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ANCIENT AYURVEDIC PRINCIPLES AND MODERN SURGICAL PRACTICES: A CORRELATIVE REVIEW ON THE MANAGEMENT OF *GALASHUNDIKA* (ELONGATED UVULA)

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ABSTRACT

Background: In *Sushruta Samhita*, *Galashundika* is described in *Nidana Sthana*[1] and its surgical treatment outlined in *Chikitsa Sthana*.[2] The procedure involves traction, use of a *Mandalagra* instrument, and removal of only the lower one-third of the elongated tissue. *Aṣhṭanga Sangraha*[3] and *Yogratnakara*[4] provide complementary accounts of the disease, operative precautions, and aftercare. **Objective:** To present the classical pathology and surgical management of *Galashundika*, highlight *Sushruta's* precise recommendation for partial excision, and examine its meaningful points of convergence with modern uvular surgery. **Methods:** A narrative review was conducted using primary Ayurvedic texts *Sushruta Samhita (Nidana Sthana*[1] and *Chikitsa Sthana)*[2], *Aṣhṭanga Sangraha (Uttara Sthana)*[3] and *Yogaratnakara (Talu roga adhyaya).*[4] Contemporary clinical literature and professional guidelines on uvular disorders and surgical interventions were also examined. Findings were synthesized qualitatively. **Results:** Classical sources describe *Galashundika* as a soft, elongated swelling at the palate root, linked to *Kapha-Rakta* and associated with symptoms such as thirst, cough and breathlessness.

Sushruta prescribes drawing out the swelling and excising only its lower one-third, preserving the upper portion. *Aṣhṭanga Sangraha* specifies the use of *Muchundi Yantra* (forceps) and cautions against both insufficient and excessive excision. *Yogaratnakara* adds adjunctive therapies including topical applications, gargling, dietary measures and fumigation. **Conclusion:** *Sushruta's* directive to excise only one-third of the elongated uvula, along with the warnings against excessive excision and hemorrhage, demonstrates a clear principle of controlled, tissue-conscious surgery. This approach resonates strongly with modern surgical efforts to tailor resections while safeguarding function, making *Galashundika* a valuable subject in both historical and contemporary surgical discourse.

KEYWORDS: *Galashundika*, Uvula, Uvulectomy, *Talu roga*, *Shalakya tantra*, *Ayurveda*, Otorhinolaryngology, Surgery.

INTRODUCTION

The uvula is a small, centrally positioned structure that extends downward from the soft palate into the oropharynx. Closely integrated with the palatal muscles, it plays an important role in speech, swallowing and oropharyngeal function. Even minor changes in its appearance can produce clinically significant symptoms. When subjected to chronic irritation, the uvula may become elongated, thickened and edematous. Common contributing factors include persistent nasopharyngitis, habitual tobacco use and mechanical trauma from long-standing snoring, where repetitive vibrations lead to tissue swelling and fibrous overgrowth. Patients often report a reflex cough when the uvula contacts the epiglottis or tongue base, this cough is typically dry and spasmodic. Additional complaints may include morning nausea, vomiting, throat irritation, foreign-body sensation, painful swallowing or dysphagia. Importantly, an enlarged or low-hanging uvula represents a clinical sign rather than a definitive diagnosis.[5] [6]

The present review focuses on *Sushruta's* account while also considering related descriptions in the *Ashtanga Sangraha* and *Yogaratnakara.* The disease is discussed in *Sushruta Nidana Sthana*[1], with treatment in *Chikitsa Sthana.*[2] *Sushruta Nidana Sthana* lists *Galashundika* among palate disorders, describes a long swelling arising from the palate root, attributed to *Kapha* and *Rakta*, likened to an inflated bladder, and associated with thirst, cough and breathlessness. That verse uses the name *Kanthashundi.*[1]

This review places the classical operative instructions in dialogue with modern uvular surgery. Both traditions emphasize the importance of measured excision, careful handling of the uvula, and vigilance against bleeding, underscoring a shared principle of tissue-conscious surgical reasoning. By presenting these sources within their historical and clinical contexts, the comparison highlights the continuity of operative precision across time.

