



# International Journal of Homoeopathic Sciences

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India

## A case of infertility due to PCOS treated successfully with homoeopathy

**Dr. Padmalaya Rath**

### Abstract

Infertility is defined as “the inability to conceive after multiple sustained attempts of unprotected intercourse for at least 2years. Polycystic ovarian syndrome (PCOS) which affects 8-10% of reproductive-aged females is the most common endocrine cause of infertility. Earlier reports in literature have highlighted the role of individualized homoeopathic treatment in the management of PCOS with infertility. A case report of successful management of secondary infertility due to PCOS with homoeopathic treatment presented herewith.

A 31 years old obese lady presented to OPD of CRI(H),NOIDA with clinical presentation of PCOS and secondary infertility. She was diagnosed as PCOS based on Androgen society and Rotterdam criteria and managed on the lines of individualized homoeopathic medicine Sepia and followed for a period of 2years.

Regularization of menstrual cycle, reduction in serum testosterone level, significant improvement in insulin sensitivity, normalization of ultrasound pattern of ovaries followed with conception and normal delivery with homoeopathic medicine were observed.

**Keywords:** Homoeopathy; hyperandrogenism, polycystic ovary syndrome; secondary infertility, sepia

### Introduction

Infertility is defined as inability to naturally conceive a child or inability to carry a pregnancy to full term. It is a condition where the couple is unable to conceive after multiple sustained attempts of unprotected intercourse for at least two years. The World Health Organization (WHO) estimates that 60 to 80 million couples worldwide currently suffer from infertility <sup>[1]</sup>. Infertility varies across regions of the world and is estimated to affect 8 to 12 per cent of couples worldwide <sup>[2, 3]</sup> Infertility tends to be highest in countries with high fertility rates, an occurrence termed “barrenness amid plenty” <sup>[4]</sup>

Infertility in India has been a grossly neglected medical condition since it is not a life threatening. However, the truth is that it creates a considerable psychological impact on couples.

Both men and women react in different ways to infertility, sometimes resulting in rift in the couple and at times leading to their separation. Individually, both partners often experience depression and anxiety which might elevate stress levels. But it is absolutely important for the couple to stand together during this phase and support each other. Infertility is a medical condition not by choice, some cases of which can be overcome with proper treatment while others cannot.

Total infertility is divided into primary and secondary infertility. Definitions of primary infertility vary between studies, but the operational definition, put forth by the WHO, defines primary infertility as the “Inability of women during to conceive within two years of exposure to pregnancy (*i.e.* sexually active, non-contraception, and non-lactating) among women 15 to 49 yr old <sup>[5]</sup>. Secondary infertility refers to the inability to conceive following a previous pregnancy.

In women, the causes of infertility include Fallopian tubal defects or disease, ovulatory dysfunction, polycystic ovarian disorder or PCOD (in almost 40 percent of cases), endometriosis, hormonal imbalances like hypothyroidism, immunological factors, congenital abnormalities and sexual dysfunction. Other common causes are genital tuberculosis (a chief factor in rural India), a condition characterized by abnormal growth in the woman's reproductive system, STDs that may permanently destroy the woman's reproductive system, obesity, use of certain medications, smoking and alcohol consumption <sup>[6]</sup>

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India

The most common cause of medically treatable infertility is polycystic ovarian syndrome (PCO). A prospective observational study conducted in Muhammad Medical College from 2005 to 2008, reported PCOS as the cause of infertility in 38.5% [7]

Polycystic ovary syndrome affects 8-10 percent of reproductive-aged females, making it the most common state of endocrine dysfunction in women. Polycystic ovary syndrome affect woman's Quality of life as well as her fertility & obstrical outcomes. It represents 80% of anovulatory infertility cases [8]. PCOS has adverse effect on pregnancy & miscarriage. Various treatment modalities are available in conventional medicine for infertility in PCOS including further surgical intervention.

Patients with PCOS are often treated for the signs and symptoms of the condition without consideration for the underlying syndrome, causing frustration for many affected patients. Abnormal uterine bleeding, endometrial hyperplasia and cancer, hirsutism and other skin changes, obesity, glucose intolerance, hypertension, and hyperlipidemia often accompany the syndrome, making it imperative to address these issues.

Homoeopathy has been used in the management of broad spectrum of diseases. Constitutional Homoeopathic medicine acts on psychic, somatic & pathological levels providing holistic approach to cure diseases. However in gynaecology ,its use remains limited when it comes to the context of evidence and publication. A case is presented here, where constitutional homoeopathy was successful in the treatment of PCOS with infertility.

**Case report**

A 31 year old obese woman presented with a clinical history of secondary infertility for the last 2 years despite of regular unprotected intercourse. Concurrent signs and symptoms of oligomenorrhoea, amenorrhoea / irregular menses for 12 months (L.M.P.- 2.2.14) and hyperandrogenism (Hirsute, F.G. score-8) of similar duration were noted. She had gained 6kgs of weight in last 2months. The general examination revealed a normal bp of 100/70mmhg with high BMI of 36.2 with waist and hip ratio of 0.965. Ultrasonography of abdomen revealed features suggestive of polycystic ovaries (PCO) on both sides. The RT. ovarian volume was 17cc and Lt ovarian vol.15.5cc with multiple peripheral follicles more than 12 in numbers measuring 4-5mm on both sides.. Biochemically, hyperinsulinaemia (HOMA IR -4.3, raised) was observed in association with a raised serum luteinizing hormone (LH) and raised testosterone concentrations. Her fasting sugar was 103mg/dl. Other biochemical and hormonal levels are within normal range as shown in table-1 The patient had been suffering from irregular and painful menstruation of more than 45 days duration and was unable to conceive for the last 2 years for which she was taking allopathic treatment without satisfactory result. She reported for to DDPRCRI (H), NOIDA for homoeopathic intervention and has diagnosed as a case of bilateral polycystic ovarian disease. The description of the case is as follows:

**Present Complaints:** Failure of conception since 2yrs after 1<sup>st</sup> child who was of 6yrs old. Irregular, painful menstruation for last 1 year, character of blood was bright red and heavy in amount being thick dark clotted, offensive (fishy) odor with cramping pain in pelvis leading to

weakness.

