



CASE REPORT

A Case Report On Ayurvedic Management Of Rigidity Predominant Parkinsons Disease

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Abstract

Rigidity-predominant Parkinsonism is a variant of Parkinson's disease (PD) characterized primarily by muscular stiffness rather than tremors, often resulting in a more rapid decline in motor abilities and increased issues with posture and gait. This case study describes a 60-years old male patient with rigidity-dominant Parkinsonism, also managing Type 2 diabetes mellitus and hypertension. The clinical presentation closely aligned with *Kampavata*, a condition outlined in Ayurveda under *Vata Vyadhi*, marked by tremors, stiffness, and impaired movement. The treatment strategy involved a comprehensive Ayurvedic regimen combining internal medications and *Panchakarma* therapies. Herbal formulations such as *Gandharvahasthadi kashaya*, *Mashathmaguptadi Kashaya*, *Dhanwantaram* tablets, and *Gorochanadi tablet* were prescribed to pacify aggravated *Vata* and enhance neurological function. This was supported by *Panchakarma* procedures including *Udwartana*, *Takradhara*, *Snehapana*, *Vamana*, *Abhyanga*, *Shirodhara*, and *Nasya*, aimed at balancing *Vata-Kapha doshas*, improving cognition, and restoring motor coordination. Following treatment, the patient demonstrated significant clinical improvement, as reflected in reduced UPDRS scores, improved posture, reduced rigidity, and enhanced ability in daily activities. This case underscores the promising role of ayurvedic interventions in managing rigidity-predominant Parkinsonism and emphasizes the importance of further research in this area.

Introduction

Parkinsonism refers to a neurological syndrome marked by a combination of bradykinesia, resting tremors, muscular rigidity, and issues with postural balance. These clinical manifestations mainly occur because of the gradual degeneration of dopamine-producing neurons in the substantia nigra pars compacta, leading to reduced dopamine availability in the basal ganglia.^[1] The most commonly encountered form is Idiopathic Parkinson's Disease (PD), which typically has a slow progression and can significantly affect both motor and non-motor aspects of life over time.

A specific variant known as Rigidity-Predominant Parkinsonism is distinguished by stiffness being the leading symptom, rather than tremors. This type often results in a faster decline in motor abilities, increased postural abnormalities, and greater difficulties with gait compared to tremor-dominant presentations^[2].

In *Charaka Samhita*, the condition known as *Vepathu* is classified under the 80 *Nanatmaja Vata Vyadhis* (disorders caused purely by *Vata*), indicating its origin as a *Vata* imbalance. It is marked by *Kampa* (involuntary movements), *sthambha* (rigidity), *gathi sanga* and *chesta sanga* (reduced mobility, and balance disturbances) all of which are seen as manifestations of aggravated *Vata dosha*^[3]. The term *Kampavata* was introduced by Bhasavaraja, the author of *Bhasavarajeeyam*, where it is described with clinical features such as *karapadathala kampa* (trembling of hands and feet), *deha bhramana* (giddiness), *matiksheena* (impaired intellect), and *nidra bhanga* (disturbed sleep)^[4]. In the *Charaka Samhita*, however, the term *Kampavata* is not used; instead, *Vepathu* is listed among the 80 *Nanatmaja Vata Vyadhis*, signifying its origin from a predominant *Vata* imbalance^[5]. In the *Sushruta Samhita*, the presentation of symptoms such as *Chesthasanga* (impaired coordination), *Stambha* (rigidity), and *Guru Gatratata* (heaviness of the limbs) are associated with *Kaphavruta Vyana Vata*, suggesting that tremors can result from obstructed *Vata* flow due to *Kapha*^[6]. *Ashtanga Hridaya* links *Kampa* to generalized *Vata* vitiation, specifically in *Sarvanga Vata*^[7]. Similarly, *Ashtanga Sangraha* proposes *Dhatu Kshaya* (depletion of *Rasa*, *Pitta*, and *Kapha*) as another causative mechanism behind tremors^[8]. *Kashyapa Samhita* also enlists *Vepathu* under *Vataja Nanatmaja Vyadhis*, reinforcing its classification as a *Vata*-predominant disorder^[9].

