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# PANCHAKARMA IN THE MANAGEMENT OF GRAHANI ROGA: A NARRATIVE REVIEW OF CLINICAL EVIDENCE

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## ABSTRACT

Grahani Roga is described in Ayurveda in relation to impaired Agni and altered gastrointestinal function. Some clinical presentations overlap with irritable bowel syndrome (IBS), although the diagnostic constructs are not synonymous. This narrative review discusses published clinical reports on Panchakarma interventions used for Grahani Roga and clinically correlated IBS, with particular attention to Basti procedures. The available literature includes small clinical studies, comparative investigations and case reports. Takra Basti and Erandamooladi Niruha Basti have been associated with symptomatic improvement in small studies, while Piccha Basti reports describe improvements in bowel frequency, mucus, bloating and, in some recent cases, validated IBS outcome scores. Evidence for Vamana is limited, and no efficacy conclusion can be drawn from a registered Virechana trial without an available outcome report. Interpretation is constrained by small samples, heterogeneous diagnostic criteria and treatment protocols, concomitant therapies, and inconsistent outcome reporting. Reports involving inflammatory bowel disease or ulcerative colitis are considered separately from functional IBS/Grahani evidence. Current findings are hypothesis-generating rather than definitive; well-designed prospective studies with

standardized interventions, validated outcomes, systematic safety reporting and longer follow-up are needed.

**KEYWORDS:** Basti, Grahani Roga, Irritable bowel syndrome, Panchakarma, Piccha Basti, Takra Basti.

## INTRODUCTION

Grahani Roga is described in Ayurveda in close functional relationship with Agni and is associated with impaired digestion and altered bowel function. Contemporary presentations may overlap with irritable bowel syndrome (IBS), but Ayurvedic and contemporary diagnostic constructs should be reported separately.

Panchakarma literature is dominated by Basti, particularly Takra Basti, Erandamooladi Niruha Basti, and Piccha Basti, whereas evidence for Vamana and Virechana is sparse. Multimodal treatment is common, limiting attribution to an individual procedure. This review therefore evaluated the clinical evidence, outcomes, and principal limitations of Panchakarma interventions used for Grahani Roga and clinically correlated IBS.[1-10]

## SCOPE OF THIS NARRATIVE REVIEW

This article provides a narrative overview of clinical literature concerning Panchakarma in Grahani Roga and clinically correlated IBS. It discusses direct Panchakarma reports alongside relevant contextual Ayurvedic evidence, while keeping organic inflammatory bowel disease distinct from functional IBS/Grahani. The literature summarized here is not presented as an exhaustive or reproducible systematic search, and the discussion should be interpreted in light of the limitations of the available publications.

**Interpretation of the evidence:** The clinical reports differ in design, sample size, diagnostic criteria, intervention details, concomitant treatment and outcomes. Case reports are particularly limited for causal inference because they lack controls and often describe multimodal treatment. The studies are therefore discussed descriptively; quantitative pooling would not be appropriate for this heterogeneous body of evidence.

**Table 1: Key clinical and contextual evidence.**

| Year | Study | Design/sample | Intervention | Principal finding |
|---|---|---|---|---|
| 2010 | Joshi and Deshmukh | Comparative clinical record; n=35 | Vamana + Palashadi Yoga vs Palashadi Yoga | Greater benefit reported with Vamana.[6] |
| 2017 | Mallikarjun and Channabasavanna | Clinical study; n=15 | Erandamooladi Niruha Basti + Changeryadi Ghrita Anuvasana | Significant symptomatic improvement.[7] |
| 2017 | Mallikarjun et al. | Clinical study; n=15 | Takra Basti + Changeryadi Ghrita Anuvasana | Significant symptomatic improvement.[8] |
| 2019 | Nakka et al. | Case report | Piccha Basti/Yapana Basti | Improvement in bowel frequency, mucus, and bloating.[9] |
| 2020 | Joshi et al. | Case report | Basti + Sirodhara + oral medicines | Improvement in Grahani /IBS symptoms after 45 days.[10] |
| 2023 | Markunda et al. | Comparative study; n=30 | Takra Basti vs Erandamooladi Niruha Basti | Overall improvement 78.96% vs 56.72%; benefit persisted at follow-up.[11] |
| 2025 | Jamra et al. | Case report | Piccha Basti + Shamana therapy | Improvement in symptom scores in a severe IBS/Grahani case.[12] |
| 2026 | Chandil et al. | Case report | Piccha Basti within multimodal Ayurvedic therapy | Improvement in IBS-U symptoms and contemporary outcome measures.[15] |
| 2026 | Mungale and Thatere | Case report | Ayurvedic multimodal management including Panchakarma | Reported improvement in IBS/Grahani symptoms; attribution to an individual procedure remains uncertain.[16] |
| 2011 | Patel et al. | Clinical study; n=32 children (3–12 years) | Devadarvyadi-Vati vs Bhunimbadi-Vati | Contextual non-Panchakarma evidence; marked improvement in 21.43% and moderate improvement in 57.14%.[19] |
| 2024 | Verma et al. | Case report | Ayurvedic Shamana/Shodhana management | Organic inflammatory bowel disease; retained as |

