



# Status of *Dhātu sārātā* (the Level of Tissue Excellence) and its Association with *Deha prakṛti* (Body Constitution) in Patients with Chronic Kidney Disease

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## Authors' contributions

This work was carried out in collaboration among all authors. Author WS was responsible for conceptualization, designing the study/ methodology, managing the literature searches, data curation, and writing the original draft of the manuscript. Authors S-CNP, WES and WPR did the manuscript reviewing and editing, supervision and project administration. Author CNV provided the guidance and supervised the data analysis related to the study. All authors read and approved the final manuscript.

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## ABSTRACT

At present, Chronic kidney disease (CKD) has emerged as a significant global health concern even in Sri Lanka. The statistical data regarding the increased incidence and prevalence rate of CKD have already proven that there is still no identification of a permanent cure or solution instead of renal replacement therapy for disease management. This remains a tremendous challenge for Western and Āyurveda medical systems. Although the Āyurveda medical system is well nourished by its own concepts such as *Dhātu sārātā* (tissue excellence), *Deha prakṛti* (body constitution), which can potentially contribute to the prevention and management of CKD, their clinical applicability appears to be limited. Therefore, this study was planned to assess the status of *Dhātu sārātā* (the level of tissue excellence) and its association with *Deha prakṛti* (body constitution) in patients with CKD – Western Province, Sri Lanka. This is a prospective observational case – control study. University Nephrology Clinic at the National Hospital, Sri Lanka and the Renal Clinic at Bandaranaike Memorial Āyurveda Research Institute, Nawinna, Sri Lanka. 113 patients with a diagnosis of CKD and 122 healthy volunteers residing in the Western Province were enrolled in the study. *Dhātu sārātā* status of *Rasa* to *Sattva* was assessed using a standardized and validated questionnaire and ĀyuSoft software was used to assess the type of *Deha prakṛti* of the research participants. Data analysis was done by using Microsoft Excel 2007 version and appropriate statistical software. The study results revealed that a majority between 43 – 50 % of CKD patients exhibited a predominance of *Madhyama sāra* status (moderate level of tissue excellence) for *Rasa*, *Rakta* and *Māṃsa dhātu*. A considerable percentage (over 60%) of patients displayed *Avara sāra* status (inferior or lower level of tissue excellence) in their subsequent *dhātu* (including *Sattva*), commencing from *Asthi*. Compared to the CKD patients, the number of healthy individuals/ controls with *Pravara sāra* status (superior level of tissue excellence) of each *dhātu* and *Sattva* is substantially high. None of the healthy individuals had *Avara sāra* status of *Dhātu* nor *Sattva*. Furthermore, it was observed that the mean percentage scores of all *dhātu* (commencing from *Rasa* to *Sukra dhātu*) and *Sattva sārātā* significantly differed according to CKD stages under a 5% level of significance. It was also observed that the status of *Dhātu* commencing from *Rasa* to *Śukra dhātu* and *Sattva sārātā* was significantly associated with the *Deha prakṛti* types i.e., *Vāta*, *Pitta* and *Kapha pradhāna prakṛti* in CKD patients – Western Province, Sri Lanka, under a 5 % level of significance. It can be concluded that *Dhātu sārātā* status including *Sattva* depends on the type of *Deha prakṛti* in CKD patients and *Sāra* status of each *Dhātu* including *Sattva* declines from *Pravara sāra* to *Avara sāra* as the disease progresses. In addition, the CKD patients with *Kapha pradhāna prakṛti* type can be considered to have the maximum *Deha bala* whereas those with *Pitta* and *Vāta pradhāna prakṛti* types exhibit average and lowest levels of *Deha bala* respectively.

**Keywords:** CKD; *Dhātu sārātā*; *Vāta – Pitta - Kapha pradhāna prakṛti*; *Pravara – Madyama - Avara sāra*.

## 1. INTRODUCTION

At present, Chronic Kidney Disease (CKD) has emerged as a significant global health concern, even in Sri Lanka. Based on the findings of the Global Burden of Disease Study conducted in 2015, CKD is identified as the twelfth leading cause of mortality, accounting for around 1.1 million deaths worldwide. The study additionally demonstrated that mortality associated with CKD experienced a substantial increase of 31.7% between 2005 and 2015, with a notable upward trend [1]. In terms of CKD prevalence in Sri Lanka, a recent cross-sectional epidemiologic study conducted in the Western Province revealed a CKD prevalence of 15% among adults [2]. Additionally, a study based on the

experience of a tertiary care center among the population of Sri Lanka found that the Western Province had the highest percentage of CKD patients, accounting for 68.5% of all reported cases [3]. Furthermore, according to the Demographic and Health Survey Report released by the Department of Census and Statistics, Sri Lanka in 2016, the prevalence of CKD in the Western Province, which includes the districts of Colombo, Gampaha, and Kalutara, is at 1% and this percentage corresponds to a total of 60,230 individuals affected by CKD in the aforementioned region. The above data indicates that the Western Province exhibits the greatest prevalence of CKD in comparison to the other provinces within the country [4]. However, it was also reported that apart from the Western

Province, there was a higher prevalence of CKD in the Northern and North Central Provinces in comparison to the Central and Uva Provinces in Sri Lanka [5]. However, the aforementioned facts emphasized the global impact of CKD, including its effects on the Sri Lankan population.

According to Western medicine, Kidney damage that involves structural or functional abnormalities of kidneys other than decreased GFR, present for longer than three months, with health implications, is defined as CKD [6] and staging of CKD had been done into a grade (stages) 1 to 5 according to the severity, based on the National Kidney Disease Outcomes Quality Initiative (KDOQI) criteria [7]. Although the early stages of CKD are asymptomatic [8], it is very challenging to diagnose the disease in its early stages. As the identification of the disease takes time, it may badly affect the disease prognosis and management. This would be the closest explanation for why CKD has become one of the most hazardous health impacts worldwide. Moreover, the aforementioned facts regarding the increased incidence and prevalence rate of CKD have already proven that there is still no identification of a permanent cure or solution instead of renal replacement therapy for disease management. This remains a tremendous challenge for the healthcare system of the country, especially the Western and Āyurveda medical systems. Hence, it is imperative to ascertain integrative and novel strategies that combine Āyurveda and Western therapy in order to effectively address the disease. The field of Āyurveda, which pertains to the study of life sciences, benefits from a rich array of concepts, theories, and hypotheses. These elements are important in establishing effective strategies for the prevention and management of chronic diseases and thus contribute significantly to the field of healthcare.

As an entry to approach the disease, the study focus has been considered the fundamental theories described in the Āyurveda medical system as they provide the foundation for new beginnings and enhance the opportunities to explore optimal solutions for even the most difficult problematic situations. Accordingly, the study focused on the concepts of *Dhātu sārātā* (tissue excellence) and *Deha prakṛti* (body constitution) mentioned in Āyurveda science and the associations between them which can be applied effectively in the prevention and management of CKD. The effort to emphasize

the associations between the chosen concepts would definitely lend a hand to facilitating the effective implementation of strategies for the prevention and management of CKD.

