

Derma-Roller Assisted Prachhana Karma As a Contemporary Alternative to Parijataka Patra in the Management of Viruddhaahara – Induced Switra (Vitiligo): A Case Report “Ayurvedic Management of Switra”

^{1*} Dr. Shubhangi Karanje, ²Dr. Arati A. Shinde, ³Dr. Dhiraj Jangale, ⁴Dr. Alban T. Sebastian and ⁵Dr. Monika Patel

¹Associate Professor, Department of Agada Tantra evam Vidhi Vaidyaka, Dr D.Y Patil College of Ayurved and Research Centre, Dr. D.Y. Patil Vidyapeeth, (Deemed to be University) Pimpri, Pune-411018

²Professor and HOD, Department of Agada Tantra evam Vidhi Vaidyaka, Baba Mastnath Ayurved College, Rohatak

³Professor and HOD, Department of Shalya Tantra, Shivajirao Pawar Ayurvedic Medical College and Research Centre, Panchegaon

⁴Assistant professor, Department of Ayurveda Samhita Siddhanta, Rashtriya Ayurveda College, Research Institute. Hatnoor

⁵Assistant professor, Department of Agada Tantra evam Vidhi Vaidyaka, J S Ayurveda Mahavidhyalaya, Nadiad, Gujarat
Ishubhra161089@gmail.com, 2abhayarati@rediffmail.com, 3djangale777@gmail.com, 4alban7alb@gmail.com

*Corresponding Author: Dr. Shubhangi Karanje, Associate Professor, Department of Agada Tantra evam Vidhi Vaidyaka, Dr D.Y Patil College of Ayurved and Research Centre, Pimpri, Pune-411018
Email Id.: shubhra161089@gmail.com

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ABSTRACT

Background: In Ayurveda, Switra is known as Ayurvedic correlate of vitiligo and is blamed on Viruddhahara (dietetically incompatible combination) and its action through Gara Visha (a cumulatively toxic state) which is caused by consumption of two or more substances which are individually wholesome and are taken together in a way contrary to the Samyoga principles. A Veerya Viruddha combination, fish and milk is repeatedly listed as a provoking combination for Twak Vikara across the Brihatrayee.

Aim: To record the clinical course of a patient of Switra with long-standing fish-milk Viruddhahara and to analyse Prachhana Karma with derma roller as a standardised and contemporary method as compared to classical Parijataka Patra based Raktamokshana.

Case Presentation and Methods: A 40-year-old homemaker, came with complaints of progressive depigmented macules on hands, perioral region and feet over a period of 8 months, on the background of 5 years of a fish-milk habit. It has been diagnosed clinically and correlated with Switra of Gara Visha Samprapti, which was the cause of Non-segmental vitiligo. For four fortnightly follow-ups for a total of more than 60 days, Prachhana Karma was done with a sterile 192-needle derma roller along with local application of Avalgujjadi Churna. Oral Sutshekhar Rasa, Svayambhu Guggulu, Jatamansi-Tagar Vati and Vitinil ointment (later) in topical maintenance were started together and tapered in a progressive manner while Gandhaka Rasayana was added in the second follow up.

Results: The procedure was well tolerated with no adverse events at each sitting. By the third follow up, perifollicular pigment stippling was present, which continued to coalesce over the next 60 days.

Conclusion: Dermal roller based Prachhana Karma provided a reproducible, hygienic, patient acceptable method of Raktamokshana which could be combined with specially designed Ayurvedic pharmacotherapy, but needs to be confirmed under controlled conditions. An attempt to describe everything regarding the study in an image form is made in Figure 1

Keywords: Vitiligo, Switra, Gara Visha, Viruddhahara, Prachhana karma, Derma roller, Psoralea corylifolia

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*Author for Correspondence: shubhra161089@gmail.com

