Management of *Avabahuka* (stage I primary frozen shoulder) through Wet cupping therapy: A single case report

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**ABSTRACT**

Frozen shoulder goes through three progressive phases of pain, stiffness and gradual recovery, as initially proposed by Reeves in 1975. Patients experience both pain and restriction of movement, the timing and extent of these symptoms is a matter of debate. Frozen shoulder is often described as ‘self-limiting’ meaning that recovery will be achieved over time, regardless of treatment approach. A 51 years old home maker, type I diabetic female patients was complaining of right dominating shoulder pain with stiffness and actively restricted shoulder joint movement since last 4 months. A case successfully managed by 3 sessions of wet cupping in 7 days of intervals. The patient was assessed by Visual Analog Scale score and active range of movement. This case report shows that the cases of primary frozen shoulder can be successfully managed with wet cupping therapy.

**Keywords:** *Avabahuka*, Ayurveda, frozen shoulder, wet cupping.

**Background:** Acharya sushruta known as father of surgery narrated different type of *raktamokshana* (bloodletting) methods and *shringa* (cupping therapy ) one among them is extensively practiced in India by seers.\(^1\) There are two forms of cupping: wet cupping (bloodletting cupping) and dry cupping according to traditional Chinese medicine which is widely practiced in China for musculoskeletal disorders.\(^2\) Wet cupping therapy (WCT) is gaining popularity to treat musculoskeletal disorders, particularly in In-

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dia to treat cervical pain, lower back pain, frozen shoulder, and hypertension. WCT appears to exert pleiotropic effects and is employed for multiple indications.

Patients with established diabetes have a greater likelihood of developing frozen shoulder than the normal population, and a diagnosis of frozen shoulder may be the first warning sign of a diabetic condition. Frozen shoulder or primary idiopathic stiff shoulder. This term should be used exclusively to describe the primary idiopathic stiff shoulder. It develops without any trauma or specific shoulder disease period. If a patient has a condition that may be linked to a stiff shoulder, but not known to specifically cause the stiffness, it will still be considered idiopathic. Examples include predisposing factors such as diabetes, thyroid conditions, Dupuytren contracture, smoking, etc.\(^3\)

Frozen shoulder patients usually present in the sixth decade of life, and onset before the age of 40 is very uncommon. The peak age is 56, and the condition occurs slightly more often in women than men. In 6-17% of patients, the other shoulder becomes affected, usually within five years, and after the first has resolved. The non-dominant shoulder is slightly more likely to be affected.\(^4\)

The first phase or the freezing phase is distinguished mainly by pain and gradually increasing stiffness and lasts 2 to 9 months. Pain starts often in the night and is sometimes so severe that it prevents the patient from sleeping on the affected side. Gradually, pain increases and is present all the time. During the freezing phase, when pain is the principal problem and stiffness is not yet evident, differentiation between other causes of shoulder pain on purely clinical grounds is difficult. In the second phase or the frozen phase lasting from 4 to 12 months, pain is less severe and there is minor discomfort in the shoulder, but stiffness is substantial. In the third phase or the thawing phase, function is gradually restored and pain is resolved. This can take a further 5 to 26 months. Some patients may regain full use of their shoulder within 12 to 18 months, whereas others may have persistent symptoms for several more months.\(^5\)

**Case history:** A 51 years old home maker, type I diabetic female patients was complaining of right dominating shoulder pain with stiffness since last 4 months. There was actively restricted shoulder joint movement since last 4 months. Pain was dull ache type from shoulder to deltoid region and increased particularly at night sleeping on same side, after sour food consumption and strenuous activity. There was none of history of any disease condition or trauma to shoulder joint in past. Patient was known case of diabetic mellitus (DM) II since last 5 years. Patients was taking combination of metformin 500mg and Glimepiride 1 mg for glycaemic control.

Clinically, the patient had swelling at the right shoulder and Grade II tenderness at the glenohumeral joint. The patient could attain all the movement with pain except internal rotation in extension. Internal rotation found up to L5 level. The Xray of right shoulder joint anteroposterior view alone was done and it was demonstrated normal in study. Patient diagnoses with stage I primary frozen shoulder.

All routine blood investigation were done for screening purpose only and within normal limits.
While fasting blood sugar (FBS) 129 mg/dl and post prandial blood sugar (PPBS) 221 mg/dl were found.

**Case management:** The patient was managed with three sittings of WCT

**Cupping procedure:** The patient was advised to take *yavagu* 1 hour before the procedure. Informed written consent was taken before procedure and vitals were checked. Local *Abhyanga* (massage) with *Bala taila* and *Dashmool kwatha nadi swedana* was done at the right shoulder joint. In sitting position, four modified *Shringa Yantra* (Chinese cup) were applied on the most tender point at the right shoulder and a negative pressure was created by suction and maintained for 3–4 min and then the cups were removed. Approximately 0.5 cm deep needling was done with a 24G needle on the demarcated area of cups. Then again, cups were reapplied on the needle-marked area and negative pressure was created by suction. After termination of bleeding, cups were removed and the site cleaned with povidone-iodine solution followed by Haridra (*Curcuma longa* L.) powder dusting was done. The patient was advised to avoid water contact at least for 24 h. The same procedure was repeated after 07 days of interval.

**Outcome and follow up:** Improvement was assessed on the basis of change in pain and ROM of shoulder joint. On the first visit, Visual Analog Scale (VAS) score was 5, all ROM e.g., abduction, flexion, extension, external rotation painful except internal rotation in extension was restricted up to L5 level. After 1st session of cupping pain decreased from VAS 5 to 3 and no any improvement noted in internal rotation. After 2nd session of cupping pain decreased up to VAS 2 and slight changed was noted in internal rotation. Complete pain less normal ROM archived after 3rd session of cupping and internal rotation in extension reached up to L1 level.

**Discussion:** Direct reference of cupping in *Avabahuka* not available in Samhita. But *siravedha* specified in *Avabahuka* caused by *Rakta Apruta Vata* in at mid of the shoulder joint region. But acharya Gayadas mention *Siravedha* in *Bahumadhaye* (arm/ forearm). But *Siravedha* contraindicated in *Sudhha Vatik Avabhuca*. When it needed, *Siravedha* can be perform after use of luke warm water and *Lavanadi Vatahar Dravya for Kleda Utklesha*.6

The precise etiology of FS remains unclear, current evidence finds synovial cells and capsular fibroblasts are the initial target of an inflammatory-fibrotic cascade, 7 a cytokine-mediated fibroblastic hyperplasia of the synovium is generated by the contemporary overexpression of transforming growth factor-β (TGF-β) and its receptor, tumour necrosis factor-α (TNF-α), platelet-derived growth factor and its receptor, hepatocyte growth factor, interleukin (IL) 1, and 8,9 This primes to a preliminary, transient hyperplasia and hyper vascular environment, which contains principally synovial cells, with only occasional T-cells in primary frozen shoulder. Inflammation might occur in an early stage of the disease, in a later stage fibrosis occurs as a result of collagen and matrix synthesis.10

Probable anti-inflammatory action of cupping theory is blood detoxification. In short, cupping therapy has been shown to augment blood circulation which in turn elicit removal of inflammatory toxins and waste products from body.11
This could apparently be accomplished by simplifying microcirculation, capillary endothelial cell repair, granulation, and angiogenesis in local tissues. And subsequent a regulated functional of shoulder joint.

In this case, after 3 sessions of WCT Patient yielded complete painless ROM of shoulder joint and swelling also resolved totally.

**Conclusion:** A single case report proved that pain dominant primary frozen shoulder can be successfully managed with wet cupping therapy.

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