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Nidanpanchak of Ardhavbhedaka and Its Correlation with Migraine: A Critical Integrative Review of Classical Ayurvedic and Contemporary Neurological Perspectives

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Abstract : **Background:** Migraine is the second leading cause of years lived with disability worldwide and remains under-diagnosed and under-treated in India. Ayurveda describes a closely comparable hemicranial headache, Ardhavbhedaka, within *Shiroroga*, and analyses it through *Nidanpanchak*, the fivefold diagnostic method of *Nidan*, *Purvarupa*, *Rupa*, *Upashaya* and *Samprapti*. Earlier comparisons have mostly listed classical verses beside migraine symptoms without stating methods or grading the strength of agreement.

Objective: To critically map each *Nidanpanchak* domain of Ardhavbhedaka onto contemporary migraine epidemiology, ICHD-3 diagnosis and pathophysiology, separating clinical concordance from mechanistic analogy, and to define research priorities.

Methods: An integrative literature review. Classical descriptions were taken from the Charaka Samhita, Sushruta Samhita, Ashtanga Hridaya, Madhava Nidana and Yogaratnakara, with verse locators cross-checked against public digital editions. PubMed/MEDLINE, Google Scholar, the AYUSH Research Portal and Shodhganga were searched for January 2000 to August 2026. Each correspondence was graded Direct/Strong, Direct/Moderate or Analogous/Moderate.

Results: Agreement was strongest for *Hetu* versus modern triggers (meal irregularity, exertion, exposure, sleep loss and stress) and for *Rupa* versus ICHD-3 attack features (unilateral severe pain with nausea or vomiting). Sushruta records recurrence every ten days or fortnight or without fixed periodicity, while Vagbhata records fortnightly or monthly recurrence; this supports a cautious link with cyclical and menstrual patterns. *Purvarupa* agreed moderately with the migraine premonitory phase. *Samprapti* and the trigeminovascular model are analogous only, and the medication-overuse parallel is interpretive. Ayurvedic research on Ardhavbhedaka is dominated by therapeutic trials, and observational data on *Nidanpanchak* in ICHD-3-confirmed patients are scarce.

Conclusion: *Nidanpanchak* is a useful clinical scaffold for dual-system assessment of migraine, but claims of mechanistic identity are not warranted. Prospective observational mapping in ICHD-3-confirmed cohorts is the next essential step.

IndexTerms **- Ardhavbhedaka, Nidanpanchak, Migraine, Shiroroga, ICHD-3, Integrative Review**

I. INTRODUCTION

Headache disorders are among the most common and disabling conditions of the nervous system. In the Global Burden of Disease Study 2019, migraine ranked second among all causes of years lived with disability and first among young women [1]. The International Classification of Headache Disorders, 3rd edition (ICHD-3) defines migraine by recurrent attacks of usually unilateral, pulsating, moderate-to-severe headache lasting 4–72 hours, aggravated by routine activity and accompanied by nausea, vomiting, photophobia or phonophobia [2]. In India, a community survey in Karnataka found one-year prevalence of headache disorders that included a substantial migraine burden [3], yet access to guideline-based care remains uneven. Even with calcitonin gene-related peptide (CGRP)-targeting drugs now recommended as a first-line preventive option [4], this care gap justifies a careful look at complementary diagnostic frameworks that can enrich clinical assessment without displacing biomedical diagnosis.

Ayurveda groups disorders of the head under *Shiroroga*. Among them, Ardhavbhedaka (from *Ardha*, half, and *Bhedaka*, splitting or piercing) is described in the Charaka Samhita, Sushruta Samhita, Ashtanga Hridaya, Madhava Nidana and Yogaratnakara [5–9]. The Ayurvedic diagnostic method applied to it is *Nidanpanchak*, the combined analysis of *Nidan* (*Hetu*, causative factors), *Purvarupa* (prodrome), *Rupa* (manifest features), *Upashaya* (response to therapy) and *Samprapti* (pathogenesis). Vagbhata states this fivefold scheme compactly in Ashtanga Hridaya Nidanasthana 1/2 [7].

