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GRIDHRASI THROUGH AN INTEGRATIVE LENS EXPLORING AYURVEDIC CONCEPTS AND CONTEMPORARY PERSPECTIVES ON SCIATICA

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ABSTRACT

Background: Gridhrasi is an Ayurvedic clinical description involving radiating lower-limb pain, stiffness, and related symptoms. Its resemblance to sciatica has encouraged comparative interpretation, although traditional diagnostic categories and contemporary neurological diagnoses are not interchangeable. **Aim:** To review Ayurvedic concepts, selected management approaches, and clinical evidence relevant to Gridhrasi alongside contemporary perspectives on sciatica. **Methodology:** A focused narrative review used selected classical resources, indexed clinical studies, and public clinical guidance. No systematic search or meta-analysis was undertaken. Review findings: Ayurvedic management considers the symptom pattern and individual patient, with approaches including external therapies, basti, Agnikarma, and siravedha. Selected comparative studies report short-term improvement, but small samples, active-treatment comparisons, and limited follow-up restrict conclusions. Symptom relief does not establish reversal of disc pathology or nerve compression. Modern assessment requires attention to neurological findings and urgent warning symptoms, with treatment directed toward function and recovery. **Conclusion:** A responsible integrative approach combines careful diagnosis and established care with critical

evaluation of any proposed Ayurvedic adjunct. Better controlled studies, standardized interventions, and complete safety reporting are required.

KEYWORDS: Gridhrasi; Sciatica; Ayurveda; Vatavyadhi; Kayachikitsa; Radicular pain; Integrative care; Narrative review.

INTRODUCTION

Gridhrasi is described within the Ayurvedic discussion of Vatavyadhi. Classical features include stiffness, aching or pricking pain, and intermittent twitching along a distribution extending from the gluteal region toward the leg and foot. Additional heaviness, drowsiness, and reduced appetite are described in presentations involving kapha. These descriptions provide a traditional clinical framework rather than a modern anatomical diagnosis.[1]

Sciatica commonly involves pain radiating into a leg and may include tingling, numbness, or weakness. Irritation or compression associated with a disc problem, spinal narrowing, or other conditions can produce such symptoms. The resemblance to Gridhrasi is clinically useful for discussion, but does not establish a one-to-one correspondence between the two categories.[2]

Clinical studies have investigated Ayurvedic procedures for patients identified as having Gridhrasi or sciatica. An open randomized comparison of siravedha and Agnikarma reported symptomatic improvement, illustrating interest in procedural care. Interpretation requires attention to the comparator, diagnostic criteria, follow-up, and distinction between reported relief and demonstrated correction of an underlying lesion.[3]

AIM

To review the Ayurvedic understanding and management of Gridhrasi, examine selected clinical evidence, and relate these findings to contemporary assessment and care of sciatica.

METHODOLOGY

This focused narrative review was prepared using selected sources consulted on 24 October 2026. Searches addressed Gridhrasi, sciatica, Ayurvedic treatment, Agnikarma, siravedha, Katibasti, and clinical guidance. Sources included an online classical resource, PubMed-indexed studies, NHS information, NICE recommendations, and NCCIH safety information. Selection was purposive rather than exhaustive. No registered protocol, systematic screening, formal risk-of-bias scoring, or quantitative pooling was performed. Historical concepts,

clinical observations, and the interpretations proposed in this review were considered separately.

Detailed Review

Ayurvedic clinical description

The classical account emphasizes a sequence of symptoms involving the buttock, lower back, thigh, knee, calf, and foot. Ruk denotes pain, toda a pricking sensation, stambha stiffness, and spandana twitching. The symptom pattern offers a way to describe a patient's experience and movement restriction. It should not be treated as proof of a particular affected nerve root. Descriptions distinguish predominantly vata-associated features from presentations involving vata and kapha. These distinctions have meaning within Ayurvedic assessment. Their proposed relationship to modern clinical subgroups would require direct investigation using reproducible definitions, neurological findings, and patient outcomes.

