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# Ayurveda Management of Recurrent Ischiorectal Abscess - A Case Report

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## ABSTRACT

Anorectal abscesses are one of the potentially debilitating diseases among them perianal abscess and ischiorectal abscess are common. An ano-rectal abscess originates from an infection arising in the crypto-glandular epithelium lining of the anal canal spreading into adjacent spaces. A perianal abscess can cause pain, swelling, redness, and localized warmth around the anus. An ischiorectal abscess, on the other hand, occurs in the deeper tissues surrounding the anus. It often originates from an anal gland infection and progresses to involve the ischiorectal space. The ischiorectal space is located between the anal sphincter muscles and the outermost layer of the pelvic floor muscles. Symptoms of an ischiorectal abscess include severe pain, swelling, tenderness. Ischiorectal abscesses require medical attention. If left untreated, the infection can spread and lead to complications such as fistula formation. The treatment for anorectal abscesses usually involves surgical intervention. The treatment of Guda vidradhi (Anal abscess) is early, adequate drainage and proper healing process. This case was based on recurrent ischiorectal abscess with below mentioned line of treatment.

***KEYWORDS:*** *Abscess, recurrent ischiorectal abscess, Guda vidradi, Bhedana karma*

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## INTRODUCTION

Most common causative organism is E. coli (60%). Others are Staphylococcus, Bacteroides, Streptococcus, B. proteus. Commonly occurs due to infection of anal gland in perianal region. 95% of anorectal abscesses are due to infection of anal glands in relation to crypts-cryptoglandular disease. Other causes are injury to anorectum, cutaneous infection, blood born infection, fissure-in-ano, perianal haematoma, post anorectal surgery, crohn's disease, and tuberculosis[1]. Followings are the types of anorectal abscesses- 1. Perianal, 2. Ischiorectal, 3. Submucous and 4. Pelvi-rectal. Of these perianal (60%) and ischiorectal (30%) are the common abscesses[2]. Among these abscesses, ischiorectal abscesses are more vulnerable to infection because of reduced vascularisation of fat tissue[3]. According to Ayurveda Vidhradhi formation is a phenomenon that occurs when the vitiated doshas progressively affect the twacha (skin), rakta (blood), mamsa (muscles), and meda (fat) tissues, resulting in the formation of an excessively severe inflammatory swelling,. This swelling is characterized by its maha-mulam (deep-rooted nature), rujavantam (severe pain) and either a vruttam (round) or aayatam (elongated in shape) that is referred to as vidhradhi[4].Vidhradhi having mainly 2 types - bahya and abhyantara. Gudavidradhi comes under abhyantara vidradhi. Main causes of abhyantaravidradhi is guru, asatmya, viruddhaanna, vyayam, atyadhik-vyavaay, vegavarodha and vidahidravyasevana[5]. Main places of abhyantaravidradhi are guda, bastimukha, nabhi, kukshi, vankshan, vrukka, pleeha, klom, Hridaya[6]. In Ayurveda, ischiorectal abscess can be correlated with Gudavidradi (perianal abscess) because of vataavarodha lakshana[7] can be seen in gudavidradhi and also similarity in place and symptoms. Due to

excess vitiation of rakta causes instant vidaha called as vidradhi[8]. Improper treatment of guda vidradi leads to nadi vrana (sinus) and in future it may end up in formation of Bhagandara (fistula in ano). Acharya sushruta indicated bhedana karma (incision) is the primary line of management[9]. Here we report a case of recurrent ischiorectal abscess with extension of abscess cavity upto the base of scrotum 11 cm at 12'o clock direction, 7 cm at 6'o clock direction and 4cm at 3'o clock direction with small multiple pus pockets. So, Bhedana and visravana karma followed by kshara karma application was planned in this case. This has showed significant result in the wound healing.

