



Case Study

AYURVEDIC MANAGEMENT OF PAKSHAGHATA (POST STROKE HEMIPLEGIA)

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Article info

Article History:

Received: 12-01-2026

Accepted: 14-02-2026

Published: 26-03-2026

KEYWORDS:

Pakshaghata,
Hemiplegia,
Ischemic stroke,
Vatavyadhi.

ABSTRACT

Pakshaghata is one among the *eighty Nanatmaja Vata Vyadhis* afflicting half of the body due to vitiation of *Vata Dosha*. In contemporary medicine, it closely resembles hemiplegia following ischemic stroke, which remains a major cause of long-term disability worldwide. This case report presents a 47-year-old male with left-sided hemiplegia secondary to right middle cerebral artery occlusion. Clinical findings included spasticity, reduced muscle power (2/5 in left upper limb and 3/5 in left lower limb), slurred speech, impaired gait, and severe dependence in activities of daily living (Barthel Index – 35; Modified Rankin Scale – Grade 4). Based on Ayurvedic assessment, the condition was diagnosed as *Avaranajanya Pakshaghata*. Management was planned according to the underlying *Samprapti* and included *Deepana-pachana* and *Rookshana* measures for removal of *Margavarana*, followed by *Vatahara* and *Brimhana* therapies along with physiotherapy for 35 days. Significant clinical improvement was observed after treatment, with muscle power improving to 4/5 in the affected limbs, reduction in spasticity, improved gait, and better speech clarity. Functional assessment showed improvement in Barthel Index from 35 to 75 and Modified Rankin Scale from Grade 4 to Grade 3. The findings suggest that a structured Ayurvedic approach based on *Samprapti*, combined with physiotherapy, may contribute to meaningful functional recovery in post-stroke hemiplegia.

INTRODUCTION

Pakshaghata is one among the *eighty Nanatmaja vata vyadhis* described in the Ayurvedic classics and is characterized by the affliction of one half of the body.^[1]

The term is derived from “*Paksha*,” meaning one side, and “*Aghata*,” meaning impairment, collectively denoting unilateral motor dysfunction. Acharya Charaka explains that aggravated *Vata dosha*, either due to *Avarana* (obstruction of normal *Vata* pathways) or *Dhatu Kshaya* (tissue depletion), plays a pivotal role in its pathogenesis.^[2] The vitiated *Vata* localizes in the *Shiras* and causes *Vishoshana* of the *Sira* and *Snayu*, leading to *Cheshta nivritti* (loss of voluntary movements) on one side of the body, often

accompanied by *Vakstambha* and other neuromuscular impairments.^[3]

In contemporary medicine, the condition most closely resembling *Pakshaghata* is hemiplegia. It is defined as paralysis of one side of the body resulting from ischemic or hemorrhagic stroke.^[4] Hemiplegia occurs in nearly 80% of stroke survivors and represents the most common cause of chronic motor disability, significantly contributing to functional dependence, reduced quality of life, and socioeconomic burden.^[5]

An integrative understanding of *Pakshaghata* in the context of stroke-induced hemiplegia may provide valuable insights into comprehensive management approaches.

Case Report

A 47-year-old moderately built male patient, not a known case of Diabetes Mellitus, hypertension, or dyslipidaemia, was apparently asymptomatic until 2½ months prior to admission. Approximately, 2½ months before presentation, he developed generalized

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Quick Response Code	https://doi.org/10.47070/ijapr.v14i3.4073
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weakness and loss of appetite, which he initially ignored. Fifteen days later, while walking, he suddenly experienced dizziness followed by weakness of the body and loss of consciousness. He was immediately taken to a nearby allopathic hospital, where he was diagnosed with ischemic stroke secondary to cerebral artery occlusion. Emergency management was instituted promptly. The patient regained consciousness, his vital parameters stabilized, and he was discharged after two days of hospitalization. However, weakness of the left upper and lower limbs persisted, along with difficulty in walking and mild slurring of speech. Due to the residual hemiplegic symptoms, he was subsequently admitted to the In-Patient Department of Government Ayurveda College Hospital, Kannur, for further management

Past medical history

No history of diabetes mellitus, hypertension or dyslipidaemia

Personal history

Appetite – Reduced

Bowel – Regular

Bladder- 4-5 times/day, 1/night

Addictions- Tobacco (10 packets per day since 30 years).

Diet – Predominantly non-vegetarian (consumption of red meat on most days).

Sleep- Irregular as part of job (day sleep was common).

Vitals

RR- 18/min

PR-72/min, HR 72/min

Temp- 98°F

BP- 150/100 mm Hg

General examination

No signs of pallor, icterus, cyanosis, clubbing, lymphadenopathy.

