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Case Study

AYURVEDIC MANAGEMENT OF CERVICAL SPONDYLOTIC COMPRESSIVE MYELOPATHY THROUGH SEQUENTIAL *PANCHAKARMA*

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ABSTRACT

Cervical compressive myelopathy is a progressive condition caused by spinal cord compression, commonly due to disc herniation, osteophytes, or trauma. Conventional management is surgical decompression, but Ayurveda offers an integrative approach using Panchakarma (bio-purification) and internal medication. **Patient Details:** A 42-year-old male presented with bilateral lower limb weakness (left>right), tingling, hand clumsiness, and bowel disturbances. MRI showed C5–C6 level cord compression with edema. **Therapeutic Intervention:** The patient underwent two phases of Ayurvedic therapy, including *Baluka* (sweating induced by warm sand packs), *Deepana-Pachana* (appetizer and digestive stimulation- *Triphala Churna* 5gm+ *Nimba Churna* 5gm as *Paniya*-6 days), *Snehapana* (internal oleation 30 to 120ml in *Arohana kram*- 5 days), *Sarvanga Abhyanga Swedana* (Application of oil to body and fomentation- 5 days), *Virechana* (therapeutic purgation), *Samsarjana Krama* (post-therapy dietary regimen for revival of digestion- 5 days), *Kala Basti* (course of sixteen therapeutic enemas (decoction- 450ml, oil-60ml)), *Pristha Basti* (therapeutic retention of oil over thoracolumbar region-14 days), and *Shirobasti* (therapeutic retention of oil over head -14 days), along with Ayurvedic medicines and dietary regimen. **Results:** Over time, the patient showed motor recovery (5/5 in all limbs), gait improved, bowel movements normalized, sleep improved, and cumulative weight loss of 5.5kg in this sitting. Minor tingling in fingers persisted. A follow-up MRI showed no major spinal cord compression. **Conclusion:** This case suggests that Ayurvedic Panchakarma treatments help improve symptoms and quality of life in cervical myelopathy patients. More research is needed to confirm these results.

INTRODUCTION

Myelopathy refers to any neurological deficit resulting from pathology of the spinal cord. The most common etiology is spinal cord compression, which may arise from degenerative changes such as osteophyte formation, intervertebral disc protrusion or extrusion, particularly in the cervical region, extradural masses due to metastatic carcinoma, and blunt or penetrating trauma.

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Less commonly, myelopathy may result from infectious, inflammatory, neurodegenerative, primary neoplastic, vascular, nutritional, or idiopathic causes. Intradural lesions, including benign neoplasms (e.g., meningiomas and nerve sheath tumors) and cystic conditions such as arachnoid or epidermoid cysts, can also produce cord compression. [1]

Cervical myelopathy specifically denotes spinal cord dysfunction secondary to compression at the cervical level. The clinical presentation typically includes upper motor neuron signs such as spasticity, hyperreflexia, pathological reflexes, hand and digit clumsiness, and gait disturbances. Without timely intervention, patients may experience progressive neurological decline leading to significant functional impairment and paralysis. The condition often has an insidious onset with stepwise neurological deterioration. Poor prognostic indicators include

symptom duration exceeding 18 months, female sex, and markedly reduced cervical range of motion. Surgical management remains the standard of care in moderate to severe cases and involves anterior or posterior decompression with or without spinal fusion. It has been reported that nearly all patients develop myelopathy when spinal canal stenosis exceeds approximately 60% (disc–cord space < 6 mm). [2,3]

Commonly performed surgical procedures include anterior cervical discectomy and fusion (ACDF), anterior cervical corpectomy and fusion (ACCF), anterior corpectomy with discectomy and fusion (ACCDF), laminoplasty (LP), and laminectomy with fusion (LF). Although these procedures are effective, they are associated with potential complications such as C5 nerve palsy, dysphagia, cerebrospinal fluid leak, surgical site infection, axial neck pain, hoarseness, epidural hematoma, graft dislodgement or subsidence, and fusion failure. [4,5]

