



AYURVEDIC MANAGEMENT OF DERMATITIS HERPETIFORMIS: A CASE REPORT

Dr. Mishrita Tala

3rd Year PG Scholar Department of Kayachikitsa, J.S. Ayurveda Mahavidyalaya, Nadiad, Gujarat, India

ABSTRACT

Dermatitis herpetiformis (DH) is a chronic, intensely pruritic autoimmune blistering disorder associated with gluten sensitivity. A 51-year-old female developed recurrent fluid-filled lesions with severe itching and burning in April 2021, predominantly involving the extensor aspects of bilateral elbows and back. Histopathological examination demonstrated neutrophilic microabscesses in the dermal papillae and a focal subepidermal vesicle, with the clinical and histopathological findings being compatible with DH. The patient was admitted to P.D. Patel Ayurveda Hospital in January 2025 and received multimodal Ayurvedic treatment comprising Snehapana, Virecana, Niruha Basti and Samana Cikitsa, followed by discharge in February 2025. Clinical improvement was observed, with disappearance of blisters, reduction in itching, and absence of new lesions. Monthly follow-up from March to August 2025 demonstrated continued maintenance of clinical improvement during follow-up. This case documents an individual clinical response following multimodal Ayurvedic management and supports further systematic investigation using standardized diagnostic and outcome assessment methods.

KEYWORDS : Dermatitis Herpetiformis; Ayurveda; Kustha; Visphota

INTRODUCTION

Dermatitis herpetiformis (DH) is a chronic, intensely pruritic autoimmune blistering disorder associated with gluten sensitivity. It typically presents with grouped vesicles or papulovesicular on extensor surfaces, particularly the elbows, knees and buttocks, and generally follows a relapsing course (Reunala et al., 2021). Diagnosis requires correlation of clinical findings with histopathology, direct immunofluorescence (DIF) and, when appropriate, serological investigations. Histopathology may show neutrophilic microabscesses in the dermal papillae with subepidermal vesiculation, while granular IgA deposition in perilesional skin on DIF is the characteristic immunopathological finding (Görög et al., 2021). Conventional management includes a gluten-free diet for long-term control and dapsone for rapid relief of cutaneous symptoms (Nguyen & Kim, 2021). From an Ayurvedic perspective, vesiculobullous manifestations may be considered within the broader spectrum of *Kustha* and *Visphota* according to their clinical features. A previous Ayurvedic case report described multimodal *Sodhana* and *Samana* management in *Visphota Kustha*, providing a rationale for documenting individual therapeutic experiences while recognizing the limitations of case-level evidence (Aiswarya et al., 2019). The present report describes Ayurvedic management of a patient whose clinical and histopathological findings were compatible with DH, with six months of clinical follow-up.

Case Presentation

A 51-year-old female presented with recurrent fluid-filled skin lesions associated with severe itching and burning. The first episode of blistering occurred in April 2021, followed by intermittent recurrent episodes. Lesions were predominantly present over the extensor aspects of bilateral elbows and the back. Her recorded dietary and lifestyle history included spicy food, *Viruddha Ahara*, disturbed sleep and *Divasvapna*. A previous gastrointestinal endoscopy approximately 15 years earlier was also documented. The patient was admitted to P.D. Patel Ayurveda Hospital in January 2025 for Ayurvedic management and was discharged in February 2025 after completion of the planned inpatient protocol.

Clinical Examination

At the examination, the patient was conscious, oriented and hemodynamically stable. Pulse was 72/min, respiratory rate 20/min, temperature 98.6°F and blood pressure 100/70 mmHg. Cutaneous examination showed irregular reddish fluid-filled lesions with excoriation and crusting, predominantly over the extensor aspects of bilateral elbows and the back, with severe itching. Ayurvedic assessment included *Prakrti*, *Vikrti*, *Agni*,

Kostha, *Aharasakti* and *Vyayamasakti*. Findings included *Pitta-Kaphaja Prakrti*, *Sama Jihva* and reduced *Aharasakti* and *Vyayamasakti*. The presentation was considered within the spectrum of *Kustha/Visphota* for therapeutic planning.

