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CLINICAL EFFICACY OF SHOTHAHARA MAHAKASHAYA KALA BASTI IN KAPHA-VATAJA SHOTHA (HYPOTHYROIDISM)

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Abstract

Hypothyroidism, with an Indian prevalence of approximately 10.95%,¹² presents clinically as myxedema – a non-pitting edema from dermal glycosaminoglycan deposition – alongside fatigue, weight gain, cold intolerance, dry skin, and constipation. These features map precisely onto the classical Ayurvedic description of Kapha-Vataja Shotha, where Kapha produces the heavy, immobile, unctuous, cold swelling (Guru, Sthira, Snigdha, Shita) and Vata produces the dryness, numbness, and constipation (Ruksha, Prasupti, Apana-Avarana). This literature review synthesises classical Ayurvedic references from the Brihatrayi and Laghutrayi with contemporary endocrine science to evaluate the clinical rationale for combining Shothahara Mahakashaya – the Dashamoola group of ten roots (Charaka Samhita, Sutra Sthana, Chapter 4) – with Kala Basti, a 16-session Basti schedule of 6 Niruha and 10 Anuvasana (Charaka Siddhi Sthana, Chapter 1). The Shothahara Mahakashaya exhibits Tridoshaghna action with specific efficacy against Kapha-Vata, while Tila Taila (the principal Sneha of Kala Basti) provides Lekhana, Sukshma, and Ushna properties that disrupt the Kapha-Avarana central to hypothyroid pathogenesis. Recent clinical studies on related Basti protocols (Kshara Basti, Lekhana Basti) report TSH reductions of 31.1–5.76 mIU/mL and 10.60–4.08 mIU/mL respectively, supporting the classical rationale. This review concludes that Shothahara Mahakashaya Kala Basti offers a rational Ayurvedic intervention for hypothyroidism, meriting prospective randomised trials.

Keywords: Shotha; Kapha-Vataja Shotha; Shothahara Mahakashaya; Dashamoola; Kala Basti; Hypothyroidism; Myxedema; Galaganda; Avarana.

1. Introduction

Hypothyroidism, a state of thyroid hormone deficiency, has emerged as one of the most prevalent endocrine disorders worldwide, with Indian prevalence estimated at 10.95% in the landmark eight-city epidemiological study by Unnikrishnan et al.¹² Global estimates suggest 5–10% of the adult population is affected, with a striking female preponderance of 5–8:1.^{13,14} Despite the widespread availability of levothyroxine replacement therapy, conventional management demands lifelong medication and is frequently complicated by persistent symptoms despite biochemical euthyroidism.¹⁵ These limitations have sustained scholarly interest in the classical Ayurvedic framework, which offers a sophisticated nosological vocabulary for understanding mixed Kapha-Vata pathology.

Within Ayurveda, hypothyroidism is classified as an Anukta Vyadhi – a condition not explicitly named in the classical texts but comprehensible through the application of Ayurvedic nosological principles.¹ The cardinal manifestation, myxedema, is a non-pitting edema arising from dermal glycosaminoglycan (GAG) deposition, producing a boggy, mucinous swelling most pronounced in the periorbital region, hands, and feet.^{14,16} This corresponds precisely with the classical description of Kaphaja Shotha, characterised by Guru (heavy), Sthira (immobile), Snigdha (unctuous), and Shita (cold) qualities.^{1,3} Concurrently, the systemic features of hypothyroidism – dry skin, fatigue, constipation, neuropathy, and bradycardia – mirror Vataja Shotha, characterised by Ruksha (dry), Parusha (rough), Prasupti (numbness), and Harsha (tingling).¹ This mixed presentation is captured in Vagbhata's classification of nine types of Shotha, which explicitly recognises the Kapha-Vataja Dvandvaja subtype.³

The classical therapeutic strategy for Kapha-Vataja disorders hinges on Avarana Bhanga – dissolution of the Kapha-driven covering of Vata – followed by Vata pacification. Basti Karma (medicated enema) holds the foremost position for Vata disorders, with Charaka declaring it “Ardha Chikitsa” (half of all treatment).¹ The Kala Basti, a moderate-duration schedule of 16 sessions comprising 6 Niruha (decoction) and 10 Anuvāsana (oil-based) administrations, is specifically indicated for moderate Vata-predominant disorders.¹ Combined with the Shothahara Mahakashaya – the Dashamoola group of ten roots enumerated as the 38th of Charaka's 50 Mahakashayas^{1,11} – this intervention offers a rational integration of Shodhana (purification) and Shamana (palliation) targeting the dual Kapha-Vata pathogenesis. Recent clinical studies on related Basti protocols have demonstrated significant TSH reductions,¹⁷⁻²⁴ lending preliminary empirical support to the classical rationale. This review synthesises the relevant classical references with contemporary endocrine science to establish the conceptual and pharmacological rationale for this combined intervention.

