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EXPLORATION OF *APAMARGA KSHARA PRATISARANA* (LOCAL APPLICATION AT FISSURE BED) FOLLOWED BY PARTIAL SPHINCTEROTOMY IN THE MANAGEMENT OF *PARIKARTIKA* WITH SPECIAL REFERENCE TO CHRONIC FISSURE IN ANO: A CASE STUDY

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ABSTRACT

Apamarga Kshara Pratisarana (local application at fissure bed) followed by Partial Sphincterotomy was conducted on a female patient with the complaint of chronic fissure in ano with the duration of chronicity of 12 years. The main aim was to evaluate the role of *Apamarga kshara pratisarana* followed by partial Sphincterotomy in chronic fissure in ano and to observe the required duration for healing of fissure. Assessment of result was done on the basis of change in the subjective and objective parameters.

The conclusion drawn from this study was *Apamarga kshara pratisarana* followed by partial sphincterotomy shows good response and the healing period was 4 weeks. Thus it can be stated that this study holds good in the management of chronic fissure in ano and fits to the goal of treatment of fissure. The damage to the anal mucosa is minimized and the fissure bed *lekhana* can be achieved just with the application of *kshara* instead of excision, which helps in healing of fissure and this procedure can be performed on day care basis itself.

Key words: *kshara* (an alkali paste), *pratisarana* (application), *lekhana* (scraping), *parikartika*

INTRODUCTION

According to *Acharya Sushruta*, excruciating cutting type of pain all around *guda*, *bastishiras* and *nabhi* is termed as *Parikartika*[1]. In Ayurvedic classics, besides the medical management for diseases, surgical treatments are also given importance. For *Parikartika, Acharyas* have described treatments, both local as well as general. When *Vata* is covered with faeces, the stool is constipated, patient suffers from severe pain and passes hard stools with difficulty and evacuation is delayed. This causes *parikartana* leading to *Parikartika.*[2] Description of this condition is very much suggestive of the modern ailment Fissure in ano when it is limited to anal region. Fissure in ano is very commonly encountered in current day to day practice. It comprises of 6-15% of anorectal disorders and is characterized by excruciating pain during and after defecation, bleeding per anum with spasm of anal sphincter.

Need and Significance of Study: The goal of treatment for anal fissure is to break the cycle

of sphincter spasm, thus reducing the agonizing pain, to heal the wound at anal mucosa and avoid repeated tearing of the anoderm. From the available explanations in the classics, we can infer that *Parikartika* is a *vranalakshanayukta gudavikara*. *Acharya Sushruta* has indicated the *pratisaraneeya kshara* in *dushtavrana*. By taking this reference and considering the need of *vranavat chikitsa* in the management of *parikartika*, the *pratisaraneeya kshara* was chosen for the study followed by sphincterotomy.[1] Sphincterotomy was chosen by taking the reference from *sanniruddhagudachikitsa*, where *Sushruta* has described *bhitwavasevanimuktwa,* and as hypertonicity of the sphinctor can be taken as *sanniruddhaguda* itself.[1]

This modality of treatment will help to tackle the fissure bed which is formed in a case of chronic fissure. According to modern science the fissurectomy i.e. excision of the fissure bed is followed but here in this study instead of excision the fissure bed will be tackled by application of *Apamarga kshara*, which helps to avoid excision and also prevent the complications as well as recurrence observed after fissurectomy. The procedure is taken up in order to minimize the damage to the anal mucosa, as well as bleeding. The damage to the anal mucosa is minimized and the fissure bed *lekhana* can be achieved just with the application of *kshara* instead of excision which helps in healing of fissure and this procedure can be performed on day care basis itself.

CASE STUDY

A female patient named Shanta (name changed), aged 42 years visited our hospital with the complaints of pain, burning and bleeding during defecation since 12 years, patient also had a complaint of hard stools and constipation associated with the main complaints. The complaints use to aggravate by taking spicy and hard foods like *chapati* and use to get relieved by taking cold items like buttermilk, cold milk according to the patient's version. The findings on examination were chronic posterior fissure with anterior and posterior sentinel tags and hypertonic sphincter.

Patient was admitted to the hospital (IP no. 11553) and was sent for routine investigations i.e- Hb%, TC, DC, ESR, BT, CT, RBS, urine routine, HbsAg, HIV.

Investigation reports: Hb%- 13.6g%, Total count- 7000cells/cumm, Differential count- Neutrophils- 57%, Lymphocytes- 38%, Eosinophils- 4%, Monocytes- 1%, ESR- 11mm/hr, CT-6mt 10 sec., BT- 2 mts, RBS- 105 mg/dl.

Urine routine: Physical examination: color- pale yellow, reaction- acidic, appearance– clear, chemical examination- albumin and sugar – nil; microscopic examination- pus cells: 2-4; EPIcells- 0-3; RBCs – nil; Cast/ crystals- not seen

Procedure:

Pre-operative procedure: Fitness approval from physician was taken to conduct the procedure.

Collection of the instruments i.e. slit proctoscope, sterilized mosquito forceps, artery forceps, spatula (BP handle) gauze pieces, pads, *Apamarga kshara*, electric thermal cautery, lemon juice, saline povidone solution, sterile gloves, 5ml and 10 ml syringes. All aseptic precautions were be taken for the procedures.

