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# AYURVEDIC MANAGEMENT OF BUDD CHIARI SYNDROME – A CASE STUDY

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**ABSTRACT**

Ayurvedic therapy has been shown to be effective in treating various liver disorders. Budd chiari syndrome (BCS) is a rare but serious disorder characterized by obstruction of the hepatic venous outflow. The prognosis is usually poor. A 33years old obese female patient from Vijaypura visited the *kayachikitsa* OPD of BLDEA'S AVS Ayurveda mahavidyalaya hospital and research centre Vijaypura, on 20/08/25 presenting with complaints of pedal edema, abdominal distention and was treated for BCS exclusively with *shodana* and *shamanaoushadis*. This patient had portal hypertension, mild ascites, enlarged liver size with mild caudate lobe hypertrophy. The main line of treatment given was one sitting *virechana* along with ayurvedic *shamanoushadis* which showed significant improvement in symptoms and USG changes are not significant I,e major changes in USG scan is not seen. This case study provides primary evidence of probable potential of Ayurveda medicine in improving therapeutic outcomes in patients with BCS.

**KEYWORDS:** Budd chiari syndrome, *yakritodara*, *virechana*.

## INTRODUCTION

Budd chiari syndrome occurs in one out of a million individuals. The five year survival rate for patients with BCS is around 38 – 87 % following post systemic shunting and 70% following liver transplantation. The prognosis is poor and varies according to treatment type.[1]

*Ayurvedic* classics has no explaination of any condition exactly resembling the presentation or pathogenesis of BCS. Thus, based on basic *ayurvedic* parameters and the signs and symptoms of the disease, we prepared a treatment plan with *shodana* line of treatment I,e *virechana*. Here as the disease is many related with *yakrit* and *raktavaha srotas*, here *virechana* helps in *srotoshodana* and some of *ayurvedic* formulations which have indications resembling the liver and and blood pathologies are administered. The aim treatment was to improve the hepatic venous outflow and prevent deterioration of liver functions.[2]

## CASE STUDY

Distention of abdomen

No proper evacuation of stool Pain in the right side of flanks Loss of appetite

Associated with generalized weakness, edema in both upper and lower limbs and also pain and stiffness in lower back region.

History of present illness

A 33yr old female patient came to OPD with C/O Distention of abdomen, no proper evacuation of stool, pain in the right side of flanks and loss of appetite since one year and these increased symptomatically since 3wks

and patient is known case of hypothyroidism was on medication and discontinued medicines by herself. Patient took treatment of conventional medicine for this and not got satisfactory relief so came to our hospital for the treatment.

History of past illness:
N/k/c/o DM2, HTN and thyroid disorder N/k/c/o Trauma and Surgery
K/c/o Hypothyroidism
Family History
Nothing significant
Personal history
Diet: Mixed Appetite: Reduced Bowel: constipated
Bladder: 4 - 5 times/day Sleep: Sound
Habits: Nil
General examination
Built : Moderately built
Nourishment : Well nourished
Pallor : Absent
Icterus : Absent Cyanosis
Absent Clubbing : Absent
Lymphadenopathy: Absent Edema: in both hands and feets

Systemic examination
CVS: S1 and S2 heard normal, no murmurs and no added sounds
RS: Air entry B/L equal and no added sounds
CNS: Patient is conscious, well oriented to place and time
Local examination: P/A
Inspection: Abdomen - distended and symmetrical
Auscultation: Bowel sound heard
Palpation - Soft to touch
No mass, swelling and rigidity Tenderness in right hypochondrium
Percussion - Resonant sound present
Vitals
PR - 78 bpm
BP - 120/80 mmhg Temp - normal
RR - 18/min
Astha sthana pareeksha
*Nadi : Vatapitta*
*Mala. : Vibandha*
*Mutra : Prakruta*
*Jihwa : Alipta*
*Shabda : Prakruta*
*Sparsha: anushna sheeta*
*Drik : Prakruta*
*Akriti : Madhyama*
Dashavidha pareeksha
*Prakriti: Vatapittaja*
*Vikriti : hetu - Akala bhojana, excessive intake of katu rasa ahara.*
*Vihara - Ativyayama, ratrijagarana. Dosha - Vata, pitta dosha*
*Dushya - Rasa, Rakta Desha - Jangala Bala - Madhyama*
*Sara: Madhyama Samhanana: Madhyama Pramana: Madhyama Satmya: Madhyama Satva: Madhyama*
*Ahara Shakti: Abhyavarana shakti - Madhyama*
*Jarana Shakti - Madhyama Vyayama Shakti: Madhyama*
*Vaya: madhyama*
Samprapti ghataka
*Dosha - Pitta pradhana tridosha Dushya - Rasa and Rakta*
*Agni – Jataragni manda*
*Ama - Jataragni mandya janya Srotas - Rasavaha, Raktavaha Srotodusthi - Sanga Rogamarga - Abhyantara Udbhavasthana - Amashayotta, kostha Sanchara sthana – sarva sharira Vyaktasthana - Udara and Yakrut Roga swabhava - Chirakari*
*Sadhya asadhyata – krichra sadhya*
Investigations
USG Abd and Pelvis Impression

