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# A COMPARATIVE CLINICAL STUDY ON THE ROLE OF *GOMUTRASIDDHA HARITAKI* INTERNALLY WITH OR WITHOUT EXTERNAL USE OF *SARJARASA TAILA* IN *PAMA* (SCABIES)

**Ritika Chaurasia[1]*, Aniruddha Prasad[2], Debabrata Ghosh[3], Tapas Bhaduri[4], Joydip Tripathi[5]**

[1]Final Year Postgraduate Scholar, Department of Kayachikitsa, Institute of Post Graduate Ayurvedic Education and Research at Shyamadas Vaidya Shastra Pith, Kolkata, West Bengal, India.
[2]Assistant Professor, Department of Kayachikitsa, Nitishwar Ayurved Medical College and Hospital and PG Research Institute, Muzaffarpur, Bihar, India.
[3]Lecturer, Department of Kayachikitsa, Institute of Post Graduate Ayurvedic Education and Research at Shyamadas Vaidya Shastra Pith, Kolkata, West Bengal, India.
[4] Reader and Head of the Department, Department of Kayachikitsa, Institute of Post Graduate Ayurvedic Education and Research at Shyamadas Vaidya Shastra Pith, Kolkata, West Bengal, India.
[5] Lecturer, Department of Swasthavritta and Yoga, J.B. Roy State Ayurvedic Medical College and Hospital, Kolkata, West Bengal, India.

***Corresponding Author: Ritika Chaurasia**

Final Year Postgraduate Scholar, Department of Kayachikitsa, Institute of Post Graduate Ayurvedic Education and Research at Shyamadas Vaidya Shastra Pith, Kolkata, West Bengal, India.

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## ABSTRACT

**Background:** *Pama* is described among the *Kshudra Kushtha* in Ayurvedic literature and is predominantly characterized by *Kandu* (itching), *Pidika* (papular eruptions), and *Vaivarnya* (alteration of skin colour). Its clinical presentation shows considerable similarity with scabies, a contagious ectoparasitic infestation caused by *Sarcoptes scabiei* var. *hominis*. **Objective:** To compare the clinical efficacy of oral *Gomutrasiddha Haritaki Churna* alone with oral *Gomutrasiddha Haritaki Churna* combined with external application of *Sarjarasa Taila* in patients with *Pama* (scabies). **Materials and Methods:** A prospective, randomized, open-label, two-arm comparative clinical study was conducted in 60 patients clinically diagnosed with *Pama* (scabies). Participants were allocated into two groups of 30 patients each. Group A received *Gomutrasiddha Haritaki Churna* 3 g twice daily after meals with warm water for 28 days. Group B received the same internal medication along with external application of *Sarjarasa Taila* twice daily for 28 days. Clinical outcomes were assessed on Days 0, 7, 14, 21, and 28 using four-point ordinal grading scales for *Kandu*, *Pidika*, and *Vaivarnya*. The trial was registered with the Clinical Trials Registry–India under registration number CTRI/2025/02/080332. **Results:** Group A demonstrated reductions of 58.5% in *Kandu*, 52.0% in *Pidika*, and 44.1% in *Vaivarnya* by Day 28. Group B demonstrated greater reductions of 86.2%, 82.4%, and 74.6%, respectively. Within-group changes were statistically significant ($p<0.001$). Inter-group comparison demonstrated significantly greater improvement in Group B for *Kandu* ($t=5.42$, $p<0.001$), *Pidika* ($t=4.88$, $p<0.001$), and *Vaivarnya* ($t=3.95$, $p<0.001$). **Conclusion:** Both treatment regimens produced significant clinical improvement in *Pama* (scabies); however, the combination of internal *Gomutrasiddha Haritaki Churna* and external *Sarjarasa Taila* produced greater improvement over 28 days. The findings support further adequately powered, objectively assessed randomized controlled studies with longer follow-up.

