JETIR.ORG ISSN: 2349-5162 | ESTD Year : 2014 | Monthly Issue
JOURNAL OF EMERGING TECHNOLOGIES AND INNOVATIVE RESEARCH (JETIR)
An International Scholarly Open Access, Peer-reviewed, Refereed Journal

AN IN-DEPTH LITERATURE REVIEW ON PARIKARTIKA (FISSURE IN ANO)

Dr. Preeti[1*], Dr. Shailendra[2], Dr Poona Nath Chouhan[3]

[1]P. G. Scholar, Dept. of Shalya Tantra, Govt. P.G. Ayurveda College and Hospital, Varanasi

[2] Former Associate Professor, Dept. of Shalya Tantra, Govt. P.G. Ayurveda College and Hospital, Varanasi

[3] Consultant, Nootan Ayurvedic College and Research Centre, Sankalchand Patel University, Visnagar, Mahesana

Corresponding Author

Dr. Preeti

P. G. Scholar, Dept. of Shalya Tantra,

Govt. P.G. Ayurveda College and Hospital, Varanasi

ABSTRACT:

Parikartika, commonly referred to as fissure in ano, is a painful ailment characterized by the presence of a tear in the anal mucosa. Affected individual often experience significant discomfort and distress. There is a reported yearly incidence of 1.1 per 1000 person, which translates to an average lifetime risk of 7.8%. Although study figures vary greatly, the number of new cases identified in the United States of America each year is roughly 342,000, which is comparable to the number of appendectomies performed. According to *Ayurveda*, *Parikartika* is primarily associated with the aggravation *Vata* and *Pitta dosha*. The word *Parikartika* comes from the Sanskrit phrases "*Parikṛi*," which means "all around," and "*Kartanam*." This indicates that Patient experiences severe cutting pain around the anus. This abstract explores the *Ayurvedic* perspective on *Parikartika*, highlighting the importance of a holistic approach that tackles both the physical manifestations and the underlying *Doshic* imbalances contributing to the condition. Therefore, a comprehensive treatment strategy that includes dietary modifications, herbal medicines, and lifestyle changes to restore balance.

KEYWORDS: *Parikartika, Vata, Pitta, Parikṛi, Kartanam* etc.

1. INTRODUCTION:

Parikartika is thoroughly explained in *Ayurveda* in a fragmented way as a consequence of different diseases and illegal administration of purgatives or enema like- *Vatika Jwara (Cha. Chi.-3/186), Vatika Pakwa Atisara (Cha. Chi.-19/5), Sahaja Arsha (Cha. Chi.-14/8), Kaphaja Arsha (Cha. Chi.-14/17), Arsha Purvarupa (Su. Ni. -2/9), Adhmana (Su.Chi.-34/15), Udavarta (Cha. Chi.-26/5-6),* In *Garbhini (Ka. Khi. - 10/100), Virechana Vyapada (Su. Chi.-34/8), Basti Vyapada (Su. Chi.-36/36), Basti Netra Vyapada (Su. Chi.-36/3)* and Excessive use of *Yapana Basti (Cha. Si. -12/30-31).*

In modern terms, a fissure in ano is considered as *Parikartika*, according to the classical description of signs and symptoms[1]. A linear or oval shaped tear in the anal canal that extends to the anal verge from just below the dentate line is known as an anal fissure. It was originally explained by Lockhart-Mummery in 1934. Anal cracks may occur suddenly or gradually. Acute fissures are a type of superficial anoderm tear. Acute fissure symptoms can include anal pain, spasms, and/or blood during bowel movements. Fissures that are chronic last longer than 6 to 8 weeks. A hypertrophied anal papilla proximally, exposed internal anal sphincter fibers at the base, and a sentinel pile distally are characteristics of a chronic fissure in ano.[2]

2. INCIDENCE:

There is a reported yearly incidence of 1.1 per 1000 person, which translates to an average lifetime risk of 7.8%. Although study figures vary greatly, the number of new cases identified in the United States of America each year is roughly 342,000, which is comparable to the number of appendectomies performed.

