

Ayurvedic Management of *Kitibha Kushtha* (Psoriasis) with *Shamana Chikitsa*: A Case Report

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Abstract

Psoriasis is a chronic, immune-mediated inflammatory skin disorder affecting approximately 2–3% of the global population and is correlated with *Kitibha Kushtha* in Ayurveda, a *Kshudra Kushtha* characterized by the vitiation of *Vata* and *Kapha Doshas* along with *Rakta Dhatu*. Although *Shodhana Chikitsa* is considered the classical line of management, *Shamana Chikitsa* serves as a practical outpatient alternative. A 42-year-old male painter presented with a three-year history of erythematous, scaly plaques over the chest, abdomen, back, and upper limbs, with seasonal aggravation during winter. Previous allopathic treatment had failed to provide sustained relief. Based on classical Ayurvedic features and clinical examination, a diagnosis of *Kitibha Kushtha* was established. The patient was treated exclusively with *Shamana Chikitsa* for 30 days using *Arogyavardhini Vati*, *Manjisthadi Vati* (*Bruhat*), *Gandhak Rasayan*, *Haridrakhanda Churna*, and topical application of 777 oil. Clinical response was assessed using the Psoriasis Area Severity Index (PASI), which showed a reduction from 16.0 at baseline to 0 by Day 30, indicating complete remission. The patient remained asymptomatic without recurrence during a six-month follow-up. This case demonstrates that a structured *Shamana Chikitsa* protocol can achieve rapid and sustained remission in *Kitibha Kushtha* and supports the need for larger controlled clinical studies to further evaluate its therapeutic efficacy.

Key words : *Kitibha Kushtha*, *Shamana Chikitsa*, Psoriasis, PASI, *Ayurveda*.

Psoriasis is a chronic, relapsing, immune-mediated inflammatory skin disorder with a global prevalence of approximately 2–3%, affecting individuals across all age groups and ethnic backgrounds.¹⁰ It is characterized by well-demarcated erythematous plaques covered with silvery-white scales, typically distributed over the extensor surfaces, scalp,

and lumbosacral region. Beyond its dermatological manifestations, psoriasis is associated with a significant burden of comorbidities, including psoriatic arthritis, cardiovascular disease, metabolic syndrome, and psychological distress, all of which substantially impair quality of life.⁴

In the classical Ayurvedic system of medicine, skin disorders are collectively categorized under *Kushtha*, a term encompassing eighteen distinct conditions described in the *Brihatrayi* (the three major classical texts). Acharya Charaka classified *Kushtha* into *Mahakushtha* (seven major skin diseases) and *Kshudra Kushtha* (eleven minor skin diseases). *Kitibha Kushtha* belongs to the latter group and is characterized by *Shyava* (blackish discolouration), *Kina Sparsha* (rough texture resembling the surface of hide), and *Parusha* (hardness) — features that correspond closely to the clinical presentation of plaque-type psoriasis.¹

From an Ayurvedic pathophysiological standpoint, *Kitibha Kushtha* arises from the aggravation of *Vata* and *Kapha Doshas*, which subsequently vitiate *Rakta* (blood), *Twak* (skin), *Mamsa* (muscle tissue), and *Ambu* (lymph/fluid component), collectively referred to as the four *Dushyas* in *Kushtha Nidana*.³ This multidosha involvement renders the condition inherently complex and places it among the *Kruchhrasadhya Vyadhis* (diseases that are difficult to cure). Some classical references further categorize *Kushtha* among the *Ashta Mahagada*, a group of eight grave diseases demanding sustained therapeutic intervention.¹³

Treatment of *Kitibha Kushtha* in

classical Ayurveda involves a two-pronged approach. *Shodhana Chikitsa* (bio-purification therapies, including *Vamana* and *Virechana*) is considered the primary intervention for eliminating deeply lodged *Doshas*, while *Shamana Chikitsa* (palliative therapy) is employed to mitigate symptoms, restore *Agni* (digestive fire), and achieve long-term equilibrium.¹ However, *Shodhana* procedures require stringent patient eligibility criteria, institutional infrastructure, and careful monitoring, which may not always be immediately accessible in routine outpatient practice.

