website : www.ijacare.in e-ISSN No.: 2457-0443

INTERNATIONAL JOURNAL OF AYUSH CASE REPORTS

Ayurvedic Management of Kitibha Kushta (Guttate Psoriasis with Secondary Lichenification): A Case Report

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ABSTRACT:

Guttate psoriasis, characterized by abrupt onset of multiple small scaly lesions, can be correlated with *Kshudra Kushta* conditions such as *Kitibha Kushta* with *Vata-Kapha* predominance. Secondary lichenification reflects chronicity and repeated irritation, indicating deeper *Doṣha-Dhatu* involvement. This is a case report of a 15-year-old female patient presenting with multiple blackish, scaly papular lesions predominantly over the lower and upper limbs, associated with severe itching, skin thickening, discoloration, and dryness for 1 month duration. Clinical features such as *Syava, Kina Khara Sparsha, Parusha* (dry and scaly), *Kandu*, and *Tvak Rukshata* supported the Ayurvedic diagnosis. Assessment was carried out using the Psoriasis Area and Severity Index (PASI) and Dermatolology Life Quality Index Questionnaire (DLQI). The treatment protocol included *Deepana, Pachana*, *Purvakarma* followed by *Sodhana* in the form of *Virecana*, along with *Samana* therapies such as external applications and *Rasayana Yoga* as internal medication during follow up. The treatment was administered for 17 days with regular follow-up. Marked improvement was observed in scaling, erythema, induration, discolouration and pruritus, reflected by a significant reduction in PASI score from 9.2 to 2.6 and DLQI score from 13 to 7 by the end of treatment. Although classical Ayurvedic texts describe comprehensive therapeutic approaches for *Kushta*, systematic clinical documentation using objective assessment tools is limited. This case report highlights the potential role of a systematic Ayurvedic treatment approach in managing guttate psoriasis with secondary lichenification by addressing underlying *Doṣha* imbalance, improving *Agni*, purifying *Rakta*, and restoring skin integrity using standardized assessment parameters.

KEYWORDS: Guttate Psoriasis, *Kitibha Kushta*, PASI, DLQI.

Received: 24.01.2026	Accepted: 10.02.2026	Published: 22.02.2026

QR Code

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INTRODUCTION:

Guttate psoriasis is an inflammatory papulosquamous disorder marked by the abrupt onset of multiple small, scattered, 'drop-like', scaly pruritic papules and plaque lesions, commonly involving the trunk and proximal extremities [1]. Guttate Psoriasis is common and affects 0.5 - 2% of individuals in paediatric age group [2]. Guttate Psoriasis is most frequently seen in children, adolescents and young adults, although individuals of other age groups may also be affected [2]. There may be history of preceding streptococcal infection [1]. From an Ayurvedic perspective, guttate psoriasis can be correlated with *Kṣudra Kuṣṭha*, particularly *Kitibha Kushta* based on clinical features such as *Syava (Asitha), Ruksham, Kina Khara Sparsha, Kandu and Parusha [3]. Kuṣṭha* in Ayurveda encompasses a wide spectrum of dermatological disorders characterized by chronicity, recurrence, and multisystem involvement. Classical Ayurvedic texts describe *Kuṣṭha* as a *Tridoṣhaja Vyadhi* with predominant vitiation of *Doṣha*, *Rakta Dhathu*, *Tvak, Lasika* and *Mamsa.*

In contemporary medicine, guttate psoriasis is managed using topical corticosteroids, systemic immunosuppressants, and phototherapy. Although these modalities offer symptomatic relief, long-term use is often associated with adverse effects, recurrence, and limited disease modification. Ayurveda, on the other hand, advocates a holistic approach emphasizing *Sodhana*, *Samana and Rasayana Chikitsa*. Adjunct therapies such as *Snehana*, and appropriate *Bahya Prayoga* play a crucial role in restoring *Doṣha* balance and preventing recurrence.