In *Madhava Nidana*, *Vepathu* receives a detailed clinical description under *Vata Vyadhi*, with its categorization into *Sarvanga Kampavata* (generalized tremors) and *Ekanga Kampavata* (localized tremors)^[10]. *Sharngadhara Samhita* considers *Kampa* a *Vata* disorder and lists *Sirakampa* (head tremors) under *Siroroga* (diseases of the head), with *Mashadi Nasya* indicated as a therapeutic intervention^[11]. In *Bhava Prakasha*, *Snayugata Vata* is described as presenting with both *Stambha* and *Kampa*, attributing these manifestations to *Vata* vitiation affecting the ligaments and nervous structures. Dietary factors such as excessive intake of *Tikta Rasa* are implicated in the aggravation of this condition^[12]. *Yogaratanakara* addresses *Sarvanga Kampa* and *Sirakampa* under *Vepathu* within *Vata Vyadhi*, reflecting its diverse anatomical involvement^[13].

Vangasena employs the term *Kampavata* synonymously with *Vepathu*, and prescribes a therapeutic

protocol comprising *Abhyanga*, *Swedana*, *Niruha Vasti*, *Anuvasana Vasti*, *Shirovasti*, and *Virechana*^[14]. *Chakradatta* recommends medicated oils like *Dwitiya Mashataila*, *Tritiya Mashataila*, and *Saptaprastha Mahamasha Taila* for treating specific tremor types such as *Bahukampa*, *Sirokampa*, and *Hastakampa*. Additional treatments include *Snehapana*, *Abhyanga*, *Nasya*, and *Vasti* therapies^[15].

The *Nidana* of *Kampavata* are primarily those that lead to the vitiation of *Vata Dosha*, as it is a *Vataja Nanatmaja Vyadhi*. Indulgence in *ativyayama*, *ruksha seeta laghu ahara*, *alpa ahara* and *langhana* contribute to *Vata* aggravation. *Vega Dharana*, particularly of *mutra*, *purisha*, and *kshavathu dhatus*, creating a conducive environment for *Vata prakopa*. Additionally, *manasika nidana* such as *chinta*, *bhaya* and *soka*, leads to improper movement of *Vata*. Conditions like *Kshaya* and *Karshya* resulting from chronic illness or malnutrition further debilitate the body and are understood to indirectly aggravate *Vata*.

The key observed symptoms of *Kampavata* available in various ayurvedic include *karapadathala kampa*, *sthambha*, *chesta sanga*, *chestahani*, *vakvikriti*, *avanamana*, *vinamana*, *deha bhramana*, *smriti kshaya*, *smriti hani*, *vibanda*, *vishada*, *gathi skalana*, *nidranasa* and *atiksheena*. Ayurvedic management focuses on calming the disturbed *Vata* using internal medications and purification therapies like *Snehapana*, *Vamana Virechana*, *Basti*, and *Nasya*, along with *Rasayana* treatments aimed at rejuvenation and neurological support^[16]. This article presents a case of rigidity-predominant Parkinsons disease, in which notable improvement was achieved through Ayurvedic management.

CASE HISTORY

Patient information

A 60 years old moderately built male patient, with known case of type 2 diabetic mellitus and hypertension since past 5 years came to our OPD with the complaints of difficulty in walking, tendency to fall sideways and backwards, shivering of right hand while writing, mild weakness of whole body and multiple joint pain (especially over right knee joint and shoulder joint) since 4 years.

He was a Civil Engineer by profession, was apparently normal upto his retirement age. He was a less talkative personality and lead a sedentary lifestyle after retirement. 4 yrs back he once noticed difficulty in driving as the vehicle deviated to one side. He stopped using two wheeler and started to go to temple by walking. Thus he developed right knee joint pain but neglected it. His nature of walking started changing, speed was gradually increased, goes to one side. But did not bothered about that.

One of their neighbour told his family members that there are changes in his way of walking and while climbing up of stairs he is having tendency to fall backwards. Then only the family members started noticing slowness in his movements, difficulty in walking ie: tendency to fall sideways and backwards along with increasing speed while walking, difficulty in turning around etc. He also noticed slight shivering while writing and also changes in his handwriting (previously very neat and beautiful). He used to fall backwards when he sit without support (postural instability). He once developed giddiness and consulted an ENT specialist. The doctor suggested for MRI brain and gave several medications. But no any relief for balance problem was obtained so they consulted another ENT doctor.

The doctor noticed his peculiar walking style, on examination, tremors were also detected in right hand. Thus he was referred to a neurologist and finally diagnosed as Parkinsonism disease. He was advised to take medication for the same and review in every 6 months. Tremors got reduced and walking difficulty reduced, gained more postural stability. Later he developed neck pain radiating to b/l shoulder joints, occasional LBA, and b/l knee and ankle joint pain for which he consulted a nearby ayurvedic treatment centre and took some treatments (details of which are not available). But gave relief for his joint pain. Now he came here for further management.

