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Case Report

Multimodal Panchakarma management of chronic recurrent venous ulcers (Vatarakta) in a young male – A Case Report

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ABSTRACT:

Background: Chronic Venous ulcers are conventionally disease of older adults, with venous hypertension secondary to valvular incompetence as primary mechanism. Recurrence following standard compression and wound-care therapy remains major clinical problem, and presentation in young adult without classical risk factors is comparatively uncommon. **Clinical findings:** This report describes 26-year-old male laborer with a 6 year history of progressively worsening, recurrent, non-healing ulcers over left lower limb of 9cm × 7cm × 0.5 cm, which had previously been treated elsewhere but relapsed on resumption of occupational standing work. Color Doppler confirmed superficial venous incompetence with multiple incompetent perforators, without deep venous thrombosis (CEAP-C2,3,4,6s; Ep; As,p; Pr). Based on Clinical examinations, patient was diagnosed with venous ulcer secondary to chronic venous insufficiency correlating to *Vatarakta.* **Intervention:** Patient underwent sequential courses of *Panchakarma* over eight months, comprising repeated *Virechana* (Purgation therapy), *Jalaukavacharana* (Leech therapy), *Basti* (Enema therapy) along with wound care and internal medications. **Outcomes**: Treatment yielded marked result both in terms of wound healing and resolution of symptoms assessed by VAS/Bates-Jensen/PUSH scores. Ulcers got completely healed leaving only minimal residual pigmentation without any complications. Follow-up was uneventful. **Conclusion**: This case suggests that sequential, multimodal *Panchakarma* and oral *Shamana* (palliative) therapy can achieve durable healing in a chronic, recurrent, multiple venous ulcers where Pain (VAS) fell from 9 to 0, itching (VAS) from 7 to 0, and PUSH tool total score from 16 to 0, with complete ulcer healing and leaving only residual pigmentation by the end of treatment. This case suggests the effectiveness of ayurvedic therapies and proper wound care in the management of long-standing venous ulcers. No recurrence was reported over an eight-month follow-up period, in contrast to his six-year history of repeated relapse under earlier treatment.

KEYWORDS: *Basti*, Case report, Chronic Venous insufficiency, *Panchakarma, Vatarakta*; Venous leg ulcer; *Virechana*.

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1. INTRODUCTION

Venous ulcers are most common chronic lower-extremity wounds, and venous hypertension resulting from valvular reflux or obstruction is their principal underlying mechanism. [1] They carry substantial burden of recurrence and reduced quality of life, and conventional management compression therapy, wound care, and, where indicated, surgery remains limited by frequent relapse. Venous ulcers are most common chronic lower-extremity wounds, accounting for approximately 70–80% of all leg ulcers, with a prevalence of 0.5–1% in general adult population and an annual incidence of 0.2–0.3%. [2] *Samprati* - Ayurveda describes *Vatarakta* as a condition arising from vitiation of *Vata* together with *Rakta Dushti* (vitiation of blood) closely parallel varicose veins and venous ulceration. In present patient, several of these classical *Nidana* (Causative factors) — occupational standing, irregular dietary habits, and marked psychological stress — were identifiable on history-taking, supporting this Ayurvedic correlation. [3] Patient's occupation as a laborer, requiring prolonged standing, together with a raised body mass index (39.5 kg/m²), likely acted as contributory mechanical and metabolic stressors.

Few recently published articles [4] reaffirm that presentation in a young adult in absence of deep venous thrombosis or overt comorbidity, as in present case with chronicity of 6years with recurrent relapsing nature of ulcerations, is atypical and is unique which adds to limited literature on primary venous insufficiency in younger patients.

2. PATIENT INFORMATION

A 26-year-old male, a laborer by occupation, resident of Raichur, of middle socioeconomic status, with no known comorbidities (not known case of diabetes mellitus or hypertension).

Background: Patient was apparently healthy for six years prior to presentation. He gradually developed prominent, visible veins in left lower limb, which progressed to blisters on lateral aspect of leg worsened over time and evolved into multiple non-healing ulcers. He sought treatment at a local clinic which comprised mainly of antibiotics and local wound dressings in interim, with partial relief, but complaints recurred each time he resumed labor work involving prolonged standing. As outcomes of his visits to local hospitals for wound management with supportive oral medications proved to be ineffective, patient had approached to outpatient department with multiple non-healing ulcers over left lower limb, ranging from approximately 9 × 7 cm to 2 × 2 cm, covered with slough, and associated with pain, itching, and hyperpigmentation over both lower limbs.

Past medical history: Not known case of diabetes mellitus or hypertension. Family history: Non-contributory.

Personal history: Bowel habit clear, twice daily; appetite-reduced; micturition-clear; sleep-sound; no addictions; and marked mental stress.

