Vipadika (Kshudra Kushtha): An Integrative Review of Ayurvedic Pathogenesis, Clinical Features, Modern Dermatological Correlates, and Therapeutic Perspectives

Prashant Prabhu Koyte[1*], Bhagyesha K[2]

[1]P.G. Scholar, Dept. Of P.G. Studies in Kayachikitsa, K.V.G. Ayurveda Medical College and Hospital, Ambate Adka, Sullia, D. K. District, Karnataka, India -574327.

[2]Guide, Professor and Hod, Dept. Of P.G. Studies in Kayachikitsa, K.V.G. Ayurveda Medical College And Hospital, Ambate Adka, Sullia, D. K. District, Karnataka, India – 574327

Corresponding Author*
Prashant Prabhu Koyte
Email ID: prashantkoyte@gmail.com

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Abstract

Vipadika is described in Ayurvedic literature among the Kshudra Kushtha and is characterized primarily by fissuring of the palms and soles, accompanied by pain and, in some descriptions, itching and burning. These manifestations may interfere with walking, occupational activities, manual function, and quality of life. Similar clinical presentations occur in modern dermatological conditions, including palmoplantar psoriasis, chronic hand eczema, plantar xerosis, and palmoplantar keratoderma. This narrative review examines the classical description, etiological factors, pathogenesis, clinical manifestations, diagnostic considerations, dermatological differentials, and therapeutic principles of Vipadika, drawing on the supplied dissertation, A Comprehensive Clinical Study of Dhatturabeejadi Taila in Vipadika, and relevant contemporary dermatological literature. Classical Ayurvedic concepts are considered alongside modern clinical descriptions without assuming that Vipadika corresponds exclusively to a single biomedical diagnosis. Ayurvedic descriptions emphasize Dosha–Dushya involvement, particularly Vata and Kapha, in the development of fissuring and associated symptoms. Modern dermatology recognizes epidermal barrier impairment, inflammation, hyperkeratosis, contact dermatitis, and mechanical stress as possible contributors to similar manifestations. Accurate clinical assessment is essential for differential diagnosis and appropriate management. Ayurvedic therapeutic principles include Nidana Parivarjana, individualized Dosha-based treatment, Shamana Chikitsa, and suitable external therapies. However, the effectiveness and safety of specific formulations require further investigation. Standardized diagnostic criteria, validated outcome measures, systematic safety monitoring, and controlled clinical trials are necessary to establish the clinical utility of Ayurvedic interventions in Vipadika.

Keywords: Vipadika; Kshudra Kushtha; palmoplantar fissures; palmoplantar psoriasis; hand eczema; Ayurvedic dermatology; skin barrier; narrative review.

Introduction

Skin disorders involving the palms and soles are clinically important because these anatomical sites are essential for locomotion, handling objects, occupational activities, and routine self-care. Painful fissures may produce considerable discomfort and functional limitations, particularly when they extend into deeper layers of the skin or become secondarily infected.

In Ayurveda, Kushtha represents a broad group of dermatological disorders classified according to their clinical manifestations, Dosha involvement, affected tissues, and prognosis. Within this framework, Vipadika is described among the Kshudra Kushtha. Its characteristic manifestations include Pani Sphutana, or fissuring of the palms; Pada Sphutana, or fissuring of the soles; and Teevra Vedana, or severe pain. Itching and burning are also described in the classical accounts discussed in the supplied dissertation.

Vipadika is traditionally understood as a Dosha-related disorder, commonly associated with Vata–Kapha involvement. This interpretation provides a framework for understanding dryness, roughness, fissuring, and associated symptoms within Ayurvedic pathophysiology. The classical literature also describes dietary, behavioral, and therapeutic considerations relevant to its management.

From a contemporary dermatological perspective, however, palmoplantar fissuring is a clinical manifestation rather than a single disease entity. It may occur in inflammatory dermatoses, disorders of keratinization, xerosis, and irritant or allergic contact dermatitis. Palmoplantar psoriasis is one important differential diagnosis, but its identification requires consideration of the overall clinical presentation and, when appropriate, additional investigations.

