

Efficacy of Viddha Karma in Brachial Neuralgia

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ABSTRACT

Brachial neuralgia—used clinically for brachial neuritis, cervical radiculopathy—related arm pain, and brachial plexopathy—presents with severe neuropathic pain, paresthesia, and upper limb functional limitation. Ayurveda describes comparable symptom clusters under Viśvācī and related Vāta vyādhi entities. Viddha Karma, a para surgical needling (Vedhana/Suchivedhana) procedure from the Suśruta tradition that stimulates selected anatomical or Marma/Srotas loci to relieve āvaraṇa, normalize Vāta gati, and reduce śūla, has been modernized with fine sterile needles analogous to dry needling/acupuncture, with reports of rapid analgesia in pain syndromes. This paper consolidates theoretical basis, indications, contraindications, standardized technique, patient care pathway, and integrative (Ayurvedic + biomedical) mechanisms for applying Viddha Karma in brachial neuralgia, and proposes a prospective research plan: open label Phase I/II pilot and/or pragmatic randomized comparison with standard conservative care in adults with brachial neuralgia (including cervical radicular arm pain or idiopathic brachial neuritis) treated at predefined cervical–shoulder–upper limb points mapped to the classical Viśvācī mārṅga. Primary outcomes: NPRS, VAS, DN4, DASH; secondary: ROM, grip strength, PGIC, and safety over 6 week follow up. By reducing local doṣa saṁcaya / pressure, modulating segmental nociception, improving microcirculation, and activating descending endorphinergic /serotonergic inhibition, Viddha Karma may provide short term analgesia and functional gains, potentially augmented by Vāta hara internal therapy and rehabilitation; standardized protocols support reproducible evaluation.

Keywords: Viddha Karma, Vedhana, Suchivedhana, Brachial Neuralgia, Viśvācī, Vāta-vyādhi, Marma Therapy, Neuropathic Pain, Dry Needling, Integrative Medicine.

I. INTRODUCTION

1.1 Clinical Problem: Brachial Neuralgia / Brachial Neuritis / Cervical Radicular Arm Pain

Brachial neuralgia presents as sharp, burning, shooting, or electric pain radiating from the neck or shoulder girdle into the arm and hand, frequently accompanied by paresthesia, weakness, or sensory changes. Etiologies include inflammatory brachial neuritis (Parsonage-Turner syndrome), cervical nerve root compression (as in cervical spondylotic radiculopathy), post-infectious immune neuropathy, traction or compression injury of the brachial plexus, and metabolic neuropathies. Conservative care—analgesics, neuropathic agents, corticosteroids, physiotherapy—often provides incomplete relief, and medication intolerance is common.

1.2 Ayurvedic Correlates: Viśvācī & Vāta-vyādhi Spectrum

Classical Ayurvedic nosology groups painful, movement-restricting disorders of the upper limb under the broad rubric of *Vāta-vyādhi*. **Viśvācī** is characterized by severe pain starting at the *Bāhu-mūla* (root of the arm / axillary-shoulder junction) and radiating distally along tendino-neural tracks (*Kaṇḍarā-mārga*) to the fingers, with difficulty in flexion/extension—features that map clinically onto brachial neuralgia/neuritis. Related entities include *Amsa-sūla* (shoulder pain), *Avabahuka* (frozen shoulder/adhesive capsulitis analogue), and *Manyāstambha* (cervical stiffness) that often coexist with cervical radiculopathy.

1.3 Therapeutic Gap

Rapid, safe, and cost-effective pain relief modalities are needed in resource-constrained settings. Injectable therapies may not always be accessible; long-term pharmacotherapy raises safety and adherence concerns. Simple, office-based parasurgical interventions from the Ayurvedic surgical armamentarium—particularly Viddha Karma—offer a

potentially scalable option when standardized and practiced aseptically.

1.4 What is Viddha Karma?

In the Sushruta tradition of **Aṣṭāvidha Śāstrakarma** (eight fundamental surgical actions), **Vedhana** / **Viddha** denotes controlled puncturing or boring. Later commentators describe **Suchivedhana**—therapeutic needling at selected loci—to drain accumulated vitiated *Doṣas*, relieve obstruction (*Āvaraṇa*), and alleviate pain (*Śūla*). Contemporary Ayurvedic clinicians often employ fine-gauge (e.g., 24–30G) sterile disposable needles; slight bleeding or expression of interstitial fluid may or may not be elicited depending on indication. Clinically, Viddha Karma has been reported to give prompt analgesia in several *Vāta*-dominant disorders (sciatica, low back pain, frozen shoulder, calcaneal spur), suggesting neuromodulatory potential that warrants systematic evaluation in brachial neuralgia.

