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REVIEW ARTICLE

Comparative Perspectives on *Ksharasutra* Preparations in *Arsha* Management: A Scoping Review of Available Clinical Evidence

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Abstract

Background: *Arsha* (haemorrhoids) is among the commonest anorectal disorders, and *Ksharasutra* (medicated alkaline thread), a parasurgical modality of *Shalya Tantra*, has been applied to it in several pharmaceutical variants. The literature is dispersed across Ayurvedic journals of variable indexing and has not been mapped. **Objective**: To identify and describe published clinical evidence on different *Ksharasutra* preparations in *Arsha*, charting composition, clinical application, reported outcomes and safety, and to identify gaps. **Methods**: A preliminary scoping review followed Joanna Briggs Institute guidance and is reported with the PRISMA extension for scoping reviews. Twenty-two web queries and one academic search-engine query were run on 7 November 2026 across PubMed/MEDLINE, Google Scholar, Semantic Scholar and Ayurvedic journal portals. Records reporting patient-level haemorrhoid outcomes were eligible; fistula-in-ano studies were excluded. Screening and charting were performed by a single reviewer, without registration or duplicate screening. **Results**: Eleven reports published between 2010 and 2026, all from India, were charted: four comparative studies, one 125-patient prospective series, two single-arm studies, one two-patient case series and three case reports. The conventional Apamarga-based thread dominated; modifications included *Durva*-coated and *Guggulu-, Udumbara-* and *Snuhi*-based threads. Reported improvements in bleeding, pain and prolapse were consistent in direction but derived from small, largely unblinded, single-centre studies with non-standardised outcomes and follow-up of four weeks to two months or unstated. Only one 33-patient three-arm study compared preparations directly, and its findings could not be verified. **Conclusions**: The evidence base is exploratory. Pharmaceutical and procedural heterogeneity, inconsistent grading, non-standardised outcomes and absent long-term follow-up preclude any judgement of comparative effectiveness. A minimum reporting set for preparation, a core outcome set and adequately powered registered comparative trials are required.

Keywords: *Arsha;* Ayurvedic Surgery; Clinical Outcomes; Haemorrhoids*; Ksharasutra*; Parasurgical Procedures

Introduction

Haemorrhoidal disease is a leading reason for consultation in colorectal and general surgical practice, and its symptom burden — bleeding per rectum, prolapse, perianal discomfort, discharge and pruritus — impairs occupational and social function. Contemporary management stratifies patients by degree of prolapse, moving from fibre supplementation through office procedures such as rubber band ligation, sclerotherapy and infrared coagulation to excisional surgery for grade III–IV disease.[6,7] Each option has drawbacks: office procedures carry measurable recurrence, and haemorrhoidectomy is associated with appreciable postoperative pain and a small risk of stenosis and continence disturbance.[6,7]

Ayurvedic literature describes the same territory as Arsha, counted among the *Ashta Mahagada*. *Sushruta* classified *Arsha* by *Dosha* and location and set out a fourfold scheme of *Bheshaja* (drug therapy), *Kshara* (alkaline cautery), *Agni* (thermal cautery) and *Shastra* (surgery) in the sixth chapter of the *Chikitsa Sthana*[1]; *Charaka* treats the subject in the fourteenth chapter of his *Chikitsa Sthana*.[2] Within this tradition the medicated thread developed. *Ksharasutra* is best known from the *Bhagandara* (fistula-in-ano) literature, where unit cutting time became a standard outcome.[19] That evidence cannot be transposed: in fistula the thread traverses a fibrosed track, whereas in *Arsha* it transfixes and ligates a vascular pedicle, so target tissue, mechanics of cutting, complications and outcome set all differ.

Several preparations circulate — the conventional *Apamarga*-based thread, *Snuhi*-based variants and modified threads incorporating *Udumbara*, *Guggulu* or *Durva* — yet whether each has been studied in haemorrhoidal disease, and with what methodological quality, is unmapped; narrative reviews tend to summarise outcomes without distinguishing preparation or design. This review therefore asks what clinical evidence exists on different *Ksharasutra* preparations in

Arsha, and how preparation methods, applications, outcomes and safety vary. Secondary questions concern ingredients, grades studied, procedures used, adverse events documented, availability of direct comparisons, and remaining gaps.

