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Case Study

AYURVEDIC MANAGEMENT OF NEUROGENIC PTOSIS SECONDARY TO A CAVERNOUS SINUS LESION

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ABSTRACT

Cavernous sinus lesions may present with orbital pain, headache, visual disturbances, and progressive ptosis due to involvement of the cranial nerves traversing the sinus. This case highlights the role of Ayurvedic management as an adjunctive therapeutic approach. **Methodology:** A 55-year-old male with a history of hypertension and dyslipidemia presented with left orbital pain, left-sided headache, blurring of vision, double vision and progressive left upper eyelid ptosis of six months' duration. MRI brain demonstrated a heterogeneously enhancing left cavernous sinus-centered extra-axial lesion, suggestive of cystic degeneration of a schwannoma (probably involving the ophthalmic division of the trigeminal nerve) or a venolymphatic malformation. The patient underwent Ayurvedic treatment comprising *Kashayadhara, Snehapana, Abhyanga* with *Ushma Sweda, Virechana, Ksheera Dhooma Nasya, Karnapoorana, Anjana, Shirovasti, Tarpana*, and *Putapaka*, along with suitable internal Ayurvedic medications based on clinical assessment. **Results:** Following treatment, the patient experienced reduction in orbital pain and headache, along with gradual improvement in left upper eyelid ptosis and associated visual symptoms. The treatment was well tolerated, and no adverse events were observed during the treatment period. **Conclusion:** The multimodal Ayurvedic approach incorporating *Shodhana* and *Brimhana* therapies may help alleviate symptoms by addressing *Vata* imbalance and supporting neuromuscular function. Although structural lesions of the cavernous sinus require continued neurological and ophthalmological follow-up, this case suggests that Ayurvedic interventions may provide beneficial symptomatic support. Further controlled clinical studies are needed to evaluate their efficacy and establish evidence-based recommendations.

INTRODUCTION

Ptosis, or drooping of the upper eyelid, is a clinical sign that can arise from abnormalities at different levels of the eyelid and its neuromuscular control system. Depending on the underlying mechanism, ptosis may be myogenic, aponeurotic, mechanical, traumatic, or neurogenic.

Neurogenic ptosis is particularly important from a neurological perspective because it may indicate involvement of the neural pathways responsible for elevation of the upper eyelid.

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The two major neural pathways involved are the oculomotor nerve, which supplies the levator palpebrae superioris, and the sympathetic pathway supplying the superior tarsal muscle (Muller's muscle). Therefore, careful clinical evaluation of ptosis can provide valuable information regarding the anatomical site of a lesion.[1,2]

The cavernous sinus is an important anatomical structure located on either side of the sella turcica and has close relationships with several structures responsible for ocular movement and facial sensation. The oculomotor (III), trochlear (IV), ophthalmic (V1), and maxillary (V2) nerves are closely related to the lateral wall of the cavernous sinus, while the abducens nerve (VI) and the internal carotid artery pass through the sinus. Sympathetic fibres surrounding the internal carotid artery also traverse

this region. Because multiple cranial nerves and autonomic fibres are concentrated within a relatively small anatomical compartment, even a localized lesion of the cavernous sinus can result in a combination of ocular and neurological manifestations.[3,4]

Ptosis associated with cavernous sinus pathology can occur through more than one neural mechanism. Involvement of the oculomotor nerve can impair the function of the levator palpebrae superioris and produce significant ptosis, frequently accompanied by abnormalities of ocular motility and, in some cases, pupillary involvement. In contrast, interruption of the sympathetic pathway supplying the superior tarsal muscle can produce a relatively mild ptosis as part of Horner syndrome. Thus, the nature and severity of ptosis, together with the presence or absence of ophthalmoplegia and pupillary abnormalities, may provide important clues regarding the structures involved.

