Efficacy of Ayurvedic Formulations in the Management of Prameha: A Review

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ABSTRACT

Prameha is a comprehensive Ayurvedic disease complex characterized principally by Prabhuta Mutrata and Avila Mutrata, together with abnormalities of Kapha, Meda, Mamsa, Kleda, Lasika, Rasa, Ojas and the Mutravaha system. Classical authorities describe twenty varieties—ten Kaphaja, six Pittaja and four Vataja—and emphasize that management must be individualized according to Dosha dominance, tissue involvement, Agni, Ama, Bala, body build, chronicity and Upadrava. This narrative review evaluates the efficacy of Ayurvedic formulations in Prameha through the internal logic of Ayurveda and through review-level evidence, without constructing a clinical study.

Classical Samhitas, later therapeutic compendia, official formularies and pharmacopoeial sources were examined alongside Ayurveda-focused scholarly reviews. The synthesis shows that formulation efficacy is not a property of a product name alone. It depends on correct diagnosis and on the concordance of Rasa, Guna, Virya, Vipaka, Prabhava, dosage form and Anupana with the patient's Samprapti. In Sthula and Kapha-Meda-Kleda-dominant presentations, formulations with Tikta, Kashaya and Katu attributes, Deepana-Pachana, Lekhana, Kleda-Shoshana and Medohara orientation are repeatedly prioritized. In Krisha, Durbala or advanced Vata-Dhatukshaya presentations, excessive depletion is discouraged and the therapeutic emphasis shifts toward Mridu Shamana, Brimhana, Rasayana and protection of Ojas.

Frequently discussed classical options include Nishamalaki, Darvyadi Kashaya, Nyagrodhadi- and Asanadi-group preparations, Guduchi-based combinations, Chandraprabha Vati and selected Shilajatu-containing formulations. Review-level evidence supports potential benefit across several Ayurvedic medicines but also reveals substantial heterogeneity in formulations, pharmaceutical quality, co-interventions, outcome reporting and methodological rigor. The most defensible conclusion is that Ayurvedic formulations may be clinically valuable when embedded in a complete Chikitsa framework comprising Nidana Parivarjana, Pathya-Apathya, individualized formulation selection, pharmaceutical standardization and continuing assessment. Future reviews should preserve classical diagnostic categories while improving transparent reporting of ingredients, manufacturing, dose, Anupana, patient phenotype and safety.

Keywords: Prameha; Madhumeha; Ayurvedic formulations; Shamana Chikitsa; Nishamalaki; Darvyadi Kashaya; Chandraprabha Vati; Pathya; narrative review

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1. Introduction

Prameha occupies a major position in Ayurvedic nosology because it is not restricted to one urine abnormality or to a single Dosha. The term describes a group of disorders in which excessive or abnormal urination is accompanied by disturbances of body fluids, adipose tissue, muscle, metabolic transformation and vitality. Charaka provides a detailed Nidana, Purvarupa, Samprapti, classification and therapeutic account, while Sushruta places Prameha among conditions demanding careful prognosis and sustained management [1,2]. Vagbhata consolidates the Tridosha-based classification and repeatedly links disease expression with Kapha, Meda and Kleda in early stages and with Vata and Dhatu depletion in advanced stages [3,4].

The classical description of Prabhuta Mutrata and Avila Mutrata is clinically important because it directs attention to both quantity and quality of urine rather than to one laboratory value. The twenty varieties ten Kaphaja, six Pittaja and four Vataja—represent patterns produced by different relationships among Dosha and Dushya. Madhavakara and Bhavamishra preserve this diagnostic architecture and discuss progressive features, prognostic distinctions and complications [5,6]. Consequently, the efficacy of a formulation cannot be assessed meaningfully without identifying the relevant pattern. A medicine suited to Kapha-Meda excess may be inappropriate when the patient is lean, weak, dry and depleted.

Ayurvedic therapeutics therefore treats formulation selection as a reasoning process. The physician evaluates the origin and strength of the disease, Agni, Ama, Koshta, Satmya, Prakriti, Vikriti, age, season, diet, activity, Ojas and the presence of Upadrava. The same formulation can act differently when its dosage form, dose, timing or Anupana changes. Sharangadhara's systematic description of pharmaceutical preparations and later compendia such as Bhaishajya Ratnavali, Chakradatta and Yogaratnakara show how classical principles were converted into practical powders, decoctions, pills, medicated fats and compound preparations [7-10].

