

Pilonidal sinus of perianal location. Difficult differential diagnosis with perianal fistula

Sinus pilonidal de localización perianal. Difícil diagnóstico diferencial con fístula perianal

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Abstract

Pilonidal disease usually arises in the sacrococcygeal area in young men. We present a case of a 39-year-old male with an initial diagnosis of perianal fistula. Despite clinical examination and pelvic magnetic resonance image, only during surgery was revealed that the origin of the fistula was in perianal pilonidal disease. Perianal pilonidal sinus are very rare in the literature. It is often confused with other perianal diseases such as anal fistula. Thus, perianal pilonidal disease should be considered in the differential diagnosis of perianal fistula.

Keywords: Pilonidal sinus. Fistula. Anus.

Resumen

La enfermedad pilonidal generalmente surge en el área sacrococcígea en varones jóvenes. Se presenta el caso de un varón de 39 años con diagnóstico inicial de fístula perianal. A pesar de la exploración clínica y la resonancia magnética pélvica, solo durante la cirugía se evidenció que el origen de la fístula se encontraba en una enfermedad pilonidal perianal. El sinus pilonidal perianal es muy raro en la literatura. A menudo se confunde con otras enfermedades perianales, como la fístula anal. Por ello, la enfermedad pilonidal perianal debe tenerse en cuenta en el diagnóstico diferencial de la fístula perianal.

Palabras clave: Sinus pilonidal. Fístula. Ano.

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Introduction

Pilonidal disease is a suppurative disease that most frequently affects males between 15 and 30 years of age. It is characterized by a cyst containing hair, located in the sacrococcygeal region, which can become infected and fistulize to the skin¹. The presence of pilonidal sinuses located in the perianal region is very infrequent.

Case report

This is the case of a 39-year-old man, with no previous anal surgical procedures or other relevant past medical history, was evaluated in consultation with a 1-year history of intermittent perianal suppuration. Physical examination revealed an external fistulous opening (EFO) located at the 2 o'clock position, 3 cm from the anal margin in the lithotomy position, with active supuration and no changes on the digital rectal examination. T2-weighted images of pelvic magnetic resonance imaging (MRI) (Fig. 1) apparently revealed the presence of an anterior transsphincteric fistula with a small hyperintense collection in the intergluteal cleft. Due to the suspicion of an anal fistula, a surgical exploration was performed (Fig. 2), observing an EFO located at the 2 o'clock position, with signs of abscess formation (asterisk), and another EFO at the 7 o'clock position in lithotomy. Similarly, it was associated with a pilonidal opening in the coccygeal region (circle). The EFOs were cannulated, and hydrogen peroxide was injected, without evidence of communication with the anal canal on anoscopy, contrary to what the MRI suggested. The EFO at the 2 o'clock position communicated with the abscess cavity, and the EFO at the 7 o'clock position communicated with the posterior pilonidal pit. Fistulotomies were performed, which showed chronic pilonidal cavities, with a large amount of hair and granulation tissue (Fig. 3). Complete excisions of the pilonidal cavities and subsequent marsupialization of the edges were performed to promote healing by secondary intention. One and a half months after the intervention (Fig. 4), the patient was asymptomatic, with correct healing of the surgical wounds. At the 2-year follow-up, the patient remains without any signs of recurrence.

Discussion

The diagnosis of pilonidal sinus is usually straightforward. It is a clinical diagnosis, based on the presence of a pilonidal opening in the upper part of the intergluteal sulcus, 4-10 cm from the anal margin¹. Chronic pilonidal

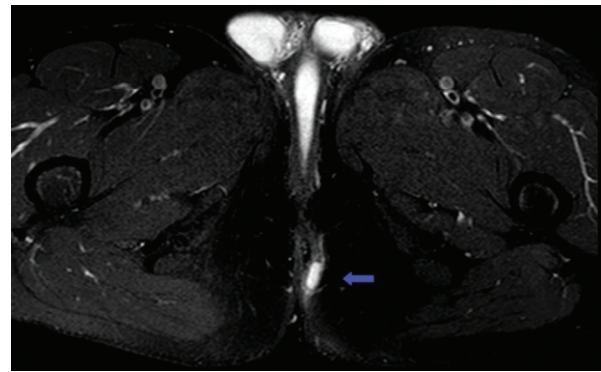


Figure 1. Pelvic magnetic resonance imaging (T2-weighted image) showing an anterior transsphincteric fistula with a small hyperintense collection in the intergluteal cleft (arrow).



Figure 2. Surgical exploration. Presence of 2 external fistulous openings, one at the 2 o'clock position (arrow), with signs of abscess formation (asterisk), and the other one at the 7 o'clock position in lithotomy (arrow), with presence of a pilonidal opening in the coccygeal region (circle).

disease presents with scars and fistulas that communicate with the skin, being almost exclusively limited to the sacrococcygeal region and without communicating with the anal canal. However, in the scientific literature, reduced cases of perianal pilonidal disease have been published, in which, as in our patient, the correct diagnosis is not reached until surgical exploration²⁻⁸.

Pelvic MRI is the imaging modality of choice for the differential diagnosis of perianal disease, presenting a sensitivity rate of 100% and a specificity rate of 98% for the diagnosis of perianal fistula, and it is very useful in preoperative planning⁹. However, as Sert² argues, it is not useful in the differential diagnosis between perianal fistula and perianal pilonidal disease, which we believe is partly due to the low index of suspicion for the latter.



Figure 3. Fistulotomies showing chronic pilonidal cavities, with hair and granulation tissue content.



Figure 4. Healing of surgical wounds one and a half months after the intervention.

Authors such as Eberspacher et al.³ and Aggarwal et al.⁴ report that, infrequently, perianal pilonidal disease can produce abscesses that fistulize to the anal canal. In our patient, although the pilonidal cyst did not present an apparent relationship with the sphincters, nor evidence of an anal fistula, there would be a risk that it would have developed in the long term.

Treatment of perianal pilonidal disease is based on the same principles as in the sacrococcygeal location, taking special care in the obliteration of the fistulous tract and the preservation of the sphincters. Although Sert² administered conservative management by incision and phenolization, the most widely used technique in the published cases has been excision, with or

without primary closure^{3,5,7,8}. In our patient, a wide excision with marsupialization of the edges and healing by secondary intention was performed, with good results during follow-up.

Conclusions

Although pilonidal sinus of perianal location is very infrequent in clinical practice, it should be taken into account in the differential diagnosis of perianal fistula, especially in those patients with a simultaneous diagnosis of pilonidal sinus. Finally, we consider that our patient can be added to the few published clinical cases.

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Conflicts of interests

The authors declared no conflicts of interests.

Ethical considerations

Protection of people and animals. The authors declare that no experiments on humans or animals have been carried out for this research.

Confidentiality, informed consent, and ethical approval. The authors have obtained approval from the Ethics Committee for the analysis of routinely and anonymously obtained clinical data, so informed consent was not necessary. The relevant recommendations have been followed.

Declaration on the use of artificial intelligence. The authors declare that they did not use any type of generative artificial intelligence for the writing of this manuscript.

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