A CASE OF ANAL FISTULA BY EFFECTIVENESS OF SIDDHA KARANOOL THERAPY (CHEMICAL CAUTERIZATION)- A SINGLE CASE STUDY

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ABSTRACT

Siddha Medicine is a system of traditional medicine originating in ancient Tamil Nadu in South India and Sri Lanka. Traditionally, it is taught that the siddhars laid the foundation for this system of medicine. Siddhars were spiritual adepts who possessed the ashta siddhis or the eight supernatural powers. Agasthiyar is considered the first Siddhar & the guru of all siddhars, the Siddha system is believed to have been handed over to him by Shiva (1). Siddha system considers the human body as a collection of tri-humors & seven basic elements. Vatham, Pitham & Kapham are the tri-humors which are the life constituents of the human body. The equilibrium of humors is considered as health & its disturbance or imbalance leads to disease (2). The treatment modality is classified into three types namely Manida Maruthuvam, Vinnavar Maruthuvam and Asura Maruthuvam (3). Surgery is a phenomenal technique substantiated by siddhars was used to treat many acute and chronic conditions. Karanool, under the classification of Asura Maruthuvam is a minimal invasive siddha technique used in treating several conditions such as fistula, external haemorrhoids, Pilonidal sinus, skin tag and warts. According to the Sambasivampillai dictionary the term Fistula can be compared with Powthiram. (4) Fistula is an acquired condition often presenting with recognizing signs of infection. This study elicits a case report of Fistula treated with karanool therapy. The patient recovered with complete excision of the tract in a period of one month. This research finding will lead to explore the administration of this specialized therapy karanool to treat Fistula without any adverse effects globally.

***Keywords**: Karanool, Asura Maruthuvam, Powthiram, Fistula.*

I. INTRODUCTION

Siddha system of medicine has recognised surgery as one of its branches of treatment. Extensive references are seen in ancient tamil literature with regards to the various methods of treatment with surgical measures. In “Kambaramayanam” the following version reads as

“Udalidai thoondritru ondrai aruthadhan udhiram oothri

sudalura suttu veroor marunthinaar thruyaraththeervar”.

Another version in “Naalaiera divya pirapandam” read as

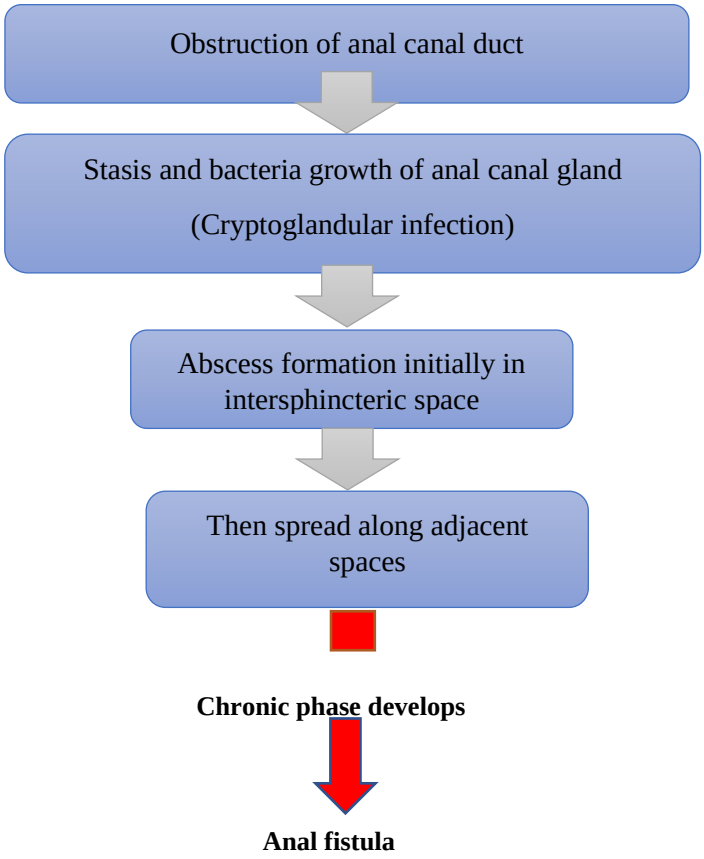
“Vaalaalaruthu sudinum maruthuvanpaal

Maalaadha kadhal nooyalan pola”.

