

Clinical Evaluation Of Iftak Technique In The Management Of Complex Infrascrotal Fistula With Associated Ischioanal Abscess.

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ABSTRACT

Background - Complex fistula-in-ano represents a challenging anorectal disease and the management becomes even more challenging in rare cases of Infrascrotal Fistula in ano with ramified fistulous tracts with associated ischioanal abscess. The Interception of Fistulous Tract with Application of Ksharasutra (IFTAK) is a minimally invasive, sphincter-preserving modification of conventional Ksharasutra therapy that aims to shorten the treatment duration. The present case report reveals successful management of a rare case of complex infrascrotal fistula-in-ano along with ischioanal abscess using a multimodal treatment approach.

Methodology - A 26-year-old male presented with a two-month history of pain, swelling, intermittent purulent discharge, and burning sensation in the perianal region was diagnosed as infrascrotal transsphincteric fistula with an inverted Y-shaped ramified configuration and an associated left ischioanal abscess. Conventional Nadi Purana with Saindhavadi Taila was performed to establish patency of the ramified fistulous tract followed by IFTAK along with drainage of left ischioanal abscess. Postoperatively, broad-spectrum antibiotic coverage, analgesics internal Ayurvedic drugs and standard wound care was performed till complete healing of fistula. The patient was reviewed weekly for Ksharasutra changing and periodic assessment of wound healing.

Results - Interception of the fistulous tract reduced the Ksharasutra-bearing segment from 7.70 cm to approximately 3.43 cm, thereby decreasing the number of weekly Ksharasutra replacement sessions and shortening the anticipated treatment duration. The associated ischioanal abscess healed satisfactorily following drainage and postoperative wound care. Complete cut-through of the tract was achieved on postoperative Day 22, with complete wound healing by Day 50.

Conclusion - This case report of a complex infrascrotal fistula with associated abscess was successfully managed by integrative approach comprising of Nadi Purana with Saindhavadi Taila followed by IFTAK, drainage of the ischioanal abscess and periodic Ksharasutra ligation. The procedure resulted in fewer replacement sessions, shorten the treatment duration, sphincter preservation without recurrence...

Keywords: Fistula-in-ano; Infrascrotal fistula; IFTAK; Ksharasutra; Bhagandara; Nadi Puran....

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INTRODUCTION

Fistula-in-ano is one of the most challenging anorectal disorders encountered in surgical practice because of its recurrent nature and complexity. The incidence of anorectal diseases has increased considerably in recent years, largely due to unhealthy dietary practices, sedentary lifestyles, and altered living habits. *fistula* refers to an abnormal granulation tissue-lined tract that creates a communication between two epithelialized surfaces, most commonly the

anal canal and the perianal skin. ¹ Cryptoglandular infection of the anal glands is the principal etiological factor responsible for most cases of fistula-in-ano. ²

Other causes include inflammatory bowel diseases such as Crohn's disease and ulcerative colitis, tuberculosis, and a few less common pathological conditions.^{3,4} Clinically, patients usually present with persistent or recurrent mucopurulent discharge through one or more external openings around the anus, often accompanied by pain,

bleeding, recurrent abscess formation, and perianal discomfort.⁵ The prevalence of this condition is 8–23 per 100,000 people. Data confirm that 90% are cryptogenetic but IBD-associated lesions should always be considered because a mean prevalence of 4 per 100,000 people was recently calculated.⁶

In Ayurveda, fistula-in-ano can be co-related with *Bhagandara*. According to Acharya Sushruta, the disease begins as a painful perianal swelling (*Pidika*), which, if neglected or inadequately treated, suppurates and ruptures to form a sinus tract known as *Bhagandara*.⁷ Based on the predominance of *Doshas* and etiological factors, Acharya Sushruta classified *Bhagandara* into five varieties: *Shatapornaka*, *Ushtragreeva*, *Parisravi*, *Shambukaavarta*, and *Unmargi*.⁸ Owing to its difficult management and tendency to recur, *Bhagandara* has been included among the *Ashta Mahagada* (eight grave diseases) in Ayurveda.⁹

