

# Management of the Excised Pilonidal Wound

Monica Joyner, MD  
St. Francis Wound Care Institute  
Beech Grove, Indiana

Pilonidal disease is acute and chronic, affects young men three times more frequently than women, and is believed to be caused by ingrown hairs that stimulate an inflammatory and granulomatous process. In our clinic, most patients with the disease present after surgical excision and curettage; a few have undergone marsupialization, which decreases the surface area left to heal but still leaves an open wound. Wound size varies from 2 cm to 4 cm deep with an equally wide wound base. Typical postoperative instructions include dry gauze dressing changes and sitz baths.

Comfort during wound dressing application, wearing, and removal seems to be a primary patient concern. Dry gauze, while inexpensive, often sticks to the wound on removal and can leave fibers; some patients complain of the sensation of “sitting on something.” For persons with active lifestyles, the need for dressing change during the day because of strikethrough or saturation is cumbersome and embarrassing. Sitz baths, while comforting, do not provide a clean environment for the wound once the perineum enters the water.

Our approach to the pilonidal wound begins with ensuring all surrounding hair is adequately clipped so it will not fold into the wound bed. The dressing should be easy to apply, have as little bulk as possible, and not adhere on removal. Ideally, the dressing should keep the wound bed moist but absorb, wick away, and contain excess fluid and exudate. Lastly, at the termination of the sitz bath, the patient is asked to elevate the perineum out of the tub and use a 60-cc syringe or other plastic bottle with nozzle to irrigate the wound with clean water. ■

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## Commentary from Ferris Mfg. Corp.

Self-management of a pilonidal wound can be very challenging for the patient. First, the location is usually approximately over the coccyx, near the top of the cleft of the buttocks. Second, these often recurring and painful wounds are typically very inflamed and tender to the touch.

In a representative case study,<sup>1</sup> a 17-year-old female patient presented to the wound care physician 5 days after her pilonidal cyst was incised and drained by Emergency Department staff. She was directed to remove and replace the ribbon gauze that was inserted into the opened cyst, but it was too painful for her to touch, much less change 5 days later. The wound care physician removed 3 feet of ribbon gauze and flushed the wound with saline. At this initial visit, the wound was 1 cm x 1 cm x 4 cm deep with 25% of the wound having 4-cm deep undermining. The patient's pain level was 10 (0–10 scale). The physician initiated oral antibiotics, inserted nonadherent PolyMem Wic<sup>®</sup> Silver Rope dressing into the cavity, and covered it with gauze. The patient was instructed to change the rope dressing in 3 days and the covering gauze as required.

At the 6-day follow-up visit, the patient's pain level was 1 to 2 (0–10 scale). The infection was resolved and the cavity had decreased from 4-cm deep to 2-cm deep. At 12 days, the cavity was 1-cm deep and the patient's pain level was 0. At 1 month, the wound was ready for a flap procedure to prevent reoccurrences. ■



Both physician and patient were able to easily insert and remove the nonadherent, mesh reinforced PolyMem Wic<sup>®</sup> Silver Rope into the drained pilonidal wound.

## Reference

1. Tamir J. Extremely Painful Pilonidal Cyst Infection Resolved Quickly and Easily Using New Reinforced Rope Dressing. Poster presented at the 8th Annual American Professional Wound Care Association. Philadelphia, PA. April 2–6, 2009.

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