| Before treatment |
|---|
| 1. Liver parenchymal disease of vascular etiology echotexture in the form of enlarged size, slightly altered and surface lobulation with mild caudate lobe hypertrophy. |
| 2. Hepatic venous abnormality as described above - Budd Chiari syndrome. |
| 3. Changes of portal hypertension in the form of dilated portal and mild ascites. |

Diagnosis, assessment and treatment
The Diagnosis of budd chiari syndrome was made based on USG findings along with clinical features of the patient. Total two assessment was Carried out before the treatment and after the treatment of 6 months.
Treatment given

**Table 1: *Shodhana chikitsa* from 20/8/24 to 26/8/24.**

| | |
|---|---|
| *Snehapana with Panchatikta guggulu ghrita* | 1st day - 30 ml 2nd day - 60 ml<br>3rd day - 90 ml |
| *Sarvanga abhyanga and bhashpa sweda* | *Kottamachukkadi taila* |
| *Virechana* | *Trivrut avaleha* (60gm) |
| No. of *vegas* | 13 |

**Table 2: After *Shodana Shamanoushadhi* from (29/08/24 to 27/ 09/24)**

| | |
|---|---|
| *Arogyavardini vati* | 1BD/AF for 1 month |
| *Asanadi Kashaya* | 3 tsf / BD/AF for 1 month |
| *Liv 52* | 1 BD/AF for 1 month |
| *Rohitakarista* | 3 tsf / BD/AF for 1 month |

On 2nd follow up *Shamanoushadhi's* given were (28/09/24 to 28/10/24)

| | |
|---|---|
| *Revirol plus* | 1BD/AF |
| *Arogyavardini vati* | 1BD/AF |
| *Amrutottara kashaya* | 3tsf/BD/AF |
| *Tab Nishamalaki* | 1BD/AF |
| *Rohitakarista* | 3tsf/BD/AF |

**OBSERVATION AND RESULTS**

| **Signs and symptoms** | **BT** | **Shodana (20/08/24 – 26/08/24)** | **Shamano ushadhi (29/08/24 – 27/09/24)** | **Shamanoush adhi (28/09/24 – 13/10/24)** | **Shamanousha dhi (14/10/24 – 28/10/24)** |
|---|---|---|---|---|---|
| Pain abdomen | Present | Improved | Improved | Improved | Improved |
| Distention of abdomen | Present | Present | Present | Slightly reduced | Slightly reduced |
| Edema in both upper and lower limbs | Present | Present | Slightly improved | Slightly reduced | Markedly improved |
| Generalised weakness | Present | Present | Slightly improved | Present | Slightly reduced |
| Bowel | Constipated | Normal | Normal | Normal | Normal |

**DISCUSSION**

Budd chiari syndrome is an uncommon condition caused by thrombosis of the larger hepatic veins and sometimes the inferior vena cava. It is characterized by upper abdominal pain, marked ascites and occasionally acute liver failure due to acute venous occlusion. More gradual occlusion causes gross ascites and, often, upper abdominal discomfort. Hepatomegaly, frequently with tenderness over the liver, is almost always present. Peripheral oedema occurs only when there is inferior vena cava obstruction.

The treatment of this disorder is focused on alleviating the obstruction, preventing the progression of the clot, limiting progressive liver injury, and preventing or managing complications.[3]

As per Ayurveda, any sort of obstruction leads to derangement of the Vata dosha and this is further aggravated by constipation.[4] there is no exact clinical entity mentioned in Ayurveda like BCS but on the basis of signs and symptoms, it can be co-related with *yakritodara* associated with starting stage of *jalodara*. *Mandagni* is the main cause of *Udararoga*, where excessive *Dosha* accumulates in *Udara*. The main aim of treatment is *Agnideepana*, *Nitya virechana* followed by *Shamanachikitsa*.[5]

Derangement of liver functions and clot formation is related to the vitiation of *Pitta dosha.* Thus, treatment plan is to establish harmony in *Pitta dosha* and *Vata dosha*. In this case *Snehana* and *swedana* dissolve and dislodge the morbidity in *koshta* and *virechana* help to expel them out.

