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Gridhrasi TO SCIATICA: UNFOLDING THE AYURVEDIC GENESIS OF A MODERN NEUROMUSCULAR DISORDER" - A LITERARY EXPLORATION THROUGH TIME

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ABSTRACT

Gridhrasi, one among the Vāta Nanātmaja Vyādhis elaborated in Ayurvedic classics, represents the earliest documented description of the condition that modern science later identified as Sciatica. It is characterised by radiating pain starting from the Sphik region and extending through the Kati, Uru, Janu, Jangha, and Pada, accompanied by Ruk, Toda, Stambha, and Spandana. The disorder arises due to vitiation of Vāta or Vāta–Kapha doshas, affecting Kandaras and Sira. In modern terms, Sciatica results from compression or irritation of the sciatic nerve, commonly due to lumbar disc herniation or spinal stenosis. This review aims to correlate Ayurvedic and modern perspectives of Gridhrasi and Sciatica by analyzing their Nidāna, Rūpa, Samprāpti, and Chikitsā. Ayurvedic management includes Snehana, Swedana, Basti, Agnikarma, and Raktamokshana, focusing on Vāta–Kapha śamana and functional restoration, while modern treatments emphasize anti-inflammatory medications, physiotherapy, nerve blocks, and surgical procedures like laminectomy or discectomy. The conceptual similarity between Gridhrasi and Sciatica suggests that the modern understanding of this condition is rooted in Ayurvedic pathology, reflecting the scientific foresight and holistic approach of ancient scholars.

KEYWORDS: *Gridhrasi, Sciatica, Vāta Vyādhi, Basti Chikitsā, Agnikarma, Vāta–Kapha Gridhrasi.*

INTRODUCTION

The term *Gridhrasi* originates from the Sanskrit root *Gridhra dhatu* combined with the *runn pratyaya*, which conveys the meaning of desire, eagerness, or striving after something intensely. The word formation follows the derivation *गृध्* + *सो* + *क* = *गृध्रसस*, as cited in the *Vachaspatyam* lexicon.[1] Etymologically (*Nirukti*), the condition is termed *Gridhrasi* because the gait of an afflicted person resembles that of a vulture (*Gridhra*), a bird known for its greedy and forceful movement while tearing flesh.[2] The word *syaati*—meaning "to cause suffering"—aptly describes the sharp, radiating pain experienced in this disease, aligning with the vulture-like limping gait.[2]

In Ayurvedic literature, *Gridhrasi* is defined as a *Vata-vyadhi* characterized by *Stambha* (stiffness), *Ruk* (pain), *Toda* (pricking sensation), *Grahana* (restricted movement), and *Spandana* (involuntary twitching).[3] The pain originates in the *Sphik pradesha* (gluteal region) and progresses downward through the *Kati* (lumbar area), *Uru* (thigh), *Janu* (knee), *Jangha* (leg), and *Pada* (foot), following a descending course along the posterior aspect of the body.[3] According to *Acharya Sushruta*, vitiated *Vata dosha* affects the *Kandaras* (ligamentous or tendinous structures), resulting in difficulty in leg extension and characteristic radiating pain.[4] He describes two major *Kandaras*—one extending downward from the heel (*Pārśhni*) to the toes, and another ascending from the heel to the groin (*Vitapa*), which correspond anatomically to the course of the sciatic nerve.[4]

From a contemporary medical perspective, *Gridhrasi* can be correlated with *Sciatica*, a condition derived from the Latin term *Sciaticus* and Greek term *Ischiadikos*, both referring to the sciatic nerve or the ischial region.[5] It is also known as *ischiadic neuralgia*, *Cotugno's disease*, or *sciatic neuritis*.[6] Sciatica manifests as sharp, radiating pain along the distribution of the sciatic nerve and its branches, particularly the common peroneal nerve.[6] The pain generally begins in the gluteal region or lower back and travels along the posterior or lateral aspect of the thigh and leg, extending to the dorsum of the foot.[6] Depending on the compressed nerve root, the pain distribution varies: compression of the S1 root produces pain radiating along the back of the calf and heel, while L5 root compression leads to discomfort along the lateral leg and ankle.[7] In higher-level disc herniations such as L2–L3, pain may involve the anterior thigh.[7] Typically, sciatica pain

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worsens with walking and improves with rest, a pattern described as neurological claudication.[7] Thus, *Gridhrasi* in Ayurveda and *sciatica* in modern medicine represent analogous clinical entities, both signifying a syndrome of radiating lower limb pain due to neural compression or *Vata* vitiation, bridging ancient and modern medical understanding.

