

Tamaka Shwasa and Bronchial Asthma: A Critical Ayurvedic Review With Detailed Clinicopathological Correlation

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Abstract: *Tamaka Shwasa is a clinically important variety of Shwasa Roga described in the Ayurvedic classics and is characterized by recurrent respiratory distress, Ghurghuraka, Kasa, Pinasa, difficulty in expectoration, disturbed sleep, aggravation in recumbency, relative comfort in the sitting posture and episodic worsening under specific environmental conditions. The classical pathogenesis gives a central position to Kapha-associated Srotorodha and the consequent Pratiloma Gati of Vata in Pranavaha Srotas. Bronchial asthma, in contemporary medicine, is a heterogeneous chronic airway disease defined by variable respiratory symptoms and variable expiratory airflow limitation. Airway inflammation, bronchial hyperresponsiveness, bronchoconstriction, mucosal oedema, mucus hypersecretion and, in some patients, airway remodelling contribute to its clinical expression. The present narrative review critically examines Tamaka Shwasa with direct reference to selected Sanskrit verses from Charaka Samhita and develops a detailed, cautious correlation with bronchial asthma. Classical features are compared with wheeze, airflow limitation, nocturnal symptoms, mucus-related obstruction, orthopnoea-like positional distress, triggers and the recurrent nature of asthma. The paper also analyses the possible research interface between Srotorodha and airflow obstruction, Kapha and mucus-dominant clinical expression, Pratiloma Vata and disturbed expiratory mechanics, Agni-Ama and systemic disease modifiers, and Yappa status and chronic disease control. These comparisons are presented as conceptual and clinical correlations rather than proven one-to-one biological equivalences. Future integrative research should combine reproducible Ayurvedic phenotyping with spirometry, peak expiratory flow variability, validated asthma-control scores, exacerbation frequency, medication use and biomarkers. Such methodology may preserve the integrity of Ayurvedic reasoning while allowing objective evaluation of its clinical relevance.*

Keywords: Tamaka Shwasa; bronchial asthma; Pranavaha Srotas; Vata; Kapha; Srotorodha; Pratiloma Vata; Ghurghuraka; Ayurveda

I. INTRODUCTION

Respiration is an immediately vital function, and disorders that compromise breathing produce substantial morbidity and may become life-threatening during severe attacks. The classical Ayurvedic literature recognizes this clinical gravity. Charaka places Shwasa and Hikka among disorders capable of rapidly threatening Prana and provides a detailed account of their causation, pathogenesis, clinical varieties and management³.

कामं प्राणहरा रोगा बहवो न तु ते तथा ।

यथा श्वासश्च हिक्का च प्राणानाशु निक्कन्ततः ॥६॥

Charaka Samhita, Chikitsa Sthana 17/6

The verse emphasizes the potential severity of disturbed respiration. In contemporary respiratory medicine, asthma is recognized as a heterogeneous chronic airway disease. The Global Initiative for Asthma describes asthma through a



history of variable respiratory symptoms, such as wheeze, shortness of breath, chest tightness and/or cough, together with variable expiratory airflow limitation¹. The World Health Organization similarly identifies asthma as a major chronic respiratory disease and notes that airway inflammation and narrowing contribute to breathing difficulty². Tamaka Shwasa is frequently correlated with bronchial asthma because the classical clinical picture contains recurrent dyspnoea, Ghurghuraka, cough, nocturnal aggravation, episodic attacks and environmental precipitation. Nevertheless, the two diagnostic constructs arise from different medical frameworks. The purpose of a scholarly correlation is therefore not to declare them identical, but to determine where clinical observations overlap, where conceptual comparison is plausible, and where modern objective measurements can be used to test Ayurvedic clinical hypotheses.

II. AIM AND OBJECTIVES

1. To critically review Tamaka Shwasa from the classical Ayurvedic literature.
2. To present important classical Sanskrit verses related to Dosha predominance, Nidana, Samprapti, Lakshana and prognosis.
3. To describe the contemporary pathophysiology and clinical expression of bronchial asthma.
4. To develop a detailed symptom-wise and pathogenesis-wise correlation between Tamaka Shwasa and bronchial asthma.
5. To distinguish useful clinical correlation from unsupported biological equivalence.
6. To identify objective variables for future integrative clinical research.

III. MATERIALS AND METHODS

The present work is a narrative review. Classical Ayurvedic material was organized primarily from Charaka Samhita, Chikitsa Sthana, Hikka-Shwasa Chikitsa Adhyaya, with contextual support from Sushruta Samhita, Ashtanga Hridaya and Madhava Nidana³⁻⁶. Selected Sanskrit verses were reproduced for academic discussion and should be checked by the submitting author against the exact printed edition cited in the final journal manuscript. Contemporary asthma concepts were reviewed using Global Initiative for Asthma strategy material, the World Health Organization asthma fact sheet and peer-reviewed respiratory and Ayurvedic literature [1,2,7-14].

