

**AYURVEDIC PERSPECTIVE ON *PARIKARTIKA* (FISSURE-IN-ANO):
A COMPREHENSIVE REVIEW OF AETIOPATHOGENESIS,
CLINICAL FEATURES AND AYURVEDIC THERAPEUTIC
STRATEGIES**

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ABSTRACT

Parikartika is a classical ano-rectal disease described in ancient Ayurvedic texts and closely corresponds to fissure-in-ano in contemporary surgical practice. ¹Fissure-in-ano is defined as a longitudinal tear or crack in the mucosa lining the lower segment of the anal canal, representing one of the most prevalent and acutely painful conditions encountered in anorectal surgery and proctological medicine.^[4] The condition is characterised by intense cutting and burning pain during and after defecation (*kartanvat vedana*), constipation (*malavashtambha*), redness, pruritis, and occasionally a streak of fresh blood in the stool. In Ayurveda, *Parikartika* is primarily attributed to vitiation of *Vata dosha* and *Pitta dosha*, compounded by *ruksha guna* (dryness), *Kapha* involvement, and pre-existing *strotovaigunya* (structural weakness of the concerned channels).^[1,2,3] Classical texts including *Charaka Samhita*, *Sushruta Samhita*, and *Kashyapa Samhita* provide detailed descriptions of its aetiology, pathogenesis, and

therapeutic management.^[1,2,3] The primary causative factors encompass inappropriate dietary habits — particularly excessive consumption of constipating foods, inadequate liquid intake, and disregard for natural dietetic principles — combined with adverse lifestyle practices such as irregular sleep schedules and sedentary routines. Ayurvedic management targets *nidanaparivarjana* (elimination of causative factors), *Vatanulomana* (normalisation of *Vata*), correction of constipation, local wound healing, and tissue rejuvenation through a combination of internal medications and external applications.^[1,2,3] This review consolidates the classical Ayurvedic conceptual framework of *Parikartika*, its pathophysiological correlation with modern surgical understanding of fissure-in-ano, the role of dietary and lifestyle factors in its aetiopathogenesis, and the evidence base for Ayurvedic therapeutic interventions, with the objective of providing a structured academic reference for clinicians and researchers in integrative proctology.

KEYWORDS: *Parikartika, Fissure-in-ano, Vata vyadhi, Malavashtambha, Kartanvat vedana, Strotovaigunya, Guda, Nidanaparivarjana, Ayurveda, Anorectal diseases, Vatanulomana, Yashtimadhu tailam.*

1. INTRODUCTION

Anorectal diseases constitute a significant and growing component of the global burden of gastrointestinal disorders, with constipation-related anorectal pathologies exhibiting a marked increase in prevalence attributable to changing dietary habits and increasingly sedentary urban lifestyles. Among these conditions, fissure-in-ano represents one of the most frequently encountered and acutely debilitating anorectal disorders, characterised by a longitudinal mucosal tear at the lower end of the anal canal, producing severe pain, bleeding, and functional impairment of defecation.^[4] The condition affects individuals across age groups but demonstrates a preponderance in young to middle-aged adults engaged in occupations characterised by irregular dietary schedules, high-stress environments, and physical inactivity.

In the classical Ayurvedic medical system, the equivalent condition is designated as *Parikartika* — a term derived from the Sanskrit root *parikartana*, signifying a cutting or circumscribing pain. The disease is described in the *Charaka Samhita (Siddhithana, Chapter 7)* as a complication of improperly administered *Niruha basti*, wherein the application of an excessively sharp (*tikshna*) enema in a patient with soft bowel constitution (*mrudu koshta*) and minimal *dosha* accumulation (*alpa dosha*) produces *kartanvat vedana* (cutting pain) at

the *Guda* (anal canal).^[1] *Sushruta Samhita* elaborates upon the anatomical constitution of the *Guda* and its disease spectrum.^[2] *Kashyapa Samhita* specifically addresses *Parikartika* as a complication of pregnancy (*Garbhini vyapad*), providing differentiated management protocols based on *Vataj*, *Pittaja*), and *Kaphaja* sub-types.^[3]

