WORLD JOURNAL OF PHARMACEUTICAL RESEARCH
SJIF Impact Factor 8.074
Volume 7, Issue 18, 481-486. Review Article ISSN 2277– 7105

REVIEW OF SHWITRA KUSHTHA WITH SPECIAL REFERENCE TO VITILIGO

Dr. Ambalal N. Vasave*[1] M.D. and Dr. Deepnarayan Shukla[2] M.D. (Sharir Rachana)

[1]Scholar (Sharir Rachana),

[2]HOD & Professor,

R.A.Podar (Govt.) Medical College (Ayu), Attached to M.A.Podar Hospital, Worli, Mumbai, Maharashtra.

Article Received on
24 August 2018,

Revised on 14 Sept. 2018,
Accepted on 04 October 2018

DOI: 10.20959/wjpr201818-13519

***Corresponding Author**
Dr. Ambalal N. Vasave
Scholar (Sharir Rachana), R.A.Podar (Govt.) Medical College (Ayu), Attached to M.A.Podar Hospital, Worli, Mumbai, Maharashtra.

ABSTRACT

Many skin Diseases described in ayurveda, shwitra kushtha are one of the disease, in which virechan (purgative) and Aatap sevan (sun-light rays) are very effective, As well as Lepa also very effective Treatment.

KEYWORDS: Shwitra-kushtha, Virechan, Aatap-sevan, lepa, Melanocytes.

INTRODUCTION

Shwitra kushtha is one of the skin Disease, in which Twak (skin) are affecting, so Twak Dushti are present in vitilligo, so that Aatap sevan are effective treatment in this Disease. The Lepa also very effective, because Lepa is direct contact to skin. The Aacharya charak and sushruta both also Described the shwitra kushtha in their Ayurved samhita with special kushthaadhyaya(chapter).

MATERIAL AND METHODS

Various literature has been collected from Ayurved samhitas and also collected information from modern textbooks and internet.

Hetu (causes) are Described in charak chikitsasthan

- Asatya bhashhan
- Insult of God and senior respected persons like Guru, parents.
- Previous Birth sin-work.

- Opposite food-eating etc.

Types of shwitra kushhtha

A)Darun B)Arun C)Kilaas

Other Types By charak

A)Raktaj-Rakta-varniy (like blood) B)Maansaj-Tamra-varniy

C)Medoj-shweta-varniya (like white colour).

Lakshan (Symptoms)

Doshaja lakshanas by Ashhtanga-Hridaya- A)Vaataj:- Rukshha, Arun-varniy skin B)Pittaj:-Red like lotus flower, Dah (heatness), Rom-nashak. C)Kaphaj:-White, heavy, itching sensation at skin region.

Shwitra kushtha Sadhyasadhyata (Prognosis)

a) Vataj-Rakta Dhaatugami - Krushha

b) Pittaj-Maansa Dhaatugami- Krushhatar

c) Kaphaj-Meda Dhaatugami- Krushhatam

Shwitra-kushhtha Asadhyata

- The shwitra kushhtha, which are mix with each other.
- Large amount of kushhtha are present on skin.
- Colour changes.
- Long Duration.

Shwitra-kushhtha Sadhyata

- Hair colour- Not changes
- Very few amount present on skin
- White coloured
- Newly developed
- Lesions are not intermixed.

Shwitra kushtha Chikitsa

A) Panchakarmas (Body purification treatment)

- Initially Vaman then Virechana followed by mild purgation by Malapoo (Kakodumbar)

and Guda (Jaggery)

- Atap sevan- Exposure to early morning sunlight
- Lepas- a) Manashiladi lepa

b) Kakodumbaradi lepa

c) Avalgujadi lepa

d) Tutthakadi lepa.

B) Shamana Chikitsa

- Khadir saar Jala
- Kilasnashak yog
- Jalagandaj kshara.

VITILIGO (Modern aspect)

Vitiligo is an acquired condition affecting 1% of the population worldwide. It may be familial and is associated with other autoimmune diseases characterized by asymptomatic depigmented macules.

Causes of vitiligo

- Transmitted by an autosomal dominant gene with irregular penetration
- 10-30% of the patients have some relative having vitiligo
- Vitiligo seen on the flanks of some ladies who wear tight strings petticoats are due to prolong pressure
- Lesions occur very frequently on knees, elbows, ankles, knuckles and other areas of skin subjected to repeated trauma
- Linear lesions at the site of scratching (Koebner's phenomenon)
- Repeated trauma, even minor one, may produce depigmentation.

