Case Study

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A CASE STUDY ON A COMPLEX FISTULA-IN-ANO BY AYURVEDIC MANAGEMENT

Rahul Kumar Verma [1]*, Suman Yadav [2], Ashutosh Kumar Yadav [3]

[1] PG Scholar, Department of Shalya Tantra, Government Ayurvedic PG Collage & Hospital, Varanasi, Uttar Pradesh, India

[2] Reader & HOD, Department of Shalya Tantra, Government Ayurvedic PG Collage & Hospital, Varanasi, Uttar Pradesh, India

[3] Reader, Department of Rachna Sharir, Government Ayurvedic PG Collage & Hospital, Varanasi, Uttar Pradesh, India

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***Corresponding author**
E-mail: rahuldgreat05@gmail.com

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ABSTRACT

Fistula-in-ano can be a complicated disease to manage. An anal fistula is divided into simple and complex fistula. Managing complex fistula is even more challenging, which typically affects younger people and causes persistent morbidity. It is pertinent to define complex anal fistula. From a practical point of view, a fistula that is difficult to manage has a higher risk of recurrence, poses a greater threat to continence and is classified as a complex fistula. Due to its difficulty in treating medically and surgically, *Bhagandara* (fistula-in-ano) is one of the eight major disorders classified under *Astamahagada* in Ayurveda. Ayurvedic surgeons frequently use the effective fistula treatment known as *Ksharasutra*; however, cutting the passage takes a very long time. As a result, this procedure is now sometimes referred to as partial fistulectomy with *Ksharasutra* ligation, fibrin glue, fistula plug (FP), Fistula-tract Laser Closure (FiLaC), Seton techniques, video-assisted anal fistula treatment (VAAFT), LIFT (ligation of intersphincteric fistulous tract), and IFTAK (interception of fistulous tract with application of *Ksharasutra*), also known as window technique, where the *Guggulu* based *Apamarg Ksharasutra* is placed. This method shortens the healing time and allows repairing such a complicated fistula-in-ano with little tissue injury. Infected anal crypt, secondary extension and related conditions are the key factors that lead to the recurrence of complex anal fistulas. Surgery in complex anal fistula aims to prevent recurrence, avoid incontinence and avoid damaging the sphincter muscles (the ring of muscles that open and close the anus).

Keywords: *Bhagandara,* Fistula-in-Ano, *Astamahagada, Ksharasutra,* IFTAK.

INTRODUCTION

Bhagandara, mentioned in *Ayurvedic* texts, is the condition equivalent to fistula-in-Ano. Early details of the condition are available from *Charaka Samhita*, which is mentioned in the context of *Swayathu*.[1] Later on, *Sushruta*, in his treatise *Sushruta Samhita*, gives a detailed description of *Bhagandara. Bhagandara* is mentioned as one of the "*Astamahagada*" (eight serious diseases that are difficult to treat by nature itself).[2] According to him, the condition is called *Bhagandara* because it breaks through the *bhaga* (perineum), *guda* (anus), and *basti* (bladder regions). Further, he adds that those without an opening are called *Bhagandara-pidaka* (anorectal abscesses), and those with an opening are called *Bhagandara* (fistula-in-ano).[3] Complications of all types of *Bhagandara* have been given in detail.[4] *Vagbhata*, the author of *Ashtanga Hridaya,* has followed *Sushruta* in his description, with a slight difference in the classification. He describes eight types of *Bhagandara* in detail. In addition to the above five types, he has added *Parikshepi, Riju,* and *Arsobhagandara*.[5] Modern view The fistula-in-ano is an abnormal connection (an inflammatory tract lined by unhealthy granulation tissue and fibrous tissue) between the anal canal and the perianal skin.[6] It is difficult and recurrent surgical disease. It usually results from an ano-rectal abscess (50%), which bursts spontaneously or opens inadequately.[7]

Case report

A 66-year-old male patient visited Shalya tantra Department OPD No. 25 of Govt. PG Ayurvedic College & Hospital, Varanasi, UP, India, with complaints of a boil-like structure with pus discharge from the perianal region for eight months. The study was carried out per ICMR National Ethical Guidelines for Biomedical and Health Research Involving Human Participants.

