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Case Study

AYURVEDIC MANAGEMENT OF POST TRAUMATIC DIFFUSE AXONAL INJURY

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ABSTRACT

Traumatic axonal injury (TAI) is characterized by multiple, diffusely distributed hemorrhagic or non-hemorrhagic lesions, often accompanied by cerebral edema, predominantly affecting specific regions of the cerebral white matter on neuroimaging. At the cellular level, TAI involves disruption of axonal transport, axonal swelling, and subsequent axonal disconnection as a consequence of traumatic brain injury (TBI). The objective of this study is to evaluate the role of Ayurvedic management in post-traumatic diffuse axonal injury. This is a case study of a 54-year-old male patient who complaints of weakness of bilateral upper and lower limb and mild slurring of speech since 8 months. Based on the history and clinical findings, the case was diagnosed as Post traumatic diffuse axonal injury (*Shiro marmabhigata janya Sarvangaroga*). The patient was treated with internal medications and external therapies including *Kashaya dhara* (controlled pouring of medicated decoction over body), *Abhyanga* (application of oil to body), *Shirodhara* (therapeutic streaming of medicated fluids to head), *Kayaseka* (controlled pouring of liquids over body) and *Shastika Shali Pinda Sweda* (sweating induced by application of a poultice) along with internal medications. The outcome was evaluated using Fugl Meyer Assessment and Modified Ashworth Scale, and significant improvement was seen within a relatively short duration.

INTRODUCTION

Diffuse axonal injury (DAI) is a severe manifestation of traumatic brain injury (TBI), characterized by widespread disruption and structural damage to axons predominantly within the cerebral white matter. It is considered an important determinant of clinical outcome, as severe cases can result in prolonged neurological disability and increased risk of mortality[1]. It is typically characterized by impaired consciousness or coma without a significant focal brain lesion. It involves widespread axonal damage, particularly affecting the brainstem, corpus callosum, and parasagittal white matter, resulting in disruption of neuronal connectivity and consequent cognitive, autonomic, motor, and sensory dysfunction [2].

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In 2019, traumatic brain injury (TBI) accounted for approximately 27.16 million new cases worldwide. Despite this substantial global burden, the age-standardized incidence rate of TBI declined by approximately 5.5% between 1990 and 2019 [3].

According to Ayurveda, *Shiro abhighata* causes aggravation of the *Doṣas*, particularly *Vata*, and *Dushti* of *Rakta*.[4] In traumatic brain injury can be correlated with *Siromarmabhighata* (trauma to the vital structures of the head), which is described to produce manifestations, *Chaksuvibhrama* (ocular disturbance), *Cheṣṭanasa* (loss of motor activity), *Muka* (inability to speak), *Gadgada* (stuttering), *Aksinimilana* (involuntary closure of the eyelids), *Svarahani* (loss of voice/aphonia)[5]. Similarly, *Sarvangaroga* is characterized by features including *Akarmanya* (loss of motor function), *Vichetana.* [6]

Case Report

Patient information: Age– 54 years, Gender– Male, Marital status- Married, Socioeconomic status- middle class

A 54-year-old male presented with complaints of weakness of the bilateral upper and lower limbs and slurred speech for 8 months. According to the patient's wife, he was apparently normal before 8 months. The patient had a history of a road traffic accident on 04 July 2025 at approximately 4:00 PM, when he was hit as a pedestrian and was found lying on the roadside. He reportedly remained at the roadside for approximately 30 minutes before being taken to the hospital. He was taken to nearby hospital, at the time of admission, he was unconscious with a GCS score of E1V2M1 (3/15). There was no history of vomiting, seizures, epistaxis, or otorrhagia. He had post-traumatic amnesia, with impaired recall of events preceding the accident, and subsequent impairment of recent memory.