Several surgical techniques are currently available for the management of fistula-in-ano, including fistulotomy, fistulectomy, seton placement, ligation of the intersphincteric fistula tract (LIFT), VAAFT, endorectal advancement flap (ERAF), FiLaC, and other sphincter-preserving procedures.^{10,11,12,13,14} Nevertheless, recurrence and postoperative complications continue to remain significant therapeutic concerns.¹⁵

Ksharsutra therapy is a well-established Ayurvedic minimal invasive procedure in which a linen thread is repeatedly coated with herbal latex, alkaline preparations, and medicinal powders. This sphincter-preserving technique promotes gradual debridement, drainage, fibrosis, and healing of the fistulous tract while minimizing recurrence and postoperative fecal incontinence.¹⁶ The medicated thread is passed through the tract after proper probing, allowing continuous drainage and progressive obliteration of the fistulous channel without extensive tissue excision.¹⁷ Further its proven efficacy, conventional Ksharsutra therapy requires prolonged treatment, repeated sittings, and is often associated with persistent discharge and patient discomfort. To address these limitations, the Interception of Fistulous Tract and Application of Ksharsutra (IFTAK) technique was developed.¹⁸ By intercepting the fistulous tract at the level of intersphincteric groove and applying Ksharsutra only to the proximal segment of fistulous tract connected to the anal canal, IFTAK facilitates effective drainage while allowing the distal tract to heal naturally. This modification reduces tissue trauma, shortens treatment duration, and improves patient comfort, making it particularly useful in complex and recurrent fistula-in-ano.¹⁹

The present article describes the successful management of a complex infrascrotal fistula using the IFTAK technique, highlighting its clinical efficacy and favorable healing outcome.

Patient Information

A 26-yrs male presented to the Department of Shalya Tantra, with complaints of pain and swelling in the perianal region associated with intermittent purulent discharge and burning sensation for the past two months. The symptoms had an insidious onset and gradually progressed in severity,

causing significant discomfort during daily activities. The patient had initially received conservative treatment, but experienced only temporary symptomatic relief.

There was no history of previous anorectal surgery, tuberculosis, Crohn's disease, ulcerative colitis, diabetes mellitus, or any other major systemic illness. The patient had no known drug allergies. His bowel and bladder habits were normal, appetite and sleep were adequate, and there was no history of smoking or alcohol consumption. Family history was non-contributory except for diabetes mellitus in both parents.

Clinical Findings -General and systemic examination was not significant for any systemic illness.

Local examination revealed an external fistulous opening in the right anterior infrascrotal region, approximately 10 cm from the anal verge, with intermittent purulent discharge. An associated abscess cavity measuring approximately 3 × 2 cm with surrounding induration and tenderness was noted in the right perianal region. Digital rectal examination demonstrated normal sphincter tone, and the internal opening was palpated at the 12 o'clock position. Gentle probing confirmed a communicating fistulous tract.

MRI fistulography revealed a T2/STIR hyperintense transsphincteric fistulous tract measuring approximately 5.5 mm in width and 7.7 cm in length arising from the right anterior infrascrotal region. The diagrammatic representation of the MRI along with labelling and track course has been mentioned in figure 01.

As per the MRI reports it was seen that the tract bifurcated into an inverted "Y"-shaped configuration; the medial branch traversed both anal sphincters to open internally at the 12 o'clock position, while the lateral branch extended into the right ischioanal space, forming an infective collection measuring 4.3 × 1.3 × 2.5 cm. The fistula was classified as St. James's classification Grade 3 Trans-sphincteric fistula with abscess cavity as per MRI. Based on the clinical examination and radiological findings, the patient was diagnosed as a case of high complex trans-sphincteric Infrascrotal fistula and the patient was planned for surgical management after pre-operative investigation, pre-anesthesia clearance and physicians fitness as per the institution protocol. The routine investigations along with pus culture and sensitivity have been mentioned in table no 1.

