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Nirudhaprakasha and Phimosis: Classical Ayurvedic Concepts and Contemporary Clinical Review

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Abstract

Background: A foreskin that will not retract is one of the most common reasons a boy is brought to a pediatric surgeon and one of the most commonly mismanaged. Much of the difficulty lies in telling a normal developing foreskin from a truly scarred one. Classical Ayurvedic surgery describes a condition called Nirudhaprakasha and places it among the kshudra rogas the so called minor diseases. Objectives: To set out what the classical texts say about Nirudhaprakasha compare it point by point with the modern understanding of phimosis and ask whether the Ayurvedic stepwise approach has anything to offer present-day practice. Methods: A narrative review of the Sushruta and Charaka Samhitas their translations Ayurvedic journal literature and indexed modern studies of foreskin development epidemiology pathology and treatment. Results: Nirudhaprakasha is attributed to vitiated Vata acting on the penile skin which thickens narrows the preputial opening and leaves the glans covered. The classical plan is graded oleation with Vata pacifying oil progressive dilatation with a lubricated tube and only then a controlled incision that spares the raphe. Modern practice follows a strikingly similar order with reassurance first then topical corticosteroids and surgery for failure scarring or recurrent infection. The two traditions differ most in their treatment of the physiological foreskin of early childhood which the modern literature insists should be left alone and in the evidence base which is robust for corticosteroids and almost absent for Ayurvedic dilatation. Conclusion: Nirudhaprakasha corresponds closely to pathological phimosis and the Sushruta approach is best read as an early staged tissue sparing strategy. Controlled clinical studies are needed before any Ayurvedic measure can be recommended alongside or in place of established therapy.

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1. Introduction

Phimosis is the inability to retract the prepuce over the glans. [1] The definition is simple enough but the clinical picture is not because a non retractile foreskin is the normal state of affairs in a newborn and remains so for many boys well into childhood. What matters is whether the tightness is a stage of normal development or the result of disease. Getting this wrong carries real costs. Forceful retraction of a developing foreskin can tear the delicate preputial epithelium and healing by scar may turn a

harmless variant into genuine pathology. [2] A boy with true disease who is merely reassured can go on to recurrent balanoposthitis and urinary tract infection.

Circumcision has long been the default answer and in many settings it is still the first one offered. Reviews of practice have argued that many circumcisions performed for phimosis in boys are unnecessary because the foreskin was simply immature. [3] Growing evidence that topical corticosteroids can resolve true phimosis without surgery has shifted the emphasis toward conservative care. [4]

The Ayurvedic surgical tradition took up the same problem many centuries ago. Sushruta describes a condition of the penile skin called *Nirudhaprakasha* literally a state in which *Prakasha* (exposure) is *Nirudha* (obstructed) and he lists it among the *Kshudra Rogas.* [5] His treatment is notably gradual. Dilatation comes first and the knife is kept for the case that does not respond. Recent *Ayurvedic* writing has begun to read this passage against modern pediatric urology.

This review has three aims to gather the classical description of *Nirudhaprakasha* in one place with the *Sthana Adhyaya* and shloka for each source to lay it beside modern knowledge of the physiology epidemiology pathology and treatment of phimosis and to identify where the two accounts agree where they diverge and which questions remain open.

2. Method

This is a narrative review and was not conducted as a formal systematic review. Classical material was read from the *Sushruta Samhita* with its *Dalhana* commentary and English translations and from the *Charaka Samhita* for the general doctrine of Vata. References to the classics follow the pattern of *Sthana Adhyaya* and *Shloka*. Verse numbering differs between published editions so the numbers given here belong to the edition named in the reference list. The reference to *Ashtanga Sangraha* which classifies the condition as *Niruddhamani* under the *Guhya Rogas* comes from published *Ayurvedic* scholarship rather than a primary reading of the text.

Modern literature was chosen for relevance and quality of evidence. We gave priority to population studies of foreskin development controlled and cohort studies of topical corticosteroids systematic reviews of circumcision outcomes and published guidance. Case reports and uncontrolled opinion pieces were used only to illustrate points that better evidence did not address. No quantitative synthesis was attempted. Figures 1 4 and 5 are original schematic illustrations prepared for this article. Figures 2 3 and 6 are replots of data from the sources named in their captions.

