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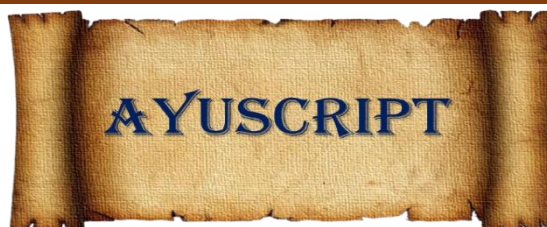
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ॐ नमो भगवते वासुदेवाय ॥ १ ॥ विश्वकर्मो एमादृष्टपुरीहाटकनि
र्मेता ॥ तत्र योऽशसाहस्रस्त्रीणां वैवश्राधिकम् ॥ ११ ॥ भवनानि मनोज्ञा
नि योमध्यकल्पयन् ॥ परिजानतस्तत्रैवतासां भोगाय कल्पयन् ॥ १२ ॥ या
सानां गृहास्तत्र धृष्टपेचाशतकोटयः ॥ अन्यपि बहुलोलोकावसिनिविता
राः ॥ १३ ॥ यत्किंचित्त्रिषु लोकेषु सुंदरं न च दृश्यते ॥ स वा जितप्रज्ञेनाप्यो
तु युगस्य विद्युते ॥ १४ ॥ अमोघं नीरमासाद्य तन्मनस्कं न याचसः ॥ स चाजि
तपस्तेपेत्सर्वं मुदि शृणुष्विदं ॥ १५ ॥ अर्जुन निरसनं ह्यस्य सर्वं सर्वदुःखं
नः ॥ प्रसन्नो भगवान्मनोजितपुरं स्थिता ॥ १६ ॥ सत्राजितोऽपि तुष्टावदष्टाद्वे वेदि
करम् ॥ निजोऽश्विनमस्तिस्तनमस्ति सर्वलोमुखः ॥ १७ ॥ विश्वव्यापिन्मस्ति
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तु हि देवा सुदृष्ट्या मां दिवाकरे ॥ ध्येयं सत्कथमानोऽसौ देवदेवादिवाकरः ॥ २० ॥
सिंहासनेऽभीरतः परं स वा जितमवावहः ॥ चरं हृदि यस्य नित्यं यत्नेन नित्यं





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Causative Factors (Nidana) in the Manifestation of Vatarakta (Gout) and its Management through Ayurveda: A Critical Review

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ABSTRACT:

Vatarakta is a chronic, painful joint disorder described extensively in the Ayurvedic classics, and is widely correlated with gout in contemporary biomedicine. The disease arises when aggravated Vata and vitiated Rakta (blood) act upon one another, obstructing the channels and lodging characteristically in the small joints of the extremities—most typically the great toe—a presentation that closely mirrors the classical podagra of gout. This review consolidates the etiological factors (Nidana) responsible for Vatarakta as enumerated by Charaka, SuShruta, Vagbhata and Madhavakara, examines the pathogenesis (Samprapti) and clinical features, and correlates these with the modern concept of hyperuricemia and monosodium urate crystal deposition. The role of contemporary investigations in confirming the diagnosis is discussed, followed by a structured account of Ayurvedic management encompassing avoidance of causative factors (Nidana Parivarjana), purificatory therapies (Shodhana)—particularly bloodletting (Raktamokshana)—palliative medication (Shamana), and dietetic regulation (Pathya-Apathya). The review concludes that a lifestyle- and diet-driven etiological model of Vatarakta aligns remarkably with the epidemiology of gout, and that an integrative approach centred on nidana parivarjana offers a rational framework for prevention and long-term management.

Keywords: Vatarakta, Gout, Hyperuricemia, Raktamokshana, KaiShora Guggulu, Pathya-Apathya.

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Introduction:

Vatarakta is regarded among the Ayurvedic classics as one of the important disorders arising from the combined vitiation of Vata doSha and Rakta dhatu. The term itself is a compound of "Vata" and "Rakta", indicating the two principal factors involved in its causation. The condition is also known by several synonyms in the classical literature, including VataShonita, Khudha, Adhya-vata and Vata-balasa, each of which reflects an aspect of its presentation, chronicity, or its tendency to afflict those of affluent and sedentary living. In contemporary practice, Vatarakta is most commonly correlated with gout, an inflammatory arthropathy resulting from the deposition of monosodium urate crystals in and around joints in the setting of chronic hyperuricemia. The striking clinical parallel—an acutely painful, red, swollen, and burning small joint, classically the first metatarsophalangeal joint of the great toe—makes this correlation one of the most convincing among Ayurvedic and modern nosological pairings. Both conditions share a strong association with dietary indulgence, alcohol consumption, sedentary habits, and prosperity, a relationship recognised by the ancient physicians long before the biochemistry of uric acid was understood. Because Vatarakta is fundamentally a disease of dietary and behavioural origin, an accurate understanding of its causative factors (Nidana) is of the highest clinical value: it not only explains the pathogenesis but also directly informs prevention and management. The present review therefore places the causative factors at its centre, and proceeds from etiology to pathogenesis, diagnosis, investigations, and the classical scheme of management.

