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CASE REPORT

Ayurvedic Management of Refractory Childhood Plaque Psoriasis (*Ekakushtha*): A Case Report

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ABSTRACT

Introduction: Psoriasis is a chronic, non-communicable, painful, disfiguring, and disabling disease for which there is no cure and with great negative impact on patients' quality of life (QOL). Psoriasis causes great physical, emotional, and social burden. Both internal and environmental causes, including minor trauma, sunburn, infections, systemic medicines, and stress, can cause psoriasis. In the Ayurveda, all the skin disease has been described under *Kustha*. *Ekakushtha* is one of the *Kshudra-Kustha* described in *Ayurvedic* text. *Ekakustha* is a *Vata-Kaphaj* predominance disease. According to symptom of *Ekakushtha*, it can be compared to Psoriasis.

Methods: A 14-year-old female child came to Kaumarbhritya outpatient department, with the chief complaint of crusted skin rashes with oozing, itching and pain over lips, face, and all over body. The patient was first administered *Deepana-Pachana* drugs along with *Srotoshodhana Chikitsa* for 15 days. *Shamana Aushadhi* along with immunomodulatory drugs was then given for a period of 3 months. After 3 months, immunomodulatory drugs along with *Rasayana* drugs were administered for 1 month.

Results: At the end of Ayurveda therapy, complete remissions of symptoms were observed and photographs taken before and after treatment evidenced it. Furthermore, there were significant decreases in Psoriasis Area Severity Index score and Adolescent Psoriasis QOL score.

Conclusion: The treatment given for *Ekakushtha* was *Deepana, Pachana, Srotoshodhak, Vatanulomna, Rasayana,* and *Tridoshahara*; so above treatment helped to relieve symptoms of disease and also an attempt to provide safe and effective treatment to the patient.

1. INTRODUCTION

Psoriasis is a chronic, non-communicable, painful, disfiguring, and disabling disease for which there is no cure and with great negative impact on patients' quality of life (QOL). The etiology of psoriasis remains unclear, although there is evidence for genetic predisposition.[1] Although no specific auto-antigen has been identified as the cause of psoriasis, it may be an autoimmune condition. Both internal and environmental causes, including minor trauma, sunburn, infections, systemic medicines, and stress, can cause psoriasis.[2]

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Psoriasis causes great physical, emotional, and social burden.[3] QOL, in general, is often significantly impaired.[4,5] Individuals with psoriasis commonly experience deformity, disability, and a significant reduction in productivity. In addition, there are major costs associated with maintaining mental health, such as higher rates of depression, which have an adverse effect on both individuals and society.[6] People with psoriasis and their families experience psychologically painful social isolation, discrimination, and stigma. The majority of the exclusion is due to society's response to psoriasis. Psoriatic arthritis a chronic inflammatory arthritis characterized by joint deformities and functional impairment develops in individuals with psoriasis and has a reported prevalence ranging from 1.3%[7] to 34.7%[8] among patients with psoriasis. Nail involvement has been reported in 4.2% to 69% of patients with

psoriasis.[9] According to reports, people with psoriasis are more likely to develop other major clinical illnesses such as cardiovascular disease and other non-communicable diseases.[10] Psoriasis is a chronic, multifactorial inflammatory disease that can involve various anatomical sites, including the scalp, face, trunk, limbs, palms, and soles. Its onset and exacerbations may be triggered by several factors, including infections, medications, and physical trauma.[11] The diagnosis of psoriasis is primarily based on the clinical presentation, including the characteristic morphology and distribution of skin lesions. Histopathological examination of a skin biopsy may be performed in atypical cases to confirm the diagnosis. The major clinical subtypes of psoriasis include plaque psoriasis (*psoriasis vulgaris*), inverse psoriasis, guttate psoriasis, pustular psoriasis, and erythrodermic psoriasis.[12]

The primary goal of psoriasis treatment is to control disease activity and manage symptoms. Treatment options include topical therapy, phototherapy, and systemic therapy, which are often used in combination depending on disease severity and patient characteristics. As psoriasis is a chronic relapsing disease, long-term treatment aimed at achieving and maintaining remission is often required. In Ayurveda, all skin diseases are described under the broad category of *Kuṣṭha* (Kustha).[13] *Ekakuṣṭha* is one of the *Kṣudra Kuṣṭhas* (minor skin disorders) described in the classical Ayurvedic texts,[14] it is predominantly a *Vata-Kapha* disorder.[15] Based on its clinical features and symptomatology, *Ekakuṣṭha* is considered too closely correspond to psoriasis in contemporary medicine.

2. PATIENT INFORMATION

2.1. Chief Complaint

A 14-year-old female child came to *Kaumarbhritya* outpatient department (OPD), National Institute of Ayurveda Jaipur on 2023.12.01 (OPD Reg. No. 33202300073291) with chief complaint of crusted skin rashes with oozing, itching and pain over lips, face, and chest.

