



Case Report

Multimodal Ayurvedic and Rehabilitation Approach in Chronic Post-stroke Hemiplegia (*Pakshaghata*): A Case Report

Aashish Patel¹, Krishna Priya G^{2*}, Vijay Bhaskar S³, Kartik Sharma⁴

1. PG Scholar, Department of Kayachikitsa, KAHER's Shri B.M. Kankanawadi Ayurveda Mahavidyalaya, Belagavi (590003), Karnataka, India.
2. Assistant Professor, Department of Kayachikitsa, KAHER's Shri B.M. Kankanawadi Ayurveda Mahavidyalaya, Belagavi (590003), Karnataka, India.
3. Assistant Professor, Department of Panchakarma, KAHER's Shri B.M. Kankanawadi Ayurveda Mahavidyalaya, Belagavi (590003), Karnataka, India.
4. PG Scholar, Department of Kayachikitsa, KAHER's Shri B.M. Kankanawadi Ayurveda Mahavidyalaya, Belagavi (590003), Karnataka, India.

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Abstract

Introduction: Stroke is a leading cause of long-term disability; hemiplegia may be clinically correlated with *Pakshaghata*, a *Vata*-dominant Ayurvedic disorder, on the basis of overlapping features. **Case Presentation:** A 66-year-old male presented with right hemiplegia and dysarthria of approximately 19 months duration following an ischemic stroke, with MRC power 2/5 in the right upper and lower limbs, spasticity, and inability to walk unsupported. Comorbidities included hypertension and ischemic heart disease status post-CABG. **Intervention:** A 17-day inpatient Ayurvedic protocol combined *Sthanik Lepa*, *Koshtha Shodhana*, *Udvardhana*, *Parisheka*, *Sarvanga Abhyanga*, *Pinda Sweda*, and *Shiropichu* with *Basti* therapy (4 *Matra Basti*, plus 6 *Anuvasana Basti* and 6 *Niruha Basti*), oral *Shamana* medications, and concurrent physiotherapy. **Outcome:** Right upper-limb MRC power improved from 2/5 to 3/5 and lower-limb power from 2/5 to 4/5; tone, sitting balance, and gait improved, ambulation with support was achieved, and the previously noted tendency to fall was not observed after treatment. **Barthel Index** improved from 5/100 to 40/100, with no adverse events during the treatment period. **Discussion:** The phase-wise protocol addressed both *Margavarana* and *Dhatukshaya*; *Basti* regulated *Vata* while *Pinda Sweda* provided *Brimhana* effects. Concurrent physiotherapy may have contributed to recovery, but its independent contribution cannot be separated from that of the Ayurvedic interventions in a single case. **Conclusion:** This single case suggests a structured Ayurvedic protocol may be associated with functional improvement in chronic post-stroke hemiplegia. Findings are hypothesis-generating and require evaluation in controlled studies before conclusions on efficacy or safety can be drawn.

Keywords: *Pakshaghata*, Hemiplegia, Stroke, *Panchakarma*, *Basti* Therapy, Physiotherapy.

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Introduction

The World Health Organization defines stroke as rapidly developing clinical signs of focal (or global) disturbance of cerebral function, lasting more than 24 hours or leading to death, with no apparent cause other than a vascular origin (1). Stroke is a leading cause of hemiplegia and hemiparesis and affects quality of life and the ability to perform activities of daily living (2). It typically presents with sudden-onset weakness, numbness, or

paralysis, speech and language impairment, visual disturbance, dizziness, gait instability, and severe headache with nausea or vomiting, and it commonly affects one side of the body, resulting in hemiplegia and facial drooping (3). The Global Burden of Disease (GBD) study ranks stroke as the second leading cause of death after ischemic heart disease (4).