The analysis was performed at three levels: (1) clinical phenotype correlation, comparing symptoms and temporal patterns; (2) functional pathogenesis correlation, comparing the classical concepts of Srotorodha and disturbed Vata Gati with measurable airflow disturbance; and (3) research correlation, identifying variables that may be objectively studied. Correlations are explicitly described as possible interfaces and not as proof that Ayurvedic terms represent individual cells, cytokines, receptors or anatomical lesions.

AYURVEDIC FOUNDATION OF SHWASA ROGA

Charaka describes Shwasa and Hikka as predominantly Vata-Kapha disorders arising from Pittasthana. This statement establishes the Dosha background for subsequent interpretation of Tamaka Shwasa.

कफवातात्मकावेतौ पित्तस्थानसमुद्भवौ ।
हृदयस्य रसादीनां धातूनां चोपशोषणौ ॥८॥
Charaka Samhita, Chikitsa Sthana 17/8

The five classical varieties of Shwasa are Maha Shwasa, Urdhva Shwasa, Chhinna Shwasa, Tamaka Shwasa and Kshudra Shwasa³⁻⁶. Tamaka Shwasa differs clinically from the rapidly fatal patterns described in severe varieties and is assigned a Yappa course, although a newly developed condition may be considered Sadhya in the classical description.

NIDANA OF SHWASA AND RELEVANCE TO ASTHMA TRIGGERS

रजसा धूमवाताभ्यां शीतस्थानाम्बुसेवनात् ।
व्यायामाद्वायुधर्माध्वरूक्षात्रविषमाशनात् ॥११॥
Charaka Samhita, Chikitsa Sthana 17/11



The verse includes Raja, Dhuma, Vata, cold exposure and exertion among important factors. The clinical importance of Raja and Dhuma is particularly evident in a modern respiratory context because inhaled particulate matter, smoke and other irritants can provoke respiratory symptoms in susceptible individuals. Exercise and cold air are also recognized asthma symptom triggers in some patients. The parallel is strongest at the level of exposure-response observation; the classical terms should not be retroactively restricted to specific modern allergens or pollutants.

Classical Nidana / factor	Ayurvedic interpretation	Possible asthma-related clinical interface
Raja	Dust exposure; aggravating environmental factor	Airborne particles, occupational dust or allergen-containing dust may precipitate symptoms in susceptible patients
Dhuma	Smoke exposure	Tobacco smoke, biomass smoke and irritant fumes may worsen asthma symptoms
Shita Sthana / Shita Ambu	Cold exposure	Cold air can provoke bronchoconstrictive symptoms in some patients
Vata / environmental wind	Environmental aggravation	Weather-associated symptom variability may be reported by patients
Vyayama	Exertion	Exercise-induced bronchoconstriction or exertional symptom precipitation
Vishamashana / Agni disturbance	Irregular dietary-metabolic context	No direct equivalent; may be recorded as an Ayurvedic disease modifier
Ama-related state	Improper processing within Ayurvedic pathology	No validated one-to-one biomarker; requires prospective operational definition

GENERAL SAMPRAPTI OF SHWASA

यदा स्रोतांसि संरुध्य मारुतः कफपूर्वकः ।
विष्वग्भ्रजति संरुद्धस्तदा श्वासान्करोति सः ॥४५॥
Charaka Samhita, Chikitsa Sthana 17/45

This verse provides the core pathological sequence: Kapha-associated obstruction of Srotas is followed by obstruction and abnormal movement of Maruta, producing Shwasa. The sequence is central to the interpretation of Tamaka Shwasa. In Ayurvedic terms, Srotorodha is the obstructive event and Vata Gati disturbance is the dynamic functional consequence.

A concise Samprapti may be represented as: Nidana Sevana → Dosha Prakopa with Kapha-Vata predominance → Agni disturbance and/or Ama in suitable patients → Kapha involvement in Pranavaha Srotas → Srotorodha → obstruction of physiological Vata Gati → Pratiloma Vata → recurrent Shwasa, Kasa, Ghurghuraka and associated features.



Figure 1. Proposed Ayurvedic Samprapti sequence of Tamaka Shwasa

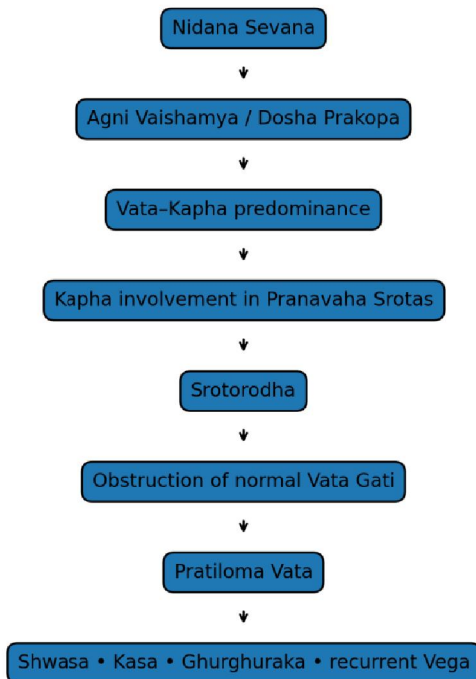


Figure 1. Proposed Ayurvedic Samprapti sequence of Tamaka Shwasa.

