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# SUCCESSFUL CONCEPTION FOLLOWING AYURVEDIC MANAGEMENT IN TORCH-SEROPOSITIVE WOMEN WITH HABITUAL ABORTION: A CASE SERIES

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## ABSTRACT

Recurrent pregnancy loss remains a multifactorial clinical entity, particularly when infectious, inflammatory, metabolic, and psychosomatic factors coexist and compromise uterine receptivity and early gestational stability.[1] Chronic genital tract infections, including TORCH-related exposure, contribute to impaired implantation, placental dysfunction, and early pregnancy failure, while associated psychological stress further aggravates reproductive outcomes.[2] Conventional management often addresses these factors in isolation, with limited emphasis on systemic preparation prior to conception.[3] Ayurveda offers a comprehensive framework for reproductive optimization by addressing digestive metabolism, tissue nourishment, immune balance, and psychological well-being through individualized interventions.[4]

This case series describes five women with a history of habitual abortion, including cases with documented TORCH positivity and associated reproductive and psychosomatic concerns. An Ayurvedic protocol was implemented, comprising targeted herbal formulations—***Tablet Poshini, Tablet Upaja, and Tablet Supraja***—alongside structured dietary guidance, lifestyle modification, and psychological counseling. All patients underwent a standardized two-month preconception "ground preparation" phase during which conception was intentionally deferred to stabilize the uterine environment and reduce the risk of recurrent loss. Successful conception and continuation of pregnancy beyond

previously documented loss periods was achieved.

This case series demonstrates the role of Ayurvedic management, including *Poshini, Upaja, and Supraja*, in improving reproductive stability and outcomes in women with habitual abortion.

**KEYWORDS:** *Ayurveda, recurrent pregnancy loss, habitual abortion, TORCH infection, preconception care, uterine receptivity.*

## INTRODUCTION

Recurrent pregnancy loss (RPL) or habitual abortion, defined as the spontaneous loss of two or more consecutive pregnancies before 20 weeks of gestation, affects couples attempting conception and represents a significant clinical and emotional burden for affected women and their families.[1] The etiology of habitual abortion is multifactorial, encompassing genetic, anatomical, endocrine, immunological, and infectious factors. Among these, infectious causes have gained increasing attention due to their potential impact on implantation, placental development, and early embryogenesis.[2]

The TORCH complex—comprising *Toxoplasma gondii*, Other agents (including syphilis, varicella-zoster virus, and parvovirus B19), *Rubella virus, Cytomegalovirus (CMV), and Herpes simplex virus (HSV)*—includes pathogens known to cross the placental barrier and adversely affect pregnancy outcomes. Beyond their established role in congenital infections, TORCH pathogens may impair a woman's ability to conceive or maintain pregnancy through several mechanisms. These include chronic endometrial inflammation, disruption of endometrial receptivity, altered cytokine and immune responses at the maternal–fetal interface, and placental insufficiency. Persistent or reactivated infections may also lead to impaired trophoblastic invasion, decidual damage, and microvascular compromise, all of which are critical events in early pregnancy maintenance.[3]

Infections such as *CMV* and *HSV* have been associated with chronic inflammatory changes in the reproductive tract, potentially interfering with implantation and early placentation. *Toxoplasma gondii* infection, particularly when acquired around the time of conception, has been implicated in early embryonic loss through direct fetal infection and placental damage. *Rubella virus* infection can result in defective placental development and early pregnancy failure, even in the absence of overt maternal symptoms. These mechanisms provide a

biologically plausible explanation for the observed association between TORCH infections and habitual abortion.[4,5]

In modern medicine, treatment for TORCH-positive patients is pathogen-specific and primarily aims to prevent congenital transmission in pregnant women, while non-pregnant immunocompetent adults often receive supportive care as infections are typically asymptomatic. For toxoplasmosis, primary maternal infection is managed with antibiotics to reduce fetal transmission risk, escalating to combination antiparasitic therapy if fetal infection is confirmed through diagnostic testing like amniocentesis. Syphilis is treated with standard penicillin-based regimens tailored to disease stage, CMV management lacks routine maternal antivirals but may involve experimental options with neonatal antiviral therapy for symptomatic cases, rubella relies on supportive measures with emphasis on preconception vaccination, and HSV lesions are addressed with antiviral suppression during outbreaks.