Most published work on Ardhavbhedaka evaluates treatments, particularly *Nasya* and oral formulations [10–16]. Narrative comparisons with migraine usually place classical verses next to modern features without describing a search method, without grading the strength of agreement and without separating clinical similarity from mechanistic analogy. This review addresses that gap. Its central argument is that *Nidanpanchak* is best understood as a clinical phenotype scaffold that organises triggers, prodrome, attack features and treatment response, rather than as a ready-made molecular account of migraine. Agreement should therefore be strongest where both traditions describe bedside observations and weakest where they describe theoretical mechanisms.

The objectives were to (a) summarise the classical descriptions of Ardhavbhedaka with verifiable locators; (b) outline each *Nidanpanchak* domain as it applies to clinical assessment; (c) summarise current understanding of migraine epidemiology, diagnosis, triggers, phases and pathophysiology; and (d) map classical observations to modern correlates, stating where agreement is direct, where it is only analogical and where earlier literature has overstated it. Figure 1 summarises the resulting framework.

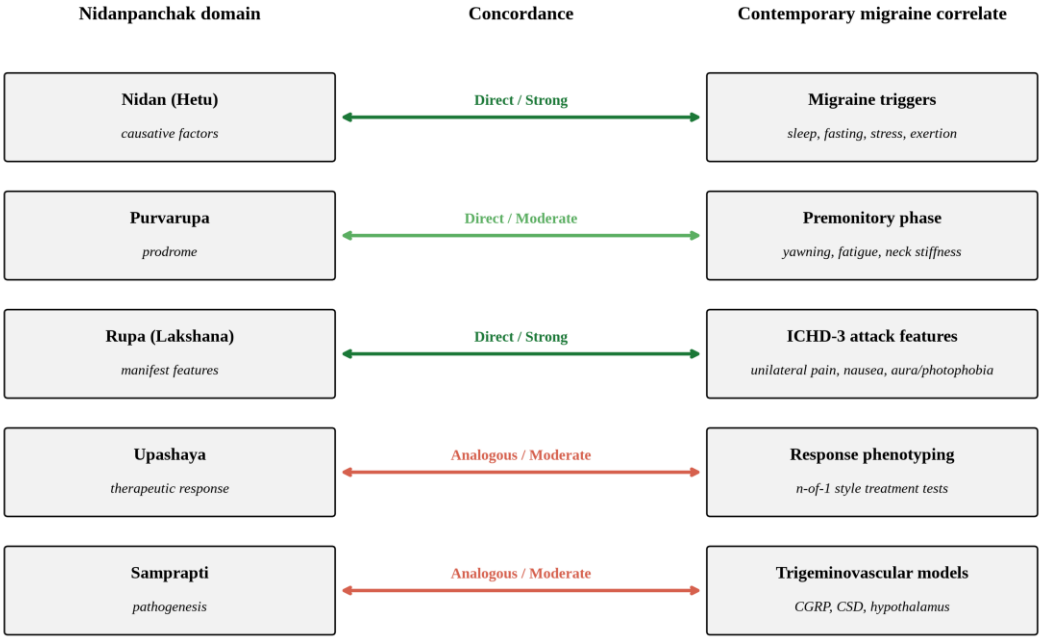


Figure 1. Conceptual crosswalk between the *Nidanpanchak* domains of Ardhavbhedaka and contemporary migraine constructs, with author-assigned concordance grades

II. MATERIALS AND METHODS

2.1 Review design

This is an integrative literature review following the method of Whittemore and Knafl, which allows classical texts, clinical studies and biomedical reviews to be combined in one theory-informed synthesis [17]. It is not a registered systematic review or meta-analysis, and no protocol was registered in PROSPERO.

2.2 Classical sources

Classical descriptions of Ardhavbhedaka and *Nidanpanchak* were taken from standard Sanskrit–Hindi editions used in postgraduate Ayurveda teaching in India: the Charaka Samhita with the Ayurveda Dipika commentary, the Sushruta Samhita, the Ashtanga Hridaya with the Sarvangasundara commentary, the Madhava Nidana with the Madhukosha commentary and the Yogaratnakara [5–9]. Chapter and verse locators were cross-checked against publicly available digital teaching editions to reduce errors carried over from secondary citations. Chapter numbering that differs between editions, particularly for the *Shiroroga* chapter of the Madhava Nidana, is stated where relevant.

