American Journal of Psychiatric Rehabilitation Expert Opinion Article

Understanding Mootraghata In Ayurveda With Special Reference To Benign Prostatic Hyperplasia: A Conceptual Review

Dr. Kiran Kumari[1]*, Dr. Sunita Dangi[2], Dr. Prakash Chhipa[3], Prof.(Dr.) Pramod Kumar Mishra[4], Dr. Brahmanand Sharma[5], Dr. Praveen Kumar[6]

[1,2,3]PG Scholar, PG Department of Kaychikitsa, Post Graduate Institute Of Ayurveda, DSRRAU Jodhpur Rajasthan.
[4]Professor and HoD, PG Department of Kaychikitsa, Post Graduate Institute Of Ayurveda, DSRRAU Jodhpur Rajasthan.
[5]Associate Professor & HoD, PG Department of Swasthvrita, Post Graduate Institute Of Ayurveda, DSRRAU Jodhpur Rajasthan.
[6]Associate Professor, PG Department of Agadtantra evum vidhi vaidhyaka, Post Graduate Institute Of Ayurveda, DSRRAU Jodhpur Rajasthan.

***Corresponding Author-** Dr. Kiran Kumari
*Email: (kirangurjar1306@gmail.com)

Abstract
Benign Prostatic Hyperplasia (BPH) represents a significant global health challenge, characterized by lower urinary tract symptoms (LUTS) that impact the quality of life for aging men. In parallel, Ayurvedic medicine describes a spectrum of urinary disorders under the umbrella term *Mootraghata*, which shares considerable symptomatic and pathophysiological commonalities with BPH. This conceptual review aims to bridge the understanding between these two medical paradigms, exploring their parallels in etiology, pathogenesis, clinical features, and therapeutic strategies. The analysis reveals that *Mootraghata* functions as a broad syndrome encompassing various urinary pathologies, with specific subtypes like *Vatashteela* demonstrating a close resemblance to BPH. Central to Ayurvedic understanding is the vitiation of *Apana Vayu* and the suppression of natural urges (*vegavarodha*), which offer a unique, holistic perspective on the dynamic component of bladder outlet obstruction. Furthermore, the involvement of *Kapha* and *Meda Dhatu* aligns with the static component of prostatic enlargement. Traditional Ayurvedic therapies, particularly *Basti Karma* (including *Matra Basti* and *Uttarbasti*) and specific herbal formulations like *Varuna*, *Shilajit*, *Kanchanara Guggulu*, and *Gokshura*, are discussed for their potential to address BPH-like symptoms by balancing *Doshas* and supporting urogenital health. This review underscores the potential for an integrative approach, leveraging the strengths of both systems for comprehensive BPH management and prevention.

Keywords: Ayurveda, Mootraghata, Benign Prostatic Hyperplasia (BPH), Lower Urinary Tract Symptoms (LUTS), Apana Vayu, Basti Karma, Conceptual Review, Integrative Medicine.

1. Introduction [i]

The global demographic shift towards an aging population has brought various age-related health conditions into sharper focus. Among these, Benign Prostatic Hyperplasia (BPH) stands out as a highly prevalent urological disorder affecting older men. BPH is a common cause of lower urinary tract symptoms (LUTS), which include a range of bothersome urinary abnormalities such as increased frequency, urgency, weak stream, and incomplete voiding. The histological prevalence of BPH is notable, affecting approximately 8% of men in their 40s, rising significantly to 50% in their 60s, and reaching 80-90% in men over 70 years of age. This condition significantly impacts the health-related quality of life for affected individuals and contributes substantially to global healthcare expenditures.[ii]

In parallel, Ayurveda, an ancient holistic medical system originating from India, offers a comprehensive framework for understanding health and disease. Rooted in the principles of *Dosha* (Vata, Pitta, Kapha), *Dhatu* (body tissues), and *Mala* (waste products), Ayurveda emphasizes maintaining physiological balance through individualized approaches encompassing lifestyle, diet, herbal medicine, and specialized detoxification therapies like *Panchakarma*. Within this system, urinary disorders are broadly categorized, with *Mootraghata* being a significant term representing conditions characterized by obstruction or suppression of urine flow. These conditions often manifest with symptoms strikingly similar to those observed in BPH. The concept of *Mootraghata* is deeply embedded in classical Ayurvedic texts, including the *Charaka Samhita*, *Sushruta Samhita*, and *Ashtanga Hridaya*, indicating its long-standing recognition and study within the tradition.

It is important to recognize that *Mootraghata* is described in Ayurvedic literature as a "broad term" or a "syndrome" that encompasses a wide array of

pathological entities within the urinary system, classified into twelve or thirteen distinct types. This characterization is crucial, as it suggests that *Mootraghata* is not a singular disease but rather a collection of signs and symptoms that can arise from various underlying conditions, much like Lower Urinary Tract Symptoms (LUTS) in modern medicine. Therefore, a direct one-to-one correlation between the entire *Mootraghata* syndrome and BPH might be an oversimplification. Instead, BPH can be understood as one specific manifestation or a prominent subtype within the broader *Mootraghata* syndrome. This nuanced perspective allows for a more flexible and accurate comparative analysis, acknowledging both the significant overlap and the inherent distinctions between the two concepts. This understanding helps explain why different *Mootraghata* types might correlate with various modern urinary conditions, with BPH being a particularly relevant and common correlation. This review aims to bridge the traditional Ayurvedic understanding of *Mootraghata* with the contemporary medical understanding of BPH. By exploring the conceptual parallels in their etiology, pathogenesis, clinical features, and therapeutic strategies, this paper seeks to provide a nuanced understanding that can foster improved diagnosis, management, and potentially novel integrative treatment paradigms for BPH.

