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Ayurvedic Management of Primary Infertility Associated with Anovulation with Psychological Disturbances: A Single Case Study

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ABSTRACT:

Primary infertility is a growing concern in modern society with Anovulation, often accompanied by psychological stress, depression, and lifestyle-induced reproductive disorders. From an *Ayurvedic* standpoint, it correlates to *Vandhyatva,* often resulting from *Vata–Kapha dosha* vitiation, *Agnimandya*, and *Manasika bhavas* such as *Chinta* and *Shoka*. This case study presents a 32-year-old female patient with a 4-year history of primary infertility, compounded by psychiatric illness and long-term use of antidepressants and sedatives. The treatment protocol emphasized *Manas–Sharira samyak chikitsa*, beginning with cessation of modern psychotropic drugs under medical supervision, followed by administration of *Medhya Rasayana* (*Ashwagandha, Brahmi*, and other *Rasayana dravyas*) for neurological and hormonal balance, ovulation induction therapy, and *Panchakarma* procedures. Specific *Garbhashaya poshak* herbs were given as oral formulations, along with *Yogabasti*, *Uttarbasti*, and *Vatshrunga Nasya* during the ovulatory phase. After conception, strict adherence to *Garbhini Paricharya* ensured a healthy intrauterine environment. The intervention led to natural conception within 2 months, and a healthy male child weighing 3.8 kg was delivered on 21/9/23. This case highlights the efficacy of an integrative *Ayurvedic* approach combining *Rasayana, Srotoshodhana*, and *Manasika chikitsa* in restoring ovulation and achieving successful conception in complex infertility cases.

KEYWORDS: Anovulation, *Basti*, *Nasya*, Primary infertility, Psychological disorders, *Medhya Rasayana, Uttarbasti.*

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INTRODUCTION:

Infertility is defined as the inability to conceive after at least 24 months of regular, unprotected sexual intercourse and affects approximately 10–15% of couples worldwide. [1] Among the various etiological factors, anovulation contributes to nearly 25–30% of female infertility cases. [2] Anovulation may result from hypothalamic–pituitary–ovarian axis dysfunction, endocrine disorders such as polycystic ovarian syndrome, thyroid disorders, hyperprolactinemia, or stress-induced hypothalamic amenorrhea.

Psychological factors, including depression, anxiety, and chronic emotional stress can interfere with GnRH pulsatility, suppress luteinizing hormone (LH) surges, and impair follicular development. [3] Furthermore, chronic psychiatric illness and long-term use of antidepressant or sedative medications can further aggravate ovulatory dysfunction. [4] An integrative approach that addresses both hormonal regulation and emotional well-being is increasingly recognized as essential in complex infertility cases.

In *Ayurveda*, anovulatory infertility can be correlated with *Vandhyatva*.

In anovulatory infertility associated with psychological disturbances, chronic mental stress acts as a primary *hetu*, initiating *Vata-Pitta* vitiation and *Mano-vaha srotas dushti*. This leads to *Prana*, *Sadhaka* and *Apana Vayu* imbalance, causing impaired HPO-axis regulation and disruption of *Artavavaha srotas*. The resulting *Agnimandya* and *Ama* formation further aggravate *Vata*, leading to follicular arrest, anovulation and menstrual irregularities. Thus, psychological imbalance directly contributes to ovulatory dysfunction through *dosha* vitiation, *srotas* obstruction and neuro-endocrine disturbance.

"चिन्ता-शोक-भय-क्रोध-क्षय-वृद्ध्यतिसेवनात् । मनोऽभिघाताः रोगाणां निदानानि शरीरिणाम् ॥" (Ch. Su. 1/58)

Furthermore, *Sushruta Samhita* highlights *Beeja dosha* and *Rakta dhatu kshaya* as causes of infertility [5] and *Kashyapa Samhita* emphasizes *Rasayana* therapy and *Satvavajaya chikitsa* for healthy conception and progeny. [6]

CASE REPORT:

A 32-year-old female patient with (OPD No. 36086; IPD No. 1270), presented to the *Prasuti and Striroga* OPD at Government Ayurved college & Hospital (AYU0026), Panigate, Vadodara, Gujarat, India on October 2022 with a primary complaint of infertility for the past 4 years. The patient reported regular but scanty menstrual flow since menarche. She also complained of generalized weakness, mood instability, and disturbed sleep patterns.

