THE HOMOEOPATHIC HERITAGE

Bringing Classical and Contemporary Homoeopathy Together

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Homeopathic Approach in cases of Infertility

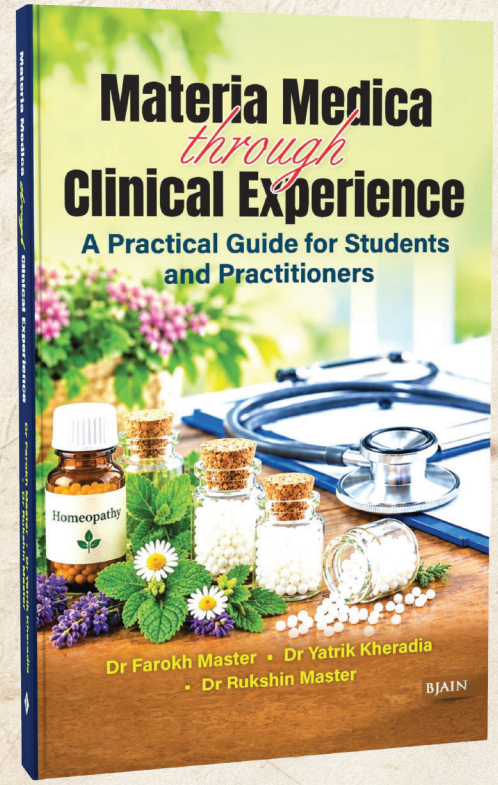
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- Successful Outcome of Primary Infertility with Individualized Homoeopathy: A Case Report

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Dear Readers,



Infertility is defined as a failure to conceive within one or more years of regular unprotected coitus. Primary infertility denotes those patients who have never conceived. Secondary infertility indicates previous pregnancy but failure to conceive subsequently. According to the World Health Organization (WHO), infertility affects approximately one in six people of reproductive age worldwide during their lifetime. As the field of reproductive medicine continues to advance, the challenge before the homoeopathic profession is not simply to offer another therapeutic perspective, but to strengthen its clinical approach through research, transparency and patient-centred practice. This issue of The Homoeopathic Heritage explores the homoeopathic approach to infertility, bringing attention to the importance of individualisation, comprehensive case-taking and understanding the physical and emotional dimensions of reproductive health. We are honoured to feature *The Editor's Desk*, eloquently written by **Dr. B. T. Rudresh**, M.D. (Homoeo), D.Sc. (h.c.), (PhD) shares his thoughts on "Beyond Conception: A Homoeopathic Perspective on Infertility: Science, Individualisation and the Human Story" . The In Italics section features a scholarly contribution by **David Mundy, F.S.Hom.** discussing a live OPD: A Clinical Case of Infertility with PMOS.

Infertility is not merely a medical condition; it is an experience that often touches the emotional, psychological, social and personal dimensions of an individual's life. The desire to conceive, coupled with repeated disappointments, uncertainty and the pressure of expectations, can make the journey particularly challenging for couples.

Infertility is defined as a failure to conceive within one or more years of regular unprotected coitus. Primary infertility denotes those patients who have never conceived. Secondary infertility indicates previous pregnancy but failure to conceive subsequently.

Fecundability is defined as the probability of achieving a pregnancy within one menstrual cycle. In a healthy young couple, it is 20 percent. Fecundity is the probability of achieving a livebirth within a single cycle.

The incidence of infertility, seen in an average of 15-20 of every 100 couples, increases with age. According to the World Health Organization (WHO), infertility affects approximately one in six people of reproductive age worldwide during their lifetime

Due to anovulation, infertility is the rule prior to puberty and after menopause. But it should be remembered that the girl may be pregnant even before menarche and pregnancy is possible within a few months of menopause. Conception is not possible during pregnancy as the pituitary gonadal axis is suppressed by hCG and hence, no ovulation.

Causes of Male Infertility not just include defective spermatogenesis, Obstruction of the efferent duct system or failure to deposit sperm high in the vagina or Errors in the seminal fluid, it also include: *Undescended testes*, *Kartagener syndrome* (autosomal disease)- when there is loss of ciliary function and sperm motility, *Hypospadias* causes failure to deposit sperm high in vagina.

Causes of Female infertility: Infertility may arise due to several factors, including ovulatory dysfunction, polycystic ovary syndrome (PCOS), endometriosis, tubal abnormalities, diminished ovarian reserve, uterine factors.

According to FIGO manual (1990) causes are: Tubal and peritoneal factors (25–35%), Ovulatory factor (30–40%) and Endometriosis (1–10%). *Ovarian factors:* The ovulatory dysfunctions (dysovulatory) encompass:

- Anovulation or oligo-ovulation
- Decreased ovarian reserve
- Luteal phase defect (LPD)
- Luteinized unruptured follicle (LUF)

Some of the remedies chosen in cases of Infertility

1. Nuphar luteum :



Nuphar lutea is an aquatic plant of the family Nymphaeaceae, native to temperate regions of Europe, northwest Africa, and Western Asia. It was an important medicinal plant for Aboriginal peoples. Nuphar has been used widely in the medicinal field for leaucorrhea, Tuberculosis, infections, bites and swellings also. Plant also possesses anti-leishmanial activity, antineoplastic, antiinflammatory, antifungal, and antibacterial activities.

Clinically shows miraculous results in Male infertility (Azoospermia and low sperm count), Erectile dysfunction, Entero-colitis and morning diarrhoea. Nuphar luteum Mother tincture is prepared from the rhizome of Yellow Pond Lily. It produces marked weakness in the sexual sphere. There is entire absence of erection and sexual desire (Agnus). Voluptuous ideas fill imagination but do not cause excitement. The penis is retracted and the scrotum is relaxed. Involuntary seminal losses frequent during sleep (Phosphoric acid). There may be involuntary emissions during stool or urination. Pain in testicles and penis.

2. Agnus castus:



Clinical indictaed in Impotency, Premenstrual Hyperprolactinaemia syndrome, Preparation: Agnus castus Mother tincture is prepared from the fresh berries of Chaste tree. Symptoms: Low sexual vitality with corresponding mental depression and loss of nervous energy. It shows distinctive influence in both sexes, but is more pronounced in men. It is of service in impotency in those who are suffering from indiscretion. The genitals are relaxed, flaccid and cold. There is no sexual desire. It is beneficial in the management of consequences of onanism and masturbation. Also a remedy for sprains and strains; tachycardia caused by tobacco in neurotic young men. In diseases of women, there is a general relaxed condition of the genital organs with transparent leucorrhoea, an abhorrence of sexual intercourse and a sad, despondent mental condition. Premature old age from abuse of sexual power.

Chaste trees have been shown to have activity in the brain by inhibiting prolactin production and increasing melatonin secretion. The inhibition of prolactin is mediated through dopamine receptors. Chaste tree has also been shown to increase LH secretion and reduce FSH production.

3. Caladium seguinum



Proved by Dr. Berridge. For the preparation of its Mother tincture fresh roots of Elephant ear or

Poison American Arum are used.

Addressed for erectile dysfunction, premature ejaculation, and a lack of libido, particularly when accompanied by coldness and relaxation of the organs. It is a remedy of impotency due to sexual excesses in males. It is a specific remedy of relaxed penis with sexual excitement, no erection even after caress and embrace. Pruritus, erection when half-asleep, cease when fully awake. It is mainly used to increase the density of sperm.

Despite potential physical impotence (penis remains relaxed even with desire and excitement), there can be strong lascivious thoughts. This remedy is noted for impotence resulting from sexual excess or abuse. [Kent J.T., Lectures on Homoeopathic Materia Medica]

A Quick word on issue Content

This issue of The Homoeopathic Heritage explores the homoeopathic approach to infertility, bringing attention to the importance of individualisation, comprehensive case-taking and understanding the physical and emotional dimensions of reproductive health. We are honoured to feature *The Editor's Desk*, eloquently written by **Dr. B. T. Rudresh** M.D. (Homoeo), D.Sc. (h.c.), (PhD). The In Italics section features a scholarly contribution by **David Mundy, F.S.Hom.** discussing a live OPD: A Clinical Case of Infertility with PMOS. The contributions highlight clinical experiences, case reports, research studies, review articles and scholarly insights to encourage meaningful academic discussion and broaden our understanding of infertility within the context of homoeopathic practice.

Happy Reading!

Dr Mansi Tyagi

Editorial Team,

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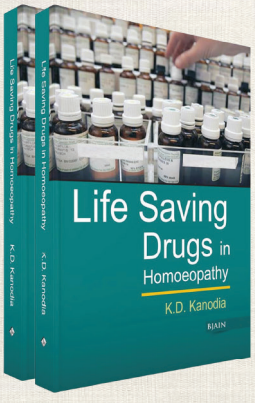
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Dr. K.D. Kanodia

Beyond Conception: A Homoeopathic Perspective on Infertility: Science, Individualisation and the Human Story



Dr. B. T. Rudresh

M.D. (Homoeo), D.Sc. (h.c.), (PhD)

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- Karnataka Knowledge Commission (Ex.), Government of Karnataka
- Member, Editorial Board – Journal of Ayush Sciences, Rajiv Gandhi University of Health Sciences, Bangalore
- Chairman, Homoeopathy Foundation

Infertility is often described in the language of biology: ovulation, sperm count, tubal patency, ovarian reserve, hormones, implantation and pregnancy. Yet for the couple experiencing it, infertility is rarely merely a biological problem. It can become a story of expectation, uncertainty, repeated investigations, social pressure, disappointment and, sometimes, profound emotional exhaustion. The World Health Organization estimates that approximately one in six people of reproductive age experience infertility during their lifetime. Infertility is defined clinically as failure to achieve pregnancy after 12 months or more of regular unprotected sexual intercourse. Importantly, it may arise from female factors, male factors, combined factors or remain unexplained.

This simple definition reminds us of something fundamental: infertility is not exclusively a woman's problem. Nor is it exclusively a man's problem. It is a reproductive-health concern that deserves investigation and care involving both partners. For homoeopathy, therefore, the contemporary question should not simply be, *"Which homoeopathic remedy is useful in infertility?"* The more meaningful question is: "How can the homoeopathic physician contribute responsibly to the care of a person or couple experiencing infertility?"

The conventional fertility work-up has become increasingly sophisticated. Assessment may include ovulatory function, ovarian reserve, tubal and uterine factors, semen analysis, endocrine evaluation and other investigations according to the clinical context. Contemporary guidance also recognises the importance of assessing both partners.

The woman presenting with polycystic ovarian morphology is not necessarily therapeutically identical to another woman with the same diagnosis. Similarly, two men with abnormal semen parameters may have entirely different clinical histories, constitutional characteristics, lifestyles and psychosocial circumstances. This is where individualisation remains conceptually important within homoeopathic practice. The diagnostic label, *PCOS, endometriosis, diminished ovarian reserve,*

oligozoospermia, asthenozoospermia or unexplained infertility, may describe the clinical problem. It does not necessarily describe the whole person.

A careful homoeopathic consultation may therefore explore menstrual history, thermal preferences, sleep, appetite, bowel function, emotional responses, fears, grief, stress, relationship dynamics, sexual history and other individual characteristics, while maintaining appropriate clinical boundaries. The purpose, however, should never be to substitute an elaborate symptom portrait for essential medical investigation.

Homoeopathic literature contains numerous remedies traditionally associated with reproductive complaints. *Sepia, Pulsatilla, Natrum muriaticum, Lachesis, Folliculinum, Oophorinum, Sabina, Calcarea carbonica, Lycopodium* and others have been discussed in different contexts involving menstrual, ovarian, uterine, sexual or reproductive symptoms.

A remedy should instead be considered within the totality of the patient's symptoms and the clinical context, consistent with the practitioner's chosen homoeopathic methodology. At the same time, traditional remedy indications should not be represented as proof that a remedy improves conception, ovarian reserve, sperm quality, implantation or live-birth rates. The effectiveness of complementary therapies for fertility problems has not been adequately established, and current NICE guidance states that further research is required before such interventions can be recommended for fertility problems. This distinction is crucial.

Materia medica provides a therapeutic tradition; evidence-based research determines what can responsibly be claimed about clinical effectiveness. The future of homoeopathy in reproductive health will depend considerably on our ability to respect both.

One of the persistent social problems surrounding infertility is the disproportionate burden of blame placed upon women. Biologically, however, male factors are an important component of infertility. WHO identifies abnormalities involving sperm production, concentration, morphology, motility, ejaculation and reproductive-tract obstruction among possible male causes. Lifestyle and environmental factors may also influence reproductive health. A responsible fertility consultation should therefore ask a simple question, have we investigated the couple, or only the woman?

Homoeopathic practitioners can contribute to changing this culture by normalising evaluation of both partners and encouraging appropriate investigations rather than allowing social assumptions to determine the clinical pathway. A semen analysis should not be interpreted as an assault on masculinity. Likewise, a diagnosis of diminished ovarian reserve should not be interpreted as a failure of womanhood.

Infertility is a health condition, not a moral judgement. There is another dimension that deserves far greater attention. For many couples, every menstrual cycle becomes a psychological event. Hope rises around ovulation, anxiety grows while waiting, and menstruation may become a monthly experience of grief. Repeated consultations, investigations and assisted-reproduction procedures can intensify this emotional burden. NICE specifically recognises the psychological stress associated with fertility problems and recommends counselling before, during and after investigation and treatment. The homoeopathic consultation can potentially provide something valuable here, not as a replacement for psychological care, but as a human clinical encounter in which the patient is listened to.

Couples may experience pressure from parents, relatives and communities. Women may face questions about motherhood almost immediately after marriage. Men may experience silent anxiety about sexual or reproductive adequacy. Couples may spend substantial financial resources pursuing treatment. WHO identifies infertility as having significant psychosocial and financial consequences, while access to fertility care remains unequal globally.

The physician therefore encounters not merely a reproductive system, but a person situated within a family and society. Homoeopathic practice has an opportunity to contribute to a more compassionate culture by avoiding blame, respecting confidentiality, recognising the couple's autonomy and referring appropriately when specialist intervention is indicated.

Perhaps the most important question for the future is whether homoeopathy must stand outside modern fertility medicine. It need not. A patient receiving homoeopathic care may simultaneously require a gynaecologist, reproductive endocrinologist, urologist/andrologist, embryologist, nutrition professional or counsellor. Depending on the diagnosis, interventions such as ovulation induction, surgery, intrauterine insemination or IVF may be clinically appropriate.

The 2025 WHO global guideline on infertility emphasises evidence-based, people-centred fertility care and aims to support prevention, diagnosis and treatment across different health-system settings. The responsible homoeopathic physician should therefore not discourage necessary investigations or delay proven fertility treatment while promising that a remedy will restore fertility. Instead, homoeopathic care can exist within a framework of informed choice, appropriate referral, transparency and continuity of care. This is not a dilution of homoeopathy. It is an expression of professional responsibility.

If homoeopathy wishes to make stronger claims regarding infertility, the answer cannot be anecdote alone. The field needs well-designed research examining outcomes that matter to patients: conception rates, clinical pregnancy, miscarriage, live birth, time to pregnancy, quality of life and psychological well-being. Research should also distinguish between different infertility diagnoses and should include both male and female factors.

Ultimately, infertility challenges medicine to remember that a successful clinical encounter is larger than a pregnancy test. Pregnancy is, understandably, an important desired outcome. But the journey toward it should not strip people of dignity, autonomy or emotional well-being. The homoeopathic physician has a distinctive opportunity to preserve the individuality of the patient while participating responsibly in a multidisciplinary fertility-care environment. Our strength should not lie in claiming that every reproductive problem has a homoeopathic answer. Nor should it lie in rejecting developments in reproductive medicine. Our strength should lie in careful observation, individualised clinical reasoning, compassionate communication, ethical practice and intellectual honesty.

As I conclude this reflection, I would like to address the young homoeopath who is entering this profession with hope, curiosity and the desire to make a difference. Infertility is one of those clinical situations that will test not only your knowledge of Materia Medica and Repertory, but also your maturity as a physician. You will meet couples who arrive with investigations in their hands, expectations in their hearts and, sometimes, years of disappointment behind them. Listen to them before you prescribe.

Learn to see the person behind the diagnosis, but never ignore the diagnosis. Develop the discipline to take a complete case, the humility to acknowledge the limits of your knowledge, and the wisdom to recognise when another specialist's expertise is needed. Never allow individualisation to become an excuse for avoiding scientific investigation, and never allow modern investigation to make you forget the individuality of the patient.

Do not promise a pregnancy merely because a remedy appears in the Materia Medica. Do not convert clinical experience into proof without appropriate evidence. At the same time, do not lose the rich tradition of observation that has been handed down to you. Your responsibility is to carry that tradition forward with greater scientific rigour. The future of homoeopathy will not be secured merely by defending its past. It will be strengthened by better clinical practice, better documentation, better research, better teaching and, above all, better physicians.

When you encounter infertility, remember that you are not treating a uterus, an ovary, a sperm count or a laboratory report. You are caring for a human being, and often for a couple whose emotional world has become inseparable from their medical journey. Therefore, let your practice be guided by three qualities, be scientifically responsible; be clinically individualised; be deeply human. If you can combine these three, you will not merely become a practitioner of homoeopathy. You will become the kind of physician whom patients remember, not only for the medicine you prescribed, but for the dignity with which you treated them. That, in my view, is the enduring promise of homoeopathy.

Live OPD: A Clinical Case of Infertility with PMOS



David Mundy, F. S. Hom.

Bachelor of Acupuncture; Diploma in Osteopathy; Homoeopathy Studies (1975), The College of Homoeopathy, London.
Over 45 years of clinical practice; extensive experience in teaching Homoeopathic Philosophy and Materia Medica in the UK and internationally.
Awarded a Fellowship of the Society of Homoeopaths for contributions to homoeopathy (1993).

Teaching Experience:

- The School of Homoeopathy, Stroud
- The Welsh School of Homeopathy, Carmarthen
- The North West College of Homoeopathy, Manchester
- The College of Homoeopathy, Regent's Park, London
- The Tiverton School of Homoeopathy, North Devon
- The Purton House School of Homoeopathy, Buckinghamshire
- The London College of Classical Homoeopathy, South London
- The College of Homoeopathy, Edinburgh

Date: **5 January 2010**

Gender/Age: Female/28

OCCUPATION: Business Development Executive

Marrital Status: Married

Children: None

DESCRIBE BRIEFLY YOUR MAIN REASON(S) FOR CONSULTING A HOMOEOPATH:

I want to have a baby. Been trying for two years Since coming off the pill in September 2008 I have had extremely erratic and painful periods. In April I was diagnosed with polycystic ovarian syndrome and have been seeing a consultant gynecologist ever since. He is concerned not only at the irregularity of the periods, but that scans seem to suggest that I am not ovulating properly.

Unfortunately, I have not responded well to treatment – various drugs providing neither results nor insight into reasons for my symptoms. I have recently paused my consultations to pursue other alternative treatments.

Whilst pregnancy is a longer-term goal, I am actually very keen to focus on getting my body in a good fit state so that I can conceive naturally and in my own time – for this reason I am turning to homeopathy as a more holistic form of treatment for my PCOS.

LIST ANY MEDICATION THAT YOU ARE CURRENTLY TAKING (INCLUDING THE CONTRACEPTION PILL, VITAMINS AND FOOD SUPPLEMENTS):

Currently none – although I had previously been taking evening primrose and sea kelp to help

regulate my periods over the past 12 months

GIVE DETAILS OF ANYTHING THAT YOU ARE ALLERGIC TO - FOODS, DRUGS, AND ANIMALS ETC.:

I have suffered had allergy related asthma for about 4 years, although symptoms have significantly eased recently. As a child I suffered from severe hay fever, which although still affects me in late spring is now quite mild.

FAMILY HEALTH HISTORY

Please give details of the health history of your relatives. For example:

Diabetes, heart disease, cancer, tuberculosis, thyroid, mental disease, suicide, alcoholism, etc.

FATHER:

Born 1944. **Cleft palette at birth** – repaired successfully at 18 months of age.

Broken leg / broken arm (different incidents). **Hernia repairs (both sides).**

High blood pressure – identified 2004 and controlled satisfactorily by ace inhibitor. High cholesterol – controlled since January 2007 satisfactorily by statins. Generally in very good health.

MOTHER:

Born 1946. **Hospitalised with pneumonia when 7 years of age.** Cyst on the ovary at age 25 – surgically removed. Migraines – more or less stopped since the menopause (age 56). Varicose veins. Miscarriage 1980. **Glaucoma** diagnosed at age 50. Tubilectomy on one eye 2007, other eye pressure controlled with drops. 3 daughters and 1 son

PATERNAL GRANDMOTHER:

Born 1917. No conditions known. Died at age 69 of **aortic aneurism.** 2 sons.

PATERNAL GRANDFATHER:

Born 1913. One hip replaced. High blood pressure. No other conditions known. Died at age 69 of heart attack.

MATERNAL GRANDMOTHER:

Born 1922. Diphtheria as a child. **Thyroid removed** (age 28). Died at age 57 **from bowel cancer**. 3 daughters

MATERNAL GRANDFATHER:

Born 1920 – last child of 7 to mother of 44. **Tuberculosis** (spent 3 years in sanatorium from age 17). Early blindness (at 56) due to **congenital macular degeneration**. **Alcoholism** – bouts throughout adult life. Lifelong smoker. **Died of cancer** at age 76.

SISTER ONE:

Born 1966. **Dislocated hip at birth** – encased in plaster from waist down until age 10 months – completely cured. Childhood convulsions caused by high temperatures – until age 5. **Glandular fever – age 7.** Now has two children, a son aged 7 and a daughter aged 4.

SISTER TWO: (also your client)

Born 1968. Glandular fever – age 5 or 6. Pneumonia. Pre-cancerous cervical cells – successfully treated. One daughter, age 5.

She did well on NATRUM MUR and SEPIA and TUB BOV from another homeopath

BROTHER:

Born 1977. In good health

UNCLE: (Father's brother)

Born 1950. Fitted with pacemaker/defibrillator at age 58. No other conditions known.

AUNT ONE: (Mother's sister): Born 1950. In good health

AUNT TWO: (Mother's sister): Born 1958. In good health

PERSONAL HEALTH HISTORY

Please fill in this section giving as much information as possible including dates. Remember to mention your approximate age at the time of any health problems.

INFECTIOUS CHILDHOOD DISEASES: *(Measles, mumps, chicken pox, whooping cough, glandular fever etc. / State if mild or severe):*

Chicken Pox – severe

Glandular fever - mild

Mumps - mild

Measles - mild

Bladder infection - mild

ANY ADVERSE REACTIONS TO IMMUNISATIONS/VACCINATIONS:

None

INJURIES AND ACCIDENTS:

6 months ago I suffered excruciating back pain that was diagnosed as a mechanical disc problem between two vertebrae in the lower back. I was signed off work for 2 months and was treated with an intensive course of physio. I have since taken up yoga and have had no recurrence of the problem.

The cause of the problem was stated as postural, however I have felt there was some connection to my PCOS or its treatment – the issue (my first ever back problem) occurred whilst I was taking the first cycle of metformin – although this was ruled out as a cause by my GP and my consultant.

OPERATIONS AND SURGICAL PROCEDURES:

None

SKIN: *Warts, verrucae, herpes (cold sores), abscesses, boils, moles, eczema, impetigo etc.*

I have quite a few moles all over my body (some of which are flat, some raised, and a couple have hairs). When I was a teenager, I had a mole removed from the back of my right hand due to it changing colour and shape.

As for eczema I have a small area of dry skin/eczema around my nostrils and I sometimes I get very pronounced bumpy and itchy skin on my elbows (and when I was a child on my knees too). This stays for days, sometimes weeks and I have never managed to identify the trigger or cause.

WEATHER & ENVIRONMENT REACTION: *(What weather suits you best? Do you feel the cold/heat/wind/drafts/damp/humidity? Do you prefer warm rooms or desire fresh air etc.?)*

I generally I like to be warm and seem to deal better than most in very warm humid conditions. I enjoy feeling the warmth of the sun (especially in Autumn and Winter when the air is cold – I will often find a patch of sunshine and follow it as it moves through a room or garden. I find windy weather quite energising. Cold and wet is my least favourite combination, but can tolerate it quite well.

I hate drafts when I'm eating, but enjoy feeling fresh air on my face when I sleep.

I'm not sure if this is relevant, but my feet are particularly sensitive to the cold and once they get cold they seem to drag my general body temperature down are often very difficult to warm up.

APPETITE & THIRST: *(What foods/drinks/flavours/condiments etc. do you either crave or have a strong dislike of? Does any food or drink cause an adverse reaction? How thirsty are you?)*

I generally have a very good appetite and really enjoy eating (my husband is a fantastic cook and food plays a huge part of our relationship!). When at work or occupied mentally I can however miss meals easily. A good hot breakfast is a joy to me, but very rarely undertaken!

I tend to crave savoury food. Over the past few years I have longed for avocados which is strange for 2 reasons: first that I hated them up until the age of about 19 and second that my mother craved and ate a huge quantity of them when she was pregnant with me.

The food I hunger after is relatively healthy (often including lots of veg), but often quite salty. Marmite is frequently craved. Since travelling to China I have craved many of the fantastic salty-sweet dishes I had there or anything that contains miso, raw fish, sesame, seaweed or tofu.

I also have a strong attraction to sour foods – particularly those in vinegar like gherkins, roll-mops,

pickled onions/walnuts etc.

There are no foods that I have a strong dislike of, or that cause adverse reactions.

I would say I am quite rarely thirsty – I drink frequently because I know I should, rather than because I feel thirsty. When I do feel thirsty I feel the need to drink large quantities before my thirst is quenched. My mother says as a child I would never complain of being too hot/cold/thirsty/hungry.

FEARS OR PHOBIAS: *(For example - heights, closed spaces, dark, germs, ghosts, animals, insects, snakes, spiders, storms, examinations, disease, poverty, failure etc.)*

I really struggle to think of anything that I am actually afraid of. Some things make me feel a little uncomfortable – I am not fond of great heights and flying has previously mad me nervous, but I somehow manage to control that. I guess the fear that crops up most recently is the fear of not being able to have children.

DREAMS: *(Any dreams that stay in your memory. Any recurring dreams. Include childhood dreams. Please try to recall at least one dream that you have had in your life.)*

Childhood nightmare consisted of me curled up in a ball on the floor of a huge hall, where rows and rows of other women where also curled up. In the distance a large faceless man walks up and down the rows beating the women. He would get closer and closer to me before I finally woke up. I had this from a very young age until about 12 years old.

As a horse rider I recently experienced a horse bolting towards the open gate in a field. Aware of the dangers of the cattle grid at the field entrance I fought with the horse to stop it or turn it away, but I had to use all my physical force to fight it until it finally came under control just before the grid.

This incident (particularly a scene where the horse seemed to turn its head full round and look me in the eye) was replayed almost every night for several months. I still dream of it occasionally.

Animals always seem to feature strongly in my dreams and I frequently dream about seeing large fish in a river. I grew up in a house which had a river at the bottom of the garden and I spent a large part of my childhood by the water. It was always a great joy to see large chub or pike in the river and my dreams are often set in that garden and/or involve sightings of large fish or creatures in the water.

Noise also features – one of the most affecting childhood dreams would include the loud sound of breaking glass (a noise that whilst awake I found very upsetting).

ANY OTHER HEALTH PROBLEMS INCLUDING LIFE TRAUMAS, GRIEFS, SHOCKS ETC:

I'm not sure if this counts as a life trauma, but it was a significant incident in my recent past that you might feel has some relevance to my current health issues.

I had a brief but very intense affair 3 years ago, having been married for 2 years. Despite still being in love with my husband I fell in love with this other man and we had a very intimate, fun and intellectual relationship. I ended the affair after he suggested he left his wife and young family for me – and whilst I loved him and our relationship, in the end I could not take the responsibility of ruining two marriages and ripping apart a young family. I ended the affair, but found the experience of letting go of him and struggling to console both the challenge to my previously strongly held morals and my intense feelings for this man.

Since ending the affair, my husband and I have worked hard on our marriage and we are now enjoying a very positive relationship – better than we have ever experienced. However, the whole episode has had a profound effect on me and I have for a long time fought with my feelings of guilt, pain, loss and regret at hurting those around me and losing a man and a relationship I loved. Because I had to work on my marriage and **hide many of the feelings the affair brought up,** I feel I have only recently managed to deal with the affairs' effects on me. It might be that this stress and emotional trauma may have some bearing on my current health issues.

I want to have a family eventually.

Taken fertility drugs

Trying to conceive form two years

Since coming off the pill in September 2008 I have had extremely erratic and painful periods. In April I was diagnosed with polycystic ovarian syndrome and have been seeing a consultant gynecologist ever since. He is concerned not only at the irregularity of the periods, but that scans seem to suggest that I am not ovulating properly.

MENSES are very heavy and very painful CRAMPS can't stand up.

Emotional… two weeks before…

Not quite anger **it's frustration….** I get anger and am forced to fight to look after myself.

I give too much of self to others…. ANGRY that I got pushed to that level.

Aware of other's needs… I'm a strong person, take on a lot from others.

Like to HELP people if they are down. But …. Too focused on others!

What about ME! I need support too!

Happy outgoing positive person generally

I'm philosophical about the world.

Quite communicative, outgoing, positive. Enjoy social interaction but enjoy being on my own too.

Assertive, **feisty and passionate about things.**

Passionate about politics, like debating and arguing… **passionate about HUMAN BEINGS** too.

I love travel and seeing different cultures…

*Laughs! Affected by **UNFAIRNESS+++** Enrages me! Inequality and **INJUSTICE**+++

Global too.

Your heart goes out but you get angry too. UNFAIRNESS.

SUPPORT not there.

Even as a child was upset by unfairness.

About what is right/wrong – fairness.

I'm not judgemental though.

As **HUMAN BEINGS** we have different issues.

Some people think I am **aggressive.**

Q: FOOD? Always have good food. Mum a good cook and later dad too. Connection to family …. 2 elder sisters and a elder brother – 6 at home.

Meal is key to the whole group.

Q: Animals? Always liked animals, not many pets growing up. Always wanted a cat when 4 – more than life itself… when 7 got one. But my cat would not be bossed around! Then decided a dog would be better!!! Got Bruno when 11. Labrador.

I'm always in the garden outside…… big and safe. I love watching wildlife…

I became allergic to husband 's cat – it was **aggressive!!!**

Then I developed asthma!

Now it's HORSES. I love horses – I go riding every week.

Really enjoy learning about an animal… the dynamic of the relationship with the animal.

Control element – you must get the horse to do what you want them to do, control them.

Always wanted a horse since I was 6 or 7 years old

Q: What is it you admire in horses?

Interesting animals. They are **Strong and powerful creatures, yet they are also peaceful and gentle.** And they are pack orientated – there is a **hierarchy in the GROUP.**

I like their STRENGTH. Controlled wildness

Ancient thing – how much of a difference they made to **HUMAN civilisation.**

If they were intelligent, why do they let **humans domesticate** them, my dad says!

I'm In awe of horses, they are bloody **big creatures.**

Q: Who do you admire? I admire my parents hugely.

Mum is **STRONG and PASSIONATE.**

Came from restrictive conservative background. He has …. Mum talks of **revolution** and change but she is **strong and solid** – leader of the **family group.**

I admire strong people like **Nelson Mandela**… political people's rights.

I have a friend who is **STRONG** and outgoing.

Q: Books? Favourite is 'In the skin of a Lion'. Fantastic story of **HUMAN** interaction.

DREAMS

Childhood nightmare consisted of me curled up in a ball on the floor of a huge hall, where_rows and rows of other women were also curled up. In the distance a large faceless man walks up and down the rows beating the women. He would get closer and closer to me before I finally woke up. I had this from a very young age until about 12 years old.

As a horse rider I recently experienced a horse bolting towards the open gate in a field. Aware of the dangers of the cattle grid at the field entrance I fought with the horse to stop it or turn it away, but I had to use all my physical force to fight it until it finally came under control just before the grid.

This incident (particularly a scene where the horse seemed to turn its head full round and look me in the eye was replayed almost every night for several months. I still dream of it occasionally.

Once had an argument with A FRIEND – I never forgave her.

When I was 17. Used to dream of her. She let me down.

I'm very LOYAL.

Q: Married 4 years in April…

He is lovely… he is a **BIG guy. Very SOLID** and a **reliable steady** kind of man.

Fell in love with another man 3 years ago. He said he would leave his wife.

But that goes against my **belief in the importance of the family unit.**

Q: Tell me more about being STRONG?

I don't tolerate weakness. Need to **CONTROL** and keep **a REIGN on things!**

Fear I could go off the rails again…

I'm quite hedonistic and enjoy myself… food and sex and drink… unless I controlled those things I could be in the gutter! If I did not control my animal impulses

I have one person in **my TEAM at work** She wants to **compete with me**

She sees me as a threat.

She wants to **claw herself up** to me or cut me down **– all I want to do is work together as a team…**

Work is gearboxes for wind turbines… **Nice people in my team.** We **travel** together.

ANALYSIS:

Themes of the case:

- Family unit, the group
- Teamwork
- Frustration by bad teamwork
- Duty to others, what about me?
- Infertility (ovaries)
- Animals – cats, dogs, horses, birds etc.
- Horses
- Human beings – human civilization (Talks of humans – animal cases often do this)
- Passionate
- Travelling
- Strong, strength, big, powerful
- Control

- Loyalty
- Unfairness - injustice
- T.B. Miasm

The theme of strength and control ran through the whole case. Horses were central to her life.

I call this the Law of the Magnet.

Patients who require an animal remedy often talk of humans.

She had many animal themes of hierarchy (mammals) competitiveness, sexual nature.

Lac equinum has the theme of *groups working together in harmony* and is frustrated when disharmony is present. There is the delusion of *drowning in disorganisation*. She was very upset when she fell out with a friend.

Ben Hur, the movie, features a horse race where Ben Hur trains his horses to *work together as a group* in order to win.

Huge strength held in check and controlled, is a major theme of the remedy.

An important symptom is *'Peaceful wants to be yet forced to violence'* which reminded me of Nelson Mandela, who was a peaceful man who was forced became a terrorist to fight injustice.

Our late Queen was admired for her strength and leadership qualities. She loved horses and no doubt was very affected by the disharmony in her family! Interestingly the Lion and the Unicorn (a horse) are symbols of Royalty and appear on the British Royal Coat of Arms.

Lac equinum has a strong sense of responsibility and duty. They try hard to help the family and are much aggravated when their help is rejected.

Repertorial Totality

The following repertorisation shows many rubrics that relate to my case:

Polycystic Ovaries case

Analysis September 14, 2022, Polycystic Ovaries Case

Analysis uses 17 rubrics.

		lac-eq	con
		100	40
		17	7
66	Mind; Conflicts, discords; agg., ailments from; relatives, friends, between	3	4
246	Mind; Fight; wants to	1	3
147	Mind; Injustice, cannot support	1	3
148	Mind; Passionate, intense	1	3
1	Mind; Riding horseback amel.	3	
127	Mind; Travel; desire to	1	
487	Female; Ovaries	3	4
25	Dreams; Beaten, being	1	
3	Dreams; Groups, of; working well together	3	
1	Dreams; Help; rejected by those he tries to	1	
4	Dreams; Teamwork, of	3	
692	Mirilli's themes; Family	3	4
53	Q-Rep; Control; Control primary remedies	3	3
3	Fdd-Dreams; Beating someone; stick, somebody with a	1	
4	Fdd-Dreams; Frustration, of	1	
1	Fdd-Dreams; Peaceful; wants to be; violence, yet forced to	1	
10	Fdd-Dreams; Teamwork; cooperating, everybody is	1	

She received a single dose of Lac-equinum 200 in my clinic.

The follow up two months later:

'I just wanted to inform you of some quite unexpected news. I cannot quite believe it myself, but following some tests this week, my GP has confirmed that I am nearly 4 weeks pregnant! My deepest and most genuine thanks to you - needless to say you have made a very big difference to me and my life for which I am sincerely thankful. I am feeling very good

I'm very hungry these days. I Could eat a horse!

The horses treated me different. They Followed me around!

I was more in communication with them.

DREAMS

1. Reconciliation dreams (of people I fell out with) Apologised.

Sleeping heavily.

The week after I saw you this woman at work who was disruptive moved to another dept.

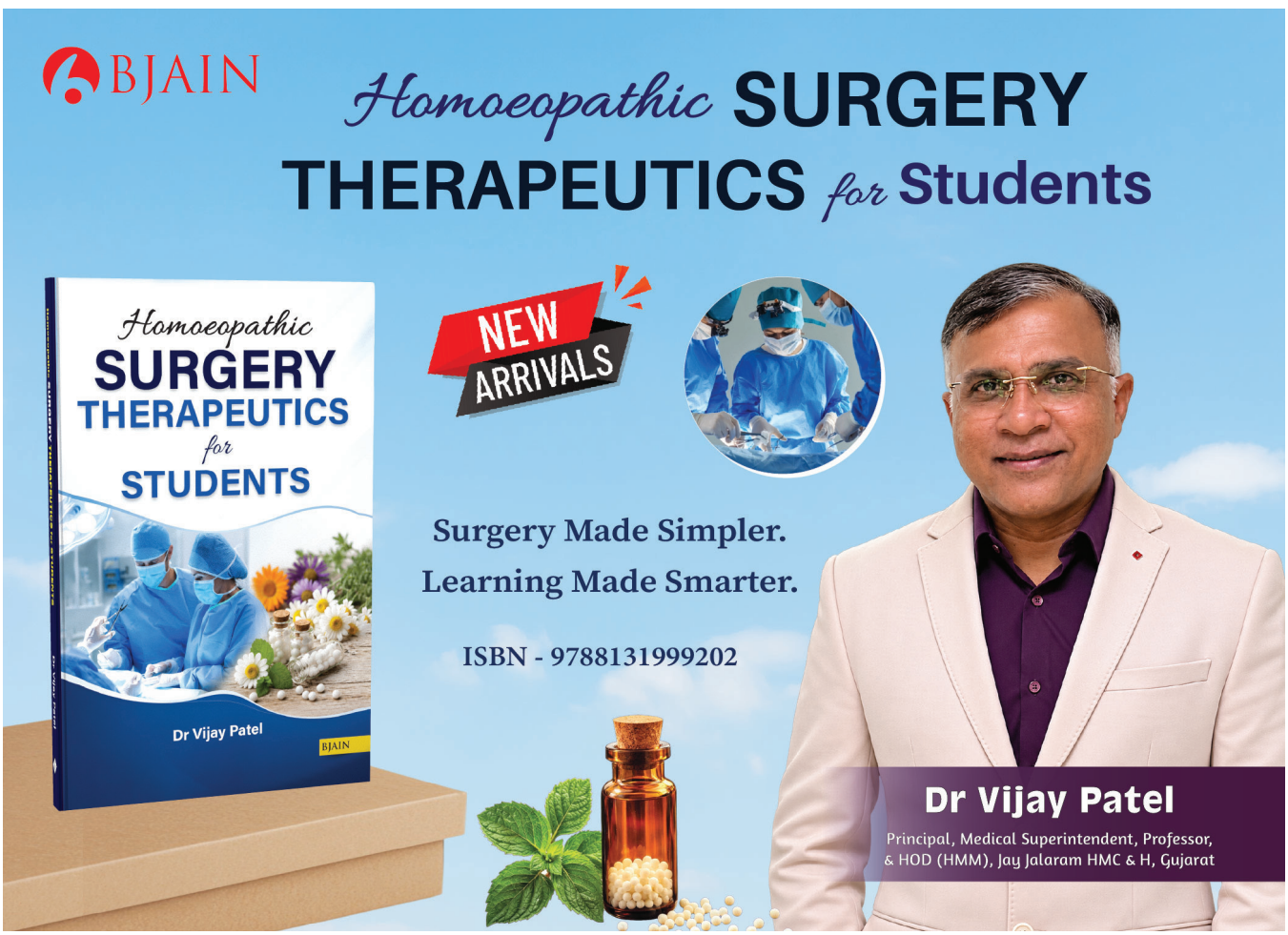
The way people reacted to me after I had your remedy changed.

Senior management even asked for my opinion!

I developed a cold about a week after I saw you. And some back pain. It felt like when I damaged the disk in June - an old symptom.

The sense of smell was really strong+++ after seeing you.'

RX Wait…. (The patient was well and required no further treatment)



The Shadow After Trying – A Narrative Review



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Abstract

Assisted reproductive technology (ART) offers hope to millions, yet repeated ART failure, across intrauterine insemination, in vitro fertilisation and intracytoplasmic sperm injection imposes a burden that compounds with each unsuccessful cycle rather than remaining constant. This article reviews the physical, psychological, relational, social and financial impact of repeated ART failure on both women and men, examines the reasons couples discontinue treatment, and considers the homoeopathic perspective on this cumulative burden through the lens of vital force and individualisation. It proposes an expanded, six-dimension, gender-differentiated Treatment Shadow framework for homoeopathic case-taking, alongside a Failure Load heuristic for tracking cumulative burden across cycles. The aim is to support more individualised and gender-aware case-taking, without replacing indicated reproductive investigation or treatment.

Keywords: *ART failure, In Vitro Fertilisation, Quality of Life, Recurrent implantation failure, Gender differences, Treatment shadow, Homoeopathy, Case-taking*

Introduction

Assisted reproductive technology (ART) has transformed the treatment of infertility, yet it remains, for most patients, a process defined more by failure than by success: a single ART cycle carries only a modest chance of live birth, and a substantial proportion of patients undergo multiple cycles of intrauterine insemination (IUI), in vitro fertilisation (IVF) or intracytoplasmic sperm injection (ICSI) before either conceiving or discontinuing treatment altogether. Infertility itself affects roughly one in six adults over their lifetime worldwide, with broadly comparable rates across high-, middle- and low-income countries. [1] What prevalence figures cannot convey is what repeated ART failure specifically does to the person and the couple living through it - physically, psychologically, relationally, and financially.

Homoeopathy has long held that disease cannot be fully understood, nor correctly treated, without understanding the individual who has it, a principle central to case-taking since the Organon. [2] Hahnemann described health as the harmonious operation of a dynamic, self-regulating vital force, and disease as a dynamic disturbance of that force manifesting through symptoms. [2] Applied to repeated ART failure, this principle demands more than recording a reproductive diagnosis; it requires understanding what repeated hormonal stimulation, invasive procedure, disappointment and renewed hope have done to this particular vital force, in this particular patient.

This article has three aims: first, to review the evidence on how repeated ART failure specifically as distinct from infertility broadly affects women and men across every relevant domain of life; second, to examine why so many couples discontinue ART before achieving a pregnancy, and what this reveals about cumulative burden; and third, to articulate a homoeopathic perspective on this burden, grounded in the concept of the vital force and supported by the available clinical evidence for homoeopathy in infertility.

Repeated ART Failure: A Closer Look

Not a single event, but an accumulating process

Most infertility QoL research describes distress at a single point in time. ART, however, is rarely a single event. A prospective pilot study measuring stress, anxiety and self-efficacy across an IVF cycle found that while anxiety and perceived stress did not differ markedly between first-time and repeat patients, self-efficacy patients' belief in their own capacity to cope, declined significantly more steeply across the cycle in repeat patients than in first-timers, a pattern the authors linked to possible cumulative burnout. [3] This is an important distinction: repeated ART failure may not always show up as more anxiety on a questionnaire, but as an erosion of the psychological resources needed to keep going.

A 2026 systematic review and meta-analysis of recurrent implantation failure (RIF), affecting an estimated 10 to 20 percent of couples undergoing ICSI/IVF found that RIF patients, especially women, had worse quality of life and significantly higher depression and anxiety scores than patients without RIF, with negative emotions predominating over positive ones. [4] A cross-sectional study of 137 women with RIF found that financial difficulties, male-factor infertility, body mass index, depression and family social support were the principal predictors of fertility-specific quality of life. [5]

Why couples stop: what discontinuation reveals about cumulative burden

Perhaps the clearest window into the cumulative impact of repeated ART failure is why couples stop treatment before achieving a pregnancy. A systematic review of reasons for discontinuation across five stages of fertility treatment found that psychological and physical burden, together with postponement and relational strain, were among the most frequently cited reasons and, notably, that these reasons became more prominent the further couples progressed through repeated ART cycles, particularly after the first failed ART attempt. [6] An earlier cohort study of IVF discontinuation found psychological burden was the single most common stated reason, cited by roughly a quarter of couples who stopped, ahead of poor prognosis.

Discontinuation research also offers one of the clearest gender-specific pictures available in the ART literature. A study of couples discontinuing IVF found that women most often cited unsuccessful treatment and fear of coping with further failure as their primary reason for stopping, while men most often cited depletion of financial resources a difference the authors attributed to differing roles and priorities within the family. [7] This single finding captures something the rest of this article will return to repeatedly: repeated ART failure burdens women and men differently, not because one partner suffers more than the other, but because each carries a differently shaped weight.

Physical, relational, social and financial impact across repeated cycles

The physical burden of repeated ART cycles is cumulative in a literal sense: repeated ovarian stimulation, repeated retrieval procedures, repeated semen collection under pressure, and repeated hormonal fluctuation, each with its own recovery period before the next cycle begins. Relationally, repeated failure has been associated with sexual dysfunction and a shift in intimacy from spontaneous connection toward scheduled, procedure-oriented activity. Socially, repeated cycles often mean repeated absences from work, repeated explanations avoided or given, and repeated rounds of family questioning that must be answered again after each failure. Financially, the burden compounds directly: costs escalate with every additional cycle, and out-of-pocket ART expenses have driven documented reliance on crowdfunding platforms in some healthcare systems, with

per-cycle IVF costs reported in the tens of thousands of dollars. [5,6]

The Homoeopathic Perspective

Vital force, dynamic disturbance, and the ART journey

Homoeopathic philosophy offers a specific and clinically useful lens on repeated ART failure. Hahnemann taught that the body is governed by an immaterial, dynamic vital force (dynamis) that maintains all organs in harmonious vital operation; disease is not fundamentally a material lesion but a dynamic disturbance of this force, which then expresses itself through the totality of symptoms available to observation. [2] Repeated ovarian stimulation, repeated invasive procedure, repeated hormonal manipulation and repeated emotional shock are, from this perspective, not merely stressful events layered on top of a stable person they are repeated dynamic disturbances to the vital force itself, each one potentially altering the terrain on which the next cycle, and the next remedy, must act.

Kent extended this model by describing the human being as expressing disturbance simultaneously across three interconnected planes physical, mental/emotional and what he termed the deeper 'internal' economy of the will and understanding. [8] For Kent, the deepest and most reliable individualising information is often found not in physical pathology alone but in disturbances of will, of hope, and of the patient's fundamental orientation toward life precisely the territory that repeated ART failure so often disturbs.

Clinical evidence for homoeopathy in infertility

While large-scale controlled trials of homoeopathy specifically in ART-experienced patients remain scarce, published case series report positive pregnancy outcomes following individualised homoeopathic treatment across a range of underlying causes, including polycystic ovarian syndrome, chronic pelvic inflammatory disease, endometriosis and tubal blockage. A prospective observational study of 40 infertile women treated with constitutional homoeopathic medicine reported an overall conception rate of 67.5 percent, with statistically significant results in polycystic ovarian syndrome (85%) and chronic pelvic inflammatory disease (70 percent). [9] A further case series describes successful conception, within six months of individualised treatment, in cases involving structural causes in both partners, with both partners receiving homoeopathic treatment concurrently, an approach directly consistent with the couple-centred, gender-differentiated framework proposed later in this article. [10]

These findings should be read cautiously: most available evidence is observational, uncontrolled, and drawn from single centres, and none of it specifically isolates patients with a history of repeated ART failure. What it does suggest, at minimum, is that individualised homoeopathic treatment is worth serious clinical and research attention as a supportive, adjunctive intervention alongside, before, or between ART cycles never as a replacement for indicated reproductive investigation or treatment where ART itself is clinically appropriate.

An Expanded, Gender-Differentiated Treatment Shadow

The Treatment Shadow was previously proposed as the accumulated physical, reproductive, emotional, relational, social and experiential state that develops around a patient during infertility investigation and treatment, and that may become superimposed upon the original clinical presentation. The evidence reviewed above supports extending this construct in two specific directions.

