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CASE STUDY

Effect of *Bhedan* and *Ksharsutra* as a Sphincter Saving Technique in the Management of Ischiorectal Abscess

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ABSTRACT

Abscess is a collection of pus in the body. The acute and chronic phases of the same anorectal infection are referred to as an abscess and a fistula, respectively. The causative factors of abscesses are germs, such as bacteria and foreign substances entering the body through needles piercing the skin and contaminating the injection site. An infection in the anal glands, which spreads to adjacent spaces and causes a fistula, is the first sign of an abscess. The management is described in two step procedure involving incision and drainage followed with fistula management. According to *Acharya Sushruta* – " *Sheegra vidhahivat* " . *Acharya Sushruta* mentions that if *vidradhi* attains *pakvaavastha*, *bhedana* is the first line of treatment to drain the pus and later, it should be treated as *Vrana.*

In this case study female patient, age 65 years old came to the OPD of Akhandanand Ayurved Hospital, Ahmedabad with the complaints of left gluteal region swelling and pain, unable to sit, pain during defecation since 6 months. Patient was diagnosed as left sided Ischiorectal abscess and treated with *bhedan* (incision) and *ksharsutra* technique. After every week thread was changed and wound was completely healed with normal scar without any complication within two and half months.

Key Words *Ischiorectal abscess, Ksharsutra, Vidradhi*

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INTRODUCTION

Abscess is a collection of pus in the body. The acute and chronic phases of the same anorectal infection are referred to as an abscess and a fistula, respectively. The causative factors of abscesses are germs, such as bacteria and foreign substances entering the body through needles piercing the skin and contaminating the injection site. An infection in the anal glands, which spreads to adjacent spaces and causes a fistula, is the first sign of an abscess. The most cardinal feature of Ano rectal abscess (called as *Gudavidradhi* in ayurveda) is severe pain at anal region along with pus discharge if fistula is formed. The treatment of an anorectal abscess is early, adequate, dependent drainage. Despite being surgical in all cases, treating a fistula is more difficult since sphincterotomy may cause

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faecal incontinence and can occasionally result in complications and recurrence[1]

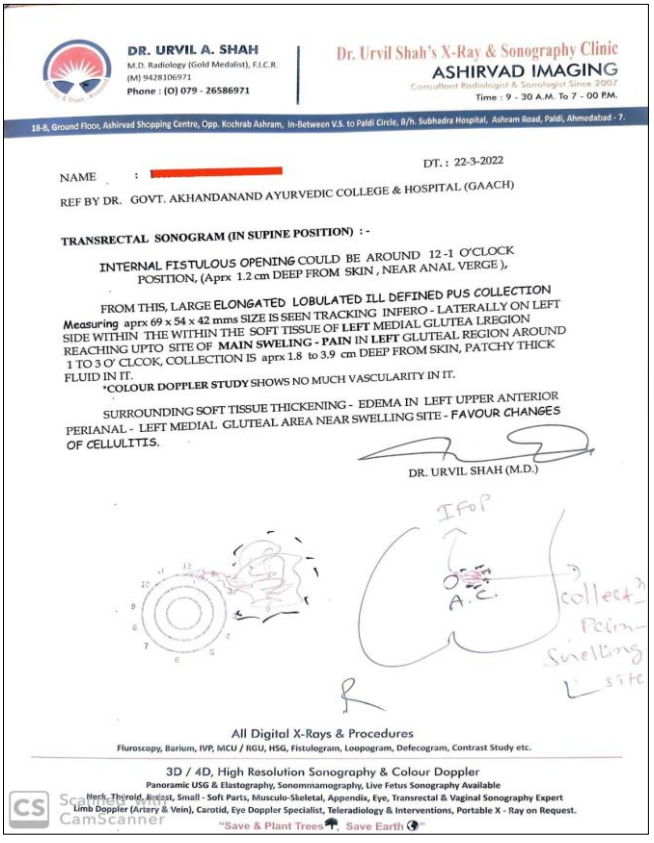
Abscess is referred to as vidradhi in the classical Ayurvedic texts, which is divided into two categories: bahya and abhyantara. This study deals with the *Bahyavidradhi* of gluteal abscess. The definition of vidradhi, "Sheegra vidhahivat," by Acharya Sushruta suggests that the condition is destructive. The skin, blood, muscle, fat, and bone tissues are negatively affected by aggravated doshas, and as a result, these tissues become gradually inflamed, deeply rooted, painful, and oblong, or vidradhi. *Sushruta* mentioned that *Nimnadarshanam Angulya Avapidite Pratyunnaman Bastavivodaka Sancharanam*[2] means when *vidradhi* gets ripen it shows fluctuation test positive and pitting oedema. *Acharya Sushruta* mentions that if *vidradhi* attains *pakvaavastha*, *bhedana* is the first line of treatment to drain the pus and later, it should be treated as *Vrana*.