These quotations evince that even from the very early period the practice of surgery was so popular in siddha system to tamilnadu.(5) Siddha medicine could be divided in three major divisions, which are Vinnavar maruthuvam (Devine medicine), Manidar maruthuvam (General medicine) and Asura maruthuvam (Surgical medicine). Devine medicine deals with chant and rituals, General medicine is based on internal medicines and external therapies, and the surgical medicine is deal with pre surgical, surgical & Para-surgical procedures and post-surgical practices in Siddha. The surgery in Siddha medicine is also incredibly primeval practices. Many ancient Tamil literatures and Siddha texts had mentioned of numerous evidence for practices on surgery in Tamil culture from primordial. Karanool is a chemical cauterization method used in treating anorectal problems in siddha. It is used to get rid of the non-viable tissues in the body and promote healing. (6) Fistula-in-ano is an abnormal communication between the anal canal or rectum and the perianal skin, which causes a chronic inflammatory response. Anatomically, fistulas are subdivided into two categories, internal and external. Internal fistulas are connections between two internal structures. A few examples of an internal fistula would be enterocolic, ileosigmoid, and aortoenteric. Alternatively, external fistulas form connections between an internal structure and external structure. Examples of this would be enterocutaneous, enteroatmospheric, and rectovaginal fistulas. When categorized physiologically, the fistula is differentiated based on fluid output. Low-output fistulas drain less than 200 ml of fluid per day, high-output fistulas drain greater than 500 ml of fluid per day, and medium-output fistulas fall between the two. (7,8,9) The prevalence of non-specific anal fistulae has been estimated to be 8.6 to 10/100,000 of the population per year, with a male to female ratio of 1.8:1.1(10) The most common cause is nearly always by a previous anorectal abscess. There is usually a history of recurrent abscess that ruptured spontaneously or was surgically drained.(11,12) The occurrence of such abscess is mostly secondary to infection of an anal gland (Cryptoglandular hypothesis of Eisen hammer).(13) Tuberculosis, lymphogranuloma inguinale, inflammatory bowel disease like Crohn’s or ulcerating proctocolitis can also lead to development of anal fistula. Throughout the surgical history fistula-in-ano has been a troublesome pathology to both patient and physician Fistulae have been reported following external injury or probing an abscess or low anal fistula.(14) More frequently, in the absence of acute suppuration, a fistula is seen as a draining sinus in the perineal area. A long history may result in the formation of several lateral secondary openings with a "watering-can" appearance. Digital rectal examination remains the main stay of diagnosis in anorectal fistula cases.(13) Commonly done

investigations in fistula-in ano are Sigmoidoscopy, Colonoscopy, Fistuloscopy, Endo anal/ endorectal ultrasound, Magnetic Resonance Imaging (MRI), Computerized Tomography Scan (CT scan), A barium enema/small bowel series, Fistuloscopy.(15) But thorough physical examination is most needed. This study elicits a case report of Fistula treated with karanool therapy. The patient recovered with complete excision of the tract in a period of two months. This research finding will lead to explore the administration of this specialized therapy karanool to treat Fistula without any adverse effects globally.

II. PATHOPHYSIOLOGY OF ANAL FISTULA



III. Materials and Methods

Ingredients

Papaya latex - Carica papaya

Nayuruviuppu - Achyranthes aspera

Manjal - Curcuma longa

Preparation of karanool: The Barbour's surgical linen thread (no 20) is tied on a hanger. Freshly collected latex of Papaya *(Carica papaya)* is soaked in a gauze piece and smeared over the thread and then hanger should be replaced into the cabinet at a temperature of 40°C for a period of 6 hours. This process is repeatedly done for 7 times. The above smeared thread coated with latex and then processed through fine powder of Nayuruviuppu *(Achyranthes aspera)* and repeated for 9 times. Similarly, the above

thread was smeared with fine powder of Manjal *(Curcuma longa)* for 11 times. Thus, the total number of coatings is done for 27 times.

