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AYURVEDIC MANAGEMENT OF INFERTILITY ASSOCIATED WITH POLYCYSTIC OVARIAN DISEASE LEADING TO SUCCESSFUL CONCEPTION AND LIVE BIRTH: A CASE REPORT

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ABSTRACT

Background: Polycystic Ovarian Disease (PCOD) is one of the most common endocrine-metabolic disorders affecting women of reproductive age and is a leading cause of anovulatory infertility. In Ayurveda, the clinical presentation of PCOD correlates with Artava Kshaya and Nashtartava leading to Vandhyatva (infertility), arising from vitiation of Kapha and Vata Dosha affecting the Artava Vaha Srotas. This report presents a case of long-standing PCOD with infertility managed with classical Ayurvedic formulations, which resulted in spontaneous conception and a successful term delivery.

Case Summary: A 34-year-old married woman with a 17-year history of PCOD, presenting with oligomenorrhea, hirsutism, acanthosis nigricans and obesity (BMI 37.2 kg/m²), along with chronic hypertension, was managed on an OPD basis with Ayurvedic formulations including Arogyavardhini Vati, Hingwashtak Churna and Rasonadi Churna, together with lifestyle advice, over several months. Ultrasonographic findings at baseline were consistent with polycystic ovarian morphology. Following treatment, the patient conceived spontaneously; the pregnancy was confirmed on ultrasonography at 6.5 weeks of gestation with good cardiac activity. The antenatal course was complicated by gestational diabetes mellitus superimposed on chronic hypertension, both of which were co-managed with the treating obstetric team. The pregnancy culminated in an emergency lower segment caesarean section at 36+4 weeks for premature rupture of membranes with failed induction, with delivery of a healthy live male baby (APGAR 9/10, birth weight 2.632 kg).

Conclusion: This case illustrates the potential role of individualised Ayurvedic management, integrated with conventional monitoring, in improving reproductive outcomes in a woman with long-standing PCOD-related infertility and co-existing chronic hypertension, and supports the value of an integrative approach in high-risk subfertility.
Keywords: PCOD, Nashtartava, Vandhyatva, Infertility, Ayurveda, Arogyavardhini Vati, Hingwashtak Churna, Rasonadi Churna, Case Repor

1. INTRODUCTION

Polycystic Ovarian Disease (PCOD) is a heterogeneous endocrine disorder affecting an estimated 6–20% of women of reproductive age worldwide, and is among the foremost causes of anovulatory infertility, accounting for nearly 30–40% of such cases. It is characterised by oligo/anovulation, clinical or biochemical hyperandrogenism, and polycystic ovarian morphology on ultrasonography, with frequently associated insulin resistance, obesity and an elevated long-term risk of type 2 diabetes mellitus and hypertensive disorders.

Classical Ayurvedic literature does not describe PCOD as a single entity, but its clinical features are well represented under Artava Kshaya, Nashtartava and Yonivyapad, all of which may culminate in Vandhyatva (infertility) when Artava Vaha Srotas is persistently vitiated. Kapha and Meda Dushti obstructing Vata, with resultant Agnimandya, is commonly implicated in the Samprapti (pathogenesis), providing a rationale for therapy directed at Kapha-Medohara, Vata-anulomana and Artava-janana action. Several published case reports have similarly documented restoration of ovulatory cycles and successful conception in PCOD-related infertility following individualised Ayurvedic management, using formulations selected according to the patient's Dosha predominance and associated Dushya.

The present case is reported to document the course and outcome of a woman with long-standing PCOD and coexisting chronic hypertension who conceived following sustained Ayurvedic management, and whose pregnancy was subsequently co-managed with the allopathic obstetric team through to a successful delivery.

CASE PRESENTATION

Patient Information

A 34-year-old married woman presented to the Prasutitantra evum Streeroga OPD with a known history of PCOD of 17 years' duration. She gave a history of scanty, irregular menstrual cycles, and was under evaluation for subfertility in the setting of PCOD. She was also a known case of chronic hypertension. There was no history of diabetes mellitus at presentation.

