

**AYURVEDIC MANAGEMENT OF A PATIENT WITH MULTIPLE SCLEROSIS: A CASE
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ABSTRACT

Background: Multiple sclerosis (MS) is a chronic immune-mediated inflammatory and demyelinating disorder of the central nervous system causing variable neurological disability. From an Ayurvedic perspective, its manifestations may be interpreted predominantly through *Vāta* involvement, with *Majjā Dhātu* impairment, *Āvaraṇa*, and *Dhātu-kṣaya* contributing to neurological dysfunction. **Aim and Objectives:** To evaluate the clinical response of an individualized Ayurvedic treatment protocol in a patient with long-standing MS, focusing on lower-limb weakness, stiffness, balance, and functional disability. **Materials and Methods:** A 42-year-old male with a 19-year history of episodic neurological symptoms presented with progressive difficulty in walking and stair climbing, bilateral lower-limb weakness, stiffness, tremor, and impaired balance. Ayurvedic assessment revealed predominant *Vāta* involvement with *Majjā Dhātu* involvement, *Āvaraṇa*, and *Dhātu-kṣaya*. Treatment included *Rukṣa Chūrṇa Piṇḍa Sveda*, *Takradhāra*, *Virecana*, *Sarvāṅga Abhyāṅga*, *Śāṣṭika Śālī Piṇḍa Sveda*, and *Mustādi Rājayāpana Kāla Basti*, along with oral *Śamana Auśadhis*. Outcomes were assessed using the Expanded Disability Status Scale (EDSS), Berg Balance Scale (BBS), Modified Ashworth Scale (MAS), clinical parameters, and MRI findings where available. **Results:** After two months of treatment, improvement was observed in lower-limb function, stiffness, balance, and mobility. Changes in EDSS, BBS, and MAS indicated improvement in functional status and muscle tone. **Conclusion:** An individualized Ayurvedic multimodal approach may provide supportive benefits in managing neurological disability and functional impairment associated with long-standing MS. Controlled studies with standardized outcomes and longer follow-up are warranted.

KEYWORDS: Multiple Sclerosis, Vatavyadhi, Majja dhatu, Avarana, Basti, Panchakarma.**INTRODUCTION**

Multiple Sclerosis (MS) is a chronic, immune-mediated neurological disorder of the central nervous system (CNS), characterized by inflammation, demyelination, and neurodegeneration. It occurs when the immune system mistakenly attacks the myelin sheath, resulting in impaired nerve conduction and progressive neurological dysfunction. MS presents with a wide range of clinical manifestations, including sensory disturbances, motor weakness, optic neuritis, fatigue, and cognitive impairment.^[1] The disease is classified into various clinical types, such as Relapsing-Remitting MS (RRMS), Primary Progressive MS (PPMS), and Secondary Progressive MS (SPMS). Diagnosis is established based

on clinical evaluation, magnetic resonance imaging (MRI) showing demyelinating lesions in the white matter, cerebrospinal fluid (CSF) analysis revealing oligoclonal bands, and evoked potential studies.^[2]

Diagnosis is based on clinical and radiological evidence demonstrating dissemination of lesions in space and time, together with exclusion of alternative neurological disorders. The 2017 McDonald criteria incorporated cerebrospinal-fluid-specific oligoclonal bands as evidence supporting dissemination in time, while the revised 2024 criteria further recognize the optic nerve as an anatomical site and incorporate additional MRI and CSF biomarkers.^[3]

In Ayurveda, there is no direct classical disease entity corresponding exactly to MS. Based on its clinical manifestations, correlated MS with *Kaphavrta Vyana Vata*, *Avaranajanya Vata Vyadhi*, and *Majja Dhatu Kshaya*.^[4] Chronic neurological manifestations such as weakness, stiffness, gait disturbance, tremor and sensory impairment may be interpreted according to the predominance of *Vata Dosha* and the tissues and channels involved. The core pathogenesis involves obstruction (*Avarana*) of *Vyana Vata* by *Kapha Dosha*, leading to impairment in sensory and motor functions. This is further compounded by depletion of *Majja Dhatu*, which weakens structural and functional integrity of nervous system. The disease process primarily affects *Majjavaha* and *Rasavaha Srotas*, resulting in a progressive neuromuscular decline marked by symptoms such as muscle weakness, stiffness, fatigue, and impaired coordination.^[5]

