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Multimodal Ayurvedic treatment along with *Icchabhedi Rasa Lepa* in the Management of Moderate Alopecia Areata (*~Indralupta)*: A Case Report

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ABSTRACT:

Alopecia areata (~*Indralupta*) is an immune-mediated, non-scarring hair disorder corresponding to Alopecia Areata (ICD-10: L63.9). Clinically, *Indralupta* is characterized by well-defined areas of hair loss, typically presenting as smooth, circumscribed patches on the scalp. A 33-year-old female homemaker presented with a six-month history of progressive patchy hair loss over the parieto-occipital region, aggravated following self-application of a non-prescribed herbal oil. Disease severity was graded as moderate (SALT Score S2: 25–49% scalp involvement), with an AASIS score of 76 and DLQI score of 18. She was managed with a multimodal Ayurvedic protocol comprising *Nidana Parivarjana*, internal *Shamana* medications medications (*Br. Manjishthadi Kwatha* 20 mL, *Gandhaka Rasayana* 125 mg, *Arogyavardhini Vati* 500 mg, *Avipattikara Churna* 3 g, *Saptamrita Lauha* 250 mg; each orally twice daily for 4–5 weeks), *Madhuyashthyadi Taila* Nasya (2 drops/nostril once daily for 3 months), and local applications of *Icchabhedi Rasa Lepa* and *Dhatturadi Taila*, with concurrent dietary and lifestyle modification. The protocol was adjusted mid-course based on an *Anupashaya* response to the initial *Amalaki–Yashtimadhu Lepa*. Visible hair regrowth was observed within 21 days of treatment initiation, with complete regrowth achieved at approximately three months. SALT improved from S2 to S0, AASIS from 76 to 29, and DLQI from 18 to 6. Mild, transient scalp erythema and local irritation were noted following topical therapy, with no systemic adverse drug reactions recorded, and no recurrence was reported over a one-year follow-up period. A multimodal Ayurvedic protocol incorporating *Icchabhedi Rasa Lepa*, along with internal *Shamana* medications, *Nasya*, and dietary–lifestyle modification showed clinically meaningful improvement in moderate Alopecia Areata. Findings from this case warrant further evaluation in larger, controlled studies.

KEYWORDS: Alopecia Areata, DLQI, Hair regrowth, *Icchabhedi Rasa*, *Indralupta*, SALT score.

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INTRODUCTION:

Hair loss constitutes one of the most distressing dermatological conditions observed in clinical practice owing to its profound impact on psychosocial functioning and quality of life. Among the various forms of alopecia, *Alopecia areata* (AA) is characterised by non-scarring, patchy hair loss caused by a T-cell-mediated autoimmune attack on anagen-phase hair follicles. The global prevalence of AA is estimated at approximately 0.1–0.2%, with a lifetime risk approaching 2%, affecting individuals across all age groups without significant sex prediction.[1]

Classical literatures describe a condition termed *Indralupta*, a *Shirogata Vyadhi* (disease of the head) and *Kapalagata* (disease of the scalp), characterised by sudden, patchy hair loss without associated inflammation or scarring. Its pathogenesis attributes to *Pitta-murchita Vata* residing within the *Romkoopa* (hair follicles), subsequently aggravated by *Kapha* and vitiated *Rakta*, leading to follicular obstruction and cessation of hair growth.[2]

Conventional allopathic management of AA employs intralesional or topical corticosteroids, minoxidil, contact immunotherapy (diphenylcyclopropenone), Janus kinase (JAK) inhibitors, and immunosuppressants modalities that are associated with variable response rates and potential adverse effects including skin atrophy, systemic immunosuppression, and disease relapse upon withdrawal.[3] In contrast, the Ayurvedic approach targets the underlying *Samprapti* (pathogenesis) through a combination of systemic *Shamana* (palliative) therapies, local applications, *Nasya* karma, and *Nidana Parivarjana* (avoidance of causative factors), offering a holistic and potentially safer alternative.

