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Clinical and Ultrasonographic Changes in two Patients with PCOS Features Treated with an Integrative *Ayurveda-Homoeopathy* Regimen: A Case Series

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ABSTRACT:

Polycystic ovary syndrome (PCOS) may present with menstrual irregularity, acne and hirsutism, while ultrasonography may show polycystic ovarian morphology (PCOM). In resource-limited settings, biochemical evaluation may be incomplete, making transparent clinical and ultrasonographic documentation important. This retrospective case series describes two females with PCOS features. Case 1, aged 19 years, had oligomenorrhea, scanty short menses, leucorrhoea, acne and mild anemia; ultrasonography showed prominent bilateral ovaries with multiple peripheral small follicles and fluid in the pouch of Douglas (POD). Case 2, aged 15 years, had delayed/irregular menses, dark clots, copious leucorrhoea, weight gain and facial hirsutism; ultrasonography showed bilateral multiple small cystic-like ovarian lesions and mild POD fluid. Following computerized repertorization, Case 1 received *Graphites* 6CH and Case 2 received *Pulsatilla* 6CH, one oral dose twice weekly. Both received *Kanchnar Guggulu* 500 mg, two tablets daily, and *Vriddhi Vadhika Vati* 250 mg, two tablets daily, for approximately 3.5-4 months. Follow-up ultrasonography reported normal ovaries in both cases. In Case 1, the Global Acne Grading System (GAGS) score decreased from 24 to 0 and hemoglobin increased from 10.1 to 10.6 g/dL, with persistent anemia. In Case 2, the modified Ferriman-Gallwey (mFG) score decreased from 11/36 to 3/36. The changes were temporally associated with the combined regimen; causality and component-specific efficacy cannot be established because of the uncontrolled two-case design, combined interventions and incomplete endocrine work-up.

KEYWORDS: *Ayurveda, Graphites, Homoeopathy,* PCOS features, polycystic ovarian morphology, *Pulsatilla.*

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INTRODUCTION:

PCOS is a heterogeneous endocrine disorder characterized by combinations of ovulatory dysfunction, clinical or biochemical hyperandrogenism and PCOM. Diagnostic interpretation requires caution in adolescents because normal pubertal maturation can overlap with PCOS features, and ultrasound-based ovarian morphology has limited specificity in this age group. [1]

In pluralistic Indian clinical practice, patients may seek *Ayurveda* and *homoeopathy* for menstrual and ovarian complaints. Transparent case reporting requires cautious terminology, source-report accuracy, objective chronology and disclosure of limitations; the present report was prepared with reference to CARE principles. [2]

This case series presents two patients with PCOS features and baseline ultrasonographic ovarian abnormalities who were managed with individualized low-potency *homoeopathic* remedies and a supportive *Ayurveda* regimen. The aim is to document the clinical course and follow-up ultrasonographic findings without claiming disease cure, endocrine mechanism or component-specific efficacy.

CASE HISTORY:

Case 1

A 19-year-old female presented with menstrual cycles at approximately 2-3-month intervals. Flow was scanty and lasted 1-2 days. She also reported chronic leucorrhoea and acne flares around menses. Examination suggested a lean/underweight phenotype with fatigue and pallor. The Global Acne Grading System (GAGS) score recorded at baseline was 24, corresponding to moderate acne. [3]

Baseline whole-abdomen ultrasonography dated 12 March 2026 reported an anteverted uterus measuring 76.3 x 39.8 x 31.6 mm, normal myometrium and endometrium, bilateral adnexal thickening and fluid in the POD. Both ovaries were prominent and showed multiple small follicles in a predominantly peripheral distribution, with the largest follicles measuring 10.6 mm on the right and 9.9 mm on the left. The radiological impression was bilateral polycystic ovarian disease with fluid in the POD, with advice for clinical correlation and LH/FSH confirmation.

Complete blood count dated 4 April 2026 showed mild anemia: hemoglobin 10.1 g/dL, RBC count 3.97 million/cu.mm, packed cell volume 32.5%, MCV 81.9 fL and MCH 25.5 pg. Conventional prescriptions dated 12 and 22 March 2026 were available and were recorded as prior/early symptomatic treatment. No long-term oral contraceptive pill, anti-androgen or metformin use was documented in the available case record.

