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Homoeopathic management in complicated case of PCOS and hypothyroidism: Case report

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Abstract

Polycystic Ovarian Syndrome/Disease' is abbreviated as PCOS/PCOD respectively. PCOS/PCOD is a heterogeneous, multisystem endocrinopathy in women of reproductive age with the ovarian expression of metabolic disturbances and a wide diapason of clinical features similar as, hyperinsulinemia, menstrual abnormalities (Oligomenorrhea, Amenorrhoea/Anovulation) and hyperandrogenism. PCOS, also known as Stein-Leventhal pattern (the first to recognize an association between polycystic ovaries and signs of hirsutism and amenorrhoea), is an endocrine complaint primarily affecting individualities with female reproductive systems. It is illustrated by hyperandrogenism, oligomenorrhea or amenorrhea, and polycystic ovarian morphology observed on medical imaging. PCOS is associated with insulin resistance and frequently leads to irregular menstrual cycles, anovulation, and an increased threat of metabolic disturbances, including rotundity, type 2 diabetes, and cardiovascular complications. Its aetiology is multifactorial, involving complex inheritable, hormonal, and environmental factors. Opinion generally relies on specific clinical and laboratory criteria, and operation strategies encompass life variations, hormonal curatives, and addressing associated comorbidities.

'Hypothyroidism' is a widely discussed term these days in medical field owing to its affection which involves different organ system and hypometabolism. Also the cardiac and OBG complications wrapped as an essential prognosis makes its management even more controversial. The adequate clinical examination, intricate investigative measures with proper screening leads to well established diagnosis of the above. The survey report study suggests, around 1.8% of the population is affected by it, which positions it almost 2nd to DM in terms of endocrine disorders.

Keywords: PCOD/PCOS, polycystic ovarian syndrome, endocrinopathy, metabolic disorders, Hypothyroidism, hypometabolism, thyroid function test

Introduction

1. Polycystic ovarian syndrome

Based on the 'PCOS Consensus workshop' in Rotterdam in 2003, PCOS can be defined as a condition characterized by ovarian dysfunction, hyperandrogenism, and polycystic ovarian morphology.

Pathophysiology^[6]

Key characteristics of PCOS are irregular menstrual cycles, lack of ovulation, and excess androgen levels. Although the exact cause has not been accurately defined, the aetiopathophysiology can be understood.

This dysfunction prevails in the hypothalamic-pituitary-ovarian system, where there is a consistent increase in plasma testosterone levels as a biochemical characteristic. Women with a diagnosis of PCOS who experience ongoing lack of ovulation exhibit higher average levels of luteinizing hormone (partly because their pituitary gland is more responsive to stimulation from gonadotropic releasing hormone), but have low or normal levels of follicle-stimulating hormone.

Because FSH levels are not fully depleted, there is ongoing stimulation of new follicular growth. However, this stimulation is not enough for full maturation and ovulation to occur. As a result, multiple follicular cysts with diameters ranging from 2-10 mm are formed. The hyperplastic theca cells surrounding the follicles become luteinized. Some of the follicles undergo atresia and are replaced by new follicles.

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Clinical features of PCOS [5]

1. **Oligomenorrhea / amenorrhoea:** a) Affects 65 -75 % of patients with PCOS, b) Predominantly related to chronic anovulation.
2. **Hirsutism:** Affects 30-70% of women.
3. **Subfertility:** Causes difficulty in conceiving in up to 70 % of women with PCOS.
4. **Obesity (BMI > 25), (WAIST LINE>88cm):** At least 40 % of patients are clinically obese.
Fat distribution that favours the upper body is associated with greater insulin resistance as compared to the lower body segment.
5. **Recurrent Miscarriage:** 50-60 % of women are affected with more than 3 early Pregnancy losses.
6. **Acanthosis Nigricans:** Velvety / popular hypertrophic pigmented skin with increased skin coloration and altered texture can be found on the back of the neck, underarms, chest, and vulva.
Affects around 2% of women with PCOS.
7. **Prone to acne.**

Hypothyroidism [9]

Hypothyroidism is a medical condition characterized by an insufficient production or activity of thyroid hormones by the thyroid gland. Thyroid hormones play a crucial role in regulating various metabolic processes in the body. When there is an inadequate amount of thyroid hormone circulating in the bloodstream, it can lead to a slowing down

of metabolic functions, resulting in a range of symptoms such as fatigue, weight gain, cold intolerance, dry skin, and changes in mood and cognitive function⁷. The most common cause of hypothyroidism is autoimmune thyroiditis, also known as Hashimoto's thyroiditis, but it can also result from other factors like iodine deficiency, certain medications, or surgical removal of the thyroid gland. Hypothyroidism is typically diagnosed through blood tests measuring thyroid hormone levels, and treatment usually involves thyroid hormone replacement therapy^[8].