1.5 Objectives

- To synthesize classical Ayurvedic and contemporary clinical literature on Viddha Karma relevant to upper-limb neuropathic pain states.
- To map brachial neuralgia to Ayurvedic diagnostic constructs (esp. Viśvācī) and identify therapeutic rationale.
- To define indications, contraindications, and safety guidelines for Viddha Karma in the cervical-shoulder-brachial region.
- To propose a standardized Viddha Karma operating protocol (Purva, Pradhana, Paścāt Karma) suitable for clinical practice and research.
- To outline an evidence-informed integrative mechanism of action bridging Ayurvedic concepts with modern neurophysiology.
- To present a research framework (pilot and comparative designs) for evaluating efficacy and safety in brachial neuralgia.

II. REVIEW OF LITERATURE

2.1 Classical Ayurvedic Sources

- **Sushruta Samhitā** (Śārīrasthāna & Cikitsāsthāna) enumerates Aṣṭāvidha Śastrakarma, with *Vedhana* indicating puncture to relieve accumulations and facilitate drainage; depth and angulation vary by anatomical site. Commentaries (e.g., Ambika Dutta Śāstrī editions) elaborate instrument selection (*Succi* / needle types) and precautions near *Marma*.
- **Aṣṭāṅga Hr̥daya** and later surgical digests similarly classify puncture/needling among core operative measures; applied judiciously in *Śūla* of obstructive pathologies.
- **Viśvācī** descriptions in *Vāta-vyādhi* chapters: acute radiating pain from axilla/shoulder extending to fingertips, limited movement—compatible with brachial neuritis.
- Classical *Marma* anatomy (Sushruta Śārīrasthāna 6): *Amsa*, *Amsaphalaka*, *Kaksha*, *Bahu*, *Ani* etc. provide locational guidance for safe/therapeutic stimulation while honoring vital structures.

2.2 Contemporary Ayurvedic & Integrative Clinical Reports

- **Practo clinical note (Dhruv, 2023)**: Describes Viddha Karma technique, needle gauge (~26G), comparative remarks vs. Chinese acupuncture; includes **Brachial Neuritis** among indications; lists environmental timing precautions.
- **Ayushdhara Case (2023)**: Viddha Karma provided rapid pain relief in *Katigata Vāta* (lumbar spondylosis), supporting analgesic potential in radicular patterns.
- **JAIS Transformative Viddhaagnikarma (Eiram, 2024)**: Discusses mechanical stimulation + thermal synergy variants; emphasizes rapid *Śūlahruta* effect via endorphin release and *Āvaraṇa* clearance.
- **Clinical Evaluation reports (multiple small case series & theses)**: Viddha / Suchivedhana shown beneficial in musculoskeletal and neuropathic

pain presentations (frozen shoulder, knee pain, calcaneal spur) in low-resource outpatient settings.

- **Ayurvedic Management of Brachial Plexopathy (2024 case report; ResearchGate / IJAR)**: Multi-modal Ayurvedic regimen (*Nasya*, *Greeva Basti*, *Abhyanga*, *Śālī Piṇḍa Sveda*, etc.) improved upper limb weakness and stiffness; though not Viddha-focused, demonstrates responsiveness of brachial plexus pathology to *Vāta-hara* interventions.
- **EasyAyurveda Brachial Neuritis (2015, updated)**: Correlates clinical brachial neuritis with *Viśvācī*; outlines *Vāta* pacifying, *Snehana–Svedana*, and supportive internal medicines—context for combining with Viddha.

