

Title	Guideline: The Management of People with Pilonidal Sinus Wounds
Background	See “Guideline: The Assessment of People with Pilonidal Sinus Wounds
Indications	This guideline is intended to be used by health care providers, to guide their management of individuals with a pilonidal sinus wound.
Guideline	<ol style="list-style-type: none"> 1. Position the patient in a prone jackknife position. One or two pillows may need to be placed under the patient’s anterior pelvis when they are lying prone to achieve the desire effect. The patient must then separate their buttocks using both hands <p>Healing Wounds</p> <ol style="list-style-type: none"> 2. If it is determined that the wound in question is on a healing trajectory (based off of the health care providers holistic assessment and clinical judgement) cleanse the wound with an appropriate wound cleansing solution. Ensure that you have irrigated to the base of any sinuses present using a 20G angiocatheter, wound irrigating tip, small Foley catheter, or pediatric NG tube Note: follow the manufacturer’s instructions when using a wound cleansing solution 3. Debridement of loose, non-viable tissue in the wound should be performed by a trained health care provider who has the knowledge, skill, and competency to do so. Please refer to your respective college and employer’s policies and procedures before undertaking this task. For further guidance see “Guideline and Procedures: Wound Debridement” and “Guideline and Procedure: Conservative Sharp Wound Debridement” 4. Cleanse the wound again post debridement. Gently <u>pat</u> the wound dry with gauze as needed. NOTE: you may consider gently packing a piece of gauze strip packing into sinus areas to remove any excess cleansing solution, and then removing that wet packing 5. Cleanse the perineal skin extending 5cm around the wound with 0.5% chlorhexidine, leaving the solution in place for 1 minute. NOTE: if the patient is sensitive to chlorhexidine, consider using povidone 10% in its place 6. Dress the wound with an appropriate conventional moist wound dressing(s) per the physician or nurse practitioners orders. If there are no specific orders for a wound dressing consider the following when choosing a dressing or see “Guideline: The Assessment and Management of Moisture in Acute and Chronic Wounds” for guidance: <ol style="list-style-type: none"> i. Promote an ideal moist wound healing environment ii. Prevent wound bed cooling and disruption iii. Avoid wound contamination by fecal matter and/or hair iv. Matches the contours of the natal cleft, sealed at all edges v. Reduce interface friction and shear vi. Prevent strike through of exudates that potentiates bacterial contamination, while wicking moisture away from the wound base vii. Be cost effective, i.e. do NOT use expensive products for daily dressings