The contemporary discussion of efficacy often isolates one herb or one branded product from the wider Ayurvedic plan. This reduction obscures the role of Nidana Parivarjana, Ahara, Vihara, patient phenotype and sequential treatment. It also creates an evidentiary problem: two preparations sharing the same name may differ in ingredients or proportions across texts, while the same ingredients prepared as Churna, Kwatha or Vati need not be therapeutically interchangeable. Later formularies such as Gada Nigraha, Vangasena Samhita and Sahasrayoga demonstrate the breadth of Pramehahara combinations and the importance of source-specific identification [11-13].

This review was undertaken to present a systematic, Ayurveda-dominant account of the efficacy of formulations used in Prameha. It has five objectives: to summarize the classical disease framework; to explain the formulation-selection logic; to organize major formulation categories and representative preparations; to synthesize review-level evidence without presenting a clinical study; and to identify limitations affecting interpretation, quality and safety. Rasaushadhi references are considered only within their classical and pharmaceutical context, because Rasaratna Samuccaya and Rasendra Sara Sangraha emphasize specialized processing and do not justify unsupervised use [14-15].

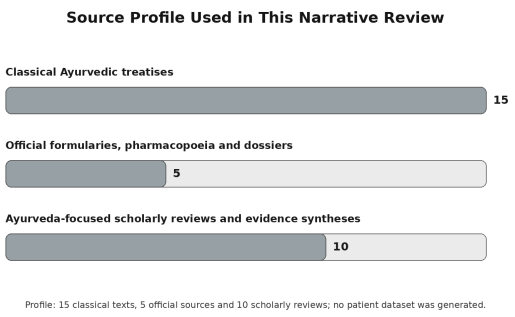
2. Review Methodology

This article is a structured narrative review. The primary knowledge base comprised Brihattrayi and Laghutrayi texts, later Chikitsa and Yoga compendia, and classical works describing pharmaceutical preparation. Official sources were used to support standard nomenclature, identity and formulation quality, including the Ayurvedic Formulary of India, the Ayurvedic Pharmacopoeia of India and publications of the Central Council for Research in Ayurvedic Sciences [16-20]. Ayurveda-focused scholarly reviews were used to examine the continuity of the classical framework, formulation groupings, diet, prevention and the current state of evidence [21-30].

Sources were included when they addressed Prameha or Madhumeha from an Ayurvedic perspective; described classical formulations, ingredients, dosage forms, Pathya or treatment principles; or synthesized evidence on Ayurvedic medicines. Case reports, stand-alone clinical trials, modern pharmacological mechanism papers and articles without an identifiable Ayurvedic formulation basis were not used as primary evidence. Clinical studies summarized within systematic reviews were considered only at the aggregate level. No new patient data were collected, no pooled statistical analysis was performed and no claim of cure was inferred from textual indication alone.

Information was extracted under the following domains: disease definition and classification; Nidana and Samprapti; patient phenotype; Chikitsa Siddhanta; formulation or drug group; dosage form; Ayurvedic pharmacodynamic rationale; Pathya-Apathya; pharmaceutical standardization; safety; and limitations of evidence. The review treats classical indication as a source of therapeutic rationale and historical continuity, not as a substitute for transparent contemporary evaluation.

Figure 1. Source profile used in the review.



3. Literature Review

3.1 Classical definition and classification

The derivation of Prameha conveys excessive or profuse flow, but the clinical concept is broader than frequency alone. Classical texts describe urine that is abundant, turbid, altered in color, consistency, odor or other observable qualities, depending on the Dosha-Dushya combination [1-6]. The general signs Prabhuta Mutrata and Avila Mutrata function as an entry point to diagnosis. They are then refined through Dosha-specific features, Purvarupa, body build, strength, appetite, thirst, sleep, skin changes, sensory complaints, Pidaka and other complications.

The classification into twenty varieties is therapeutically meaningful. Kaphaja varieties arise when Kapha interacts strongly with Meda, Mamsa and Kleda; they are generally described as more amenable to treatment when recognized early. Pittaja varieties exhibit more heat, discoloration, burning or altered odor and require correction without aggravating Pitta. Vataja varieties represent deeper tissue depletion, abnormal movement of Dhatu components and reduced reversibility. Madhumeha is included under Vataja Prameha and may also develop when chronic obstruction and tissue disturbance eventually provoke Vata [1-6,21-23].