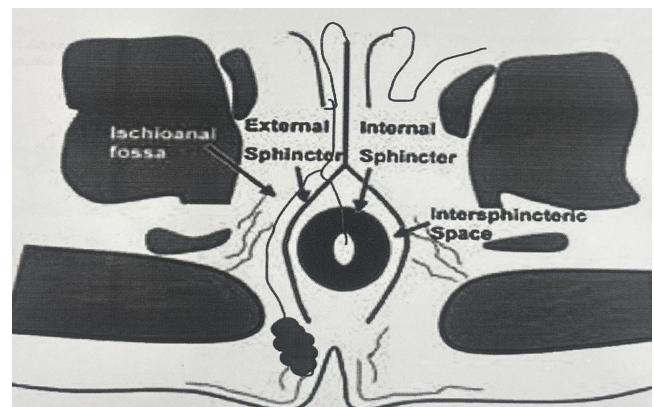


Figure.01 – Diagrammatic Illustration of the MRI Fistulogram and track course.

Table No 1. Pre-operative Investigations

Investigation	Result
Hemoglobin	16.0 g/dL
Total Leukocyte Count	8,500 cells/mm ³
ESR	45 mm/hr (Raised)
Platelet Count	3.47 lakh/mm ³
Random Blood Sugar	80 mg/dL
Blood Urea	30 mg/dL
Serum Creatinine	1.4 mg/dL
Total Bilirubin	0.4 mg/dL
AST (SGOT)	22.8 IU/L
ALT (SGPT)	19.4 IU/L
HIV I & II	Non-reactive
HBsAg	Negative
Anti-HCV	Non-reactive
Bleeding Time	2 min 05 sec
Clotting Time	5 min 30 sec
Pus Culture & Sensitivity	Growth of <i>Escherichia coli</i> ; sensitive to Ciprofloxacin, Ceftriaxone, Ceftazidime, Meropenem and Amikacin; resistant to Cefixime and Cefuroxime.

Therapeutic Interventions

The patient was managed with a multimodal treatment approach comprising of *Nadi Puran* with *Saindhavadi Taila* twice a day to ensure the patency of the fistula track followed by the operative procedure of Ksharasutra ligation using the IFTAK (Interception of Fistulous Tract with Application of Ksharasutra) technique under Spinal Anesthesia. Borad spectrum IV antibiotic Inj. Augmentin (amoxicillin 1000mg and clavulanic acid 200mg), Inj-Metronidazole-500mg IV thrice a day for 3 days followed by oral antibiotic Tab. Clavum (amoxicillin 500mg and clavulanic acid 125mg), Tab Metrogyl-ER-600mg 1tab twice daily and Analgesic Tab-Diclofenac 50mg + Paracetamol 325mg + Serratiopeptidase 15mg) once during morning and evening for 3 days was given to the patient.

Along with the standard regimen adjuvant internal Ayurvedic medications such as *Triphala Guggulu* 360mg, *Gandhak Rasayana* 350mg and *Sanshamani Vati* 140mg twice a day Morning and Evening after food was advised for a duration of 30 Days. For laxative in post operative phase *Gandharva haritaki churna* 5gms at night with warm water was also prescribed until resolution of symptoms. The patient was assessed periodically throughout the treatment using predefined clinical parameters, including pain, pus discharge, and fistula tract length. The details of the assessment have been mentioned in table no 02. The therapeutic interventions, regimen, and duration has been mentioned in table no.03. The Clinical timeline of the events has been mentioned in Table.no.4.

Table no 2-Assessment Criteria

Assessment Parameter	Grade 0	Grade 1	Grade 2	Grade 3
Pain (VAS Score) ²⁰	0	1–3	4–6	7–10
Pus discharge (Grading of Wound Exudate (adapted from BWAT Bates-Jensen Wound Assessment Tool) ²¹	0 None (No visible discharge from the external opening)	1 Scant (Minimal discharge, occasional staining)	2 Moderate (Noticeable Serosanguineous discharge)	3 Copious (Profuse purulent discharge)
Residual fistula tract length (cm) ²²	Complete healing (0 cm)	≤2.5 cm	>2.5–5.0 cm	>5.0 cm

Table 3. Therapeutic interventions, regimen, and duration.

