



Review Article

VANDHYATVA DUE TO FALLOPIAN TUBAL BLOCKAGE

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ABSTRACT

Vandhyatva is an important gynecological condition described in Ayurveda and may be correlated with female infertility in appropriate clinical settings. Among the many causes of female infertility, fallopian tubal blockage is clinically significant because the fallopian tubes are essential for transport of ovum, fertilization, and early embryo movement. The present review notes that females are directly responsible in about 40-55 percent cases of infertility and that tubal obstruction is found in about 19 percent of women with primary infertility and 29 percent with secondary infertility. Tubal blockage is therefore presented as a major contributor to infertility and a condition requiring a safe, established, and cost-effective treatment approach. Ayurvedic interpretation places this disorder within the broader framework of *Vandhyatva*, especially through concepts such as *Kshetradushti*, *Artavavaha Srotodushti*, *Sanga*, and *Avarodha*. The present review explains that the fallopian tubes can be considered a part of *Kshetra* and also as *Artava-Beeja-Vaha Srotas* because they are functionally linked with conception. The *Samprapti* is described as a *Vatapradhana Tridoshaja* process involving *Rasa*, *Rakta*, and *Artava*, with manifestation at the level of *Garbhashaya-nalika*. The present review also presents *Uttar Basti* with *Lashunadi Taila* as an important therapeutic approach because *Uttar Basti* is a unique local procedure described for *Vandhyatva* and allied gynecological disorders, while *Lashunadi Taila* is selected for its *Tridosha-shamaka* orientation. This review article presents a full-length narrative and discusses prevalence, need for study, previous work, conceptual basis, *Samprapti*, modern correlation, review of the drug, review of the procedure, and the broader clinical relevance of *Vandhyatva* due to fallopian tubal blockage.

INTRODUCTION

Infertility is one of the most important reproductive health concerns in contemporary clinical practice, and female factors account for a substantial number of cases. The present review states that females are directly responsible in about 40-55 percent of infertility cases¹, which makes female reproductive disorders a major focus for both modern gynaecology and Ayurveda. Among the many causes of female infertility, tubal blockage occupies a central place because conception depends not only on ovulation and healthy endometrium, but also on normal tubal patency and tubal function.

The fallopian tube is not merely a passive conduit between ovary and uterus; it serves as the site of fertilization and supports transport of gametes and the fertilized ovum. Once this structure is obstructed or functionally impaired, natural conception becomes difficult or impossible.

The present review identifies tubal blockage as the second major cause of female infertility and highlights the limitations of modern management. According to the present review, available modern options include reconstructive tubal surgery, IVF, and embryo transfer, but these approaches have limitations such as low success rate, anesthetic complications, postoperative wound infection, surgical failure, and a higher incidence of ectopic pregnancy. It also argues that these interventions mainly address the anatomical aspect of the tube and do not necessarily establish normal tubal function. This

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concern forms the basis for exploring a safe and cost-effective Ayurvedic protocol.

The present review further notes that encouraging results had already been obtained in earlier departmental studies using *Uttarbasti* with different medicated oils such as *Yavakshara Taila*, *Apamarga Kshara Taila*, and *Kumari Taila*. Building on that line of work, the present theme selects *Lashunadi Taila* because of its *Tridosha-shamaka* properties and proposes its evaluation in tubal blockage. The review article form is particularly useful here because it allows the condition to be discussed in a broader conceptual and clinical context rather than only as a trial protocol.

Ayurveda does not necessarily describe fallopian tubal blockage under this exact modern terminology, yet the condition can be meaningfully understood through classical principles. The present review interprets it mainly through *Kshetra*, *Artavavaha Srotas*, *Dosha*-vitiation, *Srotodushti*, and *Vandhyatva*. This approach is methodologically sound within Ayurveda because classical disease understanding often proceeds through *Dosha*, *Dushya*, *Adhishthana*, *Linga*, and *Ayatana* rather than requiring a direct one-word nosological equivalence. On that basis, *Vandhyatva* due to fallopian tubal blockage emerges as a valid and clinically relevant topic for review.

Need of study

The present review gives a strong rationale for studying this topic. It clearly states that tubal blockage is a major cause of female infertility and that a satisfactory modern management is still lacking when the goal is restoration of natural tubal function. Surgical and assisted reproductive options may be useful in selected patients, but they can be invasive, costly, and inaccessible for many women. Moreover, when the fallopian tube is viewed as a dynamic organ responsible for transport, fertilization, and early embryonic support, management must aim at functional restoration in addition to anatomical patency.

