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Case Report

Management of polycystic ovarian syndrome using individualized homoeopathic medicine: a case report

Rajdeep Lahiri[1]*, Rupali Bhaduri[1], Arnab Ranjan Das[2], Abhishek Gupta[1]

[1]Department of Practice of Medicine, The Calcutta Homoeopathic Medical College and Hospital, Kolkata, West Bengal, India
[2]Department of Organon of Medicine and Homoeopathic Philosophy, The Calcutta Homoeopathic Medical College and Hospital, Kolkata, West Bengal, India

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***Correspondence:**
Dr. Rajdeep Lahiri,
E-mail: rajdeep.swords@gmail.com

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ABSTRACT

Polycystic Ovary Syndrome (PCOS) is a very common endocrine disorder affect mainly women of reproductive age group. It was described by Stein and Leventhal in 1935, a syndrome manifested by amenorrhea, hirsutism and obesity associated with enlarged polycystic ovaries. Clinical manifestations include infertility, anovulation, metabolic and psychological dysfunction. This is a case of 24 years old female suffering from PCOS with complaints of irregular menstruation, visited the outpatient department of The Calcutta Homoeopathic Medical College and Hospital, Kolkata, West Bengal, was treated with individualized homoeopathic medicine and repetition was done as per necessity. The improvement was evident by her menstrual cycle regularity and from ultrasonography (USG) reports having reduction of ovary size to normal with normal menstrual flow.

Keywords: Polycystic ovary syndrome, Individualized homoeopathic medicine, Infertility, Hirsutism, Anovulation

INTRODUCTION

Polycystic ovary syndrome (PCOS) is a most common and most prevalent endocrine disorder characterized by high androgen levels, ovulatory dysfunction, infertility, insulin resistance etc. These changes often manifest as hyperandrogenism manifested as scalp hair loss, acne, hirsutism etc. or sometimes in combination. PCOS is established as a metabolic condition now associated with cardiovascular diseases, type 2 diabetes mellitus, obstructive sleep apnea (OSA), endometrial cancer, metabolic dysfunction and sometimes associated with psychological disorders.[1]

Delay in diagnosis can cause the progression of comorbid conditions, hampering lifestyle interventions which will complicate the chances of improvement of quality and life and PCOS features.

Etiology

PCOS is a multifactorial and polygenic condition having strong association of epigenetic factors. This heterogenous disorder is mainly due to excessive androgen production by the ovaries, upregulation of enzymes in androgen biosynthetic pathology, dysregulation of CYP11a gene.[2,3]

Twin studies have shown to have an estimation of about 70% of the PCOS pathogenesis is attributed to genetic components.[4] Epigenetic factors such as obesity affect hypermethylation in ovary granulosa cells, hence inhibiting gene expression. Some hypotheses also include

foetal androgen exposure can be a potential etiology though this is not yet established and needs validation.[5]

Epidemiology

PCOS is the most common endocrine disorder in reproductive age group of females, worldwide affecting between 5% and 26% of females. Rotterdam criteria, the most commonly used criteria used prevalence studies. The Revised Rotterdam Criteria by the Androgen Excess Society (RCAES) are more sensitive in identifying the PMOS phenotype with polycystic ovarian morphology (PCOM) and infertility than the Rotterdam criteria.[6] As per the NIH 2012 workshop report, PCOS is estimated to have affected about 5 million reproductive-aged females in the United States. Studies have suggested a higher prevalence of PCOS found among Mexican Americans than among non-Hispanic whites and African Americans.[7,8]

The global burden of the disease is increasing rapidly. In 2019, an age standardised point prevalence of 1677.8 per 100 000 and an annual incidence of 59.8 per 100 000 population reported as per data from 204 countries, representing increases of 30.4% and 29.5%, respectively, since 1990.[9]

Pathophysiology

The exact etiology of PCOS is far from clear. The pathophysiology of PCOS depends on multifactorial causes and is a complex one, with aberrations in insulin resistance, ovarian steroidogenesis, anti-mullerian hormone (AMH) and luteinizing hormone (LH) excess resulting due to hypothalamic-pituitary-ovarian (HPO) axis dysfunction. These pathways interact in various ways at various points. However, as per recent literature it is recognized as a metabolic disease. The link between excess androgen and hyperinsulinemia is an essential pathogenetic feature.[10]

Background cause behind this dysregulation involves hyperinsulinemia due to insulin resistance, seen in 70% of females with PCOS.[11] Familial studies show that PCOS exhibits higher prevalence first-degree relatives. A study revealed that 35% of premenopausal women having PCOS had female siblings affected equally by the ailment, and 40% of those female siblings were also diagnosed with the same condition.[12] A separate study indicated that 22% of the female siblings of women with PCOS were similarly affected, while 24% displayed hyper-androgenemia.[13] Genetic factors are more important in the etiology of PCOS, with many gene variants directly linked to its development. About 241 gene variants are associated with PCOS, including single nucleotide polymorphisms (SNPs).[14]

