EUROPEAN JOURNAL OF BIOMEDICAL AND PHARMACEUTICAL SCIENCES
http://www.ejbps.com

ISSN 2349-8870
Volume: 6
Issue: 6
542-545
Year: 2019

A REVIEW STUDY OF FISTULA- IN- ANO (BHAGANDARA)

Dr. Satish Chaurasiya*[1] and Dr. Deepak Kulshrestha[2]

[1]M.S., PhD Scholar, Dept. of Shalya Tantra.
[2]Professor, Dept. of Shalya Tantra, & Principal, Govt. Ayurvedic College, Rewa.

***Corresponding Author: Dr. Satish Chaurasiya**
M.S., PhD Scholar, Dept. of Shalya Tantra.

Article Received on 21/04/2019 **Article Revised on 11/05/2019** **Article Accepted on 01/06/2019**

ABSTRACT
Fistula- in- ano (Bhagandara) is one of the most common ano rectal disease which dealt with surgical approach. The word Bhagandara is composed of two words bhag and darana. Ayurveda described Bhagandara under the Ashta Mahagada considering its consequences. Bhagandara is a common disease occurring in the Ano- rectal region around the anus which extends up to the genitalia. The formation of a pidika leads development of Bhagandara characterised by opening around gud Pradesh along with painful discharge. In this article we will study about Bhagandara, its causes, classification, sign & symptoms, management and many more descriptions according to Ayurveda and modern medicine.

KEYWORDS: Bhagandara, Fistula-in-Ano, Astamahagada, Ano-rectal etc.

INTRODUCTION

An anal fistula is a small channel that develops between the end of the bowel, known as the anal canal or back passage, and the skin near the anus. The anus is the opening where waste leaves the body. An anal fistula is painful and can cause bleeding when you go to the toilet. Some fistulae can be connected to the sphincter muscles (the rings of muscles that open and close the anus).

Anal fistula (plural fistulae), or fistula-in-ano, is a chronic abnormal communication between the epithelialised surface of the anal canal and (usually) the perianal skin. An anal fistula can be described as a narrow tunnel with its internal opening in the anal canal and its external opening in the skin near the anus. Anal fistulae commonly occur in people with a history of anal abscesses. They can form when anal abscesses do not heal properly.

Anal fistulae originate from the anal glands, which are located between the internal and external anal sphincter and drain into the anal canal. If the outlet of these glands becomes blocked, an abscess can form which can eventually extend to the skin surface. The tract formed by this process is a fistula. Abscesses can recur if the fistula seals over, allowing the accumulation of pus. It can then extends to the surface again - repeating the process.

Definition

The Daran of Bhag, Guda and Vasti with surrounding skin surface called Bhagandara. Further he has described that a deep rooted Apakvapidika with in two Angula circumference of Guda Pradesh associated with pain and fever is called Bhagandarapidika after bursting of Bhagandarapidika is called Bhagandara.

PATHOPHYSIOLOGY OF ANO-RECTAL SEPSIS

Widely accepted cryptoglandular theory leading to abscess formation and fistula development needs to be well understood as this is the pathology responsible for almost 90% of the perineal sepsis and anal fistulas. The obstruction of anal crypt gland with inspisitted debris leads to infection in these glands, which penetrate, into the anal complex in varying degrees and suppuration follows the path of least resistance.

In context to spread of infection, understanding the perineal and anal anatomy is must. As the abscess collects in anatomical spaces where the anal gland terminates and from there on follows in the perineal spaces. It needs to be emphasized that Anorectal abscess is an acute manifestation of the crypto-glandular infection and fistula is a chronic sequelae of this infection. Almost one third of the patients who undergo drainage of the Anorectal abscess develop the anal fistula. Any recurrent perineal abscess that occurs at the same site as the previous abscess is also a part of the continuation of the same old process and should be considered as a fistula and should be treated accordingly.

In 10% of the patients, the notable cause of the perineal sepsis is not crypto-glandular infection but it could be inflammatory bowel disease, fungal infection, tubercular

infection, neoplasm or trauma. Such fistulas are classified as secondary and known to have a complex nature, requiring non-standard methods of management. There is a need to understand this because their management and outcomes.

