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Management of Low Anal Fistula by *Chedana* and *Ksharkarma* A Case Study and Review of Literature

Research Article

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Abstract

Introduction:-*Bhagandara* is considered under the *Ashta Mahaarogas* (Eight grave disorders).The prevalence rate of fistula-in-ano has been accepted as second highest after piles in ano-rectal disorders. Sushruta has given equal emphasis to surgical as well as parasurgical measures for the management of *bhagandara*, he advocated *chedana* (fistulectomy) of fistulous tract followed by *ksharkarma*. Aim: To evaluate the efficacy of *chedana* (fistulectomy) with *ksharakarma* in management of low anal fistula. Material & Methods: A 43 years old male patient visited OPD with throbbing pain in ano, swelling and fever with chills. On examination external opening was seen at 11 o'clock approximately 4 cm from anal verge with abscess. TRUS (Transrectal Ultrasonography) was done to confirm the diagnosis. Patient had history of surgery before 2 years for drainage of perianal abscess. So, it was diagnosed as a case of perianal abscess with intersphicteric low anal fistula. *Chedana* (fistulectomy) followed by *teekshna Apamarga kshara* application under spinal anesthesia (Xylocaine 2% with adrenaline) was done. Observation And Results: The wound was assessed weekly and it was observed that in first week pain was reduced completely. On second week healthy granulation was observed without any discharge. The wound healed completely within one and half month with minimal scar formation and normal skin coloration. Conclusion: This single case study concluded that *chedana (*fistulectomy) with *ksharkarma* is one of the option for management of low anal fistula.

Keywords: *Bhagandara*, Fistula-in-ano, Fistulectomy, *kshara , ksharakarma*, *chedana*.

Introduction

On looking to the scientific description of *Bhagandara*, it can be concluded that Sushruta was well versed regarding its complexity and outcome of surgical management. It is only disease in ancient surgical treatises, where Sushruta was more puzzled to develop a gold standard treatment. It is notorious for its chronicity, recurrence and frequent acute exacerbations. The prevalence rate of fistula-in-ano has been accepted that it is second highest after piles. About 17-20% cases are diagnosed as fistula-in-ano in ano-rectal clinic. About more than 90% fistula-in-ano develops due to cryptoglandular infection and rest of the 10% fistula-in-ano due to non-cryptoglandular causes like pulmonary tuberculosis, ulcerative colitis, crohn's disease, colloid carcinoma of rectum, lymphogranuloma venerum, actinomycosis, post haemorrhoidectomy, sclerotherapy and other abdominal conditions those produce pelvi–rectal type of abscess.(1) As per the general observations of the patient flow and data of anorectal disorders collected from *Shalya Tantra* department IPGT & RA, Jamanagar, more than 15% patients are found suffering from *Bhagandara* (fistula-in-ano). Among them recurred, refused and complicated cases constituted more than 5%, while rest of the cases were found fresh. These are several options for the treatment of fistula-in-ano in today's surgical practice with their own limitations as mentioned below. Fistulotomy or Fistulectomy, these may cause incontinence. New techniques like Fibrin glue injection, Fistula plug, Endorectal advancement flap, LIFT Technique (ligation of intersphincteric fistula tract), VAAFT (Video Assisted Anal fistula treatment), PERFACT (proximal superficial cauterization, emptying regularly fistula tracts and curettage of tracts).These new techniques are too costly so they are not affordable for low economy country like India and also not free from recurrence. *Bhagandara* described in *Ayurveda* classics can be co-related with fistula-in-ano. As per Sushruta, *Bhagandara* occurs if *Bhagandarpidika* which can be co-related with ano-rectal abscess is not treated.(2)Sushruta suggested *chedana* (excision) of fistulous tract and *ksharakarma* for the management of *Bhagndara.*(3) Sushruta included *Bhagandara* in *Chedana yogya vyadhi* (diseases in which excision is required).(4)In chapter eleven of Shusrut samhita *sutrasthana* while describing about the indications of *pratisarniya kshara,* he mentioned *bhagandara* also. (5)

Kshara is made up of several drugs,in their most concentrated and subtle forms. Hence effective over all the *doshas*. It has *shodhana* properties as it has got *ushna* and *teekshna gunas* which help in desquamation of sloughs (debridement) and draining of pus when used externally.*Kshara* helps in *ropana* or healing process in a *vrana* (wound) because of their cleansing and antiseptic properties.(6)

Material and Methods

Case Report

A fourty three years old male patient visited OPD with throbbing pain in ano, swelling and fever with chills from last six months. Patient had a history of incision and drainage for perianal abscess two years back. Patient was electrician by profession.On perineal examination in lithotomy position external opening was

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seen at 11 o'clock approximately 4 cm from anal verge with abscess. On digital examination internal opening was felt at 11o'clock. TRUS was done to confirm the diagnosis. As per TRUS report, there was a thin track extension (5mm thickness) of abscess medially and reaches intersphincteric space at 11 o'clock position with further superior extension at 11 0'clock position. Internal opening at 11 o'clock (length from anal verge 15mm).So, it was diagnosed as a case of perianal abscess with inter-sphicteric low anal fistula. Routine blood and urine examinations were done and found within normal range. Hence, based on clinical findings and TRUS the case was diagnosed as a case of *Bhangandara* (Low anal fistula) and patient was admitted in male *shalya* ward for further management.