A second classification distinguishes Sahaja from Apathyanimittaja and Sthula from Krisha. These divisions prevent the error of prescribing the same depleting formulation to all patients. In a Sthula, strong patient with Kapha-Meda excess, the therapeutic plan may tolerate stronger Apatarpana, Langhana,

Rukshana or selected Shodhana. In a Krisha or Durbala patient, the priority shifts toward maintaining nutrition, strength and Ojas while applying gentle Dosha-specific Shamana [1-4,22].

Table 1. Classical classification of Prameha and its therapeutic significance.

Class	Number	Dominant classical interpretation	General prognostic direction	Formulation-selection emphasis
Kapha ja	10	Kapha with Meda, Mamsa and Kleda; urine commonly pale, turbid, dense, slimy or sweet-like in different varieties	Earlier stage generally more responsive when Bala is preserved	Kapha-Medohara, Kleda-Shoshana, Deepana-Pachana and appropriate Apatarpana
Pittaja	6	Pitta associated with Rakta and fluid disturbance; urine may show yellow, blue, dark, reddish or alkaline-like qualities	More difficult than uncomplicated Kaphaja patterns	Pitta-compatible Shamana, Tikta-Kashaya selection, avoidance of excessive heat and irritants
Vataja	4	Vata with Dhatu-Kshaya or movement of Vasa, Majja, Ojas and other tissue components	Advanced and often Yapya or difficult	Mridu Shamana, Brimhana-Rasayana logic, protection of Bala and Ojas; avoid indiscriminate depletion
Madhumeha	Included among Vataja; may also follow chroni	Madhura-Kashaya-like urine description with systemic tissue disturbance	Requires sustained, individualized management	Nidana Parivarjana, phenotype-specific formulation, Pathya and long-

Class	Number	Dominant classical interpretation	General prognostic direction	Formulation-selection emphasis
	c progression			term observation

3.2 Nidana, Purvarupa and Samprapti

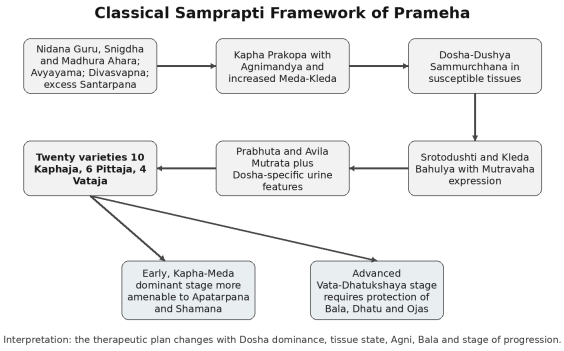
The principal Nidana described for Prameha are dominated by Santarpana: frequent use of Guru, Snigdha, Picchila and Madhura foods; excessive intake of new grains, milk products, jaggery preparations and heavy meats; inactivity; day sleep; comfort-seeking habits; and lack of exertion [1-6]. Later analyses emphasize that these factors must be read as patterns of chronic excess and incompatibility rather than as an inflexible list. Ayurveda-focused observational work has also suggested that classical etiological questioning can identify meaningful lifestyle clusters, although such findings require cautious interpretation and do not replace the classical examination of the individual [24].

Kapha is the usual initiating Dosha, but Prameha is Tridoshaja in its full expression. Agnimandya and excess Kleda facilitate the accumulation and abnormal movement of Meda, Mamsa, Rasa, Lasika and other Dushya. The Dosha-Dushya complex reaches the Basti and Mutravaha system, where the characteristic urine changes become apparent. The Samprapti is dynamic: Kapha-Meda excess and Srotorodha may dominate initially, whereas chronicity, tissue loss and Ojas disturbance increasingly bring Vata to the foreground [1-4,21,22].

Purvarupa such as excessive coating or dirt accumulation, altered body odor, drowsiness, heaviness, excessive sweating, numbness or burning in the extremities, attraction of insects to urine, dryness of the mouth and changes in hair or skin are described in different textual traditions [1-6]. Their value lies in prevention. A review of the translational potential of Ayurvedic pre-disease information argued that systematic attention to Prameha Purvarupa and Nidana could support earlier risk recognition, but also noted the need for standardized tools and prospective validation [25].

