

Integrative Ayurveda Management of Steroid-Dependent Chronic Exudative Eczema: A Case Report

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Abstract

Introduction: Chronic exudative eczema is a relapsing inflammatory dermatosis characterized by epidermal barrier dysfunction, immune dysregulation, intense pruritus, vesiculation, and serous discharge. Misdiagnosis, particularly as psoriasis, may result in prolonged corticosteroid use, steroid dependence, and recurrent exacerbations.

Aim: To evaluate the effectiveness of an integrative Ayurveda management approach in a case of steroid-dependent chronic exudative eczema (Vicharchika) and to highlight the importance of accurate differential diagnosis.

Methods: A 13-year-old female with a six-year history of recurrent pruritic, oozing skin lesions, previously diagnosed as psoriasis and treated intermittently with topical corticosteroids, was assessed clinically. Based on detailed evaluation, psoriasis and xeroderma were excluded, and a diagnosis of chronic exudative eczema was established. Ayurveda assessment correlated the condition with Vicharchika, characterized by predominant inflammatory and exudative features. The patient was managed with an integrative Ayurveda treatment protocol focusing on blood purification, metabolic correction, anti-inflammatory action, and topical wound-healing therapy.

Conclusion: The patient showed marked clinical improvement, with approximately 70% reduction in pruritus and exudation within 14 days, followed by sustained recovery over a four-month follow-up period without corticosteroid use. This case highlights the importance of accurate differential diagnosis, particularly in steroid-dependent dermatoses initially misdiagnosed as psoriasis, and demonstrates the potential of samprapti-based integrative Ayurveda management in achieving sustained steroid-free recovery.

Keywords: Chronic exudative eczema, Steroid dependent dermatosis, Vicharchika, Integrative medicine, Pruritus, Ayurveda management

Abbreviations: BMI – Body Mass Index, BD – Twice daily, HS – At bedtime, GMP – Good Manufacturing Practice, WFO – World Flora Online.

1. Introduction

Chronic eczema, commonly included within the atopic dermatitis spectrum, is a multifactorial inflammatory dermatosis characterized by epidermal barrier dysfunction and immune dysregulation. Impaired filaggrin expression leads to increased transepidermal water loss (TEWL), facilitating allergen penetration and microbial colonization, thereby perpetuating chronic inflammation. Clinically, acute lesions present with erythema, vesiculation, and serous exudation, whereas chronic lesions exhibit lichenification due to persistent scratching. Topical corticosteroids remain the mainstay of conventional management; however, prolonged or inappropriate use may result in steroid dependence, rebound flares, and diagnostic masking, often complicating disease course and management outcomes. Psoriasis, a Th1/Th17-mediated hyperproliferative disorder, is an important differential diagnosis and typically presents with well-demarcated erythematous plaques and silvery scaling, with minimal exudation features that help distinguish it from exudative eczema [1].

In Ayurveda, dermatological conditions are described under Kushta [2], with Vicharchika [3] (a subtype of Kshudra Kushta) showing close clinical resemblance to chronic eczema. It is characterized by kandu (intense itching), srava (discharge), pidaka (eruptions), discoloration, and dryness. The predominance of exudation (srava) differentiates it from other conditions such as Eka Kushtha [4] and Kitibha Kushtha [5], which are primarily dry and scaling in nature. Chronicity is often associated with involvement of Rakta dhatu (blood tissue) and multiple doshas. Given the challenges of misdiagnosis, steroid dependence, and recurrent disease, there is a need to explore integrative and pathogenesis-based approaches. This case report highlights the role of Ayurveda management in a steroid-dependent chronic exudative eczema case, emphasizing accurate diagnosis and individualized therapeutic intervention.

2. Patient Information

A 13 year old female presented with a six year history of recurrent dermatological complaints characterized by severe pruritus, burning sensation, profuse watery exudation, and intermittent foul odor. The patient first presented to the outpatient department in October 2025 and was subsequently followed up regularly for four months (November 2025 to February 2026). The patient also reported occasional bleeding following scratching. The condition had an insidious onset with a relapsing course and periodic exacerbations. She had previously been diagnosed with psoriasis at a tertiary care center and was treated intermittently with topical corticosteroids, which provided temporary symptomatic relief; however, lesions recurred upon discontinuation, suggestive of steroid dependence. There was no history suggestive of hereditary xerotic disorders, atopy, or any known systemic illness. Dietary history revealed frequent consumption of non-vegetarian food, particularly fish and chicken multiple times per week. Additionally, the patient reported a long-standing habit of consuming milk with banana. From an Ayurveda perspective, such dietary patterns are considered incompatible (Viruddha Ahara) and may contribute to disease chronicity. The patient had discontinued the use of topical corticosteroids prior to initiation of Ayurveda treatment and did not use them during the course of therapy.

