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CLINICAL FEATURES, ETIOPATHOGENESIS AND THERAPEUTIC APPROACHES IN *SHWETA PRADARA* W.S.R. TO LEUCORRHOEA: A CRITICAL REVIEW

Dr. Pooja Choudhary[1], Dr. Prataprao Ighe[2], Dr. Karishma Rabha[3]

[1]PG Scholar, PG Department of *Prasuti Tantra Evam Stri Roga*, Shri *Dhanwantri Ayurvedic* Medical College & Research Centre, Mathura

[2]Associate Professor, PG Department of *Prasuti Tantra Evam Stri Roga*, Shri *Dhanwantri Ayurvedic* Medical College & Research Centre, Mathura

[3]Assistant Professor, PG Department of Kayachikitsa, Shri *Dhanwantri Ayurvedic* Medical College & Research Centre, Mathura

Corresponding Author: Dr. Pooja Choudhary, PG Scholar, PG Department of *Prasuti Tantra Evam Stri Roga*, Shri *Dhanwantri Ayurvedic* Medical College & Research Centre, Mathura

Email: chd.pooja159@gmail.com

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ABSTRACT

Background: *Shweta Pradara* is an *Ayurvedic* descriptive concept for excessive or abnormal whitish vaginal discharge and is encountered clinically as a symptom rather than a single uniform disease entity. Leucorrhoea may be physiological, but persistent or symptomatic discharge can reflect vaginitis, cervicitis, cervical pathology, reproductive tract infection, hormonal change, or irritant and inflammatory disorders. A critical review is therefore required to connect classical symptom-based understanding with contemporary etiological diagnosis and safe, cause-specific management. **Aim:** To critically appraise *Shweta Pradara* with special reference to leucorrhoea from *Ayurvedic* and contemporary gynecological perspectives. To describe the classical clinical features, *Nidana*, *Dosha-Dushya* involvement and *Samprapti* of *Shweta Pradara*. To summarize the principal physiological and pathological causes of leucorrhoea and their distinguishing features. To review *Ayurvedic* and modern therapeutic approaches with emphasis on rational case selection and safety. To identify clinically relevant areas of integration and limitations in the available evidence. **Materials and Methods:** Classical *Ayurvedic* texts, commentaries and later compendia were reviewed for concepts related to *Shweta Pradara*, *Yoni Vyapad*, vaginal discharge, *Dosha-Dushya* involvement and Chikitsa. Contemporary gynecology textbooks, peer-reviewed reviews and evidence-informed guidelines on vaginal discharge and vaginitis were also examined. The material was synthesized narratively with emphasis on clinical interpretation and safety. **Results & Discussion:** The two systems converge in recognizing that abnormal discharge is a manifestation of an underlying disturbance rather than a diagnosis by appearance alone. Integration is most defensible when *Ayurvedic* constitutional and supportive care is used after appropriate exclusion or treatment of infectious, cervical and systemic causes. **Conclusion:** *Shweta Pradara* can be clinically correlated with the symptom complex of abnormal whitish vaginal discharge, but not with every cause of leucorrhoea as a single disease. A structured diagnostic approach followed by individualized, evidence-conscious therapy provides the safest basis for integrative clinical practice.

Keywords: *Shweta Pradara*; leucorrhoea; vaginal discharge; *Kapha*; *Yoni Vyapad*; vaginitis.

INTRODUCTION

In *Ayurveda*, abnormal genital discharge is interpreted within the broader framework of *Yoni Vyapad* and related disturbances of the reproductive tract. The exact term *Shweta Pradara* is more prominent in later literature, while the *Brihattrayi* describes whitish or abnormal *Yoni* Srava in the context of several gynecological conditions. Clinically, the concept is useful when it is treated as a descriptive symptom complex that requires assessment of *Dosha*, *Dushya*, *Agni*, local tissue state and associated *Lakshana* rather than as a stand-alone label.[1]

In modern gynecology, vaginal discharge is a normal physiological phenomenon when it is clear or white, nonoffensive and not accompanied by pruritus, pain, dysuria, bleeding or pelvic symptoms. The amount and consistency vary with estrogen exposure, ovulation, pregnancy and sexual activity. The term leucorrhoea is commonly used for white or mucoid discharge, but a clinically significant complaint arises when the discharge is excessive, altered in color or odor, or associated with vulvovaginal or pelvic symptoms.[2]