Hemiplegia and hemiparesis may be clinically correlated with *Pakshaghata* on the basis of overlapping presenting features, though the two are not synonymous diagnostic constructs. In hemiplegia, weakness affects one half of the body, principally the upper and lower limbs, and may also affect speech and facial musculature; it most commonly results from stroke or interruption of cerebral blood supply (5). *Pakshaghata* is classified among the *Vatavyadhi* and is considered one of the *Ashtamahagada* (6). It may arise from *Dhatukshaya* or *Margavarana*, where *Paksha*

* Corresponding Author:

Krishna Priya G

Assistant Professor, Department of Kayachikitsa, KAHER's Shri B.M. Kankanawadi Ayurveda Mahavidyalaya, Belagavi (590003), Karnataka, India.

Email Id: krishnapriyakedaram1994@gmail.com

denotes either half of the body and *Aghata* denotes impairment of the *Karmendriyas* and *Gyanendriyas*; *Pakshaghata* is accordingly described as an *Indriyapradoshaja Vikara* (7) classified under the *Madhyama Rogamarga*. Its cardinal features include *Chestahani* (impaired motor activity), *Ruja* (pain), and *Vakstambha* (slurred speech) (8).

This report describes a case of chronic post-stroke hemiplegia managed with an Ayurvedic protocol comprising *Shodhana*, *Shamana*, and *Rasayana* measures, together with concurrent physiotherapy. As a single case, it offers a preliminary clinical observation of the combined use of *Panchakarma*, *Shamana Aushadhis*, and physiotherapy in this condition, rather than evidence of comparative efficacy.

Case Presentation

Table 01: Patient Timeline

Date / Period	Event
Oct 2023	Sudden-onset right-sided weakness and slurred speech; admitted to a local hospital and diagnosed as a case of cerebrovascular accident (CVA); treated as inpatient for 12 days with no relief of weakness.
29 to 31 Oct 2023	CT and MRI brain performed at the time of the acute event; 2D-echocardiography performed 01 Nov 2023.
Nov 2023 to May 2025	Residual right hemiplegia and dysarthria persisted without further improvement (chronic phase, 19 months).
28 May 2025	Presented to our hospital; baseline hematology and lipid profile recorded; admitted for Ayurvedic management.
28 May 2025 to 13 Jun 2025	17-day inpatient <i>Panchakarma</i> , <i>Basti</i> , <i>Shamana</i> , and physiotherapy protocol (detailed in Tables 8-11).
13 Jun 2025	Discharged on oral <i>Shamana</i> medications with outcome assessed at discharge (Tables 12-14).

History of Present Illness

A 66-year-old male presented with weakness of the right upper and lower limbs, of sudden onset with gradual progression to right hemiplegia, together with dysarthria of similarly sudden onset and gradual progression. There was no history of fever, vomiting, abdominal pain, fainting attacks, palpitations, breathlessness, orthopnea, or dyspnea. As reported by the patient's attendant, the patient had been well until approximately 19 months prior to the current presentation, when he sustained a sudden fall in the morning and subsequently developed reduced strength in the right upper and lower limbs, with associated difficulty walking and slurred speech. He was admitted to a local hospital, diagnosed with a cerebrovascular accident (CVA) with right hemiplegia, and treated as an inpatient for 12 days; the weakness did not improve. He subsequently presented to our hospital for conservative Ayurvedic management and was admitted for the 17-day inpatient protocol described below.

History of Past Illness

Known case of hypertension, on tablet Metoprolol XL 1 tablet once daily. Not a known case of diabetes mellitus or thyroid dysfunction.

Surgical History

Known case of ischemic heart disease (IHD), status post coronary artery bypass grafting (CABG) in 2009; ejection fraction 65% at that time.

Clinical Findings

On general examination the patient was well nourished.

- Vital parameters: blood pressure 130/84 mmHg, pulse rate 70/min, respiratory rate 17/min, and normal body temperature.
- Respiratory and cardiovascular examination was unremarkable.
- Per abdomen examination showed a soft, non-tender abdomen with no organomegaly.

Central Nervous System (CNS) Examination

Higher mental function: Patient conscious and oriented to person, place, and time. Speech was dysarthric (slurred). Immediate, recent, and remote memory intact.

Judgment and insight normal.

