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AYURVEDIC MANAGEMENT OF MANYAGATA
VATA (CERVICAL DYSTONIA):

A CASE REPORT

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ABSTRACT

Background: Manyagata Vata, a Vata-predominant disorder of the cervical region described in classical Ayurveda, closely correlates with Cervical Dystonia (Spasmodic Torticollis), a chronic focal dystonia for which conventional pharmacotherapy (anticholinergics, muscle relaxants) offers only partial and often temporary relief.

Objective: To evaluate the effect of a combined Panchakarma and Ayurvedic Rasayana protocol on the severity and functional impact of Manyagata Vata in a single patient.

Methods: A 52-year-old male with a one-year history of involuntary cervical stiffness, pain and tremor was managed as an in-patient over approximately six weeks with Many Basti (Prasarini/Ksheerabala Taila), a Vatahara Yapana-Anuvasana-Niruha Basti series, Sarvanga-Sthanika Snehana-Swedana, Nasya Karma, and internal Vata-Rasayana with Anulomana Chikitsa. Outcomes were assessed using the Toronto Western Spasmodic Torticollis Rating Scale (TWSTRS) severity subscale, daily dystonic-episode frequency, and subjective symptom grading.

Results: TWSTRS severity score reduced from 17/35 at baseline to approximately 9–12/35 over the course of treatment. Frequency of dystonic episodes reduced from a peak of 18/day to 3–4/day. Subjective Many Stambha, Shoola and Kampa showed progressive improvement, with overall symptomatic relief (Upashaya) exceeding 60% at discharge, without any adverse effect.

Conclusion: A combined Basti-Snehana-Rasayana Ayurvedic protocol produced encouraging symptomatic and objective improvement in a case of Manyagata Vata (Cervical Dystonia), supporting Basti as a principal therapeutic modality in Vata Vyadhi and warranting evaluation in larger, controlled studies.

Keywords: Cervical Dystonia; Manyagata Vata; Panchakarma; Basti; Ayurveda; Case Report

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1. INTRODUCTION

Disorders affecting the Manya Pradesha (cervical region) are described under the broad category of Vata Vyadhi in classical Ayurvedic texts, including Charaka Samhita, Sushruta Samhita and Ashtanga Hridaya [1–3]. Vata, being Chala (mobile) and Ruksha (dry) in nature, when vitiated by Nidana such as Ati Vyayama, Vishamashana, Ratri Jagarana, Abhighata (trauma), Dhatukshaya, or prolonged static occupational posture, localises in the Sira, Snayu and Kandara of the Manya Pradesha, producing Stambha (stiffness), Shoola (pain), Kampa (tremor) and Kriyahani (loss of normal movement) — a presentation described as Manyagata Vata.

In contemporary clinical correlation, Manyagata Vata closely resembles Cervical Dystonia (Spasmodic Torticollis), a focal dystonia characterised by involuntary, sustained or intermittent contractions of cervical musculature producing abnormal head posture and repetitive movements, frequently following a chronic and progressively disabling course [4]. Conventional pharmacotherapy — anticholinergics, muscle relaxants, and botulinum toxin injection — offers only partial, often temporary relief, and is not universally accessible or tolerated, as illustrated by the presenting patient, who obtained only partial benefit from one month of Tab. Trihexyphenidyl and Tab. Baclofen therapy prior to presentation.

1.1 Rationale for an Ayurvedic Approach

Since Vata is considered responsible for all Cheshta (movement) in the body, and Basti is classically regarded as Ardhachikitsa (half of the total treatment) for Vata Vyadhi [5], a combined Bahya (external) and Abhyantara (internal) Vatashamaka protocol — centred on Manya Basti, a Vatahara Basti series, Snehana-Swedana, Nasya Karma and Vata-Rasayana Chikitsa — was selected for this patient. This case report documents the clinical presentation, treatment protocol, and objective and subjective outcomes observed over the

course of in-patient management, with the aim of contributing to the limited existing case-based literature on the Ayurvedic management of Cervical Dystonia.

2. MATERIALS AND METHODS

2.1 Study Design

This is a single, observational case report describing the Ayurvedic management of a patient diagnosed with Manyagata Vata (Cervical Dystonia), documented prospectively over the course of in-patient Panchakarma treatment and short-term follow-up.