CASE REPORT:

A 33-year-old married female homemaker presented to the Out-Patient Department (OPD), with complaints of patchy hair loss over the parieto-occipital region of the scalp for six months. The patch had progressively enlarged over the preceding weeks. The patient reported diffuse hair shedding without associated symptoms such as itching, pain, burning sensation, inflammation, or discharge. Approximately four weeks prior to presentation, application of a non-prescribed topical oil, recommended by a social acquaintance, was followed by increased hair shedding and enlargement of the existing patch. The patient had also undergone treatment from a local practitioner for nearly six months; however, details regarding medications and dosage were unavailable. The patient reported discontinuing this prior treatment before presenting to the OPD; the exact discontinuation date and washout duration before 14 November 2024 could not be ascertained. No concurrent Ayurvedic or allopathic medications were used during the study period. The progressive nature of hair loss and inability to conceal the patches resulted in considerable psychological distress, reduced self-confidence, and social withdrawal. There was no history

suggestive of autoimmune disorders, major systemic illness, drug intake for comorbid conditions, or relevant family history. There was no history of tobacco smoking, alcohol consumption, or any other substance abuse.

General examinations revealed a moderately built female with stable vital parameters (height: 158 cm; weight: 76 kg; BMI: 30.4 kg/m^2). Local scalp examination demonstrated a single large (8.4 cm × 7.6 cm), Oval shaped patch of alopecia over the parieto-occipital region [Figure 1] without dandruff, scarring, pruritus, inflammatory changes, or discharge.

Diagnostic Assessment

Laboratory investigations were performed to identify associated abnormalities and exclude other possible causes of hair loss. [Table 1]

Disease severity and patient-reported outcomes were assessed using the Severity of Alopecia Tool (SALT), Alopecia Areata Symptom Impact Scale (AASIS), and Dermatology Life Quality Index (DLQI). Based on clinical findings and Ayurvedic assessment, the patient was diagnosed as a case of *Indralupta*, clinically corresponding to Alopecia areata (ICD-10: L63.9). At baseline, disease severity was classified as moderate with a Severity of Alopecia Tool (SALT) score of S2 (25–49% hair loss). The patient also demonstrated substantial symptom burden and impaired quality of life, reflected by an Alopecia Areata Symptom Impact Scale (AASIS) score of 76 and a Dermatology Life Quality Index (DLQI) score of 18, indicating substantial baseline symptom burden and impairment in quality of life. The calculated SALT percentage corresponding to the S2 category, independent verification of the 25–49% scalp-involvement classification. Diagnosis of *Indralupta*, corresponding to Alopecia areata, was established on clinical morphological grounds together with exclusion of other causes of hair loss through laboratory evaluation; dermoscopic or trichoscopic evaluation was not performed, which is acknowledged as a limitation in objective diagnostic documentation.

THERAPEUTIC INTERVENTION:

Details of the prescribed medications and treatment procedures are presented in Table 2. The patient reported a slight increase in hair fall in the surrounding area, which was tentatively associated with the stickiness of the *Amalaki + Yashtimadhu lepa* both constituents having reported Keshya (hair-growth-promoting) properties.[4] This observation was noted as a possible clinical lead, prompting modification of the *lepa* formulation and recognition of enhanced *Kapha* involvement in the pathogenesis.

Along with the prescribed medications, dietary and lifestyle modifications were recommended. The patient was advised to consume freshly prepared, light, and easily digestible meals (e.g., moong dal khichdi, vegetable soups, warm water, and seasonal fruits), Regular meal timings; early dinner (before 7:00 PM), and take *Krishna Tila* (black sesame) 1 tsp daily on empty stomach daily. Brisk walking 20–30 minutes daily, adequate sleep, and stress reduction were encouraged. Foods known to aggravate the condition, including excessive salt,

Abhishyandi and incompatible foods, junk and fried foods, milk and frozen dairy products, were avoided. Daytime sleeping, late-night awakening, and overeating were also discouraged.