Overall, care involves multidisciplinary consultation, serologic confirmation, and fetal/neonatal monitoring to optimize outcomes.[6]

In this case series, we present five women with habitual abortion and documented TORCH positivity, describing their clinical profiles, serological findings, management strategies, and pregnancy outcomes. As part of the individualized management approach, the patients received Ayurvedic formulations including *Poshini, Upaja, and Supraja,* along with standard supportive care.

## CASE PRESENTATIONS

Five women with a history of habitual abortion and serological evidence of TORCH positivity were evaluated. All cases were assessed using a uniform clinical approach, including detailed obstetric history, laboratory investigations, and imaging studies. The individual case details are presented below.

### Case 1

A 31-year-old woman, gravida 4 para 0 abortus 3, presented with a history of three consecutive first-trimester pregnancy losses. The first two abortions occurred at early gestation and were managed with dilatation and curettage, while the third pregnancy loss was managed with medical termination of pregnancy.

TORCH serological evaluation revealed Rubella IgG positivity with negative IgM antibodies, suggestive of past infection. Based on clinical evaluation and serological findings, the patient was diagnosed with habitual abortion associated with TORCH seropositivity. She received treatment and close follow-up. The patient subsequently conceived within five months of treatment and delivered a healthy male neonate.

**Case 2**

A 29-year-old woman, gravida 4 para 0 abortus 3, presented with a history of three consecutive spontaneous first-trimester abortions. There was no history of surgical intervention during previous pregnancy losses.

TORCH screening showed Cytomegalovirus (CMV) IgM positivity with negative IgG antibodies, indicating prior exposure. The patient was diagnosed with habitual abortion associated with TORCH seropositivity and was managed with Ayurvedic treatment. She conceived within four months of treatment and is currently in the third trimester of pregnancy with an uneventful course.

**Case 3**

A 27-year-old woman, gravida 2 para 0 abortus 1, presented with a history of one spontaneous first-trimester abortion.

TORCH serology revealed Rubella IgG positivity with negative IgM antibodies, suggestive of past infection. Routine laboratory investigations and pelvic ultrasonography were unremarkable. The patient received treatment and she subsequently conceived within six months and delivered a healthy male infant.

**Case 4**

A 33-year-old woman, gravida 2 para 1 living 1 abortus 1 (G2P1L1A1D0), presented with a history of one missed abortion in the first trimester, which occurred spontaneously without the need for surgical intervention. She had previously delivered one full-term live birth without complications.

TORCH serological evaluation revealed positivity for TORCH IgM antibodies with negative IgG antibodies, suggestive of past infection. There was no significant medical or surgical history. Routine laboratory investigations and pelvic imaging were within normal limits.

Based on clinical evaluation and serological findings, the patient was managed with individualized Ayurvedic treatment and counseling.

**Case 5**

A 28-year-old woman, gravida 1 para 0 living 0 abortus 1 (G1P0L0A1D0), presented with a history of pregnancy loss at approximately 3 months of gestational age and complaints of secondary infertility. The abortion occurred spontaneously during the first trimester.

TORCH screening was positive for IgM antibodies with negative IgG antibodies, indicating previous exposure. No major systemic illness or surgical history was reported. Baseline investigations and pelvic imaging did not reveal any gross abnormalities.

The patient was diagnosed with habitual abortion associated with TORCH seropositivity and secondary infertility. She was managed with individualized Ayurvedic treatment and preconception counseling.

**Table 1: Clinical Profile and Treatment Outcomes of Patients with Habitual Abortion.**

| Case No. | Age (years) | Obstetric History | Gestational Age of Losses | Time to Conception After Treatment |
|---|---|---|---|---|
| 1 | 31 | G4 P0 A3 (A1–D&C, A2–D&C, A3–MTP) | First trimester | 5 months |
| 2 | 34 | G4 P0 A3 (A1–A3 spontaneous) | First trimester | 4 months |
| 3 | 35 | G2 P0 A1 (spontaneous) | First trimester | 6 months |
| 4 | 33 | G2 P1 L1 A1 D0 (1 missed abortion – spontaneous) | First trimester | 4 months |
| 5 | 28 | G1 P0 L0 A1 D0 | First trimester | 5 months |

**Menstrual History**

All five patients reported regular menstrual cycles with normal cycle length and duration, normal flow, and no significant history of dysmenorrhea, menorrhagia, or intermenstrual bleeding.