2.2. History of Present Illness

According to the patient's informant (mother), the patient was apparently healthy until approximately 1.5 years before presentation, when she developed a small pruritic vesicular lesion over the chest. The lesion gradually evolved into a dry, scaly plaque. Over time, similar lesions progressively spread to the lips, face, and subsequently involved the major parts of entire body, with the cheeks and lips being the most severely affected. The lesions were associated with intense pruritus, and scratching resulted in bleeding from the affected areas. The persistent itching caused significant sleep disturbance and anxiety. As the disease progressed, the patient also experienced considerable psychological distress and social isolation, which adversely affected her QOL.

2.2.1. Past history

The patient and all family members had a documented history of COVID-19 infection before the onset of the dermatological manifestations.

2.2.2. Psychosocial history

The patient experienced significant social isolation and depressive symptoms secondary to the disease, resulting in a substantial impairment in QOL.

2.2.3. Treatment history

The patient received allopathic treatment for 1 year, followed by homeopathic treatment for 6 months; however, no significant clinical improvement was observed.

2.2.4. Personal history

The patient was a 14-year-old vegetarian with disturbed sleep due to intense itching. Bowel habits were irregular, while appetite and micturition were normal. The patient was less physically active. On examination, body weight was 48.5 kg, height was 148.5 cm, and body mass index was 22 kg/m^2. The body temperature was 98.4°F, and the pulse rate was 80 beats/min.

2.2.5. Dietary history

- The patient consumed junk food approximately once per week
- Dadhi (curd) and Takra (buttermilk) were regular components of the patient's daily diet.

3. CLINICAL FINDINGS

3.1. Dermatological Examination

Multiple, well-demarcated erythematous to hyperpigmented indurated plaques with thick adherent silvery-yellow scales and crusting were observed over the face (cheeks and lips), chest, trunk, and extremities. The plaques measured approximately 4–5 cm in diameter and exhibited irregular margins. The lesions were accompanied by severe pruritus, dryness, intermittent tenderness, and occasional pinpoint bleeding after scratching. Both Koebner's phenomenon and Auspitz sign were positive, consistent with chronic plaque psoriasis.

4. TIMELINE

A detailed chronological timeline of the patient's clinical course is presented in Table 1.

5. DIAGNOSTIC ASSESSMENT

The patient was a known case of plaque psoriasis. Presence of both Koebner's phenomenon and Auspitz sign supported the diagnosis.

5.1. According to Ayurveda

1. *Aswedanam* (No sweating)
2. *Matsyasakalopam* (Scaling and crusting present) – Plaques on chest, face, trunk, arms, and legs
3. *Twakvaivarnyam* (Discoloration of skin) – Present
4. *Kandu* (Itching) – Present
5. *Nistoda* (Pain) – On and off
6. *Rukshata* (Dryness) – Present

5.2. According to Modern

1. Chest – Erythematous lesion overlapped with indurated and hyper-pigmented discoid scaly lesions (4–5 cm diameter) with irregular emarginated scaly eruption
2. Face – On cheeks and lips (4–5 cm. diameter)
3. Koebner's phenomenon – Positive
4. Auspitz sign – Positive

Assessment was done using Psoriasis Area Severity Index (PASI) and Dermatology Life Quality Index scoring. At the time of the first visit to the Kaumarbhritya OPD, the PASI score was calculated as 6.6, Adolescent Psoriasis QOL Psychosocial Impact was calculated as 42, and Adolescent Psoriasis QOL Physical Symptoms and Treatment was calculated as 17.

6. THERAPEUTIC INTERVENTION

- The patient was advised to follow *Nidana Parivarjana* (avoidance of etiological factors), including the restriction of *Guru Ahara*

(heavy-to-digest foods), *Viruddha Ahara* (incompatible foods), *Amla Rasa* (sour-tasting foods), *Dadhi* (curd), fish, meat, *Tila* (sesame seeds), *Guḍa* (jaggery), excessive consumption of milk and milk products, and other dietary factors considered aggravating in Ayurveda.

- The management protocol was planned in a phased manner, comprising *Dipana–Pacana* (enhancement of digestive and metabolic functions), *Doṣha Anulomana* (mild *Shodhana* with bowel cleansing), *Kuṣṭhahara Chikitsa* (anti-psoriatic therapy), and *Rasayana* (rejuvenative and immunomodulatory therapy), as detailed in Table 2.

7. FOLLOW-UP AND OUTCOME

Improvement of clinical features, PASI score and APSO-QOL score of the patients were observed before treatment and after treatment as in Table 3 also the improvement was appreciable in photograph taken before and after therapy shown in Figures 1 and 2.