Timeline

Time line of the case is described in [Table 3].

Follow-up and outcome

The patient was reviewed at regular follow-up visits to monitor clinical response and treatment modifications. No significant improvement was observed during the first week of treatment. At the second follow-up, mild reduction in hair fall was noted, although slight scalp erythema and local irritation were observed following topical therapy. By the fifth week, fine brownish hair regrowth was evident over the previously bald patch, indicating early follicular recovery. Progressive increase in hair length and density was observed during subsequent follow-up visits. [Figure 2] At the end of three months, the alopecic patch was almost completely covered with terminal hairs, with marked improvement in disease severity and quality of life (SALT: S2 to S0; AASIS: 76 to 29; DLQI: 18 to 6). [Figure 3] No systemic adverse drug reactions were observed during the follow-up period, and no recurrence was observed at the one-year follow-up.

Table 1: Baseline Laboratory Investigations

Haematological Parameter	**Observed Values**	**Reference Range**
Haemoglobin	**9.8 g/dL (Low)**	12–16 g/dL (F)
Total RBC Count	4.83 million/cumm	4.2–5.4 million/cumm
TLC	7,600/cumm	4,000–11,000/cumm
Platelet Count	173 × 10^3/µL	150–400 × 10^3/µL
PCV	**29.7% (Low)**	37–47% (F)
ESR	**40 mm/hr (Elevated)**	<20 mm/hr (F)
Fasting Blood Sugar (FBS)	**121 mg/dL (Borderline)**	70–100 mg/dL
S. Cholesterol	150 mg/dL	<200 mg/dL
S. Triglycerides	73 mg/dL	<150 mg/dL
SGPT	13 IU/L	7–40 IU/L
SGOT	23 IU/L	10–40 IU/L
Total Bilirubin	0.5 mg/dL	0.2–1.2 mg/dL
Direct Bilirubin	0.1 mg/dL	<0.3 mg/dL
S. Calcium	10.7 mg/dL	8.5–10.5 mg/dL

Table 2: Therapeutic Intervention

Treatment	Dose, route & administration	Start date	End date
Br. Manjishthadi Kwatha	20 ml *Kwath* orally twice daily, *Abhakta*	14 Nov 2024	19 Dec 2024
Gandhaka Rasayana	125 mg orally with *Br. Manjishthadi Kwatha*, *Abhakta*	21 Nov 2024	19 Dec 2024
Avipattikara Churna	3 g orally Two times in a day with lukewarm water, *Pragbhakta*; changed to 3 g HS with lukewarm water, *Bhojanottara*	14 Nov 2024	19 Dec 2024
Arogyavardhini Vati	500 mg orally Two times in a day with lukewarm water, *Pragbhakta*	14 Nov 2024	19 Dec 2024
*Saptamrita Lauha**	250 mg orally Two times in a day with lukewarm water, *Bhojanottara*	21 Nov 2024	19 Dec 2024
Madhuyashthyadi Taila (Nasya)	2 drops in each nostril once daily in the morning	14 Nov 2024	15 Feb 2025
Amalaki Churna + Yashtimadhu Churna Lepa	5 g each, local application over scalp once daily	14 Nov 2024	21 Nov 2024
*Icchabhedi Rasa Lepa**	Local application over scalp with water once daily (avoiding afternoon); reduced to twice weekly from 19 Dec 2024 & once weekly from 19 Jan 2025	21 Nov 2024	15 Feb 2025
Dhatturadi Taila	Local application after *lepa* removal; continued as maintenance after completion of treatment	14 Nov 2024	15 Feb 2025

