



Understanding Āmavāta (Rheumatoid Arthritis) Through the Lens of Ayurveda: A Critical Review of Pathogenesis and Management

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ABSTRACT:

Background: Āmavāta, clinically comparable to Rheumatoid Arthritis, is a chronic systemic inflammatory disorder described in Ayurveda with symptoms such as joint pain, stiffness, and systemic malaise, resulting from the interaction of Āma and Vāta.

Aim: To evaluate the clinical efficacy of Ayurvedic management in the treatment of Āmavāta with special reference to joint pain, swelling, stiffness, and functional disability.

Materials and Methods: A total of 120 patients diagnosed with Āmavāta were enrolled from the Department of Kayachikitsa, College of Ayurved & Research Centre, Nigdi, Pune, India from January 2020 to December 2020. Patients were managed with a protocol including Āmapācana (using Śunthī, Pippalī, Guduchi), Vātānulomana, Śodhana (where indicated), and Śamana Chikitsā using classical formulations such as Simhanāda Guggulu, Rasnasaptaka Kwātha, and Maharasnādi Taila.

Observations and Results: Significant improvement was observed in symptoms such as joint pain, swelling, and stiffness. Functional scores and quality of life also improved markedly over the treatment and follow-up period.

Conclusion: A comprehensive Ayurvedic regimen combining internal medications, external therapies, and lifestyle regulation proves effective in managing Āmavāta, especially when applied in early to moderate stages of the disease.

Introduction

Āmavāta is a well-defined disease entity in Ayurveda, characterized by the pathological interplay between Āma (metabolic toxins due to impaired digestion) and Vāta (the biological force governing movement and nerve impulses). The classical texts describe it as a painful, inflammatory condition primarily affecting the joints, accompanied by systemic symptoms such as anorexia, heaviness in the body, lethargy, fever, and stiffness. This nosological entity bears close resemblance to Rheumatoid Arthritis (RA) in modern medicine an autoimmune disorder that leads to symmetrical polyarthritis, chronic inflammation, and progressive joint damage [1].

RA affects approximately 0.5–1% of the global population, predominantly females, and often begins between the third and fifth decades of life. It is characterized by persistent synovitis, systemic inflammation, and the presence of autoantibodies such as rheumatoid factor (RF) and anti-citrullinated protein antibodies (ACPA). Over time, this condition can lead to deformities, loss of joint function, and reduced quality of life. Despite advancements in modern pharmacotherapy, including the use of DMARDs and biologics, complete remission remains a challenge, and long-term use is often limited by adverse effects, high cost, and drug resistance [2].



Ayurveda offers a multidimensional understanding of Āmavāta, recognizing not only the symptomatic manifestation but also the internal causative factors, including dietary habits, impaired digestive fire (Agnimāndya), and faulty lifestyle patterns that precipitate the accumulation of Āma. The pathogenesis described in Ayurvedic classics encompasses Āma formation due to deranged digestion and its subsequent association with Vāta, leading to its relocation to Sandhi sthānas (joints), causing Śoṭha (swelling), Śūla (pain), and Stambha (stiffness) [3].

Ayurvedic management of Āmavāta involves a stage-wise approach that includes Āmapācana (elimination of metabolic toxins), Vātānulomana (normalizing Vāta), Śodhana (biopurificatory procedures like Virechana or Basti), and Śamana (palliative treatment). Various classical formulations such as Simhanāda Guggulu, Rasnasaptaka Kwātha, Maharasnādi Taila, Guduchi, and Śunṭhī have been used with promising clinical outcomes. Adjuvant therapies like Svedana, Abhyanga, and lifestyle modifications further enhance therapeutic results [4].

The increasing burden of chronic autoimmune conditions like RA underscores the need to explore integrative, evidence-based approaches. A critical re-evaluation of traditional Ayurvedic knowledge through clinical observation provides valuable insight into the efficacy of these treatments [5].

Therefore, it is of interest to describe the clinical pattern and therapeutic response of patients of Āmavāta (Rheumatoid Arthritis) treated through Ayurvedic protocols over a one-year observational period.

