

A COMPARATIVE CLINICAL STUDY OF KANAMOOI CHURNA AND JATAMANSI CHURNA IN CASES OF ANIDRA

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Abstract: Acharya charak, has described TRAYOPSTAMBHA as AHARA, NIDRA, BRAMHACHARYA. But unfortunately all the three upasthambha are grievously affected due to rapidly growing modernization. But Nidra seems to be affected the most. Sleep affects our daily functioning, Physical, mental and spiritual health in many ways. Happiness and misery, nourishment and emaciation, strength and weakness, virility and sterility, Knowledge and ignorance, life and death of an individual depend on the proper or improper sleep. In the present era everyone is struggling for existence, so man is working hard for day and night without taking adequate sleep. Beside that mental stress, addiction of alcohol, and tobacco leads to insufficient sleep, insomnia, sleep disorder, sleep apnea, which are included in Nidranash. In basic texts Aswapna, Nidralpata, Nidrakshaya, Nidrahani, Nidraghat, Mandanidra and Nidrabhransha all these terms are included in Anidra. The disease Nidranash is found to be gradually increasing in the society and has become one of the common health Problem. In the above situation, we need an alternative therapy which is useful and devoid of the hazards of modern drug therapy. Fortunately we find a ray of hope in treating the patients of Anidra with an age old therapy of Ayurveda. So the study was undertaken to evaluate the efficacy of Kanamool churna and jatamansi churna in the management of Nidranasha.

Keywords: Anidra, Kanamool Churna, Jatamasi Churna.

INTRODUCTION:

“EARLY TO BED AND EARLY TO RISE MAKES JACK HEALTHY AND WISE”. Well quoted but has not lasted for long. Human beings in their eternal efforts to triumph over nature, are finding themselves engulfed in the day-night compartments of concrete jungle called modern life. In their very quest filled with emotional stress and physical strain humans are encountering an enormous army of diseases which is highly successful in creating major hurdles in "Journey"¹. Sometimes these problems become so intense that humans often find themselves entangled in the web of solving and creating problems into a vicious circle, which makes them forget their real purpose in life deprives them their basic right, the perfect health. Among the web of diseases, Sleeplessness is the most problem which is often neglected, until it becomes an irreversible hazard. Gelder. M. etal (1990) have estimated that atleast 10-20 % of the population is suffering from Insomnia, among them 15% are suffering from this condition where the cause is not known. i.e., Primary Insomnia.

In Atharvaveda Shounakeeya shakha the physiology of Nidra has been described as: Sleep is the non-deliberate absence of thought waves or knowledge. Dreamless sleep is an inert state of consciousness in which the sense of existence is not felt. In sleep, the senses of perception rest in the mind, the mind in the consciousness and the consciousness in the being. In deep sleep, the senses of perception cease to function because their king, the mind is at rest. This is Abhava, a state of void, a feeling of emptiness.² Lord Shri Krishna has explained the importance of proper sleep for a Dhyana Yogi in Bhagwad Gita³. According to him, both excessive sleep and ceaselessly awakening are not good.

‘युक्ताहारविहारस्य युक्तचेष्टस्य कर्मसु ।

युक्तस्वप्नावबोधस्य योगो भवति दुःखहा ॥17॥’

(Bhagvadgeeta adhyay 6 shlok 17)

The condition of Insomnia may not be a life threatening illness but it has a tendency to damage the person's daily life, including his social and occupational life. If it is very chronic, the person may develop varieties of Psychiatric illness also. Considering this, Insomnia is considered to be a major health hazard, drawing the attention of professionals and researchers all over the world, Nidranasha is not explained as a separate disease in any of classical text books of Ayurveda. The minimum descriptions that are available are also scattered and mentioned incidentally in the context of Vatajananatmaja Vikara, Vatajaj hridroga etc.

Primary insomnia where the cause of sleeplessness is obscure, is normally treated with anti depressant drugs, sedatives, tranquilizers and hypnotic drugs etc. But these drugs may lead to many complications such as hang-over, tolerance towards the drug, re-occurrence of the symptoms on the withdrawal of the drug, etc. Other modalities such as Relaxation therapy and Psychotherapy also have their limitations.

