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Dr. Dhanaraj Kumar Rana
Research Officer/S-1, Assistant
Professor, Department of
Psychiatry, National
Homoeopathy Research
Institute in Mental Health,
Kottayam, Kerala, India

Dr. Jaseela Villan
Post Graduate Trainee,
Department of Psychiatry,
NHRIMH, Kottayam, Kerala,
India

Corresponding Author:
Dr. Jaseela Villan
Post Graduate Trainee,
Department of Psychiatry,
NHRIMH, Kottayam, Kerala,
India

A case of endometriotic cyst treated with homoeopathic medicines

Dr. Dhanaraj Kumar Rana and Dr. Jaseela Villan

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Abstract

Endometrial ovarian cysts are one of the most common gynecological disorders found among reproductive-age women. They account for the commonest surgical interventions, undertaken not only by gynecologists but also by pelvic surgeons in these age groups. In this context, endometrial ovarian cysts should be considered as an area of the interdisciplinary approach. Here we present a case of 22 years old female having irregular periods, dysmenorrhea with heavy menstrual bleeding for the last 9 months, she had consulted with Gynecologist and was diagnosed with a left ovarian Endometriotic Cyst. She was treated with conventional medical therapies for the last 1 year but had no successful result. After she came under homoeopathic treatment (Pulsatilla followed by Medorrhinum) and showed normal USG findings within one year. This case demonstrates the positive role of constitutional anti-miasmatic homoeopathic treatment in Endometriotic cysts.

Keywords: Endometriotic cyst, homoeopathy, constitutional medicine, Pulsatilla, Medorrhinum

Introduction

Endometriosis is one of the common benign gynecologic disorders characterized by the presence of uterine endometrial tissue, such as endometrial glandular epithelium and stroma, outside the normal location. The endometriotic cyst is an ovarian endometriosis that contains chocolate-like fluid due to the accumulation of menstruation-like hemorrhagic blood in the cyst during the woman's reproductive period. It is well-known fact that ovarian cancer arises in endometriotic cysts. However, the mechanism of malignant change potential of the endometriosis in the endometriotic cyst is not yet elucidated [1]. Endometriosis is a chronic benign estrogen-dependent disease. It is present commonly in patients of reproductive age, and its prevalence in this age group is estimated at 5–10%. Endometriosis is defined as the presence of active endometrial tissue outside the uterine cavity, especially on the peritoneum of the minor pelvis, in the myometrium, ovaries, and fallopian tubes, as well as extraperitoneal sites. Endometriotic lesions can also be present in the intestines, urinary bladder, lungs, and brain tissues. Based on the site of the lesions, the disease is classified as peritoneal, ovarian, or deep infiltrating endometriosis [2].

Etiopathogenesis of endometriosis is still not fully understood. There are many theories on the etiology of this condition. The most widely accepted one is Sampson's theory, according to which the formation of ectopic endometrial tissue is a consequence of retrograde menstruation. During this process, some of the endometrial debris leaves the uterus with small volumes of menstrual blood, reaches the abdominal cavity via the fallopian tubes, and is implanted into the peritoneum, usually within the pelvis [3]. Furthermore, immune and genetic factors are postulated to play a crucial role in the etiopathogenesis of endometriosis [4]. The common manifestations of endometriosis are dysmenorrhea with heavy menstrual bleeding, pelvic pain, dyspareunia, infertility, and sometimes pain during defecation. Ovarian endometriosis is the most common type of this condition. Ovarian endometrial cysts (endometriomas) are found in 20–55% of women with endometriosis [5].

An ovarian mass can be qualified as an endometrial cyst based on its features in ultrasonographic presentation, based on the criteria that have been published by the International Ovarian Tumor Analysis (IOTA) collaboration in 2013. These criteria include size, shape, echogenicity of the lesion, the structure of its capsule, presence of any projections to the cyst's lumen, vasculature, and relationship with surrounding anatomical structures [6].

