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GUDA MARMA: A CRITICAL REVIEW

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ABSTRACT

An ancient medical science Ayurveda was developed to treat human suffering and to protect people's health. injuries to the arteries, muscles, nerves, bones, and other different types of body structures. generally speaking, and specifically Marma when combined, visceral organs. The most significant of India's hidden sciences is called Marma science. Marmas are significant physio-anatomical features that are deeply seated and not only surface-level landmarks on the body. In ancient Ayurvedic texts, marma is portrayed as the human body's critical point, damage to which results in the loss of life. Descriptions of 107 Marmas given by all Acharyas being classified into five varieties on the basis of structure involved; five on the basis of effect of injury and five on the basis of location on the body. According to anatomical consideration Marmas can be divided into Mansa-marma, Siramarma, Snayu-marma, Sandhimarma, and Asthi-marma (respectively, Marma of muscle, blood vessel, ligament, joint and bone). According to Vagabhatta there are six types of Marma. He has enumerated a sixth group of marma known as Dhamani Marma. Dhamani Marma is one such vital region in human anatomy which falls under the classification on the basis of structure involved. This study is aimed to emphasize on Guda Marma to fulfil the lacuna in the subject.

INTRODUCTION

One of Ayurveda's most well-known topics is marma. The Vedas contain instructions on how to defend Marma (essential parts) in warfare and attack Marma locations to incapacitate an adversary. In Susruta-samhita, several Marmas are listed and discussed in relation to various bodily parts' anatomical considerations. The definition of Marma is considered as vital organs in several literature, according to Dr. Ghanekar in the chapter on Marma in his commentary on the SusrutaSamhita. It is also obvious in practise that any injury to these crucial areas may result in demise. In regards to the heart and brain, it is also accurate. These parts are referred

regarded as crucial parts because damage to them may result in a loss of vitality. Marma's description is a crucial component of Ayurvedic anatomy. There is no denying that the significance of these components has not been properly evaluated. However, this chapter has a very descriptive discussion of several anatomical components that was not covered earlier. The Sanskrit word Dhatu "mri" (marma), which meaning "which causes death or disability," is where the word "marma" originates. Marma's literary definition includes the following concepts: shape, element, living spot, conjugation of various body structures, essence, and vital component. According to Ayurvedic terminology, Marmas are spots that are extremely prone to injury and may cause problems or death. It is clear that the human body contains a number of critical crucial sites (locations) that contain considerable, concealed, and hidden energy. Marma were given a lot of attention by Acharya Susruta, who provided a full description of them in Sharirastana 6:2 along with information on their types, numbers, locations, and signs of injury. By keeping physicians in mind, Acharya Charaka accorded the Trimarmas among the 107 Marmas a great deal of importance.[3] Both Astanga Hridaya (Sharirastana 4th chapter) and Astanga Sangraha (Sharirastana 7th chapter) provide in-depth descriptions of Marma. You may find a thorough discussion of the anatomical structures associated to the Marma region in a number of contemporary anatomy textbooks.[4,5]

Aims

To collect the references from different Ayurvedic texts regarding the concept of Guda Marma.

METHODOLOGY

This study is conceptual; all available references of Marmas and Guda have been collected from Ayurveda treaties and modern science. Websites also have been searched for the same.

Guda Marma

Sharirsthana is distinctive of Sushruta Samhita and Marma is the soul of Sharirsthana. As it has been said that Marma Sharir is the Shalya Vishayardha[6] i.e., half knowledge of surgery, one should give importance to this ancient traumatological anatomy,presented by the great Acharya Sushruta. Acharya Sushruta has defined Marma as anatomical site where Mamsa, Sira, Snayu, Asthi and Sandhi meet together and Prana specially lives at these places. So Marma are also called as Jeevasthans or Pranayatan.[7] Acharya Sushruta classified Marmas into categories like regional Marma, structural dominance wise Marma and the most important classification is Marma according to effects of injury e.g. Sadyah Pranhara,