2. Mootraghata: An Ayurvedic Perspective

2.1. Definition, Etymology, and Historical Context

The term *Mootraghata* in Ayurveda is derived from two Sanskrit words: 'Mootra,' meaning urine, and 'Aghata,' implying obstruction. Thus, *Mootraghata* literally translates to "obstruction of urine" and represents a category of urinary disorders characterized by the suppression or significant obstruction of urine flow, leading to symptoms such as low urine output and urinary retention. This condition is conceptually distinct from *Mutrakricchra* (dysuria), where the primary feature is difficulty or pain during micturition, rather than outright obstruction or retention. This differentiation demonstrates a inherent precision within Ayurvedic nosology. It is not merely a linguistic distinction but reflects a sophisticated ancient understanding of distinct urinary pathologies. This allows for targeted diagnosis and treatment within the Ayurvedic framework, highlighting the structured approach of the system to disease classification.

2.2. Classification and Types of *Mootraghata*

- **Charaka Samhita** (Sharma, 1981-1994; Tiwari, 2018): *Acharya Charaka* mentions eight types of *Mootraghata* in his *Sutrasthana*. Additionally, in *Siddhisthana*, thirteen types of *Bastirogas* (diseases of the urinary bladder) are described under the heading of "Mutradosha," which are considered similar to the *Mootraghata* types elaborated by *Sushruta*.[iii]
- **Sushruta Samhita** (Bhishagratna,1911;): *Sushruta* details twelve types of *Mootraghata* in his *Uttaratantra*. Notably, *Sushruta* does not include the *Bastikundala* and *Vidvighata* varieties found in *Charaka's* descriptions. Furthermore, *Sushruta* describes two types of *Mutraukasada* (Pittaj and Kaphaj), whereas *Charaka* and *Vagbhat* mention only one type. [iv]
- **Ashtanga Sangraha** (Athridev_gupta, 1951; Vagbhata, 1995) **& Ashtanga Hridaya** (Vagbhata, 1995; Vidyanath, 2013): These texts provide an elaborate description of *Mootraghata* in the "Mutraghata Nidana" section. A unique aspect of these texts is their categorization of *Mutravaha Srotas* diseases into two broad groups: *Mutra Atipravrittijanya* (conditions characterized by excessive urination) and *Mutra-Apravrittijanya Rogas* (conditions involving reduced or obstructed urination). [v]

For a clearer understanding, the 12 types of *Mootraghata* can be broadly grouped based on their predominant symptomatology:-

- ***Vata Kundalika:*** Characterized by vitiated *Vata Dosha* lodged in the bladder, often due to consumption of dry food, insufficient water intake, or suppression of natural urges, leading to urinary retention.
- ***Ashteela (Vatashteela):*** In this condition, vitiated *Apana Vayu* generates a solid, stone-like growth located between the rectum and the urinary bladder. This growth obstructs the passage of urine, feces, and flatus, causing excruciating pain in the suprapubic region. This specific type is explicitly correlated with benign prostatic disease or enlarged prostate in modern parlance.
- ***Vata Basti:*** Here, the suppression of natural urges activates *Vata*, which then obstructs the mouth of the bladder, resulting in acute urinary retention and severe discomfort in the bladder and abdomen.
- ***Mutrateeta:*** This describes a condition where urine, having been withheld for an extended period, is subsequently passed very slowly and in fragmented streams, rather than a continuous flow.
- ***Mutrajathara:*** Caused by the suppression of the urge to urinate, leading to vitiation of *Apana Vayu*, which causes severe abdominal distension and intense pain below the navel.
- ***Mutrotsanga:*** Characterized by vitiated *Vayu* in the urinary bladder, resulting in slow, scanty, and sometimes painful urination. *Sushruta* specifically correlated this condition with urethral stricture.
- ***Mutrakshaya:*** Refers to a condition of reduced urine formation, often described as *Shoshana*.

- ***Mutragranthi:*** Presents with severe symptoms and has been scientifically linked to prostatic abscess.
- ***Mutrashukra:*** Occurs when an individual engages in coitus while experiencing the urge to urinate, leading to the ejaculation of semen mixed with urine or the excretion of urine immediately before or after seminal ejaculation.
- ***Udavarta:*** Arises from the suppressed urge to urinate, causing the urine to flow upward or in a retrograde direction.