The concept of "*Dhātu sāra*" is one of the fundamental theories mentioned under "*Daśavidha āthura parīkṣa*" which offers essential facts on the healthy – unhealthy status of an individual's body tissues and knowing the *Sāra* status of every *Dhātu* of the body would provide enormous support in the prevention and management of diseases. *Sāra* is an essence of *Dhātu* (tissues) with excellent quality and the qualitative assessment of *Dhātu* is known as "*Sāra parīkṣā*". Based on the excellence of *Sapta dhātu* (*Rasa* - plasma, *Rakta* - blood, *Māṃsa* - muscles, *Medas* - fat, *Asthī* - bones, *Majjā* – bone marrow, *Śukra* – sperms/ova) and *Sattva* (mental status), eight types of *Sāra* have been explained by *Acārya* Caraka in Caraka Saṃhitā Vimānasthāna 8/102-110. Moreover, Caraka Saṃhitā Vimānasthāna 8/114 indicated that the concept of *Dhātu sārātā* primarily can be used as an imperative parameter to determine the strength of an individual, indicating whether they are healthy or diseased [9]. Simply, it measures the "*Bala pramāṇa*" (strength) of an individual according to Āyurveda and also, *Sāra* status of *Dhātu* has been classified as *Pravara* (persons having a superior level of the essence), *Madhyama* (persons having a moderate level of the essence) and *Avara sāra* (persons having less or no essence) in Caraka Saṃhitā Vimānasthāna 8/111-113. An assessment of "*Bala pramāṇa*" (strength) has importance in the context of applying medications to the patients as quoted in Caraka Saṃhitā Kalpasthāna 12/57, *Madhyama* (average) and *Hīna/Avara* (inferior) *bala* persons should be given *Madhyama* and *Mṛdu bala auśada* (medium and mild drugs) respectively as medium and mild drugs are defective for strong persons and they do not eliminate the entire impurity. *Auśadha kāla* (time schedule for drug administration) also depends on the *Bala pramāṇa* of the patient. As specified in Caraka Saṃhitā Cikitsāsthāna 30/296-297 *Balwana rogī* (patients who are strong in nature) are given medicine by skipping breakfast or without food early in the morning. *Durbala rogī* (patients who are weak in nature) are instructed to take medicine with a light, wholesome diet [9]. Accordingly, when it comes to disease management, physicians must select the appropriate method of treatment regime according to the *Bala pramāṇa* of the patient.

Given the aforementioned information, it is imperative to evaluate the *Dhātu sārātā* in an individual afflicted with a disease in order to make decisions regarding disease diagnosis – prognostication, recommend appropriate treatment regimens and effectively manage persistent conditions such as CKD.

Significantly as the chronicity of the disease will definitely affect the *Dhātu* of that patient, it is essential to assess the status of the *Dhātu sārātā* of that particular patient before commencing the treatments. Unlike in the genetic design, i.e., *Prakṛti* of the body, *Sārātā* status of *Dhātu* can be changed every moment. For example, CKD patients with stages 1 and 2 might have *Pravara bala* as the vitiation has not happened in deeper (*Gambhīra*) *Dhātu* at those stages. But their level of *Sattva sāra* might be in *Avara* status. In that case, physicians should pay attention to bringing the level of *Avara sāra sattva* to *Pravara sāra sattva* while treating them with potent drugs. If clinicians apply intensely powerful drugs to an *Avara bala* patient (weak patient) by mistake or without proper examination of patient's *Deha bala*, it may affect the patient badly. Therefore, it is important to examine *Bala pramāṇa* of a patient before starting treatments. Another important factor of knowing *Deha bala* in a CKD patient is that there may be patients with *Pravara sāra rasa - Rakta dhātu*, *Madhyama sāra māṃsa - Medas dhātu* and *Avara sāra asthi - Majjā* and *Śukra dhātu*. If the clinicians find the exact status, specific medications or treatment regimens can be planned and applied to bring *Avara sāra dhātu (asthi, majjā and śukra dhātu)* to *Madhyama sāra* status and *Madhyama sāra dhātu (māṃsa and medas dhātu)* to *Pravara sāra* status.

*Prakṛti* which is always referred to as "*Deha prakṛti*" as covered in Caraka Saṃhitā Sūthrasthāna 7/43 [9], is one of another imperative and practical evidence - based concept mentioned under *Daśavidha āthura parīkṣā* (ten - fold examination of the patient) in Caraka Saṃhitā Vimānasthāna 8/94 [9]. As mentioned in Sushruta Saṃhitā Śārīrasthāna 4/74, *Prakṛti* is also known as the psychosomatic constitution of an individual, which remains invariant throughout the lifespan [10]. It reflects the physical, physiological and psychological qualities of that individual. According to *Acārya Cakrapāṇidatta*, *Prakṛti* means "Nature" (*swabhāva*) [11] and it reflects the natural state of human beings at an anatomical, physiological, and psychological level [12]. Simply, *Deha prakṛti*

represents the unique characteristics of the psychosomatic condition of an individual. *Deha prakṛti* is determined based on the dominance of any single or a combination of two or three *Doṣā* called *Vāta*, *Pitta* and *Kapha* at the time of conception [10]. The assessment of *Prakṛti* holds significant importance in the patient examination protocol outlined in the *Āyurveda* medical practice. It will basically facilitate early detection, forecast susceptibility to diseases, prognosticate disease progression, determine optimal treatment protocols and potentially result in significant reductions in mortality rates. Hence, the implementation of the concept of *Deha prakṛti* in the prevention and management of CKD would represent an important step forward in the field of healthcare.

Therefore, examining the type of *Deha prakṛti* is also important as determining the "*Sāra*" status of *Dhātu* and assessment of their applied aspects, especially the association of the above two aspects will give immense support in effectively managing chronic diseases such as CKD. If there is an association, the treatment regimes, including dietary and behavioral patterns, can be planned according to the type of *Deha prakṛti* and the status of *Dhātu sārātā* of that particular CKD patient. Moreover, the tissues that may be prone to become *Avara sāra* status from *Madhyama sāra* or *Pravara sāra* status could be prevented by making appropriate clinical decisions as per the patient's *Sāra* status and *Deha prakṛti*.

The previous studies regarding the status of *Dhātu sārātā* and its association with *Deha prakṛti* of patients with CKD have not been found in the existing literature. In this circumstance, examining "*Sāra*" status and its association with *Deha prakṛti* would serve as a highly supportive tool in the prevention and management of patients with CKD. Therefore, the study has focused on assessing the *Sāra* status of *Sapta dhātu* and *Sattva* as well as its association with *Deha prakṛti* types in CKD patients in Western Province, Sri Lanka.

## 2. METHODOLOGY

### 2.1 Study Design

Prospective Case – Control Observational Study.

### 2.2 Study Population

The study focused on two groups. i.e., patients with CKD and healthy controls. 113 patients were

selected from the University Nephrology Clinic at the National Hospital, Sri Lanka and the Renal Clinic at Bandaranaike Memorial Āyurveda Research Institute, Nawinna, Maharagama. The Western Province residents in Sri Lanka with a diagnosis of CKD were enrolled. 122 healthy volunteers residing in Western Province, Sri Lanka who accompanied the CKD patients to the above clinics were considered as controls.

### 2.3 Inclusion and Exclusion Criteria used to Select the Research Participants

Patients between 18 and 80 years of age who have been attending the aforementioned two clinics and have a documented diagnosis of CKD were included if they had either an estimated Glomerular Filtration Rate (eGFR) below 60 ml/min/1.73m<sup>2</sup> or proteinuria irrespective of eGFR. The eGFR calculation was based on the CKD – EPI formula [13]. CKD Patients, below 18 years and above 80 years, who are suffering from Human Immunodeficiency Virus (HIV) infection, Malignant disorders, Psychiatric disorders, Dementia, etc., who had immunotherapy for the last six months, who had chemotherapy for the last two years, females who are pregnant or breastfeeding, who unwilling to give informed consent, patients with Acute Kidney Injury (AKI) were excluded from the study.

Healthy controls/individuals were selected based on their clinical history as reported by them and physical examination. Baseline investigations including serum creatinine were done to confirm that they were healthy.

### 2.4 Data Collection

#### 2.4.1 Assessment of *Deha prakṛti* (body constitution) types of the research participants

ĀyuSoft software which is in the form of a standardized and validated questionnaire was used to assess the types of *Deha prakṛti* (body constitution) of the research participants [14,15,16,17,18,19]. The assessment of *Deha prakṛti* was executed using weightage configuration in ĀyuSoft. Data were collected only once from each participant during the study period via direct interview by the principal investigator. The type of *Deha prakṛti* of each participant was determined automatically by ĀyuSoft according to the percentage of predominant *Doṣa*. The research participants

were divided into four groups according to the types of *Deha prakṛti* as follows.