3. CLINICAL FINDINGS

3.1 General examination: Height-178 cm, weight-125 kg, BMI-39.5 kg/m² (obese), well-built. Pallor, icterus, cyanosis, clubbing, and lymphadenopathy were absent. No generalized oedema noted; localized oedema present at ulcer site (see Section 3.3).

3.2 Systemic examination: Conscious and oriented. Respiratory system clear with equal air entry bilaterally. Cardiovascular: S1 and S2 heard, no added sounds. Abdomen soft, non-tender, no organomegaly. Vitals: BP-120/70 mmHg, Pulse rate-78 beats/min, respiratory rate-18 cycles/min— all within normal limits.

3.3 Local examination of ulcer (left lower limb, ankle and foot)

- Inspection — Multiple ulcers, oval to elongated, size ranging 9 × 7 cm to 2 × 2 cm; edges well-defined, sloping, and erythematous.
- Palpation — Tenderness present (++); base adherent; floor reddish; depth 2–3 mm; localized peri-ulcer oedema present.

4. Timeline

Table 1 – Timeline of events

Date	Event
~2019 (6 years prior)	Onset of prominent veins, left lower limb, progressing to blisters and non-healing ulcers; treated at local clinic with partial relief; recurrence on resuming labor work.
27/10/2025	Baseline investigations and examinations were done.
27/10/2025–09/11/2025	Course I — *Nitya Virechana*, *Snehapana, Abhyanga, Parisheka sweda, Virechana, Jalaukavacharana*; daily *Nimba Patra Kalka* dressing; oral medications (*Shamana* therapy)
16/12/2025–24/12/2025	Course II — *Abhyanga, Parisheka sweda, Manjishtadi + Dashamoola Niruha Basti* with *Yashtimadhu Taila Anuvasana*; continued dressing and oral medications (*Shamana* therapy)
29/01/2026–08/02/2026	Course III — Repeat *Virechana* protocol (*Snehapana, Abhyanga, Swedana,Virechana*);
30/04/2026–12/05/2026	Course IV — Repeat *Virechana* protocol with *Dhanyamladhara*; two self-limiting episodes of vomiting noted.
16/06/2026–24/06/2026	Course V — *Manjishtadi Niruha Basti* with *Balaaduchyadi Taila Anuvasana, Aragwadha + Nimba Patra Parisheka, Suvarnikarna (Varnya) Lepa*
24/06/2026	Final follow-up photographic documentation — ulcers fully healed with residual pigmentation

5. DIAGNOSTIC ASSESSMENT

Investigations: Renal function and Complete blood counts were within normal limits. Bilateral lower-limb venous Doppler (05/4/2025) revealed few superficial varicosities. No evidence of deep venous thrombosis was observed.

According to CEAP {clinical findings (C), etiology (E), anatomy (A), and pathophysiology (P)} classification [5] for venous disorders, this wound corresponds to (CEAP-C2,3,4,6s; Ep; As,p; Pr), reflecting visible varicose veins, local edema, skin pigmentation changes, an active ulcer with associated symptoms, a primary (non-thrombotic) etiology, superficial and perforator venous involvement, and a reflux-predominant pathophysiology.

Diagnostic challenges: Recurrence of ulcer and its presentation at a young age made case clinically challenging, eliciting concerns such as possible underlying malignancy, DVT-related pathology, and osteomyelitis changes. Careful evaluation was required to rule out these conditions and plan appropriate management.

6. DIFFERENTIAL DIAGNOSIS

Table 2 – Differential Diagnosis

Disease	Inclusion criteria met	Exclusion/Remarks
Varicose/venous ulcer	Site above medial malleolus; pain/swelling reduced on foot-end elevation; perforator incompetence confirmed	Included because of appearance and similarity with classical features. So final diagnosis was established.
Arterial ulcer	Lower-limb discolouration	Absent claudication; pulses palpable; pain pattern and site inconsistent with arterial aetiology
Diabetic foot ulcer	Non-healing ulcer	No history of diabetes mellitus

Diagnosis: Clinical and Doppler findings were consistent with a venous ulcer secondary to chronic venous insufficiency due to perforator incompetence, without deep venous thrombosis. Correlating *Dosha, Dushya*, and *Samprapti* analysis, an Ayurvedic diagnosis of *Vata-pradhana Tridoshaja Vatarakta* was made.

Prognosis: Chronic venous ulcers are associated with delayed healing and a high risk of recurrence owing to persistent venous hypertension and underlying venous insufficiency. In present case, patient demonstrated complete ulcer healing with marked improvement in pain, edema, and functional status following Ayurvedic

management. No recurrence or treatment-related adverse events were observed during entire course of treatment and follow up of about 1 and half years.

