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A positive role of homoeopathy in treatment of PCOS: A case report

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Abstract

Polycystic ovary syndrome (PCOS) is an endocrine disorder that affects approximately 5% of all women which are very commonly found in day-to-day practice. Women suffering from PCOS present with a constellation of symptoms associated with menstrual dysfunction and androgen excess, which significantly impacts their quality of life. However, these cases present with many complications and it is difficult to cure in contemporary system and treatment is also very costly. A case of 35 yrs old female suffering from PCOS reported, was treated successfully within one and half year by a single individualised homoeopathic medicine *Natrum muraticum 30* with the repetition as per requirement. The improvement is evident from regularity of menstrual cycle, from USG reports and with increased score of PCOS questionnaire. The case as observed for further till date without reoccurrence which suggests that permanent cure is achievable through individualised homoeopathic treatment.

Keywords: Polycystic ovary syndrome; diagnosis, quality of life, *Natrum muraticum 30*

Introduction

Polycystic ovary syndrome (PCOS) is a complex condition characterized by elevated androgen levels, menstrual irregularities, and/or small cysts on one or both ovaries. The disorder can be morphological (polycystic ovaries) or predominantly biochemical (hyperandrogenaemia). Hyperandrogenism, a clinical hallmark of PCOS, can cause inhibition of follicular development, microcysts in the ovaries, anovulation, and menstrual changes. According to the National Institutes of Health Office of Disease Prevention, PCOS affects approximately 5 million women of childbearing age in the U.S. Costs to the U.S. health care system for the identification and management of PCOS are approximately \$4 billion per year^[1].

Research suggests that 5% to 10% of females 18 to 44 years of age are affected by PCOS, making it the most common endocrine abnormality among women of reproductive age in the U.S. Women seeking help from health care professionals to resolve issues of obesity, acne, amenorrhoea, excessive hair growth, and infertility often receive a diagnosis of PCOS. Women with PCOS have higher risk of endometrial cancer, cardiovascular disease, dyslipidemia, and type-2 diabetes mellitus. This article explores the pharmacotherapeutic management of PCOS and their lifestyle^[1].

Diagnosis

Three tools can be used to diagnose PCOS (Table 1). In 1990, the National Institute of Child Health and Human Development (NICHD) of the National Institutes of Health (NIH) hosted a panel of experts who developed the first known criteria for PCOS. Over the next decade, it was discovered that ovarian morphology was a key component in the diagnosis. The European Society of Human Reproduction and Embryology (ESHRE) and the American Society for Reproductive Medicine (ASRM) sponsored a workshop in Rotterdam. During the workshop, polycystic ovarian morphology on pelvic ultrasound was added to the NICHD/NIH criteria. It was then decided that only two of the three criteria had to be met for a diagnosis of PCOS^[1].

Signs and symptoms in patients with PCOS (Rotterdam, 2004; Chhabra *et al.*, 2005; Legro *et al.*, 2013)^[3]

This female was diagnosed as PCOS case after fulfilling two criteria among three as was mentioned in Rotterdam criteria. After that, a complete case history of patient was performed.

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Table 1: Diagnostic Tools for Polycystic Ovary Syndrome²

NICHD/NIH Criteria (1990)	ESHRE/ASRM Rotterdam Criteria (2003)	Androgen Excess Society (AES) Criteria (2006)
Hyperandrogenism	Hyperandrogenism	Hyperandrogenism
Oligo-ovulation/anovulation	Oligo-ovulation/anovulation	Oligo-ovulation/anovulation
Exclusion of other related disorders	Polycystic ovaries	Polycystic ovaries
		Exclusion of other related disorders

Hyperandrogenism

- Clinical examination: hirsutism, acne, androgenetic alopecia, and acanthosis nigricans
- Laboratory values: high circulating levels of testosterone or androstenedione

Menstrual Irregularity

- Clinical examination: oligomenorrhea or amenorrhea
- Laboratory values: high levels of luteinizing hormone

Polycystic Ovaries on Ultrasonography

- ≥ 12 follicles in each ovary
- Follicle size between 2 and 9 mm ± > 10 ml ovarian volume

Fig 1: Before and after reports of USG should be attached

Case report

A 35 years old married women with clinical history of irregular menses for more than two years approached on 25 November 2017. Her duration of cycle was 60 days even to 90 days delayed sometime. She also complained of abnormal hair growth on her breasts which are dark, hard and coarse from last 2 years. Apart from these complaints, she was having hair fall and white dandruff from last 3 to 4 years.

The weight of patient was 64kg having BMI 25.03. She took allopathic medicine for few months to regularise her menstrual cycle but without improvement, after it she approached for homoeopathic treatment.

