

Siddha Therapeutic Regimen in the Management of Paediatric Impetigo: A Case Report

V. Priyadarshini, ^{1*} P. Arul Mozhi, ² M. Meenakshi Sundaram³

¹ Final year PG Scholar, ² Professor and Guide, ³ Professor and HOD, Department of Kuzhandhai Maruthuvam, National Institute of Siddha, Tambaram Sanatorium, Chennai-47, Tamil Nadu, India

ABSTRACT:

Bacterial skin infection is a common diagnosis among children with skin problems, accounting for 17% of all clinic visits. The most common is impetigo, which is highly contagious. There are two classic forms of impetigo non-bullous and bullous. Non-bullous impetigo accounts for more than 70% of cases. Lesions typically begin on the face or on extremities and may spread to other parts of the body. According to siddha literature, impetigo resembles *Perusirangu* (itch with wide vesications) due to derangement in *Pitham* (infectious, erythema) and *Kabham* (pustule formation). Modern treatment involves antibiotics and topical antiseptics, but recurrence and antibiotic resistance remain challenges. This case study demonstrates the efficacy of siddha intervention in a paediatric patient with impetigo who shows non-responsiveness to a prior 10-day course of empiric antibiotics. Beyond symptomatic relief, this treatment aims to neutralize the deranged *thodam* through detoxification, blood purification, wound healing, thereby ensuring complete recovery and preventing recurrence. The therapeutic intervention comprised a structured siddha regimen, including internal medicines like Arugan kattai kudineer and external applications like Mathan Thylam. Significant clinical improvement was observed within 7 days and complete clearance of lesions was achieved by 21 days of treatment. This study suggests that Siddha management serves as a potent, safe and sustainable alternative to conventional antibiotics, providing a comprehensive model for managing paediatric dermatological conditions without recurrence or drug resistance.

KEYWORDS: Bacterial skin diseases, Impetigo, Non-bullous impetigo, *Perusirangu*, *Pitha* diseases, Siddha management, *Sirangu*.

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*Corresponding Author:

Dr. V. Priyadarshini

Final year PG Scholar

Department of Kuzhandhai Maruthuvam, National Institute of Siddha, Tambaram Sanatorium, Chennai-47, Tamil Nadu, India

Email: priyavenkatesan2797@gmail.com

INTRODUCTION:

Impetigo is a highly contagious, superficial bacterial skin infection that most commonly affects infants, preschool children and young adults. It is classified as a primary infection with direct bacterial invasion or a secondary infection (e.g., in association with scabies or eczema). Impetigo clinically presents as a bullous or non-bullous type. Nonbullous impetigo is the most common form of impetigo, caused by *Staphylococcus aureus* in 80% of cases and Group A β -hemolytic *Streptococcus* alone or in combination with *S. aureus* in the remainder.^[1] It is characterised by thin-walled vesicles that rupture quickly, leaving red wet erosions, or dry up forming gummy, golden-yellow or reddish brown crusts. The crust eventually separates and leaves erythema that fades without scarring. The lesions are scattered and discrete, 1-3 cm in diameter, round or oval and show central healing; regional lymph nodes may be enlarged and tender. The face is the common site, but it also occurs on the scalp, arms, legs and buttocks.^[2] When left untreated, impetigo can lead to severe skin, soft tissue and bone infections and sepsis, which contribute to a 5% to 10% case fatality rate. Impetigo also leads to serious sequelae, including glomerulonephritis and rheumatic heart disease. An estimate of 162 million children globally experience impetigo at any given time. The global prevalence of impetigo is estimated to be 11.2%, being 2.5-fold higher in children (12.3%) than adults (4.9%)^[1]

Management strategies of impetigo vary; limited number of lesions are typically treated with topical antibiotics, whereas numerous lesions, in remote communities where it is considered endemic, oral or intramuscular antibiotics are recommended.^[3]

The rapid emergence and spread of antibiotic-resistant bacteria, including Methicillin-Resistant *S. aureus* (MRSA), pose serious threats to public health.^[4] The increase in antimicrobial resistance to topical antibiotics has had adverse consequences for individuals and communities, necessitating the development of newer treatment alternatives or strategies to promote the judicious use of existing drugs.