2.3 Related Needling Sciences Informing Mechanism

- **Acupuncture in Cervical Radiculopathy (Zhao et al., 2024; Li et al., 2024; Zuo et al., 2019 protocol)**: Systematic reviews suggest acupuncture may reduce radicular neck/arm pain and improve neurologic symptoms; mechanisms proposed include anti-inflammatory modulation, segmental analgesia, neuromodulation of dorsal horn activity, and improved microcirculation.
- **Dry Needling Umbrella Review (2023, multiple SRs)**: Demonstrates short-term pain reduction and functional benefit in neck, shoulder, and upper-quarter musculoskeletal pain; safety acceptable when performed by trained personnel. Though targeting myofascial trigger points, mechanistic overlap (local twitch response, neuromodulation) is relevant to Viddha Karma adaptation.
- **Marma Therapy Scientific Potential (Singh et al., 2022; Vijaynath et al., 2023)**: Controlled stimulation of Marma points influences autonomic tone, circulation, and analgesia; supports structured point-based interventions for pain.

III. INDICATIONS & CONTRAINDICATIONS FOR VIDDHA KARMA IN THE CERVICO-BRACHIAL REGION

3.1 Indications (Clinical + Ayurvedic Mapping)

- Brachial neuralgia / brachial neuritis with predominant pain component.
- Cervical radicular arm pain (CSR) when imaging or clinical exam suggests nerve root irritation and conservative care is suboptimal.
- Viśvācī (Vāta-vyādhi presenting with radiating upper-limb pain, stiffness, dysesthesias).
- Amsa-śūla, early Avabahuka with acute pain spikes.
- Myofascial pain trigger points in upper trapezius, scalene, infra-/supraspinatus, pectoralis minor, etc., contributing to neuropathic amplification.
- Adjunctive analgesia in brachial plexopathy rehabilitation (post-injury) where severe pain impedes therapy.
- Select cystic or tense localized swellings (non-vascular) producing nerve irritation—after imaging clearance (use drainage variant if indicated).

3.2 Relative Indications

- Refractory neuropathic arm pain unresponsive or intolerant to medications.
- Patient preference for minimally invasive, low-cost office procedure.

3.3 Contraindications

Absolute

- Uncorrected bleeding diathesis (INR > therapeutic range; platelet <50k) or anticoagulant therapy not interruptible.
- Severe anemia (Hb <7 g/dL) if bloodletting anticipated.
- Local cellulitis, abscess, dermatitis, burns at needle site.
- Known vascular malformation, aneurysm, or arteriovenous fistula at/near target.

- Unstable spine pathology requiring urgent surgical referral (progressive motor deficit, myelopathy).
- Patient inability to consent / cooperate.

Relative / Situational

- Uncontrolled diabetes (infection risk) — proceed only with strict asepsis.
- Immunocompromised states (HIV with low CD4, chemotherapy) — weigh risk.
- Pregnancy (avoid deep needling in upper thoracic outlets that might trigger sympathetic responses; consider safer alternatives).
- Severe neuropathic allodynia where touch provokes extreme distress—pre-medicate.
- Extreme environmental conditions (heavy damp heat, very cold, lightning storms) noted traditionally to influence outcomes; modern interpretation: maintain thermal comfort & sterility.
- Immediately post-prandial state; allow digestion interval (~1–2 h) to reduce vasovagal episodes.

IV. MATERIALS & METHODS: STANDARDIZED VIDDHA KARMA PROTOCOL FOR BRACHIAL NEURALGIA

Adapt for institutional SOP; steps below reflect a hybrid classical-modern sterile technique.

4.1 Study / Practice Setting

- Outpatient Ayurvedic parasurgical suite or pain clinic equipped for sterile minor procedures.
- Resuscitation kit available (oxygen, antihistamine, epinephrine, BP cuff).
- Clean, well-lit, temperature-controlled room.

4.2 Personnel & Training

- Ayurveda Vaidya / MS (Ay) Shalya Tantra trained in Viddha / Suchivedhana.
- Assistant for instrument handling & vitals monitoring.
- Cross-training with modern aseptic technique recommended; co-management

with neurologist/orthopedist for research studies.

4.3 Patient Selection Criteria (Research)

Inclusion

- Age 18–70.
- Clinical diagnosis of brachial neuralgia / neuritis / cervical radicular arm pain ≥ 4 weeks and ≤ 12 months OR recurrent episodic pattern.
- NPRS ≥ 4 at baseline.
- Motor grade $\geq 3/5$ in affected myotomes (safety for positioning).
- Willingness to abstain from new analgesic modalities during primary study window.

Exclusion

- Progressive motor deficit requiring urgent decompression.
- Prior cervical surgery in last 6 months (unless stable and cleared).
- Significant coagulopathy or infection at site.
- Pregnancy.

