



Case Study

AYURVEDIC MANAGEMENT OF RELAPSING-REMITTING MULTIPLE SCLEROSIS (SNAYUSADA)

Amrutha Y^{1*}, Ishwarakeerthi²

^{*1}Assistant Professor, Department of Kayachikitsa, ²Assistant Professor, Department of Panchakarma, Sri Paripoorna Sanathana Ayurveda Medical College Hospital & Research Centre, Bengaluru, Karnataka, India.

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ABSTRACT

Multiple sclerosis is a chronic, immune-mediated demyelinating disorder of the central nervous system in which scattered plaques of myelin loss produce a fluctuating combination of motor, sensory, visual and autonomic deficits. Within Ayurveda the condition is best understood in the spectrum of *Vata vyadhi*, correlating with *Snayugata-Majjagata Vata* (*Snayusada*) arising from *Majja dhatu kshaya*, *Srotodushti* and progressive *Dhatukshaya*. The present report describes a 35-year-old male, presenting with blurring of vision in the right eye, paraesthesia and weakness of both lower limbs, unsteady gait, abnormal fatigue and urinary urgency, diagnosed as relapsing-remitting multiple sclerosis on the basis of magnetic resonance imaging scan report, visual evoked potentials and cerebrospinal fluid examination. He was managed over eight weeks of inpatient care followed by a four-week follow-up using a combined *Shamana* and *Shodhana* protocol- internal *Vatahara-Brimhana* medication, *Snehapana*, *Sarvanga Abhyanga* with *Shashtika Shali Pinda Sweda*, *Shirodhara*, *Akshitarpana* and *Yapana basti*- supported by dietary and lifestyle modification, *Yoga* and *Pranayama*. Symptom-severity scores fell by about 65% and the Expanded Disability Status Scale improved from 5.0 to 3.0, with restoration of independent ambulation. The case illustrates the supportive role of Ayurvedic intervention in improving function and quality of life in multiple sclerosis.

INTRODUCTION

Multiple sclerosis is the commonest immune-mediated disorder of the central nervous system and is characterised by chronic inflammation with selective destruction of central myelin, while the peripheral nervous system is spared. The resulting demyelinated, gliotic scars- termed plaques- are multifocal and disseminated in both space and time, and their location dictates the clinical picture. Susceptibility is regarded as the outcome of an interaction between genetic predisposition and environmental triggers.

The disease most often appears between the late twenties and early thirties and is roughly twice as common in women. Reported prevalence varies widely

with geography, being low in equatorial regions and rising steeply with latitude. Four broad clinical patterns are recognised- relapsing-remitting, primary progressive, secondary progressive and the rare progressive-relapsing form- of which the relapsing-remitting type accounts for the large majority of cases.^[1]

Conventional management relies chiefly on immunomodulators, corticosteroids and, in selected cases, newer biological and cellular therapies; these are expensive and carry appreciable adverse effects, and quality of life often remains impaired. Ayurveda offers a complementary, function-oriented approach. The constellation of wasting, weakness, incoordination, sensory disturbance and visual dimness corresponds to *Snayusada* together with *Nadibalakshaya*, and is ultimately rooted in *Majja dhatu kshaya* with associated *Kapha* and *Oja kshaya*.^[2]

Decline of *Majja* manifests as *Bhrama*, *Asthisaushirya* and *Timiradarshana*; *Ojokshaya* causes exhaustion, loss of strength, sensory disturbance and

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confusion- features that map closely onto the symptomatology of multiple sclerosis. The therapeutic aim is therefore *Vata-shamana* with *Balya* and *Brimhana* measures. This report documents such an approach in a young professional with relapsing–remitting disease.^[3]

Case Report

Patient Profile and Chief Complaints

A 35-year-old male, software engineer by profession, presented to the outpatient department with progressive neurological complaints of approximately six months duration. His complaints, with their duration, were: blurring of vision in the right eye with retro-orbital pain on eye movement (4 months); numbness and “pins-and-needles” sensation in both lower limbs (5 months); heaviness and weakness of both lower limbs with difficulty in walking (3 months); unsteadiness of gait (2 months); abnormal, disproportionate fatigue (6 months); and urinary urgency with increased frequency (2 months).

History of Present Illness

The onset was insidious and the course relapsing. The patient recalled a self-limiting episode of transient visual blurring about a year earlier that had resolved without treatment. Over the preceding six months the symptoms had recurred and progressed, characteristically worsening with heat, physical exertion and occupational stress and partially recovering during periods of rest- a pattern consistent with a relapsing–remitting demyelinating illness.

Past, Personal and Family History

There was no history of diabetes, hypertension, tuberculosis or thyroid disease. The patient led a sedentary life with prolonged screen exposure, irregular and largely processed diet, inadequate sleep and high occupational stress. He consumed alcohol occasionally and did not smoke. Family history was non-contributory.