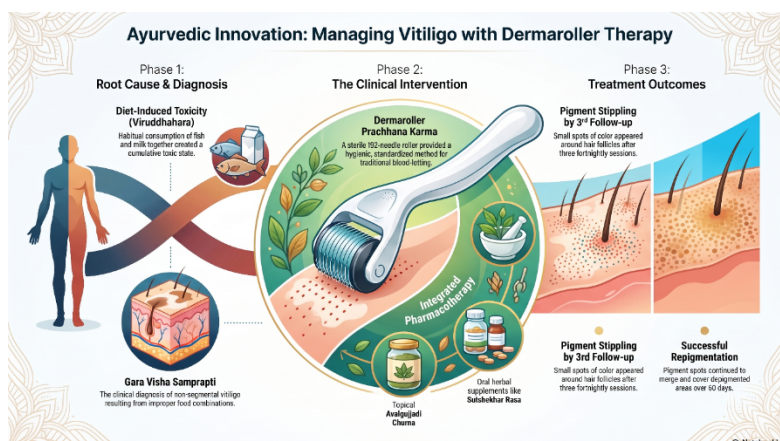


Figure 1: Infographic Representation of the Abstract of the Case Report

1. INTRODUCTION

Vitiligo is a pigmentary disease acquired by progressive damage to the epidermal melanocytes that gives rise to well-demarcated depigmented macules that have a great social burden. It has been suggested that autoimmune destruction of melanocytes and oxidative stress play a role in the disease and that it occurs equally in both sexes, but is slightly more common in females and in all age groups. [1]

In the larger spectrum of *Twak Vikara*, *Ayurveda* identifies another entity in the context of several *Nidana*, *Matsya-Dugdha Sevana*, a combination of two wholesome substances, fish and milk, whose qualities when combined together are antagonistic, is repeatedly referred throughout the *Brihatrayee* as a *Veerya Viruddha* combination of fish and *Sheeta Virya* milk and vitiates *Rakta* and aggravates the *Srotas* that presents as chronic dermatoses. [2,3]

In classical literature, there is a good argument for a relationship to the onset of vitiligo and the diet of *Viruddhaahara*, but there is no solid clinical documentation to correlate a specific diet with the onset of the disease, and what to do about it in an *Ayurvedic* integrated approach. The use of traditional *Shashtra Karma* instruments like thorny *Parijataka Patra* (*Nyctanthes arbor-tristis* leaf) for *Prachhana* based *Raktamokshana* has not been investigated and the standardised modern instrument used is yet to be explored. This report describes such an instance and the present work is directed towards the evaluation of the application of *Prachhana Karma* in *Switra Chikitsa* in the form of single use, sterile dermaroller as a modern reproducible substitute to *Parijataka Patra*. [4,5,6]

2. CASE PRESENTATION AND METHODS

2.1 Patient Information

A 40-year-old woman, a homemaker from semi-urban area, on periphery of Pune presented with progressively increasing painless depigmented patches noticed first over both dorsa of hands and later over perioral area and dorsal feet of both feet. Under direction a dietary enquiry was done and it has been found that the practice of eating fish regular along with milk or milk-based sweets in the same meal and in the same meal is there for several years called *Veerya Viruddha*. There was no history of preceding trauma, contact sensitisation, thyroid disease or family history of depigmentation and no history of abnormal menstrual and obstetric history (AOH).

2.2 Clinical Findings and Diagnostic Assessment

On examination, well demarcated, chalkwhite macules 2-4cm in maximum dimension were noted on the dorsa of both hands, the perioral skin and dorsal feet, which were not atrophic nor scalp. Wood's lamp was used to enhance the depigmented borders. There was no leukotrichia, Koebner phenomenon or sparing of mucosal surfaces. An examination of the rest of the body and a full blood count and thyroid tests were normal, also a good sign that it was not associated with a systemic autoimmune disorder. Morphology alone was used to make a clinical diagnosis of non-segmental (vulgaris-pattern) vitiligo. Diagnosis of *Switra*, due to *Gara Visha Samprapti*, was supported by *Ayurvedic Nidana Panchaka* which was synthesized and presented in Table 1, by considering *Matsya-Dugdha Viruddhaahara*. [7] Figure 2,3 and 4 are the initial diagnostic findings.



