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Contraindication of 'Ksharasootra' in the Management of Fistula in Ano

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ABSTRACT
The condition of complicated, recurrent and high anal fistula, although not a major surgical task; but always remains a nagging issue not only to the patients but to the surgeon as well. The present method of Kshaar Sootra treatment in anal fistula has been found efficacious and have been accepted by many countries in world. All cases which look like fistula in ano may not be fistula in ano. Therefore, it is essential to investigated all cases of recurrent, complicated and difficult fistula by new gazeits (i.e. CT scan, MRI, fistulogram, USG, etc.) There are certain conditions which can be regarded as definite contra indication for KSHAAR SOOTRA therapy. There are conditions where the patient is having a true simple fistula but he/she is also suffering from other systemic diseases, which either interfere in the healing process of the wound or present a potential risk of life for the patient.
Keywords: *Kshaar Sootra, fistulectomy, fistula-in-ano.*

Introduction

As we all know the application of KSHAAR SOOTRA in a patient of fistula in ano is a simple process. It may be difficult also if the surgeon is not conversant with the pros and cons of the procedure.

It is true that KSHAAR SOOTRA can be applied in all types of fistula; bur at the same time it is also important to know the conditions where KSHAAR SOOTRA should not be applied.

All cases which look like fistula In ano may not be fistula in ano. Therefore, it is essential to investigated all cases of recurrent, complicated and difficult fistula by new gazeits (i.e. CT scan, MRI, fistulogram, USG, etc.)

There are certain conditions which can be regarded as definite contra indication for KSHAAR SOOTRA therapy. There are conditions where the patient is having a true simple fistula but he/she is also suffering from other systemic diseases, which either interfere in the healing process of the wound or present a potential risk of life for the patient.

There is two part of contra indicated conditions.

1) Definite contraindicated conditions
2) Associated contraindicated conditions

1. Definite contraindicated conditions-

Following conditions are definite contra indicated conditions for KSHAAR SOOTRA therapy.

1. Osteomylitis
   a. Pelvic bones
   b. Femur
2. Tuberculosis
   a. Hip joint
   b. Spine
3. Ulcerative colitis
   a. Chronic
   b. Acute
4. Appendicitis
5. Malignancies
   a) Intestinal
   b) Pelvic
   c) Ano-rectal
6. Crohn's disease
7. Heart disease
   a) RVF
   b) LVF
8. Veneral diseases
9. H.I.V.

These are the conditions in which the systemic disease carrying "Potential risk of life", so it is better to not applying KSHAAR SOOTRA in such cases.

The treatment of the other debilitating diseases is of prime concern rather than the treatment of fistula.

2. Associated contraindicated conditions –

a) Systemic
b) Local

a) Systemic conditions

These are the conditions in which KSHHAR SOOTRA can be applied cautiously but the treatment for the systemic conditions should also be instituted.

- Tuberculosis (pulmonary)
- D.M.
- H.T.
- I.H.D.
- Amoebiasis (chronic)
- B.P.H.
- Anaemia
- Uraemia
- U.T.I.
- Naturopathic conditions (e.g. paraplegia, etc.)

These are the conditions which adversely influence the healing process of the body.

Here, KSHAAR SOOTRA should be applying after obtaining proper control of these diseases.

In H.T. and I.H.D. , KSHHAR SOOTRA should be applied cautiously under the influence of some analgesic drug so that the pain experienced by the patient during application of KSHAAR SOOTRA is minimal.

b) Local conditions

In this group, patients having local lesions of the anorectal canal with Fistula in ano.

- Haemorrhoids
- Fissure in ano
- Anal polyp
- Anal wart

KSHAAR SOOTRA may be applied in such a local conditions but it should be remembered that if the piles and fistula are situated at the same clock position there is a potential danger for a profuse haemorrhage, when the KSHAAR SOOTRA cuts through the Haemorrhoidal vessel. Therefore it is always wise to remove the pile mass first in such case.

Another common condition, which is often associated with fistula, is fissure in ano. It should be understood that KSHAAR SOOTRA itself by virtue of its cutting action, will cause a fissure at the anal verge in due course of time. Therefore the presence of a fissure in ano is not a contraindication for KSHAAR SOOTRA application, only utmost gentleness is required. The other local lesions of the ano-rectal canal like anal polyp, anal wart, etc. should be treated and removed before the application of KSHAAR SOOTRA into a fistulous tract.