2. Conceptual Framework of Shotha in Ayurveda

2.1 Definition and Pathogenesis

Shotha, derived from the Sanskrit root “śvi” (to swell), is synonymously termed Shvayathu (Charaka) and Shopha (Sushruta, Vagbhata). Charaka defines Shotha in Chikitsa Sthana, Chapter

12 (verse 8) as a condition where vitiated Vata, reaching the external Siras (channels), vitiates Kapha, Rakta, and Pitta, obstructing the channels and producing elevation (Utsedha) and spreading (Visarpa).¹ Sushruta, in Chikitsa Sthana, Chapter 23, similarly defines Sopha as localised manifestation of vitiated Doshas in the Dhatus.² Vagbhata, in Ashtanga Hridaya, Nidana Sthana, Chapter 13 (verses 21b-22a), provides a parallel definition emphasising Twak (skin) and Mamsa (muscle) as the site of manifestation.³

Bāhyāḥ sirāḥ prāpya yadā kaphāśṛkpittāni sandūṣayatīha vāyuh| Tairbaddhamārgaḥ sa tadā visarpannutsedhaliṅgaṁ śvayathum karoti ||8||

(Charaka Samhita, Chikitsa Sthana 12/8) [1]

The Nidana (aetiology) of Shotha, enumerated in Charaka Chikitsa 12/5-7, encompasses four categories: dietary (Ahara – Kshara, Amla, Teekshna, Guru, Lavana, Viruddha, Dadhi, Pishtanna); lifestyle (Vihara – Adhvagamana, Atimaithuna, Diwaswapna, Atijagara, Vyayama, Ajirna Bhojana); iatrogenic (improper Panchakarma, Ashuddhi, Marma Upaghata); and secondary to systemic diseases (Shwasa, Kasa, Atisara, Arshas, Udara, Pandu, Visarpa).^{1,2} The Samprapti (pathogenesis) follows a sequential process: Nidana Sevana provokes Vata (particularly Vyana and Apana subtypes) with secondary Kapha-Pitta involvement, mediated through Agnimandya and Ama formation; the provoked Vata reaches the external Siras and vitiates the resident Kapha, Rakta, and Pitta; the obstructed Siras produce localised fluid stasis, manifesting as Utsedha (elevation) and Visarpa (spreading).^{1,3}

2.2 Classification

Charaka classifies Shotha by origin (Nija vs Agantuja), extent (Ekanga vs Sarvanga), anatomical location (Urdhva, Adhah, Madhya, Gala), and predominant Dosha (Vataja, Pittaja, Kaphaja, Sannipataja, with Dvandvaja subtypes implied).¹ Sushruta (Chikitsa 23/3) introduces a distinctive anatomical classification into Shad-vidha Avayava-samuttha (six body-part based types) and Pancha-vidha Sarvasara (five generalised types: Vataja, Pittaja, Kaphaja, Sannipataja, Visaja).² Vagbhata's Navavidha Sopha classification (AH Nidana 13/22b-24a) explicitly recognises the three Dvandvaja subtypes, including Kapha-Vataja – the foundational textual basis for the present study.³ Madhava Nidana (Chapter 36) follows Vagbhata's nine-type framework with systematic diagnostic elaboration.⁵ Sharangadhara and Yogaratnakara largely follow Vagbhata's tradition,^{6,8} while Bhavaprakasha enumerates Shothaghna drugs distributed across all fourteen Vargas of the Nighantu, reflecting the distributed pharmacological nature of anti-inflammatory drugs in the Ayurvedic tradition.⁷

3. Kapha-Vataja Shotha: Clinical Description

The textual foundation for Kapha-Vataja Shotha rests primarily on Vagbhata's explicit classification of the Dvandvaja Sopha subtypes in Ashtanga Hridaya, Nidana Sthana, Chapter 13, with the principle (verse 37b) that Dvandvaja Sopha exhibits combined features of both constituent Doshas.³ While Charaka's Chikitsa Sthana, Chapter 12 describes individual Vataja (verse 12) and Kaphaja (verse 14) types in detail, the Dvandvaja subtypes are synthesised from

these individual descriptions.^{1,11} The combined clinical picture exhibits Kapha-dominant features (Guru heaviness, Sthira immobility, Shita coldness, Snigdha unctuousness, Shukta-like whitish discoloration, slow onset, delayed refilling upon pressure) alongside Vata-dominant features (Ruksha dryness, Parusha roughness, Prasupti numbness, Harsha tingling, Arti pain, Diva Bali daytime worsening).^{1,3}

