IJAYUSH
International Journal of AYUSH
AYURVEDA • YOGA • UNANI • SIDDHA • HOMEOPATHY
https://internationaljournal.org.in/journal/index.php/ijayush/
ISSN: 2349-7025
OPEN ACCESS
★ PEER REVIEWED ★
MONTHLY

Original Research Article	Volume 15 Issue 10	October 2026

RESTORATION OF OVULATORY CYCLES AND NATURAL CONCEPTION IN PCOS-ASSOCIATED SECONDARY INFERTILITY: AN AYURVEDIC CASE REPORT

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DOI: https://doi.org/10.5281/zenodo.23716803

Abstract

Background

Polycystic Ovary Syndrome (PCOS) is a multifaceted neuro-endocrine-metabolic disorder characterized by hyperandrogenism, ovulatory dysfunction, and polycystic ovarian morphology. In reproductive-aged women, PCOS is the leading contributor to anovulatory infertility. In Ayurveda, this presentation correlates with *Artava Kshaya / Pushpaghni Revati (Jataharini)* and *Vandhyatva* (infertility) rooted in *Kapha-Vataja Sroto-avarodha* (channel obstruction) and impaired *Dhatvagni*.

Case Presentation

A 29-year-old female presented to the outpatient department with complaints of delayed, oligomenorrheic menstrual cycles (cycle length 60–90 days, flow lasting 1–2 days), progressive weight gain (BMI: 28.4 kg/m^2), facial hirsutism, and an inability to conceive for 2.5 years following the birth of her first child (secondary infertility). Transvaginal ultrasonography (TVS) confirmed bilateral polycystic ovarian morphology, and endocrine profiling demonstrated an inverted LH:FSH ratio (2.3:1) and hyperinsulinemia. Semen analysis of the spouse was normal.

Intervention

A structured, phased Ayurvedic protocol was instituted: initial metabolic detoxification and channel cleansing (*Deepana-Pachana* and *Kostha Shodhana* via *Virechana Karma*), followed by targeted herbal formulations (*Kanchanara Guggulu*, *Pushpadhanva Rasa*, *Varunadi Kashaya*, and *Shatapushpa Churna*) aimed at clearing *Avarodha*, augmenting *Agni*, and stimulating the follicular microenvironment. Intrauterine administration of *Phala Ghrita* (*Uttara Basti*) was administered post-menstruation for three consecutive cycles.

Outcome

Within four months of intervention, the patient established regular, spontaneous 30–32 day menstrual cycles with physiologic flow (3–4 days). Serial follicular monitoring confirmed follicular maturation leading to spontaneous ovulation (dominant follicle measuring 21 × 19 mm with subsequent rupture). In the fifth month, the patient missed her menstrual period; a urine pregnancy test and subsequent obstetric ultrasonography confirmed a viable single intrauterine gestation with cardiac activity.

Conclusion

Sequential Ayurvedic intervention incorporating systemic bio-purification (*Shodhana*), targeted ovulatory stimulants (*Shamana/Artavajanana*), and local organ-specific therapy (*Uttara Basti*) reversed ovarian channel obstruction, restored hypothalamo-pituitary-ovarian axis physiology, and facilitated successful natural conception in chronic PCOS-associated secondary infertility.

Keywords: Polycystic Ovary Syndrome (PCOS); Secondary Infertility; *Artava Kshaya*; *Uttara Basti*; *Virechana*; *Vandhyatva*; Case Report.

Introduction

Polycystic Ovary Syndrome (PCOS) represents the most common endocrine and metabolic disorder in females of reproductive age, with an estimated global prevalence of 8% to 13%, and regional estimates in South Asia extending up to 22%. Clinically defined by the Rotterdam Consensus criteria, it encompasses oligo- or anovulation, clinical and/or biochemical signs of hyperandrogenism, and polycystic ovarian morphology on ultrasonography. Pathophysiologically, hyperinsulinemia driven by peripheral insulin resistance drives thecal cell androgen production and blunts hepatic sex hormone-binding globulin (SHBG) synthesis, arresting antral follicle maturation and culminating in chronic anovulation. [1,9] [2] [1,10]

Secondary infertility is defined as the inability to achieve clinical pregnancy after 12 months or more of regular, unprotected intercourse following at least one prior documented conception. When superimposed on PCOS, secondary infertility often manifests after excessive weight gain, sedentary habits, or postpartum metabolic shifts trigger latent neuro-endocrine dysfunction. Conventional interventions rely on oral ovulogens (letrozole, clomiphene citrate), injectable gonadotropins, and assisted reproductive technologies (ART), which frequently pose financial burdens, emotional distress, and risks of ovarian hyperstimulation syndrome (OHSS) or multiple gestation. [9] [1,10]