Another important point raised in the present review is the scope for Ayurvedic intervention. *Uttar Basti* is described as a unique procedure mentioned in the classics especially for *Vandhyatva*, *Artavadushti*, and other *Yoniroga*. The present review suggests that when other measures fail, this local procedure may still hold therapeutic promise. Because the pathology concerns the female reproductive tract directly, local intrauterine administration of a medicated oil becomes conceptually meaningful within the Ayurvedic framework.

The selection of *Lashunadi Taila* further strengthens the need for study. The present review emphasizes its *Tridosha-shamaka* properties and

presents it as a continuation of earlier successful work using other oils. Thus, the need of study is not based on speculation alone; it arises from prevalence of disease, limitations of current care, classical therapeutic rationale, and previous academic experience.

Aim, objective and plan of study

This review aims to examine infertility (*Vandhyatva*) through published modern medical and Ayurvedic literature. It will succinctly summarize modern knowledge on causes, diagnostics, and management-especially regarding fallopian tube pathology-and collate classical and contemporary Ayurvedic concepts (*Kshetradushti*, *Artavavaha srotas*, *Samprapti*) relevant to tubal infertility. The review will describe and categorize Ayurvedic management options (systemic and local approaches, *Shodhana* and *Shamana* measures, diet-lifestyle, and medicinal strategies) and outline how these modalities may be applied, together with a brief account of their putative mechanisms. Finally, it will appraise available evidence for Ayurvedic interventions in tubal infertility and indicate priority areas for future research.

Conceptual basis in Ayurveda

The conceptual foundation of this topic rests on one of the most important classical formulations regarding conception. According to Acharya Sushruta, there are four factors responsible for creation of *Garbha*: *Ritu*, *Kshetra*, *Ambu*, and *Beeja*². The present review interprets these as ovulatory period or period suitable for copulation, reproductive field including uterus, fallopian tubes and ovaries, nutritive fluid for fertilized ovum and fetus, and the male-female reproductive elements respectively. Among these, *Kshetra* is especially relevant for the present disease because any defect in the reproductive field can directly impair conception.

The present review therefore treats tubal blockage as a deformity of *Kshetra*, that is, *Kshetradushti*. This is a strong conceptual step because it connects fallopian tube pathology with a recognized classical reproductive principle. *Kshetra* here is not a narrow anatomical label but a functional reproductive environment whose integrity is essential for conception. If this field is structurally narrowed, blocked, inflamed, or functionally abnormal, successful conception cannot occur even when the other factors are relatively preserved.

The fallopian tubes are further described in the study material as very important structures of *Artavavaha Srotas* because they carry *Beeja-rupi Artava*. On this basis, they are termed *Artava-Beeja-Vaha Srotas*. This interpretation expands the relevance of tubal pathology from the structural domain of *Kshetra* to the channel-based domain of *Srotas*. In Ayurveda, disturbance of a *Srotas* implies impairment of transport, nourishment, and normal physiological

movement. Therefore, obstruction in the fallopian tube can be meaningfully read as a type of *Artavavaha Srotodushti*.

The present review also invokes Charaka's principle for understanding newly diagnosed or unnamed diseases through *Prakriti*, *Adhishthana*, *Linga*, and *Ayatana*³. This methodological statement is extremely important because tubal blockage is a modern clinical label not literally found in the classics. The present review uses classical diagnostic logic to interpret it through *Dosha*, *Dushya*, seat, features, and causative factors⁴. This is a legitimate and classically grounded way of correlating modern pathology with Ayurvedic understanding.

Doshic understanding of tubal blockage

The present review explains tubal blockage through *Tridosha* involvement, with *Vata* and *Kapha* given special importance and *Pitta* included where infection or inflammatory change is prominent. This *Tridoshic* approach is one of the strongest aspects of the study material because it accommodates different pathological patterns rather than reducing all cases to one mechanism.

Vata is implicated because of its *Ruksha*, *Daruna*, and *Khara Gunas*⁵. The present review explains that *Darunatva* is responsible for *Kathinya*⁶, which may conceptually correspond to sclerosis or stiffness of the tubes. *Rukshatva* is interpreted as contributing to abnormal function, stenosis, and narrowing of the tubes. Thus, *Vata* dominance may be suspected where tubal pathology is more constrictive, spastic, dry, or stenotic in nature.