*Panchatikta guggulu ghrita* The *Panchatikta* ingredients, dominated by *tikta rasa*, perform *pitta-kapha śamana*, *raktaprasādana*, *dīpana-pācana*, and *lekhana*, thereby reducing *āma*, correcting dushita *Agni*, and purifying the *raktavaha srotas*.

*Arogya vardini vati* – it has *katuki* as main ingredient which has *tikta rasa* and *ushna veerya* in property and helps in *ama pachana* and acts as *yakrittotejaka*. This *vati* helps in balancing *tridoshas* and promotes *Agni*, and has anti flatulent property and reduces bloating and abdominal distension. It also promotes liver function.[6]

*Asanadi kashaya* – it contains ingredients like *Haritaki*, *Asana*, and *Haridra*, Which are *Kashaya Rasayukta,* And *Raktashodhaka* properties. It purifies *Dushita Pitta* and *Rakta*. Hence it is used in most of the *Raktaja Vyadhis*, as this disease is related to *yakrit* and venous outflow obstruction so this drug is more beneficial.[7]

Tab Liv 52 DS – it acts hepato protective and also has anti inflammatory, diuretic and immunomodulatory properties.[8]

*Rohitakarista* – helps in normalizing liver function, has anti flatulent and anti inflammatory properties.

Tab *Nishamalaki* – it has anti oxidant and anti-inflammatory property and also boosts immunity.

**CONCLUSION**

In *Ayurveda*, the liver is called *Yakrit*, which is dominated by *Pitta dosha*. This means most liver conditions are the onset of aggravated *Pitta*. So, *virechana* would help in better results.

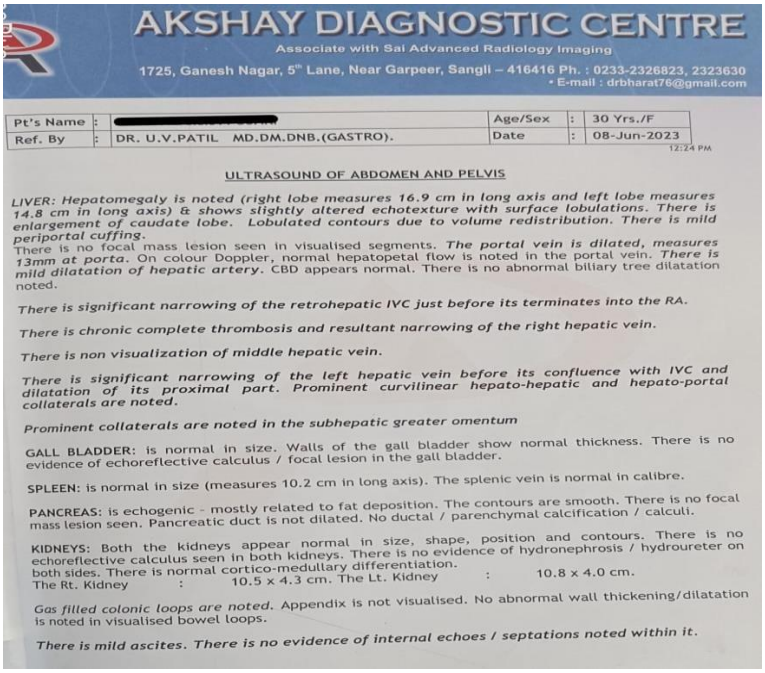
BCS with IVC and hepatic vein thrombosis is considered a serious health problem with a poor prognosis. So, in *Ayurveda* there are some non - invasive way to prevent and help ease the symptoms of this *yakrit roga*.

In current case, *virechana* has played an important role in restoring the liver function. Patient has got symptomatic relief and the USG changes are not significant I,e. major changes in USG scan is not seen.

