

## INTEGRATED AYURVEDIC MANAGEMENT OF PREMATURE EJACULATION (SHUKRAGATA VATA) WITH REDUCED PSYCHOLOGICAL WELL-BEING USING SEQUENTIAL BASTI AND UTTARBASTI: A CASE REPORT

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### ABSTRACT

**Background:** Premature ejaculation (PE) is a common male sexual dysfunction associated with impaired ejaculatory control and psychological distress. In Ayurveda, its clinical presentation may be correlated with Shukragata Vata, particularly Kshipra Munchana, involving disturbance of Apana Vata and Shukravaha Srotas. **Case Presentation:** A 40-year-old married male presented with premature ejaculation, performance anxiety, marital distress, and reduced subjective well-being. Baseline IELT was 40 seconds, PEDT score was 16, and WHO-5 score was 7. The condition was correlated with Shukragata Vata. **Intervention:** The patient received Sarvanga Abhyanga with Ksheerabala Taila, Sarvanga Swedana, Yoga Basti comprising Anuvasana Basti with Ashwagandha Ghrita and Dwi Panchamooladi Niruha Basti for 8 days, followed by Uttarbasti with Ashwagandha Ghrita for 7 days. Oral Ashwagandha Ghrita was continued during follow-up for 15

days. **Outcome:** At 30-day follow-up, IELT increased from 40 seconds to 3.5 minutes (210 seconds), PEDT decreased from 16 to 7, and WHO-5 increased from 7 to 22, indicating improvement in ejaculatory control and subjective well-being. **Conclusion:** The observed improvement suggests a potential role of sequential Basti and Uttarbasti in the integrative management of PE from an Ayurvedic perspective. The therapeutic response may be related

to regulation of Vata, particularly Apana Vata, along with Brimhana, Vrishya, and Rasayana support. As this is a single case with short-term follow-up, the findings are preliminary and warrant confirmation through well-designed clinical studies.

**KEYWORDS:** Premature ejaculation, Shukragata Vata, Uttarbasti, Ashwagandha Ghrita.

## INTRODUCTION

Premature ejaculation(PE) is among the most prevalent male sexual disorders worldwide, affecting up to 30% of men across age groups.<sup>[1]</sup> Clinically, it is characterized by ejaculation happens sooner than desired sexual activity, often within one minute of penetration is associated with an inability to delay ejaculation during almost all sexual encounters, as well as psychological distress, including frustration, anxiety, and diminished sexual self-confidence.<sup>[2]</sup> The etiology of premature ejaculation (PE) is multifactorial, involving a complex interaction between neurobiological, endocrine, psychosexual, and lifestyle factors. Centrally, the condition is primarily mediated by serotonergic dysfunction—specifically altered sensitivity of 5HT<sub>1A</sub> and 5HT<sub>2C</sub> receptors and genetic polymorphisms in the serotonin transporter gene (5-HTTLPR)—which lowers the ejaculatory threshold. Peripherally, penile hypersensitivity, pelvic floor hypertonicity, chronic prostatitis, and endocrinopathies such as hyperthyroidism and hypoprolactinemia contribute significantly to rapid ejaculatory latency. Furthermore, substance use and lifestyle disorders serve as key exacerbating factors: chronic cigarette smoking induces endothelial dysfunction and autonomic dysregulation, chronic or heavy alcohol intake impairs both central neurotransmission and the peripheral pudendal-sympathetic reflex, and metabolic syndrome (obesity, dyslipidemia, and hypertension) promotes systemic inflammation and subclinical erectile dysfunction, leading patients to unconsciously rush climax. These physiological and toxicological perturbations are frequently reinforced by psychological mechanisms, including heightened sympathetic tone from performance anxiety, maladaptive early psychosexual conditioning, and interpersonal distress.<sup>[3]</sup> Conventional medical management primarily includes oral selective serotonin reuptake inhibitors and topical local anaesthetics applied to the glans penis to reduce penile sensitivity.<sup>[4]</sup> Although these interventions may temporarily prolong ejaculatory latency, their use is frequently limited by adverse effects, including nausea, headache, erectile difficulties, and gastrointestinal disturbances. Symptoms may also recur following treatment discontinuation, thereby increasing the demand for sustainable, non-hormonal, and integrative therapeutic approaches.