Kapha is regarded as another major causative dosha because of its *Avarodhaka* and *Shophajanaka* properties. The present review explains that when *Kapha* vitiates with *Sthira Guna*⁷ it can produce blockage. It also notes that suppuration⁸ is not possible without *Kapha* and that *Kapha* is responsible for *Shopha* or inflammation. These ideas conceptually match states of edema, mucosal thickening, exudation, adhesion, and chronic obstructive changes in the tubes. The present review further mentions that newer Ayurvedic gynecological books also consider tubal block to be caused by *Vata-Kaphajanya Avarodha*⁹.

Pitta is not ignored. The present review states that *Pitta* is responsible for *Paka*¹⁰ and that many tubal blockages are consequences of urogenital infection, which justifies including *Pitta* in the *Samprapti*. Therefore, in cases where active infection, inflammation, heat, irritation, or tissue damage is prominent, *Pitta* may be considered the dominant factor.

The present review finally concludes that all three *Doshas* can be causative in tubal blockage. Some cases may be *Vata*-dominant, some *Kapha*-dominant, and some *Pitta*-dominant depending on their

pathology and history. This flexible interpretation is clinically useful because it allows individualized management rather than a rigid single-dosha model.

Samprapti of Vandhyatva due to fallopian tubal blockage

The *Dosha* is described as *Vatapradhana Tridosha*, indicating that all three *doshas* participate with *Vata* as the leading factor. The *dushyas* are *Rasa*, *Rakta*, and *Artava*. *Agni* is *Dhatvagni*, the relevant *srotasa* is *Artavavaha* or *Artava-Beeja-Vaha*, the *Udbhavasthana* is *Amapakvashaya*, the *Srotodushti* type is *Sanga*, the *Vyaktisthana* is *Garbhashaya*, the affected *Avayava* is *Garbhashaya-nalika*, the *Roga Vinishchaya* is *Garbhashaya-nalika-avarodha*, and *Sadhyasadyata* is *Krichhrasadya*.

This framework can be expanded narratively. *Vataja*, *Kaphaja*, and *Pittaja Nidanas* produce *dosha prakopa*. When aggravated *Vata* acts through *Ruksha Guna*, it leads to *Samkocha* or constriction. *Kapha* through *Sthira* and *Manda Gunas* leads to *Shopha* and obstruction. *Pitta* through *Ushna* and *Drava* qualities contributes to *Paka* and inflammatory changes. These disturbed doshas then localize in *Artava-Beeja-Vaha Srotasa*, specifically in *Garbhashaya-nalika* or the fallopian tube. There they produce *Sanga*, resulting in *Garbhashaya-nalika Avarodha*, which clinically manifests as tubal blockage and ultimately *Vandhyatva*.

The prognosis is described as *Krichhrasadya*. This indicates that the condition is difficult to treat, which aligns with the modern clinical reality that tubal infertility is often chronic and challenging. At the same time, the prognosis is not hopeless, thereby justifying active management through carefully designed therapy.

Review of modern literature

The present review gives a concise review of modern anatomy and infertility science. It describes the female reproductive organs as including the ovaries, uterine tubes, uterus, vagina, and external genital organs. The ovaries produce secondary oocytes and hormones such as progesterone, oestrogens, inhibin, and relaxin. The uterine or fallopian tubes transport secondary oocytes and fertilized ova to the uterus. Fertilization usually takes place in the lateral part of the tube.

The fallopian tubes are described as paired tortuous ducts measuring about 10 cm and situated in the upper free margin of the broad ligament. The present review lists their four parts from medial to lateral as intramural, isthmus, ampulla, and infundibulum. Ampulla is identified as the most common site of fertilization. The important functions of the tube are transport of gametes, facilitation of fertilization, and survival of the zygote through secretions¹¹.

The present review also explains that the tubes are lined with simple columnar epithelium with cilia, and these cilia, along with peristaltic contractions from the muscular layer, move the fertilized egg toward the uterus. This detail is clinically important because it reinforces that fertility depends on tubal function as well as tubal patency. A tube may appear open yet function poorly if ciliary movement or muscular coordination is impaired. This observation also resonates with the Ayurvedic view that disease in this region may involve both structural and functional disturbance.

