

Case Report

Ayurvedic management and rehabilitation of brachial plexopathy:

A case report

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ABSTRACT:

Background: Brachial plexopathy is a neurological disorder caused by injury to brachial plexus leading to weakness, sensory disturbances, and impaired upper limb function. Traumatic injuries especially resulting from road traffic accidents are the most common causes of brachial plexopathy. In Ayurveda it can be correlated with *Kakshadhara marmabhighata* causing *Pakshaghata* (Paralysis). This case report evaluates the role of Ayurveda management along with rehabilitation exercises in improving functional recovery. **Clinical findings:** A 56-year-old male presented with 1 year and 4 months history of weakness of the right upper limb following a road traffic accident. MRI suggested brachial plexus injury with preserved nerve continuity. **Intervention:** The patient underwent Ayurveda management including stagewise treatment with *rukshana* (drying), *snehana* (oleation), *shodhana* (purification), *shamana* (pacification), and *brimhana* (nourishing) therapies, both externally and internally, along with rehabilitation exercises. **Results:** Gradual improvement was observed in shoulder mobility, muscle strength, girth and overall functional use of the affected limb. Grip strength and coordination improved as well. The DASH score reduced from 55 to 29, indicating improvement in upper limb function. Tinel's sign became negative, indicating nerve recovery. **Conclusion:** The outcome in the present case of post-traumatic postganglionic brachial plexopathy with preserved nerve continuity was satisfactory. Following 2 months of stagewise Ayurvedic management and rehabilitation exercises, improvement was observed in ROM, muscle strength, grip function, and upper limb performance, with benefits maintained during the 2-month follow-up period, suggesting potential role of ayurveda in conservative management of such cases.

KEYWORDS: Brachial plexopathy, Case report, *Kakshadhara marmabhighata*, *Pakshaghata*, Rehabilitation

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1. INTRODUCTION

Brachial plexus is a complex network of interwoven nerve strands vulnerable to damage from variable causes. [1] Brachial plexopathy is a peripheral neuropathy that occurs in the brachial plexus. [2] Most brachial plexus lesions result from trauma of the shoulder, often in the form of stretch, compression, disruption, or tear injuries. [3] The incidence of traumatic brachial plexus injury is estimated to be about 1–2 per 100,000 population per year and is commonly associated with road traffic accidents. [4] Clinically, brachial plexus lesions present with weakness, muscle wasting, sensory disturbances, reduced tendon reflexes and pain. [5]

In Ayurveda, the root region of the upper limb corresponds to *Kakshadhara marma*, a *Vaikalyakara marma* [Vital point causing deformity while injured] located between *Kaksha* (axillary region) and *vaksha* (Chest). Injury to this region may lead to muscle wasting and loss of upper limb function, which can be correlated with the *Viddha lakshana* (signs of injury) of *Kakshadhara marma* described as *Pakshaghata*. [6] The peculiarity of the present case lies in the management of postganglionic traumatic brachial plexopathy in a patient who had neurological and motor deficits despite 6 months of physiotherapy and had been advised surgery. This case highlights the potential role of Ayurveda and stagewise

rehabilitation in improving functional outcomes in brachial plexopathy

2. PATIENT INFORMATION

A 56-year-old male with no known comorbidities was apparently healthy until he sustained a severe road traffic accident. The injury was associated with loss of consciousness and required intensive care management. Following recovery, he developed a complete inability to move the right upper limb with profound weakness. He thereafter underwent physiotherapy. Initially, no active movements were present in the limb. After six months of therapy only partial recovery was noted. However, the weakness of the right upper limb persisted. Grip strength remained poor, and was unable to perform overhead activities requiring sustained strength, coordination and fine motor control, which affected his daily activities. He did not report numbness, tingling, or neuropathic pain. As functional recovery remained limited despite prolonged conservative management, surgical intervention was advised. The patient came here for nonsurgical options to improve functional recovery. The timeline of events is presented in [\(Table 1\)](#).