History of Past Illness

History of Hypertension (HTN) and Type 2 Diabetes Mellitus (DM) since five years. Current medications included Tab. Melmet -500 SR (Metformin) and Tab. Glizid-MR 60 (Gliclazide) for diabetes, and Tab. Cilacar 10 mg (Cilnidipine) for Hypertension. No other significant past illnesses were reported.

Personal History:

Bowel - constipated (pass hard stools on alternate days) since 4 yrs

Micturition -WNL, urinary urgency present

Appetite - good, but intake only less food

Sleep- sound, day sleeping -present

Allergies - allergic to dust

Diet - mixed, likes fish more

Habits- 2-3 cup of black tea daily

Addictions - nil

Drug abuse - nil

Socio-economic Status:

Retired, from a middle-class background.

Family History:

No family history of Parkinson's disease or other similar neurological disorders. Also there was no history of toxic chemical exposure, poisons, or significant head trauma.

On examination

Higher mental function:

The patient is conscious and right-handed. He appears moderately built, neat, but with an unpleasant face. He is oriented to time, place, and person. Recent memory is slightly impaired, as he occasionally forgets what has been told to him, while remote memory remains intact. His intelligence is preserved. There are no signs of hallucinations or delusions. No speech disorder is present, and there is no slurring of speech.

Cranial nerve examination

The olfactory nerve is intact, with normal smell sensation. The optic nerve shows normal visual acuity and visual fields, and the light reflex is intact. There is no ptosis. The oculomotor, trochlear, and abducent nerves are functioning properly, with full range of eyeball movements in all directions. The pupils are normal in position, shape, size, and symmetry, with no abnormalities detected. The trigeminal nerve is intact. Sensory functions including touch, pain, and pressure sensations are present. Motor functions are also normal, with the patient able to clench teeth and perform lateral jaw movements. In the assessment of facial nerve, Forehead wrinkling was present, and eyebrow raising was possible. The patient was able to close the eyes against resistance. When asked to show the teeth, there was no deviation of the angle of the mouth. However, blowing of the cheeks was not possible. The nasolabial folds were equal on both sides. Examination of the vestibulo cochlear nerve revealed a negative Rinne's test, and the Weber's test indicated that sound was heard equally on both sides. Assessment of the glosso pharyngeal and vagus nerves showed that the uvula was positioned in the midline with no deviation. Taste sensation was found to be intact. The accessory nerve was intact so that shoulder shrugging and neck movements were possible against resistance and examination of the hypoglossal nerve revealed that tongue protrusion and all tongue movements were possible.

Sensory System Examination

Superficial sensations including touch, temperature, and pain, were found to be intact. Deep sensations such as crude touch, vibration, position sense, and pressure sense were also intact. Cortical sensations, including tactile localization, tactile discrimination, stereognosis, and graphesthesia, were assessed and found to be intact.

Motor System Examination

In the case of Muscle Tone, Cogwheel rigidity was observed in both the upper and lower limbs, with greater rigidity on the left side compared to the right. The Muscle Bulk of the left upper limb measured 29 cm, and the right upper limb measured 29.5 cm when measured 14 cm below the acromion process of shoulder. The left lower limb measured 38 cm, and the right lower limb measured 37 cm when measured 15 cm below patella. Involuntary movements like tremors were noted, more pronounced in the left hand than in the right. Bilateral hand grip was found to be intact and the patient exhibited an independent gait with mild gait impairment and occasional swaying towards left side while walking.

Muscle Power

Shoulder movements including flexion, extension, abduction, adduction, and internal and external rotation were graded 4/5 on the right and fully preserved at 5/5 on the left. Elbow and wrist flexion and extension mirrored this pattern, showing 4/5 on the right and 5/5 on the left. Hip joint evaluation demonstrated slightly reduced power, with all movements graded 4/5 on the right and 3/5 on the left. Knee flexion measured 4/5 on the right and 3/5 on the left, while extension remained 4/5 bilaterally. Ankle strength was notably diminished, with plantar flexion at 3/5 on the right and 2/5 on the left, and dorsiflexion similarly at 3/5 on the right and 2/5 on the left.

