

## A REVIEW ON CONCEPT OF MOOTRASTEELA W.S.R TO BPH (BENIGN PROSTATIC HYPER-PLASIA)

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### ABSTRACT

*Ayurveda* oldest system of medicine had explained about the Urology. *Acharya Sushruta* has described urology under the heading of *Ashmari*, *Mutrakricchra* and *Mutraghata*. *Acharya Sushruta* explained in detail about obstructive and irritative symptoms of bladder under the heading of *Mutraghata*. Benign prostatic hypertrophy is one of the obstructive uropathy of which is usually seen in after 5<sup>th</sup> decade. It occurs in about half of men in their fifties and about 90% of men over 85 years of age. BPH is a condition where there is increase in size of the prostate inside its capsule which exerts pressure on the urethra leading to the obstruction to the flow of urine.

**Keywords:** *Mutraghata*, *Mootrasteela*, Benign Prostatic Hyperplasia.

### INTRODUCTION

The word “*Mutraghata*” is composed of two words i.e. “*Mutra*” and “*Aghata*”, which stands for low urinary output. *Mutraghata* means “*Mutraghate Mutravarodah*”<sup>1</sup>. *Mutraghata* is condition where there is obstruction to the *Mutra* which causes disturbance to the patient. *Mutraghata* is of 12 types<sup>2</sup>. *Vatasteela* is one among the 12 *Mutraghata*, *Vatasteela* is a condition where there is a vitiation of *Vata* which takes shelter in *Shakrith Marga* and *Basti Pradesha* leading to the formation of *Asteelavat Ghana Granthi* which is *Achala* and *Unnata* leads to *Vin*, *Mutra* and *Anila Sanga*, *Admana* and *Vedana* at *Basti Pradesha*<sup>3</sup>. As this *Asteelavat Ghana granthi* occurs in *Mootra marga*, so it is also named as *Mootrasteela*.

*Acharya Dalhana* had explained very clearly about structure and location of *Paurusha Granthi* in the body, i.e. in *Bastimoola pradesha*<sup>4</sup>.

It seems like *Vatasthila* explained in view of *Mutraghata* is same to that of the *Vatavyadhi*, because the word *Mootrasteela* has two faces of one coin, here as it is related with the *Mootra Roga* and there it is mentioned as the main cause is *Apana Vata*, otherwise symptoms given in both places are same.

### MATERIALS AND METHODS:

#### *Mootrasteela /Vatasthila:*

The vitiated *Apana Vayu* when takes the seat in the space between *Basti* and *Shakruth Marga* i.e *Guda pradesha* produces firm lobulated growth like that of

*Asthila* (stone). The growth is turn to produce obstruction to the passage of *Vida*, *Mutra*, *Anila* and leads to *Aadhmana* of the *Basti* and also *ruja* in the *Basti pradeshai*.

The name *Asthila* is given by *Charaka* for the diseases vitiated by *Vayu* obstructing the *Basti Mukha* and *Guda* leading to prominent moveable tender hard rock like mass which obstructs the channel of urine and feces<sup>5</sup>.

#### **Nidana<sup>6</sup>:**

We don't find straight away references for *Nidana* to *Mootrasteela*. Therefore one can consider the general *Nidana* which are as follows:

- *Ativyayama*
- *Teekshna Aushadha*
- *Rukshamadhya prasanga*
- *Nityadrutha prishtayaana*
- *Anupa mamsa*
- *Adhyashana*
- *Ajeernat*

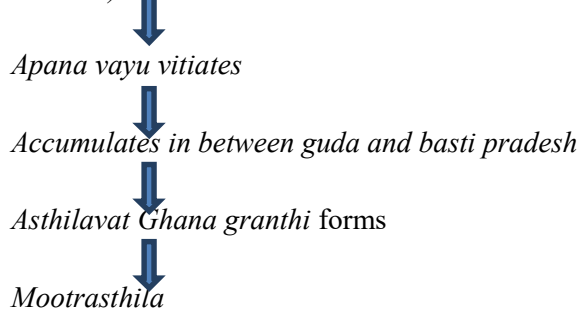
These all above *nidanas* are responsible for the *Vata Dushti* and which is the root factor in the manifestation of all the varieties of *Mutraghata* as *Dalhanacharya* coated - i.e "Sarveshu Mutraghateshu Yatho Vatah Karanam"<sup>7</sup>.

#### **Samprapti<sup>8</sup>:**

*Acharya Dalhana* had justified that *Vayu* is the main element in the focalization of *Mutraghata*.

