RESEARCH PAPER

Management of Crohn's & IBD through Chakrasiddh Spine Expert Therapy (CSET) and Chakrasiddh Energy Release therapy (CERT): An Observational Case Series of Five Individuals

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ABSTRACT

Background: Crohn's disease (CD) is a chronic, relapsing inflammatory disorder of the GI tract and a major subtype of IBD. Its multifactorial origin from immune dysfunctioning, microbial imbalance, and gut–brain axis disruption, makes its treatment more challenging. While standard therapies help control symptoms, long-term remission is often difficult to maintain, prompting interest in alternative and integrative approaches.

Objective: To evaluate the efficacy of an integrative Siddha-based therapeutic protocol incorporating Chakrasiddh Energy Release Technique (CERT) and Chakrasiddh Spine Expert Therapy (CSET) in patients with Crohn's disease/IBD.

Methods: Five patients (age 16–23 years; 4 females, 1 male) diagnosed with Crohn's and IBD were selected for the observational case series over a period of 18 months. The patients were subjected to 24-days CSET (Varmam therapy, spinal correction, abdominal myofascial release) sessions, four CERT sessions and personalized dietary modifications. Monitoring of pre and post clinical symptoms, laboratory parameters (fecal calprotectin, ESR, CRP, hemoglobin, albumin), and Crohn's Disease Activity Index (CDAI) were assessed every 3–4 months.

Results: All patients demonstrated significant improvement in clinical symptoms, reduction in inflammatory markers, and enhanced quality of life. Mean fecal calprotectin levels reduced from 1786 µg/g to 184 µg/g. CDAI scores improved from severe/moderate (mean 286) to mild/remission range (mean 109). One female patient showed some relapse of symptoms after 6-months but overall, her quality of life was deemed improving. Emotional stressors identified during CERT sessions correlated with disease chronicity.

Conclusion: CSET and CERT Siddha therapies combining energy modulation, Varmam stimulation, and dietary correction may serve as a beneficial complementary approach in managing Crohn's disease and IBD; though larger observational studies and controlled clinical trials are warranted to further validate the effectiveness, and long-term benefits of CSET & CERT.

Abbreviation's: CD (Crohn's Disease), IBD (Irritable bowel disease), CSET (Chakrasiddh spine Expert therapy), CERT (Chakrasiddh Energy release therapy), CDAI (Crohn's Disease activity Index)

Keywords: *Crohn's disease, IBD, CERT, CSET, gut–brain axis, integrative medicine*
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1. INTRODUCTION

Crohn's disease (CD) is a long-standing inflammatory condition of the gastrointestinal tract in which the inflammation extends through the full thickness of the bowel wall and can involve any region from the oral cavity to the anal canal. It is one of the principal forms of inflammatory bowel disease, alongside ulcerative colitis. Both Crohn's disease and other forms of IBD are characterized by a relapsing–remitting course, where periods of relative stability are interrupted by episodes of active disease[1]. This fluctuating nature significantly impacts not only the physical health of patients but also their emotional well-being, daily functioning, and overall quality of life [2]. Over recent decades, the incidence of IBD,

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including Crohn's disease, has been steadily rising worldwide, particularly among adolescents and young adults[3,4]. Clinically, patients have symptoms such as persistent abdominal pain, recurrent diarrhoea that may occasionally be blood-stained, unintended weight loss, fatigue, and features of malabsorption; in addition, extraintestinal manifestations like joint pain, dermatological conditions, and in some cases ocular inflammation may also be observed, all leading to overburdened treatment cost to patients[5]. Among laboratory markers, fecal calprotectin has emerged as a reliable indicator of intestinal inflammation and is widely used in monitoring disease activity in both Crohn's disease and IBD[6].

The underlying causes of Crohn's disease and related IBD conditions are complex and not attributable to a single factor. Instead, they are believed to arise from an interplay of immune system dysregulation, imbalance in the gut microbiota, genetic predisposition, environmental influences, and disturbances in gut–brain communication[7]. Conventional treatment approaches primarily focus on suppressing inflammation and maintaining remission through medications such as corticosteroids, immunosuppressants, and biologic agents like anti-TNF therapies[8,9]. While these treatments can be effective in controlling symptoms, long-term use may be associated with side effects, reduced responsiveness, and dependency, prompting many patients to seek additional supportive and complementary therapies for disease management[10].

