



ORIGINAL RESEARCH PAPER

Ayurveda

A CASE STUDY ON PLAQUE PSORIASIS – AN AYURVEDIC TREATMENT PROTOCOL

KEY WORDS: Sidhma Kushta, Ayurveda, Plaque Psoriasis, Shodhana

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ABSTRACT

Psoriasis is a chronic inflammatory skin disease involving genetic and immunological factors, often manifesting as erythematous, scaly plaques. In Ayurveda, this condition is correlated with Sidhma Kushta, a Vata-Kapha predominant disorder characterized by white or coppery discoloration and dust-like scaling upon scratching. This case report details the successful management of a 23-year-old male with a 11-month history of dry, silvery-scaly lesions and a baseline PASI score of 30.8. A personalized Ayurvedic protocol was implemented, consisting of deepana-pachana, internal oleation with Aragwadha Mahatiktaka Ghritam, and repeated Shodhana. Due to clinical findings of bradycardia, Virechana was selected over Vamana as the primary purification therapy, alongside external treatments such as Takradhara and medicated baths. The intervention resulted in a significant clinical remission, with the PASI score reducing from 30.8 to 3.6 and the DLQI score improving from 21.5 to 1 after inpatient treatment and one month of follow-up. Thickened lesions and persistent itching were completely resolved, leaving only hyperpigmented non-elevated marks. The primary strength of this study is the implementation of a personalized Ayurvedic treatment plan for a patient with poor R wave progression and bradycardia on ECG, in whom Vamana could not be administered. The patient also had a history of bleeding per rectum and a haemorrhoidectomy, which made Virechana contraindicated or advisable only with caution. However, as Kushta is a Bahudoshha Avastha, Shodhana is absolutely indicated for effective management. This case report demonstrates that the condition was effectively managed with Shodhana despite these contraindications.

INTRODUCTION

Psoriasis is a chronic inflammatory skin disease affecting 2-3% of the global population (Neena & Kumar, 2015, pp. 11-12). It is considered a genetic, immunological, and systemic disorder. In India, prevalence ranges from 0.5-1.5% (Neena & Tejaswi, 2011, pp. 1-6). The condition is characterized by well-defined, erythematous, scaly papules and plaques, particularly on the scalp, ears, genitalia, and skin over bony prominences. Plaque psoriasis is the most common type, featuring raised, well-demarcated erythematous plaques of variable size. In untreated cases, silver-white scales are evident, often with a positive Auspitz sign. Common sites include extensor surfaces such as the elbows and knees, as well as the lower back (Ibbotson, 2023, p. 1100).

Males are affected by psoriasis twice as often as females. Clinical patterns include plaque psoriasis (psoriasis vulgaris), inverse psoriasis, guttate psoriasis, pustular psoriasis, and erythrodermic psoriasis (Neena & Kumar, 2015, pp. 11-12). Ayurveda adopts a personalized, holistic approach, tailoring treatments to individual patient needs through targeted medicines, dietary modifications, and lifestyle adjustments.

In Ayurveda, chronic skin disorders fall under the umbrella of "Kushtha," which causes skin discoloration (Vagbhata, n.d., p. 369). Kushtha manifests from vitiation of all three doshas, leading to dhatu impairment and discoloration. No single dosha predominates in the pathology of Kushta. Acharyas classify Kushtha into Mahakushta and Kshudrakushta. Psoriasis correlates with Sidhma Kushta, described by Acharya Charaka among the Sapta Mahakushta, and by Acharya Sushruta and Vagbhata under Kshudrakushta. It features shweta (white), tamra (coppery), and alabupushpa

varna (discoloration); ghrishtam raja kiret (scales resembling dust on scraping) and lesions on the chest or upper body with the pathology of rooksha (rough) externally, snigdha (oily) internally, and predominantly of vata-kapha dosha (Vagbhata, n.d., p. 371)

Treatment targets dosha predominance based on roga and rogi bala (disease and patient strength). Repeated shodhana is indicated for bahudoshavastha to eliminate aggravated doshas, followed by rasayana to prevent recurrence. This report describes a plaque psoriasis case with notable causative factors, treated via internal and external modalities. After 1 month of inpatient management, significant reductions in itching, lesion extent, and thickness were observed, with sustained improvement during 1 month of outpatient follow-up.

