

AVABAHUKA (FROZEN SHOULDER): A COMPREHENSIVE LITERARY REVIEW OF ITS AYURVEDIC AND CONTEMPORARY UNDERSTANDING

¹Dr. Sanket U. Shinde*, ²Dr. Mangesh W. Nalkande

¹PG Scholar, Dept. of Kayachikitsa, GAC Nanded, Maharashtra 431601, India.

²PG Guide & Associate Professor, Dept. of Kayachikitsa, GAC Nanded, Maharashtra 431601, India.

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*Corresponding Author

Dr. Sanket U. Shinde

PG Scholar, Dept. of Kayachikitsa, GAC
Nanded, Maharashtra 431601, India.



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ABSTRACT

Avabahuka is a Vata-predominant Amsa Sandhigata Vyadhi described by Acharya Sushruta among the eighty varieties of Vata Vyadhi, characterised by progressive pain, stiffness and restriction of movement at the shoulder joint. Clinically it corresponds closely to 'frozen shoulder' or adhesive capsulitis of contemporary orthopaedics, a condition affecting roughly two to five percent of the general population but rising to ten-to-thirty-six percent among diabetics, in whom it also tends to be more severe, more often bilateral, and more resistant to treatment. Modern management, centred on analgesics, physiotherapy, intra-articular corticosteroids and, in refractory cases, manipulation or arthroscopic capsular release, offers symptomatic relief but is frequently associated with recurrence, incomplete restoration of range of motion, or procedure-related

morbidity. Beyond a conventional literary review of Avabahuka's Nirukti, Nidana, Samprapti, Purvarupa, Rupa, Sadhya-Asadhyata and classically indicated Chikitsa Sutra (Snehana, Swedana, Basti, Nasya, Agnikarma, Raktamokshana and Shamana Aushadhi), this article specifically addresses two areas under-represented in existing Avabahuka reviews: the pathophysiological and classical (Avarana-based) correlation between Avabahuka and Prameha (diabetes mellitus), and a structured synthesis of the sample sizes, interventions and outcome measures reported across published Ayurvedic clinical studies on Avabahuka. The review finds a coherent classical rationale for the clinically observed severity of diabetic

frozen shoulder, and finds that, while every located clinical study reports a favourable direction of effect with no serious adverse events, the evidence base remains limited to small, heterogeneous, largely uncontrolled studies, highlighting a clear need for adequately powered comparative trials using validated composite outcome measures.

KEYWORDS: Avabahuka, Frozen shoulder, Adhesive capsulitis, Vata Vyadhi, Amsa Sandhi, Prameha, Diabetes mellitus, Avarana, Snehana-Swedana, Basti Chikitsa, Evidence synthesis.

1. INTRODUCTION

The shoulder (Amsa Sandhi) is the most mobile joint of the human body, permitting flexion, extension, abduction, adduction, internal and external rotation, and circumduction. This wide range of motion, however, is achieved at the cost of inherent joint laxity, which predisposes the shoulder to a variety of painful and disabling conditions. Among these, frozen shoulder, also termed adhesive capsulitis or periarthritis of the shoulder, is one of the most common causes of shoulder pain and restricted mobility encountered in orthopaedic and physiotherapy practice, with a reported prevalence of two to five percent in the general population and up to twenty percent among individuals with diabetes mellitus.

Ayurveda, as a science of life, has described a strikingly comparable clinical entity under the term Avabahuka. Acharya Sushruta enumerated Avabahuka among the eighty varieties of Vata Vyadhi, while Acharya Vagbhata described it under Nidana Sthana as a condition in which vitiated Vata, upon reaching the Amsa-Moola Pradesha, constricts the Sira of that region and produces loss of movement of the Bahu (arm). Because chronic, unaddressed Vata vitiation with progressive loss of Shleshaka Kapha at the shoulder joint mirrors the fibrosing, capsule-contracting process recognised in adhesive capsulitis, a meaningful clinical correlation exists between these two descriptions separated by more than two millennia.

Despite the availability of numerous modern therapeutic options, the management of frozen shoulder remains unsatisfactory in a considerable proportion of patients, with symptom recurrence, prolonged morbidity, and the invasiveness of procedures such as manipulation under anaesthesia or arthroscopic capsular release being significant concerns. This has renewed interest in traditional systems of medicine, including Ayurveda, as a potentially safer and more holistic alternative. The present article aims to compile and critically review the classical Ayurvedic literature pertaining to Avabahuka and to correlate this understanding

with the contemporary description of frozen shoulder, so as to provide a consolidated reference for clinicians and researchers working in this field.

