



Therapeutic Potential of Ayurvedic and Herbal Interventions in Vaginitis: A Critical Narrative Review

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ABSTRACT:

Introduction: Vaginitis is considered the most prevalent gynecological condition during the reproductive age of women, defined by the symptoms of vaginal discharge, burning sensation, malodor, pruritus, and inflammation. In *Ayurveda* it can be correlated with *Yonivyapada* or *Shwetapradara*. **Objective:** This narrative review aims to assess the effectiveness of *Ayurvedic* & herbal interventions for the treatment of vaginitis.

Methods: This narrative review synthesizes total 22 studies and clinical evidences published between 2014 & 2025 from databases like PubMed, Google Scholar, and Science Direct to evaluate *Ayurvedic* management of vaginitis. The interventions included local, systemic, and also combined therapy for vaginitis and its different forms like vulvovaginal candidiasis, bacterial vaginosis, trichomoniasis, leucorrhea, and nonspecific vaginitis. **Results:** The reviewed studies demonstrated significant improvement in symptoms ($p < 0.05$) and recurrence rates. Several studies showed improvement in Nugent and Amsel scores, vaginal pH, normalized vaginal flora and demonstrated anti-fungal, anti-microbial, anti-inflammatory, and wound-healing activities. Mostly, local treatments like *Yonipichu* & *Yoniprakshalana* demonstrated clinically superior results. **Conclusion:** In current findings, *Ayurvedic* and herbal interventions reduce the symptoms of vaginitis comparable to conventional treatment but the results are constrained by heterogeneity in methods, varied treatment protocols, and small sample sizes. However, further well-designed, large-scale trials with standardized methodologies & longer follow-up should be designed to investigate the safety and efficacy of *Ayurvedic* treatment and strengthen its evidence in vaginitis management.

KEYWORDS: *Ayurveda*, Bacterial vaginitis, Herbal medicines, Trichomoniasis, Vulvovaginal Candidiasis, *Yonivyapada*

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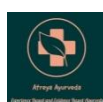
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1. INTRODUCTION

In the primary healthcare system, vaginitis is thought to be the most common gynecological condition affecting women worldwide. [1] It is described as any condition that manifests as abnormal vaginal discharge, malodor, discomfort, itching, or burning sensation. The predominant forms of vaginitis include Bacterial vaginosis (BV), Vulvovaginal candidiasis (VVC), and Trichomoniasis. BV occurs when there is a reduction in *Lactobacillus* species and an overgrowth of anaerobic bacteria, leading to a change in normal vaginal microbiota. Trichomoniasis is a sexually transmitted infection caused by *Trichomonas vaginalis*, showing vaginal inflammation, frothy discharge, dysuria, dyspareunia, and so on. VVC is a fungal infection caused by *Candida albicans* characterized by curdy discharge and pruritus. [2] Among these, BV accounts for 40% to 50% of cases, VVC 20% to 25%, and trichomoniasis 15% to 20% of cases. Non-infectious forms such as atrophic, irritant, allergic, and inflammatory vaginitis are less common, constituting 5% to 10% of vaginitis cases. [3] The global prevalence of bacterial vaginosis and trichomoniasis is estimated to be 26% & 5.3%, respectively, with significant geographical variation. [4, 5] Approximately, 75% of women may experience at least one episode of vaginal candidiasis during their lifetime. [6] All age populations experience BV and VVC, although women of reproductive age, primarily those between 15-40 years have the highest incidence. [7] Significant risk factors for vaginitis include urethritis, pelvic inflammatory illness, preterm births, and infections of the amniotic fluid in pregnant women. [8] Vaginitis is not described as a separate disease entity in *Ayurveda*, but its clinical manifestations resemble various *Yonivyapada* (gynecological disorder) and *Shwetapradara* (white discharge) conditions. *Yonivyapada* mainly manifests due to *dosha dushti* (derangement of bodily humors), predominantly *Vata* (the biological principle of kinetic energy, movement, and neuro-regulation) along with involvement of *Pitta* (the biological principle of metabolic transformation, heat, and digestion) and *Kapha* (the

biological principle of structural cohesion, anabolism, and fluid lubrication). *Apanvata* (the downward-moving physiological force in pelvis), a subtype of *Vata*, is considered the principal *dosha* (humor) involved in the pathogenesis of *yoniroga* because it governs menstruation, conception, ovulation, and expulsion functions in the body. [9]