**Case Presentation**

A 23 year old unmarried male patient named XYZ visited shalya OPD of R.P.K. Ayurvedic Hospital with presenting complaints of severe throbbing pain and discharge since two weeks. Patient having complaint of severe throbbing pain at anal region, sanguinopurulent discharge (Blood mixed pus), unable to sleep and even seat properly due to pain, pain increased after defecation, fever on off since one week, Constipation on-off. There was no history of Hypertension, Diabetes mellitus and any other co-morbidity. After proper History and examination found that patient undergone incision and drainage procedure before 6 months from nearby government hospital and had relief for some months but after complaint started again and gradually symptoms increased so he came here for further suggestion and treatment. The patient did not have any history of food, drug allergies or addictions. A general examination revealed vitals like blood pressure of 120/70 mm Hg, pulse of 80 bpm, respiratory rate of 20 cycles per minute, temperature of 98 F, and no abnormalities were detected on systemic examination. Clinical examination revealed on inspection previous scar and large oedema with discharge found at left gluteal region at 4'O clock. On palpation pain, tenderness and fibrosis present around the lesion and brawny induration Present over the lesion at 4'O clock. Per rectal examination was painful and felt bogginess on side of lesion suggesting big cavity. Patient advised for surgery.

**Diagnosis**

In per rectal examination and proctoscopic examination there is no any internal opening, no any buttonhole defect, no dimple, no any lump or mass, no fibrosis at anal and rectal wall found so differential diagnosis for fistula in ano deleted from mind and diagnosed as ischiorectal abscess with extending cavity and multiple tract

**Investigation**

**MRI Fistulogram**

1. Intersphincteric type of perianal fistula (Grade-II) in left posterior perineal area (detailed as in text) (Image no.1-2)
2. Ramification of tract seen at the level of internal sphincter with tract extending left antero-laterally ending blindly. (Image no.1-2)
3. Collection/abscess formation in deep subcutaneous tissue plane in left gluteal area. (Image no.1-2)

**Haematology Investigation**

| | | | |
|---|---|---|---|
| HB | 13.4 gm% | BT | 2 min. 25 sec. |
| RBC | 3.9 million/ul | CT | 4 min. 40 sec. |
| WBC | 8600 cells/cumm | Tridot | Negative |
| Platelet count | 286000 cells/cumm | HbSAg | Negative |
| CRP | 25.1 mg/dl | | |

**Treatment protocol**

The standard treatment principle for abscess is incision and drainage, so it was posted for incision and drainage under spinal anaesthesia after proper evaluation of the patient's condition and investigation. Patient was discharged after 7 days of surgery. Treatment was continued for 30 days after surgery. As patient having compliant of pain and discharge. Daily dressing was done upto 15 days of surgery, after that alternate dressing was done for next 2 week and weekly twice for last 15 days with jatyaditaila. Panchavalkal kashaya is used for vrana prakshalana.

**Ingredients of medicine used**

| Name of formulation | Key ingredients |
|---|---|
| Triphala Guggulu[10] | Haritaki churna, bibhitaki churna, aamlaki churna, pippali churna, shuddha Guggulu |
| Gandhak Rasayana | Sita, shuddha gandhak, ghrita, ela, twak, patra, nagakesara, guduchi, haritaki, vibhitaki, dhatri, shunthi, bhringaraja, ardraka |
| Arogyavardhini vati | Shuddha parade, shuddha gandhak, loha bhasma. Abhraka bhasma, tamra bhasma, haritaki, vibhitaki, amalaki, shilajatu guggulu, eranda, katuki, neemba. |

| | |
|---|---|
| Cap. Grab | Vranapahari Rasa, Triphala Guggulu, Gandhaka Rasayana, Arogyavardhini Vati, Guduchi, Manjistha |
| Sarivaadi vati | Sariva, mulethi, kushta, twaka, ela, tejpatra, priyangu, neelotpala, guduchi, lavong, triphala, abhrak bhasma, loha bhasma, bhringaraj, arjuna, madhook, gunja. |
| Avipattikara churna | Trikatu, triphala, mustak, vida lavana, vidang, ela, tejpatra, lavong, nishoth, sharkara |
| Jatyadi taila[11] | Jati, nimba, patola, naktamala, sikhtha, madhuka, kushtha, haridra, daruharidra, manjistha, katurohini, padmaka, lodhra, abhaya, nilotpala, tuthhaka, sariva, naktamalabija, til taila |
| Panchavalkal kashaya | Nyagrodha, udumbara, ashvatha, parisha, plaksha |

