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AYURVEDIC MANAGEMENT OF CHRONIC KIDNEY DISEASE: A SINGLE-CASE REPORT

SAJJANAVAR A[1*] AND PRASHANTH AS[2]

1: PhD Scholar, Ayurveda Mahavidyalaya Hubballi, Associate Professor, BLDEA'S AVS Ayurveda Mahavidyalaya Hospital & Research Center Vijayapur

2: Research Guide, Principal, Associate professor, Department of Kayachikitsa Ayurveda Mahavidyalaya Hubballi

***Corresponding Author: Dr. Ashwini Sajjanavar: E Mail: dr.ashwini.sajjan@gmail.com**

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ABSTRACT

Introduction: Chronic kidney disease (CKD) does not have a one-to-one description in the classical Ayurvedic texts; however, its clinical presentation may be interpreted through the framework of Mutravaha srotas disorders and conditions such as Mutrakricchra, Mutraghata and Mutrotsanga. The kidney, referred to as Vrikka, is discussed in relation to Vrikka rogas. Disturbance of Kledata and Ambuvaha Srotas may contribute to the pathogenesis, while Basti is an important therapeutic procedure for disorders involving the Pakwashaya. Since Basti is closely associated with vital functions, improper management may produce serious complications. Materials and methods: The patient was managed in the Kayachikitsa OPD of BLDEA's AVS Ayurveda Mahavidyalaya, Vijayapur. Results and discussion: A 46-year-old male patient received Mustadi Yapana Basti according to the Kala Basti schedule, followed by Veerataradi Ghanavati for 30 days, with improvement in selected clinical features and biochemical parameters of CKD.

Keywords: Vrikkarogas, Prameha, Veerataradi Ghanavati, CKD

INTRODUCTION:

In the Ayurvedic perspective, Vrikka may be correlated functionally with the kidneys described in contemporary medicine. The kidneys participate in

elimination of metabolic waste through urine. Vrikka is described as a Moolasthana of Medovaha Srotas, and disturbance involving Shonita and Meda may be considered in the understanding of Vrikka roga **[1]**. Therefore, the clinical manifestations of renal disorders described in contemporary medicine may be interpreted in relation to relevant Mutraroga presentations in Ayurveda.

Chronic renal failure may be understood as a disorder involving the Mutravaha Srotas, with participation of Tridosha and Srotodushti. Depending on the extent of glomerular involvement, impairment of filtration, reabsorption and secretion may occur, producing progressive functional changes in the renal system.

Although chronic kidney disease is not described as a distinct entity in the classical Ayurvedic literature, elevated serum creatinine may be considered an indicator of Mutravaha Srotas dysfunction in the present clinical context. Vrikka is described in relation to Rakta and Meda; hence, disturbance of these tissues along with Vata involvement may be considered while interpreting reduced renal filtration. Urine formation and its subsequent passage are discussed in relation to Pakvashaya and Mutrashaya. As Pakvashaya is regarded as an important site of Vata and Basti acts primarily in this region, Basti therapy was considered relevant in the present management.

Charaka Samhita, Siddhisthana, describes Mustadi Yapana Basti and Punarnavadi Ksheera Basti in the context of dosha alleviation. Punarnava has been reported to possess activities such as antioxidant, hepatoprotective, fibrinolytic, lipid-peroxidation inhibitory and smooth-muscle-relaxant effects. These properties have been considered supportive in the present therapeutic rationale, particularly with respect to renal function and elimination of metabolic waste **[2]**.

The drugs belonging to Veeratarvadi Gana are described as having Mutrala, Mutravirechaniya, Shothahara, Medohara and Grahi actions. The formulation may therefore support urinary output and help address oliguria in the present clinical setting. Gokshura and Apamarga are also attributed Rasayana-related benefits, and their antioxidant potential may contribute to protection against tissue damage. Thus, the therapeutic approach was planned according to the Ayurvedic principle of supporting and preserving the function of the Mutravaha Srotas **[3]**.

CASE HISTORY:

A 46-year-old male patient (OP/IP No. 2820/198), with a five-year history of diabetes mellitus, presented with bilateral lower-limb swelling of one-month duration. This was associated with reduced appetite

for approximately 20 days and nausea and vomiting for two weeks. A reduced haemoglobin level had also been noted during the preceding month. The patient had been symptomatic for about three months and had previously received symptomatic treatment from a local physician. Subsequent elevation of serum creatinine and urea, accompanied by persistent nausea and vomiting, led to admission for further Ayurvedic management.

Personal history:

Appetite - reduced

Bowel: normal, once a day

Bladder: 2-3 times a day, dysuria-present, scanty micturition.

Sleep: disturbed (due to mental stress)

Habits: Nil

General examination:

BP- 140/100mmHg

Pulse- 76bpm

RR- 20/min

Pallor- Present +

Icterus- absent

Cynosis- absent

Clubbing-absent

Edema- bilateral pedal edema

Diagnostic criteria:

Subjects having classical common signs and symptoms of Mutraghata and Shotha:

• Dourbalya - Fatigue

• Anavasthita utseda - Swelling

• Padashotha – Pedal oedema

• Gandaakshi kootashotha- Periorbital edema

• Siratanutwa – Prominent thin veins

• Angavivarnata – Discolouration

• Sashoola mutrata- Dysuria

• Alpamutrata- oliguria

• Raktamootrata –Hematuria

2. Subjects having cardinal features of Chronic Kidney Disease such as

Pruritis, Edema , Hematuria, Weakness, Nausea.

