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REVIEW ARTICLE

Role of *Panchakarma* in Urban Lifestyle: An Ayurvedic Narrative Perspective on Prevention, Restoration and Lifestyle-Related Health

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Abstract

Background: Urban living has reorganised the everyday context in which health is gained or lost. Sedentary occupation, irregular eating, screen-delayed and shortened sleep, chronic psychological load, and reduced exposure to natural light and seasonal variation have together reshaped population risk for noncommunicable disease. **Objective:** Ayurveda has long framed comparable disruptions of daily conduct (*Dinacharya*), seasonal regimen (*Ritucharya*) and digestive-metabolic capacity (*Agni*) as precursors of disease, and offers *Panchakarma*, its classical purification protocol, as a structured therapeutic response. This review examines whether, and under what conditions, that framework can be responsibly related to contemporary urban lifestyle disorders. **Conceptual approach:** Classical descriptions of *Purvakarma*, *Pradhana Karma* and *Paschat Karma*, and of *Dosha*, *Agni*, *Ama*, *Srotas*, *Dhatu* and *Mala*, are set alongside contemporary literature on sedentary behaviour, circadian disruption, allostatic load and metabolic disease, with classical principle, biomedical evidence, conceptual interpretation, clinical hypothesis and established evidence kept explicitly distinct throughout. **Discussion:** Individualisation according to *Prakriti* and clinical context, the current clinical evidence base for *Panchakarma*-based interventions, safety and contraindications, and the gap between classical description and modern validation are each examined critically, without treating *Panchakarma* as a universal detoxification procedure or a proven treatment for modern lifestyle disorders. **Conclusion:** *Panchakarma* is a structured, individualised and moderately evidenced tradition whose classical rationale intersects conceptually with several features of urban lifestyle disease. Its responsible use in contemporary urban healthcare depends on qualified clinical supervision, honest evidence framing, and continued methodologically rigorous research.

Keywords: *Panchakarma*; Ayurveda; urban health; *Dinacharya*; noncommunicable disease; integrative medicine; preventive medicine

Introduction

Urbanisation is one of the defining demographic transitions of the present century, and with it has come a reorganisation of the everyday conditions under which health behaviour occurs. The World Health Organization has described urban noncommunicable disease, persistent infectious disease risk and injury as a compounding "triple threat" for city populations, driven in part by unhealthy living and working conditions, inadequate green space and environments that discourage walking, cycling and other forms of active living.¹ This is not merely a shift of address; it is a shift in occupational structure toward sedentary and screen-mediated work, in food environments toward processed and irregularly timed eating, in sleep architecture toward later and shorter sleep under artificial and device-emitted light, and in psychosocial structure toward higher and more chronic stress load. Contemporary preventive medicine has developed a substantial evidence base describing these changes and their

association with noncommunicable disease. It has been comparatively slower to develop frameworks for restoring baseline physiological regularity once disruption has already accumulated, as distinct from treating a single, already-diagnosed condition. Ayurveda, the classical Indian system of medicine, contains an extensive tradition concerned with exactly this intermediate problem: the erosion of habitual regularity (*Dinacharya*), seasonal adaptation (*Ritucharya*) and digestive-metabolic capacity (*Agni*), and the therapeutic restoration of these through *Panchakarma* — a structured sequence of five principal purification procedures embedded within defined preparatory and post-procedural phases.

Panchakarma is frequently invoked, in both clinical and commercial literature, as a remedy for the accumulated burden of modern urban life, often under the loosely defined banner of "detoxification." This review does not adopt that framing. It instead asks, as a matter of conceptual and evidentiary examination, what a

disciplined reading of *Panchakarma's* classical rationale and contemporary evidence base can and cannot responsibly say about its role in the health of urban populations, and where the present boundaries of knowledge lie. The literature underlying this review was identified through targeted searches of PubMed, PubMed Central, Scopus-indexed Ayurveda journals and the websites of the World Health Organization and the Ministry of AYUSH, Government of India, using combinations of the terms *Panchakarma*, *Dinacharya*, *Ritucharya*, *Agni*, *Ama*, *Prakriti*, urban lifestyle,

noncommunicable disease, sedentary behaviour, sleep and allostatic load; classical textual concepts are described according to their standard treatment in secondary Ayurvedic academic literature.

Throughout this review, five categories of claim are kept deliberately distinct: classical Ayurvedic principle, contemporary biomedical evidence, conceptual interpretation, clinical hypothesis, and established evidence. Table 1 sets out this framework with a worked example for each category, and the same distinctions are marked explicitly in the text that follows.

