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Case Study

AYURVEDIC MANAGEMENT OF *NASHTARTAVA* WITH SUSPECTED RESISTANT OVARY SYNDROME

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ABSTRACT

Resistant Ovary Syndrome (ROS) is a rare endocrinological disorder characterized by hypergonadotropic hypogonadism with preserved ovarian follicles but poor responsiveness to gonadotropins. Management remains challenging due to unclear pathogenesis and limited effectiveness of conventional therapies. In Ayurveda, such conditions can be correlated with *Nashtartava*, involving derangement of *Apana Vata*, *Artavavaha srotas*, and *Beeja*. A 43-year-old female presented with secondary amenorrhea of 5 months duration, along with weight gain, hirsutism, and acanthosis nigricans. Hormonal evaluation revealed elevated follicle-stimulating hormone (FSH) levels (46.60IU/ml), and ultrasonography showed thin endometrium with follicular atresia. The condition was diagnosed as *Nashtartava* with suspected Resistant Ovary Syndrome. The patient was managed with *Shodhana* and *Shamana* therapies, including *Udwarthana* with *Vara churnam*, *Snehapana*, *Virechana*, and *Yogavasti*, along with internal medications such as *Gandharvahastadi kashaya*, *Sapthasaram kashaya*, and *Varasanadi kashaya* etc. These interventions aimed at *Kapha hara*, *Medohara*, *Vata anulomana*, and *Srotoshodhana*. Following treatment, the patient showed significant clinical and radiological improvement, with restoration of menstrual cycles, improved follicular development, increased endometrial thickness, reduction in hyperpigmentation and hirsutism, and weight loss. This case highlights the potential role of Ayurvedic management in restoring ovarian function and menstrual regularity through a holistic approach.

INTRODUCTION

Resistant Ovary Syndrome (ROS), also referred to as Savage syndrome, is a rare endocrinological disorder presenting as hypergonadotropic hypogonadism, wherein ovarian follicles are present but fail to respond to endogenous or exogenous gonadotropins.[1] Clinically, it manifests as primary or secondary amenorrhea, infertility, and elevated serum follicle-stimulating hormone (FSH) levels in the presence of morphologically normal ovaries.[2] The etiopathogenesis of ROS is complex and multifactorial, encompassing gonadotropin receptor defects, post-receptor signaling abnormalities, autoimmune mechanisms, and genetic predispositions.

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Management of Resistant Ovary Syndrome remains challenging due to its unclear pathogenesis and poor ovarian responsiveness to gonadotropins. Currently, no definitive curative therapy exists, and treatment is mainly supportive and individualized.[3]

From an Ayurvedic perspective, the normal functioning of the ovaries and menstrual cycle depends upon the harmonious balance of *Tridoshas*, particularly *Vata*, along with the integrity of *Artava*, *Artavavaha srotas*, and *Beeja*. Conditions such as Resistant Ovary Syndrome can be correlated with *Nashtartava*,[4] characterized by the absence of menstrual flow due to derangement of *Apana Vata* and dysfunction of *Artavavaha srotas*. Despite the presence of reproductive structures, functional impairment occurs due to *Avarana* and *Dhatukshaya*, leading to disruption of follicular maturation and ovulation. Vitiation of *Apana Vata*, impaired *Agni*, and obstruction of *Srotas* play a pivotal role in the pathogenesis. Ayurveda emphasizes a holistic approach involving *Shodhana*,

Samana therapies, *Rasayana*, and lifestyle modifications aimed at correcting *Doshic* imbalance, restoring the function of *Artavavaha srotas*, and improving reproductive health.

Case Presentation

Patient Information

Age/Sex: 43-year-old/female

Occupation: House wife

Marital Status: Married

Chief Complaints

- Absence of menstruation since 5 months.
- Blackish discoloration over nape of neck, facial hair growth and increased weight gain (73-78.5kg) since 6 months.
- Low back ache since 2 months.

History of presenting complaints

The patient was a 43-year-old married woman complaining of absence of menstruation for 5 months. She attained menarche at 13 years and had normal menstrual cycles with an interval of 28-32 days and duration of 2-3 days. She got married at the age of 18 years. After 3 years of marriage, the couple were on allopathic treatment for primary infertility. Her husband was known to have oligospermia. They stopped allopathic treatments in 2020 and currently she is not trying for pregnancy.

She also presented with blackish discoloration over nape of neck, facial hair growth and increased weight gain (73-78.5kg) since last 6 months. She also reported low back pain since 2 months. She consulted the OPD and took internal medication for 1 month and underwent OPD level *Udwarthana* with *Triphala churna* for 14 days and was admitted in the IPD for further management.