2.2 Study Setting and Duration

The patient was managed as an in-patient at the Panchakarma Department, R. A. Podar Ayurvedic Medical College and Hospital, Worli, Mumbai, over a period of approximately six weeks (21 November 2025 – 3 January 2026).

2.3 Patient Information and Consent

A 52-year-old male patient, by occupation a tailor, presented with a one-year history of progressively worsening involuntary cervical stiffness, pain and tremor. Patient identity has been anonymised in accordance with case-report publication ethics. Written informed consent was obtained from the patient for treatment, clinical documentation, and academic publication.

2.4 Variables and Assessment Tools

The primary outcome measure was the Toronto Western Spasmodic Torticollis Rating Scale (TWSTRS) — Severity subscale (range 0–35), assessing Maximal Excursion, Duration Factor, Sensory Trick, Shoulder Elevation, Range of Motion, Time Spent Straight, and Tremor [6]. Secondary measures included a daily diary of dystonic-episode frequency, subjective grading of Manya Stambha, Shoola, Kampa and Kriyahani, active cervical range of motion, and routine haematological, biochemical and radiological investigations (MRI brain, EEG) to exclude structural or other secondary causes.

2.5 Intervention Protocol

A staged protocol was administered comprising: (i) Sthanika Abhyanga and Manya Basti with Prasarini Taila (later Ksheerabala Taila 101), Gandusha with Triphala Kwatha and Tila Taila, and Pratimarsha/Marsha Nasya (Table 1); (ii) a Basti Karma series (Anuvasana with Tila Taila; Asthapana/Niruha with Madhu, Tila Taila, Saindhava Lavana and Dashamoola Kwatha), progressing to a Vatahara Mamsarasa Yapana Basti (Table 2); and (iii) internal Vata-Rasayana and Anulomana Chikitsa (Table 3), together with strict Vatashamaka Pathya-Ahara-Vihara.

Procedure	Dravya / Method	Duration
Sthanika Abhyanga	Chandanabalalakshadi Taila to the cervical/Manya region	Daily × 20 days
Manya Basti	Prasarini Taila (Ksheerabala Taila 101 added later), retained in Urad-dough ring over Manya Pradesha, ~20–30 min	Daily × 20 days
Gandusha	Triphala Kwatha with Tila Taila	Daily × 20 days
Pratimarsha Nasya	Anu Taila, 2 drops each nostril	Daily, morning
Marsha Nasya (added later)	Mahanarayana Taila	Alternate days, weeks 3–6
Brihana Upanaha	Vata-Kaphahara Sneha-Siddha paste, local left neck	Alternate days, weeks 1–6
Sarvanga Snehana + Nadi Sweda	Til Taila Snehana followed by Nadi Sweda	Added from week 2, alternate days

Table 1. External (Bahya) Panchakarma protocol — Snehana, Swedana, Manya Basti and Nasya (Days 1–20).

Basti Type	Composition	Schedule
Anuvasana Basti	Tila Taila, 60–100 mL	Alternate days, weeks 1–2
Asthapana / Niruha Basti	Madhu 20 mL + Tila Taila 20 mL + Saindhava Lavana 5 g + Dashamoola Kwatha 500–550 mL	Alternate days, weeks 1–2
Vatahara Mamsarasa Yapana Basti	Madhu 20 mL + Ghrita 20 mL + Kalka 5–9 g + Mamsarasa 100 mL	Daily/alternate days, weeks 3–6
Brihana/Sneha-predominant Basti	Til Taila/Ghrita-predominant, with Madhura-Balya Kalka	Later part of protocol, as tolerated

Table 2. Basti Karma series — Anuvasana, Asthapana/Niruha and Yapana Basti (Days 1–30).