The specific Samprapti of Kapha-Vataja Shotha follows the Avarana framework, a distinctive Ayurvedic contribution to understanding mixed-Dosha pathology.³ Kapha-provoking Nidana (Guru, Snigdha, Sheeta, Amla, Dadhi; Diwaswapna; Avyayama) combined with Vata-provoking factors (Ruksha, Laghu, Sheeta, Katu; Adhvagamana; Atijagara) produce chronic Agnimandya.¹ The consequent Kapha vriddhi forms an Avarana (covering) over Vata, particularly over Apana and Vyana subtypes. The obstructed (Avarita) Vata becomes further provoked, carrying the vitiated Kapha into the external Siras where the combined Dosha complex produces the characteristic mixed-features Shotha. The dense Kapha composition manifests as heavy, immobile, non-pitting edema, while the obstructed Vata produces systemic symptoms of dryness, numbness, and altered pain perception.^{1,3} This dual pathology has direct therapeutic implications: treatment must address both the Kapha Avarana (the covering) and the Avarita Vata (the covered Vata), in that order – a sequence central to the rationale for Kala Basti intervention.

4. Shothahara Mahakashaya: The Dashamoola Group

4.1 Classical Reference and Constituent Drugs

The Shothahara Mahakashaya is enumerated as the 38th of the 50 Mahakashayas described by Charaka in Sutra Sthana, Chapter 4 (Shadvirechanashatashritiya Adhyaya, shloka 19).¹ Chakrapani, in his Ayurveda Dipika commentary, identifies the constituent drugs as the Dashamoola (literally, “ten roots”), conventionally sub-divided into the Brihat Panchamoola (five large-tree roots: Patala, Agnimantha, Bilva, Shyonaka, Kashmarya) and the Laghu Panchamoola (five small-shrub roots: Kankari, Brihati, Shalaparni, Prishniparni, Gokshura).^{1,10,11} Table 1 presents the ten constituent drugs with their botanical identities.

Table 1. The Ten Constituent Drugs of Shothahara Mahakashaya (Dashamoola)

Sanskrit Name	Botanical Name	Family	Sub-group
Patala	Stereospermum suaveolens DC.	Bignoniaceae	Brihat Panchamoola
Agnimantha	Clerodendrum phlomidis L. f.	Verbenaceae	Brihat Panchamoola
Bilva	Aegle marmelos Corr.	Rutaceae	Brihat Panchamoola
Shyonaka	Oroxylum indicum Vent.	Bignoniaceae	Brihat Panchamoola

Kashmarya (Gambhari)	Gmelina arborea Roxb.	Verbenaceae	Brihat Panchamoola
Kantakari	Solanum xanthocarpum Schrad.	Solanaceae	Laghu Panchamoola
Brihati	Solanum indicum L.	Solanaceae	Laghu Panchamoola
Shalaparni	Desmodium gangeticum DC.	Fabaceae	Laghu Panchamoola
Prishniparni	Uraria picta Desv.	Fabaceae	Laghu Panchamoola
Gokshura	Tribulus terrestris L.	Zygophyllaceae	Laghu Panchamoola

4.2 Pharmacological Properties

The Dashamoola group, as a collective entity, exhibits Rasa comprising Katu (pungent), Tikta (bitter), and Kashaya (astringent), with the Laghu Panchamoola additionally contributing Madhura (sweet); Guna of Laghu (light) and Ruksha (dry), with several drugs additionally Snigdha (unctuous) and Guru (heavy); collective Virya of Ushna (hot) with individual variation (Gokshura and Shalaparni exhibit Sheeta Virya); and Katu Vipaka.¹⁰ The aggregate Karma includes Tridoshaghna (especially Kapha-Vatahara), Shothahara (anti-inflammatory), Vedanasthapana (analgesic), Balya (strengthening), Rasayana (rejuvenating), Deepana (digestive-enhancing), and Mutrala (diuretic).^{10,11,26} The pharmacological profile exhibits a deliberate balance: the Brihat Panchamoola (Patala, Agnimantha, Bilva, Shyonaka, Kashmarya) predominantly provides Kapha-Vatahara action through Katu-Tikta-Kashaya Rasa and Ushna Virya, while the Laghu Panchamoola (Kantakari, Brihati, Shalaparni, Prishniparni, Gokshura) introduces Madhura-Tikta Rasa with Sheeta Virya, providing Vata-Pittahara action. The combined group achieves Tridoshaghna effect with particular emphasis on Vata and Kapha pacification – the precise requirement for Kapha-Vataja Shotha.^{10,11} Contemporary pharmacological research has demonstrated anti-inflammatory action (via TNF- α , IL-6, PGE2 inhibition), antioxidant action, and immunomodulatory action, particularly relevant to the autoimmune Hashimoto's thyroiditis subtype.²⁶ Additionally, classical Shothaghna drugs such as Punarnava (*Boerhavia diffusa*), Guduchi (*Tinospora cordifolia*), Devadaru (*Cedrus deodara*), and Katurohini (*Picrorhiza kurroa*), enumerated across the Vargas of Bhavaprakasha Nighantu, may supplement the Dashamoola in the Kala Basti formulation for enhanced Shothahara action.⁷

