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Case Study

TROPICAL ATAXIC NEUROPATHY: AN INTEGRATIVE AYURVEDIC APPROACH IN THE MANAGEMENT OF *DUSHIVISHA JANYA VATAVYADHI*

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ABSTRACT

Tropical Ataxic Neuropathy (TAN) is a rare, chronic neurodegenerative disorder seen in tropical populations, associated with prolonged consumption of improperly processed cassava containing cyanogenic glycosides, compounded by micronutrient deficiency, particularly of thiamine. **Materials and Methods** A 40-year-old male presented with a three-year history of progressive sensory ataxia, bilateral sensorineural hearing loss, tinnitus, visual disturbance, and slurred speech, with chronic dietary cassava intake. Examination revealed wide-based ataxic gait, and positive Romberg's sign; audiometry confirmed bilateral sensorineural hearing loss. The condition was diagnosed as *Dushivisha Janya Vatavyadhi* (*Anukta Vatavyadhi*), with vitiation of *Prana*, *Udana*, and *Vyana Vata* and progressive *Dhatukshaya*. Chronic cassava ingestion was considered *Dushivisha*, precipitating *Agnimandya*, *Ama* formation, and *Srotodushti*. Management included *Koshtashodhana*, *Sarvanga Abhyanga*, *Nasya* with *Lashunaksheerapaka*, *Shashtika Shali Pinda Sweda*, and *Mustadi Rajayapana Basti*, with supportive *Shamana Aushadhis*. **Results:** Notable improvement in speech clarity and vision, with modest gain in tinnitus and gait. Markedly reduced lower-limb tingling and further improved gait, easing tandem walking, though Romberg's sign persisted. **Discussion**: This case illustrates the interplay of chronic neurotoxicity, gut–brain axis dysfunction, and micronutrient deficiency in TAN pathogenesis, and demonstrates the potential of Ayurvedic *Vata-hara* approach in a chronic neurodegenerative disorder.

INTRODUCTION

Tropical Ataxic Neuropathy (TAN)[1], also known as Strachan-Scott syndrome, is a chronic, progressive neurological disorder predominantly affecting poor, tropical populations of Africa, South-East Asia, South India and the Caribbean, typically in the 60-79-year age group, although younger patients are also reported. Dr. Henry Strachan first described the syndrome in Jamaica between 1887 and 1897 as "Strachan's Disease" or "Jamaican Neuropathy"; the term "tropical ataxic neuropathy" was subsequently coined by Money in 1958. The disorder is characterized by a constellation of sensory ataxia, peripheral neuropathy, bilateral optic neuropathy and bilateral sensorineural deafness.

The etiology[2] of TAN, though not fully elucidated, is strongly linked to chronic dietary dependence on cassava (Manihot esculenta), a drought-resistant tuber that constitutes a food-security crop across the tropics. Cassava contains the cyanogenic glycosides linamarin and lotaustralin[3]; when the tuber is inadequately processed (soaked, fermented, sun-dried, boiled or roasted), residual cyanide is absorbed systemically. Cyanide inhibits the mitochondrial enzyme cytochrome-c oxidase, producing histotoxic hypoxia, axonal degeneration and demyelination that selectively affects the posterior columns of the spinal cord, peripheral nerves, optic nerve and cochlear nerve[4]. A near-total dependence

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on cassava also predisposes to thiamine (vitamin B1) deficiency, both through low intrinsic thiamine content of the diet and through linamarin binding sulfur groups of thiamine, further compounding neuronal injury. Contemporary biomedical management remains largely supportive nutritional rehabilitation, thiol-donor amino acids to facilitate cyanide-to-thiocyanate conversion, and vitamin B-complex/vitamin A supplementation- without a curative or disease-modifying option[5].

In Ayurveda, a comparable state of chronic, low-grade, cumulative toxicity is conceptualized as *Dushivisha*[6]- a *Visha* (toxin) that, having lost its *Veerya* (potency) through processing, time, or environmental exposure, is enveloped (*Avruta*) by *Kapha* and lies dormant in the body for years before manifesting protean symptoms. The clinical symptoms of TAN closely resemble with *Sarvanga Gata Vata*[7], *Karnanada*[8], *Badhirya*[9], *Timira*[10] and *Padaharsha*[11]- closely mirrors the description of *Dushivisha Janya (Anukta) Vatavyadhi,* arising from *Vata prakopa* superimposed on progressive *Dhatukshaya*. This integrative correlation offers a rational foundation for Ayurvedic intervention in a condition for which conventional medicine offers no curative pathway.