In classical Ayurvedic ontology, PCOS is not defined by a single eponymous disease entity; rather, it is understood through the clinical matrix of *Yonivyapad* and *Artava Dushti*. It primarily aligns with: [3–5]

- ***Artava Kshaya***: Scanty, irregular, and delayed menstruation associated with *Vata-Kapha* vitiation. [3,4]
- ***Pushpaghni Jataharini***: Characterized by ovulatory failure where a woman menstruates irregularly or ineffectively without producing viable seeds (*Vrindam pushpam tu nastam*), frequently associated with corpulence and abnormal body hair. [3,4]
- ***Vandhyatva***: Anovulatory female factor infertility emerging from pathology in the four essential procreative factors (*Garbha Sambhava Samagri*): *Ritu* (ovulatory fertile window), *Kshetra* (uterine endometrium and reproductive tract), *Ambu* (nutrient-hormonal nourishment via *Rasa Dhatu*), and *Bija* (competent ovum/sperm). [3–5]

Achieving conception requires clearing functional channels (*Artavavaha Srotas*), rectifying cellular metabolism (*Dhatvagni*), and restoring the downward physiological vector of *Apana Vayu*. This clinical case report documents the clinical course, multi-modality Ayurvedic management, and successful natural conception in a patient with long-standing PCOS-associated secondary infertility. [3–5]

Patient Information

Parameter	Patient Details
Age	29 years
Gender	Female
Occupation	Desk-bound Software Analyst
Residence	Urban, Madhya Pradesh, India
Socioeconomic Status	Upper-Middle Class (Modified Kuppuswamy Scale Class II)
Diet	Mixed, high refined carbohydrate and dairy intake
Appetite (*Agni*)	Irregular, sluggish (*Vishamagni* trending to *Mandagni*)
Sleep (*Nidra*)	Disturbed, non-restorative (6 hours/night)
Bowel Habits (*Kostha*)	Mild constipation, sluggish motility (*Krura Kostha*)
Micturition	Clear, 4–5 times/day, non-dysuric
Addictions	Excess caffeine intake (4–5 cups tea/coffee daily); no tobacco or alcohol
Family History	Mother had Type 2 Diabetes Mellitus; no familial infertility
Obstetric History	Gravida 1, Para 1, Living 1, Abortion 0 (); spontaneous vaginal delivery 4 years prior
Past Medical History	No history of hypertension, tuberculosis, thyroid dysfunction, or pelvic inflammatory disease
Surgical History	None; episiotomy repair healed without complications
Drug History	Intermittent medroxyprogesterone acetate for withdrawal bleeds; stopped 6 months prior
Allergy History	No known drug or food allergies

Ayurvedic Systemic Assessment (Pariksha)

Examination Domain	Clinical Finding	Ayurvedic Interpretation
Prakriti	*Kapha-Vata*	Predisposing to metabolic sluggishness and channel stagnation
Sara	*Madhyama* (Medium)	Moderate tissue essence
Samhanana	*Madhyama* (Medium)	Moderate physical compactness
Satmya	*Madhyama*	Mixed adaptiveness
Satva	*Madhyama* (Medium)	Moderately distressed regarding childbearing
Ahara Shakti	*Avara* to *Madhyama*	Suboptimal digestion and assimilation
Vyayama Shakti	*Avara* (Poor)	Sedentary lifestyle
Vaya	*Madhyama* (29 years)	*Pitta-pradhana* reproductive phase
Nadi	76 bpm, *Manda-Kaphaja*	Sluggish arterial impulse reflecting *Ama* and *Kapha*
Mutra	Clear, normal frequency	*Prakrita* (physiological)
Mala	Constipated, hard consistency	*Apana Vata Dushti*
Jihva	Mild white coating (*Alpa-Sama*)	Presence of endotoxins (*Ama*)
Shabda	Clear, normal phonation	Normal
Sparsha	Normal temperature, rough abdominal skin	Normal
Drik	Normal vision, pale sclera	*Prakrita*
Akriti	*Sthula* (Overweight, BMI: 28.4 kg/m^2)	*Medo Dhatu Vriddhi*

Chief Complaints

- **Infrequent, delayed menses:** Menstrual bleeding occurring once every 60 to 90 days for the past 2 years.
- **Scanty menstrual flow:** Bleeding lasting only 1 to 2 days, using 1 pad per day (scant spotting).
- **Inability to conceive:** Actively trying for second conception for 2.5 years without contraception.
- **Unintentional weight gain:** Increase of 9 kg over the preceding 24 months.
- **Mild facial hirsutism:** Coarse terminal hair over the chin and upper lip.