Ovarian endometriotic cysts are more frequently located on the left ovary (~60%); this is justified by the menstrual reflux theory and the anatomical differences between the left and right hemipelvis [7]. In hormonal therapies, the ovarian endometriomas may be decreased in their volume [8]. However, when these therapies are discontinued, ovarian endometriotic cysts frequently grow. Alternatively, endometriomas may be excised at laparoscopy. However, the recurrence rate of endometriomas after surgical intervention is between 11.7 and 30.4% at 2–5 years follow-up [9]. Furthermore, surgical treatment of ovarian endometriotic cysts may decrease the ovarian reserve [10]. In the case of surgical intervention, healthy ovarian tissue may be inadvertently removed particularly when the procedure is performed by surgeons with limited experience [11]. Furthermore, the changes in the ovarian reserve may also be related to the presence of the ovarian endometriotic cysts per se. A histopathological investigation of the functional morphologic features of the ovarian cortex surrounding benign cysts demonstrated that endometriomas are associated with reduced follicular number and activity compared with teratomas or other benign cystadenomas [12]. It is observed that women with endometriomas have lower anti-Mullerian hormone (AMH) levels and antral follicle count compared with women who do not have ovarian cysts, suggesting that the presence of endometrioma per se is associated with a reduction in ovarian reserve [13]. Ovarian endometrioma rarely exceeds 10–15 cm in diameter [14, 15]. Approximately 0.7% to 1.0% of patients with endometriosis have lesions that undergo malignant transformation [16]. When the diameter of an ovarian cyst exceeds 10 cm, malignancy must be suspected [17].

Case report

A 22 years old female presented at OPD of NHRIMH, Kottayam in January 2020, with complaints of having irregular menses for the last 9 months. Her menstrual cycle was irregular with profuse dark, clotted bleeding associated with severe vomiting, lower abdominal pain, and weakness of the body. Flow lasts for 5 to 6 days. She consulted the gynecologist and was diagnosed with an endometriotic cyst on the left ovary. (USG Findings on 09/02/19 showed enlarged left ovary with two cystic lesions measuring 4.5x4.2 cm and 3.0x3.0 cm (Fig.1). She was under allopathic treatment for the last year. Then she stopped medications when there was no improvement in the symptoms. She had complaints of hemorrhoids with bleeding and burning pain during stool for 2 years.

History

There was a history of Dengue fever at the age of 18 yrs. Took allopathic treatment and got relief.

Family history

Father – Diabetes Mellitus, Hypertension
 Mother – Hypothyroidism
 Brother - Diabetes Mellitus.

Mental generals

Reserved, Affectionate, Sensitive.

Physical generals

Her appetite was good. Thirst reduced. There was a desire for spicy things+++ & aversion to meat++; She had constipation with dry hard stool and hemorrhoids with occasional bleeding. Thermally patient was hot. Menarche at the age of 13th year. Menses was regular and without pain for the first 2 years, later dysmenorrhea with profuse bleeding started. The nature of the blood was dark and clotted for 5-6 days, associated with severe abdominal pain, vomiting, and weakness of the body.

Regionals

Warty growth on the back of neck, face, and both axilla.
 Head – Hair fall and Dandruff

General Physical Examination

The patient is moderately built and nourished, No Pallor, Cyanosis, Icterus, Clubbing, Oedema, Lymphadenopathy, Temperature: 98.6° F. (Afebrile), Height:160 cms, Weight:55 kgs, Pulse rate:70 bpm, Respiratory cycle: 18cpm. Bp-110/80 mm of hg.

Investigations

R/E Blood Examination –All parameters were within the normal limit.

USG Abdomen and Pelvis- enlarged left ovary with two cystic lesions measuring 4.5x4.2 cm and 3.0x3.0 cm (on 09-02-2019)

Clinical Diagnosis: Endometriotic Cyst.

Analysis of the case

Pulsatilla was selected based on the totality and reportorial result followed by placebo with the general improvement of the patient. To complete the cure, MEDORRHINUM was selected as an anti sycotic nosode. There was a slight aggravation of the uterine symptoms followed by the rapid improvement of the patient which was evident by USG findings.

