फेब्रुवारी २०२४

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आयुर्विद्या

ISSN - 0378 - 6463

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ISSN - 0378 - 6463

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ISSUE NO. - 9 **FEBRUARY - 2024**

PRICE Rs. 25/- Only.

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राष्ट्रीय शिक्षण मंडळाच्या शताब्दी वर्ष पूर्ततेनिमित्त अनंत शुभेच्छा!

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- An Integrated Approach To Rheumatology

"**AYURVIDYA**" Magazine is printed at 50/7/A, Dhayari - Narhe Road, Narhe Gaon, Tal. - Haveli, Pune -41 and Published at 583/2, Rasta Peth, Pune 11.
By Dr. D. P. Puranik on behalf of Rashtriya Shikshan Mandal, 25, Karve Road, Pune 4.

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"AYURVIDYA" MAGAZINE Subscription Rates : (Revised Rates Applicable from 1st Jan. 2014)
For Institutes -Each Issue Rs. 40/- Annual :- Rs. 400/- For 6 Years :- Rs. 2,000/-
For Individual Persons - For Each Issue :- Rs. 25/- Annual :- Rs. 250/- For 6 Years :- Rs. 1,000/-
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संपादकीय

उदात्त आणि प्रशंसनीय

डॉ. दि. प्र. पुराणिक

अलीकडे वैद्यकीय क्षेत्राशी संबंधित अनेक बातम्या ह्या क्षेत्राबद्दल घृणा अथवा अप्रिती निर्माण करणाऱ्या असतात. निष्काळजीपणामुळे मृत्यू, डॉक्टर्सची लाचखोरी, भ्रष्टाचार, डॉक्टर्सकडून पेशंटची लुबाडणूक अशा प्रकारच्या बातम्यांमुळे एरवी वैद्यकीय व्यवसायाबद्दल असलेली समाजाची उदात्त, आदराची भावना तसेच डॉक्टर हा परमेश्वर असल्याची भावना एका क्षणात लोप पावते आणि परमेश्वराच्या ठिकाणी असलेला डॉक्टर हा 'दानव' भासू लागतो. त्याचबरोबर वैद्यकीय व्यवसाय, रुग्णालये ही रुग्णांची लुबाडणूक करुन 'नागवी' करणारी केंद्रे भासू लागतात.

ह्या पार्श्वभूमीवर नुकत्याच झळकलेल्या 'दोघांच्या अवयवदानातून सात रुग्णांना जीवदान' ह्या बातमीने जनमत सुखावले नसते तरच नवल! महाराष्ट्रातील सातारा शहरात अकरा वर्षांचा मुलगा आणि पंचावन्न वर्षांच्या पुरुषाचे अपघाती निधन झाले. दोन्ही दुर्दैवी जीवांच्या मेंदूचे कार्य पूर्ण थांबल्याचे निष्पंन्न (Brain Dead) झाले. मृत्यू झालेल्या रुग्णालयातील तज्ज्ञ डॉक्टर्सनी परिस्थितीचे गांभीर्य ओळखून मुलाच्या पालकांना व सदर मृत पुरुषाच्या नातेवाईकांना अवयव दानाबद्दल (Organ Donation) सविस्तरपणे समजावून सांगत समुपदेशन केले. कार्यरत असलेल्या अवयव दानामुळे काही व्यक्तींचे प्राण वाचणार असून त्यांना नवीन आयुष्य लाभणार असल्याचे पटवून दिले. अवयवदानामागील उदात्त भावना नातेवाईकांना पटवून देण्यात सदर तज्ज्ञ डॉक्टर्स यशस्वी ठरले.

लहान मुलाचे एक मूत्रपिंड (Kidney) लष्करी रुग्णालयातील रुग्णावर प्रत्यारोपित केले तर दुसरे मूत्रपिंड सिंबायोसिसच्या हॉस्पिटलमधील गरजू रुग्णास प्रत्यारोपित केले. तसेच हृदय डॉ. डी. वाय. पाटील रुग्णालयातील गरजू रुग्णावर प्रत्यारोपित केले.

दुसऱ्या ब्रेन डेड रुग्णाचे एक मूत्रपिंड मणिपाल रुग्णालयातील (बाणेर) गरजू रुग्णावर प्रत्यारोपित केले तर दुसरे मूत्रपिंड डॉ. डी. वाय. पाटील रुग्णालयातील गरजू रुग्णावर प्रत्यारोपित केले. दान केलेले यकृत (Liver) सह्याद्री रुग्णालयातील (हडपसर) रुग्णावर प्रत्यारोपित (Transplant) केले आणि हृदय हे एम. जी. एम. रुग्णालय (चेन्नई) येथील गरजू रुग्णावर प्रत्यारोपित केले.

एकूणच दोन व्यक्तींच्या (Brain Dead) अवयवदानामुळे सात गरजू रुग्णांना (Recipient) नवजीवन प्राप्त झाले. यामध्ये मृत व्यक्तींचे नातेवाईकांनी अतिशय अवघड परीस्थितीत घेतलेला अवयवदानाचा निर्णय, त्यामागची उदात्त भावना अत्यंत वाखाणण्याजोगीच म्हटली पाहीजे. तसेच समुपदेशक आणि संबंधित तज्ज्ञ व कुशल डॉक्टर्स यांची भूमिका व तत्परतेने घेतलेले निर्णय व केलेले प्रत्यारोपणाचे शस्त्रकर्म तितकेच महत्त्वाचे आहे. म्हणूनच सर्व अंतर्भूत घटकांचे अभिनंदन!

या निमित्ताने समोर आलेल्या झोनल ट्रान्सप्लांट कमिटीच्या अहवालानुसार पुणे, मुंबई, नागपूर व संभाजीनगर यामध्ये पुणे झोन अवयवदानात अग्रेसर ठरले असून महाराष्ट्रात सन २०२३ मध्ये एकूण १४८ अवयवदानात पुणे झोनमध्ये सर्वात जास्त म्हणजे ५८ अवयवदानाची संख्या आहे. ही बाबदेखील प्रशंसनीय म्हटली पाहीजे. या घटनेच्या निमित्ताने अवयवदानाचे महत्त्व पुनश्च अधोरेखीत झाले आहे.

जगातील पहीले अवयवदान श्री. रोनल ली एरीक यांनी सन १९५४ साली केले. जुळ्या भावाला त्यांनी आपले एक मूत्रपिंड दिल्याची नोंद आहे. त्यानंतर अनेक देशांत अवयवदानाची प्रक्रीया सुरु झाली आणि आता ही जागतिक चळवळ झाली आहे. जागतिक पातळीवर १३ ऑगस्ट हा दिवस दरवर्षी "World Organ Donation Day" म्हणून पाळला जातो. तर भारतात ३ ऑगस्ट हा दिवस "Organ Donation Day" म्हणून संपन्न होतो. अवयवदानाचे महत्त्व आणि जनजागृती करणे आणि त्याबद्दल सामान्यांमध्ये असलेल्या भ्रामक कल्पना दूर करणे असा त्याचा उद्देश असतो.

भारतात "अवयवदान" चळवळीत तमिळनाडू व आंध्र प्रदेश अग्रभागी आहेत. इतरही राज्ये या चळवळीत सहभागी होत असून त्याचे दृष्य परीणाम आता दिसत आहेत. सर्वच वैद्यकीय व्यवसायीकांनी या चळवळीत सामिल होवून ती यशस्वी करणे हे प्रत्येकाचे कर्तव्य आहे हे निश्चितपणे म्हणावेसे वाटते.

Randomized Controlled Clinical Trial Of Shunthyadi Kwatha And Eranda Sneha In The Management Of Margavrodhajanya Sandhigatvaat

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Introduction - Sandhigatvaat is a common diagnosis in everyday practice and can be differentiated in 2 varieties based on the pathogenesis like Dhatukshayjanya and Margavrodhajanya Sandhigatvaat. Out of which Margavrodhajanya Sandhigatvaat is a prevalent issue in society, primarily affecting joints, causing intense pain, inflammation, and disability. Described as Amajanya vyadhi[1] in classical texts, it tends to manifest at a relatively young age, with females being more susceptible than males. Modern lifestyle and dietary changes contribute significantly to various diseases such as diabetes, hypertension, obesity, and rheumatoid arthritis. Some conditions, like Marga varodhajanya Sandhigatvaat, pose challenges in treatment, where Ayurveda has demonstrated its efficacy convincingly.

According to Charaka, when Vata affects the bones (Asthi), it results in painful joint swelling and immobility. The Sushruta Samhita adds that, in Vatavyadhi disorders, joints not only experience inflammation, immobility and pain but also deform over time.

According to the clinical features, Margavrodhajanya Sandhigatvaat very closely resembles with clinical features of rheumatoid arthritis. Rheumatoid arthritis is a chronic, progressive autoimmune arthropathy and characterized by bilateral symmetrical involvement of joints with systemic clinical features.[5,6] This disease affects mainly young population and the patients are gradually crippled physically as well as mentally due to bad prognosis of the disease.[7] Maharshis also highlight this by describing symptoms like Jadyata, Sankocha and Khanja etc which correlated with deformities.[8] Hence it is a most burning problem in the society, needing the reliable, long-lasting, effective treatment or medicine for these conditions achieved through this study.

Aim : To study the efficacy of Shunthyadi kwatha and Eranda sneha in the management of Margavrodhajanya Sandhigatvaat.

Objectives : Comparison between the effectiveness of Shunthyadi kwatha with Eranda Sneha in the treatment of Margavrodhajanya sandhigatvaat.

Material and Methods : The Bruhattrayi and Laghuttrayi, modern textbooks, journals and online databases like PubMed, Dhara, Google Scholar etc were reviewed for this purpose.

Study Groups : Randomized controlled clinical trial.

Sample size : 100 (50 in each group)

Study design: The selected patients were divided into two groups.

Group-A (Trial Group)- 50 cases were treated with Shunthyadi Kwatha.[3]

Group-B (Control Group)- 50 cases were treated with Eranda sneha.[4]

Inclusion Criteria : 1) Patients suffering from symptoms since more than 6 months. 2) Age from 19-60yrs, both sexes. 3) No complications like joint deformities, RHD present.

Exclusion Criteria : 1) Patients of age group <19 yrs and >60yrs. 2) STD, Infectious disease, Stroke, Cardiac disorders. 3) Steroid dependent patients.

Subjective and Objective parameters : Generalized symptoms mentioned in samhitas like Sandhishoola, shotha etc.

Assessment Criteria : In the present trial, age, sex etc. demographic parameters were analyzed. The assessment was analyzed on subjective tests using Wilcoxon signed rank method. Comparison of efficacy was done using Mann-whitney U test in subjective parameters. Statistical analysis on the percentage of improvement in each parameter willevaluate by

the formula: Average BT Average AT * 100/Average BT.

Table 1: Grading system adopted for Assessment

Sr. No.	Parameter	Description	Grade
1.	Shoola	No pain	0
		Mild pain during movement	1
		Pain even at rest	2
		Unable to move body parts due to pain	3
2.	Sandhi-shoth	No swelling	0
		Slight swelling	1
		Moderate swelling	2
		Severe swelling	3
3.	Sandhi-graha	Nil	0
		Stiffness only in early morning	1
		Prolonged stiffness for 2 hours	2
		Stiffness restricts daily routine	3
4.	Agni-mandya	Absence of indigestion	0
		Feeling hungry 8 hrs after intake of food	1
		Feeling hungry 12 hrs after intake of food	2
		Feeling hungry 24 hrs after intake of food	3
5.	Angagaurav	Nil	0
		Angagaurava but can carry out daily work	1
		Angamarda restricting daily work	2
		Unable to do daily work	3
6.	Aruchi	Equal willing towards all food substances	0
		Willing towards some specific food	1
		Willing towards only 1 rasa	2
		Willing towards only most liking food	3
7.	Jwara	No fever	0
		Jwaralakshana without rise in temp.	1
		Jwaralakshana up to 100'F	2
		fever above 100'F	3
8.	Alasya	No feeling of laziness	0
		Daily work does satisfactorily but delayed	1
		Daily work does unsatisfactorily and delayed	2
		Reduced work due to unenthusiasm	3
9.	Angamarda	Nil	0
		Angamarda but able to do daily routine	1
		Angamarda restricts daily routine	2
		Cannot move due to angamarda	3
10.	Dourbalya	Nil	0
		Can carry out daily activities	1
		Disturbed daily activities	2
		Unable to carry out daily activities	3
11.	Bahu-mutrata	Nil	0
		Increased frequency of micturition	1
		Increased frequency of micturition at day time	2
		Increased frequency of micturition even at night	3
12.	Utsahahani	Nil	0
		Does daily work without interruption	1
		Reduced daily work	2
		Unable to do any work	3
13.	Nidra-viparyaya	Nil	0
		Disturbed sleep	1
		Frequent disturbed sleep	2
		Unable to fall asleep	3

Drug intervention :

Trial drug : Shunthyadi kwatha (Chakradatta, Amavatadhikara25/9)

• Ingredients : Shunthi (Zingiber oficinale) and Gokshur (Tribullus terrestris) - each equal quantity mix with water in 1:16 ratio and heat until liquid remain 1/8th part.

• Dose : 40ml Kwatha once a day with lukewarm water in Rasayana kaal.

• Route of Administration : Oral

Control drug : Eranda Tail (Riccinus communis)(Nighantu Tailvarga, 23-25)

• **Dose :** 10ml once a day with lukewarm water in Abhakta kaal.

• Route of administration : Oral
Duration of study : 1 year
Follow up : every 7th day

Observation and Results - (See Table 2)

Mann Whitney U Test is carried out for comparison between Group A and Group B. From above table, we can observe that, P-Value for almost parameters is less than 0.05. Hence, we can conclude that, there is significant difference between Group A and Group B.

Further, we can observe that, mean rank for Group A is greater than Group B. Hence, we can conclude that, effect observed in Group A is better than Group B.

Table 2: Comparison between Group A and Group B

Variable	Group	No. Of Patients	Mean Rank	Sum of Ranks	Mann-Whitney U	P-Value
SHOOLA	Group A	50	58.09	2904.50	870.500	0.00037
	Group B	50	42.91	2145.50		
	Total	100				
SANDHISHOTHA	Group A	50	58.00	2900.00	875.000	0.00199
	Group B	50	43.00	2150.00		
	Total	100				
SANDHIGRAHA	Group A	50	57.40	2870.00	905.000	0.00195
	Group B	50	43.60	2180.00		
	Total	100				
AGNIMANDYA	Group A	50	57.00	2850.00	925.000	0.00012
	Group B	50	44.00	2200.00		
	Total	100				
ANGAGARURVA	Group A	50	56.70	2835.00	940.000	0.00846
	Group B	50	44.30	2215.00		
	Total	100				
ARUCHI	Group A	50	58.78	2939.00	836.000	0.00077
	Group B	50	42.22	2111.00		
	Total	100				
JWAR	Group A	50	55.00	2750.00	1025.000	0.02609
	Group B	50	46.00	2300.00		
	Total	100				
ALASYA	Group A	50	55.99	2799.50	975.500	0.02933
	Group B	50	45.01	2250.50		
	Total	100				
ANGAMARD	Group A	50	54.26	2713.00	1062.000	0.03138
	Group B	50	46.74	2337.00		
	Total	100				
DORBAULYA	Group A	50	63.50	3175.00	600.000	0.00000
	Group B	50	37.50	1875.00		
	Total	100				
BAHUMUTRATA	Group A	50	48.50	2425.00	1150.000	0.36121
	Group B	50	52.50	2625.00		
	Total	100				
UTSAHAHANI	Group A	50	58.66	2933.00	842.000	0.00087
	Group B	50	42.34	2117.00		
	Total	100				
NIDRAVIPARYAYA	Group A	50	56.60	2830.00	945.000	0.00032
	Group B	50	44.40	2220.00		
	Total	100				

Discussion : % Relief in Patients : As per the findings of table no. 2, In Group A, 25 patients showed marked improvement, 25 patients have shown Moderate improvement. In Group B, 18 patients have shown Mild improvement, 27 patients show moderate improvement, 05 patients have shown marked improvement.

