Unit 7.2 — Yakṛt Vikāra

Yakṛt-śotha (Hepatitis), Yakṛt-dālyodara (Cirrhosis), Madya-janya Yakṛt Vikāra (ALD), Madya-etar Yakṛt Vikāra (NAFLD), NASH, Yakṛt-kośakīya Arbuda (Hepatocellular carcinoma)

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1) Concept-map: “Modern Liver Disorders” in Ayurvedic language

Ayurveda does not name “hepatitis / NAFLD / cirrhosis” in the modern way, but their **clinical patterns** and **pathology** are well expressible through:

- **Kāmala** (pitta–rakta pradhāna; haritā/peetā varṇa, dāha, tṛṣṇā, aruci, mutra-pīta, etc.)
- **Udara roga** spectrum (yakṛt/pliha involvement → yakṛt-vṛddhi / jalodara / dālyodara—advanced chronic stage patterns)
- **Madātyaya** (alcohol-related systemic derangements; later may culminate in kāmala + udara features)
- **Medo-rasa duṣṭi** patterns (for NAFLD/NASH phenotypes) with **kapha-meda pradhāna**, plus **pitta anubandha** when inflammation rises
- **Arbuda** (for liver mass / HCC pattern) with chronicity, deep-rootedness, and progressive nature

So, clinically you will often see **a continuum**:

Agnimāndya/Āma → Rasa-Meda duṣṭi → Yakṛt śotha/āmāśaya-pitta prakopa → Kāmala → Udara (yakṛt/pliha/jalodara) → Arbuda-like phenotype in chronic cases

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2) Core Samprāpti (pathogenesis) — the “Yakṛt axis”

2.1 Doshā

- **Pitta** (rāñjaka pitta, pācaka pitta) + **Rakta duṣṭi** = “yellow” phenotypes (kāmala, dāha, pīta netra/mūtra)
- **Kapha-Meda** = fatty infiltration phenotype (NAFLD)
- **Vāta** rises in chronicity → fibrosis-like dryness, wasting, ascites tendency, conduction of complications (udara upadrava)

2.2 Dūṣya & Srotas

- **Rasa-Rakta-Meda** (common triad)
- **Raktavaha / Rasavaha / Medovaha srotas** and **Udakavaha srotas** involvement in advanced edema/ascites patterns

2.3 Agni

- **Jāṭharāgni + dhātvagni** become weak → improper rasa formation → burden on yakṛt-pāka/rāñjana functions

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3) Key classical anchor verses (for conceptual stability)

3.1 Arbuda-definition (for malignant mass phenotypes such as HCC)

सुश्रुतसंहिता, निदानस्थान 11/13

गात्रप्रदेशे क्वचिदेव दोषाः सम्मूर्च्छिता मांसमभिप्रदूष्य ।
वृत्तं स्थिरं मन्दरुजं महान्तमनल्पमूलं चिरवृद्ध्यपाकम् ॥१३॥
English sense: In some body region, doṣas localize, vitiate māṁsa, and produce a swelling that is rounded, firm, mildly painful, large, deep-rooted, slowly growing and not suppurating—this describes *arbuda*.

Clinical use: chronic, progressive, deep-rooted liver mass phenotype with systemic decline aligns better with an *arbuda* framework than with "simple gulma."

3.2 Udara spectrum and progression difficulty (useful in cirrhosis/ascites continuum)

चरकसंहिता, चिकित्सास्थान 13/50

भवन्ति चात्र- वातात्पित्तात्कफात् प्लीह्नः सन्निपातात्तथोदकात् ।
परं परं कृच्छ्रतरमुदरं भिषगादिशेत् ॥५०॥
English sense: Udara may arise from vāta, pitta, kapha, spleen (pliha), sannipāta, and then udaka (jalodara). Each subsequent type becomes progressively more difficult to manage.

