

Surgical Consent for Pilonidal Cystectomy

Diagnosis:

• You have been diagnosed with a Pilonidal Cyst. This cyst occurs near your tailbone. A cyst is a closed tract that is filled with fluid and hair; it is frequently infected.

Name of Procedure/Treatment:

• Pilonidal cystectomy which is the surgical removal of the tract and its contents

Nature and Purpose of proposed treatment:

An incision is made in the area of the cyst. The sinus tract or sac with the abnormal or infected tissue is removed. The
incision is then closed with stitches and/or staples. A dressing will then be applied to the area. Occasionally, a small
drain will be inserted into the incision to allow drainage from the site. This drain will be removed in a few days.
 Sometimes the wound is left open and will be packed with gauze if the tract was infected.

Risks common to all surgical procedures:

- Injury to a blood vessel or excessive bleeding. This may require a blood transfusion.
- Infection, which may require the use of antibiotics. In rare cases, another surgical procedure may be necessary to remove the infection.
- Complications with anesthesia. This may include nausea, vomiting, or in rare cases, death.
- Tobacco use, excessive alcohol use and obesity can increase the risk of any surgical procedure or general anesthetic. Any of these factors may substantially affect healing and can result in an increase of major complications including pneumonia, wound infection, blood clots in the legs and lungs, or death.

Risks and complications of the proposed treatment:

- Pain after surgery, which may require you to take pain medication
- An infection, which may require you to take antibiotics
- Recurrent disease may occur in 25-30% of all cases, which may require further surgery
- Non-healing wound requiring more surgery

Risks or complications of the proposed treatment that is specific and unique to the patient:

Alternative treatments:

- Analgesics, for pain
- · Antibiotics, to treat any infection
- Sitz baths (sitting in a tub of warm water)

Prognosis if the proposed treatment is NOT accepted:

• If you choose not to have surgery, you may experience continued discomfort and progression of the disease



CONSENT

Consent: I hereby authorize and direct the designated authorized physician/group, together with associates and assistants of his choice, to administer or perform the medical treatment or surgical procedure described in this Consent Form, including any additional procedures or services as they may deem necessary or reasonable, including the administration of any general or regional anesthetic agent, x-ray or other radiological services, laboratory services, and the disposal of any tissue removed during a diagnostic or surgical procedure, and I hereby consent thereto.

I have read and understand all information set forth in this document and all applicable blanks were filled in prior to my signing. This authorization for and consent to medical treatment or surgical procedure is and shall remain valid until revoked by me in writing.

I acknowledge that I have had the opportunity to ask any questions about the contemplated medical procedure or surgical procedure described in this consent form, including risks or alternatives, and acknowledge that my questions have been answered to my satisfaction.

Signature of Patient	Date/Time	Signature of Patient Representative	Date/Time
Signature of Witness	Date/Time	Print Representative's Name	
		Relationship to Patient	