% Relief in Symptom: As per the findings of table no. 2, Sandhishoola, Sandhishoth, Aruchi, Dourbalya and Utsahahani symptoms of Amvata show significant relief while Sandhigraha, Jwara, Alasya, Bahumutrat were insignificant.

Hence according to average % relief, Shunthyadi kwatha is more effective than Eranda sneha in Margavrodhajanya sandhivaat.

Conclusion : The results presented in this article shed light on the clinical impact of Shunthyadi Kwath and Eranda Sneha, offering evidence-based considerations for their integration into contemporary healthcare practices. This research addresses a critical gap in existing literature, providing a foundation for further exploration and discussion on Ayurvedic interventions in the context of modern rheumatological disorders. Through this study we are able to state that Shunthyadi kwatha is better and more significant in treating Margavrodhajanya Sandhivaat.

References :

1) Tripathi B, editor. Madhav Nidana of Madhavkar. Vol. 1. Ch. 25, Ver. 2. Varanasi: Chaukhabha Sanskrit Sanshtan; 2006. p. 571.

2) Sharangdhar Samhita, Bramhanand Tripathi, Purva Khand, chapter 5, ChaukambaPrakshan Varanasi, 2nd Edition 1994, shlok no 46. Page no. 23.

3) Chakradatta by GangavishnuShrikrushnadas, AamvatChikitsa 09, Page no.185

4) Bhavaprakasha Samhita, Vd.Bramhashankara Mishra, Madhyam khand, Taila varga, Chaukamba Sanskrit sansthan Varanasi, shlok no.23-25, Page no 61.

5) Ian Penman et al, editor. Davidson's principle of Internal Medicine, Clinical features of RA, chapter-24., Elsevier Health Sciences; 24th edition (30 April 2022); P. 1002-1003.

6) J.Larry Jameson, Anthony S. Fauci et al, editor. Harrison's Principles Of Internal Medicine, chapter 313, McGraw Hill Education; Twentieth edition (2018) P. -1880

7) Rohini Handa, Pre-clinical Rheumatoid Arthritis - Identification and Implication, P 171-172, https://apiindia.org/uploads/pdf/medicine_update_2017/mu_037.pdf

8) Tripathi B, editor. Madhav Nidana of Madhavkar. Madhukosha, Commeted by Vijay rakshikta, Reprint Ed. Vol. 1. Ch. 25, Ver. 6-10. Varanasi: Chaukhabha Sanskrit Sanshtan; 2006. p. 572.

A Concept Paper On - Assessment Of Disease Severity In Amavata - An Integrative Approach

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Introduction - Joint disorders are highly prevalent and are the most common conditions for which patients visit Ayurveda practitioners. Ayush (NAMASTE Portal) records show that highest number of patients attending out-patient departments are those of sandhigatavata (766 thousand till December 2023). Amavata (over 103 thousand cases) is the 12th most common condition with over one lakh cases till date. These conditions are a leading cause of disability and resultant low quality of life in the affected population. Most common conditions described in contemporary medicine are osteoarthritis (OA), rheumatoid arthritis (RA), gout, viral arthritis and spondarthritis (SpA). The prevalence of RA ranges from 0.28% to 0.70%.[1] Untreated RA leads to joint deformities, disability, systemic complications, and affects psychological wellbeing.

The diagnosis of RA, a prototype of amavata, is based on the classification criteria laid down by American College of Rheumatology (ACR)

and European League Against Rheumatism (EULAR) and its activity is assessed by various validated scores such as DAS-28 (Disease Activity Score, 28 joints) and CDAI (Clinical Disease Activity Index).Assessment of disease activity is necessary for planning therapy and for assessment of response to therapy during subsequent follow-up visits.

The general concept of assessment of severity of a disease is described in Ayurvedic texts though it is not specified for individual diseases. Therefore, it is essential to develop validated tools for evaluation disease severity for each condition based on Ayurvedic descriptions.

Severity of a disease (Vyadhibala) - Assessment of disease severity (vyadhibala) is necessary for planning the management because an aggressive management is required in a severe disease. A mild drug may not be effective in a severe disease and an aggressive management can lead to adverse effects in a mild disease.[2] A sukh-sadhya disease is one with mild etiological factors and clinical features without any complications. Kruchra-sadhya disease is characterized by medium-grade causative factors and clinical features. Other factors such as region (desh), kala (season), number of vitiated doshas, deranged systems (dooshya), dosha-gati, chronicity of the disease, and bala (strength) of the patient are also important in deciding the possibility of good therapeutic response in a particular patient.[3] However, it is evident that all these factors together contribute to the severity of clinical features. Thus, severity of clinical features needs to be evaluated for an objective assessment of disease severity. There is a need to develop a comprehensive tool for assessment of disease severity in amavata considering the classical descriptions.

Assessment of Ama - Ama was assessed in 100 patients of amavata (RA in 86 patients)with disease duration (DD) of < 6 months (n = 13), 6-12 months (n = 9), and > 12 months (n = 64). All features of ama as described by Vagbhata were found in more than 70% patients except malasanga in those with DD < 6 months, apakti and nishthiv in those with DD 6-12 months and gaurav and apakti in those with DD > 12 months.[4]

32 patients of amavata were assessed for 14 features of ama graded as 0-3 (maximum score 42). Fever, joint pains, body ache, coated tongue, and abnormalities seen at stool examination were additional features. 18.7% patients were found to be nirama (score 0-7), whereas 65.6% and 15.6% patients had moderate (score 8-14) and severe (score 15-21) ama involvement respectively.[5]

A validated instrument for assessment of severity of systemic features of ama in amavata (RA) has been recently developed.[6] This instrument consists of 10 clinical features finalized by 10 expert clinicians from a list of 21 features. Clinical validation of this instrument was carried out in 79 RA patients diagnosed as per ayurvedic and ACR criteria. The ama score reduced during monthly follow up visits for 3 months though the DAS-28 score did not show any significant improvement.

The clinical features of amavata as described in Madhavnidan[7] and the features used for ama assessment by the above-mentioned studies are tabulated here (Table 1). Aruchi and balabhransha are the only common feature in these three studies. Five of these 24 features viz. srotorodha, alasya, klama, gourav, and apakti are included in two studies. The remaining 17 features are included in a single study. The clinical features of amavata described in Madhavnidan may be considered as prodromal features (purvarupa) because involvement of joints is mentioned in severe (pravruddha) form of the disease. It is important to note that balabransha, aalasya, sadan, gourav, and klama appear to indicate asingle progressive pathological process. Coated tongue, though widely used as an indicator of ama-avastha, is not mentioned in any of the classical texts. Moreover, it is difficult to clinically evaluate srotorodha based on answer provided by the patient to the question "Do you feel any stiffness in your body/body parts these days?"

Assessment of joint involvement - Examination of joints for swelling and tenderness is an integral part of disease activity assessment in contemporary rheumatology practice. The activity score is higher if a greater number of joints are involved. The joints that are counted can be 28, 44, or 68 in number. The commonly practiced DAS-28 and CDAI scores include examination of proximal interphalangeal (PIP), metacarpo-phalangeal (MCP), interphalangeal

Table 1. The features for assessment of ama in amavata alongwith the classical features of amavata

Features of Ama	Saini, Byadagi[4]	Renu K, Tiwari [5]	Pandey,Rastogi [6]	Madhav[7]
Srotorodha (obstructed channels) Stiff body	+		+	
Balabransha (weakness)/ Lack of energy	+	+	+	
Aalasya (laziness)*	+		+	+
Sadan (feeling tired) Klama (fatigue)/Sleep whole day	+	+	+	
Gourav (heaviness)*	+		+	+
Anilmoodhata (diminished vata movement)	+			
Apakti (indigestion)	+	+		+
Nishthiv (salivation)*	+			
Malasanga (constipation)*	+	+		
Aruchi (tastelessness)/Dislike food*	+	+	+	+
Arati (restlessness/distress)			+	
Udar guruta (heaviness of abdomen)			+	
Shoth			+	+
Trushna (thirst)*				+
Fever		+		+
Headache		+		
Vedana/ Angamarda (Body aches)		+	+	+
Pain in joints		+		
Coated Tongue		+		
Watery stool		+		
Stool has pungent smell		+		
Sticky stool		+		
Stool sink in water		+		

*Included in features of severe (pravruddha) amavata

(IP), wrist, elbow, shoulder, and knee joints on right and left sides. Ankles, metatarsophalangeal (MTP), sternoclavicular (SC) and acromio-clavicular (AC) joints are included in 44-joint counts. 68-joint examination includes distal interphalangeal (DIP), hip, tarsal, toe PIP, and temporomandibular (TM) joints in addition to the above-mentioned joints. Swelling at hip joint cannot be assessed by palpation. Hence, it is known as 66/68 joint count (66 swollen, 68 tender). Most of these scores also include inflammatory markers (ESR or CRP) and assessment of global disease activity by patient as well as by the provider. However, there are many difficulties in interpretation of patient reported outcome measures. Low joint count but high patient global assessment is possible due to unrelated symptoms (e.g., back pain, headache, fibromyalgia), fatigue, joint damage and secondary OA, a single joint with severe pain, and a combination of these factors.[8] A similar problem is possible when ama assessment is based on a questionnaire filled in by the patient.

Pain and swelling of joints along with various other symptoms are described as features of severe (pravruddha) amavata in Madhav-nidana. In clinical practice, the most important diagnostic feature of amavata is painful swelling of joint/s. Hand, feet and head joints along with ankle, sacrum, knee and hip joints are affected in severe amavata.[9] Other complications of severe amavata include contractures of joints and crippling deformities.[10] The joints in skull are sutures (tunna-sevani) and do not contain sheshmadhara-kala (synovial membranes).[11] These joints are not known to be affected in RA. We, therefore, need to examine TM and

atlantoaxial (AA) joints that can be affected in inflammatory arthritisas representatives of shira (head). Sacroiliac (SI) joint (Trik) is another important joint from ayurvedic descriptions though it is affected in another type of inflammatory arthritis viz. SpA (e.g., ankylosing spondylitis) and not in RA. AA and SI joints cannot be palpatedand hence, they cannot be assessed for swelling. We need not include SC and AC joints as the joints of chest are not mentioned in classical descriptions.

Thus, we need to examine 61 swollen (excluding hips, SI and AA joints) and 65 tender in every case of amavata.[12] Higher number of tender and swollen joints will indicate a more severe disease. Swelling indicates ongoing inflammation. Hence, deformed painful joints without swelling do not indicate active disease. Deformities without inflammation do not require aggressive therapeutic interventions and may need surgical correction.

Composite Assessment Instrument - We need to combine ama assessment instrument with joint examination for swelling and tenderness. We can also add patient and physician global assessments to these measurements. The severity index can then be calculated as follows:

Amavata Severity Index (ASI) = (maximum score = 246)

Ama score (0-100) + Joint count (65T + 61Sw) + Patient Global (0-10) + Physician Global (0-10)

Such a score needs to be validated in sufficient number of patients for regular use in clinical practice. We will then be able to classify the disease severity as mild, moderate and severe in each patient of amavata.

Conclusion - Amavata is a common condition leading to joint deformities and disability. Its severity needs to be assessed in every patient for planning of management and for evaluating the efficacy of treatment during follow-up visits. A simple clinical tool would be useful for management decisions regarding maintaining, changing or adding treatment regimens to achieve the desired target of low disease activity or remission. Such a tool is also essential in research to quantify clinical features in each case. However, it requires training of practitioners in clinical examination of joints for swelling and tenderness. Formulation of a severity index for patients with amavata is suggested here by integrating the classical description in Ayurveda and contemporary rheumatology practice. Similar instruments can be formulated in grahani, atisar, pandu, kamala, udar, shwasa, and other conditions.

Funding : none Competing interest : none

References - 1) Handa R, Rao URK, Lewis JFM, et al. Literature review ofrheumatoid arthritis in India. Int J Rheum Dis [Internet]. 2016;19(5):440-451.

2) Acharya JT (Ed) (7th Ed).Sushrut Samhita of Sushrut, SutrasthanSamshodhan-samshamaniya Adhyaya: Chapter 39 Verse 10. Varanasi: Choukhamba Orientalia, 2002; p. 172

3) Acharya JT (Ed). Charak Samhita by Agnivesh, Sutrasthan, MahachtushpadAdyaya: Chapter 11 Verse 11-16. New Delhi, Chaukhamba Publications, 2018; p. 66

4) Saini N, Byadagi PS. Clinical and scientific evaluation of Amavata. Int. J Ayu. Pharmacy. 2014; 5(5): 587-593

5) Kumari R, Tiwari S. Validation & Assessment of Aam and Agni in Aamvata with itsNidanatmak Study. Int Ayu Med J. {online}2022 {cited July 2022}Available from: http://www.iamj.in /posts/images /upload/ 1718_1725.pdf

6) Pandey P, Rastogi S, Lawrence A, Agrawal GG. Development and validation of an ama instrument for assessing the disease activity on the basis of constitutional features in Amavata (Rheumatoid Arthritis). J Ayurveda Integr Med [Internet]. 2023; 14(2):100689. Available from: http://dx.doi.org /10.1016/j.jaim.2023.100689

7)Upadhaya Y, Editor. Madhavnidanam of Madhavkar, Amavatnidanam Adhaya, Chapter 25, Verse 6. Varanasi: Chaukhamba Prakashan, 2021; p 511.

8) Felson D, Feathers V, Naik C, et al. Meaning of patient global assessment when joint counts are low in rheumatoid arthritis. RMD Open 2022;8:e002346. doi:10.1136/rmdopen-2022-002346

9)Upadhaya Y, Editor. Madhavnidanam of Madhavkar, Amavatnidanam Adhaya, Chapter 25, Verses9-10. Varanasi: ChaukhambaPrakashan, 2021; p 511.

10) Upadhaya Y, Editor. Madukosh commentary by Vijayrakshit on Madhavnidanam of Madhavkar, Amavatnidanam Adhaya, Chapter 25, Verse 10. Varanasi: ChaukhambaPrakashan, 2021; p 511.

