Successful Management and Reversal of Decompensated Liver Cirrhosis with Severe Hyperbilirubinemia and Ascites via Structured Ayurvedic Intervention: A Case Report

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Abstract

Background: Decompensated liver cirrhosis presenting with refractory ascites and profound hyperbilirubinemia (Total Bilirubin > 30 mg/dL) marks end-stage liver disease, carrying a grim prognosis where orthotopic liver transplantation stands as the sole conventional therapeutic resolution.
Case Presentation: A 43-year-old male farmer presented with progressive abdominal distension, severe icterus, bilateral pedal edema, anorexia, and profound cachexia. Diagnostic indicators confirmed F4 decompensated liver cirrhosis complicated by moderate-to-severe ascites and a critical total bilirubin level of 33.9 mg/dL. He had been clinically advised to undergo immediate liver transplantation.
Intervention: A targeted, multi-phasic Ayurvedic protocol was instituted, focused on therapeutic bio-cleansing (*Nitya Mridu Virechana*), systemic channel detoxification (*Srotoshodhana*), and targeted hepatic rejuvenation (*Yakrit Punarnirman*) utilizing standardized formulations of *Picrorhiza kurroa* (Katuki), *Phyllanthus niruri* (Bhumyamalaki), and cow urine-infused preparations.
Outcome: Over a continuous 5-month longitudinal follow-up, the patient exhibited comprehensive clinical remission. Total bilirubin normalized from 33.9 mg/dL to 1.2 mg/dL; abdominal girth reduced from 98 cm to 75 cm with absolute sonographic resolution of ascites; and serum transaminases normalized perfectly. The patient avoided surgical transplantation and successfully returned to his baseline occupational activities.
Conclusion: This case underscores the therapeutic potential of structured, metabolic-based Ayurvedic protocols as a viable, highly affordable, and non-invasive alternative for reversing end-stage hepatic decompensation.

Keywords: End-Stage Liver Disease; Jalodara; Kamala; Picrorhiza kurroa; Therapeutic Purgation (Virechana); Transplant Avoidance.

Introduction

Decompensated liver cirrhosis is characterized by a severe loss of functional hepatic parenchyma, resulting in systemic complications such as refractory ascites, portal hypertension, hepatic encephalopathy, and profound hyperbilirubinemia. Within conventional therapeutic paradigms, when total serum bilirubin exceeds 30 mg/dL alongside established ascites, the condition is classified as end-stage, carrying an exceptionally high mortality rate. At this juncture, medical management is primarily palliative, and orthotopic liver transplantation remains the only definitive, albeit resource-intensive and structurally limited, intervention.

In classical Ayurvedic text, this advanced metabolic state aligns with *Yakrit Vriddhi janya Jalodara* (ascites secondary to hepato-splenomegaly) and complicated *Kamala* (severe icterus). Classical pathophysiology attributes this state to the profound vitiation of the *Ranjaka Pitta* localized within the liver (*Yakrit*), which concurrently disrupts the *Raktavaha Srotas* (hematopoietic and vascular channels). Acharya Charaka explicitly

dictates that continuous, controlled bio-cleansing or mild metabolic purgation (*Nitya Mridu Virechana*) forms the primary line of defense in managing fluid accumulation within the peritoneal cavity (*Jalodara*). This case report details the successful clinical reversal of a patient with end-stage decompensated liver cirrhosis utilizing a structured, multi-modal Ayurvedic framework.

Case Presentation

A 43-year-old male farmer residing in Warud, Maharashtra, India, presented with a 2-month progressive history of severe abdominal distension (*Udar Vriddhi*), generalized weakness (*Daurbalya*), persistent nausea (*Hrillasa*), complete anorexia (*Aruchi*), and intense deep-yellow discolouration of the skin and urine. Prior to presenting at our facility, the patient underwent diagnostic evaluations at a tertiary care conventional hospital, where a diagnosis of decompensated liver cirrhosis (Child-Pugh Score C, Model for End-Stage Liver Disease score highly elevated) was established. Due to the refractory nature of the ascites and a critical total bilirubin level peaking near 34 mg/dL, the patient was officially counselled to undergo immediate liver transplantation.

Physical examination upon admission revealed profound Grade 4 clinical icterus, marked conjunctival pallor, and significant bilateral pitting pedal edema (*Ubhaya Pada Shotha*). Abdominal examination demonstrated a tensely distended abdomen with an initial abdominal girth of 98 cm measured at the umbilicus. Both shifting dullness and fluid thrill were strongly positive. Due to the high volume of ascites, deep palpation of the liver and spleen was impossible. The patient's initial body weight was recorded at 71.4 kg (highly confounded by fluid retention). Baseline transabdominal ultrasonography revealed a coarse hepatic echotexture indicative of advanced cirrhosis, significant splenomegaly, and moderate-to-severe free peritoneal fluid. An initial transient elastography (Fibroscan) confirmed Stage F4 hepatic fibrosis.

