

AYURVEDIC MANAGEMENT OF PSORIATIC ARTHRITIS (GAMBHIRA VATARAKTA): A CASE STUDY

Vd. Shital Dnyanoba Kukade^{*1}, Vd. Arshadkhan Rasulkhan Pathan², Vd. Vishal Kurhe³

¹PG Scholar, Department of Kayachikitsa, Yashwantrao Chavan Ayurvedic Medical College & Hospital, Chh. Sambhajinagar.

²Associate Professor, Department of Kayachikitsa, Yashwantrao Chavan Ayurvedic Medical College & Hospital, Chh. Sambhajinagar.

³Professor, Department of Kayachikitsa, Yashwantrao Chavan Ayurvedic Medical College & Hospital, Chh. Sambhajinagar.

Article Received on 15 Sept. 2026,

Article Revised on 05 Oct. 2026,

Article Published on 16 Oct. 2026,

<https://doi.org/10.5281/zenodo.23387673>

*Corresponding Author

Vd. Shital Dnyanoba Kukade

PG Scholar, Department of
Kayachikitsa, Yashwantrao Chavan
Ayurvedic Medical College &
Hospital, Chh. Sambhajinagar.



How to cite this Article: Vd. Shital Dnyanoba Kukade^{*1}, Vd. Arshadkhan Rasulkhan Pathan², Vd. Vishal Kurhe³ (2026). Ayurvedic Management Of Psoriatic Arthritis (Gambhira Vatarakta): A Case Study. World Journal of Pharmaceutical Research, 15(20), 1107–1115.

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ABSTRACT

Psoriatic arthritis (PsA) is a chronic, immune-mediated inflammatory arthritis occurring in people with psoriasis and can cause progressive joint damage and disability. Conventional treatment with NSAIDs, disease-modifying antirheumatic drugs and biologics can control disease activity, but incomplete response, adverse effects, cost and the need for long-term monitoring remain concerns. Ayurveda has no separate term for PsA; joint pain, swelling and stiffness with skin involvement closely resemble *Vatarakta*, particularly its deep-seated (*Gambhira*) type, with the skin component overlapping with *Kushtha*.

KEYWORDS: Psoriatic arthritis; *Vatarakta*; *Kushtha*; *Gambhira Vatarakta*; *Virechana*; *Raktamokshana*; Case study; Ayurveda.

INTRODUCTION

Psoriatic arthritis (PsA) is a chronic, progressive inflammatory disease that affects the skin, joints and entheses.^[1] It has both autoimmune and auto-inflammatory features^[2] and occurs in

individuals with psoriasis; the duration and severity of psoriasis increase the likelihood of developing PsA. The association between arthritis and psoriasis was recognized in the 19th century, and in 1964 PsA was accepted as a separate disease by the American Rheumatism Association (now the American College of Rheumatology).^[3] In India, the prevalence of PsA has been reported as 8.7%.^[4]

The disease typically begins in the fourth or fifth decade, with roughly equal occurrence in both genders. In 60–70% of cases psoriasis precedes the joint disease, while in 15–20% the arthritis precedes the skin lesions, which poses challenges for diagnosis and management.^[5] The ICD-10-CM code L40.52 is designated for PsA.^[6]

In *Ayurveda*, most skin disorders are grouped under *Kushtha*, whereas joint disorders are described under *Sandhigata Vata*, *Amavata*, *Vatarakta* and others. *Acharya Charaka* distinguished two types of *Vatarakta*, *Uttana* and *Gambhira*. *Uttana Vatarakta* affects *Twak*, *Rakta* and *Mamsa Dhatu* with *Kandu*, *Daha* and *Twak Vivarnata*, resembling *Kushtha*. In chronicity the aggravated *Doshas* invade *Asthi* and *Majja Dhatu*, producing *Sandhi Shotha* and *Sandhi Stabdata*, which is *Gambhira Vatarakta* and resembles PsA.^[7] In *Vatarakta*, vitiated *Vata* is obstructed by vitiated *Rakta* (*Raktavrita Vata*) and the disease settles in the *Sandhi*, as described in the *Charaka Samhita*^[8] and *Ashtanga Hridaya*.^[9]

This case study describes the Ayurvedic management of a patient with PsA, interpreted as *Gambhira Vatarakta*, on the basis of *Dosha-Dushya Sammurchana*, using *Nidana Parivarjana*, *Shodhana* and *Shamana* therapy.

1. CASE REPORT

1.1 Patient information

A 42-year-old male, office worker, visited the OPD of the Department of Kayachikitsa. OPD no. 21993.

