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Case Report

Spontaneous regression of uterine fibroids in a perimenopausal woman: a case report on alternative approaches to symptom management

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ABSTRACT

Uterine fibroids are the most common benign tumours in females, with the highest incidence in women aged 35 to 45 years. Although conventional treatments typically involve hormonal therapy, myomectomy, or hysterectomy, some patients seek non-surgical alternatives due to concerns about invasiveness, fertility preservation, or personal preferences. This case is notable for its use of an indigenous remedy, Lachesis, traditionally derived from snake venom, as a complementary treatment in managing symptomatic uterine fibroids. The novelty lies in the documented improvement following this alternative therapy, providing a potential avenue for further exploration in non-surgical management. A 40-year-old female presented with a three-year history of irregular, heavy, and painful menstrual cycles. Imaging studies revealed multiple uterine fibroids involving the body and posterior wall of the uterus, with subserosal extension. Despite multiple surgical recommendations, the patient declined operative intervention and instead pursued an indigenous treatment plan. She initiated therapy with Lachesis, an indigenous remedy known for its use in hormonal and circulatory disorders, after ensuring compatibility with tranexamic acid, which was prescribed for bleeding control. Over time, she reported progressive symptom relief, including reduced menstrual pain and improved cycle regularity. Serial follow-up ultrasounds showed a decrease in fibroid size, correlating with clinical improvement. Her medical history was notable for left oophorectomy in 2015 and a family history of fibroids, with both her mother and sister affected, the former undergoing hysterectomy and the latter opting for conservative management. This case suggests the potential of an indigenous, non-surgical approach in managing uterine fibroids, particularly in patients who refuse surgery. Although the precise mechanism of action of Lachesis in fibroid regression remains uncertain, its association with symptomatic and radiological improvement indicates a possible therapeutic role. These findings support the need for more rigorous investigation into alternative and complementary therapies. As patient demand grows for non-invasive treatment options, such cases underscore the importance of further clinical studies to evaluate efficacy, safety, and integration of traditional remedies into modern gynaecological care.

Keywords: Uterine fibroids, Lachesis, Alternative medicine, Fibroid regression, Perimenopausal health, Non-surgical treatment, Holistic therapy

INTRODUCTION

Uterine fibroids, also known as leiomyomas, are the most prevalent benign solid tumours affecting women, particularly during their reproductive and perimenopausal years. It is estimated that up to 20% of women by the age of 30 have fibroids, with peak prevalence between the ages of 35 and 45. These hormone-dependent growths are primarily influenced by estrogen and other hormonal factors, often resulting in symptoms such as heavy menstrual bleeding, pelvic pain, and reproductive challenges.[1] Conventional treatment strategies for uterine

fibroids vary based on symptom severity, size, and patient preference. They include watchful waiting, pharmacological therapies such as hormonal modulators and antifibrinolytics like tranexamic acid, as well as surgical interventions like myomectomy or hysterectomy. However, surgery, particularly hysterectomy, is often seen as the definitive treatment, leaving patients with limited non-invasive options. As a result, many women seek complementary and alternative therapies to manage symptoms and avoid surgery.[2,3]

This case report presents a 40-year-old woman diagnosed with multiple uterine fibroids who experienced irregular, heavy, and painful menstruation for three years. Despite being advised to undergo surgical intervention by multiple gynecologists, she declined surgery and chose to pursue an indigenous treatment using Lachesis, a remedy derived from snake venom and traditionally used to manage hormonal and circulatory imbalances. Her concurrent use of tranexamic acid was carefully reviewed to avoid interactions.[4]

Follow-up ultrasound revealed a reduction in the size of her fibroids, suggesting a potential therapeutic effect of the alternative treatment. Although the precise mechanism of Lachesis remains uncertain and lacks robust clinical validation, such cases prompt further investigation into its role in fibroid management. This case highlights the importance of exploring integrative approaches, particularly for patients who are not candidates for or decline surgical options, and underscores the potential of alternative medicine in addressing perimenopausal health concerns.