Cavernous sinus syndrome therefore has a diverse clinical presentation. Patients may develop ptosis, diplopia, ophthalmoplegia, facial sensory disturbances, proptosis, chemosis and, depending on the extent and location of the lesion, pupillary abnormalities. The involvement of cranial nerves III, IV and VI can result in abnormalities of ocular motility, while involvement of the ophthalmic and maxillary divisions of the trigeminal nerve may cause sensory changes over the corresponding areas of the face. The clinical picture may be unilateral or, in more extensive disease, bilateral. Consequently, an apparently isolated unilateral ptosis should be assessed systematically, with particular attention to ocular movements, pupil size and reactivity, facial sensation and other cranial nerve functions. The association of ptosis with ophthalmoplegia, pupillary abnormalities or trigeminal sensory loss should raise the possibility of a lesion involving the cavernous sinus or neighboring orbital apex. [5]

According to the Ayurvedic principle of *Loka–Purusha Samya Siddhanta,* the human body is considered a reflection of the universe, and disturbances occurring within the body may be expressed in specific organs, including the eyes. From an Ayurvedic perspective, aggravation of *Vata Dosha* may manifest in the eye through features described under *Vatahata,*[6] a condition associated with *Vata*-related dysfunction of the eyelids. Since *Vata* is considered an important factor in the regulation of movement and neuromuscular functions, management principles aimed at restoring *Vata* balance are considered relevant in the treatment of such conditions. Ayurvedic management is individualized according to the patient's clinical presentation and is directed towards maintaining or restoring the equilibrium of the three *Sarira Doshas- Vata, Pitta,* and *Kapha*.[7]

The present case describes a patient who presented with drooping of the left upper eyelid and was initially diagnosed with neurogenic ptosis. The patient was subsequently managed according to Ayurvedic principles, with treatment directed primarily towards the presumed *Vata* involvement. The therapeutic approach included both internal medication and external procedures and *Arditha chikitsa* also adopted. Internal management included *Snehapana*, involving the controlled oral administration of medicated ghee or oil. External therapies included *Nasyam*,[8] the administration of medicated preparations through the nasal route; *Yoga vasthi* (enema with medicated preparations) *Karnapooraṇa*, in which medicated oil is instilled into the ear[9] *Anjana*,[10] the application of medicated collyrium to the eyes; *Sirovasti*,[11] involving retention of medicated oil over the head; *Tarpana*,[12] in which medicated ghee or other preparations are retained around the eyes; and *Putapaka*,[13] an Ayurvedic ocular therapeutic procedure. These interventions were selected as part of an individualized treatment plan with the aim of addressing the underlying *Vata* imbalance and improving the patient's ocular symptoms.

Case History

Presenting Complaints

Drooping of left upper eye lid associated with pain on left side of head since six months.

Case Presentation

A 55-year-old male patient presented with complaints of pain in the left eye, blurring of vision in the left eye, and progressive drooping of the left upper eyelid. The patient initially developed pain in the left eye, which gradually extended to the left side of the head and was associated with blurring of vision. He initially consulted an ophthalmologist and was prescribed topical eye drops; however, there was no significant improvement. On subsequent consultation at the same hospital, spectacles and additional eye drops were advised, but the symptoms persisted.

Approximately two weeks later, the patient was referred for an ENT consultation, following which imaging of the head was performed. Based on the clinical and radiological evaluation, the patient was informed that the condition was likely neurological in origin and was prescribed medication. The patient experienced mild relief of pain while taking the medication; however, the symptoms recurred after discontinuation of treatment.

Approximately two months before seeking Ayurvedic treatment, the patient noticed drooping of the left upper eyelid, which gradually progressed. In

view of the progressive unilateral ptosis associated with ocular pain and visual symptoms, further evaluation was undertaken. The patient was subsequently diagnosed with neurogenic ptosis associated with a left cavernous sinus lesion and opted for Ayurvedic management.

Medical and Family History

The patient had a history of hypertension and dyslipidaemia for approximately five years and was receiving regular treatment. There was no significant family history of similar ophthalmic or neurological illness.

Personal History

Diet- Mixed
Bowel -1 time/day
Appetite - Good
Micturition- Within normal limits
Sleep- Sound
There was no history of any known allergy.

Clinical findings

Table 1: Ophthalmic Examination Findings

S.No.	Ocular structures	Right Eye (OD)	Left Eye (OS)
1	Upper eyelid	Normal	Severe ptosis with absent eyelid crease
2	Eyeball position	Normal	Normal
3	Eyeball movements	Normal	Normal
4	Conjunctiva	Normal	Normal
5	Cornea	Clear	Clear
6	Pupil	Round, reactive	Round, reactive
7	Iris	Normal	Normal
8	Lens	IMSC	IMSC