2. AIM AND METHOD OF REVIEW

This is a literary and conceptual review. Classical Ayurvedic texts, namely the Charaka Samhita, Sushruta Samhita, Ashtanga Hridaya, Ashtanga Samgraha and Madhava Nidana, along with their standard commentaries, were referred to for information regarding the Nirukti, Nidana, Samprapti, Purvarupa, Rupa, Sadhya-Asadhyata and Chikitsa of Avabahuka. Contemporary understanding of frozen shoulder was compiled from standard textbooks of orthopaedics and from peer-reviewed articles indexed in PubMed, Google Scholar and other academic databases. The information gathered from both streams was thereafter analysed and correlated to present an integrated perspective.

3. NIRUKTI (ETYMOLOGICAL AND CONCEPTUAL UNDERSTANDING)

The term Avabahuka is derived from the root 'Bahu' (arm), prefixed by 'Ava', broadly conveying a condition in which the function of the Bahu is diminished or lost. Acharya Vagbhata explains that when vitiated Vata lodges in the Amsa-Moola Pradesha (root of the shoulder), it produces Sira Sankocha (constriction of the vessels/ligamentous structures) of that region, thereby restricting the normal movement of the arm; this state is designated Avabahuka. Acharya Sushruta lists Avabahuka among the eighty Vataja Nanatmaja Vyadhis, though several later compilers, including certain commentators of the Madhava Nidana, discuss it in continuity with Amsashosha, a related but distinct entity characterised by wasting (Shosha) rather than painful restriction. Many contemporary scholars correlate the early, painful, restrictive stage of Avabahuka with the 'freezing' and 'frozen' phases of adhesive capsulitis, while advanced Amsashosha, with muscular wasting, is sometimes correlated with disuse atrophy of the shoulder girdle musculature.

4. NIDANA (ETIOLOGICAL FACTORS)

4.1 Classical Nidana

The general Vata-prakopaka Nidana described in the Samhitas for Vata Vyadhi apply equally to the causation of Avabahuka. These may be grouped as follows.

Aharaja (dietary) causes – habitual intake of Ruksha (dry), Sheeta (cold), Laghu (light) and Katu-Tikta-Kashaya Rasa Pradhana Ahara; irregular and untimely meals (Vishamashana); and excessive fasting (Langhana).

Viharaja (lifestyle) causes – Ati Vyayama (excessive or sudden strenuous exercise involving the shoulder), Ati Maithuna, Ratri Jagarana (habitual loss of sleep), prolonged immobilisation of the upper limb, faulty posture, and sudden Abhighata (trauma) or jerks to the shoulder region.

Manasika (psychological) causes – Chinta (anxiety), Shoka (grief) and Krodha (anger), which are recognised in Ayurveda as independent Vata-vitiating factors and are increasingly acknowledged in modern literature as contributors to chronic musculoskeletal pain through heightened sympathetic tone.

Age-related factors – Vata Dosha is naturally predominant in Vardhakya Avastha (the third stage of life, from approximately the fourth decade onward); the Dhatus, particularly Mamsa and Meda, undergo a natural decline (Kshaya) during this period, rendering the Sandhi more vulnerable to Vata vitiation, which parallels the peak incidence of frozen shoulder between the fourth and sixth decades observed clinically.

4.2 Contemporary Risk Factors

Frozen shoulder is classified as primary (idiopathic), where no clear precipitating cause is identified, or secondary, where it follows a defined event or is associated with a systemic condition. Recognised risk factors include diabetes mellitus (present in up to a third of cases), thyroid dysfunction, prolonged shoulder immobilisation following trauma, surgery or stroke, cardiac disease, Parkinson's disease, and female sex, with peak incidence between forty and sixty years of age.

