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Case Study

AYURVEDIC MANAGEMENT OF ANOVULATORY INFERTILITY IN A WOMAN WITH POLYCYSTIC OVARY SYNDROME (PCOS)

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ABSTRACT

Polycystic Ovary Syndrome (PCOS) is a common endocrine disorder affecting 8–13% of women of reproductive age and is a major cause of anovulatory infertility. It is characterized by ovulatory dysfunction, hyperandrogenism, and polycystic ovarian morphology, often associated with obesity, acne, hirsutism, and metabolic abnormalities. In Ayurveda, PCOS can be correlated with *Pushpagni Jathaharini*, which involves impaired ovulation due to *Kapha* and *Medo Dushti* causing *Srotorodha*. This case report describes a 34-year-old female presented with irregular menstruation since menarche, obesity (BMI 36.6kg/m^2), hirsutism, acne, and infertility for eight years. From an Ayurvedic perspective, the condition was diagnosed as *Pushpagni Jathaharini* with predominant *Kapha-Medo Dushti* and *Srotorodha* affecting the reproductive system. The patient underwent a 75-day inpatient Ayurvedic treatment protocol comprising *Shodhana* therapies, including *Vamana*, *Virechana*, *Yogavasti*, and *Uttaravasti*, followed by individualized internal medications aimed at correcting *Kapha-Medo Dushti*, restoring *Agni*, and improving reproductive function. Following the 75- day inpatient protocol, the patient reported regular menstrual cycles over two subsequent cycles with improvement in weight, hirsutism (Ferriman-Gallwey score 22 to 17) and acne. This case highlights the potential role of a comprehensive Ayurvedic treatment approach in the management of PCOS. The integration of *Shodhana* therapies and individualized internal medications may effectively address the underlying pathophysiology, improve menstrual regularity, and enhance reproductive health in women with PCOS. Findings are based on a single case without biochemical hormonal confirmation and short term follow up; controlled studies are needed to establish efficacy.

INTRODUCTION

Polycystic ovary syndrome (PCOS) affects 8% to 13% of reproductive-aged women and is diagnosed using the Rotterdam criteria, which require at least two of the following:

- Oligo- or anovulation,
- Clinical or biochemical hyperandrogenism,
- Polycystic ovaries on ultrasound.[1]

In this case diagnosis was based on clinical and ultrasonographic Rotterdam criteria; biochemical hyperandrogenism markers were not assessed.

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Common symptoms include irregular menstruation, obesity hirsutism and acne. Biochemical findings often show elevated LH:FSH ratio, insulin resistance with hyperinsulinemia, decreased SHBG, dyslipidemia, and elevated AMH levels. Ultrasound typically reveals enlarged ovaries with ≥12 follicles (2–9mm) or volume >10cc. PCOS is associated with several short-term and long-term health risks, including infertility due to anovulation or oligo-ovulation (responsible for approximately 21% of female infertility), pregnancy complications and increased risk of miscarriage, endometrial carcinoma due to unopposed estrogen stimulation, increased cardiometabolic risks such as insulin resistance, type 2 diabetes mellitus, hypertension, and dyslipidemia. Women with PCOS are more likely to experience difficulties with conception and may require assisted

reproductive technologies such as in vitro fertilisation (IVF).[2]

PCOS can be correlated with *Pushpaghni Jathaharini*, a condition described by *Acharya Kashyapa* in the *Revathi Kalpa Adhyaya*.[3] This Ayurvedic concept reflects menstrual irregularities and ovulatory dysfunction, aligning with the clinical presentation of PCOS.

Patient Information

A 34-year-old female, complaints of delayed and irregular menstrual cycles since menarche and inability to achieve a viable pregnancy despite 8 years of unprotected intercourse came to the OPD of Prasuti tantra & Streeroga, Govt. Ayurveda College, Tripunithura.

