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Original Research Paper

Ayurveda

ROLE OF PANCHKARMA IN THE MANAGEMENT OF ACUTE MOTOR AXONAL NEUROPATHY- A CASE STUDY

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ABSTRACT

Guillain-Barré syndrome (GBS) is one of the most common life- threatening diseases of the peripheral nervous system. The disease is characterized by an ascending paralysis, with weakness in the distal limbs but rapidly advancing to affect more proximal muscles functions. The annual incidence is 1 to 2 cases per 100, 000 persons in the United States. There are several subtypes of GBS are recognized and Acute motor axonal neuropathy one of them. Children's and young's are more prevalent for this condition. In children is said to be favorable as compared to adults. Direct correlation of GBS with Ayurvedic terminology is difficult. The presentation and *Doshadooshyasamoorchana* is considered first and then one should proceed with the treatment. Here a case of 21 year old male adult presented with sudden onset of pain in lower back region and then gradually developed stiffness and weakness in lower limbs, after some time him unable to bilateral foot in upward direction. He had a past history of fever (chikengunia). He came OPD of Panchkarma Rishikul Campus. Hardwar. He was provisionally diagnosed as a case of acute motor axonal polyneuropathy (AMAP-type of GBS). As per Ayurvedic classics, this condition we have taken as *Snaugataga Vata.* Hence, the line of treatment we have adopted *Vatavyadhi Chikitsa* which included as well as *Brihmana chikitsa and Rasayana Chikitsa* along with *Shaman Aushadhis.* The outcome was very remarkable with the patient able to walk on his own.

KEYWORDS : Guillain-barré Syndrome (gbs), Acute Motor Axonal Polyneuropathy (aman-type Of Gbs), Panchkarma.

INTRODUCTION

Guillain-Barré syndrome (GBS) is an acute, frequently, sever and fulminant polyrediculoneuropathy that is autoimmune in nature. It occurs year round at a rate between 1 and 4 case sper 100,000 annually, in the United States 5000-6000 cases occurs per year. Males are slightly higher risk for GBS than female sand the western countries adults are more frequently affected than children1. It is characterized by evolving are flexic motor paralysis with or without sensory disturbance. During the acute phase, disability can be severe and can result in respiratory in-sufficiency and death. The usual pattern is an ascending paralysis that may be first noticed as rubbery legs. Weakness typically evolves over hours to a few days and is frequently legs are affected than arms1. Several subtypes of GBS are recognized, as determined primarily by electro diagnostic and pathologic distinctions. The most common variant is acute inflammatory demyelinating polyneuropathy, axonal variants, which are often clinically severe either acute motor axonal neuropathy (AMAN) or acute motor sensory axonal neuropathy (AMSAN)2. Per Ayurvedic classics this condition taken as Sarvangavata which precedes Jwara. Hence the prime line of treatment was Jwaraharachikitsa- Amapachana for which we have selected Shamanoushadhis followed by Vatavyadhichikitsa it included Patrapotali Swedana Abhyanga (oleation therapy) and Shashti shalikapindsveda (sudation using hot Shashtika rice) along with Yoga Basti (medicated oil enema).

Case report

A 21-year-old male patient admitted at Rishikul Campus Hardwar, presented with sudden onset of weakness in bilateral feet from 6 months. The patient was asymptomatic before 8 months back. Then he was suffering from fever for 3 weeks. After one month he had started pain in lower back region and stiffness and weakness in bilateral lower limbs and he couldn't move his lower limbs and couldn't stand or walk. So, they took him to nearby Hospital and got some relief in pain, stiffness and weakness. But after some time he noticed weakness only in bilateral feet and unable to bilateral feet in upward direction. He was again admitted and investigations were done and a probable diagnosis of AMAP was done and was referred to a higher center for further treatment. By the suggestion of their relative, he came to the OPD of Panchkarma Rishikul Campus, Hardwar for further treatment. There was no h/o respiratory, bowel and bladder incontinence.

Past history- Past history of Chikengunia fever (3 weeks) and subsided with treatment in local hospital.

Examination on Admission

General Examination

The general condition of patient was good, moderate build and nourished afebrile with pulse 80/min, respiratory rate- 16/min, and height-150 cm, weight-67kg.

Systemic Examination

In the systemic examination, findings of respiratory and cardiovascular system were within the normal limits. Abdomen was scaphoid, non-tender, and bowel sounds were present. Patient was conscious and well oriented and pupillary reaction to light was normal. All sensory system was intact.

On examination during admission

Hughes GBS Disability Scale	**3/6**
Cranial nerve examination	All cranial nerves are intact.

Hughes functional grading scale for GBS Score Description3

0- Healthy,
1- Minor symptoms or signs, able to run,
2- Able to walk 5 m independently,
3- Able to walk 5 m with a walker or support,
4- Bed- or chair-bound,
5- Requiring assisted ventilation,
6- Death

Motor system	Left u/l	Right u/l
Muscle wasting	Absent	Absent
	Left L/L	Right L/L
	Absent	Absent
Muscle tone	Left U/L	Right U/L
	Normal	Normal
	Left L/L	Right L/L
	Normal	Normal
Muscle power	Left U/l	Right U/l
Elbow	5/5	5/5
Wrist	5/5	5/5
Palmar grip	Normal	Normal

