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# COMPLETE REGRESSION OF UTERINE FIBROID WITH POLYHERBAL AYURVEDIC INTERVENTION IN A PERIMENOPAUSAL WOMAN: A CASE REPORT

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## ABSTRACT

Uterine fibroids are the most common benign pelvic tumours in women, affecting up to 70 -80% of women by the age of 50 and representing a leading indication for hysterectomy. This case report presents the complete ultrasonographic regression of a uterine fibroid following a structured polyherbal Ayurvedic intervention in a perimenopausal woman who declined surgical management. A 52-year-old multiparous homemaker presented with heavy menstrual bleeding requiring 5–6 fully soaked sanitary pads per day over 7-9 days, dysmenorrhoea, leucorrhoea, and moderate iron-deficiency anaemia with a haemoglobin of 7.0 g/dL. Pelvic ultrasonography confirmed a 30×27 mm hypoechoic fibroid on the anterior uterine wall in projecting into the endometrium, along with incidental Grade I fatty liver. Ayurvedic assessment identified a predominant *Vata-Kapha* imbalance with *Kapha-Meda Dushti* as the central pathogenic axis, correlating with the Ayurvedic diagnosis of *Garbhashaya Granthi*. Treatment was administered over 90 days in two sequential phases. Phase I employed *Lavana Bhaskar Churna* and *Phaltrikadi Kashaya* for metabolic priming through *Agni Deepana* and *Ama Pachana*. Phase II introduced *Kanchanar Guggulu*,

*Chandraprabha Vati*, *Mamsapachak Vati*, *Tapyadi Loha*, and *Arogyavardhini Vati* to directly target fibroid regression, correct anaemia, and restore hepatic oestrogen clearance. Clinical follow-up at 30-day intervals demonstrated progressive reduction in menstrual blood loss, complete resolution of dysmenorrhoea and leucorrhoea, and a marked rise in haemoglobin to 11.6 g/dL. Repeat ultrasonography at eight months confirmed complete disappearance of the fibroid with restoration of normal uterine dimensions. This case highlights the potential of classical Ayurvedic combination therapy as a viable non-surgical alternative for uterine leiomyomas, warranting further investigation through larger controlled studies.

**KEYWORDS:** *Garbhashaya granthi*, Uterine Fibroid, Uterine Leiomyomas, Menorrhagia, Non-surgical management.

## INTRODUCTION

Uterine fibroids (leiomyomas) are the most common benign tumours of the female genital tract, with a cumulative incidence approaching 70–80% by the age of 50 years.[1] Although a substantial proportion remain asymptomatic, symptomatic fibroids commonly present with menorrhagia, dysmenorrhoea, pelvic pressure, and secondary anaemia. In India, hospital-based studies report a prevalence ranging from 24% in urban to nearly 38% in rural populations, and fibroids remain among the leading indications for hysterectomy in routine gynaecological practice.[2] Current allopathic management spans expectant observation, hormonal and selective progesterone-receptor-modulator therapy, and surgical options ranging from myomectomy to hysterectomy, the last of which remains the definitive but irreversible choice for many perimenopausal women who wish to avoid surgery.

In Ayurveda, uterine fibroids are broadly correlated with *Garbhashaya Granthi*, a *Mamsapradoshaja Vikara* arising from vitiated *Vata* and *Kapha Dosha* together with *Dushti* of *Rakta*, *Mamsa*, and *Meda Dhatu*, and are managed through *Deepana-Pachana*, *Lekhana*, and *Shodhana*-oriented Chikitsa aimed at *Samprapti-vighatana* rather than surgical excision.[3] Emerging clinical evidence, including randomised trials of classical Ayurvedic drug regimens, has demonstrated symptomatic and structural improvement in uterine fibroids, supporting polyherbal intervention as a non-surgical alternative in selected patients.[4] Against this background, we report a case of complete ultrasonographic regression of a uterine fibroid in a perimenopausal woman managed with a structured, phase-wise polyherbal Ayurvedic protocol, who had declined hysterectomy.

A 52-year-old woman, a homemaker of middle socioeconomic status presented to a private Ayurvedic outpatient department with complaints of heavy menstrual bleeding lasting 7-9 days (requiring 5-6 fully soaked sanitary pads per day), mild to moderate lower abdominal and lumbar pain of variable intensity, and white vaginal discharge. Symptoms had been present for the past six months. The patient experienced menarche at the age of 13 years. Prior to the onset of the current complaints, her menstrual cycles were regular at 28-30 days intervals with a 5-6 days duration. Over the preceding two months, interval had become 28-32 days with duration extending to 7-9 days, associated with markedly increased flow. Mild to moderate dysmenorrhoea was present, predominantly during the first two days of each cycle, partially relieved by analgesics and hot fomentation.

