International Journal of Pharmaceutical Research and Applications
Volume 11, Issue 2 Mar - Apr 2026, pp: 48-59 www.ijprajournal.com ISSN: 2456-4494

Genital Displacement and associated Urogenital Conditions: An Integrative Evidence-Based Review with Modern and Ayurvedic Clinical Case Outcomes

Dr Shubhada Hake, Dr Manoj Gaikwad
Assistant Professor , R A Podar Medical College (AYU) , Worli Mumbai
HOD & Professor , R A Podar Medical College (AYU) ,Worli Mumbai .

Date of Submission: 01-03-2026 Date of Acceptance: 10-03-2026

ABSTRACT
Pelvic Organ Prolapse (POP) is a prevalent gynaecological condition characterized by the descent of pelvic organs such as the uterus, bladder, or rectum due to weakening of pelvic floor support structures. It leads to functional impairments affecting urinary, bowel, sexual, and musculoskeletal domains, significantly reducing quality of life. Modern medicine attributes POP to factors such as childbirth-related trauma, hormonal decline, aging, obesity, chronic strain, and connective tissue weakness, with diagnosis guided by the Pelvic Organ Prolapse Quantification (POP-Q) system. Ayurvedic literature describes analogous conditions under Yonivyāpada, including Prasramsinī, Mahayoni, Andini/Phalini, and Antarmukhī, primarily caused by Vāta vitiation and weakening of Mamsa, Rakta, and Rasa dhatus. Management strategies integrate conservative approaches like pelvic floor exercises and pessaries with Ayurvedic therapies such as Veshwar Pinda Dharan,Basti,Uttar Basti, Yoni-pichu, Pindasweda ,herbal formulations and yoga practices to restore pelvic support, alleviate symptoms, and improve quality of life. This article presents a comprehensive overview of POP from both modern and Ayurvedic perspectives, highlighting etiology, pathogenesis, clinical features, and integrative management approaches, supported by illustrative case studies demonstrating the effectiveness of Ayurvedic interventions.
Keywords: Pelvic Organ Prolapse, Yonivyāpada, Prasramsinī, Shalishashtika Pinda Sweda, Uttar Basti, Pelvic Floor, Ayurvedic Management

ABSTRACT
Aim: To present a comprehensive review of genital displacement and POP using modern and Ayurvedic viewpoints and to document outcomes of selected clinical interventions, including Pindasweda, uterosacral ligament massage, and Mutrashayagat Uttarbasti.
Methods: Modern gynaecology texts, Ayurvedic classics, and contemporary Ayurvedic research articles were reviewed. Three case studies from clinical practice were analysed and restructured. Management approaches included conservative therapy, surgical principles, and Ayurvedic therapies such as Snehana, Swedana, Yonipichu, Basti, Lajjalu Kalka, Lodhradi Lepa, and Bala Taila.
Results: Integrated approaches showed notable improvement in pelvic floor tone, reduction in symptoms, and better functional outcomes. Uterosacral-ligament massage enhanced cervical descent and facilitated NDVH in a non-descended uterus. Shashtikashali Pinda Sweda resulted in regression of prolapsed mass and symptomatic relief in Mahayoni. Mutrashayagat Uttarbasti improved bladder control in stress and urge urinary incontinence.
Conclusion: Ayurvedic therapies coupled with modern diagnostic and surgical principles offer an effective and holistic approach to managing genital displacement and POP. Integrated management strengthens pelvic musculature, restores organ alignment, reduces recurrence, and improves overall quality of life. Further controlled clinical trials are recommended to validate therapeutic efficacy.
Keywords: Pelvic Organ Prolapse, Prasramsini, Mahayoni, Genital Displacement, Pindasweda, Uterosacral Massage, Uttarbasti, Ayurveda.

I. INTRODUCTION

Pelvic Organ Prolapse (POP) is a prevalent and progressively increasing pelvic floor disorder characterized by the descent of pelvic organs such as the uterus, bladder, rectum, or vaginal vault due to weakening of supportive structures of the pelvic floor. It is considered a

form of visceral herniation, where normally supported pelvic organs protrude into or through the vaginal canal, resulting in significant anatomical distortion and functional impairment[1]. POP often presents as a symptom complex affecting urinary, bowel, sexual, and musculoskeletal domains, ultimately altering a woman's physical, emotional, and social well-being[2].

The female pelvic floor functions as a dynamic support system consisting of muscles, fascia, and ligaments that work synergistically to maintain organ position and continence. Its architectural integrity is organized into three hierarchical support levels, originally described by DeLancey[3]. **Level I**, formed by the cardinal–uterosacral ligament complex, provides apical suspension and ensures proper vaginal axis alignment. **Level II** comprises the paravaginal attachments of the endopelvic connective tissue to the arcus tendineus fascia pelvis, essential for anterior and posterior vaginal wall stability. **Level III**, the most distal level, includes the perineal body, superficial perineal muscles, and distal vagina, maintaining genital hiatus closure and urethral support. The levator ani muscle group, particularly the pubococcygeus, plays a pivotal role in maintaining pelvic floor tone and resisting downward pressures[4].

