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REVIEW ARTICLE

Ardhavabhedaka in Ayurveda and Its Relationship to Migraine: A Critical Review of Classical Concepts and Contemporary Clinical Evidence

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ABSTRACT

Ardhavabhedaka is a classical Ayurvedic description of a head disorder frequently compared with migraine in contemporary literature. However, the extent of this correspondence and the strength of clinical evidence for Ayurveda-related interventions remain uncertain. This review critically examines classical descriptions of *Ardhavabhedaka*, their relationship to contemporary migraine concepts, and the available clinical evidence on relevant interventions. A critical narrative approach was used to examine classical texts, contemporary diagnostic and pathophysiological perspectives, and published clinical studies. The analysis identifies symptom-level similarities. These include predominantly unilateral head pain, but they do not establish diagnostic equivalence between Ayurvedic and biomedical frameworks. Clinical studies of Ayurvedic formulations, *Nasya*, other therapeutic procedures, and combined *Ayurveda–Yoga* interventions report improvements in selected outcomes. However, methodological limitations, including attrition, small samples, non-randomized designs, heterogeneous interventions, and inconsistent outcome assessment, limit the certainty and generalizability of these findings. Current evidence is insufficient to establish the efficacy and safety of these interventions conclusively. This review contributes a critical synthesis of classical interpretations and contemporary clinical research, highlighting the need for verified textual analysis, rigorous controlled trials, reproducible intervention protocols, validated patient-centered outcomes, and systematic safety monitoring.

1. INTRODUCTION

Migraine is a disabling primary headache disorder characterized by recurrent attacks that can substantially impair daily functioning, social participation, and quality of life. Its consequences extend beyond individual symptoms to wider societal costs, while underdiagnosis and inadequate treatment remain important concerns.[1] Advances in migraine research have clarified aspects of its pathophysiology, including trigeminovascular pathways, calcitonin gene-related peptide (CGRP) signaling, and peripheral and central pain processing.[2] The International Classification of Headache Disorders, third edition (ICHD-3), provides standardized diagnostic criteria for migraine with and without aura, supporting consistent clinical assessment and research classification.[3]

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Within Ayurveda, *Ardhavabhedaka* is classified among the disorders of the head (*śiroroga*). Its classical descriptions interpret the condition through characteristic symptoms and Ayurvedic concepts of *doṣa* involvement and disease pathogenesis. These accounts offer a historically situated framework for understanding head disorders, but their relationship to contemporary migraine remains a question for critical investigation. Similarities in pain location or associated symptoms may support comparison at the descriptive level; they do not, by themselves, establish diagnostic equivalence. Moreover, classical Ayurvedic explanations developed within a distinct theoretical tradition and cannot be assumed to correspond directly to contemporary biomedical mechanisms. Interpretation therefore requires attention to textual context, differences among classical authorities, and the limitations of retrospectively mapping historical descriptions onto modern diagnostic categories.

Clinical research has investigated several Ayurveda-related approaches to migraine, including oral formulations, nasal therapies (*nasya*),

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traditional procedures, and combined *Ayurveda–Yoga* interventions,[4] for example, reported outcomes following a multicomponent Ayurvedic treatment program for migraine without aura. However, interpretation of such findings must account for study design, participant attrition, outcome measurement, follow-up duration, and adverse-event reporting.[5] Reviewing 12 clinical studies published between January 2000 and July 2020 likewise identified methodological limitations in the available literature. Variation in interventions, comparators, and outcome measures further complicates comparisons across studies. Consequently, reported improvements cannot be treated as conclusive evidence of efficacy or generalized to Ayurveda as a whole.

The central gap is therefore twofold: The relationship between classical descriptions of *Ardhavabhedaka* and contemporary migraine criteria requires careful contextual analysis, whereas the clinical evidence for Ayurveda-related interventions requires appraisal according to the quality and limitations of individual studies. Addressing these questions together is necessary to distinguish conceptual comparison from demonstrated clinical benefit. Accordingly, this critical review examines classical Ayurvedic understandings of *Ardhavabhedaka*, their relationship to contemporary migraine concepts, and the available human clinical evidence concerning relevant interventions. It focuses on diagnostic comparability, methodological quality, clinical outcomes, and safety reporting to clarify what current evidence supports and identify priorities for more rigorous interdisciplinary research.

