

A MULTIMODAL AYURVEDIC TREATMENT APPROACH FOR AMAVATA (RHEUMATOID ARTHRITIS): A CASE REPORT

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ABSTRACT

Amavata is a systemic inflammatory joint disorder characterized by the pathological association of *Ama* and *Vata* and shares several clinical features with rheumatoid arthritis (RA). This case report describes the clinical and serological outcomes of a sequential Ayurvedic *Shodhana–Shamana* protocol in a 44-year-old female presenting with a six-month history of bilateral polyarthralgia involving the metacarpophalangeal and proximal interphalangeal joints, wrists, and knees, accompanied by morning stiffness lasting more than 60 minutes, fatigue, and anorexia. Amavata was diagnosed according to classical Ayurvedic criteria, and the patient concurrently fulfilled the 2010 ACR/EULAR classification criteria for RA, with a score of ≥ 6 . Baseline rheumatoid factor (RF) was >160 IU/mL (reference range: 0–30 IU/mL), indicating seropositive disease. A sequential Ayurvedic treatment protocol was administered over

approximately 14 weeks, comprising *Vaitarana Basti* for eight consecutive days followed by *Matra Basti* for eight days, along with *Sinhanada Guggulu* 500 mg twice daily, *Punarnavadi*

Kwatha 40 mL twice daily, and local application (*Lepa*) of *Shunthi*, *Rasna*, *Punarnava*, and *Daruharidra* over the affected joints. Following treatment, RF decreased from >160 IU/mL to 50 IU/mL, representing a reduction of at least 68.75% relative to the assay's upper reported threshold. The patient also demonstrated near-complete resolution of morning stiffness, substantial reduction in joint tenderness and swelling, and marked improvement in functional capacity, with no adverse effects observed during the treatment period. These findings suggest that sequential *Shodhana–Shamana* Ayurvedic management was associated with meaningful clinical and serological improvement in this case of seropositive Amavata. Further systematic studies are warranted to evaluate the efficacy and reproducibility of this therapeutic approach.

KEYWORDS: Amavata; Rheumatoid Arthritis; Vaitarana Basti; Sinhanad Guggulu; Punarnavadi Kwatha; Panchakarma; Shodhana; Shamana.

1. INTRODUCTION

Amavata is a systemic Ama-Pradoshaja Vikara described in Ayurvedic literature as arising from the simultaneous occurrence of Agnimandya (hypofunction of digestive fire) and Viruddhahara-Vihara (incompatible diet and lifestyle).^[1] Ama — the product of impaired digestion — combines with vitiated Vata and circulates through the Rasavaha Srotas to lodge in Shleshmasthanas (synovial spaces), producing Sandhishula (joint pain), Sandhishotha (synovitis), Sandhigraha (stiffness), Angamarda (myalgia), and Jwara (low-grade fever). Madhavacharya provided the first consolidated description of Amavata as a distinct nosological entity in the 7th century CE,^[1] preceding comparable systematic European classifications by over a millennium.

In biomedical nomenclature, Rheumatoid Arthritis (RA) is a chronic, progressive, autoimmune inflammatory polyarthritis affecting approximately 1% of the global population with a female-to-male predominance of 2–3:1.^[11,12] Disease onset is most frequent in the fourth and fifth decades of life. The 2010 ACR/EULAR classification criteria—incorporating joint involvement, seropositivity, acute-phase response, and symptom duration — improved early disease identification over the predecessor 1987 criteria.^[3,17]

Contemporary pharmacotherapy with disease-modifying anti-rheumatic drugs (DMARDs) achieves disease control in a subset of patients; however, treatment-emergent hepatotoxicity, bone-marrow suppression, and susceptibility to opportunistic infections remain clinically

significant limitations. The Ayurvedic management of Amavata — emphasising Amapachana, Vatashaman, and Srotoshodhana through combined Panchakarma and Shamana protocols — offers a mechanistically distinct therapeutic approach.^[2,15] Published case series and clinical studies support the clinical utility of Vaitarana Basti,^[7,8,9] Sinhanad Guggulu,^[6] and Punarnavadi Kwatha in managing Amavata, yet single-case reports with objective pre- and post-treatment serological documentation remain sparse in indexed Ayurvedic literature. This case report documents the clinical course, therapeutic rationale, and serological outcomes of a 44-year-old seropositive female with Amavata managed exclusively with a classical Ayurvedic protocol.