This review aims to provide a structured academic synthesis of the Ayurvedic conceptual framework of *Parikartika*, its pathophysiological correlation with the modern surgical understanding of fissure-in-ano, the dietary and lifestyle determinants of aetiopathogenesis, the classical evidence base for therapeutic interventions, and the role of *Pathyapathya* in disease management and relapse prevention. The review is intended to serve as an academic and clinical reference for Ayurvedic physicians, surgeons, and integrative medicine practitioners engaged in the management of anorectal conditions.

2. EPIDEMIOLOGY AND CLINICAL RELEVANCE

Fissure-in-ano is one of the most common anorectal conditions encountered in surgical outpatient settings globally, with reported prevalence rates of 1 in 350 adults in population-based studies.^[4] It occurs with near-equal frequency in both sexes, with a slight predisposition in women, particularly in the context of obstetric history, constipation during pregnancy, and traumatic delivery. Acute fissures, when untreated or improperly managed, frequently transition to the chronic form — characterised by sentinel skin tags, hypertrophied anal papillae, and indurated ulcer bases — necessitating more invasive interventions.^[5]

In Ayurvedic epidemiology, *Parikartika* is categorised under *Guda vyadhis* (anorectal diseases), which collectively represent a class of conditions directly attributable to unhealthy dietary and lifestyle habits — rendering them highly preventable through Ayurvedic lifestyle medicine (*svasthavritta*). The condition demonstrates a strong association with constipation (*malavashtambha*), which itself is among the most prevalent gastrointestinal complaints in contemporary India, driven by low dietary fibre intake, inadequate hydration, irregular meal timings, and minimal physical activity. Young working-age individuals and homemakers represent the most commonly affected demographic, as irregular dietary patterns, stress-driven lifestyle choices, and inadequate fluid consumption collectively predispose to recurrent anorectal morbidity.^[1]

3. AYURVEDIC CONCEPTUAL FRAMEWORK OF PARIKARTIKA

3.1 Historical and Textual References

The earliest systematic description of *Parikartika* appears in the *Charaka Samhita* (*Siddhithana*, Chapter 7, Verse 5) within the enumeration of *Niruha basti vyapada* — iatrogenic complications arising from improper therapeutic enema administration.^[1] *Charaka* additionally identifies excessive consumption of sprouts (*virudhaka*) as a constipating dietary factor in the *Sutrasthana*, recognising the role of specific food categories in predisposing to anorectal morbidity.^[1] *Sushruta Samhita* contributes the embryological and anatomical understanding of the *Guda*, establishing that its formation during intrauterine life derives from the essence of *Rakta* (blood), *Kapha*, *Pitta*, and *Vayu* — providing the foundational basis for its doshic pathology.^[2]

Kashyapa Samhita (*Khilasthana*) presents *Parikartika* within the context of obstetric complications (*Garbhini vyapad*), offering a clinically significant sub-classification into *Vataja*, *Pittaja*, and *Kaphaja* types with differentiated therapeutic protocols — an approach that remains clinically relevant in contemporary Ayurvedic proctology.^[3] The principal classical teaching holds that the fundamental causative factor (*mukhya nidana*) of *Parikartika* is *ruksha guna* (dryness quality), operating through *Vata prakopa* and culminating in *malavarodha* (obstruction of faecal flow), which then produces mechanical mucosal injury.^[2,3]

3.2 Nidana (Aetiology)

The aetiology of *Parikartika* is multifactorial, encompassing dietary, lifestyle, and predisposing factors that collectively culminate in *Vata* and *Pitta* vitiation, constipation, and mucosal vulnerability.^[1] Dietary causes include excessive consumption of *virudhakas* (constipating legume sprouts) — moth beans, kidney beans, and chickpeas — which possess *ruksha* and *vishtambhi* (bowel-obstructing) properties. Insufficient liquid intake, avoidance of ghee and natural fats, and frequent consumption of processed, spicy, Chinese, and bakery foods disrupt normal *Agni* function (digestive fire) and impair *Purishavaha srotas* (large intestinal channel) integrity.^[1]