1.1. Aim and Objectives

This critical narrative review aims to examine classical Ayurvedic descriptions of *Ardhavabhedaka*, explore their relationship to contemporary migraine diagnostic criteria and biomedical understanding, and critically evaluate the available clinical evidence on Ayurveda-related interventions. The specific objectives are to: (1) Analyze the clinical features and explanatory frameworks of *Ardhavabhedaka* in selected classical Ayurvedic texts; (2) distinguish symptom-level similarities from conceptual and diagnostic differences between *Ardhavabhedaka* and contemporary migraine; (3) assess published clinical studies of Ayurveda-related interventions in terms of study design, interventions, comparators, reported outcomes, follow-up, and safety reporting; and (4) identify research priorities to improve textual and diagnostic clarity, intervention reproducibility, and the reliability of evidence on clinical effectiveness and safety.

2. REVIEW METHODOLOGY

2.1. Review Design

This article adopts a critical narrative review design to examine *Ardhavabhedaka* in classical Ayurvedic literature, its relationship to contemporary concepts of migraine, and the available clinical evidence on Ayurvedic interventions. The approach integrates textual interpretation with critical examination of biomedical literature and clinical research. It aims to identify conceptual similarities and differences, assess the limitations of the available evidence, and highlight priorities for further investigation. The review is not presented as a systematic review or as Preferred Reporting Items for Systematic Reviews and Meta-Analysis-compliant.

2.2. Sources and Literature Identification

The evidence base comprises classical Ayurvedic texts, contemporary literature on migraine classification and pathophysiology, human clinical studies of Ayurvedic interventions, published reviews, and safety-related literature. The available evidence bank contains sources identified during an initial literature search. However, a complete search log documenting databases, search platforms, search dates, search strategies, and supplementary retrieval methods was unavailable for verification. The literature identification process therefore cannot be considered fully reproducible or exhaustive.

2.3. Eligibility and Source Selection

Sources were considered relevant if they addressed at least one of four areas: classical descriptions of *Ardhavabhedaka*; contemporary diagnostic criteria or pathophysiology of migraine; clinical evaluation of Ayurvedic formulations, procedures, or combined interventions; and treatment-related safety. However, the available documentation does not establish prespecified formal eligibility criteria or a complete record of title, abstract, and full-text screening. Accordingly, no screening counts or claims of independent duplicate screening are reported. Sources with incomplete bibliographic information or limited accessible evidence were interpreted cautiously, and unverified details were not assumed.

2.4. Evidence Organization and Critical Synthesis

Classical texts were examined for descriptions of the condition. Clinical features, doṣa involvement, pathogenetic explanations, and traditional management were examined. Contemporary clinical studies were considered in relation to study design, participant characteristics, interventions, comparators, outcome measures, reported findings, follow-up, and adverse event reporting.

The synthesis followed a thematic approach, focusing on differences and similarities between classical Ayurvedic descriptions and contemporary migraine concepts, the methodological strengths and limitations of clinical studies, variation among interventions, and gaps in safety reporting. Attention was given to diagnostic comparability, sample size, participant attrition, outcome assessment, and the distinction between reported clinical improvement and established treatment efficacy. Classical textual descriptions were distinguished from findings derived from human clinical research. No formal risk-of-bias instrument or evidence-certainty grading framework is claimed because the use of such methods was not documented.

These methodological limitations should be considered when interpreting the review's conclusions. The synthesis provides a critical overview of the available literature rather than an exhaustive or quantitatively pooled estimate of the effectiveness or safety of Ayurvedic interventions for migraine.

3. CLASSICAL AYURVEDIC UNDERSTANDING OF *ARDHAVABHEDAKA*

3.1. Definition and Classical Description

Ardhavabhedaka is classified among the *śiroroga* (disorders of the head) in classical Ayurvedic literature and is characterized by severe pain affecting one half of the head. *Caraka* discusses the condition in *Siddhi Sthāna* 9.74–78, whereas *Suśruta* describes it in *Uttara Tantra*, Chapter 25.[6,7] The *Caraka* tradition associates it with aggravated *vāta*, alone or in combination *with kapha,* whereas *Suśruta* describes the involvement of all three *doṣas*. Although unilateral head pain provides a basis for comparison with migraine, this feature alone does not establish diagnostic equivalence.