Epidemiology and Etiopathogenesis of Sciatica

Sciatica is a painful condition caused by irritation or compression of the sciatic nerve, which arises from the lower spine and extends down the back of the leg. [7] It typically presents with sharp, radiating pain, numbness, or tingling along the nerve pathway. Around 5–10% of patients with low back pain suffer from sciatica, and in nearly 90% of these cases, the main cause is a herniated intervertebral disc pressing on the nerve roots.[8] The condition is most commonly seen in individuals between 45 and 65 years of age, when spinal degenerative changes are more prevalent.[9] Factors such as tall stature, smoking, mental stress, and strenuous physical activity increase the risk of developing sciatica.[10] Thus, the disorder results from a combination of mechanical, degenerative, and lifestyle-related factors that together contribute to nerve irritation and pain.[11]

Anatomical Course of the Sciatic Nerve

The sciatic nerve, the largest and longest peripheral nerve in the human body, originates from the lumbosacral plexus, primarily deriving its fibres from the anterior rami of the L4 to S3 spinal nerves.[7] After its formation, the nerve exits the pelvis through the greater sciatic foramen, entering the gluteal region beneath the piriformis muscle.[12] It then descends along the posterior compartment of the thigh, lying deep to the long head of the biceps femoris muscle, where it supplies several branches to the surrounding musculature.[13] Continuing its downward course, the sciatic nerve reaches the apex of the popliteal fossa, where it terminates by dividing into its two major branches — the tibial and the common fibular (peroneal) nerves.[14] This long and well-defined anatomical pathway explains the characteristic distribution of pain and sensory disturbances observed in sciatica.[7]

Etiological Considerations of Sciatica

Sciatica is a painful neuromuscular condition resulting from irritation, compression, or inflammation of the sciatic nerve, which extends from the lower spine down to the feet.[11] The underlying causes are multifactorial, involving mechanical, degenerative, muscular, and occasionally pathological factors that lead to nerve impingement.[10] The major etiological factors are outlined below:

1. Intervertebral Disc Herniation

Disc herniation represents the most frequent cause of sciatica, accounting for nearly **90% of cases**.[8] It occurs when the nucleus pulposus of an intervertebral disc protrudes through the annulus fibrosus, compressing the adjacent nerve roots.[9] The most common sites of involvement are the **L5** and **S1** spinal levels, where herniation results in radiating pain along the posterior thigh and leg. [15]

Example

A patient presenting with low back pain radiating to the lateral aspect of the foot, accompanied by tingling and numbness, typically suggests L5–S1 nerve root compression due to disc prolapse.

2. Spinal Stenosis

Spinal stenosis refers to the narrowing of the spinal canal that places excessive pressure on the spinal cord or nerve roots. [16] The condition most often develops due to age-related degenerative changes, including bone overgrowth, thickening of ligaments, and intervertebral disc degeneration.[7]

Example

Elderly patients commonly experience pain or numbness in the lower limbs during walking, which improves with rest—a classic symptom of neurogenic claudication due to spinal stenosis.

3. Spondylolisthesis

Spondylolisthesis occurs when one vertebra slips forward over the one beneath it, resulting in compression of the nerve roots.[17] This slippage may arise from degenerative joint changes, repetitive spinal stress, or stress fractures in the pars interarticularis.[18] The resultant narrowing of the vertebral canal may cause symptoms similar to spinal stenosis.

Example

Middle-aged adults involved in heavy physical labour may experience radiating back pain due to degenerative spondylolisthesis.

4. Piriformis Syndrome

In certain individuals, the sciatic nerve pierces through or passes beneath the piriformis muscle in the gluteal region.[19] When this muscle undergoes excessive contraction or spasm, it can entrap the sciatic nerve, producing characteristic pain radiating down the leg.

Example

Prolonged sitting or overuse of hip muscles, such as during cycling, can trigger piriformis-related sciatica.

5. Pregnancy-Related Sciatica

Sciatica can also occur during pregnancy due to mechanical compression of the sciatic nerve by the growing uterus or foetal weight.[20] Hormonal changes leading to ligament relaxation and muscle spasm may further exacerbate the condition.

Example

Pregnant women may complain of unilateral radiating leg pain that worsens while sitting or standing for long periods.

6. Other Contributing Causes

Apart from the above major aetiologies, several additional factors may precipitate or aggravate sciatica:[15]

- **Spinal infections** causing inflammation or abscess formation.
- **Traumatic injury** to the vertebral column or adjacent soft tissues.
- **Spinal tumours** leading to direct compression of nerve roots.

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- **Spinal trauma** due to falls, accidents, or forceful impacts resulting in vertebral displacement or soft-tissue damage.

In essence, sciatica is a multifactorial disorder, most commonly arising from disc herniation, spinal stenosis, or spondylolisthesis, and less frequently from muscular entrapment, pregnancy, or pathological lesions.[7] Understanding the underlying cause is crucial for accurate diagnosis, appropriate intervention, and prevention of recurrence.

Clinical Manifestations of Sciatica

Sciatica typically presents with radiating pain originating in the gluteal region and extending down the posterior aspect of the thigh and leg, following the course of the sciatic nerve. Patients often describe associated cramping or tightness in the thigh, accompanied by tingling, numbness, or a burning sensation in the leg and thigh regions. In more severe cases, muscle weakness may develop due to prolonged nerve compression. Clinically, the condition is most commonly unilateral, affecting only one side of the body; however, when symptoms are present bilaterally, it generally indicates a more pronounced disc herniation or severe nerve involvement. The pattern and intensity of these symptoms provide important diagnostic clues correlating with the level and severity of nerve compression.