USG Reports of various stages during the treatment are attached in Fig 1-5.

Follow up of the case given in table 1.

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KOTTAYAM

Patient: [REDACTED]
 MR No.: [REDACTED]

Visit Date : 09-Feb-2019
 Age & Gender: 21 Y/F

WHOLE ABDOMEN SONOGRAM REPORT

Liver is normal in size, span measures 13.5 cm and shows homogeneous parenchymal echoes. No focal parenchymal abnormality seen. Intra hepatic biliary radicles are not dilated. Portal vein and hepatic veins are normal.

Gall bladder normally distended. There is no calculus. No pericholecystic collection. CBD is not dilated.

Pancreas normal head/ body seen. Tail obscured. Size and echotexture are normal. Main pancreatic duct is not dilated. There is no calcifications or calculi.

Spleen is normal in size measures 8.0 cm. Normal parenchymal echotexture. No focal lesions seen.

Kidneys Bilateral renal sizes and parenchymal echotexture is normal with maintained corticomedullary differentiation. There is no calculus. Normal sinus echoes noted. Pelvicalyceal system is not dilated. No dilatation of ureters seen.

Urinary bladder: normal in contour with uniform wall thickness. There is no calculus.

Uterus is anteverted and normal in size 8.4 x 3.6 x 4.4 cm. Normal myometrial echoes noted. Endometrium thickness measures 7.0 mm.

Right ovary is normal.

Left is enlarged with two cystic lesions, measuring 4.5 x 4.2 cm and 3.0 x 3.0 cm. The lesion show fine internal echoes. No evident solid areas.

No adnexal mass lesion. Retrouterine pouch is clear.

No evidence of inflammed bowel loops or obvious bowel mass seen.

No free fluid noted in peritoneal cavity. No paraaortic lymphadenopathy.

CONCLUSION:

1. Left ovarian endometriotic cysts.

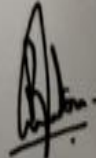

 Dr. Binston Thomas MBBS, MD, DNB.