The Samprapti explains why formulations alone are insufficient. If Nidana continues, the medicine must continuously oppose the same etiological pressure. If Ama and Mandagni are ignored, a heavy nutritive medicine may worsen obstruction. Conversely, if an advanced depleted patient is treated only with Ruksha, Tikshna and Lekhana substances, the intervention may further reduce Bala. Classical efficacy is therefore conditional: it emerges from a fit between the medicine, the disease stage and the patient.

Figure 2. Classical Samprapti framework of Prameha.



3.3 Chikitsa Siddhanta: the basis of formulation efficacy

Nidana Parivarjana is the first therapeutic principle because it reduces the continuing production of Dosha and Dushya disturbance. In Sthula and Balavan patients, the classical plan may include Langhana, Rukshana, Vyayama, Udvartana and Shodhana when indications, season and strength permit. Shamana formulations are then selected to sustain correction. In Krisha or Durbala patients, Brimhana, nourishing Pathya,

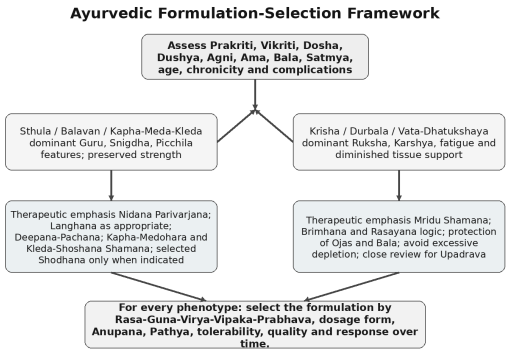
Rasayana logic and Mridu Shamana protect against further Dhatu-Kshaya [1-4,22].

The term Shamana should not be understood as merely symptomatic palliation. Properly selected Shamana aims to normalize Dosha without expelling it through major purification. It may act through Deepana, Pachana, Medohara, Lekhana, Kleda-Shoshana, Mutrasangrahaniya, Rasayana or other actions, depending on the formulation. The physician decides whether a Churna, Kwatha, Vati, Avaleha, Ghrita or another Kalpana best serves the required action. Sharangadhara's pharmaceutical framework and official formularies support the need to preserve source, proportion and method [7,16].

Ayurvedic formulation efficacy also depends on Anupana and administration. Honey, warm water, specific decoctions, milk or other vehicles are not interchangeable. Each can redirect, enhance or moderate the action and may be unsuitable in a particular Dosha or stage. The dose must consider age, Bala, Agni, Koshta, Satmya and chronicity. For this reason, a review article can organize therapeutic logic but cannot responsibly prescribe a universal dose.

Official compendia provide an essential bridge between textual knowledge and reproducible manufacture. The Ayurvedic Formulary of India standardizes recognized formulations, while the Ayurvedic Pharmacopoeia provides identity, purity and quality parameters for raw materials [16,17]. CCRAS compilations further document evidence-based practice and medicinal-plant information relevant to frequently used Pramehahara drugs [18,19]. These sources strengthen authenticity but do not remove the need for individualized clinical judgment.

Figure 3. Ayurvedic formulation-selection framework.



3.4 Major formulation categories and representative preparations

3.4.1 Nishamalaki and simple polyherbal combinations

Nishamalaki combines Haridra and Amalaki, generally in equal proportion in commonly cited practice. It is a useful example of rational pairing: Haridra contributes Katu-Tikta orientation and Kapha-Kleda-reducing intent, while Amalaki contributes Amla-dominant Pancharasa, cooling and Rasayana qualities. The combination is traditionally positioned to address Prameha without relying on a large number of ingredients [6,8,10,18]. Its apparent simplicity is an advantage for identity, sourcing and reproducibility, but it does not make the preparation universally suitable. Digestive capacity, Pitta sensitivity, body build, concurrent medicines and the selected Anupana remain relevant.

The review-level value of Nishamalaki is conceptual as well as practical. It demonstrates that a formulation can combine Shamana with tissue support, rather than pursuing aggressive depletion alone. It also illustrates why whole-formulation reasoning should not be replaced by isolated constituent claims. The therapeutic identity arises from the relationship between both drugs, their qualities, dose and administration.

Figure 4. Authentic botanical images of two principal ingredients used in Nishamalaki.

Haridra (Curcuma longa L.) Amalaki (Phyllanthus emblica L.)