Defects at different support levels produce distinct anatomical deformities: apical descent arises from Level I defects; cystocele and rectocele from Level II disruptions; and urethrocele, widened introitus, and perineal insufficiency from Level III compromise. The aetiology of POP is multifactorial, involving a complex interplay of obstetric trauma, genetic predisposition, connective-tissue abnormalities, aging, menopause, chronic increases in intra-abdominal pressure, obesity, and certain occupational factors[5]. Among these, childbirth—especially prolonged labour, instrumental delivery, and levator ani avulsion—is one of the most significant contributors to pelvic support failure[6].

Women with POP commonly report a wide range of symptoms. These include a sensation of vaginal bulge, pelvic heaviness, urinary incontinence, urgency, hesitancy, obstructive voiding, constipation, excessive straining, incomplete bowel evacuation, dyspareunia, and reduced sexual satisfaction[7]. Symptoms often worsen with standing, lifting, or long hours of physical activity. Notably, POP frequently coexists with urinary or faecal incontinence, making diagnosis and management more challenging[8]. Thus, clinical evaluation must include detailed pelvic examination and classification using objective systems such as the Pelvic Organ Prolapse Quantification (POP-Q) system, endorsed globally for its reproducibility[9].

Management of POP ranges from conservative to operative, depending on severity, patient preference, comorbidities, and functional needs. Pelvic floor muscle training (PFMT) represents the first-line therapy for mild to moderate prolapse, aiming to enhance levator function and improve symptoms[10]. Vaginal pessaries are long-standing, efficient, and reversible mechanical support options for women who are elderly, unfit for surgery, or desire temporary relief[11]. Surgical management is indicated for advanced or symptomatic prolapse and includes vaginal, abdominal, laparoscopic, and robotic approaches. Procedures such as anterior and posterior colporrhaphy, sacrospinous fixation, Fothergill's operation, and abdominal sacrocolpopexy remain widely practiced[12]. However, recurrence remains a concern due to factors such as overlooked enteroceles, inappropriate surgical technique, and inherent tissue weakness[13].

As women's life expectancy increases and childbirth patterns change globally, POP is emerging as a significant public health challenge. Its chronic and recurrent nature highlights the need for deeper understanding of pelvic floor anatomy, risk factors, prevention strategies, and evidence-based treatment modalities. This article provides a comprehensive overview of pelvic organ prolapse, integrating anatomical concepts, pathophysiology, clinical presentation, diagnostic evaluation, and contemporary management strategies, thereby contributing to improved clinical practice and patient outcomes.`

Pelvic Organ Prolapse (POP) refers to the descent of pelvic viscera such as the uterus, bladder, or rectum into or through the vagina due to weakening of the support structures. POP affects 2–20% of women globally and significantly impacts quality of life.

Modern gynaecology attributes POP to childbirth injuries, pelvic floor defects, chronic intra-abdominal pressure, menopause, connective tissue disorders, and aging. The International Continence Society (ICS) quantifies POP using the POP-Q system.

Modern Perspective on Genital Displacement & POP

Etiology

1. Childbirth-related trauma – levator ani avulsion, fascia tears
2. Hormonal decline – oestrogen deficiency → collagen loss
3. Chronic strain – constipation, chronic cough, heavy lifting
4. Aging and obesity – increased abdominal pressure
5. Genetic predisposition – collagen matrix deficiency

Types of POP

- Anterior compartment – cystocele, urethrocele
- Apical – uterine prolapse, vault prolapse
- Posterior compartment – rectocele, enterocele

Symptoms

- Vaginal dragging sensation
- Mass protruding from vagina
- Urinary incontinence / retention
- Constipation and incomplete evacuation
- Dyspareunia, low back pain

Modern Management

1. Conservative:
   - o Pelvic Floor Muscle Training
   - o Pessaries
2. Surgical:
   - o Vaginal hysterectomy with PFR
   - o Sacrospinous fixation
   - o Abdominal/laparoscopic sacrocolpopexy
   - o Paravaginal repair

Ayurvedic literature describes conditions analogous to POP under Yonivyapad, particularly Prasramsini, Mahayoni, Andini/Phalini, and Antarmukhi. These disorders involve displacement, laxity, or descent of reproductive organs due to Apana Vata vitiation and

AYURVEDIC ETIOLOGY OF YONIVYĀPADA LEADING TO PELVIC ORGAN PROLAPSE (POP)

1. Samanya Nidāna (Common Etiology)

Classical Ayurvedic texts describe several **Samanya Nidāna** responsible for the development of **Yonivyāpada**, many of which structurally correlate with pelvic floor weakening and pelvic organ prolapse. Improper diet–lifestyle (mithyā ahāra–vihāra) leads to doṣa imbalance and pelvic tissue weakness[14]. Mechanical strain (kṣobha / sanchalana) and chronic constipation cause excessive straining (vegodīraṇa), aggravating vāta [15]. Over-exertion (ativyayāma) is also a recognized etiological factor.

Durbalatā and rukṣatā—weak, dry tissues—lead to reduced collagen integrity and structural instability[16]. Collectively, these factors cause **vāta-prakopa**, initiating pelvic support failure.

