Two stage operative management of horseshoe fistula in ano – A case report

ABSTRACT:

Introduction: Horseshoe fistula in ano presents unique clinical challenges due to its involvement with the sphincter muscle and its intricate configuration. This condition may result in anal sphincter incontinence and higher recurrence rates, making operational care particularly demanding. This case report highlights the successful management of a complex horseshoe fistula, emphasizing the operative strategy to preserve continence while achieving complete healing. **Patient's Main Concerns and Clinical Findings:** The patient, a 30-year-old male, presented to the *Shalyatantra* OPD with complaints of recurrent perianal boils, pain, and pus discharge for one and a half months. Perianal examination revealed multiple external openings bilaterally, and digital rectal examination indicated an internal opening at the 6 o'clock position. Trans-rectal ultrasonography (TRUS) confirmed a horseshoe fistula with a 15–16 cm long branching tract and external openings at 8, 4, and 2 o'clock positions, with the internal opening located 10 mm proximal to the anal verge between 6 and 7 o'clock positions. The case was classified as grade II according to the Pankaj Garg classification. **Primary Diagnosis**: Horseshoe fistula in ano with grade II classification as per Pankaj Garg system. **Interventions**: **Stage 1**: A patency test and probing were performed to confirm the fistula's path and depth, followed by partial fistulectomy and strategic incisions. A simple Barbour linen thread was used to maintain sphincter integrity and drainage. **Stage 2**: Six weeks post-first-stage surgery, further steps were taken to reduce the number of *Ksharasutras* and size of the wound. Wound management was carried out to promote healing and maintain continence. Weekly changes of *Ksharasutra* were performed using the railroad technique. **Outcomes**: The wound healed completely within nine weeks. Sphincter integrity was preserved, and there was no incidence of incontinence. Minimal scarring was observed. **Conclusion:** This case demonstrates that a structured two-stage operative approach for horseshoe fistula in ano can effectively manage the condition, preserve sphincter function, and minimize recurrence. The use of *Ksharasutra* in combination with staged surgical intervention provides a successful and reliable treatment modality, highlighting the importance of individualized care in complex fistula cases.

Keywords: *Bhagandara*, Horseshoe fistula, Incontinence, *Ksharsutra*, Two stage operation, Case Study

Introduction

Fistula- in-ano is a chronic abnormal track lined by granulation tissue. It connects externally to the perianal skin and internally to the anal canal or rectum. According to the crypto glandular theory, fistula in ano is caused by the sudden bursting of an ano-rectal abscess. [1] The primary etiology of Horse-shoe fistula is an ischio-rectal abscess. Purulent discharge originating from the ischiorectal spaces passes through the sphincters and spreads towards the anterior and lateral sides, affecting both the ischiorectal fossa. This track is observed to have a communication pathway located posterior to the anus, resembling the shape of a 'Horse pedal' or a 'Horse-shoe'. In certain instances, two external openings are visible on both sides of the perianal area, whereas the internal opening is located at the posterior midline (6 o'clock position). [2]

Ayurvedic texts extensively discuss this condition as *Bhagandara*. *Bhagandara* (~fistula-in-ano) is considered one of the eight serious diseases, known as *Ashtamahagada*, due to its notorious nature.[3] The term *Bhagandara* (~fistula-in-ano)literally means *Darana* (~splitting/piercing) around *Guda* (~anus), *Yoni* (~vagina), *Basti* (~urinary bladder). Initially, it resembles a *Pidaka* (~boil), but when it bursts, it becomes manifest as *Bhagandara* (~fistula-in-ano). [4] Based on the signs and symptoms described in the literature, a horseshoe fistula in ano can be associated with *Parikshepi Bhagandara*. [5]

Conventional surgical treatment of simple fistulas is relatively safe and widely accepted in clinical practice. In cases of complex fistula, treatment modalities include advancement flap techniques, seton application, de-roofing, fistula plug, fistula-tract laser closure and video-assisted anal fistula treatment. The ultimate aim of such treatment is complete eradication of fistulous tract, should not compromise with the anal sphincters and prevention of recurrence. Horseshoe fistula is complex due to sphincter involvement, operative surgery might lead to compromised function of sphincter muscle. As the wound is placed in the anal area, it is more prone to infection, hence takes considerable time to heal and the condition remains troublesome. An operational technique often leads to problems such as recurrences and fecal incontinence. [6] Despite above mentioned multiple treatment approaches, seton application has been widely accepted as it helps in slowly diving the tract and sphincter muscle by preventing retraction of sphincter ends through its sphincter saving approach.[7] In Ayurveda, seton has been replaced through '*Ksharasutra'* application which act as seton along with additional chemical actions locally. It is simple, minimally invasive, debride the unhealthy tissue in the track and also helps in preservation of surrounding healthy tissues. [8]