A CT whole-body trauma protocol performed on 04 July 2025 revealed multiple acute petechial hemorrhages at the grey-white matter junction involving the frontal and parietal lobes, along with thin subarachnoid hemorrhage within the frontal sulcal spaces, findings suggestive of traumatic diffuse axonal injury. There were no craniofacial fractures. No evidence of haemothorax, pneumothorax, haemoperitoneum, or pneumoperitoneum was noted. The patient was shifted to ICU and managed with ventilatory support, antibiotics, antiepileptics, analgesics, and other supportive measures. In view of the prolonged ventilatory support, tracheostomy was done on 08 July 2025. During the ICU stay, he developed persistent fever, and blood and sputum cultures shown Klebsiella pneumoniae, for which antibiotic therapy was administered. His sensorium gradually improved to GCS E4VTM6. He received intensive chest and limb physiotherapy during the hospital stay. He became neurologically stable and had no significant tracheal secretions; he was decannulated on 31 July 2025. At discharge on 06 August 2025, the patient was conscious but had marked weakness of the left upper limb, with inability to move the limb, along with occasional irrelevant speech. He was receiving nutrition through a nasogastric (NG) tube, and physiotherapy was continued at home.

Approximately 1½ months later, he developed cough while taking food, reduced speech, generalized tiredness, and difficulty maintaining a sitting posture. He was subsequently evaluated at Welcare Hospital, where he continued medications, Ryle's tube feeding, and physiotherapy. He showed symptomatic improvement and was discharged after approximately one week. Subsequently, the Ryle's tube was removed following an episode of nasal bleeding.

Despite these interventions, the patient continued to experience persistent bilateral upper and lower limb weakness, impaired postural control, difficulty in walking, slurred speech, and cognitive impairment. In view of the residual neurological and functional deficits following traumatic brain injury, he was admitted for further management.

Comorbidities

No K/H/O T2 DM, Systemic hypertension, DLP, thyroid dysfunction.

History of Past Illness

H/o RTA – 4th July 2025

H/o pneumonia – July 2025

Family History: Nothing relevant

Ongoing Medications

Montek LC– 0-0-1, Liofen 10– 0-0-1, Nebulization with: Iprasure Pulmules– morning, Budeprl mg– night, Deriphyllin retard 150mg– 1-0-1, Ambroxol hydrochloride tab 30mg – 1-0-1, Rabizet DSR– 1-0-0, Quitipin 100– 0-0-1, Encorate chrono 500– 1 HS, Encorate chrono 200– 1 HS, Olzic Plus – 0-0-1, Carispec 1.5– 1 HS, Nitrosun 5 mg– SOS

Personal History

Bowel– frequency- irregular, consistency- hard, micturition- 4-5 times/day, 0-2 times/night, appetite-good, sleep- sound, previously reduced. addiction: alcohol- occasionally before RTA.

Socioeconomic status- middle class, occupational history- construction worker at Kochi metro

Table 1: Timeline

Date	Clinical event/intervention
04/07/2025	RTA, altered sensorium, CT brain demonstrated traumatic axonal injury
08/07/2025	Tracheostomy performed
31/07/2025	Decannulation
06/08/2025	Discharged, persistent left upper-limb weakness, dysarthria and cognitive abnormalities
17/09/2025	Dysphagia, reduced speech, postural difficulty evaluated at hospital, MRI done
26/02/2026	Admitted for Ayurvedic management

Clinical Findings

Nervous System Examination

Higher mental function: The patient was conscious and oriented to place. Immediate, recent and remote memory were impaired. Speech was dysfluent and dysarthric. Calculation and judgment were impaired.