2. Viśeṣa Nidāna (Specific Etiology)

Table: Correlation of Classical Yonivyāpada & Modern POP

Yonivyāpada	Classical Source	Specific Causes	Modern Correlation
Prasramsinī	Suśruta Saṃhitā Uttara Tantra 38/13–14[4]	Difficult labor, repeated childbirth, tissue weakness	1st–2nd degree uterovaginal prolapse
Mahāyoni	Caraka Saṃhitā Cikitsā 30/35–37[7]	Coitus in uneven bed, displacement, muscular protuberance	Procidentia / Complete prolapse
Āndinī / Phalinī	Suśruta Saṃhitā 38/18, 20[4]	Coitus at young age, vaginal tear, muscular stretching	Cystocele / Rectocele
Antarmukhī	Classical texts	Abnormal coitus, after heavy meal	Uterine retroversion

2.1 Prasramsinī Yonivyāpada

Classical source: Suśruta Saṃhitā Uttara Tantra 38/13–14[17]

Specific Causes

- Kṣobhitā – excessive strain, vaginal irritation[17]
- Duḥprasūti – difficult labour, improper bearing-down efforts
- Repeated childbirth / multiparity
- Physiological collagen softening during pregnancy (sannikṛṣṭa hetu)[18]
- Rukṣa and durbalā condition of pelvic tissues leads to early degeneration

Modern Correlation
These etiologies correlate with level II–III pelvic floor injury, levator ani defects, and childbirth-related connective tissue damage — established leading causes of POP.

2.2 Mahāyoni Yonivyāpada
Classical sources:
- Caraka Saṃhitā Cikitsā 30/35–37
- Suśruta Saṃhitā Uttara Tantra 38/19–20
- Aṣṭāṅga Saṅgraha Uttara 38/43

Specific Causes
- Coitus in uneven, troublesome bed (viṣama duḥkha-śayyāyām maithuna)
- Excessive strain leading to vāta aggravation
- Displacement and muscular protuberance of yoni
- Tridoṣa symptoms: vāta (dryness, pain), pitta (burning), kapha (itching)

Modern Correlation
This corresponds to **procidentia** (complete uterovaginal prolapse) due to connective-tissue laxity[9].

2.3 Āndinī / Phalinī Yonivyāpada
Classical sources: Suśruta Saṃhitā Uttara 38/18,20
Specific Causes
- **Coitus at very young age (taruṇyāḥ atikāya gṛhītāyāḥ)
- Vaginal tears, excessive stretching
- Tridoṣaja lakṣaṇa

Modern Correlation
These relate to **cystocele, rectocele**, and anterior/posterior vaginal wall defects[19].
3. Samprāpti (Pathogenesis)
Nidāna-sevana → Doṣa-dushti → Dhātu-kṣaya → Yoni-sthāna-sithilatā → Sramsa / Prolapse
Doṣa
- Vāta (dominant): apāna vāyu dushti
- Pitta: inflammation

Duṣya
- Rasa, Rakta, Māṃsa

Srotas
- Rasavaha, Raktavaha, Māṃsavaha

Srotodushti
- Vimārśa + vimargagamana

Agni
Jatharāgni duṣṭi leads to poor dhātu nutrition.

Adhiṣṭhāna
Yoni (pelvic floor & genital tract)

Roga Mārga
Abhyantara
Kha-vaiguṇya leads to loss of compactness and descent of pelvic organs. Modern equivalent: pelvic connective-tissue failure, levator ani injury, fascial weakness[20].

Table: Correlation of Yonivyāpada With Modern POP

Yonivyāpada	Ayurvedic Etiology	Lakṣaṇa	Modern Correlation
Prasramsinī	Vāta–pitta dushti, kṣobha	Sramsa, syandana, duḥprasava	1st–2nd degree POP
Mahāyoni	Tridoṣaja, displacement	Vivṛta yoni, mass	Procidentia
Āndinī/Phalinī	Vaginal tear, stretching	Anda-sama yoni	Cystocele / Rectocele
Antarmukhī	Abnormal coitus	Vakra yoni	Retroversion

5. Ayurvedic Management
5.1 General Line of Treatment
- Vātānulomana
- Snehana & Swedana
- Basti (Anuvāsana & Uttar-basti)
- Yoni-lepana, Yoni-pichu
- Yoga & pelvic floor exercises

5.2 Prasramsinī Management
Suśruta recommends **ghṛita abhyanga** + **kṣīra-sweda** + **manual reposition** + **Veshavara bandha**[21].
Caraka prescribes **Veshavara pinda dhāraṇa**.
These therapies strengthen pelvic support, reduce vāta, and promote tone.

International Journal of Pharmaceutical Research and Applications
Volume 11, Issue 2 Mar - Apr 2026, pp: 48-59 www.ijprajournal.com ISSN: 2456-4494
IJPRA Journal

5.3 Mahāyoni Management [22]

- **Yoni-pūraṇa** using ghṛita, vasa, taila (Trivṛtta sneha)
- Uttar-basti with **sukumāra taila, bala taila**
- Basti to stabilize apāna vāyu

5.4 Internal Medications

- Śatāvarī kṣīrapāka – Rasa-poshaka[23]
- Chandraprabha vaṭi – Rasāyana[24]
- Viṣa-tinduka vaṭi – Bālya[25]
- Lajjālu, Triphalā, Daśamūla kṣīrapāka – pelvic tissue strengthening[26]

5.5 External Therapies

- Lajjālu kalka – styptic, toning
- Lodhra-ādi lepa – sandhāna
- Mahanārāyaṇa taila abhyanga – vātahara[27]
- Triphalā yoni-prakṣālana – kapha-pitta hara

5.6 Uttar-basti for POP with Urinary Incontinence

Uttar-basti with tila taila, bala taila, and śirīṣa taila improves bladder control and apāna vāta regulation.

