AYUSHDHARA
ISSN: 2393-9583 (P)/ 2393-9591 (O)
An International Journal of Research in AYUSH and Allied Systems

Case Study

AYURVEDIC MANAGEMENT OF GUILLAIN-BARRE SYNDROME

Shrilatha Kamath T[1], Athira C K[2]*
[1]Professor and Head, *[2]PG Scholar, Department of PG & PhD Studies in Kayachikitsa, Shri Dharmasthala Manjunatheshwara College of Ayurveda, Hospital and Research Centre, Udupi, Karnataka, India.

Article info
Article History:
Received: 10-05-2026
Accepted: 18-06-2026
Published: 06-07-2026
KEYWORDS:
Guillain–Barre Syndrome, Acute Motor Axonal Neuropathy, *Sarvanga Vata, Vatavyadhi.*

ABSTRACT
Guillain–Barre syndrome is an acute autoimmune disorder affecting the peripheral nerves, often triggered by preceding infections. The condition typically begins with tingling or numbness in the extremities, followed by progressive motor weakness. In severe cases, involvement of autonomic functions affecting speech, swallowing, respiratory and cardiac activity may occur, which can be life-threatening. Timely initiation of appropriate therapy can greatly shorten the disease course and minimizing the potential for chronic disability. This case report presents the Ayurvedic management of a patient diagnosed with Guillain–Barre Syndrome, acute motor axonal neuropathy variant. The condition was clinically assessed as *Sarvanga Vata*, and a therapeutic approach was planned according to the treatment principles of *Vatavyadhi*, including *Rukshana*, *Snehana*, *Shodhana*, and *Shamana Chikitsa*. The patient achieved significant functional and symptomatic improvement within a short duration.

INTRODUCTION
Guillain-Barre Syndrome (GBS) is a heterogeneous group of immune-mediated conditions involving acute inflammation of the peripheral nerves. The disease is characterized by distal paresthesia and pain, which commonly precede the onset of muscle weakness that often ascends from the lower to the upper parts of the body.[1] Progressive symmetrical weakness with areflexia or hyporeflexia of deep tendon reflexes is the key diagnostic criterion of the disease. The weakness develops abruptly and usually reaches its peak within four weeks of onset. Although the exact cause remains unclear, GBS is frequently preceded by an infectious illness such as a respiratory or gastrointestinal infection. The immune system, activated by these triggers, targets components of peripheral nerves or their myelin sheaths, resulting in impaired nerve conduction.[2] Guillain–Barre Syndrome encompasses several subtypes, each defined by distinct patterns of peripheral nerve involvement. These include demyelinating forms, axonal variants, and mixed motor-sensory types, which differ in progression, severity, and prognosis. GBS occurs worldwide with an overall incidence rate of 1–2 cases per 100,000 people per year. Dysfunction in the autonomic system occurs in approximately 70% of patients and mortality, or severe disability due to GBS, occurs in around 20% of patients.[3]

In the present study, GBS can be correlated with *Sarvanga Vata*.[4] *Vatadushti* can occur due to primary increase in *Vata* alone or due to the involvement of other *Doshas* and *Dhathus.* State of *Vata* can be *Saama* or *Nirama,* with pathological staging as *Avarana, Anubandha Doshaja* or *Kevala Vataja.* By assessing these factors, the treatment was planned in accordance with the principles of *Vatavyadhi Chikitsa.*

Case Report
A 50-year-old female patient presented with weakness of bilateral lower limbs associated with cramping pain for the past one month. She had been unable to stand or walk during this period. She also reported abdominal pain, irregular bowel movements, and occasional episodes of vomiting and nausea for 2 weeks.

Access this article online
Quick Response Code
https://doi.org/10.47070/ayushdhara.v13i3.2394

The patient had a history of febrile illness accompanied by cough and sputum approximately one and a half months prior, which persisted for 5-7 days. After two weeks, she developed sudden-onset of bilateral lower limb weakness, which progressively worsened and was associated with difficulty in swallowing. At the previous hospital, nerve conduction studies confirmed Guillain–Barre syndrome, acute motor axonal neuropathy (AMAN) variant, and she underwent five cycles of plasmapheresis. Enteral nutrition was initiated through a Ryle's tube.