3.2. *Nidāna:* Etiological Factors

The *Caraka* account identifies factors associated with *vāta* aggravation, dry or unctuous substances (*rūkṣa*), excessive eating (*atyadhyaśana*),

exposure to easterly winds and dew, sexual activity (*maithuna*), suppression of natural urges (*vegasandhāraṇa*), exhaustion (*āyāsa*), and exercise (*vyāyāma*).[6] These factors should be interpreted within their classical explanatory framework rather than treated as established biomedical causes of migraine. Any proposed relationship with contemporary dietary, behavioral, or environmental factors requires independent empirical evidence.

3.3. *Samprāpti:* Classical Pathogenetic Explanation

In the *Caraka* tradition, aggravated *vāta*, either independently or with *kapha*, is associated with pain affecting one half of the head and adjacent regions, including the neck (*manyā*), eyebrows (*bhrū*), temples (*śaṅkha*), ears (*karṇa*), eyes (*akṣi*), and forehead (*lalāṭārdha*).[6] *Suśruta* presents a different interpretation involving all three *doṣas*.[7] These explanations belong to the Ayurvedic conceptual framework and should not be equated directly with biomedical mechanisms involving trigeminovascular pathways or CGRP.

3.4. *Doṣic* Interpretation across Classical Texts

The *Aṣṭāṅga Hṛdaya* also discusses *Ardhavabhedaka* within its account of head disorders, with the relevant passage identified in *Uttara Sthāna* 23.7–8.[8] Differences among classical accounts warrant comparative examination of their wording, textual context, and commentarial interpretations. They should not be reconciled into a single explanatory model without adequate textual justification.

3.5. *Lakṣaṇa:* Clinical Features

Severe unilateral head pain and its extension to adjacent anatomical regions are prominent features of the classical description. Contemporary migraine diagnosis, however, requires consideration of attack duration, associated symptoms, recurrence, and other specified criteria.[3] Accordingly, *Ardhavabhedaka* may be compared with migraine based on selected clinical features, but the available descriptions alone do not establish that the conditions are diagnostically equivalent.

3.6. Classical Management

Caraka describes therapeutic measures for *Ardhavabhedaka* in *Siddhi Sthāna* 9.77–78, including *catuḥ*-sneha, purificatory procedures, *nāḍī-sveda*, aged ghee, *basti, anuvāsana, upanāha, śirobasti,* and *dahana*. These recommendations represent classical therapeutic practice; their inclusion in a text does not independently establish contemporary efficacy or safety. Classical therapeutic recommendations require critical appraisal against primary clinical evidence, including study design, comparators, outcomes, and adverse-event reporting.

3.7. Critical Synthesis

Classical Ayurvedic sources characterize *Ardhavabhedaka* principally through severe unilateral head pain but differ in their interpretation of *doṣic* involvement. These differences should be preserved and examined within their respective textual contexts. Although selected features overlap with migraine, descriptive similarity does not establish diagnostic equivalence, shared pathophysiology, or therapeutic effectiveness. A critical review must therefore distinguish classical textual accounts from contemporary diagnostic standards and clinical evidence when evaluating the potential relevance, efficacy, and safety of Ayurvedic interventions.

4. CONTEMPORARY UNDERSTANDING OF MIGRAINE

4.1. Definition and Clinical Classification

Migraine is a primary headache disorder characterized by recurrent headache attacks and associated neurological or sensory symptoms. It can substantially affect daily functioning and quality of life. The ICHD-3 distinguishes migraine without aura, migraine with aura, and chronic migraine. Chronic migraine is characterized by headache occurring on at least 15 days per month for more than 3 months, with migraine features on at least 8 days per month.

4.2. Pathophysiology

Migraine involves complex interactions. These include neural signaling, sensory processing, and pain-modulating pathways. The trigeminovascular system contributes to migraine-associated pain, whereas CGRP has substantial mechanistic and therapeutic support as an important mediator. The effectiveness of CGRP-targeting therapies further supports its clinical relevance.[9] Other processes, including central sensitization and cortical spreading depolarization, contribute to current explanatory models, although their roles vary across clinical manifestations. These biomedical mechanisms should not be directly equated with Ayurvedic concepts such as *doṣa* without independent supporting evidence.

