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Case Study

REVERSAL OF FUNCTIONAL DISABILITY IN CHRONIC INFLAMMATORY DEMYELINATING POLYNEUROPATHY THROUGH AYURVEDIC INTERVENTION

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ABSTRACT

Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) is an immune-mediated demyelinating neuropathy characterized by progressive motor weakness, sensory deficits, and diminished reflexes, often leading to severe functional disability. The present case highlights the role of Ayurvedic management in neurological rehabilitation of CIDP. A 42-year-old male presented with progressive weakness of all four limbs, reduced superficial and deep sensations, and diminished tendon reflexes for three months. The patient had gradually become bedridden with near-complete loss of voluntary movements and dependence for routine activities. Based on clinical features, the condition was correlated to *Vatavyadhi* involving *Avarana* leading to *Dhatu Kshaya*, resulting in impaired neuromuscular conduction and degeneration. The patient underwent a structured Ayurvedic treatment protocol for six months comprising *Snehana*, *Swedana* and *Yapana Basti* along with *Rasayana* and supportive physiotherapy. These interventions were aimed at alleviating obstructed *Vata*, nourishing depleted tissues, improving functional integrity of nerves and muscles, and enhancing mobility. Marked clinical improvement was observed following treatment. The patient, who was initially bedridden without significant limb movements, gradually regained motor strength, sensory perception, and functional independence, ultimately achieving independent ambulation. This case demonstrates the potential of integrative Ayurvedic approaches in restoring functional capacity and improving quality of life in CIDP patients.

INTRODUCTION

Guillain–Barré syndrome (GBS) comprises a heterogeneous group of immune-mediated disorders causing acute inflammation of the peripheral nerves, with an incidence of approximately 1–2 cases per 100,000 population per year. The most common variant is Acute Inflammatory Demyelinating Polyneuropathy (AIDP).

Axonal variants, including Acute Motor Axonal Neuropathy (AMAN) and acute motor-sensory axonal neuropathy, are more frequently observed in China and Japan, while they account for nearly 10% of GBS cases in Western countries and are often associated with *Campylobacter jejuni* infection.

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The hallmark feature of GBS is acute paralysis progressing over days to weeks, accompanied by loss of tendon reflexes. Nearly two-thirds of patients with AIDP report a preceding history of infection, and the resulting autoimmune response triggered by the infection is believed to initiate peripheral nerve inflammation.

Distal paraesthesia and pain usually precede the onset of muscle weakness, which characteristically ascends rapidly from the lower limbs to the upper limbs and is often more pronounced proximally than distally. Facial and bulbar muscle involvement are common, and nearly 20% of patients develop respiratory muscle weakness requiring ventilatory support. The weakness typically progresses over a period of less than four weeks, although rapid deterioration leading to respiratory failure may occur within hours. Clinical examination commonly reveals diffuse muscle weakness associated with diminished or absent tendon reflexes.

When these neurological symptoms persist beyond eight weeks or show repeated relapses, the condition is considered as Chronic Inflammatory Demyelinating Polyneuropathy (CIDP), a chronic immune-mediated demyelinating neuropathy. CIDP usually presents with relapsing or progressively evolving motor and sensory deficits extending over more than eight weeks. The estimated prevalence ranges from 1–9 cases per 100,000 population, with a higher predominance among males.

CIDP is distinguished from GBS by its chronic course. In other respects, this neuropathy shares many features with the common and the EDx findings of acquired demyelination. Most cases occur in demyelinating form of GBS, including elevated CSF protein levels adults, and males are affected slightly more often than females. The incidence of CIDP is lower than that of GBS, but due to the protracted course, the prevalence is greater.

Clinical Manifestations

Onset is usually gradual over a few months or longer, but in a few cases, the initial attack is indistinguishable from that of GBS. An acute-onset form of CIDP may mimic GBS but should be considered if it deteriorates >9 weeks after onset or relapses at least three times. Symptoms are both motor and sensory in most cases. Weakness of the limbs is usually symmetric but can be strikingly asymmetric in multifocal acquired demyelinating sensory and motor (MADSAM) neuropathy variant (Lewis-Sumner syndrome) in which discrete peripheral nerves are involved.