According to a retrospective population-based study, males and females between the ages of 55 and 64 were shown to be more typically impacted by anal fissures.

2.1 Risk Factors:

Prolonged constipation, obesity, hypothyroidism, and solid tumors were risk factors.[3]

3. AIMS AND OBJECTIVES: To review the literature on *Parikartika* in Ayurvedic classics and modern science.

4. MATERIAL AND METHODS:

Following a methodical examination of modern science and *Ayurvedic* literature to acquire information regarding the *Parikartika* and its manifestation. Both modern and ancient texts are included in the search.

5. *NIDANA PANCHAKA OF PARIKARTIKA:*

It describes a situation when the sufferer feels as though they are having their *Guda* sliced with scissors. The word comes from the Sanskrit phrases "*Parikṛi*," which means "all around," and "*Kartanam*" means to cut off. This indicates that Patient experiences severe cutting pain around the anus.

Nirukti:

- *Pari –sarvato bhavaha*
- *Parikrit – krintati*, to cut off, cut round,
- *Pari* – round about· *Kartana* – cutting·

According to *Acharya Kashyapa*, the person experiencing cutting and tearing agony, as stated by *Acharya Dalhana. Acharya Jejjata* foresaw the situation and expressed his opinion in a clear and concise manner, stating that *Vatika* pain is widespread in a certain region of *Guda* and is *Parikartika*.

5.1 Nidana:

Because *Guda* is the actual location of *Vata*, particularly *Apan*, *Vayu*, *Vata* is the predominant or primary *dosha* in *Parikartika*. *Tikta*, *Ushana*, *Kashaya*, *Alpa Bhojana*, *Vega dharana*, *Udirana*, excessive *Shodhana* therapy, and diurnal and seasonal changes are *Vata* vitiation variables[4]. *Pitta* is the second dominating *dosha* that appears to be significant. It is weakened by *Katu*, *amla*, *Lavana Ahara and Krodha*; it is further weakened by seasonal and diurnal fluctuations. Although not the primary factor in the condition's onset, *kapha dosha* nevertheless has a variety of effects. *Madhura*, *Amla*, *Lavana*, *Adhyashana*, *Sheeta*, *Guru Bhojana*, *Divaswapna*, and fluctuations in the day and season are the variables that vitiate *Kapha*. Acharya *Sushruta* has given *Rakta Dhatu* the most consideration in addition to the other three *doshas*; in fact, he goes so far as to suggest that *Rakta* is the fourth *dosha*. He adds that *Vrana* is created when *Vayu* combines with blood. Acharya *Charaka* in *Chikitsasthan Dwivraniya Adhyaya* has noted that when *doshas* occur in *Bahya Roga Marga*, they produce *Vrana*. *Prakupita Vata* and *Pitta Doshas*, notably the causes of *Parikartika*. In *Parikartika*, *Vrana* is primarily *Nija* in origin.

The *Nidana* of *Parikartika*, according to *Acharya Sushruta*, are classified into three categories:

1. *Nija Nidana*
2. *Agantuja Nidana*
3. *Nidanarthakari Roga*

1. *Nija Nidana*: These are the *Nidana* that vitiate *Rakta* and *Apana Vayu*. *Ruksha* and *guru anna*, the natural impulses of micturition and feces, excessive vehicle travel, and frequent walking to different locations are recognized as causal elements for *Apana* Vayu *Vikruti*.

2. *Agantuja Nidana*: *Parikartika* is caused by the trauma at *Guda*. *Virechana* and other iatrogenic problems during *panchakarma* treatments can result in the development of *Parikartika*. Another name for this is *Vaidya Nimittaja*.

