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Case Study

CLINICAL EFFICACY OF CERTAIN AYURVEDIC DRUGS IN THE MANAGEMENT OF COMPLEX HAEMORRAGIC OVARIAN CYST

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ABSTRACT

In this present case study, a 24-year-old female patient consulted the Ayurvedic OPD with pain in the lower abdomen, irregular menses, burning maturation, nausea, loss of appetite from last 2-3wks. She was advised for ultrasonography (USG) and the findings suggested a left ovarian haemorrhagic cyst measuring 4.5cm x 3.7cm. She was supposed to be treated with traditional ayurvedic formulations; but the case was treated for three months with a combination of different traditional Ayurvedic drugs, with the goal of relieving symptoms and dissolving the ovarian cyst. This patient was treated with traditional Ayurvedic formulations like *Prabhakar vati, Trivrita avleha, Haritki churana, Triphala guggul, Kanchanar guggul, Phalatrika* and *Varunadi Kwatha,* Syp Evecare forte + Evecare capsule. Only traditional Ayurvedic medicines were used during the course of the treatment. Patient's condition was assessed through USG after six months of treatment for ovarian cyst which was completely relieved. Therefore, this study was conducted to evaluate one of the treatment regimens for ovarian cyst.

INTRODUCTION

Ovaries in female are concerned with germ cell maturation, storage there release and steroidogenesis.[1] In their active reproductive life normal ovary measures 2.55cm in length, 1.5-3cm in breadth and 0.7-1.5 cm in width. Ovaries consist of outer cortex and inner medullar[2]. Cortex have stromal cells studded with numerous follicular structures, called the functional units of ovary in various phase of their development. The structural changes during the ovarian cycle are primordial follicle, mature follicle, graafian follicle and corpus luteum. The graafian follicle itself or any of its products such as corpus luteum, corpus albicans and corpus fibrosum may remain cystic for some time prior to their ultimate replacement by fibrous tissue, where Medulla has loose connective tissue tissues, few unstriped muscles, blood vessels and nerves.

These ovaries can be site of various diseases. Ovarian masses are frequently found in general gynaecology, and most are cystic.[3] When normal cystic changes of ovaries proceed beyond the normal range the condition is referred to as cystic ovary. Cystic enlargement in one or other of the normal ovarian structures is so common that it can be regarded as physiological[4]. Ovarian masses can occur at any age but is most common in the reproductive age and increase in menarche females due to endogenous hormone production. These can be non- neoplastic (follicular and luteal cysts) or neoplastic.

Non-neoplastic enlargement of ovary derives their mass from accumulation of intrafollicular fluids rather than cellular proliferation[1]. Follicular cyst formation, hormonal dysfunction prior to ovulation results in the expansion of the follicular antrum with serous fluid. On other hand excessive hemorrhage from the vascular corpus luteum following ovulation may fill its center to create corpus luteum cyst[3].

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Follicular and corpus luteal cyst

Follicular cysts are the most common functional cyst. They form as a result of failure of absorption of the fluid in an incompletely developed follicle or when follicle fail to rupture during ovulation[5] because of either excessive FSH stimulation or absence of usual LH surge at mid- cycle just before ovulation. Histologically, they are lined by granulosa cells, so these under the hormonal stimulation leads to continuous growth forming excess of estradiol production and in turn decreased frequency of menstruation. They may be single or multiple, may be bilateral and vary in size from small blebs to cyst of large size. These remains asymptomatic unless hemorrhage, rupture or torsion supervenes, in which case symptoms and signs of an acute abdomen develop.

Corpus luteum life span is 14 days. If the egg is fertilized, the corpus luteum continues to secrete progesterone until its dissolution at 14 weeks, when the cysts undergo central haemorrhage. If the dissolution of the corpus luteum does not occur, it may result in a corpus luteal cyst, which usually grows to 3cm.

Luteal cysts are formed by rupture and sealing of corpus haemorrhagicum[5].