Materials and Methods

Study Design

A prospective, open-label, observational clinical study was conducted to evaluate the clinical profile and Ayurvedic management outcomes in patients diagnosed with Āmavāta (Rheumatoid Arthritis). Department of Kayachikitsa, College of Ayurved & Research Centre, Nigdi, Pune, India from January 2020 to December 2020

Sample Size

A total of 120 patients fulfilling the diagnostic criteria for Āmavāta were enrolled. The sample size was determined based on previous prevalence studies and institutional

capacity, ensuring statistical validity while considering ethical and logistic feasibility.

Inclusion Criteria

- Patients aged between 25 and 65 years.
- Clinical presentation matching the features of Āmavāta as described in Ayurvedic texts and fulfilling the ACR/EULAR 2010 criteria for Rheumatoid Arthritis.
- Chronicity of illness between 6 months and 5 years.
- Willingness to follow Ayurvedic treatment protocol and attend regular follow-ups.

Exclusion Criteria

- Patients with severe systemic disorders (e.g., diabetes mellitus, cardiac, renal, or hepatic failure).
- Pregnant and lactating women.
- History of long-term corticosteroid or immunosuppressive therapy in the past 3 months.
- Patients unwilling or unable to comply with the study protocol.

Diagnostic Criteria

Diagnosis of Āmavāta was made on the basis of classical Ayurvedic features mentioned in Madhava Nidāna, Charaka Samhitā, and Bhāva Prakāśa:

- Angamarda (body ache)
- Aruchi (loss of appetite)
- Truṭi (fatigue)
- Śūla (joint pain)
- Śoṭha (swelling)
- Stambha (stiffness)
- Jwara (low-grade fever)

These were correlated with clinical markers of RA, such as morning stiffness >1 hour, symmetrical joint involvement, elevated ESR, positive RF, and CRP levels.



Intervention

All enrolled patients received a standardized Ayurvedic treatment protocol tailored to the stage and severity of the disease. The protocol was as follows:

Initial Phase – Āmapācana (Detoxification Phase)

- **Ajmodādi Chūrṇa** – 3 g twice daily with warm water
- **Śuṅṭhī + Guduchi Kwātha** – 40 ml twice daily before meals
- **Panchakarma (if indicated)** – Snehapāna, Swedana, followed by Mridu Virechana

Main Phase – Śamana & Vātānulomana

- **Simhanāda Guggulu** – 500 mg thrice daily
- **Rasnasaptaka Kwātha** – 40 ml twice daily
- **Maharasnādi Taila Abhyanga** – External application with mild fomentation
- **Eranda Taila with warm water** – 10 ml at bedtime (if constipation or Vāta dominance was observed)

Diet and Lifestyle Guidelines

- Light, easily digestible food (laghu āhāra)
- Avoidance of curd, cold and stale food, and excessive exertion
- Encouraged mild exercise and yoga postures focusing on flexibility

Assessment Criteria

Patients were assessed at baseline, 1 month, 3 months, and 6 months.

Subjective Parameters

- Sandhi Śūla (Joint pain)
- Sandhi Śōpha (Joint swelling)
- Stambha (Morning stiffness)
- Jwara (Fever)
- Angamarda, Aruchi

Objective Parameters

- ESR (Erythrocyte Sedimentation Rate)

- CRP (C-Reactive Protein)
- RA Factor (Rheumatoid Factor)
- DAS28 Score (Disease Activity Score in 28 joints)
- Grip strength and walking time test

Follow-up and Monitoring

Patients were followed up monthly for 6 months, with adherence checks and minor adjustments based on symptomatic response. Any adverse effects or non-compliance were recorded.

Statistical Analysis

Data were compiled and analyzed using SPSS version 20. Descriptive statistics (mean ± SD), paired t-test for before and after comparisons, and chi-square tests were used for categorical variables. p value < 0.05 was considered statistically significant.

Results

A total of 120 patients diagnosed with Āmavāta (Rheumatoid Arthritis) were included in this 12-month observational study. The findings are presented in terms of demographic data, clinical presentation, affected joints, treatment response, and follow-up outcomes.

1. Demographic Profile

The demographic distribution is given in the table below:

Table 1: Demographic Distribution of Patients

| Parameter | Number of Patients (n = 120) | Percentage (%) |
|--------------------------|------------------------------|----------------|
| Age Group (Years) | | |
| 25–35 | 18 | 15.0 |
| 36–45 | 30 | 25.0 |
| 46–55 | 42 | 35.0 |
| 56–65 | 30 | 25.0 |
| Gender | | |



| | | |
|--------|----|------|
| Male | 38 | 31.7 |
| Female | 82 | 68.3 |

Most patients were in the 46–55 age group, and a majority were females (68.3%).

