

Ayurvedic approach in treatment of urethral stricture by *Uttarbasti* with a case study

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Abstract

Urethral stricture is a common condition that can lead to serious complications such as urinary infections and renal insufficiency secondary to urinary retention. Treatment options include catheterization, *urethroplasty*, endoscopic internal *urethrotomy*, and dilation. Optical internal *urethrotomy* offers faster recovery, minimal scarring, and less risk of infection, although recurrence is possible. However, technical difficulties associated with poor visualization of the stenosis or of the urethral lumen may increase procedural time and substantially increase the failure rates of internal *urethrotomy*. In ayurved *uttarbasti* has definite contribution which encourages us to find solution for this burning problem of society. *Uttarbasti* is a prime approach for *mutraghat*. so this topic was chosen for review.

KEYWORDS- *Urethral stricture, mutraghat (mutrotsang), Urethral dilatation, uttarbasti*

Introduction:

URETHRAL STRICTURE

Urethral strictures are fibrotic *narrowings* composed of dense collagen and fibroblasts. Fibrosis usually extends into the surrounding corpus *spongiosum*, causing spongio-fibrosis.

These *narrowings* restrict urine flow and cause dilation of the proximal urethra and prostatic ducts. Prostatitis is a common complication of urethral stricture. The bladder muscle may become hypertrophic, and increased residual urine may be noted.

Acquired urethral stricture is common in men but rare in women. Most acquired strictures are due to infection or trauma.

1. Infection-

Although gonococcal urethritis is seldom a cause of stricture today, infection remains a major cause—particularly infection from long-term use of indwelling urethral catheters.

2. Trauma-

a. Internal trauma-

Large catheters and instruments are more likely than small ones to cause ischemia and internal trauma.

- b. External trauma-
for example, pelvic fractures can partially or completely sever the membranous urethra and cause severe and complex strictures. Straddle injuries can produce bulbar strictures.

Clinical Findings

A. SYMPTOMS AND SIGNS

1. A decrease in urinary stream is the most common complaint.
2. Spraying or double stream is often noted, as is post voiding dribbling.
3. Chronic urethral discharge, occasionally a major complaint, is likely to be associated with chronic prostatitis.
4. Acute cystitis or symptoms of infection are seen at times.
5. Acute urinary retention seldom occurs unless infection or prostatic obstruction develops.
6. Urinary frequency
7. mild dysuria may also be initial complaints.
8. Indurations in the area of the stricture may be palpable.
9. The bladder may be palpable if there is chronic retention of urine.

B. LABORATORY INVESTIGATIONS-

1. haemogram
2. urine r and m
3. rfts
4. uroflowmetry

C. X-RAY INVESTIGATIONS-

urethrogram (RGU) or voiding cystourethrogram.

D. INSTRUMENTAL EXAMINATION-

Urethroscopy

Treatment

A. SPECIFIC MEASURES

1. Dilation—

Dilation may initially be required because of severe symptoms of chronic retention of urine. The urethra should be liberally lubricated with a water-soluble medium before instrumentation. First, a 22F sound should be passed down to the stricture site and gentle pressure applied. If this fails, a 20F sound should be used. Smaller sounds should be used with care, because they can easily perforate the urethral wall and produce false passages. Bleeding and pain are major problems caused by dilation.

2. Urethrotomy under endoscopic direct vision—

Lysis of urethral strictures can be accomplished using a sharp knife attached to an endoscope.

3. Surgical reconstruction—If urethrotomy under direct vision fails, open surgical repair should be performed. Short strictures (≤ 2 cm) of the anterior urethra should be completely excised and primary anastomosis done. Strictures > 2 cm in length can be managed by patch graft urethroplasty.

Prognosis

A stricture should not be considered “cured” until it has been observed for at least 1 year after therapy, since it may recur at any time during that period. Urinary flow rate measurements and

urethrograms are helpful to determine the extent of residual obstruction.

MATERIALS AND METHODS-

1. Til taila-30ml
2. Madhu-10ml
3. Saidhav-10gm
- 1.2.3. Mixed together and autoclaved in glass bottle.
4. xylocain gelly 2%
5. Male urethral dilators
6. Foleys catheter no.16

CASE STUDY-

Utratrul stricture

Pt.name. xyz

Age-71 yrs/ male

Add-wagholi pune

Occupation- farmer

Opd no.12863

Ipd no.14/542

Dt of first visit- 23/05/2019

Chief complains-

1. Burning micturation since 1yr
2. Dribbling micturation since 1yr
3. Dysurea since 1yr
4. Pain in abdomen since 1yr
5. Acute on chronic retension of urine since 3days

History of present illness-

1. Pt was having symptoms of chronic retension of urine since 1to1.5 yrs.
2. two days before date of admission pt was admitted in pvt hospital for acute retension of urine with urosepsis where he was operated for suprapubic cystostomy under L.A
3. In pvt hospital pt was advised surgical procedure for urethral stricture. Pt came in Dhanwantari Hospital.wagholi to avoid surgical procedure.

Past history-

No any

General examination-

- G.C. good , afebrile
- Pulse-66/min
- B.P-130/80 mm of hg
- c.v.s- s1s2 normal
- c.n.s-concious and oriented
- r.s- mild bil. Basal crepts.
- R/R-20/min
- P/A . soft mild tenderness over lower abdomen

1. Lab investigation-

- Hb-9 gm%
- Wbc-15900/cumm
- R.b.c-3.90 millions/ul
- Dc- n-92, l-06, e-1, b-00, m-01
- Plt-167000/cumm
- Bsl®- 118 mg/dl
- B.u.l- 122 mg/dl
- Sr. Creatinine-3.1 mg/dl
- Urine r and m- pus cell-30-40/hpf; others normal

3. USG(ABD+PELVIC)

Bladder shows minimally thickened irregular wall s/o chronic cystitis. Other no obvious abnormality seen.