History of Present Illness

The patient had menarche at 13 years of age with regular 28–30 day menstrual cycles until her first pregnancy at age 25. That pregnancy and spontaneous vaginal delivery proceeded without complications.

Approximately 18 months postpartum, she noticed progressively delayed menstrual cycles that gradually lengthened to 60–90 days. Menstrual flow diminished markedly to 1–2 days of scanty, dark-colored spotting. Concurrently, she developed gradual weight gain and coarse hair on her chin.

She attempted to conceive her second child over the subsequent 2.5 years without success. She consulted a modern gynecologist 10 months prior to presentation and was diagnosed with Polycystic Ovary Syndrome. She was prescribed cyclical medroxyprogesterone acetate to induce withdrawal bleeding and underwent two unsuccessful cycles of ovulation induction with clomiphene citrate (50 mg and 100 mg), during which follicular tracking failed to demonstrate mature follicle development. Seeking a holistic, non-hormonal approach, she presented to our Ayurvedic specialty clinic. [1,10]

Clinical Findings

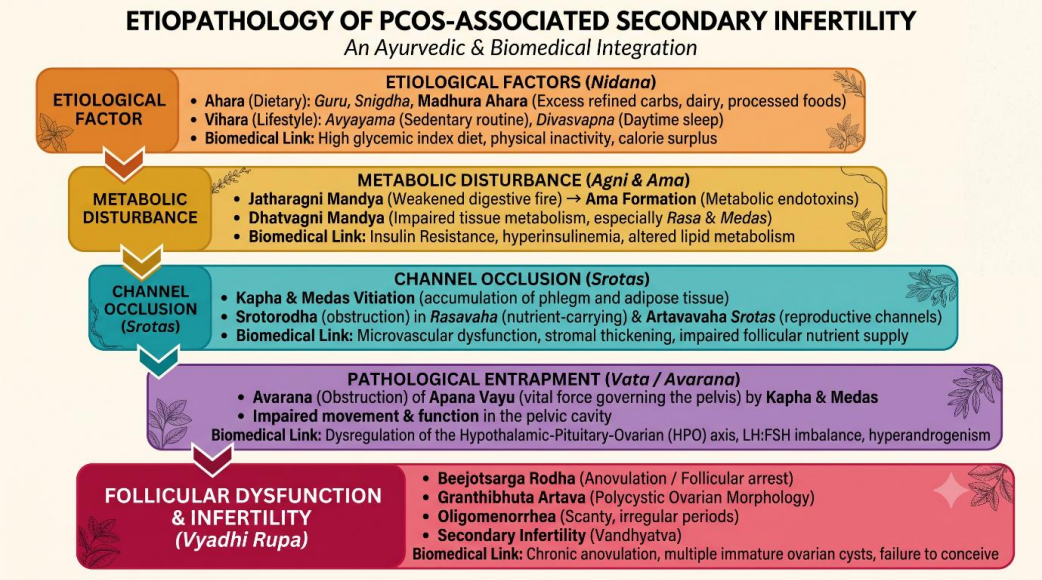
- **General Physical Examination:**
- Height: 157 cm; Weight: 70 kg; BMI: 28.4 kg/m^2 (Overweight / Class I Asian Obesity).
- Blood Pressure: 118/76 mmHg; Heart Rate: 74 bpm; Respiratory Rate: 16/min.
- Pallor, icterus, cyanosis, clubbing, and lymphadenopathy: Absent.
- Dermatological: Mild acanthosis nigricans over the nape of the neck; terminal hirsutism on chin (Ferriman-Gallwey score: 9).
- **Systemic Examination:**
- Cardiovascular: normal, no murmurs.
- Respiratory: Clear breath sounds bilaterally, no rhonchi or crepitations.
- Gastrointestinal/Abdominal: Soft, non-tender, adiposity predominantly centripetal; no organomegaly.
- Central Nervous System: Fully conscious, oriented, intact cranial nerves.
- **Gynecological Examination:**
- External genitalia: Normal female pattern, no structural anomalies.
- Per-speculum: Cervix appeared healthy, external os closed, no erosion, no pathological discharge.
- Per-vaginal: Uterus anteverted, normal size, mobile, non-tender; fornices clear, non-tender.