CASE REPORT

A 40-year-old Indian female was referred for pelvic ultrasound by her gynecologist after presenting with a 3-year history of irregular, heavy, and painful menstruation. The menstrual flow was profuse, occurred at irregular intervals, and was accompanied by significant lower abdominal discomfort during menses. Pelvic ultrasound confirmed the presence of multiple uterine fibroids, primarily involving the uterine body and posterior wall, some with subserosal extension abutting the endometrium.

Despite consulting multiple gynecologists, all of whom advised surgical intervention, the patient declined operative management. After confirming with her gynecologist that there would be no negative interaction with her prescribed tranexamic acid (used to manage bleeding), she opted for alternative indigenous treatment, including the Lachesis remedy.

The patient has been married for 20 years and is gravida 3, para 3, with all three offspring living. She underwent a left oophorectomy in 2015.Her family history is notable for uterine fibroids in first-degree relatives. Her mother was diagnosed with uterine fibroids and underwent hysterectomy approximately 20 years ago. Her elder sister has also been diagnosed with uterine fibroids and is currently receiving symptomatic management.

On general evaluation, bowel habits are regular, and urinary function is normal, with clear urine and no dysuria. She reports frequent episodes of hot flushes accompanied by profuse sweating, described as recurrent and exhausting in nature. Her menstrual cycles occur at intervals of 35–45 days and last for 6–8 days, with profuse flow characterized by dark brown to blackish discharge. On physical examination, pallor is present. Vital signs are stable, with a blood pressure of 110/74 mm Hg and a regular pulse rate of 88 beats per minute.

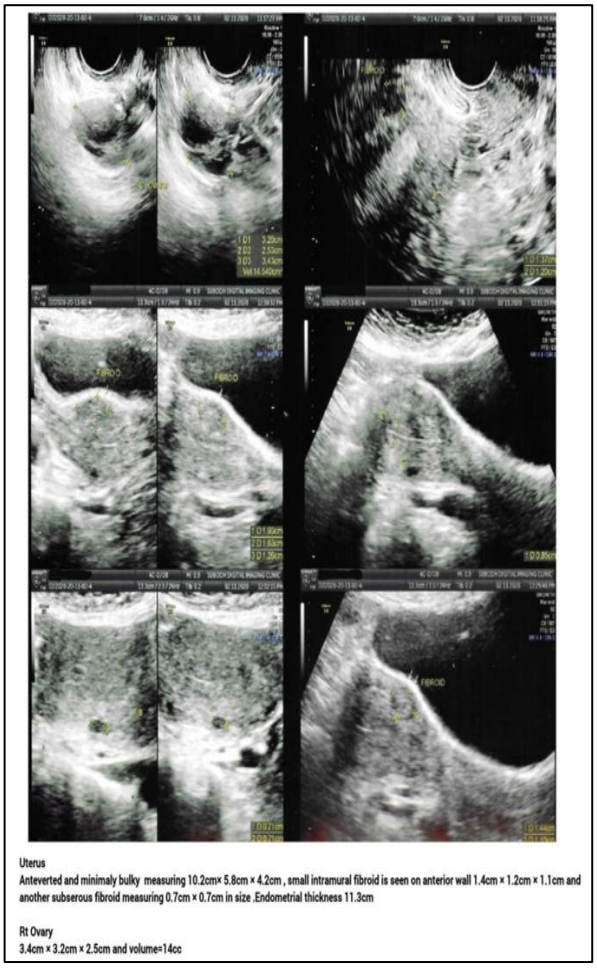

Figure 1: USG taken on 2 November 2020.

Ultrasonographic evaluation revealed two discrete leiomyomatous lesions. An intramural fibroid measuring 1.4×1.2×1.1 cm was identified within the anterior uterine wall. In addition, a smaller subserosal fibroid measuring 0.7×0.7 cm was observed along the uterine wall (Figure 1). These findings are consistent with localized benign smooth-muscle proliferations contributing to the patient's symptomatology.

