

AN AYURVEDIC CASE REPORT ON DYSLIPIDAEMIA**Dr. Anupama G. L.^{1*}, Dr. Madhushree H. S.² and Dr. Ganesh Puttur³**

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Article Received on 25 Feb. 2026,
Article Revised on 17 March 2026,
Article Published on 01 April 2026,

<https://doi.org/10.5281/zenodo.19331032>

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How to cite this Article: Dr. Anupama G. L.*,
Dr. Madhushree H. S. and Dr. Ganesh Puttur.
(2026). An Ayurvedic Case Report on
Dyslipidaemia. World Journal of Pharmaceutical
Research, 15(7), 1035–1043.

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INTRODUCTION

Dyslipidaemia, a metabolic disorder characterized by derangements in serum lipid levels—such as elevated total cholesterol, low-density lipoprotein cholesterol (LDL-C) and triglycerides, or reduced high-density lipoprotein cholesterol (HDL-C). It is a major, modifiable risk factor for atherosclerotic cardiovascular disease. In India, the burden of dyslipidaemia has risen steadily over recent decades, mirroring rapid urbanisation, lifestyle transition, and increasing prevalence of obesity and metabolic syndrome. National and regional epidemiological surveys consistently report that a significant proportion of Indian adults exhibit at least one abnormal lipid parameter. Prevalence rates ranging between 60–80% in urban cohorts, with low HDL-C being the most common abnormality, underscore the magnitude of the problem.^[1,2] Dietary transition towards refined carbohydrates,

saturated fats and ultra-processed foods, coupled with declining fibre intake, has transformed traditional eating patterns. Rising rates of overweight, central adiposity, and insulin resistance particularly pronounced among South Asians even at lower body mass indices contribute to an atherogenic lipid profile characterised by high triglycerides and low HDL-C.^[3] Sedentary lifestyles, widespread mechanisation, smoking, harmful alcohol consumption, and increasing comorbidities such as diabetes mellitus further compound the metabolic burden. Additionally,

limited screening, low treatment initiation rates, and socio-economic disparities hamper early detection and effective management.

From the perspective of Ayurveda, dyslipidaemia cannot be directly correlated to *Sthoulya* or *Atisthula* since the *Purvarupa* or *Rupa* explained in these diseases cannot be seen in all the patients suffering from Dyslipidaemia. It can be correlated to *Bahu Abaddha Medas*^[4] which is a pathological process leading to the pathological increase of *Poshaka Medo Dhatu* which is in free-flowing state and even in dyslipidaemia there will be increase of the lipids in the plasma. Classical texts describe the role of *Mithya Ahara-Vihara*, *Guru-Snigdha Ahara*, sedentary habits as key etiological determinants.^[5] These etiological factors parallel contemporary risk contributors, including high-calorie processed diets, reduced physical activity, chronic stress, and disrupted sleep that significantly influence lipid metabolism. Studying *Bahu Abaddha Medas* with specific reference to dyslipidaemia provides a unique opportunity to integrate Ayurvedic pathophysiology with contemporary biomedical understanding.

AIM

To evaluate *Bahu Abaddha Medas* with specific reference to dyslipidaemia through an integrative clinical case study, correlating Ayurvedic pathophysiology with contemporary biochemical lipid parameters.

OBJECTIVES

1. To analyse the integrative understanding of disease mechanisms from Ayurvedic and biomedical perspectives.
2. To highlight the scope of *Panchakarma* interventions in the management of dyslipidaemia.

MATERIALS AND METHODS

PATIENT INFORMATION: A 43yr old, moderate built, male patient with 176 cm height, 74 kg weight approached our hospital with presenting complaints of increased bloating immediately after consumption of food associated with raised blood pressure and highly elevated values of triglycerides found during routine checkup.

