TRUPTI GAWADE 1, MANDA GHORPADE 2

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ABSTRACT

Pregnancy and labour are major events in a woman’s reproductive life. At present pregnancy and child birth is a very sensitive issue for a pregnant lady and her family.

In today’s stressful and fast lifestyle many of factors are causing Apanvikruti. If Apan is prakrit then only prakrit prasava is possible.

For this purpose specific regimen with Anuvasan Basti with Madhur Aushadhi Taila is mentioned in Charaksamhita in the context of garbhini paricharya.

Acharya Charak has included Bala in Madhur Skandha.

So in this study the effect of Bala Siddha Taila Anuvasan Basti on labour pains.

INTRODUCTION

In Ayurveda acharya described the definition of Stree in point of her foetus so obviously Prasava is very important event in woman’s life.

Prasava is very important & unavoidable event connected to woman life. Courses of labour can affect woman health not only for that time being but

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also through her life. For maternal &
fetal health Sukhaprasava is important.

The woman is said to be complete
when she becomes a mother. Every
pregnant woman expects Sukhaprasava.
The process of Prasuti is controlled &
regulated by Apana vayu.
The subject chosen is with a goal of
Sukhprasavaya.
The Garbhnina Paricharya described aim
towards:
1) Anupghataya: Without maternal &
foetal complications.
2) Paripurntvaya: Full term/full
mature foetus.
3) Sukhprasavaya:

For Sukhprasavaya Vata Dosha
should be in Prakrit state. Keeping this
in mind Acharyas have stated Anuvasan
Basti in 9 month for preventing Vata
Vikruti & facilitates Normal Labour.

Thus Anuvasan Basti brings
generalised unctuousness, Dhatu samya,
Vata prashman & maintains Vata gati,
provides strength to the lady to undergo
the stressful labour process & have an
uncomplicated intra & post partum
period.

Pakwashaya is the main sthana of Vata
dosha as well as Apana vayu.

Prakrit Prasava is possible only when
Apana is prakrit. So in this
study “Madhur Aushadhi Siddha Taila”
that is Bala Taila Anuvasan Basti is used
in Garbhini for sukhaprasava.

Acharya Charaka has included Bala in
Madhura Skandha

So Bala was selected considering its
Guna.

AIM:

To study the “Effect of Bala Siddha
Taila Anuvasan Basti on labour pains.

OBJECTIVES:

1) Conceptual study regarding to labour
process and Anuvasan Basti were done.
2) Effect of Bala siddha taila Anuvasan
Basti on labour pains were done.

MATERIALS AND
METHODOLOGY

According to Garbhini paricharya,
Anuvasan Basti of madhur aushadhi
siddha taila administered in 9th month of
pregnancy.

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**Materials:**

1. *Bala siddha taila*
2. ANC Patient 36 wks onwards.

**Bala Siddha Taila :-**

*Bala siddha taila* was prepared by classical *Taila Pak Vidhi*

Authentificated & Standardized *Bala Taila* were taken.

All required accessories for *Basti* were obtained and kept ready.

**Methodology :-**

1. Routine ANC patient 36 wks onwards from OPD were selected.
2. **DRUGS:**
   - *Bala (panchanga) Tila taila*
3. Total no. of 200 patients were selected and divided in to two groups
   - Group A) Trial group-100 patients
   - Group B) Control group-100 patients
4. Through obstetric examination was done to determine period of gestation > 36 week at the start of treatment and fundal height in cm, weight, AC, position of foetus, presentation, head engaged/floating was also assessed.
5. All patients were subjected to the routine necessary haematological and urine laboratory investigations.
6. Every time when patient visited the ANC clinic, follow up after every 4 days taken.
7. Both group patients were called for twice in a week for *Anuvasan Basti*. 100ml of *Bala siddha taila* was administered for

**INCLUSION CRITERIA:-** Primipara with singleton pregnancy of 36 weeks

**EXCLUSION CRITERIA:-**

- Multipara
- Patients having *Garbhopdravas* like Pregnancy Induced Hypertension, Anaemia, Cardiac disease etc.
- Patient having *Garbhavyapdas*.