Classical Background and Evolution of *Ksharasutra* Preparations

Kshara is described in classical surgery as a caustic alkali obtained by burning and lixiviating specified plants. Sushruta is reported to have listed some twenty-two plant sources, including *Apamarga (Achyranthes aspera)* and *Snuhi (Euphorbia neriifolia),* and to have regarded *Apamarga kshara* as qualitatively superior.[8] Classical use in Arsha refers principally to *Ksharakarma*: topical application of alkali to an isolated pile mass, adjacent tissue protected and the cauterised surface treated afterwards with *Takra* (buttermilk), honey and ghee.[8] That is a different intervention from the thread, although the two are frequently conflated.

The thread itself is a later development. Authors of the retrieved reports trace the indication in haemorrhoids and fistula to *Chakradatta* and *Bhavaprakasha* rather than to the *Brihatrayi*.[13] and the standardised thread — surgical linen ligature coated sequentially with Snuhi latex, *Apamarga Kshara* and *Haridra* powder under Indian Council of Medical Research guidelines at Jamnagar — is a twentieth-century construction.[9,14] Attributing a contemporary protocol directly to a classical text is therefore unwarranted; classical citations here are given at chapter level only. Two axes of variation must also be kept apart: pharmaceutical (alkali source, binding latex, coating cycles, added drugs) and procedural (ligature number and tension, anaesthetic setting, sittings, postoperative regimen). Studies that vary one axis while leaving the other undefined cannot be compared on efficacy.

Materials and Methods

Design and reporting

This preliminary scoping review followed Joanna Briggs Institute (JBI) guidance[3,4] and is reported in line with PRISMA-ScR.[5] A scoping design was chosen because the aim was to map the extent and nature of the evidence rather than to pool effects. The review was not prospectively registered, no protocol was published and no formal risk-of-bias appraisal was undertaken; the report should therefore be read as a structured evidence map, not as a completed systematic scoping review.

Review question and PCC framework

The primary question was: what clinical evidence is available on different *Ksharasutra* preparations in *Arsha*, and how do preparation methods, applications, outcomes and safety vary? Population: patients with *Arsha* receiving a *Ksharasutra*-based intervention. Concept: the preparations — composition, preparation method, application, outcomes and safety. Context: Ayurvedic teaching hospitals, *Shalya Tantra* departments and standalone anorectal centres. Haemorrhoids were kept distinct from fistula-in-ano, fissure-in-ano & other anorectal conditions throughout.

Eligibility criteria

Eligible records were peer-reviewed publications reporting patient-level data on *Ksharasutra*, or closely related *Kshara*-based parasurgical therapy, in haemorrhoidal disease, of any design. Records were excluded if they concerned fistula-in-ano or another anorectal condition exclusively, were pharmaceutical or analytical studies without patient outcomes, were reviews or commentary, duplicated a cohort, or did not permit eligibility to be established. No date restriction was applied, and all eligible reports retrieved were in English.

Information sources and search strategy

Searches were run on 7 November 2026 in PubMed/MEDLINE (including PubMed Central full texts), Google Scholar, Semantic Scholar and the public sites of Ayurvedic journals (AYU; Journal of Ayurveda and Integrative Medical Sciences; International Research Journal of Ayurveda and Yoga; Journal of Clinical Case Practice; International Journal of AYUSH Case Reports; Journal of Natural Remedies; Journal of Ayurveda Campus). The core string, adapted to each interface, was: ("*Ksharasutra*" OR "*Kshara Sutra*" OR "*Ksharsutra*") AND ("Arsha" OR "Haemorrhoids" OR "Piles"). Variants substituted preparation names (*Apamarga, Snuhi, Udumbara, Guggulu,* modified) and comparators (haemorrhoidectomy, rubber band ligation, *Agnikarma*, infrared coagulation). 22 web queries and one academic search-engine query were executed and are reproducible from these terms.

