



Sanjeevani Darshan

ISSN: 2584-0304

<http://sanjeevanidarshan.com>



National Journal of
AYURVEDA & YOGA

Year - 2026

Volume 4, Issue 3

“AYURVEDIC MANAGEMENT OF PAKSHAGHATA (RECURRENT CEREBROVASCULAR ACCIDENT): A CASE STUDY”

Dr. Nikita G. Deulkar¹, Dr. Archana Dachewar-Singam²

1. PG Scholar of Kayachikitsa department of Shri Ayurved Mahavidyalaya, Nagpur.
2. HOD and Professor Kayachikitsa department of Shri Ayurved Mahavidyalaya, Nagpur.

ABSTRACT:

Stroke or cerebrovascular accident (CVA) is characterized by a sudden, localized neurological deficit caused by disturbance in the cerebral vasculature, and remains one of the leading causes of death and disability in India, particularly in patients with longstanding, poorly-controlled hypertension. Ayurveda describes such unilateral motor and sensory impairment as Pakshaghata, a Vata-predominant Vatavyadhi affecting the Sia, Snayu and Kandara of one half of the body. Recurrent stroke in an already hemiparetic, hypertensive patient carries a particularly high burden of residual disability, and integrative documentation of such cases can help guide clinical decision-making. **Material and Methods:** A 49-year-old male with an 11-year history of poorly-compliant hypertension and a first right-sided CVA in 2015 presented with a second right-sided CVA of 10 days' duration, with right hemiparesis, gait difficulty, slurred speech, difficulty rising from sitting and insomnia. MRI brain showed an acute non hemorrhagic infarct in the left corona radiata superimposed on chronic small-vessel ischemic change, old right occipital gliosis and diffuse cerebral atrophy; 2D echocardiography showed hypertensive heart disease with concentric left ventricular hypertrophy. The patient was admitted for 15 days and managed with Shaman (oral) Ayurvedic formulations along with Snehana, Nadi Sweda, an 8-day Yoga Baste regimen followed by continued Baste, Nasya, Sahastishali Panda Swede and physiotherapy. **Observation and Result:** At discharge, muscle power in the right upper limb improved from 3/5 to 5/5 and in the right lower limb from 3/5 to 5/5 (MRC scale), with a corresponding increase in deep tendon reflex amplitude on the right side; gait, speech clarity and sleep also improved subjectively, though the right plantar response remained extensor throughout.

KEY WORDS:- Ayurveda, Basti, Cerebrovascular Accident, Nasya, Pakshaghata, Snehana, Stroke, Swedana.

Corresponding Details:

Dr. Nikita Deulkar

Teachers colony, Darwha, dist. Yavatmal

Mobile No. 9405950854

E-Mail: nikitagdeulkar@gmail.com

How to cite article:



Dr. Nikita Deulkar, Dr. Archana Dachewar

Ayurvedic Management of Pakshaghata (Recurrent Cerebrovascular Accident): A Case Study, Sanjeevani Darshan
- National Journal of Ayurveda & Yoga 2026; 4(3): 32-43 : <http://doi.org/10.55552/SDNJAY.2026.4304>

INTRODUCTION

CVA is defined as a focal neurological deficit due to a vascular lesion, and stroke remains one of the leading causes of death and disability in India.[1] Systematic reviews of population-based registries report a crude annual incidence in the range of roughly 105–172 per 100,000 population, with uncontrolled hypertension identified as the single largest attributable risk factor for both first-ever and recurrent stroke.[1] Survivors frequently live with residual hemiparesis, gait disturbance and speech impairment long after the acute event has been managed. Ayurveda describes such unilateral motor and sensory impairment as Pakshaghata, a vatapredominant Nanatmaja Vatavyadhi affecting the Sia, Snafu and Kandara of one half of the body, including the face.[2] The term Pakshaghata is derived from Pasha, meaning either half of the body, and Agatha, meaning impairment of Karmendriya (motor function) and Gyanendriya (sensory function).[11] Management described across classical texts centers on Snehana, Swedana, Baste (regarded as the principal therapy for Vatavyadhi), Nasha and Vata-Kapha-pacifying internal medication, frequently combined in contemporary practice with physiotherapy. We report a case of Ayurvedic management of recurrent right-sided post-stroke hemiplegia (Dakshina Pakshaghata) in a chronically hypertensive patient, managed at the Department of Kayachikitsa, and documented in accordance with the CaRe (Case Report) guidelines.[7]

