



A Structured Siddha Therapeutic Approach for the Management of Dermatophytosis (Pundareega Kuttam): A Case Report

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ABSTRACT

Dermatophytosis, known as Pundareega Kuttam in the Siddha system of medicine, is a common superficial fungal infection that presents significant therapeutic challenges due to its recurrent nature and the limitations of prolonged antifungal therapy. This case report describes the successful management of Pundareega Kuttam using Siddha medicine. A 25-year-old female patient presented with chronic hyperpigmented, pruritic, mildly scaly patchy lesions with occasional bleeding over the right cubital fossa, abdominal region, and the back of the trunk for a duration of 2 years. The patient had a history of recurrent episodes with only short-term relief following conventional antifungal treatment. Based on Siddha diagnostic principles, treatment was initiated with internal administration of Parangipattai Mathirai, Palagarai Parpam Mathirai, and Gandhaga Rasayanam, along with external application of Amirtha vennai and Pungan Thailam. The treatment was continued for 48 days with regular monitoring for clinical response and safety. Dietary and lifestyle modifications were also advised and followed throughout the treatment period. Significant improvement, including reduction in pruritus, bleeding, and scaling, was observed within 2 weeks of initiation of therapy. Complete resolution of lesions was achieved by the end of the treatment period, with no recurrence was observed during a 6 months of follow-up period. No adverse drug reactions were reported. This case highlights the potential of Siddha medicine as a safe and effective therapeutic approach in the management of dermatophytosis, demonstrating sustained remission and improved clinical outcomes. It also emphasizes the importance of Siddha-based dietary and lifestyle modifications in the effective management of Pundareega Kuttam.

Keywords: Pundareega Kuttam; Dermatophytosis; Siddha Medicines; Tinea Corporis.

INTRODUCTION

Dermatophytosis is a superficial fungal infections caused by dermatophytes affecting the skin, hair and/or nails. They are also termed tinea infections.¹ Tinea is known as ringworm. This is because it can cause red patches on the skin in the shape of rings. But it's not caused by worms. It's caused by different types of fungi. But it most often occurs in moist areas of the body and around hair. The fungus can be spread from person to person.² They are clinically classified by infection site as *Tinea capitis* (head), *Tinea faciei* (face), *Tinea barbae* (beard), *Tinea corporis* (body), *Tinea manuum* (hand), *Tinea cruris* (groin), *Tinea pedis* (foot) and *Tinea unguium* (nails).¹ dermatophytosis affects 20-25% of the world population. A prevalence of 6.09% to 27.6% has been reported in studies from South India, while a high prevalence of 61.5% has been recorded in North India. Men are more frequently affected than women because of the significantly high incidence of tinea cruris, tinea pedis and *Tinea unguium* in men, and outdoor work predisposes men to hot, humid and sweaty conditions conducive to the growth of dermatophytes. Male:female ratio is < 2 in all the studies published in the last 3–4 years.³

According to Siddha classical texts, certain skin disorders are collectively referred to as *Kuttam*, which are classified

into 18 distinct types. Among these, Padarthamarai is identified as Pundareega Kuttam. The Tamil verse describing Pundareega Kuttam states that the skin lesions resemble the sepals of a lotus flower. It also mentions symptoms such as erythematous or hyperpigmented lesions, lesions are clearly defined, accompanied by severe itching and burning sensation with slightly elevated border discharge from the lesion and it spread across the body in a circular pattern.⁴ Therefore, given the strong clinical similarity between dermatophytosis and Pundareega Kuttam as described in Siddha texts, along with the issues of recurrence and the limitations of conventional antifungal treatments, there is a need to investigate alternative therapeutic options. In this context, the present case report seeks to assess the effectiveness of Siddha treatment modalities in managing Pundareega Kuttam (dermatophytosis) and to emphasize their potential in achieving long-term remission.

CASE PRESENTATION

A 25-year-old female presented to the Outpatient Department of the National Institute of Siddha on 01.08.2024 with complaints of chronic dermatological lesions suggestive of tinea corporis for 2 years. The lesions were described as hyperpigmented, pruritic, mildly scaly



patches distributed over the right cubital fossa, the abdominal region, and the back of the trunk, with occasional bleeding due to scratching. The condition initially began as small erythematous circular patches that progressively increased in size and spread to adjacent areas, showing a recurrent pattern with intermittent exacerbation and partial remission. The patient reported severe itching aggravated by heat and sweating. She had previously undergone conventional antifungal treatment, which provided only temporary relief, with recurrence upon discontinuation. There was no significant past or family history of systemic illness. The patient was a non-vegetarian, with a regular menstrual cycle. There was no history of previous surgeries or drug allergies, and no history of food allergy. Her appetite was good, bowel and bladder habits were regular, and sleep was reported to be disturbed. On clinical examination, multiple well-defined circular lesions with mild scaling and bleeding on scratching were observed.