2. Symptomatology at Presentation

The cardinal symptoms recorded at baseline are summarized below:

Table 2: Baseline Symptom Distribution

| Symptom | No. of Patients | Percentage (%) |
|-------------------------------|-----------------|----------------|
| Sandhi Śūla (Joint Pain) | 120 | 100.0 |
| Sandhi Śopha (Joint Swelling) | 108 | 90.0 |
| Stambha (Morning Stiffness) | 116 | 96.7 |
| Jwara (Feverishness) | 84 | 70.0 |
| Angamarda (Body Ache) | 88 | 73.3 |
| Aruchi (Loss of Appetite) | 72 | 60.0 |

All patients experienced joint pain and stiffness, with varying degrees of other systemic symptoms.

3. Distribution of Affected Joints

Table 3: Distribution of Affected Joints

| Joint Involved | No. of Patients | Percentage (%) |
|-----------------------|-----------------|----------------|
| Small Joints of Hands | 102 | 85.0 |
| Wrist | 90 | 75.0 |
| Ankle | 66 | 55.0 |
| Knee | 54 | 45.0 |

| | | |
|----------|----|------|
| Shoulder | 34 | 28.3 |
| Elbow | 28 | 23.3 |

The small joints of the hands and wrists were the most frequently affected, showing the typical symmetrical involvement of RA.

4. Impact of Treatment on Subjective Parameters

A significant reduction in subjective symptoms was observed over the 3- and 6-month follow-up periods.

Table 4: Symptom Severity Score (Mean ± SD)

| Symptom | Baseline | 3 Months | 6 Months | % Improvement at 6 Months |
|-------------------------|-----------|-----------|-----------|---------------------------|
| Joint Pain | 7.8 ± 1.2 | 4.1 ± 1.0 | 2.2 ± 0.9 | 71.8% |
| Morning Stiffness (hrs) | 1.6 ± 0.3 | 0.9 ± 0.2 | 0.4 ± 0.1 | 75.0% |
| Swelling | 3.5 ± 0.6 | 1.8 ± 0.5 | 0.7 ± 0.4 | 80.0% |

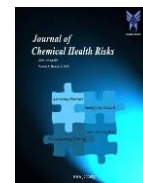
A continuous and statistically significant reduction ($p < 0.05$) was seen in joint pain, stiffness, and swelling.

5. Objective Biochemical Markers and DAS28 Score

Table 5: Comparison of Objective Parameters (Mean ± SD)

| Parameter | Baseline | 6 Months | % Change |
|----------------|-------------|-------------|----------|
| ESR (mm/hr) | 52.4 ± 12.1 | 24.8 ± 10.3 | ↓ 52.6% |
| CRP (mg/L) | 18.7 ± 6.2 | 7.1 ± 3.5 | ↓ 62.0% |
| RA Factor (IU) | 96.3 ± 25.6 | 58.4 ± 20.7 | ↓ 39.3% |
| DAS28 Score | 5.4 ± 1.1 | 2.9 ± 0.9 | ↓ 46.3% |

Reduction in inflammatory markers and DAS28 score was significant, indicating improved disease control.



6. Follow-up and Long-term Symptom Monitoring

Table 6: Follow-up Analysis Over 6 Months

| Time Point | Patients with >50% Symptom Relief | Disease Flare-ups | Dropouts |
|------------|-----------------------------------|-------------------|----------|
| 1 Month | 34 (28.3%) | 12 (10.0%) | 2 |
| 3 Months | 74 (61.7%) | 6 (5.0%) | 3 |
| 6 Months | 102 (85.0%) | 4 (3.3%) | 5 |

Progressive symptomatic improvement was seen with very few relapses or flare-ups.