National Journal of Ayurveda & Yoga

CASE REPORT

OPD No.: 28457

IPD No.: 1183

NAME: Ashwin Rajendra Chandarana

Age/Sex: 49 years / Male

Add.: Nagpur, Maharashtra

Occupation: Advertising Board Making

DOA: 15 June 2026

DOD: 29 June 2026

Provisional Diagnosis: Dakshina Pakshaghata with Hypertension

CHIEF COMPLAINTS

Table No. 1

Complaint	Duration
Dakshina Hastapada Kriya-alpata (weakness of right upper & lower limb)	10 days
Chakramana Kashtata (difficulty in walking)	10 days
Vak-Aspashtata (slurred speech)	10 days
Asanotthana Kashtata (difficulty in rising from a sitting position)	10 days
Anidra (insomnia)	1 month

PAST HISTORY

K/C/O Hypertension since 11 years, on irregular medication (Tab. Telmisartan 40 mg + Chlorthalidone 12.5 mg)

H/O Right-sided CVA (2015); second attack of rightsided CVA 10 days prior to the present admission N/H/O Diabetes Mellitus or Thyroid disorder

H/O Chikungunya (2.5 years prior to admission)

H/O Stab injury to the abdomen (1996), managed surgically

H/O Inguinal hernia (6 months prior to admission)

FAMILY HISTORY

Mother — K/C/O Hypertension. No other contributory family history reported.

PERSONAL HISTORY

Ahara (Diet): Katu (pungent) Rasa; lacto-vegetarian (non-vegetarian: no)

Vihara (Lifestyle): Sedentary; no daytime sleep

Vyasana (Addictions): Smoking, tobacco (Kharra) and alcohol for approximately 40 years; discontinued 15 days prior to admission

HISTORY OF PRESENT ILLNESS

The patient was apparently well till about 10–15 days prior to admission. He has a known case of hypertension since 2011, for which he had been taking irregular medication. He suffered a first rightside CVA in 2015, for which he received conventional (Allopathic) treatment with good relief. About 10 days prior to the present admission, he had a second attack of right-sided CVA, presenting with vertigo, dizziness and right-sided weakness, for which he received 4 days of intensive care with only partial relief. He was then admitted to the Department of Kayachikitsa, Pakwasa Samanvaya Rugnalaya, Nagpur, for further Ayurvedic management.

GENERAL EXAMINATION

On admission, the patient was moderately built. Blood pressure was 160/100 mmHg and the pulse rate was 80/min.

Cardiovascular examination revealed normal S1 and S2. The patient was conscious and oriented.

Respiratory examination showed air entry bilaterally equal and clear.

The pre-abdominal examination was soft and non-tender.

Sanjeevani Darshan

ASHTAVIDH PARIKSHA

National Journal of Ayurveda & Yoga

1. Nadi: 80/min;
2. Mala: once daily, hard stool;
3. Mutra: daytime 7–8 times and night 4–5 times;
4. Jivha: Saam;
5. Shabda: Vak-aspashtata;
6. Sparsha: Samashitoshna;
7. Druk: Prakrita;
8. Akrti: Madhyama.

