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A CRITICAL REVIEW: PARIKARTIKA W.S.R. FISSURE- IN -ANO

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ABSTRACT

Proctologic diseases include a diverse group of pathological disorders that generate significant discomfort to the patient. Parikartika is a common painful condition among anorectal diseases which resembles with fissure-in-ano. In the present era due to changing life style such as sedentary work pattern, increased stress, improper dietary and sleep habit, various life style disorders are increasing continuously. Anal fissure (fissure-in-ano) is a very common anorectal condition. The exact etiology of this condition is disputed, however there is a clear association with elevated internal anal sphincter pressure. Hard bowel movements are implicated in fissure etiology. The exact cause of an anal fissure is not entirely clear, but it is thought to result from trauma to the anal canal. This includes trauma to the anoderm during the passage of hard or large bowel movements, local irritation from diarrhoea, anorectal surgery, and anoreceptive intercourse. Half of all patients with fissures heal with non operative management such as high fiber diet, sitz baths, and pharmacological agents (topical/oral). When non operative management fails, surgical and parasurgical treatment will be the choice. In which lateral internal sphincterotomy has a high success rate but some complications like incontinence. In this article, we will review the symptoms, pathophysiology, and management of anal fissures.

KEYWORDS: Parikartika, Fissure in ano, internal anal sphincter, sphincterotomy, sitz bath.

INTRODUCTION

The word *parikartika* can be explained by its root terms i.e. *pari* (all around) and *Kartika (kartanvat peeda*), so excruciating cutting type of pain all around *guda*, *basti shirah* and *nabhi* is termed as *parikartika*. An anal fissure is an elongated ulcer in the long axis of anal canal. The site for occurrence for an anal fissure is the midline posteriorly (90%), the next most frequent situation is the midline anteriorly. In males, fissure occurs usually midline posteriorly and in females it is midline anteriorly. *Parikartika* (fissure in ano) is a very painful anorectal condition. It has no separate disease entity, but it is mentioned as sign and symptoms of other diseases or complications of ayurvedic procedures like *vasti, virechana* etc. and as a complication of various diseases like *Vatika jwara, Vatika pakwaatisar*, *arsha poorvaroopa*, *udavarta* and also as *Garbhini vyaapad*. It may also originate due to intervention of some instruments like enema nozzle. Fissure in ano is very commonly encountered in current day to day practice. Anal Fissure comprises of 10-15% of anorectal disorders and is characterized by excruciating pain during and after defecation, bleeding per anus with spasm of anal sphincter. *Parikartika* is characterized by *kartanvat* and *chhedanvat shoola* in *guda.*

Etiology

In Ayurveda, the vitiated *Apan vaayu* can be considered as a chief causative factor for the manifestation of *parikartika*. *Mandagni* due to vitiated *vaatadi doshas* is primary trigger for it. It has been proved that constipation is the primary and sole cause of initiation of fissure. Passage of hard stool, irregularity of diet, consumption of spicy and pungent food stuffs, faulty bowel habits and lack of local hygiene can contribute for initiation of this pathology. Anal fissure may be acute or chronic. Acute type is a deep tear through the skin of the anal margin extending in to the anal canal. There is also inflammatory induration and oedema of its edges accompanying spasm of anal sphincter muscles. Chronic anal fissures are those present for more than 6 weeks and often having a sentinel tag distally. Secondary causes of anal fissure must be rememberd, these may be- ulcerative colitis, crohn’s disease, syphilis and tuberculosis.