5. SAMPRAPTI (PATHOGENESIS)

The Samprapti of Avabahuka is best understood as a localisation of generalised Vata vitiation, specifically of Vyana Vata, at the Amsa Pradesha. Nidana Sevana vitiates Vata, which, on account of its Ashukari (rapidly spreading) and Chala (mobile) Guna, obtains Sthana Samshraya at the Amsa Sandhi. There, the aggravated Vata brings about progressive Shoshana (dessication/depletion) of the Shleshaka Kapha that normally lubricates the joint, along with Shoshana of the surrounding Mamsa (muscle), Sira (vessels/ligaments) and Snayu (tendons/fascia) of that region. Loss of the unctuous, lubricating Shleshaka Kapha and the consequent Ruksha (dry) state of the local tissues produces Sankocha (contraction/stiffness) of the Sira-Snayu, which clinically manifests as restriction of shoulder movement (Bahu Prasandana Hataratwam), pain (Shoola) on attempted movement, and stiffness (Stambha).

Chakrapani and other commentators note that when this process is allowed to progress unchecked, further Dhatukshaya (tissue depletion) may ensue, culminating in the more advanced state of Amsashosha, characterised by visible wasting of the shoulder musculature — conceptually analogous to the muscular disuse atrophy that can accompany long-standing, untreated adhesive capsulitis.

Table 1: Samprapti Ghataka (Factors of Pathogenesis) of Avabahuka.

Samprapti Ghataka	Involvement in Avabahuka
Dosha	Vata Pradhana (specifically Vyana Vata), with Kapha Sahaya (Shleshaka Kapha Kshaya)
Dushya	Mamsa, Sira, Snayu, Rakta
Srotas	Mamsavaha, Asthivaha, Sirasnayuvaha
Srotodushti Prakara	Sanga (obstruction), Vimarga Gamana
Udbhavasthana	Pakvashaya (seat of Vata)
Sancharasthana	Sarva Sharira, particularly the Rasa-Rakta Vaha Srotas
Vyaktasthana / Adhishtana	Amsa Sandhi (shoulder joint) / Amsa-Moola Pradesha
Roga Marga	Madhyama (affecting Sandhi, Snayu and Asthi)
Sadhya-Asadhyata	Sadhya in early (Sashoola/Sotha) stage; Kashtasadhya to Yapyia if Shosha/Stambha becomes chronic

6. PURVARUPA AND RUPA (PREMONITORY SIGNS AND CLINICAL FEATURES)

Distinct Purvarupa are not separately elaborated for Avabahuka in the classics, and the disease is generally recognised by its Rupa (manifest signs and symptoms), which include:

Amsa Sandhi Shoola – pain localised to the shoulder joint, typically aggravated on movement, particularly abduction and external rotation.

Amsa Sandhi Stambha – stiffness and restriction of movement of the shoulder joint, most marked on attempted elevation of the arm above the head or reaching behind the back.

Bahu Prasbandana Hataratwam – diminished or lost capacity for normal, spontaneous movement of the arm.

Akunchana-Prasarana Asamarthyam – inability to comfortably flex and extend the arm, with functional limitation of daily activities such as combing hair, dressing, or reaching overhead.

In chronic or neglected cases, Mamsa Kshaya (muscle wasting) around the shoulder girdle may be observed, corresponding to the disuse atrophy of deltoid and periscapular musculature described in long-standing adhesive capsulitis.

7. SADHYA-ASADHYATA (PROGNOSIS)

Classical texts, while not assigning a fixed prognosis specifically to Avabahuka, place it among the Vata Vyadhis affecting Sandhi, Snayu and Asthi, which are generally considered Kashtasadhya (difficult to cure) once chronicity and Dhatukshaya set in, though amenable to Yasya (palliative, long-term control) with sustained Vata-Shamana Chikitsa. Early presentation, with predominant Shoola and Stambha but without significant Shosha, is comparatively Sukhasadhya (easily manageable) and responds well to timely intervention — paralleling the modern observation that frozen shoulder treated during the early 'freezing' stage carries a better prognosis than disease allowed to progress to established capsular fibrosis.

8. CHIKITSA SUTRA (PRINCIPLES AND MODALITIES OF TREATMENT)

The line of treatment for Avabahuka follows the general Vata Vyadhi Chikitsa Sutra described by Acharya Charaka, individualised according to the Dushya involved and the Bala (strength) of the patient. The principal modalities are outlined below.

8.1 Nidana Parivarjana

Avoidance of the causative dietary and lifestyle factors described above forms the first and essential step of management, without which Chikitsa alone rarely provides durable relief.