Psychosocial history: No relevant past, family or psychological history. The patient experienced distress due to his functional limitation.

Table 1: Timeline of clinical events

Timeline	Clinical events
January 2024	Sustained road traffic accident with ICU admission
Post-injury	Developed right upper limb weakness; Diagnosed with brachial plexopathy on MRI
July 2024	Underwent physiotherapy for 6 months with partial improvement
Before admission	Surgical intervention advised by neurosurgeon
02/04/2025	Admitted for Ayurveda management
April- May 2025	Phase-wise Ayurveda treatment and rehabilitation
05/06/2025	Discharged with clinical improvement
07/08/2025	On follow-up, further improvement in functional activities noted.

Clinical findings

Personal history:

Bowel: regular, Appetite: normal, Sleep: disturbed due to pain, Micturition: normal.

No known comorbidities

General examination:

- No pallor, cyanosis, clubbing. On systemic examination: Bilateral air entry equal, S1 and S2 heard. Patient was conscious, well-oriented.

Inspection

➤ Attitude:

- Right shoulder adducted and internally rotated

Table 2: Motor examination

Nerve	Root	Muscle tested	grade	Action tested	Remarks
Musculocutaneous	C5-C6	Biceps	M3	Elbow flexion	Possible
		Brachialis	M2	Forearm supination	Restricted
Axillary	C5-C6	Deltoid	M2	Shoulder abduction	Restricted
		Teres minor	M2	External rotation	Restricted
Suprascapular	C5-C6	Supraspinatus	M3	Initiates abduction	Possible
		Infraspinatus	M2	External rotation	Restricted
Radial	C6 -C8	Triceps	M2	Elbow extension	Restricted
	C5-C6	Brachioradialis	M3	Forearm flexion in mid pronation	Possible
	C6-C7	Wrist Extensor	M1	Extension wrist	Restricted
	C7-C8	Finger extensor	M1	Finger extension	Restricted
Median	C6-C7	Pronator teres	M3	Forearm pronation	Possible
	C6-C7	Flexor carpi radialis	M3	Wrist flexion	Possible
	Mainly T1	thenar muscles	M2	Thumb abduction	Restricted
Ulnar	C8 mainly	Flexor carpi ulnaris	M3	Wrist flexion, Ulnar deviation of wrist	All Possible
	T1 mainly	interossei	M3	Finger adduction, abduction	
	C8-T1	adductor pollicis	M3	thumb adduction	

M0 = No contraction, M1= Flicker/trace of contraction, M2 = Active movement with gravity eliminated, M3 = Active movement against gravity, M4 = Active movement against gravity and resistance, M5 = Normal muscle power

Diagnostic assessment

MRI Findings

MRI showed mild enlargement of the right C6 and C7 nerve roots with features suggestive of post-traumatic contusion and edema, indicating brachial plexus injury. Nerve continuity was

- Elbow flexed, forearm pronated
- Wrist and fingers flexed
- Horner's sign & scapula winging: absent
- Muscle wasting: present

Palpation

- Pain and tenderness: absent
- Sensory: both crude touch and deep touch were intact
- Tinel's sign: positive
- Biceps, brachioradialis, triceps reflexes: reduced

Muscle power was assessed using Medical Research Council (MRC) grading system, and corresponding motor actions were evaluated ([Table 2](#)). [7]

preserved. Denervation edema noted in the right rotator cuff muscles. ([Figure 1](#))

Diagnostic challenges: Diagnosis was challenging due to overlapping features of preganglionic and postganglionic brachial plexus injuries and other shoulder pathologies like

rotator cuff injury. Predominant motor weakness and minimal sensory involvement with a positive Tinel's sign made localization difficult. Absence of Horner's sign and MRI evidence of preserved nerve continuity helped exclude preganglionic root avulsion and confirm postganglionic brachial plexus injury.

Diagnosis Workup

Differential diagnosis presented in [\(Table 3\)](#). Considering MRI findings and clinical findings, the condition was diagnosed as traumatic postganglionic brachial plexus injury, predominantly involving the C6–C7 roots with preserved nerve continuity. From an Ayurvedic perspective it can be correlated with *Pakshaghata* resulting from *Kakshadhara marmabhighata*.

