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A CONCEPTUAL STUDY OF ARSHA W.S.R. TO INTERNAL HEMORRHOIDS

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ABSTRACT

Background: *Arsha* is one of the most commonly described anorectal disorders in Ayurveda and is explained in detail under *Gudagata Vyadhi*. It is characterized by *Gudagata Mamsa Vriddhi*, bleeding, pain, itching, and difficulty in defecation. Classical texts consider it a *Tridoshaja Vyadhi* with predominance of *Vata* and *Pitta*, originating from *Agnimandya* and disturbance of *Apana Vayu*. In modern medicine, internal hemorrhoids are defined as dilated venous plexuses within the anal canal, commonly associated with chronic constipation and straining. The similarity in etiology, pathogenesis, and clinical features suggests a strong conceptual correlation between *Arsha* and internal hemorrhoids. **Aim:**

To conceptually analyze *Arsha* from classical Ayurvedic literature and correlate it with internal hemorrhoids described in modern medicine. **Objectives:** To review classical references regarding *Nidana*, *Samprapti*, and *Lakshana* of *Arsha*. To understand the involvement of *Dosha*, *Dushya*, and *Srotas* in *Arsha*. To correlate the Ayurvedic pathogenesis with the modern concept of internal hemorrhoids. To establish a conceptual framework linking classical and contemporary perspectives. **Materials and Methods:** This conceptual study was carried out through an extensive review of classical Ayurvedic texts including *Charaka Samhita*, *Sushruta Samhita*, and *Ashtanga Hridaya*, along with standard modern surgical textbooks and peer-reviewed articles on hemorrhoids. Comparative analysis was performed to identify similarities in etiopathogenesis and clinical presentation. **Results:** The review reveals that *Arsha* develops due to *Agnimandya*, formation of *Ama*, vitiation of *Tridosha*, and obstruction of *Apana Vayu* in the *Guda Pradesh*. These factors lead to vascular congestion and fleshy growths in the anal canal. Similarly, internal hemorrhoids arise due to increased venous pressure, chronic constipation, and weakening of supporting tissue. The overlap in causative factors, pathogenesis, and symptomatology confirms a strong conceptual relationship. **Conclusion:** *Arsha* and internal hemorrhoids share common etiological factors and pathological mechanisms, though explained through different theoretical frameworks. The Ayurvedic concept provides a holistic understanding by emphasizing digestive impairment and systemic imbalance, while modern medicine focuses on vascular pathology. Integrating both perspectives enhances understanding and supports rational management strategies.

Keywords: *Arsha*, Internal Hemorrhoids, *Agnimandya*, *Apana Vayu*, *Tridosha*, Anorectal Disorders

INTRODUCTION

Arsha[1] is a well-described anorectal disorder in Ayurveda and is classified under *Gudagata Vyadhi*.[2] The term *Arsha* is derived from the Sanskrit root "Hṛ," meaning something that afflicts or troubles like an enemy. It is considered a distressing condition because it interferes with daily activities, particularly defecation. Classical texts describe it as a *Tridoshaja Vyadhi*[3] with predominance of *Vata* and *Pitta*, and emphasize that impaired digestive fire or

Agnimandya[4] plays a central role in its origin. When digestion becomes weak, improper metabolism leads to vitiation of *Dosha*, which localize in the *Guda Pradesh*[5] and produce pathological growths.

The etiological factors of *Arsha* mainly include improper dietary habits, excessive intake of spicy and heavy food, suppression of natural urges, sedentary lifestyle, and chronic constipation. These factors disturb *Agni*[6] and lead to formation of *Ama*, which further aggravates *Dosha* and obstructs normal function of *Apana Vayu*.[7] Repeated straining during defecation increases pressure in the anorectal region, contributing to swelling and bleeding. Thus, the Ayurvedic explanation integrates systemic digestive dysfunction with local vascular changes.

In modern medicine, internal hemorrhoids are defined as dilated and inflamed venous plexuses located above the dentate line within the anal canal. They commonly present with painless bleeding per rectum, prolapse, and mucous discharge. Risk factors include chronic constipation, prolonged sitting, low-fiber diet, and increased intra-abdominal pressure. The pathogenesis involves venous congestion, weakening of supporting connective tissue, and increased pressure during defecation.

