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REVIEW ARTICLE

Ayurvedic Phenotyping of Skin Disorders: Integrating Nidana Panchaka with Contemporary Dermatological Classification: A Narrative Review

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Abstract

Background: Structured phenotyping, the systematic capture of observable disease characteristics in standardized terminology, has become central to contemporary dermatology and to international classification projects. **Objective:** To examine, conceptually, whether the fivefold Ayurvedic diagnostic framework (Nidana Panchaka) — etiological factors (Nidana), premonitory manifestations (Purvarupa), manifested clinical features (Rupa), the diagnostic trial of suitability and unsuitability (Upashaya/Anupashaya) and pathogenesis (Samprapti) — can be documented alongside contemporary dermatological descriptors to yield an "Ayurvedic phenotype" of skin disorders. **Conceptual approach:** Classical accounts of the skin-disease category (Kushtha) from the Charaka Samhita, Sushruta Samhita and Ashtanga Hridaya are examined against contemporary dermatological classification as represented in authoritative textbooks, the WHO ICD-11 dermatological taxonomy and standardization initiatives including the Ministry of AYUSH NAMASTE portal. **Discussion:** Conceptual correspondences are identified between Nidana and etiological/contextual documentation, Purvarupa and prodromal description, Rupa and morphological phenotyping, Upashaya/Anupashaya and response-to-intervention information, and Samprapti and pathophysiological interpretation. These are affinities of documentation, not validated equivalences. A proposed integrated documentation framework is presented. **Epistemological differences, translation problems, unproven reliability and the risk of pseudo-equivalence are discussed, together with testable research directions.** **Conclusion:** An integrated framework may improve structured characterization and research communication, but it remains a conceptual proposal requiring formal validation.

Keywords: Ayurveda; Nidana Panchaka; Kushtha; phenotyping; dermatology; disease classification; case documentation; integrative medicine

Introduction

Modern dermatology has invested heavily in the disciplined description of disease. The dermatological chapter of the WHO International Classification of Diseases, 11th Revision (ICD-11), developed with dermatologists, organises skin diseases so that morphology and anatomical site are recorded as first-class information rather than buried in free text.¹ In parallel, genomics-era medicine treats systematic, ontology-based description as a scientific instrument in its own right: the Human Phenotype Ontology standardises the vocabulary of phenotypic abnormalities,² and deep-phenotyping studies in disorders such as atopic dermatitis use granular clinical capture to define severity-associated subgroups.³

Ayurvedic medicine is undergoing a comparable, if less visible, formalisation. The Ministry of AYUSH's National AYUSH Morbidity and Standardised Terminologies

Electronic (NAMASTE) portal provides standardised terminologies and national morbidity codes for Ayurveda, designed for electronic health records and for dual coding with ICD-10/11.⁴ The World Health Organization has published international standard terminologies for Ayurvedic diagnosis.⁵ This infrastructural work presumes that Ayurvedic clinical constructs can be documented with the same discipline as biomedical ones — a presumption examined more often in rhetoric than in practice.

This article takes up one specific facet of that presumption. It asks whether the fivefold Ayurvedic diagnostic framework (Nidana Panchaka) — etiological factors (Nidana), premonitory manifestations (Purvarupa), manifested signs and symptoms (Rupa), the diagnostic trial of suitability and unsuitability (Upashaya/Anupashaya) and pathogenesis (Samprapti) — can contribute to a structured phenotype of skin

disorders when documented alongside contemporary dermatological descriptors such as morphology, distribution, chronology, symptoms, etiological factors and investigations. The framework is expounded in the opening chapter of the diagnostic section (Nidana Sthana) of the Charaka Samhita and is applied throughout classical diagnosis.⁶

Two caveats govern the argument. First, the discussion is conceptual: it proposes a documentation framework, not a validated instrument. Second, no equivalence is claimed between Ayurvedic and biomedical diagnostic categories; affinities are treated as points of comparison, never as identities.