Table 3: Differential diagnosis

Differential diagnosis	Inclusion	Exclusion/final interpretation
Cervical root avulsion/ preganglionic injury	Traction injury can involve cervical roots with upper limb weakness	No Horner's syndrome, scapular winging, no loss of nerve continuity in MRI
Cervical radiculopathy	Can present with upper limb weakness and reduced reflexes	Absence of radiating pain; MRI findings suggested plexus injury rather than root pathology.
Neurogenic thoracic outlet syndrome	Weakness of upper limb muscles, reduced grip strength	Clear traumatic onset and MRI evidence, no sensory loss/numbness
Rotator cuff/ Shoulder injury with pseudo-paresis	Shoulder weakness, restricted movements	Neurological pattern including reflex reduction and Tinel positivity
Traumatic postganglionic brachial plexopathy	History of trauma, upper limb weakness, MRI showing nerve edema with preserved continuity	Final diagnosis

Prognosis

Postganglionic lesions occur distal to the ganglion and with preserved nerve continuity, have better recovery potential than preganglionic injuries. [8] However, functional recovery is challenging as it is often slow, variable and requires continued treatment and follow-up. Denervation edema in the rotator cuff muscles indicates peripheral nerve involvement. Positive Tinel's sign suggests local nerve irritation and ongoing nerve regeneration.



Figure 1: Coronal brachial plexus MRI on 28/01/2024 showing enlarged right C6-C7 nerve roots (circled) at lesion site with preserved nerve continuity

Therapeutic intervention

After a detailed clinical examination, the patient underwent 2 months of stage-wise ayurvedic treatment and rehabilitation exercises. Treatment was initiated with *udvarthana*, followed by *snehanapana* until *samyak snigdha lakshana* was achieved. For *shodhana*, *virechana* was done, followed by a 5-day *samsarjana krama*, as the patient had 18 *vegās*. Later, *shamana* treatments were done and ended with *brimhana* and *rasayana* treatments. [\(Table 4\)](#).

Table 4: Timeline of interventions

Date	External Ayurveda procedure	Internal medication	Rehabilitation exercises																
2/4/25-15/4/25	Udvarthana with Kolakulathadi churna (AVS-240315B)	1.Gandharva hasthadi ksm (OUSH-250104) 15 mL+45 mL warm water+1 pinch saindhava and jaggery at bed time 2.Punarnavadi Kashaya (OUSH-240134) 15mL+45mL warm water BID 3.Vaiswanara churna (AVS-241256) 6 g BID with hot water	PHASE 1 - Isometric shoulder exercises [ROMs] with pillow hold - Isometric scapular retraction, depression, elevation - Isometric serratus anterior punch (Wall press hold) - Pendulum exercise																
16/4/25-22/4/25	Nil	Snehapana with guggulutiktha ghrita (AVS-243018) <table><tr><th>Day</th><th>Dose</th></tr><tr><td>16/4</td><td>15mL</td></tr><tr><td>17/4</td><td>30mL</td></tr><tr><td>18/4</td><td>60mL</td></tr><tr><td>19/4</td><td>80mL</td></tr><tr><td>20/4</td><td>110mL</td></tr><tr><td>21/4</td><td>130mL</td></tr><tr><td>22/4</td><td>175mL</td></tr></table>	Day	Dose	16/4	15mL	17/4	30mL	18/4	60mL	19/4	80mL	20/4	110mL	21/4	130mL	22/4	175mL	REST
Day	Dose																		
16/4	15mL																		
17/4	30mL																		
18/4	60mL																		
19/4	80mL																		
20/4	110mL																		
21/4	130mL																		
22/4	175mL																		
23/4/25-25/4/25	Abhyanga kottamchukkadi taila (OUSH-243412) +ushma sweda	Nil																	
26/4/25	Virechana with Gandharveranda taila (OUSH-250132) 30 mL [No of vegas: 18]																		
26/4/25-1/5/25	Samsarjana krama (2 annakala, peya (thin gruel) at evening of virechana day, then vilepi (thick gruel), akruta yusha with green gram, kruta yusha, then yusha of vishkira (gallinaceous birds), finally samanya bhojana																		
2/5/25-8/5/25	Abhyanga with Karpasthyadi taila+ ushma sweda (AVS-240143) Nasya with Karpasthyadi taila (3 mL each nostril)	1.Prasaranyadi kashaya (AVS-250201) 15mL+45mL warm water BID 2.Cap Dhanwantharam tailam 101 avarthi (AVN-T5487) 1.0.1 after food	PHASE 2 -Without resistance band or weight Concentric Phase (Active Movement) and its eccentric Phase (Controlled Return) - Wall finger climbing and walk-down [flexion, abduction plane] - Forward & backward arm circles and Controlled lowering from arm circles																
9/5/25-15/5/25	JPS with Karpasthyadi taila	3.Trayodasanga guggulu DS 1.0.1 (AVN-T17405) after food		- Scaption (elevation in scapular Plane) and controlled return - Active shoulder ROMs - Active elbow flexion (Biceps curl without weight) and controls extension - Active forearm supination & pronation and controlled return															