The present case describes the Ayurvedic assessment and individualized management of a patient with long-standing MS, with particular emphasis on *Avarana*, *Majja Dhatu* involvement and *Dhatukshaya*, using a multimodal therapeutic approach comprising *Shodhana*, *Basti*, *Brimhana* and supportive therapies.

CASE PRESENTATION

Chief complaints

Patient complains of difficulty in walking and climbing stairs and weakness of both lower limbs since one month.

Associated complaints

Imbalance while standing and walking, tremors, stiffness, difficulty standing for prolonged periods, and impaired postural balance.

Timeline of major clinical events

Year/date	Clinical event
2006	Insidious right lower-limb pain and weakness, proximal-to-distal progression.
2007–2008	Distal right upper-limb weakness.
2012	Difficulty in climbing stairs/rising from squatting, slipping of footwear, diagnosis of multiple sclerosis; two rituximab doses.
2013	Episodes of diplopia without blurring.
2017	Increased urinary frequency; subsequent left lower-limb pain and weakness.
2021- 2023	Took 6 doses of rituximab injection
10–23 Nov 2025	Previous Ayurvedic treatment course at Hitech Panchakarma Hospital.
1–16 Dec 2025	Index inpatient Ayurvedic treatment course documented in the supplied case.

Clinical Examination

General physical examination

General condition was fair. Built was normosthenic and nourishment was moderate. Pallor, icterus, cyanosis, clubbing, lymphadenopathy and edema were absent. The patient was afebrile. Pulse was 76 beats/min, blood pressure 100/80 mmHg, and respiratory rate 16 cycles/min. Height was 173 cm, weight 70 kg, and BMI 20.23 kg/m².

History of present illness

A 42-year-old male patient, Mr. Vijith, with no history of diabetes mellitus, hypertension, or thyroid disorders, was apparently normal until 19 years ago. In 2006, he initially developed pain, weakness, and difficulty in using the right lower limb. He consulted a nearby hospital and received symptomatic treatment. Over the next one year (2007–2008), the symptoms gradually progressed to the right upper limb, following which there was partial reduction of symptoms. Later, in 2012 he noticed difficulty in climbing stairs and getting up from a squatting position and slipping of footwear while walking, with awareness. He then visited a hospital where, after evaluation, he was diagnosed with Multiple Sclerosis. He was advised medical treatment and received Rituximab injections once every 15 days, of which he took two doses only, after which he discontinued the medication. In 2013, he developed episodes of double vision without blurring of vision. In 2017, he noticed increased frequency of urination. Subsequently, he developed pain, weakness, and difficulty in using the left lower limb as well. The symptoms were episodic in nature, with periods of worsening followed by partial improvement, and were not continuously progressive. At present, since 1 month the patient complains of difficulty in walking and climbing stairs, weakness of both lower limbs, difficulty in standing for a prolonged period, inability to maintain balance while standing and walking, and mild tremors. For these complaints patient got admitted to Hitech Panchakarma Hospital for better management.

On Ashtasthana Pariksha, Nadi was recorded as Kaphaja; Mala and Mutra were Prakruta; Jihwa was Lipta; Shabda was Prakruta; Sparsha was Ushna; Drik was Prakruta; and Akrti was Madhyama.

On Dashavidha Pariksha, Prakruti was Kapha-Vataja and Vikruti was predominantly Vata, with Rasa, Rakta, Mamsa, Asthi, and Majja documented as Dushya. Sara, Samhanana, Pramana, and Satva were Madhyama; Satmya was Sarvarasa. Ahara Shakti was Madhyama both before and during illness, whereas Vyayama Shakti

changed from Pravara before illness to Avara during illness. Age was assessed as Madhyama Vaya.