History

- Menarche at 10 years of age; cycles subsequently irregular with a cycle length ranging from 28–30 days and scanty flow (1 pad/day, spotting on later days) over recent cycles.
- Known case of PCOD for 17 years; known case of chronic hypertension (approx. 10–12 years' duration), on treatment.
- Complaints at various visits included lower abdominal pain, on-and-off white (vaginal) discharge, burning micturition, and progressive darkening/pigmented patches over the body (approx. 2 years) consistent with acanthosis nigricans.
- No history of diabetes mellitus prior to pregnancy; gestational diabetes was newly diagnosed during the antenatal period (discussed below).

Clinical Findings

- General/anthropometric: Weight 77.9 kg, height 4'9", BMI 37.2 kg/m² (Class II obesity) at the initial visit.
- Vitals: Blood pressure ranged 130–150/70–90 mmHg across visits (on antihypertensive treatment); pulse rate 74–88/min.
- Local examination: Hirsutism present; acanthosis nigricans present; per-abdomen soft, non-tender on most visits.
- Systemic examination: CVS and respiratory system within normal limits on all visits.

Timeline

Date	Event / Findings
Oct 8, 2024	First recorded OPD visit. K/c/o PCOD (17 yrs). C/o abdominal pain, white discharge, scanty menses. BMI 37.2. Ayurvedic treatment initiated along with USG advised.
Oct 11, 2024	Follow-up. C/o abdominal pain, acanthosis nigricans (~2 yrs), constipation. Referral discussion for further work-up.
Jan 21, 2025	Recently married (~2 months). C/o burning micturition, acidity, white discharge. BP 140/80 mmHg.
Mar 4, 2025	K/c/o chronic HTN with PCOD. Hirsutism and acanthosis nigricans confirmed on examination. Hormonal work-up (LH, FSH, serum testosterone, fasting insulin) sent.
Mar 3, 2025	Pelvic ultrasonography performed (see Diagnostic Assessment).
Mar 11, 2025	USG-confirmed PCOS morphology reviewed. Ayurvedic formulations continued/revised (Arogyavardhini Vati, Hingwashtak Churna, Rasonadi Churna).

Apr 1, 2025	Follow-up; BP 130/90 mmHg; treatment continued.
Oct 20, 2025	C/o amenorrhea (~5.3 weeks); urine pregnancy test positive. Diagnosis of pregnancy pending confirmatory USG; prognosis explained as guarded in view of chronic HTN.
Oct 21, 2025	Admitted for BP monitoring; antihypertensive (Nicardia) and, in view of glucose intolerance, Gluconorm (metformin) started.
Oct 31, 2025	Confirmatory obstetric USG: single live intrauterine gestation, ~6.5 weeks, good cardiac activity (153 bpm).
Nov 7, 2025	Antenatal visit; gestational diabetes mellitus (newly diagnosed) noted alongside chronic HTN; folic acid, antihypertensive and antidiabetic therapy continued; infection screen sent.
Nov 2025	NT scan advised; antenatal booking bloods essentially unremarkable (HIV, HBsAg, HCV, VDRL non-reactive); continued antihypertensive/antidiabetic and folic acid supplementation.
28 May – 03 Jun 2026	Admitted at 36+4 weeks with PROM and failed induction on the background of chronic HTN with GDM; underwent emergency LSCS; delivered a live male baby; discharged well on the 6th postoperative day.

DIAGNOSTIC ASSESSMENT

Pelvic ultrasonography (03 March 2025) revealed a uterus of normal size (6.0 × 4.5 × 3.2 cm) with an endometrial thickness of 7.3 mm. Both ovaries were bulky, the right measuring 4.1 × 3.7 × 1.7 cm (volume 14.2 cc) and the left 3.3 × 3.3 × 2.4 cm (volume 14.4 cc), each showing multiple sub-centimetre peripherally arranged follicles with increased stromal echogenicity — findings reported as most likely suggestive of polycystic ovarian syndrome or its variant, with a suggestion for hormonal correlation. Incidental findings included Grade I fatty liver and a right renal simple cortical cyst (3.5 × 2.6 cm).

