



## Case study

### Management of bronchial asthma by Shringyadi churna and Vasadi kwath

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#### ABSTRACT

Bronchial asthma is a chronic inflammatory disorder of the airways in which many cells plays a role in particular mast cells, eosinophils and T-lymphocytes. It is characterized by the responsiveness of the tracheobronchial tree to a multiplicity of stimuli. It is manifested physiologically by a widespread narrowing of the air passages. In susceptible individuals, this inflammation causes recurrent episodes of wheezing, breathlessness, chest tightness and cough particularly at night or in the early morning. These symptoms are usually associated with wide spread but variable air flow limitation that is at least partly reversible either spontaneously or with treatment. This patient was treated with Shringyadi churna and Vasadi Kwath. There was an improvement in subjective and objective criteria after treatment. There was a reduction in swasakricchta, Muhurmuhurswasa vega, Asinolabhatesoukhyam, Kaphanishtivan and peenasa. The symptom Kasa and Ura-parshva shoola were abolished. There was no side effect observed during the treatment as well as after the completion of treatment.

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## INTRODUCTION

Bronchial asthma is defined as a chronic inflammatory disease of airways that is characterised by the responsiveness of the tracheobronchial tree to a multiplicity of stimuli (Longo et al., 2011). It is manifested physiologically by a widespread narrowing of the air passages, which may be relieved spontaneously or as a result of therapy and clinically by paroxysms of dyspnea, cough and wheezing. Bronchial Asthma is an episodic disease, with acute exacerbations interspersed with symptom-free periods. In the present era, many chronic recurrent airway disorders are increasingly seen all over the world and bronchial asthma is one of them. It is the most common lung disease affecting about 5% of the population.

It occurs at all ages but predominantly in early life. About one-half of cases develop before age 10, and another third occur before age 40 (Singh et al., 2016). According to WHO, the prevalence of bronchial asthma has increased over the recent decades which may be due to change in lifestyle, rapid industrialisation, increased air pollution, excessive smoking and tobacco usage. The prevalence of bronchial asthma in India is 2.38% (Aggarwal et al., 2006).

In contemporary medical science, management of bronchial asthma is carried out with the usage of a bronchodilator, a leukotriene antagonist, mast cell stabilizers and corticosteroids. Long lasting usage of these drugs produces adverse effects and also reduces the effectiveness of the therapy.

## CASE STUDY

### Patient description

A 54-year-old normal built government employee suffered from a cough, hoarseness of voice, difficulty in breathing on lying position and chest pain. He had a history of asthmatic attack. The symptoms started with mild fever and cough, then attack of a cough again & again, breathlessness during the night and wheezing. He feels comfortable in sitting posture and on taking hot beverages. This patient exercised regularly and reported an active lifestyle. Initially, the frequency of attacks was often less; it was associated only with dust, smoke, cold weather or seasonal change. Presently the frequency and duration of the attack were increased repeatedly. Past family medical history was non-contributory in this patient.

## General physical examination

The body weight of the patient was recorded to 70 kg with a pulse rate of 88/min, blood pressure of 130/85 mm Hg and respiration rate of 22/min. The chest examination showed persistent scattered rhonchi.

## Subjective and objective parameters

The cardinal and associated symptoms of the patients are given in Table 1. The peak expiratory flow rate, breath holding time, chest expansion and spirometry were taken as objective criteria. In the present case study, investigations done with the patients were blood (Hb%, TLC, DLC, ESR, AEC), x-ray (chest PA view) and sputum examination to rule out tuberculosis.

**Table 1.** cardinal and associated symptoms

| Cardinal symptoms                                 | Associated Symptoms                |
|---|------------------------------------|
| Swasakricchta (Dyspnea)                           | Lalat Sweda                        |
| Kasa (Cough)                                      | Greevashiradi Parigraha            |
| Muhurmuhurswasa vega (Paroxysm of attack)         | Krichha Bhashitam                  |
| Asinolabhatesoukhvam (Relief on sitting position) | Kanthodhvamsanam                   |
| Kaphanishtivan (Cough expectoration)              | Sleksma Vimoksante muhurtam sukhām |
| Peenasa (Rhinitis)                                | anidra and bhrama                  |
| Urashoola/Parshvashool (Pain in chest region)     | Ushna Abhinandati                  |
|   | Vishushkasyata                     |

## Treatment schedule

Shringyadi churna (5 g BD) was given with lukewarm water after a meal for one month. The ingredients present in the churna are karkatshringi, pippali, sunthi, marich, haritaki, vibhitak, amalaki, kantakari, pushkarmula, bharangi and pancha lavan. Vasadi kwath (40 mL BD) was given after meal for one month. Its ingredients are vasa, haridra, dhania, guduchi, bharangi, pippali, sunthi, kantakari and marich.

