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Ayurvedic Management of Amavata with Vaitarana Basti and Shamana Chikitsa: A Case Report

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Abstract:
Background: Amavata is a chronic inflammatory disorder characterized by joint pain, swelling, stiffness, and restricted movements. Based on similarities in clinical manifestations, it may be clinically correlated with rheumatoid arthritis (RA). Impairment of Agni leads to the formation of Ama, which, in association with aggravated Vata Dosha, becomes localized in the joints. **Case Presentation:** A 42-year-old female presented with symmetrical pain and swelling involving multiple joints, morning stiffness lasting 90 minutes, fatigue, reduced appetite, and restricted joint movements. Laboratory investigations revealed elevated erythrocyte sedimentation rate (ESR), C-reactive protein (CRP), rheumatoid factor, and positive anti-cyclic citrullinated peptide antibodies. **Intervention:** The patient was treated with Deepana-Pachana therapy, Valuka Swedana, Vaitarana Basti, Simhanada Guggulu, Amavatari Rasa, Rasnasaptaka Kashaya, and appropriate Pathya-Apathya for three months. **Outcome:** Improvement was observed in joint pain, swelling, tenderness, morning stiffness, and functional capacity. ESR decreased from 68 to 24 mm/h, CRP from 18.6 to 4.8 mg/L, and DAS28-ESR from 6.2 to 3.1. No adverse effects were reported. **Conclusion:** The individualized Ayurvedic treatment protocol was associated with improvement in clinical symptoms, inflammatory markers, and disease activity. Further controlled clinical studies are required to validate these findings.
Keywords: Amavata, rheumatoid arthritis, Vaitarana Basti, Valuka Swedana, Panchakarma.

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INTRODUCTION:

Rheumatoid arthritis (RA) is a chronic systemic autoimmune condition that predominantly affects the synovial joints. Persistent synovial inflammation may lead to progressive destruction of articular cartilage, bone erosion, joint deformities, functional impairment, and a substantial reduction in quality of life. [1] the condition commonly presents as symmetrical polyarthritis involving the small joints of the hands and feet. Typical clinical manifestations include joint pain, swelling, tenderness, prolonged morning stiffness, fatigue, and limitations in physical functioning.[2] The diagnosis of RA is established by considering the clinical pattern, including the number and distribution of involved joints and the duration of symptoms, together with serological investigations such as rheumatoid factor and anti-cyclic citrullinated peptide (anti-CCP) antibodies, as well as inflammatory markers including erythrocyte sedimentation rate (ESR) and C-reactive protein (CRP). The 2010 ACR/EULAR classification criteria provide a standardized framework for the classification of patients with RA.[3] the clinical characteristics of rheumatoid arthritis show considerable similarity with the Ayurvedic description of Amavata. According to Madhavakara, Mandagni, or impaired digestive/metabolic fire, plays an important role in the pathogenesis of Amavata. Impaired Agni is believed to result in the formation of Ama, which, in association with aggravated Vata Dosha, circulates through the Dhamani and subsequently localizes in Shleshma Sthana, particularly the Sandhi or joints. This process is associated with characteristic manifestations such as joint pain, swelling, stiffness, tenderness, heaviness, and restricted joint movement.[4] The classical Ayurvedic approach to Amavata includes therapeutic measures such as Langhana, Swedana, administration of Tikta and Katu Rasa preparations, Deepana-Pachana therapy, Virechana, Snehapana, and Basti.[5] The selection and sequencing of these interventions depend on several factors, including the stage of the disease, the relative predominance of Ama and Dosha, the patient's strength, and the severity of clinical manifestations. The present case report describes the clinical outcomes of an individualized Ayurvedic treatment protocol consisting of Deepana-Pachana, Valuka Swedana, Vaitarana Basti, Shamana therapy, and appropriate Pathya-Apathya measures in a patient diagnosed with both rheumatoid arthritis and Amavata.