General and Neurological Examination

Vital parameters were stable and the body-mass index was marginally raised. Higher mental functions and speech were intact. Examination of the right eye showed reduced visual acuity (6/18), a relative afferent pupillary defect and temporal pallor of the optic disc, indicating a healed optic neuritis; fine nystagmus appeared on lateral gaze. Tone was increased in both lower limbs; power was Medical Research Council grade 3/5 in the lower limbs and 5/5 in the upper limbs. Vibration and joint-position sense were impaired distally in the lower limbs. The knee and ankle jerks were exaggerated with bilateral extensor plantar responses. Romberg’s sign was positive, the gait was ataxic, and Lhermitte’s sign was elicited on neck flexion, indicating cervical cord involvement.

Dashavidha Pareeksha

The patient was of *Vata–Kapha prakriti*, *Madhyama sara*, *Samhanana* and *Pramana*, *Krura koshtha*, *Vishama agni* and *Madhyama satva*. The clinical picture was assessed as *Snayugata–Majjagata Vata* with *Majja dhatu kshaya* and *Srotorodha–Srotodushti*.

Table 1: Demographic and Baseline Clinical Data

Parameter	Detail
Age / Sex	35 years / Male
Occupation	Software engineer (sedentary, high screen exposure)
Duration of illness	Approximately 6 months
<i>Prakriti</i>	<i>Vata–Kapha</i>
<i>Koshtha / Agni</i>	<i>Krura / Vishama</i>
Clinical diagnosis	Relapsing–remitting multiple sclerosis
Ayurvedic diagnosis	<i>Snayusada (Snayugata–Majjagata Vata)</i>
Baseline EDSS	5.0

EDSS = Expanded Disability Status Scale.

Investigations

Magnetic resonance imaging (MRI) confirmed demyelination, and the supporting electrophysiological and cerebrospinal-fluid findings satisfied the accepted radiological–clinical criteria for multiple sclerosis. The relevant results are summarised in Table 2.^[4]

Table 2: Laboratory and Radiological Investigations

Investigation	Finding
MRI brain & cervical spine	Multiple T2/FLAIR hyperintense demyelinating plaques (periventricular, juxtacortical); one contrast-enhancing lesion at C4 cord level — dissemination in space and time
Visual evoked potential	Prolonged P100 latency, right eye
CSF analysis	Oligoclonal bands positive; raised IgG index
Visual acuity	Right 6/18, Left 6/6
Complete blood count	Within normal limits
ESR	28 mm/hr (mildly raised)
Serum vitamin B12	Low-normal
Serum 25-OH vitamin D	14 ng/mL (deficient)
RBS / RFT / LFT / TFT	Within normal limits

MRI = magnetic resonance imaging; CSF = cerebrospinal fluid; ESR = erythrocyte sedimentation rate; RBS = random blood sugar; RFT = renal function test; LFT = liver function test; TFT = thyroid function test.

Samprapti (pathogenesis) in brief

Mithya ahara and *Vihara*, excessive mental strain and irregular routine aggravated *Vata* and impaired *Agni*. The resulting *Ama* and *Srotorodha* obstructed the channels carrying nourishment to *Majja*; the consequent *Majjakshaya* and *Ojokshaya* resulted in *Snayusada*, producing the motor, sensory and visual manifestations observed.

Treatment protocol

A combined *Shodhana-Shamana* regimen was planned with the twin objectives of *Vatashamana* and *Brimhana*. Because over-reliance on *Ushna* and *Snigdha* measures can paradoxically promote degeneration, the procedures were graded and individualized to patient based on *Roga-Rogi Bala*. The schedule is given in Table 3.^[5]

Table 3: Ayurvedic Treatment Protocol

Category	Intervention	Dose / duration
<i>Shamana</i> (oral)	<i>Ashwagandha</i> + <i>Shatavari churna</i>	5g + 5g, twice daily with warm milk
	<i>Chandraprabha vati</i>	500 mg twice daily before food
	<i>Mahayogaraja guggulu</i> with <i>Ashwagandharishta</i>	500 mg + 20 ml twice daily after food
<i>Shodhana / Bahya</i> (Panchakarma)	<i>Snehapana</i> – <i>Rasnadi /Jeevantyadi ghrita</i>	Graded internal oleation, 5–7 days
	<i>Sarvanga Abhyanga</i> (<i>Bala taila</i>) + <i>Shashtika Shali Pinda Sweda</i>	Daily for 8 weeks
	<i>Shirodhara</i> (<i>Ksheerabala taila</i>)	Alternate days, 14 sittings
	<i>Matra basti</i> → <i>Yapana (Ksheera) basti</i>	<i>Matra basti</i> × 16 days, then <i>Yapana basti</i> × 16 days
Adjuvant	<i>Yoga, Pranayama</i> , meditation	Daily, supervised

Assessment criteria

Each cardinal symptom was graded on a 0–3 ordinal scale (0 = absent/normal, 1=mild, 2=moderate, 3=severe). Disability was assessed using the Expanded Disability Status Scale, visual acuity by the Snellen chart, and lower-limb power by the Medical Research Council grade. Assessments were made before treatment and at 2, 4, 8 and 12 weeks. The grading framework is shown in Table 4.