Chronological Laboratory and Clinical Monitoring

The patient's clinical biomarkers were tracked continuously over a 5-month longitudinal period, revealing a steady, systemic resolution of hepatic dysfunction without any paracentesis or conventional interventions:

Date	Wt (kg)	Abd Girth	Hb (g%)	Platelets	Total Bili	Direct Bili	Indirect Bili	SGOT (U/L)	SGPT (U/L)
24/05/25	71.4	98 cm	5.8	60,000	33.9	15.8	18.1	--	--
31/05/25	59.4	85 cm	6.7	70,000	22.32	11.32	11.0	220	186
17/06/25	--	--	7.9	133,000	24.93	8.84	16.09	169	143
01/07/25	53.8	80 cm	7.0	107,000	21.0	12.8	8.2	115	277
16/07/25	51.0	82 cm	6.7	141,000	12.9	7.8	5.1	108	148
01/08/25	--	--	6.8	150,000	7.8	4.6	3.2	84	146
17/08/25	51.5	77 cm	7.8	148,000	4.7	3.1	1.6	60	40
15/09/25	--	--	7.9	128,000	3.0	2.0	1.0	56	70
23/10/25	52.0	75 cm	9.25	130,000	1.2	1.0	0.2	40	45

Therapeutic Interventions

The clinical management strategy was segmented into two functional operational phases, designed to execute sequential metabolic detoxification (*Shodhana*) and organ rejuvenation (*Shamana*).

Phase 1: Deep Detoxification & Bio-cleansing (Days 1 to 15)

• **Nitya Mridu Virechana:** Facilitated by the administration of *Ichhabhedi Rasa*, *Arogyavardhini Vati*, and *Patola Katurohinyadi Kwath*. This combination was titrated precisely to maintain 3 to 4 controlled, loose liquid stools per day, accelerating the clearance of systemic bilirubin through the gastrointestinal tract.
• **Srotoshodhana:** Administration of *Gomutra Haritaki* (3 grams, twice daily) to clear micro-channel obstructions.
• **Ascites and Anemia Management:** Instillation of *Punarnava Mandura* and *Punarnavashtaka Kwath* to stimulate renal clearance and enhance erythropoiesis.

Phase 2: Hepatic Rejuvenation & Stabilization (Months 2 to 5)

• **Targeted Hepatoprotection:** Pure *Katuki* (*Picrorhiza kurroa*) churna administered at 500 mg three times daily, complemented by *Bhumyamalaki* (*Phyllanthus niruri*) extract at 500 mg twice daily, to drive cellular regeneration.
• **Hematinic and Platelet Rebound:** Co-administration of *Kasisa Bhasma* (50 mg) and *Loha Parpati* (125 mg) with honey.
• **Biological Diuresis:** A synergistic combination of *Punarnava*, *Gokshura*, and *Guduchi* to promote steady fluid clearance.
• **Dietary Compliance:** Absolute restriction of dietary sodium, supplemented by a strict regimen of buttermilk (*Takra*), green gram broth (*Mudga Yusha*), and bitter vegetables (*Tikta Shaka*). All incompatible dietary profiles (*Viruddha Ahara*) were completely omitted.

Discussion

The significant turnaround observed in this patient challenges the conventional surgical axiom that end-stage hepatic decompensation represents a structural point of no return. The massive clearance of total serum bilirubin—dropping sharply from an alarming 33.9 mg/dL to a physiological baseline of 1.2 mg/dL within 5 months—points directly to the clinical efficacy of *Nitya Virechana*. In Ayurvedic theory, the liver is the anatomical locus of *Ranjaka Pitta*. Continuous, mild therapeutic purgation facilitates the direct excretion of highly accumulated bile pigments through the bowel, thereby decreasing hepatic congestion and mitigating biliary stasis (neocholestasis clearance).

Concurrently, *Picrorhiza kurroa* (Katuki) and *Phyllanthus niruri* (Bhumyamalaki) supply verified anti-fibrotic, antioxidant, and membrane-stabilizing phytochemical profiles that safeguard surviving hepatocytes and foster localized cell regeneration. The rapid induction of fluid loss—reflected by an initial 18 kg reduction in body mass representing the total evacuation of retained peritoneal fluid—occurred via *Punarnava*'s natural diuretic mechanisms. Crucially, this occurred without inducing the electrolyte instability, severe hypokalemia, or precipitate hepatorenal syndrome typically linked with high-dose conventional loop diuretics. Furthermore, the stabilization of platelets (rising from 60,000 to 130,000/mcL) suggests an alleviation of portal pressures, resulting in a reduction of splenomegaly-induced sequestration.

Conclusion

This clinical case report demonstrates that structured, classical Ayurvedic protocols focusing on therapeutic metabolic purgation and targeted hepato-rejuvenating botanicals can successfully reverse advanced decompensated liver cirrhosis and eliminate the requirement for orthotopic liver transplantation. This standardized approach offers a non-invasive, profoundly cost-effective, and safe medical pathway that warrants further validation through rigorous, large-cohort prospective clinical trials.

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