Aetiology [10]

1. Primary
 - a) Autoimmune hypothyroidism: Hashimoto’s thyroiditis, atrophic thyroiditis
 - b) Congenital
 - c) Drugs
 - d) Radiation therapy
 - e) Infiltrative disorders /iodine deficiency
2. Transient
 - a) Silent thyroiditis
 - b) Postpartum disorders
 - c) Subacute thyroiditis

Secondary

- a) Tumors, trauma, infiltrative disorders, idiopathic
- b) TSH deficiency or inactivity

INTERPRETATION OF THYROID FUNCTION TEST:			
	LOW T4	NORMAL T4	HIGH T4
LOW TSH	<u>Pituitary/hypothalamic hypothyroidism</u>	<u>Subclinical hyperthyroidism</u>	<u>hyperthyroidism</u>
NORMAL TSH	<u>Severe non thyroidal illness</u>	<u>normal</u>	<u>-----</u>
HIGH TSH	<u>Primary hypothyroidism</u>	<u>Subclinical hypothyroidism</u>	<u>Pituitary hyperthyroidism</u>

Clinical features of hypothyroidism [10]

SIGNS AND SYMPTOMS:	
SYMPTOMS	SIGNS
<u>TIREDFNESS/PROSTRATION/EXHAUSTION</u>	<u>DRY MOUTH/TONGUE/SKIN</u>
<u>DRY SKIN AND COLD TENDENCY</u>	<u>SLOW MOVEMENT/ LETHARGIC FEELING</u>
<u>HAIR LOSS</u>	<u>BRADYCARDIA</u>
<u>DYSYPNEA</u>	<u>PERIORBITAL OEDEMA</u>
<u>CONSTIPATION</u>	<u>DIASTOLIC HYPERTENSION</u>
<u>MYALGIA</u>	<u>SLOW REFLEX</u>
<u>DEPRESSION</u>	<u>PALPITATIONS</u>
<u>ANXIETY</u>	

Case proper [13, 14]

A female of age ‘27 years old’ visited the opd of NIH on 10/08/22 with complaints of irregular menstruation followed by excessive exhaustion and prostration accompanied with rise in palpitation, vertigo, loss of appetite, persistent insomnia and weight gain as stated by the patient (since 1

year) based on clinical examination and extensive lab investigation reports submitted, other possibilities were excluded and the diagnosis was established to be, ‘Bilateral PCOS Associated With Hypothyroidism’.

Identification

- **OPD REG. No.:** 907519
- **Name:** Miss XYZ
- **Age:** 27 Years
- **Sex:** Female
- **Religion:** Hinduism
- **Address:** 24 parganas (N)
- **P.S.:** JAGADDAL
- **Date of case taking:** 10/08/22

Present complaint

- Scanty/Late/Intermittent and Irregular Menses Accompanied with Dysmenorrhoea.
- Sensation: Bearing Down Sensation, Violent Stitching and Clutching Pains, Painful Coition
- Modalities: > Pressure, Hot Applications; < Washing, Sweat, Lying on Left Side.

History of present complaints

- **Duration:** Since 1 year
- **Mode of onset:** Gradual
- **Probable cause:** Not known
- **Treatment taken:** Allopathic medication
- **Result:** No relief

Family history

- **Paternal side:** Father-suffers from diabetes mellitus
- **Maternal Side:** Mother – suffers from Cancer

Personal history

- **Occupation:** Housewife
- **Accommodation:** Pakka house/well ventilated
- **Diet:** Mixed, non veg, warm food
- **Socio-Economic Status:** Upper middle class
- **Habits and Hobbies:** Nothing significant
- **Marital Status:** Married (since 2.5 years)
- **Sexual History:** Aversion to coition due to pain
- **No. of Children:** Nulliparous
- **Relation With Family Members/Field of Occupation:** Cordial
- **History of Vaccination:** Taken with no adverse effect.