Investigation revealed normal fasting glucose, thyroid-stimulating hormone, Serum DHEA-S estimation, serum Insulin, LH, FSH, Testosterone, Prolactin and Anti-Mullerian hormone. A pelvic ultrasound revealed polycystic ovarian disease (PCOD) and nabothian cyst.

She was very reserved and depressed due to her disease and her anxiety increases as her daughter also suffering from same disease. It was recognised that her psychological features were likely to have negative impact on her life quality of life as noted on modified PCOS questionnaire.

Past History - History of Jaundice in 2005.

Family history-Apart from her mother having complaints of joint pain all were healthy.

Physical generals-The patient was overweight. She had good appetite and desire for sweets. She has habit of taking of salt from above. She has thirst for large quantity at a time. Her perspiration is normal and little offensive. But sometime she sweats while eating. Bowel movements were regular, satisfactory.

Gynaecological and Obstetrics History: Flow was scanty and for 2 to 3 days only. Before marriage it remained for 6 to 7 days. She complaints for backache during menses. Her last menstrual period-25th November 2017 previous was on 4th Sept. 2017. Before that she was taking allopathic medicine for last three months, then left and found the same irregularities of period. She had history of one abortion.

Clinical findings: Discolouration on both cheeks. Tongue was thin coated with mapped on sides. Height-160cm, weight-64kg. Other general and systemic examination suggests no abnormal sign.

Investigation revealed PCOD on pelvic Sonography done on 30th June 2017. Figure 1

		nat-m.	sep.	ign.	phos.	sulph.	graph.	lyc.	ars.	kali-c.	puls.	lach.	sil.	calc.	caust.	merc.	nik-ac.	thuj.
	Sum of degrees	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
01. MIND - RESERVED	1	116																
02. MIND - GRIEF	1a	121																
03. MIND - CONSOLATION - agg. - sympathy agg.	1	18																
04. MOUTH - MAPPED tongue	1	50																
05. PERSPIRATION - EATING - white	1	49																
06. FEMALE GENITALIA/SEX - MENSES - scanty	1	224																
07. FEMALE GENITALIA/SEX - MENSES - late, too	1	211																
08. BACK - PAIN - menses - during	1	99																
09. HEAD - HAIR - falling	1	170																
10. HEAD - DANDRUFF - white	1	11																
11. GENERALS - HAIR - distribution in women; masculine	1	8																
12. FACE - CHLOASMA	1	14																

Fig 2: attached reportorial sheet

Repertorisation done on basis of totality of case

Patient was reserved.
 Suffering from long lasting grief.
 She don't like to be consol.
 Patient perspires while taking meals.
 Mapped and thin coated tongue.
 Menses are scanty.
 Menses delayed.
 Back pain during menses.

Hair fall with dandruff.
 Discolouration of both cheeks.

First prescription and basis of prescription

Natrum muraticum 30 was prescribed on 25th Nov. 2017 after repertorisation, considering its totality and chronicity of case. After that medicine was repeated or placebo as given as per symptoms.

Table 2: Timeline including follow-up of the case.

Follow-up date	Indications for prescription	Weight	Medicine, Potency and doses
5/12/17	LMP-25/11/17. Scanty flow. Hairfall and dandruff is there. Discolouration on checks is same.	Wt.-64Kg	Natrum muraticum 30 x b.d.-30days
19/12/17	Hairfall is still there. Discolouration on checks is still almost same.	Wt.-64Kg	Natrum muraticum 30 x b.d.-20 days.
9/1/18	Hairfall, dandruff was better than before. Menses was not came till yet.	Wt.-64Kg	Natrum muraticum 30 x b.d.-10 days.
20/1/18	LMP-15/01/18 with backache. Flow was scanty and only for 2 days.	Wt.-63.5Kg	Natrum muraticum 30 x o.d.-40 days.
10/3/18	LMP-15/02/18. Cholasma was better. Mentally she looks much calm and confident.	Wt.-63.5Kg	P.L 30 x o.d-20 days.
3/4/18	LMP-21/03/18. Menses scanty, only for one day, dark red in colour, heaviness in breast, incomplete stool.	Wt.-63Kg	Natrum muraticum 30 X 2 dose. -20 days.
28/4/18	LMP-22/04/18. Cholasma was much better. Menses for 3 days with no backache. Hair fall decreased than before.	Weight-63Kg.	P.L 30 X o.d-30 days.
28/05/18	LMP-24/05/18. No constipation.	Weight-62.5Kg.	P.L 30 X o.d-30 days.
30/06/18	LMP-24/06/18.Hairfall is not there. Cholasma was much better.	Weight-61Kg.	P.L 30 X o.d-15days.
17/7/18	No heaviness and backache from last three months.	Wt.-60Kg	P.L 30 X o.d-15 days.
12/8/18	LMP-24/07/18. Menstrual cycle is almost regular now.	Wt.-60.5Kg	P.L 30 X o.d-45 days.
7/10/18	LMP-24/09/18.Before it was on 22/8/19. Menstrual cycle is much regular now.		P.L 30 X o.d-20 days
1/11/18	LMP-28/10/18.Menses delayed a little, because of some family problem she was tensed from last few days. Cholasma was too better.	Wt.-59Kg	Natrum muraticum 30 X 1 dose. - 20days
3/12/18	LMP-27/11/18. Tongue is clean now. Cholasma was much lighter than before. Flow was normal and for 4 to 5 days.	Wt-58Kg	P.L 30 X o.d-30 days
5/1/19	LMP-27/12/18. Discolouration was almost clear. Menstrual cycle is regular now.	Wt.-57Kg	P.L 30 X o.d-30 days.