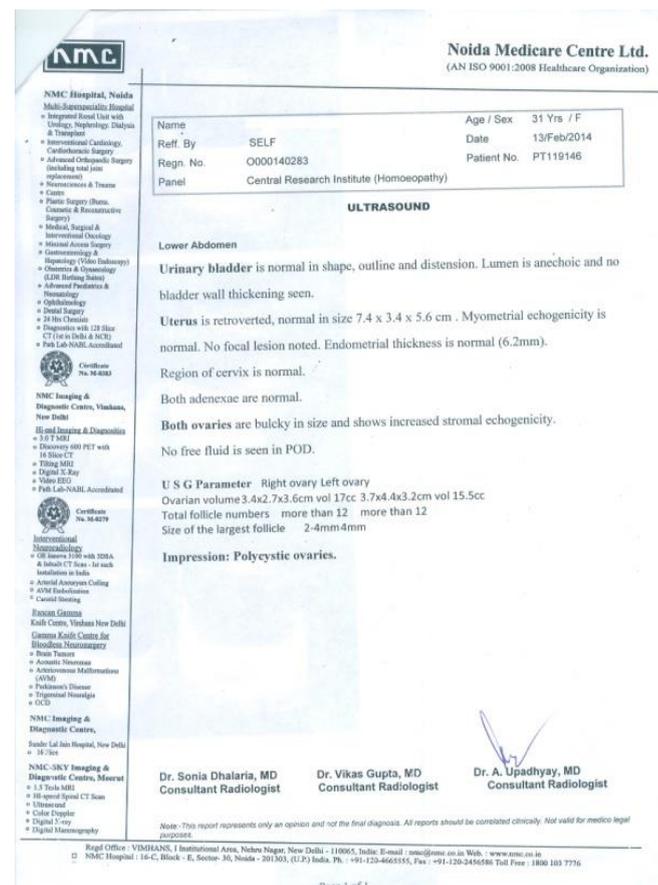
- No significant past history.
- Strong sycotic family history as mother had uterine fibroid, father who had hypertension, expired due to Heart failure at age of 65, Paternal grandmother had Diabetes mellitus and grandfather had Hypertension and died of cardiac arrest.
- BMI- 36.2,Hirsutism (Ferriman score-8)

**Homoeopathic Generalities**

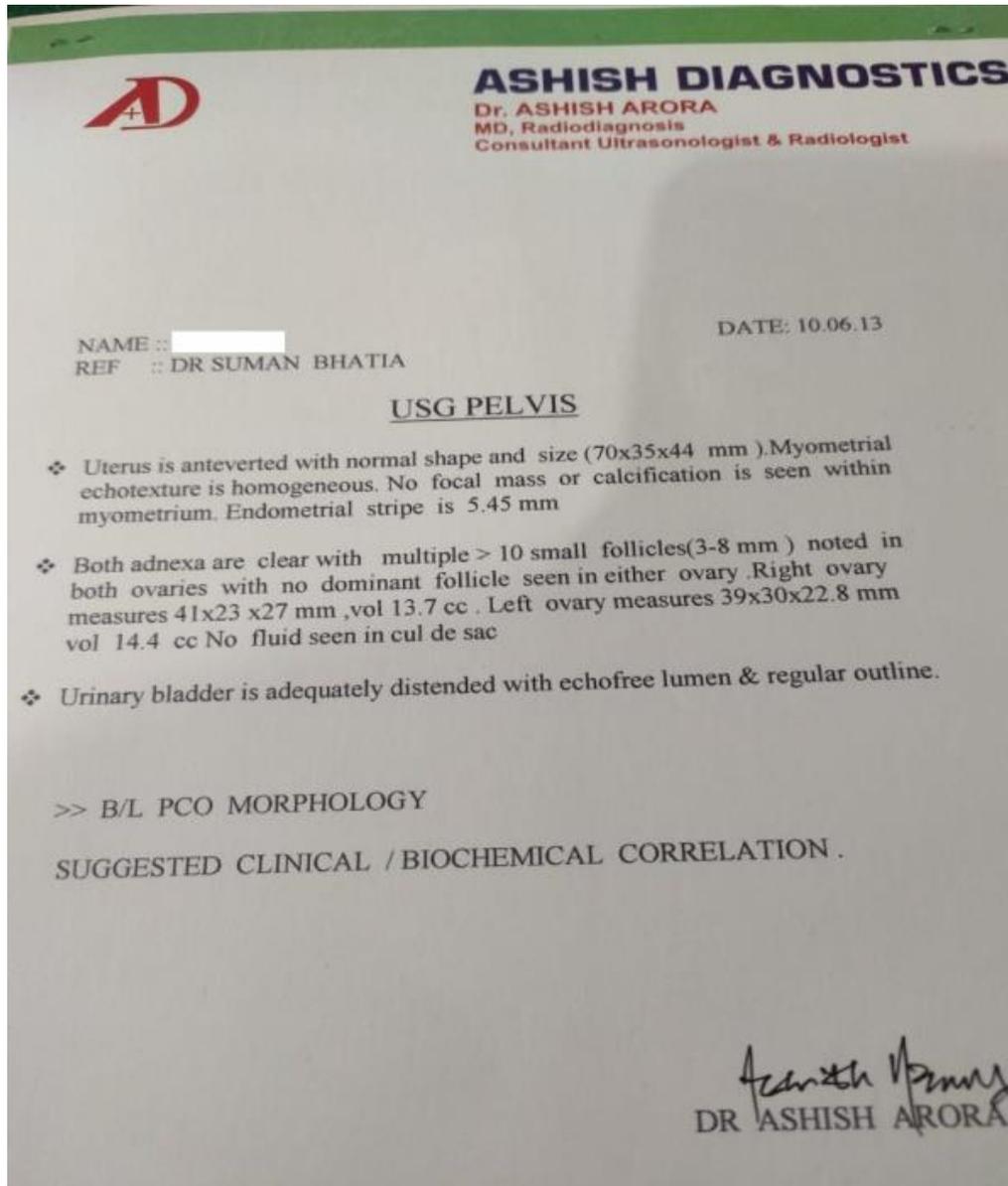
- Physical constitution – fat, flabby.
- Chilly patient; general aggravation in winter. Tendency to catch cold
- Appetite – good. can wait for food
- Desire for spicy food, fried food.
- Intolerance to sour things causes throat pain
- Moderate thirst for large quantities at long intervals.
- Stool satisfactory.
- Urine normal in frequency and consistency.
- Sleep sound.
- Sweat profuse on armpits, forehead, offensive, staining white
- Mind – Irritability angered easily, didn't like consolation which was making her more irritable, couldn't bear contradiction, she was reserved, wept when alone.