CASE REPORT

A female patient, age 65 years old came to the OPD of Akhandanand Ayurved Hospital, Ahmedabad with the complaints of left gluteal region swelling and pain, unable to sit, pain during defecation since 6 months. She was a vegetarian in diet and house wife. Patient had no any addiction. There is no any past history. On inspection in lithotomy position left ischiorecal swelling and anterior and posterior sentinel tag was observed and P/R examination found the internal opening at 12 o'clock position and tenderness present at left gluteal region.

According to patient she was apparently normal before 6 months after that she gradually developed the increase swelling and pain at left gluteal region so she came to OPD and she was admitted in female surgical ward for further treatment. All pre operative regular investigations were done and all are within normal limit. On examination, vitals like blood pressure, pulse and systemic examination was normal.

No any past history of hypertension, diabetes mellitus, tuberculosis and any drug reaction.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NAME : [redacted] DT. : 22-3-2022

REF BY DR. GOVT. AKHANDANAND AYURVEDIC COLLEGE & HOSPITAL (GAACH)

TRANSRECTAL SONOGRAM (IN SUPINE POSITION) : -

INTERNAL FISTULOUS OPENING COULD BE AROUND 12-1 O'CLOCK POSITION, (Aprx 1.2 cm DEEP FROM SKIN, NEAR ANAL VERGE),

FROM THIS, LARGE ELONGATED LOBULATED ILL DEFINED PUS COLLECTION Measuring aprx 69 x 54 x 42 mms SIZE IS SEEN TRACKING INFERO - LATERALLY ON LEFT SIDE WITHIN THE WITHIN THE SOFT TISSUE OF LEFT MEDIAL GLUTEA LREGION REACHING UPTO SITE OF MAIN SWELING - PAIN IN LEFT GLUTEAL REGION AROUND 1 TO 3 O' CLCOK, COLLECTION IS aprx 1.8 to 3.9 cm DEEP FROM SKIN, PATCHY THICK FLUID IN IT.

*COLOUR DOPPLER STUDY SHOWS NO MUCH VASCULARITY IN IT.

SURROUNDING SOFT TISSUE THICKENING - EDEMA IN LEFT UPPER ANTERIOR PERIANAL - LEFT MEDIAL GLUTEAL AREA NEAR SWELLING SITE - FAVOUR CHANGES OF CELLULITIS.

DR. URVIL SHAH (M.D.)

All Digital X-Rays & Procedures
Fluroscopy, Barium, IVP, MCU / RGU, HSG, Fistulogram, Loopogram, Defecogram, Contrast Study etc.

3D / 4D, High Resolution Sonography & Colour Doppler
Panoramic USG & Elastography, Sonommamography, Live Fetus Sonography Available
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Limb Doppler (Artery & Vein), Carotid, Eye Doppler Specialist, Teleradiology & Interventions, Portable X - Ray on Request.