Kalantara Pranhara, Vishalyaghna, Vaikalyakar and Rujakara Marmas. Out of these, Sadyah Pranhara Marmas are said to be very important and injury to these structure cause sudden death. Among the nineteen Sadyah Pranhara Marmas, Guda Marma is one of the most crucial Marma of abdominal locale. It is the part which is attached to large intestine and serves as the passage for stool and flatus. It is conjointly made up of several structures and any harm to this Marma may prove to be pernicious or promptly fateful. Guda is the Mulastana of Purishavaha Strotas[8] to which proctologists, doctor specializing in disease of rectum and anus comes in contact with. As per Marmaghata Lakshanas explained by Acharyas, any injury or trauma to this structure is immensely igneous in nature likewise in routine practice also while dealing with surgery if ano rectal region get traumatized it may lead to peritonitis, internal haemorrhage, septicaemia, toxaemia, shock or even death. It defines its impulsive disposition and its importance while performing delicate procedures in proctological diseases. DISCUSSION Guda Marma is the part, which is attached to the large intestine and serves as the passage for stool and flatus. Acharya Vagbhatta also approves the anatomical part of description. This leaves no place for doubt, that the structure caudally attached to the end of the large intestine is Guda. So far as structural status of Marma is concerned, Sushrut upholds it Mamsa Marma[9] where as school of Vagbhatta refers it, under Dhamani Marma.[10] Thus a controversy is raised regarding its structural status. The work of Acharya Sushruta is said to be about 1000 BC and Acharya Vagbhatta‘s work belongs to the period of five hundred fifty A.D. (550 AD). Examining from this angle, the view of Vagbhatta needs more weightage going thought the Marma Nirdesha of Sushruta Samhita, it is for perusal that Acharya Sushruta has not considered Dhamani Marma as separate Marma, but it shall be undermined thought that the school of Sushruta was not clear about theof Dhamani and Sira. A thorough exploration of this chapter of Acharya Sushrut, speaks itself that, it has considered Sira as a vessel. In favor of this concept the structural classification of Marma may be focused upon. While classifying the Marma under Sira Marma Neela and Manya have been considered as Sira Marma. But in the usual detailing of Sira Marma, it has been classified that Neela and Manya are not vein rather arteries. It is clear from this very fact that Acharya Vagbhatta‘s classification of Dhamani Marma is nothing, but the sub-classification of Sira. Acharya Sushrut has considered Guda under Mamsa Marma and Acharya Vagbhatta classifies it under Dhamani Marma. This controversy needs further and deeper consideration along with the fact of traumatic events on it; since the Marma is Sadyah Pranahar Marma (instant fatal). Acharya Ghanekar considered anal canal and the muscles surrounding it. Anal canal begins where the lower end of the ampulla of the rectum suddenly narrow passing downwards and backward to

and at the anus. It is about 3.8 cm long in the adult. Posteriorly it is in contact with a mass of fibrous and muscular tissues termed the anococcygeal ligament, which separates it from the tip of the coccyx. Anteriorly it is separated by the perineal body laterally it is related to the ischiorectal fossae, the whole length of it is covered by the sphincter muscles normally keeping the canal closed. The upper half of the anal canal is plum coloured owing to the blood in the subjacent internal rectal venous plexus. The column of the anal contains terminal radical of the superior rectal artery and vein. The anal canal and rectum are supplied by three sources of arteries e.g. superior rectal artery (direct continuation of inferior mesenteric artery) constitutes the chief arterial supply to the rectum, opposite the third sacral vertebra, the artery divides into right and left branch. About half way down the rectum the right branch sub-divides in an anterior and posterior branch, the terminal branches are run straight downwards. The middle rectal artery arises on each side from internal iliac and passes in close proximity to the lateral ligament of the rectum. The inferior rectal artery in each side as a branch of internal pudendal artery enters Alcock‘s canal, it breaks up into branches, which supply the anal sphincter, anal canal and skin of the anal margins. The internal rectal venous plexus lies in the loose sub-mucosa of the anal canal and external from the level dentate line to that the ano-rectal ring. The six collecting venous plexus unite to form the superior rectal vein, important tributary of the portal vein. The middle rectal veins are small and drain into the internal iliac vein. The external rectal venous plexus lies under the skin of the anal canal below the dentate line and beneath the skin of the anal margin. The external rectal plexus is communicated to the internal venous rectal plexus through communicating veins. The lower part of the external rectal plexus drains in external pudendal veins and thence into internal iliac veins. The rectal or anal canal may be injured uncommonly in a number of ways. By falling in a sitting posture on to a spiked or blunt pointed object. The upturned leg of a chair, bundle of broom, floor mop, pitch-fork, or a broken shooting have all resulted in anal impalement by the foetal head during child birth, during the administration of an anima by a syringe fitted with a bone, glass or vulcanite nozzle, during sigmoidoscopy, usually examining the patient suffering from ulcerative protocolitis or amoebic dysentery. Sigmoidoscopy performed under general anesthesia is especially dangerous. Splint perineum a lacerated wound of perineum, involving the anal canal, is an occasional pillion-riding accident. Any definite pattern of the injury has not been accessed by exploration of the literature including research journals the instant fatality can also not be certain under these circumstances, the possibility of the shock and peritonitis via perforation of the bladder cannot be ruled out but in the absence of definite literature only a guess can approve the

