International Surgery Journal
Kansal A et al. Int Surg J. 2016 Aug;3(3):1669-1671
http://www.ijsurgery.com
pISSN 2349-3305 | eISSN 2349-2902

DOI: http://dx.doi.org/10.18203/2349-2902.isj20162772

Case Report

A rare case of recurrent pilonidal sinus of scalp

Abhishek Kansal[1], Rajiv Jain[1]*, Suraj Jain[1], Kavita Munjal[2]

[1]Department of Surgery, Sri Aurobindo Medical College and PG Institute, Indore, MP, India
[2]Senior Histopathologist and Head, Metropolis Laboratories, Indore, MP, India

Received: 26 April 2016
Revised: 04 June 2016
Accepted: 04 July 2016

***Correspondence:**
Dr. Rajiv Jain,
E-mail: rajivrameshjain@gmail.com

ABSTRACT

Pilonidal sinus can sometimes be found at the rare site. History of previous surgery can give important diagnostic clue. In the present study, we reported a case of a middle aged lady who has undergone surgery of scalp nodule for misdiagnosed infected sebaceous cyst. On evaluation and exploration, this turned out to be a recurrent pilonidal sinus of scalp. Pilonidal sinus should be included under the differential diagnosis of any long standing sinus over a hairy area.

Keywords: Pilonidal sinus, Sacrococcygeal area, Ultra sonography

INTRODUCTION

Chronic pus discharging sinus over head and neck area is a frequently encountered annoying problem. In a developing country like India, many times, Tuberculosis is the underlying cause. Occurence of pilonidal sinus is usually in the sacrococcygeal area, although rare cases have been described in other sites, including chin, neck, face, nose, scalp, supra auricular area, external ear, interdigital space and umbilicus.[1] We are reporting an extremely rare case of misdiagnosed chronic pus discharging sinus of the scalp which was finally diagnosed as a recurrent pilonidal sinus and managed successfully.

CASE REPORT

A 42 year old illiterate female from a remote rural area presented in the department of surgery in our institute, Sri Aurobindo Medical College and PG Institute with 8 month history of pus discharging nodular sinus over left retroauricular area. She had a history of surgery of suspected infected sebaceous cyst over the same site at a peripheral hospital about 1 year back, when the swelling was excised and the wound was primarily closed. About 4 months later, she developed hard nodule over the operated site associated with thick purulent discharge.

She also gave a history of some surgery for a swelling over the same site about 20 years back, but the details were unavailable.

On physical examination, there was an indurated palpable tract of the size of 1.5 cm under a linear scar mark over the left retroauricular region. The tract was extending downwards, forwards and medially and terminating into a 0.5×0.5 cm size tender hard nodule, with a central orifice. On pressing the tract and nodule, there was presence of slight purulent discharge from the orifice. On examining though a magnifying lens, a single hair was seen protruding through the orifice. So the clinical diagnosis of recurrent pilonidal sinus of scalp was made.

The routine hematological and biochemical tests were normal. Radiograph of the skull was unremarkable. Ultra sonography of the local area was suggestive of a localized, ill-defined hyperechoic lesion with few internal echoes in the subcutaneous tissue in retroauricular region which is suggesting subcutaneous collection.

Figure 1: Postoperative photographs (day 3) of patient showing healing wound.

Figure 2: Postoperative photograph (day 10) of patient showing epithelisation.

The patient was operated in right lateral position under local anaesthesia. Initially, the collected pus was fully expressed and the area was cleaned with antiseptic solution. Then methylene blue dye was injected through the orifice. Incision was taken from the orifice and extending though the well demarkated tract.

After opening the tract, a tuft of hairs was found inside the tract, the hairs were intermixed with the pus which was foul smelling. The tuft of hair and the whole tract was excised and the base was curetted upto the skull bone and the wound was left open for healing by secondary intention.

Histopathology of the excised sinus tract was suggestive of epidermal tract with underlying stroma showing mixed inflammatory infiltrate by lymphoplamacytic cells and entrapped hair shaft. There was no evidence of tuberculosis and any other chronic granulomatous disease. So the histopathology confirmed the clinical diagnosis of pilonidal sinus of the scalp.

The wound healed well by secondary intention and got epithelized in 12 days. The patient was followed for 6 months postoperatively and there is no evidence of recurrence or any other complication.