To quantify menstrual blood loss, a Modified pictorial blood loss assessment chart (PBAC) was applied based on detailed clinical history. The patient reported menstrual

cycles lasting 6–8 days at intervals of 25–35 days, with profuse flow described as dark brown to blackish in color. Passage of clots and the need for frequent sanitary pad changes during each cycle were also noted, indicating substantial blood loss. Clinical examination further demonstrated pallor and fatigue, findings consistent with chronic blood loss and probable secondary anaemia. Integrating these parameters, the estimated PBAC score ranged between 150 and 190, significantly exceeding the diagnostic threshold score of 100 for menorrhagia. This scoring supports the classification of moderate to severe menstrual blood loss and substantiates the diagnosis of abnormal uterine bleeding secondary to uterine fibroids, warranting therapeutic intervention.

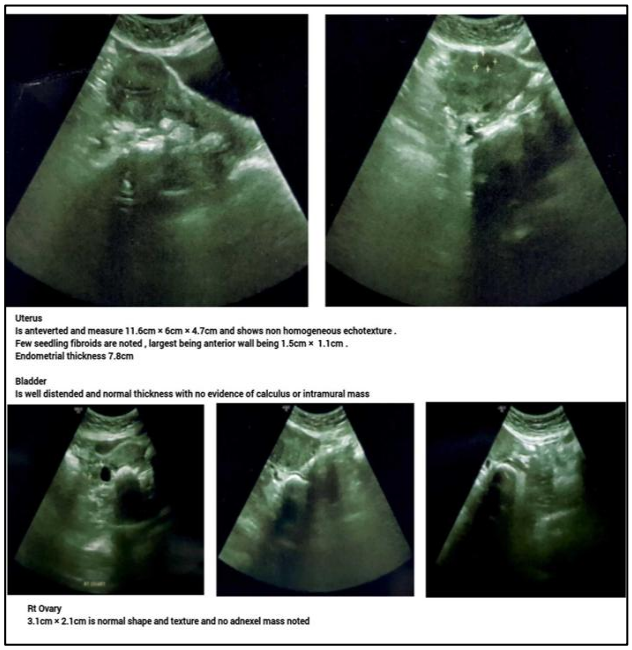

Figure 2: USG taken on 3 May 2023.

Hormonal profile interpretation suggested a perimenopausal endocrine pattern. Estrogen (E2) levels were fluctuating to declining, a pattern typical of the menopausal transition; given the estrogen-dependent nature of fibroid growth, such variation remains clinically relevant. Progesterone levels were reduced, consistent with luteal phase insufficiency, a factor that may exacerbate fibroid-related symptoms. Follicle-stimulating hormone (FSH) levels were rising, suggestive of diminishing ovarian reserve, while luteinizing hormone (LH) demonstrated variability, a less diagnostically specific but recognized perimenopausal feature. Anti-müllerian hormone (AMH) levels were low, reflecting ovarian aging in the context of both chronological age and prior unilateral oophorectomy.

Based on clinical, radiological, and hematological correlation, the provisional diagnoses included uterine fibroids (ICD-11 Code:2E86.0) and abnormal uterine bleeding (ICD-11 Code:GA34.3). Diagnostic reasoning was grounded in the presence of profuse uterine bleeding in a perimenopausal patient, accompanied by pallor and imaging-confirmed fibroid pathology, supporting the dual diagnosis. From a pathophysiological standpoint, the patient's hormonal milieu appeared to be transitioning toward menopause. While the natural decline in estrogen during this phase is known to reduce fibroid growth, hormonal transition alone does not fully account for the degree of clinical regression observed, indicating the likelihood of additional modifying factors.

