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MANAGEMENT OF YAKRIT VIKARJANYA JALODAR (ASCITES) IN AYURVEDA – A CASE STUDY

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ABSTRACT
A 35 year old male presented with chief complaints of breathing difficulty, swelling in both legs, anorexia, palpitation, yellowish sclera, itching all over the body, lassitude and distended abdomen with everted umbilicus was referred to Kayachikita department of Rajiv Lochan Ayurved Medical College hospital. He was presented with past history of chronic alcoholism; typically drinks every day would be suggestive of one of the risk factor of the GIT disease. The prime etiology of the condition was due to liver disease. By thorough examinations and investigations, he was eventually diagnosed as sub-acute ascitic syndrome nearly correlated to jalodar as per Ayurveda. The differential included parasitic infections, liver cirrhosis and chronic gastroenteritis. Microbilogical test stool and blood culture for parasite was negative. The liver function test shows elevated level of serum bilirubin which was suggestive of underlying hepatic pathology. The treatment modalities given mild laxative drugs like Gomutra sevan at morning time at a dose of 40 ml per day for the duration of 45 days followed by intake of dry haritaki powder along with luke warm water. For the external application Aragwadhadi trivritt lepa was prepared and applied over the whole abdomen, the thickness of the applied paste was according to the ayurved classical texts. The patient responded well to the above treatment.

KEYWORDS: Ascites, Jalodar, Gomutra, Haritaki churn, Aragwadhadi trivritt dasang lepa.

BACKGROUND
Ascites is a gastroenterological disorder manifested as accumulation of free fluid in the peritoneal cavity that exceeds 25 ml.[1] Ascites may be considered under broader domain of udararog which indicates a classical example which involves prana, agni and apan vayu in Ayurveda.[2] Though it is a tridoshaj vyadhi due to the Prakupita Vata dosha free fluid gets accumulated in Udara between Twaka and Mamsa leading to Shotha; this is being termed as Jalodar.[3] In the context of general pathophysiology charak has described pran and apan vayu along with agni is the prime culprit in the occurrence of jalodar where there is an impediment of swedavaha and udakvaha srotas.[4,5] The swelling of abdomen due to ascites is termed as prana vayu vikritijanya jalodar if there is vitiation of prana vayu in rasavaha srotas (Ascites due to heart disease). (charaka udar rg). similarly when there is vitiation of jatharagni and dhatwagni there is obstruction of primarily rasavaha srotas with mild impediment of raktavaha srotas, which is termed as agni vikritijanya jalodar (Acites due to liver disease). Then when there is impairment of apan vayu in mutravaha srotas and udakavaha srotas it leads to obstruction in the said channels or srotas causing apanvayu dustijanya jalodar (ascites due to renal disease). In these three kinds of pathophysiology, ascites may be termed as partantra jalodar (secondary ascites). Again there is another type of acites which is manifested without any underlying cause or diseases termed as swatantra jalodar (primary jalodar).[6]

Case presentation
A 35 year old male who was previously diagnosed of having acites due to chronic alcoholism since 6 months was referred to Kayachikitsa department of Rajiv Lochan Ayurved Medical College hospital presented with chief complaints of abdominal colic, anorexia, generalized weakness, palpitation, vertigo, breathing difficulty, swelling in both legs with pitting oedema since 3 months, yellowish sclera, itching all over the body, lassitude and distended abdomen with everted umbilicus.

History of present illness
The patient was alright before 2 years. After that, the patient had low grade fever with mild jaundice and after investigations, diagnosis of hepatical jaundice was done. After the treatment the clinical symptoms of jaundice was subsided, he had mild pain in the right and left

hypochondriac region, for which he started using analgesics (Diclofenac sodium with paracetamol) frequently without prescription. Thereafter, the patient felt anorexia, vomiting and heaviness of abdomen, respiratory distress, pedal edema etc. For this, the patient consumed allopathic medicines for 12 months but didn't get relief, hence he came to Kayachikitsa Department, Rajiv Lochan Ayurvedic college hospital Chandkhuri Durg and was admitted to the indoor patient department for further treatment.

Family history
No evidence of this type of disease in the family.

Physical examination
• Bilateral pedal edema with pitting ++
• Body temperature: 98.6 F
• Mild yellowish sclera
• Blood pressure: 110/70 mmHg
• Pulse: 76/min
• Icterus preent +
• Respiratory rate: 20/min
Systematic examination (per abdomen)

Respiratory System: B/L Clear
Cardiovascular system sound: S_1-S_2 regular.
• Inspection: Distended abdomen with everted umbilicus.
• Palpation: Mild Hepatomegaly (1 cm below the right lower costal margin in Right hypochondriac region). Splenomegaly (3 cm below the Left lower costal margin from left hypochondriac region towards umbilicus).
• Percussion: Shifting dullness and fluid thrill: Present.

Investigation
Table 1: Summarizes the blood profile and ultrasound investigations before and after treatment.