The patient attained menarche at the age of 12 years, since then she is having irregular delayed menstrual cycles, with an interval of 2 to 3 months,4 days duration with moderate bleeding (D1-spotting, D2 & D3-4 pads (XL)fully soaked, D4-2 pads partially soaked D5 & D6-spotting-moderate sized clots on D2 & D3), associated with mild lower abdominal pain starting 1 week prior to menstruation and intensity reduces after the bleeding starts. She also complaints of increased weight gain, hirsutism (Ferriman-Gallwey score-22) and acne. In 2008, she consulted a gynecologist and was diagnosed as PCOD and took hormone medications for 3 months (OC pills -21 days). Afterwise, her periods got regular for a period of 2 to 3 years, which later became irregular. She got married at the age of 25 years to a non-consanguineous male (NCM) of age 31 years. She got conceived naturally in 2018, but D&E was done due to reduced fetal heart rate at 3rd month of gestation. In 2024 June, IVF resulted in conception but the pregnancy was lost via spontaneous abortion at approximately 3 weeks of gestation. After the second IVF failure (August 2024) She took allopathic medication for one month, before discontinuing it and pursuing Ayurvedic treatment. She underwent IP based Ayurvedic treatment from February 2025. She had a history of bronchial asthma in childhood. Patient had no diabetes mellitus, hypertension or thyroid issues.

Clinical Findings

Her bowels were regular, not constipated, appetite was normal and she had occasional burning micturition (had a history of urinary tract infection), sleep was disturbed due to stress and worry. She had no allergy towards any medications or food, but allergic to dust. Her sister is also a known case of PCOD. There is no abnormality in coital history and the couple used contraceptives for initial 1 year. Her vitals were within normal limits. Height of the patient is 164.5cm and weight was 99kg, with BMI-36.6kg/m2. She had no pallor, no edema, no icterus and on detailed examination, central nervous system, respiratory and cardiovascular system was intact. Her hematological and biochemical investigations revealed variations in lipid profile, Postprandial Blood Sugar (PPBS) and Liver Function Tests (LFT).

Table 1: Blood Investigations (8/02/25)

FBS-100 mg % PPBS-214 mg %	**Lipid Profile** Total Cholesterol-211 mg % Serum Triglycerides -210 mg % HDL-44 mg% LDL-125mg % VLDL-42 mg %	 Bilirubin(D)-0.3 mg % Bilirubin (T)-1.6 mg % SGOT-31 U/L SGPT-50 U/L

Per speculum examination done on 25/2/2025 revealed mild cervical erosion at upper lip, along with mild mucoid discharge (+) without any per vaginal bleeding.

Treatment History

2024 June - 1st IVF-successful, spontaneous abortion at 3rd week gestation.

2024 August- 2nd IVF-unsuccessful

Surgical History

D&E done on 2018

Diagnostic Assessment

Investigations.

HSG (17/12/2022)

Normal hysterosalpingogram

Table 2: USG (Abdomen & Pelvis)

	07/12/2024	**10/04/2025**
Liver	Mildly enlarged in size (15.4 cm.) mild increase in echotexture	Borderline enlarged in size (15.6 cm) Mild to moderate fatty infiltration noted.
Uterus	Anteverted -7.2x4.1x2.8 cm ET- 5mm	Anteverted -6.3x3.1cm ET-4.9mm
Ovary	Right Ovary- 4.5x3.2x2.8 cm (Vol -22 cc) Left Ovary- 4.2x2.8x2.7 cm (Vol -17.2 cc) Both ovaries appear bulky with multiple tiny peripherally arranged follicles (>9 mm). Total antral count >12. Central echogenicity is increased. No dominant follicle bilaterally	Right Ovary- 4.4x2.5x2.5 cm (Vol-15 cc) Shows corpus luteum Left Ovary- 3.4x3.2x2.3 cm (Vol -13.7 cc) Both ovaries show multiple peripherally arranged tiny follicles and central hyper echogenic stroma. No dominant follicle
Impression	Mild hepatomegaly with Grade 1 Fatty changes polycystic morphology of ovaries	Grade 1 fatty infiltration of liver polycystic morphology of both ovaries.

Spouse Factor

Age- 40 years

Occupation – Project manager

Addictions/allergy-Ex-smoker, occasional intake of alcohol.

No history of chicken pox, mumps.

