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Management of Unmargi Bhagandar (Fistula-in-ano with foreign body) - A rare Case Report and Review of Literature

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ABSTRACT:

The clinical features of *Bhagandar* resembles with Anal Fistula i.e. discharge of pus and blood or blood mixed pus discharge, pain(throbbing), itching in perianal region, backache, fever, etc. In modern science the most widespread and useful classification of Anal fistulae proposed by Park are- Intersphincteric Fistula, Trans-sphincteric Fistula, Supra-sphincteric Fistula, Extra-sphincteric Fistula [1,2]. In Ayurveda, 8 types of fistulae are mentioned depending on its track and on nature of discharge seen - *Shatponak, Ushtragreeva, Parisravi, Shambukavarta*, *Unmargi, Parikshepi* can be classified as complex Anal fistulae while *Rujju* and *Arsho-Bhagandar* as Simple fistulae due to their linear tracts. In this case study a 33 years old male patient predominantly a non-vegetarian comes with an ill- treated and misdiagnosed anal condition is diagnosed to have Unmargi Bhagandar and treated as directed in Sushruta Samhita. This proves how age old narrated *Nidanpanchak* and management of *Bhagandar* holds true and practical even in today's world of Proctology.

KEYWORDS: *Agantuja Bhagandar*, Anal Fistula, *Bhagandar*, Foreign body, *Kshataja Bhagandar Unmargi Bhagandar.*

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INTRODUCTION:

The true prevalence of Anal Fistula is unknown. The incidence of the Anal Fistula developing from an anal abscess range from 26-38%. A study conducted by Sainio P. showed that the prevalence rate of Anal Fistula is 8.6 cases per 100,000 populations [3]. The prevalence in men is 12.3 cases per 100,000 populations and in women is 5.6 cases per 100,000 population. The male-to-female ratio is 1.8:1. The mean age of patients is 38.3 years. Most scientific description about *Bhagandar* is found in *Sushruta Samhita* [4]. In Ayurveda *Sushruta* has included *Bhagandar* in group of *Asthamahagada*, implying it is a disease difficult to treat. If untreated / illtreated the *Bhagandar pidika* in the *Gudapradesh* proceeds into formation of the *Bhagandar*. It is characterized by single or multiple opening around *Gudapradesh* (perianal area) with different types of discharge associated with severe pain. An Anal fistula is a chronic abnormal communication tract between two epithelial lining usually lined to some degree by granulation tissue, which

runs outwards from the anorectal lumen (the internal opening) to an external opening on the skin of the perineum or buttock.

Samprapti of *Bhagandar* has explained by *Sushrutaacharya* as follows-

Nidana:	*Mithyaharvihar, Apathyasevana*
Pradhanadosha:	*Vata Anubandadosha - Pitta kapha*
Dushaya:	*Mamsa, Rakta*
Adhisthana:	*Guda.*

Sushruta has described the manifestation of any disease in 6 stages namely *ShatkriyaKala* and precisely described in case of *Bhagandar* as well. The pathogenesis of *Bhagandar* can be explained as follows.

1. *Sanchaya awastha* (Stage of Accumulation)- The *Mithyaaharvihar* and or local trauma causes *Sanchaya* (accumulation) of *Dosha*'s at its normal site.
2. *Prakopa awastha* (Stage of provocation)- '*vilayanarupavriddi*' The *Dosha* further aggravates *Vata* predominantly and *Pitta* and *Kapha* passively.
3. *Prasara awastha* (Stage of propagation)- Vitiated *Doshas* migrate from *swasthan* (their own place) and circulate throughout the body.
4. *Sthanasamshraya awastha* (Stage of localization or prodromal symptoms)- *Dosha* lodged in *Gudamamsa* & the *Raktadusti* cause the prodromal symptoms like *katiruja, kandu, daha, sopha.*
5. *Vyakti awastha* (Stage of manifestation)- There is formation of *BhagandarPidika, NadiVrana* and *Bhagandar.*
6. *Bhed awastha* (Stage of complication) – shows communicating unhealthy tracks between different adjacent discharging flatus, urine and semen.

As in this article we discuss the case study of *Unmargi Bhagandar*, we now review the literature pertaining to it.

