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Case Report

An Overview of Anorectal Diseases and Case Report on Hemorrhoids with Homoeopathic Medicine

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Abstract Anorectal diseases encompass a wide range of disorders affecting the lower gastrointestinal tract, particularly the anus and rectum. These conditions are common and often lead to significant discomfort, impairment of daily activities, and a reduction in quality of life. Among the most prevalent anorectal disorders are hemorrhoids, anal fissures, anorectal abscesses, and fistulas, each contributing to varying degrees of morbidity. Hemorrhoids, characterized by the swelling and inflammation of veins in the rectum and anus, are particularly common and can present with symptoms such as bleeding, pain, itching, and prolapse. The etiological factors for hemorrhoids include prolonged sitting, straining during bowel movements, pregnancy, and chronic constipation. Diagnosis typically involves a physical examination, often supplemented by anoscopy or colonoscopy in more complex cases. Treatment for hemorrhoids varies depending on the severity and may range from conservative measures like dietary modification and stool softeners to minimally invasive procedures, such as rubber band ligation, and, in more severe cases, surgical intervention. This aims to provide a concise overview of the pathophysiology, clinical presentation, and treatment options for anorectal diseases, with a focus on hemorrhoids, highlighting the importance of early diagnosis and appropriate management to prevent complications and enhance patient outcomes.

Keywords *Homoeopathy, Anorectal, Hemorrhoids, Rectum, Fissure, Anal Warts, Carcinosin*

Abbreviation O.P.D. – Out Patient Department, PR –Pulse Rate, RR – Respiratory Rate, Temp.- Temperature, Ht. – Height, Wt. – Weight, B.P – Blood Pressure, CVS – Cardiovascular system, CNS – Central Nervous System, RESP. – Respiratory System, GIT – Gastro Intestinal System

Introduction

Benign anorectal disease is commonly encountered in clinical practices across specialties and hemorrhoids, fissures, and fistulas continue to have a significant impact on patients' lives. Hemorrhoids and fissures frequently benefit from non-operative management, but occasionally require surgery, while the treatment of anorectal abscess and fistulas is mainly surgical.

Hemorrhoids

Hemorrhoidal columns are normal anatomic clusters of vascular and connective tissue, smooth muscle, and overlying epithelium that exist in the left lateral, right anterior, and right posterior anal canal and serve in providing continence. They become pathologic when engorged and subsequently symptomatic. Internal hemorrhoids are proximal to the dentate line, covered in columnar epithelium, and have visceral innervation.

Internal hemorrhoids are clinically classified when they become symptomatic:

- Grade 1 hemorrhoids do not prolapse;
- Grade 2 prolapse with straining;
- Grade 3 require manual reduction to reduce prolapse; and
- Grade 4 are irreducible.

External hemorrhoids are perianal subcutaneous venous plexuses distal to the dentate line, somatically innervated, and covered by squamous epithelium.

External hemorrhoids may become pathological when these venous plexuses spontaneously rupture, resulting in a painful subcutaneous hematoma or “thrombosed external hemorrhoid.”

The etiology of hemorrhoids was originally thought to be caused by portal hypertension; however, the most popular modern theory is that symptomatic hemorrhoids occur with deterioration of the tissues that support the anal cushions, causing abnormal downward displacement and venous dilation. This process can be exacerbated by lifting, straining, and prolonged sitting. Other risk factors include a low fiber diet and constipation, though epidemiological studies have shown that hemorrhoids and constipation have different distributions among the population. Some studies have shown that diarrhea, rather than constipation, is associated with hemorrhoids. Squatting produces a straighter anorectal angle, compared to sitting on a toilet.

Internal hemorrhoids most often present with painless bleeding during bowel movements and/or prolapse. Prolapse may be associated with mild fecal incontinence, mucous drainage, perianal fullness, and painful skin irritation. Although rare, prolapsed internal hemorrhoids can strangulate, causing significant pain. Thrombosed external hemorrhoids tend to be more painful, given their somatic innervation, and patients present with a tender perianal mass that can bleed if it ulcerates. Thrombosed external hemorrhoids usually degenerate into perianal skin tags over time. The diagnosis of hemorrhoidal disease is based on history and physical exam. Anoscopy is necessary to visualize internal hemorrhoids and identify anorectal pathology on exam.

Pruritis Ani

Pruritis ani means "itchy anus." Patients may experience severe itching or an unclean feeling. Over time, pain and stinging in the anal area may develop. This condition can significantly affect quality of life and often is very frustrating to treat. Pruritis ani may be a patient's diagnosis or a symptom of an underlying disorder, such as fungal or bacterial infection, chronic skin condition, another anorectal condition or cancer.

