Re: *JSLS*. 2017 Jul-Sep; 21(3): e2017.00043. DOI: 10.4293/JSLS.2017.00043. Endoscopic Pilonidal Sinus Treatment: Long-Term Results of a Prospective Series

To the Editor:

The article by Giarratano et al[1] highlighted the results of the endoscopic treatment of pilonidal sinus disease. Although this treatment seems impressive, there are a few points that merit discussion.

The high success rate (92%) of endoscopic treatment demonstrates that wide local excision (WLE) or even a simple excision is not a mandatory requirement for the cure of pilonidal disease. The same concept has been amply demonstrated by the high cure rate of pilonidal disease by laying open (deroofing) and curettage of pilonidal sinus under local anesthesia (LOCULA).[2,3] Extensive meta-analysis of 13 studies (n = 1445) published from 1960 through 2014 showed a cure rate of 95.5% with the LOCULA procedure.[2] These results reiterate that incision/deroofing is as effective as excision/WLE for treatment of pilonidal disease. This finding is understandable, as pilonidal disease is a localized sepsis or an abscess, not a malignancy. An abscess anywhere else in the body is treated by incision (preferably deroofing), not by excision, and the same principles should hold for pilonidal disease.

The argument in favor of flap procedures (the Karydakis[4] and the similar Bascom[5] procedure) is that they alter the contour of the buttock cleft and thus help to prevent long-term recurrence. However, the long-term results of the LOCULA and endoscopic procedures have shown that removing surrounding hairs is equally effective in preventing recurrence.[1–3]

Comparing the endoscopic procedure with LOCULA, the latter has a slightly better success rate (95.5–97%) than the endoscopic procedure (90–94.5%). LOCULA does not need any training or expensive endoscopic equipment or irrigation solution (glycine or mannitol), as is needed in endoscopic treatment.[3] LOCULA is effective as a primary therapeutic option in all kinds of pilonidal disease, including recurrent disease and pilonidal abscess.[2,3] Endoscopic treatment is usually avoided in acute abscess.[1] It requires sedation along with local anesthesia,[1] whereas LOCULA can be performed under local anesthesia without sedation. LOCULA involves deroofing[2,3] whereas endoscopic treatment entails just widening of sinus openings.[1] Undoubtedly, deroofing leads to proper and thorough débridement of the hairs and infected lining of the pilonidal sinus cavity than is possible with an endoscope. Deroofing also leads to better drainage and cleaning of the cavity in the postoperative period. Therefore, deroofing is preferred over simple incision in any abscess or localized sepsis. Thus, LOCULA has several advantages over endoscopic treatment.

The use of endoscopic treatment is logical and justified in deeper places like the abdominal cavity where access otherwise would entail a large incision. However, the use of endoscopic equipment in subcutaneous pathology is difficult to justify, especially when simple laying the skin open and deroofing the cavity leads to better results and has several additional advantages.[2,3]

Thus, the LOCULA procedure has all the advantages of endoscopic treatment (simple, performed with local anesthesia, little morbidity, short hospital stay, and early return to work), plus several other benefits (low cost, requires no training, no need for sedation, more thorough débridement, and enhanced drainage in the postoperative period). However long-term controlled studies are needed to corroborate this conclusion.

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