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ROLE OF ĀYURVEDA-PAÑCAKARMA THERAPIES IN THE MANAGEMENT OF ABHIGHĀTAJA PAṄGUVĀTA (TRAUMATIC PARAPARESIS): A CASE REPORT

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ABSTRACT

Abhighātaja Paṅguvāta denotes functional impairment or paralysis of the lower limbs resulting from traumatic injury. It can be correlated with Traumatic Paraparesis. Paraparesis is the partial loss of motor and/ or sensory function involving both lower limbs, while the upper limbs remain unaffected. It commonly results from spinal cord injury at or below the T1 spinal cord level. Depending on the level and severity of the lesion, trunk function may also be affected. A 35-year-old male patient was apparently normal 15 months ago. Then he sustained electrocution followed by fall from an electric pole about 10 feet height. He developed weakness of bilateral lower limbs (Lt > Rt). He was taken to an allopathic hospital necessary investigations were done and treated conservatively. Then he came to SV Ayurvedic hospital for better treatment. Comprehensive Ayurvedic modalities planned for the management consisting of *Abhyaṅgam* and *Nāḍī Svedam*, *Ṣaṣṭika Śāli Piṇḍa Svedam*, *Mātrā Basti* and *Vājīgandhādi Basti* in *yoga basti* format. Assessment was performed before and after treatment by using ASIA scale and Walking time. The ASIA score improved from 272 before treatment to 302 after treatment. The patient showed marked improvement in muscle strength, paresthesia, and walking ability following treatment.

KEYWORDS: *Abhighātaja Paṅguvāta,* Traumatic Paraparesis, *Vājīgandhādi Basti*, ASIA scale.

INTRODUCTION

Paṅguvāta is described as a *Nānātmaja Vātavyādhi*.[1] *Abhighātaja Paṅguvāta* occurs due to *Abhighāta* (trauma), which causes vitiation of *Vāta Doṣa*, resulting in impaired movement and weakness of the lower limbs. When aggravated *Vāta* affects the *Snāyu* and *Kaṇḍarā* of a single lower limb, it results in *Khañja*. When these structures are affected in both lower limbs, it results in *Paṅgu.*[2] which can be correlated with paraparesis.

In contemporary medicine, paraparesis refers to partial weakness of both lower limbs, commonly associated with spinal cord lesions, particularly an intraspinal lesion at or below the upper thoracic spinal cord level is most commonly responsible, but a paraparesis also may result from lesions at other locations that disturb upper motor neurons and lower motor neurons.[3] Traumatic spinal cord injury may result in bilateral motor weakness of lower limbs along with sensory disturbances and impairment of bladder and bowel functions. The degree of motor and sensory involvement depends on the level and extent of spinal cord injury. The disease is considered to originate in the *Kaṭi* region, due to the derangement of *Apāna Vāta* and *Vyāna Vāta*. Functional impairment of the lower limbs, along with disturbances in urination, defecation, and sensory perception, indicates the involvement of both *Apāna Vāta* and *Vyāna Vāta*.

Chief Complaints

Patient complains of weakness of bilateral lower limbs (Lt > Rt) since15 months
Associated with pain, numbness, stiffness and difficulty to walk and climb stairs.

History of Present Illness

A 35-year-old male patient was apparently normal 15 months ago. On 08/10/2024 at around 10AM, he sustained electrocution followed by a fall from an electric pole (approx. 10 feet height). He was unable to move both lower limbs with loss of sensation below the upper abdomen, along with bowel and bladder incontinence.

He was taken to an allopathic hospital where necessary investigations including MRI of the spine were performed. It revealed Cord contusion with edema at the D8-D9 level, for which

Surgery was advised, but the patient was not willing for operative intervention and hence was managed conservatively and later discharged.

Although he regained bowel and bladder control as he was experiencing difficulty in walking he approached SV Ayurvedic hospital for further management and better recovery.

MRI Dorso- Lumbar Spine shows

Wedge compression fractures of D6, D7, D8 and D9 vertebral bodies.

T2, STIR hyperintense signals in dorsal spinal cord at the level of D8- D9 with adjacent edema – Cord contusion.

Past History

No significant past medical history.

Personal History

Diet: Mixed

Sleep: Sound

Bowel: Regular

Micturition: Normal.

General Examination

Pulse- 78 bpm, RR- 16/min, BP- 120/80mmhg, Temperature- Afebrile

Built- Moderate

Pallor, icterus, cyanosis, clubbing, edema, lymphadenopathy- absent

CVS/RS/PA- Within Normal Limits

Sensory system- Altered sensation from D9 level.