Method of sealing

Each thread is removed from the hanger and folded in the Centre. It is then kept in a polythene bag of appropriate size and gently sealed. This thread is again put into sterile glass tube. Before sealing put a small silica bag into the glass tube because of little moisture is left inside the tube, will be absorbed by silica. The sealed tubes are again put into the cabinet and exposed to ultra- violet radiation.

Case Report

A 20 years old male patient came to the OPD of Aruvai Thol Maruthuvam department at National Institute of Siddha with complaints of Painful bowel movements and urination, Burning sensation present after defecation, Bleeding, A foul-smelling liquid oozing from a hole near the anus**,** mild discomfort present while sitting and lying posture since 1 week. Patient had no history of bleeding per rectum, mucus or any kind of discharge through the anus.

History of past illness

No history of Diabetes mellitus, Hypertension, Bronchial asthma, Tuberculosis.

Family history

No relevant family history

Local examination

Inspection

Patient had a small abscess present in 6 o'clock position of peri-anal skin in the midline gluteal region, and mild pus discharge present.

Palpation

A cord like structure present above the abscess to below the anal verge. Mild tenderness and pus discharge were present while palpating.

Fistula Probing

Probing was done and the length of the tract was measured to be 3.8 cm.

External opening present at 5 o'clock position, Internal opening present at 6 o'clock position.

Other Examinations

The patient was assessed for any other pathological conditions of the anal region, such as external pile mass, skin tag, anal fissure, rectal prolapse and perianal dermatitis. All other routine investigations such as CBC, blood sugar level, blood urea, serum creatinine, bleeding time, clotting time were within normal limit. HBsAg, HIV, HCV, **MANTOUX TEST** were found to be non-reactive.

IV. Treatment procedure

Pre - operative procedure

Enema was given at early morning on day to be operated. After proper bowel evacuation, patient was taken to recovery room and injected 2%xylocaine intradermal for sensitivity test. Operative procedure Under local anaesthesia, probe was inserted through the opening and the tract was traced till its blind end and another opening was made over the skin up to the tip of the probe. Caustic thread was inserted using malleable probe and thread was drawn from another opening. Tie the thread with three secure knots.

Post-operative

After finishing operative procedure patient was monitored up to 2 hours. Follow ups During the treatment period patient was asked to change the thread once in 7 days. Patient was kept under the OPD medication. The wound was cleaned and dressed twice a day. Duration of treatment the patient recovered with complete excision of the tract in a period of 1 month.

Surgical techniques and steps

Patients were put in lithotomy position and site of external opening/s located. An endoscope view of proctodaeum by proctoscope or anal speculum was performed in identify the internal opening and other associated lesion like haemorrhoids if present. Patient were operated under local/regional anaesthesia.

Application of Karanool

A long metallic malleable probe with an eye was introduced through the external opening and attempted to pass the tip of probe through the internal opening. Care was taken not to create false passage. The eye of the probe was threaded with Karam and probe was gently withdrawn, so the entire tract was threaded with medicated Karam. Following which the two ends of the thread were snugly tied using two knots outside the anal canal.

