WORLD JOURNAL OF PHARMACEUTICAL RESEARCH
Coden USA: WJPRAP Impact Factor 8.453
Volume 15, Issue 3, 1514-1523. Case Study ISSN 2277–7105

ROLE OF VIRECHANA, UTTARAVASTI AND AMRUTAPRASHA RASAYANA YOGA IN AZOOSPERMIA (SHUKRA KSHAYA) - A SINGLE CASE STUDY

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

https://doi.org/10.5281/zenodo.18480019

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How To Cite This Article: [1]*Dr. Sumayya Begum, [2]Dr. Madhava Diggavi, [3]Dr. Fareeda Begum Sheikh. (2026). Role of Virechana, Uttaravasti and Amrutaprasha Rasayana Yoga In Azoospermia (Shukra Kshaya) - A Single Case Study "World Journal of Pharmaceutical Research, 15(3), 1514–1523.

ABSTRACT

Azoospermia is a cause of male infertility. A male patient showed improvement after intervention; hence, it has potential to be published as a single case study. The objective was to assess the efficacy of Shodhana, Uttarabasti, and Vṛṣya Rasāyana in azoospermia. **Methodology:** A 48-year-old male patient, diagnosed with azoospermia and infertility since 10 years, was treated with Śuṇṭhi cūrṇa 1 tsp TID with Uṣṇa jala before food. Dāḍimādi ghṛta Snehapāna was administered—50 ml on the first day and 75 ml for the next four days. Sarvāṅga Abhyaṅga with Yaṣṭimadhu taila followed by Bāṣpa sveda was done for three days. Nimbāmṛta Eraṇḍa taila 60 ml with 100 ml of milk was administered for Virecana. Saṃsarjana krama was followed for three days. Uttarabasti with Kalyāṇaka ghṛta (45 ml) was given for three days. Subsequently, Śamana auṣadhi—Aśvagandhā cūrṇa 1 tsp BD with milk, Śilājatu vaṭi 500 mg capsule 2 TID, and Amṛtaprāśa rasāyana 1 tsp OD with milk—was administered for three months. **Results:** Sperm count increased from 0 million/ml before treatment to 58 million/m

after treatment at the end of three months. Active spermmotility was 20%, slow motility was 10%, and immotile sperm was 70% after treatment. **Discussion:** Even though azoospermia is described as Asādhya, principle-based Śodhana followed by Uttarabasti and Vṛṣya Rasāyana showed significant improvement in sperm count and motility, which is a novel and unique achievement. Probably, Śodhana altered the internal milieu and hormonal stimulation. Uttarabasti might have stimulated the sthānika śukradhārā kalā and local spermatogenesis. Vṛṣya Rasāyana kalpas may have contributed to the normalization of spermatogenesis. **Conclusion:** Śodhana, Uttarabasti, and Vṛṣya Rasāyana when judiciously administered can produce results in azoospermia. Details of this original unpublished work will be discussed in the full paper.

KEYWORDS: Azoospermia, Śukrakṣaya, Virecana, Uttarabasti, Kalyāṇaka ghṛta, Aśvagandhā yoga, Śilājatu vaṭi, Amṛtaprāśa ghṛta.

INTRODUCTION

Azoospermia is defined in contemporary andrological science as the complete absence of spermatozoa in the ejaculate, affecting approximately 1% of the general male population and 10–15% of infertile men. It arises from three principal mechanisms—pre-testicular (hormonal dysfunction), testicular (primary testicular failure), or post-testicular (obstructive) causes—leading to impaired spermatogenesis or sperm transport. Clinically, azoospermia manifests with infertility, altered semen parameters, endocrine abnormalities, and may coexist with genetic defects, testicular atrophy, or varicocele. Despite advances in diagnostics and assisted reproductive technologies (ART), azoospermia remains a challenging condition due to limited spontaneous recovery of spermatogenesis and the need for invasive procedures such as TESE, micro-TESE, or ICSI, which provide variable success rates and do not address underlying systemic dysfunction. In Ayurveda, disorders of male reproductive insufficiency are broadly described under Śukravaha Srotoduṣṭi, Śukrakṣaya, and Klaibya, conditions that reflect quantitative and qualitative depletion of Śukra Dhātu. Classical texts describe Śukrakṣaya as presenting with Alpa Śukra / Tanu Śukra (reduced semen volume or density), Bīja Upaghāta (defective spermatozoa), and diminished sexual vigor, arising from the vitiation of Vāta and Pitta Doṣa along with depletion of Meda, Majjā, and Śukra Dhātus. Ācārya Caraka emphasizes that improper diet, excessive exertion, emotional stress, chronic illness, and suppression of natural urges weaken Agni and lead to Dhātu-kṣaya, ultimately compromising Śukra formation. Similarly, Ācārya Suśruta and Vāgbhaṭa highlight

