



Case Study

KSHARASUTRA THERAPY IN THE MANAGEMENT OF RECURRENT TRANS-SPHINCTERIC FISTULA-IN-ANO

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ABSTRACT

Bhagandara, which may be clinically correlated with fistula-in-ano, is a chronic and recurrent anorectal disorder. Recurrent trans-sphincteric fistula-in-ano following previous surgery presents a therapeutic challenge because repeated procedures may increase the risk of sphincter injury and recurrence. This case study describes a 54-year-old male with recurrent fistula-in-ano after two previous fistulectomy procedures. Magnetic resonance imaging demonstrated a recurrent left-sided fistulous tract with an internal opening at the 6 o'clock position. *Ksharasutra* ligation was performed under local anaesthesia, followed by weekly replacement, local wound care and adjuvant Ayurvedic treatment. Eight weekly *Ksharasutra* changes were completed over approximately two months, resulting in progressive cutting and healing of the fistulous tract. Following complete cut-through, the residual wound was managed with *Karanja Taila* and healed within approximately seven days. Pain, pus discharge and perianal swelling resolved, while anal continence was preserved. At the final documented follow-up, the patient became symptom-free with no clinical evidence of recurrence. This case suggests that *Ksharasutra* therapy can be considered for selected recurrent fistula-in-ano cases after previous surgery.

INTRODUCTION

Fistula-in-ano is a chronic inflammatory condition characterized by an abnormal tract connecting the anal canal or rectum with the perianal skin. In Ayurveda, *Bhagandara* is described as a difficult-to-treat anorectal disorder and may be clinically correlated with fistula-in-ano. Transsphincteric fistulas traverse the sphincter complex and require treatment that balances eradication of the fistulous tract with preservation of continence.

Conventional management includes fistulotomy and fistulectomy, whereas sphincter-preserving approaches include seton placement, ligation of the

intersphincteric fistula tract and advancement flap procedures. Recurrent disease after previous surgery is particularly challenging because postoperative fibrosis and altered anatomy may complicate identification and management of the fistulous tract.

Ksharasutra is a medicated thread-based Ayurvedic para-surgical procedure used in the management of *Bhagandara*. The medicated thread is placed through the fistulous tract and replaced periodically, allowing gradual cutting, drainage and healing. Previous clinical studies have evaluated *Ksharasutra* therapy in fistula-in-ano.^[1,2] The present case study describes the management of recurrent transsphincteric fistula-in-ano after two previous fistulectomy procedures.

Case Study

A 54-year-old married male from Jodhpur, Rajasthan, India, presented to the Department of Shalya Tantra, Sanjeevani Ayurveda Hospital, with recurrent pus discharge from the perianal region for approximately one year, associated with pain while

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sitting and mild perianal swelling. He reported a four-year history of recurrent perianal abscesses that ruptured spontaneously, healed temporarily and recurred at the same site. He had undergone two previous fistulectomy procedures at a tertiary care hospital, both followed by recurrence.

Past History

No significant comorbidities or known drug allergies were documented.

Family History

No significant family history of similar illness was documented.

Treatment History

The patient had undergone two previous fistulectomy procedures at a tertiary care hospital, both followed by recurrence.

Surgical History

History of two previous fistulectomy procedures with subsequent recurrence.

First fistulectomy done -24/11/2024

Second fistulectomy done - 02/08/2025

Personal History

Diet	Mixed
Appetite	Normal
Bowel	2-3 time/day with semisolid Occasionally constipated
Micturition	Regular, 8-9/0, Day/Night
Thirst	Normal
Sleep	Disturbed
Addiction	Tabacco chewing

General Examination

GC	Fair
Built	Medium
Height	5'6 ft
Weight	84kg
Blood pressure	124/82mm hg
Pulse	84/min
Respiratory rate	16/min
Pallor	Not Present at palpebral conjunctiva
Icterus	Not present at bulbar conjunctiva
Cyanosis	Not present
Clubbing	Not present
Oedema	Not present
Lymphadenopathy	Not present

Clinical Findings

On perianal inspection, an external opening was noted at the 3 o'clock position, with a well-healed

post-surgical scar over the left buttock. No active pus discharge, bleeding or surrounding erythema was observed at the time of examination.



Fig. 1: Perianal region and external opening at presentation

Digital rectal examination revealed adequate anal sphincter tone, a firm indurated area along the left lateral anal canal wall and a mild depression along the posterior wall. No obvious intraluminal growth or active tenderness was elicited.

