WORLD JOURNAL OF PHARMACEUTICAL RESEARCH
Coden USA: WJPRAP Impact Factor 8.63
Volume 15, Issue 14, 915-920. Case Study ISSN 2277–7105

ROLE OF PANCHAKARMA THERAPEUTICA PPROACHES IN THE MANAGEMENT OF BAHU SOSHA W.S.R TO BRACHIAL AMYOTROPHIC DIPLEGIA(BAD) – A CASE STUDY

Dr. P. Lakshmi Prasanna*[1], Dr. V. Lakshmana Prasad[2]

[1,2]Post Graduate Scholar, Pg Professor, Department of Panchakarma, Sri Venkateswara Ayurvedic College, Ttd, Tirupati, India.

Article Received on 16 June 2026,
Article Revised on 06 July 2026,
Article Published on 16 July 2026

https://doi.org/10.5281/zenodo.21368232

***Corresponding Author**

Dr. P. Lakshmi Prasanna

Post Graduate Scholar, Pg Professor, Department of Panchakarma, Sri Venkateswara Ayurvedic College, Ttd, Tirupati, India.

How to cite this Article: Dr. P. Lakshmi Prasanna*[1], Dr. V. Lakshmana Prasad[2] (2026). Role Of Panchakarma Therapeutica Pproaches In The Management Of Bahu Sosha W.S.R To Brachial Amyotrophic Diplegia(Bad) - A Case Study. World Journal of Pharmaceutical Research, 15(14), 915–920.

ABSTRACT

Bahu sosha is a condition explained by charaka under vataja nanatmaja vikaras . It is characterized by weakness and atrophy of muscles in upper limbs. In modern perspective this can be correlated with Brachial Amyotrophic Diplegia(BAD). It is a slowly progressive focal variant of Motor Neuron Disease, also known as bi-brachial motor neuron disease or Flial Arm Syndrome. The main clinical features include progressive weakness and wasting of muscles in arm, fasiculations and sensory loss in upperlimbs. A global 2022 estimate reports an overall MND prevalence of ~5 cases per 1,00,000, with an incidence of ~1.5 - 2 per 1,00,000 person per year. Case report:- A 45-year-old male patient presenting with the complaints of weakness and heaviness of both upper limbs associated with pricking sensation and muscle wasting predominantly of left shoulder and palm for 2 years, got admitted in male Panchakarma ward at Sri Venkateswara Ayurvedic College and Hospital, Tirupati. The clinical and laboratory features suggested diagnosis of Brachial Amyotrophic Diplegia. Patient was treated with Abhyangam and Nadi swedam for 3 days followed by Shashtika shali pinda swedam for 14 days along with Nasya karma with Karpasasthyadi tailam for 14 days. Moderate improvement was noticed in terms of clinical features like weakness and heaviness which is well reflected in bulk of arms.

INTRODUCTION

Brachial amyotrophic diplegia (BAD), also known as Vulpian–Bernhardt syndrome or flail arm syndrome, is a rare motor neuron disorder considered a regional variant of amyotrophic lateral sclerosis (ALS). It is characterized by progressive, predominantly symmetrical weakness and wasting of the proximal upper limbs, particularly affecting the shoulder girdle and arm muscles, while the lower limbs and bulbar functions remain relatively preserved in the early stages. First described in 1886, BAD accounts for a small proportion of motor neuron disease cases and is distinguished from classic ALS by its slower progression and comparatively longer survival. Although the exact pathogenesis remains unclear in most patients, the condition has been associated with genetic factors such as SOD1 mutations and, rarely, paraneoplastic syndromes. Recognition of this distinct clinical phenotype is important for accurate diagnosis, prognostication, and management.

Brachial Amyotrophic Diplegia (BAD) can be correlated with **Bahu Śoṣa**, a type of **Vata Vyadhi** in Ayurveda. This correlation is based on the characteristic features of progressive weakness, muscle wasting, and loss of function predominantly affecting the upper limbs, which resemble the clinical presentation of Bahu Śoṣa resulting from aggravated Vata. Through yukti pramana a case of BAD was treated with panchakarma.

MATERIALS AND METHODS

Various references have been collected from available ayurvedic text and their commentaries, modern texts and related websites have been searched.

CASE PRESENTATION

A 45-year-old male patient presenting with the complaints of weakness and heaviness of both upper limbs associated with pricking sensation and muscle wasting predominantly of left shoulder and palm for 2 years, got admitted in male Panchakarma ward at Sri Venkateswara Ayurvedic College and Hospital, Tirupati.

Chief complaints

- Patient complaints of progressive weakness of both upper limbs since 2 years
- unable to lift his hands over his head since 2 years
- Also unable to hold objects firmly with left hand followed by right hand since 1 year.
- Wasting of shoulder and arm muscles noted since 1 year
- Difficulty in buttoning, writing, holding pen since 6 months.

• No sensory symptoms involved.