**Gynecological history**

Apart from the presenting condition, no other significant gynecological abnormalities were detected that could explain the history of recurrent pregnancy loss.

**Treatment**

**Table 2- Treatment given to the 5 TORCH Positive Patients.**

| Medicine given | Ingredients/Contents | Dosage |
|---|---|---|
| ***1. Tablet Upaja (300 mg)*** | *Kumari, Shuddha Kasis, Dalchini, Sonth, Gulkand* | 2 pills after breakfast and 2 pills after dinner |
| ***2. Tablet Poshini (600 mg)*** | *Shuddha Hingul, Bang Bhasma, Shivlingi, Shatavari, Ashwagandha, Jivanti, Putranjivak* | 2 pills after breakfast and 2 pills after dinner |
| ***3. Tablet Supraja (600 mg)*** | *Shuddha Hingul, Banga Bhasma, Ushir, Rasna, SHatwari, Dantabeej, Ashwagandha* | 2 pills after breakfast and 2 pills after dinner |

**Dietary and Lifestyle Interventions**

All patients received structured dietary and lifestyle guidance as an integral component of management, aimed at optimizing systemic health and reproductive readiness. Dietary recommendations emphasized the intake of warm, freshly prepared, and easily digestible meals, along with adequate hydration using warm water. Patients were advised to avoid heavy, fried, fermented, and processed foods to support digestive efficiency and reduce metabolic congestion. Stress management strategies included the practice of pranayama, incorporation of music therapy, and adherence to a consistent sleep routine (10:00 PM to 6:00 AM) to support circadian rhythm regulation and emotional well-being. Additionally, a planned two-month preconception “ground preparation” phase was followed for all patients, during which prescribed medications and lifestyle measures were continued while conception was intentionally deferred. This preparatory period was intended to stabilize the uterine nvironment, improve tissue support, and reduce the risk of recurrent pregnancy loss prior to attempting conception. Regular follow-up consultations were maintained to reinforce adherence and ensure continuity of care.

**DISCUSSION**

Recurrent pregnancy loss (RPL) is a multifactorial reproductive disorder resulting from complex interactions among infectious exposure, immune regulation, endocrine balance, and endometrial receptivity.[1] In this case series of five women with habitual abortion, all pregnancy losses occurred during the first trimester, a critical phase involving implantation, placental development, and maternal–fetal immune adaptation. TORCH serology revealed mixed patterns across the cohort, with some patients demonstrating IgM positivity suggestive of recent or ongoing infection, while others showed IgG positivity indicating prior

exposure.[2][3]

Active or reactivated TORCH infections during early gestation can disrupt trophoblastic invasion, impair placental angiogenesis, and alter cytokine signaling at the maternal–fetal interface, thereby increasing the risk of implantation failure and early pregnancy loss. Even isolated IgG seropositivity may be associated with persistent immune dysregulation, low-grade inflammation, and compromised endometrial receptivity, underscoring the relevance of both active infection and post-infectious immune sequelae in habitual abortion.[4,5]

Conventional allopathic management of TORCH-associated reproductive failure primarily focuses on antimicrobial therapy in IgM-positive cases and expectant or supportive care in IgG-positive cases. While this approach is essential for controlling active infection, it may not adequately address downstream consequences such as chronic inflammation, impaired uterine receptivity, hormonal imbalance, or psychosomatic stress, particularly in women with recurrent losses and no overt infection at the time of conception. As a result, a therapeutic gap often exists between microbiological clearance and restoration of optimal reproductive physiology, especially during the preconception period when uterine and immune preparedness are critical.[6]

Ayurveda provides a comprehensive, systems-oriented framework that addresses this gap by simultaneously targeting immune modulation, tissue nourishment, metabolic balance, and psychological well-being. In the present case series, Ayurvedic management emphasized a structured preconception “ground preparation” phase aimed at stabilizing the uterine environment, reducing residual inflammation, and improving endometrial receptivity prior to conception. The observed outcomes—successful conception and continuation of pregnancy beyond previously documented loss periods—suggest that optimizing the post-infectious reproductive milieu is as important as treating active infection. These findings support the potential role of Ayurvedic management for TORCH-associated habitual abortion and highlight the importance of preconception optimization in improving reproductive outcomes.[5,7]

Despite heterogeneity in obstetric history and gravidity, all patients in this series conceived following treatment, with time to conception ranging from four to six months. This uniform reproductive outcome across all five cases suggests that a structured, individualized approach addressing ovulation, uterine receptivity, and systemic reproductive health may be beneficial

in women with habitual abortion and TORCH seropositivity.