First, the dimensions should be applied in a gender-differentiated way. The same categories apply to women and men, but their typical content differs meaningfully, and case-taking should listen for different things accordingly (Table 1). Women's shadow material more often surfaces through verbalised emotional distress, sexual dissatisfaction, fear of further failure and explicit identity statements such as "my body has failed me." Men's shadow material more often surfaces through withdrawal, reduced disclosure, financial preoccupation and behavioural change reported by the partner rather than by the man himself, consistent with the discontinuation evidence discussed above. A case-taker listening only for spontaneous emotional disclosure in men risks under-detecting a Treatment Shadow that is

present but differently expressed.

Second, none of the six dimensions explicitly capture how burden changes as failures accumulate. This article proposes Failure Load: a simple, non-validated, descriptive heuristic to sit alongside the Treatment Shadow in case notes, a brief note of the number of failed ART cycles, the duration since diagnosis, and whether the patient's own account suggests escalation, plateau or partial recovery between attempts. Failure Load is not a score; its purpose is to prompt the case-taking question the evidence above makes important, has this patient's presentation deepened since the last failed cycle, and in which dimension?

Figure 1. Cumulative treatment shadow across repeated ART cycles: parallel female and male pathways converge into couple context, the six treatment shadow dimensions, and multidimensional quality-of-life outcome assessment.

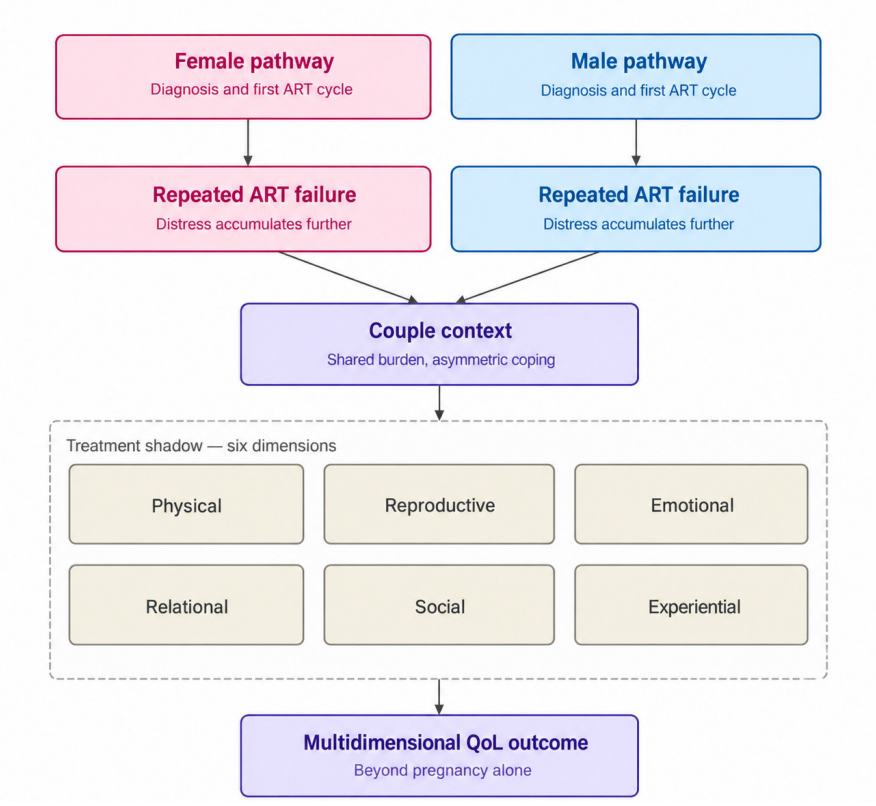


Table 1. Treatment Shadow matrix by gender: typical female and male manifestations across the six treatment shadow dimensions.

Dimension	Typical female manifestation	Typical male manifestation
Physical	Ovarian stimulation effects, procedure discomfort, weight/cycle changes	Semen collection stress, procedure-related discomfort, fatigue
Reproductive	Ovulation vigilance, timed intercourse, repeated testing	Repeated semen analysis, performance pressure at collection
Emotional	Higher reported depression/anxiety in most comparative studies	Guilt, inadequacy, self-esteem loss; often under-verbalised
Relational	Communication strain, differing coping styles from partner	Withdrawal, distancing as coping, perceived loss of role
Social	Stigma, family pressure, comparison with peers	Silence, reluctance to disclose, masculinity-linked stigma
Experiential	"My body has failed me"; identity shift toward "infertile"	"I can't give her this"; identity shift toward inadequacy

Implications for Homoeopathic Case-Taking

For consultation practice, this evidence supports three adjustments. First, routinely asking about ART cycle and loss history in a way that surfaces Failure Load, not only current symptoms. Second, explicitly inviting the male partner's own account rather than treating the woman's presentation as representative of the couple, and listening especially for financial preoccupation and withdrawal as male-typical shadow material. Third, listening for the gender-typical shadow patterns summarised in Table 1, while remaining alert to any individual patient departing from them.

The Treatment Shadow, Failure Load and the gender comparison in Table 1 remain proposed conceptual and heuristic tools, not validated diagnostic instruments. Homoeopathic case analysis using this framework should not replace appropriate reproductive investigation or indicated ART treatment for either partner, and should always follow the individual patient's actual presentation over the general pattern described here.

CONCLUSION

Repeated ART failure is not infertility experienced once, more intensely; it is a distinct, cumulative process with its own physical, psychological, relational, social and financial signature, a signature that differs meaningfully between women and men and deepens with each additional failed cycle.

The expanded Treatment Shadow proposed here, gender-differentiated across six dimensions, paired with the Failure Load heuristic and grounded in the homoeopathic understanding of the vital force, is offered as a structured way to bring this fuller evidence base into individualised case-taking, for both partners, across the full arc of repeated trying- body, mind, and relationship.

*Science may help us understand the process of **conception,** but the process of **creation** remains mystical.*

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ABBREVIATIONS

1. Assisted reproductive technology - ART
2. Intrauterine Insemination - IUI
3. In Vitro Fertilisation - IVF
4. Intracytoplasmic Sperm Injection - ICSI
5. Quality of life – QoL
6. Recurrent Implantation Failure - RIF

Opinion Piece

Homoeopathic Approach To Infertility: An Integrated Clinical, Investigative And Materia Medica-Based Review

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Abstract

Infertility is a multifactorial disorder involving female, male, combined or unexplained factors. Appropriate evaluation of both partners is essential before treatment. Homoeopathy approaches the individual through totality of symptoms and individualization rather than diagnosis alone.

Materials and Methods: A narrative review was undertaken using contemporary infertility guidelines, biomedical literature, published homoeopathic research and classical Homoeopathic Materia Medica. Particular attention was given to practical investigation, clinical differentiation and individualised prescribing.

Results: Infertility requires systematic evaluation of ovulation, reproductive anatomy, tubal patency and male reproductive factors. Homoeopathic literature contains observational studies, case series and other clinical evidence; however, infertility-specific evidence remains limited. Materia Medica provides characteristic reproductive symptom pictures for several remedies, but these should not be converted into diagnosis-based prescriptions.

Conclusion: A clinically responsible Homoeopathic approach should integrate appropriate fertility investigation with individualized case-taking, repertorisation, Materia Medica confirmation, objective follow-up and timely referral. Better-designed prospective studies are required to establish the effectiveness of individualized Homoeopathy in infertility.

Keywords: infertility, individualization, Homoeopathic Materia Medica, repertorisation, female infertility, male infertility, reproductive medicine, fertility evaluation

Abbreviations:

AMH – Anti-Müllerian Hormone

AFC – Antral Follicle Count

FSH – Follicle-Stimulating Hormone

LH – Luteinising Hormone

HSG – Hysterosalpingography

SHG – Sonohysterography

TVS – Transvaginal Ultrasonography

IVF – In Vitro Fertilisation

IUI – Intrauterine Insemination

Introduction

Infertility is defined as failure to achieve pregnancy after 12 months or more of regular unprotected sexual intercourse. It may result from female factors, male factors, combined factors or remain unexplained. The World Health Organization's current infertility guideline emphasizes systematic diagnosis and progressive management according to the underlying cause and the needs of the individual or couple [1]

Infertility is not exclusively a female disorder. Contemporary reproductive medicine recommends

parallel evaluation of both partners where applicable. Female assessment focuses principally on ovulation and the structure and patency of the reproductive tract, while male assessment includes reproductive history and semen evaluation [2]

For the Homoeopathic physician, this presents two complementary responsibilities. First, clinically significant pathology must be recognized and appropriately investigated. Second, the patient should be understood as an individual rather than reduced to a diagnosis such as polycystic ovary syndrome, endometriosis, oligozoospermia or unexplained infertility.

Homoeopathic individualization therefore has potential relevance as a method of case analysis, but it should be practiced alongside not instead of appropriate reproductive evaluation.

Clinical Classification Of Infertility

A practical classification is:

1. Female-factor infertility
    - Ovulatory dysfunction
    - Tubal/peritoneal disease
    - Endometriosis
    - Uterine cavity abnormalities
    - Diminished reproductive potential associated with increasing age
2. Male-factor infertility
    - Abnormal sperm concentration
    - Reduced motility
    - Abnormal morphology
    - Ejaculatory or obstructive disorders
    - Endocrine or systemic causes
3. Combined infertility
4. Unexplained infertility

A particularly important clinical point is that normal menstruation does not exclude infertility. Likewise, the presence of an ovarian abnormality on ultrasonography does not automatically establish the cause of infertility.

When Should Investigation Begin?

The timing of investigation should be individualized.

For women younger than 35 years, evaluation is generally initiated after 12 months of unsuccessful attempts. At 35 years or older, evaluation is recommended after 6 months, while women above 40 years may require more immediate assessment. Earlier investigation is appropriate when there is a known condition associated with infertility [2]

Practical Investigative Approach

1. **Detailed history**
    - The first consultation should establish:
    - Duration of infertility
    - Primary or secondary infertility
    - Previous conceptions and pregnancy outcomes
    - Menstrual cycle length and regularity
    - Dysmenorrhoea
    - Intermenstrual or post-coital bleeding
    - Symptoms suggestive of ovulation
    - Vaginal discharge
    - Dyspareunia
    - Sexual frequency and timing
    - Previous pelvic infection or surgery
    - Endometriosis
    - Medications
    - Thyroid or metabolic disease
    - Weight changes
    - Lifestyle and substance exposure
    - Previous fertility treatment
    - The male partner should be questioned regarding previous conception, genital disease, surgery, trauma, infection,

medications, heat exposure, smoking, alcohol and occupational exposures.

2. Ovulatory assessment

In women with regular cycles of approximately 21–35 days, additional confirmation of ovulation is generally unnecessary unless clinical circumstances suggest otherwise [2]

Irregular or absent menstruation should prompt assessment for causes such as:

- Polycystic ovulatory dysfunction
- Thyroid dysfunction
- Hyperprolactinaemia when clinically indicated
- Hypothalamic dysfunction
- Primary ovarian insufficiency
- Other endocrine disorders

3. Ovarian reserve

AMH and AFC may assist in estimating ovarian reserve and predicting response to ovarian stimulation, but they should not be interpreted as independent tests of whether a woman can conceive naturally. Ovarian-reserve markers are adjuncts to the complete fertility evaluation. [2]

4. Tubal and uterine assessment

HSG or SHG may be used to assess tubal patency. Transvaginal ultrasonography helps evaluate uterine and ovarian anatomy and may identify fibroids, endometriomas, polycystic ovarian morphology and other structural abnormalities.[2]

Further procedures such as hysteroscopy or laparoscopy should be selected according to clinical indication rather than performed indiscriminately.

5. Male evaluation

Semen analysis is an essential component of infertility assessment when a male partner contributes sperm. Abnormal results generally require appropriate clinical interpretation and, when indicated, repeat testing and specialist assessment.

Homoeopathic Case Analysis

After appropriate clinical evaluation, the Homoeopathic case should be constructed from the individual totality.

Important domains include:

Mental generals

- Emotional state
- Anxiety and anticipation
- Grief
- Irritability
- Indifference
- Fear
- Desire for company or solitude
- Response to consolation
- Relationship to spouse and family

Physical generals

- Thermal preference
- Appetite
- Thirst
- Food desires and aversions
- Sleep
- Energy
- Perspiration
- General modalities

Reproductive particulars

- Menstrual periodicity
- Quantity and character of flow
- Dysmenorrhoea
- Ovulatory symptoms
- Leucorrhoea

- Pelvic sensations
- Sexual desire
- Dyspareunia
- Post-coital symptoms
- Ovarian or uterine pain
- Characteristic concomitants

The diagnosis should establish the clinical framework, while the characteristic symptoms guide individualization.

Materia Medica: Important Differential Remedies

Sepia officinalis

Sepia officinalis is one of the major remedies traditionally associated with the female reproductive sphere. Its value is not merely its association with infertility but the characteristic combination of pelvic and constitutional features.

Important Materia Medica features include pelvic bearing-down, a sense that the pelvic organs may descend, characteristic menstrual disturbances, leucorrhoea, sexual aversion or reduced sexual interest, exhaustion and an altered emotional relationship with loved ones.[3-5]

A particularly important differentiation is that the menstrual abnormality itself is not sufficient. The characteristic mental state, pelvic sensation and modalities strengthen the indication.

Lilium tigrinum

Lilium tigrinum deserves differentiation from Sepia officinalis in patients presenting with marked pelvic symptoms and characteristic emotional or sexual manifestations.

Its Materia Medica picture includes prominent pelvic pressure, uterine symptoms and a distinctive conflict between sexual impulses, emotional states and a sense of responsibility. Classical provings provide the foundation for its Materia Medica.[6]

Pulsatilla nigricans

Pulsatilla nigricans may enter the differential in menstrual and reproductive complaints when its characteristic constitutional picture is present. Variability of symptoms, thirstlessness and characteristic emotional modalities are more valuable than the diagnosis of anovulation itself.

Differentiation:

Do not equate "irregular menses + infertility" with Pulsatilla nigricans. The totality must correspond.

Lachesis mutus

Lachesis mutus becomes relevant when reproductive symptoms are associated with its characteristic mental, vascular and menstrual pattern. Particular attention should be paid to modalities and the relationship between symptoms and the menstrual cycle.

Its selection should depend on characteristic symptoms rather than menopausal or ovarian diagnosis alone.

Apis mellifica

Apis mellifica may be considered when ovarian or pelvic symptoms possess its characteristic stinging, burning, oedematous and hypersensitive quality.

Clinical pearl: "Ovarian cyst" is not a sufficient indication for Apis mellifica. The characteristic symptom complex is essential.

Agnus castus

Agnus castus has a pronounced traditional affinity for the sexual sphere. Classical Materia Medica describes profound reduction of sexual vitality, genital relaxation, impotence and characteristic reproductive symptoms in both sexes. [7]

It may therefore be important in selected male-factor presentations when the complete Agnus castus picture is present.

Aletris farinosa

A. farinosa is a valuable lesser-used remedy in the differential diagnosis of female reproductive weakness. Classical Materia Medica describes marked exhaustion, anaemia, uterine weakness, prolapse, leucorrhoea and menstrual

abnormalities [8]

Clinical pearl: Consider the remedy particularly when reproductive complaints are embedded in a picture of profound weakness and anaemic/atonic constitution.

Helonias dioica

Helonias dioica has a characteristic uterine and constitutional picture involving pelvic heaviness, uterine atony, exhaustion and characteristic mental irritability or depression. Classical sources emphasise pelvic soreness/heaviness and weakness associated with reproductive disorders.[9]

Its differentiation from Aletris farinosa and Sepia officinalis depends upon the complete constitutional picture.

Oophorinum

Oophorinum is a sarcode remedy with a historical Materia Medica association with ovarian and climacteric disorders. Clarke describes its use particularly in ovarian disease and symptoms following oophorectomy.[10]

Because its traditional evidence base differs considerably from that of well-proved polychrests, it should be treated as a specialised differential remedy, not as a routine infertility prescription.

Rare Remedies: How Should They Be Used?

The presence of reproductive symptoms in a lesser-known remedy does not automatically make that remedy suitable for infertility.

A rare remedy should be considered when:

1. The case contains characteristic symptoms strongly represented in its Materia Medica.
2. Common remedies have been carefully differentiated.
3. The repertorial result supports the possibility.
4. Materia Medica confirmation is obtained.
5. The prescription is followed objectively.

This avoids the common error of selecting rare remedies merely because the pathology appears "unusual".

Repertorisation And Materia Medica Confirmation

A practical sequence is:

Clinical diagnosis → complete case-taking → characteristic symptoms → hierarchy of symptoms → repertorisation → differential diagnosis → Materia Medica confirmation → prescription → objective follow-up.

Repertorisation should be considered a tool for analysis, not a substitute for Materia Medica.

This approach is reflected in published infertility case-series literature, in which individualised remedies were selected following repertorisation and Materia Medica confirmation.[11]

Evidence From Homoeopathic Research

The evidence base should be interpreted critically.

A prospective observational study involving 45 subfertile men reported improvement in sperm density and progressive motility following individualised Homoeopathic treatment.[12]

However, the observational design prevents firm conclusions regarding causality.

A 2022 case series described seven couples who conceived after individualised treatment, with monthly follow-up and pregnancy confirmation. [11]

Although clinically interesting, a case series without a control group cannot establish treatment efficacy.

A 2014 publication described five women with infertility who reportedly conceived following Homoeopathic treatment.[13]

Again, such evidence is hypothesis-generating rather than definitive.

Therefore, the appropriate academic position is that promising clinical observations exist, but high-quality infertility-specific evidence remains insufficient to establish Homoeopathy as an

alternative to established fertility treatment.

Clinical Management: An Integrated Model

The Homoeopathic physician should follow a patient-centred pathway:

1. Confirm infertility and establish duration

↓

2. Evaluate both partners

↓

3. Identify the major infertility factor

↓

4. Identify urgent or time-sensitive conditions

↓

5. Explain prognosis and available treatment options

↓

6. Conduct individualised Homoeopathic case-taking

↓

7. Repertorise characteristic symptoms

↓

8. Confirm the remedy in Materia Medica

↓

9. Prescribe and document potency, scale, dose and repetition

↓

10. Monitor objective outcomes

↓

11. Reassess if pregnancy does not occur

↓

12. Co-manage or refer when indicated

The WHO recommends progressively appropriate fertility care, ranging from fertility information and simpler interventions to more complex options such as IUI and IVF according to clinical circumstances.[1]

Homoeopathic treatment should therefore not delay indicated fertility treatment.

Clinical Red Flags And Referral

Early specialist referral should be considered in situations including:

- Age-related decline in reproductive potential
- Suspected bilateral tubal disease
- Severe endometriosis
- Markedly diminished ovarian reserve
- Primary ovarian insufficiency
- Severe male-factor infertility
- Significant uterine pathology
- Recurrent pregnancy loss
- Persistent infertility despite appropriate management
- Need for assisted reproductive technology

The Homoeopathic physician should also recognise that certain investigations are not routinely required in every patient. For example, ASRM does not recommend routine prolactin, laparoscopy, advanced sperm testing, immunological testing or thrombophilia testing unless clinically indicated.[2]

Follow-Up: What Should Be Measured?

A common weakness of infertility case reporting is reliance solely on subjective improvement.

Follow-up should document:

- Menstrual regularity
- Ovulatory status when indicated
- Pain and pelvic symptoms
- Sexual function
- Semen parameters when relevant

- Ultrasonographic findings when clinically appropriate
- Pregnancy test
- Clinical pregnancy
- Ongoing pregnancy
- Live-birth outcome where follow-up permits

Pregnancy alone should not be the only endpoint.

A scientifically documented case or clinical study should distinguish biochemical pregnancy, clinical pregnancy, miscarriage, ongoing pregnancy and live birth.

Future Research Directions

Future Homoeopathic infertility research should move beyond retrospective case reports.

Important research priorities include:

- Prospective cohorts
- Randomised controlled trials
- Clearly defined infertility populations
- Standardised outcome measures
- Transparent case-taking methodology
- Repertorisation documentation
- Materia Medica confirmation
- Separate analysis of male and female factors
- Time-to-pregnancy
- Clinical pregnancy rate
- Live-birth rate
- Semen parameters
- Ovulatory outcomes
- Adverse-event reporting
- Documentation of concomitant fertility treatment

Research should also clearly distinguish individualised Homoeopathy from complex or non-individualised preparations, because combining different therapeutic models can obscure interpretation.

CONCLUSION

Infertility requires a comprehensive and time-sensitive approach in which both partners are appropriately evaluated and the underlying reproductive factor is identified whenever possible.

Within such a framework, Homoeopathic individualisation may be approached through careful case-taking, identification of characteristic symptoms, repertorisation and Materia Medica confirmation. Remedies such as Sepia officinalis, Lilium tigrinum, Pulsatilla nigricans, Lachesis mutus, Apis mellifica, Agnus castus, Aletris farinosa, Helonias dioica and selected lesser-used remedies may have a place in differential Materia Medica analysis when their characteristic pictures correspond with the individual patient.

The fundamental clinical principle is that infertility is a diagnosis requiring investigation, whereas the Homoeopathic prescription is individualised according to the patient.

A responsible Homoeopathic approach should therefore integrate modern fertility evaluation, individualised Materia Medica, repertorisation, objective follow-up, patient counselling and timely specialist referral. Such integration preserves the distinctive methodology of Homoeopathy while maintaining scientific and ethical responsibility.

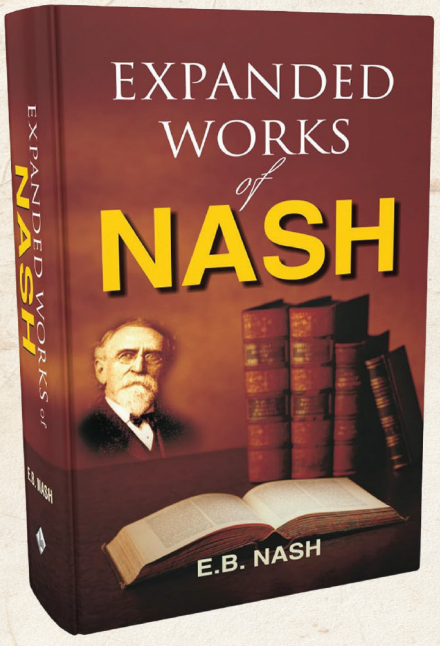
High-quality infertility-specific research is still required to determine the effectiveness, limitations and appropriate clinical role of individualised Homoeopathic treatment.

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Individualized Homoeopathic Management of Secondary infertility associated with PMOS: A Case Report with PCOSQOL Assessment

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Abstract

The article aims to present a case of secondary infertility associated with polyendocrine metabolic ovarian syndrome (PMOS), managed through an individualized homoeopathic approach.. A comprehensive case assessment was undertaken through systematic case taking, symptom evaluation, repertorial analysis, Materia Medica verification and miasmatic assessment. The patient's quality of life was evaluated using a 10-item PCOS-specific questionnaire, alongside documentation of clinical and reproductive outcomes during follow-up. The case exemplifies the application of the fundamental homoeopathic principle of individualisation and selection of the similimum on the basis of the totality of characteristic symptoms, rather than on the pathological diagnosis alone.

Keywords

Individualisation, Secondary Infertility, Polyendocrine metabolic ovarian syndrome (PMOS), PCOSQOL Questionnaire

Introduction

Definition: Infertility is defined as a failure to conceive within one or more years of regular unprotected coitus. Primary infertility denotes those patients who have never conceived. Secondary infertility indicates previous pregnancy but failure to conceive subsequently.

Amongst infertile women, about 20% infertility is attributed to anovulation caused by PCOS/PMOS. The condition was traditionally known as polycystic ovary syndrome (PCOS). It was reconsidered because the disorder extends beyond ovarian morphology and has important endocrine and metabolic manifestations. Following an international consensus process, PMOS was proposed as the new name in 2026.

PMOS is a common endocrine and reproductive disorder affecting women of reproductive age, associated with reproductive, metabolic and psychological manifestations and affects approximately 10–13% of reproductive-aged women globally. It is now proved that insulin resistance with resultant hyper insulinaemia initiates PMOS in 50–70% cases, though hypothalamic–pituitary–ovarian axis and adrenal glands are also involved to some extent.

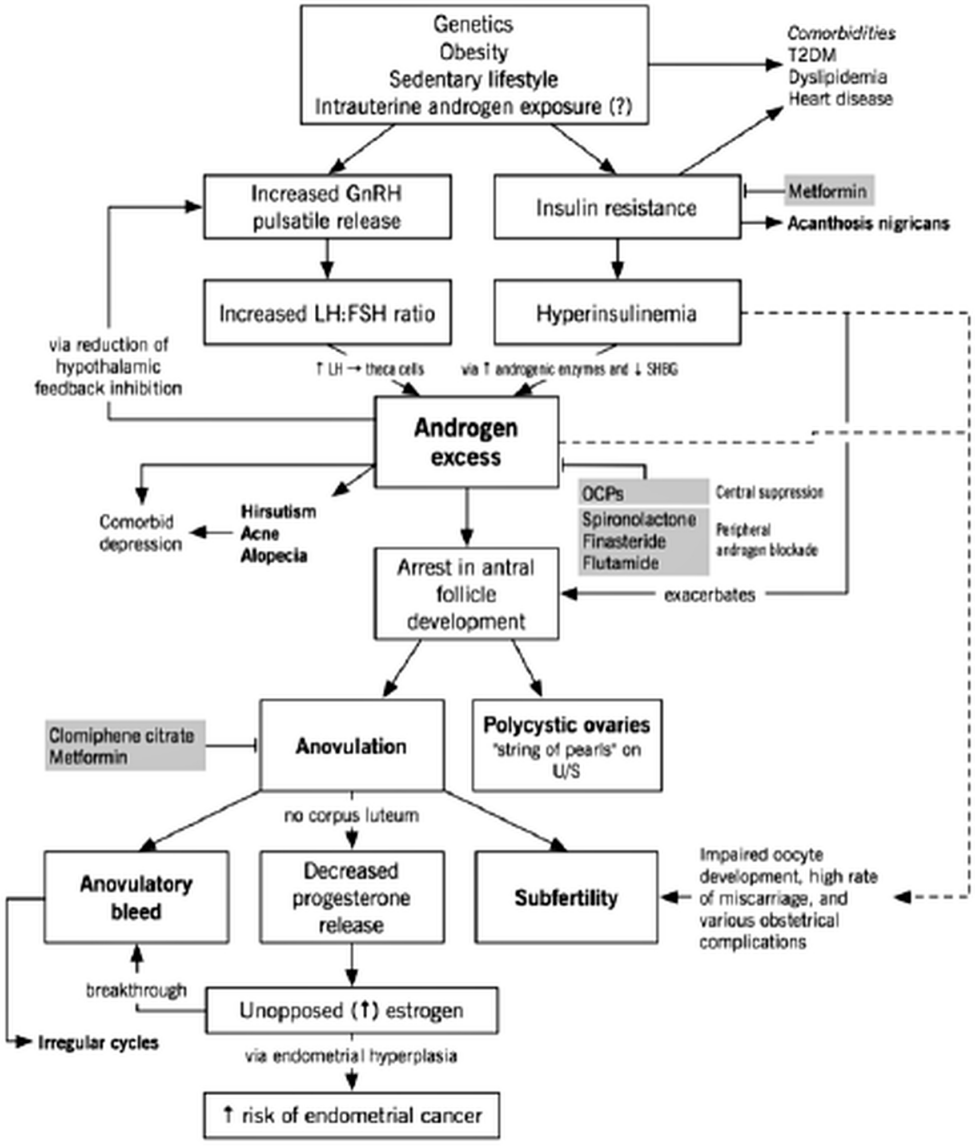
Clinically, these abnormalities manifest as ovulatory dysfunction, menstrual irregularity, and infertility, endorsing the explicit inclusion of ovarian in the new nomenclature. Other features of the condition, such as psychological and dermatological changes, are important but are largely secondary to endocrine changes, and these terms were not supported for inclusion in the new name.

PMOS-related quality of life was assessed using a 10-item questionnaire, is rated on a 7-point scale. Higher scores indicated better quality of life. It assessed PCOS impact, body image, fertility concerns, and menstrual irregularity before and after intervention.

Aetiology of female Infertility:

S no.	Causes:	Pathology
1.	Vaginal/ coital factors	Vaginal atresia, transverse vaginal septa, narrow introitus, Dyspareunia,
2.	Cervical factors.	Congenital elongation of the cervix, Uterine prolapse, pinhole os, cervical polyps, Infections, Anti sperm antibodies
3.	Uterine causes	Fibroids, Asherman's Syndrome, Genital Tb, Congenital Malformations, Polyp
4.	Tubal factors.	PID, Salpingitis, Tubal Endometriosis, Previous Tubal Surgery, Polyps
5.	Ovarian / Ovulatory factors	PMOS, Luteal Phase Defect, Luteinized Unruptured Follicle Syndrome, Decreased Ovarian Reserve, Oocyte Maturation Defects
6.	Peritoneal causes.	Peri tubal, intratubal adhesions, pelvic endometriosis
7.	General, Hormonal & Combined Factors	Advanced Maternal Age, Endocrine Disorders Obesity or marked underweight, stress, heavy smoking, alcohol, DM.
8.	Unexplained Infertility	Normal reports but no conception

Pathphysiology of PMOS:



Criteria for PMOS/PCOS:

Framework	Diagnostic Criteria
Rotterdam Criteria *(Diagnosis requires at least 2 out of 3 criteria)*	Oligo- and/or Anovulation Hyperandrogenism Polycystic Ovaries on USG
Ultrasonographic Morphology (TVS)	Follicle Count & Size Arrangement Ovarian Volume
Biochemical & Endocrine Profile	LH: FSH Ratio Serum Total Testosterone SHBG Insulin Resistance 17-OHP AMH

Miasmatic Background:

	PSORA	SYCOSIS	SYPHILIS	TUBERCULAR
	Functional disturbance of ovaries and uterus, amenorrhea of functional origin	Inflammation, cystic degeneration of ovaries and fallopian tube etc. tumor formation of ovaries and fallopian tube etc. PMOS		Symptoms associated with bleeding disorders.
Menses	Bland, scanty, too short and the flow is intermittent. Amenorrhea. Watery menses. Menses are slow in setting in after puberty and may appear one or more times and then cease for several months or even for a year before returning. Retarded, protracted menses and of short duration.	Acrid, excoriating, with burning in the pudendum and flow is accompanied by pain. Odor of fish-brine, and the stain of the blood is difficult to wash off. abundant and painful.	Profuse menstrual flow, acrid and offensive, metallic odor. Irregular periods in quantity & frequency.	Exhaustive, prolonged, and copious, every 2 weeks, profuse, bright red menses with clots. Patient feels poorly a week before menstruation starts. long lasting flow
Pain	Dysmenorrhea at puberty with sharp pains.	Spasmodic, colicky and paroxysmal pains.	Menses with bone pains and lumbago	May not be painful but always exhaustive .
Discharges	Bland and scanty	Acrid, painful, and with pruritic. Blood is offensive, clotted, and stringy, clots are large and dark. Profuse.	Acrid, putrid and offensive	Flow is watery, long lasting and rarely offensive, profuse, blood tinged or hemorrhagic with clots
Face	Face dry, itching pimple and simple acne.	Face pale, bluish and dropsical	Hard acne	Bloated appearance of face, especially after sleep
Infertility	Impotency and sterility from lack of sexual desire, without any organic defect in the sexual parts	Incapability to conceive due to hormone imbalance. Sterility and infertility result from PID and endometriosis	Failure to ovulate, resulting in infertility.	Infertility results from prolonged menstrual bleeding.
Skin	Pimples with dryness and scurfy scales	Skin hyperpigmentation, patchy or diffuse; oily skin.	Depigmentation of the skin	

CASE REPORT

Date: 10-04-2024

ICD 11 – 5A80.1 -GA31.1

Presenting Complaints:

A 28-year-old female homemaker from Anand, presented with secondary infertility despite having having a child of 3 years of age. She presented with irregular, delayed menses for 1 year with cycles every 40-60 days and occasional skiiping for 1-2 months. Menses were scanty, black, with clots (+2) and lasted 2 days instead of the previous 5 days. She experienced severe abdominal pain (+3) during the first 2 days, requiring analgesics. She also reported fluctuating moods (+2) and decreased sexual desire (+3)

Associated complaint:

- Hair fall since 2 years (+2).
- Acne on face and back since 6 – 7 months with scarring and pus (+1)
- Nausea since 6-7 months particularly after waking up in the morning and after tea consumption.(+3)

Gynecological History:

Menarche: 13 years of age

LMP – 20/03/2024

Obstetrics History:

G3 P1 L1 A2

P1 – FTNVD of male, 2021, had PPH after 2 hours of delivery. Hb was 6 g/dL and blood was transfused.

A1 – MTP at 2 months of pregnancy, 2.5 years ago, managed medically.

A2 – Spontaneous Abortion in January 2023, after which the alteration in her menstrual pattern was observed. UPT was Negative.

Physical Generals:

Appetite	Adequate, 3 meals/day, Veg
Thirst	Markedly increased (+3); drinks normal water, 2.5l/day
Desire	Hot food, Sweets
Urine	7-8 times/day
Stool	1-2 time/day
Perspiration	Normal.
thermals	Hot Patient
Sleep	On the back, 6-7 hours, sound sleep.

Past history:

Recurrent fever once monthly in childhood, took allopathic medicines

Chickenpox at10 yrs of age, allopathic treatment.

Premature greying of hair since 12 yrs of age, black hairs appeared after marriage.

Life space and Mentals:

The patient is the second daughter-in-law in her family. She is irritable when frequently advised, becomes angry when contradicted but suppresses her anger toward elders, and takes it out on her son by hitting him. She has frequent conflicts with her elder sister-in-law due to excessive household responsibilities. She finds it difficult to express herself to her dominating husband and desires company.

General Examination

Ht : 154cm Wt : 58 Kg BMI : 24.5 Kg/m2

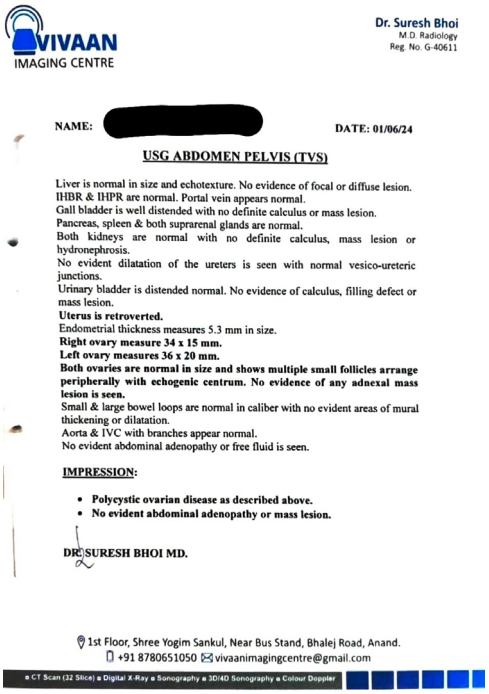
PR : 84/min BP : 110/74 mmHg T : 98.6 F

Lab investigations:

USG Abd Pelvis (TVS) and hormonal panel was advised. The patient declined to undergo the blood tests at that time.

Diagnosis:

USG Reports - 1/6/2024 shows polycystic ovarian morphology.



VIVAAN IMAGING CENTRE

Dr. Suresh Bhoi
M.D. Radiology
Reg. No. G-40611

NAME: [redacted] DATE: 01/06/24

USG ABDOMEN PELVIS (TVS)

Liver is normal in size and echotexture. No evidence of focal or diffuse lesion.
IHBR & IHPR are normal. Portal vein appears normal.
Gall bladder is well distended with no definite calculus or mass lesion.
Pancreas, spleen & both suprarenal glands are normal.
Both kidneys are normal with no definite calculus, mass lesion or hydronephrosis.
No evident dilatation of the ureters is seen with normal vesico-ureteric junctions.
Urinary bladder is distended normal. No evidence of calculus, filling defect or mass lesion.
Uterus is retroverted.
Endometrial thickness measures 5.3 mm in size.
Right ovary measure 34 x 15 mm.
Left ovary measures 36 x 20 mm.
Both ovaries are normal in size and shows multiple small follicles arrange peripherally with echogenic centrum. No evidence of any adnexal mass lesion is seen.
Small & large bowel loops are normal in caliber with no evident areas of mural thickening or dilatation.
Aorta & IVC with branches appear normal.
No evident abdominal adenopathy or free fluid is seen.

IMPRESSION:

- **Polycystic ovarian disease as described above.**
- **No evident abdominal adenopathy or mass lesion.**

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CT Scan (32 Slice) Digital X-Ray Sonography 3D/4D Sonography Colour Doppler

Analysis and evaluation BY KENTIAN METHOD

Symptoms	Classification	Grade
Desire company	Mentals will	3
Anger suppressed	Mentals emotion	2
Anger from contradiction	Mentals emotion	1
Ailments from domination	Mentals characteristic	1
Hot patient	Physicals	2
Loss of sexual desire	Physical characteristic	1
Desire sweets	Physicals	2
Thirsty	Physicals	2
Sleep position back	Physicals	3
Menses irregular	Physical particular	2
Menses scanty	Physical particular	2
Menses black with clots	Physical particular	1
Nausea - waking in morning, drinking tea	Physical particular	1
Acne- face, back, leaving scars	Physical particular	3
Hair fall	Physical particular	2
Mood swings during menses	Physical particular	3

Miasmatic evaluation:

Fundamental Miasm: Sycosis

Dominant Miasm: Psora -Sycotic

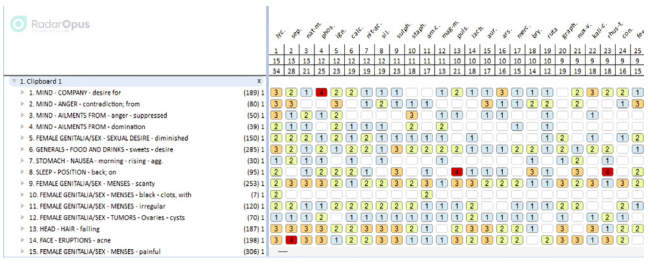
Reasons:

1. Incapability to conceive
2. Abdominal pain during 1st 2 days of menses
3. Loss of sexual desire
4. Premature greying of hairs

Totality of Symptoms:

1. Anger from contradiction
2. Anger suppressed
3. Ailments from domination
4. Desire company
5. Hot Patient
6. Desire sweets
7. Thirsty
8. Nausea < waking up in the morning, drinking tea
9. Loss of sexual desire
10. Acne on back and face
11. Abdominal pain during 1st 2 days
12. Menses – irregular, scanty, black in color with clots.

Repertorial Totality (using Radar Opus Software)



RadarOpus

1 Clipboard 1

1. MIND - COMPANY - desire for (189) 1
2. MIND - ANGER - contradiction; from (80) 1
3. MIND - AILMENTS FROM - anger - suppressed (50) 1
4. MIND - AILMENTS FROM - domination (39) 1
5. FEMALE GENITALIA/SEX - SEXUAL DESIRE - diminished (150) 1
6. GENERALS - FOOD AND DRINKS - sweets - desire (285) 1
7. STOMACH - NAUSEA - morning - rising - agg. (30) 1
8. SLEEP - POSITION - back; on (95) 1
9. FEMALE GENITALIA/SEX - MENSES - scanty (253) 1
10. FEMALE GENITALIA/SEX - MENSES - black - clots, with (7) 1
11. FEMALE GENITALIA/SEX - MENSES - irregular (120) 1
12. FEMALE GENITALIA/SEX - TUMORS - Ovaries - cysts (70) 1
13. HEAD - HAIR - falling (187) 1
14. FACE - ERUPTIONS - acne (198) 1
15. FEMALE GENITALIA/SEX - MENSES - painful (306) 1

Remedy selection: Lycopodium Clavatum

Remedy Justification:

Lycopodium clavatum was selected based on the totality of symptoms including desire company, ailments from domination, anger from contradiction, desires sweets and hot food, menses irregular, scanty, black with clots. The patient also has a past history of premature greying of hair.

Prescription: Lycopodium 200 single dose stat in globules (4 pills)

SL for 15 days

Advise: Eat home cooked meals and include high fiber in diet.

Walk Daily for 45 minutes.

Follow up:

Date	Complaint	Prescription
1st Follow up on 25-04-2024	LMP - 22-04-2024, more mood swings and irritability.	Rx SL BD 15 Days
2nd Follow up on 20-05-2024	Acne and Nausea reduced	Rx SL BD 15 Days
3rd Follow up on 15-06-2024	LMP- 24-05-2024 Acne on face and back reduced, Mood swings better Nausea Reduced	Rx SL BD 15 Days
4th Follow up on 30 -06-2024	No Menses yet, no nausea, Acne reduced. Skin became clearer. Hair fall has also decreased.	Rx SL BD 15 Days Advised UPT
5th Follow up on 15-07 - 2024	Slight breast tenderness and Nausea on waking up in the morning	Rx SL BD 15 Days UPT was positive on 06-07-2024. Patient was advised to visit a gynecologist for USG.

PCOSQOL QUESSTIONAAIRE

Before treatment

Fig.1 PCOSQOL rating is 3

PCOSQOL (Polycystic Ovary Syndrome Quality of Life) Questionnaire

Name [redacted] Age: [redacted] Date: 10/04/2024

Questionnaire

Please indicate how often you experienced each of the following issues over the past 4 weeks.

Item No.	Question	Rating (1–7)
1	I feel unhappy about my body weight.	7
2	I feel embarrassed about excess hair on my body.	7
3	I feel anxious or depressed.	2
4	I feel my PCOS is affecting my chances of becoming pregnant.	1
5	I worry about my irregular periods.	1
6	I avoid social situations due to my PCOS symptoms.	4
7	I feel unattractive because of my skin/acne problems.	3
8	I feel less confident in relationships.	2
9	I feel frustrated with managing my PCOS symptoms.	1
10	I struggle to cope with my emotions due to PCOS.	2

B.T. = $\frac{7+7+2+1+1+4+3+2+1+2}{10} = \frac{30}{10} = 3$

After treatment

Fig. 2 PCOSQOL rating is 6.2

PCOSQOL (Polycystic Ovary Syndrome Quality of Life) Questionnaire

Name [redacted] Age: [redacted] Date: 15/07/2024

Questionnaire

Please indicate how often you experienced each of the following issues over the past 4 weeks.

Item No.	Question	Rating (1–7)
1	I feel unhappy about my body weight.	7
2	I feel embarrassed about excess hair on my body.	7
3	I feel anxious or depressed.	5
4	I feel my PCOS is affecting my chances of becoming pregnant.	6
5	I worry about my irregular periods.	7
6	I avoid social situations due to my PCOS symptoms.	7
7	I feel unattractive because of my skin/acne problems.	6
8	I feel less confident in relationships.	6
9	I feel frustrated with managing my PCOS symptoms.	5
10	I struggle to cope with my emotions due to PCOS.	6

A.T = $\frac{7+7+5+6+7+7+6+6+5+6}{10} = \frac{62}{10} = 6.2$

Interpretation

Score Range	Interpretation
1.0–2.9	Severe QOL impairment
3.0–4.9	Moderate impact
5.0–6.4	Mild disturbance
6.5–7.0	Minimal or no impact

Figure 3: UPT showing a positive result on 20 July 2024.

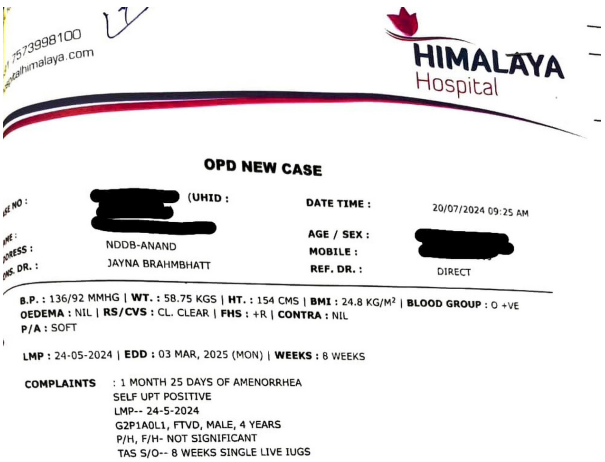
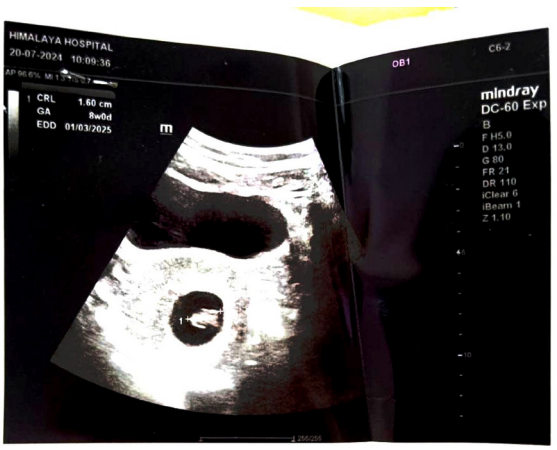


Fig. 4: Transvaginal USG of 20.7.2024 demonstrating a single intrauterine gestational sac with a yolk sac and a visible fetal pole, consistent with an early intrauterine pregnancy



RESULT:

Progressive clinical improvement was observed during the three-month follow-up period. After receiving Lycopodium clavatum, on 22/04/2024 patient experienced her regular menses with gradual improvement in acne, mood swings and nausea. Simultaneously, PCOSQOL score increased to 6.2 from 3.0 on 15/07/2024, and her UPT came positive. Considering the positive finding, on 20/07/2024 her USG revealed one month and twenty-five days of pregnancy.

DISCUSSION

The present case highlights the role of individualized homoeopathic prescribing in secondary infertility due to PMOS. Lycopodium clavatum was selected on the basis of characteristic symptom totality. A single-dose Lycopodium was given, with no repetition, according to Organon principles and follow-up continued with S.L. A favorable reproductive outcome was subsequently documented.

CONCLUSION

The case suggests that individualized homoeopathic intervention was associated with clinical improvement of PMOS symptoms ending with pregnancy. Objective assessment using the PCOSQOL Questionnaire supported the observed response. Further controlled studies are required to evaluate these findings in a larger population.

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Homeopathic Approach in Cases of Infertility

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Introduction

Infertility is an important reproductive-health problem affecting individuals and couples worldwide. The World Health Organization (WHO) defines infertility as the failure to achieve pregnancy after 12 months or more of regular, unprotected sexual intercourse. It may be classified as primary infertility, when pregnancy has never occurred, or secondary infertility, when pregnancy has occurred previously. Infertility may arise from female factors, male factors, combined factors or remain unexplained. WHO emphasizes that infertility should be appropriately prevented, diagnosed and treated through evidence-based reproductive healthcare.[1,2]

Female infertility may be associated with ovulatory disorders, polycystic ovary syndrome (PCOS), endometriosis, tubal obstruction, uterine abnormalities, diminished ovarian reserve and endocrine disorders. Male infertility may result from abnormalities of sperm concentration, motility or morphology, reproductive-tract obstruction, endocrine abnormalities, varicocele, genetic factors and environmental or lifestyle factors.[3,4]

Homeopathy approaches the individual through the principle of individualization and considers the totality of symptoms, constitutional characteristics, mental and emotional features, menstrual and reproductive history, modalities and associated complaints. In the context of infertility, this approach may be used by some practitioners as a complementary form of care. However, infertility requires appropriate medical investigation, and homeopathy should not replace established fertility treatment.

Homeopathic Perspective in Infertility

The classical homeopathic approach does not consider infertility merely as an isolated disease. The physician attempts to understand the individual patient as a whole and evaluates reproductive symptoms along with general and constitutional characteristics.

In traditional homeopathic practice, medicines such as Sepia, Pulsatilla, Lachesis, Natrum muriaticum, Folliculinum, Sabal serrulata and others have been discussed in relation to female or male reproductive complaints. Their selection, according to classical homeopathic principles, is based on individual symptom similarity rather than simply on the diagnosis of infertility.

For example, menstrual irregularities, dysmenorrhoea, changes in libido, vaginal symptoms, emotional characteristics and constitutional features may be considered during case analysis. However, these traditional indications should not be interpreted as evidence that a particular homeopathic medicine is capable of correcting a specific anatomical or physiological cause of infertility.