In Ayurveda, management strategies may incorporate Panchakarma-based therapeutic interventions aimed at systemic detoxification, metabolic correction, and neuromuscular support. The classical *Panchakarma* framework comprises five principal bio-purificatory procedures, supported by preparatory (*Purvakarma*) and post-therapeutic (*Paschatkarma*) measures. The clinical management of *Vatavyadhi* utilizes a multi-procedural approach to address Vata predominance and neuromuscular dysfunction. [6] *Purvakarma* like *Deepana–Pachana* (digestive and metabolic enhancement) causes digestion of adhered *Dosha*, *Snehapana* (internal oleation) liquidifies the adhered *Dosha*, *Sarvanga Abhyanga* and *Swedana* (whole-body oleation and fomentation) causes the mobilization of *Dosha* from their adhered place. *Pradhana karma Virechana* (therapeutic purgation) expels the *Dosha* from body through anal orifice. *Paschat karma Samsarjana Krama* (graduated post-purgation dietary regimen) remodulates and rejuvenates the body. *Kala Basti* (scheduled course of medicated enemas) is the main treatment of *Vata Dosha* after *Shrotoshodhana* (clearance of channels), and localized treatments like *Pristha Basti* (localized oil retention therapy over the thoracolumbar region), and *Shirobasti* (cranial oil retention therapy for a defined duration) supports the systemic treatments matrix.

Patient Information

A 42-year-old male presented to the Panchakarma outpatient department of a tertiary Ayurvedic care hospital on 18 April 2024 with a four-year history of progressively worsening lower limb weakness with asymmetrical onset, initially more pronounced on the left side and later involving both legs. His primary complaints included bilateral lower limb weakness(left>right), numbness and tingling sensations, abdominal tightness, chronic constipation, neck pain, and low back pain. He reported difficulty lifting the left leg due to pain and weakness. The clinical course was marked by intermittent episodes of clumsiness lasting approximately 5-10 minutes, during which he was unable to bear weight adequately on the left leg and experienced difficulty stabilizing himself while riding a motorcycle. These symptoms progressively limited his mobility and daily functional activities.

There was no documented history of major systemic illness, spinal surgery, or significant spinal trauma. No relevant hereditary or genetic neurological disorders were reported in the family. The patient had previously received symptomatic conventional treatment, including analgesics, with only temporary relief. In January 2024, he was evaluated by a spine specialist and advised surgical intervention in the form of anterior cervical discectomy and fusion; however, the surgery could not be undertaken due to a prolonged waiting period. Seeking supportive and alternative management, he presented to our center for further care. Oral Ayurvedic medications were prescribed for approximately six weeks while awaiting inpatient admission for planned Panchakarma therapy which are listed in table no 1.

Clinical Findings

General and systemic examination

General examination showed that patient was hemodynamically stable, conscious, and oriented. Systemic examination showed no abnormalities in cardiovascular system, respiratory system. The clinical findings of general examination, along with laboratory findings are mentioned in table no 2.

***Dashvidha Pariksha* (tenfold examination):** The patient was assessed to have a *Pitta-Kaphaja Prakriti* (constitutional type with predominance of *Pitta* and *Kapha*). The *Sara* (tissue essence) was found to be *Madhyama* (moderate), while *Samhanana* (body compactness) was also *Madhyama*. The *Pramana* (body measurement) was assessed as *Pravara* (excellent). The *Satmya* (habitual suitability) indicated *Sadh Rasa Satmya* (adaptation to all tastes). The *Ahara Shakti* (digestive capacity) was noted to be *Avara* (low), whereas *Vyayama Shakti* (exercise tolerance) and *Satwa* (psychological strength) were both *Madhyama* (moderate). The *Vaya* (age) of the patient was 42 years. The *Vikriti* (present imbalance) was diagnosed as *Kapha Pradhan Pitta Anubandhi*, indicating a *Kapha*-dominant disorder with associated *Pitta* involvement.

***Rogi Samanya Pariksha* (general examination as per Ayurveda)**

Astavidha Pariksha (eightfold physical examination) was performed on patient which showed *Hamsa Gati* (slow, steady and Swan like) *Nadi* (pulse) at 72/min. *Mala* (stool) was found to be *Amaja (*undigested*)*, *Picchila* (slimy), painful on straining and hard stool. *Mutra* (urine) was found to be *Prakruta* (normal) *Jihva* (tongue) of patient was found to be *Sama* (white coated tongue), *Sabdha* (speech), *Sparsha* (temperature, sensitivity) and *Druka* (vision) were *Prakruta* and patient had a *Sthoola Akruti* (properly nourished) patient was *Kapha Pradhan Pitta Anubandhi Prakriti* (inherent characteristics).