Treatment phase	Therapeutic intervention	Regimen	Duration
Preoperative	<i>Nadi Puran</i> with <i>Saindhavadi Taila</i>	Local administration, once daily	4 days
Operative	Ksharasutra ligation (IFTAK technique)	Tract interception and Ksharasutra application under spinal anaesthesia	Single procedure
Postoperative	IV antibiotic therapy	Inj-Amoxicillin 1.2 g + clavulanic acid 200 mg IV BD + Inj-Metronidazole 500 mg IV TDS	3 days
	Oral antibiotic therapy	Amoxicillin 500 mg + clavulanic acid 125 mg BD + Metronidazole Extended release-600 mg BD after food	3 days
	Anti-inflammatory therapy	Diclofenac 50 mg + paracetamol 325 mg + serratiopeptidase 15 mg BD	3 days
	Adjunctive therapy	Trypsin + chymotrypsin BD; Ascorbic acid 500 mg OD	10 days
	Ayurvedic adjuvant therapy	<i>Triphala Guggulu</i> 360 mg × 2 BD; <i>Gandhak Rasayan</i> 350 mg × 2 BD; <i>Shanshamani Vati</i> 140 mg × 3 TDS	30 days
	Bowel regulation	<i>Gandharva Haritaki Churna</i> 5 g HS	30 days
Ksharasutra Changing			Weekly once
Wound care	Dressing and sitz bath	With Povidone-iodine followed by topical Metrogyl -P ointment; lukewarm-water sitz bath for 10 min after defecation	Until complete wound healing
Clinical monitoring	Clinical assessment	Pain, pus discharge, fistulous tract length and wound healing	Throughout treatment

(Note: BD-Twice a day; OD-Once a day; TDS-Three times a day; HS- At Bedtime)

PROCEDURAL DETAILS -

1-Standard Operating Procedure of Nadi Puran with Saindhavadi Taila²³

Purva Karma (~preoperative procedure):

Baseline vital parameters were recorded. The patient was placed in the lithotomy position, and the perianal region was prepared under aseptic precautions. A sterile 5 mL disposable syringe filled with Saindhavadi Taila and fitted with an appropriate irrigation cannula was kept ready for the procedure.

Pradhana Karma (~procedure):

After cleansing the perianal region with povidone-iodine solution, *Saindhavadi Taila* was gently instilled through the external opening of the fistulous tract using the sterile syringe fitted with an irrigation cannula. The passage of the oil through the corresponding internal opening was observed to confirm communication of the fistulous tract. The procedure was then repeated in the reverse direction by instilling *Saindhavadi Taila* through the corresponding opening, thereby confirming the continuity and patency of the fistulous tract.

Paschat Karma (~postoperative procedure):

Following completion of the procedure, sterile gauze packing was placed over the external opening to absorb any residual oil draining from the fistulous cavity or tract. The perianal region was then covered with a sterile dressing.

2-Operative Procedure of Ksharasutra Ligation (IFTAK Technique)

Purva Karma (~preoperative procedure):

After obtaining written informed consent, the patient was kept nil per oral and shifted to the operating theatre. Under spinal anaesthesia, the patient was placed in the lithotomy position. Foley catheterization was performed, and the perianal region was painted and draped under strict aseptic precautions.

Pradhana Karma (~operative procedure):

Following examination under anaesthesia, the primary external opening was identified in the anterior infrascrotal region at the 12 o'clock position, approximately 10 cm from the anal verge. A secondary external opening with an associated abscess cavity was identified at the 9 o'clock position. Instillation of povidone-iodine solution through the abscess cavity demonstrated communication with the primary external opening and the internal opening at the 12 o'clock position in the anal canal.

The fistulous tract was gently probed through both external openings to confirm the communicating tract. Plain setons were initially passed through the tract to delineate its course. An interception incision was then made in the intersphincteric plane, and the primary fistula tract was isolated. The tract was subsequently intercepted, and *Ksharasutra* was ligated through the intercepted proximal segment connected to the anal canal at the 12 o'clock position, and the abscess cavity at the 9 o'clock position was adequately drained. The previously placed plain seton in the intercommunicating track was then replaced with *Ksharasutra* to facilitate continuous drainage and gradual cut-through of the fistulous tract. Haemostasis was achieved, following which the operative field was

thoroughly irrigated with povidone-iodine solution and a sterile dressing was applied.