Fig 1: Pelvic USG Before treatment

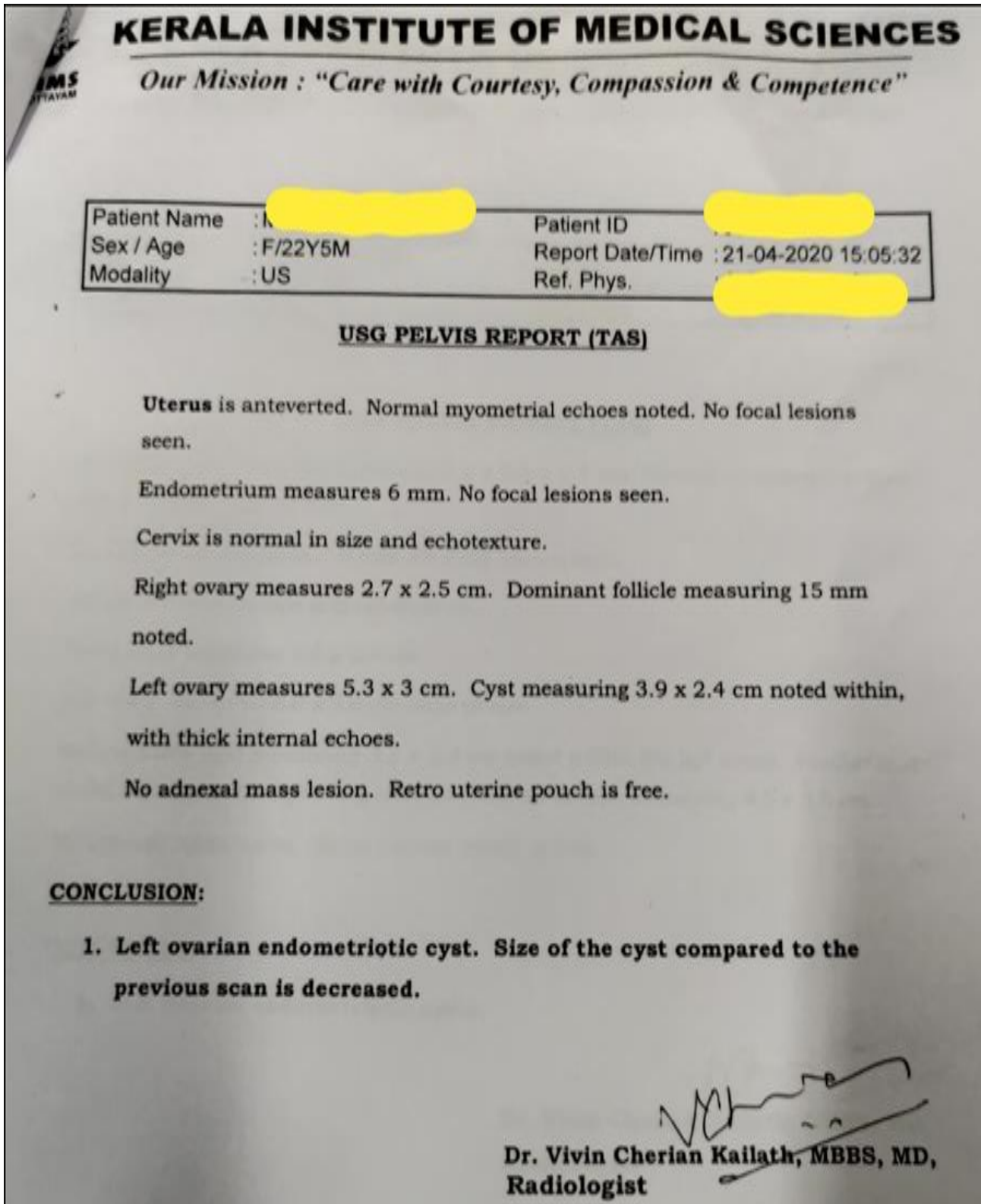