Fissures

An anal fissure is a linear tear in the anal mucosa, usually extending from the dentate line to the anal verge. Fissures occur in all age groups, but appear to be more common in young and otherwise

healthy people. If one persists for more than 4-8 weeks, it is considered chronic. Most fissures occur at the posterior midline (90%). Anterior midline fissures occur in 10-25% of female fissures and 1-8% of male fissures. Anterior and posterior midline fissures can occur concomitantly in about 3% of cases. A lateral fissure should raise concern for inflammatory bowel disease, tuberculosis, human immunodeficiency virus, or syphilis. Anal fissures cause significant pain and negatively impact quality of life.

Anal fissures were initially thought to be due to anal canal trauma from hard stools or diarrhea, but this explains only acute fissures. Additionally, constipation and hard bowel movements are associated with fissures. It appears that persistently high internal sphincter tone leads to chronicity of fissures. There is a separate entity of fissures associated with childbirth that appear to be due to shear forces from the baby's head during birth, causing tethering of the mucosa to muscle and local trauma. About 11% of chronic fissures, associated with difficult or instrumented deliveries, occur after childbirth, and are most common in the anterior midline. The diagnosis of anal fissure is a clinical one. Patients usually present with anal pain, most commonly for several hours after bowel movements, and may have painful bleeding with bowel movements. A fissure may be found upon examination, although this may be difficult because of pain and internal sphincter spasm. Chronic fissures develop indurated edges and may have visible sphincter muscle at the base with associated hypertrophic papilla proximally and sentinel tags distally

Perianal Abscess and Fistulas

Anorectal abscesses represent a very common disease process that typically results from a cryptoglandular infection in the anal canal and can occur in the ischiorectal, intersphincteric, supralevator, perianal or submucosal spaces.

They are more common in men and their incidence peaks around age 20-40 years. Abscesses and fistula often occur concomitantly, with 30-70% of those with active abscesses having a current fistula. Of people with anorectal abscesses who do not currently have a fistula, 30-50% will develop one in the future.

An anal fistula is a persistent epithelialized tract from the anal canal to the perianal skin, and can be intersphincteric, transsphincteric, suprasphincteric, or extrasphincteric. Fistulas are considered simple if they are low transsphincteric or intersphincteric and cross less than 30% of the external sphincter. Complex fistulas include those that are high transsphincteric (involving more than 30% of the external sphincter), extrasphincteric or suprasphincteric, and cryptoglandular in origin, in addition to fistulas associated with inflammatory bowel disease, radiation, malignancy, chronic diarrhea or preexisting incontinence. Eighty percent of fistulas are secondary to cryptoglandular infection, with the remainder due to Crohn's disease, trauma, radiation, malignancy or various infectious diseases. The external opening of a fistula does not predict the internal opening in patients with long fistulas, Crohn's disease or recurrent fistulas.

The diagnosis of anorectal abscess or fistula is generally based on history and exam. Patients with a perianal or ischiorectal abscess will present with fever, pain, tenderness, erythema and often a fluctuant mass. Patients with supralevator or intersphincteric abscesses may have minimal external exam findings, but will have rectal tenderness and fluctuance on digital rectal exam. It is vital to differentiate an anorectal abscess from other inflammatory processes that may occur in the area, such as hidradenitis, furuncles, or pilonidal disease. Computed tomography with intravenous contrast can be useful to localize high abscesses, especially supralevator abscesses. Fistulas will present with persistent purulent or fecal drainage or intermittent perianal swelling and tenderness relieved with spontaneous drainage. Multiple fistulas and large skin tags can be suggestive of Crohn's disease.

Anal Warts

Condyloma, or anal warts, are caused by the human papilloma virus (HPV) and form on the skin around the anus. There are many types of papilloma virus. Some types develop warts on the hands and feet while others cause genital and anal warts. Many people do not complain of any complications from anal warts. Others complain of itching, bleeding or moisture in the anal area.

Pilonidal Disease

Pilonidal disease affects the top of the gluteal cleft near the tailbone. In this condition, broken hair is drawn into small breaks in the skin, which leads to inflammation and infection. The hair can burrow quite deep into the skin, creating long sinuses. Symptoms may include pain, redness, or drainage or abscess in the area. Pilonidal disease is most common in young men but can affect men and women in all age groups.

