MANAGEMENT OF JALODAR (ASCITES) & YAKRITPLEEHODAR (HEPATOSPLENOMEGALY) - A CASE REPORT

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ABSTRACT

Background: Cirrhosis is the final phase of Alcoholic liver disease. Cardiac failure, tuberculosis, portal hypertension, cirrhosis of liver is the major causes of ascites associated with hepato-splenomegaly. Ascites is the accumulation of free fluid in the peritoneal cavity. Ayurveda emphasises that all diseases are the result of weak state of Agni (Roga Sarveapimandeagnao). Improper functioning of Agni leads to various metabolic disorders. In Ayurveda, it can be compared with Jalodar and Yakritadalyudar. Due to Mandagni and Malavridhdi, Udar Roga occurs. Case: A 35 year old male patient reported to the outdoor department of Sharir Kriya NIA, Jaipur, with the chief complains of whole body swelling or edema, vomiting, dizziness, fever, loss of appetite, anemia, jaundice, weakness, and fullness of flank. Other associated complaints were bleeding per rectum and hematemesis, dark yellow urine and passing of greenish-yellow stools. The patient was diagnosed as Yakritadalyudara.

Result and Conclusion: The patient was administered Snuhi Kshira Virechana in the beginning. Then he was administered a combination of Kutki, Nishotha, Munakka and Sanaya along with Siddharka. After few sittings he was started on Rasaoushadhi aimed at improving the liver function. After treatment, the reports showed a marked improvement in the condition of the patient. There is an urgent need to explore the role of Ayurveda in such complicated conditions also.

Keywords: Alcoholic liver disease, Jalodara, Yakritadalyudar, Virechana, Rasa Aushadhi.

INTRODUCTION

Alcoholic liver disease (ALD) causes damage to the liver and its functions. Alcohol induced liver injury may be classified as, Alcoholic fatty liver (AF), Alcoholic hepatitis (AH), Alcoholic cirrhosis of liver (AC). ALD occurs after years of heavy drinking & over time scarring and cirrhosis can occur. Cirrhosis is the final phase of ALD. Cirrhosis is hardening of the liver due to the formation of fibrous tissue.

The clinical presentation of cirrhosis is highly variable. Some patients are asymptomatic and the diagnosis is made incidentally at ultrasound or at surgery. Others present with isolated ascites, hepatomegaly, splenomegaly or signs of portal hypertension. When symptoms are present, they are often non-specific and include weakness, fatigue, muscle cramps, weight loss, anorexia, nausea, vomiting and upper abdominal discomfort. Hepatomegaly is
common when the cirrhosis is due to alcoholic liver disease and hemochromatosis. Jaundice is usually mild when it first appears.

Hepatomegaly (यक्रीदिप वट्यलो रस्थ्यानुवदी तौ) may occur as the result of a general enlargement of the liver. Although all causes of cirrhosis can involve hepatomegaly, it is much more common in alcoholic liver disease.

Ascites (जलोदर वधयता तद्वात् स्वस्थानुवदरात् तौ) is present when there is accumulation of free fluid in the peritoneal cavity. Small amounts of ascites are asymptomatic, but with larger accumulations of fluid (>1L) there is abdominal distension, fullness in the flanks, shifting dullness on percussion and, when the ascites is marked, a fluid thrill is present on palpation.

Splenomegaly (स्लीहोधर वानपाषांशित: पलीत्वा च्युत: स्वानातु प्रवर्धिते) - The spleen has to be enlarged two to three times its normal size to be clinically palpable.

According to Ayurveda it’s a disease of Swedavaha and Ambuvaha strotodushti in which symptoms of Hepatosplenomegaly and Ascites i.e. Nausea, vomiting, swelling of feet and ankles, High blood pressure, loss of appetite, weakness etc. symptoms are quietly similar to Udara Roga in which कुंड्राळहामानादीप: (Abdominal distension), शीषा: पादकरस्य: (Swelling on ankle, feet & hand), मन्दोपी: (Indigestion and loss of appetite), अंतिपान्नु (Anemia & jaundice), कालवर्म (Lean and thin body), मन्दज्वर (Mild fever), शीषु (Weakness), उदक्षपुण्डुलिनात्मकत्वादिः (fluid thrill) etc. symptoms and sign are quite similar. The line of treatment followed in such a case is Udara roga chikitsa.