Despite detailed descriptions of *Kuṣṭha Chikitsa* in classical Ayurvedic texts, documented clinical evidence on the Ayurvedic management of guttate psoriasis remains limited. An individualized treatment approach based on *Doṣha* predominance and disease chronicity is essential for effective outcomes. Hence, the present case study aims to highlight the efficacy of Ayurvedic interventions in the management of guttate psoriasis through a structured treatment protocol grounded in classical principles.

CASE REPORT:

A 15-year-old female patient visited hospital in May 2025 with complaints of itchy blackish skin lesion over both lower limb and blackish skin lesions over both upper limb since 1month.

The patient developed generalized blackish discoloration of skin following menarche three years ago. She slowly developed small blackish drop like multiple papular lesions with itching all over the body. She initially took allopathic treatment with only temporary relief and experienced recurrence after discontinuation, while homeopathic treatment provided no significant benefit. Subsequently, she underwent Ayurvedic treatment for the past two and a half years, resulting in marked improvement. At present, the lesions are confined to the upper and

lower limbs and are associated with scaling, itching, dryness, and hyperpigmentation, with secondary lichenification over both ankles due to footwear friction and persistent scratching. Dusting was noted on rubbing the lesions, which reduced on oil application, and she was admitted in our hospital for further management.

History of past illness:

History of Cracked feet (plantar aspect) since childhood (around 3 years of age) with relapsing and remitting nature.

History of Severe throat infection with fever 3 years ago.

Clinical Findings:

The patient had a gradual onset of lesions which spread all over the body immediately. Small drop like multiple blackish lesions are present over both upper and lower limb. The clinical findings were given in the Table.No .1

The diagnosis was established based on an integrated Ayurvedic and modern clinical evaluation. The patient presented with *Syava Varna (blackish discolouration)*, *Kiṇa Khara Sparsa (rough lesions with induration)*, and *Parusha (*dry and scaly*)* skin lesions, which are characteristic features of *Kitibha Kushta* as described in Ayurvedic classics. Clinically, the lesions were rough, scaly, mildly raised, blackish, and intensely pruritic, distributed symmetrically over the body involving both flexor and extensor surfaces, as well as exposed and unexposed areas. From a modern dermatological perspective, the presence of multiple small, scaly papular lesions with an abrupt onset, along with a preceding history of severe throat infection accompanied by fever, supported the diagnosis of guttate psoriasis. Guttate psoriasis is more prevalent in children and young age which also added to the diagnosis. Furthermore, the chronicity of the disease and persistent scratching led to skin thickening in the ankle region, indicative of secondary lichenification. Based on the above findings, the final diagnosis was made as Guttate Psoriasis with Secondary Lichenification, correlating with *Kitibha Kushta* in Ayurveda.

Severity was assessed using the Psoriasis Area and Severity Index (PASI)[4] and Dermatology Life Quality Index (DLQI)[5] before and after treatment as mentioned in Table- 4,5.

After one-month, the patient was reassessed and showed sustained improvement with only mild residual blackish discoloration persisting in the bilateral ankle region. No adverse effect was reported during the treatment period.

THERAPEUTIC INTERVENTIONS:

The management was a combination of treatment modalities including *Snehana, Virechana*, and *Samana Aushadhi* for 17 days as mentioned in Table-2. Discharge medicine is mentioned in Table-3.

Table 1: Clinical findings:

Inspection	Palpation	Special test
Site of lesion: Extensor and Flexor aspect of both lower and upper limb **Colour and Pigmentation:** Blackish discolouration, Hyperpigmented **Surface characteristics of Lesion:** a) **Texture-** Rough **b) Elevation –** Raised **c) Border definition –** Indistinct **Distribution of skin lesion:** Symmetrical, on both flexor and extensor aspect and on both exposed and unexposed areas. **Morphology of lesions:** Scaly **Number:** Multiple lesions present	**Rough and thick lesions:** Present **Dusting from lesions:** Present **Temperature:** No rise **Swelling:** Absent	**Auspitz sign:** Positive **Candle grease sign**: Not elicited **Koebner's phenomenon:** Absent