The patient had been under psychiatric treatment for depression and anxiety for 2 years and was taking multiple antidepressants and sedatives daily. She had discontinued these medicines under supervision at the start of *Ayurvedic* treatment.

Past History

- No history of tuberculosis, diabetes mellitus, hypertension, or major systemic illness.
- No past surgical interventions related to reproductive organs.

Personal History

- **Diet:** Mixed (predominantly vegetarian), irregular meal timings.

- **Sleep:** Disturbed prior to treatment initiation; improved during follow-up.
- **Bowel and bladder habits:** Regular.
- No addiction to tobacco, alcohol, or other substances.

Menstrual and Obstetric History

- Menarche at age 13 years.
- Cycle: Regular (28–30 days) with scanty flow (2 days, reduced quantity).
- No dysmenorrhea.
- Married life: 4 years.
- Obstetric history: G0P0A0L0 (no previous conception).

Psychological and Emotional Status

The patient reported persistent anxiety and low mood before treatment, primarily due to infertility-related psychological stress and social pressure.

Satva assessment was conducted according to the *Ayurvedic* psychological evaluation criteria described in *Charaka Samhita* (*Vimanasthana* 8/119), which considers parameters such as tolerance (*Sahana Shakti*), confidence (*Dhairya*), patience (*Kshama*), emotional stability, and coping ability under stress.

On assessment, the patient demonstrated moderate emotional endurance, average tolerance, low stress resistance, and a tendency toward worry. These features indicated *Madhyama Satva* & representing moderate mental strength and stability. (Table 3)

Clinical Examination

- **General examination:** Average build, mildly pale, afebrile, pulse 78/min, BP 110/70 mmHg.
- **Systemic examination:** Cardiovascular, respiratory, and CNS within normal limits.
- **Gynecological examination:** Normal external genitalia, healthy cervix, normal uterine size and position. No adnexal tenderness.

Investigations

- **Hemoglobin:** 10.2 g/dl (mild anaemia) (24/3/22)
- **Pelvic ultrasonography:** Bilateral ovaries of normal size; endometrium normal found on 2nd day of menstruation during uterine & adnexal study through TVS. (24/3/22)
- **Hormonal profile**: FSH–8 mIU/mL, LH–6 mIU/mL, S. TSH–2 microIU/ml (24/3/22)
- **Ovulation Study:** Anovulation confirmed on the 16th day of menstruation. (9/4/22)

THERAPEUTIC INTERVENTION:

***Panchakarma* Procedures:**

The patient underwent *Yogabasti* for 8 days. *Uttarabasti* was administered for 6 consecutive days during the ovulatory phase in one menstrual cycle, using *Phala Ghrita.* [7] During the peri-ovulatory period, *Vatashrunga* processed in cow's milk was administered as *Nasya.* [8] (Table-1).

Internal Medicines:

The patient was advised the following internal medicines as per Table-2: Medhya Rasayana, Kanchnara Gugglu, Chitrakadi Vati and Beeja dharaka Yog

Table-1: *Panchakarma* Procedures:

Panchakarma	**Drugs**	**Quantity**	**Days**
Yoga Basti	***Asthapana*** *– Makshika,* *Sainshava,* *Sneha: (Dashmoola Taila)* *Kalka: (Shatpushpa, Shatavari, Yasthimadhu, Variyali, Trikatu)* *Kashaya: Dashmoola* ***Anuvasana*** *–* *Dashoola Taila*	40 gm 5 gm 60 ml (10,10,5,10,5 gm) 350 ml 80 ml	8 *Basti* Course (Alternate days)
Uttar Basti	*Phala Ghrita*	5 ml	6 days
Nasya	*Vatashruna* crushed and mixed with cow milk	(8 drops in each nostril)	3 days (on 12th, 13th 14th day of menses)

Table-2: Internal Medicines:

Medicines	**Ingredients**	**Form**	**Properties**	**Dosage**	***Route of Administratuion & Anupana***
Medhya Rasayana (Anubhuta)	*Ashwagandha Churna* [9] *Yashtimadhu Churna* [10] *Shatavari Churna* [11] *Brahmi Churna* [12] *Guduchi Churna* [13]	Powder	*Vatashamaka* *Pittashamaka* *Pitta-Vata shamaka* *Tridoshgana* *Tridoshgana*	5 gm (1 gm each)	Orally with warm milk on an empty stomach, twice daily
Kanchanara Guggulu [14]	*Kanchanara, Triphala, Varuna, Ela, Tejpatra, Dalchini, Guggulu*	Tablet	*Kapha–Vata shamaka, Medoghna, Srotoshodhaka*	500 mg	Orally with warm water BD after meals
Chitrakadi vati [15]		Tablet	*Kapha-Vata hara, Ama-nashaka, Agni-deepaka*	250 mg	Orally with warm water BD before meals
Bija dharak Yoga (Anubhuta)	*Shatapushpa Churna + Trikatu Churna* [16]	Powder	*Vata-Kapha shamaka, Ama-pachaka, Strotoshodhaka*	4 gm (2 gm each)	Orally mixed, with honey during peri-ovulatory period

FOLLOW-UP: The patient was reviewed every 7 days in OPD for continuous assessment.

***Pathya–Apathya*:** Iron- rich, light, warm, digestible meals with avoidance of cold, heavy, stale foods. Daily practice of simple *yogasanas–Baddha Konasana, Setubandhasana* & *bhujangasana* and *Pranayama – Anulom-Vilom, Bhramari* for reproductive health support.

Table 3: *Satva* Assessment of the Patient (as per *Ayurvedic* Psychological Criteria)

Parameters	Observation	Interpretation
Tolerance (*Sahana Shakti*)	Moderate	Occasionally irritable under stress
Confidence (*Dhairya*)	Average	Hesitant in decision-making
Patience (*Kshama*)	Moderate	Manages stress with support
Emotional Stability	Fluctuating	Prone to worry and low mood
Coping Ability	Moderate	Able to recover with guidance
Over all *Satva* Level	-	*Madhyama Satva* (moderate mental endurance

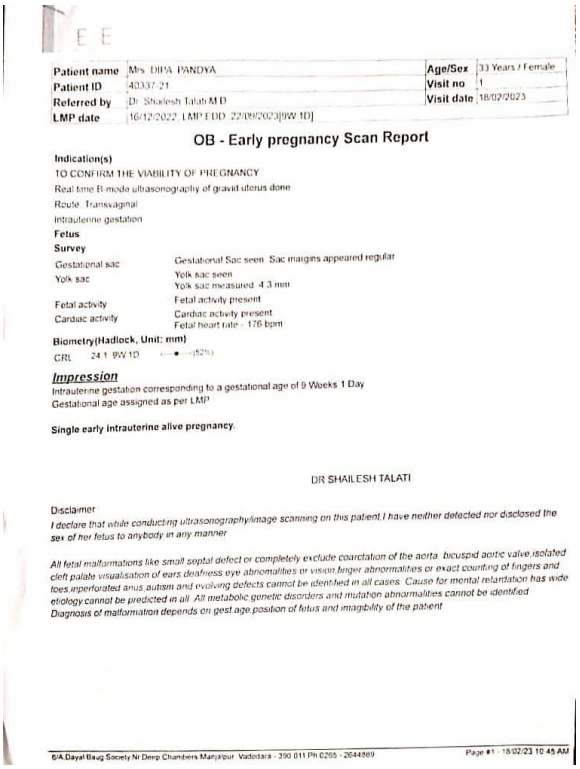
Table 4: Perceived Stress Scale (PSS)

PSS – 10 score Range	Level of Perceived Stress
0-13	Low Stress
14-26	Moderate Stress
27-40	High Stress

(Scoring pattern: The 10 items are rated on a 5-point, ranging from 0 to 4) (0= Never, 1= Almost Never), 2= Sometimes, 3= Fairly Often, 4= Very Often)