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|---|---|---|---|---|
| | | | | contextual evidence, not functional IBS efficacy evidence.[13] |
| 2025 | Sharma et al. | Case report | Kalpit Piccha Basti + Lajjalu Churna | Ulcerative-colitis case; retained as contextual organic-disease evidence.[14] |
| 2024 | Yadahalli et al. | Case report | Takra Basti followed by Piccha Basti + Shirodhara + Shamana | Ulcerative-colitis case with reduced stool frequency and improved mucus, pain, and tenesmus; contextual evidence only.[24] |

## CLINICAL EVIDENCE

### Characteristics of Clinical Evidence

The literature consisted of comparative clinical investigations, randomized controlled trials, case reports and relevant ayurvedic studies. The direct Panchakarma evidence was concentrated on Basti whereas Vamana and Virechana were fewer reports. Clinical populations were heterogeneous, with some studies employing Ayurvedic diagnostic categories (e.g., Vataja or Shlaishmika Grahani) and more recent findings using Rome IV IBS subtypes. This variability matters for comparison of therapy effectiveness, as the same Panchakarma procedure may be adopted for different clinical phenotypes.

The procedure reporting was more extensive in the Basti trials than in some publications of other therapies. The most typical Purva Karma in Takra Basti protocols were Abhyanga and Swedana, followed by Niruha Basti with Takra based formulations and Anuvasana components. Likewise, in the main comparison research, Erandamooladi Niruha Basti was given with Changeryadi Ghrita Anuvasana. The formulations for Piccha Basti vary throughout sources, including mixtures of Shalmali, Ghrita, Madhu, Dugdha, and herbal Kalka. This heterogeneity implies that Basti cannot be regarded as one single standardized intervention.

The assessment of outcomes also altered throughout time. Previous studies have generally used symptom grades for stomach discomfort, frequency of bowel movements, consistency of stools, mucus, and hunger. Recent reports have included the Irritable Bowel Syndrome Severity Scoring System (IBS-SSS), Irritable Bowel Syndrome Quality of Life measure (IBS-QoL), IBS Adequate Relief (IBS-AR), Bristol Stool Form, and stool frequency. This shift

increases interpretability and should be considered in future clinical studies. Procedure characteristics are summarized in Table 2.

**Table 2: Panchakarma procedure characteristics.**

| Procedure | Clinical evidence | Reported context | Interpretation |
|---|---|---|---|
| **Takra Basti** | Small clinical studies and comparative trial | Often with Changeryadi Ghrita Anuvasana and Yoga Basti schedule | Most informative direct comparative evidence.[8,11] |
| **Erandamooladi Niruha Basti** | Small clinical studies and comparative trial | With Changeryadi Ghrita Anuvasana | Improvement reported, but evidence is limited.[7,11] |
| **Piccha Basti** | Case reports | Yapana/Kala Basti patterns; formulations vary | Promising phenotype-specific signal in functional IBS/Grahani reports; organic IBD cases remain contextual.[9,12,15,16] |
| **Vamana** | Early comparative clinical record | Palashadi Yoga with Vamana | Insufficient contemporary evidence.[6] |
| **Virechana** | Registered randomized trial; no published outcome report identified | Virechana followed by Shamana therapy | No efficacy conclusion can be drawn from the registered trial alone.[17] |

**Direct Panchakarma Evidence**

Direct Panchakarma evidence was concentrated on Basti. The most informative comparative evidence was a 2023 study of 30 patients comparing Takra Basti with Erandamooladi Niruha Basti; both groups improved, while the reported overall improvement was 78.96% with Takra Basti and 56.72% with Erandamooladi Niruha Basti. The study also reported better persistence of benefit with Takra Basti during follow-up.[11]

