IJCRT.ORG ISSN : 2320-2882

INTERNATIONAL JOURNAL OF CREATIVE RESEARCH THOUGHTS (IJCRT)

An International Open Access, Peer-reviewed, Refereed Journal

Horse Shoe Fistula (Parikshepi Bhagandara) Treated Successfully With Partial Fistulectomy And Iftak Technique – A Case Report

Dr Arjun V [1] Dr Udaya D K [2] Dr Elizabeth John [3]

[1]Final year PG Scholar (Dept. of Shalya Tantra), Karnataka Ayurveda Medical College and Hospital, Mangaluru, D.K District, Karnataka, India

[2]Professor, Dept of PG Studies in Shalya Tantra, Karnataka Ayurveda Medical College and Hospital, Mangaluru, D.K District, Karnataka, India

[3]Professor and Head of Department, Dept of PG Studies in Shalya Tantra, Karnataka Ayurveda Medical College and Hospital, Mangaluru, D.K District, Karnataka, India

Abstract

Fistula-in-ano is a condition which has been recognised as a difficult surgical disease in all the ancient and modern medical sciences in the world. It is the recurrent nature of this disease which makes it more and more difficult for treatment. This is one condition for which the maximum types of surgical, para-surgical, and medical applications have been described. Sushruta had described a detailed surgical approach involving excision of the fistulous tract but was not quite satisfied with the surgical excision which often resulted into recurrence. Kshara sutra proved that 'chemical fistulectomy' is more complication free rather than 'surgical fistulectomy.' A 65-year-old male patient complaining of pus discharge with mild pain at the right side of perianal region since the last 5 months came to the shalya tantra opd of Karnataka Ayurveda Medical College. After assessing the case it was diagnosed as horseshoe fistula and was advised ksharasutra.

Keywords –Horseshoe fistula, Ksharasutra, Parikshepi bhagandara

Introduction

A Fistula in ano or anal fistula is a chronic abnormal communication, usually lined to some degree by granulation tissue, which runs outwards from the anorectal lumen (internal opening) to an external opening on the skin of the perineum or buttock (or rarely, in women, tot the vagina).[1]. During its development the primary opening may sometimes close and the purulent discharge flows out through the external opening only in which case it is termed as the 'blind external fistula.'[2] Ischiorectal fossa on each side, most often communicates with each other behind the anus causing horse shoe fistula when a track forms secondary to ischiorectal abscess.[3] Sushruta described has described bhagandara, one among the ashtamahagathas. Sushruta classified Bhagandara into five subtypes namely- Shatponaka, Ustragriva, Parisravi, Shambukavarta and Unmargi.[4] Acharya Vagbhata has added 3 more Riju, Parikshepi and Arshobhagandara.[5] Of these, parikshepi bhagandara can be taken as horse shoe fistula. Kshara sutra is a medicated seton, which was told by Sushrutha in the

treatment of nadivrana as well as bhagandara.[6] Initially barbour's linen thread number 20 was smeared for 11 coatings of snuhi ksheera. It was then followed by 7 coatings of snuhi ksheera with apamarga kshara, finally 3 coating of, snuhi ksheera and haridra churna.[7] The Interception of Fistulous Tract with Application of Ksharsutra (**IFTAK**) or Window method is used to treat horseshoe fistula.[8] The Ksharasutra method, when performed to intercept a fistulous tract, promotes excellent healing, and has a low (3-7%) recurrence rate.[9]

CASE REPORT

Age - 65 year

Gender- Male

Chief complaints and duration

Patient complains of pus discharge with mild pain at the right side of perianal region since the last 5 months.

H/o present illness

Patient was apparently normal before 5 months. Gradually he developed a boil on the right side of peri anal region later associating with pain and intermittent pus discharge. Therefore, for further treatment he came to OPD of Shalyatantra, Karnataka Ayurveda Medical College, Ashok Nagar, Mangaluru.

H/o past illness

Patient had undergone partial fistulectomy and ksharasutra therapy 1 year back for a anterior fistula opening at 1'O clock with no internal opening extending till 4'O clock.

K/C/O Type II Diabetes mellitus under medication.

N/K/C/O HTN or any other major illness.

General examination

CVS – S1 S2 Normal.