Local examination (Evaluation): On local examination, thinning of the bilateral thenar and hypothenar muscles was observed, indicating muscular atrophy. Muscle tone was found to be increased in both upper and lower limbs bilaterally, suggesting spasticity. Romberg's sign was present, indicating impaired proprioception and balance. Deep tendon reflexes were hyperactive in both upper and lower limbs. The patient's gait was unsteady, with evident imbalance. Neurological signs included positive Hoffman sign, positive crossed radial reflex, and positive inverted radial reflex, all pointing toward motor neuron involvement. The finger escape sign was also positive, further suggesting intrinsic hand muscle weakness. The Lhermitte sign was absent. The grip test showed failure to form a tight fist, which was considered positive. On muscle power assessment, the right upper limb showed a strength of 3/5, while the right lower limb was 4/5. On the left side, the upper limb also demonstrated 3/5 strength, but the lower limb showed a marked weakness with a power of only 1/5.

Timeline

It is mentioned in table 3 and 4.

Diagnostic Assessment

Diagnostic assessment was based on clinical examination and radiological investigations. Neurological physical examination demonstrated upper motor neuron signs, including increased muscle tone in all limbs, hyperreflexia, positive Hoffman and pathological reflexes, impaired balance, intrinsic hand muscle wasting, and reduced motor power, more marked on the left side. Routine laboratory investigations were within acceptable limits except for a mildly elevated erythrocyte sedimentation rate.

Magnetic resonance imaging (MRI) of the cervical spine (plain study dated 25 July 2022) revealed block vertebra at C2–C3 level and a moderate-sized posterior osteophyte–disc complex at C5–C6 with broad posterior central disc herniation causing spinal cord compression, circumferential cerebrospinal fluid effacement, and moderate-to-severe spinal canal stenosis. T2-FLAIR hyperintense signal changes were present within the spinal cord at C5–C6, extending from C4–C5 to C7 levels, suggestive of cord edema consistent with compressive myelopathy and likely venous congestion. Additional findings included a posterior osteophyte–disc complex at C4–C5 lateralized to the left side with moderate narrowing of the left neural foramen and compression of the left C5 nerve root, along with mild posterior central disc herniation at C6–C7. Ultrasonography of the abdomen showed mild hepatomegaly with grade-I fatty liver and features suggestive of enteritis.

The principal diagnostic challenge was the chronic, gradually progressive course with mixed sensory, motor, and functional features overlapping with other neurological and musculoskeletal disorders, which can delay definitive localization without imaging correlation. Differential diagnostic considerations included degenerative cervical spondylotic myelopathy, disc-related compressive myelopathy, and combined radiculomyelopathy. Based on the clinical findings and MRI correlation, a working diagnosis of cervical compressive myelopathy with multilevel degenerative cervical spondylotic changes was established. Prognostic indicators included long symptom duration and radiological evidence of cord signal change (edema), which are generally associated with a guarded neurological prognosis if left untreated.

Therapeutic Intervention

The Ayurvedic treatment plan began with sweating induced by warm sand packs and bowel cleansing using a combination of *Gandarvahastadi Eranda Taila* and *Triphala Kwatha* for 3 days to prepare the system for further interventions. This was followed by appetizer and digestive stimulation using a combination of *Triphala Churna* 5gm and *Nimba Churna* 5gm, administered in the form of *Paniya* (drinkable decoction) for 6 days. Additionally, Massage with medicated herbal powder was performed for 3 days to reduce *Kapha* and enhance circulation.

Internal oleation was then initiated with *Goghrita* (cow's ghee), with a gradually increasing dose schedule of 30 ml, 60 ml, 80 ml, 90 ml, and 120 ml over successive days. This was followed by application of oil to body and Fomentation for 3 days to facilitate the mobilization of toxins.

Subsequently, therapeutic purgation was administered using a combination of *Trivrit Avaleha* (80 g) and *Abhayadi Modaka* (2 tablets), following the application of oil to body and fomentation. A total of 10 *Vegas* (purgation bouts) were observed, and the patient reported hunger approximately 24 hours post-procedure, indicating proper completion of the Therapeutic purgation process.

This was followed by a post-therapy dietary regimen for 5 days, involving a gradual reintroduction of food, and a subsequent rest period of 4 days. On the 9th day after Therapeutic purgation, *Madhuyasthi Taila* therapeutic oil enema was administered, preceded by application of oil to the body and Fomentation.