Pincer grip	Normal	Normal
	Left L/L	**Right L/L**
Hip	Adduction – 5/5	Adduction – 5/5
	Abduction – 5/5	Abduction – 5/5
	Flexion – 5/5	Flexion – 5/5
	Extension – 5/5	Extension – 5/5
Knee	Flexion – 5/5	Flexion – 5/5
	Extension – 5/5	Extension – 5/5
Ankle	Plantar flexion- 3/5	Plantar flexion- 3/5
	Dorsiflexion -2/5	Dorsiflexion -2/5
Deep reflexes	**Left U/L**	**Right U/L**
Biceps	2+	2+
Triceps	2+	2+
Supinator	2+	2+
	Left L/L	**Right L/L**
Kneejerk	1+	1+
Ankle jerk	1+	1+

Gradation for muscle power

0- No muscular contraction
1- Flicker or trace of contraction
2- Active movement with gravity eliminated
3- Active movement against gravity
4- Active movement against gravity and some resistance
5- Active movement against full resistance

Gradation for reflexes

0- No response
1+ -Diminished, low normal
2+ -Average(normal)
3+ - Brisker than average
4+ -Very brisk, hyperactive, with clonus

Gait & co-ordination	Could not be elicited - foot drop
Babinski sign	No response

Investigation

Routine studies of blood, urine, renal functions, serum electrolytes, CPK were within normal limits. EMG-NCV suggestive of AMAN (sub-type GBS).

Management

Patrapotli Swedana and Sarvangaswedana (Dasmoola for seven days followed by *Shashtikashali pindasweda* for next 14 days.

Yoga Basti (Medicated oil Enema) with Erandmooladi *Niruha Basti* (600ml) and *Dhanvantaram Tailam* for *Anuvasana* – 120 ml for 8 days.

Internally patient was administered

Ashwagandha Churna 3gm,*KapikachuChurna* 2g, *Sudha Kupilu* 50 *mg,Praval Pishti* 100 *mg, Giloya Satva* 200mg, *Svarnayograja Guggulu,*2BD *Makardwaja Vati* 1OD.

After 21 days of treatment patient started feeling better. Able to stand and walk without support for 20-30 steps .

OVSERVATION

Hughes GBS Disability Scale	**1/6**
Cranial nerve examination	All cranial nerves are intact.

Motor system	**Left u/l**	**Right u/l**
Muscle wasting	Absent	Absent
	Left L/L	**Right L/L**
	Absent	Absent
Muscle tone	**Left U/L**	Right U/L
	Normal	Normal
	Left L/L	Right L/L
	Normal	Normal
Muscle power	Left U/l	Right U/l
Elbow	5/5	5/5
Wrist	5/5	5/5
Palmar grip	Normal	Normal
Pincer grip	Normal	Normal
	Left L/L	Right L/L
Hip	Adduction – 5/5	Adduction – 5/5
	Abduction – 5/5	Abduction – 5/5
	Flexion – 5/5	Flexion – 5/5
	Extension – 5/5	Extension – 5/5
Knee	Flexion – 5/5	Flexion – 5/5
	Extension – 5/5	Extension – 5/5
Ankle	Plantar flexion- 5/5	Plantar flexion- 5/5
	Dorsiflexion -4/5	Dorsiflexion -4/5
Deep reflexes	Left U/L	Right U/L
Biceps	2+	2+
Triceps	2+	2+
Supinator	2+	2+
	Left L/L	Right L/L
Kneejerk	2+	2+
Ankle jerk	2+	2+

DISSCUSSION –

The line of treatment for this condition based on *Deepana Karma* to promote *Dhatwagni .Santarpan Chikitsa – Mamsa Dhatu Poshana* and for saman of *vata* and *Rasayana Chikitsa*- To replenish the loss of *Mamsa Dhatu* Considering the *Dhatwagni* level *Aama* and *Avarana* we started with *Sanshaman Chiktsa* with Patrapotli Swedana for 7 days by which patient responded very good. Then we moved to the next step by selecting *Abhyanga* (oleation therapy) with *Santarpana chikitsa* as *Balashwagandha tailam* and Shastikashalipindasweda4. All ingredients of the *Shashtikashali Pindasweda* such as *Kshira (milk), Shashtikashali* (type of red rice with 60 days old), and Balamoola possess *Santarpana* (nourishing)qualities with *Prithwi* and Ap *Mahabhuta* and is indicated for Balya, Bruhmana, and strengthening *Dhatus* and Vata pacification. Abhyaṇga (oleation therapy) mitigates *Vātadoṣa* act gives *Puṣṭi* (promotes strength). Doṣa involved is *Vāta* and the disease is caused due to the reduction in its Chala Guṇa *causing* inability to transmit nerve impulses, this helps in opening up of blocks in nerve conduction and facilitates remyelinating of nerves; thereby helps to transmit nerve impulses. Vata is the prime factors responsile for the neurological disorders.*Pakwashaya* as *Moola sthana* for the Vata so have selected Basti. So mitigate \Vata, Basti is better line of treatment5. As *Samshaman Aushdhies Swarna Yograja Guggulu* works as *Rasayana* and replenish the loss of *Mamsa Dhatu.* Others drugs worked on nerve root of spinal cord and stimulate the regeneration process of nerves

CONCLUSION

The analysis of GBS in terms of Ayurveda concludes that the GBS is a symptom complex where we can't correlate particular Ayurvedic term, but based on the symptoms here we have taken as *Sarvangavata*. In this way the Panchkarma therapy is not merely a therapeutic regime but also check the pathogenesis of disease. All these treatments together helped the patient to attain fastest recovery.

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