CLASSICAL DESCRIPTION OF TAMAKA SHWASA: SELECTED SHLOKAS AND INTERPRETATION

प्रतिलोमं यदा वायुः स्रोतांसि प्रतिपद्यते ।
ग्रीवां शिरश्च सङ्गृह्य श्लेष्माणं समुदीर्य च ॥५५॥
करोति पीनसं तेन रुद्धो घूर्घुरकं तथा ।
अतीव तीव्रवेगं च श्वासं प्राणप्रपीडकम् ॥५६॥

Charaka Samhita, Chikitsa Sthana 17/55–56

These verses describe Pratiloma movement of Vata, involvement of the channels, Kapha aggravation, Pinasa, Ghurghuraka and severe attacks of respiratory distress. Ghurghuraka is the most frequently discussed clinical bridge with wheeze. In modern asthma, wheeze is generated by airflow through narrowed intrathoracic airways. The comparison is clinically useful, but Ghurghuraka is a descriptive Ayurvedic sign and should not automatically be defined as spirometrically confirmed asthma.

श्लेष्मण्यमुच्यमाने तु भृशं भवति दुःखितः ।
तस्यैव च विमोक्षान्ते मुहूर्तं लभते सुखम् ॥५८॥

Charaka Samhita, Chikitsa Sthana 17/58

The patient is described as suffering when Shleshma is not released and obtaining temporary comfort after its expulsion. This observation can be compared with a mucus-dominant obstructive symptom pattern. In asthma, mucus hypersecretion and mucus plugging may contribute to airflow limitation, particularly in severe disease. Kapha,



however, is broader than airway mucus; therefore the appropriate wording is that Shleshma-related obstruction has a possible clinical interface with mucus-associated airflow impairment.

अथास्योद्ध्वंसते कण्ठः कृच्छ्राच्छक्नोति भाषितुम् ।

न चापि निद्रां लभते शयानः श्वासपीडितः ॥५९॥

पार्श्वे तस्यावगृह्णाति शयानस्य समीरणः ।

आसीनो लभते सौख्यमुष्णं चैवाभिनन्दति ॥६०॥

Charaka Samhita, Chikitsa Sthana 17/59-60

Difficulty speaking during respiratory distress indicates the intensity of the attack. Disturbed sleep and worsening while lying are prominent classical observations. The phrase Asino Labhate Saukhyam describes relative comfort in the sitting posture. Severe asthma can cause marked work of breathing, and patients in respiratory distress may prefer an upright position to optimize respiratory mechanics. This resemblance is clinical; the classical feature should not be labelled as cardiogenic orthopnoea.

उच्छ्रिताक्षो ललाटेन स्विद्यता भृशमर्तिमान् ।

विशुष्कास्यो मुहुः श्वासो मुहुश्चैवावधम्यते ॥६१॥

Charaka Samhita, Chikitsa Sthana 17/61

Prominent eyes, forehead sweating, severe distress, dryness of the mouth and repeated episodes of Shwasa portray a patient with intense respiratory effort. In an acute asthma exacerbation, tachypnoea, accessory muscle recruitment, difficulty speaking and visible distress may occur. Sweating is nonspecific and reflects physiological stress rather than a diagnostic marker.

मेघाम्बुशीतप्राग्वतैः श्लेष्मलैश्चाभिवर्धते ।

स याप्यस्तमकश्वासः साध्यो वा स्यान्नवोत्थितः ॥६२॥

Charaka Samhita, Chikitsa Sthana 17/62

Aggravation with clouds, rain, cold, easterly wind and Kapha-promoting factors is described, followed by the prognostic statement that established Tamaka Shwasa is Yasya and a newly developed disease may be Sadhya. The recurrent, trigger-sensitive and controllable nature of Tamaka Shwasa provides an important clinical interface with chronic asthma, which also requires long-term control and risk reduction. Yasya should not be simplistically translated as 'incurable'; in research, it may be explored through recurrence, long-term control, exacerbation burden and treatment dependence.