METHODS

This review was conducted as a narrative synthesis drawing upon classical Ayurvedic texts and modern clinical literature. Primary sources included the *Sushruta Samhita*—particularly *Nidana Sthana* and *Chikitsa Sthana*—alongside *Aṣhṭanga Sangraha* (*Uttara Sthana*) and *Yogaratnakara* (*Taluroga Adhyaya*).[1–4] Both Sanskrit originals and accessible English translations were consulted. For the contemporary perspective, PubMed/MEDLINE databases were searched using keywords such as "elongated uvula," "uvular edema," "uvulitis," "uvulectomy" and "uvulopalatoplasty."

We included sources addressing classical descriptions and operative methods, the presentation and differential diagnosis of uvular disorders, contemporary management, and surgical outcomes. Clinical guidance, systematic reviews, and observational studies were prioritised for the modern evidence. Findings were synthesised narratively because the sources cover different patient groups and procedures.

RESULTS

Classical description and pathology

Sushruta identifies *Galashundika* among disorders of the palate, characterizing it as a long swelling at the root of the palate caused by *Kapha* and *rakta*. He compares its appearance to an inflated bladder (*Dhamaat basti prakasha*) and notes symptoms such as thirst, cough, and breathlessness, referring to it as *Kanthashundi* (1). In *Aṣhṭanga Sangraha*, the condition is described as a soft, elongated, sticky mass at the base of the palate, likened to a fish bladder filled with air (*Matasaya basti*), with potential to obstruct the throat.[3] *Yogaratnakara* similarly describes a swelling arising from the palate root with thirst, cough, and breathlessness, calling it *Kanthashundi* or *Galashundi.*[4] Collectively, these texts provide a detailed classical understanding of the lesion's site, morphology, clinical features, and underlying Ayurvedic pathology.

Across these sources, *Galashundika* is depicted as a distinct, localized swelling that warrants direct surgical intervention. The emphasis on how the tissue is grasped, the extent of excision, and the precautions against bleeding reflects a structured and deliberate operative approach.

OPERATIVE METHOD AND PARTIAL EXCISION

In the *Sushruta Samhita*, the physician is instructed to draw the *Galashundika* forward using the thumb and index finger or by grasping it with forceps, followed by excision with a *Mandalagra* (round-headed instrument).[2] The specified resection is the lower one-third, leaving the upper two-third part of the elongated uvula. *Sushruta* cautions that excessive excision can cause severe hemorrhage and death, while insufficient cutting may leave swelling and salivation and produce other complications. He therefore emphasizes that the procedure belongs in the hands of a physician well trained in surgery and practical operative work.[2] The combination of defined traction, instrument selection, measured tissue removal, and explicit hemorrhage prevention makes this a notably precise surgical account.

Ashtanga Sangraha operative account

Ashtanga Sangraha describes grasping the swelling with *Muchundi yantra* (forceps) and excising it with a *Mandalagra Shastra*.[3] The text highlights the dangers of both insufficient and excessive excision, inadequate removal fails to relieve obstruction and may worsen swelling and salivation, while cutting too deeply at the root risks fatal bleeding. Read alongside *Sushruta*, this reinforces a consistent operative principle—excision must be deliberate, limited, and protective of the root and surrounding structures.

Textual aftercare and adjunctive measures

Yogaratnakara expands the classical account by detailing local care following excision. Recommended *pratisarana* formulations include combinations such as *Trikatu*, *Vacha* and rock salt with honey or powders containing *Kushtha*, black pepper, *Vacha*, long pepper, *Patha* and *Musta*, mixed with honey. Gargling with decoctions of *Vacha, Ativisha, Patha, Rasna, Katuki* and *Nimba* is advised, along with *Kapha*-reducing fumigation twice daily, dietary measures such as *Yavakshara* and green-gram soup, venesection near the nasal vein (*Upanasa Siravyadha*) and chewing *Shefali (Harsingar)* root.[4] These recommendations complete the classical account by extending care beyond excision to local treatment and convalescence.