Traditional systems of medicine, including Ayurveda, Traditional Chinese Medicine, and Siddha medicine, have gained attention for their holistic perspective in chronic inflammatory disorders[11,12]. Siddha Medicine, which originated in South India, places emphasis on holistic health by maintaining the balance between the body, mind, and vital energy systems. In his literature, Sage Yugi mentioned IBD as *Vanni Pitham* and Crohn's as one chronic form of IBD characterized by severe inflammation and ulcerations in Terminal Ileum and colon. Within the Siddha framework, conditions like Crohn's disease and IBD are interpreted as disturbances in the equilibrium of Vaatham and Pitham, along with impairment of digestive fire (Agni) and disruption in the flow of vital energies (Uyir Thathukkal)[13]. Ancient Siddhar's also recognized that past actions (karma) and spiritual imbalances may manifest as chronic diseases like crohn's that require comprehensive correction[14]. Rather than focusing solely on symptomatic relief, the traditional approaches of siddha medicine consider chronic inflammation as a manifestation of deeper systemic imbalance that requires holistic approach. Based on this perspective, the present study evaluates an integrative therapeutic model that combines Chakrasiddh Energy Release Technique (CERT) for addressing emotional and energetic disturbances, Chakrasiddh Spine Expert Therapy (CSET) involving Varmam-based stimulation and physical correction, along with individualized dietary and lifestyle modifications aimed at restoring gut health, reducing inflammation and overall quality of life balance.

2. MATERIALS AND METHODS

2.1 Study Design

This was a prospective observational case series conducted over 18 months, with continuous monitoring every six months with lab reports.

2.2 Participants

A total five patients; four females and one male who were diagnosed with Crohn's disease or IBD and who visited Chakrasiddh Holistic healing centre between July, 2024 to Sept, 2024 were included in the case series [Table-1]

Case 1

A 22-year-old female diagnosed with Crohn's ileocolitis presented with a 4-year history of recurrent abdominal pain, frequent loose stools (5–6 episodes per day), occasional blood in stools, severe fatigue, poor appetite, joint pains and progressive weight loss of nearly 12 kg. Previous management included corticosteroids and mesalamine, with partial symptomatic relief and frequent relapses. Baseline investigations revealed markedly elevated fecal calprotectin levels of 2400 µg/g. Haemoglobin was reduced to 9.2 g/dL, ESR was 55 mm/hr, CRP was 32 mg/L, and serum albumin was low at 2.8 g/dL, suggesting active inflammation with nutritional compromise. Colonoscopy showed patchy ulcerations, mucosal edema, and cobblestoning in the terminal ileum; histopathology confirmed chronic active ileitis. During CERT sessions, unresolved emotional stress related to prolonged parental conflict during adolescence was identified as a major psychosomatic contributor leading to chronic anxiety and emotional distress.

Case 2

A 19-year-old female with a 3-year history of Crohn's colitis presented with abdominal cramps, urgency, mucus-mixed stools, bloating, anxiety, and menstrual irregularities. She complained of poor appetite, severe fatigue, and a loss of 8 kg weight over the previous year. She also presented with intermittent skin rashes suggestive of extraintestinal involvement and had been steroid-dependent with inadequate response to immunomodulators. Laboratory findings showed fecal calprotectin of 1850 µg/g, hemoglobin of 10.1 g/dL, ESR of 48 mm/hr, CRP of 28 mg/L, and albumin of 3.0 g/dL. Her baseline CDAI score was 295, reflecting moderate-to-severe disease activity. Colonoscopy revealed diffuse erythema, friability, and superficial ulcerations in the sigmoid and descending colon. During energy release sessions, significant academic stress due to her condition and persistent fear of failure were identified as the major emotional triggers contributing to prolonged disease activity and symptom exacerbation.

Case 3

A 17-year-old female diagnosed with indeterminate IBD presented with a 2-year history of moderate abdominal pain, diarrhoea occurring 3–4 times per day without blood,

reduced appetite, fatigue, and a 6 kg weight loss. She had no significant extraintestinal manifestations. Her abdominal pain severity was recorded as 7 on VAS. Baseline investigations revealed fecal calprotectin of 1100 µg/g, haemoglobin of 10.8 g/dL, ESR of 40 mm/hr, CRP of 20 mg/L, and serum albumin of 3.2 g/dL. Endoscopy revealed aphthous ulcers and segmental inflammation in the ileocecal region. During CERT sessions, her father's personal history was revealed and was genetically transferred in patient causing deeply rooted emotional stressors contributing to chronic internal stress and gut–brain axis imbalance.

Case 4

A 15-year-old female with early-stage Crohn's disease and a disease duration of 1.5 years presented with abdominal discomfort, diarrhoea occurring six times per day, occasional blood in stools, poor appetite, fatigue, and approximately 15 kg of weight loss. She also complained of excessive hair fall, which was associated with nutritional deficiency and chronic stress. Her abdominal pain was rated moderate to high on VAS. She had prior exposure to steroids and biologics with persistent low-grade disease activity. Investigations showed fecal calprotectin levels of 980 µg/g, hemoglobin of 11.2 g/dL, ESR of 38 mm/hr, CRP of 18 mg/L, and serum albumin of 3.4 g/dL. Her baseline CDAI score was 245, indicating moderate disease activity. CERT sessions revealed unresolved fear related to her illness and hospitalization, which had created long-standing anxiety and emotional vulnerability.