Menstrual history

She had her last menstrual cycle on 23 September 2024. The interval of cycle was 28-32 days and duration of bleeding was 3 days with 2-3 moderately soaked pads /day.

Personal history

Diet: Mixed

Bowel: Regular

Appetite: Good

Micturition: Normal

Sleep: Sound

Addictions: Nil

Medical History

No known history of diabetes mellitus, hypertension or thyroid disorders.

Obstetric and Gynecological History

G0 P0

Examination Findings

General Examination

Obese, short stature

BP: 128/80mmHg

Ht: 156cm

Wt: 78.5Kg

BMI: 32.2kg/m^2 (Obesity class I)

Systemic Examination

Cardiovascular system

Inspection – Normal precordial area

Auscultation – Normal, S1 S2 heard

Respiratory system

RR- 18/min

Auscultation – Normal vesicular breathing

Locomotor system

Spine examination

Inspection – Symmetrical spine, no swelling

Palpation – Tenderness over L5 spine

Straight Leg Raise – Negative on both sides

Investigations

USG Pelvis (12/02/25)

Uterus:

Anteverted.

9.5 x 4.3 x 4 cm.

ET: 2.4 mm, thin.

A few nabothian cysts in cervix, largest measuring 12x11 mm

Right ovary: 1.7x1.2 cm

Left ovary: 1.7x1.1 cm

Both ovaries appear mildly small in size and shows mild atresia of follicles.

Impression

Grade I-II fatty liver

Left renal non obstructive calculi.

Small left renal cortical cyst.

Thin endometrium, mild atresia of follicles in both ovaries.

Blood Reports

Haematology (02/01/25)

Hb: 13.3 gm/dl

ESR: 50 mm/hr

FBS: 100 mg/**dl (12/02/25)**

Lipid profile (02/01/25)

Total Cholesterol: 222 mg/dl

Triglyceride: 136 mg/dl

HDL: 43 mg/dl

LDL: 152 mg/dl

VLDL: 27 mg/dl

Hormonal assay (12/02/25)

FSH: 46.60 IU/ml

Diagnosis

Nashtartava with suspected Resistant Ovary Syndrome

Therapeutic intervention

Treatment Principles

- *Srotoshodhana* (purification of the body channels).
- *Vata Anulomana* (facilitating natural downward movement of *Vata*).
- *Kaphahara* treatments
- *Agneya Dravya* (drugs of hot potency).

Table 1: OPD and IPD Management

OPD Management				
Date	**Complaints**	**Medicine**	***Kriyakrama***	**Remarks**
06/02/2025	Absence of menstruation since 5 months. Blackish discoloration over nape of neck, facial hair growth and increased weight gain (73-78.5kg) since 6 months. Low back pain since 2 months.	*Gandharvahastadi kashaya* - 90 ml twice daily before food. *Ayaskriti* [5]– 15 ml twice daily with *Kashaya*.		Height: 156cm Weight: 78.5kg BMI: 32.2kg/m^2
13/02/2025		*Sapthasaram kashaya* + *Varasanadi kashaya*- 90ml twice daily before food. *Ayaskriti* – 15 ml twice daily with *Kashaya*. *Shatahwadi tailam* –E/A		
24/02/2025			*Udwarthanam* with *Vara churnam* x 14 days.	Low back pain reduced
IPD Management				
Date	**Complaints**	**Medicine**	***Kriyakrama***	**Remarks**
12/03/2025	Absence of menstruation since 6 months. Blackish discoloration over nape of neck, facial hair growth and increased weight gain (73-78.5kg) since 7 months. Low back pain since 3 months.		*Snehapanam* with *Mahamasha tailam* x 7 days (starting dose -20ml and ending dose- 100 ml)	
19/03/2025			*Abhyanga* with *Sahacharadi taila*+*Ushma sweda* x 3 days	
22/03/2025			*Virechanam* with *Gandharva eranda tailam*-15 ml with lukewarm water	Number of *Vegas*: 5
23/03/2025			*Yogavasti* started. *Snehavasti* with *Dhanwantaram mezhupakam* 90 ml x 2 days	

25/03/2025			*Madhutailika vasti*	
26/03/2025			*Snehavasti* with *Dhanwantaram mezhupakam* 90 ml	
27/03/2025			*Madhutailika vasti*	
28/03/2025	Left shoulder joint pain.	*Thalam* with *Rasnadi churnam*.	*Snehavasti* with *Dhanwantaram mezhupakam* 90 ml	
29/03/2025			*Madhutailika vasti*	Shoulder pain reduced.
30/03/2025			*Snehavasti* with *Dhanwantaram mezhupakam* 90 ml	
31/03/2025				Discharged from IPD.