HISTORY OF PRESENT ILLNESS

• Patient was apparently normal 2 years ago. Gradually developed weakness in upper limbs, initially noticed in left arm later involving the right arm.

• Weakness is insidious in onset and progressive in nature. First noticed difficulty in lifting the arm above the head for domestic activities like wearing clothes, carrying weights etc. later developed difficulty in the motor tasks like buttoning, writing, holding objects. Patient's family noticed wasting of shoulder and arm muscles.

• No history of numbness, tingling or sensory loss.

• No history of neck pain, radicular pain or trauma.

• No complaints of difficulty in walking, imbalance, bladder and bowel involvement or lower limb.

• He was then take to a allopathy hospital where they have done investigations like MRI and nerve conduction test on 31/07/2023. later diagnosed as asymmetric progressive bibrachial weakness- motor dominant disease.

Personal history

• No H/o DM, HTN or any other medical / surgical illness & no any other drug sensitivity's in the past.

•Diet : mixed.

Appetite : Regular

Bowel : Once a day, normal

Micturition : 5-6times

Sleep : Disturbed

VITALS

•Pulse : 82 bpm, Regular

• BP : 130/90 mm of Hg

Temperature : 98.4°F

Respiratoryrate : 19/min

SYSTEMIC EXAMINATION

•CVS : S1S2 heard.

•CNS : Conscious, oriented to time, place and person.

•P/A : Soft, No Organomegaly. RS : Bilateral equal air entry, Normal vesicular breath sounds.

INVESTIGATIONS

MRI scan: Usually looks normal.

Nerve conduction study (NCS): Sensory nerves are normal. Motor nerves show reduced strength signals because the motor nerves supplying the arms are weak, but the speed of signals is usually normal.

EMG test: Shows that the nerves supplying the arm muscles are weak and the muscles show signs of weakness and wasting due to long-term nerve damage.

DIAGNOSIS

Brachial Amyotrophic Diplegia (BAD)

THERAPEUTIC FOCUS

BAHIRPARIMARJANA CHIKITSA

Abhyangam and nadi swedam for 3 days followed by shashtika shali pinda swedam for 14 days.

ANTAHPARIMARJANA CHIKITSA

Nasyam with karpasasthyadi tailam for 14 days

OBSERVATIONS AND RESULTS

BEFORE TREATMENT

PARAMETER	RIGHT UPPER LIMB	LEFT UPPER LIMB
POWER	3/5	2/5
BULK – MID ARM	24.5cm	24cm
BULK – MID FOREARM	18cm	17cm
TONE	Flaccid	Flaccid
REFLEXES	diminished	Diminished
SENSORY	normal	normal

AFTER TREATMENT

PARAMETER	RIGHT UPPER LIMB	LEFT UPPER LIMB
POWER	-4/5	3/5
BULK – MID ARM	25cm	25cm
BULK – MID FOREARM	18cm	18.5cm
TONE	Flaccid	Flaccid
REFLEXES	diminished	Diminished
SENSORY	normal	normal

MODE OF ACTION

Sarvanga abhyangam and nadi swedam helps in subsiding vata dosha and imptoves the tone of muscle and compactness of the body.

Shashtika shali pinda sweda has nourishing effect on muscles and soft tissues. It is effective in neuropathies.

Nasyam helps in installation of drug through nasal route .it is effective in pacifying disorders occurring in head and neck region.

DISCUSSION

Brachial Amyotrophic Diplegia (BAD) is a rare motor neuron disease characterized by progressive weakness and wasting of both upper limbs due to anterior horn cell degeneration. In Ayurveda, it can be correlated with Bāhu Śoṣa, a Dhātu-kṣaya janya Vātavyādhi, where depletion of Māṃsa and Majjā dhātus leads to Vāta aggravation. Hence, treatment was planned on the principles of Vyādhiviparīta Chikitsā and Brimhaṇa Chikitsā. Sarvāṅga Abhyanga with Kṣīrabala Taila pacifies Vāta and improves muscle nourishment and tone, while Nāḍi Sveda enhances circulation and relieves stiffness. Śaṣṭika Śāli Piṇḍa Sveda, prepared with Śaṣṭika rice, Bala decoction, and milk, acts as a potent Brimhaṇa therapy, promoting muscle strength and replenishing depleted tissues. Nasya with Kṣīrabala Taila, administered based on the principle “Nāsa hi Śiraso Dvāram,” may exert neuroprotective effects through intranasal drug delivery. The combined Panchakarma interventions helped alleviate Vāta, nourish affected tissues, and improve functional ability in this patient with BAD.

CONCLUSION

BAD diagnosed according to Ayurveda can be treated with ayurvedic principles. The present study shows that BAD can be anaged with satisfactory outcome with Ayurveda-panchakarma proceedures. These findings may prove helpful for conducting further treatment and research work for Brachial amyotrophic diplegia and similar conditions.