SYSTEMIC EXAMINATION: CENTRAL NERVOUS SYSTEM

Table No. 2

Parameter	Finding
Consciousness	Conscious and oriented
Cranial Nerve Examination	Dysarthria (slurred speech); other cranial nerves not separately documented
Motor Examination — Muscle Power (MRC /5)	Right UL 3/5, Right LL 3/5; Left UL 5/5, Left LL 5/5
Deep Tendon Reflexes — Right	Biceps +++ Triceps +++ Brachioradialis ++ Knee +++ Ankle ++
Deep Tendon Reflexes — Left	Biceps ++ Triceps ++ Brachioradialis ++ Knee ++ Ankle ++
Plantar Response	Right — extensor (extension of great toe with flexion of other toes); Left — flexor
Parameter	Finding
Gait	Significantly impaired due to right hemiparesis (Chakramana Kashtata); ambulation required assistance

Grades of Deep Tendon Reflexes: 0 = Absent, + = Diminished, ++ = Normal, +++ = Brisk/Exaggerated, ++++ = Clonus.

OBJECTIVE FINDING

MRI brain (Plain), performed at the time of the acute event, showed: a patchy area of acute nonhemorrhagic (ischemic) infarct in the left corona radiata; no intracranial hemorrhage; a gliotic area in the right occipital lobe with ex-vacuo dilatation of the right lateral ventricle (sequela of the 2015 event); a small chronic hemorrhagic residue in the left basal ganglia; multiple discrete T2-weighted/FLAIR hyperintensities in the bilateral periventricular frontoparietal white matter consistent with chronic small-vessel ischemic change; chronic lacunar infarcts — deep, small infarcts located in the basal ganglia or deep white matter[10] — in the bilateral ganglio-capsular region; and diffuse cerebral atrophy. 2D-Echocardiography: Hypertensive heart disease with concentric left ventricular hypertrophy and Grade I diastolic

dysfunction; no mitral or aortic regurgitation; no pulmonary hypertension. Lipid Profile (08 June 2026): Total cholesterol 153 mg/dL; Triglycerides 102 mg/dL; HDL-C 41 mg/dL; VLDL-C 20.4 mg/dL; LDL-C 91.6 mg/dL; LDL-C/HDL-C ratio 2.23; Total cholesterol/HDL-C ratio 3.73 — all within generally accepted desirable limits.

Laboratory investigations (08 June 2026):

Investigation	Result
---------------	--------

Haemoglobin	15.1 g/dL
-------------	-----------

Total leukocyte count	12,100/cu mm
-----------------------	--------------

Neutrophils (P)	75%
-----------------	-----

Lymphocytes (L)	20%
-----------------	-----

Eosinophils (E)	03%
-----------------	-----

Monocytes (M)	02%
---------------	-----

Basophils (B)	00%
---------------	-----

Investigation	Result
---------------	--------

MCV	90.6 fL
-----	---------

MCH	31.7 pg
-----	---------

MCHC	35.0%
------	-------

Platelet count	3.33 lakh/cumm
----------------	----------------

RDW-CV	13.1%
--------	-------

Serum creatinine	1.27 mg/dL
------------------	------------

HIV and HBsAg were negative.

DIAGNOSIS

On the basis of the clinical presentation and MRI brain findings, this was diagnosed as a case of recurrent ischemic cerebrovascular accident (Dakshina Pakshaghata) against a background of longstanding, poorly-controlled hypertension.

SAMPRAPTI (PATHOGENESIS)

Dosha: Vata (Viana Vāyu) predominant, with secondary Pitta involvement. Dushya: Rasa, Rakta, Mamsa, Asthi and Marja Dhatu. Rotas: Pranav aha, Annavaha, Rasavaha, Asthivaha, Majjavaha and Manovaha. Longstanding Nidana-sevana (irregular medication, tobacco and alcohol use, sedentary Mihara) over more than a decade progressively vitiated Vata; recurrent Rakta-Vaha Srotodushti culminated in obstruction of Vata's normal course, producing Ardhangata Vata (unilateral motor and sensory loss) — the classical Samprapti of Pakshaghata, corresponding here to a recurrent ischemic cerebrovascular event.

TREATMENT PROTOCOL

The patient was admitted to the ID of Kayachikitsa, Pakwasa Samanvaya Rugnalaya, Nagpur. Plans of Shaman and Shodhan Chikitsa were adopted at various stages of the disease, along with physiotherapy.

