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Case Study

AYURVEDIC MANAGEMENT OF CHRONIC CATHETER-DEPENDENT NEUROGENIC BLADDER

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ABSTRACT

Neurogenic bladder is a challenging complication of neurological disorders, often resulting in urinary retention or incontinence. Conventional management primarily focuses on symptomatic relief through pharmacotherapy and clean intermittent catheterization (CIC), both of which are associated with limitations and long-term complications. Ayurveda describes urinary dysfunctions under *Mutraroga* and attributes their pathogenesis to derangement of *Vata Dosha*, particularly *Apana Vata.* **Case Presentation:** A 59-year-old male with neurogenic bladder presenting with impaired bladder emptying and catheter dependence was managed with Ayurvedic interventions. Based on clinical features and Ayurvedic assessment, the condition was correlated with *Mutravrita Vata.* The treatment protocol included oral *Vatahara* medications and *Vasti* with medicated *Taila*, aimed at correcting *Apana Vata* dysfunction and improving bladder contractility. **Intervention and Outcome:** The patient underwent a planned course of therapy with periodic assessment of voiding function. Gradual improvement was observed in urinary flow and reduction in catheter dependency. Over the treatment period, the patient achieved satisfactory spontaneous voiding without the need for catheterization. No adverse events were reported during the course of therapy. **Conclusion:** This case suggests that Ayurvedic management, particularly *Vata* modulating therapies and *Vasti*, may offer a potential complementary approach in the management of neurogenic bladder dysfunction. Systematic clinical studies are warranted to evaluate the reproducibility and long-term efficacy of these interventions.

INTRODUCTION

Neurological disorders constitute a significant global health burden and are among the leading causes of long-term disability worldwide. It is estimated that neurological conditions affect a substantial proportion of the global population, contributing markedly to morbidity and reduced quality of life. In India, stroke represents one of the major contributors to neurological disease burden, accounting for a considerable share of disability-adjusted life years [1,2]. Secondary complications arising from neurological disorders further aggravate patient morbidity, among which bladder dysfunction is clinically important.

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Neurogenic bladder is defined as dysfunction of the lower urinary tract resulting from damage to the central or peripheral nervous system pathways involved in micturition control[3]. Depending on the level and extent of neurological involvement, patients may present with impaired bladder storage (urgency or incontinence) or impaired bladder emptying (urinary retention). In many neurological conditions, including multiple sclerosis, Parkinson's disease, and stroke, the prevalence of bladder dysfunction is notably high[4]. If inadequately managed, chronic urinary retention may lead to complications such as recurrent urinary tract infections, vesicoureteral reflux, urolithiasis, and even progressive renal impairment[3]. Long-term management frequently requires clean intermittent catheterization or other supportive measures, which may be associated with discomfort, infection risk, and reduced quality of life.

Although a direct nosological equivalent for neurogenic bladder is not described in classical Ayurvedic texts, conditions under *Mutraroga (Mutraghata)* and *Avarana Vata* exhibit similar clinical features [5]. Among the *Tridosha*, *Vata* plays a dominant role in neuromuscular regulation and functional coordination. *Apana Vata*, in particular, governs elimination functions including *Mutranishkramana.* Disturbance or obstruction of *Apana Vata* may result in urinary retention, diminished urge, and incomplete voiding, which can be correlated with *Mutravrita Vata* [5].

Management of *Vata* predominant urinary disorders in Ayurveda emphasizes *Vatanulomana* and *Vata shamana* therapies. Procedures such as *Avagaha Sweda* and *Snehana* are described for local and systemic regulation of *Vata*[6]. However, *Vasti* is considered the prime therapy for *Vata* disorders, as it acts at the level of *Pakwashaya*,the principal seat of *Vata* [5]. Classical formulations containing *Bala* and *Sneha*, such as *Dhanwantara Taila*, are indicated in *Vata Vyadhi* and *Mutraghata* due to their *Vatahara* and *Balya* properties [7]. The therapeutic rationale lies in restoring the normal movement of *Apana Vata,* nourishing neuromuscular tissues, and facilitating physiological elimination.

Considering the central role of *Vata* in the pathogenesis of urinary retention and the classical indications of *Vasti* and *Vatahara* formulations in *Mutrarogas*, evaluating their clinical utility in neurogenic bladder appears rational. Generally, *Uttaravasti* is regarded as a prime therapeutic approach in the management of *Mutravikara, Striroga,* and *Shukravikara*. It is especially indicated in diseases of the urinary and reproductive systems because of its targeted mode of administration.

According to Sushruta, *Uttarvasti* is particularly useful in conditions affecting the bladder and urethra, as the medicine acts directly on the structural components such as *Vasti sira* (vessels), *Snayu* (ligaments and nerves), and *Mamsa* (muscle tissue) [8]. Owing to this localized action, it facilitates better functional restoration of the lower urinary tract.

The present case report explores the potential role of a *Vatanulomaka* and *Vasti* based Ayurvedic approach in the management of chronic catheter dependent neurogenic bladder.

