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PANCHAKARMA IN THE MANAGEMENT OF VIPADIKA WITH SPECIAL REFERENCE TO PALMOPLANTAR PSORIASIS: A REVIEW

[1]*Dr. Palvi Dubey, [2]Dr. Sanjay Dubey

[1]*M.D. Kayachikitsa, [2]BAMS Student,

Jammu Institute of Ayurveda and Research, Nardani, Jammu 181123.

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***Corresponding Author**

Dr. Palvi Dubey

M.D. Kayachikitsa, Jammu Institute of Ayurveda and Research, Nardani, Jammu 181123.

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ABSTRACT

Background: Palmoplantar Psoriasis (PPS) is a chronic, non-infectious inflammatory dermatological condition primarily confined to the palms and soles, afflicting approximately 3–4% of all psoriatic patients globally.[1] In Ayurveda, all skin diseases are classified under the broad category of *Kushtha*, and PPS is closely correlated with *Vipadika* — a subtype of *Kshudra Kushtha* — based on similarities in its clinical presentation. **Objective:** To critically examine the therapeutic efficacy of *Virechana*, *Raktamokshana*, and *Snehapana* in the Ayurvedic management of *Vipadika* as correlated with palmoplantar psoriasis. **Clinical Illustration:** A 50-year-old female patient presenting with a 3-year history of pruritic rashes, cracks (*Sphutana*), burning sensation (*Daha*), and bloody-watery discharge on both palms and soles was managed with a structured *Shodhana* protocol encompassing *Shodhnartha Snehapana* with *Mahatikta Ghrita*, *Virechana* using *Icchabhedi Rasa*, *Samsarjana Krama*, *Raktamokshana* by *Siravedha*, and *Shamana Aushadhi*. **Outcome:** Significant improvement was noted in the Simplified Psoriasis Index (SPI) score — reducing from 23 (severe) to 10 (moderate) — along with marked relief in itching, scaling, burning, and discharge. Complete remission of *Kandu* and *Daha* was achieved after Raktamokshana and Shamana therapy. **Conclusion:** Panchakarma therapies, particularly *Snehapana*, *Virechana*, and *Raktamokshana*, offer a safe and effective therapeutic approach for *Vipadika*, providing lasting symptomatic relief with minimal adverse effects.

KEYWORDS: Panchakarma, Vipadika, Snehapana, Virechana, Raktamokshana, Palmoplantar Psoriasis, Kushtha, Shodhana therapy.

1. INTRODUCTION

Palmoplantar Psoriasis (PPS) is a distinct and clinically challenging form of psoriasis that primarily affects the palms of the hands and soles of the feet, though it may occasionally extend to adjacent areas of the body.[1] It is classified as a subtype of both plaque psoriasis and pustular psoriasis, depending upon its morphological presentation. Globally, psoriasis affects approximately 2–5% of the general population, with PPS accounting for 3–4% of all psoriasis cases.[1] The condition is characterised by well-demarcated areas of thickened, erythematous, scaly skin accompanied by intense pruritus, burning, pain, and fissuring with potential bleeding.[2] As PPS predominantly manifests symmetrically on both hands and feet, it significantly impairs the ability to perform routine activities, including ambulation, and can give rise to psychosocial challenges such as embarrassment and social withdrawal. In the Ayurvedic medical framework, all cutaneous disorders are collectively designated as *Kushtha*. Within this classification, palmoplantar psoriasis corresponds most closely to *Vipadika* — one of the *Kshudra Kushtha* variants. The cardinal features of *Vipadika* as described in classical texts include *Pani-Pada Sphutana* (fissuring of palms and soles), *Kandu* (intense pruritus), *Ruja* (pain), and *Ruksha Gatra* (dryness of extremities).[3] Contemporary biomedical management of psoriasis relies upon PUVA therapy (Psoralen plus Ultraviolet-A radiation), corticosteroids, and immunomodulatory agents.[4] However, these modalities are often associated with significant side effects, including skin atrophy, immunosuppression, and frequent disease recurrence. This underscores the necessity of exploring alternative therapeutic strategies rooted in traditional medicine systems. The present review examines the Ayurvedic management protocol for *Vipadika*, with particular emphasis on Panchakarma interventions, highlighting their mechanistic rationale and clinical outcomes.