Diagnostic Evaluation

A vesicular lesion from the dorsum of the left arm was examined histopathologically. Aggregates of neutrophils with a few eosinophils were present within the dermal papillae, forming microabscesses. A focal subepidermal vesicle containing fibrin, neutrophils and a few eosinophils was also observed. These findings, together with the characteristic clinical presentation, were compatible with DH. Histopathology is supportive but not independently specific for DH; similar subepidermal vesiculation and neutrophilic inflammation may occur in other autoimmune blistering disorders (Antiga & Caproni, 2015). A perilesional skin biopsy was also submitted for DIF evaluation. DIF of uninvolved perilesional skin is the key immunopathological investigation in DH, with granular IgA deposition at the dermal papillae or dermo epidermal junction being characteristic (Dmochowski et al., 2019). The present case report relies on documented clinical and histopathological findings for compatibility with DH.

Ayurvedic Assessment

The recurrent blistering, itching and burning were considered under *Kustha* with resemblance to *Visphota*. *Pitta* and *Kapha* predominance were considered in therapeutic planning. The recorded dietary and lifestyle factors were considered relevant to the Ayurvedic assessment. The treatment strategy therefore incorporated *Sodhana* and *Samana Cikitsa* with the objective of addressing the assessed *Dosa* involvement and clinical manifestations.

Treatment

The patient received a planned multimodal inpatient Ayurvedic protocol consisting of preparatory procedures, *Sodhana Cikitsa* and subsequent *Samana Cikitsa*. *Pañcatikta Ghrta Snehapana* was administered in increasing doses from 40 ml twice daily to 120 ml according to tolerance, followed by *Abhyanga* and *Svedana*. *Jatyadi Taila* was used for *Abhyanga*, followed by *Nadi Svedana*. *Trivrti Curma* was administered as *Virecana* in a single 5-g therapeutic dose, with 18 *Vegas* documented. *Samsarjana Krama* was then followed with *Peya*. *Niruha Basti* using *Pathyadi Kwatha* was subsequently administered. *Samana* treatment comprised *Kaishora Guggulu*, *Manjisthadi Kwatha*, *Haridra Khandra*, *Lelitaka Maksika*, *Pañcatikta Ghrta*, *Sarjarasa Malahara* and *Samsamani Vati*. The treatment schedule is presented in Table 1.

Assessment Criteria

Clinical assessment was based on presence or absence of blisters, intensity of itching and occurrence of new blisters. Status was documented at baseline, after inpatient treatment in February 2025 and at the first follow-up in March 2025. Monthly follow-up continued from April through August 2025, focusing on recurrence of blisters, new lesion development and persistence of improvement.

Follow-up and Outcome

After completion of inpatient treatment in February 2025, clinically evident blisters had disappeared and itching had reduced. In March 2025, no new blisters were observed and itching had reduced from severe to mild. Monthly clinical follow-up continued through August 2025, during which the documented improvement was maintained. The observed outcome represents the clinical course of this individual patient following multimodal Ayurvedic treatment and does not establish treatment efficacy.

DISCUSSION

The clinical pattern in this case—recurrent intensely pruritic fluid-filled lesions predominantly involving the extensor aspects of the elbows and back—is compatible with the recognized distribution of DH (Reunala et al., 2021). The several-year history of recurrent manifestations before admission is also consistent with the chronic and relapsing nature of the disorder (Salmi & Hervonen, 2020). Histopathology in DH commonly shows neutrophilic microabscesses at the tips of the dermal papillae with or without subepidermal blistering; eosinophils may also be present. The present biopsy demonstrated these supportive features (Görög et al., 2021). However, histopathology alone cannot reliably distinguish DH from other subepidermal autoimmune blistering disorders (Antiga & Caproni, 2015). Current diagnostic guidance places particular importance on DIF of appropriately obtained perilesional skin (Dmochowski et al., 2019). From the Ayurvedic perspective, the presentation was considered under Kustha with resemblance to Visphota, with Pitta-Kapha predominance guiding therapeutic planning. The intervention combined *Snehapana*, *Abhyanga*, *Svedana*, *Virecana*, *Samsarjana Krama*, *Niruha Basti* and multiple *Samana* medicines. A previous case report of *Visphota Kustha* described improvement following multimodal *Sodhana* and *Samana* treatment, providing a related Ayurvedic clinical precedent (Aiswarya et al., 2019). However, that report involved a different clinical diagnosis, and its findings cannot be taken as evidence of efficacy for DH. In the present case, disappearance of blisters, reduction in itching and absence of new lesions were observed after inpatient treatment and were maintained during six months of clinical follow-up. Because several interventions were administered concurrently, the contribution of any individual medicine or procedure cannot be separated. The absence of a comparator, use of mainly clinical outcome measures and lack of standardized DH-specific activity or quality-of-life instruments further limit causal interpretation. The case therefore provides descriptive clinical documentation rather than proof of treatment efficacy. Prospective studies should incorporate standardized diagnostic confirmation, validated outcome measures, appropriate comparators and longer follow-up.