Ksharasutra, a cotton thread covered with the latex of *Snuhi* (*Euphorbia nerifolia* Linn.), powder of turmeric (*Curcuma longa* Linn.), and *Apamarga Kshara* (alkaline powder of *Achyranthes aspera* Linn). A study has been done in a large number of patients and established the treatment as an effective, ambulatory, and safer alternative treatment for patients with fistula in ano. [9] The effectiveness studies reported total recurrence rate of 5.88%. [10]

The Indian Council of Medical Research (ICMR) had validated this therapy and emphasized that *Ksharasutra* is better than the conventional surgery in fistula in ano. [11] Every therapy has its own limits. Application of *Ksharasutra* in cases with complex, posterior horseshoe fistula when the length of track is approximately 15 – 16 cm is not only challenging in discovering appropriate route of track but also entire therapy takes very much time to heal as well. Hence, this type of situation can be treated with combination technique of surgery and *Ksharasutra*.

In light of the aforementioned information, this study was designed to address the challenges encountered in managing *Bhagandara*. The study utilized a combination of the traditional *Ksharasutra* technique and a two-stage surgical method to effectively manage complex posterior horseshoe-shaped fistula-in-ano.

Patient Information

A 30 year old male patient came to the outpatient department (OPD) of *Shalya Tantra*, with complaints of multiple boils with pus discharge in perianal region and throbbing pain in ano since 1.5 year. The patient was a cook by profession and does not have a history of any addiction. Vitals were normal. He was incidentally diagnosed Type 2 diabetes mellitus during pre op investigation and started Metformin 500mg once daily under prescription by physician. No significant family and psychosocial history were found.

Clinical Findings

Peri-Anal Examination: On inspection, multiple external openings were noted on the perianal region. Two external openings on the left side, one at 2 o'clock and second at 4 o'clock position and a third external opening on the right side at 7 o'clock position. On palpation, there was marked induration associated with tenderness in the course of tract involving post anal space. On digital examination, internal opening was felt at 6o'clock position and one papilla was found at 9 o'clock position. On proctoscopic examination, internal opening was seen at 6 o'clock and papilla at 9 o'clock.

Timeline

Timeline of the present case is depicted in table 1, table 2 and table 3.

Diagnostic Assessment

Investigations: Hematological, biochemical and urine investigations including bleeding time, clotting time, blood count, blood urea, serum creatinine, random blood sugar, post prandial blood sugar, HIV, HbsAg, VDRL, HCV and urine routine were done, PPBS was raised that was 260 mg/dl, rest investigations were within normal limits. Patient was advised for Trans-rectal-ultra-sonography (TRUS). TRUS showed 15 to 16 cm long horse-shoe shaped branching fistula in perianal region with three external openings at 8 o' clock, 4 o' clock & 20' clock positions & internal opening between 6 to 7 o'clock positions. Internal opening was 10 mm proximal to anal verge. Maximum width of the fistula was 7 mm. Maximum depth of the fistula was 16 mm. Hence, based on clinical observations and TRUS, the case was diagnosed as complex, trans-sphincteric and posterior horseshoe fistula in ano [Figure 1 and Figure 2].

Therapeutic Intervention

It is Two-stage surgery for horse-shoe fistula-in-ano.

Pre-Operative Procedure: After all routine investigation, physician's reference was taken. Prior informed written consent was taken, xylocaine sensitivity test was done with Inj. xylocaine 2% ID [1 ml diluted in 10 ml distilled water] and prophylactic dose of tetanus was given through IM route. Part preparation was done. Proctolysis enema was given and patient was advised nil by mouth (NBM) 12 hour before operation.

Operative Procedure: Pre and post-operative measures were adopted as per standard surgical procedures. [12] After obtaining written informed consent, under aseptic precautions, spinal anesthesia was given. Patient was made to lie in lithotomy position. Painting was done with aseptic and antiseptic solution followed by sterile draping [Figure 3]. Patency test was done from external opening at 7 o'clock to know the depth and direction of the track with betadine and H_2O_2 solution which came out from internal opening at 6 o'clock. After identifying the course of the track, probing was done from 7 o'clock and probe came out from internal opening at 6 o'clock. Once the fistula tract was identified, incision was taken as a "T" portion of the fistula tract within the deep post anal space and partial fistulectomy was carried out through the posterior sphincter complex to the primary internal opening at 6 o'clock and

window was created at deep post anal space for draining of both the tracks. Simple plain Barbour linen thread was kept to partial fistulectomy wound of the primary tract from 6 o'clock internal opening to window created at deep post anal space (internal to external track) [Figure 4]. The simple plain Barbour linen thread allowed preservation of the external and distal internal sphincter muscles overlying the primary fistula tract. Later the lateral secondary openings at 7 and 5 o'clock were enlarged to allow curettage and adequate drainage after performing an internal sphincterotomy over the primary fistula tract while leaving sphincter complex intact may provide adequate eradication of the fistula while preserving continence.