8.2 Snehana (Oleation)

Both Abhyantara Snehana (internal oleation, with medicated Ghrita or Taila such as Mahanarayana Taila or Dashamoola Taila, when Bala permits) and Bahya Snehana (external Abhyanga with Vata-Shamaka Taila such as Bala Taila, Mahanarayana Taila or Ksheerabala Taila) are advocated to counter the Ruksha Guna of vitiated Vata and to restore unctuousness to the depleted Shleshaka Kapha and surrounding Sira-Snayu.

8.3 Swedana (Sudation)

Snehana is classically followed by Swedana to further liquefy and mobilise the vitiated Dosha. Nadi Sweda (steam fomentation), Patra Pinda Sweda (bolus fomentation with medicated leaves) and Shashtika Shali Pinda Sweda (bolus fomentation with medicated rice) over the Amsa Sandhi are commonly employed, providing local analgesia, improved circulation and softening of periarticular tissues.

8.4 Basti Chikitsa

Basti is regarded as the foremost treatment (Ardha Chikitsa) for all Vata Vyadhis, including those affecting the Sandhi. Anuvasana Basti with Vata-Shamaka Taila, alternated with Niruha/Asthapana Basti prepared with Dashamoola Kwatha or Erandamuladi Kwatha, is indicated to pacify Vata at its Moolasthan (Pakvashaya) and thereby address the systemic component of the disease rather than the local manifestation alone.

8.5 Nasya

Since the shoulder lies within the domain influenced by Urdhvajatrugata Chikitsa, Nasya with Vata-Shamaka Taila (such as Anu Taila) is indicated, particularly as Pratimarsha Nasya for sustained, gentle Vata pacification of the upper body.

8.6 Agnikarma

Agnikarma (therapeutic thermal cauterisation) applied over specific Marma and tender points around the Amsa Sandhi is described as an effective measure for Vata Vyadhi affecting Sandhi, Asthi and Snayu, providing prompt relief from Shoola and Stambha through local counter-stimulation and improved regional circulation.

8.7 Raktamokshana

In cases with a significant Rakta-Avarana or associated Shotha (swelling), Raktamokshana (bloodletting, including Jalaukavacharana) has been suggested by some authorities to relieve local congestion and facilitate resolution of Avarana Janya Vata.

8.8 Shamana Aushadhi (Internal Medications)

Classical Vata-Shamaka and Snayu-Balya formulations commonly employed include Rasnasaptaka Kashaya, Maharasnadi Kashaya, Dashamoola Kashaya, Yogaraja Guggulu, Simhanada Guggulu, Ashwagandha Churna and Ashwagandharishta, administered according to the patient's Agni and Bala.

8.9 Bahya Lepa and Adjunctive Measures

Local application of Vata-Shamaka Lepa, along with graded Shoulder Vyayama (mobilisation exercises) once acute pain subsides, is recommended to prevent Sandhi Sankocha and to restore functional range of motion, conceptually paralleling the graduated physiotherapy protocols used in the thawing phase of frozen shoulder.

9. MODERN CORRELATION: FROZEN SHOULDER (ADHESIVE CAPSULITIS)

Frozen shoulder is defined in orthopaedic literature as a condition of uncertain aetiology characterised by painful restriction of both active and passive shoulder movement, resulting from progressive fibrosis and contracture of the glenohumeral joint capsule. It classically progresses through three overlapping clinical stages.

Freezing (painful) stage – lasting two to nine months, characterised by diffuse, often severe shoulder pain with progressive loss of movement.

Frozen (stiffening/adhesive) stage – lasting four to twelve months, in which pain gradually diminishes but marked stiffness and restriction persist, most notable in external rotation.

Thawing (resolution) stage – lasting five to twenty-six months, during which range of motion gradually improves, though a proportion of patients are left with some residual restriction.

Histopathologically, the condition involves synovial inflammation followed by capsular fibrosis with dense collagen deposition and a reduction in capsular volume, closely mirroring the Ayurvedic description of progressive Shleshaka Kapha Kshaya with Sira-Snayu Sankocha. Conventional management includes NSAIDs and analgesics for pain relief, structured physiotherapy, intra-articular corticosteroid injections, hydrodilatation, and, for refractory cases, manipulation under anaesthesia or arthroscopic capsular release; however, recurrence, incomplete recovery of motion, and procedure-related complications remain recognised limitations of these interventions.

