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The role of *Ayurvedic* formulations in the management of *Yakrut-Pleehodar* with special reference to alcoholic cirrhosis of liver with ascites- a case study.

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ABSTRACT:

Ascites is present when there is accumulation of free fluid in the peritoneal cavity. Ascites occurs as a result of Renal Sodium Retention or portal Hypertension or cirrhosis of Liver. Cirrhosis is the final phase of alcoholic Liver Diseases. According to Ayurveda all diseases are result of *Agnimandya*. *Agnimandya* leads to *Malavrudhi* and *Strotorodha (swedavaha and ambuvaha). Yakrutpleeha Dushti* occurs that leads to *Vikrut pachak pitta* formation. *Ushana Guna* of *pitta* increases and Dhatu Pak occurs that leads to formation of excessive fluid and it's accumulation in the Peritoneal cavity. **Case**: A 40 years old male patient presented in outdoor wing of *Kayachikista* Department of L. k. Ayurved Rugnalaya, Yavatmal with complaints of abdominal Distension, Pedal edema, Dysponea, loss of Appetite, Anemia, jaundice, weakness, Diziness, Fullness in Flanks, Yellow urine etc. **Result and Conclusion**: The patient was administered *Icchabhedi Ras* for *Nitya Virechan*. *Jalodarari Ras* was administered that eliminate excessive fluid. *Dughahar*, *takrapaan* was adviced. *Pittashamak*, *Mutravirechaniya*, *Yakrit-Uttejaka*, *Shotahar*, *Virechak*, *Strotorodha nashak kalps* were administered. Patient showed good improvement in his condition which is evident by changes in his signs and symptoms, General well being and investigative findings.

(**Keywords :** *jalodar*, Ascites, *yakrut pleehodar*, liver cirrhosis)

Introduction:

Alcoholic Liver Disease(ALD) causes damage to the liver. ALD occurs after years of heavy drinking. Cirrhosis is the final phase of ALD. Cirrhosis is characterized by diffuse hepatic fibrosis

and nodule formation. [1] The clinical presentation is highly variable. Some patients are asymptomatic and the diagnosis is made incidentally at ultrasound or at surgery. Others present with hepatomegaly, splenomegaly[5], signs of portal hypertension. Increased portal vascular resistance leads to a gradual reduction in the flow of portal blood to the liver and simultaneously to the development of collateral vessels, allowing portal blood to bypass the liver and enter in the systemic circulation directly. Increased portal flow contributes to portal hypertension. The most important consequence of portal hypertension is *variceal* bleeding, which commonly arises from esophageal varices located within 3-5 cm of gastro-esophageal junction.[1] Ascites occurs as a result of renal sodium retention and portal hypertension. Ascites (*जलोदर – वर्धयेतां तदेवाम्बु स्वस्थानादुदराय तौ*) is present when there is accumulation of free fluid in the peritoneal cavity. Mild Ascites is Asymptomatic. With large Accumulation of fluid (>1L) there is Abdominal distension , fullness in the flanks, shifting dullness on percussion. According to Ayurveda it is a disease of *swedavaha* and *Ambuvaha strotodushti*[11] in which following sings and symptoms are seen, *कुक्षेराध्मानआटोप:* (Abdominal distension), *शोफ: पादकरस्य* (pedal edema), *श्वासमृच्छति* (Dyspnea), *क्षुन्नाक्ष:* (loss of appetite), *क्षीणबल* (weakness), *गमनेऽशक्ति* (difficulty in walking), *भुक्तंविदहयते* (indigestion), *कार्श्य* (thin and lean body), *अतिपाण्डु* (Anemia with jaundice).[4]

METHOD:

CASE STUDY: A 40yrs old hindu married male patient (Reg. No: 1671)residing in arni yavtmal, clinically diagnosed with *Yakrutpleehodar* (chronic alcoholic liver disease, chronic liver cirrhosis with portal hypertension with Ascites with esophageal varices with severe Anemia) presented in outdoor wing of *kayachikista* department of L. K. Ayurved *Rugnayala Yavatmal*, on 26th June 2022 with chief complaints of Abdominal distension, pedal edema, dyspnea, loss of Appetite, Anemia, jaundice, weakness, fullness in flanks, patient also complained that his urine is dark yellow and stool is greenish yellow in color. For further management he was admitted in our hospital

History Of Present Illness:

Patient was severe alcoholic since last 12 years. He was diagnosed with alcoholic liver disease and chronic liver cirrhosis 4 years before and had history of ascites since 1 year. Patient had history of *paracentesis* done (3 times). Patient also had complaint of hematemesis two month before.

Past History:

- Patient gave history of multiple CBD calculi. Avg. size – 7mm since 3 months.
- Patient had history of blood transfusion. (3 times)
- H/O- paracentesis (3 times) since 1 year.
- No H/O DM, HTN, Thyroid disorder.

Family history: No family history is present related to this disease.

General and Systemic Examination:

- Temp. 98ºF, R.R-18/min, B.P-100/60mm of Hg
- Weight – 76 Kg (Before Rx), After Rx: 63Kg(30/6/22), 60 Kg(3/7/22).
- Pallor- present
- Icterus- present
- Edema: B/L pedal edema present, scrotal edema present.
- CVS: S_1S_2 heard, no murmurs
- CNS: patient conscious, well oriented, remembers the events very clearly.
- RS: Inspection: Diminished mobility of chest wall on both side
- Palpation: Diminished TVF (Tactile vocal fremitus) [(2)]
- Percussion: Dullness- Lower Lobes B/L lung in axillary and Mid axillary line.
- Auscultation: Diminished vocal fremitus
- Diminished breath sound, No whizzing.
- P/A: Inspection: Shape of abdomen: distension due to fluid umbilicus-smiling umbilicus everted.
- Dilated veins-seen due to portal hypertension.
- Palpation: Tenderness present, No guarding, rigidity,

जलपुर्णदृतिस्पर्श

Percussion: Dull note on percussion in all quadrant

Shifting dullness present.
Fluid thrill present.

Auscultation: Bowel sound present

Abdominal girth	On Admission (26/6/22)	After treatment(03/7/22)
Above umbilicus	40 inch	35 inch
Umbilicus	41 inch	36 inch
Below umbilicus	40 inch	35.5 inch

Investigation	before treatment	after treatment
USG abdomen Pelvis with x-ray chest	Gross hepatomegaly with altered liver Echotexture s/o Alcoholic liver disease With splenomegaly With Ascites (18/06/22)	Liver parenchymal disease with mild Ascites. On (03/9/22)
LFT	Total Billrubin-4.40 Direct Sr. Bilirubin-1.92 Indirect Sr. Bilirubin-2.48 On 24/06/22	Total bilirubin – 3.57 Direct sr. Bilirubin- 1.03 Indirect sr. Bilirubim – 2.54 On (29/7/22)
HB%	HB-7 gm%, PLT-58000 On 24/06/22	HB – 7gm% PLT -99, 000 On (29/7/22)

Based on clinical presentation, patient was diagnosed as case of *Yakrut-pleehodar.*

Method and Material :

Method :

1) Case study

2) Centre : *kayachikista* department of L.K Ayurved *rugnalaya yavatmal* affiliated to *DMM ayurved* college *yavatmal.*

Material:

Shodhan Chikista:

- Tb. *Icchabhedi Ras* (250mg) daily one tablet during first 15 days followed by half tablet for next 8 days with shit jal.
- *Udarpatbandhan* done.
- Tb. *Jalodarari Ras* 250mg for 1 month given.