1. *Vāta pradhāna prakṛti*
2. *Pitta pradhāna prakṛti*
3. *Kapha pradhāna prakṛti*
4. *Sama doṣaja prakṛti*

#### 2.4.2 Assessment of *Dhātu sārātā* status (the level of tissue excellence) of the research participants

The *Dhātu sārātā* status of the research participants was assessed using the questionnaire designed and published in the study "Weighted mean: A possible method to express overall *Dhātu sārātā*" by Gunawat et al. [20]. It expresses an individual's overall *Dhātu sārātā* based on weighted mean scores. This questionnaire provides the percentage of *Sārātā* status of each *Dhātu* of an individual separately.

The selected questionnaire was designed only to assess the *Dhātu sārātā* from *Rasa dhātu* to *Śukra dhātu*. However, *Aṣṭavidha sāra parikṣā* includes another component. i.e., *Sattva sāra* (quality of mind). Therefore, to assess the *Sattva sārātā* of the participants, the questions were prepared according to the characteristics of *Sattva sāra* in an individual given in CS.Vi.8/110 [9] and SS.Sū.35/16 [10]. The newly designed portion of the questionnaire to assess *Sattva sārātā* was pre - tested.

#### 2.4.3 Criteria for determination of the *Sāra* status of each *Dhātu* (the level of tissue excellence in each *Dhātu*) of research participants

At the end of the questionnaire, each participant received a calculated percentage of each *Dhātu sārātā* (tissue excellence) separately. That was considered as the *Sāra* percentage of each *Dhātu*. The status of each *Dhātu sārātā* (tissue excellence) is then divided into three equal categories [20] according to the percentages as follows.

- If the calculated *Sāra* percentage is between 0 – 33.3%, that *Dhātu* was considered as *Avara sāra*
- If the calculated *Sāra* percentage is between 33.4 – 66.6 %, that *Dhātu* was considered as *Madhyama sāra*
- If the calculated *Sāra* percentage is between 66.7 – 100 %, that *Dhātu* was considered as *Pravara sāra*

(*Pravara sāra* status indicates the superior/optimal level of tissue excellence, *Madhyama sāra* status indicates the moderate/medium level of tissue excellence and *Avara sāra* status indicates the inferior/ lower level of tissue excellence)

## 2.5 Data Analysis

Microsoft Excel 2007 version and appropriate statistical analysis software were used to analyze the collected data. Data analysis included descriptive statistics, correlation analysis, comparison of two medians (Mann – Whitney U test), comparison of multiple medians (Kruskal Wallis test) and associations between categorical variables (Chi - square test). Tables and bar charts were used to demonstrate how the status of *Dhātu sārātā* varied according to disease stages as well as the distribution pattern of participants based on each *Dhātu sārātā* status. The *Sama doṣaja prakṛti* type was removed from the *Deha prakṛti* classification only for the statistical analysis related to the associations between *Dhātu sārātā* status and the types of *Deha prakṛti* in CKD patients due to the underrepresentation of participants. Accordingly, the total number of CKD patients analyzed for associations was 112 and the number of healthy controls/individuals was 119.

## 3. RESULTS AND DISCUSSION

### 3.1 Distribution pattern of CKD patients and healthy controls/individuals according to the status of *Dhātu sārātā* (tissue excellence)

Table 1. summarizes the count and percentages of CKD patients as well as the healthy controls/individuals according to the classification done to clarify their status of *Dhātu sārātā*, namely *Pravara sāra* (superior/ optimal level), *Madhyama sāra* (moderate/ medium level) and *Avara sāra* (inferior/ lower level). Additionally, it demonstrates how the percentage of participants varies according to the *Sāra* status of each *Dhātu*, including *Sattva* (irrespective of the type of *Deha prakṛti* and CKD stages).

Table 1 demonstrates how the number of CKD patients and healthy controls/individuals varies with the status of *Dhātu sārātā*, i.e., *Pravara*, *Madhyama* and *Avara*. The study results revealed that a majority of patients with CKD exhibited a predominance of *Madhyama sāra* status for *Rasa*, *Rakta* and *Māṃsa dhātu*.

Accordingly, 50%, 49% and 43% of patients had *Madhyama sāra* status of *Rasa*, *Rakta* and *Māṃsa dhātu* respectively. A limited proportion (below 23%) of CKD patients exhibited the presence of *Avara sāra* initial *dhātu*, namely *Rasa*, *Rakta* and *Māṃsa*. Nevertheless, it was noted that a considerable percentage (over 64%) of patients displayed *Avara sāra* status in their subsequent *dhātu*, commencing from *Asthī*. There were patients exhibiting *Pravara sāra* for all *dhātu* including *Sattva* although their prevalence was relatively low (below 33.6%). Furthermore, the proportion of patients demonstrating *Pravara sāra dhātu* exhibited a declining trend subsequent to the *Māṃsa dhātu* while the percentages of patients with *Pravara sāra rasa*, *Rakta* and *Māṃsa dhātu* remained stable at 33.6%. The above scenario is well illustrated with the percentages in Fig. 1.

Fig. 2. depicts how the percentage of healthy controls/ individuals varies according to the *Sāra* status of each *Dhātu* (tissue excellence related to each *Dhātu*).

Compared to the CKD patients, the number of healthy controls/ individuals with *Pravara sāra* status of each *dhātu* is substantially high. For instance, 100% of healthy controls/ individuals had *Pravara sāra* status of *Rakta dhātu* and *Sattva*, while nearly 98% had *Pravara sāra* status of *Rasa* and *Māṃsa dhātu*. Among all the healthy controls/ individuals, 93 %, 85 %, 90 % and 86 % had *Pravara sāra* status of *Medas*, *Asthī*, *Majjā* and *Śukra dhātu*, respectively. None of the healthy controls/individuals had *Avara sāra* status of *Dhātu* nor *Sattva*. However, there was a low number of healthy controls/ individuals who held the *Madhyama sāra* status of *Dhātu* except for *Rakta dhātu* and *Sattva* whose status is at *Pravara* in 100% of healthy controls/ individuals.

### 3.2 Stage - wise *Dhātu sārātā* (tissue excellence) status based on *Dhātu sārātā* mean percentage score (mean percentage score related to each tissue excellence) in CKD patients and healthy controls/ individuals

Table 2 illustrates how the status of each *Dhātu sārātā* of CKD patients changes according to the stages of the disease and how the status of each *Dhātu sārātā* varies from *Rasa dhātu* to *Sattva* in healthy controls/ individuals.

According to Table 2, the *Sāra* status of *Rasa*, *Rakta*, *Māṃsa*, *Medas*, *Asthī*, *Majjā* and *Śukra*

*dhātu* were at optimal levels in the patients with stage 1 CKD. i.e., they were all in the state of *Pravara sāra*. However, it was observed that the mean percentage score of each *Dhātu sāratā* in CKD patients with stage 1 decreased from *Rasa dhātu* to *Śukra dhātu*. The decrease was shown to be 94% to 76%. The *Sāra* status of *Sattva* of CKD stage 1 patients was at the status of *Pravara sāra*. In patients with stage 2 CKD, the *Sāra* status of *Rasa dhātu* to *Śukra dhātu* was optimal, while the *Sāra* status of *Sattva* was at *Madhyama sāra*. The patients with stage 3 CKD had *Pravara sāra* status only up to *Medas* while the remaining *dhātu* were at *Madhyama sāra* status. There were no patients with *Pravara sāra*

*dhātu* in CKD stages 4 and 5. Patients with CKD stages 4 and 5 also had their *Dhātu sāra* status changed from *Madhyama* to *Avara sāra*. The peculiarity here is as the disease progressed, *Avara sāra* status could be seen even in the initial *Dhātu*. For example, in CKD stage 3 patients, the *Pravara sāra* status of *Medas dhātu* could be observed, in stage 4 CKD patients *Medas dhātu* was in *Madhyama sāra* and stage 5 patients it was in *Avara sāra* status. However, in general, it was observed that the mean percentage scores of *Dhātu sāratā* decreased from *Rasa dhātu* to *Sattva* at each stage in all cases.

