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AYURVEDIC MANAGEMENT OF ANOVULATORY INFERTILITY ASSOCIATED WITH POLYCYSTIC OVARY SYNDROME (PCOS): A CASE REPORT

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ABSTRACT

Polycystic Ovary Syndrome (PCOS) is a common cause of ovulatory dysfunction and female infertility. In Ayurveda, infertility is described as Vandhyatva, and menstrual and ovulatory disturbances may be interpreted in terms of Artava Dushti and Artavavaha Srotodushti. A 26-year-old woman presented with PCOS-associated anovulatory infertility, irregular menstrual cycles, and a history of infertility treatment without conception. Investigations revealed bilateral polycystic ovarian morphology and anovulatory cycles. The patient received an individualized Ayurvedic treatment protocol comprising Virechana Karma, Basti Chikitsa, including Uttara Basti, oral medications, and supportive procedures. The treatment approach was based on the Ayurvedic principles of Dosha Shamana, Agni Deepana, and management of Artava Dushti. Following the treatment course, the patient conceived and subsequently delivered a healthy male infant weighing 3.5 kg. This case describes a favorable reproductive outcome following an individualized Ayurvedic treatment protocol in a woman with PCOS-associated anovulatory infertility. However, as this is a single case involving multiple interventions, a causal relationship between the treatment and conception cannot be established, and the contribution of individual therapies cannot be determined. Further systematic clinical studies are required to

evaluate the efficacy and safety of this approach.

KEYWORDS: Polycystic Ovary Syndrome, Anovulatory Infertility, Vandhyatva, Ayurveda, Virechana, Uttara Basti.

INTRODUCTION

Infertility is a significant reproductive health concern affecting individuals and couples worldwide. According to the World Health Organization, approximately one in six people of Reproductive age experience infertility during their lifetime. Infertility is generally defined as the inability to achieve pregnancy after 12months or more of regular, unprotected sexual intercourse.[1] Ovulatory dysfunction is an Important cause of female infertility, and Polycystic Ovary Syndrome (PCOS) is one of its Common underlying conditions. PCOS is a Heterogeneous endocrine disorder associated With ovulatory dysfunction, hyperandrogenism, And, in some women, polycystic ovarian morphology. Women with PCOS may experience Irregular menstrual cycles, infrequent ovulation, And difficulty conceiving, Metabolic Abnormalities may also accompany this Condition.[2] In Ayurveda, infertility is described as Vandhyatva, and a woman experiencing infertility is referred to as Vandhya. Acharya Sushruta has discussed Vandhyatva in relation to Nashtartava.[3]

Ayurvedic classics emphasize the importance of Garbha Sambhava Samagri, the essential factors required for conception, including the appropriate condition of Ritu, Kshetra, Ambu and Beeja.[4] The proper functioning of Vayu, particularly Apana Vata, and the normalcy of the reproductive tissues are also considered important for conception.[5] Shuddha Artava, representing the healthy reproductive element, plays a significant role in female reproductive physiology. From an Ayurvedic perspective, menstrual irregularities and impaired ovulatory function associated with PCOS may be interpreted through the concepts of Artava Dushti and Artavavaha Srotodushti. Depending on the individual clinical presentation, disturbances involving Vata-Kapha Dosha, Agni and Meda Dhatu may also be considered in understanding the pathogenesis. However, these Ayurvedic concepts represent a traditional interpretative framework and are not direct equivalents of the modern diagnosis of PCOS.

The Ayurvedic management of Vandhyatva aims to address the underlying Dosha imbalance and associated Srotodushti, while supporting reproductive health. Depending on the patient's clinical condition, treatment may involve Shodhana procedures, Basti Chikitsa and appropriate oral medications. Virechana Karma is traditionally employed for therapeutic

purification, whereas Basti procedures are described in Ayurvedic practice for the management of conditions involving Vata Dosha. Uttara Basti has also been described in the context of female reproductive disorders. The selection of these interventions should be based on individual assessment and appropriate clinical indications. Their effectiveness in PCOS-associated anovulatory infertility, however, requires further systematic evaluation.