Assessment criteria: Subjective parameters, such as pain and itching, were assessed using VAS. [6] Objective wound parameters were assessed using both Bates-Jensen Wound Assessment Tool [7] and Pressure Ulcer Scale for Healing (PUSH) tool, [8] recorded before treatment and after completion of each of five treatment courses.

7. THERAPEUTIC INTERVENTION

Patient received internal (*Shodhana* and *Shamana*) and external (local dressing, *Parisheka, Lepa, Raktamokshana*) Ayurvedic therapy across five sequential courses spanning approximately eight months, with oral *Shamana* medication continued at home between hospital admissions. (Table 3)

Table 3 - Therapeutic intervention

Course-I: 13days [27/10/2025 – 09/11/2025]	
Date of intervention	**Intervention**
Nitya Virechana: 5 Days(27/10/25 to 31/10/25)	*Nimbamrutadi Eranda Taila* (10ml) + *Triphala Kwatha* (100ml) BD
Jaloukavacarana on day 5(31/10/25).	5 Leeches Were Applied around Wound.
Virechana: 8 Days(1/11/25 to 8/11/25)	*Snehapana - Guggulu Tiktaka Ghrita* – For 4 Days 1/11/25 to 4/11/25. Day1- 50ml, day2 – 75ml, day 3-150ml, day 4-250ml.; *Abhyanga - Pinda Taila* followed by *Aragwadha+Nimba+Karanja Patra Parisheka* – For next 4 Days 5/11/26 to 8/11/26; *Virechana - Trivrutta Lehya* 75gm+ *Triphala Kashaya* 100ml on 8/11/26.
Wound Dressing: 13 Days (27/10/25 to 9/11/25)	Daily dressing - *Nimba Patra Kalka.*
Oral Medications (27/10/2025-31/10/25)	*Kaishora Guggulu* (Ds) 1TID(A/F); *Gukshuradi Guggulu*(Ds) 1 TID(A/F) *Gandhaka Rasayana*(Ds) 1 TID(A/F); *Mahatiktaka Kashaya* 20ml TID(A/F) *Anupana:* Hot Water for all medications. ; *Ahara:* Barley-Rice BD; *Takrapana* 1 Litre/Day.
Observations /Remarks:	Initiated *Nityavirechana* and *Rookshana* with *shamana* therapy where patient had attained 3,4,4,3&3 *vegas* on day 1,2,3,4&5 respectively. Followed by *Jalaukavacharana* – 210ml of Blood Collected. *Virechana - 15 vegas* (Purgation bouts) attained on *Virechana* day. Local wound care was given targeting detoxification at local and systemic levels. Post discharge patient continued with further *shamana* (as shown in Table 6).
Course-II: 9days [16/12/2025– 24/12/2025]	
Basti karma: 7 Days(16/12/25 to 22/12/25)	*Sarvanga Parisheka sweda* with *Aragwadha Patra+Karanja Patra.* *Manjishtadi +Dashamoola Niruha Basti* & *Anuvasana Basti* with *Yashtimadhu Taila* 50ml *(Kala basti pattern-4A&6N)*
Wound Dressing: 9 Days (16/12/25 to 24/12/25)	Dressing Daily with *Nimba Patra Kalka*.
Oral Medications: [16/12/2025–24/12/2025]	*Kaishora Guggulu*(Ds) 1 TID(A/F); *Gukshuradi Guggulu*(Ds) 1 TID(A/F) *Gandhaka Rasayana*(DS) 1 TID(A/F); *Pancha Tiktaka Kashaya* 20ml TID(A/F) *Anupana:* Hot Water for all medications; *Ahara*: Barley-Rice Twice Daily.
Observations /Remarks:	*Manjistadhi niruha basti* – to target deeper pathology. Local wound care and *shamana* continued even post discharge (as shown in Table 6).
Course-III: 11days [29/01/2026–08/02/2026]	