Discussion

Polycystic ovary syndrome (PCOS) is associated with a wide range of reproductive, cardiometabolic and dermatological abnormalities. One of the most prominent symptoms in patients with PCOS is oligomenorrhoea. Consequently, women with PCOS are highly likely to be infertile and potentially develop endometrial hyperplasia due to continuing secretion of oestrogen without ovulation. Furthermore, emerging evidence has suggested that ~50–70% of patients with PCOS have insulin resistance regardless of their body weight or body mass index. Consequently, women with PCOS are at an elevated risk of developing various common metabolic disorders compared with the general population. In addition, many patients with PCOS are observed to have an elevated androgen level, which leads to hirsutism, alopecia and acne^[4]. The prevalence of PCOS was investigated in many studies in different continents. The results of study suggested the lowest prevalence in Chinese women (2003 Rotterdam criterion: 5.6% 95% interval: 4.4–7.3%), and then in an ascending order for Caucasians (1990 NIH criterion: 5.5%

95% interval: 4.8–6.3%), Middle Eastern (1990 NIH 6.1% 95% interval: 5.3–7.1%; 2003 Rotterdam 16.0% 95% interval: 13.8–18.6%; 2006 AES 12.6% 95% interval: 11.3–14.2%), and Black women (1990 NIH: 6.1% 95% interval: 5.3–7.1%). There is variation in prevalence of PCOS under different diagnostic criteria and across ethnic groups according to this study^[5]. The management of PCOS targets the symptomatology for which patients usually present, anovulation, infertility, hirsutism, or acne being the most common complaints. Excessive weight, is associated with adverse metabolic and reproductive health outcomes in women with PCOS. For instance, female fertility significantly decreases with a BMI >30–32 kg/m² (Teede *et al.*, 2011). Multiple small uncontrolled trials have shown that a body weight decrease of as little as 5% regulates the menstrual cycle, improves fertility, reduces insulin and testosterone levels, decreases the degree of acne and hirsutism, and benefits psychological wellbeing (Clark *et al.*, 1998; Knowler *et al.*, 2002; Pasquali *et al.*, 2006; Norman *et al.*, 2007)^[3]. Guidelines recommend exercise therapy and calorie-

restricted diet as a crucial part of the management of obesity in women with PCOS. In fact, lifestyle modifications are considered as a cost-effective first line treatment and as a necessary adjunct to medication (Legro *et al.*, 2013; Misso *et al.*, 2014) ^[3].

The symptomatic presentation of PCOS usually varies with age, young women mainly complaining of reproductive and psychological problems while older women complaining of metabolic symptoms (Teede *et al.*, 2011). In this case, the diagnosis of PCOS confirmed according to Rotterdam's Criteria. The symptoms of PCOS are a major source of psychological morbidity and can negatively affect quality of life. Natrum muraticum ultimately proved to be the indicated medicine as the first prescription, going by the result of repertorisation. Although the case was successfully treated, a better compliance from patient's side in terms of regular follow ups noted till date ^[3].

Conclusion

Homoeopathy can take care of chronic hormonal syndrome in an individual, where allopathic hormone related treatment or surgery is otherwise advised. It was observed in this case that with management of lifestyle along with medication plays a positive and effective role in treatment of PCOS cases.

Potential areas of further research activity include the analysis of predisposing conditions that increase the risk of PCOS, particularly genetic background and environmental factors, such as endocrine disruptors and lifestyle ^[6]. Furthermore studies related to PCOS and its effect on lifestyle need to be more researched.

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