Table 1: Classification of Mootraghata Across Classical Ayurvedic Texts

Classical Text	Number of Types Described	Key Types Mentioned	Unique Features/Distinctions
Charaka Samhita	8 (Sutrasthana), 13 (Bastirogas in Siddhisthana)	Vatakundalika, Vata Basti, Mutrajathara, Mutrateeta, Mutrakshaya, Mutrotsanga, Mutragranthi, Mutrashukra, Udavarta (inferred from common types)	13 *Bastirogas* under *Mutradosha* similar to *Sushruta's Mootraghata*; only one type of *Mutraukasada*
Sushruta Samhita	12 (Uttaratantra)	Vatakundalika, Ashteela, Vata Basti, Mutrateeta, Mutrajathara, Mutrotsanga, Mutrakshaya, Mutragranthi, Mutrashukra, Udavarta, Mutraukasada (Pittaj & Kaphaj)	Excludes *Bastikundala* and *Vidvighata* varieties; describes two types of *Mutraukasada* (Pittaj & Kaphaj)
Ashtanga Sangraha & Ashtanga Hridaya	Elaborately described in *Mutraghata Nidana*	Includes *Mutrakricchra* and *Ashmari rogas* within *Mutravaha Srotas* diseases	Categorizes *Mutravaha Srotas* diseases into *Mutra Atipravrittijanya* (excessive urination) and *Mutra-Apravrittijanya Rogas* (reduced/obstructed urination)

2.3. Etiology (Nidana) and Pathogenesis (*Samprapti*) [vi]

The primary causative factor (*Nidana*) for *Mootraghata* is consistently identified as *Mutra vegavarodha*, which refers to the voluntary suppression of natural urges, particularly the urge to micturate. This act of suppression is considered highly detrimental in Ayurveda, as it directly deranges *Apana Vayu*, the sub-type of *Vata Dosha* responsible for the normal downward movement and voiding of urine. The profound impact of *Vegavarodha* as a root cause extends beyond just urinary issues in Ayurveda, affecting various bodily systems. This concept highlights a fundamental lifestyle-related cause that leads to systemic *Dosha* imbalance, primarily *Vata*, which then manifests as specific organ pathology, such as urinary obstruction.

Mootraghata is primarily considered a *Vata Dosha* illness. The vitiated *Vata* combines with urine, leading to its obstruction. In addition to *Vata*, *Kapha Dosha* is also frequently implicated in the pathogenesis of *Mootraghata*, particularly in conditions resembling BPH, suggesting a *Vata-Kaphaja* predominance in many cases. The condition inherently involves *Mutravaha Srotodushti*, meaning disorders of the urinary channels. *Apana Vayu*, being the governing force of the *Mutravaha Srotas*, ensures proper elimination. Any abnormality in *Apana Vayu* directly correlates with diseases of the urinary system. The pathological progression often begins with vitiated *Vayu* (aggravated by factors such as excessive consumption of *Rukshya Ahara* (dry foods) or the aforementioned urge suppression) impacting the urinary bladder, leading to obstruction of urine flow and associated pain. In specific types like *Vatashteela*, the vitiated *Apana Vayu* is described as generating a solid growth.

From an Ayurvedic perspective, hyperplasia (excessive growth) of the prostate gland, a glandular and reproductive organ, conceptually involves *Meda Dhatu* (fatty/glandular tissue) and *Shukra Dhatu* (reproductive tissue). This can be understood as an imbalance (*Dushti*) of *Meda* and *Shukra Dhatus* under the influence of aggravated *Kapha*. The modern understanding of hormonal changes in aging men, such as the decline in blood testosterone levels leading to dihydrotestosterone (DHT) imbalance, can be conceptually linked to age-related alterations in *Shukra Dhatu* and the broader hormonal equilibrium described in Ayurveda. The conceptual mapping of the "static component" of BPH (prostatic enlargement) to *Kapha Dosha* and *Meda Dhatu* involvement, and the "dynamic component" (increased stromal smooth muscle tone/obstruction) to the vitiation of *Vata Dosha* (specifically *Apana Vayu*), provides a powerful

mechanistic analogy. This reveals how Ayurvedic *Dosha-Dhatu* theory, despite its different terminology, describes and categorizes pathophysiological processes that align with modern understanding, thereby providing a rational basis for applying targeted Ayurvedic treatments (e.g., *Kapha*-reducing for static growth, *Vata*-pacifying for dynamic obstruction).

2.4. Clinical Manifestations (*Lakshanas*)

Table 2: Symptomatic Correlation: *Mootraghata* and Benign Prostatic Hyperplasia

Ayurvedic Symptom (Lakshana)	Description in Ayurveda	Corresponding Modern LUTS/BPH Symptom	Description in Modern Medicine
Mootravarodha / Mootraghata	Obstruction or suppression of urine flow	Bladder Outlet Obstruction (BOO) / Urinary Retention	Blockage to urinary flow, inability to empty bladder
Bahumutrata	Increased frequency of urination	Frequency	Need to urinate more often
Manda Mootradhara	Weak stream of urine	Weak or Intermittent Stream	Urinary stream not strong or stops and starts
Ashteela / Vatashteela	Solid growth obstructing urine, suprapubic pain	Prostatic Enlargement	Increased size of the prostate gland
Incomplete Voiding	Sensation of bladder not being fully empty	Incomplete Emptying	Sensation that the bladder has not been completely emptied
Dribbling	Involuntary leakage of urine, especially post-void	Post-void Dribbling / Incontinence	Involuntary leakage after urination or continuous leakage
Hesitancy	Difficulty in initiating the urinary stream	Hesitancy	Difficulty in starting the urinary stream
Mootradaha	Painful micturition / Dysuria	Dysuria / Burning Sensation	Pain or burning during urination

3. Benign Prostatic Hyperplasia (BPH): A Modern Medical Perspective

3.1. Definition and Epidemiology

Benign Prostatic Hyperplasia (BPH) is fundamentally a histological diagnosis characterized by the nonmalignant growth or unregulated proliferation of connective tissue, smooth muscle, and glandular epithelium within the prostatic transition zone. This cellular proliferation leads to an increase in the overall size of the prostate gland, a condition often termed Benign Prostatic Enlargement (BPE). The enlarged prostate can then physically compress the urethra, resulting in anatomic Bladder Outlet Obstruction (BOO).