3. Development of the Prepuce

The prepuce forms during fetal life as a fold of skin that grows forward over the glans. At birth the inner preputial layer is still joined to the glans by a thin epithelial adhesion which is why the foreskin cannot be pulled back in most newborns. [6] Over the following years the adhesion dissolves from the periphery inwards helped by shed epithelial cells that collect as small pearls of smegma and by spontaneous erections until the glans can be fully exposed.

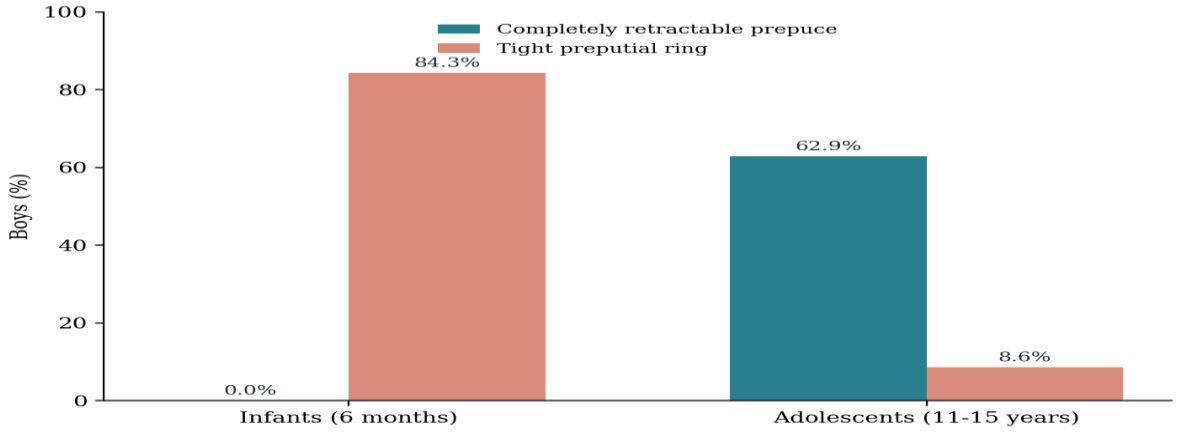


Fig 1: Preputial retractability and tight ring by age. Re-plotted from the data reported by Kayaba and colleagues.

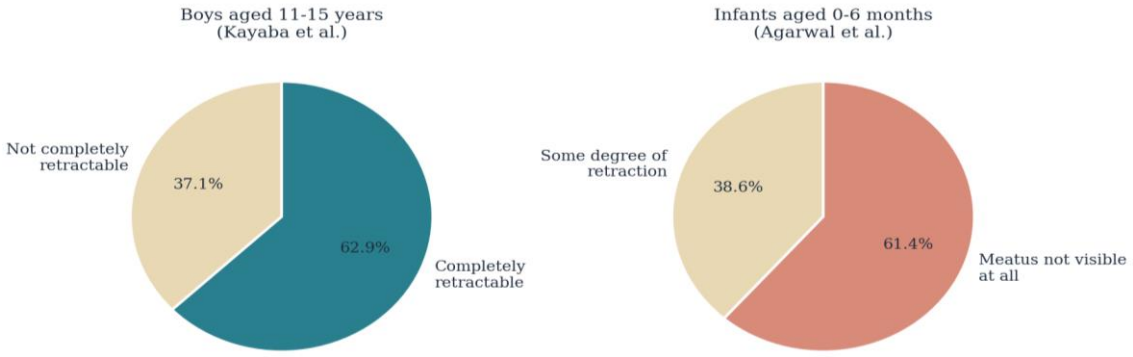


Fig 2: Preputial retractability in older boys and infants. Percentages are those reported by the original authors the complementary slices are derived.

4. Epidemiology and Natural History

The older European studies framed the question that later work has refined. Gairdner found that the foreskin is retractable in only a small minority of newborns that around half are retractable by the end of the first year and that roughly nine in ten are retractable by the age of three. [9] Øster's survey of Danish schoolboys followed the problem into adolescence and recorded a small residue of boys with a non retractile prepuce at the age of 16 to 17 years. [10] Table 1 collects the main figures.