Consequently, Vipadika should not automatically be equated with palmoplantar psoriasis or any other single modern diagnosis. A clinically useful review must distinguish the

classical disease concept from possible biomedical correlates and identify areas in which further evidence is required.

The present review examines these dimensions to establish a structured understanding of Vipadika and its relevance to contemporary clinical practice.

Methodology

This article follows a narrative review approach. The primary conceptual source was the supplied dissertation, *A Comprehensive Clinical Study of Dhatturabeejadi Taila in Vipadika*, particularly its sections on Ayurvedic classification, Nidana, Samprapti, Lakshana, Chikitsa, and modern dermatological differentials.

Relevant contemporary literature on palmoplantar psoriasis and hand eczema was additionally considered to contextualize the diagnostic and therapeutic discussion. Selected publications were identified through PubMed-indexed literature.

This article is not a systematic review. A reproducible database search strategy, formal study-selection process, risk-of-bias assessment, and quantitative synthesis were not undertaken. Accordingly, it should not be interpreted as an exhaustive assessment of all available evidence.

Ayurvedic Concept of Vipadika

Classification and clinical identity

Vipadika is described among the Kshudra Kushtha in several Ayurvedic texts, including the Charaka Samhita and Ashtanga Hridaya, as summarized in the supplied dissertation. The clinical description centers on fissures affecting the hands and feet, with pain as a prominent symptom.

The term is clinically associated with the development of cracks or fissures, particularly on the palms and soles. Depending on the presentation, these lesions may be accompanied by dryness, roughness, itching, burning, and localized discomfort.

The designation Kshudra Kushtha reflects its position within the classical classification of Kushtha. It should not be interpreted to mean that every presentation is mild or functionally insignificant. Severe fissuring can substantially impair daily activities.

Classical descriptions of Lakshana

The principal clinical features described in the dissertation include the following:

- **Pani Sphutana:** Cracking or fissuring of the palms.
- **Pada Sphutana:** Cracking or fissuring of the soles.
- **Teevra Vedana:** Severe pain associated with fissures.
- **Kandu:** Itching.
- **Daha:** Burning sensation.

The dissertation also discusses the descriptions of Pani Dari, Pada Dari, and Teevra Aarti in the Ashtanga tradition, together with itching, burning, and pain in the classical descriptions attributed to Sushruta.

These manifestations provide a useful symptom-based framework for clinical documentation. Nevertheless, their intensity and distribution may vary among patients. The presence of fissures alone is insufficient to establish the diagnosis because several unrelated dermatological conditions can produce similar lesions.

Dosha involvement

The supplied dissertation principally characterizes Vipadika as a Vata–Kapha-predominant disorder.

Within the Ayurvedic explanatory framework, Vata involvement is associated with Rukshata, roughness, cracking, and pain, whereas Kapha-related features may contribute to thickening and changes in the consistency of affected tissues. Burning and inflammatory manifestations may indicate an additional Pitta component in selected presentations.

These interpretations are relevant to traditional clinical assessment and individualized treatment planning. They should, however, be understood as concepts within Ayurvedic pathophysiology rather than direct equivalents of specific inflammatory pathways established in modern dermatology.

Nidana: Etiological considerations

The dissertation discusses dietary, behavioral, and constitutional factors in the context of Kushtha and Vipadika.

Ahara-related factors include Viruddha Ahara, Adhyashana, consumption of food during indigestion, and certain dietary patterns described in the classical texts. The dissertation also records curd consumption and other dietary exposures among the factors observed in its clinical population.

Vihara-related factors include Diwaswapna, Vegadharana, and selected forms of inappropriate physical activity or lifestyle practices.

The Ayurvedic concept of Nidana Parivarjana emphasizes identifying and avoiding factors considered relevant to the individual patient's presentation.