11) Bhavmishra. Pratyaksha-sharir Part 1 p. 114-117 Cross ref: Sushrutsamhita of Sushrut (7th ed.), Sharirsthan, Sharirsankhya-vyakaran Sharir Adhyaya, Chapter 5 Verse 27. Varanasi, Chaumaba Orientalia, 2002, p 367

12) Wagh S, Raut A. Aam assessment instrument for disease activity in Aamavata: Scope and challenges. J Ayu and Integr Med 14 (2023) 100816https:// doi.org/10.1016/j.jaim.2023.100816

Ankylosing Spondylitis - A Case Report

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Introduction - A male aged 16 years came to opd with pain over bilateral sacroiliac joint, associated with morning stiffness lasting for more than 45 minutes. On examination, his Passive SLR, Flip, Heel walk and Toe walk tests were negative. But Iliac compression test, pump handle test, thigh thrust tests were found to be positive. Considering the age and gender of the patient and regarding the differential diagnosis of Ankylosing spondylitis, he was advised to do a basic radiological investigation, pelvis with both hip AP view and blood investigation, CBC, CRP, ESR. X-ray of sacroiliac joint showed grade II sacroiliitis. Based on clinical and radiological findings, it was provisionally diagnosed as Ankylosing spondylitis. HLA(human leukocyte antigen)B27 was not advised, because it's not affordable to this patient.

Spondyloarthropathy[1]**-** Spondyloarthritis, or spondyloarthropathy, is an inflammatory arthritis affecting the spine. The main symptom in most patients is low back pain. This occurs most often in axial spondyloarthritis.

Seronegative spondyloarthropathies[2] (SpA) are a family of rheumatologic disorders that classically include : 1) Ankylosing spondylitis (AS). 2) Psoriatic arthritis (PsA). 3) Inflammatory bowel disease (IBD) associated arthritis. 4) Reactive arthritis (formerly Reiter syndrome; ReA). 5) Undifferentiated SpA.

Many people with axial spondyloarthritis progress to have some degree of spinal fusion, known as ankylosing spondylitis. In a minority of patients, the major symptoms are pain and swelling in large joints of the arms and legs. This type is known as peripheral spondyloarthritis.

Spondyloarthritis often inflames the entheses, the sites where ligaments and tendons enter bone. Spondyloarthritis more often affects males in their teens or 20s. Ankylosing spondylitis (AS) is associated with the HLA-B27 gene. Psoriatic arthritis, reactive arthritis and enteropathic arthritis associated with inflammatory bowel disease, such as Crohn's disease and ulcerative colitis, are types of spondyloarthritis.

Clinical features - Low back pain is the most common symptom. Some spondyloarthropathies may affect the hands, feet, arms, or legs. Patients may have pain, fatigue or stiffness that is continuous or comes and goes.

Correct diagnosis requires assessing the patient's medical history and doing the physical examination. X-ray changes of the sacroiliac joints, known as sacroiliitis, are a key sign of spondyloarthritis.

Among the blood tests, it's advisable to test for the HLA-B27 gene. However, having this gene does not mean spondyloarthritis will always develop. The presence of the HLA-B27 antigen is a useful adjunct to the diagnosis, but cannot be diagnostic alone. Less than 5% of people with the HLA-B27 gene have AS.

Conventional management - Spondyloarthritis patients should get physical therapy and do joint-directed exercises to promote spinal extension and mobility. First-line medications for symptom relief are nonsteroidal anti-inflammatory drugs (NSAIDs). For localized joint swelling, corticosteroid injections into the joint or tendon sheath are quickly effective. If patients do not respond, disease-modifying antirheumatic drugs (DMARDs) may be used to relieve symptoms and prevent joint damage. Some members of a newer class of drugs, known as biologics, are very effective in treating both the spinal and peripheral joint symptoms of spondyloarthritis. Oral corticosteroids are not recommended. Antibiotics are used to treat reactive arthritis only. Surgery, such as total hip replacement, may be helpful for some patients. Spinal surgery is rarely needed.

Living with Spondyloarthritis - With newer treatment options, most people with spondyloarthritis lead normal, productive lives and have a normal lifespan. People with spondyloarthritis should exercise frequently to maintain joint and heart health. People with spondyloarthritis who smoke should quit or get help to do so.

Ankylosing spondylitis[3] **-** Ankylosing spondylitis (AS) is a chronic, inflammatory disease primarily affecting the axial spine that can manifest with a range of clinical signs and symptoms. The hallmark features of the condition include chronic back pain and progressive spinal stiffness. Chronic back pain and progressive spinal stiffness are the most common features of this disease. Involvement of the spine, sacroiliac joints, peripheral joints, digits, and entheses are characteristic. Impaired spinal mobility, postural abnormalities, buttock pain, hip pain, peripheral arthritis, enthesitis, and dactylitis are all commonly associated with ankylosing spondylitis.

In addition to skeletal involvement, AS can affect various organs outside the joints. These extra articular manifestations of AS include inflammatory bowel disease (affecting up to 50% of individuals), acute anterior uveitis (seen in 25%-35% of cases) and psoriasis (approximately 10% occurrence).

AS is additionally linked to an increased risk of cardiovascular disease which is believed to stem from the systemic inflammation present in individuals with AS. Pulmonary complications are also associated with AS, as diminished chest wall expansion and limited spinal mobility can predispose individuals to a restrictive pulmonary pattern.

Finally, individuals with AS are at least twice as likely to experience vertebral fragility fractures. Additionally, they face an increased risk of atlantoaxial subluxation, spinal cord injury, and, rarely, caudaequina syndrome.

Epidemiology - Ankylosing spondylitis (AS) commonly presents in individuals younger than 40, with approximately 80% of patients experiencing their first symptoms before age 30. Less than 5% are diagnosed after the age of 45. AS is more prevalent in men than women. Moreover, there is an increased risk of developing AS in relatives of affected patients.

Investigations -Laboratory findings in ankylosing spondylitis (AS) are typically nonspecific but may provide supportive evidence for diagnosis. Approximately 50% to 70% of patients with active AS show elevated levels of acute phase reactants, such as erythrocyte sedimentation rate (ESR) and elevated C-reactive protein (CRP). However, a normal ESR and CRP should not be used to exclude the possibility of AS.

Classic findings on plain film are 1) “shiny corner (sclerosis at the attachment of annulus fibrosus to the anterior corner of vertebral endplate) also known as romanus lesion, 2) “bamboo spine” (calcification of fibrous ring of the intervertebral discs forming marginal syndesmophytes) and 3) “squaring” of vertebral bodies.

During the initial years of AS, plain radiographic changes in the SI joints can be subtle; however, these changes will usually become more evident over the first decade of the disease. The most noticeable abnormalities on radiographs are subchondral erosions, sclerosis, and joint fusion. These changes are typically symmetrical, affecting both sides of the SI joints similarly.

Radiographic Grading of sacroiliitis[4] **-** A standardized plain radiographic grading scale exists for sacroiliitis. This scale ranges from normal (0) to most severe (IV), as detailed below.

- 0: Normal SI joint width, sharp joint margins
- I: Suspicious
- II: Sclerosis, some erosions
- III: Severe erosions, pseudo dilation of the joint space, partial ankylosis
- IV: Complete ankylosis

Throughout AS, a series of distinct radiographic changes characteristics can progressively develop. In the early stages, a notable sign is the "squaring" of vertebral bodies, which is best visualized on lateral X-rays. This squaring occurs due to inflammation and bone deposition, resulting in the loss of normal concavity of the anterior and posterior borders of the vertebral body. Additionally, early-stage radiographs may reveal Romanus lesions, also known as "shiny corner signs," characterized by small erosions and reactive sclerosis at the corners of the vertebral bodies.

Late-stage findings on radiographs include ankylosis (fusion) of the facet joints of the spine, the presence of syndesmophytes, and calcification of the anterior longitudinal ligament, supraspinous ligaments and interspinous ligaments. This calcification may be seen on imaging as the "dagger sign," appearing as a single radiodense line vertically running

down the spine on frontal radiographs.

The classic radiographic finding in late-stage AS is the "bamboo spine sign," which refers to vertebral body fusion by syndesmophytes. The bamboo spine typically involves the thoracolumbar or lumbosacral junctions. This spinal fusion predisposes the patient to progressive back stiffness.

Differential diagnosis -

Mechanical low back pain - • Mechanical back pain and AS can be distinguished based on several factors. The onset of symptoms is a key differentiating factor, as mechanical back pain can occur at any age, while AS typically presents before age 40. Unlike AS, mechanical back pain improves with rest, and morning stiffness is mild and short-lived. Mechanical back pain is not associated with peripheral arthritis or the extraskeletal manifestations commonly seen in AS.

Lumbar spinal stenosis - • Lumbar spinal stenosis (LSS) is a condition characterized by the narrowing of the spinal canal, which leads to spinal cord compression. Like AS, it may present with chronic back pain and morning stiffness. However, unlike AS, LSS usually presents in individuals older than 60 and is not associated with peripheral arthritis or extraskeletal features.

Rheumatoid arthritis - • Rheumatoid arthritis (RA) is another chronic inflammatory disorder of the joints that often presents with progressive back pain and morning stiffness in patients 40 or younger, similar to AS. However, peripheral arthritis is highly prevalent in RA, but not in AS. Another distinguishing feature of RA is the presence of rheumatoid nodules, which are pathognomonic for RA and are not usually observed with AS.

Diffuse idiopathic skeletal hyperostosis (DISH) - • Diffuse idiopathic skeletal hyperostosis (DISH) is a degenerative disorder characterized by ossification in the spine occurring primarily in the anterior longitudinal ligament, paravertebral tissues and peripheral aspect of the annulus fibrosus. Like AS, DISH may present a history of postural changes and back pain. Unlike AS, DISH is not an inflammatory disorder and lacks inflammatory characteristics such as morning stiffness or improvement with exercise but not with rest. Also, DISH does not exhibit any evidence of sacroiliitis on radiographic imaging.

Conventional Management - The treatment goals for AS aim to alleviate pain and stiffness, preserve axial spine mobility and functional ability, and prevent spinal complications. Non-pharmacological interventions should include regular exercise, postural training, and physical therapy. First-line medication therapy involves using non-steroidal anti-inflammatory drugs (NSAIDs) on a daily, long-term basis. If NSAIDs do not provide adequate relief, they can be combined with or substituted for tumor necrosis factor inhibitors (TNF-Is). The response to NSAIDs should be assessed 4 to 6 weeks after initiation, while the response to TNF-Is should be evaluated after 12 weeks.

Rehabilitation - Exercise programs have demonstrated significant benefits in managing ankylosing spondylitis, addressing pain management, flexibility, mobility and overall function. While there is no specific protocol universally recommended for AS management, multiple studies have shown improvements across various exercise programs, including home exercise programs and group therapies.

Hydrotherapy is one area widely cited for its cardiovascular benefits and pain management effects in individuals with AS. Respiratory and postural exercises are important in AS, as the disease process can impact proper breathing mechanics and posture.

Patient education - Patient education is vital in the management of ankylosing spondylitis (AS). Patients should be educated about the chronic nature of the disease, the medications used for treatment, and their potential side effects. There should be an emphasis on regular exercise programs that reduce symptoms. Physical therapy, including water therapy and swimming, can be highly beneficial in reducing symptoms, improving functionality, and maintaining overall fitness. Given the potential of pulmonary involvement in AS, it is essential to emphasize the importance of smoking cessation.

Assessment and Evaluation - The assessment and evaluation of outcome can be measured with the following criterion, 1) BASDAI (Bath Ankylosing Spondylitis Disease Activity Index). 2) HAQ-DI/HAQ-S (Health Assessment Questionnaire Disability Index / Health Assessment

Questionnaire for the Spondyloarthropathies). 3) ASQoL (Ankylosing Spondylitis Quality of Life Instrument).

Discussion - In this case, as the patient consulted in the initial stage of disease, the Occiput to wall test and Schober's sign were negative. Chest expansion was normal. Cervical involvement can be measured by the occiput-to-wall distance. The patient stands with the back and heels against the wall and the distance between the back of the head and the wall is measured.

The thoracic spine can be tested by the chest expansion. It is measured at the fourth intercostal space and in women just below the breasts. The patient should be asked to force a maximal inspiration and expiration and the difference in chest expansion is measured. A chest expansion of less than 5 cm is suspicious.

The lumbar spine can be tested by the Schober's test. This is performed by making a mark between the posterior superior iliac spines at the 5th lumbar spinous process. A second mark is placed 10 cm above the first one and the patient is asked to bend forward with extended knees. The distance between the two marks increases from 10 to at least 15 cm in normal people, but only to 13 or less in case of AS.

Protocol of AS -1) Amapachana and sophahara. 2) Transitional phase. 3) Internal sneha -samana/ brumhana. 4) Rasayana. 5) Rehabilitation - starting from the very first day of consultation.

1) The first treatment protocol is amapachana and sophahara - If there's intense pain, severe tenderness, severe morning stiffness, and rest pain with night time discomfort, it's considered as a pittavrutavata condition. For this, we can choose ama-pachana drugs like Amruthotharam or Pachanamrutham, typically used for pitta disorders. For kaphavrutavata conditions, in which there will be more swelling and heaviness, Dasamoola and Rasnapanchakam would be the appropriate choice.

Application of rookshavasthi with pachanamruta kashaya 300ml, vasiwanara choorna 30 g and saindhava 15 g shall be administered as an op procedure for quick amapachana and pain relief.

2) In the transitional phase, we can opt for Eranda - If they mention that the morning stiffness and rest pain have eased but they now experience exertional or mechanical pain, it's possible to transition to a different phase. Rehabilitation should commence only after amapachana to avoid aggravation of pain and symptoms.

For Pitta Kopa Condition :

• Nimbamritadi Eranda can be used. It is recommended to take five drops of Nimbamritadi Eranda twice daily. Yashtichoorna (1 tsp) can be added.

For Kapha Kopa Condition :

• SindhuvaraEranda is suggested. Additionally, Triphalachoorna (1 tsp) can be added. The dosage is twice daily.

3) In the third phase, we can give internal sneha - For internal sneha, as madhyamarogamarga is affected, we shall opt for taila or mahasneha internally. It's a kevalavata situation after the first 2 phases. For the same, we shall take - Dhanwantharamtaila.

The dose of internal sneha should be based on the agnibala of the patient. It's advisable to take internal Sneha in a large quantity (eg:- 10-20 ml) for a small period (2-3 weeks) than a small quantity (5 ml) for a large period(8 weeks).

We can give it as shamanasneha or brumhanasneha. The patient should take shamanasneha or brumhanasneha only at the time of appetite. And next time, when the patient feels appetite after snehapana, it's possible to take food in samanasnehapana.

4) After snehaprayoga we can go for rasayanaprayoga - Selection of Rasayana depends on the structure or dhatu affected. Here, it's the bone or its sub-tissue (upadhatu) is affecetd, it's better to prescribe GandhaTailam (10 drops) for 23 months or Krishna Tila (5 gm) with AmalakiChoorna (5 g) in hot water for the same period.

