

Management of Endometrial Polyp through Ayurveda: A Single Case Study

Vidya K P,^{1*} Asha Sreedhar,² Udayasree U³

¹Assistant Professor, ² Professor and HOD, ³ House surgeon, Department of Prasuti Tantra Stri Roga, Govt. Ayurveda College Kannur, Kerala, India.

ABSTRACT:

Menorrhagia is a common gynecological condition that significantly affects women's quality of life. The presence of endometrial polyps and Nabothian cysts may further complicate the clinical presentation. Ayurveda describes excessive menstrual bleeding as *Asrigdhara* and advocates a comprehensive treatment approach based on *Shodhana* and *Shamana* principles. A 35-year-old female diagnosed with *Asrigdhara*, suspected endometrial polyp, and multiple Nabothian cysts presented with heavy menstrual bleeding with clots, lower abdominal pain, and symptoms of *Medo Dhatu Dushhi*. Associated metabolic disturbances included Grade 2 fatty liver and elevated HbA1c. The patient was admitted for an Ayurvedic inpatient protocol involving *Udwartanam*, *Abhyanga* with *Ushma Swedana*, *Snehapana*, followed by *Mridu Vamana*, *Churna Vasthi*, and final *Virechana*, supported with internal *Shodhana* and *Shamana* medications. The treatment resulted in marked symptomatic improvement, stabilization of metabolic parameters, and complete resolution of the endometrial polyp as observed during follow-up assessments. This case demonstrates the potential effectiveness of a comprehensive Ayurvedic *Shodhana* therapy in managing menorrhagia associated with endometrial polyps while also addressing underlying metabolic dysfunctions. Further clinical studies are recommended to validate these findings.

KEYWORDS: *Asrigdhara*, Endometrial Polyp, Menorrhagia, *Mridu Vamana*, Nabothian Cysts, *Vasthi*, *Virechana*.

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***Corresponding Author:**

Dr. Vidya K P

Assistant Professor,

Department of Prasuti tantra Stri roga,

Govt Ayurveda College Kannur, Kerala, India

Email: drvidyakp@gack.kerala.gov.in

INTRODUCTION:

Endometrial polyps are benign, localized growths arising from the inner lining of the uterus, known as the endometrium. These

polyps may vary in size from a few millimeters to several centimeters and are generally attached to the uterine wall either by a thin stalk (pedunculated) or directly

through a broad base (sessile).^[1] While many cases remain asymptomatic, endometrial polyps commonly present with abnormal uterine bleeding, which is the most significant clinical feature. Symptoms may include menorrhagia (excessive menstrual bleeding), intermenstrual spotting, or postmenopausal bleeding. Therefore, endometrial polyps form an important differential diagnosis in women presenting with abnormal bleeding patterns.

Transvaginal ultrasound (TVUS) is commonly used as the preliminary diagnostic tool for suspected endometrial polyps.^[2] However, definitive diagnosis and therapeutic management often require hysteroscopy, a procedure that allows direct visualization of the uterine cavity and facilitates the removal of the polyp. Although the majority of endometrial polyps are benign, their presence may raise concern for endometrial carcinoma, particularly in peri-menopausal and post-menopausal women. It is therefore important to evaluate such polyps comprehensively, even though most do not exhibit malignant potential.

The exact pathogenesis of endometrial polyps remains uncertain, but existing research suggests that they arise from localized hyperplasia of the endometrial glands, which is strongly influenced by hormonal imbalances—particularly excess estrogen. Elevated estrogen levels stimulate the proliferation of endometrial tissue, increasing the risk of polyp formation. Several risk factors have been associated with endometrial polyps, including obesity, hypertension, diabetes mellitus, and the use of tamoxifen in breast cancer treatment. These conditions may cause significant alterations in hormonal regulation, further contributing to the development of polyps. While a significant proportion of women with endometrial polyps remain asymptomatic, others experience symptoms

that can severely impact quality of life. Heavy menstrual bleeding, pelvic discomfort, and associated anemia are frequent clinical consequences. Conventional management emphasizes surgical removal through hysteroscopic polypectomy. However, in Ayurveda, abnormal uterine bleeding is described under the condition *Asrigdhara*, and the treatment approach includes *Shodbhana* and *Shamana* therapies aimed at correcting the underlying *dosha* imbalance and restoring reproductive health.

