World J Surg (2017) 41:1145
DOI 10.1007/s00268-016-3790-9

LETTER TO THE EDITOR

A Backwards Step for Pilonidal Sinus Flap Surgery?

Arkadiusz Peter Wysocki[1,2,3]

Published online: 7 November 2016

Dear Editor,

Is pilonidal sinus disease (PSD) is still "too close to the anus" to have surgical prestige? Gupta et al. [1] compared short-term outcomes of the Karydakis and "Limberg" flaps performed by 17 surgical residents under indirect consultant supervision [2]. As each surgical resident performed a mean of 3 flaps each, the high surgical site complication rate may reflect inadequate technique rather than a deficiency of the Karydakis flap. Disappointingly, despite the title there is no attempt to investigate the learning curves of these flaps. In no way has the study "irrefutably established the superiority of off-midline closure"—this has been done by meta-analyses.

Gupta et al. [2] suggest an experienced surgeon is one who has performed at least 20 such operations, but the surgical residents had performed as few as two flaps prior to this study. These numbers are inadequate—proficiency takes between 30 and 51 modified Karydakis flaps and may depend on the frequency with which the operation is performed [3].

Of equal concern, the rhombic flap described by the authors is actually the Dufourmentel flap and not that described by Limberg [4]. Even though Hodges' article was published in 1880 (not 1980 as stated), it is currently accepted PSD was first described in 1833 by Mayo (not 1847 by Anderson as stated) [1]. Antibiotic prophylaxis by Gupta et al. [5] with only a second-generation cephalosporin is inadequate given the almost ubiquitous presence of anaerobes. This may have contributed to the rate of surgical site infection.

Multiple head-to-head comparisons between Karydakis and Limberg flaps for primary PSD have been published showing broadly equivalent results. The most important point made by this study is that whatever flap reconstruction for PSD is performed, it needs to be taught and executed precisely to ensure desirable patient outcomes.

Funding The author is the president of the Australian Pilonidal Sinus Society and routinely performs the Anderson modified Karydakis flap for primary and recurrent pilonidal sinus disease.

References

1. Doll D et al (2015) Stop insulting the patient: neither incidence nor recurrence in pilonidal sinus disease is linked to personal hygiene. Pilonidal Sinus J 1(1):8
2. Gupta A et al (2016) Learning curve for pilonidal sinus surgery: the best option for budding surgeons. World J Surg. doi:10.1007/s00268-016-3669-9
3. Wysocki AP (2015) Defining the learning curve for the modified Karydakis flap. Tech Coloproctol 19(12):753–755
4. Lister GD, Gibson T (1972) Closure of rhomboid skin defects: the flaps of Limberg and Dufourmentel. Br J Plast Surg 25(3):300–314
5. Zukiwskyj M, Webb PM (2016) The associated microbiology of pilonidal sinus disease in a small rural hospital. Pilonidal Sinus J 2(1):1–4

✉ Arkadiusz Peter Wysocki
arek_p@ecn.net.au

[1] Department of Surgery, Logan Hospital, Corner Meadowbrook and Loganlea Roads, Meadowbrook, QLD 4133, Australia

[2] Griffith Health Centre - G40, Griffith University Medical School, 58 Parklands Drive, Southport, QLD 4215, Australia

[3] Australian Pilonidal Sinus Society, Mount Gravatt East, QLD 4122, Australia