2.3 Biomedical and contemporary Ayurveda sources

PubMed/MEDLINE and Google Scholar were searched, together with the AYUSH Research Portal and the Shodhganga thesis repository, for January 2000 to August 2026. Search strings combined Ayurvedic terms (Ardhavbhedaka OR Ardhavabhedaka; *Shiroroga*; *Nidanpanchak* OR *Nidana Panchaka*; *Nasya* AND migraine) with biomedical terms (migraine; ICHD-3; trigeminovascular; CGRP; menstrual migraine; medication overuse headache). At the final PubMed search (August 2026), the string Ardhavbhedaka/Ardhavabhedaka returned 6 records, migraine AND Ayurveda returned 25, and migraine[Title] AND (Ayurveda OR Ayurvedic)[Title/Abstract] returned 15. The first 100 Google Scholar hits per main string were screened, and reference lists of included reviews and theses were hand-searched.

2.4 Eligibility, screening and synthesis

Included were (1) classical passages describing the *Nidan*, *Purvarupa*, *Rupa*, *Upashaya* or *Samprapti* of Ardhavbhedaka; (2) peer-reviewed biomedical articles on migraine diagnosis, epidemiology, triggers, phases, pathophysiology or major guidelines; and (3) Ayurvedic clinical studies or MD/MS theses on Ardhavbhedaka with usable diagnostic or therapeutic content. Excluded were encyclopaedic web pages, journals that could not be verified, abstracts without full text, animal-only studies and articles with no content usable for mapping. Records were screened by title and abstract and then in full text by the author.

For each domain, the classical description was compared with the modern construct using a pre-defined grading. **Direct/Strong** means a close match of clinical observation supported by both the classical text and modern clinical evidence. **Direct/Moderate** means clear clinical similarity with incomplete overlap or mixed modern evidence. **Analogous/Moderate** means a structural or functional resemblance between different explanatory systems without any claim of shared mechanism. Points of disagreement were recorded rather than forced into agreement. These grades are interpretive judgments for synthesis and are not formal GRADE ratings.

III. NIDANPANCHAK AS A DIAGNOSTIC FRAMEWORK

Nidanpanchak is the core of Ayurvedic clinical reasoning: an integrated analysis of cause, prodrome, manifest disease, therapeutic response and pathogenesis, not a checklist [7]. A physician who fully understands these five aspects of a disease is classically considered equipped to diagnose and manage it.

3.1 *Nidan* (*Hetu*): causative factors

Classical texts group causes as dietary (*Aharaja*), lifestyle (*Viharaja*), psychological (*Manasika*), seasonal or temporal (*Kalaja*) and external (*Agantuka*). For Ardhavbhedaka, the Charaka Samhita and the Madhava Nidana attribute the disease to *Vata*, alone or with *Kapha*, provoked by dry food (*Ruksha Ahara*), eating before the previous meal is digested or overeating (*Adhyashana*, *Atyashana*), exposure to easterly wind (*Pragvata*) and frost (*Avashyaya*), excessive sexual activity (*Maithuna*), suppression of natural urges (*Vegavidharana*), fatigue (*Ayasa*) and over-exertion (*Vyayama*) [5,8]. Secondary literature and clinical teaching commonly add night waking (*Ratrijagrana*), fasting (*Anashana*) and mental stressors such as worry, grief and anger (*Atichinta*, *Shoka*, *Krodha*). These additions are clinically plausible and match modern triggers well, but they are a synthesis of tradition and teaching, not a single verse list shared by all three major treatises (*Brihatrayee*) [6,7].

3.2 *Purvarupa*: prodromal features

Purvarupa are early signs that appear while the *Doshas* are vitiated, before the disease is fully expressed. A distinct *Purvarupa* list specific to Ardhavbhedaka is not given uniformly in the *Brihatrayee*; Charaka Siddhisthana 9 describes the causes, features and treatment more clearly than any dedicated prodrome [5]. Clinical writing often lists heaviness of the head (*Shirahgurutva*), throbbing (*Shirasphuranam*), yawning (*Jrimbha*), mild puffiness around the eyes (*Netrashotha*) and early one-sided discomfort as *Purvarupa*. This review treats that list as a useful teaching synthesis that still needs observational confirmation.