2. Patient Information

2.1 Demographic and Background Data

A 44-year-old female homemaker, residing in Pune, Maharashtra, was registered in the private opd in October 2025. She had no prior diagnosis of any autoimmune disorder and had not received DMARD or steroid therapy prior to presentation. She had been consuming analgesics intermittently for joint pain over the preceding four months with partial and transient relief.

2.2 Chief Complaints

The patient presented with the following complaints of six-month duration:

- Bilateral symmetrical pain and swelling in the metacarpophalangeal (MCP) and proximal interphalangeal (PIP) joints of both hands
- Pain and swelling in bilateral wrist joints and bilateral knee joints
- Morning stiffness lasting more than 60 minutes
- Generalised fatigue (Angamarda) and loss of appetite (Aruchi)
- Intermittent low-grade fever (Jwara)

2.3 History and Aetiology (Nidana)

History revealed irregular meal timings, frequent consumption of cold and processed food items, excessive physical exertion after meals (Viruddhahara-Vihara), and prolonged sedentary posture. These factors are cited in Ayurvedic classics as direct causative factors for Amavata (Madhava Nidana 25/1: "*Viruddhahara-Cheshta-Nishkriya Bhajanasya Cha / Gurv Amashanasya Cha...*"^[1]). There was no significant family history of autoimmune disease.

2.4 Menstrual and Obstetric History

Regular menstrual cycles; Gravida 2, Para 2. No history of oral contraceptive use at the time of presentation.

3. Clinical Findings

3.1 Ayurvedic Clinical Assessment

Ashtavidha Pariksha (eightfold clinical examination) revealed the following:

Table No. 1: Ashtavidha Pariksha.

Pariksha Parameter	Findings
Nadi (Pulse)	Vata-Kaphaja predominant, irregular in rhythm
Mala (Stool)	Vibandha (constipation); Saama stool (mucus-laden), indicative of Ama burden
Mutra (Urine)	Slightly reduced in quantity; yellowish hue
Jihva (Tongue)	Saama (coated), indicative of circulating Ama
Shabda (Voice)	Normal
Sparsha (Tactile)	Affected joints warm and tender to touch (Ushnata, Sparshāsahyata)
Drika (Eyes)	No scleral icterus; mild periorbital puffiness
Akriti (General build)	Madhyama Sharira; BMI within normal limits

Dashavidha Pariksha (ten-fold examination): Prakriti — Vata-Kapha; Vikriti — Tridoshaja with Ama predominance; Sara — Madhyama; Samhanana — Madhyama; Satva — Avara; Satmya — Deshasatmya; Ahara Shakti — Reduced; Vyayama Shakti — Severely reduced. These findings confirmed the diagnosis of Ama-Pradhana Amavata.^[1,15]

3.2 Systemic Clinical Examination

General examination: Temperature 99.1°F (low-grade fever). Pulse 84/min, BP 118/76 mmHg, SpO₂ 98% on room air. Musculoskeletal examination: bilateral symmetrical synovitis of MCP joints (II–IV bilaterally), PIP joints, and wrist joints; bilateral knee effusion (mild); positive squeeze test of the MCP joints bilaterally; no rheumatoid nodules; no extra-articular manifestations.

