Role of Shamana Chikitsa in Vatarakta (Gout): A Combined Ayurvedic and Modern Medical Perspective

Dr. Lata D. Patil[1*], Dr. Onkar V. Hendre[2], Dr. Dhananjay Patil[3], Dr. Sudeep Menon[4], Dr. Sangram Mane[5], Dr. Pravina S. Adhikari[6], Dr. Ankita Pawar[7]

[1*]Associate Professor, Department of Rognidan Evam Vikriti Vigyan, College of Ayurveda, Bharati Vidyapeeth Deemed University, Dhankawadi, Pune, Maharashtra, India (Corresponding Author)

Email: lata.patil1@bharatividyapeeth.edu

[2]PG Scholar, Department of Rognidan Evam Vikriti Vigyan, College of Ayurveda, Bharati Vidyapeeth Deemed University, Dhankawadi, Pune, Maharashtra, India

[3]Associate Professor, Department of Swasthavritta Evum Yoga, Bharati Vidyapeeth Deemed University College of Ayurved, Pune, Maharashtra, India

[4]Professor & HOD, Department of Swasthavritta Evum Yoga, Bharati Vidyapeeth Deemed University College of Ayurved, Pune, Maharashtra, India

[5]HOD & Professor, Department of Rognidan Evam Vikriti Vigyan, College of Ayurveda, Bharati Vidyapeeth Deemed University, Dhankawadi, Pune, Maharashtra, India

[6]Associate Professor, Department of Rognidan Evam Vikriti Vigyan, College of Ayurveda, Bharati Vidyapeeth Deemed University, Dhankawadi, Pune, Maharashtra, India

[7]Assistant Professor, Department of Rognidan Evam Vikriti Vigyan, College of Ayurveda, Bharati Vidyapeeth Deemed University, Dhankawadi, Pune, Maharashtra, India

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ABSTRACT

Vatarakta is a classical Ayurvedic disorder produced by the reciprocal aggravation of Vata and Rakta. Its characteristic involvement of the peripheral joints, severe pain, erythema, burning, swelling and recurrent attacks permits a practical clinical correlation with gout, although the two diagnostic constructs are not identical. Shamana Chikitsa is especially relevant when the patient is unsuitable for immediate Shodhana, when the disease is in an early or moderate stage, and as maintenance therapy after purification. To synthesize classical doctrine and Ayurveda-focused clinical literature concerning Shamana Chikitsa in Vatarakta, while using modern gout terminology only for clinical and biochemical correlation.

Methods: A structured narrative review was performed using major Ayurvedic compendia, official formularies and pharmacopoeias, and Ayurveda journals available up to July 2026. Sources were included when they described Vatarakta Nidana, Samprapti, Rupa, stage-wise treatment, Shamana drugs or formulations, dietary regulation, or Ayurveda clinical outcomes. Purely biomedical mechanistic papers and non-Ayurvedic interventions were excluded. Thirty references were retained.

Results: The literature consistently supports a staged approach comprising Nidana Parivarjana, assessment of Ama and Agni, Dosha-Rakta predominance, judicious Deepana-Pachana, Vata Anulomana, Rakta-prasadana, Shothahara and Mutrala measures, followed by individualized use of Guduchi, Guggulu, Punarnava, Kokilaksha and classical compound formulations. Small clinical

studies report improvement in pain, swelling, burning, stiffness, functional limitation and serum uric acid; however, heterogeneity, limited sample sizes and incomplete blinding restrict certainty.

Conclusion: Shamana Chikitsa offers a coherent Ayurveda-based framework for symptom control, metabolic correction and recurrence prevention in Vatarakta. Its rational use depends on stage, Bala, Agni, Ama, Dosha predominance, renal status, diet and follow-up rather than on a single universal formulation.

Keywords: Vatarakta; gout; Shamana Chikitsa; Guduchi; Guggulu; hyperuricemia; Grahani; irritable bowel syndrome; Shunthi.

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1. Introduction

Vatarakta occupies a distinctive place among the disorders in which a mobile Dosha and a circulating Dhatu become mutually pathogenic. Charaka describes the condition as the consequence of aggravated Vata obstructed by vitiated Rakta and, in turn, further contaminating Rakta; the resulting cycle produces intense pain and discoloration, particularly in the distal parts of the body [1]. Sushruta and Vagbhata elaborate the progression from superficial involvement to deeper tissues and emphasize the variable dominance of Vata, Pitta, Kapha and Rakta [2-4]. Madhava Nidana and later compilations preserve a clinically useful description of abrupt joint pain, swelling, burning, itching, altered colour, tenderness and recurrent disability [5-7].

