

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

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ABSTRACT

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

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

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

INTRODUCTION

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

The clinical presentation of cirrhosis is highly variable. Some patients are asymptomatic and the diagnosis is made incidentally at ultrasound or at surgery. Others present with isolated ascites, hepatomegaly, splenomegaly or signs of portal hypertension. When symptoms are present, they are often non-specific and include weakness, fatigue, muscle cramps, weight loss, anorexia, nausea, vomiting and upper abdominal discomfort. Hepatomegaly is

common when the cirrhosis is due to alcoholic liver disease and hemochromatosis. Jaundice is usually mild when it first appears.

Hepatomegaly (यकृदपि दक्षिणपार्श्वस्थं कुर्यात् ।) may occur as the result of a general enlargement of the liver. Although all causes of cirrhosis can involve hepatomegaly, it is much more common in alcoholic liver disease.

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

Splenomegaly (प्लीहोदर- वामपार्श्वस्थितः प्लीहा च्युतः स्थानात् प्रवर्धते ।) - The spleen has to be enlarged two to three times its normal size to be clinically palpable.

According to *Ayurveda* it's a disease of *Swedavaha and Ambuvaha strotodushti* in which symptoms of Hepatosplenomegaly and Ascites i.e. Nausea, vomiting, swelling of feet and ankles, High blood pressure, loss of appetite, weakness etc. symptoms are quietly similar to *Udara Roga* in which कुक्षेराध्मानमाटोपः (Abdominal distension), शोफः पादकरस्य (Swelling on ankle, feet & hand), मन्दोऽग्निः (Indigestion and loss of appetite), अतिपाण्डु (Anemia & jaundice), काश्यं (Lean and thin body), मन्दज्वर (Mild fever), क्षीणबल (Weakness), उदकपूर्णदृत्तिकोभसंस्पर्श (fluid thrill) etc. symptoms and sign are quite similar. The line of treatment followed in such a case is *Udara roga chikitsa*.

CASE STUDY

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

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

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

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

GENERAL & SYSTEMIC EXAMINATION

PR: 90/min, BP: 160/100 mmhg, RR: 22/min

Pallor: present

Icterus: present

Edema: b/l pedal edema present

Weight: 76 kg, Height: 168cm

RS: lung fields clear.

CVS: S1, S2 heard, no murmurs.

CNS: Patient conscious, well oriented, remembers the events very clearly.

P/A: abdomen distended and painful, fluid thrill present, shifting dullness present, umbilicus everted, and skin over abdomen is glossy.

INVESTIGATIONS:**Table 1:** Assessment before and after treatment

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

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

TREATMENT PLAN:

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

Afterwards, following medicines were started:

2. *Kutaki* (2gm) *Manjishtha* (2gm) + *Siddharka* (100ml) + *Munakka* (10) *Sanaya* (2gm)

3. A combination in powder form of

Malla sindoora (125mg),

Aarogyavardhini vati (500mg),

Punarnavamandoor (500mg),

Yavakshar (500mg),

Jalodarari rasa (250mg)

Sweta parpati (500mg)

Administered with *Rakta sodhak avaleha* (10g-10g) twice a day before Meal.

4. *Punarnavadi* and *Trina panchamoola kwath* twice daily (40ml) were administered before Meal, twice daily.

5. Syrup *Livamaritam* two teaspoon twice daily after meal.

6. *Avipattikar churna* (3gm) twice daily after meal.

7. *Triphala guggulu* two tablets twice daily after meal.

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

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

DISCUSSION

Udara roga is *Swedavaha* and *Ambuvaha Strotodushiti Vikar* due to *Jatharagnimandata*, *Pranavayu* and *Apanvayudushiti*. Due to obstruction of *Swedavaha* and *Ambuvaha strotas* excessive accumulation of fluid, especially in peritoneal cavity, occurs.

1) *Nitya Virechana* is the line of treatment in *Udara roga* and hence *virechaka oushadha* are the first choice of drug in such a case.

2) *Snuhi* is *tikshana virechaka*. Depending on the presentation of the patient in this case, *virechana* was started with *snuhi kshira*.

3) *Kutki* is *Pittavirechak*, *Bhedaniya*, *Lekhaniya*, *Sothahar* and *Yakriduttejaka*. So it tends to ex-

crete out the extra accumulated fluid in ascites (*Jalodar*).

S.No.	Drug	Properties
1.	<i>Katuki (Picrorhiza kurroa)</i>	<i>Bhedniya</i> ¹⁰ & <i>lekhniya</i> ¹⁰ , <i>Kaphahara</i> ¹⁰ , Potent liver stimulant
2.	<i>Manjishtha (Rubia cordifolia)</i>	<i>Vishahara</i> ¹⁵ , <i>Shothahara</i> ¹⁵ , <i>Kaphahara</i> ¹⁵ , <i>Rakta shodhaka</i> ¹⁵ .
3.	<i>Markandika (Sanay – Cassia angustifolia)</i>	<i>Urdhwa-Adhahkaya shodhini</i> ¹¹ , <i>Vishahara</i> , <i>Gulma</i> ¹¹ & <i>Udarahara</i> ¹¹
4.	<i>Punarnava (Boerhavia diffusa)</i>	<i>Shothahara</i> ¹² , <i>Dipan</i> ¹² , <i>Gara</i> & <i>Vishahara</i> ¹²
5.	<i>Makoya (Solanum nigrum)</i>	<i>Shothahara</i> ¹⁶ , <i>Yakritauttejak</i> ¹⁶ , <i>Pittasarak</i> ¹⁶ & <i>Rechana</i> ¹⁶
6.	<i>Kasani (Cichorium intybus)</i>	Potent Hepato-protective action & <i>Yakritavikarnasak</i> ¹⁷
7.	<i>Sounf (Foeniculum vulgare)</i>	<i>Agnimandhyahara</i> ¹⁸ , <i>Ushna</i> , <i>Pachani</i> , <i>Shleshma-Vatahara</i>
8.	<i>Munakka (Vitis vinifera)</i>	<i>Virechanopaga</i> ¹⁹

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

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

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

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

अपां दोषहराण्यादौ प्रदद्यादुदकोदरे |

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

CONCLUSION

Jalodara and *yakritpleehodara* are described in Ayurveda as the type of *udar roga*. The management of this disease complex is difficult due to the presence of complications. An effort was made to manage the present case successfully with Ayurveda treatment following the *Chikitsa Siddhant* of *Udara*

Roga. Patient showed good overall improvement in his condition which is evident by changes in his investigative findings as well as his general well-being. In this case study, *Ayurvedic* treatment was found very effective in the management of Ascites & Hepatosplenomegaly (*Yakritpleehodar*). Through the *Strotoshodhak* principle the root cause was treated and this improved the normal functioning of body. This *Ayurvedic* treatment is safe, cost effective and has no side effect. Further studies to evaluate the role of Ayurveda treatment in the management of such complicated cases needs to be carried out.

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