8. DISCUSSION

The present case report describes a case of childhood plaque psoriasis, which was correlated with *Ekakushtha*, one of the *Kṣudra Kuṣṭha* described in Ayurveda, characterized by the predominance of *Vata* and *Kapha Dosas*. The patient was managed using an Ayurveda treatment protocol. Although *Vamana Karma* (therapeutic emesis) and *Virecana Karma* (therapeutic purgation) constitute the principal *Shodhana* therapies recommended for the management of *Kusṭha*, the patient declined both procedures despite detailed counseling regarding their therapeutic importance. The refusal was attributed to fear of the procedures and the patient's underlying psychological distress with depressive symptoms.

The treatment was, therefore, initiated with *Dipana–Pacana* and *Srotoshodhana* therapies for 15 days. *Abhayariṣṭa* syrup and *Triphala* powder, classical Ayurvedic formulations possessing *Uṣṇa Virya* (hot potency) and *Dipana–Pacana* properties, were prescribed during this initial phase to improve digestion, metabolize *Ama*, and facilitate the restoration of normal *Srotas* function. Thereafter, *Shamana Chikitsa* along with immunomodulatory and anti-psoriatic Ayurveda formulations was administered for 3 months. Marked clinical improvement was observed, including a reduction in scaling, crusting, and pruritus. In view of the favorable therapeutic response, the same anti-psoriatic and immunomodulatory *Rasayana* formulations were continued for an additional 1 month, resulting in complete resolution of scaling and substantial improvement in the skin lesions.

8.1. Probable Mode of Action of *Abhyarishta* and *Triphala Churna*

Triphala, due to its *Rasayana* (rejuvenative), *Koshthashuddhikara* (bowel-cleansing), and immunomodulatory properties, helps restore normal bowel function, eliminates *Ama* (accumulated metabolic toxins), enhances host immunity, and promotes systemic health. *Abhyarishta*, in the given dose, acted as a mild laxative. The distinctive *Ushna* (hot) and *Tikshna* (sharp) properties of the *Arishta* formulation stimulate *Agni* (digestive fire) and facilitate delivery of the active ingredients to the target site. Once the medication reaches the site of *Dosha-Dushya* vitiation, it helps pacify the deranged *Doshas*, thereby restoring tissue homeostasis. The *Vyavayi* (rapid systemic spread before digestion) and *Ashukari* (quick-acting) properties of *Arishta* formulations further enable swift action at the affected site and help clear obstruction within the *Srotas* (channels).

8.2. Probable Mode of Action of Shaman *Aushadhi* along with Immunomodulatory Drugs and *Rasayana* Drugs

8.2.1. Psorlyn tablet

Tab. Psorolin is a compound formulation comprising *Svetakutaja* (*Wrightia tinctoria*), *Avalguja* (*Psoralea corylifolia*), *Arushkara* (*Semecarpus anacardium*), *Katuki* (*Picrorhiza kurroa*), and *Ankot* (*Alangium salvifolium*), each contributing specific properties beneficial in the management of *Kushtha*.

Svetakutaja possesses *Kashaya-Tikta Rasa, Laghu-Ruksha Guna*, and is classically described as *Kushthaghna* property. These attributes are believed to facilitate Kleda-shoshana (reduction of excessive moisture), Rakta-prasadana (purification of blood), and restoration of normal skin integrity. Due to these properties, *Svetakutaja* is traditionally employed in the management of various dermatological disorders and may help reduce inflammation, scaling, and pruritus associated with chronic skin diseases.[16]

Avalguja (Bakuchi, *P. corylifolia* L.) is classically described as *Tvachya* (beneficial for skin health) and *Kushthaghna* (effective in the management of skin disorders). Its therapeutic potential is primarily attributed to bioactive constituents such as psoralen and isopsoralen, which have demonstrated antiproliferative, immunomodulatory, anti-inflammatory, and melanogenic activities. These pharmacological effects may help regulate abnormal keratinocyte proliferation, reduce cutaneous inflammation, and promote restoration of normal skin architecture, thereby supporting its use in the management of chronic inflammatory skin disorders such as psoriasis.[17]

Katuki (*P. kurroa*) is characterized by *Tikta Rasa* and *Sheeta Virya* and is traditionally indicated for disorders involving *Pitta* and *Rakta Dushti*. It is described as a *Rakta-prasadana* and *Yakrit-uttejaka* (hepatoprotective) drug in Ayurveda classics.[18] Experimental studies have demonstrated hepatoprotective, anti-inflammatory, antioxidant, and immunomodulatory activities, which may contribute to the regulation of systemic inflammation and restoration of metabolic homeostasis.[19] These properties support its potential role as an adjuvant in the management of chronic inflammatory skin disorders**.**