CONCLUSION

This case documents the Ayurvedic management of a 51-year-old female with clinical and histopathological findings compatible with Dermatitis Herpetiformis. Multimodal inpatient treatment during January–February 2025 was followed by disappearance of blisters, reduction in itching and absence of new lesions. The documented clinical improvement was maintained during monthly follow-up from March through August 2025. As a single case involving multiple simultaneous interventions and no comparator, the

findings should be interpreted cautiously. Further prospective clinical studies using standardized diagnostic and outcome measures are required to evaluate the reproducibility and therapeutic significance of Ayurvedic management in DH.

Patient Consent

Written informed consent was obtained from the patient for publication of the clinical information and relevant investigations in anonymized form.

Acknowledgement

The authors acknowledge the Department of Kayachikitsa and the clinical staff of P. D. Patel Ayurveda Hospital for their support in the management and documentation of the case.

Table 1. Treatment Schedule

Treatment / Procedure	Dose / Administration	Treatment Period
Pañcatikta Ghrta Snehapana	40 ml twice daily, gradually increased to 120 mL	For 7 days
Jatyadi Taila Abhyanga	As per procedure	Days 8–10
Nadi Svedana	Following Abhyanga	Days 8–10
Trivrt Curna Virecana	5 g, single therapeutic administration; 18 Vegas	Day 10
Samsarjana Krama	Peya	Day 11
Niruha Basti	Pathyadi Kwatha, 320 mL	Day 12 until discharge
Kaishora Guggulu	300 mg × 3 tablets, three times daily after meals	During IPD duration
Mañjisthadi Kwatha	40 mL twice daily on an empty stomach	During IPD duration
Haridra Khanda	3 g three times daily after meals	During IPD duration
Lelitaka Maksika	375 mg × 2 tablets twice daily after meals	During IPD duration
Pañcatikta Ghrta	30 mL twice daily with Kwatha, on an empty stomach	During IPD duration
Sarjarasa Malahara	5 g three times daily, local application	During IPD duration
Samsamani Vati	—	During IPD duration

Table 2. Clinical Assessment Criteria

Parameter	Baseline	February 2025	March 2025
Blister formation	Severe; multiple blisters present	No blisters observed	No blisters observed
Itching	Severe	Moderate	Mild
New blisters	1–5/day	0/day	0/day

REFERENCES

- Aiswarya IV, Namboothiri KP, Anandaraman PV. Effect of a multimodality Ayurveda treatment in a case of Visphota Kustha. *Journal of Ayurveda and Integrative Medicine*. 2019;10(3):207–213. doi:10.1016/j.jaim.2018.06.005.
- Antiga E, Caproni M. The diagnosis and treatment of dermatitis herpetiformis. *Clinical, Cosmetic and Investigational Dermatology*. 2015;8:257–265. doi:10.2147/CCID.S69127.
- Dmochowski M, Gornowicz-Porowska J, Bowszyc-Dmochowska M. An update on direct immunofluorescence for diagnosing dermatitis herpetiformis. *Advances in Dermatology and Allergology*. 2019;36(6):655–658. doi:10.5114/ada.2019.91415.
- Görög A, Antiga E, Caproni M, Cianchini G, De D, Dmochowski M, et al. S2k guidelines (consensus statement) for diagnosis and therapy of dermatitis herpetiformis initiated by the European Academy of Dermatology and Venereology (EADV). *Journal of the European Academy of Dermatology and Venereology*. 2021;35(6):1251–1277. doi:10.1111/jdv.17183.
- Nguyen CN, Kim SJ. Dermatitis herpetiformis: An update on diagnosis, disease monitoring, and management. *Medicina*. 2021;57(8):843. doi:10.3390/medicina57080843.
- Reunala T, Hervonen K, Salmi T. Dermatitis herpetiformis: An update on diagnosis and management. *American Journal of Clinical Dermatology*. 2021;22(3):329–338. doi:10.1007/s40257-020-00584-2.
- Salmi T, Hervonen K. Current concepts of dermatitis herpetiformis. *Acta Dermato-Venereologica*. 2020;100(5):adv00056. doi:10.2340/00015555-3401.