Again same simple plain Barbour linen thread was kept from external 7 o'clock to internal 6 o'clock (external to internal track). Then after probing was done from external opening at 5 o'clock, which came out from window at deep post anal space below 6 o'clock. Simple plain Barbour linen thread was kept here, from 5 o'clock to window at deep post anal space below6 o'clock (external to external track). Then syringing or patency test was done from 2 o'clock external opening that collected in periphery. Probing was done from 2 o'clock to 5 o'clock. Simple plain Barbour linen thread was kept from 2o'clock to 5 o'clock (external to external track). [Figure 4]. After identifying the course of all tracks, those were laid open, drained, and high anal extension were scooped. Complete hemostasis was achieved. Sterile dressing was done. 6 o'clock window was packed with sterile abgel. Patient was shifted to recovery room with stable vitals.

Daily aseptic dressing with *Panchavalkala* ointment was performed. Patient was advised to change *Apamarga Ksharasutra* after every 7 days. Then after 3 post op weeks, *Ksharasutra* (external to external - at 2 to 5 o'clock) was removed [Figure 7].

After six weeks, the patient was again taken in the lithotomy position. After achieving appropriate anesthesia, remaining space between partial fistulectomy wound (5 o'clock) to window at deep post anal space (below 6 o'clock) was opened. Then *Apamarga Ksharasutra* was replaced and tightened from 6 o'clock (internal opening) to below 6 o'clock window [Figure 8]. Remaining wounds were packed with tight bandages.

Post-Operative Procedure: Daily aseptic dressing with *Thumari* ointment, *Avagaha* (~sitz bath) with *Panchavalkala Kwatha* twice in a day, in morning after defecation and in the evening were advocated. *Kanchanara Guggulu* 2 tablets (500 mg each) thrice in a day, *Varunadi Kwatha* (20 ml) twice daily before meal, *Isabgol* husk (5 gm) at morning with water were prescribed along with using of diclofenac sodium (SOS) if pain is complained.

The patient was assessed weekly for postoperative pain, discharge, and wound healing. *Ksharasutra* were changed weekly by rail-road method and were tightened progressively to cut through the track naturally. The patient was advised not to consume non vegetarian, spicy - oily food, junk food, and alcohol. The patient was advised to avoid long sitting and riding or travelling for the next one year. Complete recovery of the wound took place in about nine weeks' time.

Follow-Up and Outcome

After nine weeks of treatment, all *Ksharasutra* were cut through and wounds were healed completely with local application of *Ayurveda* formulations. [Figure 10]. The patient was followed up for the next six months and no signs of recurrence or complications were noted.

Discussion

Acharya Sushruta advocated different treatment modalities to treat *Bhagandara* (~fistula-in-ano) according to different types of *Dosha*. *Acharya Sushruta* mentioned that all types of *Bhangadara* are difficult to treat.[13] In modern surgery also, it is known for its callus nature to cure and for its high recurrence rate with treatment like fistulotomy & fistulectomy. There are different modalities available for fistula but horse shoe fistula is difficult due to high recurrence rate. The ICMR (Indian Council of Medical Research) has been studied on *Ksharasutra* in fistula-in-ano and concluded better than conventional fistulectomy/fistulotomy with minimum recurrence rate. [14]

This case is a posterior horseshoe-shaped fistula-in-ano having multiple openings on both perianal region. Two external openings on the left side and a third external opening on the right side involving both ischio-rectal fossae, with associated tenderness and marked induration. Internal opening was in anal canal, midline posteriorly at 6 o'clock with the length of both the track approximately 15 to 16 cm. The case was complex as there were involvement of both internal and external sphincters. Although MRI is a gold standard investigation in such kind of complex fistula to know the exact extension of tracks, [15] TRUS was advised as it is being a relevant, cost-effective investigation to diagnose and to assess the result of surgery. [16] These clinical findings were also supported by TRUS. As the case was complex, surgical management was planned in two stages. [17]

Horseshoe fistula is considered complex when it penetrates the conjoint longitudinal muscle at posterior midline and extend upto deep post anal space. The management of this complex horse shoe fistula is focused on adequate drainage of deep post anal space and to manage

cryptoglandular infection former and cutting the fistula track with preservation of sphincter to heal the wound later. Garg grade I–II are simple fistulas and can be safely managed by fistulotomy without any risk to continence whereas Garg grade III–V are complex fistulas and fistulotomy should not be even attempted in these fistulas. [18]

This case was treated in two stages. Benefit of two stage surgery is that, it requires less hospital stay. The patient can be ambulatory after 6 hours of surgery and postoperative wound can will be less. Thus, daily routine of the patient can not hamper, and the patient can live his normal social life as postoperative pain can also be minimal.