3.3 Jalodara samprāpti clue (advanced hepatic failure phenotypes)

चरकसंहिता, चिकित्सास्थान 13/46

स्रोतःसु रुद्धमार्गेषु कफश्चोदकमूर्च्छितः ।
वर्धयेतां तदेवाम्बु स्वस्थानादुदराय तौ ॥४६॥
English sense: With channel obstruction, kapha mixed with water increases the fluid, dislodges it from its site, and accumulates in the abdomen causing udara filled with water (jalodara).

3.4 Kāmala-oriented classical formulation (pitta–rakta–yakṛt support)

चरकसंहिता, चिकित्सास्थान 16/53 (पाण्डु/कामला-प्रकरण)

हरिद्रात्रिफलानिम्बबलामधुकसाधितम् ।
सक्षीरं माहिषं सर्पिः कामलाहरमुत्तमम् ॥५३॥
English sense: Ghṛta processed with haridrā, triphalā, nimba, balā, madhuka along with buffalo milk is an excellent remedy for kāmala.

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4) Diagnosis framework (Ayurvedic + Contemporary correlation)

4.1 Yakṛt-śotha (Hepatitis phenotype)

Ayurvedic pattern: pitta–rakta duṣṭi predominance; kāmala-prāya symptoms may appear.
Contemporary pointers: fever, fatigue, nausea, RUQ discomfort, raised bilirubin/ALT/AST.

Ayurvedic clinical checklist

- Varṇa: netra + tvak pītata / haritā
- Mutra: pīta mutra
- Aruci, tṛṣṇā, dāha, avipāka
- Jihvā: āma coat may exist if agni is low

4.2 Yakṛt-dālyodara / Cirrhosis phenotype

Ayurvedic pattern: chronicity → vāta-pradhāna with kapha/pitta history; udara-spectrum features: hepatosplenomegaly, ascites, wasting, edema.
Contemporary pointers: portal HTN signs, ascites, low albumin, varices, coagulopathy.

Ayurvedic clinical checklist

- Udara-vṛddhi, jalodara features
- Śotha (peripheral edema)
- Bālya (debility), aruci, srotorodha signs
- Chronic dryness, weight loss = vāta dominance

4.3 ALD (Madya-janya Yakṛt Vikāra)

Ayurvedic pattern: madātyaya → pitta aggravation + ojas-kṣaya; later kāmala/udara phenotypes.
Contemporary pointers: fatty liver, hepatitis, cirrhosis, cardiomyopathy/neuropathy.

4.4 NAFLD & NASH (Madya-etar vasāmayaja yakṛt vikāra)

Ayurvedic pattern (practical mapping):

- **Kapha–meda pradhāna** (manda agni, sthaulya tendencies, sedentary habits)
- **Pitta anubandha** in NASH (inflammation: dāha, mild kāmala tendency, raised enzymes)
- **Rasa–meda duṣṭi** as the base pathology; later rakta involvement

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4.5 HCC (Yakṛt-kośakīya Arbuda phenotype)

Ayurvedic pattern: long-standing doṣa–dūṣya sammūcchanā with māṁsa/rakta involvement → arbuda features (deep, slow-growing, firm, non-suppurating).
Contemporary pointers: liver mass, weight loss, pain, tumor markers (AFP sometimes), imaging confirmation.

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5) Samprāpti-vighaṭana (breaking the chain): the common algorithm

Step A — Nidāna-parivarjana (non-negotiable)

- Madya tyāga (ALD)
- Guru-snigdha-madhura excess reduction (NAFLD)
- Viruddhāhāra, atyāmla, atilavaṇa, kṣāra, vidāhi items avoidance (kāmala/pitta)

Step B — Agni correction (base of yakṛt recovery)