Diagnostic Assessment

Diagnostic Comparison

Criteria / System	Diagnostic Conclusion	Primary Indicators
Modern Medicine [1,2,10]	**PCOS with Secondary Infertility** (Rotterdam Criteria)	Oligo-anovulation, clinical hirsutism, TVS showing polycystic ovaries (>20 peripheral follicles/ovary), secondary subfertility >2 years.
Ayurveda	***Artava Kshaya*** / ***Pushpaghni Jataharini*** causing ***Vandhyatva*** [3–5]	*Yathochitakala Adarshana* (delayed cycle), *Alpatva* (scanty flow), *Stholya* (obesity), *Roma-vriddhi* (hirsutism), *Bija-utsarga Rodha* (anovulation).
Differential Diagnosis	1. Hypothyroidism 2. Hyperprolactinemia 3. Non-Classic CAH	Ruled out: TSH normal (2.1 mIU/L), Prolactin normal (14.2 ng/mL), 17-OHP within reference range.

ETIOLOGICAL FACTORS (Nidana)



Pathophysiological Components (Samprapti Ghataka)

- **Dosha:** *Kapha-Vata Pradhana* (*Samana* and *Apana Vata Dushti*; *Kledaka Kapha Vriddhi*).
- **Dushya:** *Rasa*, *Medo Dhatu*, and *Artava* (Upadhatu of *Rasa*).
- **Agni:** *Jatharagni Mandya* leading to *Dhatvagni Mandya* (*Rasagni* and *Medodhatvagni*).
- **Ama:** *Jatharagnijanita* and *Dhatvagnijanita Ama* (manifesting as metabolic endotoxemia and insulin resistance).
- **Srotas:** *Rasavaha*, *Medovaha*, and *Artavavaha Srotas*.
- **Sroto-Dushti Type:** *Sanga* (obstruction) and *Vimarga Gamana* (aberrant pathway routing).
- **Udbhava Sthana (Origin):** *Amashaya* (stomach) and *Pakvashaya* (pelvic bowl/colon).
- **Sanchara (Circulation):** *Sarva Sharira* (systemic vascular/lymphatic network via *Rasavaha Srotas*).
- **Vyakta Sthana (Site of Manifestation):** *Garbhashaya* (uterus) and *Bijagranthi* (ovaries).
- **Adhisthana:** *Artavavaha Srotas* / *Pelvic organs*.
- **Rogamarga:** *Abhyantara* (internal) and *Madhyama* (marrow/bone/reproductive tissues).
- **Vyadhi Avastha:** *Jirna* (chronic, >2 years duration), *Sama Avastha* transitioning to *Nirama*.

- **Roga Bala / Rogi Bala:** *Madhyama* (moderate disease chronicity) / *Madhyama* (moderate patient constitution).

Timeline of Clinical Course

Date / Milestone	Clinical Features	Diagnostic Status	Interventions Implemented	Clinical Outcome
Day 0 (Baseline)	Cycle length 75 days, scanty bleeding (1 day), BMI 28.4, hirsutism.	Confirmed PCOS with Secondary Infertility. Normal male factor.	Baseline blood tests, TVS ordered; dietary modification initiated.	Treatment roadmap planned.
Weeks 1–4	Sluggish appetite, mild abdominal fullness.	Baseline investigations completed: LH:FSH 2.3:1, Fasting Insulin high.	*Deepana-Pachana* (*Chitrakadi Vati*) followed by Classical *Virechana Karma*.	Improved appetite, regular bowel motions, tongue coating cleared, weight reduction of 2.2 kg.
Weeks 5–8	Post-Virechana recovery. Spontaneous bleed at Day 34.	Cycle interval shortened from 75 to 34 days; flow 2.5 days.	Started oral *Shamana* medications: *Kanchanara Guggulu*, *Varunadi Kashaya*, *Shatapushpa Churna*.	Substantial reduction in bloating; weight down by another 1.8 kg.
Weeks 9–12	Cycle 2 arrived at Day 31. Duration 3 days.	Ultrasonography: Ovarian volumes reduced from 13.5 mL to 9.2 mL.	Initiated *Uttara Basti* (Cycle 1) with *Phala Ghrita* on days 6, 7, and 8 of menstrual cycle. Added *Pushpadhanva Rasa*.	Normal painless menstrual flow; cervical mucus elasticity improved mid-cycle.
Weeks 13–16	Cycle 3 arrived at Day 30. Good flow (3–4 days).	Baseline mid-luteal serum progesterone 11.2 ng/mL (confirmed ovulation).	*Uttara Basti* (Cycle 2) repeated; continued oral medications.	Regular cyclicality maintained, basal body temperature showed biphasic pattern.
Weeks 17–20	Cycle 4 arrived at Day 30. Flow normal.	Serial TVS Follicular Tracking: Day 13 follicle 21 × 19 mm; Day 15 ruptured.	*Uttara Basti* (Cycle 3) performed; timed intercourse advised around Days 12–16.	Documented spontaneous ovulation; endometrial thickness reached 9.4 mm triple line.
Week 24	Missed period (Day 36). Mild morning nausea, breast fullness.	Urine Pregnancy Test (UPT) positive. Serum -hCG: 1,840 mIU/mL.	Withdrew *Guggulu* and *Rasa* preparations; started prenatal *Garbhapala Rasa* and *Phala Ghrita* orally.	Clinical pregnancy established; TVS confirmed single live intrauterine pregnancy at 6.2 weeks.

