CASE REPORT

Management of complex fistula-in-ano by a IFTAK technique

Monica Shrestha¹, Tukaram S. Dudhamal²

1 Ayurvedic Medical Officer, Government of Uttarpradesh, India, 2 Associate Professor,
Department of Surgery, IPGT&RA, Gujarat Ayurveda University, Jamnagar, Gujarat, India

ABSTRACT:

Ksharsutra is a Medicated seton which is made by coating the Barbour thread with 21 coatings of *Ksharai.e.*, an herbal alkaline powder, turmeric and latex of *Euphorbia nerrifolia*. *Ksharsutra* application is a minimal invasive well-established procedure in management of fistula-in-ano. Research on *Ksharsutra* started since 1968 and it is being used till date with high success rate. In this case report the patient was asymptomatic before 15 years but then a boil developed at perianal region which spontaneously burst and pus discharge was seen from the boil. Patient was diagnosed with Grade 5 St. James's university hospital classification of perianal fistulae. This was a case of high anal horse shoe fistula. In this case Fistulectomy or Fistulotomy would cause incontinence. So, in this case the *Ksharsutra* was used but with a modification of classical technique called as IFTAK (**Interception of fistulous track with application of *Ksharsutra***) technique. In which a window was created at 6 o'clock and intersphincteric tract was identified and, in that tract, *Ksharsutra* was placed. This technique cures such types of complex Fistula in ano with minimal tissue damage and duration of healing is also reduced.

Keywords: Ayurveda, Bhagandara, Fistula-in-ano Seton

INTRODUCTION

Sushrut the pioneer of *Ksharsutra* treatment has mentioned *Ksharsutra* in the context of Treatment of *Naadevrana* (sinus), *Bhagandara* (Fistula in ano) etc with this reference research on *Ksharsutra* started since 1968. *Ksharsutra* is a Medicated

seton which is made by coating thread with 21 coatings of *Ksharai.e.*, an herbal alkaline powder, turmeric and latex of *Euphorbia nerrifolia*. *Ksharsutra* application is a minimal invasive procedure mentioned in Ayurveda classics for the management of piles, fistula in ano, tumors etc. It is considered among *Astamahagada* by Sushrut, which

Access the article online

Quick Response Code

www.thehealerjournal.org

DOI: 10.51649/healer.47

*Corresponding Author:

Dr. Monica Shrestha

Ayurvedic Medical Officer,

Shahjhanpur Uttarpradesh, UP, India

E-mail: shresthamonica33@gmail.com

Submitted: 11.11.2020

Received: 20.01.2021

Revised: 21.01.2021

Accepted: 26.01.2021

bespeaks the gravity of this disease.¹ This may be due to its peculiar location; the disease presents many problems for proper management. Wound contamination and consequent sepsis is one of the major hurdles in treating the disease. The recurrence of disease is a constant threat to the surgeons and patients alike. In cases of low anal fistula, fistulotomy is done in modern medicine, it's success rates can be as high as 93 to 100 % if done by experienced hands. The incontinence is usually minor and can range from 11.5 to 20 %. ². In this case an integrated approach was opted with the aim of early healing and to avoid recurrence as this was a case of complex fistula with high anal extension.

CASE REPORT

According to the patient he was apparently asymptomatic before 15 years but then a boil developed at perianal region which spontaneously busted and pus discharge was seen coming out from the boil. He took some medicines then and got symptomatic relief. But a month back he had severe pain at perianal region, again a boil developed which bursted and there was gross pus discharge, he had fever too. He visited some general surgeon and he was suggested to undergo Fistulectomy and colostomy. So, he came to our hospital. He had no history of any other medical or surgical illness.

Local Examination: The local examination revealed an external opening at 10 and 11 o'clock over perianal region. Induration was felt between 11 to 6 o'clock. Per rectal examination revealed an internal opening between 5 to 6 o'clock and firm bulges at 4 o'clock and 8 o'clock around 2 cm above the dentate line. MRI showed Internal opening at 5 o'clock position just above the anal verge. Tract was seen going posterior and give rise to ramifications within intersphincteric region in horseshoe pattern with it travels inferiorly and posterior within right side gluteal region with external opening within right side of gluteal region at 10 o'clock position. From left side intersphincteric ramification left side and upwards just above the level of levator ani. Maximum length of tract was 7 mm width 9 mm. Left side upwards transversing tract measures 20mm. Grade 5 St. James's university hospital classification of perianal fistulae All the investigations were found within normal limit. Pus culture from the tract did not show any evidence AFB.

