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Preventive Aspects of Arsha (Piles): An Integrative Review of Ayurvedic Hetu, Modern Risk Factors, and Non-Pharmacological Preventive Strategies

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ABSTRACT:

Arsha (haemorrhoids) is one of the most common anorectal disorders worldwide and is recognised in Ayurveda as one of the Ashta Mahagada (eight major diseases). While existing literature predominantly focuses on treatment, preventive approaches remain underexplored. This narrative review synthesises classical Ayurvedic Hetu (causative factors) with contemporary epidemiological evidence to develop an evidence-informed, non-pharmacological prevention framework. Literature was reviewed from major biomedical databases and eight classical Ayurvedic texts. Findings indicate strong convergence between classical Aharaja, Viharaja, Manasika, and bowel habit-related Hetu and modern risk factors such as constipation, prolonged sitting, obesity, pregnancy, diabetes, hypertension, and family history. Preventive measures including fibre-rich diet, adequate hydration, regular physical activity, weight management, proper toilet posture, and stress reduction closely correspond with the Ayurvedic principles of Nidana Parivarjana, Dinacharya, Ritucharya, and Sadvritta. Integrating these complementary perspectives may reduce the incidence, recurrence, and healthcare burden of Arsha, although further high-quality prospective and interventional studies are needed.

Keywords: haemorrhoids; Arsha; Nidana Parivarjana; prevention; constipation; dietary fibre; lifestyle medicine.

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Introduction:

Hemorrhoidal disease (Arsha) is one of the most prevalent anorectal disorders encountered in both general and specialist practice. A recent global systematic review and meta-analysis pooling data from 8,960,338 individuals across 45 countries estimated a global point prevalence of 25.92% (95% CI 22.62–29.22), a lifetime prevalence of 27.19%, and a one-year prevalence of 21.65%, with the African region showing the highest point prevalence (28.07%) — corroborated by facility-based data from Ethiopia reporting a comparable burden among surgical outpatients [16] — and prevalence rising modestly by roughly 1.2% per year of data collection, a trend attributed to global shifts toward sedentary behaviour, dietary westernization and an ageing population rather than to improved diagnosis alone [1]. Earlier population-based colonoscopy data from Austria found a comparable prevalence of 38.93% among screened adults, of whom fewer than half were symptomatic [3], while symptomatic disease is reported in 40–50% of those affected [3]. Independent web-based survey data corroborate that hemorrhoidal disease affects a substantial proportion of adults across Europe and the Americas, with under-recognition and under-treatment common because of embarrassment and limited health-seeking behaviour [2]. The public-health significance of Arsha extends well beyond its prevalence. Hemorrhoidal disease measurably impairs quality of life through pain, bleeding, itching and soiling, and contributes to work absenteeism and reduced productivity [31]. In the United States alone, outpatient haemorrhoid-related care generated an estimated $770 million in direct costs in a single year within the employer-insured population when haemorrhoids were the primary diagnosis, a figure that rises to roughly $2.5 billion when haemorrhoids are captured as a secondary diagnosis, and these estimates exclude over-the-counter expenditure and Medicare-age adults [8]. Recurrence further compounds this burden: even after definitive surgical management, recurrence has been documented in the range of 5–12% on long-term follow-up [10,11], and recurrence is strongly correlated with the persistence of poor defecation habits after treatment, including straining, prolonged toilet time and irregular bowel routines [9]. This recurrence pattern is telling: it demonstrates that Arsha is fundamentally a disease of sustained behavioural and physiological exposure rather than a single anatomical event, and that treatment directed at the anatomical lesion alone, without correction of the underlying causative behaviour, is destined to relapse. This observation is the central rationale for a preventive, rather than purely curative, approach to Arsha. Prevention avoids the morbidity, cost and recurrence risk associated with both conservative and surgical treatment, and is consistent with the broader paradigm shift in global healthcare toward lifestyle medicine — an evidence-based medical specialty built on therapeutic lifestyle interventions across nutrition, physical activity, restorative sleep, stress management, avoidance of risky substances and social connectedness, which collectively influence a majority of the chronic, largely preventable disease burden encountered in contemporary practice [13]. Hemorrhoidal disease sits squarely within this lifestyle-medicine framework: its principal correlates — constipation, obesity, sedentary behaviour, and dietary patterns — are the same modifiable factors that drive cardiometabolic and colorectal disease more broadly [1,14].