4.4 Pre-Procedure Evaluation (Purva Karma)

1. **History & Examination:** Pain distribution map; neuropathic descriptors; aggravating factors; red flags.
2. **Ayurvedic Assessment:** *Doṣa*, *Dhātu*, *Mārga*, *Avasthā* (acute vs chronic), presence of *Āvaraṇa*; correlate with *Viśvācī* / *Amsa-śūla*.
3. **Investigations (as needed):** CBC, coagulation profile if bleeding anticipated; blood glucose; imaging (X-ray, MRI, US) if structural concern.
4. **Pain & Function Baseline Scores:** NPRS, VAS, DN4, DASH, ROM goniometry.
5. **Informed Consent:** Explain procedure, expected short-lived discomfort, possible bleeding, bruising, vasovagal episodes, infection risk.
6. **Marking Points:** See §4.6. Use dermatographic pen; ultrasound guidance optional for research.
7. **Skin Preparation:** Clip excessive hair; cleanse with soap + water; final prep with chlorhexidine/alcohol (modern) or classical antiseptic decoctions (e.g., Panchavalkala) if culturally preferred (ensure sterility).

4.5 Collection of Materials / Instruments

- Sterile disposable hypodermic or acupuncture needles (22–30G; length 25–40 mm depending depth). Traditional *Succi* needles may be used if sterilizable.
- Sterile gloves, drapes, gauze.
- Tourniquet (optional, for controlled minimal blood expression variant).
- Kidney tray / sharps container.
- Sterile cotton swabs; povidone iodine or chlorhexidine.
- Small sterile bowl with *Haridrā* (turmeric) + *Madhu* paste OR povidone for post-puncture sealing.
- Ayurvedic analgesic externals (optional): *Mahanārāyaṇa Taila*, *Saindhava* warm compress for Paścāt Karma.
- Documentation forms, sterile marker.

4.6 Pradhāna Karma: Procedure Steps (Analgesic / Neuro-Modulatory Variant)

Position: Patient semi-recumbent or side-lying; affected arm supported.

Target Zones:

- **Cervical paraspinal exit points** corresponding to symptomatic dermatomes (approx. 1–1.5 cm lateral to spinous processes C5–T1; superficial only—do not deep needle without image guidance).
- **Supraclavicular brachial plexus window** (very superficial; advanced operators only; avoid vascular injury).
- **Amsa Marma / Amsa-phalaka region** (upper trapezius trigger band).
- **Shoulder girdle peri-articular points:** supraspinatus notch, infraspinatus fossa trigger points.
- **Arm channel points** tracing patient's pain radiation—palpate taut bands or tender nodules along biceps groove, radial tunnel, medial arm.
- **Distal hand points** (Talahridaya, Kshipra) for reflex modulation (optional adjunct).

4.7 Technique (basic superficial–moderate depth needling):

1. Re-swab site with antiseptic.
2. Stretch skin; insert needle swiftly at 30–60° angle to skin, depth 5–20 mm depending tissue thickness, avoiding known neurovascular bundles.
3. Elicit brief pain reproduction or local twitch (if myofascial contribution suspected) then withdraw ~2–3 mm.
4. Option A (dry stimulation): gentle pistoning or rotation 5–10 sec.
5. Option B (micro-bleed): advance slightly to capillary ooze; collect on gauze; believed to relieve *Doṣa sanchaya*; limit total blood <2 mL/session.
6. Withdraw; apply pressure 30 sec; seal with Haridrā–Madhu paste or sterile adhesive.
7. Proceed sequentially 5–12 points/session (tailor to patient tolerance).

Session Duration: 10–20 min active needling.

Frequency: 1–2 / week for 3 weeks; reassess; taper.

4.8 Observation & Immediate Post-Procedure (Paścāt Karma)

- Monitor for dizziness, vasovagal syncope; keep patient recumbent 5–10 min.
- Inspect puncture sites for bleeding; apply gentle compression.
- Record immediate NPRS change (within 5 min) to capture rapid analgesic response.
- Advise gentle active ROM exercises while seated to integrate neuromuscular reset.
- Home advice: keep sites dry 12 h; avoid strenuous lifting same day; report redness, swelling, fever.