			Functional movement patterns [Concentric & eccentric] - PNF D1, D2 flexion pattern (Active phase) for shoulder and upper trunk and controlled return from flexion ➤ Muscle re-education
16/5/25-22/5/25	<i>Taila dhara with Yamaka sneha</i> [Indukantha ghrita (AVS-241732) + Dhanwantharam tailam (AVN-T17352)]	1. <i>Mashatmaguptadi kashaya</i> (AVS-248341) 2. <i>Trayodasanga guggulu DS</i> 1-0-1 4. <i>Brihat chagaladi ghrita</i> 1 tsp HS (AVS-247210) 5. <i>Cap Dhanwantharam tailam</i> 101 avarthi 1.0.1 after food (On Discharge advised to continue <i>Brihat chagaladi ghrita</i> and <i>dhanwantharam</i> capsule for 2 months along with phase 3 exercises)	Phase 3 - Resisted isotonic concentric and eccentric strengthening with TheraBand & Dumbbells ➤ Fine motor training A. Basic dexterity training - Finger tapping - Thumb-to-finger opposition B. Grip & manipulation activities - Soft ball squeezing - Buttoning and unbuttoning practice C. Precision and coordination tasks - Writing practice - Keyboard/ mobile typing practice D. Functional task simulation - Simulated feeding activity - Combing hair practice etc
23/5/25-29/5/25	<i>Mamsa + shastika pinda sweda</i> in <i>balamoola kashaya</i>		
30/5/25-05/6/25	<i>Mustadi rajayapana basti</i> : 800 mL		

3. OUTCOME AND FOLLOW-UP

After 2 months of inpatient care, the patient showed considerable improvement. Increased ROM of the affected upper limb was noted after the initial phase of *rukshana*. Further improvement in joint mobility was observed after *Snehapana*, followed by *virechana*. In the next phase, *abhyanga*, *nasya* and *JPS*, along with strengthening exercises and internally disease specific medicines, helped to reduce stiffness and improve functional movements. With continued treatment, which is *brimhana* along with strengthening exercises in the final phase, there was considerable improvement in muscle power, bulk, grip strength and coordination. Recovery was more pronounced in proximal upper limb muscles, whereas distal forearm and hand muscles showed comparatively less improvement. Functional assessment using the DASH score

showed improvement, score decreasing from 55 to 29 after treatment. This indicated better upper limb function and daily activity performance. Grip strength showed noticeable improvement. Tinel's sign, which was positive before treatment, became negative, suggesting nerve recovery. This indicated reduced nerve irritation, resolution of local edema and inflammation and improved axonal conduction. During follow-up after 2 months, the patient showed further improvement in muscle power and grip strength. He was able to do some daily activities using the affected limb that had not been possible previously. However, full functional recovery had not been achieved. Hence, ongoing rehabilitation was advised.

