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CASE REPORT

Ayurvedic Management of *Mandal Kustha* (Guttate Psoriasis) – A Case Report

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ABSTRACT

Guttate psoriasis, affecting 0.5–2% of children, presents with sudden-onset, drop-shaped, scaly lesions often following streptococcal infection. It may resolve spontaneously or progress to chronic Guttate psoriasis. Early treatment may help prevent chronic progression and recurrence. Guttate psoriasis is a dermatological condition characterized by small, drop-like lesions (0.5–1.5 cm in diameter) primarily affecting the upper trunk and limbs, commonly seen in young adults. In Ayurveda, this condition correlates with *Mandal Kushta*, a type of *Maha Kushta* (minor skin disorder) involving vitiation of *Kapha doshas*. The skin disease in Ayurveda has been classified under *Kushta*, which is categorized as *Maha Kushta* and *Kshudra Kushta*. Conventional treatments include topical steroids, phototherapy, and immunosuppressants, which may have side effects. This case study demonstrates the efficacy of *Shodhana* (purification), *Shamana* (palliative), and *Bahirparimarjana* (external) therapies in managing *Mandal Kushta*. A 35-year-old male presented with multiple erythematous lesions and itching for 5 years. Treatment included *Vamana* (therapeutic emesis), *Virechana* (purgation), and internal and external medications. Significant improvement (90% relief) was observed in symptoms, with enhanced quality of life. This study highlights Ayurveda's holistic approach in treating guttate psoriasis without adverse effects. *Mandal Kushta* is a type of *Maha Kushta*. A 35-year-old male patient presented with brown, rough, hard, and dry lesions on the face, scalp, limbs, and trunk, accompanied by itching for 5 years. The patient was treated with *Shodhana* (purification therapy) followed by *Shamana* (pacification therapy). *Shamana*.The Ayurvedic treatment modalities demonstrated significant improvement in *Mandal Kushta*.

1. INTRODUCTION

Psoriasis is a chronic, immune-mediated inflammatory skin condition characterized by sharply demarcated, scaly, erythematous plaques and, in some cases, sterile pustules. It manifests in multiple clinical forms, including plaque-type, guttate, and pustular variants. Joint involvement is common, often resulting in psoriatic arthritis, while nail changes are observed in approximately 10–80% of cases.[1] The disease usually presents with various cutaneous manifestations, and different clinical types may coexist in a single patient.

Guttate psoriasis represents a distinct subtype, typically precipitated by streptococcal infections such as pharyngitis or perianal streptococcal colonization. It predominantly affects children and adolescents more than adults. Clinically, it presents with numerous small, drop-shaped papules.[2]

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In Ayurveda, skin diseases are broadly classified under *Kushta Roga*, which is considered one of the *Ashta Mahagada* (eight major difficult-to-treat diseases). The pathogenesis of *Kushta* involves behavioral, immunological, genetic, dietary, and environmental factors. *Kushta* is further classified into *Maha Kushta* and *Kshudra Kushta*, encompassing all skin disorders described in Ayurveda. *Mandal Kushta is classified as a Tridosaja* imbalance, with symptoms such as large lesions, fish-like scales, and reddish-black patches. The classical Ayurvedic texts identify factors such as Diva Svapna, sinful actions, suppression of Vega, and incompatible food as causative components[3]. The classical Ayurvedic texts identify factors such as *Diva Svapa* (day sleep), indulgence in *Papakrma* (sinful activities), suppression of *Vega Dharana* (natural urges), and consumption of *Viruddha Ahara* (incompatible food) as causative components.[4]

