Review Article

Short Duration Minimal Invasive Guggulu Ksharsutra (Medicated Seton) Therapy in Fistula in Ano

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Abstract
Ksharsutra is emerging as a specialized modality of treatment in the field of surgery in Ayurveda. Not only it is panacea to treat fistula-in-ano but also it is a sure-shot remedy for different type of sinuses, injection abscess, hemorrhoids and polyps. Ksharsutra has revolutionized the treatment of fistula in ano, which was considered previously the notorious to tackle and cure. In spite of many benefits, ksharsutra causes certain discomforts such as long duration, morbidity, pain and discomfort in the management of fistula in ano.

The present study was devised to minimize duration of therapy and pain in fistula in ano. The results were documented and analyzed. The results were encouraging. The duration of therapy was reduced and the pain was significantly less in all patients.

Keywords: Ksharsutra, fistula in ano, bhagandara, interceptive ksharsutra therapy

Introduction:
Results of surgical procedures such as fistulotomy and fistulectomy have been embarrassing as the recurrence is inevitable in most of the cases even after complete excision of the track and meticulous dressing. The surgical management of fistula has got several problems, complications and recurrence. The recurrence is not by chance but as a rule. Ksharsutra therapy is the answer to this utterly embarrassing problem. The treatment of Fistula-in-ano has been revolutionized after the invention of the Kshara-sutra. The recurrence rate is almost nil after the application of this thread. Moreover, it causes little tissue damage and causes lesser trauma to the patient. The patients remain ambulatory with this therapy and got cosmetically acceptable scar as a reward in the end of the therapy.

Causes of fistula in ano: The main cause is cryptoglandular infection. Apart from it, there are other causes such as - infected fissure-in-ano, sclerosing injections, tuberculosis, Crohn’s disease, ulcerative colitis, pelvic inflammation, trauma, rectal and anal carcinomas, radiation, leukemia, lymphoma, lymphogranuloma venerum, rectal, gynecological & obstetrical operations etc.

Why surgery is not beneficial? 
1. Recurrence rates are very high
2. Prolonged dressing and loss of great amount of tissue
3. Operative site is the potential space for infection by faeces

Does kshara-sutra heal all fistula-in-ano? 
1. No, there are certain contraindications
2. Osteomyelitis of pelvic bones and femur
3. Tuberculosis of hip joint, spine and cold abscess
4. Ulcerative colitis, Crohn’s disease, venereal diseases
5. Intestinal and pelvic malignancies
6. Ksharsutra may be applied after treating the following diseases such as tuberculosis, diabetes mellitus, chronic amoebiasis, anaemia, B.P.H.

If these diseases are not treated, the recurrence will be there even after healing of the wound.
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Fig. 1: Crypto glandular infection

Fig. 2: Fistula in ano due to fissure in ano

Fig. 3: Carcinoma in anus

Fig. 4: Fistula in ano due to tuberculosis – inverted edge of wound

Fig. 5: Post operative infection causing fistula in ano

Fig. 6: Extensive scar and recurrence after surgery

Causes of recurrence after surgery
1. Inadequate excision
2. Inadequate removal of anal glands
3. Deep pus pockets are not corrected
4. False assessment of internal opening
5. Primary disease untreated
6. Presence of faecal matter in the wound
7. Moisture in the wound leads to bacterial infection
8. Bridge formation during healing of wound

Fig. 7: Inadequate drainage and removal along with contamination of wound

Why ksharsutra therapy is beneficial?
1. Slow cutting of the track by pressure necrosis caused by thread
2. Debridment of the infected material by Kshar including infected anal glands
3. Formation of healthy granulation tissue leads to good healing
4. Minimal sphincter mechanism disturbance
5. Recurrence after therapy is almost negligible
6. Minimal trauma and no tissue loss
7. Minimal bleeding in comparison to surgery
8. No need to hospitalization; patient can perform his daily tasks
9. Minimal scarring after completion of procedure
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Fig. 8: Healthy healing wound of fistula

Fig. 9: Fistula due to osteomyelitis – desperate attempt by Ksharsutra failed

Problems during KS therapy: Although Ksharsutra therapy has been in use for the management of fistula in ano, yet it is not as comfortable as it should be. The major problem is the long duration of treatment in complicated and trasphincteric fistula. There is pain during and after the application of the thread. [11]

Fig. 10: Long transphincteric fistula – Long ksharsutra therapy

Material and Methods

The study was conducted in department of Shalya tantra, A & U Tibbia college, Karol bagh, New Delhi for a period of almost two years. The follow ups of all patients were documented.

