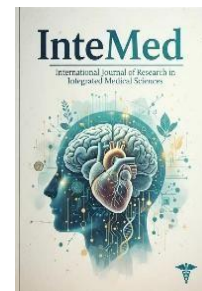




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Review Article

A Comparison of Ayurveda's Viddhakarma and TCM Acupuncture

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Abstract:

Background: Point-specific needling therapies developed independently in several traditional medical systems. Ayurveda's Viddhakarma — a parasurgical, minimally invasive puncture technique rooted in the Sushruta Samhita — and Traditional Chinese Medicine (TCM) acupuncture both use needle stimulation of discrete body points to relieve pain and restore function, yet they arose in different civilisations, under different theoretical frameworks, centuries apart.

Objective: To systematically compare Viddhakarma and TCM acupuncture across their historical origins, theoretical foundations, technique and instrumentation, clinical indications, proposed mechanisms of action, evidence base, and safety profile.

Methods: A narrative comparative review of classical Ayurvedic texts (Sushruta Samhita, Ashtanga Hridaya)

and contemporary peer-reviewed Ayurveda and TCM literature, including systematic reviews, randomised controlled trials, and comparative anatomical studies of marma points and acupoints.

Discussion: Both systems share the conceptual architecture of a vital force (Prana/Qi) circulating through a channel network (Nadi-Srotas/Jingluo) and accessible at discrete surface points, and both converge heavily on musculoskeletal pain indications, notably frozen shoulder (Avabahuka) and sciatica (Gridhrasi). They diverge substantially in technique — Viddhakarma is a brief, high-threshold puncture with an intended minor drainage effect, retained for roughly a minute, whereas acupuncture uses sustained needle retention of 15–30 minutes to elicit deqi — and in the depth of their modern clinical evidence base, which is considerably larger and more methodologically mature for acupuncture.

Conclusion: Viddhakarma and acupuncture represent two independently evolved but conceptually convergent needling traditions. Their overlap in musculoskeletal indications makes them promising candidates for integrative and translational pain-management research, provided future studies adopt standardised, controlled comparative methodology.

Keywords: *Viddhakarma; Acupuncture; Marma; Ayurveda; Traditional Chinese Medicine; Siravedhana; Suchivedhana; Comparative review*

1. Introduction

Interest in traditional and complementary medicine has grown steadily worldwide, with needling-based therapies attracting particular clinical and research attention as low-cost, largely drug-free options for pain and functional disorders. Two of the oldest documented systems of body-point therapy arose independently in ancient India and China: Ayurveda's marma-point tradition, within which Viddhakarma is a specific parasurgical needling technique, and Traditional Chinese Medicine's acupuncture, built around the meridian and acupoint system [1,2].

Viddhakarma (from Viddha, "to pierce," and Karma, "procedure") is classified in the Sushruta Samhita as a refined, localised form of Siravedhana (venesection), itself one of the five classical techniques of Raktamokshana (therapeutic bloodletting), and is used principally as a Shoolaghna (pain-relieving) therapy [1]. Acupuncture, by contrast, is the practice of inserting fine needles at classical acupoints distributed along the meridians (Jingluo) to regulate the flow of Qi and Blood [2]. Although both are frequently described in popular literature as "equivalent" systems, a systematic side-by-side comparison of their historical origin, theoretical logic, technique, indications, mechanism, and evidence base is rarely undertaken. This review aims to provide that comparison, drawing on classical texts and the contemporary peer-reviewed literature of both traditions.

2. Historical and Textual Origins

2.1 Viddhakarma

Viddhakarma is documented in the Sushruta Samhita (Sharira Sthana, Chapter 8; Sutra Sthana, Chapter 8), the Charaka Samhita, and the Ashtanga Hridaya, and is recognised as one of the Ashta Vidha Shastra Karma — the eight surgical procedures described by Acharya

Sushruta — as well as among the Shashthi-Upakrama, the sixty therapeutic procedures for wound and disease management [1]. Acharya Sushruta emphasised the centrality of Siravedhana to surgical practice, stating that it accounts for roughly half of all treatments in Shalya Tantra; Viddhakarma is best understood as a smaller-scale, more localised variant of this venesection tradition, used where visible veins are not easily accessible for full Siravedhana [1].

2.2 TCM Acupuncture

Acupuncture's theoretical foundations were systematised in the Huangdi Neijing (Yellow Emperor's Inner Classic), which described 277 acupoints; this expanded to 649 points in the Zhenjiu Jiayi Jing (A–B Classic of Acupuncture and Moxibustion, 3rd century CE), and to 718 points in the modern Chinese national standard (GB 12346-1990) [2]. Unlike the marma system, which has remained fixed at 107 points since the Sushruta Samhita, the acupoint system has continued to expand as clinical experience accumulated over roughly two millennia [2].