The search surfaced 165 unique web records and six academic search-engine records, 171 in total. Because

records were not exported to a reference manager, overlap was not quantified and no automated de-duplication was performed; 171 counts records surfaced by the interfaces, not de-duplicated hits. Screening and charting were done by one reviewer; a second reviewer and arbitration were unavailable, and the process is not represented as dual-independent.

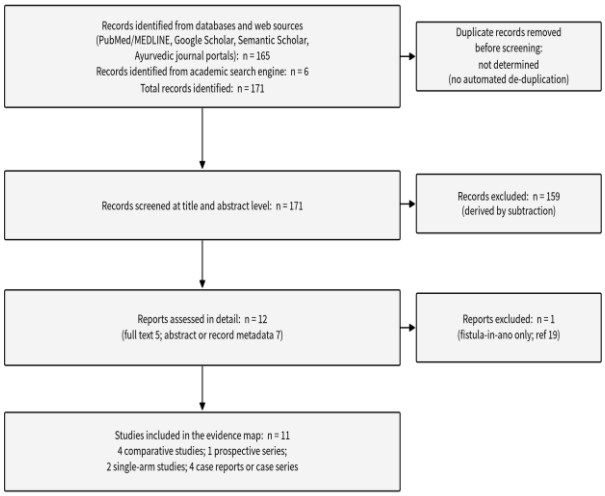
Selection and data charting

Titles and abstracts were screened against the criteria. Twelve reports were assessed in detail; full text was obtained for five and seven were charted from abstract or metadata, with the limitation noted. One record was excluded because it reported fistula-in-ano exclusively.[19] A structured form captured setting, design, sample size, grade, preparation, ingredients, coating method, application, comparator, follow-up, outcomes, results, adverse events and stated limitations. Where an item was absent, "Not reported" was entered; no value was estimated and no aggregate statistic was computed. Synthesis was descriptive and tabular; no meta-analysis or risk-of-bias instrument was applied.

Results: Mapping of Available Clinical Evidence

Eleven reports published between 2010 and 2026 met the criteria (Table 1; Figure 1). All originated in India, mostly in Shalya Tantra departments or dedicated anorectal centres. Four compared two or more interventions[9,10,16,18]; one was a prospective series of 125 patients[15]; two were single-arm studies[8,17]; four were case reports or a small case series.[12,13,14,16] Only one report gave a trial registration number.[10]

Figure 1. PRISMA-ScR flow of records



Characteristics of included studies.

Studies specifying a sample size enrolled one to 125 participants, comparative arms commonly of 10 to 35 patients. The largest clinically detailed dataset was the 125-patient series[15]; the largest comparative dataset the 61-patient study of ligation versus haemorrhoidectomy.[9] Grading was inconsistent: recruitment was restricted to grades I–II in one study[10] and I–III in another[8]; grades II–IV were admitted in one report[9] and III–IV in three[13,14,17]; one series described haemorrhoid origin without grading[15]; two gave clinical descriptions without a formal grade[12,16]; grade was unstated in two.[11,18] Follow-up was four weeks in one study[17], weekly for a month with a further month of observation in another[10], weekly for two months in a third[8], and unstated in six. [9,11,12,14,15,16]

Types of preparations

The conventional *Apamarga*-based thread dominated, described consistently as 20-number Barbour surgical linen thread coated with Snuhi latex, Apamarga kshara and Haridra powder under Indian Council of Medical Research guidelines[9,18], and later as prepared according to the Ayurvedic Pharmacopoeia of India.[14] Modifications appeared in three reports: a *Durva* (*Cynodon dactylon*) powder-coated thread[18], and, in one three-arm study, ligatures in which the coating drug was *Snuhi (Euphorbia neriifolia), Guggulu (Commiphora mukul)* or *Udumbara (Ficus racemosa),* with an alkaline pH of 10.3 reported.[11] One report described sequential multiple coatings without stating their number.[15] Kshara used as a topical paste rather than a thread featured in two studies and is pharmacologically distinct from ligature.[8,10]] (Table 2). Coating sequences, drying intervals, thread calibre verification and batch analysis were absent from every clinical report.

