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Case Study

A MINIMAL INVASIVE TECHNIQUE FOR 'A LONG TRANS-SPHINCTERIC FISTULA IN ANO'- A CASE STUDY

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ABSTRACT
Fistula in ano is an uncommon condition of the GIT, with a prevalence of 0.01% in the general population, with higher frequency in men than in women at 2:1 ratio. Complete fistulotomy is the current surgical procedure opted by many surgeons but it may concedes potential complications such as displacement of the anal canal, incontinence, uneven gluteal contour with ugly scar and high rate of recurrence. **Presentation of case:** Study was conducted on a male patient aged 28 years, with non-healing wound on left gluteal region since eight months pain and swelling in perianal region since two days, on per rectal examination internal opening was found on 6 'o'clock and external opening at 4 'o' clock approx.6 inches from the anal verge, diagnosed as trans-sphincteric fistula in ano. In this case study we applied a technique to save the tissue and low complications. We applied two *Ksharsutra*, one for cutting the tract and second for drainage was used . Second *Ksharsutra* removed within 2 week after proper drainage. After 6 *Ksharsutra* change cut through was done at *6 'O'* clock position .wound was healed after six weeks. **Conclusion:** Fistula in ano having distant external opening such as in gluteal region is rare condition. The present study involved a minimal invasive technique which has negligible complications with a sure cure.

KEYWORDS: *Bhangander*, *Ksharsutra,* A Long Trans-Sphincteric Fistula in Ano, Medicated seton thread.

INTRODUCTION

The Fistula-in-ano is an abnormal connection (An inflammatory track lined by unhealthy granulation tissue and fibrous tissue) between the anal canal and the perianal skin [1]. Difficult and Recurrent surgical disease. It usually results from an Ano-rectal abscess (50%), which burst spontaneously or opened inadequately.[2]

In Ayurveda *Bhagander* (fistula in ano) is considered under *Ashtmahagada* due to its chronicity and incurability[3], as it leads to major physical, psychological and social problems due to persistent discharge. The treatment of perianal fistulas is diverse because no single technique is universally effective, the present trend in the management of fistula in ano is surgery like fistulotomy, fistulectomy, new techniques like fistula plug, and LIFT (Ligation of Inter-sphincteric Fistulous Tract). [4]

These disease is generally not a threat to life, but causes considerable discomfort, fear, enforced bed-rest, sphincteric incontinence, stenosis, discomfort, recurrence absence from work with consequent economic strain while in long term effect of this disease induce weakness which finally decreases energy and enthusiasm of patient.

As described by *Acharya Baghbhatt Rijubhagandar*[5] can be correlate with long trans-sphinteric fistula in ano.

The incidence of the patients with one or two defects (incontinence, recurrence etc.) *Kshara sutra* is a unique and an established procedure for difficult surgical diseases like fistula in ano.

Case Study

A male patient aged 28 yrs. came to Shalya Tantra OPD, National Institute of Ayurveda, Jaipur. Patient was not a k/c/o DM, HTN etc. Patient was thoroughly examined and vitals were taken. Patient was diagnosed trans-sphincteric fistula in ano and admitted in male Shalya Tantra ward Pt. Came to NIA Shalya tantra OPD with Chief complaints of, Pus discharge from gluteal region since 8 months, Swelling p resent at perianal region x 2 days, On examination trans-sphincteric fistula in ano with an ext. opening at 4 'o'clock position, Appro x 6 inch away from anal verge, internal opening at 6 'o'clock position in the anal canal at the level of dentate line.

METHOD

1. Pre-Operative

Triphala choorna 1tsp at bed time/Rectal irrigation with enemas on the morning of the operation.

Preoperative I.V. antibiotics given.

Inj. TT I.M. given

B.P.-120/84 mm of hg, P.R.-76/min, Temp- Afebrile Informed concern taken

Nill per orally for 6 hrs

2. Operative

A surgical technique was adopted in which dissect the long fistulous track in the intersphincteric space by using two *Ksharsutra*, one for cutting and second for proper drainage. Patient was operated in spinal anesthesia. Ass mixture of hydrogen per oxide and betadine was pushed from external opening, the mixture

was coming out from the internal opening at six 'O' clock confirming the patency of the tract from gluteal region to the anal canal. A incision was made in intersphincteric groove to divide the long tract into a small tract from internal opening to inersphincteric groove which is approx. 2 cm from the anal verge and a long tract from intersphincteric groove to external opening. then two *Ksharsutra* was applied one in the smaller tract and second in the larger tract. cleaning and dressing was done.

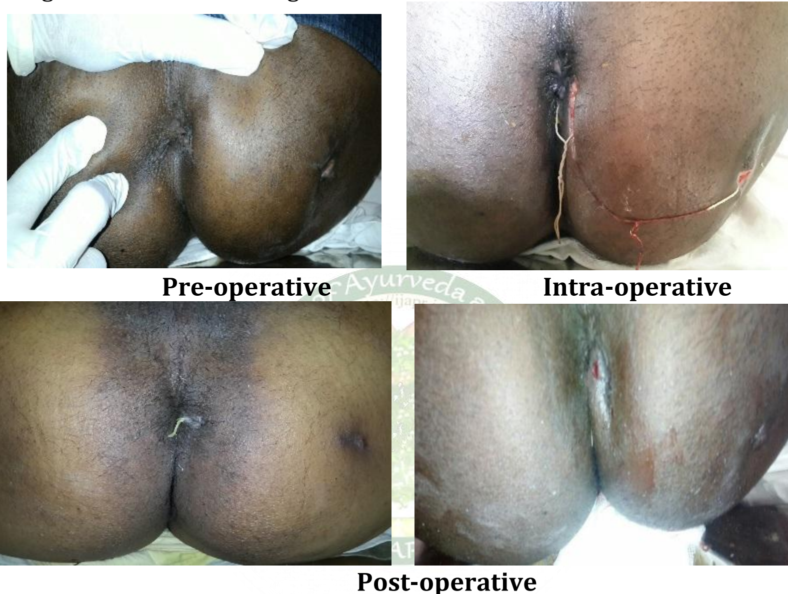
3. Post-Operative

B.P.-130/84mm of Hg, P.R.-88/min

Daily dressing with *Jatyadi tail pichu*. Regular follow up was done weekly. On follow up patient was satisfied with the treatment. During treatment pain was reduced in perianal region. Pus discharge was reduced from external opening. Second *Ksharsutra* removed within 2 week after proper drainage when no discharge was noticed. After 6 *Ksharsutra* change cut through was done at 6 'O' clock position. Wound was dressed with *Jatyadi tail pichu* and after 6 weeks wound was completely healed.

RESULT AND DISCUSSION

A minimal intervention heals the condition completely. Leaving no contour disturbance or ugly scar considerably less recurrent. Patient remain ambulatory. No need of long duration hospitalization. Less discomfort during treatment. Minimal damage of sphincter and soft tissues. There are no data in the literature to indicate the healing rate of perianal fistulas when using an operative strategy that routinely avoids division of any part of the anal sphincter. The present study involved a minimal invasive technique, Cryptotomy - in which *Ksharsutra* was applied to damage the affected anal gland posterior midline, which has negligible complications with a sure cure.



Pre-operative **Intra-operative**

Post-operative

CONCLUSION

This is a minimal invasive technique for long fistulous track, not require to excise whole fistulous tract forming large wound, not distorted the normal anatomy of the perianal region, wound healing time is very less with minimal scar formation. Present technique emerges as a unique and desirable procedure for this rather intractable disease.

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