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Case Study

MULTIMODAL AYURVEDIC MANAGEMENT OF PERIPHERAL ARTERIAL DISEASE IN THE CONTEXT OF *VATARAKTA*: A CASE REPORT EMPHASIZING *GUDUCHI RASAYANA*

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ABSTRACT

Peripheral arterial disease (PAD) is a manifestation of systemic atherosclerotic disease characterised by arterial narrowing and reduced peripheral perfusion, commonly presenting with intermittent claudication, altered peripheral pulses, and ischemic changes of the lower limbs. From an Ayurvedic perspective, the clinical features of PAD can be correlated with *Uthana Vatarakta* (superficial polyarthritis due to vitiated *Vata* and blood), with the concepts of *Dhamani Sankoca* (constriction of blood vessels) and *Margavaraṇa* (obstruction of channels/pathways) providing a possible framework for understanding vascular obstruction. This single case report describes the clinical outcome of Ayurvedic management in a patient with PAD. A 56-year-old male presented with bilateral burning sensation of the feet, intermittent claudication, reduced walking distance, cold extremities, and diminished peripheral pulses. CT angiography revealed significant arterial occlusions and stenotic changes involving the bilateral lower-limb arteries. The patient was managed with systematic Ayurvedic treatment protocol mentioned for *Gambeera Vatarakta* (deep-rooted polyarthritis due to vitiated *Vata* and blood) comprising *Shamana* (palliative therapy) and *Shodhana chikitsa* (cleansing therapy), including *Gugguluthiktaka Kashaya, Kaishora Guggulu, Mahatiktaka Ghrita, Guduchi Rasayana, Virechana, Vasti, Dhanyamla Dhara, Abhyanga, Swedana, Upanaha* and *Siravyadha* according to the stages of pathological corrections (*Samprapti vighattana).*The significant improvement observed in this case highlights the potential role of multimodal Ayurvedic management in improving clinical symptoms and functional status in PAD.

INTRODUCTION

Peripheral arterial disease (PAD) is a frequently encountered consequence of systemic atherosclerotic disease and affects more than 200 million individuals globally. It is particularly prevalent among older adults and individuals with risk factors such as diabetes mellitus, tobacco use, and chronic kidney disease. PAD develops primarily due to the gradual narrowing of peripheral arteries, commonly involving the aortoiliac, femoropopliteal, and infrapopliteal vessels. The resulting reduction in arterial perfusion can compromise blood supply to the lower limbs, leading to varying degrees of limb ischemia.[1]

Peripheral arterial disease (PAD) may develop as a consequence of reduced arterial compliance, abnormal platelet activation and aggregation, and an increased risk of microvascular damage. These vascular alterations are commonly associated with conditions such as hypertension, hyperglycemia, dyslipidemia, hypercholesterolemia, and cigarette smoking. Persistent and poorly controlled hypertension impairs the normal vasodilatory function of the vascular endothelium and stimulates the renin–angiotensin–aldosterone system (RAAS). These changes contribute to vascular remodeling, hyaline deposition, atherosclerotic changes, and progressive loss of arterial elasticity. Type 2 diabetes mellitus is also strongly associated with PAD, with chronic hyperglycemia and leukocyte-mediated endothelial injury contributing to vascular dysfunction [2].

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Cigarette smoking further promotes the development of PAD by impairing endothelial-dependent vasodilation and enhancing platelet aggregation, thereby increasing the likelihood of atherosclerotic plaque formation and thrombotic complications[2]. Smoking represents one of the most important modifiable risk factors for peripheral arterial disease (PAD), with smokers having approximately a fourfold higher risk of developing the condition and experiencing greater disease severity.[3]

The clinical spectrum of PAD is broad, extending from asymptomatic disease to intermittent claudication (IC), while advanced disease may progress to chronic limb-threatening ischemia (CLTI), which carries a substantially increased risk of limb loss and mortality.[3] Intermittent claudication is the most characteristic clinical presentation and is typically manifested by pain, cramping, discomfort, or fatigue in the lower limbs during physical activity, with symptoms usually resolving after cessation of exercise and rest, generally within about 10 minutes.[4]