Treatment intervention

This remedy is often prescribed for women with uterine fibroids who experience worsening symptoms before menstruation. Lachesis, derived from the venom of the South American pit viper *Lachesis muta*, has been explored in some studies for its potential antiproliferative effects, particularly in relation to cancer cells. As per alternate indigenous therapeutic practices, including Lachesis, are primarily used for symptomatic treatment in alternative medicine, there is some interest in the pharmacological actions of Lachesis venom, especially in terms of its ability to influence cellular behaviour. The anti-proliferative function refers to the ability of a substance to inhibit or reduce the growth and multiplication of cells, including cancer cells. In relation to Lachesis, its venom contains various proteins and enzymes that might impact cell growth, potentially offering a mechanism for reducing cellular proliferation.

Research has indicated that venom from certain snake species, including *Lachesis muta*, contains molecules that can have anti-cancer properties, such as the inhibition of cell division and apoptosis (programmed cell death) in tumour cells. This has sparked interest in Lachesis as a potential source for developing treatments that could stop the uncontrolled cell growth characteristic of cancer. However, it is important to note that these effects are typically studied in a more traditional pharmacological or laboratory setting, and the homeopathic use of Lachesis, in which it is highly diluted, is far removed from these direct mechanisms. The reduction in the size of the fibroids as detected on the ultrasound in a 40-year-old female could be due to various factors, and it's important to understand that this could involve a combination of influences. In the case of Lachesis, the explanation could be viewed from a few different perspectives:

Action of Lachesis

Therapeutic remedies like Lachesis are believed to stimulate the body's healing mechanisms, potentially addressing hormonal imbalances or circulatory issues that can contribute to the growth of fibroids. Lachesis is traditionally thought to help with conditions exacerbated by hormonal fluctuations, particularly in women, which could include uterine fibroids. It may also have an indirect effect on reducing symptoms like pain or swelling. In indigenous medicine the principle is that the body's vital force (or energy) is rebalanced, which can help reduce the

size or symptoms of fibroids, though the mechanism of this action is not well-understood scientifically.

Hormonal regulation

Fibroid growth is influenced by hormones, particularly estrogen. Treatments using Lachesis are sometimes used with the aim of restoring hormonal balance. If the remedy successfully influenced hormonal regulation, it might lead to a reduction in fibroid size. Lachesis could also impact blood flow and circulation, which might influence the growth of fibroids, especially if they are vascularized (having a lot of blood vessels).

Table 1: Therapy table with USG findings.

Date	Findings and examinations	Medications
02/11/2020	Menses profuse and blackish. Frequent hot flushes with sweating for 3 days. LMP-(27/10/2020 to 01/11/2020) USG-1.4 cm×1.2 cm×1.1 cm (intramural fibroid) 0.7 cm×0.7 cm (subserosal fibroid)	Placebo 200/4 doses OD×8 weeks
08/01/2021	Menses moderate in amount. Pain in the lower abdomen during menses is less than before. LMP-(02/01/2021 to 07/01/2021)	Lachesis 1 m/1 dose OD×1 day Placebo 200/4 doses×8 weeks
17/04/2021	Hot flushes frequent and exhausting. LMP-(10/04/2021 to 17/04/2021)	Placebo 200/4 doses OD×8 weeks
10/07/2021	Frequent exhausting hot flushes with sweating. LMP- (05/07/2021 to 09/07/2021) USG-1.9 cm×1.7 cm×1.8 cm (intramural fibroid with multiple other fibroids, volume 3 CC)	Placebo 200/4 doses OD×8 weeks
13/10/2021	Frequent hot flushes with sweating. LMP-(07/10/2021 to 13/10/2021)	Lachesis 1 m/1 dose OD×1 day Placebo 200/4 doses×8 weeks
27/02/2022	Frequent hot flushes. LMP-(22/02/2022 to 27/02/2022)	Placebo 200/4 doses OD×8 weeks
19/04/2022	Frequent hot flushes. LMP-(11/04/2022 to 16/04/2022)	Placebo 200/4 doses OD×8 weeks
21/12/2022	Frequent hot flushes. LMP-(16/12/2022 to 21/12/2022)	Placebo 200/4 doses OD×8 weeks
03/05/2023	Hot flushes. LMP-(26/04/2023 to 02/05/2022) USG-1.5 cm×1.1 cm (largest fibroid with other smaller seedlings seen)	Lachesis 10 m/1 dose OD×1 day Placebo 200/4 doses×8 weeks
11/06/2023	Frequent hot flushes. LMP-(04/06/2023 to 09/06/2023)	Placebo 200/4 doses OD×8 weeks