Table 3: Timeline

Date	Findings
14 Nov 2024	Diagnosed with *Indralupta* (Alopecia areata). Single parieto-occipital patch (8.4 × 7.6 cm). SALT S2, AASIS 76, DLQI 18. Ayurvedic treatment initiated.
21 Nov 2024	No improvement. Slight increase in peripheral hair fall due to sticky *lepa (Anupashaya*), suggesting *Kapha* predominance. *Gandhaka Rasayana* and *Saptamrita Lauha* added. *Amalaki–Yashtimadhu* Lepa discontinued and *Icchabhedi Rasa Lepa* initiated.
05 Dec 2024	Mild reduction in hair fall. Scalp slightly reddish with mild local irritation. Treatment continued.
19 Dec 2024	Fine brownish hair regrowth observed over the lesion. *Br. Manjishthadi Kwatha* with *Gandhaka Rasayana* and *Arogyavardhini Vati* discontinued. *Icchabhedi Rasa Lepa* reduced to twice weekly.
19 Jan 2025	Hair length increased with evident regrowth. *Icchabhedi Rasa Lepa* reduced to once weekly. *Dhatturadi Taila* continued.
15 Feb 2025	Near complete hair regrowth. SALT S0, AASIS 29, DLQI 6. No systemic adverse drug reactions; mild local irritation noted earlier had resolved. *Dhatturadi Taila* continued for maintenance; remaining medications discontinued.
8 Mar-2026	After one-year follow-up no patchy hairloss, hairfall or any other complaints noted.



Figure- 1: A single large, Oval shaped patch of alopecia over the parieto-occipital region on 14-11-2024.



Figure-2: During treatment Prognosis of the patch with tiny hair regrowth on5-12-2024



Figure-3 : During treatment Prognosis of the patch with tiny hair regrowth-19-12-2024



Figure-4 : During treatment Prognosis of the patch with tiny hair regrowth on 19-01-2025



Figure 5: After treatment Complete hair regrowth on 15-02-2025

DISCUSSION:

Indralupta is described in the Ayurvedic classics as a disorder resulting from the vitiation of *Pitta* and *Vata* at the level of *Romakoopa*, followed by obstruction of hair follicles by *Kapha* and vitiated *Rakta*, leading to arrest of hair growth. In contemporary science, Alopecia areata is recognised as a T-cell-mediated autoimmune disorder characterised by inflammatory insult to anagen hair follicles while preserving follicular integrity. [5]

In the present case, detailed Ayurvedic assessment revealed *Pitta–Kapha* predominance disturbed sleep, psychological stress, and physical inactivity, all of which were considered contributory factors in disease pathogenesis. Mild anaemia and elevated inflammatory markers further supported the involvement of *Rakta* as one of the affected *Dushyas*. Accordingly, treatment was planned to address both the underlying *Samprapti* and local follicular pathology rather than focusing solely on hair regrowth.

An important clinical observation during treatment was the slight increase in hair shedding following application of the *Amalaki–Yashtimadhu Lepa* probably due to the sticky, *Guru–Snigdha* (heavy, unctuous) *Kapha-vardhaka* nature of *Amalaki–Yashtimadhu*, which may have transiently aggravated the underlying *Kapha*-predominant *Romakoopa Avarodha*, and mechanical traction from the adherent *Lepa* during application and removal.

These findings are broadly consistent with previous Ayurvedic case reports on *Indralupta*/Alopecia areata. Hair regrowth following a combined Ayurvedic surgical (*Kuttanam*- a minor scarification procedure involving multiple superficial pricks to induce localised capillary bleeding) and internal-medication protocol,[6] and clinical improvement in Alopecia areata using classical *Shamana* therapies.

The primary internal medication, *Br. Manjishthadi Kwatha*, was selected for its well-established *Raktaprasadaka* (blood-purifying) and *Srotoshodhaka* (channel-clearing) properties. *Manjishtha* (*Rubia cordifolia L.*) contains purpurin and other anthraquinones with immunomodulatory and anti-inflammatory activity, consistent with its role in combating the proposed *Kapha-Rakta* obstruction in follicular channels. [7]

