



International Journal of Traditional and Integrative Health Sciences

An Official Publication of Susruta Academic Publishing House

Peer Reviewed

Volume 1, Issue 1 (2026)

ISSN: [to be assigned]

DOI: [to be assigned]

REVIEW ARTICLE

Targeting Marma Chikitsa in the Management of Shoulder Pain, Shoulder Stiffness and Frozen Shoulder (Avabahuka): A Narrative Review

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ABSTRACT

Frozen shoulder, or adhesive capsulitis, is a common and disabling condition of the glenohumeral joint characterised by progressive pain, stiffness and restriction of both active and passive range of motion. It affects approximately 2–5% of the general population, rising to 10–30% among people with diabetes mellitus, and remains a therapeutic challenge because its underlying trigger is largely unknown and conventional pharmacological and surgical options offer variable, often short-lived, relief. In classical Ayurveda, this presentation is described under *Avabahuka*, a *Vata*-predominant disorder of the *Amsa Sandhi* (shoulder joint) accompanied by *Kapha* involvement causing stiffness. *Marma Chikitsa*, the Ayurvedic science of stimulating vital anatomical points (*marma*) where muscle, vessel, ligament, bone and joint converge, has re-emerged as a non-pharmacological, low-cost and low-risk intervention for musculoskeletal pain. This narrative review synthesises classical Ayurvedic descriptions of *Avabahuka* and *Marma Sharira* with the emerging clinical literature on *Marma Chikitsa* in shoulder pain, stiffness and frozen shoulder, and examines the proposed neurophysiological basis — including gate-control analgesia, parasympathetic modulation and local circulatory effects — that may underlie its observed benefits. Across the available case studies, case series and pilot work, Marma stimulation at *Amsa*, *Kurpara*, *Kshipra*, *Manibandha*, *Indrabasti* (*Aani*) and *Bahvi* points was consistently associated with reduced pain scores and improved shoulder range of motion within 10–15 days of treatment. While encouraging, the existing evidence base is limited to small, largely uncontrolled studies. We conclude that *Marma Chikitsa* holds credible promise as an adjunct or stand-alone modality for *Avabahuka*/frozen shoulder and merits evaluation through adequately powered randomised controlled trials with standardised protocols and objective outcome measures.

Keywords: Marma Chikitsa, Avabahuka, Frozen shoulder, Adhesive capsulitis, Shoulder stiffness, Ayurveda, Vata Vyadhi, Amsa Marma

Introduction

Shoulder pain and stiffness are among the most frequent musculoskeletal complaints encountered in both primary care and specialist orthopaedic practice, and frozen shoulder (adhesive capsulitis) represents one of their most functionally disabling forms. The condition is defined by a pathological process of glenohumeral capsular fibrosis and contracture that restricts both active and passive movement, typically progressing through painful, stiffening and thawing phases over months to years^{1–5}.

Epidemiological data place the prevalence of adhesive capsulitis at roughly 2–5% of the general population, with a mean age of onset around 55 years and a mild female predominance (approximately 1.4:1)^{4,5}. Diabetes mellitus is the strongest identified risk factor, conferring a three- to five-fold increase in risk and affecting 10–30%

of diabetic patients compared with 2–5% of the general population, while thyroid disease confers an additional 1.5–2-fold risk^{1,3,4}. Despite decades of research, the precise trigger of primary (idiopathic) adhesive capsulitis remains unclear, and current biomedical management — analgesics, intra-articular corticosteroids, physiotherapy, hydrodilatation and, in refractory cases, manipulation under anaesthesia or arthroscopic capsular release — provides variable and often incomplete relief, particularly for pain and early stiffness^{1,5,6}.

Ayurveda, the traditional Indian system of medicine, describes a closely corresponding clinical entity, *Avabahuka*, under the eighty varieties of *Vata Vyadhi* (*Vata*-predominant disorders). Acharya Sushruta classifies *Avabahuka* as a disease of the *Amsa Sandhi* (shoulder joint) arising from vitiation of *Vata dosha* with *Anubandha* (association) of *Kapha dosha*, producing

Shoola (pain), *Stambha* (stiffness) and *Sankocha* (restricted movement) that closely mirror the clinical picture of adhesive capsulitis; *Amsa Shosha*, or wasting/dryness of *Sleshaka Kapha* at the shoulder joint, is regarded as its preliminary stage^{7–10}.