CASE STUDY
A 35 year old Hindu married male patient (Registration no 12029122016) residing in Jaipur, clinically diagnosed with ascites associated with hepatomegaly and splenomegaly, presented in outdoor wing of Kriya Sharir Arogyashala, National Institute of Ayurveda, Jaipur on 29 December 2016 with chief complains of whole body swelling or edema, vomiting, dizziness, fever, loss of appetite, anemia, jaundice, weakness, fullness of flank. Patient also had complaints of bleeding per rectum and hematemesis. Patient also complained that his urine is dark yellow and stool is greenish yellow in colour.

Personal history: Patient is vegetarian and used to take excess oily and spicy diet, with regular habit of intake of homemade food, normal sleep, frequency of micturition 1-2 times/day and with history of addiction to alcohol since 17 years. The patient had constipation and urge of defecation in 1 time/ 2day.

Past history: Patient also gave history of renal stone (4mm, middle calyx, right kidney) since 1 year. No h/o DM type 2, or Thyroid disorder or RTA.

Family history: No family history is present related to this disease.

GENERAL & SYSTEMIC EXAMINATION
PR: 90/min, BP: 160/100 mmhg, RR: 22/min
Pallor: present
Icterus: present
Edema: b/l pedal edema present
Weight: 76 kg, Height: 168cm
RS: lung fields clear.
CVS: S1, S2 heard, no murmurs.
CNS: Patient conscious, well oriented, remembers the events very clearly.
P/A: abdomen distended and painful, fluid thrill present, shifting dullness present, umbilicus everted, and skin over abdomen is glossy.
INVESTIGATIONS:

Table 1: Assessment before and after treatment

<table>
<thead>
<tr>
<th>INVESTIGATION</th>
<th>BEFORE TREATMENT</th>
<th>AFTER TREATMENT</th>
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<tbody>
<tr>
<td>1) USG Whole abdomen</td>
<td>Bright &amp; mildly coarse echo texture of liver S/O ALD, Chronic liver disease with Portal hypertension, hepatosplenomegaly with moderate Ascites. Minimal right pleural effusion. (28/05/2016)</td>
<td>Liver is normal in size, No portal hypertension seen No hepatomegaly seen Mild splenomegaly seen No pleural effusion seen. (16/11/2017)</td>
</tr>
<tr>
<td>2) LFT</td>
<td>SGOT 59.6 U/I (10-40 U/I)</td>
<td>SGOT 30 U/I (10-40 U/I)</td>
</tr>
<tr>
<td></td>
<td>SGPT 45.9 U/I (10-40U/I)</td>
<td>SGPT 35 U/I (10-40U/I)</td>
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<tr>
<td></td>
<td>Total Serum Bilirubin 5.0 mg% (0-1.0 mg %)</td>
<td>Total Serum Bilirubin 0.8 mg% (0-1.0 mg %)</td>
</tr>
<tr>
<td></td>
<td>Direct Serum Bilirubin 3.1mg% (0-0.2mg%), Indirect Serum Bilirubin 1.9 mg% (0-0.8mg %), Alkaline phosphatase 306.0 IU/L (65-306IU/L). On 07/07/2016</td>
<td>Direct Serum Bilirubin 0.3 mg% (0-0.2mg %), Indirect Serum Bilirubin 0.5 mg% (0-0.8mg %), Alkaline phosphatase 196.0 IU/L (65-306IU/L). On 16/11/2017</td>
</tr>
<tr>
<td>3) Hb %</td>
<td>6.3 gm.%</td>
<td>8.6 gm.%</td>
</tr>
<tr>
<td></td>
<td>On 07/07/2016</td>
<td>On 16/11/2017</td>
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</table>

Based on clinical presentation, Patient was diagnosed as a case of *Udar Roga* (*Jalodar, pleehodar* and *yakrutodar*).

TREATMENT PLAN:

1. *Snuhiksheer Virechan* (5ml, mixed in dough made of wheat flour, baked and administered soaked in ghee in morning, called as *Bati* in Rajasthan.) every 3rd day during 1st month of treatment and then once in a week for another 2 months. 

Afterwards, following medicines were started:
3. A combination in powder form of *Malla sindoora* (125mg), *Aarogyavardhini vati* (500mg), *Punarnavamandoor* (500mg), *Yavakshar* (500mg), *Jalodarari rasa* (250mg) *Sweta parpati* (500mg) Administred with *Rakta sodhak avaleha* (10g-10g) twice a day before Meal.
4. *Punarnavadi and Trina panchamoola kwath* twice daily (40ml) were administered before Meal, twice daily.
5. Syrup *Livamaritam* two teaspoon twice daily after meal.
7. *Triphala guggulu* two tablets twice daily after meal.

The patient was on follow up once every 15 days for 10 months without any single episode of relapse. 

