Viddhagnikarma - A Widespread Perspective to Counteract Malady Featuring Katigata vata i.e. Pelvic Disc Herniation - A Unique Case Report."

Mangi Pure[1], Sudesh Lamoria[2]

Assistant-Professor, Department of Rog Nidan Evam Vikriti Vigyan, Sumandeep

Ayurveda Medical College, Vadodara, Gujarat

Associate-Professor, Department of Prasuti Tantra Evum Stri Roga,

Gokul Ayurved College, Sidhpur, Gujarat

[1]puremangi@gmail.com, [2]beniwalsudesh1@gmailcom

Abstract:

An approach to therapy recognized as "Viddhagnikarma" is a special blend of two entirely distinct therapeutic strategies: Agnikarma (thermal cauterization) and Viddhakarma (piercing). This is a concept modification that conforms an array of agnikarma techniques outlined by Acharya Sushrut, that stipulate the use of multiple instruments at various locations for agnikarma. With the goal to prevent skin burns, the heat emitted must reach the deep structures of muscles, tendons, and ligaments through an alternate pathway than the skin. This is the rationale how viddhagnikarma was employed. Given the fact both conditions illustrate similar signs and symptoms, pelvic disc herniation and katigata vata are possibly related. People with poor spinal alignment, experiencing morning stiffness in their lumbar region, difficulty turning around, pain radiating with tingling in the lower limbs, are predicted to experience katigata vata. The ultimate goal of research is to yield substantial relief from pain and an offset from other symptoms while resuming normal lower limb and back movements without causing any adverse consequences. Although NSAIDs and a variety of other drugs have been used more often, they need to be replaced with an alternative form of therapeutic intervention that is economical and suitable for individuals of every age. This research paper conveys a treatment strategy known as viddhagnikarma for the management of pain in a 30-year-old gentleman diagnosed with katigata vata (pelvic disc herniation), who failed to respond well to topical analgesics or muscle relaxants. The oral medication used was Vata vidwansa rasa and Tryodashanga guggul. In two sittings, following seven days, the patient endured remarkable relief without any negative effects.

Kewords: *Katigata vata,* Lumbar pelvic disc herniation, *Viddhagnikarma, Viddhakarma, Tryodashanga guggul, Vata vidwansa rasa*.

- **Introduction**:

Ayurveda is a blessing for degenerative orthopedic diseases such as pelvic disc herniation, pelvic disc herniation. In terms of its etiology and symptoms, "*Katigata Vata*" is an impairment that is analogous to pelvic disc herniation. The symptoms of *katigata vata* disease tend to begin in the lumbar region, or *kati*, and progress to the foot of the lower limb. *katigata vata* is one of the *vata* malady which 'Acharya Madhavkara' in his conventional text clarified very well namely '*Madhava Nidan'*[1] and Acharya Sushrut described it in *Sushrut samhita*[2]. The genesis of *katigata vata* demonstrates the overwhelming influence of *vata dosha*. The disorder labeled *katigata vata* is highlighted by symptoms like pain radiating from the posterior of the leg to the foot[2].

Adults over 30 years of age typically become impacted by pelvic disc herniation, a disorder characterized by degeneration of the lumbar spine. The inability to rotate their bodies freely when traveling, composing texts, exercising, and other tasks causes low back strain in people who have a bad lumbar stance or those who have a susceptibility to it. The source for this pathology is the intervertebral discs. Disc degeneration causes a decline in disc space, and eventually leads to the emergence of osteophytes. Pain is caused by the secondary involvement of the posterior intervertebral joints. Osteophytes resting on the nerve roots is the cause of radicular pain. Infrequently, the osteophytes may compress the spinal cord and provoke symptoms[3].

In this case study, we evaluated *katigata vata's* radicular discomfort using "*Viddhagnikarma*." Combining two distinct therapies, *viddhakarma* (piercing)[6] and *agnikarma* (heat cauterization), is known as *viddhagnikarma*. The concept of conceptual ideology merely modifies the idea of Acharya Sushruta regarding the deep penetration of heat through heated oil, ghee, honey, or jaggery to reach tendons, ligaments, and bone[4]; nevertheless, this may have negative effects and result in blisters or other burn-like indications. In essence, *viddhagnikarma* is puncturing a needle at the most sensitive spot and heating the other end in order to prevent burn symptoms by using the conduction method to transfer heat to deeper structures at the distal end of the needle without passing through the skin.

As the instructions of Acharya Sushruta, *agnikarma* is possibly advantageous in lowering pain under such circumstances. Since *agnikarma* keeps diseases from forthcoming again, Acharya Sushruta suspects it to be a superior treatment than *Kshara* (Alkali), *Bheshaj* (Medicine), and *Shastra* (Surgery). Furthermore, it's beneficial in *katigata vata* treatment[4]. Acharya Sushruta clarifies *viddhakarma* as *vyadhana* (to puncture) in the *sharira sthana* of Sushruta Samhita. Acharya persists to assert that when *lepa* or *snehan*-like procedures fail to relieve pain, *siravyadhan* can prove valuable[5].