The increasing prevalence of cardiovascular and lifestyle-associated diseases has contributed to the growing global burden of PAD, making it an important cause of morbidity and impaired quality of life. Nevertheless, PAD continues to be considerably underrecognized and undertreated worldwide, partly because many affected individuals remain asymptomatic and routine screening is not consistently performed in clinical practice.[3]

Vatarakta (polyarthritis due to vitiated *Vata* and blood) predominantly affects the lower extremities and exhibits several clinical features that show resemblance to peripheral vascular diseases. Manifestations such as *Tvakvaivarnya* (discoloration of skin), *Tvak*-related changes including *Vrana* (ulcer), *Dalitatvak* (cracked skin) and *Tvaksphuṭana* (fissuring of skin), along with prominent *Shoola* and *Toda* (pricking pain) in the affected region, may be correlated with the clinical features of peripheral vascular disease.[4] The Ayurvedic concepts of *Dhamani Sankocha* and *Margavarana* can be interpreted in relation to arterial narrowing and obstruction associated with atherosclerosis, particularly involving the distal arteries. Hence, based on these overlapping clinical manifestations and pathological mechanisms, *Vatarakta* may be considered as a possible parallel diagnostic correlate of peripheral vascular disease.[4]

Case Report

Patient information: Age– 56 years, Gender– Male, Marital status- Married, Socioeconomic status- lower middle class

A 56-year-old male patient with no known comorbidities was apparently asymptomatic until approximately 1½ year ago, when he gradually developed a burning sensation over the plantar aspect of the left foot. The symptoms were insidious in onset and initially localized to the left sole. After approximately one-month, similar symptoms developed over the right plantar region, following which the symptoms gradually progressed bilaterally.

The patient also complained of cramping pain over the bilateral calf regions during walking for the past one year. Initially, the pain occurred after prolonged walking, at a distance of approximately 1km, and was relieved on stopping the activity and taking rest. As the condition progressed, his pain free walking distance gradually decreased, and subsequently he developed calf pain after walking for approximately 150m, which compelled him to discontinue walking and take rest, following which the pain subsided. There was no history of pain at rest or nocturnal pain. The pain was aggravated on elevation of the lower limbs and relieved on dependency. As the condition progressed, the patient also noticed coldness of the feet, reduced sweating and loss of hair over the lower limbs. There was no history of spontaneous ulceration or gangrenous changes. The patient also complained of bilateral knee joint pain, which had progressively increased over the preceding approximately nine months. The pain was aching in nature, aggravated by walking and climbing stairs and relieved by rest. There was no associated joint swelling, morning stiffness, local warmth or restriction of movements.

He had a significant history of tobacco, alcohol and cannabis use. He has been smoking cigarettes continuously for approximately 38 years. He has also been consuming alcohol for approximately 15 years and has a history of cannabis (ganja) use for approximately 22 years. In view of the above complaints, he consulted at Kottayam Medical College, where relevant investigations were performed. CT angiography of the lower limbs revealed significant arterial occlusive changes, following which he was advised to undergo bypass surgery. The patient was unwilling to undergo surgical intervention and subsequently opted for Ayurvedic inpatient management.

Comorbidities

No known comorbidities

History of Past Illness

H /O pulmonary TB (6 months back)

Cystic lesion in dorsum of left foot since 30 years.

Gastric ulcer (6 month back).

Family History: Nothing relevant

Drug History

Anti-tubercular treatment under DOTS programme for 6 months.

Medications at the Time of Admission

Currently not taking any medications.