This case report documents the clinical outcome of a 42-year-old male patient with established *Kitibha Kushtha*, managed exclusively with *Shamana Chikitsa* over a period of 30 days. The aim is to present a structured, reproducible protocol and to highlight the therapeutic potential of classical Ayurvedic formulations in achieving measurable clinical remission, as assessed by the internationally validated Psoriasis Area Severity Index (PASI).

Informed Consent :

Written informed consent was obtained from the patient for publication of this case report and any accompanying data. The patient's identity has been protected in accordance with ethical guidelines.

Patient Information :

A 42-year-old male painter, a non-smoker with no history of alcohol consumption, presented to the outpatient department with complaints of multiple scaly lesions over the chest, abdomen, back, and upper limbs, persisting

for the past three years. Associated pruritus had been present for approximately one year. The lesions were noted to exacerbate during the winter months and partially remit during summer, suggesting a seasonal pattern consistent with *Kitibha Kushtha*.

History of Present Illness :

The patient had been in good health until three years prior to presentation, when he first noticed erythematous scaly patches over the chest. Over the subsequent months, the lesions progressively extended to the abdomen, back, and upper limbs. He consulted multiple dermatologists and received various allopathic treatments, including topical corticosteroids and emollients, over this period; however, no sustained improvement was achieved, and the lesions recurred after cessation of treatment.

It is noteworthy that the patient is employed as a painter, a profession involving regular exposure to chemical solvents, paints, and varnishes — substances that may act as environmental triggers or exacerbating factors in immune-mediated skin conditions such as psoriasis.

Past History: No history of diabetes mellitus, hypertension, or other systemic illness. No prior history of psoriatic arthritis or joint involvement.

Family History :

No similar dermatological condition reported in any first-degree or second-degree relative.

General Physical Examination :

Parameter	Finding
Pulse	76 beats/min, regular
Temperature	98.4°F (afebrile)
Blood Pressure	130/90 mmHg (borderline elevated)
Respiratory Rate	18 breaths/min
Height	170 cm
Weight	70 kg
BMI	24.2 kg/m ²

Ayurvedic Examination (Ashtavidha Pariksha):

Parameter	Finding
Nadi (Pulse)	Vatakaphaja
Mala (Stool)	Regular
Mutra (Urine)	Normal
Jihwa (Tongue)	Mildly coated
Shabda (Speech)	Normal
Sparsha (Skin/Touch)	Rough, dry
Druk (Eyes)	Normal
Akriti (General appearance)	Moderate built
Prakriti	Vatakaphaja

Dermatological Examination :

On local examination, multiple well-demarcated erythematous plaques with adherent silvery-white scales were observed over the chest, abdomen, back, and upper limbs. Shedding of scales was present. Skin texture was rough and dry. The Auspitz sign was not formally documented. No joint swelling or nail changes were noted.

Investigations :

Routine haematological and biochemical investigations were performed. Complete blood

count (CBC), renal function tests (RFT), liver function tests (LFT), random blood sugar (RBS), lipid profile, and stool routine examination were all within normal limits.

Diagnosis

Kitibha Kustha

Treatment Plan :

The patient was managed with *Shamana*

Chikitsa (palliative Ayurvedic therapy) for a period of 30 days on an outpatient basis, with follow-up visits scheduled at 10-day intervals (Day 10, Day 20, and Day 30). The treatment protocol was selected based on the classical Ayurvedic principles of *Vata-Kapha Shamana* (pacification of aggravated Vata and Kapha Doshas), *Raktashodhana* (blood purification), and *Deepana-Pachana* (restoration of digestive fire and elimination of Ama).

Table -1. Treatment Protocol

Medicine	Dose	Anupana	Timing	Route	Duration
<i>Arogyavardhini Vati</i>	500 mg twice daily	Lukewarm water	After meals	Oral	30 days
<i>Manjisthadi Vati (Bruhat)</i>	500 mg twice daily	Lukewarm water	After meals	Oral	30 days
<i>Gandhak Rasayan</i>	250 mg twice daily	Lukewarm water	After meals	Oral	30 days
<i>Haridrakhand Churna</i>	3 g twice daily	Lukewarm water	After meals	Oral	30 days
777 Oil	Applied liberally to affected areas after bathing and at night	—	External	Topical	30 days

Dietary and Lifestyle Advice (Pathya-Apathya) :

The patient was advised to avoid foods known to aggravate *Vata* and *Kapha Doshas*, including excess salt, sour foods, fermented preparations, non-vegetarian foods, and cold beverages. Regular sleep, avoidance of daytime sleeping (*Diwaswapna*), and stress reduction were recommended. Exposure to chemical irritants in his occupational environment was discussed and protective measures were advised (Table-1).