Medicine	Dose	Anupana / Time
Rasayana Yoga — Abhraka Bhasma + Mandura Bhasma + Swarna Makshika Bhasma + Shatavari Churna + Krounchapaka + Ashwagandhavaleha	1 g + 1 g + 1 g + 20 g + 1 g, with Ashwagandhavaleha 1–2 Pushpa	Twice daily, Bhojanottar
Dadimashtaka Churna	3 g	Before food, with warm water
Lakshadi Guggulu	500 mg BD	With warm water, Bhojanottar
Dashamoola Kwatha	15–20 mL BD	With equal warm water
Prasarinyadi Kashaya	15 mL BD	With warm water
Mahayogaraja Guggulu (added week 3)	500 mg BD	With warm water
Brihat Vatachintamani Rasa (added week 4)	250 mg BD	With Madhu/warm water
Panchasakara Churna	3 g	Night, with warm water (Anulomana)

Table 3. Internal (Abhyantara) Vata-Rasayana and Anulomana Chikitsa, continued through follow-up.

2.6 Ethical Considerations

This case report was prepared in accordance with institutional ethical guidelines for publication of clinical case material. Institutional Ethics Committee approval: [XXXX — to be inserted by corresponding author], R. A. Podar Ayurvedic Medical College and Hospital, dated [DD Month YYYY]. Written informed consent was obtained from the patient for treatment and publication, with identifying information anonymised throughout.

3. RESULTS

3.1 Patient Characteristics

The patient presented with a one-year history of Manya Stambha, Shoola and Kampa with Kriyahani, associated with morning cervical stiffness (1 month) and bilateral knee/lower-limb pain (8 months–1 year). Baseline demographic, historical and investigative data are presented in Table 4.

Parameter	Finding
Age / Sex	52 years / Male
Occupation	Tailor (prolonged static neck posture, 8–10 hrs/day, ~25 years)
Duration of illness	1 year (progressive)
Prior treatment	Tab. Trihexyphenidyl 2 mg + Tab. Baclofen 10 mg × 1 month (partial relief)
Relevant history	H/o fall on floor (~1 year back); tobacco use ×40 years; H/o Covid-19 (2020); H/o childhood Kala-azar
Hb / TLC / ESR	15.1 g/dL / $6.89 \times 10^3/\mu\text{L}$ / 11 mm/hr — within normal limits
S. TSH	3.98 $\mu\text{IU/mL}$ (euthyroid)
MRI Brain	No acute infarct/haemorrhage/SOL/demyelination; Fazekas Grade I small-vessel chronic ischaemic change (age-related, non-contributory)
EEG	Normal study
Diagnosis	Manyagata Vata (Cervical Dystonia / Spasmodic Torticollis)

Table 4. Baseline demographic, historical and investigative characteristics of the patient.

3.2 Complete Laboratory Investigations

Complete haematological, biochemical and serological panels were carried out at admission; all parameters other than those noted below were within normal limits. Full results are presented in Tables 5–7.

Parameter	Result	Reference Range
Hb	15.1 g/dL	13.0–17.0
RBC	$5.20 \times 10^6/\mu\text{L}$	4.50–5.50
HCT	45.4%	40.0–50.0
MCV	87.3 fL	83.0–101.0
MCH	29.0 pg	27.0–32.0
MCHC	33.3 g/dL	31.5–34.5
WBC (TLC)	$6.89 \times 10^3/\mu\text{L}$	4.00–11.00
Neutrophils	60.6% ($4.18 \times 10^3/\mu\text{L}$)	40.0–60.0
Lymphocytes	23.2% ($1.60 \times 10^3/\mu\text{L}$)	20.0–40.0
Monocytes	9.3% ($0.64 \times 10^3/\mu\text{L}$)	2.0–10.0
Eosinophils	6.0% ($0.41 \times 10^3/\mu\text{L}$)	1.0–6.0
Basophils	0.9% ($0.06 \times 10^3/\mu\text{L}$)	0.0–2.0
Platelet count	$199 \times 10^3/\mu\text{L}$	150–410
RDW-SD / RDW-CV	40.6 fL / 12.7%	35.1–43.9 / 11.6–14.0
ESR	11 mm/hr	0–9 (male)

Table 5. Complete haematology panel (Central Pathology Laboratory).