1. Granulosa lutein cysts found within the corpus luteum.
2. Theca lutein cysts associated with a trophoblastic disease and chorionic gonadotropin therapy.

Normally follicles and corpus luteum do not exceed a diameter of 2cm. To define as cyst, it must be more than 2cm, but not more than 7cm. Both follicular and corpus luteal cysts can be single or complex depending on the substance that are inside them. Simple cyst is common and filled with fluid whereas complex cysts are less common containing either blood or a hard substance turn into hemorrhagic cysts. Ovarian cyst is often benign and can undergo spontaneous resolution. A simple ovarian cyst of is considered physiological and represents a mature follicle whereas a complex cyst of is considered abnormal and requires treatment. Most women with ovarian cyst are asymptomatic. If symptoms develop, pain is common. In contrast, pressure or ache may be the sole symptom and can result from ovarian capsule stretching. They can remain asymptomatic or produce local discomfort, nausea, vomiting, headache, pain in abdomen or pelvis, menstrual disturbances, infertility, or in rare case as hemorrhage, rupture or torsion[3]. They are mostly diagnosed by ultrasound. Medical management include hormonal treatment with combined oral contraceptive pills and surgical management like laparotomy and pelvic laparoscopy in case where cystic mass exceeds 6cm and persists without any regression foe 6-8 wks.

The annual hospitalization for functional ovarian cyst to be high as 500 per 100,000 woman-year in united states. In a survey of 33,739 premenopausal and postmenopausal women, 46.7% had an adnexal cyst on transvaginal ultrasound, with 63.2% showing resolution of the abnormality on subsequent ultrasounds so mere finding of cysts in an ovary should not therefore be regarded as being of pathological significance. Failure to recognize this fundamental fact has led to many young women having a normal ovary removed. Many more ovaries have been sacrificed for possessing a normal corpus luteum.

Ayurvedic classics explain pathogenesis of granthi (glandular swelling, cyst etc.) as when deranged *Vataadi dosha* vitiate the *Mansa, Shonita*, and *Meda* mixed up with *Kapha* they produce circular, raised and knotted inflammatory swelling and *Granthi*. In classics we have five types of *Granthi* i.e., *Vataja*, *Pittaja, Kapaja, Medoja* and *Siraja*[6]. Complex hemorrhagic cyst from classics can be best correlated with *Siraja granthi*. According to Acharyas, *Siraja granthi* has pulsatile. Acharya Sushruta says that in a weak person aggravated *Vayu* leads to influencing blood and network cause the compression, constriction, displacement and desiccation produces quickly a protuberant and round *Granthi*. If this *Granthi* is painful and mobile then it is cured with difficulty. Tortuousness in cyst can also be best applicable to *Siraja granthi*[6].

Case report

An unmarried female patient of 24 years, came to Prasuti Tantra evam Stri Roga OPD of Abhilashi Ayurvedic College and Research Institute, chailchowk, Mandi, Himachal Pradesh on April 8, 2024, with a chief complaint of pain in the lower abdomen, irregular menses, burning micturation, nausea, loss of appetite from last 2-3wks.

On detail evaluation, she attained her menarche at the age of 12 years and presently from last 1 year she is having irregular menstrual cycle of duration 4-5 days at an interval of 20-21 days. In between cycles patient complained of non-radiating pricking pain in left iliac fossa and nausea, loss of appetite during menstruation. Ultrasonography findings of abdomen and pelvis revealed uterus is normal in bulk and echotexture. No focal lesion seen. Endometrial thickness 8mm. She was diagnosed with complex left ovarian cyst measuring (4.5cm x 3.7cm) lesion with internal echoes and few internal separations, suggestive of haemorrhagic cyst. She was advised for surgery by allopathic doctors but she was

not ready for surgery. Hence, she came to our hospital for further advice and Ayurvedic management.