Aṣṭasthāna Parīkṣā

Nāḍī: 78 bpm

Mala: *Prākṛta*

Mūtra: *Prākṛta*

Jihvā: *Alipta*

Śabda: *Prākṛta*

Sparśa: *Supti* in bilateral lower limbs

Dṛk: *Prākṛta*

Ākṛti: *Madhyama*

Investigations

Hb%- 14.9gm%, ESR- 16mm/1hr, RBS- 92mg/dl

Diagnosis:

Āyurvedic- Abhighātaja Paṅguvāta

Modern- Traumatic Paraparesis.

Assessment

ASIA impairment grading scale.

Walking time- Calculated in seconds per 10 meters on an average of 3 times with or without support.

Plan of treatment

Based on the clinical diagnosis, the patient was managed according to the treatment principles of *Vāta vyādhi*[4]

METHODS AND MATERIALS

Management

1. Śamana Cikitsā

a. *Mahavata vidwamsini ras* 1-0-1

b. *Triphala guggulu* 1-0-1

c. *Atibala qwatha churnam* 10ml-0-10ml

d. *Cap. Maharaja prasarini* 21 A 1000mg 1-0-1

e. *Cap. Neurowin* 1-0-1

2. Śodhana Cikitsā

Procedure	**Contents**	**No. of days**
Sarvāṅga Abhyaṅgam and *Nāḍī Svedam*	*Nirguṇḍī Tailam* and *Vātahara dravyas* like *nirgundī* etc.	3
Ṣaṣṭika Śāli Piṇḍa Svedam	*Ṣaṣṭika Śāli, Kṣīra, Balāmūla, Māṣa*	7
Mātrā Basti	*Nirguṇḍī* tailam	7
Vājīgandhādi Basti[5]	With *Balāmūla, daśamūla, aśvagandhā, bilva*	8

***Mātrā Basti* ingredients**

S. No.	Ingredients	Dose
1.	*Saindhava lavaṇa*	3gms
2.	*Śatapuṣpā Cūrṇa*	3gms
3.	*Nirguṇḍī tailam*	60ml

Vājīgandhādi Basti **ingredients**

S. No.	*Nirūha Basti* ingredients	Dose
1.	*Mākṣika*	100gms
2.	*Saindhava lavaṇa*	6gms
3.	*Eraṇḍa tailam*	100ml
4.	*Śatapuṣpā kalka*	24gms
5.	*Vājīgandhādi Kaṣāyam*	300ml

Vājīgandhādi yoga basti **schedule**

Day of treatment	***Basti***	Retention time
1st day	*Anuvāsana*	3 hrs
2nd day	***Nirūha***	2 min
3rd day	*Anuvāsana*	5 hrs
4th day	***Nirūha***	5 min
5th day	*Anuvāsana*	5 hrs
6th day	***Nirūha***	8 min
7th day	*Anuvāsana*	4 hrs
8th day	*Anuvāsana*	6 hrs

OBSERVATIONS

ASIA impairment grading scale

Gradation		
A	Complete	No motor, no sensory, no sacral sparing
B	Incomplete	No motor, sensory only
C	Incomplete	50% of muscles LESS than grade 3 (Can't raise arms or legs off bed)
D	Incomplete	50% of muscles MORE than grade 3 (Can raise arms or legs off bed)
E	Normal	Motor and sensory function are normal

Sensory subscores

	Before treatment	After treatment
Light Touch Right	44	56
Light Touch Left	44	56
Pin Prick Right	56	56
Pin Prick Left	56	56
Total	200	224

Motor subscores

	Before treatment	After treatment
Upper Extremity Right	25	25
Upper Extremity Left	25	25
Total	50	50

Lower Extremity Right	Before treatment	After treatment
Hip flexors	3/5	4/5
Knee extensors	4/5	4/5
Ankle dorsiflexors	4/5	4/5
Long toe extensors	4/5	4/5
Ankle Plantar flexors	4/5	4/5
Total	19/25	20/25

Lower Extremity Left	Before treatment	After treatment
Hip flexors	0/5	1/5
Knee extensors	3/5	3/5
Ankle dorsiflexors	0/5	1/5
Long toe extensors	0/5	1/5
Ankle Plantar flexors	0/5	2/5
Total	3/25	8/25
Total motor subscores	72/100	78/100
Total ASIA score	272/324	302/324
ASIA-Grade	ASIA-D Incomplete	ASIA-D Incomplete

Post-treatment, the patient continued to meet the criteria for AIS Grade D. Nevertheless, significant neurological improvement was demonstrated by normalization of sensory function and enhanced lower limb muscle strength, reflecting clinical recovery within the same AIS grade.