This case report's principal objective is to treat the condition with less-invasive pain alleviation approach that alleviates the discomfort without the need for future NSAID use. In India, the prevalence of pelvic disc herniation fluctuates between 22% to 39%. Individuals usually encounter pain and take NSAIDs, opioids, analgesics, muscle relaxants, topical analgesics, lumbar collars, and lumbar traction. These remedies are pricey and only provide short-term relief; there is a risk of long-term complications. *Viddhagnikarma* is relatively inexpensive, efficient, and yields side effects.

Epidemiology[6]: About 25% of people under 40, 50% of people among 40 and 60, and 85% of those over 60 exhibit signs of degenerative disease, which most commonly affects L4-L5, then L5-S1.

Aim: To evaluate the efficacy of *Viddhagnikarma* in the management of *Katigata Vata* i.e Pelvic Disc Herniation.

Objectives:

Primary objective: To evaluate the efficacy of *viddhagnikarma* in relieving pain and stiffness in *katigata vata* (pelvic disc herniation).
Secondary objectives: To restore normal function of back and leg, to provide safe and cost-effective treatment mostly in geriatric age group, to seek for non-invasive therapy with ameliorate results.

- **A Case Report**:
  A 30-years old gentleman, who runs a business with long sitting presented with complaints of low back ache and stiffness that aggravated by movements, radiating pain with tingling sensation from lower back to left lower limb and minimal weakness in left lower limb since the past 2 years. He disclosed oral administration of NSAID'S, Tab. Peg SR M75 and multivitamins from his family doctor. He experienced poor relief so visited spine surgeon and was advised laminectomy procedure but patient was against it so visited the institution for further conservative management.

Table 1: Personal history of the patient.

Name- ABC	Bala- Moderate
Age- 28 years	Sex- Male
Marital status- Unmarried	Occupation- Business
Weight- 60 kgs	Bowel habit- Regular
Sleep- Regular (7 hours)	Diet- Vegetarian

- Patient is not a known case of Hypertension, Diabetes mellitus or any major illness.
- Patient has not undergone any previous surgery.

General examination:

Table 2: General examination

Pulse rate	72/min regular with normal volume
Blood pressure	110/80 mm of Hg
Respiratory Rate	16/min
Temperature	97.8ºF
Pallor/Icterus/Clubbing	Absent

Systemic examination:

Table 3: Systemic examination

Respiratory system	Air entry bilaterally equal, no abnormal lung sounds heard.
Cardio-vascular system	S1 and S2 heard.
Central nervous system	Conscious and well oriented
Per abdomen	Soft and non-tender

Local examination of lumbar spine & left lower limb region:

On Inspection: Absence of swelling, redness or scar at lower back and both lower limbs region.

- **On examination**:

Table 4: Signs and symptoms of the patient (Before treatment).

Parameter's	**Observation (Before treatment)**	
Tenderness	Present (++)	
Swelling	Absent	
Morning Stiffness	Present	
Tingling Sensation (Low back to Left Lower Limb)	Present	
Lower limb weakness	Right	Left
	Absent	Present (Minimal)

Table 4 describes the present signs and symptoms of the patient after evaluation that had tenderness, tingling sensation from low back region up to left lower limb and weakness in the same limb was noted with absence of swelling.

- **Clinical examination findings**: (Table 2)

Table 5: Clinical examination of the patient (Before treatment).

