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Original Research Article

Standardization of Siddha Diagnostic Methodology, Line of Treatment and Dietary Regimen for "Raththa Soolai" (Dysmenorrhea): A Clinical Approach

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Abstract

Dysmenorrhea is one of the most common causes of pelvic pain. It negatively affects patient's quality of life and sometimes results in activity restriction. A history and physical examination, including a pelvic examination in patients who have had vaginal intercourse, may reveal the cause. The prevalence of dysmenorrhea is difficult to determine because of different definitions of the condition, the estimates varying from 45% to 95%.A recent systematic review of the world literature on chronic pelvic pain reports prevalence of dysmenorrhea ranging between 17% and 80%. Although dysmenorrhea is a common gynecological problem in females but there are limited studies in this subject especially in central India. Siddha system of traditional medicine provides differential diagnostic techniques which aid in proper identification of dysmenorrhea and to initiate the therapy at the earliest. This promoted us to pursue the present clinical investigation on adopting differential diagnostic techniques based on Indian system of traditional medicine like siddha on clinical evaluation of dysmenorrhea also known by its name Raththa Soolai. Investigation was carried out at 40 subjects reported with clinical condition dysmenorrhea. Various aspects of examination including Mukkutram , Udalthathukkal , Envagai Thervugal , and Pancha Patchi were done and recorded. Outcome of this study provides evidence based data on clinical, geographical and biochemical factors that influence dysmenorrhea. Further it was concluded that altered food habits, hereditary factors, and hormonal therapy and other habitual changes are the etiological reasons for the raththasoolai.

Keywords: Dysmenorrhea, Raththasoolai, Siddha, Diagnostic techniques, Etiological reasons

1. Introduction

Dysmenorrhoea is commonly divided into two categories based on pathophysiology. Primary dysmenorrhoea is menstrual pain without organic disease, and secondary dysmenorrhoea is menstrual pain associated with an identifiable disease. Common causes of secondary dysmenorrhoea include endometriosis, fibroids (myomas), adenomyosis, endometrial polyps, pelvic inflammatory disease, and the use of an intrauterine contraceptive device.

The prevalence of dysmenorrhoea (painful menstrual cramps of uterine origin) is difficult to determine because of different definitions of the condition—prevalence estimates vary from 45% to 95%. However, dysmenorrhoea seems to be the most common gynaecological condition in women regardless of age and nationality. Absenteeism from work and school as a result of dysmenorrhoea is common (13% to 51% women have been absent at least once and 5% to 14% are often absent owing to the severity of symptoms) [1]. Dysmenorrhoea, especially when it is severe, is associated with a restriction of activity and absence from school or work. Yet despite this substantial effect on their quality of life and general wellbeing, few women with dysmenorrhoea seek treatment as they believe it would not help [2-3].

Abnormal uterine bleeding, dyspareunia, noncyclic pain, changes in intensity and duration of pain, and abnormal pelvic examination findings suggest underlying pathology (secondary dysmenorrhea) and require further investigation. Transvaginal ultrasonography should be performed if secondary dysmenorrhea is suspected. Endometriosis is the most common cause of secondary dysmenorrhea. Symptoms and signs of adenomyosis include dysmenorrhea, menorrhagia, and a uniformly enlarged uterus [4].

Variations in the definition of dysmenorrhoea make it difficult to determine prevalence precisely. Studies tend to report on prevalence in adolescent girls, and the type of dysmenorrhoea is not always specified. Adolescent girls tend to have a higher prevalence of primary dysmenorrhoea than older women, as primary dysmenorrhoea can improve with age (see Prognosis). Secondary dysmenorrhoea rates may be lower in adolescents, as onset of causative conditions may not yet have occurred [5]. The main objective of the present investigation is to validate the dysmenorrhea by systematic siddha diagnostic techniques.

2. Materials and Methods

2.1. Study design

An open-labeled observational study comprises of 40 subjects with the clinical symptoms of *Dysmenorrhea* called by its name "*RaththaSoolai*" was chosen for the individualized in-depth evaluation. The entire study was conducted on Out-patient and In-patient department of Govt. Siddha Medical College Hospital, Palayamkottai - 627 002.

