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**Ayurvedic Insights into Jirna Shwasakrichchhrata
(Chronic Obstructive Pulmonary Disease): Therapeutic
Potential of Rasayana Chikitsa—A Review**

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ABSTRACT

Chronic Obstructive Pulmonary Disease (COPD) has settled into modern life as one of its quieter epidemics — not always headline news, yet steadily climbing the list of causes of death and disability worldwide, driven along by tobacco smoke, biomass fuel, and the pollution that now hangs over most Indian cities. Once a person's airways narrow and their lung tissue begins to break down, the damage rarely reverses; treatment becomes a matter of slowing the decline and easing the breathlessness rather than offering a cure. Ayurveda approached this same territory many centuries ago through a different lens. The persistent breathlessness, cough, and progressive debility described as Jirna Shwasakrichchhrata sit closest to Tamaka Shwasa and, in its long-standing and difficult-to-reverse form, to Maha Shwasa within the broader Shwasa Roga classification of Charaka, Sushruta, and Vagbhata. Involving vitiated Vata and Kapha lodged in Pranavaha, Udakavaha, and Annavaha Srotas, the disease is understood not merely as an airway problem but as a whole-body derangement of Agni, Dhatu nourishment, and Ojas. This review draws together classical textual material on the Nidana, Samprapti, and Chikitsa of Shwasa Roga with the specific rationale of Rasayana therapy — Pippali Vardhamana Rasayana, Chyawanprasha, Agastya Haritaki, Vasa and Kantakari-based formulations among others — and places these against recent published clinical and experimental work on Ayurvedic COPD management. The aim is to build a coherent picture of how Rasayana chikitsa, used both independently and as an adjuvant to Shodhana and conventional pulmonary care, may support Dhatu Poshana, immunomodulation, and Samprapti Vighatana in this chronic, progressively disabling condition, and to point toward the gaps that further clinical research still needs to close.

Keywords: Jirna Shwasakrichchhrata, Chronic Obstructive Pulmonary Disease, Tamaka Shwasa, Rasayana Chikitsa, Pippali Vardhamana Rasayana, Pranavaha Srotas.

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1. Introduction

Breathlessness that never quite lifts is one of the more distressing complaints a physician encounters, precisely because it announces itself gradually — a flight of stairs taken more slowly, a cough that lingers past the season, an evening walk cut short — long before it forces anyone to a hospital bed. This gradual, grinding quality is the signature of Chronic Obstructive Pulmonary Disease, defined in current pulmonology as a heterogeneous lung condition marked by chronic respiratory symptoms arising from abnormalities of the airways and alveoli that cause persistent, often progressive, airflow obstruction. Global estimates place the disease burden at well over 200 million cases, with projections suggesting the number could approach 600 million by mid-century, and the toll is not confined to smokers alone; a substantial share of cases in India and other low- and middle-income countries trace back to household biomass smoke, occupational dust, and outdoor air pollution rather than cigarettes.

Modern medicine manages COPD reasonably well at the level of symptom control — bronchodilators, inhaled corticosteroids, pulmonary rehabilitation, and increasingly biologic agents all have a place — but none of these reverse the underlying structural damage, and long-term pharmacotherapy carries its own burden of side effects and cost. It is exactly this gap, between control and cure, where classical Ayurvedic thought has something distinct to contribute.

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Ayurveda never described a disease called COPD, naturally enough, but its account of Shwasa Roga — breathing disorders arising from Vata and Kapha vitiation obstructing Pranavaha Srotas — maps with striking consistency onto the clinical picture of chronic, irreversible airway disease. Among the five varieties of Shwasa described by Charaka, Tamaka Shwasa is the one most often equated with obstructive airway disease in contemporary Ayurvedic scholarship, while its long-standing, treatment-resistant form — Jirna or Chirakari Shwasa, shading at its most severe into Maha Shwasa — corresponds closely to established, symptomatic COPD rather than to a fresh respiratory illness.

What makes the Ayurvedic model worth revisiting is not simply the terminological overlap but the therapeutic architecture built around it. Where allopathic treatment is largely palliative, classical texts frame the management of chronic Shwasa around Shodhana to clear obstructed channels, Shamana to pacify aggravated Doshas, and, crucially, Rasayana to rebuild what the disease has worn away — Dhatu strength, respiratory reserve, and general Vyadhikshamatva or disease resistance. Rasayana is not a single drug but a therapeutic category defined in the very first chapter of Charaka's Chikitsa Sthana as that which delays ageing, restores optimal function to the tissues, and sharpens the body's capacity for Agni and immunity. Applied to a wasting, chronic respiratory illness, this rejuvenative dimension addresses precisely what symptom-suppressing bronchodilators cannot touch. This review brings together the classical description of Jirna Shwasakrichchhrata, the textual and pharmacological basis for Rasayana intervention in this condition, and the recent Ayurvedic clinical literature that has begun testing these classical claims in real patients.