The epidemiology of BPH reveals a strong association with age. Histological prevalence of BPH is observed in approximately 8% of men in their 40s, rising significantly to 50% in their 60s, and affecting 80-90% of men in their 90s. Prostate volume also demonstrates a consistent increase with age, with data suggesting a growth rate of 2.0-2.5% per year in older men. The incidence of Lower Urinary Tract Symptoms (LUTS) similarly increases with age; for instance, a prospective study of men over 65 years in the US found that 29% of those without LUTS at baseline developed clinically significant LUTS within two years.

3.2. Etiology and Pathophysiology

Non-modifiable risk factors include:

- **Age:** As discussed, age is the most significant predictor of BPH development.
- **Genetics:** Evidence suggests a genetic predisposition, with men under 64 who underwent BPH surgery having a four-fold increased risk among all male relatives and a six-fold increase among brothers.
- **Geography:** International studies indicate regional differences in BPH prevalence and prostate volume.

Modifiable risk factors that present opportunities for prevention and treatment include:

- **Sex Steroid Hormones:** Dihydrotestosterone (DHT) plays a central role, as testosterone is converted to DHT by 5-alpha-reductase 2 in prostatic stromal cells, potently stimulating prostate growth. Higher serum DHT levels are associated with an increased risk of BPH.
- **Metabolic Syndrome and Cardiovascular Disease:** These conditions are linked to increased risks of BPH and LUTS.
- **Obesity:** Consistently associated with larger prostate volumes and higher risks of BPH surgery and medical therapy initiation.
- **Diabetes:** Increases the risk of BPH, LUTS, and the need for prostatic surgery.

- **Inflammation:** Histological inflammation is frequently observed in BPH.
- **Diet:** While patterns are inconsistent, some dietary factors (e.g., high total energy intake, red meat) may increase BPH risk, while others (e.g., vegetables, fruits, Vitamin A/D) may decrease it.
- **Physical Activity:** Robustly linked to decreased risks of BPH.

The pathophysiology of BPH involves two distinct mechanisms contributing to bladder outlet obstruction (BOO):

- **Static Component:** This is a direct consequence of the physical enlargement of the prostate gland, which causes periurethral compression and obstruction of the bladder outlet. The increased prostate volume necessitates higher voiding pressures to overcome the resistance to urine flow. Enlargement of the median lobe can create a "ball-valve" effect, further restricting urination.
- **Dynamic Component:** This involves an increase in the tone of the stromal smooth muscle within the prostate. This phenomenon is explained by decreased elasticity and collagen content in the prostatic urethra of men with BPH, which exacerbates symptoms of BOO due to reduced compliance and increased flow resistance. This also clarifies why prostate size alone is not always a reliable predictor of symptom severity.

Progressive BPH and BOO can also lead to primary bladder dysfunction, which independently worsens LUTS. Long-term, untreated disease may result in chronic high-pressure retention, a potentially life-threatening condition that can cause permanent changes to the bladder detrusor muscle. The distinction between the static (enlargement) and dynamic (smooth muscle tone) components of BPH pathology offers a rich conceptual analogy within Ayurveda. The static component can be linked to *Kapha Dosha* accumulation and *Meda Dhatu* involvement, representing the growth, bulk, and stagnation. The dynamic component, involving smooth muscle tension and obstruction, directly corresponds to the vitiation of *Vata Dosha*, particularly *Apana Vayu*, which governs downward movement and excretion. This mapping suggests that Ayurvedic treatments targeting *Kapha* (for reducing growth) and *Vata* (for relaxing obstruction and improving flow) are addressing these distinct pathophysiological components, even if the terminology differs.

3.3. Clinical Presentation and Diagnostic Criteria

The diagnostic criteria for BPH involve a comprehensive evaluation:

- **History:** A detailed medical history focuses on the onset, timing, severity, and impact of urinary symptoms on the patient's quality of life. It also screens for "red flags" and non-urological conditions (e.g., diuretic use, neurological problems, diabetes) that can cause or exacerbate urinary symptoms.
- **Physical Examination:** Includes an abdominal examination, external genitalia examination, neurological examination, and a crucial Digital Rectal Examination (DRE) to assess the prostate's size, shape, symmetry, nodularity, and consistency. A smooth, enlarged prostate is characteristic of BPH.
- **Standard Investigations:**
  - **Urinalysis:** To detect infection, hematuria, or metabolic disorders.
  - **International Prostate Symptom Score (IPSS) or American Urological Association (AUA) symptom score:** Validated questionnaires used to quantify symptom severity (scores 0-35), with a score ≥10 generally indicating a need for BPH treatment.
  - **Postvoid Residual Volume (PVR):** Measures the volume of urine remaining in the bladder after voiding, typically via bladder scan. A PVR of <100-150 mL is normal, while >200 mL is considered pathological.
  - **Frequency-volume chart or 24-hour voiding diary:** Optional but helpful for evaluating urinary patterns, especially nocturia.
  - **Peak flow test:** Optional, measures peak urinary flow rates to assess objective evidence of obstruction. A peak flow ≥13 cc/sec with a voided volume of at least 150 cc is considered acceptable.
  - **Laboratory evaluation for kidney function:** Blood Urea Nitrogen (BUN) and creatinine to establish baseline renal function, and fasting glucose or Hgb A1c to identify diabetes.
  - **Prostate-Specific Antigen (PSA) test:** Performed if prostate cancer is suspected or before certain treatments, as BPH can increase PSA levels.
- **Advanced Diagnostic Studies:** For specific cases, these may include pressure/flow studies, urodynamics, renal ultrasound, and cystoscopy to further characterize bladder function, obstruction, or rule out other pathologies.

3.4. Conventional Management Approaches [vii]

Conventional management of BPH encompasses a range of approaches, from watchful waiting to various medical and surgical interventions, tailored to the severity of symptoms and their impact on a patient's quality of life.

- **Observation (Watchful Waiting):** This approach is suitable for patients with mild symptoms and involves lifestyle modifications. These include weight loss, reducing caffeine intake, restricting evening fluid intake, practicing pelvic floor (Kegel) muscle exercises, and avoiding constipation. Patients are informed about the potential for disease progression, which in one study showed a

31% progression rate requiring further treatment over 48 months.

- **Medical Therapy:** These treatments target both the static (prostate enlargement) and dynamic (prostatic smooth muscle tension) components of BPH.
  - **Alpha-blockers:** Medications such as Tamsulosin, Alfuzosin, and Silodosin relax the smooth muscles in the prostate stroma and bladder neck, leading to improved urinary flow and symptom relief, often within 72 hours. Common side effects include ejaculatory issues, dizziness, and low blood pressure.
  - **Five alpha-reductase inhibitors (5-ARIs):** Finasteride and Dutasteride block the conversion of testosterone to dihydrotestosterone (DHT), thereby reducing prostate tissue volume. These medications take several months for noticeable improvement, with maximal effectiveness at six months, and are most beneficial for patients with prostates larger than 30 grams. They can reduce serum PSA by 50% and prostate volume by up to 25%.
  - **Tadalafil:** A phosphodiesterase type 5 inhibitor, also used for erectile dysfunction, can be effective for BPH symptoms, particularly in patients with both conditions.
  - **Antimuscarinics:** Medications like Solifenacin are used to manage urinary frequency, urgency, and bladder overactivity symptoms, especially those related to detrusor instability.
  - **Combination Therapy:** Often, alpha-blockers are combined with 5-ARIs for enhanced efficacy in improving voiding symptoms.
- **Surgical Management:** Surgical intervention is considered for patients who do not respond to or tolerate medical therapy, or who present with specific indications such as bladder stones, refractory hematuria, recurrent urinary retention, or renal failure due to bladder outlet obstruction. The "gold standard" surgical procedure is Transurethral Resection of the Prostate (TURP), which debulks prostate tissue to create an adequate urinary channel. Other procedures include Transurethral Incision of the Prostate (TUIP) for smaller prostates, various Laser Vaporization techniques (e.g., Greenlight Photoselective Vaporization), Holmium Laser Enucleation of the Prostate (HoLEP), and newer minimally invasive options like Robotic Waterjet Treatment (Aquablation), Prostatic Urethral Lifts, and Water Vapor Thermal Therapy (Rezūm system). These minimally invasive procedures aim to reduce risks and preserve sexual function, though they typically do not provide tissue for pathological examination.

4. Conceptual Correlation and Overlap: *Mootraghata* and BPH [viii]

4.1. Symptomatic Parallels and Shared Clinical Features

Common symptomatic parallels include:

- **Urinary Retention (*Mootravarodha*):** Both conditions are characterized by the inability to completely empty the bladder.
- **Low Urine Output:** Reduced formation or passage of urine.
- **Increased Frequency of Urination (*Bahumutrata*):** A common complaint in both BPH and *Mootraghata*.
- **Sense of Incomplete Voiding:** The persistent feeling that the bladder has not been fully emptied after urination.
- **Weak Stream (*Manda Mootradhara*):** A diminished force of the urinary stream.
- **Dribbling:** Post-void dribbling or continuous leakage of urine.
- **Hesitancy:** Difficulty in initiating urination.
- **Incontinence of Urine:** Involuntary leakage of urine.
- **Painful Micturition (*Mootradaha*):** Discomfort or burning sensation during urination.

4.2. Pathophysiological Analogies: Bridging Dosha-Dhatu with Modern Mechanisms

The conceptual correlation between *Mootraghata* and BPH extends beyond mere symptomatic overlap to deeper pathophysiological analogies.