A critical correlation is necessary because the appearance of discharge does not by itself identify the cause. The differential diagnosis includes physiological secretion, bacterial vaginosis, vulvovaginal candidiasis, trichomoniasis, cervicitis, pelvic inflammatory disease, genitourinary syndrome of menopause, foreign body, irritant or allergic vaginitis and, less commonly, neoplastic or fistulous disease. Therefore, the review of *Shweta Pradara* should combine classical etiopathogenic reasoning with contemporary diagnostic safeguards and avoid assuming that all white discharge has the same origin or treatment.[3]

AIM AND OBJECTIVES

Aim: To critically appraise *Shweta Pradara* with special reference to leucorrhoea from *Ayurvedic* and contemporary gynecological perspectives.

- To describe the classical clinical features, *Nidana*, *Dosha-Dushya* involvement and *Samprapti* of *Shweta Pradara*.
- To summarize the principal physiological and pathological causes of leucorrhoea and their distinguishing features.
- To review *Ayurvedic* and modern therapeutic approaches with emphasis on rational case selection and safety.
- To identify clinically relevant areas of integration and limitations in the available evidence.

MATERIAL AND METHODS

This narrative critical review was prepared by examining major *Ayurvedic* compendia and commentarial literature relevant to *Yoni Vyapad*, *Shweta Srava* and *Shweta Pradara*, together with later therapeutic texts describing local and internal measures. Contemporary evidence was drawn from standard gynecology textbooks, peer-reviewed reviews and international or professional guidance on vaginal discharge, vaginitis and sexually transmitted infections. Concepts were organized under clinical features, etiological factors, pathogenesis, diagnosis and therapy; areas of conceptual similarity were discussed without assuming exact nosological equivalence. The review did not pool outcomes quantitatively because the classical literature is primarily descriptive and the available *Ayurvedic* clinical studies are heterogeneous in interventions, diagnostic criteria and outcome measures.

AYURVEDIC REVIEW

Shweta Pradara literally denotes a whitish vaginal discharge. Classical descriptions suggest that the symptom may occur in several *Yoni Vyapad* rather than representing one independent disease with a

single *Samprapti*. Later texts use the term more explicitly, while commentators also employ expressions such as *Pandura Pradara* or *Shukla Asrigdara* for pale or whitish genital discharge. This historical evolution supports a symptom-oriented reading: the clinician must identify the accompanying *Dosha* pattern, local inflammatory features, chronicity and systemic context before deciding management.[4]

Nidana and Predisposing Factors

From an *Ayurvedic* standpoint, causation may be organized into *Aharaja*, *Viharaja*, local and host-related factors. Excessive intake of *Guru*, *Snigdha* and *Kapha*-promoting food, *Mandagni* with *Ama* formation, sedentary habits, poor local hygiene, inappropriate sexual practices, repeated local irritation and neglect of gynecological disorders are commonly interpreted as contributors. Recurrent illness, nutritional depletion and disturbed *Artava* physiology may alter local tissue resistance. These factors are not equivalent to microbiological causes, but they form a constitutional and behavioral framework for understanding susceptibility and recurrence.[5]

Dosha-Dushya-Srotas Involvement

The dominant functional pattern is generally described as *Kapha* predominance because whiteness, increased secretions, heaviness, sliminess and *Picchila* quality correspond to *Kapha* attributes. *Vata*, particularly *Apana Vayu*, is relevant to the direction and expulsion of genital secretions, while *Pitta* becomes important when burning, yellow discoloration, inflammation or foul odor is prominent. *Rasa Dhatu* and *Artava Dhatu* are commonly considered the principal *Dushya*; *Artavavaha Srotas* and the local *Yoni-Garbhashaya* region form the clinical field of expression. Thus, mixed *Dosha* presentations are expected rather than a purely *Kaphaja* pattern in every patient.[6]

Table 1. Ayurvedic conceptual framework of Shweta Pradara

Component	Predominant consideration	Clinical interpretation
Dosha	*Kapha* dominant; *Vata* association; *Pitta* if inflammatory features	Explains variation in quantity, consistency, pain, burning and odor
Dushya	*Rasa Dhatu*, *Artava Dhatu*; local *Mamsa*/*Rakta* when inflamed	Tissue and secretion-level involvement
Srotas	*Artavavaha Srotas*; *Rasavaha Srotas*	Abnormal genital secretion and reproductive tract expression
Srotodushti	*Atipravritti* with local *Kleda*	Excessive discharge / persistent wetness
Agni-Ama	*Mandagni* with *Ama* where clinically relevant	Systemic digestive-metabolic contribution in the *Ayurvedic* model
Adhisthana	*Yoni* and reproductive tract	Site of clinical manifestation