- ***Virechana Vyapada***: According to Acharya *Sushruta*, if *Tikshna*, *Ushana*, or *Ruksha* medications are taken for *Virechana*, there is a significant risk of "*Parikartika*".
- ***Basti Vyapada***: Excessive dosages of *Ruksha Basti*, which contains the medications *Tikshna* and *Lavana*, might result in *Parikartika*.
- ***Basti Netra Vyapada***: This sickness may be brought on by improper administration of *Basti Netra* as well as *Basti Netra* flaws.

3. ***Nidanarthakari Roga*:** These types of problems are brought on by any underlying illnesses. *Udavarta* is the main cause of *Parikartika*.

Rupa: [5,6]

According to *Acharya Charaka*:

- *Trikavamkshanabastinam Todam* (Cutting pain in Groin, Flanks and Sacral region).
- *Nabheradho ruja* (Pain in Para-Umbilical region)
- *Vibandha* (Constipation)
- *Alpalpamuthanam* (Passage of scanty stool)

According to *Acharya Sushruta:*

- *Guda Sadaham Parikartanam* (Cutting Pain & Burning sensation in Guda)
- *Nabhi Medhrabasti Shirasu Sadaham Parikartanam* (Referred pain to Umbilical region, Penis and Fundus of Bladder).
- *Anila Sanga* (*Avrodha* of *Apana Vayu*)
- *Vayu Vishatambha*
- *Aruchi*

5.2 Samprapti:

Tridosha, in their balanced state, preserves the structural and functional integrity of the human body. However, they are always vulnerable to vitiation and imbalance. By adhering to the correct *Dincharya* and *Ritucharya*, it is possible to restore the *doshas* to their normal state. This *doshas* imbalance is caused by *Asatmya Indriyartha Samyoga*, *Prajnaparadha*, and *Parinama*[5]. This leads to a morbidization process that goes through six stages, or *kriyakala- Sanchaya*, *Prakopa*, *Prasara*, *Sthanasamshraya*, *Vyakti*, and *Bheda*. Disease appears at these phases. There are striking parallels between *Parikartika* and *Arsha's Samprapti*. The fact that both of these conditions appear in *Purişhavaha Srotas*, the same *Srotas* makes this clear[6]. This idea is further reinforced by the significance of particular etiological elements and the place of illness presentation. *Vata Prakopa* predominates in this illness, along with related *Pitta*. In *Guda Pradesh* in particular[7], *doshas* are localized. The pathophysiology turns *Twak* into *Ruksha*, who has a propensity to break. *Vata* vitiates from the skin, and *Sushruta* and *Vagbhata* have made it abundantly evident that identical changes take place in the skin. *Ruksha*, *Tikshna Ahara*, and *Ruksha Aushadha* are indulged in by *Ksham* and *Mridu Koshtha*, which results in *Agnidushti*, which ultimately leads to *Vata-Pita Prakopa*. *Kha-Vaiguṇya* occurs as a result of *daurbalya* of *Dushya*, i.e., *Mamsa* and *Twak*, especially of *Purişavaha Srotas*. *Purişhavaha Srotas* experiences *sthana Samşhraya* with intensified *Vata* and *pitta dosha* due to this *kha-Vaiguṇya*. Due to this *kha-Vaiguṇya Purişhavaha Srotas* experiences *sthana Samşhraya* of aggravated *Vata* and *Pitta Dosha*, which culminates in *Dosha Dushya Sammurchana*. There is frequent, painful defecation as a result of this *Twak Mamsa Dushti* or *Vrana*. In the end, this results in *Parikartika*.

A. The second type of Samprapti involves preexisting pathology leading to *Guda Vikruti* and ultimately *Parikartika* if diseases like *Atisara*, *Grahani*, etc. are not correctly treated and the patient continues to participate in *Aharaja Nidana*.
B. The third kind of *Samprapti* is caused by *Agantuja Nidana*, in which the *doshas* become positioned in the *Vrana*, causing further symptoms, after the initial stage of wound creation. Parallel production of the wound causes *doshas* to become vitiated, which ultimately results in *Parikartika*.