Methods:

This is a structured narrative review rather than a formal systematic review or meta-analysis, reflecting the heterogeneous nature of the source material, which spans classical Sanskrit compendia, epidemiological studies, Mendelian randomization analyses and randomized controlled trials that are not amenable to pooled quantitative synthesis. Nonetheless, the search and reporting

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process was informed by the principles underlying the PRISMA 2020 statement to promote transparency.

Classical Ayurvedic texts consulted: Eight primary classical compendia were consulted for the Nidana (etiology), Samprapti (pathogenesis) and Chikitsa (management) of Arsha: Charaka Samhita (Chikitsa Sthana), Sushruta Samhita (Nidana Sthana and Chikitsa Sthana), Ashtanga Hridaya (Nidana Sthana and Chikitsa Sthana), Ashtanga Sangraha, Kashyapa Samhita, Madhava Nidana, Bhava Prakasha, and Yogaratnakara

Ayurvedic Concept of Arsha:

Definition and Nirukti:

The term Arsha derives from the Sanskrit root meaning "to torment" or "to pierce", and classical commentators explain the name on the ground that the condition "afflicts" or "torments" the body like an enemy (Arshati/Pidayati Sharirem). Clinically, Arsha denotes fleshy, vascular outgrowths (Mamsankura) arising from the Guda Vali — the three mucocutaneous folds/cushions of the anal canal — that project into or around the anal verge, obstructing the smooth passage of stool and causing pain, bleeding or prolapse. This description corresponds closely to the modern anatomical concept of haemorrhoids as symptomatic distal displacement and vascular engorgement of the normal fibrovascular anal cushions [4,7].

Synonyms and importance of the disease: Guda Ankura ("anal sprouts/buds") is used descriptively for the fleshy growths. Arsha is enumerated among the Ashta Mahagada (eight great diseases) in classical surgical literature, a classification that signals both the chronic, recurrence-prone natural history of the disease and the historical difficulty of achieving a durable cure — an observation that resonates strikingly with modern reports of 5–12% recurrence even after definitive surgical treatment [10,11].

Nidana Panchaka: Classical Ayurvedic diagnosis of any disease, including Arsha, follows a five-fold framework (Nidana Panchaka): Nidana (aetiological factors), Purvarupa (prodromal features such as mild anal discomfort, flatulence and altered bowel sensation), Rupa (the fully manifest signs — painless bleeding per rectum, palpable Mamsankura, prolapse, pruritus), Upashaya–Anupashaya (symptomatic relief or aggravation with specific diet, regimen or empirical therapy, used to confirm the dominant Dosha), and Samprapti (the pathogenetic sequence). Contemporary preventive practice maps most directly onto the first two components of Nidana Panchaka — removing Nidana (Hetu) and recognising Purvarupa early — which correspond respectively to modern primary and secondary prevention.

Samprapti(brief): Sustained exposure to causative dietary, behavioural and psychological factors vitiate Vata (particularly Apana Vata, which governs downward movement including defecation), Pitta and, in many presentations, Kapha and Rakta (blood). This Doshic vitiation impairs Agni (digestive-metabolic fire), disturbs normal Mala (stool) consistency and transit, and produces localized Dushti (vitiation) of Rakta and Mamsa Dhatu at the Guda Vali, culminating in the formation of Mamsankura — Arsha. Classical nosology further classifies Arsha by the predominant Dosha involved (Vataja, Pittaja, Kaphaja, Sannipataja) and by a separate axis of Raktaja (bleeding) presentation, as well as by origin — Sahaja (congenital/constitutional, corresponding conceptually to the strong family-history association seen in modern data, odds ratio 4.19) [1] — versus Janya (acquired through Hetu Sevana, sustained exposure to causative factors).

Hetu (Aetiological Factors) According to Ayurveda

Dietary causes (Aharaja Hetu):

Classical texts enumerate a specific cluster of dietary transgressions as causative of Arsha, summarised in Table 2. Guru Ahara (heavy, difficult-to-digest food) and Viruddha Ahara (incompatible food combinations) impair Agni and generate