Table 1: Principal population studies of preputial development and phimosis

Study	Population	Principal finding	Comment
Gairdner	British boys	Retractability rises steadily from birth about nine in ten retractable by age 3 (as reported)	Foundation of the fate of the foreskin concept
Øster	Danish schoolboys	Non retractile foreskin falls with age a small residue persists at 16 17 years	Often quoted to show that true phimosis is uncommon
Kayaba *et al.*	603 Japanese boys 0-15 years	Retractable 0% at 6 months to 62.9% at 11 15 years tight ring 84.3% to 8.6%	Introduced a five grade description of the prepuce
Hsieh *et al.*	149 schoolboys	Progressive separation before adolescence	Variation of the grading scheme
Agarwal *et al.*	960 boys Indian hospital	Meatus not visible in 61.4% at 0 6 months 0.9% at 10 12 years	Indian data true phimosis rare in children
Shankar and Rickwood	Population based incidence study	Incidence about 0.4 per 1 000 boys per year about 0.6% by age 15	Incidence of true pathological phimosis

The practical lesson is that a large number of children will be labelled phimotic who are developing normally while true pathological phimosis affects well under one boy in a hundred. Any serious discussion of treatment has to start from that distinction.

5. Classification and Aetiology

5.1. Physiological and Pathological Phimosis

Physiological phimosis is the non retractile foreskin of infancy and early childhood. [11] It is painless the skin of the preputial opening is soft and healthy and it improves with time. Pathological phimosis is an acquired narrowing caused by scarring. The foreskin is firm the opening may look pale or puckered and the ring does not stretch. A foreskin that has never retracted and a foreskin that once retracted and no longer does are clinically different problems and the history usually makes this plain.

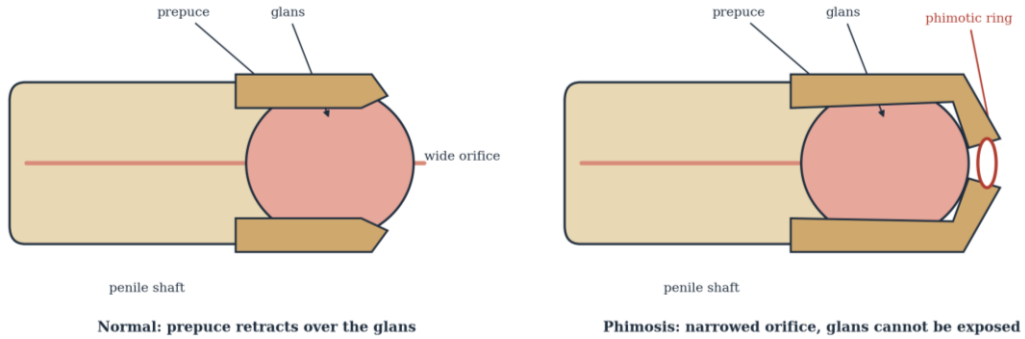


Fig 3: Stylized schematic of the normal and phimotic prepuce showing the narrowed preputial orifice (original illustration not to scale).

5.2. Causes of Pathological Phimosis

In boys the chief causes are repeated balanoposthitis scarring after forced retraction and lichen sclerosus (balanitis xerotica obliterans) a chronic inflammatory skin disease that produces a white hardened ring and is the most important cause of true phimosis requiring surgery. [12] Balanoposthitis itself has several infective and non infective causes and recurrent episodes can leave a fibrotic ring. In adult men new onset phimosis should prompt a check of glycaemic status since diabetes can first show itself through recurrent preputial infection. [13]

5.3. Clinical Grading

Several grading schemes have been described. The five grade pattern first used by Kayaba and colleagues is easy to apply at the bedside and has been used in Indian studies. Table 2 gives a practical version adapted from that approach later authors have reordered the grades so the grade number should always be accompanied by a description.

