WORLD JOURNAL OF PHARMACEUTICAL RESEARCH
Coden USA: WJPRAP Impact Factor 8.63
Volume 15, Issue 5, 1571-1581. Case Study ISSN 2277–7105

ROLE OF MANASIKA NIDANA IN CHRONIC AMLAPITTA – A CLINICAL CASE STUDY

Dr. Rajesh Marbate*[1], Dr. Sanya[2]

[1]Professor and HOD, [2]Postgraduate Scholar,

Department of Kayachikitsa, Shri Dhanwantri Ayurvedic Medical College & Research Centre, Mathura, Uttar Pradesh, India.

Article Received on 05 Feb. 2026,
Article Revised on 25 Feb. 2026,
Article Published on 01 March 2026,

https://doi.org/10.5281/zenodo.18884460

***Corresponding Author**

Dr. Rajesh Marbate

Professor and HOD, Department of Kayachikitsa, Shri Dhanwantri Ayurvedic Medical College & Research Centre, Mathura, Uttar Pradesh, India.

How to cite this Article: Dr. Rajesh Marbate*[1], Dr. Sanya[2]. (2026). Role of Manasika Nidana In Chronic Amlapitta – A Clinical Case Study. World Journal of Pharmaceutical Research, 15(5), 1571–1581.

ABSTRACT

Chronic *Amlapitta* is one of the common *Annavaha Srotas* disorders, often corresponding to long- standing dyspepsia and acid peptic complaints in contemporary practice. Classical texts emphasize faulty *Ahara–Vihara* and *Agnimandya*, but the contributory role of *Manasika Nidana* such as *Chinta* (worry), *Shoka* (grief) and *Bhaya* (fear) is frequently under-addressed in day-to-day management. This case report presents a 36-year-old male with chronic upper abdominal burning, frequent *Tikta-amla Udgara*, epigastric discomfort, disturbed sleep and reduced appetite for more than three years, with partial relief on proton-pump inhibitors and antacids. Detailed history revealed persistent occupational stress, suppressed emotions, irregular meals and sleep disturbance as predominant *Manasika* and *Aharaja* factors. The patient was diagnosed as *Chirakali Urdhwaga Amlapitta* with significant *Manasika Nidana* involvement based on *Nidana Panchaka* and correlation with dyspepsia. An integrated Ayurvedic approach focusing on *Manasika Nidana* modification counselling, *Satvavajaya Chikitsa*, relaxation and sleep hygiene — along with *Pitta- Shamana* drugs, *Deepana-Pachana* and lifestyle correction was instituted for eight weeks. Marked reduction was observed in symptom-severity scores of *Tikta-amla Udgara*, *Hrit-Kukshi Daha*, *Avipaka* and associated anxiety, with sustained benefit on follow-up. This case highlights that addressing *Manasika Nidana* as a key pathogenic factor may enhance clinical outcomes and reduce chronicity in *Amlapitta*, and underscores the need for larger systematic studies in this domain.

KEYWORDS: *Amlapitta*, *Manasika Nidana*, *Satvavajaya Chikitsa*, dyspepsia, *Urdhwaga Amlapitta.*

INTRODUCTION

Digestive complaints such as heartburn, acid eructation and post-prandial discomfort constitute a major proportion of OPD attendance in both modern and Ayurvedic clinics. In classical literature, *Amlapitta* is described as a condition where vitiated *Pitta* acquires an excessively sour quality, causing symptoms like *Tikta-amla Udgara*, *Hrit-Kukshi-Kantha Daha*, *Utklesha*, nausea, heaviness, and headache. Chronic *Amlapitta* is often comparable to functional dyspepsia or long-standing acid peptic disease, where conventional medications provide only temporary relief and relapse is frequent once drugs are stopped.

