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LETTER TO THE EDITOR

Management for pilonidal disease: Before you compare, use a classification system

To the Editor,

We read with great interest the article by Bayhan et al,¹ whose work shows that when compared with modified Limberg flap procedure, phenol treatment appears to be a convenient treatment of choice for pilonidal sinus disease because of its many advantages. They also stated that they are currently running a prospective study to add more data to this subject.

In their study, they did not use a classification system for pilonidal disease. It is impossible to compare the two procedures because they, in fact, do not know the exact severity of the disease in each patient. The retrospective nature of the study may also cause a bias. In that study, there is a possibility of choosing the flap procedure in patients with a severe disease. We believe that there must be a difference between the management of a patient with a small asymptomatic pit on the natal cleft and another patient with a complex extensive symptomatic disease where multiple sinus openings lie outside the natal cleft. In order to avoid introducing bias, we should compare the same group of patients. We would like to express our opinion, based on two important questions. First, was the seriousness or involvement of the disease similar in all patients? Second, was there a correlation between recurrence and extension of the disease?

An easy, practical, and realistic clinical classification system that reflects the extension of the disease should be proposed so that we can compare the results of the management procedures according to the type of pilonidal disease being treated. Although Tezel² proposed such a system, which is based on the navicular area concept, it has not been accepted worldwide—because according to the Tezel classification system, the same type of operation is recommended for different types of pilonidal diseases. Starting from this stand point, Irkörüçü et al³ proposed an

easy five-point classification system for pilonidal disease based on the natal cleft in 2012.

- Type I: pit(s) on the natal cleft
- Type II: pit(s) on either side of the natal cleft
- Type III: pits on both sides of the natal cleft
- Type IV: complex pilonidal disease with multiple pits on and beside the natal cleft
- Type V: recurrent pilonidal disease

We recommend to the authors to read the above-mentioned manuscript before beginning a new study in this field.

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Reply to the Letter to the Editor: “Crystallized phenol application and modified limberg flap procedure in treatment of pilonidal sinus disease: A comparative retrospective study”

We would like to thank Dr. Irkorucu for his kind interest to our article¹ and responding with his letter. We agree with the suggestions of him that retrospective nature of our study is a limitation as we have already stated in the manuscript. However, both groups carry similar features and similar disease severity; therefore the groups are completely comparable, in our opinion, as described in the method section.

Although, many surgical procedures have been described for the treatment of sacrococcygeal pilonidal disease, it is still hard to decide to choose the best one. Studies comparing different surgical methods are not conclusive enough. Deficiency of proper classification of pilonidal disease in those studies is one of the major shortfalls to reach a conclusion about what method is better than the others. Efforts of Dr. Irkorucu and others to classify pilonidal disease are admirable and clearly helpful to choose correct management for pilonidal disease.² We acknowledge his classification system and share the same opinion with him, that using such classification makes easier to compare different surgical techniques.

On the other hand, crystallized phenol treatment for pilonidal disease is quietly a different form in comparison with the commonly used excision and flap procedures. Since, it is an extremely minimal invasive approach, there are several advantages including a very short procedure time, prompt return to daily activities without any restriction with acceptable healing period. Additionally, it is easily repeatable several times. One of the most important aspects of phenol treatment is that patients with complex pilonidal disease characterized by high pit numbers, big cavity size or recurrence also suit phenol treatment very well.^{3,4} Thus, the classification systems created to make a decision between the excision-flap procedures are not applicable for phenol treatment. Yet, a different

classification addressing to phenol treatment may be developed to estimate success rate and healing time.

We are very thankful to Dr. Irkorucu for his insightful comments and we would clearly benefited from his remarks for our ongoing study about pilonidal disease.

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