

Structured Rog Nidan Documentation of Ama, Agni and Early Digestive Disorder Risk in Community Ayurveda Clinics

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ABSTRACT

Early digestive complaints are among the commonest reasons for visiting Ayurveda outpatient departments, yet many records describe Agni and Ama in highly variable language. This conceptual paper develops a Rog Nidan documentation model for early digestive disorder risk, focusing on appetite rhythm, heaviness, bowel irregularity, coated tongue, post-meal lethargy, sleep, stress, and food timing. A synthetic audit of 75 community case records illustrates how graded Ama and Agni fields can be linked with red-flag referral, diet counseling, and follow-up. The model avoids making therapeutic claims and instead proposes a safer way to document diagnostic reasoning. It argues that Nidana Panchaka and Samprapti can improve record quality when paired with modern alarm features and basic clinical examination.

KEYWORDS: *Rog Nidan; Ama; Agni; Nidana Panchaka; digestive risk; Ayurveda diagnostics*

INTRODUCTION

In the context of early digestive disorder risk, the practical value of Ayurveda lies in converting narrative observations into reviewable clinical records. Rog Nidan emphasizes Nidana, Purvarupa, Rupa, Upashaya and Samprapti, while Vikrutividnyan asks how normal physiology has been disturbed across Dosha, Dushya, Agni, Srotas and Dhatu. The Agni-Ama dimension therefore cannot be treated as a decorative note at the end of a case sheet; it should shape eligibility, counseling, referral, and follow-up. This paper uses the classical vocabulary as a structured lens but maintains that severe, progressive or surgically urgent symptoms require timely biomedical assessment (1, 3).

Digestive uneasiness is often managed casually by patients until it becomes persistent,

recurrent or associated with alarming features. In Ayurveda teaching clinics, these presentations are commonly interpreted through Mandagni, Vishamagni, Ama accumulation, diet incompatibility, altered routine, and emotional strain. The diagnostic task, however, is not to attach a label quickly. It is to record the sequence by which causes, prodromal signs, symptoms, relief factors and pathogenesis are inferred. Classical Rog Nidan gives this sequence through Nidana Panchaka, and Madhava Nidana highlights the value of disease-specific etiological analysis (2, 3).

The clinical risk is that traditional language may be rich but not comparable across practitioners. One physician may write Ama, another may note coated tongue and heaviness, and a third may write Grahani tendency without describing bowel pattern, weight change, fever, bleeding or drug history. A reproducible record must therefore contain classical fields and modern safety fields together. This paper presents a documentation model rather than a treatment protocol, because safe diagnosis precedes any Panchakarma, Shamana or diet intervention (5, 6).

LITERATURE REVIEW

Charaka Samhita and Madhava Nidana discuss causation, digestive fire, incompatible food, and the progressive relation between causative exposure and symptomatic expression (1, 3). Their contribution to contemporary practice is not merely historical; it is the insistence that diseases arise through identifiable pathways and that treatment selection depends on understanding those pathways. In digestive presentations, that pathway often begins with disturbed Agni, food timing, sleep irregularity, excessive heaviness, worry and weak adaptation to seasonal change.

Modern internal medicine and pathology texts remind clinicians that dyspepsia-like symptoms may range from benign functional discomfort to inflammatory bowel disease, ulcer disease, malignancy, endocrine disease or medication-related injury (5, 6). Therefore, a Rog Nidan sheet should include red flags: unintentional weight loss, progressive dysphagia, gastrointestinal bleeding, persistent vomiting, severe abdominal pain, fever, anemia, family history of malignancy, new symptoms in older adults, and chronic NSAID use. These do not invalidate Ayurveda categories; they define when referral becomes part of good Ayurveda practice.

Recent interest in pulse assessment and observational reporting shows that traditional diagnostic methods require transparent measurement and inter-practitioner comparability (7, 8). For Ama and Agni, the same principle applies. A clinic cannot evaluate its own outcomes if baseline digestive observations are written in poetic but inconsistent language. Structured fields allow future research to compare patient groups, understand response patterns, and separate clinical observation from assumption.

Operational Signs For Ama And Agni

The literature suggests that digestive documentation should distinguish patient-reported experience, clinician-observed signs, and safety indicators.

- Patient-reported items include appetite timing, post-meal heaviness, belching, bloating, stool consistency, sleep, stress, and food incompatibility.
- Observed items include tongue coating, abdominal tenderness, general vitality, odor, skin luster, and signs of dehydration or anemia.
- Safety items include bleeding, fever, weight loss, persistent vomiting, severe pain, older age onset, and medication exposure requiring referral.