Paschat Karma (~postoperative procedure):

Following completion of the procedure, the patient was shifted to the recovery room and monitored for

haemodynamic stability, postoperative bleeding, and pain. The patient was subsequently shifted to the ward after satisfactory recovery from anaesthesia.

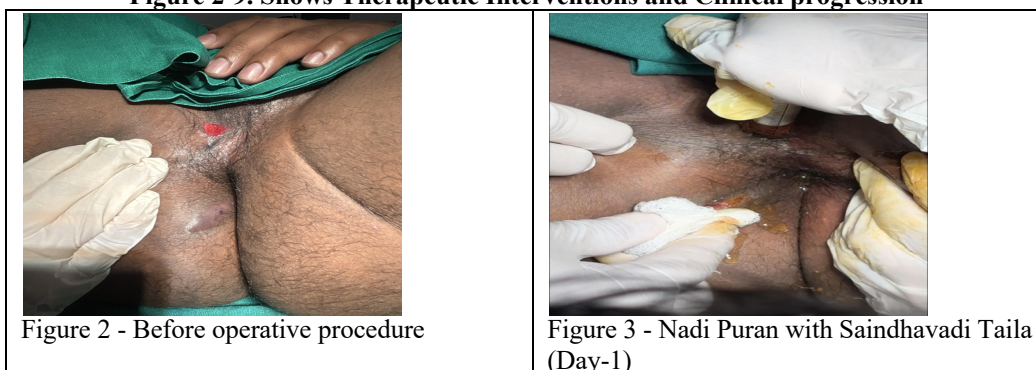
Timeline

The clinical events in the case are described in Table 04.

Table 4. Timeline of clinical events

Treatment week	Date	Clinical events
Pre-treatment	February 2026	The patient was diagnosed with infrascrotal fistula-in-ano during an OPD consultation. Regular follow-up was advised, along with preoperative investigations and fitness assessment for definitive comprehensive management.
Pre-treatment	February–April 2026	Regular follow-up consultations were undertaken, and advised preoperative investigations and fitness assessment were completed.
Week 0	April 30, 2026	The patient was admitted for definitive management of infrascrotal fistula-in-ano. <i>Nadi Puran</i> with <i>Saindhavadi Taila</i> was initiated.
Week 0–1	April 30–May 03, 2026	<i>Nadi Puran</i> with <i>Saindhavadi Taila</i> was performed daily to facilitate restoration of patency through the fibrosed segment of the fistulous tract prior to definitive surgical intervention.
Week 1	May 04, 2026	<i>Ksharasutra</i> ligation using the <i>IFTAK</i> technique was performed under spinal anaesthesia. The fistulous tract was delineated and intercepted, followed by <i>Ksharasutra</i> ligation, and drainage of the associated abscess cavity as indicated.
Week 1	May 04–08, 2026	Postoperative pharmacological therapy was administered as per the therapeutic regimen described in Table 3.
Week 1–5	From May 04, 2026	Ayurvedic internal medication was administered as per the therapeutic regimen described in Table 3.
Week 2	May 11, 2026	First <i>Ksharasutra</i> change was performed.
Week 3	May 18, 2026	Second <i>Ksharasutra</i> change was performed.
Week 4	May 25, 2026	Complete cut-through of the fistulous tract was observed. The <i>Ksharasutra</i> was removed, and a plain seton was ligated to facilitate healthy granulation of the residual wound.
Week 5–7	May 30 – June 15, 2026	Postoperative wound care and dressing were performed on May 30, June 04, June 08, and June 15. Progressive wound healing was observed.
Week 8	June 22, 2026	Complete wound healing was observed on clinical examination

Figure 2-9. Shows Therapeutic Interventions and Clinical progression





The patient was reviewed at regular follow-up visits. Clinical outcomes were assessed using predefined grading criteria (0–3 scale) based on pain in the perianal region, pus discharge from the external opening, and fistula tract length. The assessment parameters and grading criteria are presented in Table no.2. The VAS score decreased from 3 at baseline to 0 by Week 5, while pus discharge gradually reduced from grade 3 to complete resolution at the final

assessment. Reduction in tract length from 3.43 cm to complete cut-through by Week 3, followed by healthy granulation, wound healing, and complete healing without continence impairment or recurrence during follow-up. The clinical outcome assessment during follow up has been mentioned in Table.no 5 and Clinical progression of complex Infrascrotal fistula-in-ano during treatment showed in Figure-2 to Figure-9.