Parallelly, a sequence of rejuvenative and localized therapies was undertaken, including Therapeutic retention of oil over head and thoracolumbar region for specific duration, each continued for 14 days. In addition, *Yashtyahvadi Ksheera Basti* (milk-based enema with *Yashtimadhu* formulation) was administered for 16 days as a part of *Rasayana* (rejuvenative) therapy.

Procedures

The treatment protocol began with sweating induced by warm sand packs, wherein heated sand was wrapped in a cloth *Pottali* (bolus) and used for fomentation across the body. To avoid direct contact with the skin and prevent burns, a thin cloth layer was used while ensuring effective heat transmission.

For correcting bowel habit, the patient was administered *Gandarvahastadi Eranda Taila* (30ml) mixed with *Triphala Kwatha* (50ml) orally after *Swedana* for three consecutive days, early in the morning on an empty stomach. Until bowel evacuation or the return of hunger was achieved, the patient was kept nil per oral to promote effective digestion and detoxification.

For appetizer and digestive stimulation, the patient was provided a drinkable decoction prepared from *Triphala Churna* and *Nimba Churna*, which served as the sole form of fluid intake- plain water was completely avoided during this phase.

Internal oleation was administered with *Goghrita* (cow's ghee), taken early in the morning around 6:45 AM on an empty stomach after freshening up. This was done in increasing doses as per classical protocol.

Application of oil to body and Fomentation was performed using *Dashmool Taila* for massage and *Dashmool Kwatha* for steam fomentation.

Following Therapeutic purgation, Posttherapy dietary regimen for revival of digestion was implemented for five days. The sequence included: two *Annakala* of *Peya* (thin gruel), followed by two *Annakala* of *Yavagu* (semi-thick gruel), then two *Annakala* of *Yavagu* with *Dal* (first *Akrita*– without spices, and then *Krita*– with Saindhava, cumin, and ghee), followed by two *Annakala* of Khichdi (again, one *Akrita* and one *Krita*), after which normal diet was gradually resumed.

On the 9th day after Therapeutic purgation, Application of oil to body and Fomentation was administered, followed by *Matra Basti* using *Madhuyashti Taila* (60 ml) mixed with *Saindhava* (rock salt) and *Satapushpa Kalka* (herbal paste), given post-meal as per classical guidelines.

Therapeutic retention of oil over thoracolumbar region for 14 days was carried out by *Dashmool Taila*. The retention dam for the *Basti* was prepared using a dough made from *Masha flour* (black gram) in line with the SOP (Standard Operating Procedure) of *Bahya Basti*.

Therapeutic retention of oil over head for 14 days was performed as per the institutional SOP of *Shirobasti*, ensuring coronal dough dam supported by the leather cap of the crown region and maintaining adequate oil temperature throughout the duration.

Lastly, *Yashtyahvadi Ksheera Basti* was given on empty stomach on left lateral position by traditional *Basti Yantra*(instrument), after mild Application of oil to body and Fomentation. Ingredients of it are in table 5.

Follow Up and Outcome

At the time of discharge, both clinician-assessed and patient-reported outcomes indicated substantial clinical improvement. On neurological examination, gait instability had reduced and the patient was able to walk in a straight line with improved coordination and balance. Motor assessment showed restoration of muscle strength to grade 5/5 in all four limbs. Functional recovery was evident, as the patient was able to lift the left lower limb up to 90 degrees at the hip, indicating significant improvement in motor control. Patient-reported outcomes included normalization of sleep pattern with 6–8 hours of uninterrupted sleep, resolution of anorexia and abdominal pain, and regularization of bowel habits to once daily evacuation. A measurable reduction in body weight of 5.5kg (from 94.5kg to 89kg) was also recorded during the treatment period.

At follow-up, a few residual symptoms persisted, including mild tingling sensation in the fingers of the right hand and incomplete fine motor grip strength, although the patient was able to hold a pen and write. Mild stretching-type pain in the lower back region was also reported, suggestive of residual musculoskeletal strain. Follow-up MRI of the cervical spine dated 31 May 2025 demonstrated disc desiccation changes and multilevel mild posterior disc bulges from C3–C4 through C6–C7 with mild thecal sac indentation. Radiological evidence of significant spinal cord compression or active myelopathy was not evident. Bilateral lateral foraminal encroachment was present at C3–C4 and C5–C6 levels with mild nerve root compression.