Table 1. Framework for distinguishing categories

Category of claim	What it means in this review, with a worked example
Classical Ayurvedic principle	A statement drawn directly from classical Ayurvedic theory, presented as the tradition's own internal logic rather than as a scientific claim. Example: " <i>Panchakarma</i> is classically held to eliminate vitiated Dosha through the bodily channel nearest to its site of accumulation."
Contemporary biomedical evidence	A finding reported in peer-reviewed biomedical or clinical-epidemiological literature, cited on its own terms. Example: "Chronic sedentary behaviour and disrupted sleep are independently associated with elevated allostatic load in urban populations."
Conceptual interpretation	An explicitly labelled analogy drawn between a classical construct and a biomedical one, offered as a way of thinking about the two systems together rather than as a claim that they describe the same biological mechanism. Example: describing a phenomenological correspondence between impaired Agni and features of metabolic dysregulation.
Clinical hypothesis	A proposition that has some classical or preliminary empirical support but has not been confirmed in adequately powered, controlled trials, and is presented as a direction for research rather than as established practice guidance. Example: that individualised Basti protocols may have a restorative role in urban populations with chronic low back pain.
Established evidence	A conclusion supported by systematic review or meta-analytic synthesis of controlled trials, stated with the qualifications that synthesis itself attaches. Example: systematic reviews indicate that <i>Panchakarma</i> -based interventions for knee osteoarthritis show preliminary positive signals but remain constrained by small samples and heterogeneous protocols.

Urban Lifestyle as a Changing Health Environment

Contemporary biomedical evidence: the global decline in habitual physical activity and the corresponding rise in sedentary time have been identified by the World Health Organization as major contributors to the changing landscape of noncommunicable disease, with an estimated 500 million people projected to develop heart disease, obesity, diabetes or other noncommunicable conditions attributable to physical inactivity between 2020 and 2030 in the absence of stronger policy action.² Reviews of cardiometabolic risk note that mechanisation, urbanisation and technological change have altered how, and how much, populations move, sit and travel, with office and screen-based work now occupying a much larger share of daily time than in earlier generations.³ Sleep and circadian regularity are similarly affected. Evening exposure to light-emitting diode screens has been shown, through the melanopsin-mediated intrinsically photosensitive retinal ganglion cell pathway, to blunt nocturnal melatonin secretion and delay

circadian timing, and narrative synthesis of this literature in an Indian urban context has linked rising smartphone use with one of the highest reported prevalences of insomnia symptoms in the available cross-national data.⁴ Independently of screen exposure itself, later bedtimes, psychological arousal from digital content and irregular waking times compound the disruption of a previously more regular sleep-wake and light-dark cycle. Chronic psychosocial stress associated with urban occupational and social structures has been conceptualised in biomedicine through the construct of allostatic load — the cumulative physiological burden imposed on neuroendocrine, cardiovascular, metabolic and immune systems by repeated or unremitting stress exposure. A systematic review of this literature concludes that elevated allostatic load and allostatic overload are consistently associated with poorer physical and mental health outcomes across clinical and general population settings, and that assessment of allostatic load usefully supports understanding of the psychosocial determinants of health relevant to lifestyle medicine.⁵ Taken together,

sedentary behaviour, circadian and sleep disruption, and chronic psychosocial load describe a health environment materially different from the one in which many traditional preventive frameworks, Ayurvedic and biomedical alike, were originally formulated — a divergence that itself motivates renewed interest in structured lifestyle-restoring interventions.

Ayurvedic Concepts Relevant to Inappropriate Lifestyle and Disease Development

Classical Ayurvedic principle: Ayurvedic pathophysiology holds that health is a dynamic equilibrium among three functional principles, or *Dosha* — *Vata*, *Pitta* and *Kapha* — expressed through the tissues (*Dhatu*), waste products (*Mala*) and bodily channels (*Srotas*) of the individual, and governed by *Agni*, the digestive and metabolic capacity that transforms ingested substances into usable tissue. Classical texts describe *Agni* as existing along a spectrum of functional states, from balanced (*Samagni*) to diminished (*Mandagni*), irregular (*Vishmagni*) and excessive (*Tikshmagni*), and hold that sustained deviation from balance — through unsuitable diet, disrupted routine, suppressed natural urges or psychological disturbance — impairs digestive capacity and results in the formation of *Ama*: an incompletely processed, heavy and obstructive metabolic residue.⁶

Ama is described classically as accumulating within the *Srotas*, obstructing normal physiological transit and giving rise, over time, to a wide range of disease states; a recent narrative review frames this relationship explicitly as one of conceptual similarity, noting that chronic inflammation, oxidative stress and metabolic dysfunction as understood in contemporary biomedicine show a phenomenological — not mechanistic — resemblance to the classical description of *Ama*-related pathology.⁶ This distinction matters: the correspondence proposed in such literature is offered as a conceptual interpretation that aids cross-system understanding, not as a claim that *Ama* and, for example, circulating inflammatory cytokines are the same biological entity.