**KEYWORDS:** *Pama*, scabies, *Gomutrasiddha Haritaki*, *Sarjarasa Taila*, *Kandu*, *Pidika*, *Vaivarnya*, Ayurveda, *Kshudra Kushtha.*

## INTRODUCTION

Ayurveda describes a broad group of dermatological disorders under the category of *Kushtha Roga*. Within this classification, *Kshudra Kushtha* includes several comparatively localized or less extensive cutaneous conditions. *Pama* is described as a disorder characterized predominantly by itching and eruptions over the skin. Classical descriptions emphasize symptoms such as *Kandu* and *Pidika*, with associated changes in the appearance of the affected skin.[1]

The clinical description of *Pama* is further represented in classical Ayurvedic literature, where itching and papular eruptions constitute important manifestations.[2] Similar descriptions are found in *Ashtanga Hridaya*, supporting the recognition of *Pama* as a distinct cutaneous disorder within *Kushtha*.[3]

In contemporary dermatology, scabies is an ectoparasitic infestation caused by the human itch mite *Sarcoptes scabiei* var. *hominis*. Transmission occurs predominantly through prolonged skin-to-skin contact, although fomites may contribute under particular circumstances. Scabies remains an important public health problem, particularly in overcrowded communities and resource-limited settings.[4]

The public health burden of scabies is substantial, with affected populations experiencing not only dermatological morbidity but also social and economic consequences. Population-based investigations have demonstrated the considerable healthcare burden associated with scabies and its complications.[5]

The pathogenesis of scabies involves penetration of the female mite into the superficial stratum corneum, where eggs are deposited and subsequent developmental stages occur. The host immune response to mites, eggs, and fecal material contributes substantially to the characteristic inflammatory response and intense pruritus. Clinically, scabies commonly presents with intense, often nocturnally aggravated pruritus, erythematous papules, vesicles, excoriations, and characteristic burrows. Typical sites include the interdigital spaces, wrists, axillary regions, periumbilical area, buttocks, and genital region.[6]

Contemporary management relies primarily on anti-scabetic therapy, particularly topical permethrin and, in selected situations, oral ivermectin. Although these therapies are effective, treatment failure, reinfestation, post-scabetic dermatitis, secondary bacterial infection, and continued household transmission can complicate management.[4]

Mass drug administration has also been investigated as a population-level intervention in areas with high scabies prevalence. Such approaches demonstrate the importance of addressing transmission at both individual and community levels.[17]

Ayurvedic management of skin disorders traditionally emphasizes a combination of internal and external therapeutic measures.[9] Classical formulations and therapeutic approaches described for *Kushtha* include *Shamana* and *Bahya Parimarjana Chikitsa*, reflecting the importance of addressing both systemic and local manifestations.[7]

*Gomutrasiddha Haritaki Churna* is an Ayurvedic formulation in which *Haritaki* (*Terminalia chebula*) is processed with *Gomutra*. *Haritaki* is extensively described in Ayurvedic pharmacology and is traditionally employed in a wide range of disorders.[8] The therapeutic processing of herbal drugs with *Gomutra* has also been discussed in relation to possible modification of their pharmacological properties.[16]

External therapeutic approaches involving medicated oils and applications have traditionally been used in cutaneous disorders.[13] *Sarjarasa Taila*, containing *Sarjarasa* derived from *Vateria indica*, represents an external therapeutic formulation used in the Ayurvedic management of skin-related conditions.[14] The phytochemical and pharmacological properties of *Vateria indica* have been investigated in experimental literature, although direct clinical evidence for scabies remains limited.[15]

Previous clinical investigations have evaluated Ayurvedic interventions in *Pama* and related *Kshudra Kushtha* conditions. Clinical evaluation of *Marichyadi Taila* has demonstrated the potential role of external Ayurvedic therapy in *Pama*.[10] Comparative clinical work involving *Shodhana* followed by *Shamana* therapy has also explored the management of *Kshudra Kushtha* with particular reference to *Pama*.[11]

The therapeutic rationale for combining internal and external treatment is therefore consistent with the Ayurvedic principle of addressing disease through systemic and local therapeutic approaches.[13] However, comparative clinical evidence specifically evaluating oral *Gomutrasiddha Haritaki Churna* alone against the same oral regimen combined with external *Sarjarasa Taila* remains limited.[12]

Therefore, the present study was undertaken to comparatively evaluate these two therapeutic approaches in patients presenting with clinical features of *Pama* corresponding to scabies.

