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EVALUATION OF SURGICAL OUTCOMES FOLLOWING IFTAK AND FISTULECTOMY IN PATIENTS WITH FISTULA-IN-ANO: A REVIEW OF EXISTING LITERATURE

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ABSTRACT

Fistula-in-ano is a chronic inflammatory condition characterized by an abnormal tract between the anal canal and perianal skin, most commonly arising from cryptoglandular infection. Surgical intervention remains the mainstay of treatment; however, recurrence and postoperative complications such as fecal incontinence continue to challenge surgeons. **Fistulectomy**, a conventional surgical method, involves complete excision of the fistulous tract but is associated with significant tissue loss, postoperative pain, and delayed healing. **IFTAK** (Interception of Fistulous Tract with Application of Ksharasutra) is an Ayurvedic parasurgical technique that offers a minimally invasive and sphincter preserving approach. This review aims to compare both modalities based on healing time, postoperative pain, recurrence, sphincter preservation, and overall outcomes. The literature suggests that while fistulectomy is effective in simple fistulas, IFTAK provides superior outcomes in complex and recurrent cases with minimal morbidity.

KEYWORDS: Fistula-in-ano, IFTAK, Ksharasutra, Fistulectomy, Bhagandara, Shalyatantra.

INTRODUCTION

Fistula-in-ano is defined as an abnormal communication between the anal canal and theperianal skin, usually resulting from infection of anal glands, as described in the cryptoglandular theory.[3] It is characterized by chronic discharge, pain, and recurrent abscess formation, significantly impairing patient quality of life.

Management of fistula-in-ano remains challenging due to high recurrence rates and the risk of damage to the anal sphincter. Conventional surgical techniques such as fistulotomy and fistulectomy aim at complete removal of the tract but may lead to complications like delayed healing and fecal incontinence.[5]

In Ayurvedic literature, fistula-in-ano is described as Bhagandara, and Ksharasutra therapy is advocated as an effective treatment modality.[1]

IFTAK is a modified approach that focuses on interception of the fistulous tract at its origin and application of Ksharasutra to promote healing while preserving sphincter function.[14]

MATERIALS AND METHODS

This study is a narrative literature review based on classical Ayurvedic texts and modern surgical literature.

Sources of Data

- Classical Ayurvedic texts (Sushruta Samhita)
- Standard surgical textbooks
- Indexed journals (PubMed, AYU, IJAPR, etc.)

Inclusion Criteria

- Studies on fistulectomy and Ksharasutra/IFTAK
- Comparative and observational studies
- Review articles

Parameters Assessed

- Healing time
- Postoperative pain
- Recurrence rate
- Sphincter preservation
- Hospital stay and complications

REVIEW OF LITERATURE

Fistulectomy

Fistulectomy involves complete excision of the fistulous tract, resulting in a raw wound that heals by secondary intention. According to Parks classification, it is most suitable for low anal fistulas.[3]

Goligher and Bailey & Love describe fistulectomy as a definitive procedure but emphasize its drawbacks, including prolonged healing time and postoperative morbidity.[4,5] Studies indicate healing duration of 4–8 weeks and risk of incontinence up to 18% in complex cases.[6]

IFTAK Surgery

IFTAK is a minimally invasive modification of Ksharasutra therapy. It involves interception of the tract near the internal opening and application of medicated thread to ensure continuous drainage and healing.

The Ksharasutra possesses properties such as

- Chemical cauterization
- Antimicrobial action
- Debridement and healing

Studies by Gupta et al. and Sharma et al. have demonstrated its effectiveness in complex fistulas with minimal recurrence and preservation of continence.[14,15]

RESULTS (COMPARATIVE ANALYSIS)

1. Healing Time Fistulectomy results in delayed healing due to large wound size (4–8 weeks).[5] IFTAK promotes gradual healing with smaller wounds and better tissue preservation.[14]

2. Postoperative Pain Fistulectomy causes significant postoperative pain due to extensive tissue excision.[5] IFTAK results in comparatively less pain, with mild discomfort during Ksharasutra changes.[15]

3. RECURRENCE

Recurrence after fistulectomy may occur due to incomplete excision or missed tracts. IFTAK reduces recurrence by addressing the internal opening and ensuring continuous drainage.[14]

4. Sphincter Preservation Fistulectomy carries risk of sphincter injury and incontinence.[6] IFTAK preserves sphincter integrity, making it suitable for complex cases.