5) Rehabilitation - Extension exercises and pranayama are effective methods in AS. Incorporating yoga and rehabilitation exercises are found to be effective. It is effective to follow Swimming exercises. It's important to emphasize that these interventions should be based on the individual's constitution, the specific nature of the condition, and other relevant factors.

Note : Internal Sneha, Rasayana and Rehabilitation are the three most important factors that help us to provide Sudha Chikitsa

(complete cure without recurrence).

In a patient with A.S, which is a yapya disease, ask the patient to come for a follow-up in a gap of 3 months or 6 months, regularly. After assessing the agnibala of the patient, either advise the patient to do virechana after sadyasneha and give internal sneha for a period of 2 weeks. It will help the patient maintain the result obtained by the above-mentioned management protocol. The approach for managing A.S, incorporating Sadyovamana using Yashti kashaya preceding it with vaitaranavasti and ending with Virechana using Agasthyar kuzhampu, is found to be effective in maintaining the relief.

Vaitaranabasti : • Vaitaranabasti is advisable as a prophylactic measure before ritusandhi to avoid aggravation of symptoms before cold season, which may exacerbate the symptoms.

Sadyovamana : • Sadyovamana, is advised before Virechana. Yashtikashaya shall be used for Sadyovamana.

Virechana with AgasthyarKuzhampu (100 mg): • Virechana, is suggested using Agasthyar kuzhambu, 100 mg at 6 am in the morning.

This sequential approach is aimed at reducing recurrence and prolonging the relief achieved through the protocol.

NB. Lifestyle Modification (Pathya) is a crucial factor in the relief and avoidance of recurrence and relapse.

Conclusion - Our aim in AS is to maintain quality of life and extend life expectancy. The effective methods in A.S can be concluded as : • Early diagnosis. • Incorporation of internal medicines and sodhana therapy of Ayurveda. • Rehabilitation. • Yoga, both pranayama and extension postures like Bhujangasana and Salabhasana. • Educate patient to never stop rehab a single day. • Swimming. • Avoid active and passive smoking. • Follow ups and reviews at regular intervals.

Patient centric approach with integration and without compromising our principles yields effective results in the management of AS.

Reference - 1) https://rheumatology.org
2) Https:// www.ncbi. Nlm.nih. Gov/ books /NBK459356
3) Https:// www.ncbi. Nlm.nih.gov/ books/ NBK470173
4) Https:// www.ncbi. Nlm.nih.gov/ books/ NBK470173

A Case Study On Amavata (Rheumatoid Arthritis)

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Introduction - Amavata is caused by dysfunction in Asthivaha and Rasavaha strotas. Amavata is mainly caused by formation of Ama and Vata Dosha vitiation. The Ama is transmitted by the vitiated Vata and stored in the septs of kapha (joints etc.) resulting in symptoms such as Angamarda (body ache), Aruchi (loss of appetite), Alasya (weakness), Sandhiruk, Sandhishootha (joint pain and swelling). Whereas Acharya Cakradatta was the first to explain Amavata treatment, Madhavakara (700 AD) was the first to describe the features of Amavata in Madhava Nidana. Since Amavata is a condition caused by Madhyama Rogamarga, it is also referred to as Krichhasadhya or Yapya.

Based on the clinical characteristics, there is a strong similarity between Amavata and Rheumatoid arthritis. A chronic, progressive autoimmune arthropathy, rheumatoid arthritis is typified by bilateral, symmetrical joint involvement along with some systemic clinical features.

This illness primarily affects young people, and because of the poor prognosis, patients gradually become physically and psychologically disabled. Thus, it is the society's most pressing issue. The side effects of modern medicine's treatments have limitations. Approximately 0.8% of the population (range: 0.3%-2.1%) has RA, with women affected roughly three times more frequently than men.

In the older age group, sex differences

decrease and the prevalence rises with age. Eighty per cent of patients develop the disease between the ages of 35 and 50, with the fourth and fifth decades of life being the most common times for it to start. The primary cause of Amavata (RA) is treated by Ayurveda, which breaks the Samprapti of the illness. The Chikitsa Siddhant for Amavata was explained by Acharya Chakradatta. It includes Langhana, Swedana and use of drugs having Tikta, Katu Rasa with Deepana property, Virechana, Snehapana and Vasti. Here a case of Amavata was treated by using Shaman Chikitsa given in this Chikitsa Sutra.

Materials And Methods -

Type of study : Simple random single case study.

Methodology - A female patient diagnosed with Amavata has been taken for the study and administered with Shamana chikitsa.

Case History - A 57-year-old female patient came to us with chief compliant of.

Table No. 1 Chief Complaint :

Chief compliant Duration	Duration
Ubhya Parvasandhi Shool (Bilateral finger pain)-	1.5 years
Ubhya janusandhi shool-shotha (Bilateral knee pain and swelling).	
Ubhay Manibandha Shool, Shotha and Sparsha-Asahatwa.	
Angamarda.	
Aruchi.	
Sandhi Stabdhhata (Morning stiffness.)	

History of Personal Illness - A female patient aged 57 years was visited to O.P.D. of Kayachikitsa Dept of Ashvin Rural Ayurveda Hospital, Manchi Hill, Maharashtra. Reg. no. 16187, with complains from Ubhya Parvasandhi Shool (bilateral finger pain) Ubhay Janusandhi Shool-Shotha (Bilateral knee pain and swelling), Vaam Ansa-Kurpara Sandhi Shool., Vaam Manibandha Shool, Shotha and Sparsha-Asahatwa., Angamarda, Aruchi, Morning stiffness, reduced appetite, often constipation since 3 year, was diagnosed case of seropositive RA, CRP also positive with raised ESR. She was treated methodically as per Chikitsasutra of Amavata.

Ashtavidh- Parikshna - 1) Nadi: 80/min (vaat pittaj). 2) Mala: Malavashtmbha. 3) Mutra: 4 to 5 time in day/ 1- 2 times night. 4) Jihva: Sama. 5) Shabda: Prakrut. 6) Sparsha: Anushna. 7) Drik: Prakrut. 8) Akriti: Sthula.

Dashavidha-Parikshna -

1) Prakruti: Vata pradhana-kapha anubandhi.

2) Vikruti: • Dosha- Vatapradhana tridosha,

• Dooshya- Rasa, Meda, Ashti.

3) Satwa: Madhyama. 4) Sara: Majja. 5)Samhanana: Madhyama. 6) Pramana: Madhyama. 7) Satmya: Sarva rasa. 8) Aharasakti: Madhyama. 9) Vyayamasakti: Avara. 10) Vaya: 57 years. **(See Table 2 to13)**

Discussion of Amavata - Hetu/ Etiology of Amavata - 1) Viruddha Ahara (Incompatible food) - Viruddha Ahara is main cause to produce Ama. 2) Viruddha Cheshta (Improper physical activity) Leads to Mandagni. Further extends to Vitiation of Vata and Ama formation. 3) Nischalata (Lack of physical activity) - Lack of physical activity or sedentary life style is the main cause of formation of Ama and Vaata dosha vitiation. 4) Snigndham bhuktavato Annam vyayaamam:- Performing physical exercise soon after intake of heavy food causes Apachit Aharrasa further leads to aam and vata vitiation. **(See Chart 1).**

Discussion on Medicine (Sampraptibhnga)

1) Langhana:- In Amavata is Langhana which helps in digestion of Ama. Here in this case Langhana means not complete fasting but, intake of light food according to agni.

2) Swedana:- Amavata is a Vata Kapha Pradhan Vyadhi having Stambha, Gaurava and Sheeta as Pradhan Lakshanas. Swedana indicated here is - Ruksha Swedana (Valuka and Pottli)

3) Snehana:- As it aggravates Ama so contraindicated in Amavstha. But to remove the Dosa sanga and to pacify the Vata Dosa Snehana is required. Erand is a vyadhi pratyanika Sneha in Amavata.

4) Aushadhi chikitsa:- Katu, Tikta and Pachak Aahar and Aushadhi: - The drug which possess Katu (pungent), Tikta (bitter) and which act as deepana, pachana are recommended in Amavata. These drugs, by virtue of their qualities does Aapachana, hence may help in relieving shotha and shoola.

Treatment Plan

Table 2: Showing material for Management of Aamvata internal medicine as.

Sr.No.	Medicine	Dose	Anupana	Duration
1	Dhashamool Ghan Vati	500mg, twicea day after food	Koshnajala	30 days
2	MaharasnadiKwath	40 ml, twicea day before food	Koshnajala	30 days
3	Gandharva Haritaki Tab	500 mg HS	Koshnajala	30 days

Table 3: Showing material for Management of Aamvata Tropical medicine as.

Ruksha Swedana	Valuka Pottali sweda
Snehana	ErandTail

Table No. 4: Pathya-apathya (dos and don'ts) - Adviced to patient as follow:

	Pathya	apathya
Aaharaja (Food)	Yava (barley), kulattha (horse Gram), raktashali (rice)	Flour of mash (black gram), Rajmah (kidney beans), sweets.
	shigru (drum Sticks), Punarnava, karvellak (bitter gourd), parawar, ardrak (ginger)	Fast food, uncooked food, salty, spicy, oily food.
	Jangal mansa (Meat).	Fish
	Sunthi Sidhha Jala	Cold water, Curd, jaggery, milk, cold beverages, ice creams.
Viharaja (Behaviour)	Sunlight exposure for at least 15 minutes in a day.	Daytime sleeping, vegavadharan (suppression of natural urges); exposure to cold, Wind, A.C., excess of stress

Langhan (Alpa Bhojana) advised to patient.

Duration-30 days.

Assessment Criteria : Assessment of patient was done with table 5 to table 8. As follows,

Tableno.5.-GradingofSandhishoola (pain)

Sr.no	Severityof Pain	Grade
1	No pain	0
2	Mild pain	1
3	Moderate, but nodifficultyin moving	2
4	Muchdifficultyinmoving thebodyparts	3

Tableno.6.-Gradingof Sandhishotha (swelling)

Sr.no	Severityof swelling	Grade
1	No swelling	0
2	Slight swelling	1
3	Moderate swelling	2
4	Severes welling	3

Tableno.7.-Grading of Sparshasahatwa (tenderness)

Sr.no	Severityof tenderness	Grade
1	No tenderness	0
2	Subjective experience of tenderness	1
3	Wincing of face on pressure	2
4	Wincing of face and Withdrawal of the affected part on pressure	3

Objective Criteria:

Tableno.8.-Gradation of walkingtime

Sr.no	Walkingtime (For25 feet in number of seconds)	Grade
1	15-20sec	0
2	21 30 sec	1
3	31-40sec	2
4	>40sec	3

Observation and Results:

Tableno.9.-Assessment of Sandhishoola

Left		Name of joint	Right	
BT	AT		BT	AT
2	1	Kneejoint	3	1
2	0	Wristjoint	2	

Tableno.10.- Assessment of Sandhishotha

Left		Nameof joint	Right	
BT	AT		BT	AT
2	0	Kneejoint	3	2
2	0	Wristjoint	3	1

Tableno.11.-Assessment of Sparshasahatwa

Left		Nameof joint	Right	
BT	AT		BT	AT
3	0	Kneejoint	3	0
3	0	Wristjoint	3	0

Table no.12.-Assessment of Objective Criteria

Criteria	BT	AT
Walkingtime (for25 feet in Number of seconds)	2	1

Investigations -

Tableno.13.-Showing Laboratory values before and after treatment :

Investigations	B.T	A.T
Hb%	9.1gm%	11.3 gm%
TLC	8,700/cumm	6,100/cumm
Neutrophils	81%	67%
Lymphocytes	29%	24%
Monocytes	2 %	1%
Eosinophils	2%	1%
Total Platelet Count	2.63 Lacs/cu.mm	1.44 Lacs/cu.mm
ESR	32mm/hr	12 mm/hr
RATest	Negative	Negative
CRP	Positive	Negative
Uric acid	3.8mg/dl	3.5mg/dl

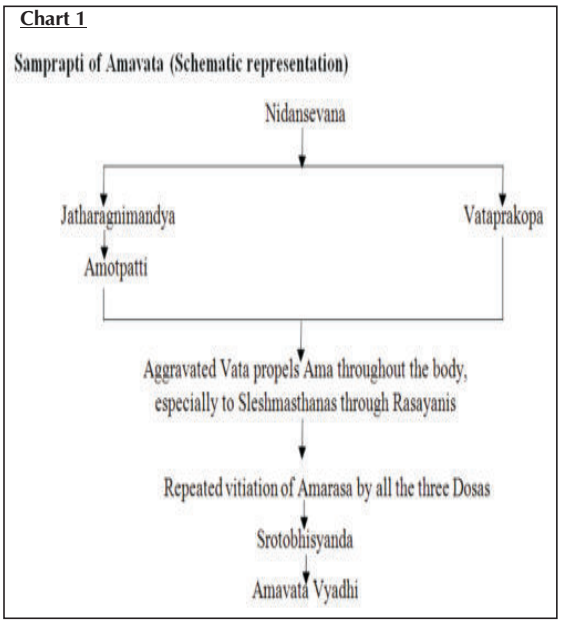
A) Dashmoola Ghanvati : It is the drug in amavata (RA) due to its capacity to improve digestive fire (agni), pacify vitiated vata and kapha especially in joints and improve strength of joints.

C) Rasnasaptakam kwath : Its contain Rasna, Amruta, Aragvadha, Devdaru, Trikantaka, Ernada, punarnava, Shunthi. Synergetic effect of this kwatha is as shoolaghna (analgesic), vata-kapha shamaka, immunomodulator, anti-inflammatory, carminative, and appetizer.

D) Gandharva haritaki : Gandharva haritaki is polyherbal Ayurvedic medicine. Contains of this medicine are erand tail, balharitaki, sunthi, sandhav and savarchal lavana.it has purgative and laxative action. Gandharva haritaki evacuates bowel and remove sanchita mala.

Conclusion - Amavata is one among the most prevalent disease in the present era, and day by day it is challenging issue for medical science due to change in life style. Ama and Vata have complete opposite properties of each other and involvement of uthanadhatu (RASA) and gambheradhatu (ASTHI) makes the treatment more complicated so there is necessity of a systematic treatment protocol based on the principles of Ayurveda, because any measure adopted will principally oppose one another so

Chart 1



very careful approach can only benefit the patient. Early diagnosis helps to prevent deformities with appropriate management. Panchakarma procedures will help in checking autoimmune mobility and elimination of Bahudoshavastha. This case study showing that shaman chikitsa is a better modality of treatment for treating Amavata for relieving symptoms and as well as correction in biochemical parameters. From this case study it can be concluded that Amavata can be effectively and safely treated by using Chikitsa Siddhant described by Acharya Chakradatta. But this is a single case study hence to prove its efficacy there is a need to conduct a study on large number of patients.

References : 1) Madhavakara, Madhavanidana, Vimala Madhudhara Teeka by Tripathi Brahmanand, Chaukhambha Surabharati Prakashana, Varanasi, ed. 2010, poorvardha, adhyaya 25, (Page.571-577).