Table -2: Procedures & Medicines:

Date	Treatment	Medicines	Assessment of Patient
03/05/2025	*Takrapanam +Vaishwanara Choorna*	1.5 litre *Takra* + 12g *Vaiswanara Choorna* per day in divided doses for 2 days	Appetite improved
03/05/2025 to 05/05/2025	*Sarvanga parisheka*	*Triphala Kashaya* for 3days	Felt mild relief in itching but had dryness over lesion
05/05/2025 to 09/05/2025	*Snehapanam* -5days	*Mahatiktaka ghrita*- 30 ml to 60 ml (6:00 am)	*Snigdha Lakshana* assessed on each day

06/05/2025 to 08/05/2025	*Abhyangam*	*Vetpala Thailam*	Dryness over lesion started to reduce
The patient started menstruating on 09/05/2025, so was discharged for 5 days and readmitted on 15/05/2025.			
15/05/2025	*Deepana Pachana*	*Vaiswanara Choorna* 5g BD for 1 day	
15/05/2025 to19/05/2025	*Abhyangam*	*Vetpala Thailam* for 5 days	
16/05/2025 and 17/05/2025	*Sadhya Snehapanam*	*Mahatiktaka* ghrita30 ml BD (6:15 am and 6:30 pm) with 2.5g *Vaiswanara Choorna* for 2 days	Felt hunger at 2:05 pm
18/05/2025 and 19/05/2025	*Ushnambu Snana* and *Guru Pravarana*	For 2 days	As *Swedana karma* is contraindicated in *Kushta,* adviced only *Ushnambu Snana* and *Guru Pravarana* before *Virechana*
19/05/2025	*Virechana*	*Avipathi choorna* – 20 g with honey	No of *Vega*-8
Internal medicine	Dermcare tab 2 BD (except on *Snehapana* and *Virechana* day)		

Table -3: Discharge Medicines:

Medicine	**Dosage**
Siddhamakaradwajam	62.5 mg BD for 7 days 125 mg BD for 7 days 250 mg BD for 5 days 125mg BD for 12 days
Kalyanaka Ghrtam	5g with *Siddhamakara dwajam* BD
Vetpala Thailam	External Application

Table 4: PASI SCORING – BEFORE AND AFTER TREATMENT

	Before Treatment		After Treatment	
	Upper limbs	**Lower limbs**	**Upper limbs**	**Lower limbs**
Area	2	3	1	3
Itching	0	4	0	1
Erythema	0	0	0	0
Scaling	1	1	0	0
Thickness	1	2	0	1
Scoring	0.8	8.4	0.2	2.4
Total PASI Scoring	9.2		2.6	

Table 5: DLQI QUESTIONNAIRE SCORING – BEFORE AND AFTER TREATMENT

Before treatment	**After treatment**
13(Very large effect on Patient's life)	7(Moderate effect on Patient's life)