Table 2: Practical clinical grading of preputial retraction (adapted)

Grade	Finding on gentle retraction	Usual significance
I	No retraction the meatus cannot be seen	Normal in infants pathological if it persists with scarring or symptoms
II	Only the urethral meatus can be exposed	Common in early childhood observe
III	The glans is partly exposed	Normal during development
IV	The glans is exposed but a tight ring remains behind the corona	Observe treat if symptomatic or scarred
V	Complete retraction without a ring	Normal

6. Clinical Presentation and Assessment

The usual complaints are ballooning of the foreskin during micturition a weak or sprayed stream pain or irritation and recurrent balanoposthitis. A few children present with a urinary tract infection or rarely with retention. Circumcision has been associated with a lower risk of urinary tract infection in boys and this is one reason why recurrent infection is accepted as an indication for treatment. [14] Paraphimosis in which the retracted foreskin cannot be returned is an emergency and usually follows forced retraction. [15]

Examination should be gentle. The clinician looks at the colour and texture of the preputial skin the shape of the opening the presence of any whitish sclerotic band and whether ballooning occurs on voiding. Force is never used to make a diagnosis. A white rigid ringed opening should raise the suspicion of lichen sclerosus which changes both prognosis and treatment. [16] In adults urine and blood glucose should be checked.

7. The Ayurvedic Perspective *Nirudhaprakasha*

7.1. Position in the Classics

Sushruta describes *Nirudhaprakasha* in the *Kshudraroga Nidana* (*Nidana Sthana adhyaya* 13) alongside two neighboring penile conditions *Parivartika* and *Avapatika* (Su.Ni.13/50 54). Its treatment is given in the *Kshudraroga Chikitsa* (*Chikitsa Sthana adhyaya* 20). [17] The word *kshudra* means small or minor and the category covers conditions that are troublesome rather than life-threatening although the surgical measures prescribed for some of them are far from trivial. *Ashtanga Sangraha* according to Ayurvedic reviewers uses the term *Niruddhamani* and groups it among the *guhya rogas* the diseases of the genitalia. [18]

7.2. Nidana and Samprapti

The classical explanation is a *Vata* disorder. *Vata* is the dosha of movement and of drying constricting change its qualities and its role in structure and function are set out in the general doctrine of the *Charaka Samhita* (Ch.Su.12/8). [19] And its disorders are classified by *Sushruta* at the beginning of the *Nidana Sthana* (Su.Ni.1). [20] In *Nirudhaprakasha* aggravated *Vata* settles in the *shishna charma* the skin of the penis and thickens it so that the *mani* (glans) stays covered and the passage of urine is impeded. [21] The classical picture is of a slow thin stream without pain. A *Vata* predominant disease of this kind can be read as belonging to the broad family of *Nanatmaja Vata Vyadhis* described in the *Charaka Samhita* (Ch.Su.20/11). [22]

Contemporary *Ayurvedic* authors add that the disease may be congenital as in the newborn or acquired through injury or infection of the prepuce. These causes were not set out as separate *Nidanas* by *Sushruta* and the addition is best read as an interpretive bridge to modern thinking rather than classical doctrine. Figure 4 summarizes a proposed *Samprapti* built on the classical description and Table 3 sets out the *Samprapti* G*hatak*.