4.3. Clinical Features and Diagnostic Criteria

Migraine commonly presents with a moderate-to-severe headache that may be unilateral, pulsating, and aggravated by routine physical activity. Nausea, vomiting, photophobia, and phonophobia are frequently associated symptoms.

Under ICHD-3, migraine without aura requires at least five attacks. lasting 4–72 h, with at least two characteristic headache features – unilateral location, pulsating quality, moderate or severe intensity, or aggravation by routine activity – and either nausea and/or vomiting or both photophobia and phonophobia. A migraine with aura involves recurrent attacks. It features fully reversible neurological symptoms, commonly visual, sensory, or speech and language disturbances.

Although *Ardhavabhedaka* and migraine may share features such as unilateral head pain, symptomatic resemblance alone does not establish diagnostic equivalence. Their comparison must account for differences in historical context, diagnostic frameworks, and the evidence available.

4.4. Current Treatment Approaches

Migraine management includes acute treatment to relieve attacks and preventive treatment to reduce their frequency and burden. Acute options include analgesics, non-steroidal anti-inflammatory drugs, and triptans; selected migraine-specific medicines may also be appropriate. Preventive options include established pharmacological agents, onabotulinumtoxin A for chronic migraine, and CGRP-targeting therapies. The American Headache Society recognizes CGRP-targeting therapies as a first-line preventive option. Patient education, regular sleep and meal patterns, physical activity, and behavioral interventions may complement medical care. Frequent use of certain acute medicines can contribute to medication-overuse headache.

For this review, contemporary migraine management provides a framework for evaluating Ayurvedic interventions. Their efficacy and safety require appropriate diagnostic criteria, robust study designs, clinically relevant outcomes, and systematic adverse-event reporting.

Neither symptom improvement nor historical resemblance alone establishes therapeutic efficacy or mechanistic correspondence.

5. CONTEMPORARY CLINICAL EVIDENCE ON AYURVEDIC INTERVENTIONS FOR MIGRAINE

5.1. Evidence on Ayurvedic Formulations

Vaghela *et al*. reported a randomized clinical trial involving 150 registered patients[10] assigned across four arms: Oral *Laghu Sutashekhara Rasa, Brihat Dashamoola Taila Nasya,* placebo, and Go-ghrita Nasya. However, the abstract favored oral *Laghu Sutashekhara Rasa,* group-specific estimates, and methodological details that require full-text verification. By comparison, Vaidya *et al*. reported outcomes after 90 days of a multicomponent Ayurvedic regimen with dietary and lifestyle measures. Only 204 of 406 patients completed the uncontrolled study, limiting causal interpretation.

5.2. Evidence on Panchakarma-based Interventions

Clinical evidence includes *Nasya* studies and a pilot study of *Agnikarma* with *Pathyadi* decoction. A double-blind trial randomized 90 participants to low- or medium-viscosity *Vrihatajivakadya* oil. However, verified between-group effect estimates and detailed safety findings were unavailable in the evidence bank. The findings of the *Agnikarma* study likewise require full-text verification; neither intervention should be considered effective based on its study description alone.

5.3. Evidence on Lifestyle and Dietary Interventions

Lifestyle and dietary measures formed part of Vaidya *et al*.'s multicomponent regimen but were not independently evaluated. A non-randomized study compared 30 participants receiving purgation followed by Yoga with 30 controls continuing symptomatic treatment over 90 days; related reports describe quality-of-life and disability-related outcomes but may represent overlapping participants.[11,12] Improvements were reported in the intervention group, but the combined intervention and non-randomized design prevent attribution to Yoga or Ayurveda separately. The characteristics, reported findings, and methodological limitations of the selected clinical studies and trial protocol are summarised in Table 1.

5.4. Clinical Outcomes and Safety

The studies differ in intervention, comparator, outcome assessment, and follow-up, precluding direct comparison of their results. Although one trial abstract reported no adverse drug reactions, incomplete safety reporting does not establish safety. Overall, the evidence is preliminary: clinical signals warrant further investigation, but attrition, design limitations, heterogeneous interventions, and incomplete reporting restrict conclusions about efficacy and safety.