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Ama (a state of incomplete digestion/metabolic toxin accumulation), which in turn disturbs normal peristaltic and evacuatory function governed by Apana Vata. Abhishyandi Ahara (channel-obstructing, typically heavy dairy or mucus-forming foods) and Ati Snigdha Ahara (excess unctuous/fatty food) provoke Kapha-Meda accumulation and sluggish transit, while the opposite extreme, Ati Ruksha Ahara (excess dry, fibre-poor food consumed without adequate unctuousness or fluid), aggravates Vata and hardens stool consistency — a mechanism directly analogous to the modern, well-established association between low dietary fibre intake, hard stool, straining and haemorrhoidal symptom persistence [24]. Ati Lavana (excess salt) and Ati Katu (excess pungent/spicy food) are held to vitiate Pitta and Rakta, producing local heat and irritation in the Guda region that predisposes to the bleeding (Raktaja) variant. Adhyashana (eating before the previous meal is digested) and Vishamashana (irregular meal timing) further destabilise Agni and bowel regularity. Taken together, these classical dietary Hetu converge on a single modifiable pathway — impaired Agni and inadequate "fibre-consistent" Ahara — that closely parallels the modern mechanistic model in which low fibre intake produces harder, lower-volume stool, prolonged straining, and increased anal-cushion venous engorgement [13,24].

Probable mechanism: Dietary Hetu act principally through two convergent pathways: (i) direct mechanical/rheological effects on stool consistency and transit time (Ruksha/Guru/low-fibre patterns → harder stool → straining), and (ii) Agni-mediated metabolic disturbance producing Ama and downstream Vata-Pitta vitiation, which is conceptually analogous to the low-grade inflammatory and dysmotility states now implicated in haemorrhoidal pathogenesis [7].

Lifestyle causes (Viharaja Hetu): Suppression of natural urges (Vega Dharana) — most importantly of Purisha Vega, the urge to defecate — is explicitly identified in classical literature as a direct precipitant of Arsha, since habitual suppression allows stool to remain in the rectum, harden, and require greater straining force on eventual evacuation. Excessive, prolonged sitting (Ati Asana) and travel on jolting vehicles or animal-back (Adhwagamana, Yana-Yugya Sevana) are cited as mechanically traumatic to the Guda Vali, while heavy weight-bearing (Bharavahana) raises intra-abdominal pressure in a manner directly comparable to modern occupational heavy-lifting exposure. Diwaswapna (daytime sleep) is associated with Kapha-Meda accumulation and sluggish Agni, while Ratri Jagarana (nocturnal wakefulness) aggravates Vata; both disturb the regularity of the Dinacharya-governed bowel routine. Deficient physicalactivity (Vyayama Abhava) is held equally undesirable as its excessive counterpart, consistent with the general Ayurvedic principle of moderation (Sarvatra Atiyoga Varjayet, "avoid excess in all things").

Correlation with modern evidence: The classical emphasis on prolonged sitting and travel finds strong contemporary corroboration: a case–control study from Sudan found that sitting for five or more hours per day nearly quadrupled the odds of developing symptomatic haemorrhoids or anal fissures (odds ratio 3.68, 95% CI 2.1–6.47) [22], and sedentary behaviour and occupational sitting are consistently identified as modifiable correlates in broader lifestyle-factor reviews of haemorrhoidal disease [12]. Notably, when physical activity level itself (rather than sitting time specifically) was examined as a discrete variable in pooled case–control data, no significant association emerged [1], suggesting that prolonged static sitting/immobility — rather than low physical activity per se — is the more

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precise modern correlate of the classical Ati Asana Hetu.

Psychological factors (Manasika Hetu):

Chinta (worry/anxiety), Shoka (grief) and Krodha (anger) are listed among the Manasika (psychological) Nidana capable of vitiating Vata and Pitta and of disturbing Agni, thereby predisposing to Arsha; deliberate or emotionally driven suppression of the defecatory urge is also implicated. Modern gut–brain axis research provides a plausible physiological correlate: chronic psychological stress modulates visceral sensorimotor function and gastrointestinal motility via the hypothalamic–pituitary–adrenal axis and autonomic pathways, and is an established contributor to functional constipation and altered bowel habit [27] — the very antecedent state that classical texts and modern epidemiology alike identify as a proximate cause of Arsha [1,15].

Bowel-habit-related causes:

Vibandha (constipation), habitual straining beyond the natural evacuatory urge, delayed or postponed defecation, and prolonged toilet sitting are named directly among the precipitating factors for Arsha in classical surgical texts, on the reasoning that repeated forceful evacuation mechanically traumatises the Guda Vali and predisposes to Mamsankura formation. This is, again, the single most robust point of convergence between the classical and modern nosologies: constipation is among the strongest and most consistently replicated modern risk factors for haemorrhoidal disease, first demonstrated epidemiologically over three decades ago [15] and subsequently confirmed in contemporary pooled case–control data (unadjusted odds ratio 2.51, 95% CI 1.35–4.67) [1].