Lifestyle factors include *divaswap* (daytime sleep), which promotes *Kapha* and *Pitta* imbalance, and *jagarana* (late-night wakefulness), which aggravates *Vata* and *Pitta dosha*, impairing bowel regularity. Heavy fasting followed by consumption of *sabudana* (sago) and *vari* (samo rice) — both inherently constipating — combined with curd creates a particularly

unfavourable dietary combination for anorectal health. Predisposing conditions include prior history of anorectal disease, pregnancy-related anorectal changes (*strotovaigunya*), and complications of *Basti* or *Virechana* procedures.^[1,2,3]

Table 1: Nidana (Aetiological Factors) of Parikartika.

Aharaaja Nidana (Dietary Causes)	Viharaaja Nidana (Lifestyle Causes)	Nimitta Nidana (Predisposing Causes)
Excessive intake of sprouts (virudhakas) — moth beans, kidney beans, chickpeas	Low fluid intake (dravahara hani)	Dislike for ghee and fatty acids essential for mucosal protection
Heavy consumption of sago (sabudana) and samo rice (vari) combinations	Frequent intake of spicy, junk, and Chinese food	Bakery and processed food products
Excessive fasting followed by heavy constipating food loads	Irregular and infrequent meal schedules	Suppression of defecation urge (purishavegadhara)
Afternoon sleep (divaswap) disrupting Pitta-Kapha equilibrium	Late night sleeping hours (jagarana) aggravating Vata	Sedentary lifestyle with reduced physical activity
Past history of fissure / anorectal surgical procedures	Pregnancy-related anorectal changes (Garbhini vyapad)	Complications of Basti or Virechana procedures (Vyapad)

3.3 Samprapti (Pathogenesis)

The *Samprapti* (pathogenesis) of *Parikartika* follows a sequential disease progression beginning with *strotovaigunya* — a pre-existing structural vulnerability or weakness of the *Purishavaha srotas* (channels governing faecal transit).^[1] This predisposition, created by prior anorectal pathology, obstetric history, or procedural complications, renders the anal mucosal tissue susceptible to injury upon exposure to aetiological factors. The intake of *Ushna*, *Ruksha*, *Vishtambhi* (hot, dry, constipating) foods and adoption of adverse lifestyle practices aggravates *Vata* and *Kapha doshas*, impairing intestinal motility and promoting *malavashtambha* (constipation).^[1,2]

Progressive hardening of faecal matter compels straining at defecation, which produces mechanical shear stress and tearing of the delicate anal mucosal lining, resulting in a longitudinal ulcer — the anatomical basis of fissure-in-ano. The resulting *kartanvat vedana* (cutting pain) reflexively induces sphincter spasm, which impairs anodermal blood supply, perpetuating the mucosal ischaemia responsible for chronic non-healing fissures. The

patient's instinctive postponement of defecation to avoid pain further consolidates constipation, creating a self-perpetuating vicious cycle of constipation, straining, and mucosal trauma.^[1,3]

Table 2: Stepwise Samprapti (Pathogenesis) of Parikartika.