Surgical Procedure: Under aseptic precautions patient was layed in lithotomy after giving spinal anaesthesia. Two openings were seen at 10 and 11 o'clock (Figure 1). Methylene blue was pushed through the external opening at 11 o'clock and dye was seen coming out from internal opening at 6 o'clock. (Patency test) Probing was done through external opening at 11 o'clock which was felt coming towards 6 o'clock. Elliptical incision was taken including both the external openings. The track was cored and two branches of tract was visualised one went towards 6 o'clock and other towards rectum. The tract going towards 6 o'clock was partially excised and in the rest of tract Ksharsutra was tied. A window was made at 6 o'clock approximately 2 cm from verge, the intersphincteric tract was visualised and Ksharsutra was tied 6 to 6 o'clock. (Figure 2) The tract going towards 5 o'clock was scooped well and the wound was packed for haemostatsis.

Dressing was done daily using herbal medicament like *Panchvalkalqath*, *jatyadi tail* etc until complete wound healing and *Ksharsutra* was changed every week by rail road method.

OBSERVATION AND RESULTS

On operation table it was observed that there were two openings at 10 and 11 o'clock. (Figure 1) Methylene blue revealed at the tract extends from 11 o'clock to 6 o'clock. The tract from 11 to 6 o'clock was partially excised and the high anal extension at 9 and 5 o'clock were scooped well. On post-operative day 1 wound was seen at 6 to 11 o'clock with the Ksharsutra connected to 6 o'clock another Ksharsutra was seen at 6 to 6 o'clock with a window at 6 o'clock. (Figure 2). Wound healed partially by post-operative 3rd week healthy granulation was observed there was no pus discharge and only 2 cm Ksharsutra were present in each tract. (Figure 3) Observation on post-operative 7th week revealed 1 cm Ksharsutra in both the tract no bulge felt at 9 o'clock now the bulge at 3 o'clock was now felt at 5 o'clock. (Figure 4) Post-operative 9th week observation revealed Ksharsutra at 6 to 7 o'clock and wound at 6 o'clock healed completely. (Figure 5) On 12th week Ksharsutra got cut through and wound healed completely. (Figure 6)

Clinical Images

Figure 1: Pre-operative – 2 external openings seen at 10 and 11 o'clock

Figure 2: Post operative Day 1

Figure 3: Post-operative 3rd week

Figure 4: Post operative 7th week

Figure 5: Post-operative 9th week

Figure 6: Post operative 12th week

DISCUSSION:

Patient came with a history of recurrent boils at perianal region and was diagnosed as a case of high anal horse shoe fistula. MRI confirmed the diagnosis. In modern surgery the only option is fistulectomy. Since this is a case of high anal horse shoe fistula so fistulectomy will lead to sphincter

damage causing incontinence, so he was also advised for colostomy.

In this case partialexcision of track was done along with IFTAK technique which included partial coring of tract along with *Ksharsutra* in the tract running from 11 to 6 o'

clock, this help in proper drainage of the tract and removal of unhealthy tissue besides that *Ksharsutra* prevents incontinence as it induces fibrosis. *Ksharsutra* has alkaline pH it cauterizes the unhealthy tissue and drains the tract. Partial coring of tract helps in early healing of wound. IFTAK (**Interception of fistulous track with application of *Ksharsutra***) technique was opted. This technique is based on Park's cryptoglandular origin of fistula. In this technique interception of proximal part of fistulous track is done at the level of external sphincter along with the application of *Ksharsutra* from site of interception to the infected crypt in anal canal. This technique mainly aims at eradicating the infected anal crypts with minimum or no damage to anal sphincter by using *Ksharsutra* which induces extensive fibrosis and favour proper healing which reduces the change of healing.

CONCLUSION: So, it can be concluded that complex fistula like these can be treated such integrated approach.

ACKNOWLEDGEMENTS: Not Applicable

CONFLICT OF INTEREST: Author declares that there is no conflict of interest.

SOURCE OF SUPPORT: None

REFERENCE

1. Shastri A, Commentor. Sushrutsamhita, Sutrasthana, AvadhaniyaAdhaya, 33/4-6, Chaukhamba Sanskrit sansthan, Varanasi, Reprint, 2010; 163.
2. Tozer P, Sala S, Cianci V, Kalmar K, Atkin GK, Rahbour G, Ranchod P, Hart A, Phillips RK. Fistulotomy in the tertiary setting can achieve high rates of fistula cure with an acceptable risk of deterioration in continence. J Gastrointest Surg. 2013 Sep 4

How to cite this article:

Shrestha M, Dudhamal TS, Management of complex fistula-in-ano by a IFTAK technique - case report, The Healer Journal, 2021;2(1):1-9.