**Investigations**

10.6.13 USG of Pelvis – rt ovary- 14.4cc, Lt ovary-13.7 cc Multiple cysts in both ovaries >10 (Bilateral polycystic ovaries) and on 13/02/2014 – USG of Pelvis – rt ovary-17cc, Lt ovary-15.5 cc Multiple cysts in both ovaries >12 (Bilateral polycystic ovaries) (Figure-1,1a)



**Fig 1: Ultrasound**



**Fig 1a:** USG PELVIS

**Table 1:** (Biochemistry and hormonal assessment): (Figures- 2, 3, 4, 5)

12/02/2014 – Blood report(biochemistry)	Serum cholesterol	174mg/dl
	Serum triglycerides	89mg/dl
	HDL (High density lipoprotein)	40mg/dl
Hormonal assessment done on 28/02/2014 during luteal phases as LMP on 02/02/2014	freeT3 (Triiodothyronin)	- 2.8pg/dl
	FreeT4 (Triiodothyroxine)	1.82ng/dl
	TSH (Thyroid stimulating hormone)	3.2uIU/ml
	Serum prolactine	7.1
	Fasting blood sugar (FBS)	103mg/dl
	Fasting insulin	16.9mg/dl
	Glucose insulin ratio	6.094
	DHEA-S (Dehydroepiandrosterone sulfate)	136ug/dl
	Total testosterone	66.57ng/dl
	SHBG (Sex hormone binding globulin)	27.70nM/L
	F.S.H. (Follicle stimulating hormone)	6.19ng/dl
	L.H. (leutinizing hormone)	11ng/dl

**NMC Hospital, Noida**  
 Multi-Specialty Hospital  
 • Integrated Road Care with  
 Urology, Nephrology, Dialysis  
 & Transplant  
 • Interventional Cardiology,  
 Cardiothoracic Surgery  
 • Advanced Orthopedic Surgery  
 (including total joint  
 replacement)  
 • Neurosciences & Trans-  
 Cranial  
 • Plastic Surgery (Burns,  
 Cosmetic & Reconstructive  
 Surgery)  
 • Medical, Surgical &  
 Interventional Oncology  
 • Maxillofacial Surgery  
 • Gastroenterology &  
 Hepatology (Video Endoscopy)  
 • Obstetrics & Gynaecology  
 (LCR Starting Society)  
 • Advanced Paediatrics &  
 Neonatology  
 • Ophthalmology  
 • Dental Surgery  
 • 24 Hrs Chemists  
 • Diagnostics with 128 Slice  
 CT (1st in Delhi & NCR)  
 • Path Lab-NABL Accredited

**NMC Imaging & Diagnostics, Vindhans**  
 Hybrid Imaging & Diagnostics  
 • 3.0 Tesla MRI  
 • Discovery 600 PET with  
 16 Slice CT  
 • Tiling MRI  
 • Digital X-Ray  
 • Ultrasound  
 • Echo  
 • TMT  
 • Video EEG  
 • Path Lab-NABL Accredited

**Interventional Neuroradiology**  
 • GE Inverse 3TR with 3D DSA  
 & Inwalk CT Scan - for such  
 Installation in India  
 • Arterial Aneurysm Coiling  
 • AVM Evaluation  
 • Carotid Stenting

**Rancan Gamma Knife, Vindhans**  
 • Brain Tumors  
 • Acoustic Neuroma  
 • Arteriovenous Malformations  
 (AVM)  
 • Parkinson's Disease  
 • Trigeminal Neuralgia  
 • DSD

**NMC SuperSpecialty Hospital, Vindhans**

**Noida Medicare Centre Ltd**  
 (AN ISO 9001:2008 Healthcare Organization)

Name: SELF  
 Ref. By: SELF  
 Regn. No.: O000140410  
 Panel: Central Research Institute (Homoeopathy)  
 Sample Date: 18/Feb/2014

Age / Sex: 31 Yrs / F  
 Date: 18/Feb/2014  
 Patient No.: PT119232  
 REP. TIME: 20/Feb/2014 10:05

**BIOCHEMISTRY**

Test Name	Result	Units	Normal Range
Blood Sugar Fasting (HEXOKINASE METHOD)	103.0	mg/dl	(60-110)
Insulin Fasting	16.9	uIU/ml	(2-25)

**Dr. Manoj Kumar**  
 MD (Path)  
 Pathologist

**Dr. Anju Gupta**  
 MD (Path)  
 Pathologist

**Dr. Raj Kumar M.D.**  
 Microbiologist

Note:- This report represents only a professional opinion and not the final diagnosis. Not valid for medico legal purposes. # Test Under NABL Scope  
 Lab Technician Typed By

**25 Years**

Certific No. M-0183

Certific No. M-0279

Page 1 of 3

Fig 2: FBS and Serum Insulin

**REPORT**

Tel No: 9716565666

Age:31.00 Years Sex:FEMALE

Reference Dr. Organisation:C.R.I. (Homoeopathy) SEC-24 NOIDA

SID: 130203209  
 130203209  
 Collected On: 20/02/2014 08:08 AM  
 Registered On: 20/02/2014 08:08 AM  
 Reported On: 21/02/2014 2:28PM

