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CASE STUDY

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A Single Case Study to Evaluate the Efficacy of *Virechana Karma* in Psoriatic Arthritis w.s.r to *Vatarakta*

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ABSTRACT

Ayurveda is the oldest existing medical science whose principles of treatment still prove effective even in today's changing era. The lifestyle now-a-days has become very hectic and has become a major reason for the growth of prevalence of autoimmune disorder. In this paper, a single case study has been discussed as to how there were changes in the samprapthi and how ayurvedic principles held true in the samprapthi vighatana. This patient was diagnosed with psoriatic arthritis and was subjected to virechana karma. The efficacy of the treatment before and after has been discussed in the paper and an attempt has been made to identify, a possible correlation between psoriatic arthritis and vatarakta for proper management in the future times.

KEYWORDS

Psoriasis, Psoriatic Arthritis, Vataraktha, Samprapthi, Samprapthi Vighatana

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INTRODUCTION

Psoriasis is a papulosquamous disorder of skin, characterized by sharply defined erythyematosquamouse lesion. They vary in size from pinpoint to large plaques. At times, it may manifest as localized or generalised pustular eruption. Besides the skin, it may also affect the joints and the nails. It is universal in occurrence and the incidence is 1 to 3% of the world population. It affects either sex, usually in the 3rd decade of life. A family history of psoriasis is found in 30% of patient. Familial aggregation and the higher concordance rates in monozygotic over dizygotic twin pairs emphasize the pathogenetic importance of heredity in psoriasis. The histocompatibility locus antigens (HLAs) are regarded as the most important genetic markers for psoriasis. HLA-Cw6 is most strongly associated with psoriasis. HLA-B27 show a strong association with psoriatic sacroiliitis and HLA-Bw38 with patient exhibiting psoriasis and distal arthritis[1].

PATHOLOGY OF PSORIASIS

The pathogenesis of psoriasis is debatable. However, one accepted fact is that the time necessary for a psoriatic epidermal cell to travel from basal cell layer to the surface and be cast off is 3 to 4 days, in contrast to the normal 26 to 28 days. The **epidermis** is the outermost of the three layers that make up the skin, the inner layers being the dermis and hypodermis. The cell cycle time of hyperproliferating psoriatic keratinocytes is short. While maturation and shedding of keratinocytes takes 26 days in normal epidermis, it occurs in 4 days in psoriatic epidermis. Alternatively, there is recruitment of the resting cells into the active cell cycle. In any event, this accelerated epidermopoiesis does not allow normal event of cell maturation and keratinization. This is reflected clinically histologically and chemically. Thus, there is production of thick white scales markedly thickened epidermis with immature nucleated cells in the stratum corneum and a reduction of tonofilament formation and keratothyaline granules. Histochemical analysis revels a high concentration of lipids and phospholipids, an increase in acid mucopolysaccharides, alpha amino acids, and sulphydryl groups and the retention of taurine along with increased urinary excretion of uric acid[1].

HISTORY

- Patient was said to be normal 10years back. He developed skin lesion behind ears which was rough silver white in color about 2 x 2 cm in the year 2010. Gradually it spreads to other parts of the body. Later patient was enrolled as a volunteer for a clinical trial of the drug

itilomab in 2010-2011. Soon after one month his condition aggravated and lesions. Then after lesion spreaded whole body within 6 months

- Associated with itching, lesion was sliver white in color
- Condition aggravates during winter, also had morning stiffness and multiple joint pain which was on and off in nature.

PERSONAL HISTORY

- Appetite-good
- Bowel- regular
- Micturation habbit-regular
- Sleep- disturbed
- H/o alcoholism 20yrs back

PAST HISTORY

Patient is known case of diabetes mellitus since 4 years on glymystar M2 1-0-0

SYSTEMIC EXAMINATION

CVS-S1 S2 heard no added sound

CNS-higher mental function intact cranial nerves- INTACT

RS-normal vesicular sound heard

SKIN EXAMINATION

INSPECTION

- - > OR = 0.5 cm circumscribed elevation of skin
- Redish brown discolouration
- Irregular indistinct boarded
- Distribution – distributed all over body
- Bleeds on single

PALPATION

- Rough texture
- Scaling ++
- Erythema ++
- Edema in both lower limbs ++

TEST

- Koebner phenomenon + ve
- Candle greese sign +ve

DIAGNOSIS

Here patient was diagnosed as vatarakta.