Coordination Test

The finger-nose test was possible, though performed a little slowly. Tandem walking was achievable but with mild difficulty. The heel-shin test was performed successfully. The supination-pronation test was also possible, although it was noticeably slower on the left side. Diadochokinesis was intact. Stereognosis was preserved. Romberg's sign was negative, with only mild swaying observed towards the right side.

Reflexes

Knee jerk, ankle jerk, biceps reflex and triceps reflex which are the deep tendon reflexes were present bilaterally. The Babinski

sign was negative on both sides. The glabellar tap was positive. Superficial reflexes, such as corneal, conjunctival, and abdominal reflexes, were found to be intact.

Archimedes spiral diagram evaluation: Figure no: 1

Unified Parkinson's Disease Rating Scale (UPDRS) score is enlisted as Table no:1

Neurological Examination:

The pull test which is used to assess postural stability, was positive, indicating mild impairment. Finger tapping, in which the patient rapidly taps the index finger against the thumb, was performed successfully. The Toe tapping, which involves tapping the toes of each foot rapidly and with large movements, was found to be difficult on the left side compared to the right. The patient was able to rise from a seated position with arms crossed, indicating preserved strength and coordination in that task. The Gait assessment showed reduced stride length, walking speed, and diminished arm swing. The Tone testing, involving passive movement of the limbs to assess muscle tone, was also conducted.

Locomotor System Examination:

The cervical spine showed no abnormality on inspection, there was no tenderness on palpation, and the range of motion was intact. Both shoulders appeared normal on inspection. Palpation revealed Grade 1 tenderness over the anterior aspect and trapezius muscles. All shoulder movements were possible but associated with mild pain. The knee joints bilaterally showed no abnormality on inspection. There was no tenderness on palpation; however, crepitus was noted more pronounced on the right (++), and mild on the left (+). Movements were possible with mild pain. Both ankle joints demonstrated mild edema and blackish discoloration on inspection. Palpation revealed no tenderness, and the edema was non-pitting in nature. Movements were possible with mild pain. The lumbosacral spine showed no abnormality on inspection or palpation, and range of motion was possible with mild pain.