Concept of Ayurvedic Phenotyping in Skin Disorders

In clinical usage, a phenotype denotes the observable characteristics of a person or disorder — what can be seen, elicited and documented — in contrast to a diagnosis, which assigns the observed pattern to a nosological category, and to pathogenesis, which explains it. Contemporary phenotyping formalizes this act: the Human Phenotype Ontology, for instance, provides a standardized vocabulary of phenotypic abnormalities used across rare-disease and dermatological research.² In dermatology, phenotype description typically aggregates morphology, distribution, course, symptoms and response to intervention.

The term "Ayurvedic phenotyping" is used here in the same restricted, documentation-oriented sense: a documented configuration of attributes that Ayurveda recognises in a disease episode — causative exposures, prodromal features, manifested signs, therapeutic responsiveness and an inferred pathogenetic account — recorded in standardised terminology. Used this way, the term does not denote an established or standardised diagnostic system. No such system for skin disorders has been validated, and none is proposed here.

The distinction matters. Phenotype (observed attributes), diagnosis (for example, assignment of an episode to a named subtype of skin disorder (Kushtha; IAST Kuṣṭha), pathogenesis (the dosha-and-tissue account of how the disorder arose) and classification (the ordering of disorders into groups such as major and minor dermatoses) are separable levels of description in both systems. Conflating them is the commonest source of spurious integrative claims. What follows concerns the

phenotyping level — how each system documents what it observes — and not the standing of either system's diagnostic or pathogenetic interpretations.

Ayurvedic Understanding of Skin Disorders

Classical Ayurveda treats skin disease under the umbrella category of skin disorders (Kushtha), which covers presentations from circumscribed patches to widespread, disfiguring disease. The principal diagnostic account appears in the fifth chapter of the Nidana Sthana of the Charaka Samhita, with a parallel chapter in the Nidana Sthana of the Sushruta Samhita.^{6,7} Causative factors (Nidana) listed there are largely dietary and behavioural: abrupt alternation of hot and cold exposures, contrary food combinations, intake during indigestion, overeating, and certain emotionally conditioned exposures. These are classical constructs, framed in the language of humoral qualities, and should not be read as proto-lists of modern allergens or irritants.

The pathogenesis (Samprapti) is described as simultaneous vitiation of the three humours (dosha) acting upon four tissues (dushya) — the skin (Twak), muscle (Mamsa), blood (Shonita) and serous fluid (Lasika) — with deeper involvement and tissue destruction characterising the more severe types. Premonitory manifestations (Purvarupa) include disordered sweating, altered skin texture, discoloration, itching, abnormal sensation and the chronicity of even minor ulcers; manifest features (Rupa) then permit the classical texts to name diseases according to sensation, discoloration, lesion site and effect. Classification distinguishes seven major dermatoses (Maha Kushtha) from eleven minor dermatoses (Kshudra Kushtha), eighteen named types across the principal compendia. Vagbhata's Ashtanga Hridaya devotes a comparable diagnostic section to disease-specific diagnosis.⁸

The subtype names are descriptive rather than etiological: they encode colour, shape, texture, size or extent. One of them, single-patch type (Eka Kushtha), is the designation most frequently used in contemporary Ayurvedic case reporting of plaque-type psoriasis — an interpretive correlation advanced by modern authors, not a classical diagnosis of a modern entity.⁹ It does not follow that every modern dermatological disease maps onto a single Ayurvedic category.

Nidana Panchaka as a Diagnostic Framework

The opening chapter of the Nidana Sthana presents five means of diagnostic knowing: Nidana, Purvarupa, Rupa, Upashaya and Samprapti.⁶ Because the five are staged — cause before prodrome, prodrome before manifestation, manifestation before response — they invite reading as a documentation sequence rather than a list. Their classical meanings and their possible relevance to structured phenotyping are best considered separately.

