WORLD JOURNAL OF PHARMACEUTICAL RESEARCH
Coden USA: WJPRAP Impact Factor 8.63
Volume 15, Issue 21, 1508-1515. Case Study ISSN 2277–7105

A SINGLE CASE STUDY ON THE AYURVEDIC MANAGEMENT OF GRIDHRASI (SCIATICA) THROUGH BASTI CHIKITSA

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Article Received on 05 Oct. 2026,
Article Revised on 25 Oct. 2026,
Article Published on 01 Nov. 2026,

https://doi.org/10.5281/zenodo.23911503

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How to cite this Article: Nirma B.*[1], Priyadarshini D.[2] (2026). A Single Case Study On The Ayurvedic Management Of Gridhrasi (Sciatica) Through Basti Chikitsa. World Journal of Pharmaceutical Research, 15(21), 1508–1515.

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ABSTRACT

Gridhrasi is a Vata-predominant Nanatmaja Vata Vyadhi described in classical Ayurvedic texts, presenting with pain radiating from the lower back to the lower limb, closely correlating with sciatica in contemporary medicine. This case report discusses the management of a 36-year-old male cook presenting with a 3-month history of low back pain radiating to the left lower limb with associated tingling and numbness, significantly restricting his gait and daily activities. The patient was managed with Churna Basti followed by Yoga Basti along with Patra Pinda Sweda for 7 days, and oral Ayurvedic formulations. Following an 8-day inpatient protocol, the patient showed marked symptomatic improvement, with VAS score reducing from 8/10 to 0/10 and SLR becoming negative bilaterally at discharge. This case highlights the efficacy of a combined Basti-based Panchakarma protocol in the management of Gridhrasi.

KEYWORDS: Gridhrasi, Sciatica, Basti Chikitsa, Yoga Basti, Patra Pinda Sweda, Ayurveda.

INTRODUCTION

Gridhrasi is one of the eighty Nanatmaja Vata Vyadhis described by Acharya Charaka, characterized by Ruk (pain), Toda (pricking pain), and Stambha (stiffness) starting from the

Sphik (gluteal region) and extending down to the Kati (lower back), Prushtha, Uru (thigh), Janu (knee), and Pada (foot) along the course of the affected limb.[1,2] Clinically, this presentation closely corresponds to sciatica, most commonly caused by lumbar disc pathology, piriformis syndrome, or degenerative spinal changes in contemporary medical understanding.[3] Sciatica affects a significant proportion of the adult population (reported prevalence ranging from 1.2% to 43%, depending on the definition used)[4] and often results in considerable functional disability, particularly in individuals engaged in occupations involving prolonged standing, bending, or heavy lifting.

Contemporary management largely relies on analgesics, muscle relaxants, physiotherapy, and in refractory cases, surgical intervention — approaches that provide symptomatic relief but are often accompanied by adverse effects with prolonged use, or carry the risks associated with invasive procedures.[5] Ayurveda offers Basti Chikitsa as the principal line of management for Vata Vyadhis, as Basti is regarded as Ardha Chikitsa (half of all treatment) for disorders of Vata Dosha.[1] This case report presents the successful management of an acute-on-chronic presentation of Gridhrasi using a combination of Churna Basti, Yoga Basti, and Patra Pinda Sweda.

In the classical texts, two types of Gridhrasi are described: Vataja, characterised by Ruk, Toda, Stambha and Spandana, and Vata-Kaphaja, in which Tandra, Gaurava and Arochaka accompany the pain.[1] Acharya Vagbhata highlights the inability to raise the leg (Sakthyutkshepa Nigrahana) as the cardinal feature.[6,7] In contemporary terms, the commonest cause of sciatica is lumbar disc herniation with compression or chemical irritation of the L4 to S1 nerve roots, often aggravated by occupational strain, obesity and metabolic factors.[3]

Because the course of Gridhrasi is often chronic and relapsing, and because the pharmacological options for radicular pain are limited by adverse effects, there is a need for documented, protocol-based Ayurvedic management. This report describes the clinical course, imaging correlation and outcome of one such patient treated with a short inpatient Basti-based protocol.

CASE PRESENTATION

Patient Information: A 36 years, male, occupation — cook, resident of Mandya district, Karnataka.