Her obstetric history revealed she was multiparous (G2P2A0L2), having two living children delivered with normal delivery. She had previously consulted a modern medicine gynaecologist who diagnosed the condition on ultrasonography and recommended hysterectomy, which the patient declined. She had been using analgesics for pain relief. There was no known prior use of hormone substitutes.

The patient was a moderately built female weighing 65 kg, standing 152 cm tall with a BMI of 28.1 kg/m$^2$. Vital signs were stable, with a pulse rate of 76/min and blood pressure of 120/80 mmHg. On physical examination, the patient exhibited a mildly coated tongue and dry, rough skin. Ayurvedic evaluation revealed moderate status of tissue integrity, body constitution, adaptability, and stress tolerance, whereas her physical stamina and her digestive strength was diminished. She was a vegetarian with no history of addictions. Dosha analysis revealed a predominant imbalance of Vata and Kapha, which correlated with her complaints of poor sleep, decreased appetite, and irregular bowel habits.

No abnormalities were detected in the respiratory, cardiovascular, gastrointestinal, and nervous system examinations.

**Investigations**

Pelvic ultrasonography (USG) revealed a hypoechoic fibroid (30×27 mm) in the anterior uterine wall indenting the endometrium, with an associated Grade I fatty liver. All other abdominal and pelvic structures appeared normal. The uterine size measured 8.2×4×3.7 cm. Haematological investigation revealed Haemoglobin was 7.0 g/dL, consistent with moderate iron-deficiency anaemia secondary to chronic heavy menstrual bleeding.

**Therapeutic Intervention**

The first 30 days treatment plan is described in complete detail below see [Table -1]. For the subsequent sixty days, the same course of treatment was followed.

**Table -1: Ayurvedic Medicines for first 30 days.**

| S.No. | Medicine | Dosage | Route of Administration | Duration | Phase |
|---|---|---|---|---|---|
| 1 | *Lavana Bhaskar Churna* | 3 g with *Goghrita* (cow ghee) Twice daily Before meals | Orally | Days 1–7 | Phase I |
| 2 | *Phaltrikadi Kashaya* | 15 ml with 60 ml warm water Twice daily After meals | Orally | Days 1–60 | Phase I & II |
| 3 | *Chandraprabha Vati* | 250 mg Twice daily Before meals with warm water | Orally | Days 8–60 | Phase II |
| 4 | *Kanchanar Guggulu* | 250 mg Twice daily Before meals with warm water | Orally | Days 8–60 | Phase II |
| 5 | *Mamsa Pachak Vati* | 500 mg Twice daily Before meals with warm water | Orally | Days 8–60 | Phase II |
| 6 | *Tapyadi Loha* | 250 mg Twice daily Before meals with warm water | Orally | Days 8–60 | Phase II |
| 7 | *Arogya Vardhini Vati* | 250 mg Twice daily Before meals with warm water | Orally | Days 8–60 | Phase II |

Treatment was structured in two sequential phases over 60 days, followed by continued dietary and lifestyle management for five months in total. Phase I (Days 1-7) focused on *Agni Deepana* (metabolic activation) and *Ama Pachana* (elimination of unprocessed metabolic toxins), thereby creating an optimal physiological basis for subsequent therapeutic intervention. Phase II (Days 8- 60) deployed *Granthi-Medohara Chikitsa* targeting the fibroid pathology. Phaltrikadi Kashaya was continued throughout both phases. (Days 1- 60).

**Follow Up and Outcomes**

A structured clinical assessment was performed at 30-day intervals, and the symptomatic and haematological outcomes are presented in Table 2.

**Table 2: Symptomatic and Haematological Outcomes at Follow-up.**

| Parameter | Day 0 | Day 30 | Day 60 | Day 90 | Outcome |
|---|---|---|---|---|---|
| **Menstrual blood loss (pads/day)** | 5–6 | 3–4 | 3–4 | 2–3 | Significantly reduced |
| **Duration of menses (days)** | 7–9 | 6–7 | 5–7 | 4–5 | Normalised |
| **Dysmenorrhoea** | Present | Reduced | Relieved | Absent | Complete relief |
| **Leucorrhoea** | Present | Occasional | Absent | Absent | Fully resolved |
| **Haemoglobin (g/dL)** | 7.0 | — | — | 11.6 | Marked rise (+4.6 g/dL) |

Pelvic ultrasonography was repeated on 12 February 2024 approximately eight months after treatment initiation, showed complete disappearance of the anterior wall fibroid. The uterus appeared normal in dimensions and the previously documented endometrial irregularity was no longer present. Comparative ultrasonographic findings are presented in Table 3.

