Case Report
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Kutipraveshika Rasayana for 45 Days: A Case Report of Protocol, Adaptations and Longitudinal Observations

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Abstract:

Background. Kutipraveshika Rasayana, the indoor modality of Rasayana therapy, is described in all the major classical texts but is very seldom performed. It requires a purpose-built three-chambered structure, an extensive course of preparatory purification, and residence in isolation for a period of weeks. Descriptive documentation of the regimen as delivered is largely absent from the published literature. **Case presentation.** This is a self-experiential report; the author is also the subject. A 33-year-old woman underwent Kutipraveshika Rasayana for 45 days in November and December 2016 at an Ayurvedic centre in Kerala, India, supervised by a physician who had himself undergone the regimen. Preparation extended over five and a half months and comprised Vamana, Virechana, a Karma Basti series of thirty enemas, Nasya and Shiravedha. Within the kuti the subject received Amalaki Rasayana prepared to the Charaka formulation, 100 g daily with 600 ml of milk until day 32 and 50 g daily with 300 ml of milk thereafter, together with six metallic preparations. The regimen was modified from the classical prescription of subdued light to the total darkness of the yogic variant, Kaya Kalpa. No efficacy endpoint was defined and none is claimed. **Observations.** Observations were recorded in a daily journal. The report documents the architecture of the Trigarbha Kuti and proposes the geometric mechanism by which it excludes light; complications arising from the conditions of the regimen rather than from any medication; circadian disruption from approximately day 21; persistent visual phenomena with full retention of insight and preserved spatial orientation; and two menstrual episodes differing markedly in severity. Re-exposure to light was carried out in four stages corresponding to the layers of the structure, and no photophobia followed. Verification of light-proofing proved possible only by a dark-adapted occupant, residual points of light being invisible to an observer entering from daylight. The regimen was completed without serious adverse event. **Conclusion.** Kutipraveshika Rasayana remains deliverable under contemporary conditions. This account provides a protocol, an architectural description with a proposed optical mechanism, and a record of the complications and adaptations that arise in practice, as a basis for a future prospective study.

Keywords:
Rasayana; Kutipraveshika; Kaya Kalpa; Panchakarma; Amalaki Rasayana; sensory deprivation; Ayurveda; case report.

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Introduction

Rasayana occupies a distinct position within Ayurveda. It addresses not a disease but the qualities of the tissues themselves, and the classical literature assigns it a chapter of its own. Two modalities are described. Vatatapika Rasayana is undertaken while the subject continues ordinary life and remains exposed to wind and sun. Kutipraveshika Rasayana requires entry into a specially constructed dwelling and residence within it, in isolation, for the duration of the regimen.

The two are not regarded as equivalent. Kutipraveshika is presented as the superior form, and the reason given is the completeness of the control it exerts: over light, sound, diet, social contact, activity and the timing of everything administered. That control is also why the regimen has fallen out of use. It requires a purpose-built three-chambered structure, a demanding course of preparatory purification, a physician available throughout, an attendant, and a subject able to remain in isolation for weeks. Most centres offer only the Vatatapika form.

The consequence is an asymmetry in the literature. The textual prescription is available in detail and has been discussed extensively; what is largely absent is an account of the regimen as delivered — how the structure achieves its effect, what is administered and in what quantity, what complications arise, and how re-exposure to light is managed. Published reviews set out how the regimen is to be performed, but accounts of anyone who has actually performed it are hard to find.

This report describes a single instance of Kutipraveshika Rasayana carried out for 45 days in 2016, documented in a daily journal maintained throughout by the subject, who is also the author.

Subject and design

This is a self-experiential case report, based on a contemporaneous daily journal, supplemented by photographs taken at the time and by product labels retained from the preparations used.

The account is published ten years after the intervention, for two reasons. The subject wished to observe what followed over a period long enough to be informative, rather than reporting immediate impressions. And the experience was a private one: until now she had described it only within a close personal circle, and considers that she has needed this length of time to acquire the maturity, the professional experience and the means of expression required to set out something so personal in a public form.

The subject was a 33-year-old woman, 1.64 m in height and weighing 54 kg on entry into the kuti, with a body mass index of 20.1 kg/m². Constitution was Vata-Kapha Prakriti with Pitta-dominant Manasika Prakriti. Apart from severe primary dysmenorrhea, disabling on the first day of menstruation, she reported no medical conditions and took no conventional medication. The dysmenorrhea was not an objective of the intervention described here. It was resolved several years later by a separate protocol, which the author has reported in this journal [1].

She had been lacto-ovo-vegetarian since the age of 15. She had 17 years of yoga practice at the time of entry, predominantly meditative and intermittent rather than continuous, and 16 years of study and practice of Ayurveda. From the age of 16 she had undertaken detoxification practices including Shankha Prakshalana and Sadyo Vamana with saline. Her first classical Virechana was performed in 2008, and from that year she had undergone at least one major Panchakarma procedure annually and had taken metallic bhasmas daily. From 2010 she had followed a self-designed Rasayana regimen of sattvic food with the exception of eggs, excluding refined ingredients and excluding preserved, frozen and previously cooked foods, and had replaced commercial hygiene products with preparations made from edible ingredients. She is a trained psychotherapist, a background relevant to several of the observations reported below.

The intervention was not undertaken for a clinical indication. The physicians at the centre concluded before entry that no measurable rejuvenative benefit should be expected, the subject already presenting the relevant parameters at their maximum. The motivation was personal and spiritual, and

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the completion of the full sequence of Ayurvedic therapeutic procedures. No efficacy outcome was defined and none is claimed.

The intervention was supervised by Dr Sreejith S.P. at the Athreya Ayurvedic Centre, Pallom, Kottayam, Kerala, who had himself previously undergone Kutipraveshika Rasayana for 30 days.

1. Preparatory phase

The preparatory phase extended from 29 June to 15 November 2016 and comprised the full sequence of Panchakarma procedures together with Raktamokshana, each preceded by its own Snehapana and Swedana where indicated. Each procedure was carried out at high intensity: Vamana was continued to a volume of 10 litres ingested and expelled; Virechana reached 30 vega, the criterion for maximal purification; Basti was given as the full Karma Basti course of thirty enemas; Nasya was continued for nine days; and in Shiravedha the blood was allowed to flow until it stopped spontaneously.

A classical Virechana had been performed at the end of March 2016; this was deliberately disregarded for the purposes of the KPR preparation, on the grounds that the interval to the planned entry would exceed six months, and the Virechana was repeated in July.