Rectal Varices

Rectal varices are portosystemic collaterals that form as a complication of portal hypertension; their prevalence has been reported as high as 94% in patients with extrahepatic portal vein obstruction. The diagnosis is typically based on lower endoscopy (colonoscopy or sigmoidoscopy). Rectal varices are collaterals between the portal and systemic circulations that manifest as a dilation of the submucosal veins and constitute a pathway for portal venous flow between the superior rectal veins which branch from the inferior mesenteric system and the middle inferior rectal veins from the iliac system.

Rectal Prolapse

Rectal prolapse is a condition where the rectum, or the lower part of the large intestine, bulges out of the anus. It can occur when the muscles and ligaments that attach the rectum to the pelvis weaken. Rectal prolapse can be partial or complete:

Partial rectal prolapse: Only the lining of the rectum drops through the anus

Complete rectal prolapse: The entire wall of the rectum drops through the anus

Rectal prolapse can be caused by: Chronic constipation, Chronic diarrhea, Straining while going to the bathroom, and Underlying conditions such as cystic fibrosis and Hirschsprung's disease.

Anal Stenosis

Anal stenosis, also known as anal stricture, is a rare condition that causes the anal canal to narrow, making it difficult to pass stool. Symptoms include: Constipation, Narrow stools, Painful bowel movements, and Rectal bleeding. Anal stenosis can be caused by a number of factors, including:

- Surgical procedures, such as hemorrhoid removal or anorectal wart treatment
- Inflammatory bowel disease
- Scar tissue formation, which can occur after trauma
- Overuse of laxatives
- Blood infection

- Loss of blood
- AIDS and venereal diseases

Fecal Incontinence

Fecal incontinence, also known as accidental bowel leakage, is the involuntary loss of bowel contents. It can range from occasionally leaking a small amount of stool to a complete loss of bowel control. Fecal incontinence can be caused by many things, including:

- Diarrhea or constipation
- Damaged muscles or nerves in the rectum
- Birth defects
- Diabetes
- Severe dementia
- Inflammation in the digestive tract
- Tumors
- Injuries during childbirth
- Surgery that separates or widens the anal sphincters

There are two types of fecal incontinence:

- Urge incontinence: A strong urge to have a bowel movement that can't be stopped before reaching a toilet.
- Passive incontinence: Leakage occurs without you knowing it.

Miasmatic Diagnosis

- Haemorrhoids are generally syco-psoric and are classified under the psoric miasm when associated with discomfort and itching.
- Rectal hemorrhoids with extreme sensitiveness and pain are sycotic.
- Rectal fissures and hemorrhoids with putrid and foetid discharges are syphilitic. They may also ooze pus and sanious fluids.
- Strictures, hemorrhoids, sinuses, fistulas, and pockets in the rectum are all tubercular origin and are much aggravated when combined with sycosis and syphilis.
- Cancerous rectal symptoms are a combination of tubercular and sycotic miasms.
- Bleeding haemorrhoids are tubercular.
- In this miasm, hemorrhoids which are suppressed or operated on, may result in asthma-like lung difficulties or heart troubles.

Psoric miasm has-

- constipation and morning diarrhea.
- Constipation is primarily psoric but in psora, we also find morning diarrhoea.
- Soreness of the rectum and sore bruised, pressive pain are characteristic of psora.

Sycotic rectum-

- Prolapse of the rectum.
- Diarrhoea and any stool where colic predominates.
- IBS (irritable bowel syndrome)
- Blind and non- bleeding haemorrhoids and polyps.

- Diarrhoea is sycotic.
- The sycotic stool is sour, grass green in colour and may be accompanied by constant, gripping colic.

Syphilitic rectum-

- Perineal pyogenic inflammations, perineal abscess.
- Dysentery with blood and pus where pus and mucus in stool predominate.
- Fistulas and abscesses.

Case Study

Summary: A male aged 56 years, in O.P.D. with complaints of stitching pain bleeding during stool for more than 1 year along with constipation and no desire.

Identification Details

OPD Regn: 55218

Name: Siddhart Daruwala Sex: Male Age: 56 years Address: Vivek Nagar, Lane I, Sidhpur Gujarat. Religion: Hindu Occupation: Self-employed, (Gems Dealer)

History of presenting complaints:

- Patient suffered 1 year back also
- Mode of onset – rapid, 10 days ago, recurrence
- Most probable cause – not known to the patient
- He has undergone allopathic treatment for the same without any remarkable improvement and the doctor advised for surgery.