SHAMAN CHIKITSA

Table No. 3

Name of Medicine	Dose	Frequency & Duration
Bruhatvatachintamani Rasa	1 tablet	BD × 5 days
Sukshma Bruhatvatachintamani Rasa with Guduchi Satva	As advised	QID × 1 month (from day 6)
Cap. Palsineuron	1 capsule	TDS
Vacha + Chitrak + Pippali churna	2 g each	Jivha Pratisarana
Eranda Taila	10 ml	H.S.
Name of Medicine	Dose	Frequency & Duration
Brahmi Vati	2 tablets	H.S.
Vatahara Samshamana Churna + Asthiposhaka Yoga	3 g each	BD
Mukta Vati	2 tablets	BD
Jatamansi Phanta	30 mL	BD

SHODHAN CHIKITSA

Table No. 4

Name of Procedure	Name of Drug	Quantity	Durati on
Sarvanga Snehana (local)	Bala Taila	—	Daily
Nadi Sweda (local)	—	—	Daily
Yoga Basti (phase 1) — Anuvasana / Niruha	Sahachar Taila / Dashamuladi Kwatha	60 mL / 350 mL	Days 1–8
Yoga Basti (phase 2) — Anuvasana / Niruha	Sahachar Taila / Mustadi Yapana Basti	60 mL / 150 mL	Days 9 onward
Nasya	Panchendriya Vardhana Taila	—	Course during admission
Sahastishali Pinda Sweda	—	—	For 15 days

PHYSIOTHERAPY — adjunct rehabilitative limb exercises, daily throughout the admission (15 days).

OBSERVATION

A formal activities-of-daily-living scale (e.g., the Barthel Index) was not administered in this case, unlike some published Pakshaghata case reports; its use is recommended for future documentation of this kind.^[8]

MUSCLE POWER GRADE

Table No. 5

Extremity	BT (Before Treatment)	AT (After Treatment)
Rt. Upper Limb	3/5	5/5
Rt. Lower Limb	3/5	5/5
Lt. Upper Limb	5/5	5/5
Lt. Lower Limb	5/5	5/5

(BT — Before Treatment, AT — After Treatment)

DEEP TENDON REFLEXES — BEFORE AND AFTER TREATMENT**Table No. 6**

Reflex	Rt. BT	Rt. AT	Lt. BT	Lt. AT
Biceps	+++	+++	++	++
Triceps	+++	+++	++	++
Brachioradialis	++	+++	++	++
Knee	+++	+++	++	++
Reflex	Rt. BT	Rt. AT	Lt. BT	Lt. AT
Ankle	++	+++	++	++
Plantar	Extensor	Extensor	Flexor	Flexor

DISCUSSION

This case illustrates recurrence of ischemic cerebrovascular disease in a patient with over a decade of poorly-controlled hypertension — a pattern well recognized in Indian stroke-epidemiology data, where uncontrolled blood pressure is consistently identified as the leading modifiable risk factor for both first and recurrent stroke.[1] Ayurveda views Vata as the primary causative Dosha in Pakshaghata, and its pathogenesis is described as progressing from an early, correctable stage of muscular flaccidity to a later stage of fixed contracture; Snehana and Swedana administered early are said to prevent this progression, with Abhyanga additionally improving local blood supply and preventing disuse muscular changes.[12] Swedana specifically alleviates Sthambha (stiffness), Gaurav (heaviness) and Sheetata (coldness) in the affected limbs, [13] which corresponds to the Nadi Sweda given to this patient's right upper and lower limb. Virechana is considered an important line of management in Pakshaghata, since both Vata and Pitta Doshas are held to be disturbed, and Virechana helps eliminate the vitiated Doshas;[14] in this patient, a Veranda Tail was administered at bedtime for this purpose, Errand Tail being classically and pharmacologically documented for its Vata pacifying and mild purgative actions.[20] Baste was given as Saha char Tail Anuvasana with Dashamuladi Katha Niruha is on an eight-day Yoga Baste schedule, followed by a Yapana-type maintenance Baste; Saha char Tail is a well-described Vatashamaka oil used in Basti for Vatavyadhi, [15] and Dashamula-based Niruha Baste is specifically indicated in Vata-predominant disorders. Nadya with Panchendriya Vardhana Taila was used for its Vatashamaka action and its classically described access to Shirah-Pradesh, the principal seat (Adhishthana) of the Indriyas, by way of the nasal route.[16] Among the oral formulations, Bruhat Vatachintamani Rasa is attributed with Madhya (nervine), Ramayana, Bala and Ojovardhana properties and has a documented, targeted role