2) Shah Ankur, E.William St. Clair, Harrison's Principles of Internal MedicineVolume 2, 18th edition, Chapter 321, Rheumatoid Arthritis, (Pg. 2739).

3) Churchill Livingstone, Davidson's Principle and Practice of Medicine. 19th ed.: Elsevier Publication; 2002. (pp. 10027).

4) Chakrapani Datta. Chakradatta commentary by Indradev Tripathi. Amavatarogadhikara 25/31-36. Varanasi: Chaukhamba Sanskrit Sansthan; 2010. (Pg. 167-168).

5) Arnett FC, Edworthy SM, Bloch DA, McShane DJ,

Fries JF, Cooper NS et al. The American Rheumatism Association 1987 revised criteria for the classification of rheumatoid arthritis. Arthritis & Rheumatism Arthritis & Rheumatism-Arthritis Care & Research 1988; 31(3):315-324).
6) Tripathi Ravidatta, Charaka samhita with Vidyamanorama Hindi commentary, Chaukhamba Sanskrit Pratishthan, Delhi, 2009. Ni 8/31 (Pg.542)
7) Tripathi Ravidatta, Charaka samhita with Vidyamanorama Hindi commentary, Chaukhamba Sanskrit Pratishthan, Delhi, 2009. Su 23/25 (Pg.319).
8) Tripathi Ravidatta, Charaka samhita with Vidyamanorama Hindi commentary, Chaukhamba Sanskrit Pratishthan, Delhi, 2009. Su 22/11 (Pg.309)
9) Das Govinda, Bhaishajya Ratnavali, Hindi commentary by Ambikadatta Shastri, Chaukhambha Prakashana, Varanasi, Edition2014, Amavata chikitsa, 29/181-189, (Pg no.628)
10) Murthy K.R.,Shrikantha,Chaukhambha Prakashan, by Sharngadhara, Sharangdhara Samhita Madhyamakhanda 2/89 95.Page-66-68
11) Das Govinda, Bhaishajya Ratnavali Volume -II, English commentary by Kaajiv alaochan, Choukhambha Sanskrit Bhavan Varanasi, chapter 26, shloka no.593-606; 2005.p.233.

A Literary Review Of Secondary Sjogren's Syndrome With Special Reference To Vatapradhan Vatarakta.

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Introduction :- In Ayurveda, as autoimmune disorders are concerns, it is always having an association of Raktadhatu with visham avastha of tridosha. Sjögren Syndrome (SS) is a chronic autoimmune disorder in which the moisture producing glands do not function properly leading to oral and ocular dryness. It is also associated with other autoimmune diseases like RA, Lupus, Inflammatory myositis and Systemic sclerosis. Primary SS is a common disease that affects 0.1 to 0.6% of the general adult female population. Primary SS has a female preponderance (female-to-male ratio at least 9:1). The age peak of the disease occurs after menopause in the mid-50s. If the condition is allowed to progress the pain may begin to migrate from one joint to another joint with an intensive burning sensation. Sjögren's Syndrome cannot be mirrored directly with any particular disease condition in Ayurveda classics. Ayurvedic concept of SS is obscure and studies are lacking in this area. The Sjögren Syndrome in Ayurveda involves the hypothetical understanding of the varied nidanas involved .Based on the lakshanas, Secondary Sjögren Syndrome can be understood under the banner of Vatapradhan Vatarakta.

Sjögren's Syndrome is an auto-immune chronic inflammatory disease with multisystem involvement. It is a systemic disease named after Swedish Ophthalmologist Henrik Sjögren. Autoimmunity is a state in which the body's immune system failed to distinguish between self and non-self and react by the formation of auto-antibodies against once own tissue antigens. It typically occurs in women between 40-50years of age. Female to male ratio is 9:1.[1]

- **There are two categories for Sjögren's Syndrome:** 1) Primary Sjögren's Syndrome-If patient don't have other rheumatic disease.

2) Secondary - When Sjögren's Syndrome is associated with rheumatic conditions.[2]

The cardinal features of this Syndrome are dryness of mouth and eyes which is indicative of Ruksha guna of Vata (Vataadhikya), Shushkakshipaka' (inflammatory eye disease associated with dryness) is mentioned in the classical literature of Ayurveda under 'Sarvagata Netraroga' (diseases affecting all parts of the eye). Lymphocytic infiltration in the exocrine gland is indicative of Raktadushti and Polyarthritis correlated with Shoola guna of Vaatadhikya Vatarakta. Symptoms like fever, arthralgia, fatigue, and generalised weakness are

indicative of the presence of excessive Vata and Ama in thebody.[3]

Aim and Objectives -

Aim:- A Literary Review Of Secondary Sjogren's Syndrome with Special Refrence To Vatapradhan Vatarakta.

Objective:- 1) To study SJOGRN'S SYNDROME in Modern view. 2) To study Ayurvedic perspective of Sjogrn's syndrome according to Ayurveda classic. 3) To study Vatapradhan Vatarakta according to Ayurveda classic.

Material Andmethod - Information related to **Sjogren's Syndrome** is reviewed from-

1) Classical Ayurvedic texts.

2)Modern text books of musculoskeletal disorder and physiopathology.

3) Publications/Article related to **Sjogren's Syndrome**

Pathophysiology - Genetic predisposition, exogenous triggering factors (e.g. glandotropic viruses) and hormonal changes are thought to initiate and maintain the immunopathogenesis of the disease. Glandular epithelial cells supposedly play a central pathophysiological role in the development of auto-immune epithelitis, especially with regard to antigen presentation of Ro/SSA- and La/SSB-protein complexes which are found on the surface of apoptotic cells. Both the innate (e.g. pDC/monocytes) and the adaptive immune system (T-/B-cells) are involved in the initiation of the disease and perpetuation of the immune response Via the activation of various CD4+ T-helper cell subsets. B cells play an important role in autoantibody production, from the formation of ectopic germinal centre-like structures to the malignant transformation to Non Hodgkin Lymphoma.

The Diagnostic Criteria For Sjögren Syndrome - A set of preliminary criteria for SS classification was proposed by an expert consensus panel (American College of Rheumatology [ACR]-Sjögren International Collaborative Clinical Alliance [SICCA]). According to these criteria, classification of an individual as a pSS patient requires the presence of two out of three of the following objective items: (1) a positive serum test for anti-Ro/SSA and/or anti-La/SSB antibodies, or positive rheumatoid factor (RF) and antinuclear antibody (ANA) (titter > 1: 320); (2) presence of keratoconjunctivitis sicca, defined by an ocular staining score over 3; and (3) presence of focal lymphocytic sialoadenitis, defined by a focus score of 1 focus/4 mm2 or above in a labial salivary gland biopsy. Because the disease is mild in many people, the first signs of mucosal dryness may be present for years before the disease becomes clearly evident.

Ayurvedic Aspect - The secondary Sjögren Syndrome in which it is associated with other autoimmune diseases can be considered under paratantra vyadhis. The Secondary Sjögren Syndrome mainly manifests as Rheumatoid Arthritis, Systemic Lupus Erythematous, Inflammatory myositis, and Systemic sclerosis. SS in the setting of RA usually follows RA diagnosis by many years and is mainly manifested by keratoconjunctivitis sicca, with systemic features being rather uncommon. Associated with other systemic autoimmune disease, the presentation of sSS is very close to pSS. The diseases caused in association with Sjögren Syndrome include vasculitis, Raynaud phenomenon, polyarthralgia, polyarthritis, scleroderma, myositis among others.

The undigested particles are understood as Ama. This is applicable at the level of doshas and dhatus also. Considering the uric acids crystals which are the excess collagen materials, as ama which accumulates at the sandhis, though initial consideration of amavata is appreciable due to the amaja nidana and involvement of sandhi, but on detailed examination considering the dosha, dhatu and samprapti involved, the symptoms can be considered under the umbrella of Vatarakta rather than Amavata. The samprapti of vatarakta explains that the sites of manifestations start from hands and feet and spread to all the joints. From this base, it spreads to all the other parts of the body by the sukshma and sara guna of Vata and Rakta.[4] Vatarakta is one of the unique disorders among the Vatavyadhi (a group of nervous disorder) which is the result of Avarana of morbid Vata dosha by vitiated Rakta (blood) dhatu (tissue).[5] This causes the derangement of Rakta dhatu resulting in Vatashonita In addition

to this, Vatarakta is also produced by the Margavarana of Vayu by Kapha and Medas. In Shabdakalpa druma.[6] Definition of Vatarakta is given as "Vata dushtiam raktam yatra roga vishesha", i.e. it is caused due to the vitiation of Rakta initiated by the morbid Vata is called Vatarakta. The main feature of RA or SLE associated with Sjögren Syndrome is arthralgia which is the main feature of Vatarakta.

Samprapti Ghataka[7]

Dosha -- Vaat-pittadhikya, Kaphakshaya Dushya -- Rakta, Asthi, Majja

Srotasa -- Udakvaha srotodushti -- Vimargaman

Adhishthan -- Talu Klom, Akshi

Swabhav -- Chirkaari, Daruna

Agni -- Agnimandhya

Sadhyasadhyata -- Kashtsadhya/Asadhya

Discussion - The whole concept of Autoimmune disorders can be understood under various banners. Depending on the nidanas, the samprapti of the roga is usually understood. Generally, we can interpret it as the decrease/variation in the vyadhikshamatwa of the patient due to any of the nidanas, especially viruddha ahara which brings about the alteration in the udakavaha srotas leading to the udakavaha srotodushti which is understood by the features of dryness in the shareera, whereas in sSS, the clear manifestations of Vatarakta in later stages calls for its chikitsa, The Viddha lakshanas. 8 of Udakavaha srotas need not infer only the external injury. It could be interpreted as internal injury due to vitiation of doshas also. The imbalance between the want and compensation of water and feeling of thirst form the key components of Udakavaha srotos vitiation. Since thirst is invariably associated with water imbalance or dehydration in the body, any causes of dehydration can be considered as causes of udakavaha sroto dushti. Hence dryness of mouth, lips and tongue seem to be the main symptom of vitiation of Udakavaha srotas.

Conclusion - Ayurvedic concept of SS is obscure and -studies are lacking in this area. Things have become difficult for an Ayurvedic physician to evaluate and manage the cases of SS due to lack of literature. So, The Ayurvedic Diagnosis of Vataadhikya Vatarakta is made for 'Sjögren's Syndrome' in present area. There is no definite cure for Autoimmune diseases in Contemporary sciences. In Ayurveda, we can play a vital role in management of the symptoms without further derangement of the body by applying the concepts mentioned. This may help in the overall health status of such patients.

Refrences - 1) Abdulkareem FA, ALAswad FD, Alasami MH. The incidence of secondary Sjögren's syndrome in relation to disease activity & disease duration of rheumatoid arthritis patients. International Journal of Science and Research. 2017;6 (5):97100.

2)*Dr. Raja Singla, 2Dr. Harish Kumar and 2Dr. Anjali Kamboj , Management of sjögren's syndrome through panchkarma modalities w.s.r. vataadhikya vatarakta: a case study www.wjpr.net Volume 11, Issue 16, 2280-2285.

3) Shereen Sreenivas1*, Muralidhara2 and Sindhura A. S. 3 UNDERSTANDING SJÖGREN SYNDROME IN AYURVEDA wjpls, 2019, Vol. 5, Issue 12, 103-107 Review Article ISSN 2454-2229 www. https://www.wjpls.org/in

4) Decoction of the bark of Asvattha (Ficus religiosa Linn.) is useful in Vatarakta (C. S. Ci. 29/158) [16] .Decoction of the bark of Asvattha (Ficus religiosa Linn.) is useful in Vatarakta (C. S. Ci. 29/158) [16] . 16. Decoction of Trivrit (Operculina turpethum Linn.) and Vidari (Pueraria tuberosa DC.) cures vatarakta (B. P. Ci 29/40; B. S. Vatarakta. 40) [19, 22] . 17. Dhanyaka one part and two part of Jeerak (Cuminum cyminum Linn.) cooked with jiggery alleviates vatarakta (H. S. 3/23/10) [20]

5) Decoction of Trivrit (Operculina turpethum Linn.) and Vidari (Pueraria tuberosa DC.) cures vatarakta (B. P. Ci 29/40; B. S. Vatarakta. 40) [19, 22] .

6) Dhanyaka one part and two part of Jeerak (Cuminum cyminum Linn.) cooked with jiggery alleviates vatarakta (H. S. 3/23/10) [20]

7)*Dr RajaSingla, **Dr HarishKumar management of Sj?gren's Syndrome through Ayurveda: A case study e-ISSN: 2455-5134; p-ISSN: 2455-9059 DOI: http://doi.org/10.37648/ijrmst.v11i01.006

8) Sushruta, Sushruta Samhita with Nibandha Sagraha commentary by Dalhana, edited by Vaidya Jadhavaji trikamji Acharya. Varanasi: Chaukhamba Surabharathi prakashan 1997, Shareera Sthana 9/12, P.No-386.

An Integrated Approach To Diagnosis And Differential Diagnosis Of Rheumatic Disorders : A Review

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Introduction : Rheumatic disease is an umbrella term that refers to arthritis and several other conditions that affect the joints, tendons, muscle, ligaments, bones, and muscles (arthritis refers to disorders that mainly affect the joints). Rheumatic diseases, like osteoarthritis, can lead to severe joint pain from the breakdown of cartilage, the firm but soft tissue that protects a joint, when not managed well.

Years ago, conditions like this fell under the broad heading of rheumatism. Now there are more than 200 distinct rheumatic diseases. Among the most common ones are: Osteoarthritis, Rheumatoid arthritis (RA), Lupus, Spondyloarthropathies ankylosing spondylitis (AS) and psoriatic arthritis (PsA), Sjogren's syndrome, Gout, Scleroderma, Infectious arthritis, Juvenile idiopathic arthritis.

Rheumatology is described in detail in ancient Ayurvedic texts under 'Sandhigat Roga', the diseases of joints, and involves Asthi (bones) and Majj a(connective) dhatus (tissues). Symptoms may involve pain, stiffness of joint, swelling and fever as a result of immune dysfunction and dhatu kshyaya (tissue damage)[23]

Aim : To review and correlate the diagnostic approach and differential diagnosis of rheumatic disorders as per ayurveda and modern classics.

Objectives: 1) To study the diagnostic criteria and differential diagnosis of rheumatic disorders.

2) Correlation between diagnostic and differential diagnostic criteria as per ayurveda and modern science.

Material and Methods : The Bruhattrayi, modern medicine textbooks, journals and online database like Google Scholar, PubMed, etc were reviewed for this purpose.