When the classical description of *Arsha* is compared with the modern understanding of internal hemorrhoids, striking similarities are observed in causative factors, clinical features, and disease progression. However, Ayurveda explains the condition through the framework of *Dosha*, *Dushya*, and *Agni*, offering a more systemic perspective. Therefore, a conceptual study correlating *Arsha*[8] with internal hemorrhoids becomes important to bridge traditional knowledge and contemporary understanding, and to provide a comprehensive approach to anorectal disorders.

AIM AND OBJECTIVES

Aim:

To conceptually analyze *Arsha* from classical Ayurvedic literature and correlate it with internal hemorrhoids described in modern medicine.

Objectives:

1. To review classical references regarding *Nidana*, *Samprapti*, and *Lakshana* of *Arsha*.

2. To understand the involvement of *Dosha*, *Dushya*, and *Srotas* in *Arsha*.
3. To correlate the Ayurvedic pathogenesis with the modern concept of internal hemorrhoids.
4. To establish a conceptual framework linking classical and contemporary perspectives.

CONCEPTUAL STUDY

The term *Arsha* is derived from the Sanskrit root "Hṛ," which means to afflict, torment, or trouble. It is called *Arsha* because it troubles the individual like an enemy. The disease causes persistent discomfort, pain, and disturbance during defecation, thereby affecting daily life. The name itself reflects the chronic and distressing nature of the condition.

Definition of *Arsha*

Arsha is defined as a pathological growth occurring in the *Guda Pradesh*[9] due to vitiation of *Dosha*. It manifests as fleshy projections associated with pain, bleeding, itching, and difficulty in passing stool. Classical texts explain that it mainly involves *Mamsa Dhatu* and *Rakta Dhatu* along with derangement of *Apana Vayu*.[10] It is not merely a local swelling but a systemic manifestation of impaired metabolism.

Nidana of *Arsha*

The causative factors of *Arsha* include improper dietary habits, intake of excessive spicy, sour, salty, dry, and heavy food, irregular eating patterns, and suppression of natural urges. Sedentary lifestyle and chronic constipation further aggravate the condition. These factors weaken *Agni*, leading to formation of *Ama* and vitiation of *Tridosha*.[11] Continuous straining during defecation increases pressure in the anorectal region, initiating pathological changes.

Samprapti of *Arsha*

The pathogenesis begins with *Agnimandya*, resulting in improper digestion and production of *Ama*. This leads to vitiation of *Dosha*, particularly *Vata* and *Pitta*.[12] The aggravated *Dosha* localize in the *Guda Pradesh*[13] and disturb the normal function of *Apana Vayu*. Obstruction and stagnation in the anorectal channels cause vascular congestion and gradual formation of fleshy masses, which characterize *Arsha*.

Agnimandya
↓
Improper digestion (*Apakwa Ahara Paka*)
↓
Formation of *Ama*
↓
Vitiation of *Tridosha* (Predominantly *Vata* and *Pitta*)
↓
Aggravated *Dosha* circulate through *Srotasa*
↓
Localization in *Guda Pradesh* (*Sthanasamshraya*)
↓
Vitiation of *Apana Vayu*
↓
Obstruction in *Purishavaha Srotas*
↓
Stagnation and increased local pressure
↓
Vascular congestion in anorectal region
↓
Gradual development of fleshy projections
↓
Manifestation of *Arsha*

Dosha Dominance in *Arsha*

Although *Arsha* is considered a *Tridoshaja Vyadhi*, the predominance of specific *Dosha* influences clinical presentation. In *Vataja Arsha*, severe pain and dryness are prominent. *Pittaja Arsha* is marked by burning sensation and bleeding. *Kaphaja Arsha*[14] presents with heaviness, itching, and mucous discharge. Chronic cases may show mixed features, indicating involvement of all three *Dosha*.

Classification of *Arsha*

Classical texts classify *Arsha* on different bases. It may be congenital (*Sahaja*) or acquired. Based on location, it is categorized as internal or external depending on its position in the anal canal. It is further classified into *Vataja*, *Pittaja*, *Kaphaja*, *Sannipataja*, and *Raktaja* types according to *Dosha* predominance. This classification helps in understanding severity and planning treatment.