Systemic examination

Respiratory examination was normal, with centrally placed trachea, symmetrical vocal fremitus, resonant percussion note, and bilateral vesicular breath sounds without added sounds. The abdomen was soft and non-tender, with no palpable organomegaly and normal bowel sounds. Cardiovascular examination revealed a palpable apex beat at the fifth intercostal space, normal cardiac dullness, and audible S1 and S2 without murmurs.

Neurological examination

Gait - spastic.

Higher mental functions were normal: the patient was conscious and oriented to time, place, and person; immediate, recent and remote memory were documented as intact; behavior, intelligence, attention, mood and affect were appropriate; hallucinations, delusions and speech disturbance were absent.

Cranial nerve examination – Intact

Motor System Examination

Muscle bulk was symmetrical without wasting or hypertrophy.

Muscle bulk	Right	left
Mid arm	30cm	30cm
Mid forearm	23cm	23cm
Mid thigh	51cm	51cm
Mid calf	31cm	30cm

Muscle Power

Muscle group	Right	Left
Arm	5/5	5/5
Forearm	5/5	5/5
Thigh	4/5	5/5
Calf	4/5	4/5
Foot	5/5	5/5

Therapeutic Intervention

Therapy	Composition	Duration	Treatment period
Ruksha pinda sweda and takradhara	Jadamayadi churna ruksha pinda sweda Takradhara with amalaka churna and mustha with takra	5 days	1/12/2025 to 5/12/2025
Virechana	Snehapana with Guggulutiktaka ghruta for 4 days Sarvanga abhyanga with mahanarayana taila for 3 days Virechana with trivruth lehya 50 g with milk	8 days	6/12/2025 to 13/12/2025
Sarvanga abhyanga f/b	Mahamasha taila + Ksheerabala taila	7 days	1/1/2026 to 7/1/2026

Muscle Tone

Muscle tone	Right	Left
Upper limb	Normotonia	Normotonia
Lower limb	Spasticity	Spasticity

Deep tendon reflexes were graded ++ bilaterally at biceps, triceps, supinator, knee and ankle. Babinski sign was positive.

Involuntary Movements-Tremor was present.

Coordination Test

Romberg test - Positive.

Finger–nose test- Negative

Dysidiadochokinesia-Absent

heel–shin testing- Negative

Sensory System Examination

Superficial sensations-Intact

Deep Sensation- Two-point discrimination was diminished in both upper limbs at the forearm and in both lower limbs at the calf region.

Cortical Sensation-Intact

Diagnostic Assessment

MRI of the brain showed bilateral near-symmetric T2/FLAIR hyperintensities in the periventricular and deep cerebral white matter and middle cerebellar peduncles. Expanded Disability Status Scale (EDSS)^[6], Berg Balance Scale^[7], Modified Ashworth Scale^[8], were utilized to evaluate the effect of therapy on overall health status, balance, and disease-specific quality of life in this patient.

Autoimmune and immunological investigations

The available 2018 autoimmune evaluation from the National Institute of Mental Health and Neuro Sciences (NIMHANS) documented serum anti-aquaporin-4 (NMO) IgG antibodies as negative and anti-MOG IgG antibodies as negative. A contemporaneous biochemical report documented IgE 5.7 IU/mL, IgA 118 mg/dL, IgG 918 mg/dL, and IgM 175 mg/dL. These findings provide supportive information against AQP4-IgG-positive NMOSD and MOG-antibody-associated disease in that historical sample, but do not by themselves establish or exclude all alternative diagnoses.