6. DISCUSSION

6.1. Classical Concepts and Contemporary Evidence

Classical descriptions of *Ardhavabhedaka* provide a historically situated framework for understanding head disorders in Ayurveda. The *Suśruta Saṃhitā* describes the condition within its account of diseases of the head, offering a basis for examining pain location and associated clinical features. These descriptions may inform contemporary research questions, but their interpretation depends on careful textual verification and attention to the concepts in their original context. In particular, the Ayurvedic constructs of *doṣa* and *samprāpti* should not be treated as direct equivalents of biomedical disease mechanisms.

The principal point of comparison with migraine is symptom-level resemblance, particularly predominantly unilateral head pain. However, this overlap does not establish diagnostic equivalence. Contemporary migraine diagnosis relies on defined attack characteristics, duration, associated symptoms, and clinical history, as specified in the ICHD. Similarly, contemporary accounts involving trigeminovascular pathways and CGRP signaling provide a biomedical explanation of migraine; they do not independently validate classical Ayurvedic theories. The value of comparison therefore lies in generating testable questions, not in assuming that the two explanatory systems are interchangeable.

Clinical evidence for Ayurveda-related interventions remains inconclusive overall, although some studies report improvements in selected outcomes. Vaidya *et al*. reported improvement following a multicomponent regimen, yet the uncontrolled design, substantial attrition, and accompanying lifestyle advice limit causal interpretation. Vaghela *et al*. conducted a randomized clinical trial, although its comparative findings require appraisal against the full methods and results. A double-blind trial compared low- and medium-viscosity *Vrihatajivakadya* oil Nasya; because both groups received active preparations, the comparison cannot establish efficacy against placebo or usual care.[13] Likewise, the pilot study of *Agnikarma* combined with *Pathyadi* decoction reported symptom improvement, but its small sample and combined intervention limit generalization.[14] These findings should be interpreted individually rather than pooled conceptually into a single claim about Ayurveda.

Differences in diagnostic procedures, sample size, allocation, blinding, comparators, treatment duration, outcome measures, and follow-up further constrain comparison across studies. Statistical significance does not necessarily indicate clinically meaningful or sustained benefit. Safety conclusions are also limited when adverse events, treatment discontinuations, product composition, and potential interactions are incompletely assessed. Reports of contamination in some marketed Ayurvedic products reinforce the importance of quality assurance, without implying that all such products carry the same risk.[18] The conceptual relationship and interpretive boundaries between the classical Ayurvedic and contemporary biomedical frameworks are illustrated in Figure 1.

Future interdisciplinary research should combine verified textual analysis with reproducible migraine diagnostic criteria, clearly specified interventions, appropriate control groups, validated measures of headache frequency and disability, adequate follow-up, and systematic safety monitoring. This approach would allow researchers to investigate the clinical relevance of classical concepts while evaluating specific interventions on their own evidence. The central task is not to prove equivalence between traditional and biomedical models but to determine precisely where meaningful comparison is possible and what reliable clinical conclusions the available evidence supports.

7. RESEARCH GAPS AND FUTURE DIRECTIONS

7.1. Diagnostic and Textual Clarity

Exact classical passages require edition-level verification, whereas clinical studies need clearer diagnostic criteria. Future research should map classical descriptions against ICHD-3 criteria without assuming diagnostic equivalence.

7.2. Stronger Trial Designs

The evidence includes substantial attrition in an uncontrolled study, non-randomized combined interventions, and trials requiring fuller methodological appraisal. Adequately powered controlled studies, transparent allocation, appropriate comparators, and longer follow-up are needed. The Ayush M-3 study is a published protocol, not evidence of efficacy.[17]

7.3. Intervention Reproducibility

Studies examine different formulations, *Nasya* procedures, and combined treatments. Detailed reporting of composition, dosage, administration, co-interventions, and adherence is necessary for replication and meaningful comparison.

7.4. Patient-centered Outcomes

Heterogeneous outcome measures limit cross-study interpretation. Trials should report monthly migraine days, attack frequency, disability, acute-medication use, and validated quality-of-life measures, alongside effect estimates and confidence intervals.

7.5. Safety and Interdisciplinary Integration

Incomplete adverse-event reporting warrants systematic monitoring and product-quality assessment. Collaboration between Ayurvedic scholars and clinical researchers should preserve classical concepts in their textual context while evaluating specific interventions using contemporary research standards.

These priorities would improve diagnostic clarity, reproducibility, and confidence in clinical conclusions without overstating the existing evidence.