Central nervous system examination

Higher mental functions

Consciousness- Fully conscious

Orientation to time, place and person – Intact

Memory - Intact

Speech – Slurred

Handedness – Right

Motor system examination

Gait- difficulty in walking and patient was moving with the help of wheelchair

Muscle tone -left – spasticity was present
right-normotonic

Muscle power -Right upper and lower limb – 5/5

left upper limb - 2/5

left lower limb- 3/5

Deep tendon reflexes were exaggerated (+++) on left side and normal on right side (++)

Sensory system

Superficial, deep and combined were intact bilaterally.

Coordination-left impaired and right normal.

Other system examination-no abnormalities noted.

MRI brain on 26/11/2025

MRI brain suggestive of right middle cerebral artery occlusion, right MCA watershed infarct along with chronic infarct with gliosis seen in right basal ganglia.

Diagnosis

Contralateral hemiplegia due to ischemic stroke based on clinical presentation, physical examination and imaging techniques.

In Ayurvedic view condition is *Pakshaghatha*.

Samprapthi ghataka

Dosha – Vata kapha pradhana tridosha

Dushya – Rasa, Rakta, Sira, Snayu, Dhamani

Srotas- Rasa, Rakta

Srotodushti – Sanga

Agni-Manda

Adishtana- Sira, Snayu, Mastishka

Rogamarga- Madhyama

Vyadhi Avastha - Nava

Sadhyaasadyatha – Krichra

Nidana panchaka

Nidana

Aharaja- Habitual intake of *Guru snigdha*, *Abhishyandi ahara* especially red meat.

Viharaja-*Pramithasana*, *Ratrijagarana*, *Divaswapna*, chronic tobacco addiction.

Poorvarupa- *Avyaktha*

Rupa- *Cheshtavaishamya*, *Vamakayasada*, *Alpabalatwa*, *Vaksanga* (*Kaphavrutha Vyana-Gativaishamya*, *Gurutaangeshu*, *Kaphavruthaudana- Vakgraha*

Kaphavrutha Prana-Sada)

Upasaya- Not noticed

Samprapthi

The patient had a history of regular consumption of *Guru, Snigdha*, and *Abhishyandi ahara* (red meat), along with *Viharas* such as *Divaswapna*, which led to *Kapha dushti*. This resulted in *Mandagni* and subsequent *Ama* formation. The accumulated *ama* caused *Avarana* to the normal *Gati* of *Vata*, (particularly affecting initially *Samanavata* and *Vyanavata* followed by finally *Prana vata*) thereby leading to *Vata prakopa*. Associated *Vata*-aggravating factors such as *Pramitashana* and *Ratri jagarana* further intensified the pathology. Chronic tobacco use may have predisposed *Khavaigunya* in *Sira* and *Kandara* and contributed to *Raktavaha srotodushti*. Ultimately, the vitiated *Dosha-dushya Sammurchana*

localized in the *Shiras*, resulting in *Sira-snayu Vishoshana* of the left side (*Vama Kaya*) and clinical manifestation of *Pakshaghata*.

Therapeutic Intervention

MATERIALS AND METHODS

Ayurvedic management of *Pakshaghatha* was adopted in accordance with the underlying *Samprapthi* through a well-planned protocol of both internal medications and external therapies combined with physiotherapy

Table 1: Internal medications

Internal medications	Dose and time of administration
<i>Gandarva hastadi kashayam</i>	90ml twice morning and evening B/F
<i>Dhanwantaram gulika</i>	1 <i>Gulika</i> with <i>Gandarvahastadi Kashaya</i> morning
<i>Vaiswanara choornam</i>	1 tsp with <i>Gandarvahastadi kashaya</i>
<i>Gandarvahastadi eranda tailam</i>	15ml with lukewarm water early morning B/F once in every week

Table 2: Procedures done

Procedures	Medicines used	Duration
<i>Udwarthanam</i>	<i>Kolakulattadi choornam</i>	7 days
<i>Abhyangam</i>	<i>Karpasasthyadi thailam</i>	7 days
<i>Patrapinda sweda</i>	<i>Dhanwantaram+ Kottamchukkadi tailam</i>	7 days
<i>Pizhinj thadaval</i>	<i>Dhanwantaram+ Sahacharadi tailam</i>	7 days
<i>Nasyam</i>	<i>Ksheerabala 101</i> , 6 drops each nostril, morning	7 days
<i>Sirodhara</i>	<i>Ksheerabala taila</i>	7 days

OBSERVATIONS AND RESULTS

Assessment was done on the 35th day based on

- Neurological parameters like gait, muscle tone, muscle power and speech.
- Barthel index scale (before treatment on 0th day and after treatment on 35th day).
- Modified ranking scale (before treatment on 0th day and after treatment on 35th day).

Table 3: Assessment of neurological parameters

Parameter	Before treatment	After treatment
Gait	Unable to stand and walk without support	Able to walk and stand without support
Muscle power	Left upper limb 2/5, left lower limb-3/5	Left upper limb 4/5, left lower limb 4/5
Muscle tone	spasticity of left upper and lower limb.	Reduced spasticity of left upper and lower limb.
Coordination	Unable to perform	improved
Speech	Slurred	Considerable improvement in speech.