The addition of *Gandhaka Rasayana* on the second visit was rationalised on the basis of sulphur's critical role in keratin biosynthesis. Sulphur-containing amino acids (cysteine, methionine) are essential for disulfide bond formation in keratin, the principal structural protein of hair. Furthermore, *Gandhaka Rasayana* possesses *Kapha-Pitta Shamana* properties and improves microcirculation to hair follicles, thereby addressing both the obstruction (*Sanga*) and the follicular nutrition deficit identified in the pathogenesis. [8]

Arogyavardhini Vati, containing *Kutaki* (*Picrorhiza kurroa Royle ex Benth*) as a principal constituent, served multiple roles: *Deepana-Pachana* (stimulation of digestive fire), *Srotoshodhana*, and *Vatanulomana*. Picroside compounds in *Kutaki* are known hepatoprotective and immunomodulatory agents, potentially attenuating the autoimmune follicular damage characteristic of AA. [9]

Avipattikara Churna, with its *Pitta Shamana* and mild laxative action (*Virechaka*), addressed the constipation and *Amalpitta* tendency, thereby reducing the overall *Pitta* burden in the system.[10] *Saptamrita Lauha* probably acted through multiple convergent mechanisms. Its principal constituent, *Loha Bhasma* which is rich in iron likely restored adequate iron/ferritin stores required for rapid matrix-cell proliferation during the anagen phase of the hair cycle, since iron deficiency is independently associated with impaired follicular matrix activity and premature anagen-to-telogen transition in the dermatological literature. Concurrently, its *Yashtimadhu* and *Triphala* components, described as *Tridoshahara* and *Rasayana* (rejuvenative) in classical texts are rich in polyphenolic and flavonoid constituents with antioxidant activity, which may have mitigated the oxidative and inflammatory follicular microenvironment implicated in Alopecia areata pathogenesis. Together, correction of the systemic anaemic state and the *Rasayana* action of its herbal constituents may have synergistically supported follicular recovery. [11]

The topical protocol was particularly innovative. Direct application of *Jaipal* (*Croton tiglium L.*.) seed is contraindicated due to its caustic and toxic properties; hence, *Icchabhedi Rasa* a classical preparation containing *Jaipal* in proportionally controlled quantity was utilised as a *Lepa* (topical paste). The counterirritant effect of *Jaipal* is hypothesised, though not established, to stimulate localised blood flow and local immune modulation within the scalp; the precise mechanism by which such counterirritation might influence follicular immune activity in Alopecia areata remains speculative and warrants further investigation.[12]

Dhatturadi Taila (containing *Datura metel* L. leaf and seed paste in a coconut oil base) was applied immediately after *Icchabhedi Rasa* removal to mitigate local irritation and provide *Keshya* (hair-promoting) benefits. The coconut oil base has been shown to reduce protein loss from hair. Safety was actively monitored throughout topical therapy: application quantity and frequency were proportionally controlled (avoiding afternoon application) and tapered progressively from daily to twice-weekly and then weekly use as clinical response occurred, with clinical assessment for local or systemic toxicity at each visit. Only mild, transient erythema and local irritation were observed, with no vesication, scarring, or systemic adverse effects; this supports a cautious safety profile for proportionally controlled *Icchabhedi Rasa Lepa*, although the known caustic potential of Croton tiglium warrants continued vigilance and comparable safeguards in any future use.[13]

Madhuyashthyadi Taila Nasya is indicated in all *Urdhvajatrugata Vyadhi* (diseases above the clavicle) as per *Bhaishajya Ratnavali*. *Yashtimadhu* (*Glycyrrhiza glabra L.*) is reported in Ayurvedic and pharmacological literature to have anti-inflammatory, antioxidant, and immunomodulatory properties. As a *Nasya* medication, it reaches the *Shringataka Marma* and distributes through cranial channels (*Siras*) to the scalp, providing targeted *Keshya* benefit. [14]

CONCLUSION:

The present case demonstrates that a systematically planned, multimodal Ayurvedic *Shamana* protocol guided by *Samprapti Vighatana* can achieve clinically meaningful and sustained improvement in moderate Alopecia Areata (*Indralupta*). Complete hair regrowth was achieved within three months, supported by objective improvement in SALT (S2 to S0), AASIS (76 to 29), and DLQI (18 to 6) scores. This was accompanied by only mild, transient local irritation, with no systemic adverse events, and no recurrence over one year of follow-up, underscoring the therapeutic potential of this integrated approach. The individualized treatment modifications guided by *Anupashaya* further highlight the value of classical Ayurvedic clinical reasoning in tailoring therapy to patient response.