Range of motion (Table 5)

Range of motion improved following treatment (Figure 2)

Table 5: Range of motion

Domain	Before treatment	After treatment
Shoulder Flexion	45°	130°
Shoulder Abduction	50°	100°
Elbow extension lag	40°	10°
Wrist extension	restricted	50°



Figure 2: Shoulder ROM before and after treatment (a) Restricted flexion and abduction before treatment; (b) Improved ROM after treatment

Muscle girth and strength (Table 6)

Muscle girth and power showed improvement after treatment (Figure 3).

Table 6: Muscle girth and power before and after treatment

Measuring site	Circumference BT	Circumference AT
Muscle girth		
Deltoid	34.25 cm	36 cm
mid-arm	26 cm	27.25 cm
above-elbow	24 cm	25.73 cm
forearm	23 cm	23.65 cm
Muscle power		
Deltoid, Biceps, M2		M4
Supraspinatus		
Triceps, Wrist extensors, M2		M3
Brachialis, Thenar muscles		
Finger extensors	M1	M2



Figure 3: Posture and Muscle bulk of patient (a) Before treatment; (b) After treatment showing improvement

Adherence

Treatment adherence was ensured through daily supervision during the IP period. After discharge, adherence was assessed during follow-up visits and through patient self-reporting. The patient complied well with the prescribed treatment.

Tolerance

All treatments were well tolerated. No treatment interruptions were required, and no worsening of symptoms was observed.

Adverse events

No adverse drug effects were noted during treatment period.

4. DISCUSSION

Discussion of disease

From an ayurvedic perspective, Postganglionic brachial plexus injury can be correlated with *Kakshadhara marmabhighata*.



Flowchart 1 : Pathogenesis of disease

Classical descriptions of *kapha-avrita vyana* by Charaka include *gurugatrata* (heaviness), *gati sangha* (restricted movements) which clinically correspond to heaviness and restricted upper limb movement seen in this condition. [9] The principal *dhatu*s

involved are *mamsa* and *majja*, reflected as muscle weakness and axonal dysfunction ([Flowchart 1](#)).

Discussion of treatment

A stagewise therapeutic approach was adopted for *Kapha-avrita vata* at *Kakshadhara marma* sequentially through *Rukshana*, *snehana*, *shodhana*, *shamana*, and *brimhana* for *samprapti nashana* (Pathogenesis breaking). ([Table 4](#))

Phase 1-Rukshana

The initial phase aimed at *Rukshana* to relieve *kapha avarana*, *shotha* and *ama* at the level of *snayu-mamsa-majja srotas*. Externally *udvarthana* with *Kolakulathadi churna* was selected to mobilize *kapha* and relieve heaviness and stiffness. *Kolakulathadi Churna* possesses *vata-kaphahara*, *ushna virya* (hot potency). [10] Internally, *Gandharvahastadi Kashaya* [11] along with *Vaiswanara churna* were administered to support *vata anulomana*, *agnideepana*, *srotoshodhana*, while *Punarnavadi kashaya*, having *sothahara*, *mutrala* (diuretic) properties mitigate post-contusion inflammation. [12] Static isometric exercises support muscle strength without increasing neural edema and prevent disuse atrophy in denervated muscles. Also promoted pain gate modulation and endorphin release, which helped to relieve pain. [13]

Phase 2: Snehana, Shodhana, Shamana

This phase aimed to support nerve regeneration, prevent post-regenerative stiffness and to restore functional range of motion. *Snehapana* with *Guggulutiktaka Ghrita* after reduction of *Kapha-avarana*, nourished *Snayu*, *mamsa*, *majja*, pacified *Vata*. *Ghrita*, by its nature, ensures lipid nourishment to nerve tissue and helps restoration of myelin sheath. Thereafter *virechana* with *Gandharvahastadi taila* having *anulomana* (downward movement) and *tikshna* (penetrating) properties clears metabolic waste and addresses post-traumatic inflammation. [14] *Virechana* is specifically mentioned in *Pakshaghata chikitsa* also.