Clinical applications

Application was by transfixation and ligation of the pile pedicle in most reports, under local anaesthesia in two[15,17], spinal anaesthesia in two[9,14], and with no stated anaesthetic in the remainder. *Ksharapatana* — topical *Apamarga Kshara* applied to the mass for about two minutes, washed off with *Takra*, then dressed with honey and *Ghee* — was described in detail in one study and repeated for each mass at the same sitting[8], and as a paste applied over one to three sittings in another.[10] Post-procedural regimens included sitz baths, *Jatyadi Ghrita* dressings and graduated anal dilatation from the tenth postoperative day.[14] Comparators were open

haemorrhoidectomy[9,18], infrared coagulation and an oral herbal formulation[10], & bipolar diathermy *Agnikarma*.[16]

Table 1. Characteristics of clinical reports included in the scoping review.

Author, year	Design	n	Grade	Preparation / intervention	Comparator	Major Outcomes
Dudhamal et al., 2010[8]	Single-arm clinical study, random sampling	30	I–III	Apamarga kshara paste (ksharapatana), 3 g daily × 7 days	None	Bleeding, pain, burning, discharge, prolapse, pruritus
Gupta et al., 2011[9]	Comparative clinical study	61 (35/26)	II–IV	Ksharasutra ligation (standard Apamarga thread)	Haemorrhoid-ectomy	Bleeding, pain, constipation, cure rate, hospital stay, stenosis
Sudarmi et al., 2017[10]	Open-label prospective three-arm study	30	I–II	Apamarga kshara paste, 1–3 sittings	Infrared coagulation; oral Arshohara Vati	Bleeding, pain, prolapse, discharge, complete remission
Saxena & Singh, 2018[11]	Three-arm comparative clinical study	33	Not stated in retrieved record	Snuhi, Guggulu and Udumbara ligatures	Inter-preparation comparison	Pain, healing time, tolerance (direction not extractable)
Khattra, 2023[13]	Case report	1	Prolapsed mass, 3 o'clock	Ksharasutra ligation	None	Symptom relief, healing
Swami & Sharma, 2023[14]]	Case report	1	III (3, 7, 11 o'clock)	Ksharasutra ligation prepared per Ayurvedic Pharmacopoeia of India	None	Tissue separation day 6–7, healing day 25, continence, stenosis
Sharma et al., 2025[15]	Prospective observational study, single centre	125	Not graded (origin reported)	Ksharasutra ligation (Apamarga-based)	None	Tissue separation time, symptom regression, complications, recurrence
Barange et al., 2025 [16]	Comparative clinical study	Not extractable	Interno-external	Apamarga Kshara Sutra ligation	Agnikarma (bipolar diathermy)	Not extractable from retrieved record
Gupta et al., 2026[17]	Prospective clinical study	30	III–IV	Ksharasutra ligation under local anaesthesia	None	Bleeding, pain (VAS), prolapse grade, sloughing, complications
Mohan, 2026 [18]	Comparative clinical study	Not reported	III–IV	Durva-coated Ksharasutra transfixation ligation	Open haemorrhoid-ectomy	Pain (VAS), bleeding, operative time, stenosis, hypotonia, sepsis

Reported outcomes

Bleeding was the most consistently assessed symptom: complete relief by day 21 in the *Apamarga Kshara* arm[10]; 84.33% relief in bleeding and pain combined after *Ksharapatana*[8]; prevalence falling from 90% to 15% at four weeks in grade III–IV disease.[17] Pain was measured on a visual analogue scale in two reports, with a mean fall from 7.5 ± 0.8 to 1.8 ± 0.6[17] and significantly lower early postoperative scores for Durva-coated ligation than for haemorrhoidectomy.[18] Prolapse improved by 70% in one series.[17] Complete remission was 80% with Apamarga *Kshara* application, against 20% with infrared coagulation and 30% with oral therapy, in a 30-patient three-arm study[10]; 56.66% were markedly improved after *Ksharapatana*, 16.66% unimproved, with an insignificant effect in grade III disease.[8] Tissue separation occurred within five days in 12%, by day six in 23.2% and at seven days or later in 64.8% of 125 patients[15]; ligated masses cut through by day six or seven with healing by day 25 in one case report.[14] Operative time was shorter and postoperative sepsis less frequent with Durva-coated ligation.[18] No report used a validated satisfaction, continence or quality-of-life instrument.