Risk Factors for Sciatica

Several factors increase the likelihood of developing sciatica, including age-related, metabolic, occupational, and lifestyle influences. Advancing age contributes to degenerative spinal changes such as disc herniation and osteophyte formation, which predispose to nerve compression. Obesity adds mechanical stress to the spine, while diabetes mellitus increases susceptibility to nerve damage. Occupational activities involving repetitive twisting, heavy lifting, or prolonged driving, as well as a sedentary lifestyle with extended sitting, further elevate the risk. Awareness of these factors is important for the prevention and early management of sciatica.

Clinical Examination for Sciatica

Clinical assessment of sciatica involves specific **provocative tests** designed to identify nerve tension, compression, or irritation. These tests are essential for differentiating sciatic nerve involvement from other neuropathies and musculoskeletal conditions.

1. Straight Leg Raise (SLR) Test

The SLR test is widely used to assess sciatic nerve irritation. The patient lies supine while the examiner gently elevates the affected leg with the knee fully extended. A **positive test** is indicated by sciatic pain or radiating discomfort down the leg when hip flexion ranges between 30° and 70°, suggesting nerve root involvement.

2. Bragard Test

A modification of the SLR test, the Bragard test involves **dorsiflexion of the foot** while maintaining leg elevation. Reproduction of sciatic pain confirms nerve irritation.

3. Sicard Test

Similar to the Bragard test, the Sicard test focuses on **dorsiflexion of the great toe** instead of the entire foot. Positive reproduction of symptoms indicates sciatic nerve tension.

4. Slump Test

The Slump test evaluates overall nerve tension and can reveal **nerve impingement or irritation**. With the patient seated, the examiner performs a combination of spinal flexion, neck flexion, and ankle dorsiflexion. A positive result is indicated by pain or tingling radiating down the leg.

5. FAIR Test (Flexion, Adduction, Internal Rotation)

The FAIR test is primarily used to detect **piriformis syndrome**, where the piriformis muscle compresses the sciatic nerve. The patient may be seated or supine with hip and knee flexed, followed by hip internal rotation while the examiner applies resistance to external rotation and abduction. Sciatic pain reproduction signifies a positive test.

6. Femoral Nerve Tension Test

This test helps distinguish between **femoral nerve pathology** and sciatica. While sciatic nerve involvement causes pain along the posterior and lateral aspects of the leg, femoral nerve irritation typically presents as anterior thigh discomfort. Correct differentiation guides diagnosis and management.

Management of Sciatica

The treatment of sciatica is **multimodal**, ranging from conservative measures and pharmacotherapy to interventional procedures and surgery, depending on the severity and underlying cause.[21] The management approach is generally **stepwise**, starting with supportive care and lifestyle modification, progressing to medications and physical therapy, and, if required, interventional or surgical interventions.

1. Supportive Care

Supportive measures aim to reduce pain, inflammation, and nerve irritation while promoting early mobilisation.[22]

- **Ice Packs:** Application of cold packs to the affected area helps reduce local inflammation and dulls the sensation of pain.
- **Heat Therapy and Rest:** Short-term rest and controlled application of heat may relieve muscle spasm and discomfort.

2. Pharmacological Management

Medications are used to alleviate pain, reduce inflammation, and manage associated muscle spasm.[23]

- **Nonsteroidal Anti-inflammatory Drugs (NSAIDs):** Ibuprofen, naproxen, and diclofenac.
- **Analgesics:** Acetaminophen for mild pain relief.
- **Muscle Relaxants:** Tizanidine and cyclobenzaprine to relieve muscle spasm.
- **Corticosteroids:** Prednisone and methylprednisolone for short-term inflammation control.
- **Nerve Pain Medications:** Opioids like tramadol or oxycodone may be prescribed for severe or refractory pain.

3. Physical Therapy and Manual Interventions

Physical and manual therapies aim to improve mobility, reduce nerve compression, and strengthen supporting musculature.[24]

- **Chiropractic Care:** Includes spinal manipulation, mobilization, decompression therapy, and adjunctive modalities such as heat/cold therapy or ultrasound.

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- **Stretching and Strengthening Exercises:** Targeted exercises help strengthen the core and lower limb muscles, relieve nerve tension, and prevent recurrence.

4. Complementary Therapies

Complementary approaches can be considered for symptomatic relief and functional improvement.[25]

- **Acupuncture:** Involves stimulation of specific points on the body to modulate pain pathways and reduce discomfort.
- **Lifestyle Modifications:** Ergonomic corrections, posture management, weight reduction, and activity adjustments can prevent exacerbation.

5. Interventional Procedures

For persistent or severe symptoms unresponsive to conservative care, **epidural corticosteroid injections** may be considered.[26]

- **Procedure:** Steroid medications such as methylprednisolone, triamcinolone, betamethasone, or dexamethasone are injected into the epidural space under imaging guidance, usually completed within 30 minutes.
- **Purpose:** Reduces local inflammation and nerve irritation, providing temporary or sustained relief.

6. Surgical Management

Surgery is reserved for patients with severe neurological deficits, unrelenting pain, or structural spinal compromise.[27] Common surgical interventions include:

- **Microdiscectomy:** Removal of the herniated portion of the disc compressing the nerve.
- **Laminectomy:** Excision of part of the vertebral lamina to relieve nerve compression.
- **Laminoplasty:** Reconstruction to create additional space for nerve passage.
- **Foraminotomy:** Enlargement of the intervertebral foramen to allow nerve decompression.
- **Spinal Fusion:** Stabilization of two or more vertebrae, often performed after disc removal to maintain spinal alignment.