Table 4: Grading of Cardinal Symptoms

Grade	Vision / sensory	Motor (power)	Gait / balance	Fatigue / bladder
0	Normal	Grade 5/5	Steady	Absent
1	Mild	Grade 4/5	Occasional sway	Mild
2	Moderate	Grade 3/5	Needs occasional support	Moderate
3	Severe	≤ Grade 2/5	Needs constant support	Severe

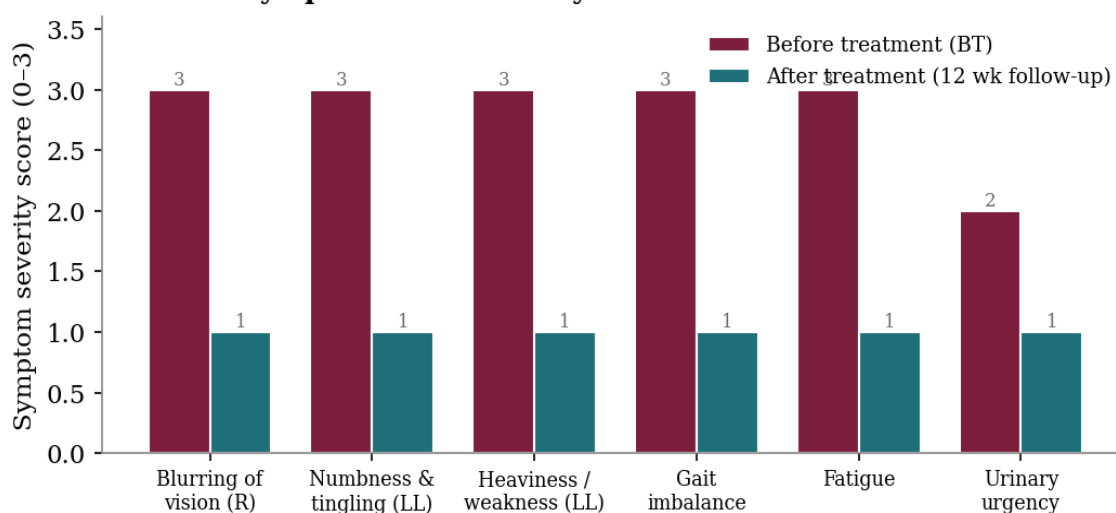
OBSERVATIONS AND RESULTS

The patient tolerated the regimen well, without adverse events. Symptoms improved progressively, most clearly from the fourth week onward. The symptom-severity scores at each time point are given in Table 5 and depicted in Figures 1 and 2; functional outcomes are summarised in Table 6.

Table 5: Symptom Severity Scores Across Time Points

Symptom	BT	2 weeks	4 weeks	8 weeks	12 weeks	% relief
Blurring of vision (R)	3	3	2	1	1	66.7
Numbness & tingling (LL)	3	2	2	1	1	66.7
Heaviness / weakness (LL)	3	3	2	2	1	66.7
Gait imbalance	3	2	2	1	1	66.7
Fatigue	3	2	1	1	1	66.7
Urinary urgency	2	2	1	1	1	50.0
Total score	17	14	9	7	6	64.7

BT = before treatment; wk = week; R = right; LL = lower limbs. % relief = $(BT - 12\text{ wk}) / BT \times 100$.

Symptom-wise severity: before vs after treatment**Fig. 1: Symptom-wise severity before and after treatment**