Methodology

Pre-operative

Informed written consent was taken. Part preparation was done. Proctoclysis enema was given in early morning 3 hours before operation. Injection T.T 0.5cc IM was given and inj.Lignocaine 2% sensitivity test was done.

Operative Procedure

Under all aseptic condition patient was taken in OT with normal vital data. Then spinal anaesthesia was given in sitting recumbent position. Thereafter, patient was asked to lay down in lithotomy position.. Cleaning and draping was done. Patency test was done using methylene blue, which was seen coming out from internal opening at 11°'clock. Then probing was done with probe from external opening at 11°'clock external. The tract was excised (*chedana*) and *teekshna apamarga kshar* was applied then covered by a gauze piece and left for approximately 30 seconds, later flushed with lemon juice followed by normal saline. At 12 °'clock position chronic fissure tag was seen, tag was excised. Proper haemostasis was achieved, dressing done and patient was shifted in ward with normal vital data.

Post – operative

From next evening, patient was advised to take sitz bath with *Panchavalkala* decoction and then antiseptic dressing with *ksharaplota* and *matra* b*asti* with *jatyaditaila* was done daily. *Varun shrigru guggulu* 1gm three times per day orally was given with luke warm water after meal till complete cure.

Observation and Results

The wound was assessed weekly and it was observed that in first week pain was reduced completely and patient could do his daily work, there was mild serous discharge from the postoperative wound. On second week healthy granulation was observed without any discharge. On 4th week wound was healthy and contracted. The wound healed completely within one and half month with minimal scar formation and normal skin coloration.

Discussion

In this case there was a big abscess cavity with a low anal intersphicteric fistula at 11 °'clock with internal opening at 11 °'clock. *Chedana* (Fistulectomy) was done and t*eekshna Apamarga kshar* was applied. As a fistulous tract is lined by unhealthy granulation and fibrous tissue so it fails to heal and if even after surgery this unhealthy tissue is left behind there is recurrence of fistula. So, in this case fistulectomy was done and *teekshna kshara* was applied. Fistulectomy helps in complete drainage of the fistulous tract and abscess cavity. Since, this is a case of low anal fistula, fistulectomy does not cause incontinence besides that after fistulectomy if *teekshna kshar* is applied it debrides the unhealthy granulation and fibrous tissue. It also cauterizes the branches which may be left undetected, thus preventing recurrence. Besides *sodhana* property *Kshara* also has *ropana* property so it promotes wound healing also.(7)*Panchvalkala kwath* sitz bath enhances the wound healing(8) and decreases inflammation. *Jatyadi* tail *matra bast*i was given as pain in any part of the body is due to vitiation of *vata*(9) and oil itself is *vatashamak* in nature(10) so reduces pain and it also lubricates the anal canal preventing constipation, eases the passage of stool and promotes wound healing.(11)*Varun shigru gugglu* has antibacterial(12) and anti inflammatory (13)properties so reduces pain and prevents infection.

Conclusion

This case study concluded that *Chedana* (fistulectomy) followed by *Ksharkarma* is one of the option for management of low anal fistula-in ano.

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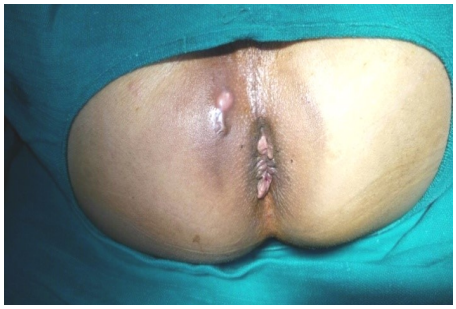