"Save & Plant Trees, Save Earth"

Scanned with CamScanner

USG findings as per image 1 on 22/3/22 was internal fistulous opening could be around 12-1 o'clock position, (aprx 1.2 cm deep from skin, near anal verge), from this, large elongated lobulated ill defined pus collection measuring

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aprx 69 x 54 x 42 mms size is seen tracking infero - laterally on left side within the soft tissue of left medial gluteal region reaching upto site of main swelling -pain in left gluteal region around 1 to 3 o' clock, collection is aprx 1.8 to 3.9 cm deep from skin, patchy thick fluid in it.

METHODOLOGY

Pre-operative:

Patient was advised nil by mouth 6 hour before surgery. Informed written consent was taken. The local part preparation of patient was done. As per figure-1 abscess was shown on operation table. Early morning proctolysis enema was given before procedure. Inj. T.T. 0.5cc IM and sensitivity test for inj. Xylocaine 0.1% ID was given.

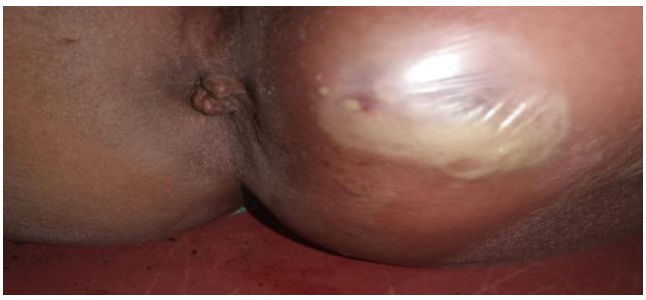

Figure 1 Pre operative

Operative:

Under all aseptic conditions spinal anaesthesia was given. Then patient was kept in lithotomy position on O.T. table. Painting was done with the betadine solution at perianal region then drapping was done with sterile linen sheet. PR rectal examination as well as proctoscopy examination was done to rule out other pathological conditions. Cruciate incision was make on most prominent part of abscess with the help of 11 no. blade as per shown in figure-2 and then pus was drained out and all the loculi were broken by inserting finger in abscess cavity. After that four edges of skin were excised.