Investigations

Semen analysis (24/11/22)

Liquefaction time -> 30 min

Impression- Normozoospermia & hyper viscosity, which can transiently impair sperm motility assessment. (did not receive any treatment for the condition).

H/o Mild varicocele

Diagnosis

Pushpagni

Therapeutic Intervention

Table 3: Chronological Record of Inpatient Therapeutic Interventions (15 Feb -30 Apr 2025)

Date	**Complaints**	**Internal Medications**	***Kriyakrama***	**Remarks**
15-02-25to 25-02-25	Delayed irregular menstrual cycle since menarche	*Varanadi kashayam* -90 ml bd b/f *Nisakathakadi kashayam* - 90 ml bd -11 am 4 pm	*Udwarthanam* with *Vara churnam* -10 days	Height-164.5cm Weight -99 kg BMI-36.6kg/m^2
24-02-25to 26-02-25			*Ruksha vasti* - 3 days *Amruthotharam kashayam* - 300ml *Vaiswanara churnam*- 20gm	
27-02-25 to 3-03-25			*CPS (R) –Kolakulathadi churnam*-5 days	
04-03-25 to 08 -03-25			*CPS(S)* with *Murivenna*-5 days	
09-03-25			*Virechanam* with *Trivrut churnam* -15gm with *Draksha swarasa*	4 *Vega*
10-03-25to 11-03-25			*Peyadi krama*	Weight -91 kg BMI-33.6kg/m^2

12-03-25 to 14-03-25			*Snehapana* with *Pippalyadi anuvasana tailam* - 3 days D1-25 ml D2-50 ml D3-75 ml	
14-03-25	Menstruation started			Duration -5 days, moderate bleeding, no associate complaints
19-03-25 to 22-03-25			*Snehapanam* restarted with *Pippalyadi Anuvasana Tailam* D4-50 ml D5-65 ml D6-90 ml D7-110 ml	
23-03-25 to 25-03-25			*Abhyangam* and *Ushmasweda* with *Sathahwadi tailam* -3 days	
26-03-25			*Vamana* done	*Vega* -6 *Upavega* -7 loose bowels -8
27-03-25 to 29-03-25			*Peyadi krama*	
01-04-25 to 08-04-25			*Yogavasthi* started *Snehavasthi -Pippalyadi anuvasana tailam* *Kashaya vasti-Madhutailikam*	
05-04-25 to 07 -04-25			*Utharavasthi* with *Dhanwantharam tailam* -3 days	
08-04-25		*Gandharvahasthadi kashayam* -90ml bd *Abhayarishtam* -30ml bd a/f *Rajapravarthini vati*-2 tablets twice daily *Hinguvachadi churnam* -5gm bd		
17-04-25	Menstruation started	Stopped on 3rd day of periods		Duration -6 days, moderate bleeding
24-04-25 to 30-04-25			*Yogavasthi* started *Snehavasthi -Pippalyadi anuvasana tailam* *Kashaya vasti-Madhutailikam*	
26-04-25			*Utharavasthi* with *Dhanwantharam tailam* -3 days	Weight 90 kg BMI-33.3 kg/m^2

Table 4: Timeline

Age 12	Menarche; irregular cycles (2–3 months intervals) from onset
2008	Diagnosed as PCOD; treated with OC pills -temporary regularization
Age 25	Marriage
2018	Natural conception; D&E done in 3rd month (reduced fetal heart rate)
2018–2024	No treatment sought
Nov 2022	HSG normal; spouse semen analysis - normozoospermia with hyperviscosity
June 2024	1st IVF -conceived, spontaneous abortion at 3rd week
Aug 2024	2nd IVF -unsuccessful
Dec 2024	USG -bilateral polycystic ovarian morphology, Grade 1 fatty liver
Feb 2025	Baseline investigations; BMI 36.6
15 Feb – 30 Apr 2025	75-day inpatient Ayurvedic treatment
14 Mar 2025	Menstruation (mid-treatment) - 5 days, moderate bleeding
10 Apr 2025	Repeat USG - corpus luteum seen, reduced ovarian volume
17 Apr 2025	Menstruation - 6 days, moderate bleeding
30 Apr 2025	Discharge; weight 90kg, BMI 33.3
17 May & 20 Jun 2025	Regular menstrual cycles; F-G score improved to 17

