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Ayurvedic Management of Supraspinatus Calcific Tendinitis: A Case Report

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ABSTRACT:

Calcific tendinitis of the shoulder is characterized by deposition of calcium phosphate crystals within the rotator cuff tendons and may present with chronic pain, stiffness and restriction of shoulder movements. The supraspinatus tendon is the most frequently involved site. This case describes the clinical response to a sequential Ayurvedic treatment protocol in a patient with chronic supraspinatus calcific tendinitis. A 65-year-old female with no reported comorbidities presented with gradual-onset left shoulder pain of one-year duration, with night pain, difficulty lying on the affected side and restriction of activities such as combing the hair and touching the opposite shoulder during bathing. She had a history of trauma to the shoulder 10 years earlier, intermittent pain and restricted movements for several years, and a history of heavy weight lifting. Clinical examination showed tenderness around the shoulder, restricted range of motion and positive Empty Can, Belly Press and Hawkins-Kennedy tests. Apley scratch test could not be elicited because of restricted movements, while the Drop Arm test was negative. Ultrasonography of the left shoulder was performed. The patient underwent a sequential treatment protocol such as *rooksha sweda , upanaha, choorna pinda sweda, jambeera pinda sweda ,vicharana snehapana ,nasya ,matra vasti* each for a period of 7 days and 2 sitting *jaloukavacharana* .Internal medications such as *amruthotharam kashaya* 90 ml twice daily with *shaddharana* tab ,*prasarnyadi kashaya* second stage with *yogaraja guggulu*. Following treatment, pain reduced, sleep improved and shoulder movements increased. Flexion improved from 80° to 130°, while active abduction improved from 70° with pain and restriction to 160°. Tenderness was reduced and the painful arc became negative.

KEYWORDS: Calcific tendinitis, *Jaloukavacharana, Matra Vasti, Nasya*, Shoulder pain, Supraspinatus, *Swedana.*

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INTRODUCTION:

Calcific tendinitis of the shoulder is associated with deposition of calcium phosphate crystals within the rotator cuff tendons. [1] It is a recognized cause of shoulder pain, stiffness and restriction of movement, particularly abduction. The condition is reported

more commonly on the right side, although bilateral involvement may occur. The supraspinatus tendon is the predominant site of involvement, accounting for approximately 80% of cases in the material presented, followed by the infraspinatus (15%) and subscapularis (5%). Bilateral involvement has been reported in approximately 10–25% of patients. The usual site of calcification in the supraspinatus is described as approximately 1.5–2 cm from its insertion at the greater tuberosity.[1]

From an Ayurvedic perspective, the presentation in this case was considered a *Vata-Kapha* predominant disorder and interpreted as *Kapha avrita Vata* at the level of *Amsa Marma. Kapha* was considered responsible for stiffness and heaviness, while *Vata* was related to pain and restriction of movement. The treatment was planned with the principles of *Avaranahara, Kapha Vilayana, Vata Anulomana*, *Rakta Prasadana*.

CASE REPORT:

A 65-year-old female with no other reported comorbidities presented with gradual-onset left shoulder pain of one-year duration. The pain was aggravated at night, and she was unable to lie on the left side. Initially, she experienced difficulty in putting up her hair and touching the opposite shoulder while taking a bath. Rest provided relief. For further management, she was admitted for treatment

The clinical examination demonstrated both local tenderness and restriction of active and passive shoulder movements. The restriction of flexion, abduction and rotation measured using goniometer indicated significant functional impairment. The positive Empty Can test supported involvement of the supraspinatus mechanism, while the positive Hawkins-Kennedy test indicated painful subacromial/shoulder impingement-type provocation. A positive Belly Press test suggested involvement of the subscapularis functional unit as well. The Drop Arm test was negative, making a gross functional failure of the rotator cuff less evident clinically. The Apley scratch test could not be assessed because the restricted range of movement prevented completion of the manoeuvre.

Clinical examinations

Inspection of the left shoulder showed muscle wasting in the scapular region and swelling over the lateral aspect of the upper arm. Tenderness was graded as Grade 1 over the anterior joint line, Grade 2 over the left humeral head, Grade 1 near the coracoid process and Grade 2 over the medial border of the scapula.

Range of motion was restricted. Flexion was 80°, extension was restricted, and internal and external rotation were restricted. Active abduction was painful and restricted at 70°, while passive abduction was painful at 100°.

Special tests showed a positive Empty Can test, positive Belly Press test and positive Hawkins-Kennedy test. The Apley scratch test could not be elicited because of restricted movements. The Drop Arm test was negative.