Epidemiology of Endometrial Polyps

Understanding the clinical presentation, diagnostic methods, and management strategies for endometrial polyps is essential for healthcare providers to address women's reproductive health concerns and ensure appropriate treatment and follow-up.

General Population Prevalence

- Overall Prevalence: Clinical studies estimate that the prevalence of endometrial polyps in the general population ranges from 10% to 30%. The prevalence varies depending on age, symptomatology, and whether the population studied consists of symptomatic or asymptomatic individuals.^[3]
- Asymptomatic Women: Among women without gynecological complaints who undergo routine pelvic imaging, approximately 10% may have endometrial polyps detectable through transvaginal ultrasound (TVUS) or hysteroscopy. Most of these polyps are small in size and do not produce noticeable symptoms.

Age-Related Prevalence

- Reproductive Age (Premenopausal Women): The prevalence of endometrial polyps among premenopausal

women is estimated to be 10–15%, particularly in women in their fourth and fifth decades of life. Polyps in this age group are more likely to be influenced by hormonal fluctuations associated with the reproductive years.^[4]

- Postmenopausal Women

The prevalence of endometrial polyps increases significantly after menopause, with estimates suggesting that 25–30% of postmenopausal women may develop polyps. The risk is notably higher in women undergoing hormone replacement therapy (HRT) or those with obesity, as these conditions can intensify hormonal imbalances, particularly excess estrogen.

- Perimenopausal Women

During the transition into menopause, the incidence of endometrial polyps rises, with reports indicating that 15–25% of women in this age group may be affected. Increased hormonal activity during this period, especially fluctuations in estrogen levels, can contribute to the formation and growth of polyps.

Symptomatic vs Asymptomatic Cases

Symptomatic Women

In women presenting with abnormal uterine bleeding, the prevalence of endometrial polyps is considerably higher. Studies indicate that around 20–30% of women with abnormal bleeding symptoms are found to have an endometrial polyp. This makes endometrial polyps a key differential diagnosis in patients with menorrhagia, intermenstrual bleeding, or postmenopausal bleeding. Early identification and appropriate management are essential to reduce symptoms and prevent complications.

Association of Fatty Liver and Endometrial Polyps

There is a significant association between MASLD Metabolic Dysfunction Steatotic Liver Disease and endometrial polyps, indicating a possible metabolic link between hepatic dysfunction and reproductive hormonal imbalance.^[5]

Association of Fatty Liver Disease and Endometrial Polyps

Endometrial polyps are frequently observed in women diagnosed with MASLD, likely due to shared metabolic and hormonal risk factors. Although neither condition directly causes the other, both commonly coexist, especially in women with metabolic syndrome or obesity.

Several studies have reported that women with MASLD have a higher likelihood of presenting with:

- Endometrial thickening
- Endometrial hyperplasia
- Endometrial polyps

While MASLD and endometrial polyps are not causally linked, they often occur concurrently among women with:

- High body mass index (BMI)
- Type 2 diabetes mellitus
- Polycystic ovarian syndrome (PCOS)
- Sedentary lifestyle

Both conditions represent manifestations of systemic metabolic and hormonal dysregulation, particularly involving insulin resistance, hyperinsulinemia, and estrogen dominance. These factors can stimulate endometrial proliferation and contribute to polyp formation.

Abnormal Uterine Bleeding (AUB)

Abnormal uterine bleeding (AUB) is one of the most common gynecological complaints among women of reproductive age and in the non-gravid state. AUB frequently prompts clinical evaluation by primary healthcare providers or gynecologists.

Anovulation, without any underlying medical illness or pelvic pathology, represents one of the leading causes of AUB.

A wide range of reproductive and non-reproductive pathologies may lead to bleeding abnormalities, and bleeding occurring in the absence of ovulation is termed anovulatory bleeding. Therefore, it is essential to obtain a focused menstrual history combined with a comprehensive clinical evaluation, including a pelvic examination.

A vaginal speculum examination assists in differentiating anovulatory bleeding from other structural or infective causes of bleeding. In clinical practice, heavy menstrual bleeding or associated symptoms often indicate underlying conditions such as endometrial polyps, hyperplasia, fibroids, thyroid dysfunction, or coagulopathies.

Abnormal Uterine Bleeding (AUB): Clinical Evaluation

Variation in pathology within, or outside, the reproductive tract may present as anovulatory bleeding. Therefore, obtaining a focused menstrual history, followed by a systematic clinical evaluation, is essential. A pelvic examination, including a vaginal speculum assessment, is required to distinguish anovulatory bleeding from other causes of uterine bleeding.