Case Report

A 40-year-old male farmer from a low socio-economic background, resident of Kesturu, Chamarajanagara, presented to the Department of Panchakarma, Government Ayurveda Medical College and Hospital, Mysuru, on 08/10/2025 with complaints of progressive imbalance while standing and walking, difficulty walking with slippers, bilateral hearing impairment of two years' duration, buzzing sound in both ears (right greater than left) since three years, weakness in bilateral lower limbs with low back pain, tingling sensation in both lower limbs since one-and-a-half years, and occasional blurring of vision with slurred speech since ten months. There was no known history of diabetes mellitus, hypertension, thyroid dysfunction or any other systemic illness, and no history of fever or falls preceding the illness. Family history was non-contributory.

The illness had evolved gradually over three years. Mild buzzing sounds in both ears, initially ignored, intensified over the following year. Approximately two years prior to presentation, the patient developed episodic giddiness - particularly on change of head position and while bathing- associated with reduced hearing and worsening tinnitus on head movement, together with imbalance while standing and walking and low back pain. He was evaluated at Chamarajanagara Institute of Medical Sciences (05/10/2023), where MRI of the brain and lumbosacral spine was advised but not undertaken; symptomatic treatment produced partial relief of back pain alone. His imbalance progressively worsened with frequent forward or backward falls, and he developed numbness with intermittent tingling in both legs, together with increasing tinnitus and giddiness. About one-and-a-half years before presentation he developed slurred speech and was evaluated at K.R. Hospital, Mysuru (20/04/2024); audiometry revealed moderate sensorineural hearing loss in the right ear and mild sensorineural hearing loss in the left ear. MRI of the brain (20/02/2025) showed lacunar changes in the left frontal lobe white matter, and on 21/03/2025 he was provisionally diagnosed as Tropical Ataxic Neuropathy at K.R. Hospital, without significant symptomatic improvement on continued follow-up. Ophthalmology evaluation for blurred vision led to prescription of spectacles, which paradoxically worsened his giddiness and were discontinued. Evaluation at the All-India Institute of Speech and Hearing (15/07/2025) suggested a provisional central vestibular lesion; hearing aids were recommended but discontinued owing to increased sound intolerance. He presented to this institution on 08/10/2025 with the above complaints persisting.

A detailed dietary history revealed chronic weekly consumption of cassava since childhood, a predominantly vegetarian diet (ragi balls, chapati, rice with spicy curry) with occasional non-vegetarian intake (chicken and mutton occasionally; fish weekly for the past four years), and a history of occasional binge alcohol consumption (rum, brandy, and locally brewed "kallu-batti") once or twice monthly for fifteen years, discontinued three years prior to presentation

Clinical Findings

General examination: The patient was conscious, moderately built and moderately nourished. Pallor, icterus, clubbing, cyanosis, lymphadenopathy and oedema were absent. BMI was 21.5kg/m^2 (height 170 cm, weight 62kg). Vitals: pulse 77/min, blood pressure 140/90 mmHg, respiratory rate 19/min.

Systemic examination: Respiratory, cardiovascular and per-abdomen examinations were unremarkable and within normal limits.

Central nervous system examination: Higher mental functions were intact - the patient was conscious, well-oriented, with normal memory, comprehension, behavior, intelligence, attention and mood; speech was slurred. Cranial nerve examination was normal for the olfactory, optic, oculomotor–trochlear–abducent, trigeminal, facial, glossopharyngeal–vagus, accessory and hypoglossal nerves- visual acuity was 6/6 bilaterally despite subjective intermittent blurred vision, and no nystagmus was noted. The vestibulocochlear nerve was affected: the vestibular component showed inability to maintain posture in standing (Romberg's sign positive), and the cochlear component (Rinne's and Weber's tests) could not be

reliably elicited owing to the patient's inability to distinguish the tuning-fork tone from his tinnitus.

On sensory examination, higher sensory functions (graphesthesia, stereognosis, localization) were normal, but two-point discrimination was diminished in both lower limbs at the feet. Superficial sensations (touch, pain, pressure, temperature) were intact throughout. Among deep sensations, position sense was normal in all fingers and toes; vibration sense was present and normal in both upper limbs but absent at both feet; joint sense was intact in the right first two toes but impaired in the last three toes of the right foot, and intact in all toes of the left foot.