5.3 Bheda:

In *Parikartika*, Acharya *Charaka* and *Sushruta* both discussed the *Vata* and *Pitta Doshas*. While providing a detailed *chikitsa* of the disease *Parikartika*, Acharya *Kashyapa* has described the involvement of all three *doshas (Vata*, *Pitta*, and *Kapha*) in the *Adhyaya* of *Garbhini Chikitsa*, despite the fact that almost all *ayurvedic* texts lack detailed descriptions regarding the classification of diseases, their *Samprapti* and their corresponding symptomatology. *Kashyapa Samhita* is known to be an incomplete book, it is plausible that he thought about the *Nidana Panchaka* of *Parikartika* in detail in some of the lost portion over time, but that he only gave a brief account of it in reference to a gravid woman later on.

Table 1: Symptoms according to *Dosha* Involvement

Sr. No.	Types	Symptoms
1.	*Vatika*	Shooting, Cutting, or Pricking pain
2.	*Paittika*	Scorching pain, Bleeding per rectum
3.	*Kaphaja*	Dull ache type, Mucous discharge

Types as per Modern:

Anal fissures are categorized according to their physical appearance and degree of chronicity.
fissure in ano is of two types-

A. Acute fissure in ano:

Acute fissure in ano is characterized by symptoms that last no more than six weeks. Constipated hard stool while passes through the anal canal in patients where there is spasm of internal sphincter and hypertrophied anal papilla an acute tear of the anal canal occurs called acute fissure in ano. It will cause spasm, pain during and after defecation and passage of bright streaks of blood along with stool or will be seen in the tissue paper. They frequently heal on their own.

B. Chronic fissure in ano:

If the acute fissure fails to heal, it will gradually develop into a deep undermined ulcer. This is termed chronic fissure in ano. A typical fissure in ano will have in its upper end a hypertrophied anal papilla. At its lower end a tag of hypertrophic skin, which is called a sentinel pile and canoe shaped ulcer in between the upper and lower ends.

Differential diagnosis:

Perianal pain and bleeding per rectum can also be symptoms of other illnesses such as anal fistula, single rectal ulcer, crohn's disease, tuberculosis, or thrombosed hemorrhoid. A thorough clinical assessment and history can be used to rule these out.

***5.4Sadhya- Asadhyata*:**

It is simple to treat *Parikartika*, which affects the anal skin (the outermost layer of the *Twak*). It can therefore be a part of the *Sadhyata* group. If it impacts the more profound layers, it indicates resistance to healing. As a result, it fits into the *Kricchasadhya* group. If connected to *Kushtha*, *Visha Dushti*, or *Shosha*, *Varna's* healing will be postponed. *Parikartika* is regarded as *yapya* if it is associated to *Sanniruddha Guda*.[8]

5.5Chikitsa:

Acharya Sushruta and numerous authors after him have briefly discussed *Parikartika* as an illness. They have given a very succinct description of *Parikartika's* treatment. There was no need for surgery because the disease was completely cured with the use of medicinal preparations alone, and Acharya *Kashyapa* mentioned managing it in accordance with *Doshika* predominance. Others have not classified it under this type of classification, but it is a fact that none of them have described surgical management.

Drugs are separated into two groups based on how they are administered:

1) *Shodhana*
2) *Shamana*.

5.5.1 Shodhana Chikitsa:

This is merely *Basti Karma*, nothing more. *Basti* is made with the aid of various medications in *Ghrita*, T*aila*, and milk. The majority of medications utilized in *Basti karma* are *Vata Shamaka, pitta shamaka*, and *Varaṇa Shodhana - Ropaka*. *Sushruta* and other *Ayurvedic* writers have identified three different kinds of *Basti* :