The treatment was delivered sequentially rather than as a single isolated intervention. The initial emphasis was on *Rooksha Sweda* and local *Kapha*-reducing measures, followed by procedures intended to reduce stiffness and pain and subsequently support *Vata* pacification and functional recovery. This sequence was based on the Ayurvedic interpretation of the presentation as *Vata-Kapha* predominant with *Kapha avarana* of *Vata* at *Amsa Marma*.

Rooksha Sweda with *Kolakulathadi Choorna* was administered for seven days. This was followed by *Upanaha* using *Kottamchukkadi* and *Dhanyamla* for seven days. *Choorna Pinda Sweda* with *Kolakulathadi Choorna* was then administered for seven days, followed by *Jambeera Pinda Sweda* with *Kottamchukkadi Taila* for seven days. *Vicharana* S*nehapana* with *Guggulutiktakam Ghrita* was administered for seven days. *Nasya* with *Karpasasthyadi Taila* was given for seven days at eight drops, followed by *Matra Vasti* with *Dhanwantharam Taila* for seven days. J*aloukavacharana* was performed twice as part of the treatment sequence.

Internal medication was also changed according to the treatment stage. During the first stage, *Amruthotharam Kashaya* 90 mL twice daily before food and *Shaddharanam* tablets two tablets with *Kashayam* were prescribed. During the second stage, *Prasarnyadi Kashaya* 90 mL twice daily before food and *Yogaraja Guggulu* one tablet with *Kashayam* were administered. The patient was managed with a sequential Ayurvedic treatment protocol.

Table- 1: Relevant history and timeline

Events	Timeline
History of trauma to left shoulder	10 years back (June 2014)
On-and-off pain and restricted movements started	8 years back (August 2016)
History of heavy weight lifting	March 2023
Pain started 1 yr back	October 12, 2023
Admission for treatment	November 20, 2024

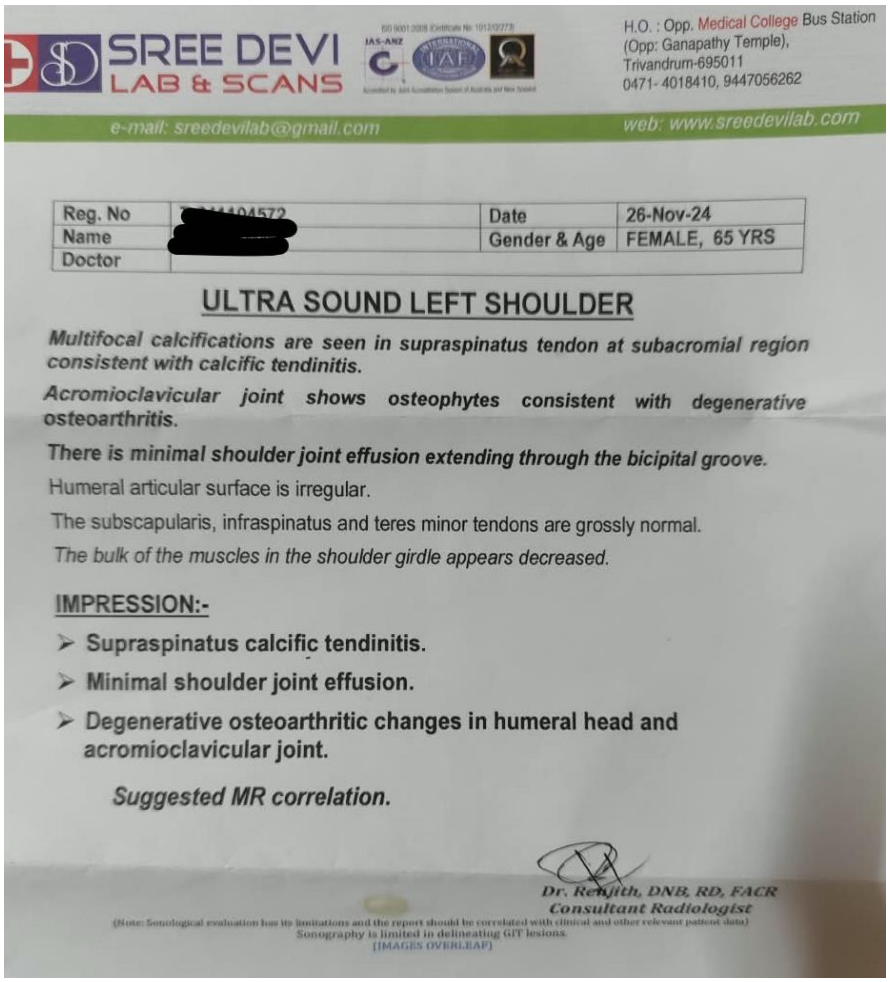
Table -2: Therapeutic intervention

Procedure	Duration	Medicine/material used	Documented response
Rooksha Sweda	7 days	*Kolakulathadi Choorna*	Initial VAS score 8
Upanaha	7 days	*Kottamchukkadi and Dhanyamla*	Stiffness slightly reduced
Choorna Pinda Sweda	7 days	*Kolakulathadi Choorna*	Night pain slightly reduced; movements started improving
Jambeera Pinda Sweda	7 days	*Kottamchukkadi Taila*	VAS score 6