Etiological factors (Nidana): In its diagnostic sense, Nidana names the causes — dietary, behavioural, environmental, psychological and traumatic — whose accumulation antecedes disease; the term also carries the secondary sense of "diagnosis" itself, an ambiguity the classical literature exploits deliberately. For phenotyping, a structured Nidana inventory would capture exposures and context: diet, occupation, seasonal and climatic setting, psychological state and accumulated habits. Contemporary practice collects similar information — contactants, occupational exposure, drug history, travel — but keeps it outside the formal lesion description. The parallel is contextual rather than conceptual identity: classical etiological categories are theory-laden, referring to humour-aggravating qualities of substances and behaviours, and cannot be transposed into biomedical etiological categories without translation loss.

Premonitory manifestations (Purvarupa): Purvarupa denotes a disease's earliest, often subtle features after onset has begun but before full manifestation. In Kushtha, the classical list — disordered sweating, altered texture, discoloration, itch and abnormal sensation — is precisely the material modern medicine would call prodromal or early presenting. Contemporary dermatology records such information descriptively, for evolving lesions and antecedent symptoms, but gives the prodrome less formal diagnostic weight than the classical framework does.

Manifested features (Rupa): Rupa is the fully manifested clinical picture — the descriptive core. It corresponds to what dermatologists document as morphology, distribution and symptoms, though the systems differ in granularity: contemporary lesion description (primary and secondary lesions, colour, surface, border) is considerably more granular than classical Rupa, which aggregates sensory, visual and systemic features into a recognisable whole.⁶

Diagnostic trial (Upashaya/Anupashaya):

Upashaya denotes the suitability- perceived benefit or non-aggravation — of diet, drug or behaviour for a suspected condition; Anupashaya its unsuitability. The classical texts treat therapeutic response as evidence that refines diagnosis.⁶ Contemporary dermatology retains this logic in the diagnostic therapeutic trial response to a targeted treatment, or lesion clearance on withdrawal of a suspected contactant but rarely formalises it within classification. As phenotyping information, response to intervention is increasingly recognised as discriminating between look-alike disorders.

Pathogenesis (Samprapti): Samprapti narrates the disease process: vitiation, spread, localisation in channels and tissues, and tissue alteration.^{6,7} It is the interpretive analogue of modern pathophysiological reasoning — histopathological and immunological mechanism — but the two accounts are built on different theory. Samprapti explains in dosha-and-tissue terms; biomedical interpretation explains in cellular and molecular terms. The two can be recorded side by side in one document; they cannot be merged into a single explanation.

Contemporary Dermatological Classification

Contemporary dermatological diagnosis rests on the disciplined reading of lesions: primary lesions (macule, papule, plaque, nodule, vesicle, bulla, pustule, wheal) and secondary changes (scale, crust, erosion, ulcer, fissure, lichenification, atrophy, scar), read together with distribution and anatomical pattern, chronology and symptoms. This morphological core is the organising skeleton of the major textbooks¹⁰⁻¹² and of the ICD-11 dermatological taxonomy, which is deliberately structured around morphology and site.

Etiological and category-based groupings overlay this core: infectious disorders (fungal, bacterial, viral, infestational); inflammatory disorders, including eczema/dermatitis and its variants and the papulosquamous diseases; pigmentary disorders; vesiculobullous disease; acneiform disorders; genetic syndromes; and neoplastic disease. Classification is periodically revised as evidence accumulates, and some diagnostic categories — atopic dermatitis is the canonical example — are anchored in formal criteria sets that standardise which features suffice for diagnosis.¹³

A further layer is clinicopathological. Histopathology adjudicates ambiguous inflammatory patterns and characterises neoplasms; dermoscopy has developed its own standardised lexicon through successive International Dermoscopy Society consensus conferences, extended to proposals for standardised reporting;^{14,15} mycology and bacteriology confirm or exclude infectious aetiology; immunological investigations — autoantibody profiles, direct immunofluorescence, patch testing — resolve immunologically mediated disease. Each modality adds descriptors that a phenotype may incorporate.^{10,11}

Two features of this edifice deserve emphasis for the comparison that follows. First, its categories are explicitly revisable and frequently contested; second, its investigative layer means that the "phenotype" of a modern dermatological disorder often includes microscopic and laboratory findings that no bedside observer could record.

