

Interdisciplinary Dialogue Is Needed When Defining Perioperative Recommendations: Conflicting Guidelines for Anesthetizing Patients for Pilonidal Surgery

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National or international guidelines can help surgeons and anesthesiologists make treatment decisions, but the existence of conflicting recommendations can hinder treatment rather than helping. A case in point is the treatment of pilonidal sinus disease, a chronic subcutaneous infection located in the sacrococcygeal area. Its incidence is rising, reaching almost 100/100,000 inhabitants. Three surgical societies have proposed guidelines for treating the disease, but these guidelines vary greatly in their approach to anesthesia. Who should provide input into guidelines? And how can medical disciplines successfully collaborate? Anesthesiologists must be involved in defining perioperative recommendations not only in patients with pilonidal sinus disease. (A&A Practice. 2018;11:227–9.)

Pilonidal sinus disease (PSD) is a chronic subcutaneous infection located in the sacrococcygeal area. Its incidence is rising, reaching almost 100/100,000 inhabitants per year in a recent report.¹ The surgical approach and the type of anesthesia are controversial, with both having a broad range of described methods.

Over the past 5 years, 3 surgical societies have proposed national guidelines for treating PSD.^{2–4} While the report of the task force of the American Society of Colon and Rectal Surgeons does not mention anesthesia in its practice parameters,² the report of the Italian Society of Colorectal Surgery states that local anesthesia is major risk factor for recurrence of PSD.³ The German national guidelines, on the other hand, conclude that because “there are no significant differences between general or regional anesthesia beyond the immediate periprocedural period, the patients’ preference should be taken into account when discussing the mode of anesthesia.”⁴

Evidence pertinent to defining guidelines for the choice of anesthesia for the surgical treatment of PSD is sparse, but some studies provide hints. Schmittner et al⁵ compared patients undergoing PSD surgery under spinal versus general anesthesia in a randomized clinical trial. They found

that spinal anesthesia with 7.5 mg hyperbaric bupivacaine was superior to total intravenous anesthesia with respect to pain control and recovery time in the postanesthesia care unit. Another randomized clinical trial comparing local versus general anesthesia for patients undergoing PSD surgery found that surgery under local anesthesia required significantly less analgesic medication, was associated with a shorter hospital stay, and led to significantly lower pain scores as reported by patients at a 3-day follow-up.⁶ Luedi et al⁷ have previously reported “significantly higher recurrences after local- or cryo-anesthesia,” while Khodakaram et al⁸ reported excellent outcomes for PSD surgeries under local anesthesia with significantly lower postoperative pain and faster operating room turnover.

The heterogeneity of surgical options to treat PSD is illustrated in Table 1 (adapted from Stauffer et al⁹). In addition, available guidelines consider only 1 viewpoint—that of surgeons—as demonstrated in Table 2. For the anesthesiologist, whose perspective has not been considered, conflicting recommendations with a focus on the surgeon’s perspective can hinder treatment, rather than help. Reconciling this contradictory evidence depends on an analysis of the details, particularly with regard to the various surgical approaches used. Considering the significant differences in surgical approaches, it appears that guidelines are comparing apples with oranges in their approach to recommending an anesthesia technique for a surgical problem that is anything but homogeneous. As stated previously by Butterworth,¹⁰ “consumers of clinical practice guidelines would hope that, when there is high-quality medical evidence, the conclusions and recommendations would be very similar, regardless of the authors or participants.” Yet, because “the busy clinician or clinical investigator typically does not have sufficient time to research the original literature on every topic that may come to his or her attention,”¹⁰ surgical guidelines can be very helpful in the perioperative setting.

In a hallmark editorial considering the definition of standards of care, Butterworth and Rathmell¹¹ asked “who

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Accepted for publication March 9, 2018.

Funding: None.

Conflicts of Interest: See Disclosures at the end of the article.

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DOI: 10.1213/XAA.0000000000000780

Table 1. Surgical Options and Approaches for Pilonidal Disease

Incision and drainage	Incision and curettage
Phenol treatment	Classic phenol treatment with liquid or crystal
Laser treatment	Primary laser techniques, alone or in combination
Pit picking^a	Bascom pit picking with a lateral incision,^a Farrell drills, Lord-Millar, pit excision, pit picking
Limited excision	Curettage, deroofing, drainage, lay open, minor excision, sinotomy
Primary open	Excision, “exhairese,” sinusectomy VAC, and any other primary open approaches
Marsupialization	Marsupialization as described by Buie, Colp, Deprizio, McFee, Mutschmann, Obeid
Partial closure	Partial closure techniques of the wound, leaving subcutaneous tissue exposed through partially open skin
Primary median closure	Any primary midline closure approach
Primary asymmetrical closure	Casten and modified Casten approach, D-shape closure, D-flap, oblique crossing, S-shape closure
Flaps	Bilateral gluteus muscle advancement flap, classical advancement flap, gluteus flap, infragluteal flap, “Kopp gluteo-fascial plasty,” lateral advancement flap, “Iembo di lator,” local fasciocutaneous flap, pope musculofascial advancement flap, rotation flap, Schrudde-Olivari, V-Y advancement flap
Karydakis/Bascom ^a	Bascom cleft lift, ^a modified Bascom cleft lift, ^a cleft lift procedure, Karydakis and modified Karydakis approach
Limberg/Dufourmental	Limberg and Dufourmental approach as well as their modifications, rhomboid flap, teardrop flap, and z-plasty
Other treatments	Plug and Seton technique, as well as endoscopic approaches, cryotherapy, histoacryl glue injection, aspiration and antibiotics, and conservative approaches such as ayurveda therapy

The entries in bold identify procedures that can be performed under local anesthesia. Abbreviation: VAC, vacuum-assisted closure.