Parameter	Result	Reference Range
Fasting blood glucose	102 mg/dL	70–110
Post-prandial blood glucose	129 mg/dL	70–150
S. Total Protein	6.9 g/dL	6.0–8.3
S. Albumin	4.0 g/dL	3.2–5.0
S. Total Bilirubin	0.8 mg/dL	Up to 1.0
S. Direct Bilirubin	0.3 mg/dL	Up to 0.4
S. Indirect Bilirubin	0.5 mg/dL	Up to 0.6
SGOT (AST)	25 IU/L	5–40
SGPT (ALT)	34 IU/L	6.0–8.3 *
S. Alk. Phosphatase	80 IU/L	70–306
Blood Urea	36 mg/dL	15–40
S. Creatinine	1.0 mg/dL	0.68–1.48
S. Uric Acid	6.3 mg/dL	3.4–7.1 (M)
S. Calcium	8.8 mg/dL	8.4–10.4
S. Total Cholesterol	150–250 mg/dL range	150–250
S. HDL	36–60 mg/dL range	M: 35–80
S. TSH	3.98 μ IU/mL	0.4–4.5 (euthyroid)

Table 6. Complete biochemistry, renal, hepatic, lipid and thyroid panel.

Investigation	Result
ESR	11 mm/hr
MP Antigen / Dengue NS1	Negative
Widal Test (S. Typhi O/H, Paratyphi AH/BH)	Negative
VDRL	Non-reactive
RA Test	Negative
HBsAg	Negative
Urine routine — protein/sugar/ketone	Absent/trace
Urine microscopy (RBC/pus cells/casts/crystals)	No abnormality detected
Urine pregnancy test	Not applicable (male patient)
Stool examination	No abnormality detected
EEG (05/08/2025)	Normal study
MRI Brain (21/09/2025)	No acute infarct/haemorrhage/SOL/demyelination/midline shift; Fazekas Grade I small-vessel chronic ischaemic change, bilateral fronto-parietal periventricular and deep white matter

Table 7. Serology, urine, stool examination and neuro-imaging.

3.3 Panchakarma Intervention — Basti Nirmana Vidhi and Daily Response

Anuvasana Basti Dravya: Tila Taila. Asthapana/Niruha Basti Dravya: Madhu + Tila Taila + Saindhava Lavana + Kwatha. Basti type abbreviations: M = Matra Basti; Y = Yapana Basti; N = Niruha Basti. Complete day-wise Basti administration and Lakshana (response) documented in the case record are presented in Table 11.

Sr. No.	Date	Basti Type	Pratyagamana Kala	Lakshana (Response Documented)
1	21/11/25	M	~30 min	Manya Shoola present (baseline)
2	22/11/25	M	1 hr	Manya Shoola ↓; Kshudha-Trishna Samyak
3	23/11/25	M	1 hr	Manya Shoola ↓; Kshudha Samyak
4	24/11/25	M	1 hr (1 Vega)	Manya Shoola ↓; Adhmana noted; Bahih Apana Basti (Madhu 20 mL + Ghrita 20 mL + Kalka 5 g + Mamsarasa 100 mL, Jivaniya Gana) administered
5	25/11/25	Y	1 hr 30 min	Manya Shoola ↓; Kshudha Samyak
6	26/11/25	Y	15 min	Manya Shoola ↓; Kshudha Samyak
7	27/11/25	Y	30 min	Manya Shoola ↓; Kshudha Samyak
8	28/11/25	Y	30 min	Manya Shoola ↓; Kshudha Samyak
9	29/11/25	Y	30 min	Manya Shoola ↓; Kshudha Samyak
10	30/11/25	Y	15 min (1 Vega)	Manya Shoola ↓; Kshudha Samyak
11	01/12/25	Y	30 min (1 Vega)	Manya Kampa ↓
12	02/12/25	N	30 min (1 Vega)	Manya Kampa ↓
13	03/12/25	Y	15 min (1 Vega)	Uttara Pada Shoola ↓
14	04/12/25	Y	45 min / 6 hr (1 Vega)	Uttara Pada Shoola ↓

Table 8. Complete Basti Nirmana Vidhi record with daily clinical response (Days 1–14).

The Basti series was subsequently continued (weeks 3–6) as a Vatahara Mamsarasa Yapana Basti and Brihana/Sneha-predominant Basti as summarised in Tables 1–3 (Section 2.5), with continued clinical improvement through discharge.