- ***Apana Vayu* and Bladder Outlet Obstruction (BOO):** The derangement of *Apana Vayu* is a central tenet in the pathogenesis of *Mootraghata*. *Apana Vayu* is the sub-type of *Vata* responsible for the normal voiding of urine and downward bodily movements. Its vitiation directly leads to obstruction of urine flow. This Ayurvedic concept strongly correlates with the dynamic component of BPH, where increased stromal smooth muscle tone contributes to BOO. The *Vata* principle, governing movement and obstruction, aligns well with the neurological and muscular dysfunction observed in BPH-related BOO.
- ***Vata-Kapha* Involvement and Prostatic Enlargement:** *Mootraghata* involves the vitiation of both *Vata* and *Kapha Doshas*. While *Vata* is responsible for obstruction and pain, *Kapha* is understood to contribute to the physical enlargement or growth of tissues. This dual *Dosha* involvement aligns directly with the static component of BPH, which is characterized by the physical increase in prostate volume due to cellular proliferation. The *Vatashteela* type of *Mootraghata* is particularly relevant here, being explicitly linked to prostate enlargement, serving as a specific Ayurvedic analogue for BPH.
- ***Dhatu* Involvement (Inferred Correlation):** Although not explicitly detailed in all provided

materials as direct *Mootraghata* pathogenesis, the prostate gland, being a glandular and reproductive organ, conceptually involves *Meda Dhatu* (glandular/fatty tissue) and *Shukra Dhatu* (reproductive tissue) in its pathology from an Ayurvedic perspective.

5. Ayurvedic Therapeutic Approaches for Mootraghata/BPH-like Conditions

5.1. General Principles of Management

Ayurvedic treatment for *Mootraghata* (and by correlation, BPH-like conditions) is fundamentally aimed at restoring the balance of *Doshas*, with a particular focus on pacifying vitiated *Vata* and *Kapha*. The overarching principle is to rectify the deranged *Apana Vayu* to re-establish normal urinary functioning. Ayurvedic management employs a multi-faceted approach, including *Ausadha Chikitsa* (internal medication), *Basti Karma* (enema therapy), and *Pathya Palan* (adherence to specific lifestyle and dietary regimens). This conservative approach often aligns well with the initial conservative management strategies in modern medicine for BPH.

5.2. *Panchakarma* Procedures (with emphasis on Basti Karma) [ix]

- ***Purva Karma:*** This preparatory phase includes *Snehana* (oleation, which can be internal through medicated ghee or external through oil massage) and *Swedana* (fomentation or steam therapy).

- ***Pradhana Karma:***
- ***Basti Karma:*** This procedure, in particular, is considered a cornerstone treatment in Ayurveda, especially for *Vata*-predominant disorders and various urinary tract issues. It is sometimes referred to as 'Ardha Chikitsa' (half treatment) due to its wide-ranging efficacy. The mechanism involves the administration of medicated herbal oils or decoctions into the rectum (or urethra/vagina), which directly influences the colon and urinary system. This process helps to eliminate aggravated *Vata Dosha*, soothe inflammation, cleanse channels, promote proper movement of energy, and remove *Ama*.
- ***Matra Basti (Anuvasana Basti):*** This involves the daily administration of a smaller dose of *Sneha Dravya* (medicated oil or ghee), typically 60 ml, through the rectal route. Studies have shown that *Bala Taila Matra Basti* can provide significant relief in BPH symptoms, reduce prostate size, decrease Post Void Residual Urine (PVRU), and improve Average Urine Flow Rate (AUFR).*Dhanyaka Gokshura Ghrita Matra Basti* has also demonstrated high efficacy in improving IPSS and quality of life *Bala Taila* contains beta-sitosterol, which has scientifically proven anti-inflammatory and anti-androgenic/anti-estrogenic effects, contributing to prostate growth control.[x], [xi]
- ***Niruha Basti (Kashaya Basti/Asthapana Basti):*** This is a water-based enema primarily composed of herbal decoctions, along with honey, rock salt, herbal pastes (*Kalka*), and lipids. Its main purpose is purification, cleansing bodily channels, and pacifying *Vata*. It is specifically indicated for *Mootra Sangha* (retention of urine). To prevent over-purification and maintain balance, *Niruha Basti* is often preceded and followed by *Anuvasana Basti*.
- ***Uttarbasti (Urethral Basti):*** This specialized procedure involves the direct administration of medicated oils or decoctions into the urinary bladder via the urethra. It is particularly recommended for obstructive uropathies and various urinary disorders. Clinical studies indicate that *Uttara Basti* with *Shilodbhidadi taila* can lead to reduced prostate size, increased maximum urine flow rate, and decreased International Prostate Symptom Score (IPSS). This procedure specifically targets diseases of the urinary and genital systems.[xii]
- ***Virechana (Purgation):*** This *Panchakarma* procedure involves the administration of purgative substances to cleanse *Pitta Dosha* through the lower pathways. It is known to cleanse blood toxins, sweat glands, kidneys, stomach, small intestine, colon, liver, and spleen. *Virechana* is indicated for genito-urinary issues and inflammatory conditions and is typically performed after preparatory *Snehana* and *Swedana*.[xiii]
- ***Svedana (Fomentation/Sweating):*** As part of *Purva Karma*, this procedure helps restore cell metabolism and eliminate accumulated toxins by inducing sweat.