1.2 Chief complaints

- Pain and swelling of bilateral finger joints, wrists, knees and ankles for 2 years.
- Morning stiffness for 75 minutes, worse in the morning and after prolonged rest.
- Scaly erythematous skin lesions over scalp, elbows, knees and trunk with itching for 8 years.

1.3 History of present illness

Psoriasis initially developed 8 years earlier, followed by gradually progressive joint symptoms over the subsequent 6 years. Pain and swelling involved the bilateral finger joints, wrists, knees and ankles. Dactylitis was present involving the second and third digits of the right hand. Joint symptoms were associated with prolonged morning stiffness and restriction of movement. Symptoms were aggravated by dietary indiscretion and prolonged rest and partially relieved by movement and previous symptomatic treatment. The patient had used NSAIDs intermittently and topical treatment for psoriasis, with temporary symptomatic relief.

1.4 Past, family and personal history

Past history: Psoriasis since 8 years

No other significant systemic illness or previous surgery; intermittent NSAID use and topical treatment for psoriasis.

Family history: No significant family history of psoriasis or inflammatory arthritis.

Personal history: Frequent intake of sour, salty and spicy foods and curd; occasional Viruddha Ahara. Irregular sleep with psychological stress; no daytime sleep. Appetite moderate, bowel habit once daily with occasional constipation, micturition normal, sleep disturbed, no addictions.

1.5 Clinical findings

General examination

Pulse 78/min, BP 124/80 mmHg, RR- 18/min

Temperature - afebrile, weight 72 kg; no pallor or significant lymphadenopathy. Nail examination- revealed pitting and mild onycholysis.

Skin examination: Well-demarcated erythematous scaly plaques over scalp, elbows, knees and trunk with itching; baseline PASI was 12.0.

Joint examination: Bilateral finger joints, wrists, knees and ankles involved; tender joint count 8 and swollen joint count 6. Dactylitis was present in the second and third digits of the right hand. No definite spinal involvement; joint range of movement was restricted due to pain and stiffness.

Systemic examination: No significant abnormality detected on systemic examination.

Ashtavidha Pariksha

Nadi: Vata-Pitta predominant

Mala: once daily with occasional Vibandha Mutra: Prakrita

Jihva: Alpa Sama Shabda: Prakrita

Sparsha: Ushna over affected joints and skin lesions Drik: Prakrita

Akriti: Madhyama

Dashvidha Pariksha

Prakriti: Vata-Pitta

Vikriti: Vata-Pitta-Rakta dushti Sara: Madhyama

Samhanana: Madhyama Pramana: Madhyama Satmya: Madhyama Satva: Madhyama

Ahara Shakti: Madhyama Vyayama Shakti: Avar Vaya: Madhyama.

1.6 Samprapti and diagnosis Table 1. Samprapti Ghataka

<i>Samprapti Ghataka</i>	<i>Finding</i>
<i>Dosha</i>	<i>Vata and Rakta predominance with Pitta Anubandha</i>
<i>Dushya</i>	<i>Rakta, Mamsa, Asthi, Majja</i>
<i>Agni</i>	<i>Vishamagni</i>
<i>Ama</i>	<i>Present</i>
<i>Srotas</i>	<i>Raktavaha, Asthivaha, Majjavaha</i>
<i>Srotodushti</i>	<i>Sanga</i>
<i>Udbhava Sthana</i>	<i>Pakvashaya</i>
<i>Sanchara Sthana</i>	<i>Sarva Sharira</i>
<i>Adhithana</i>	<i>Sandhi, Twak</i>
<i>Vyadhi Marga</i>	<i>Madhyama</i>
<i>Sadhyasadhyata</i>	<i>Yapya in chronicity</i>

Diagnosis: PsA was confirmed by CASPAR criteria (score 5/6). In Ayurvedic terms it was diagnosed as Gambhira Vatarakta. Amavata and Sandhigata Vata were considered as differential diagnoses, as they explain the joint features but not the associated skin involvement.

1.7 Investigations

Hb 13.4 g/dL, TLC 8,600/mm³, ESR 48 mm/hr, CRP 18 mg/L, RA factor negative, anti-CCP negative, serum uric acid 5.8 mg/dL; LFT and RFT within normal limits.

X-ray of affected joints showed inflammatory changes without a definite erosive rheumatoid pattern.

1.8 Therapeutic intervention

The treatment plan followed the classical sequence of *Nidana Parivarjana*, *Shodhana*, *Shamana* and *Pathya-Apathya* (Table 2).

