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COMPREHENSIVE LITERARY REVIEW ON PARIKARTIKA W.R.T FISSURE IN ANO

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ABSTRACT

An individual's overall health is strongly shaped by dietary habits and lifestyle choices. In *Ayurveda*, food is regarded as a central factor in both the onset and treatment of *Parikartika*. Mentions of this condition appear as early as the *Sushruta Samhita* (1500 B.C.), with further elaborations in the *Bruhatrayees* and other classical works. Notably, *Parikartika* is not classified as an independent disease in these texts; instead, it is described as a complication (*Vyapath*) that may arise following therapeutic procedures such as *Bastikarma* and *Virechana*. In contemporary medicine, fissure-in-ano is one of the most common anorectal disorders. Research indicates that 30 - 40% of people experience proctologic issues at some point, with anal fissures accounting for 10 -15% of these cases. The hallmark features include sharp pain during and after defecation, rectal bleeding, and spasm of the anal sphincter.

Ayurvedic descriptions of Parikartika emphasize symptoms such as *Kartanavat Shoola* and *Chedanavat Shoola* (cutting or tearing pain in the anal region), which closely mirror the clinical presentation of fissure-in-ano. Both conditions are characterized by severe pain (*Teevra Shoola*) and bleeding (*Raktasrava*). *Ayurvedic* management focuses on internal remedies and localized applications prepared with substances that are *Madhura* (sweet), *Sheeta* (cooling), and *Snigdha* (unctuous). Treatments such as *Anuvasana Basti*, *Piccha Basti*, medicated oil infusions (*Madhura-Kashaya Dravya Siddha Taila Poorana*), topical pastes

(*Lepa*), and gauze applications (*Pichu Dharana*) are considered effective in reducing symptoms and supporting healing. Chronic fissure-in-ano often progresses to the formation of sentinel piles. Although *Ayurvedic* texts do not directly describe sentinel piles as a consequence of Parikartika, similarities can be drawn with conditions such as *Shushkarsha*, *Bahyarsha*, *Vataja Arsha*, and *Janmottar-Kalaja Arsha*. These references provide a conceptual basis for linking sentinel piles with *Ayurvedic* understanding of pathogenesis.

KEYWORDS: Acute fissure, Chronic fissure, *Chikitsa*, Fissure In Ano, Management, *Parikartika*.

INTRODUCTION

The human body is a remarkable product of evolution, built to adapt and survive in changing environments. While once oriented toward physical labour, modern lifestyles emphasize mental work, often at the cost of health. Poor diet, fast food consumption, lack of fiber, irregular eating habits, sedentary routines, and stress commonly disrupt digestion, leading to constipation. This condition affects up to 80% of people worldwide and is a major contributor to anorectal disorders.

Among these, fissure in ano (AF) is the most frequently reported. AF is a linear tear in the anoderm, usually at the posterior midline. Though small and superficial, it causes intense pain, burning, and rectal bleeding. Its incidence is about 1 in 350 adults, with acute fissures accounting for 18% of anorectal cases. Studies show AF significantly reduces quality of life, impacting vitality, social functioning, and mental health.

Ayurveda, the "science of life," emphasizes longevity and holistic health. Classical texts describe numerous diseases, including lifestyle-related conditions. Parikartika, mentioned in Ayurvedic literature, is often correlated with anal fissure. Traditionally considered a symptom rather than a distinct disease, Parikartika relevance today lies in its connection to AF, offering insights into ancient perspectives on modern health challenges.[1,2,3,4]

Parikartika

Paribhasha (Definition)

Parikartika refers to intense, circumferential pain in the anal region, described as sharp and cutting, similar to the sensation of scissors. The word comes from Sanskrit: *Parikr* ("all

around") and *Kartana* ("cutting"), together signifying severe encircling pain localized to the anus.[5]

Nidana (Aetiology)

According to *Acharya Sushruta*, the *nidana* of *Parikartika* is classified into