Table 5: Before and After Treatment Assessment

Parameters	Before Treatment	After Treatment	Observation
Psychological Evaluation (PSS)	28 (moderate stress)	16 (mild stress)	Improved emotional stability
***Satva* Assessment**	*Madhyama Satva*	*Pravara Madhyama Satva*	Better mental endurance
Ovulation	Anovulatory	Ovulatory (confirmed by follicular study)	Ovulatory cycle established
Cycle Duration	2 days (scanty)	3–4 days (moderate)	Improved menstrual flow
Premenstrual Symptoms	Anxiety, mood swings	Mild irritability only	Significant reduction



Patient name	Mrs. DIPA PANDYA	Age/Sex	33 Years / Female
Patient ID	40337-21	Visit no	1
Referred by	Dr. Shailesh Talati M.D	Visit date	18/02/2023
LMP date	16/12/2022, LMP EDD 22/09/2023[9W 1D]		

OB - Early pregnancy Scan Report

Indication(s)
TO CONFIRM THE VIABILITY OF PREGNANCY
Real time B-mode ultrasonography of gravid uterus done.
Route: Transvaginal
Intrauterine gestation

Fetus
Survey

Gestational sac	Gestational Sac seen. Sac margins appeared regular
Yolk sac	Yolk sac seen Yolk sac measured 4.3 mm
Fetal activity	Fetal activity present
Cardiac activity	Cardiac activity present Fetal heart rate - 176 bpm

Biometry(Hadlock, Unit: mm)
CRL 24.1 9W 1D (52%)

Impression
Intrauterine gestation corresponding to a gestational age of 9 Weeks 1 Day
Gestational age assigned as per LMP

Single early intrauterine alive pregnancy.

DR SHAILESH TALATI

Disclaimer
I declare that while conducting ultrasonography/image scanning on this patient,I have neither detected nor disclosed the sex of her fetus to anybody in any manner.

All fetal malformations like small septal defect or completely exclude coarctation of the aorta, bicuspid aortic valve,isolated cleft palate visualisation of ears,deafness,eye abnormalities or vision,finger abnormalities or exact counting of fingers and toes,imperforated anus,autism and evolving defects cannot be identified in all cases. Cause for mental retardation has wide etiology,cannot be predicted in all. All metabolic,genetic disorders and mutation abnormalities cannot be identified. Diagnosis of malformation depends on gest.age,position of fetus and imagibility of the patient.

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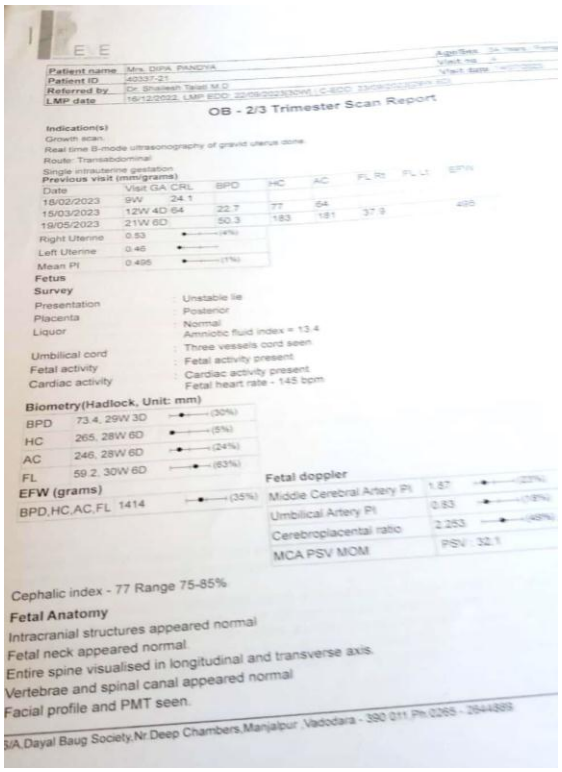
Figure-1: OB Early Scan 18/2/23



OB - 2/3 Trimester Scan Report

Indication(s)
Growth scan.
Real time B-mode ultrasonography of gravid uterus done.
Route: Transabdominal
Single intrauterine gestation

Previous visit (mm/grams)

Date	Visit GA	CRL	BPD	HC	AC	FL	RI	PI	EFW
15/02/2023	9W	24.1							
15/03/2023	12W 4D	64	22.7	77	64				
19/05/2023	21W 6D		50.3	183	181	37.9			495

