

Management of Refractory Pemphigus Vulgaris through Ayurvedic *Shodhana* Therapy: A Case Report

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ABSTRACT

Pemphigus Vulgaris (PV) is a chronic autoimmune blistering disorder characterised by painful mucocutaneous erosions. Standard management relies on systemic corticosteroids and immunosuppressants; however, many patients experience relapses when doses are tapered, leading to refractory disease. Present case report is of a 36-year-old female with extensive erosions (60% body surface area) and recurrent “rebound flares” despite prolonged steroid therapy. Seeking a *steroid-sparing* alternative, she underwent a structured Ayurvedic *Shodhana* (bio-purification) protocol comprising *Vamana* (therapeutic emesis), *Virechana* (therapeutic purgation), and adjunctive *Jalaukavacharana* (leech therapy), along with supportive internal and external care. Over 12 weeks, progressive improvement was observed, with near-complete clinical remission with full re-epithelialisation of cutaneous and mucosal lesions. While this case highlights the potential role of Ayurvedic detoxification therapies in refractory PV, the absence of standardised scoring indices and immunopathological confirmation limits generalisability. Larger, controlled studies are warranted to objectively evaluate efficacy and long-term outcomes.

Keywords: Autoimmune disease, Blisters, Complementary therapies, Lesions, Visphota

CASE REPORT

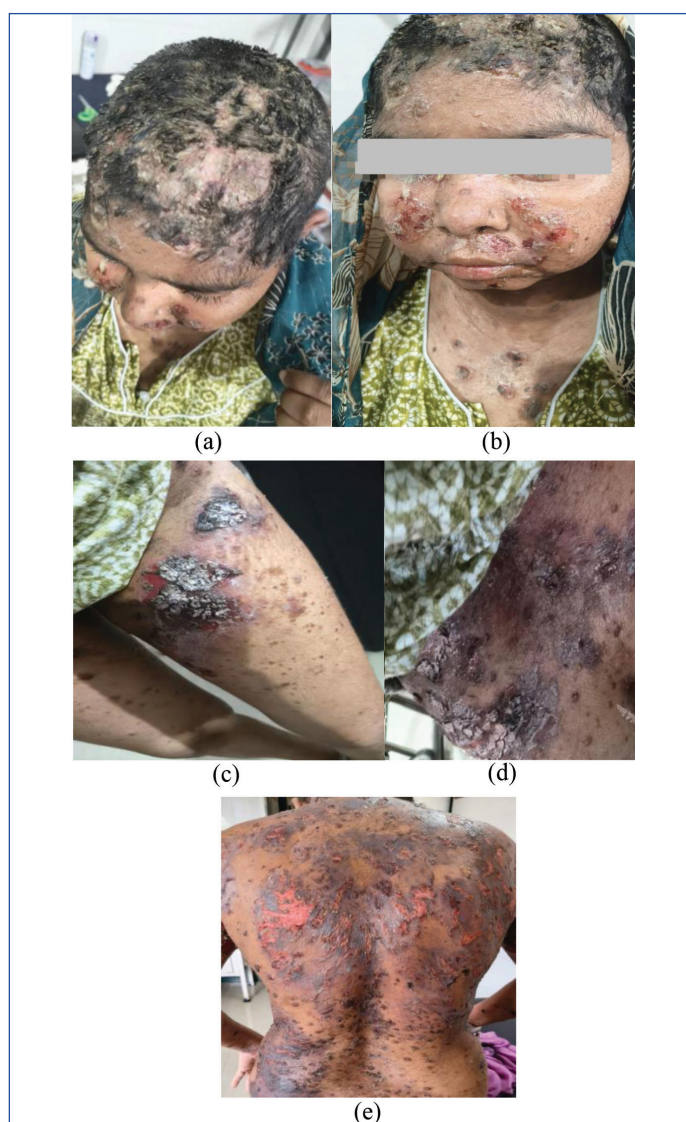
A 36-year-old female presented to the *Kayachikitsa* outpatient department with a previously confirmed diagnosis of PV by a dermatologist one year earlier, based on clinical morphology. Her main complaints included painful, fluid-filled blisters (*Visphota*) and extensive raw, erythematous erosions (*Vrana*) affecting her scalp, face, trunk, and back [Table/Fig-1].

