



Case Study

THERAPEUTIC EFFICACY OF MANDURA BHASMA AND ROHITAKARISHTA IN SEVERE ANEMIA: A CLASSICAL AYURVEDIC APPROACH

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ABSTRACT

Severe anemia remains a major public health issue among children, particularly in low-resource settings. Iron deficiency is the most common cause, and while conventional iron supplements are effective, they often cause gastrointestinal side effects and poor compliance. Ayurveda offers traditional remedy for anaemia, with historical usage in paediatric cases. **Aims:** To evaluate the therapeutic role of *Mandura Bhasma* and *Rohitakarishtha* in improving hemoglobin levels and clinical symptoms in a child with severe anemia. **Materials and methods:** A 10-year-old child presented with symptoms of pallor, fatigue, and reduced appetite. Laboratory investigations revealed severe anemia. After ruling out hemolytic and malignant causes, a treatment regimen including *Mandura Bhasma*, *Rohitakarishtha* and iron-rich dietary recommendations was initiated. In between time, continuous monitoring of hemoglobin, iron profile levels and clinical improvement noticed. **Results:** By the end of the treatment period, the child's haemoglobin level increased significantly. Clinically, there was drastic improvement in energy levels, appetite, and overall well-being. No adverse effects were reported throughout the intervention. **Conclusion:** This case suggests that *Mandura Bhasma* and *Rohitakarishtha* in combination with Ayurvedic supportive therapies, can be a safe and effective approach in the management of severe anaemia in children. Further controlled studies are recommended to substantiate these findings and standardize paediatric dosing guidelines.

INTRODUCTION

Anemia, particularly Iron Deficiency Anemia (IDA), is one of the most prevalent nutritional disorders affecting children globally. It is estimated that nearly 50% of children under the age of 5 in developing countries are anemic, with iron deficiency being the leading cause. IDA in children results from inadequate dietary intake of iron, poor absorption, increased physiological demands during growth, or chronic blood loss due to infections or parasitic infestations. Clinically, it manifests as pallor, fatigue, irritability, poor concentration, decreased physical endurance, and delayed growth and development.

Pandu Roga in children is a well-recognized condition in *Kaumarbharitya Balrog*. This case report presents the clinical outcome of administering *Mandura Bhasma* and *Rohitakarishtha* in a 10 years old child diagnosed with severe iron deficiency anaemia. The purpose of this report is to explore the integrative potential of Ayurvedic interventions in managing pediatric anaemia, highlight the conceptual parallels between *Pandu Roga* and IDA, and suggest a need for further evidence-based research to validate traditional therapies in modern clinical settings.

Anemia in children

When the blood hemoglobin level is two standard deviations below the average for the given age and sex, it is referred to as anemia. Anemia is defined physiologically as a condition in which tissue hypoxia results from insufficient blood oxygen carrying capacity. The incidence of anaemia in children is 55.9% in urban areas, 59.4% in rural areas, and 58.4% in total, according to data from the National

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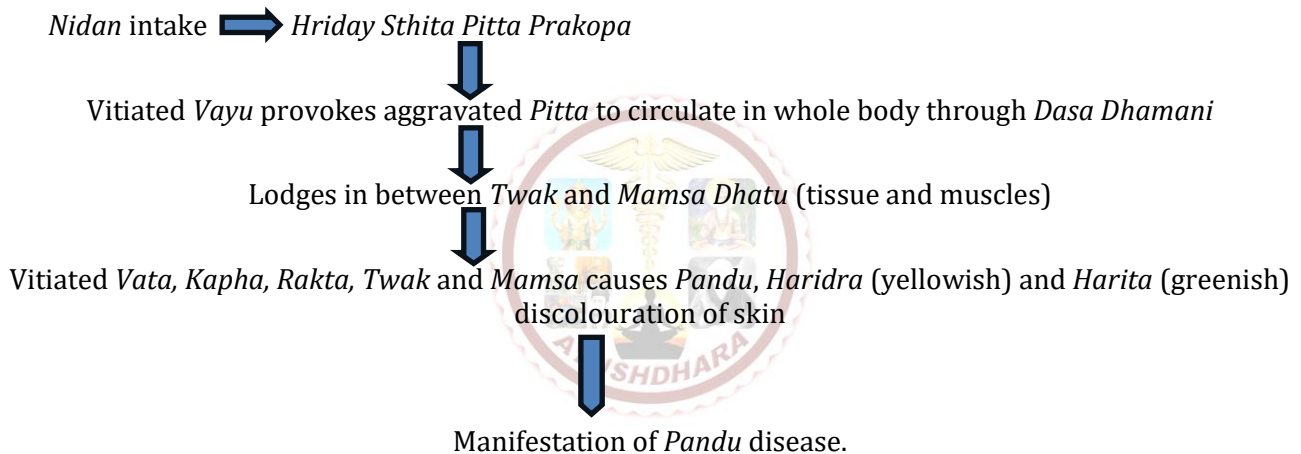
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Family Health Survey (NFHS-4). The hemoglobin level at which symptoms of anemia develop depends on two factors, the rate of development of anemia and state of the cardiovascular system.