Ayurveda believes that life sustains on Ahar, Nidra, Brahmacharya i.e. known as Trayopastambhas⁴. Importance of Nidra is clearly illustrated by Ayurveda. As mentioned in Sushruta Sharirsthan 4th chapter, Vayu, Manastap, Kshya and Abhighat are the cause of Anidra⁵. Charaka included the Aswapna on 80 Nanatmaja vata diseases⁶. Kanamool churna was indicated in the management of Nidranasha in Bhaishajya Ratnavali, Bhava prakasha, etc. Jatamansi is indicated as nidra janan by Bhavaprakash Nighantu, Priya Nighantu. According to Koyadev Nighantu, Dhanantari Nighantu, Saligram Nighantu, Bhavaprakash Nighantu it has properties of vata shamak and pitta shamak. According to Koyadev Nighantu it has daha prashamak property. According to Bhavaprakash Nighantu Jatamansi has the property of vedana sthapan and samgya sthapan and according to Saligram Nighantu, Priya Nighantu, Bhavaprakash Nighantu it has medhya property. Due to these karma of Jatamansi help to treat anidra^(7,8,9).

AIMS AND OBJECTIVES:

- i) To evaluate the efficacy of kanamool churna in Anidra.
- ii) To evaluate the efficacy of Jatamansi churna in Anidra.
- iii) To evaluate mode of action of Kanamool churna in Anidra.
- iv) To evaluate mode of action of Jatamansi churna in Anidra.

This study is focused on the management of Anidra with kanamool churna and jatamansi churna given orally.

Sample size - 60 Patients

FORMULA: $4pq/L^2$

Where, P= prevalence 10%

l = Allowance error

q = 1-p

After calculation n = 56.25

Hence 60 patients were selected as sample size.

GROUP A -30- Kanamool churna

GROUP B- 30- Jatamansi churna

Study duration : 3 months (For every Patient, from start to end of the trial) Follow up Monthly.

Source of data : O.P.D and I.P.D of the institute department of kayachikitsa, gomantak ayurveda Mahavidyalaya & research centre, shiroda, goa.

MATERIAL & METHOD:

A) DIAGNOSTIC CRITERIA

- Sleep efficiency index.
- Clinical history

Detailed Information about the Symptom Complex

Lakshanas - Patients were examined on the basis of a specific proforma especially prepared for the purpose. Classically mentioned Lakshanas / upadravas of nidranasha were used as the spectrum of clinical features to be sought in a patient of Anidra. They are as follows:

1. Jrimbha
2. Tandra
3. Angamarda
4. Shirogaurav

B) INCLUSION CRITERIA

- Patients aged 18 years and above.
- Patients complaining of reduction in sleep time, difficulty in initiation of sleep, wakefulness during night
- Patient lying in between the range of 15-21 score as per the PSQI scale.

C) EXCLUSION CRITERIA

- Pregnancy & Lactation.
- K/C/O any systemic Disorder.

D) WITHDRAWAL FROM THE STUDY:

- Discontinuation of treatment during trial.
- Development of life threatening complication.

- Development of any non related ailments which may require other medications.

DRUG ADMINISTRATION DETAILS:

GROUP A: 30 patients

- **DOSE OF DRUG** : 2.5 gm Kanamool churna + 5 gm Guda
- **AUSHADH SEVAN KAL:** Nishakal
- **MODE OF ADMINISTRATION:** Orally
- **DURATION:** 3 months daily
- **ANUPAN:** koshna jal

GROUP B: 30 patients

- **DOSE OF DRUG** : 2gm Jatamansi churna
- **AUSHADH SEVAN KAL:** Nishakal
- **MODE OF ADMINISTRATION:** Orally
- **DURATION:** 3 months daily
- **ANUPAN:** koshna jal

ASSESSMENT CRITERIA: On the basis of improvement of sign & symptoms

OBSERVATIONS: Total 60 patients were enrolled for the present study. Group A had 30 numbers of patients and Group B had 30 patients, respectively.

