Re: Laparoscopic EndoClose fixation of a peritoneal catheter reduces migration

Dear Editor,

We read the recent article by Rouse *et al*. comparing peritoneal dialysis (PD) catheter insertion either without or with fixation using an EndoClose device (Medtronic, Macquarie Park, Australia).[1]

We agree that laparoscopic insertion of Tenckhoff catheters to be the superior technique over open insertion. The authors describe a novel laparoscopic technique utilizing the EndoClose device to secure the catheter to the anterior abdominal wall. They proceed to place the catheter in the right iliac fossa which may potentially affect future renal transplantations on that side. While the three-port technique used is a common practice, this appears superfluous alongside the EndoClose device.

Catheter malposition is a common complication following PD catheter insertion. The incidence reported in this study is 7.3%. Similarly, a study in the paediatric population comparing laparoscopic fixation of PD catheter with EndoClose with open technique quotes a migration rate of 8% (three in 36 procedures) acknowledging this is a smaller sample size. The authors reference Shen *et al*. who uses a similar technique of suture-passer hernia forceps which reports 0% migration in 39 patients with a follow-up period of between 6 and 42 months.[2] Gunes *et al*. describe the technique of preperitoneal tunnelling and extracorporeal pelvic suture fixation resulting in an 8.53% rate of catheter dysfunction (including catheter migration).[3] Other techniques including Seldinger technique and rectus sheath tunnelling or omentopexy could be considered.

The authors' technique is limited to pigtail catheters. In practice, both straight and pigtail catheters are used. Peppelenbosch *et al*. compares both; there is less pain and little catheter tip dislocation with curled catheters but greater dialysis efficacy and time to migration with straight catheters.[4]

This article has highlighted the need for case-controlled trials of EndoClose versus laparoscopic suture fixation and the authors should be congratulated on this publication.

Author Contributions

Linda Tang: Formal analysis; investigation. **Taina Lee:** Formal analysis; investigation; methodology. **Lawrence Yuen:** Conceptualization; formal analysis. **Henry Pleass:** Conceptualization; formal analysis; methodology.

References

1. Rouse M, Choi J, Bakhit J, Soh B, Chan S. Laparoscopic EndoClose fixation of a peritoneal catheter reduces migration. *ANZ J. Surg.* 2020; **90**: 72–5.
2. Shen Q, Jiang X, Shen X *et al*. Modified laparoscopic placement of peritoneal dialysis catheter with intra-abdominal fixation. *Int. Urol. Nephrol.* 2017; **49**: 1481–8.
3. Gunes ME, Uzum G, Koc O *et al*. A modified method in laparoscopic peritoneal catheter implantation: the combination of preperitoneal tunneling and pelvic fixation. *ISRN Surg.* 2013; **2013**: 248126.
4. Peppelenbosch A, van Kuijk WHM, Bouvy ND, van der Sande FM, Tordoir JHM. Peritoneal dialysis catheter placement technique and complications. *NDT Plus* 2008; **1** (Suppl. 4): iv23-iv8.

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doi: 10.1111/ans.16605

Re: Pilonidal sinus: is histological examination necessary? – pilonidal sinus carcinoma is largely underreported and underpublished

Dear Editor,

Recently, Otutaha *et al*. wrote about the necessity of histological examination in pilonidal sinus disease (PSD) specimens,[1] analysing 325 PSD specimens.

They can be congratulated for their work. Nevertheless, we would like to add some points.

First, incidence of PSD carcinoma is between 500 and 1200 per 100 000, so their specimen volume may be slightly underpowered to find one PSD carcinoma within.

Second, PSD carcinomas are generally underreported due to several reasons. The authors may be reluctant to publish these patients at all because of the bad outcome. If they do, most PubMed journals are not interested in case reports.

Many PSD carcinomas are undifferentiated[2] and difficult to detect for the pathologist, especially if there is no clinical suspicion, and these are incidental small tumours deep in the sinus tract.

Identifying PSD carcinomas published outside PubMed is quite time-consuming. It is more convenient to consider the number from the last review article – for example, from de Bree *et al*.'s study with 59 patients – and work with those outcomes (in 2001, 73 PSD carcinoma patients were available in the literature).[2] This leads to underreporting by more than one-third in some publications.

As can be demonstrated from Figure 1, PSD carcinoma numbers stated in articles may differ substantially from reality. In fact, 19 countings underreport 25 or more cases (difference between red triangle and black line above). Astonishingly, 17 of 19 neglects can be found between 2001 and now, documenting a more recent inaccuracy despite better electronic internet libraries available.