Table 1. Chronology of the preparatory phase, 2016

Dates	Procedure	Principal details
29 Jun – 1 Jul	Snehapana I	Ghrita with Ashta Churna, 50 → 110 ml over 3 days
2 Jul	Utkleshana	Curd; rice boiled in milk with jaggery (unrefined whole cane sugar)
3 Jul	**Vamana**	Madanaphala-based leha; 10 L milk ingested and expelled
3–7 Jul	Samsarjana Krama	Five graded preparations, each taken for three consecutive meals; see Table 2
8–16 Jul	Interval	Predominantly fruit-based diet
17–19 Jul	Snehapana II	Kalyanaka Ghrita, 50 → 90 ml over 3 days
20–21 Jul	Pitta-promoting regimen	Warm citrus juice, takra, mildly spiced vilepi, Abhyanga, Avagaha Sweda
22 Jul	**Virechana**	Icchabhedi Rasa, half tablet; 30 vega over ~8 h
23–25 Jul	Samsarjana Krama	Five graded preparations, each taken for three consecutive meals; see Table 2
13–30 Aug	**Karma Basti**	1 Anuvasana + 12 Niruha and 12 Anuvasana alternating + 5 Anuvasana
6-Sep onwards	Yoni Pichu	Mahanarayana Taila, retained overnight, nightly
17–28 Oct	**Nasya**	Guggulutiktaka Arishta, on the physician's recommendation; 5–6 drops in each nostril, 9 days of administration interrupted for 3 days by menstruation
4–6 Nov	Snehapana III	Plain ghrita, 15 ml daily for 3 days
7 Nov	**Shiravedha**	70 ml venous blood, self-performed
16 Nov	Pre-entry evacuation; **entry**	Haritakyadi Churna 20 g; entry at 15:27

1.1 Vamana

Internal oleation began on 29 June with 50 ml of ghrita mixed with 5 g of Ashta Churna at 07:30, digested in 4 h 30 min. The dose rose to 100 ml with 10 g on the second day, digested in 10 h, and to 110 ml with 10 g on the third, digested in 13 h 30 min, at which point the signs of optimum oleation appeared. Diet throughout consisted exclusively of a thin rice gruel of soup-like consistency, taken at

every meal. Each evening Abhyanga was performed with an oil processed with Pitta-pacifying drugs — Chandana, Satapatrika, Manjishtha, Nimba, Sariva, Ushira, Shatavari, Mandukaparni, Dhanyaka and Arjuna — followed by mild Swedana, and on the third evening by Avagaha Sweda.

Menstruation began on 2 July. Utkleshana was carried out the same day with curd and with rice boiled in milk and jaggery.

Vamana was performed on 3 July, preceded by Abhyanga and Avagaha Sweda [2]. At 07:30 the emetic preparation was given as a leha of powdered Madanaphala, Yashtimadhu and Vacha with honey. Akanthapana was carried out with undiluted milk. The emetic preparation itself was expelled after approximately 3 L, at which point the heaviness and fatigue resolved; emesis was nevertheless continued, since Pitta had not yet been eliminated. A total of 10 L of milk was ingested and expelled over 2 h. Pitta was not observed in an unequivocal form; the expelled material contained abundant fine bubbles, interpreted as a Vata sign.

The endpoint was determined on the volume ingested and expelled, ten litres being the point at which the subject was no longer able to continue. Pitta was eliminated later the same evening by another route: peya taken after the procedure produced epigastric distress and nausea, and was expelled per rectum within an hour together with yellow fluid identified as Pitta.

Marked mental clarity and heightened sensory acuity followed immediately upon completion of the emesis. The subject describes the experience as the return of a clarity of perception, particularly of colour, that she had not known was lost, the underlying dulling having been too gradual to register while it was taking place.

Samsarjana Krama was carried out in five graded preparations and completed on 7 July.

Table 2. Samsarjana Krama as prepared

Stage	Preparation	Rice to water	Composition
1	Peya	1 : 16	Liquid only; the rice was discarded
2	Vilepi	1 : 16	Taken whole, rice and liquid together
3	Akrita Yusha	1 : 8	Rice with a small quantity of green gram
4	Krita Yusha	1 : 8	As above, with salt, ghee and spices
5	Rasa	1 : 4	Rice and water

The sequence and schedule follow Astanga Samgraha, Sutra Sthana 27/22: the five preparations in this order, three meals of each, fifteen meals in all, for subjects who have undergone maximum purification [3]. The Charaka Samhita sets out a similar regimen after emesis, described meal by meal and likewise in groups of three [4].

The classical text defines the stages by consistency rather than by proportion; the ratios given here are those actually used. Rasa is described in the text as a meat soup, and was replaced in this case by a rice preparation, the subject being vegetarian.

For the following twelve days the subject felt a marked inclination towards fruits and ate predominantly mango, avocado, raspberries and blackberries. When the supervising physician learned of this, towards the end of that period, he advised against a large intake of fruit at that stage, on the grounds that it would increase Vata.

1.2 Virechana

Oleation for Virechana began on 17 July with 50 ml of Kalyanaka Ghrita, digested with difficulty in 11 h with the assistance of Shunthi powder in hot drinking water; 60 ml on 18 July required 8 h 30 min, and 90 ml on 19 July approximately 11 h. Snehapana was discontinued at this point. The signs of optimum oleation were present with one exception, mild dryness persisting over the skin of the lower legs, but aversion to ghrita had become pronounced and no further increase was tolerable. The subject attributed both the difficulty of digestion and the early saturation to this being her third course of Snehapana within four months.

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The two days preceding Virechana followed a Pitta-promoting regimen: 150 ml of orange juice with lemon, diluted with hot water and taken warm; warm takra prepared with Ashta Churna and Krishna Lavana; and vilepi prepared with Pitta-increasing spices. Abhyanga of 15 minutes followed by Avagaha Sweda was performed on both afternoons.

Virechana was performed on 22 July [5]. At 09:40 the subject took one half tablet of Icchabhedi Rasa (Baidyanath), approximately 124 mg; the full tablet contains Shuddha Parada, Gandhaka, Tankana, Shunthi and Maricha at 31 mg each with Shuddha Jatiphala 93 mg. Purgation was accompanied throughout by cramping and local burning. Fifteen vega occurred over five hours, followed by a pause of one to two hours, after which purgation resumed. From the twenty-sixth vega, powdered Arjuna bark was held sublingually and expelled without swallowing, on four occasions. The final count was 30 vega over approximately 8 h.