Table 1. Ayurvedic classification of Hetu (causative factors) of Arsha.

Category	Representative Hetu	Predominant Dosha Involved
Aharaja Hetu (Dietary)	Guru, Abhishyandi, Ati Snigdha, Ati Ruksha, Ati Lavana, Ati Katu, Viruddha Ahara, Adhyashana, Vishamashana	Vata, Pitta, Kapha (context-dependent)
Viharaja Hetu (Lifestyle)	Vega Dharana, prolonged sitting, Adhwagamana, Bharavahana, Diwaswapna, Ratri Jagarana, Vyayama Abhava/Atiyoga	Vata (predominant), Kapha
Manasika Hetu (Psychological)	Chinta, Shoka, Krodha, emotionally driven Vega Dharana	Vata, Pitta
Bowel-habit-related	Vibandha, habitual straining, delayed defecation, prolonged toilet sitting	Vata (Apana Vata predominant)

Table 2. Dietary causes (Aharaja Hetu) of Arsha and their probable mechanism.

Aharaja Hetu	Classical Effect	Probable Mechanism / Modern Correlate
Guru Ahara (heavy food)	Impairs Agni, generates Ama	Delayed gastric/colonic transit; sluggish bowel habit
Abhishyandi Ahara (channel-obstructing)	Kapha-Meda vitiation	Mucus-forming, low-fibre dairy-heavy pattern linked to constipation

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Aharaja Hetu	Classical Effect	Probable Mechanism / Modern Correlate
Ati Snigdha (excess unctuous food)	Kapha vitiation	Low-fibre, high-fat dietary pattern
Ati Ruksha (excess dry food)	Vata aggravation, hardens stool	Low fibre/fluid intake → hard stool → straining [24]
Ati Lavana / Ati Katu (excess salt/pungent)	Pitta-Rakta vitiation, local heat	Local irritation predisposing to Raktaja (bleeding) Arsha
Viruddha Ahara (incompatible food)	Ama formation	Disturbed Agni and gut motility
Adhyashana / Vishamashana (irregular meals)	Agni disturbance	Erratic bowel transit and habit

Table 3. Lifestyle causes (Viharaja Hetu) of Arsha and their modern correlate.

Viharaja Hetu	Classical Rationale	Modern Correlate (Evidence)
Vega Dharana (urge suppression)	Vitiates Apana Vata; stool hardens	Behavioural urge-suppression → constipation (mechanistically plausible; limited direct quantitative data)
Prolonged sitting / Ati Asana	Mechanical stasis in Guda region	Sitting ≥ 5 h/day: OR 3.68 (95% CI 2.1–6.47) [22]
Adhwagamana (excess travel, jolting vehicles)	Direct trauma to Guda Vali	Occupational driving/vibration exposure as a recognised risk correlate [12]
Bharavahana (heavy lifting)	Raised intra-abdominal pressure	Occupational heavy lifting as a mechanistic risk factor
Diwaswapna (day sleep)	Kapha-Meda accumulation, sluggish Agni	Sedentary, low-activity pattern
Ratri Jagarana (night waking)	Vata aggravation	Sleep disruption and dysregulated gut motility
Vyayama Abhava (lack of exercise)	Kapha-Meda accumulation	Sedentary lifestyle identified as a modifiable correlate in lifestyle-factor reviews [12]

Modern Risk Factors:

A large, pooled meta-analysis of case–control data identified older age (standardised mean difference 0.39), obesity (odds ratio [OR] 1.56), pregnancy (OR 2.61), diabetes mellitus (OR 1.44), family history (OR 4.19), constipation (OR 2.51) and hypertension (OR 1.77) as statistically significant, though unadjusted,

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correlates of haemorrhoidal disease [1]. These figures provide a quantitative anchor for the discussion below.

Chronic constipation and low fibre intake: Constipation is the single most consistently replicated risk factor across five decades of literature, from the original epidemiological studies of Johanson and Sonnenberg [15] to contemporary pooled data [1]. Straining against a hard, low-volume stool raises intra-abdominal and intra-anal pressure, promoting venous engorgement and distal displacement of the anal cushions [14]. Cochrane-level evidence supports fibre supplementation as an effective countermeasure: a systematic review and meta-analysis of randomised trials found that fibre reduced the risk of persistent or non-improving symptoms by 47% (relative risk [RR] 0.53, 95% CI 0.38–0.73) and reduced bleeding episodes by half (RR 0.50, 95% CI 0.28–0.89) [24]. Current clinical practice guidelines from the American Society of Colon and Rectal Surgeons endorse fibre supplementation as a first-line, evidence-based intervention [25].