(i) Anuvasana basti
(ii) Piccha basti
(iii) Sheetal basti

The remedy involves making a *Piccha Basti* using clarified butter and honey, along with *Yashtimadhu and sesamum* pasted together. Additionally, the patient should be kept on *Anuvasana Basti*. If *pitta* is the predominant body type, *Basti* should be used with clarified butter cream, and if *Vata* is the predominant body type, *Basti* should be used with *Taila* prepared with *Yastimadhu*. Additionally, *Charaka* has supported the two categories of medications that *Sushruta* has recommended. He states that *Sheeta Basti*, which is made with *Madhuyaşhthi* powder and *kwath* and contains medications with *Madhura* and *Kashaya Rasa* (*Piccha* and *Anuvasana basti*) need to be taken. *Anuvasana Basti* has also advised by *Kashyapa*. The base for this kind of *Basti* is either *Vata Shamaka* or *Pitta Shamaka*, which can be milk, oil, or *ghrita*. *Madhuyashthi* is frequently employed, and a great deal of medications with *pitta shamaka* and *Vata shamaka* characteristics have been used in various combinations. Owing to its cooling properties (*Vata-Pita-Rakta Shamaka*), *Sushruta* has widely recommended it for treating traumatic wounds, fissure, *Pittaja Vrana*, *Bhagandara*, *Upadamsa*, ulcers, and other ailments. For the treatment of *Parikartika*, both *Acharya Charaka* and *Shusruta* have recommended *Piccha Basti* together with *Madhuyaşhthi*, *Madhu*, and *Taila*.

5.5.2 Shamana Chikitsa:

There are several goals for the oral preparation. A few medications are used to treat *Agniduşhti*, while others are used as laxatives to treat anorectal problems. Drugs have been recommended as the *Tridoshashamaka*. Milk should be taken orally and cold-water baths have been recommended by *Sushruta*. The primary issues with this illness are constipation and pain in anal region.

Within a few days, the condition may largely go away if the constipation component is treated and the pain is reduced. Constipation resulting from two factors: 1) Habitual constipation and 2) Patient refusal to defecate owing to fear of discomfort caused by *Vata* and *Pitta* vitiation. In addition, Acharya *Charaka* wrote about the oral therapy for *Parikartika* and suggested drinking only milk. He has also suggested to take it because *Amla Dravya* contains the *Vata Shamaka* property and enhances the digestive fire. He stated that in cases when *Parikartika* is present together with fever, the patient should have gruel made from heart-shaped seed leaves, kokam fruits, butter tree fruits, and sour jujube. Within the *Kashyapa Samhita*, treatment has been administered based on *Dosha* predominance. This treatment is centered on the characteristics for gravid women who suffers from *Parikartika* that first to provoke the *Pitta* and *Vata* and secondly to address the abdominal discomfort as a result of the vitiated *pitta* and *Vata* in this illness.

Table 2: Yusha as per *Doshic* Involvement

S. N.	***Doshas***	**Compounds**	**Ingredients**
1.	*Vataja Parikartika*	*Yusha*	*Brihati, Bilva, and Anantamoola*
2.	*Pittaja Parikartika*	*Yusha*	*Madhuyaşti, Hanspatti, Dhaniya, Madhu,*
3.	*Kaphaja Parikartika*	*Yusha*	Salt, *Pippali, Gokshura, Kantakari*

Table 3: *Pathya Apathya*

Pathya	***Apathya***
-Hot sitz bath to subside pain. -Avoidance of constipation and strain during defecation.	*-Vegadharana, maithuna, utkata-asana, vyayama, Krodha.*
-Madhur Rasa & *Vata Anulomaka Ahara-Vihara* -leafy vegetables, old *Rakta Shali* And *Shasti Shali*, *Yava* and *Kulutha*.	*-Guru, Ati Tikshna, Ati Lavana, Ati Ruksha Aahara Sevana.*