**Follow up and Progress**

| Wound Parameter | | Assessment Duration Days | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | 1 | 7 | 14 | 24 | 34 | 44 | 54 |
| Pain(VAS) | | 8 | 5 | 4 | 3 | 3 | 1 | |
| Size | Left | 6.5x5 cm | 5.5x4.5cm | 4.5x3.3cm | 3.6x2cm | 2.6x 1.5cm | 1x1cm | 0.4x0.2cm |
| | Posterior | 4.5x4cm | 4x3.2cm | 3.5x2.5cm | 3x2cm | 2.2x1.6cm | 1.2x1cm | 0.5x0.3cm |
| Depth | Left | 11cm | 9.5cm | 8cm | 6.5cm | 4cm | 2cm | 0.5cm |
| | Posterior | 6cm | 5cm | 4cm | 3cm | 2cm | 1.5cm | 0.4cm |
| Discharge | Left | Purulent | Purulent | Sanguineous | Serosanguinous | Serosanguinous | Serous | |
| | Posterior | Sanguineous | Serosanguinous | Serosanguinous | Serosanguinous | Serous | Serous | |

**Surgical notes**

**1. Preoperative:-**

As surgery was planned under spinal anaesthesia, patient was admitted previous day of surgery. Part preparation was done before surgery. Advised for NBM before 8 hours of surgery. Enema given late night for bowel clearance. Required written consent of patient and his relatives taken before surgery. Inj. Xylocaine 2% TD given. Inj. TT given.

**2. Operative:-**

Under all aseptic measures, spinal anaesthesia administered. Patient was taken in lithotomy position. Painting and dapping was done. A cruciate incision was made over the most dependent part, i.e., the left gluteal region at 4 'o clock. Adequate portion of the skin and subcutaneous tissue are incised which forms the roof of the abscess. Thick pus was seen through the incision site with a foul smell. A pair of artery forceps is insinuated through the deep fascia into the abscess cavity. The blades are now gradually opened and the pus was seen to be expelled out. The forceps was taken out with the jaws open to increase the opening in the deep fascia. Further exploration of the cavity done by probe revealed that it was extending towards the base of scrotum 11cm at 12'O clock direction, 7cm at 6'O clock direction and 4cm at 3'o clock direction. After that finger was introduced to explore abscess cavity, septa are divided with the finger and necrotic tissue lining walls of the abscess cavity is removed by finger wrapped with gauze. Scooping was done and Apamarga kshara is applied to remove all necrotic dead tissue from the extended cavity, small pus pockets and ramification of tracts. After one minute, kshara was washed out with normal saline and lime juice. Each extension of cavity explored well to drain properly. The attempt was made to find out the extension, it was found that extension from perianal abscess (extension of low intermuscular anal abscess, laterally through external sphincter).At 6'O clock, the incision was made, by window technique the cavity was made between two sphincteric muscles (intersphincteric space) to drain properly. Patient was stable during procedure and all vitals were normal.

**3. Postoperative:-**

After surgery, proper haemostasis achieved with equipment and tight packing of cavity done with betadine soaked ribbon gauze to avoid post-operative bleeding. Patient shifted to ward with normal vitals. Nursing staff advised to measure all vitals every half hourly (BP/TPR/INPUT/OUTPUT/BLEEDING) and advised to call surgeon in any emergency. NBM released after 6 hours of surgery.

**Discussion**

Vidradi is divided into two varieties, i.e., bahya (external part of body) and antar vidradi (internal part of body).Guda vidradi falls under antar vidradi and the treatment principle explained is bhedana and visravana (drainage) karma. This procedure helps to drain pus properly, thereby reducing the pain and speeding up the healing process. The present case was diagnosed as an ischiorectal abscess secondary to an extension of lateral intermuscular perianal abscess. In ischiorectal abscess, the treatment becomes difficult due to the specific pattern of spread, reoccurrence, and formation of horseshoe fistulas. The goal of our treatment was to treat and prevent these complications as effectively as possible. In the