## AIM AND OBJECTIVES

### AIM

To compare the clinical efficacy of oral *Gomutrasiddha Haritaki Churna* alone with oral *Gomutrasiddha Haritaki Churna* combined with external application of *Sarjarasa Taila* in the management of *Pama* (scabies).

**PRIMARY OBJECTIVE**

To compare the efficacy of

- Oral *Gomutrasiddha Haritaki Churna* alone; and
- Oral *Gomutrasiddha Haritaki Churna* combined with external *Sarjarasa Taila*

in reducing the clinical manifestations of *Pama*, particularly *Kandu*, *Pidika*, and *Vaivarnya*.

**SECONDARY OBJECTIVES**

1. To review the classical Ayurvedic description of *Pama* and correlate it with the contemporary clinical presentation of scabies.
2. To assess the effect of the interventions on individual clinical parameters.
3. To evaluate the safety and tolerability of the treatment regimens over 28 days.

**MATERIALS AND METHODS**

**Study Design**

A prospective, randomized, open-label, two-arm comparative clinical study was conducted over a treatment period of 28 days.

The study compared two therapeutic regimens.

- **Group A:** Oral *Gomutrasiddha Haritaki Churna*.
- **Group B:** Oral *Gomutrasiddha Haritaki Churna* plus external *Sarjarasa Taila*.

**Study Setting**

The study was conducted under the Department of Kayachikitsa, Institute of Post Graduate Ayurvedic Education and Research (IPGAE&R) at Shyamadas Vaidya Shastra Pith Hospital, Kolkata, West Bengal, India.

**Ethical Approval**

The study received approval from the Institutional Ethics Committee vide Ref. No. **SVP/IEC 849/2024**, dated **29 May 2024**.

The study was conducted in accordance with applicable ethical principles governing clinical research involving human participants.

**Trial Registration**

The clinical trial was registered with the **Clinical Trials Registry–India (CTRI)** under registration number: **CTRI/2025/02/080332**

CTRI is the Indian public registry for registration and public disclosure of clinical studies conducted in India.

**Sample Size**

A total of 60 patients were included in the study and divided equally between the two treatment groups.

- Group A: 30 patients
- Group B: 30 patients

**INTERVENTION**

**Group A**

Patients received: **Gomutrasiddha Haritaki Churna – 3 g twice daily after meals with warm water for 28 days.**

**Group B**

Patients received: **Gomutrasiddha Haritaki Churna – 3 g twice daily after meals with warm water for 28 days**

along with.

**Sarjarasa Taila – external application twice daily for 28 days.**

The treatment was continued for a total period of 28 days.

**Clinical Assessment**

Clinical assessment was performed at baseline and subsequently on Days 7, 14, 21, and 28.

The principal clinical parameters were.

1. *Kandu* – itching
2. *Pidika* – papular eruptions
3. *Vaivarnya* – alteration in skin colour

Each parameter was assessed using a four-point ordinal grading system.

**Outcome Measures**

The primary clinical outcomes were the changes in the scores of *Kandu*, *Pidika*, and *Vaivarnya* from baseline to Day 28.

The percentage reduction was calculated using.

**Percentage reduction = [(Baseline score − Day 28 score) / Baseline score] × 100**

**STATISTICAL ANALYSIS**

The clinical observations were summarized using mean and standard deviation. Within-group changes were assessed statistically, and inter-group differences in mean change were evaluated using an unpaired statistical test.

A p-value <0.05 was considered statistically significant. A p-value <0.001 was considered highly statistically significant.

**RESULTS**

A total of 60 patients completed the 28-day treatment period, with 30 patients in each treatment group.

**DEMOGRAPHIC CHARACTERISTICS**

Among the 60 participants, 34 were male (56.7%) and 26 were female (43.3%).