^aBascom described 2 different procedures: pit picking” (merged with pit picking group) and “cleft closure/cleft lift” (merged with Karydakis group). Adapted from Stauffer et al.⁹

Table 2. Guideline Authors’ Professional Backgrounds

Countries/Societies	Author, Training	Committee Composition as Declared in the Guidelines
United States/ASCRS	Steele SR, surgery Perry WB, surgery Mills S, surgery Buie WD, surgery	“The Standards [Practice Task Force of the American Society of Colon and Rectal Surgeons] Committee is composed of Society members who are chosen because they have demonstrated expertise in the specialty of colon and rectal surgery.” ²
Italy/SICCR	Segre D, surgery Pozzo M, surgery Perinotti R, surgery Roche B, surgery	“The [SICCR] with the purpose of ensuring the highest treatment standards according to current evidence available in the literature, instructed a committee of experts to draft clinical practice guidelines on the treatment of pilonidal disease, a condition of great socioeconomic impact.” ³
Germany/DGK, BCD, CACP, DGAV, and DDG	Iesalnieks I, surgery Ommer A, surgery Petersen S, surgery Doll D, surgery Herold A, surgery	“The consensus meeting was attended by all authors of the present manuscript and all relevant representatives of local specialist organizations and societies [DGK, BCD, CACP, DGAV and DDG] were represented by all 5 authors of the present manuscript.” ⁴

Abbreviations: ASCRS, American Society of Colon and Rectal Surgeons; BCD, Berufsverband der Coloproktologen Deutschlands (Association of German Coloproctologists); CACP, Chirurgische Arbeitsgemeinschaft für Coloproktologie (Surgical Consortium for Coloproctology); DDG, Deutsche Dermatologische Gesellschaft (German Society for Dermatology); DGAV, Deutschen Gesellschaft für Allgemein- und Viszeralchirurgie (German Society for General and Visceral Surgery); DGK, Deutsche Gesellschaft der Coloproktologie (German Society of Coloproctology); SICCR, Società Italiana di Chirurgia Colo-Rettale (Italian Society of Colo-Rectal Surgery).

defines the standard for medical care?” and suggested that respective clinical and legal contexts also play a crucial role.¹¹ Although Table 2 gives a broad idea of how committee members were selected to work on the 3 national guidelines, specifics are lacking. It appears that perioperative recommendations could benefit from an interdisciplinary approach. One might even provocatively call for inclusion of affected patients in committees that are drafting guidelines. Such a step would probably induce significantly different recommendations.

Given this reality, not including recommendations about anesthesia techniques for surgeries in PSD—as was done by the American Society of Colon and Rectal Surgeons—is probably the most correct approach. The American guidelines also state that they “should not be deemed inclusive of all proper methods of care or exclusive of methods of care” and that “the ultimate judgment regarding the propriety of any specific procedure must be made by the physician in light of all the circumstances presented by the individual patient.”² Today, the accessibility of medical information on

the Internet, the ever-increasing globalization of health care, and the availability of cheap travel also teach us how interdependent our world has become,¹² emphasizing the need for data- and dialogue-driven recommendations for surgical procedures. Such dialogues between specialized teams can help reduce morbidity and mortality in perioperative care.¹²

Interdependently, surgery and anesthesiology have evolved dramatically in the past decade in terms of reduced invasiveness and enhanced recovery. Both specialties will be faced with perioperative challenges in more and more complex patients. Lessons from business sciences have taught us that teams deliver products deriving from collective work with mutual accountability under shared leadership.¹³ Katzenbach and Smith¹³ advise leaders to first define performance standards and establish a sense of urgency and then select team members based on their respective skills. Also, leaders are urged to ensure that team members spend significant time together, seek feedback, listen, and respond constructively to produce a collaborative result.¹³ By definition, unlike a hierarchical command and control approach,

collaboration is “a cross-organizational network to achieve shared goals of diverse groups.”¹⁴ Ibarra and Hansen¹⁴ advise leaders to leverage diversity by connecting different ideas, people, and resources across different organizations.

A remarkable example of a collaborative, dialogue-driven recommendation for perioperative treatments is the 2014 Guideline on Perioperative Cardiovascular Evaluation and Management of Patients Undergoing Noncardiac Surgery.¹⁵ In these practice guidelines, produced by a task force of the American College of Cardiology and the American Heart Association, the authors represented multiple disciplines involved in perioperative care, and in fact, the first author was an anesthesiologist. Furthermore, such interdisciplinary dialogue is needed to define perioperative recommendations for other specialties. We thus call for a series of procedure-centered dialogues among anesthesiologists, surgeons, and other involved professionals to define recommendations for anesthesia for surgical and interventional procedures. Anesthesiologists must be involved in defining perioperative recommendations and guidelines, and we can start with patients suffering from PSD. ■■

ACKNOWLEDGMENT

The authors thank Jeannie Wurz, medical writer/editor, Department of Anesthesiology and Pain Medicine, Bern University Hospital, for editing the manuscript.

DISCLOSURES

Name: Roland E. Andersson, MD.

Contribution: This author helped write the manuscript.

Conflicts of Interest: None.

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Contribution: This author helped write the manuscript.

Conflicts of Interest: Dietrich Doll is an author of the German national guideline on the management of pilonidal disease.

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Conflicts of Interest: None.

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Contribution: This author helped write the manuscript.

Conflicts of Interest: None.

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Contribution: This author helped write the manuscript.

Conflicts of Interest: None.

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Contribution: This author helped write the manuscript.

Conflicts of Interest: None.

This manuscript was handled by: Raymond C. Roy, MD.

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