Personal History

Bowel– frequency: regular, stool consistency: semisolid, occasionally hard stool, micturition- 4-5 times/day, 0-2 times/night, appetite- reduced, sleep- reduced. addiction: ganja – 22 years (18 yrs to 40 yrs, alcohol- 15 years, smoking– 38 years, smoking index- 950 (very high-risk category)

Socioeconomic status- Lower middle class, occupational history- mason

Timeline

Time point	Clinical event/intervention
1½ year prior to admission	Onset of symptoms
Subsequent months	Progressive bilateral calf claudication, walking distance reduced to ~150 m.
2/04/2024	CT angiography revealed significant arterial occlusions and stenosis, bypass surgery was advised.
Subsequently	Patient declined surgery and opted for Ayurvedic management.
14/5/25	Admitted for Ayurvedic management, clinical assessment performed, fontaine stage IIb PAD documented.

Clinical Findings

Peripheral Vascular System		
	Right	**Left**
Blackish Discolouration	+	+
Redness	-	-
Hair loss	+	+
Shining of skin	-	-
Temperature	Cold	Cold
Joint effusion over ankle	+	+

Peripheral pulse		
	Right	**Left**
1.Dorsalis pedis	Feeble	-
2.Posterior tibial	4/min	-
3.Popliteal	-	-

Fontaine classification

Fontaine stage IIb	
Clinical features	Intermittent claudication with walking, with pain-free walking distance <200 m

Sensory System Examination

	Finding	**Details**
Superficial – Touch	Impaired	Left great toe
	Preserved	Other sites; sensation present, right > left
Superficial – Temperature	Impaired	Left great toe
Superficial – Pain	Intact	—
Deep – Deep Pain	Intact	—
Deep – Joint Position	Impaired	Left great toe
	Intact	Right great toe
Deep – Vibration	Impaired	Dorsal aspect of both feet (right and left)

Relevant Investigations

CT –Lower limb Angiogram on 2/04/2024

Complete occlusion of right SFA, distal PTA

50-70% stenosis of right CIA, EIA.

Complete occlusion of left SFA, mid popliteal artery, terminal PTA, IΠA

70-90% stenosis of left CFA

Ayurvedic Clinical Assessment

Dasavidha Pareeksha	
Dooshyam	*Dhatu- Rasa, Rakta, Mamsa, Medas, Asthi* *Upadhatu- Sira, Dhamani*
Desham	*Bhoomi- Sadharana* *Deha- Adha kaya*
Balam	*Rogi- Madhyama* *Rogam- Madhyama*
Kalam	*Kshanadi- Sarvakala* *Vyadyavastha- Samvatsara*
Analam	*Madhyama*
Prakriti	*Kapha pitta*
Vaya	*Madhyama*
Satwam	*Madhyama*
Sathmya	*Sarvarasa*
Aharam	*Jaranasakti- Madhyama* *Abyavaharana sakti- Madhyama*

Samprapti Ghataka	
Dosha	*Pitta pradhana Tridosha*
Dhatu	*Rasa, Rakta, Mamsa, Meda*
Upadhatu	*Sira, Dhamani*
Agni	*Jadaragni Mandya*
Srotas	*Rasa, Rakta, Mamsa, Meda*
Srothodushti	*Sanga*
Rogamargam	*Madhyama*
Udbhavastanam	*Pakvashaya*
Vyaktasthanam	Lower limb-*Jangha, Pada, Anguli*

MATERIALS AND METHODS

Treatment Done

First phase – for 14 days 1. *Guluchyadi kashayam* 90ml bd before food 2. *Partharishtam* 30 ml bd after food 3. *Shaddharanam* tab 2 tds after food 4. *Manibhadra gulam* 15 g HS 5. *Avipathi churnam* 1 pinch during urge to smoke	*Dhanyamla dhara* 7 days *Kashayadhara* with *Karaskara kashayam* for 7 days *Upanaham -Upanaha churna + Dhanyamla + Murivenna + Saindhava* (B/L foot)
II phase - for 7 days 1. *Guggulutiktaka kashayam* 90 ml bd before food 2. *Kaishora guggulu* 1 bd	Mukkikizhi: *Kolakulathadi +Triphala churna* in *Karaskara kashayam* for 7 days *Snehapana* with *Madhuyashtyadi tailam* 7