These traditional factors should not automatically be interpreted as proven biomedical causes of palmoplantar fissuring. Contemporary clinical assessment should additionally investigate repeated washing, detergent exposure, occupational irritants, friction, footwear, excessive moisture, dry environmental conditions, and relevant medical history.

The relationship between specific Ayurvedic Nidana and objectively diagnosed palmoplantar disorders remains an important area for prospective research.

Samprapti: Ayurvedic Understanding of Disease Development

The Samprapti of Kushtha is explained through the interaction of Dosha and Dushya. The classical framework discussed in the dissertation emphasizes the involvement of Tridosha and the tissues or factors collectively described as Twak, Rakta, Mamsa, and Lasika.

The progression of disease can be examined through the stages of Shatkriyakala:

1. **Sanchaya:** Initial accumulation of a disturbed Dosha.
2. **Prakopa:** Further aggravation of the Dosha.
3. **Prasara:** Spread of the aggravated Dosha.
4. **Sthana Sanshraya:** Localization in susceptible tissues.
5. **Vyakti:** Manifestation of recognizable clinical features.
6. **Bheda:** Development of more differentiated or established disease patterns.

Applied conceptually to Vipadika, this model describes the progression from predisposing factors and Dosha disturbance to localized manifestations involving fissuring and pain. The model also provides a rationale for early attention to aggravating factors and the selection of individualized interventions.

A modern mechanistic interpretation requires caution. Shatkriyakala and Dosha–Dushya concepts are traditional explanatory constructs and should not be treated as validated molecular stages of epidermal disease.

Nevertheless, both traditional and contemporary approaches recognize the importance of disease duration, aggravating exposures, tissue condition, clinical severity, and recurrence in treatment planning.

Modern Dermatological Perspective

Palmoplantar psoriasis

Palmoplantar psoriasis is a chronic inflammatory dermatosis affecting the palms, soles, or both. It commonly presents with well-demarcated erythematous and hyperkeratotic plaques, scaling, and painful fissures. Because the affected skin is subjected to repeated pressure and movement, fissures may interfere with walking, standing, and manual work.

The condition can be persistent and difficult to manage. Clinical examination should include assessment of other psoriasis-affected sites and nail changes. Psoriatic arthritis and associated comorbidities may also require consideration.

Palmoplantar psoriasis is an important differential diagnosis for Vipadika because both can involve fissuring, pain, and thickened skin. However, these overlapping symptoms do not establish diagnostic equivalence. The distribution, morphology, accompanying findings, clinical history, and investigations when indicated should guide diagnosis.

Chronic hand eczema and palmoplantar dermatitis

Hand eczema is a heterogeneous inflammatory condition that may arise from irritant contact dermatitis, allergic contact dermatitis, atopic dermatitis, or overlapping causes. Similar eczematous processes can affect the feet.

Clinical manifestations include erythema, scaling, dryness, vesiculation in some presentations, itching, and fissuring. Repeated exposure to water, soaps, detergents, chemicals, and occupational irritants may contribute to disease persistence.

The diagnostic assessment should include a detailed history of occupational and domestic exposures, previous episodes, atopic background, and the distribution of lesions. Patch testing may be appropriate when allergic contact dermatitis is suspected. Fungal investigations or other tests may be required according to the clinical differential.

Plantar xerosis and heel fissures

Plantar xerosis refers to excessive dryness of the skin of the feet. Reduced stratum corneum hydration and impaired barrier function may produce roughness, scaling, and fissuring.

Heel fissures can develop when dry or hyperkeratotic skin is exposed to repetitive pressure and mechanical stress. The resulting cracks may cause tenderness, pain, and, in more severe cases, bleeding.

Relevant contributors include environmental dryness, repeated exposure to irritants, inappropriate footwear, mechanical loading, and certain systemic conditions. Diabetes mellitus and peripheral neuropathy warrant particular attention because they may increase the risk of complications in affected feet.

Although plantar xerosis and heel fissures share important symptoms with Vipadika, they are descriptive clinical findings and may arise from different underlying causes.