Methodology : Rheumatic disorders are the most prevalent of the chronic painful disorders in the world today. The specialty of rheumatology is one of the most clinically orientated. Hence the approach to rheumatic diseases must be clinical. Proper history taking and physical examination including that of the musculoskeletal system cannot be overemphasized. Special attention must be paid to the skin, mucous membrane, the eyes, the gastrointestinal and genitourinary systems. Laboratory tests are meant to supplement a thorough history and physical examination and never in place of them. Because there is so much overlap in the clinical manifestations of the different rheumatic diseases, a precise diagnosis may be difficult in the early stages. Management goals must therefore be bipartite.[1] (See Fig. 1)

Evaluation of patients with Musculoskeletal complaints [2] - Goals - Accurate diagnosis, timely provision of therapy, avoidance of unnecessary diagnostic testing, identification of acute, focal/monarticular "red flag" conditions.

Approach - Determination of chronology (acute vs chronic), determination of the nature of the pathologic process (inflammatory vs noninflammatory), determination of the extent of involvement (monarticular, polyarticular, focal, widespread), anatomic localization of complaint (articular vs nonarticular), consider the most common disorders first, formulate a differential diagnosis.

Ayurvedic approach to rheumatologic disorders- Although VPK are present throughout the body, their presence is more striking at specific sites or organs. These sites are more susceptible to vitiation of respective doshas. All vata disorders may start in the colon, pitta in the intestine and kapha in the stomach. Further aggravation (prakopa) of doshas will spread the doshas(s) to the weak sites and accumulate (sthansanchaya) to manifest (vyakti) disease(s) and may bring about disease oriented complications (bheda). Movement of dosha or irregular Prana (vata) is governed by agni(metabolic fire) and production of ama (toxin)[4].

Ama not only clogs the digestive flow but because of its obstructive nature, clogs bodily channels (srotas) and disrupts physiology including the formation and excretion of waste and it adversely influences the formation and functions of the tissues (dhatus). At a cellular level ama may disrupt the cellular movement, change cell

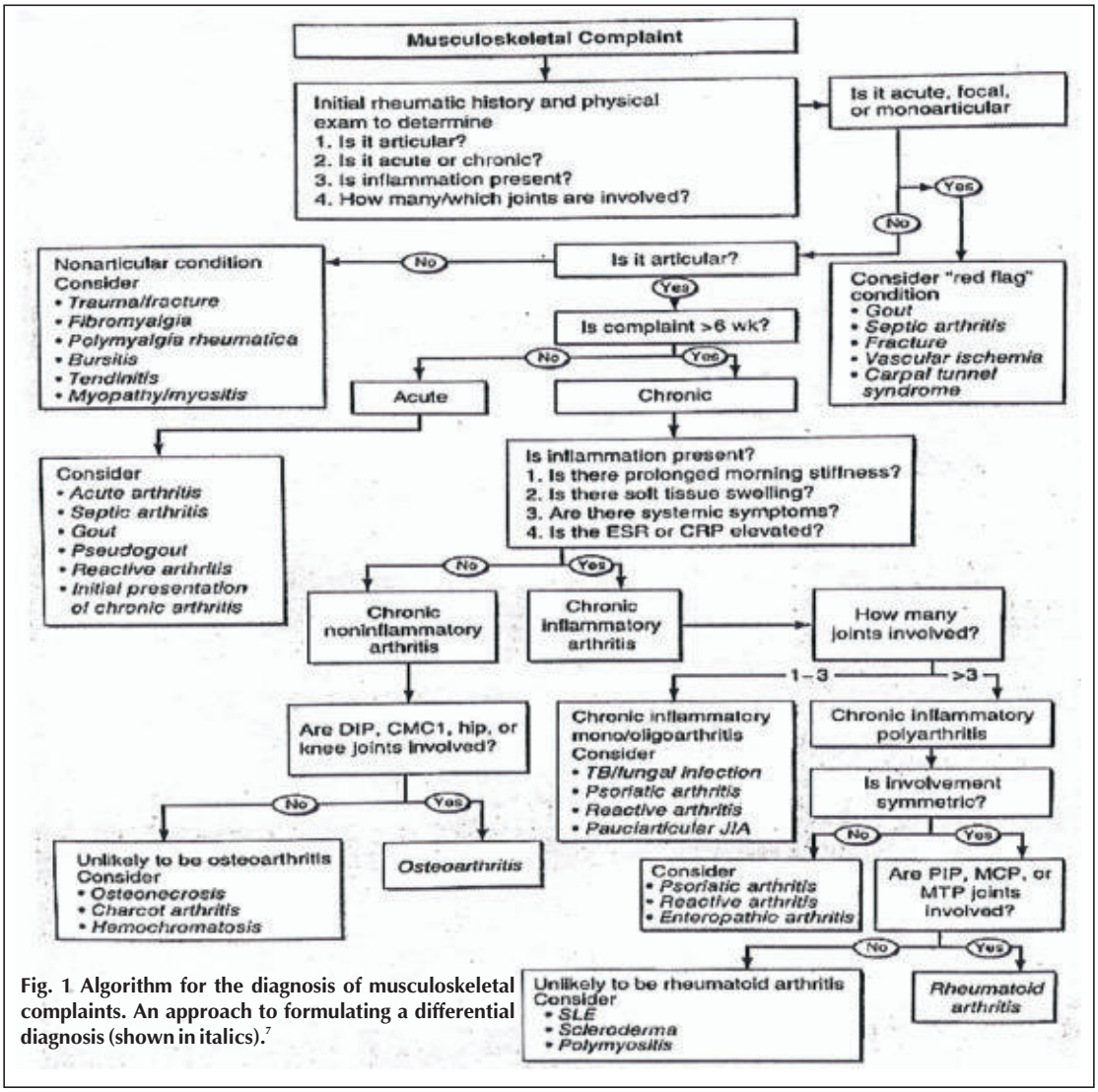

Fig. 1 Algorithm for the diagnosis of musculoskeletal complaints. An approach to formulating a differential diagnosis (shown in italics).[7]

membrane composition[5], inhibit shedding of membrane vesicles, disrupt cellular communication and membrane functions, alter antigen antibody interaction and leads to improper antigen presentation causing derangement of the immune system resulting in autoimmunity and/or autoimmune like symptoms[6].

There are two main internal causes of vata aggravation- 1) Dhatu kshyaya (depletion and degeneration of tissues) and is common in old age (vata phase of the life)giving rise to degerative arthritis. 2) Margavirodha (Clogging of channels), the clogging of the channel may be initiated by wrong diet, obesity, diabetes, Psorisis or increased uric acid build up. (See Table 1)

Discussion : Often diagnostic and classification criteria play central roles in clinical rheumatology practice. Unfortunately, existing criteria for rheumatic diseases are not always properly applied. Given the heterogeneous nature of rheumatic diseases, it is difficult to capture the full range of disease presentations by any single set of criteria. Despite well-known links between certain disorders and laboratory testing, the majority of individuals with musculoskeletal complaints can be diagnosed with a thorough history and a

Table 1- Differential diagnosis of Sandhi shoola and Sandhi sotha

Sr. No.	Symptoms	Sandhigatavata	Amavata	Vatrakta	Krosthuka sirsha	Vatakantaka
1	Sandhishoola	+	+	+	+	+
2	Sandhisootha	+	+	+	+	+
3	Kariyalpata, sashoolkriya, Kriyahani	+	+	+	+	+
4	1st involved joint	Big joints	Big joints	MCP joints	Knee joint	Ankle joint
5	Jwara	+/-	+	+	+	-
6	Sparshasahatva	+/-	+++	+	+	+
7	Ushnasparsha	+/-	+	+	+	-
8	Sanchari vedena	-	+	-	NA	NA
9	Dosha/ Dushya	Vata	Vata+ Ama	Vata+ Rakta	Vata + Rakta	Vata
10	Other c/f	Crepitation	Ama c/f	Nodules	Fluid thrill+	-
11	Sadhyata	Kashtasadhya	Kashthasadhya	Kashthasadhya	Kashthasadhya	Sukhasadhya
12	Snehopashama	+/-	-	NA	-	+
13	Swedana	Sneha/ruksha	Ruksha	Anupashaya	Anupashaya	Snehasweda

comprehensive physical and musculoskeletal examination. The initial encounter should determine whether the musculoskeletal complaint signals a red flag condition (septic arthritis, gout, or fracture) or not. The evaluation should proceed to ascertain if the complaint is (1) articular or non-articular in origin, (2) inflammatory or noninflammatory in nature, (3) acute or chronic in duration, and (4) localized (monarticular) or widespread (polyarticular) in distribution.

The process of diagnosis, particularly for complicated multisystem Involvement typical of rheumatic diseases, is a highly complex cognitive process that requires synthesis of many data points, typically beyond a simple algorithm-based set of criteria. Therefore with such an integrated approach and understanding of the pathophysiologic processes both from ayurvedic and modern perspective, the musculoskeletal complaint or presentation can be characterized (e.g., acute inflammatory monarthritis or a chronic noninflammatory, nonarticular widespread pain) to narrow the diagnostic possibilities. A diagnosis can be made in the vast majority of individuals. However, some patients will not fit immediately into an established diagnostic category. Many musculoskeletal disorders resemble each other at the outset, and some may take weeks or months (but not years) to evolve into a recognizable diagnostic entity. This consideration should temper the desire to establish a definitive diagnosis at the first encounter.

Conclusion : The goal of the musculoskeletal evaluation is to formulate a differential diagnosis that leads to an accurate diagnosis and timely therapy, while avoiding excessive diagnostic testing and unnecessary treatment (Fig .1) Therefore, any criteria would be expected to fail to capture some cases of a disease by capturing a more homogenous population and narrower range of disease severity than that treated in routine clinical practice. Nonetheless, in such scenarios ayurvedic way of classification (Table.1) and understanding disease pathophysiology would be helpful in improving diagnostic criteria's and enabling to conduct the clinical trials and epidemiologic studies with well-defined patient populations.

References : 1) Feng PH. Approach to rheumatic diseases. Ann Acad Med Singap. 1989 Jan;18(1):5-7. PMID: 2785362.

2) Charak Samhita, Sootra Sthan 28 Choukhamba Surbharati Prakashan. Varanasi III Edition

3) Charak samhita, viman Sthan 5 Choukhamba Surbharati Prakashan Varanasi III Edition

4) Singal GD, Tripathi, SN, Sharma KR. Ayurvedic Clinical Diagnosis. Voll. Chapter 22. 376-426. Chaukhmba Sanskrit Pratishthan, Delhi, India

5) A Guha, PR Mason, D Primorae, J Miller, JR Sporn, Interferon-induced growth arrest is mediated by membrane structural changes. J. Interferon and cytokines, 17:701-706. 1997

6) Murthy RKS: Ashtang Hridaya.13, 23, 187. Krishnadas Academy. Vol-1 .Chaukhambha. Varanasi, India.

7) Cush JJ. Approach to articular and Musculoskeletal disorders, HPIM, 19th edition, Chap 393, pg. 2216.

An Integrated Management Approach Of Ankylosing Spondylitis - An Overview

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Introduction : Ankylosing spondylitis (AS) is relatively rare. Older data estimate that 0.1 to 1.4% of the global population has Ankylosing spondylitis. The condition is more common in people with a gene known as HLA-B27. About 300,000 Americans (less than one percent of the adult population) have ankylosing spondylitis. Harping on the need for early disease diagnosis, "Nearly 30-40 lakh people in India suffer from Ankylosing Spondylitis. Ankylosing spondylitis is a type of arthritis that causes inflammation in the joints and ligaments of the spine. It may also affect peripheral joints like the knees, ankles, and hips. The inflammation in the joints and tissues of the spine can cause stiffness. In severe cases, this may cause the vertebrae (bones in the spine) to fuse (grow together). When the vertebrae fuse, it can lead to a rigid and inflexible spine. There is no cure for ankylosing spondylitis but there are many treatment options to help control symptoms. There is crucial role of integration in the treatment of AS. Recommended therapies may include exercise, physical and/or occupational therapy to improve mobility and posture, and medications to help manage pain, control inflammation, improve posture and body position, and slow the progression of the disease. With integrated approach of treatment, most of the people with ankylosing spondylitis can have productive lives.

Aim : To study an integrated treatment approach to ankylosing Spondylitis.

Objectives : To review ankylosing Spondylitis as per modern classics.

Material : Modern texts, Research papers, articles, Journals, etc.

Methodology : 1) Risk Factors of Ankylosing Spondylitis : a) Family history and genetics : If there is a family history of ankylosing spondylitis, an individual is more likely to develop the disease. b) Age : Most people develop symptoms of ankylosing spondylitis before age 45. However, some people develop the disease when they are children or teens. c) Other conditions : People who have Crohn's disease, ulcerative colitis, or psoriasis may be more likely to develop the disease.

2) Causes of Ankylosing Spondylitis : The exact cause of ankylosing spondylitis is unknown. However, studies show that both genes and environment may lead to the development of the disease. Moreover, HLA-B27 gene increases the risk of developing ankylosing spondylitis.

3) Symptoms of Ankylosing Spondylitis : The most common symptom of ankylosing spondylitis is lower back and/or hip pain and stiffness. Over time, the symptoms may progress to other areas of the spine or body. The pain typically worsens during periods of rest or inactivity, which may cause some people to experience more pain during the middle of the night or after prolonged sitting. Usually, moving and exercise can help improve pain. Symptoms of ankylosing spondylitis vary from person to person. Some people have mild episodes of pain that come and go, while others will have chronic, severe pain. The symptoms of ankylosing spondylitis, whether mild or severe, may worsen in "flares" and improve during periods of remission. Because the disease can affect other areas of the body, other symptoms may develop and may include:

- Pain, stiffness and inflammation in other joints, such as the ribs, shoulders, knees, or feet.
- Difficulty taking deep breaths if the joints connecting the ribs are affected.
- Vision changes and eye pain due to uveitis, which is inflammation of the eye.
- Fatigue or feeling very tired.
- Loss of appetite and weight loss.
- Skin rashes, in particular psoriasis.
- Abdominal pain and loose bowel movements.

4) Diagnosis of Ankylosing Spondylitis : a) Medical and Family History - It includes duration of pain, Site of pain, aggravating and resolving factors of pain and family history related to back pain, joint pain, or arthritis.

b) Physical Exam - It include: i) Examining the joints, spine, pelvis, heels, and chest ii) Watching movement and bending in different directions, checking for flexibility iii) Asking to breathe deeply to check for rib stiffness and inflammation.

c) Imaging Studies - X-rays help to see joint changes. However, patient may have the disease for years before the changes show on x-rays. X-rays are

useful to monitor the progression of the disease or to rule out other causes for the joint pain. Magnetic resonance imaging (MRI) can help diagnose ankylosing spondylitis in the early stages of the disease. Both x-rays and MRIs are useful to follow the progression of the disease.

d) Lab tests - No single test diagnoses ankylosing spondylitis. However there is a blood test to check for the HLA-B27 gene, which is present in most people with the disease. But each person having the HLA-B27 gene doesn't develop ankylosing spondylitis every time, but it can give more information when making a diagnosis. Complete blood counts and inflammatory markers i.e. Erythrocyte sedimentation rate, C reactive protein, these are important to understand the extent of disease.

5) Treatment of Ankylosing Spondylitis : There is no cure for ankylosing spondylitis; however, with proper treatment the disease can be managed.