Siddha medicine is one of the ancient traditional systems of medicine providing a holistic approach that encompasses physical, mental, and spiritual dimensions of health. It is particularly effective in managing dermatological conditions through its comprehensive physiological principles. Siddha therapeutics aims to restore the *7 udal thathukkal* [saaram, senneer, oon, kozhuppu, enbu, moolai, sukkilam] and the equilibrium of three humors *Vatham*, *Pitham* and *Kabham*, which provides a complete recovery; hence, recurrences and associated complications are minimized. According to classical Siddha literature, the clinical presentation of impetigo closely resembles *Perusirangu*,^[5] a condition characterized by itch with wide vesiculations primarily due to derangement in the *Pitham*. Siddha has a rich repository of herbal and herbo-mineral formulations which have potential anti-inflammatory, anti-

microbial and wound healing activities. These formulations can be safely administered to both adult and paediatric populations in age-appropriate doses, effectively aiding in disease resolution.

PATIENT INFORMATION:

An 11-year-old male child was brought to the Out-Patient Department of Kuzhandhai Maruthuvam of National Institute of Siddha, Chennai by his parents with complaints of multiple pustules with purulent discharge associated with severe itching, pain and burning sensation on the right ankle and lower leg for the past 1 month, along with fever and painful right inguinal swelling for the past 2 weeks. The lesions began as small erythematous papules on the right lower leg, which turned into fluid-filled vesicles after two days. Within a few days, the fluid turned into pus forming pustules accompanied by fever and pruritus. On scratching, oozing of pus with dried crust on the lesions were found. He had no history of scabies, eczema, insect bite, trauma at the site, drug allergy or bronchial asthma. No family history of impetigo or any other dermatological diseases. The patient had a history of 10-day course of antibiotics one month prior, with no significant clinical improvement.

Clinical findings:

The child was conscious, oriented, and febrile at presentation (99°F). Right-sided inguinal lymphadenitis was noted upon palpation. No pallor, icterus, cyanosis, or edema was observed. Local examination of the right lower leg and ankle revealed multiple irregularly

shaped pustules (1- 3 cm) on an erythematous base with oozing of purulent discharge and golden-yellow crusts from dried exudate (honey-crusted appearance) were present in some lesions. There was no swelling of the lower extremity or active bleeding from the lesions.

TIMELINE:

The line of treatment and prognosis is detailed in Table -1.

DIAGNOSTIC ASSESSMENT:

Based on clinical and physical examination, with a detailed patient history, the case was diagnosed primarily as non-bullous impetigo. This primary diagnosis was established based on the classical progression of the skin lesions and the presence of hallmark adherent, honey-coloured crust lesions. Other dermatological look-alike conditions were excluded based on clinical presentation and history. Bullous impetigo was ruled out due to the absence of flaccid bullae. Scabies was excluded based on the lack of characteristic linear burrows and absence of nocturnal pruritus exacerbation. Viral exanthems were excluded as the lesions remained strictly localized to a single lower limb rather than demonstrating a generalized or centripetal distribution. Furthermore, Siddha diagnostic assessment via *Naadi* examination revealed *Pithavatham naadi*. The marked increase of the *Pitham* confirms the acute inflammatory and infectious nature of the condition.

THERAPEUTIC INTERVENTIONS:

The treatment was given based on the patient's *Naadi*, as it revealed *Pithavatham*, the treatment strategy aimed to neutralise *Pitham* with rapid bacterial eradication and long-term immunomodulation. Thereby, the formulations possessing proven antimicrobial, anti-inflammatory, antipyretic, antiseptic and antioxidant activities along with antipitha properties were administered. The medicines were prescribed with strict dietary regulations and personal hygienic practices for 21 days with weekly review. After 14 days, *Arugan kattai kudineer* was not advised, as there was a significant reduction in lesions and systemic signs. The prescribed therapeutic intervention is detailed in Table-2. The advised medicines with their indications and their proven activities were listed in Table-3.

FOLLOW UP AND OUTCOME:

The patient was monitored weekly over a 3-week active treatment period. By day 7, significant reduction in exudation, pain, and pruritus was noted; additionally, the low-grade fever

completely resolved, and the regional inguinal lymphadenitis showed notable regression. After 14 days of intervention, a marked visible reduction in the lesions was observed. Complete clearance of all lesions and full restoration of skin integrity were achieved by day 21, with no development of new lesions. Following the active treatment phase, the patient remained under a 3-month post-treatment follow-up period, during which no recurrence of the lesions was noted. The patient, who previously showed resistance to a 10-day course of conventional antibiotics, responded successfully to siddha management within 21 days without recurrence noted during follow-up. No Adverse Drug Reactions [ADR] were reported or observed during the entire treatment course.

Fig -1,2 and 3 illustrate the presentation and progression of lesions before and after treatment.

Fig-1 illustrates the image before treatment; Fig-2 illustrates the image after 14 days of treatment; Fig-3 illustrates the image after 21 days of treatment.