In contemporary clinical language, gout is recognized by episodic inflammatory arthritis associated with urate deposition and commonly affects the first metatarsophalangeal joint. The correlation with Vatarakta is strongest at the level of presentation: sudden severe pain, red-hot swelling, exquisite tenderness, distal joint predilection, recurrence and an association with rich diet and sedentary living. Nevertheless, Vatarakta is a broader Ayurvedic construct. It includes constitutional susceptibility, Agni status, Rakta Dushti, Srotorodha, superficial and deep forms, and Dosha-specific manifestations that cannot be reduced to a laboratory value alone. Therefore, the term gout is used in this paper as a modern clinical comparator rather than as a complete translation.

Classical management includes both Shodhana and Shamana. Shodhana is selected when the patient has adequate Bala, the Doshas are sufficiently mobilized, and the disease stage warrants elimination. Shamana includes medicines, food regulation, external measures and behavioural correction that pacify Doshas without forceful expulsion. It is not merely symptomatic treatment. Properly designed Shamana may restore Agni, reduce Ama, normalize Vata movement, improve Rakta quality, diminish Shotha and support long-term prevention. The choice must be stage-specific: aggressive Ushna-Tikshna medication may aggravate Rakta-Pitta features, whereas indiscriminate cooling and heavy substances may worsen Ama, Kapha and Srotorodha.

The uploaded source manuscript correctly identified the need to connect Ayurvedic and modern clinical perspectives, but it was dominated by molecular inflammasome literature and contained duplicated sections. The present review therefore reconstructs the paper around classical Vatarakta doctrine and Ayurveda clinical evidence, retaining modern terms only where they improve diagnosis, outcome measurement or interdisciplinary communication. The objectives were: (i) to describe the Ayurvedic pathogenesis and

clinical staging of Vatarakta; (ii) to organize Shamana Chikitsa into practical therapeutic domains; (iii) to summarize available Ayurveda-focused clinical findings; and (iv) to clarify the separate, limited relevance of Grahani/IBS and Shunthi, which was specifically requested but should not be conflated with gout.

2. Literature Review

2.1 Classical disease construct and susceptible patient

The principal Nidanas of Vatarakta combine Rakta-provoking and Vata-provoking influences. Repeated intake of excessively sour, salty, pungent, alkaline, fermented, oily or incompatible foods disturbs Rakta and Pitta, while fasting, irregular meals, excessive exertion, night vigil, trauma, suppression of natural urges and other Vata-aggravating behaviours impair normal movement [1-6]. Rich food followed by inactivity is repeatedly criticized in the classical narrative. The susceptible phenotype is often described as Sukumara, affluent, over-nourished or habituated to sedentary comfort, but this does not exclude lean or physically active patients. The important principle is the mismatch between intake, digestion, tissue handling and elimination.

Agni is central to this interpretation. When digestion and tissue metabolism are impaired, improperly processed material contributes to Srotorodha. Vata loses its normal direction, and Rakta becomes a vulnerable medium because of its Drava, Sara and circulation-related properties. The disease often begins in Pada-mula or peripheral joints, where the pathways are narrow and repeatedly exposed to mechanical stress. Charaka's description of mutual obstruction explains why pain and movement disturbance coexist with redness, heat, burning and swelling [1]. Sushruta's differentiation of Uttana and Gambhira forms adds a depth dimension: superficial disease is more prominent in Tvak and Mamsa, whereas deep disease involves deeper Dhatus, marked pain, swelling, stiffness and chronicity [2].

Dosha predominance further individualizes the presentation. Vata-dominant disease tends toward severe pricking or splitting pain, dryness, stiffness, tremor, dark colour and variability. Pitta-Rakta dominance produces redness, burning, warmth, tenderness, thirst and rapid inflammation. Kapha dominance produces heaviness, coldness, itching, numbness, pallor and more stable swelling. Mixed patterns are common. The purpose of this classification is therapeutic: a formula suitable for Ama-Kapha obstruction is not automatically suitable for a hot, Rakta-Pitta-dominant flare.