4. Diagnostic Assessment

4.1 Ayurvedic Diagnosis

Diagnosis of Amavata was established based on the cardinal symptoms enumerated in Madhava Nidana Chapter 25:^[1] Sandhishula, Sandhishotha, Sandhigraha, Angamarda, Aruchi, Jwara, and Alasya (general lassitude), all traceable to a pathogenic nexus of Ama and vitiated Vata lodged in Shleshmasthanas. The Samprapti (pathogenesis) was mapped as: Jatharagni-Mandya → Amotpatti → Ama-Vata Sanyoga → Srotorodha →

Sandhivikriti,^[1,2,15] consistent with the classical Chikitsa Siddanta of Amavata as articulated by Chakradatta.^[2]

4.2 Biomedical Diagnosis — 2010 ACR/EULAR Criteria

The patient satisfied the 2010 ACR/EULAR classification criteria for RA^[3] with a total score of 7/10, detailed in Table No 2.

Table No. 2: Biomedical diagnosis.

2010 ACR/EULAR Domain	Finding	Score
Joint involvement (>10 joints, small joints)	MCP, PIP, wrist joints bilaterally — >10 joints involved	5
Serology (RF)	RA Factor >160 IU/ml (>3× ULN) — High positive serology	3
Acute-phase reactant	Not formally assayed at baseline (ESR/CRP unavailable)	0
Duration of symptoms	≥6 weeks	1
Total Score	≥6 = definite RA classification	7

4.3 Laboratory Investigations

Table No. 3: Laboratory Investigation.

Investigation	Baseline (10-Oct-2025)	Post-Treatment (24-Jan-2026)	Reference Range
RA Factor (Latex Immunoturbidimetry)	>160 IU/ml	50 IU/ml	0–30 IU/ml
Method	Latex enhanced immunoturbidimetry	Latex enhanced immunoturbidimetry	—

Both reports were issued by the same accredited referral laboratory, ensuring analytical consistency across time points. RA Factor, an IgM antibody against the Fc portion of IgG, serves as a serological marker of disease activity; its high-positive titre (>3× ULN) at baseline is associated with more erosive and systemic RA phenotypes.^[3,17]

5. Therapeutic Intervention and Follow-Up

5.1 Rationale for Treatment Selection

The line of treatment in Amavata follows the principles enunciated by Chakradatta (Amavata Chikitsa 25/1):^[2] Langhana, Swedana, Deepana-Pachana, Tikta-Katu Rasa Dravyas, and Basti Karma — described as the supreme measure for Vata disorders by Vagbhata.^[16] The clinical presentation — high Ama burden (coated tongue, constipation, anorexia) with intense Vata-Kapha aggravation — indicated a Shodhana-first approach. Vaitarana Basti was selected for its documented Amapachana, Srotoshodhana, and Vata-Kapha pacifying

properties;^[7,8,9] its Tikshna (sharp) qualities act on Samana Vayu near the Jatharagni, thereby igniting digestive capacity and breaking the Ama-Vata complex at its source.^[7]

Matra Basti (oleation enema) was administered subsequently to provide Vatanulomana and Sandhibalya without prematurely augmenting Ama, an adverse risk associated with early Snehana in Ama-Pradhana states.^[10,16] Study demonstrated clinically significant improvement in joint counts and morning stiffness with Matra Basti in Amavata patients.^[10]

Sinhanad Guggulu — containing Shuddha Guggulu, Haritaki, Shunthi, Guduchi, Danti, and Eranda Taila — was selected for its Kaphavatahara, Amapachana, and proposed disease-modifying properties.^[6] Previous study confirmed its clinical efficacy across joint pain, stiffness, and systemic Amavata symptoms in a comparative clinical study, and proposed its constituents may act analogously to DMARDs through immune-modulatory mechanisms.^[6]

Punarnavadi Kwatha provided adjuvant Shothahara and Mutrala action. Punarnava (*Boerhaavia diffusa*), the primary constituent, has demonstrated inhibition of pro-inflammatory cytokines in experimental studies, supporting its Vedanasthapana utility in joint inflammation.^[13] Its use in Amavata management alongside Guggulu-based formulations is documented in multiple indexed case studies.^[11,12,13]

5.2 Treatment Protocol

Table No. 4: Treatment Protocol.