Vicharana Snehapana	7 days	*Guggulutiktakam Ghrita*	Part of sequential treatment
Nasya	7 days	*Karpasasthyadi Taila, 8 drops*	VAS score 4
Matra Vasti	7 days	*Dhanwantharam Taila*	Movements improved; VAS score 2
Jaloukavacharana	2 sessions	—	Part of sequential treatment

Table- 3: Internal medications

Medicines prescribed	Dose	Schedule	Stage
Amruthotharam Kashaya	90 mL	BD before food	First stage
Shaddharanam Tablet	2 tablets	With *Kashayam*	First stage
Prasarnyadi Kashaya	90 mL	BD before food	Second stage
Yogaraja Guggulu	1 tablet	With *Kashayam*	Second stage


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Reg. No	[redacted]	Date	26-Nov-24
Name		Gender & Age	FEMALE, 65 YRS
Doctor			

ULTRA SOUND LEFT SHOULDER

Multifocal calcifications are seen in supraspinatus tendon at subacromial region consistent with calcific tendinitis.

Acromioclavicular joint shows osteophytes consistent with degenerative osteoarthritis.

There is minimal shoulder joint effusion extending through the bicipital groove.

Humeral articular surface is irregular.

The subscapularis, infraspinatus and teres minor tendons are grossly normal.

The bulk of the muscles in the shoulder girdle appears decreased.

IMPRESSION:-

- **Supraspinatus calcific tendinitis.**
- **Minimal shoulder joint effusion.**
- **Degenerative osteoarthritic changes in humeral head and acromioclavicular joint.**

Suggested MR correlation.

Dr. Renjith, DNB, RD, FACR
Consultant Radiologist

(Note: Sonological evaluation has its limitations and the report should be correlated with clinical and other relevant patient data)
Sonography is limited in delineating GIT lesions.
(IMAGES OVERLEAF)

Figure-1: Ultrasonography of the left shoulder was undertaken as part of the evaluation.



Figure-2: Jaloukavacharana (Leech application on shoulder joint)

RESULTS:

The response was assessed clinically using pain, tenderness, range of motion and functional activities. The VAS score showed a progressive reduction during treatment, with a documented score of 8 at the beginning, 6 following *Jambeera Pinda Sweda*, 4 following *Nasya* and 2 following *Matra Vasti*. This reduction was accompanied by improvement in shoulder mobility.

Tenderness over the left humeral head and medial border of the scapula reduced from Grade 2 to Grade 1. Tenderness over the anterior joint line and near the coracoid process, initially Grade 1, resolved completely. Flexion improved upto 80° to 130° as normal range is 150 to 180 degree,Internal and external rotation improved with minimal or no pain at the end range. Active abduction improved to 160°, with near-full passive movement. The painful arc became negative.

Functionally, the patient reported improvement in daily activities, overhead movements and abduction. Night pain and sleep disturbance improved, and the patient described better strength and stability of the shoulder. The overall response was considered clinically favourable in this individual case.

Rooksha and *Swedana* modalities were used initially with the intention of addressing *Kapha*-associated stiffness and local obstruction. *Upanaha* provided prolonged local therapeutic exposure, while *Pinda Sweda* procedures were used to facilitate local warmth, reduce stiffness and improve movement. The later incorporation of *Snehapana, Nasya* and *Matra Vasti* shifted the emphasis towards Vata

pacification and restoration of functional movement.

The use of *Jaloukavacharana* was described in the presentation under the principle of *Rakta Mokshana*. Two sittings of 1 *jalouka* was made to bite. The proposed local effect in the presentation is related to microvascular changes and clearance of local inflammatory or particulate material. This mechanism should be regarded as a proposed explanation rather than a proven mechanism for resolution of calcific deposits, particularly because this report does not provide serial imaging demonstrating disappearance or reduction of the deposit.