There is considerable variability from case to case. Some patients experience a chronic progressive course, whereas others, usually younger patients, have a relapsing and remitting course. A small proportion have cranial nerve findings, including external ophthalmoplegia. Some have only motor findings, and a small proportion present with a relatively pure syndrome of sensory ataxia. The latter can be seen in the chronic inflammatory sensory polyradiculopathy (CISP) variant of CIDP in which demyelination predominantly occurs at the sensory roots or with the distal acquired demyelinating symmetric (DADS) variant.

Diagnosis

The diagnosis rests on characteristic clinical, CSF, and electrophysiologic findings. EDx findings reveal variable degrees of conduction slowing, prolonged distal latencies, distal and temporal dispersion of CMAPs, and conduction block as the principal features. In particular, the presence of conduction block is a certain sign of an acquired demyelinating process. Evidence of axonal loss, presumably secondary to demyelination, is present in >50% of patients.

Treatment

Most authorities initiate treatment for CIDP when progression is rapid or walking is compromised. If the disorder is mild, manage- studies have shown that high-dose IVIg, subcutaneous Ig (scIg), treatment can be expectant, awaiting spontaneous remission. Controlled PLEX, and glucocorticoids are all more effective than placebo. Initial therapy is usually with IVIg, administered as 2.0gm/kg body weight given in divided doses over 2-5 days; three monthly courses are generally recommended before concluding a patient has failed treatment.

CIDP can be understood in Ayurveda as a *Vatavyadhi* involving both *Avarana* and *Dhatu Kshaya*, where conduction block and immune-mediated demyelination resemble obstructed and depleted *Vata* function. Therefore, therapies such as *Snehana*, *Swedana*, *Yapana Basti*, and physiotherapy may aid in restoring neuromuscular function, reducing disability, and improving quality of life.

MATERIALS AND METHODS

Case Report

A 42-year-old male, a known case of hypertension, was apparently asymptomatic 3 months ago. He gradually developed numbness over both upper and lower limbs, which was followed within a few days by progressive weakness of both lower limbs. Initially, he noticed difficulty in holding his slippers while walking. Subsequently, the weakness ascended to the thighs, making him unable to sit down or rise from a squatting position. As the illness progressed, he lost the ability to walk independently and experienced repeated falls.

A few weeks later, weakness involved both upper limbs as well, evidenced by inability to lift his arms and difficulty buttoning his shirt. Gradually, the weakness progressed to complete loss of movements, rendering him bedridden. He then approached an allopathic hospital, where he was treated with two courses of IVIg along with corticosteroids, following which he showed improvement. However, within two weeks, the symptoms recurred. Due to financial constraints preventing continuation of allopathic management, he subsequently approached Shri Jayachamarajendra Institute of Indian Medicine, Bengaluru for further treatment.

Past History: Known case of hypertension since 1 year (on medication).

Family History: Nothing contributory

Personal History

- Consumes mixed diet
- Has normal appetite
- Adequate sleep
- Regular bowel and bladder habits
- No H/O smoking and consumption of alcohol

General Physical Examination

- Patient was conscious, cooperative and well oriented to time, place and person.
- Well-built and nourished.
- Pallor - Absent
- Icterus – Absent
- Cyanosis – Absent
- Clubbing – Absent
- Lymph node enlargement- Absent
- Oedema – Absent
- Height- 172cm.
- Weight- 72kg.
- BMI- 24.8kg/m^2

Vitals

- Pulse– 74b/m, regular in rhythm, normal volume, normal character.
- Blood Pressure– 130/90 mmHg.
- Respiratory rate– 17cycles per minute, abdominothoracic breathing.
- Axillary temperature– 98.6°F
- JVP – Normal

CNS Examination

Higher Mental Functions

- Right-handed individual.
- Conscious, cooperative, well oriented to time, place, person.
- Appearance and Behavior– Appropriate and emotionally stable.
- Memory– Recent, immediate, remote memory intact.
- Calculation– Normal
- Speech– Fluency is normal, repetition intact and comprehension is normal.