Step	Samprapti Ghataka (Pathogenic Stage)	Pathophysiological Explanation
1	Strotovaigunya (structural weakness of purishavaha strotas — large intestinal channels)	Pre-existing channel susceptibility from prior anorectal history, pregnancy, or procedural complications
2	Ushna, Ruksha, Vishtambhi ahara sevana (hot, dry, constipating food intake)	Aggravation of Vata and Kapha doshas; impaired intestinal motility
3	Adverse lifestyle — jagarana, divaswap, vegadharana	Further vitiation of Pitta and Kapha; disruption of bowel rhythmicity
4	Malavashtambha (constipation — hardening of faecal matter)	Mechanical trauma to anal mucosa during straining
5	Straining during defecation	Longitudinal mucosal tear at the anus
6	Parikartika (fissure-in-ano)	Kartanvat vedana, kandu, daha, rakta srava — full clinical expression

4. DOSHIC CLASSIFICATION AND CLINICAL CHARACTERISATION

Kashyapa Samhita provides a clinically important sub-classification of *Parikartika* into *Vataja*, *Pittaja*, and *Kaphaja* types, each characterised by distinct symptomatic profiles, examination findings, and therapeutic responses.³ This doshic framework enables the Ayurvedic clinician to individualise treatment based on the predominant *dosha* involved, supplementing the general therapeutic principles applicable to all types. In clinical practice, mixed *Vata-Pitta* presentations predominate, as the *ruksha guna* of vitiated *Vata* and the *tikshna-ushna guna* of aggravated *Pitta* both contribute to mucosal injury.

Table 3: Doshic Classification of Parikartika with Clinical Features.

Doshik Type	Clinical Features	Modern Correlate	Predominant Nidana
Vataja	Kartanvat vedana (cutting pain); constipation; excessive dryness; postponement of defecation	Sphincter hypertonia; mucosal dryness; impaired peristalsis	Ruksha, Laghu ahara; vegadharana; cold exposure; excessive exertion
Pittaja	Daha (burning); inflammation; erythema;	Mucosal hyperaemia; inflammatory	Ushna, Tikshna ahara; jagarana; divaswap;

Doshik Type	Clinical Features	Modern Correlate	Predominant Nidana
	occasional bleeding	infiltrate; oozing ulcer	emotional stress
Kaphaja	Kandu (itching); mucoid discharge; sluggish bowel; heaviness	Mucosal oedema; anal skin tag; subacute inflammation	Guru, Snigdha, Virudha ahara; sedentary lifestyle; daytime sleep
Vata-Pitta (predominant)	Combined cutting-burning pain; hard stool with blood streak; fissure with sentinel tag	Classic fissure-in-ano with hypertonic sphincter; chronic presentation	Mixed dietary and lifestyle aetiological factors

5. LAKSHANA (CLINICAL FEATURES) AND MODERN CORRELATION

5.1 Prodromal and Manifest Symptoms

The clinical manifestations of *Parikartika* as described in classical texts correspond with remarkable precision to the symptomatology of fissure-in-ano in contemporary surgical literature.^[4,5,6] *Kartanvat vedana* — the pathognomonic cutting, knife-like pain at the *Guda* (anal canal) during and after defecation — is the cardinal symptom, persisting for 30 minutes to several hours following each bowel movement. This corresponds to the post-defecatory anal pain described in modern proctology, attributable to sustained internal anal sphincter spasm triggered by mucosal injury.^[5]

Table 4: Lakshana of Parikartika with Clinical and Examination Correlations.

Ayurvedic Lakshana	Clinical Presentation	Modern Examination Finding
<i>Kartanvat vedana</i> — cutting, knife-like pain at anus during and after defecation	Acute severe pain during defecation lasting 30 minutes to one hour	Pain on digital rectal examination; visible mucosal crack
<i>Malavashtambha</i> — constipation; infrequent hard stool passage	Straining at stool; pellet-like or hard stools	Incomplete evacuation; palpable anal sphincter spasm
<i>Daha</i> — burning sensation at anus	Post-defecatory burning; perianal erythema	Mucosal inflammation; soiling of undergarments
<i>Kandu</i> — pruritus ani (itching at anus)	Pruritus aggravated after defecation or on sweating	Perianal dermatitis in chronic cases
<i>Rakta srava</i> — streak of fresh blood in stool	Bright red blood on surface of stool or on toilet paper	Posterior midline ulcer; visible sentinel tag in chronic fissure
<i>Defecation avoidance</i> — patient	Worsening of	Vicious cycle: pain →

