

AYURVEDIC MANAGEMENT OF PELVIC INFLAMMATORY DISEASE AND ASSOCIATED REPRODUCTIVE DISORDERS TO CONCEPTION: A RETROSPECTIVE CASE SERIES OF 30 WOMEN

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ABSTRACT

Background: Pelvic inflammatory disease (PID) is a major cause of reproductive morbidity, contributing to tubal scarring, infertility, ectopic pregnancy, and chronic pelvic pain. Conventional management relies on antimicrobial therapy, yet some women experience persistent symptoms or residual reproductive complications. Ayurveda conceptualises such disorders within the framework of *Yoni Vyapat* and employs individualised, multimodal interventions; however, clinical evidence in real-world PID populations remains limited.

Methods: This retrospective case series describes 30 women (aged 20–40 years) with PID and associated reproductive disorders (habitual abortion, PCOD, tubal pathology, TORCH positivity, ovulatory disturbances) who received individualised Ayurvedic management at a single centre. The core protocol included *Tablet Poshini* (fertility support), *Tablet Upaja*

(ovulatory and menstrual regulation), and *Tablet Jivani* (infective/inflammatory component), with additional condition-specific medicines as indicated. Additional Ayurvedic medicines were prescribed individually according to the patient's associated gynecological and reproductive conditions, clinical presentation, and treatment requirements. Treatment duration ranged from 2 to 16 months. Clinical characteristics, associated conditions, and treatment parameters were extracted from case records. Time to conception was defined as the interval between initiation of Ayurvedic treatment and documented conception. **Results:** All patients had clinically documented PID, with associated conditions including habitual

abortion, PCOD, tubal blockage, hydrosalpinx, anovulatory cycles, delayed menstruation, TORCH positivity, and other pelvic or reproductive abnormalities. All 30 women achieved conception during the documented follow-up period, with time to conception ranging from 2 to 16 months. The individualized treatment approach addressed fertility support, ovulatory function, and infective/inflammatory concerns according to individual clinical needs.

KEYWORDS: Pelvic inflammatory disease; Ayurveda; Yoni Vyapat; infertility; habitual abortion; PCOD; tubal factor; case series.

INTRODUCTION

Pelvic inflammatory disease (PID) is a spectrum of inflammatory and infectious disorders involving the upper female genital tract, including the uterus, fallopian tubes, ovaries, and surrounding pelvic structures. It is most commonly associated with ascending infection from the lower genital tract and may occur with variable and often nonspecific clinical manifestations. The clinical presentation ranges from mild pelvic discomfort and abnormal vaginal discharge to severe pelvic pain, fever, adnexal tenderness, tubo-ovarian abscess, and other complications. Because symptoms may be subtle or absent, PID can remain undiagnosed, potentially allowing progressive inflammation and tissue damage.^[1,2]

PID represents an important cause of reproductive morbidity in women of reproductive age. Inadequately treated or recurrent pelvic inflammation may result in tubal scarring, infertility, ectopic pregnancy, chronic pelvic pain, and dyspareunia. The risk of long-term reproductive complications increases with delayed diagnosis, recurrent episodes, and the severity of upper genital tract involvement. Consequently, early recognition and appropriate management are essential to reduce both acute morbidity and long-term reproductive sequelae.^[3]

Conventional management of PID primarily focuses on antimicrobial therapy directed against the range of microorganisms potentially responsible for upper genital tract infection, along with supportive management and treatment of sexual partners where indicated. Despite appropriate treatment, some women may experience persistent pelvic pain, recurrent symptoms, or residual reproductive complications. These clinical challenges highlight the importance of exploring comprehensive approaches that may address not only the acute infectious component but also associated inflammation, symptom burden, and recovery of reproductive health.^[4]

Ayurveda describes disorders involving the female reproductive system within the broader framework of *Yoni Vyapat* and related gynecological conditions. Its treatment approach may incorporate individualized interventions aimed at correcting functional disturbances, reducing inflammation, supporting tissue health, and improving overall reproductive well-being. However, clinical evidence describing the use of individualized Ayurvedic management in women with PID remains limited, particularly in the context of real-world clinical practice.^[5]

Therefore, the present retrospective case series describes the clinical characteristics and outcomes of women diagnosed with PID who received individualized Ayurvedic management at a single clinical center. The case series aims to document changes in relevant clinical symptoms and reproductive health parameters following treatment and to contribute preliminary clinical evidence that may inform future systematic research on integrative approaches to the management of PID.