AIM AND OBJECTIVE

To describe the clinical outcome following an individualized Ayurvedic treatment protocol in a woman with PCOS-associated anovulatory infertility.

MATERIAL AND METHOD

A 26-year-old female, working as a nursing officer, presented to the Prasuti Tantra Evum Stree Roga outpatient department with a complaint of inability to conceive for the past 2 years despite regular unprotected intercourse. She had been married for 3 years.

The patient gave a history of irregular menstrual cycles since approximately 5 years, with occasional prolonged intermenstrual intervals. She had undergone follicular monitoring, which revealed anovulatory cycles. Ultrasonography of the pelvis showed features suggestive of polycystic ovaries bilaterally. Hysterosalpingography revealed bilateral tubal patency. Her husband's semen analysis was within normal limits. She had previously received treatment for infertility for approximately 1½ years but had not conceived. There was no significant history of pelvic tuberculosis, previous pelvic surgery, genital infection or previous pregnancy.

Family History

There was no significant family history of infertility. Her mother had attained menopause at approximately 48 years of age. No similar menstrual disorder was reported among her siblings.

Menstrual History

- Age at menarche: 13 years LMP- 25/09/2025

Menstrual cycle: Irregular

- Interval: 35–45 days
- Duration of flow: 3–4 days
- Amount: Approximately 2–3 pads/day
- Clots: Occasionally present

- Pain: Mild lower abdominal discomfort during menstruation
- Dysmenorrhoea: Absent
- Premenstrual symptoms: Occasional breast heaviness and bloating

The patient reported occasional delayed menstruation requiring medical intervention for withdrawal bleeding.

Personal History Ahara

Predominantly Guru, Snigdha and Madhura-Katu predominant diet; frequent intake of bakery products, fried snacks and fast food. Occasional excessive intake of sweets and dairy products.

Vihara

Predominantly sedentary lifestyle; minimal physical exercise; prolonged sitting during working hours; occasional daytime sleep- late-night sleep habit.

Bowel- Once daily; occasionally constipated

Micturition: 4–5 times/day; no abnormality.

Sleep: 6–7 hours/day; occasionally disturbed with late bedtime. Appetite: Moderate.

Coitus: 2–3 times/week; no dyspareunia or post-coital bleeding.

Manasika bhava: Chinta and occasional mental stress related to delayed conception.

GENERAL EXAMINATION

- Built: Moderate
- Height: 160 cm
- Weight: 68 kg
- BMI: 26.6 kg/m²
- Pulse: 80/min
- Blood pressure: 118/76 mmHg
- Respiratory rate: 16/min
- Temperature: 98.2°F
- Pallor: Absent
- Icterus: Absent
- Cyanosis: Absent
- Clubbing: Absent
- Lymphadenopathy: Absent
- Oedema: Absent

SYSTEMIC EXAMINATION

CNS: Conscious, alert and oriented to time, place and person. CVS: S1 and S2 heard; no added sounds.

RS: Bilateral vesicular breath sounds heard; no added sounds.

P/A: Abdomen soft and non-tender. No organomegaly or palpable mass.

GYNAECOLOGICAL EXAMINATION

Breast: Bilaterally symmetrical; no abnormal discharge. P/S: Cervix healthy; no abnormal vaginal discharge.

P/V: Uterus anteverted, normal in size, mobile and non-tender; bilateral adnexa non-tender; no adnexal mass palpable.