Chief Complaint: Pain in the lower back radiating to the left lower limb, associated with tingling sensation and numbness, of 3 months' duration.

History of Present Illness: The patient was apparently healthy 3 months prior to presentation, when he suddenly developed pain in the lower back radiating to the left lower limb along with associated tingling and numbness. He took modern medications but did not obtain adequate relief, following which he presented to our hospital for further management.

Past History: History of habitual heavy weight lifting.

Family History: Not significant.

Ashtavidha Pariksha

- Nadi : 78/min
- Mala : Once a day
- Mutra : 3–4 times a day
- Jihwa : Alipta
- Shabda, Sparsha, Drik : Prakruta
- Akruti : Sthula (obese)

General and Systemic Examination

Vitals were within normal limits. The patient was conscious and well-oriented.

- CNS – Higher mental functions intact, conscious and oriented
- CVS – S1S2 heard
- RS – Normal vesicular breath sounds
- P/A – Soft, non-tender

Local Examination (Musculoskeletal)

- Gait – Antalgic; patient required support to stand and walk
- SLR (Straight Leg Raise) – Negative on right; Positive at 10° on left
- Bragard's test – Positive on left
- Bowstring test – Positive on left
- Heel walk, toe walk, and coin-pick test – Not possible, due to inability to stand/walk without support
- Spine – Tenderness present; straightening of lumbar lordotic curvature noted

Investigations

- MRI of the whole spine (T2 sagittal screening, 17/04/2026).
  - Loss of normal cervical lordosis.
  - C3-4 to C6-7: broad-based central herniations causing variable impression on the thecal sac and adjacent nerve roots.
  - Multilevel dorsal centric herniations causing minimal impression on the thecal sac.
  - L2-3: bilateral shallow foraminal herniation causing minimal impression on the thecal sac and exiting bilateral L2 nerve roots.
  - L3-4: diffuse disc herniation extending into both neural foraminae, causing minimal impression on the thecal sac and adjacent nerve roots; mild ligamentum flavum / facetal hypertrophy.
  - L4-5: diffuse disc herniation extending into both neural foraminae, causing moderate impression on the thecal sac and adjacent nerve roots; mild ligamentum flavum / facetal hypertrophy.
  - L5-S1: diffuse disc herniation extending into both neural foraminae, causing minimal impression on the thecal sac and adjacent nerve roots; mild ligamentum flavum / facetal hypertrophy.

Diagnosis

- Ayurvedic diagnosis: Gridhrasi
- Contemporary correlation: Sciatica, likely secondary to multilevel lumbar disc herniation (L2-3 to L5-S1) with neural foraminal extension, most significant at L4-5, as seen on MRI.

Materials and Methods (Treatment Protocol)

The patient was admitted and managed on an inpatient basis from 6/7/2026 to 14/7/2026 (8 days) with the following combined Basti-based protocol.

Basti Karma

- **Day 1–3:** Churna Basti — Rasna, Shatapushpa, Saindhava Lavana, Vaishvanara Churna, Nimbu Swarasa, and Ushna Jala.
- **Subsequent days:** Yoga Basti pattern —
- Anuvasana Basti with Guggulu Tiktaka Ghrita
- Asthapana (Niruha) Basti with Rasna Erandadi Kwatha

Shamana Aushadhi (Oral Medications)

- Simhanada Guggulu
- Triphala Churna – 5g, at bedtime
- Rasna Saptaka Kwatha tablets
- Dolosal MR
- Nuro XT

Bahya Chikitsa (External Therapy)

- Patra Pinda Sweda – administered daily for 7 days, concurrent with Basti Karma

OBSERVATION AND RESULTS

The patient was assessed at the time of admission and at discharge using VAS (Visual Analogue Scale) for pain and SLR test for nerve root tension.

Parameter	On Admission (6/7/2026)	On Discharge (14/7/2026)
VAS score	8/10	0/10
SLR (Straight Leg Raise)	Negative (R), Positive at 10° (L)	Negative bilaterally
Gait	Antalgic; needed support to stand/walk	normal
Heel walk / Toe walk / Coin-pick test	Not possible	possible

The patient reported progressive reduction in pain and improvement in mobility over the course of the 8-day treatment protocol. By the time of discharge, he was ambulant, pain-free, and SLR had become negative bilaterally.