Cranial Nerve Examination: I, II, III, IV, V, VI, VII, VIII, IX, X, XI, XII – Intact

Motor Examination

Nutrition

Parameter	Left	Right
Arm Circumference	26 cm	26 cm
Forearm Circumference	21 cm	21 cm
Thigh Circumference	36 cm	36 cm
Calf Circumference	27 cm	27 cm

Muscle Tone

	Left	Right
Upper Limb		
Arm	Hypotonic	Hypotonic
Forearm	Hypotonic	Hypotonic
Lower Limb		
Thigh	Hypotonic	Hypotonic
Leg	Hypotonic	Hypotonic

Muscle Power – 0/5 in B/L UL and LL

Reflexes – All the reflexes were absent

Sensory Examination: All the superficial and deep sensations were diminished.

Cardiovascular system Examination: S1 & S2 heard, no murmurs.

Respiratory system examination: B/L NVBS heard

Per abdomen examination: Soft, non-tender abdomen, no organomegaly.

Ashta-sthana Pareeksha

- *Nadi: Prakrita*
- *Mala: Prakrita*
- *Mutra: Prakrita*
- *Jihwa: Lipta*
- *Shabda: Prakrita*
- *Sparsha: Vikrita*
- *Drik: Prakrita*
- *Akruti: Prakrita*

Dasha-vidha Pareeksha

- *Prakruti- Vata Kapha*
- *Vikruti- Kapha Vata*
- *Sara- Madhyama*
- *Samhanana- Madhyama*
- *Satmya- Sarva Rasa Satmya*
- *Sattva- Pravara*
- *Pramana- Madhyama Pramana*
- *Ahara Shakti- Madhyama*
- *Vyayama Shakti- Madhyama*
- *Vaya – Madhyama*

Probable Diagnosis/*Vyadhi vinischaya*

- Post GBS sequelae/CIDP
- *Vatavyadhi*

Chikitsa Yojana

From date	To date	Treatment given
18/03/25	24/03/25	*Sarvanga Abhyanga* with *Ashwagandha Bala Lakshadi Taila* followed by *Nadi Sweda*
25/03/25	07/04/25	*Shastika Shaali Pinda Sweda*
08/04/25	18/04/25	*Mustadi Yapana Basti*
19/04/25	29/04/25	*Baladi Yapana Basti*
30/04/25	21/05/25	*Matra Basti* with *Mahamasha Taila + Guggulu Tiktaka Gruta*
22/05/25	30/06/25	*Shastika Shaali Pinda Sweda* + *Matra Basti* with *Bruhat Chagaladi Gruta* + Physiotherapy
01/07/25	21/07/25	*Baladi Yapana Basti*
Shamanoushadhis	Tab *Ekanga Veera Rasa* (1-0-1) *Ashwagandha Ksheerapaka* (10ml- 0 10ml)	

Assessment

1st Visit– Bed ridden, with loss of movements, loss of reflexes and loss of sensation

3rd visit- Able to stand with support, sensation improved in B/L LL & UL

2nd Visit- Able to sit, able to move limbs and sensation improved in B/L LL

4th visit- Able to stand without support and able to walk with support, sensation improved in B/L LL & UL

5th Visit– Able to walk with minimum support, sensations improved, reflexes intact

DISCUSSION

Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) is an acquired immune-mediated disorder affecting peripheral nerves and nerve roots, characterized by progressive or relapsing motor and sensory dysfunction persisting for more than eight weeks. The disease primarily involves demyelination with secondary axonal degeneration in long-standing cases. Clinically, patients present with gradually progressive symmetrical weakness, sensory disturbances, areflexia, gait difficulty, and functional disability. In the present case, the chronic progressive ascending weakness with sensory involvement, recurrence after temporary improvement with IVIg and corticosteroids, and subsequent bedridden state closely resembles the classical presentation of CIDP.