Case 5

A 23-year-old male from Singapore diagnosed with Crohn's ileitis from last 10 years, presented with the most severe symptoms among all patients, including severe abdominal pain, diarrhea occurring 6–7 times daily, visible blood in stools, very poor appetite, severe fatigue, and a marked weight loss of 18 kg over several years. He also reported recurrent oral ulcers as an extraintestinal manifestation. His abdominal pain severity was recorded as 9 on VAS. He had previously responded partially to conventional therapy but experienced frequent flares. Laboratory parameters showed significantly elevated fecal calprotectin of 2600 µg/g, hemoglobin of 8.9 g/dL, ESR of 60 mm/hr, CRP of 35 mg/L, and low serum albumin of 2.6 g/dL, indicating severe active inflammation and poor nutritional status. Colonoscopy demonstrated patchy inflammation and erosions in the ileum. His baseline CDAI score was 320, reflecting severe disease activity. During CERT sessions, long-standing financial stress and staying far from family identified as major emotional contributors associated with disease chronicity and relapse patterns.

2.3 Inclusion Criteria - Patients were included if they met the following criteria[15]:

1. The age group of the participants ranged from 16 to 23 years, representing adolescents and young adults, which is a commonly affected population in IBD.
2. Selection was based on clinical presentation, previous medical history, colonoscopy findings where available, and laboratory confirmation of intestinal inflammation, including elevated fecal calprotectin and inflammatory markers. [Table-2]
3. Patients had been receiving conventional medical treatment such as corticosteroids, immunosuppressants, or supportive medication, but had achieved only partial symptomatic relief and continued to experience recurrent symptoms or relapses.
4. Willingness to undergo siddha-based protocol and provide written informed consent (or assent with guardian consent in the case of minors).

2.4 Assessment Scales[16,17]

Clinical outcomes of the patients were assessed on semi-structured questionnaire based on CDAI and VAS.

1. Crohn's Disease Activity Index (CDAI), a validated and widely accepted tool for measuring disease severity and quality of life in patients with Crohn's disease and IBD. The patients were subjected to semi-structured questionnaire based on parameters such as abdominal pain, frequency of diarrhea, general well-being, weight changes, and associated systemic symptoms.
2. Visual Analog Scale (VAS) was used for subjective assessment of symptom severity, including abdominal pain, bowel urgency, fatigue, bloating, weakness, and discomfort related to gastrointestinal disturbances.
3. Lab Reports: Fecal calprotectin levels were monitored as an objective biomarker of intestinal inflammation, along with laboratory parameters such as haemoglobin, ESR, CRP, and serum albumin to assess inflammatory status, nutritional improvement, and overall disease progression throughout the treatment period.

2.5 Ethical Considerations

The study protocol adhered to the ethical principles outlined in the Declaration of Helsinki. Written informed consent was obtained from all participants prior to enrolment and those who agreed to share their pre and post reports only are produced in the study. For participants below 18 years of age, consent was obtained from parents or legal guardians. Confidentiality of patient data was strictly maintained throughout the study period.

Table:1- Patient Demographics & Baseline scores

Case No.	Age/ Gender	Diagnosis	Duration (in years)	VAS Score (pre-therapy)	CDAI Score (pre-therapy)	Psychosomatic Triggers
1	22/F	Crohn's iliocolitis	4	9	310	Parental conflict, anxiety
2	19/F	Crohn's colitis	3	8	295	Academic stress,

						fear of failure
3	17/F	IBD (intermediate)	2	7	260	Genetic stress of father history
4	15/F	Early Crohn's	1.5	7	245	Fear of illness and hospitalization
5	23/M	Crohn's ileitis	10	9	320	Financial stress, far from family

Table:2- Baseline Clinical Findings (symptoms and Lab parameters)

PARAMETERS	Case 1	Case 2	Case 3	Case 4	Case 5
Abdominal pain	Severe	Moderate	Moderate	Sometimes but severe	Severe
Diarrhea/day	5–6	4–5	3–4	3	6–7
Blood in stool	Yes	Occasional	No	Occasional	Yes
Weight loss	12 kg	8 kg	6 kg	5 kg	15 kg
Appetite	Poor	Poor	Moderate	Poor	Very poor
Fatigue	Severe	Severe	Moderate	Moderate	Severe
Extraintestional	Joint pain	Skin rash	None	Hair fall	Oral ulcers
LABORATORY FINDINGS					
Fecal Calprotectin (µg/g)	2400	1850	1100	980	2600
Hb (g/dL)	9.2	10.1	10.8	11.2	8.9
ESR (mm/hr)	55	48	40	38	60
CRP (mg/L)	32	28	20	18	35
Albumin (g/dL)	2.8	3.0	3.2	3.4	2.6
ENDOSCOPIC FINDINGS					
Colonoscopy report	Ileal-ulceration, cobblestoning	Colonic erythema, ulcerations	Aphthous ulcers, ileocecal inflammation	Persistent mucosal inflammation	Ileal-erosions, patchy inflammation

3. THERAPEUTIC INTERVENTIONS

All five participants enrolled in this case series (aged 16–23 years; 4 females, 1 male) diagnosed with Crohn's and IBD selected for the observational case series; underwent a structured integrative treatment protocol based on CSET and CERT, along with individualized dietary and lifestyle modifications. The active treatment phase was carried out over a period of 5 weeks, during which each patient received a total of 24-CSET sessions (three-four sessions per week). Following completion of the intensive treatment phase, patients were monitored through periodic follow-up assessments every 3-4 months for the subsequent 18 months, making the total observation period approximately twenty months.