2.2 Meaning and scope of Shamana Chikitsa

Shamana is often translated as palliation, but in Ayurvedic therapeutics it signifies the controlled pacification of a disturbed biological pattern. It may be the primary treatment in a patient of low Bala, in early or moderate disease, during convalescence, or when Shodhana is contraindicated. It may also follow Shodhana to consolidate benefit and prevent recurrence. A classical treatment algorithm therefore begins with Rogi-Roga Pariksha rather than with the name of a proprietary medicine. Manohar's algorithmic analysis similarly emphasizes individualized sequencing according to constitution, stage, strength and dominant pathology [16].

The first component is Nidana Parivarjana. Continuing alcohol, incompatible combinations, frequent meat-heavy meals, excessive sour and salty foods, dehydration, prolonged sitting, sleep immediately after food, or sudden strenuous exercise makes pharmacotherapy inconsistent. The second component is Agni and Ama assessment. In the presence of coated tongue, heaviness, anorexia, foul eructation, constipation or sticky stools, Deepana-Pachana and light diet are prioritized. In a depleted patient or in a hot

Rakta-Pitta state without Ama, strong pungent medication may be inappropriate.

The third component is Dosha-Rakta pacification. Vata requires Anulomana, suitable Sneha and reduction of obstruction. Rakta-Pitta requires cooling, bitter and astringent measures that reduce burning and discoloration without creating digestive weakness. Kapha-Ama requires light, penetrating and channel-clearing measures. The fourth component is protection of joints and recurrence prevention through Pathya, sleep regulation, gradual activity, weight management where appropriate, adequate hydration and monitoring of uric acid and renal function. Classical reviews confirm that this multi-layered interpretation is more faithful to the Samhitas than a single-drug model [17-19].

Table 1. Ayurvedic disease constructs and their clinical correlation

Ayurvedic construct	Clinical expression / modern correlation	Shamana implication
Vata Prakopa	Severe pain, variable attacks, stiffness and restricted movement	Anulomana; obstruction relief; suitable Sneha after Ama assessment
Rakta Dushti / Pitta association	Redness, warmth, burning, marked tenderness	Tikta-Kashaya and Rakta-prasadana measures; avoid excessive heat
Srotorodha	Recurrent localization in peripheral joints; swelling	Deepana-Pachana when Ama is present; Lekhana/Mutrala support where indicated
Uttana Vatarakta	More superficial colour change, itching, burning and swelling	Shamana, Pathya and local application are often central
Gambhira Vatarakta	Deep pain, marked swelling, stiffness, chronicity or deformity	Consider staged Shodhana plus sustained Shamana under supervision
Modern gout correlation	Acute red-hot tender joint, often first MTP; hyperuricemia may coexist	Use modern diagnosis and laboratory monitoring without collapsing the Ayurvedic diagnosis

2.3 Principal Shamana Dravyas and formulations

Guduchi (Tinospora cordifolia) is among the most repeatedly cited Vataraktahara Dravyas. Its Tikta-Kashaya profile, relative compatibility with all three Doshas, Rasayana use and traditional application in Daha, Jvara, Ama and inflammatory conditions make it a logical bridge between Agni correction and Rakta-Dosha pacification [13-15]. It is used as Churna, Kwatha, Ghana, Satva and as a major component of Amrita Guggulu and Kaishora Guggulu. Clinical publications have evaluated Guduchi alone, in comparative formulations, and as part of multi-drug protocols [20-24,27]. Guggulu is selected for its Lekhana, Shothahara, Vedanasthapana and channel-

oriented use, but it is rarely prescribed without a balancing matrix. Kaishora Guggulu combines Guduchi, Triphala, Trikatu and Trivrit-type actions to address Rakta, Ama, bowel regulation and swelling. Amrita Guggulu emphasizes Guduchi with Guggulu and supportive ingredients. Punarnavadi Guggulu adds Mutrala and Shothahara orientation. These formulations should not be treated as interchangeable: bowel pattern, heat, dryness, renal status, age, concomitant medicines and product quality influence selection [8,9,11].

Punarnava is valued when swelling, heaviness and fluid retention are prominent. Kokilaksha is selected for Mutrala and Vata-Rakta applications. Manjistha, Sariva, Nimba, Patola and Katuki are considered when Rakta-Pitta signs predominate, while Haritaki supports Anulomana and bowel regularity. Shunthi, Maricha and Pippali can assist Deepana-Pachana in Ama and Kapha-associated states; however, excessive use during marked burning, bleeding tendency, intense thirst or Pitta-Rakta aggravation is contrary to individualized practice. Official formularies and pharmacopoeias provide standards for identity, composition and preparation and should be preferred over unverified market formulations [11,12].