CLINICAL EXAMINATION

General examination:

The patient was conscious, well-oriented, and afebrile. There were no signs of pallor, icterus, cyanosis, clubbing, lymphadenopathy, oedema, or varicose veins. Nutritional status and vital parameters were within normal limits.

Siddha assessment:

The Udal Thathukkal (seven physical constituents) and Envagai Thervu (eight diagnostic parameters in Siddha) were assessed.

- Saaram (nourishing juice): Affected
- Senneer (blood) : Affected
- Oon (muscle) : Affected
- Kozhuppu (fat) : Affected

(The above mentioned udal thathukkal were affected due to the presence of hyperpigmented pruritic patch with dryness and mild scaling present over the right cubital fossa, abdominal region and back of the trunk)

- Enbu (bone) : Normal
- Moolai (bone marrow) : Normal
- Suronitham (ovum) : Regular menstrual cycle

Envagai Thervu (eight-fold diagnostic method)

- Naa (Tongue) : No abnormality detected.
- Niram (Complexion): Hyperpigmented discoloration observed over the affected skin areas.
- Mozhi (Speech): Normal and coherent.
- Vizhi (Eyes) : Normal, with no signs of pallor or icterus.
- Sparisam (Palpation): Lesions were warm to touch with mild scaling and intense pruritus.

- Malam (Stool): Normal bowel habits.
- Moothiram (Urine): Normal, with no associated urinary complaints.
- Naadi (Pulse): Pitha– Kabha predominance, indicating humoral imbalance.

Based on clinical presentation she was diagnosed with Pundareega Kuttam. (ICD-10-CM code for Tinea Corporis (ringworm of the body) is **B35.4**)

Assessment of lesion:

The Clinical Assessment Severity Score (CASS) for tinea corporis was evaluated.⁵

The Assessment parameters with their grading are

- A) Erythema: 0 - Absent; 1 - Mild; 2 – Moderate and 3 - Deep brown
- B) Itching: 0 - Absent; 1 - Mild; 2 – Moderate and 3 – Severe
- C) Dryness: 0 - Absent; 1 - Mild; 2 – Moderate and 3 – Severe
- D) Eruption: 0 - Absent; 1 – 1 to 3 eruption; 2 – 4 to 7 eruption; 3 – above 7 eruption
- E) Indurations: 0 - Absent; 1 - Mild; 2 – Moderate; 3 – Severe.

MANAGEMENT PROTOCOL

The patient was treated with the following therapeutic regimen for a duration of 48 days, with observations recorded before and after treatment. An oil bath using Seeraga Thylam was administered on the first day of treatment to regulate deranged pitham and reduce the body heat and was continued throughout the treatment period at a frequency of twice weekly. On the second day, purgation was advised using Meganadha Kuligai Mathirai administered with Kuppaimeni leaf juice in the early morning. The patient was instructed to consume hot water at half-hour intervals to maintain hydration during the purgation process.

Following the onset of loose, watery stools, buttermilk and lemon juice were recommended to arrest the purgation. For the remainder of the day, the patient was advised to consume easily digestible foods such as curd rice, buttermilk rice, idly, and idiyappam. Complete rest was advised on the third day. Treatment interventions were initiated from the fourth day onward. The patient's prognosis is described accordingly. The patient was evaluated at weekly intervals during follow-up consultations at the Outpatient Department of the National Institute of Siddha. The timeline of observations and interventions is given in Table 1 while the therapeutic medications and their dosages along with adjuvant duration are detailed in Table 2.



Table 1: Timeline of symptoms and management

Date	Observation	Intervention
01.08.2024	Chronic Hyperpigmented, pruritic, mildly scaly patches distributed over right cubital fossa, the abdominal region, and the back of the trunk with occasional bleeding due to scratching since 2 years	Seeraga thylam, Meganadha kuligai, Parangipattai mathirai, Palagarai Parpam Mathirai, Gandhaga Rasayanam, Amirtha vennai, Pungan Thailam
12.08.2024	Hyperpigmented pruritic patch present in right cubital fossa, abdomen region and back of the trunk region persists. Scaling, bleeding on scratching reduced pruritus slightly reduced	Same siddha medicine was given for 1 week with diet restriction and the purgation medicine was discontinued.
19.08.2024	Pruritus moderately reduced, hyperpigmented patch slightly colour changed	Same siddha medicine was given for 1 week with diet restriction
26.08.2024	Pruritus reduced well, hyperpigmented patch slightly reduced	Same siddha medicine was given for 1 week with diet restriction
02.09.2024	Hyperpigmented patch moderately reduced, no pruritus, no newly formed lesions	Same siddha medicine was given for 1 week with diet restriction
09.09.2024	No hyperpigmentation, no pruritus, no newly formed lesions	Same siddha medicine was given for 1 week with diet restriction
16.09.2024	No hyperpigmentation, no pruritus, lesions are completely cured and no newly formed lesions.	Same siddha medicine was given for 1 week with diet restriction