The traditional management of vaginitis includes oral and intravaginal metronidazole, clindamycin, and other antibiotics, but recurrence rates are still very high. [3] However, long-term use of antibiotics may alter physiological and non-physiological changes in patients, interfere with the normal vaginal microbiota, and cause the establishment of resistant strains. [10] Due to all these complications, patients may look for safe, complementary, and alternative therapeutic approaches that have fewer side effects. The most commonly explored alternative therapies include yogurt with live acidophilus, boric acid tablets, tea tree oil, and garlic. [11]

The management of vaginitis in *Ayurveda* primarily focuses on *Vata-shamana* (pacifying) therapies such as *snehana* (therapeutic oleation), *svedana* (sudation therapy), and *shodhana* (bio-cleansing). Additionally, local therapies including *parisheka* (therapeutic streaming), *pralepana* (thin anointment), *pichu* (medicated tampon application), *abhyanga* (therapeutic oil massage), and *uttarabasti* (intrauterine medication instillation) are administered according to the predominant *dosha* involvement in the pathogenesis of disease. Vaginitis is a high prevalent global disease that is recurring, uncomfortable condition for females. The existing reviews only focus on conventional management and individual herbal formulations and interventions for vaginitis and related condition. These available studies remain scattered and have not been comprehensively synthesized. Therefore, this review was undertaken to gather the clinical evidences for its management; study the safety and efficacy along with probable mechanism of given interventions and provide a scientific evidence-based reference for future research.

2. MATERIALS AND METHODOLOGY:

The present study employed a narrative review that included a detailed search to compile, evaluate, and review all the *Ayurvedic* & herbal formulations to treat vaginitis and its related condition. Relevant studies were retrieved from electronic databases like PubMed, ScienceDirect, and Google Scholar up to December 2025. The keywords were searched alone and in combination using Boolean operators (“AND”/”OR”). The search words were “Vaginitis,” “Bacterial vaginosis,” “Trichomoniasis,” “Candidiasis,” “Abnormal vaginal discharge,” “Vaginitis AND Herbal Medicine,” “Vaginal Infection,” “*Yonivyapada*,” “*Shwetapradara*,” “*Yonivarti*,” “Medicinal Plant,” “Herbal Remedy,” “Phytotherapy” and “Complementary Medicine.” For all databases, different search strategies were used using keywords & MeSH terms. The Filters used were dates ranging from 2014 to 2025, Language used was English. The

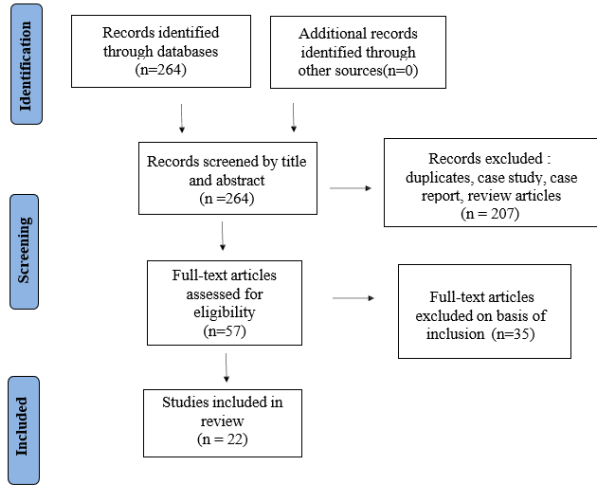
Table 1: Search Strategy Database

Databa se	Search Terms Used	Filters Applied	Results retrieved	Notes
PubMe d	(“Vaginitis” AND “Herbal Medicine”); (“Bacterial Vaginosis” AND “Herbal Medicine”); (“Vaginal Infection” AND “Herbal Medicine”); (“Abnormal Vaginal Discharge” AND “Herbal Medicine”)	Free full text, Clinical Trial, Randomized Controlled Trial, English, Humans, Date ranging from 2014 – 2025	55	Search customized with MeSH terms and Full text articles only read manually.
Science Direct	(“Vaginitis” AND “Ayurveda Medicines”)	English language; Research articles, Date ranging from 2014 – 2025	36	Full-text articles screened manually
Google Scholar	(“Vaginitis” AND “Ayurvedic medicines”, OR “vaginosis” OR “bacterial vaginosis”, OR “trichomonas”, OR “candida”)	Date ranging 2014-2025	173	Additional studies identified manually

Inclusion Criteria

- i. Original research articles evaluating Ayurveda and herbal interventions on vaginitis and related conditions. (BV, VVC, trichomoniasis, Shwetapradara, or Yonivyapada).
- ii. Randomized controlled trials, clinical trials, and in vitro studies.
- iii. Full-text articles published in the English language between 2005 and 2025.

inclusion of article types were clinical studies & RCTs. Relevant In-vitro studies were also included. A detailed search strategy is shown in the given [flowchart no. 1](#) and [Table 1](#).