The treatment protocol was designed to address both the physical manifestations of Crohn's disease/IBD and the associated emotional and autonomic disturbances that were observed in these patients.

3.1 CSET (Chakrasiddh Spine Expert Therapy)

Thokkanam Therapy (Therapeutic Manual Pressure Technique)[18]

Thokkanam therapy, a traditional Siddha manual therapy involving targeted pressure application over specific musculoskeletal and abdominal regions was administered for 15-20 minutes. This therapy included various techniques such as rhythmic tapping (*Adi Thokkanam*), controlled compression (*Pidithal*), gripping (*Irukkuthal*), and rotational mobilization (*Suzhuthal*), depending on the patient's clinical presentation. Specific abdominal regions targeted during therapy included lower & upper abdominal along with hypogastric regions for improving digestion, enhance circulation, reduce abdominal rigidity, improve gut motility, and support gut-brain axis regulation. [Table-3]

Siddha Marma/Varmam Therapy[19]

Selected Varmam points associated with gastrointestinal health, autonomic nervous system balance, and inflammatory regulation were stimulated. These points were selected based on symptom severity and patient constitution aiming to reduce inflammatory responses, improve autonomic regulation, enhance digestion, and support intestinal healing. Each Varmam point was stimulated manually for approximately 2–3 minutes, and the complete session lasted nearly 20 minutes. [Table-3]

Table:3- Marma/varmam points and their therapeutic role

SNo.	MARMA/VARMAM POINT[20,21]	ANATOMICAL LOCATION	THERAPEUTIC ROLE
1	Kizhner Marma	lower abdominal region	bowel regulation
2	Mela Marma	upper abdominal/gastric region	influencing digestion
3	Neerkal Marma	hypogastric region	regulates intestinal peristalsis

4	Ilakkal Varmam	Around umbilical region	Improves intestinal motility
5	Pittam Varmam	Right upper abdominal quadrant	Supports liver detoxification
6	Kundalini Varmam	Sacral region	Enhances parasympathetic activity

3.2 Chakrasiddh Energy Release Technique (CERT)[22]

In addition to physical therapies, all patients received four individualized CERT sessions during the treatment period. These sessions were aimed at identifying unresolved emotional stressors that were believed to contribute to chronic disease exacerbation. These sessions focused on releasing any psychological and emotional traumas, pressures, conflicts and suppressed feelings that were believed to influence gut function through the gut-brain axis[23]. Almost all participants had some kind of suppressed emotional distress in past which were cleared by the siddha expert.

3.3 Dietary Changes[24]

Each patient was provided with a customized anti-inflammatory dietary plan based on Siddha principles and modern nutritional recommendations for gut healing. The dietary protocol emphasized foods that were easy to digest, anti-inflammatory, and supportive of mucosal healing. Anti-inflammatory foods like turmeric, ginger and basil were included to reduce inflammation and support immune function. Essential fatty acid sources including flax seeds, chia seeds, and walnuts helped in reducing systemic inflammation. Foods rich in Vitamin B6, Vitamin B12, and magnesium were encouraged in diet to improve nutritional deficiencies, fatigue, and stress-related symptoms. Mucosal healing foods like aloe vera, amla were incorporated for their potential role in reducing intestinal irritation. Probiotic foods eg buttermilk, rice gruel (kanji) was used to support gut microbiota balance. Antioxidant-rich foods including berries, pomegranate, quinoa were added in diet to support immune health and increase tissue repair.

During the complete treatment phase, the patients were advised to avoid processed food, sugar, oily foods, dairy products, spicy foods, and gluten free meals

3.4 Physical Activity and Yoga-Based Rehabilitation[22]

A daily routine of gentle physical activity was charted for all participants to improve circulation, reduce stress, and support digestive health. This included 20-30 minutes walking, some mild exercises related to diaphragmatic breathing, yoga asanas like balasana, pawanmuktasana and Bandhasana for 10 minutes to reduce abdominal tension and improve relaxation. Some yog mudras like Prana and Surya mudra to be practices on an empty stomach.

4. RESULTS

Patients were reviewed at regular intervals over next 18 months following active treatment to determine the clinical improvements. All five patients demonstrated notable clinical improvement following the integrative treatment protocol over the 18-month follow-up period.

