

An Unusual Presentation of Pilonidal Sinus in the Anterior Perineum: A Rare Case Report

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ABSTRACT:

Pilonidal sinus (PNS) is a chronic inflammatory condition that most commonly occurs in the natal cleft (intergluteal region), where it typically presents as one or more sinus tracts with small cutaneous openings, intermittent purulent discharge, pain, swelling, or recurrent abscess formation. It is thought to result primarily from the penetration and subsequent inflammation of loose hairs into the skin, with factors such as local friction, prolonged sitting, obesity, excessive hair growth, and poor local hygiene contributing to its development. Involvement of the anterior perineum is exceptionally uncommon and represents an unusual anatomical presentation of pilonidal disease. In Ayurveda, can be correlate with *Nadi Vrana*, although a direct classical equivalent of pilonidal sinus has not been clearly established. We report the case of an 18-year-old male who presented with two openings in the anterior perineal region associated with intermittent purulent discharge. The condition was clinically diagnosed as pilonidal sinus and subsequently confirmed intraoperatively. The patient underwent totally surgical excision followed by wound care involving dressing with *Apamarga Kshara Taila*, sitz bath with *Sphatika churna* with luke warm water and in addition oral Ayurvedic formulation *Kanchanara Guggulu* 500 mg two tablets twice daily, *Varunadi kwatha* 15 ml +30 ml warm water twice daily was administered orally. The postoperative wound complete healed within 40 days, without complication or infection. No recurrence was observed during six-months follow-up period. This case highlights the potential role of surgical interventions in enhancing postoperative recovery and minimizing recurrence in Anterior Perineum Pilonidal Sinus.

KEYWORDS: Anterior Perineum, Ectopic pilonidal sinus, *Sphatika*, Surgical excision.

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INTRODUCTION:

Pilonidal sinus (PNS) is a chronic inflammatory condition characterized by the formation of sinus tracts containing hair and granulation tissue. It most commonly affects the sacrococcygeal (natal cleft) region and predominantly occurs in young adult males. The estimated annual incidence is approximately 26 cases per 100,000 population, with a male-to-female ratio of 3–4:1.^[1] Although the exact pathogenesis remains controversial, the widely accepted theory suggests that PNS is an acquired condition caused by the penetration of loose hair into the skin, leading to a foreign body reaction, chronic inflammation, and subsequent sinus formation.^[2] While the sacrococcygeal region accounts for the vast majority of cases, ectopic pilonidal sinus has been reported in uncommon locations, including the umbilicus, axilla, interdigital spaces, scalp, penis, groin, and perineum. Anterior perineal pilonidal sinus is exceptionally rare, with only a limited number of cases reported in the literature. Because of its unusual location, it may mimic other perineal disorders such as perianal fistula, infected epidermoid cyst, hidradenitis suppurativa, or chronic perineal abscess, making the diagnosis challenging.^[3] The definitive treatment of chronic pilonidal sinus is complete surgical excision of the sinus tract, with the primary aim of eliminating the disease, preventing recurrence, and achieving satisfactory wound healing. However, due to the rarity of anterior perineal involvement, there is limited evidence regarding its optimal

management.^[4] Till now only one case of anterior perineum pilonidal sinus reported by Matera D et al.^[5] This is a case of an 18-year-old male who presented the anterior perineum pilonidal sinus associated with intermittent purulent discharge. This case highlights the importance of considering pilonidal sinus in the differential diagnosis of chronic anterior perineal sinuses and demonstrates that complete surgical excision is an effective treatment for this rare ectopic presentation.

CASE REPORT:

An 18-year-old male non-diabetic normotensive, employed as a factory labour, presented to the *Shalya Tantra* OPD (outpatient department) with the gradual onset of sinus opening over the anterior perineal area associated with pus discharge from opening and also reports pain and itching in the affected area for 2 months. There is no history of bleeding or stool from this. No associated systemic symptoms such as fever or malaise were reported. There is no significant past history of any chronic illness, previous surgeries, or known allergies. No similar complaints have been reported in the past. The patient has a history of regular consumption of tobacco, approximately 2 to 3 packets per day, for the past 2 years. He denies any history of smoking, alcohol, or illicit drug use.

On inspection single primary opening approximately 3 cm anterior to the anal verge with no hair protruding from the sinus opening and also no erythema, oedema or pigmentation near

surrounding the skin. Purulent discharge from primary opening was presented and visible secondary sinus opening was present at perineum approximately 7-8 cm away from anal verge (Figure-1). On palpation Local tenderness grade II was present, Local temperature was normal, Induration present around the sinus tract, Fluctuation was absent around the sinus tract. Digital rectal examination revealed normal anal sphincter tone. No communication with anal canal and rectum.

