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Case Study

AYURVEDIC MANAGEMENT OF *KSHEENA SHUKRA* WITH *SHAMANA* THERAPY

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ABSTRACT

Male factors are responsible for about half of the couple infertility and oligozoospermia is a common abnormality in semen analysis. Deficient *Shukra* (reproductive tissue/semen) in Ayurveda is described in context of *Ksheena Shukra* (diminished semen), managed under *Vajikarana-Rasayana* (aphrodisiac and rejuvenation therapy). Reports describing sequential semen-parameter changes following *Shamana* (palliative) therapy without *Shodhana* (bio-purificatory) are limited. A 37-year-old married man presented with a history of inability to conceive for 11 years. He had no other comorbidities or fertility-directed therapy. The female partner had been worked up for infertility with no significant abnormality found. General and systemic examination was normal. *Ashtavidha Pariksha* (eight-fold clinical examination) revealed *Vata-Pitta-pradhana* (*Vata-Pitta*-predominant) constitution. Baseline semen analysis showed a volume of 1.0ml and occasionally 1–2 dead spermatozoa seen with no quantitative sperm concentration reported. The patient was given Ayurvedic *Shamana* therapy with *Ashwagandha Churna*, *Shilaprawanga*, *Chandraprabha Vati* and *Chandanasava* initially, and later *Ashwagandhadi* Compound Tablet, *Ashwagandha Churna* and *Brahmiadi* Compound Tablet along with *Pathya-Apathya* counseling. Sperm concentration increased from an unknown baseline to 16.0 million/ml and 58.0 million/ml over approximately 5.5 months. With progressive motility increasing from 50% to 65%, the total sperm count increased from 16 to 58 million/ejaculate. Semen volume was unchanged (1.0ml). The case demonstrates time association between *Shamana Vajikarana-Rasayana* therapy and improvement in several semen parameters in a patient assessed as having *Ksheena Shukra*.

INTRODUCTION

Infertility is estimated to affect 8–12% of couples globally[1] and male factors are responsible for approximately 50% of infertility cases either alone or combined with a female factor.[1] Oligozoospermia (sperm concentration below the lower reference limit) is one of the common abnormalities found on semen analysis in infertile men. The 6th edition of the WHO Laboratory Manual for the Examination and Processing of Human Semen (2021) establishes lower reference limits, based on the 5th centile of a fertile reference population, of 16 million/ml for sperm concentration, 39 million per ejaculate for total sperm number, 1.4ml for semen volume, 42% for total motility, 30% for progressive motility and 54% for vitality.[2] In Ayurveda, *Ashtavidha Shukra Dushti* (eight-fold vitiation of *Shukra*) refers to the disorders of the *Shukra Dhatu* (reproductive tissue). Quantitative and qualitative abnormalities of *Shukra* (reproductive tissue/semen) are described according to *Ksheena Shukra* (diminished semen) and management of these abnormalities is under *Vajikarana Chikitsa* (aphrodisiac and reproductive-health treatment), one of the eight branches (*Ashtanga*) of classical Ayurveda dealing with reproductive and sexual health. In Ayurveda also, *Rasayana Chikitsa* (rejuvenation treatment) has been described with regard to the nourishment of tissues and maintenance of *Dhatu Sara* (tissue quality).

The present case describes the sequential changes in the semen parameters during the course of the Ayurvedic treatment without adjunct *Shodhana*

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(bio-purificatory) therapy along with the Ayurvedic clinical assessment, pharmacological rationale of the constituent herbs and comparison with the previously published clinical trials and case reports on the Ayurvedic management of oligozoospermia.

Case Report

This case is reported in accordance with the CARE (CAse REport) 2013 guidelines.[3]

Patient Information

A 37-year-old married man presented to the *Kayachikitsa* Outpatient Department of a Government Ayurveda Teaching Hospital in New Delhi on 20 September 2025 with a chief complaint of inability to conceive despite 11 years of marriage. This was his first presentation to our department for infertility. He had not previously received any fertility-directed treatment.