Case

A 23-year-old male patient presented with dry, raised, silvery-scaly lesions across the body, accompanied by itching, persisting for 11 months. Six months after symptom onset, he sought treatment at the tertiary care centre for psoriasis. The regimen included tablet apremilast 30 mg twice daily, gastro-resistant tablet pantoprazole 40 mg twice daily, Homega softgel capsule once daily, and topical clobetasol propionate cream and betamethasone dipropionate cream. He took these medications for 1 month before discontinuing them. The patient also had a history of hemorrhoids, for which hemorrhoidectomy was performed 3 years prior.

Timeline of the Disease

Table 1 Timeline of the Disease

November 2024 3rd week	noticed two reddish papules over the anterior aspect of the right leg below the knee joint associated with itching.
4th week of November 2024	lesions turned blackish in color, on scratching the scales were removed leaving behind reddish lesions size of the lesions were progressive
December 2024	similar lesions appeared over left leg associated with itching
January 2025	exacerbation of symptoms after taking medicine from a folk practitioner. Lesion spread to lower back, buttock region, neck and bilateral hands
February - March 2025	Papules evolved to plaques with overlying whitish silvery scale associated with persistent itching
April 2025	Consultation at MCH and took topical and internal medications. Mild relief from itching, reoccurred after discontinuation

Family History

The patient's father has been a known case of psoriasis for 4 years. Similar complaints are present among paternal relatives.

Personal History

The patient follows a nocturnal lifestyle (sleeping 5 a.m.–3 p.m., exercising at night time), with a history of rectal bleeding (post-hemorrhoidectomy), dust allergy, occasional past smoking (discontinued 10 months ago), occasional alcohol and daily use of smokeless tobacco ("cool"). His mixed diet predominates spicy foods, red meat, daily fried fish, and four boiled eggs.

Clinical Findings

General Examination

Examination revealed that the patient is underweight with BMI 17.2 KG/M2. No evidence of pallor, icterus, clubbing, cyanosis, lymphadenopathy and edema. Heart rate was 54 bpm, pulse rate 54 bpm with BP 100/62 mm Hg.

Local Findings

Initial cutaneous lesions appeared on the anterior right lower extremity below the knee and subsequently extended to involve the buttocks, lower back, upper limbs, and scalp. They were symmetrically distributed on extensor surfaces as well-defined reddish-white papules and plaques of varying sizes with hard consistency (discrete and confluent). Secondary scaling was present; mucous membranes and genitalia were spared. Left middle fingernail pitting was noted. Auspitz and candle grease signs were positive; Koebner's phenomenon was absent. Psoriasis Area and Severity Index (PASI) score: 30.8.

Laboratory Findings

Blood report dated 12/09/2025 was found to be in normal limits.

Roga Pareeksha
Nidana

Aharaja- Guru, abhisyaandi, Katu lavana rasa Pradhana ahara Viharaja- Nisha jagarana, Divaswapna, Madyapanam, Tobacco chewing and smoking
Manasika nidana- Shoka and chinta
Sahara nidana - Beeja dushti

Samprapti

Nidana sevana leading to kapha pitta pradhana Tridosha dushti

↓
Ama utpatti –>Tiryak gamana of ama

↓
Khawaigunya -> Dushti of rasa & rakta dhatu (beejadushti)

↓
Sthana samsrya in twak
↓
Lakshanotpatti

Vyavachedaka Nidana

Table 2 Vyavachedaka Nidana

Kitibha	Rooksha, kharasparsham, kandu, parusha, asitham
Alasaka	studded with small nodules, itching, red color
Sidhma	Dry outside, moist inside, Ghrishte raja kiret, Shweta Tamra varna, prayena urdhwa kayam

Diagnosis

Plaque psoriasis presented with predominant Vata-Kapha features, including rooksha (dryness), parushya (roughness), whitish scales, utsedha (elevation), and kandu (itching), consistent with Sidhma Kushta lakshanas. Early-stage Pitta features, such as erythema, were also evident.