3.RGU-

Distal penile stricture 2cm length

Penoscrotal junction stricture 2cm length

DIAGNOSIS – Urethral stricture

CAUSE- infective cause

PROCEDURE OF UTTARBASTI-

Pre-op-

- Prepare
- Informed written cosent
- Pre op iv antibiotics, antacids and antiemetics
- Stanik Snehan with til taila and swedan with bashpa sweda

Operative-

1. Supine position given

2. Painting and drapping done
3. Xylocain gelly 2% 10cc inserted thr penile urethra
4. Then urethral dilation done with male urethral dilator 22f.
5. Suprapubic catheter which is previously inserted clamped.
6. Uttar basti preparation 40cc inserted by bladder syringe into bladder thr urthra.
7. Then Foleys catheter inserted thr urethra and clamped.
8. Pt then shifed in word in good condition.

Post op-

1. 1.After 3 hr urethral clamp released.
2. clear urine with uttarbasti preparation seen in urosac.
3. pt discharged on same day with open urethral catheter and clamped suprapubic catheter.
4. pt dischared with
 - a) Bruhat varunadi kadha 4tsf tds
 - b) Gokshuradi guggulu 2bd
 - c) Chandraprabha vati 2bd for 7 days
5. pt advised f/u after 7days.

FOLLOW UP CHART-

f/u. no	Date	Complain	WBC	bul	Sr. creat	P.C. in urine	Uttarbasti procedure	Rx given
1	31/05/19	1.pain in abd. Less 2.no other complain	10000	90	2.00	10-20	Done. Suprapubic catheter removed	Same as above
2	07/06/19	1.no pain at all	7500	45	1.2	5-10	Done	Same as above
3	14/06/19	No any fresh complain	7000	35	1.1	1-2	Done. Then urethral catheter removed. Pt passed urine with good flow Stream. No dribbling.	Same as above
4	20/06/19	No any fresh complain. No burning, no dribbling, Good urine flow stream	7300	30	1.00	3-4	R.G.U DONE.- no urethral stricture seen. Uroflowmetry- 16ml/sec	Same as above

DISCUSSION-

1. Main cause of urethral stricture is chronic cystitis and urethritis.

2. After urethral dilatation urethral narrowing get wide.
3. After use of uttarbasti chronic infection of bladder and urethra

get significant reduced and cured.

4. During treatment Leucocytosis, renal function tests, and pus cells in urine show significant curative changes.
5. Uroflowmetry show good urine flow after treatment.
6. RGU- show no urethral stricture seen after treatment.

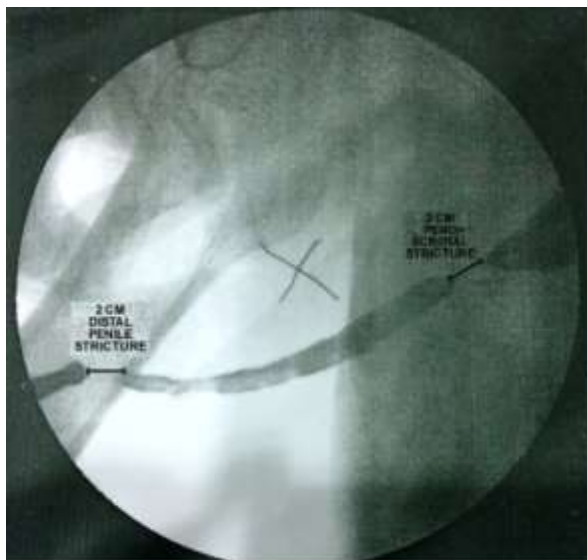
MODE OF ACTION-

- Main cause for urethral stricture is chronic infection of urinary bladder which is controlled and cured by uttarbasti.
- Urethral dilatation also help in release urethral stricture.
- Til Tail (omega 6) has antioxidant and antibacterial properties.

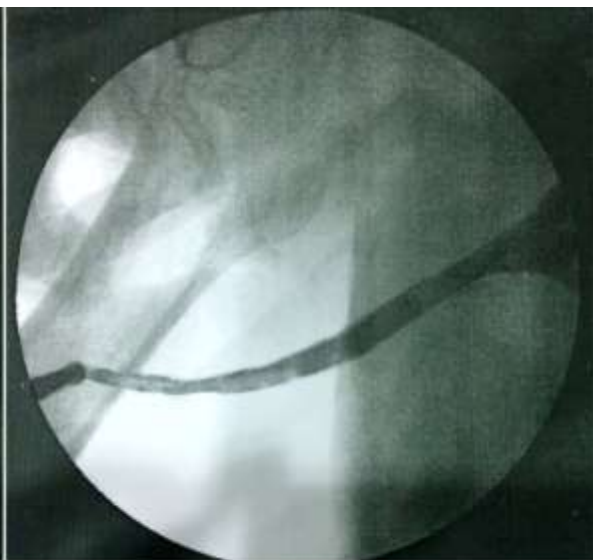
- Madhu is demulcent, antioxidant, strengthens the wbc which fight against bacterial and viral diseases, initiate growth of healthy granulation tissue.
- Saindhav-84 elements Na^+ , Mg^{++} , Ca^{2+} healing, improve circulation, remove toxins.

CONCLUSION-

1. Pt advised surgical treatment in private hospital, but by using standard uttarbasti procedure surgery should be avoided.
2. Uttarbasti show best result in infective urethral stricture.
3. It can be given on OPD basis and patients do not require any hospitalization
4. Procedure is cost effective
5. It proves to be a significant treatment in urethral stricture.



R G U Before Treatment



R G U After Treatment

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