Table 2: Quantitative Assessment of Ptosis

S.No.	Parameter	Right Eye (OD)	Left Eye (OS)
1	Degree of ptosis	Normal	Severe ptosis
2	Margin reflex distance (MRD1)	4mm	0mm
3	Margin reflex distance (MRD2)	5mm	2mm
3	Levator function	14mm	2mm
4	Palpebral fissure height	9mm	2mm
5	Upper eyelid crease	Normal	Poorly defined
6	Frontalis overaction	Absent	Present
7	Jaw-winking phenomenon	Absent	Absent
8	Bell's phenomenon	Present	Present

Investigations

Table 3: Hematological and Biochemical Investigations

Investigation	Result
Haemoglobin	14.8 Gm%
ESR	34mm/hr
Fasting blood sugar (FBS)	102 mg%
Post-prandial blood sugar (PPBS)	186 mg%
Total cholesterol	223 mg/dL
Triglycerides	226mg/dL
HDL cholesterol	40mg/dL
LDL cholesterol	137.8 mg/dL
VLDL	45.2 mg/dL
Blood urea	20 mg/dL

Serum creatinine	1.0 mg/dL
Serum uric acid	6.9 mg/dL
Total bilirubin	0.6 mg/dL
Direct bilirubin	0.2 mg/dL
SGPT/ALT	46 IU/L
SGOT/AST	25 IU/L

Table 4: Urine Examination

Parameter	Finding
Albumin	Faint trace
Sugar	Nil
Pus cells	0-1/HPF
Epithelial cells	0-1/HPF

Radiological Findings

MRI of the brain and orbits performed and revealed a heterogeneously enhancing extra-axial lesion centred on the left cavernous sinus, with the signal characteristics and extensions described in the radiological report. The radiological differential diagnoses included cystic degeneration of a schwannoma, probably arising from the trigeminal nerve and possibly involving the V1 division, and a venolymphatic malformation. Both optic nerves appeared tortuous along their intra-orbital course.

The clinical presentation of progressive unilateral ptosis, ocular pain and headache, together with the MRI findings, was consistent with left cavernous sinus pathology presenting with neurogenic ptosis.

Dasavidha pareeksha

Prakrti	*Vata-Pitta prakṛti*
Vikrti	*Vata-pradhana vikṛti*
Sara	*Madhyama*
Samhanana	*Madhyama*
Pramana	*Madhyama*
Satmya	*Madhyama*
Sattva	*Madhyama*
Aharasakti	*Madhyama*
Vyayamasakti	*Madhyama*
Vaya	*Madhyama*

Ashhtasthana Pariksha

Nadi	*Vata-pradhana naḍi*
Mutra	*Prakṛta*
Mala	*Prakṛta*
Jihva	*Nirama*
Sabda	*Prakṛta*
Sparsa	*Anushṇa sheetha*
Drk	*Vaikrutha*
Akrti	*Madhyama*

Samprapti Ghataka

Dosha	*Vata*
Dushya	*Mamsa, Snayu, Sira*
Srotas	*Mamsavaha / Majjavaha Srotas*

Srotodushti	*Saṅga / Vimarga-gamana*
Sthana	*Vartma* (eyelid), *Netra*
Adhishthana	*Vartma*
Udbhava Sthana	*Pakvaśaya*
Vyakti Sthana	*Vartma*
Roga Marga	*Madhyama roga marga*
Agni	*Vishama*
Pradhana Dosha	*Vata*
Vyadhi	*Vatahata Vartma*
Rupa	Unilateral eyelid drooping/ptosis and impaired eyelid movement

MATERIALS AND METHODS

Methodology/Treatment given:

The therapeutic intervention was given for a period of 21 days.

Table 5: Therapeutic Intervention

S.No.	Medicines	Dose	Route
1	*Punarnavaadi kashayam*	90ml daily before food, evening	Internally
2	*Ashtachoornam* with hot water	1 tsp twice daily before food	Internally
3	*Chandraprabha vati*	1 tablet twice daily after food	Internally
4	*Gandarva eranda tailam*	15 ml daily with *Kashayam* at evening	Internally
5	*Migrakot tablet*	1 tablet twice daily after food	Internally
6	*Gokshoora choornam*	1 tsp twice daily after food with hot water	Internally
7	*Pathya shadangam kashayam*	90ml daily before food, morning	Internally
8	*Rasnadi choornam + Ksheera balam*	*Thalam*	Locally
9	*Ksheera bala 7 avarthi*	Application over face	Locally
10	*Sekam* with *yasthi kashaya*	*Nethra sekam* twice daily	Locally
11	*Aschythanam*	*Durva ghritham*, one drop, twice a day	Locally