A significant reduction in abdominal pain was observed across all cases, with Visual Analog Scale (VAS) scores decreasing from severe baseline levels to mild pain levels post-treatment. All five of them showed pain scale improvement with an average reduction from severe (9/10) to mild (3/10) intensity. The frequency of diarrhoea also reduced considerably in all patients from 5–6 episodes per day to 1–2 episodes daily only Case 5 it showed reduction from 6–7 episodes to 3-4 episodes daily. Progressive weight gain was observed in all patients during the follow-up period, ranging from 5 kg to 12 kg, indicating improved nutritional absorption and better gastrointestinal functioning. Appetite improved substantially in all cases, with three patients reporting normalization of hunger patterns, while fatigue either resolved completely or reduced to mild levels in the remaining patients. A significant reduction was also observed in Crohn's Disease Activity Index (CDAI) scores. Baseline CDAI scores ranged from moderate to severe disease activity (245–320), whereas post-treatment scores decreased to mild disease activity or remission range (90–130) [Table-4].

Biochemical and inflammatory markers also showed marked improvement following therapy. Fecal calprotectin levels, which were significantly elevated at baseline in all patients, demonstrated a substantial reduction by the end of the study period, indicating decreased intestinal inflammation. The maximum improvement in calprotectin levels was seen in Case 1 from 2400 µg/g to 180 µg/g and Case 5 from 2600 µg/g to 250 µg/g. Hemoglobin levels also improved in all patients, reflecting recovery from chronic anemia and better nutritional status. Similarly, inflammatory markers such as erythrocyte sedimentation rate (ESR) and C-reactive protein (CRP) showed consistent reductions across all cases. Serum albumin levels improved in all patients, suggesting restoration of nutritional health and reduced disease burden [Table-4].

Clinically, before initiating therapy, all patients experienced active intestinal inflammation, frequent disease relapses, and significantly impaired quality of life that affected their academic, professional, and social functioning. Following the integrative intervention, most patients entered clinical remission and reported substantial improvements in physical health, emotional stability, and daily functioning. All participants were able to resume school, college, work-related activities, and social participation with greater ease.

At baseline, all patients were receiving conventional medical treatment including corticosteroids and immunosuppressive medications. By the end of the 18-month follow-up period, medication dosage was reduced in four patients due to sustained symptomatic and laboratory improvement, while one patient (Case 5), who had the most severe baseline disease presentation, required intermittent continuation of conventional medications during occasional flare episodes. Overall, the results

suggest that the integrative protocol may have contributed to significant clinical, biochemical, and functional improvements in patients with Crohn's disease and IBD.

Table-4: Post-Therapy Outcomes (Clinical and Laboratory findings after 18 Months)

PARAMETERS	Case 1	Case 2	Case 3	Case 4	Case 5
Abdominal pain (VAS Score)	Mild (2)	Mild (3)	Mild (2)	Mild (2)	Mild to moderate (4)
Diarrhea/day	1-2	2	1-2	1	3-4
Weight gain	+11 kg	+8 kg	+6 kg	+5 kg	+12 kg
Appetite	Normal	Improved	Normal	Normal	Improved
Fatigue	Resolved	Mild	Resolved	Resolved	Mild
CDAI Score	110	120	95	90	130
LABORATORY FINDINGS					
Fecal Calprotectin (µg/g)	180	220	150	120	250
Hb (g/dL)	12.5	12.8	12.9	13.2	12.2
ESR (mm/hr)	18	20	15	14	22
CRP (mg/L)	6	7	5	4	8
Albumin (g/dL)	4.0	4.1	4.2	4.3	3.9
ENDOSCOPIC FINDINGS					
Colonoscopy report (after 18 months of therapy)	Significant mucosal healing with complete resolution of ulcerations; minimal residual ileal erythema	Marked reduction in colonic inflammation with healed ulcerations and mild residual erythema	Complete resolution of aphthous ulcers with normal ileocecal mucosa	Near-complete mucosal healing with mild superficial inflammation noted	Moderate improvement with reduced erosions and decreased inflammatory patches, but mild residual ileal inflammation persisted

5. DISCUSSION

Crohn's disease and inflammatory bowel disease (IBD) remain challenging chronic inflammatory disorders because of their relapsing nature, multifactorial pathogenesis, and variable response to conventional treatment. Although corticosteroids, immunomodulators, and biologics remain the cornerstone of treatment, long-term disease control is often complicated by adverse effects, treatment dependency, financial burden, and incomplete remission[25]. These limitations have contributed to increasing interest in complementary and integrative therapeutic approaches that target inflammation, stress[23], dietary triggers[24], and quality of life[2].

The present case series demonstrated substantial improvements in all five young patients with Crohn's disease/IBD following an integrative protocol involving **Chakrasiddh Spine Expert Therapy (CSET), Chakrasiddh Energy Release Technique (CERT), dietary modification, yoga-based rehabilitation, and lifestyle interventions**. Over an 18-month follow-up period, all patients showed improvement in abdominal pain, bowel frequency, appetite, fatigue, body weight, inflammatory markers, hemoglobin levels, serum albumin, and CDAI scores. Endoscopic findings further supported mucosal healing in four patients, while one patient with severe baseline disease demonstrated moderate improvement. Reduction in medication dependency was also observed in most cases.

