

Letter to the Editor

Pilonidal disease, hidradenitis suppurativa and follicular occlusion syndrome: a diagnostic challenge

Dear Editor,

Pilonidal sinus (PS) represents a common disease in clinical and surgical practice. It is usually found in the sacrococcygeal region and it is frequently associated with obesity, hirsutism, young age, male sex, hyperhidrosis and positive family history¹. The term "pilonidal" was firstly used in 1880 by Hodges² and it derives from the Latin word *pilus* meaning hair and *nidus*=nest to indicate a disease consisting of hair-containing sinus in the sacrococcygeal area. PS may show different clinical presentations ranging from asymptomatic pits to painful draining cyst in the natal cleft. Pilonidal cyst usually appears as an inflammatory and purulent nodule which may communicate with the outside through one or more sinus tracts, located medially or laterally to the midline.

Pilonidal disease may be observed in as many as one-third of patients with hidradenitis suppurativa (HS) (Figure 1). This condition, also known as acne inversa, is a chronic, inflammatory and recurrent disease of the hair follicle that generally appears after puberty (second and third decades). HS affects apocrine gland-bearing areas of the body, most commonly the axillae, inguinal and anogenital regions. Typical cutaneous lesions include primary (nodules and abscesses), secondary (sinus tracts and drainage sinuses), and tertiary (double-ended pseudocomedones and scars) lesions^{3,4}. In 1951, the occurrence of HS, acne conglobata and dissecting cellulitis of the scalp was first described in three patients as "follicular occlusion triad"⁵. Thereafter, a fourth disorder, pilonidal disease, was added, configuring the so-called "follicular occlusion tetrad syndrome", which may be associated with genetic mutations⁵. For these reasons, the diagnosis of pilonidal disease should be adequately investigated by surgeons, considering the likely association with HS and less frequently with the follicular occlusion syndrome. The clinical diagnosis of pilonidal disease can be considered "trivial" but, in such cases, it could hide some pitfalls. In Figure 2 we propose a simple and helpful flow-chart designed to address the surgeon to an optimal approach to patients with PS, according to a consolidated collaboration at our center. General surgeon is



Figure 1. A 24-years-old woman presenting with a surgical scar from previous removal of pilonidal sinus along with nodules, abscesses and scars typical of HS.

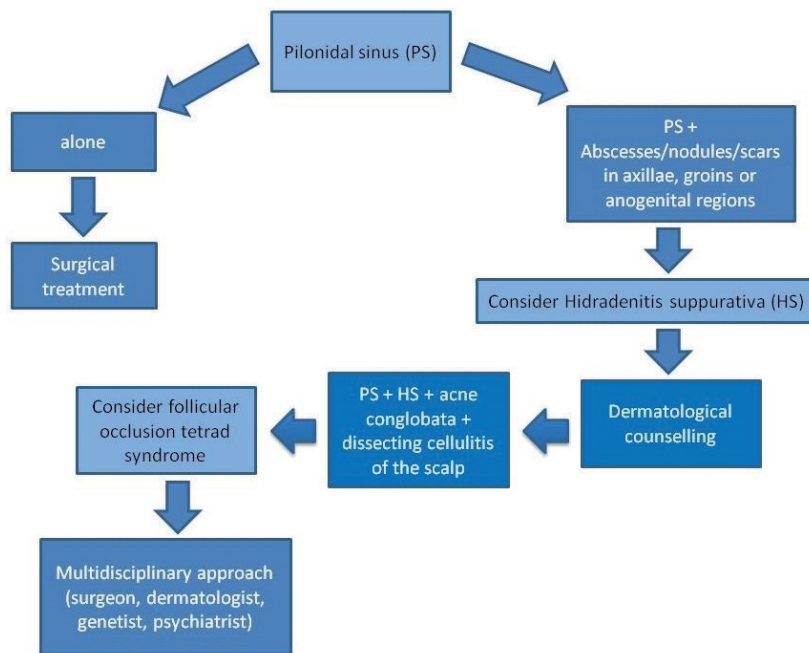


Figure 2. Diagnostic flow-chart on pilonidal sinus disease.

encouraged to perform an accurate physical examination of these patients in order to consider a possible association with HS and to address the patient to dermatological counseling. Power-Doppler ultrasound and dermatoscopy represent useful tools utilized by dermatologists to enhance the clinical diagnosis of HS. We underline the importance of a strong collaboration between general surgeons and dermatologists in such borderline clinical situations. In conclusion, a multidisciplinary approach is highly recommended in doubtful cases and young surgeons should refer to centers with a known experience on HS in order to provide patients with an integrated approach according to the most updated guidelines of care.

Conflict of interest

The authors declare no conflicts of interest.

References

- 1) PRONK AA, EPPINK L, SMAKMAN N, FURNEE EJB. The effect of hair removal after surgery for sacrococcygeal pilonidal sinus disease: a systematic review of the literature. *Tech Coloproctol* 2018; 22: 7-14.
- 2) HODGES RM. Pilonidal Sinus. *Boston Med Surg J* 1880; 103: 485-586.
- 3) MICALI G. Hidradenitis suppurativa. A diagnostic atlas. Wiley Blackwell First Edition 2017; pp. 1-5.
- 4) LACARRUBBA F, MUSUMECI ML, NASCA MR, VERZI AE, FIORENTINI F, MICALI G. Double-ended pseudocomedones in hidradenitis suppurativa: clinical, dermoscopic, and histopathological correlation. *Acta Derm Venereol* 2017; 97: 763-764.
- 5) VASANTH V, CHANDRASHEKAR BS. Follicular occlusion tetrad. *Indian Dermatol Online J* 2014; 5: 491-493.

A. Pesce¹, G. Capuzzo², B. Cammisuli³, M.L. Musumeci², G. Micali²

¹Department of Medical and Surgical Sciences and Advanced Technologies "G.F. Ingrassia", University of Catania, Catania, Italy

²Dermatology Clinic, A.O.U. Policlinico-Vittorio Emanuele, University of Catania, Catania, Italy

³Faculty of Medicine, University of Palermo, Palermo, Italy