The goals of treatment include: i) Relieving symptoms, ii) Help maintain proper posture, flexibility, and strength iii) Halt or slow the progression of the disease. In most cases, treatment includes physical therapy and medication. Sometimes, people with severe disease need surgery to repair joint damage.

I) Physiotherapy - This is a key element of the overall management of all patients. A recent Cochrane review found evidence that physiotherapy had beneficial effects for patients with ankylosing spondylitis, as it Relieve pain, Strengthen back and neck muscles, Improve core and abdominal muscle strength because these muscles provide support for your back, Improve posture, maintain and improve flexibility in joints. A physical therapist can recommend the best sleeping positions and an exercise program. Because the symptoms may worsen when inactive or at rest, it's important to stay active and exercise regularly.

II. Hydrotherapy - Exercise in water, usually a warm, shallow swimming pool or a special hydrotherapy bath; the buoyancy of the water helps make movement easier by supporting you, and the warmth can relax your muscles some people prefer to swim or play sport to keep flexible. This is usually fine, although some daily stretching and exercise is also important.

III. Medications - Most people with ankylosing spondylitis take medications, which may include one or more of the following:

Non Steroidal Anti inflammatory Drugs, the first type of painkiller usually prescribed to help relieve swelling (inflammation) in the joints.

Examples of NSAIDs include Ibuprofen, Diclofenac, Etoricoxib.

a) Paracetamol - If NSAIDs are unsuitable for or if the disease needs extra pain relief, an alternative painkiller such as paracetamol may be recommended.

Paracetamol rarely causes side effects and can be used in women who are pregnant or breastfeeding. However, paracetamol may not be suitable for people with liver problems or those dependent on alcohol.

b) Codeine - If necessary, a stronger type of pain killer called codeine should be given. Codeine can cause side effects such as weakness, constipation and drowsiness.

c) Biological treatments - i) Anti-TNF medicine - If symptoms cannot be controlled using NSAIDs and exercising and stretching, anti-tumour necrosis factor (TNF) medicine may be recommended. TNF is a chemical produced by cells when tissue is inflamed. Anti-TNF medicines are given by injection and work by preventing the effects of TNF, as well as reducing the inflammation in your joints caused by ankylosing spondylitis.

The patient on anti-TNF medicine should be closely monitored. Because in rare cases anti-TNF medicine can interfere with the immune system by then increasing the risk of developing potentially serious infections.

If symptoms do not improve significantly after taking anti-TNF medicine for at least 3 months the treatment will be stopped.

ii) Monoclonal antibody treatment - Monoclonal antibodies, such as secukinumab and ixekizumab, may be offered to people with AS who do not respond to NSAIDs or anti-TNF medicine, or as an alternative to anti-TNF medicine.

This type of treatment works by blocking the effects of a protein involved in triggering inflammation.

d) JAK inhibitors - JAK inhibitors such as upadacitinib are a new type of medicine that may be offered to people with AS who do not respond to anti-TNF medicine or cannot take it.

They work by blocking enzymes (proteins) that the immune system uses to trigger inflammation. They're taken as tablets.

e) Corticosteroids - Corticosteroids have a powerful anti-inflammatory effect and can be taken in an

injection forms by people with AS.

If a particular joint is inflamed, corticosteroids are injected directly into the joint. The injected joint needs to rest up to 48 hours after the injection.

It's usually recommended to limit corticosteroid injections to no more than 3 times in one year, with at least 3 months gap between injections in the same joint.

As corticosteroid injections can cause a number of side effects such as: i) infection in response to the injection. ii) The skin around the injection may change colour (Depigmentation) iii) The surrounding tissue may waste away. iv) A tendon near the joint may burst (rupture).

f) Disease-modifying anti-rheumatic drugs (DMARDs) - Disease-modifying anti-rheumatic drugs (DMARDs) are an alternative type of medicine often used to treat other types of arthritis.

DMARDs may be prescribed for AS, although they're only beneficial in treating pain and inflammation in joints in areas of the body other than the spine.

Salfasalazine and methotrexate are the main DMARDs sometimes used to treat inflammation of joints other than the spine.

IV. Surgery - Most people with AS will not need surgery. However, joint replacement surgery may be recommended to reduce pain and improve movement in the affected joint if the joint has become severely damaged.

For example, if the hip joints are affected, a hip replacement may be carried out.

In rare cases corrective surgery may be needed if the spine becomes badly bent.

Discussion : While studying an integrated treatment approach to ankylosing Spondylitis, both biological and environmental factors should be taken in consideration. As the exact cause of ankylosing spondylitis is unknown and studies show that both genes and environment may lead to the development of the disease. HLA-B27 gene increases the risk of developing ankylosing spondylitis, however many other gene variations that may cause the disease. Considering all this background of the disease the integrated approach is beneficial and plays crucial role in the management of the Ankylosing spondylitis.

The management of Ankylosing Spondylitis requires a team of health care professionals which include : Rheumatologists, who specialize in arthritis and other diseases of the bones, joints, and muscles as in this disease mainly manifests in these particular way. Dermatologists, who takes care of the conditions of the skin, hair and nails. Gastroenterologists, who specialize in conditions of the digestive system. Mental health professionals, who help people cope with difficulties in the home and workplace that may result from their medical conditions.

Nurse educators, who specialize in helping people understand their overall condition and set up their treatment plans. Occupational therapists, who teach ways to protect joints, minimize pain, perform activities of daily living, and conserve energy. Ophthalmologists, who specialize in conditions of the eye. Orthopaedic surgeons, who specialize in treatment and surgery for bone and joint diseases. Physiatrists (physical, medicine, and rehabilitation specialists), who supervise exercise programs. Physical therapists, who help improve joint function. A primary care doctor, such as a family physician or internal medicine specialist, who coordinates care between the different health providers and treats other problems as they arise. Psychologists or social workers, who help with psychosocial challenges caused by medical conditions.

Conclusion : An integrated treatment approach to ankylosing Spondylitis is the best treatment approach for the patient suffering from ankylosing Spondylitis AS to improve their quality of life, sustainability with the disease with no or less sufferings and enjoy the life without ailment to the fullest.

References :

1) API Textbook of medicine 12th edition, Edited by Sandhy A. Kamat. Published by Jaypee Brothers ltd. Pvt.2022.

2) Harrison's Principle of internal medicine 21st edition 2022, Edited by- Loscalzo Fauci Kasper Hauser Longo Jameson. Published by McGraw Hill Medical Publishing Division.

3) Davidson's principles and practice of medicine 24th edition, Edited by- Lan D. Penman, Stuart H. Ralston, Mark W.J. Strachan, Richard P. Hobson 2022. Published by Elsevier.

4) Harping on the need for early disease diagnosis, Dr. Jyotsna Oak, Consultant Internal Medicine and Rheumatology, Kokilaben Dhirubhai Ambani Hospital

5) Https:// www.medicalnewstoday.com /articles/ how-common-is-ankylosing-spondylitis# :~:text= Ankylosing% 20spondylitis% 20(AS)%20is%20relatively, gene%20known% 20as%20HLA%2DB27.

6)Https://www.nhs.uk/conditions/ankylosing-spondylitis /treatment.

Report

National Seminar on “Ahara as Mahabhaishajaya”

Prof. M. S. Hajarnavis

A National Seminar on "**Ahara as Mahabhaishajya (Food as Medicine)**" was organized by the Department of Swasthavritta and Yoga of Center for Postgraduate Studies and Research in Ayurved of Tilak Ayurved Mahavidyalaya, Pune on Sunday 3rd December 2023.

The Paper and Poster presentation competition of the seminar was held on 2nd December 2023. Total 50 papers and 18 posters were presented in the Seminar.

The Seminar began with the lecture by renowned Ayurvedic Physician Vd. Dilip Gadgil on the topic "**Organic Food as Medicine.**" The session was chaired by Dr. Sangeeta Salvi and Cochaired by Dr. Yogesh Kute.

The Inaugural function was held after the first lecture. Welcome address was delivered by Dr. Saroj Patil, Principal of Tilak Ayurved Mahavidyalaya. Introduction of dignitaries and details of the seminar was given by Dr. Mihir Hajarnavis, Programme Director of the Seminar. **Prof. Kamleshkumar Sharma,** Pro Vice-Chancellor of Jyoti Vidyapeeth, Womens Uniersity, Jaipur was the Chief Guest of the seminar. **Dr Jagannath Dixit,** Researcher of the Dixit Diet Plan was the Guest of Honor. **Dr. D. P. Puranik,** President, Rashtriya Shikshan Mandal, Pune Presided over the inaugural function. **Lt. Gen. (Retd.) Dr. Madhuri Kanitkar,** Vice Chancellor of Maharashtra University of Health Sciences, Nashik and **Dr. Tanuja Nesari,** Director All India Institute of Ayurved, New Delhi were the distinguished guests of the inaugural function.

Dr. Madhuri Kanitkar appreciated the concept of Food as Medicine chosen for the seminar. Dr Tanuja Nesari gave a brief introduction of Ahara Regulations passed by FSSAI. Dr Kamlesh kumar Sharma gave examples of food as medicine and described the role of food in health and disease. Prof. Dr. Jagannath Dixit explained the concept of "Dvou Kaal Bhunjeet" as mentioned in Ayurved and described its role for prevention of obesity and Diabetes Mellitus. Dr. D. P. Puranik spoke about various programmes and seminars organized on the occasion of the centenary year of Rashtriya Shikshan Mandal and 90 years completion of Tilak Ayurved Mahavidyalaya. Pune. He extended Best wishes to Seminar.

Dr. B. K. Bhagwat, Ex-Professor and HOD Swasthavritta and Dr. B. S. Keskar, Ex-Professor, Swasthavritta were felicitated for their contribution to the department of Swasthavritta of Tilak Ayurved Mahavidyalaya. Vote of thanks was delivered by Dr Neelima Shisode, Organizing Secretary of the Seminar. The Inaugural Function was compered by Dr Soniya Kale, Dr Maithili Naik, coordinators of the Seminar.

Categorywise prizes (PG and PhD / Teachers) of the Paper presentations were given in the inaugural function. Dr. Vinaya

Inaugural Function - L to R - Dr. Ujagare, Dr. Salvi, Dr. Sharma, Dr. Huparikar, Dr. Bhagwat, Dr. Kanitkar, Dr. Puranik, Dr. Dixit, Dr. Nesari, Dr. Patil, Dr. Hajarnavis, Dr. Inamdar, Dr. Shisode.

Release of Ayurvidya Special, L to R - Dr. Huparikar, Dr. Bhagwat, Dr. Sharma, Dr. Puranik, Dr. Dixit, Dr. Nesari, Dr. Shisode, Dr. Hajarnavis, Dr. Inamdar.

Felicitation of Dr. Keskar B. S. L to R - Dr. Salvi, Dr. Ujagare, Dr. Bhagwat (on stage), Dr. Huparikar, Dr. Sharma, Dr. Kanitkar, Dr. Puranik, Dr. Nesari, Dr. Patil, Dr. Hajarnavis, Dr. Dixit, Dr. Shisode.

Felicitation of Dr. B. K. Bhagwat, L to R - Dr. Huparikar, Dr. Sharma, Dr. Kanitkar, Dr. Bhagwat, Dr. Puranik, Dr. Dixit, Dr. Nesari, Dr. Hajarnavis, Dr. Patil, Dr. Shisode.

Dixit, Dr. Taaranoom Patel, Dr. Indira Ujagare, Dr. Arti Firke, Dr. Asmita Jadhav, Dr. Rucha Ganu worked as evaluators for the paper presentations.

After the Inaugural Function Prof. Dr. Jagannath Dixit delivered a Research Based Lecture on **'Dixit Diet for Effortless Weightloss and Reversal of Diabetes Mellitus'.** The session was Chaired by Prof. Dr S. G. Natu and Co Chaired by Dr. Minakshi Randive.

Dr. Pushkar Wagh delivered a talk on **'Application of Millets in Annavahasrotas Disorders.'** This session was chaired by Prof. Dr. Kamlesh Kumar Sharma and co chaired by Dr Jyoti Jagtap.

Post lunch a lecture on **"Apllication of Kshemkutuhal and Bhojan kutuhal in Clinical Practice"** was delivered by Prof. Dr. Kashinath Samagandi. This session was Chaired by Dr N. V. Borse and co chaired by Dr. Kirti Bhati.

Dr. Abhijeet Saraf delivered a talk on **"Concept to Clinical Application of Ahara as Bheshaja and Ajeerna Manjiri in Clinical Practice."** This session was Chaired by Dr. Indira Ujagare and co-chaired by Dr Apoorva Sangoram.

The last session was held by the lecture **"First Aid Diet in Ayurvedic General Practice"** by Dr. Vishakha Deulgaonkar. This session was Chaired by Dr Saroj Patil and co chaired by Dr Pravin Bhat.

Felicitations of the organizing committee was done in the valedictory session which was presided by Dr Saroj Patil, Principal of the college. Dr Indira Ujagare and Dr Sangeeta Salvi-Vice Principals were present for the valedictory function. Prizes of the Poster presentations were given. Dr. Nitesh Joshi, Dr. Deepali Manore and Dr. Deepa Bhanage worked as evaluators for the poster presentations. The seminar war supported by various pharmacies and organic food vendors by their stalls. Total 127 delegates attended the seminar.

Dr. Mihir Hajarnvavis-Programme Director, Dr Neelima Shisode and Dr Sharvari Inamdar-Organizing Secretary and Dr Soniya Kale, Dr Maithili Naik - Coordinators along with all the postgraduate students in the department of Swasthavritta and Non-Teaching staff worked for the organization of the seminar.

अहवाल

Snake Bite Management - Workshop

डॉ. शेखर घनवट

राष्ट्रीय शिक्षण मंडळ शतक महोत्सवी वर्षानिमित्त मेहेंदळे दवाखाना यांच्यावतीने टिळक आयुर्वेद महाविद्यालय पुणे येथे नुकतेच वैद्यकीय पदवी व पदव्युत्तर विद्यार्थी व डॉक्टर्स यांच्यासाठी **"Snake Bite Management"** यामध्ये सर्पदंश लक्षणे, निदान, उपचार व प्रतिबंध, प्रथमोपचार या विषयी कार्यशाळेचे आयोजन करण्यात आले होते. त्यामध्ये जागतिक सर्पदंश तज्ञ विघ्नहर मेडिकल फौंडशनचे अध्यक्ष डॉ. सदानंद राऊत यांचे व्याख्यान आयोजित करण्यात आले होते.

त्यामध्ये सर्पदंश झाल्यानंतर घ्यावयाची काळजी, प्राथमिक उपचार, विषारी, बिनविषारी सापांची ओळख, उपचार पद्धती, अंधश्रद्धा निर्मूलन तसेच सर्पदंश होऊच नये याची माहिती डॉ. सदानंद राऊत यांनी दिली.