3. *Sahacharadi 7 Avarti* drops with *Kashayam*	days *(Arohanakrama)* *Virechana: Sukumaraeranda tailam* 40ml, after 3 days *Abahyanga* & steam bath
III Phase 14 days 1. *Guggulutiktakam kashayam* 90 ml before food 2. *Kaishora guggulu* 1 bd 3. *Mahatiktaka ghritam* 1 tsp bd with *Kashayam* 4. *Guduchi rasayana*	*Snigdha Sankara sweda* for 7 days :- *Kolakulathadi churna+Triphala churna* for *Kizhi, Abhyanga* with *Pindataila + Madhuyashtyadi taila* *Erandamoola ksheeravasti* 3 days *Mustadi Rajayapana vasti* 3 days *Siravyadha* 2 sitting

Guduchi Rasayana Vidhi

Mode of preparation: Fresh *Guduchi* (*Tinospora Cordifolia*) stem collected and washed well. Outer skin removed, made into small pieces, crushed well and added with adequate quantity of water for soaking and kept overnight. Next day morning, sedimented *Satwa* is collected and was given to the patient along with equal quantity of milk in empty stomach. After commencement of appetite, *Laghu bhojana* was advised. The *Satwa* received from 5gm of fresh *Guduchi* is administered as trial dose and observed for any adverse reaction. Then the doze was increased in a gradual manner (*Arohanakrama*) for safety and to achieve peak dose threshold.

Starting dose: 5g

Dose was gradually increased according to appetite of patient, upto the dose of 120gm was given.

Anupana: Milk

Period of administration: For 21 days

Advise on Discharge

1. *Manjishtadi kashayam* 90 ml bd
2. *Madhuyashtyadi tailam* 5 ml bd with *Kashayam*
3. *Mahatiktakam ghritam* 1 tsp early morning
4. *Pindataila* for external application

RESULTS

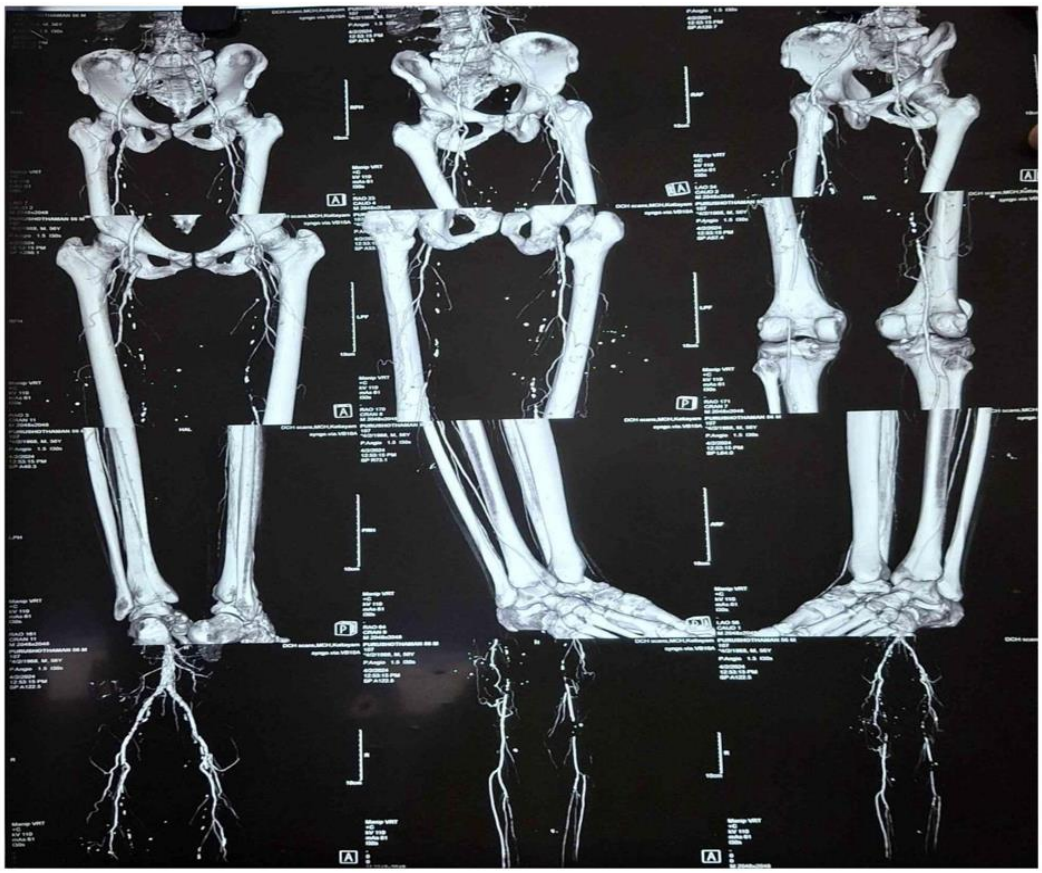
Signs and symptoms	Before treatment	After treatment
Burning sensation	++	-
Claudication pain	++	+
Claudication distance	150 m	500m
Peripheral pulse	Rt-Feeble Lt-Absent	Rt-Present Lt-Feeble
Extremity temperature	Hypothermic	Normothermic