Iron deficiency anemia:¹³ When the body's total iron concentration is low enough to maintain erythropoiesis and result in anemia, it is known as iron deficiency anemia. Iron deficiency may be caused by excessive bodily iron loss or decreased proximal small intestinal absorption of dietary iron. Dietary history, including excess cow milk consumption, weaning foods, and supplementation, is crucial. Pica (geophagia) raises the possibility so also lead poisoning and infections. In cases of severe iron deficiency anemia, angular stomatitis, glossitis, koilonychia (spoon shaped nails), are observed. Hookworm infestation is one of the commonest causes of anemia in childhood ages, that is why history of deworming is very important.

Samprapti¹¹



Mrityika Bhakshanaja Pandu¹¹ (Anemia due to PICA)

Child indulge in habitual consumption of soil → aggravation and vitiation of Doshas

Mrityika having Kashaya Rasa (astringent taste)-Vata Prakopa
 Ushara Rasa (salty taste)-Pitta Prakopa
 Madhura Rasa (sweet taste)-Kapha Prakopa

Due to Ruksha Guna of Mrityika, Agnimandya (indigestion) of Dhatus develops which leads to Srota Avarodha (obstruction of channels)

This causes impairment of: Indriya (sensory organs), Bala (strength), Teja (vitality), Virya (potency) and Oja (essence of all tissue or immunity)

Occurrence of the following consequences: Bala-Varna-Agni Nasha, swelling of cheek-eyes-umbilicus-legs-scrotum, manifestation of diarrhoea mixed with kapha and Rakta.

Pandu in Ayurveda¹¹ In the context of Ayurveda, a condition analogous to anaemia is described as *Pandu Roga*. The term *Pandu* denotes paleness or discoloration of the skin, which is one of the hallmark features of this disorder. Classical Ayurvedic texts, including *Charaka Samhita* and *Sushruta Samhita*, describe *Pandu* as a disease arising primarily due to the vitiation of *Pitta dosha* and impairment of *Agni* (digestion power), leading to improper digestion and assimilation of nutrients. This ultimately affects the formation of *Rasa* (plasma or tissue fluid) and *Rakta dhatus* (tissues), resulting in development of *Pandu*. *Pandu* is a predominantly *Rasa Pradoshaja Vikara*. There are various etiology mentioned in classical texts for *pandu* such as *Aaharaja Nidan* (dietary factors), *Viharaja Nidan* (lifestyles) and *Manasik Nidan* (psychic or mental factors).

Case History

A 10 years old child, resident of Sasaram, Bihar came in Kaumarbharitya Balrog OPD on 13/05/25 of Sir Sunderlal Hospital BHU with complain of: Reduced appetite (on/off) since last 3 months, fever (low grade) without chill/rigor on/off since last 3 months and Pain in both calf muscle on/off since last 2 months.

Child visited pediatric medicine OPD of AIIMS, Patna on 15/04/25 where preliminary investigations done to evaluate and diagnose the disease. Injectable broad-spectrum antibiotics and 2-unit PRBC transfusion done on 04/05/25. Anemia (Hb-4.1g/dl) was corrected (Hb-5.1g/dl) but no such improvement in symptoms noticed by parent.

Past history

No history of any trauma, bleeding, surgery. No history of malaria, dengue, typhoid. No any chronic illness.

Treatment history

Child took oral amoxicillin Clavulanic acid tab for 7 days, tab Paracetamol SOS, tab albendazole 2 doses and an oral iron supplement 20 days ago of visit in BHU, consulting in OPD of AIIMS, Patna.