Obesity: Obesity was associated with a 56% increase in unadjusted odds of haemorrhoidal disease in pooled case–control data [1]. Because observational associations are vulnerable to confounding and reverse causation, two independent two-sample Mendelian randomisation studies have since tested causality using genetic instruments: the first found that genetically determined body mass index, body fat percentage, waist circumference and waist-to-hip ratio were each causally associated with increased haemorrhoid risk [17], and the second, examining bowel habits, obesity and intestinal microbiota jointly, corroborated a causal contribution of adiposity [18]. This causal-inference evidence substantially strengthens the case for weight management as a genuine preventive, not merely correlative, strategy.

Pregnancy: Pregnancy more than doubles the odds of haemorrhoidal disease (OR 2.61) [1], and pooled prevalence among pregnant women reaches approximately 31%, the highest of any population subgroup studied [1]. The mechanism is multifactorial: mechanical venous compression of the rectal and pelvic veins by the gravid uterus, progesterone-mediated reduction in gastrointestinal motility, and the pregnancy-associated increase in constipation prevalence [1] together create a compounded risk state that persists into the postpartum period.

Sedentary behaviour and occupational sitting: Beyond the case–control evidence discussed under Viharaja Hetu above (OR 3.68 for ≥ 5 hours of daily sitting) [22], broader reviews of lifestyle risk factors in haemorrhoidal disease consistently identify sedentary occupation, prolonged standing, and reduced physical activity as modifiable contributors [12], reinforcing the biomechanical hypothesis that sustained pelvic venous stasis, rather than any single acute event, underlies much of the disease's behavioural risk profile.

Occupational heavy lifting and chronic cough: Any activity that repeatedly and acutely raises intra-abdominal pressure — occupational heavy lifting, chronic cough, or habitual heavy straining — is recognised in standard clinical reviews as a mechanistic contributor to anal-cushion engorgement and prolapse [5,6].

Portal hypertension: Ano-rectal varices secondary to portal hypertension in cirrhotic patients represent a distinct pathophysiological entity that is sometimes conflated with true haemorrhoidal disease in both clinical practice and older literature; standard reviews caution that this differential should be considered, particularly in patients with known chronic liver disease presenting with peri-anal bleeding [4].

Ageing and family history: Case patients are, on average, significantly older than controls (SMD 0.39) [1], consistent with cumulative lifetime exposure to causative factors and age-related connective-tissue laxity of the anal cushion suspensory

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apparatus. Family history carries the single strongest unadjusted association of any risk factor examined (OR 4.19) [1], suggesting a heritable component to connective-tissue integrity that parallels the classical Ayurvedic recognition of a Sahaja (constitutional/congenital) subtype of Arsha.

Smoking and alcohol: Evidence for smoking is comparatively weak and inconsistent: pooled case–control data showed a non-significant trend toward increased risk (OR 1.13, 95% CI 0.88–1.45) [1]. Direct, hemorrhoid-specific quantitative data on alcohol are limited, though alcohol-related portal hypertension provides an indirect mechanistic pathway relevant to secondary anorectal venous pathology [4]. Both nonetheless fall within the "avoidance of risky substances" pillar of lifestyle medicine and warrant inclusion in comprehensive preventive counselling [13].

Metabolic syndrome and diabetes mellitus: Diabetes mellitus was associated with a 44% increase in unadjusted odds of haemorrhoidal disease (OR 1.44) [1], plausibly mediated through microvascular and connective-tissue effects of chronic hyperglycaemia, and hypertension showed a comparable association (OR 1.77) [1], potentially reflecting shared vascular pathophysiology.

Inflammatory bowel disease: A Mendelian randomisation analysis found a causal association between inflammatory bowel disease and increased hemorrhoid risk, plausibly mediated through altered bowel habit, chronic local inflammation and repeated diarrhoeal or constipating episodes characteristic of active disease [19].

Gut microbiome alterations: This is an emerging and mechanistically interesting area. Compositional analysis of hemorrhoidal tissue shows a microbiomic signature distinct from both skin and gut flora, with enrichment of Prevotella species noted in thrombosed compared with non-thrombosed haemorrhoids [20]. Separately, a two-sample Mendelian randomisation analysis found genetically predicted gut microbial composition to be causally associated with hemorrhoid risk [21], while the bowel-habit/obesity/microbiota Mendelian randomisation study noted above found microbial composition to interact with adiposity and bowel habit in influencing disease risk [17]. This body of evidence provides a striking, if still preliminary, modern echo of the Ayurvedic emphasis on Agni — broadly understood as encompassing digestive and metabolic function — as central to Guda Vali health.