Fig 2: Pelvic USG during treatment

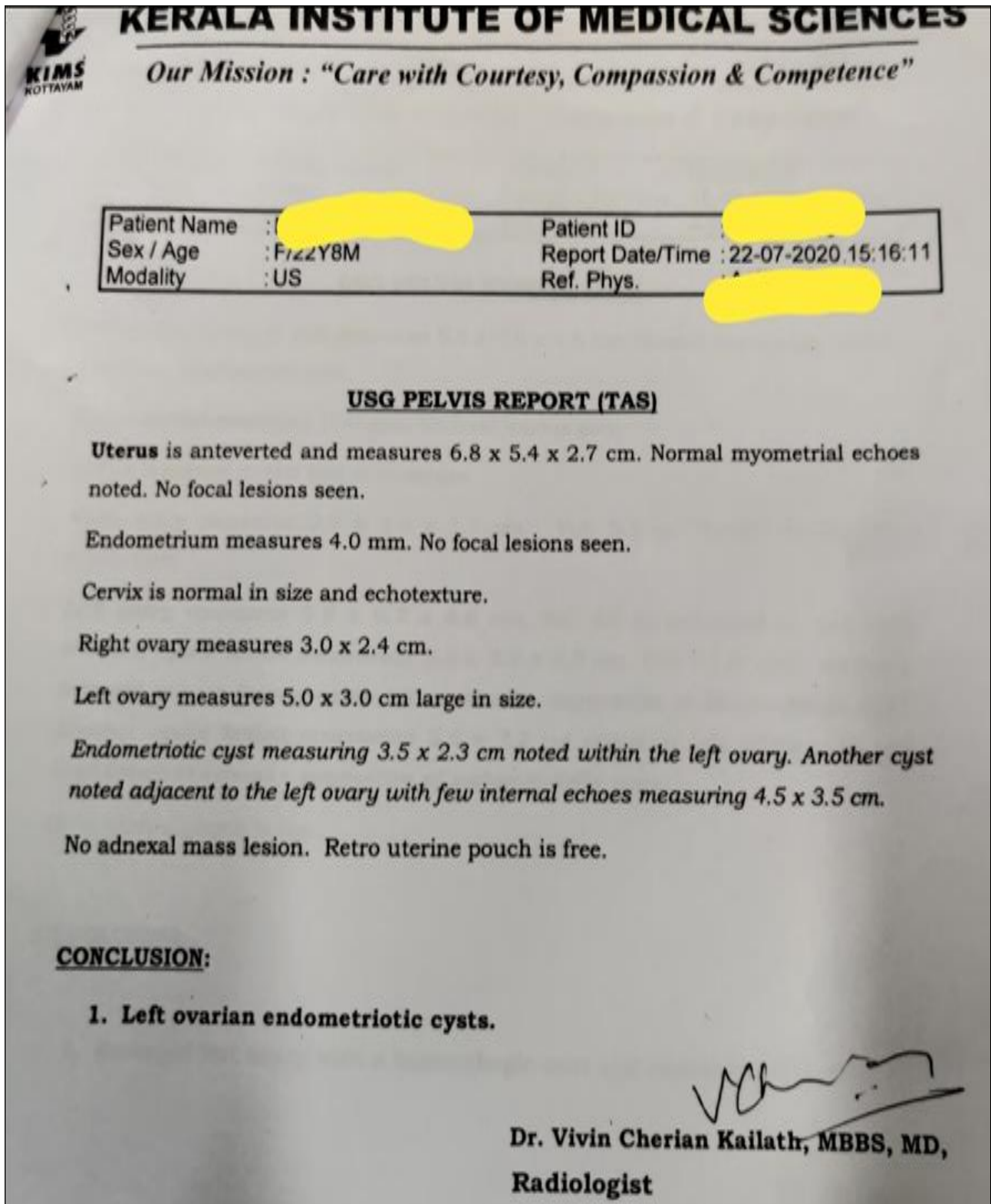


Fig 3: Pelvic USG