Case Report

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AGNIKARMA WITH GUḌA IN THE MANAGEMENT OF TRIGGER FINGER: A CASE REPORT

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ABSTRACT

Trigger finger is a common musculoskeletal condition of the flexor tendon sheath at the A1 pulley, producing painful locking of the affected digit, most commonly the ring finger and thumb. Contemporary management of trigger finger includes splinting, non-steroidal anti-inflammatory drugs (NSAIDs), corticosteroid injection and surgical release of the A1 pulley, but these carry the risk of recurrence, side effects and cost burden. In Ayurveda, trigger finger can be correlated with Snāyugata Vāta (Vāta [bioenergy] vitiated in the tendons and ligaments), a type of Vātavyādhi (Vāta disorders), with treatment modalities including Snehana (oleation therapy), Dahana (thermal cauterization; Agnikarma) and Upanāha (poultice therapy). Agnikarma, which may be of snigdha (unctuous) or rūkṣa (dry) type, acts through its uṣṇa (hot), tīkṣṇa (penetrating), sūkṣma (minute) and āśukārī (fast-acting) properties and is considered the most effective procedure for rapid relief. A 51-year-old female, a known case of Type 2 Diabetes Mellitus, presented with a two-month history of painful locking of the left thumb. We treated her with Snigdha Agnikarma using Guḍa (jaggery), along with Punarnavādi Kaṣāyam (a polyherbal decoction) and Kaishora Guggulu (a classical guggulu-based tablet) as adjuvant internal medication for the first two weeks. The results were assessed before treatment, immediately after treatment, and on the 7th, 14th and 21st day. The assessment showed improvement in pain (Visual Analogue Scale [VAS] score from 4 to 0), tenderness (grade 2 to 0), and Quinnell grading for trigger finger (grade 2 to 0), which was sustained until day 21, without adverse effects.

Keywords: Trigger finger, Snāyugata Vāta, Agnikarma, Guḍa, Case report

INTRODUCTION

Trigger finger (stenosing flexor tenosynovitis) is a disorder characterised by inflammation and hypertrophy of the flexor tendon sheath at the level of the A1 pulley. This progressive thickening restricts the smooth gliding of the flexor tendon, producing painful catching or locking of the affected digit during flexion and extension.[1] The condition has a reported prevalence of more than 3% in the general population and significantly impairs hand function and quality of life.[2] It occurs more often in women and in diabetic patients, and the thumb and ring finger are the digits most frequently involved.[3,4]

Patients typically present with pain at the root of the affected finger, tenderness, localized swelling, a palpable nodule over the flexor tendon, and uneven or catching movement of the digit during active flexion–extension. The pathophysiology involves repetitive finger motion or overuse that leads to microtrauma of the flexor tendon, progressive nodular thickening, increased friction during gliding, inflammation with tendon entrapment, and, if untreated, a chronic stage of fixed flexion with finger locking.[4]

In contemporary medicine, trigger finger is managed with splinting, NSAIDs, corticosteroid injections or surgical release of the A1 pulley.[5] Corticosteroid injection and surgical release of the tight tendon sheath remain the main methods; however, repeated use of analgesics provides only symptomatic relief, and both injections and surgery carry the risk of recurrence, side effects and cost burden.[6]

Ayurveda correlates trigger finger with Snāyugata Vāta, in which vitiated Vāta doṣa (bioenergy/humour) lodges in the snāyu (tendon/ligamentous tissue), producing symptoms such as stambha (stiffness/locking), kampa (tremor), śūla (pain) and ākṣepa (spasm/catching movement).[7] Classical management of Snāyugata Vāta includes Snehana (oleation therapy), Dahana (thermal cauterization/Agnikarma) and Upanāha (poultice therapy).[8] Among these, Agnikarma is considered the most effective procedure for rapid symptomatic relief, acting through its uṣṇa (hot), tīkṣṇa (penetrating), sūkṣma (minute) and āśukārī (fast-acting) guṇa (properties), which help pacify Vāta–Kapha (bioenergies), clear srotorodha (channel obstruction) and stimulate local tissue metabolism.[9]

In the present case, Guḍa (jaggery) was selected as the dahanopakaraṇa (cauterizing medium) for Agnikarma. Guḍa is inexpensive, readily available, and possesses snigdha (unctuous) and uṣṇa (hot) properties that allow deeper, more sustained heat penetration than conventional Śalākā (metallic probe) Agnikarma, making it a safe, cost-effective option for outpatient management.

MATERIALS AND METHODS

Patient Information

A 51-year-old female patient, a housewife, presented with difficulty in flexing and painful locking of the left thumb of two months' duration. She gradually developed pain over the palmar aspect of the left thumb, and within two months of the onset of pain, she noticed progressive locking of the left thumb during flexion, along with restricted and uneven movement of the digit.