in the management of Pakshaghata;[9,17] The improvement in sleep observed in this patient is consistent with its traditional sedative, central-nervous-systemmodulating action. Capsule Palsineuron, a combination of Ekangaveera Rasa, Mahavatavidhwamsa Rasa, Sameerpannag Rasa and Sutashekhara Rasa — all classically indicated in Vataja Roma — was continued through the course of treatment to address limb weakness and stiffness.[18] Jivha Pratisarana with Vache, Chitral and Pippali churn was used for the reported speech difficulty; Vache in particular is a key Madhya Dravya described for its role in speech and cognitive Disorders.[19]

Two observations from this case merit specific attention. First, although muscle power improved substantially on the right side (upper limb 3/5 to 5/5; lower limb 3/5 to 5/5), the right plantar response remained extensor throughout, indicating that pyramidal tract involvement had not fully resolved despite the functional gain — an important distinction for patient counseling and continued rehabilitation planning. Second, several of the prescribed formulations, notably Bruhat Vatachintamani Rasa, are herbo-mineral (RasaBhasma) preparations that should be sourced only from Good Manufacturing Practice-certified manufacturers and used under continued clinical supervision. This report, like the similar recently published Pakshaghata case series with which its findings are broadly concordant, [3–6] has the inherent limitations of a single case: no control comparison and a short (15-day) observation window without a validated stroke-specific outcome scale such as the Barthel Index or modified Rankin Scale.[8] The improvement described should therefore be interpreted as a preliminary clinical observation rather than evidence of efficacy.

CONCLUSION

Pakshaghata is a Vataja Nanatmaja Vyadhi considered among the Mahavatavyadhis, and Vata is regarded by all Acharyas as the predominant Dosha in its manifestation. A clear understanding of the physiological and pathological aspects of Vata is therefore essential before initiating treatment. In this case, a combination of Shamans Aushadhis, Panchakarma procedures (Snehana, Swedana, Baste, Nasha) and physiotherapy — planned according to the patient's Dosha and Shana Dashti — resulted in a measurable improvement in right-sided muscle power and in gait, speech and sleep by the time of discharge. The results were encouraging and support the continued documentation of integrative Ayurveda-physiotherapy protocols in post-stroke hemiplegia; controlled studies using validated outcome scales are recommended to substantiate these observations.

CONSENT, CONFLICT OF INTEREST AND SOURCE OF SUPPORT

Consent: The supplied records contain an admission consent form, but they do not clearly document specific written consent for publication of this case report. Publication-specific written informed consent should be obtained and documented before submission.