Table-1:Line of treatment and prognosis

Date	Observation	Intervention
19.01.2026	Multiple pustules with oozing, intense pruritus, localized pain, burning sensation, fever, right-sided inguinal lymphadenitis noted at presentation.	Siddha medicines initiated for 1 week with dietary restrictions.
26.01.2026	Fever and lymphadenitis resolved, pain and purulent discharge significantly reduced. Dry pustules with mild pruritus observed.	Same medicines were followed
02.02.2026	Pustules dried completely with prominent desquamation(skin peeling); pruritus resolved.	Internal medications were modified; all other medicines were followed

		the same.
09.02.2026	Complete healing with residual post-inflammatory scars was noticed without pruritus	Modified medicines were maintained.

Table-2: Advised Therapeutic regimen

Drug Name	Dosage And Adjuvant	Duration
<i>Arugan Kattai Kudineer Chooranam</i>	5g twice a day as decoction-Peroral	First 14 days
<i>Tab.Balasanjeevi</i>	1 twice a day with honey-Peroral	21 days
<i>Parangi Rasayanam</i>	3g twice a day with milk-Peroral	21 days
<i>Mathan Thylam</i>	External application during the daytime	21 days
<i>Kungliya Vennai</i>	External application at night time	21 days
<i>Padigara Neer</i>	External wash	21 days

Table-3: Medicine indications and its actions

Medicine	Indications	Activity
<i>T.Balasanjeevi</i>	<i>Pitham, Suram</i> ^[6]	Antipyretic, Antiinflammatory, ^[8] Immunomodulator
<i>Parangi Rasayanam</i>	<i>Sarumaroham</i> ^[7]	Antimicrobial,antiulcer ^[9]
<i>Arugan Kattai Kudineer chooranam</i>	<i>Viranam</i>	Antimicrobial,antioxidant ^[10]
<i>Mathan Thylam</i>	<i>Padai,Sirangu,Punn,Dhushta Viranam,Kasiyumpadai</i> ^[6]	Analgesic, ^[11] Antiinflammatory, Wound healing
<i>Kungliya Vennai</i>	<i>Viranam,Koppulam</i> ^[6]	Wound healing ^[12]
<i>Padigaraneer</i>	<i>Punn,Dhushtaviranam</i> ^[6]	Antimicrobial, Wound healing, Antiinflammatory ^[13]

		
Fig-1:Before treatment	Fig-2:After 14 days of treatment	Fig-3:After 21 days

DISCUSSION:

Impetigo is a superficial bacterial skin infection that most commonly affects infants, preschool children and young adults. When left untreated, impetigo can lead to severe skin, soft tissue and bone infections and sepsis, and also leads to post-streptococcal glomerulonephritis, acute rheumatic fever and rheumatic heart disease. According to Siddha literature, the clinical presentation of impetigo resembles *Perusirangu*, which is characterised by itching with wide vesiculations occurring due to derangement in Pitham. In this case study, the primary diagnosis of non-bullous impetigo was established through clinical examination of lesions. This was further confirmed by Siddha diagnostic assessment via *Naadi*, which revealed *Pithavatham* with *pitham* as the primary affected *thodam*, proving its acute inflammatory and infectious state. Hence, the treatment protocol was decided to focus on *Azhal* neutralization, rapid bacterial eradication and long-term immune modulation. Here, *Tab. Balasanjeevi* served as the core

intervention to reduce *Pitham* with its proven antipyretic and antimicrobial effect. This was also supported systemically by *Parangi Rasayanam* and *Arugan Kattai Kudineer*, in which *Parangipattai*(*Smilax china*), *Arugampul*(*Cynodon dactylon*) as the main component which has potent anti-inflammatory, antioxidant effects essential for deep-seated skin infections. For the topical management, cleansing the lesions with *Padigara neer* followed by the external applications of *Mathan Thylam* and *Kungliya Vennai* created a synergistic antiseptic environment which accelerated wound healing and restored cutaneous integrity.

The complete resolution within 21 days without recurrence, particularly following the failure of conventional antibiotics, demonstrates that this integrated Siddha approach is a highly effective, safe, and meaningful alternative for managing paediatric impetigo and addressing antimicrobial resistance.

CONCLUSION:

This case report shows that impetigo can be successfully managed through Siddha regimen, serving as a potent, safe, sustainable alternative to conventional antibiotics and providing a comprehensive model for managing paediatric dermatological conditions without recurrence or drug resistance. Furthermore, the findings emphasize the importance of Siddha medicine in disease treatment and underscore its unique and significant role in healthcare.

Declaration of patient consent:

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.

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