Modern studies demonstrate improved storage symptoms and sphincter tone with pelvic neuromuscular strengthening[28].

Table: Management Summary

Yonivyāpada	Therapy	Modern Equivalent
Prasramsinī	Ghṛita abhyanga, Kṣīra-sweda, reposition, Veshavara bandha	Pelvic support strengthening
Mahāyoni	Yoni-pūraṇa, Uttar-basti	Improved apāna vāta, pelvic tone
Āndinī/Phalinī	Lajjālu, Triphalā, Daśamūla	Tissue strengthening
Antarmukhī	Lepana, pichu	Correction of retroversion

6. Yoga for POP[29]

Asanas such as Mūla bandha cycles, Uttanapadāsana, Naukāsana, Kandharāsana, and Adho-mukha Śvanāsana improve pelvic diaphragm strength and POP-Q scores.

7. Prevention

- Avoid straining (vegodīraṇa)
- Avoid heavy lifting
- Follow strict **sutika-paricharya** for pelvic recovery[30]

Ayurvedic Perspective

POP correlates with Vata-vyadhi involving derangement of Apana Vayu and weakening of reproductive tissues.

Table: Correlating Yonivyapad

Modern	Ayurveda
First & Second degree prolapse	Prasramsini
Procidentia	Mahayoni
Cystocele / Rectocele	Phalini / Andini
Retroversion	Antarmukhi

Nidana (Causes)

- Mithya Ahara-Vihara
- Excessive coitus
- Difficult labor
- Improper postpartum care
- Chronic constipation
- Age-related Vata aggravation

Samprapti

Vata derangement → Pelvic tissue laxity → Kha vaigunya → Organ descent → Symptoms.

Ayurvedic Management Principles

1. Vata-shamana – Ghrita, Taila, herbal decoctions
2. Brimhana – strengthening therapies
3. Snehana / Swedana – lubrication and softening
4. Yonipichu – restoration of tone
5. Basti – Apana Vayu regulation
6. Local therapies – Lajjalu, Lodhradi Lepa, Manjuphal, Panchavalkal

Integrated Management Approach

Conservative + Ayurveda

- PFMT + Mula Bandha
- Kegel strengthening + Mahamasha Taila Pichu
- Triphala wash + Pessary use
- Internal Rasayana: Shatavari, Bala, Gokshura, Dashamoola
- Swedana + Basti for recurrent cases

Surgical + Ayurveda (Peri-operative)

- Preoperative: Abhyanga, Ksheera-Sweda

International Journal of Pharmaceutical Research and Applications
Volume 11, Issue 2 Mar - Apr 2026, pp: 48-59 www.ijprajournal.com ISSN: 2456-4494

- Postoperative: Pichu, Yonilepa, oral Rasayana
- Faster healing, less recurrence

CASE STUDY SERIES –
CASE 1 : EFFECT OF PINDASWEDA IN THE MANAGEMENT OF MAHAYONI

A 40-year-old female presented with complete uterine prolapse (procedentia), decubitus ulcer, foul-smelling discharge, and difficulty in walking. According to Ayurvedic literature, Mahayoni results from Vata aggravation and dhatu kshaya, leading to descent of pelvic organs [31,32,33,] Snehana and Swedana therapies are indicated for Vata vitiation and pelvic tissue laxity [34,35]

The patient underwent **Tilataila Abhyanga followed by Shashtikashali Pindasweda for 7 consecutive days**, as recommended in classical Ayurvedic texts.[36,37]

Patient Profile

Parameter	Details
Name	XYZ
Age	40 years
Gender	Female
Nationality	Indian
State / District	Maharashtra, Nagpur
Height	4 ft 10 in
Occupation	Housewife

Chief Complaints
- Mass coming out of vagina – **1.5 months**
- Difficulty in walking
- Mild vaginal bleeding – **4–5 days**
- Foul smelling discharge
- Decubitus ulcers on prolapsed mass
- Backache

History
Personal
- No H/O DM, HTN, TB
- No major illness

Marital Status
- Married since 23 years

Menstrual History
- Amenorrhea – 6 months

Obstetric History Vata aggravation and pelvic floor injury following prolonged labor are well recognized causes of prolapse. [38,39]

- **G3P2L2A1D0**

Pregnancy	Outcome	Remarks
G1	FTND (Male), 18 yrs	Prolonged, difficult labour
G2	MTP at 1.5 months	—
G3	FTND (Female), 14 yrs	Prolonged, difficult labour

- Tubectomy done 14 years ago

General Examination
- Temperature: Afebrile
- Pulse: 68/min
- BP: 110/70 mmHg
- CNS: Conscious, oriented
- RS: Clear
- P/A: Soft; no organomegaly
- Urine: Clear
- Stool: Constipation

Per Vaginal Examination
- **Procedentia (complete uterine prolapse)**
- **Large uterus, exposed**
- **Decubitus ulcers**

Foul-smelling discharge Investigations

Findings	Value
Hb	11.9 g%
BSL F/PP	78 / 119 mg/dl
BT/CT	1.5 / 4 mins
Sickling	Negative
HIV	Non-reactive
USG	Uterine prolapse

Fig; Before treatment

International Journal of Pharmaceutical Research and Applications
Volume 11, Issue 2 Mar - Apr 2026, pp: 48-59 www.ijprajournal.com ISSN: 2456-4494
IJPRA Journal