Patient's complaint

The patient was healthy before eight months. The patient suddenly felt a boil-like structure at the perianal region, which gradually increased and burst out after ten days. The pus discharge continued. The patient took medicine from the local doctor for one month but did not get relief, so the patient came to our Govt. PG Ayurvedic College & Hospital, Varanasi, in Shalya tantra Department, OPD No. 25, for better management.

Purva Vyadhi Vruttanta (Past History)

No History of Diabetes Mellitus type 2, Hypertension, Thyroid dysfunction, Bronchial Asthma and other systemic disorders.

Local examination

On Inspection: Perianal skin is normal, with no scar mark. The external opening of the fistula is seen at 2 and 3 o'clock positions, 3–4 cm away from the anal verge. (Figure 1)

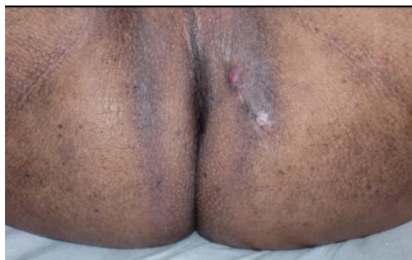

Figure 1: Pre Operative

On Digital Rectal Examination: No active bleeding, mild pus discharge, sphincter tone high, internal opening palpated at 3 and 6 o'clock position.

METHODS

1. Purvakarma (Pre-Operative)

Rectal irrigation with *Triphala churna* one teaspoon at bedtime/enema on the morning of operation. Preoperative inj. TT intramuscular given, inj. Lignocaine 2% subcutaneous sensitivity test done, antibiotics intravenous dose given for prevention of secondary infection, all injectable medicine provided by a doctor under guidelines of anaesthetic. Blood pressure- 118/82 mm of Hg, pulse rate 86/min, temperature afebrile informed concern taken nil orally 6-8 hours before the operative procedure.

2. Pradhana Karma (Operative)

A surgical IFTAK technique was adopted in which external openings at the 2 and 3 o'clock positions are connected, and then probing is done to the internal opening at the 3 o'clock position. A small incision is made at the 6 o'clock position to separate the muscle tone by an artery forceps up to the internal opening at the 6 o'clock position to create a window 3–4 cm away from the anal verge, then probing is also done between the window and the external opening at the lateral aspect, and then the lateral opening is slightly widened with the help of a mosquito forceps for better drainage. A seton primary threading (barber thread) 22 number is put into the tract external opening to the window. Primary threading was done between the window and the anal canal internal opening at 6 o'clock (Figure 2), followed by two *Guggulu*-based *Apamarg Ksharasutra*, one for cutting and the other for proper drainage (Figures 3 and 4). The patient was operated on under spinal anaesthesia (by anaesthetic). As the mixture of chlorine water and betadine solution was pushed from the external opening, the mixture came out from the internal opening at 3 and 6 o'clock, confirming the patency of the tract from the gluteal region to the anal canal. After five weeks, pus discharge continued, followed by Seton's decision to proceed externally, opening the window. The cleaning and dressing were done regularly, but after six weeks, during the examination, induration with tenderness was palpated at the left lateral aspect from the external opening to the 5 o'clock position in the lateral gluteal fossa, which is present 6–8 cm away from the anal verge. Then we create a new secondary opening at the 5 o'clock position, 6–8 cm away from the anal verge, and new rubber seton threading is put in from the primary external opening (which is present at the 2 o'clock position) to the new external opening for better drainage purposes (Figure 5 and 6).

