STUDY ON RAKTAPITTA W.S.R TO HAEMATEMESIS

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ABSTRACT

Acute Upper Gastrointestinal bleeding or Haemorrhage is a common medical emergency and carries a significant mortality. Peptic ulcer disease remains the most common aetiology, but varices are an important cause. The patient's history, physiology and blood results guide the timing of endoscopy and can disclose underlying liver disease. Resuscitation and risk assessment scoring are the main priorities in acute presentations. Haematemesis refers to vomiting of fresh red blood where as Melena refers to the dark black tarry feces both are included in Upper gastrointestinal bleeding which can be co-related to disease Raktapitta in Ayurveda. This is called as Ashukari (an acute disease). It spreads like forest fire; it should be treated immediately and carefully. When this disease changes the course (direction) it is indicative of incurability (Asaadhyatva). It is a serious disease (Mahaagada), having grave consequences. It afflicts the patient very fast (Mahaavega – greatly agitated), It is like fire and affects instantaneously (Agnivat Sheeghrakaaree)¹.

Keywords: Raktapitta, Pitta, Rakta, Gastrointestinal bleeding, Haematemesis.

INTRODUCTION

Raktapitta is a bleeding disorder where in the blood (Rakta) vitiates by Pitta flows out of the orifices (openings) of the body. Bleeding occurs due to some internal cause or as an effect of some chronic disease and importantly in the absence of injury.

Charakacharya has described it in the chapter immediately after Jwara as it arises due to the Santapa caused as a result of Jwara, whereas Sushruthacharya has described it after discussing Pandu as they have common causative factors. The disease Raktapitta is called by that name because of the below mentioned causes² -

* Samyogaat - Samyoga means association or combination. The Pitta always stays associated with Rakta. This association causes vitiates Pitta to contaminate Rakta.
* Dooshanaaat - Dooshanaath means tendency to contaminate or vitiates. The Pitta having Samyoga with Rakta tends to vitiate the Rakta.
* Saamaanyaad gandha varnayoho - Pitta attains similarity with Rakta in terms of Gandha (smell) and Varna (colour) i.e. in Raktapitta, the Pitta or colour and smell of Pitta is not identified separately since it gets blended with increased Rakta.
in totality gaining the form of Rakta, the vitiated Pitta and Rakta gets homologues.
* Since Pitta (not being identified or isolated) is being blended with Rakta seems to belong to Rakta inseparably (Raktasya pittam), the disease is called as Raktapitta.

**NIDANA (Causes)**

- **Ahara**
  - Rasa - Excessive consumption of Diet that are Amla (sour), Katu (pungent), Lavana (saline)
  - Guna - Intake of excessive Vidahi (Improper digestion leading to burning sensation of food), Tikshna (Sharp), Ushna (Hot), Kshara (Alkalis)

- **Vihara**
  - Aatapa - Excessive exposure to heat of sun
  - Vaayama - Excessive physical exercise
  - Vyavaaya - Excessive indulgence in sexual activities
  - Adhwa - Excessive walking

- **Manas**
  - Shoka - Excessive grief
  - Kopa - Anger

- **Other**
  - Excessive of Virechana

**SAMPRAPTI (Pathogenesis)**

The disease Raktapitta develops and manifests as the pathogenesis runs through the below mentioned steps in that order -
* Pitta aggravated by the above said nidanas and leaves its site and reaches Rakta (blood).

- Being a mala (waste product) of Rakta, the Pitta on getting mixed with Rakta attains quantitative increase.

- The Pitta in turn vitiates the Rakta. Due to the heat of Pitta, the drava dhatu or the liquid portion (fluid) of other tissues like Mamsa (muscles), Meda (fat) etc oozes out of their respective tissues and gets mixed with Rakta.

- This further enhances the quantity of blood flowing in the blood vessels creating immense pressure in the blood vessels.

- Due to the pressure of the blood and heat of Pitta, the walls of the blood vessels get damaged and the blood starts flowing through various openings of the body.

- Bleeding occurs through mouth, nose, ears, skin, anus, penis and vagina.

