Many clinicians and patients have ideas about pilonidal disease. Some of these ideas are based on experience, training, and word-of-mouth in the real or virtual worlds. I have had an interest in pilonidal disease for over 20 years, and here are my answers and observations to common questions and misconceptions I have heard over the years.

**About Pilonidal Disease in General**

- **It is caused by a "cyst" and removal of the cyst is the treatment.** It is not caused by a cyst, it is the result of a deep cleft between the buttocks. This deep cleft causes irritation in the base of the cleft because it is never open to air. Enlarged pores develop, and sinus tracts begin to grow from the skin down into the fat underneath. Hairs get caught in these tracts, and burrow their way under the skin where they can cause discomfort, or initiate an infection.

- **It only occurs in hairy men.** No, it happens in women with minimal body hair also, but more frequently in men.

- **It only occurs in people with sedentary lifestyles.** This can occur in people with all kinds of activity levels, including those who are very active and those who are not. Sitting for long periods may make the pilonidal disease become more bothersome - but it did not cause the problem.

- **It only occurs in obese people.** This is not true either. The vast majority of patients I have seen are of normal weight, or thin.

- **Shaving the area will prevent problems.** While it is possible that shaving the area may decrease the amount of hair that is available to get into the pores, hair that naturally is shed from other areas of your body can find their way into the pores also. For this reason, I do not feel that local hair removal is a complete solution to pilonidal disease, nor a necessary part of any treatment regimen.

- **It is caused by sitting, trauma, riding a bike, etc.** These activities may make pre-existing, but unrecognized, pilonidal disease suddenly become symptomatic or flare up. But, it does not cause the disease. The disease is caused by the configuration of the cleft.

- **An MRI is helpful in defining whether I have pilonidal disease, and determining what operation I will need.** My doctor is worried about a bone infection (osteomyelitis). I don't agree with this. The visible findings on physical exam, coupled with the patient's symptoms are all that is needed to diagnose pilonidal
disease. A cleft-lift procedure, if properly done, will find and remove any tracts and prevent them from coming back. Defining them pre-operatively is not necessary. Osteomyelitis from this is extremely rare, and usually is in a patient with a predisposing disease process, other than just pilonidal disease.

- **Open excision has the lowest recurrence rate because it removes all the disease.** Actually, it has one of the highest recurrence rates because it does not necessarily change the anatomy of the cleft. It is very frustrating to go through 3 months of wound care and healing, to have new pilonidal disease develop a few months later. A cleft-lift has the lowest recurrence rate.

- **Sitting is not allowed for many weeks after pilonidal surgery.** Although some surgeons may restrict sitting after pilonidal surgery, I never do. The weight of sitting is on the ischial bones, not over the coccyx and sacrum - so there is no significant pressure on the incision. Furthermore, there is no evidence that sitting interferes with blood flow to the surgical site. Of course, patients need to be gentle with the area and avoid trauma, and if a special cushion is more comfortable it is fine to use one -- but I have never had a patient have a healing problem from sitting.

- **If the symptoms are minimal, it is better to just live with the disease because the surgery is painful and difficult.** If a physician is telling you this, then they are not familiar with cleft-lift surgery. The cleft-lift procedure is fairly straightforward, the recovery is usually quick, the recurrence rate is low, and the discomfort is usually less than having a pilonidal infection. However, other operations for pilonidal disease are problematic - and may have generated the erroneous idea that surgery for pilonidal disease is difficult.

- **Topical treatments or antibiotics can cure pilonidal disease.** There are no known creams, lotions, homeopathic remedies, antiseptics, or antibiotics that will make the pilonidal disease under the skin resolve. It is possible, with diligent wound care to get the outward openings, such as the sinus tracts or pores, to heal shut temporarily; and antibiotics can make a flare up of pain or infection subside. But, the disease can still exist under the skin waiting for a time to become symptomatic. The most effective way to promote external healing is to allow air to circulate around the affected skin - usually by placing a dry gauze pad between the buttocks and changing it frequently.

- **Silver nitrate helps wounds heal.** This is a caustic chemical that has very limited usefulness in the treatment of pilonidal disease. It chemically burns and destroys cells. It will not make a wound that isn't healing because of its position in the cleft suddenly heal closed. It's only utility is in situations where there is chronic inflammation, and there is exuberant healing with heaped up granulation tissue coming out of an incision or open area. By destroying the excessive granulation tissue, it can help the skin close and stop the drainage coming from the granulation tissue. It is used, instead of surgical excision or surgical cautery because it can be done in the office with no anesthesia and minimal equipment.
or cost. Except in this very unusual instance, it is counter-productive to healing and should be avoided.

- A wound vac is a good solution for healing pilonidal wounds. A wound vac is an excellent way to speed up the healing of wounds that normally would heal if given enough time. Unfortunately, pilonidal wounds often will not heal until the gluteal cleft is flattened - and although a wound vac may initially speed up healing, they do not do anything to prevent recurrence of the pilonidal disease. A wound vac is often a temporary measure that gives the illusion of solving the problem, but sadly does not. It is a cumbersome, time consuming, uncomfortable, expensive, and awkward solution for young active patients. A cleft lift is a much quicker and less painful solution.

**About Pilonidal Abscess**

- I had a pilonidal abscess drained, and now it looks and feels good. They told me I don't have to do anything else. Well, although it is possible that you won't have any further problems - many, many patients do go on to have recurrent problems months or years in the future. And, this usually occurs at the worst possible time, such as when you've just started a new job and have no insurance. My advice is to consider having a definitive procedure, like a cleft-lift, in the near future at a convenient time.