Since the diagnosis had already been established, further immunological investigations, such as Direct Immunofluorescence (DIF) and serum Enzyme-Linked Immunosorbent Assay (ELISA), were not repeated. According to her history, she had been admitted to a tertiary hospital one year prior due to an acute exacerbation of the disease. During that admission, systemic stabilisation was achieved with intravenous dexamethasone (2 mL twice daily), broad-spectrum antibiotics, and oral cyclophosphamide (Endoxan) at 50 mg twice daily. Nutritional support was provided with multivitamins, and local wound care was managed using topical Soframycin and Gentian violet lotion. Following this treatment, she was transitioned to oral prednisolone at 40 mg daily for four weeks, along with oral Endoxan at 50 mg twice daily for 16 weeks. A standard tapering protocol was attempted, reducing prednisolone by 5 mg every two weeks. However, disease control was lost once the dose fell below 15 mg, leading to a systemic rebound flare. Concerned about persistent disease and the adverse effects of long-term steroid therapy, the patient discontinued allopathic medication and chose Ayurvedic *Shodhana* (bio-purification) therapy.

On clinical assessment, the patient was in significant pain with restricted mobility. Her vital parameters were stable: pulse 88/min, blood pressure 110/70 mmHg, and respiratory rate 18/min. A systemic examination of the respiratory, cardiovascular, and central nervous systems revealed no abnormalities.

From an ayurvedic perspective, *Astavidha Parikshan* (eight-fold examination) was conducted [Table/Fig-2].

Local examination revealed multiple flaccid bullae and extensive “beefy red” erosions involving about 60% of the body surface area, with haemorrhagic crusting most marked on the face and scalp. Nikolsky’s sign was positive. Differential diagnosis excluded



[Table/Fig-1]: Clinical presentation at baseline showing generalised flaccid bullae and extensive raw erosions on the: a) Scalp; b) Face; c) Lower leg; d) Buttocks; e) Back.

Ashtavidha Pariksha	Result
Nadi (pulse)	Vata-Pitta dominant
Mala (Stool)	Asamyak (once or twice a day)
Mutra (Urine)	Samyak (5-7 times a day)
Jivha (tongue)	Saama (coated)
Drik (Eye)	Avikrita (Clear vision, no pallor, icterus)
Shabdha (Speech)	Spashttha
Sparsh (Touch)	Anushna
Akrti (Physique)	Madhyam

[Table/Fig-2]: Astavidha Parikshan (eight fold examination).

Bullous Pemphigoid, which presents with tense sub-epidermal blisters, negative Nikolsky's sign, and minimal mucosal involvement. Drug-induced emergencies such as Stevens-Johnson Syndrome (SJS), Toxic Epidermal Necrolysis (TEN) and Erythema Multiforme (EM) were ruled out due to the absence of high-risk drug exposure and targetoid lesions. The chronic relapsing course triggered by corticosteroid tapering was consistent with refractory PV. A fresh biopsy was avoided to reduce infection risk, and the diagnosis of severe "rebound" PV was established from prior tertiary-care records, pathognomonic signs, and active presentation.

In this case, the primary therapeutic goal was to break the chronic "rebound" cycle of PV by eliminating deep-seated vitiated *Doshas*, primarily *Pitta* and *Rakta*. Treatment began with *Purva Karma* (preparatory measures).

The structured sequence- *Purva Karma*, *Shodhana* (*Vamana*, *Virechana*, *Jalaukacharana*), external wound care, and *Shamana* provided a comprehensive approach to stabilise refractory disease and achieve sustained remission [Table/Fig-3].

Phase	Procedure/drug	Dosage and duration	Purpose
Deepana Pachana	Chiktrakadi Vati	500 mg twice a day For five subsequent days	To optimise metabolic and digestive capacity (<i>Ama pachana</i> and increase the digestive fire for digestion of heavy dosages of <i>ghrita</i>), and clear initial tissue level obstruction (<i>Shrotorodha</i>)
Purva Karma	Snehapana (<i>Mahatiktaka Ghrita</i>)	30 mL to 150 mL (5 days) dose was titrated as per the patient's <i>Agnibala</i> (metabolic and digestive capacity)	To mobilise toxins (<i>Doshas</i>) from deep tissues to the gut.
Pradhan Karma (1)	Vamana (Therapeutic emesis)	<i>Madhyam Shudhi</i> (seven Vegas) Within clinical tolerance. (Followed by <i>Sansarjanya Krma</i> for seven days)	To clear <i>Kapha Dosha</i> from the upper body.
Pradhan Karma (2)	Virechana (Therapeutic purgation)	Adequate Vegas was achieved within clinical tolerance. Followed by the <i>Sansarjanya krma</i> , seven days.	To clear systemic <i>Rakta-Pitta</i> and stop the "rebound" effect
Local Shodhana	Jalaukavacharana (Leech Therapy)	Three settings (weekly) for six weeks	To improve local microcirculation and accelerate <i>Ama</i> facial healing
Internal Shamana	Arogyavardhini Vati	500 mg BD (12 weeks)	To balance liver metabolism and prevent <i>Ama</i> (Toxin) formation.
Internal Shamana	Kaishore Guggulu	500 mg BD (12 weeks)	To stabilise the immune system and reduce skin inflammation.
External care	Triphala Kwath (wound wash and bath)	Twice a daily (12 weeks)	To prevent secondary infection in raw areas.
External care	Shatadhauta Grita	Local application (12 weeks)	To provide a cooling effect and promote new skin growth (<i>Ropana</i>).