- This bleeding of blood vitiated by Pitta through various orifices of the body is called Raktapitta.

**POORVAROOPA**

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Description</th>
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<tbody>
<tr>
<td>Anannabhilasha</td>
<td>Loss of interest in food</td>
</tr>
<tr>
<td>Bhuktasya vidahata</td>
<td>Burning/very quick digestion of consumed food</td>
</tr>
<tr>
<td>Sukta Amla Udgara</td>
<td>Sour belching or belching having taste of fermented liquid</td>
</tr>
<tr>
<td>Swarabheda</td>
<td>Hoarseness of voice</td>
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<tr>
<td>Paridaha</td>
<td>Feeling of burning sensation in the body</td>
</tr>
<tr>
<td>Klama</td>
<td>Fatigue</td>
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<tr>
<td>Shiro gowrava</td>
<td>Heaviness of head</td>
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<tr>
<td>Kasa</td>
<td>Cough</td>
</tr>
<tr>
<td>Swasa</td>
<td>Dyspnoea</td>
</tr>
<tr>
<td>Bhrama</td>
<td>Giddiness</td>
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</table>

**BHEDA (Types)**

1. Based on the Dosha predominance:
   1. Vataja
   2. Pittaja
   3. Kaphaja
   4. Samnipataja
   5. Vatapittaja
   6. Pittakahaja
   7. Kaphavataja

2. Based on direction of bleeding:
   a. Urdhvaga - Raktapitta in which the bleeding of contaminated or vitiated blood takes place in the upward directions and from upward passages or orifices i.e. from Mukha (mouth), Karna (ears), Akshi (eyes), Nasa (nostrils). Here the causative attributes are Snigdha and Ushna guna which vitiates the combination of Kapha and Pitta.
   b. Adhoga - Raktapitta in which the bleeding of contaminated or vitiated blood takes place in the downward directions and from downward passages or orifices i.e. from Guda, Yoni, Mootramarga. Here the attributes are Rooksha and Ushna guna which causes vitiation of Vata and Pitta.
   c. Ubhaya or Tiryak - When all the Doshas are vitiated and are circulating in the blood stream, the manifestation is subcutaneous here.
LAKSHANAS (Signs and Symptoms)

- **Vataja Raktapitta**: When it is associated with *Vata* dominance, the blood will be
  - *Shyava-Aruna* - Brownish red
  - *Saphena* - Frothy
  - *Tanu* - Thin
  - *Rooksha* - Dry

- **Pittaja Raktapitta**: When it is associated with *Pitta* dominance, the blood will be
  - *Kashaya* or Pink red, like the colour of the *Patala* flower
  - *Black like Go mutra* (Cow's urine)
  - *Mechaka* (Greasy-black)
  - *Agara dhuma* - Horse soot
  - *Anjana* - Black collyrium

- **Kaphaja Raktapitta**: When it is associated with *Kapha* dominance, the blood will be
  - *Sandra* - Dense, Viscous
  - *Sa pandu* - Whitish discolouration
  - *Sa sneha* - Oiliness, unctuousness
  - *Picchila* - Sticky, Slimy

- **Sannipataja Raktapitta**: When vitiated by all the 3 *Doshas* then the signs and symptoms of all the 3 *Doshas* are manifested in the blood.

- **Samsargaja Raktapitta**: When vitiated by 2 *Doshas*, the signs and symptoms of the aggressive two *Doshas* are manifested in the blood.

SADHYA ASADHYATVA

The *Raktapitta* is associated with 6:
- One *Dosha* - *Sadhya* (Curable)
- Two *Doshas* - Its *Krichrasadhya* (Palliable) or *Yapya*
- All the 3 *Doshas* - *Asadhya* (Incurable)
  - *Urdhvaga* which is *Kaphaamubandhee* is *Saadhya*.
  - *Adhoga* which is *Vaataamubandhee* is *Yapya*.
  - *Ubhaya* which is *Vatakaphaamubandhee* is *Asaadhya*.
- It also becomes *Asadhya* in following conditions:
  - If patient is having *Mandagni* (less power of digestion and metabolism).
  - *Ativegavat* - if the disease has an acute attack

CHIKITSA - LINE OF TREATMENT

1) "Pratimargaha rahanam Rakta pitta vidheyathe" *Pratimaarga (Viruddha) Maarga Harana* (*Shodhana*): Eliminating the causative, vitiated *Dosha* from the opposite direction of its manifestation is the key to management of *Rakta Pitta*.

