



Research Article

Association of Sharir Prakriti with Ocular Biometrics in Children with Simple Developmental Myopia: A Pilot Cross-Sectional Study

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Abstract

Background: The global prevalence of simple developmental myopia in children is increasing rapidly. *Sharir Prakriti* in Ayurveda is a key determinant of an individual's structural and physiological characteristics including propensity to diseases. Its potential association with ocular biometric parameters in myopia has not been systematically explored. **Objective:** To explore the association between dominant *Sharir Prakriti* and ocular biometric parameters in children with simple developmental myopia. **Materials and Methods:** This exploratory cross-sectional pilot study included 30 children aged 10 years with simple developmental myopia (-0.50 D to -5.00 D). *Sharir Prakriti* was assessed using the AyuSoft C-DAC software and classified according to the dominant *Dosha* (*Kapha*, *Pitta* or *Vata*). Ocular biometric parameters including axial length (AL), anterior chamber depth (ACD), vitreous length, and corneal curvature (K1, K2) were measured using A-scan biometry and keratometry. Descriptive statistics, correlation analysis and non-parametric group comparisons were performed. **Results:** *Kapha* dominance was observed in 53% of participants, followed by *Pitta* (30%) and *Vata* (17%). Axial length showed a significant moderate negative correlation with refractive error ($r = -0.65$, $p < 0.001$) reflecting the negative diopter scale of myopia. A significant difference in axial length was observed across *Sharir Prakriti* groups ($p = 0.024$), with the highest mean values in the *Vata*-dominant group. Among the biometric parameters examined, the AL:CRC ratio showed the largest absolute correlation with refractive error in this sample. **Conclusion:** This pilot study provides preliminary evidence of a possible association between *Sharir Prakriti* and ocular biometric variation. Given the small sample and cross-sectional design, these findings require cautious interpretation and confirmation in larger studies.

Keywords: Ayurveda, Corneal Curvature, Myopia, Ocular Biometry, *Sharir Prakriti*

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Introduction

Myopia, or near-sightedness, is the most common refractive error worldwide, affecting approximately 1.5 billion people (22% of the global population) (1, 2). Its prevalence is increasing rapidly among school-aged children in India, ranging from 6.9% to 19.7% (3). Uncorrected myopia is a leading cause of avoidable visual impairment and a priority under the World Health Organization's VISION 2020 initiative (4, 5).

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Myopia is a refractive condition in which parallel rays of light are focused in front of the retina when accommodation is relaxed. Simple developmental myopia is characterized by a refractive error between -0.50 D and -5.00 D and is primarily associated with axial elongation (6). Even minor changes in ocular biometric parameters can significantly affect refractive status (7, 8).

Ayurveda emphasizes the role of *Prakriti* in determining health, disease susceptibility and physical structure (9). *Prakriti* is classified according to the predominance of three *Doshas*—*Vata*, *Pitta* and *Kapha*—each having distinct physical, physiological and psychological characteristics (10).

Modern research has examined genetic influences on myopia (11), biological correlates of *Prakriti* (12), and relationships between ocular dimensions and refractive status (13). However, evidence regarding the relationship between *Sharir Prakriti* and ocular biometric parameters remains limited. The present exploratory pilot study was designed to examine the direction and magnitude

of possible associations between *Sharir Prakriti* classification using AyuSoft C-DAC and objective ocular biometric parameters in a paediatric population and to generate preliminary estimates of variability for planning future research. The proposed novelty is the exploratory comparison of dominant *Prakriti* categories with objective ocular biometric measures rather than an assertion of a causal mechanism.

Materials and Methods

Study Design and Setting: This cross-sectional observational pilot study was conducted at Dr. D. Y. Patil College of Ayurved & Research Centre, Pimpri, Pune.

Sample Size: Thirty children aged 10 years were recruited consecutively. As no reliable prior effect-size estimate was available, a formal hypothesis-testing power calculation was not performed. A pragmatic sample of 30 participants was selected for this exploratory pilot study. The resulting estimates are preliminary and were not intended to provide confirmatory statistical inference (14).

Inclusion Criteria:

- Age 10 years. (Either Sex)
- Spherical equivalent refractive error between -0.50 D and -5.00 D in at least one eye. Both eyes were examined. After confirming that there were no statistically significant differences between corresponding right- and left-eye measurements, only right-eye data were included in the subsequent analyses to avoid inter-eye correlation. The right eye met the myopia eligibility criterion in all participants.

