

POST-ABORTAL CERVICITIS AND GARBHASRAVA–GARBHAPATA PARICHARYA: A CRITICAL AYURVEDA–MODERN MEDICINE REVIEW

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ABSTRACT

Cervicitis is inflammation of the cervix. When it is found after an abortion or miscarriage, the first task is to determine whether it is limited to the cervix or is part of an infection involving the uterus and other pelvic organs. This distinction matters because delayed treatment of a serious infection can cause lasting harm. Ayurveda describes *Garbhasrava* and *Garbhapata* and gives advice on care after pregnancy loss. This critical narrative review compares that advice with modern guidance on diagnosis, infection prevention, treatment and recovery. Classical passages were read in an English translation of the *Sushruta Samhita*. Clinical recommendations were drawn from international abortion care and sexually transmitted infection guidance. The classical material describes diet, care adapted to strength and digestion, and attention to symptoms after pregnancy loss. These ideas may inform supportive care,

but they do not establish a treatment for a confirmed cervical infection. Current clinical guidance supports appropriate testing, antibiotics when indicated, partner care for sexually transmitted infections, and urgent referral for suspected uterine infection or sepsis. A safe combined approach would retain these measures and study clearly defined, low-risk supportive care separately. Direct clinical evidence for *Garbhasrava–Garbhapata Paricharya* in confirmed post-abortion cervicitis remains unestablished in the sources reviewed. Future studies should measure recovery and safety without delaying proven treatment.

KEYWORDS: Post-abortion cervicitis; *Garbhasrava*; *Garbhapata*; *Paricharya*; post-abortion care; Ayurveda.

INTRODUCTION

Discharge, bleeding or pelvic discomfort after an abortion needs a clear diagnosis. Cervicitis may be present, but similar complaints can arise from the vagina, uterus or an incomplete abortion. The term post-abortion cervicitis describes when cervical inflammation is identified; it does not prove that the abortion caused it. The main clinical signs are pus-like discharge from the cervical canal and bleeding that occurs easily when the cervix is gently examined.^[1]

In this review, post-abortion care includes care after induced abortion and spontaneous pregnancy loss. The circumstances may differ, but both require attention to bleeding, infection, pain and recovery. World Health Organization guidance treats follow-up support and access to care for complications as parts of comprehensive abortion care.^[2]

Ayurveda discusses pregnancy loss through terms such as *Garbhasrava* and *Garbhapata*. Sushruta describes a distinction based on the stage and development of the pregnancy and also gives advice after miscarriage.^[3,4] These passages deserve careful study. Their value is reduced when they are presented as if they describe a modern laboratory-confirmed infection. This review asks which classical ideas may support recovery, where the comparison with modern medicine is limited, and what evidence would be needed before a combined approach could be recommended.

REVIEW APPROACH

This is a critical narrative review, not a systematic review or a clinical trial. Targeted web searches and direct sources. Search terms included post-abortion cervicitis, post-abortion infection, *Garbhasrava*, *Garbhapata*, *Paricharya* and miscarriage aftercare. Sources were selected for their direct relevance to clinical decisions or to the classical comparison. The review uses accessible WHO and CDC recommendations, professional guidance, and a digital transcription of Bhishagratna's English translation of the *Sushruta Samhita*.

DEFINING THE CLINICAL PROBLEM

Cervicitis affects the lower genital tract. Pelvic inflammatory disease, or PID, covers infection and inflammation involving structures above the cervix, including the uterine lining and fallopian tubes. Pelvic pain with uterine, adnexal or cervical motion tenderness should

raise concern for PID. A negative cervical test does not exclude infection higher in the genital tract.^[5] In a patient who has recently had an abortion, the same symptoms also require assessment for retained pregnancy tissue and other complications.

The 2025 Society of Family Planning guidance describes upper genital tract infection as uncommon in settings providing safe abortion care. Its reported frequency should not be used as an estimate of isolated cervicitis in India or in a different care setting.^[6] Studies that combine cervical inflammation, endometritis and sepsis under one outcome cannot answer how often isolated post-abortion cervicitis occurs. Table 1 separates the conditions that matter at the first assessment.

Table 1: Conditions that may present after abortion.

Condition	Findings that help distinguish it	Main implication
Cervicitis	Cervical discharge or easy contact bleeding	Assess the cervix and test for likely infections.
Vaginitis	Discharge with vaginal irritation or itching	Identify the vaginal cause; symptoms may overlap.
Endometritis or PID	Pelvic pain with uterine, adnexal or cervical motion tenderness	Evaluate and treat an upper genital tract infection.
Retained pregnancy tissue	Persistent or heavy bleeding, pain or incomplete resolution	Assess completion of abortion and the need for evacuation.
Septic abortion	Infection with systemic illness; shock may develop	Immediate hospital care and treatment of the source.
Other causes	Trauma, ectropion, polyps or a concerning cervical lesion	Use examination findings to guide further assessment.