during treatment

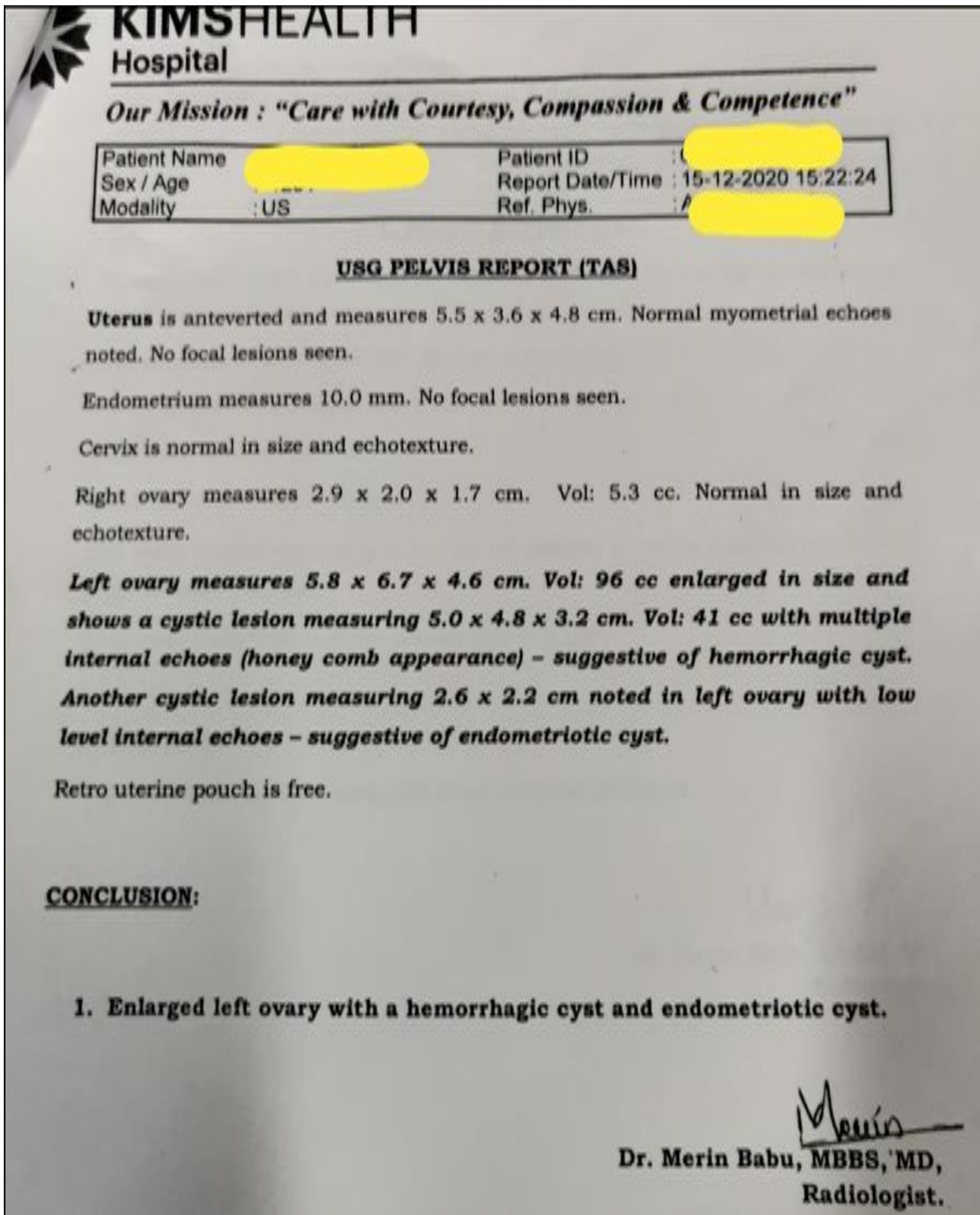


Fig 4: Pelvic USG during treatment