CNS – Conscious and oriented to time and place

RS – B/L NVBS heard.

PA – Soft, non-tender, no organomegaly

Pulse - 78/min

BP - 130/80 mm Hg

Digestive System

Appetite – normal

Bowel - constipated.

Uro-genital System – NAD

Local Examination

Per Rectal Examination

On Inspection

Position of the Fistula track: External opening noted at 8'0 Clock and 5'O Clock

No of opening - 2 in number

Previous operated scar mark – Present at 1'O clock

Pus discharge present – At 8'O clock opening

Quantity of discharge – Moderate

On palpation:

Tenderness – ++ - Present

Induration – Present

Digital examination

Sphincter tone – Normal

No active bleeding.

Could not feel the internal opening

Proctoscopic examination

1st degree internal haemorrhoids at 7'O Clock

No other pathology seen

On Probing

Internal opening – Absent, on probing through 8'O Clock the track led to 5'O clock opening

Fresh discharge – Present

Direction of track – Curved

Length of the track – 12.5 cm.

Haematological Investigation

Hb – 14gm%

PPBS – 142mg/dl

HIV I/II and HBsAg – Negative

MRI Perineal region done

METHODOLOGY:

Pre-operative:

The patient and relatives were informed of the prognosis and result and written consent was taken. Inj. Xylocaine test dose and Inj. Tetanus toxoid 0.5ml (IM) was given. Part preparation done. Patient was kept NBM (Nill by Mouth) for 6 hours prior to surgery. Soap water enema given 2 hours prior to surgery.

Operative:

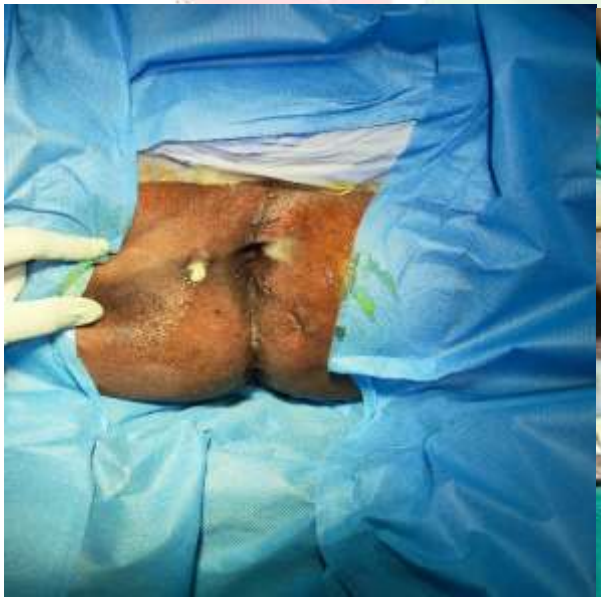
After confirming the vitals are stable, the patient was shifted to the operation theatre. Patient was given lithotomy position. Painting (povidone iodine solution) and draping done. Local anaesthesia of approximately 40ml lignocaine was given as rhomboid block around the anal verge along with pudental block. Lord's 4 finger anal dilatation was done. On infiltrating povidone iodine solution at 8'O Clock opening, it was observed that the solution exited through the opening at 5'O Clock. On probing through 8'O Clock opening, it was observed that the probe passes through the posterior midline to the opening at 5'O Clock with no internal opening as such. Partial fistulectomy of the track was done near the 8'O Clock opening. A window was created at 6 o'clock, 5 to 6 cm from the anal margin in midway intercepting the whole track. Then apamarga ksharasutra threading was done from both external opening to the window. Haemostasis was achieved. Packing and bandaging was done and the patient was shifted for recovery.

Post – operative:

Patient was advised to take Tab. Triphala guggulu 2BD B/F, Tab. Gandhaka rasayana 2BD A/F, Tab. GRAB 1BD A/F, sitz bath TID with Panchavalkala kwatha. Advised for changing ksharasutra in weekly interval by railroad technique.

