

AYURVEDIC MANAGEMENT OF PAKSHAGHATA FOLLOWING ISCHEMIC STROKE: A SINGLE CASE STUDY

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ABSTRACT

Background: *Pakshaghata* is characterized by weakness or paralysis on one side of the body and has clinical features that may overlap with post-stroke hemiparesis. This illustrative case describes Ayurvedic care alongside conventional stroke treatment and rehabilitation. **Case presentation:** A 46-year-old man with hypertension and a history of tobacco use developed sudden right-sided weakness and slurred speech. Brain MRI showed a left-sided ischemic stroke. After acute hospital treatment, he had persistent right hemiparesis and needed assistance with walking and daily activities. An illustrative four-week care plan comprised supervised physiotherapy, ongoing prescribed stroke medicines, and individualized Ayurvedic treatment including *abhyanga* (oil massage) and *swedana* (fomentation). **Outcome and conclusion:** In this hypothetical course, right upper-limb muscle power improved from 2/5 to 3/5 and lower-limb power from 3/5 to 4/5; the Modified Barthel Index rose from 45/100 to 65/100. These changes describe recovery during combined care and cannot establish the effect of the Ayurvedic procedures. The case illustrates how functional measures and concurrent treatments can be reported transparently in post-stroke care.

KEYWORDS: Pakshaghata; cerebrovascular accident; ischemic stroke; right hemiparesis; Ayurveda; stroke rehabilitation; case report.

INTRODUCTION

Cerebrovascular accident (CVA), or stroke, occurs when blood flow to part of the brain is interrupted or when a blood vessel in the brain ruptures. It can cause lasting problems with movement, speech, swallowing, and daily activities. Timely medical assessment, appropriate stroke treatment, and rehabilitation are important to recovery and prevention of further disability.^[1]

Pakshaghata is described in Ayurveda as a condition affecting one side of the body and is discussed under *Vata Vyadhi*. Its prominent features of unilateral weakness or paralysis resemble the hemiparesis or hemiplegia that may follow a stroke. The terms are clinically related in this respect, although *Pakshaghata* is an Ayurvedic diagnosis and CVA identifies a vascular event in the brain.^[2]

Classical Ayurvedic management of *Pakshaghata* is guided by the patient's presentation and includes measures described under the treatment of *Vata Vyadhi*.^[3] Interest in these approaches during stroke rehabilitation has led to clinical studies, but a systematic review found that the available research does not yet provide robust evidence of their efficacy and safety.^[4] Careful documentation of diagnosis, treatment, concurrent rehabilitation, and outcomes is therefore essential.

This single case study describes the clinical presentation, Ayurvedic management, and observed course of a patient with *Pakshaghata* following CVA. It aims to document the treatment and outcomes transparently. Any change observed in one patient must be interpreted in light of the natural course of stroke recovery and other care received; a case study alone cannot establish treatment effectiveness.

AIM

To describe the Ayurvedic management and clinical course of one patient with *Pakshaghata* following a cerebrovascular accident.

METHODOLOGY

This single case study documents the confirmed stroke diagnosis, Ayurvedic and concurrent treatments, and changes in recorded clinical and functional measures during follow-up.

Patient information and presenting complaint

A 46-year-old man presented with sudden weakness of the right arm and leg, accompanied by slurred speech. In this illustrative history, his family noticed the symptoms on waking and took him to an emergency department. He had a five-year history of hypertension and regularly used smokeless tobacco. No previous stroke was reported.

The patient received acute hospital assessment and treatment before being referred for rehabilitation. Two weeks after symptom onset, he continued to have difficulty lifting his right arm, walking without support, and performing daily tasks such as dressing and bathing. He was alert and able to follow instructions. His speech remained mildly slurred.

Diagnostic assessment

For this example, brain MRI demonstrated a left-sided ischemic stroke, consistent with the right-sided motor findings. The stroke diagnosis and subtype were based on imaging and neurological assessment. The patient's unilateral weakness was also assessed in Ayurveda as *Pakshaghata*, a condition described under *Vata Vyadhi*. These diagnoses

describe the case from different clinical frameworks; the Ayurvedic assessment does not replace confirmation of the CVA.

At the start of the illustrative rehabilitation period, right upper-limb muscle power was graded 2/5 and right lower-limb power 3/5 on the Medical Research Council scale. He required assistance to stand and walk and needed help with several activities of daily living. His Modified Barthel Index was 45/100. Blood pressure monitoring and review of prescribed stroke medicines formed part of his ongoing medical care.

Treatment

The four-week illustrative treatment plan combined conventional post-stroke care, supervised rehabilitation, and Ayurvedic procedures. His stroke medicines and hypertension treatment were continued under the treating medical team; this example does not assign drug names or doses without a prescription record. Physiotherapy focused on supported standing, walking practice, balance, range of movement, and task-based use of the affected arm. Rehabilitation is an essential part of care for people with functional limitations after stroke.

The illustrative Ayurvedic plan consisted of supervised abhyanga (oil massage) followed by swedana (fomentation) on treatment days, adjusted to the patient's tolerance. These procedures were selected within the *Vata Vyadhi* approach to Pakshaghata. Published accounts have described their use as additional care in post-stroke patients, but their inclusion here does not establish that they are effective for this patient.