Investigations

Laboratory and Endocrine Biomarkers

Parameter	Baseline (Pre-Treatment)	Post-Intervention (Month 4)	Reference Range	Clinical Significance
Hemoglobin	12.4 g/dL	12.8 g/dL	12.0–15.5 g/dL	Within normal limits
Fasting Blood Sugar	108 mg/dL	88 mg/dL	70–99 mg/dL	Reversal of impaired fasting glucose
Fasting Serum Insulin	19.8 IU/mL	8.4 IU/mL	2.6–12.0 IU/mL	Correction of hyperinsulinemia
HOMA-IR	5.27	1.82	< 2.0	Resolution of insulin resistance

Parameter	Baseline (Pre-Treatment)	Post-Intervention (Month 4)	Reference Range	Clinical Significance
Serum LH (Day 3)	14.8 mIU/mL	6.2 mIU/mL	2.0–10.0 mIU/mL	Significant reduction in elevated LH
Serum FSH (Day 3)	6.4 mIU/mL	5.8 mIU/mL	3.0–10.0 mIU/mL	Normalized ratio
LH : FSH Ratio	**2.31 : 1**	**1.07 : 1**	~1 : 1	Reversal of inverted neuro-endocrine ratio
Total Testosterone	68 ng/dL	34 ng/dL	15–45 ng/dL	Resolution of hyperandrogenemia
Serum Prolactin	14.2 ng/mL	12.1 ng/mL	4.8–23.3 ng/mL	Excluded hyperprolactinemia
Serum TSH	2.1 mIU/L	1.9 mIU/L	0.4–4.0 mIU/L	Euthyroid state confirmed
Mid-Luteal Progesterone (D21)	1.4 ng/mL	**12.6 ng/mL**	> 10.0 ng/mL	Conclusive objective proof of ovulation

Radiological Assessment (Ultrasonography)

Feature	Baseline Transvaginal USG	Month 4 Follicular Study & Pelvic USG
Right Ovary	Enlarged (Volume: 13.8 mL); >22 peripheral follicles (<9 mm) with dense echogenic stroma ("string of pearls").	Volume: 8.4 mL; clear architecture, dominant follicle measuring 21 × 19 mm on Day 13.
Left Ovary	Enlarged (Volume: 12.6 mL); >20 subcapsular follicles with increased central stroma.	Volume: 7.8 mL; baseline stroma normalized, follicles evenly distributed.
Endometrial Thickness (ET)	4.8 mm on Day 45 of delayed cycle (hyperechoic, thin, disorganized).	**9.4 mm** on Day 13 of ovulatory cycle (multilayered, distinct triple-line pattern).
Pouch of Douglas (POD)	Clear	Free fluid visualized in POD on Day 15 confirming follicular rupture.
Obstetric USG (Week 24)	N/A	**Single intrauterine gestational sac with fetal pole, crown-rump length (CRL) corresponding to 6 weeks 2 days, positive fetal cardiac pulsations (128 bpm).**

Therapeutic Intervention

The clinical strategy was segmented into three distinct functional phases:

- **Phase 1:** *Deepana-Pachana* and Classical *Shodhana* (bio-purification via *Virechana Karma*).
- **Phase 2:** *Shamana Chikitsa* (clearing channel obstruction, regulating metabolic hormones, and balancing *Medo-Dhatu*).
- **Phase 3:** *Garbhashaya Shodhana & Brmhana* via intrauterine *Uttara Basti* and ovulation induction.

Internal Medications (Shamana Chikitsa)

Medicine	Key Ingredients	Dose	Freq. / Route	Timing	Anupana	Duration	Pharmacological & Ayurvedic Rationale
Chitrakadi Vati	*Plumbago zeylanica*, *Piper nigrum*, *Five salts*, *Hingu*	500 mg (2 tabs)	Twice daily, Oral	30 min before meals	Warm water	7 days (Phase 1)	Stimulates *Jatharagni*, digests systemic *Ama*, and breaks down metabolic stagnation.