Consequently, recent research has increasingly focused on innovative modalities, including low-intensity extracorporeal shock wave therapy and transcutaneous electrical nerve stimulation. These interventions are intended to modulate neurobiological pathways and improve local microcirculation.<sup>[5]</sup> Preliminary clinical evidence indicates that, whether administered alone or in combination with established pharmacological treatments, these modalities may produce synergistic improvements in intravaginal ejaculatory latency time and patient-reported sexual outcomes.

Furthermore, the identification of distinct clinical subtypes—including lifelong, acquired, and premature-like ejaculatory dysfunction—is essential for developing individualized management strategies that address the underlying pathogenesis.<sup>[6]</sup> Despite these advances, the validity of these subclassifications remains debated. The absence of a universally accepted, evidence-based framework continues to complicate clinical assessment and compromise the accuracy of epidemiological data.<sup>[7]</sup> Accordingly, standardized diagnostic criteria, such as those recommended by the International Society for Sexual Medicine, are necessary to reduce ambiguity and ensure that assessment protocols distinguish effectively among the heterogeneous aetiologies of the condition.<sup>[8]</sup>

From the Ayurvedic perspective, the clinical features of PE may be interpreted within the framework of Shukragata Vata<sup>[9]</sup>, particularly the concept of Kshipra Munchana, denoting rapid or premature expulsion of Shukra. In Ayurveda, the physiological processes of ejaculation and expulsion are closely associated with the normal functioning of Apana Vata, which governs downward-moving physiological activities. Disturbance of Apana Vata, in association with factors such as excessive psychological stress, irregular dietary practices, inadequate nourishment, disturbed sleep, and other Vata-provoking lifestyle factors, may therefore be considered relevant to the manifestation of disorders involving ejaculatory control.

The Ayurvedic understanding of PE is consequently not restricted to the local genital manifestation but considers the involvement of Dosha, particularly Vata, together with the status of Agni, Dhatu, Srotas, psychological factors, and individual lifestyle. Within this conceptual framework, Basti Karma assumes particular importance because of its established role in the management of Vata-predominant disorders. Classical Ayurvedic texts describe Basti as a principal therapeutic modality for Vata disorders, providing the rationale for its consideration when Apana Vata is implicated.

Based on this therapeutic rationale, a sequential Ayurvedic protocol comprising Basti through rectum followed by Uttarbasti through the urethra was employed in the present case at the Institute of Post Graduate Ayurvedic Education and Research (IPGAER) at SVSP, Kolkata. Rectal Basti was administered with the intention of addressing systemic Vata imbalance, particularly in relation to Apana Vata, while Uttarbasti was subsequently incorporated as a localized therapeutic intervention directed towards the genitourinary system. The sequential approach was therefore designed to combine systemic Dosha management with localized therapeutic support rather than treating the symptom of premature ejaculation in isolation.

The present case study documents the clinical response to this therapeutic protocol, with particular emphasis on changes in ejaculatory control and associated psychological manifestations, including depressive symptoms. The case is presented as an exploratory clinical observation and may provide a basis for further investigation into the role of Ayurvedic interventions, particularly Basti and Uttarbasti, in the multidisciplinary management of premature ejaculation. Further controlled clinical studies are required to establish their efficacy, safety, reproducibility, and possible mechanisms of action.

## CASE REPORT

### Patient Information and Clinical History

#### May 2025 (14 Months Before Hospital visit)

- Onset of severe ejaculatory insufficiency, with Intravaginal Ejaculatory Latency Time (IELT) dropping to less than 40 seconds on nearly every attempt.
- Beginning of associated psychological and social impacts, including marital disharmony, profound performance anxiety, low self-esteem, and persistent low mood.