2) For *Urdhvaga Raktapitta* *Kashaaya* and *Tikta Rasa* are criteria. *Virechana* should be given (using *Nishottara*, *Hariyati*, *Aragvadha*, *Indrayana* etc. For *Adhoga Raktapitta* *Shamana Dravya* and *Madhura Rasa* is to be used. *Vamana* should be done using *Indrayava*, *Musta*, *Madana*, *Yashti* etc.

3) In *Urdhvaga Raktapitta* - *Tarpana* should be given in the beginning

4) In *Adhoga Raktapitta* - *Peya* should be given in the beginning 8.

5) *Bahya prayoga: Abhyanga, Lepa, Parishechana, Seka, Avagaha, Sheeta Upachara*.

6) *Ksheera prayoga (in vataamubandha)*:
  - *Chaga Dugdga*
  - *Go Dugdha* boiled with *Draksha* or *Nagaraka* or *Bala* or *Gokshura*
7) Kshara Prayoga: The Ksharas should be prepared of Neela (stalk) of Utpala, Mrunala, Kesha of Padma and Utpala, Palasha, Madhuka and Asana should be administered.

8) Shamana Chikitsa -
- In all patients with Raktapitta, Sheeta - Upachara by all means are Shodhanarha patients. Advised in Granthas. In case of patients eligible for Shamana; Stambhan, Langhan and Brumhana should be followed by oral medication as well as medicine.
- Internally - Diet should be Mrudhu (soft), Madhura (sweet), Sheeta (cold), Tikta (bitter) & Kashaya (astringent).
- Aushadhi Yoga - Bolabaddha Rasa, Kamadugha Rasa, Chandrakala Rasa Palasha Ghrita, Kshiri Ghrita, Vasa Ghrita, Vasavaleha.

PATHYA
- Rasa - Kashaya
- Dhanya - Jeerna Shashtika Shali, Priyangu, Nivara, Yava, Godhuma.
- Shimbhi - Mudga, Masoora, Chanaka, Adhaki, Makushta, Koradoosha, Shyamaka
- Mamsa - Aja, Pakshi, Harina, Kukkuta
- Dugdha - Godugdha, Ksheeranavaneet, Ghrita, Aja Dugdha, Santanika
- Drava - Sheeta Jala, Narikel Jala, Varuni, Audbhid Jala, Shrutasheeta Jala, Madhu + Jala, Laghu Panchamoola Siddha Jala.
- Phala - Kadali, Talaphala, Dadima, Amalaki, Narikela, Kapittha, Draksha, Ikshu, Pakva Amra Phala, Shrugata, Kamalgadda, Gambhari, Kharjura, Panasa, Mocharasa, Karkati, Taruni, Vidarikanda, Shatavari, Ksheruk, Shrugata etc
- Krutanna - Utpaladi Siddha Ksheera, Peya, Yoosha, Yavagu, Mamsa Rasa.
- Other - Mishreyam, Laja, Saktu, Madhu, Shrakara, Gajapippali, Guda, Vasa-Meda-Majja.

APATHYA
- Rasa - Katu, Amla, Lavana
- Guna - Vidahi
- Drava - Kaupa Jala, Madya

HAEMATEMESIS
“Hematemesis or Haematemesis is vomiting of red blood or coffee-ground materials.” It is the most common presentation of the Upper Gastro Intestinal bleeding. Melena develops after as little as 50-100ml of blood loss in UGIT bleeding. Hematochezia requires more than 1000ml it suggest lower bleeding source. Upper gastro intestinal bleeding presents with Hematochezia in 10% of the cases. It has a wide range of possible causes, depending on the site of blood loss and the tissue that is actively bleeding. Indeed, patients with haematemesis can present in a number of clinical states.