Modern clinical presentation and assessment

A retrospective review of 375 patients seen over 14 years found a varied set of uvular conditions, including trauma, papilloma, infection, allergy, symptomatic elongation, asymptomatic elongation, and squamous cell carcinoma. Symptoms ranged from irritation to vomiting, pain, and dysphagia.[7] This variability highlights why visual inspection alone cannot determine etiology or justify excision. Documented risks include bleeding, altered swallowing, and velopharyngeal insufficiency. Evidence for isolated uvular elongation remains limited, whereas more substantial data exist for uvulopalatoplasty in sleep apnea.[8,9]

Clinical evaluation should determine whether symptoms are acute or persistent and assess for respiratory distress, rapidly progressive swelling, fever, allergic features, recent airway instrumentation, medication exposure, inhalational irritants, snoring or signs of sleep-disordered breathing. Examination must include the uvula, palate, and pharynx, with urgent airway assessment prioritized when voice change, drooling, stridor or worsening swelling is present. Differential diagnoses include infection, angioedema, trauma and lesions requiring biopsy or excision. Reports of isolated uvular edema demonstrate that allergy, infection, medication effects, trauma and sleep apnea may overlap clinically.[10,11]

Contemporary management and role of surgery

Management of uvular disorders depends on the underlying cause and severity. Transient edema or mild uvulitis is generally treated conservatively while addressing the precipitating factor. Suspected bacterial infection, allergic angioedema or airway compromise requires targeted, condition-specific therapy. These approaches are not interchangeable and empirical use of medication or surgery should never replace a thorough assessment of airway risk and etiology.[10,11]

For cases of persistent symptomatic elongation, specialist evaluation is essential to confirm that the uvula itself is responsible for the symptoms and to rule out alternative causes such as focal masses. Excision or reduction may be considered selectively, but the evidence supporting surgery for isolated elongated uvula remains limited and largely observational. In contrast, surgical intervention for obstructive sleep apnea is a separate clinical decision. The American Academy of Sleep Medicine, advises considering surgical referral in adults who cannot tolerate or decline positive airway pressure therapy, with management guided by objective diagnosis and individualized assessment.[12] A conspicuous or long uvula alone is not proof of sleep apnea or an indication for an operation.

A systematic review of laser-assisted uvulopalatoplasty (LAUP) for sleep-disordered breathing reported 42 studies involving 3,093 patients. Reported complications included globus sensation (8.2%), dryness (7.2%), bleeding (2.6%) and velopharyngeal insufficiency (3.9%), follow-up and complication reporting were variable.[13] These figures concern LAUP, not isolated partial uvulectomy for *Galashundika*, and should not be transferred directly to that operation. They nonetheless show why risks, including pain, altered swallowing or speech, bleeding, and persistent throat sensation, require explicit discussion.

Correlative Synthesis

The principal surgical correspondence is *Sushruta*'s recommendation to remove a defined portion of the uvula while preserving the remainder. Contemporary uvular surgery likewise seeks to relieve symptoms through appropriately limited resection while maintaining palatal function. The classical descriptions add operative details—traction, forceps, a round-headed cutting instrument, and explicit attention to hemorrhage—that make the comparison especially relevant to surgical history and the evolution of tissue-conscious technique.

DISCUSSION

Classical accounts portray *Galashundika* as a distinct swelling at the root of the palate, with characteristic throat and respiratory symptoms. *Sushruta's* treatment moves seamlessly from diagnosis to a clearly specified operation, demonstrating early operative reasoning.

The texts converge on a practical surgical principle: effective management requires removing sufficient tissue to resolve symptoms while safeguarding surrounding anatomy. *Sushruta's* instruction to excise one-third of the uvula exemplifies this principle, while both *Sushruta* and *Aṣhṭanga Sangraha* caution against the dangers of excessive or inadequate removal. This mirrors modern uvular procedures, which balance symptom relief against risks such as bleeding, altered swallowing, speech changes, and loss of palatal function.