5. Kala Basti: The Therapeutic Schedule

5.1 Definition and Schedule

Basti Karma (medicated enema) holds the premier position among Ayurvedic therapeutic modalities for Vata disorders. Charaka, in Siddhi Sthana, Chapter 1 (verse 48), declares Basti as

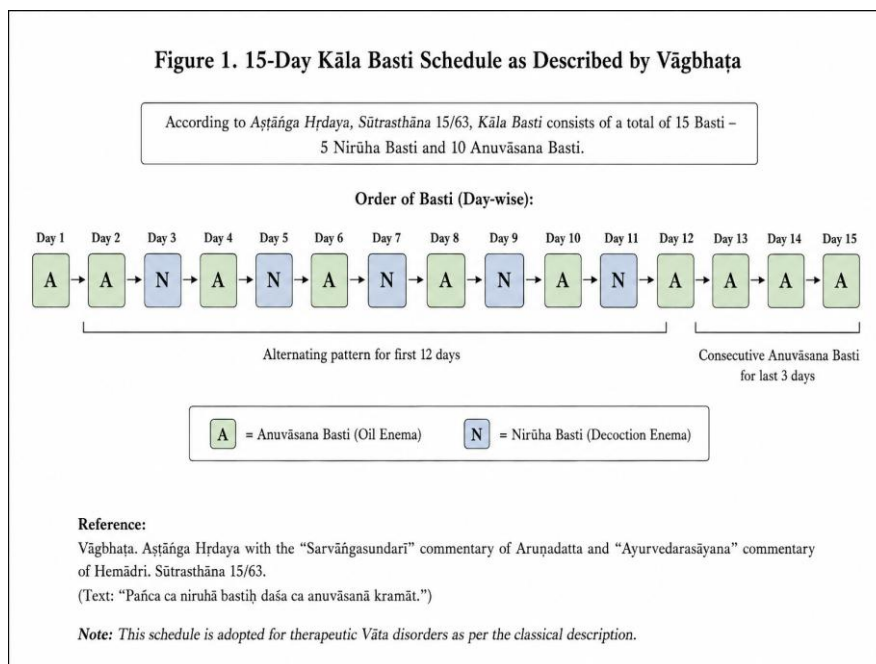
“Ardha Chikitsa” (half of all treatment), and in the management of complex Vata-Avarana conditions, as the entirety of therapeutic intervention.¹ Sushruta (Chikitsa Sthana, Chapter 35) classifies Basti into Niruha (decoction-based) and Anuvasana (oil-based) types,² while Vagbhata (AH Sutra Sthana, Chapter 19) further elaborates the Basti Vidhi.³ By therapeutic schedule, Charaka classifies Basti into three principal categories based on the number of sessions and the proportion of Niruha and Anuvasana: Karma Basti (30 sessions), Kala Basti (16 sessions), and Yoga Basti (8 sessions).^{1,4}

The Kala Basti, as described by Charaka in Siddhi Sthana, Chapter 1 (Kalpana Siddhi Adhyaya, verses 47–49), represents the moderate-duration schedule, comprising a total of 16 sessions consisting of 6 Niruha and 10 Anuvasana administrations.¹ Chakrapani’s Ayurveda Dipika commentary is particularly illuminating: while the literal interpretation of “Kala” as half of “Karma” (30 sessions) would yield 15 sessions, Chakrapani explicitly states that 16 Bastis are administered, the additional session preserving the classical pattern of commencing and concluding the schedule with Anuvasana.¹ Vagbhata (AH Sutra 19) follows the literal interpretation of 15 sessions (5 Niruha + 10 Anuvasana);³ the Charaka-Chakrapani convention of 16 sessions is the more widely accepted in contemporary clinical practice.