Arushkara (Bhallataka), due to its *Ushna Virya* and *Vata-Kaphahara* properties, exhibits *Rasayana* and *Kushthaghna* activities. These actions help pacify the vitiated *Vata* and *Kapha Doshas*, which are predominantly implicated in psoriasis, while its *Rasayana* effect may contribute to tissue rejuvenation, immune modulation, and reduction in disease recurrence.[20]

Ankot contributes *Kaphahara* and *Kushthaghna* actions, aiding in the reduction of scaling and local inflammation.[21]

8.2.2. Tab. Imunie

Tab. Immunie contains *Yashad Bhasma* and *Ashwagandha.* Antibacterial, antifungal and immunomodulatory activity of *Yashad Bhasma* might have prevented the recurrence of such immunosuppressive diseases.[22] *Ashwagandha* contains Withaferin A and 3-b-hydroxy-2,3-dihydrowithanolide F isolated from *Withania somnifera* show promising antibacterial, antitumoral, immunomodulating, and anti-inflammatory properties.[23]

8.2.3. SIVA drops

SIVA drops comprising *Shivanimba* (*Indigofera aspalathoides*), *Jyotishmati* (*Celastrus paniculatus*), *Sukanasa* (*Shyonaka; Oroxylum indicum*), *Karpura,* and *Kantakari* (*Solanum xanthocarpum*) in an oil base. *Shivanimba* exhibits significant antioxidant,[24] antimicrobial,

and wound-healing activity.[25] *Jyotishmati* methanolic extract demonstrates significant antinociceptive and anti-inflammatory activity, and has been additionally documented for anti-psoriatic action in pharmacological reviews.[26] *Kantakari* ethanolic extract shows significant anti-inflammatory activity in carrageenan- and histamine-induced edema models, while network pharmacology studies support its multi-target action against psoriasis.[27] *Karpura* contributes counter-irritant and antimicrobial relief from itching,[28] and *Sukanasa* (*Shyonaka*) adds supportive antibacterial activity.[29]

8.2.4. Psorlyn oil

Psorlyn oil is a polyherbal formulation comprising *Shweta Kutaja* (*Wrightia tinctoria*), *Aragvadha* (*Cassia fistula*), *Durva* (*Cynodon dactylon*), *Madhuyashti* (*Glycyrrhiza glabra*), *Avalguja* (*P. corylifolia*), *Karanja* (*Pongamia pinnata*), *Nimba* (*Azadirachta indica*), *Eranda* (*Ricinus communis*), and *Narikela* (*Cocos nucifera*). In Psorolin Oil, the *Kutaja, Bakuchi* action has already been explained under Tab. Psorolin, the remaining ingredients contribute the following actions: *Nimba,* through its nimbolide constituent, mitigates imiquimod-induced psoriasis-like inflammation and reduces epidermal hyperproliferation and erythema.[30] *Madhuyashti* contributes anti-inflammatory, antioxidative, and antimicrobial action that soothes redness and itching.[31] *Karanja,* through karanjin and pongapin, inhibits keratinocyte hyperproliferation with docking efficacy comparable to methotrexate, directly addressing the accelerated epidermal turnover of psoriasis.[32] *Aragvadha* supports anti-inflammatory and wound-healing action that aids resolution of scaling and plaque damage,[33] while *Durva* promotes tissue repair and reduces local inflammation through its antioxidative and *Vrana-ropaka* (wound-healing) properties.[34] *Eranda,* with its *Sukshma-Tikshna-Snigdha Guna*, penetrates micro-channels to relieve *Daha, Raga,* and *Kandu*,[35] and *Narikela* acts as an emollient carrier that suppresses inflammatory cytokines (tumor necrosis factor-alpha, interferon-gamma, and interleukin-6) while enhancing transdermal delivery and barrier repair.[36]

8.2.5. Lippu oil

Lippu oil contains *Karanja* and *Narikela Taila*, whose modes of action have been discussed previously under psorlyn oil the content of formulation are mention in table 4.

9. CONCLUSION

This case demonstrates that an individualized Ayurveda treatment protocol comprising Deepana–Pachana, Shamana Chikitsa, external herbal applications, and appropriate dietary modifications was associated with significant clinical improvement in a pediatric patient with chronic plaque psoriasis correlated with *Ekakushtha* (correlated with *Ekakushtha* in Ayurveda). A progressive reduction in erythema, scaling, pruritus, plaque thickness, and lesion extent was observed over the course of treatment, without the development of new lesions or disease exacerbation. The patient also experienced improvement in QOL, and the treatment was well tolerated, with no treatment-related adverse events reported.