**REFERENCES**

1. Medscape eMedicine https://share.google/xkhmLaRKL1NDzgh9W

2. Chaudhary M, Goyal M, Mehta C. Ayurvedic management of Budd Chiari Syndrome: A case report. J Ayurveda Integr Med. 2025. doi:10.1016/j.jaim.2025.101184.
3. Davidson's principles and practice of medicine 23rd edition 2018. Page no. 898- 899, 22nd chapter.
4. Agnivesha, *Charaka Samhita, sutra Sthana* Editor Kashinath Shastri, Ed-2017: Chaukhambha Sanskrit Sansthan Varanasi; 2017. Chapter 8.
5. Agnivesha, *Charaka Samhita, Chikitsa Sthana* Editor Kashinath Shastri, Ed- 2017: Chaukhambha Sanskrit Sansthan Varanasi; 2017. Chapter 13.
6. https://www.researchgate.net/publication/354634333_Arogyavardhini_Vati_-
7. A_Boon_for_Liver_Disorders_from_Ayurveda_Fatty_Liver
8. Acharya SG, Acharya RS. *Clinical indications of Asanadi Kwatha: A scientific and experiential view*. Int Res J Ayurveda Yoga, 2022; 5(1): 184-186. doi:10.47223/IRJAY.2022.5129.
9. National Institutes of Health (.gov) https://share.google/7ni3gn3rZze6mAGyq



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| | | | | | |
|---|---|---|---|---|---|
| Pt's Name | : | [redacted] | Age/Sex | : | 30 Yrs./F |
| Ref. By | : | DR. U.V.PATIL MD.DM.DNB.(GASTRO). | Date | : | 08-Jun-2023 |

12:24 PM

ULTRASOUND OF ABDOMEN AND PELVIS

*LIVER: Hepatomegaly is noted (right lobe measures 16.9 cm in long axis and left lobe measures 14.8 cm in long axis) & shows slightly altered echotexture with surface lobulations. There is enlargement of caudate lobe. Lobulated contours due to volume redistribution. There is mild periportal cuffing.*
There is no focal mass lesion seen in visualised segments. *The portal vein is dilated, measures 13mm at porta.* On colour Doppler, normal hepatopetal flow is noted in the portal vein. *There is mild dilatation of hepatic artery.* CBD appears normal. There is no abnormal biliary tree dilatation noted.

*There is significant narrowing of the retrohepatic IVC just before its terminates into the RA.*

*There is chronic complete thrombosis and resultant narrowing of the right hepatic vein.*

*There is non visualization of middle hepatic vein.*

*There is significant narrowing of the left hepatic vein before its confluence with IVC and dilatation of its proximal part. Prominent curvilinear hepato-hepatic and hepato-portal collaterals are noted.*

*Prominent collaterals are noted in the subhepatic greater omentum*

GALL BLADDER: is normal in size. Walls of the gall bladder show normal thickness. There is no evidence of echoreflective calculus / focal lesion in the gall bladder.

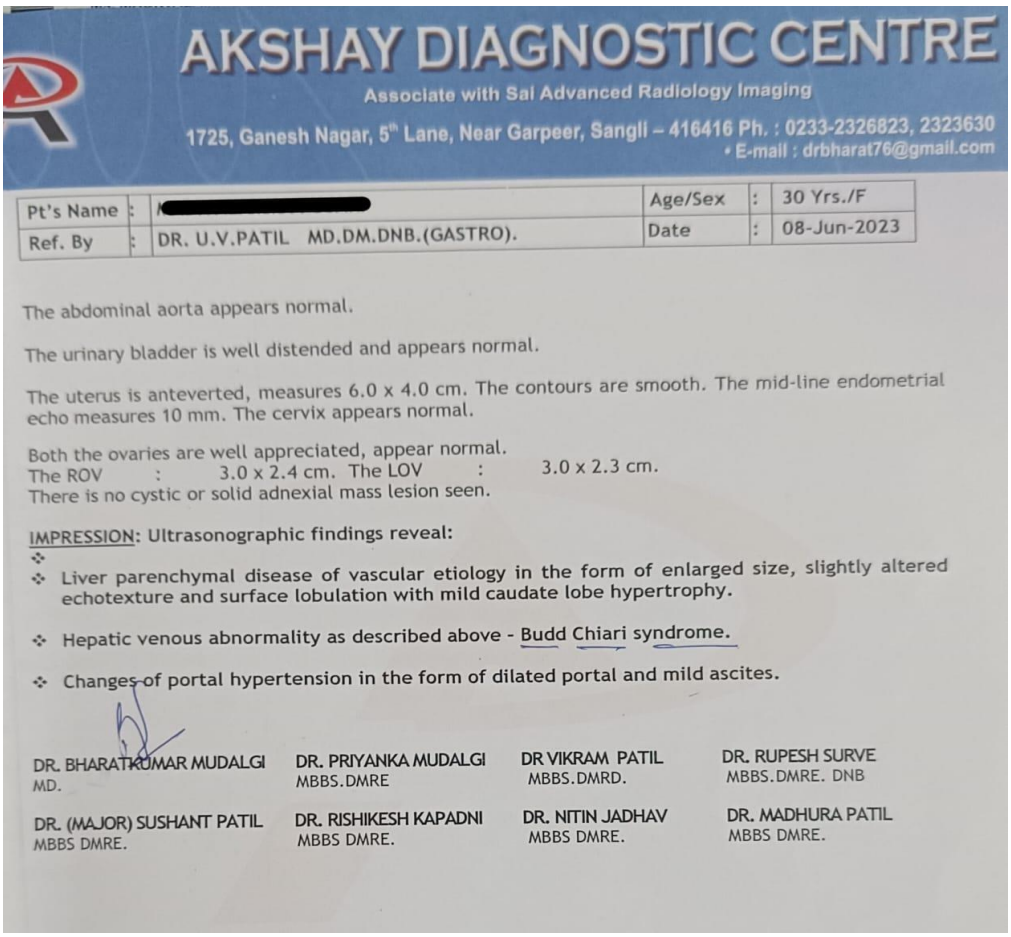
SPLEEN: is normal in size (measures 10.2 cm in long axis). The splenic vein is normal in calibre.