Guttate psoriasis is common and affects 0.5–2% of individuals in the pediatric age group. This review aims to familiarize physicians with the clinical manifestations, evaluation, diagnosis, and proper management

of guttate psoriasis. This case study is notable as it presents a holistic Ayurvedic approach to treating Guttate psoriasis, offering insights into an alternative treatment method that addresses the symptomatic manifestations and root cause imbalances in the body. By integrating these principles, this case contributes to expanding the understanding of Ayurvedic psoriasis interventions, especially considering conventional therapies' limitations. Psoriasis affects approximately 2% of the global population, with higher prevalence rates–up to 4%–reported in countries such as the United States and Canada. The condition exhibits a bimodal age distribution, with peak onset typically occurring between 20–30 years and again between 50–60 years of age. Guttate psoriasis comprises less than 30% of all psoriasis cases. It occurs with equal frequency in males and females and is predominantly seen in children and adolescents, being relatively uncommon in individuals over 30 years of age. The development of psoriasis involves a complex interaction between genetic predisposition and environmental triggers. It is primarily an immune-mediated condition driven by T lymphocytes, with CD8+ T cells predominantly found in the epidermis and both CD4+ and CD8+ T cells present in the dermis. A characteristic immune imbalance is observed, wherein pro-inflammatory Th1 cytokines–such as interferon-gamma (IFN-γ), interleukin-2 (IL-2), IL-1, IL-6, and tumor necrosis factor-alpha (TNF-α)–are elevated, while anti-inflammatory Th2 cytokines like IL-10 are suppressed. A key discovery in recent years has been the pivotal role of interleukin-23 (IL-23) in psoriasis pathogenesis. Secreted by dendritic cells, IL-23 stimulates Th17 cells, leading to the production of IL-17 and IL-22. These cytokines contribute to inflammation in the dermis and promote excessive keratinocyte proliferation. This cytokine-mediated pathway has formed the basis for the development of targeted biologic therapies that have significantly advanced psoriasis management. Genetically, the most significant locus associated with psoriasis is PSORS1, located on chromosome 6p, which includes the HLA-Cw6 allele. This allele has a strong association with early-onset plaque psoriasis as well as guttate psoriasis. Other HLA alleles, including HLA-B13 and HLA-B17, are also notably linked with guttate and erythrodermic variants of psoriasis. The differential diagnoses of guttate psoriasis include tinea corporis, secondary syphilis, nummular eczema, and pityriasis rosea. Guttate psoriasis can be distinguished from these entities by history and physical examination. However, further studies, such as potassium hydroxide (KOH) scrapings and serologies, may help rule out the other disorders in the differential diagnoses.[5]

1.1. Objective

- This study evaluates the effectiveness of a holistic Ayurvedic approach incorporating *Shamana Chikitsa* for symptomatic relief, followed by *Shodhana Chikitsa* for detoxification, in managing *Mandal Kustha* (Guttate psoriasis).
- Describe the pathophysiology of guttate psoriasis.
- Outline the presentation of guttate psoriasis.[6]

2. CASE STUDY

A 35-year-old male reported having red, scaly skin lesions for the past 5 years, associated with severe itching and pain. The lesions were extensive, severely affecting his daily routine and quality of life. He had previously undergone multiple treatments, including corticosteroids and methotrexate, at several hospitals, but these offered no significant relief, and his condition continued to deteriorate. His primary complaints included persistent skin lesions, intense pruritus and pain, stiffness in the body, and disturbed sleep due to discomfort. His medical history revealed a past episode of tuberculosis in 2016. There was no history of diabetes, hypertension, or metabolic conditions. General examination showed normal appetite, thirst, blood pressure, pulse, and respiratory rate. There was no family history of psoriasis or other autoimmune diseases, and no known genetic factors were reported. The chronic and unresponsive nature of the condition caused considerable psychological stress, particularly due to the ongoing discomfort and its impact on his daily activities and sleep. Despite receiving prolonged conventional treatment, there was no noticeable improvement in symptoms.

2.1. Clinical Examination

- Lesions were rough, hard, and dark brown.
- Distribution: Primarily on the limbs and trunk.
- Associated symptoms: Severe itching and dryness.

The patient was evaluated using the *Dashavidha Atura Pariksha* (ten-fold examination), which helped determine his overall strength (*Atura Bala Pramana*). His *Ahara Shakti* (digestive power), *Jarana Shakti* (metabolic ability), and *Satva* (mental resilience) were assessed to be of a moderate level (Madhyama). However, his Vyayama Shakti (physical endurance), Satmya (habitual suitability), and *Vaya* (age-related strength) were considered to be low (*Avara*). The individual's *Prakriti* (body constitution) was determined as *Kapha-Vataja*. In addition, factors such as *Sara* (tissue quality), *Samhanana* (structural integrity), and *Pramana* (body measurements) were also assessed as low (*Avara*).

