



AYURVEDIC MANAGEMENT OF PRIMARY INFERTILITY ASSOCIATED WITH OVARIAN CYST THROUGH PANCHAKARMA THERAPY: A CASE REPORT

Dr. Priya J. Walwatkar

Associate Professor, APM's Ayurved College, Sion, Mumbai

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ABSTRACT

Infertility is a prevalent reproductive health concern affecting approximately 10–15% of couples globally and is associated with significant psychosocial stress and reduced quality of life [1]. Female factors such as ovulatory dysfunction and ovarian cysts constitute a major proportion of infertility cases [2]. Ayurveda describes infertility under the concept of *Vandhyatva*, attributed to vitiation of Doshas affecting *Artava* and *Artavavaha Srotas* [3].

This case report presents a 21-year-old female with primary infertility and ovarian cyst managed successfully with *Panchakarma therapy*, including *Virechana* and *Yogabasti*, followed by *Shamana Chikitsa*. Restoration of ovulation was confirmed by follicular study, and natural conception was achieved within three months. The case demonstrates the clinical utility of classical Ayurvedic management in infertility associated with ovarian pathology.

KEYWORDS: Primary infertility; *Vandhyatva*; Ovarian cyst; *Panchakarma*; *Yogabasti*; *Virechana*

INTRODUCTION

Infertility is defined as the inability to conceive after one year of regular unprotected intercourse [1]. Female infertility accounts for nearly half of infertility cases, with ovulatory disorders being the most common etiological factor [2]. Functional ovarian cysts may interfere with follicular maturation and ovulation, thereby impairing fertility [4]. Modern medical management includes ovulation induction, hormonal therapy, and assisted reproductive techniques. Although effective, these modalities are associated with adverse effects, high cost, and limited accessibility in resource-constrained settings [5].

Ayurveda conceptualizes conception as dependent on the integrity of *Ritu*, *Kshetra*, *Ambu*, and *Beeja* [3]. Any imbalance in these factors may result in *Vandhyatva*. Vitiation of *Apana Vata*, often associated with *Kapha obstruction*, leads to

Artavavaha Srotorodha, resulting in anovulation or defective ovulation [6]. *Panchakarma* therapies aim to eliminate morbid Doshas and restore physiological balance, thereby improving reproductive function [7].

• Case Presentation

A 21-year-old married female presented with primary infertility of one-year duration. Menstrual cycles were regular with mild dysmenorrhea. There was no history of systemic illness or pelvic surgery. Psychological stress related to infertility was evident. Her spouse's semen analysis revealed oligo-asthenozoospermia, which was considered a contributory factor.

On examination, vitals were normal. *Ashta-Vidha Pariksha* findings were within normal limits except for mild *Mandagni*. Gynecological examination was unremarkable.

Investigations

Table 1: Investigations and Findings

Investigation	Findings	Clinical Significance
USG Pelvis(12/11/25)	Ovarian cyst (2.64 cm)	Ovulatory dysfunction
Semen analysis(15/11/25)	Oligo-asthenozoospermia	Contributory male factor
Follicular study (8/12/25 to 15/12/25)	Follicle rupture, ET 11.5 mm	Ovulation restored
UPT(3/2/25)	Positive	Conception achieved
USG (OBST)(3/3/2025)	Intrauterine gestational sac 4 wks 5 days	

Diagnosis

- **Modern diagnosis:** Primary infertility with ovarian cyst



- Ayurvedic diagnosis: Vandhyatva due to Vata-Kapha Dosha Dushti with Artavavaha Srotorodha [3,6]

Therapeutic Intervention

Table 2: Treatment Protocol

Phase	Therapy	Dose/Details	Duration	Rationale
Purvakarma	Deepana–Pachana, Ghritpan, Snehana, Swedana	As per classical guidelines	5 days	Dosha Utkleshana, Srotoshodhana
Pradhana Karma	Virechana	1–2 Purgative doses	1 day	Pitta–Kapha Shodhana, Ovulatory facilitation
Paschat Karma	Yogabasti	8 medicated enemas	8 days	Apana Vata Anulomana, Artava support
Shamana	Shatavari, Chandraprabha Vati, Sanshamani Vati	Classical dosage	2 month	Artava Janana, reproductive support