***Unmargi / Agantuja /Kshataj Bhagandar*:**

All the Ayurvedic texts mentioning the *Agantuja Bhagandar* [4,5,6,7,8] give similar insights on its etiopathogenesis, symptoms, outcomes, prognosis and management. If a person gets traumatized at anal region or if is habituated of eating *mamsa* (meat) in excess amount then there are high chances of ingestion of bone pieces along with flesh. Owing to this and in event of Constipation wherein increased intrarectal pressure causes the ingested piece of bone to get lodge into the *Gudapradesh* and cause trauma to mucosa thereby causing *Vrana* (wound). Further causing *Kotha* (gangrene) resulting into blood and pus discharge, leading to *krimi* (infection), thereby form *Bhagandar* in *Gudapradesh*. The patient experiences pain, itching, swelling around anal region, discharge of *krimi*, flatus, feaces, semen via external opening.

Previously some cases of the *Unmargi Bhagandar* have also been reported and treated successfully with Ksharasutra. [9]

CASE HISTORY:

A 33 years young male patient comes with complaint of anal pain, peri anal itching with P/R seropurulent discharge for a duration of 3 months. Patient had been on conservative treatment but had no relief. A thorough history taking reveals he is a non-vegetarian (daily) predominantly red meat and had habitual constipation was noted.

On local examination in lithotomy position an external opening at 3'o clock position with minimal seropurulent discharge noted. On Digital Rectal Examination (PRE) internal opening with a pointed body was palpable at 3'oclock (Fig.1). Patient was sent for MRI Fistulogram, which was suggestive of grade 2 perianal fistulous tract in left paramedian perineal subcutaneous tissue showing branching tract Intersphincteric extension and internal opening at 3'o clock position approximately 1.9 cm from anal verge. It

shows subtle thin elongated T2 hypointensity within likely a foreign body (Fig.2).

THERAPEUTIC INTERVENTION:

The patient was investigated, assessed and posted for surgery with all preoperative protocols followed. The patient was given Lithotomy position in OT and under all aseptic precautions and under spinal anesthesia, Fistulectomy with foreign body removal was done (Fig 3). A piece of bone measuring 2.5cm x 0.5cm was identified and removed. Hemostasis achieved followed by dressing and patient was shifted to ward in good condition.

Post operatively patient was put on Antibiotics (Cefotaxime), Anti-inflammatory (Ibuprofen+Paracetamol) and Laxative (Liquid Cremaffin) for 5 days and lukewarm *Panchavalkal kwatha* sitz bath, dressing with Betadine solution followed by Anometrogyl ointment local application twice a day and Laxative at night. Follow up visit after every 5 days for first 3 weeks and later after every 10 days for 4 weeks.