NIDHANA

- लवणाम्लकटुक्षारस्निग्धोष्णाजीर्णभोजनैः|

क्लिन्नशुष्काम्बुजानूपमांसपिण्याकमूलकैः||५||

कुलत्थमाषनिष्पावशाकादिपललेक्षुभिः|

दध्यारनालसौवीरशुक्ततक्रसुरासवैः||६||

विरुद्धाध्यशनक्रोधदिवास्वप्नप्रजागरैः|

प्रायशः सुकुमाराणां मिष्टान्नसुखभोजिनाम् ||७||

Patient was a non-vegetarian since birth with a habit of having curd and meat together. Even he had history of alcoholism and also had history of having milkshakes and combination of non-vegetarian food with curd which can be considered as virudha ahara. These can be considered as nidhana for the present disease.

PURVAROOPA

त्वग्रूक्षा स्फुटिता सुप्ता कृशा कृष्णा च तुद्यते|

आतन्यते सरागा च पर्वरुक् त्वक्स्थितेऽनिले||३०||CHA.CHI. 28/30

Patient first developed twak gata vata lakshana that is ruksha (roughness), sputana (cracked skin), supta (benumebed), krusha

(thin) , developed pricking pain , raaga (reddish discolouration associated with burning sensation) , parvaruk (pain in joints) [2].

Then patient continued nidhana which caused roopa

ROOPA

स्वेदोऽत्यर्थंनवाकाष्ण्र्यंस्पर्शाज्ञत्वंक्षतेऽतिरुक्|

सन्धिशैथिल्यमालस्यंसदनंपिडकोद्गमः||१६||

जानुजङ्घोरुकट्यंसहस्तपादाङ्गसन्धिषु|

निस्तोदःस्फुरणंभेदोगुरुत्वंसुप्तिरेवच||१७||

कण्डूःसन्धिषुरुग्भूत्वाभूत्वानश्यतिचासकृत्|

वैवर्ण्यं मण्डलोत्पत्तिर्वातासृक्पूर्वलक्षणम्||१८||

CHA.CHI.29/16-18[3]

कण्डूदाहरुगायामतोदस्फुरणकुञ्चनैः|

अन्विता श्यावरक्ता त्वग्बाह्ये ताम्रा तथेष्यते||२०||CHA.CHI.29/20

Patient developed blackish red or blackish coppery discolouration first behind the ears then to lesion was seen in scalp, gradually lesions were observed all over the body associated with itching and burning sensation. Patient also complaints of multiple joint pain[4] .

SAMPRAPTHI

Nidhana leads to prokopa of tridosha. All these tridosha takes stanasamsraya in twak which results in twak sputana, discolouration of skin (redish discoloration) leading to twakgata vata. Nidana was continued by the patint which led to the involvement of rasa,rakta, asti. Even parva sandi involment was seen in pain in small joints of fingers of hands and legs. Later satge where lesion expanded in size as seen in fig 1 (seems like vrana). Later stage where patient had pain in multiple large joints like knee joint , elbow and wrist joints. These syptoms led to lakshana of VATARAKTA.

INVESTIGATIONS – As per Table 1

Table 1 Investigation

DATE	ESR	CRP
2-12-2015	106mm/hr	101.1mg/l
6-03-2017	46mm/hr	Negative
13-08-2018	16mm/hr	Negative

TREATMENT PROTOCOL: Table 2

Table 2 Treatment protocol

1/12/15	• KARANJA NIMBA PARISHEKA • NIBAMRITHA ERANDA 50ML+200ML MILK + GUDA @9:30AM X 7 days
18/01/16	• KARANJA NIMBA PARISHEKA • NIBAMRITHA ERANDA 50ML+200ML MILK + GUDA @9:30AM X 7 days
21/6/2016	• KARANJA NIMBA PARISHEKA • NIBAMRITHA ERANDA 50ML+200ML MILK + GUDA @9:30AM X 7 days
22/09/16	• KARANJA NIMBA PARISHEKA • NIBAMRITHA ERANDA 50ML+200ML MILK + GUDA @9:30AM X 7 days
11/01/17	• ABYANGA+ KARANJA NIMBA PARISHEKA • NIBAMRITHA ERANDA 50ML+200ML MILK + GUDA @9:30AM

6/09/17	• SNEHAPANA WITH TRIPHALA GRITHA • VIRECHANA WITH TRIVRIT AVALEHA
31/04/18	• KARANAJA NIMBA PARISHEKA • AVIPATTIKARA CHOORNA 1TSP TID WITH HOT WATER
24/12/18	• KARANAJA NIMBA PARISHEKA • NIMBAMRITADI ERANDA TAILA 50ML +250ML MILK

Fig 1- this picture was taken before treatment.