Serum hormonal parameters (LH, FSH, testosterone and fasting insulin) were sent on 04 March 2025 as part of the endocrine work-up; exact reported values are on file with the treating unit and are not reproduced here pending verification against the original laboratory reports. On the basis of oligomenorrhea, clinical hyperandrogenism (hirsutism, acanthosis nigricans) and polycystic ovarian morphology on ultrasonography, a diagnosis of PCOD-associated infertility was made, corresponding in Ayurvedic parlance to Nashtartava leading to Vandhyatva.

THERAPEUTIC INTERVENTION

The patient was managed predominantly on an OPD basis with a combination of classical Ayurvedic formulations aimed at Kapha-Medohara, Artava-janana and Vata-anulomana action, along with dietary and lifestyle counselling for weight reduction. Antihypertensive treatment (and, later in pregnancy, antidiabetic and antenatal supportive therapy) prescribed by the treating physicians was continued in parallel throughout, reflecting an integrative approach given the patient's comorbid chronic hypertension.

Formulation	Approximate Dose / Schedule	Rationale (Ayurvedic action)
Tab. Arogyavardhini Vati	2 tablets twice daily	Deepana–Pachana, Medohara, hepato-metabolic correction
Hingwashtak Churna	3 g twice daily (courses of ~5 days)	Agni-deepana, Vata-anulomana, relief of abdominal distension/pain
Rasonadi Churna	5 g twice daily (courses of ~1 month)	Artava-janana, Vata-Kapha Shamana — supports ovulatory/menstrual regularity in PCOD
Syp. Stoneuill / renal-supportive formulation	As advised, short course	Adjunct management for the incidentally noted right renal simple cyst

Tab. Ovulife Plus / folic-acid–containing preconceptional supplement	As advised, periconceptional course	Nutritional/preconceptional support
Lifestyle advice	Weight-reduction diet, regulated routine (Dinacharya)	Address obesity/insulin resistance underlying PCOD

[Author to verify]: A small number of additional prescriptions recorded in the case sheets — including a churna advised on 11 March and 01 April 2025 and certain supportive tablets from the first visit — were not fully legible in the original handwritten notes and have been omitted from the table above; please add these from the original records before submission.

FOLLOW-UP AND OUTCOMES

Following several months of Ayurvedic management combined with continued antihypertensive treatment, the patient conceived spontaneously. She presented with amenorrhea of approximately 5–6 weeks and a positive urine pregnancy test on 20 October 2025; given her background of chronic hypertension, the pregnancy was initially classified as high-risk with a guarded prognosis pending confirmatory scan. Obstetric ultrasonography on 31 October 2025 confirmed a single live intrauterine gestation of approximately 6.5 weeks, with a crown-rump length of 7.5 mm and good fetal cardiac activity of 153 bpm.

The antenatal course was notable for newly diagnosed gestational diabetes mellitus superimposed on pre-existing chronic hypertension; both conditions were jointly managed by the obstetric and medicine teams with metformin (Gluconorm), antihypertensive therapy (Nicardia), and folic-acid supplementation, alongside regular blood-pressure and glycaemic monitoring. Serial antenatal visits and investigations, including a nuchal translucency scan, infection screening (HIV, HBsAg, HCV, VDRL — all non-reactive) and routine haematological work-up, were unremarkable apart from the known hypertensive and diabetic comorbidities.

At 35+5 weeks the patient was admitted with premature rupture of membranes; induction of labour was attempted but was unsuccessful, and she underwent an emergency lower segment caesarean section at 36+4 weeks in view of chronic hypertension, gestational diabetes, prelabour rupture of membranes and failed induction. A live male baby was delivered with an APGAR score of 9/10 and a birth weight of 2.632 kg. The postoperative course was uneventful, and the mother and baby were discharged in stable condition on the sixth postoperative day.