Patient Information:

A 42-year-old female patient, employed as a schoolteacher, reported to the Panchakarma outpatient department with pain, swelling, stiffness, and restricted movements involving multiple joints for three years. The patient was apparently healthy three years before consultation, when she gradually developed pain and stiffness in the small joints of both hands. Initially, the symptoms were intermittent and were partially relieved after taking analgesic medication. Over the following year, pain and swelling progressively involved both wrist joints, knee joints, and ankle joints. Morning stiffnesslasting close to 90 minutes was among the patient's most troubling symptoms. Alongside this, she described generalized body ache, fatigue, a sense of heaviness, diminished appetite, occasional constipation, and difficulty carrying out everyday tasks — gripping objects, opening containers, writing, climbing stairs, and walking for extended periods. A rheumatologist consultation followed, along with laboratory testing. The combination of symmetrical involvement of small joints, prolonged morning stiffness, raised inflammatory markers, and positive results for both rheumatoid factor and anti-CCP antibodies led to a diagnosis of rheumatoid arthritis. She had already been under conventional medical care for around two years, and while this brought some symptomatic relief, pain, swelling, stiffness, and difficulty with daily tasks kept recurring. It was this incomplete response that led her to pursue Ayurvedic treatment as a supportive measure.

Chief Complaints

Sr. No.	Chief Complaint	Duration
1	Pain in multiple joints	3 years
2	Swelling over small joints of both hands	2 years
3	Morning stiffness lasting approximately 90 minutes	2 years
4	Restricted joint movements	18 months
5	Generalized body ache and fatigue	1 year
6	Reduced appetite and heaviness	8 months

Past History:

There was no history of diabetes mellitus, hypertension, thyroid disorder, tuberculosis, major trauma, or surgical intervention. The patient had no known history of psoriasis, inflammatory bowel disease, gout, or other autoimmune disease.

Family History:

No family history of rheumatoid arthritis or other autoimmune disorder was reported.

Clinical Findings

General Examination:

The patient was conscious, cooperative, and oriented to time, place, and person. Her nutritional status was moderate.

Parameter	Finding
Blood pressure	118/76 mmHg
Pulse rate	78/minute
Respiratory rate	18/minute
Temperature	Afebrile
Height	158 cm
Weight	61 kg
Body mass index	24.4 kg/m²
Pallor	Mild
Icterus	Absent
Cyanosis	Absent
Clubbing	Absent
Lymphadenopathy	Absent
Pedal edema	Absent

Musculoskeletal Examination:

Symmetrical swelling and tenderness were observed over bilateral wrist, metacarpophalangeal, and proximal interphalangeal joints. Mild swelling and tenderness were also observed over both knee and ankle joints. Local temperature was mildly raised over actively inflamed joints. Movements of both wrist and knee joints were painful and restricted.

Grip strength was reduced bilaterally.

Clinical Parameter	Baseline Finding
Tender joint count out of 28 joints	16
Swollen joint count out of 28 joints	10
Duration of morning stiffness	90 minutes
Visual Analogue Scale for pain	8/10
DAS28-ESR	6.2
Disease activity	High

Diagnostic Assessment:

Laboratory Investigations

Investigation	Baseline Value
Hemoglobin	10.8 g/dL
Total leukocyte count	8,600 cells/mm³
ESR	68 mm at the end of the first hour
C-reactive protein	18.6 mg/L
Rheumatoid factor	186 IU/mL
Anti-CCP antibody	Positive
Serum uric acid	4.8 mg/dL
Serum creatinine	0.8 mg/dL
SGOT	24 IU/L
SGPT	27 IU/L

Modern Diagnostic Assessment:

The patient fulfilled the 2010 ACR/EULAR classification criteria based on the involvement of multiple small joints, positive rheumatoid factor, positive anti-CCP antibodies, elevated acute-phase reactants, and persistence of symptoms for more than six weeks.[3]

Modern diagnosis: Seropositive rheumatoid arthritis with high disease activity.

Ayurvedic Diagnostic Assessment:

The clinical picture — poor appetite, heaviness, a coated tongue, generalized body ache, pain across multiple joints, swelling, tenderness, and restricted movement — pointed toward Amavata. It was distinguished from Sandhigata Vata based on the clear presence of Ama-related features, namely Aruchi, Gaurava, Angamarda, Sama Jihva, and inflammatory swelling. Vatarakta, on the other hand, was ruled out, since hallmark signs like intense burning sensation, discoloration, itching, and predominant foot involvement were all absent.