Test Description	Observed Value	Biological Reference Interval
<b>Hormones :</b> Testosterone, Total, serum by CMIA	<b>66.57</b>	Puberty, Tanner Stage pg/dl 1 2 - 10 2 5 - 30 3 10 - 30 4 15 - 40 5 10 - 40 21 - 49 Yrs 7 - 79 > 50 Yrs 8.6 - 36.9 CMIA: Chemiluminescence Microparticle Immunoassay
SHBG-Sex Hormone Binding Globulin,serum (CMIA)	<b>27.70</b>	11.7 - 137.2 nM/L CMIA :- Chemiluminescence Microparticle Immunoassay

The test has been processed at Metropolis Health Service (I) Ltd., Mumbai (NABL & CAP Accredited)

End of Report

**Dr. GEETA CHOPRA (MD)**

Page 1 of 1  
 Results relate only to the sample, as received. Refer to conditions of reporting overleaf.  
 \*This test was outsourced to Metropolis Healthcare Ltd., Mumbai.

**METROPOLIS**  
 EXCELLENCE IN DIAGNOSTICS

Fig 3: Testosterone and SHBG



**Noida Medicare Centre Ltd**  
(AN ISO 9001:2008 Healthcare Organization)

**25 Years**

Name	Age / Sex	31 Yrs / F
Ref. By	SELF	Date
Regn. No.	0000140410	Patient No.
Panel	Central Research Institute (Homoeopathy)	REP. TIME
Sample Date	18/Feb/2014	20/Feb/2014 10:05

**HORMONES**

Test Name	Result	Units	Normal Range
<b>Thyroid Function Test (CLIA METHOD)</b>			
LH - Leutinising Hormone, Serum	11.0		Normally menstruating women: Follicular Phase - 1.9 to 12.5 mIU/ml Mid cycle peak - 8.7 to 76.3 mIU/ml Luteal phase - 0.5 to 16.9 mIU/ml Pregnant - Below 1.5 mIU/ml Post menopausal - 15.9 to 54 mIU/ml On oral contraceptive - 0.7 to 5.6 mIU/ml
Prolactin, Serum	7.1	ng/mL (1-25)	Non Pregnant - 2.8 to 29.2 ng/ml Pregnant - 9.7 to 208.5 ng/ml Post Menopausal - 1.8 to 20.3 ng/ml
FSH - Follicle Stimulating Hormone, Seru	6.19		Normally menstruating women: Follicular Phase - 2.5 to 10.2 mIU/ml Mid cycle peak - 3.4 to 33.4 mIU/ml Luteal phase - 1.5 to 9.1 mIU/ml Pregnant - Below 0.3 mIU/ml Post menopausal women: 23.0 to 116.3 mIU/ml
Free Triiodothyronine (FT3)	2.8	pg/ml	(2.2-4.2)
Free Thyroxin (FT4)	1.82	ng/dl	(0.8-1.7)
Thyroid Stimulating Hormone (TSH)	3.2	µIU/mL	(0.3-3.6)

Dr. Manoj Kumar  
MD (Path)  
Pathologist

Dr. Anju Gupta  
MD (Path)  
Pathologist

Dr. Raj Kumar M.D.  
Microbiologist

Note: This report represents only a professional opinion and not the final diagnosis. Not valid for medico legal purposes. © Test Under NABL, Scope Lab Technician

Fig 4: LH, FSH, Prolactin, T3, T4, TSH



**Noida Medicare Centre Ltd**  
(AN ISO 9001:2008 Healthcare Organization)

**25 Years**

Patient's Name	Collection Date	18/02/2014
Referred by	Self	Print Date
MRN No/ NMC No	OPD	Age
Lab No		Sex
		Female

**CLINICAL BIOCHEMISTRY REPORT**

TEST NAME RANGE	RESULTS	UNITS	NORMAL
Dehydroepiandrosterone (DHEA-S)	136	ug/dL	35-430

Fig 5: DHEA-S

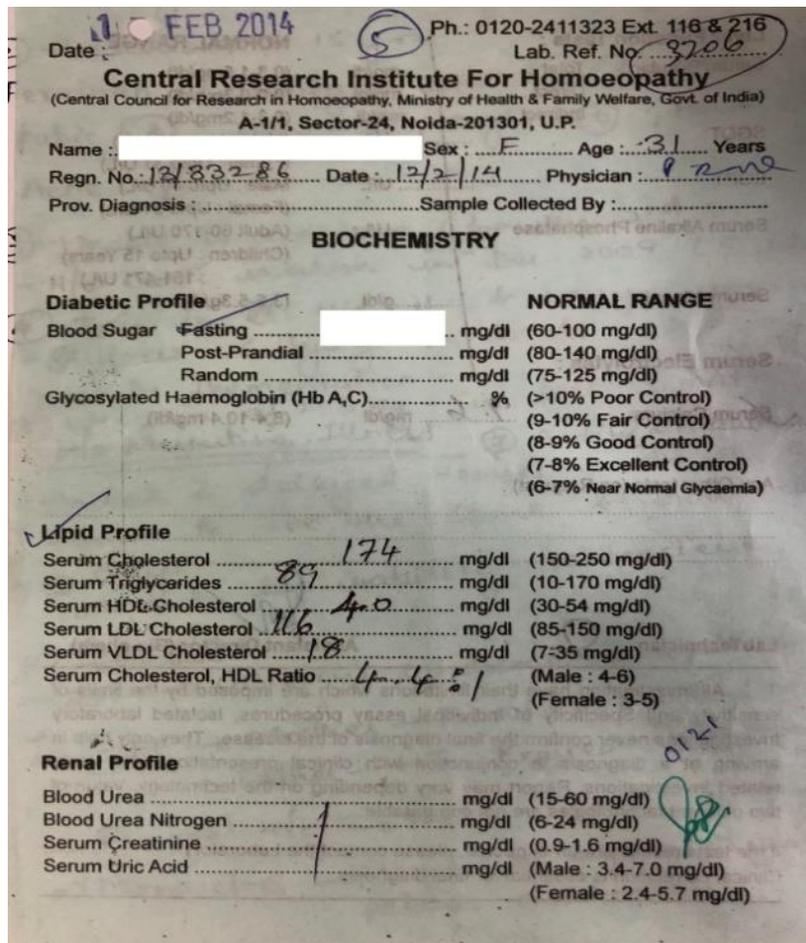


Fig 6: Lipid Profile

Diagnosis – polycystic ovarian syndrome.