- ***Nija nidana*** – endogenous causes
- ***Nidanarthakari roga*** – secondary conditions/complications
- ***Agantuja nidana*** – exogenous causes

Nija Nidana* of *Parikartika

The term *Nija Nidana* refers to the causative factors that specifically vitiate *Apana Vayu* and *Rakta*, as described by *Acharya Charaka* and *Acharya Vagbhata*.[6,7]

According to *Acharya Vagbhata*.[8,9] the vitiation of *Apana Vayu* may occur due to various dietary and lifestyle factors, such as:

a) **Dietary factors** – Consumption of food possessing *Tikta* (bitter), *Lavana* (salty), and *Katu* (pungent) tastes; intake of food in lesser quantity than required; frequent use of *Ruksha* (dry) and *Guru* (heavy) substances; or indulgence in excessive eating.

b) **Suppression of natural urges** - Avoiding or delaying urination and defecation.

c) **Sleep disturbances** – Remaining awake during night hours

d) **Vocal strain** – Speaking in a loud voice or for long durations.

e) **Prolonged vehicular travel** – Spending extended time travelling in vehicles (*Yāna sevana*).

f) **Excessive walking** – Moving frequently or covering long distances on foot.

***Nidānārthakāri Roga Nimittaja*.*Charaka Samhita*[10]** Mentions Parikartikā as a symptom of *Vātika Atisāra*, where patients pass scanty, hard stools with froth and sound, accompanied by severe pain in the rectal region and sometimes rectal prolapse. In the *Grahaṇi* chapter, *Charaka* also lists *Parikartikā* among features of *Vātika Grahaṇi*, alongside cachexia, weakness, chest discomfort, and loss of taste.	***Sushruta Samhita.*[11]** While not using the term directly, *Sushruta* describes symptoms resembling *Parikartikā* in the prodromal stage of *Arśa* (hemorrhoids).
***Ashtanga Hridaya (Vagbhata)*[12,13]** Supports *Charaka's* view, linking *Parikartikā* to *Vāta* vitiation and bowel obstruction in *Atisāra Grahaṇī Doṣa Nidāna*	***Kāśyapa Samhita*** Notes its frequent occurrence in pregnant women (*Garbhiṇī Cikitsā Adhyāya*) and classifies it based on *doṣa* predominance—*Vāta*, *Pitta*, or *Kapha*.

Vaidya Nimittaja

Vaidya Nimittaja refers to complications caused by external medical interventions, especially when performed by an inexperienced practitioner. Intensive *Pañcakarma* therapies - such as *Virecana*, *Basti*, and *Vamana* - demand precision and careful monitoring. If carried out without proper skill or supervision, they can lead to adverse outcomes. *Suśruta* identifies nine possible complications from such improper practice, one of which is Parikartikā.[14]

Virechana Vyapad In the context of *Vamana* and *Virechana* complications, both *Charaka* and *Suśruta* highlight *Parikartika* as a significant risk. They note that individuals with *Mrdu Kostha* (delicate intestines) and *Alpa Bala* (low strength), when given purgation using agents that are *Tikshna* (sharp), *Ushna* (hot), and *Ruksha* (dry), are more prone to this disorder. *Suśrutha* further explains that the condition primarily arises from disturbances in *Vata* and *Pitta* doshas.[15], [16]	***Basti Vyapad*** Use of high-volume *Ruksha Basti* prepared with *Tikshna* and *Lavana* substances has been linked to the onset of *Parikartika*. Texts also caution that administering excessive doses of such formulations can precipitate this complication.[17] [18]
Basti Netra Vyapad Improper use of the *Basti Netra* or defects in the instrument can lead to *Parikartika*. In some cases, incorrect application may also cause *Gudaksata* due to direct mechanical injury.[19]	***Excessive use of Yapana Basti*** Overuse of *Yapana Basti* has been associated with *Parikartika* and related disorders[20], and *Kashyapa* notes its occurrence in pregnant women. Key causes include *Virechana*, *Basti Vyapad*, *Basti Netra Vyapad*, and *Vataja Atisara*, with trauma as the common underlying mechanism: • In *Virechana* and *Basti Netra Vyapad*, excessive drug volume is the main risk factor. • In *Basti Netra Vyapad*, direct trauma to the rectal tissue (*Guda Twak*) is the cause. • In *Vataja Atisara*, hard stools damage the rectal mucosa, leading to *Parikartika*.