present case, the presentation was an extension of ischorectal abscess connection with Y shaped cavity in left ischiorectal fossa. In this case, the extension of abscess cavity upto the base of scrotum 11 cm at 12'o clock direction, 6 cm at 6'o clock direction and 4cm at 3'o clock direction. So, Bhedana and visravana karma followed by kshara karma application was planned in this case. This will also help in chemical cauterization of the unhealthy granulation tissue at the same time and remove all necrotic tissue from small pus pockets and ramification of tracts. This has showed significant result in the wound healing. Bhedana karma over the most dependent part (left perianal region) with counter incisions on the previous scar mark and the left perianal region promoted proper pus drainage and exploration of the cavity and tract. The incision was made, by window technique the cavity was made between two sphincteric muscles (intersphincteric space) to drain properly. Triphala guggulu is mainly indicated in Bhagandara, Arsha (haemorrhoid), and Sotha (inflammation). Triphala, which helps in relieving constipation and healing wounds, also soothes the inflamed mucous layer. Guggulu is best-known for its anti-inflammatory herbs of Ayurveda. Pippali promotes digestion and has Vata Shamaka, Shothahara (Anti-inflammatory), and vrana ropana properties. As Triphala Guggulu is better alternative for antibiotics and Guggulu can be beneficial in healing process as it reduces oedema. Avipattikara churna as it works as dipana and laxative, patient doesn't has to be straining while defecation so there may be reduction in the pain after defecation. Jatyadi taila as we all know is a good in wound healing and proper granulation of the wound and it also protects wounds from secondary infection. Panchavalkal Kashaya is used for vrana prakshalana as it has properties of vrana shodhana and vrana ropana.

## Conclusion

As in recurrent ischiorectal abscess there may be improper hygiene, improper dressing and improper drainage of the abscess. Ischiorectal abscess with horseshoe connection is difficult for the management due to complications like horseshoe fistula tract and reoccurrence. So, there may be another chance for the kshara application to completely remove the unhealthy granulation tissue and necrotic tissue from small pus pockets and abscess cavity. The present case was managed successfully with bhedana and visravana karma followed by kshara application. Exploration of abscess and identifying the extension of cavity with small multiple pockets of pus and ramification of tract play an important role in effective management. Post-operative wound care, proper drainage of pus and dressing with jatyadi taila has given promising results in managing recurrent ischiorectal abscess.