SIGNIFICANCE
Patients with Haematemesis and melaena require admission to hospital. The condition has a high mortality and demands a systematic approach to the initial resuscitation process, the diagnostic method and the therapeutic program. The overall management of this condition has been revolutionised by the introduction of new endoscopic techniques to control bleeding.

CAUSES
1. Oesophageal causes:
   - Oesophageal varices
   - Mallory –Weiss tear
   - Erosive oesophagitis
   - Oesophageal Carcinoma

Oesophageal varices
- Oesophageal varices refer to dilations of the Porto-systemic venous anastomoses in the oesophagus. These dilated veins are swollen, thin-walled and hence prone to rupture, with the potential to cause a catastrophic haemorrhage.
- The most common underlying cause for oesophageal varices is Portal hypertension resulting from alcoholic liver disease. Any Haematemesis in a patient with known history of alcohol abuse
should be investigated with an urgent OGD. (oesophago-gastroduodenoscopy - OGD)

- Dilated sub mucosal veins commonly occur in the distal 5cms of the oesophagus.

Mallory –Weiss Tear

- A Mallory-Weiss tear is a relatively common phenomenon, typified by episodes of severe or recurrent vomiting, then followed by minor Haematemesis. Such forceful vomiting causes a tear in the epithelial lining of the oesophagus, resulting in a small bleed.

- Most cases are benign and will resolve spontaneously, therefore providing the patient reassurance and monitoring is usually all that is required. Any prolonged or worsening haematemesis warrants investigation with an OGD.

- Mucosal laceration of the Gastroesophageal junction

- Alcoholism is the strong pre-disposing factor

2. Gastric causes:

- Peptic ulcers
- Acute gastric erosions
- Gastric carcinoma
- Gastric polyp
- Gastric cancer

3. Duodenal causes:

- Duodenal ulcer
- Duodenal carcinoma
- Aortoduodenal fistula diverticulae
- Arteriovenous malformation

4. Other causes:

* Coagulation disorders: Any disorder that disrupts normal clotting may result in GI bleeding and moderate to severe Haematemesis.

* Eating contaminated meat from an animal infected with gram positive, spore forming bacterium bacillus anthracis may progress to Haematemesis.

* Marburg virus diseases and Ebola virus disease Haematemesis occur between seventh and sixteenth day.

* Malaria, Yellow fever also causes Haematemesis, but it’s most characteristic effects are chills, fever, headache, muscle pain, and Splenomegaly as well as Bradycardia, Jaundice, and severe prostration.

* When acute diverticulitis affects the duodenum, GI bleeding and resultant Haematemesis occur with abdominal pain and a fever.

* In elderly patients Haematemesis may be caused by vascular anomaly, an aortoenteric fistula or upper GI cancer. With GI involvement, secondary syphilis can cause Hematemesis; more characteristic signs and symptoms include a primary chancre, a rash, a fever, weight loss, Malaise, Anorexia, and a headache.

* In addition chronic obstructive pulmonary diseases chronic liver or renal failure or chronic NSAID are all predisposing factors for Haematemesis in elderly people.

DIAGNOSTIC EVALUATION

- Liver function test
- Bleeding time, urea and Electrolyte
- Hemoglobin concentration.
- Upper Endoscopy

**Glassgow-Blatchford Bleeding Score**

The Glassgow-Blatchford Bleeding score (GBS) is a scoring system used to risk stratify patients admitted with an Upper GI bleed, based purely on clinical and biochemical parameters. This allows for appropriate management of further investigations, especially as the score can be calculated prior to any OGD.

