

Ayurvedic Management of *Vandhyatwa* with Special Reference to Thin Endometrium: A Case Report

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ABSTRACT

Infertility is defined as the inability to conceive even after one year of regular unprotected sex. Conception requires four essential elements: *Rutu* (Timing), *Kshetra* (Uterus), *Ambu* (Nutrition) and *Beeja* (Gametes). Although significant advancements have been made in human reproduction, the implantation process remains poorly understood. Among these, the receptive endometrium plays an important role. Thin Endometrium (TE) is a known cause of infertility, contributing to implantation failure and early miscarriages. A 22-year-old married female patient presented with an inability to conceive for 2.5 years, with a history of two early pregnancy losses. On Ultrasonography (USG), it was noted that the endometrium was thin (4 mm). The diagnosis of TE was based on transvaginal USG findings and clinical correlation alone, as the patient refused invasive diagnostic evaluation. The patient was treated with internal ayurvedic medicine and local therapies for a duration of four months. Endometrial Thickness (ET) increased from 4-4.9 mm to 8-10 mm with evidence of ovulation and successful conception. A healthy female infant was delivered at term. Ayurvedic therapy enhanced endometrial quality and receptivity, promoting implantation and a successful pregnancy. This approach shows promise for infertility occurring due to a TE.

Keywords: Gametes, Implantation failure, Infertility, *Kshetra*

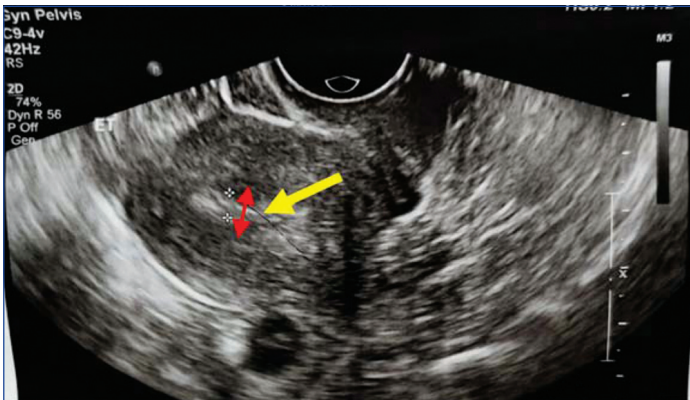
CASE REPORT

A 22-year-old married female presented to the Outpatient Department with a primary complaint of infertility for 2.5 years. She had been married for four years in a non consanguineous union, with satisfactory sexual life, regular cohabitation and awareness of the fertile window. There was no history of contraception. Childhood and developmental history were normal.

She was well-nourished, with normal appetite, bowel habits and micturition. Sleep was disturbed. She had no history of Type 2 diabetes mellitus, hypertension, thyroid dysfunction, or other chronic medical conditions and no significant family history of infertility. Menarche occurred at age of 11 years, with regular cycles every 30-35 days, lasting 1-2 days, with dark red flow requiring two pads per day. Dysmenorrhoea was present on the first day. Obstetric history was Para 0, Living 0, Abortions 2 (POL0A2), with two spontaneous abortions at six weeks and eight weeks. Detailed investigations from those pregnancies were unavailable.

A TE was diagnosed based on the clinical signs and symptoms correlating with the USG report. As the patient declined hysteroscopic evaluation, intrauterine pathology, including endometrial adhesions or submucosal lesions, could not be definitively excluded. The following assessment parameters were checked before and after the treatment. The thyroid profile and prolactin were within normal ranges, with the Phospholipid antibodies panel showing Serum Immunoglobulin G (IgG) and IgM equal to 1.00 IgG Phospholipid Units per millilitre (GPL U/mL) and 1.00 IgM Phospholipid Units per millilitre (MPL U/mL), respectively, which were also within the normal range. The husband's semen analysis showed normozoospermia with a count of 90 million/mL, progressive motility of 68% and total normal morphology of 6% (Normal $\geq 4\%$), which is within normal limits. and male factor subfertility could not be entirely excluded.