The largest age category was 15–30 years, comprising 45.0% of participants, followed by the 31–45-year age group, comprising 31.7%.

**Table 1: Demographic Characteristics of Participants.**

| Characteristic | Number | Percentage |
|---|---|---|
| Total participants | 60 | 100 |
| Male | 34 | 56.7 |
| Female | 26 | 43.3 |
| Age 15–30 years | 27 | 45.0 |
| Age 31–45 years | 19 | 31.7 |
| Other age groups | 14 | 23.3 |

**EFFECT ON *KANDU***

In Group A, the mean *Kandu* score decreased from **2.60 ± 0.50** at baseline to **1.08 ± 0.45** on Day 28.

The mean reduction was 1.52 points, corresponding to a **58.5% reduction**.

In Group B, the mean score decreased from **2.68 ± 0.47** to **0.37 ± 0.49**, representing a mean reduction of 2.31 points and an **86.2% reduction**.

The improvement was highly significant within both groups ($p<0.001$).

Inter-group comparison showed a significantly greater reduction in Group B, with **t=5.42 and p<0.001**.

**Table 2: Effect on *Kandu.***

| Group | Baseline Mean ± SD | Day 28 Mean ± SD | Mean Change | Reduction | p-value |
|---|---|---|---|---|---|
| Group A | 2.60 ± 0.50 | 1.08 ± 0.45 | 1.52 | 58.5% | <0.001 |
| Group B | 2.68 ± 0.47 | 0.37 ± 0.49 | 2.31 | 86.2% | <0.001 |

**Inter-group:** t=5.42, p<0.001.

**EFFECT ON *PIDIKA***

In Group A, the mean *Pidika* score decreased from **2.50 ± 0.51** at baseline to **1.20 ± 0.48** on Day 28.

The mean reduction was 1.30 points, corresponding to a **52.0% reduction**.

In Group B, the mean score decreased from **2.56 ± 0.50** to **0.45 ± 0.50**, representing a mean reduction of 2.11 points and an **82.4% reduction**.

Within-group improvement was highly significant in both groups ($p<0.001$).

The inter-group difference was also highly significant, with **t=4.88 and p<0.001**.

**Table 3: Effect on *Pidika.***

| Group | Baseline Mean ± SD | Day 28 Mean ± SD | Mean Change | Reduction | p-value |
|---|---|---|---|---|---|
| Group A | 2.50 ± 0.51 | 1.20 ± 0.48 | 1.30 | 52.0% | <0.001 |
| Group B | 2.56 ± 0.50 | 0.45 ± 0.50 | 2.11 | 82.4% | <0.001 |

**Inter-group:** t=4.88, p<0.001.

**EFFECT ON *VAIVARNYA***

The mean *Vaivarnya* score in Group A decreased from **2.22 ± 0.55** at baseline to **1.24 ± 0.51** on Day 28.

The mean reduction was 0.98 points, corresponding to a **44.1% reduction**.

In Group B, the mean score decreased from **2.28 ± 0.52** to **0.58 ± 0.50**, representing a mean reduction of 1.70 points and a **74.6% reduction**.

The within-group changes were highly significant ($p<0.001$).

Inter-group comparison demonstrated a statistically significant greater improvement in Group B, with **t=3.95 and p<0.001**.

**Table 4: Effect on *Vaivarnya.***

| Group | Baseline Mean ± SD | Day 28 Mean ± SD | Mean Change | Reduction | p-value |
|---|---|---|---|---|---|
| Group A | 2.22 ± 0.55 | 1.24 ± 0.51 | 0.98 | 44.1% | <0.001 |
| Group B | 2.28 ± 0.52 | 0.58 ± 0.50 | 1.70 | 74.6% | <0.001 |

**Inter-group:** t=3.95, p<0.001.

**COMPARATIVE SUMMARY**

**Table 5: Comparative Effect of the Two Treatment Regimens.**

| Parameter | Group A Reduction | Group B Reduction | Inter-group p-value |
|---|---|---|---|
| *Kandu* | 58.5% | 86.2% | <0.001 |
| *Pidika* | 52.0% | 82.4% | <0.001 |
| *Vaivarnya* | 44.1% | 74.6% | <0.001 |

The findings demonstrate that both groups improved over the 28-day treatment period. However, the magnitude of improvement was consistently greater in Group B, which received both internal *Gomutrasiddha Haritaki Churna* and external *Sarjarasa Taila*.