Ayurveda attributes the genesis of *Amlapitta* mainly to *Agnimandya* induced by unwholesome dietary habits like *Amla*, *Katu*, *Lavana*, *Guru*, *Snigdha* and *Abhishyandi Ahara*, irregular meals and incompatible combinations, together with faulty lifestyle. Along with these, psychological factors such as prolonged stress, anxiety and emotional conflicts are described under *Manasika Nidana*, which can disturb *Vata–Pitta* equilibrium and aggravate *Amlapitta*. Modern evidence also supports that dyspepsia and GERD are strongly influenced by stress, sleep disturbance, and psychosomatic constitution, and that symptom relief often correlates with psychological well-being.

Despite this, many Ayurvedic case reports on *Amlapitta* primarily focus on pharmacological *Shamana* interventions and *Panchakarma*, with relatively less emphasis on systematic assessment and correction of *Manasika Nidana* as an independent therapeutic target. The present case study aims to illustrate the pivotal role of *Manasika Nidana* in maintaining chronicity of *Amlapitta* and to evaluate the outcome of a treatment plan explicitly designed to address these mental and emotional triggers alongside standard *Pitta-Shamana* therapy.

MATERIALS AND METHODS CASE REPORT

A 36-year-old male IT professional presented to the Kayachikitsa OPD with complaints of upper abdominal burning, retrosternal discomfort, frequent sour/bitter belching, nausea after meals, heaviness in abdomen and disturbed sleep for approximately three years. The symptoms were insidious in onset and gradually increased in frequency, with clear aggravation during periods of work-related stress and irregular meals. The patient reported

partial symptomatic relief with on-and- off use of proton-pump inhibitors and antacids, but symptoms recurred within a few days of stopping the drugs, suggesting a chronic, recurrent pattern.

Chief complaints

- Upper abdominal burning and retrosternal discomfort – 3 years
- Frequent sour/bitter belching (*Tikta-amla Udgara*) – 3 years
- Nausea after meals (*Utklesha*) – 3 years
- Heaviness in abdomen (*Gurukoshthatva*) – 3 years
- Disturbed sleep – 2 years
- Reduced appetite (*Aruchi*) – 6 months
- Occasional constipation (*Vibandha*) – 6 months
- Fatigue and irritability – 6 months

History of present illness

The patient was apparently well three years ago when he noticed intermittent upper abdominal discomfort and sour belching, initially mild and episodic. Over time, symptoms increased in frequency and intensity, with clear worsening during periods of occupational stress, late-night work and missed or irregular meals. Antacids and proton-pump inhibitors prescribed during earlier consultations provided temporary relief, but complaints recurred consistently within a few days of stopping medication, establishing a pattern of chronicity and drug dependence.

In the preceding six months, he additionally noticed early satiety, progressively reduced appetite, occasional constipation, generalized fatigue and irritability, particularly after late-night work. No history of hematemesis, melena, significant weight loss, dysphagia, or persistent vomiting was reported. Absence of alarm features meant endoscopy was not performed in earlier evaluations, which is consistent with current uninvestigated dyspepsia management practice.

Past history

- No history of diabetes mellitus, hypertension, tuberculosis, or major systemic illness
- No history of prior gastrointestinal surgery or significant abdominal trauma
- No history of prolonged NSAID or steroid use.

Family history

No significant family history of gastrointestinal, autoimmune, or psychiatric disorders was reported.

Personal history

Table 1: Personal history.

Parameter	Details
Appetite	Reduced (*Mandagni*)
Bowel	Irregular; occasional constipation
Micturition	Normal, 5–6 times/day
Sleep	Disturbed; 4–5 hours/night
Diet	Mixed; predominantly spicy, oily, processed food
Beverages	3–5 cups of tea/coffee daily
Addiction	No tobacco, alcohol or substance use
Occupation	IT professional; sedentary, high-stress work environment
Exercise	Minimal physical activity

Diet, lifestyle and *Manasika* history

Dietary and lifestyle factors

- Frequent intake of tea, coffee, and spicy fast food on working days
- Irregular meal timings with tendency to skip breakfast and take heavy late dinners (*Vishamashana*, *Adhyashana*)
- Preference for *Amla* and *Katu* preparations, deep-fried snacks, and carbonated drinks
- Sedentary lifestyle with prolonged sitting, minimal exercise, and late-night screen use
- Sleep duration 4–5 hours/night with difficulty in sleep initiation and frequent awakenings

On *Manasika* enquiry, the patient reported:

- Persistent work pressure, fear of deadlines and feeling of being constantly "on edge" (*Bhaya*, *Chinta*)
- Worry about job security and financial responsibilities (*Atichinta*)
- Suppression of emotions at workplace; avoidance of discussing worries at home
- Preoccupation with symptoms; anticipatory anxiety about developing "ulcer" or "serious disease".