Physical generals

- **Thermal Reaction:** Chilly Pt.
- **Appetite:** Good
- **Desire:** Sour+++, Sweet
- **Aversion:** Boiled Milk

- **Thirst:** Great thirstlessness
- **Tongue:** Flabby, yellowish coated
- **Mouth:** Offensive odour throughout the day
- **Stool:** Obstinate constipation
- **Urine:** Involuntary dribbling occasionally, Cutting pain in bladder during menses
- **Perspiration:** Scanty
- **Sleep:** Disturbed, wakes up frequently

Menstrual History

- a. menarche-12 years of age
- b. LMP- 10/06/22
- c. Nature and character- menses darkish red /clotted/thick blood flow almost blackish in colour, too late with scanty flow, accompanied with intermittent spotting.

Mental generals

- Nervous, anxious, irritable and easily offended.
- Miser
- Feels better when husband is not at home.
- Indifference yet dreads to be alone with poor memory
- Feels unfortunate and breaks down into weeping.
- Suicidal disposition, feels stuck in a miserable state.

Totality of symptoms

- Craves sympathy, mild, timid, emotional and easily disposed to weeping.
- Fear of darkness /being alone
- Suicidal disposition, feels stuck in a miserable state
- Feels better when husband is not at home.
- Indifference yet dreads to be alone with poor memory likes to cut down expenses
- Easily offended
- Thermal Reaction: Chilly but great desire for cold air
- Desire: Sour+++
- Aversion: Milk
- Intolerance: Sour food, spicy salty food (gastritis/eructations)
- Thirst: Great thirstlessness
- Aversion to coition; painful
- Sleep: Peaceful, great drowsiness throughout the day
- Nature and Character- menses darkish red /clotted/thick blood flow almost blackish in colour, too late with scanty flow, accompanied with intermittent spotting.

Repertorization ^[15]

Rubric	Drug remedy				
	SEP.	LYC.	SULPH.	KALI-C.	MAG-C.
Total symptom	12	9	7	7	7
Total degree	30	14	12	8	7
1.Mind-Aversion-husband,to	3			1	
2.Mind-Indifference	3	1	2	2	1
3.Mind-Suicidal disposition-despair,from-miserable	2				
4.Mind-Fear-misfortune,of	2	1			
5.Mind-Memory-weakness of memory	3	3	2	1	1
6.Stomach-Eructations;Type of-food-salty	2	1		1	
7.Stomach-Eructations;Type of-foods-sour	2	1	2	1	1
8.Female Genitalia/Sex-Coition-aversion to	3	2	1	1	1
9.Back-Pain-lumbar region-night	2	2	2		1
10.Back Pain-Lumbar Region-night-aching	3	1	1		1
11.Generals-Food And Drinks-milk-aversion	2	1	2	1	1
12.Generals-Motion-amel.-violent motion	3				

Lab investigation reports

A) Before treatment

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Feeder Road (Near Annapurna Bazar)
Shyamnagar, 24 Parganas (N)

NAME : MRS. RUMI HALDER AGE : 27 Yrs SEX : FEMALE.
REFERRED BY : DR. ARCHANA KUMARI DATE : 18/07/2022

USG OF LOWER ABDOMEN

UTERUS : Uterus is Anteverted, normal position. Endometrial echo is normal in thickness [5.8 mm.]. Myometrium is normal. Cervix appear normal. Uterus measures : 7.8 cm x 5 cm x 3 cm.

OVARIES : Right ovary is poly cystic in character, measures : 3.6 x 3 x 1.6 cm , Vol – 9.3 cc. Left ovary is enlarged in size with a large cystic lesion (6.3 cm x 4.3 cm) compressing the ovarian tissue in periphery.

P.O.D. : - Clear.

IMPRESSION : Cystic left ovary & poly cystic right ovary.

Dr. Manojit Ghosh
Consultant Radiologist
Reg. No. – 55812 (W.B.M.C.)