Clinical distinctions drawn from CDC and RCOG guidance.^[1,5,7]

ASSESSMENT AND DIAGNOSTIC TESTING

The history should record the date and method of abortion, pregnancy duration, whether completion was confirmed, and the timing of symptoms. Previous test results, antibiotics, drug allergies and any products inserted into the vagina also matter. Sexual history should be taken privately and without blame. A newly detected sexually transmitted infection may have been present before the abortion; timing alone cannot establish when it was acquired.

Examination should assess general condition and vital signs before focusing on the cervix. Heavy bleeding, marked abdominal tenderness, low blood pressure, a fast pulse or rapid breathing require urgent assessment. When an infected incomplete abortion is suspected,

hospital treatment may include immediate broad-spectrum antibiotics and urgent uterine evacuation by a trained clinician.^[7] Cultures and imaging can assist care, but they should not delay emergency treatment.

Testing should answer a specific question. Nucleic acid amplification tests, which detect genetic material from an organism, are preferred for *Chlamydia trachomatis* and *Neisseria gonorrhoeae*. A vaginal or cervical sample or an appropriate urine sample may be used according to the assay.^[8,9] Test results must be interpreted alongside examination findings. Ultrasound can help assess suspected retained tissue or another pelvic cause, but it is not a test for isolated cervicitis.

Trichomonas vaginalis should also be considered. A negative wet-mount examination does not reliably exclude it because the test can miss infection.^[10] Testing for *Mycoplasma genitalium* is relevant in selected persistent or recurrent cases, particularly after treatment when reinfection is unlikely. Routine screening of people without symptoms for this organism is not recommended by CDC.^[11] Repeated discharge should prompt reassessment rather than an automatic change to another treatment.

MODERN TREATMENT AND INFECTION PREVENTION

Treatment depends on the site of infection, the likely organism, pregnancy status and the patient's general condition. For uncomplicated chlamydial infection in a nonpregnant adult, CDC recommends doxycycline 100 mg orally twice daily for seven days. Pregnancy requires a different treatment choice.^[8] Gonorrhoea requires a ceftriaxone-based regimen, with treatment for chlamydia when it has not been excluded.^[9] These are organism-specific principles. A short course aimed only at cervical infection is not adequate treatment for septic abortion.

PID needs broader antibiotic coverage, including anaerobic bacteria. Hospital care is indicated when illness is severe, a pelvic abscess or surgical emergency is possible, or oral treatment cannot be followed or is not working. Patients managed as outpatients should show clinical improvement within about 72 hours; a poor response requires reassessment.^[5] Local protocols and resistance patterns should guide the exact regimen.

For trichomoniasis in women, CDC recommends oral metronidazole 500 mg twice daily for seven days.^[10] Persistent *M. genitalium* infection requires a treatment plan that accounts for

antibiotic resistance. A single 1 g dose of azithromycin should not be used for this infection.^[11] This is one reason that treating every episode of discharge with the same antibiotic can fail.

Prevention and treatment are separate. WHO recommends antibiotic prophylaxis for surgical abortion and recommends against prophylactic antibiotics for medical abortion.^[2] The Society of Family Planning also recommends prophylaxis before procedural management of pregnancy loss, with a single pre-procedure dose of doxycycline 200 mg or azithromycin 500 mg as options. Prophylaxis is stopped after the procedure; a diagnosed infection still needs its full treatment course.^[6] In the same guidance, indicated testing and treatment for gonorrhoea or chlamydia should not create unnecessary delay in abortion care.

THE CLASSICAL MEANING OF PREGNANCY LOSS AND AFTERCARE

In *Nidana Sthana* chapter 8, the cited translation distinguishes loss during the first four months from loss in the fifth and sixth months, based on the described state of fetal development.^[3] This provides historical context for *Garbhasrava* and *Garbhapata*. These categories do not map exactly onto modern gestational limits, ultrasound diagnoses or legal definitions. They also do not distinguish cervical infection from infection in the uterus.

Sharira Sthana chapter 10, section 49, gives a specific regimen after miscarriage. It describes *Yavagu*, a thin rice preparation, cooked with digestive herbs, without added salt or fat, for a number of days related to the month of pregnancy.^[4] This is a historical prescription. It should not be converted into a fixed modern diet without considering nutritional needs, blood loss, appetite and other illness. Nor does it provide evidence of antimicrobial action.

A different setting appears in *Chikitsa Sthana* chapter 15. After removal of an obstructed or dead fetus, the text describes washing, oil use, medicines for pain and discharge, and a gradual diet during recovery. Its prolonged regimen belongs to that particular obstetric context.^[12] It cannot be applied automatically to every early miscarriage or uncomplicated medical abortion. Table 2 shows why the setting of each passage must remain visible.