In contrast, Heavy Menstrual Bleeding (HMB) is typically described as ovulatory bleeding exceeding 8 days, frequently associated with underlying conditions such as uterine fibroids, adenomyosis, intrauterine copper device, or coagulation disorders.

PALM-COEIN Classification

The PALM-COEIN system was developed by the Federation Internationale de Gynaecologie et d'Obstétrique (FIGO) to

standardize terminology and define the underlying etiology of AUB.

The acronym PALM-COEIN includes:

- P: Polyp
- A: Adenomyosis
- L: Leiomyoma
- M: Malignancy and Hyperplasia
- C: Coagulopathy
- O: Ovulatory Dysfunction
- E: Endometrial
- I: Iatrogenic
- N: Not-yet-classified

AUB presents with a range of clinical features such as:

- Heavy menstrual bleeding (HMB)
- Intermenstrual bleeding (IMB)
- Combined heavy and prolonged menstrual bleeding (MB)

Terminology such as Dysfunctional Uterine Bleeding (DUB) and menorrhagia are currently unified under the broader category of AUB.

Menorrhagia

Menorrhagia refers to regular cyclical menstruation with excessive flow or prolonged duration. Clinically, blood loss exceeding 80 mL per cycle or menses lasting more than 7 days is classified as menorrhagia. Bleeding occurs on schedule, but the intensity and duration are abnormal. This is among the most prevalent gynecological complaints in contemporary clinical practice.

CASE REPORT:

A 35-year-old moderately built female presented to the Prasuthi Tantra and Stree Roga Department, Government Ayurveda College, Kannur, with complaints of heavy menstrual bleeding with clots, associated with lower abdominal pain and low backache for the past two years. She also reported a history of curdy white vaginal discharge during the same period.

The patient described significant fatigue during menstruation, which adversely affected her routine activities. She is a known case of type 2 Diabetes (T2D), MASLD, and dyslipidemia, but was not on any regular medications for these conditions at the time of presentation.

She visited the hospital seeking further management for her symptoms.

Past Medical History

- History of chickenpox at 9 years of age
- History of mumps at 10 years of age

Family History

No relevant family history was noted

Menstrual History

- Menarche: 13 years

Cycle interval: 30 days Obstetric History

- Gravida: 3
- Para: 2
- Live births: 2
- Abortions: 1 (medical termination of pregnancy)
- Mode of delivery: Two normal vaginal deliveries
- Last childbirth: 6 years ago
- Duration of bleeding: 4–5 days
- Recent menstrual periods:
 - LMP: 19/12/2024
 - Previous cycles: 24/11/2024, 20/10/2024

Menstrual Pattern and Flow Characteristics

The patient reported a regular menstrual cycle of 30-day interval with a bleeding duration of 4–5 days.

- Day 1: approximately 2–3 cups/hour
- Day 2: 3 cups
- Day 3: 3 cups
- Day 4: 3 cups

She described associated premenstrual symptoms (PMS), including lower abdominal pain and low backache. Menstrual blood contained brownish-black clots measuring approximately 2.5 cm in diameter. A curdy, sticky, white vaginal discharge was also Personal and Lifestyle History

- Diet: Mixed diet
- Appetite: Good
- Sleep: Sound
- Bowel habits: Regular
- Micturition: Within normal limits
- Allergies: No known allergies
- Addictions: None

Anthropometry

- Height: 160 cm
- Weight: 70 kg

BMI: 27.3 kg/m² (Overweight category)

Gynecological Examinations

General Examination

- Conscious, oriented, afebrile
- Pulse: 76/min
- Blood Pressure: 120/80mmHg
- Pallor: —Mildly Present
- Edema: —Absent

Per Abdomen Examination

- Abdomen soft, non-tender
- No mass palpable

Per Speculum Examination

- Vulva: healthy
- Vagina: normal mucosa
- Cervix: healthy/erosions?
- Vaginal discharge: curdy, white, non-foul smelling

Per Vaginal Examination

- Uterus: normal size/anteverted
- Fornices: free/non-tender
- Adnexa: no palpable mass

This ultrasound suggests chronic endometrial pathology, likely early

endometrial hyperplasia/polyp, and chronic cervicitis manifested as Nabothian cysts.