Investigation Done

CBC, BT, CT, RBS - Within normal limit

HIV, VDRL, HBsAg - Non-reactive

Diagnostic Criteria

Diagnosis was based on clinical history, perianal examination, digital rectal examination and magnetic resonance imaging. The earlier available magnetic resonance imaging report dated 02/08/2025 described a left-sided transsphincteric fistulous tract approximately 5.3cm in length and 5.5mm in diameter, crossing the external sphincter at the 6 o'clock position, with two blind-ending secondary tracts and no supralelevator extension. The report assigned St James University Hospital grade 4. A repeat magnetic resonance imaging examination dated 26/04/2026 described a left perianal curvilinear tract approximately 6.2cm long and 5.8mm wide, with an internal opening at the 6 o'clock position, an external opening in the left gluteal cleft, mild adjacent inflammatory changes and no supralelevator extension. The final clinical diagnosis was recurrent fistula-in-ano following two previous fistulectomy Procedures.

MATERIALS AND METHODS

Poorva Karma

Informed and written consent was taken.

Bowel preparation was done.

Inj. TT 0.5ml I/M

Xylocaine 0.5ml (2%) sensitivity.

- Sterile gloves and sterile dressing materials.
- Betadine solution and antiseptic preparation.
- Hydrogen peroxide for tract delineation.
- Probe and standard proctosurgical instruments.
- *Apamarga Ksharasutra*.

- Sitz bath / *Panchavalkala Kwatha* for local care.
- *Karanja Taila* for management of the residual wound.

Pradhan Karma

Based on the report dated 26/04/2026. The patient was taken to the operation theatre and placed in the lithotomy position. The perianal region was painted and draped under aseptic precautions. Local anaesthesia was achieved using 2% lignocaine (10ml) infiltrated along the fistulous tract and at the 6 o'clock position. Hydrogen peroxide was introduced through

the external opening to delineate the fistulous tract. The tract was probed from the external opening towards the internal opening, and *Apamarga Ksharasutra* was passed through the tract and ligated. Haemostasis and wound dressing were ensured.

Paschat Karma

Apamarga Ksharasutra was changed weekly with appropriate wound care and maintenance of perianal hygiene. Eight *Ksharasutra* changes were performed over approximately two months.

For internal use medicine

<i>Mahamanjishthadi Kwath</i>	20ml twice daily after food for 12 weeks
<i>Panchatikta Ghrita Guggulu</i>	500 mg twice daily after food for 5 weeks
<i>Sanshamani Vati</i>	2 tablets twice daily after food for 8 weeks
<i>Panchsakar Churna</i>	2 teaspoonfuls at bedtime for 3 weeks

Local care included.

Daily cleansing.

Sitz bath with lukewarm *Panchavalkala Kwatha*,

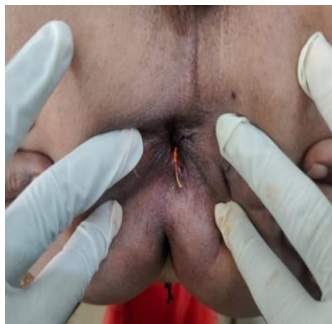
Dressing after *Ksharasutra* changes and maintenance of perianal hygiene.



Presentation before the surgery



2nd day after surgery



During *Ksharasutra* changing



During complete cutting of fistula tract



Complete heal the tract

RESULTS

The patient was assessed regularly for pain, pus discharge, wound healing and progressive cutting of the fistulous tract. Within approximately two months, eight *Ksharasutra* changes were completed and the tract was completely cut through. The residual wound was subsequently managed with daily packing using *Karanja Taila* and healed completely within approximately seven days. Progressive reduction and eventual complete resolution of pus discharge, pain and perianal swelling were observed. Anal continence was preserved throughout treatment. Mild temporary perianal itching was reported during treatment. Follow-up assessments were conducted at 15-day intervals to monitor wound healing, symptom resolution, continence and recurrence. At the final documented follow-up on 01/09/2026, the patient remained symptom-free with preserved anal continence and no clinical evidence of recurrence.

DISCUSSION

Recurrent fistula-in-ano following previous fistulectomy is clinically challenging because postoperative scarring and altered local anatomy may complicate identification and treatment of the fistulous tract. In the present case, magnetic resonance imaging was useful for evaluating the recurrent tract, its course and the presence of secondary extensions. The patient had already undergone two fistulectomy procedures and subsequently developed recurrent disease.

Ksharasutra functions as a medicated seton and provides gradual division of the fistulous tract while allowing drainage and simultaneous healing. The weekly replacement schedule used in this case was associated with progressive cutting of the tract and eventual wound healing. Preservation of anal

continence was clinically important because of the patient's history of repeated surgery. Previous studies have reported the clinical use of *Ksharasutra* and modified *Ksharasutra* techniques in fistula-in-ano.^[1,2]

CONCLUSION

Ksharasutra therapy may be considered as a treatment option in selected cases of recurrent fistula-in-ano after previous surgery. In the present case, *Ksharasutra* therapy was associated with progressive tract healing, complete resolution of symptoms and preservation of anal continence, with no clinical evidence of recurrence at the final documented follow-up. Further well-designed studies with standardized outcome measures and long-term follow-up are required.

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