Adverse Effects :

No adverse drug reactions or treatment-related complications were observed during the 30-day treatment period or at the 6-month follow-up visit.

Clinical Assessment Tool :

Disease severity and treatment response were evaluated using the Psoriasis Area Severity Index (PASI), a validated and internationally recognized scoring tool for quantifying the extent and severity of psoriatic involvement, originally described by Fredriksson and Pettersson²

The PASI evaluates three clinical parameters within each of four body regions:

- **Erythema (E):** redness of plaques
- **Induration (I):** thickness of plaques
- **Desquamation (D):** degree of scaling

Each parameter is graded on a scale of 0 (absent) to 4 (maximum severity). The

sum of these three parameters (E + I + D) constitutes the severity score (Grade B) for each region. The body surface area affected within each region is assigned a separate area grade (Grade A) on a scale of 0–6, as detailed in Table-2.

Table-2. PASI Area Grading Scale

Area of Involvement	Grade
0%	0
Less than 10%	1
10–29%	2
30–49%	3
50–69%	4
70–89%	5
90–100%	6

The regional PASI score is calculated as: **Grade A × Grade B × body surface area constant**, where the constants are: Head = 0.1, Arms = 0.2, Trunk = 0.3, Legs = 0.4. The total PASI score is the sum of all four regional scores, ranging from 0 to 72. Standard severity classification is as follows: mild (<7), moderate (7–12), and severe (>12) (Tables 2 & 3).

In this case, on clinical examination, only the arms and trunk demonstrated active psoriatic plaques; the head and lower limbs were unaffected at the time of presentation. Accordingly, PASI scores were calculated for the arms and trunk only. Assessments were performed at four time points: Baseline (Day 1), Day 10, Day 20, and Day 30.

Table-3. PASI Score Assessment at Baseline and Follow-up Intervals

Parameter	Baseline (Day 1)	Day 10	Day 20	Day 30
Arms				
Area Involved (Grade A)	4	3	1	0
Erythema (E)	2	3*	1	0
Induration (I)	3	2	0	0
Desquamation (D)	3	0	0	0
Grade B (E+I+D)	8	5	1	0
Arms PASI (A×B×0.2)	6.4	3.0	0.2	0
Trunk				
Area Involved (Grade A)	4	3	1	0
Erythema (E)	2	3*	1	0
Induration (I)	3	2	0	0
Desquamation (D)	3	0	0	0
Grade B (E+I+D)	8	5	1	0
Trunk PASI (A×B×0.3)	9.6	4.5	0.3	0
Total PASI Score	16.0	7.5	0.5	0
% Improvement	—	53.1%	96.9%	100%

*The transient increase in erythema grade at Day 10 (from 2 to 3) likely represents an initial inflammatory response — a recognised phenomenon during early detoxification in Ayurvedic therapy — despite significant reductions in overall plaque area, induration, and desquamation. The total PASI score nonetheless declined substantially at this assessment point.

Outcome :

At baseline, the patient presented with a total PASI score of 16.0, corresponding to severe psoriatic disease. The arms and trunk were the primary areas of involvement, each demonstrating grade 4 area involvement, with significant erythema, induration, and desquamation.

By Day 10, the total PASI score had decreased to 7.5, representing a 53.1% reduction from baseline. Scaling (desquamation) showed the most rapid response, resolving completely within the first 10 days of treatment. A transient increase in erythema grading was noted at this assessment point, which is discussed further in the Discussion section.

By Day 20, the PASI score had fallen to 0.5 — a 96.9% reduction from baseline — with near-complete resolution of plaques, minimal residual erythema, and complete resolution of induration and scaling. The area of skin involvement had reduced to grade 1 in both assessed regions.