GRIDHRASI

Acharya Sushruta's (Su. Ni. 1/74)

पार्ष्णिप्रत्यङ्गुलीनां तु कण्डरा याऽनिलार्दिता ।
सक्थ्नः क्षेपं निगृह्णीयाद् गृध्रसीति हि सा स्मृता ॥

Acharya Sushruta describes ***Gridhrasi*** as a condition that occurs when *Vata dosha* vitiates the *Kandara* (tendinous structures) extending between the *Pārśhni* (heel) and *Anguli* (toes). This vitiation leads to stiffness and restriction in the upward movement (*utkshepa*) of the lower limb, particularly affecting the thigh (*Sakthi*). The inability to lift the leg properly, along with pain radiating through the posterior aspect, is the characteristic sign of Gridhrasi. Sushruta thus highlights the neuromuscular involvement, emphasizing the role of vitiated *Vata* in disturbing the function of *Kandaras*, analogous to sciatic nerve irritation in modern terms.

2. Acharya Vāgbhata's (A. Hr. Ni. 15/54)

पार्ष्णिं प्रत्यङ्गुलीनां या कण्डरा मारुतार्दिता ।
सक्थ्युत्क्षेपं निगृह्णाति गृध्रसीं तां प्रचक्षते ॥

Acharya *Vāgbhata* provides a similar explanation, reinforcing that ***Gridhrasi*** arises due to the vitiation of *Vata* affecting the *Kandara* extending from the heel (*Pārśhni*) to the toes (*Anguli*). This pathological involvement causes restriction in the elevation or movement of the thigh (*Sakthi*). The description emphasizes functional impairment and pain following the course of the affected nerve-like structure. *Vāgbhata's* view corresponds to neurological dysfunction, where Vata derangement leads to both sensory (pain, tingling) and motor (movement restriction) disturbances—reflecting the Ayurvedic understanding of **neuro-musculoskeletal pathology**.

3. Acharya Charaka's (Ch. Chi. 28/56)

स्फिक्पूर्वा कटिपृष्ठोरुजानुजङ्घापदं क्रमात् ।
गृध्रसी स्तम्भरुक्तोदैर्गृह्णाति स्पन्दते मुहुः ॥

Acharya Charaka gives the most comprehensive clinical picture of ***Gridhrasi***, outlining the sequential progression of pain. The disease begins in the *sphik* (gluteal region) and radiates downward through the *kati* (waist), *prushtha* (back), *uru* (thigh), *janu* (knee), *jangha* (leg), and finally to the pada (foot). The main symptoms include *stambha* (stiffness), *ruk* (pain), *toda* (pricking sensation), and *spandana* (involuntary twitching). This detailed pathway mirrors the course of the sciatic nerve described in modern anatomy. Charaka thus correlates the classical features of Vata aggravation with the clinical entity of **sciatica**, showing remarkable precision in understanding the disease's neuroanatomical pattern.

Collectively, these classical references establish ***Gridhrasi*** as a ***Vatavyadhi*** (neuromuscular disorder) involving the *Kandaras* and characterized by pain, stiffness, and restricted movement, following a radiating pattern from the hip to the foot. The harmony between these Ayurvedic descriptions and modern sciatic nerve pathology demonstrates the deep clinical insight of the Acharyas in identifying and explaining nerve-related disorders.

Nidāna (Etiological Factors) of Gridhrasī

In the classical Ayurvedic texts, specific Nidānas (causative factors) of *Gridhrasī* are not explicitly mentioned. However, as *Gridhrasī* is described as a Nānatmaja Vātavyādhi—a disease arising predominantly from the vitiation of *Vāta Dosha*—the general *Vāta-prakopaka nidānas* can be considered responsible for its manifestation, these causative factors can be broadly classified into

Āhāraja (dietary), Vihāraja (behavioural), Mānasika (psychological), and **Anya Hetuja (other causes).**

Āhāraja Nidāna (Dietary Factors)

Consumption of *Rūkṣa* (dry), *Śīta* (cold), and *Laghu* (light) food items, taking *Alpa Āhāra* (insufficient food), or following a diet dominated by *Kaṭu* (pungent), *Tikta* (bitter), and *Kaṣāya* (astringent) tastes leads to aggravation of *Vāta Dosha*. Practices such as *Langhana* (excess fasting) and *Abhojana* (skipping meals) further vitiate *Vāta*, thereby predisposing an individual to *Gridhrasī*.

Vihāraja Nidāna (Lifestyle Factors)

Excessive physical exertion (*Ativyāyāma*), overindulgence in sexual activity (*Ativyāvāya*), prolonged wakefulness

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(*Atiprajāgara*), irregular therapeutic regimens (*Viṣama Upacāra*), and suppression of natural urges (*Vegadhāraṇa*) are major lifestyle-related causes that disturb *Vāta* and contribute to the onset of *Gridhrasī.*

Mānasika Nidāna (Psychological Factors)
Mental factors such as *Chintā* (excessive worry), *Śoka* (grief), *Krodha* (anger), and *Bhaya* (fear) are known to cause imbalance in *Vāta Dosha*, which can indirectly lead to *Gridhrasī* through neurological and muscular disturbances.