One week later, the patient developed productive cough and respiratory distress, requiring intubation and BiPAP support. Her respiratory condition subsequently improved. She was transitioned to a face mask, which was removed once normal oxygen saturation on room air was maintained. Later, the Ryle's tube was removed, and she was able to resume oral feeding. Severe pain and weakness of the lower limbs persisted. Despite one week of physiotherapy and supportive treatment, no improvement was observed. Over the following two weeks, she experienced abdominal pain, irregular bowel movements, and occasional episodes of vomiting and nausea. The patient was referred to Shri Dharmasthala Manjunatheshwara Ayurveda Hospital, Udupi, on 19th May 2025 for further management.

On admission, the patient was afebrile, with a pulse rate of 86/min and blood pressure of 110/60 mmHg. Pallor was observed on general examination. Respiratory and cardiovascular examinations were within normal limit. Abdominal examination revealed tenderness over the umbilical and hypogastric regions. Neurologically, the patient was conscious, alert, oriented and no memory impairment was noted during examination. Patient remained bedridden. Muscle strength was Grade 4 in both upper limbs and Grade 0 in both lower limbs. Flaccidity was noted in the bilateral lower limbs. Deep tendon reflexes were absent in the lower limbs and hyporeflexia in the upper limbs. Cranial nerve examination was normal. Superficial reflexes, including abdominal and plantar responses, were preserved, and sensory examination demonstrated no deficits across modalities such as touch, pain, temperature, vibration, and proprioception.

Dashavidha Pariksha showed *Vata-Pitta Prakriti* with *Avara Ahara* and *Jarana Shakti*. A detailed evaluation of the patient's history, presenting symptoms, and clinical findings indicated the *Samprapti* of *Vata Dushti* due to *Kaphavarana.* The presence of *Avaraṇa* is considered as contributing factor to the severity and rapid progression of motor deficits.

Intervention

Table 1: Intervention

On admission	
Procedures	**Duration**
Dhanyamladhara	3 days (20/5/25-22/5/25)
Dashamula Kashaya Parishekha	7 days (20/5/25-26/5/25)
Alepa	4 days (23/5/25-26/5/25)
Matrabasti with *Sukumara Ghrita*	2 weeks (25/5/25-7/6/25)
Sarvanga Taila Seka with *Mahanarayana Taila* f/b *Shastikashali Pinda Sweda*	7 days (27/5/25-2/6/25)
Sarvanga Mridu Abhyanga with *Mahanarayana Taila* f/b *Shastikashali Pinda Sweda*	5 days (3/6/25-7/6/25)
Oral medications	**Dosage**
Avipattikara Churna with lukewarm water	5 gm HS (20/5/25-24/5/25)
Sutashekhara Rasa	2 TID B/F (20/5/25-7/6/25)
Rasaraja Rasa	1 TID A/F (27/5/25-7/6/25)
Guduchi Satwa(50g) + *Abhraka Bhasma*(1g)	2.5gm BD A/F (29/5/25-7/6/25)
Swarna Malini Vasanta Rasa	1 TID A/F (29/5/25-7/6/25)
On discharge	
Advised to continue same oral medication for 1 month	

RESULTS

Pre- and post-treatment assessments were conducted using muscle strength evaluation,[5] the Hughes Disability Scale,[6] and symptomatic changes to monitor patient improvement.

Table 2: Assessment of muscle strength and disability scale before and after treatment

		Before Treatment	After Treatment
Muscle Strength	Bilateral upper limb	4/5	5/5
	Bilateral lower limb	0/5	4/5
Hughes Disability Scale		4/6	3/6

Table 3: Symptomatic changes before and after treatment

Symptoms	Before Treatment	After Treatment
Functional mobility	Bedridden	Walking with support
Pain in the lower limbs	Severe	Reduced
Bowel movement	Irregular, manual evacuation was required intermittently.	Regular
Abdominal pain	Severe	Absent
Nausea and vomiting	Occasional	Absent

DISCUSSION

The clinical findings were consistent with the diagnosis of *Sarvanga Vata.* Management was initially focused on *Kaphavarana*, and once *Vata* was relieved of *Avarana,* the treatment was shifted to *Kevala Vatahara Chikitsa.*