Menstrual History

Patient said that the duration of her menstrual cycle was 4–5 days with intervals of 20-21days, amount of bleeding was normal and associated with lower abdominal pain, nausea, burning micturation.

LMP – 6/4/24

Previous LMP – 13/3/24 for 4-5 days

Menstrual History	Previous	Present
Regularity	Regular	Irregular (20-21 days)
Duration	4-5 days	5-6 days
Pain	Slight dysmenorrhea	Present (pricking pain in left iliac fossa during menses and in between cycle)
Clots	Present (1-2)	Present (++)
Flow	Normal (1-2 pads/day)	Normal (2-3 pads/day)

Family History No relevant family history was found.

Past Medical History: No H/O thyroid disfunction, DM, HTN or significant medical history.

History of Allergy – Nil

Past surgical History There was no significant history found.

Personal History

- Appetite - Reduced since 15days
- Sleep – Normal (disturbed of 8-9 hrs)
- Urine – On and off burning micturation, frequency – 5-6/day, colour – pale to dark yellow, smell – not present
- Bowel – Clear (once /day, satisfactory, semisolid)

Examination

- Built – Normal
- Height – 168 cm
- Weight – 52 kg
- Temperature – 98.3 F
- B.P – 116/ 70 mm of Hg
- P.R – 74/ min
- Respiration – 18/min

Per abdomen– Soft, non-tender, and no organomegaly detected.

Per speculum - Not done

Per vaginum – Not done

Asthavidhapriksha

- *Nadi - Pittavataja*
- *Mutra – Dhaayukta samyaka mutra praviti*
- *Mala – Sama*
- *Jihwa – Sama*
- *Shabda – Samyaka*
- *Sparsha – Samsheetausna*
- *Drika – Samanya*
- *Aakriti - Madhyama*

Systemic Examination

- Cardiovascular system heart sounds (S1 and S2) normal
- Respiratory system bilaterally normal air entry, no added sounds

Subjective Symptoms (BT)

- Appetite - Reduced since 15days
- Sleep – Disturbed
- Urine – On and off burning maturation, colour – pale to dark yellow

Objective symptoms (BT)

USG - Abdomen and pelvis revealed uterus is normal in bulk and echotexture. No focal lesion seen. Endometrial thickness 8mm. She was diagnosed with complex left ovarian cyst measuring (4.5cm length and 3.7cm breadth) lesion with internal echoes and few internal separations, suggestive of haemorrhagic cyst.

Treatment Schedule

Date of visit	LMP Post treatment	Complaints	Medicine Given	Dose	Duration	Before / After
8/4/24	(24-days of cycle) 29/4/24	Irregular menses, pain in lower abdomen and left iliac fossa, burning	*1) Prabhakar vati* *2) Trivrita avleha + Haritki churana* *3) Triphala guggul + Kanchanar gugglu*	250mg ½ tsf +2gm 250mg	1BD x 30 days 1BD x 15 days 1BD x 30 days OD + OD x 30	After meal with *Madhu.* After meal with water.

		maturation, loss of appetite.	*4) Phalatrika & Varunadi Kwatha* 5) Syp Evecare forte + Evecare capsule	20ml + 20ml 1tsf + 1cap	days 1 BD x 30 days 1 BD x 30 days	After meal with lukewarm water. After meal with double water. After meal
5/5/24	(28-day cycle) 27/5/24	Regular menses, slight pain in the left iliac fossa.	*1) Prabhakar vati* *2) Trivrita avleha + Haritki churana* *3) Triphala guggul +Kanchnar gugglu* *4) Phalatrika & varunadi Kwatha* 5) Syp Evecare forte + Evecare capsule	250mg ½ tsf +2gm 250mg 20ml + 20ml 1tsf + 1cap	1BD x 30 days 1BD x 15 days 1BD x 30 days OD + OD x 30 days 1 BD x 30 days	After meal with Madhu. After meal with water. After meal with lukewarm water. After meal with double water. After meal
2/6/24	(32-day cycle) 28/6/24	Regular menses	*1) Prabhakar vati* *2) Trivrita avleha + Haritki churana* *3) Triphala guggul +Kanchnar gugglu* *4) Phalatrika & varunadi Kwatha* 5) Syp Evecare forte + Evecare capsule	250mg ½ tsf +2gm 250mg 20ml + 20ml 1tsf + 1cap	1BD x 30 days 1BD x 15 days 1BD x 30 days OD + OD x 30 days 1 BD x 30 days	After meal with *Madhu.* After meal with water. After meal with lukewarm water. After meal with double water. After meal
25/10/24	(28-day cycle) 26/7/24	Regular menses	**Not given**	-	-	-