Some of the suggestive group of medicine with their indication-

1. Folliculinum

   Source: An ovarian follicular hormone preparation used in homoeopathic practice.

   Traditional indications:

   Menstrual irregularities associated with hormonal complaints.

   Premenstrual symptoms.

Heavy or prolonged menstrual bleeding.

Menopausal complaints, including hot flushes.

Symptoms traditionally described as occurring between ovulation and menstruation.

Reproductive complaints associated with a history of hormonal medication.

2. Aristolochia clematitis

Source: Birthwort. Indications:

Certain menstrual complaints.

Symptoms similar to pulsatilla, sepia and arnica.

Climacteric or menopausal symptoms.

Selected traditional indications involving wounds and ulcers.

3. Oophorinum

Source: An ovarian tissue-derived preparation described in homoeopathic materia medica and organotherapy literature.

Traditional indications:

Menstrual disturbances.

Ovarian complaints described in organotherapy.

Symptoms attributed traditionally to ovarian functional disturbances.

Oophorinum is sometimes discussed in connection with ovarian insufficiency and infertility. However, there is insufficient reliable clinical evidence to conclude that it improves ovarian reserve, ovulation, or pregnancy rates.

4. Luteinum

Source: A preparation associated with the corpus luteum or progesterone-related hormonal concepts in some homoeopathic literature.

Traditional indications:

Menstrual irregularities.

Reproductive complaints traditionally associated with luteal function.

Symptoms described in relation to the menstrual cycle.

Luteinum should not be confused with prescribed progesterone. It is not an established substitute for progesterone treatment when that treatment is clinically indicated.

5. Ustilago maydis

Source: Corn smut.

Traditional indications:

Congestive passive or slow bleeding or in clots blood dark but watery.

Heavy or prolonged menstruation.

Hypertrophy of uterus, sub-involution.

This remedy is more relevant to the study of abnormal uterine bleeding than to infertility itself. Heavy menstrual bleeding requires assessment for structural, hormonal, and other medical causes.

6. Thlaspi bursa-pastoris

Source: Shepherd's purse.

Traditional indications:

Heavy menstrual bleeding.

Irregular uterine bleeding.

It removes the ill effects of suppression of haemorrhage or vaginal discharges from uterus.

The medicine is traditionally associated with bleeding symptoms, not with proven restoration of fertility.

7. Sabina

Scientific name: Juniperus sabina.

Traditional indications:

Uterine bleeding between periods with sexual excitement.

Menstrual complaints.

Pain from sacrum to pubis.

These indications do not establish an effect on conception. Suspected pregnancy with bleeding or pelvic pain requires prompt medical evaluation.

8. Helonias dioica

Source: False unicorn root.

Traditional indications:

Haemorrhage from atony of dark foul blood.

Uterus heavy sore tender ulcerated or prolapsed or other malpositions.

Symptoms traditionally associated with reproductive weakness and fatigue.

It is sometimes mentioned in traditional literature concerning female reproductive complaints.

9. Aletris farinosa

Source: Star grass or true unicorn root.

Traditional indications:

Menstrual irregularities.

Pelvic discomfort.

Reproductive complaints traditionally associated with fatigue and weakness.

Its remedy for anaemic, debilitated, relaxed females who always feel tired and suffer from prolapses, leucorrhoea, rectal distress.

10. Viburnum opulus

Source: Cramp bark.

Traditional indications:

Painful menstruation.

Menstrual cramping.

Certain pelvic discomfort complaints.

Uterine pains extend around the pelvis often extending down the thigh.

11. Cimicifuga racemosa

Synonym: Actaea racemosa.

Traditional indications:

Painful menstruation.

Pelvic discomfort.

Menstrual symptoms associated with muscular or neuralgic pain.

12. Caulophyllum thalictroides

Source: Blue cohosh.

Traditional indications:

Violent, intermittent, cramping pains, with little flow; dysmenorrhoea.

Many of the complaints are due to uterine disorders.

In labour the pains are weak or irregular, they cease from exhaustion or they are too painful.

It should not be recommended to induce labour or manage pregnancy-related conditions without appropriate obstetric supervision. It has no established role in improving conception rates.

Comprehensive Evaluation of the Infertile Couple

A major principle of responsible infertility care is evaluation of both partners. Male factors contribute substantially to infertility, and current reproductive-medicine guidelines recommend that assessment of the male partner should occur concurrently with evaluation of the female partner. [3,4]

A detailed history should include the duration of infertility, frequency and timing of intercourse, previous pregnancies and pregnancy outcomes, menstrual history, ovulatory symptoms, previous pelvic infections or surgery, contraceptive history, sexual dysfunction, medications, occupational exposures and lifestyle factors.

Female evaluation may include assessment of ovulation, ovarian reserve when clinically indicated, uterine anatomy and tubal patency. Male

evaluation generally includes reproductive and medical history and semen analysis. The American Society for Reproductive Medicine recommends systematic and timely evaluation, with earlier assessment in women with risk factors for infertility and in women of increasing reproductive age.[3]

Diagnostic investigations for infertility are tailored to the individual, but generally involve a combination of hormonal blood tests and structural or functional assessments. It is important to note that "normal" reference ranges can vary significantly between different laboratories and testing methods.

Male Infertility:

Semen Analysis

A semen analysis is the cornerstone of male fertility evaluation. It assesses several key parameters. Followings are common reference values based on World Health Organization (WHO) standards, though laboratories may use slightly different thresholds.

Parameter	Common Normal Reference Value
Volume	1.5 mL or greater
Sperm Count (Total)	39 million or more per ejaculate
Sperm Concentration	15 million or more per mL
Total Motility (Moving sperm)	40% or more (or 32% progressive motility)
Morphology (Normal shape)	4% or more

Other male fertility investigations may include blood tests to check hormone levels such as testosterone, follicle-stimulating hormone (FSH), luteinizing hormone (LH), and prolactin.

Female Infertility:

Female fertility investigations focus on ovarian reserve, ovulation, and structural anatomy.

Hormonal Blood Tests -

These tests are typically performed on specific days of the menstrual cycle (often Day 2–5):

Anti-Müllerian Hormone (AMH): Used to estimate the size of the remaining egg supply (ovarian reserve). Values vary by age and lab.

Follicle-Stimulating Hormone (FSH) & Estradiol (E2): Checked early in the cycle to assess ovarian function. High FSH levels can sometimes indicate a diminished ovarian reserve.

Thyroid Stimulating Hormone (TSH): Evaluates thyroid function, as thyroid imbalances can affect ovulation and fertility.

Prolactin: High levels can interfere with ovulation.

Structural/Functional Assessments -

Transvaginal Ultrasound: Used to visualize the uterus and ovaries and count antral follicles (another marker of ovarian reserve)

Hystero-salpingogram (HSG): An X-ray procedure that uses contrast dye to check if the fallopian tubes are open and to examine the shape of the uterine cavity.

Homeopathic physician should therefore recognize situations requiring referral to a gynaecologist, reproductive-medicine specialist, urologist or infertility centre.

Areas of Complementary Support

A homeopathic physician may provide an opportunity for detailed patient counselling and attention to emotional and psychosocial aspects of infertility. Infertility can be associated with anxiety, depression, marital stress, social pressure and reduced quality of life. Psychological support and patient-centred communication are therefore important components of comprehensive fertility care.[5]

Lifestyle counselling is another important component. Maintenance of a healthy body weight, regular physical activity, balanced nutrition, adequate sleep and avoidance of tobacco and excessive alcohol are relevant to reproductive health. Preconception counselling should also address medications, occupational exposures and other potentially modifiable risk factors.[6,7]

It is important, however, to distinguish supportive care from treatment of the underlying cause.

Lifestyle measures and emotional support cannot substitute for treatment of conditions such as bilateral tubal obstruction, severe endometriosis, premature ovarian insufficiency or severe male-factor infertility.

Homeopathy and the Evidence Based-

The scientific evidence supporting homeopathy in infertility remains limited and inconclusive. Although individual studies and observational reports have suggested possible benefits in particular reproductive conditions, methodological limitations, small sample sizes and lack of adequately controlled trials prevent firm conclusions regarding its effectiveness in achieving pregnancy or live birth.

Systematic reviews of homeopathy more broadly have also reported insufficient reliable evidence to establish homeopathy as an effective treatment for specific medical conditions.[8,9] The U.S. National Center for Complementary and Integrative Health (NCCIH) states that there is little evidence supporting homeopathy as an effective treatment for any specific health condition.[9]

Therefore, claims that homeopathy can reliably restore ovarian reserve, open blocked fallopian tubes, correct major anatomical abnormalities or replace assisted reproductive technologies should be avoided.

Role of Conventional Fertility Care -

Modern infertility management depends on the underlying cause. Depending upon the diagnosis, treatment may include ovulation induction, treatment of endocrine disorders, surgical correction of selected abnormalities, intrauterine insemination (IUI), in-vitro fertilization (IVF), intracytoplasmic sperm injection (ICSI), donor gametes or other assisted reproductive techniques.[1,2,10]

The WHO's current infertility guideline provides evidence-based recommendations covering evaluation and treatment of ovulatory dysfunction, tubal disease, uterine disorders, male-factor infertility and unexplained infertility.[1]

If a patient chooses homeopathy as a complementary approach, communication between healthcare providers is desirable. The patient should be encouraged to continue appropriate investigations and not postpone interventions for which there is established evidence of benefit.

Safety and Ethical Considerations

Safety is particularly important in infertility because patients may become pregnant while treatment is continuing. Practitioners should document all medicines, supplements and other therapies being used. Some products marketed as homeopathic may contain measurable amounts of active ingredients and may cause adverse effects or interactions.[9]

Ethical practice requires practitioners to communicate honestly about the strength and limitations of available evidence. Patients should not be given unrealistic assurances regarding conception. Early referral is particularly important in women aged 35 years or older, women with irregular or absent menstruation, suspected endometriosis or tubal disease, and couples with known male-factor infertility.[3,11]

CONCLUSION

The homeopathic approach to infertility emphasizes individualization, holistic assessment, detailed case-taking and attention to physical, emotional and lifestyle factors. It may provide a patient-centred and supportive framework for individuals who choose complementary care.

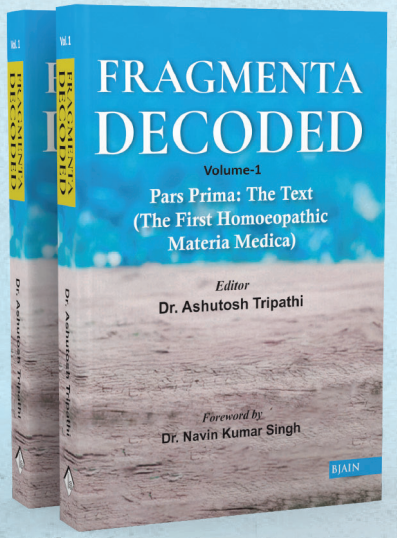
Nevertheless, infertility is a multifactorial reproductive disorder requiring systematic evaluation of both partners. Current evidence does not establish homeopathy as an effective standalone treatment capable of reliably increasing pregnancy or live-birth rates. Consequently, homeopathy, when used, should be presented as a complementary approach rather than a substitute for evidence-based infertility diagnosis and treatment.

An ethically appropriate approach combines individualized patient care, psychological and lifestyle support, appropriate investigations, timely referral and evidence-based fertility management. Such integration can respect patient preferences while maintaining scientific integrity, reproductive safety and the best interests of the patient.

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Management of Corns with Antimonium Crudum: A Clinical Observation



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Abstract

Corns are the localised hyper-keratotic lesions commonly caused by repeated friction and pressure over bony prominences of the feet. They are often associated with pain, difficulty in walking, and recurrence after mechanical removal. Conventional treatment usually includes paring, keratolytic agents, or surgical intervention, which may provide only temporary relief. Homoeopathy offers an individualised and non-invasive therapeutic approach for such conditions.

Keywords

Hyperkeratosis, Callosity, Acanthosis, Parakeratosis

Introduction

A corn, medically referred to as **clavus, heloma,** or **focal intractable plantar hyperkeratosis,** is a localised area of excessive skin thickening that develops in response to repeated pressure or friction. It represents a distinct form of callosity characterised by a well-circumscribed, hyperkeratotic lesion of the skin.

Corns differ from calluses in that calluses are generally broader and more diffuse, whereas corns are smaller, clearly defined, and concentrated over specific pressure points. These lesions can cause significant discomfort and pain, particularly during standing and walking.

The condition commonly affects individuals who experience abnormal mechanical stress on the feet, such as athletes, people wearing poorly fitting footwear, and those with gait abnormalities. Corns are also frequently observed in older adults, individuals with diabetes mellitus, and amputees due to altered pressure distribution and increased frictional forces on the skin.

- This case highlights the successful homoeopathic management of a painful corn on the left ring toe with Antimonium crudum.

Case Presentation :

Corn on Left Ring Toe Successfully Treated with Antimonium crudum

Patient Information

A male patient presented with the complaint of a painful corn on the left ring toe for the past 3 months.

The patient stated that he initially noticed a small, hard corn on the left ring toe. After watching YouTube videos, he attempted to remove the corn himself with a knife. The corn temporarily reduced, but after 15–20 days it reappeared.

The patient again attempted to remove the corn using a knife. During this attempt, the injury became deeper and resulted in bleeding from the toe. He managed the wound temporarily by applying a bandage.

On the following day, he visited a nearby medical store and informed the pharmacist about his complaint. He was advised to use a corn cap regularly until recovery. The patient used the corn cap, and although the wound healed, the corn remained unchanged and continued to cause pain

while walking.

Later, the patient consulted for homoeopathic treatment.

Clinical Findings:

On examination, a single hard, painful corn was present over the left ring toe. The lesion was tender on pressure and painful during walking.



No discharge, infection, or surrounding inflammation was noted at the time of consultation.

General Symptoms

The patient did not report any significant mental or physical complaints. Appetite, thirst, sleep, bowel habits, and perspiration were normal. No associated complaints were present.

Case Analysis And Repertorisation:

Since the patient presented with a single local complaint and general symptoms were normal, Repertorisation was done mainly based on the local symptoms using Boericke's Repertory.

Repertorization from Boericke's Manual of Homoeopathic Materia Medica and Repertory

Selected Rubrics

1. Corns
2. Painful hard skin eruptions
3. Thickened skin lesions/callosities

Remedy	Corns	Painful Hard Skin	Thickened Skin / Callosities	Total Score
Antimonium Crudum	3	3	3	9
Graphites	2	2	3	7
Silicea	2	2	2	6
Thuja occidentalis	2	2	2	6
Nitric Acid	2	3	1	6
Causticum	2	2	1	5
Ranunculus bulbosus	3	1	1	5
Ferrum picricum	2	1	2	5

After evaluating the characteristic features of the case, Antimonium crudum was selected as the similimum.

Antimonium Crudum — Score: 9/9

Key Indications:

- Painful corns with thick, hard skin
- Horny excrescences and callosities
- Aggravation from walking and pressure
- Marked hyperkeratosis

Therapeutic Intervention:

The patient was prescribed: Antimonium crudum

- Once daily for 7 days.

- The patient was advised:
  - » Avoid self-cutting of the corn.
  - » Avoid excessive pressure on the affected toe.
  - » Maintain proper foot hygiene.

Follow-Up And Outcome

After 4–5 days of treatment, the patient reported a significant reduction in pain while walking.

Gradually, the hardness and size of the corn reduced over the following weeks.

During subsequent follow-ups, only Saccharum lactis was given, and continuous improvement was observed without any new symptoms.

After 2 months of treatment, the corn completely disappeared, and the patient remained symptom-free.

No recurrence was reported during follow-up.

1ST IMAGE



2ND IMAGE



3RD IMAGE



4TH IMAGE



DISCUSSION

Repeated mechanical irritation and improper self-treatment may worsen corns and can lead to deeper tissue injury. In this case, repeated cutting with a knife caused bleeding and tissue trauma, while the use of a corn cap did not provide complete relief. Homoeopathic individualised treatment helped in relieving pain initially and later resulted in complete resolution of the corn.

- Antimonium crudum is known for its usefulness in thickened, horny skin, corns, and painful callosities, especially when the lesions are hard and sensitive to pressure.

Differential Comparisons:

1. Graphites
   - Thick cracked skin
   - Moist eruptions
   - Useful when corns ooze or fissure
2. Silicea
   - Deep painful corns
   - Sensitive feet
   - Tendency to suppuration
3. Thuja occidentalis
   - Wart-like overgrowths
   - Thickened, unhealthy skin
   - Sycotic tendency
4. Nitric Acid
   - Sharp splinter-like pains
   - Painful fissured corns

Clinical Conclusion

Based on the selected rubrics, Antimonium Crudum emerges as the most suitable remedy with the highest repertorial score, especially for:

- hard, painful corns,
- excessive thickening of skin,
- pressure sensitivity,
- hyperkeratotic lesions.

CONCLUSION

This case describes the effectiveness of homoeopathic medicine Antimonium crudum in the treatment of painful corn on the toe.

The patient experienced significant pain relief within a few days and complete recovery within 2 months without recurrence.

This case also emphasises the importance of avoiding self-treatment methods such as cutting

corns with sharp instruments, which may lead to injury and complications.

Suggested References

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Extremities.--Twitching of muscles. Jerks in arms. *Arthritic pain in fingers*. Nails brittle; grow out of shape. Horny warts on hands and soles. Weakness and shaking of hands in writing followed by offensive flatulence. *Feet very tender*; covered with large horny places. Inflamed corns. Pain in heels.

Skin.--Eczema with gastric derangements. Pimples, vesicles, and pustules. Sensitive to cold bathing. Thick, hard, honey-colored scabs. *Urticaria*; measle-like eruption. Itching when warm in bed. Dry skin. *Warts (Thuja; Sabina; Caust)*. Dry gangrene. Scaly, pustular eruption with burning and itching, worse at night.

Sleep.--*Continual drowsiness in old people*.

Fever.--Chilly even in warm room. Intermittent with disgust, nausea, vomiting, eructations, coated tongue, diarrhœa. Hot sweat.

Modalities.--*Worse*, in evening, from heat, acids, wine, water, and washing. Wet poultices. *Better*, in open air, during rest. Moist warmth.

2. Boericke W. Boericke's Repertory.

Sensibility, diminished -- Carbon. s.
SOLES

Blistered -- Bufo, Calc. c., Cepa.
Burning -- Anac., Apoc. andr., Arundo, Calc. c., *Calc. s.*, Canth., *Cham.*, Cupr., Ferr. m., Graph., Ign., Kreos., *Lach.*, Lachnanth., Limul., Lyc., Mang., *Med.*, Niccol. s., Petrol., Phos. ac., Puls., *Sang.*, Sanic., *Sul.*
Callosities (See Skin) -- Anac. oc., *Ant. c.*, Lyc., Ran. b., Sil.
Injury, with intolerable pain -- Hyper.
Itching -- *Agar.*, Ananth., Anthem., *Calc. s.*, *Hydrocot.*, Indium, Nat. s., Sil.
Numbness -- *Cocc.*, Limul., Raph., Sep.
PAINS -- *Apoc. andr.*, Bor., Can ind., Ferr., *Guaco*, Kali iod., *Led.*, Limul., Mur. ac., Nat. c., Petrol., Phos. ac., *Puls.*, Verbasc.

Aching -- Limul., Puls.
Cramps -- Agar., Am. c., Apoc. andr., Carbo v., *Colch.*, *Cupr.*, Med., *Nux v.*, Stront., Sul., Verbasc., Zinc.

Worse at P. M. -- Cupr., *Eug. j.*, Zing.

Walking [when] -- *Aloe*, Caust., Graph., Lyc., Mur. ac., *Petrol.*, Phos. ac.
Ulcerative, unable to walk -- Canth., Ign., Phos.

CORNS:

Etiology

The development of corns is primarily associated with chronic mechanical stress caused by repetitive friction and pressure on the skin. Several factors contribute to their formation, including poorly fitting footwear, structural abnormalities of the foot resulting in bony prominences, and activities that subject the feet to repeated trauma. Corns most frequently occur over pressure-bearing areas such as the dorsal surfaces of the toes, the interdigital spaces—particularly the lateral web spaces—and the plantar aspect of the feet.

Epidemiology

Corns are a common dermatological condition affecting individuals across various age groups, although they occur more frequently in older adults. Studies suggest that people with darker skin pigmentation may have an increased tendency to develop corns. A slight female predominance has been observed, which is often attributed to the use of narrow or constricting footwear. In the elderly population, age-related atrophy of the plantar fat pad reduces the natural cushioning of the foot, thereby increasing susceptibility to pressure-induced lesions and painful corn formation.

Pathophysiology

Corn formation represents an adaptive response of the skin to persistent mechanical irritation. Continuous pressure and friction over areas covering bony prominences stimulate excessive keratin production, resulting in localised hyperkeratosis. This thickening of the epidermis serves as a protective mechanism designed to minimise tissue damage and prevent the development of skin breakdown or ulceration. However, the accumulation of keratinised tissue may itself become painful due to concentrated pressure on the underlying structures.

Histopathology

Histopathological evaluation is generally unnecessary for the diagnosis of corns, but it may be useful in distinguishing them from other

hyperkeratotic lesions, particularly plantar warts. Microscopic examination typically reveals epidermal hyperplasia (acanthosis) involving all layers of the epidermis, along with marked thickening of the stratum corneum. Parakeratosis may be present, indicating incomplete maturation of keratinocytes. The granular layer is often reduced or absent. Changes within the dermis may include dense fibrous connective tissue, hypertrophy of nerve fibres, and extension of scar tissue into the subcutaneous layer, findings that may contribute to the tenderness associated with the lesion.

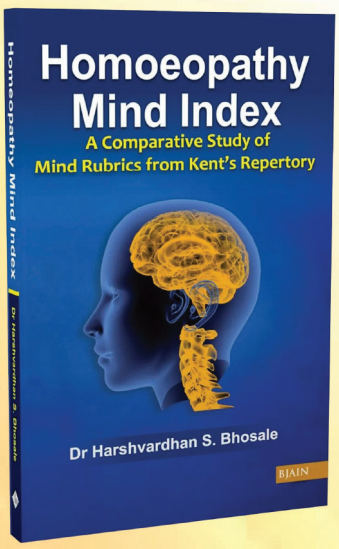
Types Of Corns:

1. **Hard Corns (Heloma Durum):** Hard corns typically develop on weight-bearing areas of the feet, such as the tops or sides of toes, and are characterised by a dense, thickened core of dead skin surrounded by a ring of inflamed tissue. They are often caused by prolonged pressure or friction and may be exacerbated by ill-fitting footwear. Antimonium crudum is beneficial for hard corns that are painful, inflamed, and aggravated by pressure.
2. **Soft Corns (Heloma Molle):** Soft corns occur between the toes, where moisture and friction combine to soften the skin and create a painful, macerated lesion. These corns are prone to infection and may cause considerable discomfort, especially during walking or other activities. Antimonium crudum helps alleviate the pain, redness, and moisture associated with soft corns, promoting healing and preventing recurrence.
3. **Seed Corns:** Seed corns are small, superficial corns that often appear on weight-bearing areas of the feet, such as the heels or balls of the feet. They are characterised by their tiny size and tenderness, which may be exacerbated by pressure or walking barefoot. Antimonium crudum can be useful for seed corns that are tender to the touch and worsened by pressure, helping to soothe discomfort and promote resolution.

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ISBN - 9788131999363

Homoeopathy Mind Index

A Comparative Study of Mind Rubrics from Kent's Repertory

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From Barren Womb To Bloom: Early Homoeopathic Management For Future Fertility

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PG Scholar - Department of Homoeopathic Materia Medica

Anand Homoeopathic Medical College & Research Institute, Anand, Gujarat

"From out of the dainty the rude, the strong from out of the frail,

Eternally through the ages from the female comes the male" [14]

Abstract

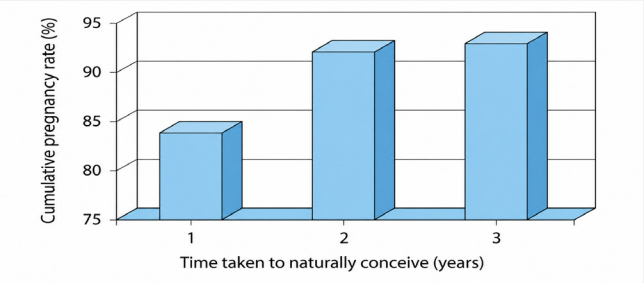
Female infertility affects nearly 15% of couples worldwide, with PCOS/PMOS being a major cause of ovulatory infertility. This review correlates common causes of infertility with homoeopathic miasmatic concepts and outlines individualized management using constitutional remedies, sarcodes, Bach flower remedies, and removal of obstacles to cure. A clinical PMOS case highlights the potential role of early homoeopathic intervention in preserving future fertility.

Keywords

Female infertility, causes, homoeopathy, organon of medicine, individualization

Introduction

Conception is the fertilization of the female ovum by a spermatozoa. Approximately 70% of couples conceive within 6 months, 80% within 1 year, and 90% within 2 years of regular, unprotected intercourse.[1] Infertility is defined as the failure to achieve pregnancy after 12 months of regular, unprotected sexual intercourse.[1] Primary infertility refers to couples who have never conceived, whereas secondary infertility refers to the inability to conceive following at least one previous pregnancy.[2]



Stress can have direct influence on hypothalamic-pituitary-ovarian (HPO) axis, interfering with regular ovulation, and indirectly reduce libido and frequency of intercourse. [3]

Epidemiology [4]–

Approximately 15% of couples worldwide experience infertility, with female factors contributing to nearly 50% of cases. Beyond reproductive health, infertility has significant psychological, social, and medical consequences, including anxiety and depression, highlighting the need for a holistic approach.

Female infertility is multifactorial. Ovulatory dysfunction accounts for 25–40% of cases, with PCOS causing nearly 70% of anovulatory infertility. Tubal factors contribute 20–35%, endometriosis 10–15%, while obesity, smoking, alcohol, and endocrine-disrupting chemicals further impair reproductive function.

Physiology And Etiology-

Sperm remain capable of fertilization for about 24 hours after ejaculation, while the ovum is viable for only 12 hours after ovulation. Therefore, fertilization occurs only if intercourse takes place around ovulation, which usually occurs 14 days

before the next menstrual period. During ovulation, the fimbriae pick up the ovum, and tubal peristalsis transports it toward the uterus. The first sperm to penetrate the zona pellucida fertilizes the ovum and prevents polyspermy. By the time the fertilized ovum reaches the uterus, progesterone has transformed the endometrium into the secretory phase, preparing it for implantation. [1]

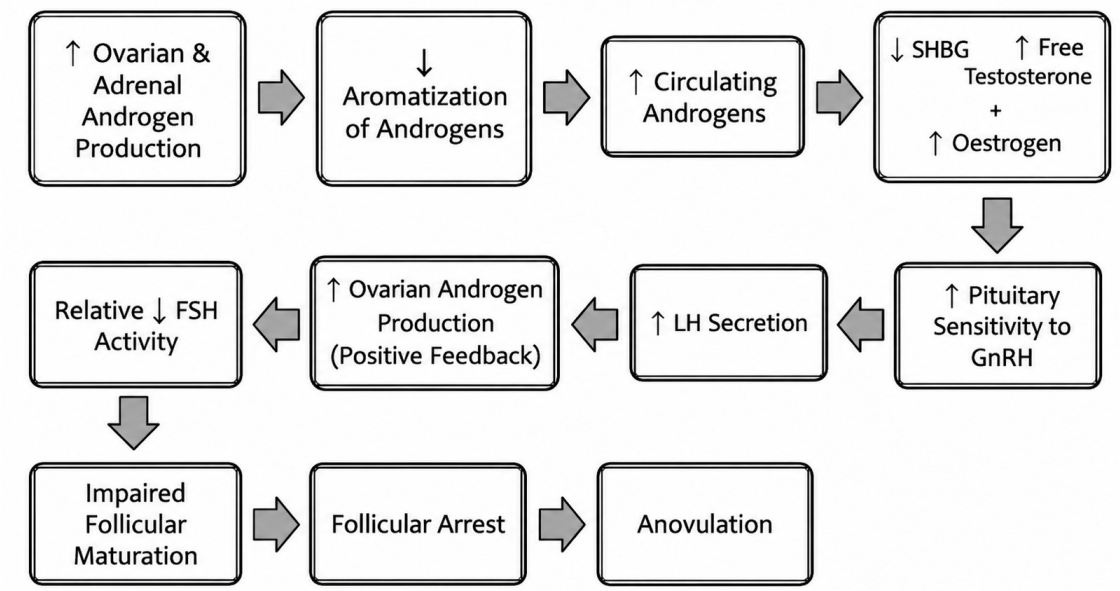
Causes-

According to FIGO manual (1990) causes are: tubal (1-10%) and uterine factors (25-35%) and Ovulatory factors (30-40%)

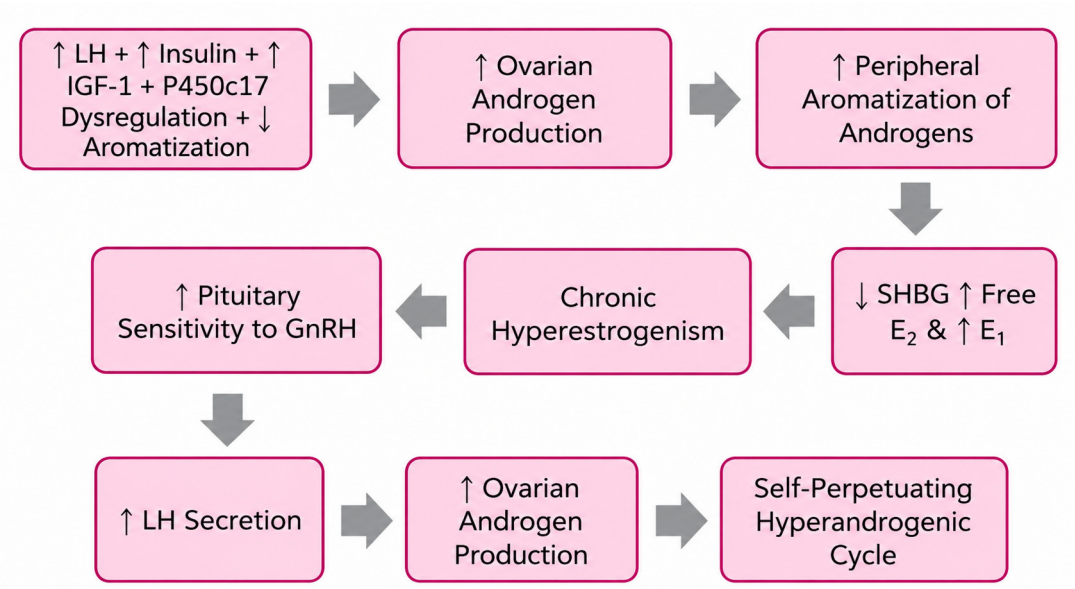
OVARIAN FACTORS-

POLYENDOCRINE METABOLIC OVARIAN SYNDROME-

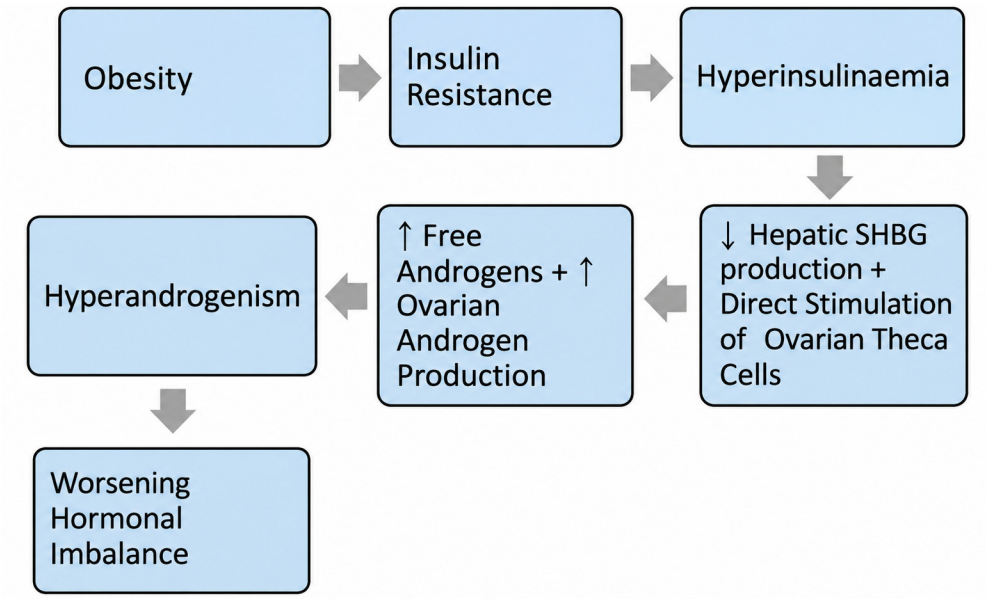
a. Hypothalamic Pituitary Compartment Abnormality and Anovulation –



b. Androgen Excess-



c. Obesity and Insulin Resistance –



Tubal Factors-

Endometriosis- Presence of the functional endometrium (glands and stroma) in sites other than uterine mucosa is called endometriosis. Endometriosis is a disease of contrast. It is a benign but it is locally invasive. Cyclic hormones regulate growth but continuous hormones suppress it.[3]

Site-

TABLE 21.1-SITES OF ENDOMETRIOSIS	
Common sites	**Rare and remote sites**
• Ovaries	• Umbilicus
• Pelvic peritoneum	• Abdominal scar
• Pouch of Douglas	• Episiotomy scar
• Uterosacral ligaments	• Lungs
• Rectovaginal septum	• Pleura
• Sigmoid colon	• Ureter
• Appendix	• Kidney
• Pelvic lymph nodes	• Arms • Legs
• Fallopian tubes	• Nasal mucosa

Uterine Factors-

- Uterine Fibroid- Fibroid is the gynaecological term for uterine leiomyoma, occasionally involving the cervix. It develops in the myometrium and forms a false capsule of compressed myometrial tissue.

- Fibroids are benign, oestrogen-dependent tumours that enlarge during pregnancy, increase with reproductive age, and regress after menopause. They may undergo degeneration due to inadequate blood supply.[3]

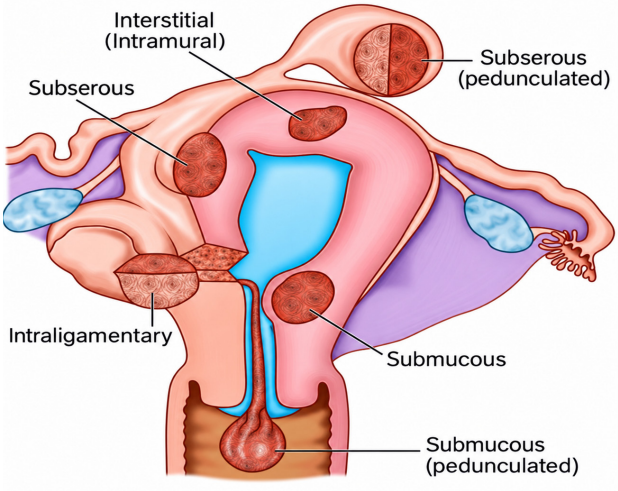
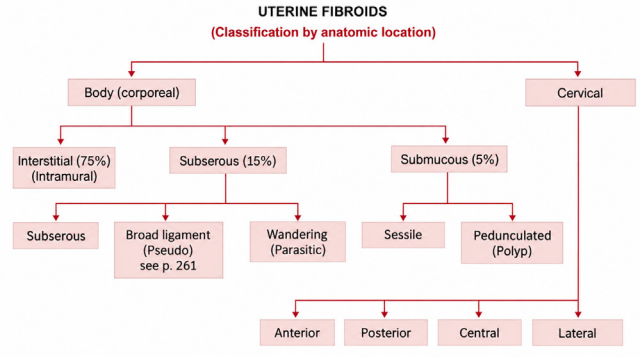


Fig. 19.1: Various types of uterine fibroids



Psychodynamic Effects-

Psychodynamic Theme (Sankaran's approach)	Possible Manifestation in Female Infertility
Unresolved grief or disappointed love	Emotional trauma suppresses the vital force, affecting reproductive function.
Conflict between desire for motherhood and fear of pregnancy	Ambivalence towards conception leading to internal conflict.
Suppressed emotions	Long-standing suppression of anger, grief, humiliation, or disappointment affecting endocrine balance.
Insecurity or fear of failure	Fear of being an inadequate mother or inability to fulfil expectations.
Emotional deprivation or lack of love	Deep longing for affection and emotional security influencing reproductive health.

Clinical Features Of-

- Menorrhagia – Classical feature of fibroid. [2]
- Acne and oily skin due to excess sebum production – PMOS.
- Progressive secondary dysmenorrhoea beginning before menses, worsening during menstruation, and persisting afterwards (co-menstrual dysmenorrhoea) – Endometriosis.[2]
- Lower abdominal pain – Fibroid. [2]
- Pain radiating to the lower back, legs, and vagina – Endometriosis. [3]
- Lower abdominal heaviness or palpable lump – Fibroid. [2]
- Polymenorrhoea/epimenorrhoea with premenstrual spotting (when ovaries are involved) – Fibroid. [2]
- Dyspareunia – Endometriosis. [1]
- HAIR-AN syndrome – Hirsutism, vertex alopecia, polydipsia, polyuria, acanthosis nigricans, and multiple skin tags – PMOS.

Investigations-

1. Estrogen- Timing range(pg/mL)

   Follicular phase= 19.5-144.2

   Periovulatory phase= 64.9-356.7

   Luteal phase= 55.8-214.2

   Postmenopausal phase= 32.2 or lower

2. Progesterone- Timing range(ng/mL)

   Follicular phase=1 or lower

   Mid-cycle= 5-20

3. Follicle Stimulating Hormone (FSH)-timings (mLU/mL)

   Follicular phase= 3.5-12.5

   Periovulatory phase= 4.7-21.5

   Luteal phase= 1.7-7.7

   Postmenopausal phase= 25.8-134.8

4. Luteinizing Hormone (LH)- timings range (IU/ml)

   Follicular phase= 1.68-15

   Mid-cycle phase= 21.9-56.6

   Luteal phase= 0.61-16.3

   Postmenopausal phase= 14.2-52.3

5. Anti-Mullerian Hormone (AMH)-Test range (ng/ml) [6]

Ages	Median serum AMH level
20-24	2,16
25–29	2,15
30–34	1,71
35–39	0,8

6. Testosterone [7]- 43.96-18.63 (pg/mL)

Age (years)	Range
15–29	1,000–5,000
30–39	600–3,500
40–49	400–2,500
>50	200–1,500

7. DHEA- Test range (ng/ml) [8]

8. Thyroid hormone-

Test	Normal Value	Unit
TSH	0.4–4.5	mLU/L
T3	80–200	ng/dL
T4	5–12	µg/dL
Free T3	2.3–4.2	pg/mL
Free T4	0.8–1.8	ng/dL

9. Prolactin- Less than 25 ng/mL

Miasmatic Interpretations [9]-

Miasm	Characteristic Pathology	Relation to Infertility	Disease Examples
Psora	Reduced vital force causing functional weakness and early miscarriages without structural abnormalities.	Functional infertility without gross structural pathology; disturbed ovulation or hormonal imbalance.	Unexplained infertility, functional anovulation, stress-related infertility.
Sycosis	Tissue overgrowth and chronic inflammation causing recurrent miscarriage.	Mechanical or proliferative causes interfering with fertilization or implantation.	PMOS, Ovarian cysts, Uterine fibroids, Endometrial polyps, Endometriosis.
Syphilis	Destruction, ulceration, degeneration, fibrosis, deformity, habitual miscarriages.	Irreversible damage to reproductive organs resulting in severe infertility.	Premature ovarian insufficiency (POI), extensive intrauterine adhesions.

Homoeopathic Approach Through Materia Medica-

Medicines	*Miasm*	*Indications*
Pulsatilla	Psora	• Delayed, scanty, suppressed or irregular menses • Menstrual flow constantly changing in character • Infertility associated with delayed ovulation/menstrual irregularity. • Mild, yielding, emotional disposition; thirstless; better in open air.
Natrum muriaticum	Psora	• Delayed or irregular menstruation • Vaginal dryness causing painful coitus • Sterility following grief, disappointment or long-standing emotional suppression • Headache associated with menses • Reserved, sensitive personality; craving for salt; aversion to consolation
Medorrhinum	Sycotic	• Ovarian cysts and enlarged ovaries • Irregular or suppressed menses • Dyspareunia with pelvic congestion • Recurrent miscarriage due to sycotic miasm.
Calcarea fluorica	Sycotic	• Infertility associated with uterine fibroids or indurated ovarian/uterine tissues • Relaxation of uterine ligaments with prolapse • Chronic pelvic weakness with tissue laxity • Varicose veins of pelvic organs accompanying infertility.
Merc sol	Syphilitic	• Recurrent pelvic inflammatory conditions with marked inflammation and ulceration. • Acrid, offensive leucorrhoea. • Cervical erosions or ulcerative lesions. • History of repeated abortions associated with septic or destructive pelvic pathology.
Syphilinum	Syphilitic	• Habitual or recurrent abortions, especially in early pregnancy. • Repeated stillbirths or fetal loss. • Congenital syphilitic history in the family.

Along with individualized homoeopathic medicines, Sarcodes may be used for predominant organ/endocrine dysfunction, while Bach flower remedies help address the emotional and psychological effects of infertility, based on the totality of symptoms.

Sarcodes	*Bach Flower Remedies* [11]
Oophorinum- Ovarian insufficiency with failure of ovulation. Menstrual irregularities associated with ovarian dysfunction.	**Aspen-** Vague, unexplained fears about conception or pregnancy. Anxiety without a known cause during infertility treatment. Apprehension regarding the future or motherhood.
Folliculinum- Irregular or absent ovulation associated with hormonal imbalance. Female infertility due to ovarian dysfunction, especially in PCOS or other ovulatory disorders.	**Pine-** Excessive guilt or self-blame for inability to conceive. Feelings of unworthiness or self-reproach. Persistent remorse after miscarriage or infertility.
Corpus luteum- Luteal phase insufficiency with inadequate progesterone support. Habitual or threatened abortion due to poor implantation.	**Gentian-** Discouragement after unsuccessful conception attempts. Loss of confidence following repeated treatment failures. Tendency to become pessimistic when progress is slow.

Homoeopathic Approach- Diet And Regimen, Obstacle To Cure- [12]

Obstacle to cure/ Diet and Regimen	*Relevant aphorisms with explanations*
Obesity or underweight	**§5** advises identifying maintaining causes such as occupation, habits, diet, lifestyle, and constitution. Abnormal body weight can impair ovulation. **§94** emphasizes detailed assessment of habits and lifestyle to detect obesity or malnutrition as obstacles to cure.
Smoking and tobacco	**§260** advises removing medicinal substances and harmful influences that interfere with cure. Hahnemann specifically warns that tobacco may hinder recovery and should be avoided when harmful.
Alcohol and recreational drugs	**§260** advises avoiding harmful stimulants and medicinal substances that hinder cure. **§261** permits only diet that does not interfere with treatment, so intoxicants should be restricted.
Chronic mental stress, anxiety, grief	**§5** directs the physician to identify exciting and maintaining causes, including emotional stress. Persistent grief, anxiety, or stress can maintain illness and delay recovery.
Poor adherence to treatment and follow-up	**§3** requires the physician to know how to restore health. Successful treatment depends on proper case management, patient compliance, and regular follow-up.
Environmental toxins	**§260** advises avoiding harmful substances and external influences that hinder cure. Toxic chemical exposure can act as an obstacle to recovery.
Uncontrolled endocrine disorders	**§3** requires identifying the disease and its maintaining causes. Conditions like hypothyroidism or diabetes should be recognized and managed alongside homoeopathic treatment.

Although PMOS is a recognized cause of infertility, early individualized homoeopathic intervention may prevent progression to reproductive dysfunction. This case demonstrates the management of PMOS before infertility, highlighting the role of timely treatment in preserving future fertility.

Family Member	Disease / Condition
Mother	Anaemia Hypotension
Father	Gallstones
Sister	Asthma
Paternal Grandmother	Hypertension
Maternal Grandmother	Diabetes Mellitus

Case Summary-

Presenting Complaints-

A 25-year-old unmarried female presented with amenorrhoea for 5 months, cramping lower abdominal pain during the expected menstrual period, abdominal bloating, constipation, weight gain, hair fall, premenstrual facial acne, and headache aggravated by exposure to sunlight. She was a diagnosed case of PMOS on ultrasonography.

History of Present Illness-

The patient was apparently healthy until one year

ago when dysmenorrhoea developed, followed by premenstrual acne. Within 5–6 months, she developed amenorrhoea and was diagnosed with PMOS. Despite conventional treatment, weight gain and hair fall progressively increased.

Past history- Renal calculus (homoeopathically treated), meniscal tear (operated), and jaundice during childhood.

Physical Generals-

General / Particular	Observation
Appetite	Normal
Desire	Salty & spicy food
Aversion	Sweets
Intolerance	Potatoes
Thirst	Desires cold water
Stool	Constipation on alternate days
Thermal State	Hot patient
Skin	Dry
Perspiration	Scanty, mainly over face & neck
Sleep Position	Sleeps on left side

Mental Generals-

Brooding over past failures, cries in solitude, consolation aggravates, irritable over trifles, talkative, extroverted, emotionally reserved, prefers solitude during emotional distress.

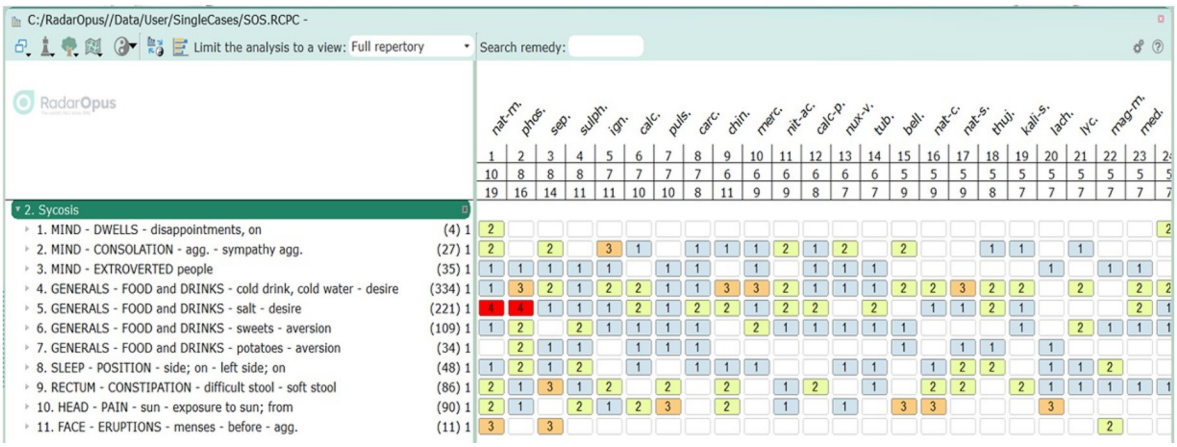
Numerical Totality-

1)Amenorrhoea, 2) Dysmenorrhoea, 3) Abdominal bloating, 4) Constipation, 5) Weight gain, 6) Premenstrual acne, 7) Headache < sun, 8) Desire for salty food, 9) Aversion to sweets, 10) Thirst for cold water, 11) Hot patient, 12) Dry skin, 14) Left-sided sleep, 15) Brooding, 16) Consolation aggravates, 17) Extroverted

Analysis-

The case was evaluated by giving maximum importance to characteristic mental generals (brooding, consolation aggravates, cries alone), followed by physical generals (hot patient, dry skin, desire for salt, thirst for cold water, aversion to sweets) and characteristic particulars. The dominant miasm- Sycosis.

Repertorial Totality-



Prescription- *Natrum muriaticum 200C, one stat dose, followed by Saccharum lactis three times daily* with dietary and lifestyle advice.

Follow-up-The patient showed gradual improvement with restoration of menstruation, marked reduction in dysmenorrhoea, complete relief from constipation, decreased headache intensity, reduction in acne, improvement in emotional symptoms on subsequent follow-ups.