Shamana

External therapies during this phase included *abhyanga*, *ushma sweda*, *nasya* and later *JPS*. *Abhyanga* with *Karpasthyadi taila*, due to its *snigdha* and *guru guna* nourishes *majja*, *mamsa*, *snayu* and prevents muscle wasting during nerve regeneration period. Thereafter, *nasya* which is specially indicated in *urdhvajatru rogas* and *avabahuka* was done. *Karpasthyadi taila* administered through nostrils reaches the *Sringataka marma* from where it disseminates through the cervical *siras* near brachial plexus origin. [15] *Jambira (amla rasa)* in *JPS* helps *vataharatva*, *srotoshuddhi*, thereby relieving residual stiffness. Internal medications were modified to address remaining *vata-kapha* pathology and to support neuromuscular recovery. *Prasaranyadi kashaya* indicated in *avabahuka*, with its components *Prasarani*, *Nagara*, *Rasona* with *kapha-vatahara* and *ushna virya* reduce inflammation, enhance circulation and improve mobility. *Rasona* supports regeneration of denervated muscles while *Bala* and *Masha* having *guru guna* nourishes and stabilizes them. [16] *Dhanwantharam tailam* used to balance *vata-kapha doshas* in musculoskeletal disorders. Its bioactive components such as oleic acid, dodecanoic acid may reduce pain and inflammation. Its zinc content supports collagen synthesis and neural healing.[17] Along with these *Trayodasanga guggulu* having drugs of *snigdha*, *guru guna*, *ushna virya* supports *vataharatva* and *dhatuposhana* and has antioxidant properties. [18] Phase 2 exercises without resistance respected axonal regeneration time and prevented overload. Concentric movements reactivated weakened motor units. Eccentric training improved muscle balance, PNF D1 flexion pattern helped hand-to-mouth actions and PNF D2 flexion enhanced external rotation and shoulder stability. [19]

Phase 3: Brimhana

This phase aimed at rebuilding muscle bulk, improving overall functional recovery and preventing reinjury through gradual resistance training along with *brimhana* therapies. Initially, external *taila dhara* with *Yamaka sneha (Indukantha ghrita + Dhanwantharam taila)* enhances *sneha* absorption, provides

deeper penetration. *Yamaka sneha* offers combined *vatahara* effect of *taila* and nourishing, stabilizing effects of *ghrita* together. *Yamaka sneha dhara* is popular among traditional *marma* practitioners in the management of *kakshadhara marmabhighata*. [20] *SPS* nourishes *mamsa*, *majja dhatu* with *madhura*, *mamsavardhana* effects through *Shashtika shali*, *Ksheera*, *Balamoola*. [21] *Mustadi rajayapana basti* offers *sadyo balajanaka* (strengthening), *rasayana*, and *yogavahi* (enhancing carrier) effects (Table 7). Also replenishes depleted tissues and supports neuromuscular regeneration in *vata* disorders with muscle atrophy and motor weakness. [22] Internally, more nourishing medicines were added, aimed at promoting stability and better functional rehabilitation. *Mashatmaguptadi Kashaya* specially indicated for *pakshaghata*, containing *masha*, *atmagupta*, *bala* provides *madhura*, *snigdha*, and *balya* effects, nourishing *mamsa dhatu*, countering muscle wasting. *Eranda* in it helps *srotoshodhana*. [23] *Brihat chagaladi ghritam* is *rasayana* and *brimhana* and is indicated for unilateral motor weakness and muscle wasting (*pakshaghata*, *ekanga spandana*, *shosha*, *ksheenata*). Nourishes *mamsa*, *majja*, *asthi dhatus* through *Chagala*, *Dasamoola*, and *brimhana dravyas* and strengthens denervated muscles, enhancing rotator cuff recovery. [24] Phase III exercises were resisted isotonic strengthening to enhance shoulder muscle power and stability. (Table 6) Concentric and eccentric contractions improved motor unit activation and neuromuscular coordination. Fine motor training restored hand function, grip strength and coordination, supporting daily activity performance.