8. CONCLUSION

Ardhavabhedaka represents a classical Ayurvedic framework for understanding head disorders, with selected symptom-level similarities to contemporary descriptions of migraine. However, these similarities do not establish diagnostic equivalence or demonstrate that Ayurvedic and biomedical explanatory frameworks are interchangeable. Meaningful comparison requires contextual interpretation of classical texts alongside clearly defined contemporary diagnostic criteria.

Clinical evidence on Ayurveda-related interventions remains preliminary and inconclusive. Although some studies report improvements in headache symptoms, disability, or quality of life, substantial attrition, small samples, non-randomized designs, heterogeneous interventions, and inconsistent outcome assessment limit the reliability and generalizability of these findings. Current evidence is insufficient to establish efficacy and safety conclusively.

This review highlights the importance of distinguishing classical conceptual descriptions from symptom-level similarities and demonstrated clinical outcomes. Its narrative approach and incomplete verification of some textual references and clinical study details limit the comprehensiveness of the synthesis. Future research should integrate rigorous textual analysis with well-designed controlled trials, reproducible intervention protocols, validated patient-centered outcomes, adequate follow-up, and systematic safety monitoring. Such research may clarify the clinical relevance of specific Ayurveda-related interventions without presuming equivalence between Ayurvedic and biomedical frameworks.

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10. AUTHORS' CONTRIBUTIONS

All authors have read and approved the final version of the manuscript.

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12. ETHICAL STATEMENT

Ethical approval was not required for this study, as it was a review article with data obtained through a literature search.

13. CONFLICTS OF INTEREST

The authors declare no conflicts of interest in relation to the publication of this paper.

14. DATA AVAILABILITY STATEMENT

The data analyzed in this review were obtained from publicly available sources, including peer-reviewed articles, observational studies, and classical Ayurvedic texts.

15. 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.

16. 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.

17. PUBLISHERS' NOTE

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REFERENCES

1. World Health Organization. Migraine and other Headache Disorders; 2025. Available from: https://www.who.int/news-room/fact-sheets/detail/headache-disorders [Last accessed on 2026 Jul 25].
2. Russo AF, Hay DL. CGRP physiology, pharmacology, and therapeutic targets: Migraine and beyond. Physiol Rev. 2023;103(2):1565-644. doi: 10.1152/physrev.00059.2021
3. Headache classification committee of the international headache society (IHS) the international classification of headache disorders 3rd edition. Cephalalgia. 2018;38(1):1-211. doi: 10.1177/0333102417738202
4. Vaidya PB, Vaidya BS, Vaidya SK. Response to ayurvedic therapy in the treatment of migraine without aura. Int J Ayurveda Res.