Serial transvaginal sonography was performed to assess Endometrial Thickness (ET) on cycle days 12-16 [Table/Fig-1], along with menstrual characteristics (duration, interval, quantity, clots, dysmenorrhoea). Local examination findings are summarised in [Table/Fig-2].



[Table/Fig-1]: Transvaginal Ultrasonography (USG): A pre-treatment scan showing ET of 4.1 mm on Day 12 of the menstrual cycle.

Per-speculum examination	Per vaginal examination
Vagina - Healthy, pH 4.0 Cervix - Mild Inflammation, Os - Transverse, slit-like Discharge - Transparent Consistency - Stretchy	Uterus - Ante-verted, Anteфлекed Fornices - free Cervical sensitivity - Absent Two-finger admission noted

[Table/Fig-2]: Local examination.

The treatment plan targeted the reduction of cervical inflammation and improvement of ET [Table/Fig-3].

Following therapy, the patient experienced complete resolution of cervical inflammation and dysmenorrhoea, with ~6 mm improvement

Presenting complaints	Intervention	Duration
LMP-05.11.2022 Mild cervical inflammation on local examination Dysmenorrhoea ++	<i>Yoni pichu</i> (medicated vaginal tampon) with <i>Jatyadi taila</i> (~30 mL) in the morning for 7 days. Tab. <i>Anuloma DS</i> (Sagar Pharmaceuticals) 2 tablets at night, before food, orally. Diet - She was advised to follow a consistent and healthy eating schedule and avoid fermented food. Daily exercise of half an hour- walking and 10 cycles of <i>Suryanamaskara</i> (Sun salutation) was advised.	7 days

Cervical inflammation has reduced.	<i>Chandraprabha vati</i> (Shri Dhootpapeshwar Limited) 1 tablet twice a day with warm water after food. <i>Phala ghrita</i> (<i>Vaidyaratnam Oushadhashala</i>) 2 tablespoons with warm water twice a day on an empty stomach.	30 days
LMP-05.12.2022 Dysmenorrhoea +	Continued <i>Chandraprabha vati</i> + <i>Phala ghrita</i> (<i>Vaidyaratnam</i>)	28 days
LMP-09.01.2023 Dysmenorrhoea resolved	<i>Trikatu churna</i> (fine powder of black pepper, long pepper and ginger-KLE Ayurveda Pharmacy) + <i>Nagakesara churna</i> (fine powder of <i>Messua ferrea</i>) in the dose of 6g once a day with <i>Phala ghrita</i> . <i>Yoni picchu</i> (medicated vaginal tampon) with <i>Mahanarayana taila</i> (~30 mL) in the morning for 7 days. She was advised to keep the <i>picchu</i> for at least 2-3 hours.	28 days
LMP-13.02.2023, No dysmenorrhoea	Continued <i>Trikatu</i> + <i>Nagakesara churna</i> with <i>Phala ghrita</i> ; <i>Yoni picchu</i> with <i>Mahanarayana taila</i>	30 days
LMP-08.03.2023 No dysmenorrhoea	<i>Tab. Leptaden</i> (Alarsin) 300 mg-1 tablet twice a day after food. <i>Kalyanaka ghrita</i> (<i>Vaidyaratnam Oushadhashala</i>) 1 tablespoon with warm water twice a day on an empty stomach. <i>Yoni picchu</i> (medicated vaginal tampon) with <i>Mahanarayana taila</i> (~30 mL) in the morning for 7 days. She was advised to keep the <i>picchu</i> for at least 2-3 hours.	30 days

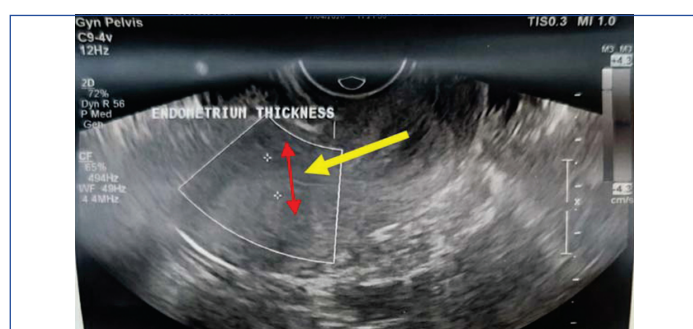
Urine pregnancy test positive-19.04.2023