Conclusion

In this way, it is now clear that the majority of patient of fistula in ano, rather all the patient of true fistula are the subjects for treatment by KSHAAR SOOTRA with due regard is paid to the associated local and systemic conditions.

Therefore it is very important to select the cases after thorough examination not only of the fistula but of the patient as a whole.

Only those cases which apparently look like fistula but turnout to be connected with a different pathology elsewhere, should be debarred from KSHAAR SOOTRA applications.

KSHAAR SOOTRA is a matter of gentleness, assurance and soft handling.

References

1. Seow-Choen F and Nicholls RJ. Anal fistula, Br J Surg., 1992; 79: 197-205.
2. Seow-Choen F. Relation of abscess to fistula in anal fistula, Phillips RK and Lunnis PJ (eds.). Chapman & Hall, 1996.
3. Saino P. Fistula-in-ano in a defined population: incidence and epiderniological aspects, Annales Chirurgiue et Gynaecologiae., 1984; 73: 219-24.
4. Ramanujam PS, Prasad ML and Abcarian H. Perianal abscesses and fistulas. A study of 1023 patients, Dis Colon Rectum., 1984; 27: 593-7.
5. Paks AG, Gordon PH and Hardcastle JD. A classification of fistula-in ano, Er J Surg., 1976; 63: 1-12.
6. Chiari H. Uber die Naten Divertikelder Recttumschleimhaut und ihre Beziehung zu den Anal ftsteln, Med Jahrbucher Wien., 1880; 8: 419- 27.
7. Herrmann G and Desfossess L. Bur la muquese de la region doacale durectum, Comptes Rend Acad Sci (III)., 1880; 90: 1301-2.
8. Lockhart-Mummery JP. Discussion on fistula-inano, Proc R Soc Med., 1929; 22: 1331-41.
9. Rankin FW, Bergen JA and Buie LA. The colon, rectum and anus. Philadelphia, WB Saunders, 1932.
10. Tucker CC and Hellwig CA. Histopathology of anal glands, Surg Gynecol Obstet., 1933; 58: 145-9.
11. Seow-Choen F and Ho JMS. Recent insights into anal glands, Dis Colon Rectum., 1994; 37: 24.
12. Grace RH, Harper IA and Thompson RG. Anorectal sepsis; microbiology in relation to fistula-in-ano, Br} Surg.,1982;69:401-3.
13. Seow-Choen F, Leong AFPK and Goh HS. Acute anal pain due to ingested bone, fnt j Colorectal Dis., 1991; 6: 21-3.
14. Shafik A. A new concept of the anatomy of the anal sphincter mechanism and physiology of defectation. VI. The central abscess: a new clinopathological entity in the genesis of anorectal suppuration, Dis Colan & Rectum., 1979; 22: 336-41,
15. Hiller RJ. The anal sphincter and the pathogenesis of anal fissure and fistula, Surg Gynecol Obstet., 1931; 52: 921-40.
16. B. Seow-Choen F, Hay AJ, Heard S and Phillips RKS. Bacteriology of anal fistula, Br J Surg., 1992;79: 27-8.
17. McColl I. The comparative anatomy and pathology of anal glands, Ann R Coil Surg Engl., 1967; 40: 36- 67.
18. Seow-Choen F and Nicholls RJ. Anal fistula, Br} Surg., 1992; 79: 197-205.
19. Sainio P. Fistula-in-ano in a defined population: incidence and epi-demiological aspects, Ann Chir Gynaecol., 1984; 73: 219-24.
20. Parks AG, Gordon PH and Hardcastle JD. A classification of fistula-in-ano, Br / Surg., 1976; 63: 1-12.
21. Hanley PH. Reflections on anorectal abscess fistula: 1984, Dis Colon Rectum., 1985; 28: 528-33.
22. Parks AG, Gordon PH and Hardcastle JD. A classification of fistula-in-ano, BrJSurg., 1976; 63: 1-12.
23. Edward S. On some of the rarer forms of rectal fistulae, Lancet., 1887; 1089.
24. Weisman RI, Orsay CP, Pearl RK and Abcarian H. The role of fistulography in fistula-in-ano, Dis Colon Rectum., 1991; 34: 181.