Cranial nerve examination:

- Olfactory: sense of smell intact.
- Optic: visual acuity and visual fields normal.
- Oculomotor, trochlear, abducens: pupils equal, round, and reactive to light; extraocular movements full; no diplopia or ptosis.
- Trigeminal: jaw movement, corneal reflex, and facial sensation normal bilaterally.
- Facial: right lower facial weakness with forehead sparing, and deviation of the angle of the mouth to the left, consistent with an upper motor neuron facial palsy.
- Vestibulocochlear: hearing normal by Rinne and Weber tests; no vertigo.
- Glossopharyngeal/vagus: palate elevates symmetrically; gag reflex present.
- Spinal accessory: normal power of sternocleidomastoid and trapezius.
- Hypoglossal: no abnormality detected.

Motor Examinations

Muscle power: Muscle power was graded using the Medical Research Council (MRC) 0–5 scale, and spasticity was assessed clinically on passive movement (increased resistance/tone); a standardized spasticity scale (e.g., Modified Ashworth Scale) was not reported and its use is recommended in future cases for objective grading.

Table 2: Motor system examination

Parameter	Right side	Left side
Bulk	Mild wasting	Normal
Tone	Increased (spastic)	Normal

Table 3: Muscle power (MRC grading)

Limb	Right	Left
Upper limb	2/5	5/5
Lower limb	2/5	5/5
Facial muscles	4/5 (lower face only)	5/5

Table 4: Superficial reflexes

Reflex	Right side	Left side
Abdominal (upper,	Absent	Present and normal
Cremasteric	Absent	Present and normal
Corneal	Present	Present
Gag	Present	Present

Table 5: Deep tendon reflexes

Reflex	Right side (grade)	Left side (grade)
Biceps	3	2
Triceps	3	2
Supinator	3	2
Knee	3	2
Ankle	3	2

Babinski sign: positive on the right, negative on the left.

Sensory system:

- Superficial sensation (pain, temperature, touch) intact bilaterally;
- Deep sensation (proprioception, vibration, joint position) intact;
- Two-point discrimination normal.

Coordination: Right side: could not be assessed due to paralysis.

Left side: normal on finger-nose and heel-knee tests.

Gait and station: Unable to walk without support due to right hemiplegia.

Meningeal signs: No neck stiffness; Kernig's and Brudzinski's signs negative.

Investigations

Hematology and lipid profile were obtained on 28 May 2025, at the time of admission for the current treatment episode (Tables 6-7). CT brain, MRI brain, and 2D-echocardiography reports dated October–November 2023 were part of the patient's existing medical records from the acute stroke event and were reviewed at admission; repeat neuroimaging was not performed in May 2025, as the presentation was one of stable, chronic sequelae rather than a new event.

Table 6. Hematology profile

Parameter	Value
Hemoglobin	13.8 g/dL
Total WBC count	4600 cells/cumm
Neutrophils	66%
Lymphocytes	26%
Eosinophils	7%
Monocytes	1%
ESR	88 mm/hr

Table 7. Lipid profile (28 May 2025)

Parameter	Value
Total cholesterol	116 mg/dL
Triglycerides	76 mg/dL
HDL-cholesterol	39 mg/dL
LDL-cholesterol	63 mg/dL
VLDL	15.2 mg/dL
Serum creatinine	0.8 mg/dL

CT Brain (29 Oct 2023): Focal hypodense areas in the bilateral centrum semiovale, corona radiata, thalami, and left lentiform nucleus, suggestive of chronic lacunar infarcts due to old vascular insult. Additional hypodensities in the fronto-parieto-occipital white matter indicated hypertensive ischemic changes, with age-related cerebral and cerebellar atrophy.

MRI Brain (31 Oct 2023): Subacute infarcts in the left corona radiata and right parietal region, with chronic lacunar infarcts in the bilateral centrum semiovale and right frontal white matter. Diffuse hypertensive microangiopathy with multiple microbleeds. Hypertensive ischemic changes in the periventricular and subcortical white matter, with age-related atrophy. Right internal carotid artery atheromatous plaque and mild right vertebral artery narrowing. Incidental left temporal arachnoid cyst and mild sphenoid sinusitis.