Table 2: Cranial Nerves

Cranial Nerve	Findings
CN II	Distant Vision: R–HM, L–6/24 Near Vision: N36 B/L, Colour vision: R–impaired, L–normal; Visual Field: R–Hemianopia, L–full
CN III, IV, VI	Extraocular movement: Abduction: Rt- Moderate limitation, Lt- Mild limitation
CN IX, X	Swallowing: mildly impaired
CN XI	Trapezius: 4/5(B/L), Sternocleidomastoid: 4/5 (B/L)

Motor system Examination: Muscle tone: Upper and lower limb - Hypertonic (B/L)

Muscle power: Rt upper limb- G4

Rt lower limb - G 4 +

Left upper limb - G 3

Left lower limb - G4

Fugl-Meyer Assessment[7]

Table 3: FMA-Upper extremity

A.	**Upper Extremity**	
1.	Reflex activity	4
2.	Volitional movement within synergies	12
3.	Volitional movement mixing synergies, without compensation	4
4.	Volitional movement with little or no synergy	2
5.	Normal reflex activity	0
B.	**Wrist**	
1.	Stability at 15° dorsiflexion	1
2.	Repeated dorsifexion	0
3.	Stability at 15° dorsiflexion	1
4.	Repeated dorsifexion	0
5.	Circumduction	0
C.	**Hand**	
1.	Mass flexion	1
2.	Mass extension	1
3.	Grasp	3
D.	Coordination/speed	3
FMA-UE Motor Total (A–D)		32/66
H.	Sensation	12
J.	Passive joint motion	18
J.	Joint pain	18

Table 4: FMA-Lower Extremity

Reflex activity	4
Movements within synergies	9
Movements with mixed synergies	2
Movements with little or no synergy dependence	0
Normal reflex activity	0
Coordination / speed	2
FMA-LE Motor Total (E-F)	17/34

Table 5: Modified Ashworth scale[8]

Muscle Group	Right	Left
Elbow flexors	1+	2
Wrist flexors	1	1+
Knee flexors	2	3
Ankle plantar flexors	1+	2

Lab Investigations

FBS, PPBS, BRE, Lipid profile, LFT, RFT, URE – Values WNL

Relevant Investigations

1. CT- Whole Body-Trauma plan (04/07/2025)
   Brain- Multiple acute petechial hemorrhages at grey white mater junction of frontal and parietal lobes, Thin SAH – sulcal spaces of frontal lobe.
   Thorax- Subpleural ground glass opacities with reticulations noted in basal segments of lower lobes.
2. MRI Brain (17/9/2025)
   Few discrete T2/FLAIR hyperintensities in bilateral periventricular and subcortical white mater -could represent chronic small vessel/ ischemic changes
   Multiple chronic microbleeds in peritrigonal, pericallosal frontal and Lt parietal lobes.

Dasavidha Pariksha

Dosa- Vatakapha Vata- Prana, Vyana, Udana, Apana, Dushya-Rasa, Rakta, Majja Bala- Madhyama, Anala-Vishama, Prakrti- Pittakapha, Vaya- Madhyama, Satva-Madhyama, Satmya -Sarvarasa, Sara -Mamsa, Pramana -Madhyama, Samhanana -Madhyama Aharasakti -Abhyavaharana Shakti and Jarana Shakti were Madhyama.