Figure 2: Initial Pigmentation marks over hand



Figure 3: Initial Pigmentation marks over head



Figure 4: Pigmentation marks over neck

Table 1: Nidana Panchaka and Samprapti Synthesis correlating Ayurvedic and modern Diagnostic Parameters

Parameter	Ayurvedic correlate	Modern correlate
Hetu (cause)	<i>Matsya–Dugdha Sevana (Veerya Viruddha Ahara); sedentary Vihara</i>	Chronic dietary antigenic/inflammatory load; possible gut–immune dysregulation
Purvarupa	<i>Twak Vaivarnya</i> , mild <i>Kandu</i> at future lesion sites (retrospective)	Subclinical perilesional colour change/pruritus, patient-reported
Rupa	<i>Sita Varna Mandala</i> , <i>Anupalepa</i> (non-scaly), <i>Sparshajnana Avikruti</i>	Well-demarcated depigmented macules; normal sensation; Wood’s lamp accentuation
Dosha (Samprapti Ghataka)	<i>Tridoshaja – Kapha–Vata</i> predominant, <i>Pitta anubandha</i>	–
Dushya	<i>Twak, Rakta, Mamsa</i>	Epidermal melanocytes, dermo-epidermal junction
Agni	<i>Jatharagni</i> and <i>Dhatvagni Mandya</i>	–
Srotas	<i>Rasavaha, Raktavaha Srotodushti</i>	Cutaneous microvasculature / immune trafficking
Ama	Present (<i>Viruddhahara-janya</i>)	Correlate: chronic low-grade inflammatory mediators
Sadhya–Asadhya	<i>Krichrasadhya</i> – chronic, non-segmental, limited extent	Guarded but treatable; involved area < 10% BSA

3. THERAPEUTIC INTERVENTION

Management was continued for >60 days, comprising of an initial visit (Day 0) and 4 follow-up visits every 14 days (Table 2). A depigmented patch was washed with antiseptic swab at each visit and then a sterile and single-use dermaroller (needle length 0.5-1 mm) was rolled over each patch in multiple directions until uniform superficially located pin point bleeding points appeared – the clinically described end point of *Parijataka Patra* based *Prachhana*. Immediately after each session, the formulation, consisting of a *Psoralea corylifolia* predominant formulation (*Avalgujjadi Churna*) levigated

in appropriate liquid vehicle, was applied to exploit the microchannels created transcutaneously for better transcutaneous absorption. The four *Rasaushadhi* were given together in the oral protocol and then gradually withdrawn from the protocol step by step according to the clinical response of the patient and at the second follow-up period, *Gandhaka Rasayana* was added and at a later follow-up period, *Vitinil* ointment was added in the oral protocol in addition to continued *Avalgujjadi Churna* as maintenance local therapy (Table 3). Table 4 shows the differences between the classical and dermaroller-assisted approaches to *Prachhana*, which are the key focus of comparison throughout this report.

Table 2: Visit wise timeline of intervention across 60 days

Visit / Day	Procedure	Local application	Oral drug modification	Clinical observation
V1 – Day 0	Diagnosis confirmed; first <i>Prachhana Karma</i> with dermaroller	<i>Avalgujjadi Churna</i> started	<i>Sutshekhar Rasa</i> , <i>Svayambhu Guggulu</i> , <i>Sirish Panchang Vati</i> , <i>Jatamansi–Tagar Vati</i> initiated	Baseline lesion documentation and photography
V2 – Day 15	<i>Prachhana Karma</i> repeated	<i>Avalgujjadi Churna</i> continued	All four oral drugs continued unchanged	No adverse effect; lesions clinically static
V3 – Day 30	<i>Prachhana Karma</i> repeated	<i>Avalgujjadi Churna</i> continued	<i>Gandhaka Rasayana</i> added; <i>Jatamansi–Tagar Vati</i> tapered	Mild perilesional colour change at margins
V4 – Day 45	<i>Prachhana Karma</i> repeated	<i>Vitinil</i> ointment introduced alongside <i>Avalgujjadi Churna</i>	<i>Sutshekhar Rasa</i> and <i>Sirish Panchang Vati</i> tapered	Early perifollicular pigment stippling over hand lesions

V5 – Day 60	Final <i>Prachhana Karma</i> ; outcome assessment	<i>Avalgujjadi Churna</i> and Vitinil ointment continued	Remaining drugs tapered off; <i>Svayambhu Guggulu</i> continued at maintenance dose	Progressive coalescence of pigment islands
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Table 3: Oral Pharmacological Protocol