Flowchart No. 1: Database and number of records identified and included.

Exclusion Criteria

- i. Review articles, case series, case reports, conference abstracts, editorials, and duplicate articles from multiple databases.
- ii. Studies lacking full-text access & non-English articles.
- iii. Studies with insufficient methodological data and outcome reporting.

3. RESULTS:

A total of 22 articles, including 13 RCTs, 6 Single-Arm Trials, 1 Triple-Arm Trial, and 2 In-Vitro Studies, met the study eligibility criteria evaluating herbal and Ayurvedic

interventions for vaginitis. The characteristics and outcomes of these studies are summarized in [Tables 2-5](#).

Table 2: Randomized Controlled Trials evaluating Ayurvedic & Herbal Interventions for vaginitis and its related conditions.

Sr.no.	Grouping & Sample Size	Intervention, Dose, Duration, Follow-up	Result
1.	Pregnant women with vulvovaginitis (<i>upapluta yonivyapada</i>) Total sample size (n = 80) divided into two groups. Group A: (n=46) Group B: (n=34) Age: 19-40 yrs.	Group A treated with <i>Dhatakyadi Varti</i> – 3 g, and Group B with Clingen vaginal suppository (clotrimazole & clindamycin per 100 mg). Both administered intravaginally once HS for 14 days. Follow up: 15 th day & 30 th day.	<i>Dhatakyadi Varti</i> (DV) showed complete remission in 34.88% cases compared to the 34.88% in Clingen vaginal suppository. DV showed few unchanged cases (2.32%) compared to 20% in Clingen. Highly significant relief (P < 0.05) in fungal infection. Recurrence was lower in DV (5 cases) vs. Clingen (12 cases). [12]
2.	Women diagnosed with vulvovaginal candidiasis. Total sample size (n = 94) divided into two groups. Group A: (n = 47) Group B: (n = 47) Age: 18-45 yrs.	Group A treated with 10% curcumin vaginal cream- 5g, and Group B with 1% clotrimazole vaginal cream. Both administered with applicator for one week during bedtime. Follow-up: 4–7 days after the completion of treatment.	Clinical recovery in 66% of participants in curcumin cream compared with 48.9% in the clotrimazole. Microbiological cure rates higher in clotrimazole arm (76.6%) than in the curcumin arm (59.6%). [13]
3.	Women diagnosed with bacterial vaginosis. Total sample size (n = 90) divided into two groups. Group A: (n = 45) Group B: (n = 45) Age: 18-50 yrs.	Group A treated with <i>Cymbopogon olivieri</i> vaginal herbal capsule (500 mg extract). And Group B treated with metronidazole vaginal capsule. Both administered once daily for 7 days. Follow-up: Evaluation after completion of treatment (around 10 days).	Both groups improved BV symptoms and Amsel's criteria scores significantly with no significant differences observed. [14]
4.	Women diagnosed with <i>Kaphaj Yonivyapad</i> (w.s.r. to <i>Trichomonas</i> vaginitis). Total sample size (n = 90) divided into two groups. Group A: (n = 45) Group B: (n = 45) Age: 18-50 yrs.	Group A treated with <i>Nimba-Jambu-Vasa Kwath Yoniprakshalana</i> & Group B treated with <i>Triphala Kwath Yoniprakshalana</i> . Both administered 200 ml vaginally OD for 7 days. Follow Up: 14 th day	Both groups A & B showed mean overall improvement 73.78% and 74.22%, respectively. <i>Triphala Kwath</i> exhibited comparatively good improvement. [15]
5.	Women diagnosed with <i>Pittaj Yonivyapad</i> w.s.r. (pelvic inflammatory disease). Total sample size (n = 60) divided into two groups. Group A: (n = 30) Group B: (n = 30) Age: 20-40 yrs.	Group A treated with <i>Brihat Shatavari Ghrita</i> orally for 7 days + <i>Shatavari Ghrita Pichu</i> vaginally retained 4 hours once daily and Group B with Tab. Clindamycin 450 mg four times a day for 7 days + clindamycin vaginal pessary 100 mg at bedtime for 7 days. Follow-up: 7 days during treatment & 14 th day.	<i>Brihat Shatavari Ghrita</i> orally and <i>Pichu</i> together showed symptomatic improvement (50–75%), especially in reducing vaginal discharge and backache. [16]

