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AN INNOVATIVE APPROACH IN THE MANAGEMENT OF HORSE-SHOE FISTULA-IN-ANO WITH IFTAK

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ABSTRACT -

Anal fistulas and abscess of the ano-rectal region are different manifestations of the same clinical disease. Ischio-rectal abscess usually develops from infection arising in the crypto glandular epithelium lining in the anal canal extension laterally through the external sphincter. Horse-shoe fistula usually have an internal opening in the posterior midline and external anteriorly and laterally to one or both ischo-rectal spaces by way of the deep potential space. The "*Parikshepi Bhagandara*" described by *acharya Vagbhata* in *astanga hrudaya uttarasthana* can be correlated with the Horse-shoe type of fistula. The overall prevalence rate of fistula-in-ano is 8.6 cases/1,00,000 population. In this condition, neither fistulotomy nor *ksharasutra* treatment alone, are useful hence, there is need of newer innovative surgical techniques to tackle this challenging disease. An integral approach of incision and drainage(I&D) of ischio-rectal abscess of the arms of the horse-shoe fistula with interception from internal opening to IFTAK artificial window and external opening to IFTAK artificial window proves to be successful. An innovative approach was used to manage horse-shoe fistula by making an additional IFTAK window. *Ksharasutra* was changed weekly and foleys catherter was kept in cavity for drainage as well as for easy wash and dressing the fistulous track healed completely by 2 months.

Keywords – Ischio-rectal abscess, Horseshoe fistula-in-ano, local anaesthesia, *Ksharasutra*

INTRODUCTION –

Horseshoe fistula-in-ano represents a complex and challenging variant of anal fistula, characterized by a curved, circumferential tract that typically extends across the posterior midline of the anal canal, resembling the shape of a horseshoe. This condition commonly arises from cryptoglandular infection originating in the posterior anal glands, with subsequent spread into the deep post-anal space and bilateral ischiorectal fossae. Due to its extensive anatomy, multiple external openings, and frequent association with deep-seated abscesses, horseshoe fistula-in-ano is associated with high recurrence rates and a significant risk of sphincter damage if not managed appropriately. In *Ayurveda*, *Bhagandara* is named from the fact that it bursts the rectum, the perineum, the bladder and the place adjoining to them. The abscess which appear in this area are called as *Bhagandara pidaka* in their *apakwa avastha* and they are called *Bhagandara* in the stage of *pakwavastha*. According to *Acharya Sushruta*, *ahara, vihara, mandagni* and *papakarma* are the main causative factors for *Bhagandara.* In modern science, Fistula-in-ano can be chronic abnormal communication, usually lined by some degree of granulation tissue, which runs outwards from the anorectal lumen (the internal opening) to an external opening on the skin of the perineum or buttock (or rarely in women, to the vagina). The drainage of an anorectal abscess results in cure for about 50% of patients. The remaining 50% develop a persistent fistula-in-ano. In recent years, there has been growing interest in sphincter-preserving techniques that combine precision, minimal invasiveness, and improved functional outcomes. Among these, Interception of Fistulous Tract with Application of *Ksharasutra* (IFTAK) has emerged as a novel and promising modality, especially in the management of complex fistula-in-ano, including horseshoe fistula. Rooted in *Ayurvedic* surgical principles and adapted with contemporary anatomical understanding, IFTAK aims to intercept the fistulous tract at a strategic point, thereby minimizing the length of tract subjected to treatment while ensuring effective drainage and eradication of sepsis. In spite of all the advancement in surgery, fistula-in-ano difficult to treat due to its recurrence, more sphincter injury and incontinence, deformity after surgery, physiological upset and depression. The mechanical and chemical action of thread coated with medication do the cutting, curetting, draining and cleaning of fistulous track. An innovative approach of incision and drainage (I and D) of ischiorectal abscess of the arms of horseshoe fistula-in-ano was managed by making an additional IFTAK artificial window followed with ligation from internal opening to IFTAK artificial window and external opening to IFTAK window proves to be successful.

Case Report -

A 46 years old male patient reported in outpatient department of *shalya tantra* at Shri Shivayogeeshwara rural ayurvedic hospital, Inchal. With complaints of swelling and redness at the right side of peri- anal region since 1 week. Associated with history of fever with chills on and off since 4 days. There was no prior history of diabetes, hypertension. Personal Habits were Nil. It was clear that, patient was not using any particular drugs for any other ailments with a subtle beginning, the ischio-rectal pain and pus discharge were progressively getting worse. He was vegetarian in diet and was working as Farmer in his field. There was no prior history of a such disease in his family. Aim of the study is to evaluate the effect of a modified technique of surgery with *ksharasutra chikitsa* in *Parikshepi Bhagandara* (Horseshoe fistula-in-Ano).