External Shamana measures are useful adjuncts. Pinda Taila is classically associated with burning, pain and inflamed Vatarakta and has been used in clinical protocols with Amrita Guggulu [21]. Cooling or Dosha-appropriate Lepa, gentle local application and protection from pressure may improve comfort. During an acute, exquisitely tender episode, forceful massage and vigorous exercise are unsuitable. Once pain settles, gradual range-of-motion activity helps prevent stiffness and deconditioning.

The classical texts also place Shamana within a wider treatment continuum. When repeated attacks, deep involvement, extensive Dosha burden or inadequate response are present, appropriately selected Virechana, Basti or Raktamokshana may be considered by a qualified physician [1-4]. The present paper focuses on Shamana, but it does not imply that every case should be managed without Shodhana.

Figure 1. Ayurvedic Samprapti of Vatarakta and stage-wise therapeutic entry points

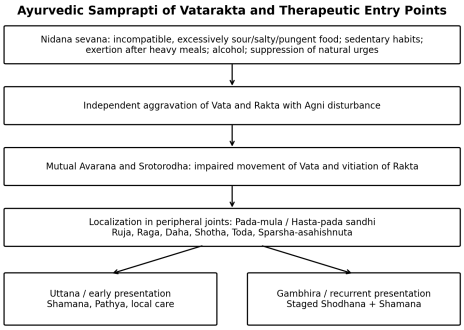


Table 2. Major Shamana drugs and formulations used in Vatarakta

Drug/formulation	Ayurvedic rationale	Preferred clinical context	Important caution
Guduchi / Amrita	Tikta-Kashaya, Rasayana, traditionally Tridosha-balancing	Ama-associated inflammation, Daha, recurrent Vatarakta; base for several Guggulu formulations	Use authenticated material; individualize in very dry/depleted patients
Kaishora Guggulu	Guduchi, Triphala, Trikatu and purgative/anulomana architecture	Rakta-Dosha with Ama, swelling and recurrent joint pain	Assess bowel habit, heat, dehydration and concomitant

Drug/formulation	Ayurvedic rationale	Preferred clinical context	Important caution
			medicines
Amrita Guggulu	Guduchi-Guggulu dominant Shothahara formulation	Pain, swelling and metabolic obstruction; studied with Pinda Taila	Avoid unsupervised prolonged use; ensure product quality
Punarnava / Punarnavadi Guggulu	Shothahara, Mutrala and channel-oriented use	Prominent swelling, heaviness or fluid-retention tendency	Renal disease requires medical assessment, not empirical diuresis
Kokilaksha	Mutrala and Vata-Rakta-oriented traditional use	Selected hyperuricemia/gout-like presentations	Dose and form should follow classical/clinical judgement
Manjistha, Sariva, Nimba, Patola	Rakta-prasadana, Tikta-Kashaya, cooling orientation	Pitta-Rakta dominant redness, burning and skin colour change	Strongly cooling/bitter treatment may weaken Agni if
			overused
Shunthi / Trikatu	Deepana-Pachana, Vata-Kapha reduction	Ama, heaviness, anorexia, sluggish digestion	Use cautiously in intense Daha, Rakta-Pitta aggravation or bleeding tendency
Pinda Taila / local measures	Cooling, soothing external support	Burning, pain and tenderness in suitable presentations	No forceful massage during an acutely inflamed, exquisitely tender joint

2.4 Pathya, Apathya and long-term prevention

Dietary advice in Vatarakta should be specific enough to be followed and flexible enough to preserve nutrition. The central rules are regular meals according to appetite, avoidance of overeating, preference for freshly prepared light food during a flare, adequate fluid intake unless medically restricted, and reduction of alcohol, fermented products, excessive sour and salty items, heavy fried food and incompatible combinations. Old grains, green gram, selected vegetables, pomegranate and

Dosha-appropriate bitter vegetables are commonly used within classical Pathya planning [6-8]. The exact diet must consider diabetes, kidney disease, hypertension, undernutrition and local food habits.