The subject notes that her response to Virechana varies inversely with the strength of Agni: in spring 2016, when Agni was strong, three quarters of half a tablet produced only 7 vega.

After the procedure Agni recovered quickly, with hunger recurring every two hours, and the fifteen meals of Samsarjana Krama were completed within three days, on 25 July. Body weight at that point was 50.5 kg.

1.3 Karma Basti, Nasya and Shiravedha

A Karma Basti series of thirty enemas was begun on 13 August with a single Anuvasana in the evening. From the following day the enemas were given twice daily: Niruha in the morning, on an empty stomach, and Anuvasana in the evening, alternating in this way for twelve days of each. The series concluded with five further Anuvasana, given in the evening, and was completed on 30 August.

Anuvasana used Mahanarayana Taila, initially 60 ml retained for 11 h. Niruha used the formulation given in the Charaka Samhita [6] — two prasritas of milk with three prasritas of honey, oil and ghrita taken together — administered as 192 ml milk, 96 ml honey, 96 ml ghee and 96 ml sesame oil. It was chosen for its unctuous and nourishing character, in anticipation of the cramping the subject characteristically experiences.

The first Niruha, on 14 August, had been prepared at too high a temperature; only about 100 ml could be introduced and evacuation was severely painful, with weakness and reduced Agni for the rest of the day, and the evening Anuvasana was reduced to 40 ml. Tolerance of the Niruha improved over the series. From 18 August it became tolerable, with only slight cramping as the basti was expelled. The Anuvasana caused no difficulty at any point.

Menstruation began on 31 August, two days early, attributed to stimulation of Apana Vayu by the enema series; the inflammatory character of the pain was substantially reduced.

From 6 September, on the physician's advice, Yoni Pichu [7] with Mahanarayana Taila was performed each evening, the cotton retained overnight, and this was continued nightly thereafter, including throughout the intervention. The intention was to reduce the severity of the pain before entering the kuti, since pain of the intensity the subject ordinarily experienced would have been difficult to manage in isolation, where examination was impossible and leaving was not an option.

A gap of approximately six weeks separates the completion of the Basti series from the commencement of Nasya. During September the subject developed a cold which persisted for approximately three weeks, and Nasya was postponed until it had resolved. No allopathic medication was taken at any point during the illness. She attributed it to cold weather in combination with reduced resistance following the extensive course of Shodhana already completed.

Nasya was performed with Guggulutiktaka Arishta, chosen on the recommendation of the supervising physician, over nine days of administration, the longest of the durations specified in the classical text [8]. The dose was 5 drops in each nostril on the first day and 6 drops in each nostril thereafter, beginning on 17 October. After the fourth day the course was interrupted for three days on

account of menstruation and then resumed until all nine days had been given, ending on 28 October. Menstruation during this period was free of pain.

Oleation preceding Raktamokshana was carried out over three days, on 4, 5 and 6 November, with 15 ml of plain ghrita daily. Shiravedha was performed on 7 November, self-administered [9]. Blood was allowed to flow freely until it stopped of its own accord, without any attempt to arrest it; the total was 70 ml, 30 ml from one arm and 40 ml from the other. Mild generalised discomfort resolved within one day.

1.4 Arrival and entry

The subject arrived at the centre on 13 November and chose to reside within the kuti during the days preceding the intervention, in order to become familiar with its facilities and to prepare for the period of darkness.

On the morning of 16 November, 20 g of Haritakyadi Churna [10] was given as a final evacuant; the expected response was four to five loose stools. No purgative effect occurred. Entry took place at 15:27 on 16 November in the presence of Dr Sreejith S.P. and Dr Jayalakshmi, at a time calculated astrologically, on the physician's recommendation, by an astrologer of his choosing.

The evacuant was attempted twice more within the kuti: 200 ml of Haritakyadi decoction on 17 November produced a single loose stool, and 300 ml on 18 November produced no effect. The supervising physician attributed the failure to the strength of the subject's Agni, itself increased by the preparatory Shodhana, which had been carried out at high intensity. No further attempt was made, and the Rasayana was begun as planned.

2. The kuti

2.1 Configuration

The structure is a Trigarbha Kuti: three enclosures arranged concentrically, so that the innermost chamber is separated from the exterior by two intervening layers of masonry and two circulation corridors [11]. It stands apart from the other buildings, in landscaped grounds with mature trees, in a rural setting where there are no tall structures nearby and no significant street lighting.

Construction follows the traditional building methods of the region: exposed laterite block on a masonry plinth, and a hipped clay-tile roof carried on an exposed timber structure. There is no ceiling; the walls rise approximately three metres to a timber wall plate on which the roof structure sits directly. A colonnaded verandah runs along the principal elevation.

The innermost chamber is whitewashed, with a granite slab floor and a heavy timber door; the corridors are left in unfinished laterite. The thermal mass of laterite, with the roof pitch and a wall height of approximately three metres beneath an open roof structure, kept interior temperatures within a narrow range, assisted only by a wall-mounted fan running continuously.

The doorways are not aligned. Those in the outer wall lie on one side of the plan and those in the middle wall on the opposite side, so that a person entering must traverse the full length of each corridor before reaching the next opening. No straight line of sight exists from the exterior to the innermost chamber. The bathroom occupies a corner of the innermost chamber, enclosed by a partition, and is therefore reached without crossing any intervening layer (Figure 1).

2.2 The fenestration as an optical mechanism

The most significant feature of the design, and the one least described in the literature, is the vertical positioning of the window openings, which varies between the three layers. On the outer wall the windows are set at approximately shoulder height; on the second wall they begin close to floor level; on the wall of the innermost chamber they are set above head height, near the top of the wall. All openings are fitted with mesh rather than glazing.

The key interruption of the light path occurs between the second layer and the innermost chamber. Light entering the outer wall at shoulder height travels downward through the first corridor and reaches the second wall close to floor level. It then passes through a low window into the second corridor, where

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it continues at or near floor level. The window into the innermost chamber is set high in the wall, immediately below the level at which the roof structure begins. Because of this difference in height, light entering from outside cannot pass directly through all three walls into the inner chamber (Figure 2). The offsetting of the doorways performs the equivalent function in the horizontal plane, removing any direct path between the exterior and the interior.

The Trigarbha Kuti is thus not simply a structure of three walls providing thermal and acoustic isolation. The arrangement of its openings constitutes a deliberate optical trap: a system that admits air while extinguishing light through successive geometric interruptions. The openings are fitted with mesh rather than glass, consistent with the same intention: air passes through, light is held back.