Table 6: Procedures

S.No.	Name of procedure	Days	Medicines
1.	*Kashaya dhara*	5 days	With *Varanaadi Kashaya + Guluchyadi Kashaya*
2.	*Snehapanam*	3days	*Rasna dasamoola ghritham + Panchagavya ghritham*
3.	*Abhyanga* and *Ushma swedam*	2 days	*Dhanwantaram tailam*
4	*Virechanam*	1 day	*Gandarva erandam* 10ml + milk + *Thriphala kashayam*
5	*Ksheera dhooma nasyam*	5 days	*Mamsa rasam*
6	*Anjanam*	5 days	*Vasanjanam*
7	*Yoga vasthi*	8 days	*Sneha vasthi* [*Kalyanaka ghritham+ Dhanwantaram mezhupakam] Kashaya vasthi* [honey, *Sainadavam, Kalyanaka ghritham+ Dhanwantaram mezhupakam, Satapushpa kalkam, Dasamoola kashaym*]
8	*Karna pooranam*	14 days	*Ksheera bala 7 Avarthi*
9	*Shirovasthi*	7 days	*Ksheerabala tailam + Karpasasthyadi tailam*
10	*Tarpanam*	5 days	*Jeevanthyadi ghritham*
11	*Putapakam*	1day	*Snehanam*

OBSERVATION AND RESULTS



Before Treatment **After Treatment**

Table 7: Comparison of Ptosis Measurements Before and After Treatment

S.No.	Parameter	Before Treatment – Right Eye (OD)	Before Treatment – Left Eye (OS)	After Treatment – Right Eye (OD)	After Treatment – Left Eye (OS)
1	Degree of ptosis	Normal	Severe	Normal	Normal
2	Margin reflex distance (MRD1)	4 mm	0mm	4mm	4 mm
3	Levator function	Normal-15 mm	Poor-2mm	Normal-15 mm	Good – 10 mm

DISCUSSION

Ptosis is characterized by abnormal drooping of the upper eyelid and may arise from dysfunction of the levator palpebrae superioris, its aponeurosis, the oculomotor nerve, the sympathetic pathway or mechanical abnormalities of the eyelid. In the present case, the clinical presentation was considered in relation to the radiological evidence of a lesion centred in the cavernous sinus. Anatomically, the cavernous sinus contains the oculomotor, trochlear, ophthalmic and maxillary divisions of the trigeminal nerve and the abducens nerve; therefore, a lesion in this region can produce a combination of ptosis, diplopia, ocular-motor disturbances and trigeminal sensory manifestations.

From the Ayurvedic perspective, the clinical manifestation of abnormal eyelid position and impaired eyelid movement may be correlated with *Vatahatavartma*, a condition described among the disorders of the *Vartma* (eyelid). Sushruta describes *Vatahatavartma* in relation to abnormal or impaired function of the eyelid, with or without pain. This provides a classical basis for considering a *Vata*-dominant therapeutic approach in selected patients presenting with neuromuscular dysfunction of the eyelid. Contemporary Ayurvedic research has also reported the use of *Vata*-pacifying systemic and local interventions in neurological presentations associated with ptosis, although the available evidence is presently limited mainly to case reports rather than controlled clinical trials.

The therapeutic strategy adopted in the present case was multidimensional and was designed according to sequential Ayurvedic principles. The initial phase consisted of *Deepana-Pachana* and *Rookshana*, followed by *Snehapana*, *Swedana*, *Shodhana*, and subsequently *Shamana* and *Brimhana* interventions. This sequence was intended to address presumed *Agni* impairment and *Ama*, facilitate appropriate metabolic and physiological processing, and subsequently provide nourishment and *Vata* pacification. Rather than relying on a single formulation, the treatment incorporated systemic medications together with local procedures directed towards the head, sensory organs, and ocular region.

During the initial *Deepana-Pachana* and *Rookshana* phase, *Ashtachoornam* administered with buttermilk was used with the intention of supporting *Agni*, promoting *Ama Pachana*, and reducing *Kapha-Vata* aggravation. The predominance of preparations possessing *Katu* and *Lavana Rasa* and *Rooksha*, *Theekshna*, and *Laghu Guna* was considered appropriate within this therapeutic stage because these attributes are traditionally associated with *Deepana*, *Pachana*, and reduction of excessive *Kapha* and *Ama*.