Prevention:

Ayurveda's overarching preventive principle, Nidana Parivarjana — the deliberate avoidance of identified causative factors — maps closely onto the modern public-health framework of primary, secondary and tertiary prevention, and provides a natural organising structure for evidence-based preventive counselling in Arsha.

Primary prevention:

Primary prevention aims to prevent the initial onset of Arsha by removing or minimising exposure to established Hetu/risk factors. Ayurveda operationalises this through several interlocking constructs: Nidana Parivarjana (avoidance of the specific dietary, behavioural and psychological Hetu detailed above); Dinacharya (a structured daily regimen prescribing timely waking, prompt attendance to natural urges, appropriate Vyayama, and a regulated Ahara schedule); Ritucharya (seasonal regimen, adjusting diet and activity to prevent season-driven Doshic vitiation that can disturb bowel habit); and Sadvritta (a code of right conduct that includes emotional regulation, directly addressing the Manasika Hetu of Chinta, Shoka and Krodha).

- Fibre-rich diet, targeting approximately 25–35 g/day, supported by Cochrane-level trial evidence for symptom and bleeding reduction [24].
- Adequate hydration to complement fibre intake and maintain soft stool consistency.

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- Regular bowel habits and timely defecation, avoiding Vega Dharana (urge suppression).
- Regular physical activity and yoga, counteracting sedentary behaviour (OR 3.68 for prolonged sitting) [22].
- Weight management, supported by Mendelian-randomisation evidence for a causal role of adiposity [17,18].
- Stress management, addressing the gut–brain axis contribution to altered bowel habit [27].
- Avoidance of prolonged sitting, with scheduled movement breaks in sedentary occupations.
- Correct toilet ergonomics, favouring a squatting-consistent anorectal angle [23,26].
- Workplace modifications for occupations with prolonged sitting, standing or heavy lifting.
- Population-level public education on fibre intake, bowel habit and the risks of urge suppression.

Secondary prevention:

Secondary prevention targets early identification of Arsha at the Purvarupa (prodromal) stage, before progression to higher-grade prolapse, and is particularly relevant in populations identified as high-risk by the modern risk-factor data summarised above — pregnant women, individuals with obesity, those with a family history, and people in sedentary occupations [1]. Key elements include structured screening or symptom-enquiry among these high-risk groups; patient and clinician recognition of early symptoms such as mild bleeding, pruritus or discomfort; prompt dietary correction (fibre and hydration) and lifestyle modification at first presentation, before mechanical straining injury becomes established; and scheduled follow-up to confirm resolution of early symptoms and reinforce adherence to preventive behaviour.

Tertiary prevention:

Tertiary prevention is directed at preventing recurrence and complications after Arsha has been diagnosed and treated — a domain of particular importance given that recurrence has been documented in 5–12% of patients after definitive treatment [10,11], and is significantly correlated with the persistence of poor defecation habits postoperatively [9]. This applies equally after classical Ayurvedic Kshara Karma (parasurgical alkali-cauterisation) and after modern surgical procedures such as rubber-band ligation, stapled hemorrhoidopexy or excisional hemorrhoidectomy. Core elements include long-term correction of bowel habit (fibre, hydration, avoidance of straining); sustained lifestyle adherence (activity, weight management, avoidance of prolonged sitting); and structured rehabilitation and follow-up counselling to reinforce the preventive behaviours established during primary and secondary prevention, closing the loop between treatment and durable disease control.

Non-Pharmacological Management:

This section focuses specifically on non-drug interventions with either direct or strongly extrapolated evidentiary support, organised by domain.

Diet:

A high-fibre diet built around fruit, vegetables and whole grains, together with adequate water intake, avoidance of heavily processed food, and regular meal timing, remains the single best-supported non-pharmacological intervention, with Cochrane-level meta-analytic evidence of a near-halving of persistent symptoms and bleeding episodes [24]. This dietary pattern corresponds closely to the classical Ayurvedic principles of balanced Ahara Vidhi (dietary regimen) and directly counters the Guru, Ati Ruksha and Ati Snigdha Hetu discussed above.