2010;1(1):30-6. doi: 10.4103/0974-7788.59941
5. Soman A, Venkatram S, Chikkanna U, Ramakrishna KK, Bhargav H, Mailankody P, Varambally S. Ayurveda for management of migraine: A narrative review of clinical evidence. J Family Med Prim Care. 2022;11(8):4228-35. doi: 10.4103/jfmpc.jfmpc_2109_21
6. Sharma RK, Dash VB, editors. Caraka saṃhitā. Vol. 6. Original work published c 1st Millennium BCE. Varanasi: Chowkhamba Sanskrit Series Office; 2012.
7. Murthy PK, Uttara tantra. Śiro-roga vijñānīya. Translator. Suśruta saṃhitā. Vol. 3., Ch. 25. Varanasi: Chaukhambha Orientalia; 2012.
8. Murthy KRS. Uttara sthāna. Translator. Aṣṭāṅga hṛdaya. Ver. 7-8., Vol. 3., Ch. 23. Varanasi: Chowkhamba Krishnadas Academy; 2000.
9. Charles AC, Digre KB, Goadsby PJ, Robbins MS, Hershey A. Calcitonin gene-related peptide-targeting therapies are a first-line option for the prevention of migraine: An American headache society position statement update. Headache. 2024;64(4):333-41. doi: 10.1111/head.14692
10. Vaghela DB, Mata S, Dhiman KS, Manjusha R. A randomized clinical trial on ardhavabhedaka-migraine and its ayurvedic management. Int J Ayurvedic Med. 2016;7(1):74-80. doi: 10.47552/ijam.v7i1.721
11. Sharma VM, Manjunath NK, Nagendra HR, Ertsey C. Combination of Ayurveda and Yoga therapy reduces pain intensity and improves quality of life in patients with migraine headache. Complement Ther Clin Pract. 2018;32:85-91. doi: 10.1016/j.ctcp.2018.05.010
12. Vasudha MS, Manjunath NK, Nagendra HR. Changes in MIDAS, perceived stress, frontalis muscle activity and non-steroidal anti-inflammatory drugs usage in patients with migraine headache without aura following Ayurveda and yoga compared to controls: An open labeled non-randomized study. Ann Neurosci. 2019;25(4):250-60. doi: 10.1159/000492269
13. Kanakhara B, Chaudhari V. A pilot study on clinical efficacy of agnikarma and pathyadi decoction (an ayurvedic formulation) in the management of ardhavabhedaka (migraine). Ayu. 2018;39(1):56-61. doi: 10.4103/ayu.AYU_84_17
14. Singh SK, Rajoria K, Kumar A, Sharma S. A double-blind controlled clinical trial to evaluate the effects of nasal therapy with Vrihatajivakadya oil on different viscosities in patients with migraine. J Ayurveda Integr Med. 2023;14(2):100662. doi: 10.1016/j.jaim.2022.100662
15. Vishwas SK, Sharma KK, Srivastava AK. A randomized controlled open clinical study to evaluate the efficacy of Nagara Ksheera Nasya in the management of Ardhavabhedaka with special reference to migraine. Res Rev J Ayurvedic Sci Yoga Naturopathy. 2023;10(1):18-32.
16. Saini SB, Agrawal SK. A randomised clinical trial to evaluate the preventive effect of Anutaila Pratimarsha Nasya with and without Badama Paka in Ardhavabhedaka WSR to chronic migraine. J Ayurveda. 2025;19(3):236-43. doi: 10.4103/joa.joa_206_21
17. Chaudhary S, Khanduri S, Mata S, Rao BC, Anand KS, Kumar RK, Kumari KS, Mahajan B, Rana RK, Singhal R, Mata S, Makhija R, Bharti, Srikanth N, Dhiman KS, Acharya R. Randomized double blind placebo controlled multicentric clinical trial of Ayush M-3 in the management of migraine- a study protocol. J Ayurveda Integr Med. 2025;16(2):101054. doi: 10.1016/j.jaim.2024.101054
18. Saper RB, Kales SN, Paquin J, Burns MJ, Eisenberg DM, Davis RB, Phillips RS. Heavy metal content of ayurvedic herbal medicine products. JAMA. 2004;292(23):2868-73. doi: 10.1001/jama.292.23.2868

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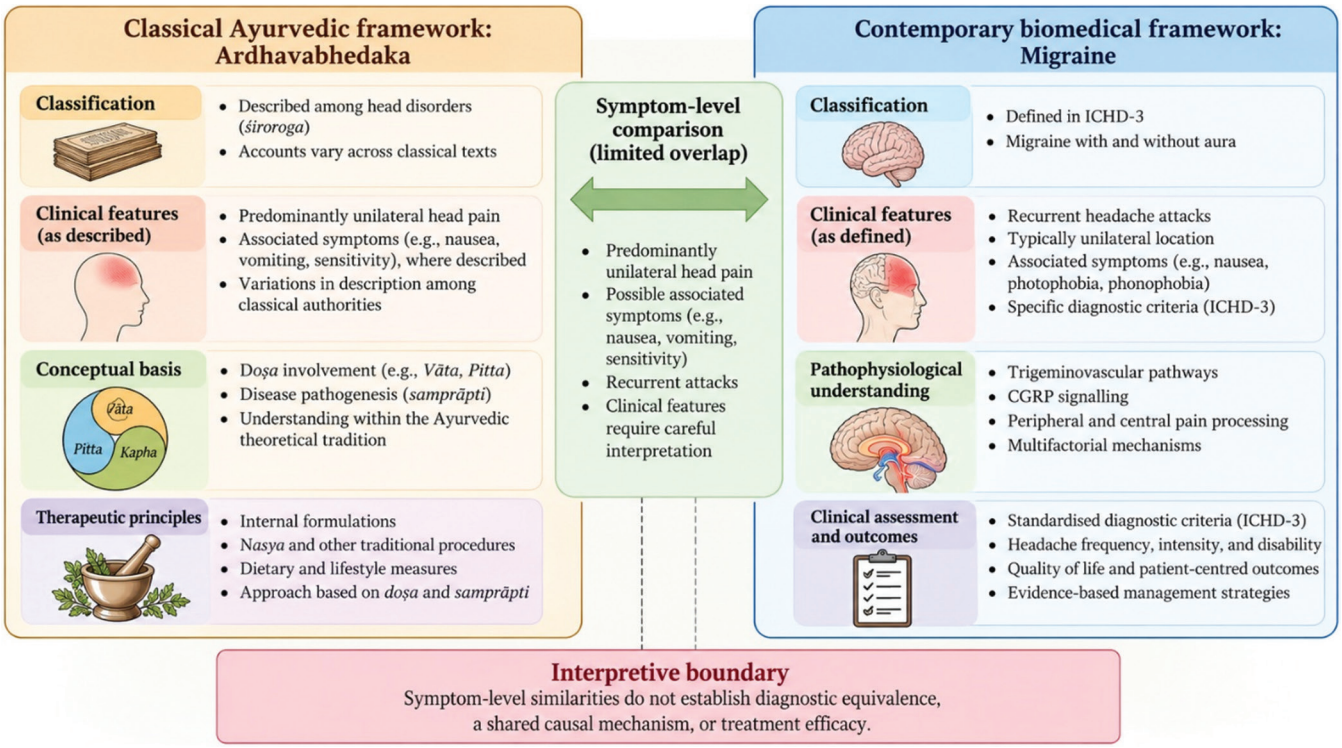