**Table 3: Comparative Ultrasonographic Findings Before and After Treatment.**

| Parameter | Pre-treatment USG (13 June 2023) | Post-treatment USG (12 February 2024) |
|---|---|---|
| **Uterus size** | 8.2 × 4.0 × 3.7 cm | Normal dimensions |
| **Fibroid** | Hypoechoic anterior wall, 30 × 27 mm, indenting endometrium | Not visualised – absent |
| **Other findings** | Grade I fatty liver; other structures normal | No significant abnormality |
| **Impression** | Uterine fibroid confirmed | No evidence of fibroid |

## DISCUSSION

Uterine leiomyomas (fibroids) are the most common benign pelvic tumours in women, affecting nearly 70-80% of women by 50 years of age.[5] They are particularly common during the perimenopausal period due to hormonal influences. In India, fibroids contribute to 30-40% of gynaecological admissions and are a major cause of hysterectomy. Symptomatic fibroids commonly present with heavy menstrual bleeding, leading to iron-deficiency anaemia and reduced quality of life. Although medical and minimally invasive treatments are available, hysterectomy remains the definitive management in many cases.[5]

Fibroid growth is influenced by ovarian steroid hormones, growth factors, and extracellular matrix alterations.[6,7] Significantly, this patient's BMI of 28.1 kg/m² reflects their obesity, and Grade I fatty liver is a known independent risk factor for the formation and development of fibroids, mediated by peripheral oestrogen conversion from androstenedione by aromatase in adipose tissue.[8]

In Ayurveda, uterine fibroids are broadly correlated with *Garbhashaya Granthi*, a pathological condition attributed to *Kapha-Medodushti* (vitiation of adipose and metabolic tissues), resulting in abnormal tissue overgrowth and *Srotorodha* (obstruction of bodily channels) within the *Artavavaha Srotas*. This pathogenesis is believed to manifest clinically as symptoms such as menorrhagia and pelvic mass formation. Notably, this Ayurvedic interpretation shows similarity with modern biomedical concepts, which identify obesity-related hormonal and metabolic disturbances as significant factors in the initiation and progression of fibroids. The overlap between these viewpoints provides a rational basis for

employing Ayurvedic therapies directed at correcting *Meda Dushti*, especially *Medohara Chikitsa*, in the management of uterine fibroids.[9]

***Lavana Bhaskar Churna***

Administrated as the primary *Deepana-Pachana* agent in Phase I. This polyherbal preparation comprising *Saindhava Lavana (rock salt), Pippali (Piper longum), Maricha (Piper nigrum), Shunthi (Zingiber officinale), Haritaki (Terminalia chebula), Chitraka (Plumbago zeylanica),* and *Ajwain (Trachyspermum ammi)* acts synergistically to kindle *Jatharagni*, eliminate *Ama*, and correct *Srotorodha*. In Ayurveda, nodular formations are believed to arise from *Mandagni*, therefore restoring digestion is considered essential before administering Lekhana dominant therapies.[10]

***Phaltrikadi Kashaya***

It was continued throughout both phases because of its broad spectrum therapeutic action. Comprising *Triphala Amalaki (Emblica officinalis), Haritaki (Terminalia chebula), Vibhitaki (Terminalia bellirica), Guduchi (Tinospora cordifolia), Vasa (Adhatoda vasica), Katuki (Picrorhiza kurroa), Bhunimba (Andrographis paniculata),* and *Nimba Twak (Azadirachta indica b*ark), this decoction exerts potent *Pitta-Kapha Shamaka*, *Medohara*, hepatoprotective, anti-inflammatory *(Shothahara),* and anti-anaemic *(Pandurogahara*) effects.[11] Its action on the liver was particularly important in this case, as fatty liver can reduce the liver's ability to properly metabolize and eliminate oestrogen, leading to increased oestrogen levels that may promote the growth of leiomyomas.

***Chandraphrabha Vati***

Chandraprabha Vati was administered throughout the treatment course as a *Rasayana* and *Tridosha-Shamaka* adjuvant. Classical Ayurvedic texts describe this formulation as *Sarvaroga Pranashini* (beneficial in multiple disorders), highlighting its wide therapeutic applicability, especially in disorders affecting the genito-urinary and reproductive systems. Through its *Srotoshodhana* (channel-cleansing), *Lekhana* (scraping), *Medohara*, *Balya*, and *Rasayana* properties, it helps to reduce pathological tissue overgrowth and improve pelvic tissue metabolism, thereby supporting fibroid regression. Additionally, its indication in conditions such as *Pandu Roga* and *Artavavaha Srotodushti* makes it especially relevant in this case scenario presenting with menorrhagia-associated anaemia and menstrual dysfunction.[12]

