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MANAGEMENT OF CONSTIPATION ASSOCIATED WITH *AGNIMANDYA* AND SECONDARY ANORECTAL LESIONS: A CASE REPORT

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ABSTRACT

Chronic constipation is a common gastrointestinal disorder that significantly impairs quality of life and may predispose to secondary anorectal pathology due to persistent straining and altered anorectal dynamics. In Ayurveda, *Agni* is regarded as the central determinant of digestion and metabolism. Impairment of digestive fire (*Agnimandya*) results in *Ama* formation and vitiation of *Apana Vata*, leading to *Vibandha* (constipation) and its complications. A 33-year-old male presented with severe constipation, abdominal distension, hyperacidity, persistent urge for defecation, anal pain, and perianal swelling for one year. Digital rectal examination revealed increased anal sphincter tone with papillomatous growth at the 10 and 11 o'clock positions and a sentinel tag. Ayurvedic assessment demonstrated *Mandagni* with features of *Vidagdha Ajeerna* and *Apana Vata Dushti*. Management included *Deepana–Pachana* therapy, dietary regulation, *Vatanulomana* measures, and *Pitta-shamana* medications. Due to persistence of structural lesions, anal dilatation followed by surgical excision was performed. The symptom severity score reduced from 17 to 5 following integrative management. This case highlights the importance of correcting *Agnimandya* in chronic constipation and supports an integrative therapeutic approach for preventing and managing secondary anorectal pathology.

KEYWORDS: Chronic constipation, *Agnimandya*, *Ama*, *Vibandha*, *Apana Vata*, Integrative management.

INTRODUCTION

Chronic constipation is characterized by infrequent, difficult, or incomplete evacuation of stool persisting for several months. Its global prevalence ranges between 10% and 20%, affecting both physical comfort and psychological wellbeing.[1] Persistent constipation may result in anorectal complications such as fissure-in-ano, hypertrophied anal papillae, sentinel tag formation, mucosal prolapse, and hemorrhoidal changes.[2]

From a modern perspective, chronic constipation may arise from delayed colonic transit, dyssynergic defecation, altered gut microbiota, and increased anal sphincter tone.[3] Repeated straining elevates intrarectal pressure and produces mechanical stress on the anorectal mucosa, thereby predisposing to secondary structural changes.[4]

Ayurveda attributes gastrointestinal integrity to the proper functioning of *Agni*. Charaka emphasizes that impaired *Agni* forms the basis of disease manifestation, stating "*Rogah Sarve Api Mandagnau*" (Charaka Samhita, Sutra Sthana 28/7).[5] *Agnimandya* leads to incomplete digestion and formation of *Ama*, which possesses obstructive properties and disturbs *Dosha* equilibrium. *Apana Vata*, which governs defecation and pelvic functions, becomes vitiated in the presence of *Ama*, leading to *Vibandha* (Charaka Samhita, Chikitsa Sthana 15).[6] Sushruta further correlates *Vata* aggravation with anorectal disorders due to excessive strain and pressure in the anorectal region (Sushruta Samhita, Nidana Sthana 1).[7]

The present case demonstrates the classical *samprapti* of *Agnimandya* progressing to *Vibandha* and culminating in

secondary anorectal lesions, managed effectively through Ayurvedic therapeutic approach.

CASE REPORT

A 33-year-old male presented with complaints of severe constipation for one year. He reported passing stool two to three times daily, particularly after meals, yet experienced incomplete evacuation requiring moderate to severe straining. He also complained of abdominal distension, excessive flatulence, hyperacidity, burning micturition, anal pain, and perianal swelling.

The patient had undergone hemorrhoidectomy three years earlier. There was no history of diabetes mellitus, hypertension, or other systemic illness. His dietary history revealed irregular eating habits with frequent intake of heavy and incompatible foods, predisposing to *Mandagni*.

Clinical Examination

On general examination, the patient was moderately built and nourished. Vital parameters were stable with blood pressure recorded as 110/70 mmHg and pulse rate of 80 beats per minute. He was afebrile.

Abdominal examination revealed mild generalized distension without tenderness, guarding, or organomegaly. Bowel sounds were present and normal.

Local anorectal examination demonstrated increased sphincter tone on digital rectal examination. A papillomatous growth was palpated at the 10 and 11 o'clock positions within the anal canal. A sentinel tag was observed near the anal verge. There was no active bleeding or discharge.

Ashtavidha Pariksha

Examination of the pulse (*Nadi*) revealed *Vata-Pitta* predominance. The tongue (*Jihva*) was coated, indicating the presence of *Ama*. Bowel examination (*Mala*) revealed irregular evacuation with straining and incomplete defecation. The patient reported burning sensation during micturition (*Mutra*). Other parameters such as *Shabda*, *Sparsha*, *Drik*, and *Akruti* were normal. These findings were suggestive of *Mandagni* with *Ama* accumulation and *Apana Vata Dushti*.

