MANAGEMENT OF POST OPERATIVE GUDAJ VIDRADHI (PERIANAL ABSCESS) ASSOCIATED WITH FOURNIER’S GANGRENE AND NECROTIZING FASCIAITIS WITH PANCHTIKTA GHRITA - A CASE STUDY

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INTRODUCTION

An anal abscess is an infected cavity filled with pus found near the anus or rectum. Ninety percent of abscesses are the result of an acute infection in the internal glands of the anus. Occasionally, bacteria, fecal material or foreign matter can clog an anal gland and tunnel into the tissue around the anus or rectum, where it may then collect in a cavity called an abscess. Fournier’s gangrene (FG) is a rare, synergistic, fulminant form of necrotizing fasciitis that involves the genital, perineal, and perianal regions. Its mortality rate remains high. Fournier’s gangrene was first described in 1883 in a review of five patients as a fulminant spreading infection of the subcutaneous tissues and superficial fascia of the scrotum and penis. It causes thrombosis in small vessels, obliterative endarteritis, and eventually skin and tissue necrosis. The dead or dying tissue in people with this type of gangrene is often found in the genitals and can stretch to the thighs, stomach, and chest.
CASE STUDY
A 28 years old male came to the shalya OPD no 116 of Parul Ayurveda Hospital, Vadodara, Gujarat with the complaints of pain in perianal region and high grade fever with chills along with lethargy and weakness with untolerable foul smell since 4 days. Upon physical examination a perianal abscess was identified. Furthermore, the perianal region was gangrenous with necrotizing fasciitis. A diagnosis of Fournier’s gangrene was made. After complete routine investigation and examination as per the protocol, I&D was planned under spinal anesthesia.

MATERIALS
- Surgical blade no. 11
- Artery forceps
- Fine scissors
- Pancha tikta ghrita

METHODS
Preoperative preparation:
- Written informed consent from the patient for surgery was taken
- 2% Inj. xylocaine sensitivity test.
- Part preparation of the patient.
- Administration of injection tetanus toxoid 0.5ml, I/M
- Preparation of operation theater and sterilization of instruments.

Operative procedure:
Under spinal anesthesia I&D done along with slough debridement done.
Wound cleaned and packed with pancha tikta gritha.

Post operative measures:
- Patient was kept NBM till complete waving off of the anesthesia, 6h for spinal anesthesia.
- General management- Recording of pulse, blood pressure and vital function done.
- After 1 day:
  - Dressing done with panchatikta gritha
  - Usnodaka avagaha( sitz bath) with Triphala Kwath twice daily was prescribed.
Internal medicines:
- Tb. Kaishora guggul 2-2-2
- Tb. Gandhaka rasayan 2-2-2
- Tb. Septilin 2-0-2
- Panchatikta ghrita 2tsf-0-2tsf

RESULT

Within the period of 28 days the wound was healthy and almost 80% healed. This was achieved without using any antibiotics and was cured with ayurvedic medicines.
DISCUSSION:
The syndrome of FG is an uncommon but quite serious problem. This entity affects both men and women and at a wide age range, from neonates to the very elderly. Despite this, the mean age of patients appears to range from 40 to 50 years. Our patient was 28 years old, which is in accordance to some recent reports of an decrease in the peak age incidence.

Earlier, FG was considered to be an idiopathic entity but nowadays the most common initial ports of entry are thought to be local trauma or extension of a urinary tract or perianal infection. With regards to the genitourinary tract, urethral strictures and transurethral instrumentation are the most
frequent etiologies, other causes include surgery of the penis and scrotum, transrectal prostate biopsy, urethral calculi, bladder cancer infiltrating the urethra, and phlebitis of dorsal penis vein. Anorectal sources of infection include ischiorectal, perianal, and intersphincteric abscesses, especially those inadequately treated. Diverticular perforation, carcinoma of the sigmoid colon and rectum, perforated acute appendicitis, internal hemorrhoids ligated with rubber bands, and anal dilatation, have also been reported in the etiology of FG. In our patient, a perianal abscess was found to be cause of FG.

The infection arises from bacteria inoculation in the perineal area. The bacteria most frequently isolated from FG are anaerobic Bacteroides fragilis, peptostreptococci, Clostridium and aerobic E. coli and streptococci. E. coli was identified in the pus in our patient.

The most common clinical features are perianal pain and swelling if the anorectal area is the portal of entry, whereas urinary retention, testicular, or scrotal pain are present if the infection launches from the genitourinary tract [8]. Other systemic manifestations such as fever, tachycardia, electrolyte imbalances, and hyperglycemia may also be present. Our patient was admitted to our hospital with pain in perianal region, high grade fever with chills along with lethargy and weakness with untolerable foul smell.

Once a diagnosis of FG has been established, the central principles of management are aggressive hemodynamic stabilization, within the period of 28 days the wound was healthy and almost 80% healed. This was achieved without using any antibiotics and was cured with ayurvedic medicines.

In order to ensure a successful outcome, the critical step is urgent and extensive surgical debridement. All frankly necrotic tissue and those with doubtful viability should be carefully debrided and excised.

Although the number of patients with FG has decreased due to medical progress, the mortality is still high. In patients presenting with sepsis, diabetes mellitus, and late admissions to the hospital mortality rates were found to be highest. Hospitalization for this disease is extremely long with a
reported average of six weeks. Our patient survived and was discharged 28 days after admission to the hospital, despite the severity of his condition and the negative prognostic factors.

CONCLUSION

Fournier’s gangrene represents a severe condition with a high morbidity and mortality. Therefore, an aggressive multidisciplinary management is mandatory, nutritional support and surgical debridement remain the cornerstone of the therapeutic approach.

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