Anya Hetuja (Other Causes)
Conditions such as *Dhātukṣaya* (tissue depletion), *Marmābhighāta* (trauma to vital points), *Mārgāvaraṇa* (obstruction of channels), and direct *Abhigāta* (injury) are also recognized as potential etiological factors in the pathogenesis of *Gridhrasī.*

Thus, the Nidāna of *Gridhrasī* primarily centres around the **vitiation of *Vāta Dosha*** due to improper diet, faulty lifestyle, mental strain, and physical or structural causes, all of which disturb the *Vāta* balance, leading to the characteristic pain and stiffness observed in this condition.

Pūrvarūpa of Gridhrasi
In the Ayurvedic classics, specific *pūrvarūpa* (premonitory symptoms) of *Gridhrasi* are not described distinctly. However, since *Gridhrasi* is classified under *Vāta-vyādhi*, its early manifestations can be understood through the general *avyakta lakṣaṇas* (vague or indistinct symptoms) of *Vāta-vikāra*. Chakrapāṇi Datta, while commenting on the term *avyakta*, has explained that certain subtle and mild features preceding the full manifestation of disease can be considered as *pūrvarūpa*. Accordingly, in the initial stage of *Gridhrasi*, mild presentations of *rūk* (pain), *todā* (pricking sensation), *stambha* (stiffness) and *spandana* (twitching or pulsation) are observed. These subtle manifestations indicate the initial vitiation of *Vāta* in the *kaṭi-pradeśa* (lumbar region) and *pāda-mārga* (lower limb pathway), which, if not addressed promptly, may progress to the full-blown clinical stage of *Gridhrasi*. Such understanding of *pūrvarūpa* is crucial, as it enables early detection and timely preventive interventions in the management of *Vāta-vyādhi*.

Rūpa of Gridhrasi
Acharya Charaka describes the classical symptomatology of *Gridhrasi* as—**"*Sphikpūrvā kaṭipṛṣṭhorujānujanghāpadaṁ kramāt, Gridhrasī stambha-ruk-todair gṛhṇāti spandate muhuḥ; vātād vāta-kaphāt tandrā-gauravārochakānvitā*" (*Ch. Chi. 28/56*).**
This verse highlights the hallmark manifestations of the disease, where pain (*rūk*), pricking sensation (*todā*), stiffness (*stambha*), and intermittent twitching (*muhuḥ-spandana*) occur sequentially along the course of the sciatic nerve. The pain typically originates in the *sphik pradeśa* (gluteal region) and radiates through the *kaṭi* (lumbar area), *prṣṭha* (back), *ūru* (thigh), *jānu* (knee), *jaṅghā* (leg), and finally extends to the *pāda* (foot) in a downward direction. This progressive radiation of pain is considered a distinctive diagnostic feature of *Gridhrasi*, closely resembling the path of sciatica in modern medicine.

In *Vātaja Gridhrasi*, the dominance of *Vāta doṣa* produces symptoms like shooting pain, stiffness, and pricking sensations, while in *Vāta-kaphaja Gridhrasi*, additional features such as heaviness (*gaurava*), drowsiness (*tandrā*), and loss of appetite (*arocaka*) are observed due to the association of *Kapha doṣa*. These clinical features reflect the combined effect of *Vāta* vitiation and structural obstruction caused by *Kapha*, leading to the characteristic *ruk-stambha-spandana* pattern of discomfort. Timely recognition of these *rūpas* is crucial for appropriate diagnostic assessment and individualized therapeutic planning in the management of *Gridhrasi*.

Types and Clinical Presentation of *Gridhrasi*
Gridhrasi has been classified into two main types according to the predominance of *doṣas—Vātaja Gridhrasi* and *Vāta-Kaphaja Gridhrasi*.
1. *Vātaja Gridhrasi*
Acharya *Mādhava* has described the *Vātaja* type as follows:
"*Vātajāyāṁ bhavet todaḥ dehasthyāpi pravakratā; jānukaṭyūru saṁdhnāṁ sphuraṇaṁ stambhatā bhṛśam*" (*Mā. Ni. 22/55*).
This variety is mainly characterized by *toda* (needle-like pricking pain), *vakratā* (bent or altered posture due to pain or stiffness), and *stambha* (rigidity or tightness) in the *kaṭi* (lumbar), *ūru* (thigh), and *jānu sandhi* (knee joints). Additionally, fasciculations or spasmodic twitching in the affected limb (*sphuraṇa*) may also be present. These features reflect the predominance of *Vāta doṣa*, leading to intense pain, restricted movement, and postural deformity due to *mārga-āvaraṇa* (obstruction in the nerve pathways).