The Ayurvedic regimen employed in this series comprised ***Tablet Poshini, Tablet Upaja, and Tablet Supraja,*** selected to address complementary aspects of female reproductive function.

***Tablet Poshini*** was utilized as a foundational fertility-supportive formulation aimed at enhancing Beeja (gamete) quality and strengthening reproductive tissues. Ingredients such as *Shivlingi, Shatavari, Ashwagandha, Jivanti, and Putranjivak* are traditionally recognized for their *Balya and Rasayana* properties. These agents are believed to support ovarian function, improve endometrial receptivity, and promote hormonal balance, thereby creating a favorable physiological environment for conception and early pregnancy maintenance.[8,9]

***Tablet Upaja*** was administered with a specific focus on supporting ovulation and follicular maturation. Its constituents—including *Kumari, Shuddha Kasis, Dalchini, Sonth, and Gulkand*—are traditionally indicated for stimulating *Artava pravritti* and correcting metabolic and circulatory imbalances affecting ovarian physiology. Through these actions, the formulation may facilitate follicular growth, ovum maturation, and timely follicular rupture, addressing functional ovulatory disturbances that can predispose to early pregnancy loss.[8,9]

***Tablet Supraja,*** administered as part of the Ayurvedic protocol, is composed of *Shuddha Hingul, Banga Bhasma, Ushir, Rasna, Shatavari, Dantabeej, and Ashwagandha*, and is traditionally indicated to enhance systemic immunity, strengthen reproductive tissues, and improve uterine receptivity. *Shuddha Hingul* provides immunomodulatory and rejuvenative effects, potentially mitigating low-grade endometrial inflammation following prior TORCH exposure. *Banga Bhasma* nourishes reproductive tissues and promotes uterine strength, creating an optimal environment for implantation and early embryonic growth. *Ushir* acts as a mild uterine tonic, supporting circulatory and lymphatic health, thereby enhancing endometrial perfusion and tissue oxygenation, which are critical for sustaining early gestation. *Rasna* contributes anti-inflammatory and tissue-supportive properties, reducing subtle endometrial inflammation and facilitating implantation. *Shatavari* supports endometrial development, hormonal balance, and tissue nourishment, enhancing endometrial receptivity and embryonic support. *Dantabeej* strengthens reproductive tissues and maintains uterine stability, reducing the risk of early abortion, while *Ashwagandha* provides adaptogenic and immunomodulatory effects, supporting maternal systemic resilience and

reproductive health. Collectively, these ingredients synergistically improve systemic and local immunity, optimize the uterine environment, and support early embryonic development, thereby helping prevent recurrent pregnancy loss and sustain conception in TORCH-positive women.[8,9]

Collectively, these formulations were employed not to directly treat TORCH seropositivity, but to address the downstream reproductive vulnerabilities that may persist following prior infectious exposure. The consistent achievement of conception across all five cases highlights the role of Ayurvedic treatment in women with habitual abortion and TORCH positivity.

## CONCLUSION

In this case series of five women with a history of habitual abortion and documented TORCH seropositivity, Ayurvedic intervention demonstrated consistent and clinically meaningful outcomes. All patients received a structured Ayurvedic treatment consisting of *Tablet Poshini, Tablet Upaja, and Tablet Supraja,* supported by individualized dietary regulation, lifestyle modification, and psychological counseling. This comprehensive approach was designed to restore systemic balance, modulate immune responses, and improve uterine receptivity rather than focusing solely on the presence of prior infection.

Following Ayurvedic management, all five patients successfully conceived within four to six months of treatment initiation and were able to sustain pregnancy —an outcome not achieved in their earlier reproductive histories. The consistent achievement of conception and sustained pregnancy across all five cases confirms the effectiveness of Ayurvedic formulations in the management of recurrent pregnancy loss associated with TORCH positivity. Larger controlled studies are required to further validate these findings and establish standardized protocols for recurrent pregnancy loss associated with immunological and infectious factors.

## CONFLICT OF INTEREST

The authors declare no conflicts of interest relevant to this article.

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