Table 2: Classical passages and limits of the comparison.

Passage	What it addresses	Limit in modern use
<i>Nidana Sthana</i> 8/5–7	Stages of pregnancy loss	Does not diagnose a pathogen or site of infection.
<i>Sharira Sthana</i> 10/49	Diet after miscarriage	Does not establish a treatment for cervicitis.
<i>Sharira Sthana</i> 10/15–17	Care after childbirth	Postpartum advice needs adaptation after pregnancy loss.
<i>Chikitsa Sthana</i> 15/12–15	Care after a difficult fetal extraction	Describes a different degree of illness and intervention.

The word *Paricharya* is used here for care during recovery. The comparison focuses on food, comfort, activity and observation of symptoms. Ayurvedic concepts such as *Agni*, *Bala* and *Apana Vayu* may help describe the traditional reasoning about digestion, strength and pelvic function. They should retain that meaning. Equating them with a laboratory marker or a named microorganism would add a claim that the classical passage does not make.

Similar caution applies to labels such as *Garbhashaya Griva Shotha* or *Karnini*. A descriptive Ayurvedic label cannot, by itself, separate infection from ectropion, trauma or a cervical lesion. The question is not whether the two systems use similar words for discharge or swelling. It is whether the patient has been assessed accurately and whether the proposed treatment improves a defined outcome.

SUPPORTIVE CARE THAT CAN BE CONSIDERED

After serious complications have been excluded or treated, patients still need help with daily recovery. The useful part of a combined approach is to make this care practical and acceptable. Advice should reflect the patient's appetite, food preferences, responsibilities and access to help. Table 3 offers a proposed way to discuss such care; it is not a tested package or a prescription.

Table 3: Possible supportive care and its limits.

Care element	Reasonable aim	Boundary
Food and fluids	Help the patient eat and drink adequately	A restricted gruel diet is not treatment for infection or anaemia.
Rest and activity	Adjust activity to symptoms and comfort	Do not impose a fixed period of bed rest on everyone.
External hygiene	Support comfort with gentle routine care	Avoid untested vaginal washes or inserted products.
Pain and bleeding	Notice whether recovery is	Worsening symptoms require clinical

review	progressing	assessment.
Emotional support	Offer a private, nonjudgmental discussion	Do not assume how the patient should feel.

Rice gruel may be acceptable for someone with a poor appetite, but it should not become a reason to continue an inadequate diet. Blood loss, persistent weakness or suspected anaemia needs assessment and appropriate treatment. A claim that a diet “rebuilds blood” should be tested with suitable measures rather than accepted from symptom improvement alone.

Rest should allow recovery without unnecessary restriction. RCOG advises that return to activity after miscarriage depends on how the patient feels; a person who feels well need not remain inactive because of a fixed timetable.^[13] In a study, the amount of rest, return to work and help at home should be recorded. Otherwise, an apparent benefit from a medicine may partly reflect differences in ordinary care.

Emotional responses also vary. A person may feel grief, relief, anxiety, or several feelings together. Care should allow these responses without judgment. Support after spontaneous loss should not be based on the assumption that stress or ordinary sexual activity caused the miscarriage; RCOG does not support those claims.^[13] A combined care plan should not add guilt through rigid rules about diet, conduct or recovery.

LOCAL PROCEDURES AND HERBAL MEDICINES NEED SEPARATE EVIDENCE

The cited *Chikitsa Sthana* passage includes local oil use and washing in its historical aftercare description.^[12] Their presence in a classical text does not establish the safety of applying a preparation to an inflamed cervix soon after abortion. *Yoni Pichu*, vaginal washing and intrauterine procedures such as *Uttara Basti* are different interventions. Evidence for one route cannot be assumed to support another.

CDC notes a possible role for frequent douching or chemical irritation in cervicitis.^[1] An untested local product may also make it harder to judge discharge or to interpret symptom change. The concern is greater when a procedure passes through the cervix into the uterus. Such interventions should not be introduced as routine care for suspected post-abortion infection on the strength of traditional use alone.

An oral herbal product also needs a clear identity. A study should state every ingredient, botanical identity, plant part, preparation method and batch. WHO guidance provides methods for checking herbal materials, including contamination and other quality concerns.^[14] These checks help establish what was given. They do not show that it cures an infection. Laboratory antimicrobial or anti-inflammatory activity, if reported for an ingredient, would still need confirmation at a safe dose in the complete product and in the intended patient group.

FOLLOW UP AND REPRODUCTIVE HEALTH

WHO does not require a routine follow-up visit after every uncomplicated abortion when the patient has clear information and access to care. A review may still be offered for symptoms, contraception or emotional support.^[2] Confirmed cervicitis is a different situation: response to treatment and test results need follow-up. The distinction avoids both unnecessary visits for a well patient and inadequate review of someone with infection.