[Table/Fig-3]: Detailed of interventions, timelines and drug dosages.

Note: Drug dosage and frequency were selected on the basis of patient parameters, including age, sex, physical strength (*Bala*), digestive capacity (*Agni*), and the severity of the disease

Over the 12 weeks Ayurvedic *Shodhana* protocol, the patient showed marked and stepwise clinical improvement. After *Vamana*, documented 10-15 days later, there was a significant reduction in the formation of new blisters and a decrease in the "moistness" (*Kledatva*) of lesions [Table/Fig-4].

One month post-*virechana*, noticeable epithelialisation across the trunk and back, with marked reduction in erythema indicating *Pitta-Rakta shama* [Table/Fig-5].

Three settings (weekly) *Jalaukavacharana* applied to stubborn facial erosions, targeted local *Shodhana* improved microcirculation and produced rapid healing of chronic raw areas [Table/Fig-6]. By the end of 12 weeks, the regimen resulted in near-complete clinical remission with full re-epithelialisation of all mucocutaneous lesions,

indicating resolution of the refractory rebound flares that had previously characterised the disease [Table/Fig-7].

DISCUSSION

The term "pemphigus" is derived from the Greek word "pemphix" (meaning blister or bubble) and refers to a group of autoimmune, mucocutaneous blistering diseases. The global annual incidence ranges from 0.7 to 32 cases per million individuals [1]. The prevalence of the disease fluctuates depending on geographic location and ethnic background. In India, the prevalence is reported between 0.09% and 1.8%, a range that is lower than what is observed in other parts of the world. The condition is more prevalent in women, with a female-to-male occurrence ratio of 2:1 [2]. PV typically manifests between the fifth and seventh decades of life. Historically, the disease was frequently fatal before the availability of systemic steroids. Despite representing only 2% of intraoral ulcerative lesions, its clinical severity makes it a necessary consideration when evaluating patients with chronic oral ulcerations or desquamative gingivitis [3]. Clinically, it manifests as thin-walled bullae that rupture rapidly to form large denuded areas. Finally, the disease is distinguished by a positive "Nikolsky's sign," where applying oblique pressure to the skin induces blistering or epidermal sloughing [4,5].

Ayurveda correlates PV with *Visphota*, a condition driven by *Pitta-pradhana tridosha* involving *Rakta*, *Mamsa*, and *Asthi Dhātu*. Based on this pathology, treatment focused on *pitta-kapha hara* through *shamana* and *shodhana cikitsa* [6].

This case is clinically significant because the patient experienced recurrent flares whenever corticosteroids were tapered. To break this cycle, a comprehensive *Panchakarma* regimen was initiated to achieve systemic detoxification and sustained remission rather than temporary symptom suppression. *Virechana* was used to

expel vitiated doshas and toxins, improving circulation and health restoration [7]. *Vamana Karma* targeted accumulated *Kapha* and removed morbidity from the *Koshta* and respiratory tract [7]. *Jalaukavacharana* (leech therapy) eliminated *Dushita Rakta* and vitiated *Pitta*, pacifying its hot and sharp qualities [8].

Supportive formulations included *Arogyavardhani vati* for balancing *Kapha* and *Pitta*, reducing inflammation, and aiding liver detoxification [9]; *Kaishore Guggulu* for blood purification and immunomodulation [10]; *Triphala Kwath* for antibacterial, antioxidant, and collagen-supportive wound healing [11]; and *Shatadhauta Ghrita* as a cooling topical application to relieve burning and stabilise the skin barrier [12].