Selection of Treatment

The patient presented with Vata kapha pradhana Kushta, evidenced by a PASI score (Psoriasis Area Severity Index [PASI] Calculator, n.d.) of 30.8, with significant scaling, dryness, itching and elevation. Case conception emphasized deep involvement of rasa and rakta dushti, requiring a structured Shodhana protocol. Initial preparation included deepana-pachana with Panchakolasavam to optimize agni, followed by snehapana using Aragwadha Mahatiktaka Ghritam.

Abhyanga and ushnambu snanam was done with Ayyappala and Durvadi keratailam. Although Vamana is indicated for the treatment of Kushta, due to ECG changes (bradycardia, poor R wave progression) Virechana was given with Avipathi Choornam (25 g) with milk, followed by three-day peyadi samsarjana krama. Takradhara was done to address the underlying psychosomatic stress, alongside localized kshalana with Guluchyadi Kashayam. A secondary Shodhana phase involving snehapana and Virechana resolved persistent pruritus and lesion hardness, reducing PASI score from 30.8 to 6.

Post-procedural management focused on rakta-prasadana via Gandhaka Rasayana and Rasa Sindhoora, with strict pathya excluding kshara, amla, lavana dwidala and Shaka. Medicated baths using Nalpamara tvak, Aragwadha tvak, and Triphala were advised.

Table 3 Treatment Protocol and Remarks

	Internal medications	External treatment	Remarks
Deepana pachana	Panchakolasava m 15ml bd after food - 3 days		Appetite improved
Snehana	Aragwadha Mahatiktaka ghritam (10g-175g) - 7 days		Lesion became more erythematous
Shodhana		Abhyangam and ushnamabu snana with Ayyapala kera tailam + Durvadi kera tailam - 3 days	Scaling reduced
	Virechana with Avipathy choornam 25g with milk		No of vegas - 6
	Peyadi Krama - 3 days		

Shamana	Aragwadha Mahatiktaka ghritam - 10g bd before food	Takradhara - 7 days Guloochydi kashaya kshalana over itchy area Self abhyangam with Ayyapala and Durvadi kera tailam	erythema reduced
Snehana	Aragwadha Mahatiktaka ghritam 25g-150g- 7 days		Increased itching
Shodhana	Virechanam with Avipathy choornam with drakshadi kashayam - 25g peyadi Krama for 3 days	Abhyangam and ushnambu snanam with Ayyapala kera tailam and Durvadi kera tailam - 3 days	
Shamana	Aragwadhadi Mahatiktaka ghritam 10g bd before food	Takradhara on head - 7 days Bathing in guloochyadi kashayam	Itching is reduced. Hardness of lesions reduced.

Advice on Discharge

Aragwadha mahatiktaka ghritam 10gm in the morning
Gandhaka Rasayana 1-0-1 a/f
Rasasindhuram 1-0-1 a/f
Ayyapala Keram and Durvadi tailam - E/A
Advised bathing in water boiled with Aragwadha twak, Nalpamara twak and triphala choornam.

Follow up was done at OPD level for one month. Aragwadha mahatiktaka ghritam 10 gm bd along with Rasasindhura 1bd and Gandhaka Rasayana 1 bd were continued. After 1 month of follow up the PASI score was reduced to 3.6 The symptoms such as thickened lesion, itching and erythema were completely reduced leaving behind hyperpigmented non elevated marks. No new lesions were found. No adverse reactions noted during the treatment and follow up.

Assessment

Assessment was done before and after the treatment using Psoriasis Area And Severity Index - PASI (0-72), Dermatology Life Quality Index - DLQI (Cardiff University, 2018) (0-30).

The score 30.8, 21.5 respectively, was reduced to 6, 3 after IPD management and to 3.6 and 1 after one month of follow up.