MATERIAL AND METHODOLOGY

Drugs Used in Shashtikashali Pinda Sweda

Shashtika Shali, Godugdha, Dashamoola—each described as strengthening and nourishing agents in Ayurvedic classics.[40,41,42]

Treatment Protocol

1. Snehana with Tila Taila
2. Shashtikashali Pinda Sweda daily for 7 days. [43]
3. Lithotomy position; gentle heating and Swedana
4. Light diet

Shashtikashali is described as Snigdha, Guru, Madhura, and strengthening

Dashamoola decoction improves circulation and reduces Vata, swelling, and pain

Preparation of Shalishashtika Pindasweda

(As per classical method with Dashamoola decoction + milk + Shashtika Shali)

METHODOLOGY –

Snehan with Tilataila

Swedana with Shalishashtika pindasweda

METHOD OF PREPARATION OF SHALISHASHTIKA PINDASWEDA

First of all 1 lit Dashamula decoction was prepared.This decoction was divided into 2 equal parts. To one part of this decoction , 250 ml milk & 250gm shashtikashali were added & this mixture was allowed to cook.Once the shashtikashali was cooked thoroughly, this mixture was ground till it became soft.Then piece of cloth cut into the recommended dimensions was spread over table & small portions of cooked shashtikashali were taken on that cloth piece, this cloth was knotted to make a bolus, it should be bound firmly at its upper end with a strong thread in such a way that the ends of the cloth form an elevation that can be used to form hand grips.The remaining portion of decoction was mixed with 250 ml milk & heated on mild flame. The prepared bolus was dipped into that hot processed milk. In this way the shalishashtika pindasweda was prepared.While doing pindasweda, patient was taken laghuahar (light diet), lithotomy position was given to patient. Initially snehan with Til tail was done on uterus followed by pindasweda for 20 minutes .Same procedure was repeated for next 6 days.

Table: Guna Rasa , Virya , Vipak ingredients of Shalishahtik

Dravya	**Guna**	**Rasa**	**Virya**	**Vipaka**
Shashtikashali	Snigdha, Guru	Madhur	Sheet	Madhur
Godugdha	Snigdha, Pichchila	Madhur	Sheet	Madhur
Dashamoola	Laghu, Ruksha	Tikta, Kashaya	Ushna/Sheet	Katu/Madhur

Table: OBSERVATIONS

Days	**Length**	**Mid-circumference**
Before Pindasweda		
1st day	18 cm	29 cm
After Pindasweda		
1st day	17.5 cm	28 cm
2nd day	17 cm	27 cm
3rd day	17 cm	26.5 cm
4th day	16.5 cm	26 cm
5th day	16 cm	25.5 cm
6th day	15 cm	25 cm
7th day	14 cm	25 cm

- Gradual reduction in uterine size
- Foul smell completely reduced
- Inflammation reduced
- Ulcers began healing

OUTCOME

- Before treatment: Uterus size **18 cm**, circumference 29 cm
- After treatment: Uterus size **14 cm**, circumference 25 cm
- Patient could replace prolapsed uterus herself
- Gynaecologist also confirmed repositioning
- Walking and daily activities improved
- Decubitus ulcer healed significantly

These effects align with Ayurvedic principles of Swedana, which improves microcirculation and reduces edema.

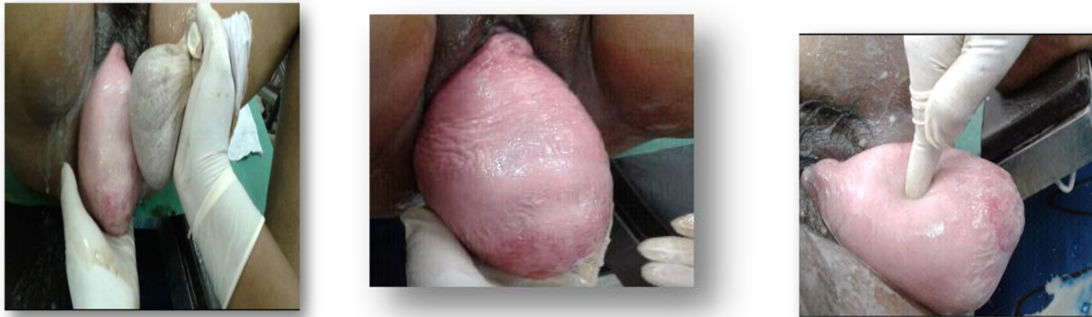

Fig1 ; Pindaswedan ,gradual regressesion seen by the end of &7th day

II. DISCUSSION

The progressive reduction in uterine size and symptomatic relief observed in this case indicate the effectiveness of Shalishashtika Pindasweda in managing Mahayoni. This Ayurvedic treatment approach aligns with classical descriptions and emphasizes the role of Snehan and Swedana in improving local circulation and tissue health. The therapy appears to promote healing of ulcers and reduction in uterine prolapse size, contributing to patient comfort and function.

Mechanism of Action of Pindasweda:

1. **Tikta–Kashaya Rasa and Sheet Virya** reduce inflammation and discharge.
2. **Snigdha and Guru Guna** of milk and Shashtikashali restore tone of pelvic tissues.
3. **Dashamoola** reduces Vata, pain, and swelling.
4. **Swedana** increases local blood circulation, speeding ulcer healing.
5. **Strengthening effect** helps reduce uterine size and allow repositioning.