3.3 *Rupa* (*Lakshana*): clinical features

The Madhava Nidana (*Shiroroga* chapter; Chapter 60 in widely used teaching editions) describes severe one-sided pain involving the neck (*manya*), eyebrow (*bhru*), temple (*shankha*), ear (*karna*), eye (*akshi*) and half of the forehead (*lalata*), likened to cutting or churning, with a risk of damage to sight or hearing if the disease advances [8]. Teaching summaries often present these sites as seven *Lakshanas* (one-sided head pain, *Ardhaparshwa Shula*, plus the six sites). That framing is useful clinically, but it is a structured reading of one pain-distribution verse rather than seven separate features. Associated features in the wider *Shiroroga* literature include vomiting (*Chardi*), thirst (*Trisha*), giddiness (*Bhrama*), visual disturbance (*Drishti Vibhrama*), drowsiness (*Tandra*) and mental agitation.

3.4 *Upashaya*: response to therapy

Upashaya uses the response to a specific measure as a diagnostic probe: relief after a *Dosha*-specific intervention supports an inference about which *Dosha* predominates. In Ardhavbhedaka, relief with *Vata–Kapha*-pacifying measures such as unctuous diet (*Snigdha Ahara*), oil-based *Nasya* and *Shirobasti* is traditionally read as support for *Vata–Kapha* predominance [5,7].

3.5 *Samprapti*: pathogenesis

In the primary accounts of Charaka and Madhava, *Samprapti* is brief: *Vata*, alone or with *Kapha*, provoked by the causes listed above, seizes half of the head and produces severe one-sided pain [5,8]. Teaching reconstructions add the upward movement of the vitiated *Doshas* (*Urdhvagamana*), obstruction of the *Rasavaha* and *Raktavaha Srotas* in the head, the head as the site of manifestation (*Vyakti Sthana*) and the middle disease pathway (*Madhyama Rogamarga*). These elaborations are retained as teaching *Samprapti* and are kept distinct from the shorter primary verses [6,7].

IV. ARDHAVBHEDAKA IN THE CLASSICAL LITERATURE

The principal classical descriptions, with verified locators, are summarised in Table 1.

Table 1. Classical descriptions of Ardhavbhedaka with verified locators

Text	Locator	Key description	Source
Charaka Samhita	Sutrasthana 17/13–14	Named among disorders of the head; no full case definition	[5]
Charaka Samhita	Siddhisthana 9/74–78	*Vata* alone or with *Kapha* seizes half the head; severe churning or piercing pain in neck, eyebrow, temple, ear, eye or forehead; eye or ear damage if aggravated; detailed management	[5]
Sushruta Samhita	Uttaratantra 25/15	Splitting, pricking one-sided pain with giddiness; *Tridoshaja*; recurs every ten days (*dashaha*) or fortnight (*paksha*) or without fixed periodicity (*akasmat*)	[6]
Ashtanga Hridaya	Nidanasthana 1/2	Fivefold knowledge of disease: *Nidan*, *Purvarupa*, *Rupa*, *Upashaya*, *Samprapti*	[7]
Ashtanga Hridaya	Uttarasthana 23/7–8	Vataja pain in half the head recurring every fortnight (*paksha*) or month (*masa*) and remitting spontaneously; eye or ear damage if aggravated	[7]

Text	Locator	Key description	Source
Madhava Nidana	Chapter 60 (*Shiroroga*)	Pain distribution across *manya*, *bhru*, *shankha*, *karna*, *akshi* and half of *lalata*; closely follows Charaka	[8]
Yogaratnakara	Uttarardha, *Shiroroga Chikitsa*	Consolidates *Vata–Kapha* pathogenesis and combined *Shodhana–Shamana* treatment	[9]