Table 2. Comparison of the Three Principal Basti Schedules

Schedule	Total	Niruha	Anuvasana	Indication
Karma Basti	30	12	18	Chronic / severe Vata disorders
Kala Basti	16 (Charaka) / 15 (Vagbhata)	6 / 5	10 / 10	Moderate Vata disorders
Yoga Basti	8	3	5	Mild Vata; wellness

This 15-session Kāla Basti schedule, shown in Figure 1, as described by Vāgbhaṭa in Aṣṭāṅga Hṛdaya (Sūtrasthāna 15/63), comprises two initial Anuvāsana sessions (Days 1–2), followed by an alternating sequence of Niruha and Anuvāsana Basti (Days 3–12: 5 Niruha + 5 Anuvāsana), and four concluding Anuvāsana sessions (Days 13–16), giving a total of 15 Basti procedures – 5 Niruha and 10 Anuvāsana. This sequence represents the classical Kāla Basti regimen described by Vāgbhaṭa. “If there is constipation (Vata-Pratibandha) and if the Shotha is caused by Vata, then Niruha (decoction enema) is administered.”¹ Given that hypothyroidism characteristically produces constipation and gastrointestinal hypomotility, this classical indication is directly applicable.

Figure 1. 15-Day Kāla Basti Schedule as Described by Vāgbhaṭa

5.2 Method of Administration

Purvakarma (pre-procedure) comprises Snehana via Abhyanga with warm Tila Taila-based medicated oils (Dhanvantara, Bala, Sahacharadi, or Saindhavadi Taila) for 30–45 minutes, followed by Swedana via Bashpa Sweda or Nadi Sweda for 15–20 minutes to open the Srotas.^{1,3,6} Patient preparation includes Agni-Bala-Koshtha assessment, light meal before Anuvāsana, empty stomach before Niruha, and empty bladder. Pradhana Karma (main procedure) for Niruha Basti (480–960 ml) follows the classical Basti-dravya Krama mixing order: Madhu (honey, 80–120 ml) as Yogavahi; Saindhava Lavana (5–10 g) for absorption; Sneha (Tila Taila, 80–120 ml); Kalka (Shatapushpa or Rasna, 40–60 g); and Kashaya (Dashamoola Kwatha, 320–480 ml).¹ Retention time is one Muhurta (approximately 48 minutes). Anuvāsana Basti (60–240 ml) is administered after a light meal and retained for 3–6 hours.^{1,3} Paschat Karma (post-procedure) includes supine rest with elevated legs (Niruha) or left lateral position (Anuvāsana), warm light diet (Khichdi, Moong dal soup), avoidance of heavy/cold/raw food and strenuous activity, and Sansarjana Krama (graduated diet) for 3–5 days after the course.¹

5.3 Importance of Tila Taila

The principal Sneha of Kala Basti is Tila Taila (sesame oil), derived from *Sesamum indicum*. Charaka identifies Tila Taila as the best among Sneha Dravyas for promoting Bala and Snigdha (Sutra Sthana 13), and as the best among drugs pacifying Vata (Sutra Sthana 27).¹ Vagbhata (AH Sutra 5) declares: “Of oils, sesame oil is the foremost,” and Sharangadhara codifies the convention that sesame oil is implied when oil is unspecified.^{3,6} The pharmacological properties of Tila Taila include Madhura-Tikta Rasa (with Kashaya Anurasa); Sukshma (minute), Ushna (hot), Vyavayi (spreading), Teekshna (piercing), Vishada (clear), Guru (heavy), Sara, Vikasi, and Lekhana (scraping) Guna; Madhura Vipaka; and Ushna Virya.^{1,10} The Tridosha effect specifically suits Kapha-Vataja pathology: Ushna Virya and Tikta-Kashaya Rasa pacify Kapha; Snigdha Guna and Madhura Vipaka pacify Vata. The unique Lekhana Guna enables dissolution of the dense

Kapha-Avarana, while Sukshma and Vyavayi Gunas enable penetration to the deep interstitial spaces where myxedema is localised – pharmacologically ideal for the Kapha-Vataja Shotha pathology of hypothyroidism.^{1,10}

6. Hypothyroidism: Contemporary Medical Perspective

6.1 Definition, Epidemiology, and Aetiology

Hypothyroidism is biochemically defined as thyroid hormone deficiency, characterised by elevated TSH with low or low-normal free T₄. The American Thyroid Association guidelines define overt primary hypothyroidism as TSH > 4.0–4.5 mIU/L with low fT₄ (<0.8 ng/dL), and subclinical hypothyroidism as TSH > 4.0–4.5 mIU/L with fT₄ within the reference range.¹⁵ The Indian eight-city epidemiological study by Unnikrishnan et al. (n=5,360) established an overall prevalence of 10.95%, with approximately 3.9% having subclinical hypothyroidism.¹² Global estimates suggest 5–10% of adults are affected, with a female-to-male ratio of 5–8:1 and a striking 7–10:1 ratio in Hashimoto's thyroiditis.^{13,14} The principal causes, in descending order of prevalence, include Hashimoto's thyroiditis (autoimmune, anti-TPO positive, the most common cause in iodine-sufficient regions), iodine deficiency (most common globally), iatrogenic causes (post-thyroidectomy, post-radioactive iodine, drug-induced from lithium, amiodarone, checkpoint inhibitors), thyroiditis, and rare infiltrative diseases.¹⁴