**DISCUSSION**

The present randomized comparative clinical study evaluated the effect of oral *Gomutrasiddha Haritaki Churna* alone and the same internal therapy combined with topical *Sarjarasa Taila* in patients with clinically diagnosed *Pama* (scabies). Both treatment groups demonstrated progressive improvement in the assessed clinical manifestations over the 28-day treatment period. However, the magnitude of improvement was consistently greater in the group receiving combined internal and external therapy. Group A demonstrated reductions of 58.5%, 52.0%, and 44.1% in *Kandu*, *Pidika*, and *Vaivarnya*, respectively, whereas Group B demonstrated corresponding reductions of 86.2%, 82.4%, and 74.6%. The statistically significant differences observed between the groups indicate that addition of topical *Sarjarasa Taila* may have provided an additional clinical benefit over oral therapy alone.

The improvement observed in Group A indicates that oral *Gomutrasiddha Haritaki Churna* was associated with clinically meaningful reduction in the manifestations evaluated. However, because both groups received the same internal intervention, the substantially greater improvement in Group B is particularly relevant. The major difference between the treatment regimens was the addition of topical *Sarjarasa Taila* in Group B. Therefore, the superior response observed in the combined-treatment group may reasonably be attributed, at least in part, to the additional contribution of topical therapy. Nevertheless, the present study does not allow the independent contribution of each component or the presence of a synergistic interaction between them to be established.

Among the evaluated parameters, *Kandu* showed the greatest degree of improvement. The reduction was 58.5% in Group A and 86.2% in Group B. This finding is clinically important because itching represents one of the most prominent and distressing manifestations of *Pama*. Persistent pruritus may interfere with sleep and daily activities and may result in repeated scratching, further irritation, and excoriation of the skin. The substantially greater reduction in *Kandu* in Group B suggests that the addition of topical treatment may have enhanced symptomatic control and provided greater relief of local cutaneous discomfort. However, the study did not investigate the specific biological mechanism responsible for this improvement. Therefore, the reduction in itching should be interpreted as a clinical therapeutic response rather than definitive evidence of a particular antipruritic, antiparasitic, anti-inflammatory, or immunomodulatory mechanism.

A similar pattern was observed for *Pidika*. Group A demonstrated a 52.0% reduction, while Group B demonstrated an 82.4% reduction by Day 28. The greater reduction in papular manifestations in the combined-treatment group suggests that topical therapy may have contributed to improved control of the cutaneous component of the disease. Since both groups received the same oral medication, the additional improvement observed in Group B is clinically consistent with a beneficial contribution from the external intervention. Nevertheless, the assessment of *Pidika* was based on an ordinal clinical score and did not include detailed lesion-level evaluation. Consequently, the present findings cannot determine whether treatment specifically influenced lesion number, size, morphology, inflammatory characteristics, or other individual features.

The improvement in *Vaivarnya* was comparatively lower than that observed for *Kandu* and *Pidika*, although the combined-treatment group again demonstrated greater improvement. Group A showed a 44.1% reduction, compared with 74.6% in Group B. The comparatively slower improvement in skin-colour changes may reflect the persistence of residual cutaneous alterations after the active inflammatory manifestations have subsided. Changes in pigmentation or residual erythema may require a longer period to resolve than active symptoms such as itching and papular eruptions. Thus, the observed improvement in *Vaivarnya* may represent gradual recovery of the affected skin rather than a direct effect on pigmentation. Since colour changes were evaluated clinically rather than with objective colorimetric assessment, this finding should be interpreted cautiously.

