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35-year Onset of a Squamous Cell Carcinoma Originating from Sacral Pilonidal Sinus

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Pilonidal sinus is a benign inflammatory disease characterized by fistulas with exudative discharge. This disease is commonly seen in areas rich in hair follicles that penetrate the skin under direct pressure such as the sacrococcygeal region in the predominantly male population.[1] Pilonidal sinuses can be transformed to malignancies in untreated, chronic conditions. Squamous cell carcinoma (SCC) is the most reported malignant alteration of pilonidal sinus with 20 years of mean onset.[2] We present a SCC case with 35 years of unhealed pilonidal sinus history.

A sixty-seven-year-old man presented to the outpatient clinic with an 8 × 7 cm^2 ulcerative defect with fistulas and exudative discharge in his sacrococcygeal region (Fig. 1). According to his history, he had multiple operations due to pilonidal sinus correction that started 35 years ago. Incisional biopsy was taken for excluding malignancy from the open wound. The biopsy result was compatible with squamous cell carcinoma. Systemic scans were performed; no loco regional lymph node enlargements and far metastatic findings were seen. The patient was taken to operation. All unhealed pilonidal sinus was excised by 2-cm clear margins including presacral fascia. The defect was reconstructed with gluteal transposition flap. The biopsy specimen result was confirmed as squamous cell carcinoma with clear margins. No postoperative complications, relapses, and far metastasis were seen for 2 years of follow-up (Fig. 2).

The generally accepted SCC etiology is chronic inflammation and irritation of skin. Malignant transformation should be suspected under recurrent, long-standing and rapidly growing cases, and cases with bleeding or excessive discharge.[3] Fine needle biopsy or incisional biopsy should be taken in different sites of the ulceration for diagnosis.[4] Poor outcome was reported in some cases with distant metastasis. Surgical excision with clear margins is the most curative treatment. Primary or secondary closure can be chosen. Ipsilateral or bilateral local skin flaps, fasciocutaneous or musculocutaneous flaps are preferred according to the

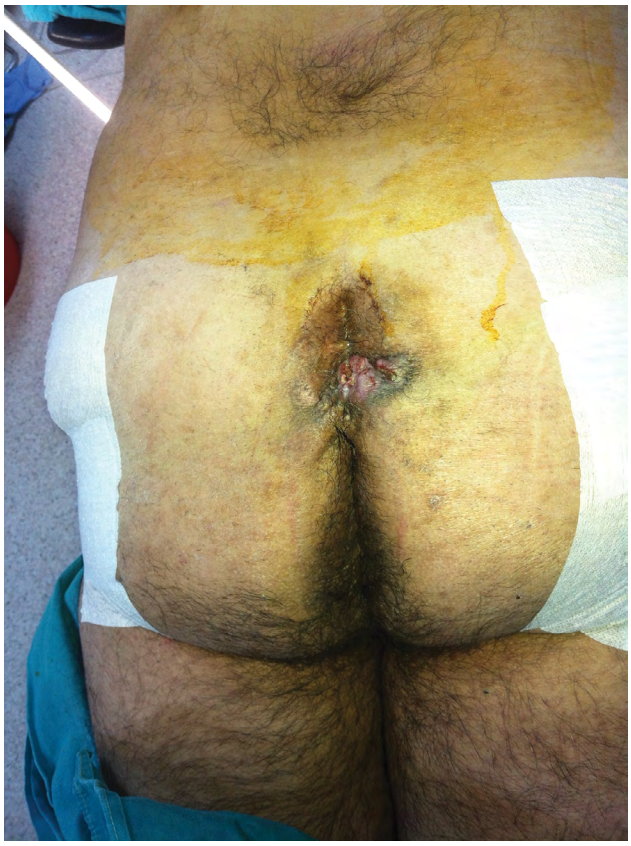

Fig. 1. Preoperative view shows 8 × 7 cm^2 ulcerative pilonidal sinus.

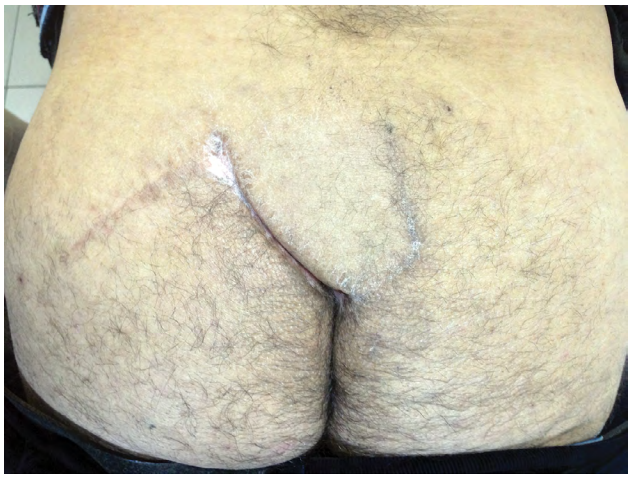

Fig. 2. Postoperative first year image shows well healed gluteal transposition flap.

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defect's size, depth, and surgeon's preference. Radiotherapy and chemotherapy are the reported treatment modalities in cases of recurrence or when surgery is not feasible.[5]

In summary, squamous cell carcinoma should be suspected in long-standing, unhealed pilonidal sinus cases.

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DISCLOSURE

The authors have no financial interest to declare in relation to the content of this article.

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