4.1 Charaka Samhita

In Sutrasthana 17, Charaka names Ardhavabhedaka among the disorders of the head (verses 13–14) without giving a full case definition [5]. The detailed causes, features and treatment are given in Siddhisthana 9 (Trimarmiya Siddhi), verses 74–78: *Vata*, alone or with *Kapha*, seizes one half of the head and produces severe churning or piercing pain in the neck, eyebrow, temple, ear, eye or forehead of that side, with possible damage to the eye or ear if the disease is aggravated. Management centres on the four unctuous substances (*Chatuhsneha*), purgation of the head and body (Shiro- and Kaya-*virechana*), tubular fomentation (*Nadi-sveda*), old ghee (*purana ghrita*), enema (*basti*), poultice (*upanaha*), *Shirobasti* and related *Vata–Kapha*-pacifying measures. Some secondary sources place this case definition in Chikitsasthana 26 (Trimarmiya *Chikitsa*); that chapter covers broader treatment of the three vital organs, and the specific description belongs to Siddhisthana 9.

4.2 Sushruta Samhita

Sushruta (Uttaratantra 25/15) describes severe splitting and pricking one-sided head pain with giddiness (*sambheda*, *toda*, *bhrama*), caused by all three *Doshas*, which recurs every ten days (*dashaha*) or every fortnight (*paksha*) or arises without fixed periodicity (*akasmat*) [6]. Sushruta does not mention monthly (*masa*) recurrence in this verse; monthly recurrence is stated by Vagbhata. Secondary sources sometimes combine these intervals into a single "*paksha–masa*" statement attributed to Sushruta, which the text does not support. The *Tridoshaja* label supports clinical heterogeneity, but the detailed *Vata*, *Pitta* and *Kapha* symptom tables found in some modern reviews are interpretive expansions rather than content of Uttaratantra 25.

4.3 Ashtanga Hridaya

Vagbhata (Uttarasthana 23/7–8) defines Ardhavabhedaka as Vataja head pain in one half of the head that recurs every fortnight or month (*paksha*, *masa*) and remits spontaneously, with a risk of damage to the eye or ear when greatly aggravated [7]. This is the clearest classical source for monthly recurrence. Teaching accounts add obstruction of the *Rasavaha* and *Raktavaha Srotas* when explaining *Shiroroga*; that channel-obstruction model is treated here as secondary teaching, not as content of these verses.

4.4 Madhava Nidana and Yogaratnakara

The Madhava Nidana (*Shiroroga* Nidana; Chapter 60 in common teaching editions, Chapter 62 in some citations owing to edition differences) gives a structured account of causes, pathogenesis and features that closely follows Charaka Siddhisthana 9, and it remains a standard reference for teaching pathology [8]. The Yogaratnakara consolidates *Vata–Kapha* pathogenesis and combined purificatory and palliative (*Shodhana–Shamana*) treatment, contributing more to therapy than to disease classification [9].

V. CONTEMPORARY UNDERSTANDING OF MIGRAINE

5.1 Classification and burden

ICHD-3 classifies migraine as a primary headache disorder and recognises migraine without aura (code 1.1), migraine with aura (1.2) and chronic migraine (1.3) [2,18]. Migraine is a leading cause of disability worldwide, with the greatest impact on women of working age [1], and Indian estimates confirm a substantial population burden [3].

5.2 Pathophysiology and treatment anchors

Current models view migraine as a disorder of sensory processing involving activation of the trigeminovascular system, CGRP-mediated neurogenic inflammation, cortical spreading depression as the basis of aura and hypothalamic and brainstem involvement in attack initiation [19–21]. Genetic contribution is substantial, and genome-wide studies have identified multiple susceptibility loci [22]. The clinical success of CGRP-targeting monoclonal antibodies and gepants, and the 2024 American Headache Society position that these agents are a first-line preventive option, confirm the central role of CGRP without explaining all of migraine biology [4].

5.3 Triggers, phases and diagnosis

Common precipitants include psychological stress, sleep disruption, fasting or missed meals, hormonal change, weather change and sensory overload [23]. Menstrual migraine is a recognised and under-diagnosed pattern [24], and medication overuse is a major complication of frequent acute treatment [25]. Attacks may pass through a premonitory phase, an optional aura, the headache and a postdrome [26]. Diagnosis remains clinical by ICHD-3; imaging is used to exclude secondary causes, not to confirm migraine [2,18,21].