3. Clinical findings

The patient weighed 42.3 kg and had a height of 148 cm, with a body mass index (BMI) of 19.3 kg/m², which falls within the normal range. General physical examination revealed no pallor, icterus, cyanosis, clubbing, lymphadenopathy, or edema. Vital parameters were within normal limits. Systemic examination did not reveal any abnormalities.

3.1 Ayurveda clinical assessment

3.1.1 Ashtavidha Pariksha [6] (Eight-fold examination of the patient)

The Ayurveda examination revealed a Pitta-predominant Nadi (pulse). Mala and Mutrapravritti (bowel and bladder habits) were normal. The Jihva (tongue) was prakrita (normal), and Shabda (speech/voice) was clear. Sparsha (tactile sensation) was Ushna (warm). Drika (vision) was normal, and overall body build (Akriti) was moderate (madhyama).

3.1.2 Dashavidha Pariksha [7] (Ten-fold of examination)

The patient's Prakriti (constitution) was Pitta-Kaphaja, while the current disease state (Vikriti) was Tridoshaja. Sara (tissue excellence) was Mamsasara (muscle predominance). Samhanana (body compactness) was moderate (madhyama). Satmya (adaptability) was good (pravara), and Satva (psychological strength) was moderate. Aharashakti (digestive capacity) and Vyayamashakti (exercise tolerance) were both moderate. The patient belonged to Balavastha (adolescent age group), with overall strength (Bala) assessed as moderate.

3.2 Dermatological Examination

Cutaneous examination revealed multiple ill-defined, erythematous, inflamed plaques distributed extensively over the body, involving both upper and lower limbs as well as the trunk. The lesions were characterized by profuse serous discharge, excoriations, and areas of crusting, with active oozing observed at several sites. Associated features included scaling, fissuring in some areas, and secondary changes due to persistent scratching. The surrounding skin appeared inflamed with mild discoloration. The patient exhibited marked hypersensitivity of the lesions, reporting exacerbation of itching and irritation even with minimal external stimuli such as air exposure or light touch. Due to severe pruritus and discomfort, the patient preferred to keep the affected areas covered with a blanket and avoided exposure during examination. No classical features of psoriasis, such as well-demarcated plaques or silvery scaling, were observed (Figure 1).

4. Ayurveda Samprapti [8] (Pathogenesis)

According to Ayurveda principles, the chronic consumption of incompatible dietary combinations (Viruddha Ahara) leads to impairment of digestive metabolism (Agni mandya), resulting in the formation of Ama (metabolic toxins). The accumulation of Ama contributes to the aggravation of Kapha and Pitta doshas, along with vitiation of Raktadhatu, thereby initiating and sustaining inflammatory processes. Aggravated Pitta is responsible for features such as burning sensation (daha), erythema, and inflammation, while vitiated Rakta contributes to chronicity, discoloration, and persistent lesions. The predominance of Kapha manifests as excessive exudation (srava), whereas associated Vata involvement (anubandha) contributes to fissuring and bleeding due to tissue

dryness and instability. From an integrative perspective, prolonged corticosteroid use may suppress local inflammatory manifestations without addressing the underlying metabolic imbalance (Ama) and Rakta pathology, potentially leading to recurrence upon withdrawal. Thus, the overall pathogenesis in this case can be understood as Kapha-Pitta predominant Vicharchika with Raktadushti and Vataanubandha.

5. Diagnostic assessment and differential diagnosis

A detailed differential diagnosis was performed to distinguish chronic exudative eczema from other clinically overlapping dermatological conditions such as psoriasis and xeroderma (Table 1).