Past History

- Typhoid – 3 years ago
- Family History
- Father – Haemorrhoids undergone surgery. Cancer
- Mother – Diabetes milletus.
- Physical generals: His appetite was good. He has a desire for salt, fats, and chocolate; his thirst is a moderate amount. Bowel movement is irregular, hard stool and not satisfactory, and has no feeling.
- The thermal reaction of the patient is hot and affected by heat.
- General modality: pain < during passing stool; > by pressure and passing urine
- General Physical Examination:
- He was obese with fair complexion and all the vitals were normal. There were no signs of anemia, jaundice, cyanosis and lymph nodes that were not palpable PR. - 80/min., RR.: 18/min., TEMP: 97.6^{0}F, Ht.-168 cm., Wt.-80 Kg.; B.P.-134/82 mm Hg.

Systemic Examination:

- C.V.S. - No abnormal sound during auscultation, C.N.S. - Sensory and motor functions are normal, RESP.-Chest clear, G.I.T.-Abdomen soft, no tenderness.

Mental Generals:

- Anxiety health, very desire to journey and go abroad.
- Excited during thunderstorm

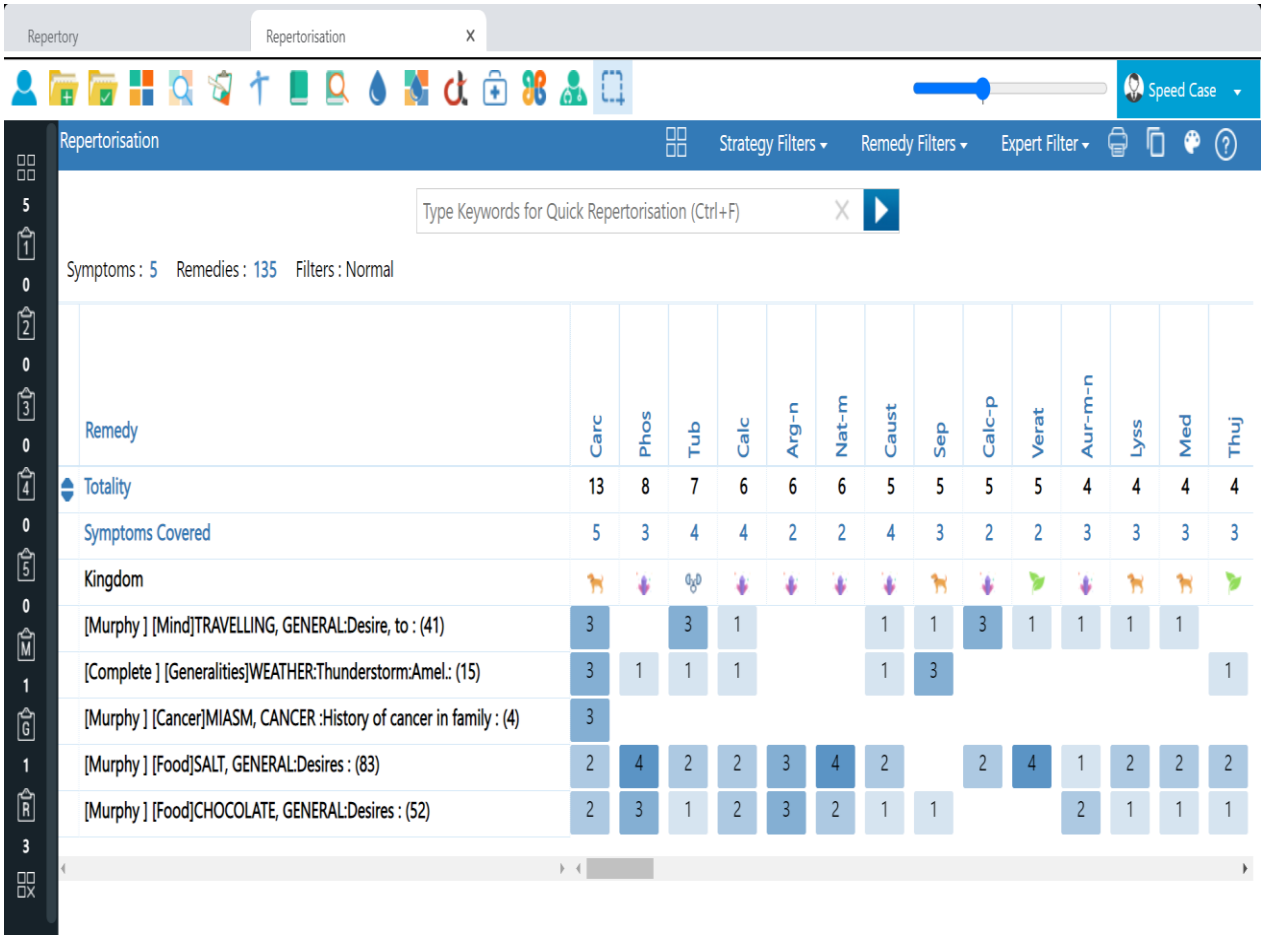
Diagnosis:

- The case diagnosis was made based on the symptomatology and rectal examination.