Definitive immunopathological tests (DIF, ELISA) were not performed due to extensive skin denudation, and diagnosis relied



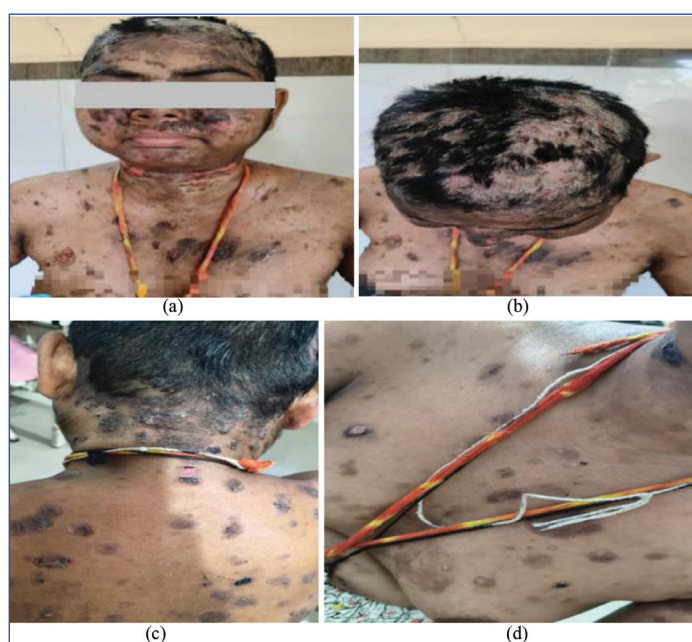
[Table/Fig-4a-d]: Clinical photographs demonstrating early improvement 10-15 days after *Vamana* (therapeutic emesis).

Note: Erythema persists but erosions appear drier, indicating initial clearance of upper-body *Kapha* and *Urdhva-anga* channels



[Table/Fig-5]: Clinical status one month after *Virechana* (therapeutic purgation).

Note: Raw, denuded areas show early granulation tissue and reduced haemorrhagic crusting, reflecting systemic detoxification of deep-seated *Pitta* and *Rakta* doshas.



[Table/Fig-6a-d]: Targeted local healing during *jalaukavacharana* (Leech Therapy).

on clinical presentation and tertiary-care records. Limitations include absence of standardised indices (PDAI, ABSIS) and a short



[Table/Fig-7]: Near-complete clinical remission at 12 weeks.

12-week follow-up. Contemporary reports support the therapeutic utility of Ayurvedic *Samshodhana* in PV. Singh H and Panwar G documented the efficacy of *Virechana Karma* and *Raktamokshana* in a 47-year-old male presenting with *Agnivisarpa*. Their case demonstrated immediate post-treatment clearance in a patient who had responded inadequately to modern systemic medication, though the presentation was relatively straightforward and did not involve severe recurrent flare patterns [13].

Sayani PV et al., reported a case of a 47-year-old female school teacher with chronic mucocutaneous PV. Her presentation included severe dysphagia, loss of taste, and multiple flaccid blisters (*Sphota*) across the sub-mammary region, abdomen, and axillae, which ruptured into painful erosions accompanied by intense burning (*Daha*). Systematic *Virechana Karma* combined with *Takradhara* successfully targeted the vitiated doshas, leading to rapid epithelialisation within seven days. However, this intervention primarily addressed a single acute flare triggered by steroid tapering, rather than a refractory disease course [14].

Chaturvedi P and Namdeo N described a 32-year-old male with recurrent painful oral ulcers and blistering eruptions (*Pidakas*) over the face and back, accompanied by joint pain. Clinical features included painful fluid-filled bullae that progressed to crusting erosions with burning (*Daha*), pus discharge, and redness (*Raga*). Management involved sequential *Vamana Karma* followed by *Virechana Karma*, along with internal *Shamana* medications. This regimen resolved acute lesions and reduced dependence on corticosteroids and antihistamines within a short period. Nevertheless, the therapeutic scope was limited to localised disease management and did not extend to refractory states prone to cyclical relapses [15].

In contrast to these reports, this study addresses a critical clinical gap by demonstrating successful management of a highly unstable, strictly refractory variant of PV characterised by vicious rebound phenomena and frequent acute relapses. Ayurvedic protocol broke the continuous cycle of rapid relapses, stabilised hyper-reactive epidermal responses, and prevented secondary flare-ups after therapy. This establishes a distinct therapeutic advantage in managing hyper-acute, fluctuating autoimmune blistering disorders.

CONCLUSION(S)

This case highlights that Ayurvedic bio-purification (*Shodhana*), including *Vamana* and *Virechana*, combined with local therapies such as leech application (*Jalaukavacharana*), can be an effective approach for managing refractory PV-like conditions. Unlike conventional regimens that provide only temporary symptomatic relief, this protocol addresses the disturbed systemic *Doshic* milieu and eliminates deep-seated metabolic toxins (*Ama*). Importantly, it achieves clinical stability without dependence on costly biologics or high-dose immunosuppressants, offering a viable therapeutic alternative for patients with severe, steroid-dependent disease.

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