RESULTS

USG Follicular study (05/06/25)

Uterus

72 × 35 × 45 mm (within normal limits)

ET: 6 mm, 3-layered

Cervix: Nabothian cyst ~16 mm

Adnexa: Both ovaries normal in size (reduced in volume)

POD: Normal

Table 2: Follicular Study (05/06/25)

Date	Day of Cycle	Endometrial Thickness (ET)	Right Ovary	Left Ovary	POD
05-06-2025	10th day	6 mm, 3-layered	Follicle 7 mm	NDF	N
09-06-2025	12th day	6 mm	Follicle 9 × 8 mm	NDF	N
11-06-2025	16th day	7.6 mm	Follicle 14 mm	NDF	N
14-06-2025	19th day	8.6 mm	Follicle 16.9 mm	NDF	N

Abbreviations: ET – Endometrial Thickness; POD – Pouch of Douglas; N – Normal; NDF – No Dominant Follicle

Following the course of treatment, the patient showed significant clinical and radiological improvement. The treatment appeared to restrict further ovarian degeneration, as ultrasonography demonstrated improvement from previously atrophied ovaries to ovaries of normal size in the recent scan, though with reduced ovarian volume. Follicular monitoring revealed progressive follicular development in the right ovary, reaching a near-mature size of 16.9mm, along with a gradual increase in endometrial thickness, suggesting improved ovarian function.

Menstrual bleeding was documented on 01-04-2025, 26-05-2025 and 27-06-2025, with each episode lasting 2–3 days and requiring approximately 1–2 pads per day. Additionally, blackish discoloration over the nape of the neck and facial hair growth were reduced, and the patient experienced a body weight reduction from 78.5kg to 76.1kg following treatment.

DISCUSSION

Resistant Ovary Syndrome (ROS), also known as Savage syndrome, is a rare condition characterized by hypergonadotropic hypogonadism with preserved ovarian follicles and impaired ovarian responsiveness to endogenous or exogenous gonadotropins. In the present case, the serum FSH level was elevated at 46.60 IU/ml, indicating hypergonadotropic ovarian dysfunction. However, the diagnosis of ROS remains presumptive, as the available investigations did not establish the presence of preserved ovarian reserve or definitive ovarian resistance to gonadotropins. The initial ultrasonography demonstrated mildly small ovaries with mild follicular atresia and a thin endometrium, indicating compromised ovarian function.

Considering the patient's age of 43 years, early menopause or diminished ovarian function also represents an important differential diagnosis. Although the clinical presentation of hypergonadotropic amenorrhea may overlap between ROS and diminished ovarian function, the distinction is clinically relevant. In the present case, comprehensive hormonal evaluation including LH, estradiol, prolactin and AMH, as well as repeat assessment of FSH, was not available. Antral follicle count was also not documented. Furthermore, ovarian histological confirmation and assessment of ovarian response to exogenous gonadotropins were not performed. Therefore, a definitive diagnosis of ROS cannot be established from the available data, and the condition is appropriately described as *Nashtartava* with suspected Resistant Ovary Syndrome.

The follicular study demonstrated progressive development of a follicle in the right ovary, reaching 16.9 mm on the 19th day of the documented cycle, along with a progressive increase in endometrial thickness. No dominant follicle was observed in the left ovary during the follicular monitoring period. These findings indicate progressive follicular development in the right ovary during the study period.

From an Ayurvedic perspective, the clinical presentation may be understood in the context of *Nashtartava*, with involvement of *Apana Vata* and *Artavavaha srotas*. The associated obesity, acanthosis nigricans and hirsutism were considered indicative of *Kapha* and *Meda* involvement. The treatment was therefore planned with the principles of *Srotoshodhana*, *Vata Anulomana*, *Kaphahara* and *Agneya* therapy.

Udwarthana with *Vara churnam* was administered with the intention of addressing *Kapha-Meda* predominance and reducing excess adiposity. The subsequent *Snehapana* with *Mahamasha taila* was intended to provide *Brimhana* and *Vata samana*, followed by *Abhyanga* with *Sahacharadi tailam*,[6] and *Ooshma sweda*. *Virechana* with *Gandharva eranda* was administered as a *Shodhana* intervention, while *Yogavasti* comprising *Snehavasti* with *Dhanwantaram mezhupakam*,[7] and *Madhutailika vasti*[8] was employed with the intention of supporting *Apana Vata* regulation.