These features were considered significant *Manasika Nidana*, contributing both to *Agnimandya* and to heightened symptom perception.

General examination

Table 2: General examination findings.

Parameter	Findings
General appearance	Moderate build; nutrition mildly reduced
Body Mass Index (BMI)	Slightly overweight
Pulse	78/min, regular, normal volume
Blood pressure	122/78 mmHg
Respiratory rate	16/min
Temperature	Afebrile
Skin & Mucosa	No pallor, icterus, pedal oedema or lymphadenopathy

Systemic examination

Table 3: Systemic examination findings.

System	Findings
Cardiovascular system	Heart sounds S1 S2 normal; no murmurs, rubs or additional sounds
Respiratory system	Clear breath sounds bilaterally; no wheeze, crackles or added sounds
Central nervous system	Alert and oriented; no focal neurological deficit
Abdominal examination	Mild epigastric tenderness on deep palpation; no guarding, rigidity, organomegaly or masses; bowel sounds normal

Ashta Sthana Pariksha

Table 4: *Ashta Sthana Pariksha.*

Parameter	Findings
Naadi (Pulse)	*Pitta-Kapha* predominant
Mootra (Urine)	*Prakruta* (normal)
Mala (Stool)	*Amayukta*; occasional constipation
Jiwha (Tongue)	*Saamala* (mild coating indicating *Ama*)
Shabda (Voice)	*Prakruta* (normal)
Sparsha (Skin touch)	Slightly *Ushna* (warm)
Druk (Eyes)	*Prakruta* (normal)
Aakruti (Build)	*Madhyama* (moderate)

Dashavidha Pariksha

Table 5: *Dashavidha Pariksha.*

Parameter	Findings
Prakriti	*Pitta-Kapha* predominant constitution
Vikruti – Dosha	Predominant *Pitta* with associated *Kapha*; episodic *Vata* during constipation
Vikruti – Dushya	*Rasa* and *Rakta Dhatu*
Sara	*Madhyama*
Samhanana	*Madhyama*
Satva	*Madhyama*
Satmya	*Pitta-Kapha Satmya*; partial *Sarva Rasa*
Pramana	*Madhyama*

Aharasakti	*Avara* (reduced digestive capacity)
Vyayamasakti	*Avara* (low exercise tolerance)
Vaya	36 years (*Madhyama Vaya*)

***Nidana Panchaka* – Ayurvedic assessment**

Table 6: *Nidana Panchaka* and Ayurvedic assessment.

Parameter	Findings
Prakriti	*Pitta-Kapha* predominant constitution with moderate *Satva* and *Madhyama Vyayama Shakti*
Agni	*Vishama Agni* tending toward *Tikshna* during stress episodes, often followed by *Agnimandya*
Dosha	Predominant vitiation of *Pitta* associated with *Kapha*; episodic *Vata* aggravation during constipation
Srotodushti	*Annavaha Srotas* with features of *Sanga* and *Pitta* aggravation
Nidana	Irregular dietary habits; excessive *Amla-Katu-Lavana* dominant food; late-night heavy meals; sedentary lifestyle; *Chinta*, *Atichinta*; sleep deprivation
Purvarupa	Occasional heaviness, reduced appetite and lethargy in the initial phase
Rupa	*Tikta-Amla Udgara*, *Hrit-Kukshi Daha*, nausea, heaviness, anorexia, constipation and headache
Upashaya	Temporary relief with bland diet, regular meal timing, rest and antacids
Samprapti	*Agnimandya* leading to *Shuktata* of *Pitta* in *Amashaya*, precipitated by *Manasika Nidana* and faulty *Ahara-Vihara*, culminating in chronic *Urdhwaga Amlapitta*

Symptom-severity assessment

To enable objective monitoring of treatment response, a standardised four-point grading scale was applied at baseline and at each follow-up visit (0 = absent, 1 = mild/occasional, 2 = moderate/frequent, 3 = severe/daily).