Barthel index score

Before treatment - 35 to ➡ After treatment 75

Barthel index measures activity of daily living in stroke patients (0-20 ➡ total dependence, 21-60 ➡ severe dependence, 61-90 ➡ moderate dependence 91-99 ➡ slight dependence)

Here improvement from 35 to 75 points shows significant functional recovery

Assessment with Modified ranking scale

Score improved from grade 4 before treatment to grade 3 after treatment indicating functional improvement.

DISCUSSION

Pakshaghata is one among the *Vata Vyadhis* characterized by affliction of one half of the body, resulting in functional impairment. *Vata* vitiation may occur either due to *Avarana* (obstruction to the normal movement of *Vata*) or *Dhatu Kshaya* (tissue depletion).^[2]

In the present case, the *Samprapthi* indicated *Avaranajanya Pakshaghata*. Hence, the initial line of management focused on removal of *Margavarana*. *Rookshana* therapies such as *Udwarthana* were administered along with appropriate *Deepana-Pachana* internal medications to digest *Ama* and

correct *Mandagni*. After alleviating the obstruction, *Vatahara* therapies were adopted to pacify aggravated *Vata*. Subsequently, *Brimhana* measures were implemented to restore strength and improve functional capacity.

Internal medications

The initial management was directed towards *Deepana-Pachana* and *Srotoshodhana* to clear *Margavarana*. *Gandarvahastadi Kashaya* was administered for its *Vatanulomana* property facilitating removal of obstruction and normalization of *Vata*.⁷ Along with this, *Vaiswanara Choorna* was prescribed owing to its potent *Agnideepana* action to enhance metabolism and correct *Mandagni*^[8]. *Dhanwantaram Gulika* was also given for its *Vatanulomana* and *Vata*-pacifying effects.^[9] Further, *Maharasnadi Kashaya*, specifically indicated in *Pakshaghata*, was administered for its *Vatahara* action, helping reduce muscle stiffness and improve mobility.^[10] *Gandarvahastadi eranda tailam* was administered for *Vatanulomana*.

External therapies

Management commenced with *Rookshana* Chikitsa aimed at clearing *Margavarana*. *Udwarthana*, specifically indicated for its *Kaphaharatva* and *Medasa Pravilayana* properties, was adopted^[11]. It also aids in inducing *Laghutva* and reducing *Stambha* (stiffness). Subsequently, *Abhyanga* with *Karpasasthyadi Taila* was administered for *Vata* mitigation. This formulation is specifically indicated in *Pakshaghata* for its strengthening and neuromuscular supportive effects.^[12]

Patra Pinda Sweda using *Kottamchukkadi Taila* and *Dhanwantaram Tailam* was employed to achieve both *Vatanulomana* and *Srotoshodhana*. *Kottamchukkadi Taila* possesses *Stambhahara* and *Lekhaniya* properties, facilitating channel cleansing, while *Dhanwantaram Tailam* contributes to *Vataharana*.

Pizhichil was administered for its *Brimhana* effect, providing sustained nourishment and enhancing strength of the neuromuscular structures. *Nasya* with *Ksheerabala* also helps in mitigating *Vata*. *Sirodhara* with *Ksheerabala taila* is *Vatahara* as well as help in stimulating the nerves and thus neuro restorative in action.

Along with classical Ayurvedic internal and external therapies, physiotherapy was incorporated to improve mobility, coordination, and motor function recovery.

CONCLUSION

This case demonstrates that a structured Ayurvedic management protocol formulated on the basis of *Avaranajanya Samprapti* of *Pakshaghata* can result in significant functional improvement in post-

ischemic stroke hemiplegia. Importantly, early-stage intervention appears to have played a crucial role in achieving better therapeutic outcomes, even though the *Nidana* and underlying pathology were strong. Timely administration of appropriate internal medications along with sequential external therapeutic procedures contributed to marked enhancement in muscle strength, mobility, speech function, and activities of daily living. Significant improvement observed in objective outcome measures such as the Barthel Index and Modified Ranking Scale further suggests that early, integrative Ayurvedic intervention may serve as an effective supportive strategy in the rehabilitation of stroke-induced hemiplegia, even in cases with considerable etiological strength.

Acknowledgement

We sincerely thank the teaching faculty of the Departments of Roganidana and Kayachikitsa for their guidance and support. We also acknowledge the postgraduate scholars, nursing and paramedical staff, patients, and bystanders for their valuable cooperation in the successful management of this case.

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Cite this article as:

G Gangalakshmi, Mini P, Sreelatha Chandroth. Ayurvedic Management of Pakshaghata (Post Stroke Hemiplegia). International Journal of Ayurveda and Pharma Research. 2026;14(3):159-163.

<https://doi.org/10.47070/ijapr.v14i3.4073>

Source of support: Nil, Conflict of interest: None Declared

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