Palmoplantar keratoderma

Palmoplantar keratoderma comprises a heterogeneous group of disorders characterized by abnormal thickening of the stratum corneum on the palms and soles. The condition may be inherited or acquired and can present with diffuse or focal hyperkeratosis.

Fissures may develop when thickened skin loses flexibility or is subjected to repeated mechanical stress. The age at onset, distribution, family history, associated clinical features, and pattern of keratinization help determine the likely diagnosis.

The presence of prominent hyperkeratosis, especially when persistent or associated with a suggestive family history, should prompt consideration of palmoplantar keratoderma rather than assuming that the presentation represents Vipadika or psoriasis.

Why these conditions should not be treated as interchangeable

Vipadika is an Ayurvedic disease category, whereas psoriasis, eczema, xerosis, and keratoderma represent distinct modern diagnostic categories or clinical entities. Their symptoms may overlap, but their causes, associated findings, prognosis, and appropriate treatments may differ.

The most defensible approach is to use Vipadika as the traditional clinical framework while independently documenting the patient's dermatological phenotype and establishing a modern diagnosis when possible.

Clinical Assessment and Differential Diagnosis

A structured assessment is essential for patients presenting with painful palmoplantar fissures.

History

The clinical history should document:

- Duration, progression, recurrence, and previous treatment.
- Whether the palms, soles, or both are affected.
- Pain, itching, burning, bleeding, discharge, and functional limitations.
- Occupational and domestic exposure to water, detergents, chemicals, friction, and footwear.
- Personal or family history of psoriasis, eczema, or keratoderma.
- Nail changes and skin lesions elsewhere.
- Relevant medical conditions, particularly diabetes and disorders associated with impaired wound healing.

Within an Ayurvedic assessment, the clinician may additionally document Prakriti, Dosha predominance, Agni, dietary patterns, lifestyle factors, and relevant Nidana.

Physical examination

Examination should assess the location and symmetry of lesions, degree of dryness, erythema, scaling, hyperkeratosis, fissure depth, tenderness, and signs of secondary infection. Nails and other skin sites should also be examined where appropriate.

Clinical photographs and standardized severity assessments may improve documentation during follow-up, provided that appropriate consent and privacy safeguards are maintained.

Investigations

Investigations should be guided by the suspected diagnosis rather than performed routinely in every patient.

- **Fungal microscopy or culture:** When dermatophyte infection is suspected.
- **Patch testing:** When allergic contact dermatitis is a plausible explanation.
- **Skin biopsy:** When morphology is atypical or the diagnosis remains uncertain.
- **Relevant systemic assessment:** When the history or examination suggests diabetes, neuropathy, vascular impairment, or another associated condition.

Differential diagnosis table

Condition	Characteristic features	Diagnostic considerations
Vipadika	Palmoplantar fissures, pain, and variable itching or burning in the Ayurvedic description	Apply classical criteria while independently evaluating the dermatological diagnosis
Palmoplantar psoriasis	Well-demarcated plaques, hyperkeratosis, scaling, and painful fissures	Examine nails and other psoriasis-affected sites
Chronic hand or foot eczema	Inflammation, scaling, itching, dryness, and fissuring	Investigate irritant, allergic, and atopic factors
Plantar xerosis	Dry, rough, scaling skin with possible fissures	Assess barrier-disrupting exposures and systemic risk factors
Palmoplantar keratoderma	Persistent focal or diffuse thickening of the palms or soles	Consider age of onset, family history, and associated findings
Dermatophyte infection	Scaling, fissuring, and sometimes asymmetric or characteristic border patterns	Perform mycological testing when indicated

Ayurvedic Management Principles

Nidana Parivarjana

Nidana Parivarjana is a central principle in Ayurvedic disease management. Its application to Vipadika involves identifying and reducing relevant dietary, behavioral, and environmental factors.

From a contemporary perspective, this principle can be incorporated into a practical prevention plan that reduces repeated irritant exposure, excessive washing, friction, and other clinically identified triggers. Such measures should be individualized according to the established diagnosis.