**Table 1. The distribution pattern of CKD patients and healthy controls/ individuals according to *Dhātu sāratā* (tissue excellence) status – irrespective of the type of *Deha prakṛti* (body constitution) and disease stages**

Types of <i>Dhātu</i>	The status of <i>Dhātu sāratā</i>	CKD patients (n = 113)		Healthy controls/ Individuals (n = 122)	
		Count	Percentage	Count	Percentage
<i>Rasa dhātu</i> (represents the skin)	<i>Avara</i>	19	16.8 %	0	0 %
	<i>Madhyama</i>	56	49.6 %	2	1.6%
	<i>Pravara</i>	38	33.6 %	120	98.4%
	Total	113	100%	122	100%
<i>Rakta dhātu</i> (blood tissue)	<i>Avara</i>	20	17.7 %	0	0 %
	<i>Madyama</i>	55	48.7 %	0	0 %
	<i>Pravara</i>	38	33.6 %	122	100 %
	Total	113	100%	122	100%
<i>Māmsa dhātu</i> (muscle tissue)	<i>Avara</i>	26	23 %	0	0 %
	<i>Madhyama</i>	49	43.4 %	03	2.5 %
	<i>Pravara</i>	38	33.6 %	119	97.5%
	Total	113	100 %	122	100%
<i>Medas dhātu</i> (fat tissue)	<i>Avara</i>	45	39.8 %	0	0%
	<i>Madhyama</i>	38	33.6 %	08	6.5%
	<i>Pravara</i>	30	26.5 %	114	93.4%
	Total	113	100%	122	100%
<i>Asthi dhātu</i> (bone tissues)	<i>Avara</i>	74	65.5%	0	0%
	<i>Madhyama</i>	14	12.4%	18	14.8%
	<i>Pravara</i>	25	22.1%	104	85.2%
	Total	113	100%	122	100%
<i>Majjā dhātu</i> (bone marrow tissues)	<i>Avara</i>	75	66.4%	0	0%
	<i>Madyama</i>	12	10.6%	12	9.8%
	<i>Pravara</i>	26	23%	110	90.2%
	Total	113	100%	122	100%
<i>Śukra dhātu</i> (reproductive tissue - semen/ovum)	<i>Avara</i>	72	63.7 %	0	0 %
	<i>Madhyama</i>	16	14.2%	17	13.9%
	<i>Pravara</i>	25	22.1 %	105	86.1%
	Total	113	100%	122	100%
<i>Sattva</i> (mind)	<i>Avara</i>	79	70 %	0	0 %
	<i>Madhyama</i>	25	22.1 %	0	0 %
	<i>Pravara</i>	09	8 %	122	100%
	Total	113	100%	122	100%

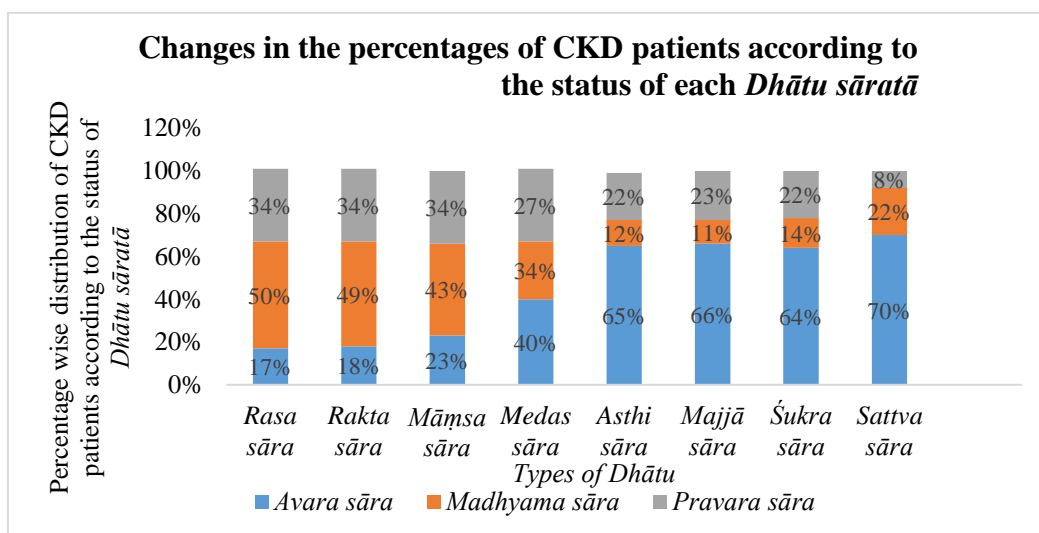


Fig. 1. Changes in the percentages of chronic kidney disease (CKD) patients according to the status of each *Dhātu sārātā* (tissue excellence) (n = 113)

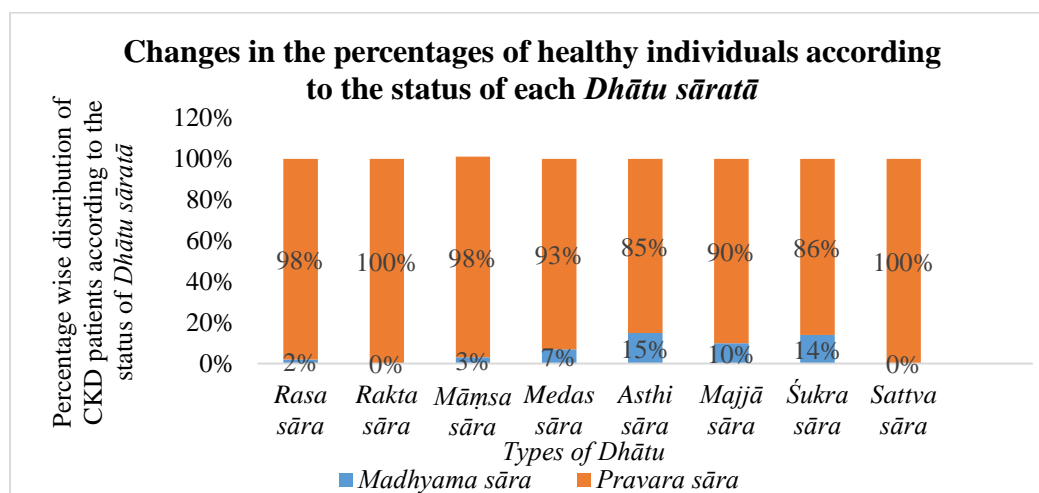


Fig. 2. Changes in the percentages of healthy individuals according to the status of each *Dhātu sārātā* (tissue excellence related to each *Dhātu*) (n = 122)

Moreover, it was also observed that the mean percentage score of each *Dhātu sārātā* decreased as the disease progressed. For instance, the mean percentage score of *Rasa dhātu sārātā* of patients with stage 1 was the highest among the other stages. It was 94% in patients with stage 1 CKD, 85.9% in patients with stage 2 CKD, 75.3% in patients with stage 2 CKD, 54% in patients with stage 4 CKD, and 36.7% in patients with stage 5 CKD.

In healthy controls/ individuals, the mean percentages of all *Dhātu sārātā* were at *Pravara sāra* status and the mean percentage score of *Sattva sāra* was the highest among the others. It was 82%.