Clinical Features and *Ayurvedic* Differentiation

The cardinal manifestation is excessive *Shweta Srava* from the *Yoni*. Associated features may include *Kandu*, local discomfort, *Kati Shula*, *Daurbalya*, dyspareunia, urinary irritation or altered odor depending on the underlying condition. A predominantly *Kaphaja* presentation is more likely to be white, thick or slimy and associated with itching or heaviness; *Pitta* association may produce burning, yellowish discoloration or inflammatory signs; *Vata* association may be accompanied by pain, dryness, irregularity or frothy character. These patterns are heuristic within *Ayurveda* and should not be used to replace examination or microbiological testing when infection is possible.[7]

Samprapti - Pathogenetic Interpretation

A practical *Samprapti* model begins with causative diet, behavior or local factors that aggravate *Kapha* and disturb *Agni*. Accumulation of *Kleda* and impaired tissue processing may involve *Rasa* and *Artava*, while disturbance of *Apana Vayu* facilitates abnormal downward discharge. Localization in the *Yoni* and

related reproductive channels results in *Atipravritti* in the form of persistent whitish secretion. Where *Pitta* or *Rakta* participation is greater, inflammatory symptoms become more prominent; where chronic *Vata* and tissue depletion dominate, pain, dryness, weakness or recurrent symptoms may coexist.[8]

SAMPRAPTI FLOW CHART

Nidana: *Kapha*-promoting *Ahara*/*Vihara* + local or host predisposing factors
↓
Agni disturbance / *Mandagni* with increased *Kleda* and possible *Ama*
↓
Kapha aggravation with *Vata* (*Apana Vayu*) association; *Pitta* if inflammation is present
↓
Rasa Dhatu and *Artava Dhatu* involvement
↓
Artavavaha Srotas disturbance with *Atipravritti*
↓
Localization in *Yoni* / reproductive tract
↓
Shweta Srava ± *Kandu*, *Shula*, burning, odor or weakness
↓
Chronicity/recurrence if *Nidana* persists or underlying pathology remains untreated

Ayurvedic Chikitsa Siddhanta

Therapeutic reasoning is directed toward *Samprapti Vighatana* rather than suppression of discharge alone. In a *Kapha*-dominant pattern, measures with *Kaphahara*, *Grahi* and *Stambhana* properties are traditionally emphasized, while *Deepana-Pachana* may be considered when *Mandagni* and *Ama* are present. Classical formulations often employ *Kashaya Rasa* drugs such as *Lodhra* and related astringent botanicals, with selection modified according to *Vata* or *Pitta* association. Internal *Shamana* measures, diet and behavior are intended to correct the systemic milieu, whereas local measures address irritation, secretion and tissue tone. Strong *Shodhana* or local procedures require individualized assessment and should not be generalized to all patients with discharge.[9]

7. Local Therapy and Evidence Caution

Traditional local approaches described in *Ayurvedic* practice include *Yoni Prakshalana*, *Yoni Pichu*, *Avachurnana* and *Yoni Dhoopana* with selected preparations. Contemporary reports also describe combinations of local and internal therapy, but most studies are small, heterogeneous and do not establish equivalence to pathogen-directed treatment. Therefore, local *Ayurvedic* procedures should be viewed as carefully selected adjuncts after exclusion of pregnancy-related complications, cervicitis, sexually transmitted infection, pelvic inflammatory disease and significant cervical pathology. Irritant substances, unsterile intravaginal preparations and unsupervised repeated douching should be avoided because they may disrupt mucosal integrity or vaginal microbiota.[10]

CONTEMPORARY CORRELATION: LEUCORRHOEA AND ABNORMAL VAGINAL DISCHARGE

8. Clinical Features and Differential Diagnosis

Normal vaginal discharge is usually clear to white, nonoffensive and not associated with vulvar inflammation. Pathological discharge is suggested by a new or persistent change in volume, color, odor or consistency, especially when accompanied by itching, burning, dysuria, dyspareunia, postcoital or intermenstrual bleeding, pelvic pain or systemic symptoms. Bacterial vaginosis typically produces a thin homogeneous discharge with characteristic odor; vulvovaginal candidiasis more often causes pruritus

and thick white discharge; trichomoniasis may produce yellow-green or frothy discharge with irritation. Cervicitis may present with mucopurulent discharge and bleeding, while noninfectious vaginitis may follow hypoestrogenism, irritants or inflammation.[11]