SAMPRAPTI GHATAKA OF TAMAKA SHWASA

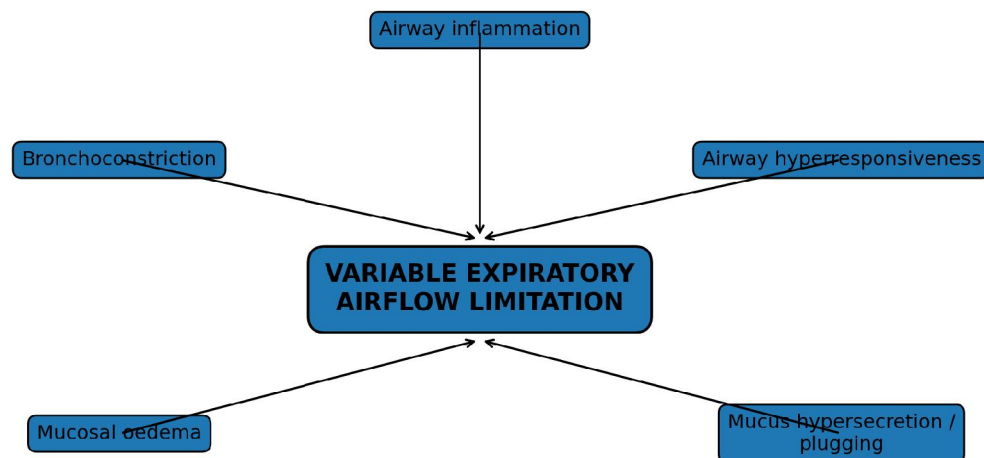
Samprapti component	Predominant interpretation
Dosha	Vata-Kapha predominance
Vata	Prana Vayu is clinically relevant to respiratory function; Pratiloma Gati is central
Kapha	Obstructive Kapha/Shleshma involvement; Avalambaka Kapha is commonly discussed in thoracic functional context
Dushya	Rasa and associated Dhatu involvement according to classical context
Agni	Agnimandya or Agni Vaishamya may contribute in selected patients
Ama	May participate when clinically present; should not be assumed in every patient
Srotas	Pranavaha Srotas
Srotodushti	Sanga/Srotorodha with disturbed Vata Gati
Udbhava Sthana	Pittasthana in the Charaka framework of Shwasa-Hikka
Adhisthana	Pranavaha system / Uras-centered clinical expression
Rogamarga	Abhyantara
Vyadhi Swabhava	Yasya; newly developed disease may be described as Sadhya



BRONCHIAL ASTHMA: CONTEMPORARY CLINICAL AND PATHOPHYSIOLOGICAL OVERVIEW

Bronchial asthma is a heterogeneous chronic airway disease characterized by variable respiratory symptoms and variable expiratory airflow limitation¹. The symptoms commonly include wheeze, breathlessness, chest tightness and cough. The intensity and frequency of symptoms vary over time and may be influenced by viral infections, allergens, exercise, weather, irritants and other patient-specific triggers.

Major mechanisms contributing to the clinical expression of bronchial asthma



Clinical expression: wheeze • dyspnoea • cough • chest tightness • variable symptoms

Figure 2. Major mechanisms contributing to variable expiratory airflow limitation and the clinical expression of bronchial asthma.

Airway inflammation

Airway inflammation is a central feature of asthma, although inflammatory patterns vary between patients. Epithelial activation, immune-cell participation and mediator release contribute to airway dysfunction. Type 2 inflammatory pathways are prominent in many, but not all, patients. The heterogeneity of asthma is important when making an Ayurvedic comparison because a single modern asthma phenotype should not be assumed for all Tamaka Shwasa presentations.

Bronchial hyperresponsiveness and bronchoconstriction

Hyperresponsive airways may narrow excessively after exposure to specific or nonspecific stimuli. Contraction of airway smooth muscle reduces airway calibre and increases resistance to expiratory airflow. Because intrathoracic airway narrowing becomes particularly evident during expiration, patients may develop expiratory wheeze and prolonged expiration. Variable bronchoconstriction is one contributor to the variable airflow limitation characteristic of asthma^{1,11,12}.

Mucosal oedema and mucus

Inflammatory swelling of the airway wall and excessive or altered mucus can further narrow the airway lumen. Mucus plugs may produce marked regional obstruction in severe disease. This mechanism provides a clinically interesting



comparison with the classical observation that distress increases when Shleshma is not expelled and temporary comfort may follow its release.