Although conclusions from a single case report are inherently limited and cannot establish causality or be generalized to the broader patient population, the favorable clinical outcome suggests that an individualized Ayurveda therapeutic approach may have potential as a complementary management strategy for pediatric plaque psoriasis. Further well-designed prospective studies, including controlled clinical trials with larger sample sizes, longer follow-up periods, and standardized clinical outcome measures, are warranted to evaluate the efficacy, safety, and long-term therapeutic role of Ayurvedic interventions in the management of plaque psoriasis.

10. DECLARATION OF PATIENT CONSENT

The authors certify that they have obtained all appropriate patient consent forms; the legal guardian has given her consent for images and other clinical information to be reported in journal. The guardian understands that her names and initials will not be published and due efforts will be made to conceal the patient's identity, but anonymity cannot be guaranteed.

11. PATIENT PERSPECTIVE

Following the Ayurvedic treatment, both the patient and her guardian reported substantial improvement in itching, scaling, pain, and the extent of skin lesions. The visible reduction of facial and body plaques was associated with better sleep quality, greater comfort during daily activities, and enhanced self-confidence. The patient and her guardian expressed overall satisfaction with the treatment outcome and reported no recurrence of symptoms during the follow-up period.

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13. AUTHORS' CONTRIBUTIONS

All authors give equal contribution in making of this manuscript.

14. FUNDING

Nil.

15. ETHICAL STATEMENT

Ethical approval was not required for this study as it is a case report.

16. CONFLICTS OF INTEREST

The authors declare no conflicts of interest regarding the publication of this paper.

17. DATA AVAILABILITY STATEMENT

The data analyzed in this review were obtained from publicly available sources, including peer-reviewed articles, observational studies, and surveys accessible through databases.

18. DISCLAIMER/VIEW AND OPINIONS

The opinions expressed in this article are solely those of the authors and do not reflect the views of the International Research Journal of Ayurveda and Yoga or its editorial board.

19. AI-USE DECLARATION

The authors declare that no generative AI tools were used to create scientific content, interpret data, or draft any sections of this manuscript. AI-based tools were used solely for minor language and

grammar refinements to improve clarity and readability. All scientific content, analysis, and conclusions remain the sole responsibility of the author.