2.2. *Samprapti Ghataka*

In *Mandal Kushtha*, the predominant Doshas are *Kapha* and *Vata*, with the affected *Dhatus* (Dusyas) being *Tvak* (skin), *Rakta* (blood), *Mamsa* (muscle), and *Ambu* (bodily fluids).[7] The signs of *Srotodusti* (vitiation of body channels) observed were *Sanga* (obstruction) and *Vimargagamana* (displacement of substances). The involved *Srotasas* (channels) were *Rasavaha* and *Raktavaha*. The disease pathway (*Rogamarga*) was identified as *Bahya Rogamarga* (external path), with its origin (*Udbhavasthana*) traced to the *Amashaya* (stomach) and *Pakvashaya* (large intestine). The patient's digestive fire (*Agni*) was found to be *Manda* (weak). The mode of doshic spread was through *Triyakgami Sira Gati*, indicating a lateral movement within the channels the detail is mentioned in table 1 below.[6]

2.3. General Dermatological Examination

The clinical evaluation revealed numerous reddish, scaly, erythematous papules, and plaques distributed asymmetrically across the body. These lesions were well-demarcated, with a firm, raised, rough, and dry texture. A positive Auspitz sign, characterized by pinpoint bleeding upon removal of scales, was observed. Additional findings included skin tightness and visible stretching. Inspection confirmed extensive involvement with marked redness and scaling. On palpation, the skin was noted to be dry, warm, and coarse. Disease severity was assessed using the Psoriasis Area and Severity Index (PASI), indicating a moderate to severe condition, suggestive of significant cutaneous and possible systemic involvement.

2.4. Laboratory Investigations

The laboratory profile suggested a mild systemic inflammatory response. ESR was slightly elevated at 10 mm/h, and CRP measured 0.88 mg/dL, indicating low-grade inflammation. The complete blood count showed a normal white blood cell count ($5.80 \times 10^3/\mu L$), normal hemoglobin level (16.1 g/dL), and platelet count ($290 \times 10^{\square}/L$), all

within standard limits. There was no evidence of secondary infection. The rheumatoid factor was negative (13.5 IU/mL), which helped to exclude autoimmune conditions. Metabolic parameters were also within normal limits, including serum uric acid (23.1 mg/dL), urea (22.7 mg/dL), serum creatinine (0.80 mg/dL), serum glutamic oxaloacetic transaminase (27.4 U/L), serum glutamic pyruvic transaminase (23.1 U/L), triglycerides (84.9 mg/dL), total cholesterol (172.0 mg/dL), fasting glucose (90.9 mg/dL), and hemoglobin A1C (5.8%). Thyroid function tests (T3, T4, thyroid-stimulating hormone) were also within normal range. Collectively, these findings support the diagnosis of a non-infectious, chronic inflammatory disorder without underlying metabolic or systemic complications.

2.5. Diagnostic Considerations

The primary diagnostic challenge was to differentiate *Mandal Kushtha* from other dermatological conditions with overlapping presentations. Eczema (*Vicharchika*) typically shows intense pruritus without clearly defined plaques. Seborrheic dermatitis presents with oily, yellowish scales primarily on the scalp and face. Tinea corporis (*Dadru Kushtha*) features annular lesions with central clearing, which was ruled out with a negative KOH test. Leprosy (*Kushtha*) often includes hypopigmented patches with sensory loss, confirmed through skin smear examination. *Mandal Kushtha* also needed differentiation from other types of Kushtha. Based on lesion morphology–circular, scaly, dry plaques–and chronicity, this condition aligned more closely with *Mahakushtha* rather than *Kshudrakushtha*. Conditions such as *Vipadika* (localized palmoplantar keratoderma) and *Kitibha Kushtha* (psoriasiform dermatitis) were also ruled out due to the absence of characteristic signs. Based on both Ayurvedic features and modern dermatological correlation, the diagnosis of *Mandal Kushtha*, resembling Chronic Plaque Psoriasis, was confirmed.