2. *Vāta-Kaphaja Gridhrasi*
In *Vāta-Kaphaja Gridhrasi*, Acharya *Mādhava* states:
"*Vāta-śleṣmādoṣabhavayāṁ tu nimittaṁ vahnimāndyaṁ tandrā mukhaprasekaśca bhaktadveṣaśca*" (*Mā. Ni. 22/56*).
Here, the association of *Kapha doṣa* adds heaviness and sluggishness to the clinical picture. Patients experience *agnimāndya* (poor appetite), *tandrā* (drowsiness), *lālāsrāva* (excessive salivation), and *bhaktadveṣa* (aversion to food or anorexia). These symptoms signify *kapha-saṁsarga* along with *vāta-prakopa*, resulting in obstruction of *vāta-mārga* and subsequent manifestation of *rūk*, *stambha*, and *gaurava*.

In summary, *Vātaja Gridhrasi* primarily exhibits pain, stiffness, and muscular spasms due to pure *Vāta vitiation*, whereas *Vāta-Kaphaja Gridhrasi* presents additional symptoms of heaviness, lethargy, and digestive impairment because of *Kapha* involvement. Recognizing these subtypes aids in individualized assessment and doshic-specific management of *Gridhrasi*.

Sādhyāsādhyatā (Prognosis) of Gridhrasi
The *Sādhyāsādhyatā* of *Gridhrasi* depends upon the chronicity, severity of *doṣa vitiation*, and the involvement of *dhātu* and *marma*. As mentioned in the classics, *Vāta-vyādhi* persisting for more than one year or presenting as a chronic condition is considered difficult to cure (*kṛcchra-sādhya*) or even incurable (*asādhyā*). *Ācāryas* have classified *Vāta-vyādhi* among *mahāgada* owing to its recurrent, degenerative, and often fatal nature. When the patient of *Gridhrasi* develops complications such as *śūna* (oedema or inflammation), *suptatvacā* (loss of

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tactile sensation), *bhagna* (fracture or structural damage), *kampa* (tremors), *adhmāna* (abdominal distension with tenderness), and internal organ pain, the disease is regarded as *asādhyā*. Thus, early diagnosis and prompt management aimed at *doṣa-śamana* and *vāta-anulomana* are essential to prevent chronicity and complications of *Gridhrasi*.

Sāmānya Chikitsā (General Line of Management) of Gridhrasi

Gridhrasi, being one among the *Vāta-nānātmaja vyādhis*, follows the *sāmānya cikitsā sūtra* of *Vāta-vyādhi*. The management primarily aims at *vāta-śamana* and *vāta-anulomana* by avoiding *vāta-prakopaka hetus* such as excessive fasting, strain, suppression of natural urges, and intake of *rūkṣa*, *śīta*, and *laghu* foods. Substances possessing *madhura*, *amla*, and *lavaṇa rasa* with *snigdha* and *uṣṇa guṇa* are ideal for pacifying *vāta doṣa*.

The line of treatment includes *snehana* (oleation) and *swedana* (sudation) to relieve stiffness and pain, followed by *basti karma*—both *āsthāpana* and *anuvāsana*—which are considered the foremost therapies for *vāta-vyādhi* as they directly act on the *pakvāśaya*, the main site of *vāta*. *Nasya* (nasal administration of medicated oils) and *abhyanga* (massage with medicated oils) help in reducing rigidity, pain, and neurological discomfort. Additionally, *parisheka* (pouring of warm medicated liquids) may be employed to promote muscle relaxation and improve joint mobility.
Thus, the *sāmānya cikitsā* of *Gridhrasi* emphasizes restoring *vāta doṣa* balance and improving neuromuscular function through *sneha*, *uṣṇa*, and *mṛdu* therapies.

Viśeṣa Chikitsā (Specific Line of Treatment) of Gridhrasi

The *viśeṣa cikitsā* of *Gridhrasi* primarily focuses on pacifying aggravated *Vāta* and *Kapha doṣas*, restoring neuromuscular balance, and relieving pain. Classical texts such as *Charaka Samhita (Chikitsa Sthana 28th)*, *Sushruta Samhita (Chikitsa Sthana 5th)*, and *Ashtanga Hridaya (Sutra Sthana 27th)* describe specific protocols for its management [28-30].

Charaka emphasizes *Basti karma* as the most effective therapy, being the prime treatment for *Pakvashaya-sthita Vāta vyādhi*. Both *Āsthāpana* and *Anuvāsana bastis* are alternated using medicated oils like *Sahacharādi taila*, *Mahanārāyana taila*, or *Dhanvantara taila* to relieve pain and stiffness. *Snehana*, *Swedana*, and *Mridu Virechana* are advised as preparatory measures to eliminate *doṣic obstruction* [28].

Sushruta prescribes *Agnikarma* and *Raktamokṣaṇa* as effective *śodhana* procedures [29]. *Agnikarma* done with *Loha shalaka* at tender points alleviates pain by balancing *Vāta–Kapha*, while *Raktamokṣaṇa* helps reduce inflammation and stiffness, especially in *Vāta-Kaphaja Gridhrasi*.

Vāgbhaṭa recommends a combined approach of *Basti*, *Abhyanga*, and *Swedana* with *Vāta-hara dravyas* such as *Sahacharādi ghṛta* and *Ksheerabala taila* [30]. These measures collectively correct *vāta vitiation*, strengthen nerves, and improve lower limb mobility.