Two organising frameworks — *Dinacharya*, the daily regimen, and *Ritucharya*, the seasonal regimen — are classically presented as the primary preventive countermeasures to *Agni* impairment and *Ama* accumulation, prescribing regular waking and sleeping times, appropriately timed meals, physical activity suited to individual constitution, and behaviour calibrated to

seasonal change. When digestive disturbance nonetheless progresses to a stage where *Ama* has become entrenched — clinically inferred from features such as coating of the tongue, heaviness, lethargy and irregular elimination — classical texts distinguish between management by dietary and behavioural correction (*Samsarjana Krama*, a graded reintroduction of solid food) and, where indicated, more active elimination of accumulated morbid material through *Panchakarma*; a published case study of *Agnimandya* associated with coexisting metabolic disturbance illustrates the clinical use of graded dietary correction as a first-line, non-eliminative response before more intensive intervention is considered.⁷

The Classical Rationale of *Panchakarma*

Classical Ayurvedic principle: Ayurvedic therapeutics classically distinguishes two broad strategies for correcting doshic imbalance — *Shamana*, pacification of vitiated *Dosha* in place through diet, herbal preparations and behavioural regulation, and *Shodhana*, active elimination of vitiated *Dosha* and accumulated *Ama* from the body through one of several defined channels. *Panchakarma* — literally "five actions" — constitutes the principal *Shodhana* protocol of classical Ayurveda, and is conceptually distinguished from *Shamana* on the classical premise that morbid material lodged in deeper tissue is more durably resolved by removal than by ongoing suppression, though this premise itself belongs to the classical framework rather than to a proven biomedical mechanism.

A concise account of the tradition, published within a peer-reviewed volume on evidence-based complementary and alternative medicine, describes *Panchakarma* as comprising the five procedures of *Vamana* (emesis), *Virechana* (purgation), *Nasya* (nasal instillation), *Basti* (medicated enema) and *Raktamokshana* (bloodletting), each intended to eliminate a particular category of vitiated *Dosha* through its nearest and most physiologically appropriate channel, and notes that these procedures are classically understood to be most effective, and safest, when correctly preceded by preparatory measures and followed by structured post-procedural care.⁸ The same source observes that *Panchakarma* is used classically for preventive and restorative purposes in addition to disease-directed treatment, a point of particular

relevance to its proposed role in urban lifestyle contexts, where the presenting problem is frequently a pattern of accumulated dysregulation rather than a single diagnosed disease entity.

Purvakarma, Pradhana Karma and Paschat Karma: The Three-Phase Structure

Classical Ayurvedic principle: *Panchakarma* is classically structured as a three-phase protocol, and the omission or truncation of any phase is held, within the tradition, to compromise both the efficacy and the safety of the procedures that follow. The preparatory phase, *Purvakarma*, comprises internal oleation (*Snehana*), typically through the graded oral administration of medicated ghee or oil, and therapeutic sudation (*Swedana*), together intended to mobilise deep-seated

Dosha and *Ama* toward the gastrointestinal tract and other accessible channels from which they can subsequently be eliminated. Without adequate *Purvakarma*, classical texts and their contemporary academic summaries hold that the main eliminative procedures act on inadequately mobilised morbid material, producing incomplete results and a higher risk of complications.⁸ The main eliminative phase, *Pradhana Karma*, comprises the five principal procedures summarised in Table 2, selected and sequenced according to the individual's predominant vitiated *Dosha*, the channel most directly implicated in the presenting disturbance, and the practitioner's overall clinical assessment.

Table 2. The Five Pradhana Karma Procedures of Classical Panchakarma.