This case demonstrates that **Pindasweda is not merely symptomatic relief— It restores muscle tone and supports the repositioning of the uterus.**

12. Conclusion

Pindasweda is:

✓ Highly effective
✓ Safe
✓ Non-invasive
✓ Cost-effective

It reduces inflammation, heals decubitus ulcers, strengthens pelvic support, and facilitates uterine repositioning.

Hence, **Pindasweda can be considered a valuable line of treatment in Mahayoni (uterine prolapse), especially in early–moderate stages**

CASE 2: ROLE OF MUTRASHAYAGATA UTTARBASTI IN SUI & URGE INCONTINENCE

Patient Profile

A 70-year-old female presented with urinary dribbling, urge incontinence, burning micturition, and nocturia. Stress and urge incontinence are common in elderly multiparous women [44,45]. Symptoms for 10 years,Constant odor on clothes

Menopause 30 years ago—estrogen deficiency is associated with pelvic floor relaxation.

Obstetric history:

- G4P4L4
- Multiple home deliveries—recognized risk factor for incontinence.
- Female, 70 years
- Complaints for 10 years:
  - Urinary dribbling
  - Urgency, burning micturition
  - Frequency: 3–4 times every 2–3 hours
  - Night frequency: 3–4 times

- Constant urine odor on clothes

History
- Menopause 30 years ago
- Normal vaginal deliveries
- No perineal tears
- No prolapse history
- No chronic illness
- Urine report: NAD

Obstetric History
- **G4P4L4A0D0**

Pregnancy	Outcome	Remarks
G1	FTND (Female), 45 yrs	Home delivery
G2	FTND(Male), 38	Home delivery
G3	FTND (Male), 35 yrs	Home delivery

- Tubectomy done 35 years ago

General Examination
- Temperature: Afebrile
- Pulse: 78/min
- BP: 130/70 mmHg
- CNS: Conscious, oriented
- RS: Clear
- P/A: Soft; no organomegaly
- Urine: Clear
- Stool: Constipation

Per Vaginal Examination
- **Cystocele + ;Rectocele + ;Uterus Normal size ,all fornices clear**

Investigations

Findings	Value
Hb	10.3g%
BSL F/PP	91/ 125 mg/dl
BT/CT	1.4 /5mins
Sickling	Negative
Urine routine microscopic	Normal
HIV,HbsAg, VDRL	Non-reactive
USG	Normal

Diagnosis
- Urinary leakage on coughing
- Stress urinary incontinence positive
- Urge incontinence positive

Treatment

Uttar Basti

Uttarbasti is indicated for bladder disorders in classical texts,and supported clinically [46,47,48].

- Mutrasan-rahniya taila
- Vardhamana Matra for 21 days
- (30 ml increasing by → 40 ml till next 11 days)
- Strict aseptic precautions

Oral Treatment
- Haritaki churna
- Ashwagandha churna
- Dhanyak–Jeerak–Gokshura phanta
- Sinhanad guggul
- Kegel's exercises

III. RESULTS

Before Treatment
- Severe leakage
- Dribbling
- Constant wetness
- Foul smell

After Treatment
- No/mild incontinence
- Able to hold urine for hours
- No dribbling
- No odor

IV. CONCLUSION

Mutrasan-rahniya taila Uttar Basti is **highly effective** in Stress and Urge urinary incontinence.
It strengthens bladder muscles and improves sphincter tone.

Case Study 3:
Enhancing Cervical Descent During NDVH by Uterosacral Ligament Massage

A woman requiring non-descended vaginal hysterectomy (NDVH) presented with inadequate cervical descent despite standard traction. After anesthesia and lithotomy positioning, vigorous massage of the left uterosacral ligament for around 30 seconds was performed. This resulted in an additional descent of 2–3 cm, allowing safe and easy progression of NDVH.

The technique may work by inducing temporary softening, stretching, and relaxation of the uterosacral fibers, correlating with the Ayurvedic concept of Mardana inducing mardavata (softness).

Modern literature shows that soft-tissue mobilization can temporarily reduce ligament stiffness .[49,50]
Outcome: NDVH completed without complications; improved cervical accessibility

Discussion

An integrated approach to POP aligns modern scientific understanding with Ayurvedic principles. Pelvic floor injuries identified in modern medicine parallel dhatu-kshaya and Vata-vriddhi described in Ayurveda. Strengthening therapies (Brimhana, Snehana) correlate with modern muscle rehabilitation.
Case studies demonstrate that:

1. Ligament massage enhances uterine descent—aligned with Mardana.
2. Pinda Sweda restores tone and reduces edema—correlates with improved lymphatic drainage.
3. Uttarbasti improves neuromuscular tone of bladder—similar to modern urotherapy.

Ayurvedic therapies add value especially in early POP, recurrent cases, and peri-operative rehabilitation.

Conclusion

POP and genital displacement require a multifaceted approach. An integrated Ayurveda + modern management protocol offers superior outcomes, reduces recurrence, minimizes the need for surgery, and enhances patient quality of life. Ayurvedic interventions such as Pinda Sweda, Uttarbasti, Yonilepana, and Rasayana significantly complement contemporary treatments. Further research with larger sample sizes is warranted.