A 2017 clinical study of 15 patients evaluated Takra Basti with Changeryadi Ghrita Anuvasana in a Yoga Basti schedule and reported significant improvement across assessed Grahani /IBS parameters. A separate 2017 study evaluated Erandamooladi Niruha Basti with Changeryadi Ghrita Anuvasana and likewise reported symptomatic improvement. These findings provide supportive clinical signals but are constrained by small samples and the absence of robust controls.[7,8]

Piccha Basti has been reported mainly through case-based evidence. A 2019 report described

a 14-day Yapana Basti regimen using Shalmali, Krishna Tila, Ghrita, Madhu, and Dugdha, with improvement in bowel frequency, mucus, and abdominal bloating. A 2025 case report and another recent Grahani case report described further symptomatic improvement with Ayurvedic management, although multimodal treatment limits attribution to Basti alone.[9,12-14]

More recent reports have used contemporary IBS outcome measures. A 2026 case of Rome IV-defined IBS-U treated with Piccha Basti and multimodal Ayurvedic therapy reported a reduction in IBS-SSS from 350 to 50. Another 2026 case of Rome IV-confirmed IBS-D reported a reduction in IBS-SSS from 320 to 70, improvement in IBS-QoL from 50 to 86, and a reduction in stool frequency from 4–5 to 1–2 stools per day. These findings are clinically interesting but cannot establish independent efficacy because Shamana therapy and other components were administered concurrently.[15,16]

Evidence for Vamana is limited to an early comparative clinical record involving 35 patients with Shlaishmika Grahani, in which Palashadi Yoga with Vamana was compared with Palashadi Yoga alone and greater benefit was reported in the Vamana group.[6] For Virechana, a randomized clinical study is registered in the Clinical Trials Registry–India, but no published outcome report was identified in the present audit; it therefore cannot be used to support an efficacy claim.[17]

Non-Panchakarma studies provide useful context. A clinical study of an indigenous herbal compound, a pediatric comparative study of Devadarvyadi-Vati, a randomized whole-system Ayurveda trial, and a 2026 case report all reported improvement in Grahani /IBS-related outcomes, but these studies do not demonstrate the independent effect of Panchakarma. Patel et al. evaluated Devadarvyadi-Vati in 32 children, while Sahu et al. reported an integrative Ayurvedic case using Kapithadi Peya and Takrarista.[18-21]

The 2018 report describing Ayurvedic management with lifestyle modification provides additional contextual evidence, but its non-Panchakarma design means it cannot be used to estimate the independent effect of Panchakarma.[22]

Evidence involving IBD should remain separate. A 2025 case report described improvement in fecal calprotectin and fecal elastase following Basti-based treatment in a patient with inflammatory bowel disease and sarcoidosis. A 2024 ulcerative-colitis case report described

Takra Basti followed by Piccha Basti, together with Shirodhara and Shamana medicines, with reduction in stool frequency and improvement in mucus, abdominal pain, and tenesmus.

The 2024 and 2025 reports involved inflammatory bowel disease rather than functional IBS. These reports are important for hypothesis generation but should not be pooled with functional IBS/Grahani evidence. They also emphasize the importance of appropriate contemporary diagnostic assessment when blood in stool, weight loss, inflammatory markers, or other red flags are present.[13,14,23,24] The principal quantitative and outcome findings are summarized in Table 3.

**Table 3: Outcomes reported in recent clinical evidence.**

| Outcome | Examples of reported findings |
|---|---|
| IBS-SSS | 350→50 in one IBS-U case; 320→70 in one IBS-D case.[15,16] |
| IBS-QoL | 50→86 in a 2026 IBS-D case.[16] |
| Stool frequency | 4–5/day→1–2/day in a 2026 IBS-D case.[16] |
| Overall symptom response | 78.96% with Takra Basti vs 56.72% with Erandamooladi Niruha Basti in a 2023 comparative study.[11] |
| Bowel symptoms | Improvements in frequency, stool consistency, mucus, abdominal pain, and bloating were reported across direct functional Grahani /IBS studies.[7-9,11,12,15,16] |
| Organic inflammatory disease | Case reports described reduced stool frequency and improved mucus, abdominal pain, and tenesmus; one case also reported improved fecal calprotectin and fecal elastase. These findings are contextual and should not be pooled with functional IBS/Grahani evidence.[13,23,24] |