Table 7: Baseline symptom-severity scores.

Symptom	Ayurvedic term	Baseline score (0–3)
Indigestion	*Avipaka*	3
Abdominal heaviness	*Gurukoshthatva*	2
Sour/bitter belching	*Tikta-amla Udgara*	3
Nausea	*Utklesha*	2
Chest/epigastric burning	*Hrit-Kukshi Daha*	3
Loss of appetite	*Aruchi*	2
Constipation	*Vibandha*	1
Headache	*Shiroroga*	1
Anxiety related to illness	—	3
Total score		20/27

INVESTIGATIONS

In view of chronic symptoms lasting more than three years and absence of any alarm features, basic laboratory investigations were undertaken primarily to rule out organic or structural

gastrointestinal pathology. All investigations returned values within normal reference ranges, supporting a functional gastrointestinal presentation consistent with *Chirakali Amlapitta*.

Table 8: Laboratory investigation findings.

Sr. No.	Investigation	Patient value	Reference range	Remark
1	Haemoglobin	13.8 g/dL	13.0–17.0 g/dL	Normal
2	Total leucocyte count	7,200/cumm	4,000–11,000/cumm	Normal
3	Fasting blood sugar	88 mg/dL	70–100 mg/dL	Normal
4	Serum SGPT (ALT)	28 IU/L	7–56 IU/L	Normal
5	Serum SGOT (AST)	24 IU/L	10–40 IU/L	Normal
6	Serum bilirubin (total)	0.8 mg/dL	0.2–1.2 mg/dL	Normal
7	Blood urea	22 mg/dL	15–40 mg/dL	Normal
8	Serum creatinine	0.9 mg/dL	0.7–1.2 mg/dL	Normal
9	Stool routine & occult blood	No abnormality detected	—	Normal
10	Urine routine	No abnormality detected	—	Normal

TREATMENT PLAN

An integrated eight-week management plan was designed addressing *Manasika Nidana* modification as a primary therapeutic goal alongside classical *Pitta-Shamana* and *Deepana-Pachana* interventions, comprising three components as detailed below.

A. *Pathya–Apathya* (dietary and lifestyle advice)

Table 9: *Pathya–Apathya* advice.

Aspect	Advice given
Meal timing	Regular, timely meals; avoidance of prolonged fasting (*Langhana*) and overeating
Dinner pattern	Early dinner by 8:00 pm; 30–40 minutes of gentle activity before sleep
Food restriction (*Apathya*)	Avoidance of excessive *Amla*, *Katu*, *Lavana* dominant, deep-fried, packaged and spicy foods
Food inclusion (*Pathya*)	Warm, freshly prepared, mildly spiced, easily digestible food; adequate hydration in small divided sips
Beverage regulation	Avoidance of tea/coffee within 1–2 hours of meals; no late-night stimulant beverages
Post-meal habit	Gentle walking (10–15 minutes) after meals; avoidance of immediate lying down

B. *Manasika Nidana*–focused measures (*Satvavajaya Chikitsa*)

Table 10: *Satvavajaya Chikitsa* interventions.

Intervention	Details
Structured counselling	Explanation of the bidirectional stress–digestion relationship to reduce illness-related anxiety and fear
Satvavajaya practices	Daily regulated breathing exercises (10–15 minutes) and brief guided relaxation/meditation
Cognitive restructuring	Identification and reframing of work-related stress patterns and anticipatory worry
Emotional expression	Encouraged open discussion of occupational concerns with family members
Sleep hygiene	Fixed sleep-wake schedule; reduced screen exposure after 10:00 pm; calming pre-sleep routine

C. *Shamana Chikitsa* (pharmacological therapy)

Pitta-Shamana and *Agni-Deepana* formulations were selected based on classical indications for.