Examination –

General examination –

Built - moderate

Pallor - absent

Icterus - absent

Clubbing - absent

Cynosis - absent

Lymphadenopathy - absent

Edema - absent

Systemic examination -

CVS - S1 and S2 heard

RS – AEBE, normal vesicle breathing sound heard

P/A - soft, no organomegaly

CNS - conscious and oriented

Local examination –

- on inspection, in lithotomy position perianal swelling was noticed.
- On palpation local raise of temperature with marked induration and tenderness was elicited and was identified as ischiorectal abscess at right side.
- On proctoscopic examination internal opening at 6'O clock position was detected.

Methodology -

Pre-operative procedure -

Patient was advised nil by mouth 6 hrs before surgery. Written informed consent was taken and educated the patient about full procedure in his own understandable language, inj T T 0.5CC IM and sensitivity test for Inj Xylocaine 0.1 % was given. Besides local part preparation of the patient, bowel clearance were also carried out prior to procedure.

Operative procedure -

Under aseptic precaution painting and drapping done for the patient in lithotomy position. Local anesthesia inj Lignocaine with adrenaline was infiltrated , the incision was made on ischiorectal fossa at 9'O clock to drain the abscess, about 300 ml was drained respectively. Slit proctoscope was introduced and probing was done through external opening. An internal opening IFTAK artificial window was created at 6'o clock position and *ksharasutra* was ligation (IFTAK) was done. A foley's catheter was placed at cavity to drain the secretion and for daily dressing. All the track were kept patent and anal pack containing *Jatyadhi taila* was placed. Interception of fistulous track with application of *ksharasutra* (IFTAK) from external opening to artificial IFTAK window and internal opening to artificial IFTAK window established successfully. Finally proper betadine solution syringing followed by wound packing with betadine gauze was done.

Post operative -

Patient was administered IV fluids with suitable antibiotics and analgesics as per requirements. From Post op day 1 onwards patient was advised for sitz bath with betadine followed by antiseptic dressing with *Jatyadhi taila*. Orally *Triphala guggulu* and *Gandhaka rasayana* 1 BD daily for 8 days was prescribed.

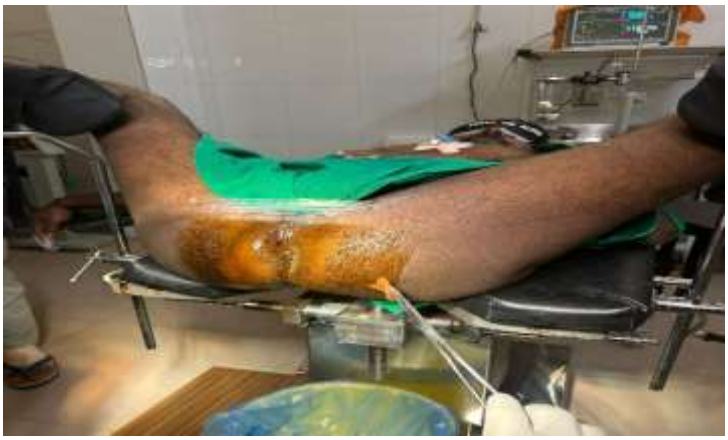

Figure 1

Figure 2

Figure 3

Figure 4

Observation –

On post operative 1st day the *ksharasutra* was in situ

- On examination - mild pus discharge and oozing from surgical site was noted.
- On the post operative 7th day minimal pus discharge was present from the track and patient complained about on and off pain and itching.
- On the post operative 11th day besides healthy granulation tissue, absence of discharge noted at wound floor and completely cut through fistulous track were observed.
- On followup after 2 months the wound healed completely with minimal scar Fig.4

Discussion –

Acharya Sushrut described the treatment of fistula-in-ano as *Bheshaja, ksharakarma, agnikarma,* and *shastrakarma* as the standpoint. *Ksharakarma* is considered best among these four as it reduces the chances of incontinence, minimize the time requirement, it drains the pus and discharge from the track. The procedure of interception of fistulous tract with application *ksharasutra* is said to be the best option experienced in this case report as it minimize the patient hospital stay and early return to routine work. The application of *ksharasutra* is having anti-inflammatory and anti-microbial property that helps in cutting and healing. Hence, the interception of fistulous tract with *ksharasutra* helps to drain the pus from remaining part of track and early healing of the wound takes place.

Conclusion-

The management of horse-shoe fistula is difficult and complicated because of involvement of sphincters. Management of these cases with interception of Fistulous track with application of *ksharasutra* (IFTAK) is effective and in that it helps by cutting and healing of fistulus track simultaneously with reduced bleeding, minimal pain. There is less chance of infection almost no post-operative complications.

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