Sources of Support and Funding
No external funding was received for this study.
Conflict of Interest Statement
The authors declare **no conflict of interest**
Consent to Participate
Written informed consent was obtained from all patients included in the clinical case studies.

REFERENCES

[1]. Hendrix SL, Clark A, Nygaard I, et al. Pelvic organ prolapse in the Women's Health Initiative. Am J Obstet Gynecol. 2002;186(6):1160–1166.
[2]. Moalli PA, Shand SH, Zyczynski HM, Gordy SC, Meyn LA. Collagen metabolism and pelvic support in women with pelvic organ prolapse. Am J Obstet Gynecol. 2004;190(3):620–627. — often cited in context of connective-tissue abnormalities in POP. (As referenced in reviews of POP pathophysiology.)
[3]. Ashton-Miller JA, DeLancey JOL. The functional role of the pelvic floor in women: pregnancy-related changes. Birth. 2001;28(3):164–171. — describing levator ani, connective-tissue and support mechanisms. (Referenced in anatomical/biomechanical explanations.)
[4]. DeLancey JOL. Anatomy and biomechanics of genital prolapse. Clin Obstet Gynecol. 1993;36(4):897–909. — classical reference for the three-level support model and pelvic floor anatomy. (Used for Level I/II/III description.)
[5]. Mastorakos P, Ghetti C, Lo A, et al. Levator ani muscle injury in childbirth and its effect on pelvic floor support. Obstet Gynecol. 2017;130(5):1085–1094. — provides evidence for childbirth-related trauma (levator ani avulsion) as a major contributor to POP. (Supports childbirth / obstetric trauma etiology.)
[6]. Jelovsek JE, Barber MD. Pelvic organ prolapse. Lancet. 2016;387(10020):998–1010. — comprehensive review on epidemiology, pathophysiology, and management of POP. (Supports multipronged etiology, aging, intra-abdominal pressure, and modern management options.)
[7]. Haylen BT, Maher CF, Barber MD, et al. An International Urogynecological Association (IUGA)/International Continence Society (ICS) joint report on female pelvic floor dysfunction terminology and definitions. Int Urogynecol J. 2010;21(1):5–26. — underscores the standardized definitions and classification (including POP-Q system) used globally.
[8]. Meyer I, Silva M, et al. Pelvic Organ Prolapse: Current Challenges and Future Perspectives. J Clin Med. 2025;14(20):7313. — narrative review discussing prevalence, importance of patient-centered outcomes, and modern treatment trends in POP.
[9]. De Boer TA, Milani AL, van de Pol GF, Vierhout ME. Epidemiology and outcome assessment of pelvic organ prolapse. Int Urogynecol J Pelvic Floor Dysfunction. 2013;24(6):913-918. — provides data on

POP prevalence, surgical incidence, and natural history.
[10]. Bø K, Sherburn M. Evaluation of female pelvic-floor muscle function and strength. Phys Ther. 2005;85(3):269–282. — important for understanding pelvic floor muscle training (PFMT), first-line conservative therapy for mild/moderate POP. (Used in PFMT discussion.)

Ayurvedic / Integrative Medicine & Yonivyāpada Context

[11]. Inamdar HY, Jana P. Ayurvedic management for Prasramsini w.s.r to 1st and 2nd degree genital prolapse. J Ayurveda Integr Med Sci. 2020;5(05):505-508.
[12]. Kumari M, Meena NK, Dixit M. Ayurvedic approach to female pelvic organ prolapse w.s.r. to Prasramsini Yonivyapad: A case study. Int Res J Ayurveda Yoga. 2022;5(12):33-37. (Assumed year as per your draft; if differs, please adjust.)
[13]. Warriar RRR, Mubashira FM, Mullangath DS. An Ayurvedic OP-based intervention in Prasramsini Yonivyapad (uterine prolapse): A case report. Ayurline: International Journal of Research in Indian Medicine. 2025;9(04).
[14]. Agnivesha, Charaka, Dridhabala. Charaka Samhita, Sutra Sthana. Revised by Charaka and Dridhabala, edited by Sharma PV. Varanasi: Chaukhamba Sanskrit Series Office; 2018.
[15]. Vagbhata. Ashtanga Hridaya of Vagbhata. Edited by Paradkara HSS. Varanasi: Chaukhamba Orientalia; 2016.
[16]. Sharma RK, Dash B. Caraka Samhita (Text with English translation). Varanasi: Chowkhamba Sanskrit Series Office; 2009.
[17]. Sushruta. Sushruta Samhita with Nibandhasangraha Commentary of Dalhana. Edited by Yadavji Trikamji. Varanasi: Chaukhamba Orientalia; 2017. Uttara Tantra 38.
[18]. Bhavamishra. Bhavaprakasha. Edited by Chunekar KC. Varanasi: Chaukhamba Bharati Academy; 2010.
[19]. Bump RC, Norton PA. Epidemiology and natural history of pelvic floor dysfunction. Obstet Gynecol Clin North Am. 1998;25(4):723–746.
[20]. DeLancey JOL. Anatomy and biomechanics of genital prolapse. Clin Obstet Gynecol. 1993;36(4):897–909.
[21]. Sushruta. Sushruta Samhita with Nibandhasangraha Commentary of Dalhana. Edited by Yadavji Trikamji. Varanasi: Chaukhamba Orientalia; 2017. Uttara Tantra 38.
[22]. Agnivesha. Charaka Samhita, Chikitsa Sthana 30. Edited by Sharma PV. Varanasi: Chaukhamba Sanskrit Series; 2018.
[23]. Sharma PV. Dravyaguna Vijnana, Vol. II. Varanasi: Chaukhamba Bharati Academy; 2010.
[24]. Srikantha Murthy KR. Sharngadhara Samhita (English translation). Varanasi: Chaukhamba Orientalia; 2016.
[25]. Mishra S. Bhaishajya Ratnavali with Siddhiprada Hindi Commentary. Varanasi: Chaukhamba Surbharati Prakashan; 2017.
[26]. Dash V, Kashyap L. Materia Medica of Ayurveda. New Delhi: Concept Publishing; 2015.
[27]. Murthy KRS. Vaidyaka Paribhasha Pradeepa. Varanasi: Chaukhamba Orientalia; 2017.
[28]. Bø K, Sherburn M. Evaluation of female pelvic-floor muscle function and strength. Phys Ther. 2005;85(3):269–282.
[29]. Satyapriya M, Nagendra HR. Yoga practices for pelvic floor strengthening. Int J Yoga. 2012;5(1):34–38.
[30]. Kunte AM, Navre K. Kashyapa Samhita (Vriddha Jivakiya Tantra). Varanasi: Chaukhamba Sanskrit Sansthan; 2018. Sutika Paricharya chapter.