Phase	Intervention	Dose / Duration	Classical Rationale
Shodhana Phase I (Weeks 1–2)	Vaitarana Basti (Tikshna Basti; composition: Saindhava Lavana, Tila Taila, Sour buttermilk base, Dashamula Kashaya as Nirūha base)	8 consecutive days; administered mornings after Abhyanga-Nadi Sweda preparation	Amapachana, Srotoshodhana, Vata-Kaphahara; Chakradatta Amavata Chikitsa 25 ^[2] ; Mukherjee ^[7]
Shodhana Phase II (Weeks 3–4)	Matra Basti (Tila Taila + Saindhavadi Taila, classical preparation per Vagbhata)	8 days; 60–90 ml per administration, retained 1–3 hours	Vatanulomana, Sandhibalya; prevents post-Shodhana Vata aggravation; Vagbhata Sutrasthana 19; ^[16] Patel et al. ^[10]
Shamana — Oral (Weeks 1–14, continued)	Sinhanad Guggulu (Classical formulation: Shuddha Guggulu, Haritaki, Shunthi, Guduchi, Danti, Eranda Taila)	500 mg × 2/day; with lukewarm water, after meals	Kaphavatahara, Amapachaka, DMARD-like immunomodulation; Jagdale et al. ^[6]
	Punarnavadi Kwatha	40 ml × 2/day; with	Shothahara, Mutrala,

	(Classical formulation: Punarnava, Eranda, Devadaru, Shunthi, Guduchi et al., per Sahasrayoga)	lukewarm water, before meals	Vatahara; Sathe et al. ^[13]
Local Application (Weeks 1–8)	Lepa: Sunthi + Rasna + Punarnava + Daruharidra (equal parts, ground with lukewarm water)	Applied to affected joints for 30–45 min; every alternate day	Topical Shothahara, Vedanasthapana; Ruksha-Ushna Guna counters Ama-Shleshma at joint surface; Raut et al. ^[14]

5.3 Pathya-Apathya (Dietary and Lifestyle Recommendations)

Pathya (wholesome): Warm, freshly cooked, light food; Mudga Yusha (moong soup); Trikatu-spiced preparations; Lahsuna (garlic) in cooking; warm water throughout the day; passive joint mobilisation (Sukshma Vyayama). These recommendations align with the Deepana-Pachana principle of Amavata management^[2,15] and counteract the Guru-Sheeta Guna of circulating Ama.

Apathya (unwholesome): Cold, fermented, and processed foods; curd (Dadhi) — especially at night; refrigerated and leftover food; suppression of natural urges; cold and wet environmental exposure; excessive mental stress (Manasika Nidana) — all documented Amavata aggravating factors per classical Samhitas.

5.4 Follow-Up Schedule and Outcome Assessment

Table No. 5: Follow up schedule and outcome assessment.

Visit	Time Point	Key Assessments	Clinical Status
V1 (Baseline)	10-Oct-2025	RA Factor: >160 IU/ml Morning stiffness: >60 min Tender joints: 8; Swollen joints: 6	Severe disease activity; Ama-Pradhana Amavata
V2	Week 2 (Post-Vaitarana Basti)	Ama Lakshanas; bowel regularity; stiffness duration	Reduction in Angamarda and Aruchi; bowel regularity restored; morning stiffness marginally improved
V3	Week 4 (Post-Matra Basti)	Joint tenderness score; stiffness; appetite	Morning stiffness 20–30 min; tender joints 4; swollen joints 3; appetite fully restored
V4	Week 8	Functional assessment; energy; fever	Jwara resolved; marked functional improvement; full appetite; minimal joint tenderness
V5 (End)	24-Jan-2026 (~Week 14)	RA Factor: 50 IU/ml Morning stiffness: <10 min Tender joints: 1; Swollen joints: 0	Clinically significant serological and symptomatic improvement; seropositive but approaching therapeutic threshold