**Evidence Appraisal**

The principal comparative evidence was judged low certainty because of the small sample, absence of reported blinding, and shared concomitant treatment. Single-arm clinical evidence was also low certainty because of the lack of robust comparators. Piccha Basti evidence was very low certainty because it was predominantly case-based and multimodal. Evidence for Vamana was low to very low certainty because of limited reporting, while the Virechana evidence remained uncertain because a registered trial did not have a published outcome report identified in the present audit. Reports involving inflammatory bowel disease or ulcerative colitis were retained separately and were not used to estimate efficacy for functional irritable bowel syndrome or Grahani Roga.

**Table 4: Evidence appraisal.**

| Evidence category | Main strength | Principal limitation | Overall certainty |
|---|---|---|---|
| Takra Basti/Erandamooladi comparative evidence | Direct comparison and follow-up | Small sample; no blinding; shared Anuvasana | Low |
| Takra Basti single-arm evidence | Procedure-specific clinical data | No robust comparator | Low |
| Piccha Basti | Detailed case phenotyping; some validated outcomes | Case-based and multimodal | Very low |
| Vamana | Direct comparative clinical record | Limited reporting | Low/very low |
| Virechana | Comparative design reported | Limited reporting and replication | Low/uncertain |
| IBD/Grahani case reports | Some objective clinical or laboratory measures | No comparator; organic disease; multimodal treatment.[13,14,23,24] | Very low |

## CLINICAL OUTCOMES AND COMPARATIVE FINDINGS

The most consistently reported improvements were reduction in abnormal stool frequency, improvement in stool consistency, reduction in abdominal discomfort and bloating, and reduction in mucus or incomplete evacuation. In some cases, appetite, body weight, and quality of life also improved. However, outcome definitions and scoring systems were not uniform, and several studies did not use validated contemporary IBS instruments.

The 2023 Takra Basti versus Erandamooladi Niruha Basti study provides the clearest direct comparative finding. Both groups showed improvement, but the reported overall improvement was greater with Takra Basti. Because each group contained only 15 patients, blinding was not reported, and both groups received the same Anuvasana component, the finding should be interpreted as evidence of a promising comparative signal rather than definitive superiority.[11]

The Takra Basti single-arm study and the Erandamooladi Niruha Basti study are useful for understanding procedure-specific clinical practice, but their uncontrolled design prevents separation of treatment effects from regression to the mean, dietary changes, concomitant therapy, and natural variation in symptoms.[7,8]

Piccha Basti deserves further study because recent reports provide a plausible phenotype-specific rationale and increasingly objective outcomes. The 2019 report emphasized mucus,

bowel frequency, and bloating; later reports provided additional case-based evidence; and the 2026 reports incorporated Rome IV classification and IBS-SSS or IBS-QoL. The progression from symptom description to validated outcomes is encouraging, but the evidence remains based on individual cases and multimodal treatment.[9,12,15,16]

Validated outcomes should be central to future studies. IBS-AR or another prespecified global response measure can capture overall response; Bristol Stool Form and stool frequency characterize bowel phenotype; and IBS-QoL captures patient-centered benefit. These measures have been used in an Ayurveda IBS trial and are supported by relevant outcome-measure literature. Where inflammatory disease is suspected or established, objective measures such as fecal calprotectin and appropriate endoscopic assessment should be used rather than relying solely on symptom improvement.[20,25-27] Evidence involving fecal calprotectin in this manuscript comes from an individual IBD case report and should be interpreted cautiously.[23]

## DISCUSSION

The available clinical literature suggests a consistent but preliminary signal for improvement in selected Grahani /IBS phenotypes following Panchakarma, with Basti accounting for most of the direct evidence. Takra Basti is currently the strongest comparative signal. But the evidence is not strong enough to prove its superiority over other Basti processes. The comparative study for 2023 is informative as it had a comparator and follow-up however the sample was limited and interventions were common with Changeryadi Ghrita Anuvasana.[11]

Piccha Basti is clinically promising for diarrhea- or mucus-predominant presentations because recent reports demonstrated bowel frequency, stool shape, and validated IBS results. But the evidence is almost all case-based. The improvement in individual patients may be the result of combination of Basti, Shamana medications, dietary adjustment, counseling and other procedures. Literature thus supports clinical plausibility rather than definite causal inference.[9,12-16]