Exclusion Criteria:

- Congenital, pathological, or degenerative myopia.
- Refractive error > -5.00 D.
- Associated systemic diseases, other ocular pathologies, hypermetropia and astigmatism.
- History of ocular trauma or surgery.

Ethical Considerations: The study protocol was approved by the Institutional Ethics Committee. Written informed consent was obtained from parents/guardians, and assent was obtained from participating children. The study involved non-invasive procedures only and no pharmacological agents (including cycloplegic drugs) were used. The study adhered to ethical principles for biomedical research involving children as per guidelines of Indian Council of Medical Research.

Assessments:

Sharir Prakriti Assessment:

Sharir Prakriti was assessed using the structured, computer-based AyuSoft *Prakriti* analysis tool (version 1.1) developed by C-DAC, Pune. (15) The tool quantifies the relative predominance of *Vata*, *Pitta* and *Kapha Doshas*. Each participant was assigned to the dominant-*Dosha* group corresponding to the highest percentage score. In dual-*Dosha* labels, the *Pradhan Dosha* determined the dominant group used for statistical analysis.

Ocular Biometric Assessment:

Ocular biometric parameters were assessed using standard clinical techniques, including A-scan biometry and keratometry.

1. Visual Acuity was assessed using Snellen's chart.
2. Refractive error was measured without cycloplegia using a closed-field autorefractor (AARK 6000, Appasamy Associates, Chennai, India) and subsequently verified by retinoscopy. Refractive measurements were expressed in dioptres (D).

Spherical equivalent (SE) was calculated as: $SE = \text{Sphere} + (\text{Cylinder} / 2)$. Cycloplegic refraction was not performed because the ethics-approved pilot protocol was restricted to non-pharmacological procedures and did not permit administration of cycloplegic agents. Because refraction was performed without cycloplegia using a closed-field auto refractor, residual accommodation and instrument-induced proximal accommodation may have resulted in overestimation of myopia in these 10-year-old children. The refractive measurements should therefore be interpreted cautiously (16).

3. Ocular Biometry Parameters i.e. Axial Length (AL, mm), Anterior Chamber Depth (ACD, mm), Lens Thickness (mm) and Vitreous Length (mm) were measured using the AXIS Nano A-scan ultrasound biometer (Quantel Medical, France).
4. Corneal curvature was measured in the two principal meridians using a KMS-6 manual keratometer (Appasamy Associates, Chennai, India). The flat (K1) and steep (K2) corneal radii were recorded in millimetres, and mean corneal radius was calculated as $CRC = (K1 + K2)/2$.
5. The AL:CRC ratio was calculated as: $AL:CRC = \text{axial length (mm)}/\text{mean corneal curvature radius (mm)}$.

Examiner Training, Masking and Measurement Reliability

All ocular measurements were performed by one trained examiner who did not have access to the participants' *Sharir Prakriti* classifications during ocular assessment. *Prakriti* classifications and ocular measurements were recorded on separate forms and linked only by participant codes before analysis, thereby reducing observer bias.

Each biometric parameter was measured at least three times, and the mean was used for analysis. The same calibrated instruments and standardized protocols were used throughout. As individual replicate measurements were not retained in the analytical dataset, intra-observer reliability could not be assessed using the intraclass correlation coefficient (ICC).

Statistical Analysis

Statistical analysis was performed using IBM SPSS Statistics, version 31. Continuous variables were summarized as mean $\pm$ standard deviation (SD). No statistically significant differences were observed between the right and left eyes for refractive or ocular biometric parameters (paired t-test, $p > 0.05$) and corresponding measurements between the two eyes were positively correlated (Pearson's $r = 0.60-0.97$, $p < 0.05$). Therefore, to avoid inter-eye correlation and maintain independence of observations, only right-eye measurements were included in the analysis.

Pearson's correlation coefficient was used to assess associations between the degree of myopia and ocular biometric parameters. Holm correction was applied to account for multiple correlation tests. Owing to the small and unequal *Prakriti* groups and the exploratory nature of this pilot study, differences in ocular biometric parameters among the *Vata*-, *Pitta*- and *Kapha*-dominant groups were evaluated using the Kruskal-Wallis test. When the overall test was statistically significant, Dunn's post-hoc pairwise comparisons with Holm correction were performed.