Motor examination revealed a wide-based ataxic gait with normal, symmetrical muscle bulk (mid-arm 26/25.5cm, mid-forearm 23.5/23cm, mid-thigh 40.5/40cm, mid-calf 33/33cm right/left) and normotonia, without wasting or hypertrophy. Power was 5/5 in all major muscle groups (MRC grading) of the upper and lower limbs. Deep tendon reflexes (biceps, triceps, supinator, knee, ankle) were normal and symmetrical (++ bilaterally); superficial (abdominal and plantar) reflexes were present and normal, and no pathological reflexes (Babinski, clonus) were elicited. Coordination examination showed a normal finger-nose test without intention tremor and absent dysdiadochokinesia in the upper limbs, and a normal heel-shin test in the lower limbs; tandem walking was difficult, consistent with the ataxic gait, and Romberg's sign was positive. Musculoskeletal and lumbar spine examination showed no visible structural abnormality, a negative straight-leg-raise test and no tenderness.

***Ashtavidha Pareeksha*:** *Nadi* -77 bpm; *Mala- Prakruta*, once/day, normal colour and consistency; *Mutra- Prakruta*, 3–4 times/day, occasionally once at night; *Jihwa- Lipta; Shabda- Vikruta* (mild hearing loss, slurred speech); *Sparsha- Vikruta* (loss of joint sensation in the last three toes*); Drik - Vikruta* (blurred vision); *Akruti - Madhyama*.

***Dashavidha Pariksha*:** *Prakriti -Vata-Kaphaja; Vikriti- Vata (Prana, Udana, Vyana), Pitta (Pachaka, Alochaka), Kapha (Tarpaka); Satva, Sara, Samhanana* and *Satmya- Madhyama; Jarana Shakti* and *Abhyavaharana Shakti - Madhyama; Vyayama Shakti - Madhyama* both before and during illness; *Pramana -Madhyama*.

Investigations

Haemoglobin, packed-cell volume and RBC count were at the lower limit of normal while MCH and MCV were toward the upper limit, suggestive of underlying vitamin B12 and folate deficiency. CT of the head (02/05/2025) showed no significant intracranial abnormality. MRI of the brain (20/02/2025) revealed a lacunar change in the left frontal lobe white matter, with an otherwise normal study. Audiometry (K.R. Hospital, 20/04/2024) confirmed moderate sensorineural hearing loss in the right ear and mild sensorineural hearing loss in the left ear.

Timeline

Disease course, management and outcomes.

Date/Period	Event / Intervention
~2022	Insidious onset of mild buzzing sound in both ears, initially ignored; gradually intensified over the following year.
~2023	Episodic giddiness on change of head position/bathing, worsening tinnitus and hearing loss, and onset of imbalance while standing and walking with low back pain.
05/10/2023	Evaluated at Chamarajanagara Institute of Medical Sciences; MRI brain and LS spine advised but not performed; symptomatic treatment gave partial relief of back pain only.
~2024 (early)	Progressive worsening of imbalance with frequent falls; numbness and intermittent tingling in both legs; worsening tinnitus and giddiness.
20/04/2024	First visit to K.R. Hospital, Mysuru, for slurred speech; referred to ENT. Audiometry: moderate SNHL (right), mild SNHL (left). Advised MRI brain and CT head.
20/02/2025	MRI brain: lacunar change in left frontal lobe white matter.
21/03/2025	Provisional diagnosis of Tropical Ataxic Neuropathy made at K.R. Hospital; continued follow-up without significant improvement.
02/05/2025	CT head: no significant intracranial abnormality. Ophthalmology evaluation for blurred vision; spectacles prescribed but discontinued as they worsened giddiness.
15/07/2025	Evaluated at All India Institute of Speech and Hearing; provisional diagnosis of central vestibular lesion; hearing aids recommended but discontinued due to sound intolerance.
08/10/2025	Presented to Department of Panchakarma, GAMC Mysuru. Baseline assessment recorded (see Section 2.1).