A key strength of recent studies is the increasing use of current IBS criteria and verified outcome measures. The 2023 whole-system Ayurveda experiment reveals that IBS-SSS, IBS-AR, Bristol Stool Form, complete spontaneous bowel movement (CSBM) and IBS-QoL can be used in Ayurveda clinical research. Future Panchakarma trials should include such measurements along with well-characterized Ayurvedic diagnostic features so that both

therapeutic traditions may be represented without confounding their diagnostic architecture.[20,25,26]

Safety reporting is too limited to conclude that these procedures are generally safe; the small size of most studies also restricts detection of uncommon adverse events. Prospective trials should report a priori definitions of adverse events, criteria for cessation of therapy, and duration of follow-up. They should provide sufficient details about Basti composition, volume, preparation, administration sequence, Purva Karma, duration, practitioner expertise for reproducibility.

The primary priority of research is a multi-center, prospectively recorded randomized comparison of standardized Takra Basti, Piccha Basti and Erandamooladi Niruha Basti in well-characterized IBS phenotypes. Trials should report Ayurvedic diagnostic criteria separately, stratify by IBS with diarrhea (IBS-D), IBS with constipation (IBS-C), IBS with mixed bowel habits (IBS-M), and IBS unclassified (IBS-U), and use Rome IV criteria where the current diagnosis is IBS, report IBS-SSS, IBS-AR or other prespecified global response measure, Bristol Stool Form, stool frequency, and IBS-QoL as prespecified outcomes. Durability and relapse require longer follow-up.[1,7-9,11,25,26]

## LIMITATIONS

Literature is limited by a predominance of small clinical studies and case reports. Diagnostic criteria, Basti formulations, treatment regimens and outcome measures vary across publications, restricting direct comparison. Multimodal treatment makes it difficult to attribute reported changes to an individual Panchakarma procedure. Publication bias and incomplete adverse-event reporting are also possible. The discussion is based on accessible published reports and should not be interpreted as an exhaustive systematic evidence inventory.

## CONCLUSIONS AND FUTURE WORK

Panchakarma, particularly Basti, has been associated with symptom improvement in selected reports of Grahani Roga and clinically correlated IBS; however, the available evidence is limited and does not establish efficacy. Takra Basti offers the most useful comparative evidence. Piccha Basti has an increasing case-based signal for diarrhea- and mucus-predominant presentations. Vamana and Virechana need stronger clinical examination. Future research should integrate rigorous current trial methodology with specific Ayurvedic

phenotyping and standardized reporting of Panchakarma procedures and outcomes.

**Implications for the Clinic**

In clinical practice, Panchakarma should be customized. Patients presenting with chronic diarrhea, constipation, stomach discomfort or altered bowel habits should be subjected to adequate clinical screening to rule out the other diseases before labeling as functional IBS or Grahani Roga. Look for organic disease for alarm symptoms such as gastrointestinal bleeding, unexplained weight loss, anemia, prolonged fever or abnormal inflammatory studies. The IBD reports in the literature show why this distinction is important.[23,24]

Selection of Basti should be based on the patient's Dosha predominance, Agni, Ama, bowel pattern, strength and chronicity in an Ayurvedic context rather than following the same regimen to all individuals. From the point of view of modern research, however, the tailored treatment should be defined in sufficient detail to allow for reproducibility. Thus, future publications should include the rationale for choosing a particular Basti, its formulation and volume, the sequence of Purva Karma and Paschat Karma, concomitant drugs, diet and lifestyle advice, and the experience of the treating physician.

Takra Basti has been examined in a single-arm study and also in a comparison study. Hence, it can be considered as a promising procedure for further comparative research. Piccha Basti is also a reasonable option for studies in diarrhea or mucus-predominant phenotypes. Neither of them should at present be proposed as being absolutely superior to other Panchakarma treatments.[7-9,11]

**Directions for Future Research**

Future trials should be multicenter, prospectively recorded and well powered. Direct comparison of Takra Basti, Piccha Basti, and Erandamooladi Niruha Basti would be especially relevant if subjects were stratified by IBS phenotype and the Ayurvedic phenotype reported separately.[1,7-9,11,25,26]

