

SPONTANEOUS CONCEPTION FOLLOWING INDIVIDUALIZED AYURVEDIC TREATMENT IN WOMEN WITH ENDOMETRIOSIS: A RETROSPECTIVE CASE SERIES

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ABSTRACT

Background: Endometriosis is a chronic gynecological disorder associated with pelvic pain, menstrual disturbances, inflammation, and impaired fertility. Endometriosis-associated infertility can be challenging to manage, particularly in women seeking fertility-preserving approaches. Ayurveda provides a holistic approach aimed at managing the clinical manifestations of endometriosis while supporting reproductive health. **Methods:** This retrospective case series evaluated 15 women with clinically diagnosed endometriosis who underwent Ayurvedic management with the objective of improving reproductive health and achieving conception. Treatment included *Tablet Srujan*, *Tablet Vayu*, *Tablet Upaja*, and *Tablet Poshini*, along with dietary and lifestyle modifications. Patients were followed for 2–12 months, and clinical outcomes including pelvic pain, dysmenorrhea, menstrual symptoms, ovarian endometrioma size where applicable, and conception were assessed. **Results:** Following Ayurvedic treatment, patients demonstrated improvement in endometriosis-associated symptoms, including dysmenorrhea, pelvic pain, and menstrual discomfort. Regression in ovarian endometrioma size was observed in selected patients on serial ultrasonographic evaluation. During the follow-up period, all 15 patients achieved conception, including women with a history of endometriosis-associated infertility. **Conclusion:** Ayurvedic management with *Tablet Srujan*, *Tablet Vayu*, *Tablet Upaja*, and *Tablet Poshini*, together with dietary and lifestyle interventions, was associated with improvement in clinical symptoms and favorable reproductive outcomes in women with endometriosis. The observed conception outcomes suggest the potential role of Ayurveda in supporting fertility among women with endometriosis and warrant further prospective investigation.

KEYWORDS: Endometriosis, Endometriosis-associated infertility, Ayurvedic management, Ayurveda, Fertility preservation, Female infertility, Pelvic pain, Dysmenorrhea, Ovarian endometrioma.

INTRODUCTION

Endometriosis is a chronic, estrogen-dependent inflammatory disorder characterized by the presence of

endometrial-like glands and stroma outside the uterine cavity. It affects approximately 10% of women of reproductive age and up to 30–50% of women presenting

with infertility or chronic pelvic pain. The condition is commonly associated with dysmenorrhea, chronic pelvic pain, dyspareunia, dyschezia, menstrual irregularities, and subfertility, significantly impairing physical, emotional, and social well-being and adversely affecting quality of life.^[1-3]

The pathogenesis of endometriosis is complex and multifactorial, involving retrograde menstruation, immune dysfunction, chronic inflammation, angiogenesis, oxidative stress, hormonal imbalance, and genetic susceptibility. Persistent inflammation and the formation of ectopic endometrial lesions may contribute to pelvic adhesions, ovarian endometriomas, chronic pain, altered pelvic anatomy, and impaired reproductive function. These changes can adversely affect ovulation, tubal function, implantation, ovarian reserve, and overall fertility, making endometriosis an important cause of infertility among women of reproductive age.^[4]

Conventional management primarily consists of hormonal therapies, including combined oral contraceptives, progestins, gonadotropin-releasing hormone (GnRH) agonists and antagonists, as well as surgical excision or ablation of endometriotic lesions. Although these approaches may provide symptomatic relief and improve disease-related morbidity, recurrence following discontinuation of medical therapy or after surgery remains common. Hormonal therapies also suppress ovulation and are therefore unsuitable during attempts to conceive. Surgical intervention, while beneficial in selected patients, may potentially affect ovarian reserve, particularly when ovarian endometriomas are treated surgically. Consequently, there is a need for therapeutic approaches that can address endometriosis-associated symptoms while also supporting reproductive function and conception.^[5,6,7]

In Ayurveda, endometriosis does not correspond to a single disease entity but may be understood through the principles of *Artava Dushti*, *Vata-Pitta vitiation*, *Rakta Dushti*, *Granthi*, and dysfunction of the *Artavavaha Srotas*. Impaired *Agni*, accumulation of *Ama*, and derangement of *Doshas* are considered to contribute to inflammation, pain, abnormal tissue changes, and reproductive dysfunction. Ayurvedic management focuses on restoring physiological balance through approaches such as *Deepana-Pachana*, *Dosha Shamana*, *Shodhana* where indicated, Rasayana therapy, dietary and lifestyle modifications, and herbal formulations intended to support reproductive health.^[8,9]

Preliminary clinical studies and published case reports have suggested that Ayurvedic interventions may improve endometriosis-related symptoms, including pelvic pain and dysmenorrhea, while potentially supporting menstrual health and reproductive outcomes. However, clinical evidence regarding the use of Ayurveda in women with endometriosis who are attempting to conceive remains limited. In particular, there is a paucity of clinical reports describing outcomes extending from management of endometriosis-associated symptoms to achievement of conception.