Drug	Dose / frequency	Primary classical action	Rationale in this case
<i>Sutshekhar Rasa</i>	250 mg BD	<i>Pitta-shamaka, Rasayana</i>	Pacifies <i>Pitta–Rakta dushti</i> contributing to local inflammation
<i>Svayambhu Guggulu</i>	250 mg BD, after meal	<i>Rakta-shodhaka, Kapha–Vata hara</i>	Guggulu-based <i>Rakta Shodhana</i> supports systemic detoxification of <i>Gara Visha</i>
<i>Sirish Panchang Vati</i>	250 mg BD	<i>Kandughna; anti-allergic (Albizia lebbek)</i>	Addresses the hypersensitivity component associated with <i>Viruddhahara</i>
<i>Jatamansi–Tagar Vati</i>	250 mg OD, after meal	Medhya, nervine sedative	Mitigates psychological stress, a recognised exacerbating factor in vitiligo
<i>Gandhaka Rasayana</i> (from FU2)	250 mg BD	<i>Twakdosahara, Rasayana, mild Rechana</i>	Consolidates <i>Rakta-Prasadana</i> during the tapering phase

Table 4: Classical *Parijataka Patra* versus Dermalroller assisted *Prachhan Karma*

Parameter	<i>Parijataka Patra</i>	Dermalroller-assisted <i>Prachhana</i>
Instrument source	Thorny leaf of <i>Nyctanthes arbor-tristis</i> , freshly procured	Manufactured, sterile, single-use medical-grade device
Puncture depth	Operator-dependent; not standardised	Fixed needle length (0.5–1.0 mm); reproducible across sessions
Sterility / infection risk	Variable; dependent on leaf cleanliness and handling	Factory-sterilised, single-use; lower cross-infection risk
Patient tolerability	Often perceived as more painful / aversive	Generally better tolerated; briefer procedure time
Standardisation across sittings	Difficult to reproduce identical puncture density	Uniform 192-point needle density per roll
Drug-delivery enhancement	Presumed; not systematically studied	Documented enhancement of transcutaneous absorption in contemporary microneedling literature [8,9,10,11]
Availability / reproducibility	Seasonal and regional plant availability	Commercially available; reproducible across centres

4. RESULTS

Prachhana Karma using the dermaroller was performed without technical difficulty during all of the five visits over a period of 60 days, each of 5-7 minutes per patch, resulting in a uniform pin-point bleeding, which was superficial and subsided in a few minutes. At follow-up no adverse events such as secondary infection, hypertrophic scarring or contact reaction to *Avalgujjadi Churna* [12] or Vitinil ointment were observed.

The earliest clinically recognised sign of activation of melanocytes was perifollicular pigment stippling, which was first noted at the outer edge of the lesions around the third visit (Day 45) and increased in coalescence until the fourth visit (Day 60), most noticeably around the margins of the perioral skin and in the dorsal hand, where there were fewer hair follicles. Overall lesion assessment revealed a lesser amount of depigmented surface area at treated sites at Day 60, but not all lesions repigmented the same amount.

No gastrointestinal upset, change in bowel pattern or other systemic reactions was reported with the use of any of the oral medications, including the tapering schedule, as well as with the addition of *Gandhaka Rasayana*. Patient reported good adherence to dietary counselling, which was followed by almost full discontinuation of the

consumption of fish and milk during the observation period, and was satisfied with the procedural comfort of the dermaroller, compared to the puncture with a leaf that she had expected. Figure 4,5 and 6 the observed findings at the 60th day of the assessment



Figure 5: After treatment Re-pigmentation on hand



Figure 6: Re-Pigmentation of head after Treatment



Figure 7: Re-Pigmentation at Neck after Treatment

5. DISCUSSION

There are two different ways of interpreting the clinical course: classically and in the contemporary way. There is a lack of controlled biochemical validation studies in contemporary literature on *Viruddha Ahara* (those dealing with detoxification), but there are plausible theories: the interaction between eicosanoids and immune system dysfunction and/or the disruption of gut-immune crosstalk, which could be temporally correlated with the oxidative-stress and immune-dysregulation pathways cited in the etiology of vitiligo in this patient, who had been consuming the same food for many years before initiating the 8-month period of visual depigmentation.