09/10/2025	*Koshtashodhana* with *Eranda Taila* 40ml with 1 glass *Ksheera*; 5 *Vegas* obtained.
10/10/2025–16/10/2025	*Sarvanga Abhyanga* with *Ashwagandha Bala Lakshadi Taila* (emphasis on *Shiras, Shravana, Pada*) followed by *Nadi Sweda*; *Nasya* with *Lashunaksheerapaka* (2ml each nostril) followed by *Lashunaksheerapaka Pana* (10ml) half an hour post-*Nasya.*
16/10/2025	Post-*Nasya* assessment: clarity of speech improved 70%; buzzing sound reduced 20%; blurring of vision reduced 60%; imbalance reduced 20%; gait improved 10%; tandem walking still difficult; Romberg's sign persisted.
27/10/2025–3/11/2025	*Sarvanga Abhyanga* with *Ksheerabala Taila* followed by *Shashtika Shali Pinda Sweda; Yoga Basti - Anuvasana* with *Ashwagandha Ghrita + Ashwagandha Taila* (35ml each) and *Niruha* with *Mustadi Rajayapana Basti.*
3/11/2025	Post-*Basti* assessment: tingling in lower limbs reduced 90%; walking with slippers markedly easier; weakness in lower limbs improved 30%; gait improved a further 20%; tandem walking possible with ease; Romberg's sign persisted.

Diagnostic Focus and Assessment

- ***Nidana Panchaka***

Nidana: *Aharaja-* chronic intake of Cassava*, Anupa Mamsa* (fish), *Dadhi* and *Madya; Viharaja - Ativyayama, Atibhara, Sheetajala Snana,* and working in *Pravata Sthana* (exposure to draughts/wind while in the fields).

Purvarupa: *Avyakta* (non-specific/unmanifest prodrome).

Rupa: *Gati hani* (loss of gait/imbalance), *Karnanada* (tinnitus), *Badhirya* (deafness), *Shabda asahishnuta* (sound intolerance), *Timira darshan* (blurred/dim vision), *Pada daurbalya* (weakness of feet) and *Padaharsha* (tingling/numbness of feet).

- ***Samprapti Ghataka***

Dosha - *Vata (Prana, Udana, Vyana), Pitta (Pachaka, Alochaka), Kapha (Tarpaka); Dushya -Rasa, Rakta, Mamsa, Meda, Asthi, Majja; Srotas- Rasavaha, Raktavaha, Majjavaha; Srotodushti Prakara -Sanga, Vimargagamana; Agni- Jatharagni and Dhatvagni; Ama- Jatharagni-* and *Dhatvagni-mandya janya; Udbhava Sthana - Amapakvashaya; Sanchara Sthana - Sarva Shareera; Adhishthana -Shiras; Rogamarga- Madhyama; Sadhyasadhyata -Kashtasadhya .*

Excessive and habitual consumption of raw/inadequately processed cassava root acted as a *Dushivisha* since childhood. This latent toxin, initially rendered inert and enveloped by *Kapha* (*Avarana*), remained clinically silent for years. Concomitant *Nidanas - Ativyayama, Sheetajala Snana,* exposure to *Pravata,* and intake of *Anupa Mamsa, Dadhi* and occasional *Madya* (*Abhishyandi Ahara*) - progressively provoked *Vata* and *Kapha.* With *Jatharagni-mandya, Ama* accumulated in the *Amapakvashaya;* combined with the reactivated *Dushivisha* and aggravated *Vata-Kapha*, this led to *Vimargagamana* and *Sthanasamshraya* at the *Shiras* and *Snayu* (correlating with the posterior columns of the spinal cord, peripheral nerves, optic and cochlear nerves), producing progressive *Uttarottara Dhatukshaya* from *Rasa* through to *Majja,* manifesting as the combined *Dhatukshaya-Vatavyadhi* seen in this patient-consistent with the classical description of *Dushivisha* that, having lost its potency, becomes *Kaphavruta* and "*Varshaganaanubandhi*"[12] (persisting silently for years).

Dhatukshaya Lakshanas* exhibited**[13]:*** *Rasa - Shabda asahishnuta, Rukshata; Rakta- Shishira-preeti* (cold intolerance); *Mamsa- Bala-kshaya; Meda- Swapana* (numbness); *Asthi - Asthibheda-* type discomfort; *Majja - Bhrama* and *Timira darshana.*

Treatment Plan

Name of the Drug	Dose / *Anupana* / Frequency
Ajamodadi Choorna + Hingvastaka Choorna	½ tsp twice daily, after food
Ashwagandha Churna	6 g – 0 – 6 g with warm milk, after food
Brihat Vata Chintamani (plain)	1 – 0 – 1, after food
Ksheerabala 101 capsules	1 – 0 – 1, after food

Outcome Measures and Follow-up

The patient was assessed for clarity of speech, tinnitus, blurring of vision, imbalance, gait, tandem walking, Romberg's sign, lower-limb tingling, difficulty walking with slippers and lower-limb weakness at baseline, after the course of *Nasya karma* (16/10/2025) and after the course of *Basti karma* (24/10/2025).