She had been a known case of Type 2 Diabetes Mellitus (T2DM) for one year and was on allopathic medication, with no other significant past medical or surgical history. She had previously taken analgesics and a corticosteroid injection for the same complaint but obtained only symptomatic relief, with recurrence of pain and locking, following which surgery was suggested. As she was not willing to undergo surgery, she came to the Outpatient Department (OPD) of Shalyatantra (Ayurvedic surgery), Government Ayurveda College, on 04 May 2026.

On general examination, the patient was conscious, oriented, and moderately built and nourished.

Vital parameters – pulse rate 73/min, blood pressure 126/82 mmHg, respiratory rate 16/min and temperature 37 °C – were within normal limits, and she remained afebrile and hemodynamically stable throughout the course of treatment.
Local examination of the left hand revealed slight swelling, no discolouration and grade 2 tenderness at the level of the A1 pulley over the palmar aspect of the left thumb, with restricted and catching movement on active flexion–extension, consistent with a diagnosis of trigger finger of Quinnell grade 2.

Routine haematological investigations (Hb 13.3 g/dL, ESR 20 mm/hr, FBS 100 mg/dL, PPBS 140 mg/dL and HbA1c 5%) were done prior to the procedure.

Ethical Statement and Consent
This case was managed and reported in accordance with the ICMR National Ethical Guidelines for Biomedical and Health Research Involving Human Participants[10] and the CARE (Case Report) reporting guidelines[11]. Written informed consent was obtained from the patient for the treatment and for the publication of the clinical details and photographs, and the identity of the patient has been kept confidential.

Diagnostic Assessment
Clinical examination revealed Quinnell grade 2 trigger finger (grading 0 to 4),[12] in which the digit locks in flexion but can be extended actively without external assistance. Pain intensity was measured using the Visual Analogue Scale (VAS) and was 4, indicating mild to moderate pain during thumb movement. Tenderness over the affected thumb was grade 2, with the patient reporting pain and wincing on palpation. Patient progress after treatment was tracked using the same parameters.

Treatment Given
The patient was given internal medications for the first week to subside the slight swelling over the palmar aspect of the left thumb. Punarnavādi Kaṣāyam (a polyherbal decoction) and Kaishora Guggulu (a classical guggulu-based tablet) were prescribed. Punarnavādi Kaṣāyam was administered at a dose of 15 ml of kaṣāya (decoction) mixed with 45 ml of lukewarm water, twice daily, before food, and Kaishora Guggulu tablet at a dose of 1-0-1 (one tablet in the morning and one at night) along with the kaṣāya.

After one week, Bindu-type (dot-type) Snigdha Agnikarma with Guḍa was performed at the points of maximum tenderness on the affected thumb. Guḍa was purchased from a Food Safety and Standards Authority of India (FSSAI) certified source. The patient was informed in detail about the treatment procedure and informed consent was obtained. The patient was advised to consume slimy and unctuous (snigdha) foods before the procedure. The area over the tender points of the affected digit and palm was cleaned and the tender points were marked. Twenty grams of Guḍa, together with 20 ml of water, was taken in a sterile bowl and heated over a gas stove until it reached a syrup-like consistency at 130–140°C, monitored with a probe thermometer. One drop of the heated Guḍa was applied to each of the five marked tender points using a Borosil dropper, performed as a bindu-type dahana viśeṣa (dot-type cauterization) and done as a single, one-time procedure. The site was allowed to cool briefly and then carefully wiped off after one minute. Following the procedure, a mixture of Madhu (honey) and Ghṛta (ghee) was applied locally over the cauterized site. The patient was observed for 30 minutes, and no blister formation or burning pain was noticed after the procedure. She was advised to continue applying honey and ghee locally at the site of the procedure for one week and to continue the internal medications for one more week.

Figure 1: Materials required: Guḍa (jaggery), kidney tray, gas stove, probe thermometer, mixture of Madhu (honey) and Ghṛta (ghee), Borosil dropper, betadine swab

Figure 2: Agnikarma with Guḍa

Figure 3: Before treatment

Figure 4: After treatment on the 21st day

Table 1: Assessment of outcome parameters before and after treatment

Parameter	Before treatment	Same day (after treatment)	Day 7	Day 14	Day 21
Pain (VAS)	4	2	1	0	0
Tenderness	Grade 2	Grade 1	0	0	0
Quinnell grading for trigger finger	Grade 2	Grade 2	0	0	0

OBSERVATION AND RESULT

The patient was assessed for pain (using the Visual Analogue Scale, VAS), tenderness grading, and Quinnell grading of the trigger finger at five time points: before treatment, immediately after treatment on the same day, and on day 7, day 14, and day 21. We observed progressive, consistent improvement across all three outcome parameters. The pain score decreased from 4 to 2 immediately after treatment, to 1 on day 7, and to 0 by day 14 and day 21. Tenderness improved from grade 2 to grade 1 immediately after treatment, with complete resolution (grade 0) by day 7, which was sustained till day 21. Quinnell grading remained at grade 2 immediately after the procedure but showed complete resolution to grade 0 by day 7, sustained through day 21. No scar mark or adverse effect was noted at the treatment site during the follow-up period.