Dashavidha Pariksha

Assessment of *Prakriti* indicated a *Vata-Pitta* predominant constitution. *Vikriti* reflected *Apana Vata Dushti* with associated *Pitta* aggravation. *Sara* and *Samhanana* were moderate, suggesting average tissue integrity and compactness. *Pramana* was within normal anthropometric limits. *Satmya* was moderate, with history indicating mixed dietary adaptability but irregular habits. *Satva* was moderate, and the patient was cooperative and mentally stable. *Ahara Shakti* was diminished, reflecting *Mandagni*, while *Vyayama Shakti* was moderate. *Vaya* corresponded to *Madhyama Avastha*.

The overall Ayurvedic assessment established the diagnosis of *Mandagni* with *Vidagdha Ajeerna* leading to *Vibandha* and secondary anorectal pathology.

Assessment Methodology

Clinical improvement was objectively assessed using a symptom severity grading scale ranging from 0 to 3, where 0 represented absence and 3 represented severe manifestation. Parameters assessed included constipation severity, straining, abdominal distension, hyperacidity, anal pain, and incomplete evacuation. Evaluation was conducted before initiation of therapy and after completion of integrative management.

Table 1: Before and After Treatment Symptom Assessment.

Parameter	Before Treatment	After Treatment
Constipation severity	3	1
Straining	3	1
Abdominal distension	3	1
Hyperacidity	3	1
Anal pain	2	0
Incomplete evacuation	3	1
Total Score	**17**	**5**

The substantial reduction in total score indicates significant clinical improvement following therapy.

Intervention

Management initially focused on correction of *Agnimandya*. *Deepana–Pachana* therapy with Chitrakadi Vati was administered to enhance digestive fire and digest *Ama*. Kamadudha Rasa was prescribed to pacify aggravated *Pitta* and alleviate hyperacidity. *Vatanulomana* was achieved through administration of Isabgol and mild *Virechana* therapy to regulate bowel movements and reduce straining. Dietary modifications included *Laghu ahara* and *Mudga Siddha Peya* to minimize digestive burden. Milk and sugar were restricted to prevent further *Ama* formation.

Despite correction of digestive dysfunction, structural lesions persisted. Therefore, anal dilatation was performed to relieve sphincter hypertonicity, followed by surgical excision of the papilloma and sentinel tag under local anesthesia. Postoperative care included continuation of bowel-regulating therapy.

DISCUSSION

The pathogenesis in this case reflects the classical Ayurvedic progression beginning with *Agnimandya*. Impaired digestive fire leads to incomplete transformation of ingested food into *Ahara Rasa*, resulting in *Ama* formation. *Ama*, characterized by its heavy (*guru*) and sticky (*picchila*) properties, obstructs

gastrointestinal channels and disrupts normal *Vata* movement.[5]

Apana Vata, responsible for defecation, becomes vitiated when obstructed by *Ama* and aggravated *Pitta*. This results in *Vibandha*, characterized by straining, hard stool, and incomplete evacuation.[6] The patient's hyperacidity and burning symptoms correspond to *Vidagdha Ajeerna*, where *Pitta* predominance interacts with weakened *Agni*.

Modern gastroenterological studies demonstrate that chronic constipation is associated with increased anal resting pressure and dyssynergic defecation.[3] Persistent straining elevates intrarectal pressure and induces mucosal hypertrophy, contributing to secondary anorectal lesions.[4] The increased sphincter tone observed in this case supports this pathophysiological correlation.

Deepana–Pachana therapy restores digestive efficiency and reduces *Ama* accumulation. Correction of *Agni* improves gut motility and reduces fermentation-related bloating. *Vatanulomana* normalizes bowel evacuation and minimizes mechanical stress. Surgical excision addresses established hypertrophic lesions that may not regress with conservative therapy alone.

This case illustrates that anorectal pathology may represent a downstream manifestation of systemic digestive impairment. Addressing only the structural lesion without correcting *Agnimandya* may predispose to recurrence. Therefore, an integrative approach targeting both systemic and local pathology ensures comprehensive management.

CONCLUSION

Chronic constipation associated with *Agnimandya* may predispose to secondary anorectal lesions due to persistent straining and altered anorectal dynamics. Early correction of digestive impairment and regulation of *Apana Vata* are fundamental to prevent complications. Integrative management combining Ayurvedic therapy with minor surgical intervention resulted in significant clinical improvement and objective symptom reduction in this case.

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