Intervention adherence was assessed through inpatient treatment records, daily procedure logs, and supervised administration of therapies and medications, which indicated full compliance with the prescribed Panchakarma protocol and internal medications. The interventions were well tolerated overall. No serious adverse events or unanticipated complications were observed during the treatment or follow-up period. Mild transient post-procedural fatigue during intensive therapy phases was noted and managed conservatively. (Figure 2,3)

DISCUSSION

From a contemporary biomedical perspective, cervical compressive myelopathy is a progressive spinal cord disorder most commonly managed with surgical decompression when neurological deficits are significant. However, variability in clinical course, surgical waiting periods, patient preferences, and comorbidity profiles often necessitate supportive and integrative management strategies.

In classical Ayurvedic literature, there is no direct one-to-one nosological equivalent for compressive myelopathy; nevertheless, comparable symptom complexes involving progressive neuromuscular weakness, sensory disturbance, spasticity, and functional decline are broadly interpreted under the spectrum of *Vatavyadhi*. In the present case, associated gastrointestinal symptoms like reduced appetite, abdominal discomfort, constipation, and metabolic impairment were interpreted as features of *Agnimandya* and *Ama* formation preceding systemic involvement. This interpretive model is supported by classical descriptions of *Udara Roga* and *Vatavyadhi* pathogenesis. [7,8,9]

As illustrated in Figure 1, the proposed classical principle of pathogenesis (*Samprapti*) starts from *Mandagni* and *Ama* formation, where chronic gastrointestinal derangement instigates the neurological pathology. Since the first symptom was traced as constipation along with other GI symptoms, long-standing dysfunction within *Annavaha* and *Purishavaha Srotas* (GI and excretory channels) has caused *Agnimandhya* generating *Ama* vitiating *Kapha* and *Pitta*. These morbid *Ama dosha* circulate systematically and lodge into structurally vulnerable (due to other environmental and anatomical factors) *Majjavaha Srotas* (channels governing Nervous System) causing *Srotorodha*. This caused *Margavarodhajanya Vata Prakopa*, leading to *Avarana* of *Vata* in *Grihva Pradesh*. This cascade caused localized tissue degeneration (*Dhatu Kshaya*) amd changes of compression myelopathy were observed in patient. This mirrors the descriptions of *Avarana* and *Apanavrita Vyana* pathways (*Charaka Samhita Chikitsa* 28/222-224).

Based on this framework, the therapeutic strategy prioritized metabolic correction and channel clearance through *Deepana–Pachana* using *Triphala Churna* and *Nimba Churna* in *Paniya* form [10], followed by bio-purification through *Virechana* [11]. Therapeutic purgation was administered using *Trivrit Avaleha* and *Abhayadi Modaka*, targeting *Pitta–Kapha* imbalance and systemic obstruction. Adequate purgation response (*Vegas*) and timely return of appetite guided post-procedure dietary regimen (*Samsarjana Krama*) to stabilize digestive and metabolic function.

Subsequent *Vata*-pacifying and tissue-supportive interventions included *Anuvasana* and *Kala Basti* protocols, including *Madhuyasthi Taila* and *Yashtyahvadi Ksheera Basti* (composition shown in Table 3 [12]), along with localized therapies such as *Pristha Basti* and *Shirobasti*. These measures were selected to address *Vata* predominance at its principal sites and to support neuromuscular and connective tissue function. Clinically, the patient demonstrated progressive functional recovery with restoration of limb power, gait stability, bowel regularity, and sleep quality. Though Follow-up imaging (Figure 2, Figure 3) showed no significant residual spinal cord compression, mild degenerative and foraminal changes persisted.

The strengths of this case include longitudinal clinical documentation, objective neurological examination findings, pre- and post-treatment imaging correlation, structured inpatient protocol delivery, and measurable functional outcomes summarized in Table 2 and the disease–intervention timeline in Table 3 and 4. Intervention adherence was high due to supervised inpatient administration. Limitations include the single-case design, absence of controls, multimodal intervention preventing component-wise attribution, and the possibility of confounding by natural disease variation, weight reduction, and supportive care. However, claim of complete resolution of active myelopathy is denied because though symptoms has disappeared temporarily, they might reappear on long follow up. Also, single T2 MRI slice was only available and evaluated. Radiological changes should also be interpreted cautiously in degenerative spine disease.