Case 2

A 15-year-old adolescent female presented with delayed/irregular menses at approximately 2-3-month intervals,

dark clots during menstruation, copious leucorrhoea, weight gain and facial hirsutism over the upper lip and chin. The modified Ferriman-Gallwey (mFG) score recorded at baseline was 11/36. [4] Serum endocrine testing was not performed because of financial constraints.

Baseline whole-abdomen ultrasonography dated 8 February 2026 reported an anteverted uterus measuring 62 x 25 x 38 mm with a normal central endometrial cavity. Both ovaries showed multiple small cystic-like lesions arranged in a "bunch of grapes" appearance, measuring approximately 3-7 mm on the right and 4-9 mm on the left. Mild fluid collection was noted in the POD. The radiological impression was suggestive of bilateral ovarian PCOS/PCOD with mild POD fluid. Because the patient was an adolescent and exclusion testing was incomplete, this case was conservatively interpreted as an adolescent PCOS phenotype or PCOS features rather than a fully confirmed endocrine diagnosis. Key baseline and outcome data for both cases are summarized in Table 1.

THERAPEUTIC INTERVENTION:

In both cases, *homoeopathic* remedies were selected by computerized repertorization of the recorded totality of symptoms using Kentian rubrics and the *Synthesis Adonis* repertory in RadarOpus. [5-6] Case 1 rubrics covered ovarian cystic changes, irregular/scanty and short menses, leucorrhoea, anemia-associated leucorrhoea, acne during menses and desire for salt; *Graphites* ranked highest. Case 2 rubrics covered copious leucorrhoea, delayed/irregular and scanty menses in girls, dark clotted flow, ovarian cystic morphology, weight gain, chilliness, premenstrual headache/back pain, fat-food aggravation and reserved disposition; *Pulsatilla* ranked highest. The repertorial charts are shown in Figures 1 and 2.

Case 1 received *Graphites* 6CH, one oral dose twice weekly on Sundays and Wednesdays on an empty stomach. Case 2 received *Pulsatilla* 6CH on the same schedule. Both patients received *Kanchnar Guggulu* 500 mg, two tablets daily, and *Vriddhi Vadhika Vati* 250 mg, two tablets daily. According to the available chronology, the combined regimen continued for approximately 3.5-4 months until the documented follow-up assessments. The retrospective prescriptions recorded these strengths, but manufacturer and batch numbers were unavailable; independent verification of product composition was therefore not possible.

Table -1: Comparative summary of the two cases.

Parameter	Case 1	Case 2

Parameter	Case 1	Case 2
Age and presentation	19 years; cycles every 2-3 months, scanty flow for 1-2 days, leucorrhoea and acne.	15 years; delayed/irregular cycles every 2-3 months, dark clots, leucorrhoea, weight gain and facial hirsutism.
Baseline measures	GAGS 24; hemoglobin 10.1 g/dL.	mFG 11/36; endocrine testing not performed because of financial constraints.
Baseline ultrasound	12 March 2026: prominent bilateral ovaries with multiple peripheral small follicles and POD fluid.	8 February 2026: bilateral multiple small cystic-like ovarian lesions and mild POD fluid.
Individualized medicine	*Graphites* 6CH, one dose twice weekly.	*Pulsatilla* 6CH, one dose twice weekly.
Common supportive regimen	*Kanchnar Guggulu* 500 mg, two tablets daily, and *Vriddhi Vadhika Vati* 250 mg, two tablets daily, for approximately 3.5-4 months.	
Documented outcome	Shorter menstrual intervals, flow 3-4 days, leucorrhoea ceased; GAGS 0; hemoglobin 10.6 g/dL with persistent anemia.	Approximately 30-day menstrual pattern, dark clots disappeared; mFG 3/36.
Follow-up ultrasound	24 June 2026: both ovaries reported normal; no significant diagnostic abnormality.	17 June 2026: both ovaries reported normal; no ascites.
Later follow-up	No later documented assessment was available; long-term sustainability could not be determined.	

Abbreviations: GAGS, Global Acne Grading System; mFG, modified Ferriman-Gallwey; POD, pouch of Douglas.