Ayurvedic Lakshana	Clinical Presentation	Modern Examination Finding
postpones defecation due to fear of pain	constipation as a secondary consequence	avoidance → constipation → harder stool → more pain

5.2 Modern Surgical Perspective

In modern surgical classification, fissure-in-ano is categorised into acute and chronic subtypes.^[4] Acute fissures present as superficial mucosal tears with clean, well-defined margins and respond well to conservative management. Chronic fissures are characterised by: indurated ulcer edges exposing the white horizontal fibres of the internal anal sphincter at the base; an associated sentinel skin tag at the external margin; and a hypertrophied anal papilla at the dentate line — the triad constituting pathognomonic features of the chronic form.^[6] The posterior midline position (6 o'clock) accounts for approximately 90% of all fissures, attributable to the relatively poor vascular supply of the posterior commissure of the anodermis.^[5]

Modern aetiological understanding identifies internal anal sphincter hypertonia as the central pathophysiological mechanism in chronic fissure-in-ano — a finding that directly parallels the *Vata*-driven muscular rigidity and *stambha* (spasm) described in Ayurvedic pathophysiology. Additional modern aetiological associations include Crohn's disease, ulcerative colitis, tuberculosis, sexually transmitted infections, prior anorectal surgical procedures, and childbirth-related anal trauma — all recognised as predisposing factors corresponding broadly to *nimitta nidana* in the Ayurvedic framework.^[4,5,6]

6. CHIKITSA (THERAPEUTIC MANAGEMENT)

6.1 Nidanaparivarjana (Elimination of Causative Factors)

The primary and most critical therapeutic step in the management of *Parikartika* — as in all Ayurvedic disease management — is *nidanaparivarjana*: the systematic identification and elimination of all aetiological factors.^[1] This principle is of particular importance in *Parikartika* because both the dietary and lifestyle causes are highly modifiable and directly responsible for the perpetuating mechanism of constipation. Without addressing the root cause of *malavashtambha*), pharmacotherapy alone yields only transient benefit, as the pathogenic cycle is re-established upon resumption of the causative habits.

Specific dietary modifications include: discontinuation of excessive sprout consumption (*virudhaka sevana*); avoidance of sago-samo rice-curd combinations; elimination of processed, spicy, and junk food; and cessation of constipating fasting practices. Lifestyle corrections include regularising sleep schedules (avoidance of *divaswap* and *jagarana*), responding promptly to the urge to defecate (*mala vegadharan nivritti*), and initiating structured physical activity to promote intestinal motility.^[1]

6.2 Shamana Chikitsa (Internal Pharmacotherapy)

Ayurvedic pharmacotherapy for *Parikartika* is directed at four concurrent therapeutic objectives: (i) correction of *malavashtambha* through gentle laxation; (ii) *Vatanulomana* (normalisation of downward *Vata* function); (iii) reduction of *Pitta*-mediated mucosal inflammation and pain; and (iv) *Rasayana* (tissue rejuvenation and restoration of mucosal integrity).^[1,2,3]

Table 5: Ayurvedic Formulations Used in Parikartika Management.