Table 2: Table with dates of USG scan and fibroid impressions.

Dates of ultrasound sonography scans	Size of fibroids
02/11/2020	1.4 cm×1.2 cm×1.1 cm (intramural fibroid) 0.7 cm×0.7 cm (subserosal fibroid (Figure 1)
10/07/2021	1.9 cm×1.7 cm×1.8 cm (intramural fibroid with multiple other fibroids, volume 3 CC)
03/05/2023	1.5 cm×1.1 cm (largest fibroid with other smaller seedlings seen) (Figure 2)

Spontaneous regression of fibroids

While less common, fibroids can sometimes shrink on their own, especially during perimenopause and menopause, when hormone levels fluctuate or decrease. If the individual was approaching menopause, this could explain a natural reduction in the size of the fibroid. The size reduction could also be related to changes in lifestyle, diet, or medical treatments unrelated to the prescribed remedy, or it could be a natural course of the fibroid's progression.

Placebo effect

It is also worth considering that the placebo effect could contribute to a perceived reduction in the size of the

fibroid. If the patient believed that the treatment with Lachesis would work, their body might respond positively to that belief, leading to symptom improvement or a perceived reduction in fibroid size.

Interventions and outcomes

The reduction in the size of fibroids in a 40-year-old woman could be due to various factors, including the action of Lachesis, hormonal regulation, natural regression of fibroids, or the placebo effect (Table 1) (Table 2). While there is some interest in Lachesis for its potential to address fibroid-related symptoms, more research is needed to confirm its direct effects on fibroid growth. It is important for individuals with fibroids to consult with a healthcare provider to determine the most appropriate treatment based on the severity of symptoms, fibroid characteristics, and overall health (Figure 2).

In this case, fibroid size increased during the early observational period but showed a measurable decrease in size and associated symptom relief only after the administration of Lachesis, particularly at higher potencies, suggesting a temporal association between the homeopathic remedy and fibroid regression. Given the known circulatory and hormonal balancing indications of Lachesis in indigenous systems of medicine, its targeted use aligned with perimenopausal symptomology supports the likelihood that Lachesis played a contributory therapeutic role in the fibroid's regression.

Confounding factors

Perimenopausal transition represents a phase of natural hormonal decline characterized by fluctuating and progressively decreasing estrogen and progesterone levels. Given that uterine fibroids are hormonally responsive particularly estrogen-dependent—this endocrine shift may contribute to spontaneous regression or stabilization of fibroid growth. In the present context, the patient's prior left-sided oophorectomy is also clinically relevant, as unilateral ovarian removal results in partial reduction of overall ovarian hormone production. This diminished estrogenic stimulation may further attenuate fibroid proliferation. Additionally, a placebo effect mediated by strong therapeutic belief cannot be entirely excluded; such psychobiological responses may influence subjective symptom relief, particularly in domains such as perceived pain intensity and vasomotor symptoms including hot flushes.