[Table/Fig-3]: Therapeutic intervention with duration.

in ET over four months. Natural conception occurred, confirmed by urine pregnancy test [Table/Fig-4,5]. She was referred to the *Prasuti Tantra* department for antenatal care and subsequently delivered a healthy female infant weighing 2.7 kg at term.

Variables	Day of cycle	Rt. Ovary	Lt. Ovary	Endometrial Thickness (ET)	Remarks
Previous investigation-12.10.2022	12 th day	11.2×9.9	9×5.3	4.1 mm	-
	14 th day	15×11.5	11×7.9	4.5 mm	-
	16 th day	19×18.2	14.1×11	4.9 mm	No signs of ovulation
1 st time investigation-20.01.2023	12 th day	Nil	8×6.8	6 mm	-
	14 th day	Nil	11×8	6.8 mm	-
	16 th day	Nil	16×11.2	7.5 mm	No signs of ovulation
2 nd time investigation-24.02.2023	12 th day	11×9.3	Nil	8.3 mm	-
	14 th day	17.9×13.6	Nil	9 mm	-
	16 th day	22 mm	Nil	10 mm	Ovulation observed.
3 rd time investigation-19.04.2023	The urine pregnancy test is positive.				

[Table/Fig-4]: Follicular study and Endometrial Thickness (ET).



[Table/Fig-5]: Post-treatment UG scan showing Endometrial Thickness (ET) of 8-10 mm.

Arrows indicate endometrial lining.

DISCUSSION

Infertility is the failure to achieve pregnancy after 12 months of regular unprotected sexual intercourse [1]. Around 17.5% of the adult population, roughly one in six worldwide, experiences infertility [2]. TE incidence in infertility treatment cycles is 2-3% [3]. TE is

defined as a mid-luteal ET ≤ 7.5 mm [4]. TE can affect endometrial tolerance, leading to lower embryo implantation rates and clinical pregnancy rates and is also associated with impaired outcomes from assisted reproductive treatment [5]. Ayurveda explains that conception requires four essential elements: *Rutu* (Timing), *Kshetra* (Uterus), *Ambu* (Nutrition) and *Beeja* (Gametes) for a healthy progeny. Although significant advancements have been made in human reproduction, the implantation process remains poorly understood. Among these, the receptive endometrium plays an important role [6].