The present retrospective case series was undertaken to describe the clinical and reproductive outcomes of women with endometriosis who underwent Ayurvedic treatment. The study evaluated changes in pain and menstrual symptoms, regression of ovarian endometrioma where applicable, and, most importantly, the occurrence of conception following treatment. The case series aims to contribute clinical evidence regarding the potential role of Ayurvedic management in women with endometriosis seeking to achieve pregnancy.

Table 1: Baseline Clinical Characteristics of the Patients.

Patient	Age (years)	Endometrioma	Associated Clinical Features
1	29	Yes (unilateral) 3.8 × 3.2 cm	—
2	31	Yes (unilateral) Left ovarian endometrioma, 3.5 × 3.9 cm	—
3	26	Previous right ovarian endometrioma (4.2 cm), status post laparoscopic cystectomy	History of laparoscopic cystectomy; infertility for 1.5 years
4	39	No	Right tubectomy, low AMH, previous myomectomy, anovulation, previous abortion, Endometriosis
5	26	No	—
6	28	Yes (bilateral) (3.2 × 2.9 cm and 3.5 × 2.8 cm)	Bilateral ovarian endometriomas
7	37	Yes (3.2 × 3.4 cm)	Low AMH

8	29	No	Adenomyosis
9	31	No	Adenomyosis
10	35	Yes (bilateral) (2.5 × 2.4 cm and 3.2 × 3.4 cm)	Tubal block, low AMH, bicornuate uterus
11	28	Yes (left)	PID, low AMH
12	31	No	Adenomyosis
13	38	Yes (bilateral) (2.7 × 2.4 cm and 3.2 × 3.6 cm)	Bilateral ovarian endometriomas
14	32	No	Adenomyosis
15	33	Yes (left) (1.8 × 3.4 cm)	—

Table 2: Coexisting Infertility-Related Clinical Factors Among the Patients.

Patient	Low AMH	Tubal Factor	Bicornuate Uterus	PID	Previous Ovarian Surgery	Previous Myomectomy	Anovulation	Previous Abortion
1								
2								
3					✓			
4	✓	✓				✓	✓	✓
5								
6								
7	✓							
8								
9								
10	✓	✓	✓					
11	✓			✓				
12								
13								
14								
15								

Table 3: Ayurvedic Medicines, Ingredients, and Dosage-Female.

Medicine	Ingredients	Dosage
Tablet Srujan (600 mg)	<i>Bang Bhasma, Lauha Bhasma, Shuddha Hingul, Trikatu, Yashtimadhu, Taj, Guduchi, Punarnava, Gokshur</i>	<i>Two tablets after breakfast and two tablets after dinner</i>
Tablet Vayu (500 mg)	<i>Haritaki, Triphala, Rasna, Shunthi, Ashwagandha, Gokshur</i>	<i>Two tablets at bedtime</i>
Tablet Upaja (500 mg)	<i>Kumari, Shuddha Kasis, Dalchini, Sonth, Gulkand</i>	<i>2 pills after breakfast and 2 pills after dinner</i>
Tablet Poshini (600 mg)	<i>Shuddha Hingul, Bang Bhasma, Shivlingi, Shatavari, Ashwagandha, Jivanti, Putranjivak</i>	<i>Two tablets after breakfast and two tablets after dinner</i>

Table 4: Treatment Duration and Reproductive Outcomes Following Ayurvedic Management.

Patient	Duration of Treatment	Outcome
1	6 months	Spontaneous conception
2	8 months	Spontaneous conception
3	9 months	Spontaneous conception
4	12 months	Spontaneous conception
5	1 month	Spontaneous conception
6	9 months	Spontaneous conception
7	7 months	Spontaneous conception
8	4 months	Spontaneous conception
9	2 months	Spontaneous conception
10	5 months	Spontaneous conception
11	10 months	Spontaneous conception
12	2 months	Spontaneous conception
13	2 months	Spontaneous conception
14	4 months	Spontaneous conception
15	6 months	Spontaneous conception

RESULTS

Fifteen women with endometriosis- or adenomyosis-associated infertility were included in this retrospective case series. The mean age was 31.6 ± 4.3 years (range, 26–39 years). Seven patients (46.7%) were aged 26–30 years, five (33.3%) were 31–35 years, and three (20.0%) were 36 years or older. Current ovarian endometriomas were present in 9 of 15 patients (60.0%), including four unilateral, three bilateral, and two left-sided endometriomas. One additional patient (6.7%) had a

history of laparoscopic cystectomy for a previous ovarian endometrioma, while five patients (33.3%) had no detectable endometrioma at presentation. Adenomyosis was identified in 4 patients (26.7%).