VI. CRITICAL SYNTHESIS: NIDANPANCHAK MAPPED TO MIGRAINE

This section evaluates the strength of each correspondence, records disagreements and states the limits of inference. The question is not whether Ardhavbhedaka "is" migraine, but which *Nidanpanchak* domains remain useful as clinical crosswalks once over-attribution and anachronism are removed. Table 2 gives the feature-level mapping and Table 3 the domain-level judgments.

Table 2. Feature-level correlation of Ardhavbhedaka *Nidanpanchak* elements with modern migraine constructs

Ardhavbhedaka element	Migraine correlate	Concordance	Interpretive note
Ardhaparshwa Shula (one-sided head pain)	Unilateral moderate–severe pain	Direct / Strong	Core ICHD-3 location criterion; ICHD-3 also allows bilateral pain
Regional pain sites (*manya*, *bhru*, *shankha*, *karna*, *akshi*, *lalata*)	Cervical, frontal, temporal and periocular radiation	Direct / Moderate	Reading of Madhava's pain-distribution verse; not seven separate diseases
Chardi (vomiting) and nausea-related features	Nausea / vomiting	Direct / Strong	Strong overlap of associated symptoms; lists vary by text
Drishti Vibhrama (visual disturbance)	Visual aura / photophobia	Direct / Moderate	Mixed classical descriptor; not equivalent to aura alone
Teaching *Purvarupa* (*Jrimbha*, heaviness, early throbbing)	Premonitory phase, including yawning	Direct / Moderate	Yawning is documented in modern studies; classical attribution is uneven
Ruksha Ahara, *Adhyashana*, *Vegavidharana*, *Vyayama* (Charaka, Madhava)	Meal-pattern, exertion and lifestyle triggers	Direct / Strong	Core classical causes; match published trigger inventories
Teaching additions (*Ratrijagrana*, mental stress, *Anashana*)	Sleep loss, stress and fasting triggers	Direct / Strong	Strong modern match; mark as teaching synthesis where not in the verses
Medication-overuse parallel	Medication-overuse headache	Analogous / Moderate	Not a distinct classical cause of Ardhavbhedaka; interpretive only
Pragvata and seasonal change	Weather / barometric change	Analogous / Moderate	Similar direction; causal specificity limited in both traditions
Sushruta: *dashaha*, *paksha*, *akasmat*	Episodic recurrence	Direct / Moderate	Supports episodicity; not menstrual biology as such
Vagbhata: *paksha*, *masa*	Cyclical / menstrual migraine pattern	Direct / Moderate	Best classical source for monthly recurrence; not a hormonal theory
Teaching *Srotavarodha Samprapti*	Trigeminovascular / neurovascular models	Analogous / Moderate	Structural analogy only; no mechanistic identity

Concordance grades in Tables 2 and 3 are author-assigned interpretive judgments, not formal evidence ratings.

Table 3. Domain-level synthesis: agreements, disagreements and implications

Domain	Agreement	Disagreement / limit	Implication
Hetu vs triggers	High overlap for exertion, meal irregularity and exposure, and (through teaching synthesis) sleep loss, stress and fasting	Lists differ between texts; *Rasapanchaka* dietary terms do not reduce to nutrient trigger lists; the medication-overuse parallel is interpretive	Use combined trigger diaries that separate classical and teaching-derived *Hetu*
Purvarupa vs prodrome	Premonitory phase, including yawning, is well documented; conceptual fit is strong	No uniform Ardhavbhedaka-specific *Purvarupa* list in the *Brihatrayee*	Do not treat as verse-level proof; test prospectively
Rupa vs ICHD-3	Severe one-sided pain with digestive and visual features aligns closely	ICHD-3 allows bilateral pain; ear and eye pain exceed minimum criteria	Case forms should record ICHD-3 criteria plus extended *Lakshanas*
Upashaya vs response phenotyping	Parallels n-of-1 therapeutic tests and response-guided care	Open to placebo, expectation and natural resolution of attacks; not causal proof of *Dosha*	Use bias-controlled n-of-1 or adaptive designs
Samprapti vs pathophysiology	Shared interest in the head's neural and vascular interface	*Dosha* and *Srotas* concepts are not CGRP or trigeminovascular concepts	Keep the analogy explicit; prioritise clinical concordance research