Procedure	Classical target	Classical indication (illustrative)	Status of contemporary clinical evidence
<i>Vamana</i> (therapeutic emesis)	Elimination of vitiated <i>Kapha</i> via the upper alimentary route	<i>Kapha</i> -predominant respiratory and skin conditions described in classical texts	Sparse; mainly case series and small pre-post studies
<i>Virechana</i> (therapeutic purgation)	Elimination of vitiated <i>Pitta</i> via the lower alimentary route	<i>Pitta</i> -predominant hepatic, dermatological and metabolic conditions	Included as a co-intervention in several small controlled trials; rarely isolated
<i>Basti</i> (medicated enema)	Regulation of vitiated <i>Vata</i> ; described as the most broadly applicable procedure	Neuromuscular, musculoskeletal and <i>Vata</i> -predominant disorders	Most frequently studied procedure; evidence strongest for osteoarthritis, still limited by trial quality
<i>Nasya</i> (nasal instillation)	Elimination of vitiated <i>Dosha</i> from the head and upper respiratory region	Sino-nasal, cranial and selected neurological conditions	Limited controlled data; largely uncontrolled clinical series
<i>Raktamokshana</i> (therapeutic bloodletting)	Elimination of vitiated blood tissue (<i>Rakta Dhatu</i>)	Selected dermatological and localised inflammatory conditions	Rarely included in modern systematic reviews of <i>Panchakarma</i> ; evidence base minimal

The closing phase, *Paschat Karma*, governs the restoration of digestive capacity and normal dietary intake following elimination, principally through *Samsarjana Krama* — a graded sequence from liquid to semi-solid to normal solid food — together with continued dietary and lifestyle guidance intended to consolidate the gains of the eliminative phase and to re-establish a functioning *Agni*.⁷ Classical and contemporary academic sources agree that this closing phase is not a minor addendum: an eliminative procedure that is not followed by appropriate dietary restoration is considered, within the tradition, to leave its therapeutic work substantially incomplete.

Individualisation According to Prakriti, Disease State, Age, Strength and Season

Classical Ayurvedic principle: a defining feature of Ayurvedic therapeutics, and one frequently underemphasised in popular accounts of *Panchakarma*, is that the protocol is classically prescribed only after

individualised clinical assessment, encompassing *Prakriti* (constitutional type), current disease state and predominant vitiated *Dosha*, age, physical and digestive strength (*Bala* and *Agni Bala*), and season (*Ritu*), since particular eliminative procedures are classically considered more or less appropriate at different points in the annual cycle. This individualisation is presented in the classical literature as a precondition for both safety and efficacy, rather than as an optional refinement.

Contemporary biomedical evidence and conceptual interpretation: interest in relating *Prakriti* to measurable biological variation has grown substantially, on the premise that a constitution-based framework of this kind could, in principle, inform personalised preventive strategy in a manner conceptually adjacent to contemporary precision medicine. A 2025 critical review of *Prakriti* assessment instruments, however, concludes that most existing tools remain insufficiently validated: assessment has historically relied on subjective clinician

judgement, formal psychometric evaluation of instruments is limited, and further work is required before *Prakriti* can be regarded as a clinically validated, measurable construct suitable for standardised use in personalised healthcare.⁹ This is best treated, at present, as a clinical hypothesis under active investigation rather than as an established diagnostic framework, and the same caution applies to age-, season- and strength-based dosing rules for *Panchakarma*, which remain grounded chiefly in classical description and accumulated clinical experience rather than in controlled comparative research.

Potential Preventive, Restorative and Therapeutic Contexts in Urban Populations

Conceptual interpretation and clinical hypothesis: taken together, the classical picture of impaired Agni, accumulating Ama and obstructed Srotas bears a structural — though not a demonstrated mechanistic — resemblance to several features of urban lifestyle disease as currently understood in biomedicine: chronic low-grade inflammation, insulin resistance, dysregulated circadian and stress-response physiology, and allostatic overload.^(5,6) It is on this basis that some authors have proposed *Panchakarma*, alongside *Dinacharya* and *Ritucharya*, as a candidate framework for restoring physiological regularity in populations whose lifestyle has drifted from a more regular, seasonally attuned pattern of activity, diet and sleep.

This proposal should be read as a clinical hypothesis rather than an established finding. It is plausible, and consistent with the classical rationale described above, that individuals presenting with a pattern of accumulated dysregulation- irregular digestion, disturbed sleep, chronic musculoskeletal discomfort, and stress-related complaints without a single dominant diagnosis — may be a population in whom a structured, individualised, multi-week programme of dietary correction, oleation, sudation and (where clinically indicated) eliminative procedures could plausibly offer restorative benefit. Whether this benefit, if present, exceeds that obtainable through non-eliminative components alone (regular sleep and meal timing, physical activity, stress reduction, dietary counselling), and whether it is mediated through any process resembling the classical account of *Dosha* and *Ama* elimination, has not been established and should not be asserted. *Panchakarma* is, on the evidence

available, neither a validated preventive intervention for noncommunicable disease nor a general detoxification procedure in the sense that term is sometimes used in popular literature.