<table>
<thead>
<tr>
<th>Glassgow-Blatchford Bleeding Score</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urea (mmol/L)</td>
<td>1</td>
<td>6.5-8.0</td>
<td>8.0-10.0</td>
<td>10.0-25.0</td>
<td>&gt;25</td>
<td></td>
</tr>
<tr>
<td>Hb (g/L)</td>
<td>2</td>
<td>12.0-12.9</td>
<td>10.0-11.9</td>
<td>&lt;10.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Systolic BP</td>
<td>3</td>
<td>100-109</td>
<td>90-99</td>
<td>&lt;90</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulse (bpm)</td>
<td>4</td>
<td>&gt;100</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

IAMJ: Volume 6, Issue 5, May, 2018
Melena | Present
---|---
Syncope | Present
Known Hepatic Failure | Present
Cardiac Failure | Present

**Interpretation** will vary across endoscopy departments, but scores ≥6 have been associated with a >50% risk of needing an intervention. Other risk scores are used in the clinical setting, such as the AIMS65 Score (risk score for in-hospital mortality from upper GI bleeding) or Rockall Score (severity score for GI bleeding post-endoscopy).

**MANAGEMENT**
- Resuscitation
- Airway and oxygen
- Correct clotting abnormalities
- Blood Transfusion
- Monitor
- Insert urinary catheter and monitor hourly urine output if shocked.
- Consider a CVP line to monitor CVP and guide fluid replacement.
- Organize a CXR, ECG, and check arterial blood gases in high-risk patient.
- Arrange an urgent endoscopy.
- Endotracheal intubation frequently needed
- Band ligation is preferred method.

**DISCUSSION**

*Raktapitta* is a *Mahagada* (dreadful disease) which has *Mahavega* (having severe intensity in terms of heavy bleeding which if life threatening) and is *Sheegrakari* (that which destroys the body quickly just as a small spark of fire destroys a big heap of grass i.e. quickly brings about death of an individual). Therefore a wise physician who has a clear-cut knowledge of the *Hetu* and *Lakshanas* of *Raktapitta* i.e. a physician who has skills of diagnosing this condition as quickly as possible should treat it immediately, without any delay.

Bleeding from the upper gastrointestinal (GI) tract is a common medical emergency, with an incidence of between 50-150 cases per 1,00,000 per year. The commonest cause is from a chronic ulcer of the stomach to life threatening diseases like Malignancy, Oesophageal varices. Approximately 85% of patient stop bleeding spontaneously within 48hrs. Emergency resuscitation is required in patients with large bleeds and the clinical signs of shock. Early endoscopy helps to make diagnosis and make decision regarding the treatment.

Hematemesis and Melena occurs in gastric ulcers in the ratio of 60:40. In Duodenal ulcers in the ratio of 40:60, both may occur together in duodenal ulcer than in Gastric ulcer. Bleeding from the stomach unless in slight usually accompanied by nausea and vomiting.

**CONCLUSION**

*Raktapitta* (Internal haemorrhage) having excess vitiated *Dosha* in person who is not emaciated or weak and takes normal diet should not be checked. *Shodhana* type of *Langhana* is advised in patients who are strong with excess *Kapha, Pitta, Rakta and Mala*. Though the blood expelling out of the body is not *Shuddha Jeeva Rakta*, but due to the nature of the disease Rakta - the *Pranaashraya* itself gets vitiated. Thus, this *Ashukari* (acute), *Raktapradoshaja* disease can be considered as one of the life threatening disorders.

Severity depends upon the cause and the blood loss, it can be judged by the degree of shock and pallor, rapid thready pulse, low blood pressure, repeated vomiting of blood. Prognosis from this condition will depend upon the underlying cause and the clinical state of the patient.

Decisions as to correct treatment of the patient with haematemesis most often depend on clinical judgment and there is need for a method of investigation that will yield reliable diagnostic information in the acute stages of illness.
Overall, Haematemesis and melaena patients have a high mortality and morbidity rate, varying from 5% to 20% in most series. This is because most patients with haematemesis and melaena are elderly, often with cardiac and pulmonary disease. These patients tolerate surgery poorly. Thus, the balance between surgical intervention and persisting with medical management in the face of continuing haemorrhage is often very fine and the best results are obtained in dedicated units for the management of this condition.

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Source of Support: Nil
Conflict Of Interest: None Declared