2. Aim and Objectives

- To review the Ayurvedic understanding of Jirna Shwasakrichchhrata and its correlation with Chronic Obstructive Pulmonary Disease as described in modern pulmonology.
- To compile the classical Nidana, Samprapti, and Chikitsa principles of Shwasa Roga relevant to its chronic, progressive form.
- To examine the concept, mechanism, and specific formulations of Rasayana chikitsa applicable to this condition.
- To survey recent published clinical and experimental literature on Ayurvedic and Rasayana-based management of COPD.

3. Materials and Methods

This is a review article compiled from classical Ayurvedic Samhitas — Charaka Samhita, Sushruta Samhita, and Ashtanga Hridaya, along with their principal commentaries — and later compendia such as Bhaishajya Ratnavali and Sharangdhara Samhita, which detail Rasayana formulations indicated in Shwasa and Kasa Roga. These were supplemented with a search of peer-reviewed Ayurvedic and biomedical literature published in the last five years across databases including PubMed, DHARA, and AYUSH Research Portal, using the keywords Tamaka Shwasa, COPD, Rasayana, Pippali Vardhamana Rasayana, Abraka Bhasma and Jirna Shwasa. Relevant case reports, clinical trials, and pharmacological studies were reviewed and synthesised narratively rather than through a systematic meta-analytic protocol, in keeping with the descriptive-review design of this study.

4. Modern Perspective: Chronic Obstructive Pulmonary Disease

The Global Initiative for Chronic Obstructive Lung Disease (GOLD) currently describes COPD as a heterogeneous lung condition characterised by chronic respiratory symptoms — dyspnoea, cough, sputum production, exacerbations — due to abnormalities of the airways that cause persistent, often progressive, airflow obstruction. Its two classical pathological faces, chronic bronchitis and emphysema, usually coexist in varying proportion in any given patient. Cigarette smoking remains the most extensively studied risk factor, but the 2023 GOLD etiology classification now formally recognises several other pathways to the disease — biomass and occupational exposure, early-life lung growth impairment, asthma-COPD overlap, and genetic predisposition such as alpha-1 antitrypsin deficiency — and Indian cohort data confirm that a considerable proportion of COPD here occurs in people who have never smoked, with pollution-related disease disproportionately affecting women. Because airflow limitation, once established through small-airway remodelling and alveolar destruction, is largely irreversible, the disease trajectory tends toward gradual decline punctuated by acute exacerbations, and current management — bronchodilators, inhaled corticosteroids in selected phenotypes, pulmonary rehabilitation, and oxygen or biologic therapy in advanced disease — aims chiefly to slow this trajectory rather than reverse it.

5. Ayurvedic Perspective: *Jirna Shwasakrichchhrata*

Ayurveda situates all disorders of breathing under Shwasa Roga, arising when aggravated Vata, carrying along disturbed Kapha, obstructs the Pranavaha Srotas and disturbs the normal movement of Prana Vayu through the chest. Charaka enumerates five varieties — Maha Shwasa, Urdhva Shwasa, Chhinna Shwasa, Tamaka Shwasa, and Kshudra Shwasa — of which the first three are described as difficult or impossible to cure, Tamaka Shwasa as chronic but manageable, and Kshudra Shwasa as mild and self-limiting. *Jirna Shwasakrichchhrata*, understood as the chronic, long-standing, difficult-to-reverse state of breathlessness, corresponds most closely to established Tamaka Shwasa that has progressed over years, with its more advanced and irreversible presentation shading toward the classical description of Maha Shwasa.

This describes Tamaka Shwasa as breathlessness accompanied by cough and a sense of nausea or discomfort, occurring when Vata, its passage blocked by Kapha lodged at the joints and channels, becomes provoked and reverses direction upward. The patient characteristically experiences a whistling or wheeze-like sound (*Ghurghurakam*), cannot lie flat (*Utthana Prabhava Shwasa*), feels some relief sitting upright, and the attacks are aggravated by cold, damp weather, and dust — descriptions that map closely onto the modern clinical picture of orthopnoea, wheeze, and environmentally triggered exacerbation seen in obstructive airway disease. *Nidana*, or causative factors, include *Ruksha* and *Sheeta Ahara-Vihara*, exposure to dust and smoke, suppression of natural urges, excessive exertion, and repeated Kapha-Vata vitiating habits — a list that resonates with the modern risk-factor profile of smoking, biomass exposure, and occupational dust.