## RESULTS

After completion of treatment, clinical assessments were made from the interrogation and symptoms of the patient. There was a drastic change in the symptoms of the patients. The results before treatment (BT) and after treatment (AT) are given in Table 2.

**Table 2.** Results of before treatment (BT) and after treatment (AT)

| Symptoms/ Criteria       | BT | AT |
|--------------------------|----|----|
| <b>Cardinal symptoms</b> |    |    |
| Swasakricchta (Dyspnea)  | 3  | 1  |
| Kasa (Cough)             | 2  | 0  |

|   |       |       |
|---|-------|-------|
| Muhurmuhurswasa vega (Paroxysm of attack)         | 3     | 1     |
| Asinolabhatesoukhvam (Relief on sitting position) | 3     | 1     |
| Kaphanishtivan (Cough expectoration)              | 2     | 1     |
| Peenasa (Rhinitis)                                | 3     | 2     |
| Urashoola/Parshvashool (Pain in chest region)     | 1     | 0     |
| <b>Associated symptoms</b>                        |       |       |
| Lalat Sweda                                       | 3     | 1     |
| Greevashiradi Parigraha                           | 1     | 1     |
| Krichha Bhashitam                                 | 3     | 1     |
| Kanthodhvamsanam                                  | 1     | 0     |
| Sleksma Vimoksante muhurtam sukhām                | 2     | 1     |
| Anidra  | 1     | 0     |
| Bhrama  | -     | -     |
| Ushna Abhinandati                                 | 1     | 0     |
| Vishushkasyata                                    | 1     | 1     |
| <b>Objective criteria</b>                         |       |       |
| Peak Expiratory Flow Rate -                       | 131   | 160   |
| Breath Holding Time                               | 31    | 44    |
| Chest Expansion                                   | 1.32  | 1.85  |
| Spirometry – FVC                                  | 1.34  | 1.64  |
| FEV1  | 1.11  | 1.31  |
| FEV1%   | 73.25 | 77.15 |
| <b>Investigation</b>                              |       |       |
| Hb%   | 10.4  | 11.1  |
| TLC   | 6700  | 6500  |
| Neutrophil  | 63    | 66    |
| Lymphocyte  | 30    | 27    |
| Eosinophil  | 5     | 6     |
| Monocyte  | 2     | 1     |
| ESR   | 12    | 10    |

There was an improvement in subjective and objective criteria after treatment. There was a reduction in swasakricchta, muhurmuhurswasa vega, asinolabhatesoukhyam, kaphanishtivan and peenasa. The symptom Kasa and Ura-parshva shoola were abolished. There was no side effect observed during the treatment as well as after the completion of treatment upto one month.

## DISCUSSION

Asthma & COPD are the most common causes of death in Rural India. Patients suffering from infective respiratory diseases such as tuberculosis, Pneumonia can be cured after treatment but a sizeable number of patients continue to suffer from fibrotic sequelae of these diseases. Apart from these, there is going to be a large group of potential respiratory patients in future. They are persons exposed to smoke, pollution & various types of occupational dust which are more prone to develop Asthma & therefore constitute the group of potential respiratory patients.

Many attempts have been made to define Asthma in terms of its impact on lung function i.e., airflow limitation, its reversibility and airway hyper-responsiveness. But these attempts have been frustrated by a lack of understanding of the mechanism involved in asthma. Appreciation of the

key role of underlying inflammatory response in Asthma leads to a more complete definition of Asthma.

Most of the drugs of Shringyadi churna (Seth et al., 2015) and Vasadi kwath (Srivastava et al., 2017) are Vatakapha shamaka, Laghu, Teekshana, Ushna virya, Swasa-kasaghna, Deepana, Pachana, Vatanulomana, antitussive, expectorant, bronchodilator, antimicrobial, anti-inflammatory, antihemorrhagic, antioxidant, antispasmodic, anthelmintic, appetite stimulant, mild sedative, purgative and mild anti-hypertensive and they are used in combating Kasa-swasa. So by their virtue, it helps in the treatment of Tamaka swasa. Similarly, the drugs dominated by Tikta and Katu rasas are also supposed to control this disease.

## CONCLUSION

This small case study demonstrates that patient with bronchial asthma can make significant gains in cardinal and associated symptoms in relatively short periods of time. The drug acts by preventing the inflammatory process with anti-bacterial, antitussive, expectorant and bronchodilator properties and abolished the symptoms. Shringyadi churna and Vasadi kwath shows marked improvement in subjective and objective criteria and haematological parameters which shows anti-inflammatory, bronchodilator and antihistaminic property of the drug. Despite the limitations of this case study, conclude that the treatment may be an effective option in the treatment of bronchial asthma.

## CONFLICTS OF INTEREST

The authors declare no conflicts of interest.

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