For Husband--- Tab Addyzova 2 BD Shatavari +Ashwagandha churna 2g each with milk twice a day

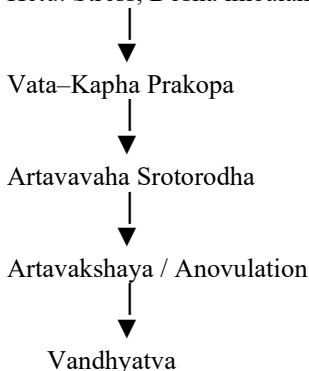
Samprapti (Ayurvedic Pathogenesis)

Samprapti Formation

Hetu such as stress and lifestyle imbalance result in Vata-Kapha Prakopa, leading to obstruction of Artavavaha Srotas and impaired Artava formation, culminating in Vandhyatva [6,8].

Pathogenesis Flow

Hetu: Stress, Dosha imbalance



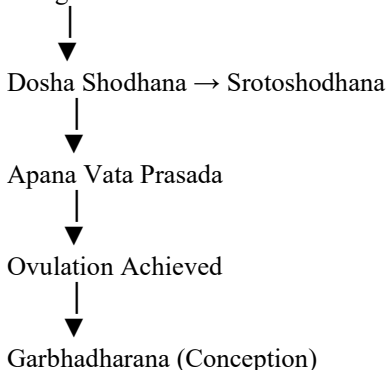
Samprapti Vighatana

Virechana eliminates vitiated **Pitta and Kapha**, while Yogabasti corrects **Apana Vata**, facilitating ovulation and conception [7,9].

Therapeutic Flow (Samprapti Vighatana)

Panchakarma Intervention

- Virechana
- Yogabasti





Follow-up and Outcome

Follicular studies after therapy demonstrated rupture of dominant follicle, indicating restoration of ovulation. □ Urine pregnancy test at follow-up confirmed conception. □ No adverse effects were reported during or after Panchakarma and Shamana therapy. □ Psychological wellbeing improved alongside physiological recovery.

DISCUSSION

.Virechana is indicated in disorders involving **Pitta-Kapha Dushti** and has a regulatory effect on endocrine and metabolic pathways [7]. Yogabasti is considered the most effective therapy for **Vata disorders**, particularly Apan vayu, those affecting the reproductive system [9].

Shatavari is documented for its phyto-estrogenic and folliculogenic properties, supporting ovarian function [10]. Chandraprabha Vati improves pelvic circulation and corrects metabolic disturbances [11]. This combined approach not only restored normal ovulatory cycles but also enabled natural conception in a short time frame, highlighting the integrative potential of classical Ayurvedic therapies. The case aligns with literature indicating Panchakarma's efficacy in selected cases of infertility due to ovarian dysfunction [12].

CONCLUSION

This case demonstrates that Panchakarma, followed by Shamana therapy, may serve as a safe, effective, and holistic approach in managing primary infertility associated with ovarian cysts. A carefully tailored protocol focusing on **Dosha balance**, **Srotoshodhana**, and **Apana Vata regulation** can facilitate ovulation and conception.

Patient Consent

Written informed consent was obtained.

Conflict of Interest

None declared.

Funding

Nil.

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NISHCHAY IMAGING CENTRE
 Ultrasonography + Colour Doppler + 3D Echocardiography

Patient Name: Mrs. Indira Gupta
 Age: 31 years
 Referred by: Dr. Anand Gupta

ULTRASOUND OF PELVIS- FOLLICULAR GROWTH STUDY CLASSIVE

L.M.P : 01.10.2022
 Menstruation is normally delayed.
 Menstruation is not observed with appropriate hormonal as well as clinical estimation.
 No evidence of any fetal lesion.

Both ovaries are normal in size, shape and echotexture. Both ovaries are normal.
RIGHT OVARY: Measures 3 x 3 cm. Follicles 8 in size and shows 1 dominant follicle measuring 18 x 14 mm.
LEFT OVARY: Measures 2.8 x 2.3 cm. Follicles 4 in size.
 No evidence of any fluid in pelvis.