Among the non-pharmacological tools available within classical Ayurveda, *Marma Chikitsa* — the stimulation of *marma*, vital points described as the confluence of *Mamsa* (muscle), *Sira* (vessels), *Snayu* (ligaments), *Asthi* (bone) and *Sandhi* (joints) — has attracted renewed clinical and scientific interest as a rapid, non-invasive intervention for pain and restricted mobility [11–13]. This review brings together the classical Ayurvedic understanding of *Avabahuka* and *Marma Sharira* with the modern biomedical understanding of frozen shoulder, and critically appraises the currently available clinical evidence on *Marma Chikitsa* in the management of shoulder pain, stiffness and frozen shoulder.

Methods

A narrative literature review was conducted using PubMed, Scopus, Google Scholar, ResearchGate and the AYUSH Research Portal, supplemented by hand-searching of Ayurveda-focused journals (Journal of Ayurveda and Integrated Medical Sciences, International Ayurvedic Medical Journal, International Research Journal of Ayurveda and Yoga, AYUSHDHARA). Search terms included combinations of “Marma Chikitsa”, “Marma therapy”, “Avabahuka”, “frozen shoulder”, “adhesive capsulitis”, “shoulder pain”, “shoulder stiffness” and “Vata Vyadhi”. Classical Ayurvedic treatises — Sushruta Samhita, Charaka Samhita and Ashtanga Samgraha/Hridaya — were consulted directly for the foundational descriptions of Marma Sharira and Avabahuka. Case reports, case series, pilot studies and narrative/critical reviews published in English were included; sources not related to shoulder pathology or lacking a clearly described Marma protocol were excluded. Given the paucity of controlled trials in this area, this review is intentionally narrative rather than systematic, and is intended to map the current evidence landscape and generate hypotheses for future controlled research.

Avabahuka: the Ayurvedic construct of frozen shoulder

Ayurvedic nosology situates *Avabahuka* within *Vata Vyadhi*, disorders arising from the derangement of *Vata*

dosha, the physiological principle governing movement, and the nervous and musculoskeletal systems. In *Avabahuka*, aggravated *Vata* becomes lodged in the *Amsa Sandhi*, producing *Ruk* (pain) and *Sankocha* (contraction/stiffness), while an associated depletion or dryness of *Sleshaka Kapha* — the lubricating sub-type of *Kapha* responsible for joint nourishment and smooth articulation — contributes to progressive restriction of movement, corresponding to *Amsa Shosha* in earlier stages.^{7–10} This dual *Vata-Kapha* pathology maps reasonably well onto the modern biomedical picture of capsular fibrosis (a *Vata*-type dry, contractile change) superimposed on synovial and capsular inflammation (a *Kapha*-type process of tissue thickening), lending biological plausibility to the classical correlation between *Avabahuka* and adhesive capsulitis that is now widely used in Ayurvedic clinical literature^{11, 17–22}.

Ayurvedic treatment principles for *Vata Vyadhi* in general, and *Avabahuka* in particular, favour *Snehana* (oleation), *Swedana* (sudation), *Abhyanga* (therapeutic oil massage), *Basti* (medicated enema) and local *Marma* stimulation, all aimed at pacifying *Vata*, replenishing *Sleshaka Kapha* and restoring free movement (*Cheshta*) at the joint. *Marma Chikitsa* is increasingly used either as a stand-alone rapid-acting intervention or as an adjunct within this broader *Panchakarma*-based protocol^{17–22}.

Frozen shoulder: the modern biomedical perspective

Frozen shoulder is now understood as a fibro-inflammatory process affecting the glenohumeral joint capsule and the coraco-humeral ligament, with histopathological features of synovial hyperplasia, chronic inflammatory infiltrate, and fibroblast proliferation leading to type III collagen deposition and capsular contracture^{1,5,6}. Neoangiogenesis & neoinnervation of the thickened capsule have been implicated in the disproportionate pain experienced relative to the degree of structural change, and recent work has proposed a role for central and peripheral neuro-immune interactions — including altered pain processing and a possible GABAergic contribution — in sustaining the chronic pain and stiffness of the condition⁶.