Direct comparative evidence

Only one study compared *Ksharasutra* preparations with each other in haemorrhoids: a 33-patient evaluation of *Snuhi, Guggulu* and *Udumbara* ligatures.[11] Its full text could not be retrieved, and the indexed abstract reported only that patients receiving one of the three experienced least pain, shortest average healing time and best tolerance, without identifying which preparation or giving verifiable figures. This single, small, incompletely reported study cannot support any ranking. The remaining comparisons set a preparation against haemorrhoidectomy[9,18], infrared coagulation and oral therapy[10], or *Agnikarma*[16], and therefore address the position of the technique within the repertoire rather than the relative merits of preparations.

Comparative Perspectives on Different Preparations

Read side by side, the reports describe pharmaceutical variation far more consistently than they evaluate it.

Every ligature study names its coating drugs, and the *Apamarga*-based thread is described in essentially the same terms across more than a decade.[9,14,18] What is missing is what would make two preparations distinct pharmaceutical entities: alkali concentration, coating mass per unit length, number of cycles, thread diameter, pH and batch uniformity. Without these, *Durva*-coated and *Guggulu*-based threads differ from the standard thread nominally rather than measurably, and any observed difference remains as plausibly attributable to operator, patient mix or co-intervention as to the coating.

Table 2. *Ksharasutra* preparations and related *kshara* interventions reported in Arsha management.

Preparation	Pharmaceutical ingredients	Preparation / coating method	Reported application
Standard Apamarga Ksharasutra[9]	Barbour surgical linen thread no. 20; Snuhi latex; Apamarga kshara; Haridra powder	Prepared under ICMR guidelines (IPGT & RA) seven Apamarga kshara coatings cited as the operative dose; drying intervals not reported	I–III
Standard thread, pharmacopoeial method[14]	Snuhi latex; Apamarga kshara turmeric Barbour thread no. 20	Prepared as per Ayurvedic Pharmacopoeia of India; coating sequence not stated	II–IV
Multiple-coating Apamarga thread[15]	Apamarga kshara; Snuhi latex; Haridra	"Multiple coatings applied sequentially" to achieve potency; number not reported	I–II
Durva-coated Ksharasutra[18]	Durva powder added to the conventional coating	Powder-coated modification; quantitative composition not reported	Not stated in retrieved record
Snuhi, Guggulu and Udumbara ligatures[11]	Snuhi Guggulu Udumbara thread pH reported as 10.3	Preparation described only at abstract level in the retrieved record	Prolapsed mass, 3 o'clock
Apamarga kshara (topical; not a thread)[8,10]	Apamarga kshara; takra; honey; ghee; Yashtimadhu ghrita	Classical ksharapatana: alkaliapplied to the isolated mass for ~2 minutes (count of 100), washed with takra, emollients applied; repeated for each mass	III (3, 7, 11 o'clock)

Procedural heterogeneity compounds the problem: ligature tension, number of ligatures per sitting, whether all masses are ligated together, anaesthetic choice and postoperative care all varied and were often implicit. Because cutting and healing depend jointly on tissue tension and on caustic load delivered per unit time, a study that changes the coating while leaving tension unstandardised cannot isolate a pharmaceutical effect. The converse also holds: *Ksharapatana* delivers a timed dose to a defined surface[8], which is more controllable than a ligature, yet it addresses grade I–II disease and cannot be compared directly with ligature studies in grade III–IV disease.

Outcome assessment diverges enough to foreclose pooling. Bleeding is graded on different scales; pain is sometimes a visual analogue score and sometimes a categorical *Vedana* grade; prolapse is a clinical grade, a measured distance or a proctoscopic impression; healing is time to separation, time to wound closure, or unrecorded. Follow-up ranges from four weeks to two months where stated and is unstated in six reports, so recurrence — the outcome on which the durability of any sphincter-preserving procedure turns — is effectively unmeasured, and the two reports claiming no recurrence did so within windows too short to detect it.[15,17] It is possible to say that several preparations have been used and that improvement was reported; it is not possible to say that any preparation performs better than another.