The overall pattern of results supports the clinical value of combining internal and external therapeutic approaches. The greater improvement in Group B across all three parameters suggests that topical treatment may complement the effect of internal medication by addressing the local manifestations of the disease. From an Ayurvedic perspective, the combined approach is compatible with the principle of addressing both systemic and local components of a disorder. In the context of the present study, this therapeutic strategy appears to have produced a more pronounced clinical response than internal therapy alone. However, the term “synergistic” should be avoided because the present two-arm design cannot statistically establish interaction between the individual treatment components. The more appropriate interpretation is that the combined regimen demonstrated greater clinical effectiveness than the oral regimen alone under the conditions of this study.

The clinical response observed with *Gomutrasiddha Haritaki Churna* should be interpreted in relation to the complete formulation rather than attributed to any individual constituent. The study was designed to evaluate the clinical efficacy of the formulation as administered to the participants and did not include separate treatment arms for *Haritaki*, *Gomutra*

processing, or individual phytoconstituents. Therefore, the present findings cannot establish the specific contribution of any single component to the observed therapeutic response. Similarly, although the formulation may have plausible pharmacological effects, the present clinical data do not establish a particular antimicrobial, antiparasitic, anti-inflammatory, or immunological mechanism.

The additional improvement observed after administration of topical *Sarjarasa Taila* provides a clinically relevant observation. The reduction in itching, papular eruptions, and skin-colour changes was consistently greater in the group receiving the topical preparation. The effect may potentially involve local modification of inflammation, irritation, or other cutaneous processes. However, the present study did not include microbiological, parasitological, pharmacological, or mechanistic investigations. It is therefore not possible to determine whether the observed benefit was related to direct activity against the causative mite, local anti-inflammatory effects, symptomatic relief, improvement in skin condition, or a combination of these factors.

An important consideration in interpreting the present findings is the distinction between clinical improvement and parasitological clearance. The study demonstrated substantial reductions in clinical manifestations, particularly itching and papular lesions, but did not include objective confirmation of mite eradication. Consequently, improvement in the clinical scores cannot be considered equivalent to confirmed elimination of *Sarcoptes scabiei*. Residual itching or skin-colour changes may persist after successful treatment, while clinical improvement may also occur without complete parasitological clearance. Therefore, the present findings should be described as improvement in clinical manifestations rather than definitive evidence of parasitological cure.

The contagious nature of scabies also introduces additional factors that may influence treatment response. Re-exposure to infected household contacts, inadequate treatment of contacts, and environmental factors may contribute to reinfestation and recurrence. These factors were not systematically evaluated in the present study and therefore may have influenced individual treatment outcomes. Future clinical studies should incorporate assessment and management of household contacts and appropriate environmental measures when evaluating interventions for scabies.

The study has several methodological strengths. Both groups received the same internal treatment, allowing the additional clinical contribution of the topical intervention to be explored. Repeated assessments at baseline and during the treatment period permitted evaluation of the progression of clinical response rather than relying solely on a single pre- and post-treatment comparison. Assessment of three separate manifestations also provided a broader evaluation of therapeutic response. The consistent direction of improvement across all assessed outcomes strengthens the internal clinical interpretation of the findings.

Several limitations should nevertheless be considered. The sample size was relatively small, which limits the precision and generalizability of the findings. The open-label design may have introduced participant and observer bias, particularly because *Kandu* is a subjective clinical outcome. The treatment period was limited to 28 days, and longer-term follow-up was not available to evaluate sustained response or recurrence. Objective confirmation of scabies diagnosis and parasitological clearance was not incorporated, preventing definitive conclusions regarding mite eradication. In addition, household exposure and reinfestation were not systematically assessed. Finally, the absence of a conventional anti-scabetic comparator prevents direct assessment of the efficacy of the Ayurvedic regimen against established standard treatment.

The findings nevertheless provide preliminary clinical evidence supporting further investigation of the combined internal and external treatment approach. Future studies should include larger sample sizes, rigorous randomized allocation, validated clinical outcome measures, objective confirmation of diagnosis and parasitological clearance, longer follow-up, and appropriate comparator groups. Studies comparing the combined Ayurvedic regimen with established anti-scabetic therapy would be particularly valuable for determining comparative clinical effectiveness. Pharmaceutical standardization and mechanistic investigations of both formulations may also help clarify the biological basis of the observed clinical response.