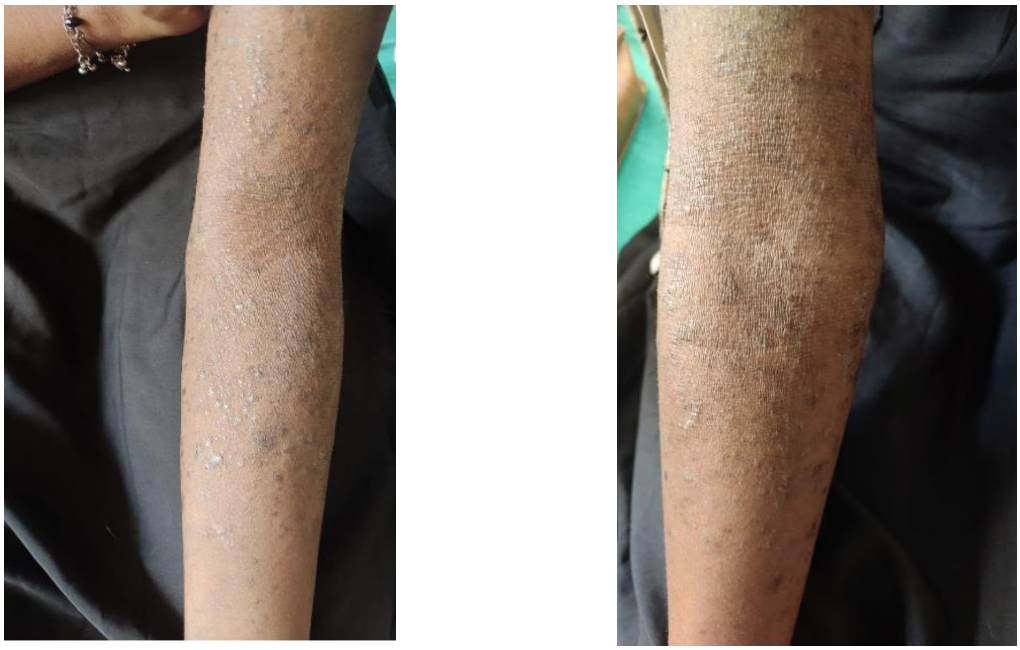

Figure 1: BEFORE TREATMENT - ARM

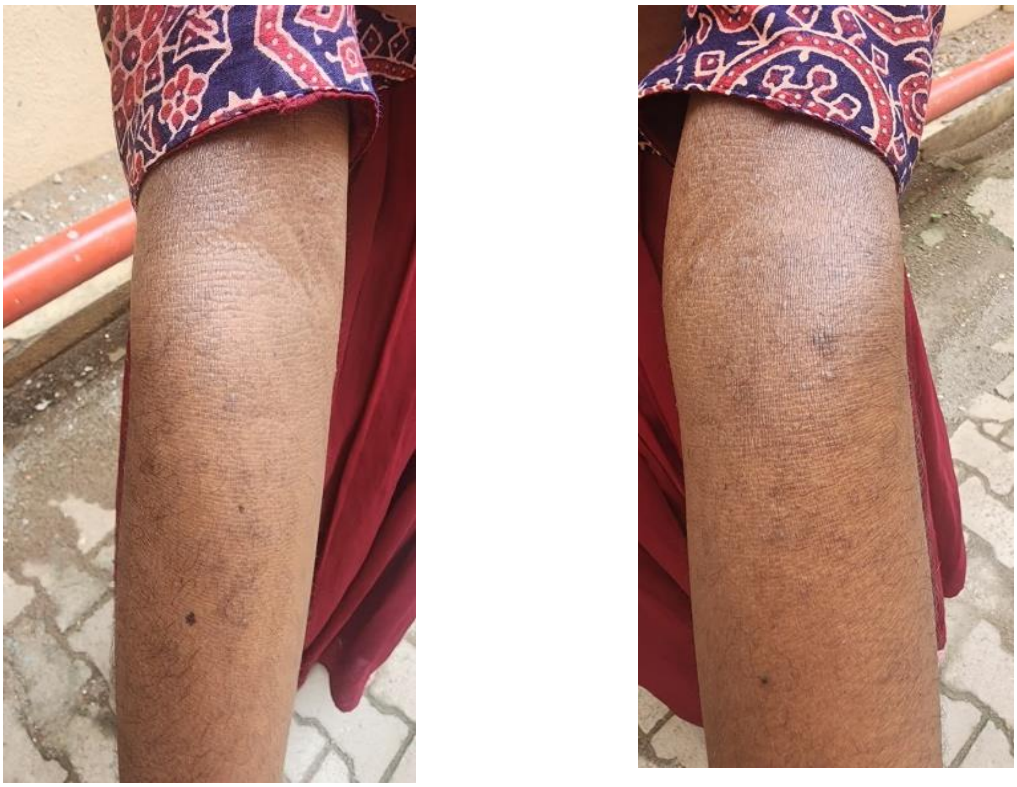

Figure 2: AFTER TREATMENT - ARM

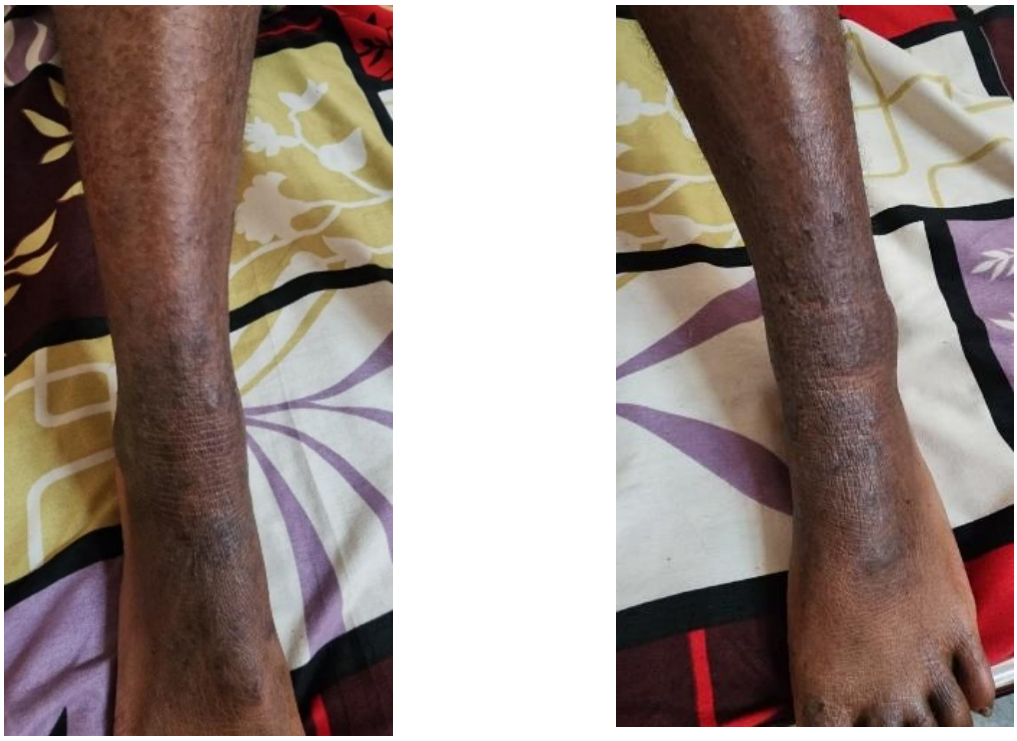

Figure 3:BEFORE TREATMENT- LEG

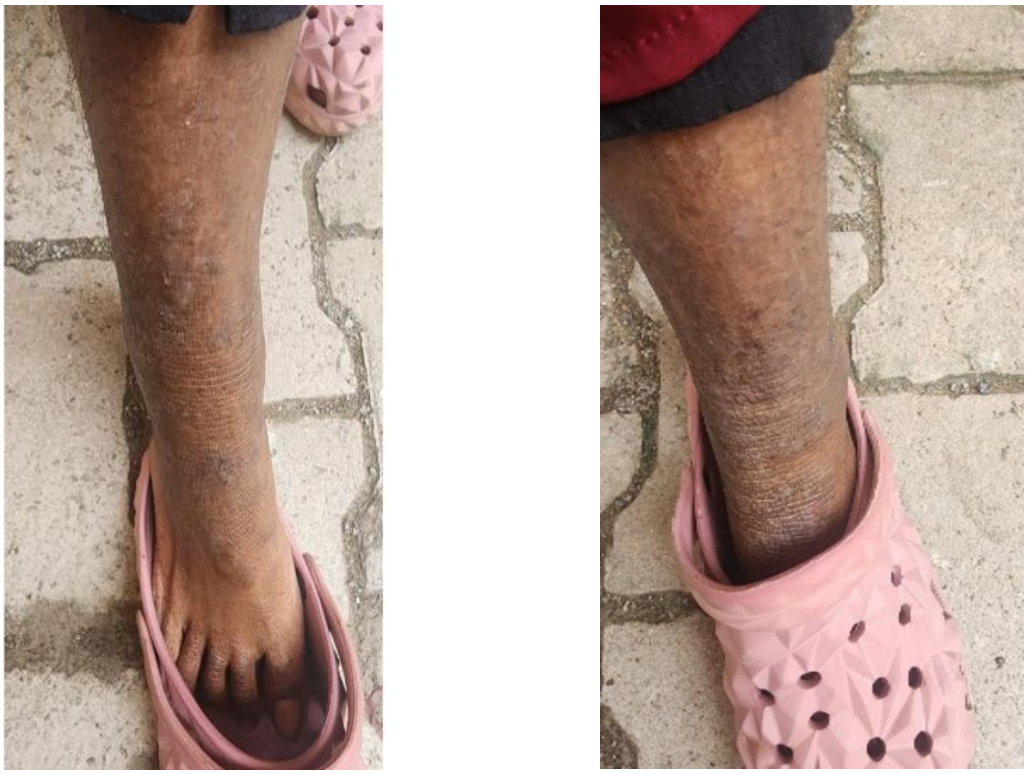

Figure 4:AFTER TREATMENT - LEG

RESULTS

The patient showed marked clinical improvement following the intervention. Significant reduction in blackish discolouration, scaling, induration (thickness), itching, and lichenification was observed. The objective assessment tools demonstrated significant improvement, with the PASI score reducing from 9.2 to 2.6 and DLQI score improving from 13 (very large effect) to 7 (moderate effect). These changes indicate not only clinical remission but also a meaningful