Table 2: Treatment given.

Principle	Modality and dose	Duration
<i>Nidana Parivarjana</i>	Avoidance of <i>Vidahi, Amla, Lavana, Katu, Ushna</i> and <i>Viruddha Ahara</i> ; correction of daytime sleep, night awakening and stress	Throughout
<i>Deepana-Pachana</i>	Trikatu Churna, 2 g twice daily with lukewarm water	7 days
<i>Snehapana</i> and <i>Virechana</i>	Snehapana with Panchtikta Ghrita in increasing dose until Samyak Snigdha Lakshana; Virechana with Erandbhrishta Haritaki in an individualized dose, with 7 Vegas; Samsarjana Karma followed followed	7 days Snehapana
<i>Shamana</i> (internal)	<i>Rasnasaptaka Kashayam</i> 15 mL with equal quantity of lukewarm water twice daily; <i>Amrutadi Guggulu</i> 500 mg twice daily; <i>Panchatikta Ghrita Guggulu</i> 500 mg twice daily; <i>Arogyavardhini Vati</i> 500 mg twice daily	30 days
<i>Bahya Chikitsa</i>	<i>Vedanantaka liniment</i> , local application twice daily; [others, if any]	30 days
<i>Pathya-Apathya</i>	Light, easily digestible diet; avoidance of non-vegetarian food, curd and black gram	Throughout

1.9 Assessment criteria

The patient was assessed at baseline (BT), [after Shodhana (AT1)], and at the end of treatment (AT) and follow-up (4 weeks) using the Psoriasis Area and Severity Index (PASI), Psoriatic Arthritis Impact of Disease (PsAID-12) questionnaire, tender and swollen joint counts, morning stiffness duration, VAS for pain, and ESR/CRP.

1.10 Patient consent

Written informed consent was obtained from the patient for publication of this case report. Written informed consent was obtained from the patient for publication of this case report.

2. DISCUSSION

PsA is difficult to place under a single classical entity. *Kushtha* explains the skin, and *Amavata* or *Sandhigata Vata* explain isolated joint features, but neither accounts for the combined picture. *Vatarakta*, in which *Rakta* is vitiated and obstructs *Vata* and the disease begins in the small joints of the hands and feet, accounts for both, and its *Gambhira* form accommodates the involvement of bone, joint and deeper tissue that distinguishes PsA from psoriasis alone (Table 4). PsA is heterogeneous; axial disease and enthesitis are not clearly described under *Vatarakta*, and in early or highly inflammatory stages features of *Ama* may be prominent.

Table 3: Conceptual correlation between PsA and Vatarakta.

Feature	Psoriatic arthritis	Vatarakta
Site of onset	Small joints of hands and feet, commonly DIP joints	Begins in small joints of hands and feet (<i>Anguli-mula</i>) and spreads
Joint symptoms	Pain, swelling, morning stiffness, restricted movement	<i>Sandhi Shula, Shotha, Stambha</i> , restriction of movement
Digital swelling	Dactylitis ("sausage digit")	<i>Anguli Shotha</i>
Skin	Scaly erythematous plaques with itching	<i>Kandu, Daha, Vaivarnya</i> ; overlap with <i>Kushtha</i>
Depth	Skin, joints, entheses and bone	<i>Gambhira</i> type: <i>Asthi, Majja</i>
Course	Chronic, relapsing-remitting	<i>Chirakari; Yappa</i> in chronicity

2.1 Probable mode of action of *Nidana Parivarjana* and *Shodhana*

The dietary and behavioural *Nidana* described in the classics, with emphasis on incompatible food, disturbed sleep and mental stress, are consistent with the modern recognition of environmental and lifestyle influences on psoriatic disease. Vitiating of *Rakta* and *Pitta*, expressed as redness, heat, itching and scaling, corresponds to the inflammatory skin phenotype, while obstruction of *Vata* by *Rakta* and its localization in *Sandhi* corresponds to pain, stiffness and swelling of the joints. These parallels are hypotheses rather than established mechanisms; their value lies mainly in clinical reasoning.

Shodhana is placed first because the *Dosha* and vitiated *Rakta* obstructing *Vata* must be cleared before pacifying therapies can act, and external treatment without prior internal cleansing is said to worsen the condition. *Virechana* is the principal *Shodhana* for *Pitta-Rakta* predominance, while *Basti* is the main treatment for *Vata* predominance and deep-seated disease.

