SURGICAL MANAGEMENT OF MANIFESTATIONS IN FILARIASIS

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The Disease elephantiasis is existing from ancient days in our country which is quoted even in Manusmriti. Today India has seventy million established lymphatic filariasis cases and another three hundred million at risk. The world's two thirds of the lymphoedema population is in our country. So we have to do something for these unfortunate people.

Filarial lymphoedema is the most common cause of secondary lymphoedema. This can affect lower limb most commonly and the upper limb too. The commonest cause of secondary hydrocele in our country is filariasis. Genital filariasis (filarial scrotum, ramhorn penis, vulvar oedema, warty lesions are also common manifestations. Lymphadenovarix and filariasis also require surgical intervention.

The filarial lymphoedema is clinically classified into four stages.

- STAGE I : Lymphangitis with pitting edema and totally disappears on treatment and may recur subsequently.
- STAGE II : Uniform persistent pitting edema with clinical history of filariasis.
- STAGE III : Uniform non pitting fibrous persistent lymphoedema of considerable size.
- STAGE IV : Non pitting lymphoedema with complications like ulcer, warty growths etc., of long duration.

Depending upon the stages of the disease,

the management can be medical, surgical and non surgical. The medical management is common for all the stages, like DEC 300mg a day for five days a month every month, and long acting penicillin injection ie., Penidure 12 lakhs once in three weeks, for one year. If there is associated fungal infections in the nail or web space, the warty growths are due to fungal infection, an antifungal locally as well as systemically has to be used. Cleaning of the feet, taking care of secondary infection like caries teeth are very important for the management of lymphoedema. Along with this, the simple massage from below upwards; elastic stockinet support; are mandatory for reduction as well as control of the lymphoedema.

Stage I usually can be managed conservatively. Stage II nodovenal shunt with conservative management. Stage III & IV nodovenal shunt with reduction surgery and sculpturing are done. For filarial scrotum, bilateral NV shunt with reduction is the treatment of choice. Ramhorn penis can be treated with circumcision and skin excision with split skin graft. Genital filariasis in female is best treated with excision and primary closure or skin grafting.

In conclusion, lymphatic filariasis with clinical manifestations can be effectively treated and controlled with regular cyclic antibiotics, antifilarial drugs along with elastic support and local hygiene of the area.

In late stages if it is combined with nodovenal shunt and excisional surgery and a meticulous follow up, it helps in controlling the disease.