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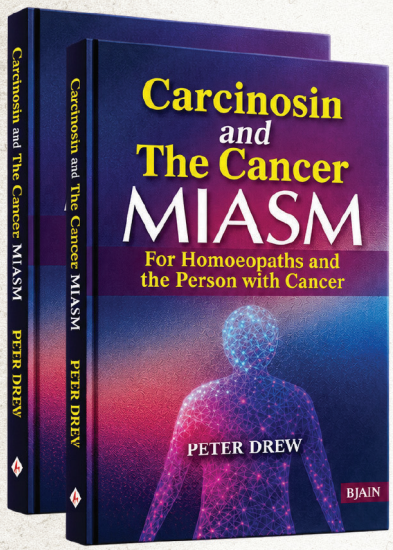
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From Cysts to Conception: A Case Report of Individualised Homoeopathic Management in a Woman with Infertility

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JSPS Government Homoeopathic Medical College, Ramanthapur, Hyderabad.

Abstract

Female infertility is a growing global health concern, with ovulatory dysfunction and structural pathologies such as ovarian cysts and endometriosis being among the leading causes. Conventional management including hormonal therapy and surgical intervention, while effective, is associated with significant side effects and financial burden, particularly in low-resource settings. Individualised homoeopathic treatment offers a safe, cost-effective, and holistic alternative.

Case summary: A 27-year-old female homoeopathic student presented to the OPD in October 2025 with anxiety to conceive for two years, associated with a history of left ovarian endometrial cyst, polycystic ovary in the right ovary, and a history of renal calculi. Menstrual cycles were regular with scanty flow of two days duration. Based on thorough case taking, individualisation, and repertorisation using the Complete Repertory, Calcarea carbonicum was selected as the similimum and administered in 200C and 1M potency. Folliculinum 1M was subsequently prescribed based on clinical progress. During the eight-month follow-up period, pregnancy was confirmed, evidenced by a positive urine pregnancy test on 9/05/2026, Beta-HCG of 817 on 12/05/2026, and early intrauterine pregnancy on ultrasonography dated 16/05/2026.

Keywords

Female Infertility, homoeopathy, ovarian cyst, calcarea carb, folliculinum.

Introduction

The incidence of female infertility is rapidly increasing among the Indian population which is also a reflection of what is happening all over the world. Today, almost one in six couples face difficulty in conceiving. Infertility is the inability of a couple to achieve conception after one year of unprotected coitus[1]. Around 36 to 44% of infertility in women is due to ovulatory dysfunction[2]. Chronic P.I.D. is also seen in reproductive age group and is an important cause of female infertility[3]. Endometriosis is one of the main illnesses affecting women during their fertile age. In infertility, apart from surgical and medical treatment, like hormonal therapies etc.,[4],

Homoeopathy, is emerging as one such treatment with a definite role. The role of homoeopathy in treating infertility successfully is invaluable and often taken for granted thus creating a lacunae for genuine evidence based research findings. Despite the availability of established medical and assisted reproductive approaches, some patients seek complementary or alternative systems of medicine. Such clinical experiences warrant systematic documentation and further investigation. In a third world country like India, often the infertile females cannot afford surgery or expensive medication and they are always targeted and blamed for being infertile, causing immense psychological and mental torture, affecting their health and social status. Homoeopathic medicines are simple, safe, cost effective result oriented and being holistic can address these factors also by treating the underlying causes and preventing the ill effects of conventional medicine. This study has been carried out with the objective of

assessing and evaluating the efficacy of Homoeopathic medicines (intervention) in treating infertile females to successful conception.

Patient information:

A 27 years old women, homoeopathic student presented with anxiety regarding conception for two years.. She was apparently healthy until the age of 25 years. Her marriage occurred in January 2023, she was healthy till may 2023, she suddenly developed pain in left iliac fossa for two days. She underwent USG abdomen& Pelvis suggests impression of left simple ovarian cyst which is of 5cm, small bilateral renal calculi. Used only painkillers for 2 days. Pain subsided in two days. She was healthy up to 2 months, then suddenly developed severe left loin-to-groin pain, nausea, 5-6 episodes of vomiting, immediately admitted in hospital. Treatment given was painkillers iv fluids. Underwent USG Abdomen & Pelvis impression suggests of obstructive renal calculi and also a left ovarian endometrial cyst. Since then never experienced any kind of pain. She consulted a homoeopathic physician after 1 week, used homoeopathic medicines for 2 months. After repeated USG abdomen and pelvis, she developed PCOS in right ovary and left complex cyst in left ovary. During the reported eight-month treatment period, the patient did not receive hormonal therapy, ovulation induction, assisted reproductive treatment, or surgical treatment for infertility. Then she came to homoeopathic hospital OPD in 2025 October, with complaint of anxious to conceive. On further inquiry of her complaint, Her menstrual cycle were regular with 2 days scanty flow, 28-30 days of cycle, no clots, no pain during the menses, and no associated symptoms. She underwent the investigations on 25 june 2025 which includes 3.810 ng/mL, prolactin 10.44 ng/mL, LH 5.29 mIU/mL, testosterone 31.19 ng/mL, FSH 4.85mIU/mL. The CA125 – 7.6 had been measured previouly on 4 September 2024.

Past history: History of renal calculi.

History of vomitings during travel in car, especially downward motion.

Not a known case of diabetic, hypertension and thyroid disorders.

Family history: mother- apparently healthy, father – diabetic, spouse-apparently healthy, sibling younger brother- apparently healthy. Grand parents- died of old age. Marriage – third degree consangunity.

Personal history:

Appetite: 3times a day, satisfactory.

Desires & Aversions: not specific.

Thirst:3-4L/day,

Bowels: once in a day, no burning, no bleeding, satisfactory.

Urine: pale yellow, no burning and no pain.

Perspiration: only on the exertion.

Sleep: 6-8hours, refreshing

Dreams: does not remembered

Thermal modality towards chilly.

Menstrual history: regular with 2 days scanty flow, 28-30 days of cycle, no clots, no pain during the menses, any kind of assosciated symptoms. LMP 16/09/2025,15/08/2025.

Life space Investigation: patient hails from low socioeconomic family. She was intern in homoeopathic medical college. She got married at 24 years of age.

Mental generals: she is calm, gentle. She always things due to her complaints what her in-laws or other people will think.

On examination: her vitals are stable at the time of examination.

Diagnosis of case: Female Infertility due to Ovulatory and Structural Dysfunction

ICD-10: N97.8 — Other specified female infertility

ICD-11: GA30.Y — Other specified female infertility.

Analysis of case: After analyzing the symptoms, the characteristic mentals and physical generals and particulars were considered to frame the

totality of case.

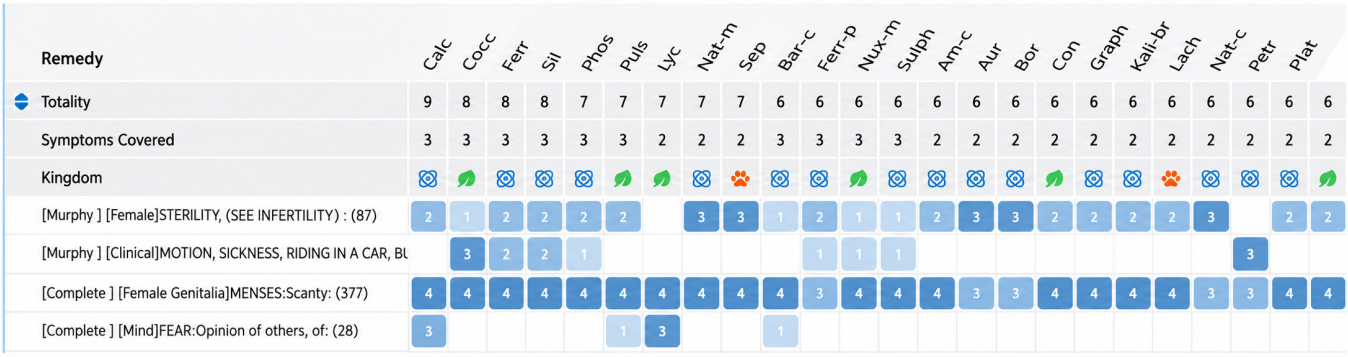
Totality of the case:

- Anxious to conceive.
- Menstrual cycle 2 days scanty flow.
- Vomiting during travel in car, downward motion.
- She always things due to her complaints what her in-laws or other people will think.

Therapeutic Intervention:

Repertorial analysis: Considering the symptomatology, the complete repertory was preferred. After repertorisation the maximum number of symptoms was seen to be covered by calcarea carbonicum with the highest score (9/3) 200C potency; 3 doses were administered.

Figure-1 repertorisation chart



Follow-Up And Outcome: After administration of Calcrea carb twice followed by folliculinum 1M as intercurrent remedy over a course of 8 months. An improvement was seen in menstrual flow to pregnancy positive . The follow up details are given below table 1 and outcome results are given in figures 2-6.

Table 1 follow up details.

8/10/2025	Menses scanty flow for 2 days Anxious to conceive LMP-16/09/2025	Cal Carb 200C, 3 doses
5/11/2025	Menses scanty flow for 2 days Anxious to conceive LMP-09/10/2025	Rubrum
9/12/2025	Menses scanty flow for 2 days Anxious to conceive LMP-05/11/2025	Cal Carb 1M 1dose
9/01/2026	Menses improvement flow to 3 days Anxious to conceive LMP-16/12/2025	Rubrum
9/02/2026	Menses improvement flow to 3 days Anxious to conceive LMP-12/01/2026	Rubrum

10/03/2026	Menses improvement flow to 3 days Anxious to conceive LMP-10/02/2026	Rubrum
7/04/2026	Menses improvement flow to 3 days Anxious to conceive LMP-04/04/2026	Folliculinum1M 1dose
18/05/2026	UPT positive 9/05/2026 Beta hcg 817(12/05/2026) 16/05/2026 early intra uterine pregnancy	Rubrum

Figure 2

VIJAYA

Beside Ratnadeep, Sri Sai Complex, Vaidehi Nagar, Vanastalipuram, Hyderabad-500070, Telangana

TEST REPORT

Name :
Age/Gender :
Registration ID : 230330026117
Ref. By : Dr Self

Registered on : 18-May-2023 22:26
Released on : 19-May-2023 12:14
Printed on : 05-Sep-2026 14:40
Regn Centre : **: Vanasthalipuram - 33**

DEPARTMENT OF RADIOLOGY AND IMAGING SCIENCES
ULTRASOUND OF ABDOMEN & PELVIS

History : Stomach pain.

Liver : Normal in size (135 mm) and shows homogenous echotexture. No focal or diffuse pathology seen. There is no evidence of intrahepatic biliary dilatation. CBD and portal vein appear normal.

Gall Bladder : Physiologically distended and shows no wall thickening.

Pancreas : Normal in size, shape and echopattern.

Spleen : Normal in size (102 mm), shape and echopattern.

Kidneys : Right kidney : 98 x 42 mm; Left kidney : 111 x 44 mm
Both kidneys are normal in size, shape and echopattern.
Collecting system appears normal.
Single calculus measuring 3.4 mm noted in right kidney.
2 Calculus measuring 3.8 mm noted in left kidney.

Urinary Bladder : Well distended. No wall thickening seen.

Uterus : Size : 84 x 43 x 36 mm; Anteverted. Retroflexed.
Normal in size, shape and echotexture.
Endometrial thickness measures 11 mm.
Cervix appears normal.

Ovaries : Right ovary : 27 x 22 mm; Normal in size, shape and echotexture.
Simple cyst measuring 50 x 49 mm noted in left ovary with no septations and solid components.

Page 1 of 2

* Suggested Clinical Correlation, If Necessary Kindly Discuss with signatory

Customer Care 9240 222 222

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VIJAYA

VIJAYA DIAGNOSTIC CENTRE

Beside Ratnadeep, Sri Sai Complex, Vaidehi Nagar, Vanastalipuram, Hyderabad-500070, Telangana

TEST REPORT

Name :
Age/Gender :
Registration ID : 26117
Ref. By : Dr Self

Registered on : 18-May-2023 22:26
Released on : 19-May-2023 12:14
Printed on : 05-Sep-2026 14:40
Regn Centre : **: Vanasthalipuram - 33**

DEPARTMENT OF RADIOLOGY AND IMAGING SCIENCES
ULTRASOUND OF ABDOMEN & PELVIS

Other Findings : No free fluid in Pouch of Douglas.

No ascites.

Impression : *** BILATERAL SMALL RENAL CALCULI.**

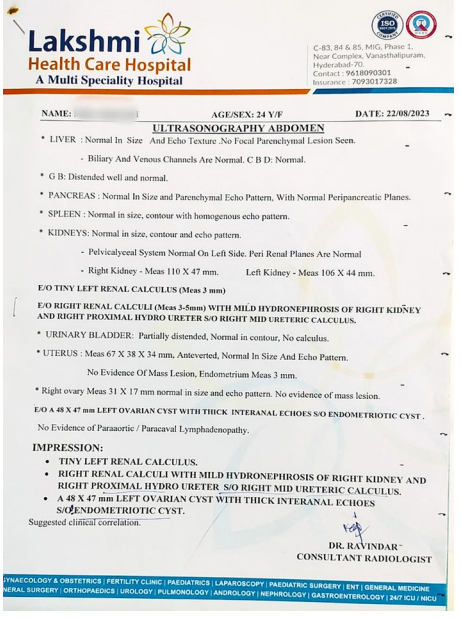
*** LEFT OVARIAN SIMPLE CYST.**

- FOR CLINICAL CORRELATION.

---------- End of Report ----------

DR. MASUK PRAVEEN KUMAR
MBBS, MD, DNB
Registration No:81680

Figure 3



Lakshmi
Health Care Hospital
A Multi Speciality Hospital

C-83, 84 & 85, MIG, Phase 1, Near Complex, Vanasthalipuram, Hyderabad-70. Contact : 9618090301 Insurance : 7093017328

NAME: AGE/SEX: 24 Y/F DATE: 22/08/2023

ULTRASONOGRAPHY ABDOMEN

* LIVER : Normal In Size And Echo Texture .No Focal Parenchymal Lesion Seen.
- Biliary And Venous Channels Are Normal. C B D: Normal.
* G B: Distended well and normal.
* PANCREAS : Normal In Size and Parenchymal Echo Pattern, With Normal Peripancreatic Planes.
* SPLEEN : Normal in size, contour with homogenous echo pattern.
* KIDNEYS: Normal in size, contour and echo pattern.
- Pelvicalyceal System Normal On Left Side. Peri Renal Planes Are Normal
- Right Kidney - Meas 110 X 47 mm. Left Kidney - Meas 106 X 44 mm.

E/O TINY LEFT RENAL CALCULUS (Meas 3 mm)

E/O RIGHT RENAL CALCULI (Meas 3-5mm) WITH MILD HYDRONEPHROSIS OF RIGHT KIDNEY AND RIGHT PROXIMAL HYDRO URETER S/O RIGHT MID URETERIC CALCULUS.

* URINARY BLADDER: Partially distended, Normal in contour, No calculus.
* UTERUS : Meas 67 X 38 X 34 mm, Anteverted, Normal In Size And Echo Pattern.
No Evidence Of Mass Lesion, Endometrium Meas 3 mm.
* Right ovary Meas 31 X 17 mm normal in size and echo pattern. No evidence of mass lesion.

E/O A 48 X 47 mm LEFT OVARIAN CYST WITH THICK INTERANAL ECHOES S/O ENDOMETRIOTIC CYST .

No Evidence of Paraaortic / Paracaval Lymphadenopathy.

IMPRESSION:

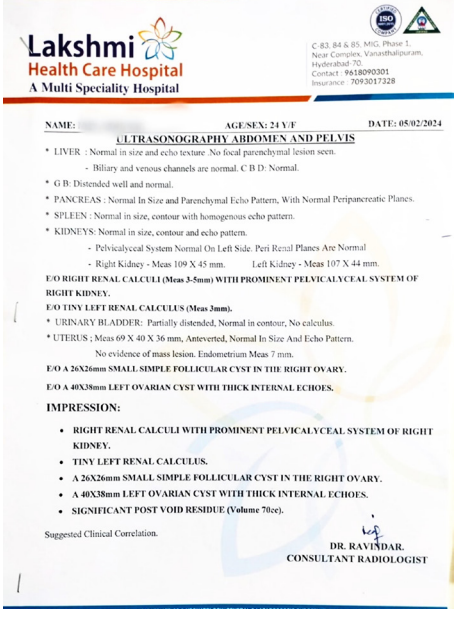
- **TINY LEFT RENAL CALCULUS.**
- **RIGHT RENAL CALCULI WITH MILD HYDRONEPHROSIS OF RIGHT KIDNEY AND RIGHT PROXIMAL HYDRO URETER S/O RIGHT MID URETERIC CALCULUS.**
- **A 48 X 47 mm LEFT OVARIAN CYST WITH THICK INTERANAL ECHOES S/O ENDOMETRIOTIC CYST.**

Suggested clinical correlation.

DR. RAVINDAR
CONSULTANT RADIOLOGIST

GYNAECOLOGY & OBSTETRICS | FERTILITY CLINIC | PAEDIATRICS | LAPAROSCOPY | PAEDIATRIC SURGERY | ENT | GENERAL MEDICINE
NERAL SURGERY | ORTHOPAEDICS | UROLOGY | PULMONOLOGY | ANDROLOGY | NEPHROLOGY | GASTROENTEROLOGY | 24/7 ICU / NICU

Figure 4



Lakshmi
Health Care Hospital
A Multi Speciality Hospital

C-83, 84 & 85, MIG, Phase 1, Near Complex, Vanasthalipuram, Hyderabad-70. Contact : 9618090301 Insurance : 7093017328

NAME: AGE/SEX: 24 Y/F DATE: 05/02/2024

ULTRASONOGRAPHY ABDOMEN AND PELVIS

* LIVER : Normal in size and echo texture .No focal parenchymal lesion seen.
- Biliary and venous channels are normal. C B D: Normal.
* G B: Distended well and normal.
* PANCREAS : Normal In Size and Parenchymal Echo Pattern, With Normal Peripancreatic Planes.
* SPLEEN : Normal in size, contour with homogenous echo pattern.
* KIDNEYS: Normal in size, contour and echo pattern.
- Pelvicalyceal System Normal On Left Side. Peri Renal Planes Are Normal
- Right Kidney - Meas 109 X 45 mm. Left Kidney - Meas 107 X 44 mm.

E/O RIGHT RENAL CALCULI (Meas 3-5mm) WITH PROMINENT PELVICALYCEAL SYSTEM OF RIGHT KIDNEY.

E/O TINY LEFT RENAL CALCULUS (Meas 3mm).

* URINARY BLADDER: Partially distended, Normal in contour, No calculus.
* UTERUS ; Meas 69 X 40 X 36 mm, Anteverted, Normal In Size And Echo Pattern.
No evidence of mass lesion. Endometrium Meas 7 mm.

E/O A 26X26mm SMALL SIMPLE FOLLICULAR CYST IN THE RIGHT OVARY.

E/O A 40X38mm LEFT OVARIAN CYST WITH THICK INTERNAL ECHOES.

IMPRESSION:

- **RIGHT RENAL CALCULI WITH PROMINENT PELVICALYCEAL SYSTEM OF RIGHT KIDNEY.**
- **TINY LEFT RENAL CALCULUS.**
- **A 26X26mm SMALL SIMPLE FOLLICULAR CYST IN THE RIGHT OVARY.**
- **A 40X38mm LEFT OVARIAN CYST WITH THICK INTERNAL ECHOES.**
- **SIGNIFICANT POST VOID RESIDUE (Volume 70cc).**

Suggested Clinical Correlation.

DR. RAVINDAR.
CONSULTANT RADIOLOGIST

Figure 5



MedPlus+ Diagnostics

Name		Order	PTGOC2500700508
Age / Sex		Test Registered	26-Dec-24 / 03:00 PM
Contact		Test Accepted	26-Dec-24 / 03:03 PM
Collection Centre		Test Reported	26-Dec-24 / 03:29 PM
Referral Doctor		Report Status	Final

Ultrasound - Transvaginal Scan

DEPARTMENT OF RADIOLOGY AND IMAGING

FINDINGS :

UTERUS : 58 x 48 x 31 mm.
Retroverted,Normal in size and echotexture. No focal lesions.
Endometrium thickness: 6.7 mm .

OVARIES :

Right Ovary : 37 x 36 x 27 mm.Vol ; 12 cc. **Right ovary appears bulky in size with peripherally arranged follicles & central echogenic stroma.**

Left Ovary :27 x 25 x 22 mm. Vo : 8 cc.

E/o simple cyst m/s 25 x 20 mm in the left ovary - likely follicular cyst.

Another two cysts seen wihtin left ovary m/s 22 x 26 mm & 21 x 17 mm appearing close to each other with abutting walls appearing as septation. Doppler shows mild peripheral vascularity.No e/o any sonographic features s/o endometriotic / haemorrhagic cyst noted in both.

No free fluid in Pouch of Douglas.

IMPRESSION:

*** Right ovary shows polycystic pattern.**

*** Left ovarian simple cyst - likely follicular cyst.**

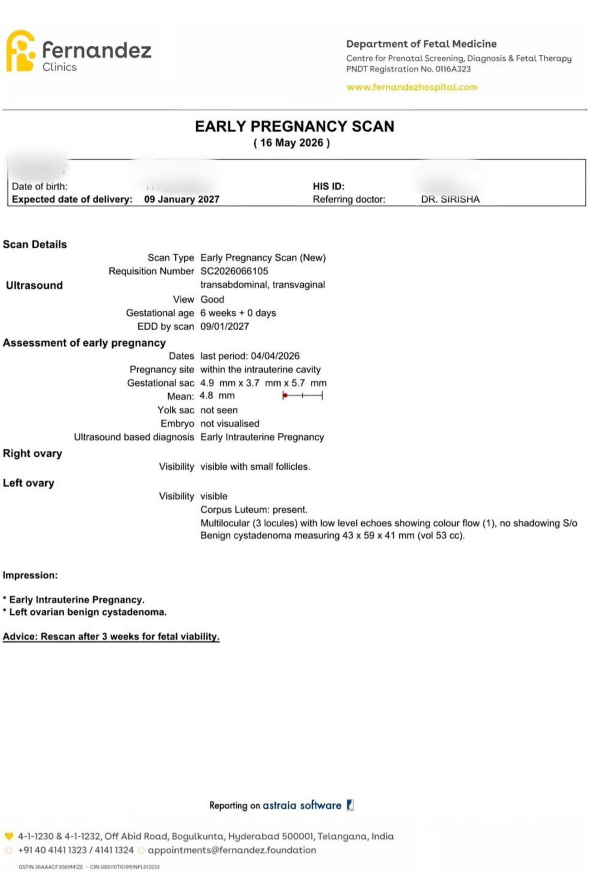
*** Another left ovarian two simple cysts close to each other as described above - may be follicular cysts.**

- For clinical / lab / harmonal correlation & Follow up.

**** END OF THE REPORT ****

Dr Vijaya Sree
Consultant Radiologist

Figure 6



Fernandez Clinics

Department of Fetal Medicine
Centre for Prenatal Screening, Diagnosis & Fetal Therapy
PNDT Registration No. 0116A323
www.fernandezhospital.com

EARLY PREGNANCY SCAN
(16 May 2026)

Date of birth:
Expected date of delivery: 09 January 2027
HIS ID:
Referring doctor: DR. SIRISHA

Scan Details

Ultrasound
Scan Type: Early Pregnancy Scan (New)
Requisition Number: SC2026066105
transabdominal, transvaginal
View: Good
Gestational age: 6 weeks + 0 days
EDD by scan: 09/01/2027

Assessment of early pregnancy
Dates: last period: 04/04/2026
Pregnancy site: within the intrauterine cavity
Gestational sac: 4.9 mm x 3.7 mm x 5.7 mm
Mean: 4.8 mm
Yolk sac: not seen
Embryo: not visualised
Ultrasound based diagnosis: Early Intrauterine Pregnancy

Right ovary
Visibility: visible with small follicles.

Left ovary
Visibility: visible
Corpus Luteum: present.
Multilocular (3 locules) with low level echoes showing colour flow (1), no shadowing S/o Benign cystadenoma measuring 43 x 59 x 41 mm (vol 53 cc).

Impression:

*** Early Intrauterine Pregnancy.**
*** Left ovarian benign cystadenoma.**

Advice: Rescan after 3 weeks for fetal viability.

Reporting on astraia software

4-1-1230 & 4-1-1232, Off Abid Road, Bogulkunta, Hyderabad 500001, Telangana, India
+91 40 4141 1323 / 4141 1324 appointments@fernandez.foundation

DISCUSSION

The present case illustrates the successful application of individualised homoeopathic treatment in a young female presenting with infertility of two years duration, compounded by ovarian pathology including a right polycystic ovary and left ovarian endometrial cyst.

The selection of **Calcarea carbonicum** as the similimum was based on the characteristic totality of symptoms: anxiety to conceive with deep concern about the opinion of her in-laws and society, chilly thermal modality, scanty menstrual flow of two days, tendency to form deposits (history of renal calculi), and vomiting on downward motion during car travel. These symptoms are well documented in the materia medica of Calcarea carbonicum — a remedy known for its profound affinity for the female reproductive system, glandular dysfunctions, ovarian pathology, and patients of the chilly constitution who are deeply affected by social opinion, responsibility, and anxiety regarding health and future.(8,9) Kent's repertory prominently lists Calcarea carbonicum under "Ovaries, cysts," "Menses, scanty," and "Anxiety, what people think of her," further confirming its selection as the similimum in this case.

Following the administration of Calcarea carbonicum 200C and subsequent escalation to 1M, a positive constitutional response was observed — menstrual flow progressively improved from two days to three days duration over a period of three months. However, after this initial improvement, the case arrived at a **standstill**, wherein no further perceptible progress was noted despite the continuation of the similimum. The chief complaint of anxiety to conceive persisted, and no further improvement in the menstrual or reproductive sphere was recorded over the subsequent follow-up visits.

In such situations, the Hahnemannian concept of the **intercurrent remedy** becomes relevant. According to the principles of Organon of Medicine, when the indicated remedy acts only partially and the case reaches a point of arrest where the vital force appears to be blocked by an underlying miasmatic obstruction or a specific organ-based dyscrasia an intercurrent remedy is employed to remove the obstacle and re-establish the curative

momentum.(9) The intercurrent remedy does not replace the similimum but acts as a catalyst, clearing the impediment so that the action of the constitutional remedy may resume and complete the cure.

Within homoeopathic literature, Folliculinum has been described in relation to female reproductive and ovarian symptoms. In the present case, it was prescribed as an intercurrent remedy according to the treating physician's clinical assessment.

Following the administration of Folliculinum 1M as an intercurrent remedy, the case resumed its curative trajectory. The patient achieved a confirmed pregnancy within the subsequent month — evidenced by a positive urine pregnancy test on 9/05/2026, Beta-HCG of 817 on 12/05/2026, and early intrauterine pregnancy confirmed on ultrasonography dated 16/05/2026. This outcome strongly suggests that Folliculinum successfully removed the therapeutic standstill and restored the momentum of cure initiated by Calcarea carbonicum.

The **Modified Naranjo Criteria for Homoeopathy (MONARCH)**[7]was applied to assess causal attribution of the clinical outcome to the homoeopathic intervention. A score of +7 was obtained, indicating that the improvement — specifically the achievement of conception — was attributable to the homoeopathic treatment. This score reflects objective confirmation of improvement via laboratory and ultrasonographic evidence, improvement within a plausible timeframe relative to drug intake, improvement beyond the chief complaint (menstrual flow), and overall enhancement of wellbeing, while appropriately accounting for the absence of any concurrent conventional treatment during the course of management.

This report has several limitations. First, as a single case report without a comparator, it cannot establish a causal relationship between homoeopathic treatment and conception. Second, the infertility evaluation presented was incomplete with respect to certain established fertility investigations, including documentation of ovulation and tubal patency and, if not performed, semen analysis of the partner. Third, serial imaging demonstrating the evolution or resolution of the ovarian pathology was not available throughout the treatment period. Fourth, spontaneous conception cannot be excluded as an alternative explanation for the pregnancy. Finally, the subjective nature of some reported improvements and the retrospective application of causal-attribution criteria may introduce reporting and attribution bias

This case thus demonstrates two important principles of classical homoeopathy working in clinical practice: firstly, the power of the individualised similimum (Calcarea carbonicum) in initiating constitutional recovery in a case of female infertility with ovarian pathology; and secondly, the judicious use of the intercurrent remedy (Folliculinum) in resolving therapeutic standstill and completing the cure — both grounded in the Hahnemannian philosophy of the Organon of Medicine.

Table 2 modified Naranjo criteria for homoeopathy (MONARCH).

Domains	Yes	No	Not sure
1. Was there an improvement in the main symptom or condition for which the homeopathic medicine was prescribed?	+2		
2. Did the clinical improvement occur within a plausible time frame relative to the drug intake?	+1		
3. Was there an initial aggravation of symptoms?			
4. Did the effect encompass more than the main symptom or condition (i.e., were other symptoms ultimately improved or changed)?	+1		
5. Did overall well-being improve? (suggest using validated scale)	+1		
6A. Direction of cure: did some symptoms improve in the opposite order of the development of symptoms of the disease?	+1		
6B Direction of cure: Did at least two of the following aspects apply to the order of improvement of symptoms: –from organs of more importance to those of less importance? – from deeper to more superficial aspects of the individual? - From the top downwards?	+1		

7. Did "old symptoms" (defined as non-seasonal and non-cyclical symptoms that were previously thought to have resolved) reappear temporarily during improvement?			
8. Are there alternate causes (other than the medicine) that—with a high probability— could have caused the improvement? (Consider known course of disease, other forms of treatment, and other clinically relevant interventions)	-3		
9. Was the health improvement confirmed by any objective evidence? (e.g., laboratory tests, clinical observation, etc.)	+2		
10. Did repeat dosing, if conducted, create similar clinical improvement?	+1		

Total score = +7

Declaration Of The Patient: Written informed consent was obtained from the patient for publication. The patient understands that her name will not be published, and all the efforts will be made to conceal her identity. **Financial Support And Sponsorship**: None

Conflict Of Interest: None

CONCLUSION

This case describes the management of a woman with infertility and associated ovarian pathology who received individualised homoeopathic treatment and subsequently achieved a confirmed intrauterine pregnancy during the reported follow-up period. The case demonstrates the application of case taking, individualisation, repertorisation and follow-up within a homoeopathic clinical framework. However, because this is a single case without a comparator and because alternative explanations for spontaneous conception cannot be excluded, the temporal association should not be interpreted as evidence of treatment efficacy. Further well-designed prospective studies with comprehensive fertility evaluation and objective outcome measures are required to investigate the potential role of individualised homoeopathy in patients with infertility.

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It Takes Three To Make A Child: The Woman, The Man And The Physician In Individualised Homoeopathic Care Of Infertility

Dr. Sai Shreya Roy

PG Scholar, Department of Organon of Medicine and Homoeopathic Philosophy,

JSPS Government Homoeopathic Medical College, Ramanthapur, Telangana, India

Abstract

Background: Infertility involves two biological partners, while prescribing remains individualised. This case series examines both partners separately while managing the couple as one reproductive unit. Case presentation: Three presentations were followed: female infertility with PCOM, male infertility with oligozoospermia, and a couple with right hydrosalpinx in the woman and oligozoospermia in the man. Each patient underwent case-taking, repertorisation and objective follow-up. Results: Case 1 showed absent PCOM on later ultrasound and positive β-hCG; Case 2 showed oligozoospermia followed by normozoospermia; Case 3 showed positive β-hCG in the woman and normozoospermia in the man. Conclusion: The couple is the reproductive clinical unit, but each partner remains an individual homoeopathic case. The physician integrates investigation, individualisation and monitoring.

Keywords: infertility, individualisation, homoeopathy, female infertility, male infertility, oligozoospermia, hydrosalpinx, polycystic ovarian morphology

INTRODUCTION

Infertility is failure to achieve pregnancy after 12 months of regular unprotected intercourse. It may be female, male, combined or unexplained; both partners therefore require assessment.[1,2]

For homoeopathic case-taking, the reproductive diagnosis does not constitute the whole individualised picture. PCOM, oligozoospermia and hydrosalpinx require investigation, while prescribing remains based on the individual totality. The series illustrates female-factor, male-factor and combined-couple presentations.

The central proposition is: it takes two to conceive, but it takes three to care for the journey. The physician is the third participant who evaluates both partners, individualises treatment and recognises therapeutic limits.

CASE 1 — FEMALE INFERTILITY WITH POLYCYSTIC OVARIAN MORPHOLOGY

Case history

A 28-year-old homemaker, married three years, presented with primary infertility after approximately 1.5 years of attempting conception. Menarche occurred at 14 years. Cycles had lengthened from 35–40 to 42–45 days. Flow lasted about three days and was scanty, dark and clotted, with first-day dysmenorrhoea.

During menstruation she became markedly irritable ,desired silence, and was sensitive to noise and artificial light. She was generally irritable, sensitive to criticism, desired order, disliked change and preferred routine. A recurrent dream of stabbing her husband was recorded as a dream symptom.

Appetite was normal. She was thirstless, taking approximately 1 L/day in small quantities, especially with food. She desired fried/junk foods. Perspiration was scanty.Sleep, bowel and urinary functions were normal. She was chilly. Past history included chickenpox; both parents had diabetes.

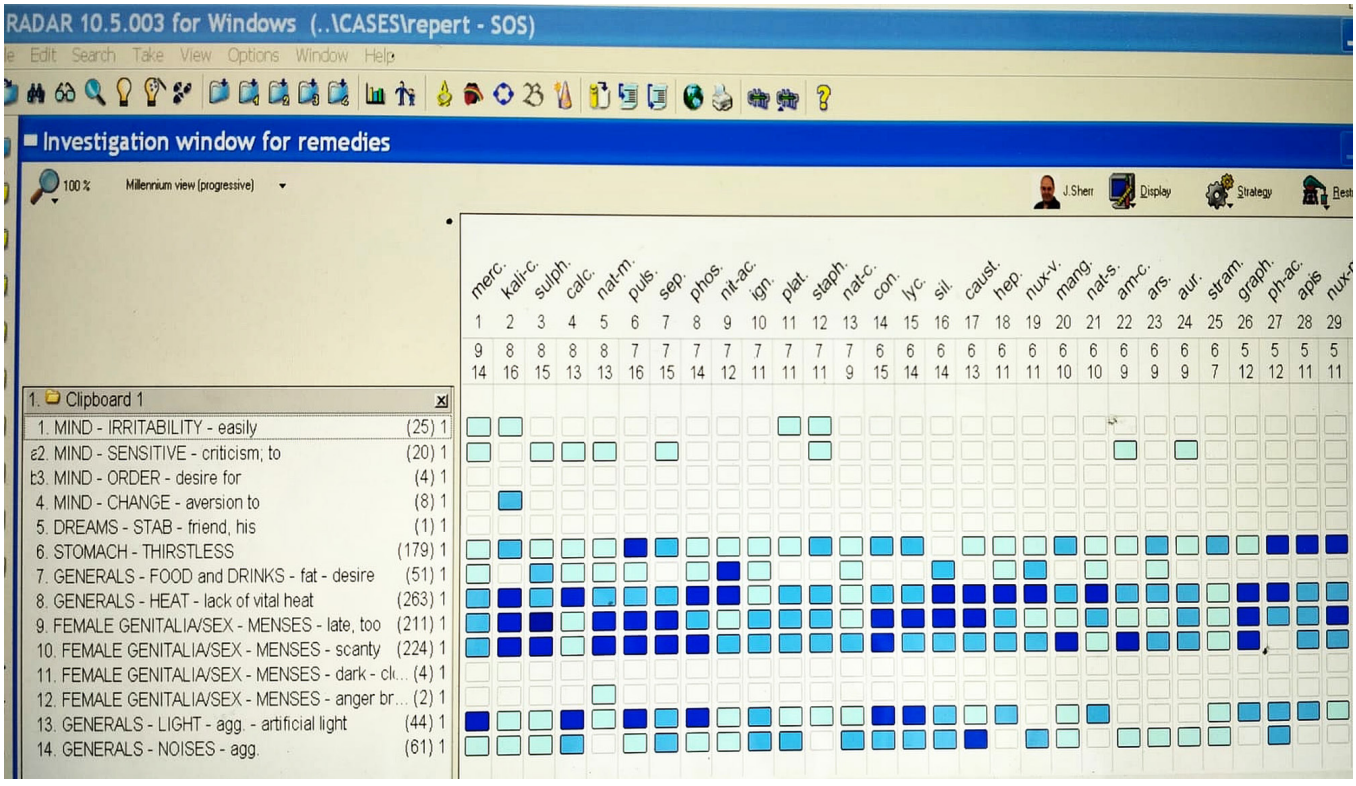
Ultrasonography on 12 May 2025 showed normal uterus, endometrium and ovarian morphology without PCOM. On 25 June 2025, ovaries were enlarged with multiple peripheral follicles and increased stromal echogenicity, reported as suggestive of PCOM; clinical and hormonal correlation was advised. A previous history of PCOS-directed hormonal treatment was reported, but PCOS was not diagnosed from morphology alone. The distinction between PCOM and PCOS is consistent with current PCOS guidance.[5]

Case analysis

Diagnosis

Primary female infertility with menstrual disturbance and transiently documented PCOM; ICD-10 N97.PCOM was treated as a sonographic descriptor, not synonymous with PCOS.

The totality included menstrual irritability/anger, sensitivity to criticism, desire for order, aversion to change, recurrent dream, thirstlessness, desire for fatty food, chilly state, delayed scanty dark-clotted menses, and sensitivity to light/noise. Radar repertorisation is Figure 1.



The repertorial result was considered with materia medica rather than the ovarian diagnosis. Mercurius solubilis was selected for the combined mental, general and menstrual picture. Mercurius solubilis 200C was prescribed as a single dose on 01 July 2025, followed by Saccharum lactis during observation. Mercurius solubilis 1M was prescribed as a single dose on 05 October 2025.

Follow-up

Ultrasonography on 12 January 2026 reported normal-sized ovaries with normal morphology and physiological follicles, with no sonographic evidence of PCOM. On 27 January 2026, at age 29 years, serum β-hCG was 186.4 mIU/mL and was reported as positive, consistent with early pregnancy.

CASE 2 — MALE INFERTILITY WITH OLIGOOZOOSPERMIA

Case history

A 34-year-old corporate human-resources worker presented with primary infertility after three

years of attempting conception. He had generalised weakness for approximately four years and fatigue, particularly after mental work. He worked on a laptop for 10–11 hours daily, had no regular exercise, was lean and tall and reported hair loss.

Appetite was moderate. He was extremely thirsty, taking large quantities at short intervals and preferring cold water. He was ambithermal; perspiration was scanty and exertional. Sleep was 6–7 hours but unrefreshing. Intercourse and erection were normal; weakness followed ejaculation.

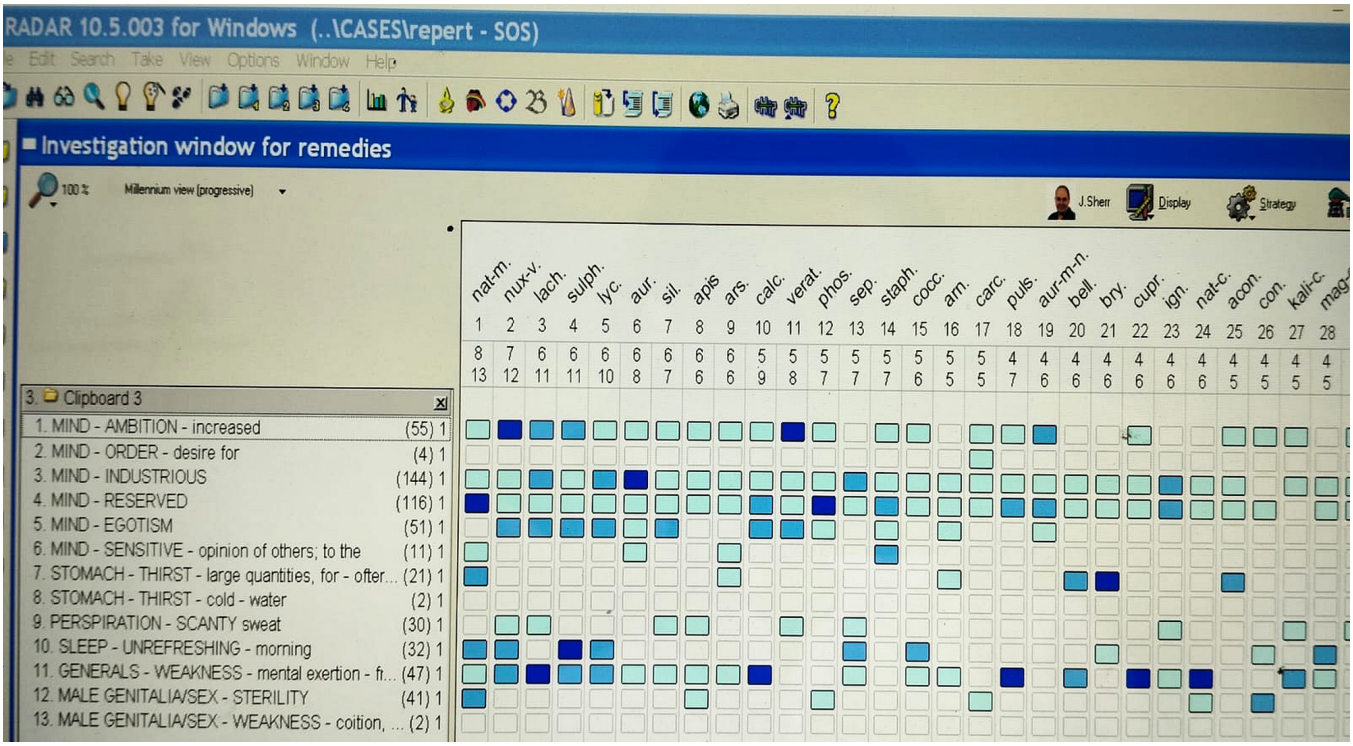
He was ambitious, industrious, organised and controlling. His wife described him as reserved and less emotionally expressive; both reported a strong preference for order. He valued financial stability and feared social judgement regarding infertility. Deeper exploration, corroborated by his wife, suggested threatened self-perception as capable and productive.He smoked 3–4 cigarettes daily.

Diagnosis

Male infertility with oligozoospermia; ICD-10 N46.Baseline semen analysis supported the diagnosis; infertility-specialist assessment reportedly found no significant female factor.

Case analysis

The 13-rubric Radar repertorisation (Figure 2) included increased ambition, desire for order, industriousness, reserved disposition, egotism, sensitivity to others' opinions, marked thirst for large quantities, desire for cold water, scanty perspiration, unrefreshing sleep, weakness from mental exertion, male sterility and weakness after coition. The totality was interpreted with the characteristic mental state and physical generals.



Lycopodium clavatum was selected after repertorisation and materia medica correlation, particularly the combination of ambition, control, concern regarding performance/social standing, weakness and marked thirst. Lycopodium clavatum 200C was prescribed as a single dose on 15 February 2025. Saccharum lactis was used during follow-up and Lycopodium clavatum 200C was repeated on 07 May 2025.

Follow-up

Semen analysis on 09 January 2025 showed volume 1.0 mL, concentration 10 million/mL, total

count 10 million/ejaculate, total motility 54%, progressive motility 37%, normal morphology 7% and live sperm 94%, with a laboratory impression of oligospermia. On 18 June 2025, concentration was 29.[6] million/mL and total count 30 million/ejaculate with a laboratory impression of normozoospermia. The change is documented without causal attribution.[3]

CASE 3 — WHEN BOTH PARTNERS BECOME PATIENTS

Case 3A: Female partner

A 32-year-old hotel receptionist had six years of primary infertility. Ultrasonography on 18 May 2024 showed a tubular, fluid-filled right adnexal structure with thin septations measuring 7.8 × 2.4 cm, reported as right hydrosalpinx with a dilated tube.

Case analysis

Cycles were regular at 30 days, with mild lower abdominal discomfort and bright-red, non-clotted flow. White discharge occurred for about seven days before and after menses and was foul/fishy smelling. There was no dyspareunia. Appetite was moderate; thirst approximately 3L/day. She desired very sweet foods and was averse to curd. Perspiration was greater over the face/scalp. She was chilly, BMI approximately 29.

She was optimistic, sociable, friendly, confident and decisive, enjoyed company and appreciation, and did not dwell on criticism or failure. Initially infertility was not a major concern; after 30 years she became apprehensive about the biological clock.

Diagnosis

Primary female infertility with right tubal factor—right hydrosalpinx; ICD-10 N97.

The repertorial totality included optimistic, decisive and confident disposition, desire for sweets, lack of vital heat, obesity, offensive white leucorrhoea, sterility and hydrosalpinx. The Radar repertorisation is Figure 3. Calcarea carbonica 200C was prescribed as a single dose on 30 January 2025, followed by Saccharum lactis. The selection was based on the totality rather than hydrosalpinx alone. The structural tubal finding is clinically relevant to fertility assessment.[2,6]



Follow-up

No subsequent tubal imaging was available; anatomical resolution is therefore not claimed. On 14 June 2026, serum β-hCG was 256.8 mIU/mL and positive, consistent with early pregnancy.

Case 3B: Male partner

Her 31-year-old husband had primary infertility and documented oligozoospermia. He had no erectile difficulty or problem with ejaculation duration, but experienced marked exhaustion after ejaculation.Appetite was low with easy satiety. He was ambithermal, desired meat, had sleep disturbed by small noises and reported sexual dreams.

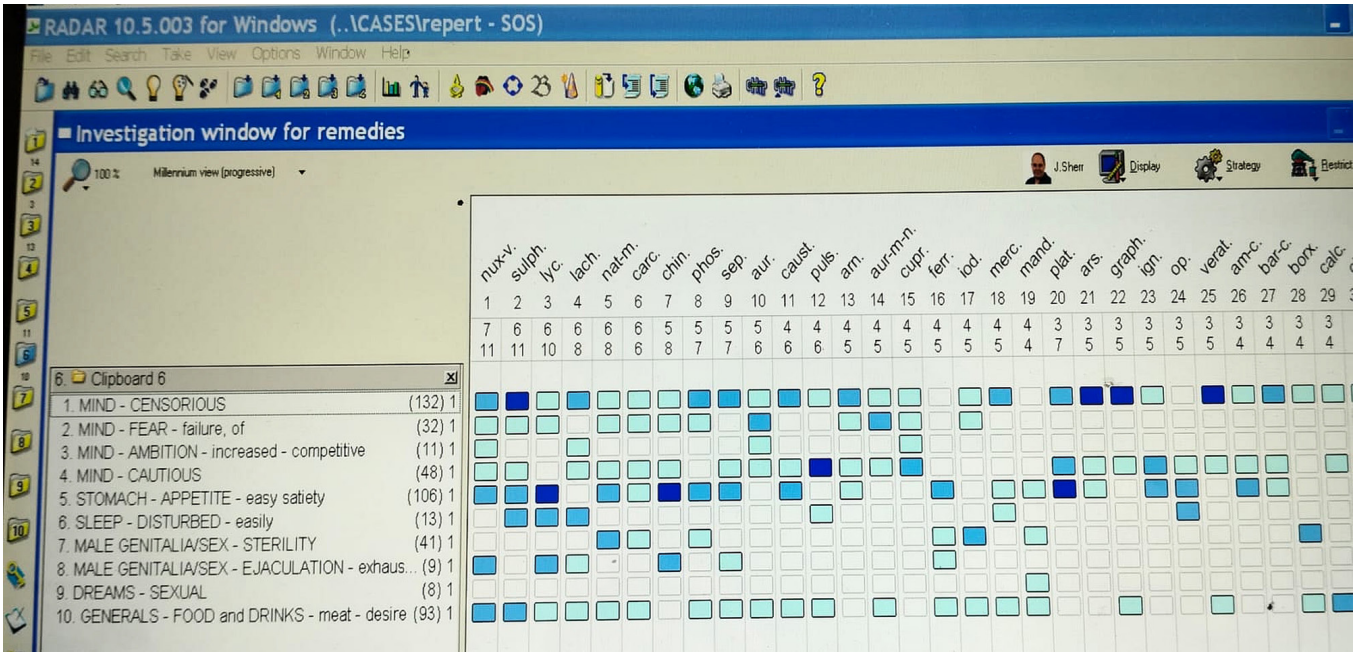
He was cautious, repeatedly reconsidered decisions because of fear of failure, censorious, ambitious and competitive. He experienced infertility as personal failure and compared himself with men who had fathered children.