Lifestyle:

Regular walking and general exercise counter sedentary behaviour; targeted pelvic floor exercises may support anorectal function; toilet hygiene practices and avoidance of prolonged straining reduce mechanical trauma; and the modern habit of prolonged mobile-phone use while seated on the toilet — which

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materially extends toilet sitting time — should be actively discouraged, as a contemporary extension of the classical caution against prolonged toilet sitting.

3.6.3 Toilet posture and squatting

Body position during defecation measurably affects the mechanics of evacuation. Manometric and radiological studies show that squatting, with marked hip and knee flexion, widens the anorectal angle relative to conventional sitting (approximately 126° versus 100°), permitting more complete relaxation of the puborectalis muscle and faster, less effortful evacuation; a controlled comparison found that satisfactory emptying took a mean of 51 seconds in the squatting position compared with 114–130 seconds when seated on a conventional pedestal toilet [23]. Body-position studies using simultaneous manometry and radiography confirm that squatting reduces the degree of straining required for evacuation compared with sitting [26]. This modern biomechanical evidence provides a compelling physiological rationale for classical advice against prolonged, effortful toilet sitting, and supports simple practical measures — such as a footstool to simulate a squat while using a Western-style pedestal toilet — as a low-cost preventive intervention.

3.6.4 Yoga

Direct, hemorrhoid-specific randomised evidence for yoga is not yet available, representing an important research gap discussed further below. However, indirect evidence from closely related functional bowel and pelvic-floor conditions is instructive. A systematic review of randomised controlled trials found that yoga produced beneficial effects on gastrointestinal symptom severity, quality of life and anxiety in patients with irritable bowel syndrome [28], and a subsequent randomised trial of virtually delivered Hatha yoga confirmed improvements in quality of life, fatigue and perceived stress among adults with irritable bowel syndrome, though the primary symptom-severity endpoint was not statistically superior to an advice-only control [29]. Extrapolating cautiously from this evidence base, several specific asanas plausibly support bowel regularity and anorectal health through complementary mechanisms:

- **Pawanmuktasana** and **Malasana** (squatting pose) mechanically approximate the physiological squatting posture, potentially facilitating puborectalis relaxation and anorectal-angle widening [23,26].
- **Vajrasana**, traditionally practised after meals, is held to aid digestion and may support post-prandial bowel regularity.
- **Bhujangasana** and **Shashankasana**, practised in sequence, alternately compress and release the abdominal cavity, plausibly stimulating peristalsis.
- **Tadasana** and **Surya Namaskar** provide general abdominal-pelvic circulatory and musculoskeletal benefit as part of a broader physical-activity regimen.

The proposed mechanisms — improved abdominal-pelvic circulation, autonomic/HPA-axis modulation of stress-related dysmotility, and mechanical facilitation of a favourable anorectal angle — are biologically plausible extensions of the yoga-and-gastrointestinal-function literature [27,28,29], but should be regarded as hypothesis-generating pending dedicated hemorrhoid-specific trials.

Discussion:

Convergence between Ayurvedic Hetu and modern risk factors:

The comparative synthesis in Table 5 reveals a substantial and, in places, striking degree of conceptual convergence between the Ayurvedic Hetu of Arsha and modern, quantified risk factors. Vibandha (constipation) and habitual straining correspond almost exactly to the modern risk factor of constipation, independently validated across five decades of epidemiological study and carrying a

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pooled unadjusted odds ratio of 2.51 [1,15]. Vega Dharana (urge suppression) anticipates the mechanistic understanding of stool hardening through delayed evacuation, although direct quantitative epidemiological data testing urge-suppression behaviour as an independent variable remain sparse — an evidence gap discussed further below. The classical emphasis on prolonged sitting and jolting travel (Ati Asana, Adhwagamana) is now robustly corroborated by case–control data demonstrating nearly four-fold increased odds with prolonged daily sitting [22]. Manasika Hetu (Chinta, Shoka, Krodha) find a plausible modern physiological correlate in gut–brain axis dysregulation of motility under chronic stress [27]. This degree of convergence is unlikely to be coincidental: it suggests that centuries of careful clinical observation, systematised within the Ayurvedic nosological framework, captured genuine behavioural and dietary determinants of anorectal disease long before the tools of modern epidemiology existed to quantify them.

