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Outcomes Of *Vipreetmala Taila* & *Ganesh Kriya* In The Treatment Of Anal Stenosis: One Centre Experience

Sudesh Gupta,[1] Manpreet Singh[2]

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[1]Professor & Head, Post Graduate Department of Shalya tantra, Jammu Institute of Ayurveda &Research, Jammu, India.

[2]PG Scholar, Post Graduate Department of Shalya tantra, Jammu Institute of Ayurveda & Research, Jammu, India.

Corresponding Author :- Sudesh Gupta, Professor & Head, Post Graduate Department of Shalya tantra, Jammu Institute of Ayurveda &Research, Jammu, India, Email: drsudeshgupta@gmail.com

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ABSTRACT: -

Introduction: An alstenosis represents an abnormal narrowing of the anal canal to a varying extent due to stricture of the epithelial lining that has been replaced by fibrous connective tissue. Although it may occur without previous surgery, it usually results from surgical procedures carried out overzealously without the required technical knowledge, most commonly after hemorrhoidectomy. Sushruta has cited administration of various oils through anus for the treatment of various disorders. The intend of this study was to share the results of oil administration into anus in the management of anal stenosis.

Methods: from 2016 to 2018, twelve patients, nine (75%) males & three (25%) females with mild to moderate anal stenosis were selected from Jammu Institute of Ayurveda & Research, Jammu, India. All the cases were advised for sitz bath followed by *Ganesh kriya* (Rectum Cleaning/Anal Cleaning) & administration of *Vipreetmala taila* into anus with red rubber catheter twice a day for one month.

Results: All the patients were complaining of Pain (100%) & constipation (100%), nine patients were complaining of Bleeding (75%) & Pain (75%) before treatment. After the completion of third month all the Patients showed complete improvement in all symptoms and follow up of the cases was done for six months.

Conclusion: The best remedy for anal stenosis is prevention. Therefore, during common surgical procedures like hemorrhoidectomy, one must refrain from interventions that will result in anal stenosis. However, the ease of administration, good functional outcome, and lack of any complications show that *Ganesh kriya* (Rectum Cleaning /Anal Cleaning) & administration of *Vipreetmala taila* into anus is safe, effective &offer commendable results.

Key Words: Sushruta, Anal stenosis, Hemorrhoidectomy, *VipreetmalaTaila, Ganesh Kriya*

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INTRODUCTION

Anal stenosis is a condition in which there is mechanical narrowing of the anal orifice & anal canal. There is loss of compliance of natural elasticity of the anal canal opening, which ultimately become abnormally tight &fibrosed. Anal stenosis may follow any circumstance that cause scarring over the ano dermal area. The most common cause of anal stenosis if previous anal surgery. Hemorrhoidectomy with excessive removal of anoderm is the usual cause. With progressive healing, the fibrous scar tissue may proliferate and contract the anal outlet. When healing is complete a narrow, fore shortened stenotic orifice may result. So, it is essential to preserve anoderm when operating in the anal canal. If adequate skin bridges are preserved the risk of stenosis is reduced, and so preservation of skin bridge is better than over zedous hemorrhoidectomy. If infection and neoplastic stricture are the cause of the anal stenosis then AIDS must be strongly suspected. Though the majority of cases of anal stenosis arc secondary to trauma, Paget's diseases of perianal region and Bowen's disease are also said to be the cause in certain cases. Sushruta the father of Indian Surgery has mentioned various medicated oils for various diseases and are administered through variety of routes, the most common being the oral and parenteral route. While rectal route is widely explained for various *Basti karma* i.e. medicated enemas for neurological diseases, constipation, distended abdomen, amenorrhea, abdominal spasmodic pain, gout, splenomegaly, paralysis, spondylosis, proctological conditions, etc. Drugs mixed with various adjuvant and administered through the rectal route do provide satisfactory pharmacokinetics with acceptable local tolerance. Medicated enemas, Oils, *Ghritas*, Suppositories are various modes of administration of drugs through anus.

Classification

Different classifications are available depending upon the pathology, severity and level of obstruction:

Pathologically anal stenosis can be classified as congenital and acquired which can be further divided as primary or secondary. The congenital forms are due to imperforate anus & anal atresia. The primary stenosis is also known as involutional stenosis and it is seen in senility. Depending upon the severity it can be classified as mild, moderate and severe. If the anal orifice admits the index finger or a medium Hill-Ferguson Retractor with some difficulty the stenosis is mild and if forceful dilatation is required to insert index finger or a medium hill-Ferguson retractor it is moderate and unable to pass the finger even with force nor a small hill-Ferguson retractor can be inserted unless a forceful dilatation is employed it is severe. Furthermore, stenosis may be diaphragmatic (after inflammatory bowel disease, characterized by a thin strip of constrictor tissue), ring like or annular (after surgical or traumatic lesions, of length less than 2 cm), and tubular (length more than 2 cm). Depending upon the level of anal canal involvement it is classified as low, mid and proximal. When the stenosis is at the distal anal canal 0.5cm below the dentate line, it is called low anal stenosis and when it is 0.5cm above the dentate line it is proximal and when it is within 0.5cm from the dentate line it is mid anal stenosis. [1]