In this case study, an incision was made below 6 o'clock in deep post anal space to drain the pus from both the lateral wings of fistula tract and partial fistulectomy were done in all 3 external openings. Once the pus was completely drained, further efforts were made towards simultaneous cutting and healing of fistulous tract using *Ksharasutra* therapy. As *Ksharasutra* were placed in the track, it cauterizes the unhealthy granulation tissue and drains the debris from the track, which induces early healing by providing healthy environment for the wound healing. *Ksharasutra* has cutting and draining properties. It also prevents damage to the sphincter and treats the crypto glandular infection which leads to speedy recovery of the disease. [19] *Ksharasutra* were changed after every week. The length of *Ksharasutra* were noted and found decreased on every change which suggested the cutting of tract. The applied *Kshara* on thread acts as anti-inflammatory and antimicrobial activity and renders chemical cauterization of tissue by virtue of its alkaline nature which facilitates cutting and healing. [20]

After fistula surgery wound healing takes few weeks to months to heal completely due to contamination of wound with feces and also due to chronic lifestyle disorders such as diabetes, this may be contributing factor for occurrence of surgical wound dehiscence. Careful postoperative care may improve wound healing and decrease the chance of recurrence. To overcome this adverse effect, *Thumari Malahara* was used for post op dressing of wound *Thumari* known as *Securinega Leucopyrus* is a potential drug for wound healing. [21]

Internal medicines like *Kanchanara Guggulu* and *Varunadi Kwatha* were given. *Kanchanara Guggulu* possess properties like *Deepana, Pachana, Vatta-Kaphashamaka, Shoth-hara, Lekhana, Bhedana, shothhara*. [22] *Isabgol* is a bulking agent which has important role in improving hygiene and decreasing discomfort with bowel movements. [23]

After 9 weeks of treatment, tracks were healed completely and post treatment, no evidence of peri-anal abscess or fistula was observed. The patient was followed up for the next six

months after treatment and no signs of recurrence or complications were noticed, which indicates efficacy of the treatment.

Conclusion:

This case concluded that two-staged surgical approach along with *Ksharasutra* was effective as it helped in cutting and healing of fistulous track simultaneously with reduced bleeding, minimal pain and scar with no fecal incontinence. There are lesser chances of infection and postoperative complications using this technique. This treatment is good alternative for management of fistula-in-ano and offers the patient a better quality of life.

Limitation:

It is difficult to conclude that two-staged surgical approach along with *Ksharasutra* will always be beneficial for complex, posterior, trans-sphincteric, horseshoe-shaped fistula-in-ano or not as it need further study in more number of cases.

Patient Perspective:

I feel better following the operations, having no pain and pus discharge currently. Now I'm able to do my work without any discomfort. I am totally satisfied with this treatment.

Informed Consent:

It was taken from the patient before starting of the treatment protocol as well as prior to publication of the case details and pictures

Financial Support and Sponsorship: Nil.

Conflicts of Interest: There are no conflicts of interest.

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312 **Table 1: Treatment during the IPD admission.**

Date	Day	Events	Details
August 21, 2023	Day 0	OPD visit	Patient visited for the first time in OPD. Following assessment, he was recommended for admission for additional evaluation and care.
August 22, 2023	Day 1	Laboratory investigations	Haematological, biochemical, serology, urine routine & microscopic, X-ray chest (PA), USG (abdo-pelvis), ECG and TRUS were done.
August 25, 2023	Day 4	First surgery (partial fistulectomy with window technique) was performed.	Partial fistulectomy with window technique was done under spinal anaesthesia in operation theatre.
September 14, 2023	Day 24	*Ksharasutra* was removed	*Ksharasutra* (external to external - at 2 to 5 o'clock) was removed
October 6, 2023	Day 40	Post-operative 6th week Second surgery was performed.	Lay open and shortening of fistulous tract
August 27, 2023 - October 11, 2023	Day 6 – Day 45	*Ksharasutra* change	*Ksharasutra* was changed on every 7th day till complete cutting of the fistula track
August 27, 2023 - October 11, 2023	Day 6 – Day 45	Dressing	Cleaning of wound was done with *Panchavalkala Kwatha*, Dressing was done with *Thumari* ointment.
October 11, 2023	Day 45	Discharge of patient	The patient was instructed to attend weekly OPD visits.