From an Āyurveda point of view, the previous *Dhātu* is said to feed the next *Dhātu*, according to the *Dhātu poṣaṇa* phenomenon discussed in *Aṣṭāṅga Hr̥da Saṃhitā Śārīrasthāna 3/62* and *Caraka Saṃhitā Sūtrasthāna 28/3* [21,9]. i.e., *Rasa dhātu* is responsible for the formation and nourishment of *Rakta dhātu*, *Rakta dhātu* is accountable for the formation and nourishment of *Māmsa dhātu*, and so on. The stage - wise decrease of the *Sāra* mean percentage score from *Rasa* to *Śukra dhātu* indicates that the lower *Dhātu* are not nourished well by the upper *Dhātu*. Not only the lower *Dhātu*, but also the mean percentage score of *Rakta dhātu sārātā* has decreased, indicating that *Rasa dhātu* is not adequately nourishing it.



**Table 2. Stage – wise *Dhātu sārātā* (tissue excellence) status in CKD patients and healthy controls/ individuals based on *Dhātu sārātā* mean percentage score (mean percentage score of each tissue excellence)**

Name of the <i>Dhātu</i>	Status of each <i>Dhātu sārātā</i> in CKD patients based on <i>Dhātu sārātā</i> mean percentage score and CKD stages (n = 113)					Status of <i>Dhātu sārātā</i> in Healthy Individuals based on the mean percentage score (n=122)
	Stage 1	Stage 2	Stage 3	Stage 4	Stage 5	
<i>Rasa</i> (represents the skin)	94 % <i>Pravara</i>	85.9% <i>Pravara</i>	75.3% <i>Pravara</i>	54% <i>Madhyama</i>	36.7% <i>Madhyama</i>	82% <i>Pravara</i>
<i>Rakta</i> (blood tissue)	92.6% <i>Pravara</i>	84.7% <i>Pravara</i>	73.6% <i>Pravara</i>	49.5% <i>Madhyama</i>	34.6% <i>Madhyama</i>	82% <i>Pravara</i>
<i>Māṃsa</i> (muscle tissue)	91.4% <i>Pravara</i>	83.5% <i>Pravara</i>	71.8% <i>Pravara</i>	47.1% <i>Madhyama</i>	33.4% <i>Madhyama</i>	81% <i>Pravara</i>
<i>Medas</i> (fat tissue)	94% <i>Pravara</i>	81.7% <i>Pravara</i>	68.1% <i>Pravara</i>	39.3% <i>Madhyama</i>	29.2% <i>Avara</i>	76% <i>Pravara</i>
<i>Asthi</i> (bone tissue)	82.5% <i>Pravara</i>	71.2% <i>Pravara</i>	53.9% <i>Madhyama</i>	21.2% <i>Avara</i>	14.9% <i>Avara</i>	74% <i>Pravara</i>
<i>Majjā</i> (bone marrow)	83% <i>Pravara</i>	67.4% <i>Pravara</i>	53% <i>Madhyama</i>	18.4% <i>Avara</i>	12.3% <i>Avara</i>	73% <i>Pravara</i>
<i>Śukra</i> (semen/ ovum)	76% <i>Pravara</i>	66.9% <i>Pravara</i>	52.8% <i>Madhyama</i>	22.4% <i>Avara</i>	13.1% <i>Avara</i>	78% <i>Pravara</i>
<i>Sattva</i> (mind)	78.2% <i>Pravara</i>	55.3% <i>Madhyama</i>	39.2% <i>Madhyama</i>	23.3% <i>Avara</i>	12.9% <i>Avara</i>	91% <i>Pravara</i>

Paying close attention to the mean percentage scores of *Sāra* from *Rasa dhātu* to *Śukra dhātu* in relation to each stage reveals that the mean percentage score of *Asthi dhātu* after *Medas dhātu* is substantially lower than those of other *Dhātu*. That is, from *Rasa dhātu* to *Medas dhātu* and from *Asthi dhātu* to *Śukra dhātu*, the respective mean percentage scores decreased by very few percentages. However, a considerable decrease could be observed between the *Sāra* mean percentage scores of *Medas* and *Asthi dhātu*. As mentioned in *Āyurveda* literature, *Vṛkka* (kidneys) are closely related to *Medovahā srotas* (the channels that carry fat tissues) and *Medo dhātu* (fat tissues). *Vṛkka* is considered to be the *Mūla* (root) of *Medovahā srotas* in *Suśruta Saṃhitā Śārirasthāna* 9/12 and *Caraka Saṃhitā Vimānasthāna* 5/7-8 [10,9] and according to *Śārangadhara Saṃhitā Pūrvakhanda* 5/45, *Vṛkka* provide nourishment to *Medo dhātu* [22]. Therefore, if *Vṛkka* are damaged, the activities/functions of *Medovahā srotas* and *Medo dhātu* are constrained, affecting the above the most. Furthermore, *Medo dhātu* would not be adequately nourished. As a result, *Medo dhātu* would not be able to nourish the next *Dhātu* i.e., *Asthi dhātu*. This may be a contributing factor to the considerable decline observed in *Sāra* status in *Asthi dhātu*. This finding merits further research studies especially related to the vitiation of *Asthivahā srotas* (the channels of bones) in CKD patients. Furthermore, when the severity of the disease increases, the *Sāra* status decreases even in the same *dhātu* because, unlike *Deha prakṛti*, the *Sāra* status of a *dhātu* can change with the chronicity of the disease. As the *Sāra* status indicates the *Bala pramāna* (strength) of each *Dhātu*, it can be concluded that the *Bala pramāna* of each *dhātu* starting from *Rasa dhātu* decreases according to the severity of the stages of the disease. Therefore, the above can be generalized and said that the *Bala pramāna* of CKD patients decreases with the progression of the disease.

When the mean percentage score of *Sattva sāra* is considered, it is also evident that the *Sāra* mean percentage score of *Sattva* decreases as the disease progresses. In stage 2, it was observed that the *Sattva sārātā* exhibited a status of *Madhyama sāra*, while the remaining *Dhātu's sāra* demonstrated percentages at the *Avāra sāra* level. It means that the *Sattva*, representing an individual's mind, has a much

lower *Sāra* status than the other *Dhātus* of CKD patients. This could be because mental strength deteriorates faster than physical strength when a person is sick.

In terms of CKD patients' mental health, studies have revealed that depression and anxiety are among the most common comorbid illnesses in CKD patients with end-stage renal disease (ESRD) [23,24,25]. Moreover, it was found that CKD patients with pre - dialysis have a high prevalence of depression and anxiety, which are associated with lower Quality of Life (QOL), according to the study conducted by Lee et al. (2013) [26]. Cruz et al. (2011) revealed that the quality of life is reduced in CKD patients even in the early stages of the disease, and no association was found between the stages of the disease and the quality of life [27]. According to Ginieri-Coccosis et al. (2008), most quality-of-life domains, including overall mental health, appear to be affected in CKD patients, particularly those who undergo haemodialysis [28]. It can be concluded that such mental disparities may exist among the patients chosen for the current study, and due to that, they may reduce the status of *Sattva sārātā* of the patients. Collectively, the decrease in quality of life in CKD patients can be correlated with the decrease in *Sāra* status in all *Dhātu*.

Statistically, it was also observed that the mean percentage scores of each *Dhātu* and *Sattva* significantly differed according to CKD stages under a 5% significance level (Kruskal Wallis test,  $P = 0.000$ ). Therefore, it is possible to contend that the mean percentage scores of all *Dhātu* and *Sattva sārātā* were significantly associated with CKD stages under a 5% level of significance. Furthermore, significant associations were identified between the mean percentage scores of *Rasa*, *Rakta*, *Māmsa*, *Medas*, *Asthi*, *Majjā*, *Śukra dhātu* and *Sattva* with all possible pairs of CKD stages such as CKD combined stages 1 and 2 with stage 3, CKD combined stages 1 and 2 with combined stages 4 and 5 as well as CKD stage 3 with combined stages 4 and 5 (Mann – Whitney U test,  $P = 0.000$ ). Moreover, the highest mean percentage scores of the above *Dhātu* were reported in CKD combined stages 1 and 2 and the lowest in CKD combined stages 4 and 5. This implies that in the late stages i.e., stages 4 and 5 of the disease, the *Sārātā* levels of the *Dhātu* are also at the lower levels.