Following treatment, a noticeable improvement was observed in the clinical features of peripheral arterial insufficiency. The burning sensation, which was moderately present before treatment (++), was completely relieved and became absent (-) after treatment. Claudication pain showed marked improvement, reducing from moderate intensity (++) to mild (+). The claudication distance increased substantially from 150m before treatment to 500m after treatment, indicating improved walking capacity and peripheral circulation. On assessment of peripheral pulses, the right-sided pulse, which was initially feeble, became palpable, while the left-sided pulse, which was initially absent, became feeble after treatment, suggesting improvement in peripheral perfusion. The peripheral temperature, initially reduced, improved to a normal level following treatment. Overall, the findings indicate improvement in symptoms and peripheral vascular status.

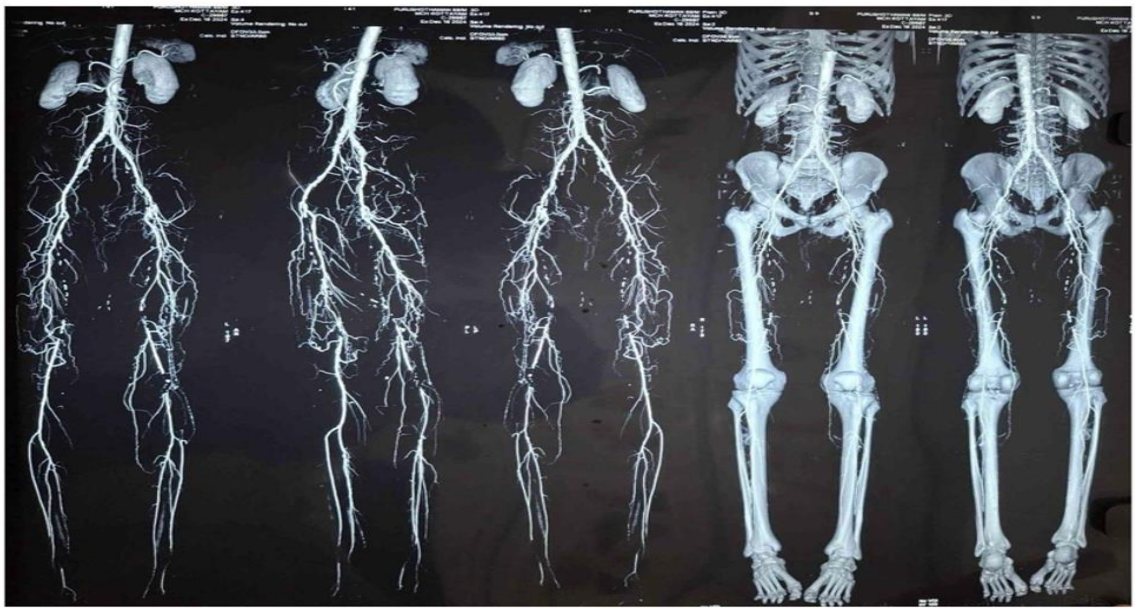
CT –Left lower limb Angiogram		
	Before treatment-2/04/2024	**After treatment-18/12/2024**
Superficial femoral artery	Completely occluded	Reformed flow noted at the region of adductor canal then again occluded for a length of 4.2 cm and again reformed in popliteal fossa
Posterior tibial artery	Terminal artery is completely occluded	Normal
Dorsalis pedis artery	Completely occluded	Normal