- If **āma**: **laṅghana + dīpana-pācana**

- If **nirāma**: pitta-shamana + yakṛt support + mild anulomana

Step C — Doṣa-specific shodhana/shamana selection

- Pitta–rakta pradhāna (hepatitis/jaundice): **mṛdu virecana** when indicated
- Kapha–meda pradhāna (NAFLD): **rūkṣaṇa → lekhanīya → dīpana**
- Vāta-pradhāna chronic (cirrhosis/ascites): careful **vāta anulomana**, **basti** consideration (as per strength), and udaka management principles

Step D — Dhātu/ojas rebuilding (after stabilization)

- **Rasāyana** tailored to stage and digestion strength

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6) Chikitsā-sūtra & Chikitsā-yojanā — by condition

6.2.1 Yakṛt-śotha (Hepatitis) — management

Chikitsā-sūtra

1. **Āma present** → laṅghana + pācana, then pitta shamana
2. **Pitta-rakta duṣṭi** → mṛdu virecana (if bala allows)
3. **Tikta-kaṣāya** dravya, cooling but agni-friendly approach
4. **Yakṛt support with ghṛta** only after nirāma stage

Classical Aushadha-yoga (stage-wise)

(A) Āma-pradhāna / avipāka + aruci

- **Pañcakola kvātha** (short course, to kindle agni)
- **Śuṇṭhī / Pippalī** in very small dose with warm water (if kapha-āma dominates)

(B) Pitta-pradhāna (yellowing, burning, bitter taste)

- **Haridrādi ghṛta**
  (Caraka Saṃhitā, Cikitsāsthāna 16/53 — shloka given above)
- **Triphala + Nimba** (kvātha) as pitta-rakta shāmaka support (nirāma preference)

(C) Recovery / convalescence

- **Guḍūcī** as rasāyana-support (dose as per digestion)
- **Triphala-ghṛta** (if bowel dryness and pitta settle)

Pathya–Apathya (Hepatitis phenotype)

Pathya: warm, light, tikta–kaṣāya dominant; old rice gruel, mudga yūṣa, peya, yava; moderate ghee only after appetite returns.
Apathya: madya, atyāmla, kṣāra, atilavaṇa, vidāhi, fried, late-night eating.

6.2.2 Yakṛt-dālyodara / Cirrhosis — management (Udara-spectrum)

Chikitsā-sūtra

1. **Udara is "mandāgni + srotorodha + udaka vikṛti" disease** → agni correction is central
2. **Udaka control** with srotoshodhana & kapha–udaka reduction principles
3. **Vāta management** in chronic stage to prevent rapid decline
4. **Complication-aware sequencing** (ascites/edema/bleeding tendency)

Classical samprāpti anchor

- Jalodara mechanism and udara difficulty progression:
  - (Caraka Cikitsā 13/46) and (Caraka Cikitsā 13/50) — shlokas given above.

Aushadha-yoga (principle-led classical choices)

(A) Early compensated (hepatomegaly, dyspepsia, mild edema)

- **Dīpana–pācana** first (short course)
- **Nitya anulomana** (mild) to reduce udāvarta/pressure
- **Tikta–kaṣāya support** to pitta–rakta, without extinguishing agni

(B) Ascites / significant fluid phenotype (jalodara-like)

- Follow **udaka-kapha** reduction principle (Caraka 13/46 logic)
- Prefer formulations that are **agni-friendly, reduce kleda**, and support bowel regularity

(C) Severe chronicity (vāta dominance, wasting)

- **Bṛṃhaṇa only after agni improves**
- Select **mṛdu rasāyana** that does not overload digestion

Pathya–Apathya (Cirrhosis phenotype)

Pathya: small frequent light meals, mudga yūṣa, peya, yava; warm water; avoid heavy salt; maintain bowel regularity; gentle rest.
Apathya: alcohol, salty-heavy foods, fried foods, suppression of urges, day sleep, extremes of fasting without supervision.