5. Hospital Stay Fistulectomy requires longer hospitalization. IFTAK is often a daycare procedure with early recovery.

DISCUSSION

The treatment of fistula-in-ano requires a careful balance between complete eradication of disease and preservation of anal sphincter function. Fistulectomy, though considered a definitive procedure, is associated with significant postoperative morbidity due to extensive tissue excision. The large raw wound produced requires prolonged healing time and frequent dressings, leading to discomfort and reduced quality of life.[5]

Postoperative pain is another major concern with fistulectomy. Extensive dissection results in inflammation and exposure of nerve endings, necessitating prolonged analgesic use. Furthermore, the risk of sphincter damage in high or complex fistulas may result in fecal incontinence, which significantly affects patient outcomes.[6]

In contrast, IFTAK represents a minimally invasive approach that targets the root cause of the disease, i.e., the internal opening and cryptoglandular infection. By intercepting the tract and applying Ksharasutra, the procedure ensures continuous drainage and gradual healing with minimal tissue destruction.[14]

The Ksharasutra plays a crucial role due to its chemical cauterizing, antimicrobial, and healing properties. It facilitates simultaneous cutting and healing of the tract, reducing infection and promoting healthy granulation tissue formation.[1]

A major advantage of IFTAK is its sphincter-preserving nature. Since the sphincter muscles are not divided, the risk of incontinence is negligible. This makes IFTAK particularly beneficial in complex, high, and recurrent fistulas.

Although IFTAK requires multiple sittings and longer overall duration of treatment, it offers better patient compliance due to reduced pain, minimal hospital stay, and improved functional outcomes. Studies have also indicated lower recurrence rates with IFTAK as compared to conventional procedures.[14]

Thus, IFTAK aligns with both modern surgical principles and Ayurvedic concepts of Shodhana and Ropana, making it a holistic and effective treatment modality.

CONCLUSION

Both fistulectomy and IFTAK are effective treatment modalities for fistula-in-ano

- Fistulectomy is suitable for simple, low fistulas requiring complete excision.

- IFTAK is more advantageous in complex and recurrent fistulas due to sphincter preservation and minimal invasiveness.

IFTAK emerges as a promising technique with better functional outcomes and lower morbidity. However, further large-scale randomized controlled trials are required for definitive evidence.

REFERENCES (VANCOUVER STYLE)

1. Sushruta. Sushruta Samhita. Varanasi: Chaukhambha Orientalia, 2014.
2. Sharma PV. Sushruta Samhita (English Translation). Varanasi: Chaukhambha, 2010.
3. Parks AG, Gordon PH, Hardcastle JD. A classification of fistula-in-ano. Br. J. Surg., 1976; 63: 1–12.
4. Goligher J. Surgery of the Anus, Rectum and Colon. 5th ed. London: Bailliere Tindall, 1984.
5. Williams NS, Bulstrode CJ, O'Connell PR. Bailey & Love's Short Practice of Surgery. 27th ed. CRC Press., 2018.
6. Sainio P. Fistula-in-ano in a defined population. Ann Chir Gynaecol, 1984; 73: 219–224.
7. Jain BK, et al. Surgical management of fistula-in-ano. Indian J. Surg., 2008.
8. Malik AI, Nelson RL. Surgical management of anal fistula. Clin. Colon. Rectal. Surg., 2008.
9. Vasilevsky CA, Gordon PH. Benign anorectal disorders. Lancet, 1984.
10. Dwivedi RR, et al. Management of Bhagandara with Ksharasutra. Anc Sci Life., 2010.
11. Singh K, et al. Comparative study of Ksharasutra and fistulectomy. Int. J. Res. Ayurveda Pharm., 2012.
12. Gupta PJ. Newer concepts in fistula management. World J Gastroenterol, 2015.
13. Malik AI, Nelson RL. Anal fistula: current management strategies. Clin Colon Rectal Surg, 2008.
14. Gupta V, et al. IFTAK technique in fistula-in-ano. J Ayurveda Integr Med., 2015.
15. Sharma R, et al. Role of Ksharasutra in fistula. AYU Journal, 2017.