5.3. Key Herbal Formulations and Their Mechanisms of Action[xiv]

Table 3: Key Ayurvedic Formulations for Mootraghata/BPH and Their Rationale/Mechanism of Action

Ayurvedic Formulation/Herb	Traditional Use/Ayurvedic Rationale	Proposed Ayurvedic Mechanism of Action	Potential Modern Pharmacological Action/Components	Specific Benefit in Mootraghata/BPH
Varuna (*Crataeva nurvala*)	Reduces glandular growth, urinary imbalances; Balances Vata & Kapha	Diuretic, Anti-inflammatory	(Not explicitly mentioned in snippets)	Reduces urinary retention, eases urine flow, manages inflammation
Shilajit (Mineral Pitch/Asphaltum)	Rejuvenative, genito-urinary disorders, vitality	Rasayana, Adaptogenic	Minerals, bioactive compounds	Tissue regeneration, vitality, overall prostate health
Punarnava (*Boerhaavia diffusa*)	Reduces fluid retention, inflammation; Balances Kapha	Mootral (diuretic), Anti-inflammatory	(Not explicitly mentioned in snippets)	Promotes urination, flushes toxins, reduces inflammation, supports kidney function
Chandraprabha Vati	Supports urinary health; Balances Pitta & Kapha	Detoxifying, Anti-inflammatory	Shilajit, Guggulu (components)	Reduces burning sensation, frequent urination, improves kidney function
Kanchanara Guggulu[xv]	Reduces glandular enlargements, abnormal tissue growth; Balances Kapha	Detoxifier, Improves lymphatic drainage	Triphala, Trikatu, Ascorbic acid	Reduces prostate size, improves urine flow
Gokshura (*Tribulus terrestris*)	Urogenital health	Diuretic, Lithotriptic, Vata-Pitta Shamaka	Diosgenin (in *Dhanyaka Gokshura Ghrita* containing Gokshura)	Improves urine flow, reduces prostate size, anti-inflammatory
Bala Taila (*Abutilon indicum*)	Strengthens pelvic muscles, rejuvenates urogenital system; Vata Shamaka	Enhances detrusor muscle function, controls prostate growth	Beta-sitosterol	Reduces prostate size, improves detrusor function (via Matra Basti), anti-inflammatory, anti-androgenic

5.4. Lifestyle and Dietary Recommendations (Pathya Palan) [xvi]

- **Avoid suppressing natural urges:** Especially the urge to urinate, as this directly disturbs bladder function and aggravates *Vata Dosha*.
- **Environmental considerations:** Avoid exposure to cold temperatures and damp environments, which are known to aggravate *Vata*.
- **Sitting posture:** Use firm chairs instead of soft sofas, as prolonged sitting on soft surfaces may weaken pelvic muscles.
- **Dietary restrictions:** Refrain from alcohol and caffeine, as these are known bladder and prostate irritants. Limit consumption of spicy, oily, and junk food.
- **Stress management:** Employ meditation or other relaxation techniques, as mental tension can exacerbate prostate symptoms.
- **Fluid intake management:** Reduce fluid intake after 6 PM to mitigate frequent nighttime urination (nocturia).
- **Smoking cessation:** Quitting smoking is advised to improve circulation and reduce systemic inflammation.
- **Beneficial dietary adjustments:** Increase consumption of anti-inflammatory foods, such as tomatoes and green leafy vegetables.
- **Hydration:** Maintain adequate fluid intake throughout the day to prevent urinary tract infections and promote overall urinary health.
- **Supportive therapies:** Incorporate warm Sitz baths to relax pelvic muscles and relieve discomfort, and practice Kegel exercises to strengthen pelvic floor muscles for improved urine control.

- **Yoga postures:** Specific yoga postures like Mandukasana (Frog Pose), Paripurna Navasana (Boat Pose), Supta Padangusthasana (Reclining Big Toe Pose), Sarvangasana (Shoulder Stand Pose), and Sirsasana (Headstand Pose) are recommended for their benefits in massaging abdominal organs, strengthening the pelvic floor, supporting hormonal balance, and improving circulation.

6. Discusion and Conclusion

This conceptual review establishes a compelling correlation between the Ayurvedic concept of *Mootraghata* and the modern medical diagnosis of Benign Prostatic Hyperplasia (BPH). The symptomatic parallels are striking, with both systems describing conditions characterized by urinary retention, weak stream, frequency, incomplete voiding, and other lower urinary tract symptoms. The Ayurvedic understanding of *Mootraghata* as a broad syndrome, with *Vatashteela* identified as a specific and precise analogue for BPH, provides a nuanced framework for comparative analysis.

The pathophysiological analogies are equally significant. The central role of deranged *Apana Vayu* and the profound impact of *vegavarodha* (suppression of natural urges) in Ayurvedic pathogenesis offer a unique, holistic, and functional perspective on bladder outlet obstruction that complements modern medicine's focus on the static (prostate enlargement due to cellular proliferation, conceptually linked to *Kapha Dosha* and *Meda Dhatu*) and dynamic (stromal smooth muscle tone, conceptually linked to *Vata Dosha*) components of BPH. This bidirectional illumination, where Ayurveda informs modern functional understanding and modern science validates Ayurvedic *Dosha-Dhatu* pathology, paves the way for a more comprehensive diagnostic and therapeutic approach. The observation of *Vata-Kaphaja Prakriti* predominance in *Mootraghata* patients further suggests the potential for Ayurvedic constitutional assessment to inform BPH risk stratification and personalized treatment.