Medicine	Key Ingredients	Dose	Freq. / Route	Timing	Anupana	Duration	Pharmacological & Ayurvedic Rationale
Varunadi Kashaya	*Crataeva nurvala*, *Strobilanthes ciliatus*, *Plumbago zeylanica*, *Asparagus racemosus*	20 mL with 40 mL warm water	Twice daily, Oral	Empty stomach (morning & evening)	Warm water	16 weeks (Phases 2 & 3)	Potent *Kaphahara*, *Medohara*, and *Srotoshodhaka* action. Reduces peripheral thecal hyperplasia, improves insulin sensitivity.
Kanchanara Guggulu	*Bauhinia variegata*, *Triphala*, *Trikatu*, *Commiphora mukul*	1 g (2 tabs of 500 mg)	Twice daily, Oral	After food	Warm water	16 weeks (Phases 2 & 3)	Classic *Granthi-hara* drug. Suppresses hyperandrogenism, dissolves ovarian follicular wall fibrosis/cysts, and clears lymphatic channels.
Pushpadhanva Rasa	*Rasasindura*, *Naga Bhasma*, *Vanga Bhasma*, *Abhraka Bhasma*, *Dhatura*, *Vijaya bhavana*	125 mg (1 tab)	Twice daily, Oral	After food	Milk with sugar candy / Ghee	Weeks 9–20 (Phases 2 & 3)	Target neuro-endocrine rejuvenator (*Vrishya*, *Artavajanana*). Modulates the hypothalamo-pituitary-ovarian (HPO) axis, inducing follicular maturation and rupture.
Shatapushpa Churna	*Anethum sowa* (fennel/dill seed powder)	3 g	Twice daily, Oral	Before food	Warm water	16 weeks (Phases 2 & 3)	*Artavajanana*, *Dipana*, and *Vata-Anulomana* property. Contains phytoestrogenic components that nourish ovarian tissue and induce physiologic menses.

Bio-Purificatory Procedures (Panchakarma Protocol)

1. Systemic Shodhana: Classical Virechana Karma (Weeks 2–3) [8]

- **Purvakarma (Preparatory):**
- *Deepana-Pachana:* Carried out with *Chitrakadi Vati* (500 mg tid) until signs of *Nirama Lakshana* (lightness of body, clear tongue, hunger) appeared (5 days).
- *Snehapana (Internal Oleation):* Administered using *Moorchita Ghrita* in escalating daily doses (30 mL, 60 mL, 90 mL, 130 mL, 170 mL) in the early morning over 5 days until *Samyak Snigdha Lakshana* (loose stools, aversion to fat, unctuous skin) was observed.
- *Abhyanga & Swedana:* Full-body therapeutic massage with *Bala Taila* followed by *Bashpa Sweda* (steam bath) for 3 consecutive days post-oleation.
- **Pradhana Karma (Detoxification Day):**
- Administered *Trivrit Lehyam* (35 g) with warm water at 09:00 AM.
- Patient achieved 18 controlled evacuations (*Vegas*) without cramping, corresponding to a *Madhyama Shuddhi*.
- **Paschat Karma (Post-Purification Regimen):**
- Graduated diet (*Samsarjana Krama*) consisting of *Peya* (thin rice gruel), *Vilepi* (thick gruel), *Akrita Yusha* (unseasoned lentil soup), and *Krita Yusha* maintained over 5 days.

2. Local Organ-Specific Therapy: Uttara Basti Protocol (Cycles 2, 3, and 4) [6,8]

- **Rationale:** Direct trans-cervical instillation of meditated lipid into the uterine cavity targets *Kshetra* (uterine lining) and *Artavavaha Srotas* directly, enhancing local vascularization, correcting endometrial receptor sensitivity, and stimulating the ovarian autonomic plexus.
- **Drug & Dose:** *Phala Ghrita* (5 mL per session). [6]
- **Timing:** Administered during the *Ritu Kala* (Days 6, 7, and 8 of the menstrual cycle) immediately post-bleeding cessation.
- **Procedure:** Under aseptic conditions in a specialized minor theater, patient in lithotomy position:
- *Purvakarma:* Local vulval preparation, gentle lower abdominal *Abhyanga* with *Dhanwantaram Taila*, and mild localized *Swedana*.

- *Pradhana Karma:* Speculum insertion, cervix visualized and cleaned with sterile saline and decoction. A sterile 4-Fr intrauterine catheter was introduced through the internal os; 5 mL of pre-warmed (body temperature) *Phala Ghrita* was instilled slowly over 60 seconds.
- *Paschat Karma:* Patient maintained supine with elevated pelvis for 2 hours. Monitored for pain or vagal reactions. The procedure was well tolerated without spotting or infection.