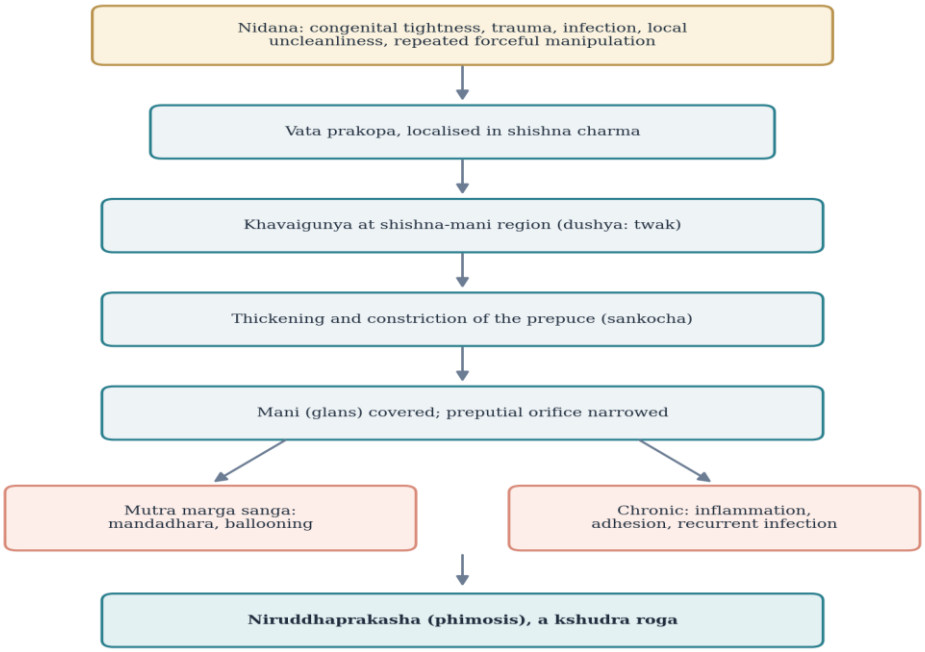


Fig 4: Proposed *Samprapti* of *Niruddhaprakasha* constructed from the classical description (original illustration).

Table 3: Proposed *samprapti ghataka* of *Niruddhaprakasha* (interpretive)

Ghataka	Description
Dosha	*Vata* predominant local aggravation in the penile skin
Dushya	*Twak* (*Shishna Charma*) the glans is secondarily covered
Srotas	*Mutravaha srotas* affected secondarily through obstruction of the outflow
Sroto dushti	*Sanga* (obstruction) seen as a narrowed outflow and slow stream
Adhishthana	*Shishna* and *Mani*
Rogamarga	*Bahya* (external)
Vyadhi	*Kshudra roga*

7.3. Neighbouring Conditions

The description of *Nirudhaprakasha* has to be read with the other conditions of the same region. *Parivartika* corresponds to paraphimosis a prepuce that has been drawn back and cannot be returned. [23] *Avapatika* is commonly equated with a split or crack in the prepuce which would in modern terms be a preputial tear. The *Shukadoshas* (Su.Ni.14) are a group of penile disorders many of them arising from faulty procedures and the *Upadamsha* group (Su.Ni.12) covers penile sores and infective lesions both enter the differential diagnosis and the corresponding treatment chapter for the *Shukadoshas* is Su.Chi.21. Table 4 sets the classical terms beside their modern counterparts.

Table 4: Correlation of classical Ayurvedic terms with modern diagnoses

***Ayurvedic* term**	**Modern correlate**	**Basis and caution**
Nirudhaprakasha	Phimosis (pathological)	Close the classical text does not distinguish physiological from pathological forms
Niruddhamani (Ashtanga Sangraha)	Phimosis	As reported by *Ayurvedic* reviewers primary text not re read here
Parivartika	Paraphimosis	Accepted correlation in *Ayurvedic* literature
Avapatika	Preputial tear or fissure	Correlation is interpretive editions differ
Shukadosha	Penile disorders of mixed causes	A group rather than one disease
Upadamsha	Penile sores or infective lesions	Broad correlation only

8. Management

8.1. Contemporary Management

For the child with a non retractile foreskin and no symptoms the correct treatment is none. Parents are reassured taught to wash the foreskin gently and told not to force it back. When true phimosis is present a course of several weeks of a topical corticosteroid applied to the preputial ring is the first line measure. [24]A Cochrane review concluded that topical corticosteroids give a better chance of resolution than placebo with few adverse effects. Cohort data including a series of more than a thousand boys treated with fluticasone and earlier studies of other preparations point the same way and steroids have worked even in boys under three years of age. [25]

Surgery is kept for failure of medical treatment recurrent infection and lichen sclerosus. Circumcision is definitive but it is a real operation with a recognized complication rate and a systematic review has documented the range of problems that follow it in newborns infants and children. The professional statement of the American Academy of Pediatrics held that the health benefits of newborn circumcision outweigh the risks but were not great enough to recommend it universally. [26] Preputioplasty is an alternative that widens the opening and saves the foreskin. Lichen sclerosus deserves a separate note steroids can help in some boys but some will still need circumcision. Circumcision is also sometimes proposed to prevent penile cancer. Observational studies link it with a lower risk but Danish registry data showed a falling incidence of penile cancer in a population that was mostly uncircumcised which suggests that factors other than circumcision status also shape risk and this is not a reason in itself to operate on a healthy foreskin. [27]