Modern Clinical Understanding

Endometrial polyps and localized hyperplastic growth of endometrium are common causes of:

- excessive menstrual bleeding
- clot formation
- dysmenorrhea
- pelvic heaviness

Ayurvedic Correlation

Based on symptoms such as:

- heavy menstrual bleeding
- presence of clots
- cervical erosion
- recurrent sticky white discharge
- bulky uterus
- Nabothian cysts

— the condition can be understood as *Yoni Arsha* due to *Kaphaja* dominance, with *Kapha-Meda* involvement at the level of:

- *Artava Vaha Srotas*
- *Garbhashaya*
- *Cervix (Garbhamukha)*

THERAPEUTIC INTERVENTION:

Based on Ayurvedic assessment, the present case was identified as *Kaphapitta-pradbana Tridoshaja Vyadhi*, presenting clinically similar to *Kaphaja Asrigdara* ^[6] with involvement of *Kapha-Meda Dushti* and *Apana Vayu* vitiation. *Dhatu*s involved were *Rakta*, *Mamsa*, and

Meda, indicating deeper metabolic derangement consistent with *Prameha-poorvarupa* features (HbA1c 6.9%, fatty liver). Thus, the treatment protocol was planned with the following objectives:

- *Kapha-Medohara*
- *Pitta-Shamana*
- *Rakta-Prasadana*
- *Apanavata Anulomana*
- *Lekhana*
- *Yoni Shodhana*

The treatment plan included internal medications, local therapies, and biopurification (*Shodhana*). The following medicines were administered:

Rationale of the Treatment

- Endometrial hyperplastic growths (polyps) share pathology with *Granthi* formation due to Sanga in *Artavavaha Srotas*.
- Nabothian cysts indicate chronic cervicitis with *Kapha-Meda* accumulation.
- Sticky discharge suggests *Kapha-Pitta dushti* in *Yoni*.
- Prediabetes and fatty liver represent systemic *Kapha-Meda* aggravation.

Therefore, *Lekhana*, *Medohara*, *Kapha-Pitta Shamaka* approach is justified both classically and clinically.

Table-1: Initial Laboratory Investigations

Blood Examination	Observed values
Hemoglobin	10.2gm%
Total count	5960 cells/cu.mm
ESR	12mm/hr
FBS	123mg/dl
PPBS	145mg/dl
HbA1c	6.9%(pre-diabetic range)
Total cholesterol	208mg/dl
Triglycerides	210mg/dl

HDL	54mg/dl
LDL	112mg/dl
VLDL	42mg/dl
Total bilirubin	0.4mg/dl
Direct bilirubin	0.1mg/dl
SGPT	23IU/L
SGOT	17IU/L
T3	128ng/dl
T4	8.2mcg/dl
TSH	1.43 µIU/ml
Urine Analysis:	
Albumin	Faint trace
Sugar	Nil
WBC(PUS CELLS)	20-25/HPF
Epithelial cells	10-12/HPF
RBCs	1-2/HPF
Bacteria	Present(+)

Table-2: Ultrasound Findings (Before Treatment)

UTERUS	<ul style="list-style-type: none"> • Bulky: 93 × 52 × 56 mm • Endometrial thickness: 10 mm • Echotexture: Uniformly hyperechoic • A vascular pedicle extending into the endometrium noted – endometrial polyp could not be ruled out
CERVIX	<ul style="list-style-type: none"> • Multiple Nabothian cysts
LIVER	<ul style="list-style-type: none"> • Grade II fatty liver
<ul style="list-style-type: none"> • Bulky uterus • Focal endometrial thickening at mid-body level with vascular pedicle – suspected endometrial polyp • Multiple Nabothian cysts • Grade II fatty liver • Suggested review post-menstrual period 	

Table-3: Local Examination (Post-Intervention)

Per speculum examination	<ul style="list-style-type: none"> • Reduction in cervical erosion at the upper lip of the cervix • No active bleeding or congestion • Vaginal discharge reduced and non-offensive
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Table-4: Laboratory Investigations AT

Fasting Blood Sugar (FBS)	112 mg/dL
Post-Prandial Blood Sugar (PPBS)	96 mg/dL
No increase in HbA1c was noted, indicating stable glycemic status during therapy.	