Subjective parameters Perianal disease activity index (PDAI)

Symptoms	Pre treatment	Middle of treatment	Post treatment
Pain/Restriction of activities	2	0	0
Discharge	1	1	0
Burning sensation	1	0	0
Tenderness	1	0	0
Degree of induration	0	0	0
Length of tract	3.8cm	1.8cm	0

Fig.1 Examination

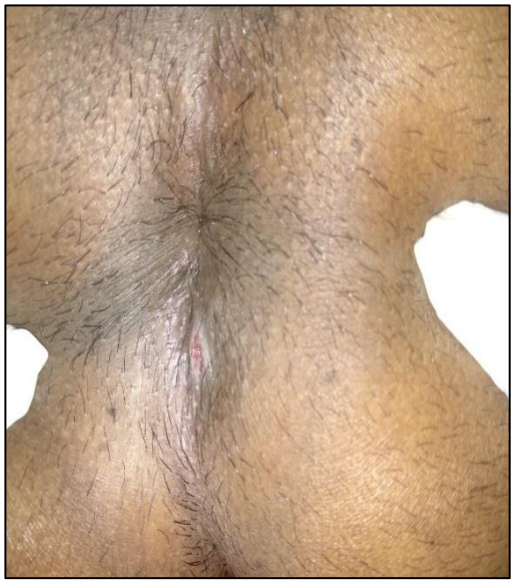


Fig.2 Fistula probing

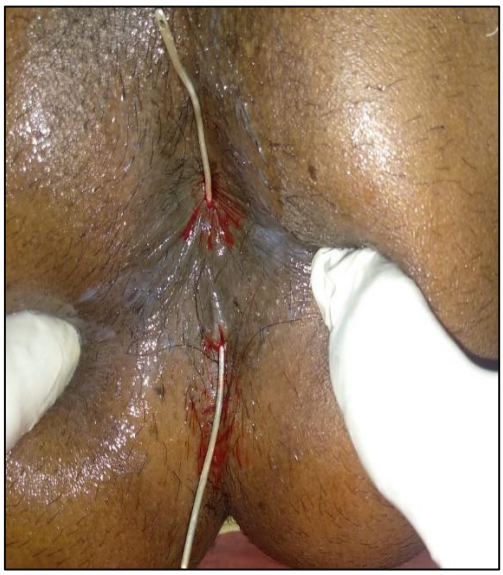


Fig .3 Primary treading

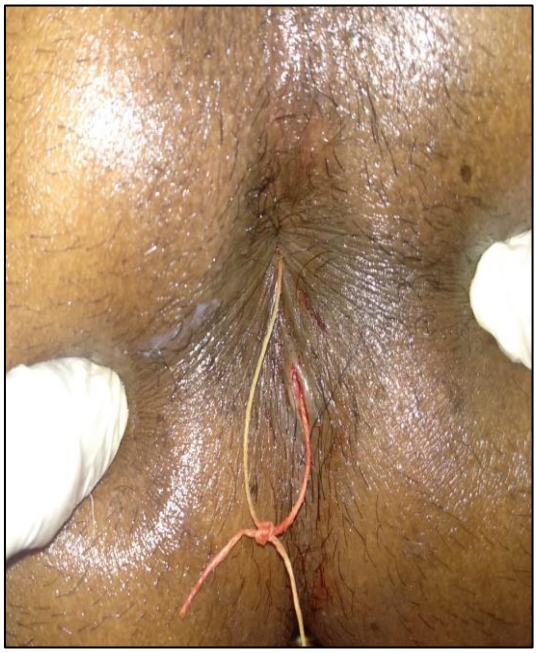
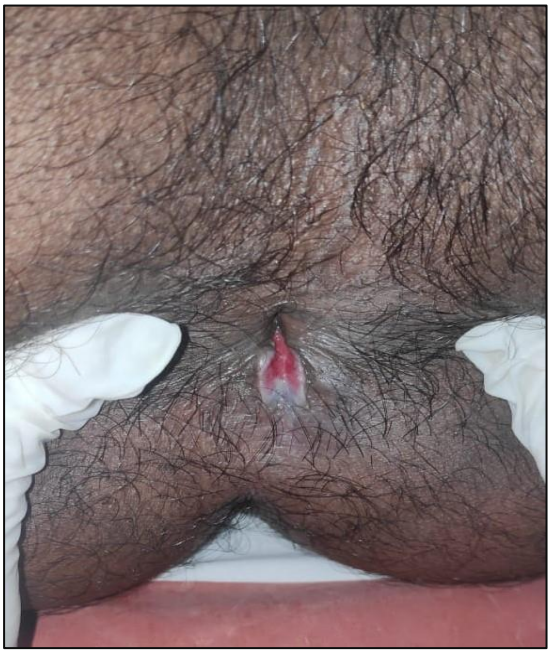