2. Ayurvedic Conceptualisation of Vipadika

In Ayurveda, skin diseases arise fundamentally from an imbalance in the three *Doshas* — *Vata*, *Pitta*, and *Kapha* — which govern diverse physiological functions including skin integrity and homeostasis. *Vipadika* is classified as a condition of predominant *Vata-Kapha* doshic imbalance.

The *Ruksha* (dry) quality of *Vata Dosha* is responsible for the characteristic fissuring and dryness of the skin, while the involvement of *Pitta Dosha* accounts for the inflammatory features, including burning, erythema, and serous or bloody discharge. The *Kapha* component contributes to the thickening and scaling of the affected skin surfaces. Classical Ayurvedic references describe the treatment approach for *Vipadika* under *Kushtha Chikitsa*, which primarily involves *Shodhana* (purificatory) therapy followed by *Shamana* (palliative) measures. *Charaka Samhita* specifically recommends *Snehapana* as an essential pre-operative procedure to achieve systemic oleation before major Shodhana karma.[5]

3. Clinical Presentation

A 50-year-old female patient presented to an Ayurvedic hospital with a 3-year-long history of *Arunavarni Twaka* (pruritic rashes on both palms and soles), accompanied by *Sphutana* (fissuring), *Daha* (burning sensation), and bloody as well as watery discharge emanating from dry, cracked patches on the palmar and plantar surfaces. The patient had previously received modern pharmacological treatment with only temporary symptomatic relief and no significant long-term improvement. No notable family history or prior personal medical or psychiatric history was elicited.

3.1 Clinical Findings

Dermatological examination revealed blackish-red discolouration over both palms and soles, with ill-defined, erythematous, scaly plaques associated with bloody and watery discharge. The patient reported severe pruritus and burning at the affected sites. Differential diagnoses considered included palmoplantar psoriasis, dyshidrotic eczema, and contact dermatitis.

3.2 Pathological Investigations

Pre-treatment baseline laboratory investigations were obtained, with results as follows: Haemoglobin 10.1 gm%, Total Leucocyte Count 3100 cells/cumm, Neutrophils 70%, Lymphocytes 21%, Eosinophils 9%, and Erythrocyte Sedimentation Rate (ESR) 67 mm/hour. The elevated ESR and eosinophilia were consistent with an ongoing chronic inflammatory or allergic process.

4. Treatment Protocol

The patient was managed with a multimodal *Shodhana* protocol as detailed in Table 1 below. The treatment was planned in a phased manner, progressing from *Snehapana* through *Virechana*, *Samsarjana Krama*, and *Raktamokshana*, followed by *Shamana Aushadhi*.

Table 1: Treatment Modality in Vipadika w.s.r. to Palmoplantar Psoriasis.