Lakshana[15] of *Arsha*

The common clinical features include swelling in the anal region, pain during defecation, bleeding per rectum, itching, irritation, and constipation. In long-standing cases, chronic blood loss may result in weakness and pallor. The intensity of symptoms varies with the involved *Dosha*, but difficulty in passing stool remains a key complaint.

Dushya and Srotas Involvement

The main tissues affected in *Arsha* are *Mamsa Dhatu*, *Rakta Dhatu*, and *Medo Dhatu*. The disease primarily involves *Purishavaha Srotas* and *Raktavaha Srotas*. Obstruction and inflammation within these channels contribute to disease progression. Thus, *Arsha* reflects both tissue-level and channel-level pathology.

Upadrava[16] of *Arsha*

If not managed properly, *Arsha* may lead to complications such as excessive bleeding, anemia, prolapse, thrombosis, and infection. Chronic irritation may also result in fissure formation. These complications significantly reduce quality of life and may require surgical intervention.

Chikitsa Siddhanta of *Arsha*

The fundamental principle of management is correction of *Agni* and regulation of bowel habits. Treatment includes *Nidana Parivarjana*, *Deepana-Pachana*, *Vatanulomana*, and use of specific *Arshoghna Dravya*. In advanced stages, *Shodhana Chikitsa* or surgical procedures may be indicated. The main aim is to treat the root cause and prevent recurrence rather than only managing symptoms.

MODERN REVIEW

Internal hemorrhoids are dilated and swollen vascular cushions located inside the anal canal above the dentate line. These vascular structures are normal anatomical components that help in continence, but when they become enlarged or inflamed, they produce symptoms. Because they are situated above the dentate line, they are usually painless in early stages, as this area is supplied by visceral nerves rather than somatic pain fibers.

Anatomy of the Hemorrhoidal Plexus

The anal canal[17] contains three primary vascular cushions positioned at left lateral, right anterior, and right posterior locations. These cushions consist of arteriovenous channels, connective tissue, and smooth muscle fibers. Internal hemorrhoids arise from the superior hemorrhoidal venous plexus. Their function in normal physiology is to assist in fine control of continence by maintaining anal closure. When supportive tissue weakens or venous pressure increases, these cushions enlarge and descend.

Etiology and Risk Factors

The development of internal hemorrhoids[18] is strongly associated with chronic constipation and repeated straining during defecation. A low-fiber diet, inadequate water intake, prolonged sitting, and sedentary lifestyle significantly increase the risk. Conditions that raise intra-abdominal pressure such as pregnancy, obesity, and chronic cough also contribute. Aging causes weakening of connective tissue support, making prolapse more likely. Thus, multiple mechanical and lifestyle factors play a role in disease development.

Pathophysiology[19]

The fundamental mechanism involves increased venous pressure and weakening of supporting connective tissue in the anal canal. Repeated straining causes downward displacement of the vascular cushions. Over time, venous congestion leads to dilatation and swelling. Chronic pressure reduces venous return, resulting in further enlargement. Inflammatory changes may occur due to friction and mucosal irritation. Progressive weakening of suspensory ligaments leads to prolapse in advanced stages.

Low-fiber diet / Chronic constipation / Prolonged sitting / Increased intra-abdominal pressure
↓
Repeated straining during defecation
↓
Increased venous pressure in superior hemorrhoidal plexus
↓
Venous congestion and dilatation of vascular cushions
↓
Weakening of connective tissue and supporting ligaments
↓
Downward displacement of anal cushions

↓
Mucosal stretching and prolapse
↓
Friction and mucosal irritation
↓
Inflammation and edema
↓
Bleeding, mucous discharge, and progressive prolapse
↓
Advanced stages (Thrombosis / Strangulation / Anemia)

Classification[20]

Internal hemorrhoids are commonly graded into four stages based on the degree of prolapse.

Grade I: Enlarged vessels without prolapse; bleeding may be present.

Grade II: Prolapse during defecation but reduce spontaneously.

Grade III: Prolapse during defecation requiring manual reduction.

Grade IV: Irreducible prolapse with possible thrombosis or strangulation.

This grading system helps in determining management approach.

Clinical Features

The most common symptom is painless bleeding per rectum, typically bright red and noticed during or after defecation. Patients may observe blood on toilet paper or dripping into the toilet. Mucous discharge and a feeling of incomplete evacuation are also common. In higher grades, prolapse may be visible. Pain usually occurs only when complications such as thrombosis or strangulation develop. Chronic blood loss may lead to anemia.