All tests were two-sided and an adjusted p value < 0.05 was considered statistically significant where correction for multiple comparisons was applied. Effect sizes and 95% confidence intervals were reported where applicable. All analyses were exploratory and were intended to estimate the direction and magnitude of associations rather than provide confirmatory inference.

Results

Distribution of Sharir Prakriti

Table 1 presents the distribution of dual-Dosha Sharir Prakriti among the 30 participants. *Kapha Pradhan Pitta* was the most frequent category (n = 9, 30%), followed by *Kapha Pradhan Vata* (n = 7, 23%), *Pitta Pradhan Kapha* (n = 6, 20%), *Vata Pradhan Pitta* (n = 5, 17%) and *Pitta Pradhan Vata* (n = 3, 10%).

Table 01: Distribution of Sharir Prakriti

Sharir Prakriti	Frequency	Percentage (%)
<i>Kapha Pradhan Pitta</i>	9	30
<i>Kapha Pradhan Vata</i>	7	23
<i>Pitta Pradhan Kapha</i>	6	20
<i>Pitta Pradhan Vata</i>	3	10
<i>Vata Pradhan Pitta</i>	5	17
Total	30	100

For statistical analysis, participants were grouped by their primary dominant Dosha (*Kapha*, *Pitta*, *Vata*). Among the 30 participants, *Kapha*-dominant Sharir Prakriti was most common (n = 16, 53%), followed by *Pitta*-dominant (n = 9, 30 %) and *Vata*-dominant (n = 5, 17 %)

Table 02: Distribution of Sharir Prakriti dominant Dosha

Sharir Prakriti	Frequency	Percentage (%)
<i>Kapha</i> Dominant	16	53
<i>Pitta</i> Dominant	9	30
<i>Vata</i> Dominant	5	17
Total	30	100

Degree of Myopia across Sharir Prakriti

The mean degree of myopia varied across Sharir Prakriti groups. Participants with *Vata*-dominant Prakriti had the greatest magnitude of myopia (-2.60 ± 0.60 D), followed by those with *Pitta*-dominant Prakriti (-1.63 ± 0.71 D) and *Kapha*-dominant Prakriti (-1.39 ± 0.59 D).

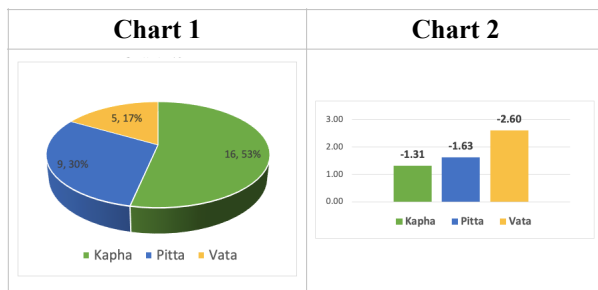


Table 03: Degree of Myopia across Sharir Prakriti

Sharir Prakriti	Mean	Standard Deviation
<i>Kapha</i> Dominant	-1.39	0.59
<i>Pitta</i> Dominant	-1.63	0.71
<i>Vata</i> Dominant	-2.60	0.60

Table 04: Comparison of degree of myopia across Sharir Prakriti groups

Test	Statistic	df	p-value	Rank ϵ^2	95% CI for ϵ^2
Kruskal–Wallis	H = 8.50	2	0.014	0.293	0.173–0.555

(Abbreviations: H - Kruskal–Wallis test statistic; df- degrees of freedom; p - probability value; ϵ^2 , rank epsilon-squared effect size; CI- confidence interval.)

In this exploratory analysis, the degree of myopia differed across the Sharir Prakriti groups (Kruskal–Wallis H = 8.50, df = 2, p = 0.014; rank ϵ^2 = 0.293, 95% CI: 0.173–0.555). Although the effect estimate suggests a potentially meaningful group difference, it should be interpreted cautiously because of the small and unequal group sizes.

Correlation of Degree of Myopia with Ocular Biometric Parameters

A statistically significant negative correlation was observed between refractive error and axial length (Pearson's $r = -0.654$, Holm-adjusted $p < 0.001$). Because myopia was expressed in negative diopters, the negative coefficient indicates that longer axial length was associated with more negative refractive error and greater myopic severity. Corneal curvature radius was positively correlated with refractive error ($r = 0.795$, adjusted $p < 0.001$); consequently, greater myopic severity was associated with a smaller corneal radius. A strong negative correlation was observed between the AL:CRC ratio and refractive error ($r = -0.895$, adjusted $p < 0.001$). Vitreous length was also negatively correlated with refractive error ($r = -0.655$, adjusted $p < 0.001$), indicating greater vitreous length with increasing myopic severity. The correlations with anterior chamber depth ($r = -0.363$, unadjusted $p = 0.049$) and lens thickness ($r = 0.395$, unadjusted $p = 0.031$) did not remain statistically significant after Holm correction (both adjusted $p = 0.061$). The association between the AL:CRC ratio and refractive error should be interpreted cautiously because the ratio is mathematically derived from axial length and corneal curvature, which are themselves associated with refractive status. These correlations do not establish causal relationships.