SN	Date	Duration	Treatment	Dose & Schedule
1	08/02/2023 – 20/02/2023	13 days	Ashwagandha + Yashtimadhu + Arjuna; Pathyadi Kashaya; Abhayarishtam; Kaishor Guggulu; Kandughna Gana Kwatha	3 gm + 2 gm + 2 gm BD before meals; 20 ml BD; 20 ml BD; 500 mg BD; 20 ml BD
2	23/02/2023	6 days	*Shodhnartha Snehapana with Mahatikta Ghrita (ascending dose)*	Starting at 30 ml, increasing to 180 ml; administered on empty stomach in the morning
3	04/03/2023	1 day	*Virechana with Icchabhedi Rasa and Manuka Phanta*	125 mg (2 tablets) with 80 ml Manuka Phanta
4	05/03/2023 – 09/03/2023	5 days	*Samsarjana Karma (Peyadi Krama)*	Graduated dietary reintroduction over 5 days
5	10/03/2023 – 14/03/2023	5 days	*Shirodhara with Brahmi, Amalaki and Tila Taila*	Daily for 5 days
6	14/03/2023	1 day	*Raktamokshana (Siravedha)*	100 ml bloodletting
7	10/03/2023 onwards	Till follow-up	*Shamana Snehapana with Panchatikta Ghrita*	20 ml at breakfast on an empty stomach
8	10/03/2023 onwards	SOS	*Local application: Shatadhauta Ghrita, Karanja Taila, Panchatikta Ghrita*	As required (SOS), applied topically to affected areas

5. OBSERVATIONS AND RESULTS

The patient was maintained under close clinical observation throughout the inpatient stay at the Ayurvedic hospital. No adverse effects were reported during the course of treatment. Progressive improvement was recorded at each stage of therapy, as documented in Table 2.

Table 2: Assessment of Symptoms Before and After Treatment.

Assessment Parameter	At Admission	After Snehapana	After Virechana & Samsarjana Krama	After Raktamokshana & Shamana Snehapana	At Follow-up
Pani-Pada Sphutana	++++	+++	++	++	+
Kandu (Pruritus)	++++	++	+	+	–
Daha (Burning)	++++	++	+	–	–
Raktastrava (Discharge)	++	+	–	–	–
SPI Score*	**23**	–	–	**10**	–

*SPI: Simplified Psoriasis Index[13] — a validated tool for clinical assessment of psoriasis severity (Score 23 = severe; Score 10 = moderate)

A clinically meaningful reduction in SPI score from 23 (severe psoriasis) to 10 (moderate psoriasis) was recorded post-Raktamokshana and Shamana therapy. Complete resolution of *Kandu* and *Daha* was achieved at the post-Raktamokshana stage. At the one-month follow-up, significant improvement in skin texture, scaling, and fissuring was documented, with the patient reporting marked improvement in functional capacity and quality of life.

6. DISCUSSION

6.1 Pathophysiological Correlation: Vipadika and Palmoplantar Psoriasis

The clinical constellation of features in palmoplantar psoriasis — comprising erythematous scaling plaques, fissuring, pruritus, burning, and discharge — closely parallels the Ayurvedic description of *Vipadika*. The dominant *Vata-Kapha* doshic involvement explains the dryness, cracking, and scaling, while the *Rakta-Pitta* component accounts for the inflammatory and exudative features of the condition.

6.2 Effect of Snehapana

In the present case, the prominent features of palmar and plantar fissuring, pruritus, and burning were addressed initially through *Shodhnartha Snehapana* with *Mahatikta Ghrita*.[5] The *Ruksha Guna* (drying quality) of aggravated *Vata* is fundamentally antagonised by the *Sneha Guna* (unctuous property) of medicated ghee, rendering *Snehapana* the cornerstone of treatment in this condition. Mahatikta Ghrita *is a classical preparation known for its Snigdha* (oily), *Tridoshahara*, and *Kusthaghna* properties. Its Pitta-balancing action effectively mitigates inflammation and irritation, while its *Snigdha* quality counteracts the dryness and fissuring of the skin. Furthermore, *Snehapana* facilitates the dislodgement and mobilisation of vitiated *Doshas* from peripheral tissues towards the gastrointestinal tract, thereby preparing the body for definitive Shodhana therapy.