Adipose tissue causes ovarian theca cells to promote and increase androgen production, resulting in hyper-androgenemia. Insulin resistance leads to type 2 diabetes and obesity, which aggravates irregularities in menstruation, infertility, anxiety and melancholy with other psychosocial disorders. Changes in gonadotropin-releasing hormone (GnRH) secretion from the hypothalamus lead to abnormal synthesis in androgen, hence promoting the advancement of insulin resistance. Abnormalities in GnRH synthesis increase luteinizing hormone (LH) levels and decrease follicle-stimulating hormone (FSH) levels.[15] Insulin collaborates with LH to increase the synthesis of androgen in the ovarian theca cells.[16] Additionally, the adrenal cortex releases androgens, and hypersecretion of adrenocorticotropic hormone (ACTH) may result in increased androgen synthesis in the adrenal glands.[17] Hyper-androgenemia makes the maturation of ovarian follicles difficult, resulting in the formation of multiple tiny antral follicles, subsequently leading to anovulation. Estrogen is produced by the excessive testosterone levels by the aromatase enzyme in peripheral adipose tissue, hence there will be reduced progesterone and excessive estrogen levels.[18,19] Infertility, hyperandrogenism, increased estrogen levels, insulin resistance and hyperinsulinemia significantly contribute to endometrial and ovarian dysfunction. Moreover, the negative effect of oxidative stress and proinflammatory cytokines in oocyte quality and endothelial function, further compromised fertility.[20,21]

Clinical features[2]

Menstrual abnormalities in about 70% cases, evidenced by oligomenorrhoea, amenorrhoea or dysfunctional uterine bleeding (DUB), Abnormal hair growth in the form of hirsutism, acne in about 70% cases, increasing obesity mostly abdominal in about 50% cases, darkening of skin mainly found in nape of neck, groin, axilla, inner thighs known by the name “acanthosis nigricans” and also thinning of hair, hair may lose in patches etc.

Investigations[2]

Sonography: Transvaginal sonography (TVS) is generally useful in obese patients. It may show more than 12 peripherally arranged cysts, each measuring approximately 2–9 mm in diameter.

Serum values: Serum luteinising hormone (LH) levels may be elevated. Oestradiol and oestrone levels may be increased, while sex hormone-binding globulin (SHBG) levels may be reduced. Androstenedione levels are often elevated, and testosterone and dehydroepiandrosterone sulphate (DHEAS) levels may also be increased. Fasting insulin levels above 25 µIU/mL and a fasting glucose-to-insulin ratio below 4.5 have been described as indicators of insulin resistance (IR), although these cut-offs are not universally accepted.

Laparoscopy: Laparoscopy may reveal bilateral polycystic ovaries, characterised by enlarged ovaries with multiple small follicles. However, laparoscopy is not routinely required to diagnose polycystic ovary syndrome (PCOS).

Management

Management of PCOS needs individualization of the patient, that depends entirely on her presenting symptoms such as menstrual irregularities, obesity, infertility, hirsutism, acne or combined symptoms. Weight reduction is the first line of treatment in case of obese patients especially. Weight reduction improves the metabolic syndrome and improves reproductive function. Losing body weight can relieve PCOS symptoms, even helps to reduce blood sugar level and androgen level. Strict maintenance of diet with low intake of calories, Aerobic exercise helps to reduce blood glucose level.[2]

Treatment

Though there are many ways to combat PCOS as per conventional method like by using combined oral contraceptive (COC) pills which is truly effective and there are other ways like anti-androgenic medicines like spironolactone, flutamide to combat the effect of hyperandrogenism. Apart from that metformin is also used to delay or prevent type 2 diabetes mellitus. Along with that, medicines like Letrozole which helps that body for ovulation.

As per homoeopathic medicine perspective, we have seen the effectiveness of homoeopathic medicine in the treatment of PCOS cases, demonstrated by Parveen et al.[22] Another study by Gupta et al indicated that Lyco and Calc carb were beneficial for PCOS.[23] In another study done by Lamba et al found that a homoeopathic treatment along with lifestyle modification can effectively manage PCOS and enhance quality of life.[24] In this particular context, the present case report is presented to show the effectiveness of individualized homoeopathic medicine chosen on the basis of totality of symptom along with lifestyle modification and change in food habits in treating a case of PCOS.