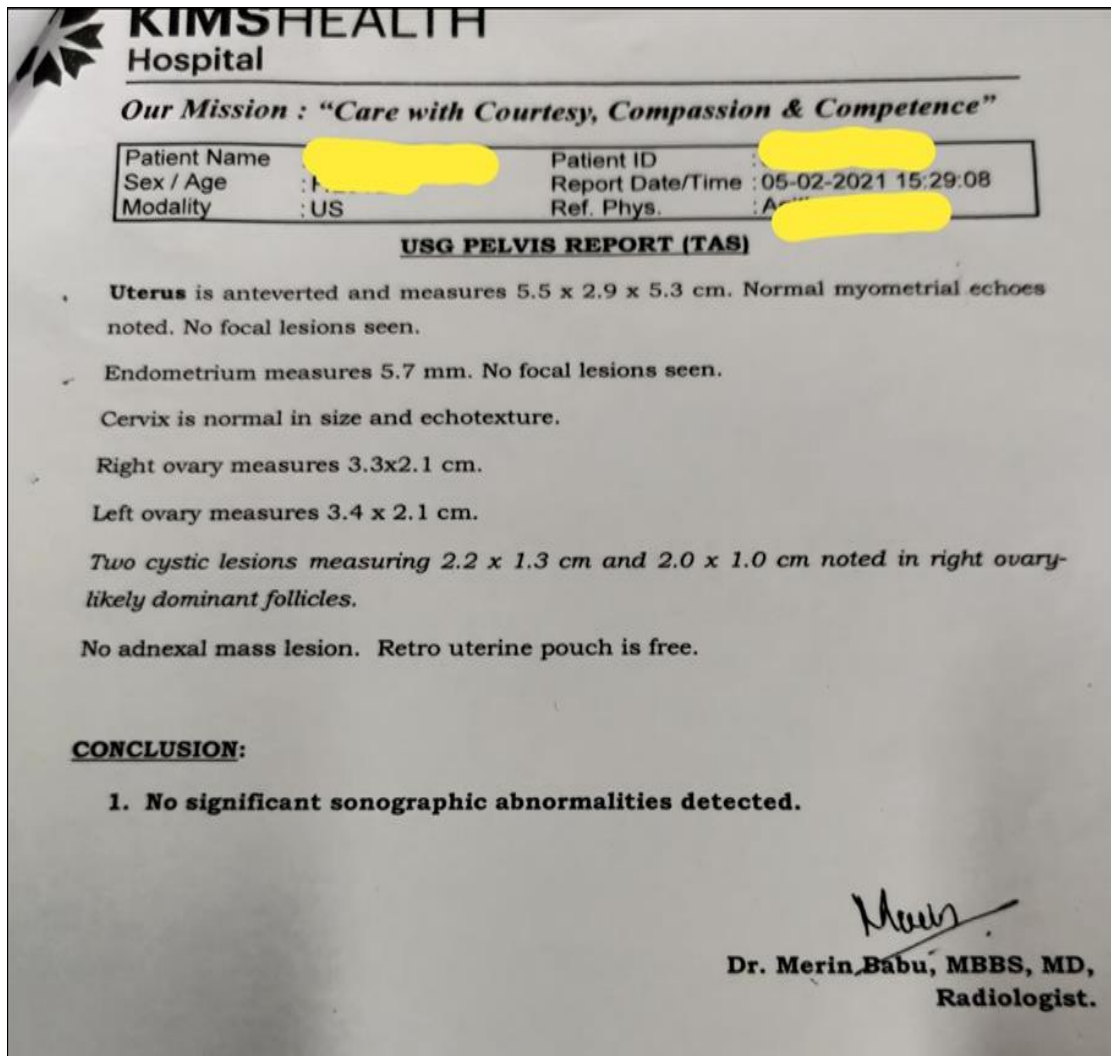
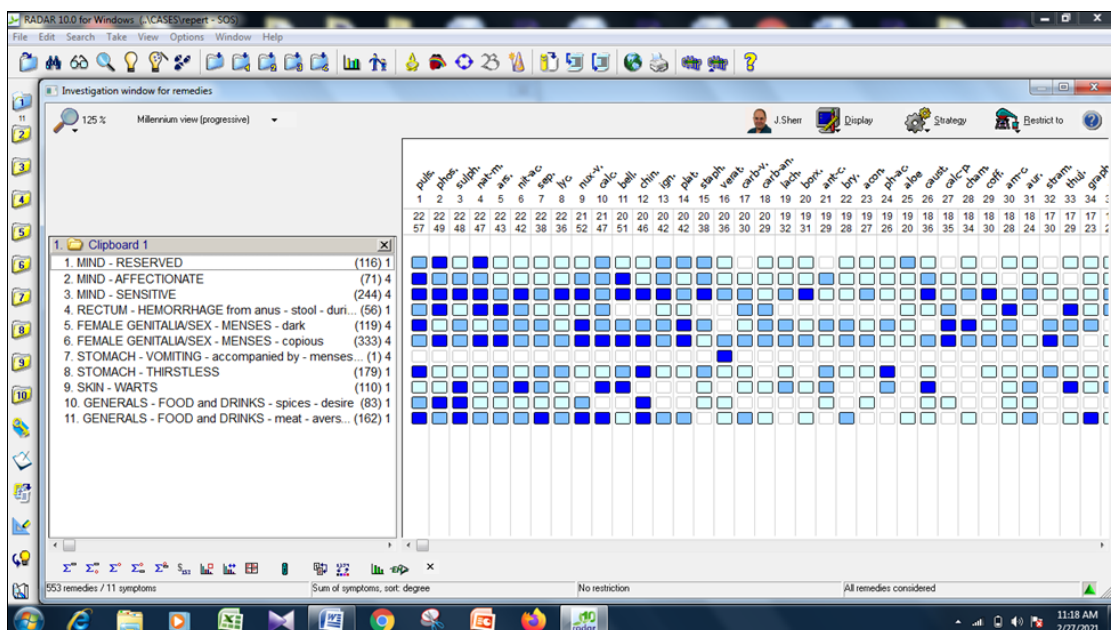