Previous date	Age at birth	Right ovary	Left ovary	FS	Remarks
01.10.2022	31 st	3x3 cm	2.8x2.3 cm	18mm	
10.12.18	15 th	16x12 mm	10x8 mm	4.5 mm	
12.12.15	12 th	16x12 mm	10x8 mm	4.5 mm	
15.12.20	14 th	21x9 mm	10x8 mm	11 mm	
15.12.20	15 th	21x9 mm	10x8 mm	11 mm	menstrual flow 1/22

Kindly correlate clinically.
 Thank you for the reference.

NISHCHAY IMAGING CENTRE
 Ultrasonography + Colour Doppler + 2D Echocardiography

Patient Name: Mrs. Indira Gupta
 Age: 31 years
 Referred by: Dr. Anand Gupta

ULTRASOUND OF THE UTERUS

L.M.P : 01.10.2022
 MUA by L.M.P: 4 weeks 6 days.

Uterus is anteverted and shows well-defined single intra-uterine gestational sac, measuring 4.2cm corresponding to 4 weeks 2 days with no fetal pole within.
 No evidence of extra-uterine gestation.
 No free fluid seen in pelvis.

DISCUSSION:
 A single intra-uterine gestational sac of 4 weeks 8 days with no fetal pole within. Follow up after 11 days for fetal pole & cardiac activity.

Kindly correlate clinically.
 Thank you for the reference.

GAATHA DIAGNOSTIC
 Digital X-Ray & Sonography Centre

Dr. Vinita Gupta
 M.B.B.S., M.M.P.D.
 Consulting Radiologist
 Phone: 97201 00495
 Mob: 9816448767

Patient Name: Mrs. MURAN GUPTA
 Age: 31 Years
 Gender: FEMALE
 Date: 02/11/2022

USG PELVIS

Bladder: Measures 3.11 cm X 4.47 cm X 3.26 cm.
 Normal in size, normal in morphology and echotexture.
 No r/o focal lesion/obstruction.
 Indistinctness in central and shows no lesions.
 DT: 9.2 mm.

Right Ovary: Measures 2.90 cm X 2.89 cm.
 Normal in size, normal in morphology and echotexture. No evidence of any fetal lesion.

Left Ovary: Measures 2.92 cm X 2.83 cm.
 Normal in size, normal in morphology and echotexture. Small complex cyst with fluid-fluid level measuring about 2.4 cm in size in upper left ovary.

No free fluid in the POU (i.e. pouch of Douglas).
 No r/o any adnexal mass seen.

IMPRESSION: SMALL COMPLEX CYST WITH FLUID-FLUID LEVEL IS SEEN IN LEFT Ovary ? CHOCOLATE CYST ? HEMORRHAGIC CYST (DROPS US CATEGORY 0) NO OTHER SIGNIFICANT ABNORMALITY IS SEEN.

ADD: Clinical correlation/follow up in next menstrual cycle.

GIEMSA REPORT

PATIENT NAME: Mrs. MURAN GUPTA
 SEX: FEMALE
 AGE: 31 Years

Specimen received at: 12:30 p.m.
 Specimen examined at: 11:45 p.m.
 Brought from home at: 11:45 p.m.

CLINICAL EXAMINATION

Specimen received at: 12:30 p.m.
 Specimen examined at: 11:45 p.m.
 Brought from home at: 11:45 p.m.

PHYSICAL EXAMINATION

Appearance: Slightly white
 Transparency: Translucent
 Self liquefaction: Observed in 24 minutes
 Viscosity: Normal
 Volume: 0.5 ml

CHEMICAL EXAMINATION

Proteins: 7% (Wobley Reaction)
 pH: 7.5

MICROSCOPIC EXAMINATION

Spores Count: The number of spores per ml: 248/field
 Total number of spores per square: 7.28/field
 Viability: 85% spores viable at the end of 1/2 hours
 Viability of spores at (at 27°C): 1/2 hours

Nature of Motility (W.O.O)	Wet and Grate	After 1/2 hrs	After 1 hr
A. Rapid Linear Progression	IV & III	10%	4%
B. Sluggish Linear Progression	II	10%	2%
C. Slow Linear Progression	I	44%	24%
D. Nonmotile	II	1%	1%

Active spores in the sporozoite (at the end of 1/2 hour): 2.88 million