Clinical Presentation

Pain during defecation is the most common complaint. Progressive constipation and feeling of

some obstruction at the level of anal orifices is the next common complaint. Bleeding per rectum occurs when there is tear in the anal verge. the constipation may be so server that the patient may need digital evacuation, provoking further trauma. The fear of fecal impaction or pain usually makes the patient to take daily enema or laxative. Diarrhea from chronic laxative use (paraffin anus) or from fecal impaction and overflow may also be a form of presentation. Long standing cases, the retrograde distension of the rectal ampule and the rectum results in mega rectum. There may be no correlation between the clinical findings and the symptomatology. Elderly patients may lead a comfortable life in spite of narrow anal canal.

Physical Examination

It may be impossible to perform a digital examination or the anal orifice will admit only small finger for examination. Sometimes it is difficult to differentiate true stenosis due to tissue loss from sphincter spasm associated with an anal fissure, local anesthetic or general anesthetic abolishes the spasm associated with an acute fissure. It is important to ascertain the cause of the stricture in order to decide the proper therapy.

Physical examination reveals the probable cause of the anal stenosis. Presence of scar indicate the cicatricial tissue from previous perineal surgery. Specifically, Bowen diseases can be suspected when there is raised, irregular, scaly, brownish plague with eczematous lesion. The Paget's disease may be suspected when there is ulcerative, crusty or papillary lesion Is present. Ulcers with classical clinical presentation of rodent ulcer or squamous cell carcinoma can be easily differentiated. In sodamy individual, perianal sexually transmitted disease is to be suspected and relevant investigation to be done.

Patients with long term laxative, there is sphincter muscle wasting resulting inn anal stricture, consequence of passing small, narrow feces over many years. Mineral oil is notorious for leading to stenosis, probably because the lubricated stool fails to dilate the anal canal.

In congenital anal stenosis, a ring like narrowing occurs in the upper end of anal canal that is about 1cm from the surface in the newborn an increase to about 2 cm in older children. Its extend varies from string like stenosis in a normal anal canal to a diffuse fibrosis involving the internal sphincter. The external appearance is normal and hence the lesion may pass unnoticed for some time. When the child starts taking solid food the constipation becomes progressive and severe. By the time, the rectum would have gone for considerable secondary dilatation.

Treatment

Medical treatment may affect defecation but do not specifically treat the cause of the problem-a narrow diameter of the anal canal. Non operative treatment is recommended for mild stenosis and for initial care of moderate stenosis. Also, with severe stenosis conservative treatment can lead to good result however surgery is always necessary. The of stool softeners and fiber supplements with adequate gain of fluids is the basis of nonoperative treatment. This gradual and natural dilatation is very effective in most patients. Anal dilation can be performed daily both digitally or with any of a number of graduated mechanical dilators. Patients are instructed to sit down on the toilet, bear down and gradually insert the smallest dilator with ample lubrication. If the patient can persist with the dilation on regular basic the result is usually excellent many patients do not tolerate this procedure. On the other hand, a dilator may tear the anal canal. Infect a complication form the use of dilator's may itself precipitate the need for surgical intervention. However, it would be a rare circumstance when mild stenosis would require surgery.

More over if the patient remains symptomatic with the usual measure it is important to be certain that anal stenosis in deed the cause patients' complaints particularly in the post-operative patients, anal fissure must be ruled out as a possible source of the problem. If stenosis is refractory to non-operative management surgery represent the last solution. However, a long course of conservative, medical

management is indicated in the treatment of mild anal stenosis before resorting to surgical approach many different surgical techniques have been described for the management of moderate to severe anal stenosis. Moderate stenosis is generally treated initially in the same patients as mild stenosis. fiber supplementation is indicated and dilation are carried out if necessary further more parcel lateral internal sphincterotomy may be quite adequate for a patient mild degree of narrowing. This technique is simple and safe and uses limited to functional stenosis it is important that the sphincterotomy is done in open faction so that the associated scarred anoderm is divided at the same time to allow full reliance of the scar the resulting wound is then left open allow to heal by secondary intent. This provides a relief of the preictal obstruction and pain cause by stenosis but the relief will be short lived without appropriate medical management. The importance of a high fiber diet and fiber supplement must be emphasized to the patient and instituted immediately after surgery. although the result have been reported as excellent it is difficult to interpret weather the patients had significant narrowing are spasm associated with the anal fissure for more severe anal stenosis if formal anoplasty should be performed to treat the loss of anal canal tissue, various types of flaps have been described for anal stenosis which allow delivery of the more pliable anoderm in to the anal canal to replace the scarred lining at that level. A lateral internal sphincterotomy is also usually necessary at the time of anoplasty.