5.5.3 Modern methods for treating fissure in ano:

The following problems must be addressed in any treatment plan: The five main interventions for constipation are: (1) supportive measures; (2) atraumatic stools; (3) pain management; (4) atypical patterns of defecation, such as excessive straining; and (5) lowering anal sphincter tone and local ischemia in patients. The first line of treatment should be non-operative care, according to the American Society of Colorectal Surgeons (ASCRS). According to ASCRS, about 50% of patients can get their symptoms under control by using supportive therapies such topical anesthetics, steroids, bulk forming agents and sitz bath two to three times a day. The anus is submerged in lukewarm water for 10 to 15 minutes, known as a hot sitz bath. A sitz bath routine added to the treatment is linked to better pain alleviation. When compared to placebo, maintenance therapy with fiber is linked to decreased risks of fissure recurrence[9].

Conservative treatment is usually effective in healing acute ulcers with a brief history. Conservative treatment consists of taking painkillers orally, preferably before a planned bowel movement. To make the stool soft enough to pass without causing anal spasms, use a stool softener. One neurotransmitter that causes the internal sphincter to relax is nitric oxide. As a nitric acid donor, glycerin trinitrate is given topically to the anal canal to cause the internal sphincter to relax. For most patients, this results in the healing of the anal fissure. Additionally, glycerin trinitrate increases blood flow to the region, aiding in the healing of the fissure. However,

glycerin trinitrate has a few negative effects, the most serious of which is a strong headache. Henceforth, calcium channel blockers, such as diltiazem, are employed. It is questionable if applying soothing ointments will be effective. A fine nozzle can be used to deliver 5% xylocaine into the anal canal. It is crucial to self-dilate because it will ease the anal musculature and promote the healing of the fissures. Applying 5% xylocaine ointment should be done for five minutes. Then, insert a little St. Marks anal dilator into the anal canal. Typically, anal dilation pumps come in three sizes: small, medium, and big. It is recommended to gradually dilate the anal canal using larger dilators. This method of dilating the anal canal after using xylocaine lubricant. For a month, it is recommended to perform the xylocaine lubrication technique twice a day followed by the dilation of the anal canal with a dilation tool. The anal fissure might mend if this time is used well. Long-acting anesthetic injection causes serious problems and offers little relief.

Chronic fissure in ano: although conservative treatment may be attempted in these patients, surgical management should be considered as this treatment is ineffective in most cases.

(i) Anal dilatation:

The most straightforward technique for relaxing the sphincters in the anal canal is Lord's procedure. In order to achieve maximum anal dilation, the index and middle fingers of each hand are simultaneously inserted into the anus while the patient is in the lithotomy posture and under general anesthesia[10].

(ii) Anal ulcer excision:

Attempts to shorten the recovery time by removing the anal ulcer and using a skin graft have not proved effective. When the ulcer was removed, the anal skin was further raised to conceal the anal canal deformity. It refers to as V-Y anoplasty. This has not worked either.

(iii) Anal flap advancement:

An inverted house-shaped flap of the posterior skin is carefully mobilized on its blood supply and advanced without tension to cover the fissure, followed by the removal of the fissure's edges and, if necessary, its base overlying the internal sphincter. The flap is then sutured with interrupted absorbable sutures. Following surgery, the patient is kept on bulk forming agents and stool softeners, and typically also receives topical sphincter relaxants. Because there is minimal likelihood of causing harm to the underlying internal sphincter and consequent incontinence, this method has gained popularity recently.[11]

(iv) Dorsal fissurectomy and sphincterotomy:

Dividing the internal sphincter's transverse fibers in the fissure's floor is a crucial component of the procedure. A sentinel pile is removed if one is found. The split muscle ends retract, leaving a smooth incision. After treatment, which typically lasts three weeks, involves taking care of the intestines, taking a daily bath, and using an anal dilator until the wounds have healed. The wound is present, but the outcomes are positive and the pain is little to nonexistent. One of the drawbacks of this procedure is the extended healing period, which is often three weeks or longer, and the occasional moderate, persistent, and permanent mucus discharge. These days, lateral sphincterotomy is the primary treatment for most chronic or recurrent anal fissures; it is only used for the worst of them.