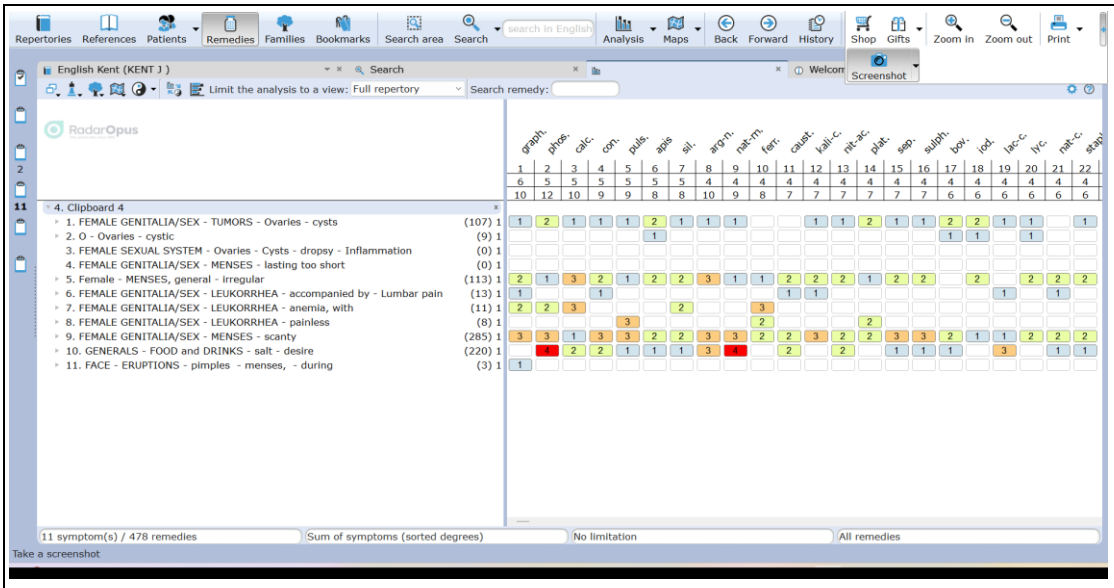


Figure 1. Computerized repertorial analysis for Case 1 showing *Graphites* as the leading remedy. Source: anonymized screenshot from the treating clinician's case record.

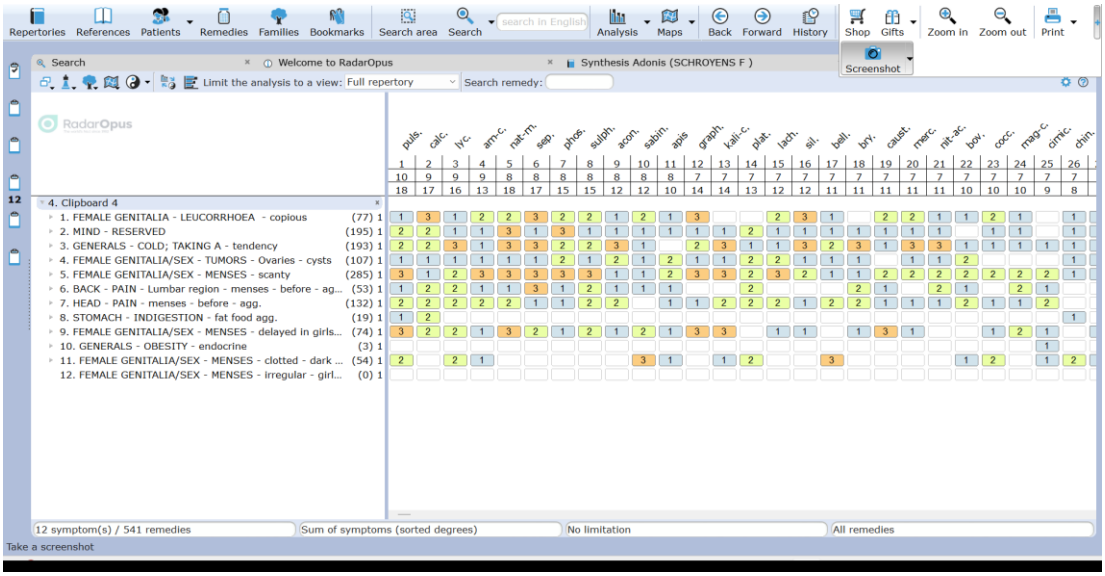


Figure 2. Computerized repertorial analysis for Case 2 showing *Pulsatilla* as the leading remedy. Source: anonymized screenshot from the treating clinician's case record.