Previous reports on brachial plexopathy often describe prolonged physiotherapy, electrotherapy, and sometimes surgery for its management. [25] This case followed a stagewise integrative protocol combining classical ayurvedic therapies with rehabilitation principles, resulting in overall improvement without surgical intervention. (Figure 2) (Figure 3)

Table 7: Mustadi rajayapana basti components

Basti components	
<i>Saindhava</i>	10g
<i>Madhu</i>	120mL
<i>Dhanwantharam tailam</i>	120mL
<i>Brihat chagaladi ghrita</i>	120mL
<i>Shatahwadi kalka</i> <i>Shatpushapa</i> , <i>Madhuyasti</i> , <i>Kutaja</i> .	30g
<i>Mustadi ksheera kashaya</i> <i>Musta</i> , <i>Ushira</i> , <i>Bala</i> , <i>Rasna</i> , <i>Aragvadha</i> , <i>Gudhuchi</i> , <i>Manjistha</i> , <i>Katurohini</i> , <i>Trayamana</i> , <i>Punarnava</i> , <i>Bibhitaka</i> , <i>Laghu panchamoola</i> , <i>Madanphala</i> .	300mL
<i>Aja mamsa rasa</i>	100mL

Limitations: Single-case design, short follow-up duration and absence of objective neurophysiological assessments such as nerve conduction studies or electromyography are limitations.

Strengths: Considerable functional and neurological improvement was observed within a relatively short period. Improvement was maintained during follow-up period without adverse effects.

5. CONCLUSION

This case describes post-traumatic postganglionic brachial plexopathy with preserved nerve continuity, characterized by motor weakness and functional limitation for 1 year and 4 months following injury, with only minimal improvement after 6 months of physiotherapy. Although surgery was advised, the patient opted for conservative management. The Ayurvedic management included inpatient sequential treatment comprising *Udvarthana*, *snehapana*, *Virechana*, *Abhyanga*, *Nasya*, *JPS*, *Taila dhara*, *SPS*, *Yapana basti* along with internal medicines and rehabilitation exercises for 2 months, followed by another 2 months of follow-up. The patient showed improvement in ROM, muscle strength, joint mobility, grip function, and overall upper limb performance. The DASH score reduced from 55 to 29, and conversion of Tinell's sign from positive to negative indicated neurological recovery. Recovery

was more pronounced in the proximal muscles of the upper limb, particularly around the shoulder and arm, whereas distal muscles of the forearm and hand, including finger extensors, demonstrated comparatively less improvement. The benefits were maintained during follow-up, with no incidental findings and treatment-related adverse effects.

This case suggests that Ayurvedic management combined with rehabilitation exercises may support functional recovery and improve quality of life in cases of post-traumatic postganglionic brachial plexopathy with preserved nerve continuity.

ABBREVIATIONS

DASH - Disabilities of the Arm, Shoulder and Hand

ICU – Intensive care unit

MRI – Magnetic Resonance Imaging

mL – Milliliter

ROM- Range of motion

BID – Twice daily

HS – At bedtime

DS – Double strength

PNF – Proprioceptive Neuromuscular Facilitation

JPS – Jambeera pinda sweda

SPS – Shashtika pinda sweda

cm - centimeter

Declaration of Patient Consent – The authors confirm that they have acquired a patient consent form, in which the patient or caregiver has granted permission for the publication of the case, including accompanying images and other clinical details, in the journal. The patient or caregiver acknowledges that their name and initials will not be disclosed, and sincere attempts will be undertaken to safeguard their identity. However, complete anonymity cannot be assured.

Patient's Perspective: After the accident, my right arm was very weak. With Ayurvedic treatment and exercises, I gradually felt improvement. My movements and grip became better. Now I can use my hand comfortably for daily activities.

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Declaration of Generative AI

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