Table- 5: Internal Medications

Medicines	Dose	Time of administration	Duration
<i>Musalikhadiradi</i> Kashaya (<i>Kapha-Medohara, Lekhana, Garbbashaya-Shodhaka</i>) ^[9]	90ml bd	Before food with honey	4weeks
<i>NishaKathakadi</i> Kashaya (<i>Raktaprasadana, Pitta Shamana, Kandughna</i>) ^[7]	90ml bd	Before food	4weeks
<i>Kaishora</i> Guggulu (<i>Raktashodhaka, Pitta-Kapha Shamaka</i>) ^[7]	1 bd	After food	3weeks
<i>Chandraprabha</i> Vati (<i>Mutravaha-Srotoshodhaka, Lekhana, anti-inflammatory</i>) ^[8]	1 tab bd	After food	3 weeks
<i>Guggulu Panchapalam Churnam</i> (<i>Lekhana, Medohara, granthihara</i>)	1 tsp tds	After food with honey	3 weeks
<i>Annabedi</i> Sindooram (<i>Rasayana, Dhatvagni dipana</i>) ^[10]	1 pinch	After food with warm water	2 weeks
<i>Rasagandhi</i> Mezḥuku (<i>Kapha-Medohara and Srotoshodhana properties</i>) ^[11]	1 capsule 100mg bd	After food	2 weeks
<i>Sadyasnehapana</i> with <i>Madhuyashtyadi Tailam</i> ^[11] (for <i>Vata-Pitta shamana</i> and <i>Srotoshodhana</i> prior to <i>Shodhana</i>)	30 ml bd	With food mixed with gruel	3 days

All medicines were selected considering the Kapha-Medo dominance, presence of endometrial hyperplasia, and metabolic comorbidities.

Table-6: External and Local Procedures

Local Therapy • <i>Yoni Prakshalana</i> with <i>Triphala Kashaya</i>	Duration • Once daily for 7 days • Purpose: local <i>Shodhana, Stambhana, and Ropana.</i>
External Procedures 1. <i>Udwartana</i> with <i>Vara Choorna</i> 2. <i>Abhyanga + Ushma Sweda</i> using <i>Pinda Taila</i>	Duration: 14 days Effect: <i>Kapha-Medohara, Lekhana, lymphatic drainage improvement</i> Duration: 14days (Daily before <i>Udwartana</i>) Purpose: <i>Vata-Anulomana, Srotoshodhana</i>

Table-7: Shodhana Therapies

Mrdu Vamana A gentle therapeutic emesis was administered after <i>Sadyasnehapana</i> to expel <i>Kapha-Meda doshas</i> .	• Indication: <i>Kapha-Medo dushti</i> , bulky uterus with endometrial hyperplasia. • Benefits: reduces Sanga in <i>Srotas</i> and <i>Granthi-Utpatti</i> tendency.
Virechana With <i>Avipatti Churnam</i> 40 g and <i>Triphala Churnam</i> 10 g administered with hot water	After <i>Vamana</i> , <i>Virechana</i> was administered to eliminate residual <i>Pitta</i> and <i>Kapha</i> and support <i>Rakta shodhana</i> . This supported:

	<ul style="list-style-type: none"> • purification of <i>Rakta</i> • normalization of <i>Apanavayu</i> • reduction of endometrial thickening • anti-inflammatory action at the endometrium.
<ul style="list-style-type: none"> • <i>Churna Vasti</i> using <i>Triphala Kashaya</i> combined with <i>Vaiswanara Churna</i> and <i>Saindhava</i> ^[12] 	<p>facilitated:</p> <ul style="list-style-type: none"> • <i>Yoni shodhana</i> (local cleansing) • Anti-inflammatory effect, aiding healing of cervical erosions • Reduction of leucorrhoea due to <i>Stambhana</i> and <i>Ropana</i> action.

