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AYURVEDA-BASED MANAGEMENT OF PRIMARY INFERTILITY IN A PATIENT WITH PARTIAL (INCOMPLETE) BICORNUATE UTERUS, PELVIC INFLAMMATORY DISEASE, AND TORCH IGG POSITIVITY: A CASE STUDY

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ABSTRACT

Background: Primary infertility is a multifactorial condition that may be influenced by congenital uterine anomalies, menstrual irregularities, and reproductive tract infections. Ayurveda offers an individualized and holistic approach aimed at improving reproductive health and menstrual function. **Case Presentation:** A 26-year-old woman presented with primary infertility of six years' duration, delayed menstrual cycles occurring every 3–4 months, moderate dysmenorrhea, thick white vaginal discharge, dyspareunia, and reduced libido. Investigations revealed a partial bicornuate uterus. Additional findings included pelvic inflammatory disease with thick curdy discharge and TORCH IgG positivity. **Intervention:** The patient was managed with a proprietary Ayurvedic fertility protocol consisting of *Tablet Poshini, Tablet Tulha, Tablet Supraja, and Tablet Jivani*. The medicines were administered in a cycle-synchronized manner with follicular monitoring. **Outcome:** Following treatment, menstrual regularity improved and ovulation was documented on follicular monitoring. The patient demonstrated restoration of reproductive cyclicity, suggesting a favorable response to the individualized Ayurvedic regimen. **Conclusion:** This case suggests that an individualized Ayurveda-based approach may help improve menstrual regularity and support ovulatory function in patients with complex reproductive tract abnormalities and chronic pelvic infection. Further clinical

studies are needed to evaluate the role, safety, and reproducibility of such interventions in infertility care.

KEYWORDS: primary infertility, bicornuate uterus, pelvic inflammatory disease, TORCH IgG, Ayurveda, case report.

INTRODUCTION

Infertility is a significant reproductive health concern affecting millions of couples worldwide and is defined as the inability to achieve pregnancy after 12 months of regular, unprotected intercourse. Female infertility may result from ovulatory dysfunction, congenital reproductive tract anomalies, pelvic infections, hormonal disturbances, or a combination of these factors. When multiple abnormalities coexist, the reproductive challenge becomes more complex and management must be individualized.[1,2]

A partial bicornuate uterus is a congenital Müllerian duct anomaly caused by incomplete fusion of the paramesonephric ducts during embryological development. It is characterized by a uterus with two distinct horns and may be associated with adverse reproductive outcomes, including infertility, recurrent pregnancy loss, preterm labor, malpresentation, and obstetric complications. Although conception is possible, the altered uterine anatomy may compromise implantation and pregnancy maintenance.[3,4]

Pelvic inflammatory disease (PID) is an infection-induced inflammation of the upper female reproductive tract involving the uterus, fallopian tubes, ovaries, and surrounding pelvic structures. Chronic PID can lead to tubal damage, pelvic adhesions, chronic pelvic pain, abnormal vaginal discharge, and impaired fertility. Persistent genital tract infection may further compromise the reproductive environment required for successful conception and implantation.[5,6]

TORCH screening is used to assess exposure to infections that may affect reproductive and fetal health, including toxoplasmosis, other infections, rubella, cytomegalovirus, and herpes simplex virus. A positive TORCH IgG result usually indicates prior exposure and acquired immunity rather than active infection, and interpretation should always be correlated with clinical findings and other laboratory investigations.[7]

From an Ayurvedic perspective, infertility may be correlated with disturbance in the factors essential for conception, including fertile timing, reproductive organs, nutrition, and gametic

integrity. Menstrual irregularity, vaginal discharge, dyspareunia, and reproductive tract disorder may reflect vitiation of Doshas and impairment of Artava Dhatu, ultimately affecting fertility potential. Ayurvedic management aims to restore physiological balance, regulate menstrual function, improve the reproductive milieu, and support the possibility of conception through an individualized therapeutic approach.

This case report describes the Ayurvedic management of a 26-year-old woman with primary infertility, delayed menstruation, pelvic inflammatory disease, TORCH IgG positivity, and a partial bicornuate uterus. The report highlights a structured Ayurveda-based fertility protocol used to support menstrual regularity and ovulatory function in the setting of complex gynecological findings.