2D-Echocardiography (01 Nov 2023): Ejection fraction 60%, concentric left ventricular hypertrophy, aortic valve thickening with trivial aortic regurgitation, and mild pulmonary arterial hypertension. No regional wall motion abnormality.

Ayurvedic Examination

Ashtasthana Pareeksha:

- **Nadi:** Vata-Kaphaja;
- **Mala:** Santushta, occasionally constipated;
- **Mutra:** Samyak (3–5 times/day);
- **Jihva:** Lipta;
- **Shabda:** Asphuta;
- **Sparsha:** Anushna-sheeta;
- **Drik:** Prakrita;
- **Akriti:** Madhyama.

Dashavidha Pareeksha:

- **Prakriti:** Pitta-Vataja;
- **Vikriti:** Vata-pradhana Tridosha;
- **Sara:** Madhyama;
- **Samhanana:** Madhyama;
- **Satva:** Madhyama;
- **Satmya:** Madhyama;
- **Pramana:** Madhyama;
- **Ahara Shakti:** Madhyama;
- **Vyayama Shakti:** Madhyama;
- **Vaya:** Vriddha.

Final Diagnosis

Biomedical diagnosis: Chronic post-stroke right hemiplegia with dysarthria, secondary to an old ischemic cerebrovascular insult with hypertensive microangiopathy (per CT/MRI brain, October 2023).

Ayurvedic diagnosis: Pakshaghata

Therapeutic Intervention

A 17-day inpatient protocol (28 May - 13 June 2025) combined external Ayurvedic procedures, Basti therapy, oral Shamana medications, and physiotherapy, summarized in Tables 8-12.

Table 8: External procedures

Day	Procedure	Formulation / ingredients	Dose / route	Duration / frequency
1-7	<i>Sthanik Lepa (local application)</i>	<i>Vacha + Shatapushpa + Devadaru + Rasna + Saindhava + Kanji</i>	Topical paste, applied to affected limbs	Once daily, Days 1-7
1-3	<i>Udvardana</i>	<i>Triphala Churna + Rasna Churna, 100 g</i>	Powder massage	Once daily, Days 1-3
1-3	<i>Parisheka</i>	<i>Erandamoola Kashayam</i>	Warm decoction poured over body	Once daily, Days 1-3
2	<i>Koshtha Shodhana</i>	<i>Gandharvahastadi Eranda Taila 40 mL + milk 100 mL</i>	Oral, single administration (6 Vegas obtained)	Day 2
4-7	<i>Sarvanga Abhyanga</i>	<i>Mahanarayana Taila</i>	Whole-body oleation massage	Once daily, Days 4-7
4-7	<i>Jambeera Pinda Sweda</i>	Lemon bolus fomentation	Bolus fomentation, whole body	Once daily, Days 4-7
8-17	<i>Sarvanga Abhyanga</i>	<i>Balaashvagandhadi Taila</i>	Whole-body oleation massage	Once daily, Days 8-17
8-17	<i>Shashtika Shali Pinda Sweda</i>	Rice bolus cooked in milk decoction	Bolus fomentation, whole body	Once daily, Days 8-17
4-17	<i>Shiropichu</i>	<i>Brahmi Ghrita + Jyotishmati Taila</i>	Oil-soaked pad applied to scalp	Once daily, Days 4-17

Basti (Enema) Therapy

A total of 4 *Matra Basti*, Days 4-7, plus 6 *Anuvasana Basti*, Days 8-17 and 6 *Niruha Basti* (Days 8-17) were administered over the course of the admission, summarized in Table 9.