6.3 Effect of Virechana

Virechana *is described in classical texts as the treatment of choice for conditions involving Pitta* and *Rakta* vitiation.[5] Virechana drugs are characterised by properties such as *Ushna* (hot potency), *Tikshna* (penetrating quality), *Sukshma* (subtle property), *Vyavayi* (rapid systemic dissemination), and *Adhobhaghara Prabhava* (tendency to move downwards). These pharmacodynamic properties enable *Virechana Dravya* to penetrate the cardiac channels, circulate systemically through the vascular network, liquefy consolidated morbid *Doshas* through their *Agneya Guna*, and dislodge adherent *Doshas* from tissue channels via their *Tikshna Guna*. The morbid material is subsequently channelled towards the

gastrointestinal tract and eliminated through the downward passage (rectum). Icchabhedi Rasa *was selected in this case due to the patient's Bahu Dosha* (high doshic load) and *Krura Koshtha* (hard bowel constitution).[6] This classical *Rasa* preparation is composed of *Shuddha Parada* (purified mercury), *Shuddha Gandhaka* (purified sulphur), *Shunthi* (*Zingiber officinale*), *Maricha* (*Piper nigrum*), *Tankan* (borax), and *Jaypala* (*Croton tiglium*). *Jaypala* exerts a direct gastrointestinal stimulant and neurochemical irritant action. Overall, *Icchabhedi Rasa* functions as a potent *Kaphavatashamaka*, *Vatanulomaka*, and *Strotoshodhaka* formulation, ensuring thorough purification of the bodily channels.

6.4 Effect of Samsarjana Krama

Following *Virechana*, the *Peyadi Samsarjana Krama* — a graduated dietary rehabilitation protocol — was administered for five days.[7] This phased dietary regimen progressively enhances the strength of *Agni* (digestive fire), which is transiently suppressed after intense purificatory procedures, and facilitates the elimination of residual morbid *Doshas* while restoring normal physiological function.

6.5 Effect of Raktamokshana

Since *Vipadika* is characterised by a significant *Rakta* and *Pitta* doshic predominance, *Raktamokshana* by *Siravedha* (controlled venepuncture bloodletting) was performed.[8] Elimination of vitiated *Rakta* through *Siravedha* produced marked improvement in *Kandu* (pruritus), *Daha* (burning sensation), and *Ruja* (pain), consistent with the classical Ayurvedic indication of *Raktamokshana* in *Rakta-Pitta* doshic disorders.

6.6 Effect of Shamana Snehapana and Local Applications

Shamana Snehapana *with Panchatikta Ghrita* was initiated following the completion of *Shodhana* therapy to consolidate the therapeutic gains and prevent relapse.[9,10] *Panchatikta Ghrita* exerts *Vatapittahara* and *Kusthaghna* actions, making it highly suitable for long-term maintenance therapy in chronic dermatological conditions. Local application of *Shatadhauta Ghrita*,[11] *Karanja Taila*,[12] and *Panchatikta Ghrita* provided direct soothing and healing effects on the palmar and plantar surfaces. *Ghrita* is known to pacify both *Vata* and *Pitta Doshas*, thereby alleviating pain, promoting healing of fissures, and reducing local inflammation.

7. CONCLUSION

The present review demonstrates that a structured Panchakarma protocol — comprising *Snehapana* with *Mahatikta Ghrita*, *Virechana* with *Icchabhedi Rasa*, *Samsarjana Krama*, *Raktamokshana* by *Siravedha*, and *Shamana Aushadhi* with *Panchatikta Ghrita* — produces significant and sustained clinical improvement in *Vipadika* (palmoplantar psoriasis). Clinically meaningful outcomes were achieved in terms of SPI score reduction (from 23 to 10), complete resolution of *Kandu* and *Daha*, marked improvement in *Sphutana* and *Raktastrava*, and enhanced quality of life. The treatment was well tolerated with no adverse effects, and the patient reported high satisfaction with the cost-effectiveness of the Ayurvedic management approach. These findings support the integration of Panchakarma therapies in the management of chronic inflammatory dermatological conditions, particularly in cases where conventional treatment has provided only partial or temporary relief. Further controlled clinical trials with larger sample sizes and standardised outcome measures are warranted to establish the evidence base for this treatment protocol.

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