After treatment for 3 months

No fresh complaint. At the completion, the patient has relief in all subjective complaints. Ultrasound scans repeated after 6 months revealed their where no evidence of any complex ovarian cyst or haemorrhagic cyst, renal calculi.

Subjective Symptoms (AT)

- Appetite – Normal
- Sleep – Undisturbed of 7-8 hrs
- Urine – Pale yellow, with no burning present

Objective symptoms (AT)

- USG - Abdomen and pelvis revealed uterus is normal in bulk and echotexture. No focal lesion seen. Endometrial thickness 8.5mm. Complex left ovarian haemorrhagic cyst completely resolved.
- No VUJ calculi with proximal splitting of PCS. PCS is compact, additionally no is calculus in left kidney inner polar.
- No findings of any cystitis.

DISCUSSION

Ovaries can be site of variety of disease. Histologically, ovarian cyst is often divided into those derived from neoplastic growth, ovarian cystic neoplasm, and those created by disruption of normal ovulation, functional ovarian cysts. An ovarian cyst of <20mm in diameter is considered physiological and represents a maturing follicle. A cyst of >20mm in diameter is considered abnormal.

Angiogenesis is an essential component for both the follicular and luteal phase of ovarian cyst. It is also a component of various pathologic ovarian processes, including follicular cyst formation, PCOS, ovarian hyperstimulation syndrome, and benign and malignant neoplasms[3].

Functional and inflammatory enlargements of the ovary develop almost exclusively during the childbearing years. They may be asymptomatic or produce local discomfort, menstrual disturbances, infertility or in rare cases cause acute symptoms due to complications such as haemorrhage, rupture or

torsion. The ovary is complex in its embryology, history, steroidogenesis and has the potential to develop malignancy. The ovary, after the cervix, is the second most common site for development of gynaecological malignancy. During the childbearing age, these ovarian enlargements are functional in 70% of cases, neoplastic in 20% of cases and due to ovarian endometriomas in 10% of cases[5].

Even a slight deviation in the menstrual cycle becomes a matter of concern as it leads to the fear of some serious pathology of internal genital organs. Sonography is a first-line tool to evaluate pelvic masses. In modern medical system treatment for ovarian cyst is hormonal therapy, under hormonal therapy, high-dose COC's supress ovarian activity and just protect against cyst development[3], COCs provide only modest protective effect, whereas pre-menopausal cysts presumed to be benign may be excised or whole ovary may be removed. However, in post-menopausal women, oophorectomy is preferred. Yet considering the factors such as age, parity and wishes of the patient with regard to contraception, future pregnancy etc, the drug which is non-hormonal, non-surgical, effective and without any adverse effects is the need of the hour. Ayurveda texts have described a variety of treatment options in the management of granthi, in non-suppurative granthi clinician should employ all the therapeutic procedures used for inflammation. Keeping these properties in mind *Prabhakar Vati*[7] and *Trivrita Avleha* with *Haritki Churana* is used keeping this thing in mind that it *Tridoshasamaka,* appetizer, initiate healthy conception. It cures *Prameha Roga* (insulin resistance which somewhere cause cystic formation), act as aphrodisiac, cure *Shool, Mutrakrcchra* and *Mutrasmari*. According to *Kashyapa, Artava* is present in body since childhood but when body elements get mature then it becomes visible in *Yoni*[8,9]. According to *Acharya Charaka, Sushruta, Vagbhatta-II Dalhana, Chakrapani Artava* is formed from *Rasa*[10]. *Acharya Bhela* believed that, *Dhatu Paripurnata* is one causative factor of '*Artava pravritti'*.[8]