### 3.3 Assessment of the association between the status of each *Dhātu sārātā* (status of tissue excellence) and *Deha prakṛti* (body constitution) in patients with Chronic Kidney Disease (CKD) - Western Province, Sri Lanka

It was observed that the status of *Rasa*, *Rakta*, *Māṃsa*, *Medas*, *Asthi*, *Majjā*, *Śukra dhātu sārātā* and *Sattva sārātā* was significantly associated with the *Deha prakṛti* types in CKD patients – Western Province, Sri Lanka, under a 5 % level of significance (Chi – square test,  $P = 0.000$ ) indicating that the *Sāra* status of each *Dhātu* and *Sattva* depends on the types of *Deha prakṛti* in patients with CKD.

If the types of association are further described, among the CKD patients with *Kapha pradhāna prakṛti* types, 100 % had *Pravara sāra rasa*, *Rakta*, *Māṃsa*, *Medas* and *Asthi dhātu* while 95.2% had *Pravara sāra Majjā* and *Śukra dhātu*. This indicates that a high proportion of CKD patients with *Kapha pradhāna prakṛti* had *Pravara sāra* status ranging from *Rasa dhātu* to *Śukra dhātu*. None of them had *Avara sāra dhātu*, while very few proportions (4.8%) had *Madhyama sāra majjā* and *Śukra dhātu*.

The study found that a significant proportion (59.6%) of CKD patients with *Pitta pradhāna prakṛti* type exhibited *Madhyama sāra rasa*, *Rakta* and *Māṃsa dhātu*. Additionally, 27.7% of these patients demonstrated *Pravara sāra Rasa*, *Rakta* and *Māṃsa dhātu*. Nevertheless, it appears that the proportion of individuals exhibiting *Pravara sāra* status for the same *Dhātu* of *Kapha pradhāna prakṛti* is significantly greater than the previously mentioned percentage. Additionally, the *Sāra* status of the initial *dhātu* in the majority of *Pitta pradhāna prakṛti* types has been observed to decrease from *Pravara* to *Madhyama*. However, the percentage of patients with *Pitta pradhāna prakṛti* type with *Pravara sāra medas*, *Asthi*, *Majjā* and *Śukra dhātu* seemed to be decreased compared to those with *Rasa*, *Rakta* and *Māṃsa dhātu*. Moreover, the proportion of *Pitta pradhāna prakṛti* CKD patients with *Madhyama sāra* status of *Rasa*, *Rakta* and *Māṃsa* remained stable up to *Māṃsa dhātu* and *Madhyama sāra* patient percentage started to decline from *Medas dhātu* while the *Avara sāra* patient percentage for the same started to increase up to *Śukra dhātu*. Although none of the patients with *Avara sāra*

*dhātu* were reported among *Kapha pradhāna prakṛti* type CKD patients, the patients with *Avara sāra dhātu* were reported among *Pitta pradhāna prakṛti* patients from the very first *Dhātu*; *Rasa dhātu*.

The CKD patient count, which represents *Pravara sāra* status from *Rasa* to *Śukra dhātu* among *Vāta pradhāna prakṛti* types, was significantly deficient compared to those with *Kapha pradhāna* and *Pitta pradhāna prakṛti* types. For instance, *Pravara sāra rasa dhātu* was found in 100% of *Kapha pradhāna prakṛti* patients and 27.7% of *Pitta pradhāna prakṛti* patients. However, it could be observed that only 6.8% of *Vāta pradhāna prakṛti* patients had *Pravara sāra* status of *Rasa dhātu*. Furthermore, a significant proportion of *Vāta pradhāna prakṛti* patients were found to have *Madhyama sāra rasa* and *Rakta dhātu* (63.6% and 61.4% respectively). It was discovered that the majority of *Vāta pradhāna prakṛti* types had *Avara sāra dhātu* ranging from *Medas* to *Śukra*. In other words, a significant proportion (more than 68.2%) of *Vāta pradhāna prakṛti* types comprised *Avara sāra* status of *Medas*, *Asthi*, *Majjā* and *Śukra dhātu* while 29.5% - 45.5% of CKD patients with *Vāta pradhāna prakṛti* types consisted of *Avara sāra rasa*, *Rakta* and *Māṃsa dhātu*.

Collectively, all types of *Dhātu* (from *Rasa dhātu* to *Śukra dhātu*) were at *Pravara sāra* status in the majority of CKD patients with *Kapha pradhāna prakṛti* type. It implies that *Kapha pradhāna prakṛti* type CKD patients are more likely to have *Pravara sāra dhātu*. A significant proportion of *Pitta pradhāna* patients consisted of *Madhyama sāra dhātu* up to *Medas*, whereas a significant proportion of CKD patients with *Vāta pradhāna prakṛti* types had *Avara sāra dhātu* from *Medas dhātu*.

*Dhātu sāra parīkṣa* mentioned in Caraka Saṃhitā Vimānasthāna 8/102 is performed under the *Rogī parīkṣa* and it provides essential information regarding the *Bala pramāna* (degree of strength or morbidity) of a patient [9]. Moreover, it is believed that if an individual consists of *Pravara sāra dhātu*, he /she has maximum *Deha bala* (excellent body strength). Those with *Madhyama sāra* or *Avara sāra dhātu*, will have medium or low degree *Deha bala* accordingly. According to the results discussed above, the patients with *Kapha pradhāna prakṛti* type who had *Pravara sāra dhātu* can be considered to have the maximum *Deha bala*. Also, according to *Deha prakṛti* literature, Caraka Saṃhitā Vimānasthāna

8/96 reported that the individuals with *Kapha pradhāna prakṛti* are the strongest among *Vāta* and *Pitta pradhāna* types [9]. Therefore, it is possible to say that *Kapha pradhāna prakṛti* patients in the present study may be perfect than the *Pitta* and *Vāta pradhāna prakṛti* types in relation to *Deha bala* due to the presence of *Pravara sāra dhātu*. As the majority of *Pitta pradhāna prakṛti* CKD patients have *Madhyama* and *Avara sāra dhātu*, it can be assumed that the CKD patients with *Pitta pradhāna prakṛti* have average *Deha bala* and *Vāta pradhāna prakṛti* patients have the lowest *Deha bala* among the three types of *Deha prakṛti* as the majority of *Vāta pradhāna prakṛti* patients had a greater amount of *Avara sāra dhātu*.

Even though the *Sāra* status of *Sattva* showed a significant association with the type of *Deha prakṛti* of CKD patients, a different distribution pattern could be observed between the two variables compared to that of *Sapta dhātu sārātā*. The majority (57.1%) of CKD patients with *Kapha pradhāna prakṛti* type had *Madhyama sāra sattva*, which is the highest proportion representing *Madhyama sāra* status among them. However, a considerable amount (38.1%) of patients had *Pravara sāra sattva*, followed by 4.8% with *Avara sāra sattva* among *Kapha pradhāna prakṛti* types. This is the only type of *Sāra* that has reached *Avara sāra* status among patients with *Kapha pradhāna prakṛti* and it was the least proportion that consisted of *Avara sāra sattva* among *Kapha pradhāna prakṛti* types when compared to the other two types of *Deha prakṛti*. It was also observed that the majority of *Pitta pradhāna* and *Vāta pradhāna* CKD patients consisted of *Avara sāra sattva* (76.6% and 95.5%, respectively) while none of the patients had *Pravara sāra sattva* among them. In the *Vāta pradhāna prakṛti* type, the patient count representing the status of *Avara sāra* was significantly high for those with *Madhyama* and *Pravara sāra* patient counts. As observed in *Sapta dhātu*, the majority of *Avara sāra sattva* were detected in the patients with *Vāta pradhāna prakṛti* types.