Dietary and lifestyle modifications may also have played a contributory supportive role. Symptom-driven behavioural changes—such as improved nutrition, weight regulation, or stress reduction—can indirectly influence hormonal balance and inflammatory pathways, thereby modulating symptom expression even in the absence of direct structural fibroid reduction. Pharmacological history is likewise pertinent. The initial prescription of tranexamic acid, an antifibrinolytic agent, would be expected to reduce menstrual blood loss by stabilizing clot formation within the endometrium. However, it bears emphasis that while effective for controlling haemorrhagic symptoms, tranexamic acid does not exert a shrinking effect on fibroid size and therefore does not modify the underlying leiomyomatous pathology.

Finally, technical considerations in imaging interpretation must be acknowledged. Ultrasonographic assessment is inherently operator-dependent, and measurement variability can occur, particularly when evaluating small fibroids. Differences in probe angulation, imaging planes, or examiner experience may influence dimensional accuracy, introducing the possibility of apparent size variation that reflects methodological rather than biological change.

While spontaneous regression of uterine fibroids in perimenopausal women is a recognized phenomenon, the temporal association between Lachesis administration and both symptom improvement and documented reduction in fibroid size alongside the patient's avoidance of other fibroid-shrinking interventions suggests that Lachesis likely contributed to the therapeutic outcome. However, natural hormonal shifts and other confounding factors should be acknowledged as potential co-contributors.

DISCUSSION

Definite aetiology still remains unknown. Although Estrogen, growth hormone and possibly human placental lactogen (HPL) are related to their growth, there is strong evidence in support of estrogen dependence. The tumour is estrogen dependent with estrogen receptors and develops during reproductive age. The association of fibroids in women with hyperestrogenism is evidenced by endometrial hyperplasia, dysfunctional metropathic bleeding and endometrial carcinoma. It's mostly seen in the 30 and 40 years old-but they may develop at any age and are rarely found before puberty. New myomas rarely appear after menopause.[4] They are seen more commonly in black people than in white. They also tend to show up earlier and grow quicker in black people.[5] Heredity is also an important factor as it's known to run in families. In many people they remain passively during their life span and they may not even know about their presence, because they often cause no symptoms. Sometimes they are accidentally discovered during routine pelvic examination or pregnancy or routine imaging procedures like ultrasound.

A myoma is derived from the smooth muscle cell and rests either from vessel walls or uterine musculature. Myomas are known to increase in size during pregnancy and with oral contraceptives. Progesterone is known to inhibit the growth of myomas and large doses of progestogens orally for 14 to 21 days of the cycle causes shrinkage of the tumour. GnRH also causes shrinkage of the tumour. The presence of myoma causes hyperplasia of the myometrial

wall. The cavity of the uterus is often distorted and enlarged.[5]

A uterine myoma is typically a well-circumscribed benign tumour characterized by a distinct pseudo capsule and firm consistency. On gross examination, the cut surface appears pinkish-white with a characteristic whorled pattern. The surrounding capsule is composed of connective tissue that anchors the tumour to the adjacent myometrium. Microscopically, the lesion consists of interlacing bundles of smooth muscle cells separated by varying amounts of fibrous connective tissue. In certain cases, areas resembling embryonic muscle tissue may also be identified, reflecting variations in cellular differentiation within the tumor.[6]

Fibroids may undergo several secondary changes and degenerative processes over time. Commonly observed alterations include atrophy, calcareous degeneration, and red degeneration. Sarcomatous transformation is exceedingly rare, occurring in approximately 0.5% of all myomas. Additional complications that warrant clinical vigilance include torsion (particularly in pedunculated fibroids), uterine inversion, capsular haemorrhage, infection, and, in some instances, coexistence with endometrial carcinoma. Recognition and evaluation of these complications are essential in comprehensive patient assessment.