Table 5: Comparison of treatment options for phimosis

Option	**Principle**	**Notes on evidence and use**
Observation and hygiene	Allow natural separation	Correct for physiological phimosis avoid forced retraction
Topical corticosteroid	Softens and thins the preputial ring	Best evidence first line for true phimosis
Gentle stretching or dilatation	Mechanical widening of the ring	Often combined with steroids poorly standardised
Preputioplasty	Surgical widening foreskin preserved	Alternative to circumcision in selected cases
Circumcision	Removal of the foreskin	Definitive indicated for scarring lichen sclerosus recurrent infection
Ayurvedic Nadi Yantra dilatation	Progressive dilatation with oiled tube then incision if needed	Classical no controlled clinical trial identified

8.2. Classical Ayurvedic Management

Sushruta's plan in Su.Chi.20 is built on the principle that the least invasive step is tried first. A hollow tube open at both ends made of metal wood or lac is lubricated with *Ghrita* and passed gently through the preputial opening. The part is then bathed with a Vata pacifying oil and the English translation names the *Chakra Taila* and animal marrow or fat preparations of the type listed in the classic. Larger tubes are introduced at intervals of three days so that the opening widens gradually and the patient is given *Snigdha* (unctuous) food in keeping with the treatment of Vata. [28] The emphasis on unctuous measures follows the general approach to Vata disorders set out in the Charaka Samhita (Ch.Chi.28). The instrument itself belongs to the family of yantras described in the *Sutra Sthana* and a tube lubricated and passed slowly is consistent with the care for instrument handling and the pre operative preparation described there.

If dilatation does not succeed *Sushruta* advises an incision on the prepuce while avoiding the *Sevani* the raphe and then treating the cut as an accidental wound. The kinds of surgical action are classified in the chapter on the eight surgical procedures (Su.Su.25) and the management of a fresh wound is covered in the chapter on *Sadyovrana* (Su.Chi.2). The instruments and technique are described in the chapter on sharp instruments. Modern *Ayurvedic* writers commonly add *Panchatikta Ghrita Guggulu* after surgery for wound healing. [29]

Table 6 summarizes the classical steps.

Table 6: Stepwise classical management of *Nirudhaprakasha*

Step	Measure	Classical source and notes
1	Lubricated hollow tube passed into the preputial opening	Su.Chi.20 tube of iron wood or lac smeared with *ghrita*
2	Local application of Vata pacifying oil	Su.Chi.20 *Chakra Taila* and marrow or fat of animals
3	Larger tubes at intervals of three days	Gradual dilatation with *Snigdha* food
4	If dilatation fails incision sparing the *Sevani*	Treated as *Sadyovrana* (Su.Chi.2)
5	Post operative care	*Panchatikta Ghrita Guggulu* as used by modern *Ayurvedic* surgeons

8.3. An Integrative Pathway

Figure 5 offers a way of using the two systems together without contradicting either. The foreskin of a young child with soft skin is left to mature and *Ayurvedic* input is limited to supportive measures. Pathological disease receives a steroid course the local infection and any underlying diabetes are dealt with and graded dilatation may be considered an adjunct where trained clinicians and suitable instruments are available. Failure lichen sclerosus or recurrent infection leads to surgery. The pathway is a proposal for discussion and has not been tested.