CT –Right lower limb Angiogram		
	Before Treatment-2/04/2024	**After treatment-18/12/2024**
Superficial femoral artery	Completely occluded for entire length	Occluded after its origin with reformed flow in adductor canal
Posterior tibial artery	Patent no stenosis	normal
Dorsalis pedis artery	Patent no stenosis	normal

CT- Angiogram Before treatment-2/04/2024



CT- Angiogram -After treatment-18/12/2024



DISCUSSION

Discussion on disease correlation

In Ayurveda the diagnosis of a clinical condition is done by *Nidana panchaka- Nidana, Poorvaroopa, Lakshana, Upasaya-Anupasaya* and *Samprapti* (fivefold diagnostic tool).

Nidana is the cause of the condition, *Poorvaroopa* is the prodromal symptoms, *Roopa* is the symptoms and signs, *Upasayanupasya* is the aggravating and relapsing factors and finally the *Samprapti* which is the probable pathology.

In the present case, the patient had burning sensation of the feet, calf pain during walking, reduced walking distance, coldness of feet, blackish discoloration, hair loss and diminished peripheral pulses. The initial burning sensation can be correlated with *Daha*, while calf pain can be correlated with *Śula* of *Vatarakta*. Coldness, colour change and altered sensation can be correlated with *Śaitya, Tvakvaivarṇya* and *Suptata* respectively. The pain was aggravated by walking and relieved by rest, which is characteristic of intermittent claudication in PAD. The patient also had a long history of smoking, alcohol and cannabis use, which may be considered relevant *Nidana*. In Ayurveda, these factors along with improper diet and excessive physical activity can contribute to *Dosha* and *Rakta dushṭi*. Charaka has explained *Vidahi anna*, virudha anna etc as *Vatarakta nidana*. Here, in this patient, it can be correlated with use of *Madya* and substance abuse etc. Thus, the patient's *Nidana*, *Purvarupa* and *Lakshaṇa* show a clinical correlation with *Utthana Vatarakta*.

The patient had significant arterial stenosis and occlusion on CT angiography, along with absent or feeble peripheral pulses. This can be understood in Ayurveda through *Rakta dushṭi*, *Sira-Dhamanī* involvement, *Srotodushṭi* and *Marga-avaraṇa*, resulting in obstruction to the normal movement of *Rakta* and *Vata*. This provides a conceptual correlation with the modern pathology of atherosclerotic arterial narrowing/occlusion and reduced peripheral blood flow in PAD. The patient's relief with rest and improvement following treatment can be considered under *Upaśaya*, while walking aggravated the symptoms and can be considered *Anupaśaya.* Therefore, the overall clinical picture can be correlated with *Utthana Vatarakta* presenting with peripheral arterial disease, while the two conditions should be considered conceptual correlates rather than identical pathological entities.

Patient-specific *Samprapti*

Long-term smoking + alcohol/cannabis use + *Agni Mandya*

↓

Kapha–Meda dushti and *Rakta dushti*

↓

Sanga / Margavarana in *Dhamani*

↓

Vata avarana and *Vata prakopa*

↓

Dhamani Sankocha + reduced *Rakta pravaha*

↓

Lower-limb ischemic manifestations

→ *Daha*/burning, *Shoola, Toda, Vaivarnya, Sheeta sparsha, Sparsha* and claudication

↓

Utthana Vatarakta

The therapeutic approach can be understood as a combination of *Shodhana, Shamana, Srotoshodhana, Vatanulomana* and *Rasayana* oriented interventions.