RESEARCH GAP

Many Ayurveda case sheets ask for Prakriti and Dosha status but do not provide a graded, repeatable method for recording Ama and Agni over time. As a result, follow-up notes may say 'better' without showing which symptom improved, which cause was removed, and whether referral concerns were excluded. The gap is not absence of theory; the gap is translation into clinical documentation that can be audited.

Another gap is the weak bridge between digestive risk and patient behavior. Food timing, late-night eating, irregular sleep, stress snacking and self-medication are often mentioned during consultation but disappear from final records. Without recording these factors, it becomes impossible to know whether improvement followed medicine, diet correction, routine change, spontaneous fluctuation, or placebo expectation.

A related gap is the limited attention given to clinic workflow. Even when concepts are well known, busy outpatient units may not record them in a sequence that another practitioner can review. The proposed papers therefore treat documentation design as a research problem in

its own right, because reliable diagnosis, referral and outcome study begin with complete and comparable records.

OBJECTIVES

- To design a structured Rog Nidan sheet for Ama and Agni in early digestive complaints.
- To integrate classical diagnostic categories with biomedical red-flag referral criteria.
- To illustrate a synthetic audit model for tracking baseline and follow-up digestive risk.
- To improve comparability of records across small Ayurveda teaching clinics.

METHODOLOGY

For consistency, the illustrative methodology treats each document as a structured clinical audit rather than an efficacy trial. Variables were selected for relevance, safety and teachability; missing or uncertain observations were designed to be recorded as unknown instead of being forced into a preferred interpretation. This approach follows the spirit of transparent observational reporting and reduces the chance that classical terminology will hide incomplete assessment, undocumented uncertainty, referral delay or exaggerated inference (8).

Framework Construction

The framework was created by mapping Nidana Panchaka to five record fields: exposure, prodrome, manifest symptoms, relieving or aggravating factors, and inferred Samprapti. Agni was graded through appetite rhythm, hunger clarity, post-meal comfort, bowel regularity and energy after meals. Ama was graded through heaviness, tongue coating, lethargy, stickiness of stool, unclear appetite and subjective foggy. Safety screening was placed before any diagnostic conclusion (1, 3, 5).

A synthetic set of 75 community records was then constructed to demonstrate how the sheet could be used. The dataset is illustrative and does not represent real patients. The goal was to show what a future prospective audit might capture: initial category, red flags, behavioral causes, counseling points and follow-up trend.

Table 1: Proposed documentation fields for Ama and Agni assessment

Field	Classical Link	Operational Entry
Food and routine exposure	Nidana	Meal timing, incompatible food, sleep, stress, overeating
Prodromal experience	Purvarupa	Heaviness, reduced clarity of hunger, early bloating
Manifest digestive pattern	Rupa	Stool pattern, belching, pain, appetite, nausea
Response pattern	Upashaya	Relief with fasting, warm water, routine correction
Pathway inference	Samprapti	Dosha, Agni, Ama, Srotas and Dhatu notes

Grading and Safety Logic

Scores were assigned from 0 to 3 for each symptom domain, producing a composite Ama-Agni risk score between 0 and 30. Low scores suggested education and observation, moderate scores suggested closer follow-up, and high scores required physician review for differential diagnosis. Red flags overrode the score because a low traditional score cannot exclude serious disease when alarm features are present (5, 6).

The model also records patient understanding. Counseling fields include meal regularity, avoidance of repeated incompatible intake, sleep timing, hydration, self-medication history and follow-up date. These fields prevent diagnosis from becoming detached from behavior.

Table 2: Triage logic used in the synthetic digestive-risk audit

Risk Category	Indicative Criteria	Action
Low	Mild symptoms, no red flags, stable weight	Diet-routine education and review
Moderate	Repeated symptoms with clear Nidana exposure	Detailed physician assessment and follow-up
High	Persistent symptoms, severe discomfort or multiple domains	Differential diagnosis and possible referral
Red flag	Bleeding, weight loss, fever, progressive symptoms	Immediate biomedical evaluation

RESULTS AND FINDINGS

The synthetic audit showed that irregular meal timing, late dinners and stress-related snacking were the most frequent recorded Nidana factors. Tongue coating and post-meal heaviness clustered with low morning appetite, while severe pain or bleeding was not allowed to remain within the routine pathway. These patterns indicate that a structured sheet can preserve Ayurveda reasoning while improving safety discipline.