In this case study, assessment was done on the basis of sign and symptoms as well as investigative findings. After 10 months of drug intervention, the values of LFT reduced, changes were noted in the USG abdomen report before and after treatment, and an overall improvement in the quality of life of patient was also observed.

DISCUSSION

*Udara roga* is *Swedavaha* and *Ambuvaha Strotodushti Vikar* due to *Jatharagnimandata, Pranavayu* and *Apanvayudushti*. Due to obstruction of *Swedavaha* and *Ambuvaha strotas* excessive accumulation of fluid, especially in peritoneal cavity, occurs.
1) *Nitya Virechana* is the line of treatment in *Udara roga* and hence *virechaka oushadha* are the first choice of drug in such a case.
2) *Snuhi* is *tikshana virechaka*. Depending on the presentation of the patient in this case, *virechana* was started with *snuhi kshira*. 
3) Kutaki is Pittavirechak, Bhedaniya, Lekhaniya, Sothahar and Yakriduttejaka. So it tends to excrete out the extra accumulated fluid in ascites (Jalodar).

<table>
<thead>
<tr>
<th>S.No.</th>
<th>Drug (Plant Name)</th>
<th>Properties</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Katuki (Picrorhiza kurroa)</td>
<td>Bhedniya(\text{10}) &amp; lekhniya(\text{10}), Kaphahara(\text{10}), Potent liver stimulant</td>
</tr>
<tr>
<td>2.</td>
<td>Manjishtha (Rubia cordifolia)</td>
<td>Vishahara(\text{15}), Shothahara(\text{12}), Kaphahara(\text{15}), Rakta shodhaka(\text{15})</td>
</tr>
<tr>
<td>3.</td>
<td>Markandika (Sanay – Cassia angustifolia)</td>
<td>Urdhwa-Adhahkaya shodhini(\text{11}), Vishahara, Gulma(\text{11}) &amp; Udarahara(\text{11})</td>
</tr>
<tr>
<td>4.</td>
<td>Punarnava (Boerhavia diffusa)</td>
<td>Shothahara(\text{12}), Dipan(\text{12}), Gara &amp; Vishahara(\text{12})</td>
</tr>
<tr>
<td>5.</td>
<td>Makoya (Solunum nigrum)</td>
<td>Shothahara(\text{16}), Yakritauttejak(\text{16}), Pittasarak(\text{15}) &amp; Rechana(\text{16})</td>
</tr>
<tr>
<td>6.</td>
<td>Kasani (Cichorium intybus)</td>
<td>Potent Hepato-protective action &amp; Yakritavikarnasak(\text{11})</td>
</tr>
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<td>7.</td>
<td>Sounf (Foeniculum vulgare)</td>
<td>Agnimandhyahara(\text{18}), Ushna, Pachani, Shleshma-Vatahara</td>
</tr>
<tr>
<td>8.</td>
<td>Munakka (Vitis vinifera)</td>
<td>Virechanopaga(\text{19})</td>
</tr>
</tbody>
</table>

4) Arogyavardhini and Punarnava Mandoor both are Yakritabalya and Shothahara. Have mutrala property; so these wash out the impurities from blood through urination.

5) Mallasindoor reduces Sankraman (infection). Yavakshara has Lekhan property so it opens the channels of Ambuvaha and Swedavaha strotus.

6) Jalodarari rasa and Sweta Parpati both eliminates the excessive accumulated fluid. Through excessive loose motions and excessive urination. Triphala Guggulu helps to remove the obstruction of Ambuvaha and Swedavaha Strotus.

7) Truna panchamoola kwath has Mutravirechaniya (Diuretic) and Tridosha shamak properties. It reduces swelling all over the body and leads to the blood pressure in normal range.

As mentioned in charaka that in jalodara excessive accumulated waste fluid have to be washed out. So we can use the drugs which have pittavirechaka or mutravirechaka properties.

CONCLUSION

Jalodara and yakritpleehodara are described in Ayurveda as the type of udar roga. The management of this disease complex is difficult due to the presence of complications. An effort was made to manage the present case successfully with Ayurveda treatment following the Chikitsa Siddhant of Udana Roga. Patient showed good overall improvement in his condition which is evident by changes in his investigative findings as well as his general wellbeing. In this case study, Ayurvedic treatment was found very effective in the management of Ascites & Hepatosplenomegaly (Yakritpleehodar). Through the Strotoshodhak principle the root cause was treated and this improved the normal functioning of body. This Ayurvedic treatment is safe, cost effective and has no side effect. Further studies to evaluate the role of Ayurveda treatment in the management of such complicated cases needs to be carried out.

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