#### May 2026 (2 Months Before Hospital visit)

- Onset of low back ache.

#### July 12, 2026 (Day of Hospital visit)

- **Event:** Patient presents to the Panchakarma Outpatient Department (OPD) at the Institute of Post Graduate Ayurvedic Education & Research (IPGAER), Kolkata.
- **Patient Profile:** 40-year-old married male; vegetable seller from a lower socio-economic background.
- **Physical Examination:** Well-built, 61 kg, 5 feet 5 inches tall, fair complexion, presenting with anxious facies.

- **Medical History Confirmed:** No history of diabetes, hypertension, spinal cord injury, or drug abuse.
- **Family History:** Both parents are Hypertensive and under the supervision of the conservative system of medicine.
- **Addiction:** No such
- **Marital History:** Married for 2 years
- **Sexually transmitted disease history:** No such

### Baseline Findings

#### General examination

Table -1.

|                       |                        |
|-----------------------|------------------------|
| <b>Blood pressure</b> | <b>110/80 mm of Hg</b> |
| Pulse rate            | 76 beats/min           |
| Respiratory rate      | 18/min                 |
| Temperature           | Normal                 |
| Anaemia               | Not present            |
| Jaundice              | Not present            |
| Clubbing              | Not present            |
| Oedema                | Not present            |
| Mental state          | Conscious              |
| Decubitus             | Normal                 |

### Systemic Examination

#### Urogenital System

Table 2.

|                               |                       |
|-------------------------------|-----------------------|
| Painful micturition           | Not present           |
| Haematuria                    | Not present           |
| Urethral discharge            | Not present           |
| Oedema of ankles, hands, face | Not present           |
| Frequency of micturition      | Normal                |
| Quantity of urine             | Normal                |
| Problems with coitus          | Premature ejaculation |

### Local Examination

On clinical examination, no abnormality was observed over the penis. Penis was normal in length and breadth; the meatus was normal in size; the testicles were also normal in shape and size. Patency of the urinary tract was checked by urinary catheterization.

**Diagnosis:** Premature ejaculation (PE), which may be correlated with Shukragata vata.

### Diagnostic Assessment

To establish objective and scientifically validated measures of treatment response, two validated diagnostic scales, along with Intravaginal Ejaculatory Latency Time (IELT), were assessed at baseline (12/07/2026) and reassessed after follow up of the treatment course (11/08/2026).

Premature Ejaculation Diagnostic Tool (PEDT): This 5-item scale evaluates ejaculatory control, frequency of premature episodes, minimal stimulation requirements, personal distress, and interpersonal difficulties. A cumulative score greater than 11 indicates explicit premature ejaculation. The patient's baseline score was 18, indicating severe PME.

The WHO-5 Well-Being Index (WHO-5) is a brief, validated self-report instrument designed to assess subjective psychological well-being. It consists of five positively worded items, each scored from 0 to 5, giving a total raw score ranging from 0 to 25. A higher score indicates better subjective well-being. A baseline score of 7 was recorded, confirming that the patient met the criteria for moderate secondary clinical depression arising from his sexual dysfunction.

### Treatment Schedule

Treatment plan included Sarvanga Abhyanga (Ayurvedic massage) with Ksheerabala Taila, Sarvanga Swedana (Sudation), Yoga Basti (Rectal enema) – five Anuvasana Basti with Aswagandha Ghrita<sup>[10,11]</sup> and three Dwi Panchamooladi Niruha Basti<sup>[12]</sup> followed by Uttara Basti (Urethral enema) for 8 days with Aswagandha Ghrita.