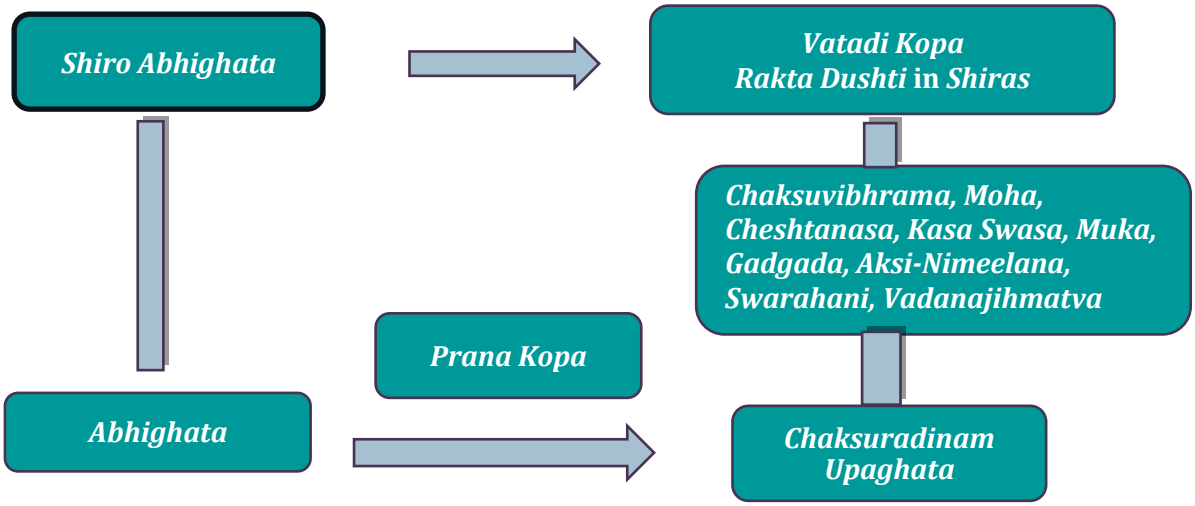
Diagnosis

The diagnosis was confirmed with CT findings dated July 4, 2025. It indicated Multiple acute petechial hemorrhages at grey white mater junction of frontal and parietal lobes, Thin SAH – sulcal spaces of frontal lobe suggestive of DAI. Further, considering the symptoms such as *Cheshtanasha*, *Vakstambha*, and *Samjanasha* can be correlated with *Sarvangaroga* and it was diagnosed as *Shiromarmabhighatajanya Sarvangaroga.* Symptoms were graded based on the presentation -spasticity (as per Modified Ashworth scale), FMA for motor assessment, coordination and muscle power.

Samprapti

Shiro Abhighata which is the *Nidana* here leads to vitiation of *Vatadi dosha* and *Rakta* in *Shiras*. This contributes to disturbances in neurological functions. It will clinically manifest as *Moha* (confusion/altered consciousness), *Cheshtanasha* (loss of motor activity), *Kasa* (cough), *Shwasa* (dyspnoea/difficulty in breathing), *Gadgadatva* (slurring of speech/ dysarthria), *Aksinimeelana* (involuntary closure of the eyes), *Swarahani* (loss of voice/aphonia), and *Vadanajihmatva* (deviation of the face/facial distortion) along with other associated manifestations.

Furthermore, *Abhighata* is a *Nidana* for *Prana vata kopa*, which can subsequently affect the functions of the sense organs, particularly *Chakshuradinam upaghata* (impairment/injury of the eyes and other sensory organs)[9] which is mentioned in classics, is seen in this case. Due to *Vyana vata dushti,* which can occur due to *Vishama cheshta* will results in *Sarvangaroga* and also motor functions like *Gati* (movement/locomotion), *Utkṣepaṇa* (upward movement), and *Apakṣepaṇa* (downward movement/ depression) will be affected [10]. Thus, impairment of HMF, motor, speech, and other neurological functions can be understood in relation to the vitiation of *Prana, Vyana* and *Udana vata* following *Shiro Abhighata.*



MATERIALS AND METHODS

Table 6: Treatment given

Date	Name of Medicine	Dose and Time of Administration
28-02-2026 to 16-03-2026	*Nayopayam kashayam* *Dhanwantaram tab* *Manasamitravatakam* *Kalyanakavaleha churna* *Gandharverandam cap*	15ml *Kashaya* with 45ml lukewarm water -BD B/F 1 BD with *Kashaya* 1 HS with lukewarm water With honey and *Nimbu swarasa* for *Pratisaranam* 1 HS
17-03-2026 to 07-04-2026	*Balasairekadi kashaya* *Dhanwantaram tab* *Gorochanadi tab* *Manasamitravatakam* *Sukumara erandam cap*	15ml *Kashaya* + 45ml lukewarm water BD B/F 1 BD B/F 1 BD A/F 1 HS with lukewarm water 1 cap HS
06-03-2026 to 26-3-2026	*Dasamula katutrayam panam*	*Muhurmuhu*
08 -03-2026 to 14-03-2026	*Vilwadi gulika*	1/2 TID A/F with ginger juice and honey