Diet history

Child is on mix diet (veg and nonveg), ground water, outside junk food and cow milk intake. History of pica (non-edible or nonnutritive objects like soil, chalk) since last 3 months.

Family history

No any history of familial hypertension, diabetes mellitus, thyroid dysfunction. But his elder sister also has complaint of iron deficiency anaemia.

Table 1: personal history

Title	Before disease manifestation	After disease manifestation
Appetite	Normal	diminished
Sleep	Regular	Disturbed, irregular
Urine	Normal (6-8 times/day)	Normal (6-8 times/day)
Stool	Normal (yellowish, semisolid without foul smell and mucus)	Normal (yellowish, semisolid without foul smell and mucus).

Personal history reveals decreased appetite, disturbed sleep and history of PICA

Table 2: General examination:

Title	Findings
General condition	Fair
Sensorium	Conscious, well alert
Temperature	Afebrile (98.6 degree)
Pallor	+++
Icterus	absent
Cyanosis	absent
Clubbing	absent
Oedema	absent
Rashes	Absent, no any petechiae
Koilonychia (spoon shaped nails)	+
Lips	No any cheilosis and angular stomatitis
Tongue	Geographic tongue, coated

General exam reveals significant findings like geographic coated tongue, pallor, spoon shaped nails.

Table 3: Systemic examination

Gastrointestinal system in details has been explained in TABLE-3 below-

System	Inspection	Palpation	Percussion	Auscultation
GI system	No visible scar mark, No any superficial vein. shape flat, inverted umbilicus.	Superficial palpation No any rigidity or muscle guarding. No any rebound tenderness. Deep palpation Liver 5cm enlarged, smooth, soft, nontender, regular. Spleen: 4.5cm enlarged, hard, regular, Nontender.	No any fluid thrill. No any shifting dullness. Dull note at right and left hypochondrium.	Normal bowel sound audible.

Most obvious findings noted in this case in GI system by inspection, palpation, percussion and auscultation are mentioned; hepatomegaly, splenomegaly significant of all.

Cardiovascular system: mid systolic grade 2, hemic murmur, Tachycardia (HR-130/min)

Respiratory system: normal vesicular breath sounds, bilateral equal air entry, no any added sound.

Central nervous system: child is conscious, alert, oriented to person-place-time.

All the relevant laboratory parameters were conducted in SSH, BHU is mentioned herby-

Table 4: Investigation

Parameter	13/05/25	17/05/25	20/05/25
Complete blood count	TLC-3600 DLC- N ₄₀ L ₅₆ M ₀₃ E ₀₁ B ₀₀ Hb-5.1g/dl PLT-50000	TLC-4200 DLC- N ₃₅ L ₆₀ M ₀₃ E ₀₂ B ₀₀ Hb-5.5g/dl PLT-93000	TLC-3370 DLC- N ₃₅ L ₅₁ M _{5.3} E _{6.5} B _{0.7} Hb-6.3g/dl PLT-107000
Recti count	4%		
Peripheral blood smear	Hypochromic microcytic anemia with severe thrombocytopenia, mild leukopenia and relative lymphocytosis (pancytopenia)	RBC-mild anisocytosis, poikilocytosis with normocyte, microcyte, macrocyte, target cells, fragmented cells, elongated cells, tear drop cells. WBC- TLC within normal limit range. DLC -N ₅₄ L ₄₀ E ₀₃ M ₃ B _{0.3} Platelet lower side of normal range. No hemoparasites.	Microcytic hypochromic with moderate thrombocytopenia and relative lymphocytosis.
Serum copper		169.10 ug/dl	
Serum IRON	21.07 ug/dl		
Serum TIBC	UIBC- 610.93ug/dl TIBC- 632 ug/dl		
Stool occult blood test	Negative		
Urine RM	WNL		
Serum folate		14.1 ng/ml	
Serum vitamin b 12		305 pg/ml	
USG whole abdomen	Mild hepatosplenomegaly		

After admission, all the relevant diagnostic tests were done like complete blood count, recti count, peripheral smear, RBC indices, iron profile, inflammatory markers, serum copper, vit B12, folic acid, sonography whole abdomen, even bone marrow aspirate for provisional diagnosis

Bone marrow aspirate

After taking written consent, this BMA procedure was done at Kashyap ward of SSH BHU on 19/05/25. Findings are: Cellularity- insignificant, erythroid series- normoblastic maturation, myeloid series-no any blast cells, megakaryocytes-not seen. Bone marrow biopsy needed for final conclusion.