Concomitant Therapies

Permitted (research note): stable doses of oral neuropathic agents if >2 weeks unchanged; *Vāta-hara* internal formulations (e.g., *Aśvagandhā*, *Daśamūla kṣīra paka*, *Rasnā saptaka kvātha*) if standardized across arms; local *Abhyanga–Svedana* on non-needling days.

4.9 Outcome Measures & Timing

Time Point	Baseline	Immediately Post-Each Session	Week 1	Week 3	Week 6 (FU)
NPRS	✓	✓	✓	✓	✓
VAS (100 mm)	✓		✓	✓	✓
DN4	✓				✓
DASH	✓			✓	✓
ROM (goniometry)	✓		✓	✓	✓
Grip Strength Dynamometry	✓			✓	✓
PGIC					✓
Adverse Events		✓	✓	✓	✓

4.10 Sample Size Guidance (Pilot)

- Phase I safety/pilot: n=20.
- Phase II efficacy signal: n=60 (single-arm) or n=80 (pragmatic 1:1 Viddha vs. standard care) powered for 2-point NPRS difference, SD ~2.5, $\alpha=0.05$, $\beta=0.2$ (approximate; refine with pilot variance).

4.11 Statistical Analysis Outline

- Continuous outcomes: paired t-test / Wilcoxon for within-group; ANCOVA for between-group adjusting baseline.
- Categorical responder rates ($\geq 50\%$ pain relief): chi-square / Fisher.
- Repeated measures mixed effects for trajectory.
- Effect sizes (Cohen's d), 95% CI.
- Safety summarized descriptively.

V. PATIENT CARE PATHWAY

5.1 Pre-Session Counseling Script (Short Form)

Explain: nature of condition; role of Viddha Karma; expected needle sensation; possible mild bleed; aftercare.

5.2 Day-of Checklist

- ID confirmed; consent signed.
- Coagulation status reviewed.
- Pain scores captured.
- Sites marked.
- Sterile field prepared.

5.3 Post-Session Instructions (Patient Handout Excerpt)

- Mild soreness 24 h is common; warm compress next day if needed.
- Do not massage puncture sites vigorously same day.
- Report fever, spreading redness, excessive swelling, numbness worsening.
- Continue prescribed *Vāta-hara* diet: warm, unctuous foods; avoid dry, cold, very spicy.

VI.MODE OF ACTION – AYURVEDIC PERSPECTIVE

Viddha Karma acts primarily on disordered **Vāta** in the *Śākhā* (peripheral tissue channels) by mechanically relieving **Āvaraṇa** (obstruction) within *Srotas* and *Kaṇḍarā* pathways. Puncture permits egress of subtly vitiated *Doṣa* fractions—especially *Vāta* entrapped with *Kapha* or localized *Rakta* congestion—thereby restoring unobstructed *Pravāha* (flow). Local stimulation of **Marma** adjacent to the brachial plexus (Amsa, Kakshadhra, Bahu) recalibrates *Prāṇa Vāta* and *Vyāna Vāta* governance of neuromuscular function. Secondary benefits include reduction in *Rūkṣatā* (dryness) when followed by unctuous *Paścāt Karma*, improved tissue nutrition (*Dhātu-pāka* harmonization), and attenuation of *Śūla* via normalization of *Agni* at the micro-level. Repeated sittings may convert an acute, mobile *Vāta*

presentation into a more stable, manageable state amenable to internal *rasāyana* and rehabilitative therapies.

VII.MODE OF ACTION – MODERN BIOMEDICAL PERSPECTIVE

Multiple convergent mechanisms may explain observed analgesia:

1. **Segmental Gate Control:** A-beta afferent stimulation by puncture competes with nociceptive C-fiber input at the dorsal horn, transiently "closing the gate" to pain transmission.
2. **Diffuse Noxious Inhibitory Control (DNIC) / Conditioned Pain Modulation:** Brief noxious stimulus (needle) triggers descending inhibitory pathways (periaqueductal gray → rostroventral medulla) releasing endogenous opioids, serotonin, norepinephrine.
3. **Local Biochemical Modulation:** Needling of myofascial trigger points reduces nociceptive substances (Substance P, CGRP) and normalizes pH; promotes local microcirculation and oxygenation.
4. **Anti-Inflammatory Effects:** Low-level tissue injury induces release of adenosine and anti-inflammatory cytokines; may down-modulate neurogenic inflammation around irritated nerve roots.
5. **Neuromodulation of Peripheral Nerve Excitability:** Mechanical stimulation can transiently alter ectopic discharges from inflamed nerves, reducing spontaneous pain.
6. **Fascial Reset & Muscle Tone Reduction:** Twitch response reduces muscle guarding around cervical and shoulder girdle, indirectly reducing foraminal compression contributing to radicular symptoms.
7. **Psychoneuroimmunologic Contextual Effects:** Ritualized care, expectancy, and patient-practitioner interaction contribute

measurable analgesic placebo components that integrate with physiological effects.