2.3 Divergent Cultural Origin

A direct comparative-history study by Wu and Wang traced the origin of marma points to the battlefield and martial culture of ancient India — points whose injury caused the greatest anatomical damage — which were only later adapted for medical and therapeutic use, whereas Chinese acupoints arose directly from accumulated clinical medical experience [2]. The study concluded that, despite their similarity in location and their shared role in regulating vital energy, marma and acupoints developed independently and reflect two distinct "body views" shaped by their respective civilisations, rather than one system being derived from the other [2].

3. Theoretical Foundations Compared

3.1 Ayurvedic Framework

Ayurveda understands health as a dynamic equilibrium of the three Doshas (Vata, Pitta, Kapha) acting on the Sapta Dhātu (seven bodily tissues). Prana (vital energy) is said to circulate through channels called Nadi and Srotas, and Marma points are the 107 anatomical junctions — of Mamsa (muscle), Sira (vessel), Snayu (ligament), Asthi (bone), and Sandhi (joint) — where this vital force is concentrated [1,2]. Marma points are classified not only by anatomical structure and size (measured in finger-

widths, or Anguli Pramana) but also by their prognostic significance if injured — ranging from Sadyahpranahara (immediately fatal) to Rujakara (causing persistent pain) — reflecting the system's origin as a map of vulnerability as much as a map of therapy [2]. Viddhakarma is theorised to act by releasing obstructed Vata and draining vitiated Rakta (blood) from the Sira, thereby clearing obstructed Srotas and restoring Doshic equilibrium [1].

3.2 TCM Framework

TCM understands health as a balance of Yin and Yang and the harmonious circulation of Qi and Blood (Xue) through twelve primary and eight extraordinary meridians (Jingluo) linking the body surface to the internal Zang-Fu organs. Acupoints are classified chiefly by their meridian assignment and functional therapeutic properties — for example, source points, connecting points, and command points — rather than by injury-based prognosis [2]. Pain and disease are attributed to Qi stagnation or Blood stasis (often described as Bi syndrome in musculoskeletal pain), and acupuncture aims to "dredge" the meridians, restoring free flow and rebalancing Yin and Yang.

3.3 Shared Conceptual Ground and Key Divergence

Both systems share four core conceptual commitments: a subtle vital energy (Prana/Qi) that must circulate freely for health; a channel network (Nadi-Srotas / Jingluo) that conducts this energy; discrete surface points where the network can be accessed; and the premise that obstruction or imbalance of this flow produces pain and disease, correctable by point stimulation [2]. The key divergence lies in classification logic and scale: marma points are fixed in number and classified substantially by anatomical vulnerability, while acupoints have expanded historically and are classified by channel function — a difference that has led some scholars to caution against treating the two systems as interchangeable, despite frequent anatomical overlap between specific points [2].

4. Procedural and Technical Comparison

Viddhakarma begins with patient positioning and site marking using the traditional Anguli Pramana (finger-width) measurement system, careful avoidance of vital Marma points, aseptic skin preparation with herbal antiseptics such as Panchvalkal or Dashmool Kwath, and insertion of a fine needle at approximately 90° to a depth calibrated in Yava (barley-grain) units according to the target tissue — a full Yava for muscle, half a Yava for skin

or bone, using instruments historically termed Breehimukha or Kutharika. The needle is retained for roughly 60 seconds, then withdrawn, with the site dressed and a therapeutic oil massage (Paschat Karma) applied afterward; the course is typically repeated daily for up to a week [1].

Acupuncture, by contrast, uses fine filiform needles inserted to point- and channel-specific depths, manipulated by twirling or lifting-thrusting to elicit deqi, and then retained for 15–30 minutes while the patient rests, often with adjuncts such as moxibustion, cupping, electroacupuncture, or infrared heat applied concurrently. A course typically involves multiple sessions per week over several weeks rather than a short daily series [3].

Table 1. Procedural and technical comparison of Viddhakarma and acupuncture.