*Acharya Charaka* had also explained that when *Amavisha* gets lodged in the *mutra marga*, leads to various *Mutra Rogas*.

*Nidana Sevana* (*Mithyaahara vihara/aghata/vega dharana*)



#### **Samprapti Ghataka:**

**Dosha:** *Vata* (*Apana*) predominant *Tridoshas*.

**Dushya:** *Rasa, Rakta, Kleda, Sveda, Mutra* (Depends on different clinical entities)

**Agni:** *Jatharagni, Mandhya*

**Udbhava Sthana:** *Kostha*

**Adhithana:** *Basti*

**Srotas:** *Mutravaha*

**Srotodusti prakara:** *Sanga, Vimarga-Gamana. Sira, Granthi*

**Roga Marga:** *Madhyma*

**Vyakthi sthana:** *Mutra pravritti*

**Sadhayasadhyata-** *Kricha sadhya*

**Lakshanas** of *Mootrasteela* mentioned in *Sushruta Samhita* are,

- *Chala Unnata Granthi* - Movable, elevated, and solid swelling.
- *Vinmootranila Sanga* - Retention of urine, flatus & faeces.
- *Basti Adhmana* - Bladder distention.
- *Vedana Ca Parabastou* - Excruciating pain in *basti pradesha*.

#### **CHIKITSA:**

For *Mootrasthila* separate *Chikitsa* has not been told hence the *Chikitsa* told for *Mutraghata* can be adopted:-

1. *Nidana Parivarjana*.
2. *Shodhana*.
3. *Shamana*.
4. *Shastra Pranidhana*.
5. *Rasayana*.
6. *Pathya-Apathya*.

##### **1. Nidana parivarjana:**

- Avoid exposure to *Nidana* of *Mootrasteela*.

##### **2. Shodhana:**

When *Doshas* are increased extremely, *Shodhana Chikitsa* becomes necessary. While describing the *Mutraghata Chikitsa Sutra*, *Acharya Sushruta* says that in case of *Mutraghata Snigdha Virechana*, *Basti* and *Uttara Basti* should be administered according to the condition of *Dosha*<sup>9</sup>.

##### **3. Shamana:**

While describing the *Mootraghata Chikitsa Acharya Sushruta* says to administer various types of *Kashaya*,

*Kalka, Ghrita, Modaka, Avaleha, Dugdha, Kshara, Asava* etc. Further he says to administer *Ashmarihara* and *Mootra Udavarta Hara Yogas*<sup>10</sup>.

#### 4. *Shastra Pranidhana Chikitsa*:

*Acharya Sushruta* has included *Mootra vishodhani Shalaka*. About its function, he said that it does *Marga vishodhana*. In this context *Dalhana* says that *Margavishodhana* is to be performed during the conditions of *Mootra Sanga* and *Pureesha Sanga*.

#### 5. *Rasayana*<sup>11</sup>:

*Acharya Vagbhata* said to prepare *Shilajatu* by giving the *bhavana* of *Veerataradi Gana dravya* and then it should be given to the patients of *Mootraghata*.

It is mainly used for *Rasayana* purpose. *Rasayana chikitsa* plays very important role in *Mootraghata*.

**Upadrava/Arishta**: If the pain of *Vatasthila*/*Mootrasthila* moves upwards towards heart causing pain and anorexia, it all indicates death beyond doubt.

#### *Pathya-Apathya*<sup>12</sup>:

##### *Pathya*:

- 1) *Abhyanga*
- 2) *Snehana*
- 3) *Virechana*
- 4) *Basti*
- 5) *Uttar basti*
- 6) *Swedana*
- 7) *Avagaahana*

##### *Apathya*:

- 1) *Virudha*- Incompatible diet
- 2) Exercise
- 3) Dry and fermented food items
- 4) Constipated food item
- 5) *Vyavaya* - over indulged in sexual act
- 6) Suppression of micturition.
- 7) *Tila*
- 8) Meat of deer.

#### Benign prostatic hyperplasia (BPH)

Benign prostatic hyperplasia is a age related disorder seen after 5<sup>th</sup> decade in men which involves the growth of the prostatic gland, situated at the base of the urinary bladder. The growth / neoplastic changes in the prostatic gland occur due to the changes in the level of hormones especially androgens and estrogens seen in men over 50 years of age. Overall incidence rate of benign prostatic hyperplasia is 22 per 1000 men per year. Incidence of Benign prostatic hyper-

plasia is at least 50 % for all men at the age of 40 years and above. In India BPH is a common pathological condition with an incidence of 95.97% and 95.3%<sup>11</sup>.