Image credits: *Haridra photograph by Simon A. Eugster (CC BY-SA 3.0); Amalaki photograph by Salil Kumar Mukherjee (CC BY-SA 4.0), Wikimedia Commons.*

3.4.2 Darvyadi Kashaya and Pramehahara Kwatha

Darvyadi Kashaya is described in the Prameha context and commonly includes Daruharidra, Devadaru, Haritaki, Vibhitaki, Amalaki and Musta. The group has a predominantly Tikta-Kashaya-Katu therapeutic direction and is interpreted through Kapha-Pitta Shamana, Deepana-Pachana, Kleda reduction and correction of Meda-related disturbance [1,6,19]. It is especially representative of the Kwatha approach, in which water extraction and fresh preparation produce a dosage form suited to a defined group of drugs.

A review of Kwatha Kalpana in the Brihattrayi identified repeated use of decoctions containing Katu, Tikta and Kashaya substances in Prameha and emphasized that the preparation method is part of the treatment, not a neutral carrier [29]. The water quantity, reduction, filtration, freshness and dose influence the final preparation. Therefore, a powdered mixture marketed under the same ingredients should not automatically be considered equivalent to the classical Kwatha.

Other decoction groups include Nyagrodhadi, Asanadi, Aragvadhadi and combinations incorporating Musta, Triphala, Daruharidra, Guduchi, Meshashringi or Jambu. Their selection depends on the textual source and the intended balance among Kapha reduction, Kleda control, Pitta moderation, bowel regulation and tissue support [1-6,8-13]. The large number of classical options is not evidence that all should be combined; rather, it allows selection of a coherent Yoga for the dominant Samprapti.

3.4.3 Guduchi-, Triphala- and Jambu-based formulations

Guduchi is repeatedly used in Ayurvedic practice because its Tikta-Kashaya profile, Madhura Vipaka and Rasayana status allow it to participate in both Dosha correction and tissue support. This makes it particularly relevant where prolonged management is required and aggressive Rukshana would be undesirable. The Ministry of AYUSH technical dossier and CCRAS medicinal-plant database support standardized identity and documentation of Guduchi, but botanical authentication remains essential because substitution or misidentification can alter safety and efficacy [19,20].

Triphala contributes a broad combination of Haritaki, Vibhitaki and Amalaki. In Prameha formulations it may support bowel regularity, Agni, Meda-Kleda management and Rasayana intent. Jambu seed, Meshashringi, Karavellaka, Nimba, Bilva and Tulasi appear in official or practice-oriented combinations, including preparations summarized by CCRAS [18]. These combinations should be interpreted as Ayurveda formulations, not as interchangeable collections of so-called sugar-lowering herbs. Their therapeutic role depends on the entire formulation, processing and patient assessment.

A review of evidence-based Ayurvedic practice lists formulations such as Ayush-82 with Shilajit, Nishamalaki, a Bilva-Nimba-Tulasi-Maricha Ghana preparation and Karavellaka-Jambu Ghana Satva among approaches used in Madhumeha-oriented care [18]. The value of this compilation lies in linking recognized Ayurvedic drug combinations with structured practice. It should not be read as a universal prescription or as proof that all products bearing similar names are pharmaceutically identical.

3.4.4 Chandraprabha Vati and complex formulations

Chandraprabha Vati is a complex classical formulation indicated across Mutravaha, reproductive and metabolic disorders in several compendia. Its versions vary by source, and a critical review identified differences in ingredients, indications, dose and Anupana among textual traditions [28]. This variability is a central methodological issue. Any research paper or clinical report should state the exact textual reference, complete composition, ingredient proportions, pharmaceutical process and manufacturer rather than citing the name alone.

The formulation is described through actions such as Tridosha Shamana, Deepana-Pachana, Mutravaha support, Shothahara, Balya and Rasayana. Its breadth may be useful when Prameha coexists with urinary symptoms, weakness or other indicated features, but complexity also increases the need for quality control and professional supervision. Some versions contain mineral ingredients and therefore require authenticated raw materials, prescribed Shodhana and Marana where applicable, validated manufacturing and appropriate clinical monitoring [7,8,10,14-17,28].

Other complex formulations in Bhaishajya Ratnavali, Yogaratnakara, Gada Nigraha, Vangasena and Rasa texts may contain Guggulu, Shilajatu, Bhasma or numerous herbs [8,10-15]. Their classical presence should not be converted into unsupervised self-medication. Efficacy and safety depend on source fidelity, processing, dose, Anupana, duration, patient selection and the competence of the prescribing physician.