Characteristic Totality

Mental generals –

- Consolation <
- Contradiction <
- Reserved
- Anger easily

Physical generals

- Sour food causes throat pain
- Desire for spicy food
- Offensive perspiration

Particular Symptoms –

- Irregular menses
- Offensive menses
- Secondary sterility
- Character of the menstrual blood – clotted.

Rubrics Taken For Repertorisation

- MIND, anger trifles at
- MIND, Consolation <
- MIND, Contradiction <
- MIND, Reserved
- GENITALIA FEMALE, MENSES, painful, Dysmenorrhoea
- Genitalia Female, MENSES, offensive
- Genitalia Female, Sterility
- Desire for spicy food

Result of Repertorisation (Figure-7)

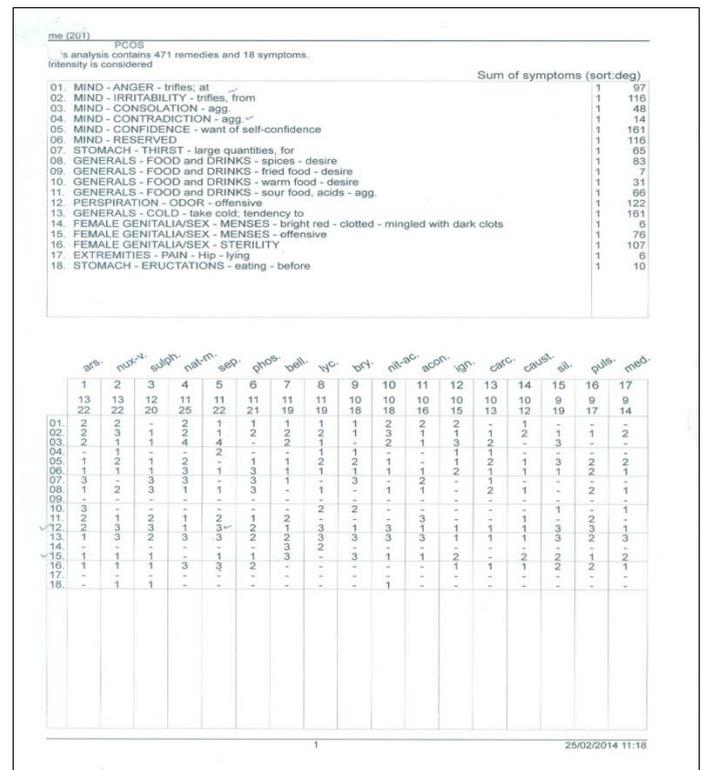


Fig 7: Result of Repertorisation

- Ars alb and Nux vom scored highest & got 13/22 each, covering the 13 symptoms out of 18 symptoms.
- Sepia got 11/22 marks and covered the 11 symptoms out of 18 symptoms.

After consulting Materia medica, Sepia is preferred to be prescribed first. The typical sycotic background, sycotic constitution, chilliness of the patient weighed more in prescribing Sepia.

#### Comments

- Arsenicum album and Nux vomica scored highest & got 13 each, but Sepia covered 11 symptoms out of 18.

**Prescription:** Sepia 30 tds/3days+ P.L.30 bd/15days on 26.2.14

**Table 2:** Date of prescription and follow ups table

Date	Symptoms	Weight	BMI	Medicine Potency Repetition DAYS
14/03/2014	Lmp-2.3.14 Bright red , clots, offensiveness decreased, weakness ,pain pelvis, cramp legs decreased	95Kg	36.198	<i>Sepia</i> 30/ T.D.S/3days P.L. 30/ B.D./ 30 days
5/04/2014	Lmp-1.4.14 ,Bright red , clots decreased, back pain , pain abdomen decreased	95kg	36.19	<i>Sepia</i> 30/ O.D./ 3days P.L. 30/ B.D./ 30 days
03/05/2014	Lmp-2/5/14 Bright red ,no clots, no pain Weakness decreased	95kg	36.19	<i>Sepia</i> 200/ O.D./ 3days P.L. 30/ B.D./ 30 days.
13/06/2014	L.M.P.-3.6.14 Bright red, no clot, nostain, not offensive. Weakness and lethargy was there	94kg	35.81	<i>Sepia</i> 1M// O.D./ 3days P.L. 30/ B.D./ 30 days.
24/7/2014	Lmp- 16.7.14 Bright red, thick, no pain no backache; weakness	96kg	36.57	<i>Sepia</i> 1M// O.D./ 3days P.L. 30/ B.D./ 30 days.
28/8/2014	Lmp-18.8.2014 Bright red, no stain, not offensive, mild pain in leg and mild weakness USG-no PCO rt.ovary-8.7cc,lt ovary-4.4cc(Fig-11)	94kg	35.81	<i>Sepia</i> 1M// O.D./ 3 P.L. 30/ B.D./ 30 days.
20.09.2014	Lmp-14.9.2014 Bright red, no stain, not offensive, mild pain in leg and mild weakness	92kg	35	<i>Sepia</i> 10M/ O.D./ 2 days P.L. 30/ B.D./ 30 days.
20.10.2014	Lmp-14.9.2014 Advised for Urine Pregnancy test ,USG Pelvis Urine pregnancy test+ve (Fig-12) EDD-21.6.2015 USG report suggest normal study,5wks gestation(fig-13) Lt.ovary-5.2cc	93kg		P.L. 30/ B.D./ 30 days
12.11.2014	Advised for USG Pelvis USG- Single intra uterine pregnancy of approx 5 wks 5days GA. Rt.ovary-4.7cc(Fig-12a)	87kg		P.L. 30/ B.D./ 30 days

Delivered a female baby on 17.06.15

After becoming pregnant she used to come for Antenatal checkup and *Rhus tox.*, *Bronia. alb*, *Nux vomica* have been given from time to time. She delivered a healthy female

child on 17.06.15 without any complication or adverse events.