Clinically, the disorder is classified as primary (idiopathic) or secondary (following trauma, surgery or

prolonged immobilisation), and typically evolves through a painful ‘freezing’ phase, a stiff ‘frozen’ phase, and a ‘thawing’ phase of gradual recovery that may extend over one to three years.^{1–5} Standard management includes analgesics and NSAIDs, intra-articular corticosteroid injection, structured physiotherapy and stretching, hydrodilatation, and, for refractory cases, manipulation under anaesthesia or arthroscopic capsular release; however, pain relief is frequently incomplete and a proportion of patients are left with residual stiffness even after prolonged treatment.^{1, 5} This gap in durable, low-risk pain relief is the principal rationale for exploring complementary approaches such as *Marma Chikitsa*.

Marma Sharira: the science of vital points

Marma points are described in the *Sushruta Samhita* — the foundational Ayurvedic text on surgery — as 107 specific anatomical loci where *Mamsa*, *Sira*, *Snayu*, *Asthi* and *Sandhi* converge and where *Prana* (vital force) is believed to be concentrated; injury to a *marma* is classically held to be capable of causing pain, disability or, at critical points, death, which underlines their physiological significance in classical Indian surgical anatomy.^{11–13,23} *Marma* points are classified by the predominant tissue at the site (*Mamsa*, *Sira*, *Snayu*, *Asthi*, *Sandhi Marma*), by their anatomical region, and by the severity of injury they can produce (*Sadyahpranahara*, *Kalantara-Pranahara*, *Vishalyaghna*, *Vaikalyakara* and *Rujakara Marma*).^{11,13,23}

Therapeutically, gentle, sustained or rhythmic pressure, massage or tapping over a *marma* point is used to ‘open’ or stimulate the point, an approach that classical texts describe as clearing obstruction to *Prana* flow and modern authors interpret through neurophysiological and myofascial frameworks analogous to acupuncture and trigger-point therapy.^{11,12,15,24} Comparative anatomical mapping suggests considerable overlap between *marma* points and both acupuncture meridian points and recognised myofascial trigger points, although the two systems are thought to have developed independently.²⁴

Proposed mechanisms of Marma Chikitsa in shoulder pain and stiffness

The clinical effects of *Marma* stimulation in musculoskeletal pain are increasingly discussed in terms

of established pain-physiology models rather than energetic concepts alone:

- **Gate-control and neuromodulatory analgesia-** non-noxious pressure or rhythmic tapping at a *marma* point is proposed to activate large-diameter afferent fibres that pre-synaptically inhibit nociceptive transmission at the spinal dorsal horn, reducing the perception of pain arising from the shoulder joint.^{14, 16}
- **Local circulatory and myofascial effects** — sustained pressure over points such as *Amsa* and *Bahvi* is thought to improve regional blood flow and lymphatic drainage, potentially reducing peri-articular oedema and easing capsular tension, similar to the rationale for myofascial trigger-point release.^{11, 12, 24}
- **Autonomic and central modulation-** several *marma* points, particularly those close to major neurovascular bundles, are proposed to engage parasympathetic pathways and central pain-modulatory circuits, contributing to muscle relaxation and reduced protective guarding around a stiff joint.^{12, 15}
- **Segmental/kinetic-chain stimulation** — distal points on the same upper limb (*Kshipra*, *Manibandha*, *Kurpara*) are used alongside the local *Amsa* point, consistent with the classical Ayurvedic principle of treating a *Vata*-dominant joint disorder through points along its *Snayu* and *Sira* pathway rather than the affected joint alone.^{17, 19}

These mechanisms remain hypothesis-generating rather than definitively proven, and direct physiological studies of *marma* stimulation (e.g. using surface electromyography, thermography or functional imaging) in frozen shoulder specifically are still lacking; this represents an important direction for future translational research.^{12, 15}

Clinical evidence for Marma Chikitsa in Avabahuka / frozen shoulder

The published clinical literature on *Marma Chikitsa* in shoulder pain and frozen shoulder currently consists of case reports, case series and a small single-arm pilot trial; no adequately powered randomised controlled trial was identified. Across these reports, a consistent protocol