2.2. Inclusion criteria

Gender-female-both married and unmarried.
Age 13-45
Headache
Heavy menstrual bleeding
Abdominal pain
Low back pain
Patients who co-operate for investigation whenever necessary.

2.3. Exclusion Criteria

Menorrhagia
Intra uterine contraceptive device
CA Uterus
Fibroid uterus
Poly cystic ovarian disease

2.4. Diagnostics Methods in Siddha system of Medicine

Siddha system has a unique diagnostic methodology to identify the diseases and their causes.

2.4.1. Mei kuri

By Mei kuri the following symptoms are observed. The temperature of the skin (heat or cold), sweating, numbness, fissures, thickening of hairs, hair falling, hair erection, ulcers, swelling, weight loss and weight gain.

2.4.2. Naa

Tongue colour (black, red, yellow, white) coating of tongue, excessive salivation, dryness, ulcers, nature of gums, teeth, taste mouth deviation, speech are noted.

2.4.3. Niram

Body colour (black, yellow, white, red, blue) flush, pallor, yellow colour in eyes and teeth are observed.

2.4.4. Mozhi

Pitch of voice (high, low, normal) hoarseness of voice, fluency, intelligence articulation, character, breathlessness are observed.

2.4.5. Vizhi

Eyes easily reflect the pathological changes of the body. Size and shape, colour (red, yellow, pallor blue, muddy), lacrimation, dryness swelling of eyelids, ulceration, visual filed, sharpness of vision, colour of vision, inflammation (ulcer in conjunctiva, cornea, pupil) are keenly observed. 96 Eye diseases are noted.

2.4.6. Malam

Colour (Yellow, red, black, white, green), froth, solid or semisolid or liquid, quantity, odour are noted.

2.4.7. Moothiram

Urine is observed under 2 headings
1. Neerkuri
2. Neikuri

2.5. Neerkuri

2.5.1.Collection of Urine for Testing :

Before the collection of urine for testing, one should take super consisting of all the six tastes at the regular time passed on one's digestive fire. After a sound overnight sleep, urine should be collected in a closed glass were and the test should be done before 90 minutes from dawn. This rule is relax able in severe cases.

2.5.2. General Features of Urine:

Niram (Colour)
Manam (Odour)
Edai (Specific gravity)
Enjal (Quantity)
Nurai (Froth)

2.6 NeiKuri :

A drop of Gingelly oil is dropped at the center of upper surface of urine bowl without any shaking. It should be ensured that the direct sunlight does not fall on it, but bright light is necessary for observation. And it should not be disturbed by the wind. The changes of the oil drop in urine suggest the diagnosis and condition of the patient.

2.6.1.General Nature of Urine in Oil Examination:

If the oil drop takes the shape of a snake (Aravu), It indicates Vali disease.
If it spreads like a ring (Ahzal) it indicates Azhal disease.
If it stands like a pearl (Muthu) it indicates Iya disease.
If the oil drop sinks in the urine, indicates Iya disease.
If any two factors of the three humours are seen together in the urine it suggests derangement of particular two humours. Eg. AravilAazhi indicates ValiAzhal.
If the oil drop spreads fast, it will indicate Asaathiyam.

2.7. Naadi

Naadi is very important tool. Diagnosis of the disease by assessing naadi gives a best way to treat the diseases. Vali Naadi is felt in tip of the index finger. Ahzalnaadi is felt in tip of the middle finger. Iyanaadi is felt in tip of the ring finger. 65

2.8. Statistical analysis

The statistical analysis was carried by using SPSS version 17 followed by non-parametric McNemar Test analysis. Probability P values < 0.05 were considered as significant.

3. Results

It was observed that out of 40 cases 22.5% of the cases belongs to 15-25 years age groups, 47.5% of cases belongs to 25-35 years of age groups, and 30% of cases belongs to 35-45 years of age groups. Further with respect to occupation is concern 20% were students , 47.5% were House wife, 5% were Tailors, 10% were Teacher 15% were beedi workers, 2.5 % were studio workers. Socio economic status of the cases play a very vital role in the present study 75% belongs to high class, 67.5 belongs to Middle class,

25% belongs to Low class. Dietary habit is one of the core factors which may influence the present clinical condition. In the present study out of 40 subjects 15% of the cases were taking Vegetarian diet and 85% of the cases were taking Non- vegetarian.