When considering IBS as the current diagnosis, use of Rome IV criteria and documentation of Ayurvedic diagnostic criteria should be followed. Primary outcomes should include IBS-SSS and a pre-specified global response measure, with Bristol Stool Form and stool frequency for bowel phenotype and IBS-QoL for patient-centered benefit. Secondary outcomes can be stomach pain, bloating, mucus, incomplete evacuation, nutritional

measurements and fecal calprotectin if clinically warranted.[1,25-27]

The description of the Panchakarma treatments should include enough details for replication purpose such as formulation, dose or volume, preparation, administration sequence, Purva Karma, duration, Paschat Karma and concomitant drugs. Safety outcome, criteria for discontinuation of treatment and adverse events should be reported prospectively. Long-term follow up (at least 6-12 months) is required to assess whether the symptomatic benefit is maintained.[7-9,11-16] Recommended future-trial domains are summarized in Table 5.

**Table 5: Priorities for future Panchakarma trials.**

| Domain | Recommended approach |
|---|---|
| Diagnosis | Rome IV criteria for IBS, with Ayurvedic diagnostic criteria reported separately.[1] |
| Phenotype | Stratify IBS-D, IBS-C, IBS-M, and IBS-U and prespecified Ayurvedic phenotypes. |
| Intervention reporting | Report formulation, dose/volume, preparation, sequence, Purva Karma, duration, Paschat Karma, and concomitant treatment. |
| Primary outcomes | IBS-SSS plus a prespecified global response measure such as IBS-AR.[20,25] |
| Secondary outcomes | Bristol Stool Form, stool frequency, IBS-QoL, pain, bloating, and relevant objective measures.[20,26] |
| Safety | Prospective adverse-event monitoring and discontinuation criteria. |
| Follow-up | At least 6–12 months to assess durability and relapse. |

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## REFERENCES

1. Schmulson MJ, Drossman DA. What is new in Rome IV. J Neurogastroenterol Motil, 2017; 23(2): 151-163. doi:10.5056/jnm16214.
2. Sorathiya AP, Vyas SN, Bhat PSN. A clinical study on the role of ama in relation to Grahani Roga and its management by Kalingadi GhanaVati and Tryushnadi Ghrita. AYU., 2010; 31(4): 451-455. doi:10.4103/0974-8520.82041.

3. Saini M, Kaur M, Pandey SD, HemRaj. A critical review of Grahani Roga w.s.r. to Irritable Bowel Syndrome (IBS). Int J AYUSH, 2026; 15(1): 115-126. DOI not verified against the journal record.
4. Ahire R, Yeola G, Khurana B. Integrating evidence with tradition: clinical review of Ayurvedic management of Grahani Dosha (irritable bowel syndrome). Int J Ayurvedic Med., 2026; 17(1): 17-24. doi:10.47552/ijam.v17i1.6479.
5. Yadav SD, Sudhakar PS, Bulliah T, Srinivas K, Darsini YRP. An inquisitive insight into the pathophysiology and management of Grahani Roga. Int J Res Ayurveda Pharm., 2021; 12(2): 71-73. doi:10.7897/2277-4343.120249.
6. Joshi RK, Deshmukh R. Clinical evaluation of effects of Vamana Karma and Charakokta Palashadi Paniya and Yavagu on Shlaishmika Grahani Roga. In: 4th World Ayurveda Congress and Arogya Expo Proceedings. Bengaluru, 2010; 306-307. Ayush Research Portal record 14885.
7. Mallikarjun, Channabasavanna BM. A clinical study of Erandamooladi Niruha Basti in the management of Grahani w.s.r. to irritable bowel syndrome. J Ayurveda Integr Med Sci., 2017; 2(6): 21-22. doi:10.21760/jaims.v2i06.337.
8. Mallikarjun, Channabasavanna BM, Srinivasulu M. A clinical study on Takra Basti in the management of Grahani w.s.r. to IBS. PIJAR., 2017; 2(2): 26-34.
9. Nakka PP, Madikonda PK, Johar B. Role of Picchavasthi in the management of Grahani w.s.r. irritable bowel syndrome. Int J Ayurvedic Med., 2019; 10(4): 338-341. doi:10.47552/ijam.v10i4.1305.
10. Joshi A, Chaudhary S, Thakar AB. Role of Basti and Sirodhara in the management of Grahani (Irritable Bowel Syndrome): a case report. Int J Ayush Case Rep., 2020; 4(3): 90-96.
11. Markunda M, Channabasavanna BM, Aggarwal S, Marri S. A comparative clinical study on the effect of Takra Basti and Erandamooladi Niruha Basti in the management of Grahani (IBS). Int J Ayurvedic Med., 2023; 14(1): 253-259. doi:10.47552/ijam.v14i1.3253.
12. Jamra S, Shukla RK, Shivhare S. Ayurvedic management of Grahani w.s.r. to irritable bowel syndrome. Int J Ayu Pharm Res., 2025; 13(8): 80-85. doi:10.47070/ijapr.v13i8.3813.
13. Verma S, Sawarkar P, Sawarkar G, Parwe S. Effective management of irritable bowel disease (Grahani) through Ayurveda: a case report. J Clin Diagn Res., 2024; 18(9): OD13-OD16. doi:10.7860/JCDR/2024/68197.19858.