6.1 *Hetu* and triggers: the strongest agreement

Trigger-level mapping is the most empirically grounded domain. The causes named by Charaka and Madhava (*Ruksha Ahara*, *Adhyashana*, *Vegavidharana*, *Vyayama*, *Ayasa*, *Pragvata*) correspond to exertion, disrupted meal patterns and environmental exposure in modern trigger inventories [5,8,23]. The teaching additions of sleep loss, psychological stress and fasting have particularly strong modern support [23] and are clinically useful, provided they are not presented as one identical list across the *Brihatrayee*. Medication-overuse headache is a major modern complication [25], but equating it with a named classical cause (sometimes glossed as *Asatmya Aushadhi* in secondary writing) goes beyond the verses reviewed; the parallel is therefore graded Analogous/Moderate. *Rasapanchaka* dietary language also does not reduce to modern lists of food triggers, and classical weather attributions exceed what barometric studies have confirmed.

6.2 *Purvarupa* and the premonitory phase

Electronic diary and clinical studies establish a reliable premonitory phase with fatigue, difficulty concentrating, neck stiffness and yawning [21,26,27]. Teaching attributions of *Jrimbha*, *Shirasphuranam* and *Shirahgurutva* as *Purvarupa* of Ardhavbhedaka therefore have a plausible modern counterpart. Because the *Brihatrayee* does not provide a uniform *Purvarupa* list for this disease, agreement is graded Direct/Moderate for the overall concept and the overlapping items, not Strong. The modern premonitory spectrum, including mood change and food craving, is also wider than the classical teaching list.

6.3 *Rupa* and ICHD-3: overlap without identity

Ardhaparshwa Shula and the associated *Chardi* and loss of appetite (*Arochaka*) map closely onto the ICHD-3 criteria for laterality and associated symptoms [2]. *Drishti Vibhrama* is best read as a mixed description of visual disturbance that may correspond to aura, photophobia or both, so it is graded Direct/Moderate. Ear and eye pain (*Karnashula*, *Akshishula*) exceed the minimum ICHD-3 criteria but are plausible as referred trigeminal pain. An important difference remains: ICHD-3 allows bilateral migraine, whereas classical Ardhavbhedaka emphasises one-sided splitting pain. The two are overlapping clinical constructs, not synonyms.

6.4 *Samprapti* and pathophysiology: analogy, not identity

Obstruction of the channels of the head by *Vata* and *Kapha*, producing pain, can be described as functionally analogous to trigeminovascular activation and meningeal pain signalling [19,20]. *Raktavaha Srotas* language resembles the vascular accompaniments of migraine pain, and the concept of disturbed digestive fire (*Vishama Agni*) invites comparison with hypothalamic metabolic and circadian models of attack generation [19,21]. These are structural analogies between traditions. They do not show that *Dosha* physiology is CGRP biology or that channel obstruction equals neurogenic inflammation. Overclaiming in this domain is a recurring weakness of integrative reviews, and this review deliberately grades it Analogous/Moderate.

6.5 Periodicity and menstrual migraine

Periodicity must be attributed accurately. Sushruta supports recurrence about every ten days or fortnight, or without fixed periodicity [6], while Vagbhata adds fortnightly or monthly recurrence with spontaneous remission [7]. Together these observations are compatible with cyclical clinical patterns and with the modern concept of menstrual migraine, which mainly affects women [24]. They do not justify reinterpreting the classical intervals as a theory of oestrogen withdrawal. The defensible claim is early recognition of patterned recurrence, not anticipation of molecular mechanisms. Sushruta's *Tridoshaja* label similarly supports phenotypic heterogeneity as a hypothesis for future *Dosha*–ICHD-3 studies.