DISCUSSION

Trigger finger can be correlated with Snāyugata Vāta, a subtype of Vātavyādhi (Vāta disorders). Vitiated Vāta causes obstruction (srotorodha) in the snāyu (tendon/ligament), which further vitiates sthānika (local) Kapha; the resultant vitiation of Vāta and Kapha in the flexor tendons of the fingers causes trigger finger.[7] In modern terms, repeated friction and microtrauma lead to thickening of the A1 pulley and nodular change in the tendon, which explains the catching and locking of the digit[4] . Agnikarma is a major treatment modality for Vāta–Kaphaja vikāra (disorders) and is particularly suited to this condition because it can simultaneously pacify aggravated Vāta and liquefy accumulated Kapha from the affected srotas (channels).

Ācārya Suśruta specifically described the use of Agnikarma with Guḍa in snāyu vikāra (disorders of the tendons).[9] Guḍa possesses a high heat-retention capacity, which results in deeper and more sustained heat penetration into the underlying snāyu compared to conventional Śalākā (metallic probe) Agnikarma. This action helps relieve symptoms of trigger finger such as stambha (stiffness/locking) and saṅkoca (contraction/catching) of the digit. In this case, the internal medications, Punarnavādi Kaṣāyam and Kaishora Guggulu, both classically indicated in Vātavyādhi, were administered as adjuvant therapy, working with Agnikarma to control local inflammation and support tendon healing.

Agnikarma has been reported earlier in the management of trigger finger[13] .A 71-year-old man with trigger finger of the left middle finger with Kshaudra (honey) Agnikarma on a daily basis for 30 sittings, along with Bandhana (bandaging) for two months and oral Dashamūla Kwātha (decoction) and Haritakī Cūrṇa (powder). They recorded an improvement in Green's severity score, with tenderness reducing from grade 2 to grade 0 after seven sittings, although occasional finger locking was still noted after the 30 sittings. A single case managed with Snigdha Agnikarma using Tila Taila (sesame oil) in bindu viśeṣa (dot-type) form over the tender points of the left middle finger, in four sittings, has also been reported as an effective procedure.[14] In comparison, in the present case Guḍa was used as the snigdha dahanopakaraṇa (unctuous cauterizing medium) and a single sitting was sufficient to resolve locking and tenderness by day 7, with the relief sustained till day 21. The present report also differs from these cases in that the affected digit was the thumb rather than the middle finger, and the patient was a diabetic woman who had already relapsed after a corticosteroid injection. These observations are in agreement with the classical view that snigdha dravyas (unctuous media such as Guḍa, Kshaudra and Taila) penetrate deeper than rūkṣa (dry) metallic Śalākā [9] and with the earlier reports that Agnikarma performed with a snigdha medium is effective in trigger finger. However, all three are single-case reports using different media, different digits, different numbers of sittings, and different adjuvant medicines, so a direct comparison of efficacy is not possible.

The patient in the present report was diabetic, a group in which trigger digits are more frequent[15] and in which conservative

treatment such as corticosteroid injection has been reported to give less satisfactory results.[16] This is in keeping with the early recurrence noted after her earlier injection. Sustained relief after a single sitting of Snigdha Agnikarma, without blister, wound, or any other adverse effect, suggests effectiveness, although satisfactory glycaemic control at presentation (HbA1c 5%) may have favoured safe healing, and this finding cannot be extended to poorly controlled diabetic patients.

The reduction in VAS pain score, tenderness and Quinnell grade observed in this patient supports the action of Agnikarma. Localised thermal stimulation may cause vasodilatation and increased blood flow, activate large touch/pressure nerve fibres that inhibit nociceptive transmission at the spinal level (gate control theory),[17] and trigger a controlled local inflammatory response that facilitates resolution of chronic tendon-sheath thickening. The fall in VAS score from 4 to 2 on the same day is consistent with the rapid, analgesic action attributed to āśukārī guṇa and with the gate control explanation, whereas the resolution of locking by day 7 may reflect reduction of swelling and sheath thickening, possibly aided by the adjuvant medicines. The single-sitting Agnikarma with Guḍa procedure achieved symptomatic resolution by day 7, sustained till day 21, without any adverse effect, and thus provides a safe, cost-effective outpatient intervention.

It is a single case with a short follow-up of 21 days, so recurrence beyond this period could not be assessed. Studies with larger samples, longer follow-up and a control group are needed to confirm these findings.

CONCLUSION

This case highlights that Agnikarma with Guḍa, administered as a single-sitting outpatient procedure and supported by adjuvant internal Ayurvedic medications, produced relief from pain, tenderness and locking in a patient with trigger finger (Snāyugata Vāta), with complete resolution of symptoms by day 7 that was maintained through day 21, and without any adverse effects. Ayurveda thus offers a non-invasive, safe, and cost-effective alternative for outpatient management of trigger finger, and this case supports Agnikarma with Guḍa, combined with oral Ayurvedic medication, as an effective non-surgical therapeutic intervention for this condition. Larger studies are needed to substantiate these findings.

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