



A Rare Case of Umbilical Pilonidal Sinus Mimicking Umbilical Adenoma

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Abstract

Although most cases of pilonidal sinus are found in the sacrococcygeal region, umbilical presentations can occur as well. There are only a few reports of umbilical pilonidal sinus in the literature. We report a case of umbilical pilonidal sinus in a 22-year young male. Sinus excision was carried out and the microscopic findings revealed umbilical pilonidal sinus. The present paper recapitulates the microscopic features and treatment of this rare disease.

Keywords: Umbilical pilonidal sinus, granulation tissue, excision, young adult, recurrence.

Introduction

Pilonidal sinus disease is a common problem of the sacrococcygeal region. However, it is also observed in the periumbilical area¹. Male sex, young age, hairiness, deep navel and poor personal hygiene were found to be predisposing factors². The predisposing factors are briefly discussed, however, the exact etiology of this disease remains unknown³. Possible mechanisms of formation are described. It is suggested that this possibility should be considered in cases of resistant or recurrent omphalitis⁴. Clinical as well as pathological patterns observed seem to support the hypothesis of a congenital etiopathogenesis⁵. Due to the risk of peritoneal extension of inflammation from this lesion, the umbilical pilonidal sinus should be treated more aggressively than its sacrococcygeal counterpart¹. The importance of differential diagnosis of

umbilical pilonidal sinus from other umbilical pathologies is also emphasized². Treatment of umbilical pilonidal sinus is usually surgical⁶.

Case Report

A 22-year-old man presented with umbilical pain, tenderness, swelling, serosanguinous discharge. Umbilical pain was the starting symptom, was followed by umbilical discharge. The discharge was serous, occasionally mixed with blood and pus. No previous history of any trauma to the umbilicus. On sinogram abdomen a linear blind ending 1.8 cm long subcutaneous tract is seen coursing inferiorly from external opening at umbilicus (Figure 1). A 1cm long branch is seen arising from lower part of the tract coursing upwards and medially. No communication with bowel is seen. No peritoneal spillage seen. The opaque material, which was released from the

orifice of the fistula at the umbilicus was seen through the fistula tract filling the tract. An infected pilonidal sinus was excised by wedge fashion after an umbilical abscess failed to respond to antibiotic treatment (Figure 2). Preformed defect was repaired by separate absorbable sutures from underneath. The center of new umbilicus was secured to fascia by single delayed absorbable suture. Then the skin was closed by running sub-cuticular fashion with absorbable suture. Antibiotic was administered to the patient in postoperative period. Histopathologic evaluation was compatible with pilonidal sinus disease. Follow-up examinations were performed at the first, third and sixth months after the surgery, and no recurrence was observed throughout in this period. The patient found the appearance of the new umbilicus “acceptable (figure -3).

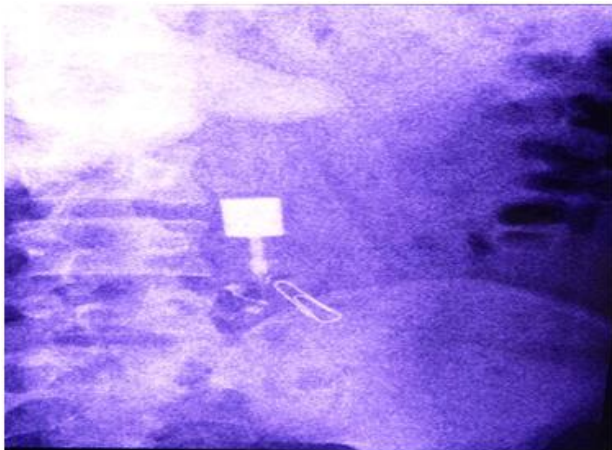


Figure 1- Abdominal Sinogram showing linear blind ending 1.8 cm long subcutaneous tract is seen coursing inferiorly from external opening at umbilicus.



Figure 2- Excised pilonidal sinus, with tuft of hairs seen in it.



Figure 3- Wound of patient on third post-operative day healed.

Discussion

Umbilical pilonidal sinus is a rare disease compared to Sacro-coccygeal pilonidal sinus, the incidence being 0.6% as reported by Goodall in his study⁷.

There are many contributory factors for the development of this disease, e.g., obesity, male gender, tight clothing, deep naval, and poor personal hygiene⁸. There are various methods for the treatment of umbilical pilonidal sinus, ranging from simple hygienic measures, removal of hair, and keeping the umbilicus dry⁹ to radical excision of umbilicus. Kareem in his study¹⁰ documented a total of 134 patients were seen out of which 90.3% were men. 76.19% of patients responded to conservative treatment and rest of 23.8% were retreated by a second session of conservative treatment. Of these 25 patients, 19 (76%) came back for the third visit and only three (15.78%) patients did not respond to the treatment. Hence he concluded that conservative treatment should be regarded as the first choice and the main method of treatment in the management of umbilical pilonidal sinus¹¹. Similarly Sarmast et al documented favourable results in over 90% of cases with conservative management¹². Keeping in view good results of conservative measures, we managed our patient conservatively, and when he did not respond to conservative measures surgery with excision of umbilicus. Other differential

diagnosis should also be kept in mind, like urachal cyst can mimic umbilical pilonidal sinus as documented by Abdulwahab et al.¹³

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