Traditional causation and pathogenesis

Ayurvedic interpretation considers disturbed vata and the circumstances of the individual patient. Clinical reasoning may distinguish depletion-related presentations from those interpreted through obstruction or associated dosha involvement. These explanatory models can organize traditional therapeutic decisions, but should not be equated automatically with disc degeneration, inflammation, or mechanical compression.

For research, traditional categories need operational definitions. Investigators should state the features used to classify a patient, who performed the assessment, and whether classification was reproducible. Without this information, claims that a particular therapy benefits one Ayurvedic subtype more than another are difficult to evaluate.

Contemporary clinical understanding

Sciatica is a clinical description of radiating leg symptoms, often associated with a lumbar nerve-root problem. Back pain alone is insufficient to establish the diagnosis. The distribution of symptoms, sensory changes, weakness, and examination findings help guide assessment. A shared label can otherwise conceal patients with different causes and different treatment needs.

History and examination should distinguish radiating pain from other sources of lower-limb symptoms. The clinician should consider whether the presentation fits the proposed diagnosis

before selecting a treatment. Using the term Gridhrasi should add useful clinical description rather than replace neurological assessment.

Assessment and warning symptoms

Baseline assessment should record symptom duration, side affected, distribution, severity, walking tolerance, sleep disruption, and limitations in daily activities. A clinician may assess strength, sensation, reflexes, and straight-leg raising where appropriate. Test findings need interpretation in context; a change in one examination measure is not a complete account of recovery.

New urinary retention or loss of bladder or bowel control, numbness around the genitals or anus, and severe or worsening bilateral leg weakness or numbness require emergency assessment. Bilateral sciatica also warrants urgent attention. These presentations should not be managed by waiting for a response to massage, medicines, or a procedural therapy.

Principles of management

A useful care plan defines goals beyond a reduction in pain: improved mobility, restoration of daily activities, and timely recognition of deterioration. Traditional and contemporary assessments can be documented alongside each other while retaining clear responsibility for diagnosis, follow-up, and escalation.

The term integrative should denote coordinated care with explicit goals and monitoring. Combining multiple treatments without documenting their indications can make adverse effects and treatment responses difficult to interpret. Each proposed component should have a stated purpose and a plan for review.

External therapies and supportive measures

Snehana and swedana describe traditional oil-based and fomentation approaches. Katibasti is an external procedure in which oil is retained over the lumbar region. It should be distinguished from basti administered through the rectal route. Similar terminology does not make the procedures equivalent in their application, risks, or evidence.

External warmth or manual contact may be experienced as comforting, but comfort does not demonstrate relief of nerve-root compression. Excessive heat is particularly concerning where sensation is reduced. Any external therapy should be evaluated by its contribution to function and patient experience, with adverse skin effects recorded.

Basti and medicinal approaches

Basti and internal formulations are discussed within Ayurvedic management of vata disorders. Their assessment requires specification of the preparation, route, composition, treatment schedule, and accompanying care. Findings for one formulation or protocol cannot validate every intervention described under the same broad therapeutic term.

The selected evidence does not establish a universally effective basti regimen or herbal prescription for sciatica. No standard dose or procedure is proposed here. Research should distinguish a complete individualized Ayurvedic programme from a single treatment, since these approaches answer different efficacy questions.

Agnikarma and siravedha

Agnikarma uses thermal cautery, while siravedha involves therapeutic venesection. An open randomized parallel-group study by Kumar and colleagues compared these approaches in Gridhrasi. The authors reported improvement in both groups and a greater response with Agnikarma. These findings concern the specific interventions and outcomes studied. An active procedural comparator does not establish benefit over sham treatment, rehabilitation, or usual care. Lack of blinding can also influence subjective outcomes. The reported comparison should therefore be regarded as preliminary rather than evidence that all patients with sciatica should receive either procedure.

Evidence comparing Agnikarma and Katibasti

Bali and colleagues studied 40 patients with Gridhrasi associated with lumbar intervertebral disc prolapse. Agnikarma and Katibasti were compared, with assessments extending to day 22. The authors reported greater improvement in pain and straight-leg raising with Agnikarma. They did not identify radiological changes with either treatment.