By Day 30, the PASI score had reached 0, indicating complete clinical remission. Skin texture had normalized, active plaques were absent, and the patient reported complete resolution of pruritus. **Six-Month Follow-up:** At the six-month follow-up assessment, the patient remained entirely asymptomatic. No recurrence of lesions, scaling, or pruritus was reported. This sustained remission suggests a durable therapeutic response to the *Shamana Chikitsa* protocol administered.

The present case demonstrates the clinical efficacy of a structured *Shamana Chikitsa* protocol in achieving complete

remission of *Kitibha Kushtha* within 30 days, as quantified by a reduction in the PASI score from 16.0 to 0. This outcome is particularly noteworthy given that the treatment consisted solely of oral Ayurvedic formulations and topical therapy, without recourse to the more intensive *Shodhana* (bio-purification) procedures such as *Vamana* or *Virechana*.

Ayurvedic Pathophysiological Basis :

According to classical Ayurvedic texts, *Kushtha* — including *Kitibha Kushtha* — arises from the simultaneous vitiation of all three *Doshas* (*Tridosha*), with predominance of *Vata* and *Kapha*, acting upon four susceptible *Dushyas*: *Twak* (skin), *Rakta* (blood), *Mamsa* (muscle), and *Ambu* (lymphatic fluid).³ This pathological process is further compounded by *Mandagni* (impaired digestive fire), which leads to *Ama* formation — incompletely metabolized metabolic waste — that circulates through the *Srotas* (body channels) and deposits in the skin, initiating the characteristic inflammatory and proliferative changes of *Kitibha Kushtha*.¹³

This pathophysiology finds a compelling parallel in modern immunology. Psoriasis is now understood as a T-lymphocyte-mediated inflammatory disorder in which dysregulated immune signalling — particularly involving $\text{TNF-}\alpha$, IL-17, and IL-23 — drives keratinocyte hyperproliferation, epidermal thickening, and the formation of erythematous scaly plaques.³ The Ayurvedic concept of *Ama* circulating through compromised channels aligns conceptually with the systemic inflammatory milieu that characterizes moderate-to-severe psoriasis.

In the present case, the patient's *Prakriti* was assessed as *Vatakaphaja*, consistent with the *Dosha* profile described in classical references for *Kitibha Kushtha*. The seasonal aggravation during winter and remission during summer further supports *Vata-Kapha* predominance, as cold and dry weather is known to aggravate both these *Doshas*. Occupational exposure to chemical solvents in his capacity as a painter may have served as an additional environmental *Nidana* (causative factor) contributing to disease chronicity.

Rationale for Shamana Chikitsa Over Shodhana :

Classical Ayurvedic treatment of *Kushtha* prioritizes *Shodhana Chikitsa* as the primary intervention, as it directly eliminates accumulated *Doshas* from their root.¹ However, *Shodhana* procedures demand specific eligibility criteria — the patient must be adequately *Snigdha* (oleated) and *Swedita* (sudated), physically robust, and available for inpatient or supervised management. In routine outpatient practice, these conditions may not always be feasible.

Shamana Chikitsa, by contrast, is accessible, non-invasive, and can be administered in an outpatient setting. While classical texts suggest that *Shamana* alone may not be sufficient for deeply rooted *Kushtha*, the present case demonstrates that when the correct combination of *Deepana-Pachana* (digestive and metabolic correctives), *Raktashodhana* (blood-purifying agents), and *Kushthaghna* (anti-dermatological) drugs is employed with precision, clinically significant and sustained remission is achievable.

Pharmacological Rationale of the Treatment Protocol :

The treatment protocol was designed to simultaneously address *Ama* elimination, *Agni* restoration, *Rakta Shodhana*, and *Twak Prasadana* (skin health restoration) — the four pillars of *Kushtha* management.

Arogyavardhini Vati, described in *Rasratnasamucchaya* and *Bhaishajya Ratnavali*, is a compound mineral-herbal formulation recognized for its *Kushthaghna* (anti-dermatological), *Deepana* (digestive stimulant), *Pachana* (digestive), and *Malashuddhi* (evacuative) properties.¹¹ Contemporary research attributes its efficacy to hepatoprotective, immunomodulatory, and antioxidant mechanisms — actions that are directly relevant to the dysregulated immune environment of psoriasis.⁷ Its mineral constituents, including *Lauha Bhasma* (iron calx) and *Tamra Bhasma* (copper calx), contribute to *Dhatu Poshana* (tissue nourishment) alongside its detoxifying action.