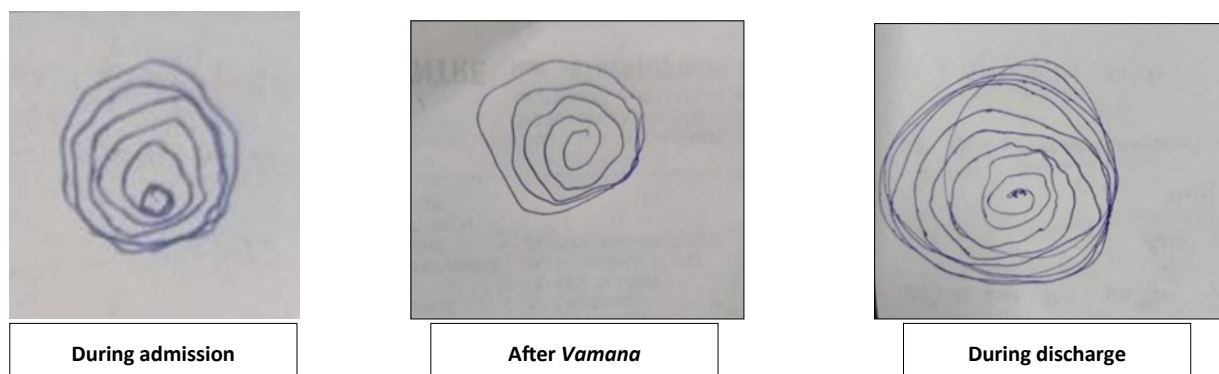


Figure 1: Archimedes spiral diagram assessment

Table no: 1 -Unified Parkinson's Disease Rating Scale (UPDRS) score

Part I: Non-Motor Aspects	At the time of admission	After Vamana	At discharge	After follow up of 2 weeks
1.1 COGNITIVE IMPAIRMENT	2	0	0	0
1.2 HALLUCINATIONS AND PSYCHOSIS	0	0	0	0
1.3 DEPRESSED MOOD	0	0	0	0
1.4 ANXIOUS MOOD	0	0	0	0
1.5 APATHY	2	1	1	1
1.6 FEATURES OF DOPAMINE DYSREGULATION SYNDROME	0	0	0	0
1.7 SLEEP PROBLEMS	0	0	0	0
1.8 DAYTIME SLEEPINESS	2	1	1	1
1.9 PAIN AND OTHER SENSATIONS	2	0	0	0
1.10 URINARY PROBLEMS	1	0	0	0
1.11 CONSTIPATION PROBLEMS	3	3	1	1
1.12 LIGHT HEADEDNESS ON STANDING	2	0	0	0
1.13 FATIGUE	0	0	0	0
Part II Motor Aspects of Experiences of Daily Living (M-EDL)				
2.1 SPEECH	1	0	0	0
2.2 SALIVA AND DROOLING	0	0	0	0
2.3 CHEWING AND SWALLOWING	0	0	0	0
2.4 EATING TASKS	2	1	0	0
2.5 DRESSING	1	0	0	0
2.6 HYGIENE	2	1	0	0
2.7 HANDWRITING	2	1	1	1
2.8 DOING HOBBIES AND OTHER ACTIVITIES	4	2	2	2
2.9 TURNING IN BED	0	0	0	0
2.10 TREMOR	2	1	1	1
2.11 GETTING OUT OF BED, A CAR, OR A DEEP CHAIR	2	1	1	1
2.12 WALKING AND BALANCE	1	1	1	1
2.13 FREEZING	0	0	0	0
Part III: Motor Examination				
3.1 SPEECH	1	0	0	0
3.2 FACIAL EXPRESSION	2	1	0	0
3.3 RIGIDITY	RT UL - 2	RT UL - 2	RT UL - 0	RT UL - 0
	LT UL - 3	LT UL - 2	LT UL - 0	LT UL - 0
	RT LL - 1	RT LL - 0	RT LL - 0	RT LL - 0
	LT LL - 2	LT LL - 0	LT LL - 0	LT LL - 0
3.4 FINGER TAPPING	RT - 0	RT - 0	RT - 0	RT - 0
	LT - 1	LT - 0	LT - 0	LT - 0
3.5 HAND MOVEMENTS	RT - 0	RT - 0	RT - 0	RT - 0
	LT - 2	LT - 1	LT - 1	LT - 1
3.6 PRONATION-SUPINATION MOVEMENTS OF HANDS	RT - 0	RT - 0	RT - 0	RT - 0
	LT - 2	LT - 1	LT - 0	LT - 0
3.7 TOE TAPPING	RT - 2	RT - 1	RT - 1	RT - 1
	LT - 3	LT - 1	LT - 1	LT - 1
3.8 LEG AGILITY	RT - 2	RT - 1	RT - 1	RT - 1
	LT - 3	LT - 1	LT - 1	LT - 1
3.9 ARISING FROM CHAIR	1	0	0	0
3.10 GAIT	2	2	1	1
3.11 FREEZING OF GAIT	1	0	0	0
3.12 POSTURAL STABILITY	0	0	0	0
3.13 POSTURE	2	0	0	0
3.14 GLOBAL SPONTANEITY OF MOVEMENT (BODY BRADYKINESIA)	3	2	1	1
3.15 POSTURAL TREMOR OF THE HAND	RT - 1	RT - 0	RT - 0	RT - 0
	LT - 1	LT - 0	LT - 0	LT - 0
	LT>RT			
3.16 KINETIC TREMOR OF THE HAND	RT - 0	RT - 0	RT - 0	RT - 0
	LT - 1	LT - 1	LT - 1	LT - 1
3.17 REST TREMOR AMPLITUDE	RT - 0	RT - 0	RT - 0	RT - 0
	LT - 0	LT - 0	LT - 0	LT - 0
3.18 CONSTANCY OF REST TREMOR	0	0	0	0
Part IV: Motor Complications				
4.1 TIME SPENT WITH DYSKINESIAS	0	0	0	0
4.2 FUNCTIONAL IMPACT OF DYSKINESIAS	0	0	0	0
4.3 TIME SPENT IN THE OFF STATE	0	0	0	0
4.4 FUNCTIONAL IMPACT OF FLUCTUATIONS	0	0	0	0
4.5 COMPLEXITY OF MOTOR FLUCTUATIONS	0	0	0	0
4.6 PAINFUL OFF-STATE DYSTONIA	0	0	0	0

Ayurvedic examination:**Ashtasthana pareeksha***Nadi-sadharanam**Mootram-anaavilam**Malam-badham**Jihwa-upalipatam**Sabda-spashtam, speak less**Sparsha-anushnasheetam**Drik-prakritam**Akrithi-madhyamam***Dasavidha pareeksha***Prakruthi- kapha vata**Vikruthi-**Dosha- Kapha, Vata**Dushyam- Rasa, rakta, mamsa, meda, asthi, majja, snayu**Sara- Madhyama**Samhanana - Madhyama**Pramana- Madhyama**Sathmya - amlarasa pradhana**Sathva - Madhyama**Ahara Sakthi**Jarana Sakthi- madhyama**Abhyavaharana Sakthi-madhyama**Vyayama Sakthi- avara**Vaya- madhyama***INVESTIGATIONS**