Limitations of the study

As findings from a single case, these observations cannot establish causality or generalizability; randomized controlled trials with larger sample sizes are warranted to validate them

Patient Perspective:

In the patient's own words (translated from Hindi): "This treatment has truly transformed my life. Not only has my hair grown back completely, but I also feel like a new person. I am no longer self-conscious about my appearance, and I am much more outgoing and confident. Losing 5.4 kg was an unexpected but welcome bonus; it has been like a complete health reset."

The patient has provided written informed consent for publication of this case report including clinical photographs and associated clinical data. Her name, initials, and all identifying information have been anonymised.

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Declaration of Patient consent:

Written informed consent was obtained from the patient for publication of this case report.

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REFERENCES:

1. Strazzulla LC, Wang EHC, Avila L, Lo Sicco K, Shapiro J. Alopecia areata: disease characteristics, clinical evaluation, and new perspectives on pathogenesis. J Am Acad Dermatol 2018;78(1):1-12.
2. Shastri AD. Sushruta Samhita Nidanasthana 13/33-34. Chaukhambha Sanskrit Sansthan, Varanasi: 2013. p-213.
3. Pratt CH, King LE Jr, Messenger AG, Christiano AM, Sundberg JP. Alopecia areata. Nat Rev Dis Primers 2017;3:17011.
4. Kumar S, Murtuza, Choudhary S, Madikonda PK. Standardizing Shirolepa: Bridging Classical Knowledge and Clinical Application. AYUSHDHARA 2025;12(3):262-271.
5. Sehgal VN, Jain S. Alopecia areata: clinical perspective and an insight into pathogenesis. J Dermatol 2003;30:271-289.
6. Deepthi GNS, Kumar CBR, Kumar VK, Surendran ES, Sudhakar D, Raj RVB. Ayurvedic management of Alopecia areata (Indralupta) with surgical procedure Kuttanam and internal medications: a case report. J Ayurveda Case Rep 2021;4(3):105-110.
7. Mitra SK, Kannan R. Manjistha (Rubia cordifolia): a review of its traditional uses, phytochemistry, pharmacology and therapeutic potential. Anc Sci Life 2008;28(1):1-12.
8. Mitra S, Prajapati PK, Shukla VJ, Ravishankar B. Impact of Bhavana Samskara on physico-chemical parameters with special reference to Gandhaka Rasayana prepared by different media and methods. Ayu 2010;31(3):382-6.
9. Pal S, Ramamurthy A, Mahajon B. Arogyavardhini Vati: a theoretical analysis. J Sci Innov Res 2016;5(6):225-7.
10. Gadad GG, Gudaganatti KS. Critical analysis of formulation and probable mode of action of Avipattikara churna: a comprehensive review. Ijppr.Human 2021;22(2):301-11.
11. Shubha. Standardization and Analytical Aspects of Saptamrita Lauha: An Ayurvedic Formulation [Dissertation]. Rajiv Gandhi University of Health Sciences, Bangalore: 2005.
12. Mehkarkar D, et al. Pharmaceutical standardization of Ichhabhedi Rasa: an Ayurvedic formulation. J Indian Syst Med 2018;6(1):10-3.
13. Krishnan Vaidyan KV, Gopalapilla S. Sahasrayogam Sujanapriyavyakhyanam, Thailayogam 43. Vidyarambham Publishers, Kerala. 25th edition, p-287.
14. Vidyashree, et al. Yashtimadhu Taila: a wonder drug for Kesha. Int J Ayu Pharm Chem 2019;11(3):477-82.