1. **AGE:** Group A- 14 Patients (46.7%) belonged to 18 to 40 age group and 16 Patients (53.3%) belonged to 41 to 60 Age group. Group B- 14 Patients (46.7%) belonged to 18 to 40 and 14 Patients (46.7%) belonged to 41 to 60.
2. **GENDER-** Group A- 14 were Female (46.7%) and 16 were (53.3%) Male. Group B –16 were Female (53.3%) and 14 were (46.7%) Male.
3. **MARITAL STATUS-** Group A- 24 Patients (80.0%) were married, 2 were unmarried (6.7%) and 4 patients (13.3%) were widow. Group B- 25 patients (83.3%) were Married, 2 were Unmarried (6.7%) And 3 patients were (10.0%) widow.
4. **RELIGION-** Group A- 27 patients (90.0%) were Hindu, 2 were Jain (6.7%), and 1 patient (3.3%) was a Muslim. Group B - 27 patients (90.0%) were Hindu, 2 were Jain (6.7%), and 1 patient (3.3%) was Muslim.
5. **OCCUPATION-** Group A- 1 was artist (3.3%), 2 patients (6.7%) were clerk, 2 were Farmer (6.7%) ,13 Patients (43.3%) were Housewife, 2 were of (6.7%) IT Profession, 3 patients (10.0%) were Salesman, 3 were Shopkeepers (10.3%) and 4 patients (13.3%) were Teacher. Group B- 5 Patients were (16.7%) clerk, 14 patients were (46.7%) Housewife, 3 were (10.0%) of IT Profession, 4 Patients (13.3%) were Teacher and 4 Patients (13.3%) were of Shopkeeper.
6. **SOCIO-ECONOMIC STATUS-** Group A- 16 Patients (53.3%) belonged to the Lower middle class, 5 Patients were Poor and 9 Patients (30.0%) were belonged to Upper middle class. Group B- 20 Patients were (66.7%) belonged to Lower middle class, 5 Patients (16.7%) were poor and 5 Patients (16.7%) were belonged to Upper middle class.
7. **NATURE OF WORK-** Group A- 20 patients (66.7%) were Active and 10 patients (33.3%) had Sedentary nature of work. Group B- 22 patients(73.3%) were Active and 8 Patients (26.7%) had sedentary nature of work.
8. **ADDICTION-** Group A- 11 Patients (36.7%) had the Habit of taking tea, 11 patients (36.7%) had the habit of taking coffee, and 8 Patients (26.7%) had the habit of taking both tea and coffee. Group B- 8 Patients (26.7%) had the habit of taking coffee, 19 Patients (63.3%) had the habit of taking Tea, and 3 Patients (10.0%) had the habit of taking both tea and coffee.
9. **DEHAPRAKRUTI-** Group A- 6 Patients (20.0%) were of Kapha-vataj Prakruti, 3 Patients (10.0%) were of Pitta-Kaphaja Prakruti and 21 were (70.0%) of Vata-Pittaja Prakruti. Group B- 4 Patients (13.3%) were of Kapha-Pittaja Prakruti, 2 Patients (6.7%) were of Pitta-Kaphaja Prakruti and 24 were (80.0%) of Vata-Pittaja Prakruti
10. **MANASPRAKRUTI-** Group A– 26 patients (86.7%) were of Raja Prakruti and 4 Patients (13.3%) were of Tama Prakruti. Group B- 26 patients (86.7%) were of Raja Prakruti and 4 Patients (13.3%) were of Tama Prakruti.
11. **SAAR-** Group A- 6 Patients (20.0%) had Avara sara, 22 had Madhyama sara (73.3%) and 2 Patients (6.7%) had Pravara sara. Group B- 4 Patients (13.3%) had Avara sara, 25 Patients (83.3%) had Madhyama sara and 1 Patient (3.35%) had Pravara sara.
12. **DIET-** Group A- 21 Patients (70.0%) consumed Mixed Diet, Whereas 9 Patients (30.0%) consumed Vegetarian diet. Group B- 24 Patients (80%) consumed Mixed diet whereas, 6 Patients (20%) consumed Vegetarian diet.
13. **SATVA-** Group A- 10 Patients (33.3%) had Avara Satva and 19 patients (63.3%) had Madhyama satva. Group B- 8 patients (26.3%) had Avara Satva and 22 patients (73.3%) had Madhyama Satva.