2.6. Prognostic Features

Mandal Kushtha is known to follow a chronic, relapsing course and may be aggravated by seasonal changes, improper diet, psychological stress, and environmental factors. Potential complications include joint involvement (*Sandhigata Kushtha* or psoriatic arthritis) and increased vulnerability to secondary infections due to pronounced skin dryness and scaling. From an Ayurvedic perspective, the predominant Dosha involvement is *Kapha* and *Pitta*, reflected by symptoms such as *Rukshata* (dryness), *Khara* (scaliness), and *Daha* (burning or inflammation). Prognosis depends on the chronicity and Dosha dominance. Mild cases often respond well to internal medications, topical formulations (*Lepa*), and dietary management. In more severe cases, Panchakarma therapies such as *Vamana* and *Virechana*, along with long-term internal treatments, are recommended for comprehensive management.

2.7. Final Diagnosis

Based on clinical signs, investigative findings, and Ayurvedic evaluation, the case was diagnosed as *Mandal Kushtha*, which correlates with Chronic Plaque Psoriasis in modern dermatology. This case illustrates a chronic inflammatory dermatosis with significant *Kapha-Pitta* Dosha involvement, systemic inflammatory markers, and diagnostic features consistent with a relapsing autoimmune skin condition.

2.8. Timeline

Based on the involvement of specific *Doshas* and *Dushyas*, the patient was managed with Shamana Chikitsa (palliative treatment), accompanied by strict dietary modifications. He was advised to avoid excessively sour, salty, spicy, and processed foods, as well as curd, jaggery, meat, fish, sesame seeds, gram flour (besan), and dairy products. Daytime sleeping was restricted, and emphasis was placed on maintaining personal hygiene. Ayurvedic formulations were prescribed for both oral and topical application (Table 2). Treatment progress was evaluated at baseline, during therapy, and on follow-up to assess the clinical response.

2.9. Treatment Plan

1. *Shodhana Chikitsa* (Purification Therapy)

After achieving clinical stability through *Shamana Chikitsa*, *Shodhana Chikitsa* (purificatory therapy) was undertaken in two separate cycles, each involving *Vamana* and *Virechana Karma*.

The first phase, conducted between late 2022 and early 2023, included *Vamana Karma* following the classical *Purvakarma* procedures – *Deepana-Pachana*, *Snehapana*, and *Abhyanga-Swedana* (Table 3). This was followed by *Virechana Karma*, preceded by the appropriate preparatory regimen and concluded with *Sansarjana Krama* (a graduated post-therapy diet) for 7 days.

2.10. Action of *Vaman karma*

Vaman does the elimination of the *prakupit* doshas, mainly *Kapha* and *Pitta*, from the *Koshtha*. The *Vamanopaga dravyas*, such as *Madanphal churna*, *Vacha churna*, *Pippali churna*, *Saindhav*, *Madhu*, *Yashtimadhu phanta*, having properties such as *ushna*, *Tikshna*, *Vyavayi,* and *Vikasi* it enhance the absorption rate and help to reach at *Hriday*. It moves from *Hriday* to the *Dhamani* to all *Sthul* and *Sukshma strotas*. It acts on the microcellular level, which removes all the toxins from the body. There is the predominance of the *Agni* and *Vayu Mahabhutas*. *Vamak dravyas* has the *Urdhwabhagaharprabhav*, which causes the elimination of *doshas* from the upward direction, i.e, from the mouth. This therapy is very effective for the elimination of aggravated doshas.[8]