Fig 2- this picture was taken after 1st course of treatment (after 15days of treatment).

Fig 3- this picture was taken after 2rd course of treatment.

Fig 4- this picture was taken after15days of last treatment

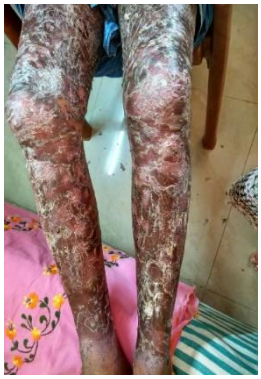

Figure 1 Before Treatment

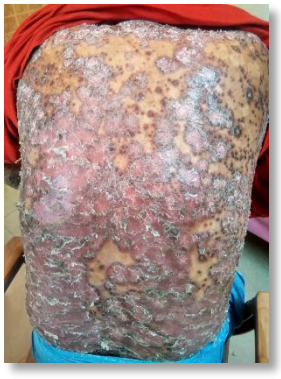

Figure 2 During 1st course of treatment

DISCUSSION

All the disorder of skin which have been described in current science of dermatology can be considered under the term kustha. Psoriasis can be consider ed as one variety of kustha which is said to be

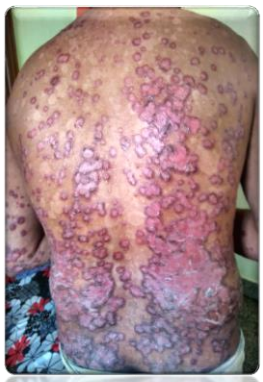

Figure 3 During 2nd course treatment

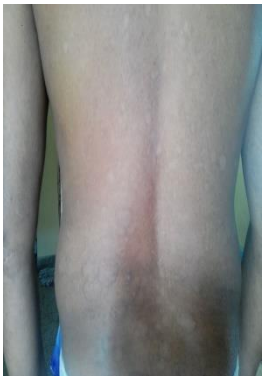

Figure 4 After treatment

deerghakaleena vyadhi and has bahudoshavasta. It is a tridoshaja vyadhi which affected the twak, rakta,mamsa and lasika (saptako dravya sangraha of kustha). As there is bhahudoshavasta, shodhana can be considered as line of treatment. Here patient had pitta *pradhana tridoshaja vyadhi*. The clincal symptoms of Psoriatic arthritis and vata raktha are similar as shown in table number 3.

Acharyas advised elimination of dosha in repeated intervals through shodhana and *virechana* is considered as ideal method of shodhana in kustha because it is procedure where all tridosha are taken care of along with shodhana of rakta dhatu.

Table 3 shows the similarities between psoriatic arthritis and vatarakta and this was the reason where this case was diagnosed as vatarakta was co-related to psoriatic arthritis.

In this case patient was advised repeated shodhana. Disease was of bahudoshavasta and patient was not fit for classical virechana. The patient was advised with repeated nityavirechana with nimabruthaearanda taila as it contains nimba which is krimigna and reduces level of infection. Eranda taila acts as snigdha virechaka as rakta involment was there.

Psoriasis is autoimmune disease, where there wiil be lesions on skin were patient cannot hide. Patient with psoriasis will be affected even in pycologiacally with embrasement to face public. Some of people say it is not curable, by this sentence patients will be still more affected. So this arcticle explains even psoriasis can be well managed in Ayurveda.

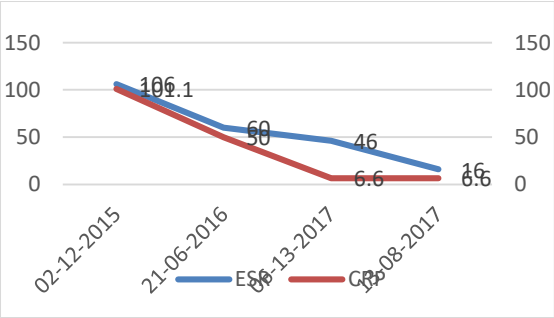

Figure 4 GRAPH CHART

CONCLUSION

1. There was reduction in the level of ESR (106mm/hr to 16mm/hr)
2. C-reactive protein which was positive was decreased from 101.1mg/l to negative after last course of treatment
3. Pain in the joints was reduced.
4. Blackish coppery discolouration associated with itching was reduced
5. We can see improvement from figure1 to figure 4.

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