Ayurvedic Diagnosis: Sama Avastha of Amavata, with Vata-Kapha predominance.

Therapeutic Intervention:

Treatment was planned according to the presence of Ama, Agnimandya, Vata-Kapha predominance, joint inflammation, and reduced functional capacity.

Phase I: Deepana-Pachana and Ruksha Swedana

Duration: Seven days

Treatment	Dose/Method	Frequency
Panchakola Churna	3 g with lukewarm water	Twice daily before food
Valuka Swedana	Local application over affected joints	Once daily
Laghu Ahara	Mudga Yusha and light, freshly prepared diet	According to appetite

Valuka Swedana was performed using heated sand tied in a cotton cloth. The temperature was assessed before application. Swedana was performed over the affected joints for approximately 15–20 minutes or until the appearance of mild perspiration and reduction in stiffness.

Phase II: Vaitarana Basti

After improvement in appetite, reduction in tongue coating, and appearance of lightness in the body, Vaitarana Basti was administered according to the Yoga Basti schedule.

Day	Type of Basti
Day 1	Anuvasana Basti
Day 2	Vaitarana Basti
Day 3	Anuvasana Basti
Day 4	Vaitarana Basti
Day 5	Anuvasana Basti
Day 6	Vaitarana Basti
Day 7	Anuvasana Basti
Day 8	Anuvasana Basti

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Vaitarana Basti Composition

Ingredient	Quantity
Saindhava Lavana	5 g
Guda	30 g
Tila Taila	30 mL
Amlika Kalka	20 g
Gomutra	200 mL

Basti Schedule

Anuvasana Basti was administered with 60 mL of Saindhavadi Taila. The patient was clinically monitored throughout the procedure. Pulse rate, blood pressure, bowel pattern, appetite, abdominal symptoms, and any treatment-related adverse events were assessed daily.

Phase III: Shamana Chikitsa

Duration: Three months

Medicine	Dose	Anupana	Frequency
Rasnasaptaka Kashaya	20 mL diluted with 40 mL lukewarm water	Lukewarm water	Twice daily before food
Simhanada Guggulu	500 mg	Lukewarm water	Twice daily after food
Amavatari Rasa	250 mg	Lukewarm water	Twice daily after food

The patient continued her prescribed conventional treatment under the supervision of the treating rheumatologist. No abrupt discontinuation or alteration of disease-modifying treatment was advised.

Follow-Up And Outcomes:

The patient was assessed at baseline, after one month, and after three months. Clinical symptoms, joint counts, inflammatory markers, disease activity, and functional ability were evaluated.

Changes in Clinical Parameters

Parameter	Baseline	After 1 Month	After 3 Months
Pain on Visual Analogue Scale	8/10	5/10	2/10
Morning stiffness	90 min	35 min	10 min
Tender joint count	16	9	4
Swollen joint count	10	5	2
DAS28-ESR	6.2	4.5	3.1
Functional difficulty	Severe	Moderate	Mild

Changes in Laboratory Parameters

Parameter	Baseline	After 1 Month	After 3 Months
ESR	68 mm/h	42 mm/h	24 mm/h
CRP	18.6 mg/L	9.2 mg/L	4.8 mg/L
Rheumatoid factor	186 IU/mL	174 IU/mL	158 IU/mL
Hemoglobin	10.8 g/dL	11.1 g/dL	11.6 g/dL

Changes in Ayurvedic Symptoms

Symptom	Baseline	After 3 Months
Sandhishoola	Severe	Mild
Sandhishotha	Moderate	Minimal
Sandhistambha	Severe	Mild
Sparsha Asahishnuta	Severe	Mild
Angamarda	Moderate	Absent
Aruchi	Moderate	Absent
Gaurava	Moderate	Absent
Sama Jihva	Present	Absent

Discussion:

The pathogenesis of Amavata is primarily associated with impaired Agni and the subsequent accumulation of Ama. Madhavakara described the interaction between Ama and aggravated Vata as a central factor in the development of the disease. Following their association, these pathological factors are believed to circulate through the body and become localized in Shleshma Sthana, particularly within the joints, resulting in manifestations such as pain, swelling, stiffness, tenderness, heaviness, and restricted mobility. [6] the initial stage of treatment focused on Deepana, Pachana, Langhana, and Ruksha Swedana. Panchakola Churna, which is predominantly characterized by Katu Rasa and traditionally recognized for its Deepana-Pachana activity, was administered with the objective of enhancing Agni and facilitating the digestion and elimination of Ama. [7] Valuka Swedana, a type of Ruksha Swedana, was subsequently employed for its Ushna and Ruksha properties. These qualities are considered therapeutically appropriate for counteracting the Sheeta, Guru, and Snigdha characteristics associated with Ama and Kapha. Local application may have contributed to reducing joint stiffness, heaviness, swelling, and impaired mobility, consistent with the classical use of Swedana in conditions characterized by Stambha, Gaurava, and Sheeta. Vaitarana Basti was incorporated into the treatment regimen in view of the clinical predominance of Ama, Kapha, and Vata, together with symptoms including pain, swelling, stiffness, and Srotorodha. Basti is traditionally regarded as an important therapeutic modality for disorders involving Vata Dosha. The Vaitarana formulation possesses Ushna, Tikshna, and Sukshma properties and is traditionally considered useful for Srotoshodhana and the management of Amavata and other Ama-Vata disorders. [8] Simhanada Guggulu, a classical formulation indicated in Amavata and containing Guggulu and Eranda Taila, was also prescribed. Its traditional therapeutic actions include Deepana, Pachana, Vata-Kapha Shamaka, and Srotoshodhana effects. [9] Amavatari Rasa was administered as an additional Shamana formulation based on the patient's clinical presentation, with the aim of alleviating Ama-associated manifestations and supporting improvement in joint-related symptoms. After three months of treatment, clinically meaningful improvement was observed in several parameters, including joint pain, swelling, tenderness, morning stiffness, appetite, fatigue, and functional ability. Objective measures also demonstrated favorable changes: ESR decreased from 68 to 24 mm/h, CRP from 18.6 to 4.8 mg/L, and DAS28-ESR from 6.2 to 3.1. These improvements should be interpreted as the outcome of a multimodal management approach rather than attributed to any individual intervention. The overall response may have resulted from the combined effects of Deepana-Pachana therapy, Ruksha Swedana, Basti, Shamana medicines, [10] dietary modifications, continued conventional treatment, and regular clinical monitoring.

Conclusion:

An individualized Ayurvedic treatment protocol comprising Deepana-Pachana, Valuka Swedana, Vaitarana Basti, Shamana medicines, and appropriate Pathya-Apathya was associated with notable clinical and functional improvement in a patient with Amavata corresponding to rheumatoid arthritis. Following the three-month intervention, reductions were observed in major clinical manifestations, including joint pain, swelling, tenderness, and morning stiffness. Improvements were also recorded in objective

inflammatory and disease-activity measures, with decreases in ESR, CRP, tender and swollen joint counts, and DAS28-ESR. In addition, the patient demonstrated favorable changes in appetite, fatigue, grip strength, mobility, and the ability to perform routine daily activities.The observed response may indicate a potential supportive role for an individualized Ayurvedic treatment strategy in the integrated management of Amavata and rheumatoid arthritis. The therapeutic approach was based on the patient's clinical presentation and incorporated interventions directed toward impaired Agni, Ama, Vata-Kapha involvement, and associated joint manifestations. However, the observed improvements cannot be attributed conclusively to any single Ayurvedic intervention because the treatment protocol involved multiple components and the patient continued conventional care. Furthermore, as this report describes only a single patient, the findings should be interpreted cautiously and cannot establish treatment efficacy, safety, or causality. Future studies involving larger patient populations, appropriate control groups, standardized outcome measures, and longer follow-up periods are necessary to determine the effectiveness, safety, reproducibility, and long-term clinical relevance of individualized Ayurvedic management in Amavata and rheumatoid arthritis.

Conflicts of Interest:

The authors declare that they have no conflicts of interest.

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