Materials and Methods:

This is a conceptual and literary review. The primary Ayurvedic source material was drawn from the Brhatrayee—Charaka Samhita (Cikitsa Sthana, Chapter 29, VataShonita Cikitsa), SuShruta Samhita (Nidana Sthana and Cikitsa Sthana), and

AShtanga Hrdaya (Nidana Sthana 16 and Cikitsa Sthana 22)—together with the Madhava Nidana (Chapter 23), Bhavaprakasha, and Yogaratnakara. Relevant commentaries were consulted for clarification. Contemporary correlations pertaining to gout, hyperuricemia, and diagnostic investigations were compiled from standard medical texts and peer-reviewed rheumatology literature. The gathered material was organised thematically under etiology, pathogenesis, clinical features, investigations, and management, and analysed for points of convergence between the two systems.

Causative Factors (Nidana) of Vatarakta:

The classical texts describe the causation of Vatarakta under two broad heads: the predisposed constitution and habits of the individual (the fertile ground), and the specific dietary and behavioural provocations that precipitate the disease. Charaka emphasises that individuals who are delicate (sukumara), who indulge in rich unctuous food while avoiding physical exertion, and who lead a comfortable, sedentary life are especially susceptible. This description of the susceptible host is itself a form of nidana, and corresponds closely to the modern risk profile for gout.

Aharaja Nidana (Dietary Factors):

Dietary factors form the largest and most emphasised group of causes. The classics repeatedly implicate foods that are excessively salty (lavana), sour (amla), pungent (katu), alkaline (kshara), unctuous (snigdha) and hot in potency (ushna), as well as foods that are wet, fermented, or difficult to digest. Specific items enumerated include the following:

- Excessive intake of alcohol (madya) and fermented sour liquids such as sukta, saiveera and aranala.
- Regular consumption of black gram (maSha), horse gram (kulattha), radish (moolaka), sesame, and germinated or flat beans (nishpava).

- Curd (dadhi), buttermilk (takra) taken inappropriately, jaggery (gudha), and other heavy, channel-obstructing foods.
- Meat of aquatic (anoopa) and marshy-land animals, fish (matsya), and other flesh foods that are rich and heavy to digest.
- Incompatible food combinations (viruddha ahara), and habitual overeating of oily, heavy preparations (krtanna).

The common thread among these items is that they aggravate both Pitta/Rakta (by their sourness, saltiness and heat) and simultaneously obstruct or vitiate the Vata-carrying channels. Notably, alcohol, organ and flesh foods, and legumes correspond well to the purine-rich and fructose-rich dietary triggers now recognised in the pathogenesis of hyperuricemia and gout.

Viharaja Nidana (Behavioural and Lifestyle Factors):

Lifestyle factors act principally by aggravating Vata or by hindering the normal movement and metabolism of the doShas. The important viharaja causes described are:

- Sleeping during the day (divasvapna) and remaining awake at night (ratri jagarana).
- Either excessive physical exertion in a delicate individual, or, conversely, a wholly sedentary, comfort-seeking existence (avyayama).
- Excessive travel—riding on horses, elephants, camels, or vehicles—causing repeated trauma and Vata aggravation.
- Suppression of natural urges (vegadharana) and habitual constipation (kroora koShtha).
- Local trauma or injury to the joints, and anger, grief and other psychological provocations (manasika nidana).

Convergence with the Modern Etiology of Gout:

When the classical causative factors are set beside the modern risk factors for gout, the parallels are compelling. Purine- and fructose-rich diets, alcohol (particularly beer and spirits), obesity, a sedentary lifestyle, and affluence are the recognised modern drivers of hyperuricemia—each of which finds a direct counterpart in the Ayurvedic nidana.

The table no.1 below summarises this correspondence.