Scientific basis of Nidana Parivarjana:

Nidana Parivarjana is, in essence, a pre-modern operationalisation of the public-health concept of primary prevention through exposure avoidance. Where contemporary epidemiology formalises this through the classical Leavell and Clark framework of primary, secondary and tertiary prevention [30], Ayurveda achieves a structurally similar outcome through the combined application of Nidana Parivarjana (avoid the cause), Purvarupa recognition (detect early), and post-treatment Sadvritta/Dinacharya adherence (prevent recurrence) — a framework that maps with reasonable fidelity onto primary, secondary and tertiary prevention respectively, as organised in Section 3.5. The scientific credibility of Nidana Parivarjana for Arsha specifically rests less on any unique Ayurvedic mechanism and more on the fact that the majority of named Hetu now possess independent modern evidentiary support, ranging from observational odds ratios to Mendelian-randomisation-confirmed causality [1,17,18].

Mechanisms behind preventive lifestyle practices:

Several converging mechanistic pathways emerge from this synthesis. Fibre supplementation increases stool bulk and softness, reducing straining force and, by extension, anal-cushion venous engorgement, with trial-level evidence of a near-halving of persistent symptoms and bleeding [24]. Squatting-consistent toilet posture widens the anorectal angle and reduces the time and force required for evacuation, an effect demonstrated using manometry, defecography and simple timed-comparison studies [23,26]. Stress-reduction practices plausibly act through autonomic and HPA-axis modulation of gut motility and visceral sensitivity [27], a mechanism directly relevant to the Manasika Hetu described in classical texts. Weight management addresses a now causally confirmed contributor to hemorrhoid risk, operating through both direct mechanical (raised intra-abdominal pressure) and adiposity-associated metabolic/vascular pathways [17,18]. Each of these mechanisms independently supports a specific, actionable component of the Nidana Parivarjana framework, lending the classical preventive model a coherent modern mechanistic scaffold.

Role of integrative medicine:

Ayurveda and modern biomedicine bring complementary strengths to hemorrhoid prevention. Ayurveda offers a systematised, centuries-refined behavioural and dietary preventive framework (Dinacharya, Ritucharya, Sadvritta) that is culturally embedded, low-cost, and demonstrably acceptable to patients across South Asian healthcare settings; modern biomedicine offers quantified risk stratification, causal inference through Mendelian randomisation, and randomised-trial-

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tested interventions such as fibre supplementation. Neither system alone currently offers a complete, rigorously validated preventive package specific to Arsha. An integrative approach — in which AYUSH primary-care counselling on Dinacharya and Nidana Parivarjana is explicitly grounded in, and cross-referenced against, the quantified modern risk-factor evidence summarised in Table 5 — may improve both the scientific credibility of Ayurvedic preventive counselling and the behavioural specificity and cultural resonance of modern lifestyle-medicine advice, particularly in the primary-care and rural settings served by India's extensive AYUSH healthcare infrastructure .

Behavioural medicine perspectives:

Ultimately, prevention of Arsha depends on sustained behaviour change across diet, toilet habit, physical activity and stress management — a challenge common to essentially all lifestyle-mediated chronic disease. It is notable that both systems converge on habit-formation as the operative mechanism of change: Dinacharya is, definitionally, a structured daily-habit framework, while modern behavioural medicine increasingly emphasises routine-based, habit-stacking interventions as more durable than episodic advice. This shared emphasis on routinisation suggests genuine translational potential for public-health messaging that explicitly borrows the structured, daily-regimen framing of Dinacharya to improve adherence to evidence-based lifestyle interventions such as fibre intake, movement breaks and prompt urge response.

Conclusion:

Arsha (haemorrhoids/piles) is a highly prevalent, frequently recurrent anorectal disorder for which prevention offers clear advantages over treatment alone — avoiding the substantial morbidity, cost and recurrence risk documented across the modern literature [1,8,9,10,11]. Nidana Parivarjana, the classical Ayurvedic principle of avoiding causative factors, remains a conceptually robust cornerstone of prevention and shows striking correspondence with modern, quantified risk-factor evidence spanning constipation, sedentary behaviour, obesity, pregnancy, and psychological stress. Integrating Ayurvedic lifestyle principles — Dinacharya, Ritucharya and Sadvritta — with evidence-based modern preventive medicine, including fibre-rich diet, weight management, physical activity, squatting-consistent toilet posture, and stress reduction, offers a low-cost, broadly acceptable, and mechanistically coherent framework capable of reducing disease burden, recurrence, and healthcare costs while improving quality of life. Realising this potential, however, requires dedicated, high-quality prospective and interventional studies that directly test Ayurvedic preventive strategies against hemorrhoid-specific clinical endpoints — a research agenda that remains largely unaddressed and represents the most pressing priority for the field.

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