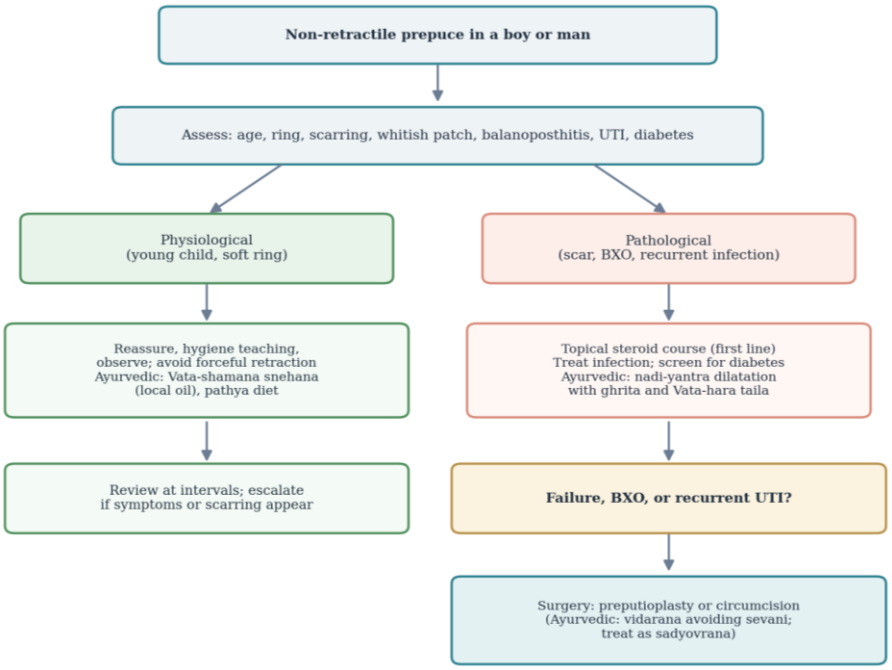


Fig 5: Proposed integrative pathway for the non retractile prepuce (original illustration for discussion not a validated protocol).

9. Discussion

The central finding of this review is that the logic of *Sushruta's* plan matches the logic of modern conservative practice. [30] Both begin with the gentlest effective step both widen the opening in stages before any cutting is done and both reserve surgery for the case that has not responded. Whether the doctrine arose from observation or from a theory of Vata its clinical shape is that of a tissue sparing strategy which is what the modern literature has also been moving towards.

The differences are as instructive as the similarities. The classical text does not separate the physiological foreskin of early childhood from the pathological one because the concept of normal preputial development had not been quantified it took twentieth century population studies to show how late separation can be. A modern *Ayurvedic* clinician who applied the classical regimen to every non retractile foreskin in a young boy would treat many normal children and the risk of damage from repeated instrumentation would be real. The correct reading is that *Nirudhaprakasha* corresponds to pathological phimosis and should be diagnosed only when the modern criteria for it are met.

There are four practical concerns. First dilatation in a child can cause pain fissuring and scarring if done carelessly so any revival of the technique needs trained operators graded instruments and attention to hygiene and probably the same caution about forced retraction that modern authors urge. Second lichen sclerosus will not respond to mechanical widening alone and is a distinct diagnosis that must be recognised. Third several of the classical oils are prepared with animal marrow or fat which raises ethical regulatory and standardization problems and a plant based formulation would have to be validated before it could replace them. Fourth an *Ayurvedic* measure that delays definitive treatment in a child with recurrent urinary tract infection could do harm because recurrent infection is itself an accepted indication for treatment.

9.1. Gaps in the Evidence

We could not identify a controlled clinical trial of *Ayurvedic* dilatation for phimosis and the Ayurvedic literature on the subject consists largely of conceptual reviews and case descriptions. By contrast there are randomized and cohort data for corticosteroids. Several lines of work would help. A pragmatic trial could compare a standard steroid course with a steroid course plus supervised graded dilatation in boys

with true phimosis. A standardized plant-based *Vata*-pacifying oil could be tested against a placebo oil for local softening. A shared case definition based on a recognized grading system and including the exclusion of lichen sclerosus would make *Ayurvedic* case series comparable with the modern literature.

10. Conclusion

Nirudhaprakasha corresponds closely to pathological phimosis and *Sushruta's* graded plan of dilatation first and incision afterwards is an early example of tissue sparing surgical thinking. Modern practice adds two things the classical account lacked a clear distinction between a developing and a diseased foreskin and a drug treatment the topical corticosteroid with solid evidence behind it. For the clinician and the student the most useful way to hold the two together is to diagnose by modern criteria treat by modern evidence and study the classical measures with the same discipline through properly designed clinical trials before they are recommended.