From an Ayurvedic perspective, the clinical presentation can be understood under the broad spectrum of *Vata Vyadhi*. The manifestations such as *Bala kshaya, Gati sanga, Supti, Gaurava*, and *Cheshta hani* indicate severe vitiation of *Vata dosha* affecting *Snayu, Mamsa*, and *Majja*. CIDP initially involves demyelination causing impaired nerve conduction, which can be interpreted as *Avarana* of *Vata*, where the normal *Gati* of *Vata* is obstructed by pathological factors. The loss of proper nerve impulse transmission due to myelin damage resembles *Margavarodha* leading to impaired neuromuscular coordination and weakness. As the disease progresses chronically, secondary axonal degeneration develops, producing muscle wasting and profound disability. This stage can be correlated with *Dhatukshaya janya Vata Vyadhi*, particularly involving *Majja* and *Mamsa dhatu kshaya*. Thus, CIDP demonstrates both *Avarana* and *Dhatukshaya* components in its *Samprapti*.

The line of management was planned considering both obstruction to *Vata gati* and nourishment of depleted *Dhatus*. *Sarvanga Abhyanga* followed by *Nadi Sweda* was adopted initially to alleviate *Ruksha, Sheeta*, and *Khara guna* of aggravated *Vata*. *Abhyanga* with medicated oils improves peripheral circulation, enhances tissue perfusion, reduces stiffness, and provides neuromuscular relaxation. From a contemporary perspective, therapeutic massage may stimulate cutaneous mechanoreceptors, improve local blood flow, reduce inflammatory mediators, and facilitate muscle activation in weakened limbs. The *Sneha* also helps in combating degeneration by providing *Brimhana* effect to deeper tissues.

Nadi Sweda administered after *Abhyanga* further potentiates *Vata shamana* by relieving *Stambha, Gaurava,* and *Srotorodha*. The localized steam induces vasodilatation and improves microcirculation to peripheral nerves and muscles. Heat therapy may enhance nerve conduction velocity, reduce muscle spasm, improve flexibility, and decrease pain perception. In CIDP, where conduction impairment and stiffness contribute to disability, Nadi Sweda possibly aids by improving tissue metabolism and facilitating better neuromuscular transmission.

Shastika Shali Pinda Sweda was administered considering the chronicity and *Dhatukshaya* predominance. *Shastika Shali* processed with *Ksheera* and *Bala mula* possesses potent *Brimhana* and *Balya* properties. The therapy provides simultaneous *Snehana* and *Swedana*, thereby nourishing weakened muscles and nerves while pacifying aggravated Vata. The heat and medicated bolus application improve circulation and muscle flexibility, whereas the nutritive properties may help counter muscle wasting and weakness. From a biomedical perspective, this therapy may improve muscle tone, reduce fatigue, enhance proprioceptive stimulation, and promote functional recovery through repeated sensory-motor activation.

Mustadi Yapana Basti was selected owing to its dual action of *Vata shamana* and *Rasayana* effect. *Yapana basti* is particularly indicated in chronic neurological and degenerative disorders because it nourishes depleted tissues while maintaining strength and vitality. *Mustadi* formulations possess *Deepana*, *Pachana*, and *Srotoshodhana* properties, thereby helping in relieving *Avarana* and correcting impaired metabolic activity at the tissue level. The *Basti dravya* administered through the rectal route may influence the enteric nervous system and autonomic pathways,

thereby exerting systemic neuromodulatory effects. By correcting *Vata* at its principal seat *Pakwashaya*, *Yapana Basti* may help restore normal neuromuscular function and improve sensory-motor deficits.

Baladi Yapana Basti was administered subsequently due to significant *Dhatukshaya* and functional disability. *Bala* is well known for its *Balya*, *Brimhana*, and *Vatashamaka* properties. The formulation nourishes *Majja* and *Mamsa dhatus*, improves strength, and supports regeneration of weakened tissues. In chronic demyelinating neuropathies, where prolonged inflammation leads to axonal damage and muscular atrophy, *Baladi Yapana Basti* may act as a restorative therapy by enhancing tissue nutrition and promoting functional recovery. The *Rasayana* effect of *Basti* may also help in preventing relapse and improving overall quality of life.