According to recent research it was suggested that drinking coffee may also contribute to dysmenorrhoea 12.5% cases had the habit of the drinking tea, 20% cases had the habit of the drinking milk, 10% of the cases had the habit of drinking coffee, 7.5% of the cases had the habit of tea, coffee and Milk.

Out of 40 cases 55 % cases were under vathakalam of their life span and 45 % of the cases were under Pithakaalam of their life span. Irregular menstrual cycle is a prominent indication for the present clinical condition. Out of 40 cases 22.5% had regular cycle and 70% of the cases had irregular menstruation. On geological distribution 95 % were reported in marutham, 5% of the cases were reported in Neithal.

It was observed all the cases of karuvai were -affected, 27.5% were eruvaai -affected, 20% were kaal affected, 5% were vaai affected. All the cases were affected sroonithavasayam, 10% were affected amarvasayam, 20% were affected pakirvasayam, 2.5% were affected salavsayam, 35% of the cases were affected malavasayam. It was noted that in all 40 cases anamayakosam and pranmayakosam and Ananthamayakosam was affected, 25% of the cases Mononmayakosamaffected.Out of the 40 cases pranan, abanan,were affected 100%   viyanan affected in 82.5% of cases udhanan were affected in 35% of cases, samanan were affected in 50% of cases, were Kirukaran were affected in 42.5% of cases and the thevatharthan were affected in 52.5% of cases. Out of 40 cases Ranchagapitham were affected 100% of cases, anarpitham were affected 52.5%of cases, sathagapitham were affected 40% of cases, and prasagapitham were affected 7.5% of cases. Avalabagam were affected in 100% of cases kilethagam were affected 45% of cases, Sandhigam were affected in 22.5% of cases. Out of 40 cases seneer and sronitham was affected 100% of cases, saaram were affected 50% of cases, oon were affected in 37.5% cases,kozhupu were affected in 45% 0f cases, enbu were affected in 32.5% of cases.

From the clinical history, it was noted that 100 % of the cases have pelvic pain ,of the cases have abdominal pain associated with menorrhagia, 30 % of the cases have a complaint amenorrhea, and 20 % of the cases have a history of abortion. It noted that 42.5% are pallor present, remaining it is not. 27.5% cases have coated tongue (mapadithal) , remaining it is not. 15.5% were Pigmentation present, remaining cases are not 75 % were affected Veluthukaanal, and the remaining are in normal condition. In the current study it was noted that out of 40 cases the sparisam was veppam in 10 % cases , and in 90 % of cases was noted in midhaveppam. 80 % were noted in thazhthaoli, and 20 % were noted samaoli. Out of 40 cases 70 % were noted in pallorness, and 20 % cases were noted in mild-pallorness. 75 % of the cases presented with normal vision and 25 % of them presented with diminished vision.

From the study it was learnt that majority 55 % of the cases has Vathapitham 42.5 % of the cases have Pithavatham and the remaning 25 % of the cases had kabavatham.

Study reveals that women's with dysmenorrhea are of highly prone to GI disturbance such as constipation. From the clinical history of the present investigation it was noted that 62.5 % of the cases passed once a day of stools and the remaining 12.5 % cases passed twice a day. Out of 40 cases, 25 % % of the cases were difficult to defecate.

Neerkuri is one of the traditional diagnostic techniques followed by siddha physicians which work behind the principle of urine analysis. Out of the 40 subjects, 57.55% of the cases were reported yellow color, 37.5% % of the cases were reported straw yellow color, 5% of the cases were reported pale white. Among the total number of cases the urine of 37.5 % of them had froth, while it in others it was absent. 55 % of the cases presented with vathaneer, 42.5 % pithaneer, and 1% of cases present with kabaneer. While observing the neikuri in patients it was observed that in 35 % of them the neikurispreaded quickly, while in others it spreaded slowly.

Out of 40 cases 18 were affected in Valarpiraigal 5.56% were affected vallru in thuyil and Aanthai in Saavu. Majority 22.22 were affected, Aanthai, kozhi in thuzhil ,kagam and mayil in saavu. 33.3 % were affected kagam in thuzhil and valluru in Saavu 16.67 % were affected mayil in thuzhil and valluru in saavu. Out of 40 cases 22 were affected in Theipiraigal . Majority of them 27.27% were affected in valluru and kagam in thuzhil ,kagam and mazhil in savau. 18.18% were affected Kozhi and Mayil in Thuzhil and Vallur

and Aanthai in Saavu. 9.09%were affected Aanthai in thuzhil and kozhi in saavu.