References

1. Hayashi Y, Kojima Y, Mizuno K, Kohri K. Prepuce: phimosis, paraphimosis, and circumcision. The Scientific World Journal. 2011;11(1):289-301.
2. REMONDINO P, SAWDAY E. 10. This Unyielding Tube of Flesh. A Surgical Temptation: The Demonization of the Foreskin and the Rise of Circumcision in Britain. 2005 Aug 1:215.
3. Preiser G. Circumcision—The Debates Goes On. Pediatrics. 2000 Mar 1;105(3):681-4.
4. Ashfield JE, Nickel KR, Siemens DR, MacNEILY AE, Nickel JC. Treatment of phimosis with topical steroids in 194 children. The Journal of urology. 2003 Mar;169(3):1106-8.
5. Sushruta Samhita, Nidana Sthana chapter number 13, shloka 50–54
6. Gairdner D. Fate of the Foreskin. British medical journal. 1949 Dec 24;2(4642):1433.
7. Myers A, Earp BD. What is the best age to circumcise? A medical and ethical analysis. Bioethics. 2020 Sep;34(7):645-63.
8. HSIEH TF, CHANG CH, CHANG SS. Foreskin development before adolescence in 2149 schoolboys. International journal of urology. 2006 Jul;13(7):968-70.
9. Gairdner D. Fate of the Foreskin. British medical journal. 1949 Dec 24;2(4642):1433.
10. Oster J. Further fate of the foreskin. Incidence of preputial adhesions, phimosis, and smegma among Danish schoolboys. Archives of disease in childhood. 1968 Apr;43(228):200.
11. Shahid SK. Phimosis in children. International Scholarly Research Notices. 2012;2012(1):707329.
12. Carocci K, Leslie SW, Hughes EC, McIntosh GV. Balanitis xerotica obliterans (male penile lichen sclerosus). InStatPearls [Internet] 2024 Dec 11. StatPearls Publishing.
13. Bromage SJ, Crump A, Pearce I. Phimosis as a presenting feature of diabetes. BJU international. 2008 Feb;101(3):338-40.
14. Schoen EJ. Circumcision for preventing urinary tract infections in boys: North American view. Archives of Disease in Childhood. 2005 Aug;90(8):772-3.
15. Simonis K, Rink M. Paraphimosis. InUrology at a Glance 2014 Jun 11 (pp. 361-364). Berlin, Heidelberg: Springer Berlin Heidelberg.
16. Kirtschig G. Lichen sclerosus—presentation, diagnosis and management. Deutsches Ärzteblatt International. 2016 May 13;113(19):337.
17. Sushruta Samhita, Chikitsa Sthana Chapter number 20 Shlok verses 43-46.
18. Ashtanga Sangraha. Uttara Sthana, Chapter 38: Shloka 11. Varanasi: Chowkhamba Krishnadas Academy; 2012.
19. Charaka Samhita, Sutra Sthana 12 (Vatakalakaliya), shloka 8.
20. Sushruta Samhita, Nidana Sthana Chapter number 1 (Vatavyadhi Nidana) verse number 7.
21. Sushruta Samhita, Nidana Sthana Chapter Number Chapter 13 (Kshudraroga Nidana)Shloka Numbers 52–54.
22. Charaka Samhita, Sutra Sthana - Chapter Number 20 (Maharoga Adhyaya), Shloka Number 11.
23. Sushruta Samhita, Nidana Sthana, Chapter 13, Verses 47–50.
24. de Freitas RG, Nobre YD, Demarchi GT, Hachul M, Macedo Jr A, Srougi M, Ortiz V. Topical treatment for phimosis: time span and other factors behind treatment effectiveness. Journal of pediatric urology. 2006 Aug 1;2(4):380-5.
25. Zavras N, Christianakis E, Mpourikas D, Ereikat K. Conservative treatment of phimosis with fluticasone proprionate 0.05%: a clinical study in 1185 boys. Journal of pediatric urology. 2009 Jun 1;5(3):181-5.
26. Task Force on Circumcision, Blank S, Brady M, Buerk E, Carlo W, Diekema D, Freedman A, Maxwell L, Wegner S. Circumcision policy statement. Pediatrics. 2012 Sep 1;130(3):585-6.
27. Frisch M, Friis S, Kruger Kjaer S, Melbye M. Falling incidence of penis cancer in an uncircumcised population (Denmark 1943-90). Bmj. 1995 Dec 2;311(7018):1471.
28. Sushruta Samhita, Chikitsa Sthana, Chapter 20, verse 43-44
29. Kapadiya MM. Ayurvedic management of ischemic ulcer in peripheral arterial disease using Panchakarma and leech therapy: A case report. Journal of Research in Ayurvedic Sciences. 2025 Mar 1;9(2):71-7.
30. Meshram M, Khandare K, Ali S. The conceptual review on Nirudhaprakash (Phimosis). Pediatric Urology Case Reports. 2022 Mar 1;9(2):160-5.

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