PANCREAS: is echogenic - mostly related to fat deposition. The contours are smooth. There is no focal mass lesion seen. Pancreatic duct is not dilated. No ductal / parenchymal calcification / calculi.

KIDNEYS: Both the kidneys appear normal in size, shape, position and contours. There is no echoreflective calculus seen in both kidneys. There is no evidence of hydronephrosis / hydroureter on both sides. There is normal cortico-medullary differentiation.
The Rt. Kidney : 10.5 x 4.3 cm. The Lt. Kidney : 10.8 x 4.0 cm.

*Gas filled colonic loops are noted.* Appendix is not visualised. No abnormal wall thickening/dilatation is noted in visualised bowel loops.

*There is mild ascites. There is no evidence of internal echoes / septations noted within it.*



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The abdominal aorta appears normal.

The urinary bladder is well distended and appears normal.

The uterus is anteverted, measures 6.0 x 4.0 cm. The contours are smooth. The mid-line endometrial echo measures 10 mm. The cervix appears normal.

Both the ovaries are well appreciated, appear normal.
The ROV : 3.0 x 2.4 cm. The LOV : 3.0 x 2.3 cm.
There is no cystic or solid adnexial mass lesion seen.

IMPRESSION: Ultrasonographic findings reveal:

- Liver parenchymal disease of vascular etiology in the form of enlarged size, slightly altered echotexture and surface lobulation with mild caudate lobe hypertrophy.
- Hepatic venous abnormality as described above - Budd Chiari syndrome.
- Changes of portal hypertension in the form of dilated portal and mild ascites.