VIII. PROBABLE INTEGRATIVE MECHANISM IN BRACHIAL NEURALGIA

Brachial neuralgia frequently arises from a convergence of inflammatory, compressive, and myofascial amplifiers. The Viddha Karma protocol targets:

- **Cervical Paraspinal Points:** Reduce paraspinal spasm → enlarge foraminal diameter; segmental modulation of dorsal root input.
- **Amsa / Shoulder Girdle Triggering:** Releases myofascial tension that may traction the brachial plexus.
- **Distal Channel Points:** Provide additional afferent barrage supporting descending inhibition; may influence peripheral nerve blood flow in the limb.
- **Micro-Bleed Variant:** Decompresses local congested capillary beds, analogous to wet cupping micro-phlebotomy; in Ayurvedic terms, clears localized *Rakta Āvaraṇa* of *Vāta*.
- **Systemic Vāta-hara Support:** Oils + fomentation reduce systemic hyperexcitability; improved sleep reduces central sensitization. The combined effect is hypothesized to rapidly reduce pain intensity, improve ROM (via muscle relaxation), and possibly improve nerve conduction over repeated sessions by mitigating chronic inflammation.

IX. SAFETY, RISK MITIGATION & ADVERSE EVENT REPORTING

Common, Mild: Transient soreness, small ecchymosis, lightheadedness, short-lived flare pain. **Less Common:** Local infection (folliculitis, abscess), persistent bleeding in anticoagulated patients, vasovagal syncope. **Rare but Serious:** Pneumothorax (if excessively deep supraclavicular needling), nerve injury (if intra-nerve

puncture), hematoma compressing vascular/nerve bundle.

Mitigation: Strict surface anatomy training; shallow angles near thoracic apex; single-use sterile needles; post-site compression; monitor vitals; document lot numbers.

X. DISCUSSION

Preliminary experiential and small case-based evidence from Ayurvedic clinics suggests that Viddha Karma can deliver rapid analgesia in *Vāta*-dominant pain states, including conditions with radiating neuropathic features (sciatica, frozen shoulder, low back radiculopathy). Given the symptomatic parallels between *Viśvācī* and brachial neuralgia, extrapolation is plausible but unproven in rigorous trials. Modern literature on acupuncture and dry needling in cervical radiculopathy and upper-quarter pain offers supportive mechanistic plausibility and modest evidence of short-term benefit. Importantly, Viddha Karma is typically brief, low-cost, and adaptable to low-resource settings—attributes valuable in community pain care.

However, heterogeneity in technique (depth, number of points, bleeding vs. dry), inconsistent aseptic practices, and absence of standardized outcome reporting hamper evidence synthesis. The protocol herein attempts to harmonize classical principles (targeting *Mārga*, clearing *Āvaraṇa*, respecting *Marma*) with modern safety and documentation. Integrative trials that include concurrent *Vāta-hara* internal therapies may show additive effects but will require factorial designs to isolate contributions.

10.1 Interpreting Rapid vs. Sustained Effects

Case reports often note immediate post-needling relief (minutes to hours). Whether repeated sittings confer durable analgesia or functional recovery remains uncertain; booster sessions may be needed. Tracking week-6 outcomes helps differentiate transient neuromodulation from true disease modification.

10.2 Placebo & Contextual Healing

Ritualized procedures inherently carry expectancy effects; sham-controlled designs are possible (superficial sham, non-active points) but may conflict with whole-system Ayurveda ethos. Pragmatic comparative effectiveness designs (Viddha + usual care vs. usual care) may be more ecologically valid for service delivery questions.

10.3 Anatomical Precision vs. Marma Targeting

Whereas modern needling often follows trigger points or dermatomes, classical guidance emphasizes *Marma* and *Srotas*. Hybrid mapping—aligning Marma with surface neurovascular landmarks—supports both safety and philosophical fidelity.