CLINICAL FINDINGS

Height – 176 cm

Weight – 74 kg

BMI – 23.9 Kg/m²

Blood Pressure – 153/90 mmHg

Pulse rate – 97 bpm

DIAGNOSTIC ASSESSMENT

Lipid profile dated – 11/06/2025

Triglycerides – 795 mg/dl

HDL – 27 mg/dl

VLDL – 159 mg/dl

Total cholesterol – 201 mg/dl

Higher triglyceride, higher VLDL and lower HDL levels indicate dyslipidaemia

ASHTASTHANA PARIKSHA (~eight-fold examination of the patient)

Nadi (pulse) - 97/min, regular with *Vata–Pitta* dominance

Mutra (urine) - *Prakrita* (~normal), with normal frequency

Mala (excreta) - normal daily once with formed stools

Jihwa (tongue) - slightly coated

Shabda (sound) - *Spashta* (clear)

Sparsha (tactile examination) - *Anushnasheeta* (~not too hot and cold)

Drik (eye sight) - *Prakrita* (normal)

Akriti (body stature) - *Madhyama* (moderate)

NIDANA PANCHAKA

Nidana – *Madhura*, *Snigdha Ahara Sevana*, *Shayyasana Sukhi* (sedentary lifestyle), *Chinta*.

Purvarupa – *Avyakta*.

Rupa – *Gasrasada* (fatigue), *Dourbalya* (reduced enthusiasm)

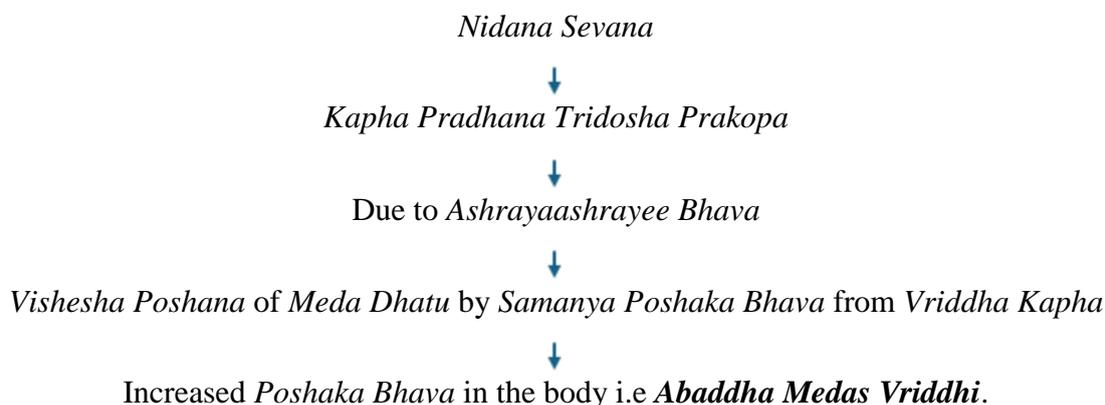
Upashaya – *Anupashaya*: NIL

Samprapti Ghataka

Samprapti Ghataka	Description
<i>Dosha</i>	<i>Kapha- Kledaka, Pitta – Pachaka, Vata – Samana and Vyana</i>
<i>Dushya</i>	<i>Meda, Rasa</i>
<i>Agni</i>	<i>Jatharagni Vriddhi; Medodhatvagni Mandyata</i>
<i>Ama</i>	<i>Medo-dhatvagni Mandya Janya</i>
<i>Srotas</i>	<i>Rasavaha Srotas, Medovaha srotas</i>
<i>Srotodushti Prakara</i>	<i>Sanga</i>

<i>Udbhava Sthana</i>	<i>Amashaya</i>
<i>Sanshara Sthana</i>	<i>Rasayani.</i>
<i>Roga Marga</i>	<i>Bahya</i>
<i>Vyakta Sthana</i>	<i>Rakta</i>
<i>Svabhava</i>	<i>Chirakari</i>
<i>Sadhya-Asadhya</i>	<i>Kricchra-sadhya / Yasya (chronic and lifestyle-related)</i>

Samprapti



THERAPEUTIC INTERVENTION

The treatment approach was based on principle of *Shodhana*.