Table 1. Key marma points used in the management of Avabahuka / frozen shoulder

Marma	Type / Location	Anatomical correlation	Relevance to Avabahuka / frozen shoulder
<i>Amsa Marma</i>	Sandhi Marma (joint), Pranahara group	Glenohumeral joint / shoulder joint proper	Directly overlies the glenohumeral capsule; primary local point for capsular pain, stiffness and restricted abduction–flexion
<i>Kurpara Marma</i>	Sandhi Marma, Vaikalyakara group	Elbow joint (cubital region)	Distal Vata-pacifying point on the same kinetic chain; used to relieve referred stiffness and improve upper-limb circulation
<i>Kshipra (Hasta) Marma</i>	Sira/Snayu Marma, Vaikalyakara group	Web space between thumb and index finger (dorsum of hand)	Classical analgesic point for upper-limb pain; comparable to LI-4 in acupuncture, used for gate-control analgesia
<i>Manibandha Marma</i>	Sandhi Marma, Vaikalyakara group	Wrist joint	Facilitates distal-to-proximal circulatory flushing along the upper limb; adjunct point in the treatment sequence
<i>Indrabasti (Aani) Marma</i>	Snayu Marma	Mid-point of the upper arm, at the belly of biceps/triceps	Believed to nourish Vata-dominant Snayu (ligamentous/myofascial) tissue of the arm; reduces muscular guarding around the shoulder
<i>Bahvi Marma</i>	Snayu Marma	Proximal arm, close to the axilla	Supports vascular and lymphatic drainage of the arm and shoulder girdle, aiding reduction of peri-articular oedema and stiffness

emerges: stimulation of *Amsa marma* (the local shoulder point) combined with distal upper-limb points – *Kshipra*, *Manibandha*, *Kurpara*, *Indrabasti (Aani)* and *Bahvi* – applied for short durations (seconds to a few minutes per point) over treatment courses of 10 to 15 days, often on a twice-daily schedule.^{17–22} Reported outcomes consistently show reductions in Visual Analogue Scale (VAS) or Numerical Rating Scale (NRS) pain scores and meaningful gains in shoulder flexion,

abduction, extension and rotation within this short treatment window (Table 2).

Taken together, these reports suggest that *Marma Chikitsa* can produce clinically meaningful, rapid improvements in pain and range of motion in *Avabahuka*/frozen shoulder, often within one to two weeks – a timeframe considerably shorter than the natural history of untreated adhesive capsulitis, which classically spans months to years.^{1, 5}

Table 2. Summary of published clinical reports on Marma Chikitsa in Avabahuka / frozen shoulder

Study (design)	Sample	Marma points / protocol	Key outcome
Chouhan et al., single case study, J. Ayurveda Integr. Med. Sci. 2024 ¹⁷	1 patient, 6-month history, right shoulder	Marma Chikitsa for 10 days	Abduction improved 45°→123°, flexion 102°→165°, external rotation 53°→65°, extension 30°→45°; VAS pain 7→4→3
Chouhan et al., pilot study, J. Ayurveda Integr. Med. Sci. 2024 ¹⁸	Small pilot cohort, Avabahuka/frozen shoulder	Marma Chikitsa as an alternate Ayurvedic modality	Reported improvement in pain, stiffness and range of motion; supports feasibility of Marma-based protocols
Case series, single-arm trial, Mahatma Gandhi Ayurved College Hospital ¹⁹	10 patients	Kshipra, Manibandha, Kurpara, Indrabasti/Aani, Bahvi and Amsa marma stimulated for 0.8 s, 15–18 repetitions, twice daily on days 1, 7 and 15	Pain relief 92.6%, stiffness relief 89.3%; ROM gains: flexion 90.5%, extension 85.7%, abduction 95%, internal rotation 81.8%, external rotation 86.7%
Case study with adjunct shoulder exercises, Pt. Khushilal Sharma Ayurveda Hospital ²⁰	1 patient, 3-year history	Marma Chikitsa combined with structured shoulder exercises, 15 days	Progressive day-wise improvement in range of motion and pain reduction
Case study, Kumar A. et al ²¹	1 patient, no metabolic comorbidity	Marma Chikitsa alone	Marked symptomatic improvement; authors propose Ojas-supportive and immunomodulatory role of Marma stimulation
Case study, Int. Res. J. Ayurveda & Yoga 2025 ²²	31-year-old male, NSAID/physiotherapy non-responder	Twice-daily Marma point pressure/stimulation	NRS pain 7→1; abduction 60°→>160°, flexion 70°→>160°, extension 30°→60°

A comparative Ayurvedic trial of *Nasya* and physiotherapy in *Avabahuka* further supports the broader principle that targeted, low-cost Ayurvedic

interventions can produce measurable functional gains in this condition, reinforcing the rationale for evaluating *Marma Chikitsa* under similarly controlled conditions.¹⁶

