INTRODUCTION

Hippocrates, in about 430 BCE, made reference to surgical therapy for fistulous disease and he was the first person to advocate the use of a seton (from the Latin seta, a bristle). This is the Kshar-Sutra method mentioned by Sushruta in ancient Indian surgical practice. Many drugs have been advised by Sushruta and other Ayurvedic texts for the preparation of Kshara sutra (the medicated thread). Reed, pipe or flute in Latin called as ‘Fistula’. In simple terms, a fistula can be described as a chronic granulating track connecting two epithelium lined surfaces, either cutaneous or mucosal. Due to the lack of a single appropriate technique for the treatment of fistula- in-ano, treatment must be navigated by the surgeon’s experience and judgment. The surgeon has to keep in mind the tradeoff between the extent of sphincter division, postoperative healing rate, and functional loss. Ksharsutra has been used to manage anal fistula from hundreds of years; however, in the literature, ksharsutra were commonly used only for high or complex anal fistula in order to avoid fecal incontinence and recurrence.

METHODS

This is a single case study of patient with High anal fistula in ano who attend our Akhandanand Ayurveda Hospital OPD. In this case after all pre operative major profile ksharsutra treatment with partial fistulectomy was done. For accurate diagnoses we also advised him for Trans- rectal Sonography. Followed over a period of 1 years.

TECHNIQUE

In the operation room, under spinal anesthesia patient was evaluated in the lithotomy position. Proctoscopy was done prior to any intervention. Betadine with hydrogen peroxide in a 3 mL syringe was used to stain the entire tract by injecting into the external opening using the hub of a 21G needle. The external opening was gently probed using a standard 3 mm blunt-tipped copper probe with an eye but probing not done through previously identified internal opening. Copper probe is used because it is highly malleable. After that coring started and fistulous tract cored out till external sphincter with clinical judgment and after that passing the copper probe through internal opening and infrasphincteric part of fistulous tract is excised as done in low anal fistula. Then a Ksharsutra is tied to the eye of the copper probe and the probe is brought out through the anal canal, during the manoeuvre the Kshar sutra is...
also dragged along the course of the fistulous tract. Now the Kshar sutra which was brought through the only part of anal sphincters to internal opening, thus traversing the whole path of anal sphincters is tied by ksharsutra. This is a purely sphincter saving method. Around 3-4 cm part of track is tied over and this took around 6 week for completely cut through. Patient was advised to come for Kshar sutra change weekly once.6

**DISCUSSION**

![Figure 1: T.R.U.S Report](image1)

**Figure 1:** T.R.U.S Report

![Figure 2: Pre operative](image2)

**Figure 2:** Pre operative

![Figure 3: Immediate post operative](image3)

**Figure 3:** Immediate post operative

![Figure 4: Final cut through after 30 days](image4)

**Figure 4:** Final cut through after 30 days

![Figure 5: Almost healed wound after 40 days](image5)

**Figure 5:** Almost healed wound after 40 days
ETIOLOGY:
The vast majority of fistulas-in-ano are nearly always caused by a previous anorectal abscess. Other fistulas develop secondary to trauma (e.g., rectal foreign bodies), Crohn disease, anal fissures, carcinoma, radiation therapy, actinomycoses, tuberculosis, and lymphogranuloma venereum secondary to chlamydial infection. In these cases the primary cause should be treated.

GOODSALL RULE

Park’s Classification for Fistula in Ano

Intersphincteric
Most common
Track confined to IS plane

Trans-sphincteric:
Goes through both sphincters

Supra-sphincteric
Track loops over sphincters, goes through levator

Extra-sphincteric
Rectum to skin without involving sphincters
Another widely used classification system which classifies the perianal fistulas as follows.

**Grade 1** - Simple linear intersphincteric fistula.

**Grade 2** - Intersphincteric with abscess or secondary track.

**Grade 3** - Trans-sphincteric.

**Grade 4** - Transsphincteric with abscess or secondary track in ischiorectal or ischioanal fossa.

**Grade 5** - Supralevator and Translevator.

**Investigations:**

- **x ray**
- TRUS (Trans rectal ultra sonography)
- CT scan
- MRI etc

**Physical Examination:** No specific laboratory studies are required in the diagnosis of fistula-in-ano (although the normal preoperative studies are performed, based on age and comorbidities). Instead, physical examination findings remain the mainstay of diagnosis. The examiner should observe the entire perineum, looking for an external opening that appears as an open sinus or elevation of granulation tissue. Spontaneous discharge of pus or blood via the external opening may be apparent or expressible on digital rectal examination.

a) Single-stage seton (cutting).

b) Multi-stage seton (draining/fibrosing).

**Modalities for Fistula In Ano Are:**

- Fistulotomy.
- Fistulectomy.
- Seton Placement.
- Mucosal Advancement Flap.
- Plugs and Adhesives
- LIFT Procedure
- Diversion colostomy
- VAAFT procedure

**CONCLUSION**

Ksharsutra is treatment of choice for high anal fistula with least recurrence rate compared to other treatment modalities and can be considered as the gold standard treatment in most of the high anal fistulas.