Fig 1:- Pre-operative

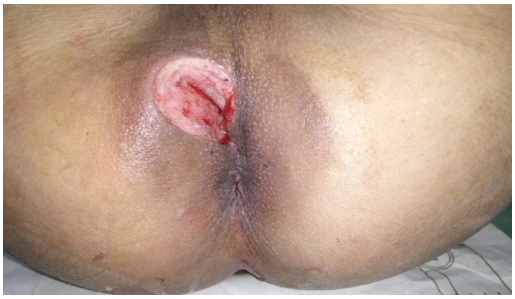


Fig 2:- Post-operative

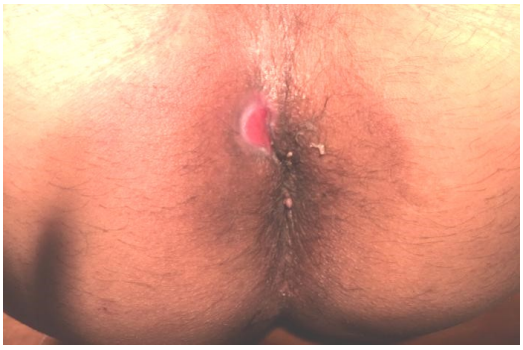


Fig 3:-Post-operative 4th week

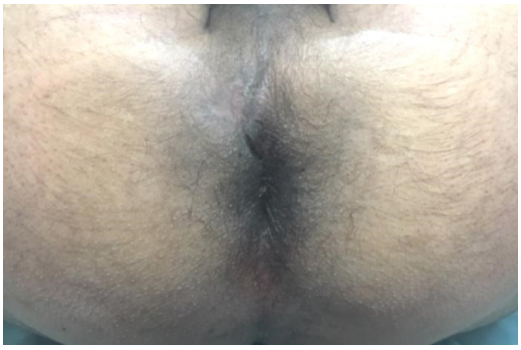
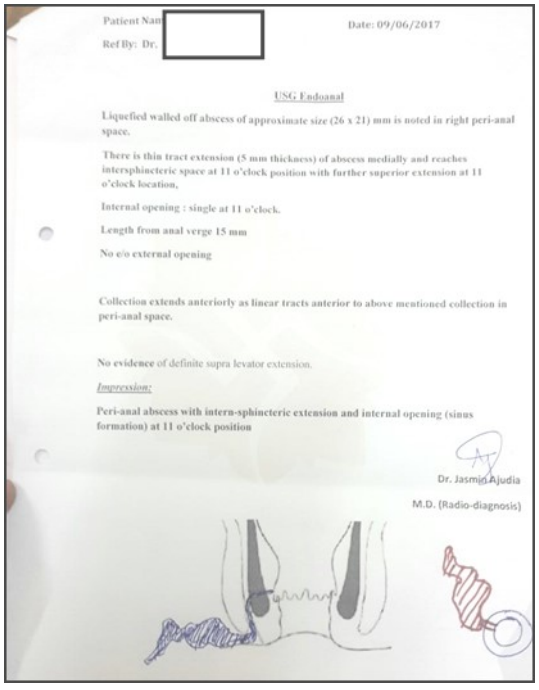


Fig 4:- Healed within 6 weeks



Patient Nam
Ref By: Dr.
Date: 09/06/2017

USG Endoanal

Liquefied walled off abscess of approximate size (26 x 21) mm is noted in right peri-anal space.

There is thin tract extension (5 mm thickness) of abscess medially and reaches intersphincteric space at 11 o'clock position with further superior extension at 11 o'clock location.

Internal opening : single at 11 o'clock.

Length from anal verge 15 mm

No e/o external opening

Collection extends anteriorly as linear tracts anterior to above mentioned collection in peri-anal space.

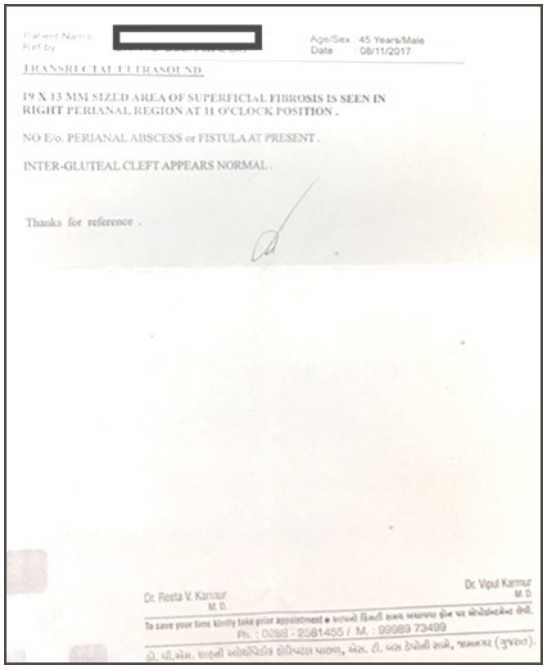
No evidence of definite supra levator extension.

Impression:

Peri-anal abscess with intern-sphincteric extension and internal opening (sinus formation) at 11 o'clock position

Dr. Jasmin Ajudia
M.D. (Radio-diagnosis)

Fig 5:- Pre- operative TRUS



Age/Sex : 45 Years/Male
Date : 08/11/2017

TRANSRECTAL ULTRASOUND

19 X 13 MM SIZED AREA OF SUPERFICIAL FIBROSIS IS SEEN IN RIGHT PERIANAL REGION AT 11 O'CLOCK POSITION .

NO E/o. PERIANAL ABSCESS or FISTULA AT PRESENT .

INTER-GLUTEAL CLEFT APPEARS NORMAL .

Thanks for reference .

Dr. Reeta V. Kanmur
M. D.

Dr. Vipul Kanmur
M. D.

To save your time kindly take prior appointment

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Fig 6:- Post-operative TRUS

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