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REFERENCES

1. Harden JL, Krueger JG, Bowcock AM. The immunogenetics of psoriasis: A comprehensive review. J Autoimmun. 2015;64:66-73. doi: 10.1016/j.jaut.2015.07.008
2. Boehncke WH, Schön MP. Psoriasis. Lancet. 2015;386(9997):983-94. doi: 10.1016/S0140-6736(14)61909-7
3. Kimball AB, Jacobson C, Weiss S, Vreeland MG, Wu Y. The psychosocial burden of psoriasis. Am J Clin Dermatol. 2005;6(6):383-92. doi: 10.2165/00128071-200506060-00005
4. De Korte J, Sprangers MA, Mombers FM, Bos JD. Quality of life in patients with psoriasis: A systematic literature review. J Investig Dermatol Symp Proc. 2004;9(2):140-7. doi: 10.1046/j.1087-0024.2003.09110.x
5. Augustin M, Krüger K, Radtke MA, Schwippl I, Reich K. Disease severity, quality of life and health care in plaque-type psoriasis: A multicenter cross-sectional study in Germany. Dermatology. 2008;216(4):366-72.
6. Sampogna F, Tabolli S, Abeni D, IDI Multipurpose Psoriasis Research on Vital Experiences (IMPROVE) Investigators. Living with psoriasis: Prevalence of shame, anger, worry, and problems in daily activities and social life. Acta Derm Venereol. 2012;92(3):299-303. doi: 10.2340/00015555-1273
7. Bedi TR. Clinical profile of psoriasis in North India. Indian J Dermatol Venereol Leprol. 1995;61(4):202-5.
8. Pariser D, Schenkel B, Carter C, Farahi K, Brown TM, Ellis CN, Psoriasis Patient Interview Study Group. A multicenter, non-interventional study to evaluate patient-reported experiences of living with psoriasis. J Dermatolog Treat. 2016;27(1):19-26. doi: 10.3109/09546634.2015.1044492
9. Reich K, Krüger K, Mössner R, Augustin M. Epidemiology and clinical pattern of psoriatic arthritis in Germany: A prospective interdisciplinary epidemiological study of 1511 patients with plaque-type psoriasis. Br J Dermatol. 2009;160(5):1040-7. doi: 10.1111/j.1365-2133.2008.09023.x
10. Augustin M, Radtke MA, Glaeske G, Reich K, Christophers E, Schaefer I, Jacobi A. Epidemiology and comorbidity in children with psoriasis and atopic eczema. Dermatology. 2015;231(1):35-40. doi: 10.1159/000381913
11. Merola JF, Qureshi A, Husni ME. Underdiagnosed and undertreated psoriasis: Nuances of treating psoriasis affecting the scalp, face, intertriginous areas, genitals, hands, feet, and nails. Dermatol Ther. 2018;31(3):e12589. doi:10.1111/dth.12589
12. Rendon A, Schäkel K. Psoriasis pathogenesis and treatment. Int J Mol Sci. 2019;20(6):1475. doi: 10.3390/ijms20061475
13. Tripathi B, editor. Chikitsa sthana. In: Charaka samhita. Ch. 7. Varanasi, India: Chaukhamba Surbharati Prakashan; 2009.
14. Tripathi B, editor. Chikitsa sthana 7/21-2. In: Charaka samhita. Varanasi, India: Chaukhamba Surbharati Prakashan; 2009. p. 305.
15. Tripathi B, editor. Chikitsa sthana 7/29. In: Charaka samhita. Varanasi, India: Chaukhamba Surbharati Prakashan; 2009. p. 306.
16. Rwigema JM, Choi J, Lee NY, Heron DE, Chen AM. Re-irradiation therapy for locally recurrent head and neck cancer: A national survey of practice patterns. Cancer Invest. 2017;35(6):393-402. doi: 10.1080/07357907.2017.1310222
17. Kassahun Gebremeskel A, Wijerathne TD, Kim JH, Kim MJ, Seo CS, Shin HK, Lee KP. *Psoralea corylifolia* extract induces vasodilation in rat arteries through both endothelium-dependent and -independent mechanisms involving inhibition of TRPC3 channel activity and elaboration of prostaglandin. Pharm Biol. 2017;55(1):2136-44. doi: 10.1080/13880209.2017.1383484
18. Raut A, Dhami-Shah H, Phadke A, Shindikar A, Udipi S, Joshi J, Vaidya R, Vaidya AD. *Picrorhiza kurroa*, Royle ex Benth: Traditional uses, phytopharmacology, and translational potential in therapy of fatty liver disease. J Ayurveda Integr Med. 2023;14(1):100558. doi: 10.1016/j.jaim.2022.100558
19. Pandey BL, Das PK. Immunopharmacological studies on *Picrorhiza kurroa* Royle-ex-Benth. Part IV: Cellular mechanisms of anti-inflammatory action. Indian J Physiol Pharmacol. 1989;33(1):28-30.
20. Semalty M, Semalty A, Badola A, Joshi GP, Rawat MS. *Semecarpus anacardium* Linn.: A review. Pharmacogn Rev. 2010;4(7):88-94. doi: 10.4103/0973-7847.65328
21. Kapoor B, Kaur G, Gupta M, Gupta R. Sub-chronic safety evaluation of aqueous extract of *Alangium salvifolium* (L.f.) Wangerin leaves in rats. J Adv Pharm Technol Res. 2017;8(3):108-13. doi: 10.4103/japtr.JAPTR_69_17
22. Nille GC, Bhuyan M, Gupta LN, Ali M, Tripathi CSP, Nille OS, Mishra SK, Vibhute A, Kamble P, Ranjan H, Singh AK, P-Tiwari A, Chaudhary AK. Characterization and potential novel applications of zinc-based traditional medicine, Yashad Bhasma. J Ayurveda Integr Med. 2025;16(5):101188. doi: 10.1016/j.jaim.2025.101188
23. Singh N, Bhalla M, De Jager P, Gilca M. An overview on ashwagandha: A Rasayana (rejuvenator) of Ayurveda. Afr J Tradit Complement Altern Med. 2011;8(5 Suppl):208-13. doi: 10.4314/ajtcam.v8i5S.9
24. Mahajan P, Gnana Oli R, Jachak SM, Bharate SB, Chaudhuri B. Antioxidant and antiproliferative activity of indigocarpan, a pterocarpan from *Indigofera aspalathoides*. J Pharm Pharmacol. 2016;68(10):1331-9. doi: 10.1111/jphp.12609
25. Balasubramani S, Brindha P, Evaluation of wound healing activity of *Indigofera aspalathoides* Vahl. Ex Dc.-a traditional Siddha drug, Int J Pharm Pharm Sci. 2012;4(2):40-4.
26. Chandrakala AN, Reddy AH, Nageswari G, Sri Vani DS, Begum SS, Venkatappa B. Anti venom and immunomodulatory functions of *Corallocarpus epigaeus* L. Int J Pharm Bio Sci. 2013;4(1):654-60.
27. More SK, Lande AA, Jagdale PG, Adkar PP, Ambavade SD. Evaluation of anti-inflammatory activity of *Solanum xanthocarpum* Schrad and Wendl (Kaṇṭakāri) extract in laboratory animals. Anc Sci Life. 2013;32(4):222-6. doi: 10.4103/0257-7941.131976
28. Kang NJ, Han SC, Yoon SH, Sim JY, Maeng YH, Kang HK, Yoo ES. *Cinnamomum camphora* leaves alleviate allergic skin inflammatory responses *in vitro* and *in vivo*. Toxicol Res. 2019;35(3):279-85. doi: 10.5487/TR.2019.35.3.279
29. Priyavardhini S, Vasantha K, Tresina Soris P, Mohan VR. Efficacy of phytochemical and antibacterial activity of *Corallocarpus epigaeus* Hook.f. Int J PharmTech Res. 2012;4:35-43.
30. More NB, Sharma N, Pulivendala G, Bale S, Godugu C. Natural product topical therapy in mitigating imiquimod-induced psoriasis-like skin inflammation-underscoring the anti-psoriatic potential of Nimbolide. Indian J Pharmacol. 2021;53(4):278-85. doi: 10.4103/ijp.IJP_591_20
31. Kang MH, Jang GY, Ji YJ, Lee JH, Choi SJ, Hyun TK, Kim HD. Antioxidant and anti-melanogenic activities of heat-treated licorice (wongam, *Glycyrrhiza glabra* × *G. uralensis*) extract. Curr Issues Mol Biol. 2021;43(2):1171-87. doi: 10.3390/cimb43020083
32. Ghosh A, Tiwari GJ. Role of nitric oxide-scavenging activity of Karanjin and Pongapin in the treatment of psoriasis. 3 Biotech. 2018;8(8):338. doi: 10.1007/s13205-018-1337-5
33. Atarzadeh F, Kamalinejad M, Dastgheib L, Amin G, Jaladat AM,