Surgery should be considered only when symptoms are persistent, the anatomy plausibly explains them, important alternatives have been assessed, and the expected benefit outweighs the risks for that individual. This is especially relevant when an operation is proposed for snoring or sleep apnea and sleep apnea requires objective evaluation and management beyond inspection of the uvula. Modern surgery can be effective in selected anatomical settings, but procedures involving the soft palate carry meaningful risks and are not interchangeable with limited excision of a benign elongated uvula.

This narrative review draws on a focused selection of classical and contemporary sources and does not provide a systematic evidence assessment. Modern studies address varied interventions and patient groups, so their results cannot be combined to estimate outcomes for isolated partial excision. Further clinical research on symptomatic uvular elongation would clarify indications, patient-reported benefits and long-term outcomes.

Future Directions

Prospective registries employing standardized definitions of uvular elongation, consistent symptom measures, airway and sleep assessments and long-term follow-up would strengthen the evidence base. Additionally, comparative scholarship across different editions of classical surgical texts could illuminate the evolution of operative methods and their enduring relevance in surgical history.

CONCLUSION

Sushruta's description of *Galashundika* integrates a clear account of the lesion with a precisely defined surgical procedure—drawing the uvula forward, excising its lower one-third using a *Mandalagra* instrument, and avoiding excessive removal that could result in fatal hemorrhage. The complementary details in *Aṣhṭanga Sangraha* and *Yogaratnakara* expand this framework by adding operative cautions and recommendations for postoperative care. Collectively, these texts articulate a lasting principle of measured excision, one that aligns closely with modern concepts of tissue-conscious surgery and deserves recognition within the broader history of surgical practice.

REFERENCES

1. Shastri AD, editor. Sushruta Samhita. Reprint ed. Varanasi: Chaukhambha Sanskrit Bhawan; 2011 Nidana Sthana 16/40-41.
2. Shastri AD, editor. Sushruta Samhita. Reprint ed. Varanasi: Chaukhambha Sanskrit Bhawan; 2011 Chikitsa Sthana 22/48-55.
3. Vriddha Vagbhata. Ashtanga Sangraha. Gupta A, editor. Reprint ed. Varanasi: Chaukhambha Krishnadas Academy; 2016. Uttarsthana chapter 25/37-38, 26/109-113.
4. Yogaratnakara. Mishra SN, editor. Varanasi: Chaukhambha Orientalia; 2019. Talu roga adhyaya.
5. Ballenger JJ. Diseases of the nose, throat, and ear. 12th ed. Philadelphia: Lea & Febiger, 197.
6. Sivapathasundharam B. Shafer's textbook of oral pathology. 10th ed. Elsevier, 2024.

7. Daghistani KJ. Conditions of the uvula: a 14 years experience. Auris Nasus Larynx, 2000; 27(3): 261–264. doi:10.1016/S0385-8146(99)00063-2.
8. Epstein LJ, et al. Clinical guideline for the evaluation, management and long-term care of obstructive sleep apnea in adults. *J Clin Sleep Med*, 2009; 5(3): 263–76.
9. Verse T, et al. Laser-assisted uvulopalatoplasty for sleep-disordered breathing: systematic review. *Sleep*, 2000; 23(2): 139–45.
10. Mohammadi L, Miller A, Ashurst JV. Quincke's disease. J Fam Med Prim Care, 2016; 5(3): 677–679. doi:10.4103/2249-4863.197308.
11. Luke L, Collins R, Gokani S, Al-Omari B. A case of recurrent isolated uvula oedema secondary to obesity and obstructive sleep apnea. Cureus, 2022; 14(9): e 29644. doi:10.7759/cureus.29644.
12. Kent D, Stanley J, Aurora RN, et al. Referral of adults with obstructive sleep apnea for surgical consultation: an American Academy of Sleep Medicine clinical practice guideline. J Clin Sleep Med, 2021; 17(12): 2499–2505. doi:10.5664/jcsm.9592.
13. Wischhusen J, Qureshi U, Camacho M. Laser-assisted uvulopalatoplasty (LAUP) complications and side effects: a systematic review. Nat Sci Sleep, 2019; 11: 59–67. doi:10.2147/NSS.S178540.