Blood test on 02/01/2025 (Table no: 2)

DIFFERENTIAL DIAGNOSIS- Modern**1. Essential Tremors (ET)**

Characterized by bilateral tremors during voluntary movements, commonly affecting the hands. It typically lacks features like bradykinesia or muscle rigidity, which helps differentiate it from Parkinsonian disorders.

Table no: 2 - Blood test on 02/01/2025

FBS	130 mg%
PPBS	248 mg%
ESR	12 mm/hr
Hb	14.5 gm%
Lipid profile	WNL
RFT	WNL
LFT	WNL
URE	WNL

2. Multiple System Atrophy (MSA)

Shows poor or minimal response to levodopa, and is often associated with cerebellar symptoms such as ataxia and dysarthria. Patients may experience early postural instability with falls and significant autonomic dysfunction, including orthostatic hypotension and urinary problems.

3. Progressive Supranuclear Palsy (PSP)

Notable for early falls, especially backward falls, and a distinctive vertical gaze palsy. Patients often show cognitive impairment and symptoms are usually symmetrical.

4. Corticobasal Degeneration (CBD)

Marked by asymmetrical presentation, often with fixed limb dystonia, limb apraxia, and cortical sensory loss. Other features include cognitive decline and the unique alien limb phenomenon, where a limb seems to act independently.

4. Lewy Body Dementia (LBD)

Primarily presents with early onset of dementia, often accompanied by visual hallucinations that are spontaneous and vivid. Parkinsonism may also be present, but the hallucinations and cognitive decline typically precede motor symptoms.

DIFFERENTIAL DIAGNOSIS - Ayurvedic

1. *Vepathu*: While both *Vepathu* and *Kampavata* involve tremors, *Vepathu* is more associated with systemic trembling without the specific neurological implications seen in *Kampavata*.

2. *Akshepaka*: Characterized by convulsions or spasmodic movements, *Akshepaka* differs from *Kampavata* as it involves sudden, forceful movements rather than the rhythmic tremors typical of *Kampavata*.

DIAGNOSIS - Kampavata -Rigidity predominant parkinsonism**TREATMENT GIVEN**

The internal medications given along with its dosage and time are enlisted in Table no: 3

Panchakarma procedure, medicines used and the duration of treatment are enlisted in Table no: 4

Results And Discussion

Patient showed remarkable improvement after above mentioned ayurvedic treatments after the initial *rukshana* procedures like *Udwartanam* and *Takradhara*, patient experienced lightness of the body and reduction in the stiffness of bilateral upperlimb and lower limb. He also became more pleasant and his gloomy nature reduced. There was a reduction in his FBS and PPBS values. the major positive response obtained after *Vamana* was reduction in the rigidity

Table no: 3 - Internal medications

Internal medicines	Dosage	Time
<i>Gandarvahasthadi kashaya</i>	90 ml BD B/F	6 am, 6 pm
<i>Dhanwantaram tablet</i>	1 BD with <i>kashaya</i>	6 am, 6 pm
<i>Nishakathakadi kashaya</i>	<i>Pana</i>	<i>Muhur muhur</i>
<i>Mashathmaguptadi kashaya</i>	90 ml BD	11 am, 5 pm
<i>Nirgundi eranda taila</i>	10 ml with morning <i>kashaya</i>	6 am
<i>Gorochanadi tablet</i>	1 BD A/F	