The *Samprapti*, or pathogenesis, begins with *Nidana Sevana* vitiating Vata and Kapha in combination; this vitiated Dosha pair lodges in the Pranavaha, Udakavaha, and sometimes Annavaha Srotas, obstructing their normal channels (*Srotorodha*) and disturbing the physiological course of Prana Vayu, which is forced to move in a reverse (*Pratiloma*) direction, producing the characteristic laboured, noisy breathing. Over time, repeated episodes deplete *Dhatu*, particularly *Rasa* and *Rakta*, weaken *Agni*, and diminish *Ojas*, so that what begins as an episodic Vata-Kapha disturbance becomes a chronic, tissue-depleting illness — the very state that justifies *Rasayana* intervention rather than *Shamana* alone.

6. Rasayana: Concept and Rationale in Jirna Shwasa

Charaka opens his account of Rasayana by defining it not as a single drug class but as any measure capable of delivering the best of what the tissues, senses, and complexion can achieve — the ability of Rasa Dhatu right down to Shukra to receive optimal nourishment, and thereby to slow senescence, prevent disease, and extend a vigorous life. Two broad routes are described: Kutipravesika, an elaborate, hospital-style rejuvenation requiring seclusion, and the far more clinically practical Vatatapika, administered to the ambulatory patient continuing ordinary life. In a chronic, tissue-depleting illness such as Jirna Shwasakrichchhrata, Rasayana is not an afterthought once the acute Dosha vitiation has been pacified; it addresses the Dhatukshaya, diminished Agni, and lowered Vyadhikshamatva that both cause and result from repeated Shwasa episodes, essentially working to prevent the next exacerbation rather than merely treat the current one.

Contemporary Ayurvedic clinical writing on COPD converges on broadly the same sequence that classical texts prescribe for Kaphaja-Vataja disorders of the chest: Deepana-Pachana to correct Agni before any further intervention, Snehapana with a Kapha-Vata balancing Ghrita, gentle Abhyanga and Swedana, a Shodhana step — usually Virechana, since Tamaka Shwasa is understood to carry a Pittanubandha even though Kapha-Vata predominate — and finally sustained Rasayana. A recently published review of an Ayurvedic COPD management protocol, for instance, described exactly this sequence: Dipana with Panchakola Churna, Snehapana with Kantakari Ghrita, Abhyanga with Tila Taila followed by Ushma Sweda, Virechana with Vidangatanduladi Churna, and Pippali Vardhamana Rasayana as the concluding rejuvenative step, on the reasoning that COPD correlates best with Tamaka Shwasa where Pitta rides alongside the primary Kapha-Vata involvement.

Pippali Vardhamana Rasayana

Among Rasayana formulations specific to respiratory disease, Pippali (*Piper longum*) occupies a position that later compendia elevate almost to a category of its own. Administered in a gradually ascending and then descending dose schedule over roughly the length of a Chandrayana-style regimen, Pippali is credited in classical texts with Kapha-Vata pacifying, Deepana, and Rasayana properties combined, making it particularly suited to a Kapha-obstructed, Vata-deranged Srotas such as is seen in chronic Shwasa. Modern pharmacological interest in piperine and related alkaloids as bronchodilatory and anti-inflammatory agents lends the classical claim some mechanistic plausibility, and a recent comparative clinical study reported that Pippali Rasayana used as an adjuvant to standard inhaled therapy produced measurably better improvement in lung function and symptom scores than standard therapy alone, without the safety concerns sometimes raised about long-term use of certain Rasa-based Rasayanas.

Chyawanprasha and Amalaki-based Rasayana

Chyawanprasha, built around Amalaki (*Emblica officinalis*) processed with a supporting cast of Dashamoola and other Vata-Kapha balancing drugs, is the most widely used general respiratory Rasayana in both classical and contemporary practice. Its antioxidant load, concentrated in Amalaki, has been associated in recent work with measurable improvement in ventilatory parameters such as forced vital capacity, offering one of the more accessible entry points for sustained Rasayana use in patients who may not tolerate more elaborate Shodhana-based protocols.

Guduchi Rasayana

Guduchi (*Tinospora cordifolia*) stands among the most extensively studied Rasayana Dravyas in contemporary Ayurvedic pharmacology, credited classically with Tridosahara action but particularly valued for pacifying Kapha and Pitta while supporting Agni and Ojas. In the context of Jirna Shwasakrichchhrata, Guduchi's traditional description as Vyadhikshamatva-enhancing and Jwaraghna finds a natural application in a disease marked by repeated exacerbations and progressive immune vulnerability, and it is frequently incorporated into Kasa-Shwasa formulations either as Swarasa, Kwatha, or Satva, or combined with other Rasayana Dravyas as an adjuvant Rasayana. Recent pharmacological studies have highlighted its immunomodulatory and anti-inflammatory alkaloid and glycoside content, lending mechanistic support to its long-standing classical use as a general-purpose Rasayana in chronic, tissue-depleting respiratory disease.

