



CLINICAL EFFICACY OF CHEDANA KARMA FOLLOWED BY KSHARKARMA IN THE MANAGEMENT OF LOW ANAL FISTULA - A CASE REPORT

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ABSTRACT

Introduction: Bhagandara is described in Ayurveda as one of the Ashta Maharogas (eight grave disorders). Among ano-rectal disorders, fistula-in-ano is considered the second most prevalent condition after piles. Acarya Susruta has given equal importance to surgical and parasurgical modalities in the management of Bhagandara. He advocated Chedana (fistulectomy) of the fistulous tract followed by Ksara karma for effective treatment. **Aim:** To evaluate the efficacy of Chedana (fistulectomy) followed by Ksara karma in the management of low anal fistula. **Materials and Methods:** A 25-year-old male patient presented to the OPD with complaints of throbbing pain in the anal region, swelling, and fever with chills. On perineal examination, an external opening was observed at the 1 o'clock position, approximately 4 cm from the anal verge. Transrectal ultrasonography (TRUS) was performed to confirm the diagnosis, and the case was diagnosed as a low trans-sphincteric anal fistula. Chedana (fistulotomy) followed by application of Tikсна Apamarga Ksara was performed under local anaesthesia using 2% lignocaine with adrenaline. **Observations and Results:** The wound was assessed weekly. During the first week, complete relief from pain was observed. By the second week, healthy granulation tissue was evident with no discharge. Complete wound healing was achieved within one and a half months, with minimal scar formation and normal skin coloration. **Conclusion:** This single-case study suggests that Chedana (fistulectomy) followed by Ksara karma is an effective therapeutic option in the management of low anal fistula.

KEYWORDS : Bhagandara, Fistula-In-Ano, Fistulectomy, Kshara, Ksharakarma, Chedana.

INTRODUCTION

A scientific appraisal of Bhagandara reveals that Acarya Susruta possessed a profound understanding of its complexity and the challenges associated with its surgical management. Bhagandara is one of the few diseases described in ancient surgical treatises for which Susruta extensively deliberated to establish an effective standard treatment. The disease is notorious for its chronicity, high recurrence rate, and frequent acute exacerbations.

Among ano-rectal disorders, fistula-in-ano is considered the second most common condition after piles. Approximately 17–20% of cases attending ano-rectal clinics are diagnosed as fistula-in-ano. More than 90% of fistula-in-ano cases develop due to cryptoglandular infections, while the remaining 10% arise from non-cryptoglandular causes such as pulmonary tuberculosis, ulcerative colitis, Crohn's disease, colloid carcinoma of the rectum, lymphogranuloma venereum, actinomycosis, post-haemorrhoidectomy complications, sclerotherapy, and other abdominal conditions leading to pelvi-rectal abscess formation.¹

Based on general observations of patient inflow and data on ano-rectal disorders collected from the Department of Shalya Tantra, P.D. Patel Ayurveda Hospital, Nadiad, more than 30% of patients were found to be suffering from Bhagandara (fistula-in-ano). Among these, recurrent, complicated, and treatment-refusing cases constituted more than 10%, while the remaining cases were newly diagnosed.

At present, several surgical modalities are available for the management of fistula-in-ano, each with its own limitations. Conventional procedures such as fistulotomy and fistulectomy may result in sphincter damage leading to incontinence. Newer techniques, including endorectal advancement flap, LIFT (ligation of intersphincteric fistula tract), VAAFT (video-assisted anal fistula treatment), and PERFECT (proximal superficial cauterization, regular emptying of fistulous tracts, and curettage), have been introduced to minimize these complications. However, these

procedures are costly, not easily affordable in low-income countries like India, and are still associated with a risk of recurrence.

Bhagandara described in Ayurvedic classics, can be correlated with fistula-in-ano. According to Susruta, Bhagandara develops when Bhagandara Pidika, which can be correlated with an ano-rectal abscess, is left untreated.² For its management, Susruta advocated Chedana (excision) of the fistulous tract followed by Ksara karma.³ He included Bhagandara among Chedana-yogya vyadhis (diseases requiring surgical excision).⁴ In the eleventh chapter of Susruta Samhita (Sutrasthana), while describing the indications of Pratisaraniya Ksara, Bhagandara has also been mentioned.⁵

Ksara is prepared from multiple medicinal substances in their most concentrated and subtle forms, rendering it effective in pacifying all three dosas. Owing to its usna and tikсна gunas, it possesses sodhana properties that facilitate debridement, slough removal, and drainage of pus when applied externally. Additionally, Ksara promotes ropana (wound healing) in vrana due to its cleansing and antiseptic actions.⁶

MATERIALS AND METHODS

Case Report

A 25-year-old male patient presented to the OPD with complaints of throbbing pain in the anal region, swelling, and intermittent fever with chills for the past six months. The patient had a history of incision and drainage for a perianal abscess two years earlier. He was a Student by profession.

On perineal examination in the lithotomy position, an external opening was observed at the 1 o'clock position, approximately 4 cm from the anal verge, associated with an abscess. On digital rectal examination, the internal opening was palpated at the 12 o'clock position. Based on clinical findings, the condition was diagnosed as a case of trans-sphincteric fistula-in-ano.