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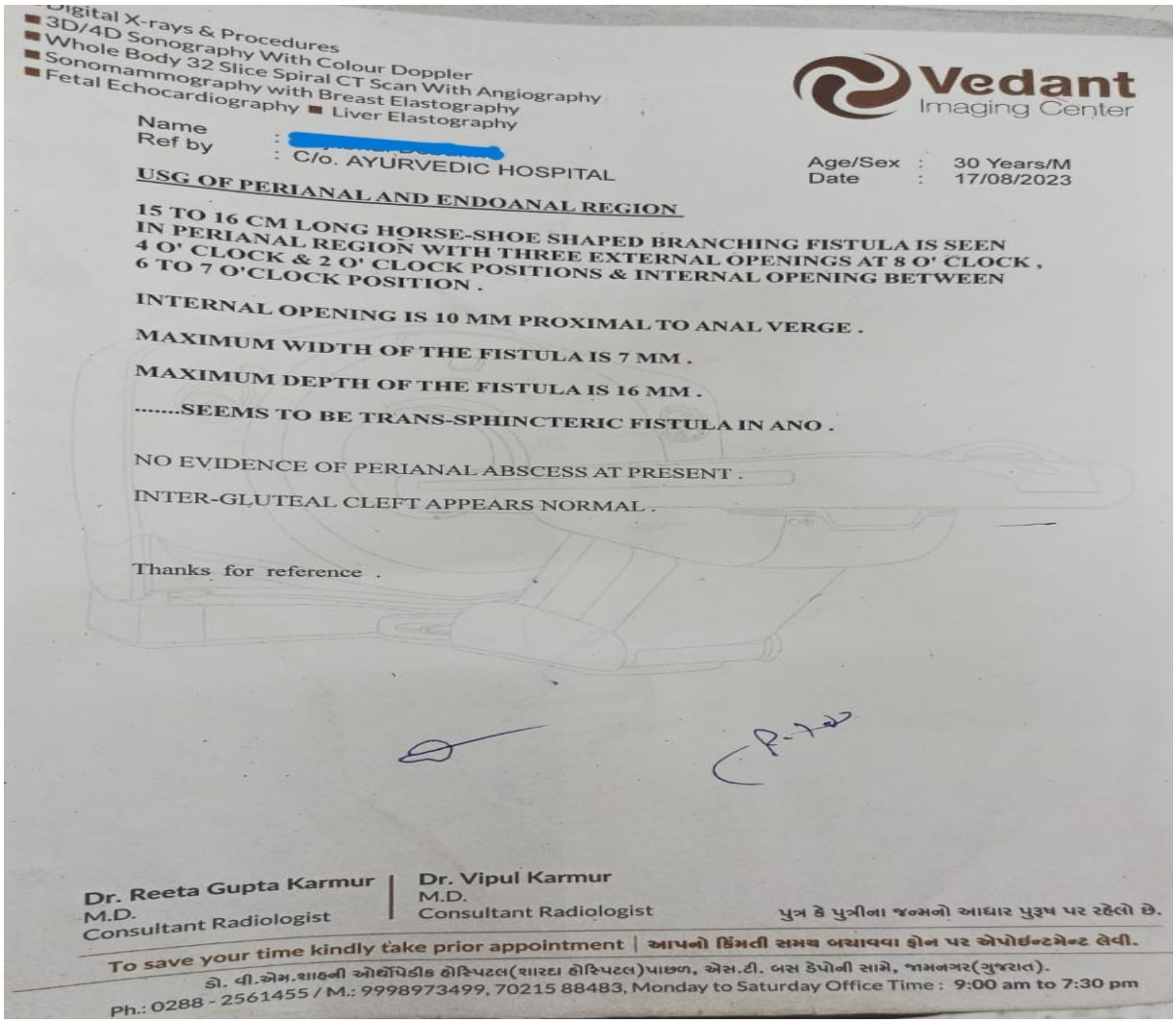
Table 2: Treatment for 16 days after discharge

Date	Day	Events	Details
October 11, 2023 - October 20, 2023	Day 45 – Day 54	*Ksharasutra* change	*Ksharasutra* was changed on every 7th day till complete cutting of the fistula track
October 11, 2023 - October 27, 2023	Day 45 – Day 61	Dressing	Cleaning of wound was done with *Panchavalkala Kwatha*, Dressing was done with *Thumari* ointment.