It included *Deepana -Pachana* with *Chitrakadi Vati* 2 tablets three times a day from 17/6/25 – 21/6/25, *Shodhananga Snehapana* with *Guggulu Tiktaka Ghrita* from 22/6/25 to 25/6/25 in the *Arohana Krama* in the doses 40ml, 80 ml, 120 ml and 150 ml respectively. Then 3 days of *Vishramakala* was given from 26/6/25 to 28/6/25 wherein *Sarvanga Abhyanga* with *Murchita Tila Taila* f/b *Bashpa Sweda* was administered. Then on 29/6/25 *Virechana* was administered with 60 gm *Trivrit Lehya* as *Virechanoushadhi* with 50 ml of *Triphala Kashaya* as *Anupana* on 29/6/25. Then 5 days of *Samsarjana Krama* was advised. Then *Shamanoushadhi - Medohara Vidangadi Loha* (1-1-1) After food, *Liposem* tablet – (2-0-2) after food, *Guggulu Tiktaka Kashaya* (15ml – 0 - 15ml with 30 ml luke warm water) Before food and *Arogya Vardhini Vati* – (1-1-1) Before food for 2 months was advised.

Treatment timeline

	DATE	MEDICINE	DOSE
<i>Snehapana</i>	22/6/25	<i>Guggulu Tiktaka Ghrita.</i>	40ml
	23/6/25	<i>Guggulu Tiktaka Ghrita.</i>	80ml
	24/6/25	<i>Guggulu Tiktaka Ghrita.</i>	120ml
	25/6/25	<i>Guggulu Tiktaka Ghrita.</i>	150ml
<i>Sarvanga Abhyanga</i> f/b <i>Bashpa Sweda</i>	26/6/25 to 29/6/25	<i>Murchita Tila Taila</i>	-
<i>Virechana</i>	29/6/25	<i>Trivrit Lehya -Virechanoushadhi</i>	60gm
		<i>Triphala Kashya - Anupana</i>	50 ml

<i>Samsarjana Krama</i>	29/6/25 –3/7/25	<i>Peyadi Samsarjana krama</i>	-
<i>Shamanoushadhi</i>	For 2 months	<i>Medohara Vidangadi Loha</i>	(1-1-1) After food
		Liposem tablet	(2-0-2) after food
		<i>Guggulu Tiktaka Kashaya</i>	(15ml – 0 - 15ml with 30 ml luke warm water) Before food
		<i>Arogya Vardhini Vati</i>	(1-1-1) Before food.

RESULTS

FOLLOW UP AND OUTCOMES

Lipid profile during the first visit which was dated 11/06/2025 revealed Triglycerides 795 mg/dl, HDL – 27 mg/dl, VLDL – 159 mg/dl, Total cholesterol – 201 mg/dl which had depicted Higher triglyceride, higher VLDL and lower HDL levels indicating dyslipidaemia. After 1 month 10 days of treatment during first follow up on 4/08/25 revealed significant decrease in Triglycerides 312 mg/dl, HDL – 29 mg/dl, VLDL – 62 mg/dl, Total cholesterol – 181 mg/dl. Then after 2 months of continuation of same oral medications, on 15/10/25 during 2nd follow up, upon repeating lipid profile it revealed Triglycerides 215 mg/dl, HDL – 29 mg/dl, VLDL – 43 mg/dl, Total cholesterol – 167 mg/dl.

Lipid profile				
INVESTIGATIONS	Previous lipid profile		Follow up lipid profile	
	Dated – 11/06/2025	Dated – 4/08/2025	Dated – 15/10/2025	
Triglycerides	795 mg/dl	312 mg/dl	215 mg/dl	
HDL	27 mg/dl	29 mg/dl	29 mg/dl	
VLDL	159 mg/dl	62 mg/dl	43 mg/dl	
Total cholesterol	201 mg/dl	181 mg/dl	167 mg/dl	

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LIFE'S ON

Name : [REDACTED] Age : 43 Yr(s) Sex : Male
 Registration No : MH000769247 Lab No : J250802233
 Patient Episode : HM0000067761 Collection Date : 04 Aug 2025 08:03
 Referred By : HOME CARE LAB SAMPLE COLLECTION Reporting Date : 04 Aug 2025 09:28
 Receiving Date : 04 Aug 2025 08:43