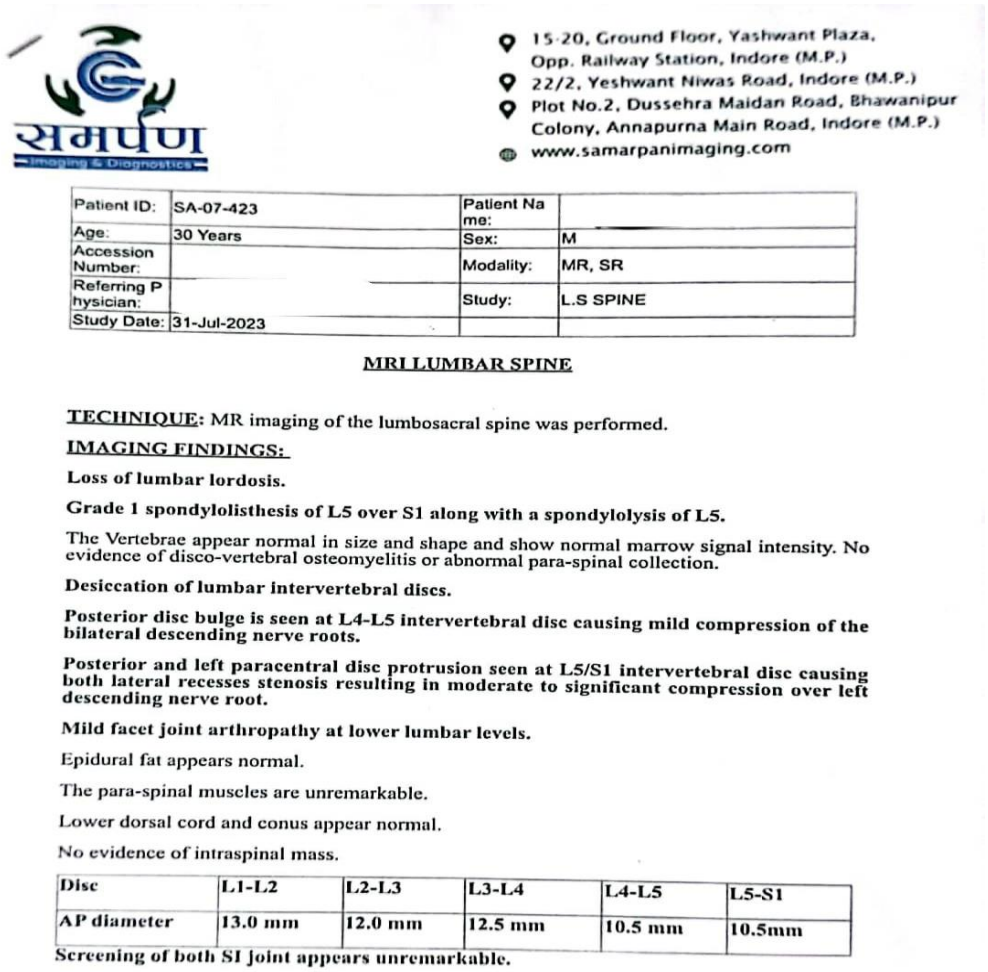
Examination Test's	**Finding's**	
Slump Test	Positive	
Straight leg raising Test	Positive (After performing test, patient experienced radiating pain at 20º.)	
Lasegue Test	Positive (Tingling sensation felt by patient after bending the knee in supine position.)	
Prone Knee Bending Test (Reverse Lasegue Test)	Positive (Tingling sensation felt by patient after bending the knee in prone position.)	
MRC Muscle power scale	Right Lower Limb	Left Lower Limb
	5/5	3/5

Table 5 mentions the results of clinical examination that were performed using assessment tests before treatment on initial day which included Slump Test, Straight leg raising Test, Lasegue Test, Prone Knee Bending Test (Reverse Lasegue Test) and MRC Muscle power scale was conducted.

VAS Scale (Before treatment): 7/10

- **Investigations**:

1. **MRI Lumbar Spine: -**



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Patient ID:	SA-07-423	Patient Name:	
Age:	30 Years	Sex:	M
Accession Number:		Modality:	MR, SR
Referring Physician:		Study:	L.S SPINE
Study Date:	31-Jul-2023		

MRI LUMBAR SPINE

TECHNIQUE: MR imaging of the lumbosacral spine was performed.

IMAGING FINDINGS:

Loss of lumbar lordosis.

Grade 1 spondylolisthesis of L5 over S1 along with a spondylolysis of L5.

The Vertebrae appear normal in size and shape and show normal marrow signal intensity. No evidence of disco-vertebral osteomyelitis or abnormal para-spinal collection.

Desiccation of lumbar intervertebral discs.

Posterior disc bulge is seen at L4-L5 intervertebral disc causing mild compression of the bilateral descending nerve roots.

Posterior and left paracentral disc protrusion seen at L5/S1 intervertebral disc causing both lateral recesses stenosis resulting in moderate to significant compression over left descending nerve root.

Mild facet joint arthropathy at lower lumbar levels.

Epidural fat appears normal.

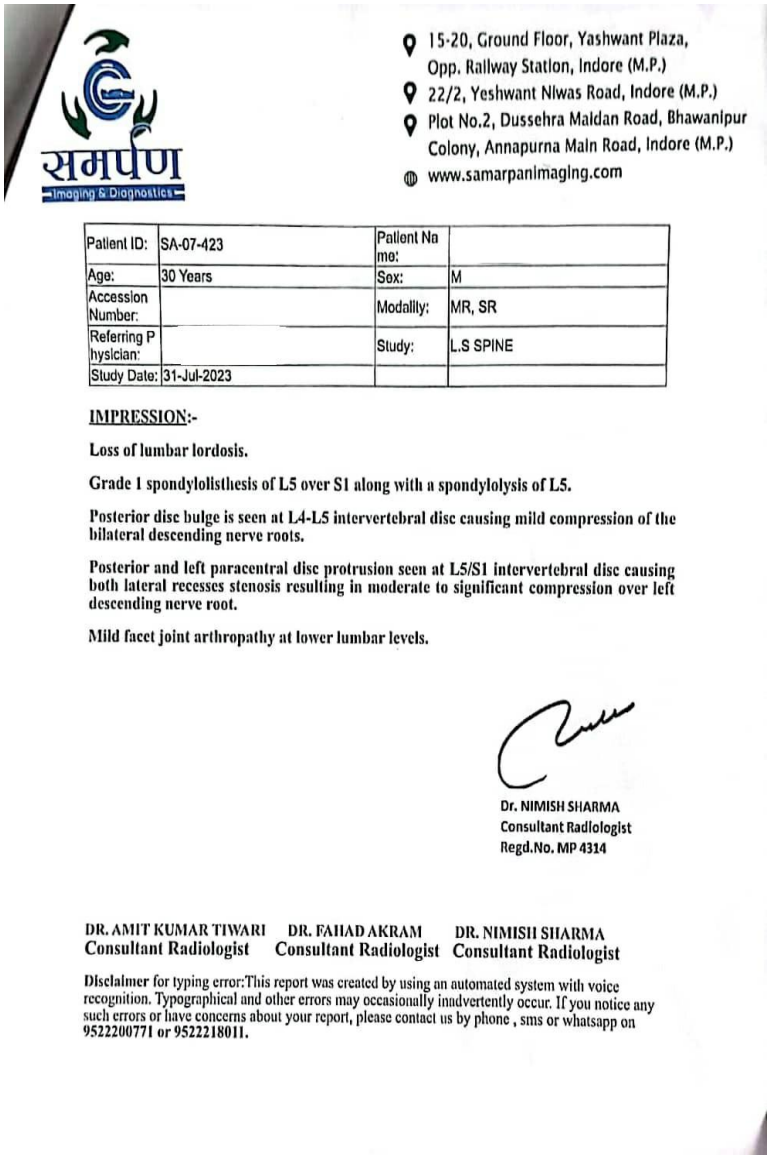
The para-spinal muscles are unremarkable.

