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Ayurvedic management of chronic rhinitis (*Vata-Kaphaja Pratishyaya*) in an eleven-year-old boy with *pratimarsha nasya* and *shamana chikitsa*: A case study

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ABSTRACT

Background: Chronic rhinitis in children disturbs sleep, school performance and quality of life, and conventional treatment relies on long-term antihistamines and nasal steroids. In Ayurveda, a chronic course with sneezing, watery discharge and cough with expectoration corresponds to *Vata-Kaphaja Pratishyaya*.

Aim and objectives: To document the Ayurvedic management of an eleven-year-old boy with chronic rhinitis and to describe the clinical and laboratory response over 28 days.

Observations: The boy had a two to three year history of running nose, recurrent sneezing and cough with expectoration. Baseline total nasal symptom score was 10 of 12, absolute eosinophil count 720 cells per microlitre, serum total immunoglobulin E 310 kIU per litre and nasal smear eosinophils 15 percent. Radiography of the paranasal sinuses showed turbinate hypertrophy and mild maxillary mucosal thickening. He was admitted for four days and received *Gojihvadi kwatha* orally, *Pratimarsha nasya* with *Anu taila*, steam inhalation with *arka* of *Tulsi*, *Vasa* and *Nilgiri*, and *Sitopaladi churna* with honey, along with dust avoidance and dietary advice.

Main findings: The symptom score fell to 6, 3 and 0 on days 7, 14 and 28. Cough resolved by day 14. Eosinophil count fell to 380 cells per microlitre and immunoglobulin E to 185 kIU per litre on day 28. Oral medicines were stopped and daily *Nasya* was continued as a preventive measure.

Conclusion: Symptoms and allergic markers improved alongside the Ayurvedic regimen. However, the single uncontrolled case, the concurrent avoidance measures and the

absence of allergen-specific testing preclude attributing the change to the treatment.

Keywords: Chronic rhinitis, *Pratishyaya*, *Pratimarsha nasya*, *Anu taila*, *Sitopaladi churna*, Total nasal symptom score, *Kaumarabhritya*, Case study

INTRODUCTION

Chronic rhinitis is among the commonest reasons for paediatric consultation, and in most children it has an allergic basis. Persistent sneezing, rhinorrhoea and nasal obstruction impair sleep and school performance, and the condition is classified by duration (intermittent or persistent) and by severity, according to effect on sleep and daily activity [1,2]. Guideline-based care consists of allergen avoidance, intranasal corticosteroids, antihistamines and, in selected children, allergen immunotherapy [3,4]. Because treatment is often prolonged, families commonly look for complementary options.

The burden is considerable. The International Study of Asthma and Allergies in Childhood documented wide variation in the prevalence of rhinoconjunctivitis between centres and changing trends over time [5]. Surveys of children and adolescents report that rhinitis disturbs sleep, causes daytime fatigue, impairs concentration and increases school absence [6,7]. Rhinitis also commonly coexists with asthma, and the nose and lower airway are regarded as one united airway, so poorly controlled nasal disease is a concern beyond nasal symptoms [8,9].

In Ayurveda the nose is regarded as the gateway of the head, and disease at this site is described as *Pratishyaya*. Five types are described according to the *Dosha* involved, and a neglected or recurrent illness may progress to *Dushta Pratishyaya* [10]. *Nasya* is the principal therapy for disorders above the clavicle, and *Pratimarsha nasya*, a light daily instillation of oil, is used for routine maintenance [11,12]. This article describes the Ayurvedic management of a boy with a chronic course, with clinical and laboratory follow-up to day 28.

MATERIALS AND METHODS

Study design and ethics

This is a descriptive single-patient case study compiled from the in-patient record of the paediatric (*Balroga*) in-patient department of Y.M.T. Ayurvedic Medical College and Charitable Hospital, Navi Mumbai, and from follow-up reviews. Reporting follows the CARE guidelines [13]. Name, address and registration numbers are omitted. Written informed consent for publication was obtained from the parent of the patient.