Several patients had coexisting infertility-related factors. Low ovarian reserve (low AMH) was present in 4 patients (26.7%), while tubal factor infertility was identified in 2 patients (13.3%), including one patient with a previous right tubectomy. Other associated

reproductive conditions included pelvic inflammatory disease (1/15, 6.7%), bicornuate uterus (1/15, 6.7%), previous laparoscopic ovarian cystectomy (1/15, 6.7%), previous myomectomy (1/15, 6.7%), anovulation (1/15, 6.7%), and previous abortion (1/15, 6.7%).

Patients received Ayurvedic treatment for 1–12 months, with most undergoing therapy for 4–10 months before conception. During follow-up, serial ultrasonography demonstrated a reduction in endometrioma size in patients with persistent ovarian cysts, accompanied by improvement in dysmenorrhea, chronic pelvic pain, menstrual regularity, and overall quality of life.

All 15 patients (100%) achieved spontaneous conception following individualized Ayurvedic management without requiring assisted reproductive techniques during the follow-up period.

DISCUSSION

Endometriosis is a chronic, estrogen-dependent inflammatory disorder characterized by the presence of endometrial glands and stroma outside the uterine cavity. Affecting nearly 10% of women of reproductive age, it is one of the leading causes of infertility. Women with endometriosis experience reduced fertility through multiple mechanisms, including chronic pelvic inflammation, oxidative stress, distorted pelvic anatomy, impaired tubal function, reduced ovarian reserve, altered folliculogenesis, progesterone resistance, and impaired endometrial receptivity. Consequently, many women require assisted reproductive technologies (ART); however, reproductive outcomes remain variable, particularly among women with advanced disease, ovarian endometriomas, adenomyosis, diminished ovarian reserve, or repeated unsuccessful ART cycles. Therefore, strategies that improve the reproductive environment and facilitate spontaneous conception remain an important unmet clinical need.^[1]

The pathogenesis of endometriosis is complex and multifactorial. Among the proposed mechanisms, Sampson's theory of retrograde menstruation remains the most widely accepted. According to this theory, viable endometrial cells reflux through the fallopian tubes into the peritoneal cavity during menstruation, where they implant on pelvic structures, evade immune clearance, establish a vascular supply through angiogenesis, and proliferate under the influence of estrogen. Depending on the site of implantation, these ectopic endometrial cells may involve the ovaries, resulting in ovarian endometriomas (commonly known as chocolate cysts); the fallopian tubes, where chronic inflammation may contribute to tubal dysfunction and, in rare cases, hematosalpinx; or the pelvic peritoneum, uterosacral ligaments, bowel, bladder, and other pelvic or extra-pelvic sites, collectively referred to as endometriosis. Adenomyosis, although a distinct gynecological disorder, frequently coexists with endometriosis and is characterized by the presence of endometrial glands and

stroma within the myometrium, contributing to dysmenorrhea, abnormal uterine bleeding, and infertility. Following implantation, ectopic endometrial tissue initiates a persistent inflammatory cascade characterized by increased production of prostaglandins, cytokines, chemokines, growth factors, and reactive oxygen species. This chronic inflammatory microenvironment promotes angiogenesis, fibrosis, neurogenesis, progesterone resistance, and adhesion formation, ultimately resulting in chronic pelvic pain, ovarian dysfunction, impaired tubal transport, reduced endometrial receptivity, and subfertility.^[2-7]

In the present retrospective case series, the primary objective of Ayurvedic management was restoration of fertility and achievement of spontaneous conception in women with endometriosis-associated infertility, rather than treatment of endometriosis as an isolated disease. Although improvements in dysmenorrhea, pelvic pain, menstrual discomfort, and regression of ovarian endometriomas were observed in several patients, these represented supportive clinical benefits. The principal outcome was successful spontaneous conception following Ayurvedic treatment, suggesting that optimization of the reproductive environment may contribute to improved fertility even in women presenting with additional factors such as low AMH, adenomyosis, tubal pathology, previous ovarian surgery, or recurrent endometriomas.^[8,9]

These findings are consistent with emerging evidence suggesting that individualized Ayurvedic interventions may support fertility in women with endometriosis-associated infertility. Although published evidence remains limited to case reports and observational studies, improvements in reproductive outcomes, including spontaneous conception, have been reported following comprehensive Ayurvedic management. Rather than focusing solely on lesion regression, these studies emphasize restoration of reproductive function, which aligns with the primary objective of the present case series.