Prabhakar Vati and *Trivrita* will normalize the vitiated *Doshas* and leading to proper circulation of *Dhatus* in body cause *Samanya Dhatu Paripurnata,* which means as a result of *Samanya Dhatu Paripurnata* normal ratio of ovarian hormones were formed, leading to no more fluid accumulation during the follicular or luteal phase of cycle, regularizing menstrual cycles with ovulation. *Haritki Laghu Tikshan, Ruksha Guna* are opposite to *Kapha* helping in *Anuloman* of metabolic waste, preventing further *Dosha* vitiation in *Srothas*.

In this study along with these drugs *Varunadi Kwatha* and *Phalatrika Kwatha* were used keeping in mind their property of *Lekhan* (reduce the size of cyst), diuretic (burning maturation) in turn controlling the glucose levels in body.

Guggul acts as analgesic and anti-inflammatory. Its *Ruksha, Lekhana, Laghu, Tikshan, Vishadha, Sara, Dipan, Anulomak, Medohar, Kapha Daurgandhya Hara, Rakta Prasadana* and *Hridya*. *Kanchnar Guggul* have *Granthihara* and *Bedhana* property which will help in pacifying *Kapha Dushti* from body and eliminating toxins causing reduction in inflammation. This will arrest further growth in cyst. Whereas *Triphala Guggul* will improve reproductive health system and regulating the normal functions of ovary and *Artava* formation.

Syp. Evecare forte with Evecare capsule have drugs which have *Shothahara, Vednasthapana, Vranashodhana, Vranaropana, Nadibalya, Deepana, Pachana, Anulomana, Kaphaghna, Srotah- shodhana, Vrishya, Garbhashayashothahara, Prajasthapana, Rasayana, Dhatuvardhakadhya, Nadibalya, Balya. Evecare* have analgesic and estrogenic properties which helps in repairing the endometrium, regulating estrogen levels and helps in healing the inflamed endometrium during menstruation. This formulation improves fertility by regulating ovarian hormones. It helps in hormonal balance in women so it is useful in treating irregular menstruation. All *these* drugs have helped in reliving in her symptoms.

CONCLUSION

Ovaries are site of various diseases. When normal cystic changes of ovaries proceed beyond the normal range the condition is referred to as cystic ovary. Ovarian masses may occur at any age but mostly during the reproductive life. These masses can be non-neoplastic (follicular and luteal cysts) or neoplastic. Non-neoplastic masses are mainly due to endogenous hormone production. Under ayurvedic classics the above symptoms can be best explained under granthi (glandular swelling) *Pakarna*. In *Granthi Vataadi dosha* is vitiated and vitiated *Vata* cause *Mansa, Shonita*, and *Meda* to mix up with *Kapha* and they collectively produce circular, raised and knotted inflammatory swelling. Above drugs in the study were selected keeping in mind about the *Dosha* and *Dhatus* involved in the formation of *Ghranthi.* Drug used in study have properties opposite to *Granthi.* This study showed the role of various Ayurvedic medications in successful management of ovarian haemorrhagic cyst and thus avoiding surgical intervention. Tho after the treatment, a repeat ultrasonography was advised after 4-5 months, sonography showed no evidences of cyst in the left ovary but few cystic changes appeared in right ovary. The current study was carried on a single patient for a partial time and it showed hopeful results.

Same study should be conducted with larger sample and with longer duration of trial period with frequent follow up so the rate of recurrence of the disease can also be studied with close monitoring of base level hormones and in different phases of menstrual cycle during drug administration with follicular studies to know the effectiveness of drug.

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