The couple reported regular unprotected intercourse without the use of contraception and no history of previous conception during the 11-year marriage. The female partner had undergone infertility evaluation, with no significant abnormality reported. The patient reported no known comorbidities, no history of tobacco, alcohol, or other substance use, and no family history of infertility or similar disorders. He had no history of prior fertility-directed medication or other medical treatment relevant to the presenting complaint. Prior to his presentation to our department, a semen analysis had been performed on 15 September 2025, the findings of which were subsequently considered as part of the baseline clinical assessment.

Clinical Findings

The patient weighed 68kg and was 177cm tall, with a body mass index (BMI) of 21.7kg/m^2, within the normal range. He was afebrile, with no pallor, icterus, cyanosis, clubbing, generalized lymphadenopathy, or pedal oedema. His blood pressure was 124/86 mmHg and pulse rate was 75 beats/min, regular. Cardiovascular, respiratory, per-abdominal, and central nervous system examinations were unremarkable. A surgical opinion was sought for evaluation of the external genitalia and scrotal contents. On examination, both testes were normal in size, position, and consistency, with no evidence of varicocele, hydrocele, or other palpable scrotal abnormality. No surgical intervention was advised.

Table 1: *Ashtavidha Pariksha* (eight-fold clinical examination)

Parameter	Finding
Nadi (pulse)	*Vata-Pitta Pradhana* (*Vata-Pitta*-predominant), regular
Mutra (urine)	*Prakrita* (normal); pale yellow, clear; no burning micturition
Mala (stool)	*Prakrita*; once daily, well-formed
Jihva (tongue)	*Alipta* (uncoated); slightly dry
Shabda (voice)	*Prakrita* (normal)
Sparsha (touch/skin)	*Samashitoshna* (neither excessively warm nor cold); slightly *Ruksha* (dry)
Drik (eyes)	*Prakrita*; clear, with normal luster
Akriti (built)	*Madhyama* (moderate build)

Timeline

Chronological summary of clinical visits, investigations, and treatment is shown in Table 2.

Table 2: Case timeline

Date	Clinical Event / Investigation	Key Findings and Management
15 September 2025	Semen analysis #1	Semen volume 1.0ml, pearly white, gel consistency, pH 8.0; laboratory report documented "occasionally 1–2 dead spermatozoa seen" under the parameter "total sperm count". Pus cells 2–4/HPF and epithelial cells 1–2/HPF.
20 September 2025	Visit 1 (Baseline visit)	Presented with inability to conceive despite 11 years of marriage. *Ashtavidha Pariksha* (eight-fold clinical examination) was performed. Treatment initiated with *Ashwagandha Churna*, *Shilaprawanga*, *Chandraprabha Vati*, and *Chandanasava*, along with *Pathya–Apathya* counselling.
05 January 2026	Semen analysis #2	Laboratory-reported total sperm count 16.0 million/ml; active motility 50%, sluggish motility 25%, dead/immotile spermatozoa 25%; pus cells 4–6/HPF and epithelial cells 1–2/HPF.
06 January	Visit 2	Semen report reviewed. Regimen revised to *Ashwagandhadi* Compound

2026		Tablet, *Ashwagandha Churna*, and *Brahmiadi* Compound Tablet for 30 days.
27 February 2026	Semen analysis #3	Laboratory-reported total sperm count 58.0 million/ml; active motility 65%, sluggish motility 10%, dead/immotile spermatozoa 25%; pus cells 2–4/HPF and epithelial cells 1–2/HPF.
28 Feb 2026	Visit 3	Improvement was noted. Semen report reviewed, and the same regimen was continued for a further 30 days.

Diagnostic Assessment

Diagnosis was based on the patient's history of prolonged inability to conceive, general and systemic clinical examination, *Ashtavidha Pariksha* (Table 1), and serial standard semen analyses performed at the same external laboratory on 15 September 2025, 5 January 2026, and 27 February 2026.