Table-8: Ultrasonographic Findings

Post-intervention pelvic ultrasonography	<ul style="list-style-type: none"> • No appreciable endometrial polyp detected • Endometrium measured 12 mm, luteal phase • Nabothian cysts present in the cervix (10 mm), unchanged in size • Two small intramural fibroids noted, seedling type • Fatty infiltration of liver and pancreas persisted • Areas of altered texture in myometrium suggestive of adenomyosis
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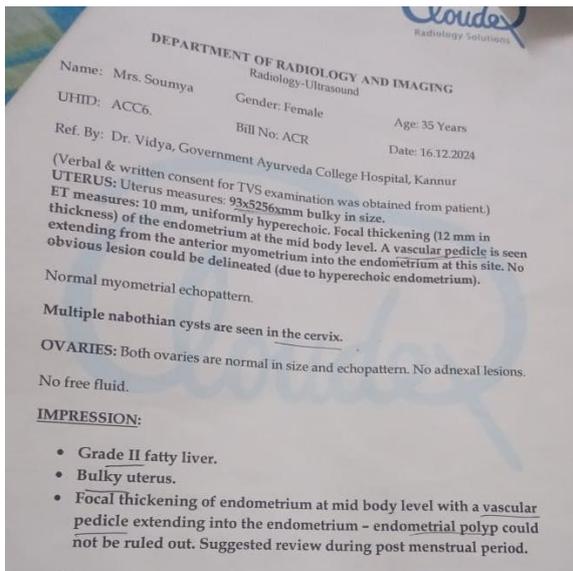