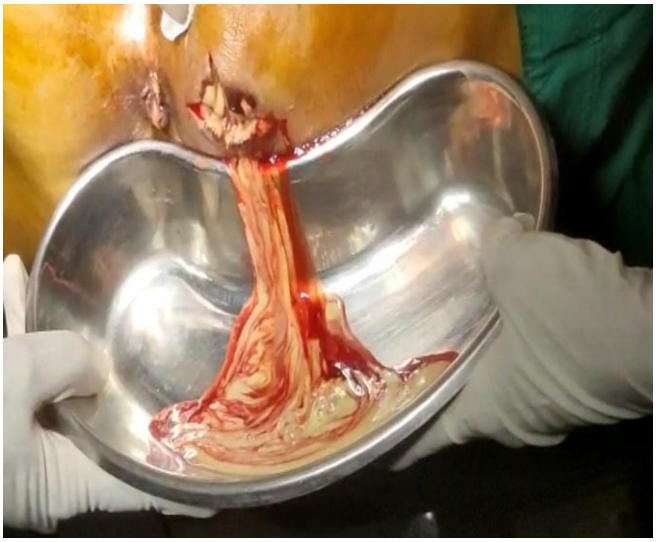

Figure 2 Operative

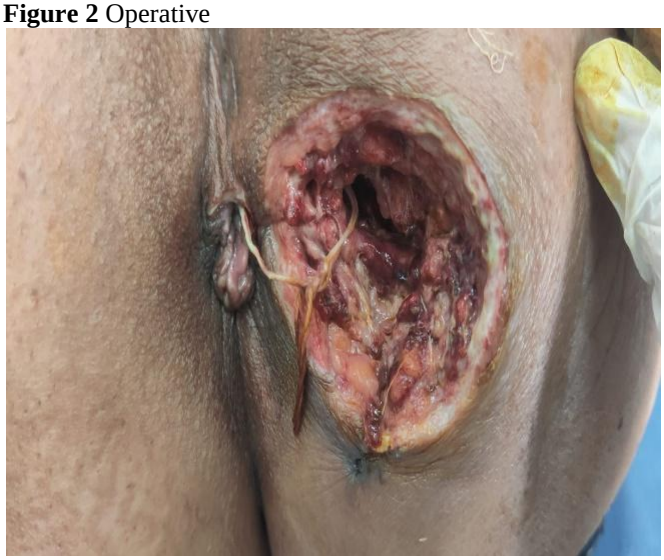

Figure 3 POD-1

All the unhealthy granulation tissues from the cavity were removed and cavity deepend till the external sphincter then probe was inserted from cavity to internal opening at 12 o' clock and ksharsutra was ligated. Then sentinel tag was catch with allies forcep and excised with the help of scissor. After proper haemostasis, suppository inserted and abscess cavity was packed with Betadine gauze.

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Post operative:

IV fluids, suitable antibiotics and analgesics were given as per requirement. From next morning patient was advised to *panchavalkala* decoction sitz bath and then antiseptic dressing with proctobath for a period of 15 days, subsequently *ksharasutra* was changed at intervals of 7 days. During this time, it was observed that cavity was filling with healthy granulation tissue, reduced discharge and the patient was able to sit and perform normal activities without pain. Every weekly *ksharasutra* was changed and after the fifth sitting the tract was found healthy with granulation tissue so removed the *ksharasutra* and left for healing process. *Triphala guggulu* 2 BD, daily 5 gm *Dindayal Churna* with luke warm water at bed time was prescribed to relieve constipation.

OBSERVATION

On 1st post-operative day the ksharsutra was in situ as per shown in figure-3. There was discharge slough out and mild oozing at operated site and mild pain at operated site. As per shown in figure-4 on 7th post operative day there was absent pus discharge and healthy granulation tissue was observed at wound floor. As per figure-5 on 14th day the wound was healthy. On 24th post operative day there was absent pus discharge and healthy granulation tissue was observed at wound floor and decrease the size of the wound as per figure-6. On 38th day most of the tract was cut through(figure-7) and on 52nd day most of the wound size was decreased with minimal scar as per shown in Figure-8 and figure-9 shows the 70th post operative day wound was healed with minimal scar.