**Table – 3.**

| Date                     | Therapeutic Intervention                        | Dosage         |
|--------------------------|-------------------------------------------------|----------------|
| 13.07.2026               | Anuvasana Basti with Aswagandha Ghrita          | 100 ml         |
| 14.07.2026               | Anuvasana Basti with Aswagandha Ghrita          | 100 ml         |
| 15.07.2026               | Dwi Panchamooladi Niruha Basti                  | 600 ml approx. |
| 16.07.2026               | Anuvasana Basti with Aswagandha Ghrita          | 100 ml         |
| 17.07.2026               | Dwi Panchamooladi Niruha Basti                  | 600 ml approx. |
| 18.07.2026               | Anuvasana Basti with Aswagandha Ghrita          | 100 ml         |
| 19.07.2026               | Dwi Panchamooladi Niruha Basti                  | 600 ml approx. |
| 20.07.2026               | Anuvasana Basti with Aswagandha Ghrita          | 100 ml         |
| 21.07.2026 to 27.07.2026 | Uttara Basti for 8 days with Aswagandha Ghrita. | 10 ml          |
| 28.07.2026 to 11/08/2026 | Aswagandha ghrita with food twice daily         | 10 ml          |

### Follow up and Outcomes

The combined treatment protocol showed significant improvement after 30 days in parameters like Intravaginal Ejaculation Latency Time, Premature Ejaculation Diagnostic Tool (PEDT) and The World Health Organization-Five Well-Being Index (WHO-5).

**Table 4.**

| Evaluation Parameter             | Before Treatment | After Follow up (on 30 <sup>th</sup> day) |
|----------------------------------|------------------|-------------------------------------------|
| Intravaginal Latency Time (IELT) | 40 Seconds       | 3.5 minutes (210 sec)                     |
| PEDT Questionnaire Score         | 16               | 7                                         |
| WHO-5                            | 7                | 22                                        |

### Premature Ejaculation Diagnostic Tool (PEDT)<sup>[13]</sup>

Five-item validated questionnaire

**Table 5.**

| Sl.No. | Question                                                                             | 0                          | 1                             | 2                         | 3                        | 4                              |
|--------|--------------------------------------------------------------------------------------|----------------------------|-------------------------------|---------------------------|--------------------------|--------------------------------|
| 1      | How difficult is it for you to delay ejaculation?                                    | Not difficult at all       | Somewhat difficult            | Moderately difficult      | Very difficult           | Extremely difficult            |
| 2      | Do you ejaculate before you want to?                                                 | Never or almost never (0%) | Less than half the time (25%) | About half the time (50%) | Over half the time (75%) | Always or almost always (100%) |
| 3      | Do you ejaculate with very little stimulation?                                       | Never or almost never (0%) | Less than half the time (25%) | About half the time (50%) | Over half the time (75%) | Always or almost always (100%) |
| 4      | Do you feel frustrated because of ejaculating before you want to?                    | Not at all                 | Slightly                      | Moderately                | Very                     | Extremely                      |
| 5      | How concerned are you that your time to ejaculation leaves your partner unfulfilled? | Not at all                 | Slightly                      | Moderately                | Very                     | Extremely                      |

### The World Health Organization-Five Well-Being Index (WHO-5).<sup>[14]</sup>

**Table 6.**

|                                                            | All of the time | Most of the time | More than half of the time | Less than half of the time | Some of the time | At no time |
|------------------------------------------------------------|-----------------|------------------|----------------------------|----------------------------|------------------|------------|
| I have felt cheerful and in good spirits                   | 5               | 4                | 3                          | 2                          | 1                | 0          |
| I have felt calm and relaxed                               | 5               | 4                | 3                          | 2                          | 1                | 0          |
| I have felt active and vigorous                            | 5               | 4                | 3                          | 2                          | 1                | 0          |
| I woke up feeling fresh and rested                         | 5               | 4                | 3                          | 2                          | 1                | 0          |
| My daily life has been filled with things that interest me | 5               | 4                | 3                          | 2                          | 1                | 0          |

