EJPMR, 2026, 13(8), 169-172 **Case Study** **Impact Factor: 8.158**

EUROPEAN JOURNAL OF PHARMACEUTICAL AND MEDICAL RESEARCH

www.ejpmr.com

ISSN (O): 2394-3211
ISSN (P): 3051-2573
Coden USA: EJPMAG

CONSERVATIVE MANAGEMENT OF FISSURE-IN-ANO VIA A COMBINED APPROACH OF ANAL DILATATION AND APPLICATION OF JATYADI TAIL: A CASE STUDY

Dr. Manisha Sikdar*[1], Dr. Shraddha Sakhare[2], Dr. Akhila Sundar[3]

*[1]MS Scholar, Second Year, Department of Shalya Tantra, Rani Dullaiya Smriti Ayurved P.G. College & Hospital, Bhopal (M.P.), India.
[2]HOD & Professor, Department of Shalya Tantra, Rani Dullaiya Smriti Ayurved P.G. College & Hospital, Bhopal (M.P.), India.
[3]Assistant Professor, Department of Shalya Tantra, Rani Dullaiya Smriti Ayurved P.G. College & Hospital, Bhopal (M.P.), India.

***Corresponding Author: Dr. Manisha Sikdar**

MS Scholar, Second Year, Department of Shalya Tantra, Rani Dullaiya Smriti Ayurved P.G. College & Hospital, Bhopal (M.P.), India. **DOI:** https://doi.org/10.5281/zenodo.21701092

How to cite this Article: Dr. Manisha Sikdar*[1], Dr. Shraddha Sakhare[2], Dr. Akhila Sundar[3] (2026). Conservative Management Of Fissure-In-Ano Via A Combined Approach Of Anal Dilatation And Application Of Jatyadi Tail: A Case Study. European Journal of Pharmaceutical and Medical Research, 13(8), 169–172.

Article Received on 24/06/2026 **Article Revised on 14/07/2026** **Article Published on 01/08/2026**

ABSTRACT

Fissure-in-ano is a painful longitudinal tear in the distal anoderm, frequently secondary to chronic constipation and subsequent internal anal sphincter hypertonicity. In Ayurveda, this condition is called as *Parikartika*, presenting as an acute, painful ulceration (*Sadyo Vrana*) driven primarily by *Vata dushti*. Modern standard protocols for chronic cases often involve surgical interventions like lateral internal sphincterotomy (LIS), which carry inherent risks of faecal or flatus incontinence. This case study evaluates a conservative, sphincter-preserving approach combining periodic anal dilatation (*Sroto vivardhana karma*[1]) and application of medicated oils through the ano-rectal route. Case Presentation - A 52-year-old female patient presented with a two-month history of severe pain and an intense burning sensation during and after defecation, secondary to chronic constipation. Local proctological examination revealed chronic anal fissures at both the anterior and posterior midlines, internal anal sphincter spasm, and secondary hypertrophied anal papillae at the 4, 7, and 8 o'clock positions. Management - The patient underwent a 7-day therapeutic protocol consisting of daily graduated periodic anal dilatation using clinical anal dilators, immediately followed by the administration of a 30 mL of *Jatyadi taila*. No oral laxatives or systemic analgesics were prescribed during the intervention. Results - A notable reduction in post-defecation pain and burning sensation was achieved by the 2nd day of treatment. By the 7th day, internal anal sphincter spasm was completely resolved, the fissure lines demonstrated advanced epithelialization, and bowel habits normalized with complete relief from constipation. Conclusion - The combination of *Sroto vivardhana karma* and application Jatyadi taila provides a safe, minimally invasive, and cost-effective conservative treatment for chronic fissure-in-ano. By addressing both the mechanical hypertonicity of the anal sphincter and the underlying *Vata*-induced constipation, this integrated regimen serves as a viable non-surgical alternative for managing *Parikartika*.

KEYWORDS: *Parikartika*, *Matra Basti*, *Sroto vivardhana karma*, *Jatyadi taila*, Anal Fissure, Sphincter Spasm.