In Ayureda, *Vatavyadhi* which is chronic, deep seated with dual dosha involvement and located in *Sandhi* is curable with difficulty. When it involves deep Dhatu, with presence of tissue wasting, it is palliable/ manageable only. Even in allopathic medicine, published biomedical literature supports decompressive surgery as standard management for moderate to severe cervical myelopathy, whereas

conservative care is generally reserved for selected cases. Ayurvedic management evidence in this condition is currently limited to case-level and observational documentation. The clinical improvement is correlated directly with the treatment timeline and was objectively confirmed via neurological examinations and follow up MRI (Figure 2, Figure 3). Nonetheless, this single case report is not enough to prove direct causality.

Take-away lesson: A structured, supervised *Panchakarma*-based Ayurvedic protocol may provide supportive functional benefit in selected cases of cervical compressive myelopathy when surgery is delayed or deferred; however, this observation requires validation through controlled clinical studies before broader clinical recommendations can be made.

CONCLUSION

This single case study reveals that symptoms of compressive myelopathy can be successfully managed by Ayurvedic Panchakarma therapies and oral medications. However, clinical trials with large sample sizes must be undertaken to establish the efficacy of Panchakarma therapy as a first line treatment protocol for cases of progressive compressive myelopathy secondary to cervical spondylosis.

Patient Perspective

I am happy that my problems have reduced and now I can do my daily work with relative ease without surgery. I can hold pen, bend leg and can stand for long time without fatigue.

Declaration Of Patient Consent

The authors certify that all the appropriate patient consent forms have been obtained. In the form, the patient has/have given his/her/their consent for his/her/their clinical information to be reported in the journal. Patient is aware of the fact that their names and initials will not be published and due effort will be made to conceal their identity, but anonymity cannot be guaranteed.

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Table 1: Oral Ayurvedic Medicines

SN	Medicines	Dose	*Anupana*
1.	*Trayodasanga Guggul* *Panchamrit lauha guggul*	500mg twice daily, *Pragbhakta* 500mg	With *Rasnasaptak kwath*

2.	*Rasnasaptak kwath*	40ml twice daily, *Pragbhakta*	With *Guggul* (1)
3.	*Ashwagandha churna* *Nagaradhya churna* *Chopchini churna*	2g 1g 2g/ twice daily, after food	Combined with warm water
4.	*Hingwastak churna*	5gm twice daily, 1st bolus of food	1 tsp cow's ghee
5.	*Mahanarayan tail*		Local application
6.	*Eranda bhristha haritaki*	5gm *Nisha*	Warm water
7.	*Abhayaristha*	20 ml twice daily, after food	equal water

Table 2: General and laboratory clinical findings

General parameter	**Laboratory Parameter**
Pulse- 72 per minute	Hb- 14.3 g/dL
BP- 120/80 mmHg	TLC- 7.27*10^3/µL
SpO2 – 98%	Platelets count- 142*10^9/L
Respiratory rate – 16/min	ESR- 25mm/hr
Weight- 104 kgs	Urine routine/microscopic- WNL pH- 6.0 Specific Gravity- 1.025 pus cells 2-3 epithelial cells- 5-7 RBCs- absent
Bowel habit- chronic constipation	
Micturition- dribbling of urine, reduced in quantity, nocturnal micturition 4 episodes/day	

Table 3: Timeline of disease progression and interventions done in previous admissions

Date	**Clinical events**	**Intervention**
Onset -2021	Numbness and tingling of left leg Tingling and pain of abdomen Pain over neck and lower back region anorexia Progressive increase in interval of bowel evacuation from 24 hours	Local analgesics
Exacerbation- March 2023	Sudden onset of weakness of left leg Inability to move, inability to lift left leg at all Bowel evacuation once in 2-3 days	Used allopathic medicine – analgesics
Surgical Advice- January 2024	Loss of weight-bearing capacity on left leg Instability- Clumsiness and sudden weakness of left leg if pressure applied for 5-10 minutes.	Advised for anterior cervical discectomy and fusion surgery
OPD presentation- March 2024	persistent neuromuscular deficits, awaiting surgery	Oral Ayurvedic medicines
1st IPD Admission - May 2024 -7th July 2024	Previous symptoms persist On discharge following changed were seen – - Weight loss of 8 kgs (from 104kg to 92kg) - Instability reduced- Could stand on left leg for 3-4 hours without weakness - Continuous neck pain relieved (pain relieved by 50%)	Admitted on Panchakarma IPD and started *Panchakarma* therapies.