In the initial phase, interventions such as *Dhanyamladhara*, *Dashamula Kashaya Parisheka*, and *Alepa* were administered. All of these procedures fall under the category of *Rukṣhana karma*, which is effective in managing *Kaphavarana* condition. The *Dhanyamla, Dashamula*, and *Lepa Dravyas* such as *Kshudra Agnimantha, Vanatulasi, Parpataka, Lashuna, Lavanga* etc have *Vata-Kaphahara* action, contributing to the removal of obstruction, and restoring the normal function of *Vata.*

After resolving *Avarana*, *Kevala Vatahara Chikitsa* was initiated using *Taila Seka*, *Shashtikashali Pinda Sweda, Abhyanga,* and *Matrabasti*. *Mahanarayana Taila* was selected for *Taila Seka* and *Abhyanga* due to its *Vedanahara*, *Balya*, and *Vata-Kapha Shamana* properties.[7] *Sukumara Ghrita*, administered through *Matrabasti* promotes gastrointestinal health, thereby relieving, abdominal discomfort, and colicky pain, which were frequent complaints of the patient. The therapeutic action of *Basti* is achieved through the penetration of the administered *Dravya* through the intestinal epithelium, with its phytochemicals absorbed into systemic circulation.[8] *Shashtikashali Pinda Sweda* involves the use of boluses prepared from *Shashtikashali, Balamoola*, and *Ksheera*. It is a *Snigdha Sweda* and possesses *Brmhana* action. All these interventions improve muscle tone and enhance muscle strength by nourishing the *Dhatus*.

Sutashekhara Rasa[9] and *Avipattikara Churna* [10] have a significant role in *Agnideepana* and *Amapachana. Sutashekhara Rasa* exhibits *Shulaghna* action, and also reduces *Hrillasa* and *Chardi*. *Avipattikara Churna* possesses *Virechana* effects, aiding in the elimination of aggravated *Doshas* and facilitating *Vatanulomana.*

Rasaraja Rasa is a herbomineral preparation which is made from the combination of *Tikta-Kashaya rasa, Sheeta virya* and *Madhura vipaka dravyas*.[11] It promotes muscle strength and functional recovery through its *Vata shamana, Balya,* and *Rasayana* actions. *Swarna Malini Vasanta Rasa* contains *Swarna Bhasma, Mouktika Bhasma, Kharpara Bhasma, Hingula and Maricha*.[12] It exhibits *Nadi Balya* and *Dhatwagni Vardhana* effects there by enhances neuronal signaling and exerts systemic benefits across multiple physiological domains. *Guduchi* possesses *Rasayana*, and *Tridoshahara* properties.[13] It has potent effects in post-infectious conditions, helping reduce inflammatory responses and modulate the immune system. *Abhraka Bhasma* is *Sarvarogahara*, *Balya* and *Rujahara*.[14] The immunomodulatory action of *Abhraka Bhasma* [15] helps in the recovery of GBS by restoring immune homeostasis and limiting immune-mediated nerve injury.

CONCLUSION

Guillain–Barre Syndrome is a rapidly progressive autoimmune neuropathy with potentially life-threatening outcomes. In the present case study, a precisely staged Ayurvedic protocol, which considered

the state of the *Doṣha, Agni,* and *Roga avastha,* enabled targeted and individualized management throughout the course of the disease. The patient showed marked improvement in a short period, progressing from being bedridden before treatment to assisted ambulation within two weeks. The overall treatment resulted in significant gain in muscle strength and alleviation of symptoms, reflecting the therapeutic potential of Ayurveda in the management of Guillain–Barre Syndrome.

Acknowledgement

We are thankful to the participant for providing informed consent to publish the result of the study.

Declaration of Patient Consent

Authors certify that they have obtained informed patient consent form, where the patient has given consent for reporting the clinical information in the journal. The patient/caregiver understands that their name and initial will not be published and due effort will be made to conceal the identity, but anonymity cannot be guaranteed.