Comparative Analysis: Nidana Panchaka and Contemporary Dermatological Phenotyping

The first is genuine overlap in what is recorded. Purvarupa and prodromal description both capture earliest manifestation; Rupa & morphological phenotyping both capture the visible disorder; a

structured Nidana inventory & the modern etiological and contextual history both capture antecedent exposure. That two systems record the same information, however, says nothing about their explanatory accounts agree.

The second is partial correspondence with different formal weight. Upashaya/Anupashaya treats therapeutic response as a diagnostic datum — a position contemporary dermatology practises (diagnostic trials, allergen withdrawal) but under-formalises. Samprapti and modern pathophysiological interpretation are both disease-process narratives, but one is dosha-and-tissue based, the other cellular and molecular; they can coexist within a single record without collapsing into each other.

The third is incommensurability at the level of etiology and mechanism. Classical etiological categories are defined by qualities attributed to substances and behaviours, not by biomedical agents; no direct mapping of classical Nidana onto biomedical etiology is possible without interpretation, and no mapping is validated here. Accordingly, the correspondences in Table 1 are conceptual and interpretive. They justify a common documentation architecture, not a claim that the two systems diagnose the same diseases or agree in their explanations. Evidence supporting specific correspondences remains limited and would require formal clinical validation.

Table 1. Plan Conceptual Comparison of Nidana Panchaka and Contemporary Dermatological

Ayurvedic domain	Core meaning (classical sense)	Potential phenotyping information	Contemporary dermatological analogue	Important limitation
Nidana (etiological factors)	Causative dietary, behavioural, environmental, psychological and traumatic factors preceding disease; secondarily, diagnosis itself	Structured inventory of exposures, context and accumulated habits preceding the episode	Etiological and contextual history: contactants, occupation, drugs, travel, triggers	Classical categories are theory-laden (humour-aggravating qualities); no validated mapping onto biomedical etiology
Purvarupa (premonitory manifestations)	Earliest, often subtle features after onset but before full manifestation	Documentation of prodromal and early-evolving features as a distinct disease stage	Prodromal or early clinical description; evolving-lesion history	Contemporary medicine records prodromes descriptively but assigns them less formal diagnostic weight
Rupa (manifested features)	The fully manifested clinical picture; recognisable aggregate of signs and symptoms	The descriptive core of the episode as observed at the bedside	Lesion morphology (primary and secondary lesions), colour, surface, borders, distribution, symptoms	Contemporary lesion description is considerably more granular than classical Rupa
Upashaya/Anupashaya (suitability/unsuitability of trial)	Perceived benefit or aggravation with diet, drug or behaviour, used to refine diagnosis	Response-to-intervention recorded as diagnostic information	Diagnostic therapeutic trial; allergen withdrawal; treatment responsiveness as a discriminator	Operates within dosha theory; not formalised in contemporary classification; response data can be confounded
Samprapti (pathogenesis)	Narrative of vitiation, spread, localisation in channels and tissues, and tissue alteration	Disease-process interpretation accompanying the observed phenotype	Pathophysiological interpretation: histopathological, immunological and molecular mechanisms	Built on a different theory of the body; may coexist in one record but cannot be merged with biomedical explanation

Proposed Integrated Phenotyping Model

Table 2 sets out a proposed documentation framework. Its logic is to separate a shared observable layer — descriptors that both systems can record without translation: primary and secondary lesions, colour, surface, borders, distribution, symmetry, symptoms, chronology, aggravating and relieving factors, systemic associations and investigations — from two system-specific interpretive layers.