enhancement in quality of life. Sustained improvement during follow-up, with only mild residual hyperpigmentation at the ankle region, further supports the effectiveness of the structured Ayurvedic protocol. The images of before treatment was given in Fig.1(Before treatment Arm) and Fig.3(Before treatment Leg) and after treatment was given in Fig.2(After treatment Arm) and Fig.4(After treatment Leg).

DISCUSSION:

Here in this condition symptoms such as *Syava, Kina Khara Sparsha* and *Parusha* are suggestive of *Vata* predominance and *Kandu* is suggestive of associated *Kapha* in the pathogenesis. The *Dhathu* involved can be understood as *Rasa* due to *Rukshatha, Rakta* due to *Kandu* and *Mamsa* due to *Karkasa* (thickening) and *Pidaka* (papule)[6].

The treatment strategy in this case aimed at correcting the root pathology rather than providing symptomatic relief alone. Since *Kapha* was the associated *Doṣha, Rukṣhaṇa* was initiated prior to S*nehapana*. External *Rukṣhaṇa* was performed through *Sarvanga Parisheka* with *Triphala*

Kashaya, while internal *Rukṣhaṇa* was achieved by *Takrapana* along with *Vaiswanara Churṇa*. *Takrapana* with *Vaiswanara Churṇa* served as an effective *Deepana* measure, correcting *Agnimandya* and preparing the *Koshta* for *Snehapana* which is crucial in *Kuṣhta* management. External *Sarvanga Parisheka* with *Triphala Kashaya* helped in reducing *Kapha*-related *Kleda,* itching, and surface inflammation, although transient dryness was noted, indicating the need for subsequent oleation.