Infertility is defined in the study material as failure to conceive after one or more years of regular and unprotected coitus. It is divided into primary infertility and secondary infertility. According to the cited FIGO manual, causes of female infertility include tubal and peritoneal factors in 25-35 percent, ovulatory factors in 30-40 percent, and endometriosis in 1-10 percent¹². This reinforces the clinical importance of tubal pathology as a major infertility factor.

Correlation of modern and Ayurvedic views

One of the most useful contributions of the study material is the possibility of correlating modern tubal pathology with Ayurvedic concepts. Structural narrowing, stenosis, and impaired motility can be read through *Vata*-dominant pathology involving *Rukshata*, *Darunata*, and *Samkocha*. Obstruction due to edema, mucus, inflammatory debris, or adhesions aligns with *Kapha*-dominant *Avarodha* and *Shopha*. Infective or suppurative tissue injury corresponds to *Pittaja Paka* and the role of *Puya* in pathology.

This integrated view has practical value. Modern medicine describes tubal infertility through anatomy, histology, infection, adhesion, and reproductive function. Ayurveda describes the same broader disorder through *Kshetra*, *Srotas*, *Dosha*, and *Avarodha*. Rather than being contradictory, these frameworks can complement each other and give a richer understanding of the disease.

Another important bridge between the two systems is the idea that treatment should restore function, not only anatomy. The present review criticizes modern methods for not always establishing tubal function. This concern fits well with the Ayurvedic emphasis on restoring normal flow, *Doshic* balance, and physiological integrity of the reproductive tract.

Review of *Lashunadi Taila*

The present review includes a classical textual basis for *Lashunadi Taila* from Kashyapa Samhita. It states that the preparation made by the prescribed method is beneficial and provides vigor, fertility, and progeny even to impotent, infertile, and very old persons¹³. This quotation provides a traditional

rationale for selecting the formulation in a fertility-related disorder.

The listed ingredients include *Rasona*, *Agnimantha*, *Bilva*, *Shyonaka*, *Kashmari*, *Shalparni*, *Patala*, *Prishnaparni*, *Kantakari*, *Gokshura*, and *Bruhati*. *Rasona* is described as *Katu-pradhana Pancharasa* with *Snigdha*, *Guru*, *Sara*, *Tikshna*, and *Picchila Guna*, *Ushna Virya*, *Katu Vipaka*, and *Vata-Kapha-shamaka* action. Several accompanying drugs are also described as *Ushna*, *Vata-Kapha-shamaka*, or *Tridosahara*.

The cumulative implication of this profile is that *Lashunadi Taila* is conceptually suitable where *Vata* and *Kapha* contribute to obstruction, stiffness, and dysfunction, while broader *Tridoshaja* involvement is also present. *Ushna* and *Tikshna* qualities may be interpreted as helpful in reducing stagnation and blockage. *Snigdha* qualities may help counter dryness and rigidity associated with *Vata*. The fertility-oriented reference from Kashyapa Samhita further supports its use in *Vandhyatva*.

The present review does not present *Lashunadi Taila* as a universal infertility remedy. Rather, it selects the drug in the specific context of tubal blockage and links it with a local route of administration through Uttar Basti. This focused therapeutic reasoning makes the proposal more coherent and clinically relevant.

DISCUSSION

Vandhyatva due to fallopian tubal blockage represents a clinically significant and therapeutically challenging condition because the fallopian tubes are indispensable for ovum transport, fertilization, and early embryo movement. The present review demonstrates that tubal obstruction contributes substantially to female infertility and therefore deserves focused attention from both modern and Ayurvedic perspectives. Modern gynecology explains tubal infertility mainly through anatomical and functional abnormalities such as stenosis, adhesions, inflammation, edema, impaired ciliary activity, and disturbed tubal motility. Ayurveda, on the other hand, interprets the same pathological state through the principles of *Kshetradushti*, *Artavavaha Srotodushti*, *Sanga*, and *Avarodha*. This conceptual correlation broadens understanding of the disease and provides a more integrated approach to management.

The review establishes that fallopian tubes can reasonably be considered a component of *Kshetra* because they are essential elements of the reproductive field necessary for *Garbha* formation. Their role in carrying *Beeja-rupi Artava* further justifies their inclusion under *Artava-Beeja-Vaha Srotas*. Thus, tubal blockage may be interpreted not only as a structural defect but also as a disturbance of physiological flow and reproductive function. This dual interpretation is important because infertility

frequently results from both anatomical obstruction and impaired functional integrity.

