# *Introduction*

Pilonidal disease is a common disorder of the sacrococcygeal region. It comprises a variety of problems, including infection, abscess, cyst and the development a chronic sinus cavity ***(Hull & Wu, 2002).***

Pilonidal disease was first reported in 1833 by Herbert Mayo who described a cyst that contained hair just below the coccyx in the following words: ***"on opening its interior, a certain quantity of pus was evacuated and a lock of loose hair is found more or less matted and of varying size and amount"***. Hodge in 1880 coined the name ***"pilonidal"*** from Latin words pilus which means hair, and nidus which means nest ***(Hodges, 1880).***

The controversies surrounding the origin of pilonidal disease first came to light during **World War II** from 1941-1944, when multiple case reports describing pilonidal cyst formation in jeep drivers. So many service men were affected with pilonidal disease that was renamed ***"Jeep disease" (Buie, 1944).***

Pilonidal disease or "jeep disease", is a well known complex surgical problem. It is an unglamorous condition that is often difficult to treat. It is an epithelium-lined track (sinus) situated a short distance behind the anus and generally containing hair ***(Purkiss, 1993).***

It is however, not restricted to the inter-gluteal region alone. It is known to occur in inter-digital space in barbers' hands ***(Patel et al., 1990),*** in the axilla, the umbilicus ***(Schoelch & Barrett, 1998),*** above-knee amputation stump ***(Goligher, 1984),*** the nose ***(Paulose et al., 1989),*** and the vault of the skull ***(Guilherm et al., 1999).***

A pilonidal sinus may be a symptomatic for some time. The majority of patients only present with the onset of symptoms, usually pain and discharge. Occasionally a painless lump or swelling may be discovered by the patient while washing, or midline pits during a routine physical examination. Symptomatic disease usually presents as an acute abscess, a chronic abscess, or complex/ recurrent pilonidal disease ***(SollA & Rothenberger, 1990).***

In 1950, pilonidal disease was thought to be of congenital origin rather than an acquired disorder. It was thought to be secondary to a congenital remnant of an epithelial lined tract from postcoccygeal epidermal cell nest or vestigial scent cells ***(Karulf & Perry, 1998).***

Pilonidal disease is now widely accepted as an acquired disorder based on observation that congenital tracts do not contain hair and are lined by cuboidal epithelium, the recurrence after complete excision of diseased tissue down to sacrococcygeal fascia and high incidence of

chronic disease in patient who are hirsute support an acquired theory ***(Karulf & Perry, 1998).***

This confusion in etiological origin led surgeons to adopt different approaches to treat pilonidal disease ranging from the least conservative approaches to the most radical and extensive reconstructive approaches ***(Hull & Wu, 2002).***

The ideal approach for treatment should be tailored according to the patient condition. With the best chance for cure and least local recurrence rate, avoid admission to the hospital, avoid general anesthesia, and require minimal wound care and minimal time off work for the patient ***(Hull &Wu, 2002).***