2.11. Action of *Virechan Karma*

Which have properties like *Ushna*, *Tikshna*, *Sukshma*, *Vyavayi*, *Vikasi*, it reaches the heart due to their potency, it enters all the over dhamanis and circulates throughout the *Sthula* and *sukshmastrotas*. Then it does the liquefaction of the dosha *sanghat* due to *its Agneya guna*. This *Doshasanghat* gets *chhinna-bhinna* and circulates throughout the *strotas* and does not get stuck anywhere because the Snehan was done in the *purvakarma*, like honey does not stick to the vessel that is coated by oil. This *doshasanghat* passes through the minute capillaries and moves towards the *koshtha* and ultimately reaches to the *amashay*. The *virechan* drug has the predominance of the Jala and *Prithvimahabhuta*, so it acts as an *Adhobhagaharaprabhav*. It does the elimination of the vitiated dosha from the *gudamarga*.[9]

The second cycle of *Shodhana*, carried out between March and April 2024, involved a repeat of *Vamana Karma* with the same preparatory steps. This was followed in April 2024 by the second *Virechana Karma*, again supported by *Sansarjana Krama*. Post-therapy monitoring included regular assessment of blood pressure and heart rate. The patient's diet was gradually advanced through stages, including *Peya*, *Vilepi*, *Akrita Mudga Yusha*, and *Krita Mudga Yusha* (Table 4).

2.12. External Applications

(A) 777 Oil + Psoralin Ointment – Applied 3–4 times a day on itching areas.

(B) Second Line of Treatment – *Shodhana Chikitsa* (Purification Therapy).

Table 2: First Phase of *Shodhana Chikitsa.*

Following *Purvakarma* (Preparatory Phase), *Pradhankarma* (main therapy), and *Paschatkarma* (post-therapy care).

2. *Shamana Chikitsa* (Palliative Therapy)

The case management began with *Shamana Chikitsa* (palliative therapy), which included a combination of internal Ayurvedic medications such as *Gandhak Rasayan*, *Arogyavardhini Vati*, *Haridrakhand* with *Panchatikta Guggul Ghrita*, *Rasmanikya*, *Vidang Churna*, and *Panchnimb***,** prescribed in suitable doses according to the patient's disease condition (*Rogavastha*) and individual strength (*Rogibala*) (Table 2). For external treatment, 777 oil and Psoralin ointment were applied topically 3–4 times daily on the affected and itchy areas to provide local relief and reduce symptoms.

2.13. Assessment Criteria

The severity of the condition was assessed using the PASI, which evaluates:

1. Area of involvement
   - Head (10% of body surface area)
   - Arms (20%)
   - Trunk (30%)
   - Legs (40%)
2. Severity parameters
   - Erythema (redness)
   - Induration (thickness)
   - Desquamation (scaling).

Grading Scale: 0 (none) to 6 (severe involvement) mentioned in table 5 and 6 below.

2.14. Clinician- and Patient-assessed Outcomes

During follow-up visits, the patient exhibited marked clinical improvement. He reported significant relief from itching, scaling, and discomfort, along with an enhanced sense of general well-being. Clinician evaluation corroborated these findings, noting better energy levels, improved digestion, more restful sleep, and a visible reduction in lesion severity–consistent with a positive therapeutic response to the Ayurvedic interventions the before and after treatment results are shown in fig 1 below.

2.15. Follow-up Diagnostic and Assessment Findings

Regular evaluations using *Nadi Pariksha* (pulse examination) and other Ayurvedic diagnostic methods indicated a gradual restoration of *Dosha balance*, particularly within the *Kapha-Vata* domain. Routine clinical assessments did not reveal any concerning abnormalities or new systemic involvement during the treatment period.

2.16. Treatment Adherence and Tolerability

The patient's adherence to the prescribed Ayurvedic regimen–which included internal herbal medications, external applications, dietary restrictions, and lifestyle modifications–was closely monitored. He demonstrated good compliance, as verified through direct consultations and self-reporting. The patient adjusted well to the changes in his diet and daily routine, showing high tolerability to the treatment without difficulty.

2.17. Adverse Events and Unanticipated Reactions

No serious adverse effects were noted during the course of therapy. Initially, the patient experienced minor gastrointestinal discomfort, likely due to metabolic adjustment, which subsided with slight alterations in the medication schedule. No unexpected reactions or complications occurred throughout the follow-up period.