Safety, Complications and Clinical Considerations

Reported adverse events were minor and local. Burning during and immediately after *Ksharapatana* occurred in a few patients and was managed with *Takra* and topical *Yashtimadhu Ghrita*; transient watery discharge and slight oozing of dark blood were self-limiting.[8] Mild bleeding on defecation was commoner after *Durva*-coated ligation than after haemorrhoidectomy, whereas moderate bleeding predominated in the surgical group.[18] Anal stenosis, worsened anal hypotonia, incontinence, stricture and sepsis were expressly not observed in the ligation arms of several reports.[9,14,17,18], and no major complication or recurrence was recorded across 125 consecutive patients.[15]

These findings represent absence of detected harm in small, closely supervised series rather than evidence of safety: samples of this size cannot exclude uncommon events such as delayed stenosis, secondary haemorrhage or pelvic sepsis, and no report described prospective ascertainment. Theoretical risks — chemical injury to uninvolved anoderm, slough-related bleeding, and stenosis where multiple ligatures sit in a narrow canal — remain only partly addressed. Patient selection is therefore a clinical judgement: the reports support

consideration of *Ksharasutra* chiefly in grade II–III internal haemorrhoids with a defined pedicle, in patients who wish to avoid excision or where surgical facilities are limited. They do not support its use across all grades, and grade IV circumferential prolapse lies outside the range in which benefit has been demonstrated.[6,7] Competence in transfixation, in managing chemical burns and in structured follow-up to complete healing are prerequisites, and established pathways should remain the reference standard against which the technique is offered and audited.

Table 3. Gaps and recommendations for future research

Identified gap	Supporting evidence	Implication	Recommended research approach
Almost no direct comparison between preparations	A single 33-patient three-arm study [11], incompletely reported	No basis for preferring any preparation	Registered multi-arm trial with the standard thread as reference
Preparations not pharmaceutically characterised	No alkali concentration, coating mass, thread calibre or batch data [9,11,14,18]	Named preparations are not reproducible products	Minimum reporting set and batch analytics
Non-standardised outcome definitions	Different bleeding scales; pain as VAS or categorical grade [8,10,17,18]	Findings cannot be pooled or compared	Core outcome set for Arsha research
Short or unstated follow-up	4 weeks to 2 months where stated; unstated in six reports [9,11,12,14,15,16]	Recurrence and durability unmeasured	Minimum 12-month follow-up with scheduled proctoscopy
Small single-centre samples	Arms of 10–35; all reports from India, mostly single institutions	Imprecise estimates; limited generalisability	Multicentre design with sample-size justification
Weak allocation and blinding	Allocation method unclear in every comparative study; no blinding described	Risk of selection and detection bias	Randomisation with allocation concealment; blinded assessor
Passive safety reporting	No predefined definitions or prospective ascertainment [15,17]	Uncommon harms cannot be excluded	Predefined adverse-event definitions; active surveillance
No patient-reported or functional outcomes	No validated satisfaction, continence or quality-of-life instrument in any report	Patient priorities unmeasured	Incorporate validated continence and quality-of-life measures
No economic evaluation	Low cost asserted without costing data [9,10]	Cost advantage unquantified	Prospective cost-effectiveness alongside a comparative trial

Research Gaps and Future Priorities

Gaps identified from the charted evidence are summarised in Table 3. The most consequential is the near-absence of direct comparison: a single 33-patient three-arm study, incompletely reported, constitutes the whole comparative literature on preparations.[11] Equally limiting is the absence of standardisation data, which prevents replication and any defensible equivalence argument. Group sizes of 10 to 35, single-centre recruitment, unclear allocation, absent blinding, non-standardised grading and follow-up of weeks to two months mean that published studies function as feasibility and safety signals rather than effectiveness evidence.

