

Clinical Corner

A Case of Worsened Pain with Improved Posture



by Gregg J. Carb, D.C.

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CASE STUDY

A young, heavy-set adult male reported lower back pain after working at his computer for prolonged periods. The severity of his pain seemed to be in direct relation to how long he sat. At the time of his initial visit in the office, he was not particularly symptomatic. Standing and sitting postural observation revealed that the patient had a habit of slumping, but was otherwise unremarkable. Active ROM, orthopedic testing and x-ray findings were mostly benign. On palpation, some tenderness was present centrally at the lower sacrum. This presentation may sound like an uncomplicated case of postural lower back strain, usually improved by correcting bad posture habits. Unfortunately, improving his sitting posture only seemed to worsen the lower back pain.

BACKGROUND

During WWII, a condition referred to as "Jeep Rider's" disease was responsible for hospitalizing over 80,000 US army soldiers, accounting for 4.2 million sick days. The actual name of the condition is pilonidal disease (pilus-hair, nidal-nest). Pilonidal disease consists of a hair-containing sinus or abscess, usually in the sacrococcygeal area. The clinical presentations range from asymptomatic pits in the intergluteal or "natal cleft" region (Figure 1), to painful draining lesions. Pilonidal disease has a male predominance (2.2 to 1.0 male to female ratio) and usually affects patients from the mid-teens into the thirties (the average age is 21). A family history of the disease is found in 38% of the patients. In the US, the incidence is 26 cases per 100,000 people.

CAUSATION

At first, it was believed that pilonidal disease was congenital. The current understanding is that pilonidal disease is an acquired condition involving midline pits in the natal cleft. These holes or pits are enlarged hair follicles in the skin. It has been suggested that gravity and motion of the gluteal folds create a vacuum that pulls on the follicle. A pilonidal cyst contains hair that has grown down into the skin instead of up as it normally does. Pilonidal cysts are more common in those who have an abundance of body hair and / or those who

have considerable rubbing of the skin in the fold of the buttocks. Overweight, hairy men account for 85 percent of the cases.

It was once thought that every pilonidal lesion contained a nest of hair. However, only 50% of cysts and sinuses are found to have hair during surgical exploration. This does not diminish the role hair plays in pilonidal disease. In the affected area, any distended hair follicles are not shed like their normal counterparts but can remain in the follicle during their expansion, contributing to local irritation and inflammation once the follicle ruptures. External hairs growing out of normal, adjacent follicles can act as secondary invaders, and contribute to a foreign body reaction through penetration and growth of the hairs into subcutaneous tissue. Neighboring hair found in the surrounding skin can also act as mechanical irritators, creating friction and adversely affecting wound healing of the damaged area.

CYST vs. ABSCESS

While a pilonidal cyst doesn't actually become an abscess until bacteria invade and cause infection, the terms pilonidal cyst and pilonidal abscess are sometimes used interchangeably. A pilonidal abscess is an infection that the body has been unable to quickly subdue. The body sends many white blood cells to the infected area to destroy invading bacteria. This battle creates the red-colored, swollen area that is characteristic of an infection. If the microscopic conflict is prolonged, an accumulation of infectious debris forms. This collection of worn out white blood cells, bacteria, body fluids and blood stretches and fills the tissue inside the pilonidal cyst, forming an abscess.

CLINICAL PRESENTATION

Most patients with pilonidal disease seek attention due to a history of progressive tenderness after physical activity or a period of prolonged sitting, such as computer data entry or after a long drive. Patients may seek advice for asymptomatic dimples or pits they notice in the gluteal fold region. There may be no symptoms or

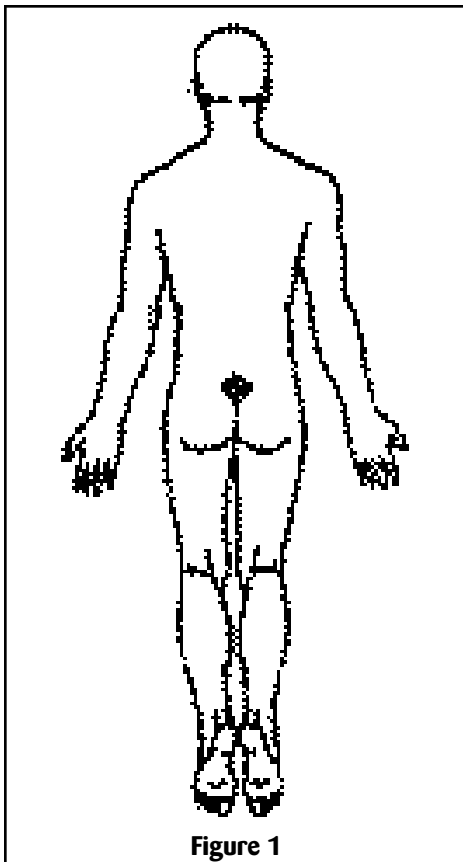


Figure 1

minimal symptoms when the area is not infected. When infected, it causes local pain, redness, tenderness, and swelling in the area. A discharge of pus may be present. Eighty percent of symptomatic presentations are exacerbations or manifestations of chronic disease, and twenty percent are due to acute abscess. Close physical inspection of the affected area will typically show lower sacral midline puffiness/edema with or without redness. If infected, the area will be warm and tender, and discharge may be present from one or more lesions.

CONSERVATIVE MANAGEMENT

The presence of an acute, infected abscess is an absolute indication for medical referral/co-management. If the cyst is not infected, conservative therapy can effectively control pilonidal disease. The patient should be advised as follows: Keep the area clean and dry. Bathe or shower daily and wash the area well with a germ-killing soap. Taking hot tub baths helps prevent re-infection. The affected area should be dried well with a towel. Light, loose-fitting clothing should be worn. Avoid tight-fitting garments as heavy perspiration and friction in the area of the cyst should be avoided. Weight loss is indicated for obese patients (diet control). Weekly shaving of the area has been shown to decrease recurrence rates. Rubbing in the sacral region should be minimized, which means sitting flush against a seatback with a lumbar support in place can be a source of irritation. The back-less ergonomic chairs with the sloping seatpans and ankle rests are a good alternative. A sit/stand workstation for patients with computer-intensive occupations would also be helpful. In summary, most painful recurrences can be avoided by practicing good hygiene, preventing the re-accumulation or re-growth of hair, and avoiding local mechanical irritation to the area.

SURGICAL CASES

For patients suffering from recurrent or acute pilonidal abscess, drainage or excision by a surgeon may become necessary. Studies have reported that these cases are typically one-day inpatient procedures, using a general or spinal anaesthetic, averaging 2-3 weeks off work, with a recurrence rate of 17.5%. Following surgery, these patients should be managed in the same manner as the chronic, non-operative outpatient cases described above.

SUMMARY

Patients with pilonidal disease may be unaware of the exact nature of their condition. They may seek out chiropractic care, as many patients do, because of lower back discomfort. It is helpful to be able to identify the pilonidal lesion, explain its cause, and guide these patients through a conservative care approach or refer them to the appropriate specialist, while tending to their chiropractic needs.

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