Table1. Comparative clinical features of chronic exudative eczema, psoriasis, and xeroderma

Sr. No.	Clinical Parameter	Chronic Exudative Eczema [9]	Psoriasis [10]	Xeroderma [11]
1.	Nature of Lesion	Inflammatory, oozing dermatitis	Hyperproliferative plaque disorder	Dry skin disorder
2.	Exudation	Profuse watery serous discharge	Minimal or absent	Absent
3.	Pruritus	Severe and persistent	Moderate to variable	Mild
4.	Lesion Margin	Ill-defined inflammatory patches	Sharply demarcated plaques	Diffuse dryness
5.	Scaling Pattern	Non-classical scaling with exudation	Thick silvery micaceous scales	Fine dry scaling
6.	Burning Sensation	Frequently present	Occasionally present	Usually, absent
7.	Foul Odor	Intermittent due to secondary colonization	Rare	Absent
8.	Bleeding	Due to scratching and excoriation	Pinpoint bleeding (Auspitz sign)	Absent
9.	Vesiculation	May be present in active stage	Rare	Absent
10.	Disease Course	Relapsing inflammatory dermatitis	Chronic immune-mediated disorder	Persistent dryness without inflammation

6. Interpretation

Based on the clinical findings, the presence of profuse watery serous discharge (a hallmark of spongiotic dermatitis), severe persistent pruritus, and burning sensation indicated an active inflammatory process. The occurrence of excoriative bleeding secondary to scratching, along with ill-defined inflammatory plaques rather than sharply demarcated lesions, further supported this diagnosis. Additionally, intermittent foul odor suggested secondary microbial colonization. These findings were inconsistent with psoriasis, which typically presents with well-demarcated plaques and minimal exudation, and xeroderma, which is characterized by generalized dryness without significant inflammation or discharge. No histopathological examination was performed due to financial and practical constraints, as the diagnosis was established clinically based on characteristic dermatological findings, disease course, and differential assessment.

7. Final Diagnosis

Chronic exudative eczema (spongiotic dermatitis), correlated with Vicharchika (Kapha-Pitta predominant with Rakta dushti and Vataanubandha).

8. Therapeutic Intervention

A conservative Ayurveda management approach was adopted using a multi-component therapeutic regimen tailored to the underlying samprapti (pathogenesis). The treatment aimed at correction of impaired metabolism (Agni), elimination of metabolic toxins (Ama), purification of blood (Rakta shodhana), and pacification of aggravated Kapha and Pitta doshas, along with promotion of tissue healing. The patient was prescribed classical Ayurveda formulations including Kanchanara Guggulu, Arogyavardhini Vati, Kaishora Guggulu, Panchanimbadi Churnam, Kamadudha Rasa, Sutashekhara Rasa, Khadirarishta, Manjishthadi Kwatham, Pathyadi Kwatham, and Haridra Khanda. External application of Kushtharakshasa Tailam was advised over affected areas. All medications

were procured from certified Good Manufacturing Practice (GMP)-compliant pharmaceutical manufacturers in India. The formulations were administered in standard therapeutic dosages under regular clinical supervision, and no quality-related concerns were reported during the treatment period. The detailed treatment protocol, including dosage, frequency, duration, and clinical response, is summarized in Table 2.

Table 2. Therapeutic interventions and clinical observations

Name of Medicine	Reference	Form	Dose	Frequency	Time	Duration	Rationale
[a] Kanchanara Guggulu	[12]	Tablet	500mg	BD	After food	4 months	Kapha-Pitta shamana, anti-inflammatory
Arogyavardhini Vati	[13]	Tablet	500mg	BD	After food		Metabolic correction, Deepana-Pachana
Kaishora Guggulu	[14]	Tablet	500mg	BD	After food		Raktashodhana, anti-inflammatory
Panchanimba di Churnam	[15]	Powder	5gm	BD	After food		Detoxification, antimicrobial
[b] Kamadudha Rasa	[16]	Tablet	250mg	BD	After food	4 months	Pitta shamana, reduces burning
Sutashekhara Rasa	[17]	Tablet	250mg	BD	After food		Pitta regulation, digestive balance
[c] Khadirarishta	[18]	Liquid	10ml	BD	After food	4 months	Blood purification, skin disorders
Manjishthadi Kwatham	[19]						Anti-inflammatory, Raktashodhana
[d]		Liquid	10ml	BD	Before food	4 months	
Pathyadi Kwatham	[20]						Mild detoxification (Mriduvirechana)
[e] HaridraKhand a	[21]	Powder	5gm	OD	At bedtime	4 months	Antipruritic, anti-allergic
[f] Kushtharaksha Tailam	[22]	Oil	Q.S.	BD	External application	4 months	Wound healing, anti-inflammatory
Follow-up							
Period	Treatment Protocol			Observation			