This distinction matters: symptomatic improvement and structural improvement are separate outcomes. The study cannot establish reversal of disc prolapse or durable protection against recurrence. Short follow-up also leaves uncertainty about later symptoms, additional treatment, and delayed adverse events.

Rehabilitation and contemporary care

Contemporary guidance emphasizes advice, self-management, and consideration of exercise adapted to the person. Routine imaging in a nonspecialist setting is not recommended for

uncomplicated low-back pain with or without sciatica; specialist imaging should be considered when it is likely to change management. These principles do not remove the need to investigate concerning presentations.

NICE advises against gabapentinoids, other antiepileptics, oral corticosteroids, and benzodiazepines for sciatica, and against opioids for chronic sciatica. Patients already receiving such medicines need clinician-led review rather than abrupt discontinuation. Selected persistent or severe cases may require specialist interventions; the choice depends on symptoms, examination, and relevant findings.

Safety and follow-up

Safety assessment should address both the intervention and the risk of delaying appropriate care. Thermal procedures can injure skin; venesection involves bleeding and infection risks. Rectal procedures require suitable technique and patient selection. The frequency of complications cannot be inferred reliably from a small short-term study.

For medicinal products, identity and manufacturing quality matter. Some Ayurvedic preparations contain potentially harmful levels of lead, mercury, or arsenic. A full medicine and supplement history supports coordinated care. Product quality testing does not, by itself, establish effectiveness for Gridhrasi or sciatica.

Follow-up should record function, neurological change, additional analgesic use, recurrence, adverse events, and patient satisfaction. An apparent reduction in pain should not obscure new weakness or altered bladder function. Treatment goals should be revised if progress is inadequate or the diagnosis becomes uncertain.

DISCUSSION

The comparison between Gridhrasi and sciatica is most useful when it encourages careful description while preserving diagnostic distinctions. Similar symptom distributions support dialogue between frameworks. They do not establish that a traditional subtype corresponds to a specific disc lesion or nerve-root level.

The Agnikarma–Katibasti comparison provides a useful example of the limits of efficacy claims. Its reported symptom improvements occurred without demonstrated radiological change. This supports separating clinical relief from structural recovery, and reinforces the need for longer follow-up and appropriate controls before claiming disease modification.[4]

An integrative model should preserve established assessment and rehabilitation principles. NICE guidance supports individualized management and selective imaging, and identifies important limits on medicine use for sciatica. Any additional Ayurvedic therapy should have a defined role within the care plan and should not delay indicated investigation or specialist referral.[5]

Safety cannot be assumed from traditional use or the description of an intervention as natural. NCCIH notes limited well-designed evidence for many Ayurvedic applications and concerns about toxic metals in some products. Coordination between practitioners and disclosure of all treatments are therefore important when evaluating benefit, harm, and interactions.[6]

Future studies should define both Ayurvedic and contemporary diagnostic criteria, record neurological status, and specify the intervention sufficiently for replication. Concealed random allocation, blinded assessment where feasible, and meaningful comparators would strengthen causal interpretation. Individualized programmes require transparent reporting of how and why treatment was adjusted.

Trials should include pain, disability, walking ability, return to usual activities, quality of life, recurrence, and adverse events. Between-group differences and confidence intervals are more informative than reporting improvement within one group alone. Longer follow-up is necessary to distinguish short-term relief from sustained recovery.

This review is limited by purposive source selection, reliance on selected accessible publications, and absence of systematic appraisal or pooled analysis. It does not establish the full extent of evidence for every Ayurvedic treatment. Its central interpretation is that traditional concepts may inform descriptive and supportive care, while claims of efficacy require intervention-specific clinical evidence.

CONCLUSION

Gridhrasi describes a traditional symptom pattern that overlaps with, but is not identical to, contemporary sciatica. Ayurvedic approaches offer concepts and interventions for further clinical investigation. Selected studies suggest short-term symptomatic benefit from some procedures, but do not establish reversal of disc pathology, permanent cure, or superiority over comprehensive standard care. Responsible integration requires accurate diagnosis, prompt recognition of neurological emergencies, coordinated rehabilitation, product and

procedural safety, and transparent follow-up. Better controlled research is needed to define which interventions benefit which patients and with what risks.

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