Patient information and clinical findings

An eleven-year-old boy was admitted on 4 June 2026 and discharged on 8 June 2026, a stay of four days. He had had a running nose for two to three years with recurrent sneezing and cough with expectoration. He had no history of hypertension, diabetes mellitus, ischaemic heart disease, tuberculosis, rheumatoid arthritis, thyroid disorder or asthma, and no previous surgery. Heart rate was 99 per minute, respiratory rate 21 per minute and oxygen saturation 98 to 99 percent. The respiratory system was clear, heart sounds were normal, the child was conscious and oriented, and the abdomen was soft and non-tender. Nasal examination

showed no deviated septum and no inflammation of the inferior turbinates. He was haemodynamically stable at discharge. Duration of individual episodes, family history of atopy, allergen triggers, school attendance and previous treatment were not recorded.

Diagnostic assessment

The diagnosis was chronic rhinitis (International Classification of Diseases code J31.0), and *Vata-Kaphaja Pratishyaya* in Ayurvedic terms. Investigations were complete blood count with absolute eosinophil count, serum total immunoglobulin E, nasal smear for eosinophils and radiography of the paranasal sinuses (Water view). Disease severity was graded with the total nasal symptom score, which sums four nasal symptoms each rated from 0 to 3, giving a range of 0 to 12 [14].

Ayurvedic assessment

The authors prepared an Ayurvedic assessment from the recorded features and the avoidance advice given (Table 1). It was made for this report and was not part of the original record. The recorded features of sneezing, watery *rhinorrhoea* and nasal congestion point to *Vata* and *Kapha*, and the cough with expectoration points to *Kapha* in the *Pranavaha srotas*.

Table 1. Ayurvedic assessment (authors' interpretation)

Element	Assessment
Probable *Nidana*	Exposure to cold and to direct air, cold water, cold, sour and heavy food, and dust (*Rajas*); inferred from the avoidance advice, as specific factors were not recorded
Dosha	*Vata* and *Kapha*; sneezing and watery discharge indicate *Vata*, while thick discharge, congestion and cough with expectoration indicate *Kapha*
Dushya	*Rasa dhatu* and *Kapha*
Srotas and *Srotodushti*	*Pranavaha srotas*, with obstruction (*Sanga*) of the nasal passage
Adhishthana	*Nasa* and *Shiras*
Course	Chronic *Vata-Kaphaja Pratishyaya* of two to three years, with a tendency towards *Dushta Pratishyaya*

Therapeutic intervention

The regimen comprised *Gojihvadi kwatha* syrup orally, *Pratimarsha nasya* with *Anu taila*, steam inhalation with *arka* (distillate) of *Tulsi* (*Ocimum tenuiflorum*), *Vasa* (*Justicia adhatoda*) and *Nilgiri* (*Eucalyptus*

globulus) leaves, and *Sitopaladi churna* with honey (Table 2). *Sitopaladi churna* is a compound of *Sita*, *Vamshalochana*, *Pippali*, *Ela* and *Twak* [15]. The child was advised to avoid direct air, cold water, dust exposure and cold, sour or heavy food, to wear a mask outdoors and to drink warm water. Reviews were held on days 7, 14 and 28, counted from admission.

Table 2. Treatment protocol as recorded

Component	Dose and schedule	Course and intended action
Gojihvadi kwatha syrup	5 ml twice daily after meals	Continued to day 28, then stopped; *Kapha-Vatahara*, to reduce congestion, discharge and sneezing
Pratimarsha nasya with *Anu taila*	2 drops in each nostril, morning and evening, on an empty stomach	Continued daily after day 28 as a preventive measure; clears nasal passages and reduces mucosal irritation
Steam inhalation with *arka* of *Tulsi*, *Vasa* and *Nilgiri*	5 minutes once daily at bedtime	Advised to be maintained at day 7; not listed in the day 28 plan; liquefies secretions and relieves congestion
Sitopaladi churna with honey	1 to 2 g with 1 teaspoon honey, twice daily	Reduced to once daily at night from day 14; stopped on day 28; for cough with expectoration
General advice	Avoid direct air, cold water and dust; wear a mask; warm water; avoid cold, sour and heavy food	Throughout