Operative procedure: Patient was made to lie in the lithotomy position in the minor OT of the hospital, part was cleaned and draped. Local anesthesia xylocaine 2% (5cc) diluted with distilled water (5cc) was infiltrated around the anal region and anal block was achieved. 4 finger dilatation was achieved by lubricating the finger with local anesthetic gel. Slit proctoscope was introduced into the anus and *kshara* was taken in a spatula (sufficient quantity to cover the fissure bed) and

applied over the fissure bed for a period of 100 *matrakala* i.e appr. 1 minute time and later it was cleaned with the lemon juice in order to neutralize the effect of *kshara*. Partial sphincterotomy was done by lifting the sphincter fibers with the help of a probe and were divided with the help of thermal cautery. Anterior and posterior sentinal tags were excised with the help of electric cautery. Haemostasis was maintained. And the anal canal was packed and bandaged with the help of pad and plaster.

Post-operative: Patient was shifted to the post-operative ward, pain was managed with the help of analgesics and *Triphala guuggulu* 2 tab twice daily, *Amritadi vati* 2 tab twice daily were given orally for 15 days, *Triphala choorna* 1 tsp was given at bed time along with hot water in order to have smooth evacuation of the bowel. Sitz bath with warm water was suggested twice daily for 1 week. Patient was discharged from the hospital on next day and was instructed to come for follow up on OPD basis.

Assessment criteria: Changes in the subjective and objective parameters were considered for the assessment of results.

Subjective parameters:

a. Pain: vas scale 1 to 10 was used for grading the pain

b. Burning sensation: Grading was done according to the presence and absence of same.

c. Bleeding per anum: Bleeding is usually seen as streaks over the stools or few drops on toilet pan in some cases. Grading was done depending on presence and absence of bleeding.

d. Bowel habit: This feature was graded based on consistency of stools and how often the patient passed stools and graded as follows. Easy evacuation/ normal consistency, once daily – 0; Hard stools passed once daily – 1; Hard stools passed once in 2-3 days – 2; Very hard stools passed once in 3-4 days – 3

e. Pruritis ani: Grading was done as per the patient's description. Absent or Present.

f. Painful flatus: Grading was done regarding presence/ absence of pain while passing flatus.

Objective parameters:

a. Length of ulcer: measured in mm

b. Skin tag: Absent /Present

c. In duration of edges: present/absent

d. Sphincter Spasm: Nominal scale of measure for Sphincter Spasm i.e. present or absent. (If the patient allows the digital & proctoscpic per rectal examination then there is no sphincter spasm.)

RESULTS & DISCUSSION

The fissure was healed completely by 30th day and patient could do her daily routine work from next day itself. Patient had mild discomfort while sitting for long for a period of 1 week, which was gradually reduced. A follow up for a period of 6 months was done on every fortnight in order to check the recurrence, but no recurrence was observed in that particular time.

Pain: pain % was same on the 1st post-operative day which gradually reduced to 50% by the 8th postoperative day and reduced to 80% and was relieved completely by 30th day. Pain intensity was same on 1st post-operative day because of the procedure which reduced later on.

Burning sensation: burning sensation was present on the 1st post-operative day which reduced gradually and was completely relieved by 30th day

Bleeding per anum: bleeding was reduced from the next day of procedure itself

Bowel habit: bowel habit was regularized by 8th day

Pruritis ani: absent

Painful flatus: reduced after 8th post-operative day

Length of the ulcer: length of the ulcer has started reducing by 8th day, on 15th day it reduced to 2.5 mm and was healed completely by 30th day.

Skin tag: absent soon after the procedure.

Induration of edges: was present for 15 days and reduced later on.

Sphincter spasm: was present on next day, mild spasm was present even on 8th day and was completely relieved on 15th day.

CONCLUSION

In the present study, complete healing of fissure with relaxation of spinceter was achieved within 30 days period. The follow up was done for 6 months, and there was no reoccurrence of the complaints in 6 month period. Thus it may be stated that the procedure played a significant role in treating the case of chronic fissure in ano with 12 year chronicity.

This modality of treatment helps to tackle the fissure bed which is formed in a case of chronic fissure. According to modern science the fissurectomy i.e. excision of the fissure bed is followed but here in this study instead of excision the fissure bed is tackled by application of *Apamarga kshara*, which helps to avoid excision and prevent the recurrence. The procedure is taken up in order to minimize the damage to the anal mucosa, as well as bleeding.

The *kshara* is considered to be superior in *shashtra* and *anushastra* according to *Acharya Sushruta*, it is having *chedana, bhedana* and *lekhana* property. Thus when it is applied over the chronic fissure it does the *shodhana* of the *dushta vrana* present in the anal canal, because of *ksharana* and *kshanana* property scrapes the unhealthy tissue and promotes the *ropana kriya.*

The damage to the anal mucosa is minimized and the fissure bed *lekhana* can be achieved just with the application of *kshara* instead of excision followed by sphincterotomy, which helps to relieve the sphincter spasm and thus influences for healing of fissure.

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