Formulation	Dose / Route / Timing	Key Ingredient(s)	Therapeutic Rationale
<i>Aragvadhakapila vati</i>	Administered before meals (apankal), twice daily	<i>Aragvadha</i> (Cassia fistula), <i>Kapila</i>	Smooth laxative; relieves <i>malavashtambha</i> ; <i>Vatanulomana</i>
<i>Abhayarishta</i>	Administered before meals (apankal)	<i>Abhaya</i> (<i>Terminalia chebula</i>) + compound fermented decoction	Laxative; corrects bowel dysregulation; <i>Tridosahara</i>
<i>Eranda tailam</i> (Castor Oil)	Mixed in dough (roti) daily	<i>Eranda</i> (<i>Ricinus communis</i>)	<i>Vatanashaka</i> ; intestinal lubricant; laxative; softens stool
<i>Yashtimadhu tailam</i>	Local application at anus daily	<i>Yashtimadhu</i> (<i>Glycyrrhiza glabra</i>) in sesame oil base	<i>Vatanashaka</i> ; <i>Jeevaneeya</i> ; <i>Vranaropaka</i> (wound-healing); lubrication; pain relief
<i>Krishna draksha</i> (Black raisin) decoction	4–5 soaked raisins boiled; taken lukewarm with <i>saindhava</i> and <i>ghee</i> before meals daily	Black raisins (dried <i>Vitis vinifera</i>)	<i>Rasadhatuposhaka</i> ; gentle laxative; anti-inflammatory; restores mucosal integrity

6.3 Bahya Chikitsa (External / Local Therapy)

Yashtimadhu tailam (medicated oil prepared from *Glycyrrhiza glabra* root in sesame oil) occupies a pivotal role in the local management of *Parikartika*.^[1] *Yashtimadhu* (licorice) possesses *Madhura rasa* (sweet taste) and *Sheeta virya* (cold potency), conferring it

Vatanashaka, *Jeevaneeya* (life-sustaining), and *Vranaropaka* (wound-healing) properties. Sesame oil (*taila*) augments these effects through its intrinsic *Vatanashaka* and lubricating properties, reducing anal sphincter tone, alleviating pain, and promoting fissure healing through enhanced perianal blood flow.^[2]

Local application of *Yashtimadhu tailam* addresses the ischaemia-spasm-ischaemia cycle that perpetuates chronic fissure healing failure, mechanistically comparable to the topical nitroglycerine and calcium channel blocker preparations used in modern conservative fissure management — both serving to relax the internal anal sphincter and restore anodermal perfusion. The Ayurvedic approach thus anticipates the pharmacological principle of chemical sphincterotomy through topical vasodilatory agents by several centuries.^[6]

6.4 Dietary Adjuncts with Therapeutic Significance

The *Krishna draksha* (black raisin, *Vitis vinifera*) decoction protocol — comprising 4–5 soaked black raisins boiled in water, consumed warm with a pinch of rock salt (*saindhava lavana*) and ghee before meals — deserves particular attention as a dietary therapeutic intervention. Black raisins are classified in Ayurveda as *Rasadhatuposhaka* (nourishing to plasma and blood tissues) and possess gentle laxative properties attributable to their soluble fibre content, tartaric acid, and phenolic constituents. The addition of *saindhava lavana* augments *Vatanulomana*, while ghee provides the lubricating *Snigdha guna* essential for softening stool and protecting the anal mucosal surface.^[1]

Buttermilk (*takra*) is specifically commended in Ayurvedic texts as therapeutically beneficial for *Guda roga* (anorectal diseases) — an empirical observation with modern relevance, given the demonstrated benefits of probiotic fermented dairy in improving intestinal microbiome composition, reducing inflammation, and normalising bowel transit. Increased intake of water, fresh fruits, and homemade ghee collectively address the *ruksha guna* (dryness) that represents the fundamental pathogenic quality in *Parikartika*.^[1,2]

7. PATHYAPATHYA (DIET AND LIFESTYLE REGIMEN)

In Ayurvedic therapeutics, *Pathyapathya* — the systematic delineation of recommended (*Pathya*) and contraindicated (*Apathya*) dietary and lifestyle factors — is regarded as inseparable from pharmacological management and, in many conditions, more impactful than medication alone. In *Parikartika*, adherence to *Pathyapathya* directly determines both the rate of healing during active treatment and the prevention of relapse — a factor of particular

significance given the high recurrence potential of fissure-in-ano when underlying constipation remains unaddressed.^[1,2,3]

Table 6: Pathya and Apathya in Parikartika Management.