Overall, the present study indicates that both oral *Gomutrasiddha Haritaki Churna* alone and its combination with topical *Sarjarasa Taila* were associated with improvement in the clinical manifestations of *Pama* over 28 days. The combined regimen produced consistently greater reductions in *Kandu*, *Pidika*, and *Vaivarnya*, with statistically significant differences compared with oral therapy alone. These findings suggest an additional clinical benefit from incorporating topical treatment into the internal therapeutic regimen. However, because the study assessed clinical manifestations rather than objective parasitological clearance, and because of the limitations related to sample size, open-label design, treatment duration, and absence of a standard-treatment comparator, the results should be regarded as preliminary. Further adequately powered and methodologically rigorous randomized controlled trials are required to confirm the clinical effectiveness and therapeutic role of this combined Ayurvedic approach in *Pama* (scabies).

## LIMITATIONS

The major limitations of the present study include.

1. Relatively small sample size of 60 participants.
2. Open-label study design.
3. Short treatment and observation period of 28 days.
4. Absence of a conventional anti-scabetic comparator.
5. Lack of objective laboratory or dermoscopic confirmation of mite eradication.
6. Clinical assessment based on ordinal symptom scores.
7. Household and environmental risk factors were not systematically controlled.
8. Long-term recurrence and post-treatment outcomes were not assessed.
9. The study does not establish the specific pharmacological mechanisms of the interventions.

## FUTURE RESEARCH

Future studies should preferably include larger sample sizes and rigorous randomized controlled designs. Objective confirmation of scabies diagnosis and clearance using dermoscopy, microscopy, or other validated diagnostic methods would strengthen the evidence.

Comparisons with established anti-scabetic treatment could help determine the relative efficacy and clinical applicability of Ayurvedic interventions.

Longer follow-up is also necessary to assess recurrence, reinfestation, post-scabetic pruritus, and sustained clinical response. Studies should additionally assess treatment of household contacts and environmental measures because these factors can substantially influence recurrence.

Pharmacological and phytochemical investigations of *Gomutrasiddha Haritaki* and *Sarjarasa Taila* may help elucidate possible antimicrobial, antiparasitic, anti-inflammatory, or immunomodulatory mechanisms. Such laboratory evidence should subsequently be correlated with well-designed clinical trials.

## CONCLUSION

The present comparative clinical study demonstrated significant improvement in the clinical manifestations of *Pama* (scabies) following treatment with oral *Gomutrasiddha Haritaki Churna* alone and with the combination of oral *Gomutrasiddha Haritaki Churna* and external *Sarjarasa Taila*.

Group A showed reductions of 58.5% in *Kandu*, 52.0% in *Pidika*, and 44.1% in *Vaivarnya*.

Group B showed greater reductions of 86.2% in *Kandu*, 82.4% in *Pidika*, and 74.6% in *Vaivarnya*.

The inter-group differences were statistically significant for all three parameters, indicating greater clinical improvement with the combined internal and external regimen.

Within the limitations of the present study, the findings suggest that addition of external *Sarjarasa Taila* to oral *Gomutrasiddha Haritaki Churna* may provide greater symptomatic improvement than oral therapy alone. However, these findings should not be interpreted as definitive evidence of parasitological cure or superiority over standard anti-scabetic therapy. Larger, adequately powered, objectively assessed randomized controlled trials with longer follow-up are required.

## DECLARATIONS

### Ethics Approval

The study received Institutional Ethics Committee approval from the concerned institution vide Ref. No. **SVP/IEC 849/2024**, dated **29 May 2024**.

### Trial Registration

Clinical Trials Registry–India (CTRI): CTRI/2025/02/080332.

### Consent

Written informed consent was obtained from the participants before enrolment in the clinical study.

### Conflict of Interest

The authors declare that there is no conflict of interest.

### Funding

No external funding was reported for the present study.

### Data Availability

The study data may be made available by the corresponding author upon reasonable request, subject to institutional policies and participant confidentiality.

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