Types

1. **Park classified the fistulas:** Depending on their relationship with the internal and external sphincter muscles, fistulae are classified into five types:

- **Extrasphincteric:** Fistulae begin at the rectum or sigmoid colon and proceed downward, through the levator ani muscle and open into the skin surrounding the anus. Note that this type does not arise from the dentate line (where the anal glands are located). Causes of this type could be from a rectal, pelvic or supralevator origin, usually secondary to Crohn's disease or an inflammatory process such as appendiceal or diverticular abscesses.
- **Suprasphincteric:** Fistulae begin between the internal and external sphincter muscles, extend above and cross the puborectalis muscle, proceed downward between the puborectalis and levator ani muscles, and open an inch or more away from the anus.
- **Transphincteric:** Fistulae begin between the internal and external sphincter muscles or behind the anus, cross the external sphincter muscle and open an inch or more away from the anus.These may take a 'U' shape and form multiple external openings. This is sometimes termed a 'horseshoe fistula'.
- **Intersphincteric:** Fistulae begin between the internal and external sphincter muscles, pass through the internal sphincter muscle, and open very close to the anus.
- **Submucosal:** Fistulae pass superficially beneath the submucosa and do not cross either sphincter muscle.

2. According to Acharya Sushruta there are five types of Bhagandara

1. **Shatponaka –** Dosha –Vata, Feature- Toda, tadana, chedana, vyadhana, gudadarana Discharge - Continous Phenila discharge Appearance-Water can or sieve like, multiple fistula

2. Ustragreva – Dosha –Pitta Features- Chosha pain like kshara or Agni being applied to a wound. Discharge- Ushna & Durgandhita smelling. Appearance- Camel's neck.

3. Parisravi - Dosha- Kapha Feature- kandu, less pain full Discharge- Continous and slimy Appearance- Whitish

4. Shabukavarta – Dosha- Vata along with Pitta Kapha Features- Toda, daha kandu migratory pain around the Anal canal. Discharge- Multi colour. Appearance – Tip of great toe, turns of conch.

5. Unmargi/Agantuj – Dosha– Trauma to Rectum or Anal canal. Features- Kotha of Mamsa and Rakta infestation with Krimi. Discharge- Pus, faces, flatus, urine, semen. Appearance- No specific course of track.

According to Asthang Sangrah 8 types of Bhagandara are described, among these five types are same that of **Sushruta** and other there types are:

6. Parikshepi- Dosha- Vata & Pitta. Feature- curved track is formed all around the Anal canal. Discharge- Pus & blood. Appearance- Horse shoe shaped fistula.

7. Riju – Dosha–Vatta & kapha Feature – Linear track associated with pain Discharge- Pus Appearance- Short straight track

8. Arshobhagandara- Dosha- Kapha & Pitta. Feature- Located at the base of the Arsha, burning pain and itching sensation. Discharge- continuous discharge, moist. Appearance- fistula arises following infection of fissure bed with sentinel tag.

Signs and symptoms

Anal fistulae can present with the following symptoms:

- Skin maceration
- Pus, serous fluid and/or (rarely) feces discharge — can be bloody or purulent
- Pruitus ani — itching
- Depending on presence and severity of infection:
- pain
- swelling
- tenderness
- fever

Diagnosing an anal fistula

Goodsalls Rules

- In general fistula with an external opening anterialy but with in1.5 inches from Anus connects to internal opening by a short radial track.
- Fistula with an external opening posterior to transverse line track in curvilinear fashion in the posterior midline and often this is a Horse shoe fistula.

- **Physical examination**
- The specialist will examine your anus (the opening where waste leaves the body) and the surrounding area for any physical signs of a fistula. The opening of a fistula usually appears as a red, inflamed (swollen) spot, which often oozes pus.
- If the opening of the fistula is found, the specialist may be able to work out where the path of the fistula lies. The path of the fistula can sometimes be felt as a hard, cord-like structure beneath the skin.

Fistula probe

Your specialist may also need to use a proctoscope (special telescope with a light on the end) to see inside your rectum. They may also use a fistula probe, which is a tiny instrument inserted through the fistula.

These examinations may be performed under general anaesthetic, where you are asleep.

Further tests

If you have a complicated fistula with several branches, you may need further tests to determine the exact position of the fistula tracts. This will help determine your treatment.

Some further tests that may be recommended include

- **Anal endosonography (ultrasound)** - this test uses high-frequency sound waves to create an image of the inside of your body. This is an accurate and frequently used way of locating the internal opening of a fistula.
- **Magnetic resonance imaging (MRI) scan** - an MRI scan uses strong magnetic fields and radio waves to produce a detailed image of the inside of your body. This type of scan is often used in cases of complex or reoccurring fistulae.
- **Computerised tomography (CT) scan** - a CT scan uses X-rays and a computer to create detailed images of the inside of your body. This may be used if you have an inflammatory bowel disease, such as Crohn's disease, as it can be used to assess the extent of the inflammation.