14. JRUMBA- Group A - all the Patients presented with the symptom of jrumbha Out of which 19 Patients (63.3%) were in grade 3 and 11 patients (36.7%) were in grade 2. At the end of the trial 6 were (20.0%) in Grade 2, 8 Patients (26.7%) were in Grade 1 and 16 were (53.3%) in Grade 0. Group B- all the Patients presented with the symptom of jrumbha, Out of which 17 (56.7%) Patients were in grade 3, 13 Patients (43.3%) were in grade 2. At the end of the trial 6 were (20.0%) in grade 2, 6 Patients (20.0%) were in grade 1 and 18 patients (60.0%) were in grade 0.
15. ANGAMARDA- Group A - all the Patients presented with the symptom of Angamarda, Out of which 20 Patients (66.7%) were in grade 3 and 10 patients (33.3%) were in grade 2. At the end of the trial 7 were (23.3%) in Grade 2, 9 Patients (30.0%) were in Grade 1 and 14 were (46.7%) in Grade 0. Group B - all the Patients presented with the symptom of Angamarda Out of which 17 Patients (56.7%) were in grade 3 and 13 patients (43.3%) were in grade 2. At the end of the trial 8 were (26.7%) in Grade 2, 8 Patients (26.7%) were in Grade 1 and 14 patients (46.7%) were in Grade 0.
16. TANDRA- Group A - all the Patients presented with the symptom of Tandra, Out of which 23 Patients (76.6%) were in grade 3 and 7 patients (23.3%) were in grade 2. At the end of the trial 7 were (23.3%) in Grade 2, 9 Patients (30.0%) were in Grade 1 and 14 were (46.7%) in Grade 0. Group B - all the Patients presented with the symptom of Tandra, Out of which 16 Patients (53.3%) were in grade 3 and 14 patients (46.7%) were in grade 2. At the end of the trial 8 were (26.7%) in Grade 2, and 9 Patients (30.0%) were in Grade 1, 13 Patients (43.3%) were in Grade 0.
17. SHIROGAURAV- Group A- all the Patients presented with the symptom of Shirogaurav, Out of which 21 Patients (70.0%) were in grade 3 and 9 patients (30.0%) were in grade 2. At the end of the trial 7 were (23.3%) in Grade 2, 8 Patients (26.7%) were in Grade 1 and 15 were (50.0%) in Grade 0. Group B - all the Patients presented with the symptom of Shirogaurav Out of which 19 Patients (63.3%) were in grade 3 and 11 patients (36.7%) were in grade 2. At the end of the trial 7 were (23.3%) in Grade 2, 8 Patients (26.7%) were in Grade 1 and 15 Patients (50.0%) were in Grade 0.
18. SUBJECTIVE SLEEP QUALITY- Group A- 21 Patients (70.0%) were in Grade 3 and 9 Patients (30.0%) were in Grade 2, At the end 13 Patients (43.3%) were in Grade 1 and 17 Patients (56.7%) were in Grade 0. Group B- 25 Patients (83.3%) were in Grade 3 and 5 Patients (16.7%) in Grade 2, At the end 14 Patients (46.6%) were in Grade 1 and 16 Patients (53.3%) were in Group 0.
19. SLEEP LATENCY- Group A- 19 Patients (63.3%) were in Grade 3 and 11 Patients (36.7%) were in Grade 2, At the end 10 Patients (33.3%) were in Grade 1 and 20 Patients (66.7%) were in Grade 0. Group B- 23 Patients (76.7%) were in Grade 3 and 7 Patients (23.3%) in Grade 2, At the end 1 Patient (3.3%) in Grade 2, 12 Patients (40.0%) in Grade 1 and 17 Patients (56.6%) in Group 0.
20. SLEEP DURATION- Group A- 20 Patients (66.7%) were in Grade 3 and 10 Patients (33.3%) were in Grade 2, At the end 11 Patients (36.7%) were in Grade 1 and 19 Patients (63.3%) were in Grade 0. Group B- 23 Patients (76.7%) were in Grade 3 and 7 Patients (23.3%) in Grade 2, At the end 12 Patients (63.3%) in Grade 1 and 18 Patients (36.7%) in Grade 0.
21. SLEEP EFFICIENCY- Group A- 19 Patients (63.3%) were in Grade 3 and 11 Patients (36.7%) were in Grade 2, At the end 1 Patients (3.3%) were in Grade 2, 13 Patients (43.3%) were in Grade 1 and 16 Patients (53.3%) in Grade 0. Group B- 21 Patients (70.0%) were in Grade 3 and 9 Patients (30.0%) in Grade 2, At the end 10 Patients (33.3%) in Grade 1, 20 Patients (66.7%) in Grade 0.
22. SLEEP DISTURBANCE- Group A- 19 Patients (63.3%) were in Grade 3 and 11 Patients (36.7%) were in Grade 2, At the end 1 Patients (3.3%) were in Grade 2, 15 Patients (50.0%) were in Grade 1 and 14 Patients (46.7%) in Grade 0. Group B- 29 Patients (96.7%) were in Grade 3 and 1 Patient (3.3%) in Grade 2, At the end 11 Patients (36.7%) in Grade 1, 19 Patients (63.3%) in Grade 0.
23. USE OF SLEEP MEDICATION- The gradation is 3 throughout the follow up, because the Patients are expected to take the medication regularly for 3 month. Hence for constant values statistical data remains constant.
24. DAYTIME DYSFUNCTION- Group A- 23 Patients (76.7%) were in Grade 3 and 7 Patients (23.3%) were in Grade 2, At the end 2 Patients (6.7%) were in Grade 2, 10 Patients (33.3%) were in Grade 1 and 18 Patients (60.0%) in Grade 0. Group B- 20 Patients (66.7%) were in Grade 3 and 10 Patient (33.3%) in Grade 2, At the end 10 Patients (33.3%) in Grade 1, 20 Patients (63.7%) in Grade 0.