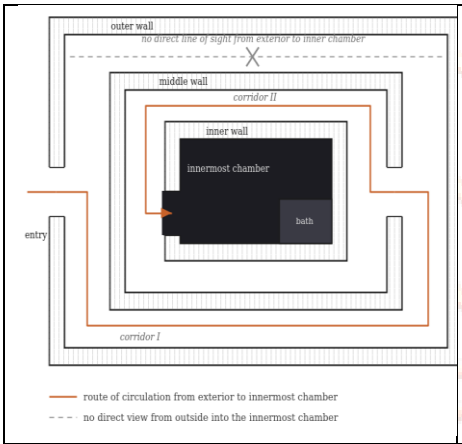


Figure 1. Plan of the Trigarbha Kuti, showing the three concentric enclosures and the offset doorways. Openings serving successive enclosures lie on opposing sides, so that each layer is traversed in full before the next is reached. Not to scale.

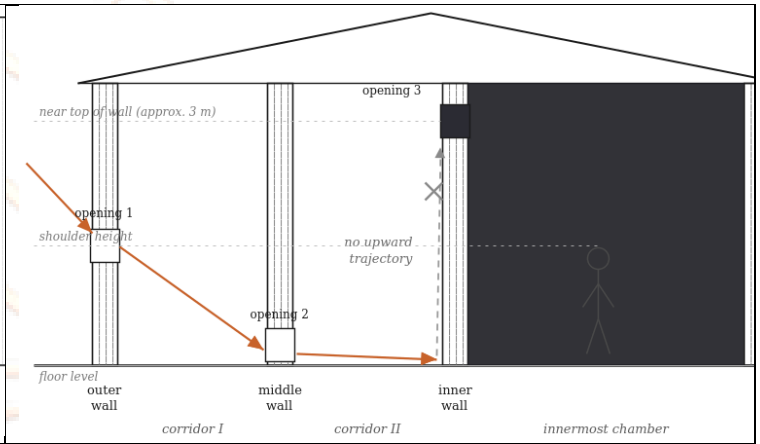


Figure 2. Schematic vertical section through the three enclosures. Daylight admitted at shoulder height descends across corridor I, passes the floor-level opening of the middle wall and arrives at ground level in corridor II; the opening of the innermost chamber lies near the top of the wall. Not to scale.

2.3 Modification to total darkness

The classical description specifies subdued light rather than the exclusion of light, and the facility was built to that specification. The subject elected instead to reproduce the conditions of the yogic variant, Kaya Kalpa, in which no light whatever is admitted. This is the principal deviation from the classical protocol in this report. The subject's reason for requesting total darkness was her expectation that it would favour the arising of altered states of consciousness.

Achieving this required modification in three stages, all completed before the regimen began. Before the subject's arrival, a contractor covered the windows of the outer wall with thick orange cloth. On arrival the subject found the innermost chamber darkened but not lightless, and the same contractor returned to apply cloth to the inner windows as well. The staff of the centre then sealed the residual pinpoints of light in the roof structure individually, with a black sealant applied by brush.

This last stage could not be completed at once, and the reason is worth stating. The residual points, most of them in the roof structure, were not visible to anyone entering from daylight. They became perceptible only after several hours of dark adaptation. The subject identified them progressively over several days before the regimen began, the staff covering each as it was reported.

2.4 Interior provision

The innermost chamber was furnished with a timber bed, a small table on which meals were placed in stainless steel vessels, a chair, an armchair and a floor mat. A wall-mounted fan provided air circulation. Two fixed telephones without indicator lights were provided, one in the chamber and one in the bathroom, so that help could be called from either room. No mobile telephone was present and no device emitting light of any kind was retained. The chamber was of sufficient size to permit walking, the practice of asanas and, on occasion, dancing.

Timekeeping was maintained by a tactile watch of the type manufactured for blind users, worn on the wrist throughout except when washing. The subject identifies this as the single most useful practical provision of the intervention.

The bathroom had no hot water supply, the classical regimen not providing for bathing. The subject washed with water at ambient temperature for the first several days and developed bodily discomfort which she attributed to this. Very hot water was thereafter supplied daily between 17:00 and 19:00 as a half-filled bucket, the remaining volume being made up by the subject with water at ambient temperature to reach a comfortably warm temperature, and poured with a mug.

Washing consisted of self-massaging the whole body with oil on dry skin, followed by rinsing with warm water; no soap was used. Hair was washed with Reetha powder, used in small quantity so that it could be rinsed out with the water available. This constitutes a further deviation from the classical protocol.

3. The intervention

3.1 Duration and counting of days

Entry took place at 15:27 on 16 November 2016 and exit at 18:37 on 31 December 2016. As entry occurred in the afternoon, the remainder of 16 November is treated as the day of entry and is not numbered; the first full day within the kuti, 17 November, is counted as day 1, and the day of exit, 31 December, is day 45. The total time spent within the kuti was 45 days, 3 hours and 10 minutes.

3.2 The Rasayana regimen

The subject had originally intended to take only milk during the regimen. A three-day trial of darkness undertaken at home during the preparatory period showed that she could not sustain this, rice being taken on the second day. On that basis the supervising physician judged that a milk-only regimen was beyond her capacity and prescribed rice soup with cherupayar thoran as the diet within the kuti.

While the attempts at final evacuation with Haritakyadi were still under way, the subject took rice soup with cherupayar thoran. After the third and last of those attempts, on day 2, yava gruel was taken for three days [12], on days 2, 3 and 4; it was initially difficult to digest, which resolved with thorough mastication. The Rasayana was begun on day 5 (21 November), once the three days of yava had been completed.

Amalaki Rasayana was compounded by the supervising physician following the formulation given in the Charaka Samhita [13] and was taken on an empty stomach. The initial dose of 30 g was raised to 50 g from the third day of administration on assessment of the subject's digestive capacity as strong, and was thereafter taken twice daily with 300 ml of milk on each occasion, a total daily intake of 100 g with 600 ml of milk.

Metallic preparations. Six preparations were taken in a single administration at 06:00 with honey. Makaradhwaja, Chaturmukha Rasa and Swarna Vasanta Malati Rasa were given as tablets of 125 mg each. Swarna, Rajata and Hiraka Bhasma were given as powders, applied to the tip of the index finger and rubbed beneath the tongue.