Pathophysiology

Constipation/altered bowel habit leads to passing of more hard stool/frequent stool causes trauma to the mucous membrane and associated skin, causing acute tear at mucocutaneous junction of anal canal. Due to tear and passage of hard stool, there is severe pain during and

after defecation with burning sensation. Patient avoid to defecate for several days due to fear of pain so it leads to passage of more hard stool and constipation. This aggravates the spasm of anal sphincter muscles because there is same somatic nerve supply of anal canal and sphincter muscles. Meanwhile strong spasm of these muscles increases the pressure in anal canal which leads to further tear of local site. Also during defecation edges of fissure pulled apart from each other leading more tear in it and delay the healing process. When etiologic factors are abolished by conservative treatment and healthy life style pattern so that there is no constipation, acute fissure heals at its own. If it fails to heal then it is converted into the chronic type. in the chronic type when tear of mucocutaneous junction repeats many time regularly and body consistently tends to repair of the tear, so healed portion converted into unhealthy fibrous tissue known as fissure bed in chronic fissures. The regenerating skin part is continuously expelled outside and it form skin tag or sentinel tag. There is low blood supply in that region due to continuous pressure on local blood vessels which may further lead to ischemia and necrosis.

Fate and Complications of Fissure- In- ANO

Acute fissure may heal spontaneously or may converted in to chronic type. Stasis of fecal matter and infectious agents in chronic wound lead to infection of anal crypts of anal canal, further infection travels to anal glands to perianal region that leads to formation of perianal abscess, which got burst out and resulted in fistula- in-ano.

Clinical Features of Fissure- In- ANO

In acute type- sharp, agonising, cutting type of pain with burning sensation during and after defecation which may last for several hours. Bright red streak type bleeding along with stool in small amount. Periods of remission occur for days or weeks. Patients want to become constipated rather than to defecate.

In Chronic type- swelling with mucoid or muco -pus discharge due to infection, with pruritis ani and presence of a sentinel tag. In long standing cases muscle become contracted by infiltration of fibrous tissue. commonly infected by fecal matter and leads to formation of abscess and cutaneous fistula.

Examination

In acute fissure patient, generally interventional examination is avoided due to severe pain as sphincter muscles are in extreme spasm. Inspection and interrogation are two main tools to diagnose the disease without giving extreme pain to the patient. When gentle traction is given to the perineum, it always reveals a fissure wound or fissure bed anteriorly or posteriorly. On palpation, tone and spasticity of sphincter muscles can be assessed along with cut or tear in case of acute fissure and a fissure bed with indurated margins with sentinel tag in case of chronic fissure. Mucous or mucopus discharge from anal canal may be associated with subcutaneous/submucosal/intersphincteric abscess. Proctoscopic examination usually not done due to fear of more tear and non- cooperation of patient. Sigmoidoscopy is necessary in case of secondary fissure to rule out associated pathology/primary focus of the disease, under general anaesthesia.

Management

There are various conservative treatments available for the management of *parikartika* like stool softeners, hot sitz bath, topical applications, botulinum injection, sclerotherapy(sodium tetradecyl sulphate) etc. But all these have their limitations and chances of recurrence can not be ignored. Various surgical procedures such as Lord's anal dialatation, fissurectomy, fissurectomy with skin grafting, open and closed lateral sphincterotomy, laser therapy etc. All these surgical procedures have also some complications like incontinence of fecal matter and/ flatus.

Ayurvedic Management

Anuvasana basti- it acts like local retention oil enema, it helps to relief constipation and smoothen the anal canal which allows easy evacuation of stool. It also acts as vaatanulomak, hence relieves the aggravation of vata dosha, it reduces local spasm and hence pain. When the oil is prepared with medicines, then it also helps in cleansing and healing of local wound

Tail and Ghrita pichu

It forms protective layer over fissure wound, it soothes the anal canal so relieves pain and burning sensation (and also reduces the risk of bleeding) by releasing sphincter tone and it cleans the wound thus helps in healing of ulcer and less chance of development of unhealthy granulation/fibrous tissue.

***Avagaha sweda* (hot fomentation-sitz bath)**: Sitting in the warm/hot water tub after each bowel movement soothes pain and relaxes spasm of internal sphincter for some time. It also helps in cleaning of fissure wound. Sitz bath is highly effective in treatment of fissure. It is done for 10 to 15 minutes daily once or twice as necessary. Caution should be taken during hot sitz bath that water should not be too hot or cold.