Complications

If untreated, internal hemorrhoids may lead to persistent bleeding, anemia, prolapse, thrombosis, and strangulation. In severe cases, ulceration and secondary infection may occur. Long-standing prolapse may cause irritation and hygiene difficulties. These complications significantly affect quality of life and may require surgical intervention.

Diagnosis

Diagnosis is primarily clinical and based on history and physical examination. Digital rectal examination and anoscopy are commonly performed to visualize internal hemorrhoids. In

patients with rectal bleeding, colonoscopy may be recommended to rule out other serious conditions such as colorectal malignancy, especially in older individuals.

Management

Management depends on severity. Early stages are treated conservatively with high-fiber diet, adequate hydration, stool softeners, and avoidance of straining. Topical agents may reduce local inflammation. For persistent or advanced cases, minimally invasive procedures such as rubber band ligation, sclerotherapy, and infrared coagulation are used. Surgical hemorrhoidectomy is reserved for severe or recurrent cases. The overall goal is to reduce symptoms, prevent complications, and address causative factors.

Preventive Measures

Prevention focuses on maintaining soft stool and avoiding prolonged straining. A diet rich in fiber, adequate fluid intake, regular physical activity, and proper bowel habits are essential. Early intervention in constipation significantly reduces recurrence risk. Lifestyle modification remains the cornerstone of long-term management.

RESULTS AND FINDINGS

- Internal hemorrhoids arise primarily due to increased venous pressure in the superior hemorrhoidal plexus.
- Chronic constipation and repeated straining are identified as the most significant contributing factors.
- Weakening of supportive connective tissue in the anal canal plays a key role in progression from mild enlargement to prolapse.
- Early-stage internal hemorrhoids commonly present with painless bright red bleeding per rectum.
- Prolapse severity increases progressively from Grade I to Grade IV.
- Venous congestion and mucosal displacement are central pathological mechanisms.
- Inflammation and edema develop due to persistent vascular dilatation and mechanical irritation.

- Advanced stages may lead to complications such as thrombosis, strangulation, and chronic anemia.
- Conservative management with dietary fiber and lifestyle modification is effective in early grades.
- Surgical or procedural interventions become necessary in advanced or recurrent cases.

DISCUSSION

Internal hemorrhoids develop primarily due to sustained increase in venous pressure within the superior hemorrhoidal plexus, most commonly caused by chronic constipation and repeated straining. Over time, this persistent pressure leads to dilatation of vascular cushions and gradual weakening of the supporting connective tissue. The downward displacement of these cushions results in prolapse, which progresses in severity if the underlying cause is not corrected. This highlights that the condition is not simply a vascular swelling but a structural and functional disorder of the anal canal.[21]

The clinical presentation strongly reflects the underlying pathophysiology. Because internal hemorrhoids lie above the dentate line, early stages are typically painless and present mainly with bright red bleeding during defecation. As prolapse advances, symptoms such as mucous discharge, irritation, and manual reducibility appear. In advanced grades, complications like thrombosis and strangulation can cause significant pain and tissue damage. Chronic untreated bleeding may also result in anemia, affecting overall health and quality of life.[22]

Management strategies emphasize correction of the precipitating factors. Dietary modification, adequate hydration, and avoidance of straining form the foundation of treatment in early stages. Minimally invasive procedures are useful for persistent cases, while surgical intervention is reserved for severe or recurrent disease. The discussion clearly indicates that successful management depends not only on treating the enlarged vessels but also on addressing lifestyle and mechanical factors responsible for venous congestion.[23]

CONCLUSION

Internal hemorrhoids are primarily a result of chronic venous congestion and weakening of supportive tissues in the anal canal, most commonly triggered by constipation and repeated

straining. The disease progresses gradually from mild vascular enlargement to prolapse and possible complications if left untreated. Early recognition and correction of lifestyle factors such as low-fiber diet, inadequate hydration, and prolonged sitting are essential for effective management. Timely conservative treatment can prevent progression, while advanced stages may require procedural or surgical intervention. Overall, understanding the underlying pathophysiology is key to both prevention and long-term control of internal hemorrhoids.

CONFLICT OF INTEREST – NIL

SOURCE OF SUPPORT -NONE

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