The internal medications were selected according to the clinical presentation and treatment principles. *Gandharvahastadi Kashaya*,[9] was administered with the intention of promoting *Vata samana* and *Vata anulomana*, while *Sapthasaram kashaya* was used to address *Vata-Kapha* involvement and support the regulation of *Apana Vata*. *Varasanadi kashaya* was incorporated in view of its *Medohara* properties and the associated features of *Sthoulya*. These interventions formed part of an individualized treatment protocol rather than a standardized treatment regimen.

As noted above, menstrual bleeding recurred on three occasions post-treatment, with the interval between episodes narrowing from 55 to 32 days. The first bleeding episode occurred one day after discharge from inpatient treatment; therefore, its relationship with the treatment cannot be definitively established. Hence, the findings are better described as resumption of menstrual bleeding with subsequent improvement in cycle interval rather than definite restoration of regular menstrual cycles.

The follicular study demonstrated progressive development of a follicle in the right ovary, reaching 16.9mm on the 19th day of the documented cycle, together with progressive increase in endometrial thickness. The left ovary findings were not documented in the available follicular-study table. Therefore, no conclusion regarding follicular activity in the left ovary can be drawn from these observations.

Other observed changes included reduction in blackish discoloration over the nape of the neck and facial hair growth, together with a body weight reduction of 2.4kg. These changes occurred during a multimodal intervention involving internal medication, *Udwarthana* and *Shodhana* procedures; therefore, the individual contribution of any particular intervention cannot be determined.

The present case has certain limitations. The hormonal assessment was restricted to a single FSH measurement, and LH, estradiol, prolactin and AMH levels were not available. Repeat FSH assessment, antral follicle count and a systematic assessment of ovarian reserve were also not documented. Definitive confirmation of ROS by ovarian histology or assessment of ovarian response to exogenous gonadotropins was not undertaken. The mildly elevated ESR was not further investigated and its clinical significance in this context remains unclear. In addition, the first episode of bleeding occurred immediately after inpatient treatment, making its nature difficult to determine. The follicular study documented progressive development only in the right ovary, while findings for the left ovary were not recorded. Finally, as this is a single case without a comparator and with limited follow-up, the observed improvements cannot establish a causal relationship between the Ayurvedic intervention and restoration of ovarian function.

Despite these limitations, the case provides clinically documented observations of changes in menstrual bleeding, endometrial thickness and right ovarian follicular development following an individualized Ayurvedic treatment protocol. These observations may provide a basis for further investigation, particularly through prospective studies

incorporating serial hormonal assessment, ovarian-reserve markers, standardized follicular monitoring and longer-term follow-up.

CONCLUSION

This case describes the Ayurvedic management of *Nashtartava* in a patient with suspected Resistant Ovary Syndrome. Following the individualized treatment protocol involving *Udwarthana, Shodhana* and *Samana* therapies, improvement was observed in menstrual bleeding, endometrial thickness, right ovarian follicular development, body weight and associated clinical features. However, the diagnosis of Resistant Ovary Syndrome remains presumptive because comprehensive hormonal and ovarian-reserve evaluation, repeat FSH assessment and definitive assessment of ovarian responsiveness were not performed. The observed clinical and ultrasonographic changes suggest a potential therapeutic benefit, but a causal treatment effect cannot be established from a single case. Further well-designed clinical studies with appropriate hormonal, ovarian-reserve and long-term outcome assessment are required to evaluate the therapeutic potential of Ayurvedic interventions in similar clinical presentations.

Patient Perspective

The patient reported improvement in menstrual bleeding and associated clinical symptoms following the treatment. She also noted reduction in facial hair growth and blackish discoloration over the nape of the neck, along with weight reduction. The patient was satisfied with the clinical improvement achieved during the treatment and follow-up period.

Ethics Committee Approval

Ethical approval for this case report was obtained from the Institutional Ethics Committee of Government Ayurveda College Tripunithura, IEC approval number: 07/ SRPK/CR/IEC 2026, dated 17/06/26.

Strengths and Limitations

The strength of this case is the documentation of clinical and ultrasonographic changes following an individualized Ayurvedic treatment protocol. The main limitations include the single-case design, multiple concurrent interventions, limited hormonal and ovarian-reserve assessment, absence of definitive confirmation of Resistant Ovary Syndrome, and relatively short follow-up.

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