3.4.5 Stage-wise use of formulations and therapeutic review

The classical progression of Prameha suggests that the same formulation should not be continued mechanically through every stage. In an early Santarpanottha presentation, heaviness, excessive sleep, lethargy, increased Kleda, preserved Bala and a Sthula body habitus indicate that medicines should support Apatarpana rather than add further Guru or Snigdha qualities. Churna and Kwatha containing Tikta, Kashaya and Katu drugs may be preferred when they also match Agni and bowel status. The therapeutic review at follow-up should examine changes in appetite, heaviness, activity, urine character, thirst, sleep and strength, not merely whether the patient has consumed the medicine [1-4,21-22].

When Pitta becomes prominent, indiscriminate use of excessively Ushna or Tikshna combinations can aggravate burning, thirst, irritability or discoloration. The formulation must retain Pramehahara intent while moderating Pitta and preserving hydration and digestion. Amalaki, Guduchi and appropriately selected Tikta-Kashaya drugs may contribute to this balance, but their use remains dependent on the complete Yoga and Anupana. Textual classification therefore serves as a practical safeguard against selecting every Kapha-reducing medicine for every Prameha [3,5-6].

In chronic disease with Karshya, dryness, weakness, reduced endurance, disturbed sleep or other indications of Vata and Dhatu-Kshaya, the treatment goal changes substantially. Strong Langhana and repeated Lekhana may no longer be suitable. A gentle formulation with Rasayana or Brimhana compatibility may be combined with nourishing yet non-obstructive Pathya. Shilajatu- or mineral-containing preparations are sometimes described in advanced contexts, but their use requires precise classical indication, purified ingredients, source-specific preparation and professional supervision [8,10,14-17].

Therapeutic review should also identify Upadrava. Pidaka, persistent urinary difficulty, marked debility, loss of appetite, fever, swelling or rapidly changing symptoms cannot be managed responsibly by repeating a

routine Pramehahara product. Such features demand re-examination of Dosha, Dushya, Srotas, Bala and prognosis, and may require referral or coordinated care. The classical concept of efficacy therefore includes timely recognition of the limits of a formulation.

Finally, discontinuation and modification are part of rational treatment. A formulation may be reduced, changed or stopped when the target Dosha features resolve, when Agni deteriorates, when intolerance appears or when the patient enters a different stage. This dynamic approach differs from indefinite product use. It also provides a better model for research: future studies should define decision points for continuation, modification and withdrawal rather than treating an Ayurvedic formulation as a fixed exposure independent of response.

3.5 Pathya-Apathya as an inseparable co-intervention

Pathya is not an optional lifestyle appendix to formulation therapy. Classical management repeatedly recommends foods and activities that reduce Kapha, Meda and Kleda while preserving Agni and strength. Yava, old grains, Mudga, selected pulses, bitter and astringent vegetables and appropriately planned physical activity are commonly emphasized, with individualization for digestion, season and body build [1-6,10]. A review dedicated to Pathya in Prameha likewise concluded that diet, activity, Yoga-related practices and disciplined routine are essential to sustained management [30].

Apathya includes continued excess of heavy, unctuous and sweet foods, frequent day sleep, inactivity, overeating, new grains and excessive dairy or jaggery preparations in susceptible patients. These instructions should not be transformed into rigid deprivation. A Krisha or depleted patient may require a different nutritional plan from a Sthula patient with clear Santarpana. The therapeutic criterion is suitability to Dosha, Agni, Bala and Dhatu state, not adherence to a generic list.

Anupana belongs to the same logic. Honey is frequently mentioned with Kapha-Meda-oriented medicines because of its classical Lekhana and Yogavahi attributes, but it must be used according to Ayurvedic rules and should not be heated. Warm water, specific decoctions or other vehicles may be selected in other contexts. The formulation and Pathya plan together determine whether the intervention actually opposes the Samprapti.

3.6 Review-level evidence on efficacy

Historical and conceptual reviews show strong continuity in the description of Prameha across major Ayurvedic texts. Roy and colleagues traced the development of Prameha descriptions and demonstrated that the disease concept evolved through careful observation of urine, body habitus, diet, progression and complications [23]. Sharma and Chandola organized the classical information into etiology, classification, pathogenesis and management, highlighting the internal coherence of phenotype-based treatment [21,22]. These reviews support conceptual validity and textual continuity; they do not, by themselves, quantify contemporary clinical efficacy.