Table 3. Daily schedule within the kuti

Time	Administration
06:00	Six metallic preparations with honey
08:00	Amalaki Rasayana 50 g with milk 300 ml
10:30	Rice soup and cherupayar thoran
15:00	Amalaki Rasayana 50 g with milk 300 ml
19:30	Rice soup and cherupayar thoran

Both meals were identical and invariant. The rice soup consisted of rice boiled in water with a small quantity of salt; the cherupayar thoran was prepared from green gram with grated coconut, mild spices and coconut oil. No other food was taken between the beginning of the Rasayana and day 42, when the exit procedures began and the subject returned to the diet she had followed before entry.

The schedule was maintained without variation until day 32 (18 December), when saturation with the Amalaki Rasayana was identified and the supervising physician discontinued the afternoon dose, reducing the daily intake to 50 g with milk 300 ml. Saturation was recognised by a change in stool consistency: stools became very liquid, and this resolved on discontinuation of the afternoon dose, without recurrence over the remaining thirteen days at half the intake. Yoni Pichu soaked in Mahanarayana Taila continued to be inserted each evening throughout.

3.3 Adverse events

Table 4. Adverse events during the intervention

Day	Date	Event	Management	Outcome
13	29 Nov	Sciatic pain, first episode	Massage with olive oil containing thyme and oregano essential oils	Controlled over subsequent days
—	—	Sciatic pain, second episode, 2–3 days	Massage with Mahanarayana Taila; hot water bottle	Resolved
21–24	7–10 Dec	Burning and watering of the right eye	Triphala water, without effect; resolved after the floor was washed	Complete resolution within 2 h of washing
25	11 Dec	Menstruation 3 days early, with violent pain and diarrhoea; 7 liquid stools within 15 min; pain from 14:00 to 06:00, no sleep	Hot water bottle; Ashoka Arishtam	Resolved after approximately 16 h
from ~21	from 7 Dec	Circadian disruption: waking at 01:00, unable to sleep again until after 08:00; daytime sleep of approximately 12 h, maximum 18 h	—	Persisted beyond the intervention
—	—	Vaginal candidiasis	Yoni Pichu with neem oil containing a few drops of thyme essential oil, several applications	Resolved
throughout	—	Tendency to accumulate mucus in the sinuses	Thyme oil taken internally intermittently	Controlled
42	28 Dec	Sciatic pain, further episode, lasting the night	Massage with Mahanarayana Taila; hot water bottle	Resolved
43	29 Dec	Headache following excessive intake on resuming normal diet	Sadyo Vamana with water	Resolved

The ocular episode illustrates the difficulty of managing a complaint without examination. The cause was not initially apparent. The supervising physician recommended triphala water, which had no effect, and then requested to use a torch in order to inspect the eye, being unable to advise without knowing what he was treating. The subject considered that this would constitute an interruption of the therapy and did not agree. She then meditated with the intention of understanding the cause, and the possibility of a dust allergy occurred to her — a condition she had not previously experienced. The floor had not been washed since day 7, seventeen days earlier. She asked for water and a cloth, washed the floor thoroughly, and the eye recovered completely within two hours.

Cleaning carried out by an attendant had been deliberately excluded. Before entry the supervising physician had asked how it was to be handled, and the subject preferred that no one should enter for that purpose, since a person unfamiliar with the light protocol might expose her to light inadvertently. She had washed the floor herself on day 7, but in complete darkness there was nothing to indicate when it needed doing again, and after that it simply went out of her mind. Following the ocular episode she asked for water and a cloth every few days and washed the floor herself, and the complaint did not recur.

Sciatic pain recurred from day 13 to day 42 and was the only complaint to persist throughout. Confinement to a single room allows little walking and no variation of terrain or posture, and in the later weeks some twelve hours a day were spent asleep, lying down. The subject considers the sciatic episodes entirely preventable by a defined programme of movement within the chamber, and such a programme should form part of the regimen.

The sleep pattern itself changed early and did not recover. From approximately day 21 the subject woke at 01:00 and was unable to return to sleep until after 08:00, when the milk was taken. The deficit was made up during the day, amounting to some twelve hours of sleep in a typical day and, on one occasion, eighteen. The inversion persisted after exit and required Ashwagandha Arishta to correct.

The subject has since observed, outside the context of this intervention, that her sleep is disturbed when the evening meal has not been sufficiently satisfying. The evening meal within the kuti was rice soup with cherupayar thoran, taken at 19:30, with nothing thereafter until the following morning. It is therefore possible that the disturbance arose from the dietary regimen rather than from the conditions of the intervention alone, and the two cannot be separated in this account.

The headache on day 43 followed the reintroduction of normal food, which was resumed in a single step rather than in stages. After six weeks of light meals the subject overestimated her capacity and required Sadyo Vamana to resolve the symptoms.

The **two menstrual episodes** differed markedly. The first occurred in the first days after entry and was painless. The second, on day 25, was the most difficult episode of the intervention. The subject attributes the difference to the stress of prolonged darkness. Raised cortisol suppresses the hypothalamic-pituitary-gonadal axis, reducing ovarian progesterone output [14]. Cortisol also binds the progesterone receptor, the two receptors belonging to the same nuclear receptor subfamily and sharing closely homologous ligand-binding domains [15], so that the effect of a given progesterone concentration may be altered under sustained hypercortisolism.

Progesterone restrains endometrial prostaglandin production, and prostaglandins are the principal mediators of the uterine contractions that produce menstrual pain; a reduction in progesterone activity would therefore be expected to increase prostaglandins and therefore the pain [16].

An episode of **vaginal candidiasis** occurred during the intervention and resolved after several applications of a Yoni Pichu of neem oil to which a few drops of thyme essential oil had been added.

3.4 Perceptual phenomena, orientation and dream content

Visual phenomena. These began soon after the onset of total darkness and persisted throughout. They took two forms. The first was flickering light. The second was the perception of walls and surfaces that were not there, appearing in front of the subject or above her. The subject describes the experience as the perception of a parallel space, and reports frequently reaching out to verify by touch that no wall lay in the path. Visual phenomena of this kind are documented in sighted subjects under prolonged blindfolding [17].

Insight was fully retained. The subject was aware at all times that the percepts were generated internally in compensation for the absence of visual input, remained oriented to the actual configuration of the room, and took care to avoid collision with real surfaces. She reports no distress and no disruption of concentration.

Orientation. Orientation to time and place was not only preserved but, by the subject's account, better than under ordinary conditions. Time was known continuously by means of the tactile watch. Spatial orientation was maintained without any aid: the subject knew at all times the position of every one of her possessions within the chamber, and describes this degree of spatial memory as exceeding her ordinary capacity. Across 45 days she records two or three occasions in total on which her estimate of her own position within the room was mistaken, by approximately two paces.