6.2.3 Madya-janya Yakṛt Vikāra (ALD) — management

Chikitsā-sūtra

1. **Madya-nidāna removal** is primary (otherwise no stable benefit)
2. **Agni rescue**: correct manda agni and āma
3. **Pitta–rakta stabilization** when kāmala features appear
4. **Ojas rebuilding** in recovery phase

Aushadha-yoga (classical orientation)

- Treat as **Madātyaya + Kāmala/ Udara** overlap depending on stage:
  - Early: dīpana–pācana + anulomana
  - If jaundice: **Haridrādi ghṛta** (Caraka 16/53)
  - If ascites: udara-spectrum principles (Caraka 13/46, 13/50)

Pathya–Apathya

Absolute apathya: madya.
Pathya: warm, light, non-irritant diet; gradual rebuilding after appetite returns.

6.2.4 NAFLD & NASH — management

Ayurvedic samprāpti lens

- NAFLD: **kapha–meda pradhāna, manda agni, rasa–meda duṣṭi**
- NASH: same base + **pitta anubandha** (inflammatory heat)

Chikitsā-sūtra

1. **Rūkṣaṇa → lekhanīya → agni deepana** (core)
2. Add **tikta–kaṣāya** to stabilize pitta-rakta in NASH
3. Avoid premature snehana/ghṛta overload until agni is stable

Aushadha-yoga

- **Lekhanīya + dīpanīya** oriented formulations (classical groups)
- When heat/inflammation signs rise: **tikta–kaṣāya** supportive medicines
- Later: mild rasāyana, only when digestion is reliable

Pathya–Apathya

Pathya: yava, mudga, tikta śāka, warm water, measured diet, early dinner.
Apathya: guru-snigdha, madhura excess, sweets, bakery, deep fried, late-night meals, sedentary lifestyle.

6.2.5 Hepatocellular carcinoma phenotype — “Yakṛt-kośakīya Arbuda” framework

Classical nidāna anchor

- Arbuda lakṣaṇa (Suśruta Nidāna 11/13 — shloka given above): deep-rooted, firm, slow-growing, non-suppurating.

Chikitsā-sūtra

1. **Doṣa–dūṣya control** (usually pitta–rakta with chronic vāta)
2. **Agni and bala preservation** is central

3. **Rasāyana** only after digestibility is ensured; choose mild, compatible forms
4. In advanced stage: focus on **kṣaya, kleda, udara, aruci** management patterns

Pathya–Apathya

- Same pitta–rakta friendly, light, agni-sustaining diet; avoid irritants, alcohol, heavy fats; maintain bowel regularity.

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7) Short clinical reasoning cases (de-identified style)

Case A — Hepatitis phenotype (Yakṛt-śotha / kāmala-prāya)

A 28-year-old presents with fatigue, nausea, mild fever, bitter taste, yellow eyes, dark urine, poor appetite. Tongue mildly coated.
Interpretation: āma + pitta–rakta involvement → start with laṅghana + pācana; after āma reduces, consider pitta-oriented kāmala management; ghṛta only in nirāma stage.

Case B — NAFLD phenotype

A 42-year-old with central obesity, heaviness, sluggish appetite, daytime sleep habit, mild RUQ discomfort; reports “fatty liver” on ultrasound.
Interpretation: kapha–meda pradhāna → rūkṣaṇa + lekhanīya + deepana; avoid early ghṛta; add tikta–kaṣāya if inflammatory markers/heat signs appear.

Case C — Cirrhosis with ascites phenotype (Udara-spectrum)

A 55-year-old with abdominal distension, pedal edema, reduced appetite, weakness, occasional breathlessness; history of chronic digestive disturbance and long-standing illness.
Interpretation: udara/jalodara continuum—treat agni, manage udaka-kapha as per Caraka Udara logic, preserve bala, and plan staged therapy.

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8) Self-check

1. Why is **agni** central in every yakṛt-vikāra phenotype?
2. In which stage is **ghṛta** helpful—and when can it worsen the condition?
3. How does NAFLD map to **kapha–meda** and NASH to **pitta anubandha**?
4. Which classical features make you think of **arbuda** rather than simple gulma?