Manjisthadi Vati (Bruhat), as described in *Sharangdhara Samhita*, is a multi-herb formulation with well-established *Raktashodhaka* (blood-purifying) and *Kushthaghna* properties. Among its constituent herbs, *Manjistha* (*Rubia cordifolia*) has been extensively studied for anti-inflammatory, immunomodulatory, and antipsoriatic activity.⁵ *Nimba* (*Azadirachta indica*) and *Guduchi* (*Tinospora cordifolia*) contribute antimicrobial and immunoregulatory effects respectively, while *Haritaki*, *Bibhitaki*, and *Amalaki* (the *Triphala* group) enhance bowel function and systemic detoxification.

Gandhak Rasayan, a classical preparation of purified sulphur (*Shuddha Gandhaka*), is particularly indicated in *Kushtha* for its *Kandughna* (antipruritic), *Krimighna* (antimicrobial), and *Vranropaka* (wound-healing) properties.¹² Sulphur's established antibacterial, antifungal, and keratolytic activity provides a sound biomedical rationale for its inclusion. While it primarily pacifies *Pitta Dosha*, its *Raktashodhaka* action is relevant in a case with significant *Rakta Dushti* (blood vitiation), which co-exists in *Kitibha Kushtha* alongside the primary *Vata-Kapha* disturbance.

Haridrakhand Churna, a classical formulation with *Haridra* (*Curcuma longa*) as its principal constituent, is well-documented for *Kandughna* (antipruritic), *Kaphaghna*, and anti-allergic properties.⁸ Curcumin, the active polyphenol in *Haridra*, has demonstrated significant inhibition of NF- κ B signalling, reduction of pro-inflammatory cytokines including TNF- α and IL-6, and suppression of keratinocyte proliferation in experimental models — mechanisms directly relevant to psoriatic pathophysiology.⁶ Its anti-histaminic action may explain the rapid resolution of pruritus observed in this patient.

777 Oil is a proprietary Ayurvedic topical preparation, primarily composed of *Indrayava* (seeds of *Holarrhena antidysenterica* / *Kutaja*) in a base of coconut (*Narikela*) oil. *Indrayava* is specifically referenced in classical texts as *Kushthagghna*, *Kandughna*, and *Tridosahara*, making it an appropriate topical agent in *Kitibha Kushtha*.¹¹ Its anti-inflammatory, antimicrobial, and emollient properties help reduce epidermal scaling, pruritus, and skin dryness — the predominant local manifestations in this case.

The synergistic interaction of these five formulations — addressing systemic *Ama* elimination, immune modulation, blood purification, and local symptom control simultaneously — likely accounts for the rapid and complete clinical response observed.

Limitations :

As a single-patient case report, no causal conclusions can be drawn and the findings cannot be generalized to the broader psoriatic population.

Future Directions :

The findings of this case report provide a basis for designing larger, controlled clinical trials to systematically evaluate the efficacy and safety of *Shamana Chikitsa* in *Kitibha Kushtha*. Future studies should incorporate randomized controlled designs with adequate sample sizes, standardized dosing protocols, validated quality-of-life instruments, and objective inflammatory biomarkers.

Inference :

This case report presents a clinically significant outcome in the management of *Kitibha Kushtha* (psoriasis) through a structured *Shamana Chikitsa* protocol comprising *Arogyavardhini Vati*, *Manjisthadi Vati* (*Bruhat*), *Gandhak Rasayan*, *Haridrakhand Churna*, and topical *777 oil*, administered over 30 days on an outpatient basis. The complete resolution of psoriatic plaques — evidenced by a reduction in PASI score from 16.0 (severe) at baseline to 0 (complete remission) by Day 30 — with no recurrence at the six-month follow-up, underscores the therapeutic potential of

classical Ayurvedic formulations in managing this chronic and often recalcitrant dermatological condition.