CASE REPORT

Patient Information

A 26-year-old woman presented with primary infertility of six years' duration. She reported delayed menstrual cycles occurring every 3–4 months, thick white vaginal discharge, and a history of difficulty conceiving despite married life. She also complained of moderate dysmenorrhea, dyspareunia, and reduced libido.

Menstrual History

Table 1: Menstrual History of Patient.

Parameter	Details
Cycle Regularity	Delayed
Duration	3-5 days
Dysmenorrhea	Moderate
No. of pads per cycle	12 pads
Breakthrough Bleeding	Absent
Presence of Blood Clots	Present (occasionally)

Obstetric History

The patient was gravida 0, para 0, living 0, abortion 0, and death 0.

General Health Examination

Table 2: Patient Vital Signs.

Vitals	Values
Pulse	82/min
BP (Blood Pressure)	122/82 mmHg
Respiratory Rate (RR)	21/min
SPO2 (Oxygen Saturation)	98%

Other Examinations

Table 3: Other Examinations.

Parameter	Observation
Naadi Pariksha	pitta
Appetite	Normal
Bowel	Normal
Sleep	Normal
Energy Levels	Normal

Personal History

Table 4: Personal History of Patient.

Alcohol Consumption	No
Smoking	No
Junk Food Intake	Occasionally
Spicy Food Intake	No
Sleep Schedule	Sound Sleep
Physical Activity	No Activity
Stress Levels	Moderate (family and work stress)

Sexual History

Table 5: Sexual History of Patient.

Vaginal Dryness	No
Dyspareunia	Yes
Loss of Libido	Yes

Past Medical and Surgical History

There was no history of major medical illness. The patient had undergone diagnostic laparoscopy previously. She was known to have chronic pelvic inflammatory disease with thick curdy vaginal discharge and TORCH IgG positivity.

Diagnostic Investigations

Transvaginal ultrasonography revealed a partial bicornuate uterus. Hemoglobin was 11 g/dL.

Treatment and Management

The patient was managed with proprietary Ayurvedic medicines selected according to her menstrual pattern, reproductive symptoms, and follicular monitoring. The treatment plan was administered in a cycle-synchronized manner.

Table 6: Ayurvedic Proprietary Medicines, Ingredients, and Dosage for Treatment.

Medicine given	Ingredients/Contents	Dosage
1. Tab. Tulha (600 mg)	*Kumari, Shatavari, Dashmool, Devdaru, Kulattha, Ulatkambal, Manjistha, Eranda, Pippali, Shatapushpa, Haritaki, Krishna Jeeraka, Gajar Beeja, Karpas Beeja, Rason, Jyotishmati, Sunthi, Tankan Bhasma, Hingula Rasa, and Kasis Bhasma.*	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 Jivani (750 mg)	*Shuddha Hingul, Bang Bhasma, Karanja, Khadir, Asvattha, Shirish, Shalmali*	2 pills after breakfast and 2 pills after dinner
4. Tablet Supraja (600 mg)	*Shuddha Hingul, Banga Bhasma, Ushir, Rasna, SHatwari, Dantabeej, Ashwagandha*	2 pills after breakfast and 2 pills after dinner

Clinical Course

After one month of treatment, the patient reported improvement in menstrual symptoms and experienced menstruation after a delayed interval. Follicular monitoring showed preservation of ovulatory function, with follicular rupture documented in the expected peri-ovulatory period. The patient's symptoms of delayed menstruation and vaginal discharge improved during follow-up.

The response was assessed clinically and with serial follicular monitoring. The treatment was associated with improvement in cyclicity and evidence of ovulation, suggesting a favorable reproductive response despite the presence of congenital uterine anomaly and chronic pelvic inflammatory disease.