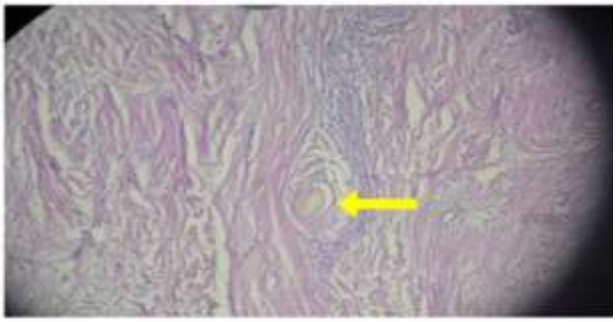

Figure 3: Histological photomicrograph showing entrapped hair shaft (yellow arrow) with inflammation around (high power).

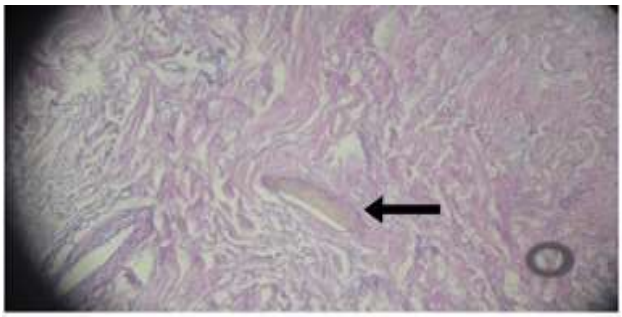

Figure 4: Histological photomicrograph of subcutaneous tissue showing entrapped hair shaft (black arrow).

DISCUSSION

Pilonidal disease is described back as far as 1833, when Mayo described a hair-containing cyst located just below the coccyx. Hodge coined the term "pilonidal" from its Latin origins in 1880 and today, pilonidal disease describes a spectrum of clinical presentations, ranging from asymptomatic hair-containing cysts and sinuses to large symptomatic abscesses of the sacrococcygeal region that have some tendency to recur.

The aetiology of pilonidal sinus remains unclear.[1-3] There are two main theories regarding its aetiology- acquired and congenital.[4]

In general, at least three conditions need to be fulfilled for a pilonidal sinus to occur: first is hair in the skin and, second, some kind of wrinkled skin, such as the natal cleft or a scar. The third condition is a mixture of hormonal and hygienic problem.[5]

Pilonidal sinus is typically encountered in the sacrococcygeal region, but rare cases have been described at other sites.[1-5] There are extremely rare cases at head and neck localizations in the literature.

Occurence of pilonidal sinus in the scalp is very rare because though scalp is a very hairy area but the scalp tissue is dry and tough. So the incarceration of hairs

inside the scalp tissue generally does not occur. But any mechanical or surgical trauma can be an initiating factor for the entry of hair inside the wound.

In the present case, there was a surgical history of excision of some swelling about 20 years back which might be the cause of inadvertent entry of hairs in the wound and initiating factor for the development of pilonidal cyst. This cyst was misdiagnosed as sebaceous cyst of scalp about 1 year back at a peripheral hospital and operated for the same, which was not the definitive surgery. So the patient continued having pus discharge from the operative site and finally diagnosed as pilonidal sinus.

Although this lesion is rare in the scalp, it should be included the differential diagnosis of subcutaneous head and neck nodule and chronic sinus.

CONCLUSION

Sacrococcygeal area is the predominant site for occurrence of pilonidal sinus. Occurrence of pilonidal sinus over scalp is extremely rare. It should be included in the differential diagnosis of any long standing sinus or nodule of head and neck area, and especially when there is history of some surgical intervention in the scalp. We recommend the complete excision of sinus tract with decision of wound closure according to the underlying conditions.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: Not required

REFERENCES

1. Oudit D, Ellabban M, Eldafl D, Crawford L, Juma A. Pilonidal sinus of the chin. Plast Reconstr Surg. 2005;115:2153-4.
2. Meher R, Sethi A, Sareen D, Bansal R. Pilonidal sinus of the neck. J Laryngol Otol. 2006;120:5.
3. Yokoyama T, Nishimura K, Hakamada A, Isoda KI, Yamanaka KI, Kurokawa I, et al. Pilonidal sinus of the supra-auricle area. J Eur Acad Dermatol Venereol. 2007;21:257-8.
4. O'Sullivan MJ, Kirwan WO. Post-traumatic pilonidal sinus of the face. Br J Dermatol. 2000;143:1353.
5. Doll D, Petersen S. Trauma is not a common origin of pilonidal sinus. Dermatol Surg. 2008;34:283-4.

Cite this article as: Kansal A, Jain R, Jain S, Munjal K. A rare case of recurrent pilonidal sinus of scalp. Int Surg J 2016;3:1669-71.