Virechana Karma: 8 Days (30/1/26 to 6/2/26)	*Snehapana* with *Guggulu Tiktaka Ghrita* to 2/2/26 For 4 Days. Day 1 -50ml, day 2-75ml, day 3-150ml, day 4-200ml; *Abhyanga* with *Pinda Taila* followed by *Dashamoola + Twak Patra Parisheka*; From 3/2/26 to 6/2/26 for 4days; *Virechana* with *Trivrita Lehya* (75 Gms) And *Triphala Kashaya* (100 ml) on 6/2/26.
Wound Dressing: 11days (29/1/26 to 8/2/26)	Dressing Daily with *Nimba Patra Kalka*
Oral Medications: [29/1/26 to 1/2/26]	*Rookshana: Shunthi Churna* (1 Tsp TID(B/F)) *Triphala Churna* (5 Gms, At Bedtime); *Anupana:* Hot Water for all medications.
Observations /Remarks:	Owing to persistent obesity and *bahu dosha avastha, shodhana - Virechana* was repeated - 24 *vegas*(Purgation bouts) attained on *Virechana* day. Local wound care and *shamana* continued even post discharge (as shown in Table 6).
Course-IV: 13days [30/04/2026–12/05/2026]	
Nitya Virechana: 4 Days (30/4/26 to 3/5/26)	*Nimbamrutadi Eranda Taila* (10 ml) with *Triphala Kwatha* (100 ml) BD
Virechana Karma: 8 Days (4/5/26 to 11/5/26)	*Snehapana* with *Guggulu Tiktaka Ghrita* For 4 Days 4/5/26 to 7/5/26 day1- 50ml, day2- 75ml, day3- 150ml, day4-200ml; *Abhyanga* with *Pinda Taila* Followed by *Dhanyamladhara* for 4days from 8/5/26 to 11/5/26; *Virechana* with *Trivrita Lehya* (80 Gms) and *Triphala Kashaya* (100 ml) on 11/5/26.
Oral Medications:[30/04/2026–12/05/2026]	*Kaishora Guggulu(DS) ; Gokshuradi Guggulu(DS)* (1 Tablet Each, TID); (A/F) *Pancha Tiktaka Kashaya* (20 ml TID(A/F) 5days during *Nitya Virechana* *Anupana:* Hot Water for all medications.
Observations /Remarks:	Initiated *Nityavirechana* - patient attained 3,4,3,3&4 *vegas* on day 1,2,3,4&5 respectively. S*hodhana* was repeated -*Virechana* -24 *vegas* (Purgation bouts) attained on *Virechana* day. Local wound care and *shamana* continued even post discharge (as shown in Table 6).
Course-V: 9days [16/06/2026–24/06/2026]	
Basti Karma: 6 Days 17/6/26 to 22/6/26)	*Aragwadha Patra + Nimba Patra Parisheka.* *Manjishtadi Niruha Basti Anuvasana Basti* with *Balaaduchyadi Taila* (30 ml) *(Kala Basti* pattern – 4A and 6N*)*
Suvarnikarna (Varnya) Lepa: 9 Days 16/6/26 to 24/6/26)	*Yashtimadhu Churna, Manjishta Churna,* and *Nirmal Churna* in Equal Parts, applied externally to Lower Limbs.
Oral medications: [16/06/2026–24/06/2026]	*Kaishora Guggulu(DS) Gokshuradi Guggulu(DS)* 1 Tablet Each, TID(A/F) *Maha Manjishtadi Kwatha* 15ml TID(A/F); *Arogyavardhini Rasa* 1 TID(A/F) *Navaka Guggulu* (Ds) 1 TID(A/F); *Anupana:* Hot Water for all medications.
Observations /Remarks:	Complete wound healing was noted with hyperpigmentation persisting around wound area. *Basti* repeated to prevent recurrence of pathology and further enhance local circulation to address hyperpigmentation.

Table 4 –Niruha formulation

Ingredient	Quantity
Madhu	80 ml
Saindhava	5 g
Moorchita Tila Taila	120 ml
Kalka Dravya — Ashwagandha Churna	40 g
Kwatha Dravya: Dashamoola Manjishtadi Kwatha	240 ml
Total	480 ml

*Used in Course II and repeated, with a different *Anuvasana oil,* in Course V.

Table 5 – *Shamana Aushadis*

Course and Date	Discharge medications	Company name
During and After Course-I [12/11/2025–15/12/2025]	*Kaishora Guggulu*(Ds) 1 TID(A/F) *Tab.Laghusootashekara* 1 TID(B/F) *Gandhaka*	SDM Pharmacy, Udupi Batchno.KFT060 SDM Pharmacy, Udupi Batchno.LST032 SDM Pharmacy,