RESULT AND DISCUSSION:

Case 1 reported shorter menstrual intervals, flow lasting approximately 3-4 days and cessation of leucorrhoea. GAGS decreased from 24 to 0. Follow-up ultrasonography dated 24 June 2026 reported an anteverted uterus measuring 58 x 26 x 45 mm, homogeneous myometrium, a free endometrial cavity,

and both ovaries normal in shape, size and echotexture. The impression was "No significant diagnostic abnormality detected." Follow-up CBC on the same date showed hemoglobin 10.6 g/dL, RBC count 3.60 million/cu.mm, packed cell volume 27.7% and MCV 77.0 fL. Hemoglobin showed only a modest increase, and anemia was not considered corrected.

Case 2 reported a more regular menstrual pattern of approximately 30 days and disappearance of dark clots. The mFG score decreased from 11/36 to 3/36. Follow-up ultrasonography dated 17 June 2026 reported a normal uterus measuring 82 x 27 x 42 mm with central endometrial thickness of 8.10 mm. Both ovaries were reported as normal at scan, and no ascites was seen. The previously described bilateral cystic ovarian morphology was not described on follow-up imaging.

The principal observation is temporal improvement in symptoms and radiology-reported ovarian morphology in both cases. GAGS and mFG provided practical clinical scoring when biochemical testing was incomplete or unaffordable. The *homoeopathic* prescriptions were individualized by repertorial analysis, while the *Ayurveda* medicines were used as supportive traditional therapy.

From an *Ayurvedic* perspective, *Kanchnar Guggulu* was prescribed in the present cases. Because manufacturer and batch details were unavailable, its traditional rationale is discussed only with reference to the classical Kancanara Guggulu formulation listed in the Ayurvedic Formulary of India. [7] Published *Ayurvedic* literature has described its use in *granthi*-like growths and has attributed *lekhana*, *shothahara* and *Vata-Kapha-shamaka* actions to it. [8] These terms represent a traditional rationale and should not be interpreted as demonstrated endocrine or biochemical mechanisms in PCOS. A scoping review of *Ayurveda* studies in women with PCOS identified *Kanchanara Guggulu* among the most frequently used compound formulations, but found heterogeneous and complex interventions and emphasized rigorous safety and adverse-event reporting. [9] *Vriddhi Vadhika Vati* was also used as supportive therapy; however, formulation-specific pharmacological effects cannot be inferred because product details were incomplete and both *Ayurveda* medicines were co-administered with individualized *homoeopathic* remedies.

FOLLOW-UP:

The last documented assessments were 24 June 2026 for Case 1 and 17 June 2026 for Case 2. At those assessments, the reported clinical improvements and normal ovarian descriptions were present. No later documented visit or post-treatment observation was available in the retrospective records; therefore, persistence of benefit beyond these dates could not be assessed. No adverse events were documented.

CONCLUSION:

In two patients with PCOS features, a combined individualized *homoeopathic* and *Ayurveda* supportive regimen was temporally associated with improvement in menstrual symptoms, clinician-recorded acne/hirsutism scores and follow-up ultrasonographic descriptions. These observations are hypothesis-generating and do not establish causality, endocrine mechanism or efficacy of either component. Prospective studies should use standardized diagnostic criteria, serial endocrine and safety assessments, verified product details and longer follow-up.

Limitation of study:

This uncontrolled retrospective series included only two patients and a combined intervention, so component-specific efficacy and causality cannot be established. Endocrine and exclusion testing was incomplete; ultrasonography was performed at different centers; the treatment products lacked manufacturer and batch documentation; and standardized adherence and safety monitoring were unavailable. Spontaneous cycle variability, adolescent maturation, lifestyle change, regression to the mean, prior/early symptomatic medication and observer variability in clinician-recorded GAGS and mFG scores are alternative explanations. Long-term durability beyond the last recorded assessments was not evaluated.

Declaration of Patient consent:

The authors certify that informed written consent was obtained from the adult patient in Case 1 and from the legal guardian of the minor patient in Case 2 for publication of anonymized clinical data and diagnostic images/reports without disclosing patient identity. The authors will provide consent documentation to the editor if requested.

Conflict of interest: The author declares that there is no conflict of interest.

Guarantor*:* The corresponding author is the guarantor of this article and its contents.

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