The initial semen examination demonstrated a markedly abnormal sperm finding, with the laboratory reporting "occasionally 1–2 dead sperms seen" under the parameter "total sperm count"; no quantitative sperm concentration was provided in that report. In the second analysis, sperm concentration was 16.0 million/mL with a semen volume of 1.0ml, giving a calculated total sperm number of 16 million/ejaculate, below the WHO 6th-edition lower reference limit of 39 million/ejaculate. Progressive motility was 50%. In the third analysis, sperm concentration increased to 58.0 million/ml, with a calculated total sperm number of 58 million/ejaculate and progressive motility of 65%, indicating normalization of these sperm parameters relative to the WHO 6th-edition reference values.

Semen volume remained persistently low at 1.0 mL on all three examinations, below the WHO lower reference limit of 1.4ml, consistent with hypospermia. Semen pH remained 8.0 throughout, with a liquefaction time of 30 minutes. The persistently reduced semen volume was not accompanied by an acidic semen pH; however, a specific structural or endocrine cause could not be established from the available investigations.

A hormonal and metabolic work-up, including follicle-stimulating hormone, luteinizing hormone, prolactin, thyroid profile, glycaemic assessment, complete blood count, liver and kidney function tests, and lipid profile, was advised but could not be performed because of financial constraints. Scrotal ultrasonography and genetic testing were also not performed.

From the Ayurvedic perspective, the clinical presentation was considered under *Ksheena Shukra*, described in the context of *Shukra Dushti* (vitiation of *Shukra*) and managed under *Vajikarana Chikitsa*. This assessment was based on the patient's history of inability to conceive together with the abnormal findings documented on serial semen analyses. Findings obtained through *Ashtavidha Pariksha* were recorded as part of the overall clinical assessment and were considered supportive clinical information for the Ayurvedic diagnosis of *Ksheena Shukra*. Accordingly, the patient was assessed as having male infertility associated with abnormal semen parameters, characterized by low total sperm number and persistent hypospermia, with subsequent normalization of sperm concentration, total sperm number and progressive motility during follow-up.

Therapeutic Intervention

The patient was managed with Ayurvedic pharmacological therapy along with *Pathya-Apathya* dietary and lifestyle counselling (Table 3). No *Shodhana* therapy, surgical intervention, or other fertility-directed treatment was undertaken. The prescribed Ayurvedic interventions were provided through the institutional pharmacy.

Treatment was initiated on 20 September 2025 with *Ashwagandha Churna* at a dose of 3gm twice daily, along with *Shilaprawanga Vati*, 2 tablets twice daily; *Chandraprabha Vati*, 2 tablets twice daily; and *Chandanasava*, 20ml twice daily with equal quantity of water.

Following review of the semen analysis performed on 5 January 2026, the treatment regimen was revised at the follow-up visit on 6 January 2026. The initial combination of *Ashwagandha Churna*, *Shilaprawanga Vati*, *Chandraprabha Vati*, and *Chandanasava* was replaced by *Ashwagandhadi* Compound Tablet, while *Ashwagandha Churna* was continued and *Brahmiadi* Compound Tablet was added.

Ashwagandhadi Compound Tablet, a *Rasayana-Vajikarana* (rejuvenation and aphrodisiac therapy) formulation, was administered at a dose of 2 tablets twice daily. Its ingredients were *Ashwagandha* [*Withania somnifera* (L.) Dunal], *Shatavari* [*Asparagus racemosus* Willd.], *Vidarikand* [*Pueraria tuberosa* (Roxb. ex Willd.) DC.], *Safed Musli* [*Chlorophytum borivilianum* Santapau & R.R.Fern.], *Gokshura* [*Tribulus terrestris* L.], *Guduchi* [*Tinospora cordifolia* (Willd.) Miers], *Amla* [*Phyllanthus emblica* L., syn. *Emblica officinalis* Gaertn.], *Shuddha Shilajit* (purified mineral pitch), *Talamkhana* [*Hygrophila auriculata* (Schumach.) Heine], *Kand* [*Dioscorea bulbifera* L.], *Akarkara* [*Anacyclus pyrethrum* (L.) Link], and *Kesar* [*Crocus sativus* L.].