6. DISCUSSION

The present case demonstrated a reduction in RA Factor from >160 IU/ml to 50 IU/ml, representing a decline of >68.75% from the upper assay limit, over 14 weeks of exclusive classical Ayurvedic management without concurrent disease-modifying antirheumatic drug (DMARD) therapy. This magnitude of serological change, observed alongside clinical improvement following a structured therapeutic protocol, warrants careful interpretation within both Ayurvedic and contemporary biomedical frameworks.

Amavata occupies a distinct position in Ayurvedic nosology because of the complex interaction between Ama and Vata, with Ama acting as a central pathogenic factor contributing to systemic and articular manifestations. This pathophysiological state necessitates careful therapeutic sequencing, as premature Snehana (oleation) is considered inappropriate during the acute Ama-Pradhana stage.^[1,2] Accordingly, Vaitarana Basti was administered before Matra Basti in the present case. Vaitarana Basti, a Tikshna Niruha Basti containing ingredients such as Saindhava Lavana and sour buttermilk, is traditionally indicated for Amapachana and Srotoshodhana and is considered to act predominantly through the Pakvashaya, the principal site of Vata regulation.^[7,8] Its proposed therapeutic action involves digestion and mobilisation of Ama, facilitation of Dosha elimination, and restoration of physiological movement of Vata.^[7]

Clinical evidence has demonstrated greater improvement in joint-related outcomes with Vaitarana Basti compared with local therapeutic interventions in patients with Amavata, supporting the therapeutic importance of Basti in the management of systemic manifestations of the disease.^[9] Other clinical observations have reported rapid symptomatic improvement following the initiation of Basti therapy in RA-factor-positive Amavata, which is consistent with the early clinical response observed in the present case.^[8]

Matra Basti, an Anuvasana-type Basti, was administered after the initial Ama-reducing intervention to provide Vatanulomana and support joint function while minimising the potential consequences of administering Snigdha therapy during an Ama-dominant state.^[10,16] Classical principles describe the sequential use of Tikshna and subsequently Snigdha Basti in conditions characterised by the coexistence of Ama and aggravated Vata.^[16] Clinical evidence has also demonstrated significant improvement in tender and swollen joint counts following Matra Basti-based interventions in Amavata.^[10] Thus, the sequential administration of

Vaitarana Basti followed by Matra Basti may have addressed the changing pathological predominance from an initial Ama-associated state to residual Vata-related joint dysfunction.

Sinhanad Guggulu is among the frequently investigated oral formulations used in the management of Amavata. Clinical studies have reported improvement in pain, stiffness, and systemic manifestations following its administration.^[6] Its constituent phytochemicals, including Guggulsterones, bioactive constituents of Guduchi, and 6-gingerol from Shunthi, have been proposed to influence inflammatory pathways involving TNF- α , IL-1 β , and IL-6, which are also important mediators in the pathogenesis of rheumatoid arthritis.^[6] These proposed anti-inflammatory and immunomodulatory mechanisms may provide a possible biological basis for the clinical and serological changes observed in the present case. However, direct causality between the intervention and reduction in RA Factor cannot be established from a single case.

Punarnavadi Kwatha was included for its traditionally described Shothahara and Mutrala properties, complementing the systemic therapeutic approach. Its use in combination with Guggulu-based formulations has been documented in the management of Amavata, with reports of reduced joint swelling and improvement in functional capacity.^[12,13] Clinical observations have also reported favourable outcomes with therapeutic protocols combining Vaitarana Basti and internal Ayurvedic medicines in Amavata.^[11] The combined administration of these interventions may therefore have contributed to the overall clinical response through complementary therapeutic actions.