Table no: 4 - Panchakarma procedures

Procedure	Medicines	Duration
<i>Udwartana</i>	<i>Triphala churna</i>	7 days
<i>Takradhara</i>	<i>Musta ,amalaki</i>	7 days
	<i>Indukanta ghrita +Kalyanaka ghrita</i>	
	Day 1 - 15ml+15ml=30ml	
	Day 2 – 25.5ml+25.5ml=55ml	
<i>Snehapana</i>	Day 3 – 62.5ml+62.5ml=125 ml	5 days
	Day 4 – 100ml+100ml=200ml	
	Day 5 – 100ml+100ml=200ml	
<i>Abhyanga and Ushma sweda</i>	<i>Chinchadi taila</i>	1 day
	<i>Akantapana- Yashti kashaya- 2L</i>	
	<i>Vamanopaga-Yashti kashaya -4L</i>	
	<i>Vamana oushada:</i>	
<i>Vamana</i>	<i>Madhanaphala pippali churna- 5gm Yashtimadhu churna -7.5gm</i>	1 day
	<i>Vacha churna 2.5 gm</i>	
	Honey -QS	
	<i>Saindhava – QS</i>	
<i>Abhyanga</i>	<i>Chinchadi taila</i>	3 days
<i>Shirodhara</i>	<i>Vatasani taila</i>	7 days
	<i>Ksheerabala 21 Avarti</i>	
<i>Marsha nasya</i>	Day 1,2 - 3 ml each nostril	7 days
	Day 3,4 - 4 ml each nostril	
	Day 5,6,7 - 5 ml each nostril	

of upper limbs. The complaints of constipation also relieved during the treatment period. Postural instability and bradikinesia was considerably reduced by the end of treatment. His quality of life and social interactions improved significantly. In the UPDRS assessment, the total score reduced from 71 to 29 after *Vamana* and at the time of discharge the score further reduced to 17 and it persisted even after the follow up period.

UPDRS assessments taken at various timepoints are enlisted as Table no: 5

Discussion on disease:

Parkinson's disease is the second most prevalent age-related neurodegenerative condition after Alzheimer's disease. It typically begins around the age of 60, with a lifetime risk of approximately 3% in men and 2% in women. Most cases of PD occur randomly without a known cause, while about 10% are linked to family history and specific gene mutations. Traditionally, diagnosis was based on the presence of two out of three key symptoms: tremors, stiffness, and slow movement. However, this approach had a significant error rate of 24%. Later studies refined the diagnostic criteria, emphasizing the combination of parkinsonian symptoms, such

as rest tremors, asymmetrical motor impairment, and a positive response to levodopa treatment. Using these revised criteria, known as the UK Brain Bank Criteria, clinicians can accurately diagnose PD in over 90% of cases.^[17]

Kampavata which is mentioned in various ayurvedic classics can be correlated with PD. It is generally considered as a *Yapya vyadhi* and *vatahara chikitsas* are adopted.

Discussion on samana treatment:

At the time of admission, *Gandharvahasthadi kashaya* was administered along with *Nirgundi Eranda taila*. *Gandharvahasthadi kashaya* has properties like *deepana*, *vatakapha shamana*^[18]. *Nirgundi Eranda taila* also possesses *vatakapha shamana* property. *Nirgundi Eranda* is a specialized formulation prepared by incorporating *Nirgundi* (*Vitex negundo*) into *Eranda Taila* as its foundational base. In this context, it was employed to provide mild *Anulomana* and *Shodhana* effects. The symptoms of *kampa* and *stambha* are interdependent and manifest as abnormal expressions of *vata's chala guna*. Therefore, the intake of *Gandharvahasthadi kashaya* along with *Nirgundi Eranda taila* helps alleviate *vata* imbalance and its associated symptoms.

Table no: 5 - UPDRS ASSESSMENTS

UPDRS	DURING ADMISSION	AFTER VAMANA	DURING DISCHARGE	AFTER FOLLOW UP of 2 weeks
PART 1 (NON MOTOR ASPECTS)	16	5	3	3
PART2(Motor Aspects of Experiences of Daily Living (M-EDL)	17	8	6	6
Part III: Motor Examination	38	16	8	8
Part IV: Motor Complications	0	0	0	0
TOTAL SCORE	71	29	17	17

Additionally, the patient was given *Mashathmagupthadi kashaya* which is indicated for *kampa*^[19,20] along with *Dhanwantharam* tablets from the beginning of the treatment. *Athmagupta*, an ingredient in *Mashathmagupthadi kashaya*, contains the dopamine precursor L-Dopa^[21]. Since dopamine, which regulates *vata*-related functions like movement, cognition, and mood, is diminished in Parkinson's disease, this treatment improved the patient's bradykinesia, depression, and cognition, and significantly reduced hypomimia. The combination of *Dhanwantharam* tablets, with their *vata*kapha *hara* and *vatanulomana* properties, yielded good results^[22].

Gorochanadi tablet, known for its *tridosahara* properties, especially *vata shamana* and *vatanulomana*, and its effectiveness as a *medhya* formulation, was also administered^[23]. For the patient's diabetes, *Nishakathakadi kashaya* was taken daily to control blood sugar levels^[24].