Figure-1: USG findings Before Treatment

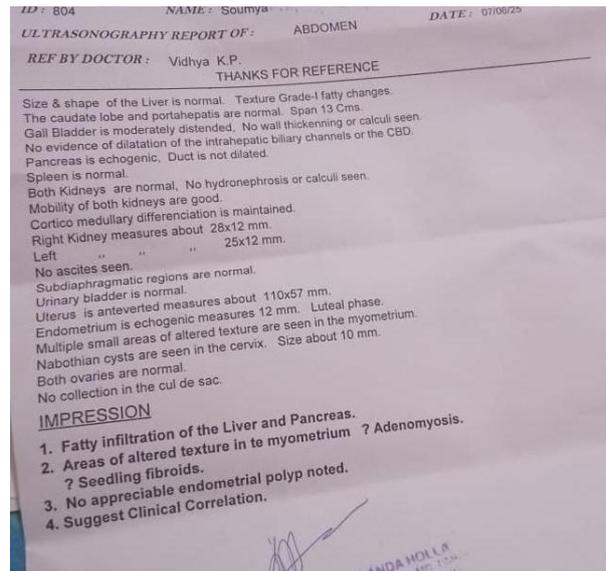


Figure-2: USG findings after treatment

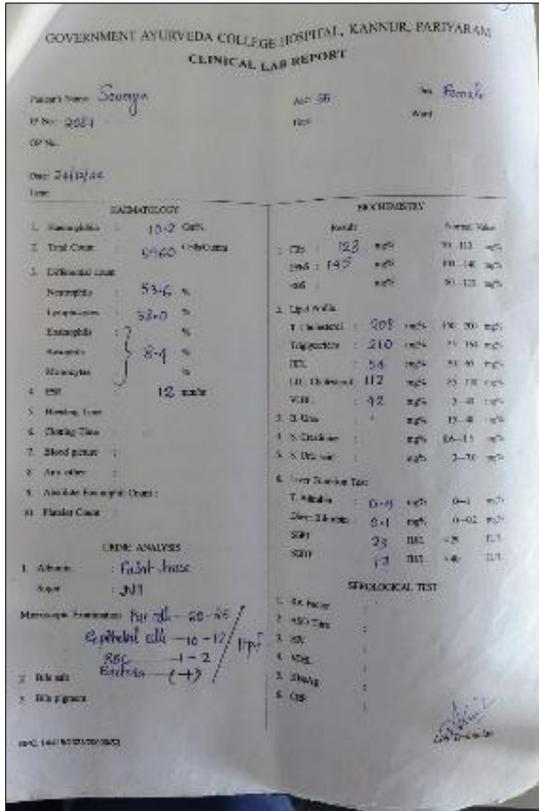


Figure-3: Blood report Before treatment

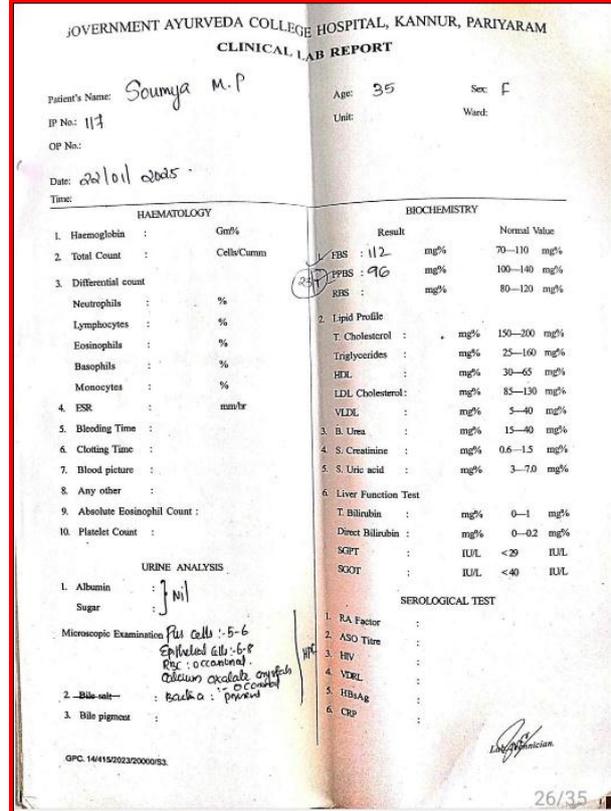


Figure-4: Blood report after treatment

RESULTS:

The patient demonstrated significant clinical improvement following the Ayurvedic intervention.

Symptomatic Relief

By the end of therapy, the patient reported marked relief in:

- Excessive uterine bleeding
- Low backache
- Fatigue
- Whitish vaginal discharge, which had significantly reduced

Menstrual flow normalized in volume and duration, with no associated clots or post-menstrual spotting.

Importantly, the previously noted endometrial polyp was not visualized post-treatment (Figure-1 and 2).

DISCUSSION:

Endometrial polyps and cervical erosions are associated with *Apāna Vāta* dysfunction,

Kapha-Meda accumulation, and *Srotorodha* (obstruction of channels) within the *Artavavaha Srotas*. The treatment approach in this case was based on the classical principles of:

- *Kapha-Medohara*
- *Pitta-Shamana*
- *Rakta-Prasadana*
- *Apānavāta Anulomana*
- *Lekhana*
- *Yoni Shodbhana*

Mechanism of Action (Ayurvedic Perspective)

Shodbhana

The combination of *Mrdu Vamana* followed by *Virechana* facilitated expulsion of aggravated *Kapha-Pitta*, clearance of *Granthi-utpatti hetu* (factors for abnormal tissue growth), improved *Rakta* circulation to pelvic organs and normalized *Apānavāta* flow, regulating menstrual pattern. [13]

Internal Medications

- *Musalikhadiradi Kashaya, Nisha Kathakadi Kashaya, and Kaishora Guggulu* worked as *Raktashodhaka, Lekhana,* and anti-inflammatory agents, reducing the inflammatory congestion in the endometrium.^[14]
- *Chandraprabha Vati* supported *Mutravaha Srotas*, acting systemically on metabolic pathways.^[15]
- *Guggulu* preparations are well documented for reducing pathological tissue proliferation (“*Granthi-hara*” property).^[16]

Local Therapy

- *Churna Vasti* using *Triphala Kashaya* combined with *Vaiswanara Churna* and *Saindhava* facilitated:
 - *Yoni shodhana* (local cleansing)
 - Anti-inflammatory effect, aiding healing of cervical erosions
 - Reduction of leucorrhoea due to *Stambhana* and *Ropana* action

Clinical Outcome

The disappearance of the endometrial polyp post-intervention supports the classical theory that *Granthi* can be dissolved by appropriate *Lekhana-Shodhana* therapy when *Kapha-Medo-Dushti* is the causative factor. (Figure-2)

Moreover, systemic conditions like fatty liver and impaired glucose tolerance indicate *dhatu-gata Kapha-Meda dushti*, which were addressed by the treatment regimen.

The stable blood glucose during treatment suggests that the chosen medicines did not negatively affect glycemic status, which is important in pre-diabetic patients.

CONCLUSION:

This case demonstrates that a well-designed Ayurvedic treatment protocol consisting of Shamana medicines, *Snehapana, Mrdu Vamana, Virechana,* and local *Yoni Shodhana*

can provide beneficial outcomes in a patient with endometrial polyp, cervical erosion, and leucorrhoea, even in the presence of metabolic comorbidities.

The disappearance of the endometrial polyp on follow-up ultrasonography and considerable improvement in symptoms suggest that *Kapha-Medobara* and *Rakta-Prasadana* therapies are effective in such cases.

Further clinical studies with larger sample sizes are encouraged to validate these findings.

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