6.2 Pathophysiology and the HPT Axis

The pathophysiology is best understood through the hypothalamic-pituitary-thyroid (HPT) axis, a classical negative-feedback endocrine system. The hypothalamus secretes TRH, which stimulates pituitary thyrotrophs to secrete TSH. TSH acts on the TSH receptor of thyroid follicular cells, stimulating synthesis and release of predominantly T₄ and smaller quantities of T₃. Peripheral T₄ is converted to biologically active T₃ by D1/D2 deiodinases, primarily in liver, kidney, and pituitary. T₃ binds TR β 2 receptors in pituitary thyrotrophs and TRH neurons, exerting negative feedback on TSHB and TRH gene transcription.^{14,16} TSH has a half-life of 50–80 minutes, with normal production of 50–200 mU/day; in primary hypothyroidism, TSH production may exceed 4,000 mU/day.¹⁶ The clinical features are multisystemic: fatigue, weight gain (5–10 kg), cold intolerance, bradycardia, diastolic hypertension, constipation, slowed cognition, delayed reflexes, menorrhagia, and hyperlipidaemia.^{14,15}

6.3 Myxedema: The Cardinal Bridge Feature

The cardinal feature bridging contemporary and Ayurvedic descriptions is myxedema – a distinctive non-pitting oedema arising from glycosaminoglycan (predominantly hyaluronic acid and chondroitin sulphate) deposition in the dermis.^{14,16} Unlike pitting oedema of cardiac or renal origin, myxedema is boggy and mucinous, attributable to the remarkable water-binding capacity of GAGs (hyaluronate swells to approximately 1,000 times its dry weight when hydrated). The mechanism involves elevated TSH acting on TSH receptors expressed on dermal fibroblasts, stimulating GAG synthesis. Distribution is most pronounced in periorbital region, hands, feet, and supraclavicular fossae; in severe cases, myxedematous deposits may affect tongue

(macroglossia), myocardium, pericardium, pleura, and kidney medulla.¹⁶ The pharmacological features of myxedema – non-pitting, boggy, mucinous, cold, heavy swelling with delayed refilling – bear a precise correspondence with the classical description of Kaphaja Shotha, providing the conceptual bridge for the Anukta Vyadhi correlation.

7. Ayurvedic Correlation of Hypothyroidism

7.1 The Galaganda Reference

The principal Ayurvedic reference to thyroid-related disorders is Galaganda, a neck-localised swelling. Sushruta Samhita, Nidana Sthana, Chapter 11 (Granthi-Apachi-Arbuda-Shotha-Galaganda Nidanam, verse 19), provides the foundational reference: “The vitiated Vata and Kapha, in conjunction with Medas (adipose tissue), localised in the neck region, give rise to Galaganda.”² Sushruta further classifies Galaganda into Vataja (pricking pain, dark colour, prominent veins), Kaphaja (large, cold, firm, heavy swelling), and Medoja (glossy, soft, fetid, hanging) subtypes.² Vagbhata (Ashtanga Hridaya, Uttara Tantra, Chapter 21, verses 53–55) provides a parallel description of Galaganda arising from Vata-Kapha-Medas vitiation.³ The Kaphaja Galaganda description – large, cold, firm, heavy swelling – corresponds to the goitrous hypothyroid state, while the Vataja features correlate with the hyperthyroid presentation.

7.2 From Galaganda to Kapha-Vataja Shotha

While Galaganda addresses the localised thyroid enlargement, the systemic manifestations of hypothyroidism – myxedema, fatigue, cold intolerance, constipation, neurological symptoms – are more comprehensively captured by the Kapha-Vataja Shotha framework. The classical Anukta Vyadhi principle permits correlation based on the similarity of clinical features, and the consequent application of the classical Chikitsa for Kapha-Vataja Shotha, namely the Shothahara Mahakashaya Kala Basti.^{1,11} Table 3 presents the systematic mapping of hypothyroidism features onto Kapha-Vataja Shotha Lakshanas, drawing on Charaka Chikitsa 12/12 (Vataja) and 12/14 (Kaphaja),¹ and Ashtanga Hridaya Nidana 13.³