Table 4 PASI Score Before Treatment

	Head	Upperlimb	Trunk	Lowerlimb
Erythema	2	2	3	3
Induration	1	2	2	3
Scaling	1	2	2	3
Sum (E+I+S)	4	6	7	9
Area score	2	3	4	5
Calculation	$4 \times 2 \times 0.1 = 0.8$	$6 \times 3 \times 0.2 = 3.6$	$7 \times 4 \times 0.3 = 8.4$	$9 \times 5 \times 0.4 = 18$

Note. Total PASI score = $0.8 + 3.6 + 8.4 + 18 = 30.8$ E = erythema; I = induration; S = scaling.

Table 5 PASI Score After One Month of Follow-up

	Head	Upperlimb	Trunk	Lowerlimb
Erythema	0	1	1	1
Induration	0	0	0	0
Scaling	0	0	0	0
Sum (E+I+S)	0	1	1	1
Area score	0	4	4	4
Calculation	$0.1 \times 0 \times 0 = 0$	$0.2 \times 1 \times 4 = 0.8$	$0.3 \times 1 \times 4 = 1.2$	$0.4 \times 1 \times 4 = 1.6$

Note. Total PASI score = $0 + 0.8 + 1.2 + 1.6 = 3.6$. E = erythema; I = induration; S = scaling.

DISCUSSION

A patient with a family history of psoriasis and hemorrhoids presented with erythematous papules evolving into blackish discoloration, persistent itching, and silvery scaling - indicative of Vata-Kapha predominant Kushta with minimal Pitta involvement. History revealed mithya ahara-vihara, addictions, irregular sleep, and psychosocial stress leading to dushti of Rakta and Rasa dhatu significantly. Initial therapy focused on agni deepana using Panchakolasavam, followed by snehapana with Aragwadha Mahatiktaka Ghritam for rakta shodhana and Vata-Kapha pacification. During snehapana marked erythema and adhagamana of doshas suggested the movement of dosha from Shaka to Koshta and pitta aggravation.

Hence abhyanga was given with Ayyapala Kera Tailam and Durvadi Tailam (Pitta-hara), along with ushnambu snanam was done, resulting in reduced erythema. Virechana was given with milk as anupana to reduce pitha. Post-Shodhana interventions included Takradhara for psychosocial relief and Guluchyadi Kashaya kshalana for Pitta pacification, yielding a PASI score reduction from 30.8 to 6.

Post-discharge, Rasasindhura and Gandhaka Rasayana were prescribed for shamana and rasayana effects, ensuring sustained dosha-dushya balance and skin rejuvenation. PASI score was reduced to 3.6 after 1 month of follow up.

CONCLUSION

The integrated Ayurvedic management of this case demonstrates a significant therapeutic breakthrough, reduction in PASI score from 30.8 to 3.6 and a near-complete restoration of quality of life DLQI from 21.5 to 1. By correlating the patient's Vata-Kapha symptoms with Sidhma Kushta, the study highlights the efficacy of a structured, multi-phase Shodhana protocol that prioritized repeated Virechana. This approach successfully addressed deep-seated Rasa-Rakta vitiation and systemic toxins, leading to the resolution of thickened, scaly plaques into flat hyperpigmented marks without any adverse reactions. The primary strength of this study is the implementation of a personalized Ayurvedic treatment plan for a patient with poor R wave progression and bradycardia on ECG, in whom Vamana could not be administered. The patient also had a history of bleeding per rectum and a haemorrhoidectomy, which made Virechana contraindicated or advisable only with caution. However, as Kushta is a Bahudosha Avastha, Shodhana is absolutely indicated for effective management. This case report demonstrates that the condition was effectively managed with Shodhana despite these contraindications.

However, as a single-patient case report, the results have limited generalizability, and the one-month follow-up period is insufficient to confirm long-term remission in a chronic, genetically predisposed condition. Despite these limitations, the study suggests that personalized Ayurvedic intervention, combining intensive internal purification with sustained Rasayana therapy, offers a potent and safe strategy for managing refractory plaque psoriasis.

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