Management of supputrative Bhangandrapidika

1. **Medical management –** Application of Vartee, Kalka, Kwatha, Tail, Ghrita.
   Drugs- Triphlagugglu, Saptavinsatigugglu, Nvavkarshi kaguggulu.
2. **Surgical Process-** According to Acharya Sushruta excision (Chedan) and incision (Behedan) over the track should be different type which is depends up on the type of the fistula.
   The general principles of management of Bhagandara by Acharya Charaka are mentioned below

a. Virechana- Preparation of bowel
b. Eshana- Probing
c. Chhedan/Patana (Laying open of the track).
d. Margavisodhana- Cleaning of track.
e. Dahana- Cauterization
f. Vranachikitsa- Wound managememt (postoperative)
g. Ksharsutra therapy – It is indicate specially for those who are unsuitable for surgical procedures.

Management of fistula-in-Ano

The treatment of fistulain-Ano still remains a surgical challenge the ideal treatment of a fistula would effectively close the track with the lowest recurrence rate and fewest complication.

1. Fistulotomy- Fistulotomy can be done in a very low anal fistula without any risk of functional compromise.

2. Seton- It is particularly for treatment of extrasphincteric fistula. A seton is a thread of foreign material that is placed in the fistulous track the seton is used for the management of high or complicated anal fistula the function of seton is to provide drainage, to induce fibrosis and to cut the fistulos track with preservation of the sphincter mechanism.

3. Anal fistula plug– The newest modality therapy for the treatment of fistula-in Ano is use of Anal fistula plug. The Surgisis AFP plug is conical device made from porcine small intestine submucosa. the principal effect of the fixing the plug from inside of anus with suture. it also stimulates native tissue remodeling to eventually close fistulous track.

4. Endorectal advancement flap- Mucosal advancement flap are used particularly for fistula in ano suchas high level fistula high transphinecteric, suprasphincteric and extrasphinctericfistula. the principle of the technique is to cover the internal opening by internal sphincter and rectal mucosa is advanced from above at the Same time.

5. Fistulectomy- It is a technique for excising the fistulous track It causes very wide wound. It heals from top causing a tunnel formation and recurrence. the technique preserve anal sphincter function.

6. LIFT (Ligation of intersphentreic fistulous track)– This procedure aims at total anal spincter pre servation and is applicable especially in fistula of intersphinteric variety. LIFT procedure is based on secure closure of the internal opening and removal of infected crypto glandular tissues through the intersphincteric approach.

7. VAAFT- VAAFT is video assisted anal fistula treatment. This technique involves use of an endoscope i.e. fistuloscope the main advantage of this technique is localization of internal opening. there is also no surgical wound postop.

CONCLUSION

The prevalence of fistula-in-Ano is increasing day by day. Treatment of fistula is remains challenging. The management of fistula in ano needs complete knowledge of perianal anatomy and pathophysiololgy. There are different modalities of treatment in Ayurveda and modern medicine. It needs to be diagnosed the type of fistula and early and appropriate treatment so there is no recurrence of fistula in ano.

REFERENCES

1. Dr. Tripathi Bhramanand in Astanghridyam, nirmala hindi commentary, chaukhambha Sanskrit sansthan Delhi, uttar sthan chapter, 28/5: 1092.
2. Shashtri A.D., Sushrut Samhita in Ayurveda Tatva Sandipika, chaukhamba Sanskrit sansthan, chiktsha sthanam chapter Su. Chi. 8/5-7: 45.
3. Shashtri A.D., Sushrut Samhita in Ayurveda Tatva Sandipika, chaukhamba Sanskrit sansthan, sutra sthanam chapter, 33: 126.
4. Shashtri A. D. Sushrut Samhita in Ayurveda Tatva Sandipika, chaukhamba Sanskrit sansthan, nidan sthanam chapter Su. Sha. Su. Ni, 4/4: 244.
5. Shashtri A.D., Sushrut Samhita in Ayurveda Tatva Sandipika, chaukhamba Sanskrit sansthan, nidan sthanam chapter Su. Ni, 4/12,p-246.
6. Chakradatta Chakradatta, Sri Chakrapanidata, by Sri Jagdishvaraprasad Tripathi, edited by Bhishagratna Pt. Brahmashankara Mishra, Chowkhamba Sanskrit

series Office, Varanasi -221001, Fifth Edition 1983, arsha chikista, 5/148: 66.

7. Bailey & Love's Short Practice of Surgery edited by Norman S. Williams, Christopher J.K. Bulstrode, P. Ronan O'Connell, Hodder Arnold publication, 25th Edition, Anus and Anal Canal, Fistula-in-ano, 1264.