DISCUSSION

This report presents an individualized Ayurvedic approach to a complex case of primary infertility in a patient with a partial bicornuate uterus, chronic pelvic inflammatory disease (PID) with persistent curdy discharge, menstrual irregularity, and TORCH IgG positivity—features that together create structural, infectious, and functional challenges to fertility. A bicornuate uterus, a rare Müllerian fusion anomaly (estimated prevalence 0.1–0.5%), produces partial duplication of the uterine cavity and can impair implantation and gestational capacity; it is associated with higher risks of first-trimester miscarriage, preterm birth, malpresentation, and cesarean delivery, with reported live birth rates of roughly 55–75% without surgical correction. PID produces inflammatory damage to the endometrium, fallopian tubes, and pelvic environment that can compromise tubal function and endometrial receptivity; in this case, tubal and endometrial impairment likely compounded the effect of the congenital anomaly despite demonstrated ovulation (follicular rupture on days 16–18).

TORCH IgG positivity suggested past exposure and an immunologic history that may be clinically relevant when considered alongside chronic pelvic infection.[1-7, 9, 10]

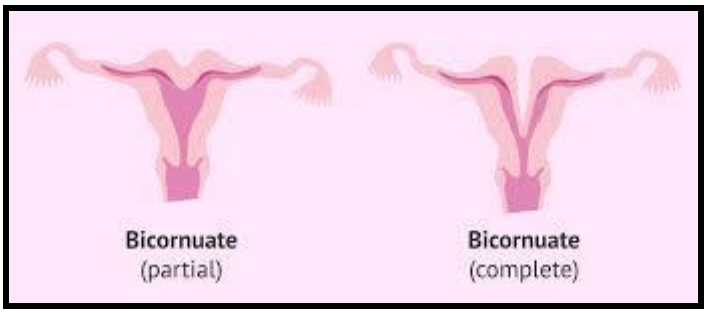

Fig. 1: Bicornuate Uterus (Partial and Complete).

From an Ayurvedic standpoint, the presentation aligns with disturbance of *Artava Dhatu* and vitiation of *Pitta,* affecting *Ritu* (fertility timing), *Kshetra* (uterine environment), and *Beeja* (ovulatory function). Therapeutic goals therefore focused on restoring endometrial health and uterine milieu, resolving chronic inflammation and abnormal discharge, regulating menstrual cycles and ovulation, and supporting systemic reproductive resilience.[8]

A cycle-synchronized, follicular-monitoring–guided protocol employed four proprietary tablets targeted to complementary dimensions of dysfunction: *Tablet Poshini (Shivlingi, Shatavari, Ashwagandha, Jivanti, Putranjivak)* to nourish reproductive tissues and support hormonal balance; *Tablet Tulha (Kumari, Shatavari, Dashmool, Devdaru, Kulattha, Ulatkambal, Manjistha)* to regulate menses, improve pelvic circulation, and promote follicular development and ovulation; *Tablet Jivani (Karanja, Khadir, Asvattha, Shirish, Shalmali)* for antimicrobial, anti-inflammatory, and tissue-healing effects to treat abnormal white discharge, resolve PID-related inflammation, and restore endometrial quality for implantation; and *Tablet Supraja (Ushir, Rasna, Shatavari, Dantabeej, Ashwagandha)* to provide immunomodulatory, anti-inflammatory, and rejuvenative support in the context of chronic infective burden. During treatment the patient achieved improved menstrual regularity and documented ovulation. Despite the congenital uterine anomaly, pregnancy ensued and was maintained until the third trimester, suggesting a favorable physiological response to the individualized Ayurvedic regimen.[11,12]

This case illustrates the need for a multidimensional strategy when structural, infectious, and functional factors coexist, and indicates that targeted Ayurvedic interventions—combined with cycle synchronization and follicular monitoring—may contribute to restoring menstrual

cyclicity, ovulation, and endometrial receptivity in multifactorial infertility. Larger, well-designed studies with extended follow-up are required to validate these observations and to develop standardized, evidence-based protocols.

CONCLUSION

This case highlights the encouraging role of an Ayurveda-based fertility protocol comprising *Tablet Poshini, Tablet Tulha, Tablet Jivani, and Tablet Supraja* in the management of primary infertility associated with partial bicornuate uterus, pelvic inflammatory disease, and menstrual irregularity. The intervention was associated with improved menstrual regularity, documented ovulation, and restoration of reproductive function, demonstrating the promising potential of Ayurveda in complex infertility management. The case further supports the value of cycle-synchronized, individualized treatment in optimizing reproductive health and enhancing fertility outcomes.

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