Table No 5- Clinical Outcome Assessment During Follow-up

Follow-up	Pain (VAS Grade)	Pus Discharge	Residual Tract Length
Baseline	3	3	3.43 cm
Week 1	2	3	2.15 cm
Week 2	2	3	1.20 cm
Week 3	1	2	Complete cut-through
Week 4	1	2	Healthy granulation
Week 5	0	1	Wound healing

Final Follow-up	0	0	Complete healing
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FOLLOW UP AND OUTCOMES

The patient was followed up weekly for *Ksharasutra* replacement and clinical assessment until complete cut-through of the intercepted fistulous tract, followed by regular wound evaluation until complete healing. At each follow-up visit, pain intensity (Visual Analogue Scale [VAS]), pus discharge, residual tract length, wound healing, continence status, and recurrence were assessed. Preoperative magnetic resonance imaging (MRI) demonstrated a 7.70-cm complex transsphincteric fistulous tract. Following interception using the *IFTAK* technique, the *Ksharasutra*-bearing tract was reduced to approximately 3.43 cm. Progressive clinical improvement was observed throughout the treatment period. Pain decreased from VAS Grade 3 at baseline to Grade 0 by Week 5, while pus discharge progressively diminished and was completely absent by the final follow-up. The residual tract length decreased from 3.43 cm at baseline to 2.15 cm in Week 1 and 1.20 cm in Week 2, with complete cut-through achieved on Day 22 (25 May 2026). Subsequently, the *Ksharasutra* was removed and replaced with a plain seton to facilitate healthy granulation tissue formation. Complete wound healing was documented on Day 50 (22 June 2026), with preservation of anal continence and no postoperative complications or recurrence during the follow-up period.

Unit Cutting Time (UCT): The UCT, calculated as the time required for complete cut-through divided by the length of the *Ksharasutra*-bearing tract, was 6.41 days/cm (22 days ÷ 3.43 cm). The reduction in the *Ksharasutra*-bearing tract length from 7.70 cm to 3.43 cm following the *IFTAK* procedure shortened the duration of *Ksharasutra* therapy while maintaining effective tract healing and preserving sphincter function, hence reduced the duration of the whole treatment with a proper drainage of associated abscess, with adjuvant ayurvedic treatment like *nadipurana* with *saindhavadi oil* with internal ayurvedic medications has definitely facilitated the treatment, yielding successful results.

DISCUSSION

Complex fistula-in-ano remains one of the most challenging anorectal disorders because successful treatment requires complete eradication of the fistulous tract while preserving anal sphincter function. Long transsphincteric tracts, secondary extensions, and associated abscesses increase the risk of recurrence and postoperative continence impairment following conventional surgical procedures. Consequently, sphincter-preserving procedures have gained increasing acceptance in the management of complex fistula-in-ano owing to their ability to eradicate sepsis while minimizing sphincter injury.²⁴

The present case involved a rare complex anterior infrascrotal transsphincteric fistula with an inverted Y-shaped branching tract and an associated ischioanal abscess, which posed significant diagnostic and surgical challenges. MRI fistulography accurately delineated the

complex fistulous anatomy, enabling appropriate surgical planning. In addition, preoperative *Nadi Puran* with *Saindhavadi Taila* restored the patency of the fibrosed tract, facilitating identification of the communicating tract and internal opening during surgery. Following restoration of tract patency, the Interception of Fistulous Tract with Application of *Ksharasutra* (*IFTAK*) technique allowed interception of the tract close to the primary source of infection, thereby reducing the length of the tract requiring *Ksharasutra* therapy while preserving the anal sphincter.²⁵ A notable finding in this case was the reduction of the original MRI-demonstrated fistulous tract length from 7.70 cm to an intercepted *Ksharasutra*-bearing segment of approximately 3.43 cm following the *IFTAK* procedure. This modification enabled complete cut-through of the intercepted tract within 22 days, corresponding to a Unit Cutting Time (UCT) of 6.41 days/cm, followed by progressive wound healing and complete epithelialization. Serial follow-up demonstrated gradual reduction in pain, complete resolution of purulent discharge, preservation of anal continence, and absence of recurrence during the observation period. These findings support the principle that interception reduces the tract length requiring medicated thread therapy while maintaining effective drainage and infection control, thereby potentially shortening the overall treatment duration.