DISCUSSION

This case demonstrates conception and a successful term(-near-term) delivery in a woman with a long-standing (17-year) history of PCOD-related infertility, following sustained Ayurvedic management. The clinical picture — oligomenorrhea since menarche, hirsutism, acanthosis nigricans, obesity and ultrasonographic evidence of bilateral polycystic ovarian morphology with increased stromal echogenicity — is a classical presentation of PCOD, and correlates well with the Ayurvedic understanding of Nashtartava and Artava Kshaya arising from Kapha-Meda Dushti obstructing Vata within the Artava Vaha Srotas.

The formulations used in this case — Arogyavardhini Vati (Deepana-Pachana and Medohara), Hingwashtak Churna (Vata-anulomana and Agni-deepana) and Rasonadi Churna (Artava-janana) — are commonly employed in the Ayurvedic management of PCOD-associated menstrual irregularity and subfertility, and their combined use targeting Agni correction, Kapha-Meda reduction and Artava normalisation is consistent with the Samprapti-Vighatana (pathogenesis-breaking) approach described in classical texts and reported in comparable case literature on PCOD-related infertility. Similar published case reports have documented restoration of regular ovulatory cycles and spontaneous conception in PCOD following individualised Ayurvedic regimens combining internal medications with lifestyle correction, lending support to the outcome observed here.

A notable feature of this case is the coexistence of chronic hypertension, which necessitated a genuinely integrative approach — Ayurvedic management for the underlying PCOD and infertility was continued alongside allopathic antihypertensive therapy throughout, and later alongside antidiabetic therapy once gestational diabetes was diagnosed. This case therefore also illustrates that Ayurvedic care for PCOD-related infertility can be safely integrated with ongoing allopathic management of comorbid conditions, and that close antenatal surveillance remains essential once conception occurs in a woman with chronic hypertension, given the recognised risk of superimposed pre-eclampsia, growth restriction and the eventual need for operative delivery, as seen in this patient.

Limitations of this report include its single-case design, the absence of numeric hormonal assay values in the reviewed records, and the fact that conception cannot be attributed to Ayurvedic therapy alone with certainty in the absence of a comparator; nonetheless, the temporal association between sustained Ayurvedic treatment and conception in a woman with 17 years of PCOD-related subfertility is clinically noteworthy and adds to the existing body of case-level evidence in this area.

CONCLUSION

Individualised Ayurvedic management, combining Deepana-Pachana, Kapha-Medohara and Artava-janana formulations with lifestyle modification, was associated with successful conception in a woman with 17 years of PCOD-related infertility and coexisting chronic hypertension. The pregnancy, though high-risk, was carried to a viable gestational age with close integrated antenatal monitoring and culminated in a healthy live birth by caesarean section. This case supports further systematic study of Ayurvedic interventions, used in an integrative framework, in women with PCOD-associated infertility.

CONSENT

Informed written consent was obtained from the patient for publication of this case report and accompanying clinical details.

CONFLICT OF INTEREST AND SOURCE OF FUNDING

The authors declare no conflict of interest. No funding was received for this work.

REFERENCES

1. Anitha K, et al. Ayurveda management of infertility associated with Poly Cystic Ovarian Syndrome: A case report. J Ayurveda Integr Med. 2021 Dec 31;13(2):100513.
2. Ayurvedic management of Secondary Infertility associated with Polycystic Ovarian Syndrome — A Case Report. Journal of Ayurveda and Integrated Medical Sciences. 2024.
3. A Case Study on OPD Level Management of Infertility due to PCOS with Ayurvedic Medicines. International Journal of Ayurveda and Pharma Research. 2023.
4. Karandikar AN. PCOS with Infertility and its Ayurveda Management — A Case Study. International Journal of Ayurveda and Pharma Research. 2018;6(10):78-80.
5. A Case Study on Ayurvedic Management of PCOS-Induced Infertility with Successful Conception. AYUSHDHARA. 2025.
6. Ayurvedic management of PCOS: A case study. Journal of Ayurveda and Holistic Medicine (JAHM). 2024.