6.	Women diagnosed with abnormal vaginal discharge Total sample size (n = 104) divided into two groups excluding dropouts. Group A: (n = 50) Group B: (n = 50) Age: 20-50 yrs.	Group A treated with <i>Nimbadi Yoni Varti</i> (3 g), and Group B was treated with Clingen vaginal suppositories (1 g). Both administered intravaginally at bedtime for 7 days. Follow-up: Every 15 days till 1 month.	<i>Nimbadi Yoni Varti</i> exhibited higher rates of marked clinical improvement (78%) compared with the Clingen suppository (66%). Only one recurrence in Group A compared with nine in Group B. [17]
7.	Women diagnosed with <i>Kaphaja yoni vyapat</i> w.s.r. to vulvo vaginal candidiasis. Total sample size (n = 40) divided into two groups. Group A: (n = 20) Group B: (n = 20) Age: 20-40 yrs.	Group A treated with <i>Triphala Kashaya Prakshalana</i> , and Group B- Treated with <i>Nimba Twak Kashaya Prakshalana</i> . Both given locally for washing once daily for 7 days.	In patients of Group A, 88.23% and in Group B, 87.38% overall improvement seen. <i>Nimba Twak Kashaya Prakshalana</i> decreased vaginal discharge and itching significantly. [18]
8.	Women diagnosed with <i>Shwetapradar</i> w.s.r. Trichomonas vaginitis. Total sample size (n = 100) divided into two groups. Group A: (n = 50) Group B: (n = 50) Age: 18-45 yrs.	Group A treated with <i>Rohitaka mula churna</i> (3 g) twice daily before meals with lukewarm water for 15 days, and Group B with a metronidazole tablet (200 mg) thrice daily after meals for 7 days. Follow-up: 2 follow-ups at intervals of 15 days.	<i>Rohitaka Mula Churna</i> exhibited good overall symptomatic relief (68.98%) compared to metronidazole (60.20%). [19]
9.	Women diagnosed with <i>Shwetapradara</i> w.s.r. vaginitis. Total sample size (n = 20) divided into two groups. Group A: (n = 10) Group B: (n = 10) Age: 20-40 yrs.	Group A treated with <i>Panchavalkala Kashaya Yoni Prakshalana</i> (1 to 2 liters decoction) and Group B with lukewarm water <i>YoniPrakshalana</i> Both administered at one time daily for 7 days. Follow-up: One day weekly for 3 consecutive weeks after treatment.	<i>Panchavalkala Kashaya</i> showed significant improvement in symptoms of vaginal discharge & itching (p < 0.001) compared to lukewarm water. [20]
10.	Women diagnosed with bacterial vaginosis Total sample size: n=120, divided into two groups. Group A: (n=60) Group B: (n = 60) Age: (18–44 yrs)	Group A treated with a garlic tablet (500 mg), and Group B with oral metronidazole (250 mg). Dosage: Both groups, 2 tablets every 12 hours (oral) for 7 days. Follow-up: After 7–10 days using Amsel's criteria & gram stain.	Garlic improved Amsel's criteria 70% compared to metronidazole 48.3%, and both showed comparable therapeutic outcomes with fewer side effects. [21]
11.	Women diagnosed with Leucorrhea Total sample size: (n=363) divided into 6 groups.	Trial Drug (NA – Novel Ayurvedic Vaginal Tablet), which contains the ingredients <i>Azadirachta indica</i> A. Juss. (<i>Neem</i>) and <i>Saraca asoca</i> Roxb. (<i>Ashoka</i>)	OVNA produced the best reduction in clinical outcomes among all treatment groups. It was comparable to clotrimazole. [22]