Table 05: Correlation analysis of Ocular Biometrics with Degree of Myopia

Dependent variable	Ocular biometric parameter	Pearson's r	Un-adjusted p-value	Holm-adjusted p-value	Lower 95% CI	Upper 95% CI
Degree of myopia (D)	Axial length (mm)	-0.654	<0.001	<0.001	-0.821	-0.384
	Corneal curvature radius (mm)	0.795	<0.001	<0.001	0.609	0.898
	AL:CRC ratio	-0.895	<0.001	<0.001	-0.949	-0.789
	Anterior chamber depth (mm)	-0.363	0.049	0.061	-0.639	-0.003
	Lens thickness (mm)	0.395	0.031	0.061	0.041	0.661
	Vitreous length (mm)	-0.655	<0.001	<0.001	-0.821	-0.386

Association of Sharir Prakriti with Ocular Parameters

Axial Length: Mean axial length varied across the dominant-*Dosha Sharir Prakriti* groups. The *Vata*-dominant group had the highest mean axial length (24.47 ± 0.45 mm), followed by the *Pitta*-dominant (24.23 ± 0.24 mm) and *Kapha*-dominant groups (23.81 ± 0.40 mm). These estimates were derived from participants grouped according to their primary dominant *Dosha*.

Table 07: Kruskal–Wallis Test for Axial Length across Sharir Prakriti

Factor	Kruskal–Wallis H	df	Un adjusted p	Holm-adjusted p	Rank ϵ^2	95% CI Lower	95% CI Upper
<i>Sharir Prakriti</i>	11.06	2	0.004	0.024	0.381	0.129	0.683

Axial length differed significantly across the dominant *Sharir Prakriti* groups (Kruskal–Wallis $H=11.06$, $df = 2$, unadjusted $p=0.004$, Holm-adjusted $p=0.024$; rank $\epsilon^2=0.381$, 95% CI 0.129–0.683). Dunn’s post-hoc pairwise comparisons, corrected separately using the Holm method, indicated greater axial length in the *Vata*-dominant and *Pitta*-dominant groups than in the *Kapha*-dominant group (adjusted $p=0.014$ and $p=0.025$, respectively). The difference between the *Vata*- and *Pitta*-dominant groups was not statistically significant (adjusted $p=0.461$). Given the exploratory pilot design and small, unequal subgroup sizes, these findings should be interpreted cautiously.

Table 06: Axial Length across Sharir Prakriti

<i>Sharir Prakriti</i>	Mean(mm)	Std. Deviation
<i>Kapha</i> Dominant	23.81	0.40
<i>Pitta</i> Dominant	24.23	0.24
<i>Vata</i> Dominant	24.47	0.45

Other Ocular Biometric Parameters

Anterior chamber depth, lens thickness and vitreous length did not differ significantly across the dominant-*Dosha Sharir Prakriti* groups. The unadjusted omnibus comparisons for corneal curvature radius ($H=6.13$, $p=0.047$) and the AL:CRC ratio ($H=7.53$, $p=0.023$) met the nominal $p<0.05$ threshold but did not remain statistically significant after Holm correction for the six ocular biometric comparisons (adjusted $p=0.188$ and $p=0.115$, respectively). Of the ocular biometric parameters examined, only axial length remained statistically significant after Holm correction ($H=11.06$, adjusted $p=0.024$). All comparisons were exploratory.