High fibre diet: The rate of intestinal movements of food particles depends on the nature of the diet and its fluid content. The greater the fibre and water content, the more rapidly it reaches the rectum and produces its distension and there after evacuation. Hence patients should take daily fibre rich food and plenty of fluids to improve digestion and regularize bowels. These are hygroscopic, which allows them to expand and become mucilaginous. These fibres are complex carbohydrate, which binds with water in the colon creating larger, softer, stool. Larger, softer, stools stretch and relax the sphincter muscles helping the blood to flow and it also require least pressure to pass.

Treatment for Chronic Fissure-In-Ano- In Ayurvedic text information available on *Shushkarsha*, *Bahyarsha* can be correlated with Sentinel Piles. *Acharya Sushruta* mentioned four modalities for the management of *arshas*- 1) *Bheshaja* (conservative line of management) 2) *Kshara* 3) *Agni* 4) *Shastra.*

***Kshara Sutra* Therapy**

It is almost like transfix and ligation method as widely applied in case of haemorrhoides. Ligation of *Kshara sutra* to sentinel pile masses, by this themselves they may fall within few days.

Kshara Lepa: Lepa of *Pratisaraneeya kshara* is very widely used and showing good results over the (Chronic fissure-in-ano) ulcer surface, by scraping action(*lekhana karma*) of *Kshara*, this reduces the excess fibrous tissue present over the fissure bed, sphincter relaxation occurs simultaneously.

Agnikarma

Para surgical procedure like *Agnikarma* has been widely advised by *Sushruta* and by doing *Agnikarma* treatment has provided marked relief and no recurrence. Excision of sentinel piles by *Agnikarma* i.e. by electro thermal cautery shows very good results.

Advance Procedures

Advanced laser therapy, fissurectomy followed by advancement flap technique.

Pathya* in *Parikartika

Increased liquid intake, fibre rich diet, use of buttermilk, use of cow *ghrita* before start the food, avoid late night sleep, not to sit at one place for long time, do regular exercise.

DISCUSSION

On the basis of site, nature of pathology and features, *parikartika* can be correlated to Fissure-in-ano. The detail description about *Nidana* (etiology), *Samprapti* (pathogenesis), *Lakshana(*symptoms) and *Chikitsa* (treatment) is mentioned in *Sushruta samhita*, *Kashyapa samhita, Astanga Hridaya* etc. There is detail description about conservative and surgical treatment for Fissure-in-ano in our ancient treatise. *Parikartika* occurs mainly due to *vata* and *pitta* doshas, but *saam dosha* also play a key role in *mandaagni* and *mandaagni* is basically responsible for *koshtha* and *mala baddhata*, so before prescribing medicine for *samshodhana* or to treat constipation, care of *saama* and *niraama* condition of *koshtha* and roughness of body is very important. In the treatment of *parikartika*, if the patient having *aama* then *langhana, paachan, rukshana* is indicated.

CONCLUSION

On the basis of above discussion it is clear that Improper dietary habits and stressful life is found to have influenced the high incidence of fissure-in-ano observed today. Passage of hard constipated stools is the prime cause of tear in the lower anal canal which results in excruciating pain during and after defecation, the cardinal feature of Fissure-in-ano. Ayurvedic preparations are very effective & these can cure fissure and regularize bowel upto 90% cases of acute fissures. These could always be offered to the patients who are not willing for operative procedure such as cardiac patients or patients with diabetes, AIDS, Hepatitis B where healing is difficult after operation. In chronic and recurrent conditions conservative treatment is not so effective as in acute cases. In these cases surgical and parasurgical interventions are required. In parasirgical mostly *kshar karma* and *agnikarma* are widely and effectively used. In surgical procedures there is a variety of above mentioned procedures. *Kshara* is used in different forms like *Kshara Lepa*, *Ksharasutra* ligation in treating *Parikartika* (Chronic Fissure-in-ano*). Agnikarma* or electric cauterisation may be helpful to remove sentinel tag permanently.

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