**Table 3:** (changes in patient's sign, symptoms and investigations)

	Before Treatment	After Treatment
BMI	36.2	35.8
Acanthosis nigricans	1	1
Waist to hip ratio	0.96	1
duration of the cycle (days)	45	32
Ferriman Total score	8	5
Acne global severity scale	0	0
Ovarian volume-Right (cc)	17	8.7
Ovarian volume-Left(cc)	15.5	4.4
Size of the largest follicle-Right (mm)	4	7
Size of the largest follicle-Left (mm)	4	7
Sex hormone binding globin	27.7	22.3
LH/FSH ratio	11/6.19	4.6/2.96
Total testosterone (ng/dl)	66.57	45.7
Dehydroepiandrosterone-sulfate (ng/dl)	136	253.3
Serum insulin( mIU/ml)	16.9	12.3
Fasting glucose (mg/dl)	103	91
Glucose insulin ratio	6.094 I:G=0.16	7.39 I:G=0.14
Tryglycerides(mg/dl)	89	150
HDL-cholesterol(mg/dl)	40	41
HOMA-IR <sup>9</sup>	4.3*	2.8*

\* HOMA-IR<sup>9</sup>

Test Description	Observed Value	Biological Reference Interval
<b>BIOCHEMISTRY :</b>		
Glucose Fasting, Fluoride plasma	91	Normal 70 - 99 mg/dL Impaired glucose tolerance : 100 - 125 mg/dL Diabetes mellitus : >= 126 mg/dL (on more than one occasion) (American diabetes association guidelines 2012) Method : Hexokinase Method
<b>Hormones</b>		
Testosterone, Total, serum by CMIA	45.70	Puberty, Tanner Stage ng/dL 1 2 - 10 2 5 - 30 3 10 - 30 4 15 - 40 5 10 - 40 21 - 49 Yrs 7 - 79 > 50 Yrs 8.6 - 36.9 CMIA: Chemiluminescence Microparticle Immunoassay
SHBG-Sex Hormone Binding Globulin,serum (CMIA)	22.30	11.7 - 137.2 nmol/L + CMIA :- Chemiluminescence Microparticle Immunoassay

Fig 8: FBS, Testosterone, SHBG

Test Description	Observed Value	Biological Reference Interval
<b>Hormones :</b>		
LH-Leutinsing Hormone, serum by CMIA	4.60	Condition mIU/mL Follicular phase 1.7 - 15.0 Midcycle peak 21.9 - 56.6 Luteal phase 0.6 - 16.3 Postmenopausal 14.2 - 52.3 Method : Chemiluminescence Microparticle Immunoassay
FSH-Follicle Stimulating Hormone,Serum by CMIA	2.96	Condition mIU/mL Follicular phase 1.4 - 9.9 Midcycle peak 0.2 - 17.2 Luteal phase 1.1 - 9.2 Postmenopausal 19.3 - 100.6 Method : Chemiluminescence Microparticle Immunoassay
DHEAS, serum by CMIA	253.30	Age ug/dL 12 - 17 yr 20 - 535 18 - 30 yr 45 - 380 31 - 50 yr 12 - 379 Postmenopausal 30 - 260 CMIA : Chemiluminescence Microparticle Immunoassay DHEAS : Dehydroepiandrosterone
Insulin, fasting, serum by CMIA	12.3	2 - 25 uIU/mL Method : Chemiluminescence Microparticle Immunoassay

Remarks :  
 1. Useful in the diagnosis of Insulinoma .  
 2. Increased levels are seen in Insulinoma, factitious hypoglycaemia, Insulin autoimmune syndrome, untreated obese patients with mild diabetes, reactive hypoglycaemia .  
 3. Decreased levels are seen in untreated IDDM and absent in severe DM with Ketosis & weight loss.  
 Abbreviations: IDDM-Insulin- dependent Diabetes Mellitus; DM-Diabetes Mellitus;

End of Report

Fig 9: LH, FSH, DHEAS, Serum Insulin

Date : 20.10.14 Ph.: 0120-2411323 Ext. 116, 216 & 217  
 Lab Ref. No. 1676

**Central Research Institute For Homoeopathy**  
 (Central Council for Research in Homoeopathy, Ministry of Health & Family Welfare, Govt of India)  
 A-1/1, Sector-24, Noida-201301, U.P.

Name: \_\_\_\_\_ Sex: f Age: 31 Years  
 Regn No. 13/33286 Date: 20.10.14 Physician: P. Rao

Investigation Required: \_\_\_\_\_  
 Provisional Diagnosis: \_\_\_\_\_ Sample Collected By: \_\_\_\_\_

**BIO-CHEMISTRY**

**Diabetic Profile:**

Blood Glucose	Fasting	mg/dl	(60-100 mg/dl)
	Post Prandial	mg/dl	(80-140 mg/dl)
	Random	mg/dl	(75-125 mg/dl)
Glycosylated Haemoglobin (HbA1C)		%	(> 10% poor Control) (9-10% Fair Control) (8-9% Good Control) (7-8% Excellent Control) (6-7 % near Normal Glycaemia)

**Lipid Profile:**

Serum Cholesterol 155 mg/dl (Normal (desirable): <200 mg/dl)  
 (Borderline High risk : 200- 239mg/dl)  
 (High risk : >240 mg/dl)

Serum Triglycerides 115 mg/dl Normal : <150 mg/dl  
 Boederline High : 150-200 mg/dl  
 High : 200-500 mg/dl  
 Very High : > 500 mg/dl

	<b>Men</b>	<b>Women</b>
Serum HDL Cholesterol	<u>37</u> mg/dl	Prognostically favorable > 55mg/dl > 65 mg /dl

(Low Risk)