MATERIAS AND METHOD

Patient Information

The present case was managed in 2019 during clinical training at a tertiary care Ayurveda hospital in Kerala. A 59-year-old male patient presented with complaints of reduced urine output for the past 1.5 years. The condition had an insidious onset. Initially, he gradually noticed a decrease in urinary output and an inability to perceive bladder fullness, as he had no urge for micturition. He consulted an allopathic physician and underwent ultrasonography, following which a provisional diagnosis of neurogenic bladder was made. He received medical management for one week; however, there was no significant improvement. He was then advised catheterization. Initially, clean intermittent self-catheterization (CISC) was performed once daily, which was later increased to twice daily due to persistent symptoms.

Eight months prior to presentation, the patient developed high grade fever with chills and was admitted to a hospital, where he was diagnosed with cystitis. He remained hospitalized for five days, during which an indwelling catheter was placed and continued for an additional 10 days. After catheter removal, spontaneous voiding did not occur. He was subsequently advised to perform self-catheterization seven times per day, including at night, which was continued for one month. Thereafter, the frequency was reduced to five times daily. Thus, for the past 1.5 years, he had been dependent on clean intermittent self-catheterization.

There was no history of trauma, hypertension, or diabetes mellitus. Seeking better management, he consulted the college hospital, where he underwent outpatient-level treatment including internal medications and sitz bath therapy. After two weeks of treatment, he reported improvement in symptoms, with the return of urinary urge sensation and the ability to perceive bladder fullness.

For further management and comprehensive treatment, the patient was admitted to the college hospital.

Personal history

- Diet- Mixed
- Appetite- Reduced
- Bowel-1/day, hard stool
- Micturition-1-2/day, 5-6 times self-catheterization
- Sleep- Disturbed

Investigations

USG Abdomen (2017)

- Bladder-over distended, post void-600 cc
- Suggestive of neurogenic bladder

Diagnosis

Modern diagnosis: Neurogenic bladder

Ayurveda diagnosis: *Mutravrita Vata*

Therapeutic Intervention

A *Vatanulomaka* line of treatment was planned to achieve systemic and local correction of aggravated *Vata*. The intervention included oral *Vata shamaka* and *Mutrala* medications to regulate *Apana Vata* and improve bladder function.

In addition, Panchakarma procedures such as *Vasti* and *Avagaha Sweda* (sitz bath) were administered. *Vasti* was given as the main therapy to pacify *Vata*, while *Avagaha Sweda* was used for local sudation and to enhance bladder function.

Internal medications

1. *Gandharvahastadi kashayam* -90 ml twice daily
2. *Vayu gulika* 2-0-2
3. *Veerataradi kashayam*-90 ml twice daily
4. *Abhayarishtam+Dantyarishtam*-45 ml
5. Cap Ural BPH 1-0-1

Procedures

1. *Avagaha* with *Vatahara patra*-22 days
2. *Abhyanga* with *Dhanwantaram tailam*-3days
3. *Pizhinjuthadaval* with *Dhanwantaram Tailam*-7 days
4. Alternate *Anuvasana vasti* and *Niruha vasti* for 8 days
5. *Anuvasava vasti* with *Pippalyadi Anuvasana tailam*-100 ml-4 days.

Table 1: *Niruha Vasti* Contents

S.No	Component	Quantity
1.	*Madhu* (honey)	100ml
2.	*Sneha* *Sahacharadi tailam* *Vastyamayanthaka ghritam*	 50ml 50ml
3.	*Kalka dravyas* *Kushta* *Shatapushpa* *Gokshura* *Madanaphala*	 2g 2g 6g 6g
4.	*Kashaya* *Veerataradi kashaya*	 400 ml

Discharge Medicines

1. *Veerataradi kashayam*-90mlBD
2. *Kasthuryadi gulika* 1-0-1
3. *Vastyamayanthaka ghritam*-10ml before food
4. *Pippalyadi anuvasana vasti*-100ml bed time

OBSERVATION AND RESULTS

Table 2: Observation

Stage	Self-voiding frequency	Catheterization frequency
Before Ayurvedic treatment	1-2 times /day, small quantity	5 times
After op level treatment and *Avagaha*	1-2 times /day Urge for urination increased	5 times
IP level treatment *Abhyanga*-3rd day	 3times/day	 5 times
Pizhinjuthadaval- 4th day	4 times/day	5 times
Anuvasana vasti- 1st day	5 times/day	4 times
Kashaya vasti - 1st day	2 times /day	4 times
Anuvasana vasti - 2nd day	5 times/day	4 times
Kashaya vasti- 2nd day	2 times/day	4 times
Anuvasana vasti- 3rd day	5 times/day	3times
Kashaya vasti- 3rd day	2 times/day	4 times
Anuvasana vasti- 4th day	5 times/day	4 times
Kashaya vasti- 4th day	2 times/day	4 times
Anuvasana vasti- 5th day	5 times/day	One time at night

Anuvasana vasti- 6th day	6 times/day, 1/night	No catheterization
Anuvasana vasti- 7th day	5 times/day, 1/night	No catheterization
Anuvasana vasti- 8th day	6 times /day, 1/night	No catheterization

Bladder sensation returned gradually. Complete cessation of catheterization was achieved.