This was followed by *Snehapana* with *Mahatiktaka Ghrta*, indicated in *Kuṣṭha*, as *Purvakarma* to *Virechana.* As *Kuṣṭha* is a *Sakhagata Doṣha Vyadhi, Snehapana* facilitates the mobilization of vitiated *Doṣha* from *Sakha* to *Koṣṭha* for effective elimination. *Mahatiktaka Ghṛta*, containing *Amalaki* in higher proportion, also acts as a *Rasayana* and was chosen considering the patient's *Taruṇa Vaya*. Its *Tikta Rasa* contributes to *Pitta-Samana*, *Rakta-Sodhana*, and *Sroto-Sodhana,* thereby addressing the pathological basis of *Kushta*. After *Snehapana,* the patient had marked reduction in scaling and thickness in the lesions.

Kuṣṭha being a *Langhana Sadhya Vyadhi*, *Virechana* was selected as the *Sodhana* therapy. *Swedana* is contraindicated in *Kushta*, so prior to *Virechana* only *Ushnambu Snana* and *Guru Pravarana* was adviced. *Virechana* with *Avipathi Churṇa* served as the principal *Sodhana* therapy, effectively eliminating vitiated *Dosha*, thereby interrupting the disease process at its systemic level. *Avipathi Churna* was selected as the *Virechana Yoga* in this case due to its *Pittahara*, *Kaphahara*, and *Vatanulomana* actions, and its well-known *Kleda Soshana* property, which constitutes the primary therapeutic principle required in this condition. Successful *Virecana* with eight *Vegas* resulted in systemic detoxification, reflected clinically by marked reduction in scaling, itching, thickness, and pigmentation. This intervention effectively interrupted the disease process at a systemic level, rather than providing temporary symptomatic relief.

Dermcare tablet also given as internal medicine, which contain the ingredients such as *Nimba* (Azadirachta indica), *Kutaja* (Holarrhena antidysentrica), *Katurohini* (Antidysentrica heliborus), *Raktacandana* (Pterocarpus santalinum) *Guggulu* (Balisamodendronmukul), *Khadira* (Acacia Katechu), *Guduchi* (Tinospora cordifolia), *Patola* (Trichosanthescucumerina), *Sariva* (Hemidesmus indicus), and *Chitraka* (Plumbago zeylanicum). All these ingredients were predominantly *Tikta rasa*, which contributes to their *Rakta Prasadana*, *Kushtahara*, *Srotoshodhana*, and *Sophahara* actions.

External therapies such as *Abhyanga* with *Vetpala Taila* complemented internal treatment by alleviating *Rookṣhata*, reducing scaling, improving skin texture and alleviating lichenification. The therapeutic regimen also incorporated *Rasayana* therapy with *Siddhamakaradwaja* during the follow-up period which was administered with strict dosage regimen and *Pathya* under the supervision of *Rasasatra* expert, to enhance tissue regeneration, modulate immune

response, and prevent relapse. One of the indications of *Siddhamakaradwaja* is *Kushta* and it has *Kanthi Vardhaka* action thereby aids in reducing the hyperpigmentation.[7]

CONCLUSION:

This single-case report highlights the effectiveness of an individualized, stage-wise Ayurvedic approach incorporating *Deepana–Pachana, Snehapana, Virechana*, and *Rasayana Chikitsa* in the management of guttate psoriasis. The treatment resulted in significant symptomatic relief, including reduction in itching, lesion severity, and improvement in skin texture, reflected by decreased PASI and DLQI scores. Sustained remission in a conventionally refractory case underscores the therapeutic potential of Ayurveda in chronic inflammatory and autoimmune dermatoses, warranting further well-designed clinical studies for broader validation and integration into mainstream dermatological care.

Consent of the patient:

The consent of the patient has been taken for publication of the case details and accompanying images without disclosing the identity of the patient.

Conflict of interest: The author declares that there is no conflict of interest.

Guarantor*:* The corresponding author is the guarantor of this article and its contents.

Source of support: None

How to cite this article:
Thushara R, Arjun Chand CP, Arun Pratap, Vishnu P. Ayurvedic Management of Kitibha Kushta (Guttate Psoriasis with Secondary Lichenification): A Case Report Int. J. AYUSH Case Reports. 2026; 10(1-A): 1-10.

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