3. Paschat Karma (Postoperative)

Daily dressing with chlorine water and betadine solution for at least one month under IPD observation; only betadine was used with *Jatyadi tail pichu* when pus discharge was reduced. After the patient was discharged, regular follow-up was done weekly. On follow-up, the patient was satisfied with the treatment. During treatment, pain was reduced in the perianal region, and pus discharge was decreased from the external opening. First, seton was removed within two weeks after proper drainage when no discharge was noticed, then *Ksharasutra* change followed, and *Ksharasutra* change cut through was done at 3 o'clock position within four weeks. After two months, we observed lateral induration and hardness absent, so we removed rubber seton material in the lateral aspect, which was put into the primary external opening and the new external opening for drainage purposes (Figures 7 and 8). The healing and cutting properties of *Ksharasutra* change weekly based on progress (Figure 9) at 16 weeks. *Ksharasutra* change cut-through was done at the 6 o'clock position of the window within 22 weeks (Figure 10). The wound was dressed with *Jatyadi tail pichu*, and after six months, the wound was completely healed (Figure 11).

Conservative Treatment

- *Pancktiktaghrit guggul* 250 mg 2 tabs BD after meals for one month,
- *Saptavinshati guggul* 250 mg 2 tabs BD after meals for two months,
- *Arogyavardhani vati* 250 mg 1tab BD after meal for one month, then gap for 15 days, then start again for one month,
- *Triphla churna* 5 gm H.S. at bedtime with lukewarm.

OBSERVATION AND RESULT

In the IPD section of the *Shalya tantra* department for dressing purposes and the healing rate of wounds. Weekly assessment was done for postoperative pain, discharge, and the cutting rate of the fistulous tract. No signs or symptoms of recurrence were observed, and sphincter tone was within normal limits during this period. After cutting through the tract, the patient was followed up for one month, weekly.