कार्यशाळेचे उद्घाटन संस्थेचे अध्यक्ष मा. प्रा. डॉ. दिलीप पुराणिक, डॉ. सदानंद राऊत, डॉ. संजय गव्हाणे यांच्या हस्ते दीपप्रज्वलन करून धन्वंतरी पूजन करण्यात आले. धन्वंतरी स्तवन डॉ. स्नेहल निकास यांनी केले. त्यावेळी मेहेंदळे दवाखाना समितीचे अध्यक्ष डॉ. संजय गव्हाणे यांनी प्रास्ताविक केले. सचिव डॉ. शेखर घनवट यांनी पाहुण्यांची ओळख व संस्थेची माहिती दिली. टिळक आयुर्वेद महाविद्यालयाचे उपप्राचार्य डॉ. मिहीर हजरनवीस, डॉ. इंदिरा उजागरे, डॉ. संगिता साळवी, तसेच डॉ. पल्लवी राऊत, डॉ. बी. जी. धडफळे इ. मान्यवर उपस्थित होते. डॉ. दिलीप पुराणिक यांनी संस्थेची शतकी वाटचालीची माहिती दिली. विषारी, बिनविषारी सर्प ओळखणे, सर्पदंशाची लक्षणे, प्रथमोपचार व गंभीर रुग्णांवरील उपचार, सर्पदंश होऊच तये म्हणून प्रतिबंधात्मक उपाययोजना या विषयीची सविस्तर माहिती डॉ. सदानंद राऊत यांना दिली. ''शून्य सर्पदंश, मृत्यूदर प्रकल्प'' हा माहितीपट दाखविण्यात आला. सर्पदंश हा शेतीसंबंधी होणारा गंभीर अपघात असून तत्काळ योग्य ते उपचार केल्यास अतिगंभीर रुग्णांचे प्राणसुद्धा वाचू शकतात त्यासाठी व्यापक प्रमाणात जनजागृती व डॉक्टरांना प्रशिक्षण देणे गरजेचे असते असे प्रतिपादन डॉ. सदानंद राऊत यांनी केले. जागतिक आरोग्य संघटनेने २०३० सालापर्यंत सर्पदंशाने मृत्यूचे प्रमाण ५०% कमी करण्याचे ठरविले आहे. डॉ. राऊत यांनी सर्पदंशाने होणाऱ्या मृत्यूचे प्रमाण लक्षणियरित्या कमी केले असून अपंगत्वाचे व किडनी निकामी होण्याचे प्रमाणही कमी करून ते जनजागृती करण्याबरोबरच डॉक्टरांना प्रशिक्षण देत आहेत ही बाब अतिशय कौतुकास्पद आहे असे डॉ. दिलीप पुराणिक यांनी सांगितले. एकूण ३०० हून अधिक पदवी व पदव्युत्तर वैद्यकीय विद्यार्थी व ८० हून अधिक मान्यवर डॉक्टर्स याप्रसंगी उपस्थित होते. प्रसिद्ध नेत्ररोगतज्ञ डॉ. विवेक कानडे यांनी कार्यक्रमाचे सूत्रसंचलन केले व कार्यक्रमाचा समारोपही त्यांनीच केला.

व्याख्यानास उपस्थित श्रोतृवर्ग.

डॉ. राउत व्याख्यान देतांना

उद्घाटन प्रसंगी डावीकडून –
डॉ. कानडे, डॉ. राउत,
डॉ. घनवट, डॉ. पुराणिक,
डॉ. पल्लवी राउत, डॉ. गव्हाणे,
डॉ. हजरनवीस.

निद्रास्वास्थ्य

डॉ. अपूर्वा संगोराम, कार्यकारी संपादक

मागील २ ते ३ महिन्यांपासून शालेय मुलांच्या झोपेबाबतचा प्रश्न अचानक ऐरणीवर आला आणि त्यातून लहान मुलांची झोप पूर्ण होत नसल्यामुळे त्यांच्या स्वास्थ्यावर त्याचा दुष्परीणाम होतो असे लक्षात आले त्यामुळे पहीली ते सातवी पर्यंतच्या विद्यार्थ्यांच्या शाळेची वेळ दुपारची असावी असा निर्णय घेण्यात आला.

एकूण निद्रा/झोप याचा स्वास्थ्याशी किती निकटचा संबध आहे याचा थोडक्यात उहापोह या लेखाच्या निमित्ताने करूया. आयुर्वेदामध्ये, व्यक्तीचे स्वास्थ्य हे आहार, विहार, निद्रा आणि ब्रह्मचर्य याचा समतोल राखल्यास उत्तम राहू शकते याचा प्राचीन कालापासूनच उल्लेख आहे. प्रत्येक व्यक्तीसाठी किती तास झोप आवश्यक आहे याचेही दाखले देण्यात आलेले आहेत. यानुसार सर्वसाधारणपणे लहान बालकांना १२ ते १४ तास, तरुण व्यक्तींना ८ ते १० तास, मध्यमवयीन व्यक्तींना ७ ते ८ तास आणि ज्येष्ठांना ६ ते ८ तास अशी झोप आवश्यक आहे. यामध्ये स्वस्थ व्यक्तींनी झोप ही रात्रीच घ्यावी दिवसा घेऊ नये असेही उल्लेख आहेत. फक्त रात्री जागरण झाल्यास किंवा रात्रीच नियमित काम करणारे कर्मचारी यांनी दिवसा झोप घ्यावी असे उल्लेख आढळतात.

निद्रा ही शरीराला किती उपकारक आहे हे सांगताना खालील श्लोकाचा उल्लेख आढळतो,

निद्रायत्तं सुखं दुःख पुष्टिः कार्श्ये बलाबलम् ।
वृषता क्लीबता झानमज्ञानं जीवितं न च ।। च. सू. २१

निद्रेवरच सुख म्हणजे अनुकुल संवदेना, प्रतिकुल वेदना शरीराची पुष्टी, बल हे अवलंबून आहे. अपुरी निद्रा झाल्यास कार्श्य म्हणजे शरीरक्षीणता, बलहानी इ. दुष्परीणाम जाणवतात.

अनेक व्यक्तींना आपल्याला निद्रानाशाचा विकार जडतो आहे हे लक्षात यायला वेळ लागतो किंवा सातत्याने झोप अपुरी होत असेल तर त्याचे शरीरावर दुष्परीणाम होऊ शकतात याची जाणीवच नसते त्यामुळे अशा प्रकारचे त्रास होत असतील तर तातडीने वैद्यांचा सल्ला घेणे आवश्यक आहे.

आयुर्वेदामध्ये अनेक निद्राजनन करणाऱ्या द्रव्यांचा उल्लेख आढळतो. यामध्ये माहिषक्षीरापासून ते जातिफळ, खसखस यासारख्या द्रव्यांपासून काही सोप्या औषधी बनवून त्याचा वापर केल्यास किंवा शिरोधारा सारख्या चिकित्सेने निद्रानाशा सारख्या भयंकर विकारा पासून सुटका होऊ शकते.

निद्रेचे महत्व सर्व जगानेही मान्य केले आहे. आजच्या धावपळीच्या व बदललेल्या जीवनशैलीमुळे झोपेचे महत्व हे संपूर्ण जगासमोर आणण्याची गरज निर्माण झाली आहे त्यामुळेच, **'वर्ल्ड स्लीप डे'** हा दरवर्षी मार्च महिन्यातील तिसऱ्या शुक्रवारी साजरा केला जातो. सर्वात प्रथम २००८ मध्ये हा दिवस साजरा करण्यात आला.

यावर्षी १५ मार्च २०२४ रोजी 'जागतिक निद्रा दिवस' साजरा करण्यात येणार आहे. यावर्षीची निद्रा दिवसाची संकल्पना, 'वैश्विक स्वास्थ्यासाठी स्लीप इक्विटी' अर्थात 'स्वास्थ्यासाठी झोप आवश्यक' अशी आहे. यानिमित्ताने संपूर्ण जगभरात चर्चासत्रे, सेमिनार, कार्यशाळा यांचेही आयोजन करण्यात येणार आहे.

संपूर्ण जग विविध व्याधींच्या कारणांचा शोध घेत असताना 'निद्रानाश' हे सुद्धा अनेक व्याधींचे कारण आहे हे पुन्हा एकदा प्रकर्षाने जगासमोर आले. आयुर्वेदशास्त्राने सुरुवातीपासूनच याचा गांभिर्याने विचार केला आहे. त्यामुळेच आयुर्वेदशास्त्राचे पाईक म्हणून सर्व जगाला निद्रेविषयी जागरुक करु या आणि स्वास्थ्याचे संवर्धन करु या.

शतश्री...

डॉ. सौ. विनया दीक्षित, उपसंपादक

स्वदेशी शास्त्र व राष्ट्रहित, स्वदेशाचा विकास व प्रगती साधण्यासाठी मूलभूत स्वदेशी ज्ञानविज्ञानाचे शिक्षण ही लोकमान्य टिळकांची स्फूर्तीदायी संकल्पना, स्वातंत्र्यपूर्व–काळात वैद्यराज पुरुषोत्तमशास्त्री नानल, साहित्यमहर्षी श्री. न. चिं. केळकर, डॉ. बा. चिं. लागू व वैद्य ना. व्यं. जोशी ह्या द्रष्ट्या धुरीणांनी ९ फेब्रुवारी १९२४ रोजी राष्ट्रीय शिक्षण मंडळ या संस्थेची स्थापना करुन प्रत्यक्षात आणली.

आयुर्वेदोपदेशेषु विधेय: परमादर:। या उक्तीनुसार आयुर्वेदीय उपचारांसाठी **'मेहेंदळे दवाखाना', 'नानल रुग्णालय'** अलिकडच्या काळातील **'कै. कृ. ना. भिडे आयुर्वेद संस्था'** या तीन घटक संस्था व संलग्न **'शेठ ताराचंद धर्मार्थ रुग्णालय'** हे राष्ट्रीय शिक्षण मंडळाचे सामाजिक आरोग्य क्षेत्रात सर्व स्तरातल्या मानवांसाठी पंचकर्मादी सर्व आयुर्वेदिक उपचार व आवश्यक तेथे अर्वाचीन शस्त्रकर्मादी आधुनिक वैद्यकाचे उपचार असे माफक दरांत उत्तम अनुभवी वैद्यांव्दारा देणारे मोठे आधारस्तंभच आहेत.

रुग्णालयात यशस्वी चिकित्सा उपचार करण्यासाठी तितकीच शुद्ध व दर्जेदार आयुर्वेदिक औषधे खात्रीशीरपणे उपलब्ध होणे गरजेचे असते. हीच बाब लक्षात घेऊन **'आयुर्वेद रसशाळेची'** स्थापना झाली. GMP Certified व स्वत:ची उत्कृष्ठ Quality Control प्रयोगशाळा असलेला हा आयुर्वेदिक औषधांचा कारखाना प्रत्येक सदस्याला अभिमान वाटावा असाच आहे. प्राचीन व आधुनिक औषधी स्वरुपात परंपरागत व संशोधनाने सिद्ध असे अनेक औषधी कल्प संपूर्ण भारतभर तसेच अनेक विविध देशांत गौरवाने पुरविणारी रसशाळा राष्ट्रीय शिक्षण मंडळाचा एक मानबिंदूच आहे.

औषधी निर्माण व रुग्णसेवा यांचा मेळ साधायचा तर आयुर्वेदीय चिकित्सेत विविध विभागांत आत्मश्विासाने व आपुलकीने काम पाहणारे चांगले गुणवान वैद्य तयार होणे ही आवश्यक असते. आयुर्वेद हे भारतीय परंपरागत वैद्यक विज्ञान आहे. त्याचे ग्रंथोक्त व व्यावहारिक ज्ञान, प्रात्यक्षिक प्रयोगांसह स्नातकांना देण्यासाठी **'टिळक आयुर्वेद महाविद्यालयाची'** स्थापना झाली. आयुर्वेदातील पदवी, पद्व्युत्तर एम डी / एम एस, पीएच. डी. असे सर्व शिक्षण देणारी ही संस्था भारतात पहिल्या क्रमांकाने प्रसिद्ध आहे. **'सेंटर फॉर पोस्ट ग्रॅज्युएट स्टडीज अँड रिसर्च इन आयुर्वेद'** ही पद्व्युत्तर शिक्षण देणारी संस्था विद्यार्थ्यांना मार्गदर्शन करते.

या शैक्षणिक संस्थेला पूरक व औषधी – रुग्णसेवेत प्रत्यक्ष व्यवहारात आणण्यासाठी आयुर्वेदातील शास्त्रीय संशोधन प्रकल्पांना आधारभूत अशी **'रीसर्च इन्स्टीट्यूट ऑफ हेल्थ सायन्सेस'** राष्ट्रीय शिक्षण मंडळची शान आहे. याबरोबरच सध्याच्या युगात आवश्यक असणारे विपणनाचे कौशल्य विकसित करणारी **'चेतन दत्ताजी गायकवाड इन्स्टीट्यूट ऑफ मॅनेजमेंट स्टडिज'** विविध एम बी ए कोर्सेस यशस्वीपणे राबवत आहे.

या सर्व संस्थांतील आयुर्वेदीय शिक्षण, संशोधन व रुग्णसेवेतील अनुभव आयुर्वेदाच्या अभ्यासकांपर्यंत पोहचवणारी आयुर्वेदीय प्रकाशन क्षेत्रातील प्राचीनतम व अद्ययावत संस्था म्हणजे आयुर्विद्या मासिक. राष्ट्रीय स्तरावरचे दर महिन्याला प्रकाशित होणारे **'आयुर्विद्या मासिक'** – Peer Reviewed Research Journal, Dedicated to Ayurved हे भारतभर नियमितपणे वाचले जाते. वर्षातून दोनवेळा प्रकशित होणारे **'Ayurvidya International'** हे Research Indexed Journal In Ayurved जागतिक स्तरावर मान्यताप्राप्त आहे. **'E-ayurvidya'** द्वारा डिजीटल वाचकांशी संवाद साधला जातो. **'आरोग्यदीप दिवाळी अंक'** हा सामान्य जनांना सुखी दीर्घायुष्याचा कानमंत्र देणारा अनेक पुरस्कारांनी गौरवलेला आहे.

या सर्व घटक संस्थांचा चमू यशस्वीपणे प्रगतीपथावर ठेणारी **'राष्ट्रीय शिक्षण मंडळ'** ही जनक संस्था एका मोठ्या टप्प्यावर आता उभी आहे. शतकवर्षाची पूर्तता! संपन्नतेचा दिमाखदार सोहळा! अभिमानास्पद गौरवगाथा! एक सदस्य म्हणून संस्थेला शतकांजली!! त्रिवार प्रणाम!!!


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Registered
Posting at PSO, Pune GPO - 411001
Posted & Published on 10 / 02 / 2024
RNI Registration No. MAH MAR - M / 1968 / 14835
This magazine is printed at Unique Offset, 607/A, Dhayari-Narhe Road, Narhe Gaon, Tal. Haveli, Pune-41 by Dinesh Deodhale & Published at 1833, Rasta Peth, Pune - 11 by Dr. S.P.Patwak on behalf of Pandurang Shikshan Mandal, 23, Karve Road, Pune - 4. Editor : Dr. S. P. Patwak