Diagnosis

Male infertility with oligozoospermia; ICD-10 N46.

Case analysis and follow-up

The 10-rubric Radar repertorisation (Figure 4) included censoriousness, fear of failure, increased competitive ambition, cautiousness, easy satiety, easily disturbed sleep, male sterility, exhaustion after ejaculation, sexual dreams and desire for meat. Nux vomica was selected after repertorial and materia medica correlation. Nux vomica 200C was prescribed as a single dose on 30 January 2025, followed by Saccharum lactis.



Semen analysis on 09 August 2024 showed concentration 17 million/mL and total count 17 million/ejaculate, with total motility 54%, progressive motility 37%, morphology 7% and live sperm 94%, with a laboratory impression of oligospermia. On 18 April 2025, concentration was 47 million/mL and total count 47 million/ejaculate, with the same motility, morphology and live-sperm values and a laboratory impression of normozoospermia.

DISCUSSION

Previous infertility reports in The Homoeopathic Heritage have described individualised homoeopathic management in female infertility, including ovarian pathology, with conception reported after treatment.[8] The present series extends this literature by treating the couple as the reproductive clinical unit while retaining each partner as an individual homoeopathic case.

The cases also show why reproductive diagnosis should not be conflated with the homoeopathic totality. In Case 1, PCOM appeared on one ultrasound and was absent on a later scan. Case 2 demonstrated objective change from oligozoospermia to normozoospermia. Case 3 combined documented right hydrosalpinx in the woman with oligozoospermia in her husband. Current fertility

guidance supports assessment of both partners and investigation of male and female factors.[1-3]

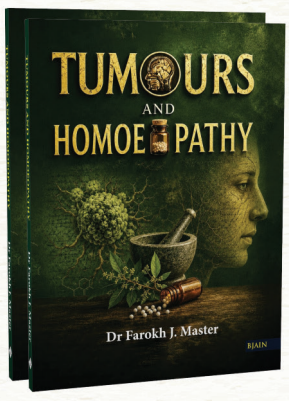
The observed outcomes are clinically notable: Cases 1 and 3A had subsequently positive serum β-hCG, while Cases 2 and 3B showed improved semen parameters with later laboratory impressions of normozoospermia. However, these observations represent temporal associations, not proof of treatment efficacy.

CONCLUSION

These cases illustrate a clinically responsible approach to infertility in which both partners are assessed, objective investigations accompany individualised homoeopathic case analysis, and structural pathology is not overlooked. Documented pregnancy in two female patients and improved semen parameters in two male patients are clinically relevant observations, but do not by themselves establish causation. The principal learning is the value of integrating individualisation with investigation, monitoring and recognition of therapeutic limits. The uniqueness of this series lies in its three-part perspective: two partners constitute the reproductive unit, while the physician integrates their care. Further systematic research is required to determine whether these observations are reproducible. It takes two to conceive; it takes three to care responsibly for the journey.

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Individualized Homoeopathic Management of Secondary Infertility Complicated by Uterine Fibroid

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Abstract

Background: Secondary infertility related to uterine fibroid is supposed to involve tough clinical difficulties requiring special assessment.

Case Presentation: A 34-year-old married woman applied to the clinic being diagnosed with secondary infertility lasting for eight years after the past pregnancy in 2017. She experienced irregular and insufficient menstruation, different annoying symptoms like left-sided aching in the pelvis, leucorrhoea with bad smell and pungent nature before menstruation. Ultrasonography revealed having uterine fibroid. The characteristic associated mental and physical signs included being temperamental, very talkative, having intolerance towards wearing things around the neck, hotness of the body, sweating too much, preference for sweet, spicy food and typical dreams.

Intervention: Taking into consideration the totality of symptoms, the medicine Lachesis mutus was prescribed.

Outcome: All clinical symptoms and the reproductive status were carefully monitored together with all necessary examinations being carried out.

Conclusion: The case indicates that homeopathy can deliver an effective solution to the problem of uterine fibroids associated with secondary infertility through the detailed analysing of the symptoms.

Keywords: Secondary infertility; Uterine fibroid; *Lachesis mutus*; Homoeopathy.

Introduction- Infertility is a major problem in reproductive health with many physical, emotional, social, and financial consequences. According to the World Health Organisation (WHO), infertility is a reproductive disease defined as the inability of an individual to become pregnant during one year or longer of regular and unprotected sexual activity. Infertility may either be primary or secondary, and secondary infertility is the term used when an individual fails to become pregnant after a previous pregnancy. Factors causing infertility may include male problems alone, female causes, and even factors not known for sure. Thus, uterine pathology by itself is enough to explain the problem.[1,4]

Uterine fibroids are known by their alternative names, which include leiomyomas and myomas. They are considered benign tumours located in the uterus. Most of the time, their presence is asymptomatic. [2,3] The relationship between infertility and fibroids is complicated, and having fibroids does not mean that fibroids are the reason for infertility. Thus, a women suffering from infertility should undergo due consideration and examination in cases of having uterine fibroids. [1–3]

The effect of fibroids on infertility in women is determined by the number, size, place of the tumour and involvement of the uterus. It is mainly the fibroid of the endometrial cavity or submucosal fibroids that corresponds to infertility and less maternity percentages .While intramural fibroids next to or involving the endometrium have been correlated with poor reproductive results, there has been a lot of debate regarding their impact and the advantage of their resection. Subserosal fibroids usually do not appear to have any

influence on the fertility status of the woman.[2] Nevertheless, some recent meta-analysis studies have indicated the reduced rate of clinical and ongoing pregnancies/births in those women who had particular intramural leiomyomas.

There are several factors that may contribute to infertility due to fibroids; these include abnormality of uterus' structure, disruption of transport of sperms and gametes, alteration of uterine and endometrial blood flow, inflammatory process, hormonal imbalance, and reduction of endometrial receptivity to implantation. All these factors are variable depending on anatomical characteristics of the leiomyoma.[5]

Managing fibroids in women with the intention of becoming pregnant is done through a personalized approach considering many factors. These factors include the age of the patient, the presence of symptoms, the size of the fibroid, presence of multiple fibroids, the sites of the fibroids, degree of involvement of the uterine cavity, and the needs of the patient.[2,3] Available management options include the choices of expectant management or conservative management, myomectomy by hysteroscopic, abdominal, or laparoscopic approaches, and the use of certain minimally invasive techniques.[2,3] Recent research shows that there is a proven advantage in regard to pregnancy outcomes when hysteroscopically removing certain submucosal fibroids in women who are concerned about their reproductive future, but not much is known about whether there is a reproductive advantage in the case of intramural fibroids that do not alter the shape of the uterine cavity[2]

The current instance has been identified for publication based on the coexistence of secondary infertility as well as uterine fibroid in a case of a woman who has had conception previously. The case is significant on account of the presence of specific mental, emotional, physical and gynaecological symptoms, which enabled the creation of the individualized picture of the symptoms without relying on the pathological diagnosis alone. The peculiarity of the case consists in the individualized homeopathic treatment, which was employed to make the selection of Lachesis mutus based on the totality of the symptoms rather than on the diagnosis of the uterus fibroid or infertility. As a result, the case is a showcase of the elements of homeopathy, including the principles of individualization, totality of symptoms and selection of an individual remedy. The evaluation of the status of the patient was done through a long-term follow-up, involving the monitoring of changes in symptoms, clinical presentation and objective measures with the subsequent improvement of the reproductive status. Therefore, the case is an example of the individual approach used in homeopathy and the applicability of homeopathic principles.

Case History

A 34-year-old married woman, Mrs. XYZ, presented with a history of **secondary infertility** of several years duration. She had been married for approximately 12 years and had a previous history of conception, with her first child born in 2017. Thereafter, she experienced persistent difficulty in conceiving despite regular attempts at pregnancy and sought consultation for evaluation and management of her infertility.

Chief Complaints

1. **Secondary infertility** – inability to conceive after 2017.
2. **Uterine fibroid** – diagnosed on investigation.
3. **Pelvic/left-sided pain**, particularly occurring before menstruation.
4. **Leucorrhoea**, with offensive smell and acrid in nature.
5. **Scanty flow**, with the patient reporting bleeding for 1-2 days from 2-3 Years.

History of Presenting Complaint

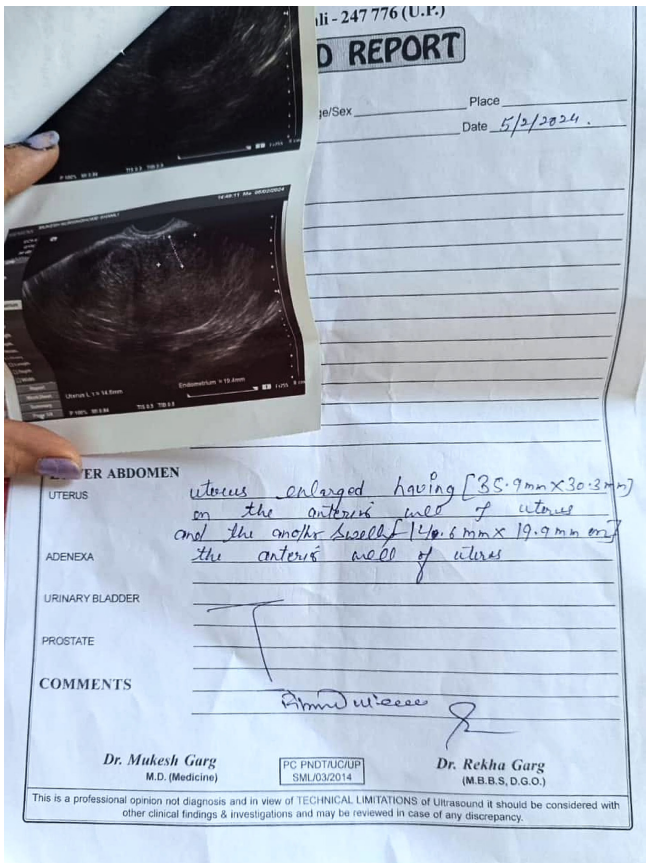
Following her previous conception in 2017, the patient experienced persistent difficulty in achieving another pregnancy. During the evaluation of her infertility, she was diagnosed with a **uterine fibroid** on 5 feb 2024.

The patient also reported menstrual complaints, particularly irregular periods and left sided pain since 2019. She further complained of leucorrhoea with offensive smell which aggravates before

menses and becomes acrid in nature since 3-4years

A detailed case history was taken to explore the patient's characteristic mental, emotional, physical and gynaecological symptoms for the purpose of individualization.

Figure 1- Before Treatment USG (5/02/24):Uterus enlarged having (35.9*30.3mm) on the anterior wall of uterus and the another swelling (14.6mm*19.9mm)on the anterior wall of uterus.



Past History

The patient gave a history of **chikungunya infection during 2017–18 and took allopathic medicine for the same**. No other significant past medical history was clearly documented in the available notes.

Family History

- **Mother:** bronchial asthma; history of cancer was also documented.
- **Father:** constipation and liver-related ailment were noted.
- **Siblings**: five sisters and one brother were documented healthy.

Menstrual History

- **Age at menarche:** approximately 12 years.
- **Cycle:** reported to be irregular.
- **Duration of flow:** 1-2 days
- **Pad used**:2 in total
- **Character of flow:** predominantly Bright red in colour.
- **Pain:** left-sided pain, particularly noted before menstruation.

Physical Generals

Appetite: 3meals per day (2-3chapati/meal)

Thirst: Approximately 3–4l

Food desires: sweet and spicy foods

Bowels: Tendency towards **constipation**.

Urine: No significant abnormality reported.

Sleep: No significant abnormality reported.

Dreams: The patient reported recurrent/characteristic dreams, including **wandering, falling from a height, electricity/shock, snakes and biting**, as documented during case-taking.

Thermals: hot.

Fear: water

Perspiration: profuse, generalised

Sensitivity: neck sensitivity to tight clothes around neck.

Mental Generals

The patient was quick-tempered and easily became angry. She reported experiencing restriction from her in-laws, which was associated with discord in her relationship with her husband. She was loquacious during the consultation. Feelings of envy were expressed in relation to not having a male child. Her sexual desire was reported to be high. These mental and emotional characteristics,

together with the patient's physical generals and characteristic particulars, were considered in the process of individualization and selection of the homoeopathic remedy.

Totality Of Symptom

Loquacious.

Distress from marital discord and persistent restriction by in-laws.

Envy regarding not having a male child.

Hot thermal

Sensitivity of the neck to tight clothing.

Fear of water.

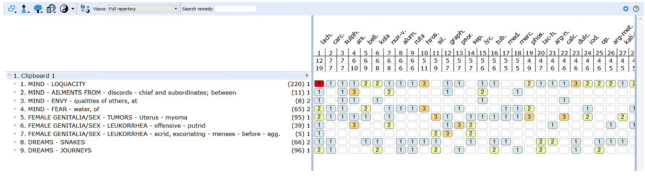
Dreams of snakes and journeying

Offensive, acrid leucorrhoea, aggravated before menstruation.

Uterine fibroid

REPETORIAL ANALYSISIS - from synthesis repertory using radar opus software

Figure 2 – Repertorization Sheet



Repertorial result

1. **Lach - 12/19**
2. **Carc - 7/7**
3. **Sulphur - 7/7**
4. **Ars - 6/10**

Remedy Justification:

Lachesis mutus was selected because of the totality of characteristic symptoms obtained through individualised case-taking. The prescription was supported by the patient's quick-tempered and Great loquacity, feelings of jealousy/envy, increased sexual desire, Cannot bear anything tight anywhere, hot thermal state and profuse perspiration. The gynaecological symptoms, including irregular and scanty menstruation, left-sided pelvic pain before menses, and offensive, acrid leucorrhoea aggravated before menstruation, further corresponded with the remedy picture. The characteristic dreams of snakes and journeying also contributed to remedy differentiation. Thus, the overall symptom similarity with the Materia medica of *Lachesis mutus* led to its selection as the individualized remedy, rather than prescribing solely on the pathological diagnosis of uterine fibroid or secondary infertility[6]

First Prescription:

5/2/24-

Baseline USG confirmed two uterine fibroids (35.9mm*30.3mm)*(14.6mm*19.9mm)

Lachesis 200C *(1 dose stat)*

SAC LAC / BD/ 30 DAYS

Figure 3 : USG (24/4/24): Uterus is enlarged having fibroid measuring 39mm*29mm on the anterior wall of uterus

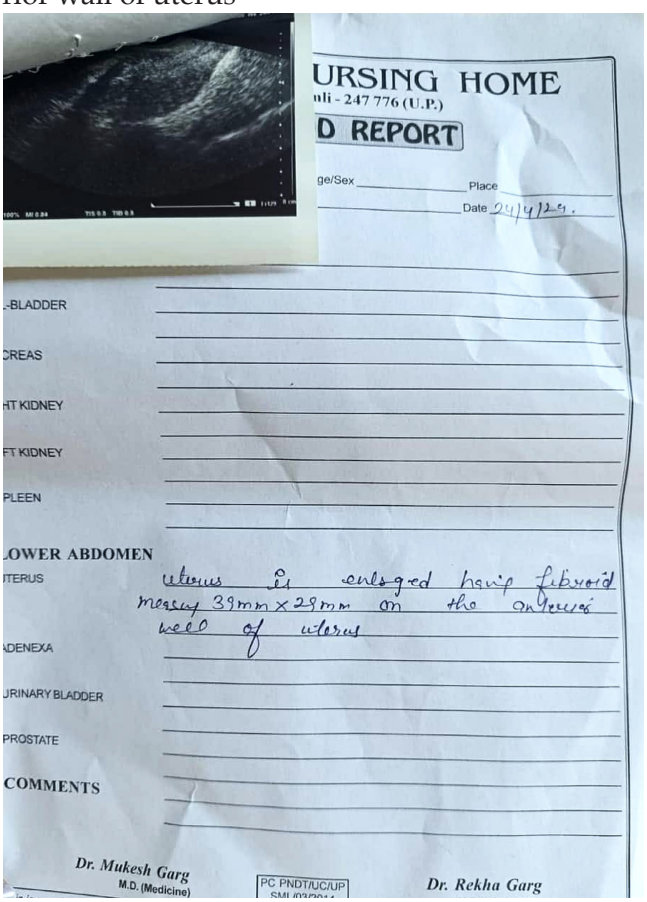
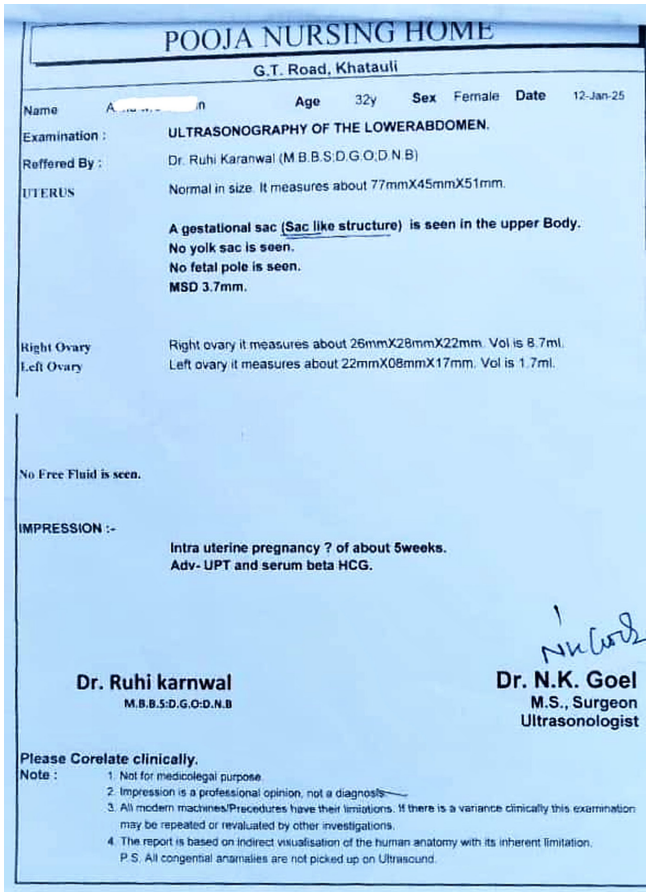


Figure 4: USG ON (12/01/25) A gestational sac is seen in the upper body. Intra uterine pregnancy? Of about 5 week



POOJA NURSING HOME

G.T. Road, Khatauli

Name A...n Age 32y Sex Female Date 12-Jan-25

Examination : ULTRASONOGRAPHY OF THE LOWERABDOMEN.

Reffered By : Dr. Ruhi Karanwal (M.B.B.S;D.G.O;D.N.B)

UTERUS Normal in size. It measures about 77mmX45mmX51mm.

A gestational sac (Sac like structure) is seen in the upper Body.
No yolk sac is seen.
No fetal pole is seen.
MSD 3.7mm.

Right Ovary Right ovary it measures about 26mmX28mmX22mm. Vol is 8.7ml.
Left Ovary Left ovary it measures about 22mmX08mmX17mm. Vol is 1.7ml.

No Free Fluid is seen.

IMPRESSION :-

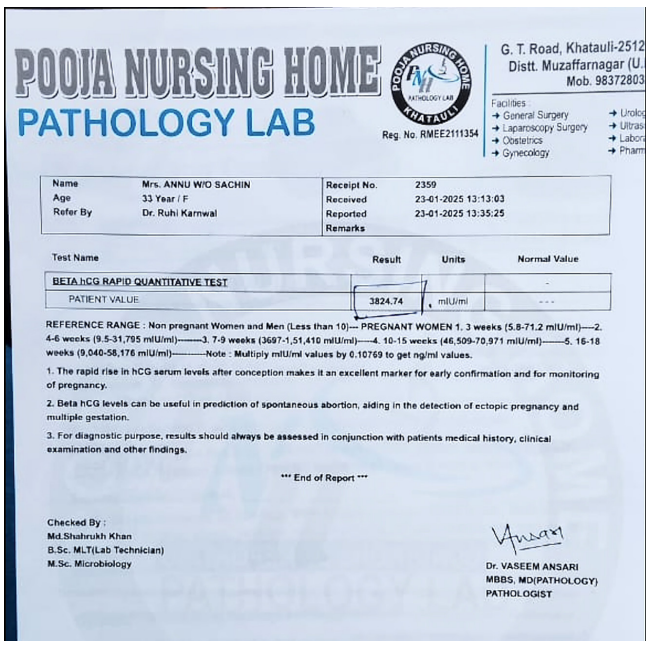
Intra uterine pregnancy ? of about 5weeks.
Adv- UPT and serum beta HCG.

Dr. Ruhi karnwal
M.B.B.S;D.G.O;D.N.B

Dr. N.K. Goel
M.S., Surgeon
Ultrasonologist

Please Corelate clinically.
Note :
1. Not for medicolegal purpose.
2. Impression is a professional opinion, not a diagnosis.
3. All modern machines/Procedures have their limitations. If there is a variance clinically this examination may be repeated or revaluated by other investigations.
4. The report is based on indirect visualisation of the human anatomy with its inherent limitation.
P.S. All congential anomalies are not picked up on Ultrasound.

Figure 5- Beta Hcg Level On 23/01/2025: 3824.74mIU/ml



POOJA NURSING HOME
PATHOLOGY LAB

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Distt. Muzaffarnagar (U...
Mob. 98372803...

Reg. No. RMEE2111354

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→ General Surgery
→ Laparoscopy Surgery
→ Oostetrics
→ Gynecology
→ Urolog...
→ Ultras...
→ Labor...
→ Pharm...

Name	Mrs. ANNU W/O SACHIN	Receipt No.	2359
Age	33 Year / F	Received	23-01-2025 13:13:03
Refer By	Dr. Ruhi Karnwal	Reported	23-01-2025 13:35:25
		Remarks	

Test Name	Result	Units	Normal Value
BETA hCG RAPID QUANTITATIVE TEST			-
PATIENT VALUE	3824.74	mIU/ml	- - -

REFERENCE RANGE : Non pregnant Women and Men (Less than 10)--- PREGNANT WOMEN 1. 3 weeks (5.8-71.2 mIU/ml)----2. 4-6 weeks (9.5-31,795 mIU/ml)--------3. 7-9 weeks (3697-1,51,410 mIU/ml)-----4. 10-15 weeks (46,509-70,971 mIU/ml)-------5. 16-18 weeks (9,040-58,176 mIU/ml)----------Note : Multiply mIU/ml values by 0.10769 to get ng/ml values.

1. The rapid rise in hCG serum levels after conception makes it an excellent marker for early confirmation and for monitoring of pregnancy.
2. Beta hCG levels can be useful in prediction of spontaneous abortion, aiding in the detection of ectopic pregnancy and multiple gestation.
3. For diagnostic purpose, results should always be assessed in conjunction with patients medical history, clinical examination and other findings.

*** End of Report ***

Checked By :
Md.Shahrukh Khan
B.Sc. MLT(Lab Technician)
M.Sc. Microbiology

Dr. VASEEM ANSARI
MBBS, MD(PATHOLOGY)
PATHOLOGIST

Date	Observation	Medicine given
7/3/24	Menses appeared on 15/02/2024. Leucorrhoea slightly reduced in quantity.	SAC LAC / BD/ 30 DAYS
5/4/24	Menses on 17/03/2024. Leucorrhoea persisted with acridity. Improvement plateaued.	***Lachesis 200C*** in water potency (1 dose) Sac Lac/BD/ 30days
1/5/24	Menses on 15/04/2024. General improvement. Repeat USG (29/04/2024): Anterior wall fibroid completely resolved; single fibroid remaining measured 39mm * 29 mm	SAC LAC / BD/ 30 DAYS
5/6/24	Menses on 12/05/2024. Leucorrhoea and low vitality stagnant.	***Lachesis 1M*** (stat) SAC LAC / BD/ 30 DAYS
3/7/24	Menses on 14/06/2024. Dreams of snakes completely ceased. Leucorrhoea resolved without acridity before menses.	SAC LAC / BD/ 30 DAYS
5/8/24	Menses on 13/07/2024. Progress reached a standstill.	***Lachesis 1M*** in water potency (1 dose) SAC LAC / BD/ 30 DAYS
3/9/24	Menses on 15/08/2024. Overall vitality and energy levels significantly improved.	SAC LAC / BD/ 30 DAYS
4/10/24	Menses on 15/09/2024. Neck hypersensitivity to clothes still remain same. Stalled recovery.	***Lachesis 10M*** (stat) SAC LAC / BD/ 30 DAYS
7/11/24	Menses on 13/10/2024. General relief across all parameters.	SAC LAC / BD/ 30 DAYS
2/12/24	Menses on 15/11/2024. Neck sensitivity resolved; sound, refreshing sleep.	SAC LAC / BD/ 30 DAYS
7/1/25	Menses overdue. Advised Urine Pregnancy Test (UPT), Pelvic USG and Serum Beta-HCG.	SAC LAC / BD/ 30 DAYS

DISCUSSION

The origins of secondary infertility are complicated, and it is possible that uterine fibroids are harmful to fertility depending on their size and position. This case features a 34-year-old woman suffering from secondary infertility with

significant background history of conception, as well as from uterine fibroids, together with the presence of key mental, emotional, physical and gynaecological issues. The patient was treated by Lachesis mutus which was chosen based on her unique symptoms instead of a disease diagnosis that has been made as such. The case shows the importance of the individuality of the patient and totality of symptoms " both very crucial in homoeopathic treatment.

CONCLUSION

This case demonstrates how individualized treatment and totality of symptoms work in homeopathy in treating secondary infertility caused by uterine fibroid. Lachesis mutus was selected based on the patient's symptom picture as well as careful clinical examination and blood tests. Improvement in clinical condition and reproductive status indicates that further studies are needed in order to elucidate the role of individualized homeopathy in these cases.

Declaration of patient consent

Patient's consent form was obtained. The patient has given their consent for clinical information to be reported in a journal, the patient understands their name will not be published and due effort was made to conceal their identity.

Conflict of Interest

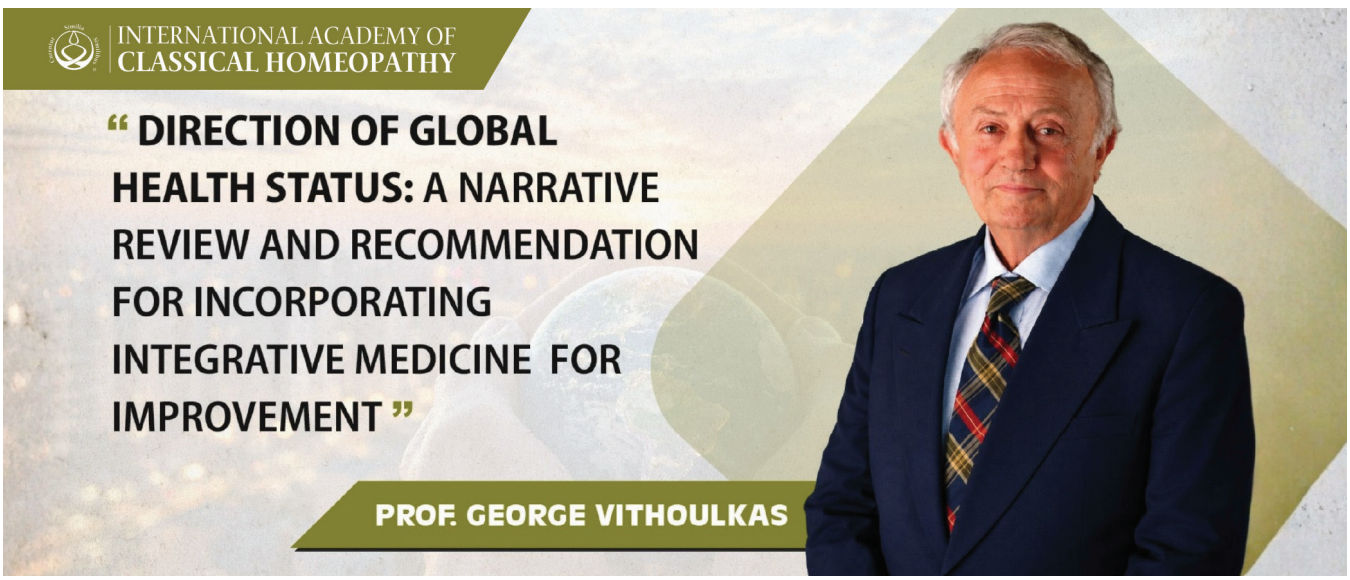
The author has no conflict of interest related to the study to disclose.

Financial Support

The author received no financial support, sponsorship, or grants related to the study to disclose.

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Individualized Homoeopathic Approach in Male Infertility Associated with Erectile Dysfunction Despite Normal Semen Parameters: A Case Report



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PEER REVIEWED

Abstract

Background: Infertility is a couple-centred reproductive health problem and may involve female factors, male factors, both partners or circumstances in which no biological cause is identified. In the male partner, infertility assessment traditionally emphasizes reproductive history and semen analysis; however, sexual function represents a separate and clinically important component of fertility. Erectile dysfunction may directly compromise the opportunity for natural conception when satisfactory penetrative intercourse cannot be consistently achieved.

Case Presentation: A 32-year-old married male presented with a three-year history of failure to achieve conception despite regular unprotected intercourse. Semen analysis demonstrated normal sperm concentration, motility and morphology with no significant abnormality identified in the available reproductive evaluation. His principal difficulty was erectile dysfunction characterized by inadequate maintenance of erection during intercourse. He reported normal sexual desire but described repeated failure during attempts at intercourse. Detailed homoeopathic case taking revealed marked anticipatory anxiety, loss of self-confidence, fear of failure, sensitivity to the perceived judgement of his wife and persistent fear of disappointing his wife and strong desire to appear competent despite underlying insecurity. The characteristic totality was repetorized and correlated with materia medica leading to selection of Lycopodium clavatum.

Intervention and Outcome: Following individualized homoeopathic management, progressive improvement was observed in anticipatory anxiety, confidence and erectile function with subsequent restoration of satisfactory intercourse. Semen analysis was within normal limits (2 ml volume, opalescent appearance and total volume of 28 million/ml and interpretation of normozoospermia) with no significant abnormality. Following improvement, the couple subsequently achieved conception. The pregnancy was therefore documented as the reproductive outcome of the case.

Conclusion: The case highlights sexual dysfunction as potentially modifiable contributor to infertility despite normal semen parameters. Individualized homoeopathic treatment was based on the characteristic mental, general and sexual symptom complex. Improvement in erectile function was followed by a confirmed pregnancy, providing a clinically significant reproductive outcome.

Keywords

Erectile dysfunction, Semen analysis, Male infertility, Lycopodium clavatum

Introduction

Infertility is defined by the World Health Organization as failure to achieve pregnancy after 12 months or more of regular unprotected sexual intercourse. It may arise from male, female, combined or unexplained factors, necessitating a couple-centred approach to evaluation rather than

attribution to either partner alone.[1]

Male fertility assessment includes reproductive history and semen analysis as fundamental components of initial evaluation. Sexual dysfunction, particularly erectile dysfunction may interfere with the ability to achieve to achieve satisfactory intercourse and consequently become a clinically relevant contributor to infertility. The ASRM notes that erection is an essential component of unassisted conception, while sexual dysfunction is commonly encountered among men presenting with infertility.[2]

Erectile dysfunction is characterized by persistent difficulty attaining or maintaining an erection sufficient for satisfactory sexual activity. Importantly, semen analysis and erectile function assess different aspects of male reproductive health; therefore, a man may have normal semen parameters while experiencing erectile difficulty that interferes with intercourse. Current EAU guidance recommends detailed medical and sexual history in the assessment of erectile dysfunction, including erection rigidity and duration, morning erections, sexual desire, ejaculation and orgasm. [3]

Thus, a man may have normal semen parameters yet experience infertility at the couple level when erectile dysfunction interferes with satisfactory intercourse. From a homoeopathic perspective, the diagnostic label alone does not constitute the totality of the case; individualization requires consideration of the characteristic metal, general and sexual manifestations. The present case therefore focuses on erectile dysfunction interfering with conception despite normal seminal parameters, with treatment guided by the patient's individualized symptom complex.

Case Study:

Patient Information: A 32-year-old married male with his wife on 18th July 2025 presented with chief concern of failure to achieve conception for three years despite regular unprotected intercourse. The patient belonged to an urban middle socioeconomic background and was employed in private sector occupation. The couple the couple got married 4 years back and had regular marital relations. There was no history of suggestive of previous conception.

Chief Complaints: Difficulty in maintaining penile erection during sexual intercourse for 3 years. There was anticipatory anxiety regarding sexual performance particularly before intercourse with progressive loss of confidence related to repeated episodes of erectile failure, associated with concern regarding his inability to achieve pregnancy with his wife.

History of Presenting Illness: The patient was apparently well at the beginning of his married life and initially had satisfactory sexual functioning. Approximately 3 years prior to presentation, he began experiencing occasional difficulty in maintaining penile erection during intercourse. Initially, the episodes were infrequent and did not cause significant concern. He was able to develop an erection adequately but noticed that the rigidity would sometimes decrease before completion of intercourse. Following repeated episodes, he gradually became apprehensive about his sexual performance. With the couple's increasing concern regarding conception, intercourse gradually acquired a performance-oriented character. The patient reported that the difficulty became particularly prominent when intercourse was consciously planned around the presumed fertile period of his wife. He described a characteristic anticipatory sequence:

"As soon as he knew that intercourse was expected that day, he would begin to feel anxious about whether he would be able to maintain an erection or not".

He would begin thinking about his previous unsuccessful attempts before sexual activity had even started. During intercourse, instead of remaining focused on sexual stimulation, he became increasingly conscious of the firmness of his erection and repeatedly assessed whether he was performing adequately. Once he noticed even a slight reduction in rigidity, he became anxious that the erection would be lost completely. This further increased his difficulty in maintaining the erection. The patient reported that the problem was uniformly present in every sexual situation but the difficulty was most pronounced when intercourse undertaken specifically with intention of achieving pregnancy.

Sexual History:

1. **Libido:** Sexual desire was preserved with normal interest in sexual activity and attraction towards his wife.
2. **Onset of erection:** Generally able to develop an erection with adequate sexual stimulation and initial erection was usually sufficient for penetration.
3. **Penile Rigidity:** Principal difficulty was maintaining penile rigidity throughout intercourse and decreases gradually during intercourse particularly when he became conscious of the possibility of losing erection. He described: "at first, erection is fine, but the firmness starts decreasing during intercourse."
4. **Duration of erection:** Erection was generally sufficient to initiate intercourse but was not consistently maintained until completion. The patient was unable to specify an exact duration in minutes but consistently described progressive loss of firmness during intercourse.
5. **Morning erections:** These were present intermittently. He noticed that erections occurring spontaneously, particularly on waking, could sometimes be firmer than those during planned ones.
6. **Erections during masturbation:** Erections during self-stimulation were comparatively better maintained than during intercourse specifically for conception.
7. **Erectile function with previous partners:** No history of previous sexual partnership.
8. **Ejaculation:** Was present and generally normal when adequate erection was maintained. But when penile rigidity decreased during intercourse to the extent that sexual activity had to be discontinued before orgasm, ejaculation did not occur on those occasions. There was no history of a primary ejaculatory disorder, painful, retrograde or delayed ejaculation.
9. **Orgasm:** Achieved on occasions when the patient was able to maintain sufficient penile rigidity; however, on most occasions progressive loss of penile rigidity during intercourse led to discontinuation of sexual activity before orgasm could be achieved. There was no history of anorgasmia.
10. **Sexual satisfaction:** Progressively declined because intercourse had become associated with fear of erectile failure. The patient stated that earlier sexual activity had become spontaneous and enjoyable whereas after onset of infertility related pressure, he increasingly approached intercourse as a task that he had to successfully accomplish.

Mental Generals:

Patient reported that anxiety begins before sexual activity. There was persistent fear that he will again be unable to maintain erection. Patient developed excessive attention to erection during intercourse. Repeated episodes of the same have progressively reduced his confidence. Patient became highly concerned regarding how his wife perceives his sexual ability. Patient desires to appear competent and conceal his insecurity from others. Feels embarrassed on sexual failure and on discussing about it. Becomes quiet and avoids conversation with his wife after unsuccessful attempt. Patient said that he becomes irritated and angry when anyone asks about pregnancy even, he loses temper on little things and gets irritated.

Physical Generals:

Appetite: 3 times a day; 3 chapatis with dal and sabzi for lunch and dinner and fruits for breakfast. Feels bloated after every meal even after fruits.

Thirst: 4-5 L per day; one to two glasses at a time

Desire: sweets, warm food

Aversion: cold food, cold water, cold drinks

Stool: once in morning; unsatisfactory most of the times

Urine: clear

Perspiration: not much

Addiction: no such

Thermal Reaction: Chilly

Sleep and Dreams: sound sleep but sometimes

unrefreshed due to erectile stress. No such dreams found.

Past Medical history: No significant history of any chronic medical illness, surgery, major infection.

Family history: No significant history of diabetes mellitus, hypertension, endocrine disorders, infertility or any other.

General Examination: Patient was conscious, oriented, co-operative, well-built and nourished with no abnormality of clinical significance. No pallor, icterus, cyanosis, lymphadenopathy with normal pulse and BP.

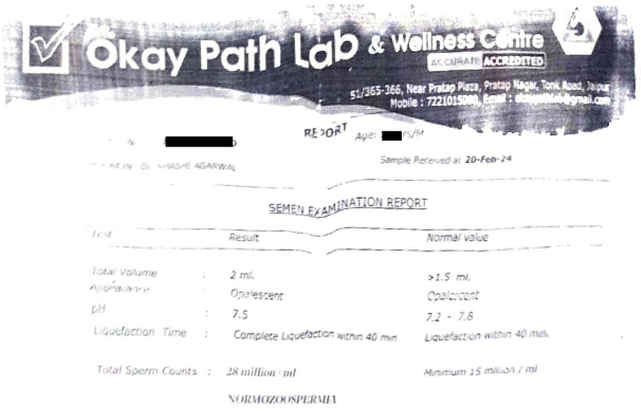
Systemic Examination: Cardiovascular, respiratory, abdominal and central nervous system examination revealed no clinically significant abnormality.

Genital Examination: External genital examination was unremarkable with no clinically abnormality of external genitalia. No local lesion, deformity or other abnormal finding relevant to presenting complaint was noted.

Investigations and Diagnostic Assessment:

1. **Semen Analysis:** The semen analysis of patient was normal indicating Normozoospermia (Fig no. 1)

Figure No. 1: Semen analysis


Okay Path Lab & Wellness Centre

ACCURATE ACCREDITED

51/365-366, Near Pratap Plaza, Pratap Nagar, Tonk Road, Jaipur

Mobile : 7221015000, Email : okaypathlab@gmail.com

REPORT Age: [redacted] Y/M

Sample Received at 20-Feb-24

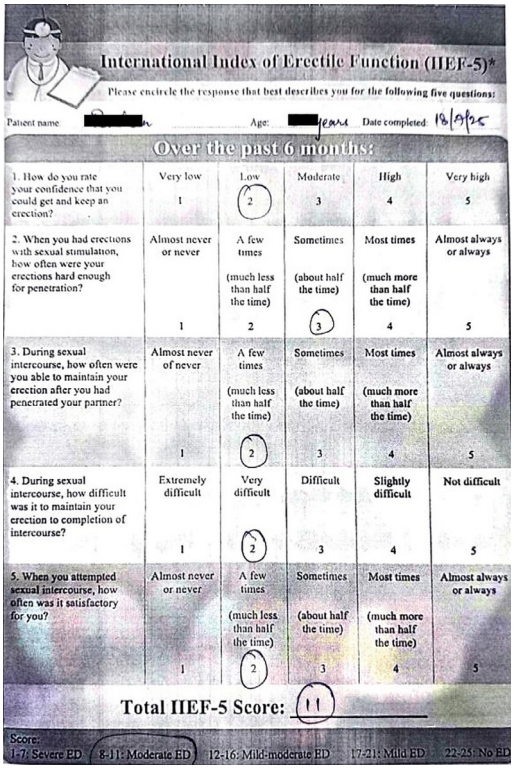
SEMEN EXAMINATION REPORT

Test	Result	Normal value
Total Volume	2 ml.	>1.5 ml.
Appearance	Opalescent	Opalescent
pH	7.5	7.2 - 7.8
Liquefaction Time	Complete Liquefaction within 40 min	Liquefaction within 40 min.
Total Sperm Counts	28 million / ml	Minimum 15 million / ml

NORMOZOOSPERMIA

2. **Assessment of Erectile Function:** Erectile function was assessed using the International Index of Erectile Function – 5 (IIEF-5). The patient scored 11 at baseline, indicating moderate erectile dysfunction. (Fig. no. 2)

Figure no. 2: Assessment of Erectile Function – Before Treatment


International Index of Erectile Function (IIEF-5)*

Please encircle the response that best describes you for the following five questions:

Patient name: [redacted] Age: [redacted] year Date completed: 19/9/25

Over the past 6 months:

1. How do you rate your confidence that you could get and keep an erection?	Very low 1	Low (2)	Moderate 3	High 4	Very high 5
2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration?	Almost never or never 1	A few times (much less than half the time) 2	Sometimes (about half the time) (3)	Most times (much more than half the time) 4	Almost always or always 5
3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated your partner?	Almost never of never 1	A few times (much less than half the time) (2)	Sometimes (about half the time) 3	Most times (much more than half the time) 4	Almost always or always 5
4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	Extremely difficult 1	Very difficult (2)	Difficult 3	Slightly difficult 4	Not difficult 5
5. When you attempted sexual intercourse, how often was it satisfactory for you?	Almost never or never 1	A few times (much less than half the time) (2)	Sometimes (about half the time) 3	Most times (much more than half the time) 4	Almost always or always 5

Total IIEF-5 Score: (11)

Score: 1-7: Severe ED | 8-11: Moderate ED | 12-16: Mild-moderate ED | 17-21: Mild ED | 22-25: No ED

Diagnosis: Male Infertility associated with Situational Erectile Dysfunction

Analysis of Symptoms:

MENTALS	PHYSICALS	PARTICULARS
• Anticipation before intercourse • Fear of failure • Loss of confidence • Sensitive to opinion of others • Feels embarrassed • Affectation • Timidity • Irritability at trifles • Anger at trifles	• Desires: warm food, sweets • Aversion: cold drink, cold water	• Weak and difficult erections • Flaccidity of genitalia

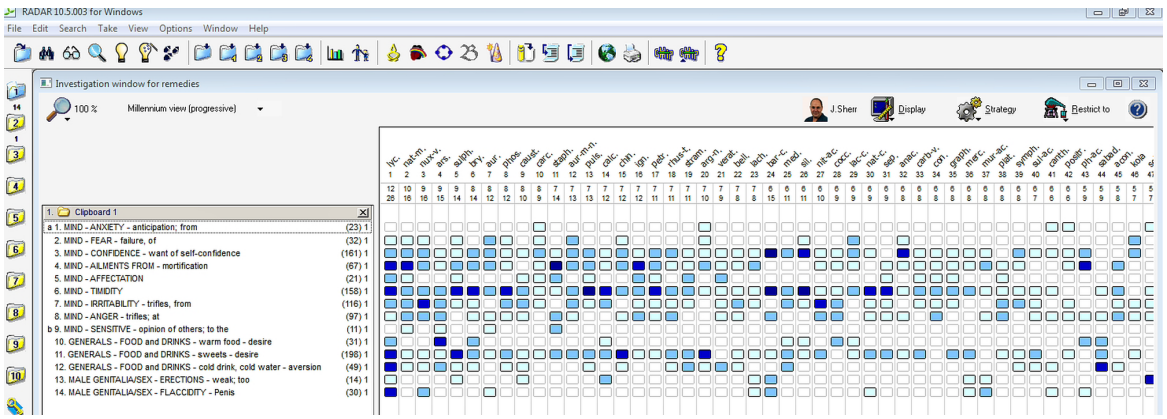
Evaluation of Symptoms:

- Anticipation before intercourse
- Fear of failure
- Loss of confidence
- Sensitive to opinion of others
- Feels embarrassed
- Affectation
- Timidity
- Irritability at trifles
- Anger at trifles
- Desires: warm food, sweets
- Aversion: cold drink, cold water
- Weak and difficult erections
- Flaccidity of genitalia

Totality of symptoms:

- Anticipation before intercourse
- Fear of failure
- Loss of confidence
- Sensitive to opinion of others
- Feels embarrassed
- Affectation
- Timidity
- Irritability at trifles
- Anger at trifles
- Desires: warm food, sweets
- Aversion: cold drink, cold water
- Weak and difficult erections
- Flaccidity of genitalia

Repertorial Analysis:



Repertorial analysis showed *Lycopodium clavatum* as leading remedy covering 26/12 rubrics because the characteristic picture of anticipatory anxiety regarding intercourse, apprehension about maintaining erection, progressive loss of penile rigidity and associated loss of confidence with preserved libido correspond most solely with Lycopodium clavatum.

Prescription:

DATE	SYMPTOM	PRESCRIPTION
18.07.2025	• Difficulty in maintaining penile erection with anticipatory anxiety before intercourse, loss of confidence and loss of penile rigidity during intercourse **Advice:** Avoidance of turning every sexual intercourse into a performance test and to maintain open communication with his partner.	Rx • LYCOPODIUM CLAVATUM 200/ HS/1 DAY • RUBRUM 30/TDS/15 DAYS

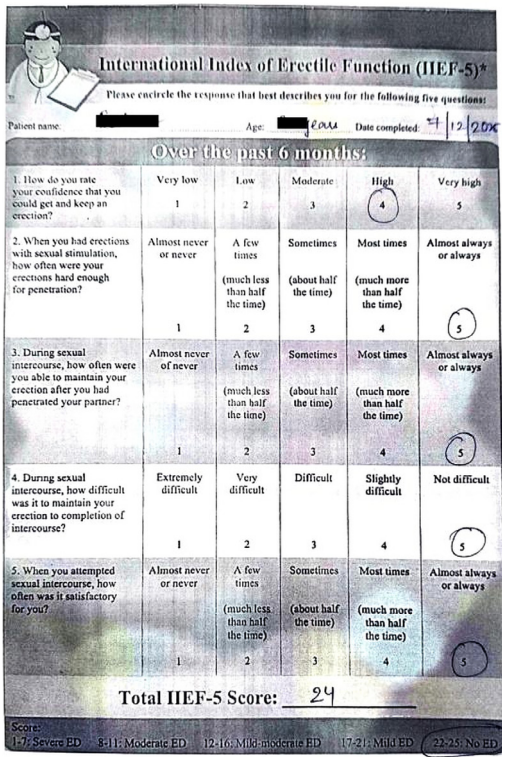
Follow up summary:

DATE	OBSERVATION AND PROGRESS	PRESCRIPTION
02.08.2025	Slight improvement in erectile function. Adequate erection achieved for penetration but penile rigidity still decreased during intercourse although less abruptly than before. Duration of maintained erection showed modest improvement. Anticipatory anxiety regarding planned intercourse persisted, but with reduced intensity.	Rx RUBRUM 30/TDS/15 DAYS
17.08.2025	Further improvement in erection maintenance and penile rigidity for longer duration with fewer interruptions during intercourse due to loss of erection. Anticipatory anxiety and preoccupation regarding erection maintenance decreased with improved confidence.	Rx RUBRUM 30/TDS/15 DAYS
01.09.2025	Marked improvement in in erectile stability. Rigidity remained adequate for most of intercourse with occasional reduction in firmness. The previous progressive loss of rigidity was reduced. Anticipatory apprehension and performance related anxiety persisted with lesser intensity.	Rx RUBRUM 30/TDS/15 DAYS
16.09.2025	Continued improvement in erectile rigidity and maintenance with occasional reduction in firmness. Mild residual apprehension regarding performance was still present, particularly during intercourse planned for conception.	Rx LYCOPODIUM CLAVATUM 200/HS/1 DAY RUBRUM 30/TDS/15 DAYS
01.10.2025	Improvement in erectile stability. Erection achieved readily and maintained with satisfactory rigidity throughout intercourse on most occasions. Anticipatory anxiety became minimal, with increased confidence during intercourse.	RUBRUM 30/TDS/15 DAYS
16.10.2025	Improvement sustained with consistent maintenance of penile rigidity and no significant interruption of intercourse due to loss of erection. Duration of satisfactory erection improved considerably. No significant anticipatory tension regarding planned intercourse with improved confidence and reduced performance related apprehension.	RUBRUM 30/TDS/15 DAYS
31.10.2025	Erectile function remained stable and satisfactory. Adequate erection for penetration and maintained throughout intercourse without previous loss of rigidity. No anticipatory anxiety regarding erection maintenance and confidence remained improved.	RUBRUM 30/TDS/15 DAYS
22.11.2025	Clinical improvement remained sustained. Satisfactory erectile rigidity and maintenance and no recurrence of earlier progressive loss of firmness. Intercourse no longer discontinued due to erectile failure. Previous anticipatory concern about maintaining erection was no longer significant.	RUBRUM 30/TDS/15 DAYS
07.12.2025	Satisfactory erectile function and sexual performance without significant recurrence of difficulty in maintaining erection. No new complaint with normal sexual desire. Previous prominent anticipatory anxiety remained absent with sustained improvement in confidence.	RUBRUM 30/TDS/15 DAYS
22.12.2025	Sustained improvement in erectile function with satisfactory attainment and maintenance of penile rigidity during intercourse. Earlier progressive loss of rigidity preventing completion of intercourse was no longer reported. Anticipatory anxiety regarding planned intercourse had resolved with restoration of confidence in sexual performance.	No more repetition with closing of case.