DISCUSSION

Neurogenic bladder is characterized by impaired detrusor contractility and altered bladder sensation due to disruption of neural pathways involved in micturition control, particularly the sacral parasympathetic segments (S2–S4). The present case demonstrated chronic urinary retention, absence of urge sensation, significant post-void residual urine (600 ml), and long-term catheter dependency without evidence of mechanical obstruction. These features indicate a functional voiding disorder rather than structural pathology.

In Ayurvedic parlance, urinary retention conditions are described under *Mutraghata*. However, *Mutraghata* represents a broader clinical category. Based on symptom predominance in this case -namely impaired urge perception, retention of urine, and *Apana Vata* dysfunction-the condition was more specifically correlated with *Mutravrita Vata*, a type of *Avarana* pathology.

Apana Vata governs *Mutra Nishkramana* (urinary excretion). When the normal *Gati* of *Apana Vata* is obstructed within the *Vasti*, retention of urine occurs. In this case, chronic accumulation of urine in an over-distended bladder can be understood as *Mutra Avarana* of *Apana Vata,* leading to functional obstruction and failure of bladder evacuation. The associated hard stool further suggests *Apana Vata vaigunya*, reinforcing the diagnosis of *Vata*-dominant pathology.

The line of management was therefore planned on the principles of *Vatanulomana*, *Vata Shamana* and *Dhatuposhana.* Internal medications played a supportive and regulatory role. *Gandharvahastadi Kashaya* was administered for its *Vatanulomana* and mild *Anulomana* properties, helping relieve associated bowel irregularity and reducing downward obstruction to *Apana Vata*. *Veerataradi Kashaya,* indicated in *Mutraghata* and *Mutrakrichra*, possesses *Mutrala* and *Vata Kapha shamaka* actions, thereby supporting urinary flow. *Vayu Gulika* acted as a *Vatahara* formulation correcting systemic *Vata* imbalance. The combination of *Abhayarishtam* and *Dantyarishtam* facilitated bowel regularization, which is crucial in *Apana Vata* disorders, as constipation can further aggravate urinary retention.

Panchakarma interventions were central to management. *Avagaha Sweda* provided local sudation, improving pelvic circulation and relieving functional obstruction. *Abhyanga* and *Pizhichil* with *Dhanwantaram Taila* imparted *Snigdha* and *Brimhana* effects, nourishing neuromuscular tissues and mitigating *Vata* aggravation.

Vasti was the principal therapeutic modality. *Vasti* therapy may exert its therapeutic action through both classical and physiological mechanisms. The rectum shares close anatomical and neural connections with the bladder via pelvic splanchnic nerves (S2–S4). Administration of medicated *Vasti* may stimulate recto-vesical reflex pathways, enhance parasympathetic activity and thereby improve detrusor contractility. This neuromodulatory influence could explain the gradual restoration of bladder sensation and spontaneous voiding observed in this case. Being the prime treatment for *Vata* disorders and acting at the level of *Pakwashaya* the main seat of *Vata* it likely exerted both systemic and local neuro-modulatory effects. *Anuvasana Vasti* with *Pippalyadi anuvasana tailam p*rovided *Snehana, Mamsa Dhatuposhana*, potentially improving detrusor muscle tone. *Niruha Vasti* played a central role in management. The formulation consisting of *Madhu*, *Vastyamayanthaka Ghrita, Sahacharadi Taila, Kalka dravyas (Kushta, Shatapushpa, Gokshura, Madanaphala*), and *Veerataradi Kashaya* provided synergistic action. *Madhu* acted as *Yogavahi*, enhancing drug delivery; *Sneha* provided *Snehana* and *Brimhana*, *Dhatu poshana* effects restoring neuromuscular integrity; *Kalka dravyas* alleviated *Vata-Kapha Avarana* and supported urinary flow; *Veerataradi Kashaya*, indicated in *Mutraghata*, functioned as the principal therapeutic medium. The gradual restoration of bladder sensation and reduction in catheter dependency suggest improved *Apana Vata* function and enhanced detrusor activity.

The stepwise improvement observed from return of urge sensation to complete cessation of catheterization indicates functional recovery rather than mere symptomatic relief. The absence of adverse effects further supports the safety of the integrated Ayurvedic approach in chronic neurogenic bladder.

CONCLUSION

The present case highlights significant functional recovery in chronic catheter dependent neurogenic bladder managed with a *Vatanulomaka* and *Vasti* based Ayurvedic approach correlated with *Mutravrita Vata*. Gradual restoration of bladder sensation, improvement in spontaneous voiding frequency, and complete cessation of catheterization indicate correction of *Apana Vata* dysfunction. The combined use of internal *Vatahara* and *Mutrala*

medications along with *Anuvasana* and *Niruha Vasti* may have contributed to neuromuscular regulation and improved detrusor activity through both systemic and recto vesical reflex mechanisms. The absence of adverse effects further supports the safety of this integrative approach. However, larger controlled clinical studies are necessary to validate reproducibility, clarify mechanisms, and establish long-term efficacy

Patient Consent

Written informed consent was obtained from the patient for publication of this case.

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