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✉ lhc2008@rediffmail.com • www.lhcindia.in, www.thelhc.in

Associate : ICH Sample Type : O.S.S.
Name : RUMI HALDER Received On : 15/07/2022
Age / Gender : 27Y / FEMALE Reported On : 15/07/2022
ID Number : LHC/16283/G-3730
Referred By : DR. ARCHANA KUMARI

DEPARTMENT OF HORMONE ASSAY

Test Description	Result	Unit	Bio. Ref. Interval
TSH (Thyroid Stimulating Hormone) Test Done By: Maglumi 800 Methodology : CLIA Specimen : Serum	7.82	µIU/ml	0.4-4.5 Pregnancy : 3.4 Third trimester : 0.38-4.0

Comment:
TSH levels have been elevated or inappropriately detectable for high thyroid hormone levels in some patients with thyrotropin-secreting pituitary adenomas. Delay in diagnosis of these tumors may lead to visual compromise. The effects of such neoplasms can be misdiagnosed as those of primary hyperthyroidism.

**** End of Report ****

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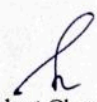



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B) After-treatment (17/10/22)


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ID No. : 520108		Patient ID : MD221035095	
Patient Name : MRS. RUMI HALDER		Exam. Date : 13/10/2022	
Sex / Age : Female / 27 Year		Report Date : 13/10/2022	
Referred By : DR. ARCHANA KUMARI			
ULTRASONOGRAPHY OF LOWER ABDOMEN			
KIDNEYS			
Both kidneys are normal in position, lie, size, shape, outline and echotexture. The corticomedullary differentiation is maintained. No calculus, mass or hydronephrosis is seen.			
The right and left kidney measure 12.3 x 4.2 cms and 10.9 x 3.7 cms respectively in length.			
URINARY BLADDER			
It is normally distended. The bladder wall is normal. No calculus, mass or diverticulum is seen. Post void study shows insignificant amount of residual urine.			
UTERUS			
It is anteverted and is normal in size, shape, outline and echopattern. No focal mass lesion is seen in myometrium or in cervical region. The endometrial echo is normal in thickness (6.0 mm). Uterus measures 6.8 x 4.9 x 3.4 cm.			
ADNEXA			
Both adnexa are clear. Both ovaries are normal in size, shape, outline and echogenicity.			
Right ovary measures 3.2 x 1.8 x 3.2 cms (10.2 cc).			
Left ovary measures 3.5 x 1.9 x 2.7 cms (9.8 cc).			
IMPRESSION:			
No significant abnormality.			
 Dr. Sarbari Chatterjee M.B.B.S. DMRD			
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Bill No. : 10/198
Patient Name : MRS. RUMI HALDER
Sex / Age : Female / 27 Year
Referred By : DR. ARCHANA KUMARI



Patient ID : MD221035095
Sample Date : 13/10/2022
Report Date : 13/10/2022

IMMUNOASSAY

Specimen : SERUM

PARAMETER

RESULT

BIOLOGICAL REFERENCE INTERVAL

Thyroid Stimulating Hormone (TSH) <small>(Method : Chemiluminescence Immunoassay)</small>	: 3.62 μ U/ml	0.5 - 4.50 μ U/ml
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Comment :- Thyroid-stimulating hormone is a glycoproteohormone with a molecular weight in the range of 28,000-30,000 Dalton and is composed of the two non-covalently bound subunits hTSH α and hTSH β . characteristic feature of the glycoproteins TSH, luteinising hormone (LH), follicle-stimulating hormone (FSH), and human chorionic gonadotropin (hCG) is their relatively high carbohydrate content as well as the nearly identical sequential homology of their α -subunits. On the other hand, the β -subunit has a different amino acid sequence in all four hormones.

TSH release and synthesis in the anterior pituitary is stimulated by the hypothalamic thyrotropin-releasing hormone (TRH). The TSH released stimulates the thyroidal release of the hormones thyroxine (T4) and triiodothyronine (T3) whose binding to transport proteins in the bloodstream exceed 99.9% and 99.7% respectively.

Only the free hormones FT3 and FT4, which are not bound to binding proteins, are physiologically active in peripheral tissues and regulate the thyroidal function via a pituitary feedback mechanism.

Determination of basal TSH is generally sufficient in the monitoring of suppression or substitution therapy.

TSH determination is also useful in diagnosing disorders of the thyroid gland.