The CSET sessions for 24-days worked on improving digestive functions, abdominal flexibility, reducing myofascial restriction, improving bowel mobility along with musculoskeletal realignment. Abdominal myofascial release technique used helped in relieving abdominal tightness, and bloating. The manual therapeutic component of CSET shares similarities with several traditional systems of medicine. For example, **Traditional Chinese Medicine (TCM)** uses abdominal massage techniques like acupressure, acupuncture and moxibustion in treating gastrointestinal diseases and significant advantages against symptoms of abdominal pain, diarrhea, fatigue and anorexia, improves digestive function, reduce abdominal tension, and promote autonomic regulation[26]. Studies have reported that abdominal Tuina massage may improve symptoms of chronic gastrointestinal disorders by enhancing intestinal motility and reducing stress-related symptoms. Similarly, Japanese **Shiatsu therapy** has also been explored for stress reduction and digestive health support[27].

Recent literatures of alternative medicine strongly support the influence of diet on IBD and Crohn's disease outcomes. Exclusive enteral nutrition[28], anti-inflammatory diets[29], Mediterranean dietary patterns[30], probiotic supplementation[31], and elimination diets have all shown potential benefits in reducing disease activity. In **Ayurveda,** Crohn's disease is often correlated with conditions such as *Grahani* or *Pittaja Atisara*, where digestive dysfunction and inflammation are managed

through herbal formulations, Panchakarma therapies, dietary regulation, and stress reduction. Published case reports have demonstrated symptomatic improvement in Crohn's disease patients using Ayurvedic interventions such as Sarvang Abhyanga (therapeutic massage)[32], **Kutaja preparations, Takra therapy, Musta, Bilva, Ashwagandha, and Panchakarma protocols[33,34]**. Similarly, **Traditional Chinese herbal [35]and other h**erbal combinations targeting intestinal inflammation, mucosal repair, and immune regulation have shown improvements in symptom control and remission rates in some studies. In this case series, the dietary component of the protocol may also have played an important role in patients' recovery. The current study used individualized dietary modifications based on Siddha principles combined with anti-inflammatory nutritional concepts, emphasizing gut-restorative foods, probiotics, antioxidants, and avoidance of inflammatory dietary triggers.

One of the important observations in this study was the possible role of the **gut–brain axis** in disease persistence and symptom exacerbation. Increasing evidence suggests that chronic psychological stress can influence intestinal permeability, gut microbiota composition, immune responses, and inflammatory cytokine activity, thereby worsening IBD symptoms[7]. Research on stress reduction interventions such as mindfulness therapy, psychotherapy, and emotional regulation techniques has shown improvement in quality of life among IBD patients[23]. The CERT model used in this case series for all patients may have contributed to symptom improvement by addressing emotional stress and autonomic imbalance[14]. Several studies have demonstrated that yoga interventions improve stress levels, fatigue, sleep quality, and overall well-being in patients with chronic gastrointestinal disorders. Yoga and breathing exercises included in the protocol may have further contributed to improved outcomes by supporting digestion, detoxification and energy balancing[36,37]. All patients in this case series had shown active and improved quality of life after the therapy, they were able to resume school, college, work-related activities, and social participation with greater ease, also substantial improvements in physical health, emotional stability, and daily functioning were visible. The observed endoscopic improvements in this case series are particularly noteworthy because mucosal healing remains an important treatment target in modern gastroenterology. While complete healing was not observed in all patients, substantial improvement in four cases and moderate improvement in one severe case suggest that integrative supportive therapies may play a role in improving disease outcomes.

Despite these encouraging findings, several limitations should be acknowledged. This was a small case series involving only five patients without a control group. The combined nature of the intervention makes it difficult to determine the independent effect of each treatment component. Placebo effects, natural disease fluctuation, and continued conventional medications may also have influenced outcomes. Additionally, standardized protocols for CSET and CERT require further scientific validation. Future research should include randomized controlled trials, larger multicenter studies, microbiome analysis, inflammatory cytokine profiling, and long-term comparative studies to better understand the role of integrative therapies in Crohn's disease and IBD management.

Overall, this case series suggests that a multidisciplinary integrative model combining manual therapy, emotional healing, nutritional interventions, and lifestyle modification may offer supportive benefits in selected patients with Crohn's disease and IBD, particularly those seeking complementary strategies alongside conventional care.

6. CONCLUSION

This case series highlights the potential role of an integrative Siddha-based approach involving Chakrasiddh Spine Expert Therapy (CSET), Chakrasiddh Energy Release Technique (CERT), individualized dietary correction, and lifestyle modification in the supportive management of Crohn's disease and inflammatory bowel disease. Across all five patients, meaningful improvements were observed in clinical symptoms, inflammatory biomarkers, nutritional status, endoscopic findings, and overall quality of life over the 18-month follow-up period. Decreased dependency on conventional medications in most patients, suggested that such integrative approaches may serve as valuable complementary strategies in long-term disease management.

Although these findings are encouraging, this study is limited by its small sample size and lack of a control group. Further large-scale, controlled clinical studies are required to better understand the mechanisms involved and to validate the role of CSET and CERT in chronic inflammatory gastrointestinal disorders such as Crohn's disease and IBD.