Contemporary Evidence Concerning Panchakarma-Based Interventions

Established evidence, stated with appropriate qualification: a literature review of *Panchakarma* and allied therapies, published within a broader evidence-based complementary medicine text, concluded that the majority of studies identified reported positive outcomes relative to comparison conditions, but that only a limited number of high-quality controlled trials had been conducted, and that preliminary findings warranted further large-scale, rigorously designed research rather than firm clinical conclusions.⁸

More recent systematic reviews focused on specific conditions offer a similarly mixed but informative picture. A 2023 systematic review of *Panchakarma*-based treatment for knee *osteoarthritis* (*Janu Sandhigata Vata*), restricted to double-arm randomised comparative trials identified across fourteen electronic databases, reported encouraging but methodologically constrained evidence for benefit, consistent with Basti being both the most classically emphasised and the most frequently studied of the five procedures.¹⁰ By contrast, a 2025 systematic review of Ayurvedic interventions, including *Panchakarma*-based approaches, for hemiplegia following stroke (*Pakshaghata*) — drawing on thirty studies comprising nine randomised trials, eight non-randomised comparative trials and thirteen pre-post studies — concluded that available evidence could not definitively establish efficacy or safety, and specifically noted that included trials frequently failed to document safety parameters, adverse events or adverse drug reactions, a methodological gap of direct relevance to responsible clinical use.¹¹

A 2025 systematic review and meta-analysis of Ayurvedic interventions — including single herbs, polyherbal formulations and *Panchakarma* therapies — for essential hypertension, incorporating ten randomised controlled trials in its pooled analysis, found that these interventions did not achieve statistically significant blood pressure reduction relative to conventional treatment, while noting a favourable safety profile and potential adjunctive clinical benefit; the authors situated

this as evidence of reasonable safety rather than of established superior or equivalent efficacy.¹² Read across these sources, the honest summary is that *Panchakarma*-based interventions show preliminary, condition-specific positive signals in several areas, a generally favourable short-term safety profile in the trials that have measured it, and a persistent shortage of adequately powered, well-controlled, safety-reporting trials — particularly for the broad, non-disease-specific "lifestyle restoration" application that is of primary interest to this review.

Safety, Contraindications and the Need for Qualified Clinical Supervision

Classical Ayurvedic principle and contemporary biomedical evidence: classical Ayurvedic pharmacology and procedural therapeutics contain an internal safety framework, distinguishing inadequate administration (*Ayoga*), excessive administration (*Atiyoga*), outright contraindication (*Anarha*) and procedural complication (*Vyapad*). A review examining Ayurvedic concepts of adverse drug reaction and drug safety against the modern pharmacovigilance framework concludes that, although the terminology differs, the underlying concern with cause, prevention and reporting of unintended harm is present throughout classical texts, and argues that this scattered classical knowledge requires systematic compilation and comparison with contemporary drug-safety concepts — a task the review characterises as not yet complete.¹³

This gap has direct clinical consequences. As noted above, a recent systematic review of Ayurvedic interventions for hemiplegia found that included trials commonly did not report safety parameters, adverse events or adverse drug reactions in a form comparable to contemporary clinical trial reporting standards, limiting the confidence with which *Panchakarma*-based procedures can be characterised as low-risk across all populations and settings.¹¹ Eliminative procedures such as *Vamana*, *Virechana* and *Basti* are, by classical description and by clinical plausibility, physiologically demanding, involve fluid and electrolyte shifts, and are contraindicated or require substantial modification in a range of circumstances, including significant cardiovascular or renal compromise, pregnancy, active infection, frailty, and concurrent conventional treatment such as chemotherapy or radiotherapy where interaction

and timing require careful multidisciplinary coordination.

Responsible clinical use accordingly requires that *Panchakarma* be administered only after adequate diagnostic screening and physician assessment, within a facility equipped and staffed to manage procedural complications, by practitioners trained specifically in *Panchakarma* technique, and with explicit informed consent that accurately conveys the present evidence level rather than a promotional characterisation of the procedure as a general detoxification or immune-enhancing intervention.