MATERIAL AND METHODS

This was retrospective study that was done in Jammu institute of Ayurveda & research, hospital, Jammu, India during 2016-2018 and the people participating in the study were informed completely.

Inclusion Criteria consisted of patients who have mild anal stenosis and moderate anal stenosis. When the internal diameter of anal canal is less than 0.5cm it is severe stenosis and when the diameter is 0.5 to 1cm stenosis is moderate and 1 to 1.5 cm of diameter is known as mild stenosis.

Exclusion Criteria was severe anal stenosis, irritable bowel disease, Tuberculous, Previous Radiotherapy, Anal malignancy and previous Anoplasty. All the patients were examined thoroughly.

Demographic data, past medical history types of previous anal procedure where collected final patients were selected medical records were all the patients were evaluated and all of them visited and examined the questionnaire contained information about the chief complaints on admission - Itching, Bleeding, Pain & Constipation.

Drug Review

In this study *Vipreetmala taila* was taken for management of mild & moderate anal stenosis. *Vipreetmala taila* is mentioned by Yogratnakar for the management of *Vrana* (wounds) in *Vrana shotha* (wound inflammation) *rogadhikara.* The Ingredients of the oil are *Sindoor* (Red oxide of mercury), *Kustha (Saussurea lappa)*, *Hingu (Asafetida)*, *Lashuna(Garlic)*, *Chitraka root (Plumbago Zeylanica), Langali (Gloriosa superba), Hartala*(Orpiment), *Sharpunka (Tephrosia purpurea), Shudh tutha, (Purified copper Sulphate) Shudh samundar phena* (Cuttle fish bone) and *tila taila* (sesame oil) .[2]Sushruta, the great Indian surgeon in his text book Sushruta Samihita has cited application of oil in *Utsannamamsa* (elevated skin), *Asnigdha* (dry) and *Alpasravi* (less discharge).[3]

Administration Techniques Of *Vipreetmala Taila*

The patient was advised to take sitz bath daily with *Triphala kshaya* for 15 minutes. Then *Vipreetmala taila* 10ml is injected in to anus with red rubber catheter or feeding tube, with patient lying on the left lateral position with the right knee bent. Emptying of bowel should be avoided for at least an hour after injection of oil to allow it to be fully absorbed.

Ganesh Kriya (Finger Dilatation Of Anus)

Lubricated index finger with *Vipreetmala taila* is

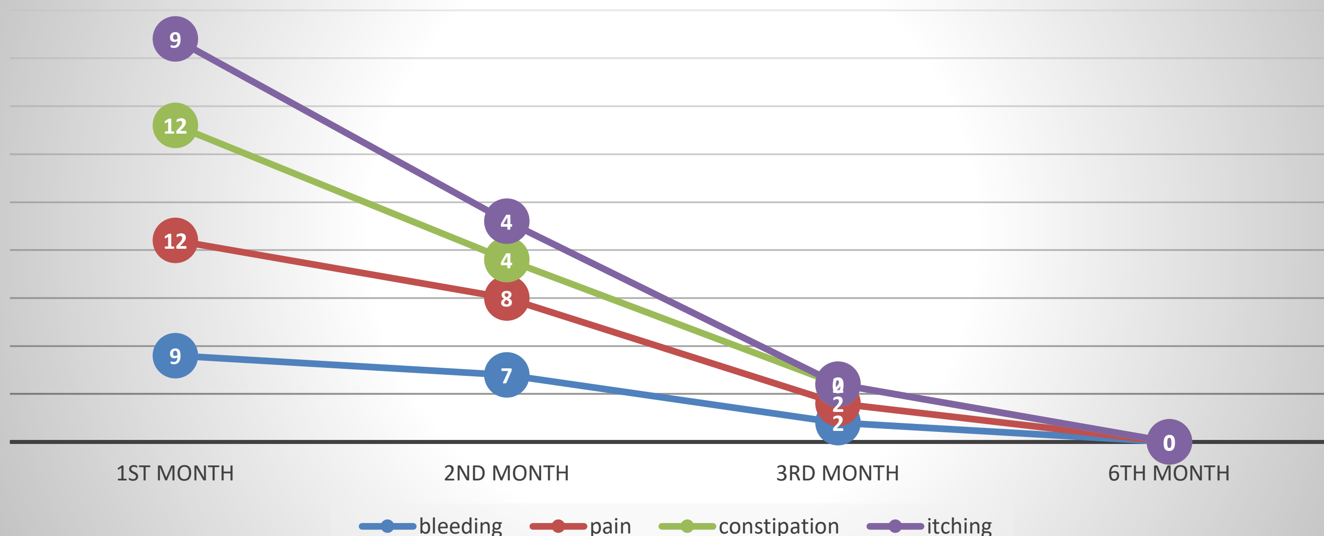
gently introduced into the anal orifices and is gradually rotated clockwise and anticlockwise for 2-3 minutes. Patients is advised to carry out this practice of *Ganesh kriya* (Rectum Cleaning/Anal Cleaning) himself by using the finger stall on right index figure after defecation in the squatting position daily for a period of 1 to 3 months such a practice is advised just avoid any chance of post ligation narrowing of the anal opening.