Outcome Assessment: Progressive improvement in erectile function was observed. The initial difficulty in maintaining penile rigidity gradually reduced, and by later, erection was adequately achieved and maintained throughout intercourse. Anticipatory anxiety regarding planned intercourse progressively decreased and was absent at final assessment with corresponding improvement in sexual confidence. The patient gradually regained the ability to maintain satisfactory intercourse without premature loss of rigidity. Intercourse was no longer interrupted due to erectile failure.

Erectile function was reassessed using International Index of Erectile Function-5 (IIEF-5). The patient scored 24, indicating no erectile dysfunction and marked improvement. (Fig. no. 3)

Fig. no. 3: Assessment of Erectile Function – After Treatment



International Index of Erectile Function (IIEF-5)*

Please encircle the response that best describes you for the following five questions:

Patient name: [redacted] Age: [redacted] Date completed: 7/12/20[redacted]

Over the past 6 months:

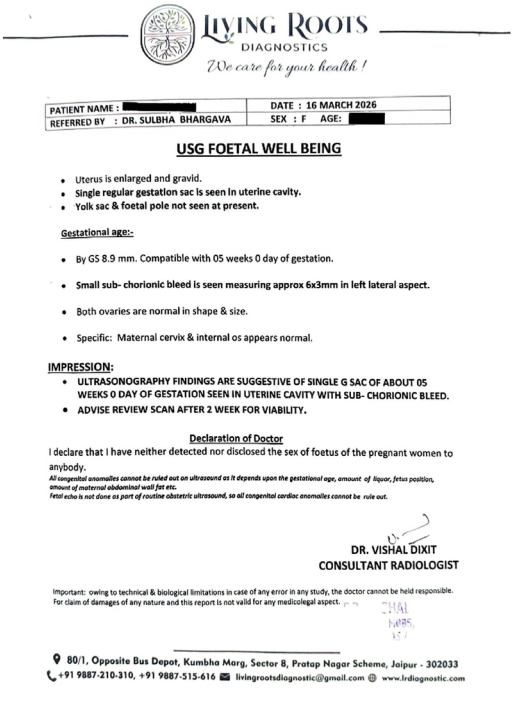
1. How do you rate your confidence that you could get and keep an erection?	Very low 1	Low 2	Moderate 3	High (4)	Very high 5
2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration?	Almost never or never 1	A few times (much less than half the time) 2	Sometimes (about half the time) 3	Most times (much more than half the time) 4	Almost always or always (5)
3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated your partner?	Almost never of never 1	A few times (much less than half the time) 2	Sometimes (about half the time) 3	Most times (much more than half the time) 4	Almost always or always (5)
4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	Extremely difficult 1	Very difficult 2	Difficult 3	Slightly difficult 4	Not difficult (5)
5. When you attempted sexual intercourse, how often was it satisfactory for you?	Almost never or never 1	A few times (much less than half the time) 2	Sometimes (about half the time) 3	Most times (much more than half the time) 4	Almost always or always (5)

Total IIEF-5 Score: 24

Score:
1-7: Severe ED 8-11: Moderate ED 12-16: Mild-moderate ED 17-21: Mild ED 22-25: No ED

Following restoration of satisfactory intercourse, Pregnancy was subsequently confirmed, representing the principal clinical outcome. (Fig. no. 4 and 5)

Fig. no. 4: USG at 5 weeks of gestation



LIVING ROOTS DIAGNOSTICS
We care for your health !

PATIENT NAME : [redacted] DATE : 16 MARCH 2026
REFERRED BY : DR. SULBHA BHARGAVA SEX : F AGE: [redacted]

USG FOETAL WELL BEING

- Uterus is enlarged and gravid.
- Single regular gestation sac is seen in uterine cavity.
- Yolk sac & foetal pole not seen at present.

Gestational age:-

- By GS 8.9 mm. Compatible with 05 weeks 0 day of gestation.
- Small sub- chorionic bleed is seen measuring approx 6x3mm in left lateral aspect.
- Both ovaries are normal in shape & size.
- Specific: Maternal cervix & internal os appears normal.

IMPRESSION:

- ULTRASONOGRAPHY FINDINGS ARE SUGGESTIVE OF SINGLE G SAC OF ABOUT 05 WEEKS 0 DAY OF GESTATION SEEN IN UTERINE CAVITY WITH SUB- CHORIONIC BLEED.
- ADVISE REVIEW SCAN AFTER 2 WEEK FOR VIABILITY.

Declaration of Doctor

I declare that I have neither detected nor disclosed the sex of foetus of the pregnant women to anybody.

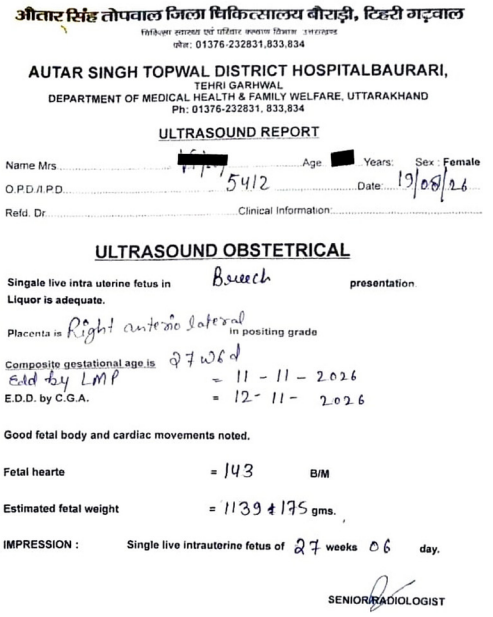
All congenital anomalies cannot be ruled out on ultrasound as it depends upon the gestational age, amount of liquor, fetus position, amount of maternal abdominal wall fat etc.
Fetal echo is not done as part of routine obstetric ultrasound, so all congenital cardiac anomalies cannot be rule out.

DR. VISHAL DIXIT
CONSULTANT RADIOLOGIST

Important: owing to technical & biological limitations in case of any error in any study, the doctor cannot be held responsible. For claim of damages of any nature and this report is not valid for any medicolegal aspect.

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Fig. no. 5: USG at 27 weeks of gestation



औतार सिंह तोपवाल जिला चिकित्सालय बौराड़ी, टिहरी गढ़वाल
चिकित्सा स्वास्थ्य एवं परिवार कल्याण विभाग उत्तराखण्ड
फोन: 01376-232831,833,834

AUTAR SINGH TOPWAL DISTRICT HOSPITALBAURARI,
TEHRI GARHWAL
DEPARTMENT OF MEDICAL HEALTH & FAMILY WELFARE, UTTARAKHAND
Ph: 01376-232831, 833,834

ULTRASOUND REPORT

Name Mrs [redacted] Age [redacted] Years: Sex : Female
O.P.D./I.P.D. 5412 Date: 19/08/26
Refd. Dr. Clinical Information:

ULTRASOUND OBSTETRICAL

Singale live intra uterine fetus in Breech presentation
Liquor is adequate.
Placenta is Right anterio lateral in positing grade
Composite gestational age is 27 W6d
Edd by LMP = 11-11-2026
E.D.D. by C.G.A. = 12-11-2026
Good fetal body and cardiac movements noted.
Fetal hearte = 143 B/M
Estimated fetal weight = 1139 ± 175 gms.
IMPRESSION : Single live intrauterine fetus of 27 weeks 06 day.

SENIOR RADIOLOGIST

Causal **Attribution – MONARCH Criteria:**

Scoring		
S.No.	**Domain**	**Score**
1.	Was there an improvement in the main symptom or condition for which the homoeopathic medicine was prescribed?	+2
2.	Did the clinical improvement occur within a plausible timeframe relative to the administration of the medicine?	+1
3.	Was there an initial aggravation of symptoms?	0
4.	Did the effect encompass more than the main symptom (i.e., improvement in other symptoms)?	+1
5.	Did overall well – being improve?	+1
6.	(A) Direction of cure: did some symptoms improve in the opposite order of the development of symptoms of the disease?	0
6.	(B) Direction of cure: did at least 2 of the following aspects apply to the order of improvement of symptoms: from organs of more importance to those of less importance, from deeper to more superficial aspects of the individual, from the top downwards	0
7.	Did "old symptoms" reappear temporarily during improvement?	+1
8.	Are there alternative causes that could have produced the improvement?	+1
9.	Was there objective evidence of improvement?	+2
10.	Did repeat dosing, if conducted, produce similar clinical improvement?	+1
Total = 10, indicating Definite Causal Relationship		

DISCUSSION:

Normal semen parameters do not exclude a functional barrier to conception. In this case, difficulty maintaining penile rigidity interfered with satisfactory intercourse despite normal semen analysis. Erectile difficulty occurred predominantly during intercourse planned for conception. Anticipatory concern about maintaining erection was followed by anxiety and progressive loss of rigidity, highlighting relationship between psychological anticipation and sexual performance. The principal dysfunction was erectile, specifically difficulty maintaining rigidity. Ejaculation was not primary complaint and did not occur when loss of rigidity required discontinuation of intercourse before completion. The case was individualized on the basis of characteristic mentals and sexual symptoms which further supported Lycopodium 200C. progressive improvement in erectile rigidity and maintenance was observed. Satisfactory intercourse was subsequently achieved and pregnancy was confirmed.

Limitations: As a single case report, the improvement cannot establish causal efficacy of homoeopathic treatment. The subsequent pregnancy represents a clinically relevant reproductive outcome following restoration of satisfactory intercourse. Further controlled studies are required to evaluate the reproducibility of such outcomes.

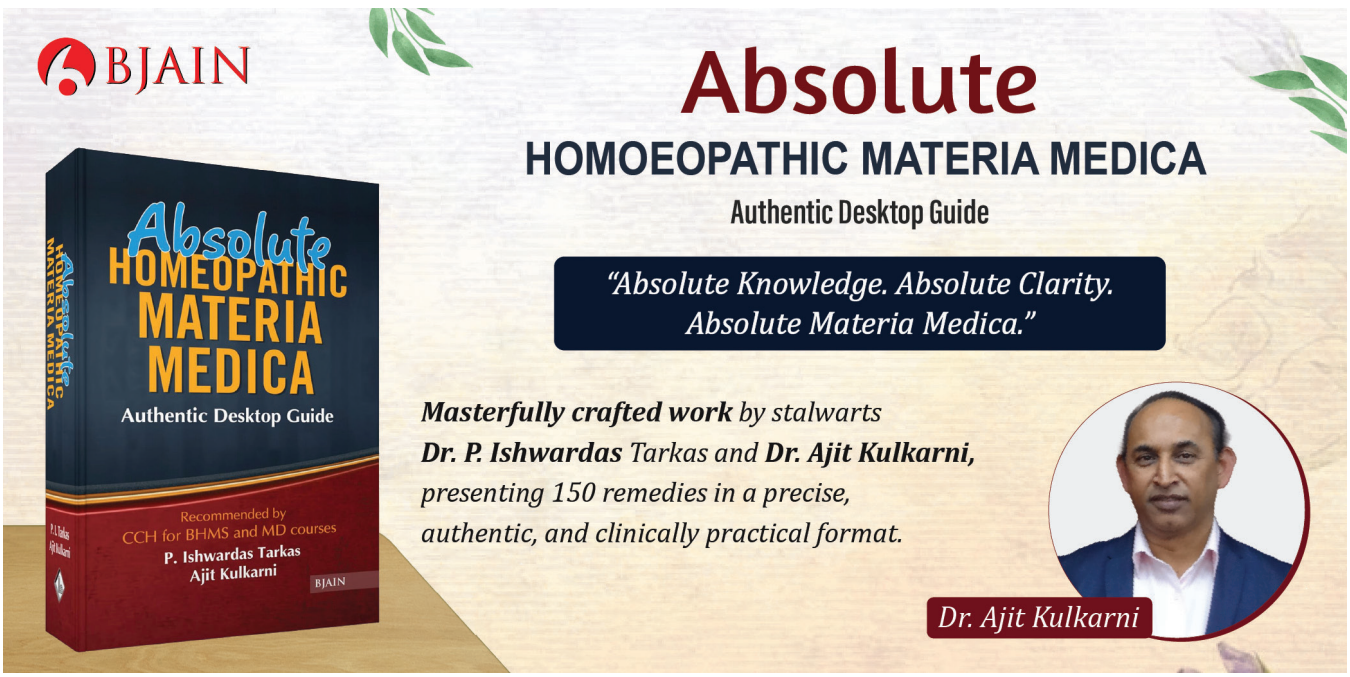
Patient Perspective: The patient reported gradual restoration of confidence in his sexual performance with reduced anxiety regarding planned intercourse and improved ability to maintain erection. He expressed satisfaction with the improvement and the subsequent achievement of pregnancy.

CONCLUSION:

This case highlights the clinical relevance of situational erectile dysfunction as a functional barrier to conception despite normal semen parameters. Individualized homoeopathic management was followed by progressive improvement in erectile function, reduction in anticipatory anxiety and restoration of satisfactory intercourse, with subsequent confirmed pregnancy.

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Successful Outcome of Primary Infertility with Individualized Homoeopathy: A Case Report

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PEER REVIEWED

Abstract

Introduction: Primary infertility is a term used to describe a couple that has never been able to conceive a pregnancy after a minimum of 1 year unprotected intercourse. Causes of infertility have an impact on their families and communities affect millions of people. Estimates suggest that approximately one in every six people of reproductive age worldwide experience infertility in their lifetime. Female infertility can be exacerbated by ovulation problems, fallopian tube obstructions, structural uterine abnormalities, endometriosis, irregular menstrual cycles, and hormonal abnormalities. Primary Male infertility can be impacted by conditions including low sperm count, slow sperm motility, irregular sperm shape, varicocele and erectile dysfunction, infections, hormonal abnormalities, Life style disorders like smoking, alcohol/drug addiction, trauma to the reproductive system.

Methods: The case was treated at JIMS Homoeopathic medical college and Hospital. A 23 years old-female patient complaints of failure to conceive from last 5years. The patient was treated with individualized homoeopathic medicine from August 2022 to June 2024. During follow up visits, treatment outcome was assessed using modified Naranjo criteria to confirm the changes due to Homoeopathic medicine.

Results: After 8 months of observational period, patient was conceived and after 14 months menses are regular with normal ovaries was seen with individualised homoeopathic medicine. This method of treatment will be followed by practitioners in the treatment of primary infertility due to PCOS, as a complimentary health practice.

Conclusion: Considering the multi-factorial aetiology of primary infertility, individualised homoeopathic medicine (iHOM) with life style modification is associated in treating primary infertility caused by PCOS.

Keywords

Primary infertility, PCOS, Individualized Homoeopathic medicine

Introduction

Infertility is a serious health issue now a day's worldwide which affects approximately 8%–10% of couple's worldwide[1]. Every year around 60–80 million couples are suffering from infertility globally. Most likely, between 15 to 20 million (25%) are in India alone[2, 3]. The definition, as well as the etiological causes associated with infertility, differs from region to region[4]. In India, the overall prevalence of primary infertility lies in between 3.9% and 16.8%, as per WHO estimates[5]. A considerable percentage of women experience the problem of primary infertility at the present date in India at national and regional levels, in which southern states are at the top of the list whereas the states from northern region have comparatively few women who experience infertility[6].

Infertility may be caused by a number of different

factors, in either the male or female reproductive systems. However, it is sometimes not possible to explain the causes of infertility.

In the female reproductive system, infertility may be caused by:

1. Tubal disorders such as blocked fallopian tubes, which are in turn, caused by untreated sexually transmitted infections (STIs), or abdominal/pelvic surgery.

2. Uterine disorders which could be inflammatory in nature (such as such endometriosis), congenital in nature (such as septet uterus), or benign in nature (such as fibroids)

3. Disorders of the ovaries, such as polycystic ovarian syndrome and other follicular disorders

4. Disorders of the endocrine system causing imbalances of reproductive hormones. The endocrine system includes hypothalamus and the pituitary glands. Examples of common disorders affecting this system include pituitary cancers and hypopituitarism.

The relative importance of these causes of female infertility may differ from country to country, for example due to differences in the background prevalence of STIs, or differing ages of populations studied.

In the male reproductive system, infertility may be caused by:

1. Obstruction of the reproductive tract causing dysfunctional ties in the ejection of semen. This blockage can occur in the tubes that carry semen (such as ejaculatory ducts and seminal vesicles). Blockages are commonly due to injuries or infections of the genital tract;

2. Hormonal disorders leading to abnormalities in hormones produced by the pituitary gland, hypothalamus and testicles – hormones such as testosterone regulate sperm production. Example of disorders that result in hormonal imbalance include pituitary or testicular cancers;

3. Testicular failure to produce sperm, for example due to varicoceles or medical treatments that impair sperm-producing cells (such as chemotherapy); and

4. Abnormal sperm function and quality. Conditions that cause abnormal shape (morphology) and movement (motility) of the sperm negatively affect fertility. For example, the use of anabolic steroids can cause abnormal semen parameters such sperm count and shape[7].

Lifestyle factors such as smoking, excessive alcohol intake and obesity can affect fertility. In addition, exposure to environmental pollutants and toxins can be directly toxic to gametes (eggs and sperm), resulting in their decreased numbers and poor quality[7, 8].

In conventional treatment, there are mainly 3 types of treatment provided. These are Fertility medicines/ Antibiotics, Surgical procedures and assisted conception-including intrauterine insemination (IUI) and in vitro fertilization (IVF). But some patients will show significant adverse effect of treatment.

In Homoeopathic treatment, investigation is required to find out the exact cause for the patient suffering with primary infertility. Then case taking and physical examination are conducted. As this system treats the patient as a whole, mental symptoms and physical symptoms are recorded in detail. Then case is analysed indetail to reach the similimum remedy. As these medicines are dynamically potentized, gentle and safe, prescribed in a single, minimum dose.

The case presented was treated with individualized homoeopathic medicine with analysis, differentiation and final prescription. The case report follows the care guidelines.

The Patient

A 23 years old female visited JIMS Homoeopathic OPD in the month of august 2022 with complaints of failure to conceive from last 5years. Earlier her menstrual cycle was regular but from last 3years it became irregular and delayed. A 35-40 days of cycle with dark red flow, small clots along with pain in lower abdomen extending to the lower back. Her last menstrual period is on 14/6/2022.

Flow was for 5 days. Leucorrhoea appears before one day of menses. Patient also complained of increased facial hair and acne on the face from last 11 months. She was under treatment for infertility under conventional treatment from last 3 yrs. She failed to conceive and could not afford the expensive care. She has chosen to get treated with homeopathic medicine.

Mental generals:

She is very shy from childhood. Find difficulty to mingle with strangers. Easily gets irritable about small issues. She cannot take anything said against her. So easily offended and like pampering from husband. She has great sadness that in spite of trying so much she never conceived. Whenever someone asks about child, more sadness and didn't want go out of house. She feels comfortable at home. She is stubborn.

Physical generals:

Her appetite decreased from few days. Thirst is good, takes 3-4lit/day. She craves for salty things and eggs. She has aversion to meat and cannot take milk which cause sour eructation. Sleep disturbed from last few days. Perspires on head, neck and palms on exertion.

Clinical findings:

General examination: weight 46 kg, Height 152 cm. BMI is 19.9. Ferryman gallaway scoring is 17 for hirsutism. Global acne severity scale score is 9 for the acne.

Vital signs:

Blood pressure: 110/70 mm of Hg, Pulse :78/min, Respiratory rate:19/min

Diagnostic assessment: Both the couple was advised for examination. Female was undergone blood test (Hormonal levels including Thyroid), Hystero-salpingography and USG. Male was asked to do Semen analysis and blood test for testosterone levels.

Investigations:

Ultrasonography of abdomen and pelvis performed on 04/07/2022. Both size ovaries enlarged with poly-cystic morphology. Right ovary size is 39x20mm and left ovary size 35x18mm.

Case analysis: Data analysis was done after preparation of totality of symptoms. Following symptoms rubric were taken for repertorization. The case was repertorised using Zomeo elite software, using Kent repertory.

1. Company Desires
2. Sadness
3. Offended Easily
4. Stubborn
5. Timidity
6. Milk Cause Sour Eructations
7. Desire Salty Things
8. Desires Eggs
9. Perspiration on Head and Neck.
10. Menses Clotted

THERAPEUTIC INTERVENTION: The case was solved using repertorization and refference of Homoeopathic Materia Medica. Finally Calc carb30, two dose, weekly one dose was prescribed after differentiating closely coming remedies. Patient was advised to go for walk daily and eat nutritious diet.

Patient perspective with Follow up: After case discussion, pt. was prescribed Calc-carb 30, /2 dose, weekly one dose, was prescribed followed by Saclac 30, BD/ 3wks on 29th Aug 2022. Pt. got her menses . Flow was for 3 days without pain. But anger and irritability was present. Pt. Advised to continue Saclac 30, BD/ 4wks. On next follow-up , appetite and thirst was improved but menses did not appear. Again Calc-carb 30/2 dose, weekly once was prescribed followed by Saclac 30, BD/ 4wks. Pt. Got her menses with 4 days painless smooth bleeding. Anger and irritability was less compare to before. Now Saclac 30, BD/ 4wks was prescribed keeping the improvement in mind. Menses appeared with 6 days flow. Again medicine was given with increased potency to attend menses in time. Advised for USG abdomen and pelvis in the next follow up. USG Abdomen and

pelvis revels Polycystic appearance of of Left ovary. Menses delayed for 12 days.Disease activity is going on, so there is a need to incraese potency. Calcarea carb 200/1 dose was prescribed again followed by Saclac 30, BD/ 2wks. On next follow up, perspiration increased. Appetite and sleep improved. Menses regular. Saclac 30, BD/ 2wks was repeated. Menses appeared. No pain. No clot. Anger was reduced. Flow was moderate and 5 days. Weakness was there. Saclac 30, BD/ 4wks was prescribed. On 27/04/2023 USG done- single live intra uterine gestation of 6 weeks 5 days. On 26/04/2023 urine pregnancy test was done -positive result. Pt. Continued the treatment for prenatal care and delivered (29-11-2023) a healthy female baby of weight 3kgs. After 4 months she got her menses. She continued her treatment. It was observed menses are regular from March 2024 to June 2024. Suggested again Ultra-sonography. It reveals normal study.

Time line:

Table 1: Timeline including follow-up of the case

Date	Symptoms	Medicine and Doses
29/08/2022	LMP was on 14 June 2022.She has hirsutism of score 17 in Ferryman gallaway scale. Also has acne with global severity scale4. **4/7/2022:USG Pelvis:** B/L polycystic morphology of ovary.	*Rx* *1. Calcarea carbonicum 30/2* dose, weekly one dose 2. Placebo BD/ 3 wks
19/09/2022	L.M.P-05/09/2022, flow for 3days with small sized clots and dark red flow, no dysmenorrhoea. Irritability and anger present.	Rx Saclac 30 BD/4 wks
17/10/2022	Menses absent. Appetite increased. sleep improved. No new complaints.	*Rx* 1. *Calcarea carbonicum 30/2* dose, weekly one dose 2. Placebo 30 BD/4wks
28/11/2022	LMP-21/11/2022, flow lasted for 4 days, dark red flow, no clots were present, irritability and anger complaints are decreased. Leucorrhoea before menses is decreased.	*Rx Placebo* 30 BD/28days
02/01/2023	LMP-23/12/2022, flow for 6 days, dark red flow with no clots. Leucorrhoea is better than before.No dysmenorrhoea. Irritability and anger reduced. Medicine was repeated with increased potency for regularity of menses. Advised for USG abdomen and pelvis in the next follow up.	*Rx* *1. Calcarea carbonicum 200/1* dose 2. Placebo BD/4 wks
13/02/2023	LMP- 4/02/2023, Flow lasted for 5 days. Dark red blood, no clots, moderate flow. After the flow there was spotting for 5-6 days. Leucorrhoea before menses profuse. **USG Abdomen and pelvis:** Polycystic left ovary.	*Rx* Placebo 30, BD/2 wks
27/02/2023	After the previous prescription perspiration increased. Appetite improved and sleep improved. Menses delayed for 12 days during last cycle. Again medicine was repeated to maintain regularity.	*Rx1. Calcarea carbonicum 200/1* dose 2.Placebo 30 BD/2 wks
13/03/2023	LMP: 05/03/2023, flow lasted for 5 days, bright red flow and no clots. No dysmenorrhoea, leucorrhoea before menses. Weakness present. Menses occur at 30 days of interval.	*Rx* Placebo 30, BD/4 wks

Discussion: As homoeopathy system of medicine is safe and gentle, cost effective, it eradicates the disease as a whole without giving any side effects. In this case patient was already under medication for primery infertility before homoeopathic treatment. But its not effective. Here the cause of infertility was evaluated for both the couple. Female showed ovulatory problem which have been addressed by individualised homoeopathic medicine. After regular treatment of 8 months, patient was come up with conception. Still continued the treatment for prenatal visits with guidance of modern medicine. Eventually, delivered a healthy baby with FTND. Her menses became regular. Her recent USG report suggests normal ovary. Eventually one costitutional remedy helped the patient not only for conception but also removed the cause with complete recovery of the patient. These are the dynamics presented in this study.

01/05/2023	LMP : 05/03/2023, On **26/04/2023 urine pregnancy test was done -positive** result. On 27/04/2023 USG done- **single live intrauterine gestation of 6 weeks 5 days.**	*Rx* Placebo 30, BD/4 wks
29/05/2023	Nausea and vomiting from 3 weeks < early morning, drinking water, smell of food, eating food,> evening	*Rx Colchicum 30*/single dose Placebo 30 BD/4 wks
29/11/2023	Morning at 7:30 am delivered a healthy female baby of weight 3kgs.	
25/06/2024	Menses regular. USG: Normal study.	No Medicine

Conclusion: Individualized homoeopathic medicine showed significant result in treatment of primary infertility and removal of the cause with complete cure in this case.

Repertory sheet:

Picture 1: Repertorial sheet

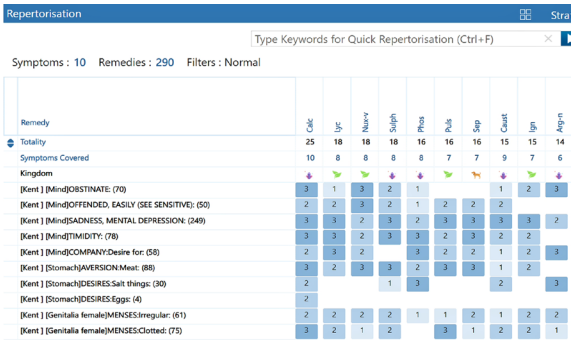
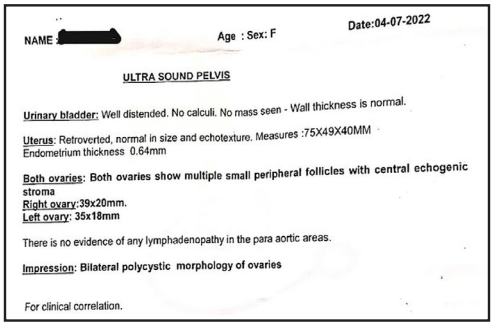


Figure 1: Ultrasound pelvis (4-7-2022)


NAME [redacted] Age : Sex: F Date:04-07-2022

ULTRA SOUND PELVIS

Urinary bladder: Well distended. No calculi. No mass seen - Wall thickness is normal.

Uterus: Retroverted, normal in size and echotexture. Measures :75X49X40MM
Endometrium thickness 0.64mm

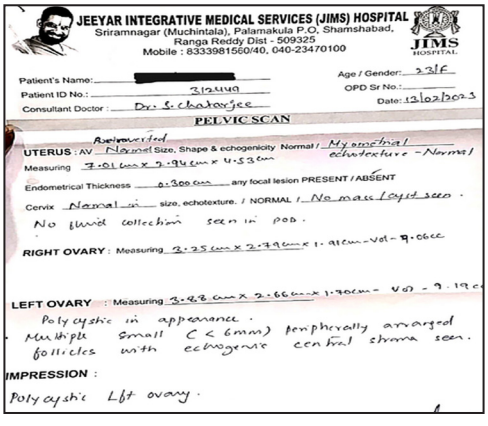
Both ovaries: Both ovaries show multiple small peripheral follicles with central echogenic stroma
Right ovary:39x20mm.
Left ovary: 35x18mm

There is no evidence of any lymphadenopathy in the para aortic areas.

Impression: Bilateral polycystic morphology of ovaries

For clinical correlation.

Figure 2: Ultrasound pelvis (13-2-2023)

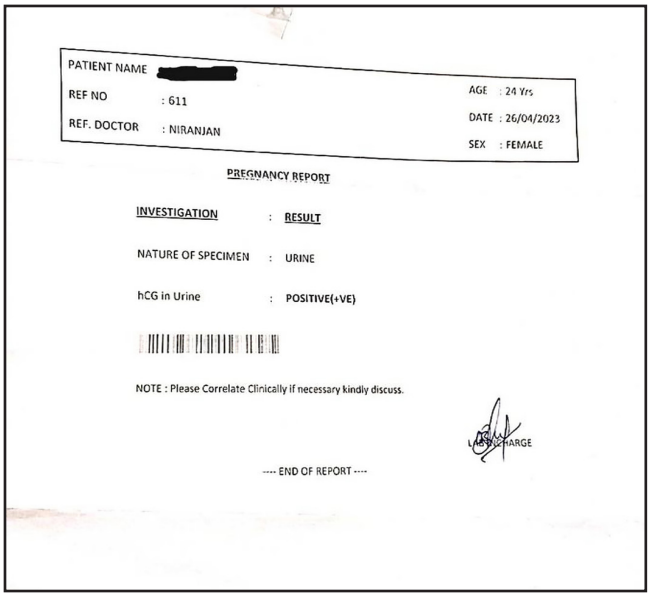

JEEYAR INTEGRATIVE MEDICAL SERVICES (JIMS) HOSPITAL
Sriramnagar (Muchintala), Palamakula P.O, Shamshabad, Ranga Reddy Dist - 509325
Mobile : 8333981560/40, 040-23470100

Patient's Name: [redacted]
Patient ID No.: 312449
Consultant Doctor : Dr. S. chatterjee
Age / Gender: 23/F
OPD Sr No.:
Date: 13/02/2023

PELVIC SCAN

UTERUS : AV Normal Size, Shape & echogenicity Normal / Myometrial echotexture - Normal
Measuring 7.01cm x 3.94cm x 4.53cm
Endometrical Thickness 0.300cm any focal lesion PRESENT / ABSENT
Cervix Normal in size, echotexture. / NORMAL / No mass/cyst seen.
No fluid collection seen in POD.
RIGHT OVARY : Measuring 3.25cm x 2.79cm x 1.81cm-Vol-9.06cc
LEFT OVARY : Measuring 3.48cm x 2.66cm x 1.70cm- Vol - 9.19cc
Polycystic in appearance.
Multiple Small (< 6mm) peripherally arranged follicles with echogenic central stroma seen.
IMPRESSION :
Polycystic Lft ovary.

Figure 3: Urine Pregnancy test


PATIENT NAME [redacted]
REF NO : 611
REF. DOCTOR : NIRANJAN
AGE : 24 Yrs
DATE : 26/04/2023
SEX : FEMALE

PREGNANCY REPORT

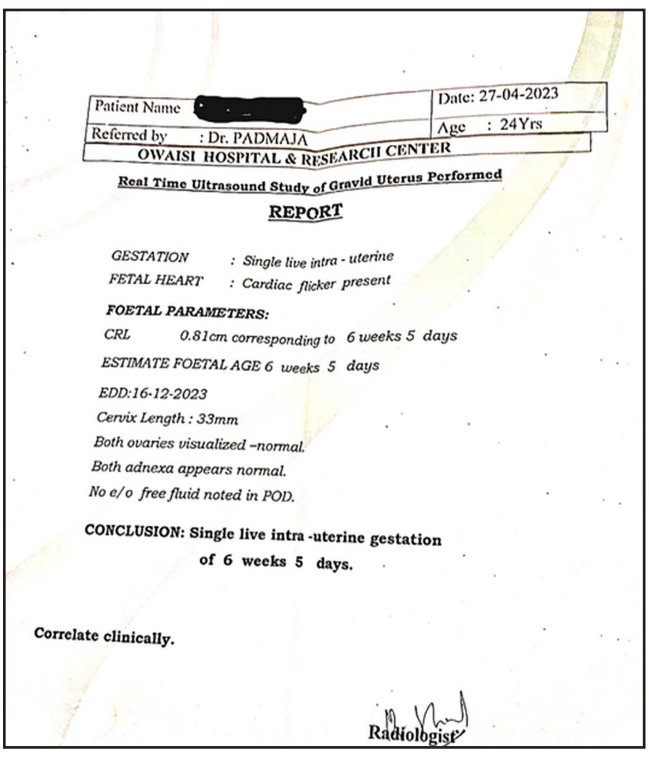
INVESTIGATION	:	RESULT
NATURE OF SPECIMEN	:	URINE
hCG in Urine	:	POSITIVE(+VE)

NOTE : Please Correlate Clinically if necessary kindly discuss.

LAB INCHARGE

---- END OF REPORT ----

Figure 4: Ultrasound Gravida uterus


Patient Name [redacted] Date: 27-04-2023
Referred by : Dr. PADMAJA Age : 24Yrs
OWAISI HOSPITAL & RESEARCH CENTER

Real Time Ultrasound Study of Gravid Uterus Performed

REPORT

GESTATION : Single live intra - uterine
FETAL HEART : Cardiac flicker present

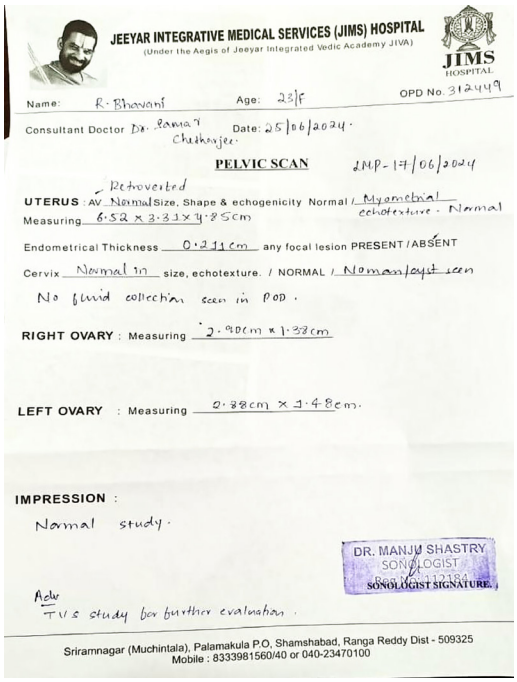
FOETAL PARAMETERS:
CRL 0.81cm corresponding to 6 weeks 5 days
ESTIMATE FOETAL AGE 6 weeks 5 days
EDD:16-12-2023
Cervix Length : 33mm
Both ovaries visualized -normal.
Both adnexa appears normal.
No e/o free fluid noted in POD.

CONCLUSION: Single live intra -uterine gestation of 6 weeks 5 days.

Correlate clinically.

Radiologist

Figure 5: Ultrasound of abdomen



JEEYAR INTEGRATIVE MEDICAL SERVICES (JIMS) HOSPITAL
(Under the Aegis of Jeeyar Integrated Vedic Academy JIVA)
JIMS HOSPITAL

Name: R. Bhavani Age: 23/F OPD No. 312449
Consultant Doctor Dr. Rama Chakraborty Date: 25/06/2024.

PELVIC SCAN LMP-17/06/2024

UTERUS : AV. Normal Size, Shape & echogenicity Normal / Retroverted Myometrial echotexture - Normal
Measuring 6.52 x 3.31 x 4.85cm
Endometrical Thickness 0.211cm any focal lesion PRESENT / ABSENT
Cervix Normal in size, echotexture. / NORMAL / No any cyst seen
No fluid collection seen in POD.

RIGHT OVARY : Measuring 2.90cm x 1.38cm

LEFT OVARY : Measuring 0.88cm x 1.48cm.

IMPRESSION :
Normal study.

DR. MANJU SHASTRY
SONOLOGIST
SONOLOGIST SIGNATURE

Adv
TVS study for further evaluation.

Sriramnagar (Muchintala), Palamakula P.O, Shamshabad, Ranga Reddy Dist - 509325
Mobile : 8333981560/40 or 040-23470100

Remedy differentiation:

After repertorization, Calcarea carb, Lycopodium, Nux vomica, Sulphur, Phosphorus are the closely coming remedies. Among them Sulphur and Lycopodium are hot but the patient is chilly. Henceforth, Calc-carb, Nux vomica and Phosphorus were taken into consideration.By nature, all these 3 remedies are anger, impatient, oversensitiveness of external impressions [9,10]. If we observe, the patient is obstinate, irritable and sad.[11] Nux vomica is sad , but irritability, anger, impatient, zealous, excitable, quarrelsome[12] and hypochondric nature is well marked.[13] In Phosphorus, wants sympathy and company with shades of indifferent to relation and loved ones[14].When we consider Calc-carb, obstinate is well marked with company desire and irritability. There is a craving of boiled eggs,with aversion to eat. After reference to Materia Medica, Calc-carb 30, 2 doses were prescribed.

Narenjo Criteria:

Table 2: Assessment by Modified Naranjo Criteria score

S.NO	ITEM	YES	NO	NOT SURE /N/A	SCORE
1	Was there an improvement in the main symptoms or condition for which the homoeopathic medicine was prescribed?	+2			2
2	Did the clinical improvement occur within a plausible time frame relative to the drug intake?	+1			1
3	Was there an initial aggravation of symptoms (need to define in glossary)		0		0
4	Did the effect encompass more than the main symptoms or condition, i.e., others were other symptoms ultimately improved or changed?	+1			1
5	Did overall wellbeing improve? (suggest using validated scale)	+1			1
6 (A)	Direction of cure: did some symptoms improve in the opposite order of the development of symptoms of disease?		0		0
6(B)	Directions of cure: did at least two of the following aspects apply to the order of improvement of symptoms • from organs of more importance to those of less importance • from deeper to more superficial aspects of the individual • from the top downwards		0		0
7	Did old symptoms (defined as non seasonal and non-cyclical that were previously thought to have resolved) reappear temporarily during the course of improvement ?			0	0
8	Are there alternate cause (other than the medicine) that with a high probability -could have caused the improvement?(consider known course of disease, other forms of treatment and other clinically relevant intervention)		+1		+1
9	Was the improvement confirmed by any objective evidence ? (e.g., laboratory test, clinical observation)	+2			+2
10	Did repeat dosing, if conducted, create similar clinical improvement?	+1			+2
	TOTAL SCORE				09

Highlights:

This case shows the individualized homoeopathic treatments positive result in case infertility from PCOS. However need randomized controlled studies can be done for the future affirm.

Consent for publication: Informed consent for the publication was obtained from the

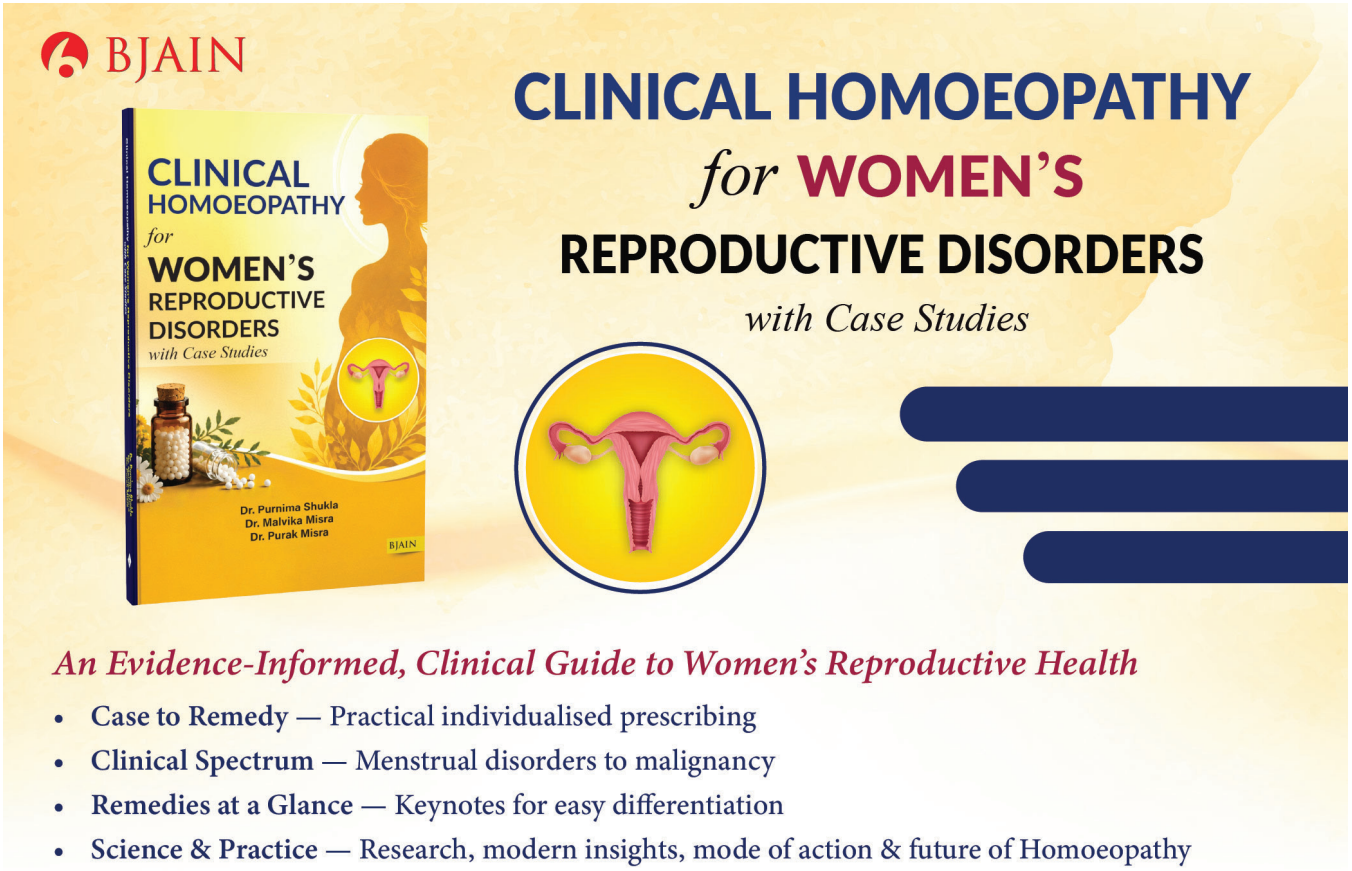
patient. The signed document is confidential.

Conflict of interest: None declared.

Financial sponsorship/ funding: NIL

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Secondary Infertility with Psychological Distress: An Individualized Homoeopathic Case Report with Pulsatilla



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Abstract

A 26-year-old woman with secondary infertility and psychological distress was treated individually with **Pulsatilla** based on her symptom totality. She subsequently conceived and delivered a healthy baby girl. This case highlights the importance of individualized homoeopathic case-taking in secondary infertility.

Keywords

Secondary infertility, Psychological distress, Pulsatilla, Individualization.

Introduction

Infertility is defined as a failure to conceive within one or more years of regular unprotected coitus.(1)

- **Primary infertility:**
  - » The woman has **never been pregnant** before.
  - » There is no history of previous conception.[1]
- **Secondary infertility:**
  - » The woman has been **pregnant before,** but is now unable to conceive again.[1]
- **Fecundability:**
  - » It means the **chance of becoming pregnant in one menstrual cycle.**
  - » In a healthy young couple, it is about **20% per cycle**.[1]
- Fecundity:
  - » It means the **chance of achieving a live birth in one menstrual cycle**.[1]

Very often, it is impossible to establish the precise cause of infertility, and such a disorder is defined as **idiopathic infertility**. Idiopathic infertility may be explained by the role of mental disorders, such as stress, depression, sleep disorders, eating disorders, and addictions. The relationship between mental disorders and human physiology was first described in detail and highlighted by Hans Hugo Selye in 1955, who stated that the stressor acts on the target (the body or some part of it) directly and indirectly through the pituitary and the adrenal glands. The first mediator travels from the injured target area to the anterior pituitary resulting in discharging of adrenocorticotropic hormone (ACTH). ACTH alone, or in cooperation with other hormones, stimulates the adrenal cortex to discharge corticoids. Mineralocorticoids stimulate the proliferative ability and

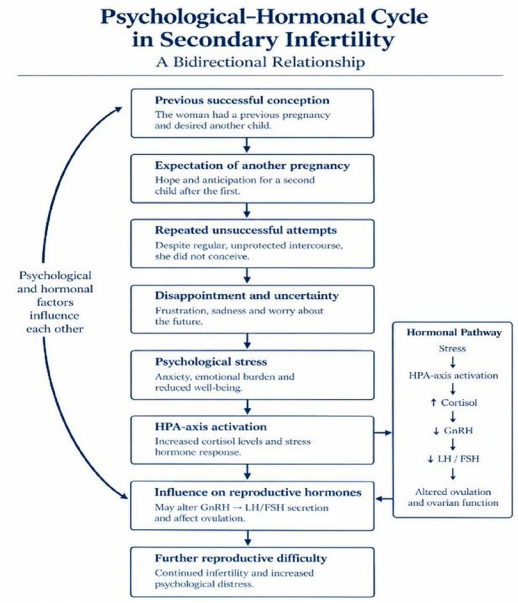
reactivity of connective tissue, thus enhancing the inflammatory potential.[2][3]

Psychological–Hormonal Cycle In Secondary Infertility

Potential **bidirectional** relationship

"Secondary infertility may contribute to psychological distress, while persistent psychological stress may potentially influence reproductive function through neuroendocrine pathways, creating a complex bidirectional relationship.[3,4,5]

(Figure)[2,3,4,5]



"The present case of secondary infertility highlights the potential bidirectional relationship between psychological distress and reproductive function."

Case Report:

Name	Abc	Age/sex	26/female
Occupation	Housewife	Marietal status	Married
Diet	Veg	Adress	Gir somnath

Chief complaint:

The patient presented with an inability to conceive a second child despite regular attempts at conception for the past 1 year. She had previously conceived and delivered a healthy female child, who was 3 years old at the time of consultation.