The *Tridoshaja* nature of the disease described in the review appears clinically meaningful. Vata contributes through *Rukshata*, *Samkocha*, and *Kathinya*, leading to narrowing, spasm, or rigidity of the tubes. *Kapha* produces *Sanga*, *Shopha*, and obstruction through its *Sthira* and *Picchila* qualities, while *Pitta* becomes significant in infective or inflammatory pathology associated with tissue damage and suppuration. Such a multidimensional interpretation accommodates the varied clinical presentations of tubal infertility and supports individualized therapeutic planning. The *Samprapti* presented in the review, involving *Vatapradhana Tridosha* with involvement of *Rasa*, *Rakta*, and *Artava* at the level of *Garbhashaya-nalika*, offers a coherent classical explanation for tubal obstruction and *Vandhyatva*.

The present review also highlights an important limitation of many modern treatment modalities. Procedures such as reconstructive surgery and assisted reproductive techniques may restore conception in selected cases, but they are often expensive, invasive, and associated with complications or limited accessibility. Moreover, anatomical correction does not always ensure restoration of normal tubal physiology. This observation strengthens the relevance of Ayurvedic approaches aimed at improving both structure and function of the reproductive tract.

Within this context, *Uttar Basti* emerges as a rational therapeutic modality. Classical Ayurvedic texts specifically indicate *Uttar Basti* in disorders related to *Vandhyatva*, *Yoniroga*, and *Artavadushti*, making its application in tubal blockage conceptually justified. Local administration of medicated oil directly to the reproductive tract may help in alleviating *Srotorodha*, correcting *Vata* vitiation, reducing inflammation, and improving functional integrity of the channels. The review further supports the selection of *Lashunadi Taila* because of its *Ushna*, *Snigdha*, *Tikshna*, and *Tridosha-shamaka* properties. Ingredients such as *Rasona* and associated drugs are traditionally known for reducing *Vata-Kapha* predominance, removing obstruction, and promoting reproductive health. The classical reference from Kashyapa Samhita further reinforces its fertility-promoting significance.

Another noteworthy aspect of the review is its methodological approach. Rather than attempting a simplistic one-to-one equivalence between modern disease nomenclature and Ayurvedic terminology, the condition is interpreted through foundational Ayurvedic principles such as *Dosha*, *Dushya*, *Srotas*, *Adhishthana*, and *Samprapti*. This reflects a more

authentic and academically sound method of Ayurvedic clinical correlation.

However, despite the strong conceptual foundation, further systematic clinical evaluation remains necessary. Larger controlled studies with objective assessment of tubal patency, tubal function, and fertility outcomes would help establish stronger clinical evidence regarding the efficacy of *Uttar Basti* with *Lashunadi Taila*. Standardization of procedure, duration of therapy, patient selection, and long-term follow-up would further strengthen future research in this area.

CONCLUSION

Vandhyatva due to fallopian tubal blockage is an important cause of female infertility and can be meaningfully understood through Ayurvedic principles such as *Kshetradushti*, *Artavavaha Srotodushti*, *Sanga*, and *Avarodha*. The condition is best interpreted as a *Vatapradhana Tridoshaja* disorder involving *Rasa*, *Rakta*, and *Artava* at the level of *Garbhashaya-nalika*. Correlation between modern concepts of tubal pathology and Ayurvedic understanding demonstrates that both structural and functional disturbances are involved in the disease process.

The present review establishes a strong conceptual basis for the use of *Uttar Basti* with *Lashunadi Taila* in tubal infertility. *Uttar Basti* is a specialized local therapy traditionally indicated in *Vandhyatva* and disorders of the female reproductive tract, while *Lashunadi Taila* possesses properties that may help relieve obstruction, reduce *Doshic* imbalance, and restore reproductive function. The review also emphasizes the need for cost-effective, minimally invasive, and function-oriented approaches in comparison with purely surgical or assisted reproductive interventions.

Overall, the study supports the clinical relevance of Ayurvedic management in fallopian tubal blockage and provides a comprehensive framework integrating classical Ayurvedic concepts with modern reproductive science. Further well-designed clinical studies are needed to validate these principles and to establish evidence-based protocols for the management of tubal infertility through Ayurveda.

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