INTRODUCTION

The ancient science of life, Ayurveda revolves around the very realistic concepts of panchamahabhootas, tridoshas, saptadathus and trimalas. For precise comprehension of science, its basic principles are to be understood. Apart from these basic principles that sustain life in balance and paint morbidity when under imbalance, there are interesting concepts that wing under them for the manifestation of a disease. One among the least discussed or focused is the concept of Leenadosha in the reflection of a disease.

In this context, understanding the term Leena is very much needed. Leena can be literally understood as attached, merged or even secluded\(^1\). Technically the term Leena means concealed\(^2\) or attached or merged\(^3\).

Hence Leenadosha is a state where the doshas are attached or concealed in dathus. The symptoms in such conditions are least expressed or even not expressed. We can frame the quality of Leenadosha as – ekadeshastita\(^4\), anutva\(^5\) and dathvantarasta\(^6\).

The term Leena has been quoted in the classics with reference to certain diseases. Some of them include vishamajvara\(^7\), svasa\(^8\), grahani\(^9\), vilambika\(^10\) and apasmara\(^11\). In the clinical practice even more diseases can be included.

POTENTIAL ETIOLOGY INSTIGATING LEENA DOSHA:

The knowledge of disease is of prime relevance before intervention in medicine\(^12\). The reasons from which a Leenaavastha can be
generated are the following: *mithyopachara, svabhava* of a *vyadhi, nidana, vyadhikshamatva*, abstaining from treatment for a disease.

The pathology of *Leena* can be made out in various diseases. In the context of *vishamajwara*, after the remission due to the following of *apathyahara* and *vihara*; *dush-tadoshas* are left behind. These *doshas* would merge with the *datus*, when a favorable environment arises the symptoms are manifested at a visible threshold at varying intervals; with remission and relapse\[^{13}\]. In *svaasa, shodhana* is the line of treatment in *bahudoshavastha* followed by *shamana – dhoopana*. If the clinician skips the latter, *doshas* undergo *Leenaavastha* where in the patient may not manifest symptoms at the time but when a favorable environment arise the conditions revert back\[^{14}\]. In *grahani* due to weak digestive fire there will be indigestion leading to the pathological state of *aama*. The *aama* is in *anutklishtaavastha* in the *pakvashaya*. The same is not strong enough to elicit the signs and symptoms \[^{15}\]. In case of *vilambika* the diseases become recurrent as the *aamaavastha* is deeply merged in state with *srotas*\[^{16}\]. In *apasmara*, the intermittent or episodic attack of the seizure is termed by the word *Leena*\[^{17}\]. Also *Leena* can be considered as *doshavastha*. Therefore *Leena* not only conveys the relapse or remission a disease.

**CONTEMPORARY GLEAM TO LEE-NA DOSHA :**

*Leenadoshaavastha* in modern pathology can be comprehended through diseases like herpes zoster, herpes simplex, AIDS, malaria, epilepsy, filariasis, leprosy and many more diseases. Among them malaria is here to explain its pathology and mechanism in symptomatic manifestation. The vector – Female *Anopheline* mosquitoes inoculates plasmodialsporozite from salivary gland into host body (blood). They invade hepatic parenchymal cell and progress to intrahepatic or pre erythrocyticschizogony or merogony. The single sporozite in the hepatocyte eventually proliferate, swollen the infected cell and eventually bursts. Further the motile merozites are discharged into the blood stream. Then, it enters the red blood corpuscles, multiply six to twenty times every forty eight to seventy two hours. When the parasites reach fifty per each micro liter of blood, symptomatic stage of infection begins. In all cases of hepatic entry, there may not be division as some forms of plasmodialsporozites remain dormant for a period ranging from weeks to years. They are called as hypnozites – dormant forms \[^{18}\].