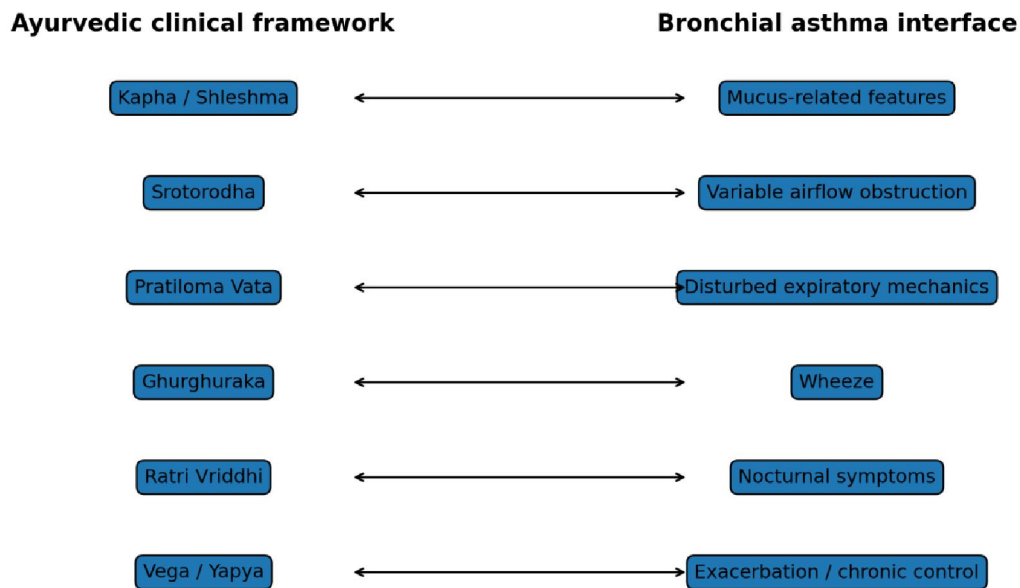
Airway remodelling

Repeated or persistent airway injury and inflammation may be associated with structural changes, including epithelial abnormalities, subepithelial fibrosis, airway smooth-muscle changes and other remodelling features¹³. In some patients, airflow limitation becomes less completely reversible. There is no direct classical synonym for airway remodelling; equating it with a single Dosha or Srotodushti term would be speculative.

Diagnosis and objective assessment

Contemporary asthma diagnosis requires a compatible clinical history and evidence supporting variable expiratory airflow limitation whenever feasible¹. Spirometry with bronchodilator testing is commonly used. Peak expiratory flow variability and other tests may be useful according to clinical context. In an integrative research protocol, objective confirmation of asthma is essential because wheeze and dyspnoea occur in multiple respiratory and cardiac disorders.

DETAILED CORRELATION BETWEEN TAMAKA SHWASA AND BRONCHIAL ASTHMA



Conceptual and clinical correlation — not one-to-one biological equivalence

Figure 3. Conceptual bridge between selected Tamaka Shwasa features and bronchial asthma. The arrows indicate possible clinical or functional correlation and not biological identity.

Tamaka Shwasa feature/concept	Bronchial asthma feature/mechanism	Critical interpretation
Shwasa Krichhrata / Tivra Shwasa	Dyspnoea and increased work of breathing	Strong symptom-level correlation; not disease-specific
Ghurghuraka	Wheeze caused by airflow through narrowed airways	Strong clinical acoustic correlation; objective chest examination and spirometry remain necessary
Kasa	Cough, including cough-predominant presentations	Strong symptom correlation; cough has broad differential diagnosis
Pinasa	Upper-airway/nasal symptoms	May interface with rhinitis-asthma



		coexistence; not equivalent in every case
Urah/Parshva distress	Chest tightness and respiratory muscle discomfort	Clinical correlation; mechanism cannot be inferred from terminology alone
Shleshma Amuchyamana	Difficulty clearing obstructive secretions	Possible interface with mucus retention or plugging
Shleshma Vimokshante Sukham	Temporary relief after expectoration	Possible mucus-dominant symptom correlation
Pratiloma Vata	Abnormal expiratory airflow / obstructive respiratory mechanics	Functional analogy only; Pratiloma Vata is not a spirometric variable
Srotorodha	Airflow limitation from bronchoconstriction, oedema and/or mucus	High-value conceptual interface, but Srotorodha is broader than bronchial narrowing
Ratri Vriddhi / sleep disturbance	Nocturnal asthma symptoms	Strong temporal-pattern correlation
Shayane Shwasa Peedita	Worsening distress while lying	Positional clinical similarity in severe respiratory distress; not synonymous with cardiac orthopnoea
Asino Labhate Saukhyam	Preference for upright posture	May reflect improved respiratory mechanics and accessory muscle use during distress
Ushnam Abhinandati	Preference for warmth	Classical Upashaya; no universal asthma equivalent
Megha/Ambu/Shita aggravation	Weather- or cold-associated symptom precipitation	Clinical trigger correlation in susceptible patients
Raja and Dhuma	Dust and smoke exposure	Strong exposure-level correlation with recognized irritant/trigger patterns
Vega	Acute episodic worsening	Comparable to an attack/exacerbation pattern at the clinical level
Yapya	Chronic recurrent, controllable course	Useful prognosis-level interface with long-term asthma control
Nava Utthita Sadhya	Better prognosis in recent disease in classical view	May generate research questions about disease duration; no direct modern equivalence

PATHOGENESIS-WISE CORRELATION: A CRITICAL MODEL

1. Kapha and airway secretions

Kapha is frequently correlated with mucus because Tamaka Shwasa includes Shleshma obstruction, difficult expectoration and relief after expulsion. The comparison is partially useful. Asthma may involve mucus hypersecretion, altered mucus properties and mucus plugging. However, Kapha is a Dosha with a wider functional meaning and cannot be reduced to mucin concentration, sputum volume or goblet-cell activity. A researchable approach would classify a Kapha-dominant clinical phenotype using predefined Ayurvedic criteria and compare it with sputum characteristics, mucus-plug scores where available, symptom patterns and lung function.



