Research Article

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MANAGEMENT OF RECURRENT PILONIDAL SINUS WITH KSHARALEPA: A CASE REPORT

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ABSTRACT

Pilonidal Sinus (PNS) is a commonest presentation in surgical practice with a high prevalence rate at more than 1 million cases per year in India, where as incidence is about 26 per 1,00,000 population. A 30-year-old male patient presented with PNS after an unsuccessful excision followed by antibiotic therapy. The challenge in this case was not only to excise the tract but also preventing its recurrence. Adopting the principles of Vranopakramas using Ksharakarma, Utsadana karma described in Ayurveda helped to manage the PNS effectively without any recurrence after 32 months of follow-up.

Keywords: Pilonidal Sinus (PNS), Vranopakramas, Ksharakarma, Utsadana karma

INTRODUCTION

Pilonidal Sinus (PNS) is a commonest presentation in surgical practice with a high prevalence rate at more than 1 million cases per year in India, where as incidence is about 26 per 1,00,000 population.[1]Pilonidal Sinus is a tract with hairs lying within (Pilus= Hair, Nidus= nest). The hair penetrates into the subcutaneous tissue, infects the deeper plane to form granuloma/ unhealthy granulation tissue which further develops into a tract. The commonest place of PNS is sacrococcygeal region. Atypically, it can be presented in groin, axilla, interdigital cleft, intermammary, suprapubic& umbilical areas.[2] Statistically,25-40% of the PNS will recur after Surgery.[3]

CASE REPORT

A 30-year-old married male, a mechanic from lower middle socio-economic group, visited JSS Ayurveda Medical College & Hospital, Shalya tantra OPD (OP No. 113058) & admitted on 10-4-2018.He presented with the painful hard swelling in between the buttocks in the past two weeks, which was discharging pus on pressurefor1 day. To start with, the pain and the swelling was mild which gradually increased and forced the patient to stay at home for the last two days. Patient denied any radiation of the pain and recalled it to be throbbing type of pain, which reduced a bit after letting the pus out, but still hinders with sitting while repairing the vehicles at his shop. He had similar complaints a year back which was diagnosed as Pilonidal Sinus and was excised. The post-operative wound was healed by secondary intention. He was not allergic to any food/drugs and didn't had co-morbidities. Patient's parents and siblings were alive and healthy. The study was carried out as per ICH-GCP guidelines.

On examination

General Survey

Patient was well built, hydrated, conscious, alert and cooperative. Karnofsky performance[4] status was 80/100. His Nutritional Status was normal with BMI of 22.9 and mid arm circumference of 29cm. There was no evidence of Pallor, Icterus, Cyanosis, Clubbing, Lymphadenopathy, Edema, Pigmentation or Distended neck veins. Patient was afebrile, normotensive and normocardic. Systemic Examination was normal.

Local Examination

On Inspection,
An ovoid abscess was present at the Intergluteal Cleft measuring approximately 2*2cm with a single regular margined pinpoint external opening at right side. Scar mark was present due to previous pilonidal sinus excision. (Figure 1)

On Palpation,
Moderate tenderness was present along the indurated are of 4*2cm extending from the abscess to linearly down towards the coccyx with little ramification to right side at the end. There was no bone thickening along the sinus. On pressing, slight pus discharge was noted without any foul smell. The sterilized copper probe could be inserted without any resistance down for about 4cm.

The differential Diagnosis considered were,
Recurred PNS
Fistula in ano
Osteomyelitis (In Order)

The patient was advised with routine blood investigations like CBC, ESR, FBS, PPBS, HbA1C, CT, BT, Blood Urea, Serum Creatinine which were within normal limit except FBS-132mg/dl, PPBS-183 mg/dl and HbA1C was 6.7mg/dl. He was tested negative for serological tests of HIV &HbSAg. Urine routine was normal.

X-ray Sinogram revealed previously operated Pilonidal Sinus. Sinus tract measuring 4.2 cm with two external opening one above the anterior part of the gluteal region, while other above the anal opening. Impression: Pilonidal Sinus with Ramification as mentioned.

Hence the excision of the Pilonidal Sinus was planned for the next day.

Pre operatively,
Part preparation was done.
Inj. TT 0.5ml IM, Inj. Xylocaine Test 0.1 ml S/C dose was given.
NBM for 6hrs prior to the surgery.

Operative Procedure (11/4/2018)

Under all aseptic precautions, after administration of Spinal Anesthesia, the patient was given prone position, and methylene blue was injected to know the ramifications of the tract and elliptical incision was taken. The incision was deepened and excised. Teeksna Apamargakshara lepa was applied for shatamatrakaala and was washed with nimbu swarasa. It was then packed with Vranaharin after attaining the complete hemostasis.

Post-operative Advise
To shift the patient after 2 hours. To start with liquid diet after the bowel sounds heard. The excised tissue was sent for histopathological examination which confirmed the diagnosis as PNS.

Orally,
T. Triphala Guggulu 2-2-2 A/F
T. Gandhaka Rasayana 1-1-1 A/F
T. Nishamalaki 2-2-2 A/F
Asanadi Kashayam15ml BD B/F with 45ml of water.

Patient was discharged next day after counselling about the importance of local hygiene, maintenance of blood sugar level, regular intake of oral medication and daily dressing. Daily dressing was advised with Vranaharin after Panchavalkala Vranaprakshalana. On the 10th Post-operative day, the slough was noticed on 3 sides with a small diverticulum as shown in the picture (Figure 2) and 2nd sitting of Ksharalepa (Figure 3) was again done in the OPD. Patient withstood the procedure well and the wound was packed with Vranaharin.