Fig 5: Pelvic USG during treatment

Repertorial totality

- | | |
|---|---|
| <ol style="list-style-type: none"> 1. Mind – Reserved 2. Mind -Affectionate 3. Mind - Sensitive 4. Rectum – Hemorrhage from anus-stool-during 5. Female genitalia -Menses, Dark. | <ol style="list-style-type: none"> 6. Female genitalia -Menses-Copious 7. Stomach-Vomiting-Accompanied by menses 8. Stomach – Thirst less 9. Skin-Warts 10. Generalities – Food and drinks-Spices-Desire 11. Generalities – Food and drinks-Meat-Aversion |
|---|---|



Repertorial analysis

Puls -57/22
 Phos -49/22
 Sulph -48/22
 Natrum mur -47/22
 Ars -43/22
 Nitric-acid -42/22
 Sepia -38/22
 Lyco -36/22

Nuxvomica -52/21

Selection of medicine

After reportorial analysis, PULSATILLA was selected as similimum, which covers reserved, affectionate, sensitive, thirstless, irregular, and painful menses, desire spices, and aversion meat.

Prescription: PULSATILLA 1M/1D on (18/1/2020)**Table 1:** Prescription with follow-up

Follow-up date	Indications for prescription	Medicine with dose
16/3/20	LMP- 8/2/20 Dysmenorrhea slightly reduced than before. Vomiting, lower abdominal pain and weakness during menstruation are also reduced. No bleeding per rectum, but burning pain persists.	Placebo
24/4/20	The intensity of dysmenorrhea was reduced. Vomiting and abdominal pain were also reduced. No bleeding per rectum, burning pain slightly reduced. Bowel movements improved LMP- 10/4/20 USG Findings (21/4/20)- left ovarian endometriotic cyst. The size of the cyst compared to the previous scan is decreased. (Figure 2.)	Placebo
22/5/2020	LMP-10/4/20 Menses not appeared Burning pain during stool remains. Hair fall persists Warts on the nape of the neck- No change	Pulsatilla 10M/1D
24/7/20	The patient feels generally better. LMP-13/6/20 Vomiting during menses reduced. Slight cramping pain on the lower abdomen during menstruation. Weakness during menses reduced. Burning pain during stool slightly reduced. USG Findings on 22/7/20 (Figure.3)	Placebo
13/11/2020	LMP-18/9/20 Menses not appeared Dysmenorrhoea and associated complaints got reduced Warts on the neck and back persist Hairfall and dandruff persist	Medorrhinum 1M/1D
18/12/20	LMP-23/11/20 Slight lower abdominal pain during the first two days. USG Findings-Enlarged left ovary with a hemorrhagic cyst and endometriotic cyst. (Fig.4)	Placebo
12/2/20	General improvement LMP - 08/02/21 Menses regular Dysmenorrhea reduced. Stool -Regular, no bleeding, and pain Warts on the back of the neck and axilla are starts to reduce in size. USG Findings- No significant sonographic abnormalities were detected. (Fig- 5)	Placebo

Discussion

Homoeopathy is a wholistic system of medicine and the treatment is based on the totality of symptoms. In this case, PULSATILLA [18, 21] 1M was prescribed as the similimum [19] by considering prominent mental symptoms such as reserved, affectionate, sensitivity, thirstlessness, and also by considering the characteristic menstrual complaints. As we all know ovarian cysts are sycotic in nature and MEDORRHINUM [20, 21] was selected as an anti sycotic nosode to complete the cure.

Conclusion

Results of this case indicate that constitutional and anti-miasmatic treatment is effective in the endometriotic cyst.

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