Nimrouzi M. *Cassia fistula*: A remedy from traditional Persian medicine for treatment of cutaneous lesions of pemphigus vulgaris. Avicenna J Phytomed. 2017;7(2):107-15.
34. Biswas TK, Pandit S, Chakrabarti S, Banerjee S, Poyra N, Seal T. Evaluation of *Cynodon dactylon* for wound healing activity. J Ethnopharmacol. 2017;197:128-37. doi: 10.1016/j.jep.2016.07.065
35. Marwat SK, Rehman F, Khan EA, Baloch MS, Sadiq M, Ullah I, Javaria S, Shaheen S. Review - *Ricinus cmmunis* - ethnomedicinal uses and pharmacological activities. Pak J Pharm Sci. 2017;30(5):1815-27.
36. Varma SR, Sivaprakasam TO, Arumugam I, Dilip N, Raghuraman M, Pavan KB, Rafiq M, Paramesh R. *In vitro* anti-inflammatory and skin protective properties of *Virgin coconut* oil. J Tradit Complement Med. 2018;9(1):5-14. doi: 10.1016/j.jtcme.2017.06.012

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Table 1: Timeline of event

Year	Incidence/Intervention
February 2021	Patient initially developed a dry, scaly patch over the areolar region of the breast, which was associated with intense pruritus. Despite persistent symptoms, the patient did not seek or receive any medical treatment for the subsequent 2–3 months.
April 2021	The lesions progressively extended to involve the cheeks and lips. They were dry, crusted, yellowish, and intensely pruritic, resulting in sleep disturbance. The visible facial lesions caused significant psychological distress, with associated depressive symptoms and social isolation, substantially impairing the patient's quality of life.
June 2021–June 2022	The patient was treated with conventional (allopathic) therapy for one year; however, the lesions persisted without significant clinical improvement.
July 2022–December 2022	Following unsuccessful allopathic treatment, the patient underwent homeopathic treatment for 6 months; however, no significant improvement in the lesions or associated symptoms was observed.
January 12, 2023	The patient presented to the NIA Kaumarbhritya outpatient department for Ayurveda management. On examination, psoriatic lesions were observed over the lips, cheeks, and chest. Considering the presence of *Ama* and *Srotorodha*, the patient was initially prescribed 15-day course of *Amapacana* therapy and a mild laxative to improve digestion, metabolism, restore the patency of the *Srotas,* and eliminate *Dosha* as the part of *Shodan* therapy.
January 28, 2023	Following *Amapacana* and Mild *Shodhan* therapy, patient subsequently received immunomodulatory formulation in combination with other Ayurveda anti-psoriatic medications for 3 months. During the course of management, progressive clinical improvement was observed, with a significant reduction in scaling, crusting, and pruritus involving the face and chest. Relief from itching led to improved sleep quality and overall well-being.
April 29, 2023	The patient received immunomodulatory Ayurveda medications in combination with Ayurveda anti-psoriatic medications for 1 month. At the completion of treatment, complete clinical resolution of scaling and crusting was observed, and the associated post-inflammatory hyperpigmentation had resolved, with restoration of near-normal skin appearance.