This heightened awareness of where her possessions were did not persist after exit; its loss was immediate, the subject recording being unable to find her headphones shortly after emerging.

Dream content. The subject reports a dream occurring on one night during the intervention which produced a distinct and lasting psychological state. She found herself in a place composed entirely of water, containing rounded structures resembling hemispheres formed of water, each surrounded by smaller water spheres arranged as satellites in a highly ordered and aesthetically striking pattern. She then experienced rapid upward movement, ascending until she reached white clouds, and on emerging above them found further structures of the same watery composition, but in the form of pyramids.

3.5 Occupation of time

No fixed programme of practice was adopted. Asanas predominated in the earlier part of the period and pranayama in the later, with meditation daily for at least one and a half hours throughout. The subject reports being absorbed into a meditative state shortly after entry, persisting almost continuously until exit. Other activities included dancing without music, the mental replaying of songs from memory, and daily writing.

3.6 Communication and the maintenance of darkness

Meal delivery followed a protocol established before the intervention began, and its purpose was to keep the chamber lightless while the door was open. The door gives onto the second corridor, which is itself dark, so what passed through it was not daylight but the small residue of light that had already crossed two enclosures — nothing an attendant coming from outside would register, but perceptible to a fully dark-adapted eye. Having resided in the kuti during the preceding days, the subject had already observed this residual light for herself, and the procedure was in place from the first delivery.

The attendant telephoned before approaching, at which signal the subject withdrew into the bathroom and closed the door behind her. The attendant entered, closed the door of the innermost chamber behind him and placed the meal; the subject emerged to communicate any request, then withdrew again so that the attendant could leave. The bathroom is in the far corner of the chamber, diagonally opposite the door. Withdrawing into it placed both distance and a wall between the subject and the opening.

3.7 Supervision

The supervising physician visited daily to assess the subject's mental state. At a point during the intervention the subject asked

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that these visits be suspended, for reasons arising outside the regimen and unrelated to her condition or to the conditions of isolation. Observation was maintained throughout by indirect means, the physician questioning the attendant in detail after each delivery. Direct supervision was resumed at the subject's own request, before the end of the intervention.

The sequence documents a situation absent from existing descriptions of the regimen: that direct supervisory contact may be interrupted mid-course, and that a means of continuing observation by another route is therefore necessary rather than optional. Control over direct contact rested with the subject throughout, and the physician neither forced contact nor withdrew from observation.

3.8 Graduated exit

The three-day trial of darkness undertaken in the preparatory period, mentioned in 5.2, had a second consequence. Re-exposure on that occasion was carried out over thirty minutes of semi-darkness followed directly by daylight, after which, for a day, her vision would not focus properly and she could not judge distances accurately. It was on account of this experience that she asked for the final exit from the kuti to be timed for the evening rather than during the day.

Re-exposure was carried out in four stages over the final four days.

Day 42 (28 December). The cloth was removed from the windows of the innermost chamber, admitting the small amount of light that had traversed the outer two layers. The subject perceived the outlines of the windows for the first time in six weeks.

Normal food was resumed on the same day, according to the diet followed before entry. Unlike the re-exposure to light, the return to diet was made in a single step rather than in stages.

Day 43 (29 December). The subject passed for the first time into the first intervening layer. She describes the light as blinding, experienced acute dizziness, and had to be supported by the supervising physician to avoid falling. She then broke into heavy, uncontrollable crying, describing the response as involuntary and necessary. The light she experienced as blinding was in fact very dim, and insufficient for her to distinguish colour.

In the evening of this day the subject ate more than her digestion could accommodate and developed a headache, which resolved after Sadyo Vamana with water.

Day 44 (30 December). The subject reached the second intervening layer and looked out at the exterior. The emotional response was markedly less intense. This was the first light sufficient to allow colour to be distinguished, and the supervising physician had brought a small purple flower, knowing this to be her preferred colour, so that it would be the first colour she saw.

Day 45 (31 December). Final exit at 18:37. The first act on emerging was to feed a banana to a cow, performed at the supervising physician's direction as a ritual observance marking the completion of the regimen.

Each stage of re-exposure corresponded to the crossing of one layer of the Trigarbha configuration, so that the increments of illumination were determined by the architecture rather than chosen arbitrarily. The structure that had extinguished the light in stages returned it in stages. The staging appears to have been adequate: the subject reported complete comfort on emerging and required no dark glasses at any point. The evening of exit coincided with a New Year celebration, at which she danced until midnight and then listened to music through headphones until morning without sleeping.

4. Follow-up

Immediate aftermath. The circadian disruption established within the kuti persisted after exit. In the days immediately following, the subject slept neither at night nor during the day. On the third day, counting the day of exit as the first, she took 30 ml of Ashwagandha Arishta, which produced approximately five hours of sleep per night. The arishta was continued for several days and an ordinary sleep pattern returned.

The heightened perceptual clarity described after the Vamana of 3 July did not persist. It diminished gradually over the weeks

following exit and returned to the subject's ordinary baseline.

A durable change in relation to darkness. One change has persisted to the time of writing. The subject sleeps at night only in complete darkness, and sleeps poorly if any light is present, including diffuse light. Entering complete darkness now reliably produces the meditative state she describes from within the kuti, and access to that state is markedly easier than before the intervention.

Observations at ten years. The following are recorded as observations, without any claim of attribution. The subject has followed a Rasayana dietary regimen continuously from 2010 to the present, and has undergone Panchakarma annually from 2008 to the present. Metallic preparations were taken daily from 2008 until 2023, with a one-year interruption in 2020. Kutipraveshika Rasayana was 45 days within that period, and nothing below can be assigned to it rather than to the rest.

At 42 years of age, and despite habitual screen exposure of eight to ten hours daily, ophthalmological examination in 2026 showed no reduction in visual acuity. Hair remains dark, with approximately ten white hairs, and has retained its density and length; no colouring is used. There are no visible facial wrinkles.

Anti-Müllerian hormone measured in June 2023, at 39 years of age, was 2.38 ng/mL, above the 75th percentile of 1.6 ng/mL reported for that age in a cohort of 22,920 women, in which the median was 0.7 ng/mL [18].

No new dental caries have appeared since 2010; dental work in the intervening years has been confined to the replacement of fillings placed before that date.

The subject is not able to compare her present memory with her memory before the intervention, the demands on it having changed substantially in the intervening years. One indication of present capacity, however, is available: she attained B2 level in Hindi in an estimated two and a half years of cumulative study, undertaken in adulthood and spread over a longer period with intervals of no study.