Shashtika shali pinda sweda			
Mustadi Rajayapana kala basti	Anuvasana: Balashwagandha Lakshadi Taila 35 mL + Mahanarayana Taila 35 ML Niruha Basti: Honey-30 mL Saindhava Lavana- 6 g Balashwagandha Lakshadi Taila 35 mL + Mahanarayana Taila 35 mL; Yashtimadhu Churna-10g Ashwagandha Churna-10g Kapikacchu Churna-10g Mustadi Yapaka Ksheerapaka-500ml Avapa—Mamsa Rasa 100 mL	16 days	1/1/2026 to 15/1/2026
Shamana chikitsa	1. Ksheerabala 101 capsule 1-0-1 after food 2. Palsinuron capsule 1-0-1 after food 3. Maharasnadi kashaya 2tsp -0-2tsp with 4tsp of luke warm water a/f 4. Narasimha rasayana 2tsp-0-0 b/f	15 days	16/1/2026 to 30/1/2026
Ksheerapaka	Ashwagandha, Kapikacchu and Yashtimadhu	15 days	16/1/2026 to 30/1/2026

Outcome and Follow-up

At the time of discharge, the patient was instructed to follow a prescribed oral medication regimen in the outpatient setting and scheduled for weekly follow-up visits.

The patient's progress was assessed at three points: prior to the initiation of *Ayurvedic* treatment, at discharge, and after one month of treatment.

Recommended/standardized assessment	Pre-treatment	Post-treatment
Expanded Disability Status Scale (EDSS)	6	3.5
Berg Balance Scale	28	45
Modified Ashworth Scale	1+	1
MRI lesion	hyperintensities in the periventricular and deep cerebral white matter and middle cerebellar peduncles.	Same as previous, no further progression

DISCUSSION

Pathogenesis can be interpreted based on the clinical manifestations and principles of *Dosha-Dushya Sammurchana*. In the present case, predominant involvement of *Vata Dosha*, particularly *Vyana Vata*, along with *Kapha Avarana* and *Majja Dhatu Kshaya*, may be considered.^[9]

The initial pathology may involve *Agni Mandya* and *Ama* formation, followed by *Kapha Prakopa* and *Srotorodha*. This can result in *Avarana* of *Vyana Vata*, leading to impairment of its normal functions and producing manifestations such as weakness, stiffness, tremor, impaired coordination, gait disturbance and balance impairment. With chronicity, persistent *Avarana* may contribute to *Vata Prakopa* and depletion of deeper tissues, particularly *Majja Dhatu*.^[10]

In the present case, involvement of *Majjavaha Srotas* is considered important due to the predominant neurological manifestations, including motor weakness, sensory impairment, tremor and spasticity. The chronic and episodic nature of the condition may further

contribute to *Dhatukshaya*, resulting in progressive functional impairment.

Thus, the *Ayurvedic* pathology may be understood as a predominantly *Vata*-associated disorder involving *Kapha Avarana*, *Srotorodha*, *Majja Dhatu* involvement and subsequent *Dhatukshaya*. This interpretation provides the rationale for adopting a sequential treatment approach aimed at correcting *Agni*, reducing *Ama* and *Avarana*, restoring normal *Vata Gati*, and subsequently providing *Brimhana* and *Rasayana* support.

a) Churna pinda sweda

In Churna pinda sweda Kolakulattadi Churna used as Ruksha Pinda Sveda acts by removing *Kapha-ama avarana* over *Vata* due to its laghu, ruksha and usha properties. The svedana opens obstructed srotas, especially *Majjavaha srotas*. By clearing obstruction, it restores normal *Vata gati*, and prepares the body as purvakarma for further *Vata-shamana* therapies such as Basti and Rasayana.^[11]

b) Takradhara

In Takra dhara, Takra with the combination of Amalaki churna and Musta is used for seven days Takra is laghu, ruksha, ushna and dipana–pacana in nature Continuous pouring over the head reduces Kapha and ama Relieves mental stress, which improves Agni Clears srotorodha and corrects agnimandya Facilitates digestion and elimination of Ama.^[12]