	Group A: (n = 51) Group B: (n = 52)	Group = Capsule Placebo (CP) Group B= Capsule [NA] (CNA)	
	Group C: (n = 54) Group D: (n = 55)	Group C=Clotrimazole Vaginal Tablet (V6) Group D= Vaginal tablet [NA] (VNA)	
12.	Women diagnosed with management of vulvovaginitis Total sample size (n = 60) divided into two groups. Group A: (n = 30) Group B: (n = 30) Age: 20-40 yrs.	Group A treated with <i>Kasisadi Gel</i> (2 g) and Group B with V-Gel (2 g). Both administered intravaginally twice daily for 7 days at bedtime. Follow-up: 7th and 14th day	<i>Kasisadi Gel</i> showed higher clinical improvement in vaginal discharge, pruritis, and dyspareunia compared to V-Gel. [23]
13	Women diagnosed with management of vulvovaginitis Total sample size Total sample size (n=175) is divided into three groups. Group A: (n = 59) Group B: (n = 60) Group C: (n=56) Age: 18-65 yrs.	Group A treated with Clotrimazole 1% vaginal cream, & Group B with Dill seed total extract (TEE) 2% cream. and Group C with dill seed essential oil (EO) 2% cream. Both administered (5 g) intravaginally for 7days at bedtime. Follow-up: 10 th day (clinical exam+ sniff test)	Dill seed total extract and essential oil creams showed higher recovery rates compared to clotrimazole cream as given; Clotrimazole – 66.1%, TEE – 86.7% EO – 87.5%. The oil formulation showed reduction in positive sniff test findings and exhibited greater relief in clinical symptoms. [24]

Table 3: Single-Arm Trials evaluating Ayurvedic & Herbal Interventions for vaginitis and its related conditions.

1.	Women diagnosed with <i>Slaishmiki Yonivyapat</i> . Total sample size (n = 33) Age: 20–30 yrs.	<i>Triphaladi Yoni Varti</i> - 3 g administered intravaginally twice a day for 7 days Follow-up: 8 th day and 14 th day	Greater symptomatic & microbiological improvement is seen with 84.4% relief in <i>Yonivedana</i> and <i>Yonikandu</i> ; 78.8% relief in <i>Picchila Srava</i> ; and 84.8% negative smear clearance for <i>Candida</i> . The therapeutic outcomes were statistically highly significant (p < 0.001), with no adverse events seen. [25]
2.	Women diagnosed with <i>Kaphaja Yonivyapada</i> (non-specific vulvovaginitis) Total sample size (n=20); Age: 18-49 yrs.	<i>Eladi Kwath</i> administered orally 50 ml twice daily after meals for 7 days. Follow-up: 7 th day.	<i>Eladi Kwath</i> exhibited significant reductions in vaginal discharge, pruritus, and foul odor with total average relief of 61.47%. [26]
3.	Women diagnosed with leucorrhea Total sample size (n = 30) Age: 18-40 yrs.	<i>Madhukadi Churna</i> administered orally, 5g twice daily after food with Anupana (therapeutic vehicle) <i>Arkapatra swarasa</i> for 20 days. Follow-up: 10 days	Good improvement in vaginal pH and smear findings (p < 0.05). Approximately in 76.7% of patients, good therapeutic response was seen. [27]
4.	<i>Kaphaja Yonivyapada</i> (Non-specific Vaginitis) Total sample size (n = 20); Age: 21–40 yrs.	<i>Pippalyadi Taila Yonipichu</i> inserted vaginally under aseptic conditions for 7 days. (retained for 3-6 hrs) Follow-up: 14 th day	Statistically highly significant improvements (p < 0.001) in multiple clinical symptoms were seen. [28]
5.	Women diagnosed with	<i>Karanj Tail Yoni Pichu</i> - 10 ml was	Overall symptomatic relief at a 61.38% rate was observed in vaginal

<i>Shwetapradara</i> sample size: (n=15) Age: 18–45 years	Total inserted intravaginally for 3 weeks daily after menses. Follow-up: Every 15 days; final assessment after 2 months	discharge and related complaints. [29]
6. Women diagnosed with abnormal vaginal discharge Total sample size: (n=30); Age: 18-40 yrs.	<i>Pushyanug Churna</i> 3-5 g twice with water for 30 days daily. Follow-up: Every week.	Overall symptomatic relief in approximately 83% of patients, showing broad-spectrum clinical efficacy. [30]

Table 4: Triple Arm Trials evaluating Ayurvedic & Herbal Interventions for vaginitis and its related conditions.

