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Successful Management of Fistula-in-Ano by IFTAK (Interception of Fistulous Tract with Application of *Ksharasutra*): A Minimal Invasive Method: A Case Report

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Abstract
Background: *Purulent discharge, frequent pain, and a high recurrence rate are the hallmarks of fistula-in-ano, a chronic anorectal condition. Anal sphincter damage is a danger associated with conventional surgical procedures, which frequently result in protracted wound healing. A cutting-edge, minimally invasive method called Interception of the Fistulous Tract with Application of Ksharasutra (IFTAK) is intended to maximise healing results while rigorously maintaining sphincter integrity.*
Presenting a Case: A 36-year-old man with recurring purulent discharge and severe perianal discomfort had no notable medical or surgical history. Chronic tobacco use and sporadic alcohol use were noteworthy aspects of the individual's past. The diagnosis of fistula-in-ano was validated by clinical examination. Following the patient's successful admission and management using the IFTAK approach, a planned three-month postoperative follow-up protocol.
Results: *Pain, drainage, induration, and wound diameters all gradually decreased, according to serial follow-up evaluations. Early in the postoperative period, healthy granulation tissue formed, leading to full wound epithelialization. Over the course of the follow-up period, no recurrence, sphincter dysfunction, or other surgical problems were noted.*
In conclusion, the IFTAK technique offers good wound healing kinetics and a smooth postoperative recovery. It is an efficient, minimally invasive, and sphincter-preserving method for treating fistula-in-ano.
Keywords: *Bhagandara, Fistula-in-Ano, IFTAK, Ksharasutra, Shalya Tantra, Wound Healing*

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I. INTRODUCTION

Because *Bhagandara* is chronic and difficult to treat, it is one of the *Ashta Mahagada* described by Acharya Sushruta. It may be associated with fistula-in-ano, a prevalent anorectal condition marked by aberrant communication between the perianal skin and the anal canal.[1] The illness typically results from a cryptoglandular infection, which causes an abscess to form and a fistulous tract to develop.[2]

Patients usually exhibit pain, swelling, irritation, discomfort during feces, and recurring pus discharge. Recurrence and degradation of anal continence continue to be major concerns despite the availability of many surgical techniques.[3] Conventional fistulotomy and fistulectomy may cause various degrees of sphincter injury and a longer recovery period..[4]

Ksharasutra therapy's simultaneous cutting, drainage, debridement, and healing characteristics have made it a popular Ayurvedic para-surgical treatment for *Bhagandara*..[5] Long treatment times and patient pain from frequent thread changes are still issues, though..[6]

The method called the Interception of Fistulous Tract with Application of *Ksharasutra* (IFTAK) was created in order to get around these restrictions. The goal of the procedure is to preserve sphincter function while

intercepting the fistulous tract close to the infection site, shortening the tract, facilitating drainage, and hastening healing.[7] Clinical reports have shown encouraging results, including good healing rates and decreased morbidity. [7,8]

II. CASE REPORT

The Shalya Tantra Outpatient Department saw a 36-year-old man who had been complaining of pain and sporadic pus discharge from the perianal area for about six months. The discharge was linked to periodic seating difficulties and localised discomfort.

The patient did not have a history of any major systemic illnesses, including diabetes mellitus, hypertension, TB, inflammatory bowel disease, or prior anorectal surgery. Personal history indicated occasional alcohol usage and long-term smoking. There was no mention of any notable family history.

A general examination showed that the patient was hemodynamically stable, cooperative, and cognizant. The vital signs were normal.

When the perianal area was examined locally, external apertures with purulent discharge and surrounding induration that suggested a fistula-in-ano were found. A digital rectal exam revealed a sphincter tone that was normal.

Fistula-in-ano (*Bhagandara)* was diagnosed based on clinical symptoms.

THERAPEUTIC INTERVENTION-

Following the acquisition of written informed consent, the patient was admitted for surgery.