definition of Sushruta and Vagbhatta. The instant death due to injury in this region can be possible under two circumstances, the extensive primary neurogenic shock; it turns into peripheral vascular failure, and this may lead to death. But under these conditions Mamsa (muscles) cannot be held responsible for the cause of death. Secondly the death may occur due to excessive hemorrhage causing irreversible shock; this may be possible when the medical aid (transfusion) is not met with in time. If hemorrhage taken into account the arterial bleeding has to be considered, the anal canal is supplied largely by inferior rectal artery, which is the continuation of the internal pudendal artery branching from the internal iliac artery through greater sciatic foramen and enters the zone of ischio-rectal fossa. It is the major artery for, it comes from the major pelvic artery and the injured person may bleed to death, if immediate hemostat is not applied. This goes in favour of Vagbhatta as this school considered this Marma as Dhamani Marma. The rectal plexus are also ultimately connected to the portal system; therefore bleeding from this plexus may also draw the person into danger zone and may succumb to bleeding. This again favours Vagbhatta‘s view. Wounds of the colon and ano-rectal region were one of most serious groups of injuries confronting the combat surgeon in Vietnam. After control of hemorrhage and shock, the greatest mortality in wars wounds resulted from sepsis. Improvement in mortality statistics and reduction in complications resulting from ano-rectal injures are undoubtedly related in large parts to decrease time between the injury and definite treatment, ready availability of the blood replacement, wide spread use of antibiotics, improvement in methods of patients management in the post operative period etc.

CONCLUSION

In light of above references, may be very well concluded that anorectal injuries as Guda marma does not loose its gravity in spite of the best management of the time. The school of Susruta belongs to surgery therefore there is no hesitation to imagine that hemostat would have been within the efficiency of surgeons. However sepsis could have not been excluded in spite of best management. The cause of sepsis for the subcutaneous and muscular trauma to fix the responsibility of muscular tissue as a causative agent to draw the patient within the zone of emergency, fascinates Susruta‘s observation. Vagbhatta belongs to school of physicians therefore there is obvious reason to believe that the hemostat, which is the first line of management, would have been very difficult to manage. It may be possible that inferior rectal artery in reference to hemorrhage is a responsible factor for the management of

anorectal injuries, I believe that the artery is responsible for hemorrhage and shock and muscle should be blamed for sepsis leading to secondary cause of mortality.

REFERENCES

1. Ghanekar B.G. Commentator, sushruta samhita sharer sthan, 6th chapter-pratyek marmanirdesha shariram, Meharchand Lkshaman das Publications, New Delhi, 2008; 183.
2. Sushrutha. & Yadavji, T. A. Editor. Sushrutha Samhitha with Nibandha Sangraha of Dalhanacharya. 8 thed. Varanasi: Choukhamba Surabharathi Publication, 2005; 824: 369-376.
3. Agnivesha. & Yadavji, T. A. Editor. Charaka Samhitha, revised by Charaka & Dridabala, with Ayurveda Deepika commentary of Chakrapani Datha. Varanasi: Choukhamba Surabharathi, 2008; 738-597.
4. William, L. P., & Warwick R. Editor. Gray‘s Anatomy. 36th ed. Edinburgh: Churchill Livingstone, 1980; 1578, 1358, 1359, 288-292, 293-314.
5. Romanes, G. J., Editor. Cunningham‘s Manual of Practical Anatomy, 15thed. New York: Oxford university press, 1996; 2, 298, 11-77, 200-210, 3, 346, 3-27, 35-92, 135-165.
6. Prof. Srikantha Murthy, K. R. Sushruta Samhita, Reprint, Chaukhamba Orientalia, Varanasi, 1, Sharirsthana 6/33, 117. ISBN-978-81-7637- 071-4 –I, 2012.
7. Dr. Bramhanand T. Charak Samhita of Agnivesha, Reprint, Chaukhamba Surbharti Prakashan, Varanasi, 1, Sutrasthana, 2007; 29/3, 533.
8. Dr. Bramhanand T. Charak Samhita of Agnivesha, Reprint, Chaukhamba Surbharti Prakashan, Varanasi, 1, Vimanasthan, 2007; 5/8: 698.
9. Ghanekar, B. G. Commentator, sushruta samhita sharer sthan, 6 th chapter-pratyek marmanirdesha shariram,Meharchand Lkshaman das Publications, New Delhi, 2008; 185.
10. Mishra, J. N. Chouhan Pradeep Kumar, Marma and its management, Chowkhambha orientalia, Varanasi, first edition, 2005; 126-130.