Increased TSH levels are found in

- Primary hypothyroidism
- Hashimoto's thyroiditis and post-partum thyroiditis
- Atrophic TSH secretion (lung, breast tumours)
- Thyroid hormone resistance
- Thyroidine deficiency or excess
- Drugs

Decreased TSH levels are found in

- Primary hyperthyroidism
- Secondary and tertiary hypothyroidism (pituitary-hypothalamic)
- Autonomous thyroid hormones secretion
- Graves' disease
- Postpartum thyroiditis
- Metastatic thyroid cancer
- Toxic nodular goiter

The prevalent disorders involving thyroid are primary hypothyroidism and hyperthyroidism in which TSH levels increased or decreased. Primary hypothyroidism is due, in most cases, to autoimmune diseases (like Hashimoto's Thyroiditis) or to a congenital deficiency of thyroid tissue. Increased levels of TSH are also due to an altered biosynthesis of thyroid hormones after radiotherapy or surgical operation. Secondary hypothyroidism is less frequent and originates to alterations of the hypothalamus-pituitary axis. Primary hyperthyroidism is due to an overproduction of thyroid hormones. Most severe pathologies are due to toxic nodular goiter, minor pathologies originate to inflammatory processes like thyroiditis or pituitary TSH hypersecretion. Laboratory diagnosis of hypothyroidism and hyperthyroidism is supported by FT3, FT4 tests.

Instrument used : DIASORIN LIAISON

** End of Report **

* All reference ranges limits mentioned herein are in accordance with the literature provided along with the kit LIAISON®


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Prescription (10-08-22)

- Rx
- SEPIA 0/1 * 16 DOSES
 - ODAC* 16 DAYS
 - SEPIA 0/2* 16 DOSES
 - ODAC * 16 DAYS
- Recurrence of menses
 - A) Duration -2 Days
 - B) Nature of Flow- Thick Blackish In Colour With No Offensive Smell

1ST Follow-UP (16/09/22)

- All Generalities Improved
- Rx
- SEPIA 0/3*16 Doses
 - ODAC* 16 Days
 - SEPIA 0/4*16 Doses

ODAC*16 DAYS

2ND Follow-UP (17/10/22)

Patient presents of improvement in clinical complaints with evidential support from lab investigation reports.

Conclusion ^[12]

The PCOS is a complex issue that involves issues related to reproduction, hormones, and metabolism. Lifestyle changes and counseling are often recommended as the initial treatment for PCOS, as they have been found to be effective in reducing the symptoms and signs of the condition. Homoeopathic treatment has been proven effective in successfully treating cases. To accomplish this, we need to take into account the constitution, relevant mental and physical characteristics when choosing the most suitable and clearly indicated homeopathic remedy. Having a properly balanced diet is a crucial part of taking care of PCOS. Certain women with polycystic ovary syndrome (PCOS) achieve positive outcomes by lowering their overall consumption of carbohydrates such as cereals, breads, and pastas, and instead opt for less refined alternatives like whole wheat, brown rice, and beans. Substituting processed carbohydrate foods with whole grains, fruits, and vegetables may lead to a decrease in insulin reaction. The diet should also contain an adequate amount of protein to regulate blood sugar levels. Exercise has the potential to assist in managing insulin levels and keeping weight under control ^[11].

The above mentioned cases show how important homeopathy is in regulating menstrual abnormalities and other symptoms associated with the elaborated syndrome. The investigation reports from the lab and the evidence of improvement overall demonstrate the effectiveness of homeopathy in treating lifestyle disorders in a brief period. This case report's successful outcome can be seen as a model for another potential approval of therapeutic approach. The use of suggestive homeopathic treatment in cases of hormonal imbalance highlights the importance of relying on another method of treatment at the same time rather than just palliation. In certain cases, it may require a bit more time; however, the purpose is not just to provide temporary relief but to completely heal and restore the sick to full health in all aspects.

It is a relatively affordable, uncomplicated, easily reproducible, and widely acceptable solution for patients of various backgrounds and beliefs.

The conclusion of the totality of symptoms is formed by considering the similarity of symptoms of disease in association with the well indicated medicinal remedy chosen.

A comprehensive, in-depth, and meticulous analysis of the case is crucial to determine the most appropriate treatment option.

Conflict of Interest

Not available

Financial Support

Not available

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