25. Law TJ, Talbot RW, Bartram CI and Northover JMA. Anal endosonog-raphy in the evaluation of perianal sepsis and fistula-in-ano, Br j Surg., 1989; 76: 752-5.
26. Cirocco WC and Reilly JC. Challenging the predictive accuracy of Goodsall's rule for anal fistulas, Dis Colon Rectum., 1992; 35: 537-42.
27. Kuypers JHC. Diagnosis and treatment of fistula-inano, Neth J Surg., 1982; 34: 147-52.
28. Seow-Choen S, Burnett S, Bartram CI et a!. Comparison between anal endoson-ography and digital examination in the evaluation of anal fistulae, Br J Surg., 1991.
29. Law PJ, Talbot RW, Bartram CI et al. Anal endosonography in the evaluation of perianal sepsis and fistula-in-ano, Br / Surg., 1989; 76: 752-5.
30. Deen KI, Williams JG, Hutchinson R et al. Fistulas in ano: endoanal ultrasonographic assessment assists decision making for surgery. Gut., 1994; 35: 391-4.
31. Cheong DMO, Nogueras JJ, Wexner SD and Jagelman DG. Anal endosonography for recurrent anal fistulas: image enhancement with hydrogen peroxide, Dis Colon Rectum., 1993; 36: 1158-60.
32. Lunniss PJ, Armstrong P, Barker PG et al. Magnetic resonance imaging of anal fistulae, Lancet., 1992; 340: 394-6.
33. Barker PG, Lunniss PJ, Armstrong P et al. Magnetic resonance imaging of fistula-in-ano: technique, interpretation and accuracy, Clin Radial., 1994; 49: 7-13.
34. Beckingham IJ, Spencer JA, Ward J et al. Prospective evaluation of dynamic contrastenhanced magnetic resonance imaging in the evaluation of fistula-in-ano, Br J Surg., 1996; 83: 1396-8.
35. Lunniss PJ, Barker PG, Sultan AH et al. Magnetic resonance imaging of fistula-in-ano, Dis Colon Rectum., 1994; 37: 708-18.
36. Chappie KS, Spencer JA, Windsor ACJ et al. Prognostic value of magnetic resonance imaging in the management of fistula-in-ano, Dis Colon Rectum., 2000; 43: 511-16.
37. Kuijpers HC and Schulpen T. Fistulo-graphy for fistula-in-ano: is it useful? Dis Colon Rectum., 1985; 28: 103-4.
38. Weisman RI, Orsay CP, Pearl RK et al. The role of fistulography in fistula-in-ano: report of five cases, Dis Colon Rectum., 1991; 34: 181-4.
39. Halligan S. Imaging fistula-in-ano, Clin Radial., 1998; 53: 85-95.
40. Sainio P A manometric study of anorectal function after surgery for anal fistula, with special reference to incontinence, Ada Chir Scand., 1985; 151: 695- 700.
41. Lunniss PJ, Kamm MA and Phillips RKS. Factors affecting continence after surgery for anal fistula, Br J Surg.,1994;81:1382-5.
42. Pescatori M, Marin G, Anastasio G and Rinallo L. Anal manometry improves the outcome of surgery for fistula-in-ano, Dis Colon Rectum., 1989; 32: 588-92.
43. Eisenhammer S. Advances in anorectal surgery with special reference to amul-atory treatment, S Afr Med.,1954; 28: 264.
44. Seow-Choen F. Relation of abscess to fistula in anal fistula. Phillips RKS and Lunnis PI (eds.), Chapman and Hall, 1996.
45. Seow-Choen F, Leong AFPK and Goh HS. Result of a policy of selective immediate fistulotomy for primary anal abscess, Aust NZ / Surg., 1993; 63: 485-90
46. Tang CL, Chew SP and Seow-Choen F. Prospective randomised trial of drainage alone vs drainage and fistulotomy for acute perianal abscesses with proven internal opening, Dis Colon Rectum., 1996; 39: 1415-17.