Fig.4 Cut through done, wounds start to heal



V. Result and discussion:

Karanool sigichai (Chemical cauterization) is a unique para surgical treatment carried out for the management of fistula-in-ano. It is a method of chemical cauterization of fistula. Achyranthus salt, Dalmia extensa salt etc. are smeared on a surgical thread which is used to cut the tract. The major advantages of this procedure are, it will preserve the function of continence and prevents the recurrence of the condition and also cost effective. This will open up a new scope of Siddha para- surgical procedure in Anal fistula.

VI. Conclusion

Although a number of surgical procedures are available for the treatment of anal fistula in modern science there is no assurance against its recurrence. The Karanool therapy seems to be a better option to prevent its recurrence and less painful than other surgical interventions.

VII. Recommendations

Thus, this therapy is strongly recommended for the treatment of anal fistula because it is simple, safe and cost effective. The efficacy of Karanool therapy in the management of peri anal fistula should be carried out in large number of subjects to reveal the undeniable success of this study.

VII. REFERENCE

1.Available: https://en.wikipedia.org/wiki/Siddha_medicine

2. Uthamaroyan CS. A compendium of Siddha doctrine. 2005;301-335.

3. Dr. K. S. Uthamaraayan Siddhar Aruvai Maruthuvam,

4. T.V Sambasivampillai dictionary, page no 490

5.Surgery in siddha system A.suresh and Velusamy Pgno -461

6.K.S.Uthamarayan,Siddhar aruvai Maruthuvam,1 st edition,2013, Published by Indian homoepathy medicine.

7.Ballard DH, Erickson AEM, Ahuja C, Vea R, Sangster GP, D'Agostino HB. Percutaneous management of enterocutaneous fistulae and abscess-fistula complexes. Dig Dis Interv. 2018 Jun;2(2):131-140

8.Rodrigues-Pinto E, Morais R, Macedo G. Combined over-the-scope clip and detachable snare placement for closure of an enterocutaneous fistula. Endoscopy. 2019 Sep;51(9):E247-E248.

9.Stevens TW, D'Haens GR, Duijvestein M, Bemelman WA, Buskens CJ, Gecse KB. Diagnostic accuracy of faecal calprotectin in patients with active perianal fistulas. United European Gastroenterol J. 2019 May;7(4):496-506.

10.Li B, Shamah S, Swei E, Chapman CG. Endoscopic closure of a refractory enterocutaneous fistula by use of a fistula plug with fixation and mucosal oversewing. VideoGIE. 2019 May;4(5):203-205.

11.Eisenhammer S (1966) The anorectal fistulous abscess and fistula. Dis Colon Rectum 9: 91-106

12.Babu AK, Naik MB, Babu MR, Madhulikia M. Seton - as a gold standard treatment for high fistula in ano. J Evidence Based Med Healthcare. 2015;2(11):1687-93.

13. Russel TR. Anorectum. In: Lawrence W, eds. Current surgical diagnosis and treatment. 10th edition. McGraw-Hill Companies; 1994.

14. Adams D, Kovalcik PJ. Fistula in ano. Surg Gynecol Obstet. 1981;153:731-2. 5. Gupta PJ. Frequency fistulotomy: a better tool radio frequency fistulotomy: a better tool than the conventional techniques in anal fistula. Indian J Surg. 2006;68:48-52.

15.Vasilevsky CA, Gordon PH. Benign anorectal: Abscess and Fistula. The ASCRS textbook of colon and rectal surgery. New York, NY: Springer; 2007:192-214.