Lower dorsal cord and conus appear normal.

No evidence of intraspinal mass.

Disc	L1-L2	L2-L3	L3-L4	L4-L5	L5-S1
AP diameter	13.0 mm	12.0 mm	12.5 mm	10.5 mm	10.5mm

Screening of both SI joint appears unremarkable.



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Patient ID:	SA-07-423	Patient Name:	
Age:	30 Years	Sex:	M
Accession Number:		Modality:	MR, SR
Referring Physician:		Study:	L.S SPINE
Study Date:	31-Jul-2023		

IMPRESSION:-

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Dr. NIMISH SHARMA
Consultant Radiologist
Regd.No. MP 4314

DR. AMIT KUMAR TIWARI Consultant Radiologist
DR. FAHAD AKRAM Consultant Radiologist
DR. NIMISH SHARMA Consultant Radiologist

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Figure 1 and 2: Radiological report of MRI Lumbar spine

Impression:
Loss of lumbar lordosis.
Grade 1 spondylolisthesis of L5 over S1 along with a spondylolysis of L5.
Posterior disc bulge is seen at L4-L5 intervertebral disc causing mild compression of the bilateral descending nerve roots.
Posterior and left paracentral disc protrusion seen at L5/S1 intervertebral disc causing both lateral recesses stenosis resulting in moderate to significant compression over left descending nerve root.
Mild facet joint arthropathy at lower lumbar levels.

- **Criteria and classification of degenerative pelvic disc herniation**:

➢ **Clinical presentation**:
Positive test results of the following:(Table 5)

1. Slump Test
2. Straight leg raising Test
3. Lasegue Test
4. Prone Knee Bending Test (Reverse Lasegue Test), and
5. MRC Muscle power scale

- **Radiological presentation:**(Figure 1&2)

- Osteoporosis
- Changes of Pelvic disc herniation.

Thus, Pelvic Disc Herniation diagnosed by above clinical and radiological findings.

- **Diagnosis**: *Katigata Vata* (Pelvic disc herniation)

- **THERAPEUTIC FOCUS-**

Table 6: Therapeutic regimen (Internal and external therapy)[7,8]

Sr. No.	Therapeutic regimen	Dosage	Duration
1.	Tab. *Vata vidwansa rasa*	250 mg BD	14 days
2.	Tab. *Tryodashanga guggul*	500mg BD	14 days
3.	*Viddhagnikarma* at most tender points	For 3-4 mins	0n 0th and 7th day

Table 6 explains the therapeutic regimen that includes both internal and external therapies along with its dosage and duration. External therapy introduced was *viddhagnikarma* that was given on initial day and seven days later and was applied for 3-4 mins.
Patient diagnosed as *Katigata vata* (Pelvic disc herniation) has been taken up for the study and will be treated with *Viddhagnikarma*[9]. (Figure 3 & 4)

Material:
5% Povidone iodine solution, 26 1-1/2 Acupuncture needles, Flame lighter, *Loha shalaka*, *Shatadhauta ghrita*, Sterile Cotton balls, Sterile hole sheet, Sponge holding forceps, Sterile gloves.

Methodology:

A) Internal medication-

- *Vata vidwansa rasa* 250mg BD with water for 14 days.
- *Tryodashanga guggul* 500mg BD with water for 14 days.

B) External Therapy

The procedure of *Viddhagnikarma* was carried out in following stages:

• Pre- Procedure:

Written informed consent. Patient was explained the whole procedure. Patient was advised to sleep in prone position. Lumbar area was painted with 5% Povidone iodine solution & was later draped with sterile sheets[10].

• Procedure:

Most tender points were marked on & aside lumbar spine on the left side. 26 1-1/2 acupuncture needles were pierced on the marked points 1-2 cm deep (in order to pierce the paraspinal muscles' underlying fibers) (Figure 3). Subsequently, heat was transmitted from the needle's proximal end until the distal, tissue-containing portion using a pre-heated *loha shalaka* (iron probe). (Figure4). Until the patient felt heat at the site, this procedure was reiterated. Then the needles were removed using artery forceps and were discarded[10].