Lifestyle correction is equally important. Long uninterrupted sitting, daytime sleep after heavy food, night vigil, erratic exercise and sudden overexertion disturb the Vata-Rakta balance. During an acute painful episode, rest and joint protection are appropriate; complete long-term inactivity is not. After recovery, regular walking or low-impact movement, gradual weight correction, sleep regularity and stress management support recurrence prevention. The patient should be taught that disappearance of pain does not necessarily indicate resolution of the underlying tendency. Follow-up therefore includes attack frequency, pain and swelling scores, functional ability, diet adherence, bowel pattern, serum uric acid where relevant, and renal and hepatic safety monitoring.

Table 3. Practical Pathya-Apathya framework for Vatarakta

Domain	Pathya emphasis	Apathya / avoid
Meals	Fresh, light, warm and regular meals according to appetite; green gram and suitable vegetables	Overeating, repeated snacking, stale/heavy fried food, incompatible combinations
Taste pattern	Moderate, Dosha-appropriate use of bitter/astringent foods	Excessively sour, salty, pungent, fermented and alkaline items
Fluids	Adequate water unless restricted for cardiac/renal reasons	Dehydration and excess alcohol
Activity	Rest during acute pain; gradual low-impact activity after recovery	Forceful massage, sudden strenuous exercise, prolonged immobility
Sleep and routine	Regular sleep-wake cycle and timely meals	Night vigil, daytime sleep after heavy meals, irregular routine
Monitoring	Attack diary, functional assessment, serum uric acid and renal profile where indicated	Stopping all follow-up as soon as pain subsides

2.5 Authentic clinical and botanical images

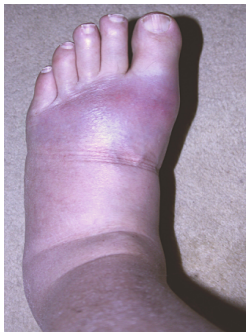
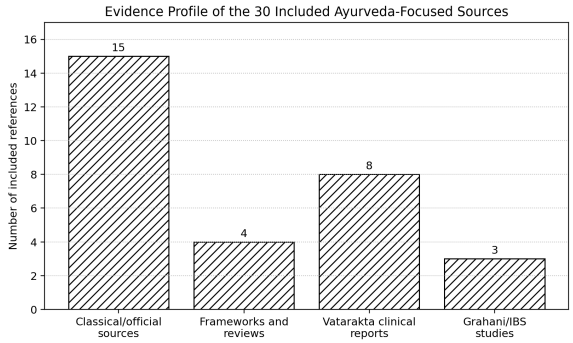


Figure 4. Inflamed foot photographed in association with gout. Source: Wikimedia Commons; photograph by vagawi; CC BY 2.0.

Figure 5. Tinospora cordifolia (Guduchi), a principal Vataraktahara drug. Source: Wikimedia Commons; public-domain image by Tmd.

Figure 2. Distribution of evidence types in the final reference set



3. Results

3.1 Synthesis of classical and clinical findings

Across the classical sources, the most stable finding was that Vatarakta is not a purely local joint disorder. It is generated by combined errors of diet, behaviour, digestion, circulation and Vata movement [1-10]. The repeated emphasis on Pada-mula and peripheral joints explains the practical correlation with podagra, while the Uttana-Gambhira distinction explains variation from superficial erythema and itching to deep, recurrent, disabling pain. The dominant therapeutic logic was to remove causes, assess Ama and strength, restore Agni without increasing Rakta-Pitta, relieve obstruction, pacify Vata and Rakta, and maintain bowel and urinary elimination.

The four applied frameworks and reviews [16-19] converged on individualized sequencing rather than a fixed prescription. Among the eight Vatarakta clinical publications [20-27], Guduchi- and Guggulu-containing interventions were prominent. Outcomes most commonly assessed were Sandhishoola, Shotha, Daha, tenderness, stiffness, walking or functional limitation and serum uric acid. The Amrita Guggulu-Pinda Taila study was multicentre and included 100 patients, whereas several other reports were small trials, case series or single cases [21,22,25,26]. The Munditika-Chinna Kwatha randomized study included 70 participants and compared the test intervention with Amrutadi Kwatha [24]. Recent studies of Kaishora Guggulu with Madhusnuhi Rasayana and Guduchi Churna extend the clinical literature but do not eliminate the need for larger confirmatory trials [23,27].