Srotorodha (obstruction), Vāta Prakopa, and Rasa–Rakta Duṣṭi as key contributors to defective Śukra production and reproductive dysfunction. From a pathophysiological perspective, persistent exposure to Nidānas impairs Dhātvāgni and Ojas, resulting in inadequate transformation of preceding Dhātus and poor nourishment of Śukra. This aligns closely with modern concepts of oxidative stress, endocrine imbalance, environmental toxins, metabolic syndrome, and testicular microvascular compromise—factors known to disrupt spermatogenesis. The Āyurvedic description of Śukravaha Srotoduṣṭi through Saṅga (obstruction), Vimārga Gamana (aberrant flow), and Kṣaya (depletion) parallels modern mechanisms such as obstructive azoospermia, hormonal insufficiency, and germ cell failure.

Although contemporary medicine offers hormonal therapy, surgical correction, or ART-based interventions, there is no definitive curative therapy to restore normal spermatogenesis in many azoospermic patients. In contrast, Ayurveda proposes a holistic approach targeting root-cause correction through Agnidīpana, Srotoshodhana, Rasāyana, Vājīkaraṇa, and Dhātu-poṣaṇa, aiming to enhance endogenous testicular function, improve semen quality, reduce oxidative stress, and promote long-term reproductive health. This integrative relevance makes Āyurvedic management particularly valuable in today's era, where rising infertility, lifestyle disorders, and environmental stressors have made azoospermia and Śukrakṣaya increasingly prevalent and clinically significant.

MATERIALS AND METHODS

CASE REPORT

A male pt of 48 years old resident of bellary visited to kayachikitsa OPD taranath govt ayurvedic medical college and hospital bellary.

Presented with chief complains of unable to beget a child since 15 years of married life.

Associated with coitophobia and loss of libido and also has problem in Long time erection.
Has dourbaly klama mukhashosha and vyanga since a year.

Habits

taking curd with every meal, milk (Twice a day), Spicy, oily food, Tea (3 times/day).

Past History

No h/o Diabetes mellitus/ Hypertension, other major medical and surgical history.

Family History

No relevant family history.

General examination

Built: moderate

Height: 5.8

Weight: 80 kg

Nourishment: moderate

Pulse: 75/min

Blood pressure: 130/80 mmHg

Temp: 98.6f

Respirator rate: 16/min

Tongue: clear

SYSTEMIC EXAMINATION

CNS: conscious, well oriented

CVS: s1 s2 normal, no added sound

RS: AEBE, no murmur

P/A: umbilicus centrally placed, soft, non-tender, no organomegaly.

Local examination

Inspection: External genitalia normally developed; penis and scrotum normal; no lesions or discharge.

Palpation: Both testes palpable, mildly reduced consistency, non-tender; epididymis and vas deferens palpable bilaterally.

Scrotal contents: Left-sided Grade II varicocele; no hydrocele.

Secondary sexual characteristics: Normal male pattern hair; no gynecomastia.

Local impression: Findings suggest obstructive azoospermia with left varicocele.