Treatment Timeline

Week 1: Deepana-Pachana (Chitrakadi Vati)

Week 2: Snehapana (Escalating Moorchita Ghrita) + Abhyanga/Swedana

Week 3: Pradhana Virechana (Trivrit Lehyam) + Samsarjana Krama

Week 4: Transition; commencement of Varunadi, Kanchanara, and Shatapushpa

Week 8: Spontaneous Cycle 1; baseline hormonal improvements recorded

Week 9: Addition of Pushpadhanva Rasa; Uttara Basti #1 (Phala Ghrita, Days 6-8)

Week 13: Spontaneous Cycle 2; Uttara Basti #2 (Days 6-8)

Week 17: Spontaneous Cycle 3; Uttara Basti #3 (Days 6-8); Follicular Tracking

Week 19: Mature follicle rupture documented (Day 15); timed natural intercourse

Week 24: Missed period; Positive UPT; Viable intrauterine pregnancy on USG

Outcome Assessment

Clinical Outcome Comparison

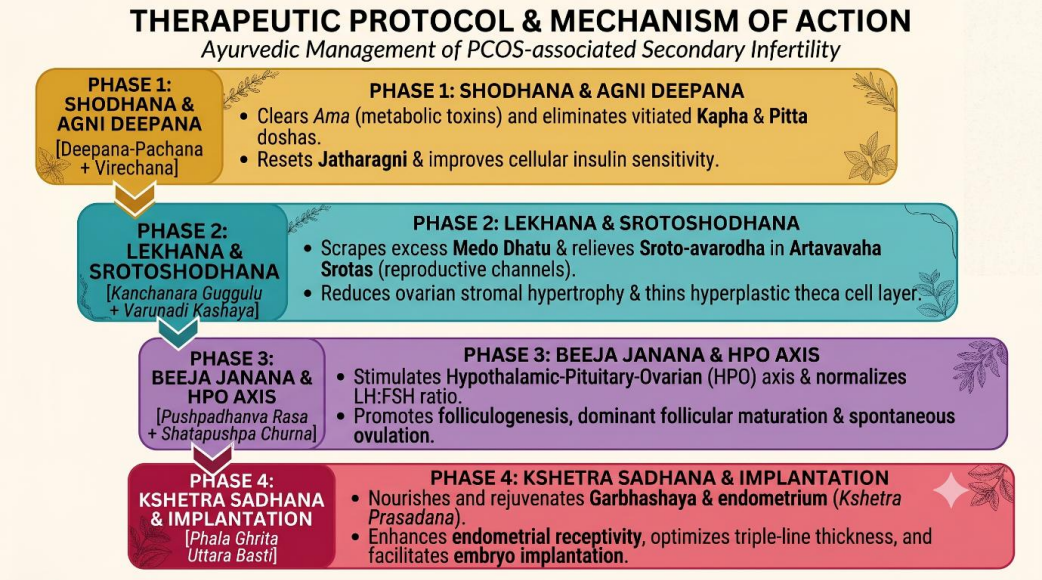
Clinical Domain	Baseline Status	Post-Treatment Status (Month 5)
Menstrual Interval	60–90 days (Oligomenorrhea)	**30–32 days (Normal Eumenorrhea)**
Bleeding Duration	1–2 days (Hypomenorrhea)	**3–4 days (Physiologic duration)**
Flow Volume	Scanty, 1 pad/day (spotting)	Moderate, 3–4 fully soaked pads/day
Dysmenorrhea	Dull pelvic heaviness	Absent; painless spontaneous menstruation
Body Weight & BMI	70 kg; BMI 28.4 kg/m^2	**63.5 kg; BMI 25.7 kg/m^2 (loss of 6.5 kg)**
Facial Hirsutism	Ferriman-Gallwey Score: 9	Ferriman-Gallwey Score: 6 (slower regrowth)
Ovulatory Status	Chronic anovulation (Mid-luteal Progesterone: 1.4 ng/mL)	**Spontaneous ovulation confirmed (Progesterone: 12.6 ng/mL; USG rupture)**
Conception Outcome	Primary failure > 2.5 years	**Natural conception achieved; live 6-week intrauterine pregnancy**
Patient Satisfaction	Severe distress and marital anxiety	Highly satisfied; positive psychological well-being
Adverse Drug Reactions	Nil reported	Zero hepatic, renal, or gastrointestinal toxicities observed