Reported direction of effect was generally favourable for pain, swelling, burning, tenderness and function. Some studies also reported reductions in serum uric acid. These findings support clinical plausibility but cannot be treated as definitive comparative efficacy because of open-label designs, short follow-up, variable co-interventions, incomplete adverse-event reporting and nonuniform diagnostic standards. The literature supports "promising with limitations," not therapeutic certainty.

Table 4. Selected Ayurveda clinical evidence for Shamana-oriented management of Vatarakta

Ref.	Intervention	Design/sample	Main interpretation and limitation
[20]	Kaishora Guggulu vs Amrita Guggulu	Comparative clinical study	Both groups improved Vatarakta symptoms; supports Guggulu-Guduchi formulations; limited by older

Ref.	Intervention	Design/sample	Main interpretation and limitation
			small-study design.
[21]	Amrita Guggulu + Pinda Taila	Open-label multicentre study; 100 patients	Improvement in clinical scales, quality-of-life measures and biochemical parameters; no blinded control.
[22]	Kaishora Guggulu + Punarnavadi Guggulu	Case series	Favourable symptom and uric-acid trends; very small sample and no comparator.
[23]	Kaishora Guggulu + Madhusnuhi Rasayana	Open-label single-arm prospective study	Reported clinical benefit in gout/Vatarakta; needs controlled replication.
[24]	Munditika Churna + Chinna Kwatha vs Amrutadi Kwatha	Single-blind randomized study; 70 patients	Both groups improved; selected between-group differences; short-term and centre-specific.
[25]	Individualized Ayurveda management	Case report	Clinical and biochemical improvement reported; cannot establish general efficacy.
[26]	Ayurvedic modalities for Vatarakta	Case report	Supports staged multimodal care; attribution to individual components is uncertain.
[27]	Guduchi Churna protocol	Clinical study; 2026	Reported improvement in Vatarakta/hyperuricemia outcomes; recent evidence requiring independent validation.

3.2 Thematic pattern of Shamana practice

Manual coding of the 12 Vatarakta-focused applied publications [16-27] showed that Nidana/Pathya counselling was the most frequent domain, followed by Agni-oriented Deepana-Pachana and Guduchi use. Guggulu-based compounds were frequent, while Shodhana was usually discussed as a stage-dependent option rather than as a compulsory first intervention. External or local measures appeared less often than oral formulations, but Pinda Taila and Dosha-appropriate local applications were clinically relevant. Rasayana was mainly used for convalescence, chronicity or recurrence prevention.

The thematic pattern suggests a practical three-phase model. Phase 1 is flare-oriented care: remove precipitating food and alcohol, rest the joint, use suitable light diet, assess Ama, and select cooling Rakta-Pitta pacification or gentle Deepana-Pachana according to presentation. Phase 2 is stabilization: continue individualized Shamana, normalize bowel function, improve mobility and monitor serum uric acid and renal safety. Phase 3 is prevention: reinforce Pathya, sleep and activity, consider Rasayana or maintenance formulations, and reassess

whether Shodhana is indicated for recurrent or deep disease.

The evidence also highlights the importance of formulation literacy. Kaishora Guggulu, Amrita Guggulu, Punarnavadi Guggulu, Guduchi preparations and Munditika-based protocols are not simply brand alternatives. Their ingredient architecture produces different balances of Tikta, Kashaya, Katu, Snigdha, Laghu, Anulomana, Mutrala, Shothahara and Rasayana actions. Selection according to the dominant pattern is more consistent with Ayurveda than choosing solely on the basis of a raised uric-acid report.

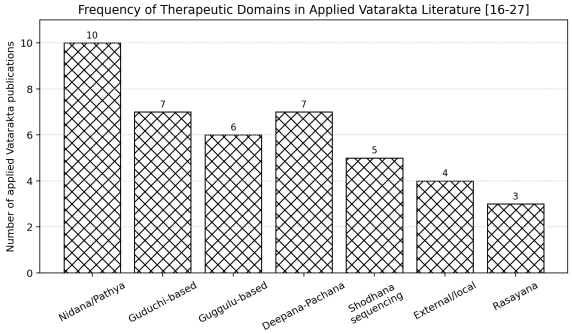
3.3 Outcome framework and interpretation of response

The included literature used a wide range of outcomes, which can be organized into four levels. The first level is acute symptom burden: Sandhishoola, Raga, Daha, Shotha, Toda, Kandu and Sparsha-asahishnuta. These features are clinically meaningful because they determine sleep disturbance, walking difficulty and the patient's immediate need for relief. The second level is physical function, including range of movement, ability to bear weight, walking distance, footwear tolerance and return to daily activity. The third level is recurrence and systemic control, assessed by frequency and duration of attacks, interval symptoms, serum uric acid and associated metabolic or renal abnormalities. The fourth level is Ayurvedic correction, reflected in appetite, bowel regularity, tongue coating, heaviness, Agnibala, Ama features and the stability of Vata movement.