Table-5: therapeutic intervention and diet

From 13/05/25(day of admission) to 21/05/25(day of discharge): oral medications and diet are described here-

Day	Treatment	Diet
Day 1	<i>Mandura Bhasma</i> 200mg (after meal) BD with citrus fruit juice. Syrup <i>Rohitakarishtha</i> 5ml TID (after meal). Syrup multivitamin 5ml BD	Iron rich diet (organic vegetables, spinach, <i>Chana</i> , <i>Guda</i> , beans, citrus fruit, dates, nuts).
Day 2 to day 8	Same treatment	Same diet

During 9 days of admission, iron rich diet advised along with oral medications like *Mandura Bhasma* 200 mg twice a day with citrus fruit, syrup *Rohitakarishtha* 5 ml thrice a day and multivitamin syrup 5ml twice a day prescribed.

From the very onset of disease to getting discharge from SSH, BHU, all the events summarized below-

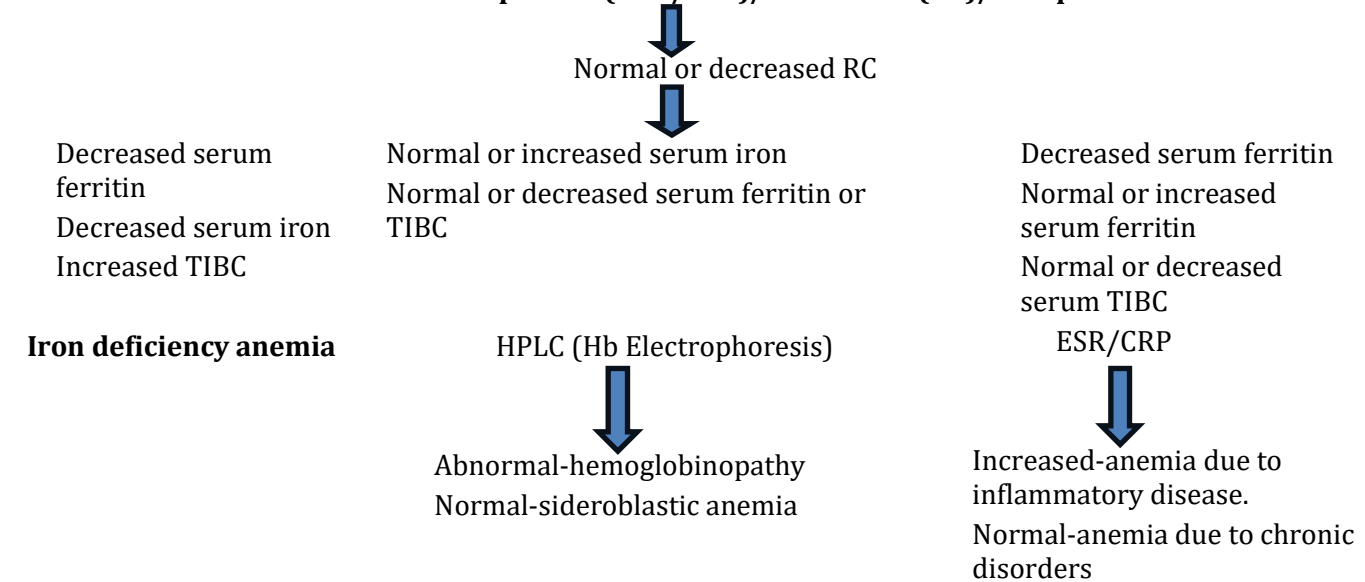
Table 6: Timeline

15/02/25	child has complaint of fatiguability, reduced appetite, low grade fever on and off, pain in bilateral lower leg since last 2 weeks.
20/02/25-10/03/25	Child taken oral antibiotic (tab cefixime), oral antipyretic (syrup paracetamol and mefenamic acid), syrup multivitamin consulting with private doctor for 2 weeks but not got significant improvement.
11/03/25-30/03/25	Parent was worried and visited local govt hospital where injectable antibiotic, intravenous fluid given for 7 days without any primary investigation.
10/04/25-01/05/25	After not getting much relief in fever, pain in leg and diminished appetite, parent went to AIIMS, Patna, pediatric OPD on 10/04/25. After doing preliminary investigation, oral antibiotic, iron supplement, multivitamin given. parent was told to admit the child for further investigation, procedure, management and diagnosis. Pt was admitted for 7 days where IV antibiotics, IV fluid and 2 unit PRBC transfusion done and bone marrow aspirate was planned but attendant refused to do.
13/05/25	Child visited <i>Kaumarbhritya Balrog</i> OPD of SSH BHU on 13/05/25 without any improvement in fever, reduced appetite and pain in calf muscle. After detail history taking and clinical examination, it was decided for admission.
13/05/25-20/05/25	Child admitted in IPD of Kashyap ward for 8 days.in this period, <i>Mandura Bhasma</i> 200mg twice a day, syrup <i>Rohitakarishtha</i> 5ml thrice a day, syrup multivitamin 5ml twice a day given along with iron rich diet. All the investigation for diagnosis was done including bone marrow aspiration procedure was performed.
21/05/25-31/05/25	After discharge pt was under follow up for 11 days. Improvement in clinical symptoms as well as in laboratory findings noticed.

Disease onset since 15th February to follow up of 10 days after admission for 9 days: all the events, disease progress, treatment, medications, prognosis, improvement mentioned.