***Samprapti* (Pathogenesis)**

Nidana (*hetu sevana*)

↓

Agni vaishamya

↓

Vitiation of *doshas* (*vata* & *pitta*)

↓

Avipaka and *Malasanchaya*

↓

Prakopa of *Apana Vayu*

↓

Doshas migrate through *Pradhana adhogami dhamani*

↓

Sthana samshraya in *guda pradesha*

↓

Dosha dushya sammoorchana

↓

Localization of *doshas* occurs in *twak* and *mamsa*

↓

Kshata in *guda* is produced

↓

Parikartika

Samprapti Ghataka

Dosha – Vata Pradhana, Pitta Anubandha

Dushya- Twak, Rakta, Mamsa

Agni – Jatharagni mandya, Vishamagni

Srotas – Purishavaha srotas, Raktavaha srotas, Mamsavaha srotas

Sroto dushti – Atipravritti, Sanga, Vimargagamana

Udbhavasthana – Pakvashaya

Adhisthana – Guda

Vyaktasthana – Guda Pradesha

Roga marga – Bahya Roga Marga

Shat kriya kala

Vitiation of *Apana vata* & *Pitta* starts due to *Nidana* - ***(Sanchaya)***

↓

Vitiated *vata* and *pitta* dosha goes to *Guda Pradesha* leading to *Rookshata* and *ushmata* - ***(Prakopa)***

↓

Aggravated dosas move to *Guda Pradesha* ***(Prasara)***

↓

Vitiated doshas settle in *guda*, initiating *Vibandha* & early tissue irritation **(*Sthana Samshraya*)**

↓

Parikartana Vat Vedhana - Paridaha, Srava, Twak Sputanam **(*Vyakta*)**

↓

Fissure becomes chronic, with persistent severe pain, potential spasm of sphincter, non – healing wounds / complications like bleeding **(*Bheda*)**

Chikitsa of Parikartika

According to *Acharya Charaka*[21] Charakacharya recommends *Basti* prepared with milk processed using drugs of *Madhura* and *Shita* qualities, such as *Ikshurasa* and a paste of *Yastimadhu* with *Tila*. He also advises formulations similar to *Suśruta's*, prescribing *Piccha Basti* and *Anuvasana Basti* made with *Madhura* and *Kashaya* properties, using *Madhuyashti* powder and *Kwatha*.	**According to *Acharya Sushruta*** *Suśrutacharya* prescribes *Piccha Basti* prepared with *Ber*, *Nagbala*, *Selu*, *Semal*, and tender *Dhanvana* leaves, all cooked in milk with *Madhu Ghrita*, along with *Yastimadhu* and black *Tila*. For *Anuvasana Basti*, he recommends a mixture of *Madhuyashti*, *Khasa*, *Gambhari*, *Kutaki*, *Kamala*, *Candana*, *Syama*, *Padmaka*, *Jeemoot*, *Indrayava*, *Atisa*, *Visambu*, oil, ghee, milk, and a decoction of *Nyagrodha Gana*. Another *Piccha Basti* formulation uses a paste of *Yastimadhu* and sesame, blended with ghee and honey, administered alongside *Anuvasana Basti*. In *Pitta*-dominant cases, ghee cream is preferred, while in *Vata*-dominant cases, oil processed with *Yastimadhu* is advised.[22,23,24,25]

According to *Kashyapa Samhita*

Kashyapa Samhita outlines treatment for *Parikartika* based on the dominant dosha