Thus, *Basti karma* remains the mainstay of *Gridhrasi cikitsā*, supported by *Agnikarma*, *Raktamokṣaṇa*, and *Snehana–Swedana* for comprehensive management.

Pathya–Apathya in Gridhrasi

In *Gridhrasi*, adherence to *pathya–apathya āhāra vihāra* is crucial for successful management and prevention of recurrence. Classical texts emphasize that *Vāta-prashamana* diets and lifestyles help maintain balance and improve recovery.

Ācārya Charaka and *Vāgbhaṭa* recommend foods that are *madhura, amla,* and *lavana rasa pradhāna* with *snigdha* and *uṣṇa guṇa*, such as *taila*, *ghṛta*, *yūṣa*, *māṃsa rasa*, and *kṣīra*, which nourish tissues and pacify *Vāta*. Light, warm, and easily digestible food like *mudga yūṣa* and *yavāgu* is also advised. Regular *abhyanga* and *svedana* form beneficial daily regimens (*dinacharya*) for maintaining *vāta śamana*.

Conversely, *Apathya* includes *rukṣa, śīta, laghu,* and *kaṣāya rasa* foods, along with habits like fasting, overexertion, sleeplessness, and exposure to cold or wind, which aggravate *Vāta*. *Ācārya Sushruta* cautions against improper posture and jerky movements, which can precipitate or worsen *Gridhrasi*.

Thus, maintaining *pathya āhāra vihāra* aids in balancing *doṣas*, preventing relapses, and enhancing the effectiveness of therapeutic interventions in *Gridhrasi*.

DISCUSSION

Gridhrasi, one among *Vāta Nanātmaja Vyādhi*, closely resembles Sciatica in modern medicine, both in pathogenesis and symptomatology. Classical texts describe it as a disorder originating from aggravated *Vāta* alone or in association with *Kapha*, leading to pain radiating from *Sphik* to *Pada* with *Ruk*, *Toda*, *Stambha*, and *Spandana* as cardinal features. This sequential pain distribution correlates well with the anatomical pathway of the sciatic nerve. The association of *Kapha* produces additional symptoms like *Tandra*, *Gaurava*, and *Arochaka*.

The pathology (*Samprapti*) of *Gridhrasi* involves *Vāta* vitiation causing *Mārga-āvaraṇa* and deranged neuromuscular function, analogous to nerve root compression in modern science. *Basti Karma* is the prime line of treatment, as it directly pacifies *Vāta* and nourishes the *Dhātus*. Use of *Āsthāpana* and *Anuvāsana Basti* with medicated oils such as *Sahacharādi Taila* and *Ksheerabala Taila* is found beneficial. *Agni Karma* and *Raktamokṣaṇa* are also advised for localised pain and stiffness, improving circulation and relieving obstruction. Supportive measures like *Snehana*, *Swedana*, *Abhyanga*, and *Nasya* help in reducing rigidity and promoting mobility.

In allopathic management, symptomatic relief is achieved through NSAIDs, muscle relaxants, corticosteroid injections, physiotherapy, and, in severe cases, surgical interventions like microdiscectomy or laminectomy, which primarily target nerve decompression.

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Dietary and lifestyle regulation play a vital preventive and curative role. *Snigdha*, *Uṣṇa*, and *Madhura–Amla–Lavaṇa* dominant diet, along with avoidance of *Rūkṣa*, *Śīta*, and fasting, are advised for *Vāta-śamana*. Regular *Abhyanga* and mild exercise maintain flexibility and prevent recurrence.

Thus, Ayurvedic management of *Gridhrasi* offers a comprehensive, root-cause-based approach, addressing both the symptomatic relief and systemic balance of *Vāta*. Its conceptual similarity with modern sciatica and holistic therapeutic strategies highlights the timeless clinical wisdom of Ayurveda and its relevance in contemporary neuromuscular care.

CONCLUSION

Gridhrasi, described in Ayurveda as a *Vāta Nanātmaja Vyādhi*, presents clinical features strikingly similar to what modern science terms *Sciatica* — a condition that appears to have its conceptual origin in the ancient understanding of Gridhrasi. The Ayurvedic management, emphasizing *Vāta–Kapha śamana*, *Basti chikitsā*, and supportive measures such as *Snehana*, *Swedana*, and *Agni karma*, offers a holistic therapeutic approach. When correlated with contemporary management strategies, it becomes evident that the classical Ayurvedic insights into *Gridhrasi* laid the foundational understanding of what modern medicine recognizes as Sciatica, highlighting the timeless relevance of Ayurvedic wisdom in neuromuscular disorders.

Scope and Relevance of the Study

The present review on *Gridhrasi (Sciatica)* bridges classical Ayurvedic knowledge with modern medical understanding, highlighting the ancient recognition of the condition and its holistic management principles. This synthesis emphasizes the potential of Ayurvedic therapies like *Basti*, *Snehana*, and *Swedana* in offering sustainable, non-invasive, and comprehensive treatment strategies. The review also supports the scope of further evidence-based studies integrating Ayurveda with modern diagnostics and rehabilitation protocols.

Limitations

The current review is limited by the scarcity of large-scale clinical trials evaluating Ayurvedic interventions for *Gridhrasi*. Many classical references describe therapeutic measures qualitatively rather than quantitatively, posing challenges for direct clinical comparison with modern treatments. Further standardized research and multicentric trials are needed to validate these traditional approaches scientifically.