Table 3: Internal medication during the IPD admission and for 30 days after discharge

S.N.	Duration	Drug	Dose, frequency	*Anupana*	Time
1	August 27, 2023 – November 10, 2023	*Panchavalkala Kwatha* for *Avagaha Sweda*	Twice daily	-	After defecation
2	August 27, 2023 – November 10, 2023	*Kanchanara Guggulu*	500 mg, two tablets thrice daily, orally	Lukewarm water	After meal
3	August 27, 2023 – November 10, 2023	*Varunadi Kwatha*	20 ml, twice daily, orally	Lukewarm water	Before meal
4	August 27, 2023 – November 10, 2023	*Isabgol* husk	5 gm, once, orally	Lukewarm water	Before meal at morning
5	August 27, 2023 – November 10, 2023	T. Matformin HCL	500mg, one tablet, once daily, orally	Normal water	After meal

Figure 1: Trans Rectal Ultra Sonography – TRUS Report



Digital X-rays & Procedures
3D/4D Sonography With Colour Doppler
Whole Body 32 Slice Spiral CT Scan With Angiography
Sonomammography with Breast Elastography
Fetal Echocardiography ■ Liver Elastography

Vedant Imaging Center

Name :
Ref by : C/o. AYURVEDIC HOSPITAL

Age/Sex : 30 Years/M
Date : 17/08/2023

USG OF PERIANAL AND ENDOANAL REGION

15 TO 16 CM LONG HORSE-SHOE SHAPED BRANCHING FISTULA IS SEEN IN PERIANAL REGION WITH THREE EXTERNAL OPENINGS AT 8 O' CLOCK , 4 O' CLOCK & 2 O' CLOCK POSITIONS & INTERNAL OPENING BETWEEN 6 TO 7 O'CLOCK POSITION .

INTERNAL OPENING IS 10 MM PROXIMAL TO ANAL VERGE .

MAXIMUM WIDTH OF THE FISTULA IS 7 MM .

MAXIMUM DEPTH OF THE FISTULA IS 16 MM .

.....SEEMS TO BE TRANS-SPHINCTERIC FISTULA IN ANO .

NO EVIDENCE OF PERIANAL ABSCESS AT PRESENT .

INTER-GLUTEAL CLEFT APPEARS NORMAL .

Thanks for reference .

Dr. Reeta Gupta Karmur
M.D.
Consultant Radiologist

Dr. Vipul Karmur
M.D.
Consultant Radiologist

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Ph.: 0288 - 2561455 / M.: 9998973499, 70215 88483, Monday to Saturday Office Time : 9:00 am to 7:30 pm