Table 2: Treatment and duration

Therapeutic intervention	Dose and anubanam (adjuvant)	Duration
Parangipattai Mathirai	2 b.i.d with ghee	48 days
Palagarai Parpa Mathirai	2 b.i.d with ghee	48 days
Gandhaga Rasayanam	5g b.i.d with milk	48 days
Pungan Thailam	Required quantity	48 days
Amirtha Vennai	Required quantity	48 days

DIETARY ADVICE AND LIFESTYLE MODIFICATION

The subject was advised to avoid incompatible dietary items, including mango, brinjal, tomato, non-vegetarian foods, sea foods like fish, prawn, crab, jackfruit, pineapple, fast foods, sour substances, as well as Agathi keerai (*Sesbania grandiflora* leaves), Pagarkai (bitter gourd), Verkadalai (groundnuts/peanuts), yellow pumpkin and was instructed to adhere strictly to these dietary restrictions. Additionally, the patient was counseled on maintaining proper personal hygiene, as dermatophytosis can spread through direct contact, shared items, infected animals such as dogs, cats, guinea pigs, and cattle, as well as through contaminated soil. Preventive measures included keeping the affected areas clean and dry, avoiding the sharing of personal items like towels and soap, regularly washing clothes, bed linens, and towels, and ensuring proper cleaning of bathing areas after use. The use of soap was minimized, and instead, gram flour was recommended for bathing.⁶ The subject was advised to avoid scratching the affected areas, as this could facilitate the spread of the infection to other parts of the body. In addition, to prevent moisture retention on the skin, she was instructed to wear loose-fitting garments made from natural fibers. Dietary advice included adequate fluid intake of around 3 liters of water per day, consumption of buttermilk in the afternoon, restriction of salt intake, and increased inclusion of fresh

vegetables and fruits. The patient was also advised to incorporate green leafy vegetables into the diet at least twice weekly.

OUTCOME AND FOLLOW UP

The lesion assessment revealed a steady decrease in the CASS score from 14 to 0 during the treatment period, as depicted in table 3, indicating marked clinical improvement in the patient.

Table 3: CASS score before and after treatment

Assessment parameters	Prognosis			
	0 th day (Before)	15 th day	30 th day	48 th day (After)
Erythema	3	2	2	0
Itching	3	2	1	0
Dryness	3	2	1	0
Eruption	2	1	0	0
Induration	3	3	1	0
Score	14	10	5	0



BEFORE TREATMENT:

Figure 1: (A) Hyperpigmented pruritic patch with dryness present in abdomen region
 (B) Hyperpigmented circular pruritic patch with mild scaling present in back on the trunk region
 (C) Hyperpigmented pruritic patch present in right cubital fossa (upper limb)

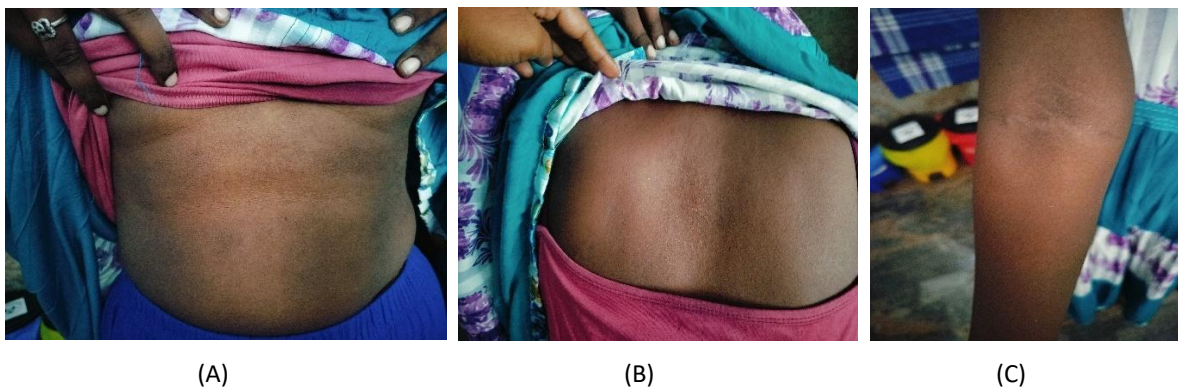
AFTER TREATMENT:

Figure 2: (A), (B), (C) After 48 days of treatment, there was no hyperpigmentation, no pruritus, no scaling, no dryness and no patches were present in the abdomen region, back of the trunk region and right cubital fossa.