Table 7

Date	Procedure	Duration
28-02-2026 to 06-03-2026	*Kashaya dhara* with *Dasamoola kashayam*	7 days
07-03-2026 to 13-03-2026	*Abhyangam* with *Sahacharadi taila*	7 days
15-03-2026 to 21-03-2026	*Shirodhara* with *Vatasini taila*	7 days
22-3-2026 to 28-03-2026	*Pizhichil* with *Prabhanjana vimardanam taila* + *Danwantaram taila*	7 days
30-3-2026 to 02-04-2026	*Shastika Sali Pinda Sweda* *Taila - Danwantaram taila*	4 days
03-04-2026 to 07-04-2026	*Abhyangam* with *Sahacharadi taila*	5 days

Adverse and Unanticipated Events

Throughout the treatment course, no adverse events were observed. Patient adherence, treatment tolerability, and both anticipated and unanticipated events were systematically evaluated through patient inquiry.

RESULTS

A. Upper Extremity		**Score(B/T)**	**Score(A/T)**
1.	Reflex activity	4	4
2.	Volitional movement within synergies	12	17
3.	Volitional movement mixing synergies, without compensation	4	5
4.	Volitional movement with little or no synergy	2	3
5.	Normal reflex activity	0	0
B. Wrist			
1.	Stability at 15° dorsiflexion	1	1
2.	Repeated dorsifexion	0	1
3.	Stability at 15° dorsiflexion	1	1
4.	Repeated dorsifexion	0	1
5.	Circumduction	0	1
C. Hand			
1.	Mass flexion	1	2
2.	Mass extension	1	2
3.	Grasp	3	8
D. Coordination/Speed		3	4
H. Sensation		12	12
J. Passive Joint Motion		18	24
J. Joint Pain		18	24

Table 9: FMA-Lower Extremity

1.	Reflex activity	2	2
2.	Movements within synergies	9	14
3.	Movements with mixed synergies	2	4
4.	Movements with little or no synergy dependence	0	2
5.	Normal reflex activity	0	0
6.	Coordination / speed	2	3

DISCUSSION

The case represents residual neurological deficits of traumatic brain injury following a road traffic accident, with persistent motor, speech, cognitive, and postural deficits after the initial trauma. Ayurvedic intervention was initiated eight months after the traumatic event, when the patient continued to have substantial neurological disability.

From Ayurvedic perspective, the clinical presentation can be interpreted through the concept of *Shiro Marmabhighata janya Sarvangaroga*. The *Shiras* is the *Pradhana marma*, and injury to *Shiro marma* is capable of producing profound neurological manifestations.

Abhigahta is recognized as an important factor capable of aggravating *Vatadi dosa* and *Rakta.* In the present case, impairment of higher neurological functions was interpreted in relation to *Praṇa Vata*[7], whereas the bilateral impairment of voluntary motor activity and postural control was considered in relation to *Vyana vata*. Speech impairment was considered in relation to the functions attributed to *Udana Vata*.

In the initial phase of management, the treatment strategy was formulated considering the patient's persistent neurological deficits together with the history of respiratory complications, subsequently continued to experience occasional cough. The treatment was therefore initially planned with consideration of *Pranavṛta vata chikitsa*.

Nayopayam Kashaya was administered initially along with *Dhanvantaraṃ gulika* considering *Pranavrta vata*, while *Manasamitravaṭaka* was given in view of the associated sleep disturbance and neurological presentation. *Kalyanavaleha Churṇa* was used for *Pratisarana* with honey and *Nimbu swarasa*, particularly in view of the associated speech impairment and cough. *Gandharveraṇḍaṃ* was given for *Anulomana* as patient had *Badha mala*.