Under spinal anaesthesia, the procedure was carried out in the lithotomy position. The fistulous tract was located with a flexible probe. The tract was stopped close to the infection site, and the internal opening was localised. Following that, *Ksharasutra* was inserted through the interposed tract in accordance with IFTAK principles. After establishing sufficient drainage, a sterile dressing was put on.

Among the postoperative care were:

Dressing In order to improve local circulation, ease discomfort, and speed up wound healing, the patient was advised to take warm sitz baths twice a day as part of postoperative therapy. To preserve hygiene and avoid infection, appropriate local wound care was carried out on a regular basis. To guarantee regular bowel movements and reduce straining during defecation, the patient was advised to eat a high-fibre diet. In order to avoid constipation and promote general recuperation, enough oral hydration was advised. In order to manage pain, analgesic drugs were prescribed as needed. Weekly follow-up evaluations were carried out to track the alleviation of symptoms, examine the degree of wound healing, and detect any problems following surgery..

ASSESSMENT CRITERIA-

A set of predetermined characteristics that represented both the subjective symptoms and the objective healing results were used in the clinical evaluation of the wound healing process. The patient's level of pain relief, the presence and intensity of tenderness (painfulness) at the wound site, and the amount of time needed for tissue healing and symptom resolution were all assessed. Additionally, granulation tissue growth and quality were closely monitored as markers of successful wound healing. Regular clinical examinations were used to assess the overall development of wound healing, taking into account elements including wound contraction, tissue regeneration, reduction of inflammation, and full epithelialization. Together, these factors offered a thorough evaluation of the treatment's efficacy and the rate of wound healing.

OBSERVATIONS-

Serial clinical photographs documented progressive wound healing.

Table 1: Clinical Assessment During Follow-up

Parameter	POD-1	POD-7	Week-6	Month-3
Pain (VAS Score 0-10)	8	3	1	0
Discharge Score	3	1	0	0
Tenderness Score	3	1	0	0
Induration Score	2	1	0	0
Granulation Tissue (%)	30%	80%	100%	100%
Wound Healing (%)	10%	50%	95%	100%

Results Section (for manuscript)

Pain, discharge, soreness, and induration gradually decreased during postoperative follow-up. By the end of the third month, the Visual Analogue Scale (VAS) pain score had dropped from 8 on the first postoperative day to 0. During the first week following surgery, purulent discharge significantly decreased, and by the sixth week,

it had totally disappeared. By the seventh postoperative day, around 80% of the wound bed had developed healthy granulation tissue. By the sixth week following surgery, 95% of the wound had contracted, and the third-month follow-up revealed full healing. There were no surgical problems, such as recurrence, secondary infection, or faecal incontinence.

Figure Legends for Your Photographs

Figure 1: Clinical appearance prior to surgery demonstrating an external opening and purulent discharge in the perianal area.

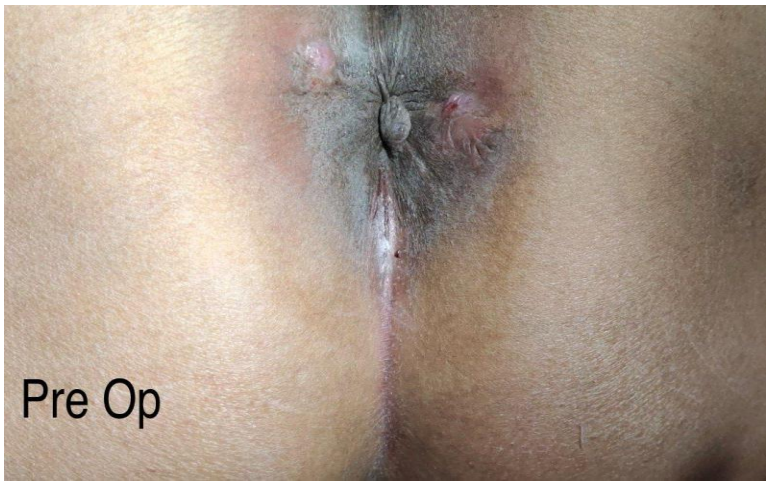

Figure 2: Day 1 after the IFTAK treatment, showing good wound margins and sufficient drainage.