1. Women diagnosed with vaginitis Total sample size: (n=120) was divided into 3 groups. Group A: (n = 40) Group B: (n = 40) Group C: (n = 40) Age: 18-55 yrs.	Group A - <i>Myrtus communis</i> L. (Myrtle) + <i>Quercus</i> <i>infectoria</i> G. Olivier (Oak gall) suppository (MOGS). Group B (Control 1) -Metronidazole vaginal tablet-100 mg Group C (Control 2) - Placebo vaginal suppository. All are intravaginally inserted once daily at bedtime for 7 days. Follow-up: 7 th day, clinical & laboratory evaluation.	The polyherbal vaginal suppository MOGS significantly showed good results in vaginal discharge, vaginal pH, and Whiff test outcomes compared with the placebo. However, metronidazole exhibited superior outcomes on Nugent scores, & the MOGS formulation showed greater efficacy against trichomoniasis and comparable efficacy in mixed vaginitis cases. [31]
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Table 5: In-Vitro Study evaluating Ayurvedic & Herbal Interventions for vaginitis and its related conditions.

1. Antimicrobial activity of a novel polyherbal combination for treating vaginal infection Microorganisms Studied were <i>E. coli</i> ; <i>S. aureus</i> , <i>and Candida albicans</i> . No human involved.	Polyherbal Formulation (PHA): Evaluation of a combination of plant extracts of <i>Azadirachta</i> <i>indica</i> A. Juss. (Neem), <i>Cichorium intybus</i> L. (Kasani), and <i>Trigonella foenum-graecum</i> L. (Methi) for antibacterial activity. Doses: Dose one (D1)- 1% of actual dose Dose two (D2)- 10% of actual dose Dose three (D3)- 25% of actual dose Dose four (D4)- 50% of actual dose Control Drugs: Chloramphenicol, Ciprofloxacin, & Miconazole	The polyherbal formulation demonstrated different antibacterial and antifungal activity against <i>E. coli</i> , <i>S. aureus</i> , and <i>Candida albicans</i> according to dosage. D3 exhibited better broad-spectrum activity against all microorganisms compared to D2, except for <i>E. coli</i> . D3 & D4 exhibited comparable microbial activity. Minimum inhibition concentration was 5-7 mg/ml. [32]
2. Study on in vitro action of <i>Panchavalka kwatha</i> & its ingredients with the culture & sensitivity technique in leucorrhea patients. 6 drug samples that contained five individual drugs (<i>Ashvatha</i> , <i>Vata</i> , <i>Udumbara</i> , <i>Plaksha</i> , and <i>Parish</i>) and one combined formulation (<i>Panchavalka Kwatha</i>).	25 vaginal discharge samples of leucorrhea patients were collected. The agar well diffusion method was used to assess the antibacterial activity of infected samples; later, the zone of inhibition was analyzed.	Among the tested formulations, <i>Panchavalka</i> <i>kwatha</i> showed the maximum bacterial zone of inhibition - 21.20 mm; <i>Vata</i> - 19.96 mm; <i>Udumbara</i> - 18.24 mm; <i>Ashvatha</i> -18.96 mm; <i>Plaksha</i> - 17.80 mm; and <i>Parish Pipal</i> least- 6.24 mm antibacterial activity. Hence, <i>Panchavalka</i> showed more antibacterial activity than its ingredients. [33]

4. DISCUSSION

The results of reviewed studies show the potential of *Ayurvedic* and herbal interventions in the management of vaginitis, like oral medications and local therapeutic procedures such as *Yoniprakshalana*, *Yonipichu*, & *Yoni Varti*, as well as combined oral and local therapies. They showed improvement in symptoms like abnormal vaginal discharge, pruritis, burning sensation, malodor, dyspareunia, vaginal inflammation, lower backache, and so on. The recurrence rate of *Ayurvedic* treatment was generally less compared to conventional therapies like clotrimazole, metronidazole, and vaginal suppositories. The overall treatment duration period observed was generally 7 to 30 days, and the follow-up period was generally from 15 to 90 days. The herbs that worked better in vaginitis have *Kashaya* (astringent) & *Tikta*(bitter) *rasa*; *Laghu* (light) & *Ruksha* (dry) *guna*; and *Kapha-shamaka* and *Krimighna* (antimicrobial), *Kandughna* (antifungal), *Shothara* (anti-inflammatory), *Vranaropaka* (wound-healing), *Yoniropana* (healing), & *Yonishodhana* (purification) properties that may have worked directly in the pathogenesis of vaginitis.