Discussion

PCOS presents a clinical challenge in reproductive medicine because of its intertwined metabolic and endocrine loops: insulin resistance enhances theca-cell androgen secretion, which suppresses pituitary gonadotropin cyclicity, arresting follicular maturation and leading to subcapsular accumulation of immature antral follicles. In the context of secondary infertility, these mechanisms compromise the classic triad of reproduction—ovulation (*Ritu* and *Bija*), endometrial receptivity (*Kshetra*), and systemic nutrient delivery (*Ambu*). [1,10]

From an Ayurvedic perspective, the disease represents a condition initiated by impaired digestion (*Mandagni*) producing toxic metabolic intermediates (*Ama*). Concurrently, vitiated *Kapha* and excessive *Medo Dhatu* clog the reproductive channels (*Artavavaha Srotas*), creating an obstacle (*Avarana*) to the physiological movement of *Apana Vayu*. Because *Artava* is considered an *Upadhatu* (secondary tissue) of *Rasa Dhatu*, metabolic sluggishness prevents healthy *Artava* formation, leading to follicular arrest (*Artava Kshaya*) and ovulatory failure (*Pushpaghni*). [3–5]

The therapeutic protocol in this patient targeted this chain of pathogenesis step-by-step:



- **Systemic Detoxification via Virechana Karma:** [8]

Virechana directly expels morbid *Pitta* and *Kapha* accumulated at the level of *Amashaya* and *Yakrit* (liver). Mechanistically, this systemic drainage improves hepatic glucose handling, increases SHBG clearance, and relieves peripheral insulin resistance. The clinical fall in fasting insulin (from 19.8 to 8.4 IU/mL) and HOMA-IR (from 5.27 to 1.82) reflects this metabolic correction.

- **Targeted Anti-Atherogenic and Resolving Herbal Therapy:**
- *Varunadi Kashaya* and *Kanchanara Guggulu* contain sterols (guggulsterones), tannins, and flavonoids that act as *Lekhana* (scraping) agents. They inhibit adipogenesis, stimulate lipolysis, and reduce hyperplastic ovarian stroma, which translated directly into the reduction of ovarian volume from ~13 mL to ~8 mL bilaterally.
- *Shatapushpa* (*Anethum sowa*) possesses phytoestrogenic and *Artavajanana* actions, enhancing pelvic blood perfusion and stimulating endometrial proliferation.
- **Restoration of Neuro-Endocrine Signalling:**

Pushpadhanva Rasa acts directly on reproductive tissue (*Shukra/Artava Dhatu*). Its bio-transformed metallic components (*Bhasmas*) act as micro-trace catalysts, modulating the hypothalamo-pituitary-ovarian axis. This led to normalization of the LH:FSH ratio from 2.31 down to 1.07, clearing the neuro-endocrine blockage that prevented follicular emergence.

- **Micro-Nourishment via Uttara Basti:** [6]

Phala Ghrita administered via *Uttara Basti* provides localized lipophilic delivery to uterine tissue during the fertile proliferative window (*Ritu Kala*). Lipid-soluble phyto-compounds stimulate sub-endometrial angiogenesis, optimize uterine natural killer (uNK) cell profiles, and promote healthy trilaminar endometrial development (evidenced by an endometrial thickness of 9.4 mm) necessary for blastocyst adhesion and implantation.

Strengths and Limitations

- **Strengths:**
- Complete, chronologically documented management combining classical bio-purification (*Shodhana*), metabolic balancing (*Shamana*), and local targeted drug delivery (*Uttara Basti*).
- Objective verification of clinical endpoints through serial endocrine profiles, metabolic markers, and transvaginal follicular tracking confirming spontaneous ovulation and subsequent intrauterine conception.
- Absence of ovarian hyperstimulation syndrome (OHSS) or multi-fetal gestation.
- **Limitations:**
- As a single-patient case report, findings cannot be directly extrapolated as a generalized standard of care without larger cohort validation. [6–8]
- Multi-component herbal formulas make it difficult to isolate the exact biochemical contribution of each constituent.

1. Conclusion

This case demonstrates that individualized, stepwise Ayurvedic management—commencing with systemic metabolic detoxification (*Virechana*), followed by channel-clearing (*Kanchanara*, *Varunadi*), neuro-endocrine stimulation (*Pushpadhanva Rasa*), and localized uterine preparation (*Uttara Basti* with *Phala Ghrita*)—can resolve insulin resistance, restore spontaneous ovulatory cycles, and accomplish natural conception in chronic PCOS-associated secondary infertility without exogenous gonadotropins or assisted reproductive technology. [6–8]

Informed Consent

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

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