3. Subjects having abnormal Glomerular Filtration Rate levels.

Study design:

Randomised open label clinical study.

Sampling technique:

• Subjects satisfying the predefined inclusion criteria, providing written informed consent, and willing to involve in the study procedures were enrolled for the trial.

ASSESSMENT CRITERIA:

➢ Signs and symptoms of Chronic Kidney Disease –

✓ Edema – edema grading scale

✓ Pruritis- Pruritis grading system

✓ Hematuria – Hematuria assessment scale

✓ Common fatigue scale

✓ Visual analogue scale – fatigue severity

✓ Composite assessment of the commonly observed features of Mutraghata and Shotha, including Dourbalya, Anavasthita udara utseda, Padashotha, Siratanutwa, Salomaharsha, Angavivarnata, Sashoolamutrata, Alpamutrata, Gandaakshikoota shotha and Raktamootrata.

➢ Patients suffering from Renal failure (e GFR Levels).

TREATMENT GIVEN:

1. Mustadi Yapana Basti

Kwatha – Mustadi yapana basti kwatha

Kalka – Mustadi yapana kalka

Madhu- 40ml

Saindhava -5gms

Ghrita- 50ml

Taila – 50ml

Ksheera-350ml

Water- 700ml

2. Anuvasana with Murchita ghrita 40ml+ murchita thaila 40ml

3. Abhyanga with Dhanwantari thaila.

4. Veerataradi Ghanavati 500mg 2TID for 30days

INVESTIGATIONS:

Hb- BT: 8.6 gm/dl AT: 9.8gm/dl

Urea

Before treatment Urea- 152mg/dl

After treatment Urea- 96mg/dl

Serum creatinine-

Before treatment: Serum creatinine – 7.5mg/dl

After treatment: Serum creatinine – 6.8mg/dl

EGFR Levels:

BT: 8 ml/min/1.73m^2

AT: 11.3ml/min/1.73m^2

RESULTS:

Table 1

S. No.	Parameters	BT	AT
1	Dourbalya – Fatigue	++	+
2	Anavasthita udara utseda- Swelling	2	1
3	Padashotha – Pedal oedema	2	0
4	Gandaakshi kootashotha -Periorbital edema	3+	0
5	Siratanutwa – Prominent thin veins	0	0
6	Angavivarnata – Discolouration	0	0
7	Sashoola mutrata- Dysuria	+	AB
8	Alpamutrata- oliguria	1	0
9	Raktamootrata –Hematuria	0	0
10	Serum creatinine	7.5	6.8
11	Hb	8.6	9.8
12	Urea	152	96
13	eGFR levels	8	11.3

DISCUSSION:

According to the interpretation presented by Ashtanga Hridaya and Arunadatta, Mutravikara may broadly be viewed in two clinical patterns: Mutra Apravruttijanya and Mutra Atipravruttijanya Vikara. On correlating the clinical features of CKD with this

framework, the present case can predominantly be considered under Mutra Apravruttijanya Vikara because of reduced urinary output and associated manifestations. Conditions such as Mutrakricchra, Mutraghata and Ashmari are discussed within this spectrum. Prameha, although primarily associated with Medovaha Srotas, may also be considered in relation to Mutra Atipravruttijanya Vikara because of its characteristic Prabhuta-avila-mutra presentation **[4]**.

Basti and Vankshana are described as Moolasthana of the Mutravaha Srotas. Considering the anatomical proximity of the kidneys to the Vankshana region, Vrikka may be interpreted as having an important relationship with the origin of the Mutravaha Srotas **[5]**. The fluid waste is ultimately transformed into urine and reaches the Basti for elimination. Sushruta describes the Mutravaha channels in relation to the Pakwashaya and the passage of urine. The functional relationship among Pakwashaya, Vrikka and Basti provides an Ayurvedic rationale for considering Basti in disorders affecting urinary function.

The reference to 'Ksheenasya' may be understood in terms of a person with diminished bodily strength. Ksheena can indicate depletion of the body as well as reduction in Bala. Bala may be considered both in terms of physical capacity and Abhyantara Bala, the latter being associated with Ojas. In the present discussion, greater emphasis is placed on Abhyantara Bala. Swabhava, Dosha and Jara are described among the factors that can contribute to weakness or reduced Bala **[6]**.

Dhatu Kshaya may develop either rapidly (Sadya) or progressively (Chira). Acute depletion may be associated with loss of Udaka, Rasa or Rakta, while conditions causing substantial volume loss are included among the causes of Kshaya. Shonita srava and excessive elimination of Mala are examples described in this context. Mutraghata is also mentioned as an Upadrava in certain acute disorders. From the perspective of CKD, disturbance of Rasa/Udaka and Rakta can therefore be considered relevant. In the present patient, the history of Prameha together with urinary and renal manifestations supported assessment of the clinical parameters and selection of Mustadi Yapana Basti **[7]** followed by the Shamana formulation Veerataradi Ghanavati **[8]**, described in the context of Vrikka disorders **[9]**.

CONCLUSION:

The present case showed improvement in clinical manifestations and selected biochemical parameters after the intervention, although the findings should be interpreted in view of the limitations of a single-case report. In accordance with the Ayurvedic management principles described for Vrikka rogas, Basti was

incorporated as the principal procedure because of its relevance to Pakwashayagata disorders. The treatment plan also incorporated drugs with Mutravirechaniya, Mutravirajaneeya and Mutrasangrahaneeya actions. These observations suggest that the adopted protocol may have therapeutic potential in CKD; however, controlled studies with larger samples are required before firm conclusions can be drawn.

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