Shodhana Chikitsa

The supplied dissertation discusses Shodhana therapies, including Vamana, Virechana, Basti, and Raktamokshana, within the broader Ayurvedic management of Kushtha.

The choice of a classical intervention is traditionally guided by Dosha predominance, disease characteristics, and patient assessment. These procedures should not be regarded as interchangeable or universally indicated for palmoplantar fissures.

Their use requires appropriately qualified supervision, individualized assessment, and consideration of contraindications and potential adverse effects. Robust condition-specific evidence is needed to determine their clinical effectiveness for patients diagnosed with Vipadika.

Shamana Chikitsa

The dissertation discusses Shamana approaches and selected classical preparations used in Kushtha and Vipadika. The treatment rationale is traditionally based on the patient's presentation and the perceived involvement of Dosha and Dushya.

For scientific evaluation, each preparation should be described in terms of its exact ingredients, manufacturing method, dosage form, quality-control parameters, intended route, treatment duration, and safety monitoring.

Evidence supporting one formulation cannot automatically be generalized to other Ayurvedic preparations, and classical indications should be distinguished from demonstrated clinical efficacy.

Bahya Chikitsa

External treatment is particularly relevant to a disorder characterized by localized fissuring. The supplied dissertation describes Dhatturabeejadi Taila, Vipadikahara Lepa, Tandula Lepa, and selected medicated oil or ghee preparations among the classical external approaches.

The dissertation identifies Dhatturabeejadi Taila as a formulation prepared using Dhattura beeja, Sarshapa taila, and Manakanda Ksharajala. Its selection for clinical evaluation is based on the classical rationale presented in the source.

However, traditional use alone does not establish effectiveness or safety. Dhattura contains pharmacologically active and potentially toxic tropane alkaloids. Therefore, a preparation containing Dhattura requires rigorous ingredient authentication, manufacturing standardization, toxicological assessment, and route-specific safety evaluation. It should not be assumed safe for unsupervised home preparation or use on broken skin.

Any claim that this formulation provides antimicrobial, anti-inflammatory, or wound-healing benefits should be supported by direct, appropriately designed studies of the actual formulation rather than inferred solely from the properties of individual ingredients.

Modern Management and Supportive Skin Care

Management of palmoplantar fissuring should address the underlying diagnosis and the factors contributing to impaired skin integrity.

Barrier protection and moisturization

Regular use of an appropriate emollient may improve skin hydration and reduce further cracking in patients with xerosis or selected eczematous conditions. Avoidance of harsh cleansers and unnecessary irritant exposure is also important.

Deep, bleeding, infected, or persistently painful fissures require clinical assessment rather than reliance on moisturization alone.

Diagnosis-specific treatment

Treatment should be determined by the underlying disorder. Palmoplantar psoriasis may require prescription topical treatment, phototherapy, or systemic therapy according to severity and response. Hand or foot eczema may require irritant avoidance, appropriate anti-inflammatory treatment, and investigation of contact allergy when indicated.

Fungal infections, keratoderma, and fissuring associated with systemic disease require different management strategies.

The use of a traditional topical preparation should not delay diagnosis or replace indicated evidence-based treatment, particularly in patients with diabetes, neuropathy, impaired circulation, or signs of infection.

Prevention and recurrence

Preventive care includes identifying aggravating exposures, protecting the skin during wet work, selecting appropriate footwear, reducing excessive friction, and maintaining a consistent skin-care routine. Patients should receive clear instructions regarding follow-up and warning signs.

For research purposes, recurrence should be measured separately from short-term symptom improvement. A reduction in fissure severity during treatment does not necessarily demonstrate long-term disease control.

Critical Appraisal of the Evidence

The available literature supports the clinical relevance of palmoplantar fissuring and provides a substantial traditional description of Vipadika. However, several evidence limitations need to be acknowledged.