Follow – up:

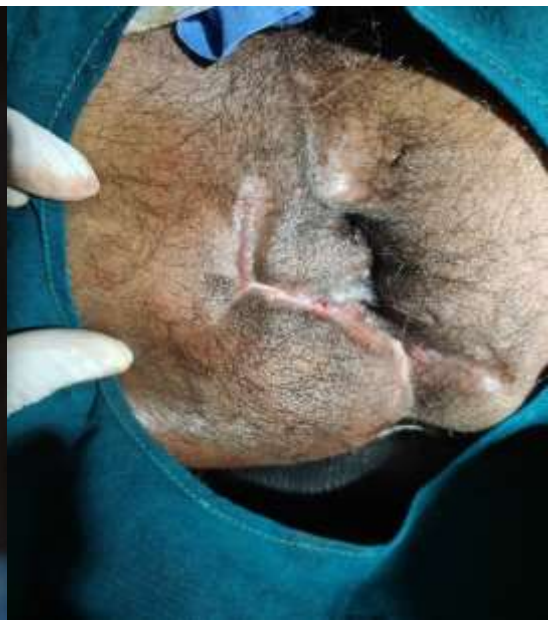
Weekly changing of ksharasutra was done. The healing and cutting of the track by ksharasutra were successful leading to the complete recovery of patient by the end of 45 days. No complications were observed.



Before procedure

During procedure after ksharasutra threading

Kshara sutra changing



After cut through at the end of 45 days

Discussion

The patient came for regular follow ups and weekly ksharasutra changing was done by rail road technique. It was observed that the integrated method (partial fistulectomy + ksharasutra) along with interception of track and application of ksharasutra (**IFTAK**) led to a faster healing with very less or no complications. The introduction of kshara sutra into the fistulous tract dissolves the tough fibrous tissue and ultimately draining it out creating a healthy base for healing. Its gradual and sustained chemical action not only removed debris from the site of fistula but it also helped in encouraging fresh healthy granulation thereby inducing a long-awaited healing pattern in the depth of tissues.

Conclusion

It is the recurrent nature of this disease which makes it more and more difficult for treatment. This is one condition for which the maximum types of surgical, para-surgical, and medical applications have been described.[10] The patient was followed up for 2 more months to rule out any recurrence. Though one of many case studies, ayurveda has again proved the effectiveness of a cost effective and minimally invasive procedure which helps in improving the quality of life of patients with no complications and no recurrence.

References

1. P. Williams NS, Ronan O'Connell P, McCaskie AW. Bailey & love's short practice of surgery. Boca Raton, FL: CRC Press; 2018. 1363 p.
2. Sharma KR, Singh K. Kshara Sutra Therapy in Fistula-In-Ano, and Other Ano-Rectal Disorders. Sharma SK, editor. New Delhi: R.A.V Publication; 15 p.
3. Sriram BM. SRB's manual of surgery. 6th ed. New Delhi, India: Jaypee Brothers Medical; 2023. 973 p.
4. Dalhanacharya S. Susruta Samhitha of Susruta. Acharya VJT, editor. Varanasi, India: Chaukhambha Surabharati Prakashan; Nidanasthana 4/3.
5. Aachaarya Vagbhatha,Ashtaanga Hridayam: Aruna Dutta's,Sarvaanga SundariCommentary And Hemadri's Ayurvedarasayana Commentary;Edited By AnnaMoreshwar Kunte,Chaukhamba Sanskrita Sansthana,Varanasi, Reprint 2018; Uttarasthana28/ 5,Pg.877
6. Dalhanacharya S. Susruta Samhitha of Susruta. Acharya VJT, editor. Varanasi, India: Chaukhambha Surabharati Prakashan; Chikitsasthana 17/29.

7. Sharma KR, Singh K. Kshara Sutra Therapy in Fistula-In-Ano, and Other Ano-Rectal Disorders. Sharma SK, editor. New Delhi: R.A.V Publication; 57 p.
8. Sahu M. A Manual Fistula in Ano and Ksharasutra Therapy, National Resource Centre on Kshara SutraTherapy, 2015 edition, Chapter 12-page no.186.
9. Sahu M, A Manual Fistula in Ano and Ksharasutra Therapy, National Resource Centre on Kshara SutraTherapy, 2015 edition, Chapter 12-page no.191.
10. Sharma KR, Singh K. Kshara Sutra Therapy in Fistula-In-Ano, and Other Ano-Rectal Disorders. Sharma SK, editor. New Delhi: R.A.V Publication; 2 p.