All Routine haematological investigations like Haemoglobin (HB), Bleeding time (BT), Clotting time (CT), erythrocyte sedimentation rate (ESR) and biochemical investigations like liver function test, renal function test, Diabetic profile and serology including human immunodeficiency virus (HIV), hepatitis B virus (HBsAg), hepatitis C virus (HCV), venereal disease research laboratory (VDRL) and also urine routine microscopic test were within normal limits.

Radiological examination revealed 22 mm long and 5 mm wide superficial subcutaneous pilonidal sinus is seen with external opening in inter-gluteal cleft in midline. No communication with anal canal. 38 × 10 × 14 mm sized oblong shaped superficial subcutaneous abscess is seen in perineum. No perianal abscess or fistula at present (Figure-2).

THERAPEUTIC INTERVENTION:

Informed written consent for surgery and anaesthesia, was obtained from the patient. Preoperative investigations were within normal limits. Under spinal

anaesthesia, the patient was positioned in the lithotomy position and surgical excision of PNS tract with hair was done (Figure- 3).

Prophylactic antibiotics, including Ceftriaxone injection (1 g) + sulbactam 500 mg intravenous (IV) administered every 12 h for 1 day, along with Rantac injection 2 mL IV given every 12 h for 1 day and Diclo-AQ intramuscular injection one ampule every 8 h for 1 day was administered. From the first postoperative day, the patient has prescribed tablet Moxifloxacin 400 mg to be taken once a day after meals, Zerodol SP tablet (aceclofenac 100 mg + paracetamol 325 mg + serratiopeptidase 15 mg) to be taken twice a day after meals, Pantocid DSR capsule (domperidone 30 mg + pantoprazole 40 mg) to be taken before meals once a day for 5 days, and Becozyme C Forte tablet once a day for 15 days. From 6th post operative day, *Varunadi Kwatha* 20 mL orally twice a day on an empty stomach, and *Kanchanar Guggulu* (500 mg) two tablets three times a day after meal with lukewarm water was administered to the patient for 40 days. Sitz bath with *Sphatika Churna* and luke warm water twice in day. Local wound dressing with *Apamarga Kshara Taila* (AKT) once for 40 days.

Case timeline

The chronological sequence of clinical events, including symptom onset, medical interventions, and treatment outcomes, is presented in Table 1.

Result and follow up:

The patient underwent complete excision of the pilonidal sinus under spinal anaesthesia without perioperative complications and

diagnosis confirm by present of hair in the PNS track. Postoperative wound care included dressing with *Apamarga Kshara Taila* and twice-daily *Sphatika Churna* (potassium aluminum sulfate) sitz bath, along with appropriate systemic medications. By postoperative day 6, the wound showed healthy granulation tissue with cessation of discharge, reduced tenderness, and pain improvement (VAS 3), permitting discontinuation of antibiotics and analgesics (Figure 4). Progressive epithelialization was observed by day

13, followed by wound contraction with minimal pain (VAS 1) by day 20. Approximately 50% wound contraction was achieved by day 27. The patient was pain-free by day 34, and complete wound healing was achieved on postoperative day 40 (Figure 5), after which all medications were discontinued. At the 6-month follow-up, the patient remained asymptomatic with complete wound healing and no evidence of recurrence or postoperative complications.

Table-1: Case Timeline

Date	Therapeutic intervention
07/01/2026	First visit to <i>Shalya Tantra</i> OPD diagnosed as pilonidal sinus. The patient was admitted to the IPD and all routine pre operative investigations along with pre-anaesthetic checkup were completed.
08/01/2026	Excision of pilonidal sinus under spinal anaesthesia. Inj. Cefotaxime 1.5 gm intravenously, 12 hourly. Inj. Ranitidine 2 ml intravenously 12 hourly. Inj. Diclofenac 75 mg intramuscular 8 hourly.
09/01/2026 (1 st post-operative day)	Intravenous antibiotics stopped. Tab Moxifloxacin 400 mg one tablet after food. Cap Rabekind DSR one tablet once before food. Tab Zerodol SP 1 tablet two times a day after food. Tab Becozyme C Forte 1 tablet at noon after food for 15 days. Aseptic dressing with <i>Apamarga Kshara Taila</i> . Sitz bath with <i>Sphatika Churna</i> and luke warm water twice in day.
14/01/2026 (6 th post-operative day)	Analgesic and antibiotic, stopped. <i>Kanchanara Guggulu</i> 2 tablets three times after food, <i>Varunadi Kashaya</i> 15 ml twice before food. Wound converted to into healthy, tenderness decreased from II to I, wound discharge ceased, pain (vas score-3).
21/01/2026 (13 th post-operative day)	Local, as well as systemic treatment continued. Wound epithelization noted.
28/01/2026 (20 th post-operative day)	Mild pain (vas score-1) and wound contraction noted. Local, as well as systemic treatment continued.
04/02/2026 (27 th	Local, as well as systemic treatment continued. Half of the

post-operative day)	wound contracted
11/02/2026 (34 th post-operative day)	No pain and tenderness were found.
17/02/2026 (40 th post-operative day)	Wound completely healed and all medicines were stopped.
6 th month after completely wound healed	No recurrence of PNS.