RESULTS

Total of 12 patients (09 male &3 female), mean age 41range. Symptoms included anal pain in 12 patients (100%), constipation in 12 patients (100%), bleeding in 9 patients (75%), itching in 9 patients (75%). All the patient had moderate stenosis. The symptom before treatment – pain, itching, bleeding & constipation in the 1st, 2nd, 3rd& 6th month are shown in table. Previous history of hemorrhoidectomy was seen in all 12 patients respectively.

Table no 1: Improvement of symptoms in 1st, 2nd, 3rd& 6th Months

Month	Bleeding	Pain	Constipation	Itching
1stMonth	09 (75%)	12 (100%)	12 (100%)	09(75%)
2ndMonth	07 (58.33%)	08 (66.67%)	04 (25%)	04(25%)
3rdMonth	02 (16.66%)	02 (16.66%)	02(16.66%)	00
6thMonth	00	00	00	00



DISCUSSION

Anal stenosis although rare, is one of the most

feared and disabling complication of a anorectal surgery and should receive great attention from anorectal surgeons it has been documented that from 1.2% to10%in patients having hemorrhoidectomy [4] most of the stenosis patients are a postoperative complication and rest are due to inflammatory disease or functional anal spasm. Non operative managements are usually dedicated mild to moderate stenosis that by definition do not require surgical intervention. Conservative approaches may include high fibre diet, laxatives and *Ganesh kriya* (self-digital dilation).

Acharya Sushruta has mentioned various *Basti's* (medicated enema) for various general and ano-rectal conditions. Today, modern as well as traditional drugs are being increasingly used in proctology practice. Rectal route with local or general effects is an interesting possibility of a treatment modality. Easy use and rapid absorption are two major advantages of these therapeutic option[5]. The local analgesic act by numbing the nerve endings and provide temporary relief from pain and itching. These act by causing a reversible block to conduction in the sensory nerves. These are well absorbed from the mucus membrane and used as surface anesthetic[6]. These provide good relief from discomfort encountered.

The active Principles of various drug in the *Vipreetmala taila* acts as anti-inflammatory and anti-pruritic agents and they eliminate inflammation and mucous discharge. The astringents present in *Vipreetmala taila* causes the cells of the anal skin to clump thereby drying the skin which gives relief from burning and itching. Passing hard and dry stool is the most traumatic experience in patients having anal pathology as it results in tearing of the skin around the anus, as also in tearing and cracking which ends in bleeding. Again, when this tender skin comes in contact with liquid or stool, it causes the skin to further itch and burn. Protectants, when applied in the form of *taila* (oil) form a physical barrier on the skin and results in reducing the pain quotient and the pruritus. These also protect the broken skin from coming in contact with offending particles in the stool.

Being a highly contaminated area, the anal and perianal skin are susceptible to variety of organisms, which can lodge there either from the adjoining area or from the contaminated stool. The chances of contamination further increase when the skin gets bruised during defecation. Antiseptics are used to keep the area clean and to prevent infection. Certain chemicals present in the *Vipreetmala taila* acts as keratolytics, they cause the outer layers of skin and other tissues to disintegrate when applied. They usually help in better penetration in the tissues of other medications contained in the taila to bring quicker relief.

In our study of twelve patients, it was observed that there is gradual significant improvement of symptoms like bleeding, pain, constipation & itching in first, second, third & sixth month respectively. The limitation of this study was small sample size. Another limitation in ability of during manometry and endorectal sonography in all patients because of anal stenosis.Hence it can be concluded that *Vipreetmala taila* injection into the anus and *Ganesh kriya* shows great results in patients with mild and moderate anal stenosis.

CONCLUSION

The best remedy for anal stenosis is prevention. Therefore, during common surgical procedures like hemorrhoidectomy, one must refrain from interventions that will result in anal stenosis. However, the ease of administration, good functional outcome, and lack of any complications show that *Ganesh kriya* & administration of *Vipreetmala taila* into anus is safe, effective & offer commendable results. Although, our study did not include a sufficient number of patients, the low recurrence and complications achieved in this study are promising for future procedures with more patients.

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