Punarnavadi Kashaya, having properties such as *Sotha hara,* anti-inflammatory, antioxidant, and diuretic activity. *Chandraprabha Gulika* was included for its *Kapha-hara* and *Lekhana* actions. *Gokshura Choorna* was used for its *Shothahara*, *Mootrala*, and *Srotoshodhaka* properties and was considered supportive in maintaining appropriate fluid balance and *Srotas* function.

Gandharva Eranda Taila administered with milk was used to facilitate regular, gentle *Virechana* and promote *Vata Anulomana* and *Srotoshodhana*. In the context of the overall treatment protocol, this intervention served both a preparatory and systemic

purpose. *Pathya Shadanga Kashaya* and *Migrakot* were incorporated as supportive measures with the intention of achieving *Vata-Pitta Samana* and alleviating pain or discomfort. Their inclusion was based on the traditional therapeutic properties attributed to the respective formulations, while the anti-inflammatory and analgesic effects reported for some of their constituent drugs may provide a possible contemporary pharmacological perspective.

The preparatory phase was followed by *Snehapana* with *Rasna Dasamoola Ghrita* and *Panchagavya Ghrita. Rasna dasamoola ghritham* explained in *Ashtanga Hridaya chikitsa sthana kasa chikitsa adhyaya*, in *Vata rogas* it can be used as *Pana*, *Navana* and *Basthi*. It is useful in *Urdhwa anila rogas*. This preparation, containing *Aja Mamsa* (goat meat) along with the *Jeevaniya* group of herbs, is especially beneficial for strengthening delivering profound immunity and nourishment, *Pancha gavya ghritha* mentioned in Ashtanga Hridaya *Apasmara chikitsa adhyaya*. Useful in *Vata pitha samana, Srotho sodhana*, *Majja dhatu poshana* external oleation using *Dhanwantaram Taila* followed by *Swedana* (sudation) was subsequently performed. These procedures were intended to prepare the patient for *Shodhana* while simultaneously addressing the classical features associated with aggravated *Vata*. *Virechana* was then administered as the principle *Shodhana* procedure. Within the Ayurvedic therapeutic framework, the sequence of *Rookshana*, *Snehana*, *Swedana*, and *Shodhana* is considered important for preparing the body before undertaking more specific therapeutic interventions.

Following *Virechana*, the treatment protocol incorporated measures traditionally described in the management of *Ardita* under *Vata Vyadhi Chikitsa* in Ashtanga Hridaya. This approach was adopted because *Ardita* management encompasses therapies directed towards disorders involving the head, sensory organs, and neuromuscular function. Classical interventions such as *Nasya*, *Murdhni Taila*, *Karna Poorana*, and *Akshi Tarpana* were therefore adapted according to the clinical manifestations of the patient and administered sequentially.

Nasya with *Mamsa Rasa* was employed as a form of *Brimhana Nasya*. In Ayurvedic therapeutics, nourishing nasal preparations are traditionally indicated when *Vata* predominance is associated with depletion, dryness, or weakness involving structures of the head and neck. The use of *Mamsa Rasa (Aja mamsa)* in this context was intended to provide a nourishing intervention for the upper body and neurological tissues. The traditional Ayurvedic rationale is based on the concept of the nose as an important route for therapeutic influence over structures of the head.

Shirovasti with *Ksheerabala Karpasasthyadi Taila* was performed as a local *Murdhni Taila* procedure. The intervention was intended to provide sustained oleation and nourishment to the head region and to support *Vata* pacification. Similarly, *Karna Poorana* was incorporated as a local therapeutic procedure. Since the ear is traditionally regarded as a major site of *Vata*, oil-based procedures involving the ear are classically employed to counteract dryness and instability attributed to *Vata* aggravation. In the present treatment protocol, *Karna Poorana* was therefore considered a supportive head-region therapy rather than a treatment directed specifically at the cavernous sinus lesion.

Ocular therapies were included to address the local manifestations involving the eyelid and eye. *Akshi Tarpana* with *Jeevanthyadi Ghrita* was administered with the intention of providing ocular nourishment and supporting the functional integrity of ocular tissues. In Ayurveda, the eye is the site of *Alochaka Pitta*, while excessive *Vata* is considered capable of producing dryness and functional deterioration. The use of a *Ghrita*-based preparation in *Akshi Tarpana* was consequently intended to provide *Snehana*, nourishment, and *Vata-Pitta* balance. *Putapaka* was also incorporated into the ocular therapeutic sequence as a traditional local procedure.