Pathya (Recommended Diet and Lifestyle)	Apathya (Contraindicated Diet and Lifestyle)
Increased intake of water (minimum 2.5–3 litres/day)	Avoidance of sprouts (virudhakas) — moth beans, kidney beans, chickpeas
Fresh buttermilk (takra) — beneficial for anorectal disorders	Avoidance of sago (sabudana), samo rice (vari), and curd combinations
Homemade ghee and butter — lubricating and Vatanashaka	Avoidance of spicy, Chinese, junk, and bakery food products
Fresh seasonal fruits rich in fibre	Avoidance of excessively dry, light, and cold foods (ruksha, laghu, sheet)
Green leafy vegetables and easily digestible warm food	Strict avoidance of daytime sleep (divaswap) and late-night waking (jagarana)
Castor oil incorporated in daily cooking (roti dough)	Avoidance of suppression of defecation urge (mala vegadharana)
Black raisin decoction with saindhava and ghee before meals	Avoidance of sedentary lifestyle; encourage regulated physical activity

8. PHARMACOLOGICAL RATIONALE OF KEY DRUGS

8.1 Aragvadha (Cassia fistula)

Aragvadha (*Cassia fistula*), commonly known as Indian laburnum or golden shower tree, is classified as a *mridu virechaka* (gentle laxative) in Ayurvedic pharmacology.^[1] Its active principles — sennosides, rhein, and mucilaginous polysaccharides — produce a smooth, non-gripping bowel action through stimulation of colonic peristalsis and softening of faecal consistency. Its *Madhura-Tikta rasa* (sweet-bitter taste), *Sheeta virya* (cold potency), and *Vatapittahara* properties render it particularly suited for *Parikartika*, where both *Vata* and *Pitta dosha* are involved.

8.2 Abhaya / Haritaki (*Terminalia chebula*)

Haritaki (*Terminalia chebula*), called *Abhaya* in classical texts — meaning 'fearless' — is celebrated as the foremost *Tridoshahara* (pacifying all three doshas) drug in Ayurveda.^[1] Its laxative action is mediated through chebulinic acid, chebulagic acid, and anthraquinone glycosides, which promote colonic motility and faecal softening without inducing electrolyte imbalance. Its *Medhya, Rasayana*, and *Vranaropaka* properties additionally support mucosal

healing and long-term bowel normalisation — making its inclusion in *Abhayarishta* formulation particularly appropriate for *Parikartika* management.^[1]

8.3 Eranda Taila (Castor Oil — *Ricinus communis*)

Eranda taila is classified as a *Vatanashaka*, *Anulomana* (promoting downward movement of *Vata*), and *Brimhana* (nourishing) drug in Ayurveda.^[2] Its laxative action is well-established in modern pharmacology: ricinoleic acid produced by intestinal hydrolysis of castor oil activates EP3 prostanoid receptors on intestinal smooth muscle and mucosa, promoting intestinal motility and fluid secretion. Its administration through incorporation into daily roti (unleavened flatbread) dough ensures a sustained, gentle laxative action without causing fluid loss, simultaneously lubricating the intestinal mucosa and softening faecal matter — a therapeutically elegant dietary delivery mechanism.

8.4 Yashtimadhu (*Glycyrrhiza glabra*)

Yashtimadhu is one of the most extensively researched Ayurvedic drugs in contemporary phytomedicine.^[2] Its pharmacological profile includes anti-inflammatory (glycyrrhizin, glycyrrhizinic acid), wound-healing (licoflavone, isoliquiritigenin), antispasmodic, demulcent, and emollient activities — all of which are directly relevant to its application in *Parikartika* management. Its topical application as *Yashtimadhu tailam* achieves mucosal demulcency, pain relief through anti-inflammatory action, reduction of anal sphincter tone, and promotion of epithelial regeneration at the fissure margin — a comprehensive pharmacological action profile supporting its classical designation as *Vranaropaka* and *Jeevaneeya*.^[1,2]