Clinically, many individuals with uterine fibroids remain asymptomatic, with lesions often detected incidentally during routine gynaecological examination or imaging performed for unrelated indications. When symptoms do occur, their nature and severity depend largely on the fibroids' size, number, and anatomical location. The most frequently reported manifestation is abnormal menstruation, particularly heavy, prolonged, and sometimes painful periods. It is noteworthy that subserosal and pedunculated fibroids rarely cause menorrhagia, whereas intramural and submucosal fibroids are more commonly associated with progressive metrorrhagia due to increased endometrial vascularity. Polymenorrhoea may occur when fibroids coexist with cystic ovarian disease or pelvic inflammatory disease, while submucosal fibroids are particularly associated with metrorrhagia. Infected polyps may additionally produce purulent vaginal discharge. Importantly, metrorrhagia in women above 40 years necessitates dilatation and curettage to exclude endometrial malignancy.[7]

Pain is another significant symptom, commonly localized to the lower abdomen, pelvis, or back, and may vary in character, with stabbing pain frequently described. Acute severe pain can occur when a fibroid outgrows its blood supply, leading to degeneration. Torsion, haemorrhage, and red degeneration are recognized causes of sudden pain, while rapid fibroid growth accompanied by pain in elderly women raises suspicion for sarcomatous change. Expanding fibroids may also produce abdominal distension, rectal discomfort, constipation, or rarely intestinal obstruction due to bowel entrapment around a pedunculated mass. Dyspareunia, urinary frequency from bladder compression, and symptoms of anaemia such as weakness and palpitations may also be present.

The etiopathogenesis of uterine fibroids is multifactorial and not yet fully elucidated. Hormonal influence plays a central role; estrogen and progesterone, which regulate endometrial proliferation during the menstrual cycle, are known to promote fibroid growth. Genetic predisposition is also significant, with increased risk observed in individuals with a positive family history. Pregnancy, through heightened estrogen and progesterone production, may further stimulate fibroid enlargement. Additional contributory factors include obesity and dietary patterns particularly diets high in red meat and low in green vegetables, fruits, and dairy products which have been associated with increased risk.

Management of uterine fibroids is individualized and depends on symptom severity, fibroid characteristics, and reproductive intentions. Asymptomatic patients may be managed conservatively through watchful waiting with periodic monitoring. Pharmacological therapy includes hormonal agents such as combined oral contraceptives and gonadotropin-releasing hormone (GnRH) agonists, which help control menorrhagia and may reduce fibroid volume. Fertility-preserving minimally invasive interventions include uterine artery embolization, myomectomy, and focused ultrasound surgery. In cases of severe symptoms or when fertility preservation is not desired, hysterectomy remains the definitive treatment. Endometrial ablation may be employed to address heavy menstrual bleeding in selected cases. Complementary and indigenous medical systems additionally propose holistic therapeutic approaches aimed at symptom relief and constitutional balance, though such modalities require critical evaluation within evidence-based frameworks.[8]

CONCLUSION

This case highlights the successful management of symptomatic uterine fibroids and associated abnormal uterine bleeding in a 40-year-old perimenopausal female using the indigenous remedy, Lachesis, as a non-surgical alternative. Faced with persistent recommendations for operative intervention, the patient achieved progressive symptomatic relief—including regularized menstrual cycles and reduced pelvic discomfort—alongside objective, radiologically documented regression of fibroid dimensions.

While the exact biological mechanisms of Lachesis remain to be fully elucidated, the close temporal correlation between its high-potency administration and the subsequent clinical improvement suggests a viable therapeutic role. It is imperative to acknowledge the interplay of confounding factors inherent to this case, specifically the patient's natural perimenopausal transition, a history of unilateral oophorectomy, and the baseline use

of tranexamic acid for immediate haemorrhage control. Nonetheless, these factors alone do not entirely account for the distinct timeline of structural regression observed after the initiation of the alternative therapy.

As global patient demand escalates for non-invasive treatments that preserve fertility and bodily integrity, this case underscores the value of exploring holistic and traditional modalities. Ultimately, these findings emphasize the need for rigorous, well-designed clinical trials to validate the safety, efficacy, and pharmacological pathways of Lachesis, paving the way for its potential integration into evidence-based, patient-centred gynaecological care.

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