Follow Up and Outcome

Following the 75-day Ayurvedic treatment, the patient attained regular menstrual cycles on 17 May 2025 and 20 June 2025, with normal cycle intervals and an adequate amount of menstrual bleeding. Subsequent menstrual periods were also regular. Follow-up ultrasonography demonstrated the presence of a corpus luteum, suggestive of successful ovulation, along with a reduction in ovarian volume compared to the pre-treatment findings. Clinically, the patient also exhibited a reduction in body weight, Hirsutism (Ferriman-Gallwey score -17) improvement in overall health and well-being. However, ovulation was not confirmed by mid -luteal serum progesterone, and the corpus luteum finding, while suggestive, is not definitive proof of the timing or completeness of ovulation.

On subsequent follow-up, the patient was found to have conceived in July 2026. This pregnancy is recent; viability is not yet confirmed, given the patient's history of two prior early losses.

DISCUSSION

Following a thorough history taking and clinical examination, it was revealed that the patient presented with menstrual irregularity with suspected anovulation associated with polycystic ovarian syndrome (PCOS). Ovulation is a key factor for maintaining normal menstrual cyclicity and typically occurs during the mid-cycle. Disturbances in ovulation may lead to irregular or delayed menstrual cycles and can adversely affect fertility outcomes. Menstrual irregularity with suspected anovulation is a common clinical manifestation of PCOS, reflecting its underlying ovulatory dysfunction.[4]

From an Ayurvedic perspective, this condition bears resemblance to *Pushpagni Jathaharini*, as described in the *Revathi Kalpa Adhyaya* of the *Kashyapa Samhita*, which denotes impaired ovulatory function and disturbed menstrual rhythm**.**

From her personal history it was clear that the patient was affected with *Kapha dushti* arises from factors like *Avyayama* (lack of exercise), excessive intake of *Madhura* (sweet)*, Snigdha* (unctuous), and *Guru* (heavy) *Ahara,* along with *Diwaswapna* (day sleep), making her prone to *Kaphaja vikara*, as she is a *Kapha vata prakruti* This aggravated *Kapha* can cause *Avarana* (obstruction) to *Apana vayu*, leading to *Vata dushti*, which is further aggravated by *Ratrijagarana* (night vigil) and *Vegadharana* (suppression of natural urges). Simultaneously, *Pitta kshaya* is observed due to an overly *Madhura-pradhana* diet. On the *Dhatu* level, *Rasa dhatu dushti* occurs due to intake of *Guru* (heavy)*, seta* (cold), *Atisnigdha* (excessive unctuous), *Atimatra* (excess quantity) *Ahara* and irregularities like *Ratrijagarana*, which further leads to *Arthava dushti* since *Arthava* is an *Upadhatu* of *Rasa*. *Raktha dhatu* is vitiated by consumption of *Vidahi, Snigdha*, and *Drava* (liquid) *Ahara*, while *Mamsa dushti* is linked to *Abhisyandi* and *Guru ahara*. *Medo dhatu* is impaired by sedentary habits and *Diwaswapna.* Collectively, *kapha* and *Medo dushti* cause *Sthana samshraya* in *Arthavavaha srotas*, leading to its vitiation and manifestation of this condition.

As the disease pathology predominantly involves *Kapha* and *Medo dushti*, internal medications and procedures that possess *Kapha-medohara*, *Srotoshodhana,* and *Arthava-pravartaka* properties

were given. *Varanadi Kashayam* and *Nishakatakadi Kashayam* was given initially.

Udvartanam with *Triphalachurnam* was selected for 10 days and *Ruksha vasthi* for 3 days (*Amruthotharam Kashaya* and *Vaiswanara churna*) as a *Rukshana therapy* prior to *Snehana*, considering its potent *Kaphahara* and *Medasa Pravilayana* properties. Given the patient's elevated BMI (36kg/m^2), *Triphalachurnam,* known for its *Lekhana* and *Deepana* effects, is ideal to reduce *Medo dhatu abhivridhi* and prepare the body for subsequent *Shodhana* procedure.[5] *Churna pinda sweda* was administered after *Udwarthanam* to enhance the therapeutic effects of the procedure and to address the underlying *Kapha-Meda* predominance seen in this condition.