9. DISCUSSION

The Ayurvedic conceptualisation of *Parikartika* demonstrates a sophisticated clinical understanding of the aetiopathogenesis, symptomatology, and management of fissure-in-ano that is both internally consistent and pharmacologically defensible in the light of contemporary evidence. The centrality of *malavashtambha* (constipation) in the pathogenic cascade correctly identifies the primary precipitating mechanism — constipation-driven mechanical mucosal trauma — which is unanimously confirmed in modern surgical literature as the initiating event in the majority of fissure cases.^[4,5,6]

The recognition of *strotovaigunya* as a predisposing factor is clinically significant, as it identifies why certain individuals — particularly those with prior anorectal history, obstetric

trauma, or iatrogenic anorectal injury — demonstrate a disproportionately high susceptibility to developing *Parikartika* upon exposure to the same dietary and lifestyle provocations that do not produce disease in individuals without such predisposition. This concept directly corresponds to the modern understanding of anodermal ischaemia and mucosal fragility as predisposing substrates in chronic fissure development.^[5,6]

The Ayurvedic therapeutic strategy — targeting constipation through gentle laxation, simultaneously reducing *Vata* and *Pitta* vitiation, and promoting local wound healing through topical medicated oil — is pharmacologically coherent and clinically validated through empirical therapeutic outcomes. The specific recommendation of *Krishna draksha* decoction with *saindhava* and ghee reflects an understanding of multi-modal bowel management that integrates prebiotic soluble fibre (raisins), electrolyte balance (*saindhava*), and mucosal lubrication (ghee) — a combination approaching the principles of modern gut-directed dietary therapy. The emphasis on buttermilk (*takra*) for *Guda roga* anticipates the current evidence supporting probiotic interventions in anorectal inflammation.^[7]

A critical observation emerging from the Ayurvedic management framework is the absolute primacy of *nidanaparivarjana* — removal of the causative factors — over pharmacotherapy. Without dietary correction and lifestyle modification, the constipation-fissure cycle is perpetuated irrespective of the medications administered. This principle aligns with the modern surgical emphasis on bowel habit normalisation as the cornerstone of conservative fissure management, before considering pharmacological sphincterotomy (topical nitrates, botulinum toxin) or surgical intervention (lateral internal sphincterotomy).^[5,6] The Ayurvedic approach thus offers a comprehensive, non-invasive management pathway that is particularly appropriate for acute fissures and early chronic fissures in cooperative patients.

10. CONCLUSION

Ayurveda provides a clinically coherent, therapeutically effective, and pharmacologically grounded framework for the comprehensive management of *Parikartika* (fissure-in-ano). The Ayurvedic understanding of the condition's aetiopathogenesis — rooted in dietary indiscretion, adverse lifestyle habits, and *Vata-Pitta* vitiation operating upon a predisposed *strotovaigunya* — is structurally consistent with modern surgical pathophysiology of fissure-in-ano.

The multi-modal Ayurvedic therapeutic approach — comprising *nidanaparivarjana*, gentle laxative pharmacotherapy (*Aragvadhakapila vati*, *Abhayarishtha*, *Eranda taila*), local wound-healing therapy (*Yashtimadhu tailam*), dietary adjuncts (*Krishna draksha* decoction, *takra*, increased fluid intake), and structured *Pathyapathya* adherence — addresses the constipation-fissure cycle comprehensively and without the adverse effects associated with chemical or surgical sphincterotomy.^[1,2,3]

The condition's high recurrence potential underscores the indispensability of sustained *Pathyapathya* compliance beyond the active treatment period. Changes in diet and lifestyle remain the most impactful long-term determinants of anorectal health and fissure recurrence prevention — a principle unambiguously affirmed by both classical Ayurvedic teaching and contemporary proctological evidence.^[4,5,6] Future well-designed clinical trials comparing Ayurvedic conservative management protocols with conventional topical pharmacotherapy will strengthen the evidence base for the integrative management of this prevalent and undertreated condition.

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