REFERENCES

1. Jena A, Mishra S, Deepak P, Kumar-M P, Sharma A, Patel YI, et al. Current management and future perspectives in inflammatory bowel disease. Front Med (Lausanne). 2023;10:1123456.
2. Savarino EV, et al. IBD impact on quality of life and perception of disease activity in Italian patients and physicians: an IBD-PODCAST study sub analysis. Dig Liver Dis. 2025;57(9):1761-71. doi:10.1016/j.dld.2025.05.006.
3. Ng SC, Kaplan GG, Tang W, Banerjee R, Adigopula B, Underwood FE, et al. Population density and risk of inflammatory bowel disease: a prospective population-based study in 13 countries or regions in Asia-Pacific. Lancet Gastroenterol Hepatol. 2020;5(1):107-15.
4. Ghersin I, Khteeb N, Katz LH, Daher S, Shamir R, Assa A. Trends in the epidemiology of inflammatory

bowel disease among Jewish Israeli adolescents: a population-based study. Aliment Pharmacol Ther. 2019;49(5):556-63.

5. Le Berre C, Ananthakrishnan AN, Danese S, Singh S, Peyrin-Biroulet L. Ulcerative colitis and Crohn's disease have similar burden and goals for treatment. Clin Gastroenterol Hepatol. 2020;18(1):14-23. doi:10.1016/j.cgh.2019.07.005.
6. Maksic M, Veljković T, Cvetković M, Marković M, Perić S, Marinkovic O, et al. Fecal calprotectin: a marker of Crohn's disease activity. Acta Facultatis Medicae Naissensis. 2023;40:160-70. doi:10.5937/afmnai40-39534.
7. Gracie DJ, Guthrie EA, Hamlin PJ, Ford AC. Bi-directionality of brain-gut interactions in patients with inflammatory bowel disease. Gastroenterology. 2021;154(6):1635-46.
8. Torres J, Bonovas S, Doherty G, Kucharzik T, Gisbert JP, Raine T, et al. ECCO guidelines on therapeutics in Crohn's disease: medical treatment. J Crohns Colitis. 2020;14(1):4-22.
9. Connors J, Basseri S, Grant A, Giffin N, Mahdi G, Noble A, et al. Exclusive enteral nutrition therapy in paediatric Crohn's disease results in long-term avoidance of corticosteroids: results of a propensity-score matched cohort analysis. J Crohns Colitis. 2017;11:1063-70. doi:10.1093/ecco-jcc/jjx060.
10. Cheifetz AS, Gianotti R, Luber R, Gibson PR. Complementary and alternative medicines used by patients with inflammatory bowel diseases. Gastroenterology. 2017;152(2):415-429.e15. doi:10.1053/j.gastro.2016.10.004.
11. Langhorst J, Wulfert H, Lauche R, et al. Systematic review of complementary and alternative medicine treatments in inflammatory bowel diseases. J Crohns Colitis. 2015;9(1):86-106. doi:10.1093/ecco-jcc/jju007.
12. Saha S, Mahapatra SJ, Roy S. Traditional Indian medicine and inflammatory bowel disease: scope and scientific relevance. J Ayurveda Integr Med. 2022;13(4):100559.
13. Muthiah K, Ganesan K, Ponnaiah M, Parameswaran S. Concepts of body constitution in traditional Siddha texts: a literature review. J Ayurveda Integr Med. 2019;10(2):131-4. doi:10.1016/j.jaim.2019.04.002.
14. Sathya Sindhuja B, Sankar I, Tiwari S. Synergistic healing of Crohn's disease with Siddha and energy-based therapy: a case insight into clinical remission and lifestyle enhancement. J Clin Case Stud Rev Rep. 2025;2(3):27. doi:10.5281/zenodo.15471476.
15. Outtier A, Janssens R, Barbier L, Sabino J, Verstockt B, Vermeire S, et al. Evolution of eligibility criteria in inflammatory bowel disease clinical trials: a clinical trial databank analysis. United European Gastroenterol J. 2025;13(4):542-51. doi:10.1002/ueg2.12731.
16. Zhou Y, Li J, Li Y, et al. Combined use of CDAI and blood indices for assessing endoscopic activity in ileocolic Crohn's disease. BMC Gastroenterol. 2023;23(1):295. doi:10.1186/s12876-023-02968-0.
17. McDermott E, Keegan D, Byrne K, Doherty GA, Mulcahy HE. The short health scale: a valid and reliable measure of health related quality of life in English speaking inflammatory bowel disease patients. J Crohns Colitis. 2013;7(8):616-21. doi:10.1016/j.crohns.2012.07.030.
18. Sindhuja BS, Sankar I, Elakya E, Tiwari S. Comparative evaluation of CSET (Chakrasiddh Spine Expert Therapy) and standard physiotherapy in management of cervical spondylosis. J Chronic Dis Prev Care. 2025;2(2):1-9.
19. Nagarajan SK, Miltonraj AV, Muthukumar NJ, Samundeeswari P, Mahalakshmi V, Miltonraj VV, et al. Brief discrimination of Varmam in Siddha system of medicine. Int J Curr Res Med Sci. 2018;4(1):10-17. doi:10.22192/ijcrms.2018.04.01.002.
20. Ramya et al. Validation of Varma points for Thandagavatham—a case series. J Res Biomed Sci. 2020;3(2):48-51.
21. Krishnapriya D, Mahadevan MV, Muthukumar NJ. Documentation of Varmam points located in the upper limb by analysing various Siddha Varmam literature. Int J Creat Res Thoughts. 2022;10(11):506-19.
22. Sathya Sindhuja B, Sankar I, Tiwari S. Synergistic healing of Crohn's disease with Siddha and energy-based therapy: a case insight into clinical remission and lifestyle enhancement. J Clin Case Stud Rev Rep. 2025;2(3):27. doi:10.5281/zenodo.15471476.
23. De Sousa JFM, Paghdar S, Khan TM, Patel NP, Chandrasekaran S, Tsouklidis N. Stress and inflammatory bowel disease: clear mind, happy colon. Cureus. 2022;14(5):e25006. doi:10.7759/cureus.25006.
24. Sigall Boneh R, Sarbagili Shabat C, Yanai H, Chermesh I, Ben Avraham S, Boaz M, et al. Dietary therapy with the Crohn's disease exclusion diet is a successful strategy for induction of remission in children and adults failing biological therapy. J Crohns Colitis. 2017;11:1205-12. doi:10.1093/ecco-jcc/jjx071.
25. Lo CH, Khalili H, Song M, Lochhead P, Burke KE, Richter JM, et al. Healthy lifestyle is associated with reduced mortality in patients with inflammatory bowel diseases. Clin Gastroenterol Hepatol. 2021;19(1):87-95.