Shaman Chikista:

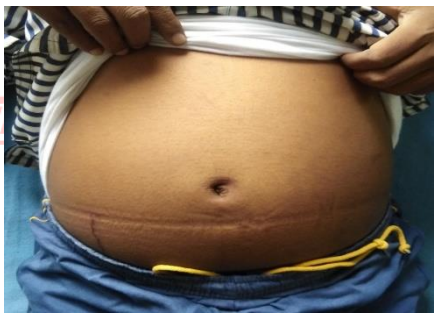
1. A combination in powder form of
   पुनर्नवादि गुग्गुळ (Punarnvadi Guggul)/500mg
   गोक्षुरादि गुग्गुळ (Gokshuradi Guggul)/500mg
   आरोग्यवर्धिनीवटी (Arogyavardhini vati)/250mg
   पुनर्नवादि मण्डुर(Punarnvadi Mandur)/250mg
   सुतशेखर रस (Sutshekhar Ras)/250mg **t**wice a day with *koshan jal* before meal.
2. *Gokshur Churn*
   Kutki Churna
   Avipattikar Churna
   Aamlaki Churna 1gm each
   Twice a day with jal before meal.
3. *Swadishta Virechan churn* 3gm at *Nishakaal.*
4. *Punarnavadi Bharad Kwath* 30ml- twice a day

5. *Syp. Punarnavasav* 2tsf TDS after meal

PATHYA: *Dugha Ahar and Dugha paan* [10], *Takra paan*[9]

APATHYA: *Jalpan*

The patient is under follow-up Since two months without single episode of relapse. In this case study, Assessment was done on the basis of signs and symptoms. As well as investigative findings. Patient is under drug in intervention.



Before treatment

After treatment

DISCUSSION:

Udar roga develops due to *jatharagnimandata, pran, saman, apan vayu* and *pachak pitta dushti, Rasavaha, annavaha, swedavaha* and *ambauaha strotodushti* occurs. Due to obstruction of *swedavaha and*

ambuvaha, strotas, ushna gun of pitta increases due to which *paak* of *dhatu* occurs leading to excessive accumulation of fluid, especially in peritoneal cavity occurs.[3]

i. *Nitya virechan* is the line of treatment in *udara roga* [6] hence *tishna virechaka aushadha* are the first choice of drug. *Icchabhedi Ras* contain *jaypala*. *Jaypala* is *tikshana virechaka*.

ii. *Jalodarari Ras*[16] contains *jaypala* and *bhavana dravya* is *snuhi kshira* which eliminates the excessive accumulated fluid, through excessive loose motions and urination. [7]

iii. *Arogyavardhini vati* contains *kutki* as main ingredient which is *pittavirechak, bhedaniya, shothhar* and *yakrut-uttejaka*. So it tends to excrete out accumulated fluid.[8]

iv. *Punarnavadi mandoor* contains *rakta punarnva, trivrutta, chitrak, vidang, pushakarmool* etc. which acts as *yakrutabalya* and *shothahara*. Have *mutrala* property. Have digestive, appetizer and carminative properties.

v. *Punarnavadi guggal* and *gokshur guggul* have *mutrala* property which helps to eliminated excessive accumulated fluid.

vi. *Avipattikar churna* and *sutshekhar ras* are good *pittashamak kalpas*. As *pachak pitta* start to become normal, formation of new fluid is also reduced.

vii. Syp. *Punarnavasava* is *mutravirechaniya*.

Probable mode of Action :

pittashamak, mutravirechniya, yakrut uttejak, shothahr,virechak, strotorodhnashak kalps were administered.

Conclusion:-

Yakrut-pleehodar is described in Ayurveda as a type of *Udar Roga*. *Udar* is a *Kashta sadhya vyadhi*. Following the *chikista siddhant* of *udar roga* an effort was made to manage the case with Ayurvedic treatment. Patient showed good overall improvement in his condition which is evident by changes in his symptoms and signs and investigative findings and general well being. In this case study, ayurvedic treatment was found to be very effective in the management of *Yakrut-Pleehodar*.Through *Nitya Virechan* principle and *Yakrit-Uttejaka dravyas* root cause was treated and this improved the normal functioning of body. Further studies to evaluate the role of Ayurvedic Management in such complicated cases needs to be carried out.

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