Diagnosis: (flowchart-1) Approach for diagnostic algorithm^[13]

General blood picture (GBP/PBS)/recti count (RC)/iron profile



Diagnostic algorithm to exclude other probable cause of anemia and for differential diagnosis purpose, this approach of flowchart is followed.

SOURCE: Ghai OP, Paul VK, Bagga A. Ghai Essential Pediatrics.9th ed. CBS Publishers & Distributors; latest edition

On basis of history, clinical findings (table-2, table-3) and laboratory investigations (table-4) the case is diagnosed IDA provisionally. After excluding all probable causes and performing related investigations to justify differential diagnoses (flowchart-1), it was concluded as a cause of severe graded IDA.

Result

- Patient, diagnosed as severe anaemia of iron deficiency, after taking medications for 8 days on IPD basis noticed improvement in both clinically and investigation.
- No any fresh complain developed in this time period like rashes, pain abdomen, bleeding disorder, allergic reaction etc.
- No post treatment complication developed and more over quality of life improved in patient.

Figure 3: Reduction in hepatomegaly after treatment



Before treatment live size was 5cm whereas after treatment it reduced to 2.5cm

Figure 4: Reduction in splenomegaly after treatment



Before treatment spleen size was 4.5cm palpable whereas after treatment it was 3cm palpable.

After 8 days of IPD treatment, there was improvement in clinical as well as laboratory findings which is mentioned hereby (table-7)

Table 7: Result and improvement in clinical and lab reports before and after treatment

Criteria/findings	Before admission	At 9 th day of discharge
Appetite	Poor, diminished	Increased oral intake
Pain in calf muscle	++	absent
fever	Afebrile	Afebrile
Tachycardia/palpitation	++	No any audible murmur
Hepatomegaly	5 cm, nontender (figure-3)	2.5cm, nontender (figure-3)
Splenomegaly	4.5 cm, nontender (figure-4)	3.0cm, nontender (figure-4)
Pallor	+++	+
General weakness	fatigue	Active, playful
Hemoglobin %	5.1g/dl (figure-1)	8.7g/dl (figure-2)

Improvement in clinical findings (appetite, calf muscle pain, palpitation, murmur, hepatosplenomegaly, pallor and general weakness) and lab findings (RBC Indices and hemoglobin %) before and treatment of 9 days.

DISCUSSION

Anemia in childhood age group is very common entity now a days because of taking pica, injudicious use of cow milk beyond infantile age without introducing complimentary diet to child, malnutrition, behavioural disorder and many more. Frequent use of oral iron supplementation to cope up anemia leads to develop GI disturbances in children. *Pandu* especially *Mrittika Bhakshanaja Pandu* which can be said as anemia due to pica or nonedible objects) is mentioned in our Ayurveda classics in details with proper pathogenesis, clinical features and management.¹¹