OVERALL EFFECT- Subjective criteria- Group A- At the end of the trial, Out of 30 patients, 13 patients had marked improvement, 14 patients had Moderate improvement where, 3 patients had mild improvement. Group B- At the end of the trial Out of 30 patients, 15 patients had marked improvement, 12 patients had Moderate improvement where, 3 patients had mild improvement.

Component score- Group A- At the end of the trial Out of 30 patients, 27 patients had No clinically significant insomnia and 3 patients had sub-threshold insomnia. Group B- At the end of the trial Out of 30 patients, 28 patients had No clinically significant insomnia and 2 patients had sub-threshold insomnia.

RESULT:

According to the history given by the patients in Group A, the general condition of majority of patients 29 (93.33%) was fair before the treatment similarly in Group B, all the 30 (100%) patients had a fair general condition prior to the treatment and none of the patients in both the groups had a good general condition. After the treatment all the patients 60 (100%) improved to the good category. All patients had both onset and maintenance anidra (insomnia). This improved considerably in both the Groups and all the patients 60 (100%) fell under none category i.e. none of the patients had any type of anidra after treatment. For an overwhelming majority of patients (29, 96.67%) in Group A and 30 (100%) in Group B no procedure succeeded in bringing sleep before the treatment. After the treatment no procedure was required in all 30 (100%) patients in Group A. In Group B, while 29 (96.6%) patients did not require any procedure to fall asleep after the treatment, 2 patients (6.6%) still required meditation etc. There was

no satisfaction from sleep in all 60 (100%) patients prior to the treatment. Post-treatment it improved to reach adequate levels in all 60 (100%) patients. Statistically, there was no significant difference in the results in two groups. Considering these facts we find that the present drugs used for the trial have produced a significant improvement in all the cases of Anidra in both groups. Patients of both the groups reported benefit in various aspects. Each and every aspect related to this disease was touched by the clinical trial. There was an overall improvement in the patients regarding ability to fall asleep, maintain sleep and satisfaction from sleep. A complete multifaceted recovery process was initiated by the treatment which was evident in an improved general condition, reduced day time effects and absence of addiction, dependence and relapse.

DISCUSSION:

In Ayurvedic classics Anidra is commonly related to involvement of manovaha srotasas and indriyas resulting in impaired ability to concentrate, poor memory, reduction in working capability, stamina and leads to behavioural changes in human beings. Murdha is the seat of prana vayu and tarpak shleshma. When these two vital elements are in equilibrium the manovaha srotasas and indriyas are able to perform in coordination and the phenomenon of nidra also occurs physiologically. When Vata, vitiated due to its naidanik hetus moves to reside in Uttamanga; manovaha srotasas and indriyas are involved and functional capacity of tarpak shleshma decreases qualitatively and quantitatively. Thus increase in vata and kapha kshaya leads to Anidra. In clinical practice variety of drugs are available to treat those types of cases symptomatically, the Ayurvedic approach to treat Anidra is multidimensional and counteracts the Naidanik Bhavas of Anidra. The present drug trial composed of oral drug therapy in established cases of Anidra. The probability of pharmacological actions of above drugs were hypothetically estimated on the basis of Ayurvedic principles and qualities of trial drugs. The constituents of these preparations presumably act in the manner discussed below.