Three priorities follow: a minimum reporting set for *Ksharasutra* preparation (alkali source and concentration, coating sequence and number, thread specification, batch analysis), so that a named preparation denotes a defined product; a core outcome set for *Arsha* research comprising bleeding, prolapse grade, validated pain measurement, time to healing, recurrence at twelve months, continence and a patient-reported measure; and adequately powered, registered, multicentre comparative trials, initially between the standard *Apamarga* thread and one well-characterised modification, with haemorrhoidectomy or rubber band ligation as active comparator for the question of positioning. Cost and equity implications deserve study, since low cost is advanced as a principal advantage without economic analysis.[9,10]

Discussion

This mapping yields a clear if unflattering picture. *Ksharasutra* has been used in *Arsha* for decades, the conventional Apamarga thread is described consistently, and several modifications have been introduced; yet the literature has not moved far beyond showing that the procedure can be performed with acceptable short-term morbidity in selected patients. The direction of effect is uniformly favourable, but designs of this kind cannot separate a specific effect of the thread from regression to the mean, co-intervention or the natural history of a fluctuating symptom. That is not a reason to dismiss the technique; it is a reason to describe the evidence accurately, which much secondary writing does not.

The link between pharmaceutical variation and outcome is the central unresolved question. A modified coating is introduced on a mechanistic rationale — *Durva* for wound healing and analgesia, *Guggulu* for anti-

inflammatory effect, *Udumbara* for haemostatic and astringent properties — and the report then shows rapid healing and low pain. Without a concurrent standard-thread arm, such observations are equally compatible with the performance of the conventional thread, which also reports healing within two to three weeks and minimal pain.[9,14,17] The one study designed to separate preparations is too small and too sparsely reported to decide the question.[11] In-vitro antimicrobial or wound-healing activity does not translate into clinical advantage in a ligature whose principal action is mechanical strangulation with chemical debridement; conflating the two is the commonest reasoning error in this field.

Two structural features shape what can be concluded. First, the much larger fistula literature has colonised the haemorrhoid question: unit cutting time has no counterpart in *Arsha*, and threads validated in fistulous tracks have been carried to pile pedicles without separate evaluation, a transfer the present search found largely undocumented.[11,19] Second, most reports appeared in Ayurvedic journals with limited indexing and variable peer review, several as short case reports; a scoping review inherits those limitations, and the absence of retrieved negative or null studies may reflect editorial preference as much as clinical reality. The contribution of this review is therefore cartographic: the evidence base comprises a small number of small studies clustered around one preparation, modifications are described but not compared, outcomes cannot be synthesised, and safety reporting is passive. These findings justify, and specify, the next generation of studies; they do not justify a claim that any preparation is superior, better tolerated or more durable than another.

Limitations of the Review

This is a preliminary evidence map, not a completed systematic scoping review. The search combined general web search, a scholarly engine and journal portals; records were not exported to a reference manager, so overlap was not quantified, de-duplication was not performed, and the count of 171 surfaced records is not a de-duplicated yield. A single reviewer screened and charted, without a second reviewer or arbitration, and the search was executed with AI assistance in one pass rather than by a standing review team. Scopus, Web of Science and the Clinical Trials Registry–India were not searched directly. Seven included reports were charted from abstracts or record metadata, and for one the author list and volume were taken from indexing metadata rather than the publisher's page. No risk-of-bias assessment was undertaken, grey literature and non-English publications were not systematically sought, and publication bias could not be examined. Numbers in Figure 1 derive solely from the search log.

Conclusion

Clinical evidence on *Ksharasutra* preparations in *Arsha* is available but thin. Eleven reports, all from India and mostly single-centre, describe the conventional *Apamarga*-based thread and a few modifications, used either as transfixation ligatures or as topical *Kshara*. Favourable short-term changes in bleeding, pain and prolapse are consistently reported, with minor local adverse events and no major complications in the published series. The evidence does not permit comparison between preparations, because almost no direct comparative data exist, preparations are not pharmaceutically characterised, outcomes are not standardised and follow-up is too short to assess recurrence. Standardised preparation and outcome reporting, and registered comparative trials with active conventional comparators, are the necessary next steps before any preparation can be recommended over another.