2nd Admission- 30th August 2024- 20th September 2024	On discharge- - Weight loss of 6kg - Could lift leg up to 5cm - Pain abdomen reduced (70%) - Stability restored- could ride bike by himself without falling	Therapeutic purgation procedure done after appetizer and digestive stimulation by *Panchakola Churna* 5gm and internal oleation by *Goghrita* in *Arohana Krama* (increasing order).

Table 4: Timeline of disease progression and interventions done during this admission

Date	Clinical events	Intervention
Current IPD Admission- 1st April 2025	Readmitted on *Panchkarma* IPD - Symptoms increased after 3-4 months of last discharge after long motorbike riding. - Sleep disturbed, delayed onset lasting for 2-3 hours with multiple dreams. - Instability and imbalance occurred, fall present, clumsiness reappeared. - Couldn't walk in same line. - Couldn't lift leg more than 5cm from hip joint. - Couldn't hold pen or any objects from right hand (fine motor functions altered). - Anorexia- dependent on bowel evacuation. - Pain abdomen - Constipation once in 2-3 days persists - Weight gain (94.5kg at time of admission).	Procedures done- - Sweating induced by warm sand packs +correcting bowel habit for 3 days. - Then, appetizer and digestive stimulation and massage with medicated herbal powder for 3 days. - Internal oleation - Application of oil to body and fomentation for 3 days. - Application of oil to body and Fomentation and therapeutic purgation. - Total no of *Vegas* 10, hunger felt after 24 hours - Post-therapy dietary regimen for revival of digestion for 5 days followed by rest for 4 days. - *Madhuyasthi Taila Anuvasana Basti* on 9th day of therapeutic purgation after application of oil to body and fomentation. - Application of oil to body and fomentation for 14 days, post-therapy dietary regimen for revival of digestion for 14 days, therapeutic retention of oil over head for specific duration for 14 days and *Yashtyahvadi Ksheera Basti* for 16 days.
10th May 2025	Discharge and follow up - No instability - Can walk on same line - Can lift left leg (90 degrees hip flexion) - Sleep sound- 6-8 hours, dreams reduced - Anorexia resolved - Pain abdomen resolved - Bowel- once daily - Weight loss 5.5 kg (94.5 kgs to 89 kgs) - Power of bilateral upper and lower limbs were restored to 5/5 Persisting symptoms - Tingling sensation on fingers of right	Discharged with maintenance oral therapies.

	hand persists. - Can hold pen by hand and write (no proper grip established). - Mild stretching type of pain on lower back region.	

Table 5: Ingredients of *Yashtyahvadi Ksheera Basti* [12]

Makshika	100 ml
Saindhava Lavana	15gms
Goghrita	100ml
Shatapushpa+ Esat Madanaphala+ Esat pippali Churna (Kalka)	25gms
Yastimadhu + Ksheerapaka	400ml

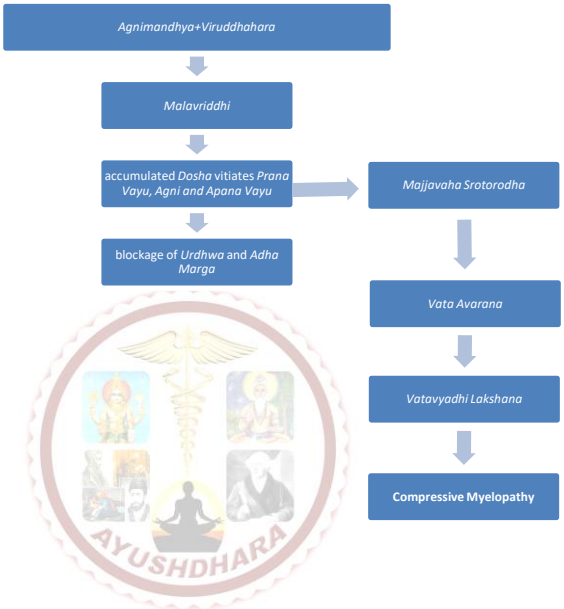

Figure 1: Pathogenesis of Compressive Myopathy

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