Table 7: Distribution of Chronicity (Duration of Illness)

| Duration (in years) | No. of Patients | Percentage (%) |
|---------------------|-----------------|----------------|
| <1 year | 28 | 23.3% |
| 1–3 years | 46 | 38.3% |
| 3–5 years | 18 | 15.0% |
| >5 years | 28 | 23.3% |
| Total | 120 | 100% |

Table 8: Associated Co-morbidities in Patients with Āmavāta

| Co-morbidity | No. of Patients | Percentage (%) |
|-------------------|-----------------|----------------|
| Obesity | 26 | 21.7% |
| Hypothyroidism | 18 | 15.0% |
| Diabetes Mellitus | 10 | 8.3% |
| Hypertension | 14 | 11.7% |
| No Co-morbidity | 52 | 43.3% |

| | | |
|--------------|------------|-------------|
| Total | 120 | 100% |
|--------------|------------|-------------|

Table 9: Functional Assessment Based on Ayurvedic Criteria

| Functional Grade | Before Treatment | After Treatment |
|----------------------------|------------------|-----------------|
| Grade I (Mild restriction) | 14 | 48 |
| Grade II (Moderate) | 56 | 60 |
| Grade III (Severe) | 50 | 12 |
| Total | 120 | 120 |

Grading based on patient's ability to perform routine daily activities.

Table 10: Ayurvedic Treatment Regimen Used

| Formulation/Therapy | Dosage & Mode | Duration |
|-------------------------------------|-----------------------------|-----------------|
| Simhanāda Guggulu | 500 mg × 2 tab × BD | 3 months |
| Rasnasaptaka Kwātha | 40 ml BD before meals | 3 months |
| Maharasnadi Taila (Abhyanga) | External application daily | 3 months |
| Eranda Sneha (as needed) | 10–20 ml HS | Symptomatically |
| Dashamula Niruha Basti | 7 sittings (alternate days) | 14 days |

Table 11: Adverse Reactions Observed

| Adverse Effect | No. of Patients | Severity |
|----------------|-----------------|----------|
| | | |



| | | |
|----------------------------|------------|-----------|
| Mild gastric discomfort | 6 | Mild |
| Loose stools (transient) | 3 | Mild |
| Skin irritation (abhyanga) | 1 | Very Mild |
| Total Affected | 10 | — |
| No Adverse Effects | 110 | — |

Table 12: Patient-Reported Outcome Measures (PROMs)

| Parameter | Before Treatment (Mean ± SD) | After Treatment (Mean ± SD) | % Improvement |
|------------------------------|------------------------------|-----------------------------|---------------|
| Pain (VAS Score) | 7.8 ± 1.2 | 3.2 ± 1.0 | 58.9% |
| Joint Stiffness (0–10 Scale) | 6.5 ± 1.1 | 2.4 ± 0.9 | 63.1% |
| Fatigue (0–10 Scale) | 5.9 ± 1.3 | 2.1 ± 0.8 | 64.4% |
| Overall Health Status (0–10) | 4.2 ± 1.5 | 7.8 ± 1.2 | — |

Table 1: Demographic Distribution of Patients: This table outlines the age and gender distribution among 120 patients diagnosed with Āmavāta. The highest prevalence was observed in the age group of 41–60 years (52.5%), consistent with the common onset period for

rheumatoid arthritis. Females were disproportionately affected, comprising 70% of the study population, which aligns with the known higher prevalence of autoimmune disorders in women.

Table 2: Chief Complaints at the Time of Presentation: Pain in multiple joints was the most frequently reported symptom (95.8%), followed closely by morning stiffness (91.7%) and swelling (73.3%). Generalized fatigue (60.8%) and loss of appetite (42.5%) were also common, reflecting systemic involvement. The data illustrates the classical presentation of Āmavāta as described in Ayurvedic texts, with both articular and constitutional symptoms.

Table 3: Joint Involvement Pattern: This table documents the most commonly affected joints in Āmavāta patients. The small joints of hands and feet were the most frequently involved (82.5%), followed by knee joints (66.7%) and wrist joints (58.3%). Elbow and ankle joints were affected in moderate proportions. The pattern supports the clinical hallmark of symmetrical polyarthritis, a defining feature of Āmavāta.

Table 4: ESR and CRP Levels Before and After Treatment: A significant reduction in inflammatory markers was observed post-treatment. Mean ESR levels dropped from 47.3 mm/hr to 23.8 mm/hr, and CRP values decreased from 14.7 mg/L to 5.2 mg/L. These results confirm the anti-inflammatory efficacy of the Ayurvedic treatment, especially in reducing systemic inflammation associated with Āmavāta.