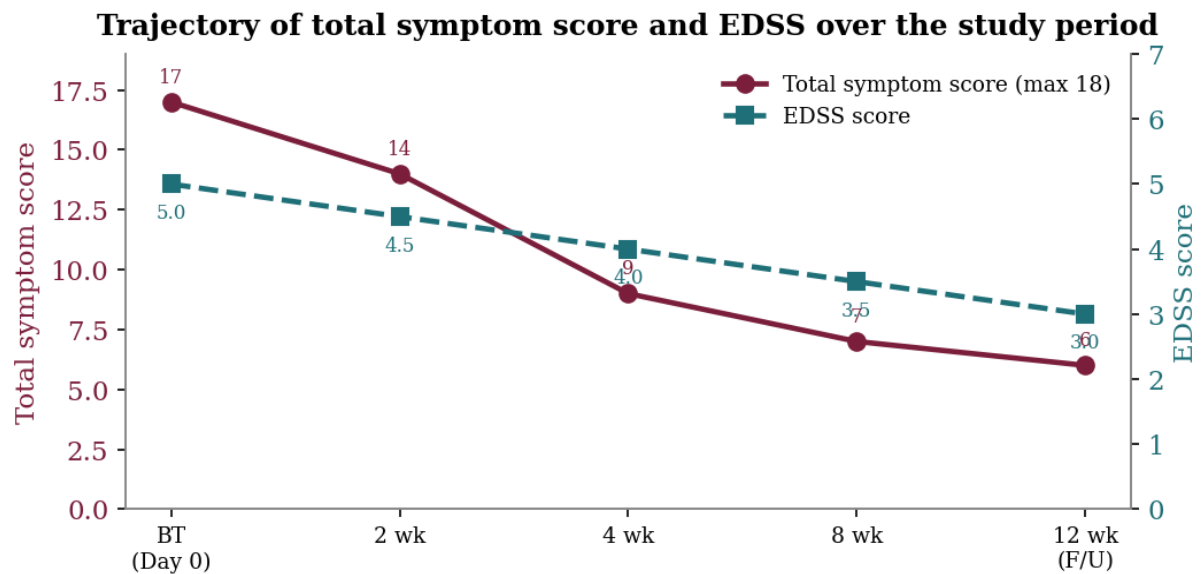


Fig. 2: Trajectory of total symptom score and EDSS over the study period

Table 6: Functional Outcomes and Overall Assessment

Outcome measure	Before treatment	At 12 weeks
EDSS score	5.0	3.0
Visual acuity (right eye)	6/18	6/9
Lower-limb power (MRC)	3/5	4+/5
Ambulation	Bilateral support	Independent (~200 m)
Overall improvement	—	Moderate (50–75%)

EDSS = Expanded Disability Status Scale; MRC = Medical Research Council

DISCUSSION

The combined regimen addressed the disease at three levels: pacification of vitiated *Vata*, clearance of *Srotorodha*, and nourishment of the depleted *Majja* and *Oja*. *Snehapana* and *Sarvanga Abhyanga* with *Bala taila*, followed by *Shashtika Shali Pinda Sweda*, provided *Snigdha-Ushna* that relieved stiffness and improved limb strength, while *Shirodhara* with *Ksheerabala taila* did *Vata shamana* in *Shiras* and improved sleep with reduction in fatigue.

Among the procedures, *Yapana basti* is the most pertinent: *Basti* is regarded as the foremost therapy for *Vata* disorders, and the *Yapana* type is simultaneously *Brimhana* and *Rasayana*, making it well suited to a chronic, wasting, *Majjagata* disorder. *Akshitarpana* with *Triphala ghrita* specifically targeted the visual deficit attributable to optic-nerve demyelination. The oral *Ashwagandha*, *Shatavari* and *Mahayogaraja guggulu* contributed *Balya*, *Rasayana* and *Vatahara* actions, while *Chandraprabha vati* supported the urinary symptoms.^[6]

Care was taken to grade the intensely *Ushna* and *Snigdha* measures, since their excess can aggravate the inflammatory, degenerative component of the disease. Adjuvant *Yoga*, *Pranayama* and

meditation, together with dietary and lifestyle correction, reduced stress and fatigue- recognised triggers of relapse. The roughly two-thirds reduction in symptom score and the fall in disability from a level requiring bilateral walking support to independent ambulation are clinically meaningful, although the relapsing-remitting nature of the illness means that part of the gain may reflect natural remission. As an uncontrolled single case the findings are necessarily preliminary and warrant confirmation in controlled studies; an integrative model combining Ayurvedic and conventional care appears the most rational way forward.^[7]

CONCLUSION

In this 35-year-old male patient, with relapsing-remitting multiple sclerosis, an individualised Ayurvedic protocol built around *Vatashamana*, *Balya*, *Brimhana* and *Yapana basti*, supported by dietary and lifestyle modification, produced substantial symptomatic relief, a two-grade improvement in disability and restoration of independent walking, with good tolerability. The case supports the value of Ayurvedic management as a safe, function-oriented adjunct in multiple sclerosis and

underlines the need for well-designed prospective trials to establish its clinical utility.

Patient Consent

Written informed consent was obtained from the patient for the publication of this case report and the accompanying clinical details.

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*Address for correspondence

Dr. Amrutha Y

Assistant Professor,
Department of Kayachikitsa,
Sri Paripoorna Sanathana Ayurveda
Medical College Hospital & Research
Centre, Bengaluru, Karnataka, India.
Email: amrutha.y156@gmail.com

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