Discussion on panchakarma procedures

The treatment began with *Udwarthana* using *Triphala churna* for 7 days. *Udwarthana* has *kaphahara* and *medo pravilayana* properties, which help remove *kapha* accumulation and *medo dosha*, particularly beneficial for diabetic patients with *Prameha*^[25]. *Triphala churna*'s properties, including *kaphadoshahara*, *medodoshahara*, and *srotoshodhana*, made it an ideal choice for *Udwarthana* in this case.^[26]

Following *Udwarthana*, *Takradhara* was performed using *amalaki* and *musta kashaya* for 7 days. This procedure calmed the mind, reduced stress and anxiety, and promoted better sleep quality^[27].

Next, *Snehapana* was conducted with *Indukantha ghrita* and *Kalyanaka ghrita* for 7 days. *Snehapana* nourishes dry tissues, enhances strength and digestion, and has *vata*shamaka properties that helps to reduce rigidity in Parkinson's disease. The *vata*kapha *hara*, *vatanulomana*, *dhatubalavardhaka*, and *srotoshodhana* actions of *Indukantham ghrita*^[28], together with the *tridosahara*, *agnivardhana*, *medhya*, *smritiprada*, *brimhana*, and *manaprasadana* effects of *Kalyanaka ghrita*, worked synergistically to enhance speech, uplift mood, and strengthen cognitive abilities^[29].

After *Snehapana*, the *Vamana* procedure was performed using *madanaphala* and *yashtimadhu kashaya*. Since *sthambhana* in Parkinson's disease is often due to *kapha*

accumulation, *Vamana karma* helped to pacify *kapha dosha*, providing relief from rigidity, masked facies, and bradykinesia.

Following *Vamana*, *Abhyanga* was done for 3 days with *Chinchadi taila*. *Chinchadi taila*'s properties, including *srothoshodhaka*, *sulaharatwa*, *sothaharatwa*, *dhatuposhakatwa* and *vata*kapha *hara* *hara*, further alleviated pain and stiffness caused by muscle rigidity.^[30,31]

The next treatment was *Shirodhara* with *Vatasani taila* for 7 days. In Parkinson's disease, both psychosomatic functions are affected. *Shirodhara* regulates emotional behavior and sleep. *Vatasani taila*'s *vata*-*pitta* *shamana*, *balya*, and *brimhana* properties promoted sound sleep patterns and neuronal regeneration.^[32]

Ultimately, *Nasya* with *Ksheerabala 21 avarti* was administered for a duration of 7 days. This treatment provided a *brimhana* effect to the degenerative brain condition, strengthening and rejuvenating nerves. *Ksheerabala*, through its *indriyaprasadana* property, was also found to enhance cognitive functions and reduce impairment^[33].

Conclusion

This case demonstrates that a structured Ayurvedic protocol comprising disease-specific internal medications along with sequential *Panchakarma* procedures can produce significant functional improvement in a patient with rigidity predominant *Kampavata* (Parkinson's disease). The treatment resulted in substantial reduction of rigidity, bradykinesia, postural instability, constipation, and emotional dullness, with a sustained decrease in UPDRS score from 71 to 17 by the end of therapy.

Among all interventions, *Vamana* following adequate *Snehapana* emerged as the turning point, producing the most notable improvement in rigidity and overall motor performance along with mental clarity. Supportive therapies such as *Takradhara*, *Shirodhara*, *Nasya* with *Ksheerabala*, and tailored *ghrita*-based *Snehapana* contributed to better sleep, improved mood, and enhanced cognitive function. The combined effect of *Shodhana* and *Samana* therapies indicates that addressing *kapha avarana* and *vata* vitiation simultaneously may be crucial in managing the core symptoms of Parkinson's disease.

While this is a single-case observation, the marked and sustained improvement suggests that the integrative Ayurvedic approach may serve as a valuable adjunct for improving quality of life and functional outcomes in Parkinson's disease. Larger clinical studies are warranted to validate these findings and further explore the mechanisms behind such therapeutic benefits.

PATIENT PERSPECTIVE

The patient and his family were very much satisfied with ayurvedic treatment, assessment and follow up as he obtained considerable reduction from his complaints which improved his quality of life and social interections.

PATIENT CONSENT DECLARATION

The authors hereby confirm that informed consent was obtained from the patient for publication of this case report. The patient was made aware that their name and initials would remain confidential, and all reasonable measures would be taken to protect their identity; however, complete anonymity cannot be guaranteed

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