In Ayurvedic understanding, *Artava*, which corresponds to the functional layer of the endometrium, is a derivative of *Prakruta Rasa Dhatu* (primary nutritive fluid) and is sustained by *Prakruta Rakta Dhatu* (blood devoid of vitiation). *Artava* is a secondary tissue formed from *Rakta Dhatu* [7]. Any alteration in these *Dhatus* or in their *Dhatu Parinama Krama* (sequence of metabolic transformation) hampers *Artava-utpatti* (proliferation of endometrium), thereby compromising uterine receptivity [7]. In this case, the patient presented with recurrent pregnancy loss and was not willing to undergo invasive procedures for diagnostic evaluation or treatment. Hence, hysteroscopic evaluation, the gold standard for diagnosing intrauterine pathologies, was not performed. Considering the patient's preference and in view of the condition, an integrative Ayurvedic regimen was devised to re-establish *Dosha-Dhatu-Srotas* balance, stimulate uterine circulation and strengthen endometrial receptivity through local as well as systemic measures. At the local level, *Yoni Picchu* with *Jatyadi Taila* was first administered for its *Vraṇa Ropana* (healing), *Shothahara* (anti-inflammatory) and *Yoni Vishodhana* (cleansing) properties. This therapy encouraged epithelial repair, restoration of normal vaginal pH, reduction of low-grade inflammation and reinforcement of local defense mechanisms, collectively generating a healthier mucosal layer conducive to implantation. Cyclic use of *Mahanarayana Taila Picchu* was selected for its *Vatahara*, *Balya* and *Prajasthapana* (fertility-enhancing) actions [8]. Systemically, *Anuloma DS* was prescribed to regulate *Apana Vayu* and promote regular menstruation, ensuring proper elimination and physiological endometrial shedding. *Chandraprabha Vati* was included for its *Tridosha-hara* (pacifying *Tridoshas*), *Rasayana* (rejuvenative) and *Vrushya* (aphrodisiac) effects, enhancing pelvic circulation and nourishing reproductive *Dhatus*. *Phala Ghrita*, owing to its *Snigdha* (unctuous) and *Sitala* (cold) properties, was used to pacify *Vata* and assist *Artava-utpatti* [9]. *Trikatu* and *Nagakesara* served to cleanse channels (*Srotoshodhana*) and support digestion and metabolism, improving assimilation and the efficacy of concurrent *Rasayana* formulations. Their mild vasodilatory action aids uterine perfusion and *Rasa Dhatu Prasada*, contributing to proper *Artava* formation. *Leptaden*, a proprietary compound, was added for its inhibitory effect on uterine *Prostaglandin F2α* (*PGF2α*) synthesis, leading to reduced uterine contractions and better endometrial blood supply, both essential for implantation. *Kalyanaka Ghrita* functioned as a *Tridosha-hara Rasayana* and *Medhya Rasayana* (nootropic), fostering emotional stability, vitality and reproductive resilience. Its *Pumsatvakaraka* (fertility-supportive) action is interpreted as removal of *leena dosha* vitiations, restoration of uterine tone and enhancement of conception potential [10-12].

A similar case described a female patient with infertility for two years, diagnosed with TE and considered under the Ayurvedic concept of *Rajah-Kshay*. She was treated with *Rasa-Rakta Pachak* medicines and *Uttarbasti* of *Phalaghrita*. During treatment, her ET improved from 6.1 mm to 9 mm, menstrual flow increased and she conceived within five months, delivering a healthy male infant. In contrast, the present case involved a 22-year-old female with infertility for 2.5 years and two early pregnancy losses. She was managed with a broader regimen of systemic *Rasayana* formulations and local *Yoni Picchu* therapies, which improved ET from 4-4.9 mm to 8-10 mm within four months, documented ovulation and resulted in conception

and delivery of a healthy female infant [13]. While the comparative case emphasised correction of *Rajah-Kshay* and enhancement of implantation capacity, the present case integrated Ayurvedic principles with biomedical correlates such as phytoestrogenic activity, prostaglandin modulation and uterine perfusion. A case reported by Asmabi MA et al., involved a 32-year-old female with primary infertility for 10 years due to endometriosis, unresponsive to hormonal therapy and multiple Assisted Reproductive Technology (ART) attempts. She was treated with internal medicines and *Shodhana* therapies, including *Virechana*, *Basti* and *Uttarabasti*, leading to conception within five months and delivery of a healthy female infant [14]. In contrast, the present case was a 22-year-old female with TE and recurrent pregnancy loss, managed with *Rasayana* formulations and *Yoni Pichu* therapies, resulting in improved ET, ovulation and natural conception within four months. Both cases highlight the effectiveness of individualised Ayurvedic regimens in infertility, though with different pathologies and therapeutic strategies.

CONCLUSION(S)

The present case demonstrates significant improvement in ET and resolution of symptoms following individualised Ayurvedic therapy, culminating in spontaneous conception without adverse effects. The patient also reported better sleep quality and overall well-being. Nonetheless, as a single case report, causality cannot be firmly established and natural variability in ET due to hormonal influences, along with limited serial assessments, constrains the findings. These observations suggest that personalised Ayurvedic interventions may support endometrial enhancement and fertility, but validation through larger, controlled studies is essential.

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