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Conflicts of Interest- Not Any

Reference

1. Sushruta. Sushruta Samhita, Chikitsa Sthana, Chapter 6 (Arsha Chikitsa). [Classical text; cited at chapter level. Edition consulted: Varanasi: Chaukhambha Orientalia.]
2. Charaka. Charaka Samhita, Chikitsa Sthana, Chapter 14 (Arsha Chikitsa). [Classical text; cited at chapter level. Edition consulted: Varanasi: Chaukhambha Krishnadas Academy.]
3. JBI. Scoping reviews. In: JBI Manual for Evidence Synthesis. Adelaide: Joanna Briggs Institute; 2024. doi:10.46658/JBIMES-24-09
4. Peters MDJ, Godfrey C, McInerney P, Munn Z, Tricco AC, Khalil H. Updated methodological guidance for the conduct of scoping reviews. JBI Evid Synth. 2020;18(10):2119–26. doi:10.11124/JBIES-20-00167
5. Tricco AC, Lillie E, Zarin W, O'Brien KK, Colquhoun H, Levac D, et al. PRISMA extension for scoping reviews

(PRISMA-ScR): checklist and explanation. Ann Intern Med. 2018;169(7):467–73. doi:10.7326/M18-0850

6. van Tol RR, Kleijnen J, Watson AJM, Jongen J, Altomare DF, Qvist N, et al. European Society of Coloproctology: guideline for haemorrhoidal disease. Colorectal Dis. 2020;22(6):650–62. doi:10.1111/codi.14975
7. Rubbini M, Ascanelli S. Classification and guidelines of hemorrhoidal disease: present and future. World J Gastrointest Surg. 2019;11(3):117–21.
8. Dudhamal TS, Gupta SK, Bhuyan C, Singh K. The role of Apamarga Kshara in the treatment of Arsha. Ayu. 2010;31(2):232–5. doi:10.4103/0974-8520.72406
9. Gupta ML, Gupta SK, Bhuyan C. Comparative clinical evaluation of Kshara Sutra ligation and hemorrhoidectomy in Arsha (hemorrhoids). Ayu. 2011;32(2):225–9.
10. Sudarmi K, et al. Comparative clinical study of Apamarga Kshara application, infrared coagulation and Arshohara Vati in the management of Arsha (1st and 2nd degree hemorrhoids). Ayu. 2017. doi:10.4103/ayu.AYU_36_17
11. Saxena V, Singh L. Evaluation of three different types Kshara Sutra ligation in Arsha roga (hemorrhoids). J Nat Remedies. 2018;18(4):143–50.
12. Kapadiya M, Dudhamal TS. Role of Kshara Sootra in complicated cases of Arsha (interno-externo haemorrhoids) — a case series. J Ayurveda Campus. 2020.
13. Khattra RS. Effect of Ksharsutra in the management of Arsha — a case study. J Ayurveda Integr Med Sci. 2023;8(8):216–21. doi:10.21760/jaims.8.8.33
14. Swami S, Sharma VD. A case report: Ksharsutra ligation treatment for Arsha. Int Res J Ayurveda Yoga. 2023;6(8):23–6. doi:10.47223/IRJAY.2023.6804
15. Sharma HR, Sharma S, Sharma D, Sharma M. Clinical efficacy of Ksharasutra in haemorrhoids: a prospective observational study from a specialized anorectal center in Himachal Pradesh. J Clin Case Pract. 2025;11(12):59–66.
16. Barange P, Kumar A, Parashar I. Comparative clinical study to evaluate the effect of Apamarga Kshara Sutra and Agnikarma in Arsha w.s.r. to interno-external haemorrhoids. J Ayurveda Integr Med Sci. 2025;10(2):32–4. doi:10.21760/jaims.10.2.6
17. Gupta DK, Gupta S, Khan MM. A clinical study on the management of Arsha (haemorrhoids) with Ksharsutra therapy (title as indexed). Int J AYUSH Case Rep. 2026.
18. Mohan V. A clinical study to evaluate the tissue repair efficacy of Durva (Cynodon dactylon (L.) pers) powder-coated Ksharasutra ligation in the management of hemorrhoids. J Ayurveda Integr Med Sci. 2026;11(2):81–7.
19. Lobo SJ, Bhuyan C, Dudhamal TS, Gupta SK. A comparative clinical study of Snuhi Ksheera Sutra, Tilanala Kshara Sutra and Apamarga Kshara Sutra in Bhagandara (fistula in ano). Ayu. 2012;33(1):85–91. doi:10.4103/0974-8520.100319

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