2. Srotorodha and variable airflow limitation

The most compelling functional correlation is between Srotorodha and obstructed airflow. In asthma, bronchial smooth-muscle contraction, airway wall swelling and mucus can narrow the airway lumen and increase resistance. In Tamaka Shwasa, Kapha-associated Srotorodha impedes Vata Gati. Both frameworks therefore identify obstruction as a pivotal event. The difference is epistemological: modern airflow limitation is measured through respiratory physiology, whereas Srotorodha is diagnosed within the Ayurvedic model. Future studies should test association rather than assume identity.

3. Pratiloma Vata and expiratory difficulty

The classical phrase Pratilomam Yada Vayuh describes disturbed directionality of Vata. Asthma characteristically produces variable expiratory airflow limitation because narrowed intrathoracic airways impede expiratory flow. This has led authors to compare Pratiloma Vata with abnormal expiratory mechanics. The comparison is conceptually attractive but remains an analogy. A stronger study design would assess whether the severity of predefined Pratiloma Vata features correlates with FEV1, FEV1/FVC, bronchodilator responsiveness or peak-flow variability.

4. Ghurghuraka and wheeze

Ghurghuraka is a directly observable sound described in the classical symptom complex. Wheeze in asthma is a musical respiratory sound associated with airflow through narrowed airways. This is one of the strongest bedside correlations. Nevertheless, wheeze may be absent in severe airflow limitation and may occur in other diseases; therefore Ghurghuraka cannot independently confirm bronchial asthma.

5. Ratri Vriddhi and nocturnal asthma

Nocturnal worsening is clinically relevant in both descriptions. Asthma symptoms often vary over the day and may worsen at night or in the early morning. Circadian variation in airway calibre, inflammatory activity and neurohumoral influences may contribute. The classical observation of disturbed sleep in Tamaka Shwasa demonstrates recognition of a temporal disease pattern. Research may compare Ratri Vriddhi with nocturnal symptom scores and diurnal peak-flow variability.

6. Vega and asthma exacerbation

Tamaka Shwasa is described with repeated severe episodes. The term Vega represents an attack-like clinical phase in Ayurvedic discussion. An asthma exacerbation is an acute or subacute worsening of symptoms and lung function requiring a change in treatment. The two concepts can be compared at the level of episodic worsening, but exacerbation definitions used in modern trials should be retained when reporting contemporary outcomes.

7. Agni and Ama as disease modifiers

Ayurveda may identify Agnimandya and Ama in the wider pathogenesis of Kapha-dominant disease. Modern asthma research recognizes systemic and metabolic modifiers, including obesity and comorbidities, but this does not establish that Ama equals systemic inflammation or that Agni equals metabolism. These direct equations should be avoided. Instead, standardized Agni and Ama assessments may be recorded prospectively and analysed against asthma control, inflammatory phenotype and comorbidity burden.

8. Yasya nature and chronic disease control

The Yasya designation is highly relevant to the long-term course. Established Tamaka Shwasa is described as manageable yet recurrent. Contemporary asthma management similarly focuses on symptom control, prevention of exacerbations and reduction of future risk rather than assuming permanent cure. The correlation is strongest at the level of chronic disease behaviour. It also supports the use of long follow-up periods in Ayurvedic clinical trials.



DIFFERENCES THAT MUST BE ACKNOWLEDGED

- Bronchial asthma is defined through contemporary clinical and physiological criteria; Tamaka Shwasa is diagnosed through an Ayurvedic disease framework.
- Not every patient with Tamaka Shwasa-like symptoms has asthma, and not every asthma phenotype will display all classical Tamaka Shwasa features.
- Kapha is not synonymous with mucus; Vata is not synonymous with neural activity or air; Srotas are not merely anatomical bronchi.
- Srotorodha should not be reported as bronchoconstriction unless bronchoconstriction is independently demonstrated.
- Pratiloma Vata should not be used as a replacement term for reduced FEV1.
- Modern asthma includes multiple inflammatory phenotypes and endotypes; a single Ayurvedic Dosha pattern should not be assumed for all patients.
- Severe acute asthma requires evidence-based emergency assessment and treatment. An integrative review should not encourage delay or withdrawal of prescribed controller or rescue therapy.

CHIKITSA SIDDHANTA OF TAMAKA SHWASA

The therapeutic approach is based on Roga-Rogi Pariksha, Dosha predominance, Bala, Agni, Ama-Nirama state and disease stage. The logic is Samprapti Vighatana: reducing obstructive Kapha where appropriate, facilitating Srotas function, restoring appropriate Vata Gati and correcting Agni disturbance when present.

Nidana Parivarjana

Avoidance of recognized precipitating factors is fundamental. Raja and Dhuma have direct practical importance in respiratory care. Individual triggers should be documented rather than generalized. In a patient with confirmed asthma, trigger reduction complements but does not replace indicated pharmacological controller treatment.

Deepana-Pachana

Deepana and Pachana may be selected when Agnimandya and Ama are identified according to Ayurvedic examination. The objective is to address the internal disease context before or alongside Dosha-directed therapy. Clinical trials should clearly define the criteria used to diagnose Ama and Agnimandya.