Benign prostatic hyperplasia means an adenomatous enlargement of the periurethral tissue of prostate gland, leading to obstruction of the urethral passage and outlet of bladder neck. Prostate gland increases in size as men approaches to 5<sup>th</sup> decade. Enlarged prostate exerts pressure over the urethra, which causes obstructive urinary symptoms like increased frequency of urination, dysuria, urinary urgency, excess urination at night and dribbling of urine etc<sup>13</sup>.

#### **Etiology**<sup>14</sup>:

The exact mechanism of prostatic hyperplasia is still a mystery but there are two theories which throw light on benign prostatic hyperplasia.

Two theories are as follows:

- 1) **Hormonal Theory**: As Age advances - Involuntary hyperplasia due to decrease in Circulating Dihydro-testosterone and oestrogen ratio and leads to BPH.
- 2) **Neoplastic Theory**: There is proliferation of all the elements of prostate like fibrous, muscular, and glandular resulting in fibromyoeidoma of prostate and causes BPH.

#### **Pathophysiology**:

The Prostatic adenoma obstructs urinary flow in two ways. First the enlarged prostate itself poses a static obstruction caused by the increased bulk of tissue from new cells growing in the peri – urethral region. Second, a dynamic obstruction believed to be a secondary contraction of smooth muscle fibers compressing the urethra & bladder neck.

#### **Symptoms of Benign Prostatic Hyperplasia**<sup>15</sup>:

- 1) Incomplete evacuation of urine; 2) Weak stream;
- 3) Increased frequency; 4) Straining; 5) Intermittency;
- 6) Increased frequency of urination at night (i.e. nocturia); 7) Urgency; 8) Suprapubic pain; 9) Painful micturition; (i.e. dysuria) etc.

### Investigation:

1. Blood examination like CBC, ESR, CT, BT etc, Prostate Acid Phosphatase & Prostate specific antigen test.
2. Urine examination (Routine and microscopic)
3. Ultrasonography (Kidney, Uerter &Bladder) & Trans rectal Ultrasound (TRUS),
4. Radiography – CT, MRI.
5. Biopsy & FNAC.

### Differential Diagnosis:

- 1) Urethral stricture; 2) Acute prostatitis, 3) Contrac-ture of the bladder neck; 4) Carcinoma of prostate; 5) Neurogenic bladder; 6) Vesicle calculus;
- 7) Prostatic calculi

### Diagnosis of BPH:

It is based on general, systemic and local examina-tion followed by supportive investigations.

- 1) International prostate symptom score
- 2) Digital Rectal examination (DRE)

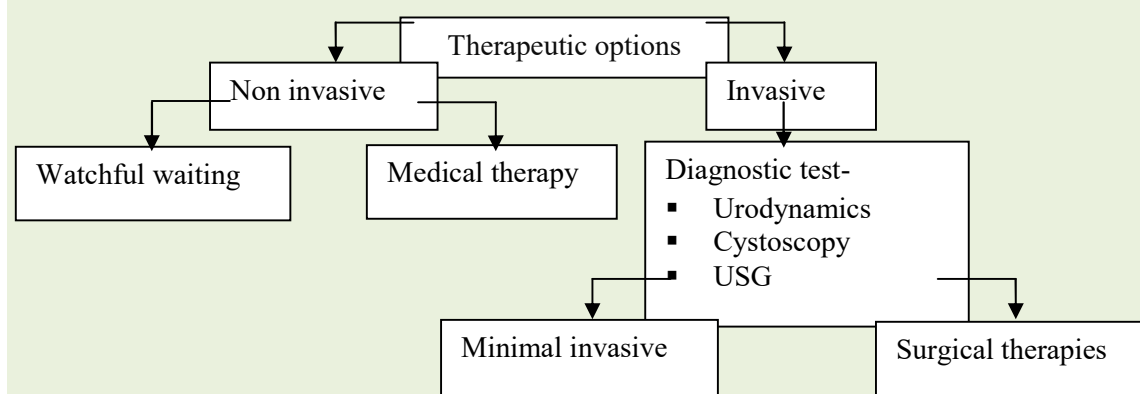
### Complications of BPH:

1. Retention of urine (Acute and chronic)
2. Recurrent urinary tract infections (UTI)
3. Bladder Calculi (Stones)
4. Secondary bladder instability
5. Renal impairment (Insufficiency)
6. Hematuria

### Management of BPH:

Current treatment strategies for BPH are dependent on the severity of the patient's symptoms. Patients with mild disease benefit most from conservative monitor-ing. If symptoms progress patients may receive medi-cal therapy for their symptoms.