Snehapana was done with *Pippalyadi anuvasana tailam* as it is *Kaphavata samana* and *Anulomana*. As the disease is predominantly of *Kapha dosha, Vamana* was done followed by *Virechana* with *Trivruth churnam* in *Draksha swarasa* as it enhances the *Virechana* property of *Trivrit churnam* and it causes *Beeja karmukatha* (enhances the quality of gamete). *Yogavasthi* was done in which, *Snehavasthi* with *Pippalyadi anuvasana taila* and *Kashaya vasthi Madhutailikam.*

Madhutailika vasthi possess *Doshanirhana* property, it also acts as *vrishya balya Deepana*. *Gandharvahasthadi kashayam* and *Pippalyadi anuvasana tailam* was used for *Vasthi.*

Utharavasthi is the main treatment in all gynecological conditions and it is indicated in anovulation (*Anruthavapi*) and the medicine used is *Dhanwantharam tailam* as it is indicated in *Yoniroga.*

This report has several limitations. As a single case without a control group, causal attribution to the Ayurvedic intervention cannot be established; spontaneous variation in PCOS symptoms and lifestyle changes inherent to inpatient care (diet, sleep regulation, physical activity) may have contributed to the observed improvements. Biochemical hormonal parameters (LH, FSH, testosterone, AMH, insulin) were not assessed, limiting confirmation of the underlying endocrine mechanism. Ovulation was inferred from ultrasonographic corpus luteum detection rather than confirmed by serum progesterone. Follow-up was limited to two menstrual cycles post-discharge; longer-term follow-up is needed to establish durability of the response.

CONCLUSION

This case report demonstrates the potential effectiveness of a comprehensive Ayurvedic treatment approach in the management of Polycystic Ovary Syndrome (PCOS), where the patient presented with menstrual irregularities, suspected anovulation, obesity, hyperandrogenic manifestations, and long-standing infertility.

The treatment strategy was based on Ayurvedic principles that consider *Kapha-Medo dushti* and vitiation of *Artavavaha srotas* as major contributors to the pathogenesis of conditions resembling *Pushpagni Jathaharini*. Sequential therapeutic interventions including *Rukshana* and *Snehana*, followed by *Shodhana* procedures such as *Vamana, Virechana, Yogavasti*, and *Uttaravasti* with *Dhanwantharam Tailam*, were employed.

Following treatment, the patient attained regular menstrual cycles with normal bleeding patterns, reduction in body weight, and improvement in associated clinical features. Ultrasonographic evaluation revealed reduction in ovarian volume and the presence of a corpus luteum, suggestive of ovulation, consistent with improvement in ovarian function, though this requires confirmation in future controlled studies.

Limitations

The spouse's mild varicocele is an undiscussed potential co-factor in the couple's infertility. Post-treatment ovarian volumes (15cc, 13.7cc) remain above the >10cc threshold, so normalisation is partial rather than complete.

Acknowledgement

We extent my heartful appreciation to my teachers and colleagues for their essential advice and support.

Patient Perspective

The patient expressed a positive perception of the treatment, reporting restoration of menstrual regularity, reduction in body weight and hirsutism, and an overall improvement in her physical and psychological well-being.

Informed Consent

Informed written consent for publication was obtained from the patient. Every effort has been made to maintain confidentiality and protect the patient privacy.

Ethical Consideration

Institutional Ethics Committee approval number-01/SRPK/CR/IEC 2026 date 17/06/26.

Author Contributions

All authors contributed to the conceptualization, clinical management, and documentation of the case, as well as the literature review and interpretation of clinical findings. All authors participated in drafting, reviewing, and critically revising the manuscript, and have read and approved the final version. All authors agree with the content and order of authorship and accept responsibility for the integrity of the work. This case report has been prepared and reported in accordance with the CARE (Case Report) guidelines.

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