(v) Adjunctive surgical techniques:

Patient discontent is frequently caused by the persistence of skin tags, polyps, and hypertrophied papillae. As part of the surgical treatment, the removal of fibrous anal polyps and hypertrophied anal papillae should be considered. In contrast to only 58% of the control group, 84% of patients who had the polyp, papilla, or skin tag removed were satisfied two years after surgery, according to a randomized controlled experiment. In addition, a radiofrequency technique may be helpful in eliminating these coexisting diseases[12].

(vi) Other medications and treatment options:

With differing degrees of success, many parasympathomimetic drugs have been tested, including beta agonists like Salbutamol, natural items like Myoxinol ointment, egg yolks, and injections of sclerosing agents. Another safe and efficient option has been proposed: percutaneous posterior tibial nerve stimulation.[13] According to studies, it is somewhat better than GTN ointment in treating chronic anal fissures. Patients were randomly assigned to receive either perianal application of GTN ointment (twice daily for 8 weeks) or percutaneous posterior tibial nerve stimulation (30 min session 2 days per week) in a prospective randomized study involving 40 patients who had persistent anal fissures despite 6 weeks of supportive measures. The recovery rate following eight weeks of treatment was 87.5 percent in the group receiving percutaneous posterior tibial nerve stimulation and 65.0% in the group receiving GTN ointment. In contrast to 15% treatment withdrawal owing to headache in the GTN group, there were no side effects or treatment withdrawals in the nerve stimulation group.[14]

6. COMPLICATIONS:

Various treatments are linked to distinct adverse effects. The research reports uneven results and adverse effects from treating anal fissures. Nitrates are linked to headache in 20–30% of cases or more, according to a recent systematic review and meta-analysis of 148 studies. While higher doses don't seem to affect efficacy, they do raise the profile of adverse effects, particularly headaches. In its topical form, oral calcium channel blockers only cause 16% of the somewhat high prevalence of accompanying headaches. There have been reports of variable incontinence rates. The documented rates of incontinence with topical calcium channel blockers are 1.4%, GTN 1.1%, and BTA injectable 2.3%. Dermatitis and perianal irritation are other adverse effects. Recurrence rates following medical interventions have been demonstrated to reach 50%. If a fissure abscess is not treated, it might result in a fistula in ano. Infections within a fissure can cause this. [15] A persistent fissure in ano is characterized by a skin tag located at its lower end. Occasionally, because of unsanitary conditions, it can become infected and cause the patient to experience excruciating agony and anguish. At the upper end of the Chronic Fissure in Ano, hypertrophied papillae are located.

7. DISCUSSION:

Vata and *pitta* are the causes of the *Parikartika* illness. In the *Guda* area, vitiated *Doshas* accumulate as a result of various etiological variables. The middle age group is particularly affected by the condition. Anal canal tears primarily occur from the passage of hard stool. According to *Charaka*, if someone with *Snigdha*, G*uru Koshtha* and *Ama Dosha* takes a radical purgative medicine, or if someone

with *Mridu Koshtha* and *Alpa Bala* takes it, it expels impurities together with *ama*, but only until it reaches the anal area, at which point it causes severe colic, cutting pain, and a slimy discharge with blood. Therefore, it is crucial to take care of *Saama- Nirama Koshtha* condition and rough body before providing medication for *Samshodhana* or to cure constipated patients, as medication may otherwise result in *Parikartika*. When treating *Parikartika*, hot, light food (*Langhana, Pachana, Ruksha*) should be given if the patient is experiencing *ama*; if the patient is weak and experiencing *Ruksha* in his body, sweet, *Brinhaniya* food should be suggested. When it comes to anorectal disorders, *Parikartika* is quite prevalent because of incorrect *Ahara- Vihar*. *Ayurvedic* medicine cures the majority of acute cases, while Western treatment fails to produce a response in over 50% of instances. Therefore, the condition of *Sama-Nirama, Koshtha,* body constitutions, and secondary reasons of *Parikartika* should be adequately assessed before prescribing the extreme purgatives for *Samshodhana chikitsa* or during the therapy of *Parikartika*.