Dysmenorrhea. The dysmenorrhea was unchanged by the intervention, and had never been an objective of it. It was addressed during the preparatory phase — by the Basti series, and by nightly pichu — for a single practical reason: pain of that severity would have been very difficult to manage in isolation, without examination and without the possibility of leaving. The aim was tolerability, not cure.

The result within the kuti was mixed. The first menstruation, in the first days after entry, was painless; the second, on day 25, was the most severe episode of the entire 45 days. At the end of the intervention the condition stood where it had stood at the beginning. It was resolved in 2021, by a protocol directed at hormonal balance which the author has reported separately [1].

Metallic preparations and a renal episode. Metallic preparations were continued after exit until 2020, discontinued for one year, resumed until 2023 and then stopped entirely. Outside the intervention the preparations taken continuously were Rajata, Praval, Abhraka, Loha and Yashada Bhasma, together with Makaradhwaja. Swarna and Hiraka Bhasma were taken intermittently.

In 2023, routine annual testing showed serum creatinine raised to 1.2 mg/dL, and ultrasonography reported the right kidney as having the appearance of chronic disease. Serum mercury measured at that point was 0.47 µg/L, against a laboratory upper reference limit of 10 µg/L. Metallic preparations were discontinued. Following Panchakarma and Ayurvedic treatment, renal function returned to normal and the ultrasonographic appearance resolved.

Concern regarding heavy metal content in rasa shastra preparations is well established [19]. In this case no causal relationship was established between the metallic preparations and the renal findings, and the serum mercury measurement does not support one. The episode is reported because a reader encountering fifteen years of bhasma administration will reasonably ask

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what was observed, and because the answer — a transient abnormality, a normal heavy metal result, and full resolution — is more informative than silence.

Subsequent practice. The subject has not repeated Kutipraveshika Rasayana, though she intends to undertake it again. She entered it during a period of considerable emotional difficulty, and one of her reasons was the hope that prolonged isolation and meditative absorption would resolve the relational distress she was then experiencing. In retrospect she considers that what she needed was a capacity for relational self-regulation, which lies outside what the regimen addresses and which she subsequently acquired through psychotherapy. She regards the intervention itself as among the most valuable experiences of her life and would repeat it.

The distinction is worth recording. A regimen of this kind may be undertaken in the expectation that withdrawal and inward absorption will resolve a difficulty of a different order. The regimen delivered what was asked of it; the difficulty required something else.

What would be done differently. Asked what she would change, the subject identifies two things. A defined programme of movement within the chamber would be introduced, to prevent the recurrent sciatic pain. The quantity of the evening meal would be increased, or the dietary schedule otherwise adjusted, with the object of preserving nocturnal sleep.

Discussion

1. The Trigarbha Kuti as an optical device

The Trigarbha configuration functions as an optical system, not merely as thermal, acoustic and social isolation. The vertical positions of the openings — shoulder height, floor level, top of wall across the three layers — combined with the horizontal offsetting of the doorways, do not attenuate light in stages but terminate its path. The mechanism is embodied in the design and was evidently understood by those who built it, though it does not appear to have been previously described [20].

The residual points of light in the roof structure could not be found by inspection. They were invisible to anyone entering from daylight, and became perceptible only after several hours of dark adaptation. The points were not all apparent at once, and were identified progressively over several days, the staff covering each as it was reported. Verification of light-proofing cannot be carried out by an observer entering from outside. It can only be done by a dark-adapted occupant, and time must be allowed for it before the regimen begins.

A further consequence concerns re-exposure. The graduated exit followed the layers of the building, and the increments of illumination were therefore determined by the architecture. The same geometry that extinguishes light in stages returns it in stages, and the structure is a device for controlled re-exposure as much as for exclusion. The absence of photophobia on emergence, and the fact that no dark glasses were required, suggests that the staging the building imposes is adequate.

The mechanism proposed here is an interpretation of geometry, not a measurement. It could be confirmed by measuring the light reaching each of the three enclosures at intervals through a full day.

2. Response to evacuant preparations

Three administrations of Haritakyadi, including one at a dose exceeding the customary quantity by a third, produced almost no purgative effect. The supervising physician attributed this to the strength of the subject's Agni. The converse observation is available in the same subject. At the Virechana of March 2016, which was later disregarded for the purposes of this preparation, Agni was strong and three quarters of half a tablet of Icchabhedi Rasa produced 7 vega. In July, after three courses of Snehapana within four months had left Agni low, a half tablet produced 30 vega. Agni thus varied across the preparatory period: strong in March, depressed by repeated Snehapana in July, and restored by November, when the evacuant failed.

These observations suggest that in a subject with strong Agni and an extensive history of Shodhana, an evacuant may simply fail to act. The explanation offered by the supervising physician is that a strong digestive capacity breaks the preparation down before it can produce its effect. On this account, giving more of it does not help: the additional quantity is digested along with the rest. What may matter instead is when the preparation is given — that is, whether Agni is high or low at that moment.

3. Saturation with Amalaki Rasayana

Saturation was identified on day 32 by a change in stool consistency, which resolved on discontinuation of the afternoon dose and did not recur over the remaining thirteen days at half the intake. This appears to be the only reported criterion for dose adjustment of Amalaki Rasayana during Kutipraveshika. The classical texts specify what is administered and for how long, but not how the occupant is to recognise that the dose has become excessive. A single case cannot establish a general criterion, but it identifies a candidate one.

4. Complications arising from the conditions

Several of the complications recorded are attributable to the conditions of the regimen rather than to any preparation administered. Recurrent sciatic pain should be regarded as a foreseeable feature of a residential regimen of this length, and a defined programme of movement within the chamber should be built into the daily routine.

The ocular complaint followed seventeen days without cleaning. Cleaning done by an attendant had been deliberately excluded before entry, since admitting someone unfamiliar with the light protocol carried its own risk, and in darkness nothing indicates that cleaning is needed. A protocol should therefore state how often the floor is to be cleaned and by what arrangement — by the occupant, with materials supplied on request, or by an attendant trained in the light protocol.

Reintroduction of ordinary food requires the same care as the reintroduction of light: after six weeks of light meals the subject overestimated her capacity on the second day of normal diet and required Sadyo Vamana, and a graded return to diet should be specified alongside the graded return to light.