Classical Nidana (Ayurveda)	Modern Correlate (Gout / Hyperuricemia)
Madya (alcohol), sukta, sauveera	Alcohol—especially beer and spirits—raising serum urate
MaSha, kulattha, matsya, anoopa mamsa	Purine-rich legumes, seafood and organ/red meats
Gudha and sweet, heavy foods	Fructose and high-calorie diets promoting urate production
Avyayama, sukumaratva, aiShvarya	Sedentary lifestyle, obesity, metabolic syndrome, affluence
Divasvapna, ratri jagarana, vegadharana	Disordered lifestyle and reduced renal urate clearance

Classical Nidana (Ayurveda)	Modern Correlate (Gout / Hyperuricemia)
Sthanika abhighata (local trauma)	Trauma as a recognised trigger of acute gouty attacks

Table 1. Correspondence between the classical causative factors of Vatarakta and the modern etiological determinants of gout.

Samprapti (Pathogenesis):

Repeated exposure to the causative factors leads first to the aggravation of Vata and the vitiation of Rakta. The vitiated Rakta, being heavy and abnormal, obstructs the pathways of the already-aggravated Vata. Unable to move freely, the obstructed Vata in turn further vitiates the Rakta; the two thus mutually aggravate one another and, spreading rapidly through the sira (vascular channels), pervade the body. Because of Vata's mobile nature and the tendency of the disorder to descend, the vitiated doSha-dooShya complex characteristically settles in the lower extremities, particularly the small joints of the feet, before ascending. The onset in the great toe and the small joints of the hands and feet described by the classics maps directly onto the podagra and small-joint predilection of clinical gout, where monosodium urate crystals preferentially deposit in the cooler, distal joints. Based on the predominant doSha, the classics describe *Vataja*, *Pittaja*, *Kaphaja*, *Raktaja* and combined (*sannipatika*) varieties. On the basis of the depth of tissue involvement, two clinically important forms are recognised: **Uttana** (superficial, confined to skin and muscle, marked by itching, burning and redness) and **Gambheera** (deep-seated, involving deeper dhatus, marked by hard swelling, deep pain and greater chronicity). The Gambheera variety corresponds well with chronic tophaceous gout and its deeper articular and peri-articular involvement.

Poorvarupa and Roopa (Prodromal and Clinical Features):

The prodromal features (*poorvarupa*) include excessive sweating or its absence over the joints, discolouration of the skin (coppery or blackish), numbness, formication (a crawling sensation), itching, occasional pain, looseness and heaviness of the joints, and loss of local sensation. These subtle premonitory signs offer an opportunity for early, preventive intervention. The fully manifested disease (*rupa*) presents with pain, burning sensation, redness, warmth, and swelling of the affected small joints—initially episodic and later persistent. The pain is characteristically severe and worse at night, and the involved joint may become intolerant even of touch. In chronic and neglected cases, deformity, restricted movement, nodular swellings and non-healing lesions may develop. The acute, exquisitely tender, red and swollen joint described here is clinically indistinguishable from an acute gouty flare, and the nodular swellings of chronic Vatarakta correspond to gouty tophi.

Diagnosis and Investigations:

In classical practice the diagnosis rests upon a careful history of causative factors, recognition of the prodromal and manifest features, and clinical examination through inspection (*darShana*), palpation (*sparShana*) and interrogation (*praShna*). In contemporary integrated practice these are supplemented by laboratory and imaging investigations that confirm the diagnosis, assess severity, and screen for the metabolic comorbidities that frequently accompany the disease.

Table 2. Investigations useful in the diagnosis and assessment of Vatarakta / gout.

Investigation	Purpose / Expected Finding
Serum uric acid	Screening for hyperuricemia; often elevated (supersaturation above ~6.8 mg/dL), though it may be normal during an acute flare
Synovial fluid analysis	Confirmatory: needle-shaped, negatively birefringent monosodium urate crystals under polarised light microscopy (gold standard)
24-hour urinary uric acid	Distinguishes over-production from under-excretion; guides therapy
ESR and CRP	Reflect the degree of acute inflammation during flares
Complete blood count	May show leucocytosis in acute attacks; baseline assessment
Renal function tests	Assess urate excretion and screen for uric-acid nephropathy
Fasting glucose and lipid profile	Screen for the metabolic syndrome commonly associated with gout
X-ray of affected joint	Chronic cases: 'punched-out' peri-articular erosions with overhanging edges; soft-tissue tophi
Ultrasonography	Double-contour sign over cartilage; detection of tophi and effusion
Dual-energy CT (DECT)	Non-invasive characterisation and mapping of urate deposition

Ayurvedic Management:

The management of Vatarakta follows the general principle of treating a disorder of Rakta and Vata together, and is organised into four complementary limbs: avoidance of the causative factors, purificatory therapy, palliative medication, and dietetic regulation. Charaka particularly cautions that Vatarakta, if neglected, behaves like an internal enemy and may cripple the patient—underscoring the value of early and sustained intervention.