Table: 1- Patient-wise Clinical Characteristics, Associated Reproductive Conditions, and Time to Conception.

Patient	Age (years)	Clinical diagnosis / associated features	PID-related symptoms*	Time to conception
1	28	Cervicitis, PID, TORCH positive	Abnormal white vaginal discharge, vaginal itching, burning sensation	8 months
2	31	PID, TORCH positive	Lower abdominal pain, chronic low back pain	2 months
3	24	PID, PCOD with delayed periods, TORCH positive	Abnormal white vaginal discharge, pelvic discomfort, dysmenorrhea	7 months
4	32	PID, PCOD with delayed periods	Vaginal itching, burning sensation, lower abdominal pain	8 months
5	33	PID, TORCH positive	Abnormal white vaginal discharge, chronic low back pain	3 months
6	28	PID, TORCH positive, low AMH, habitual abortion	Abnormal white vaginal discharge, pelvic pain, dysmenorrhea	6 months
7	30	PID, thin endometrium, anovulatory cycles	Lower abdominal pain, chronic low back pain, burning sensation	8 months
8	30	PID, delayed periods, habitual abortion	Abnormal white vaginal discharge, pelvic heaviness, chronic low back pain	16 months
9	35	PID, TORCH positive, history of PCOD, habitual abortion	Abnormal white vaginal discharge, vaginal itching, dysmenorrhea	11 months
10	30	PID, TORCH positive, PCOD with delayed	Abnormal white vaginal discharge, burning sensation,	5 months

		periods, recent miscarriage	pelvic pain	
11	29	PID, habitual abortion, PCOD with delayed periods, peritubular adhesion	Chronic pelvic pain, low back pain, dysmenorrhea	15 months
12	28	PID, right tubal blockage, habitual abortion	Abnormal white vaginal discharge, lower abdominal pain, vaginal itching	7 months
13	29	PID, anovulatory cycle	Pelvic discomfort, chronic low back pain, burning sensation	8 months
14	32	PID, TORCH positive, habitual abortion	Abnormal white vaginal discharge, dysmenorrhea, pelvic pain	5 months
15	35	PID, habitual abortion, TORCH positive	Vaginal itching, abnormal white vaginal discharge, chronic low back pain	6 months
16	20	PID, adenomyosis, fibroid, endometriosis	Dysmenorrhea, pelvic pain, burning sensation	6 months
17	33	PID, PCOD with delayed periods	Abnormal white vaginal discharge, lower abdominal pain, chronic low back pain	12 months
18	30	PID, habitual abortion, anovulatory cycles	Pelvic pain, dysmenorrhea, vaginal itching	6 months
19	28	Hydrosalpinx, left tubal block with no spill, habitual abortion, PID	Abnormal white vaginal discharge, chronic pelvic pain, low back pain	2 months
20	21	Arcuate uterus, bilateral hydrosalpinx, PID	Lower abdominal pain, abnormal white vaginal discharge, burning sensation	10 months
21	24	PID, PCOD with delayed periods	Abnormal white vaginal discharge, vaginal itching, dysmenorrhea	8 months
22	32	PID, TORCH positive, left tubal block, habitual abortion	Pelvic pain, abnormal white vaginal discharge, chronic low back pain	4 months
23	37	IUI failure, anovulatory cycle, PID	Burning sensation, lower abdominal pain, dysmenorrhea	7 months
24	31	PCOD with regular periods, bilateral tubal blocks, habitual abortion, PID	Abnormal white vaginal discharge, pelvic discomfort, chronic low back pain	6 months
25	36	Habitual abortion, PCOD with regular periods, PID, TORCH positive	Vaginal itching, burning sensation, pelvic pain	5 months
26	33	PID, history of fibroids, habitual abortion	Abnormal white vaginal discharge, dysmenorrhea, chronic low back pain	11 months
27	30	PID, left hydrosalpinx, low AMH with regular periods	Lower abdominal pain, abnormal white vaginal discharge, vaginal itching	3 months

28	40	PID, habitual abortion	Chronic pelvic pain, abnormal white vaginal discharge, chronic low back pain	4 months
29	33	PID, PCOD with delayed periods	Burning sensation, abnormal white vaginal discharge, dysmenorrhea	13 months
30	33	PID, bilateral tubal block, habitual abortion	Pelvic pain, vaginal itching, chronic low back pain	9 months

RESULTS

A total of 30 women aged 20–40 years with clinically documented pelvic inflammatory disease (PID) and associated gynecological or reproductive disorders were included in this retrospective case series. The cohort demonstrated considerable clinical heterogeneity, with PID occurring alongside habitual abortion, TORCH positivity, PCOD, tubal pathology, ovulatory disturbances, menstrual irregularities, and other pelvic abnormalities.