A systematic review of Shodhana and Shamana approaches reported a broad body of Ayurveda studies involving multiple interventions and participants, but also showed that the evidence base is heterogeneous in design, formulation, duration and outcome measures [26]. A larger systematic review and meta-analysis of Ayurvedic medicines found potential benefit across a range of preparations, while explicitly identifying inadequate reporting of randomization, concealment, blinding, placebos, adverse events and product details in many studies [27]. The appropriate conclusion is therefore cautious support, not universal effectiveness.

The evidence is especially difficult to synthesize when studies collapse all participants into a single modern diagnostic category without documenting Sthula-Krisha status, Dosha, Agni, Ama, Bala or the formulation's classical indication. From an Ayurvedic standpoint, such pooling may combine patients for whom different Chikitsa is required. Conversely, studies that use individualized treatment can be difficult to reproduce unless the decision rules are clearly reported.

Review-level efficacy should be expressed at three levels. First is textual efficacy: repeated indication and consistent rationale across authoritative sources. Second is pharmaceutical credibility: authenticated ingredients, defined preparation and reproducible quality. Third is clinical effectiveness: demonstrable benefit and acceptable safety in appropriately characterized patients. A strong review should not substitute any one level for the others.

4. Discussion

The central finding of this review is that the efficacy of Ayurvedic formulations in Prameha is relational rather than absolute. A formulation becomes rationally effective when its qualities oppose the active Samprapti without injuring the patient's strength. The repeated classical distinction between Sthula and Krisha Prameha illustrates this principle clearly. A Tikshna, Ruksha and strongly depleting intervention may be appropriate in a robust Kapha-Meda-dominant patient, yet harmful in a depleted Vata-dominant patient. Product-centered discussions that ignore this distinction are not faithful to Ayurveda.

The second finding is that classical efficacy is inherently multimodal. Nidana Parivarjana reduces the source of disease; Pathya modifies daily Dosha production; Vyayama or other Vihara addresses inactivity and Meda-Kleda excess; Shodhana may reduce accumulated Dosha in selected strong patients; and Shamana provides sustained correction. A review that attributes the entire result to one tablet or powder risks misrepresenting both the intervention and the evidence. In Ayurveda, the formulation is a central component of Chikitsa, but it is not the whole Chikitsa.

Nishamalaki exemplifies a relatively transparent formulation. It has few ingredients, a stable classical identity and a coherent balance between Kapha-Kleda correction and Rasayana-compatible support. Darvyadi Kashaya exemplifies dosage-form specificity: the choice of decoction, extraction method and fresh administration is part of the therapeutic design. Chandraprabha Vati represents the opposite end of complexity. It may have broad application, but the name covers multiple textual versions; therefore, research and practice must state exactly which version is used [28]. These three examples show that evidence standards should vary with formulation complexity.

The current evidence base offers reasonable grounds for further evaluation but not for indiscriminate claims. The broad systematic review evidence suggests that several Ayurvedic medicines may improve measured outcomes, yet the same literature contains substantial methodological limitations [26,27]. Many reports fail to describe the classical phenotype, complete formula, batch testing, Anupana, diet, adherence or adverse events. Without these details, it is difficult to determine whether a positive or negative result reflects the Ayurvedic intervention, product quality, patient selection or study design.

5. Conclusion

Ayurvedic formulations have a substantial and internally coherent role in the management of Prameha, but their efficacy must be understood within the complete Ayurvedic framework. Classical texts do not support one medicine for every patient. They support diagnosis by Dosha-Dushya interaction, stage, body build, Agni, Bala and complications,

followed by a combination of Nidana Parivarjana, Pathya, appropriate purification when indicated and individualized Shamana.

Nishamalaki, Darvyadi Kashaya, Guduchi- and Triphala-based combinations, Jambu- and Karavellaka-containing preparations, Chandraprabha Vati and selected Shilajatu formulations illustrate different therapeutic strategies. Their rational use depends on source fidelity, preparation, dose, Anupana and patient suitability. Review-level evidence indicates potential benefit across Ayurvedic medicines but remains limited by heterogeneity, incomplete product characterization and variable methodological quality.

The most reliable conclusion is therefore neither rejection nor unqualified endorsement. Ayurvedic formulations may contribute meaningfully to Prameha management when prescribed by qualified practitioners, manufactured to recognized standards and integrated with individualized diet, activity and continuing assessment. Future evidence synthesis should preserve Ayurvedic diagnostic precision while improving reproducibility, safety reporting and transparency.

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