After 1 month	Same treatment continued	Reduction in itching and burning sensation
After 2 months	Same treatment continued	Significant reduction in watery discharge
After 4 months	Same treatment continued	Marked improvement in lesions, scaling, and skin integrity

9. Follow up and outcome

The patient was followed up regularly from October 2025 to February 2026, with progressive clinical improvement observed following initiation of therapy (Figure 1). Early clinical improvement was observed within 14 days of treatment, followed by progressive improvement at 1, 2, and 4 months. After 14 days, the patient reported a marked reduction in itching and burning sensation. This improvement was also reflected by reduction in pruritus severity on the Visual Analog Scale (VAS). By the second month, a significant decrease in serous discharge was observed. Continued therapy led to further improvement, and by the fourth month, there was substantial reduction in lesion size, scaling, and exudation, along with restoration of skin integrity. No adverse events were reported during the treatment period. Importantly, the patient did not require further corticosteroid therapy, indicating sustained improvement without steroid dependence. Additionally, the patient reported improvement in overall well-being, including better scalp condition and psychological comfort (Table 3). No relapse was observed during the follow-up period, and the patient continues to remain under regular follow-up.

Table 3. Clinical outcomes over time

Sr. No.	Clinical Parameter	Baseline (October 2025)	After Treatment (December 2025)	Follow-up (February 2026)
1.	Pruritus (Itching)	Severe persistent itching	Marked reduction (~70%)	Minimal itching
2.	Serous exudation	Profuse watery discharge	Significant reduction	Nearly absent
3.	Burning sensation	Prominent burning sensation	Mild burning	Resolved
4.	Scaling	Active scaling with inflammation	Reduced scaling	Mild residual dryness
5.	Bleeding/excoriation	Present due to scratching	Rare episodes	Absent
6.	Lesion size	Diffuse inflammatory plaques	Noticeable contraction	Marked lesion reduction
7.	Skin integrity	Inflamed and fragile	Healing phase initiated	Improved skin texture
8.	Steroid dependence	Required intermittent corticosteroids	No steroid use	Sustained improvement without steroids
9.	Pruritus severity (VAS 0–10)	9/10	4/10	2/10
10.	Sleep disturbance due to itching	Severe	Moderate improvement	Minimal

	Before treatment	After treatment	
Facial lesions			
	[A1]	[A2]	[A3]
Hand lesions			
	[B1]	[B2]	[B3]
Lower limb lesions			

	[C1]	[C2]	[C3]
	Baseline (Day 0) showing extensive erythematous, exudative lesions.	After 2 months of treatment showing reduction in discharge and inflammation.	After 4 months showing marked improvement with reduced lesion size and restoration of skin integrity.

Fig. 1. Clinical progression of lesions before and after treatment

9.1 Safety Assessment

No adverse drug reactions, gastrointestinal intolerance, systemic complications, or treatment-related worsening of symptoms were observed during the treatment and follow-up period. The patient tolerated the prescribed formulations well throughout therapy, and no clinical evidence of hepatic, renal, or systemic toxicity was noted during regular follow-up visits.

10. Rationale and Components of the Therapeutic Intervention

The therapeutic approach comprised internal medications, external management of lesions, and regulated dietary and lifestyle modifications. The selection of interventions was based on the underlying samprapti, aiming to achieve dosha pacification (primarily Vata-Pitta shamana and Kaphahara), Raktaprasadana (blood purification), and correction of metabolic imbalance associated with Viruddha Ahara [23]. Internal medications were employed to restore systemic homeostasis through Agni deepana, Ama pachana [24], and anti-inflammatory actions, thereby addressing the root cause of the disease. Following adequate cleansing of lesions, Rasayana [3] therapy was incorporated to promote tissue nourishment, enhance Ojas [25], and support sustained healing. External management focused on alleviating pruritus and burning sensation, followed by healing-oriented interventions (Ropana Chikitsa) using medicated oils. Gradual removal of keratinized tissue facilitated epithelialization, while gentle cleansing measures helped maintain moisture balance. Exposure to irritants was strictly avoided. Dietary and lifestyle modifications (Pathya-Apathya) formed an integral component of the treatment protocol [26]. Incompatible dietary practices (Viruddha Ahara), particularly the concomitant intake of milk with fruits and consumption of chicken prepared with curd (Dadhi), were discontinued. A regulated, low-glycemic and metabolically balanced diet was advised, with restriction of refined foods such as white sugar, refined wheat flour (maida), sweets, dairy products, bakery items, bananas, and white rice, to prevent recurrence and support metabolic stability.