Standard Risk Level	35-55 mg/dl	45-65 mg/dl
Risk Indicator (High Risk):	< 35 mg/dl	< 45 mg/dl

Serum LDL Cholesterol 95 mg/dl Borderline: 100-190 mg/dl  
 Risk : >190 mg/dl

Serum VLDL Cholesterol 23 mg/dl Normal : < 50 mg/dl

Serum Cholesterol, HDL Ratio 4.281 Normal : < 4  
 Low Risk : 4-6  
 High Risk : >6

Fig 10: Lipid profile

मेल : crihnoida@gmail.com फोन : 0120-2411320 दूरभाष : 0120-2411323 - 2411324

**केन्द्रीय होम्योपैथी अनुसंधान संस्थान**  
**Central Research Institute (Homoeopathy)**  
**CCRH, Deptt. Of AYUSH, Ministry of Health & Family Welfare, Govt. of India**  
 (के. सी. आ. प. - आयुष विभाग - स्वास्थ्य एवं परिवार कल्याण मंत्रालय - भारत सरकार)  
 पी-१/१४, सेक्टर-२४ ए नोएडा-२०१३०१  
 A-1/1, Sector-24, NOIDA-201301

Name of Patient: \_\_\_\_\_ Age/Sex: 31Y/F Date: 12.08.14  
 Regn.No : 13/33286 I.P.D/O.P.D/Research: Research Ref.Dr.P.Rath  
 Part to Scan : Pelvis  
 Project: PCOS

**ULTRASOUND PELVIS**

Urinary bladder is well distended with smooth wall outline. No echo drop seen.  
 Uterus is anteverted and normal in size measuring 62.0x38.9x37.1mm.

Myometrial echotexture is homogeneous. No focal lesion seen.

Endometrial echo-complex is central and normal in thickness.

Cervix is normal in length. No altered echogenicity noted.

Os is closed.

Both ovaries are normal in size and echogenicity with normal follicular structures.  
 RO : 28.8x16.7x30.8 mm ( approx. 8.7 cc in vol.)  
 LO : 23.6x16.7x21.4 mm ( approx. 4.4 cc in vol.)

USG.Parameter	Right ovary	Left ovary
Ovarian volume	8.7cc	4.4cc
Total follicle numbers	10-15	10-15
Size of the largest follicle	6-7mm	6-7mm

No collection seen in posterior pouch.

IMPRESSION: Right ovary bulky.  
 Please correlate clinically

**DR. HANIKA AGARWAL**  
**MBBS, DMRE**  
 CONSULTANT RADIOLOGIST

Fig 11: USG report

20 OCT 2014

Date: 20 Ph.: 0120-2411323 Ext. 116 & 216  
 Lab. Ref. No. 2542

**Central Research Institute For Homoeopathy**  
 (Central Council for Research in Homoeopathy, Ministry of Health & Family Welfare, Govt. of India)  
 A-1/1, Sector-24, Noida-201301, U.P.

Name: [Redacted] Sex: M Age: 31 Years  
 Regn. No.: 14/20222 Date: 20.10.14 Physician: P. B. [Redacted]

Prov. Diagnosis: UPT.  
 Investigation Required: UPT.

**CLINICAL PATHOLOGY  
 URINE  
 (MICROSCOPIC)**

Colour & Appearance ..... Reaction .....  
 Sp. gravity ..... Protein .....

Sugar .....

**(MACROSCOPIC)**

RBC ..... /HPF ..... WBC ..... /HPF .....  
 Epithelial Cells ..... /HPF ..... BACTERIA .....

CASTS  
 Granular Fine ..... Coarse .....

Hyaline ..... Waxy .....

Others ..... Cylindroids .....

CRYSTALS  
 Cal. Oxalate ..... Phosphate .....

Urates Uric acid ..... Bacteria .....

Others: [Handwritten notes]

**(SPECIAL)**

Acetone .....  
 Bile Pigments .....  
 Others .....

Bile Salts .....  
 Urobilinogen .....

Lab Technician: [Signature] Asstt. Director (Pathology): [Signature]

Fig 12: Urine report suggesting Pregnancy

ई-मेल : crihnoida@gmail.com फोन : 0120-2411323 दूरभाष : 0120-2411323, 2411324

**केन्द्रीय होम्योपैथी अनुसंधान संस्थान**  
**Central Research Institute (Homoeopathy)**  
 CCRH, Deptt. Of AYUSH, Ministry of health & Family Welfare, Govt. of India  
 (के. हो. अ. प. - आयुष विभाग - स्वास्थ्य एवं परिवार कल्याण मंत्रालय - भारत सरकार)  
 ए-१/१ए, सेक्टर २४ ए नोएडा-२०१३०१  
 A-1/1, Sector-24, NOIDA-201301

Name of Patient: \_\_\_\_\_ Age/Sex: 31Y/F Date: 21.10.14  
 Regn. No : 13/33286 I.P.D/O.P.D/Research: Research Ref. Dr. P. Rath  
 Part to Scan : Lower Abdomen  
 Project: PCOS

LMP: \_\_\_\_\_

The uterus is anteverted, enlarged and gravid.

A well defined intrauterine gestation sac seen in fundal region. GSD meas. 9.7 mm corresponding to approx. 5weeks 5days of gestation age.

Good decidual reaction noted.

Cervix is normal.

Os is closed.

Adnexae are normal.

No collection is seen in posterior pouch.  
 RO: 21.6x17.9x23.2mm vol: 4.7cc  
 LO: 20.0x17.1x29.3mm vol: 5.2

EDD: 18.05.15

IMPRESSION: SINGLE, INTRAUTERINE PREGNANCY OF APPROX 5WK 5DAYS GA.