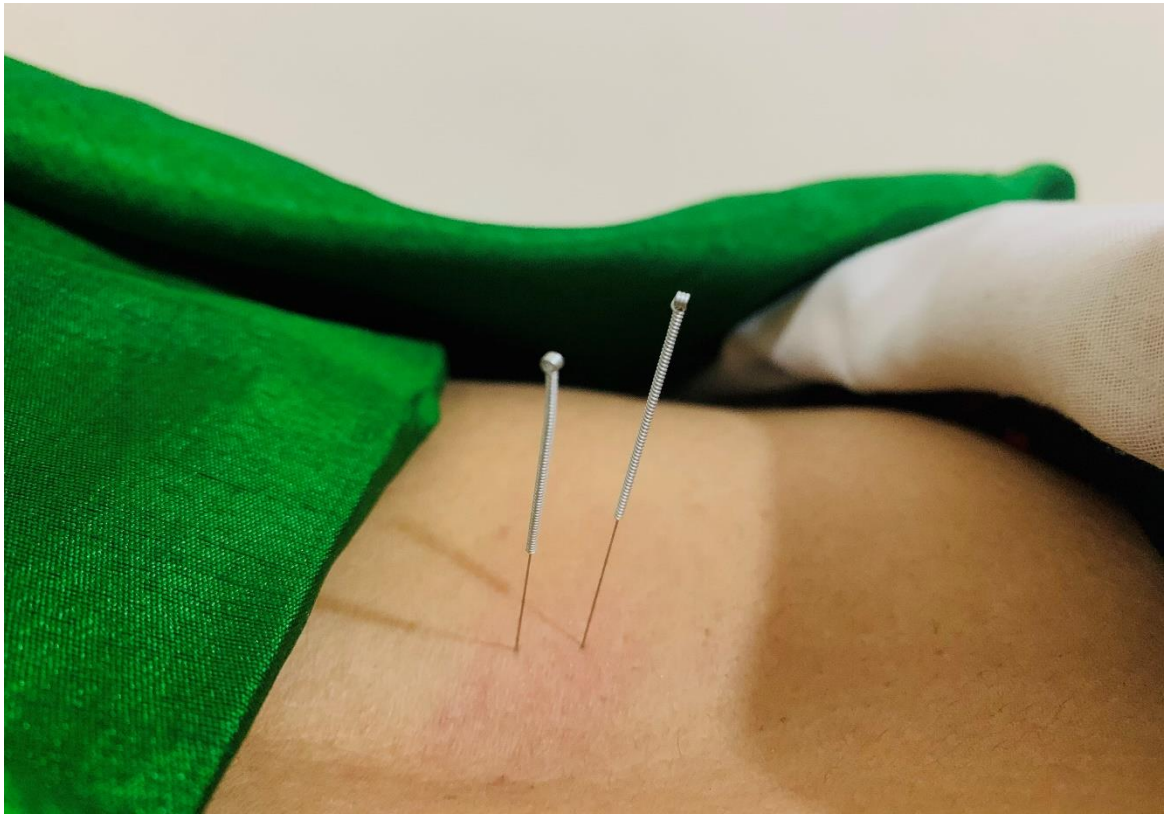


Figure 3: *Viddhakarma* using 26 1-1/2 acupuncture needles at lumbar region.