Table 9: Basti (Enema) Therapy

Day	Type	Formulation / ingredients	Dose	Frequency
4	<i>Matra Basti (Anuvasana type)</i>	<i>Sahacharadi Taila + Shatapushpa + Saindhava</i>	60 mL	Once
5	<i>Matra Basti (Anuvasana type)</i>	<i>Sahacharadi Taila + Shatapushpa + Saindhava</i>	60 mL	Once
6-7	<i>Revised Matra Basti (Anuvasana type)</i>	<i>Sahacharadi Taila + Shatapushpa + Saindhava + Brihat Vata Chintamani powder</i>	60 mL	Once daily × 2 days
8-17	<i>Anuvasana Basti</i>	<i>Sahacharadi Taila</i>	60 mL	6 administrations, alternate-day schedule
8-17	<i>Niruha Basti</i>	<i>Madhu 30 g + Saindhava 5 g + Kalka (Guduchi, Manjistha, Rasna, Punarnava, 10 g each) + Kashayam (Erandamoola, Dashamoola, Bala Kashaya, 250 mL) + Taila (Bala Taila 40 mL + Nirgundi Taila 40 mL) + Mamsa Rasa 50 mL</i>	475 mL total	6 administrations, alternate-day schedule

Shamana (Oral) Medications

The following oral *Shamana* medications were administered concurrently with the *Panchakarma* protocol, 28 May - 13 June 2025. Botanical composition of each proprietary/compound formulation is available in standard Ayurvedic formularies and departmental records; the polyherbal, multi-formulation approach reflects standard classical practice in *Vata-pradhana Vyadhi*, combining *Vata-Kapha-shamaka*, *Brimhana*, and *Rasayana* actions, and was used with attention to the patient's hypertension and prior CABG (e.g., avoiding known pro-hypertensive/stimulant *Rasaushadhis*).

Table 10: Shamana (oral) medications

Medication	Dose	Frequency	Duration
<i>Ekgangaveera Rasa</i>	1 tablet	Thrice daily, after food	28 May - 13 Jun 2025
<i>Bhramni Vati</i>	2 tablets	Twice daily, after food	28 May - 13 Jun 2025
<i>Hinguvachadi tablet</i>	2 tablets	Twice daily, after food	28 May - 13 Jun 2025
<i>Cap. Ksheerabala 101</i>	2 capsules	Twice daily	28 May - 13 Jun 2025
<i>Chandraprabha Vati</i>	2 tablets	Twice daily, after food	28 May - 13 Jun 2025
<i>Dhanadanayanadi Kashayam</i>	15 mL	Thrice daily, after food	28 May - 13 Jun 2025
<i>Balarishta with Dhanwantaram Gulika</i>	15 mL with 2 tablets	Thrice daily, after food	28 May - 13 Jun 2025
<i>Punarnava Guggulu</i>	1 tablet	Twice daily, after food	Added from Day 10

Physiotherapy

Physiotherapy was administered concurrently throughout the admission, under the supervision of a physiotherapist. Active range-of-motion (AROM) exercises were performed as 10 repetitions $\times$ 1 set for each limb; ambulation training used a walking aid (axillary crutch) for one lap per session.

Table 11. Physiotherapy protocol

Exercise	Parameters	Purpose
Active range of motion (AROM) - upper limb	10 repetitions $\times$ 1 set	Maintains joint mobility, prevents contractures, improves circulation
Active range of motion (AROM) - lower limb	10 repetitions $\times$ 1 set	Maintains joint mobility, prevents contractures, improves circulation
Dynamic quadriceps strengthening in sitting	As tolerated	Improves knee stability, supports gait training
Ambulation with walking aid (axillary)	1 lap per session	Early mobilization, balance and gait retraining
Bed mobility exercises	As tolerated	Trunk control, postural transitions
Strengthening exercises	As tolerated	Prevents disuse atrophy, supports functional

Table 12: Discharge medications

Medication	Dose	Frequency
<i>Dhanadanayanadi Kashayam + Ashtavarga Kashayam (mixed)</i>	20 mL	Thrice daily
<i>Balarishta with Dhanwantaram Gulika</i>	20 mL with 1 tablet	Thrice daily
<i>Cap. Ksheerabala 101</i>	2 capsules	Twice daily
<i>Chandraprabha Vati</i>	1 tablet	Thrice daily
<i>Gokshuradi Guggulu</i>	1 tablet	Twice daily
<i>Hinguvachadi tablet</i>	1 tablet	Thrice daily
<i>Mahanarayana Taila</i>	For <i>Shiropichu</i>	As applied
<i>Mahamasha Taila</i>	For local <i>Abhyanga</i>	As applied
<i>Kalyanaka Avaleha Churna with honey</i>	For oral	Twice daily

Treatment compliance and adverse events: The patient tolerated the therapy well; no adverse drug reactions or adverse events were observed during the 17-day treatment period.