DISCUSSION

Gridhrasi arises predominantly due to vitiation of Vata Dosha, with Kapha Dosha often contributing to the associated Stambha and heaviness, as suggested by this patient's Sthula Akruti and history of heavy weight lifting — a Vata-Kapha-aggravating factor as well as a probable precipitating cause for lumbar strain and disc-related pathology.

Probable Samprapti (pathogenesis) in this case: Habitual heavy weight lifting and strain of the Kati Pradesha acted as Vata-prakopaka Nidana, while the Sthula Akruti pointed to a Kapha and Meda component. Aggravated Vata, lodging in the Kati-Sphik region (Khavaigunya), produced Ruk, Toda and Stambha along the course of the Kandara of the left lower limb, and the associated Kapha produced heaviness and the restriction of movement.

The MRI finding of multilevel disc herniation with foraminal extension is the structural counterpart of this Samprapti.

Basti is considered the foremost treatment for Vata Vyadhi, as it acts directly on Pakvashaya, the seat of Vata, and corrects its vitiation systemically.[1] Churna Basti, administered in the initial days, was likely intended to provide prompt amaharana, shulaharana and Anulomana, given its Ushna, Tikshna and Vata-Kaphahara ingredients including Rasna and Vaishvanara Churna. The subsequent Yoga Basti protocol — alternating Anuvasana with Guggulu Tiktaka Ghrita (a formulation classically indicated in Vata-Kaphaja vyadhis) with Asthapana using Rasna Erandadi Kwatha (a Vata-hara, Shoolahara kwatha) — provided sustained Brumhana and Shodhana benefit to counter the chronicity of the complaint.

From a contemporary perspective, the effects of Basti are explained by its action on the colon, where the drug is absorbed locally and may influence the enteric nervous system, gut-associated immune and inflammatory signalling, and the gut-brain axis. Mechanical stimulation of the lumbosacral region by the Sneha and Kwatha may further modulate pain pathways. These explanations are hypotheses, and this single case cannot test them; they are offered to guide future research.

Patra Pinda Sweda, administered concurrently, would have contributed local Vata-Kapha Shamana, Vedana Sthapana (analgesic), and Stambha-hara (anti-stiffness) effects through Sthanika Sneha-Sweda, aiding muscular relaxation and improved local circulation. The oral formulations — Simhanada Guggulu and Triphala Churna — supported systemic Vata-anulomana and mild Kapha-Medohara action.

The drastic improvement in VAS (8 to 0) and normalization of SLR over 8 days supports the efficacy of this multi-modal Basti-centered protocol. MRI of the spine showed multilevel lumbar disc herniations with extension into the neural foraminae and nerve root impression, most pronounced (moderate) at L4-5, with mild ligamentum flavum and facetal hypertrophy at L3-4 to L5-S1. This provides a structural basis for the patient's radiating left lower limb symptoms and positive nerve root tension signs, and the habitual heavy weight lifting is a plausible contributing factor. Notably, symptomatic relief occurred despite the persistence of structural pathology at the time of imaging. Favourable outcomes with Basti-based regimens have also been reported in Gridhrasi associated with lumbar disc disease.[7,8]

CONCLUSION

This case demonstrates that a combined Panchakarma protocol comprising Churna Basti followed by Yoga Basti (with Guggulu Tiktaka Ghrita Anuvasana and Rasna Erandadi Kwatha Asthapana), supported by Patra Pinda Sweda and oral Shamana Aushadhi, can achieve significant and rapid relief of pain and functional disability in patients presenting with Gridhrasi. Further studies with larger sample sizes are warranted to validate the efficacy and reproducibility of this protocol in the management of Gridhrasi/sciatica.

The MRI findings of multilevel lumbar disc herniation with nerve root impression, together with the clinical picture, support the diagnosis of Gridhrasi due to lumbar disc pathology in this patient. Early symptomatic and functional improvement was observed within 8 days.

ACKNOWLEDGEMENTS

The authors thank the Department of Panchakarma, Government Ayurveda Medical College, Bengaluru, for the support extended in the management of this case.

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