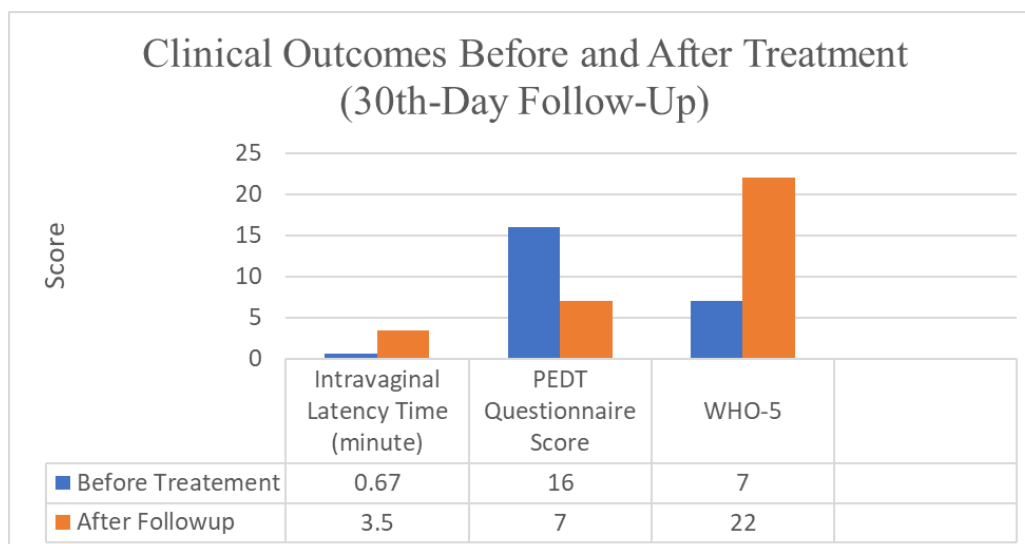


Figure – 1.

## DISCUSSION

Premature ejaculation (PE) is a multifactorial sexual dysfunction in which impaired ejaculatory control may be accompanied by considerable psychological distress and reduced quality of life. In the present case, the patient presented with markedly reduced intravaginal ejaculatory latency time (IELT) along with impaired ejaculatory control and poor subjective well-being. The baseline assessment showed an IELT of approximately 40 seconds (0.67 minutes), a PEDT score of 16, and a WHO-5 well-being score of 7. Following the treatment protocol and subsequent 30-day follow-up, IELT increased to 3.5 minutes, while the PEDT score decreased to 7 and the WHO-5 score increased to 22, demonstrating improvement across the evaluated sexual and psychological domains.

From the Ayurvedic perspective, the clinical presentation may be understood in the context of Shukragata Vata, particularly the concept of Kshipra Munchana, referring to rapid or premature expulsion of Shukra. The physiological process of ejaculation is closely associated with the normal functioning of Apana Vata. Disturbance of Apana Vata, together with factors such as excessive sexual activity, improper dietary practices, psychological stress, and other Vata-provoking factors, may contribute to dysfunction of Shukravaha Srotas.

The therapeutic approach in this case was designed to address the presumed systemic Vata imbalance followed by a localized genitourinary intervention. The initial treatment consisted of sequential Anuvasana and Niruha Basti<sup>[15]</sup>, followed by Uttarbasti with Ashwagandha Ghrita. Basti was selected considering its classical importance in Vata-predominant disorders,

while Uttarbasti was incorporated as a localized intervention directed toward the genitourinary system. This sequential approach was intended to provide systemic regulation followed by localized therapeutic support.