Ashwagandha Churna was continued at 3gm twice daily, and *Brahmiadi* Compound Tablet, a *Medhya* (nootropic)- *Vajikarana* (aphrodisiac and

reproductive-health therapy) formulation, was administered at 1 tablet thrice daily. Its ingredients were *Brahmi* [*Bacopa monnieri* (L.) Wettst.], *Shankhpushpi* [*Convolvulus pluricaulis* Choisy], *Ashwagandha* [*Withania somnifera* (L.) Dunal], *Jyotishmati* [*Celastrus paniculatus* Willd.], *Kustha* [*Saussurea lappa* (Decne.) C.B. Clarke], *Vacha* [*Acorus calamus* L.], and *Sarpagandha* [*Rauvolfia serpentina* (L.) Benth. ex Kurz].

At the subsequent visit on 28 February 2026, following the third semen analysis, the same regimen of Ashwagandhadi Compound Tablet, *Ashwagandha Churna*, and *Brahmiadi* Compound Tablet was continued for a further 30 days No further modification of the treatment regimen was made.

Table 3. *Pathya-Apathya* (dietary and lifestyle advice)

***Pathya* (advised)**	***Apathya* (avoid)**
Ksheera (milk), *Ghrita* (ghee)	Excessive tea, coffee, and carbonated drinks
Shali/*Shashtika Shali* (rice varieties), *Godhuma* (wheat)	Excessively spicy, sour, salty and hot foods
Mudga (green gram), *Masha* (black gram)	Excessively oily, fried and junk foods
Draksha (grapes), *Dadima* (pomegranate), *Kharjura* (dates), *Kadaliphala* (banana)	Excessive physical exertion and sleep deprivation
Narikela (coconut), *Tila* (sesame)	Alcohol and tobacco
Akshoda (walnut), *Badam* (almonds) and other nuts	Prolonged fasting and irregular meals

Follow-up and Outcomes

Serial semen analyses were performed on 15 September 2025, 5 January 2026, and 27 February 2026 at the same external laboratory. The initial analysis showed an extremely low sperm yield, with only occasional (1–2) dead spermatozoa observed and sperm concentration not quantifiable. Sperm concentration subsequently increased to 16.0 million/ml on 5 January 2026 and 58.0 million/ml on 27 February 2026. Progressive motility increased from 50% to 65% between the second and third analyses, while non-progressive motility decreased from 25% to 10%. Semen volume remained 1.0ml across all three assessments, and pH remained 8.0 (Table 4). As shown in Table 4, progressive motility reached the WHO lower reference limit at the second analysis, whereas sperm concentration entered the reference range only at the third analysis. No adverse or unanticipated events were reported or documented during the treatment period.

Table 4: Serial semen analysis

Parameter	**15 Sep 2025**	**05 Jan 2026**	**27 Feb 2026**	**WHO 6th Ed. (2021) LRL**
Volume (mL)	1.0	1.0	1.0	1.4
Colour	Pearly white	Pearly white	Pearly white	—
Viscosity	Gel	Gel	Gel	—
pH	8.0 (alkaline)	8.0 (alkaline)	8.0 (alkaline)	≥ 7.2
Liquefaction time	30 min	30 min	30 min	≤ 60 min
Total sperm count	Occasionally 1-2 dead sperms seen	16.0 million/mL	58.0 million/mL	16 million/mL
Total sperm number (concentration × volume)	Occasionally 1-2 dead sperms seen	16.0 million/mL	58.0 million/mL	39 million/ejaculate
Active/rapid progressive motility	—	50%	65%	30% (progressive)
Sluggish/non-progressive motility	—	25%	10%	—
Total motility %	—	75%	75%	42%
Dead / immotile	—	25%	25%	—
Pus cells	2–4/hpf	4–6/hpf	2–4/hpf	—
Epithelial cells	1–2/hpf	1–2/hpf	1–2/hpf	—

LRL = lower reference limit (5th centile), per the WHO 6th-edition laboratory manual.[2]

DISCUSSION

The clinical presentation of the patient was inability to conceive and markedly reduced sperm concentration on semen analysis which was evaluated from the Ayurvedic perspective as *Ksheena Shukra* within the framework of *Shukra Dushti*. The first semen analysis showed an extremely low sperm production that could not be quantified. The sperm concentration on later examinations was 16 million/ml and 58 million/ml. *Ashtavidha Pariksha* findings were taken as a part of the total clinical judgment. Ayurvedic clinical assessment was done and treatment was given based on *Shukra-poshana* (nourishment of reproductive tissue), *Rasayana* (rejuvenation therapy) and *Vajikarana* principles.