INTRODUCTION

Anorectal disorders have shown a rising global incidence, largely driven by contemporary sedentary lifestyles, low-fibre dietary habits, and chronic constipation. Among these conditions, fissure-in-ano represents one of the most painful ailments presenting to proctology clinics, severely impacting a patient's daily functioning and quality of life. Characterized by a longitudinal or elliptical tear in the squamous epithelium of the distal anal canal, it extends from the anal verge to the dentate line. The incidence is balanced across both genders and is most frequently observed in young adults aged 15 to 40 years, pregnant women, and during the puerperal period.

The primary aetiology involves mechanical trauma to the sensitive anoderm caused by the passage of a hard, bulky faecal bolus. This tear typically occurs in the posterior midline due to a lack of muscular support in this anatomical axis. Once the anoderm is breached, the underlying fibres of the internal anal sphincter undergo a reflex-mediated neuromuscular spasm. This persistent hypertonicity initiates a pathological cycle.

The resulting local ischemia prevents the tissue regeneration required to heal the acute tear, converting it into a chronic, indurated ulcer.

In classical Ayurvedic literature, this condition correlates with *Parikartika*, a term derived from *Kartanavat vedana*, denoting a sharp, cutting pain in the *Guda* (anal region). Because *Parikartika* presents as a fresh, painful ulceration, it is managed under the principles of a *Sadyo Vrana* (acute traumatic wound). Its successful management requires interventions that promote tissue repair (*Vrana Ropana*) alongside therapies that pacify *Vata dosha*, the primary driver of smooth muscle hypertonicity and dry, constipated stools.

When conservative measures fail, Lateral Internal Sphincterotomy (LIS) remains the surgical standard. However, surgically dividing the internal sphincter carries an inherent risk of temporary or permanent faecal and flatus incontinence.

To address this clinical limitation, non-surgical alternatives are highly desirable. *Acharya Sushruta* conceptualized *Sroto vivardhana karma* (mechanical dilatation) using tubular instruments (*Nadi Yantra*) for conditions like *Sanniruddha guda* (stricture of the anus) and *Niruddha prakash* (phimosis). Translating this principle to proctological practice, graduated clinical anal dilators can be utilized to stretch hyperactive sphincter muscles, reduce resting anal pressures, and restore tissue perfusion. When paired with *Jatyadi Taila* application, it offers a comprehensive local and systemic approach to treating chronic fissures by healing of the wound.

CASE PRESENTATION

Clinical presentation

A 52-year-old female patient presented to the *Shalya Tantra* Outpatient Department with a chief complaint of severe, sharp pain and a persistent burning sensation in the anal region during and after the passage of stools, persisting for the past two months. The patient reported that the pain was immediately triggered by defecation and would last as a deep, throbbing ache for 2 to 3 hours, severely impacting her daily activities.

She reported a long-standing history of chronic constipation extending over several years, requiring prolonged straining (*Pravahana*) to evacuate hard stools. Her medical history was negative for diabetes mellitus, systemic hypertension, tuberculosis, or inflammatory bowel diseases. There was no history of prior anorectal surgical interventions.

Clinical Findings and Objective Examination

The patient was examined in the lithotomy position under adequate illumination.

- **Inspection:** Parting of the perianal skin revealed chronic longitudinal ulcerations with raised, indurated margins located at both the anterior (12 o'clock) and posterior (6 o'clock) midlines.
- **Palpation / Digital Rectal Examination (DRE):** Initial digital rectal examination was deferred due to severe pain and instantaneous, powerful reflex contraction of the perianal muscles. Superficial palpation confirmed severe hypertonicity and reflex spasm of the internal anal sphincter muscle.
- **Proctoscopy:** Performed gently following the application of a 2% lignocaine local anaesthetic gel. Internal mucosal examination revealed distinct, prominent fibroepithelial projections consistent with hypertrophied anal papillae at the 4, 7, and 8 o'clock positions.

MATERIALS AND METHODS

The patient was admitted to the inpatient department for a structured, 7-day conservative protocol. All prior oral laxatives and systemic analgesics were completely discontinued to isolate the therapeutic effects of the local intervention. The patient was placed on a standardized, fibre-rich diet with adequate oral hydration.