On the 16th day, the wound was completely devoid of slough and clean (Figure 4). Then the wound was cleaned with Panchavalkala Kashaya and was packed with a pinch of Yashada Bhasma till the complete wound healing. The wound was completely healed on 25th Post-operative day (Figure 5). The PNS is not recurred even after 32 months (Figure 6).

DISCUSSION

PNS is disease with high recurrence rate, even after complete excision of the tract. This patient had recurrence within a year probably because of improper hygiene, irregular shaving of hair and breakage of scar while repairing vehicles. So, along with the excision, there was a need to prevent recurrence. Even this time, after complete excision of the tract with ramification, the slough and a small diverticulum appeared post operatively, which had to be managed effectively.

PNS can be compared to the Nadivrana in Ayurveda. Acharya Sushruta has dealt Nadivrana & Vrana Chikitsa in detail.[5,6] Hence, in this patient, after excision, we planned to adopt Vranopakramas post operatively.

Teeksna Apamarga kshara[7], an herbal caustic, having the qualities of Lekhana, Ropana and Tridoshagna might have helped in cauterizing the unhealthy granulation tissue, scraping it off and minimizing the infection thus promoting healing of the wound.

As per the classical guidance, in this case, the ksharakarma was applied twice to debride the slough completely from the diverticulum. Sprinkling a pinch of Yashada Bhasma, an ayurvedic zinc compound, over the wound promoted quick development of healthy granulation tissue marking utsadanakarma one among the 60 upakramas for wound management.

Zinc plays an important role in epithelialization of the wound[8].Internal medicines like Tab Triphala Guggulu and Tab Gandhaka Rasayana promoted wound healing avoiding the infections. T. Nishamalaki & Asanaadi Kashayam helped to maintain the euglycemic status contributing for wound healing with added benefits of Vitamin C of Amalaki in Nishamalaki. Counselling on the importance of local hygiene and removal of hairs influenced the patient to follow the etiquettes.

CONCLUSION

The wound management is described elaboratively in Sushruta Samhita. Adoption of these principles will help us to manage any kind of wound effectively. Timely adoption of Lekhana, Vrana Shodhana, Vrana Ropana and Utsaadana Karma in this case of recurrent PNS resulted in complete remission without recurrence after 2 years and 8 months of follow up.

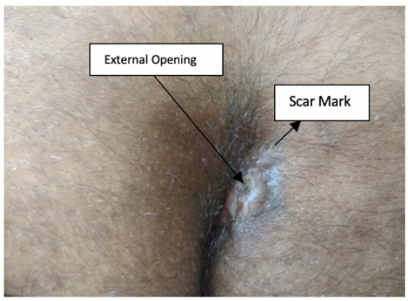

Figure 1

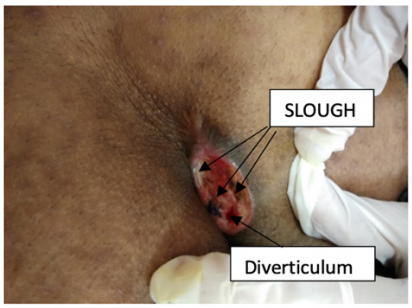

Figure 2

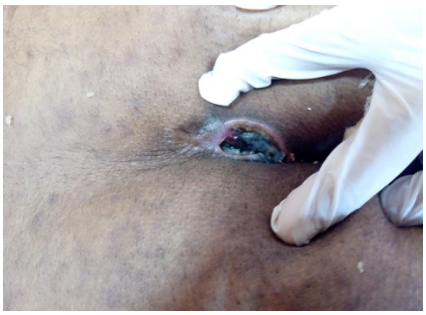

Figure 3

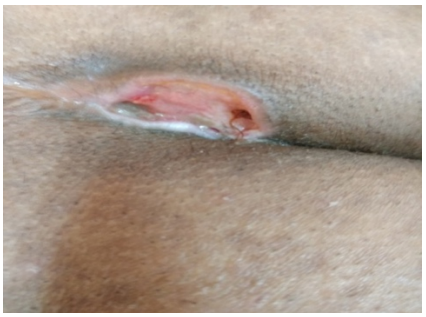

Figure 4

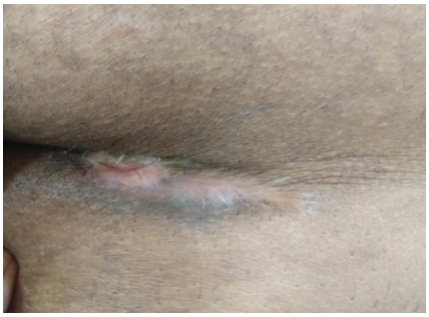

Figure 5

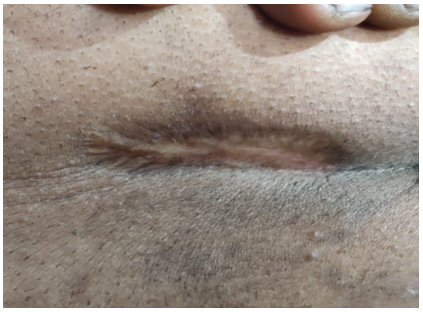

Figure 6

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