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RESULTS

At baseline the total nasal symptom score was 10 of 12, indicating severe impairment from recurrent sneezing, persistent *rhinorrhoea* and nasal congestion. Haemoglobin was 12.8 g/dL and total leucocyte count 9,200 per cubic mm. The absolute eosinophil count was elevated at 720 cells per *microlitre*, serum total immunoglobulin E was 310 *kIU* per *litre*, and the nasal smear showed 15 percent eosinophils. The radiograph showed bilateral inferior turbinate hypertrophy and mild mucosal thickening of the maxillary sinuses, without air-fluid levels or frank opacification (Table 3).

Table 3. Investigations at baseline and day 28

Investigation	Day 1	Day 28
Haemoglobin	12.8 g/dL	Not repeated
Total leucocyte count	9,200 per cubic mm	Not repeated
Absolute eosinophil count	720 cells per *microlitre* (elevated)	380 cells per *microlitre*
Serum total immunoglobulin E	310 kIU per litre (elevated)	185 kIU per litre
Nasal smear for eosinophils	15 percent	Not repeated
Radiograph of paranasal sinuses (Water view)	Bilateral inferior turbinate hypertrophy; mild maxillary mucosal thickening; no air-fluid levels or opacification	Not repeated

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On day 7 the frequency of morning sneezing bouts had fallen by about 40 percent, rhinorrhoea had changed from profuse and watery to minimal and thicker, sleep had improved mildly, and the score was 6 of 12. On day 14 nasal patency was markedly better, the cough with expectoration had resolved, there were no severe exacerbations even in the morning, and the score was 3 of 12. *Sitopaladi churna* was tapered to once daily at night. On day 28 the child was asymptomatic with a normal breathing pattern, and the score was 0 of 12 (Table 4, Figure 1). Absolute eosinophil count was 380 cells per microlitre, a fall of 47 percent, and serum total immunoglobulin E was 185 kIU per litre, a fall of 40 percent. Oral medicines were stopped, and daily *Pratimarsha nasya* was continued as a preventive measure. No adverse event was reported in the case record. The nasal smear and radiograph were not repeated.

Table 4. Clinical progression

Day	Nasal symptom score	Clinical assessment	Treatment decision
1	10 of 12	Recurrent sneezing, persistent rhinorrhoea, nasal congestion, cough with expectoration	Regimen started
7	6 of 12	Morning sneezing bouts reduced by about 40 percent; rhinorrhoea minimal and thicker; sleep mildly improved	Regimen continued; dust avoidance and steam inhalation reinforced
14	3 of 12	Marked nasal patency; cough resolved; no severe exacerbation	*Sitopaladi churna* tapered to once daily at night; *Nasya* and *kwatha* continued
28	0 of 12	Asymptomatic; normal breathing pattern; haemodynamically stable	Oral medicines stopped; daily *Nasya* continued