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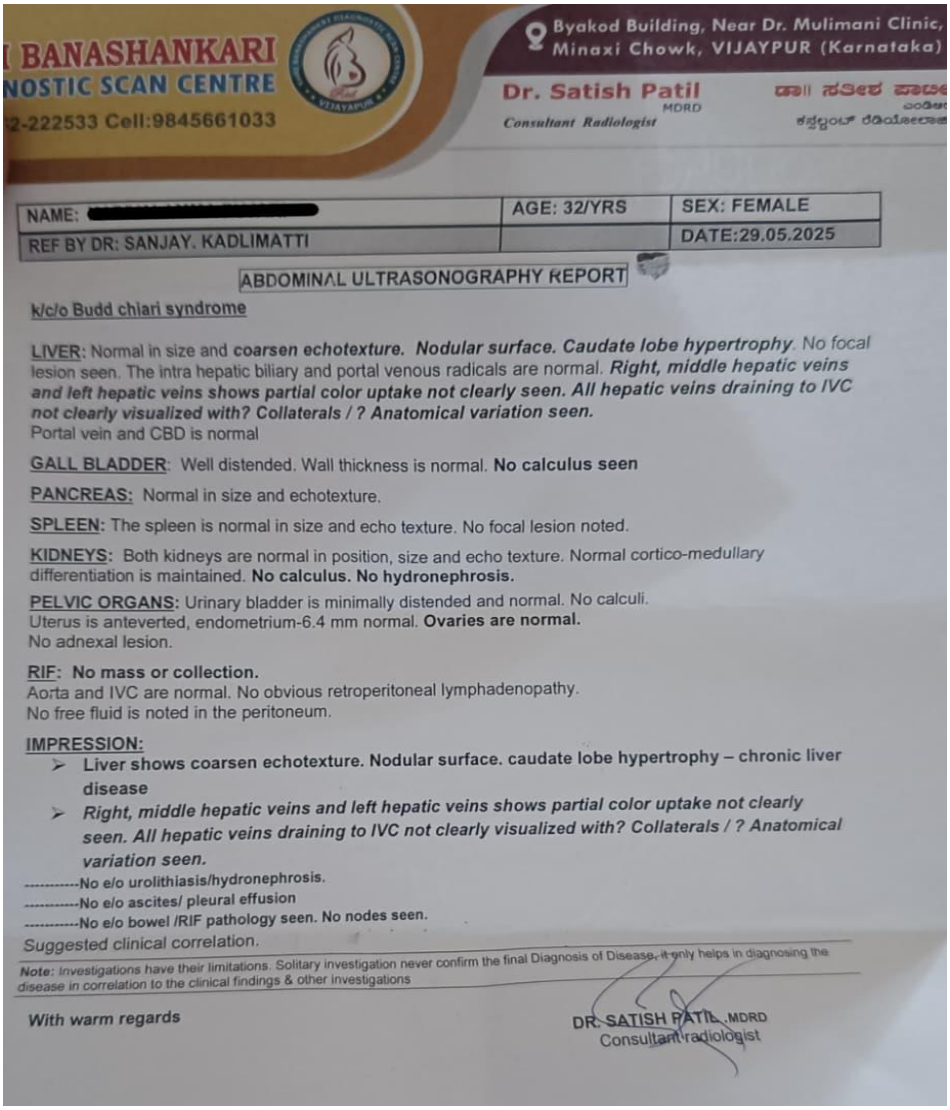

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| NAME: [redacted] | AGE: 32/YRS | SEX: FEMALE |
|---|---|---|
| REF BY DR: SANJAY. KADLIMATTI | | DATE:29.05.2025 |

ABDOMINAL ULTRASONOGRAPHY REPORT

k/c/o Budd chiari syndrome

LIVER: Normal in size and **coarsen echotexture. *Nodular surface. Caudate lobe hypertrophy.*** No focal lesion seen. The intra hepatic biliary and portal venous radicals are normal. ***Right, middle hepatic veins and left hepatic veins shows partial color uptake not clearly seen. All hepatic veins draining to IVC not clearly visualized with? Collaterals / ? Anatomical variation seen.***
Portal vein and CBD is normal

GALL BLADDER: Well distended. Wall thickness is normal. **No calculus seen**

PANCREAS: Normal in size and echotexture.

SPLEEN: The spleen is normal in size and echo texture. No focal lesion noted.

KIDNEYS: Both kidneys are normal in position, size and echo texture. Normal cortico-medullary differentiation is maintained. **No calculus. No hydronephrosis.**

PELVIC ORGANS: Urinary bladder is minimally distended and normal. No calculi.
Uterus is anteverted, endometrium-6.4 mm normal. **Ovaries are normal.**
No adnexal lesion.

RIF: **No mass or collection.**
Aorta and IVC are normal. No obvious retroperitoneal lymphadenopathy.
No free fluid is noted in the peritoneum.

IMPRESSION:

- **Liver shows coarsen echotexture. Nodular surface. caudate lobe hypertrophy – chronic liver disease**
- ***Right, middle hepatic veins and left hepatic veins shows partial color uptake not clearly seen. All hepatic veins draining to IVC not clearly visualized with? Collaterals / ? Anatomical variation seen.***

----------**No e/o urolithiasis/hydronephrosis.**
----------**No e/o ascites/ pleural effusion**
----------**No e/o bowel /RIF pathology seen. No nodes seen.**

*Suggested clinical correlation.*

***Note:*** *Investigations have their limitations. Solitary investigation never confirm the final Diagnosis of Disease, it only helps in diagnosing the disease in correlation to the clinical findings & other investigations*

***With warm regards***

DR. SATISH PATIL MDRD
Consultant radiologist