	Rasayana(Ds) 1 TID(A/F) *Mahatiktaka Kashaya* 20ml TID(A/F)	Udupi Batchno.GRT027 CKKM Pharmacy
During and After Course-II [25/12/2025-28/01/2026]	*Kaishora Guggulu*(Ds) 1 TID(A/F) *Gokshuradi Guggulu*(Ds) 1 TID(A/F) *Guduchi Rasayana* 1 TID(A/F) *MahaManjishtadi Kwatha* 15ml TID(A/F) *SwadishtaVirechana Churna* – 10gm Once/Week(At bedtime)	SDM Pharmacy, Udupi Batchno.KFT062 SDM Pharmacy, Udupi Batchno.GKT035 SDM Pharmacy, Udupi Batchno.GDE055 SDM Pharmacy, Udupi Batchno.MMA021 AyuKalp
During and After Course-III [11/02/2026-29/04/2026]	*Kaishora Guggulu*(Ds) 1 TID(A/F) Tab.*Arogyavardini Rasa* 1 TID(A/F) *MahaManjishtadi Kwatha* 15ml TID(A/F)	SDM Pharmacy, Udupi Batchno.KFT064 SDM Pharmacy, Udupi Batchno.GKT037 SDM Pharmacy, Udupi Batchno.AVT049 SDM Pharmacy, Udupi Batchno.MMA021
During and After Course-IV [15/05/2026 – 15/06/2026]	*Kaishora Guggulu* (Ds) 1 TID(A/F) Tab.*Arogyavardini Rasa* 1 TID(A/F) *MahaManjishtadi Kwatha* 15ml TID(A/F)	SDM Pharmacy, Udupi Batchno. KFT067 SDM Pharmacy, Udupi Batchno.AVT051 SDM Pharmacy, Udupi Batchno.MMA021

Note: *Anupana:* Hot Water for all medications.

8. FOLLOW-UP AND OUTCOMES

Assessments of ulcer and associated symptoms were recorded as follows.

Table 6 – VAS scores

Parameter	Before treatment	End Course-I(09/11/25)	End Course-II(24/12/25)	End Course-III(08/2/26)	AT4 (end Course IV(12/5/26)	AT5 (end Course V(24/6/26)
Pain (VAS, 0–10)	9	5	4	2	0	0
Itching (VAS, 0–10)	7	6	5	0	0	0

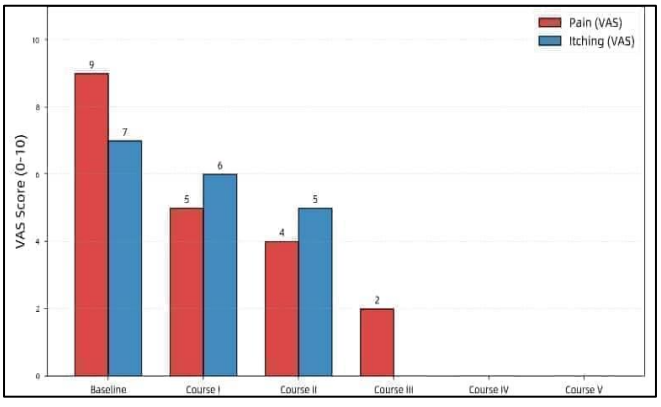

Image 1: VAS score

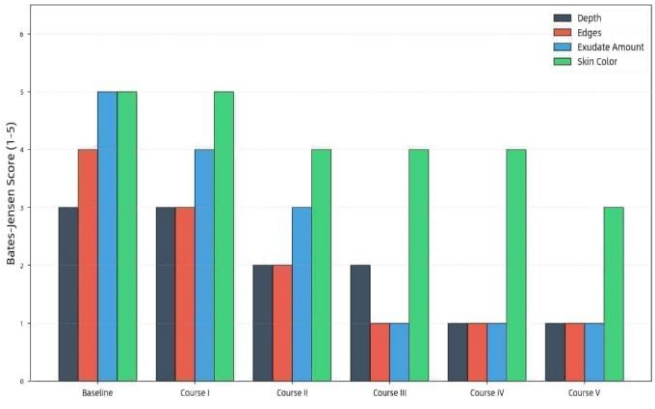

Image 2: VAS scores Bates-Jensen Wound Assessment Tool

Table 7 – VAS scores Bates-Jensen Wound Assessment Tool

Parameter	Before treatment	End Course-I(09/11/25)	End Course-II(24/12/25)	End Course-III(08/2/26)	AT4 (end Course IV(12/5/26)	AT5 (end Course V(24/6/26)
Wound size (L × B × depth, cm)	9×7×0.5 (31.5)	8×5×0.5 (20)	6×4×0.2 (4.8)	3×2×0.2 (1.2)	Granulation tissue covering wound bed	Only wound scar present
Depth (recorded value)	3	3	2	2	1	1

Edges (1–5)	4	3	2	1	1	1
Exudate amount (1–5)	5	4	3	1	1	1
Skin color surrounding wound (1–5)	5	5	4	4	4	3

Table 8 – PUSH Tool (Pressure Ulcer Scale for Healing)

Parameter	Before treatment	End Course-I(09/11/25)	End Course-II(24/12/25)	End Course-III(08/2/26)	AT4 (end Course IV(12/5/26)	AT5 (end Course V(24/6/26)
Surface area sub-score (0–10); actual area in cm² shown in parentheses	10 (63)	10 (40)	9 (24)	-7 (6)	0 (0)	0 (0)
Exudate amount sub-score (0–3)	3	2	1	0	0	0
Tissue types sub-score (0–4)	3	2	1	1	0	0
PUSH total score (0–17)	16	14	11	8	0	0