REFERENCES:

[1] Patel JR, Dudhamal TS. A comparative clinical study of *Yashtimadhu Ghrita* and lignocaine-nifedipine ointment in the management of *Parikartika* (acute fissure-in-ano). Ayu. 2017 Jan-Jun;38(1-2):46-51. doi: 10.4103/ayu.AYU_93_17. PMID: 29861592; PMCID: PMC5954261.

[2]Beaty JS, Shashidharan M. Anal Fissure. Clin Colon Rectal Surg. 2016 Mar;29(1):30-7. doi: 10.1055/s-0035-1570390. PMID: 26929749; PMCID: PMC4755763

[3] Fahadullah M, Peirce C. Fissure-In-ANO [Internet]. Proctological Diseases in Surgical Practice. InTech; 2018. Available from: http://dx.doi.org/10.5772/intechopen.76887

[4] Chouhan, Poona. (2023). Chaturavidh Nigrah Hetav in the Cancer Management: A Brief Review. International Journal of Green and Herbal Chemistry. 12. 209-222. 10.24214/IJGHC/HC/12/3/20922.

[5] Chouhan, Poona. (2022). DIAGNOSIS AND MANAGEMENT OF KATIGATAVATA (LOW BACK PAIN) IN AYURVEDA: A CRITICAL REVIEW. International Journal of Advanced Research. 10. 964-970. 10.21474/IJAR01/15929.

[6] Chouhan, Poona & Rajpurohit, Hemant. (2024). A Bird Eye Review On Role Of Yoga In Managing Anorectal Disorders.

[7] Dr Renuka Talwade ,Dr Vijaykumar Biradar, Dr Ashok G Naikar , Dr Jyoti rajole, Literary Review of Parikartika W.S.R To Fissure In Ano, international journal of creative research thoughts (IJCRT), 2023; 11:2320-2882.

[8] Sushruta, Sushruta Samhita with Nibandha Sangraha Commentary Choukhamba Sanskrit series 2002.Sutra Sthana 23/4.

[9] Jensen S. Maintenance therapy with unprocessed bran in the prevention of acute anal fissure recurrence. Journal of the Royal Society of Medicine. 1987;80(5):296

[10] Nelson RL, Chattopadhyay A, Brooks W, Platt I, Paavana T, Earl S. Operative procedures for fissure in ano. Cochrane Database of Systematic Reviews. 2011;11:CD002199

[11] Theodoropoulos GE, Spiropoulos V, Bramis K, Plastiras A, Zografos G. Dermal flap advancement combined with conservative sphincterotomy in the treatment of chronic anal fissure. The American Surgeon. 2015;81(2):133-142

[12] Scholz T, Hetzer F, Dindo D, Demartines N, Clavien P, Hahnloser D. Long-term follow-up after combined fissurectomy and Botox injection for chronic anal fissures. International Journal of Colorectal Disease. 2007;22(9):1077-1081

[13] Dessily M, Charara F, Chelala E, Donfut AL, Alle JL. Injection of a sclerosing agent as first line treatment in anal fissure. Acta Chirurgica Belgica. 2014;114(4):261-265

[14] Ruiz-Tovar J, Llavero C. Percutaneous posterior tibial nerve stimulation vs perianal application of glyceryl trinitrate ointment in the treatment of chronic anal fissure: A randomized clinical trial. Diseases of the Colon and Rectum. 2017;60(1):81-86

[15] Ebinger SM, Hardt J, Warschkow R, Schmied BM, Herold A, Post S, et al. Operative and medical treatment of chronic anal fissures—A review and network meta-analysis of randomized controlled trials. Journal of Gastroenterology. 2017;52(6):663-676