	<p>viii. Be comfortable to wear, cushioning the wound and not causing increased pain during wear time or on removal</p> <p>7. Choose an appropriate dressing change frequency based on:</p> <ol style="list-style-type: none"> Your wound assessment, including the patient's risk for infection Dressing products used and their ability to manage the exudate The patient's comfort and acceptability <p>Not-Healing/Not-Healable Wounds</p> <p>8. If it is determined that the wound in question is not-healing or not-healable due to intrinsic and/or extrinsic factors that are impeding healing (based off of the health care providers holistic assessment and clinical judgement) cleanse the wound with an appropriate wound cleansing solution and follow the manufacturer's instructions. Ensure that you have irrigated to the base of any sinuses present using a 20G angiocatheter, wound irrigating tip, small Foley catheter, or pediatric NG tube</p> <p>9. If you have determined that the wound is not healing or not-healable: DO NOT DEBRIDE</p> <p>10. Cleanse the perineal skin extending 5cm around the wound with 0.5% chlorhexidine, leaving the solution in place for 1 minute. NOTE: if the patient is sensitive to chlorhexidine, consider using povidone 10% in its place</p> <p>11. Choose an appropriate dry gauze based dressing(s) per the physician or nurse practitioners orders. Consider the following when choosing a dressing:</p> <ol style="list-style-type: none"> Promote a dry wound environment Minimize bacterial contamination and contamination by fecal matter and/or hair Matches the contours of the natal cleft, sealed at all edges Prevent strike through of exudates that potentiates bacterial contamination, while wicking moisture away from the wound base Be cost effective, i.e. do NOT use expensive dressing products for daily dressings Be comfortable to wear, cushioning the wound and not causing increased pain during wear time or on removal <p>12. Choose an appropriate dressing change frequency based on:</p> <ol style="list-style-type: none"> Your wound assessment - goal is to keep the wound clean, dry and free of infection Dressing products used and their ability to manage the exudate The patient's comfort and acceptability <p>Management Guidelines for ALL Pilonidal Sinus Wounds</p> <p>13. Treat the cause:</p> <ol style="list-style-type: none"> Modify any identified intrinsic, extrinsic, and iatrogenic factors affecting wound healing to promote healing or stabilization if healing is not the goal, and to prevent complications Remind the patient to limit excessive walking, prolonged periods of sitting and participation in sports until the wound has closed. These activities contribute to shearing, friction and pressure at the natal cleft area, which can impair wound healing.
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	<p>14. Patient centered concerns:</p> <ul style="list-style-type: none"> a. Manage pain through advocacy and collaboration with the patient and primary health care provider. Considerations may include encouraging the patient to take their pain medication prior to dressing change, non-pharmacological methods such as distraction/guided imagery. b. Ensure that the plan of care reflects and includes the patients concerns, goals, abilities, and preferences <p>15. Infection control:</p> <ul style="list-style-type: none"> a. Teach that new onset or worsening pain may be a sign of infection and requires immediate medical attention NOTE: Topical antimicrobials can be used to reduce bacterial burden in the presence of superficial wound infection, but <u>never</u> take the place of systemic antibiotics when those are needed for deeper infections b. If you suspect a superficial or spreading infectious process update the primary care provider urgently. c. Instruct the patient to attend their nearest urgent care or emergency department if there are signs of a spreading infection, cellulitis, systemic involvement, or per your clinical judgement d. Implement strategies to prevent infection, i.e.: <ul style="list-style-type: none"> i. Proper hand washing ii. Adequate/appropriate hair removal in the natal cleft. The natal cleft should be shaved at least weekly in a 5cm wide strip extending at least 2.5cm from all edges of the wound using an electric razor designed specifically for the bikini area <p>16. Advocate for or request interdisciplinary referrals:</p> <ul style="list-style-type: none"> a. General Surgeon: consideration of pilonidal incision and drainage/curettage or natal cleft excision for recurrent pilonidal sinus wounds b. Wound Care Specialist for conservative sharp debridement, treatment planning, adjunct therapies c. Registered Dietician: diet, nutrition, glycemic control, supplementation, weight control d. Speech Language Pathologist: presence of risk of developing a swallowing impairment e. Physiotherapy: mobility/exercise plan f. Occupational therapist: assistive devices, assessment of functional status g. Social Work: psychosocial and economic/community supports <p>17. Education for the patient and/or support patient(s):</p> <ul style="list-style-type: none"> a. Changing dressings as instructed, and keeping dressings clean and dry at all times b. Removing soiled dressings before showering. The patient should shower (using liquid antibacterial soap) at least once daily and may flush the wound with a hand held shower head during showers c. Quitting or reducing smoking helps improve healing
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	<ul style="list-style-type: none"> d. The importance of good nutrition and hydration e. The importance of managing pain effectively f. The importance of ongoing follow-up with a health care provider at regular intervals g. Showering or cleansing the area after each bowel movement (keep moistened sanitary wipes near the toilet to use after each bowel movement) h. Planning shower times after bowel movements if possible, to ensure the patient completes a hygiene routine at a minimum of once per day i. Using a handheld sprayer to gently flush out the inside of the wound and to direct soap, shampoo, and loose hair away from the wound during showering j. Avoiding prolonged periods of sitting and/or excessive walking k. Avoiding physical sport activities while the wound is open l. Follow the surgeons instructions regarding physical activity and driving following any surgical intervention m. Wearing loose pants and keeping belts above the wound n. Recognizing the signs and symptoms of infection/complications and when and how to seek IMMEDIATE help o. The importance of preventing constipation p. Chronic diseases and how they affect the healing process and the importance of adhering to the treatment plan q. The wound dressing technique if they or their caregiver are going to be changing dressing <p>18. Provide resources/links to reinforce health teaching:</p> <ul style="list-style-type: none"> a. SWRWCPs “My Pilonidal Sinus” available at: https://swrwoundcareprogram.ca/Uploads/ContentDocuments/SWRWCP_PilonidalSINUS.pdf <p>19. Re-evaluate</p> <ul style="list-style-type: none"> a. Regularly and consistently measure the wound, weekly at a minimum, using the same method b. Conduct a comprehensive reassessment to determine wound progress and the effectiveness of the treatment plan, i.e. using the “NPUAP PUSH Tool 3.0”, weekly at a minimum c. If the wound is not healing at an expected rate despite the implementation of best practice interventions, you need to: <ul style="list-style-type: none"> i. Update the primary care provider and wound care specialist ii. Re-evaluate plan of care and advocate for or request referrals iii. Discuss barriers or challenges with the patient d. Reassess pain at EVERY dressing change and more frequently as reported by the patient, using the same pain tool/scale each time. Report pain management issues to the patient’s primary care physician or primary care nurse practitioner
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	<p>20. Notify the primary care physician or primary care nurse practitioner immediately if the following occur:</p> <ol style="list-style-type: none"> Acute onset of pain or increasing pain Signs of localized and/or systemic infection develops <p>21. Documentation:</p> <ol style="list-style-type: none"> Document initial and ongoing assessments as per your organizations guidelines Document care plans, implementation strategies, and outcome measurements as per your organizations guidelines
Outcomes	<ol style="list-style-type: none"> Intended: <ol style="list-style-type: none"> The wound closes and drainage ceases. Expected rate of healing is a reduction of wound surface area by a minimum of 20-30% in 3-4 weeks The wound remains infection free The patient indicates that pain is resolved or manageable The patient understands their role in preventing further tissue damage and incorporates recommended activities and interventions to treat risk factors The patient can identify signs and symptoms of infection, and can describe how, when and whom to call when problems occur The patient becomes independent in self-management of their wound Unintended: <ol style="list-style-type: none"> The wound does not close in a timely fashion The wound becomes infected The patient expresses concerns about poorly managed pain The patient does not understand and/or act on their role in preventing further tissue damage and do not incorporate recommended activities and interventions to treat risk factors The patient does not understand the signs and symptoms of infection/complications, and when, how and whom to seek help from The patient does not become independent in self-management of their wound
References	<ol style="list-style-type: none"> Pilonidal Support Alliance. What is it? Accessed April 11, 2012 from: http://www.pilonidal.org/education/whatisit.php. Banerjee D. The etiology and management of pilonidal sinus. Journal of Wound Care. 1999;8:309-10. Brearley R. Pilonidal sinus a new theory of origin. Br J Surg. 1955;43(177):62-8. Sondenaa K, Pollard ML. Histology of chronic pilonidal sinus. APMIS. 1995;103:267-72. Lord P. Anorectal problems: etiology of pilonidal sinus. Dis Colon Rectum. 1975;18:661-4. Bascom JU. Pilonidal disease: long-term results of follicle removal. Dis Colon and Rectum. 1983;26:800-7. Spivak H, Brooks V, Nussbaum, et al. Treatment of chronic pilonidal disease. Dis Colon Rectum. 1996;39:1136-9.

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