In VVC, a formulation like *Dhatakyadi Varti* was found to be safe and effective in pregnancy, and lower recurrence was observed compared to the Clingen vaginal suppository. [12] An RCT study of 10% curcumin vaginal cream and dill seed curcumin vaginal cream showed good tolerability with fewer adverse effects. The antifungal activity of dill seeds may be due to its bioactive constituents like carvone and limonene that disrupts fungal cell membranes and mitochondrial function ([Table no. 2](#)). [13, 24] *Triphala*-based interventions like *Triphaladi Yoni Varti* and *Triphala Kwatha Yoniprakshalana* improved symptoms and supported restoration of vaginal pH and local microbial homeostasis. [15, 18, 25] Neem emerged as one of the most prominent drugs in the management of vaginitis. *Nimba Twak Kashaya Prakshalana* and *Nimbadi Yoni Varti* showed good results compared to clingen suppositories. [17, 18] Previous pharmacological evidence supports this by showing that neem contains bioactive constituents nimbin,

nimbidin, edunin, quercetin, tannins, and flavonoids, which show antifungal and antimicrobial properties of neem. [34] Orally administered drugs like *Eladi Kwath* & *Madhukadi Churna* showed clinically significant improvement in non-specific vulvovaginitis & leucorrhea, respectively. [26, 27] Studies on *Trichomonas*-associated vaginitis also supports the efficacy of the polyherbal vaginal suppository containing *Myrtus communis L.* & *Quercus infectoria G. Olivier*. The antimicrobial activity of the formulation is primarily due to its high content of gallic acid and hydrolyzable tannins, that disrupt microbial cell membranes, interfere with peptidoglycan synthesis, and inhibit microbial growth. Myrtucommulone, an active myrtle component, may inhibit production of prostaglandins and improve wound healing and vaginitis. [31] *Rohitaka mula churna* has symptomatic relief in *shwetapradara* w.s.r. *trichomonas* vaginitis due to bioactive constituents like β -sitosterol, lapachol, flavonoids, and terpenoids, which exhibit antimicrobial, antifungal, anti-inflammatory, and antioxidant activities. [19]

Studies on BV reported improvement in vaginal symptoms, Nugent scores, Amsel's criteria, and abnormal vaginal pH. *Cymbopogon olivier (Boiss)*. Vaginal capsules & garlic tablets showed clinical efficacy comparable to metronidazole. *C. olivier*, due to the highest amount of flavonoid, phenolic compounds, piperitone, and D-limonene, showed antimicrobial, antioxidant, and anti-inflammatory activity. The garlic possesses allicin that inhibits sulfhydryl containing enzymes needed for microbial metabolism and exhibits broad-spectrum activity against both Gram-positive & Gram-negative bacteria. [14, 21]

The in vitro experimental studies support the benefits of *Ayurvedic* formulations clinically by proving inhibition against vaginal pathogens. *Panchavalkal Kashaya*, the combined formulation of five drugs, showed synergistic action against the vaginal pathogens more than its constituent drugs ([Table no. 5](#)). Ficus plants in formulation are *Kashaya rasatmaka*, *sheet virya*, & *kapha-pitta doshahara* that work in vaginal infections like *trichomonas*

vaginalis. [33] Due to the antibacterial and anti-infective potential against Gram-positive & Gram-negative pathogens, *Panchavalka* reduces microbial burden and has tissue-healing properties. [35] The polyherbal formulation containing Neem, Chicory & Fenugreek demonstrated antimicrobial activity against common vaginal pathogens, including *Staphylococcus aureus*, *Streptococcus agalactiae*, *Candida albicans* & *Aspergillus fumigatus*. This combined hydroalcoholic extract exhibited superior antibacterial and antifungal effects and can be effective against vaginal infections. [32]