11. Discussion

Chronic eczema is a complex inflammatory dermatosis characterized by disruption of the epidermal barrier and dysregulated immune responses, leading to increased transepidermal water loss and enhanced penetration of allergens and microbial agents. Clinically, acute lesions present with erythema, vesiculation, and serous exudation, while chronic lesions may show excoriation and lichenification due to persistent scratching. In the present case, the prominent features of intense pruritus, continuous serous discharge, and inflamed ill-defined plaques strongly supported the diagnosis of chronic exudative eczema. Accurate differential diagnosis was essential, as the patient had previously been treated for psoriasis. Psoriasis typically presents with well demarcated erythematous plaques covered with silvery scales and minimal exudation, which were not observed in this case. Instead, the presence of profuse watery discharge, burning sensation, and intermittent malodor indicated a spongiotic inflammatory process rather than a hyperproliferative keratinocyte disorder. Xeroderma was also excluded, as it is characterized by generalized dryness without significant inflammation, exudation, or vesiculation.

From an Ayurveda perspective, the clinical presentation closely correlates with Vicharchika, a subtype of Kshudra Kushta. Classical features such as kandu (itching), srava (discharge), pidaka (eruptions), and discoloration were evident. The predominance of srava suggests significant Kapha involvement, while burning sensation and erythema reflect Pitta aggravation. Chronicity with excoriation and bleeding indicates associated Vata involvement, and persistent inflammation suggests vitiation of Raktadhatu. The chronic and relapsing nature of the condition despite repeated corticosteroid use suggests that the underlying pathophysiological mechanisms were not adequately addressed. From an Ayurveda toxicological perspective, such clinical patterns may be interpreted through the concept of Gara Visha, which refers to the cumulative effects of incompatible or artificially processed substances and can be understood as a state of chronic low-grade toxicity. In this condition, repeated exposure to incompatible dietary factors or exogenous substances leads to gradual physiological imbalance and persistent inflammation. This differs from Dushi Visha [27], which typically remains latent for

prolonged periods before manifesting clinically. In the present case, the recurrent inflammatory pattern was more consistent with Gara Visha [28] related pathology.

The treatment strategy was therefore directed toward correction of the underlying samprapti rather than symptomatic suppression. Formulations such as Kaishora Guggulu, Khadirarishta, and Arogyavardhini Vati were selected for their roles in Raktashodhana, metabolic regulation, and anti-inflammatory action. Kaishora Guggulu, with its bitter and astringent properties, contributes to Pitta shamana, blood purification, and reduction of inflammation and discharge, supported by its documented antimicrobial, anti-inflammatory, and antioxidant properties, along with the Yogavahi [29] (bioenhancer) action of Guggulu [30] (*Commiphora wightii* (Arn.) Bhandari), which likely enhanced the efficacy of the combined formulation. Khadirarishta is well-established in the management of chronic skin disorders due to its immunomodulatory and detoxifying properties. Arogyavardhini Vati supports Deepana-Pachana and systemic metabolic correction. Haridra Khanda was included for its anti-inflammatory, antimicrobial, and antipruritic properties due to the presence of Haridra [31] (*Curcuma longa* L.). Additional formulations such as Manjishthadi Kwatham, Pathyadi Kwatham, and Panchanimbadi Churnam provided further detoxifying and antimicrobial support. Triphala [32], a key component of Pathyadi Kwatham, consisting of Haritaki [33] (*Terminalia chebula* Retz.), Bibhitaki [34] (*Terminalia bellirica* (Gaertn.) Roxb.), and Amalaki [35] (*Phyllanthus emblica* L.), acts as a Srotoshodhaka and Rasayana, facilitating metabolic detoxification and reducing Kleda and Kandū. Considering the patient's age (Balavastha) and moderate strength (Madhyama Bala), Nitya Mridu Virechana [36] (mild purgation) using Pathyadi Kwatham was employed as a gentle and repeated purification approach, consistent with classical recommendations.