DISCUSSION ON PROBABLE MODE OF ACTION OF KANAMOOOL CHURNA IN ANIDRA:

It acts on mahasrotas particularly the sthana of vata, because it has Rochan, Deepan, Pachan and Vatanuloman action. Hence it helps to pacify the vitiated vata and somehow control the dushaya vikara of this disease. Side by side it is Balya, Brinhan, Brishya and Rasayana. Thus promotes the function of Kapha Dosha (Tarpak Shleshma) and is Kaphavardhak in nature. Pippali Mula is also Medhya, hence it nourishes the manovaha srotasas and indriyas and thereby improves the function and increases the Tama Bhava during Ratrikala. Pippalimula is katu in rasa, snigdha, laghu tikshna in guna ushma in virya madhura in vipaka. Its nidrajanan properties can be attributed to its snigdha guna and madhura vipaka. It can also be perceived to be nidrajanan due to its prabhava¹⁰.

DISCUSSION ON PROBABLE MODE OF ACTION OF JATAMANSI CHURNA IN ANIDRA:

Jatamansi has Madhur Rasa, Snigdha Guna, Sita Virya¹⁰. According to Charak anidra is nanatmaja vataja disease. Due to Madhura rasa Snigdha Guna, Sita Virya it alleviates vata. According to various Acharya karma of Jatamansi is that it alleviates all the three doshas, it is dahaprasamak, varnya and also vedanasthapak¹⁰, it has also action on the nervous system such as samgyasthapa, medhya, valya, vedanasthapan, nidrajanan. Due to these karma of Jatamansi help to treat anidra¹¹.

DISCUSSION ON EPIDEMIOLOGICAL OBSERVATIONS:

Based on 60 established cases of insomnia interesting observations have come forth. Incidence of the disease in different age groups revealed that insomnia is most common in the age group 41-60 years (30, 50%). In our social set up people belonging to this age group experience maximum mental stress, be it marital, social work related or financial boundations. Secondly, a simultaneous increase in Vata dosha ensues which is mentioned in Ayurvedic classics too. Vata vriddhi is well known as the main causative factor of Anidra. Males and females both are equally affected with anidra. Incidence of Anidra was found to be maximum (45, 75%) among those having mixed diet. But no conclusion can be drawn from the data as the sample size is very small. Married people were found to be overwhelmingly prone (49, 81.6%) to Anidra. This is clearly due to high level of responsibilities and mental stress. Majority of the registered patients (30, 50%) were addicted to tea. Tea is a stimulant. Hence addiction to tea can cause Nidranash or Anidra. People with vata pittaja (45, 75%) and rajas prakriti (52, 86.6%) were found to suffer more from Anidra. This conforms to the theory of Anidra in ayurvedic classics. Vata, pitta and rajas guna are most important factors causing Anidra. Hence prakriti with combination of these three is most likely to suffer from this disorder. Those with madhyam saar were more prone to Anidra (47, 78.3%) while people with avara saar were not far behind (10, 16.6%). With avara saar dhatuposhana and nutrition suffers. Thus rasa dhatu becomes Aposhit deficient and causes Anidra. It was found that people belonging to lower middle class (36, 60%) were greatly prone to suffer from Anidra. It is the middle class people who face social and work related stress along with marital stress and deadlines. There is a great difference between requirements and achievements resulting in dissatisfaction and stress. Thus mental stress being greater, middle class people suffer more from Anidra.

CONCLUSION:

The results were analyzed statistically which shows both kanamool churna and Jatamansi churna are effective for the management of signs and symptoms of Anidra. Kanamool churna and Jatamansi churna both are equally effective in sleep initiation, non-restorative sleep and sleep efficiency index. In this study no any adverse reaction was noted.

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