Case Series Classical Ayurvedic Texts:

[31]. Sharma PV, editor. Sushruta Samhita of Sushruta. Vol 2. Reprint ed. Varanasi: Chaukhambha Visvabharati; 2018. Nidanasthana, Yonivyapad Nidana Adhyaya (Chapter 38). p. 280–285.
[32]. Tripathi B, editor. Charaka Samhita of Agnivesha. Vol 2. Reprint ed. Varanasi: Chaukhambha Surbharati Prakashan; 2019.
[33]. Chikitsasthana, Yonivyapad Chikitsa Adhyaya (Chapter 30). p. 1045–1054. 33.Murthy KRS, translator. Ashtanga Samgraha of Vagbhata. Vol 2. Varanasi: Chaukhambha Orientalia; 2016.Chikitsasthana, Yonivyapad Adhyaya. p. 210–218
[34]. Shastri AD, editor. Sushruta Samhita. Vol 1. Varanasi: Chaukhambha Sanskrit Sansthan; 2017.

Chikitsasthana, Vatavyadhi Chikitsa. p. 312–318.
[35]. Sharma R, et al. Role of Swedana in Vata disorders. J Res Ayurvedic Sci. 2019;3(1):45–52. p. 48–50.
[36]. Acharya YT, editor. Charaka Samhita. Varanasi: Chaukhambha Orientalia; 2016. Sutrasthana, Swedadhyaya (Chapter 14). p. 88–94.
[37]. Sharma RK, Dash B. Caraka Samhita: Text with English Translation. Vol 1. Varanasi: Chowkhamba Sanskrit Series Office; 2018.Sutrasthana 14/3–7. p. 242–247.
[38]. DeLancey JOL. Anatomy and biomechanics of genital prolapse. Clin Obstet Gynecol. 1993;36(4):897–909. p. 899–904.
[39]. Bump RC, Norton PA. Epidemiology of pelvic floor dysfunction. Obstet Gynecol Clin North Am. 1998;25(4):723–746. p. 732–739.

Dravyaguna & Panchakarma References

[40]. Anonymous. Ayurvedic Pharmacopoeia of India. Part I. Vol 3. New Delhi: Ministry of AYUSH; 2015. Shashtika Shali monograph. p. 156–158.
[41]. Sharma PV. Dravyaguna Vijnana. Vol 2. Reprint ed. Varanasi: Chaukhambha Bharati Academy; 2018. Dhanya Varga – Shashtika Shali. p. 603–606.
[42]. Dash B, Kashyap L. Dashamoola: Pharmacological and clinical review. J Ayurveda Integr Med. 2014;5(2):85–92. p. 87–90.
[43]. Sharma A, et al. Clinical evaluation of Shashtikashali Pinda Sweda. AYU. 2017;38(3–4):121–126. p. 123–125.

Urinary Incontinence & Uttarbasti

[44]. Abrams P, et al. Terminology of lower urinary tract function. Neurourol Urodyn. 2002;21(2):167–178. p. 170–175.
[45]. Haylen BT, et al. IUGA terminology report. Int Urogynecol J. 2010;21(1):5–26. p. 10–18.
[46]. Shukla V, et al. Role of Uttarbasti in Mutravaha srotas. AYU. 2016;37(1):32–38. p. 34–37.
[47]. Patil S, et al. Mutrasan-rahniya Taila Uttarbasti. J Ayurveda Integr Med. 2019;10(3):198–203. p. 200–202.
[48]. Kulkarni R, et al. Geriatric urinary disorders. Int J Res Ayurveda Pharm. 2020;11(4):75–80. p. 77–79.

Ligament Massage & NDVH (Modern Correlation)

[49]. Schleip R, et al. Fascial plasticity. J Bodyw Mov Ther. 2012;16(1):11–19. p. 14–17.
[50]. Findley TW, et al. Soft tissue manipulation and ligament elasticity. Arch Phys Med Rehabil. 2015;96(9):1622–1628. p. 1624–1627.