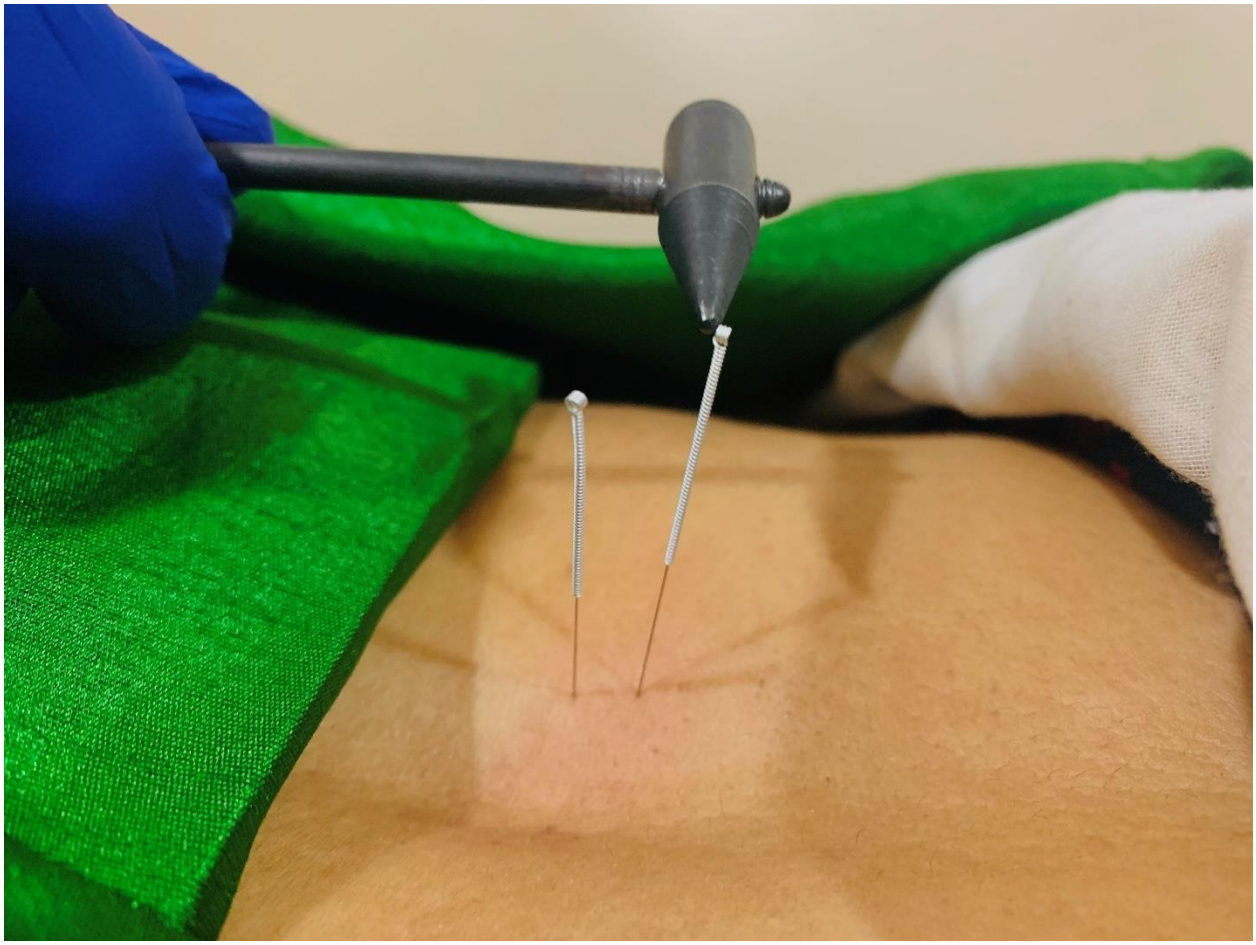


Figure 4: *Viddhagnikarma* using 26 1-1/2 acupuncture needles and pre-heated *loha shalaka* (iron probe) at lumbar region.

• **Post Procedure:**

After achieving hemostasis, *shatadhauta ghrita* was put on to the procedure site. The patient was being watched for thirty minutes. All aseptic methods were carried out when integrating dry dressing. The entire procedure was repeated seven days later on[10].

***Viddhagnikarma* was administered for 2 sittings with an interval of 7 days.**

- **Chronology in observation and result: (Table 3) (Graphs 1 and 2)**

  Clinical examination of the patient reveals regression of the symptoms of about 70% after first sitting and total relief after second sitting after 7 days.

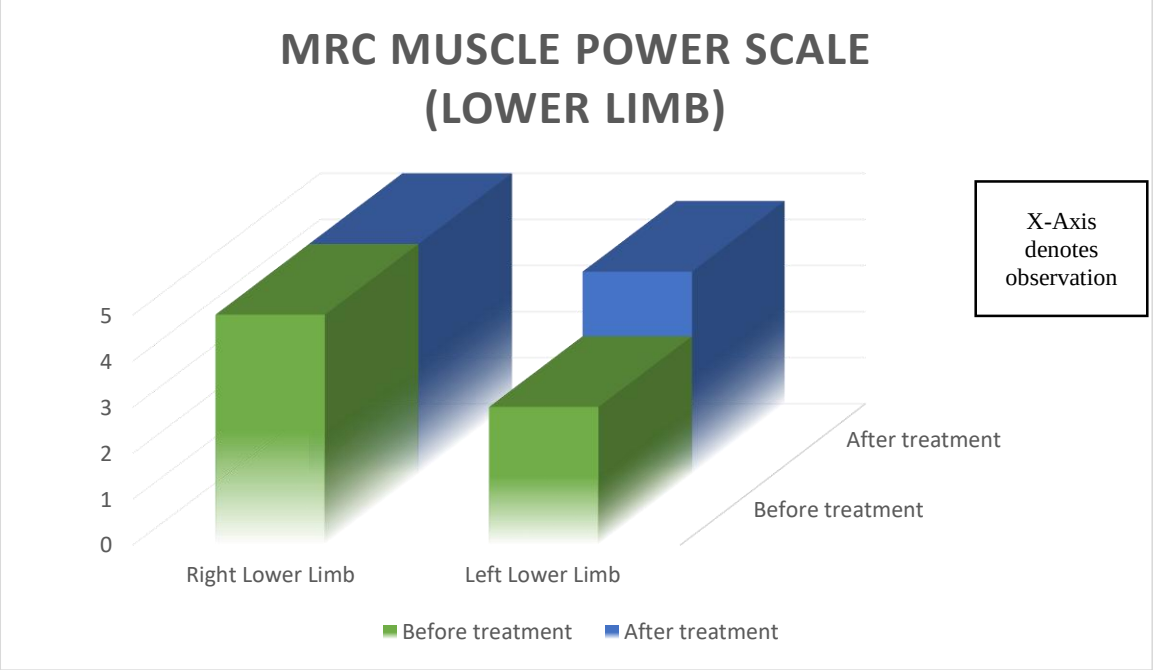
  Patient has complete relief from pain and tingling along with morning stiffness at lower back and left lower limb after the completion of the study.