Future Prospects

Future research should focus on developing standardised formulations, Standardisation-improvisation of *Anushastras and their karmas*, objective pain-assessment protocols, and comparative studies between *Basti chikitsā* and conventional physiotherapy or pharmacotherapy. Such integrative work can strengthen the scientific foundation and global acceptance of Ayurvedic management in neuromuscular disorders.

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REFERENCES

1. *Vachaspatyam Sanskrit Lexicon. Vol. 2. Chaukhamba Sanskrit Series Office; Varanasi. p. 540.*
2. *Shabdakalpadruma. Vol. 2. Chaukhamba Sanskrit Series Office; Varanasi. p. 314.*
3. *Charaka Samhita, Chikitsa Sthana 28/56–58. Edited by Sharma PV. Chaukhamba Orientalia; Varanasi, 2019.*
4. *Sushruta Samhita, Nidana Sthana 1/72–74. Edited by Murthy KRS. Chaukhamba Orientalia; Varanasi, 2020.*
5. *Dorland's Illustrated Medical Dictionary. 33rd ed. Elsevier; Philadelphia, 2020.*
6. *Cotugno D. De Ischiade Nervosa Commentarius. Neapoli; 1764.*
7. *Standring S, editor. Gray's Anatomy: The Anatomical Basis of Clinical Practice. 42nd ed. Elsevier; London, 2020.*
8. *Konstantinou K, Dunn KM. Sciatica: review of epidemiological studies and prevalence estimates. Spine (Phila Pa 1976). 2008;33(22):2464–72.*
9. *Weber H. Lumbar disc herniation: a controlled, prospective study with ten years of observation. Spine (Phila Pa 1976). 1983;8(2):131–40.*
10. *Valat JP, Genevay S, Marty M, Rozenberg S, Koes B. Sciatica. Best Pract Res Clin Rheumatol. 2010;24(2):241–52.*
11. *Stafford MA, Peng P, Hill DA. Sciatica: a review of history, epidemiology, pathogenesis, and the role of epidural steroid injection in management. Br J Anaesth. 2007;99(4):461–73.*
12. *Moore KL, Dalley AF, Agur AMR. Clinically Oriented Anatomy. 8th ed. Wolters Kluwer; Philadelphia, 2018.*
13. *Snell RS. Clinical Neuroanatomy. 8th ed. Wolters Kluwer; New Delhi, 2019.*
14. *Sinnatamby CS. Last's Anatomy: Regional and Applied. 13th ed. Elsevier; Edinburgh, 2019.*
15. *Stafford MA, Peng P, Hill DA. Br J Anaesth. 2007;99(4):461–73.*
16. *Genevay S, Atlas SJ. Lumbar spinal stenosis. Best Pract Res Clin Rheumatol. 2010;24(2):253–65.*
17. *Kalichman L, Hunter DJ. Diagnosis and conservative management of degenerative lumbar spondylolisthesis. Eur Spine J. 2008;17(3):327–35.*
18. *Denard PJ, Holton KF, Miller J, Fink HA, Kado DM, Marshall LM, et al. Lumbar spondylolisthesis among elderly men: prevalence, correlates, and progression. Spine (Phila Pa 1976). 2010;35(10):1072–8.*
19. *Boyajian-O'Neill LA, McClain RL, Coleman MK, Thomas PP. Diagnosis and management of piriformis syndrome: an osteopathic approach. J Am Osteopath Assoc. 2008;108(11):657–64.*
20. *Mohapatra DP, Reddy S. Sciatica in pregnancy: management and review. J Clin Orthop Trauma. 2015;6(2):124–9.*
21. *Valat JP, Genevay S, Marty M, Rozenberg S, Koes B. Sciatica. Best Pract Res Clin Rheumatol. 2010;24(2):241–52.*

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22. *Konstantinou K, Dunn KM. Sciatica: review of epidemiological studies and prevalence estimates. Spine (Phila Pa 1976). 2008;33(22):2464–72.*
23. *Stafford MA, Peng P, Hill DA. Sciatica: a review of history, epidemiology, pathogenesis, and the role of epidural steroid injection in management. Br J Anaesth. 2007;99(4):461–73.*
24. *Ropper AH, Zafonte RD. Sciatica. N Engl J Med. 2015; 372:1240–8.*
25. *Hopayian K, Danielyan A, Rasekhi H. Piriformis syndrome: a review of current literature. Muscle Nerve. 2010; 42:177–83.*
26. *Manchikanti L, Singh V, Falco FJ, et al. Epidural injections in the management of chronic spinal pain: an update of the literature. Pain Physician. 2013;16(1): E67–E129.*
27. *Gibson JN, Waddell G. Surgical interventions for lumbar disc prolapse: updated Cochrane Review. Spine (Phila Pa 1976). 2007;32(16):1735–47.*
28. *Charaka Samhita, Chikitsa Sthana, 28/56–58.*
29. *Sushruta Samhita, Chikitsa Sthana, 5/28–30.*
30. *Ashtanga Hridaya, Sutra Sthana, 27/5–8.*