Adjunctive Ayurvedic medications were prescribed throughout the postoperative period as supportive therapy. *Triphala Guggulu* possesses antimicrobial, antioxidant, and anti-inflammatory properties that may promote wound healing, whereas *Gandhak Rasayana* has traditionally been used for its wound-healing and *Kledaghna* (~reduction of abnormal wound discharge) effects. Sanshamani Vati, containing *Tinospora cordifolia*, has demonstrated anti-inflammatory, antioxidant, antimicrobial, and immunomodulatory activities that may facilitate postoperative recovery. *Gandharva Haritaki* Churna helped maintain regular bowel evacuation, thereby minimizing straining during defecation and reducing mechanical stress on the healing wound. Although the individual contribution of these medications cannot be established from a single case, their use as adjunctive therapy may have supported the favourable postoperative outcome observed in this patient.²⁶⁻²⁹

The strengths of this report include MRI-confirmed delineation of a rare complex infrascrotal fistula, objective serial assessment of pain, wound discharge, and tract length, and documentation of complete healing without continence impairment or recurrence during follow-up. However, this report represents the outcome of a single patient with a limited follow-up period. Therefore, the findings should be interpreted with caution, and larger prospective comparative studies are required to establish the long-term efficacy, reproducibility, and functional outcomes of the *IFTAK* technique.

This case highlights that interception of the fistulous tract before Ksharasutra application can substantially reduce the length of the tract requiring medicated thread therapy while preserving anal sphincter integrity. In carefully selected patients with complex infrascrotal transsphincteric fistula-in-ano, the IFTAK technique may provide effective infection control, shorter treatment duration, and favourable functional outcomes, warranting further evaluation in larger clinical studies.

CONCLUSION

This case highlights the successful management of a rare and highly complex infrascrotal fistula-in-ano characterized by a Y-shaped configuration, multiple ramified tracts, and an associated large ischioanal abscess. A multimodal approach was adopted, beginning with *Nadipurana* using *Saindhavadi Taila* to establish the patency of the ramified tract, followed by the IFTAK technique to intercept the primary tract. This reduced the Ksharasutra-bearing tract length from 7.70 cm to 3.43 cm, thereby minimizing the duration of Ksharasutra therapy and facilitating with minimal hospital stay and faster healing. Simultaneous drainage of the ischioanal abscess, together with appropriate adjuvant Ayurvedic internal medications, contributed to tissue healing. The patient achieved complete healing within 50 days, with a favorable Unit Cutting Time (UCT) of 6.41 days/cm, preservation of continence, and no recurrence during follow-up. This case demonstrates that a strategically planned combination of Nadipurana, IFTAK, Ksharasutra therapy, abscess drainage, and adjuvant Ayurvedic management can be a safe, effective, and sphincter-preserving treatment for selected cases of complex Infrascrotal fistula-in-ano. Nevertheless, further studies with larger sample sizes and longer follow-up are required to validate these findings and establish their broader clinical applicability.

Patient Perspective

"I experienced persistent pain, recurrent swelling, and intermittent purulent discharge from the perianal region, which caused significant discomfort during sitting and routine daily activities. After the treatment I noticed gradual relief from pain and complete resolution of discharge. The wound healed progressively during follow-up, and I was able to resume my normal daily activities without difficulty. I did not experience any impairment of bowel control or recurrence of symptoms during the follow-up period. Overall, I am satisfied with the treatment and its outcome."

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Conflicts of interest

There are no conflicts of interest...

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IJDDT, Volume 16 Issue 83s, 2026

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