Table 7: Observation and result table (Before & after treatment)

Parameter's	Before Treatment Finding's		After Treatment Finding's	
Tenderness	Present (++)		Absent	
Swelling	Absent		Absent	
Stiffness	Present		Absent	
Slump Test	Positive		Negative	
Straight leg raising Test	Positive		Negative	
Lasegue Test	Positive		Negative	
Prone Knee Bending Test (Reverse Lasegue Test)	Positive		Negative	
MRC Muscle power scale (Lower Limb)	Right	Left	Right	Left
	5/5	3/5	5/5	4/5

Table 7 denotes assessment of observations of before and after treatment in accordance to criteria mentioned previously that draws a positive result in reducing the symptoms thus, enhancing the normal function.

Graph 1: The graphical representation of MRC Muscle Power Scale before and after treatment.



Graph 1 denotes the graphical representation of MRC muscle power scale of lower limb with x-axis representing observation of before and after treatment and y-axis representing MRC muscle power gradation.

- **Discussion:**

Katigata vata, one of the *vatavyadhi's* has been correlated with Pelvic disc herniation[11]. It has been well known that *vata* is the responsible factor in the pathogenesis of *Katigata vata* that impairs the movements of low back and lower limb with presenting complaints like pain and tingling sensation in the lower limbs with weakness[11]. To overcome such condition, it is mentioned in many of the classical texts of ayurveda in the management of *vatavyadhi's* the concept of *agnikarma*[12]. *Viddhakarma* and *Agnikarma* are the opposing therapies for *vata* mentioned in the Ayurveda classical *samhita's*[12,13]. This *viddhagnikarma* is a modification of what *Acharya Sushrut* mentioned for equipment's used for *agnikarma* in *Sira, Snayu, Asthi & Sandhigata roga* that are *Gud, Kshaudra* and ~~*Sneha.*~~*Sneha*[14]*.* Acharya Sushruta explained the forementioned equipment's for *agnikarma* so as to gain heat to deeper structures like bones, muscles, ligaments and tendons. The concept behind this is the penetration power of *agnikarma* but this nowadays may cause blisters and other burn symptoms, as *bala* and *satva* of the patient is reduced compared to ancient times.
So, *viddhagnikarma* was brought into play into our study as it directly deliver's the heat via needle to the affecting muscle bypassing the skin and subcutaneous tissue[14].

Mode of action by ayurvedic perspective: The dosha's involved in *katigata vata* are mainly vitiated *vata* and *kapha* that presents with *shoola* (pain) and *stambha* (stiffness) caused by *agnimandya* of local *dhatwagni*. *Agnikarma* has totally opposing factors for *vata* and *kapha dosha's*. After penetration of heat to deeper structures, there is local rise in temperature enlightening local *dhatvagni* to its normal function. Further this normalized *dhatwagni* digests the vitiated *vata* and *kapha dosha's* and hence there is drastic relief from pain and stiffness leading to cure the disease[15].

Mode of action of Oral medication: As the name conveys, *tryodashanga guggul* contains thirteen ingredients which possess anti-inflammatory and alleviating effects. Only a handful of components comprise antioxidants that bind to free radicals to prevent further deterioration. It lessens vata, which minimizes the pain associated with arthritis[16]. *Vata vidhwansa rasa* assists in relieving pain and govern vitiated *vata*[17].

Mode of action according to modern science: Local tissue metabolism rises-excretion of unwanted metabolites and toxins-Temperature stimulates the lateral spino-thalamic tract (SST) leading to stimulation of DPI (Descending pain inhibitory factor). Endogenous opioid peptide release that binds to opioid receptor and PP substance (presynaptic inhibitor) blocks the transmission of pain sensation leading to loss of pain sensation[18].
Keeping the above concept in picture we conducted a case study and applied *viddhagnikarma* at the most tender points on knee and got 70% relief from pain sensation at the first sitting and complete pain relief by second sitting after 7 days. Thus, helping new conceptual procedure in accordance to Ayurveda principles.
Viddhagnikarma is hence useful for pain management.

Conclusion:

The conducted research study generated pleasingly favorable results for pain control. Clinical evaluation and discourse lead to the conclusion that *viddhagnikarma* is an effective treatment for Pelvic disc herniation (*Katigata vata*). It was discovered that there were no adverse consequences, none to be embarrassed of, and no possibility of the illness recurrent episodes. In order to review the results and reveal statistical proficiency, additional study on a wider group of patients needs to be conducted for this sort of treatment.

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Affiliations are centered, italicized, not bold. Include e-mail addresses if possible.