Guggulu ksharsutra: The ICMR standardized guggulu ksharsutra was used in the present study. The ingredients used were guggulu, apamarga kshar and turmeric. It was prepared in the same way as per the standard guidelines of ICMR. [11]

Ksharsutra procedure

The procedure can be divided into four categories:

1. Examination of the patient and determination of the course of the track.
2. Primary threading with interception of track
3. Subsequent changing of the thread
4. Adjuvant therapy

Examination of patient: The local examination was carried out while the patient in lithotomy position. Perianal regions, digital examination of anus and bidigital palpation were carried out. The external opening of fistula, track and internal openings were palpated. Probing was also done after making the track numb by 4% topical lignocaine. MRI fistulogram was also performed in all of the patients. [10]

Fig. 11: MRI examination of fistula

Fig. 12: Fistulogram – posterior horse shoe fistula

Inclusion criteria

The patients with primary fistula were included in the study. Long transphincteric fistulae were included in the study.

Exclusion criteria

Patients with secondary fistula were excluded. The patients with co-morbidities such as diabetes mellitus, Hepatitis, immunodeficiency were excluded of the study. Simple low anal intersphincteric fistulae were also excluded.

Interceptive approach

As we all know that the fistula in ano originates from the infected anal glands, it is quite clear that if could remove these infected glands in the anus clearly, there is no need to thread entire track up to the external opening. I did the same approach in blind external fistula where I thread the internal opening by making an artificial opening somewhere at the posterior or anterior midline position. Internal opening of the fistula was targeted. The track was probed and the internal opening was well localized. While keeping the probe in
situ, an incision was made near to anus over the probe. The track was first threaded in the usual way and then the thread was taken out from the opening made on the way to external opening from the anus. Alternatively an opening was made by feeling the track with finger. The probing was done through this opening.

Pain during and after application of thread was noted in terms of requirement of topical anaesthesia and analgesics during and after the application of thread, vasovagal syncope and gait pattern.

Discharge was noted by measuring the number of pads used by the patient. The pads were all identical in terms of weight and dimensions.

Induration was noted in terms of redness around the fistulous opening.

Recurrence was assessed in all patients after the therapy for a period of one year.

**Follow up**

After completion of therapy, all patients were instructed to come for follow up. For each follow up visit, the patient was examined for any recurrence, complication and any associated lesion. The results were entered in identification folder of each patient.  

**Discussion and Results**

The disease was prevalent in age group of 20 to 40 years. It was seen that males were affected more than females. Disturbance in bowel habits was noticed in majority of patients. The majority of fistulae had posterior midline internal opening.

**Duration of Therapy and Morbidity:** Duration of therapy was significantly reduced by shortening the length of track and taking care of crypto glandular infection. It was also noted that the external wound became dry in early sittings and it was removed. The duration in that case was very less in conventional ksharsutra therapy. The internal thread was applied in the direction of track in posterior or anterior midline; thereby, removing entire anal gland infection. A single thread cannot eradicate complete infection due to wrong axis formation.

**Pain:** The pain was significantly less in interceptive approach. The patients were comfortable during and after the procedure. There was very minimal requirement of analgesics. Since the length of thread was less, the physical trauma during changing was also less. It caused minimal discomfort to the patient. The patients resumed their work shortly after the procedure.

**Discharge:** Discharge was significantly less after adopting this technique. Peripheral track showed significant healing after cut of the infection from anus and discharge was minimal from the external opening. It reduced the morbidity and patients resumed their work very early. The discharge from central intercepted wound was normal and reduced in early sittings. Overall, the discharge was very less form the entire wound of fistula.
Induration: Since the peripheral extension of infection was cut off, the wound was seen in healing stage after one week of procedure. The induration and infection were significantly reduced after one week. Healing was fast and scar was also negligible.

Recurrence: No recurrence was noticed during one year follow ups of patients. No patients reported the recurrence of any pain, discharge or other complaints.

Conclusion
The aim of present study was to evaluate the interceptive technique in fistula to reduce duration, pain and other morbidities. Guggulu ksharsutra was used in the present study. The patients with long transphincteric fistula in ano were included. The duration of the therapy was reduced significantly by using this technique. Pain was remarkably less by using this technique as the track was divided in two halves and axis was straight. The reduced infection and induration caused less pain and discomfort in all the patients of fistula treated by interceptive approach. No recurrence and associated complication were noticed in follow up.

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