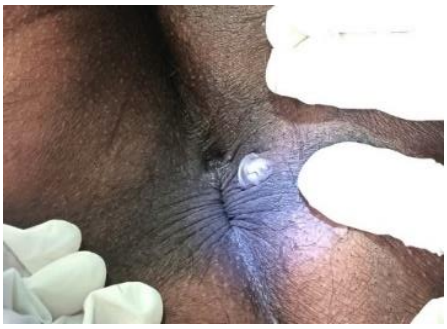

Fig1. Local examination of patient

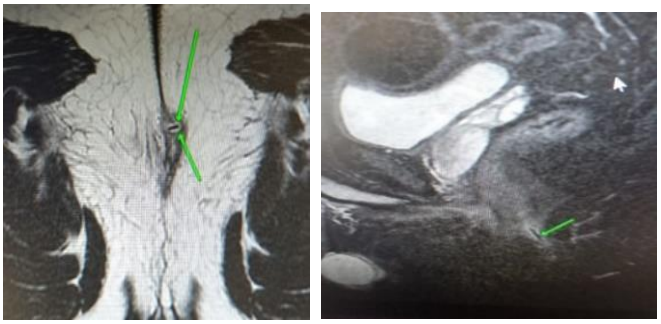

Fig. 2. MRI Fistulogram images

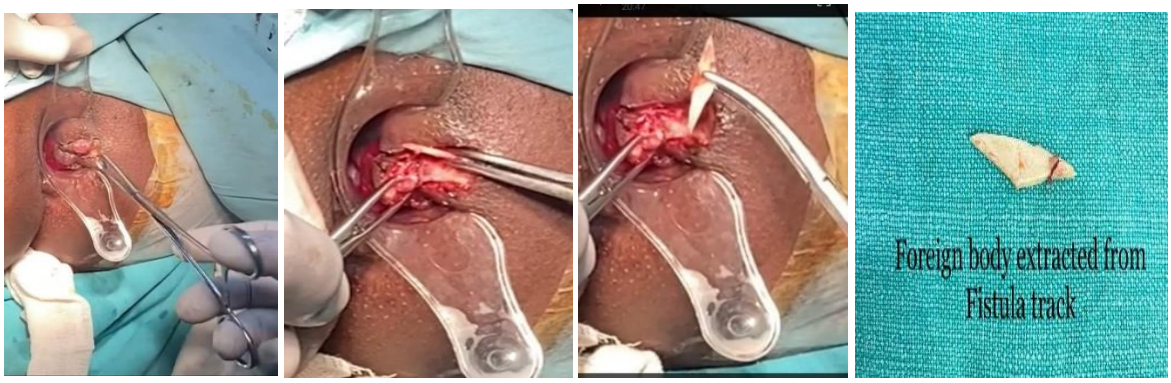

Fig. 3 Intra-operative images showing foreign body removal (bone)

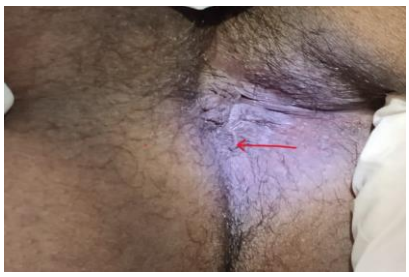

Fig.4 Post op follow up > 12 weeks

RESULT AND DISCUSSION:

In this case the patient was assessed and evaluated by *Trividha parikshana* as mentioned in classical Ayurvedic texts, allied science (Coloproctology), augmented with modern imaging technique done to confirm diagnosis of *Unmargi Bhagandar* (Anal Fistula). As *Unmargi Bhagandar* has *Agantuja* etiology, *Sushrutaacharya* has labelled it as *Asadhya* and advised to cater the *Pratyakyaya Chikitsa*. In this case as advised by *Sushrutaacharya* firstly probing of the fistulous tract done (*gati eshana* with *Shalaka*) followed by laying open and excision of the tract (*gati chedan*), foreign body removal (*Shalyanirharana*) followed by cauterization of the wound (*dahankarma* with *jambavoustha shalaakha*) and use of Antiseptics & Antibiotics (*krimighna aushadadravya*) in case of infection (*krimi*). As suggested by *Sushrutaacharya* use of analgesics (*vedhanashamak dravya*) and sitz bath (*avagaha sweda with Panchvalkal kwatha*) prescribed inorder to treat the post-op wound (*shastrakruta vrana*). The patient underwent daily dressing, advised laxative every night and was followed up regularly for next 10 weeks.

As the foreign body was removed and the fistulous tract was excised the patient was relieved from his presenting complaints as the wound healed. The patient was advised to follow *pathya-apathya* discussed in *Bhagandar* to prevent recurrence. The patient was assessed after 3 months of surgery and had no complaint. This goes to show that a thorough study of literature plays a pivotal role in the diagnosis of *Bhagandar* (Anal Fistula) and its treatment to prevent the recurrence. Ayurvedic management and following *pathya-apathya* benefitted the patient.

Sitz bath with *Panchavalkal* help for proper cleaning and healing of wound due to its antibacterial action. The application on Anometrogyl oint on the post op wound renders local anaesthetic action and local antibacterial coverage thereby promoting wound healing.

CONCLUSION

The prevalence of Anal Fistula is increasing day by day whereas their treatment still remains a challenge for an Ayurvedic practitioner. The management of Anal Fistula needs complete knowledge of Guda Sharir (perianal anatomy) and NidanPanchak (five diagnostic tools). There are different modalities of treatment in Ayurveda and Modern medicine. Hence a thorough knowledge of both worlds is need of hour in Proctology practice. It is a prerequisite to diagnose the type of Bhagandar and its stage. Apt and timely treatment needs to be done to avoid its recurrence.

Consent of patient:

A well informed consent was taken from the patient of this case report in order to publish the case and the images.

Limitation of the study:

This is a single case report.

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