Table 2. Practical differential diagnosis of vaginal discharge

Condition	Typical discharge	Associated clues	Diagnostic direction
Physiological discharge	Clear/white, nonoffensive	No itching, pain, dysuria or inflammation	History; normal examination
Bacterial vaginosis	Thin, homogeneous, gray-white	Fishy odor; often little inflammation	pH/Amsel, Gram stain or validated molecular test
Vulvovaginal candidiasis	Thick white/curdy	Marked pruritus, erythema, soreness	Microscopy; culture/NAAT in selected or recurrent cases
Trichomoniasis	Yellow-green, sometimes frothy	Odor, irritation, dysuria; STI risk	NAAT preferred where available
Cervicitis	Mucopurulent/cervical discharge	Contact bleeding, pelvic symptoms, STI risk	Cervical examination and STI testing
Atrophic/irritant/inflammatory vaginitis	Variable clear or purulent discharge	Dryness, burning, dyspareunia or exposure history	Clinical assessment; exclude infection

Etiopathogenesis and Diagnostic Approach

The modern etiopathogenesis of abnormal discharge depends on the underlying condition. Bacterial vaginosis is a dysbiosis with reduction of protective Lactobacillus-dominant flora and overgrowth of anaerobic organisms; candidiasis represents symptomatic yeast overgrowth; trichomoniasis is caused by Trichomonas vaginalis; cervicitis may be related to sexually transmitted pathogens or noninfectious inflammation. Because symptoms overlap, history alone is insufficient. Evaluation should include menstrual and pregnancy context, sexual and medication history, hygiene or intravaginal product use, speculum examination where indicated, vaginal pH and microscopy when available, and targeted NAAT or culture based on the suspected condition. Persistent, recurrent or atypical discharge warrants reassessment rather than repeated empirical therapy.[12]

Therapeutic Approaches in Contemporary Practice

Modern treatment is etiology-specific. Symptomatic bacterial vaginosis is treated with recommended antimicrobial regimens; vulvovaginal candidiasis is treated with appropriate azole or other antifungal therapy according to complexity and pregnancy status; trichomoniasis requires systemic antiprotozoal treatment with partner management and retesting according to guideline recommendations. Cervicitis and other sexually transmitted infections require organism-directed testing, treatment and partner considerations. Noninfectious causes are managed by removing irritants, treating hypoestrogenism or inflammatory disease as appropriate, and avoiding unnecessary antimicrobials. Current guidance emphasizes accurate diagnosis, because empirical or repeated over-the-counter treatment can delay recognition of a different condition.[13]

Table 3. Integrative therapeutic framework

Clinical step	*Ayurvedic* contribution	Modern safeguard / requirement
1. Define the complaint	Assess *Dosha* pattern, *Agni*, associated *Lakshana* and chronicity	Distinguish physiological from pathological discharge
2. Identify red flags	Recognize severe *Pitta*/*Rakta*-like inflammatory or systemic features	Urgent evaluation for fever, pelvic pain, bleeding, pregnancy complications or PID
3. Establish cause	Use *Nidana*-based reasoning and local examination	pH/microscopy/NAAT/culture as indicated; examine cervix when appropriate

Clinical step	*Ayurvedic* contribution	Modern safeguard / requirement
4. Treat underlying pathology	Individualized *Shamana*, *Pathya* and selected local supportive care	Cause-specific antimicrobial/antifungal/anti-inflammatory or hormonal therapy
5. Prevent recurrence	Correct *Mithya Ahara-Vihara*, hygiene and host factors	Avoid douching/irritants; address diabetes, STI reinfection and recurrent vaginitis appropriately
6. Follow-up	Reassess *Dosha-Lakshana* response	Reevaluate persistent or recurrent symptoms; do not repeat empirical therapy blindly