Figure 2: Trans Rectal Ultra Sonography – TRUS Diagram

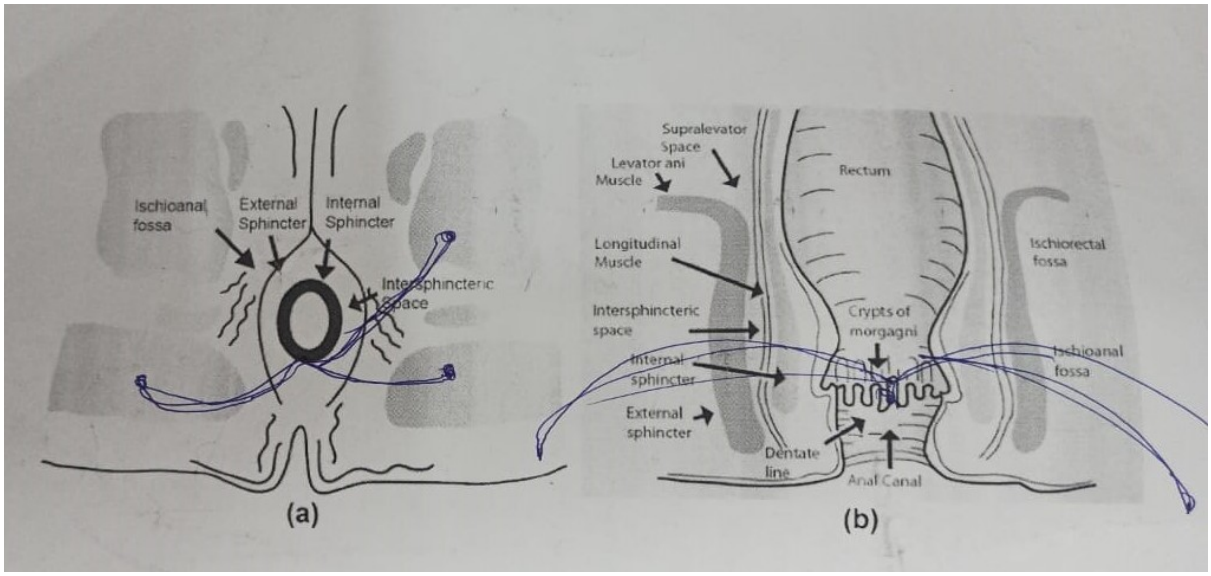


Figure 3: Pre OP

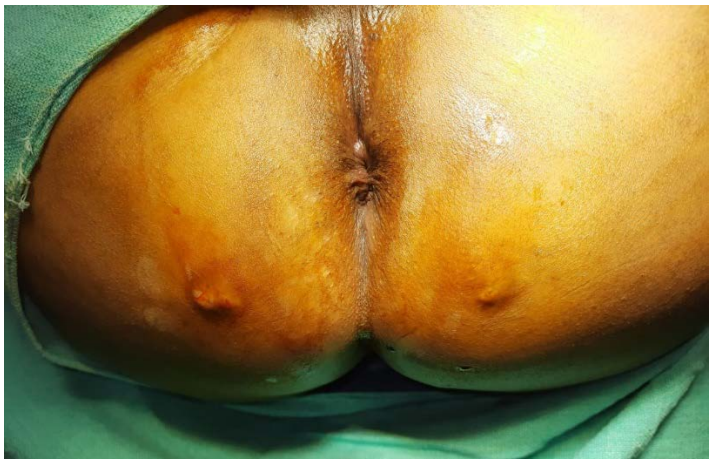


Figure 4: Post OP

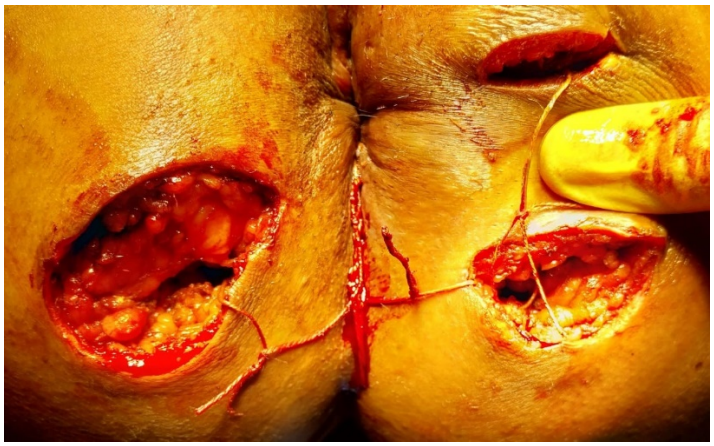


Figure 5: Post OP Day 5

Figure 6: Post OP Day 14

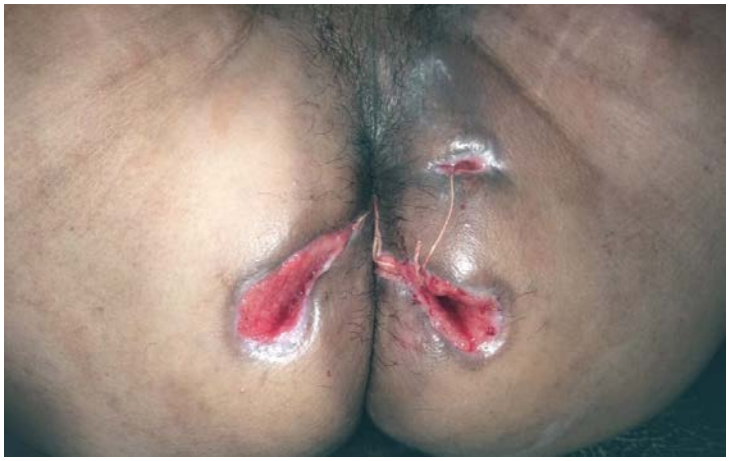
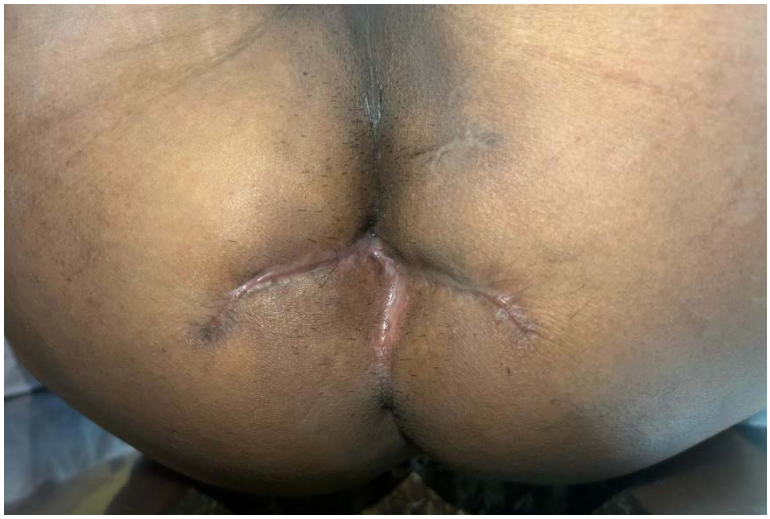