Figure 1: Classical Ayurvedic and contemporary biomedical frameworks for *Ardhavabhedaka* and Migraine: Areas of symptom-level comparison and interpretive boundaries

Table 1: Characteristics and critical appraisal of selected clinical studies and one trial protocol

Study	Design and sample	Intervention/Comparator	Findings available	Principal limitation
Vaidya *et al*. (2010) [4]	Uncontrolled, open-label study; 406 offered treatment, 204 completed 90 days	Five-medicine Ayurvedic regimen plus dietary and lifestyle advice; no control group	Improvements were reported among completers	Substantial attrition; effects cannot be attributed to individual components or separated from lifestyle advice
Ayurveda–Yoga study (2018)[11]	Open-label, non-randomized; 60 participants	Therapeutic purgation followed by Yoga versus continued symptomatic NSAID treatment	Abstract reports improvement in pain, symptoms, and quality of life in the intervention group	Combined intervention and non-randomized design prevent attribution to a specific component
Ayurveda–Yoga outcomes study (2019)[17]	Open-label, non-randomized; 30 intervention and 30 control participants	Ayurveda–Yoga intervention versus NSAID-based symptomatic treatment	Abstract reports changes in disability, perceived stress, physiological measures, and frontalis muscle activity	May involve an overlapping cohort with the related 2018 study; do not count as independent evidence without verification
Kanakhara and Chaudhari (2018)[13]	Pilot clinical study; sample details require verification	*Agnikarma* plus *Pathyadi* decoction	The study investigated this combined intervention; specific results need confirmation from the full text	Pilot design; sample, comparator, and effect estimates require verification
Vrihatajivakadya oil Nasya trial (2023)[14]	Double-blind controlled trial; 90 randomized according to the evidence bank	Low- versus medium-viscosity nasal oil	Between-group findings and outcome estimates need full-text extraction	Two active preparations do not establish efficacy versus placebo or usual care
Vishwas *et al*. (2023)[15]	Open clinical study; 40 participants, 20 per group	Nagara *Ksheera Nasya* versus valproic acid	Abstract reports improvement in both groups and favors Nasya for some reported symptoms	Small sample, open-label design, short follow-up, and comparative results requiring verification
Saini and Agrawal (2025)[16]	Clinical trial record; detailed methods and results not verified	Anutaila *Pratimarsha Nasya* with versus without *Badama Paka*	Reliable efficacy findings are not available in the reviewed record	Do not infer results from the title; full text needed
Ayush M-3 trial protocol (2025)[17]	Planned multicenter, randomiszed, double-blind, placebo-controlled trial; 360 intended participants	Ayush M-3 versus placebo	Planned outcomes include headache frequency, intensity, disability, quality of life, and rescue-medication use	Protocol only – not completed efficacy evidence

NSAID: Non-steroidal anti-inflammatory drug