Snehana and Swedana

Selected Snehana and Swedana measures are described within the classical treatment sequence. Their application depends on Dosha, Bala and the patient's current respiratory condition. Procedures should not be performed indiscriminately during unstable respiratory distress.

Shodhana

Vamana may be considered in selected Kapha-dominant, Shodhana-yogya patients. Virechana is also discussed in the therapeutic literature of Tamaka Shwasa. Published Ayurvedic clinical studies have evaluated Shodhana and Shamana approaches, but small samples and heterogeneous protocols limit broad conclusions⁷⁻¹⁰. Patient selection, contraindication screening, adverse-event reporting and standard asthma monitoring are essential in future studies.

Shamana and Vata Anulomana

Shamana treatment is individualized with the aims of Kapha Shamana, Vata Anulomana, Srotoshodhana and Agni support. Vata Anulomana is conceptually important because Pratiloma Vata is central to the Samprapti. The therapeutic rationale may be summarized as: Kapha Vilayana + Srotoshodhana + Vata Anulomana + Agni Deepana, applied according to the patient's Avastha and Bala.



Pathya-Apathya

Laghu and digestible dietary patterns, regular meals and individualized avoidance of Kapha-aggravating or symptom-provoking foods are commonly emphasized. Cold exposure, dust and smoke should be minimized where they trigger symptoms. Excessive exertion during active respiratory distress is avoided. Pathya-Apathya should be individualized according to Prakriti, Agni, Satmya and clinical response.

PROPOSED INTEGRATIVE RESEARCH FRAMEWORK

Ayurvedic variable	Modern/objective variable for parallel recording	Research question
Vata-Kapha predominance	Asthma phenotype, symptom pattern, spirometry	Do Ayurvedic Dosha patterns cluster with measurable clinical phenotypes?
Ghurghuraka severity	Auscultatory wheeze, digital lung sounds where available	Does classical grading correlate with acoustic or physiological obstruction?
Pratiloma Vata features	FEV1, FEV1/FVC, bronchodilator response, PEF variability	Is the Ayurvedic functional pattern associated with expiratory airflow limitation?
Kapha/Shleshma features	Sputum phenotype, mucus symptoms, imaging mucus-plug score in research settings	Is Kapha-dominant expression associated with mucus-related disease features?
Ratri Vriddhi	Night waking, nocturnal symptom score, diurnal PEF variability	Does classical nocturnal aggravation identify poor control or variable airflow?
Vega frequency	Standardized exacerbation frequency, rescue use	Can attack frequency be harmonized with accepted asthma outcomes?
Agni status	BMI, comorbidities, metabolic variables, asthma-control score	Are predefined Agni categories associated with disease control?
Ama assessment	Inflammatory biomarkers only as exploratory parallel variables	Is there an association without claiming equivalence?
Yapya course	12-month control, exacerbations, treatment requirement, quality of life	How does the classical prognostic category relate to longitudinal outcomes?

A future prospective study should first confirm bronchial asthma using accepted contemporary diagnostic criteria. A blinded or independently trained Ayurveda assessor should then phenotype Tamaka Shwasa using a pre-specified case-record form. Primary outcomes may include Asthma Control Test or another validated control instrument, FEV1, FEV1/FVC, peak expiratory flow variability and clinically significant exacerbations. Secondary outcomes may include rescue medication use, night waking, quality of life and adverse events. This design would permit genuine correlation analysis without converting Ayurvedic terminology into unsupported modern synonyms.

IV. DISCUSSION

The classical account of Tamaka Shwasa demonstrates detailed bedside observation. Ghurghuraka, severe episodic breathlessness, difficulty speaking, distress when secretions are not released, temporary relief after expectoration, inability to sleep comfortably, worsening in recumbency, relief while sitting and weather-related aggravation form a recognizable respiratory phenotype. These features explain why Tamaka Shwasa is repeatedly discussed in relation to bronchial asthma.



The strongest correlation is clinical. Ghurghuraka resembles wheeze; Shwasa Krichhrata resembles dyspnoea; Kasa corresponds to cough; nocturnal aggravation resembles nocturnal asthma symptoms; and Vega resembles episodic worsening. Raja, Dhuma, Shita and Vyayama also provide clinically relevant exposure or trigger parallels. These comparisons are based on observable phenomena and are therefore more defensible than direct molecular translations.

At the functional level, the sequence of Srotorodha followed by disturbed Vata Gati has an important interface with obstructive airway physiology. Modern asthma may produce airflow limitation through bronchoconstriction, airway-wall inflammation and mucus. The classical model similarly gives priority to obstruction and altered movement. However, Srotorodha remains a broader Ayurvedic construct. The correct scientific approach is to ask whether the clinical severity of Srotorodha correlates with objective airflow limitation, not to assume that the terms are identical.

The Shleshma Vimoksha observation is especially interesting. Asthma can include mucus hypersecretion and mucus plugging, and some patients report difficulty clearing secretions. Charaka's description of greater distress when Shleshma is not released and temporary relief after its release may identify a mucus-dominant clinical subgroup. Yet Kapha should not be reduced to mucus because doing so removes its broader role within Ayurvedic physiology and pathology.