INVESTIGATIONS

- Hb: 12.1 g/dL
- TSH: 2.530 µIU/mL
- Serum LH: 10.8 mIU/mL
- Serum FSH: 6.4 mIU/mL
- Serum prolactin: 20.02 ng/mL
- HbA1c: 5.7 %
- Fasting blood glucose: 88 mg/dL
- Serum AMH: -11.76
- HSG: Bilateral fallopian tubes patent
- Semen analysis: within normal limit
- Pelvic USG: Bilaterally enlarged ovaries with multiple small peripheral follicles, suggestive of polycystic ovarian morphology Rt ovary -12.9 cc, Left ovary -11.5 cc
- Follicular study: No evidence of dominant follicle rupture/anovulatory cycle

AYURVEDIC ASSESSMENT

NIDANA

The probable Nidanas identified from the patient's history were:

1. **Mithya Ahara**

- Guru and Snigdha Ahara
- Excessive Madhura Rasa
- Frequent fried and bakery foods

- Fast food and processed snacks
- Excessive intake of dairy/sweet food

2. Mithya Vihara

- Sedentary lifestyle
- Avyayama
- Divaswapna
- Prolonged sitting
- Irregular sleep pattern and late-night awakening

3. Manasika Nidana

- Chinta
- Manasika stress associated with delayed conception

Purvarupa: Specific Purvarupa were not clearly documented. Menstrual irregularity was present in the clinical history.

RUPA

- Vandhyatva
- Artava kshaya/Artava dushti
- Aniyamita Artava pravritti
- Anovulation
- Sthoulya

UPASAYA: No specific Upashaya was documented.

ANUPASAYA: No formal assessment was documented; relevant dietary and lifestyle factors were identified from the history.

VYADHI VINISHCHAYA: Vandhyatva due to anovulatory factor associated with PCOS, interpreted from an Ayurvedic perspective as Artava dushti with involvement of Vata-Kapha Dosha and Medo Dhatu, with Agnimandya and obstruction/dysfunction of Artavavaha Srotas.

AYURVEDIC EXAMINATION

Prakriti: Kapha-Vata Prakriti **Vikriti**: Kapha-Vata predominance **Nadi**: Kapha-Vata Nadi **Sara**: Madhyama **Samhanana**: Madhyama **Pramana**: Madhyama **Satmya**: Madhyama **Satva**: Madhyama

Ahara Shakti: Madhyama **Vyayama Shakti:** Avara **Vaya**: Yuva

Koshtha: Madhyama

Agni: Mandagni

Mala: Sama/occasionally constipated

Nidra: Vishama

Manasika Bhava: Chinta-pradhana

SAMPRAPTI

Nidana Sevana

↓

Agnimandya

↓

Ama formation and disturbance of Dhatu metabolism

↓

Involvement of Kapha and Meda

↓

Vata Vaigunya and disturbance of Artava formation or Artava Pravritti

↓

Artava Dushti and menstrual irregularity

↓

Anovulation associated with infertility

SAMPRAPTI GHATAK

- **Dosha**: Vata-Kapha
- **Dushya**: Rasa, Meda and Artava
- **Agni**: Jatharagni/Medodhatvagni Mandya
- **Srotas**: Artavavaha Srotas, Rasavaha and Medovaha Srotas
- **Srotodushti**: Sanga/Vimargagamana
- **Udbhava Sthana:** Aamashaya/Pakwashaya
- **Adhisthana**: Garbhashaya and Artavavaha Srotas
- **Rogamarga**: Abhyantara
- **Vyadhi**: Vandhyatva associated with Artava Dushti and Anovulation

TABLE: TREATMENT PROTOCOL.

Visit	Duration	Treatment protocol	Medicine on discharge
1st Visit (Day	28/09/2025–	Udvartana with Kola-Kulathadi	Phala Ghrita 5 g BD