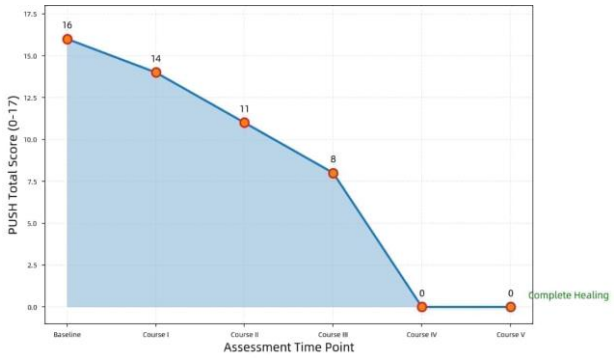

Image 3: PUSH Tool

Photographic documentation prior to start of treatment showed multiple discrete ulcers with surrounding hyperpigmentation on left ankle and leg. By end of Course IV, ulcers healed with granulation tissue covering wound bed. By end of Course V, only wound scarring remained with residual pigmentation.

Adherence: Patient adherence was assessed at each follow-up through patient self-reported medication records/log book, with no missed doses or interruptions reported.

Tolerance: Tolerance was assessed through regular clinical monitoring and patient-reported symptoms during each treatment course and follow-up, with no treatment-related intolerance reported.

Adverse events: Assessed through clinical observation and patient reporting; no adverse events were reported or noted. No episodes of secondary infections, pus discharge, or delayed wound healing were noted.

Table 9 – Blood investigation baseline and after intervention course

Test	BT(27/10/2025)	AT(24/06/2026)
Haemoglobin	13.9 g/dL	14.9 g/dL
Total WBC Count (TC)	9900 cells/mm³	8120 cells/mm³
Differential Count (DC)		
Neutrophils	58%	58%
Lymphocytes	32%	34%
Eosinophils	06%	05%
Monocytes	05%	03%
Basophils	00%	00%
ESR	18 mm/hr	06 mm/hr
Renal Function Tests		
Blood Urea	15.0 mg/dl	21.0 mg/dl
Serum Creatinine	0.99 mg/dl	0.96 mg/dl
Serum Uric Acid	5.83 mg/dl	6.00 mg/dl
C-Reactive Protein (CRP)	30.9 mg/L	10.3 mg/L
Random Blood Sugars	78mg/dl	100 mg /dl