The most frequently documented associated reproductive condition was habitual abortion, present in 15 patients (50.0%), followed by TORCH positivity in 11 patients (36.7%) and PCOD in 10 patients (33.3%). Tubal and pelvic abnormalities included unilateral or bilateral tubal blockage, hydrosalpinx, peritubal adhesion, arcuate uterus, adenomyosis, fibroids, and endometriosis. Anovulatory cycles were documented in four patients (13.3%). One patient had a history of failed IUI, while another had a recent history of miscarriage.

For descriptive analysis, patients were categorized into four age groups: 20–24, 25–29, 30–34, and 35–40 years. The largest proportion of patients belonged to the 30–34-year age group (16/30; 53.3%), followed by the 35–40-year group (6/30; 20.0%), while 4 patients (13.3%) each belonged to the 20–24-year and 25–29-year groups. Individual patient characteristics, associated diagnoses, presenting symptoms, and reproductive outcomes are presented in Table 1.

The commonly reported PID-related symptoms included abnormal white vaginal discharge, lower abdominal or pelvic pain, chronic low back pain, dysmenorrhea, vaginal itching, and burning sensation. Several patients presented with more than one symptom, reflecting the varied clinical manifestations of PID and its associated reproductive disorders.

All 30 women achieved conception during the documented follow-up period. The time to conception ranged from 2 to 16 months. Conception occurred within 2–4 months in several patients, while others required longer periods, with some conceiving between 13 and 16

months. Patients with longer time to conception generally had multiple coexisting reproductive or gynecological conditions, including habitual abortion, PCOD, tubal pathology, and ovulatory disturbances.

Overall, the cohort represented women with complex and overlapping reproductive conditions. Despite variation in age, presenting symptoms, associated disorders, and time to conception, conception was documented in all 30 patients, with individual time to conception ranging from 2 to 16 months. Detailed patient-wise clinical characteristics and reproductive outcomes are presented in Table 1.

Treatment and Management

Table: 2- Treatment and Management.

Medicine given	Ingredients/Contents	Dosage
Tablet Poshini (600 mg)	<i>Shuddha Hingul, Bang Bhasma, Shivlingi, Shatavari, Ashwagandha, Jivanti, Putranjivak</i>	2 tablets after breakfast and 2 pills after dinner
Tablet Upaja (500 mg)	<i>Kumari, Shuddha Kasis, Dalchini, Sonth, Gulkand</i>	2 tablets after breakfast and 2 pills after dinner
Tablet Jivani (750 mg)	<i>Shuddha Hingul, Bang Bhasma, Karanja, Khadir, Asvattha, Shirish, Shalmali</i>	2 tablets after breakfast and 2 pills after dinner

Advice

The patients were advised on a balanced diet, regular sleep, daily exercise (≥ 30 minutes), stress management, and avoidance of processed foods to support fertility and overall well-being. They were also guided in ovulation tracking to optimize conception. The patients adhered consistently to these recommendations alongside the treatment protocol.

DISCUSSION

The present retrospective case series included 30 women with varied reproductive and gynecological disorders, with pelvic inflammatory disease (PID), habitual abortion, PCOD, menstrual irregularities, anovulatory cycles, TORCH positivity, and tubal abnormalities being the predominant clinical features. The frequent coexistence of multiple conditions highlights the multifactorial nature of reproductive difficulties and supports the need for an individualized treatment approach.

PID is particularly relevant to fertility because persistent infection and chronic pelvic inflammation can cause tubal tissue damage, adhesions, and increased inflammatory fluid secretion and accumulation within the fallopian tubes, contributing to partial or complete tubal blockage and impaired fertility. Chronic inflammation may also adversely affect the endometrial environment and endometrial receptivity, potentially contributing to implantation failure and early pregnancy loss. In patients with recurrent pregnancy loss or habitual abortion, impaired endometrial quality may therefore represent one of several factors affecting pregnancy maintenance.^[1,2,3]