From an Ayurvedic perspective, endometriosis does not correspond to a single disease entity but may be understood through the concepts of *Artava Dushti*, *Vata-Pitta vitiation*, *Rakta Dushti*, dysfunction of the *Artavavaha Srotas*, and accumulation of *Ama*. Vitiation of *Vata* is considered responsible for severe pain, abnormal movement of *Artava*, and reproductive dysfunction, while aggravated *Pitta* and *Rakta* contribute to inflammation, congestion, excessive bleeding, and tissue irritation. Impaired *Agni* leads to the accumulation of *Ama*, perpetuating chronic inflammation and abnormal tissue proliferation. Accordingly, Ayurvedic management aims to restore Dosha balance, improve *Agni*, eliminate *Ama*, normalize *Artava*, reduce inflammation, and promote healthy reproductive tissue function through individualized herbal formulations,

dietary regulation, lifestyle modifications, and Rasayana therapy.^[8,9]

The favorable clinical outcomes observed in the present case series are likely attributable to the complementary and synergistic actions of the prescribed Ayurvedic formulations, each targeting a distinct aspect of endometriosis pathophysiology. *Tablet Srujan* was primarily prescribed to facilitate the resolution of abnormal tissue deposition and chronic inflammatory lesions. It contains *Bang Bhasma*, *Lauha Bhasma*, *Shuddha Hingul*, *Trikatu*, *Yashtimadhu*, *Taj*, *Guduchi*, *Punarnava*, and *Gokshur*, ingredients traditionally recognized for their anti-inflammatory, antioxidant, tissue-regenerative, and microcirculation-enhancing properties. Collectively, these ingredients may help reduce chronic inflammation, improve local tissue metabolism, facilitate the resolution of ectopic endometrial deposits, and minimize fibrosis and adhesion formation.^[10,11]

Tablet Vayu was administered to address the underlying pathogenic mechanisms by correcting Vata imbalance, which is considered central to pelvic pain, dysmenorrhea, abnormal movement of Artava, and chronic pelvic congestion. The formulation contains *Haritaki*, *Triphala*, *Rasna*, *Shunthi*, *Ashwagandha*, and *Gokshur*, herbs known for their anti-inflammatory, analgesic, antioxidant, adaptogenic, and digestive-enhancing properties. By improving *Agni*, reducing *Ama*, regulating *Apana Vata*, and alleviating chronic inflammation, *Tablet Vayu* may help address the root cause of disease progression while providing sustained symptomatic relief. *Tablet Upaja* was incorporated to improve ovulatory function and normalize menstrual physiology. The formulation contains *Kumari*, *Shuddha Kasis*, *Dalchini*, *Sonth*, and *Gulkand*, ingredients traditionally used to regulate ovulation, enhance pelvic circulation, improve endometrial health, and support healthy follicular development. By optimizing ovarian function and menstrual physiology, the formulation may contribute to improved fertility outcomes in women with endometriosis-associated infertility. *Tablet Poshini* was prescribed as a comprehensive female reproductive tonic to improve overall reproductive health and fertility potential. It contains *Shuddha Hingul*, *Bang Bhasma*, *Shivlingi*, *Shatavari*, *Ashwagandha*, *Jivanti*, and *Putranjivak*, ingredients well recognized in Ayurveda for their Rasayana and reproductive-supportive properties. These herbs possess antioxidant, adaptogenic, immunomodulatory, and endocrine-supportive activities that may enhance ovarian function, improve endometrial receptivity, maintain hormonal balance, reduce oxidative stress, and support healthy reproductive tissue function.^[10,11]

From a contemporary biomedical perspective, oxidative stress, immune dysregulation, and chronic inflammation are central to the initiation and progression of endometriosis. Persistent inflammatory signaling

promotes lesion survival, angiogenesis, fibrosis, and pain sensitization, thereby perpetuating disease progression. Many of the herbal ingredients included in the present treatment protocol possess documented anti-inflammatory, antioxidant, immunomodulatory, analgesic, and adaptogenic properties, providing a plausible biological basis for the clinical improvements observed. The integrated therapeutic approach employed in this case series therefore appears to address both the underlying inflammatory processes and the reproductive dysfunction associated with endometriosis.

Overall, the improvements observed in this case series are likely attributable to the synergistic effects of the individualized Ayurvedic treatment protocol rather than the action of any single formulation. By simultaneously targeting chronic inflammation, abnormal ectopic tissue deposition, pelvic pain, ovulatory dysfunction, oxidative stress, and impaired reproductive physiology, while restoring the Ayurvedic principles of *Dosha* balance and healthy *Artava*, the treatment protocol offers a comprehensive and holistic approach to the management of endometriosis.

CONCLUSION

This retrospective case series demonstrates that individualized Ayurvedic management comprising *Tablet Srujan*, *Tablet Vayu*, *Tablet Upaja*, and *Tablet Poshini*, together with personalized dietary and lifestyle modifications, was associated with favorable clinical and reproductive outcomes in women with endometriosis, adenomyosis or chocolate cyst. Patients experienced improvement in endometriosis-related symptoms, regression of ovarian endometriomas in selected cases, and successful spontaneous conception following 2–12 months of treatment.

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