Table 3. Mapping of Hypothyroidism Features onto Kapha-Vataja Shotha Lakshanas

Hypothyroid Feature	Ayurvedic Lakshana	Predominant Dosha
Myxedema (non-pitting)	Snigdha, Guru, Sthira Shotha	Kapha
Periorbital oedema	Guru, Sthira Shotha (face)	Kapha
Cold intolerance	Shita	Kapha
Weight gain / sluggishness	Guru, Sthira Shareera	Kapha
Slow onset / reflexes	Sheegrata-varjita	Kapha
Bradycardia	Vyana-Vata Avarana	Kapha over Vata
Dry, coarse skin	Ruksha, Parusha Twak	Vata

Fatigue, lethargy	Bala-Kshaya, Alasya	Vata
Constipation	Apana-Vata Avarana	Kapha over Vata
Neuropathy / tingling	Prasupti, Harsha	Vata
Depression	Tamo-Moha	Vata + Kapha

The mapping demonstrates a comprehensive correspondence: Kapha-dominant features (myxedema, periorbital oedema, cold intolerance, weight gain, slow onset) reflect GAG-driven fluid accumulation and reduced metabolic activity; Vata-dominant features (dry skin, fatigue, constipation, neuropathy) reflect systemic neurological and circulatory consequences of Vata provocation due to Kapha-Avarana; combined features (bradycardia, constipation, slow cognition) reflect dual Kapha-Avarita-Vata pathology.^{1,3} Recent scholarly work supports this correlation: a JAIMS editorial (2026) explicitly noted that Lekhana Basti acts through “Shaman of Vata Avrita by Kapha” in hypothyroidism, the precise pathogenesis identified here.²³

8. Probable Mode of Action of Shothahara Mahakashaya Kala Basti

The combined intervention operates through five principal pharmacological axes, each addressing a specific dimension of the Kapha-Vataja pathogenesis:

(i) Avarana Bhanga (Dissolution of Kapha Covering): The Tila Taila, by virtue of Lekhana Guna and Ushna Virya, dissolves the dense Kapha-Avarana; Sukshma and Vyavayi Gunas enable penetration to deep interstitial sites of myxedema.^{1,10} The Dashamoola Kwatha Niruha further contributes through Katu-Tikta-Kashaya Rasa and Laghu-Ruksha Gunas, exhibiting Kapha-nissaraka action.^{10,11}

(ii) Vata Shaman (Pacification of Freed Vata): Following Avarana Bhanga, the freed Vata requires pacification. The Snigdha Guna and Madhura Vipaka of Tila Taila, combined with Madhura Rasa of Laghu Panchamoola drugs (Gokshura, Shalaparni, Prishniparni, Kashmarya), provide Vata-pacifying action. The Anuvasana sessions consolidate this effect through sustained Sneha-varhdhana.^{1,3,10}

(iii) Shothahara (Anti-inflammatory) Action: Dashamoola drugs demonstrate anti-inflammatory action via TNF- α , IL-6, and PGE2 inhibition; antioxidant action via SOD, catalase, and glutathione peroxidase up-regulation; and immunomodulatory action relevant to Hashimoto's thyroiditis. Rectal administration provides superior bioavailability by bypassing hepatic first-pass metabolism.^{10,26}

(iv) Agni Deepana (Digestive Fire Enhancement): The Deepana and Pachana actions of Brihat Panchamoola (Katu-Tikta Rasa, Ushna Virya) address the chronic Agnimandya underlying Kapha-Avarana, preventing Ama formation. Katu Vipaka further facilitates Bhedana (waste elimination).^{1,10}

(v) Mutrala (Diuretic) Action: Gokshura and Shalaparni exhibit Mutrala action, facilitating renal elimination of excess interstitial fluid. This complements the Lekhana action of Tila Taila in resolving myxedema.¹⁰

Empirical evidence from recent clinical studies provides preliminary support. Singh et al. (2021) reported that Kshara Basti reduced TSH from 31.1 mIU/mL to 5.76 mIU/mL in hypothyroid patients.¹⁷ A JAIS study (2026) reported Lekhana Basti reduced TSH from 10.60 to 4.08 mIU/mL, with the authors explicitly noting the Shaman of Vata Avrita by Kapha – the precise pathogenesis identified here.²³ Sharma et al. (2022) demonstrated significant TSH reduction with Ayurvedic oral interventions,¹⁸ and Kulkarni et al. (2024) have registered an ongoing RCT of Kshara Basti combined with Kanchanar Guggulu versus levothyroxine.¹⁹ Additional studies on Vardhamana Pippali, Udvartana with Erandamooladi Kala Basti, and Hashimoto management based on Panduroga principles further support the broader Ayurvedic approach.²⁰⁻²⁴ However, no published trial has specifically evaluated the classical Kala Basti protocol (16 sessions: 6 Niruha + 10 Anuvasana) with Dashamoola as the principal Kashaya, representing a significant research gap.²⁵