Within the treatment approach used in this case series, *Jivani* was directed toward the infective/inflammatory component, while *Poshini* provided broader fertility support and *Upaja* supported ovulatory function. The therapeutic protocol comprised three proprietary Ayurvedic formulations—*Jivani*, *Upaja*, and *Poshini*—administered to address chronic pelvic inflammation, ovulatory dysfunction, and impaired endometrial receptivity through complementary mechanisms. **Tablet Jivani** was prescribed primarily for the management of chronic pelvic inflammatory pathology and its reproductive sequelae. The formulation contains *Shuddha Hingul* and *Bang Bhasma*, which are traditionally employed for their antimicrobial and tissue-reparative properties. *Karanja* and *Khadir* contribute potent anti-inflammatory and antimicrobial actions, supporting resolution of recurrent vaginal infections, abnormal vaginal discharge, and vaginal irritation. *Ashvattha*, *Shirish*, and *Shalmali* possess anti-inflammatory and mucosal-healing properties, facilitating restoration of endometrial integrity compromised by chronic inflammation and infection. Collectively, these actions contribute to improvement of the uterine environment. **Tablet Upaja** was administered to support physiological follicular development and ovulation. *Kumari* is traditionally recognized for its role in regulation of menstrual cyclicity and support of ovarian function. *Shuddha Kasis* contributes to improved hemopoiesis and endometrial vascularity, thereby supporting uterine receptivity. *Dalchini* and *Sonth* exert anti-inflammatory and metabolic regulatory effects, enhancing ovarian responsiveness and facilitating natural ovulatory rupture. *Gulkand* provides cooling and adaptogenic effects, supporting hormonal balance and mitigating stress-related ovulatory disturbances. **Tablet Poshini** was included to restore overall female reproductive potential and improve oocyte and uterine health. The formulation contains *Shuddha Hingul* and *Bang Bhasma*, traditionally used to strengthen reproductive tissues and enhance cellular metabolic activity. *Shivlingi* is described in classical Ayurvedic literature as a fertility-supportive agent, contributing to improvement in oocyte quality and

implantation potential. *Shatavari* supports endometrial nourishment and hormonal balance, while *Ashwagandha* aids neuroendocrine regulation and stress modulation. *Jivanti* and *Putranjivak* act as reproductive rejuvenatives, enhancing uterine receptivity and supporting early gestational stability. Together, these formulations were designed to act synergistically by resolving infection and inflammation, restoring endometrial health, regulating ovulation, and enhancing fertility outcomes through a multimodal integrative mechanism.^[6,7]

The overall treatment strategy was intended to improve the reproductive environment, including restoration of endometrial quality and receptivity, thereby supporting implantation and maintenance of pregnancy. The observed occurrence of natural conception and continued pregnancy following treatment is clinically encouraging, particularly among women with histories of PID, recurrent pregnancy loss, or associated reproductive abnormalities. However, these observations cannot establish causality in the absence of a control group.

Symptomatic improvement was also observed among patients presenting with features associated with chronic reproductive tract inflammation. These included reduction in white vaginal discharge, vaginal itching and burning sensation, pelvic discomfort, and chronic low back pain. Such improvements may indicate beneficial effects on the symptomatic inflammatory component of the condition, although objective assessment of infection and inflammation would be required in future studies.

The treatment duration varied from 2 to 16 months according to the severity and combination of associated disorders. Since treatment was individualized and multiple medicines were used according to clinical requirements, the findings should be interpreted as preliminary clinical observations rather than evidence of efficacy of any single formulation.

Overall, this case series suggests that an individualized Ayurvedic approach addressing infection and inflammation, tubal and endometrial factors, ovulatory dysfunction, and general fertility support may have potential in women with complex reproductive disorders. The observed symptomatic improvement and natural conception are encouraging and warrant further evaluation through prospective, controlled studies using objective outcomes such as ovulation, conception, clinical pregnancy, miscarriage, and live birth.

CONCLUSION

This case series suggests that individualised Ayurvedic management using *Tablet Poshini*, *Tablet Upaja*, and *Tablet Jivani*, along with additional disorder-specific medicines, may support conception in women with PID and associated reproductive disorders. PID was the predominant condition in this cohort, with coexisting factors such as habitual abortion, PCOD, tubal pathology, and TORCH positivity. The treatment approach addressed fertility, ovulatory function, and infective/inflammatory concerns according to individual clinical needs. These preliminary findings highlight the potential role of Ayurveda as a mainstream approach in supporting conception among women with PID-related and multifactorial reproductive challenges.

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