Parameter	Viddhakarma (Ayurveda)	Acupuncture (TCM)
Classical source	Sushruta Samhita, Charaka Samhita, Ashtanga Hridaya	Huangdi Neijing, Zhenjiu Jiayi Jing
Instrument	Breehimukha, Kutharika, Aara (traditional); 24–26G / insulin needles (modern)	Fine sterile filiform needles, typically 0.20–0.30 mm diameter
Depth reference	Yava (barley-grain) units; varies by tissue (skin, muscle, vessel, bone, joint)	Cun-based depth (0.3–1.5 cun); varies by point and region
Needle retention	Brief — approximately 60 seconds per point	Sustained — typically 15–30 minutes per session
Intended bleeding	Minor bleeding often expected as part of therapeutic drainage	Not intended; occasional minor bruising only
Sensory endpoint	Local release of Vata/pain at puncture	Deqi — soreness, distension, or numbness signalling needle-Qi engagement
Session frequency	Often daily for up to one week per course	Typically 2–3 times weekly over several weeks
Common adjuncts	Post-procedure oil massage (e.g., Ksheerabala, Mahanarayan)	Moxibustion, cupping, electroacupuncture, heat lamp (TDP)
Setting	Minor OT / outpatient sterile procedure room	Outpatient acupuncture clinic treatment couch

The clearest technical contrast is in intent and duration: Viddhakarma is a brief, high-threshold puncture with an intended minor drainage effect, philosophically framed as releasing trapped Vata and impure blood, whereas acupuncture is a sustained, retention-based neuromodulatory stimulation without intended bleeding, framed as restoring Qi flow [1,3].

5. Clinical Indications and Overlap

Both systems converge most strongly on musculoskeletal pain and movement disorders. Ayurvedic literature specifically lists Avabahuka (frozen shoulder) among the classical indications for Viddhakarma and Suchivedhana [1,4,5], while TCM acupuncture for adhesive capsulitis / periarthritis of the shoulder is supported by multiple randomised trials and systematic reviews demonstrating improvement in pain and range of motion [6,7,8]. Similarly, Gridhrasi (sciatica) is a recognised Viddhakarma indication [1], paralleling acupuncture's long-standing use for sciatic pain along the Bladder and Gallbladder meridians.

Table 2. Overlapping and divergent clinical indications.

Clinical domain	Ayurvedic indication (Viddhakarma)	TCM / acupuncture correlate
Frozen shoulder	Avabahuka	Jianzhouyan / periarthritis of the shoulder
Sciatica	Gridhrasi	Sciatic pain along Bladder/Gallbladder meridian
Low back pain	Katishoola / Katigraha	Lumbar Bi syndrome
Cervical pain	Manyastambha, cervical spondylosis	Neck Bi syndrome
Heel / plantar pain	Vatakantaka, Paadharsha	Heel-point acupuncture protocols
Osteoarthritis / joint pain	Sandhivata and related joint disorders	Knee/joint Bi syndrome
Beyond musculoskeletal pain	ENT, dermatological (Vicharchika), urogenital, and Manas roga (mental health) indications, reflecting its Raktamokshana lineage	Broader NIH/WHO-recognised uses (nausea, headache, some mental-health adjuncts)

Viddhakarma's indication list extends considerably further than musculoskeletal pain, reflecting its classification within Raktamokshana (bloodletting) therapy for Pitta- and Rakta-predominant disorders: classical and case-report literature describes its use in ENT conditions, dermatological disorders such as Vicharchika (eczema), urogenital and gynaecological conditions including PCOS and infertility, and neuropsychiatric conditions such as Unmada (psychotic disorders) and Apasmara (epilepsy), with emerging interest in neurodevelopmental disorders [1]. Acupuncture's evidence-supported scope, while also broad, is comparatively more concentrated in pain, nausea, and a defined set of conditions recognised in WHO and NIH consensus statements.

6. Proposed Mechanisms of Action

Classically, Viddhakarma is said to reduce excess circulating Vata and Rakta and to relieve pain by clearing blocked Siras (channels). Contemporary Ayurvedic authors propose that needling at specific points activates sensory nerve fibres, producing local inhibition of nociceptive transmission and endorphin release, though they note that confirmatory mechanistic research remains limited [1].

TCM explains acupuncture's effect as unblocking stagnant Qi and Blood and rebalancing Yin and Yang. This has been investigated far more extensively in the modern biomedical literature: proposed mechanisms include gate-control modulation of nociceptive signalling at the spinal cord, activation of descending inhibitory pathways, release of endogenous opioids (beta-endorphin, enkephalin), and local anti-inflammatory and neuro-immune regulation at needled acupoints and their target tissues, including modulation of cytokine and immune-cell activity [9].

Despite arising from entirely different explanatory cosmologies — Dosha–Rakta obstruction versus Qi–meridian stagnation — both traditions converge on a broadly similar candidate final pathway: needle-evoked activation of peripheral sensory afferents leading to local and central release of endogenous analgesic and anti-inflammatory mediators. This convergence is a promising target for translational neuroscience research bridging the two systems.