Routine blood and urine investigations were performed and

found to be within normal limits. Based on clinical examination and transrectal ultrasonography (TRUS), the case was diagnosed as Bhagandara (low anal fistula). The patient was admitted to the male Shalya ward for further management.

Methodology

Pre-operative informed written consent was obtained from the patient. Part preparation was carried out, and a proctoclysis enema was administered early in the morning, three hours before surgery. Injection T.T. 0.5 cc was given intramuscularly, and a sensitivity test for 2% lignocaine was performed.

Operative Procedure

Under strict aseptic conditions, the patient was shifted to the operating theatre with stable vital parameters. The patient was placed in the lithotomy position. Local anaesthesia with 2% Xylocaine was administered at anus region. Proper painting and draping were done.

A patency test was performed using methylene blue, which was observed to exit through the internal opening at the 12 o'clock position. Probing was carried out from the external opening at the 1 o'clock position to delineate the tract. The fistulous tract was excised (Chedana karma), and Teekshna Apamarga Kshara was applied over the tract. The area was covered with a gauze piece and retained for approximately 30 seconds. Thereafter, the area was thoroughly flushed with lemon juice followed by normal saline. Adequate haemostasis was achieved, a sterile dressing was applied, and the patient was shifted to the ward with stable vital signs.

Post-operative Management

From the next morning, the patient was advised to take a sitz bath with Panchavalkala decoction, followed by an antiseptic dressing using Ksharaplota. Varunadi kwath 40ml twice, Trifala guggul 500mg twice, Erand Bhrasta haritaki were prescribed orally three times a day with lukewarm water after meals, and continued until complete healing.

OBSERVATIONS AND RESULTS

The postoperative wound was assessed weekly. During the first week, pain was completely relieved and the patient was able to resume daily activities; mild serous discharge was noted from the operative wound. By the second week, healthy granulation tissue was observed without any discharge. By the fourth week, the wound appeared healthy with adequate contraction. Complete wound healing was achieved within one and a half months, with minimal scar formation and normal skin coloration.

DISCUSSION

In the present case, a low anal trans sphincteric fistula was observed at the 1 o'clock position, with the internal opening also located at 12 o'clock. Chedana (fistulotomy) was performed, followed by the application of Teekshna Apamarga Kshara.

A fistulous tract is typically lined with unhealthy granulation tissue and fibrous tissue, which impairs spontaneous healing. If such unhealthy tissue remains even after surgical intervention, there is a high risk of recurrence. Therefore, in this case, complete fistulotomy was carried out, and Teekshna Kshara was applied to ensure thorough removal of unhealthy tissue.

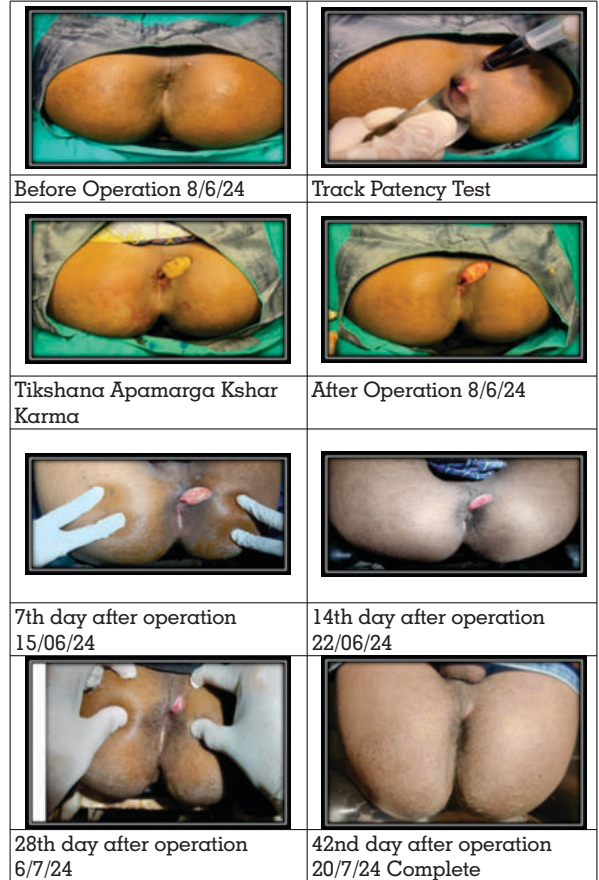
Fistulotomy facilitates complete drainage of the fistulous tract. As this was a case of low anal fistula, fistulotomy did not compromise anal continence. Furthermore, the application of Teekshna Kshara after fistulotomy aids in the debridement of unhealthy granulation and fibrotic tissue. It also cauterizes any residual or undetected secondary tracts, thereby reducing the chances of recurrence.

In addition to its Shodhana (cleansing) property, Kshara possesses Ropana (healing) properties, which promote wound healing.⁷ Panchavalkala Kwatha sitz bath enhances wound healing⁸ and helps in reducing inflammation.

Varunadikwath possesses antibacterial and anti-inflammatory⁹ properties, which help in reducing pain and preventing postoperative infection

CONCLUSION

This case study concludes that Chedana (fistulotomy) followed by Kshara Karma is an effective therapeutic option for the management of low anal fistula-in-ano, with satisfactory wound healing and minimal risk of recurrence.



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