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A LITERARY REVIW ON GUDBHRAMSHA WITH RESPECT TO RECTAL PROLAPSE

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ABSTRACT

INTRODUCTION

According to charaka, Mahasrotasa is considered as Koshta[1] (Koshta: punaruchyate Mahasrota:). Koshta contains 15 organs called as koshtaanga.[2] Out of which one is Guda. Guda is one of the vital organ of the human body and Sadyapranaharamarma.[3] It is cited as Mamsamarma[4] and Dhamanimarma[5] respectively by Sushruta and Vaghabhat. It is an Matrujavayava[6] and also a karmendriya.[7] In Nidanashtana, Sushruta has that the entire length of Guda is 4.5 angul.[8,9] According to Vaghabhata it has tree Gudavalis i.e, Pravahini, Visarjini and Samvarni respectively from proximal to distal end.[10] It has been enumerated among 15 koshtanga of the body by charaka having to parts i.e. uttarguda and adharguda.[11]

The rectum is the dilated lower part of the large intestine. It is placed between the sigmoid colon above and anal canal below. The three cardinal features of the colon i.e. taeniae coli, sacculation's and appendices epiploic are absent in the rectum. The rectum is a pelvic organ situated in the posterior part of the lesser pelvis in front of lower three sacral vertebrae and the coccyx. It begins as a continuation of sigmoid colon at the level of vertebra S3 and end by continuing as the anal canal at the anorectal junction. length 12cm long, diameter 4cm in the upper part of rectum but in the lower part it is dilated to form the rectal ampulla.[12]

The rectum in its course shows two types of curvatures,

1. Two anteroposterior curves

a. Sacral flexure-it follows the concavity of the sacrum and coccyx.

b. Perineal flexure-it is the backward bend of the rectum at the anorectal junction.

2. Three lateral curves

a. Upper lateral curves-it is the convex to the right.

b. Middle lateral curve-it is convex to the left. it is prominent.

c. Lower lateral curve-it is the convex to the Right.[13]

Material and Methodology: Gudabhramsha

According to Acharya Sushruta Gudabhramsha is a Shudraroga.[14] In Siddhisthana, Charaka stated that, It is a complication of Virechanaatiyoga.[15] Vaghabhata has coined the term 'Gudnisarana' for Gudabhramsha in Arshachikitsaadhyaya .

Defination

In Ruksha and Durbala person some part of Guda comes out due to excessive Pravahna and Atisara is called as Gudabhramsha.[16]

Hetu of Gudabhramsha

- Rukshata and Durbalata in body
- Pravahaa
- Atisara
- Arsha

Rectal prolapse

It is circumferential descent of rectum (bowel) through the anal canal. Its commonly seen in infants, children and elderly individual. Common in females (6:1). Faecal incontinence is very common feature; urinary incontinence occurs in 35% of patients; 15% of patients are associated with vaginal vault prolapse.

Rectal prolapse can be

- Partial
- Complete
- Hidden/concealed: it is internal intussusception of the sigmoid into the rectum or part of the rectum distally; they do not come out of the anal oriffice. Here only mucosa and submucosa separates from muscularis layer and descends.[17]

Aetiology

- Alexis moschowitz put his theory of 'rectal prolapse is dur to sliding herniation of the pouch of douglas through pelvic floor fascis into the anterior aspect of the rectum.
- Broden and snellman proposed that 'procidentia is a full thickness rectal intussusception starting approximately 7.5 cm above the denate line which is extending beyond the anal verge.
- Decreased sacral curvature and decreased anal canal tone are the probable causes in infants.
- Chronic constipation with straining is the common cause.
- Diarrhoea, cough, malnutrition are the additional factors in children.
- It be due reduced ischiorectal fossa fat, neurological causes, fibrocystic disease of pancreasor poorlydeveloped pelvis.
- There is diastasis of may the levator ani, abnormaly deep cul de sac, redundant sigmoid colon, patulous sphincter, loss of rectal sacral support, lax and atonic pelvic floor musculature.
- Pudendal nerve damage is said to be the cause for pelvic floor and anal apincter weakness. it may be due to obstetric injury, diabetes, sacral nerve damage.
- In adults, it is common in females, common in multipara---repeated birth injuries to perineum results in damage to the perineal nerve supply.
- Adiitional factors are due to increased intra-abdominal pressure due to any cause like chronic cough, stricture urethras.[18]

Types

Partial rectal prolapse

Here only mucosa and submucosa of the rectum descends not more than 3.75 cm there is no descent of the muscular layer. It is common type of rectal prolapse.