Prescription:

After Case taking, based on the totality of symptoms & with the consultation of Homoeopathic Materia medica [6] Carcinosin *200ch*, 4 doses, OD for four days was prescribed on 22/06/2024. Medicine should be taken at morning for 4 days, after food.

Selection of Remedy with Justification [5, 6]



Remedy	Carc	Phos	Tub	Calc	Arg-n	Nat-m	Caust	Sep	Calc-p	Verat	Aur-m-n	Lyss	Med	Thuj
Totality	13	8	7	6	6	6	5	5	5	5	4	4	4	4
Symptoms Covered	5	3	4	4	2	2	4	3	2	2	3	3	3	3
Kingdom														
[Murphy] [Mind]TRAVELLING, GENERAL:Desire, to : (41)	3		3	1			1	1	3	1	1	1	1	
[Complete] [Generalities]WEATHER:Thunderstorm:Amel.: (15)	3	1	1	1			1	3						1
[Murphy] [Cancer]MIASM, CANCER :History of cancer in family : (4)	3													
[Murphy] [Food]SALT, GENERAL:Desires : (83)	2	4	2	2	3	4	2		2	4	1	2	2	2
[Murphy] [Food]CHOCOLATE, GENERAL:Desires : (52)	2	3	1	2	3	2	1	1			2	1	1	1

The symptomatology, *Carcinosin* covers the totality of symptoms that guided us to select the remedy (mental state*)*. Based on keynote symptoms & due consultation of textbooks of Materia Medica Carcinosin seems to be the most suitable drug in this case and thus prescribed in 200ch, four doses followed by placebo for 15 days .

Selection of Potency with Justification [7]:

The potency selection and repetition were done based on the Homoeopathic principles, susceptibility of the patient, and homoeopathic philosophy.

General Management:

- Take low protein and rich fiber diet.
- Drink a large amount of water.
- Avoid spicy and meat products.
- Take regular exercise in morning

Follow Up:

Date of visit	Change in Symptoms	Prescribed Medicine/Potency/Dose	Justification
13/07/2024	Slight improvement. The pain diminished, no bleeding	Rubrum/BD/15 Days	To wait and allow the medicine to act
30/7/2024	Mild improvement. Pain markedly diminished.	Phytum /BD/30 Days	No new complaints; mild improvement occurs
02/09/2024	Appear stitching and burning sensation present. Improvement remains stan-still, no any symptoms are present	Carcinosin 10M / 1 dose Rubrum / BD / 30 Days	
05/10/2024	Improvement noticed.	Phytum /BD/30 Days	The bowel became regular after the medicine
06/11/2024	Better	Phytum /BD/30 Days	Old skin eruption appears in the right ankle without itching
10/12/2024	Skin eruption fades	Phytum /BD/30 Days	

Discussion

In anorectal diseases, Hemorrhoids are a common disorder in modern high society. Lots of people come across this condition due to improper diet and regimen. Homeopathy treats the person as a whole. It means that homeopathic treatment focuses on the patient as a person, as well as his pathological condition. The homeopathic medicines are selected after a full individualizing examination and case analysis, which includes the medical history of the patient, physical and mental constitution, family history, presenting symptoms, underlying pathology, possible causative factors, etc.

A Miasmatic tendency is also often taken into account for the treatment of chronic conditions. In this case, Carcinosin was selected because it covers the totality of symptoms and the miasmatic background. According to Dr. Hahnemann in his Organon of Medicine [8], **§ 164 & § 178.** Disease Originates at a dynamic level and Homoeopathic medicines also act on a deeper and dynamic level. Dr. Hahnemann also mentions in § 191 'Internal administration of a remedy causes important changes in general health and particularly in the affected external parts". [8] Homoeopathic medicines, i.e. medicines selected on basis of patient's totality of Symptoms or on some peculiar keynote symptoms when prepared & administered according to the Homoeopathic Principles acts curatively, removing the stone from the Excretory pathway.

Conclusion

This case report shows the positive role of homoeopathic medicine in the treatment of hemorrhoids within a short period. This single case report cannot draw any certain conclusion, more documented cases and scientific research could help to generate evidence on the usefulness of homoeopathic medicines in managing anorectal diseases such as haemorrhoids with lifestyle modification too.

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