4 of menstruation)	07/10/2025	Churna and Bashpa Swedana for 3 days. Deepana-Pachana with Panchakola Churna 3 g BD and Chitrakadi Vati 2 tablets TID with Ushna Jala for 3 days. Snehapana with Phala Ghrita in increasing doses of 30, 60, 90 and 120 ml over 4 days. Virechana with Trivrit Avaleha 30 g on the 10th day, resulting in 28 vegas (Pravara Shuddhi).	with Ushna Jala before food; Pushpadhanwa Rasa 2 tablets BD with milk after food.
2nd Visit (Day 6 of menstruation)	18/11/2025–24/11/2025	Seven-day Basti Karma: Days 1, 3, 5 and 7 – Anuvasana Basti with Sahacharadi Taila; Days 2, 4 and 6 –	For 20 days: Phala Ghrita 5 g BD with Ushna Jala before food; Pushpadhanwa Rasa 2 tablets BD with milk after food.
		Niruha Basti with Mustadi Rajayapana Basti and Uttara Basti with Prasarini Taila.	
3rd Follow-up (Day 6 of menstruation)	18/12/2025–24/12/2025	Seven-day Basti Karma: Days 1, 3, 5 and 7 – Anuvasana Basti with Sahacharadi Taila (100 ml at 2 PM); Days 2, 4 and 6 – Niruha Basti with Mustadi Rajayapana Basti (300 ml at 8 AM) and Uttara Basti with Prasarini Taila (5 ml at 2 PM). Additional therapies: Sarvanga Abhyanga with Sahacharadi Taila and Parisheka with Dashamoola Kwatha in the morning; hiropichu with Ksheerabala	For 20 days: Phala Ghrita 5 g BD with Ushna Jala before food; Pushpadhanwa Rasa 2 tablets BD with milk after food.
		Taila in the evening.	
4th Follow-up (Day 6 of menstruation)	16/01/2026–22/01/2026	Seven-day Basti Karma: Days 1, 3, 5 and 7 – Anuvasana Basti with Sahacharadi Taila (100 ml at 2 PM); Days 2, 4 and 6 – Niruha Basti with Mustadi Rajayapana Basti (300 ml at 8 AM) and Uttara Basti with Prasarini Taila (5 ml at 2 PM). Additional therapies: Sarvanga Abhyanga with Sahacharadi Taila and Parisheka with Dashamoola Kwatha in the morning; Shiropichu with Ksheerabala Taila in the evening.	For 20 days: Phala Ghrita 5 g BD with Ushna Jala before food; Pushpadhanwa Rasa 2 tablets BD with milk after food.

TABLE: ULTRASONOGRAPHIC FINDINGS BEFORE AND AFTER TREATMENT.

Assessment	Date	Cycle Day	Right Ovary	Left Ovary	Endometrial Thickness (ET)
Before Treatmet LMP-30/05/2025	By letroz treatment 12/06/2025	12th	14*20 mm	23*15 mm	6 .0 mm
After 1st Cycle LMP-25/09/2025	5/10/2025	12th	17*20mm	23*15 mm	6 .0 mm
After 2nd Cycle LMP - 13/11/2025	23/11/2025	12th	17*18 mm	**14*16mm**	6.2 mm
After 3rd Cycle LMP-13/12/2025	23/12/2025	12 th	No dominant follicle	10*12	6.4 mm
After 4th Cycle LMP-11/01/2026	21/01/2026	12 th	18*20 mm	16*18 mm	6.8 mm

Following an integrative Ayurvedic treatment regimen comprising Virechana Karma with Trivrit Avaleha, Mustadi Rajayapana Basti, Anuvasana Basti with Sahacharadi Taila, Uttara Basti with Prasarini Taila, Sarvanga Abhyanga, Parisheka with Dashamoola Kwatha, and Shiropichu with Ksheerbala Taila, the patient subsequently received oral Phalaghrita and Pushpadhanwa Rasa. The patient's LMP was on 11/01/2026, following which pregnancy was confirmed. The pregnancy subsequently resulted in the delivery of a healthy male infant weighing 3.5 kg on 16/10/2026. This represents a favorable clinical outcome.

DISCUSSION

In Ayurvedic literature, anovulation may be interpreted in relation to Nashtartava, which involves disturbances in the normal formation and functioning of Artava. The treatment approach in the present case was directed towards correcting Agnimandya, Srotodushti and Vata-Kapha Dosha imbalance, thereby supporting the formation of Shuddha Artava (healthy reproductive tissue).

Virechana Karma is an important Shodhana procedure that facilitates the elimination of vitiated Doshas and supports Srotoshodhana. In the present case, Virechana was performed using Trivrit Avaleha. Acharya Kashyapa has highlighted the role of Virechana in the management of Akarmanya Beeja.[6] Based on these classical principles, Virechana was incorporated into the treatment protocol to address Dosha imbalance and support reproductive function.