Figure-1: Pre- operative

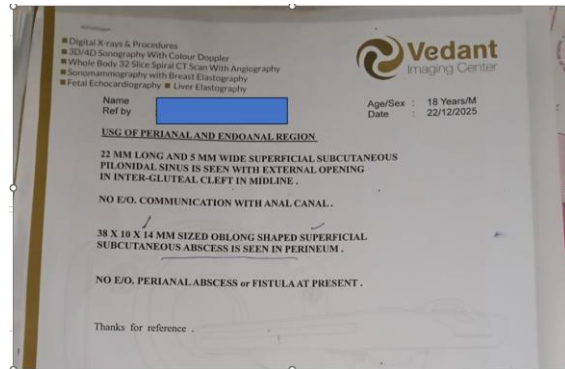


Figure-2: USG of perianal and endoanal region



Figure- 3: Intra operative



Figure- 4: 6th Post-operative day



Figure- 5: 40th Post operative day - Wound healed

DISCUSSION:

Ectopic pilonidal sinus occurring at unusual anatomical sites is rare and may create diagnostic challenges due to its atypical presentation. It may be confused with other perineal conditions such as hidradenitis suppurativa, infected epidermoid cyst, perianal fistula, abscess, or other chronic sinus-forming diseases. Therefore, careful clinical examination, identification of sinus openings, and assessment of the tract are essential for establishing the correct diagnosis. In the present case, the patient presented with a sinus opening in the anterior perineal region, and clinical evaluation suggested pilonidal sinus. The diagnosis was confirmed intraoperatively by probing the tract between the primary and secondary openings, which revealed a complete pilonidal sinus containing hair. The absence of systemic signs of infection and normal preoperative investigations allowed elective surgical management.

Varunadi Kwatha has *Kapha* (*Dosha* responsible for regulating body fluids and keeping the body constituents cohesive) and *Medonashaka* (eliminate *Dushta Medo Dhatu* which is a responsible factor for abscess formation) properties. Vitiating *Kapha* and *Medo* (adipose tissue) are key factors in *Vidradhi Vikara Prakriti* (abscess).^[6] Ultimately properties of *Vraunadi Kwatha* help break *Samprapti* (pathogenesis) and help to remove *Kleda* (watery waste or excessive moisture of body) from *Srotas* (structural or functional channels). It helps control wound exudates. *Kachanar*

Guggulu is a polyherbal formulation with has anti-inflammatory, antimicrobial and antibacterial effects against *E. coli* bacteria.^[7] It might prevent further infection. *Kanchanar guggulu* also has anti-proliferative and antimutagenic properties that may help to prevent the recurrence of PNS.

AKT has provided autolytic wound debridement and prepared a wound bed for healing.^[8]

Sphatika (potassium aluminum sulfate) has traditionally been used in wound management because of its *Vranashodhana* (wound cleansing), *Vranaropana* (wound healing), *Raktastambhaka* (hemostatic), and *Shothahara* (anti-inflammatory) properties. The astringent action of *Sphatika* causes protein precipitation, thereby reducing wound exudate, minimizing tissue oedema, and promoting wound contraction.^[9,10] Experimental studies have demonstrated that alum possesses antimicrobial activity against several pathogenic microorganisms, which may reduce bacterial colonization and lower the risk of wound infection.^[11]

This case contributes valuable clinical insight into the diagnosis and management of an unusual presentation of pilonidal sinus. Increased awareness among clinicians is important to avoid misdiagnosis and unnecessary delay in treatment.

CONCLUSION:

Anterior perineal pilonidal sinus is an exceptionally rare presentation of pilonidal disease and should be considered in the differential diagnosis

of chronic perineal sinus or discharging lesions. Complete surgical excision of the sinus tract with meticulous aseptic technique remains an effective treatment modality, providing satisfactory healing and preventing recurrence.

Consent of patients: The consent of the patient has been taken for publication of images without disclosing the identity of the patient.

Limitation of study: This report is based on a single case of anterior perineal pilonidal sinus; therefore, the findings cannot be generalized to all patients with ectopic pilonidal disease. The follow-up period was limited to six months, which may be insufficient to assess long-term recurrence.

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