5. Supervision and practical arrangements

Beyond the complications described above, the regimen imposes a limit of a different kind: there are things the occupant cannot do for herself. Over 45 days the subject managed a recurrent musculoskeletal complaint, an ocular complaint, a genital infection and a severe dysmenorrheic episode without any of them being seen. The supervising physician advised throughout and supplied what was needed. What could not be supplied was examination: assessment depended entirely on what the subject was able to report, and administration on what she could do for herself in the dark. When the physician judged that he could not advise without inspecting the eye, doing so would have required a light, and therefore an interruption of the therapy. Any protocol for Kutipraveshika should state in advance the threshold at which isolation is to be interrupted for examination, the means by which that decision is reached, and who holds it.

Two further arrangements proved necessary and are worth recording. Observation was maintained through the attendant when direct contact was suspended, and meal delivery followed a procedure by which the subject withdrew into the bathroom whenever the door was to be opened. The second of these was possible only because the subject had lived in the kuti during the preceding days and had noticed that residual light entered when the door was opened. A period of residence before entry, long enough for the occupant to become dark-adapted and to identify what needs sealing and what arrangements need to be made, should be treated as part of the protocol rather than as preparation for it.

A short trial of darkness before the full regimen would be worth adopting as standard. In this case a three-day trial undertaken months in advance established

two things that could not have been known otherwise. The first was that the dietary regimen the subject had intended was beyond her capacity, which allowed it to be changed before entry rather than during the intervention. The second concerned the exit: the trial showed how much light a dark-adapted eye can tolerate, and without it the subject would probably not have thought to ask that the final exit be timed for the evening.

6. Circadian disruption

Total darkness removes the principal external signal by which the internal clock is set to the solar day [21]. Without it the clock continues to run but is no longer anchored, and drifts, which is consistent with what the subject describes. The classical prescription is for subdued light rather than darkness, and subdued light in a structure with mesh openings varies through the day, preserving a weak but real signal; total darkness removes it.

Total darkness is therefore not simply a stronger version of the classical regimen but a different condition. Subdued light isolates the occupant while leaving the daily cycle intact; total darkness isolates the occupant from the cycle as well.

A dietary explanation for the circadian disruption cannot be excluded. The subject has since observed that her sleep is disturbed when the evening meal is insufficient, and the evening meal within the kuti was light and taken early. Darkness and diet changed together, and this account cannot separate them.

7. Perceptual phenomena and orientation

Formed and unformed visual percepts under conditions of visual deprivation are well described and are not in themselves indicative of pathology. What is notable here is the combination of duration, completeness of light exclusion and full preservation of insight across 45 days.

Alongside these phenomena, orientation was reportedly enhanced rather than impaired. The pairing is worth stating plainly, because the two findings might be expected to conflict. The subject's own explanation is that the two are connected: the presence of convincing false percepts required continuous and deliberate attention to the distinction between what was seen and what was actually there, and it was this sustained discrimination that kept her spatial representation sharp. On this account the heightened orientation was not incidental to the visual phenomena but a response to them. Such phenomena place a continuous demand on the occupant, who must hold the distinction between percept and environment without any external means of verification, and must do so for weeks. The subject's composure in the face of these phenomena is likely to owe something to seventeen years of predominantly meditative yoga practice and to her professional training, and should not be assumed to generalise.

8. Limitations

This report describes a single case, in which the author is also the subject, and every observation is self-reported. No objective measurement was obtained, and no efficacy outcome was defined or is claimed. The centre maintained its own records; access to them was not requested. The article was written retrospectively, but the journal on which it is based was kept at the time.

At the time of entry into the kuti, the subject had undergone at least one major Panchakarma procedure annually for eight years, had taken metallic bhasmas daily throughout that period, and had followed a restrictive dietary regimen for six years. She also had seventeen years of predominantly meditative yoga practice and four years of personal psychotherapy behind her. The observations reported here may not hold for a subject without such preparation.

The intervention as performed departs from the classical prescription in three respects: total darkness in place of subdued light, daily washing with warm water, and the continuation of metallic preparations alongside the Rasayana. It is reported as performed rather than as prescribed. Body weight fell from 54 kg to 52 kg across the intervention, but the diet within the kuti differed entirely in composition and variety from the subject's habitual regimen and was

accompanied by greatly reduced activity, so no inference regarding the Rasayana is available.

The classical description of the kuti includes the stipulation that no woman should enter it [22], a provision framed for a male occupant. The regimen described here was undertaken by a woman, and the two menstrual episodes recorded within the kuti, one asymptomatic and one severe, have no counterpart in the classical texts. Nothing in the texts addresses how menstruation is to be managed in isolation, and this report offers the only observations the author is aware of.

9. Further work

Photometric characterisation of a Trigarbha Kuti — illuminance measured at each layer across a full diurnal cycle — would test the mechanism proposed here directly and requires no human subject.

Prospective documentation of a supervised intervention with baseline and endpoint measurement would address the principal gap: anthropometry, full blood count, metabolic and inflammatory markers, hepatic and renal function, and heavy metal estimation before and after. Actigraphy would characterise the circadian disruption at negligible cost and without interrupting the regimen. Systematic documentation of the regimen as performed in women of reproductive age is also needed, a question the author has not found addressed in the classical or modern literature.

Conclusion

Kutipraveshika Rasayana can be delivered under contemporary conditions. This account demonstrates that a 45-day regimen, preceded by a full course of preparatory purification, is practicable in a purpose-built Trigarbha Kuti with a single supervising physician and an attendant, and that it was completed without serious adverse event.

The following findings are offered for use. The Trigarbha configuration appears to function as an optical device, excluding light through the vertical arrangement of its openings and the horizontal offsetting of its doorways, and the same geometry provides a staged route for re-exposure at the end of the regimen. Saturation with Amalaki Rasayana was recognisable by a change in stool consistency. Several of the complications encountered arose from the conditions of confinement and darkness rather than from any preparation, and are preventable by provisions that are currently absent from published descriptions of the regimen.

What this report cannot offer is evidence of effect. No efficacy outcome was defined, the physicians at the centre having concluded before entry that no measurable rejuvenative benefit was to be expected in this subject, and no objective measurement was therefore made. Nor has any prospective study with objective outcome measurement been undertaken in other subjects, so that the effects the classical literature attributes to the regimen await measurement. This account is intended as a foundation for such work rather than a substitute for it.

Declarations

Consent. The author is the subject of this report and has provided written consent for publication.

Ethical approval. The intervention was not conducted as research and was not designed as a study. This report is a retrospective account of a therapeutic engagement undertaken by the author on her own behalf.

Conflict of interest. The author is both the author and the subject of this report, and all observations are self-reported. No financial conflict of interest is declared.

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