Clinical Laboratory Report

BIOCHEMISTRY

LIPID PROFILE
 Specimen: Serum

TOTAL CHOLESTEROL (CHOD/POD)	181	mg/dl	<200
TRIGLYCERIDES (GPO/POD)	312 #	mg/dl	Moderate risk:200-239 High risk:>240 <150 Borderline high:151-199 High: 200 - 499 Very high:>500 (40-60) (2-30) <100
HDL - CHOLESTEROL (Direct)	29 #	mg/dl	Near/Above optimal:100-129
VLDL - Cholesterol (Calculated)	62 #	mg/dl	Borderline High:130-159
LDL - CHOLESTEROL (Direct)	107 #	mg/dl	High Risk:160-189 <4.0 Optimal 4.0-5.0 Borderline >6 High Risk
T.Chol/HDL.Chol ratio	6.2		<3 Optimal 3-4 Borderline >6 High Risk
LDL.CHOL/HDL.CHOL Ratio	3.7		
Non-HDL CHOLESTEROL (Calculated)	152		

LDL-Cholesterol treatment goals based on risk categories proposed by Lipid Association of India (LAI)

Risk categories	Treatment Goals (LDL-C in mg/dL)	(non HDL-C in mg/dL)
Extreme high risk - category A (CAD with >=1 feature of high risk group)	< 50 (optional <30)	< 80 (optional <60)
Extreme high risk - category B (CAD with >=1 feature of high risk group or recurrent ACS LDL-C <=50mg/dL)	<30	<60

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LIFE'S ON

Name : [REDACTED] Age : 43 Yr(s) Sex : Male
 Registration No : MH000769247 Lab No : J250608060
 Patient Episode : HM0000065228 Collection Date : 11 Jun 2025 08:17
 Referred By : HOME CARE LAB SAMPLE COLLECTION Reporting Date : 11 Jun 2025 09:51
 Receiving Date : 11 Jun 2025 08:58

Clinical Laboratory Report

BIOCHEMISTRY

LIPID PROFILE
 Specimen: Serum

TOTAL CHOLESTEROL (CHOD/POD)	201 #	mg/dl	<200
TRIGLYCERIDES (GPO/POD)	795 #	mg/dl	Moderate risk:200-239 High risk:>240 <150 Borderline high:151-199 High: 200 - 499 Very high:>500 (40-60) (2-30) <100
HDL - CHOLESTEROL (Direct)	27 #	mg/dl	Near/Above optimal:100-129
VLDL - Cholesterol (Calculated)	159 #	mg/dl	Borderline High:130-159
LDL - CHOLESTEROL (Direct)	76	mg/dl	High Risk:160-189 <4.0 Optimal 4.0-5.0 Borderline >6 High Risk
T.Chol/HDL.Chol ratio	7.4		<3 Optimal 3-4 Borderline >6 High Risk
LDL.CHOL/HDL.CHOL Ratio	2.8		
Non-HDL CHOLESTEROL (Calculated)	174		

LDL-Cholesterol treatment goals based on risk categories proposed by Lipid Association of India (LAI)

Risk categories	Treatment Goals (LDL-C in mg/dL)	(non HDL-C in mg/dL)
Extreme high risk - category A (CAD with >=1 feature of high risk group)	< 50 (optional <30)	< 80 (optional <60)
Extreme high risk - category B (CAD with >=1 feature of high risk group or recurrent ACS LDL-C <=50mg/dL)	<30	<60

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LIFE'S ON

MR VEDANK TRIPATHI
HM0000070911
42Y 6M 16D
Male

URN
Ordered By
Request Date
Patient Location

MH000769247
Home care lab sample collection
14/10/2025 12:59
HOMECARE MHB

Biochemistry

Lipid Profile AUTHORISED
15/10/2025 11:27

Specimen No: 2500842854-1; Collection Date & Time: 15/10/2025 10:00; Receive Date & Time: 15/10/2025 10:36
Specimen: SERUM;