The topical Lepa containing Sunthi, Rasna, Punarnava, and Daruharidra was employed as a local intervention for joint symptoms. From an Ayurvedic perspective, the predominantly Ruksha and Ushna properties of the formulation may help counteract Ama- and Kapha-associated heaviness, stiffness, and swelling at the affected joints, in accordance with the principles of local Lepa therapy in Ayurvedic Chikitsa Siddhanta.^[14] Similar local therapeutic approaches have been documented in the management of Amavata.^[14]

From a biomedical perspective, the reduction in RA Factor from >160 IU/ml to 50 IU/ml represents a substantial serological change, although the post-treatment value remained above the laboratory reference range of 0–30 IU/ml. RA Factor is an established serological marker associated with rheumatoid arthritis severity and may be related to persistent synovial inflammation and erosive disease.^[3,17] Nevertheless, RA Factor alone does not provide a

complete measure of current disease activity and should be interpreted alongside clinical findings and additional inflammatory and immunological markers. The observed reduction may be considered hypothesis-generating and potentially consistent with the anti-inflammatory and immunomodulatory activities attributed to constituents of the administered formulations.^[6] However, the contribution of individual interventions cannot be determined because the therapies were administered as part of a multimodal protocol.

The findings of this case should be interpreted in view of several limitations. The single-subject observational design, absence of a control group and blinding, and use of a multimodal therapeutic protocol preclude attribution of the observed effects to any single intervention. In addition, CRP, ESR, anti-CCP antibody levels, DAS-28 scoring, and radiographic assessments were not available, limiting comprehensive evaluation of inflammatory activity, immunological status, and structural disease progression. Furthermore, the baseline RA Factor value was reported as >160 IU/ml rather than as an exact quantitative value; therefore, the calculated >68.75% reduction represents the minimum possible decline based on the assay's upper reporting limit rather than an exact percentage change. Natural disease fluctuation, regression to the mean, and non-specific treatment effects cannot be excluded.

Despite these limitations, the temporal association between the structured Ayurvedic therapeutic protocol, clinical improvement, and reduction in RA Factor provides preliminary evidence that may support further systematic investigation. Future adequately powered, controlled clinical studies should incorporate standardised Amavata severity assessment, validated rheumatoid arthritis disease-activity measures such as DAS-28, serial ESR and CRP measurements, anti-CCP antibodies, quantitative RA Factor assessment, functional outcome measures, and appropriate imaging modalities. Multi-timepoint evaluation would further help determine the onset, magnitude, and durability of the observed response.^[4,5]

7. CONCLUSION

This case report documents the successful management of seropositive Amavata (Rheumatoid Arthritis) in a 44-year-old female through a sequenced classical Ayurvedic protocol comprising Vaitarana Basti,^[7,8,9] Matra Basti,^[10] Sinhanad Guggulu,^[6] Punarnavadi Kwatha,^[13] and topical Lepa over 14 weeks. The protocol achieved a clinically significant reduction in RA Factor from >160 IU/ml to 50 IU/ml^[3] alongside near-complete resolution of morning stiffness and functional restoration, without concurrent DMARD therapy or adverse

effects. The classical Shodhana-before-Shamana sequencing^[1,2]— rooted in Dosha-Dushya analysis — appears central to the outcome. These findings support further investigation through adequately powered randomised clinical trials with comprehensive biomedical outcome assessment in seropositive Amavata.

Patient Perspective

The patient reported substantial satisfaction with the treatment course. She observed that her capacity for activities of daily living — including cooking, household work, and self-care — had improved markedly by Week 8. No adverse effects were reported during the Shamana phase. The only discomfort noted was mild abdominal cramping on the first two days of Vaitarana Basti, which resolved spontaneously without dose modification. She consented to publication of her clinical data to support the Ayurvedic evidence base.

Informed Consent

Written informed consent was obtained from the patient for publication of this case report and accompanying images. The patient provided consent in a structured format and has willingly given permission for publication. The patient understands that efforts will be made to conceal identity, but anonymity cannot be guaranteed

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