Agastya Haritaki and Vasa-Kantakari group

Agastya Haritaki, a Haritaki-based Leha described in Bhaishajya Ratnavali specifically for Shwasa-Kasa, combines Rasayana action with active Kapha-Vata pacification and is traditionally continued through the aggravating seasons — Varsha and Sharad — when patients with chronic obstructive disease are most prone to exacerbation. Vasa (*Adhatoda vasica*) and Kantakari (*Solanum species*), while more Shamana than strictly Rasayana in classification, are consistently paired with Rasayana formulations in classical protocols for their Kaphaghna, Shwasahara, and mild expectorant action, supporting Srotoshodhana ahead of tissue-level rejuvenation.

Herbomineral Rasayanas(Rasaushadhi):

Formulations such as Swarna (Suvarna) Bhasma, Abhraka Bhasma, Tankana Bhasma, Lagumalini Vasanta Kalpa appear in classical Rasayana literature on chronic respiratory and metabolic disease for their reputed Rasayana and immunomodulatory action, though their herbomineral nature demands considerably more caution. Abhraka Bhasma is described in Rasa Shastra texts as Rasayana and Balya to the Pranavaha Srotas, traditionally combined with Kapha-pacifying Churnas in obstinate Kapha-Vata respiratory disease, while Tankana Bhasma is valued in classical Kasa-Shwasa formulations for its Kapha-Chhedana and Srotoshodhana action, helping to clear the sticky, obstructive Kapha that blocks Pranavaha Srotas in Jirna Shwasa. Lagumalini Vasanta, a compound herbomineral Rasayana built around Swarna and Abhraka Bhasma along with Loha, Naga, and Vanga Bhasma, is described in classical formularies as a Vata-Kapha-Shamaka and Rasayana preparation indicated in chronic Kasa-Shwasa and Jirna Jwara, and finds mention in contemporary practice as a rejuvenative adjuvant in prolonged, debilitated respiratory illness. Even well-established Rasa Dravyas — Swarna, Abhraka, Tankana, and compound preparations such as Lagumalini Vasanta alike — require standardised preparation, appropriate Shodhana of the mineral component, and monitored dosing for long-term use in a chronic disease population.

7. Discussion

Reading the classical description of Tamaka Shwasa against the modern clinical picture of COPD, the correspondence is close enough to be clinically useful rather than merely of historical interest: both are chronic, both worsen with cold and pollutant exposure, both feature progressive, largely irreversible airway narrowing, and both eventually erode overall functional capacity rather than remaining confined to the lungs. Where the Ayurvedic model earns its keep is in refusing to stop at Dosha-pacification. By building Rasayana into the core of long-term management — not as an optional tonic once symptoms have settled, but as the therapeutic answer to the Dhatukshaya and diminished Vyadhikshamatva that chronic Shwasa itself produces — classical practice anticipated, in its own idiom, what modern pulmonology now frames as the need to address deconditioning, nutritional depletion, and immune vulnerability alongside airflow obstruction.

The recent clinical literature reviewed here, while still limited in scale and mostly confined to case reports and small comparative studies, is at least consistent in direction: Pippali Vardhamana Rasayana, whether used alone or alongside conventional bronchodilator therapy, appears repeatedly across these reports to improve symptom scores and selected lung function parameters, and no serious adverse events have been documented in the published protocols. What the field still lacks, and what this review cannot manufacture from its sources, is a large, appropriately powered randomised trial with standardised outcome measures — spirometric parameters, validated dyspnoea and quality-of-life scales, and exacerbation frequency followed over at least a year — that could test the Rasayana hypothesis with the rigour COPD, as a leading global cause of mortality, genuinely warrants. The herbomineral Rasayanas in particular need this scrutiny extended to safety data before wider clinical recommendation.

8. Conclusion

Jirna Shwasakrichchhrata, read through the classical lens of Tamaka and, in its most entrenched form, Maha Shwasa, offers a coherent Ayurvedic frame for understanding chronic, irreversible airway disease as a disorder that spreads well beyond the lungs into Dhatu depletion and diminished Ojas. Within that frame, Rasayana chikitsa — led by Pippali Vardhamana Rasayana but supported by Chyawanprasha, Agastya Haritaki, and the Vasa-Kantakari group, with herbomineral options reserved for carefully monitored use — is not a supplementary afterthought but the therapeutic step that specifically targets the chronicity of the disease. The early clinical evidence is encouraging rather than conclusive, and larger, methodologically rigorous studies are needed before Rasayana therapy can be integrated confidently into mainstream COPD care; until then, it stands as a well-reasoned and clinically promising adjuvant rather than a replacement for established pulmonary treatment.

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