

Comment on: Excision and suture in the midline versus Karydakis flap surgery for pilonidal sinus: randomized clinical trial

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Dear Editor

Hemmingsson *et al.* can be congratulated for their research published recently in *BJS Open*¹. While being a randomized clinical trial with a remarkable follow-up of 6–13 years, there are some other considerations, including why midline closure was used as a comparator group?

The fact that wound healing in Karydakis is faster than in midline closure is no surprise. Midline closure is known to have the highest infection and dehiscence rates². Many national guidelines do not recommend midline closure, preferring the use of paramedian, asymmetric or flap closure. Larger meta-analyses report recurrence rates from midline closure as above 2 per cent per year of follow-up. The largest analysis of 83 000 patients reports equally poor results for midline closure³.

Although the results from this study are statistically sound, they are based on 125 operations on patients over a 10-year interval, in two hospitals performed by eight or more surgeons. This is a mean of 1.6 operations per surgeon per year during the study interval. Interestingly, there are nearly no recurrences after 6 years, and the midline recurrence rate is remarkably lower than that in previously published literature. Although follow-up was conducted properly, the reason for this remains unclear.

For future comparisons, small midline excisions may be performed in a paramedian or asymmetric fashion, which reduces recurrence rates. This has nothing to do with pressure

or tension (BMI is irrelevant, as we know from the Minnesota study) or posture, but with midline piloerection of sharp hair fragments, as outlined by Bosche⁴ and underlined by the findings of Gosselink⁵. We agree that further pilonidal disease research is required but it is crucial to incorporate existing knowledge into future trial designs to maximize patient benefit.

References

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