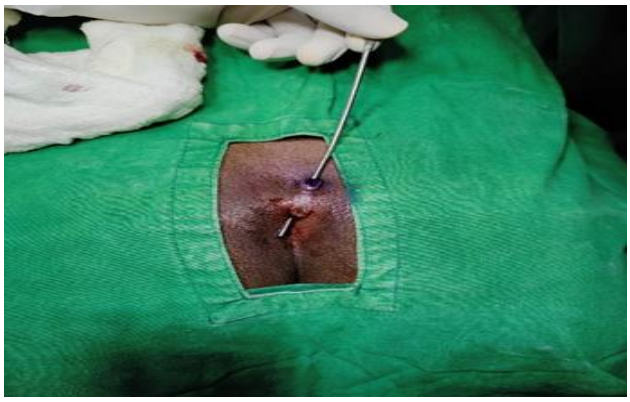

Figure 1: Before Surgery

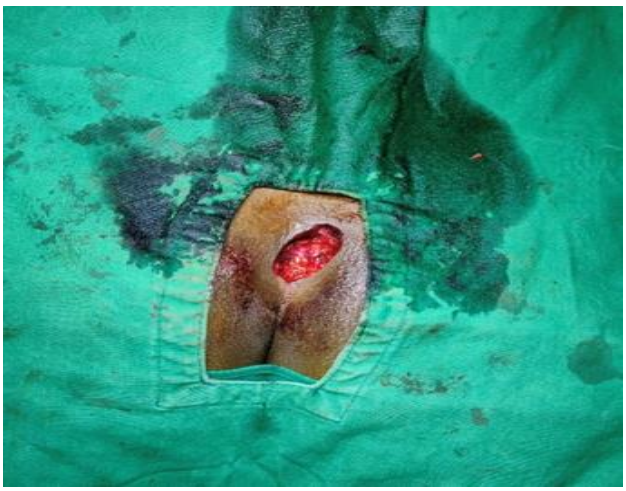

Figure 2: After Surgery

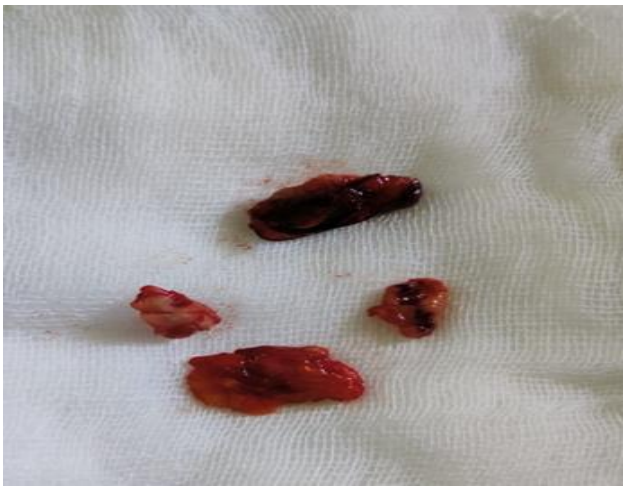

Figure 3: Excised Tract & Tuft of Hair

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