Results

Following the 17-day treatment period, the patient showed measurable improvement in muscle strength, tone, sitting balance, and gait, summarized in Table 13.

Table 13: Pre- and post-treatment clinical assessment.

Parameter	Before treatment	After treatment
Muscle strength	Right upper limb 2/5; right lower limb 2/5; left side normal	Right upper limb 3/5; right lower limb 4/5; left side normal
Muscle tone	Increased (hypertonic)	Reduced hypertonicity
Sitting balance	Able to sit but leaning to the affected side	Improved, more symmetric sitting
Gait	Unable to walk	Able to walk a few steps with support
Tendency to fall	Present, toward the affected side	Not observed
Deep tendon reflexes	Exaggerated (3+)	Reduced toward baseline

Barthel Index, before and after treatment. Total score improved from 5/100 to 40/100, 5/100 corresponds to total dependency and 40/100 to severe dependency on this scale, but reflecting a measurable within-patient gain in functional independence.

Table 14: Barthel Index

Domain	Score range	Before treatment	After treatment
Feeding	0 / 5 / 10	5	5
Bathing	0 / 5	0	0
Grooming	0 / 5	0	5
Dressing	0 / 5 / 10	0	5
Bowel	0 / 5 / 10	0	5
Bladder	0 / 5 / 10	0	5
Toilet use	0 / 5 / 10	0	5
Transfers	0 / 5 / 10 / 15	0	5
Mobility	0 / 5 / 10 / 15	0	5
Stairs	0 / 5 / 10	0	0
Total (out of 100)	-	5	40

Discussion

The patient presented with classical features of post-stroke right hemiplegia, including upper motor neuron signs such as spasticity, exaggerated deep tendon reflexes, a positive Babinski sign, and impaired voluntary movement, together with dysarthria. From an Ayurvedic perspective, this presentation may be correlated with *Pakshaghata*. *Acharya Charaka* describes *Snehana*, *Swedana*, and *Virechana* as principal therapeutic measures for *Pakshaghata* (9).

The *Panchakarma* protocol was planned in a phase-wise manner directed at *Srotoshodhana*, *Vata-shamana*, and *Brimhana*. In the initial phase, *Sthanik Lepa* (10) with *Vacha*, *Shatapushpa*, *Devadaru*, *Rasna*, and *Saindhava* was used for local *Vata-Kapha* pacification; these *dravyas* are described in classical texts as possessing *Ushna* and *Tikshna* properties relevant to *Vata-Kapha* disorders (11). Local application is proposed to act through cutaneous absorption and improved peripheral circulation (12,13), though this mechanism is extrapolated from general transdermal-delivery literature rather than formulation-specific pharmacokinetic data. *Koshtha Shodhana* with *Gandharvahastadi Eranda Taila* was used for *Vata anulomana* through bowel cleansing, since the *Pakvashaya* is considered a primary seat of

Vata and its clearance is described as preparatory to subsequent *Panchakarma* (14).

Udvartana with *Triphala* and *Rasna Churna* is described as having *Kapha-Medohara* properties that may reduce *Srotorodha* and stimulate circulation (15,16), and *Parisheka* with *Erandamoola Kashayam* is a form of *Swedana* described as pacifying *Vata* and *Kapha* and relieving stiffness (17).