Test	Result	Units	Ref. Range	Method
TOTAL CHOLESTEROL	167.00	mg/dL	<200.00	CHOD / POD
Reference Ranges: Desirable: <200 Moderate Risk: 200-239 High risk: >240				
TRIGLYCERIDES	215.00 #	mg/dL	<150.00	GPO / POD
Reference ranges: High: 200 - 499 mg/dL Very high: >500 mg/dL Borderline high: 151-199 mg/dL				
HDL - CHOLESTEROL	29.00 #	mg/dL	40.00-60.00	Enzymatic
VLDL - CHOLESTEROL	43.00 #	mg/dL	2.00-30.00	Calculation
LDL - CHOLESTEROL	107.00 #	mg/dL	<100.00	Enzymatic
Reference ranges: Optimal: <100 mg/dL Near/Above optimal: 100-129 mg/dL Borderline High: 130-159 mg/dL High Risk: 160-189 mg/dL				
T.CHOL/HDL CHOL Ratio	5.76			Calculation
Reference ranges: Optimal - <4.0 Borderline - 4.0-5.0 High Risk - >6				
LDLCHOL / HDLCHOL Ratio	3.69			Calculation
Reference ranges: Optimal - <3 Borderline - 3-4 High Risk - >6				
Non HDL cholesterol	138.00			

LDL-Cholesterol treatment goals based on risk categories proposed by Lipid Association of India (LAI)

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DISCUSSION

- **Rationale behind correlating Dyslipidaemia with *Bahu Abaddha Medas***^[6]

Dyslipidaemia cannot be directly correlated of *Sthoulya* or *Atisthula* since the *Purvarupa* or *Rupa* explained in these diseases cannot be seen in all the patients suffering from dyslipidaemia. But it can be correlated to *Bahu Abaddha Medas*, a condition mentioned by *Acharya Charaka* while explaining the *Samprapti* of *Prameha*. He mentions about the *Medas* being one of the *Dasha Dushyas* in the form of *Bahu* and *Abaddha*. Chakrapani further clarifies that, “*Abaddhamiti Asamhatam*” which means the *Medas* here is not in its solid form but free flowing state and *Bahu* i.e., in increased quantity. This can be correlated to dyslipidaemia because of the similarity where there will be increase in the lipids in the plasma. Here we can also understand that, the *Poshaka Medo Dhatu* will be aggravated rather than the *Poshya Medo Dhatu*. Aggravation of *Poshya Medo Dhatu* results in *Sthoulya*, *Atisthula* etc., *Medorogas*, whereas that of *Poshaka Medo Dhatu* results in *Bahu Abaddha Medas*.

- Effect of *Shodhananga Snehapana* followed by *Virechna* in Reducing Impaired Lipid Levels

Shodhananga Snehapana administered as a preparatory procedure for *Virechna*, plays a

significant role in correcting impaired lipid metabolism resulting in *Bahu Abaddha Meda Avastha* i.e, dyslipidaemia. Although *Snehapana* involves the internal administration of lipids in *Arohana Matra*, its pharmacodynamic action facilitates promotes the mobilisation of stored lipids and improves hepatic lipid processing, thereby contributing to reductions in serum triglycerides, total cholesterol, and low-density lipoprotein (LDL) levels. Improved bile secretion and enterohepatic circulation aid in cholesterol excretion, while normalization of metabolic pathways helps restore lipid homeostasis.

From an Ayurvedic perspective, *Bahu Abaddha Medas Avasta* is due to impairment in *Agni*, *Vata* and *Meda*. *Snehapana* increases the *Agni* and normalises the *Gati* of *Vata*.^[7] The *Virechana* acts on the *Yakrit* the site where in lipid metabolism occurs. *Yakrit* is the *Pitta Sthana*, *Virechana* detoxifies the liver and it does *Sroto Shodhana* reducing pathologically increased *Abaddha Medas*. The *Snehana* followed by *Swedana* facilitates movement of *Doshas* from *Shakha* to *Koṣṭha*. The subsequent Prabhuta elimination of vitiated *Doshas* by *Virechana*^[8] ensures sustained metabolic correction rather than transient symptomatic relief.