Various formulations used during the treatment period contained *Ashwagandha* such as *Ashwagandha Churna*, *Shilaprawanga*, *Ashwagandhadi* Compound Tablet and *Brahmiadi* Compound Tablet. A randomized, placebo-controlled pilot trial of 46 oligospermic men showed that a full-spectrum *Ashwagandha* root extract at 675mg/day for 90 days was associated with increases in sperm concentration from 9.59 to 25.61 million/ml, with improvements in semen volume and motility and with changes in serum hormonal parameters.[4] Proposed mechanisms include modulation of stress-related neuroendocrine pathways and antioxidant effects that may support the testicular and seminal environment.[5,6] The approximately 90-day period between the January and February 2026 semen analyses in the present case also broadly parallels the length of time generally considered relevant to spermatogenesis and therefore provides a plausible temporal framework for the observed change. However, the contribution of *Ashwagandha* cannot be separated from the effects of other formulations and the concomitant dietary and lifestyle changes used in this case.

Ashwagandhadi Compound Tablet contained *Shuddha Shilajit* and it was also an ingredient of *Shilaprawanga* in the first period of treatment. A controlled clinical trial of processed *Shilajit* (mineral pitch) given to oligospermic men for 90 days showed an improvement in sperm parameters and changes in oxidative stress and hormonal measures.[7] These findings are a possible pharmacological basis of its inclusion as a component of *Rasayana-Vajikarana* in the present case. However, it could not be determined whether *Shilajit* contributed specifically to the observed outcome, as it was administered in combination with other ingredients.

Gokshura (*Tribulus terrestris*). *Gokshura* was a part of *Ashwagandhadi* Compound Tablet. A double-blind randomized placebo controlled clinical trial of *Gokshura* granules in patients with *Ksheena Shukra* showed better improvement in composite clinical and semen parameters as compared to placebo.[8] It has been suggested that steroidal saponins and antioxidant activity are responsible for its proposed reproductive effects. These results may provide a rationale for its inclusion in the present *Vajikarana* formulation, though the individual effect cannot be separated from the other ingredients administered concurrently.

The *Brahmi* was found in *Brahmiadi* Compound Tablet. Experimental studies have shown that *Bacopa monnieri* may influence testicular antioxidant pathways and sperm quality.[9] These findings may offer a mechanistic justification for its inclusion in the formulation, but there is limited direct evidence relating to human oligozoospermia.

Shankhpushpi, *Jyotishmati* and *Vacha* are the *Medhya* (nootropic) and anxiolytic *Rasayana dravyas* (herbal substances) in classical texts. The inclusion of *Ashwagandha* in *Brahmiadi* Compound Tablet is most likely aimed at the *Manasika* (psychogenic) element of chronic infertility-related stress which is known to suppress the hypothalamic-pituitary-gonadal (HPG) axis independently via cortisol; calming this axis is consistent with and complementary to *Ashwagandha*'s own anti-cortisol action described above.

Sarpagandha has been traditionally described to have a calming and sedative action and is used in conditions associated with mental agitation and sleep disturbance. Therefore, its addition to *Brahmiadi* Compound Tablet can add to the wider *Medhya* and calming properties of the formulation. But its particular contribution to the outcome in the present case cannot be determined.

Shatavari, *Amla*, *Guduchi*, *Vidarikand*, *Safed Musli*, *Kustha*, *Talamkhana*, *Kand*, *Akarkara*, *Kesar*. These ingredients are traditionally used in *Rasayana* and *Vajikarana* formulations for their supportive, nutritive and reproductive-health related properties. However, no specific clinical evidence was proven for the present case for their individual effects on oligozoospermia. Thus, their contribution is to be understood as supportive and formulation-based rather than independently demonstrated.