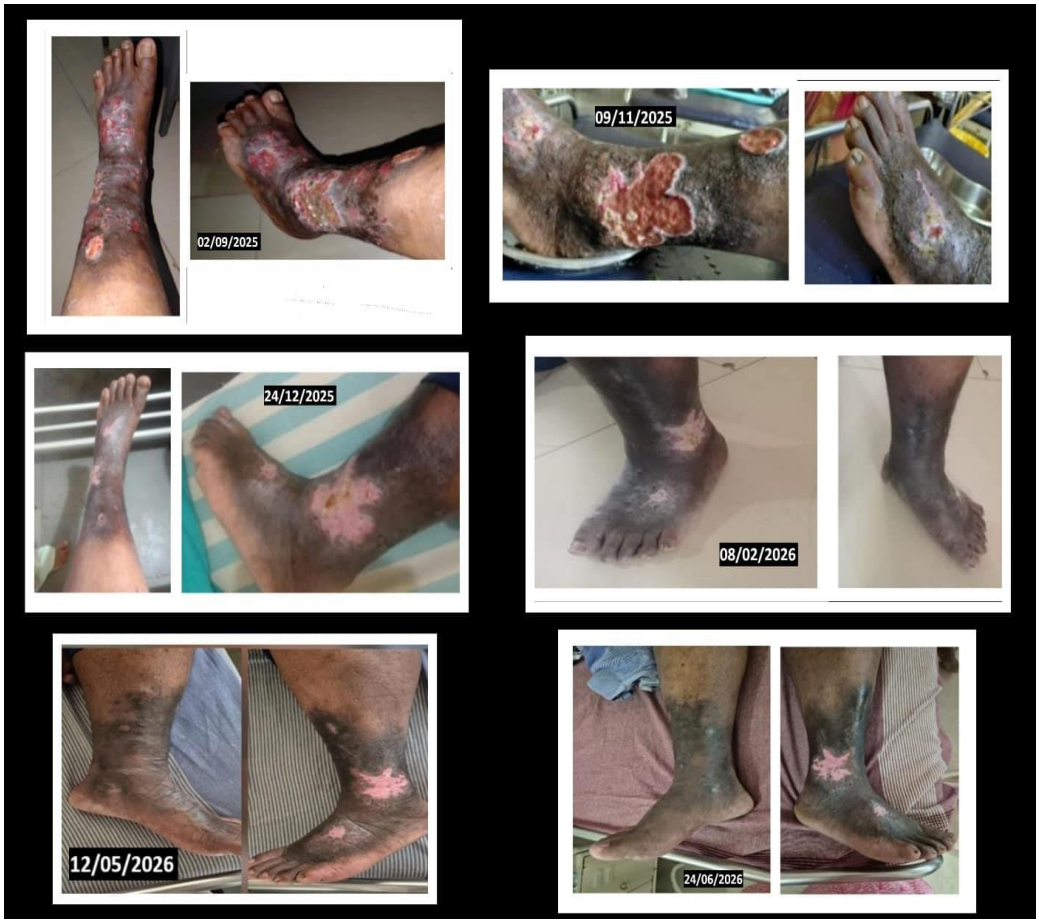

Image 4 – Sequential images showing ulcers healing process

9. DISCUSSION

Venous hypertension secondary to valvular reflux or perforator incompetence is central mechanism of venous ulceration. [9] Although venous ulcers typically present in older patients with established risk factors, [1] this patient's presentation at 26 years of age, with chronic non-healing venous ulcers suggests a primary venous insufficiency pattern. This necessitated formulation of a multimodal management protocol through repeated *shodhana (*Bio purificatory procedures) in form of more than one course of *Virechana* and *Basti karmas* along with oral medications and local wound care. Few recently published research works employed only local therapies in form of *avachuranam* [4] yielding good result in similar ulcerations but it might be because of relatively much smaller ulcer sizes and severity.

Samprapti (Ayurvedic pathogenesis): *Ashtanga Hridaya* describes that *Vidahi, Snigdha, Ushna,* and *drava ahara,* taken by those exposed to *agni* and *atapa*, vitiates the *Raktavaha Srotas* — a description consistent with differentiation of *Vata-Rakta* involvement in this case. [10]

Samprapti Vighatana (Treatment rationale): *Nitya Virechana* was initially employed as a preparatory *Rukshana* and *Srotoshodhana* measure, following which *Snehapana* was administered as part of planned *Virechana* protocol to facilitate adequate *Dosha Utkleshana* and subsequent *Shodhana*. Repeated *Virechana* was selected as *shodhana* with *poorvakarma* in form of *Rookshana* in form of *ahara*, *yava yavagu* (barley gruel) and *takrapana* (buttermilk) were administered, *vihara*, brisk walking was advised along with oral medications (as listed in Table 6). *Nitya Virechana* with *Nimbamrutadi Eranda Taila* and *Triphala Kwatha* was employed at outset and in Course IV as a preparatory *Rukshana* and *Srotoshodhana* measure, *anulomana* action of *Nimbamruta Eranda Taila* for *Shodhana. Virechana* was employed which facilitated elimination of vitiated excess

Kledatha [11] Because *Samprapti* in this patient involved *Bahudosha lakshanas* with morbidly obese presentation with Chronic reoccurring pathology, a single *Virechana* course was judged insufficient, and protocol was repeated across three of five courses over eight months to progressively reduce *doshic* load and ensuring a deeper *samprapti vighatana*.

Abhyanga with *Pinda Taila*, administered before each *Virechana* supports blood and lymphatic circulation, reduces *Srotorodha*, enhances local tissue perfusion and healing tendency.[12] *Parisheka* with *Aragwadha-Nimba-Karanja-Patra* in Courses I and II, *Dashamoola-Twak-Patra* in Course III, induced *Shodhana* effect on local venous and dermal tissue. [13]

Jalaukavacharana was employed (Course I) as local method of *Raktamokshana*, [14] application of five leeches under aseptic conditions removed approximately 210 ml of stagnant, vitiated venous blood from perilesional area, directly addressing local *Rakta Dushti*. This parallels with literature that leech therapy improves local microcirculation and reduces venous congestion. [14]

Manjishtadi-Dashamoola Basti was administered in Courses II and V (as in Table 4) for *Vata Shamana*, predominant *Dosha* in this case. *Kala Basti* (schedule of 1 *Anuvasana Basti* followed by 2 consecutive *Niruha* pattern) was adopted, targeting *Pitta*, ensuring *Srothorodha*, thereby improving tissue perfusion, microcirculation, and venous return, mechanisms that address pathophysiology of chronic venous insufficiency. [15]