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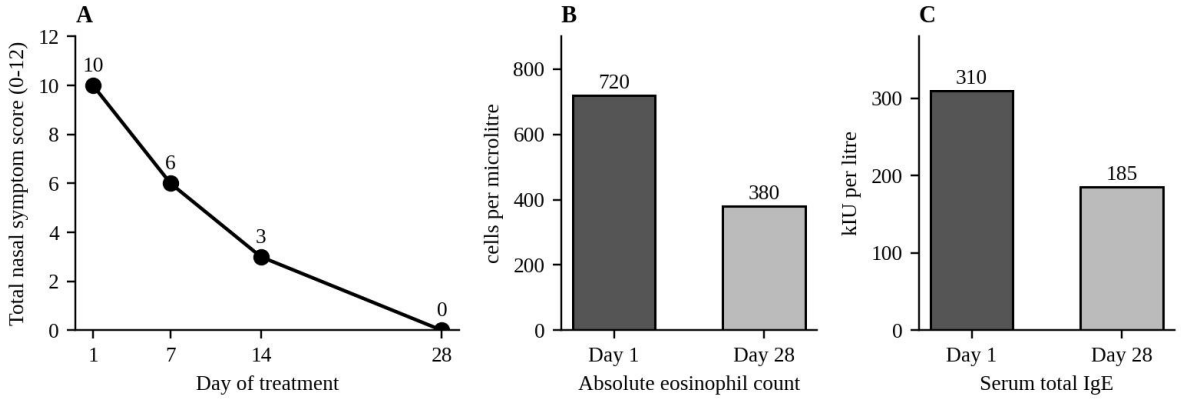

Figure 1. (A) Total nasal symptom score on days 1, 7, 14 and 28. (B) Absolute eosinophil count and (C) serum total immunoglobulin E (IgE) at baseline and day 28.

DISCUSSION

Diagnostic interpretation

The record labels the condition chronic rhinitis, but the findings point to an allergic phenotype: a long course, sneezing and watery rhinorrhoea, a raised eosinophil count, raised immunoglobulin E and 15 percent nasal eosinophils. The authors regard the picture as compatible with persistent allergic rhinitis of at least moderate severity [1,4]. Nasal cytology is a simple bedside test that shows local eosinophilic inflammation and helps to separate allergic from non-allergic

rhinitis, which makes it a useful addition to this work-up [16]. Total immunoglobulin E is less helpful, because its diagnostic accuracy for allergic airway disease is limited [17], and allergen-specific testing, which guidelines advise for patients who do not respond to empirical treatment, was not done [3,4]. The radiograph reported turbinate hypertrophy whereas clinical examination found no turbinate inflammation. The record does not resolve this discrepancy, and a Water view is a poor tool for assessing turbinates. Sinus imaging is not recommended routinely in allergic rhinitis unless sinusitis is suspected [3].

Ayurvedic interpretation

The nose is the gateway of the head, and disease that settles there is classed as *Pratishyaya*. Sneezing and watery discharge belong to *Vata*, whereas thick discharge, heaviness and cough belong to *Kapha*, so the combined label *Vata-Kaphaja Pratishyaya* is appropriate. A course of two to three years suggests that the illness has moved beyond the acute stage, and neglected *Pratishyaya* is said to progress to *Dushta Pratishyaya* with lasting damage to the nasal passage [10]. The therapeutic aims are therefore to clear *Kapha*, to pacify *Vata*, to restore the health of the nasal mucosa and to prevent recurrence by regular *Pratimarsha nasya* as part of *Dinacharya* [11,12]. Ayurvedic care of this kind is multimodal by design, combining local, internal, dietary and behavioural measures, and its evaluation should reflect that [18].

Rationale of the regimen

Nasya acts at the site of disease. The nasal mucosa is a well-vascularised surface from which drugs are absorbed, and a medicated oil spreads over the mucosa and keeps it moist [19]. *Pratimarsha nasya* with *Anu taila* is suited to children because it is gentle, can be repeated daily and serves both as treatment and as a preventive habit [11,12]. Regular nasal care has a modern parallel in saline irrigation, which has been studied in allergic rhinitis for its effect on clearance of allergen and mucus [20]. Steam inhalation corresponds to *Swedana* and liquefies *Kapha*. Evidence for heated humidified air in the common cold is inconclusive, and minor irritation has been reported, so the procedure should be supervised in children [21].