6.6 *Upashaya*: opportunity and bias

Confirming *Dosha* predominance through response to therapy is clinically practical but vulnerable to expectation bias, placebo effects and the natural end of an attack, limitations shared with uncontrolled single-patient treatment tests in biomedicine. Its integrative value lies in structured recording of treatment response, not in proof of cause.

VII. EXISTING RESEARCH AND GAP ANALYSIS

Across CCRAS-linked work, institutional theses and journal reports, research on Ardhavbhedaka is dominated by evaluations of *Nasya* oils and oral formulations such as Anutaila, Shadbindu Taila, Brihat Dashamoola Taila, Sutashekhara Rasa, Pathyadi Ghanvati and Panchagavya Ghrita, including randomised and comparative designs [10–15]. A yoga-based protocol of Nadi *Shodhana* Pranayama with meditation has also been studied [16]. These studies give useful efficacy signals, but they generally assume the classical disease construct rather than measuring the distribution of *Hetu* and *Lakshana* against ICHD-3 in present-day patients.

The observational study closest to a *Nidanpanchak*-focused inquiry identified in this review documented clinical presentation and outcomes but did not quantify the distribution of *Nidanpanchak* components or report formal agreement with ICHD-3 [28]. In short, therapeutic research has outpaced diagnostic epidemiology. Without contemporary observational data, *Nidanpanchak*-guided practice rests more on textual authority than on measured phenotype prevalence, *Dosha*–ICHD-3 relationships or prediction of treatment response. Closing this gap would (1) confirm whether classical descriptors remain valid in today's patients; (2) allow individualised, *Dosha*-informed treatment selection rather than one protocol for all; (3) generate hypotheses for stratified trials; and (4) meet integrative-medicine standards that require explicit methods and graded inference.

VIII. FUTURE RESEARCH DIRECTIONS

Four priorities follow from the limits identified above. First, multicentre observational studies should quantify *Nidanpanchak* components in ICHD-3-confirmed migraine using standardised case record forms, pre-defined agreement criteria and sex-stratified analysis of periodicity. Second, *Dosha*-phenotype hypotheses, such as *Vata*, *Pitta* or *Kapha* predominance in relation to aura status, attack frequency and trigger profile, should be tested prospectively. Third, mechanistic studies of *Nasya* should use contemporary pharmacology and, where ethical and feasible, neuroimaging or neurophysiology focused on olfactory–trigeminal pathways, without forcing *Dosha* terms into biomarker identity. Fourth, patient-reported outcomes should assess the acceptability and quality-of-life impact of *Nidanpanchak*-guided care alongside standard preventive treatment, including CGRP-targeting options where available [4].

IX. LIMITATIONS

This is a single-author integrative review rather than a registered systematic review, and screening was not duplicated by a second reviewer. Classical locators were checked against digital teaching editions; printed page numbers may differ between reprints. Several Ayurvedic theses were cited from catalogue records, and the concordance grades are interpretive. These limits are offset by explicit search reporting, verified locators and graded inference.

X. CONCLUSION

Nidanpanchak of Ardhavbhedaka is a clinically useful framework for dual-system assessment of migraine. Its strongest correspondences lie in *Hetu* versus triggers and *Rupa* versus ICHD-3 attack features, and the recurrence patterns recorded by Sushruta (*dashaha*, *paksha*) and Vagbhata (*paksha*, *masa*) allow a cautious link with cyclical and menstrual patterns without anachronism. Agreement for *Purvarupa* is moderate because the classical lists are uneven. *Samprapti* and trigeminovascular or

hypothalamic parallels are analogical only, and the medication-overuse parallel is interpretive. The contribution of this review is not a claim that Ayurveda anticipated molecular migraine biology, but a transparent, locator-verified and strength-graded mapping that can guide assessment in *Kayachikitsa* and *Shalakya* practice and that identifies prospective observational validation as the necessary next step.

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CONFLICT OF INTEREST

The author declares no conflict of interest.

ETHICS AND USE OF AI TOOLS

Ethics approval was not required because this review used only published literature and involved no human participants, animals or patient data. AI-assisted tools were used only to improve language and formatting; the author reviewed all content and takes full responsibility for the scientific content, citations and conclusions.

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