c) Shodhana karma

Virecana Karma was used as *Śodhana Chikitsā*. In Ayurvedic literature, *Pittadhara Kalā* is correlated with *Majjādhara Kalā*, and *Virecana* is described as an important therapy for disorders involving *Pitta* Therefore, *Virecana* with *Trivṛt Avaleha* administered with lukewarm milk was adopted in the present case with the objective of eliminating aggravated *Pitta* and associated *Doṣas* from the *Koṣṭha*, supporting *Agni* and facilitating subsequent *Vāta*-pacifying and *Br̥mhaṇa* therapies.^[13]

d) Brumhana chikitsa

Sarvanga abhyanga with Mahamasha taila+Ksheerabala taila f/b Shashtikashali pinda sweda¹⁴ Sarvāṅga abhyanga with Mahāmāṣa Taila and Kṣīra Bala Taila helps in MS by pacifying aggravated *Vāta*, nourishing *Majjā* and *Mamsa dhātu*, and reducing spasticity, stiffness, pain, and weakness. It improves muscle strength, nerve function, circulation, and neuromuscular coordination, while providing *br̥mhaṇa*, *balya*, and neuroprotective effects, thereby supporting functional recovery and slowing degeneration.

Shashtikashali pinda sweda It possesses *Brimhana*, *Vatahara*, and *Balya* properties. Swedana effect of the *Shastika shali pinda swedana* causes vasodilatation; as a result of this, blood circulation improves and results in increased metabolic activity with the stimulation of neural receptors within the skin or tissue and helps in carrying away the toxins.

Mustadi Rajayapana kala basti

Basti is the best treatment for vitiated *Vata Dosha*. *Yapana Vasti* has the ability to support life and promote longevity. *MRB* performs dual actions of *Shodhana* and *Rasayana* simultaneously. *Rasayana* becomes more effective when preceded by a suitable *Panchakarma* therapy. *MRB* is having "Sadyo-Balajanana" (improves strength quickly), *Vatashamaka* and *Rasayana* properties. *Thikta Rasa* may have positive impact on cell implantation and also reduce the degeneration of *Asthi* and *Majja*. Therefore, *MRV* has a positive effect on neurological disorders and wasted muscle.^[15]

e) Shamanoushadi

Ksheerabala 101^[16] was selected for its *Vāta*-pacifying, *Balya* and *Brimhana* properties, owing to the presence of *Bala*, *Ksheera* and *Tila Taila*. *Maharasnadi Kashaya*^[17], a multi-drug *Vāta*-*Kapha*-oriented formulation containing *Rasna*, *Bala*, *Eranda*, *Devadaru*, *Guduchi* and

Ashwagandha, was employed to address stiffness, pain, heaviness and impaired mobility. *Palsinuron* was used as an adjunctive *Vāta*-oriented proprietary formulation for neuromuscular symptoms. *Narasimha Rasayana*^[18] support MS management through its *Rasāyana*, *Balya* and *Br̥mhaṇa* actions, potentially contributing to improved neuromuscular strength, *Ksheerapaka* containing *Ashwagandha*^[19], *Kapikacchu*^[20] and *Yashtimadhu*, was intended to provide *Rasayana*, *Balya* and *Brimhana* effects and to counter the chronicity-associated *Dhātu-kṣaya*. Collectively, the regimen was aimed at pacifying *Vāta*, improving the functional status of *Majjā* and *Māmsa Dhātu*, reducing *Stambha* and *Daurbalya*, and supporting neuromuscular function.

CONCLUSION

This case documents a 42-year-old man with a long-standing history of multiple sclerosis and prominent lower-limb motor, sensory and postural impairment who underwent an individualized Ayurvedic treatment protocol comprising *Abhyanga*, *Shastika Shali Pinda Sweda* and *Kala Basti* during an inpatient stay. The Ayurvedic interpretation emphasized *Vata* predominance, *Majja* involvement, *Avarana* and *Dhatu-kshaya*. The available record supports the feasibility of an integrative case-report framework, but does not provide sufficient quantitative outcome data to determine the magnitude of benefit or to infer remyelination or MRI lesion reduction. Future prospective studies should incorporate validated neurological outcomes, standardized Ayurvedic reporting, serial MRI and appropriate long-term follow-up.

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