9. Discussion

This review demonstrates that the classical Ayurvedic framework provides a sophisticated nosological vocabulary for the mixed Kapha-Vata pathology of hypothyroidism, with Vagbhata's explicit recognition of the Dvandvaja subtypes offering a precise conceptual framework that the contemporary biomedical taxonomy lacks.³ The Avarana pathogenesis – the covering of Vata by dense Kapha – provides a mechanistic explanation for the paradoxical clinical picture (heavy, immobile Kapha-dominant myxedema coexisting with dry, rough, Vata-dominant systemic features) that contemporary understanding does not articulate in equivalent conceptual terms.^{1,3,14} The Shothahara Mahakashaya (Dashamoola) exhibits a balanced Katu-Tikta-Kashaya-Madhura Rasa profile and moderate Ushna Virya, producing Tridoshaghna action with particular efficacy against Kapha-Vata, complemented by contemporary pharmacological evidence demonstrating anti-inflammatory, antioxidant, and immunomodulatory actions.^{10,11,26} The Kala Basti schedule represents a sophisticated integration of Shodhana (through Niruha) and Snehana (through Anuvasana), with the alternating pattern designed to balance detoxification with Vata-pacification. The choice of Tila Taila as the principal Sneha, with its Lekhana, Sukshma, Vyavayi, and Ushna properties, is pharmacologically rational for the Kapha-Avarana pathology.^{1,3,10} The preliminary clinical evidence from related Basti protocols, reporting TSH reductions of clinically significant magnitude,¹⁷⁻²⁴ supports the broader approach. The complete absence of published trials specifically evaluating the classical Shothahara Mahakashaya Kala Basti protocol represents a significant research gap.

10. Limitations

Several limitations merit acknowledgment. First, the Anukta Vyadhi correlation of hypothyroidism with Kapha-Vataja Shotha is a conceptual synthesis rather than a direct classical

identification, resting on the application of the Anukta Vyadhi principle authorised in the classical commentarial tradition.^{1,11} Second, the cited clinical studies are predominantly case reports, case series, or small randomised trials with heterogeneous intervention protocols, limited methodological rigour, and short follow-up durations.¹⁷⁻²⁵

Robust establishment of efficacy requires well-designed, adequately powered, multicentre randomised controlled trials with extended follow-up. Third, the safety and tolerability of the Kala Basti protocol in hypothyroid patients with cardiovascular comorbidities (common due to associated hyperlipidaemia and hypertension) requires careful evaluation; Anuvasana sessions may pose a theoretical risk of rectal mucosal irritation, and Niruha sessions may produce transient electrolyte disturbances. Fourth, this review focuses on adult primary hypothyroidism; applicability to paediatric, geriatric, pregnant, or lactating populations, or to secondary/tertiary hypothyroidism, requires separate evaluation. Fifth, the present review did not conduct a formal systematic review or meta-analysis; the cited studies were selected to illustrate the empirical support rather than to provide a definitive evidence synthesis.

11. Conclusion and Implications

This literature review has established the integrated pharmacological rationale for the combined intervention of Shothahara Mahakashaya Kala Basti in Kapha-Vataja Shotha (hypothyroidism), synthesising classical Ayurvedic references with contemporary endocrine science. The Shothahara Mahakashaya (Dashamoola), enumerated by Charaka as the 38th Mahakashaya, provides the classical pharmacological intervention for Shotha with balanced Tridoshaghna action (especially Kapha-Vatahara), Shothahara, Balya, and Rasayana effects.^{1,10,11} The Kala Basti schedule of 16 sessions (6 Niruha + 10 Anuvasana, as clarified by Chakrapani) provides the therapeutic framework for the integrated administration of Shodhana and Snehana, with Tila Taila providing the Lekhana, Sukshma, Vyavayi, and Ushna properties required for Kapha-Avarana dissolution.^{1,3} The combined intervention addresses the Kapha-Vataja pathology through five axes: Avarana Bhanga, Vata Shaman, Shothahara, Agni Deepana, and Mutrala. The principal implication is the recommendation for prospective randomised controlled trials of the Shothahara Mahakashaya Kala Basti protocol in hypothyroidism, with rigorous methodological design (adequate sample size, randomisation, blinding where feasible, appropriate controls including levothyroxine monotherapy and combined therapy, and extended follow-up), with biochemical endpoints (TSH, fT4, anti-TPO), clinical endpoints (validated symptom scales, quality of life), and safety endpoints.^{17,19,25} Beyond immediate clinical implications, this review demonstrates the enduring relevance of the classical Ayurvedic conceptual framework to contemporary medical challenges, and the value of rigorous textual scholarship in informing integrative medical research. The preservation, refinement, and empirical validation of this classical knowledge represents a significant opportunity for the advancement of integrative endocrine medicine.

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