Past History – Digestive issues, no major illness

Family History – Father and Mother – No major illness

Physical Generals –

Appetite	3 time /day ,normal
Thirst	Low, 3-4 glass/day
Desire	French fried, Spicy
Aversion	Milk
Bowel	Satisfactory
Urine	N/A
Perspiration	Scanty
Thermal	Chilly
Sleep	Good (7 to 8 hr)
Sleep position	On back
Dream	Ghost, daily work

Gynecological History

Menstrual History

LMP: 3/8//2024

Duration: Flow for 4–5 days

Quantity: First 3 days moderate flow, then last 2 days scanty; no clots

Color: Bright red

Stain: No

B/D/A: No

Leucorrhoea- No any complain

Obstetric History

No. of pregnancies: 01

No. of children: 01 (3-year-old female child)

Nature of delivery: FTND (Full-Term Normal Delivery)

Abortion: 0 (No)

Mental Generals

Weeping while discussing her difficulty in conceiving.

Consolation – ameliorates (feels better when someone consoles her)

Suppression of anger (Recurrent disagreements with her sister-in-law over minor household matters she remained silent and wept, Dose not express her anger)

Desire for company (feels better when someone stays with her)

Investigation: USG conclusion reveals right ovarian cyst measuring 2.7 × 2.4 cm

Diagnosis: Secondary infertility(ICD-10-CM code:N97.9)[6]

Totality of Symptoms (Kent):

Mental general

Weeping while discussing her difficulty in conceiving.

Consolation – ameliorates (feels better when someone consoles her)

Suppression of anger (Recurrent disagreements with her sister-in-law over minor household matters she remained silent and wept, Dose not express her anger)

Desire for company (feels better when someone stays with her)

Dream of ghost, Daily work

Physical general

Thirst less(only 3-4 glass/day)

Desire for French fried ,spicy

Aversion to milk

Sleep on back

Scanty perspiration

Chilly Patient

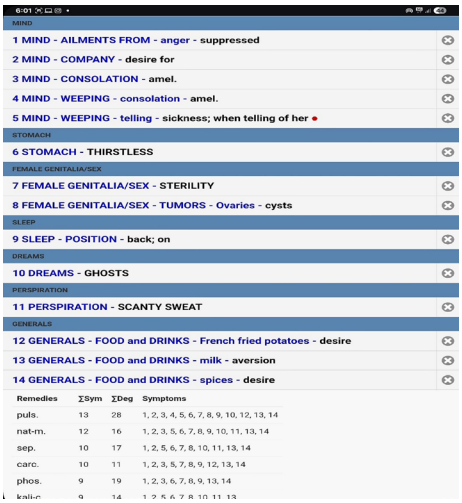
Particular

Inability to conceive a second child despite regular attempts at conception .

Right ovarian cyst

Repertory Used: Synthesis repertory[7]

Repertorial Totality & Analysis –



Remedy Selection : Pulsatilla[8]

Remedy Justification –

Pulsatilla was selected on the basis of the overall symptom totality of the case. The patient was easily moved to tears while discussing her difficulty in conceiving, felt better with consolation and company, and tended to suppress anger by remaining silent and weeping during interpersonal conflicts. These emotional characteristics, along with thirstlessness, chilliness, and aversion to milk, strongly supported the Pulsatilla picture.

Prescription –

16/8/2024

Pulsatilla 200c – 4 Globules – OD – AM – Empty stomach – for 3 days only

Sac-lac 30c – 4 Globules – BD for a 15 day

2/9/2024

The patient was on the 2nd day of menstruation.

I given sac lac 30c -4 Globules – BD for a month

Fig.1. A

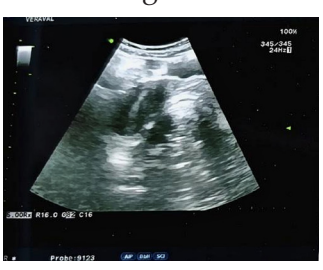


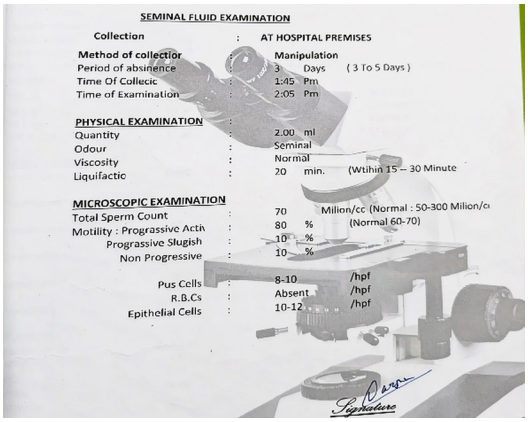
Fig.1. B



Figures 1 (A & B): Report when Pt came at first time(16/8/2024).USG revealed a simple right ovarian cyst measuring 2.7 × 2.4cm, with no other significant abnormality

The husband's semen analysis revealed normal parameters, with no significant abnormality detected.

Fig.2 : Semen Analysis reports of Husband.


SEMINAL FLUID EXAMINATION

Collection : AT HOSPITAL PREMISES

Method of collection : Manipulation
Period of absinence : 3 Days (3 To 5 Days)
Time Of Collecic : 1:45 Pm
Time of Examination : 2:05 Pm

PHYSICAL EXAMINATION
Quantity : 2.00 ml
Odour : Seminal
Viscosity : Normal
Liquifactic : 20 min. (Wtihin 15 – 30 Minute

MICROSCOPIC EXAMINATION
Total Sperm Count : 70 Milion/cc (Normal : 50-300 Milion/c
Motility : Progressive Acth : 80 % (Normal 60-70)
Progressive Slugish : 10 %
Non Progressive : 10 %

Pus Cells : 8-10 /hpf
R.B.Cs : Absent /hpf
Epithelial Cells : 10-12 /hpf

Signature

Fig.3. On 18 September 2024, in the morning, a urine pregnancy test (UPT) was performed and showed two distinct coloured lines at the control (C) and test (T) positions, indicating a positive qualitative test for urinary β-hCG. (So, Pt LMP was1/9/2024)

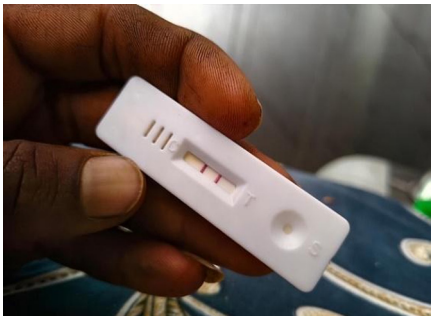
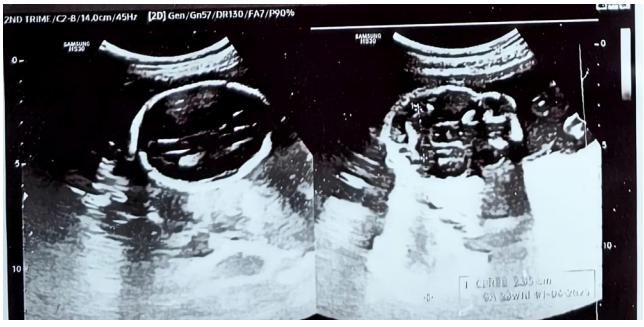


Fig. 4. Transvaginal USG(3/02/2025)



Following confirmation of pregnancy, the patient remained under regular obstetric and gynaecological supervision throughout the pregnancy. She subsequently delivered a healthy female baby on 11 June 2025.

"In the present case, the bidirectional relationship between psychological distress and reproductive function was considered as a possible contributing framework. Following previous successful conception, the patient experienced difficulty conceiving for one year, accompanied by emotional distress manifested by easy weeping, suppressed anger, and a desire for company and consolation. While the infertility itself may have contributed to her psychological distress, persistent psychological stress may potentially influence reproductive function through neuroendocrine pathways. However, a direct causal relationship cannot be established from a single case."

CONCLUSION

This case highlights the importance of individualized homoeopathic treatment based on the totality of symptoms in secondary infertility. Pulsatilla was selected according to the characteristic mental and physical generals, followed by conception and healthy delivery. However, a causal relationship cannot be established from a single case, and further clinical research is needed.

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Homoeopathic Treatment of Meibomian Cyst: Two Case Reports with Clinical Follow-up

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Abstract

Aim & Background: Chalazion is a non-neoplastic cyst of the meibomian glands of the eyelid results from a lipogranulomatous inflammatory response.

Case Description: This article describes two cases of chalazion which were successfully treated with individualized homeopathy i.e., *staphysagria* and *calcrea carbonica* respectively within 3 months of duration without any complication. The cases are reported according to the Homeopathic Clinical Case Reports (HOM-CASE) guidelines. Clinical assessment and photographic documentation were employed for evaluation, while the Modified Naranjo Criteria for Homeopathy (MONARCH) inventory was used to determine the causal relationship between homeopathic intervention and clinical outcome.

Conclusion: This case report illustrates effective results with individualized homeopathic treatment, demonstrating a remarkable improvement in chalazion.

Clinical Significance: This case report may provide a framework for future investigations into the application of individualized homeopathic medicine in the management of chalazion.

Keywords: Meibomian Cyst, Chalazion, *staphysagria, calcrea carbonica,* case report.

Introduction

A chalazion is one of the most prevalent eye conditions and appears as a lump on the eyelids. It results from a lipogranulomatous inflammatory response and develops due to retained secretions from the meibomian gland. Chalazia can occur in individuals of any age, including children. They usually are asymptomatic, but may cause blurred vision in some cases because of induced astigmatism when it pushes against the cornea. A large chalazion might lead to mechanical ptosis. It's important to distinguish chalazion from hordeolum, which refers to a common inflammation of the eyelid edge.[1, 2]

Several factors have been implicated in the development of chalazion, including evaporative dry eye illness, blepharitis, rosacea, demodex mite infestation of the eyelash follicles, low serum vitamin A levels, gastrointestinal inflammation, and smoking.[1] A study evaluating the prevalence, demographics, and clinical presentation of chalazion in patients attending a multi-tier ophthalmology network in India discovered that the condition is slightly more common in males. It is usually unilateral, involves the upper eyelid, and recurs in approximately tenth of cases.[2]

Although chalazion is one of the most common eyelid diseases seen in both general and ophthalmic practice, there is still no broadly acknowledged treatment regimen. Current management options are largely divided between conservative and invasive approaches. Conservative treatment consists of observation, maintaining eyelid hygiene, and applying warm compresses, with or without topical antibiotics or corticosteroids. Invasive therapies include intralesional corticosteroid

injections as well as lesion incision and curettage. Botulinum toxin A injection, tarsal trephination, CO_2 laser excision, and cryotherapy are some of the less prevalent treatments investigated.[1, 2]

However, treating chalazia with hot compresses associated with lower resolution rate and higher recurrence rate1 and intralesional corticosteroid injection can result in inadvertent corneal penetration and traumatic cataract.[3]

Homoeopathy has also been employed as an alternate therapy strategy for treating chalazion. Several homoeopathic medicines, such as *Apis Mellifica, Calcarea Carbonica, HeparSulphuris, Pulsatilla, Staphysagria,* and *Silicea,* may useful in efficiently treating such cases and reducing recurrences.[4]

CASE DESCRIPTION

Case 1

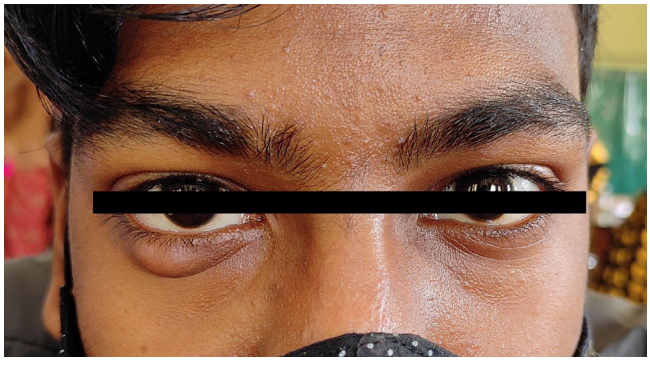
Patient Information

A 16-year-old male, thin-built and moderately nourished, with a dark complexion

Case history

The patient presented with a nodular, non-tender, persistent swelling in his right lower eyelid **[Figure 1]** for 2 months and seems to be enlarging slowly. There was no history of refractive error. The parents denied any injury or rubbing of the eyes. The patient had not taken any medication for the same. The patient appeared to have a good hygiene level. No significant past or family history was noted.

Fig 1 Before Treatment



The patient has a good appetite and had desire for sweets. His thirst was moderate and thermals relation was chilly. Mentally patient was irritable, oversensitive and easily gets offended by others.

Clinical findings

No slit-lamp test was done. On local examination, a non-tender, non-fluctuant, non-erythematous nodule was present on the right lower eyelid, consistent with chalazion.

Diagnostic Assessment

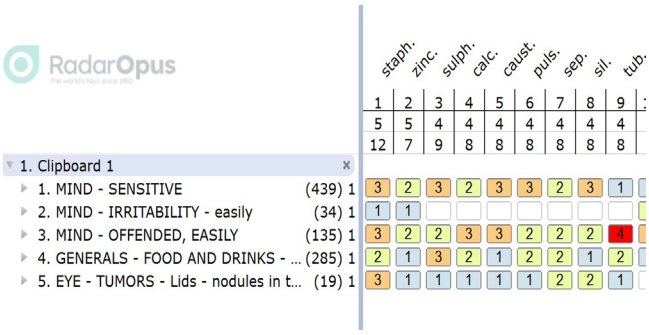
Based on the history and clinical appearance, the case was diagnosed as chalazion or meibomian cyst. The diagnosis comes under specific code, 9A02.01&XK9K&XA0JV9, in ICD-11[5] for mortality and morbidity statistics, under diseases of the visual system – which depicts chalazion internum& right & lower eyelid.

Therapeutic Intervention

Case analysis and repertorisation

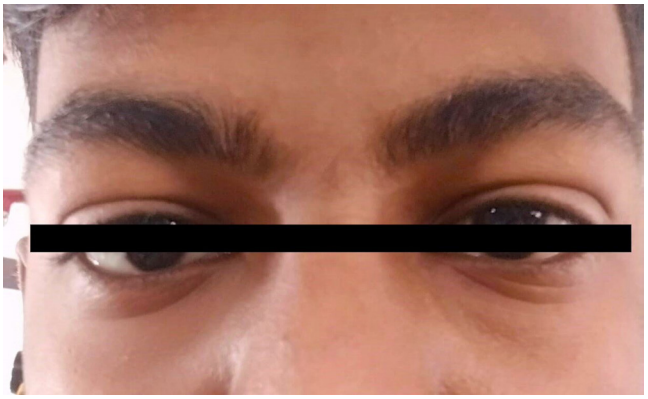
After a detailed case-taking, totality was constructed using Dr. Kent's method and classification of symptoms **[Table 1]**. The miasmatic evaluation of all the presenting symptoms of this case mostly indicated that the psoric and sycotic miasms are dominant.[6]

Fig 2: Repertorial Analysis of Case 1



The rubrics was taken from totality and following repertorisation staphysagria scored the highest in the reportorial results, covering all rubrics and being more similar to the case than other high-ranked medicines. Since there were more notable generals in this instance, repertorisation was carried out by the software RADAR OPUS 3.1.5,[7] using Synthesis Repertory. Repertorial results are shown in **Figure 2.**

Figure 3: After Treatment



Prescription

Considering the repertorial totality and consultation with Materia Medica, *staphysagria* was selected and other remedies were ruled out. *Staphysagria* prescribed in centicemal potency (200C), 1 dose in the early morning in empty stomach, along with placebo 1–2 globules once daily was prescribed for 30 days.

Follow-up sheet and outcomes

Following the use of the homoeopathic medication i. e., *staphysagria* 200, the size of the swelling gets significantly reduced. As patient delayed the follow up visit, the condition became standstill. In the second visit *staphysagria* 1M was prescribed after which the swelling is completely disappeared. The patient was followed up further for monitoring reoccurrence of the complaints. Follow-up is summarised in **Table 2**.

The possible causal attribution of the treatment outcome was assessed using the MONARCH inventory.[8] The score obtained (8) depicted in indicates that there is high probability that the improvement in the patient can be attributed to the homeopathic medicine administered **[Table 3]**.

Case 2

Patient Information

A 13-year-old girl, moderate builds and moderate nourishment, with a dark complexion.

Case history

The patient presented with a painless swelling on the right upper eyelid for two years **[Figure 4]**. The swelling developed gradually, initially appearing as a small pimple-like lesion that progressed into a persistent nodular swelling. There was no associated pain, redness, or history of trauma.

The past history revealed that she soughtconventional therapyfor the same a year ago but the ailmenthad not responded to prior conventional treatments. There was no significant family history was noted.

The patient has a good appetite and moderate thirst. She had desires for sour food, boiled eggs, and prefers warm food. She had intolerance to milk, which caused flatulence. She had perspiration especially on her scalp during eating. Her sleep was disturbed. Her thermals relation was chilly and she had tendency to catch cold easily.

Mentally she was anxious. She has desires for company and does not like to be being alone.

Fig. 4,5: Before and After treatment images



Clinical findings

No slit-lamp test was done. On local examination A non-tender, non-fluctuant, non-erythematous nodule was present on the right upper eyelid, consistent with chalazion.

Diagnostic assessment

Based on the history and clinical appearance, the case was diagnosed as chalazion or meibomian cyst.The diagnosis comes under specific code, 9A02.01&XK9K&XA9K79, in ICD-11[5] for mortality and morbidity statistics, under diseases of the visual system – which depicts chalazion internum & right & upper eyelid.

Therapeutic intervention

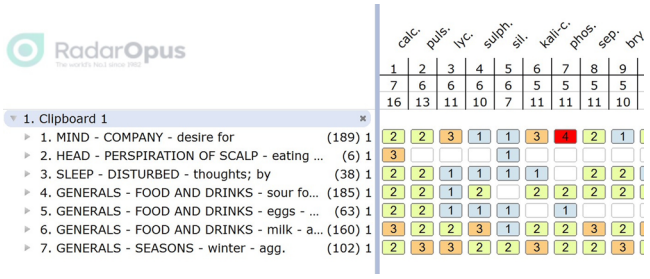
Case analysis and repertorisation

After a detailed case-taking, totality was constructed using Dr. Kent's method and classification of

symptoms **[Table 1]**. The miasmatic evaluation of all the presenting symptoms of this case mostly indicated that the psoric and sycotic miasms are dominant.[6]

The rubrics taken from totality and after repertorisation *calcarea carbonica* scored the highest in the reportorial results, covering maximum rubrics and were more similar to the case, compared to other high-ranked medicines. In this case, repertorisation was carried out by the software RADAR OPUS 3.1.5,[7] using Synthesis Repertory, as this case had more prominent generals. Repertorial results are shown in **Figure 6**.

Fig 6: Repertorial Analysis of Case 2



Prescription

Considering the repertorial totality and consultation with Materia Medica, *calcarea carbonica* was selected and other remedies were ruled out. *Calcarea Carbonica* prescribed in centicemal potency (30C), 2 doses in the early morning in empty stomach, along with placebo 1–2 globules once daily was prescribed for 30 days.

Follow-up sheet and outcomes

Following the use of the homoeopathic medication *calcarea carbonica* 30, the size of the swelling gets slightly reduced. Follow up visit continued after which the swelling disappeared. Follow-up is summarised in **Table 2**.

The possible causal attribution of the treatment outcome was assessed using the MONARCH inventory.[8] The score obtained (8) depicted in indicates that there is high probability that the improvement in the patient can be attributed to the homeopathic medicine administered **[Table 3]**.

Table 1: Analysis and evaluation for both case 1 & 2:

Mental generals	Physical generals	Particulars
	Case 1	
1. Oversensitive to slightest mental impressions 2. Easily gets offended by others 3. Irritability easily	1. Desire sweets 2. Thermal relation chilly	1. Hard, nodular swelling on the right lower eyelid
	Case 2	
1. Desire for company	1. Desire for sour, eggs 2. Intolerance for milk 3. Perspiration especially in scalp eating during 4. Sleep disturbed 5. Thermal relation chilly	1. Hard, nodular swelling on the right upper eyelid

Table 2: Follow-up visits for both case 1 & 2:

Date of Visit	Clinical Findings	Prescription
	Case 1	
First visit 01-11-2022	Baseline presenting complaints (signs and symptoms)	*Staphysagris*200C, Single dose Placebo 30C for the next 1 month
Second visit 09-02-2023	Swelling gets significantly reduced, and then became standstill, as patient delayed the next visit.	*Staphysagris*1M, Single dose Placebo 30C for the next 1 month
Third visit 07-03-2023	Swelling completely disappears **[Figure 3]**	Placebo 30C for the next 1 month

Fourth visit 11-05-2023	No recurrence of the complaints reported	Placebo 30C for the next 6 months Advised to report if complaints return
Fifth visit 05-12-2023	No recurrence or worsening of his presenting complaints was observed further. Irritability and oversensitivity much improved as per patient.	Placebo 30C, once daily for 6 months Advised to report if complaints return
Case 2		
First visit 14-12-2023	Baseline presenting complaints (signs and symptoms)	*Calcarea carbonica* 200C, Single dose Placebo 30C for the next 1 month
Second visit 09-01-2024	Slight reduction in size of swelling	Placebo 30C for the next 1 month
Third visit 12-02-2024	Swelling disappears **[Figure 6]** Sleep improved as per patient	Placebo 30C for the next 1 month
Fourth visit 21-03-2024	No recurrence of the complaints reported	Placebo 30C for the next 6 months Advised to report if complaints return
Fifth visit 05-11-2024	No recurrence or worsening of his presenting complaints was observed further.	No medicine; advised to report immediately if complaint returns

Table 3: MONARCH inventory score for both case 1 & 2:

ITEMS	YES	NO	NOT SURE	YES	NO	NOT SURE
	CASE 1			CASE 2		
1. Was there an improvement in the main symptom or condition, for which the homoeopathic medicine was prescribed?	+2			+2		
2. Did the clinical improvement occur within a plausible time frame relative to the drug intake?	+1			+1		
3. Was there an initial aggravation of symptom? (need to define in glossary			0			0
4. Did the effect encompass more than the main symptom or condition, i.e. Were other symptoms ultimately improved or changed?	+1			+1		
5. Did overall wellbeing improve?	+1			+1		
6 (a). Direction of cure: Did some symptoms improve in the opposite order of the development of symptoms of the disease?			0			0
6 (b). Direction of cure: Did at least two of the following aspects apply to the order of improvement of symptoms: • From organs of more importance to those of less importance • From deeper to more superficial aspects of the individual • From the top downwards			0			0
7. Did 'old symptoms' (defined as non-seasonal and non-cyclical symptoms that were previously thought to have resolved) reappear temporarily during the course of improvement?		0			0	
8. Are there alternate causes (other than the medicine) that – with a high probability – could have caused the improvement? (Consider known course of disease, other forms of treatment and other clinically relevant interventions)		+1			+1	
9. Was the health improvement confirmed by any objective evidence? (e.g., laboratory test, clinical observation etc.)	+2			+2		
10. Did repeat dosing, if conducted, create similar clinical improvement?			0			0
TOTAL SCORE	8			8		

DISCUSSION

Two cases of chalazion were presented here which was successfully treated using homoeopathic medicine, which was selected after a thorough case taking and on the basis of the totality.

The cases are reported according to the Homeopathic Clinical Case Reports (HOM-CASE) guidelines[9] and the improvement was corroborated by photographic evidence from pre-and post-treatment physical findings. The usefulness of individualised homoeopathic treatment in both cases was evaluated using the MONARCH Inventory. During treatment, patient did not take any other method of treatment for his/her presenting complaints.

Out of these two cases, the first was treated with *staphysagria*, and the second with *calcarea carbonica*. There is an earlier case report that effectively treated chalazion with *staphysagria*, [10] as well as two case reports that shows the successful homoeopathic treatment of chalazion using calcarea *carbonica*.[11, 12] These research studies corroborated with our findings.

Other studies have also revealed some promising results from homeopathic treatment of chalazion.[13, 14, 15] One retrospective clinical study found that demonstrated the role of homoeopathy and biochemic medicines in the treatment of chalazion. In that study, 15 of the 21 cases in chalazion resolved completely without any recurrence. Whereas in 4 cases, chalazion has reduced but did not totally disappear and in 2 cases, chalazion persisted in a status condition.[13]

CONCLUSION

These two cases presented here demonstrate that individualized homoeopathic treatment can be effective in managing chalazion. Homoeopathy addresses both local pathology and systemic susceptibility, offering a non-invasive therapeutic option with potential to reduce recurrence. Further controlled studies are required to validate these findings.

CLINICAL SIGNIFICANCE

This case report provides additional evidence of the beneficial effects of homoeopathic treatment for chalazion and emphasizes the importance of general symptoms in the selection of homoeopathic medicine. Furthermore, the strength of this case was that the chalazion, which had been non-responsive for a long time (in case 2), could be entirely treated with individualised homoeopathic treatment. Therefore, the extent of Homoeopathy in chalazion needs to be examined using well-designed research with a larger sample size, and the data from this case report may also be useful in the preparation of future case studies.

ETHICAL APPROVAL

Institutional Review Board approval is not required.

DECLARATION OF PATIENT CONSENT

The authors certify that they have obtained all appropriate patient consent.

FINANCIAL SUPPORT AND SPONSORSHIP

Nil.

CONFLICTS OF INTEREST

There are no conflicts of interest.

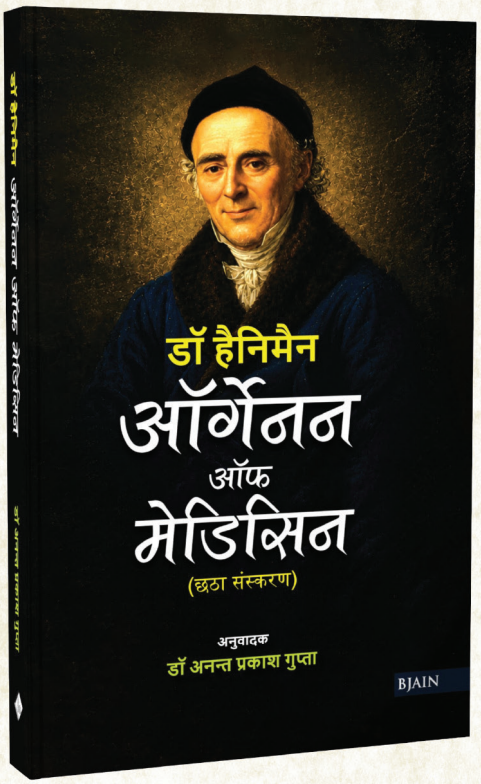
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आपकी सहज भाषा में।

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होम्योपैथी के जनक डॉ. सैमुअल हैनीमैन की मूल शिक्षाओं को हिंदी पाठकों तक सरल और सहज रूप में पहुँचाने वाला यह संस्करण, डॉ. अनंत प्रकाश गुप्ता द्वारा अनुदित है— प्रसिद्ध होम्योपैथ, शिक्षक एवं लेखक, जिनके पास होम्योपैथी के क्षेत्र में तीन दशकों से अधिक का अनुभव है।



Dr. Anant P. Gupta

Homoeopathic Approach In Cases of Infertility



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Abstract

Infertility is a major reproductive health problem affecting approximately 10-15% of couples worldwide. It is defined as inability to conceive after 1 year of regular ,unprotected sexual intercourse. The cause may be related to female factors, male factors, both partners or may remain unexplained. Modern medicine emphasizes accurate diagnosis through clinical evaluation and investigations, while homeopathy offers an individualized, holistic approach aims at restoring the patient's constitutional balance and improving overall reproductive health. This article reviews the causes, diagnosis and management of infertility with special emphasis on homeopathic approach.

Keywords

Infertility, homoeopathy, female infertility, male infertility, constitutional treatment, reproductive health

Introduction

Infertility is an important medical and social problem that affects the physical, emotional and psychological well-being of couples. Infertility is defined as the failure to achieve pregnancy after 12 month of regular, unprotected sexual intercourse. It is classified as:-

1. Primary Infertility: The woman has never conceived .
2. Secondary Infertility: Pregnancy has occurred previously, but conception cannot be achieved again.

Conception depends on fertility potential of both male and female partner. The male is directly responsible in about 30-40% ,the female is about 40-55% and both are responsible in about 10% cases. The remaining 10% is unexplained.

Etiology:

1. Male infertility:-
   - Common causes of male infertility:-
     a. Hypothalamic - pituitary disorder(1-2%)
     b. Primary testicular disorders (30-40%)
     c. Disorder of sperm transport (10-20%)
     d. Idiopathic (40-50%)
   - Congenital:-
     1. Undescended testis:- The hormone secretion remains unaffected,but spermatogenesis is depressed. Vas- deferens is absent in about 1-2% of infertile males.
     2. cystic fibrosis:- Congenital absence or obstruction of vas deferens, most men (80%) have mutations in cystic fibrosis transmembrane conductance regulator gene.
     3. Kartagener syndrome:- loss of ciliary function and sperm motility.
     4. Young's syndrome:- Inspissated mucus with sinusitis and bronchiectasis.

5. Hypospadias:- Causes failure to deposit sperm high in the vagina.

   Sperm abnormality:- loss os sperm motility (asthenozoospermia), abnormal sperm morphology (round headed sperm, teratozoospermia)are important factors.

   Error in seminal fluid:- unusually high or low volume of ejaculate.

   No ejection:- ductal obstruction, retrograde ejeculation, hypogonadism. Low volume:- absence of seminal vesicle, infection, ductal obstruction.

2. Female infertility:-

   Ovarian factors:-

   - Ovulatory dysfunction:30-40%
   - Anovulation or oligo-ovulation
   - Decrease ovarian reserve
   - Luteal phase defect (LPD)
   - Luteinized unruptured follicle(LUF)
   - Premature ovarian failure(POF)

   Anovulation or oligo-ovulation:-

   - ovarian dysfunction is likely to be linked with disturbed hypothalamo- pituitary ovarian axis either primary or secondary from thyroid or adrenal dysfunction.
   - Other causes of anovulation are, polycystic ovarian syndrome, elderly women and women with premature ovarian failure.

   Luteal phase defect(LPD):-

   - LPD is due to defective folliculogenesis which again may be due to varied reasons.
   - Drug induced ovulation, decreased level of FSH and LH, elevated prolactin, subclinical hypothyroidism, orderly women, pelvic endometriosis, dysfunction uterine bleeding are important causes.

   Luteinised unruptured follicular syndrome (trapped ovum):-

   - In this condition, the ovum is trapped inside the follicle, which gets luteinised. The cause obscure but may be associated with pelvic endometriosis or with hyperprolactinemia.

   Resistant ovarian syndrome:-

   - The follicle are present but FSH receptor is either absent or resistant.

   Other factors :-

   - Tubal disease: 25-35%
   - Uterine factors: 10%
   - Cervical factors: 5%
   - Pelvic endometriosis: 2-10%

Homeopathic concept of infertility:

Homoeopathy does not traditionally regard infertility merely as an isolated local disorder. The homoeopathic case-taking process considers the individual as a whole.

The homoeopathic approach may include:-

1. Individualization:-

   Important areas of assesment may include:-

   - Mental and emotional symptoms
   - General physical characteristics
   - Menstrual characteristics
   - Sexual symptoms
   - Obstetric and gynecological history
   - Characteristic modalities
   - concomitant symptoms

2. Totality of symptoms
3. Repertorisation
4. Materia medica confirmation
5. Constitutional approach

Evidence of homoeopathy in infertility:

The evidence for homoeopathy in infertility is limited and inconclusive.

Some case reports and case series have reported pregnancy after individualized homoeopathic treatment.

An observational study in 45 subfertile men reported improvement in some sperm parameters after individualized homoeopathic treatment.

There is currently insufficient high-quality evidence to prove that homoeopathy improves pregnancy or live-birth rate in infertility. Homoeopathy may be studied as a complementary approach, but it should not replace proper infertility investigation or evidence-based fertility treatment.

Role of homoeopathy as a complementary approach:

A responsible approach to infertility should prioritise:-

- Early and appropriate diagnosis
- Evaluation of both partners
- Identifications of reversible causes
- Evidence-based treatment of underlying condition
- Psychological support
- Healthy lifestyle

Homoeopathy, where chosen by a patient, should be considered only as a complementary approach, rather than a substitute for fertility investigations or medically indicated treatment.

Lifestyle and supportive measures:

Important measures includes:-

- Avoide tobacco exposure
- Maintaing a healthy lifestyle
- Appropriate physical activity
- Balanced nutrition
- Management of chronic diseases
- Prevention and treatment of sexually transmitted infections.
- Avoidance of unnecessary reproductive tract infection.

Assisted Reproductive Techniques:

When indicated, conventional fertility treatment may include:-

- Ovulation induction
- Intrauterine insemination (IUI)
- In-vitro fertilisation (IVF)
- Intracytoplasmic sperm injection (ICSI)
- Surgical treatment of selected tubal or uterine conditions.

Role of homoeopathy:

Take a complete and systematic case history. Assess both partners where appropriate.

Identify symptoms requiring medical referral.

Encourage appropriate diagnostic investigations. Individualized homoeopathic treatment when it is used.

The goal should be patient-centered, ethical and integrated fertility care, rather than treatment based solely on the diagnosis of infertility.

Homoeopathic Remedies:

- I-Ignatia amara :-Marked grief, disappointment, emotional suppression, and spasmodic or irregular menstrual complaints.
- N- Natrum Muriaticum:- Menstrual irregularity, leucorrhoea, vaginal dryness, and complaints associated with prolonged grief or emotional suppression.
- F- Folliculinum:- Menstrual and hormonal disturbances, especially symptoms associated with ovarian and hormonal imbalance.
- E- Elaps corallinus:- Dark, offensive discharges and marked pelvic or genital complaints.
- R- Radium bromatum:- Chronic pelvic and

uterine complaints with menstrual irregularities.

- T- Testis siccati:- – Traditionally considered in diminished testicular and male reproductive function.
- I- Iodum:- Sexual and reproductive weakness associated with glandular disturbances and constitutional emaciation.
- L- Lycopodium:- Sexual weakness, diminished erectile power, and genito-urinary complaints; may be associated with digestive disturbances.
- I- Insulinum:- Traditionally considered in metabolic and endocrine disturbances associated with reproductive dysfunction.
- T- Thuja occidentalis:- Genital condylomata, abnormal genital discharges, and chronic genito-urinary complaints.
- Y- Yohimbinum :- Traditionally associated with diminished male sexual power and erectile weakness.

Other:-

- Agnus castus :-Marked diminution of sexual desire and sexual weakness.
- Pulsatilla:- Delayed, scanty, suppressed, or irregular menstruation with a mild, emotional and changeable disposition.
- Sabina:- Marked uterine bleeding, bright-red blood with clots, and pelvic or uterine pain.
- Sepia:- Irregular or scanty menstruation, bearing-down sensation in the pelvis, pelvic congestion, leucorrhoea, and indifference.
- Selenium:- Sexual weakness, involuntary seminal emissions, and diminished sexual vitality.
- Calcarea carb:- Delayed or irregular menstruation, leucorrhoea, and constitutional weakness associated with reproductive complaints.
- Graphites:- Delayed or scanty menstruation with marked leucorrhoea.
- Lachesis:- Menstrual and pelvic complaints, often worse before menstruation and relieved after the menstrual flow begins.
- Nux vomica :- Menstrual irregularities and pelvic congestion, particularly in irritable individuals with sedentary habits.

NAME : ABC	AGE : 27 Years	Sex : Female	Occupation: Housewife
Diagnosis : Poly Cystic Ovarian Disease			
Investigation: Pre diagnosed case of PCOD. Haemoglobin_ **Before:** HB : 10.10 gm% (Date : 18/5/2020) **After:** HB : 14.8 gm% (Date : 14/4/2021) USG _ **Before:** PCOD findings : Left ovary having cyst measuring 28x29 mm in size. Right ovary have also changes of PCOS. (Date : 09/9/2020). **After: Right ovary appears normal, left ovary is not evaluated because partially filled UB.** (Date : 02/2/2021). **No ovarian cyst is found, both ovaries are normal.** (Date : 22/3/2021).			
Constitution : Person with pale complexion, black hairs, Anemic. Thermal : Chilly patient. Appetite : Regular : 3 meals / day. Thirst : 1 liter / day. Desire : Sweet+++ Disagree : Ghee+, Cheese++, Butter+. Perspiration : Over face, scanty. Menstrual history : Irregular & painful periods. Duration : 35-40 days. LMP : 27/8/2020			

Obstetric history : No children.

Mind_

She is very mild nature person, gets angry very occasionally.

While telling about her pregnancy problem she starts crying.

She feels insecure about life.

Consolation gives her relief.

Physical_

Chilly patient.

Perspiration : Over face, scanty.

Desire : Sweet+++

Disagree : Ghee+, Cheese++, Butter+.

Left side : Abdominal pain, twisting colic makes the patient bent double.

Head : Hair fall & dandruff++, itchy scalp.

Location	Sensation	Modality	Concomitant
Left side : Abdominal pain Face : Hirsutism	Twisting colic pain	<Motion >Bent double	Hair fall, Dandruff++, Itching in scalp.

Totality of symptoms_

Mind_

MILD.

Anger.

WEEPING DISPOSITION.

Insecurity.

>Consolation.

Physical_

Left side : Abdominal pain, twisting colic makes the patient bent double.

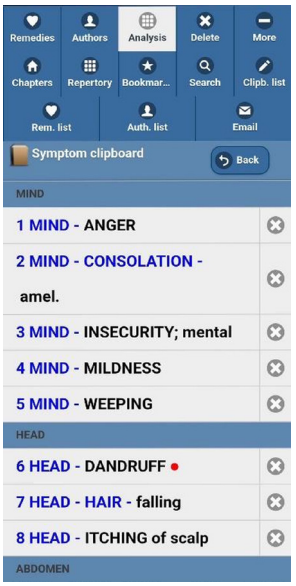
Head : Hair fall & dandruff++, itchy scalp.

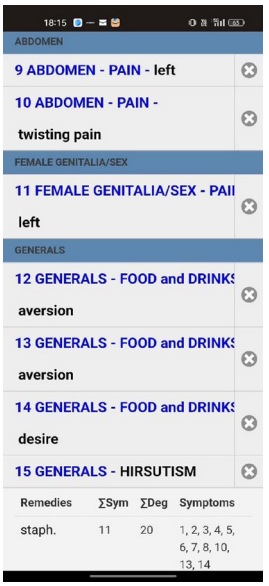
Face : Hirsutism.

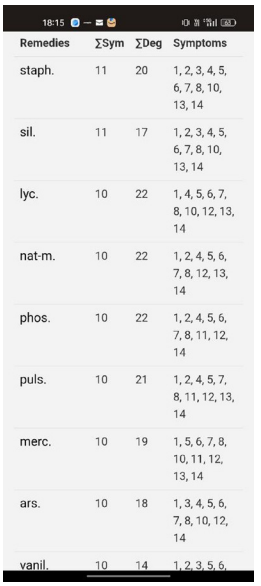
Thermal : Chilly patient.

Desire : Sweet+++

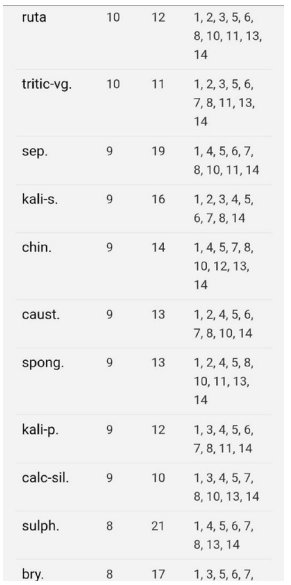
Disagree : Ghee+, Cheese++, Butter+.







Remedies	∑Sym	∑Deg	Symptoms
staph.	11	20	1, 2, 3, 4, 5, 6, 7, 8, 10, 13, 14
sil.	11	17	1, 2, 3, 4, 5, 6, 7, 8, 10, 13, 14
lyc.	10	22	1, 4, 5, 6, 7, 8, 10, 12, 13, 14
nat-m.	10	22	1, 2, 4, 5, 6, 7, 8, 12, 13, 14
phos.	10	22	1, 2, 4, 5, 6, 7, 8, 11, 12, 14
puls.	10	21	1, 2, 4, 5, 7, 8, 11, 12, 13, 14
merc.	10	19	1, 5, 6, 7, 8, 10, 11, 12, 13, 14
ars.	10	18	1, 3, 4, 5, 6, 7, 8, 10, 12, 14
vanil.	10	14	1, 2, 3, 5, 6,



ruta	10	12	1, 2, 3, 5, 6, 8, 10, 11, 13, 14
tritic-vg.	10	11	1, 2, 3, 5, 6, 7, 8, 11, 13, 14
sep.	9	19	1, 4, 5, 6, 7, 8, 10, 11, 14
kali-s.	9	16	1, 2, 3, 4, 5, 6, 7, 8, 14
chin.	9	14	1, 4, 5, 7, 8, 10, 12, 13, 14
caust.	9	13	1, 2, 4, 5, 6, 7, 8, 10, 14
spong.	9	13	1, 2, 4, 5, 8, 10, 11, 13, 14
kali-p.	9	12	1, 3, 4, 5, 6, 7, 8, 11, 14
calc-sil.	9	10	1, 3, 4, 5, 7, 8, 10, 13, 14
sulph.	8	21	1, 4, 5, 6, 7, 8, 13, 14
bry.	8	17	1, 3, 5, 6, 7,

Prescription: Pulsatilla nigricans in various potency like 30, 200, 1M.

Anti miasmatic : Thuja occidentalis 1M. (Non repertorial approach).

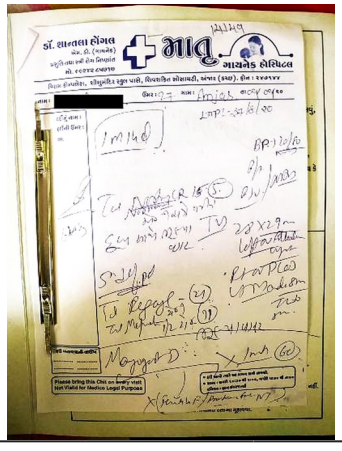
Diet: Take healthy diet rich in fiber, add protein diet, healthy fats like almonds or walnuts, avoid food which is having more carbohydrate.

Follow up :

Date	Symptoms	Prescription
5/10/2020	Left side pain is slightly decrease. Hair fall reduced. Hirsutism : No change.	Pulsatilla nigricans 30 OD for month
5/11/2020	Left side pain is decrease. Hair fall reduced more. Hirsutism : No change. LMP : 27/8/2020	Pulsatilla nigricans 30 BD for month
5/12/2020	Left side pain is decrease. Hair fall less, itching decrease. LMP : 10/11/2020 Hirsutism : Reduced.	Pulsatilla nigricans 30 TDS for month
5/1/2021	Left side pain is very occasionally, sometimes right side abdominal pain is there. Hair fall reduced. Hirsutism : Reduced. LMP : 13/12/2020	Pulsatilla nigricans 200 OD for month
5/2/2021	Left side pain is not now. Hair fall is less, new hair growth is visible. No dandruff. Feels good now psychologically. No Hirsutism. LMP : 12/1/2021	Pulsatilla nigricans 1M x 4 doses for month Thuja occidentalis 1M
5/3/2021	LMP : 14/2/2021 NO LEFT SIDED PAIN. HAIR FALL IMPROVED, NO DANDRUFF.	Pulsatilla nigricans 1M x 4 doses for month
22/3/2021	**NO SIGNS OF PCOD PRESENT ON USG ON 22/3/21** **LAST CYCLE APPEARED ON 14/3/2021**	NO MEDICINES IS GIVEN

CASE PICTURES : BEFORE & AFTER

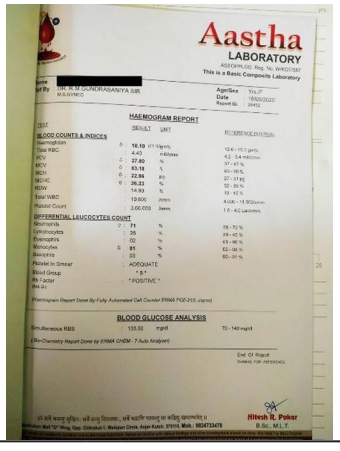
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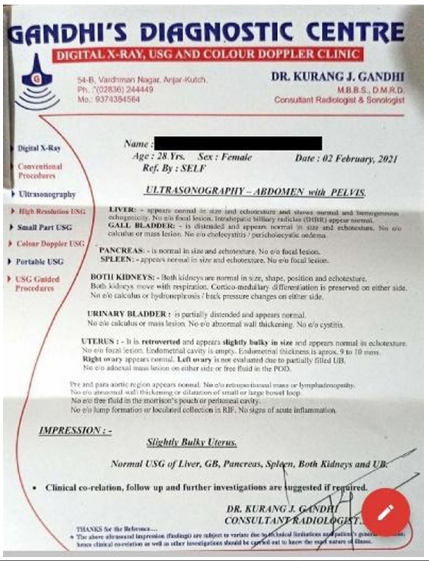
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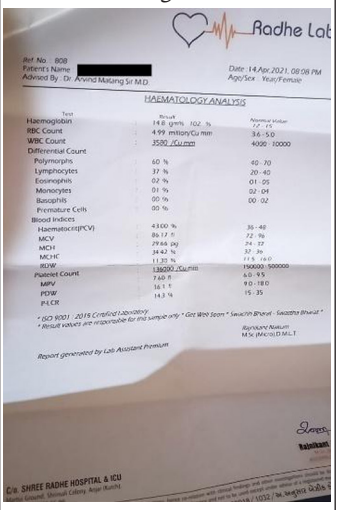
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4


GANDHI'S DIAGNOSTIC CENTRE
DIGITAL X-RAY, USG AND COLOUR DOPPLER CLINIC
DR. KURANG J. GANDHI
M.B.B.S., D.M.R.D.
Consultant Radiologist & Sonologist
54-B, Vardhman Nagar, Anjar-Kutch.
Ph. (02836) 244449
Mo.: 9374384564
Digital X-Ray
Conventional Procedures
Ultrasonography
High Resolution USG
Small Part USG
Colour Doppler USG
Portable USG
USG Guided Procedures
Name :
Age : 28 Yrs. Sex : Female
Date : 02 February, 2021
Ref. By : SELF
ULTRASONOGRAPHY – ABDOMEN with PELVIS
LIVER: - appears normal in size and echotexture and shows normal and homogeneous echogenicity. No e/o focal lesion. Intrahepatic biliary radicles (IHBR) appear normal.
GALL BLADDER: - is distended and appears normal in size and echotexture. No e/o calculus or mass lesion. No e/o cholecystitis / pericholecystic oedema.
PANCREAS: - is normal in size and echotexture. No e/o focal lesion.
SPLEEN: - appears normal in size and echotexture. No e/o focal lesion.
BOTH KIDNEYS: - Both kidneys are normal in size, shape, position and echotexture. Both Kidneys move with respiration. Cortico-medullary differentiation is preserved on either side. No e/o calculus or hydronephrosis / back pressure changes on either side.
URINARY BLADDER : is partially distended and appears normal. No e/o calculus or mass lesion. No e/o abnormal wall thickening. No e/o cystitis.
UTERUS : - It is retroverted and appears slightly bulky in size and appears normal in echotexture. No e/o focal lesion. Endometrial cavity is empty. Endometrial thickness is approx. 9 to 10 mms. Right ovary appears normal. Left ovary is not evaluated due to partially filled UB. No e/o adnexal mass lesion on either side or free fluid in the POD.
Pre and para aortic region appears normal. No e/o retroperitoneal mass or lymphadenopathy. No e/o abnormal wall thickening or dilatation of small or large bowel loop. No e/o free fluid in the morrison's pouch or peritoneal cavity. No e/o lump formation or localized collection in RIF. No signs of acute inflammation.
IMPRESSION : -
Slightly Bulky Uterus.
Normal USG of Liver, GB, Pancreas, Spleen, Both Kidneys and UB.
• Clinical co-relation, follow up and further investigations are suggested if required.
DR. KURANG J. GANDHI
CONSULTANT RADIOLOGIST
THANKS for the Reference...
• The above ultrasound impression (findings) are subject to variation due to technical limitations, inter-patient / gender variations, hence clinical correlation as well as other investigations should be carried out to know the exact nature of illness.