Figure 3: Day 7 following surgery demonstrates the development of healthy granulation tissue and a decrease in local inflammation

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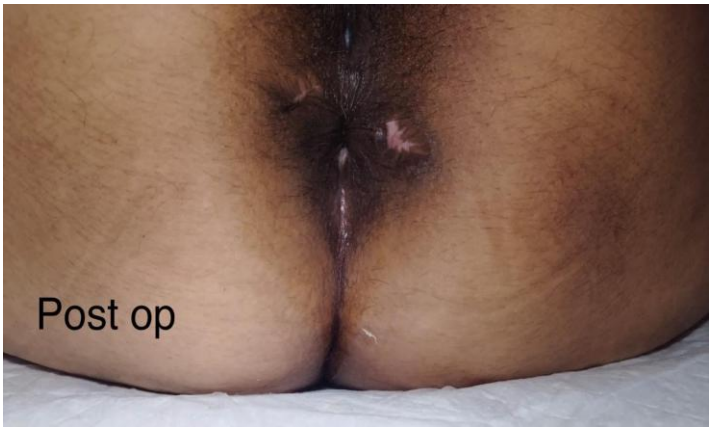
Figure 4: At the six-week mark, there was noticeable wound shrinkage and almost full epithelialization.

Figure 5: A three-month follow-up reveals full wound healing, healthy scar development, and no recurrence.



Healthy granulation tissue with a notable decrease in discharge and pain was seen by the seventh postoperative day. Subsequent follow-up revealed progressive wound constriction and epithelialization. During the three-month follow-up period, complete wound healing was attained, and no recurrence was noted.

III. DISCUSSION

Because of its chronicity, recurrence, and proximity to the anal sphincter complex, fistula-in-ano is still a difficult anorectal disease [2, 3]. Eliminating the infection while maintaining sphincter function and reducing recurrence is the main goal of treatment.[3] Because *Ksharasutra* therapy can promote drainage, debridement, and healing all at once, it is acknowledged as a successful therapeutic approach for *Bhagandara* [5,6]. Positive results with minimal recurrence rates and continence preservation have been documented in numerous investigations.[5] As an improvement on traditional *Ksharasutra* therapy, the IFTAK approach was created. The

idea is to reduce the effective tract length and promote successful drainage by intercepting the fistulous tract near the diseased anal crypt.[7] This method reduces tissue damage and speeds up the healing of wounds.

Because of its chronicity, recurrence, and closeness to the anal sphincter complex, fistula-in-ano continues to be a difficult anorectal condition [2,3]. Eliminating infection while maintaining sphincter function and reducing recurrence is the main goal of treatment.[3] Because *Ksharasutra* therapy can help with drainage, debridement, and healing all at once, it is acknowledged as a successful treatment option for *Bhagandara* [5,6]. Positive results with minimal recurrence rates and continence preservation have been documented in many investigations.[5] An improvement over traditional *Ksharasutra* therapy is the IFTAK approach. The idea is to reduce the effective tract length and enable effective drainage by intercepting the fistulous tract near the diseased anal crypt.[7) This method reduces tissue damage and accelerates the healing of wounds.

IV. CONCLUSION

The current case shows that IFTAK is a minimally invasive, safe, and efficient treatment for fistula-in-ano. Over a three-month follow-up period, the procedure produced excellent postoperative recovery, no recurrence, and adequate wound healing. To determine its long-term effectiveness and relative benefits over traditional surgical techniques, more clinical research with bigger sample sizes is needed.

Patient Agreement

The patient gave written informed consent for treatment, photography, and clinical data dissemination.

No declared conflicts of interest.

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