In Ayurveda the entire procedure of ejaculation (Sukra visarga) is maintained by Apana Vayu and vitiation of Apana vayu can lead to improper function of sukra vaha srota. The patient had nidana of Atimaithuna and pramitashana leads to Khavaigunya in Sukravaha srota and vitiation of Vata dosha and thus Sukragata Vata occurs. Dwipanchamooladi Niruha Basti was chosen for alleviating the Vata dosha. Kshirbala taila was chosen for anuvasana basti for its brimhana property. During the first phase of treatment (Days 1–8), the alternating schedule of Kshirabala Anuvasana and Dwipanchamooladi Niruha Basti focused on the colon (Pakvashaya)<sup>[16]</sup>, which is the principal seat of Vata Dosha. By soothing and regulating Apana Vata at its source, this therapy helped lower hyper-reactivity throughout the pelvic autonomic nerve plexus. By calming the underlying Chala (hyper-mobile) attribute of Vata, the systemic enemas reduced the hyper-sensitization of the autonomic nervous system, preparing the local tissues for targeted treatment. Once systemic Vata overactivity was settled, the protocol transitioned to intra-urethral Uttarbasti (Days 9–15) to deliver Ashwagandha Ghrita directly to the local mucosal linings of the genitourinary tract.

A clinically relevant improvement was observed in IELT, which increased from 40 seconds to 3.5 minutes at the 30th-day follow-up. This represents a substantial prolongation of ejaculatory latency and suggests improvement in the patient's ability to delay ejaculation. Correspondingly, the PEDT score decreased from 16 to 7, indicating improvement in perceived ejaculatory control and reduction in the difficulties and distress associated with premature ejaculation.

The improvement in WHO-5 well-being score from 7 to 22 is also noteworthy. As WHO-5 assesses subjective psychological well-being, this increase suggests a considerable improvement in the patient's overall sense of well-being following treatment. The improvement in psychological well-being may have occurred alongside improvement in sexual function, as sexual dissatisfaction and concerns regarding ejaculatory control can substantially influence emotional well-being and interpersonal relationships. However, because this is a single case, the relationship between improvement in sexual function and psychological well-being should be regarded as an observed association rather than proof of a direct causal relationship.

The possible therapeutic contribution of Ashwagandha Ghrita may also be considered within the Ayurvedic framework. Ashwagandha is traditionally described as Balya, Medhya, and Vrishya, providing a rationale for its use in conditions involving weakness, psychological stress, and impaired reproductive function. The Ghrita vehicle is traditionally considered nourishing and may complement the Brimhana and Vata-pacifying therapeutic objectives of the regimen. Nevertheless, the precise biological mechanisms by which Ashwagandha Ghrita, particularly when administered through Uttarbasti, may influence ejaculatory control cannot be established from a single clinical observation and require further investigation.

The overall pattern of improvement across IELT, PEDT, and WHO-5 is encouraging. The increase in IELT indicates improvement in ejaculatory latency, the reduction in PEDT suggests better perceived ejaculatory control, and the marked rise in WHO-5 reflects improved subjective well-being. Taken together, these findings suggest that the therapeutic response was not only limited to the primary sexual symptom but also was accompanied by improvement in the patient's broader psychological well-being.

## CONCLUSION

This case report demonstrates that a sequential Panchakarma protocol combining systemic rectal Bastis followed by localized Ashwagandha Ghrita Uttarbasti administered via a Size 12 Foley catheter is a safe, efficient, and reproducible clinical strategy. It successfully addressed both Premature Ejaculation (Shukragata Vata) and its accompanying secondary depression, offering a well-tolerated approach that resolved both the somatic and psychological aspects of the condition. However, the findings should be interpreted cautiously. This is a single-case report without a control group, and therefore spontaneous variation, placebo effects, psychological adaptation, and other confounding factors cannot be excluded. In addition, the follow-up period was relatively short. Consequently, the present findings should be considered preliminary and hypothesis-generating rather than definitive evidence of efficacy.

## PATIENT'S PERSPECTIVE

The patient reported a noticeable improvement in ejaculatory control following the treatment. He felt more confident during sexual activity and experienced less anxiety related to sexual performance. He also reported improvement in marital satisfaction and overall emotional well-being. The patient was satisfied with the treatment response and felt that his quality of life had improved.

**INFORMED CONSENT**

Informed consent was obtained from the patient.

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