Parameters	BT	AT
Hb in gm%	8	11.2
TLC (cells/cumm)	8500	8000
RBC milllian cells/ mcl	4.3	5.1
ESR mm/hour	60	30
Total protein (g/dl)	3.8	2.3
Blood urea mg/dl	40	20
Serum creatinine	1.3	0.9
GRBS mg/dl	84	82
Serum Billirubine (Total)	3.9	0.7
Unconjugated Billirubin	2.87	0.2
Conjugated Bilirubin	1.03	0.5
SGOT	80.5	35.2
SGPT	70.2	45.5
USG abdomen	Chronic liver parenchymal disease, splenomegaly with moderate ascites	Free fluid seen in peritoneal cavity suggestive of mild ascites

Treatment
External application of paste:, aragvadh phal majja, Trivrut mula kalka, dasangalep churna.
Internal application: Freshly collected Gomutra: 40ml twice a day.
Haritaki churna: 3gm at bedtime with water.
Differential Diagnosis: Fatty abdomen, Acute liver failure, Alcoholic hepatitis, Dialated cardiomyopathy, Hepatocelluler adenoma, Hepato renal syndrome, Portal hypertension, Primary billiary cholangitis.

Outcome and Results
The patients was came to kayachikitsa department of RLAMC hospital on 15th of December 2016, who was pre diagnosed with acites due to alcoholic hepatic cirrhosis was planned for systematic confirmation of previous diagnosis and treatment protocol. After the successful administration of external therapy and internal medication the patient was assessed at every 10 days interval at beginning which being concluded with 5 days interval on 30th January 2017. During this period the changes in abdominal girth was measured which showed changes as indicated in the below table. (Table no.2).

Table No. 2: Measurement of abdominal girth.

Date	4cm bellow umbilicus (cm)	At Umbilicus (cm)	4 cm above umbilicus (cm)
1st day of therapy	99	98.5	99
10 days of therapy	96.5	97	96
20 days after therapy	94	90	92
30 days after therapy	90.5	88	88
40 days after therapy	90	87	86.5
45 days after therapy	87	86	86

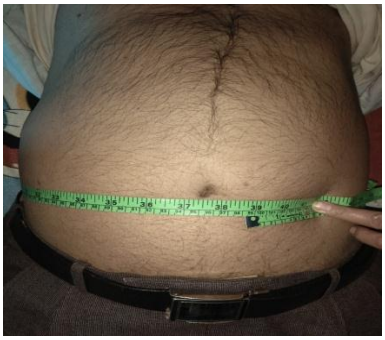

Image 1: Measuring of abdominal girth before treatment.

Image 2: Application of aragwadhadi lepa.

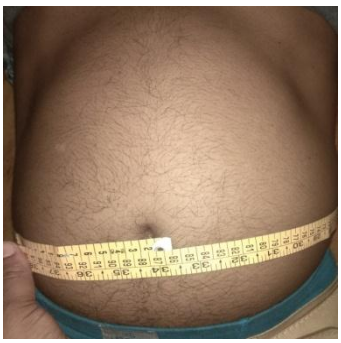

Image 3: Measuring of abdominal girth after treatment.

DISCUSSION

The treatment involves the removal of free fluid from the intraperitoneal cavity of the anterior portion of the abdomen along with stoppage of the formation and secretion of serous fluids from the peritoneal wall. As acharaya Charak has told fluid elimination by nityamevvirechayet.[7] Also as experienced by various renowned ayurvedic vaidyas the external application of aragwadhadi lepa, trivritt lepa and dasanglepa in jalodar starting at the level of infrasternal abdominal area up to suprapubic area in the manner of left lateral to right lateral flank region which is shown in the above image (image No.1) which causes the removal of fluid gradually by the process of absorption, reverse osmosis and diffusion by the bahir-virechak and anuloman action of aragwadh and trivritt. As earlier it was explained jalodar is a exaggerated variety of udar roga having abnormal abdominal distension and shotha along with the pathophysiological disparities in the accumulation of serum proteins specifically albumin and globulin whose ratio is altered substantially in the expression of grave form of acites, which might be correlated with dushi vishaja vikara. Hence the application of dasang lepa reduces the disproportionate imbalanced serum proteins by anti antioxidant activity, anti microbial and anti toxic activity. Then the prescription of freshly collected gomutra twice a day provided supportive role in elimination of excessive accumulated abdominal fluid by its ruksha ushna, tikshna guna, katu rasa and virechak property.[8] The application of haritaki churna acted as anulomak dravya by causing expulsion of free fluid from abdominal cavity to the lower intestinal tract through trans cellular membrane and also helps in absorption of extra fluid by its ushna veerya and laghu, ruksh guna.[9]

Learning points

- Acites due to liver cirrhosis may be broadly correlated to agnidustijanya jalodar to some extent.
- Aragwadh trivritt dasang lepa was quite helpful in elimination of excessive accumulated free fluid from the intraperitoneal cavity and observable reduction of abdominal girth.
- Due to ruksha and virechak guna of gomutra it causes virukshanata and jala shosana from the peritoneal cavity and helps in eliminating through urinary tract and it also prevents for the complications which is more prone in ascites patient by its evidence based immunomodulating and antioxidant activity.

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Patients consent: Obtained.

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