- A pilonidal abscess, after being drained, needs to be "packed", and the gauze removed slowly over a period of time. Once drained, a pilonidal abscess heals quickly. Packing the abscess cavity actually slows down the healing. Unfortunately, most surgeons are not aware of this. I rarely insert packing or any kind of a drain for an acute abscess (unless it is enormous in size). As long as an adequate incision is made to properly drain the abscess, the infection will quickly resolve, the abscess cavity will close, and the patient will feel better very quickly. Antibiotics may help speed up the recovery - but are probably not absolutely essential. Packing is painful and scary.

- The only way to drain a pilonidal abscess is in the clinic with local anesthesia. These can be drained in the office under local, in the operating room with sedation or general anesthesia, or somewhere in-between. How it is done depends on what the patient wants. If the abscess is clearly defined and ready to "pop", it is usually pretty easy and quick to do this in the clinic. But, if the patient has pain - but the outward visible signs are vague - draining this in the operating room with IV sedation is my preference.

- It is useful to culture the drainage from pilonidal disease, or an abscess that develops. This does not provide useful information. We find various different organisms, but the treatment is surgical drainage for an abscess, or a cleft-lift for chronic disease. When an abscess is drained, we usually start antibiotics based on our guess of the bacteria involved. By the time we have culture and sensitivity results, the abscess has usually resolved. Before a cleft-lift procedure, patients
are treated with antibiotics that cover gram positive and gram negative and anaerobic bacteria.

**About the Cleft-Lift Procedure**

- **The recovery from cleft-lift is prolonged and painful.** The recovery from cleft-lift is one of the easier recoveries when compared to the various procedures for pilonidal disease. Most patients say that the pain is minimal, and they only take analgesic pain medications for a few days. There are no open wounds, packing, or shaving. There is a small drain that is left in place for a few days, and removed in the office. Most patients are back to full activity, except contact sports, within a week.

- **Cleft-Lift is a "new" procedure.** It depends on your definition of "new". Dr Bascom began writing about this in the early 1990's, and his operation is a modification of one by Dr Karydakis which was described before that. Personally, I have been performing this since 1993.

- **Most surgeons don't do the cleft-lift because it doesn't work.** The cleft-lift, as with every procedure, has a learning curve. If it is not done properly, it will not work, so it is important to see a surgeon who has experience and success with the procedure. Most surgeons were not taught this procedure during their residency training and had to learn it afterwards. In experienced hands, the success rate is over 90%.

- **Not all patients with pilonidal disease are "candidates" for a cleft-lift.** In medicine, anything is possible, but personally I have never seen a patient in whom a cleft-lift was not possible in the last 20 years. Certainly, in some patients it is more difficult than others. If a patient finds that their surgeon does not feel that they are a candidate for a cleft-lift, they should investigate whether they can find a surgeon who is more comfortable with difficult cases.

- **I'm seeing a board certified surgeon, and he is recommending wide excision - so I should follow his/her advice.** In general, the advice given by a board certified general surgeon or colorectal surgeon is good and should be followed. But, in this specific situation there seem to be many surgeons who are not familiar with the cleft-lift procedure, and therefore do not address it. If it is not discussed by your surgeon - you should find a surgeon who is familiar with the procedure.

- **The cleft-lift is best done by a colorectal surgeon.** It is strange that pilonidal disease is categorized as a colorectal problem, since it has no relationship to the...
colon or rectum. Many colorectal surgeons are not interested or experienced in the treatment of this disease, and others are. General surgeons and plastic surgeons may or may not have an interest in this. Dermatologists, to my knowledge, are not skilled in the cleft-lift procedure. The best guideline for finding a surgeon is one that is experienced and interested in treating pilonidal disease. My bias, is that he or she should be experienced with cleft-lift also.

- The cleft-lift procedure should be reserved for difficult, severe, or recurrent disease. Different surgeons will have different criteria for when a cleft-lift is appropriate. Some will reserve it for recurrent disease, but others view it as the first line procedure for anyone with symptoms and a deep gluteal cleft. My personal observation is that patients don't want the most minimal treatment, they want the most effective. Recurrences are demoralizing, disruptive, expensive, and painful. Over the last 20 years I have gone from recommending it only for the most severe cases, to recommending it to any patient with symptomatic pilonidal disease and a deep cleft. This is based on my own personal observations and my attempt to get patients through this problem as quickly and pain free as possible.

- If I have wide excision and it fails, I can always have a cleft-lift later. This is usually true, but the scarring and distortion from the excision can make the cleft-lift more difficult. In addition, the recurrent disease often appears very close to the anus, which also makes the cleft-lift harder, and may affect the success rate.

- I'll save time and money by seeing a local surgeon who does not perform cleft-lift. If my disease comes back, I'll travel to see someone who does. This may or may not be wise. There are times when open excision results in prolonged healing, time off of work and school, expensive dressing changes, wound-vac application, multiple office visits, and significant discomfort. In general, the most successful procedure is also the most cost effective. In my opinion, a successful cleft-lift will be the most cost effective in the long run, even if you factor in out of pocket travel expenses.

- A cleft-lift will significantly change the appearance of my buttocks. Although the procedure flattens the cleft, once things heal, the contour appears quite normal - just not the way it was before. With clothes on, there is no visible change in the size of the buttocks. There is usually a vertical scar off the center-line on one side or the other.