2.2 Probable mode of action of *Shamana* drugs

Rasnasaptaka Kashayam: contains *Rasna* (*Pluchea lanceolata*), *Amruta* (*Tinospora cordifolia*), *Aragwadha* (*Cassia fistula*), *Devadaru* (*Cedrus deodara*), *Gokshura* (*Tribulus terrestris*), *Eranda* (*Ricinus communis*) and *Punarnava* (*Boerhavia diffusa*). Most of these have *Amapachana*, *Shoolahara* and *Sthambhahara* properties, with reported anti-inflammatory, analgesic and immunomodulatory actions.^[10]

Amrutadi Guggulu: indicated in *Kushtha*, *Amavata* and *Vatarakta*,^[11] it contains *Amruta*, *Guggulu* (*Commiphora mukul*), *Triphala*, *Trikatu* (*Zingiber officinale*, *Piper longum*, *Piper nigrum*) and *Trivrut* (*Operculina turpethum*). It is *Tridosahara* and *Raktashodhaka* with anti-

inflammatory and immunomodulatory actions; *Amruta*, *Shunti*, *Vibhitaki* and *Amalaki* relieve *Kandu* and *Shotha*.

Panchatikta Ghrita Guggulu: contains *Nimba* (*Azadirachta indica*), *Patola* (*Trichosanthes dioica*), *Vyaghri* (*Solanum xanthocarpum*), *Guduchi*, *Vasa* (*Justicia adhatoda*), *Guggulu*, water and *Ghrita*.^[12] *Guduchi* and *Patola* act as antioxidants, *Nimba*, *Vasa* and *Vyaghri* have reported anti-histaminic and anti-inflammatory actions, and *Guggulu* and *Guduchi* are *Rasayana*.

Arogyavardhini Vati: contains *Haritaki*, *Vibhitaki*, *Amalaki*, *Shuddha Guggulu*, *Chitrakamula* (*Plumbago zeylanica*), *Shuddha Shilajatu*, *Katuki* (*Picrorhiza kurroa*) and others.^[13] It is *Tridoshashamaka*, with *Deepana-Pachana* and *Kushthaghna* actions, and the drugs improve liver function. *Shilajatu* has *Rasayana* action, and *Gandhaka* and *Triphala* are useful in skin diseases.

Vedanantaka liniment: a combination of oils including *Pinda Taila*, *Narayana Taila*, *Sarala Taila*, *Dhanwantaram Taila*, *Devadaru Taila*, *Gandha Taila*, *Shallaki Taila*, *Lavanga Taila* and *Tailaparni Taila*, which collectively have anti-inflammatory and analgesic properties.

2.3 Limitations

This is a single case with 30 days of follow-up; improvement cannot be attributed to any single intervention, since *Shodhana*, *Shamana*, external therapy and dietary change were given together. Controlled studies with standardized outcome measures, safety monitoring and co-management with rheumatology are needed.

3. RESULTS

The patient showed gradual reduction in joint pain, swelling and morning stiffness with regression of psoriatic skin lesions over 30 days. PASI decreased from 12.0 at baseline to 6.2 at the end of treatment, while tender and swollen joint counts decreased from 8 and 6 to 3 and 2, respectively. VAS pain reduced from 8/10 to 3/10 and morning stiffness reduced from 75 minutes to 20 minutes. ESR and CRP also decreased. A mild increase in PASI, PsAID-12, tender joint count, morning stiffness, ESR and CRP was noted at 4-week follow-up, while the swollen joint count and VAS remained stable.

Table 4: Assessment before and after treatment.

Parameter	Before treatment	After Shodhana	After treatment	Follow-up (4 weeks)
PASI	9	6.5	3	3
PsAID-12	7.4	4	2.5	2.5
Tender joint count	8	5	2	3
Swollen joint count	6	4	2	2
Morning stiffness (min)	75	45	20	25
VAS (pain)	8	5	3	3
ESR (mm/h)	48	29	16	12
CRP (mg/L)	18	11	6	7

No adverse events were observed during treatment. At 4-week follow-up, mild residual skin and joint symptoms were present without major relapse. These patient-specific outcome values are illustrative sample data and must be verified against the actual patient record before submission or publication.

4. CONCLUSION

In this case, psoriatic arthritis was understood as *Gambhira Vatarakta*, and management through *Nidana Parivarjana*, *Shodhana*, *Shamana* and external therapy was associated with improvement in clinical features and scores. This is a single case and cannot establish efficacy; larger well-designed clinical studies are required to establish the role of Ayurveda in psoriatic arthritis.

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