Right Uterine 0.53 (4%)
Left Uterine 0.46 (7%)
Mean PI 0.495

Fetus
Survey

Presentation	Unstable lie
Placenta	Posterior
Liquor	Normal Amniotic fluid index = 13.4
Umbilical cord	Three vessels cord seen
Fetal activity	Fetal activity present
Cardiac activity	Cardiac activity present Fetal heart rate - 145 bpm

Biometry(Hadlock, Unit: mm)

BPD	73.4, 29W 3D	(30%)
HC	265, 28W 6D	(5%)
AC	246, 28W 6D	(24%)
FL	59.2, 30W 6D	(83%)
EFW (grams)		
BPD,HC,AC,FL	1414	(35%)

Fetal doppler

Middle Cerebral Artery PI	1.87	(22%)
Umbilical Artery PI	0.83	(18%)
Cerebroplacental ratio	2.253	(48%)
MCA PSV MOM	PSV : 32.1	

Cephalic index - 77 Range 75-85%

Fetal Anatomy
Intracranial structures appeared normal
Fetal neck appeared normal
Entire spine visualised in longitudinal and transverse axis.
Vertebrae and spinal canal appeared normal
Facial profile and PMT seen.

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Figure-2: OB 2/3 Trimester Scan 14/7/23

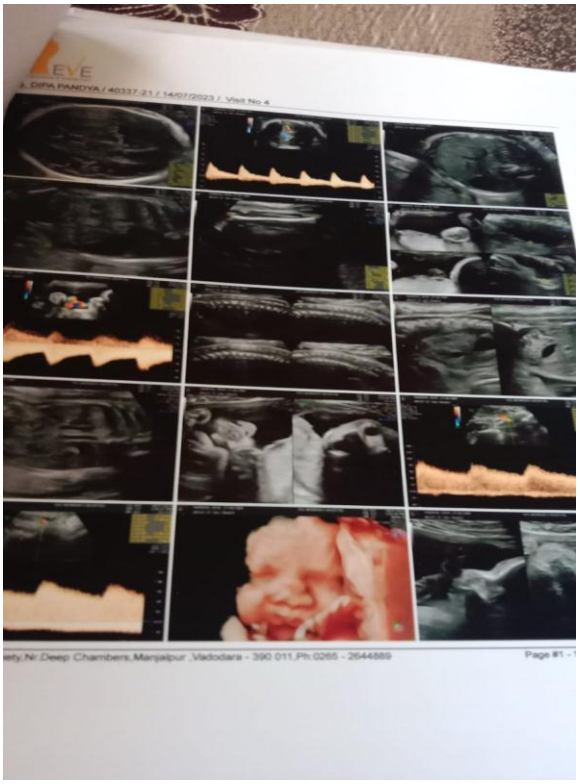

Figure-3: OB Scan 14/7/23

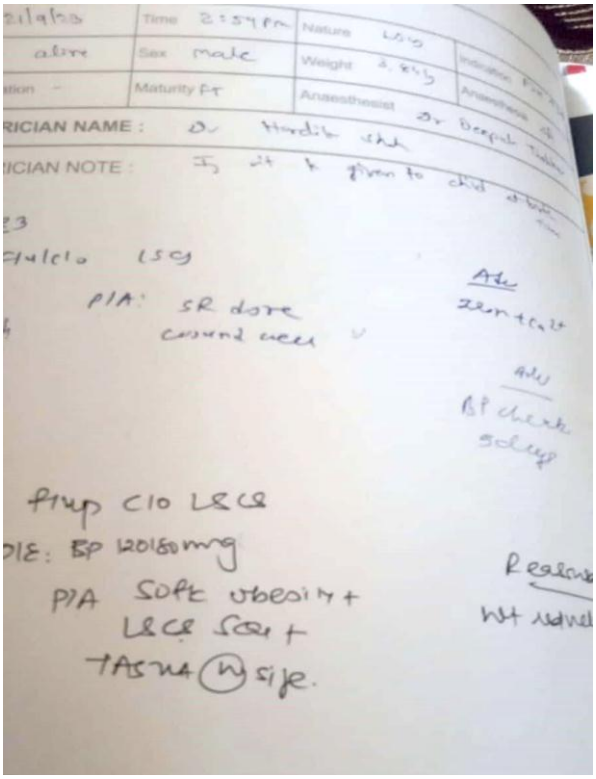

Figure-4: Delivery on 21/9/23

Observations and Results:

In the first month, the patient showed reduced psychological stress (assessed using the PSS scale [17], score improved from 26 to 13), (Table 4) along with better sleep, appetite, and improved daily energy. Menstrual flow increased from 2 scanty days to 3 moderate days, and premenstrual symptoms reduced to only mild irritability. Satva improved from Madhyama towards stability.