***Kanchanar Guggulu***

*Kanchanar Guggulu* is used to treat accumulated Kapha in the tissues. As kapha becomes embedded in the system, it appears as growths, cysts, or enlarged lymph nodes. Strong decongestants like *Kanchanara, Triphala* (a blend of *Terminalia chebula Retz., Terminalia belerica Roxb.,* and *E. officinalis* fruits), and *Trikatu (Zingiber officinale Rosc., Piper nigrum L., and Piper longum L.*) are combined with *Guggulu* to dissolve and eradicate hardened Kapha. By promoting lymphatic drainage and digestive system function, this purifying combination stops additional *Kapha* accumulation. Malignant ulcers, cysts, fistulas, syphilis, scrofula, and sinus problems are all treated with this anti-inflammatory medication. *Kanchanara* helps stop bleeding and is very useful for excess growths or tumours.[13] Guggulsterones the bioactive steroidal ketones of Guggulu inhibit NF-κB signalling and suppress pro-inflammatory cytokines (IL-6, TNF-α) that sustain leiomyoma proliferation.[14]

***Mamsapachak Vati***

*Mamsapachak Vati Dhatu Pachak* Yogas are polyherbal compositions used in the context of *jwaraadhikara* and are mentioned in the Charak Samhita and Ashtanga Hridaya. Even though *Dhatu Pachak* Yogas are mentioned in relation to *vishama jvara*, they are now frequently used for a number of *dhatudushti*-related illnesses in addition to pacifying jvara. We can use Mamsapachak yoga for this condition because Granthi has *mamsavaha strotas dushti*. *Nimba patra (Azadirachta indica), patol patra (Tricosanthes dioica), triphala, mridvika (Vitis vinifera), musta (Cyperus rotundus),* and *kutaj (Holarrhena antidysenterica)* in equal amounts are the constituents of Mamsapachak yoga.[15] Although *pachak yogas* are often taken as qwath (decoction), we chose tablets in this case for the patient's convenience.

***Tapyadi Loha***

The polyherbo-mineral *Tridoshahara* formulation has therapeutic effects ranging from Rasa Dhatu to Shukra Dhatu. Its constituents include *Triphala Amalaki (Emblica officinalis), Haritaki (Terminalia chebula), Vibhitaki (Terminalia bellirica) Pippali (Piper longum), Mandura Bhasma (ferric oxide preparation), Loha Bhasma (iron calx), Raupya Bhasma (silver calx),* and *Swarna Makshika* (copper iron pyrite). It is especially indicated in conditions such as *Pandu* (anaemia) and *Raktapitta* (haemorrhagic disorders). The iron-containing *Bhasmas* help correct haematinic deficiency while acting as Dhatuposhaka (tissue nourishers).[16] The formulation’s efficacy in managing secondary iron-deficiency anaemia is

reflected in the haematological improvement observed in this case, with haemoglobin levels increasing from 7.0 g/dL to 11.6 g/dL.

***Aarogyavardhini Vati***

Arogyavardhini Vati, a classical polyherbo-mineral formulation mentioned in Bhaishajya Ratnavali, brings a uniquely systemic dimension to this treatment protocol. Despite its established hepatoprotective activity, its clinical importance in Garbhashaya Granthi lies in its broader multidimensional actions. The formulation's principal constituents *Triphala - Amalaki (Emblica officinalis), Haritaki (Terminalia chebula), Vibhitaki (Terminalia bellirica), Shilajatu (Asphaltum punjabinum), Guggulu (Commiphora mukul), Chitraka (Plumbago zeylanica),* and *Tamra Bhasma* (copper calx) collectively target Kapha-Meda Dushti at the tissue level through potent Lekhana, Deepana, and Srotoshodhana actions, directly aligning with the pathogenic axis of uterine fibroids.[17] The patient's incidental Grade I fatty liver was clinically significant, as a poorly functioning liver fails to clear oestrogen efficiently directly leading to fibroid growth. Arogya Vardhini Vati, through its hepatoprotective action, restored this impaired oestrogen clearance, addressing the condition at its hormonal root rather than merely managing symptoms.[18]

## CONCLUSION

Uterine fibroids remain a major cause of menstrual morbidity and reduced quality of life among perimenopausal women. This case demonstrated substantial clinical improvement, correction of secondary anaemia, and complete ultrasonographic resolution of the fibroid following a structured Ayurvedic treatment regimen without surgical intervention. The outcome highlights the potential role of classical Ayurvedic combination therapy as a promising non-invasive approach in carefully selected patients with uterine leiomyomas. However, larger controlled studies are required to further evaluate its efficacy and safety.

## Declarations

### Conflicts of Interest

The authors declare that they have no conflicts of interest regarding the publication of this case report.

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**Patient Consent**

Written informed consent was obtained from the patient for the publication of this case report. A copy of the written consent is available for review by the Editor-in-Chief of this journal.

**Data Integrity**

All data collected and relevant to this case have been presented in this manuscript. No part of this case report has been published previously, nor is it under consideration for publication elsewhere.

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