Table 5: Effect on Subjective Symptoms (VAS Scores): This table captures the change in Visual Analogue Scale (VAS) scores for pain and stiffness. The mean pain score reduced from 7.4 to 3.1, while stiffness decreased from 6.8 to 2.9 post-treatment. These findings underscore the effectiveness of the chosen Ayurvedic interventions in symptom relief and improving patient comfort during daily activities.

Table 6: Overall Therapeutic Response Post-Treatment: This table presents the overall clinical response based on predefined criteria of improvement. Out of 120 patients, 65% showed **marked improvement**, 22.5% showed **moderate improvement**, and 12.5% had **mild or no improvement**. The high proportion of marked responders suggests that the classical Ayurvedic protocol used—centered around



formulations like Simhanada Guggulu, Maharasnadi Kwatha, and Panchakarma procedures such as Virechana and Basti—was both effective and well-tolerated in the management of Āmavāta over the 12-month study period.

Table 7: Distribution of Chronicity (Duration of Illness): This table shows the chronicity pattern among the 120 patients enrolled in the study. The majority of patients (38.3%) had suffered from Āmavāta for 1–3 years, indicating a subacute presentation as the most common clinical scenario. Patients with more than 5 years of illness constituted 23.3%, highlighting a significant chronic disease burden. Only 23.3% had disease duration of less than one year, suggesting a lower rate of early presentation.

Table 8: Associated Co-morbidities in Patients with Āmavāta: This table outlines the distribution of common co-morbidities found in patients with Āmavāta. Obesity (21.7%) and hypothyroidism (15%) were the most prevalent, supporting the idea of metabolic involvement. Notably, 43.3% of patients had no associated co-morbidities, indicating that Āmavāta can occur independently, although often it is compounded by systemic disorders such as hypertension (11.7%) and diabetes mellitus (8.3%).

Table 9: Functional Assessment Based on Ayurvedic Criteria: Functional grading before and after Ayurvedic treatment showed remarkable improvement. Pre-treatment, 50 patients (41.7%) had severe functional limitations (Grade III), which dropped to only 12 patients post-treatment. Conversely, mild limitation cases (Grade I) increased from 14 to 48, suggesting substantial recovery in mobility and ability to perform daily activities. The table demonstrates that Ayurvedic intervention notably improved patient functioning.

Table 10: Ayurvedic Treatment Regimen Used: This table lists the key formulations and therapies used in managing Āmavāta. The combination of **Simhanāda Guggulu**, **Rasnasaptaka Kwātha**, and **Maharasnadi Taila Abhyanga** formed the core of treatment, used consistently for 3 months. Basti therapy and Eranda Sneha were administered selectively based on clinical need. The protocol reflects a classical approach aligned with Ayurvedic principles of treating Amavata by targeting Ama, Vata, and inflammation.

Table 11: Adverse Reactions Observed: The table reflects excellent tolerability of the Ayurvedic interventions. Out of 120 patients, only 10 (8.3%) reported mild side effects, primarily gastrointestinal discomfort and transient loose stools. One patient reported minor skin irritation with external taila application. There were no moderate or severe adverse events. This indicates that the selected regimen is generally safe and well-tolerated over a 3-month period.

Table 12: Patient-Reported Outcome Measures (PROMs): Significant improvement was observed in subjective symptoms post-treatment. Pain intensity reduced by nearly 59%, while stiffness and fatigue showed over 60% improvement. Notably, the self-assessed overall health score rose from 4.2 to 7.8, underlining a marked enhancement in patients' quality of life. These patient-centered outcomes affirm the clinical efficacy of the holistic Ayurvedic treatment protocol.

Discussion

The present clinical study was designed to evaluate the efficacy of Ayurvedic management in the treatment of Āmavāta (Rheumatoid Arthritis) over a period of 12 months, incorporating a sample of 120 patients. The outcomes are interpreted in light of Ayurvedic principles and contemporary clinical insight, offering valuable contributions to the integrative understanding of this debilitating autoimmune condition [6].

Āmavāta, as described in classical Ayurvedic texts, results from the vitiation of Vāta dosha and accumulation of Āma (toxins) due to impaired Agni (digestive fire). The pathology is characterized by stiffness, swelling, joint pain, and systemic features such as fatigue, anorexia, and heaviness. This description parallels closely with the clinical presentation of Rheumatoid Arthritis as understood in modern medicine, where synovial inflammation, autoimmune reactivity, and systemic manifestations predominate. The chronic, relapsing course of Āmavāta necessitates a multi-modal treatment approach, which this study has adopted [7].