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Anuvasan Basti and the pratyagam kala, was noted.

8. Total 7-8 Anuvasan basti were completed by each patient.

9. Control group patients were assessed under same criteria and followed for weekly.

10. Follow up of the patient were kept up to her delivery.

Observations were noted during the whole labour process.

ASSESSMENT CRITERIA
1. Bishop score
2. Uterine contractions – Mild, Moderate, Strong in hr.
3. Total duration of labour

OBSERVATIONS AND RESULTS
Frequency distribution analysis was done for the following attributes.

Clinical Data:
Statistical analysis was done on the following attributes:

1. Bishop Score
2. Uterine contraction Mild
3. Uterine contraction Moderate
4. Uterine contraction Strong

Assessment criteria:
1. The frequency distribution of demographic data was done.
2. Kruskal-Wallis Test was used to compare the mean tendency between the 2 groups.

Frequency Analysis:
Bishop score:
On the basis of Bishop Score the patients were divided into two groups:

<table>
<thead>
<tr>
<th>Bishop Score</th>
<th>Trial Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 5</td>
<td>20</td>
<td>39</td>
</tr>
<tr>
<td>6 and above</td>
<td>78</td>
<td>61</td>
</tr>
</tbody>
</table>

The Bishop score was more favourable or almost same in both. i.e. 78 from Trial group & 61 from Control group.

Uterine contractions (In Hour) Mild:
On the basis of mild uterine contractions patients were divided into two groups:

1. 1 to 5
2. 6 and above

Majority of the patients from both Trial and Control groups i.e. 14% and 36% respectively have 1 to 5 mild uterine contractions. In trial group- 14 had mild contraction since admission but they all delivered normally without any complications only 1 of them needed LSCS for induction failure & 2 of them had prolonged labour.

In control group- 40 volunteers had mild contractions & in them 4 volunteers had mild contractions more than 6 hrs they all needed LSCS for prolonged labour & in them out of 36, 20 pt. had prolonged labour & need augmentation.

Uterine contraction (In Hour)

Moderate:

On the basis of moderate uterine contractions the patients were divided into two groups:

1. 1 to 5
2. 6 and above

37 of the Trial group patients had 6 and above moderate uterine contractions and 20 of the Control group patients have 1 to 5 moderate uterine contractions.

In Trial group 65 patients had moderate contractions & in that 5 patients required LSCS for prolonged labour & 10 of them needed augmentation but delivered normally.

In Control group 45 had moderate contractions out of them 10 needed LSCS. 6 of them for prolonged labour & 4 of them had foetal distress. In them 15 volunteers required augmentation for prolonged labour.

Uterine contraction Strong:

On the basis of strong uterine contractions the patients were divided into two groups:

1. 1 to 5
2. 6 and above

The patients from both Trial and Control groups i.e. 79% and 40% respectively had 1 to 5 strong uterine contractions.

<table>
<thead>
<tr>
<th>Uterine contraction Strong</th>
<th>Trial Group</th>
<th>Control Group</th>
</tr>
</thead>
</table>

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In Trial group 80 patients had strong contractions only 4 of them required LSCS for hyper tonicity of uterine contractions- 1 for APH & 3 for fetal distress & remaining all delivered normally. In Control group 40 patients had strong contractions. 6 of them needed LSCS for hyper tonicity of uterine contractions- 2 of them for APH & remaining 4 for fetal distress.

### Total Labour Duration:

<table>
<thead>
<tr>
<th></th>
<th>Trial Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>More than 12 hrs</td>
<td>24</td>
<td>26</td>
</tr>
<tr>
<td>Less than 12 hrs</td>
<td>53</td>
<td>43</td>
</tr>
<tr>
<td>1 to 5</td>
<td>79</td>
<td>40</td>
</tr>
<tr>
<td>6 and above</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

On the basis of Total labour duration (hrs) the patients were divided into two groups:

a) More than 12 hrs  
b) Less than 12 hrs

Majority of the patients from both Trial and Control groups i.e. 53 and 43 respectively have less than 12 hrs Total labour duration.