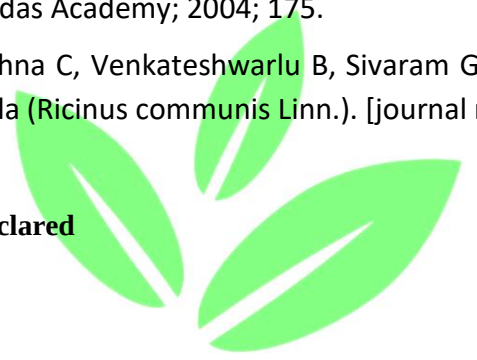
REFERENCES

1. Jones SP, Baqai K, Clegg A, Georgiou R, Harris C, Holland EJ, et al. Stroke in India: a systematic review of the incidence, prevalence, and case fatality. *Int J Stroke*. 2022;17(2):132–140.
2. Agnivesha, Charaka, Dridhabala. *Charaka Samhita, Sutrasthana, Maharoga Adhyaya*, Chapter 20. Edited by Vaidya Yadavaji Trivikramji Acharya. Varanasi: Chaukhambha Prakashana; 2013.
3. Mohan V, B D, Deva S. Ayurvedic management of Pakshaghata (left hemiplegia) — a case study. *Int J Ayurvedic Med*. 2021;12(3):733–741.
4. Lodhi S, Shukla RK, Sharma V, Sharma S. Role of Ayurvedic management in Pakshaghata (hemiplegia): a case report. *J Ayurveda Integr Med Sci*. 2024;9(3):204–207.
5. A case report on Pakshaghata: Ayurvedic intervention in hemorrhagic hemiplegia management. *J Pharm Bioallied Sci*. 2025 [Epub ahead of print]. PubMed PMID: 41846722.
6. Pakshaghat and its management through Panchakarma: a case study. Department of Panchakarma, Parul Institute of Ayurveda, Parul University, Vadodara, Gujarat, India; 2021.
7. Gagnier JJ, Kienle G, Altman DG, Moher D, Sox H, Riley D; CARE Group. The CARE guidelines: consensus-based clinical case reporting guideline development. *J Med Case Rep*. 2013;7:223.
8. Management of Pakshaghata (hemiplegia due to basal ganglia bleed) through Panchakarma — a case study documenting improvement in Hamilton D Scale, Barthel Index, Scandinavian Stroke Scale and modified Rankin Scale. *J Indian Syst Med*. 2021;9(1):45–49.
9. Islam MN, Sattar M, Haque S, Shahriar M, Choudhuri MSK. A psycho-pharmacological study of Brhat Vatacintamani Rasa, a classical Ayurvedic drug. *Orient Pharm Exp Med*. 2003;3(2):96–103.
10. Munjal Y.P. *API Text book of Medicine Volume2*. 9th ed. New Delhi: Jaypee Brothers Medical Publishers (P) Ltd.; 2012; 1410.
11. Sharma R K. *Agnivesa's Caraka Samhita Sutra Stana*. Reprint edition. Varanasi: Chaukambha Sanskrit Series; 2011; 163.
12. Acharya Vagbhatta. *Astangahridaya*. Shri Arunadatta & Hemadri, editor. Sutrasthana, 2/8. Varanasi: Chaukhambha Surbharti Prakashan; 2017; p-26.
13. Susruta. *Susruta Samhita*. Shri Dalhanacharya, editor. Chikitsasthana, 37/4. Varanasi: Chaukhambha Surbharti Publisher; 2018; p-531.
14. Sharma R, Das V. *Agnivesha's Charaka Samhita*. Chapter 28. Varanasi: Chaukhambha;

2011; p-51.

15. Ayurved Sarsangraha. Shri Baidyanatha Ayurveda Bhavana, editor. Elahabad: Shri Baidyanatha Ayurveda Bhavana Pvt. Ltd.; 2021; p787.
16. Paradakara HSS. Ashtanga Hrudayam with Sarvanga Sundaram commentary of Arunadatta and Ayurveda Rasayana of Hemadri. Chikitsasthana 21. 10th ed. Varanasi: Chaukambha Orientalia; 2011; p.726.
17. Navami LR, Aniruddha S, Shrilatha T. Review of Bruhat Vata Chintamani Rasa in the management of Pakshaghata (stroke). IAMJ. 2022 Feb. doi:10.46607/iamj3210022022. ISSN: 2320-5091.
18. Palsineuron Capsule — uses, side-effects, reviews and precautions. S.G. Phytopharma, product insert.
19. Murthy KR. Shri Bhava Mishra Bhava Prakasha Nighantu, Vol-1. 1st edition. Varanasi: Chaukhambha Krishnadas Academy; 2004; 175.
20. Anumol K, Murali Krishna C, Venkateshwarlu B, Sivaram G, Babu G. A comprehensive review on Eranda Thaila (*Ricinus communis* Linn.). [journal not specified in source].

Source of Support : None Declared
Conflict of Interest : Nil



Sanjeevani Darshan
National Journal of Ayurveda & Yoga