3. DISCUSSION

The present case illustrates the successful Ayurvedic management of *Mandal Kushtha*, clinically correlated with Guttate Psoriasis, a chronic, relapsing inflammatory skin condition characterized by numerous small, erythematous, scaly papules. The patient presented with a longstanding, treatment-refractory disease course despite receiving multiple lines of conventional therapy, including corticosteroids and immunosuppressants. The chronicity and poor response to standard medical management necessitated an integrative approach based on classical Ayurvedic principles.

Ayurvedic diagnosis was established through *Dashavidha Atura Pariksha*, revealing a *Kapha-Vata predominant Prakriti*, *Avara Bala*, *Mandagni*, and vitiation of *Tvak*, *Rakta*, *Mamsa*, and *Ambu* Dhatus. The involvement of *Rasavaha* and *Raktavaha Srotasas*, along with *Srotodushti* features such as *Sanga* and *Vimargagamana*, confirmed deep-seated doshic pathology. The condition was understood to originate in the *Amashaya* and *Pakvashaya*, with disease progression following a *Bahya Rogamarga*, consistent with the cutaneous manifestation of internal vitiation.

The pathogenesis aligned with classical descriptions of *Mandal Kushtha*, where chronic consumption of *Viruddha Ahara* (incompatible food combinations), sedentary lifestyle, excessive intake of sour and heavy foods, and improper daily routine lead to *Dosha Prakopa*, *Agni Mandya*, and *Dhatu Shaithilya* (loss of tissue integrity), resulting in persistent skin lesions. The presence of itching, scaling, erythema, and roughness pointed towards a *Kapha-Vata* dominance, with secondary *Pitta* involvement in the form of inflammation and burning sensations.

Management followed a comprehensive, stage-wise Ayurvedic protocol combining *Shamana* (palliative) and *Shodhana* (purificatory) therapies. Initial *Shamana Chikitsa* was directed towards symptomatic control and dosha pacification using classical formulations such as *Gandhak Rasayan*, *Arogyavardhini Vati*, *Rasmanikya*, *Panchatikta Ghrita*, *Panchnimb*, and *Vidanga Churna*. These medications provided *Raktashodhaka*, *Krimighna*, *Kusthaghna*, and *Agni-deepana* effects. Topical applications of *Atrisor cream*, *Vetapalai oil*, and *777 oil* alleviated itching, dryness, and inflammation.

3.1. *Arogyavardhinivati*

According to the *Rasaratnasamucchya*, *Bhaishajyaratnavali* and *Bharatbhaishajyaratnakar*, it has properties such as *Kushthanashak* (Alleviates all skin disorders), *Kandughna* (alleviates itching), *Deepan* (appetiser), *Pachan* (digestive), *Malasuddhikari* (cleanses waste material from the body), *Sarvarogaprashamani* (alleviates all disorders from the body), and *Raktavardhak* (purifies the blood). It contains *Haritaki* (Terminalia chebula Retz.), *Bibhitaki*(Terminalia bellerica Roxb.),

Amalaki(Embelica officinalis Gaertn.), *Suddhashilajatu* (Asphaltum), *Suddha guggul* (Commiphora wightii), *Errand* (ricinus communis), *Katuka* (Picrorrhiza kurroa Royle ex Benth), *Nimba* (Azadirachta indica A. Juss.), *Suddha Parad* (purified mercury), *Suddha Gandhak* (purified sulphur), *Lauha bhasma*, *Abhrak bhasma*, *Tamra bhasma*.[10] It acts as an antioxidant, removes toxins from the body.[11]

3.2. *Panchatiktaghtrit*

The ingredients of *Panchatikta* are *tikta rasa*, *ruksha* and *laghu guna*. It acts mainly on *kled*, *meda*, *lasika*,*rakta*, *pitta* and *kapha*, which helps in balancing the vitiated dosha and *dhatu*. It has properties like *Deepan*, *Pachan*, *Strotoshodhak*, *Raktashodhak*, *Raktaprasadak*, *Kushtaghna*, *Kandughna* and *Varnya*.[12] The Ghrit has lipophilic action helps to carry drugs to the target organs. It enters at its cellular level and is delivered to the mitochondria and nuclear membrane. It maintains the normal texture of skin.