The observed improvement in semen parameters is in agreement with clinical studies of the individual constituents of the present treatment regimen. Controlled clinical trials have reported improvement in sperm concentration or related semen parameters with administration of *Ashwagandha* root extract, processed *Shilajit* and *Gokshura*.[4,7,8] The findings provide context for the use of formulations containing these ingredients in the management of oligozoospermia. However, in the present case multiple formulations were administered sequentially and the contribution of any one ingredient cannot be determined.

Comparison with previously published Ayurvedic case reports of *Ksheena Shukra/ Shukrakshaya* (wasting of semen) is also relevant. Uppin and Aravinth (2025) reported a case of oligo-teratozoospermia which improved to normozoospermia within three months following a combined *Shodhana* and *Vajikarana* protocol, followed by natural conception.[10] Singh et al. (2024) reported a 35-year-old male with oligozoospermia (8 million/ml) who was managed with *Agnidipana-Aampachana* (digestive-stimulant and metabolic-correction measures) measures, *Virechana* (therapeutic purgation) followed by *Shamana-Vajikarana-Balya Chikitsa* (palliative, aphrodisiac and strength-promoting treatment) over a span of about five months resulting in subsequent normalization of sperm concentration.[11]

Both reports included *Shodhana* therapy as a part of the overall treatment protocol or before it. However, the present case was given *Shamana* (palliative) based *Vajikarana-Rasayana* (aphrodisiac and rejuvenation therapy) formulations without *Shodhana* therapy and showed progressive improvement in sperm concentration from unquantifiable level initially to 16 million/ml and then to 58 million/ml in about 5.5 months. Thus, this case provides another clinical observation of improvement using a *Shamana*-based approach without formal *Shodhana*. However, because this is a single uncontrolled case with multiple concurrent interventions, the finding may be considered hypothesis generating and warrants evaluation in appropriately designed controlled studies. This case has several limitations that should be considered. It is an uncontrolled single observation and spontaneous variability in semen parameters cannot be excluded. However, three sequential semen analyses in the same laboratory allow a longitudinal assessment of the changes observed. Hormonal, metabolic, imaging and genetic investigations were not performed and therefore a complete evaluation for the underlying cause of oligozoospermia could not be performed. Therefore, the underlying endocrine, structural, obstructive or genetic causes could not be fully assessed. The patient was treated with multiple Ayurvedic formulations sequentially along with *Pathya-Apathya* diet and lifestyle counseling. Therefore, the observed improvement cannot be attributed to any single formulation or individual ingredient.

CONCLUSION

A 37-year-old man with an initial non-measurable sperm concentration showed gradual improvement in semen parameters over a period of about 5.5 months with successive Ayurvedic *Shamana Vajikarana-Rasayana* therapy with sperm concentration reaching 58million/ml. The improvement was seen during the treatment with varied Ayurvedic formulations containing *Ashwagandha*, *Shilajit*, *Gokshura* and other *Vajikarana-Rasayana* ingredients along with *Pathya-Apathya* dietary and lifestyle counseling. No adverse events were reported or observed during the treatment period. However, due to this being a single uncontrolled case with incomplete assessment of the underlying etiology and multiple concurrent interventions, a causal relationship between the treatment and the observed improvement cannot be established. Thus, the findings are hypothesis generating and further controlled clinical evaluation of Ayurvedic *Shamana*-based approaches in *Ksheena Shukra*/oligozoospermia is warranted.

Patient Perspective

The inability to conceive for 11 years of marriage had been a major concern, said the patient. He took the prescribed Ayurvedic treatment and follow-up semen examinations and noted improvement in his semen parameters during the treatment. He was happy with the improvement and was agreeable to continue with the prescribed treatment and follow up till conception was achieved.

Informed Consent

Authors certify that they have obtained the patient consent form, where the patient has given his consent for reporting the case along with the images and other clinical information in the journal. The patient understands that his name and initials will not be published and due efforts will be made to conceal his identity, but anonymity cannot be guaranteed.

Authors' Contributions

DJ: Data collection, validation, writing – original draft; AG: Data collection, literature review; RTR: Visualisation, methodology, writing – review & editing; SY: Conceptualisation, supervision, writing – review & editing. All authors read and approved the final manuscript.

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