For example:

Author[1], Author[2] and Author[3]
[1]Affiliation
[2]Affiliation
[3]Affiliation
[1]Email, [2]Email, [3]Email

4.2. Corresponding Author

Corresponding author should have an asterisk sign (*) if possible, after the corresponding author's name. The Corresponding author (e.g., *Corresponding Author) label should be appeared at the footnote section of the first page of the paper, Times New Roman in style and 10 in font size.

5. Second and Following Pages

The second and following pages should begin 1.0 inch (2.54 cm) from the top edge. On all pages, the bottom margin should be 1-3/16 inches (2.86 cm) from the bottom edge of the page for 8.5 x 11-inch paper; for A4 paper, approximately 1-5/8 inches (4.13 cm) from the bottom edge of the page.

6. Type-style and Fonts

Wherever Times New Roman is specified, Times New Roman may be used. If not available in your word processor, please use a font closest to Times New Roman that you have access to. Please avoid using bit-mapped fonts if possible. True-Type 1 fonts are preferred.

7. Main Text

Type your main text in 11-point Times New Roman, single-spaced. Do not use double-spacing. All paragraphs should be indented 1 pica (approximately 1/6- or 0.17-inch or 0.43 cm). Be sure your text is fully justified, flush left and flush right. Please do not place any additional blank lines between paragraphs.

7.1. Tables

Place tables as close as possible to the text they refer to and aligned center. A table is labeled *Table* and given a number (*e.g.*, **Table 1. Sample Datasheet with Attributes in Linguistic Term**) it should be numbered consecutively. The table label and caption or title appears 12pt space above the table, 6pt space after the text or paragraph if any; it should be

uniforms fonts and font size, and use 11pt font size and Helvetica style, capitalized similar to paper title, aligned center and bold face. Sources and notes appear below the table, aligned left. All tables must be in portrait orientation.

For Example:

Table 1. Table Label

7.2. Figures

Place figures as close as possible to the text they refer to and aligned center. Photos, graphs, charts or diagram should be labeled *Figure* (do not abbreviate) and appear 6pt space below the figure, 12pt space before the next text or paragraph, and assigned a number consecutively. The label and title should be in line with the figure number (*e.g.*, **Figure 1. Location Error Rate of Three Schemes**), it should be uniforms fonts and font size; use 11pt font size and Helvetica style, capitalized similar to paper title, aligned center and bold face. Source (if any) appear underneath, flush left. Figures should be at good enough quality. Minimum image dimensions are 6 cm (2.3622 in) wide by 6 cm (2.3622 in) high.

For Example:

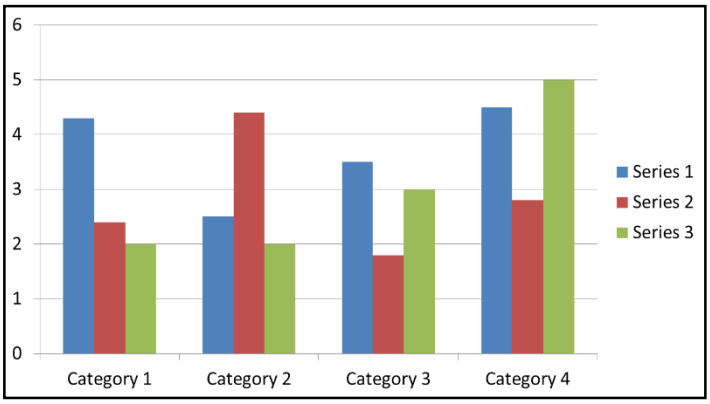

Figure 1. Figure Label

7.3. Equations

Including symbols and equations in the text, the variable name and style must be consistent with those in the equations. Equations should be indented at the left margin and numbered at the right margin, equation number is enclosed with open and close parenthesis () Time New

Roman in style and 11pt font size. Define all symbols the first time they are used. All equation symbols must be defined in a clear and understandable way.

For Example:

$$\varphi_{\mu\nu}(z) = \frac{\left\|k_{\mu\nu}\right\|^2}{\sigma^2} e^{-\frac{\left\|k_{\mu\nu}\right\|^2 \|z\|^2}{\sigma^2}} [e^{ik_{\mu\nu}z} - e^{\frac{-\sigma^2}{2}}] \quad (1)$$

8. First-order Headings

For example, "**1. Introduction**", should be Times New Roman 13-point boldface, initially capitalized, flush left, with one blank line before, and one blank line after.

8.1. Second-order Headings (Sub-heading)

As in this heading, they should be Times New Roman 11-point boldface, initially capitalized, flush left, with one blank line before, and one after.

8.1.1. Third-order Headings: Third-order headings, as in this paragraph, are discouraged. However, if you must use them, use 11-point Times New Roman, boldface, initially capitalized, flush left, and proceeded by one blank line, followed by a colon and your text on the same line.

9. Footnotes

Use footnotes sparingly (or not at all) and place them at the bottom of the column of the page on which they are referenced to. Use Times New Roman 9-point type, single-spaced. To help your readers, avoid using footnotes altogether and include necessary peripheral observations in the text (within parentheses, if you prefer, as in this sentence).

Acknowledgments

These should be brief and placed at the end of the text before the references.