**Image 1: When patient first came into OPD- Left ischiorectal abscess.**

**Image 2: Before procedure**

**Image 3: Suggesting Abscess cavity after clinical examination.**

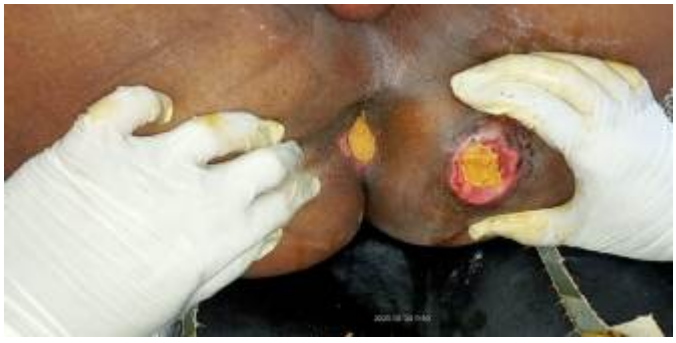


**Image 4: After Procedure Abscess cavity packed with jatyadi taila soaked ribbon gauze**

**Image 5: Day 14, before dressing**

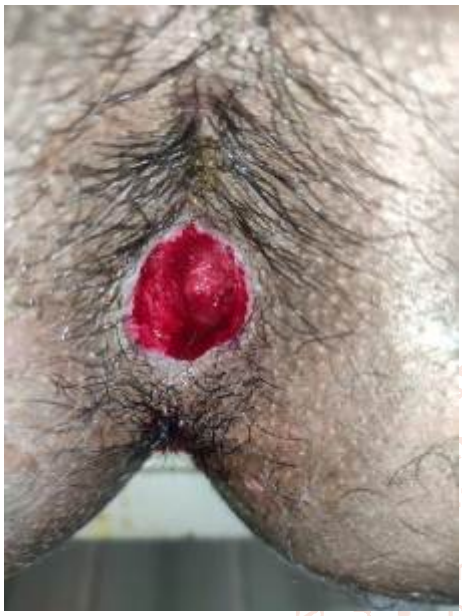


**Image 6: Day 14**

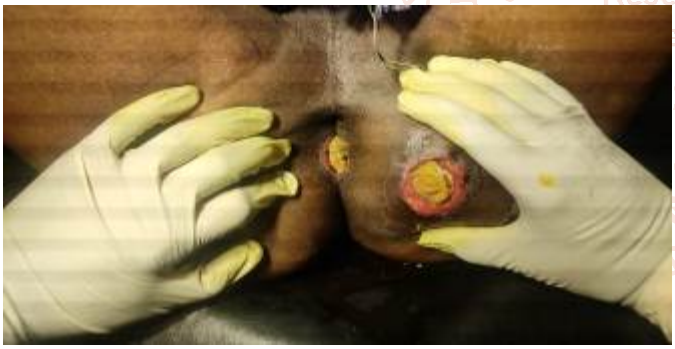


**Image 7: Day 14, after dressing**

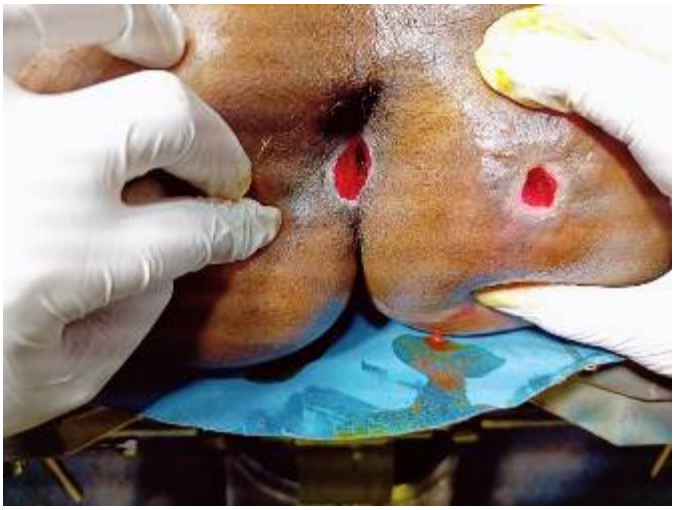