Time	Illustrative clinical course
Day 0	Sudden right-sided weakness and slurred speech; emergency stroke assessment
First 2 weeks	Acute treatment followed by referral for rehabilitation
Week 0 of case study	Persistent right hemiparesis; baseline motor and functional assessment
Weeks 1–4	Continued prescribed medical care, physiotherapy, abhyanga, and swedana
End of week 4	Repeat motor and functional assessment

Treatment Details

Treatment	Recorded dose	Frequency	Duration
Mahavatvidhwans Ras	125 mg	Twice daily	30 days
Dashmoolarishta	20 mL	Twice daily	30 days
Palsineuron capsule	1 capsule	Twice daily	30 days
Ashvagandharishta	20 mL with ½ cup water	Twice daily	30 days
<i>Shashtishali Pinda Swedana</i>	Procedure	Session frequency to confirm	10 days
<i>Nasya</i> with Vacha Taila	2 drops in each nostril	Session frequency to confirm	10 days
<i>Matra Basti</i> with Mahanarayan Taila	50 mL	Session frequency to confirm	15 days, after the initial 10-day course

Follow-up and outcomes

In the **hypothetical** follow-up, the patient tolerated the documented sessions and continued physiotherapy and prescribed medical care throughout the four-week period. At reassessment, he could stand and walk a short distance with less assistance. He also performed some dressing tasks with supervision, although fine use of the right hand remained limited.

Measure	Illustrative baseline	Illustrative week 4
Right upper-limb muscle power	2/5	3/5
Right lower-limb muscle power	3/5	4/5
Modified Barthel Index	45/100	65/100

No adverse event is assigned to this fictional course. In a real report, the authors would need to state whether adverse events were actively assessed, what was observed, and whether treatment was changed or interrupted. A longer follow-up would also be needed to describe whether functional gains persisted.

DISCUSSION

The patient's right-sided weakness is described in Ayurvedic terms as *Pakshaghata*. In the illustrative case, the left-sided ischemic stroke was the imaging-based diagnosis explaining the neurological deficit. These descriptions serve different purposes: the CVA diagnosis identifies the vascular event, while *Pakshaghata* provides the Ayurvedic framework used to select treatment. The case should retain both diagnoses without treating the terms as exact equivalents.

The supplied treatment combined four oral formulations for 30 days with a sequence of procedures: *Shashtishali Pinda Swedana* and *Nasya* with Vacha Taila for 10 days, followed by *Matra Basti* with Mahanarayan Taila for 15 days. Within the Ayurvedic framework, these procedures are used in the management of *Vata* disorders and are described in accounts of *Pakshaghata* care. Because several interventions were given during the same month, a case report cannot determine the separate contribution of any medicine or procedure.^[6]

Shashtishali Pinda Swedana was included as an external procedure during the initial phase of treatment. *Nasya* was administered with Vacha Taila at the stated dose of two drops in each nostril. The subsequent *Matra Basti* phase used 50 mL of Mahanarayan Taila. In a publishable report, the procedure record should specify the exact treatment dates, frequency of sessions, preparation used, how each procedure was performed, and whether any sessions were missed or modified. Without those details, other clinicians cannot accurately interpret or reproduce the treatment course.

The patient's rehabilitation and conventional stroke care are also central to interpreting the case. Stroke recovery may occur during the weeks after the event, and structured rehabilitation aims to improve movement and daily functioning.^[5] Any change in muscle power or independence during the 30-day treatment period would have occurred alongside these factors. For that reason, the hypothetical improvements previously drafted—upper-limb power from 2/5 to 3/5, lower-limb power from 3/5 to 4/5, and Modified Barthel Index from 45/100 to 65/100—must not be reported as this patient's results unless they are confirmed in the clinical record. Even if verified, they would demonstrate improvement during combined care, not prove that the Ayurvedic regimen caused it.

Published research provides context but does not validate this exact combination of medicines and procedures. A study of additional Ayurvedic treatment after ischemic stroke investigated a different protocol, so its findings cannot be transferred directly to the regimen used here.^[7] More recently, the multicentre RESTORE randomized trial found that its tested Ayurvedic rehabilitation protocol was not superior to conventional physiotherapy for improving sensorimotor recovery after ischemic stroke.^[9] A systematic review of Ayurvedic interventions for hemiplegia likewise concluded that the available studies did not provide robust evidence to establish efficacy and safety.^[10] These findings support cautious interpretation of any apparent improvement in a single case.

Safety reporting is particularly relevant because the regimen includes Mahavatvidhwans Ras. A medicines regulator has reported lead poisoning associated with a product sold as Mahavatvidhwansa Rasa 125 mg.^[8] That report does not establish the composition or safety of the product given to this patient. It does mean that the case study should identify

its manufacturer and batch, document available product-quality information, and report any adverse events or relevant clinical monitoring. The tolerability of *Nasya*, *Swedana*, and *Basti* should also be recorded rather than assumed.

Finally, the patient's hypertension and tobacco use are relevant to future stroke risk. Their management should be documented separately from the assessment of motor recovery, including blood pressure follow-up, ongoing prescribed stroke care, and tobacco cessation advice if provided.^[1] A strong case report would present a dated treatment timeline, verified baseline and follow-up measurements, concurrent care, adverse events, and longer-term follow-up. Its conclusion should remain limited to what was observed in this patient.

CONCLUSION

This case describes a 30-day Ayurvedic regimen for a patient with right-sided weakness following CVA. Because the clinical outcomes have not been verified and several treatments were given together, the case cannot establish treatment effectiveness. The final report should use documented follow-up findings and adverse-event records.

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