Figure 7: Post OP Day 24

Figure 8: Second Sitting Post OP Day 40

Figure 9: Post OP Day 52

Figure 10: Complete Healing Post OP Day 63



हिंदीसारांश

गुदा क्षेत्र में हॉर्सशू फिस्टुला की दो-चरणीय शल्य चिकित्सा - एक केस रिपोर्ट

परिचय: गुदा में हॉर्सशू फिस्टुला स्फिंक्टर मांसपेशी और इसके जटिल विन्यास के साथ अपनी भागीदारी के कारण अद्वितीय नैदानिक चुनौतियांप्रस्तुतकरताहै।इसस्थितिकेपरिणामस्वरूपगुदास्फिंक्टरअसंयमऔरउच्चपुनरावृत्तिदरहोसकतीहै, जिससे परिचालन देखभाल विशेष रूप से मांग वाली हो जाती है। यह केस रिपोर्ट एक जटिल हॉर्सशू फिस्टुला के सफल प्रबंधन पर प्रकाश डालती है, जिसमें पूर्ण उपचार प्राप्त करते हुए संयम को बनाए रखने के लिए ऑपरेटिव रणनीति पर जोर दिया गया

है।रोगी की मुख्य चिंताएँ और नैदानिक निष्कर्ष:रोगी, एक 30 वर्षीय पुरुष, डेढ़ महीने से बारबारउत्पन्नहोते पेरिएनल फोड़े, दर्द और मवाद निर्वहन की शिकायतों के साथ शल्यतंत्र ओपीडी में आया था। पेरिएनल परीक्षा में द्विपक्षीय रूप से कई बाहरी द्वार का पता चला, और डिजिटल रेक्टल परीक्षा ने 6 बजे की स्थिति में एक आंतरिक द्वार का संकेत दिया। ट्रांस-रेक्टल अल्ट्रासाउंड (TRUS) ने 15-16 सेमी लंबे ब्रांचिंग ट्रैक्ट और 8, 4 और 2 बजे की स्थिति में बाहरी द्वार के साथ एक घोड़े की नाल के आकार के फिस्टुला की पुष्टि की, जिसमें आंतरिक द्वार6 और 7 बजे की स्थिति के बीच गुदा के किनारे से 10 मिमी समीपस्थ स्थित था। पंकज गर्ग वर्गीकरण के अनुसार मामले को ग्रेड II के रूप में वर्गीकृत किया गया था।प्राथमिक निदान: पंकज गर्ग प्रणाली के अनुसार ग्रेड II वर्गीकरण के साथ गुदा में हॉर्सशू फिस्टुलाप्राथमिकनिदानकियागया।चिकित्साविधि: चरण 1: फिस्टुला के मार्ग और गहराई की पुष्टि करने के लिए एक पेटेंसी टेस्ट और जांच की गई, उसके बाद आंशिक फिस्टुलेक्टोमी और रणनीतिक चीरे लगाए गए। स्फिंक्टर की अखंडता और स्राव निकासी को बनाए रखने के लिए एक साधारण बारबोर लिनन धागे का उपयोग किया गया। चरण 2: पहले चरण की सर्जरी के छह सप्ताह बाद, क्षारसूत्रों की संख्या और घाव के आकार को कम करने के लिए आगे के कदम उठाए गए। घाव को ठीक करने और संयम बनाए रखने के लिए घाव प्रबंधन किया गया। रेलरोड तकनीक का उपयोग करके क्षारसूत्र के साप्ताहिक परिवर्तन किए गए।परिणाम: घाव नौ सप्ताह के भीतर पूरी तरह से ठीक हो गया। स्फिंक्टर अखंडता संरक्षित थी, और असंयम की कोई घटना नहीं हुई। न्यूनतम निशान देखे गए।निष्कर्ष: यह केस दर्शाता है कि एनो में हॉर्सशू फिस्टुला के लिए एक संरचित दो-चरणीय ऑपरेटिव दृष्टिकोण प्रभावी रूप से स्थिति का प्रबंधन कर सकता है, स्फिंक्टर फ़ंक्शन को संरक्षित कर सकता है, और पुनरावृत्ति को कम कर सकता है। चरणबद्ध सर्जिकल हस्तक्षेप के साथ क्षारसूत्र का उपयोग एक सफल और विश्वसनीय उपचार पद्धति प्रदान करता है, जो जटिल फिस्टुला मामलों में व्यक्तिगत देखभाल के महत्व को उजागर करता है।