Two structured cycles of *Shodhana Chikitsa*, involving *Vamana* and *Virechana Karma*, were administered at appropriate intervals, preceded by classical *Purvakarma* procedures (Deepana, Pachana, Snehapana, Abhyanga, and Swedana), and followed by *Sansarjana Krama*. These bio-purificatory measures effectively eliminated the accumulated Kapha and Pitta Doshas, restored *Agni*, and reversed *Srotorodha* (obstruction in body channels), thereby addressing the root pathology.

The therapeutic regimen also incorporated *Rasayana* therapy, particularly *Guduchi* and *Triphala*, to enhance tissue regeneration, modulate immune response, and prevent relapse. Dietary recommendations and lifestyle modifications were advised to maintain doshic balance and prevent further aggravation.

3.3. Clinical Outcomes

Demonstrated significant improvement, with complete resolution of lesions, normalisation of skin texture, and absence of recurrence over follow-up. The patient's PASI score decreased from 5.4 to 0, indicating total remission. In addition, systemic symptoms, including itching, sleep disturbance, and psychological distress, showed marked improvement, reflecting the holistic benefit of Ayurvedic intervention.

This case emphasizes the efficacy of an integrative, individualized approach in chronic inflammatory dermatoses, where modern therapies may fail to achieve lasting remission. The Ayurvedic framework provided both symptomatic relief and disease-modifying outcomes through its multi-targeted actions on *Doshas*, *Dhatus*, *Agni*, and *Srotasas.*

4. CONCLUSION

The present case highlights the clinical efficacy of a structured Ayurvedic treatment protocol in managing *Mandal Kushtha*, correlating with guttate psoriasis. The individualized approach–rooted in classical Ayurvedic diagnostics and incorporating both *Shamana* and *Shodhana Chikitsa*–effectively addressed the underlying *Dosha-Dushya* imbalance, corrected metabolic dysfunction (*Agni Mandya*), and alleviated both systemic and cutaneous manifestations.

The complete resolution of lesions, normalization of PASI score, and sustained remission in a conventionally refractory case underscore the therapeutic potential of Ayurveda in chronic inflammatory skin diseases. The integration of *Rasayana* therapy further supported immune modulation and long-term disease resistance.

This case affirms the relevance of classical Ayurvedic principles in managing autoimmune dermatological conditions and warrants further clinical investigation through well-designed studies to establish broader applicability and evidence-based validation of these interventions.

4.1. Declaration of Patient Consent

The authors confirm that informed consent was obtained from the patient for the publication of this case report.

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Nil.

6. FUNDING

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7. ETHICAL APPROVALS

This study does not require ethical clearance as it is a case study.

8. CONFLICTS OF INTEREST

Nil.

9. DATA AVAILABILITY

This is an original manuscript, and all data are available for only review purposes from the principal investigators.

10. PUBLISHERS NOTE

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Figure 1: (a) Before treatment. (b) After treatment

Table 1: *Samprapti Ghataka*

Dosha dominance	*Vata-Kapha*
Dushya (vitiated *Dhatus*)	*Tvak* , *Rakta*, *Mamsa* , *Ambu*
Srotas (involved channels)	*Rasavaha*, *Raktavaha*
Srotodushti Lakshan (pathological changes in channels)	*Sanga*, *Vimargagamana*
Agni (digestive and metabolic capacity)	*Jatharagni – Mandya* (low digestive fire) *Dhatwagni – Mandya* (low tissue metabolism) *Mahabhutagni – Mandya* (low elemental metabolism)
Marga (disease pathway)	*Bahya Rogmarga*
Udabhavasthana (site of origin)	*Amashaya* and *Pakvashaya* and *Sira*
Sancharastahana (site of spread)	*Triyaka Gami Sira*
Gati	*Triyak Gati*
Adhistan (source of origin)	*Twak*
Vyadhi Swabhava (nature of disease)	*Chirakari*. (chronic and slow-progressing)