Discussion

The convergence between the classical description of *Avabahuka* and the modern understanding of adhesive capsulitis provides a coherent framework within which *Marma Chikitsa* can be rationally applied: a *Vata*-dominant contractile, fibrotic process (capsular fibrosis) superimposed on a *Kapha*-type inflammatory, effusive process (synovitis) is addressed through points selected for their capacity to relieve *Vata*-type stiffness (*Amsa*, *Kurpara*, *Indrabasti/Aani*) while supporting circulatory clearance of the inflamed peri-articular tissue (*Bahvi*, *Manibandha*) and providing centrally mediated analgesia (*Kshipra*).^{7-13, 17-22}

Several features make *Marma Chikitsa* an attractive candidate for further evaluation: it is non-invasive, requires no pharmacological agent (and therefore carries a favourable interaction profile in patients with diabetes or thyroid disease who are already at elevated risk of adhesive capsulitis), can be delivered rapidly in an outpatient setting, and appears to produce measurable benefit within a shorter timeframe than the natural history of the untreated condition.^{1,4,17-22} Its integration with established Ayurvedic modalities such as *Abhyanga*, *Swedana* and structured shoulder exercises may further enhance outcomes, as suggested by combined-protocol case reports.²⁰

However, the evidence base has substantial limitations. Almost all available reports are single case studies or small case series without control groups, blinding, or standardised outcome assessment, introducing a high risk of bias, placebo effect and regression to the mean (frozen shoulder has a fluctuating natural course even without a specific treatment applied). Treatment protocols vary in point selection, duration, frequency and total treatment length across reports, limiting reproducibility. Objective imaging or biomarker correlates of capsular change with *Marma* treatment have not been reported, and the neurophysiological mechanisms proposed remain largely extrapolated from acupuncture and trigger-point literature rather than tested directly in *marma* stimulation.^{12,14,15,24}

Future research priorities include: randomised controlled trials comparing standardised *Marma Chikitsa* protocols against sham stimulation, physiotherapy and/or corticosteroid injection; use of

validated, blinded outcome measures (e.g. the Shoulder Pain and Disability Index, goniometric range-of-motion assessment, and diabetes-stratified analysis given the strong association between diabetes and adhesive capsulitis); mechanistic studies using electromyography, thermography, ultrasound elastography or functional neuroimaging to characterise the physiological effects of *marma* stimulation; and long-term follow-up to establish whether early gains are sustained through the natural thawing phase of the condition.

Conclusion

Avabahuka, the Ayurvedic correlate of frozen shoulder, is conceptualised as a *Vata*-predominant disorder of the shoulder joint with associated *Kapha* involvement, closely paralleling the capsular fibrosis and inflammation seen in adhesive capsulitis. *Marma Chikitsa*, targeting *Amsa*, *Kurpara*, *Kshipra*, *Manibandha*, *Indrabasti (Aani)* and *Bahvi* points, is consistently reported across available case studies and a small pilot series to reduce pain and improve shoulder range of motion within one to two weeks of treatment, and offers a plausible, low-risk, non-pharmacological option for a condition in which conventional treatment often provides incomplete relief. The current evidence, while encouraging, is preliminary and confined largely to uncontrolled reports. Well-designed randomised controlled trials with standardised *Marma* protocols, objective outcome measures and adequate follow-up are now needed to establish the true efficacy of *Marma Chikitsa* and to define its place within an integrative approach to shoulder pain, stiffness and frozen shoulder.

Competing interests

The authors declare that they have no competing interests.

Authors' contributions

All authors contributed to the concept, literature search and overall construction of this manuscript. All authors reviewed and approved the final manuscript.

Funding

Not applicable.

Availability of data and materials

The data supporting this review are obtained from classical Ayurvedic treatises (Sushruta Samhita, Charaka Samhita, Ashtanga Samgraha/Hridaya) and from published original research and review article.

Ethics approval and consent to participate

Not applicable

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CITE THIS ARTICLE

Vancouver: Verma HK, Dhabhai N. Targeting Marma Chikitsa in the management of shoulder pain, shoulder stiffness and frozen shoulder (Avabahuka): A narrative review. *Int J Tradit Integr Health Sci*. 2026;1(1): [9-14]