Matra Basti with *Brihat Chagaladi Ghrita* and *Maha Masha Taila* was administered to provide sustained oleation and deeper nourishment to *Majja*, *Snayu*, and *Mamsa dhatus. Matra Basti*, being a gentle form of *Sneha basti*, is especially beneficial in chronic *Vata Vyadhi* associated with severe weakness, emaciation, and fatigue. *Brihat Chagaladi Ghrita* is *Brimhana, balya*, and *Majja vardhaka* in action and may support regeneration of depleted neural tissues. *Maha Masha Taila*, owing to its potent *Vatashamaka* and *Snayubalya* properties, may help improve muscle power, reduce stiffness, and enhance neuromuscular coordination. From a contemporary viewpoint, the lipid-rich medicaments may provide neuroprotective effects, improve peripheral circulation, reduce oxidative stress, and support remyelination and muscle recovery in CIDP.

Physiotherapy was integrated along with Ayurvedic interventions to prevent contractures, maintain joint mobility, improve muscle strength, and restore functional independence. Progressive mobilization and muscle strengthening exercises help in neuro-muscular re-education and enhance motor recovery. In CIDP patients, prolonged immobilization results in disuse atrophy and worsening disability; hence physiotherapy plays an essential supportive role in rehabilitation. The combined approach of Panchakarma procedures and physiotherapy possibly produced synergistic effects by simultaneously reducing inflammation, improving circulation, nourishing tissues, and facilitating neural recovery.

Thus, the treatment protocol addressed both the *Avarana* component represented by conduction block and the *Dhatukshaya* component represented by axonal degeneration and muscle wasting. The multidimensional management involving *Snehana*, *Swedana, Brimhana, Yapana basti*, and physiotherapy may provide significant improvement in strength, mobility, and functional status in CIDP patients while offering a holistic rehabilitative approach.

CONCLUSION

In the present case, Chronic Inflammatory Demyelinating Polyneuropathy was effectively managed through an integrated Ayurvedic and rehabilitative approach. CIDP, which can be understood as a form of *Vata Vyadhi* with features of both *Avarana* and *Dhatukshaya*, showed significant clinical improvement following *Panchakarma* interventions, especially *Basti chikitsa*, along with physiotherapy.

Among all therapies, *Basti* played a pivotal role due to its direct action on aggravated *Vata* at its principal seat, *Pakwashaya. Yapana Basti* and *Matra Basti* provided simultaneous *Vatashamana, Brimhana*, *Rasayana*, and *Dhatu-poshana* effects, which possibly helped in improving nerve conduction, reducing neuromuscular dysfunction, and preventing further degeneration. The combination of *Sarvanga Abhyanga*, *Nadi Sweda, Shastika Shali Pinda Sweda, Mustadi Yapana Basti, Baladi Yapana Basti, Matra Basti* with *Brihat Chagaladi Ghrita* and *Maha Masha Taila,* along with *Guggulu Tiktaka Ghrita*, may have contributed toward restoration of strength, sensory functions, and functional mobility.

Simultaneous physiotherapy further enhanced recovery by improving muscle power, joint mobility, balance, gait training, and neuromuscular re-education. The integrated management helped in minimizing disability and promoting gradual functional independence.

The patient, who was initially bedridden with profound weakness, loss of movements, impaired sensations, and absent reflexes, gradually showed remarkable recovery over a period of five months. Improvement was observed in muscle strength, deep tendon reflexes, sensory perception, gait, and activities of daily living, ultimately leading to better mobility and enhanced quality of life.

This case highlights the potential role of *Panchakarma* therapies, particularly *Basti chikitsa*, as a promising supportive and restorative treatment modality in CIDP when combined with physiotherapy and comprehensive rehabilitative care. Patient consent is taken for uploading his details and pictures.

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