Patient Perspective

The patient expressed concern regarding the chronic and recurrent nature of the lesions and reported prior use of allopathic treatments without sustained relief, after which she opted for Siddha treatment. She noted gradual improvement after initiation of Siddha treatment, with reduction in symptoms within two weeks and complete resolution by the end of treatment, without recurrence during follow-up.

DISCUSSION

Dermatophytosis is a common superficial fungal infection characterized by a chronic and recurrent clinical course. It often shows an incomplete response or relapse following conventional antifungal therapy. Moist and warm conditions are the most suitable factors to a wide distribution of dermatophytosis in tropical countries. Clinically, Tinea corporis presents as well-defined, sharply outlined, oval or circular, pruritic, erythematous or hyperpigmented, scaly patch or plaque with a raised border and central clearing.⁷

In Siddha literature, dermatophytosis can be correlated with *Pundareega Kuttam*, one of the eighteen types of *Kuttam*. It is described as circular, well-demarcated lesions associated with pruritus, discoloration, and gradual centrifugal spread, resembling lotus-like patches on the skin.⁴ This correlation supports the applicability of Siddha therapeutic principles in its management.

Conventional management primarily focuses on anti-fungal therapy along with anti-inflammatory, immunomodulator, anti-histamine, anti-oxidant and anti-microbial agent. However, recurrence remains a major concern. In the present case, as per the management protocol oil bath was administered to regulate deranged pitham and reduce the body heat. Purgation with Meganadha kuligai was performed with the aim of balancing the humors of vadha, pitham, kabam and removal of metabolic end products (toxins) from the body. The internal medicine Parangipattai Mathirai is indicated for meganoigal and kuttam⁸, is reported to possess anti-inflammatory, anti-oxidant, anti-microbial activities.⁹ Screening studies of various Siddha drugs for antifungal activity against various strains of *Candida albicans* reveals that Parangipattai Chooranam

possessed significant antifungal activity against various strains of *Candida albicans*.¹⁰ Palagarai Parpa Mathirai is indicated for vettai, mekaccutu, nirkattu, kuttam, naccu(vitam)¹¹, has been reported to exhibit anti-histamine activity, anti-bacterial activity, and wound healing activity.¹² Gandhaga Rasayanam is indicated for mega noigal, meganeer, vellai, thol noigal, kuttam, venkuttam.¹³ It is also reported to possess anti-bacterial and anti-fungal activity.¹⁴ The external application Pungan Thailam is indicated for sori, sirangu, pun¹⁵ has demonstrated anti-fungal activity.¹⁶ Amirtha Vennai is indicated for ulcers, carbuncle, swelling, rectal inflammation, fungus infection¹⁷. The patient demonstrated early symptomatic improvement within two weeks, with progressive reduction in pruritus, scaling, and lesion extent, culminating in complete clinical resolution by the end of treatment. No recurrence was observed during the six-month follow-up period. The observed clinical improvement may be attributed to the combined pharmacological properties of the administered Siddha formulations, including antifungal, antimicrobial, anti-inflammatory, antioxidant, and wound-healing activities. These effects may have contributed to the reduction of fungal load, control of inflammation, and restoration of skin barrier integrity. Dietary and lifestyle modifications may have further supported disease control and reduced recurrence risk.

This case highlights the potential role of Siddha medicine in the management of chronic dermatophytosis (*Pundareega Kuttam*) and suggests the need for further systematic clinical studies to validate its efficacy.

Adverse Events

No adverse drug reactions were observed during the treatment period.

CONCLUSION

This case report demonstrates that Siddha therapeutic interventions can provide a safe and effective alternative in the management of chronic and recurrent dermatophytosis (*Pundareega Kuttam*). The combined use of internal and external Siddha medicines, along with appropriate dietary and lifestyle modifications, resulted in complete resolution of lesions, significant symptomatic relief, and sustained remission without recurrence or adverse effects. These findings suggest that Siddha medicine not only addresses the clinical manifestations but may also help in preventing recurrence by restoring humoral balance. However, further large-scale clinical studies are warranted to validate these outcomes and establish standardized treatment protocols.

Patient Consent: Written informed consent for publication of clinical details and photographs was obtained from the patient, and a copy can be provided upon request.

Ethical Issues: As this single case report utilized only routine Siddha therapy and did not involve experimental interventions, formal ethics committee approval was not required as per institutional policy for individual case descriptions. The report adheres to the CARE guidelines.

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Conflict of Interest: The authors declare that they have no conflicts of interest.

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