Roga pareeksha

Nidana pancha The Nidāna include excessive intake of Rūkṣa, Laghu, Uṣṇa, Kaṭu, and Tikta āhāra, Viruddha āhāra, Alpāśana, Ativyāyāma, Rati-janya Atiyoga, Rātrijāgaraṇa, suppression of natural urges (Vegādhāraṇa), chronic stress, Śoka, and Krodha. These factors predominantly vitiate Vāta and Pitta doṣas. Pūrvarūpa appear as Daurbalya, Ālasya, reduced libido, mental fatigue, and mild reduction in semen output. Rūpa include Kṣīṇa Śukra

Pravṛtti, Klaibya, Bandhyatva, and in severe stages, absence of sperm, clinically comparable to azoospermia. The Samprapti begins with Vāta–Pitta Prakopa leading to Jatharāgni Māndya and Āma formation. Impaired Agni causes defective Dhātu Poṣaṇa and Dhātvagni Māndya. Since Śukra is the last Dhātu, it becomes maximally affected. Vāta, by its Rūkṣa and Kṣaya-kara Guṇas, causes depletion and drying of Śukra, while Pitta, through Uṣṇa and Tikṣṇa Guṇas, causes degeneration of Śukra Dhātu. Concurrent Śukravaha Srotoduṣṭi, mainly Saṅga, obstructs proper formation and transport of Śukra. Progressive Dhātu Kṣaya results in severe Śukrakṣaya, manifesting as infertility and azoospermia.

Samprapti Ghaṭaka

Doṣa: Predominantly Vāta Vṛddhi causing Dhātu Śoṣaṇa; sometimes associated Pitta leading to Bīja Upaghāta.

Duṣya: Śukra Dhātu mainly; secondary involvement of Majjā and Meda due to Dhātu Kṣaya sequence.

Agni: Dhātvāgni Māndya—particularly Medo and Majjā Dhātvāgni leading to poor Śukra-nirmāṇa.

Srotas: Śukravaha Srotas with Kṣaya-type Srotoduṣṭi; sometimes Saṅga when Kapha-Āma is associated.

Srotomūla: Vṛṣaṇa and Śepha as per classics.

Udbhava Sthāna: Rasa Dhātu and Āmāśaya, where Agnimāndya initiates Dhātu Apacaya.

Vyakti Sthāna: Śukra Dhātu level with manifestation of Kṣaya Lakṣaṇas.

Roga Mārga: Bāhya Roga Mārga due to Dhātu-level pathology.

Roga Bala: Madhyama to Pravara, depending on chronicity and degree of depletion.

Roga Svabhāva: Dhātukṣayaja and Cirakārī in nature.

Rogāvasthā: Usually chronic, presenting as long-standing Dhātu Śaithilya and Kṣaya.

Upadrava: Klaibya, Alpa-Śukratā, low libido, Dhātukṣaya symptoms such as Kārśya, Śrama, and Ojokṣaya features.

Vyadhi vinischaya

Disease	**Inclusion criteria (Why it resembles Shukrakshaya)**	**Exclusion criteria (How it differs from Shukrakshaya)**
Shukrakshaya	Alpa/abhāva śukra, klaibya, bandhyatva, daurbalya, Vāta–Pitta pradhāna lakṣaṇa	Primary disease; true quantitative depletion of Shukra dhātu
Shukra-dushti	Infertility, defective reproduction	Śukra present but vitiated (phenila, picchila, kunapa, vivarṇa); no true

		kṣaya
Klaibya	Sexual incapacity, inability to perform maithuna	Functional disorder; śukra quantity may be normal
Pum Bandhyatva	Failure to achieve conception	May be due to bīja-doṣa, srotorodha or daiva; Shukrakshaya not mandatory
Bīja-doṣa	Infertility, defective progeny	Congenital/genetic defect; Shukra quantity not necessarily reduced
Shukravaha Srotorodha	Absent or reduced ejaculation, infertility	Obstruction predominant; Shukra formation intact
Ojokṣaya	Daurbalya, klaibya, mental exhaustion	Systemic depletion of ojas; immunity affected more than reproduction