In the second phase, *Sarvanga Abhyanga* with *Mahanarayana Taila* and *Jambeera Pinda Sweda* combined *Snehana* and *Swedana*, described in classical sources as beneficial in *Vata-Kapha* predominant conditions with pain and restricted movement (18,19); as the acute stiffness reduced, treatment shifted toward *Brimhana* and *Rasayana* oriented therapies, including *Sarvanga Abhyanga* with *Balaashvagandhadi Taila* (20) and *Shashtika Shali Pinda Sweda*, described as nourishing *Mamsa Dhatu* and supporting muscle bulk and neuromuscular strengthening (21). *Shiropichu*, classically indicated in *Pakshaghata* (22), was performed with *Brahmi Ghrita* and *Jyotishmati Taila*, both described as having *Brimhana*, *Balya*, *Vata-shamaka*, and *Medhya* properties (23).

Basti Karma is considered the principal *Shodhana* measure for *Vata* disorders, since *Vata* governs transit and localization of *Mala*, *Kapha*, and *Pitta* throughout the *Koshtha*, *Shakha*, *Marma* (24). *Anuvasana Basti* is described by *Acharya Sushruta* among the treatment principles for *Pakshaghata* (25); drugs administered rectally are absorbed through the rectal and colonic mucosa into the systemic circulation, and the colon (*Pakvashaya*) is considered a principal site of origin in conditions such as hemiplegia. *Niruha Basti*, containing *Madhu*, *Saindhava*, *Kalka*, *Kashayam*, *Taila*, and *Mamsa Rasa*, was intended to expel vitiated *Doshas*; the addition of *Mamsa Rasa* reflects a *Dhatukshaya* oriented *Samprapti*, in which nourishment of the depleted substrate is considered appropriate once the tissue bed is prepared to receive it (26).

Discharge medications were selected to sustain the gains achieved during the inpatient protocol and to support ongoing *Vata-shamana*, *Brimhana*, and *Rasayana* action; formulations such as *Chandraprabha Vati* and *Gokshuradi Guggulu* are traditionally used for *Srotoshodhana* (27). It should be noted that specific phytochemical and pharmacological mechanisms proposed for individual formulations (e.g., flavonoid or withanolide activity) are drawn from general phytochemistry literature on the constituent herbs rather than from formulation-specific pharmacological studies, and should be read as plausible rationale rather than established mechanisms in this patient.

Physiotherapy was administered concurrently throughout the treatment course, with range-of-motion exercises, passive stretching, and joint mobilization directed at joint integrity and muscle flexibility, and ambulation and bed-mobility exercises directed at gait and postural retraining (28,29). Because physiotherapy and multiple *Shamana* medications were administered concurrently with the *Panchakarma* protocol, the improvement observed in this patient cannot be attributed to any single intervention; the design of a single case report does not permit separation of the relative contribution of Ayurvedic *Panchakarma*, oral medications, and physiotherapy to the outcome.

Conclusion

In this single case, a combined Ayurvedic and rehabilitative protocol was associated with improvement in muscle strength, reduced spasticity, improved sitting balance and gait, and

resolution of the previously reported tendency to fall, in a patient with chronic post-stroke hemiplegia of approximately 19 months duration. From an Ayurvedic perspective, the presentation was correlated with *Pakshaghata*, a *Vata*-predominant disorder arising from a combination of *Dhatukshaya* and *Margavarana*; the therapeutic strategy of *Snehana*, *Shodhana*, and *Brimhana* was directed at both mechanisms, with *Basti Karma* administered in a structured *Anuvasana-Niruha* schedule.

No adverse drug reactions or complications were observed during the 17-day treatment period; this observation is limited to the treatment period and to this patient and does not establish the safety of the protocol more broadly. As a single case, these findings are hypothesis-generating rather than confirmatory, and the relative contributions of the Ayurvedic interventions, oral medications, and concurrent physiotherapy cannot be separated. Controlled studies with larger samples, standardized protocols, and longer follow-up are needed to evaluate the efficacy of integrative Ayurvedic and rehabilitative management in chronic post-stroke hemiplegia.

Declarations

Informed consent: Written informed consent was obtained from the patient for publication of this case report.

Conflict of interest: The authors declare no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Declaration of generative AI in scientific writing: Nothing to disclose.

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