Guggulutiktaka Kashaya: Guggulu is an important drug in the management of *Meda Avruta Anila* due to its *Anabhishyandi, Snigdha* and *Srotoshodhana* properties. Its Ayurvedic actions can be understood as *Kapha Meda hara, Lekhana* and removing *Srotorodha/Margavarana*. Pharmacological studies on *Commiphora wightii* have reported anti-inflammatory and lipid-metabolism-modulating activities, attributed partly to guggulsterones and other terpenoidal constituents. These properties may be relevant to the metabolic and inflammatory components associated with vascular obstruction.

The use of *Kaishora Guggulu* is particularly relevant in *Utthana Vatarakta*. The pathology is *Raktavaha srotorodha* and *Margavarana*, *Kapha Meda kshapana* and *Margavaranahara* is the important therapeutic objective. *Mahatiktaka Ghrita*, being predominantly *Tikta* in nature, can be understood through its *Pitta-Rakta shamana, Shothahara* and metabolic corrective actions. Since chronic vascular inflammation contributes significantly to atherosclerotic pathology, the anti-inflammatory and antioxidant potential of *Tiktarasapradhana* formulations provide a plausible supportive mechanism. The formulation may therefore have contributed to reduction of inflammatory manifestations and correction of *Rakta dushti*.

Manjishtha is *Raktaprasadana* and is having anti-inflammatory property. In *Utthana Vatarakta*, its role can be understood through correction of *Rakta dushti* and reduction of inflammatory manifestations. *Madhuyashtyadi Taila* is indicated in *Vatarakta* and is described in relation to *Vata Pitta Rakta shamana*. Its use during the discharge period may therefore have supported control of pain, inflammation and other

residual manifestations while maintaining the therapeutic effects achieved during the main treatment protocol.

Dhanyamla dhara provide continuous thermal stimulation along with topical exposure to herbal constituents. It produces peripheral vasodilatation and increases local limb blood flow. Evidence from studies of heat-based interventions suggests acute improvement in limb blood flow, while some longe term interventions have reported improvement in functional outcomes such as walking distance.

Abhyanga with *Pindataila* and *Madhuyashtyadi Taila* was administered as part of *Snigdha Sankara Sweda*. Abhyanga produce mechanical stimulation of tissues, promote local circulation and reduce muscular stiffness and pain perception. The accompanying warmth of *Sweda* may further enhance these effects. *Madhuyashtyadi Taila* is *Vata Rakta shamana*.

Virechana with *Sukumara Eranda Taila* was employed as a *Shodhana* procedure. *Snigdha virechana* is specifically indicated in *Vatarakta*. *Virechana* facilitates *Pitta-Rakta shodhana*, elimination of accumulated *Doshas* and correction of *Margavarana*, particularly where *Pitta* and *Rakta* involvement is prominent. In *Utthana Vatarakta*, this reduce *Rakta dushti* and *Dosha* accumulation and thereby support restoration of the normal movement of *Vata*.

Vasti is an important therapeutic modality for *Vata* disorders. Its actions are traditionally understood through *Vatanulomana*, *Vata-shamana* and *Srotoshodhana*. *Mustadi Rajayapana Vasti* additionally contribute through *Brimhana* and *Rasayana* effects. In a chronic vascular condition associated with impaired tissue nutrition and functional limitation, these actions support tissue nourishment, functional recovery and maintenance of tissue integrity, particularly following the *Shodhana* phase.

Siravyadha was performed at the end of the treatment protocol as a form of *Raktamokshana*. It is intended to remove vitiated *Rakta* and relieve pathological obstruction associated with *Rakta dushti*.