INTERVENTION

PURPOSE	DRUG	DOSE	ANUPANA
deepana pachana	Shunthi churna	1tsf(3gms)	Warm water
snehapana	Dadimadi ghruta	1st day test dose-50ml 2nd day -75ml 3rd day-75ml 4th day-75ml 5th day – 75ml	Warm water
virechana	Nimbamrutadi castor oil		100ml milk
purvakarma to uttarabasti	Erandamooladi basti Saindhava -10gms Madhu – 60ml Ashwagandha Ghruta -100ml Musta kalka- 10gm Erandamoola kashaya – 350ml	-	-
uttarabasti	Kalyanaka ghruta	45ml for 3 days	-
shamanaushadhi	Ashwagandha yoga	1 tsf(3gms)	milk
shamanaushadhi	Shilajatu vati	500mg 2 TID	Warm water
rasayana	Amrutaprasaha rasayana	1tsf(3gms)	milk

RESULTS

SEMEN PARAMETERS

Parameter	Before Treatment (BT)	After Treatment (AT)
Semen volume (ml)	3.5	1
Sperm count (million/ml)	Azoospermia (0)	58
Sperm motility (%)	Azoospermia	Active – 20%; Sluggish – 10%; Immotile – 70%
Sperm morphology	Azoospermia	Normal

LH (mIU/ml)	10.4	—
FSH (mIU/ml)	2.53	—
Prolactin (ng/ml)	10.2	—
Free testosterone (ng/dl)	313	—
SHBG (nmol/L)	26.6	—
Scrotal USG	Grade II varicocele (left pampiniform plexus dilated veins)	—

DISCUSSION

Azoospermia can be interpreted in Āyurveda as Vātaja Śukrakṣaya, where chronic vitiation of Vāta–Pitta Doṣhas leads to depletion of Rasa, Majjā, and Śukra Dhātus accompanied by Srotosaṅga in Śukravaha Srotas. This pathological environment arises from Agnimāndya, lifestyle disturbances, psychological stress, Rūkṣa–Uṣṇa dietary patterns, and Vāta-prakopaka activities. The cumulative result is impaired Dhātu-poṣaṇa and defective Śukra formation, maturation, or expulsion. The modern clinical picture of absent spermatozoa aligns well with the Āyurvedic description of Alpa, Rūkṣa, or Saṅga-yukta Śukra, reflecting both qualitative and quantitative deterioration. Therapeutic intervention begins with Snehapāna using Dāḍimādi Ghṛta, whose Vāta–Pittahara and Saumya qualities restore the Snigdhatā essential for Śukra Dhātu. Its Dīpana–Pācana action supports proper Dhātu-nourishment and promotes the metabolic transformation required for healthy Śukra. This also prepares the body for Virecana, which is essential because Pitta vitiation and Mūḍhāvāta obstruct the sequential Dhātu-nutrition process. Virecana corrects Pitta-induced heat and oxidative damage, clears Srotorodha, and regulates Apāna Vāta, thereby re-establishing the foundation for further Vājīkaraṇa therapy. Nirūha Basti with Eraṇḍamūladi Kaṣāya plays a pivotal role due to its direct action on deranged Vāta. This formulation, being Vṛṣya, Vātahara, and Srotoshodhaka, alleviates Śukra-saṅga and corrects Vimārga Gamana of Vāta. The therapy restores Vyāna–Apāna Vāta harmony and improves Śukra Niṣkramaṇa Kriyā, addressing a core pathology responsible for impaired ejaculation and seminal flow. Since many azoospermic cases involve Vāta-induced obstruction or hypofunction in reproductive channels, the effect of Basti here is central and disease-modifying.

Uttarabasti serves as a targeted intervention because it delivers medicated Sneha directly to the genital pathways, correcting local Srotorodha, nourishing obstructed tissues, and normalizing Apāna Vāta function. Its direct access to reproductive structures enhances both structural integrity and functional capacity, making it indispensable in conditions involving

Śukravaha Srotas Duṣṭi. The therapy improves local circulation, facilitates Śukra movement, and supports the natural mechanisms of sperm release.