**LATENCY AND LEENA DOSHA AVASTHA:**

Latency is the state of seeming inactivity \[^{19}\] or the state where there is existence but not yet developed/manifested/are hidden/concealed/dormant/a carrier stage, where in the individual is not affected. *Lee-na* is also similar to be explained as *anutklishhta*, which is not profound at a perceivable level as signs and symptoms. *Shlishta* refers to the adherence/merging of the *doshas* with the *dathus*. Thus, when a favourable environment arises, it manifests. Thus relapse and remission occurs.

**IMPACT OF LEENA DOSHA IN VYADHIKSHAMATVA:**

The references from occurrence of *punarvarthakajvara*\[^{20}\] enlighten the role of *bala* – immunity in an individual, in whom the re-
lapse of disease occurs after symptomatic cure. To understand, we can mention diseases like herpes zoster attack. Here the immune system suppresses the virus to an extent, avoiding the manifestation of symptoms. But when the immune mechanism fails to suppress, disease is manifested. But the mechanism of immune failure and relapse is poorly understood. Similar is the case of herpes simplex, where the host immunity influences the acquisition, severity of infection, resistance to development, latency and relapse. Latent phase of AIDS extends upon the strength of immunity in an individual. Regarding Leena in hyper sensitivity the sensitization of immune system towards any particular antigen can be long lived in the absence of re exposure (greater than 10 years) due to immunologic memory. We can assume the abnormality behind the cell mediated immunity as one of the modern pathological phenomenon in the causation of Leenaavastha.

INCIDENCE AND CLINICAL DISCERNMENT OF LEENA:

Leenaavastha can occur before and after the treatment of a disease. Before treatment due to the formation of saamadoshas. It can adhere or conceal to the dathus and Leenaavastha is formed. At the end of intervention or after it, though the signs and symptoms are subsided, there can be presence of sheoshadosha in the form of Leena. Clinically Leenaavastha can be inferred in a vyadhi through an exhibition of recurrent or intermittent attack of a disease, even with an assumption of well adopted treatment. Therefore merging the textual knowledge with the clinical practice, one could tackle the hurdle – Leenadoshaavastha through a non – futile intervention.

Our classics mention why and how such conditions should be approached. The saamadosha moving all over the body, when in Leenaavastha, i.e deeply merged or concealed in dathus are not feasible to be eliminated through shodhana procedures directly in such instances, if shodhana is performed can lead to the destruction of body tissues. Thus, saamadosha adhered or concealed in diseases are understood as in Leena. This understanding facilitates the further intervention.

This can be briefed as similar to that of aama, i.e measures of deepana and pachana, inturn leading to pakvaavastha, then performing shodhana. But if even after treatment sheshadoshas are present – it indicates Leenadoshaavastha, again proper deepana and pachana has to be performed followed by shodhana, followed by rasayana.

Shodanangasnehana and swedana are performed as preoperative procedures for shodhana to bring the doshas from shaka to koshta. It also aids to detach the Leenadosha from the dathus there by reducing any further occurrence of diseases – relapse. But, if the treatments are not administered properly, it leads to the stagnation of doshas (residual doshas). This can seed to the Leenaavastha, ultimately leading to relapse of the disease.

APPRAISAL:

Leenadosha is a pathological state of concealed existence of dosha. It can arise from improper treatment, abstaining from therapy, nature of a disease, cause of a disease and abnormal immunity. Its comprehension is not only cramp to the relapse and remis-
sion of a disease but also the latency and scrupulously even it can be weaned to be an abnormality in cell mediated immunity. Diagnosis of *Leenadosha* is understood through the relapse and remission. The physician should comply with treatments of *aama* followed by *rasayana*.

**REFERENCES**

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6. Ibid
7. Ibid
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CORRESPONDING AUTHOR
Dr. Nithin Krishnan
PG Scholar, Department of Roganidana,
SreeDharmasthal
Manjunatheshwar College of Ayurveda,
Hassan,Karnataka,India.
Email: nithinkris1989@gmail.com