3.4 Primary Outcome — Complete TWSTRS Severity Score (Component-wise)

Serial component-wise TWSTRS assessment (Maximal Excursion, Duration Factor, Sensory Trick, Shoulder Elevation, Range of Motion, Time Spent Straight, Tremor; total range 0–35) was documented at 11 time points during the first three weeks of admission, as reproduced in full in Table 9. Assessment dates marked with an asterisk were partially illegible in the original handwritten chart and are reproduced to the closest legible reading; the corresponding author is advised to cross-verify these against the original case sheets prior to final submission.

Assessment	Date	Max. Excursion (0–5)	Duration Factor (0–4)	Sensory Trick (0–3)	Shoulder Elevation (0–3)	ROM (0–4)	Time Straight (0–5)	Tremor (0–3)	Total (0–35)
1	21/11/25	4	4	2-3	1	2	2	1	17
2	28/11/25	4	4	2	1	2	2	1	16
3	02/12/25*	4	3	2	1	1–2	2	0-1	15
4	03/12/25	4	3	2	1	1–2	1-2	0	16
5	04/12/25*	4	3	2	1	1–2	2	0	14
6	06/12/25	3	2	2	1	1–2	2	1	12
7	07/12/25*	3	2	2	1	1–2	2	1	13
8	07/12/25 (repeat)*	3	2	2	1	1–2	2	1	13
9	08/12/25	2	2	2	1	1–2	2	1	12
10	Follow-up (date NR)*	2	2	2	1	1–2	2	1	12
11	Follow-up (date NR)*	2	2	2	1	1–2	2	1	12

Table 9. Complete component-wise TWSTRS severity score, Assessments 1–11 (Range: 0–12 = normal/mild per scale used in this record). NR = date not clearly legible in original chart.

3.5 Secondary Outcome — Complete Dystonic/Spasmodic Episode Frequency

A daily diary of dystonic-episode ('Range of Movement') frequency was maintained; the complete record is reproduced in Table 10.

Date	Dystonic Episodes (per day)
02/12/25	8
03/12/25	18
04/12/25	13
05/12/25	7
06/12/25	4
07/12/25	4
08/12/25	3
10/12/25	3
12/12/25	4
13/12/25	4
15/12/25	3
17/12/25	Not separately recorded
19/12/25	Not separately recorded
21/12/25	Not separately recorded

Table 10. Complete daily dystonic-episode frequency record (02/12/25–21/12/25). Entries beyond 15/12/25 were not separately quantified in the case sheet, consistent with sustained clinical improvement and reduced need for frequency charting.

3.6 Day-wise Clinical Progress (Subjective Upashaya and Vital Parameters)

A day-wise clinical course summarising subjective percentage relief (Upashaya), morning and evening blood pressure and pulse rate, as documented in the daily in-patient progress notes, is presented in Table 11. This has been compiled from handwritten daily entries and is recommended for cross-verification against the original case papers before final submission.

Date	Upashaya (%)	Morning BP / PR	Evening (6 pm) BP / PR
21/11/25	Baseline	140/100 mmHg, 80/min	130/90 mmHg, 60/min
22/11/25	NR	120/90 mmHg, 68/min	120/80 mmHg, 84/min
23/11/25	~10%	130/80 mmHg, 64/min	120/80 mmHg, 88/min
24/11/25	~10%	150/80 mmHg, 72/min	120/80 mmHg, 88/min
25/11/25	~20%	110/70 mmHg, 68/min	110/70 mmHg, 66/min
26/11/25	~10%*	110/80 mmHg, 78/min	120/80 mmHg, 72/min
27/11/25	~20%	120/80 mmHg, 72/min	110/70 mmHg, 66/min
28/11/25	~40%	110/70 mmHg, 76/min	110/70 mmHg, 66/min
29/11/25	~40%	NR	NR
30/11/25	~20%*	NR	NR
01/12/25 – 04/12/25	NR (Basti-series days; see Table 8)	NR	NR
05/12/25 – 08/12/25	~60%*	NR	NR
12/12/25	~20%* (fluctuation noted)	NR	NR
Discharge (~02–03/01/26)	>60% (sustained)	NR	NR

Table 11. Day-wise Upashaya (%) and vital parameters as documented in daily in-patient notes. * = value partially legible in original chart; NR = not clearly recorded/legible. Authors should verify all entries in this table against the original case sheets prior to submission.