Clinical features of partial rectal prolapse

- History of mass per anum which can be observed when child is allowed to strain in squatting position.
- It is pink in colour and circumferential.
- It differs from piles(differential diagnosis),the piles are not circumferential and are plum or blue coloured (not pink).[19]

Complete rectal prolapse

- Also called as procendentia, is less common than partial prolapse.
- It is com mon in females (6 :1:: female : male)
- It is due to weakned levator ani and supporting pelvic tissues.
- The descent is always more than 3.75cm, contains all layers of the rectum (i.e, including muscular layer). often descends down up to 10-15 cm.
- It is often associated with the uterine descent (uterine prolapse).
- It is also through to be as an intussusception of the rectum.
- Once complete prolapse is more than 5cm, anteriorly it drags peritoneum as pouch which often contains small intestine. on digital pushing it reduces with gurgling.
- Patulous anal sphincter is typical with mucus discharge and faecal incontinence.
- Mucosa of the chronic rectal prolapse is thickened, ulcerated, bleeds, and often incsrcerated below the level of anal verge.[20]

Clinical features of complete rectal prolapse

- **C**omplete descent of rectum as mass per anum circumferentially which is red in colour. mass is usually reduciable and painless. incarcerated or infected rectal prolapse is painfull.
- Faecal prolapse may be associated with the uterine prolapse (uterine procidentia) in females.
- Faecal incontinence (75%) is very common. It is due to disruption of the anal sphincter and prolapsed rectal mucosal discharge.
- Bleeding can occur because of the congestion.
- Sepsis, discharge, fever, anaemia are other features.
- P/R examination shows lax sphincter. anteriorly, peritoneal sac comes down as a pouch which may contain small bowel.[21]

Ayurvedic management of gudabhramsha (rectal prolapes)

In Ayurveda, there are number of preparation explained with proper indications for the management of Gudabhramsha. They are as follow:

1. Amlaghrutapana and Anuwasana basti is indicated, if there is pain due to rectal prolapse and there is presence of Niramapurisha avastha.[22]
2. Oral administration of Changerighruta[23] and Chavyadighruta.[24]
3. Yoga for Anuwasanabasti

- Dashmula kwotha[25]
- Bilvakalka sadhit Sneha
- Shati, Shatavha and Bilva sadhit Sneha
- Vacha sadhit Sneha[26]
- Chitraka sadhit Sneha

4. In irreducible rectal prolapse Snehana is applied firstly, Then after proper Swedana index finger covered with cotton gauze is used for repositioning of protruded part. After repositioning Gophanabanda (a lather piece having hole in centre) is applied there and slowly Swedana is done.
5. Oral administration of Kamal patra with Sharkara.
6. Mushaka tail application[27]

Management of rectal prolapes

Partial rectal prolapse

- Digital reposition

Mostly the patient is cured by this method and his or her relatives are advised to push prplapse inside anus with lubrication. In children this condition is temporary and it cures after full development of children.

Complete rectal prolapse

Laparoscopic rectopexy[28]

- It is ideal and good approach to fix the rectum to sacrum
- Laparoscopic posterior mesh rectopexy (LPMR) is the procedure done. prior bowel preparation is needed. Head down, low lithotomy position is needed. ports are placed as shown in diagram. Sigmoid colon is held with left sided port. surgeon does dissection from right side. Peritoneum on the right side of the rectum is opened from sacral promontory downwards to reach presacral avascular plane. Care should be taken to avoid injury to autonomic nerves, ureters. Dissection is extended down as posterior mobilisation into the pelvis with adequate mobilisation of the rectum. lateral ligament are either divided or left alone. Anterior mobilisation is also important. Anterior mobilisation alon the denonvilliers fascis is done 5cm below the peritoneal reflection.10×6 cm polypropylene mesh is placed in the presacral space deep to rectum which is fixed to presacral fascia along the sacral promontory. mesg is sutured to rectal wall also on both side using interrupted polypropylene sutures. Only partial wrapping of mesh is done. peritoneum is

closed using vicryl.

- Many advocate laparoscopic mobilisation and fixation of mobilesed rectum to sacral promontory using polypropylene sutures without mesh.
- Laparoscopis sigmoid resection and rectopexy (laparoscopic resection rectopexy, LPR) is done when there is rectal prolapse with constipation, with excess redundant sigmoid colon with kinking.

Other surgical procedure are[29]

- Well's operation
- Ripstein operation
- Goligher's operation
- Devadhar rectal pliction
- Lahaut's operation
- Rosoe graham operation
- Muir low anterior resection

DISSCUSION

The Guada is a organ of Mahasrotasa, In Ayurvedic text the Doshik involvement of Gudabhramsha is not explained clearly, But it is stated that Gudabhramsha develops mostly in Ruksha and Durbala. Form words like Ruksha and Durbala, explained in etiology of Gudabhramsha we can get idea about Doshik involvement. As Rukshata is due to Ruksha Guna of Vatadosha and Daurbalya is due to Kaphashaya (Rasashaya). So that we can say that vatadosha involment is present in Gudabhramsha. Other etiological factors like Pravahana, Atisara and Arsha are play major role in development Gudabhramsha. Pravahana means straning or applying pressure to pass stool, It may cause damage of rectal mucosal layer same as Pravahana, Arsha (Mostly high line haemorrhoids) may cause damage of rectal mucosal layer. So, here we consider that all tree (Pravahana, Atisara and Arsha) are collectively develops laxity in perineal muscles and pelvic floor. The preparations and methods of treatment explain in Ayurveda text helps to treat Partial rectal prolapse and to stop further deteriorations. For the complete rectal prolapse surgical intervention is needed and for that laparoscopic rectopexy is ideal and good approach to fix the rectum to sacrum.

CONCLUSION

Rectal prolapse is external visualization of rectal mucosa through the anus and in Ayurveda it

is termed as Gudbhramsha. Here it is signified through literature of both modern and ayurvedic literatures.

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