In conclusion, pilonidal sinus carcinoma is severely underreported and underpublished, and there is too little suspicion that long-standing PSD disease may harbour a neoplasia. However, with the help of the pathologist, less carcinomas go unnoticed and return as large, incurable recurrences. We recommend that a long disease

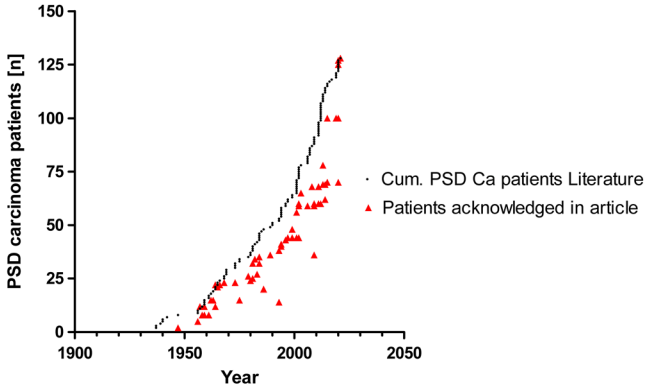

Fig. 1. Cumulative pilonidal sinus disease carcinoma patients in the literature (●) and their acknowledgement in separate articles (▲) (Courtesy: Dr Dettmer).

history of 10 years and above is a good reason to generally ask for a histology in PSD patient specimens.

Acknowledgement

Open Access funding enabled and organized by ProjektDEAL.

References

1. Otutaha B, Park B, Xia W, Hill AG. Pilonidal sinus: is histological examination necessary? *ANZ J. Surg.* 2020.
2. de Bree E, Zoetmulder FA, Christodoulakis M, Aleman BM, Tsiftsis DD. Treatment of malignancy arising in pilonidal disease. *Ann. Surg. Oncol.* 2001; **8**: 60–4.

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doi: 10.1111/ans.16623

Re: Pilonidal sinus: is histological examination necessary? – the age of patients with pilonidal carcinoma is overestimated

Dear Editor,

Otutaha *et al. published a* recommendation when to work up pilonidal sinus disease (PSD) specimens, relying on his database of 325 pilonidal specimens.[1]

We would like to disagree in one point: patient age is not a good criterion for the indication of PSD specimen analysis.

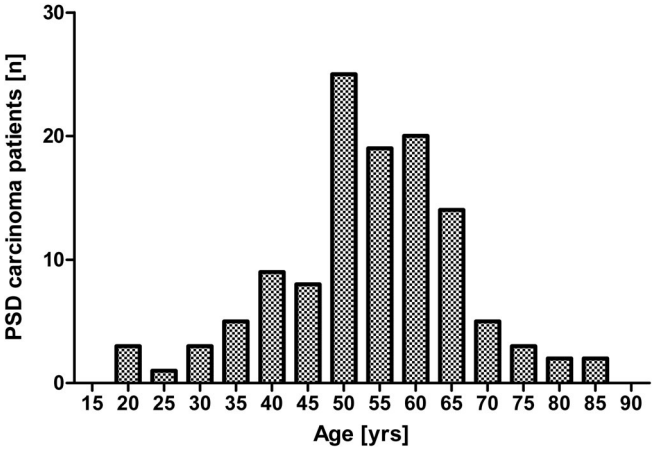

Fig. 1. Age distribution of pilonidal sinus disease carcinoma patients from 1900 to now (n = 129 patients).

Of course, it is known and was recently published that regional differences of PSD incidence do occur,[2] which are associated with gender difference incidences as well.[3] While the Australian–New Zealand region may be blessed with a lower PSD incidence and thus a lower PSD carcinoma incidence as well, it cannot be deduced from thereon that histology is not needed below the age of 50 years. We analysed a series of 129 PSD carcinomas. We found that the mean age of these patients was 54 years with an age range of 19–86 years (Fig. 1).

As can be deduced from Figure 1, more than 20% of the PSD carcinoma patients are below the age of 50 years (mean ± SD 53.7 ± 12.6 years). These would be lost with the introduction of a 50-year age barrier.

There are several reasons to omit histology in pilonidal sinus. But patient age is not a criterion, as PSD might arise in earlier or later age. Long-standing disease should raise our suspicion, as neoplasia nearly always arises in infection which is smouldering for decades. But as can be seen, there are exemptions. Interestingly, PSD carcinoma can also arise in so-called late recurrences that have been fully clinically silent over decades, as every asymptomatic pilonidal sinus tissue always contains infection of different intensity.[4]

Author Contributions

Marius Dettmer: Data curation; formal analysis; writing-original draft.

References

1. Otutaha B, Park B, Xia W, Hill AG. Pilonidal sinus: is histological examination necessary? *ANZ J. Surg.* 2020. https://doi.org/10.1111/ans.16446.
2. Doll D, Orlik A, Maier K *et al.* Impact of geography and surgical approach on recurrence in global pilonidal sinus disease. *Sci. Rep.* 2019; **9**: 15111.
3. Luedi MM, Schober P, Stauffer VK, Diekmann M, Doll D. Global gender differences in pilonidal sinus disease: a random-effects meta-analysis. *World J. Surg.* 2020; **44**: 3702–9.