14. Sharma A, Sood S, Kumar P. Management of Grahani Dosh using Kalpit Piccha Basti and Lajjalu Churna: a case study. Int J Adv Res., 2025; 13(10): 427-435. doi:10.21474/IJAR01/21930.
15. Chandil A, Daheriya D, Sharma V, Meshram R. Management of irritable bowel syndrome-unclassified (IBS-U) through Ayurvedic multimodal therapy. Ayushdhara, 2026; 13(3): 136-139. doi:10.47070/ayushdhara.v13i3.2750.
16. Mungale MM, Thatere AA. Ayurvedic management of Irritable Bowel Syndrome (Grahani Roga): a case report. J Ayurveda Integr Med., 2026; 17: 101377. doi:10.1016/j.jaim.2026.101377.
17. Clinical Trials Registry–India. CTRI/2024/07/071565: A randomised controlled clinical study to evaluate the efficacy of Virechana Karma in the management of Vataja Grahani vis-à-vis irritable bowel syndrome [Internet], 2024. No published outcome report identified in the present audit.
18. Sahu AK, Swain D, Sahoo PK, Meher D. A clinical study on Grahani Roga and its management by an indigenous herbal compound. Int J Res Ayurveda Pharm., 2020; 11(1): 46-51. doi:10.7897/2277-4343.110110.
19. Patel RV, Kori VK, Patel KS. A clinical study of Devadarvyadi-Vati on Grahani Dosha in children. AYU., 2011; 32(2): 187-191. doi:10.4103/0974-8520.92568.
20. Naik TD, Tubaki BR, Patankar DS. Efficacy of whole system ayurveda protocol in irritable bowel syndrome: a randomized controlled clinical trial. J Ayurveda Integr Med., 2023; 14(1): 100592. doi:10.1016/j.jaim.2022.100592.
21. Sahu PP, Acharjee D. Integrative Ayurvedic management of Grahani Roga using Kapithadi Peya and Takrarista: a case report. Int J Ayurvedic Med., 2026; 17(2): 564-570. doi:10.47552/ijam.v17i2.6275.
22. Jain S, Chawardol SG, Jain J, Dwivedi OP. Management of Grahani Roga by Ayurveda principles and lifestyle modification. J Drug Deliv Ther., 2018; 8(6): 393-396. doi:10.22270/jddt.v8i6.2061.
23. Kora RK, Madikonda PK, Johar B. Basti treatment improved faecal calprotectin and faecal elastase of a patient of inflammatory bowel disease with sarcoidosis - a case report. J Ayurveda Integr Med., 2025; 16(6): 101183. doi:10.1016/j.jaim.2025.101183.
24. Yadahalli SL, Misriya KH, Megha B, Desai AS. Management of Grahani Roga with special reference to ulcerative colitis: a case report. Int J Res Ayurveda Pharm., 2024; 15(1): 22-26. doi:10.7897/2277-4343.1516.

25. Francis CY, Morris J, Whorwell PJ. The irritable bowel severity scoring system: a simple method of monitoring irritable bowel syndrome and its progress. Aliment Pharmacol Ther., 1997; 11(2): 395-402. doi:10.1046/j.1365-2036.1997.142318000.x.
26. Patrick DL, Drossman DA, Frederick IO, DiCesare J, Puder KL. Quality of life in persons with irritable bowel syndrome: development and validation of a new measure. Dig Dis Sci., 1998; 43(2): 400-411.
27. Mearin F, Lacy BE, Chang L, Chey WD, Lembo AJ, Simren M, et al. Bowel disorders. Gastroenterology, 2016; 150(6): 1393-1407.e5. doi:10.1053/j.gastro.2016.02.031.