Out of 40 cases 22.5% were affected Thuzhil in Aagayam and theyu in Saavu. 25 % were affected prithvi in both thuzhil and Saavu and Aagayam in Saavu. 20% were affected Appu in thuzhil and Saaavu. 17.5% were affected theyu in thuzhil. 15% were affected vaayu in thuzhil. 12.5% were affected vaayu in Saavu. Out of 40 subjects 27.5% affected Moolatharam ,Swathithanam , in Thuzhil. 22.5% were affected moolatharam, swathithanam, and Anagatham in Saavu, Aakinai in Thuzhil. 20% were affected manipuragam in Thuzhil and Saavu ,Aakinai in Saavu.17.5% were affected Anagathm in thuzhil .15% were affected Visuthi in Saavu. Further it was observed from the present study that 27.5% affected Moolatharam, Swathithanam, in Thuzhil. 22.5% were affected moolatharam, swathithanam, and Anagatham in Saavu, Aakinai in Thuzhil. 20% were affected manipuragam in Thuzhil and Saavu ,Aakinai in Saavu. 17.5% were affected Anagatham in thuzhil.15% were affected Visuthi in Saavu.

4. Discussion

Dysmenorrhea appears to have an impact on public and occupational health, but its prevalence is unclear, with studies performed in different populations reporting rates of between 20% and 94% [6]. This wide variation may derive from ethnic, sociocultural, or biological factors of the study populations, and also from the range of definitions of dysmenorrhea.The proposed distinction between dysmenorrhea and normal menstrual cramps is "the need for medication and the inability to function normally in the latter situation." A recent large-scale survey demonstrated that the reporting of painful periods was more common than the reporting of problematic periods, indicating that pain alone is not sufficient to make a period a clinical problem [7-8].

Risk factors for dysmenorrhea include nulliparity, heavy menstrual flow, smoking, and depression. Empiric therapy can be initiated based on a typical history of painful menses and a negative physical examination. Nonsteroidal anti-inflammatory drugs are the initial therapy of choice in patients with presumptive primary dysmenorrhea [9].

The incidence of dysmenorrhea is lower incidence in multiparous women. It was seen that the incidence of primary dysmenorrhea decreased after the first

delivery. It was also found to be decreased in terms of severity. Lower consumption of eggs, fish and fruits are believed to increase the incidence of dysmenorrhea but the association is not clearly established. Various types of exercises were advocated to reduce dysmenorrhea.It was also seen that among athletes the incidence of dysmenorrhea was lower, probably due to anovulatory cycles. Emotionally dependent and overprotected girls are more likely to develop dysmenorrhea. Since the mother becomes overzealous and apprehensive around the time of menarche of her daughter which thereby makes the young girl more conscious, aware and paranoid of her forthcoming menses. Rather than being the cause of the pain, it is more likely that the psychological factors modifying the pain causing depression and anxiety.

In the present clinical study various aspects of examination including Mukkutram ,Udalthathukkal , Envagai Thervugal and PanchaPatchi were done and recorded as proof. Etiologically 46.35% of cases is recorded increased use of oral contraceptive pills and 43.9%of cases were recorded hereditary cases. Increased vathamkutram produces the symptom of abdominal pain. This is responsible for the Abaanan to increase. Increased Abaanan affects the saathagapitham and anal pitham. The increased vatham and pitham leads to increased menstrual flow. Among 40 cases 47.5% of the cases belongs to the age group between 25to 35.Most of the cases were in Vathakaalam. Due to the altered food habits pitham is increased, along with pithamvatham is increased and it causes increased menstrual flow.47.5% of cases belongs to housewife group affected commonly.67.5% of cases were belongs to middle class. 85% of the cases were belongs to intake of mixed diet.95% of the cases belong to maruthanilam. Although maruthanilam is a suitable place for living, due to seasonal variations and life style modifications there is a chances of getting altered three humor.

Acknowledgments

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