**Image 8: Day 34**

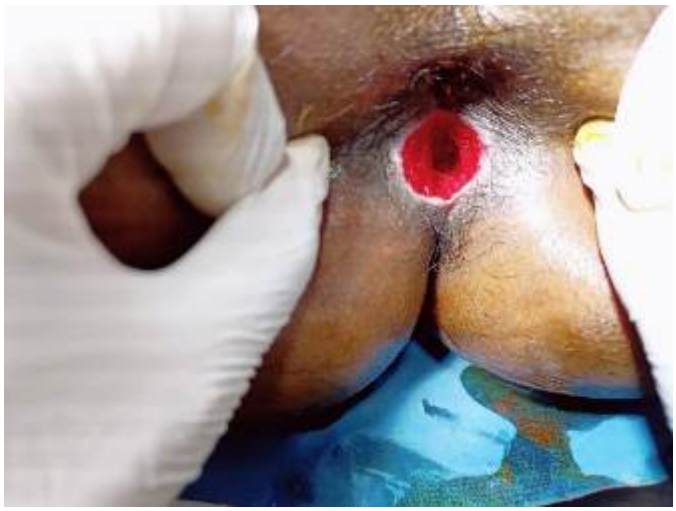


**Image 9: Day 34**

**Image 10: Day 44**

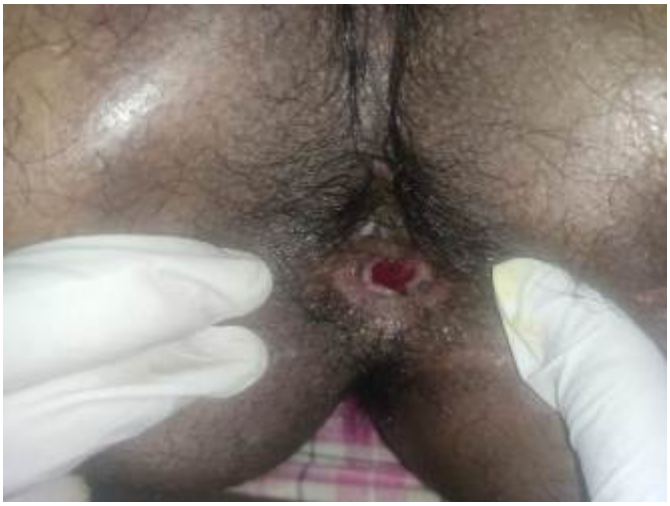


**Image 11: Day 44**

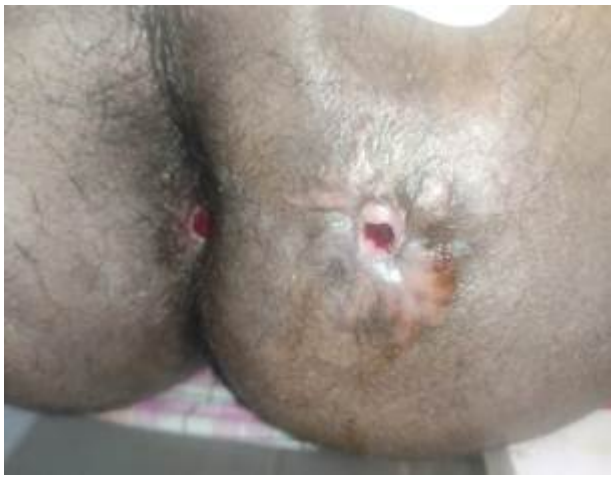


**Image 12: Day 54**

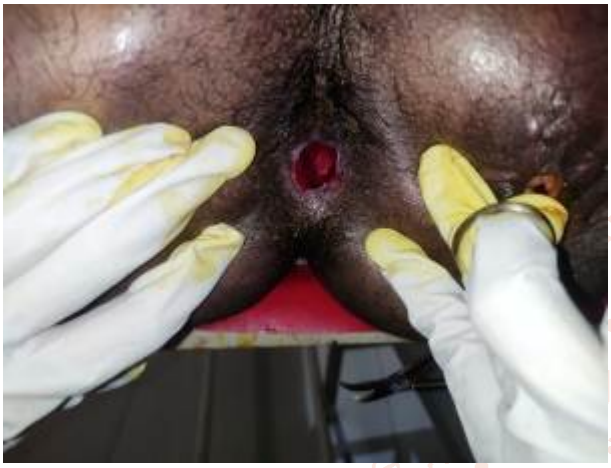


**Image 13: Day 54**

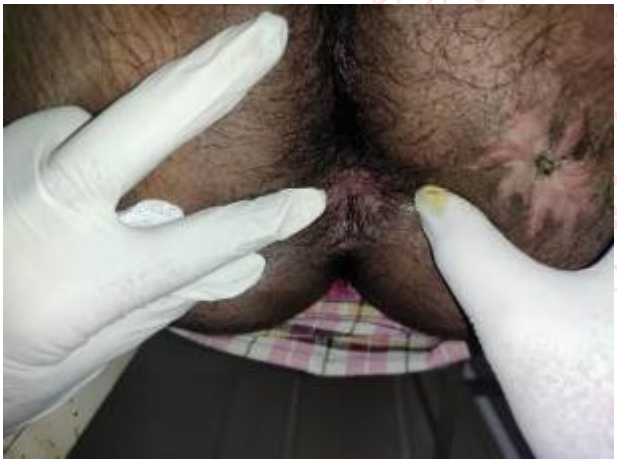


**Image 14: Day 60, complete healing**

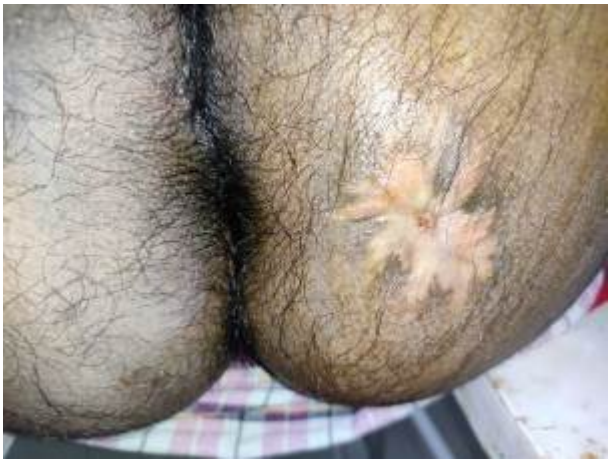
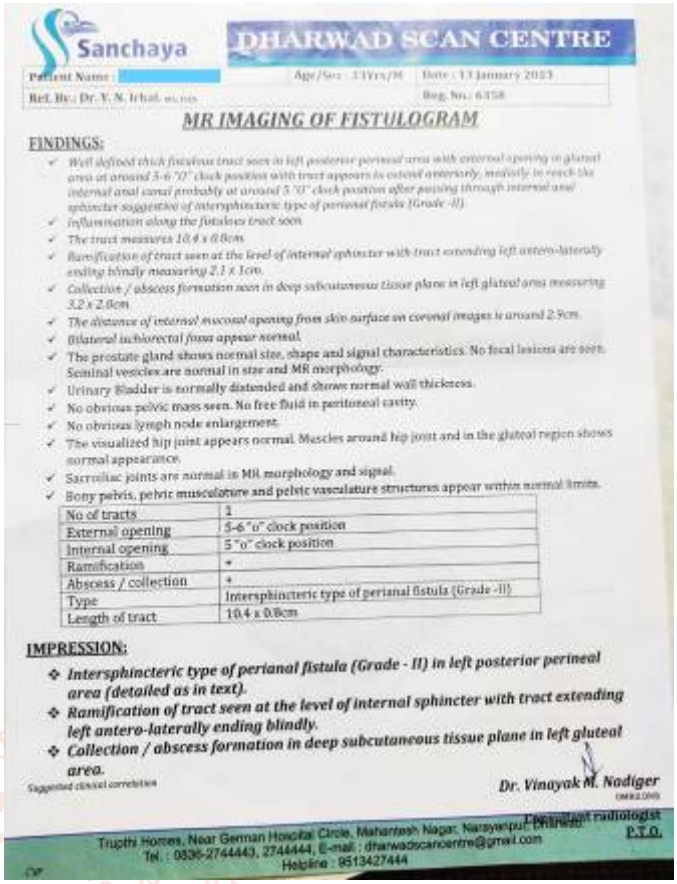