When chlamydia is diagnosed, partner assessment and treatment reduce reinfection. CDC advises avoiding sex until treatment is completed, symptoms have resolved and partners have been treated. Retesting at about three months is advised because repeat infection is common. This is different from an early test of cure, which is not routinely needed in a nonpregnant patient after appropriate treatment.^[8]

Fertility can return before the next menstrual period. Contraceptive counselling should therefore be offered according to the patient's wishes.^[2] An intrauterine device should not be newly inserted in the presence of current purulent cervicitis, gonorrhoea or chlamydia, or immediately after septic abortion. This differs from managing an infection when an intrauterine device is already in place.^[15] A traditional recovery schedule should not delay access to suitable contraception.

WHAT A USEFUL RESEARCH PROGRAMME WOULD TEST

The first task is to define the condition. A study of persistent discharge after abortion should not enrol all patients under one diagnosis. It should state how cervicitis was confirmed, how upper genital tract infection and retained tissue were assessed, and whether the abortion was induced or spontaneous. Timing, method of abortion, baseline infection and previous antibiotics should be recorded. These details make the study population understandable.

The intervention must be equally clear. If *Paricharya* means a diet and recovery plan, its content, duration, supervision and permitted changes should be described. If it includes a medicine or local procedure, that component needs its own safety justification. The TIDieR checklist provides a useful structure for describing a complex intervention so that another team can repeat it.^[16] Table 4 lists the main questions and suitable measures.

Table 4: Priority questions for research.

Research question	Suitable measure	Important safeguard
Does supportive care improve recovery?	Pain, fatigue, daily function and patient satisfaction	Both groups receive appropriate clinical care.
Does an added medicine improve infection outcomes?	Defined clinical response and indicated organism testing	Standard antibiotic treatment is not withheld.
Is the proposed care safe?	Adverse events, bleeding, irritation and drug interactions	Set stopping rules and an urgent referral plan.
Can the care be repeated reliably?	Adherence, product quality and variation between providers	Describe each component and allowed adjustment.

An early study could test a simple supportive programme after the acute condition has been treated. A later randomised trial could compare usual care with usual care plus the defined programme, if preliminary safety and feasibility are acceptable. The main outcome and sample size should be chosen before recruitment. Reporting should follow CONSORT 2025, with the herbal extension where relevant.^[17,18] A smaller amount of discharge alone should not be labelled microbiological cure.

The trial should also record other medicines, partner treatment, adherence and further procedures. Assessors should be blinded where feasible, especially for examination-based outcomes. Claims about preventing infertility would require longer follow-up and a different study size from a short trial of symptom relief. Registration, ethics review and a clear plan for reporting harm are necessary before testing the proposed care in patients.

DISCUSSION

The comparison shows that classical aftercare and modern infection treatment address related but different questions. Classical passages describe how a woman was cared for after pregnancy loss or a difficult obstetric event. Modern guidance asks where infection is present, which organisms may be involved, and whether treatment or evacuation is urgent. A useful review can explain both without claiming that one vocabulary confirms the other.

There is room to study culturally familiar food advice, recovery support and communication. These may affect comfort, adherence and the experience of care. Any benefit should be measured directly. It would be misleading to describe improved appetite or reduced fatigue as proof that a cervical infection has cleared. The same caution applies when the patient improves while receiving both antibiotics and an Ayurvedic medicine: improvement cannot be assigned to the added medicine without a suitable comparison.

The WHO recommendation on initial management of non-life-threatening post-abortion infection includes trained traditional and complementary medicine professionals within an appropriate service framework. The tasks described are recognition, stabilisation, antibiotics and referral.^[2] This concerns professional skills and care pathways. It is not a WHO endorsement of herbal treatment for post-abortion infection. That distinction is especially relevant when designing collaboration between Ayurveda and obstetric services.

LIMITATIONS

This review relies on selected accessible guidance and a limited set of classical passages. It does not provide a full survey of Indian publications, regional textbooks, unpublished studies or Sanskrit commentaries. The classical translation is historical and contains terminology that may differ across editions. No direct controlled trial of the proposed *Paricharya* programme in confirmed post-abortal cervicitis was established from the sources reviewed. This is a limit of the present evidence base and search, not proof that no relevant report exists anywhere.

CONCLUSION

Post-abortal cervicitis requires careful diagnosis and assessment for infection above the cervix. Antibiotics, partner care and urgent treatment of infected retained tissue remain essential when indicated. *Garbhasrava–Garbhapata Paricharya* offers historical ideas about care after pregnancy loss, but it has not been established as a treatment for confirmed cervical infection in this review. Its possible role is best explored through clearly defined supportive care and carefully designed studies that preserve timely modern treatment.

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