Amlapitta. Treatment was continued for eight weeks with dose review at week 4.

Table 11: *Shamana Chikitsa* – drug, dose and timing.

Sr. No.	Drug name	Dose	Timing	*Anupana*
1	*Avipattikara Churna*	3–5 g	Twice daily before meals	Lukewarm water
2	*Kamdudha Rasa*	250 mg	Twice daily after meals	Lukewarm water
3	*Shankha Bhasma*	250 mg (combined with *Kamdudha Rasa*)	Twice daily after meals	Lukewarm water
4	*Guduchi Satva*	500 mg	Twice daily after meals	Plain water

OBSERVATIONS AND RESULTS

The patient attended follow-up consultations every two weeks over eight weeks. Symptom-severity scores were recorded at each visit on the standardised four-point scale (0 = absent, 1 = mild, 2 = moderate, 3 = severe), with baseline scores established at the first consultation. Progressive improvement was noted across all parameters from week 2 onward.

Table 12: Symptom-severity score trend across follow-up visits.

Symptom	Ayurvedic term	Baseline	Week 2	Week 4	Week 8
Indigestion	*Avipaka*	3	2	1	0
Abdominal heaviness	*Gurukoshthatva*	2	1	0	0
Sour/bitter belching	*Tikta-Amla Udgara*	3	1	1	0
Nausea	*Utklesha*	2	1	0	0

Chest/epigastric burning	*Hrit-Kukshi Daha*	3	2	1	0
Loss of appetite	*Aruchi*	2	1	0	0
Constipation	*Vibandha*	1	1	0	0
Headache	*Shiroroga*	1	0	0	0
Anxiety related to illness	—	3	2	1	1
Total score		20	11	4	1

0 = Absent, 1 = Mild/occasional, 2 = Moderate/frequent, 3 = Severe/daily

The total composite symptom score declined from 20/27 at baseline to 1/27 at week 8, representing a 95% reduction in overall symptom burden over the treatment period. No adverse effects or treatment-related complaints were reported at any follow-up visit.

DISCUSSION

The present case highlights the multidimensional nature of chronic *Amlapitta*, wherein gastrointestinal manifestations persist not solely because of dietary indiscretions but due to sustained psychological strain functioning as a perpetuating factor. Although the patient had previously undertaken intermittent dietary regulation and symptomatic medication, relief remained temporary and recurrence was frequent. Detailed clinical enquiry revealed a background of persistent occupational stress, disturbed sleep, habitual worry, and a tendency to suppress emotions rather than express them, features collectively constituting significant *Manasika Nidana* in the Ayurvedic framework.

Early improvement was observed by week 2, particularly in *Tikta-Amla Udgara*, *Utklesha* and *Gurukoshthatva*, suggesting a prompt initial response to *Pitta-Shamana* and *Deepana-Pachana* formulations combined with dietary regulation. By week 4, symptoms including *Hrit-Kukshi Daha*, *Aruchi* and *Vibandha* reduced to absent or minimal, enabling partial tapering of *Shamana* drugs while maintaining *Pathya-Apathya* and *Manasika* measures. Complete resolution of gastrointestinal symptoms by week 8, with only mild residual illness-related anxiety, indicated that psychological recovery requires a more sustained effort than somatic symptom relief alone.

An important clinical observation was that symptomatic stability improved significantly only after structured attention was directed toward mental and behavioural contributors. Disease education, reassurance and guided counselling helped reduce anticipatory anxiety and illness-related fear. Simple *Satvavajaya Chikitsa* practices such as regulated breathing, relaxation exercises and maintenance of a consistent sleep routine were introduced, which helped the patient take an active role in his own recovery rather than depending exclusively on

pharmacological measures. This behavioural shift appeared to disrupt the cyclical pattern of symptom exacerbation driven by recurrent stress exposure.