The internal medicines were selected according to the Ayurvedic assessment. *Amruthotharam Kashaya* was described as an *Amapachaka* and *Tridosha-shamaka* preparation. S*haddharanam* was used in the context of *Ama* and *Dosha* management in chronic musculoskeletal disease. *Guggulutiktakam Ghrita* was selected in the setting of chronic inflammatory and *Asthi-Snayu-Gata Vata*-type manifestations. *Karpasasthyadi Taila Nasya* was intended to support *Snayu* and *Marma* and pacify *Vata*. *Dhanwantharam Taila Matra Vasti* was selected for *Vata* management and nourishment of *Snayu, Sandhi* and *Marma*. *Prasarnyadi Kashaya* was used for its described *Kapha-Vata-hara* and *Balya* properties, while *Yogaraja Guggulu* was administered as part of the second-stage internal treatment.

The improvement observed in this patient is encouraging, particularly because pain reduction occurred together with measurable improvement in range of motion and daily functional activities. Nevertheless, spontaneous changes in calcific tendinitis, natural disease progression, placebo effects, concurrent interventions and regression to the mean cannot be excluded from a single case report. In addition, the supplied presentation does not provide post-treatment imaging to demonstrate whether the calcific deposit itself changed. Hence, the present report should be interpreted as documentation of clinical improvement rather than proof of radiological resolution or definitive efficacy.[2]

DISCUSSION:

Calcific tendinitis is a common cause of chronic shoulder pain, stiffness and restriction of movements, especially abduction. In the present case, the chronicity of symptoms, history of previous trauma and subsequent heavy weight lifting were relevant clinical features.

The Ayurvedic interpretation considered the condition as *Vata-Kapha* predominant, with *Kapha avarana* of *Vata* at *Amsa Marma*. *Kapha* was considered to contribute to stiffness and heaviness, whereas *Vata* was considered to manifest as pain and restriction of movement. Accordingly, the therapeutic approach incorporated *Avaranahara, Kapha Vilayana, Vata Anulomana* and *Rakta Prasadana* principles.

Rooksha Sweda was selected for its suitability in *Kapha*-predominant presentations. *Kolakulathadi Choorna* was considered to possess *Ushna,*

Rooksha and *Lekhana* properties and was used with the intention of reducing *Srotorodha* and addressing the local pathology. *Upanaha* provides sustained warmth and deeper local application; *Kottamchukkadi* was used for its *Shothahara* and *Vedana Sthapaka* actions, while *Dhanyamla* was incorporated for *Amapachana* and *Kapha Vilayana. Choorna Pinda Sweda* was used to improve local circulation, reduce stiffness and facilitate range of movement.

Jambeera Pinda Sweda was incorporated for *Kapha Shoshana*, together with *Kottamchukkadi Taila* for *Vata* pacification and restoration of functional movement. *Guggulutiktakam Ghrita* was used in the context of chronic inflammatory and Asthi-*Snayu-Gata Vata*-type presentations. *Nasya* with *Karpasasthyadi Taila* was intended to strengthen *Snayu* and *Marma* and pacify *Vata. Matra Vasti* with *Dhanwantharam Taila* was included for *Vata* management and nourishment of *Snayu, Sandhi* and *Marma.*[3]

Jaloukavacharana was included as a local *Rakta Mokshana* intervention. The presentation discusses its possible role through increased microvascularization and clearance of microparticles at the local site. *Prasarnyadi Kashaya* was used for its described *Kapha-Vata-hara* and *Balya* properties, with the clinical aim of improving mobility and strengthening the shoulder.[2,3]

The improvement in pain, tenderness, range of motion and functional activities after the treatment sequence suggests a beneficial clinical response in this individual case. However, as this is a single case report without a comparator group, the observed improvement cannot establish causality or generalize the efficacy of the treatment to all patients with calcific tendinitis.

CONCLUSION:

In this case of chronic supraspinatus calcific tendinitis, a sequential Ayurvedic treatment protocol comprising *Rooksha* and *Snigdha Swedana, Upanaha, Snehapana, Nasya, Matra Vasti, Jaloukavacharana* and appropriate internal medications was associated with reduction in pain, improvement in shoulder range of motion and better functional ability. The case highlights the potential of an integrative Ayurvedic approach for chronic shoulder disorders.

Limitation of study:

Further controlled and adequately powered clinical studies are needed to evaluate the effectiveness, safety and reproducibility of this approach.

Patient perspective:

The patient was reported to be very satisfied with the improvement and the treatments provided. This case demonstrates a structured Ayurvedic approach to a chronic presentation of supraspinatus calcific tendinitis. The sequential combination of local *Swedana* and *Upanaha* procedures, *Pinda Sweda*, *Snehapana*, *Nasya, Matra Vasti, Jaloukavacharana* and internal medicines was associated with substantial improvement in pain, tenderness, range of motion, sleep and functional activities. The most notable

objective clinical changes were improvement of flexion from 80° to 130° and active abduction to 160°, together with reduction in VAS score from 8 to 2.

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

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