The therapeutic response observed in this case may be attributed to the synergistic action of the prescribed formulations, which collectively addressed the core Ayurvedic pathological mechanisms of Ama elimination, Agni restoration, *Raktashodhana*, and *Twak Prasadana*. These mechanisms find meaningful parallels in modern immunopharmacology, particularly in the anti-inflammatory, immunomodulatory, and antiproliferative properties documented for several constituent herbs.

Importantly, this case demonstrates that *Shamana Chikitsa*, when precisely prescribed in accordance with classical Ayurvedic principles and tailored to the patient's Dosha constitution and disease profile, may achieve outcomes comparable to more intensive therapeutic interventions — even in cases of established severe psoriasis. This is of particular clinical relevance in outpatient settings where Shodhana procedures are not immediately accessible or appropriate.

It must be acknowledged that the findings of a single case report cannot be extrapolated to establish generalized therapeutic efficacy. The observations reported here should therefore be regarded as preliminary evidence warranting rigorous validation through well-designed, adequately powered, randomized controlled clinical trials incorporating standardized outcome measures, objective biomarkers of inflammation, and comprehensive quality-of-life assessments.

The integration of validated biomedical

outcome tools — such as the PASI — into Ayurvedic clinical reporting represents a methodological advancement that enhances the credibility and communicability of Ayurvedic research within the broader scientific community. Future research in this direction will be essential to establish the evidence base for *Shamana Chikitsa* as a structured, reproducible, and globally acceptable therapeutic modality for *Kitibha Kushtha*.

References :

1. Agnivesha. (2020). Charak Samhita. Revised by Charka and Dridhabala. Vidyotini Hindi Commentary by Shastri K, Chaturvedi GN. Part 1,2. Varanasi: Chaukhamba Bharati Academy;. Sutra Sthan Chapter 7, 16 Shloka 9 20, 22 p. 223, 226, 279.
2. Fredriksson, T., and U. Pettersson, (1978). *Dermatologica*, 157(4): 238–244.
3. Griffiths, C. E., and J. N. Barker, (2007). Pathogenesis and clinical features of psoriasis. *Lancet* (London, England), 370(9583): 263–271.
4. Kakarala, C. L., M. Hassan, R. Belavadi, S. V. R. Gudigopuram, C. C. Raguthu, H. Gajjela, I. Kela, and I. Sange, (2021). Comorbidities. *Cureus*, 13(11): e19679.
5. Kasture, Sanjay & Kasture, Veena, Chopde, and Chandrabhan. (2001). *J Nat Rem. I*: 111-115.
6. Kurd, S. K., N. Smith, A. Van Voorhees, A. B. Troxel, V. Badmaev, J. T. Seykora, and J. M. Gelfand, (2008). *Journal of the American Academy of Dermatology*, 58(4): 625–631.
7. Mishra Siddhi Nandan, (2017). Editor. Bhaishajya Ratnavali. Chapter 54 (Kushtha Rogadhikara). Varanasi: Chaukhamba

- Surbharti Prakashan; p. 871
8. Mishra Siddhi Nandan, (2017). Editor. Bhaishajya Ratnavali. Chapter 55 (UdardSheet Pittakotha Rogadhikara). Varanasi: Chaukhamba Surbharti Prakashan; p. 898-899.
 9. Nadkarni KM. (1976). Indian Materia Medica. Vol. 1. Mumbai: Popular Prakashan; p. 636-649.
 10. Pariser D M, J Bagel, JM Gelfand, N J Korman, CT Ritchlin, and BE Strober, *et al.* (2007). *Arch Dermatol.* 143: 239-24.
 11. Sharma PV, (2009). editor. Rasaratnasa-mucchaya of Vagbhatacharya. Chapter 21. Varanasi: Chaukhamba Amarabharati Prakashan; p. 316-320.
 12. Sharma Shri Sadananda. (2004). Rasa Tarangini. Hindi translation. edited by Pandit Kashinath Shastri. 11th Ed. Reprint. Varanasi. Motilal banarasidas Publication. Gandhakakalpa 8/81-86. P-301.
 13. Sushruta, (2022). Sushruta Samhita, edition by Ayurveda tattva sandipika Hindi commentary, by Kaviraja ambikadutta shastri, Part 1, Chaukhamba Sanskrit Sansthan, Varanasi, reprint. Sutra Sthan Chapter 33 Shloka 4. p. 163.