Guduchi Rasayana

Guduchi is directly mentioned in *Vatarakta chikitsa* and it is having *Rasayana* action. *Guduchi* possesses *Tikta Rasa, Madhura Vipaka* and *Ushna Veerya* and is described as *Vatahara, Rakta prasadaka* and capable of alleviating *Shleshma-Rakta vibandha*. The *Tikta Rasa* of *Guduchi* supports *Jatharagni Deepana* and *Lekhana*, thereby facilitating the removal of *Ama* and *Srotorodha*. *Guduchi* is *Pitta shamana* because of *Madhura Vipaka*, which cause reduction in manifestations such as *Raga* and *Daha*. Its overall *Tridosha shamaka, Raktashodhaka* and *Rasayana* properties have provided systemic support during treatment.

Guduchi (*Tinospora cordifolia*) contains several bioactive constituents, including alkaloids, diterpenoid lactones, glycosides, steroids, phenolics, flavonoids and polysaccharides**,** with important constituents such as berberine, tinosporin, cordifolide and cordifol. These constituents are reported to possess anti-inflammatory, antioxidant and immunomodulatory activities**,** which may help reduce inflammatory changes and oxidative stress associated with vascular pathology.

These properties make it relevant in conditions involving *Vata Rakta avarana* and *Margavarana*, without irritating the vitiated *Vata* and *Rakta*. *Virudhopakramatwa* (therapeutic contraindication) is the major serious issue while managing an *Avaranaroga* especially *Vata* and *Pitta*. (*Rakta* is the *Asrayasrayi datu* of *Pitta*). *Guduchi* is said as the *Agryoushada* (best drug of choice) because of these properties, which pacifies the *Avarana* and *Avrita dosha* in *Vatarakata*. And is a *Rasayana.*

Even though the exact application of *Guduchi rasayana* is not well mentioned in classical texts, from the advice from experienced clinicians *Arohana matra Krama* is selected for this case. Because of the difficulty in measuring the fresh *Satwa*, the weight of fresh *Guduchi* was taken for daily dosage schedule.

Satwa is an ancient natural mode of taking extract/essence from a fresh medicinal plant, which maintains the entire chemical constituents in the drug. Freshly prepared and no added preservatives. The nano particles in *Satwa* will easily be absorbed and metabolised.

In the present context, its probable role can therefore be interpreted as correction of *Rakta dushti* and *Sookshma* and *Sthoola srotosudhi*, although this should not be equated with mechanical removal of atherosclerotic pathology.

CONCLUSION

The treatment protocol represents a multimodal Ayurvedic approach, incorporating *Shamana, Shodhana, Abhyanga, Swedana, Vata-anulomana, Rasayana* and *Raktamokshana chikitsa*. The internal medicines, particularly the *Guggulu, Guduchi* and *Tikta-rasapradhana oushadis* address the metabolic, inflammatory and oxidative components associated with vascular pathology through *Kapha-Meda shamana, Lekhana, Srotoshodhana, Pitta-Rakta shamana* and *Rasayana* actions. The external procedures may primarily contribute to local circulation, reduction of pain and stiffness, improved tissue function and functional mobility. The sequential use of *Shodhana* followed by *Vasti*, local therapies and *Siravyadha* done to address both systemic *Dosha Rakta Meda* involvement and local manifestations of *Margavarana/Utthana Vatarakta.* Thus, the therapeutic effect of the protocol is best understood as

the combined contribution of systemic metabolic and inflammatory modulation, correction of *Srotodushti* and *Margavarana*, symptomatic relief, and improvement of local tissue function.

Patient Perspective

The patient reported that his symptoms had significantly affected his walking, occupational activities and routine life. Although surgery was advised following vascular evaluation, he preferred Ayurvedic IP management. During treatment, he experienced gradual improvement, with complete relief of burning sensation and reduction in pain during walking. His pain-free walking distance increased from approximately 150m to 500m. He also noticed improved limb temperature and mobility, which facilitated his daily activities and work. Overall, he expressed satisfaction with the improvement experienced during the treatment period.

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