

Usefulness Of Anal Endosonography In The Diagnosis And Management Of Perianal Pilonidal Sinus

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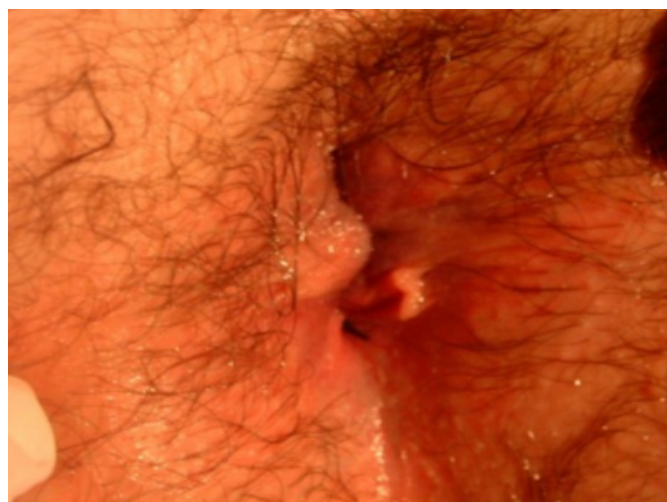
Abstract

Dear Sir:

We have recently read the article published in your e-journal written by Dr. Shankar (1). We believe it is an interesting case and a very appropriate discussion. We also successfully treated 2 years ago a case of pilonidal sinus located in the perianal region. In our case, the pilonidal sinus was in the anterior anal cleft, very close to the anus. The diagnosis was based on the protrusion of a small bundle of hair through the opening of a suppurating pit (Figure 1).

Figure 1

Figure 1: Perianal inspection, it shows the fistulous opening in the anterior anal cleft with the exit of hair.



An endoanal ultrasound was performed which showed an intersphincteric fistulous track (echoes were visualized inside, probably produced by the hair) that opened into a 3x2 cm cavity outside of the external anal sphincter in the region of the anterior cleft, without evidence of opening to the anal channel (Figures 2 and 3).

Figure 2

Figure 2: Preoperative anal ultrasound that shows the suppurating cavity.

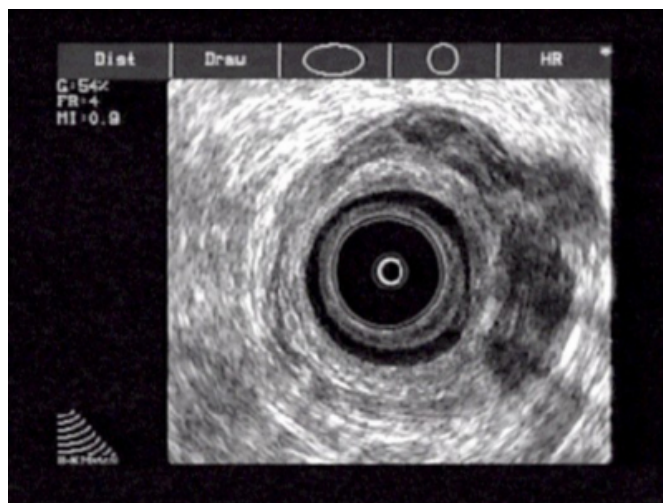
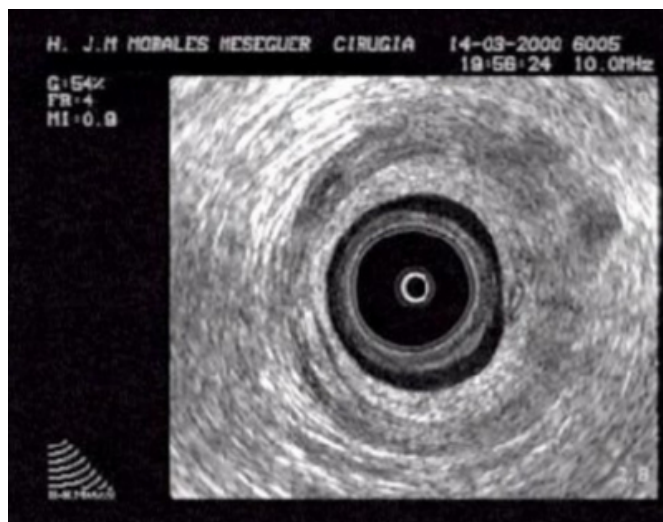


Figure 3

Figure 3: Preoperative anal ultrasound showing the fistulous tract with echoes inside produced by hair.



Under local anesthesia a drainage and curettage of the cavity was performed and a complete healing of wound happened within 23 days. After more than 2 years the patient stays free of symptoms without evidence of signs of recurrence from the sinus. A control endoanal ultrasound only shows a small defect of the internal anal sphincter (IAE) as a consequence of surgery (Figure 4).

Figure 4

Figure 4: Postoperative anal ultrasound showing a defect of the IAE.



As Dr Shankar discusses, there are different theories to try to explain these findings. Although the most accepted theory is the caudal extension of a sacrococcygeal pilonidal sinus, which happens in up to 7% of the sinuses, our case has to be included in which some authors call “anterior sinus”, where this mechanism is more difficult to happen. In our case we think that the mechanism of production was a hair penetrating through normal perianal skin (it doesn't seem that the hair penetrated through the opening of an anal fistula because there was no fistula). We emphasize how important is to make an anal ultrasound in the diagnosis and follow up of these patients.

References

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