The management protocol was executed daily for 7 consecutive days, structuring this clinical interventions.

Sroto Vivardhana Karma (Periodic Anal Dilatation) and *application of Jatyadi Taila*

- **Procedure:** Performed daily in the morning after natural bowel evacuation. The perianal region was cleansed, and a graduated clinical anal dilator coated with lubricating jelly was gently introduced into the anal canal. Then immediately after daily anal dilatation session, a sterile, disposable syringe attached to a soft, well-lubricated 8-French catheter was utilized to administer 30 mL of lukewarm *Jatyadi taila* into the anal canal.
- **Technique:** The dilator was inserted with steady, non-traumatic pressure and held in position for 3 to 5 minutes to allow the smooth muscle fibres of the internal sphincter to adapt and relax. Over the 7-day period, as the sphincter hypertonicity progressively yielded, the diameter of the clinical dilator was stepped up gradually to achieve uniform stretching without causing fresh mucosal disruptions. Then administer 30 mL of *Jatyadi taila* into the anal canal.
- **Post-Procedure Care:** The catheter was gently withdrawn, and the patient was instructed to maintain a prone position with hips slightly elevated

on a pillow for 15 to 20 minutes to optimize retention of the medicated oil within the anal canal.

- **Clinical Rationale:** This anal dilatation intervention directly operationalizes the concept of *Sroto vivardhana karma*. Administration of *Jatyadi tail* provides essential local lubrication, locally pacifying *Apana Vayu* and promoting *Vrana Ropana*.

RESULTS

The patient's therapeutic response was evaluated daily over the 7-day treatment course. Clinical parameters were monitored using the Visual Analog Scale (VAS) for pain intensity (0–10), a standardized assessment for burning sensation, digital assessment of internal sphincter tone, and daily documentation of bowel regularity.

Daily Clinical Progression

Treatment Day	Subjective Pain Score (VAS 0–10)	Burning Sensation Intensity	Internal Sphincter Tone Status
Day 1 (Baseline)	9 / 10 (Severe)	Intense (Lasting >3 hours post-stool)	Rigid reflex spasm; digital rectal examination impossible
Day 2	5 / 10 (Moderate)	Moderate (Lasting <1 hour post-stool)	Persistent hypertonicity; dilator introduced with mild resistance
Day 3	3 / 10 (Mild)	Mild (Transient, resolving within minutes)	Gradual reduction in tone; manual dilatation well tolerated
Day 4	2 / 10 (Mild)	Minimal / Negligible	Sphincter fibres noting palpable relaxation
Day 5	1 / 10 (Trace)	Absent	Tone approaching normal physiologic limits
Day 6	0 / 10 (Complete Relief)	Absent	Smooth muscle fibres fully compliant
Day 7 (End of Protocol)	0 / 10 (Complete Relief)	Absent	Spasm completely resolved; DRE entirely painless

On the 7th day, direct local inspection revealed that both the anterior and posterior chronic fissure lines had undergone advanced epithelialization, marked by healthy tissue closing the previous longitudinal gaps. The induration at the margins was completely gone.

Palpation confirmed that the internal anal sphincter spasm was entirely resolved, allowing a smooth and painless DRE with normal resting tone. The three hypertrophied anal papillae identified at baseline at the 4, 7, and 8 o'clock positions remained structurally present but were completely non-tender, non-congested, and asymptomatic. The patient reported complete relief from chronic constipation and normal daily bowel movements.

DISCUSSION

The clinical success of this case demonstrates that the synchronized combination of *Sroto vivardhana karma* (graduated periodic anal dilatation) and application of *Jatyadi taila* successfully interrupts this pathological cascade through a multi-targeted approach without surgical interventions.

1. Neuromuscular Relaxation via Controlled Mechanical Stretch

Graduated periodic anal dilatation works by stretching the hypertonic smooth muscle fibres of the internal anal sphincter. When applied progressively over a 7-day period, this manual stretch overcomes the chronic reflex spasm and it restores microvascular blood flow to the ischemic midline fissure bed also accelerating granulation tissue formation and promoting definitive epithelialization.