In the second month, follicular study confirmed ovulation with regular dominant follicle development. Emotional stability continued to improve, and Satva shifted from Madhyama to Pravara, indicating better mental strength and resilience. (Table 5)

Pregnancy & Delivery:

The patient tested positive on urinary pregnancy test on 16/12/22 & later confirmed by OB– early pregnancy scan Report on 18/2/23. (Figure 1) Ovulation was thus fully restored, and conception occurred naturally without assisted reproductive techniques. On 14/7/23, OB–2/3 Trimester Scan Report found absolutely normal. (Figure 2), (Figure 3)

The patient followed *Garbhini Paricharya* throughout pregnancy with trimester-specific medications and diet. On 21/9/23 at 2:59 PM, she delivered a healthy male child weighing 3.8 kg through Full Term LSCS. Both mother and infant were discharged in good health. (Figure 4)

DISCUSSION:

Anovulation is one of the major causes of primary infertility, accounting for nearly one-third of female factor cases. In this case, the patient's anovulation was compounded by a long-standing psychiatric history, chronic use of antidepressant and sedative medications, and Satva depletion.

From an *Ayurvedic* perspective, this presentation correlates with *Vandhyatva,* with the *Samprapti* involving *Vata–Kapha vitiation*, *Agnimandya*, and *Srotorodha* in the *Artavavaha srotas*. Psychological stress (*Chinta, Shoka, Bhaya*) further aggravated *Vata dosha*, impairing *Apana vata* function and ovulatory physiology, as described in *Charaka Samhita (Su. 1/58).*

Basti is considered the prime therapy for *Vata dosha*, particularly *Apana Vata*, which governs ovulation, menstruation, and conception. In this case, *Yogabasti* corrected *Apana Vata avarana*, removed *Srotorodha* in *Artavavaha srotas*, and improved ovarian blood flow. ***Uttarabasti*** is specifically indicated for *Artava kshaya* and *Garbhashaya shodhana*. Administered intrauterinely, it provides a local *srotoshodhana* effect, nourishes the *Garbhashaya,* and stimulates follicular maturation through direct action on the endometrium and ovaries. ***Nasya karma*** – *Vatashruna* likely modulates hypothalamic GnRH secretion, restoring normal gonadotropin (FSH, LH) release and thereby re-establishing ovulatory cycles.

Medhya Rasayana acts synergistically as adaptogens, stress relievers, immunomodulators and regulkators of hypothalamic- ovarian function. ***Kanchanara Guggulu*** **-** Reduces *Kapha-medo vriddhi* and clears *Artavavaha srotas* blockages, aiding in follicular rupture. ***Chitrakadi Vati*** **-** *Deepana-pachana*, enhances digestion and metabolism, indirectly supporting *Dhatu utpatti* including *Artava dhatu*. ***Shatapushpa + Trikatu*** **-** regulates *Apana Vata*, and supports timely follicular rupture.

CONCLUSION:

This case highlights that an integrated *Ayurvedic* approach combining external therapies and targeted internal medications can effectively correct *Vata-Kapha* vitiation, restore *Artavavaha srotas* function, and improve psychological balance. Natural conception was achieved within four months, suggesting the potential of individualized *Ayurvedic* protocols in managing anovulatory infertility.

Limitation of study:

The present report is constrained by its single-case design, limited follow-up duration, and lack of repeated hormonal or imaging assessments. Accordingly, broader studies with standardized long-term evaluation are required to substantiate these preliminary findings.

Consent of patient:

The consent of patient has been taken for publication and procedure without disclosing the identity of patient.

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