Diseases associated with vitiligo

- Hyper and hypothyroidism
- Pernicious anaemia
- Addison's disease
- Diabetes mellitus
- Malignant melanoma
- Halo naevus.

Histopathology

- Marked reduction or even absence of melanocytes and melanin in the epidermis.

Histochemical findings

- There is lack of DOPA-positive melanocytes in the basal layer of epidermis.
- Degenerating melanocytes especially at the margins of vitiligo.

Morphology

- Macules vary in size and shape as well as in colour. In some lesions the hair are also white called leucotrichia.
- Margins are usually well-defined and occasionally hyperpigmented.

Course

- Variable-static to progressive very fast
- The repigmentation is usually perifollicular
- The lesions appear any time after birth.

Clinical features

Focal loss of melanocytes causes patches of sharply defined depigmentation. Generalised vitiligo is often symmetrical and frequently involves the hands, wrists, knees and neck, as well as the area around the body orifices. Associated hair may also depigment. Segmental vitiligo is restricted to one part of the body but not necessarily a dermatome. Some spotty perifollicular pigment may be seen within the depigmented patches and is sometimes the first sign of repigmentation. Sensation in the depigmented patches is normal (in contrast to tuberculoid leprosy). The course is unpredictable but most patches remain static or enlarge; a few repigment spontaneously.

Treatment- General

- Vitiligo is an absolutely harmless disease except its cosmetic implications
- A patient of vitiligo can be as efficient physically, mentally and sexually as any other individual
- Any known factors causing vitiligo like pressure, trauma etc. should be removed or minimised as far as possible
- Nails should be trimmed and filed.

The Response to the treatment is slow in

- Pigmentation of the lesions usually starts around hair follicles
- Lesions in the hairy area show early and quick response
- Repigmentation also starts at margins of the lesion.
- There is no scientific basis for any dietary restrictions like avoidance of citrus food and vitamin C.

The response to treatment is very poor and incomplete in

- Extensive vitiligo
- Lesions with leucotrichia of long duration
- Lesion located on non-hairy areas like palms, soles, fingertips or mucosae.

Medical management

- Psoralens or its derivative 10-20 mg only
- Psoralens topical application followed by

a) Exposure to ultraviolet-A or an amal seu (PUVA)

b) Sunlight PUVASOL) 2-4 hours

- when Exposure to sight in between 10 AM to 2 PM when the UVA is maximum.

For slowly spreading disease

Levamisol 50-150 mg on two consecutive days every week orally.

For fast spreading disease

Oral corticosteroids equivalent to betamethasone 25-5 mg on two consecutives days every week has been found very effective.

Other drugs

- Topical Corticosteroids
- Placental extract.

Surgery

Dermabrading the depigmented area aand covering it with

- Split thickness graft
- Suction blister graft
- Melanocyte graft

-Taken from another area of the body preferably antero- lateral aspect of the thighs

-Multiple punches of normal skin can be grafted in different areas of depigmented lesions.

REFERENCES

1. Vaidya Y.G. Joshi, charak samhita (chikitsasthan chapter no.7), Pune, Vaidyamitra prakashan, second Aavrutti 2005. Pages 175,176, 206,207,208.
2. Professor K.R.Shrikantha murthy Sushruta Samhita (uttartantra chikitsa sthan chapter no.9) chaukhambha orientalia, Varanasi, Edition:-Reprint 2010. Pages 21-28.
3. Dr.Bramhanand Tripathi, Ashtanga-Hridaya(Nidan-sthan chapter no. 14) chaukhamba Sanskrit pratishthan U.A.Bunglow road, jawahar nagar, p.o. box no.2113, Delhi 110007 Edition:- Reprinted 2015, pages 37-39.
4. G.S. Sainani, A.P.I. Textbook of medicine, Published by Association of physicians of India, Mumbai. Sixth Edition 1991, pages 1208, 1209.
5. Comprehensive Dermatology and sexually Transmitted Diseases, Ramji Gupta, Reprint 2014, published by, Ane Books pvt. Ltd, New Delhi, India, Pages 117-121.
6. Internet:-www.medicinenet.com
7. Davidson's principles & practice of Medicine, Edited by J.Alastair Innes, Published by Elsevier, 2nd Edition 2016, Pages 717-718.