Following the initial phase, the treatment emphasis was shifted towards *Vatahara* and *Balya* measures. At this stage, the principal clinical concerns were persistent bilateral limb weakness, hypertonia, impaired postural control, restricted mobility and speech impairment. *Balasaireyakadi Kashaya* was administered as the principal *Vatahara yoga*, with the therapeutic rationale as addressing *Vata kopa* and *Vak stambha*. *Gorocanadi vaṭi* which is *Vatakaphahara* and *Kasahara* indications, which is given. *Dhanvantaraṃ Gulika* and *Manasamitravaṭaka* was continued in the second phase.

External therapies were administered sequentially, with initially *Kaphavatahara* measures and later *Vatahara, Brmhana* and *Balya* therapies. Initially, *Kaṣhaya dhara* using *Dasamula kashaya* was done for seven days which is *Vatakaphahara*, followed by *Abhyanga* with *Sahacaradi taila* for seven days. *Sahacaradi taila* was selected for initial *Snigdha kriya* as a *Vatahara* and also *Kaphahara* to an extend, in the view of motor restriction and increased muscle tone. Subsequently, *Sirodhara* with *Vatasini Taila* was performed for seven days, considering the persistent neurological manifestations following *Siro Abhighata* and impairment in higher mental function.

In further phases more *Snigdha, Vatahara* and *Brmhana kriya* were adopted, *Kayaseka* done with *Prabhanjana vimardanam taila* and *Dhanvantara taila* for seven days, followed by *Saṣṭika Sali Pinda Sveda* with *Dhanvantara Taila* for four days, followed by a further course of *Abhyanga* with *Sahacaradi taila*. These procedures were selected as part of the *Vatahara*, *Bṛṃhaṇa*, and *Balya* approach to persistent weakness, stiffness, and impaired mobility. Local therapies were done for the left shoulder drooping, comprising of *Lepa* with *Nagaradi churna* and *Dhanyamla* and *Muriveṇṇa Pichu*.

The patient was assessed with Fugl-Meyer scores and demonstrated significant improvement following the intervention. The upper-extremity motor score increased from 32/66 to 51/66, while the lower-extremity motor score increased from 17/34 to 25/34.

CONCLUSION

The condition was interpreted through the Ayurvedic framework of *Shiro Marmabhighata Janya Sarvangaroga*, with predominant involvement of *Vata* and consideration of the functional roles of *Praṇa Vata, Vyana Vata,* and *Udana Vata*. Management was planned sequentially, initially considering *Praṇavṛta Vata chikitsa*, followed by predominantly *Vatahara, Brmhana,* and *Balya* measures. Following treatment, improvement was observed in motor function, postural control, mobility, muscle tone, speech, and cognitive functioning. The Fugl-Meyer motor score improved from 32/66 to 51/66 in the upper extremity and from 17/34 to 25/34 in the lower extremity. Based on the observed improvements this therapeutic approach can be considered a potential therapeutic approach for the management of post traumatic diffuse axonal injury.

Primary Takeaway Lessons from this Case Report

This case highlights the significant clinical value of personalized, *Dosha*-specific interventions in the management of post traumatic diffuse axonal injury. The integration of internal medications, therapeutic procedures, and supportive measures facilitated not only symptomatic relief but also functional recovery within a relatively short duration. This demonstrates that classical Ayurvedic management, when applied systematically and individually, can effectively restore function even in complex presentations of Post traumatic diffuse axonal injury, underscoring the importance of *Dosha* based, patient specific therapeutic strategies.

Patient Perspective

After undergoing Ayurvedic treatment, he and his family observed improvement in sitting balance, mobility, muscle stiffness, speech, and overall functional ability. He was able to walk short distances without support, which was perceived as an important improvement in his day-to-day functioning as he was wheel chair dependent at the time of admission. The patient reported satisfaction with the progress achieved during the treatment period and expressed willingness to continue follow up. He considered the improvement meaningful for regaining greater independence.

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