2. Tissue Repair and Anti-Inflammatory Action

Jatyadi taila is highly valued in Shalya Tantra practice for its dual actions of *Vrana Shodhana* (wound cleansing) and *Vrana Ropana* (wound healing). *Jatyadi taila* is a lipid-based formulation prepared with potent herbs including *Jati*(*Jasminum officinarum*), *Nimba* (*Azadirachta indica*), *Patola* (*Trichosanthes dioica*), and *Yashthimadhu*(*Glycyrrhiza glabra*). These botanical agents possess validated anti-inflammatory, antimicrobial, and epithelizing properties, working together to achieve *Vrana Shodhana* and *Vrana Ropana*. The botanical active constituents within the oil exert a broad range of therapeutic effects. *Jati* and *Nimba* supply natural bioactive compounds providing antimicrobial and anti-inflammatory properties, keeping the fissure bed clean and free of secondary bacterial colonization from passing faecal matter. *Yashthimadhu* exerts a soothing effect that reduces local burning sensations (*Daha*) and acute pain. Concurrently, the oil base (*Tila taila*) provides physical lubrication, coating the anal canal mucosa with a protective lipid barrier. This minimizes friction and tearing forces during defecation, protecting the healing epithelium from recurrent trauma.

It is clinically important to note that while the patient's acute pain, burning, and midline ulcerations were fully resolved, the pre-existing **hypertrophied anal papillae** at the 4, 7, and 8 o'clock positions remained intact at the end of the 7-day protocol. In chronic proctological conditions, these papillae represent permanent fibroepithelial changes. Although they became completely non-tender and asymptomatic once local inflammation and sphincter spasm were resolved,

they require regular, long-term monitoring. If these hypertrophied structures undergo further mechanical enlargement or begin to prolapse through the anal verge during defecation—causing a foreign body sensation or mechanical irritation—they can act as chronic triggers to the anal canal. In such a scenario, the conservative protocol should be supplemented with a minor, targeted surgical intervention, specifically *Chhedana karma* (excision) to remove the papillae while fully preserving the underlying sphincter integrity.

CONCLUSION

The combination of periodic anal dilatation (*Sroto vivardhana karma*) and application of *Jatyadi taila* provides a highly effective, safe, non-surgical management strategy for chronic fissure-in-ano (*Parikartika*). By addressing both the local mechanical hypertonicity of the internal anal sphincter, this protocol successfully breaks the pain-spasm-ischemia cycle. It achieves complete wound healing and symptom resolution without the need for surgical sphincterotomy, preserving anatomy and entirely avoiding the risk of postoperative faecal incontinence. This approach stands as an excellent, patient-compliant alternative for the management of chronic anorectal ulcerations.

REFERENCES

1. Sushruta. *Sushruta Samhita*, *Chikitsa Sthana*, Chapter 6 (*Chidra Guda/Niruddha Prakasha* Management). Edited by Vaidya Jadavji Trikamji Acharya. Varanasi: Chaukhambha Orientalia; 2014.
2. Vagbhata. *Ashtanga Hridayam*, *Nidana Sthana*, Chapter 8 (*Arso*-Anorectal Disorders).
3. Wald, A. *Clinical Practice: Chronic Anal Fissure*. The New England Journal of Medicine, 2014; 370(16): 1516-1520.
4. Signorini, F., etc. *Role of Anal Dilators in the Treatment of Chronic Anal Fissure associated with Internal Anal Sphincter Hypertonia*. Minerva Chirurgica, 2008; 63(6): 471-476.
5. Sastri, L. *Bhesajya Ratnavali*, *Arso-Roga Chikitsa Prakaran* (Properties of *Jatyadi Taila*). Varanasi: Chaukhambha Sanskrit Sansthan, 2015.
6. American Society of Colon and Rectal Surgeons (ASCRS). *Clinical Practice Guidelines for the Management of Anal Fissures*. Diseases of the Colon & Rectum, 2017; 60(1): 7-14.