Table 2: Therapeutic interventions

Visit	Treatment advised Drug: Dose, frequency, Adjuvant, and time	Duration of medicine
Day of enrolment	• Syp. *Abhyaristha*: 20 mL twice a day with equal amount of water after food. • *Triphala Churna*: 3 g twice a day with Luke warm water	January 12, 2023, to January 28, 2023 (15 days)
1st follow up	• *Abhyarishta* and *Triphala Churna* discontinued • Tab. Psorlyn: one tablet with lukewarm water thrice a day. • Tab. Immunie: one tablet with lukewarm water thrice a day. • Nisoreia soap: for local application • Psorlyn oil: for local application • Lippu oil: for local application	January 28, 2023, to April 29, 2023 (3 month)
2nd follow up	• Tab. Psorlyn: one tablet with lukewarm water thrice a day. • Tab. Immunie: One tablet with lukewarm water thrice a day. • SIVA drops: 10 drops with half a cup of warm water, twice daily. • Nisoreia soap: for local application • Psorlyn oil: for local application • Lippu oil: for local application	April 29, 2023, to May 30, 2023 (1 month)

Table 3: Improvement in symptoms grading, PASI Score, and APso-QOL score

Symptoms	1st visit (January 12, 2023)	After *Shamana* (April 29, 2023)
Aswedanam (No sweating)	+++	-
Mahavastum (Area)	+++	-
Matsysakalopam (fish-scale-like appearance)	+++	-
Kandu (Itching)	+++	+
Rukshata (Dryness)	+++	-
Tvakvaivanyam (Skin Discoloration)	+++	+
Nistoda (Pricking Pain)	++	-
PASI score	6.6	0
APso-QOL-PI	42	18
APSO-QOL-PST	17	04

PASI: Psorasis area severity index, APSO-QOL-PI: Adolescent psoriasis quality of life psychosocial impact; APSO-QOL-PST: Adolescent psoriasis quality of life physical symptoms and treatment

Table 4: Contents of formulations

S. No.	Formulations	Contents
1.	*Triphala Churna*	*Haritaki, Bibhitaki, Amlaki*
2.	Syrup. *Abhyaristha*	*Haritaki, Amalaki, Kapittha, Indravaruni, Vidanga, Pippali, Lodhra, Maricha, Kankola, Water, Guda*
4.	Tab. Psorlyn	*SwetaKutaja, Avalguja, Arushkara, Katuki, Ankot*
5.	Tab. Immunie	*Ashwagandha, Guduchi, Tulasi, Pippali, Yashad Bhasma*
6.	SIVA drops	*Shivanimba, Jyotishmati, Sukanasa, Karpura, Kantakari, Oil*
7.	Lippu oil	*Karanja, Narikela Taila*
8.	Psorlyn oil	*SwetaKutaja, Aragvadh, Durva, Madhuyasthi, Avalguja, Karanja, Nimba, Eranda, Narikela*

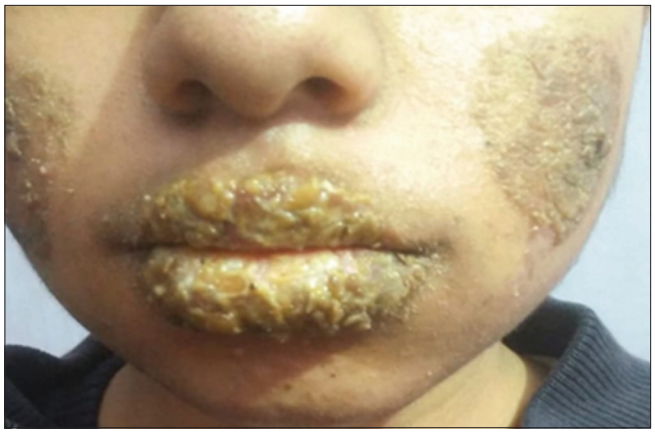

Figure 1: Lesions before treatment

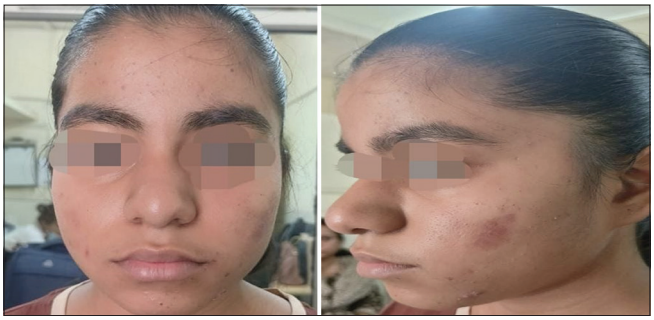

Figure 2: Lesions after treatment