Acharya Charaka emphasized the importance of a healthy Yoni and Kshetra for successful

conception. Basti Chikitsa is regarded as an important therapeutic modality in disorders associated with Vata Dosha, including selected gynecological conditions.[7] Niruha Basti is also described in the Ayurvedic management of Vandhyatva.[8] In this case, Mustadi Rajayapana Basti was administered as Niruha Basti.[9] while Sahacharadi Taila.[10] was used for Anuvasana Basti. These procedures were selected to address Dosha imbalance and support the physiological functions associated with reproduction.

Uttara Basti has a significant place in the Ayurvedic management of selected gynecological disorders involving Artavavaha Srotas. In the present case, Prasarini Taila.[11] was administered through Uttara Basti with the intention of addressing Vata-Kapha imbalance and supporting normal Artava function. Its traditional Vatahara properties provide an Ayurvedic rationale for its use in this treatment protocol. However, its specific effects on follicular development, ovarian hormone levels and endometrial receptivity require further scientific evaluation.

Sarvanga Abhyanga with Sahacharadi Taila, followed by Parisheka with Dashamoola Kwatha, was included in the therapeutic regimen. Abhyanga is traditionally considered useful for pacifying Vata Dosha and promoting relaxation. Parisheka with Dashamoola Kwatha was performed as a complementary procedure to support the overall treatment approach.[9] Psychological stress, described in Ayurveda as Chinta and Shoka, may influence reproductive health. Modern physiological research suggests that stress can affect the hypothalamic-pituitary-ovarian (HPO) axis and may contribute to disturbances in menstrual cyclicity and ovulation. In this case, Shiropichu with Ksheerbala Taila was administered in the evening to promote relaxation and psychosomatic well-being. Its specific effect on HPO axis regulation, however, cannot be confirmed from the findings of this case alone.

Pushpadhanwa Rasa is a classical Ayurvedic formulation used in the context of reproductive disorders. Its Deepana and Pachana properties are traditionally associated with the management of Agnimandya. In the present case, the formulation was prescribed twice daily with milk after food. Its inclusion in the treatment regimen was intended to support Agni, maintain Dosha balance and promote reproductive health. Nevertheless, the independent contribution of Pushpadhanwa Rasa to conception cannot be determined because it was administered alongside several other interventions.

Phalaghrita is described in Ayurvedic literature, including sharangdhar samhita in relation to

supporting conception. In this case, Phalaghrita was prescribed at a dose of 5 g twice daily with warm water before food. Ghrita-based formulations are traditionally used for their nourishing properties and in the management of selected reproductive disorders.

Phalaghrita was included to support Artava function and reproductive health. Experimental research on Phala Sarpi has also explored its potential reproductive effects however, further clinical studies are needed to establish its efficacy in anovulatory infertility.

Following four months of Ayurvedic treatment, the patient achieved conception. The pregnancy progressed and resulted in the delivery of a healthy male infant weighing 3.5 kg. This favorable outcome was observed following the combined treatment regimen.

However, the contribution of individual interventions cannot be established from a single case, and further systematic clinical studies are required to evaluate the efficacy and safety of this treatment approach in anovulatory infertility.

CONCLUSION

This case report describes a favorable reproductive outcome in a 26-year-old woman with PCOS-associated anovulatory infertility following an individualized Ayurvedic treatment protocol comprising Virechana Karma, Basti Chikitsa, Uttara Basti, oral medications and supportive interventions. The patient subseguently conceived and delivered a healthy male infant weighing 3.5 kg. This clinical observation highlights the potential relevance of further research into Ayurvedic approaches to PCOS-associated anovulatory infertility.

However, as this is a single case involving multiple interventions, a causal relationship between the treatment and conception cannot be established, nor can the contribution of individual therapies be determined. Further well-designed clinical studies with standardized treatment protocols, objective assessment of ovulation, and systematic safety monitoring are requied to evaluate the fficacy and safety of this treatment approach.

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