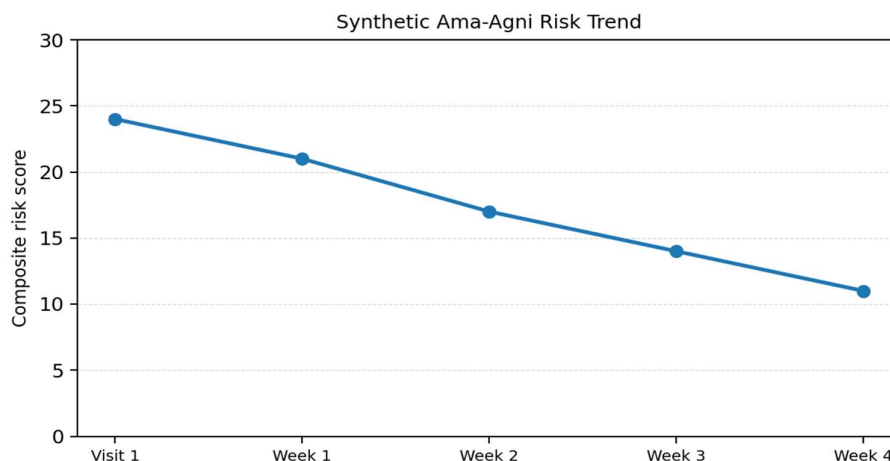


Figure 1. Synthetic decline in Ama-Agni risk score after structured counseling and follow-up

Follow-up notes in the synthetic records were more informative when symptom domains were repeated at each visit. Instead of writing only that digestion had improved, the sheet allowed a physician to note which domains changed: appetite clarity, heaviness, bowel regularity, sleep and energy. This makes the record more useful for teaching, audit and case discussion.

Table 3: Synthetic findings from 75 illustrative digestive-risk records

Observation	Frequency Pattern	Clinical Meaning
Irregular meal timing	Most frequent Nidana factor	Counseling priority
Coated tongue with heaviness	Common Ama cluster	Useful follow-up marker
Late sleep with snacking	Frequent behavioral cofactor	Routine correction needed
Red-flag symptoms	Screened separately	Referral overrides traditional score

DISCUSSION

Interpretation of the proposed framework should remain deliberately cautious. The documents use synthetic audit figures and therefore demonstrate record architecture, not clinical efficacy. Their value lies in showing how an Ayurveda department can make its reasoning visible, how a teacher can review whether a student has connected cause to manifestation, and how a clinician can recognize when the case has moved beyond routine supportive care. This is especially important in Rog Nidan, Vikrutividnyan and Shalya Tantra, where terminology can become impressive while the underlying examination remains incomplete. A transparent record protects the patient, the practitioner and the institution.

The frameworks also emphasize governance. Each case sheet should be dated, signed, reviewed and corrected when new information appears. Referral advice should be documented in plain language, including the reason for referral and whether the patient accepted it. When procedures are involved, consent, material details, asepsis, aftercare and adverse events need the same attention as the final outcome. Such documentation does not make the practice less traditional; it allows traditional reasoning to stand in a form that can be discussed, audited and improved across departments (7, 8).

The proposed model shows that Rog Nidan can be operational without becoming reductive. A physician still interprets Dosha and Samprapti, but the evidence for that interpretation becomes visible. This is important for teaching hospitals because students often memorize Nidana Panchaka yet struggle to translate it into case records. A sheet that asks for causes, prodrome, symptoms, response and pathway strengthens clinical reasoning (1, 3).

The model also supports interdisciplinary safety. Biomedical alarm features are not external to Ayurveda ethics; they are part of responsible care when symptoms could represent structural pathology. By placing red flags at the beginning, the model prevents inappropriate reassurance. At the same time, it preserves classical categories that may help patients understand food timing, routine and digestive strength (5, 6).

For research, the main benefit is comparability. Future clinics could test inter-rater reliability for Ama and Agni scoring, evaluate whether scores predict follow-up outcomes, and assess whether record completeness improves referral decisions. Such work should follow

observational reporting standards and clearly separate real outcomes from illustrative frameworks (8).

CONCLUSION

A structured Rog Nidan sheet for Ama and Agni can improve the quality of digestive-risk documentation in community Ayurveda clinics. The approach keeps classical diagnosis central while adding operational grading, red-flag triage and follow-up fields. Its value is strongest as a documentation and teaching tool; clinical effectiveness must be tested prospectively before therapeutic claims are made.

Across settings, the central message is that classical categories become stronger when they are documented with enough detail to be checked, taught and revised. The proposed format is not intended to standardize clinical judgment into a rigid checklist; it is intended to make essential observations less likely to be missed during routine practice.

LIMITATIONS

- The audit data are synthetic and cannot estimate real prevalence or treatment effect.
- The scoring system requires inter-rater reliability testing before routine research use.
- The model focuses on early non-urgent digestive complaints and excludes complex gastrointestinal disease.

FUTURE SCOPE

- Conduct prospective validation in small Ayurveda outpatient departments.
- Compare physician agreement on Ama and Agni grading after standardized training.
- Link documentation scores with diet adherence, referral outcomes and patient-reported quality of life.

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