5


Radhe Lab
Ref. No. 808
Patient's Name
Advised By : Dr. Arvind Matang Sir M.D.
Date : 14 Apr, 2021, 08:08 PM
Age/Sex : Year/Female
HAEMATOLOGY ANALYSIS
Test | Result | Normal Value
Haemoglobin | 14.8 gm% | 12 - 15
RBC Count | 4.99 million/Cu mm | 3.6 - 5.0
WBC Count | 9580 /Cu mm | 4000 - 10000
Differential Count
Polymorphs | 60 % | 40 - 70
Lymphocytes | 37 % | 20 - 40
Eosinophils | 02 % | 01 - 05
Monocytes | 01 % | 02 - 04
Basophils | 00 % | 00 - 02
Premature Cells | 00 % |
Blood Indices
Haematocrit(PCV) | 43.00 % | 36 - 46
MCV | 86.17 fl | 72 - 96
MCH | 29.66 pg | 24 - 32
MCHC | 34.42 % | 32 - 36
RDW | 11.35 % | 11.5 - 16.0
Platelet Count | 136000 /Cu mm | 150000 - 500000
MPV | 7.60 fl | 6.0 - 9.5
PDW | 16.1 | 9.0 - 18.0
P-LCR | 14.3 % | 15 - 35
* ISO 9001 : 2018 Certified Laboratory
* Result values are responsible for this sample only * Get Well Soon * Swachh Bharat * Swastha Bharat *
Report generated by Lab Assistant Premium
Rajnikant Nakum
M.Sc.(Micro) D.M.L.T
C/o. SHREE RADHE HOSPITAL & ICU

6

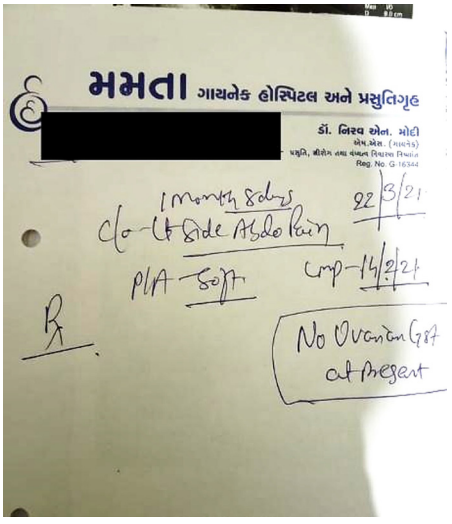

ममता ગાયનેક હોસ્પિટલ અને પ્રસુતિગૃહ
ડૉ. નિરવ એન. મોદી
1 month 8days
C/o - Lt Side Abdo Pain
P/A - Soft
Cmp - 14/2/21
22/3/21
R
No Ovarian Cyst at Present

Image 1 – Initial Consultation and Prescription Initial clinical consultation with the patient, including the prescribed treatment and medical advice.

Image 2 – Initial Ultrasonography Pelvic ultrasonography showing a cystic structure, documented during the initial investigation.

Image 3 – Initial Haematological Investigation Initial haemogram report showing the patient's blood parameters, including haemoglobin, RBC, WBC and platelet count.

Image 4 – Follow-up Ultrasonography (02/02/2021) USG of the abdomen and pelvis showing a slightly bulky uterus, with other abdominal organs appearing normal.

Image 5 – Follow-up Haematological Investigation Repeat blood examination showing updated haemoglobin, RBC, WBC and platelet levels.

Image 6 – Clinical Follow-up (22/03/2021) Follow-up consultation documenting the patient's symptoms and examination findings, with no ovarian cyst noted at that time.

Consent : Informed consent taken from the patient & the treating physician to publish the case study.

CONCLUSION

Infertility is multifactorial condition requiring proper evaluation of both partners. Homoeopathy approaches the patient individually through Totality of symptoms,

Repertorisation and Materia medica. Although some case reports and observational studies show encouraging findings, stronger scientific evidence is required.

Thus, homoeopathy may be studied or used as a complementary system of care, but it should not replace evidence- based infertility evaluation, fertility- preserving measures or medically indicated assisted reproductive treatment.

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Individualized homoeopathic treatment in a woman withprimaryinfertility, PCOS and bicornuate uterus: A case report

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Abstract

Infertility is defined as failure to achieve pregnancy after 12 months or more of regular unprotectedsexual intercourse. It may result from male factors, female factors, combined factors or unexplainedcauses. Polycystic ovary syndrome (PCOS) is an important cause of ovulatory dysfunctionassociated with infertility. [1,2].

A 25-year-old woman presented with primary infertility of two years' duration despite regular unprotected intercourse. She also reported irregular and painful menstrual cycles for approximatelyone year. Ultrasonography revealed bilateral polycystic ovarian morphology and a bicornuateuterus. The patient had a BMI of 37.4 kg/m². Individualized homoeopathic treatment was selectedbasedonthe totality of symptoms. Natrum muriaticum was selected after repertorial analysis and materiamedica correlation.

Intervention and outcome

During follow-up, the menstrual cycles progressively became more regular and the offensive character of the menstrual discharge decreased. The patient's weight decreased from89 kgto86kg. A subsequent ultrasonographic examination documented ovarian volumes of approximately10c-con the right and 9 cc on the left. On 1 January 2026, a urine pregnancy test was reported positiveand an early pregnancy scan was advised.

Keywords

Primary infertility; polycystic ovary syndrome; bicornuate uterus; individualizedhomoeopathy; Natrum muriaticum; case report.

Introduction

Infertility is a disease of the reproductive system defined by failure to achieve pregnancy after 12months or more of regular unprotected sexual intercourse. It may arise from male factors, femalefactors, combined factors or unexplained causes. The condition can have substantial psychological, social and financial consequences for affected individuals and couples. [1,2]

Polycystic ovary syndrome is a common endocrine and reproductive disorder associated withovulatory dysfunction, metabolic abnormalities and psychological morbidity. The 2023 International Evidence-based Guideline for PCOS states that, in adults, PCOS is diagnosedusingthe presence of two of three features—clinical or biochemical hyperandrogenism, ovulatory dysfunction and polycystic ovaries on ultrasound or, where appropriate, anti-Müllerian hormone—after exclusion of other causes. [3]

Congenital uterine anomalies may also be relevant to reproductive outcomes. Evidence fromsystematic reviews indicates that congenital uterine anomalies as a group may be associatedwithadverse reproductive and obstetric outcomes, although the impact varies according to the specificanomaly. [4,5]

The present case is noteworthy because primary infertility occurred in a young woman withclinical features of PCOS and a documented bicornuate

uterus. The patient was managed with individualized homoeopathic treatment and subsequently demonstrated improvement in menstrual regularity followed by a positive urine pregnancy test.

Case presentation

A 25-year-old woman presented with primary infertility for two years despite regular unprotectedintercourse. She reported irregular and painful menstrual cycles for approximately one year. Themenstrual cycle was approximately 45 days, with dark maroon to black, clotted and offensivemenstrual blood associated with cramping lower abdominal pain and weakness.

She reported a weight gain of approximately 5 kg over two months. There was no significant past medical history. According to the case record, both maternal and paternal family histories wereapparently non-contributory.

On general examination, the patient had a fair, fat and flabby constitution. Her BMI was 37.4kg/m^2 and blood pressure was 120/70 mm-Hg. She was described as chilly and susceptible to catchingcold, with aggravation during winter. Appetite was good, with tolerance of hunger. She desiredspicy, fried and warm foods and reported intolerance to sour foods, which produced epigastricburning. She preferred large quantities of water at long intervals. Bowel and bladder functions werereported as normal.

Perspiration was described as profuse, particularly over the axilla, forehead and nose, withanoffensive odour and yellowish-white staining.

The mental symptoms recorded were irritability, easy anger, aggravation fromcontradiction, aversion to consolation, reserved behaviour, weeping alone and suspiciousness toward her husband.

Diagnostic assessment

Pelvic ultrasonography dated 13 February 2025 demonstrated:

- Right ovarian volume: 11 cc
- Left ovarian volume: 9 cc
- Multiple peripheral follicles in both ovaries
- Findings suggestive of polycystic ovaries
- Bicornuate uterus
- Small nabothian cysts

Fasting blood glucose was 90 mg/dL and haemoglobin was 12.6 g/dL.

The case record gives the diagnosis as PCOS. However, the manuscript does not provide sufficient biochemical documentation of hyperandrogenism or a complete exclusion work-up for alternativecauses of irregular menstruation . the pt was advised for AMH (anti - mullerian hormone) However ,the patient did not undergo the investigation due to anxiety and her hope of conceivingnaturally. [3]

Totality of symptoms

Mental generals

Weeps alone

Consolation aggravates

Reserved

Angers easily

Contradiction aggravates

Suspicious of husband

Physical generals

Offensive perspiration

Perspiration over the nose

Sour food aggravates

Thirst for large quantities at long intervals

Particular symptoms

Irregular menstruation

Offensive menstruation

Primary infertility

Dark/black, clotted menstrual blood

Repertorisation

HOMPATH ZOMEO SOFTWARE - REPERTORY

was used. The following rubrics were selected from the case:

Mind – weeping, tearful mood, alone

Mind – consolation aggravates

Mind – anger easily

Mind – contradiction aggravates

Mind – suspiciousness

Perspiration – offensive

Face – perspiration – nose

Generalities – food and drinks – sour/acid – aggravates

Stomach – thirst – large quantities

Female genitalia – menses – irregular

Female genitalia – menses – offensive

Female genitalia – sterility

Female genitalia – menses – clotted/coagulated – dark/black

Repertorial Sheet

Remedy	Nat-m	Bell	Sulph	Lyc	Calc	Lach	Sep	Nux-v	Ars	Sil
Totality	32	31	30	29	27	27	27	26	26	26
Symptoms Covered	10	11	10	10	12	10	9	11	10	8
Kingdom	Minerals	Plants	Minerals	Plants	Miner-als	Animals, Sarcodes	Animals, Sarcodes	Plants	Minerals	Minerals
[Complete] [Mind] WEEPING, TEAR-FUL MOOD:Alone, being:Agg.: (30)	3			3					1	
[Complete] [Mind] CON-SOLATION, SYMPATHY: Ailments from, agg.: (95)	4	3	3	1	3		4	1	3	4
[Complete] [Mirilli's Themes] RESERVED: (732)	4	4	4	3	3	4	3	4	3	3
[Murphy] [Mind]AN-GER, GENERAL, (SEE IRRITABILITY, RAGE) :Easily : (35)		1		3	1	1		3	1	
[Complete] [Mind] CON-TRADICTION: Ailments from, agg.: (195)	3	3	3	4	1	3	4	3	1	3
[Complete] [Mind] SUSPI-CIOUSNESS, MISTRUST-FULNESS: Husband, to-wards: (4)										
[Complete] [Perspiration] OFFENSIVE: (234)	1	1	4	4	3	3	4	4	3	4
[Complete] [Face]PERSPI-RATION: Nose: (20)	3	2			2			1		
[Complete] [Gener-alities]FOOD AND DRINKS:Sour, acid:Agg.: (93)	4	3	3	3	3	4	4	4	4	4
[Complete] [Stomach] THIRST: Large quantities, for: (148)	4	3	4	1	3	3	1	1	4	

[Complete] [Female Genitalia]MENSES:Irregular: (167)	3	3	3	3	4	4	3	3	2	3
[Complete] [Female Genitalia]MENSES: Offensive: (99)		4	3		1	2	1	1	4	3
[Murphy] [Female]STERILITY, (SEE INFERTILITY) : (87)	3		1		2	2	3	1		2
[Complete] [Female Genitalia]MENSES: Clotted, coagulated: Dark, black: (88)		4	2	4	1	1				

Natrum muriaticum and Belladonna obtained the highest repertorial scores in the original caserecord. Natrum muriaticum was subsequently selected after materia medica correlation.

Miasmatic Analysis-

mind -weeping ,tearful mood,alone -psoric

mind - consolation agg - psoric

mind -anger easily -psoric

mind- contradiction agg - psoric

mind -suspiciousness - sycotic

perspiration- offensive- sycotic

face - perspiration - nose -sycotic

generalities - food and drinks - sour /acids - agg -sycotic

stomach - thirst - large quantities - sycotic

female genitalia - menses - irregular- sycotic

female genitalia - menses - offensive - sycotic

female genitalia - sterility- psoro-sycotic

female genitalia - menses - clotted/coagulated-dark /black -sycotic,syphilitic

Pre-Dominant Miasm- Sycotic

Fundamental Miasm-Psora

Therapeutic Intervention

On 20 February 2025, Natrum muriaticum 200 was prescribed according to the case record, followed by placebo.

The subsequent prescriptions and follow-up observations are presented chronologically below.

Follow-up and outcomes

Date	Clinical findings	Weight	Prescription/outcome
12.03.2025	LMP 02.03.2025; red, clotted, Offensive menses; decreased bleeding; weakness;lower abdominal pain	89 kg	Natrum muriaticum 200, one dose; placebo
15.04.2025	LMP 02.04.2025; redmenses, no offensiveodour; lowerabdominal pain	89 kg	Placebo
20.05.2025	LMP 01.05.2025; red,clotted, non-offensivemenses; lowerabdominal pain	86 kg	Natrum mur 1M, one dose; placebo
20.08.2025	LMP 03.08.2025;cycles regular; red, clotted and non- offensive menses; abdominal pain	—	Placebo
01.10.2025	LMP 01.10.2025;cycles regular; red, clotted and non- offensive menses; intermittent abdominal pain, particularly during days 1–3	86 kg	Natrum mur 1M; placebo
11.12.2025	LMP recorded as 28.11.2025; cycles regular; red, clotted menses; lowerabdominal pain	86 kg	Natrum mur 1M, one dose; placebo
01.01.2026	LMP 25.12.2025; scanty bleeding from day 2; lower abdominal pain; UPT-positive	_	Early pregnancy scan advised

Her lmp was 25.12.2026 and edd -1.10.2026 ,she delivered a baby on 3.9.2026 due to decreasedfetal moments and increased FHR.

DISCUSSION

Infertility is a common reproductive health problem and may result from abnormalities affectingtheovaries, uterus, fallopian tubes, endocrine system or male reproductive system. The present patient had primary infertility for two years and presented with menstrual irregularity and ultrasonographicfindings suggestive of PCOS. [1,2]

PCOS is characterized by a heterogeneous combination of reproductive, metabolic and psychological features. According to the 2023 International Evidence-based Guideline, diagnosisin

adults is based on two of three features—hyperandrogenism, ovulatory dysfunction and polycysticovaries/AMH—after exclusion of other causes. [3] In the present case, irregular menstruationandpolycystic ovarian morphology were documented. However, the case record supplied for this report does not contain adequate documentation of biochemical or clinical hyperandrogenismor a complete exclusion of alternative endocrine causes. Therefore, the diagnostic documentationshouldbe strengthened before journal submission.

The patient also had a bicornuate uterus on ultrasonography. Congenital uterine anomalies areassociated with variable reproductive and obstetric outcomes. A systematic reviewfound that unification defects, including bicornuate uterus, were associated particularly with increasedrisksofpreterm birth and fetal malpresentation, although the relationship between individual uterine anomalies and fertility is complex. [4] A later systematic review and meta-analysis also reportedincreased adverse reproductive and obstetric outcomes among women with congenital uterineanomalies as a group. [5] Therefore, the bicornuate uterus should be considered an important coexisting structural finding rather than attributing the infertility exclusively to PCOS.

In the present case, individualized homoeopathic treatment was selected on the basis of the totalityof symptoms, including mental generals, physical generals and characteristic menstrual symptoms. Natrum muriaticum was selected after repertorial analysis and materia medica correlation. Thecaserecord documents subsequent changes in menstrual characteristics and cycle regularity duringfollow-up.

An important observation was the transition from irregular, offensive and painful menses tomoreregular cycles with disappearance of the offensive character. The patient's recorded weight alsodecreased from 89 kg to 86 kg during follow-up. A subsequent ultrasound was reported in thecaserecord as showing ovarian volumes of approximately 10 mL and 9 mL. These changes are clinicallyrelevant observations, but they cannot by themselves demonstrate that the homoeopathic intervention caused the changes.

The final recorded outcome was a positive urine pregnancy test on 1 January 2026. This representsa clinically important outcome in a woman who had presented with primary infertility. Nevertheless, conception following treatment in an individual case does not establish causality. Natural variationin ovulatory function, changes in weight or lifestyle, spontaneous conception and other unmeasuredfactors may have contributed to the outcome.

Evidence concerning individualized homoeopathy remains contested and heterogeneous. Systematicreviews of individualized homoeopathic treatment have reported findings that require cautious interpretation because of methodological limitations and risk of bias. [6,7] Consequently, the present case should be regarded as a clinical observation that may generate a hypothesis for furtherinvestigation rather than evidence establishing efficacy.

The case has several strengths. It contains longitudinal clinical observations, documentationof menstrual changes, repertorial reasoning, serial treatment records and an objective pregnancytest. The coexistence of PCOS features and a bicornuate uterus also makes the reproductive historyclinically noteworthy.

However, there are important limitations. This is a single-patient, uncontrolled case report. Thesupplied record does not document all investigations normally relevant to infertility evaluation,

including complete documentation of ovulation, tubal patency and male-factor assessment. Documentation of biochemical hyperandrogenism and exclusion of other causes of menstrual irregularity is also incomplete. The contribution of the bicornuate uterus to the patient's infertilitycannot be determined from the available information. Furthermore, the final pregnancy outcomeisnot documented in the supplied record.

The CARE guidelines emphasize transparent reporting of patient information, clinical findings, diagnostic assessment, therapeutic intervention, timeline, follow-up, patient perspective andinformed consent in case reports. [8] .

CONCLUSION

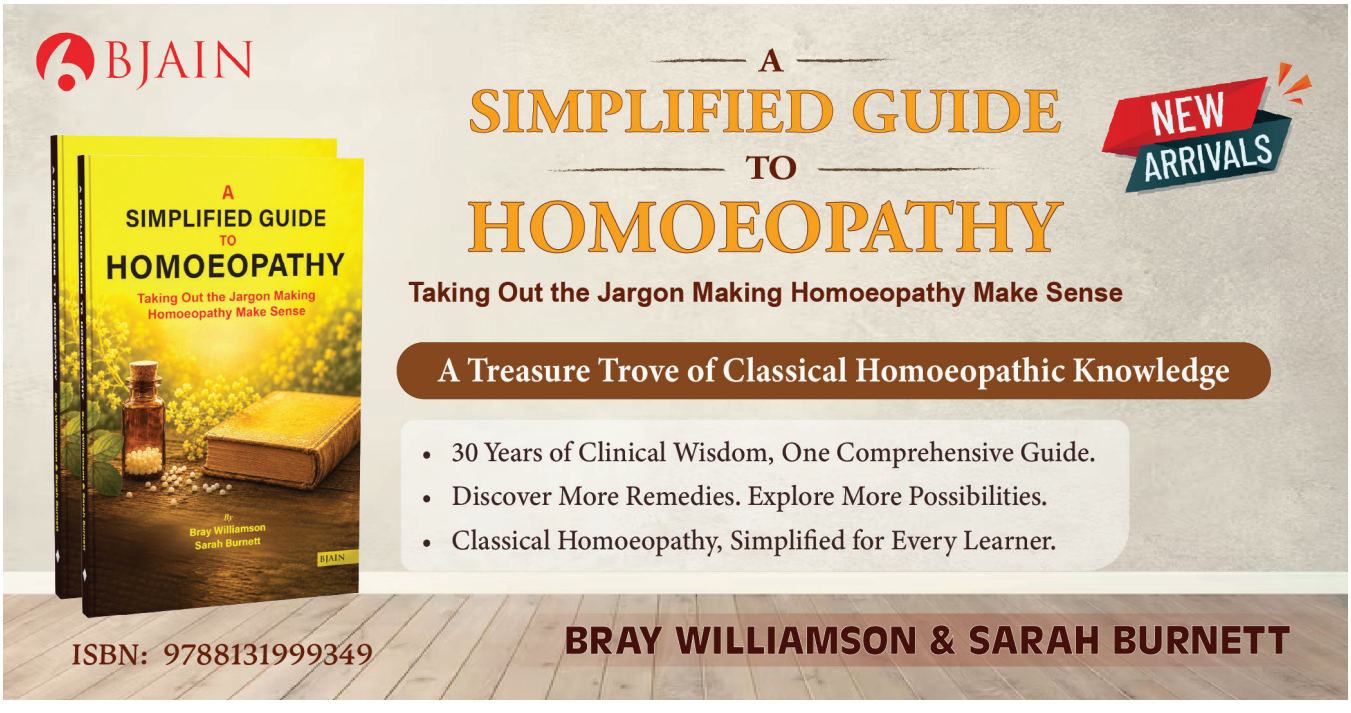
This case describes a 25-year-old woman with primary infertility, features suggestive of PCOSanda bicornuate uterus who received individualized homoeopathic treatment and subsequentlydemonstrated improvement in menstrual regularity followed by a positive urine pregnancytest. Theassociation is clinically interesting, between individualized homoeopathic treatment in primaryinfertility with pcos

Informed consent

Yes, informed consent for publication of the case report is obtained the patient before submission.

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A Holistic Approach to Infertility: Scope of Homoeopathy in Reproductive Health



Dr. Nidhi Tiwari[1]

[1]PhD, MD, (HOMO.), BHMS, GYN(DRCH), Assistant prof., HOD (Physiology depart.)



Parth Patel[2]

[2]Intern (batch 2020, A-201763), State KGK Homoeopathic medical college, Moradabad (U.P.)

Abstract:

Infertility is defined as the inability to conceive after one year od regular, unprotected intercourse and is becoming prevalent worldwide.in recent decades, a noticeable rise in infertility cases has been observed influenced by multiple factors including delayed childbearing, lifestyle modification, environment exposure and underlying medical condition.

One of the leading causes of female infertility is PCOS, a complex hormonal disorder characterized by irregular menstrual cycles, hyperandrogenism. Women with PCOS often experience anovulation, which significantly reduces their chances of natural conception.

Homoeopathic offers a valuable result in cases of female infertility. Here this cases report of OPD case of State KGK Homoeopathic medical college & hospital, Moradabad. Showing a female patient aged 28 yr married for 4 year had complain of uterine fibroid with history of PCOD, was successfully treated for infertility and even after conceving, the patient has trusted the homoeopathic treatment. This shows that with homoeopathic, a treatment of infertility as well as the antenatal care is possible if proper, well indicated remedy given on the basis of symptom similarity. Thus, homoeopathic can definietely help female to go through the beautiful phase of pregnancy.

Introduction:

Infertility has emerged as a growing global health concern, affecting a significant proportion of reproductive-age couples. Among the various contributingfactors, hormonal and lifestyle-related disorder have gained increasing attention, PCOD is one of the most common endocrine disorder in women and is closely associated with ovulation dysfunction, metabolic disturbance. The rising prevalence of PCOD, couple with modern lifestyle changes such as sedentary behavior, poor dietry habits, stress has contribute to the increasing incidence of infertililty.

Hiralal konar and DC dutta in the textbook gynaecology extensive outline the causes of infertility,

- Anovulation or oligo-ovulation decreased ovarian reserve.
- Luteal phase defect.
- Obstruction of the tubes.
- Fibroid uterus, congential malformation of uterus.
- Second degree uterine prolapse

- Physiologyical fault in the composition of the cervical mucus that the spermatozoa fail to penetrate the mucus that the mucus. The abnormally constituents include excessive, vicous or purulent discharge as in chronic cervicitis.

Vaginal Factor:

- Atresia of vagina, transverse vaginal septum, narrow introiyus.
- Vaginitis and purulent discharge.
- Dyspareunia.

General Factors:

- Advanced age
- Infrequent intercourse.
- Anxiety
- Use of lubricants during intercourse.

Case Report:

Name of Patient: Abc

Age: 26yr

Sex: Female

Marital Status: Married

Date Of Visit: 11/06/2025

Present Complaints:

- Left renal STONE.
- Follicular cyst in right ovary.
- Right sided patent tube.
- Left sided mid tubal block.
- Married for 3 year but not able to carry a full term pregnancy.

Menstrual History:

LMP 16/11/2025, irregular menses.

Obstetric History-: married for 3 year and she has no child.

Past History: Bilateral polycystic ovarian disease, Hypothyroidism, B/L renal concreations diagnosed through whole abdomen USG done in 12.7.21.

Family History: N.S

Personal History:

Appetite: 2-3 Diet Plan/Day

Thirsty: 10-12 GLASS/DAY

Desire: Curd and roti

Sleep: 6-8HR/DAY

Thermal: Hot

Mental: trustworthy, stay forward, shameful feel, defensive person, positive person, wrong intolerance, advicable, caring person, jolly nature, helping nature, friendly nature,

General Physical Examination:

Apperance: Dark Hair, Brownish.

Weight: 60kg

Temperature:37.5°c

Pulse Rate: 70-90bpm

Respiration Rate: 12-18/Min

Bloodpressure: 94-130mmhg

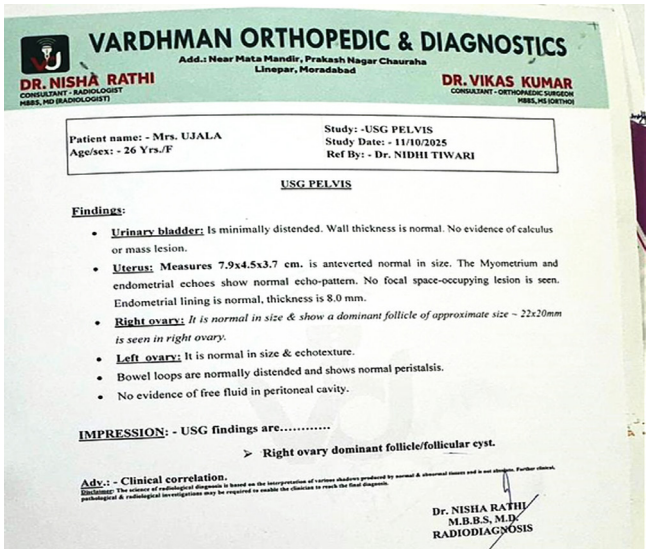
Evaluation of Symptoms

1. Irregular menses
2. Thirsty
3. Desire for curd
4. Hot patient
5. Cut to cut answer
6. Cant Wrong tolerance
7. Answer To The Point
8. Love for children
9. Working
10. Unhide.

11. Dignified.
12. anger-injustice intolerant.
13. take responsibility seriously.
14. self depended.
15. sensitive for self respect.
16. anxiety about society thing.
17. strike thought for in-law.
18. shameful feel about in-law.

Investigations Before Treatment

Fig 1: USG reports of 11.10.25 showing Rt ovary dominant follicle/ follicular cyst



VARDHMAN ORTHOPEDIC & DIAGNOSTICS
Add.: Near Mata Mandir, Prakash Nagar Chauraha
Linepar, Moradabad

DR. NISHA RATHI
CONSULTANT - RADIOLOGIST
MBBS, MD (RADIOLOGIST)

DR. VIKAS KUMAR
CONSULTANT - ORTHOPAEDIC SURGEON
MBBS, MS (ORTHO)

Patient name: - Mrs. UJALA
Age/sex: - 26 Yrs./F

Study: -USG PELVIS
Study Date: - 11/10/2025
Ref By: - Dr. NIDHI TIWARI

USG PELVIS

Findings:

- Urinary bladder: Is minimally distended. Wall thickness is normal. No evidence of calculus or mass lesion.
- Uterus: Measures 7.9x4.5x3.7 cm. is anteverted normal in size. The Myometrium and endometrial echoes show normal echo-pattern. No focal space-occupying lesion is seen. Endometrial lining is normal, thickness is 8.0 mm.
- Right ovary: *It is normal in size & show a dominant follicle of approximate size ~ 22x20mm is seen in right ovary.*
- Left ovary: It is normal in size & echotexture.
- Bowel loops are normally distended and shows normal peristalsis.
- No evidence of free fluid in peritoneal cavity.

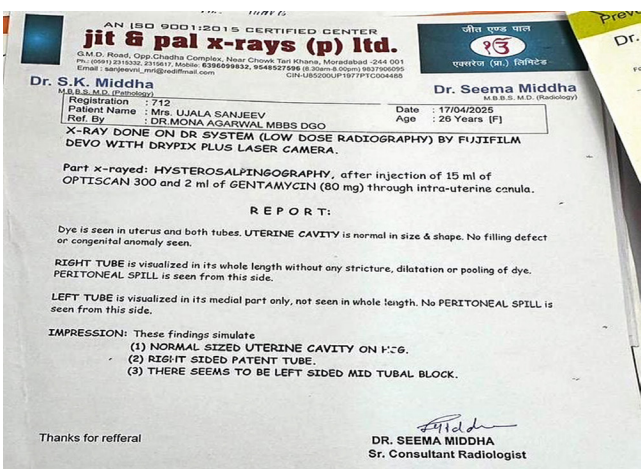
IMPRESSION: - USG findings are.....

➢ Right ovary dominant follicle/follicular cyst.

Adv.: - Clinical correlation.

Dr. NISHA RATHI
M.B.B.S, M.D.
RADIODIAGNOSIS

Fig 2: Hysterosalpongography done on 17.4.25 reveals right sided patent tube, left sided mid tubal block



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CIN-U85200UP1977PTC004485

जीत एण्ड पाल
एक्सरेज (प्रा.) लिमिटेड

Dr. S.K. Middha
M.B.B.S, M.D. (Pathology)

Dr. Seema Middha
M.B.B.S, M.D. (Radiology)

Registration : 712
Patient Name : Mrs. UJALA SANJEEV
Ref. By : DR.MONA AGARWAL MBBS DGO

Date : 17/04/2025
Age : 26 Years (F)

X-RAY DONE ON DR SYSTEM (LOW DOSE RADIOGRAPHY) BY FUJIFILM DEVO WITH DRYPIX PLUS LASER CAMERA.

Part X-rayed: HYSTEROSALPINGOGRAPHY, after injection of 15 ml of OPTISCAN 300 and 2 ml of GENTAMYCIN (80 mg) through intra-uterine canula.

REPORT:

Dye is seen in uterus and both tubes. UTERINE CAVITY is normal in size & shape. No filling defect or congenital anomaly seen.

RIGHT TUBE is visualized in its whole length without any stricture, dilatation or pooling of dye. PERITONEAL SPILL is seen from this side.

LEFT TUBE is visualized in its medial part only, not seen in whole length. No PERITONEAL SPILL is seen from this side.

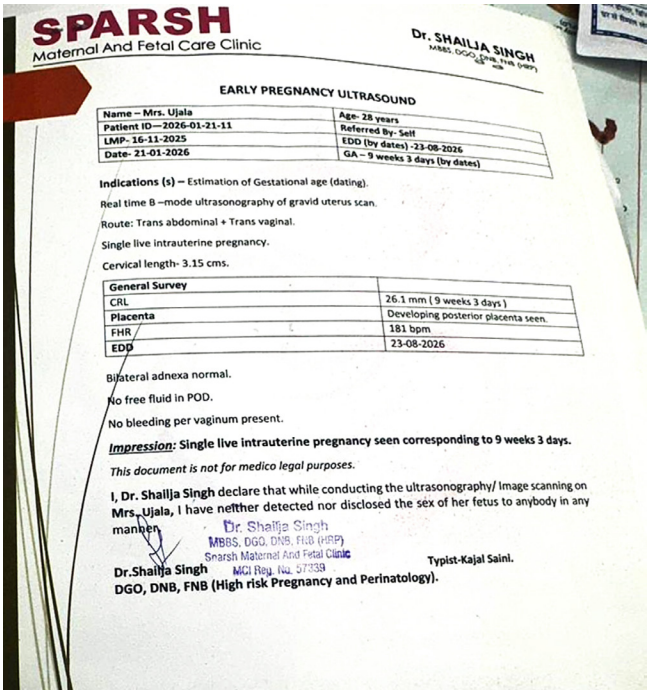
IMPRESSION: These findings simulate
(1) NORMAL SIZED UTERINE CAVITY ON HSG.
(2) RIGHT SIDED PATENT TUBE.
(3) THERE SEEMS TO BE LEFT SIDED MID TUBAL BLOCK.

Thanks for refferal

DR. SEEMA MIDDHA
Sr. Consultant Radiologist

After Treatment

Fig 3: TVS of 21.1.26 reveals single live intrauterine pregnancy of 9 weeks 3 days.



SPARSH
Maternal And Fetal Care Clinic

Dr. SHAILJA SINGH
MBBS, DGO, DNB, FNB (HRP)

EARLY PREGNANCY ULTRASOUND

Name – Mrs. Ujala	Age- 28 years
Patient ID—2026-01-21-11	Referred By- Self
LMP- 16-11-2025	EDD (by dates) -23-08-2026
Date- 21-01-2026	GA – 9 weeks 3 days (by dates)

Indications (s) – Estimation of Gestational age (dating).
Real time B –mode ultrasonography of gravid uterus scan.
Route: Trans abdominal + Trans vaginal.
Single live intrauterine pregnancy.
Cervical length- 3.15 cms.

General Survey	
CRL	26.1 mm (9 weeks 3 days)
Placenta	Developing posterior placenta seen.
FHR	181 bpm
EDD	23-08-2026

Bilateral adnexa normal.
No free fluid in POD.
No bleeding per vaginum present.

Impression: **Single live intrauterine pregnancy seen corresponding to 9 weeks 3 days.**

This document is not for medico legal purposes.

I, Dr. Shailja Singh declare that while conducting the ultrasonography/ Image scanning on Mrs. Ujala, I have neither detected nor disclosed the sex of her fetus to anybody in any manner.

Dr. Shailja Singh
MBBS, DGO, DNB, FNB (HRP)
Sparsh Maternal And Fetal Clinic

Dr.Shailja Singh MCI Reg. No. 57339
DGO, DNB, FNB (High risk Pregnancy and Perinatology).

Typist-Kajal Saini.

Diagnosis Of Disease-: infertility+ PCOS+ tubal block

Diagnosis Of Disease According To Homoeopathic:

Chronic fully developed miasmatic disease.

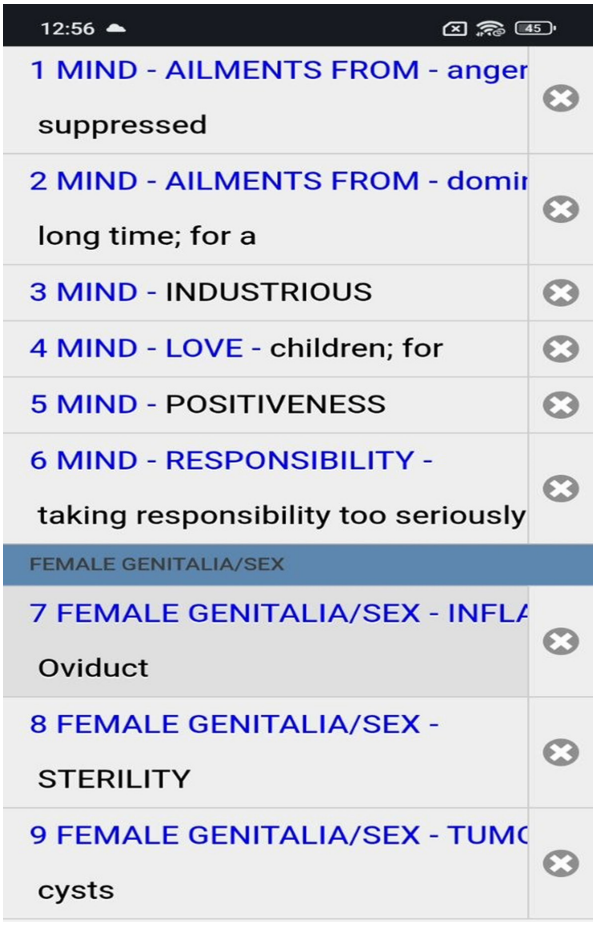
Miasmatic Diagnosis: psora+sycotic

Totailty of Symptoms:

1. Mind-Aliments form- anger suppressed
2. Mind-Aliments form- domination long time
3. Mind-Industrious
4. Mind-love- children; for
5. Mind-positiveness
6. Mind-responsibility- taking responsibility too seriously
7. Female Genitalia/sex- inflammation- oviduct
8. Female Genitalia/sex- sterility

9. Female Genitaliya/sex – tumor ovaries cyst

Selection of Medicine by Repertorial Apporach:



Repertory software used- Synthesis

Prescription: Rx SEPIA 200/1D

Sac lac 200BD/7days

Follow-up:

Sr.no.	Date	Follow up	Prescripation
1.	11/06/2025	leucorrhea	Tuberculinum-200C
2.	25/07/2025	menses irregular scanty,painful,pain in lower back	Sepia 200C/1D
3.	07/09/2025	menses improvement with normal flow,no pain no clot.	Sac lac-200/TDS
4.	12/10/2025	menses appear on time with no pain, flow 4-5 day	Sepia-200C/1D
5.	30/11/2025	menses cease advice for upt	Sac lac-200/TDS

UPT TEST: RESULT IS POSITIVE.

CONCLUSION

This case report shows that integrating constitutional medicine with chronic management provides a well-rounded approach to treating infertility. It combines long-term, root-cause-focused therapies with targeted, symptom-specific interventions. This dual approach uses the strengths of holistic medicine, which aims to balance the body and mind, along with acute management, which addresses immediate challenges that may arise during treatment. Patients benefit from personalized care plans that not only aim to improve fertility outcomes but also promote overall well-being.

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Phytochemical Analysis of Cynodon dactylon Mother Tincture and Comparative Clinical Evaluation of Cynodon dactylon Q and Achillea millefolium Q in the Management of Menorrhagia

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[1]Department of Homoeopathic Pharmacy, Government Homoeopathic Medical College & Hospital, Bhopal, Madhya Pradesh, India

[2]Associate Professor, Department of Homoeopathic Pharmacy University: Madhya Pradesh Medical Science University (MPMSU)

Abstract

Background: Menorrhagia / heavy menstrual bleeding is an important clinical problem in women of the perimenopausal age group. The present dissertation evaluated the phytochemical characteristics of Cynodon dactylon mother tincture and compared the clinical changes associated with Cynodon dactylon Q and Achillea millefolium Q in women with idiopathic menorrhagia.

Methods: The work was conducted in two phases. Phase I comprised physicochemical standardization and qualitative phytochemical analysis of Cynodon dactylon mother tincture. Phase II was a prospective, randomized, open-label comparative clinical study involving 40 women aged 35–50 years with idiopathic menorrhagia.

20 participants received Cynodon dactylon Q and twenty received Achillea millefolium Q. Menstrual blood loss was assessed using the Pictorial Blood Loss Assessment Chart (PBAC) over three consecutive menstrual cycles.

Within-group changes were analysed using the Wilcoxon signed-rank test and between-group reduction was assessed using the Mann–Whitney U test.

Results: The mother tincture showed pH 6.3, alcohol content 60% v/v, weight per mL 0.89 g/mL, total solids 0.76%, and UV maximum absorbance at 274 nm. Qualitative screening indicated alkaloids, flavonoids, tannins, phenols, phytosterols and fixed oils. In the Cynodon dactylon Q group, median PBAC decreased from 200 to 80 (Wilcoxon $Z = -3.9146$, $p < 0.001$, $r = -0.8753$). In the Achillea millefolium Q group, median PBAC decreased from 188 to 87.5 ($p < 0.001$; effect size approximately −0.87). The reported overall clinical improvement was 70% and 65%, respectively. The between-group comparison of PBAC reduction was not statistically significant (Mann–Whitney $U = 161$, $Z \approx -1.04$, $p = 0.295$).

Conclusion: The investigated Cynodon dactylon mother tincture demonstrated the reported physicochemical a qualitative phytochemical characteristics. Both treatment groups showed statistically significant within-group reductions in PBAC scores. The observed difference in reduction between the two groups was not statistically significant. Larger, controlled studies are required to further evaluate these findings.

Keywords: Cynodon dactylon; Achillea millefolium; menorrhagia; heavy menstrual bleeding; PBAC; phytochemical

analysis; mother tincture; homoeopathy.

1. Introduction

Menorrhagia, commonly described in current terminology as heavy menstrual bleeding (HMB), is a frequent cause of morbidity among women and

may affect quality of life and daily functioning. In perimenopausal women, menstrual disturbances may occur in the absence of an identifiable structural or systemic pathology.

The dissertation on which this article is based investigated Cynodon dactylon (Doob Grass) shown in Fig 1; from both pharmaceutical and clinical perspectives. The first phase examined the physicochemical characteristics and qualitative phytochemical profile of the mother tincture. The second phase compared changes in menstrual blood loss following administration of Cynodon dactylon Q and Achillea millefolium Q.

Achillea millefolium is traditionally associated with menstrual and haemostatic applications. Cynodon dactylon is also traditionally used in relation to bleeding disorders, while its phytochemical constituents provide a basis for further investigation. The present article summarizes the dissertation findings without making a claim of superiority between the two interventions.

Fig 1 Cynodon dactylon

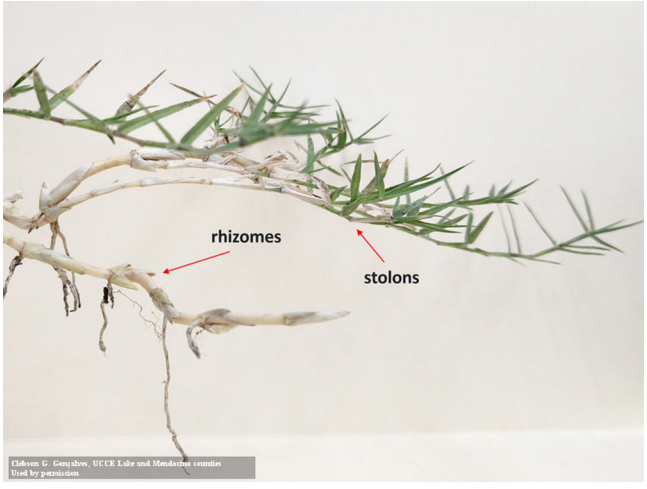


Fig 2. Achillea millefolium (yarrow)



2. Aim and Objectives

Aim: To analyse the phytochemical characteristics of Cynodon dactylon mother tincture and to comparatively evaluate Cynodon dactylon Q and Achillea millefolium Q in cases of menorrhagia.

- To evaluate selected physicochemical parameters of Cynodon dactylon mother tincture.
- To qualitatively screen the mother tincture for selected phytochemical constituents.
- To assess menstrual blood loss using the Pictorial Blood Loss Assessment Chart (PBAC).
- To compare changes in PBAC scores following treatment with Cynodon dactylon Q and Achillea millefolium Q.

3. Materials and Methods

Study design: The dissertation comprised an experimental pharmaceutical phase followed by a prospective, randomized, open-label comparative clinical phase.

Clinical participants: Forty women aged 35–50 years fulfilling the study criteria for idiopathic menorrhagia were included. Twenty participants were allocated to the Cynodon dactylon Q group and twenty to the Achillea millefolium Q group.

Outcome assessment: Menstrual blood loss was assessed using the Pictorial Blood Loss Assessment Chart (PBAC). Assessment was performed over three consecutive menstrual cycles, with comparison of baseline and post-treatment PBAC values.

Pharmaceutical evaluation: The mother tincture was assessed for pH, alcohol content, weight per mL, total solids and UV maximum absorbance. Qualitative phytochemical screening was performed for selected classes of constituents.

Statistical analysis: Distribution of the difference scores was examined before selection of the inferential test. Because the Cynodon dactylon difference scores did not meet the normality assumption (Shapiro–Wilk W = 0.8577, p = 0.007196), the Wilcoxon signed-rank test was used for within-group

comparison. The Mann–Whitney U test was used to compare PBAC reductions between groups.

Results

SN	Parameter	Standard of H.P.I.	Sample Mother Tincture
1.	Moisture content	75%	73.4%
2.	PH	5.60 to 6.60% v/v	6.3%
3.	Alcohol content	57.0 to 61.0%	60%
4.	Wt. per ml	0.890 to 0.930g	0.89g
5.	Total solid	Not less than 0.75%	0.76%
6.	HPTLC Rf1	0.11	.06
7.	HPTLC Rf2	0.25	.68
8.	HPTLC Rf3	0.36	.70
9.	HPTLC Rf4	0.75	0.75
10.	HPTLC Rf5	0.84	0.85
11.	Lamda max	274,322 nm	274nm

Table 1 : Qualitative phytochemical screening reported the presence of alkaloids, flavonoids, tannins, phenols, phytosterols and fixed oils. The dissertation reported these findings in relation to the selected H.P.I. comparison parameters.

S. No.	Phytochemical	Test Name	Result
1	Alkaloids	Ehrlich test	Negative
2	Alkaloids	Dragendorff's test	Negative
3	Alkaloids	Mayers test	Negative
4	Alkaloids	Wagners test	Positive
5	Flavonoids	Shinoda test	Negative
6	Flavonoids	Lead acetate test	Positive
7	Flavonoids	Alkaline reagent test	Negative
8	Tannins	Gelatin test	Positive
9	Phenols	Ferric chloride test	Positive
10	Saponins	Vanilline test	Negative
11	Saponins	Foam test	Negative
12	Glycosides	Keller–Killiani test	Negative
13	Carbohydrate	Molisch's test	Negative
14	Phytosterols	Sulphur test	Positive
15	Fixed oil & Fat	Spot test	Positive

Table 2. Comparison of baseline and post-treatment PBAC scores within the two treatment groups:

Treatment group	n	Baseline PBAC (Median)	Post-treatment PBAC (Median)	Statistical results
Cynodon dactylon Q	20	200	80	$Z = -3.9146$; $p < 0.001$; $r = -0.8753$
Achillea millefolium Q	20	188	87.5	$p < 0.001$; effect size ≈ -0.87

(Within-group comparison was performed using the Wilcoxon signed-rank test)

Table 3. Comparison of PBAC reduction between the two treatment groups

Statistical parameter	Cynodon dactylon Q	Achillea millefolium Q
Median PBAC reduction	110	100
Mean PBAC reduction	109.00	104.90
Mean rank	22.45	18.55
Sum of ranks	449	371

Between-group statistical analysis:

Statistical test	Result
Mann–Whitney U	161
Z-value	≈ -1.04
p-value	0.295

The dissertation reported overall clinical improvement of 70% in the Cynodon dactylon Q group and 65% in the Achillea millefolium Q group. These percentages are descriptive and should not be interpreted as evidence of a statistically established difference between treatments.

DISCUSSION

The pharmaceutical phase demonstrated measurable physicochemical characteristics of the investigated Cynodon dactylon mother tincture, together with a positive qualitative phytochemical profile for several constituent classes.

The dissertation reported the measured

parameters as being within the relevant comparison parameters used in the study.

In the clinical phase, both treatment groups showed statistically significant reductions in PBAC scores from baseline to follow-up. The large within-group effect sizes reported in the dissertation indicate substantial change within each group.

The between-group analysis did not demonstrate a statistically significant difference in PBAC reduction (U = 161, p = 0.295). Therefore, the study findings support the statement that both groups improved during the study period, while the available data do not establish a statistically significant difference between the two interventions.

The findings should be interpreted in the context of the study design, sample size, open-label nature, use of PBAC as the principal clinical measure, and the follow-up period. Further studies with larger samples, appropriate controls and longer follow-up may provide additional evidence.

LIMITATIONS

- The clinical sample consisted of 40 participants.
- The study was open-label and therefore susceptible to expectation and measurement-related bias.
- PBAC was the principal outcome measure for menstrual blood loss.
- The findings are based on the study population and follow-up period described in the dissertation and should not be generalized beyond those conditions without further evidence.

CONCLUSION

The dissertation findings indicate that the evaluated Cynodon dactylon mother tincture showed the reported physicochemical and qualitative phytochemical characteristics. In the clinical phase, both Cynodon dactylon Q and Achillea millefolium Q groups demonstrated significant reductions in PBAC scores. The between-group difference in PBAC reduction was not statistically significant. These findings provide a basis for further controlled clinical and phytochemical investigation of Cynodon dactylon in menorrhagia.

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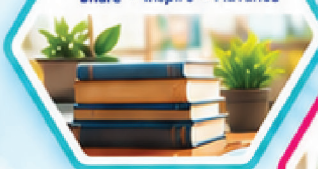


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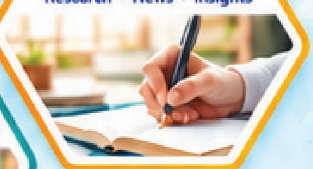


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