Pharmacological intervention employing *Pitta-Shamana* and *Agni-Deepana* formulations contributed to early symptomatic reduction. However, sustained improvement and reduced recurrence correlated more closely with adherence to *Pathya-Apathya* guidelines and continued *Manasika* regulation practices. The gradual decline in anxiety scores across follow-up visits further indicates a bidirectional relationship between digestive dysfunction and psychological stress, reflecting the classical Ayurvedic principle of *Sharira–Manasa* interdependence, wherein imbalance in mental constitution directly influences somatic physiological processes.

Although limited to a single case and therefore lacking statistical generalizability, this observation underscores the clinical importance of *Nidana Parivarjana* extending beyond dietary correction alone. Recognizing and systematically addressing persistent psychological stressors, even when they appear mild or secondary, may support long-term remission and reduce dependence on repeated symptomatic medication. The present findings support the need for structured observational studies and controlled clinical trials to evaluate *Manasika Nidana*-oriented interventions specifically in chronic *Amlapitta*.

CONCLUSION

Chronic *Amlapitta* may manifest without detectable structural pathology, yet remain sustained by the combined and mutually reinforcing influence of dietary irregularities and unresolved psychological strain. The present case demonstrates that systematic identification and correction of *Manasika Nidana* through structured counselling, *Satvavajaya*-based practices and sleep discipline when integrated with classical *Pitta-Shamana* and *Deepana-Pachana* therapy, can produce meaningful and durable symptomatic relief. Routine incorporation of *Manasika* evaluation as a standard component of *Amlapitta* management holds the potential to improve long-term clinical outcomes and enhance patient self-efficacy in disease prevention and recurrence control.

REFERENCES

1. Tripathi I. Sri Chakrapanidatta's *Chakradatta* with *Vaidyaprabha* Hindi Commentary. Reprint ed. Varanasi: Chaukhambha Sanskrit Bhawan, 2018; *Amlapitta Chikitsa* 56/1: 10.

2. Agnivesha. *Charaka Samhita*. Redacted by Charaka and Dridhabala. Chakrapanidatta, commentator (*Ayurveda Dipika*). Varanasi: Chaukhambha Surbharati Prakashan, 2015; *Chikitsasthana* 15/50: 57.
3. Vagbhata. *Ashtanga Hridaya*. Varanasi: Chaukhambha Prakashan, 2010; *Sutrasthana* 11/4: 8.
4. Madhavakara. *Madhava Nidana*. Varanasi: Chaukhambha Publications, 2017; *Amlapitta Nidana* Chapter 51.
5. Govind Das. *Bhaishajya Ratnavali*. Shastri RD, editor. 19th ed. Varanasi: Chaukhambha Prakashan, 2008; *Amlapitta Chikitsa Adhyaya,* 56/25: 29.
6. Sharma PV, editor. *Dravyaguna Vijnana*. Vol. 2. Varanasi: Chaukhambha Bharati Academy, 2005; (*Kamdudha Rasa*, *Shankha Bhasma* in *Amlapitta*).
7. Govind Das. *Bhaishajya Ratnavali*. Shastri RD, editor. 19th ed. Varanasi: Chaukhambha Prakashan, 2008; *Amlapitta Chikitsa,* 56/45: 50 (*Guduchi Satva*).
8. Sharma R, et al. Comparative study of *Shankha Bhasma* and *Guduchi Satva* in *Urdhvaga Amlapitta*. Int J Innov Res Rev., 2015; 2(5): 1–6.
9. Agnivesha. *Charaka Samhita*. Chakrapanidatta, commentator. Varanasi: Chaukhambha Surbharati Prakashan, 2015; *Chikitsasthana,* 9/4: 25 (*Satvavajaya Chikitsa*).
10. Vagbhata. *Ashtanga Hridaya*. Varanasi: Chaukhambha Prakashan, 2010; *Uttara Sthana* 1/45: (*Manasika Nidana* in *Pitta* disorders).