Following *Nasya karma*, clarity of speech had improved by 70%, buzzing sound had reduced by 20%, blurring of vision had reduced by 60%, imbalance had reduced by 20%, and gait had improved by 10%; tandem walking remained difficult and Romberg's sign remained positive.

Following the subsequent course of *Shashtika Shali Pinda Sweda* and *Mustadi Rajayapana Basti,* tingling sensation in the lower limbs reduced by 90%, the patient was able to walk with slippers with ease (previously difficult), weakness in the lower limbs improved by 30%, gait improved by a further 20% (cumulative improvement over baseline), and tandem walking could be performed with ease. Romberg's sign, however, persisted at the end of the treatment period, indicating that the underlying vestibular/ proprioceptive deficit, while functionally better compensated, had not fully resolved.

DISCUSSION

Rationale for *Koshtashodhana*

Koshtashodhana with *Eranda Taila* was administered as *Poorvakarma*, since *Eranda Taila* is a classical *Vata-anulomaka Sneha.* Beyond its purgative action, it clears accumulated *Mala* and *Ama* from the gut, opens the *Srotas* and improves subsequent absorption of medicaments. From a contemporary standpoint, gut clearance favorably modulates the gut–brain axis - improving microbiota balance, reducing pro-inflammatory endotoxin load and mucosal permeability, normalizing enteric nervous system (ENS) signaling, and thereby reducing aberrant afferent input to the central nervous system.

Sarvanga Abhyanga* and *Nasya

Acharya Sushruta locates *Sparshanendriya,* the seat of *Vata*, predominantly in the *Twak; Sarvanga Abhyanga* therefore pacifies *Vata* directly and imparts *Pushti* and *Dardhyata* to the *Dhatus. Acharya Dalhana* further comments that, over 900 *Matrakala* of *Abhyanga,* pacifying *Tridosha* at a deeper level. *Ksheerabala Taila* was selected for *Abhyanga* for its *Brimhana* and *Vatahara* properties, congruent with classical indications of *Sneha, Swedana* and *Abhyanga* for *Vata Roga*.

Nasya is specifically indicated in *Urdhwajatrugata Vikara,* since the nose is regarded as the gateway to the *Shiras* ("*Nasa hi Shirasodwaram*"), and is classically indicated in *Karnashoola, Karnakshweda, Timira, Swaropaghata* and allied *Vata-Pittaja* disorders of the head and special sense organs. In this case, *Lashunaksheerapaka* was chosen as the *Nasya* and *Pana Dravya. Lashuna* (Allium sativum) is *Snigdha, Ushna, Tikshna* and *Balya*, with documented *Medhya* and *Rasayana* properties, and its principal organosulfur phytoconstituents - diallyl thiosulfinate (allicin), S-allyl-cysteine, diallyl disulfide and diallyl trisulfide- exhibit antioxidant, anti-neuroinflammatory, mitochondrial-protective and acetylcholinesterase-inhibitory actions in the literature, in addition to reducing microglial overactivation and stabilizing synaptic function. Mechanistically, allicin (diallyl thiosulfinate) can transfer a sulfur atom to residual cyanide, converting it to thiocyanate (a reaction analogous to endogenous rhodanese-mediated detoxification), which is then readily excreted renally as urinary thiocyanate- offering a plausible, biologically coherent explanation for the marked improvement in tingling and neurological symptoms observed after *Lashuna*-based therapy in a cyanide-associated neuropathy.