The Ayurvedic layer records the Nidana inventory, Purvarupa, Rupa in classical terms, Upashaya/Anupashaya observations, the Samprapti account and the dosha-and-dushya assessment, coded where possible with NAMASTE morbidity codes and WHO standard terminologies.^{4,5} The contemporary layer records the clinical diagnosis, the ICD-11 code and the clinicopathological interpretation.^{1,10-12}

Table 2. Proposed Integrated Documentation Framework for Skin Disorders

Domain	Ayurvedic documentation	Contemporary dermatological documentation	Potential research utility
Patient/contextual factors	Constitution (<i>Prakriti</i>), age, season, habits	Age, sex, comorbidities, medications, social context	Case-mix adjustment; subgroup analysis
Etiological and triggering factors	<i>Nidana</i> inventory (diet, behaviour, exposure)	Contactants, drugs, infection, physical triggers	Etiological hypotheses testable in both systems
Predisposing factors	Humoural constitution and tissue susceptibility	Genetic, atopic and family history	Phenotype–context associations
Prodromal manifestations	Purvarupa	Early/pre-eruptive symptoms and evolving lesions	Early-diagnosis research; natural-history studies
Primary lesions	<i>Rupa</i> descriptors (classical)	Macule, papule, plaque, nodule, vesicle, bulla, pustule, wheal	Morphological concordance studies
Secondary lesions	<i>Rupa</i> descriptors (classical)	Scale, crust, erosion, ulcer, fissure, lichenification, atrophy, scar	Severity and chronicity indices
Colour	Classical colour descriptors (<i>Rupa</i>)	Colour notation (erythema, hyper-/hypopigmentation)	Standardisable observable field
Morphology	Classical form descriptors	Shape, configuration, induration, elevation	Inter-rater reliability testing
Surface	Texture descriptors (<i>Rupa</i>)	Smooth, scaly, keratotic, exudative	Standardisable observable field
Borders	Classical margin descriptors	Demarcated vs ill-defined; margins	Diagnostic-discrimination studies
Distribution	Classical site preference (<i>Rupa</i>)	Regional pattern; photo-exposed, flexural, extensor	Pattern-analysis datasets
Anatomical sites	Site in classical terms	Named dermatomes/regions, mucosal involvement	Mapping studies across systems
Symmetry/asymmetry	Classical pattern observation	Symmetrical vs asymmetrical involvement	Discriminating features
Symptoms	Classical symptom account (<i>Rupa</i>)	Pruritus, pain, burning; quality-of-life measures	Patient-reported outcomes linkage
Chronology and progression	Disease staging within <i>Samprapti</i>	Onset, duration, course, relapse	Natural-history and cohort studies
Aggravating factors	<i>Nidana</i> /Anupashaya observations	Provoking exposures (heat, friction, season)	Trigger-analysis research
Relieving factors	<i>Upashaya</i> observations	Ameliorating treatments or conditions	Response-based phenotyping
Relevant systemic manifestations	Classical associations	Systemic features, joint, nail, hair, mucosal signs	Multi-domain phenotyping
Investigations	Not classically defined; modern results recorded as adjunct	Histopathology, dermoscopy, microbiology, immunology	Clinicopathological correlation
Differential diagnosis	Classical distinction of subtypes	Morphological and clinicopathological differentials	Diagnostic-concordance studies
Ayurvedic pathological interpretation	<i>Dosha–dushya</i> assessment; <i>Samprapti</i> ; NAMASTE morbidity code	—	Terminology validation; dual-coding research
Contemporary clinicopathological interpretation	—	Clinical diagnosis; ICD-11 code; histopathological interpretation	Reference-standard definition

The framework is presented as a proposed conceptual structure only. It is not a validated diagnostic instrument; its domains are drawn from classical diagnostic categories^{6,7} and from contemporary

descriptive practice,¹⁰⁻¹² and their combination has not been tested. The ICD-11 Traditional Medicine module permits optional dual coding of traditional-medicine diagnoses alongside biomedical ones,¹⁶ which makes such an architecture technically feasible; feasibility is not validation.