Gaps Between Classical Description and Modern Evidence

Several structural gaps limit the extent to which classical description of *Panchakarma* can presently be translated into validated modern clinical guidance. First, individualisation frameworks central to classical practice, particularly *Prakriti* typing, remain without a standardised, psychometrically validated assessment instrument suitable for use across research settings, which in turn limits the comparability of trials that stratify participants by constitutional type.⁹ Second, safety and adverse-event reporting in published trials of *Panchakarma*-based interventions has been inconsistent, as documented in the hemiplegia systematic review discussed above, constraining any confident general statement about the procedures' risk profile across diverse clinical populations.¹¹

Third, procedural therapies of this kind are inherently difficult to evaluate using conventional placebo-controlled trial designs, since sham *Vamana*, *Virechana* or *Basti* procedures raise both practical and ethical difficulties; the evidence base therefore relies heavily on comparator-controlled, pre-post and observational designs that are more vulnerable to bias than blinded randomised trials. Fourth, the conceptual correspondence proposed between classical constructs such as *Agni* and *Ama* and biomedical constructs such as metabolic dysregulation and chronic inflammation remains, on the best available characterisation, a phenomenological or clinical-sequencing parallel rather than an established shared biological mechanism, and narrative reviews that draw this parallel are generally explicit that direct molecular mapping between the two frameworks has not been demonstrated.⁽⁶⁾ Closing these

gaps will require sustained investment in methodologically rigorous, adequately powered, safety-reporting clinical research specifically designed around the structural features of procedural Ayurvedic therapy, rather than the retrofitting of biomedical trial designs developed for pharmacological interventions.

A Responsible Framework for Integrating Panchakarma into Contemporary Urban Healthcare

Contemporary biomedical and policy evidence: India's Ministry of AYUSH, in collaboration with the World Health Organization, has developed the National AYUSH Morbidity and Standardized Terminologies Electronic (NAMASTE) Portal and, building on it, a dedicated Traditional Medicine Module 2 within the eleventh revision of the International Classification of Diseases (ICD-11 TM2), launched for country implementation in New Delhi in January 2024, providing for the first time a standardised international coding structure for Ayurveda, Siddha and Unani diagnostic and morbidity terminology.¹⁴ This infrastructure is of direct relevance to the responsible integration of *Panchakarma* into urban healthcare, since it creates the technical means by which Ayurvedic diagnoses, procedures and, in principle, adverse events can be documented within interoperable electronic health records alongside conventional biomedical data — a precondition for the kind of systematic, real-world safety and outcomes surveillance that the evidence gaps described above make clear is still needed.

On this basis, a responsible framework for offering *Panchakarma* within contemporary urban healthcare systems can be outlined around several principles: individualised assessment and diagnostic screening by a qualified Ayurvedic physician before any eliminative procedure is undertaken; delivery within a regulated facility with the capacity to manage procedural complications; explicit non-substitution for emergency, acute or actively progressing biomedical conditions requiring conventional treatment; coordination with a patient's existing conventional care team where relevant comorbidity or concurrent treatment exists; informed consent that accurately represents the current evidence level rather than overstated claims of detoxification, immune enhancement or disease prevention; and participation, where feasible, in standardised outcome

and adverse-event documentation consistent with NAMASTE/ICD-11 TM2 coding, so that the accumulating real-world experience of urban *Panchakarma* practice can itself contribute to closing the evidence gaps identified in this review.^{12,14}

Conclusion

Urban lifestyle has measurably altered the everyday conditions — physical activity, sleep, diet timing, light exposure and chronic psychosocial load — under which noncommunicable disease risk accumulates. Ayurveda's classical framework of *Dinacharya*, *Ritucharya*, *Agni* and *Ama* address a structurally similar problem of accumulated regulatory disruption, and *Panchakarma* offers a structured, individualised, three-phase therapeutic response grounded in a coherent internal rationale. The contemporary evidence base for *Panchakarma*-based interventions is real but preliminary: encouraging for some specific conditions, generally favourable on short-term safety where safety has been adequately reported, and consistently limited by small samples, heterogeneous protocols and inconsistent adverse-event documentation.

Panchakarma should not be presented, in scholarly or clinical communication, as a universal detoxification procedure or as a proven treatment for the broad category of modern lifestyle disorders. It is more accurately characterised as a classical, individualised therapeutic tradition with plausible conceptual relevance to several features of urban lifestyle disease, a moderate and growing but still limited contemporary evidence base, and a genuine dependence on qualified clinical supervision, honest evidence communication, and continued methodologically rigorous research before its role in mainstream urban preventive healthcare can be more firmly established.

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