10. AVABAHUKA AND PRAMEHA (DIABETES MELLITUS): AN EMERGING CORRELATION

One clinically important association that is under-discussed in existing Avabahuka literature is its strong relationship with Prameha (Madhumeha/diabetes mellitus). Modern epidemiological data indicate that the prevalence of frozen shoulder among diabetics ranges from roughly ten to thirty-six percent, several-fold higher than the two-to-five percent seen in the general population, and diabetic frozen shoulder is more often bilateral, more resistant to standard treatment, and slower to resolve. This clinical observation deserves closer integration with Ayurvedic Nidana theory than it has so far received.

10.1 Modern Pathophysiological Basis

The accepted explanation is that chronic hyperglycaemia promotes non-enzymatic glycation of collagen within the joint capsule, generating advanced glycation end-products (AGEs) that

increase collagen cross-linking, reduce normal collagen turnover, and impair tissue elasticity. This is compounded by diabetic microangiopathy, which reduces local tissue perfusion, and is part of a broader spectrum of diabetic limited joint mobility disorders that also includes cheiroarthropathy of the hand.

10.2 Ayurvedic Correlation

Prameha is classically described as a Kapha-Medo Pradhana Vyadhi in its earlier (Kaphaja/Pittaja) stages, progressing in its chronic, Dhatukshaya-dominant form (broadly corresponding to Madhumeha) to a state in which Vata becomes increasingly involved. Prameha is understood to produce Medovaha and Mamsavaha Srotodushti with excess, vitiated Kleda (moisture) circulating through the Srotas. When this Kapha-Meda-laden, Srotorodha-prone physiological state coexists with local Vata vitiation at the Amsa Sandhi, the resulting picture is best understood through the Ayurvedic concept of Avarana – obstruction of Vata by an accumulated Dosha (here, Kapha and Meda) that intensifies rather than merely accompanies the Vata vitiation once it does manifest. Avrita Vata is classically recognised as producing more severe, more Kashtasadhya, and slower-resolving Vyadhi than Vata vitiated in isolation, which offers a coherent classical explanation for the clinically observed severity, bilaterality, and treatment-resistance of Avabahuka in Prameha patients.

10.3 Therapeutic Implications

This correlation carries a direct implication for Chikitsa: in a Prameha-associated presentation of Avabahuka, indiscriminate, heavily unctuous Snehana intended purely for Vata-Shamana risks aggravating the underlying Kapha-Meda dushti and worsening glycaemic control, whereas therapy limited only to Prameha Chikitsa (Lekhana, Kapha-Medohara measures) may fail to adequately address the local Vata-driven Stambha and Shoola. A dual-pronged protocol is therefore more appropriate — combining Vata-Kapha Hara Basti and Guggulu-based Shamana formulations (such as Yogaraja Guggulu or Simhanada Guggulu, which are traditionally used in both Vata Vyadhi and Prameha) with comparatively Ruksha (rather than heavily oleaginous) Swedana, together with strict glycaemic control as Nidana Parivarjana. A small number of published reports, including a case series describing repeated Jalaukavacharana (leech application/Raktamokshana) in diabetes-associated frozen shoulder and a comparative trial of Valuka Sveda (sand-pouch fomentation) in diabetic frozen shoulder, lend preliminary support to this differentiated

approach, though controlled comparative data specifically in Prameha-associated Avabahuka remain sparse and represent an important direction for future research.

11. EVIDENCE SYNTHESIS OF PUBLISHED CLINICAL STUDIES ON AVABAHUKA

Unlike purely classical descriptive reviews, this section synthesises the clinical evidence reported in published case studies, case series and small comparative trials on Avabahuka, so as to give an evidence-based complement to the classical Chikitsa Sutra discussed above. The available literature remains dominated by single case reports and small, largely uncontrolled series, but some consistent patterns emerge across the therapies employed.