Shashtika Shali Pinda Sweda

Shashtika Shali Pinda Sweda is a specialized *Snigdha Swedana* that combines *Swedana* with *Brimhana. Shashtika Shali* itself is *Snigdha, Balavardhaka* and *Dehadardhyakara,* and when processed with *Bala Moola* and *Godugdha* (both *Snigdha, Balya, Rasayana* and *Vatahara)* the bolus delivers sustained transdermal nourishment. *Shashtika Shali* is also a source of B-vitamins and oryzanol; gamma-oryzanol has been shown in animal studies to improve exercise endurance and muscle strength, lending biological plausibility to its Balya action in this *Dhatukshaya*-predominant *Vatavyadhi.*

Mustadi Rajayapana Basti

Basti is regarded as *Ardha-Chikitsa* for *Vatavyadhi* and is specifically indicated in *Nanatmaja Vata Vyadhi* and *Avrita Vata. Mustadi Rajayapana Basti* (Sushruta Chikitsa Sthana 38/106–111)- indicated in *Vatarakta, Meha, Shopha, Arsha, Gulma, Mutravibandha, Visarpa, Jwara* and allied disorders, and credited with *Balya, Sanjivana, Vrishya, Chakshushya* and *Rasayana* properties. In the present case, its *Vata* action was analysed *Panchavata*-wise: on *Apana Vayu* it effects *Adho-apakarshana* of *Dosha* and restores normal *Vata Gati (Anulomana*); on *Samana Vayu* it corrects chronic malabsorption and supports *Agni* and micronutrient assimilation; on *Vyana Vayu* it effects *Tiryak-apakarshana,* improving proprioception, gait and circulation; on *Udana Vayu* it supports *Prayatna, Ojas, Bala* and *Varna*, aiding the observed improvement in speech; and on *Prana Vayu* it effects *Urdhwa-apakarshana* of *Dosha*, stabilizing higher neurological function. As *Vata* is corrected, *Pitta* and

Kapha are restored to their own sites (*Swasthana*), permitting *Dhatu Poshana* and re-emergence of *Prakruta Lakshanas.*

The individual *Basti Dravyas* also carry complementary, pharmacologically plausible actions: *Musta* (*Cyperus rotundus*) is *Deepana-Pachana* and *Kapha-Pittashamaka* with documented anti-inflammatory and antioxidant activity; *Ushira* (*Vetiveria zizanioides*) is *Pittashamaka* and *Mutravirechaniya,* with antioxidant and cytokine-suppressive (TNF-α, IL-1β) effects; *Bala* (*Sida cordifolia*) is *Tridoshahara* and *Balya,* with CNS-active alkaloidal constituents; *Guduchi* (*Tinospora cordifolia*) is *Rasayana, Tridoshashamaka* and *Balya*, with well-documented immunomodulatory, antioxidant and hepatoprotective actions; and *Manjishta* (*Rubia cordifolia*) is *Kapha-Pittashamaka and Rasayana*, with antioxidant and microcirculation-improving properties. A substantial component of the vitamin-B pool in the body is synthesized by gut flora (notably Bifidobacterium and Lactobacillus species) resident in the large intestine; the probiotic-supportive *Basti Dravyas* (*Guduchi, Musta, Katurohini* and allied drugs) are proposed to favor the growth of these organisms, thereby supporting endogenous vitamin-B synthesis relevant to nerve regeneration - an especially pertinent mechanism given the biochemical evidence of B12/folate deficiency noted on investigation. Gut dysbiosis is known to permit pro-inflammatory cytokine release with consequent myelin injury and axonal degeneration; the anti-inflammatory, antioxidant and immunomodulatory *Basti Dravyas* used here are proposed to counter this pathway, while the *Sneha* component (*Ashwagandha Ghrita*) nourishes the lipid-rich myelin sheath, and improved ENS–CNS modulation is proposed to underlie the observed improvement in gait and balance.

CONCLUSION

Tropical Ataxic Neuropathy is a rare disorder whose etiology points toward chronic cyanide intoxication secondary to cassava dependence, a state that finds a coherent correlate in the Ayurvedic concept of *Dushivisha* progressing to *Vatavyadhi*. A multimodal *Vata-hara, Bruhmana* approach-comprising *Koshtashodhana, Abhyanga, Nasya, Shashtika Shali Pinda Sweda* and *Mustadi Rajayapana Basti* - produced measurable functional improvement in balance, hearing-related symptoms, speech, vision and coordination in this patient, highlighting the potential role of Ayurveda in the management of chronic neurotoxic disorders for which contemporary biomedicine offers only supportive care. This case adds to the limited body of literature on Ayurvedic management of TAN and provides a foundation for larger, systematically documented case series.

Patient Consent

Written informed consent for publication of this case report, including clinical details, has been obtained from the patient.

Patient's Perspective

The patient reported subjective satisfaction with the improvement in speech clarity, reduction in lower-limb tingling, and greater ease of walking following the course of Ayurvedic treatment.

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