7. Evidence Base: Clinical Research

Acupuncture has a substantially larger and more methodologically mature evidence base. Multiple randomised controlled trials and systematic reviews/meta-analyses specifically address frozen shoulder, reporting significant improvement in pain and shoulder function compared with sham or waitlist control [6,7], and further evidence supports combining acupuncture with physical therapy for greater benefit than physical therapy alone [8]. A Cochrane review lineage exists for acupuncture in shoulder pain more broadly [10], and mechanistic work has been published in higher-impact biomedical and immunology-adjacent journals [9]. Acupuncture also benefits from WHO-endorsed standardised point nomenclature, which has facilitated cross-study comparability.

Vidhakarman's evidence base is smaller and earlier in its development, currently dominated by case reports, case series, and narrative reviews published largely in Ayurveda-specific journals [1,4,5]. Few controlled trials comparing Vidhakarman against sham needling or standard-care controls were identified in the literature reviewed. This pattern mirrors a broader methodological gap noted in critical appraisals of the Ayurveda-modern medicine interface, which have highlighted small sample sizes, absent blinding, and heterogeneous outcome measures across Ayurvedic interventional studies generally [11].

8. Safety and Adverse Events

Both therapies are generally considered low-risk when performed by trained practitioners under aseptic conditions. Acupuncture's safety profile is well documented through large prospective practitioner surveys: most adverse events are minor and self-limiting (bruising, transient bleeding, needle-site soreness), while rare serious events such as pneumothorax or infection are associated with specific high-risk points (for example, chest-wall points) and technique error rather than the modality itself.

Vidhakarman is similarly regarded as low-risk given its brief retention time and minimally invasive design, but classical and contemporary sources are explicit about its contraindications: it should be avoided in patients with bleeding disorders or a tendency to haemorrhage, in patients who are psychologically unstable, fearful, or unable to give informed consent, and vital Marma points

must be strictly avoided during point selection to prevent serious complications [1]. As with acupuncture, strict adherence to aseptic technique and biomedical waste disposal protocols is emphasised in the procedural literature [1].

9. Integrative Potential and Future Directions

The considerable conceptual and clinical overlap between these two systems suggests several productive directions for future research. First, systematic anatomical cross-mapping of the 107 marma points against the 300–700+ classical and modern acupoints could clarify which loci are genuinely convergent and which are unique to each system [2]. Second, head-to-head or combined-protocol trials in shared indications such as Avabahuka/frozen shoulder could test whether Vidhakarman's brief drainage-oriented puncture and acupuncture's sustained retention protocol produce complementary or additive analgesic effects. Third, mechanistic studies using neuroimaging or inflammatory biomarkers could examine whether both techniques converge on shared endogenous opioid and anti-inflammatory pathways despite their different explanatory frameworks. Finally, the development of standardised reporting guidelines for Vidhakarman research, analogous to the STRICTA (Standards for Reporting Interventions in Clinical Trials of Acupuncture) guidelines already used in acupuncture research, would raise the methodological quality and comparability of future Ayurvedic parasurgical studies.

10. Limitations of This Review

This is a narrative rather than a systematic comparative review; a formal systematic search protocol, dual screening, and risk-of-bias assessment were not applied. Direct head-to-head comparative trials between Vidhakarman and acupuncture are essentially absent from the literature, so the comparison presented here is necessarily indirect, drawing on separately conducted studies of each modality rather than shared trial populations. Translation and conceptual non-equivalence between Sanskrit and Chinese medical terminology introduces some interpretive risk in aligning classical concepts across the two systems. Finally, much of the Vidhakarman literature reviewed originates from Indian regional Ayurveda journals with variable peer-review rigor, which should be considered when weighing the strength of the claims summarised here.

11. Conclusion

Viddhakarma and TCM acupuncture are independently evolved needling traditions that converge strikingly on the core therapeutic logic of stimulating discrete body points to relieve obstruction, reduce pain, and restore function, while diverging in their explanatory cosmologies (Tridosha–Rakta versus Yin–Yang–Qi), their technical execution (brief drainage-oriented puncture versus sustained retention-based neuromodulation), and the depth of their modern clinical evidence base. Their substantial overlap in musculoskeletal indications — particularly frozen shoulder and sciatica — positions the two systems as promising, complementary candidates for integrative pain-management research, provided future work invests in standardised, controlled, comparative methodology.

Conflicts of Interest

The author(s) declare no conflicts of interest relevant to the content of this review.

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