*Sattva sāra* is based on the predominance of psychic factors in the body. *Sattva* denotes the mind according to *Āyurveda* [9]. It represents the mental status of an individual. The current study revealed that the mental status of CKD patients was very low, even in the patients with *Kapha pradhāna prakṛti* type. As discussed above, *Kapha pradhāna prakṛti* types must have a very high mental threshold because they are generally

regarded as the strongest or ideal of the three types of *Deha prakṛti*. But it is clear that it is not so when it comes to the status of *Sattva sārātā*. This demonstrates how much distress they experience as a direct consequence of CKD. Depression and psychological distress were found to be common among CKD patients in Sri Lanka [29]. Another study by the same author found that symptom burden had a substantial impact on both physical and mental health status in CKD patients [30], whereas Onishi et al. (2019) observed that the mental health impairment of CKD patients is linked with disease progression [31]. Therefore, it is clear that the above results are compatible with previous literature.

Regarding the associations between the types of *Deha prakṛti* and *Sāra* status of each *Dhātu* in healthy controls/ individuals, significant associations could be observed in *Dhātus*; *Māṃsa*, *Medas*, *Asthi*, *Majjā* and *Śukra* ( $P = 0.02$  for *Māṃsa dhātu sārātā*,  $P = 0.000$  for *Medas*, *Asthi* and *Majjā dhātu sārātā*,  $P = 0.002$  for *Śukra dhātu sārātā*) whereas no association could be observed between the types of *Deha prakṛti* and *Rasa dhātu sārātā* status. This implies that the *Sāra* status of *Rasa dhātu* was not varied or changed according to the type of *Deha prakṛti* in healthy controls/ individuals. In other words, *Sāra* status of *Rasa dhātu* was not dependent on the types of *Deha prakṛti* in healthy controls/ individuals.

*Rakta dhātu* and *Sattva* in healthy controls/ individuals were at their optimal level or the status of *Pravara sāra* regardless of the types of *Deha prakṛti*. 100% of healthy individuals in each *Prakṛti* type (*Vāta pradhāna*, *Pitta pradhāna* and *Kapha pradhāna* types) had *Pravara sāra rakta dhātu* and *Sattva*.

This indicates that the majority (more than 92%) of healthy controls/ individuals with *Kapha pradhāna prakṛti* consisted of *Pravara sāra rakta*, *Māṃsa*, *Medas*, *Asthi*, *Majjā*, *Śukra dhātu* and *Sattva*.

Among *Vāta* or *Pitta pradhāna prakṛti* types in healthy controls/ individuals, a considerable proportion (more than 61.3%) had *Pravara sāra Māṃsa*, *Medas*, *Majjā* and *Śukra dhātu*, whereas the majority (58.1%) represented with *Madhyama sāra asthi dhātu*.

Further, when comparing the results in CKD patients with healthy controls/ individuals, none

of the healthy individuals' *dhātu* was at the *Avara sāra* status, even among the *Vāta pradhāna prakṛti* types. However, it was reported that there were a considerable number of CKD patients with *Avara sāra* status related to each *Dhātu* among *Vāta* and *Pitta pradhāna prakṛti* types. The count of *Vāta pradhāna prakṛti* CKD patients with *Avara sāra* status ranging from *Rasa dhātu* to *Sattva* is significantly higher than that of *Pitta pradhāna prakṛti* types. It rose from 29.5% – 95.5% for *Vāta pradhāna prakṛti* patients and 12.8% – 76.6% for *Pitta pradhāna prakṛti* patients. It was observed that ranging from *Rasa dhātu* to *Śukra dhātu*, all the participants with *Kapha pradhāna prakṛti* types represented the group of CKD patients and the group of healthy controls/ individuals had *Pravara sāra* status. Regarding the *Sāra* status of *Sattva*, the majority (57.1%) of *Kapha pradhāna prakṛti* CKD patients had *Madhyama sāra sattva*, whereas the majority (95.5%) of *Vāta pradhāna prakṛti* types had *Avara sāra sattva*. However, it was reported that 100% of healthy individuals consisted of *Pravara sāra sattva* regardless of *Deha prakṛti* type. This is an example of the mental status of healthy individuals being at their best. It was found that depressive disorders are 1.5 – 4 times more common in patients than in the general population [32].

Collectively, it can be said that the *Sāra* status of some *Dhātu*, such as *Rasa*, *Rakta* and *Sattva*, does not depend on the type of *Deha prakṛti* of a healthy controls/ individual and when it applies to CKD patients, the *Sāra* status of all *Dhātu* and *Sattva* depend on the type of *Deha prakṛti* of that particular individual.

#### 4. CONCLUSION

In the light of observations and results, it can be concluded that the status of each *Dhātu* (from *Rasa dhātu* to *Śukra dhātu*) and *Sattva sāra* status are significantly associated with *Deha prakṛti* types in patients with CKD under a 5% level of significance indicating that *Dhātu sārātā* status depends on the type of *Deha prakṛti* in CKD patients. Compared with the results of CKD patients; the *Sāra* status of *Medas*, *Asthi*, *Majjā* and *Śukra dhātu* are significantly associated with the types of *Deha prakṛti* under a 5% significance level whereas, the *Rakta dhātu* and *Sattva sārātā* of healthy controls/ individuals were at their maximum regardless of the combined types of *Deha prakṛti*. Furthermore, CKD patients with *Kapha pradhāna prakṛti* type can be considered to have the maximum *Deha bala* while those with

*Pitta pradhāna prakṛti* have average *Deha bala* and *Vāta pradhāna prakṛti* CKD patients have the lowest *Deha bala*. It was also concluded that the mean percentage score of each *Dhātu* and *Sattva sāra* in CKD patients significantly differed according to the disease stages under a 5 % level of significance, indicating that each *Dhātu* and *Sattva sārātā* mean percentage score of CKD patients depends on the disease stages and the *Sāra* status of each *Dhātu* including *Sattva* declines from *Pravara sāra* to *Avara sāra* as the disease progresses.

#### CONSENT

As per international standards or university standards, written consent from each research patients has been collected and preserved by the author(s).

#### ETHICAL APPROVAL

Ethical approval for the study was obtained from the Ethics Review Committee, Faculty of Indigenous Medicine, University of Colombo (ERC/20/103) on 29.01.2021 and by the Research and Ethics Review Committee, University of Kelaniya (UOK/ERC/21/IM/004) on 21.05.2021.

#### COMPETING INTERESTS

Authors have declared that no competing interests exist.