Nidana Parivarjana (Avoidance of Causative Factors):

The first and most important measure is the systematic withdrawal of the dietary and behavioural causes described above. Because Vatarakta is so strongly diet- and lifestyle-driven, nidana parivarjana is not merely supportive but is itself a primary line of treatment; in modern terms it corresponds to restriction of alcohol, purine- and fructose-rich foods, weight reduction, regular activity, and correction of disordered sleep—the same measures that form the foundation of long-term gout control.

Shodhana (Purificatory Therapies):

RaktamokShana (bloodletting): As Vatarakta is predominantly a disorder of vitiated Rakta, bloodletting is the foremost purificatory measure. Venesection (siravyadha) and, especially, leech application (jalaaukavacarana) are favoured for their ability to remove vitiated blood locally and relieve acute inflammation. Leech therapy is particularly suited to the tender, inflamed joint where instrumentation is difficult.

Virechana (therapeutic purgation):

Mild to moderate purgation is employed to eliminate aggravated Pitta and vitiated Rakta through the gut, and is especially indicated in Pitta-Rakta predominant presentations. Preparatory oleation (snehana) with suitable medicated ghee precedes purification.

Basti (medicated enema): Where Vata predominates, basti is the principal

therapy. Nourishing and cooling enemas such as kSheera basti and tikta-kSheera basti (medicated milk enemas prepared with bitter drugs) pacify Vata while addressing the Rakta component, and are valuable in chronic, deep-seated (Gambheera) disease.

Snehana and Abhyaṅga: Internal and external oleation with appropriate medicated oils and ghee softens the tissues, pacifies Vata, and prepares the body for further purification. External applications are chosen according to whether the presentation is predominantly hot (cooling oils) or cold (mildly warming).

Shamana (Palliative Medication):

A wide range of internal formulations is used to pacify the doShas, purify the blood, reduce inflammation, and restore joint function. Commonly employed medicines include:

Table 3. Representative Shamana formulations used in the management of Vatarakta.

Formulation	Principal Use
KaiShora Guggulu	The classical drug of choice for Vatarakta; blood-purifying and anti-inflammatory
Amṛta (Gudhoocee) / Gudhoocyadi Kvatha	Immunomodulatory, anti-inflammatory; reputed to reduce uric acid
MahamañjiShṭhadi Kvatha	Rakta-Shodhaka (blood purifier) for skin and joint manifestations
Punarnavadi / Punarnava preparations	Anti-inflammatory and diuretic; helpful for swelling
Pañcatikta Ghr̥ta Guggulu	Deep-seated Vatarakta with tissue involvement
Kaṭuka, Sariva, Candana, USheera	Cooling, blood-purifying adjuvants in Pitta-Rakta presentations
Erandha (castor) preparations	Vata-pacifying, mild purgative; useful in joint pain and constipation

Local applications (lepa): Cooling external pastes such as SHatadhauta ghr̥ta, candana-based and jatyadi preparations relieve local burning, redness and pain in acute inflammation. In chronic, cold, deep-seated disease, mildly warming and Vata-pacifying applications are preferred.

Rasayana (rejuvenation): In quiescent and chronic phases, rejuvenatives such as Gudhoocee, SHatavaree and AShvagandha

support tissue repair, strengthen the joints, and help prevent recurrence—paralleling the modern emphasis on long-term maintenance therapy between flares.

Pathya-Apathya (Wholesome and Unwholesome Regimen):

Dietetic regulation is indispensable and, in effect, operationalises nidana parivarjana on a daily basis.

Table 4. Dietetic and lifestyle regimen in Vatarakta.

Pathya (Wholesome)	Apathya (Unwholesome)
Old rice (purana Shali), wheat, barley (yava)	Alcohol and fermented sour liquids
Green gram (mudga) and other light pulses	Black gram, horse gram, germinated beans
Bitter and pointed gourd (paṭola, karavella), pumpkin	RadiSh, excessively salty and sour foods
Milk and ghee in appropriate measure	Curd taken inappropriately; heavy, oily fried foods
Grapes, pomegranate and other light fruits	FiSh and meat of aquatic and marShy animals
Adequate water and regular, timely meals	Incompatible foods, overeating, day sleep

Discussion:

The examination of Vatarakta through both classical and modern lenses reveals a disease whose etiological model was, in essence, correctly intuited by the ancient physicians. The Ayurvedic emphasis on rich, sour, salty and fermented foods, on alcohol, on fleSh foods from water and marShland, and on a comfortable sedentary life maps with remarkable fidelity onto the contemporary understanding of gout as a disease driven by purine and fructose intake, alcohol, obesity, and physical inactivity. That the classics located the disease preferentially

in the small joints of the feet and the great toe—the very site of classical podagra—strengthens the correlation and suggests that the clinical observations underlying the concept of Vatarakta were acute and specific. The therapeutic logic is equally coherent. RaktamokShana, and especially leech therapy, directly targets the vitiated Rakta that both systems place at the centre of the disease, and offers rapid local relief in the acutely inflamed joint. Purgation and medicated enemas provide systemic clearance of the aggravated doShas, while blood-purifying and anti-inflammatory formulations such as KaiShora Guggulu

and Gudhoocee address the underlying process; several of these drugs have attracted modern interest for potential urate-lowering and anti-inflammatory activity, though rigorous clinical evidence remains to be consolidated. Above all, the classical insistence on nidana parivarjana anticipates the modern recognition that no pharmacological regimen for gout succeeds without concurrent dietary and lifestyle modification. Certain distinctions must nonetheless be kept in view. Vatarakta is a syndromic entity defined by its doSha-dooShya pathology and is not synonymous with gout in every case; a proportion of patients presenting with the classical picture may in fact have other inflammatory or crystal arthropathies. The prudent contemporary approach is therefore integrative: to employ modern investigations—serum uric acid, synovial fluid crystal analysis, and imaging—to confirm the diagnosis and exclude mimics, while drawing on the Ayurvedic framework for a nuanced, individualised, and prevention-oriented management strategy. Well-designed clinical studies evaluating specific Ayurvedic interventions against standard outcomes would substantially strengthen this integration.

Conclusion:

Vatarakta stands out as one of the clearest examples of concordance between classical Ayurvedic nosology and modern medicine, corresponding closely to gout in its causation, pathogenesis, site of predilection, and clinical course. Its causative factors are overwhelmingly dietary and behavioural, and a precise understanding of these Nidana is the foundation of both prevention and treatment. Ayurvedic management—built upon avoidance of causative factors, bloodletting and other purificatory measures, blood-purifying and anti-inflammatory medication, and disciplined dietetics—offers a rational and largely preventive approach that complements contemporary urate-lowering therapy. An integrative model, in which modern

investigations secure the diagnosis and the Ayurvedic emphasis on lifestyle correction guides long-term care, holds considerable promise for the management of this ancient yet increasingly prevalent disorder.

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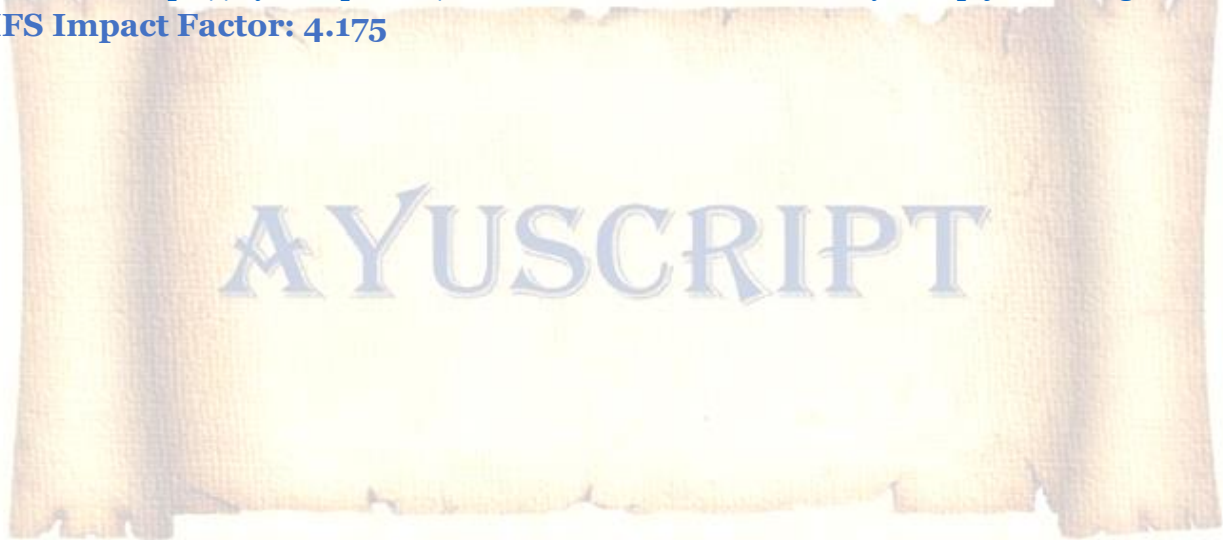
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