The comparison of Pratiloma Vata with expiratory airflow disturbance also requires caution. Asthma is characterized by variable expiratory airflow limitation, and narrowed intrathoracic airways impede expiration. The classical language of abnormal Vata directionality can therefore be used to generate a functional hypothesis. Prospective correlation with spirometric variables would be more scientifically valuable than simply declaring Pratiloma Vata to be bronchospasm.

Another major point is disease heterogeneity. Contemporary asthma includes diverse phenotypes and inflammatory endotypes. Ayurveda likewise emphasizes individualized assessment of Dosha, Agni, Ama, Prakriti, Bala and Avastha. This creates an opportunity for integrative phenotyping. It is possible that different Ayurvedic presentations may cluster with different symptom patterns or treatment responses; however, such associations require well-designed studies.

The Yappa nature of Tamaka Shwasa is clinically meaningful. The classical description recognizes a disease that can be managed but tends to recur. Modern asthma care similarly emphasizes control and future risk. This parallel suggests that Ayurvedic trials should move beyond short-term symptom relief and include exacerbation frequency, night waking, controller and rescue medication use, quality of life and long-term follow-up.

Existing Ayurvedic clinical studies provide preliminary data on Shodhana and herbal formulations in Tamaka Shwasa⁷⁻¹⁰. Their interpretation is limited by methodological heterogeneity, sample size, varying diagnostic definitions and inconsistent outcome measures. Future work should use registered protocols, reproducible Ayurvedic diagnostic criteria, objective asthma confirmation, adequate sample-size calculation, transparent randomization where applicable, comparator groups, adverse-event monitoring and appropriate statistical analysis.

The clinical safety boundary is also important. Acute severe asthma can deteriorate rapidly. Evidence-based asthma assessment and treatment should not be delayed while pursuing conceptual correlation or elective Ayurvedic procedures. Integrative care is most scientifically and ethically defensible when modern diagnostic precision and acute-care standards are retained while Ayurvedic interventions are studied as structured, individualized adjunctive strategies.

V. LIMITATIONS

This article is a narrative review and not a systematic review or meta-analysis. The Sanskrit discussion emphasizes selected verses from Charaka Samhita and does not constitute a complete comparative exegesis of every classical commentary. Modern correlations are conceptual and clinical and should not be interpreted as demonstrated mechanistic equivalence. The evidence for specific Ayurvedic interventions is not quantitatively synthesized. The exact Sanskrit text, verse numbering, page numbers and edition details must be verified against the physical classical edition selected by the author before journal submission.



VI. FUTURE DIRECTIONS

1. Develop a consensus Tamaka Shwasa case definition and standardized Ayurvedic phenotyping form.
2. Validate grading systems for Ghurghuraka, Shwasa severity, Kapha features, Pratiloma Vata and Pranavaha Srotodushti.
3. Recruit patients with objectively confirmed asthma and perform parallel Ayurvedic phenotyping.
4. Correlate Ayurvedic variables with FEV1, FEV1/FVC, bronchodilator response and PEF variability.
5. Use validated asthma-control and quality-of-life instruments.
6. Record exacerbations, rescue medication use, night waking and controller adherence.
7. Explore biomarkers only as parallel variables and avoid prematurely naming them as Dosha, Agni or Ama equivalents.
8. Conduct adequately powered randomized controlled trials of clearly standardized adjunctive Ayurvedic protocols.
9. Include adverse-event reporting and long-term follow-up.
10. Publish negative and neutral findings to reduce publication bias.

VII. CONCLUSION

Tamaka Shwasa is a Vata-Kapha predominant respiratory disorder in which Kapha-associated Srotorodha and Pratiloma Gati of Vata occupy a central position in the classical Samprapti. The verses of Charaka provide a detailed phenotype characterized by Ghurghuraka, Shwasa Krichhrata, Kasa, difficult expectoration, temporary relief after Shleshma Vimoksha, nocturnal and recumbent aggravation, comfort in a sitting posture, recurrent Vega and sensitivity to environmental factors.

Bronchial asthma shows substantial clinical overlap through wheeze, dyspnoea, cough, chest tightness, variable expiratory airflow limitation, nocturnal symptoms and trigger-related exacerbations. The most useful integrative interfaces are Ghurghuraka–wheeze, Srotorodha–airflow obstruction, Shleshma-related distress–mucus-associated obstruction, Pratiloma Vata–disturbed expiratory mechanics, Ratri Vriddhi–nocturnal asthma and Yapya–chronic disease control. These are correlations and research hypotheses, not proven one-to-one biological identities.

Future research should preserve Ayurvedic diagnostic integrity while using objective respiratory measurements and accepted asthma outcomes. A parallel-phenotyping model may provide a more rigorous pathway for studying Tamaka Shwasa in patients with bronchial asthma and may strengthen the scientific quality of Ayurveda-based respiratory research.

VIII. DECLARATIONS

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