XI. LIMITATIONS

- Current evidence base dominated by anecdote, case reports, and small uncontrolled series.
- Variable nomenclature (Viddha, Vedhana, Suchivedhana) complicates database searches and meta-analysis.
- Lack of standardized diagnostic criteria for Viśvācī vs. biomedical brachial neuralgia.
- Potential publication bias toward positive outcomes.
- Blinding challenges.

XII. CONCLUSION

Viddha Karma, an ancient puncture-based parasurgical modality of Ayurveda, is theoretically and pragmatically suited to the management of brachial neuralgia / Viśvācī spectrum disorders. When performed with modern aseptic technique at anatomically informed points correlated with classical *Mārga* pathways, it may provide rapid pain relief, facilitate functional rehabilitation, and reduce reliance on systemic analgesics. Standardized clinical protocols and well-designed prospective studies—particularly pragmatic comparative trials—are needed to establish efficacy, durability, and safety. The present paper

provides a structured template to support such research and guide clinical practice in integrative pain care.

REFERENCES

- [1]. Sushruta Saṁhitā (Śārīrasthāna 6; Cikitsāsthāna various) – Aṣṭāvidha Śāstrakarma, Marma anatomy; multiple editions (e.g., Ambika Dutta Śāstrī, Chaukambha Sanskrit Series).
- [2]. Aṣṭāṅga Hṛdaya – Surgical principles; Vāta-vyādhī chapters (Viśvācī descriptions).
- [3]. Suśruta Tantra Commentaries – Depth guidelines for Vedhana in different body regions (cite edition used). Contemporary Ayurvedic & Integrative Sources
- [4]. Dhruv N. The Hidden Treasure of Ayurveda – Viddha Karma. Practo Healthfeed; 15 Jan 2023.
- [5]. Ayushdhara Journal. Effect of Viddha Karma in the Management of Kaṭigata Vāta w.s.r. Lumbar Spondylosis. 5 Nov 2023.
- [6]. Eiram A. The Transformative Potential of Viddhaagnikarma – Bridging Tradition and Innovation in Pain Relief. JAIS; 2024.
- [7]. Kawthekar PD. Clinical Evaluation of Suchivedha in Pain Management. IJAAR; year per source (downloaded 2024).
- [8]. Avhad VA et al. Viddha Karma in Musculoskeletal Pain Disorders. (cited in JRMDs Frozen Shoulder case review; access 2025).
- [9]. EasyAyurveda. Brachial Neuritis: Ayurvedic Treatment, Medicines, Remedies. Updated access 2025.
- [10]. ResearchGate / IJAR. Ayurvedic Management of Brachial Plexopathy: A Case Report. Jan 2024.
- [10]. Surendran A. Ayurvedic Management of Neonatal Brachial Plexus Palsy. JAIS; 2025.
- [11]. AncientAyurveda.com. Viddhakarma: Ancient Litany Science. Dec 2021.
- [12]. IJCRT. Viddha Karma – A Classical Review. Nov 2023.

- [13]. Singh J et al. Exploring the Scientific Potential of Marma Therapy as a Non pharmacological Pain Intervention. AYU Journal; 2022.
- [14]. Vijaynath V. Recent Advances in Marma Therapy. Kerala Journal of Ayurveda; 2023.
- [15]. TheAyurvedaExperience Blog. 29 Marma Points for Pain Relief. Updated Aug 2017; reviewed 2025.
- [16]. Zhao H. et al. Efficacy and Safety of Acupuncture in Radicular Cervical Spondylosis: Systematic Review & Meta analysis. Pub Med 2024.
- [17]. Li HL. et al. Acupuncture for Radicular Pain: Analgesic Mechanisms Review. 2024.
- [18]. Zuo G. et al. Assessment of Acupuncture & Chiropractic in Cervical Spondylosis Radiculopathy: Systematic Review Protocol. Medicine (Baltimore) 2019.
- [19]. Umbrella Review Team. Clinical Effectiveness of Dry Needling in Musculoskeletal Pain. (PMC 2023 update).
- [20]. Cureus Review. Dry Needling with Electrical Stimulation for Shoulder Pain – Systematic Review & Meta analysis. 2023.