Local dressing with *Nimba Patra Kalka* was maintained throughout five courses as it has *Krimighna Vrana Shodhana* properties, providing wound decontamination and a stimulus to granulation tissue formation [13]. *Shamana aushadis* were kept on hold during *Snehapana*, *Vishramakala, Virechana* and two days post *Virechana*. Oral *Shamana* regimen maintained between hospital admissions provided sustained *Dosha* pacification. *Kaishora Guggulu* a *Vatarakta*-specific formulation with *Tikta-Ushna-Rakta Shodhaka* action, and *Gokshuradi Guggulu,* addressed systemic *Vata-Rakta* component effectively addressing local edema. *Gandhaka Rasayana,* with its *Raktashodhaka, Krimighna,* and *Rasayana* properties, supported tissue repair. *Mahatiktaka Kashaya* (Course I) and *Pancha Tiktaka Kashaya* (Courses II and IV) served as *Pitta-Rakta Shodhaka*, indicated in chronic inflammatory skin and vascular conditions; *Manjishtadi Kashaya* a *Varnya-Raktashodhaka* through inter-course discharge periods. [16] *Arogyavardhini Rasa,* used from Course III onward, addressed *Santarpanottha* and *Kapha-Meda Dushti* component through its *Deepana-Pachana* and *sroto shodhaka* actions, complementing *Apatarpana* strategy.

Course V was added to address hyperpigmentation around wound (Bates-Jensen skin color sub-score remaining at 4 at that stage). *Suvarnikarna Varnya Lepa* and *Basti* were directed at residual *Rakta-Twak Dushti*, after which skin color sub-score improved further to 3. Patient's weight reduced from 125 kg at baseline to 118.6 kg by Course IV, supporting efficacy of sustained *Apatarpana* throughout treatment period.

Progressive reduction in Pain VAS from 9 to 0, Itching VAS from 7 to 0, and PUSH total score from 16 to 0 across five courses, with complete wound healing by Course IV and only residual pigmentation addressed through Course V (as in Table 4, Image 1, 2, 3).

Supportive measures including limb elevation, calf muscle exercises to improve venous return, dietary modification, and sustained follow-up contributed to eight-month recurrence-free outcome. [9] Similar multimodal panchakarma was done in recently published article further reassuring safety and efficacy of Multimodal ayurvedic panchakarma interventions in management of chronic venous insufficiency. [17]

Strengths and limitations

This case demonstrates durable healing of a long-standing, previously recurrent venous ulcer in a young patient through a structured, Panchakarma using three validated outcome measures (VAS, Bates-Jensen Wound Assessment Tool, and PUSH). Absence of recurrence over an eight-

month follow-up period, despite patient's continued occupational exposure to prolonged standing, supports durable rather than purely temporary remission. As a single case report, findings cannot be generalized, and absence of a control arm means that spontaneous improvement or effect of reduced occupational strain during repeated hospital admissions cannot be excluded.

10. CONCLUSION

This case of a 6-year chronic recurrent multiple non-healing ulcers over left lower limb, ranging from approximately 9 × 7 cm to 2 × 2 cm, covered with slough, and associated with pain, itching, and hyperpigmentation over both lower limbs corresponding to C 2,3,4,6,s Ep, As,p P r, with PUSh Scores of 16, VAS pain and itching of 9 and7 respectively, managed with multimodal Ayurvedic interventions comprising of *Shodhana* (repeated *Virechana, Basti, Jalaukavacharana*), *Shamana* therapy, *Pathyapathya*, and local wound care over 8 months recurrence-free follow-up, achieved complete ulcer healing without major adverse effects; Pain, itching, and PUSH scores reduced to 0,0,0 respectively with residual pigmentation. This case highlights that staged, individualized *Panchakarma* may provide faster healing and reduce recurrence in chronic venous ulcers.

Declaration of Patient Consent – The authors confirm that they have acquired a patient consent form, in which the patient or caregiver has granted permission for the publication of the case, including accompanying images and other clinical details, in the journal. The patient or caregiver acknowledges that their name and initials will not be disclosed, and sincere attempts will be undertaken to safeguard their identity. However, complete anonymity cannot be assured.

Ethical Statement: Written informed consent was obtained from the patient(s) for publication of the clinical information and accompanying images. The requirement for Institutional Ethics Committee approval was not required in accordance with the applicable institutional policy.

Patient's Perspective: "For six years, I suffered from recurrent painful leg ulcers with severe itching that affected my mobility, daily activities, and ability to continue working. Despite receiving treatment from several hospitals, the ulcers repeatedly recurred. Following the present Ayurvedic treatment, my pain and itching resolved, the ulcers healed completely, and I regained comfort in walking and routine activities. Most importantly, there has been no recurrence during the eight-month follow-up, which has greatly improved my confidence and quality of life."

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