RESULTS AND FINDINGS

- *Shweta Pradara* is more appropriately interpreted as a symptom complex of excessive whitish genital discharge than as a single disease entity with one universal cause.
- The *Ayurvedic* model is predominantly *Kapha*-oriented, with clinically meaningful modification by *Vata* and *Pitta* and with *Rasa*/*Artava* involvement.
- Classical etiopathogenesis emphasizes *Agni*, *Kleda*, *Dosha-Dushya* interaction, *Artavavaha Srotas* disturbance and localization in *Yoni*.
- Modern gynecology distinguishes physiological secretion from pathological discharge; color or consistency alone is not sufficiently diagnostic.
- Bacterial vaginosis, candidiasis, trichomoniasis, cervicitis and noninfectious vaginitis constitute major clinical differentials and require different treatments.
- *Ayurvedic* therapy emphasizes *Samprapti Vighatana*, *Kaphahara*/*Grahi*/*Stambhana* measures, individualized *Shamana* and selected local care rather than one fixed formulation for all cases.
- The available clinical evidence for specific *Ayurvedic* formulations and local procedures remains limited by small samples, variable diagnostic criteria and heterogeneous outcomes.
- A safe integrative model requires diagnostic triage first, treatment of proven infectious or cervical pathology when present, and individualized adjunctive *Ayurvedic* care with follow-up.

DISCUSSION

The strongest conceptual bridge between *Shweta Pradara* and leucorrhoea is their shared status as a clinical manifestation rather than an etiological diagnosis. *Ayurvedic* reasoning classifies the discharge according to *Dosha* expression and tissue context, while contemporary gynecology classifies it according to physiological state, microbiological cause, cervical disease and noninfectious inflammation. The recent *Ayurvedic* literature similarly acknowledges that *Shweta Pradara* may accompany multiple *Yoni Vyapad* and that its classical management is individualized. This supports a clinically useful integrative interpretation, but it also cautions against simplistic one-to-one correlation between a *Kaphaja* description and a specific modern infection.[14]

Therapeutically, traditional astringent, *Kapha*-modulating and local measures may have a role in symptom-oriented supportive care, yet the quality of evidence for many specific *Ayurvedic* interventions remains substantially lower than that supporting established diagnosis and treatment of common infectious vaginitis. Small comparative studies may show symptomatic improvement, but heterogeneity in case definitions, microbiological confirmation, intervention standardization and follow-up limits generalizability. In practice, a patient with recurrent discharge, odor, pruritus, cervicitis risk, pelvic pain or pregnancy-related symptoms should not be managed only on the basis of discharge color or an *Ayurvedic Dosha* label; syndromic or laboratory-guided evaluation remains essential where indicated.

A rational integrative strategy therefore has three levels: first, distinguish physiological discharge from disease and identify red flags; second, establish the most likely modern cause with appropriate examination and testing; third, add individualized *Ayurvedic* measures for constitutional correction, diet, symptom control and recurrence prevention when they do not delay or conflict with definitive therapy. Persistent symptoms after treatment should trigger reconsideration of the diagnosis, including recurrent bacterial vaginosis or candidiasis, resistant or reinfected trichomoniasis, cervicitis, desquamative or inflammatory vaginitis, genitourinary syndrome of menopause and noninfectious irritant disorders. This diagnostic discipline is essential for making the traditional concept of *Shweta Pradara* clinically meaningful and safe in contemporary practice.[15]

CONCLUSION

Shweta Pradara represents an *Ayurvedic* clinical description of excessive or abnormal whitish vaginal discharge that can be usefully correlated with leucorrhoea at the level of symptomatology, but it should not be treated as a single modern diagnosis. The classical framework emphasizes *Kapha* predominance, *Apana Vayu* participation, *Rasa-Artava* involvement, *Agni* and *Kleda* disturbances, and individualized *Samprapti Vighatana* through internal, dietary and selected local measures. Contemporary gynecology demonstrates that similar discharge can arise from physiological secretion, dysbiosis, fungal or protozoal infection, cervicitis and noninfectious inflammation; therefore, diagnosis must precede treatment. The most defensible therapeutic model combines appropriate examination and cause-specific management with carefully selected *Ayurvedic* supportive care, while avoiding empirical intravaginal remedies or repeated antimicrobials without reassessment. Better designed clinical trials using standardized diagnostic criteria, microbiological endpoints, validated symptom scores and adequate follow-up are needed to establish the efficacy and safety of specific *Ayurvedic* interventions.

CONFLICT OF INTEREST

NIL

SOURCE OF SUPPORT

NONE

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