### AUA Guidelines on BPH Management



#### A. Non invasive treatment –

- a) **Watchful waiting** – When symptoms of BPH are mild, best to wait for treatment. General advice about fluid intake i.e. less intake of fluid after evening, avoiding caffeine, alcoholic beverages, and smoking.
- b) **Medical treatment** – Whether symptoms are af-fecting Quality of life, and blockage is causing se-rious complication like haematuria, inability to urinate etc requires medical treatment.
  - Alpha Blocking Agents: Terazocin, Prazocin etc.
  - Testosterone sparing Agents: 5 – alpha reductase.

- Testosterone Ablation Agents: Diethyl Stilbestrol, Flutamide, Progesterone derivatives.

**Invasive treatment:** If no improvement in medica-tion then start with minimal invasive therapy which has very rare complication. Patients with more severe disease are treated with more aggressive therapies. These includes,

#### Minimally invasive methods –

- Intraprostatic Stents.
- Contact Laser of the Prostate.
- Trans Urethral Microwave Therapy.
- Trans Urethral Laser Ablation of the Prostate
- Trans Urethral Vaporization of Prostate.

- Trans Urethral Needle Ablation of the Prostate (TUNA).

**Surgery:** If medical treatment fails, then may surgery need to be performed. This involves removing part of the prostate through the urethra which are as follows,

#### Conventional operative treatment –

- Trans Urethral Resection of Prostate (TURP),
- Bladder neck incision for the small prostate (under 20 gm),
- Open Prostatectomy for the big gland (around 80 –100 or more).
- Suprapubic Transvesical Prostatectomy.
- Simple Retropubic Prostatectomy.
- Perineal Prostatectomy.
- Trans Urethral Incision of the Prostate (TUIP).

#### Life style measures for managing BPH.

I) **Daily actives:** Cold weather and immobility may increase the risk urine retention. Keeping warm and exercising may be useful.

II) **Dietary factors:** Avoiding –alcohol, tobacco, Coffee, tea and other cold liquids (coconut water, ice, cold drinks etc.)

## DISCUSSION

Symptoms of benign prostatic hyperplasia have minor correlations with diseases mentioned in *Mutraghata*. *Mutraghata* is obstruction or suppression of flow of urine. *Dalhana* described *Mutraghata* as *mutraavarodha*. In *Ayurveda* *Mutraghata* can be considered as a bladder outlet obstruction.

Benign prostatic hyperplasia can be taken as *Paurush Granthi* enlargement in *Ayurveda*. Some of our *Ayurved Acharyas* had correlated *Astheela* or *Vatashtheela* and *MutrAGRAnthi* with Benign prostatic hyperplasia. The description of *Astheela* is more closely resembles with benign prostatic hypertrophy *Mutraghata* can be treated with *Ausadha Chikitsa*, *Bastikarma* and by following lifestyle changes. *Sushruta* had mentioned certain principles for the management of all type of *Mutraghata* with use of *Kashaya*, *Kalka*, *Avaleha*, *Kshar*, *Madya*, *Aasava*, *Snehana*, *Swedana*, *Basti* and *Uttarbasti* which is based on pathogenesis told in *Ayurveda* classics.

*Mootra-virechaniya* and *Mutra-visodhaniya* drugs are useful in benign prostatic hypertrophy like *Gokshuradi Guggulu*, *Punarnavdi Guggulu*, *Chandraprabha vati* etc. Drugs having *Vata* and *Kapha* pacifying properties like *Yavakshara*, *Moolak kshara* etc can be prescribed. The dose of all the above mentioned drugs should be adjusted according to severity of disease and strength of patient.

**Vasti karma:** *Vata dosha* is highly influencing element in the genesis of benign prostatic hyperplasia. *Vata* pacifying *Vasti* (i.e. *uttar vasti*) is effective in reducing the symptoms of BPH with *kashayas* of *Dashamool*, *Gokshuradi* and *Varunadi Gana* medicines.

## CONCLUSION

BPH is mainly old age disease where there is a predominance of *vata dosha*, if any *vata kara nidana sevan* is done *vata dusti* will occur, which may causes hormonal imbalances and leads to hyperplasia of prostate. According to signs and symptoms BPH can be compared to *Mootrasteela*.

Also we can say that treatment wise *Ayurveda* line of treatment gives good relief to the patients as *Ayurvedic* treatment does the local treatment along with root cause.

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