Table 08: Other Ocular Biometric Parameters across Sharir Prakriti

Parameter	<i>Kapha</i> ($n=16$), mean $\pm$ SD	<i>Pitta</i> ($n=9$), mean $\pm$ SD	<i>Vata</i> ($n=5$), mean $\pm$ SD	Kruskal–Wallis H	Un adjusted p	Holm-adjusted p
Anterior chamber depth (mm)	3.535 ± 0.143	3.562 ± 0.088	3.616 ± 0.271	0.12	0.943	0.943
Lens thickness (mm)	3.524 ± 0.125	3.603 ± 0.138	3.578 ± 0.184	2.06	0.357	0.714
Vitreous length (mm)	16.72 ± 0.49	17.07 ± 0.31	17.36 ± 0.51	5.59	0.061	0.188
Corneal curvature radius (mm)	7.750 ± 0.310	7.729 ± 0.284	7.418 ± 0.107	6.13	0.047	0.188
AL:CRC ratio	3.077 ± 0.141	3.139 ± 0.126	3.300 ± 0.093	7.53	0.023	0.115

Discussion

This exploratory pilot study investigated the potential association between *Sharir Prakriti* and ocular biometric parameters in children with simple developmental myopia. The findings suggest that axial length, a key anatomical determinant of myopia, may vary across constitutional phenotypes.

Consistent with existing ophthalmological literature, axial length demonstrated a moderate negative association with the degree of myopia, reinforcing its important role in refractive development (6). The negative direction reflects the use of negative dioptric values, with longer axial length corresponding to greater myopia. The AL:CRC ratio demonstrated the strongest correlation, followed by corneal curvature radius and axial length. Previous studies have also reported that the axial length-to-corneal curvature ratio (AL:CRC) may be a better index for categorizing myopia than axial length alone (13, 17). The AL:CRC ratio represents the overall refractive balance of the eye by reflecting the combined effects of posterior segment length and anterior corneal curvature.

The predominant *Dosha* in *Sharir Prakriti* is traditionally considered to influence the structural and functional characteristics of the body and its components (*Anga–Pratyanga*)

during development (9, 10). In the present study, the distribution of participants was 53% *Kapha*-dominant, 30% *Pitta*-dominant and 17% *Vata*-dominant. Since this was a cross-sectional pilot study, these proportions apply only to the study sample and should not be interpreted as the incidence or population prevalence of myopia. The higher mean axial length observed in the *Vata*-dominant group may suggest a possible association between constitutional characteristics and ocular growth patterns.

A more negative mean refractive error was observed in the *Vata*-dominant *Sharir Prakriti* group than in the *Pitta*- and *Kapha*-dominant groups. From a theoretical Ayurvedic perspective, the greater axial length observed in the *Vata*-dominant group may be interpreted in relation to the *Chala* (mobile) and *Vikasi* (expansive) properties attributed to *Vata Dosha* (9,10,18). Similarly, the *Guru* (heavy) and *Sthira* (stable) properties of *Kapha Dosha* may provide a conceptual interpretation of the lower degree of myopia observed in the *Kapha*-dominant group. However, these interpretations are theoretical and do not establish an Ayurvedic or biological mechanism linking *Dosha* characteristics to axial elongation.

An overall difference in the degree of myopia was observed across the *Sharir Prakriti* groups ($H = 8.50$, $df = 2$, $p = 0.014$; rank $\epsilon^2 = 0.293$), suggesting a potential association between constitutional

phenotype and refractive severity. However, because of the small and unequal subgroup sizes and the exploratory nature of the analysis, this finding should be interpreted cautiously.

Limitations: The small sample size ($n = 30$) and unequal distribution of participants across *Sharir Prakriti* groups limit the generalizability of the findings. Refractive error was assessed without cycloplegia, which is an important limitation and may introduce measurement bias, particularly in paediatric populations, because of residual accommodation. As participants were recruited from a single school, the possibility of selection bias cannot be excluded. The cross-sectional design can establish associations but not causation. Potential confounding factors such as outdoor activity, near work, screen time and family history of myopia were not assessed. *Sharir Prakriti* was analysed only by dominant *Dosha* due to sample-size constraints; future studies with larger samples could explore dual-*Dosha* interactions.

Conclusion

This exploratory pilot study suggests a possible association between dominant *Sharir Prakriti* and ocular biometric parameters, particularly axial length, within a small sample of children with simple developmental myopia. This possible association does not establish an independent or causal relationship and should be interpreted cautiously because of the small and unequal subgroup sizes.

Larger, adequately powered studies incorporating cycloplegic refraction, balanced *Sharir Prakriti* groups, appropriate comparison groups and adjustment for relevant confounding factors are needed to confirm these preliminary observations. Longitudinal studies would be required to determine whether *Sharir Prakriti* is associated with subsequent ocular growth or myopia progression.

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