Table 2: Clinical timeline and intervention history of the patient

Year/Date	Event/Clinical progression
2016	Patient diagnosed and treated for tuberculosis (TB). Successfully completed treatment.
2020	Onset of guttate psoriasis with small, scaly, erythematous lesions. Initially managed with homeopathic and allopathic treatments.
2020–2022	Received corticosteroids and methotrexate. Showed temporary relief and stable condition during this period.
Late 2022	Relapse occurred with worsening lesions. Underwent treatment at SMS Hospital, Jaipur. The patient was then referred to NIA Hospital, where the first Vamana was administered.
Early 2023	First Virechana therapy was performed as part of the Ayurvedic detox protocol. Moderate clinical improvement observed.
Late 2023	Second flare-up with recurrence of lesions. Conventional allopathic treatment (steroids, methotrexate, cyclosporine) provided only partial relief.
January 17, 2024	Patient visited Kriya Sharir OPD (NIA) with widespread scaly, indurated lesions and severe itching. Started on Ayurvedic internal and external medications.
March 2024	Second Vamana conducted at NIA due to persistent symptoms. Lesions began flattening, and itching significantly reduced.
April 2024	Second Virechana performed during IPD admission. Complete resolution of itching and scaling. Lesions turned dark and flat.
April 30, 2024	No new lesions observed. Patient symptom-free and in stable clinical condition.
2025 (Ongoing)	Continues under regular Ayurvedic follow-up. No recurrence reported to date.

Table 3*: Shodhana Chikitsa* Protocol

Medicine	Dose	Route	Duration
Deepana-Pachana (*Agni Deepan* with *Panchkol Churna*)	5 g BD after meals with lukewarm water	Oral	5 days
Abhyantar Snehapana (Internal Oleation) with *Panchatikta Ghrita*	30 mL (Day 1) → 60 mL (Day 2) → 90 mL (Day 3) → 120 mL (Day 4) → 150 mL (Day 5)	Oral	5 days
Sarvanga Abhyanga and *Swedana* (Full-body Massage and Fomentation) with *Dashmool Taila* followed by *Bashpaswed* with *Dashmool Kwatha*	External application		2 days
Vamana (Therapeutic Emesis) followed by *Sansarjana Karma*	*Madanphalyoga* (*Madanphal*-1 g, *Vacha*-1 g, *Saindhav*-1 g, *Madhu*-4 g, *Yastimadhu Phanta*, *Dugdhapana*)	Oral	5 days
Monitoring BP and HR every 2 h, *Sansarjana Karma* for 7 days	*Peya*, *Vilepi*, *Akrita Mudga Yusha*, *Krita Mudga Yusha*	Diet Therapy	7 days
Dashmool Tail+D*ashmool Churna* (each nostril and mouth)	3 times daily for 5 min	External	7 days

Table 4: Second Phase of Shodhana Chikitsa (April 2024)

Medicine	Dosage	Route	Duration
Abhyantar Snehapana (Internal Oleation) with *Panchatikta Ghrita*	50 mL (Day 1) → 75 mL (Day 2) → 100 mL (Day 3)	Oral	3 days
Sarvanga Abhyanga and *Swedana* (Full-body Massage and Fomentation) with *Dashmool Taila* followed by *Bashpaswed* with *Dashmool Kwatha*	External application		4 days
Virechana (Therapeutic Purgation) followed by *Sansarjana Karma*	60 g *Trivrit Avaleha*	Oral	1 day

Table 5: PASI Grading for Lesion Area

Area involved	Grade
No involvement	0
<10%	1
10–29%	2
30–49%	3
50–69%	4
70–89%	5
90–100%	6

Table 6: Clinical assessment before and after treatment

Parameter	Before treatment	First follow-up	Second follow-up
Skin area involved	Grade 3	Grade 2	Grade 1
Erythema (redness)	3	1	0
Induration (thickness)	3	1	0
Desquamation (scaling)	3	1	0
Total PASI score	5.4	1.8	0