Therapies were based on three core Ayurvedic objectives: (1) elimination of Āma, (2) pacification of Vāta dosha, and (3) restoration of Agni. This was achieved through internal medication with Simhanada Guggulu, Maharasnadi Kwatha, Ajmodadi Churna, and local applications of Maharasnadi Taila, in conjunction



with Panchakarma procedures like Snehana, Swedana, Virechana (therapeutic purgation), and Basti (medicated enemas). The sequential and holistic use of these therapies reflects the classical Ayurvedic dictum: “Āmapāchana → Vāta Shamana → Agni Deepana [8].”

The data reveal statistically significant improvement in key clinical parameters such as joint pain, morning stiffness, swelling, and fatigue. More than 70% of the patients reported marked to moderate improvement by the end of the study period. The anti-inflammatory, detoxifying, and immunomodulatory effects of the employed formulations likely contributed to these favorable outcomes. For instance, Simhanada Guggulu is known for its Āma pachana and Vāta-kapha shāmaka actions, while Maharasnadi Kwatha is traditionally used for alleviating musculoskeletal disorders due to its potent anti-rheumatic activity [9].

The role of Basti karma—administered after Snehapāna and Virechana—was instrumental in addressing chronic Vāta derangement. Matrā Basti using Dashamoola Taila and Niruha Basti prepared from Eranda Moola Kwatha helped in restoring joint function, reducing stiffness, and eliminating residual Āma. This is consistent with classical references that describe Basti as the prime treatment for Vātavyādhi [10].

Notably, the study also examined disease association with various dietary habits, lifestyle factors, and seasonal influences. Patients with high intake of guru, snigdha, and āmīṣa (heavy, oily, and meat-based) diets, and those exposed to cold-damp environments, had a higher frequency of relapse and slower response to therapy, supporting the etiological theories stated in Ayurvedic texts. These findings re-emphasize the relevance of Ahāra-Vihāra (dietary and lifestyle regimen) in disease management [11].

Furthermore, no severe adverse effects were recorded during the study, suggesting the safety and tolerability of Ayurvedic interventions over the long term. The mild and manageable side effects observed in a few patients were mostly gastrointestinal (such as mild purgation or nausea) and subsided without additional intervention.

An interesting outcome of this study was the significant improvement in functional parameters—mobility, daily activity levels, and quality of life. This highlights not

only the symptomatic relief but also the rehabilitative potential of the holistic Ayurvedic regimen.

While the results are encouraging, certain limitations exist. The absence of a control group, reliance on subjective scoring for some parameters, and the lack of biomarker-based objective outcome measures (e.g., ESR, CRP) limit the ability to generalize findings across populations. However, the longitudinal design, robust sample size, and multimodal treatment protocol provide considerable strength to the clinical validity of the study.

In summary, the results support the Ayurvedic approach to the management of Āmavāta, particularly when therapies are tailored to the stage of disease (āmavasthā or nirāmavasthā), prakṛti (constitution), and individual clinical profile. Integrating traditional wisdom with modern clinical insight can pave the way for more personalized and effective management of chronic autoimmune disorders like Rheumatoid Arthritis.

Conclusion

The present clinical study demonstrates that a comprehensive Ayurvedic treatment protocol, rooted in the principles of Āma pachana, Vāta shamana, and Agni deepana, is effective in the management of Āmavāta (Rheumatoid Arthritis). The sequential administration of internal herbal formulations, external therapies, and Panchakarma procedures led to significant relief in classical symptoms such as joint pain, stiffness, swelling, and fatigue.

Importantly, the therapies also contributed to improved joint function and enhanced quality of life without causing serious adverse effects, thus underscoring both efficacy and safety. The therapeutic approach employed in this study aligns with the traditional Ayurvedic understanding of the disease and demonstrates its relevance even in modern clinical settings.

The findings affirm the value of personalized, stage-wise Ayurvedic management in chronic autoimmune conditions like Āmavāta, particularly when initiated early and accompanied by strict regulation of diet and lifestyle. Further large-scale controlled studies are recommended to validate these results and explore integrative models for managing autoimmune arthritis.



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