Study	Design / Sample	Intervention	Key Reported Outcome
Sharma et al., 2020	Single case, n = 1 (47 yr, female, chronic since 6 months)	Bala Taila Snehana, Sarvanga Bashpa Sweda, Patra Pinda Sweda, Anu Taila Nasya, Mahayograj Guggulu, Maharasnadi Kwatha – 2 months	VAS 7→3; abduction 50°→100°; flexion 70°→110°; extension 15°→50°
Marma-therapy retrospective cohort	Cohort, assessed on day 21	Marma therapy (vital-point stimulation)	Statistically significant improvement in VAS, ROM and symptom score ($p<0.0001$); no adverse effects; larger sample recommended by authors
Marma-therapy clinical evaluation	Clinical study, n = 30 (multicentre – CG and Haridwar)	Marma therapy protocol	Consistent improvement in VAS and ROM reported across the cohort
Traumatic Apabahuka case report	Single case, n = 1 (post-traumatic)	Shamana + Shodhana + Patra Pottali Sweda	VAS 7→1; marked pain reduction
Diabetic frozen-shoulder trial (Valuka Sveda)	Pragmatic comparative trial, diabetic patients	Valuka Sveda – Tapa vs. Usma method	Comparative benefit shown between the two fomentation methods in pain and ROM in a diabetic cohort
Leech therapy (Raktamokshana) case series	Case study, diabetes mellitus with frozen shoulder	Repeated Jalaukavacharana	Reported symptomatic improvement in a diabetes-associated presentation

Across these reports, three observations recur consistently: first, virtually all published Ayurvedic evidence on Avabahuka is limited to single case reports or small, uncontrolled series, with sample sizes rarely exceeding thirty patients and no identified randomised controlled trial directly comparing an Ayurvedic protocol with standard conventional care; second, outcome reporting is inconsistent, with VAS and simple goniometric range-of-motion measurement used far more often than validated composite instruments such as SPADI or the Constant-Murley score, limiting cross-study comparability; and third, despite this methodological heterogeneity, the direction of effect is uniformly favourable, with every located study reporting clinically meaningful reductions in pain and worthwhile gains in range of motion, and no serious adverse events reported with any of the modalities used. This consistency across heterogeneous small studies is itself suggestive of a genuine treatment effect, but it falls well short of the standard of evidence needed to inform clinical guidelines, underscoring the research gaps identified in the following discussion.

12. DISCUSSION

Comparison of the two descriptions reveals a coherent conceptual overlap. The Ayurvedic understanding of Avabahuka as a disorder arising from Vyana Vata vitiation causing Shleshaka Kapha Shoshana and consequent Sira-Snayu Sankocha corresponds closely with the modern description of synovitis progressing to capsular fibrosis and contracture. The staged classical management sequence — Snehana and Swedana to counter Vata's Ruksha Guna and mechanically soften periarticular tissue, Basti to address the systemic Vata vitiation at its root rather than merely its local expression, Agnikarma and Raktamokshana for targeted local relief, and Shamana Aushadhi and graded Vyayama for sustained control and functional restoration — maps reasonably well onto the freezing, frozen and thawing stages recognised in modern medicine, suggesting that Ayurvedic Chikitsa is not merely symptomatic but is structured to address the disease at each stage of its natural progression.

A stage-wise, individualised application of these therapies, rather than a uniform protocol, appears most consistent with classical intent: predominance of Shoola in the early stage warrants emphasis on Snehana, Swedana and mild Shamana measures, while established Stambha with minimal inflammation may be more amenable to Agnikarma, intensive Basti Chikitsa and structured Vyayama. This graded approach, together with the comparatively low morbidity of Ayurvedic interventions relative to corticosteroid injection or surgical release, supports further systematic clinical evaluation of Ayurvedic protocols, ideally through

randomised controlled trials with standardised outcome measures such as the Shoulder Pain and Disability Index (SPADI) or Constant-Murley score, allowing direct comparison with conventional care.

13. CONCLUSION

Avabahuka, as described in classical Ayurvedic literature, correlates closely with frozen shoulder/adhesive capsulitis of modern medicine, both in its clinical presentation of progressive shoulder pain and stiffness and in the underlying pathological process of capsular fibrosis following an inflammatory phase. The classical Chikitsa Sutra for Avabahuka, comprising Nidana Parivarjana, Snehana, Swedana, Basti, Nasya, Agnikarma, Raktamokshana and Shamana Aushadhi, offers a rational, stage-appropriate and largely non-invasive therapeutic framework that merits wider clinical application and rigorous scientific validation. Integrating this classical wisdom with contemporary diagnostic and outcome-assessment tools may help establish Ayurvedic management of Avabahuka as an effective, safe, and cost-efficient option, either as a standalone approach or as an adjunct to conventional orthopaedic care.

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