26. Xie J, Huang Y, Wu HG, Li J. Acupuncture and moxibustion for treatment of Crohn's disease: a brief review. World J Gastroenterol. 2022;28(25):3001-3. doi:10.3748/wjg.v28.i25.3001.
27. Park HL, Lee HS, Shin BC, et al. Traditional medicine in China, Korea, and Japan: a brief introduction and comparison. Evid Based Complement Alternat Med. 2012;2012:429103.
28. Levine A, Wine E, Assa A, Sigall Boneh R, Shaoul R, Kori M, et al. Crohn's disease exclusion diet plus partial enteral nutrition induces sustained remission in a randomized controlled trial. Gastroenterology. 2019;157:440-450.e8. doi:10.1053/j.gastro.2019.04.021.
29. Limdi JK. Dietary practices and inflammatory bowel disease. Indian J Gastroenterol. 2018;37:284-92. doi:10.1007/s12664-018-0890-5.
30. Ratajczak AE, Festa S, Aratari A, Papi C, Dobrowolska A, Krela-Kaźmierczak I. Should the Mediterranean diet be recommended for inflammatory bowel diseases patients? A narrative review. Front Nutr. 2023;9:1088693. doi:10.3389/fnut.2022.1088693.
31. Carbone F, Argollo M, Colizzo FP, D'Amico F, Fiorino G, Peyrin-Biroulet L, et al. Diet and inflammatory bowel disease: review of patient-targeted recommendations. Clin Gastroenterol Hepatol. 2021;19(1):14-27.
32. Varsakiya JN, Agarwal B, Kathad D, Ravi AK, Dwivedi SP. Effectiveness of Ayurveda management in Crohn's disease. J Integr Health Sci. 2024;12(1):80-87. doi:10.4103/jihs.jihs_13_24.
33. Seyedian SS, Nokhostin F, Malamir MD. A review of the diagnosis, prevention, and treatment methods of inflammatory bowel disease. J Med Life. 2019;12:113-22. doi:10.25122/jml-2018-0075.
34. Nath R, Mahajon B, Mandal S, Sengupta A, Chattopadhyay A. Efficacy of Pippalī (fruits of Piper longum Linn.) in Grahaṇīroga: a prospective open label clinical trial. J Ayurveda Med Sci. 2017;2:197-203. doi:10.5530/jams.2017.2.13.
35. Ye BD. Introducing traditional herbal medicine into conventional health care in treating ulcerative colitis: primum non nocere. Gastroenterology. 2018;154(4):792-5. doi:10.1053/j.gastro.2018.02.004.
36. Engels M, Cross RK, Long MD. Exercise in patients with inflammatory bowel diseases: current perspectives. Clin Exp Gastroenterol. 2017;11:1-11. doi:10.2147/CEG.S120816.
37. Sathya Sindhuja B, Sankar I, Nandyal S, Tiwari S. Comprehensive spine rehabilitation through Chakrasiddh Spine Expert Therapy (CSET): a case of multi-level Musculoskeletal Disorders, J Clinical Case Studies and Review Reports. 2(5) 32, DOI: 10.5281/zenodo.17106073.