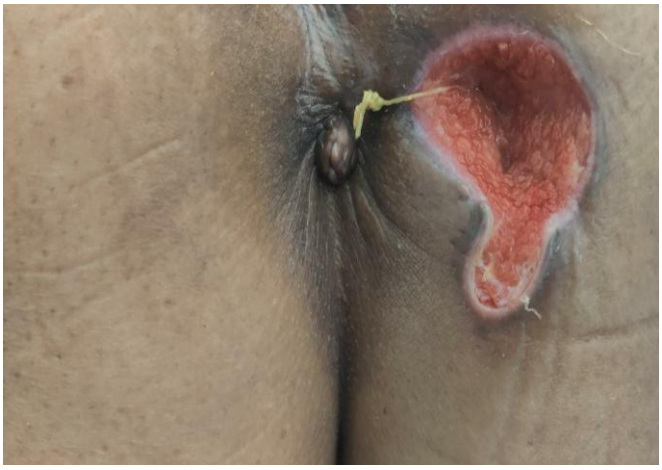

Figure 4 POD-7

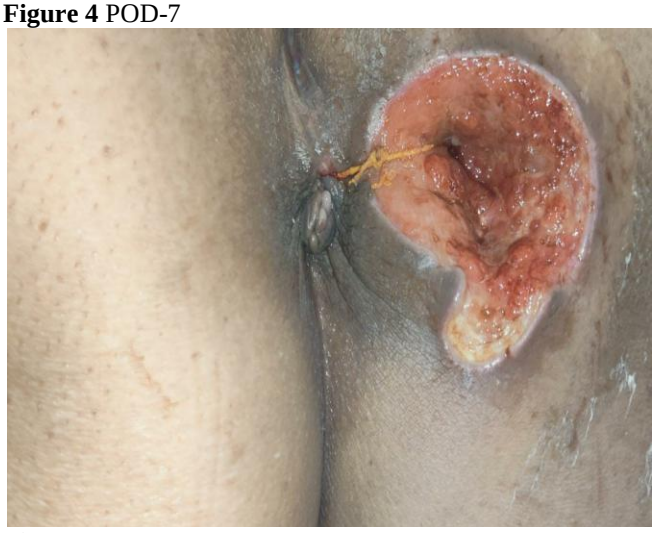

Figure 5 POD-14

Figure 6 POD-24

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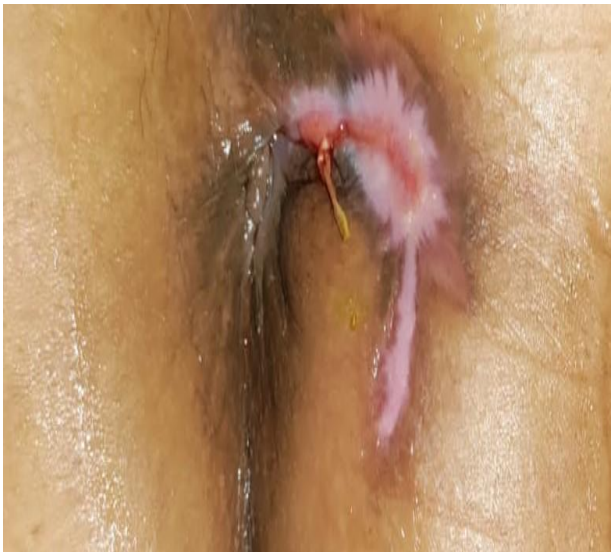

Figure 7 POD-38

Figure 8 POD-52

Figure-9 POD-70

DISCUSSION

A perianal abscess generally appears as a swollen red area near the anus. The most common bacterial isolate is Staphylococcus aureus, other organisms include Escherichia coli, Proteus, Enterobacter species, Streptococcus and Pseudomonas. In 34% of patients an acute phase of Ano-rectal abscess gets complicated into fistula in ano[3.] The basic principles regarding the treatment of fistula in ano have remained the same: resolution of perianal sepsis, and treatment of the resulting fistula without leading to impairment in continence[4]. Hematogenous spread, neoplasms, immunocompromised conditions, inflammatory bowel disease, penetrating trauma, and anal gland infection are only a few of the risk factors that have been identified. Current surgical treatment methodologies for fistula in ano include: Fistulectomy, fistulotomy with secondary healing, fistulectomy, destruction of fistula track by carbon dioxide laser beam. The significant mutilation of the ano-rectal and ischio-rectal area, protracted hospitalisation, high recurrence rate (21–36 percent), and division of the sphincter muscles resulting in faecal incontinence (3–7%) are the main issues encountered with the fistula-in-ano treatment[5].

In this case, the cruciate incision was made at left gluteal region and cavity opened and drained out the pus. All unhealthy granulation tissue removed. Then ksharsutra was ligated through the tract. Here the purpose of ligation of ksharsutra was sphincter saving and it also prevents from incontinence. Antibiotic was administered for 5 days in this case. On the other hand Ayurvedic treatment was also given.

CONCLUSION

Patient presenting with ischiorectal abscess with internal opening at 12 o'clock position. After bhedana karma pus is drained and unhealthy granulation tissue was excised and ksharsutra was ligated. Post operatively dressing was done with Proctobath liquid. Pus discharged reduced, with healthy granulation tissue and cavity completely healed within two and half months with minimal scar.

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