CASE REPORT

Patient information

In this case, a 24-year-old female patient visited the Out-Patient Department of The Calcutta Homoeopathic Medical College and Hospital on 26th August 2025, presented with gradual delay and irregular menstruation for 6 months and pain of lower abdomen which radiates to thigh during menstrual cycle. Her menstrual cycle is of thirty-five to fifty days interval. Duration of her cycle was three to six days and colour of her menstrual blood is deep red, sometimes brownish. She has slight development of abnormal hair growth on her upper lip.

Past history

The patient had a history of jaundice 7 years ago and a urinary tract infection 3 years ago.

Family history

Nothing significant.

Physical examination

General examination revealed no pallor, icterus, cyanosis, clubbing or oedema. The patient's blood pressure was 110/70 mmHg, pulse rate was 78 beats/min, and body weight was 54.6 kg.

Diagnostic assessment

The diagnosis is based on clinical findings along with USG report on 24th February 2025 revealed "both ovaries are mildly enlarged in size and show multiple (15-20) and small (4-5 mm) peripherally arranged cysts with hypertrophied echogenic stroma" and "right ovary measures (29×24×35) mm having volume 13.1 cc" and "left ovary measures (29×26×29) mm having volume 12.1 cc" marking "Mild PCOS changes in both ovaries" (Figure 1 and 2).

Generalities

On her physical sphere, she has gradual delay and irregular menstruation with slight development of hair growth on her upper lip and very much intolerance to warmth, has craving for meat, sweet and spicy foods and intolerance to spicy and rich foods, thirst is much less as compared to a normal person of her age, can't tolerate her hunger for long, has irregular bowel habits with changeable character of stool.

As per her mental sphere, she desires to stay along but fears darkness and ghosts, having sentimental mind with anger increased at times, cries later with relief from consolation but seems it difficult for her to express in words and have a good memory.

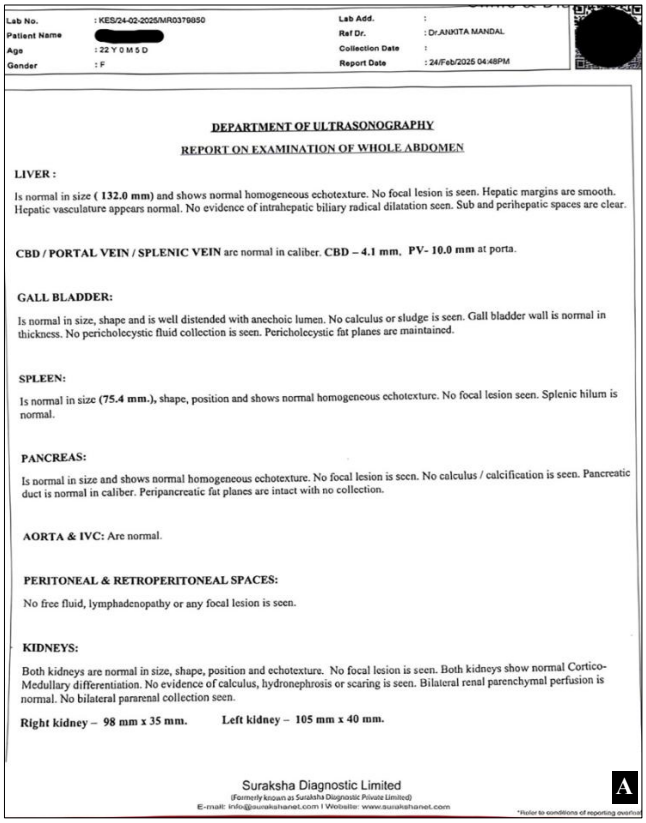
Evaluation of symptoms

Mental general symptoms are: fears of ghosts and darkness; sentimental mind; consolation amelioration; and inability to express grief and anger.

Physical general symptoms involve delayed and irregular menstruation, intolerance to warmth, cravings for meat, sweet and spicy foods, intolerance to spicy and rich foods and thirstless.

Particular symptoms are hair growth on upper lip.

Totality of symptoms are: delayed and irregular menstruation; hair growth on upper lip; fears of ghosts and darkness; sentimental mind; inability to express grief and anger; consolation amelioration; intolerance to warmth; cravings for meat, sweet and spicy foods; intolerance to spicy and rich foods; and thirstless.



Lab No.	: KES/24-02-2025/MR0379850	Lab Add.	:
Patient Name	[redacted]	Ref Dr.	: Dr.ANKITA MANDAL
Age	: 22 Y 0 M 5 D	Collection Date	:
Gender	: F	Report Date	: 24/Feb/2025 04:48PM

DEPARTMENT OF ULTRASONOGRAPHY

REPORT ON EXAMINATION OF WHOLE ABDOMEN

LIVER :

Is normal in size **(132.0 mm)** and shows normal homogeneous echotexture. No focal lesion is seen. Hepatic margins are smooth. Hepatic vasculature appears normal. No evidence of intrahepatic biliary radical dilatation seen. Sub and perihepatic spaces are clear.