Clinical and Research Implications

The most immediate application is documentation. A common record form would let Ayurvedic dermatology practice describe cases in ways colleagues from biomedicine can read, while preserving the system-specific interpretation that gives Ayurvedic care its logic. Structured reporting conventions already exist and could be extended: the CARE guideline specifies transparent case reporting and could carry a dual-system record,¹⁷ and diagnostic-accuracy research should follow STARD reporting.¹⁸

For research, a shared phenotype layer enables four things. Prospective observational cohorts could collect Ayurvedic and contemporary descriptors in parallel. Case-series and registry data coded in NAMASTE terms would become comparable across centres.⁴ Phenotype-based subgrouping of the kind now routine in deep-phenotyping studies³ could be tested against Ayurvedic descriptors. And communication between Ayurveda and dermatology researchers would improve, since disagreements could be located at a specific field — an exposure versus an interpretation — rather than lost in free text. None of this presupposes clinical effectiveness; it presupposes only that characterisation precedes evaluation.

Limitations and Methodological Challenges

The epistemologies differ fundamentally. Ayurvedic categories are theory-laden: dosha, dushya and the tissue channels are interpretive constructs, not directly observable entities, and a phenotype built on them inherits that theory. Contemporary classification, while also interpretive, anchors its categories in reproducible observation and laboratory testing.

Translation is a second obstacle. Classical terms carry meanings that shift across texts and commentators; standardisation efforts — the WHO terminologies and the NAMASTE portal — reduce but do not eliminate the problem,^{4,5} and transliteration and diacritical inconsistency persist across the literature. Third, reliability is unproven for much of the apparatus.

Empirical reliability research on Ayurvedic diagnostic methods is sparse; published studies of pulse, tongue and constitutional assessment, and of diagnostic agreement in a biomedical population, illustrate the difficulties of such measurement rather than establishing robust reliability.¹⁹⁻²¹ No validated integrated phenotyping instrument exists for skin disorders; the present proposal must therefore be treated as a hypothesis about documentation, not a finding about it.

Fourth, cross-system mapping invites reductionism. The modern practice of correlating Kushtha subtypes with biomedical entities — plaque psoriasis with Eka Kushtha, for example — is interpretive and contested,⁹ and reducing Ayurvedic categories to modern diagnoses would misdescribe both systems. Finally, any integrated form must guard against one-to-one disease-equivalence claims, which are presently unsupported.

Future Research Directions

Testable studies follow naturally. Expert consensus methods — modified Delphi panels and RAND/UCLA-style appropriateness exercises, already used within dermatology^{22,23} — could determine which Ayurvedic descriptors belong in an integrated form and in what terms. Standardised case-record forms could then be developed and their inter-rater reliability measured, using designs already applied to Ayurvedic diagnosis.^{20,21} Prospective observational studies could document skin disorders in both systems in parallel and examine concordance between Ayurvedic phenotype groups and contemporary diagnoses, with reference standards reported to STARD.¹⁸ Digital dermatology datasets, drawing on ontology-based vocabularies² and NAMASTE-coded records,⁴ could support clinicopathological correlation studies and, eventually, validation of an integrated classification framework. Each step would substitute evidence for plausibility

Conclusion

An integrated phenotyping framework for skin disorders is conceivable without collapsing the two systems into each other. The Nidana Panchaka offers a staged, etiology-to-response documentation sequence; contemporary dermatology contributes granular morphological description and clinicopathological depth; and terminology infrastructures on both sides make shared documentation technically feasible. The

correspondences are conceptual and interpretive, and the proposed framework is unvalidated. Its value — better structured characterisation, clearer case reporting, more comparable research — will be established only through consensus, reliability and validation studies conducted with the same discipline either system would demand of the other.

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Conflicts of Interest

There are no conflicts of interest.

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