Walking time

Before treatment	After treatment
2min 52sec/ 10 mts on an avg. of 3 times with stick support	38sec/ 10 mts on an avg of 3 times with stick support

RESULT

Following treatment, the patient demonstrated improvement in lower-limb muscle strength, gait stability, walking speed, and functional independence, as evidenced by improvements in the ASIA score, and 10-meter walking time.

DISCUSSION

Abhighātaja Paṅguvāta is characterized by aggravated *Vāta* resulting from trauma, leading to impaired motor function, muscle weakness, stiffness, and spasticity of the lower limbs. *Abhyaṅga* was selected as the initial intervention to counteract the *rukṣa* and *khara guṇas* of aggravated *Vāta* through the administration of *snehana*. The oleation therapy helps reduce muscle stiffness and spasticity, improves soft tissue flexibility, and facilitates better neuromuscular function. By preparing the body for subsequent sudation and *Basti* therapies,

Abhyaṅgam enhanced the overall therapeutic response and contributed to improved lower limb function.

Nāḍi Svedam was administered following *Abhyaṅgam* to potentiate the effects of oleation. Localized sudation was therefore selected to relieve muscle tightness, improve tissue extensibility, and facilitate better joint movement. The combined effect of *Abhyaṅgam* and *Nāḍi Svedam* helped reduce *Vāta*-induced rigidity, thereby improving mobility and preparing the patient for rehabilitation and subsequent *Pañcakarma* procedures.

Śaṣṭika Śāli Piṇḍa Svedam was preferred because the patient presented with weakness and reduced muscle strength following traumatic spinal cord injury. Unlike ordinary sudation, this nourishing therapy provides simultaneous *snehana* and *bṛṃhaṇa*, making it suitable for conditions associated with *dhātu-kṣaya* and neuromuscular weakness. It was intended to improve muscle strength, enhance tissue nourishment, and support functional recovery of the affected lower limbs.

Vāta is predominantly located in the *Pakvāśaya*, making *Basti* the principal treatment. *Mātrā Basti* provides continuous oleation, pacifies aggravated *Vāta*, nourishes tissues, and is safe for repeated administration in debilitated patients.

Vājīgandhādi Basti was selected because it combines *Vāta-hara* and *Bṛṃhaṇa* properties, which are appropriate for traumatic neurological deficits associated with muscle weakness. *Vājigandhādi Basti* may be beneficial in *Paṅgu Vāta* due to the combined properties of its ingredients. *Aśvagandhā* and *Balā* possess *Balya* properties, supporting strength, while *Bilva* and *Daśamūla* contribute *Śūlahara* and *Śothahara* actions. *Eraṇḍa Taila* and *Saindhava Lavaṇa* support *Vāta* pacification and *Anulomana*, while *Śatapuṣpā* contributes *Vātahara* and *Śūlapraśamana* actions. Collectively, these ingredients provide an Ayurvedic rationale for addressing *Vāta* vitiation, pain and impaired mobility in *Paṅgu Vāta*.

Mahāvāta Vidhvaṃsinī Rasa contains *Śodhita Pārada, Gandhaka, Nāga, Vaṅga, Loha, Abhraka* and *Tāmra Bhasma*, along with herbal ingredients such as *Triphalā*, *Trikaṭu*, *Vatsanābha*, *Citraka* and *Nirgundī*. Traditionally, it is used in *Vātavyādhi*, with a therapeutic rationale of *Vātaśamana* and relief of associated pain and stiffness.

Maharaja Prasāriṇī Taila 21 *Āvartita* was administered as an Ayurvedic formulation indicated for *Vātavyādhi*. Its ingredients, including *Prasāriṇī, Balā* and *Aśvagandhā,* provide a traditional therapeutic rationale for *Vātaśamana* and support of physical strength.

Neurowin contains *Aśvagandhā*, *Kavañca Bīja, Jātiphala, Vidārīkanda, Śatāvarī* and *Akkalakara*. These ingredients are traditionally associated with *Balya* and *Bṛṃhaṇa* properties, supporting strength and nourishment.

CONCLUSION

This case demonstrated the beneficial role of *Āyurvedic- Pañcakarma* therapies in the management of *Abhighātaja Paṅguvāta* (traumatic paraparesis). Above mentioned *Pañcakarma* and *Śamana auṣadhis* helps in pacifying *vāta*, improving muscle strength, reducing stiffness and enhancing functional recovery.

Thus *Pañcakarma* can be considered an effective, supportive and rehabilitative approach in traumatic paraparesis.

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