The major change in procedure in this report is replacing of *Parijataka Patra* with a dermaroller for *Prachhana karma*. *Prachhana* with a thorny leaf is localised and is believed to produces *Raktamokshana* and promotes cutaneous circulation and thus helps to alleviate *Rakta-Kapha* dosha. Table 4 highlights that the dermaroller is a more reproducible, standardised and hygienic alternative to *Parijataka Patra*, as it is independent of the influence of the operator (as is classical *Shastra Prachhana*) and reduces the operator-dependent variation by combining a

needle geometry with a fixed length and by using factory sterilisation, avoiding seasonal plant availability.

The use of *Avalgujjadi Churna* immediately after microneedling is conceptually similar to the progress of the classical *Shodhana-Rasayana* therapy, where the immediate use of *Kandughna* therapy is followed by the introduction of *Gandhaka Rasayana* after the acute *Dosha-dushti* is managed. Thus, the use of *Gandhaka Rasayana* is only after the tapering phase, continued *Rakta-shodhaka* therapy and *Kandughna* therapy.

There are several caveats that should be taken into account in considering these observations. Future studies are needed to compare the efficacy of derma roller-assisted *Prachhana* with the traditional *Shastra Prachhana* in controlled groups of patients and include numerical VASI scores and standardised serial photographs to assess the outcome of vitiligo repigmentation, and to investigate the proposed correlation between *Gara Visha* and microneedling of the skin, given the multifactorial etiology of vitiligo in modern times. [13,14] The figure no. 8 describes the infographic narration of the complete understanding of the outcome of the study defined in the discussion section.

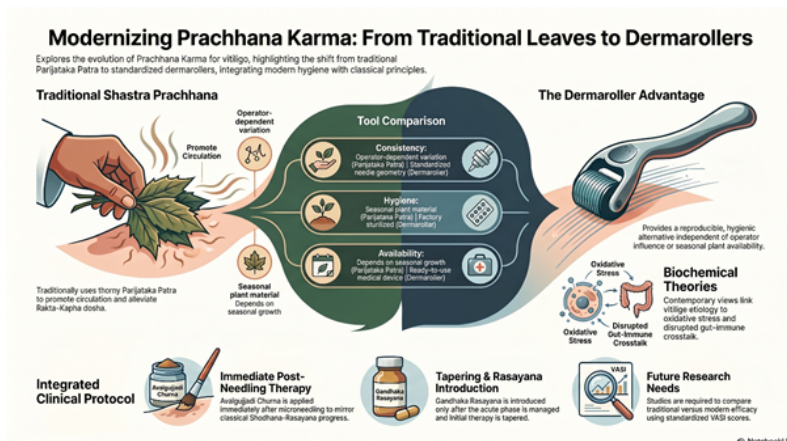


Figure 8: Infographic narration of the discussion

6. CONCLUSION

The dermaroller-assisted *Prachhana Karma* along with the sequential application of topical *Psoralea* and tapered oral *Rasaushadhi* of *Switra* was found to cause early perifollicular repigmentation in 8 weeks without any adverse procedural effects. The dermaroller provided an acceptable standardisation, sterility and patient acceptability which is not easily provided by the classical *Parijataka Patra* technique and the dermaroller seems to be a possible modern alternative to *Raktamokshana* in *Switra Chikitsa* with the help of *Prachhana*. These findings, based on a single patient experience, need to be substantiated with controlled comparative studies, also in other patients, before they can be generally recommended for clinical practice.

7. PATIENT PERSPECTIVE

The patient informed that the dermaroller based technique was much lesser distressing than she had anticipated,

tolerated the fortnightly sessions easily and expressed satisfaction with the visible outcome from the third follow-up onwards.

8. INFORMED CONSENT

Written Informed consent was obtained from the patient for the publication of the case report and using the clinical images while maintaining identification secrecy.

9. CONFLICT OF INTEREST

The authors declare NO conflict of Interest

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