Follow-up

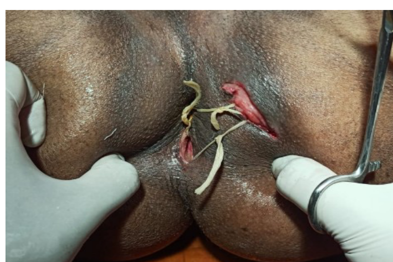

Figure 2: After 3 Days

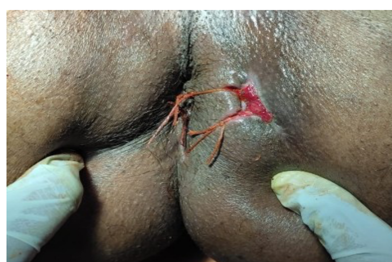

Figure 3: After 2 Week

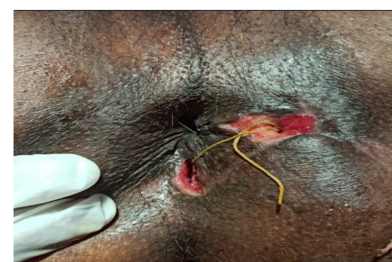

Figure 4: After 4 Week

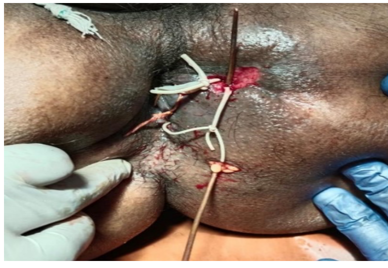

Figure 5: After 5 Week

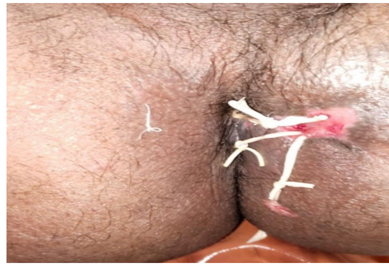

Figure 6: After 6 Week

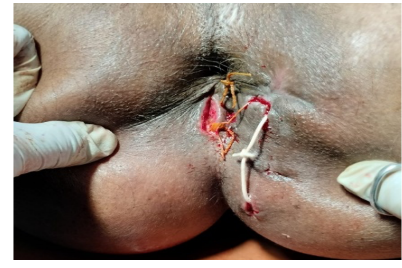

Figure 7: After 8 Week

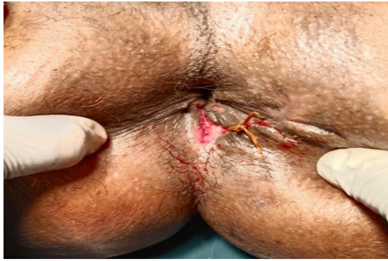

Figure 8: After 10 Week

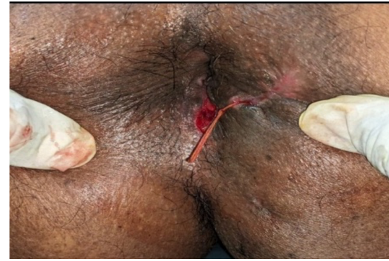

Figure 9: After 16 Week

Figure 10: After Cut through 22 Week

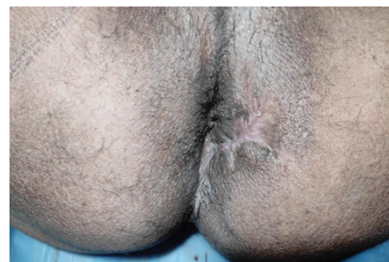

Figure 11: After 24 Week

DISCUSSION

In Ayurvedic medicine, *Ksharasutra* therapy is the gold standard treatment option for controlling anal fistulas because it has a lower recurrence rate and does not interfere with anal continence.[8] IFTAK shortens the treatment course and concentrates on eradicating the infected anal crypt, the primary pathology in the anal fistula, to shorten the treatment period.[9] The patient complained about perianal pus discharge. Based on the local examination, he was diagnosed with a complex extra sphincteric fistula-in-ano. Here, our primary objective was to minimise the recurrence rate, have fewer complications, and have minimal duration during the procedure. Modern science's treatment is less successful as each process carries a significant risk of pain, healing complications, incontinence, and damage to the sphincter muscles. Although *Guggulu*-based *Apamarg Ksharasutra* has shown better results than those used by *Ayurvedic* surgeons, it is still a time-consuming and painful process and leaves a big scar. On the contrary, the IFTAK technique gives promising results, which can be seen as negligible blood loss during the operative procedure and a lower recurrence rate. It is a cost-effective treatment, less time-consuming (less hospital stay), and shows good cosmetic results with a minimum scar mark compared to modern therapy and the conventional method of *Guggulu*-based *Apamarg Ksharasutra*. He was advised to come for regular dressing until cut through, i.e., after six months of operation. Due to her experience with previous surgeries, he had a big scar mark, but due to IFTAK, he has fewer complications and a negligible scar mark. Hence, the procedure has a cosmetically better outcome and minimal damage to the sphincter and soft tissues.

CONCLUSION

The complex and recurrent fistula-in-ano is complicated to manage and hence takes time to heal completely. The IFTAK technique is very effective in treating complex and recurrent fistula-in-ano. These are minimally invasive techniques and have a fast recovery rate; there are minimum chances of incontinence, and one's quality of life is not hampered. So, we can conclude that in complex fistula-in-ano, The present technique emerges as a unique and desirable procedure for this rather intractable disease. IFTAK was done, and *Guggulu*-based *Apamarg Ksharasutra was* changed at weekly intervals. A complete cut-through was done after six months. The regular dressing was done with chlorine water and betadine solution, and then *Jatyadi taila* was used in the anal canal until complete healing. This case study showed the effectiveness of interception of the fistulous tract with the application of *Ksharasutra* (IFTAK) in *Bhagandar* (complex fistula-in-ano).

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