Internal Rasāyana formulations support systemic rejuvenation. Kalyāṇaka Ghṛta enhances cognitive, emotional, and reproductive health by reducing stress, anxiety, and performance-related fears, which are significant contributors to Śukrakṣaya in modern contexts. Aśvagandhā counters stress-induced suppression of the reproductive axis, improves testosterone levels, enhances libido, and strengthens Dhātu metabolism. Śilājatu, through its Chedana and Yogavāhī actions, removes micro-obstructions and improves drug bioavailability, allowing deeper rejuvenation of Majjā and Śukra. Amṛtaprāśa Rasāyana, enriched with Vidārī and Gokṣura, provides Snigdha–Bṛṃhaṇa nourishment, improves sperm vitality (Vīrya Vardhana), and supports the integrity of Basti and reproductive tissues. Jīvanīya Gaṇa dravyas, dominated by Pṛthvī and Āp elements, counter Vāta–Pitta aggravation, restore Dhātu strength, act as Vṛṣya–Rasāyana, and directly support Śukra formation. Their combined influence replenishes Dhātu reserves and reverses long-standing depletion.

Collectively, the therapeutic sequence—from Snehapāna and Virecana to Nirūha Basti, Uttarabasti, and Rasāyana—addresses both systemic and local etiological factors. It restores Doṣha equilibrium, clears Srotas obstructions, enhances Dhātu nourishment, corrects Apāna Vāta dysfunction, and rejuvenates reproductive tissues. Classical Phalaśrutis supporting their use in Nāṣṭa Śukra, Aretasa, Putrada Karma, and Strīprasaktatā reinforce the textual authenticity of this approach. This integrated Āyurvedic model thus offers a comprehensive, biologically coherent, and clinically relevant framework for improving spermatogenesis and reproductive outcomes in azoospermia.

CONCLUSION

Azoospermia remains a complex reproductive disorder with incompletely understood pathophysiology, and current modern treatment strategies largely depend on identifying reversible causes, correcting hormonal disturbances, addressing anatomical defects, or resorting to sperm retrieval techniques for assisted reproductive technologies. In the present case, although the hormonal profile was normal, the presence of a Grade II varicocele suggested an obstructive type of azoospermia in which spermatogenesis itself is not profoundly impaired. Considering this, an Āyurvedic approach was adopted using a structured protocol comprising Śodhana, Uttarabasti, and Rasāyana therapies for three

months. This classical regimen focused on correcting Doṣha imbalance, clearing Srotas obstruction, restoring Apāna Vāyu function, and enhancing Śukra Dhātu nourishment. The intervention resulted in a remarkable improvement in semen parameters, with sperm count increasing from 0 to 58 million/ml, demonstrating the potential efficacy of Āyurveda in selected cases of azoospermia. These findings highlight the relevance and clinical promise of integrative Āyurvedic therapies in male infertility and support the need for larger, systematic studies to validate their therapeutic role.

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PATHOLOGIST : Dr. CHANDRASEKHAR G. MBBS, DCP, MD(PATHOLOGY).,

Lab No. : 362 **Sample Received :** 27/08/2023 11:17 AM **Reported :** 27/08/2023 12:05 PM

Name : MR.LAKSHMINARAYANA. 48 Years / M **Ref. By Dr. :** ---

SEMEN

APPEARANCE	:	Greywhite,Opaque
VOLUME	:	1 ML
VISCOSITY	:	Normal
pH	:	Alkaline
LIQUEFACTION	:	20 minuites after collection of sample
TEST FOR FRUCTOSE	:	Positive
SPERM COUNT	:	58 millions / ml
MOTILITY	:	;- -
ACTIVE	:	20 %
SLUGGISH	:	10 %
IMMOTILE	:	70 %
MORPHOLOGY	:	Majority are normal. Atypical forms are within normal limits.
IMPRESSION	:	HYPOASTHENOSPERMIA.

DMC

Ph. : 08392-241717, Cell : 8105515641.

Patient's Name : K T LAXMINARAYANA **Age :** 44 Yrs **Sex :** Male

Consultation Dr. : VASANT SHET MS. MCH [UROLOGY] **Date :** 10-Jan-22

Tests	*Result*	*Range*
SEMEN		
LIQUFACTION TIME	: 15MINS	
VOLUME	: 3.5ML	
CLARITY	: VISCOUS	
MICROSCOPY:	: SMER STUDIED SHOWS PLENTY OF SECONDARY SPERMATOCYTES ALONG WITH PUSCELLS IMP: "AZOSPERMIA" -	
SEROLOGY		
HCV	: NEGATIVE -	