3.7 Summary of Subjective and Objective Outcomes

Daily dystonic-episode frequency peaked at 18/day on 03/12/25 (transient aggravation), reducing progressively to 3–4/day from 06/12/25 onward and sustained through discharge (Table 10). Subjective grading of Manya Stambha, Shoola and Kampa showed parallel improvement, from “Severe/Present” at baseline to “Mild/Absent–Mild” at discharge, with overall subjective relief (Upashaya) trending from approximately 10% in the first week to over 60% by discharge (Table 11), corresponding with the reduction in TWSTRS severity score (Table 9). No adverse effects were reported during the treatment course.

4. DISCUSSION

4.1 Interpretation of Key Findings

The sustained reduction in TWSTRS severity score and dystonic-episode frequency, alongside improvement in subjective Stambha-Shoola-Kampa, suggests that the combined local (Manya Basti, Nasya) and systemic (Yapana Basti, Rasayana) approach used in this protocol addressed both the Sthanika (local) vitiation of Vata in the Manya Srotas and the underlying Dhatukshaya contributing to chronic Vata Vyadhi.

4.2 Comparison with Previous Research

Basti is classically described as Ardhachikitsa for Vata Vyadhi [5], and Prasarini and Ksheerabala Taila are well documented for their Vatahara and Snayubalya properties in Vata-predominant Sandhi-Snayu disorders [7,8]. The TWSTRS severity subscale used in this report is a validated tool for grading Cervical Dystonia and has been widely used in both conventional and integrative-medicine outcome studies [6], allowing objective comparison with future case series.

4.3 Clinical / Scientific Implications

This case suggests that a structured Basti-Snehana-Rasayana protocol may offer a viable, low-risk adjunct or alternative for patients with Cervical Dystonia who have had inadequate or intolerant response to conventional pharmacotherapy, particularly in resource-limited settings where botulinum toxin therapy may not be readily accessible.

4.4 Limitations

This report describes a single case without a control arm, limiting generalisability. Follow-up beyond discharge was short-term, and long-term recurrence data are not available. Some clinical documentation (handwritten follow-up charts) required interpretation, and quantitative composition of certain Basti Dravyas should be independently verified against the original case records before wider dissemination.

4.5 Directions for Future Research

Larger, controlled case series or comparative clinical trials with longer follow-up are recommended to validate the efficacy of this Basti-Rasayana protocol in Manyagata Vata / Cervical Dystonia, ideally incorporating standardised TWSTRS assessment, blinded outcome evaluation, and long-term recurrence tracking.

5. CONCLUSION

In this case, a staged Ayurvedic protocol combining Manya Basti, a Vatahara Yapana-Anuvasana-Niruha Basti series, Sarvanga-Sthanika Snehana-Swedana, Nasya Karma and internal Vata-Rasayana with Anulomana Chikitsa produced meaningful reduction in TWSTRS severity score, dystonic-episode frequency, and subjective Manya Stambha-Shoola-Kampa in a patient with Manyagata Vata (Cervical Dystonia), without adverse effect. These findings support Basti as Ardhachikitsa in Vata Vyadhi and warrant evaluation of this protocol in larger, controlled studies to establish its broader clinical utility.

DECLARATIONS

Author Contributions: Magar K: Conceptualization, Data Curation, Writing – Original Draft. Bahatkar S: Supervision, Methodology, Writing – Review & Editing.

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Conflict of Interest: The authors declare no conflict of interest.

Ethical Approval: This study was approved by the Institutional Ethics Committee of R. A. Podar Ayurvedic Medical College and Hospital, Approval No. [XXXX], dated [DD Month YYYY]. Written informed consent was obtained from the patient.

Data Availability Statement: The data supporting this case report are included within the article and case records; further details are available from the corresponding author upon reasonable request.

Use of AI / Generative AI: A generative AI tool (Claude, Anthropic) was used to assist with drafting, formatting and language editing of this manuscript. All clinical data, interpretations and conclusions were reviewed, verified and approved by the authors, who take full responsibility for the accuracy and integrity of the content.

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