- ***Vātika Parikartika*** - Managed with *Brihati*, *Bael*, and *Ananta* for their vāta-pacifying effects.[26]
- ***Paittika Parikartika*** - Treated with *Madhuyashti*, *Hanspatti*, *Dhaniya*, and *Madhu*, which soothe pitta and act as mild laxatives.[27]
- ***Kaphaja Parikartika*** - Addressed using ingredients with both kapha- and vāta-pacifying properties, such as *Kantakari*, *Pippal*, *Gokshura*, and salt.[28]
- **Pregnancy cases** - Recommended therapy includes milk processed with *Madhura rasa* drugs, combined with *Madhu*, *Sharkara*, *Tila Taila*, and *Madhuyashti*.[29]

Anuvasana Basti is advised with preparations containing *Laghu Panchamula*, *Madanphala*, *Yava*, *Kola*, *Kulatha*, *Jala*, *Dadhi Mastu*, *Taila*, *Kushta*, *Saunf*, *Vacha*, *Madhuyashti*, *Indrayava*, *Harenu* seeds, *Devadaru*, *Bilva*, *Lavanga*, *Rasna*, *Nagarmotha*, *Elaichi*, and

Priyangu.[30] Another formulation includes *Hingu*, *Daruharidra*, *Devadaru*, *Pathya*, *Putika*, *Kangi*, and castor oil.

Fissure in Ano

Definition

A fissure in ano is an elongated ulcer that runs along the longitudinal axis of the anal canal.[31] Fissure in ano is an ulcer in the longitudinal axis of the lower anal canal.[32]

Aetiology[33]

Most anal fissures occur in the posterior midline due to several anatomical factors: the backward angulation of the anal canal, limited mobility of its posterior wall, separation of external sphincter fibers in that region, and the canal's elliptical shape. Constipation is the primary cause, though internal sphincter spasm also contributes. In some cases, excessive skin removal during haemorrhoidectomy can cause anal stenosis, and hard stool passing through the narrowed canal may produce fissures. Secondary causes include conditions such as ulcerative colitis, Crohn's disease, syphilis, and tuberculosis**.**

Location[34]

Anal fissures are most commonly found in the posterior midline, accounting for about 90% of cases, while the anterior midline represents roughly 10%. Anterior fissures occur more often in women, but posterior fissures remain predominant in both sexes. When fissures appear outside the typical midline sites, they may indicate systemic conditions such as Crohn's disease or sexually transmitted infections.

Types

1. Acute
2. Chronic Acute

Acute fissure in ano appears as a small crack in the anal lining but can cause severe pain and sphincter spasm.

Chronic fissure in ano shows thickened edges, with the lower margin often swollen and hypertrophied, forming a sentinel tag. In some cases, the ulcer base exposes transverse fibers of the external sphincter.

Clinical Features

Pain & Burning: Acute fissures cause sharp, tearing pain during defecation, often followed by burning discomfort lasting 3- 4 hours. Severe pain may lead patients to avoid bowel movements, worsening constipation. Chronic fissures usually produce milder pain.

- **Bleeding:** Bleeding is often minimal, seen as streaks of blood on hard stools. It is more common in acute fissures, though rarely it may be heavy enough to cause anaemia.
- **Discharge & Itching:** Moist discharge can irritate surrounding skin, leading to persistent itching (pruritus ani).
- **Sentinel Tag:** Long-standing fissures may develop a small skin tag near the lesion.
- **Bowel Habit Changes:** Pain during defecation often causes patients to delay bowel movements, which contributes to constipation.
- **Management of Fissure-in-Ano**