- **Rationality behind Shamanoushadhi**

1. *Medohara-Vidangadi Lauha*^{[9][10][11]} – it is a classical herbo-mineral formulation indicated in *Medoroga* and *Kapha-Meda* predominant disorders. Its therapeutic efficacy is attributed to the synergistic action of *Vidanga*, *Trikatu*, and *Lauha Bhasma*, which collectively act on *Agni*, *Meda dhatu*, and *Srotas*.

Trikatu components are known to enhance digestive enzyme secretion and hepatic metabolism, thereby reducing serum triglycerides and LDL cholesterol. The *Uṣṇa* and *Tikṣṇa* properties can be correlated with increased basal metabolic rate and mobilisation of stored fat. *Vidanga* and *Lauha Bhasma* contribute to reduction of oxidative stress and support liver function, a key organ in lipid regulation.

Lauha supports mitochondrial enzymes involved in lipid oxidation and energy metabolism.

2. Liposem tablets^{[12][13][14]} - contain *Guggulu*, *Triphala*, *Chitraka*, *Musta* and *Trikatu* (*Shunthi*, *Maricha*, *Pippali*). The formulation improves *Agni*, reduces *Ama*, and corrects impaired lipid metabolism. *Guggulu* provides *Medohara* and *Lekhana* action, helping to reduce elevated cholesterol and triglycerides, while *Triphala* supports digestion and elimination of excess lipids. *Chitraka*, *Musta* and *Trikatu* enhance metabolic activity, improve drug absorption, promote fat metabolism. Thus, Liposem tablets help in reducing serum triglycerides, LDL, and total cholesterol.

3. *Arogyavardhini Vati*^{[15][16][17]} - It is a classical herbo-mineral formulation widely indicated in *Medoroga*, *Yakrt vikara* (liver disorders), and *Kapha-Meda pradhana* conditions. Key ingredients such as *Kaṭuki* (*Picrorhiza kurroa*), *Triphala*, *Trikatu*, *shilajatu*, and *Tamra Bhasma* act synergistically to correct *Jatharagni* and *Medo-dhatvagni*, promote *Srotoshodhana*, and reduce pathological accumulation of *Meda dhatu*. *Kaṭuki* is especially significant due to its *Tikta rasa* and *Ushna Virya*, which pacify *Kapha* and promote metabolic clearance. Hence helps in reduction of serum total cholesterol, triglycerides, and LDL, also acts as hepatoprotective.
4. *Guggulu Tiktaka Kashaya*^{[18][19][20]} - It is administered in dyslipidaemia due to its *Tikta rasa*, *Lekhana*, *Medohara* and *Srotoshodhana* properties, which directly address the pathogenesis of *Abaddha Medas*. The *Tikta rasa* helps in drying excess *Kapha* and *Meda*, reduces pathological lipid accumulation, and improves *Dhatvagni*. *Guggulu* acts as a potent *Medohara* and *Lekhana Dravya*, facilitating mobilization and reduction of elevated cholesterol and triglycerides. The *Tikta Dravya* in the formulation support *Deepana–Pachana*, reduce *Ama*, and prevent further abnormal lipid synthesis.

CONCLUSION

This case study demonstrates the clinical effectiveness of Panchakarma-based Ayurvedic management in a patient of Dyslipidaemia with markedly elevated triglyceride levels. The intervention comprising *Shodhananga Snehapana* followed by *Virechana* resulted in significant improvement in dyslipidaemia parameters. After two months of post *Shodhana* oral medication, there was a marked reduction in serum triglycerides and LDL cholesterol, indicating effective metabolic correction.

Importantly, continued follow-up after subsequent two-months showed further reduction in lipid levels, highlighting the sustained therapeutic impact of *Shodhana* therapy beyond the active treatment phase. This suggests that *Panchakarma* interventions can induce long-term metabolic regulation rather than temporary lipid suppression.

The findings underscore the role of *Shodhana* in correcting underlying dysfunctional lipid metabolism, that is clearing the *Bahu Abaddha Medas* in the blood, offering a durable and holistic approach to dyslipidaemia management. This case supports the integration of *Panchakarma* therapies in clinical practice for managing cardiometabolic disorders, warranting further controlled clinical studies to validate and standardize such treatment protocols.