Nimbadi Churnam, containing Nimba [37] (*Azadirachta indica* A. Juss.), further contributed anti-inflammatory and immunomodulatory effects, aiding in reduction of itching, inflammation, and secondary infection. To manage aggravated Pitta and associated burning sensation, Kamadudha Rasa and Sutashekhara Rasa were administered. External application of Kushtharakshasa Tailam facilitated local healing through its Krimighna [38], Shothaghna [39], and keratolytic properties, contributing to reduction in discharge, improvement in fissuring, and overall lesion healing. The botanical nomenclature of plant ingredients mentioned in this study was verified using the World Flora Online [40] (WFO) database. The comprehensive Ayurveda approach, encompassing dosha pacification (Vata-Pitta shamana), management of pruritus and burning sensation, metabolic regulation, and strict adherence to Pathya-Apathya, resulted in progressive and sustained recovery. Notably, significant reduction in itching and exudation was observed within the first week, followed by continued lesion healing during follow-up. Importantly, this improvement occurred without further reliance on corticosteroids, suggesting that the intervention addressed underlying pathological mechanisms rather than providing temporary symptomatic relief. The absence of recurrence and adverse effects further supports the safety and therapeutic potential of structured Ayurveda management. These findings highlight the value of samprapti based interventions in chronic inflammatory dermatoses such as Vicharchika, and underscore the potential of integrative approaches combining traditional principles with systematic clinical monitoring. Although multiple therapeutic interventions, including internal formulations, topical therapy, and dietary modifications, were administered simultaneously in accordance with individualized Ayurveda management principles, this limits attribution of clinical outcomes to any single intervention. Unlike typical eczema case reports, this case specifically addresses steroid dependence and diagnostic misclassification, highlighting a clinically relevant gap in management. This report should be interpreted as exploratory clinical evidence and not as definitive proof of efficacy, particularly given the individualized multimodal treatment approach.

12. Conclusion

The integrative Ayurveda approach employed in this case demonstrated significant clinical improvement in a patient with steroid dependent chronic exudative eczema (Vicharchika). The therapeutic strategy, based on samprapti oriented intervention, effectively addressed underlying pathophysiological factors, resulting in reduction of symptoms, restoration of skin integrity, and elimination of corticosteroid dependence. The absence of adverse effects and sustained improvement during follow-up further supports the safety and potential clinical utility of Ayurveda management in chronic inflammatory dermatoses. However, larger controlled studies are warranted to validate these findings and to further elucidate the role of integrative approaches in dermatological practice. Nevertheless, the absence of histopathological confirmation and validated eczema severity scoring scales represents a limitation of the present report. This case highlights the importance of accurate diagnosis and individualized, pathogenesis-based management in chronic dermatological conditions.

13. Patient Perspective

The patient and her caregivers reported significant relief following the Ayurveda treatment. Initially, the condition caused severe discomfort due to continuous itching, burning sensation, and excessive oozing, which interfered with daily activities and sleep. Due to the severity of the lesions and associated distress, the patient had stopped attending school and was continuing her studies at home. Following initiation of treatment, gradual improvement was observed, with early reduction in itching and discharge, followed by progressive healing of the lesions. As her condition improved, the patient was able to resume regular school attendance, which significantly enhanced her confidence and overall quality of life. The caregivers expressed satisfaction with the sustained improvement achieved without corticosteroid use. They also reported that noticeable recovery prompted other parents with children having similar skin conditions to seek consultation at the hospital. Overall, the patient and her caregivers reported that her quality of life had significantly improved compared to her previous condition.

CARE Case Report Compliance

This case report was prepared in accordance with the CARE (CAse REport) guidelines. Clinical history, diagnostic reasoning, therapeutic intervention, follow-up, patient perspective, and informed consent were documented systematically to improve reporting transparency and clinical relevance.

Informed consent

Written informed consent for participation and publication of clinical details and images was obtained from the patient's parents, as the patient was a minor.

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Declaration of generative AI and AI-assisted technologies

During the preparation of this work, the authors used ChatGPT (OpenAI) for language refinement, grammar correction, and improvement of scientific writing clarity. After using this tool, the authors carefully reviewed, edited, and validated the content and take full responsibility for the accuracy, integrity, and originality of the final manuscript.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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CREDIT authorship contribution statement

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