Netra Seka with *Yashtimadhu Kashaya* and *Aschyotana* with *Durva Ghrita* constituted additional local ocular interventions. *Yashtimadhu* (*Glycyrrhiza glabra*) is traditionally regarded as soothing and supportive to ocular tissues and is described within Ayurvedic practice in relation to *Pitta-Rakta* pacification and inflammatory conditions. Constituents of *Glycyrrhiza glabra* for anti-inflammatory and antioxidant activity. *Durva Ghrita* was selected for *Aschyotana* with the intention of supporting ocular comfort and tissue recovery. The use of a *Ghrita*-based preparation may also provide an emollient effect at the ocular surface; however, such effects should not be interpreted as evidence of direct treatment of the underlying neurological lesion.

Rasnadi Choorna combined with *Ksheerabala Taila* was applied locally over the head as *Thalam*. The intervention was considered supportive within the framework of *Snehana*, *Vata Samana*, and local nourishment. *Rasna*-containing preparations are traditionally used in disorders attributed to *Vata*, particularly those involving musculoskeletal and neuromuscular dysfunction, while *Ksheerabala Taila* is traditionally valued for its nourishing and *Vata*-pacifying properties. The local application was therefore intended to complement the systemic treatment rather than function as an isolated therapeutic measure.

Systemic management was further supported by *Yoga Vasti*, consisting of three *Asthapana Vasti* and five *Anuvasana Vasti* procedures. The inclusion of *Vasti* was based on its classical status as a principle therapeutic modality for *Vata* disorders. Within the Ayurvedic framework, this treatment was intended to provide systemic *Vata* regulation following the preceding preparatory and cleansing procedures. The combination of *Asthapana* and *Anuvasana Vasti* was selected to integrate cleansing and oleation-based approaches within the overall therapeutic sequence.

Taken together, the treatment protocol represents an integrated Ayurvedic approach involving metabolic preparation, *Vata* pacification, oleation, sudation, *Shodhana*, and subsequent nourishing and disease-oriented therapies. The progression from *Rookshana* and *Agni Deepana* to *Snehana*, *Swedana*, *Virechana*, and subsequently *Brimhana* and targeted head and ocular therapies reflects the classical principle of preparing the patient before administering more specific interventions. The sequential use of systemic and local therapies also reflects an attempt to address both the broader *Vata* imbalance and the local functional manifestations of the disease.

From a contemporary perspective, several constituents used in the treatment protocol have been investigated for anti-inflammatory, antioxidant, analgesic, neuroprotective, or diuretic activities.

An important consideration is that the Ayurvedic diagnosis of *Vatahatavartma* represents a traditional clinical construct and should not be regarded as synonymous with the anatomical or neurological diagnosis of ptosis. In this case, the Ayurvedic interpretation was used to guide therapeutic selection while the patient's clinical findings and radiological evidence were considered within the contemporary biomedical framework. This integrative interpretation may be useful for describing the rationale for treatment, but it does not establish a causal relationship between the Ayurvedic interventions and neurological recovery.

Overall, the present case illustrates how classical Ayurvedic principles can be applied to a complex neurological presentation manifesting as ptosis. The treatment was structured as a sequential and multimodal intervention, beginning with *Agni Deepana* and *Ama Pachana*, progressing through *Snehana*, *Swedana* and *Shodhana*, and followed by *Vata*-oriented, nourishing, and localized therapies involving the head and ocular region. While the observed clinical response may provide a basis for further investigation, the findings should be considered hypothesis-generating rather than definitive evidence of efficacy. Carefully designed clinical studies are necessary to establish whether this therapeutic framework has a reproducible role in the management of ptosis associated with neurological pathology.

CONCLUSION

The present case highlights the potential applicability of an integrative Ayurvedic approach in the management of ptosis associated with neurological pathology. The sequential use of *Deepana-Pachana, Rookshana, Snehana, Swedana, Shodhana,* followed by *Vata*-pacifying, *Brimhana*, and localized head and ocular therapies was guided by classical Ayurvedic principles. Although the clinical response is encouraging, the multimodal nature of the intervention and the absence of a control group limit attribution of the outcome to any individual therapy. Further well-designed clinical studies with objective outcome measures are required to establish the efficacy and safety of this approach.

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