#### REFERENCES

1. Couser WG, Remuzzi G, Mendis S, Tonelli M. The contribution of chronic kidney disease to the global burden of major noncommunicable diseases. *Kidney International*. 2011;80(12):1258–1270. Available: <https://doi.org/10.1038/KI.2011.368>
2. Wijewickrama E, Jayasinghe S, Constantine G, Katulanda G, Katulanda P. SUN-124 Prevalence of chronic kidney diseases and its associated risk factors from a non-CKDu endemic area of Sri Lanka. *Kidney Int Rep*. 2020;5:S252–S253. Available: <https://doi.org/10.1016/j.ekir.2020.02.651>
3. Wijewickrama ES, Weerasinghe D, Sumathipala PS, Horadagoda C, Lanarolle R D, Sheriff RMH. Epidemiology of chronic kidney disease in a Sri Lankan population - experience of a tertiary care center. Saudi

- Journal of Kidney Diseases and Transplantation. 2011;22(6):1289-1293.
4. Department of Census & Statistics. Demographic & Health Survey Report; 2016. Accessed 29.05.2022. Available: <http://www.statistics.gov.lk>
  5. Kafle K, Balasubramanya S, Horbulyk T. Prevalence of chronic kidney disease in Sri Lanka. a profile of affected districts reliant on groundwater. *Science of the Total Environment*. 2016;694: 1-10. Available: <https://doi.org/10.1016/j.scitotenv.2019.133767>
  6. Decreased G. Definition and classification of CKD. *Kidney International*. 2013:19–62. Available: <https://doi.org/10.1038/kisup.2012.64>
  7. Levey AS, Inker LA. Definition and staging of chronic kidney disease in adults. UpToDate; 2014. Available: <https://cmappublic3.ihmc.us/rid=1T282FT5V-1K4T77Q-CQ/Definition%20and%20staging%20of%20chronic%20kidney%20disease%20in%20adults%20-%20UpToDate.pdf>
  8. Berns JS. Routine screening for CKD. should be done in asymptomatic adults selectively. *Clinical Journal of the American Society of Nephrology*. 2014; 9(11):1988–1992. Available: <https://doi.org/10.2215/CJN.02250314>
  9. Sharma PV, editor. *Caraka Samhita (Agnivesa's treatise refined and annotated by Caraka and redacted by Drdhabala)*. Varanasi: Chaukhambha Orientalia; 2014a.
  10. Sharma PV, editor. *Sushruta Samhitha with English translation of text and Dalhana's commentary along with critical notes*. Varanasi: Chaukhambha Vishvabharathi; 2013.
  11. Sharma PV, editor. *Caraka Samhita critical notes (Incorporating the commentaries of Jejjata, Chakrapani, Gangadhara and Yogindranatha)*. Varanasi: Chaukhambha Orientalia; 2014b.
  12. Chaple J. Prakriti-important tool for health and disease. *Journal of Indian System of Medicine*. 2014;2(2):104-106.
  13. Walker G, Habboushe J. CKD-EPI Equations for Glomerular Filtration Rate (GFR). MD + CALC; 2005. Accessed 03.03.2022. Available: <https://www.mdcalc.com/calc/3939/ckd-epi-equations-glomerular-filtration-rate-gfr>
  14. Bhushan P, Kalpana J, Arvind C. Classification of human population based on HLA gene polymorphism and the concept of Prakriti in Ayurveda. *Journal of Alternative & Complementary Medicine*. 2005;11(2):349–353. Available: <https://doi.org/10.1089/acm.2005.11.349>
  15. Ghodke Y, Joshi K, Patwardhan B. Traditional medicine to modern pharmacogenomics. Ayurveda Prakriti type and CYP2C19 gene polymorphism associated with the metabolic variability. *Evidence-Based Complementary and Alternative Medicine*; 2011. Available: <https://doi.org/10.1093/ecam/nep206>
  16. Mahalle NP, Kulkarni MV, Pendse N M, Naik SS. Association of constitutional type of Ayurveda with cardiovascular risk factors, inflammatory markers and insulin resistance. *Journal of Ayurveda and Integrative Medicine*. 2012;3(3):150-157. Available: <https://doi.org/10.4103/0975-9476.100186>
  17. Rotti H, Guruprasad KP, Nayak J, Kabekkodu SP, Kukreja H, Mallya S et al. Immunophenotyping of normal individuals classified on the basis of human dosha prakriti. *Journal of Ayurveda and Integrative Medicine*. 2014;5(1):43 - 49. Available: <https://doi.org/10.4103/0975-9476.128857>
  18. Rotti H, Raval R, Anchan S, Bellampalli R, Bhale S, Bharadwaj R et al. Determinants of prakriti, the human constitution types of Indian traditional medicine and its correlation with contemporary science. *Journal of Ayurveda and Integrative Medicine*. 2014;5(3):167-175. Available: <https://doi.org/10.4103/0975-9476.140478>
  19. Thaker SJ, Gandhe PP, Godbole CJ, Bendkhale SR, Mali NB, Thatte UM et al. A prospective study to assess the association between genotype, phenotype and Prakriti in individuals on phenytoin monotherapy. *Journal of Ayurveda and Integrative Medicine*. 2017;8(1):37–41. Available: <https://doi.org/10.1016/j.jaim.2016.12.001>
  20. Gunawat CP, Singh G, Patwardhan K, Gehlot S. Weighted mean: A possible method to express overall Dhatu Sarata.

- Journal of Ayurveda and Integrative Medicine.2015;6(4):286-289.  
Available:<https://doi.org/10.4103/975-9476.172386>
21. Murthy KRS.Vagbhata's Ashtanga Hridayam (Text, English Translation, Notes, Appendix and Indices). Varanasi: Krishnadas Academy Oriental Publishers and Distributors; 2001.
  22. Murthy PHC. Sharangadhara Samhita (A treatise on Ayurveda). Varanasi: Chaukhamba orientalia; 2017.
  23. Al Naamani Z, Gormley K, Noble H, Santin O, Al Maqbali M. Fatigue, anxiety, depression and sleep quality in patients undergoing haemodialysis. BMC Nephrology. 2021;22(1):157. Available: <https://doi.org/10.1186/s12882-021-02349-3>
  24. Feroze U, Martin D, Reinapaton A, Kalantarzadeh K, Kopple JD. Mental health, depression, and anxiety in patients on maintenance dialysis.Iranian Journal of Kidney Diseases. 2010;4(3): 173-180.
  25. Goh ZS, Griva K. Anxiety and depression in patients with end-stage renal disease: impact and management challenges—a narrative review. International Journal of Nephrology and Renovascular Disease. 2018:93–102.
  26. Lee Y, Kim MS, Cho S, Kim SR. Association of depression and anxiety with reduced quality of life in patients with predialysis chronic kidney disease. International Journal of Clinical Practice.2013;67(4):363–368. Available:<https://doi.org/10.1111/ijcp.12020>
  27. Cruz MC, Andrade C, Urrutia M, Draibe S, Nogueira-Martins LA, Sesso R de CC. Quality of life in patients with chronic kidney disease. Clinics. 2011;66(6):991–995. Available: <https://doi.org/10.1590/S1807-59322011000600012>
  28. Ginieri-Coccosis M, Theofilou P, Synodinou C, Tomaras V, Soldatos C. Quality of life, mental health and health beliefs in haemodialysis and peritoneal dialysis patients: investigating differences in early and later years of current treatment. BMC Nephrology. 2008;9(1):1–9. Available:<https://doi.org/10.1186/1471-2369-9-14>
  29. Senanayake S, Gunawardena N, Paliawadana P, Suraweera C, Karunaratna R, Kumara P. (2018). Depression and psychological distress in patients with chronic renal failure: Prevalence and associated factors in a rural district in Sri Lanka. Journal of Psychosomatic Research 2018; 112:25–31. Available:<https://doi.org/10.1016/j.jpsychores.2018.06.009>
  30. Senanayake S, Gunawardena N, Paliawadana P, Senanayake S, Karunaratna R, Kumara P et al. Health-related quality of life in chronic kidney disease; a descriptive study in a rural Sri Lankan community affected by chronic kidney disease. Health and Quality of Life Outcomes. 2020;18(1):1–9. Available: <https://doi.org/10.1186/s12955-020-01369-1>
  31. Onishi Y, Uchida HA, Takeuchi H, Kakio Y, Sugiyama H, Wada J. et al. Impaired mental health status in patients with chronic kidney disease is associated with estimated glomerular filtration rate decline. Nephrology. 2019;24(9):926–932. Available:<https://doi.org/10.1111/nep.13515>
  32. Zalai D, Szeifert L, Novak M. Psychological distress and depression in patients with chronic kidney disease. Seminars in Dialysis. 2012;25(4):428–438. Available:<https://doi.org/10.1111/j.1525-139X.2012.01100>

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