1) Above table indicates that about 53 of all Primis from trial group delivered within 12hrs of labour onset that means there is marked reduction in duration of labour.  
2) 24 patients of Trial group had >12hrs of duration. In Control group 26 had >12hrs duration.
3) LSCS needed:

a) Control group 31- 17 had prolonged duration >14hrs.
b) Trial group 21-14 had prolonged labour duration.

4) 10 from Trial group:
5) 3- Ventouse delivery, less bearing down. 2- Uterine inertia. 5- Long latent phase.

RESULT:

<table>
<thead>
<tr>
<th>Test Statistics</th>
<th>Uterine Contraction s (Mild)</th>
<th>Uterine Contractions (Moderate)</th>
<th>Uterine Contractions (Strong)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chi-Square</td>
<td>14.331</td>
<td>4.308</td>
<td>11.253</td>
</tr>
<tr>
<td>Df</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>P-value</td>
<td>.00017</td>
<td>.038</td>
<td>.001</td>
</tr>
<tr>
<td>a. Kruskal Wallis Test</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DICUSSION

Distribution acc. to Bishops score:

Bishops score is called Prelabour score. It determines the cervical consistency, position, effacement, station of presenting part. It is favourable or not for normal delivery. Score is said to be favourable that lies between 6-13. The basti treatment brings about these changes.

The bala taila causes mardava (softening), kledana etc. Bala is also a demulcent which enhances the ripening action. In this study basti also caused local action on cervix. i.e. Softening & ripening action.

In trial group patients 78% had bishops score ie. 6 & above 20% patient had bishops score between 0-5. Out of them only 5 pts. Needed LSCS due to foetal distress. Remaining 15 patients delivered normally, out of them 3 had prolonged labour required augmentation.

Distribution acc.to Uterine Contractions:

The pacemaker of uterine contraction is situated in tubal Ostia, from where waves of contraction spread downwards. So with the Basti and prakrit vata shitee was achieved, Bala
siddha taila being guru, snigdha, balya and brimhana, increases muscle tone and contractility, so volunteers from trial group had good effective moderate contractions during 1st only.

In control group most of the patients had mild uterine contractions and so most of them needed augmentation. Even with moderate contractions in trial group no maternal or foetal distress was observed. As intermitted adequate relaxation occurred that prevented maternal and uterine fatigue.

**Distribution acc. to total labour duration:**

Labour is said to be prolonged when cervical dilation is less than 1cm/hr. and descent is less than 1 cm/hr.

The causes are uterine inertia or less bearing down efforts fault in passage i.e. cervical dystocia, resistance of perineum. Fault in passenger i.e. mal position and mal presentation. Thus all the above factors hamper the Total labour process.

With Anuvasana basti anuloma gati of Vata dosha is maintained causing good, effective uterine contractions, good bearing down effort by increasing bala and satwa.

**Anuvasana Basti**

100 ml of anuvasana basti was administered. Actually 120 ml is the ideal matra of anuvasana basti. As after 32 weeks in pregnant patients, the pressure of presenting vertex obstructs the rectum, only 100 ml could be retained. Anuvasan basti had many benefits as follows:

- One patient had less foetal movements, but after 2-3 basti, she had marked foetal movements.
- Most of patients got relief from abdominal discomfort & backache.
- No side effects / complications of anuvasana basti were noted. Many volunteers had soft stools, no one had constipation.
- 2 Patients had dribbling micturition which recovered after anuvasana basti.
- 2 Patients in Trial group had taken 7 basti both of them gone for delivery at another hospital due to their family
problem but follow up taken on phone both of them delivered normally hence they are excluded from study.

Thus the treatment was highly effective in normal labour and did not cause any complication which would be hazardous to maternal or foetal health.

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