The plants used in the *arka* have experimental support. *Tulsi* is reported to have anti-inflammatory, antimicrobial and immunomodulatory actions in laboratory studies and in a trial in healthy volunteers [22,23]. *Vasa* is a traditional expectorant and bronchodilator, with vasicine as its chief alkaloid, and its toxicological data have also been reviewed [24]. The main constituent of *Nilgiri* leaf, 1,8-cineole, has mucolytic and anti-inflammatory effects, although concentrated eucalyptus oil is toxic to children if swallowed [25]. These data are mechanistic, and none establishes benefit in allergic rhinitis. *Sitopaladi churna* is a classical *Kaphahara* and *Kasahara* compound, and honey is a reasonable vehicle: in a systematic review honey was superior to no treatment and to placebo for relief of acute cough in children, although the evidence is of low quality and that review did not address allergic cough [26].

Comparison with guideline-based care

Contemporary guidelines recommend a stepwise approach. Allergen avoidance and education are the base, intranasal corticosteroids are first-line treatment for moderate to severe persistent disease, oral or intranasal antihistamines are alternatives, and immunotherapy is considered in selected patients [3,27,28]. According to the record, this child received none of the standard drugs, and his symptoms resolved. If symptoms had persisted, the next step would have been a guideline-based drug, and families should be told so. The child should also be watched for the development of asthma, because persistent allergic rhinitis is a risk factor for it [8,9]. Co-management with a paediatrician or an otolaryngologist, as occurred in this hospital admission, is therefore the safest arrangement. The evidence that dust avoidance alone improves symptoms in perennial rhinitis is limited [29], which makes it less likely, though not impossible, that the avoidance advice by itself explains the improvement.

Interpretation of outcomes

The fall in score from 10 to 0 greatly exceeds the minimal clinically important difference reported for this scale [14]. Several factors prevent a causal attribution. There was no control group, and the score is subjective and was assessed by the treating team. Allergen avoidance, mask use and dietary advice were applied together with the medicines, and each may have contributed. Season and environmental allergen exposure over the four weeks were not controlled. Total immunoglobulin E and eosinophil counts fluctuate with exposure, and a single repeat measure cannot establish a treatment effect. The immunoglobulin E value of 185 kIU per litre also remains above the level that many laboratories use as the upper limit for this age, and the reference range used was not stated. Symptom scores should ideally be combined with a medication score and recorded daily, as recommended for allergic rhinitis trials [30].

Safety and practical considerations

No adverse event was reported, but three precautions deserve mention. Steam should be delivered at a safe distance with an adult present to avoid scalds. Nasal oil should be instilled in small measured doses with the head tilted back, to limit the risk of aspiration in a child. Honey is suitable at this age but is unsafe for infants. The composition and manufacturer of the *kwatha* should be stated in reports, since commercial syrups vary. Adherence, cost and acceptability of a regimen with four components also matter in outpatient practice, and they were not recorded here.

Strengths and limitations

Strengths of the report are standardised scoring at fixed intervals, objective baseline and follow-up markers, and a regimen that is practical for outpatient use. The limitations are the single uncontrolled case, several concurrent interventions, subjective assessment, absence of allergen-specific testing, unresolved discrepancy between radiograph and examination, and lack of follow-up after day 28. Relapse after stopping oral treatment is the key unanswered question, and the child should be reviewed after the next seasonal change.

Implications for future research

A suitable next step is a pragmatic randomised or crossover study in children with confirmed allergic rhinitis, with a defined Ayurvedic regimen compared with standard care or added to it. The primary outcome should be the total nasal symptom score or a combined symptom and medication score [30], and secondary outcomes should include sleep, school attendance, nasal cytology, allergen-specific immunoglobulin E and relapse over at least one year. The trial should be registered before enrolment, and should follow ethical and reporting standards for paediatric research.

Conclusion

A boy with chronic, probably allergic, rhinitis had complete resolution of symptoms and a fall in eosinophil count and immunoglobulin E over 28 days of an Ayurvedic regimen with environmental measures. The report supports further controlled evaluation of *Pratimarsha nasya* and *Kapha-Vatahara* therapy in paediatric rhinitis, but it does not establish efficacy.

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