Ayurvedic therapeutic approaches, particularly *Basti Karma* (including *Matra Basti* and *Uttarbasti*) and specific herbal formulations like *Varuna*, *Shilajit*, *Kanchanara Guggulu*, *Gokshura*, and *Bala Taila*, demonstrate considerable efficacy in managing BPH-like symptoms. The growing scientific validation of active compounds in these herbs (e.g., beta-sitosterol, diosgenin) further strengthens their credibility and provides a basis for understanding their pharmacological actions. The synergistic nature of Ayurvedic treatments, combining *Panchakarma*, herbal medicine, and detailed lifestyle and dietary recommendations (*Pathya Palan*), underscores a holistic approach that aims for deep-seated restoration rather than mere symptom suppression. This comprehensive strategy, including its strong preventative component through [xvii]*Pathya Palan*, holds significant promise for improving the quality of life for men with BPH.

References

1. [i]Kumar, B., & Singh, J. (2018). A CRITICAL REVIEW OF MUTRAGHATA IN AYURVEDA. *International Journal of Research in AYUSH and Pharmaceutical Sciences*, *1*(3), 148-154. https://ijraps.in/index.php/ijraps/article/view/24
2. [ii] Patel, N. D., & Parsons, J. K. (2014). Epidemiology and etiology of benign prostatic hyperplasia and bladder outlet obstruction. *Indian Journal of Urology: IJU: Journal of the Urological Society of India*, *30*(2), 170–176.
3. [iii] Charaka. (1890-1914). *Charaka-Samhita: Translated into English*. Avinash Chandra Kaviratna.
4. [iv] Bhishagratna, K. K. (Ed.). (1911). *An English Translation of the Sushruta Samhita, Based on Original Sanskrit Text; Volume 2*. Published by the Author.
5. [v] Vagbhata. (1995). *Astanga Samgraha of Vagbhata*. Chaukhambha Orientalia.
6. [vi] Chandrakar, N., Chandrakar, R., & Bhagat, P. (2024, August). The Concept of Dhatu and Their Role in Pathophysiology of Diseases. *International Ayurvedic Medical Journal*, *1531*-1539.
7. [vii] Chauhan, P., & Dudhamal, T. S. (2023, March 25). Management of Mutraghata (Benign Prostatic Hyperplasia) with Bala Tail Matrabasti - A Case Study. *Journal of Ayurveda and Integrated Medical Sciences*, *8*(2), 203-207.
8. [viii] Susruta. (1999). *An English translation of the Sushruta samhita based on original Sanskrit text with a full and comprehensive introduction, additional text, different readings, notes, comparative views, index, glossary and plates* (4th ed.). Chowkhamba Sanskrit Series Office.
9. [ix] Dahiya, A., Aswathy, Y. S., Sharma, A. P. V., & Dharmarajan, P. (2024, November). Effect of a Customized Panchakarma (bio-purificatory) Treatment Plan in a Case of Urethral Stricture with Cystitis: A Case Report. *Altern Ther Health Med*, *30*(11), 54-59.
10. [x] Patel, J., Dudhamal, T., Gupta, S. K., & Mahanta, V. (2015, March 20). Case report: Management of mootraghata (benign prostatic hyperplasia) with Bala Taila Matra Basti. *International Journal of Herbal Medicine*, *3*(1), 37-39.

11. [xi] Shree Lakshmi, D. (2025, February 6). *Uttara Basti: Ayurvedic Therapy for Women's Health and Reproductive Wellness*. Adyant Ayurveda.
12. [xii] Kotiya, A., Singh, L., & Dwivedi, A. K. (2023). An Ayurvedic Management of BPH by Uttar Basti Therapy (UBT). *Ayushdhara*, *10*(5).
13. [xiii] Maurya Ayurveda. (2025). *Virechana Treatment In Ayurveda | Benefits*. Retrieved from https://mauryaayurveda.com/virechana-ayurvedictreatment-mauryaayurveda/
14. [xiv] Nag, K., & Soni, K. (2024). EVALUATE THE EFFECT OF TRADITIONAL APPROACH (BASTI CHIKITSA AND AYURVEDA FORMULATIONS) IN THE MANAGEMENT OF BENIGN PROSTATE HYPERPLASIA (BPH). *AYUSHDHARA: An International Journal of Research in AYUSH and Allied Systems*, *11*(4), 209-213.
15. [xv] Patel, J. K., Dudhamal, T. S., Gupta, S. K., & Mahanta, V. (2015). Efficacy of Kanchanara Guggulu and Matra Basti of Dhanyaka Gokshura Ghrita in Mootraghata (benign prostatic hyperplasia). *Ayu*, *36*(2), 138–144.
16. [xvi] Bechis, S. K. (2024, January 31). *Making Sense of BPH: Which Treatment for Which Patient – Review of Guidelines for BPH*. grandroundsinurology.com.
17. [xvii] Adhikari, T., & Wahane, A. S. (2022). A Conceptual Study on Mutraghata (Retention of Urine) Management - The Most Prevalent Disease of India. *Journal of Ayurvedic and Herbal Medicine*, *8*(2), 136-141