First, classical disease descriptions provide a conceptual and clinical framework but do not establish equivalence with modern dermatological diagnoses. Studies that recruit patients solely on the basis of fissuring may include several distinct disorders.

Second, evidence relating specifically to Vipadika is limited in comparison with the broader literature on psoriasis and eczema. The supplied dissertation discusses previous clinical work on Vipadika and evaluates Dhatturabeejadi Taila, but its findings should not be interpreted as definitive evidence for all patients with palmoplantar fissuring.

Third, treatment evaluation requires standardized outcomes. Subjective measures such as pain, itching, and burning should be combined with reproducible assessment of fissure number, depth, extent, and healing. Validated quality-of-life and functional measures would help determine whether changes in skin lesions translate into meaningful patient benefit.

Fourth, the safety of topical preparations must be assessed independently of their traditional use. This is especially important when ingredients possess known toxicological properties or when a preparation is applied to damaged skin.

Finally, longer follow-up is necessary to determine whether treatment reduces recurrence, maintains improvement, and produces acceptable adverse-event rates.

Research Priorities

Future research on Vipadika should address the following priorities:

1. **Development of operational diagnostic criteria:** Establish reproducible criteria for identifying Vipadika and document the corresponding modern dermatological diagnosis wherever possible.
2. **Phenotypic classification:** Differentiate patients with predominantly dry fissuring from those with inflammatory plaques, prominent hyperkeratosis, eczematous changes, or evidence of infection.
3. **Validated outcome measures:** Combine symptom scales with standardized clinical assessments, functional outcomes, and quality-of-life instruments.
4. **Standardization of Ayurvedic interventions:** Document ingredient identity, preparation methods, batch consistency, stability, quality control, and route-specific safety.
5. **Controlled clinical trials:** Conduct adequately powered comparative studies using prespecified endpoints, appropriate comparators, transparent reporting, and systematic adverse-event monitoring.
6. **Long-term follow-up:** Measure recurrence, durability of improvement, treatment adherence, and functional recovery after treatment ends.
7. **Integration of clinical disciplines:** Encourage collaboration between Ayurvedic clinicians and dermatologists to improve diagnostic accuracy and ensure that research participants receive appropriate treatment for the underlying condition.

These priorities would help distinguish traditional therapeutic rationale from demonstrated clinical benefit and improve the reproducibility of research in Ayurvedic dermatology.

Limitations of the Present Review

This narrative review is based principally on the supplied dissertation and selected contemporary dermatological literature. It does not constitute a systematic review, and no formal critical appraisal of all eligible clinical studies was conducted.

The discussion of Ayurvedic pathogenesis reflects classical explanatory concepts rather than validated biomedical mechanisms. In addition, modern dermatological disorders are discussed as possible clinical correlates of the manifestations of Vipadika, not as universally equivalent diagnoses.

The available information is insufficient to establish the comparative effectiveness of individual Ayurvedic treatments, the long-term prevention of recurrence, or the safety of every formulation described in classical texts.

Conclusion

Vipadika is described in Ayurveda among the Kshudra Kushtha and is characterized principally by fissuring of the palms and soles, pain, and variable associated symptoms. Its classical interpretation emphasizes Dosha–Dushya involvement, particularly Vata–Kapha predominance, and supports an individualized approach incorporating Nidana Parivarjana, appropriate therapeutic selection, and external treatment.

Modern dermatology demonstrates that similar clinical manifestations may arise from palmoplantar psoriasis, chronic hand or foot eczema, plantar xerosis, palmoplantar keratoderma, and other conditions. Therefore, clinical

similarity should not be mistaken for diagnostic equivalence.

A clinically useful integrative approach requires the preservation of the traditional Ayurvedic description alongside independent assessment of the underlying dermatological disorder. Future studies should prioritize standardized diagnostic criteria, validated clinical outcomes, formulation quality, safety monitoring, appropriate comparators, and longer follow-up.

Such an approach may strengthen the scientific evaluation of Ayurvedic interventions for Vipadika while maintaining diagnostic accuracy and patient safety.

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