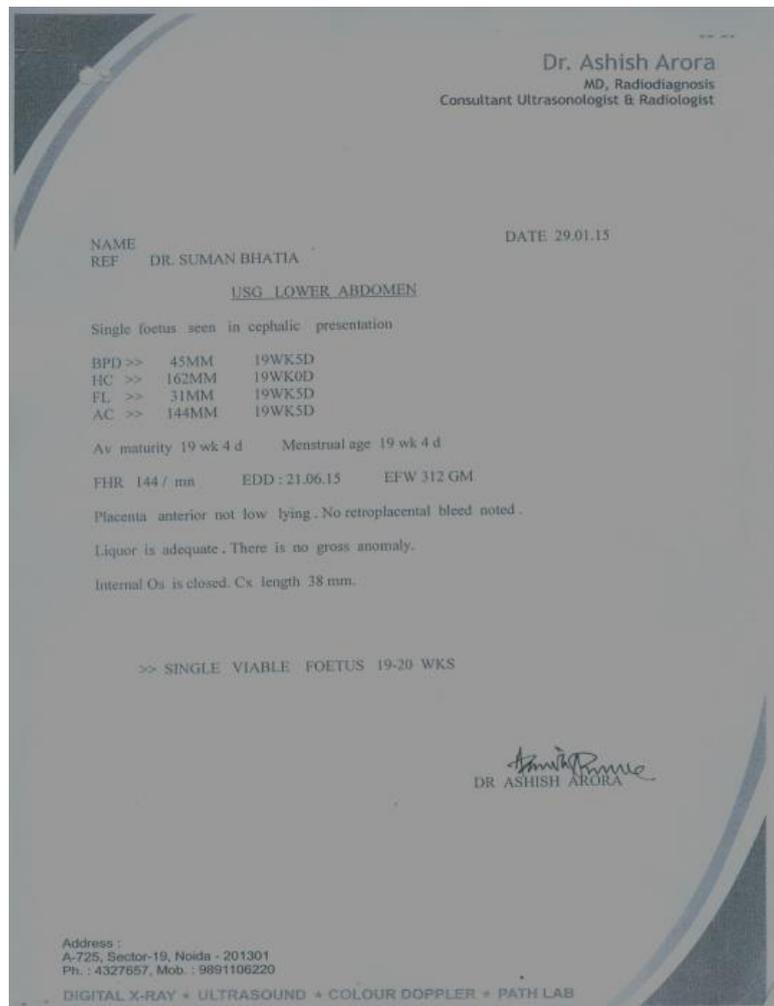
Please correlate clinically.

[Signature]  
**Dr. Monika Agarwal**  
 Consultant Radiologist

[Signature]  
**Dr. S. Ameer Ahmed, MD**  
 Consultant Radiologist

[Signature]  
**Dr. Sanjay Gupta, MD**  
 Sr. Consultant & Incharge

Fig 12a: USG report suggesting early gestation



**Fig 13:** USG suggesting 5 month pregnancy

## Discussion

Fertility tends to decrease with increasing age in both men and women due to social, biological, physical and mental, emotional and iatrogenic factors, adversely impacting the child-bearing process. Here is a case of secondary infertility, successfully treated with evidence based Homeopathic medicine showing the usefulness of homeopathy in the management of infertility due to PCOS.

Anit a lu *et al.* [10] shown effectiveness of homoeopathy in treatment of PCOD with infertility Homoeopathic constitutional remedies were successful in treating 17 out of 20 PCOD cases testing positive for Urine Pregnancy Test and USG of pelvis.

Role of homoeopathy in the management of PCOS and infertility has been well reported in literature. Different homoeopathic medicines in different strength have shown encouraging results. In different case reports, role of *Cal carb* [11], *Pulsatilla* [12] and *aurmet* [13] have resulted in successful pregnancy and normal delivery.

There are several other studies which have successfully managed the cases of PCOS. Study of Gupta *et al* [14] shows homoeopathy treatment helps to manage pcos cases.

CCRH [15] study shows very good result homeopathy in verum group than placebo group for PCOS.

The present case of PCOS with secondary infertility has been successfully managed with *sepia*. The strength of 30 th to 1M potency resulted in regulation of menstrual cycle, reduction in testosterone level and Ferrimen Galloy Score,

ovarian volume, normalization of ovarian pattern and improvement in insulin sensitivity as shown in table 3 where conception took place after prescribing 2 doses of 10 M of *sepia*. Similar effectiveness of *sepia* has been reported earlier in a case of hypothyroid with PCOD and secondary infertility [13]

This patient was a “classical” case of PCOS phenotype, characterized by truncal obesity, hyper-androgenism, oligo-amenorrhea, hirsutism, FSH/LH inversion and early insulin resistance.

The classic sign and symptoms, ultrasound pattern and hormonal as well as biochemical parameters before and after treatment are shown in table 3.

In this case Glucose insulin ratio-6.094 (fasting G/I ratio was > 4.5.) [16, 17] showing insulin resistance. However, LH/FSH ratio was within normal limits.

F.S.H. - 6.19ng/dl, L.H. - 11ng/dl which is altered as with PCOS we often see the FSH in the range of about 4-8 as well - but often the LH levels are 10-20 [18]

Testosterone level in female above 19 years is 8-60ng/dl. In this case testosterone level is higher than normal range [19].

Hence this case is a severe type PCOS.

However, AMH is an essential criterion for diagnosis of PCOS which has not been evaluated.

AMH levels are found to be significantly higher in PCOS patients with hyperandrogenism than without hyperandrogenism; indicating that hyperandrogenism is associated with an extra increase in AMH. This may reflect

the severity of disruption of folliculogenesis in patients with hyperandrogenism. Serum AMH levels may be related to the severity of the syndrome because they have been observed to be higher in women with insulin-resistant PCOS than in patients with normal insulin sensitivity (Fleming *et al.*, 2005)<sup>[20]</sup>

This case has many factor contributing for infertility i.e. PCOS, age and obesity. Still homoeopathic medicine *Sepia* helped to had conception.

This presented case is a good example for efficiency of homoeopathic medicine *Sepia* for infertility. This case may boost up the confidence of practitioner and new comers. This case implies that how homoeopathy can give a sustainable positive effect on infertility patients.

### Conclusion

Homeopathy has been found to be effective by several other works in such cases. The present case report clearly reiterate the role of individualized homeopathic treatment in the management of PCOS with secondary infertility.

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