The review suggests that the formulations that were locally given were found out to be more effective than those that were orally administered. Local formulations facilitate direct drug delivery and sustained therapeutic action due to their local cleansing, reducing inflammation and maintaining normal vaginal hemostasis through their *yonishodhana* & *yoniropana* properties. These included suppositories like *Triphaladi Varti* & *Nimbadi Varti*; local washes of *Panchavalka kashaya*, *Nimbadi kwatha*, & *Triphala kwatha*; tampons of *Brhat shatavari ghrta*, *Pippalyadi taila*, & *Karanja taila*; Gels and creams like *kasisadi gel*, and so on. Some of these like *Kasisadi gel*, *Panchavalka kashaya*, *Pushyanuga churna*, *Triphaladi varti* showed favourable effects on Nugent scores, pH scores, & Amsel's criteria that indicates symptomatic and microbiological relief from infection. *Brihat shatavari ghrta pichu* due to its *sheeta virya* & *Pittashamaka* properties works on inflammation. [16, 18, 20, 23, 25]

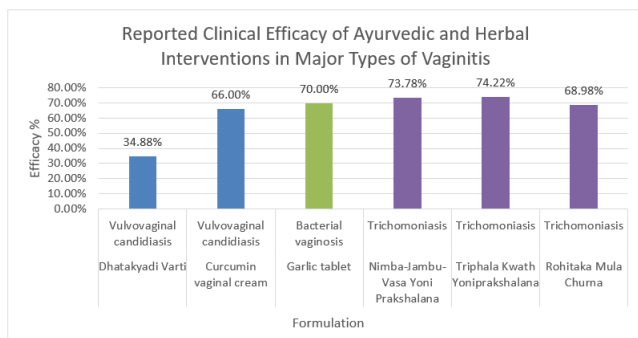


Fig 1: Reported Clinical Efficacy of Ayurvedic and Herbal Interventions in Major Types of Vaginitis

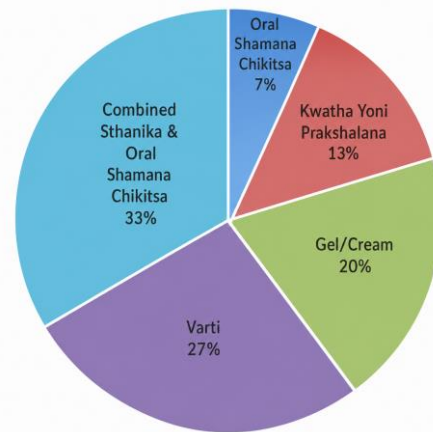


Fig 2: Distribution between results of different Ayurvedic modalities used in Vaginitis and its related conditions.

Strengths of study: The reviewed evidence supports the Ayurvedic correlation of vaginitis through the concepts of *Yonivyapada* and *Shwetapradara*. The *Kaphaja Yonivyapada* was correlated with VVC, trichomonas vaginitis, and non-specific vaginitis due to similarities in clinical features such as mucoid white vaginal discharge, pruritus, and heaviness. *Pittaja Yonivyapad* with Pelvic inflammatory vaginal disorders characterized by burning sensation, erythema, and yellowish discharge, whereas *Upapluta Yonivyapad* was correlated with vulvovaginitis during pregnancy. This correlation from reviewed articles may help interpret disease pathogenesis and understand updated overview of treatment protocols in various forms of vaginitis on the basis of clinical and preclinical evidences.

Limitations: The reviewed studies proved encouraging therapeutic outcomes of Ayurvedic interventions, but many studies only focused on symptomatic outcomes, shorter follow-up, varied diagnostic criteria, small sample sizes, and less study report on microbial status. Further, in terms of disease-specific management considering route of administration, *doshic* involvement, cause, duration of treatment & follow-up period, there is a need for multi-centric robust clinical studies with longer follow-up, larger sample size, detailed microbiological evaluation, validated outcome tools, and defined diagnostic criteria to evolve standard Ayurvedic treatment protocols (SOPs) for vaginitis.

5. CONCLUSION

The review of the above trials suggests that the *Ayurvedic* interventions like *Yonipichu* and *Yoni prakshalana*, along with oral administration of formulations, i.e., combined local and systemic interventions, demonstrated better results than individual therapy. The symptoms of vaginitis, like vaginal discharge, pruritus, burning sensation, & inflammation were reduced, and low recurrence rates were observed. The *Ayurvedic* and herbal interventions evaluated in the study demonstrated antifungal, antimicrobial, anti-inflammatory, wound healing, and pH-modulating actions, which were comparable to conventional treatment. Further, for building more evidence & for incorporating *Ayurveda* in treating vaginitis, more extensive, well-designed RCTs with preparation of standardized *Ayurvedic* formulations and microbiological assessment are necessary.

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