A credible response should show concordance across more than one level. Rapid reduction of pain without improvement in recurrent attacks or metabolic indicators may represent short-term palliation. A lower uric-acid value without functional recovery may not reflect satisfactory patient benefit. Similarly, improvement in appetite and bowel function is supportive but cannot substitute for examination of the affected joint. For future trials, a core outcome set should combine a validated pain scale, joint swelling and tenderness, patient and physician global assessments, functional limitation, attack frequency, serum uric acid, renal function, adverse events and an explicitly defined Ayurvedic assessment.

The timing of assessment also matters. Acute response may be recorded within days, but prevention requires observation over months. Several available publications used short treatment periods, making it difficult to distinguish a genuine reduction in recurrence from the natural intercritical interval. Follow-up should therefore include adherence to Pathya, changes in concomitant medication and any use of rescue analgesics. These details are essential for attributing benefit to the Ayurveda intervention and for determining whether Shamana can sustain improvement after the initial treatment course.

Figure 3. Therapeutic-domain frequency in applied Vatarakta publications



Note: one publication could contribute to more than one domain; the figure is descriptive thematic coding, not an efficacy meta-analysis.

4. Discussion

The review demonstrates that Shamana Chikitsa is best understood as a structured clinical strategy rather than as a list of anti-gout herbs. The classical concept begins before the prescription: the physician identifies the active Nidanas, determines whether Ama is present, distinguishes Uttana from Gambhira involvement, evaluates

Dosha-Rakta predominance and assesses patient strength. This sequence prevents two common errors. The first is excessive use of hot, pungent, “digestive” medicines in a patient whose dominant features are burning, erythema and Rakta-Pitta aggravation. The second is excessive use of heavy, cooling or nourishing medicines in a patient with marked Ama, heaviness, poor appetite and obstruction.

A useful combined perspective can be created without replacing Ayurveda with molecular terminology. Modern gout assessment contributes confirmation of the clinical syndrome, exclusion of septic arthritis or other emergencies, measurement of serum uric acid, renal function and comorbidity, and documentation of attack frequency and disability. Ayurveda contributes a wider account of susceptibility, digestive state, stage, bowel function, diet, activity and individualized therapeutic sequencing. These viewpoints are complementary at the level of patient care, but they remain conceptually distinct.

5. Conclusion

Vatarakta is a systemic Dosha-Dhatu disorder in which aggravated Vata and vitiated Rakta mutually obstruct and intensify one another. Its distal joint pain, redness, heat, swelling, tenderness and recurrent course create a clinically useful correlation with gout, but the Ayurvedic diagnosis extends beyond hyperuricemia. Shamana Chikitsa provides a rational, stage-sensitive framework consisting of Nidana Parivarjana, Agni and Ama correction, Vata Anulomana, Rakta-prasadana, Shothahara and Mutrala support, individualized use of Guduchi- and Guggulu-based formulations, appropriate external measures and sustained Pathya.

Ayurveda clinical studies generally report favourable changes in symptoms and, in some reports, serum uric acid. However, the evidence is limited by small samples, open-label designs, short follow-up and heterogeneous protocols. Shamana should therefore be described as promising and clinically coherent, not as universally proven or guaranteed. Future research should prioritize standardized formulations, adequately powered comparative trials, long-term recurrence outcomes and transparent safety monitoring.

The requested Grahani-IBS-Shunthi discussion is relevant only as a separate Agni-centred comorbidity note. Shunthi-containing formulations may reduce Grahani symptoms such as poor appetite, abdominal distension and irregular stools when Vata-Kapha and Ama predominate, but this does not make Grahani synonymous with Vatarakta or establish Shunthi as a stand-alone gout treatment. The most defensible clinical approach is individualized, evidence-aware and supervised integration of classical Ayurvedic reasoning with modern diagnosis and monitoring.

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