Mandura is mentioned in classics in various formulations like *Mandura Bataka*, *Punarnavadi Mandura*, *Navayas Lauha* etc for treating *Pandu*.¹¹ *Mandura Bhasma* mentioned specially in *Rasa Ratna Samucchay* (chapter 5 *Dhatu Vijnana*)¹⁰ and *Rasa Tarangini* (chapter 21 *Lohavada*).⁹ Pharmacological property of *Mandura Bhasma*⁸: *Rasa* (taste)-*Tikta* (bitter), *Kashay* (astringent). *Guna* (properties)-*Laghu* (light), *Ruksha* (dry). *Virya* (potency)-*Ushna* (hot). *Vipaka* (taste after digestion)-*Katu* (pungent). *Dosha karmata*-*Raktavardhaka* (hematinics), *Yakritpleeha hara* (destroyer of live and splenic disorder), *Pandughna* (improve anemia), *Deepana* (appetizer). Active ingredients-Elemental iron (Fe^{3+} and Fe^{2+}), Ferric oxide (Fe_2O_3), Small amounts of trace minerals. *Mandura Bhasma* typically contains approximate 40–45% elemental iron (mostly present as iron oxides: $\text{Fe}_2\text{O}_3/\text{Fe}_3\text{O}_4$) when prepared according to classical Ayurvedic methods.⁵ In vitro and in vivo study of *Mandura Bhasma* shows its efficacy in iron deficiency anaemia,¹ which is established by XRD, Scanning electron microscopy and Atomic Absorption Spectroscopy (AAS) study in various research study.²

Significant reduction in the particle size to 200–300 nm was observed in prepared *Bhasma* which can absorb and assimilate in small intestine more easily.³ *Maṇḍura Bhasma* maintained normal villous structure and intestinal enzyme activity, suggest that it may serve as a safer and effective alternative hematinic, especially where gastrointestinal tolerance is a concern.⁴

Rohitakarishtha, another classical formulation mentioned in *Bhaisajya Ratnabali* (chapter 41-*Pleehayakrt Rogadhikar*) also used in hepatosplenic disorder, jaundice etc. Main ingredient is *Rohitaka*.¹²

Pharmacological property of Rohitaka (*Tecomella Undulata*)¹²: *Rasa* (taste)- *Tikta* (bitter), *Kashaya* (astringent). *Guna* (properties)- *Laghu* (light), *Ruksha* (dry). *Virya* (potency)- *Ushna* (hot), *Vipaka* (taste after digestion) (pungent). *Doshakarmata*: *Yakritpleehahara* (destroyer of live and splenic disorder), *Krimighna* (antimicrobial), *Deepana* (appetizer), *Shothahar* (decrease swelling). In vitro study shows the active ingredients like flavonoids, gallic acid, tecomalloside, beta sitosterol etc can effective in reducing inflammation, oxidative stress and hepatocyte dysfunction by reducing level of malondialdehyde.⁶ *Rohitakarishtha* significantly mitigated elevated serum enzymes (AST, ALT, ALP), bilirubin, and histological liver damage-comparable to silymarin, the standard hepatoprotective agent in animal model.⁷

In our classical references, *Chikitsa sutra* (plan of management) of *Pandu* has been mentioned as *Mridu panchakarma* like *Vamana* (emesis) and *Virechana* (purgation) with *Snigdha* and *Tikshna* drugs. *Acharya charaka* mentioned various formulations for *Pandu* like *Navayas lauha*, *Punarnavadi mandoor*, *Silajatu vataka*, *Haridradi Ghrta*, *Vijakarishtha* and many more which are beneficial. In *Charaka Samhita*, *Mrittika bhakshanaja pandu* and its management also explained as use of *Vyoshadya ghrta*, *Kesaradya ghrta*.

To create aversion of PICA or habit of taking non edible objects, use of *Vidanga, Ela, Ativisa, Neem, Patha, Katurohini, Murva* herbs mixed with clay and given to child.

In this case report, we significantly observed drastic improvement using *Mandura Bhasma* and *Rohitakarishtha* in severe IDA along with use of iron rich diet.

CONCLUSION

From this case study, it is concluded that severe IDA can be managed by classical *Ayurvedic* interventions like *Mandura Bhasma* and *Rohitakarishtha* in appropriate classical dosages along with proper diet without any noted adverse effects or complication. Though in modern medicine, oral iron supplementation and blood transfusion remains only way of treatment, but it can be managed by Ayurvedic intervention keeping mind the economic burden.

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