REFERENCES

1. Penman ID, Raiston SH, Strachan MWJ, Hobson RP. Diseases of Peripheral nerves in Davidson's Principles and Practice of Medicine. 24th ed. Edinburgh: Elsevier; 2022. p.1192-1193.
2. Krishna Das KV. Diseases of the Peripheral Nervous System in Textbook of Medicine. 5th ed. New Delhi; Jaypee Brothers Medical Publishers; 2016. p.1323-1324.
3. Bragazzi NL, Kolahi AA, Nejadghaderi SA, Lochner P, Brigo F, Naldi A, Lanteri P, Garbarino S, Sullman MJM, Dai H, Wu J, Kong JD, Jahrami H, Sohrabi MR, Safiri S. Global, regional, and national burden of Guillain-Barr syndrome and its underlying causes from 1990 to 2019. J Neuroinflammation. 2021 Nov 11; 18(1): 264. Available from: https://jneuroinflammation.biomedcentral.com/articles/10.1186/s12974-021-02319-4
4. Acharya YT. Charaka Samhita of Agnivesha, Chikitsasthana; Vatavyadhi chikitsitam: Chapter 28, Verse 54-55. New Delhi: Chaukhambha Publications; 2018. p. 619.
5. Naqvi U, Margetis K, Sherman AL. Muscle Strength Grading. In: StatPearls. Treasure Island (FL): StatPearls Publishing; 2025 Jan–. Available from: https://www.ncbi.nlm.nih.gov/books/NBK436008
6. Hughes RAC, Cornblath DR, Jacobs BC, van Doorn PA. Guillain-Barré Syndrome Disability Scale. J Peripheral Nervous System. 2025 Dec; 30(4): e70064. Available from https://pmc.ncbi.nlm.nih.gov/articles/PMC12573220/
7. Mishra BS. Bhaisajyaratnavali of Shri Govind Das, Vatavyadhichikitsa prakaranam: Chapter 26, Verse 343-354. 20th ed. Varanasi: Chaukhambha Prakashan; 2010. p. 560.
8. Itnal SR, Kamath S. Role of Taila in Sandhigata Vata. Int Ayurvedic Med J. 2020 Jan; 8(1): p.2425. Available from: https://www.wisdomlib.org/uploads/journals/iamj/2020-issue-1-january/2420_2428.pdf
9. Tewari P, Kumari A. Yogaratnakara, part II, Amlapittadikara: Chapter 57, Verse 61-65. Varanasi: Chaukhambha Visvabharati; 2019. p. 947.
10. Mishra BS. Bhaisajyaratnavali of Shri Govind Das, Amlapittachikitsa prakaranam: Chapter 56, Verse 25-29. 20th ed. Varanasi: Chaukhambha Prakashan; 2010. p. 922.
11. Mishra BS. Bhaishajyaratnavali of Shri Govind Das, Vatavyadhi chikitsa prakaranam: Chapter 26, Verse 204-208. 20th ed. Varanasi: Chaukhambha Prakashan; 2010. p. 548.
12. Mishra S, Rasapaddhati by Acharya Bindu, 2nd ed. Varanasi: Chaukhambha Orientalia, 2005. p. 167.
13. Pandey GS. Bhavaprakasha Nighantu of Bhavamisra. Varanasi: Chaukhumbha Bharathi Academy; 2010. p. 257.
14. Mishra S. Rasaratna samuchchayah, Rasa varga: Chapter 2, Verse 2. 1st ed. Varanasi: Chaukhambha Orientalia; 2011. p. 30.
15. Vijaykumar S, Tamboli N. An in-vitro evaluation of immunomodulator effect of Shataputa Abhraka Bhasma. Indian J Anc Med Yoga. 2017; 10(4): 137–143. doi: 10.21088/ijamy.0974.6986.10417.4

Cite this article as:
Shrilatha Kamath T, Athira C K. Ayurvedic Management of Guillain-Barre Syndrome. AYUSHDHARA, 2026;13(3):219-222.
https://doi.org/10.47070/ayushdhara.v13i3.2394
Source of support: Nil, Conflict of interest: None Declared

***Address for correspondence**
Dr. Athira C K
PG Scholar,
Department of PG & PhD Studies in Kayachikitsa, Shri Dharmasthala Manjunatheshwara College of Ayurveda, Hospital and Research Centre, Udupi, Karnataka.
Email: athiracktly@gmail.com