**Image 15: Day 60, complete healing**




| | |
|---|---|
| No of tracts | 1 |
| External opening | 5-6 "o" clock position |
| Internal opening | 5 "o" clock position |
| Ramification | + |
| Abscess / collection | + |
| Type | Intersphincteric type of perianal fistula (Grade -II) |
| Length of tract | 10.4 x 0.8cm |

**Image 16: Fistulogram Report**

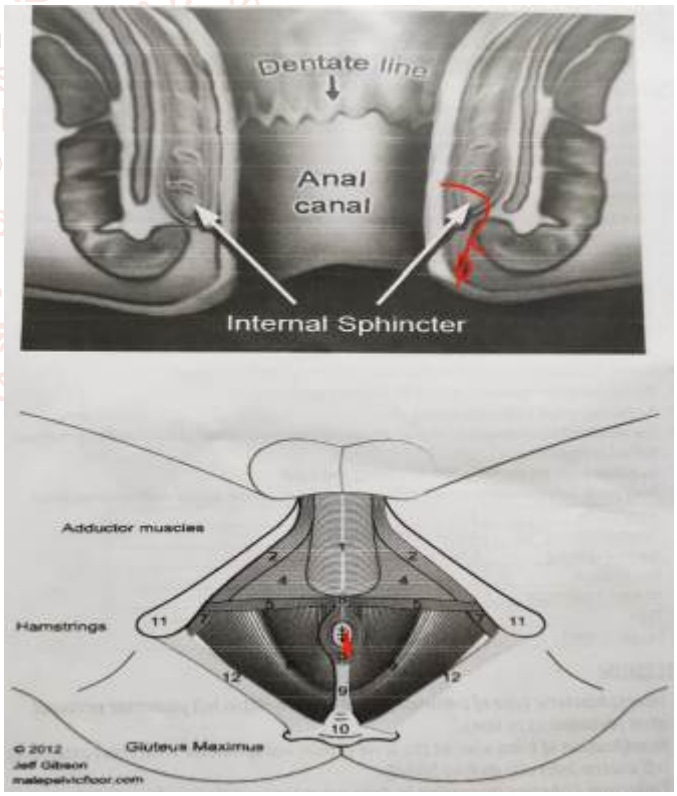



**Image 17: Fistulogram Report**

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