Treatment can be divided into two main approaches

1. **Conservative methods**
2. **Surgical procedures**

Conservative Treatment

Botulinum Toxin Injection[35] Administering 20 - 25 units of botulinum A toxin into the fissure edges and internal sphincter is a simple outpatient procedure under local anesthesia. Pain relief typically appears after a week, with sphincter function returning in a few months. Recurrence is possible, repeated injections may be needed, and overall healing rates are moderate	**Long-acting Local Anesthetics** Blocking the inferior rectal nerves with agents such as Nupercaine or Proctocaine reduces pain. These drugs are prepared in oily solutions, which slow absorption and extend their effect	**Anal Dilatation** Spasm of the internal sphincter contributes to pain. Gentle dilation, performed under anesthesia with lubricated fingers, stretches the muscle gradually to relieve discomfort. The process must be slow and controlled to avoid injury.
Use of Anal Dilators[36] Persistent pain in fissure-in-ano often results from spasm of the internal sphincter. Gentle dilation helps relieve discomfort. After applying local anesthesia, dilation may be done digitally under spinal or general anesthesia with the patient in lithotomy position. A lubricated finger is inserted to the ano-rectal line and the sphincter is gradually stretched with firm, rotating pressure. The process	**Suppositories** These may combine anesthetics, analgesics, anti-inflammatory agents (commonly hydrocortisone), emollients, and suitable bases or preservatives to reduce pain and inflammation.	**Nifedipine / Diltiazem** Both are calcium channel blockers that relax the internal sphincter, improve blood flow, and promote fissure healing, thereby shortening recovery time.

should be slow, lasting several minutes. Modern practice favors specially designed anal dilators, available in small, medium, and large sizes, over manual stretching.		

Surgical Treatment of Anal Fissure[37]

1. Posterior sphincterotomy with Fissurectomy • Done under general anesthesia in lithotomy position with Sim's speculum. • Superficial internal sphincter fibers are divided to relieve spasm; fibrotic ulcers and sentinel piles excised if present. • Care taken to avoid complete sphincter division. • Postoperative care: liquid diet for 2 days, bowel movement on day 3, daily sitz baths, and anal dilators until healing. • Recovery: 7–10 days; occasional persistent mucous discharge.	**1. Lateral anal sphincterotomy** • Internal sphincter divided laterally (right or left side), away from fissure. • Suitable for early cases; ulcer excision/biopsy not possible in same sitting. • Recovery faster, hospital stay ~4 days. Reported complications: hematoma, abscess, anal swelling, minor incontinence (10–12%), and ulcer recurrence
1. Ulcer excision with skin graft (V-Y anoplasty) • Anal skin mobilized to cover canal defect after ulcer removal. • Attempts to reduce recovery time unsuccessful; results generally unsatisfactory.	**1. Anal advancement flap** • Fissure edges excised and mobilized as full-thickness skin flap. • Flaps advanced to cover fissure site.

DISCUSSION

Parikartika, described in Ayurveda as a painful tearing sensation in the anal region, closely parallels fissure in ano in modern medicine, which is defined as a longitudinal ulcer in the anal canal caused by trauma from hard stools, constipation, or sphincter spasm. Both traditions highlight similar clinical features—severe pain during defecation, burning, bleeding, and sphincter hypertonicity—though their conceptual frameworks differ. Ayurvedic management emphasizes holistic care through oleation, fomentation, medicated oils, *kshara karma*, and lifestyle regulation, while modern medicine focuses on conservative measures like sitz baths, stool softeners, topical vasodilators, and surgical sphincterotomy for chronic cases. A comprehensive review underscores the convergence in symptomatology and divergence in therapeutic philosophy, suggesting integrative approaches may optimize patient outcomes.

CONCLUSION

A comprehensive review of *Parikartika* and fissure in ano reveals striking similarities in clinical presentation, with both traditions describing severe pain, bleeding, and sphincter spasm as hallmark features. While Ayurveda conceptualizes the condition through *Vata dosha* imbalance and emphasizes holistic management with local therapies, diet, and lifestyle regulation, modern medicine frames it as an anal ulcer caused by trauma and focuses on conservative measures and surgical intervention when necessary. The convergence in symptomatology and divergence in therapeutic philosophy highlight the potential value of integrative approaches—combining preventive Ayurvedic principles with modern medical precision—to achieve more effective and sustainable patient outcomes.

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