CBD / PORTAL VEIN / SPLENIC VEIN are normal in caliber. **CBD – 4.1 mm, PV- 10.0 mm** at porta.

GALL BLADDER:

Is normal in size, shape and is well distended with anechoic lumen. No calculus or sludge is seen. Gall bladder wall is normal in thickness. No pericholecystic fluid collection is seen. Pericholecystic fat planes are maintained.

SPLEEN:

Is normal in size **(75.4 mm.)**, shape, position and shows normal homogeneous echotexture. No focal lesion seen. Splenic hilum is normal.

PANCREAS:

Is normal in size and shows normal homogeneous echotexture. No focal lesion is seen. No calculus / calcification is seen. Pancreatic duct is normal in caliber. Peripancreatic fat planes are intact with no collection.

AORTA & IVC: Are normal.

PERITONEAL & RETROPERITONEAL SPACES:

No free fluid, lymphadenopathy or any focal lesion is seen.

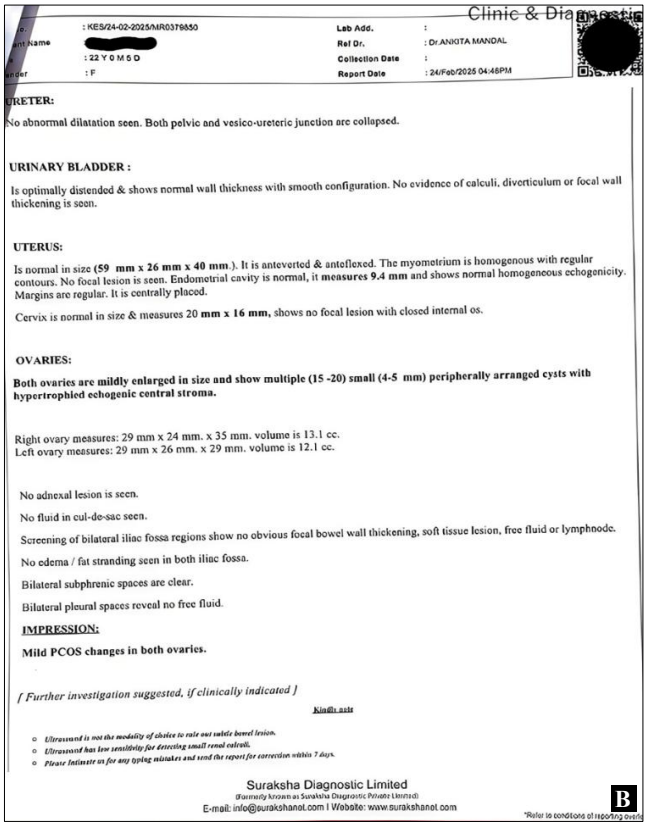
KIDNEYS:

Both kidneys are normal in size, shape, position and echotexture. No focal lesion is seen. Both kidneys show normal Cortico-Medullary differentiation. No evidence of calculus, hydronephrosis or scaring is seen. Bilateral renal parenchymal perfusion is normal. No bilateral pararenal collection seen.

Right kidney – 98 mm x 35 mm. **Left kidney – 105 mm x 40 mm.**

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A



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[illegible]	: KES/24-02-2025/MR0379850	Lab Add.	:
[illegible] Name	[redacted]	Ref Dr.	: Dr.ANKITA MANDAL
[illegible]	: 22 Y 0 M 5 D	Collection Date	:
[illegible]nder	: F	Report Date	: 24/Feb/2025 04:48PM

URETER:

No abnormal dilatation seen. Both pelvic and vesico-ureteric junction are collapsed.

URINARY BLADDER :

Is optimally distended & shows normal wall thickness with smooth configuration. No evidence of calculi, diverticulum or focal wall thickening is seen.

UTERUS:

Is normal in size **(59 mm x 26 mm x 40 mm.)**. It is anteverted & anteflexed. The myometrium is homogenous with regular contours. No focal lesion is seen. Endometrial cavity is normal, it **measures 9.4 mm** and shows normal homogeneous echogenicity. Margins are regular. It is centrally placed.

Cervix is normal in size & measures 20 **mm x 16 mm,** shows no focal lesion with closed internal os.

OVARIES:

Both ovaries are mildly enlarged in size and show multiple (15 -20) small (4-5 mm) peripherally arranged cysts with hypertrophied echogenic central stroma.

Right ovary measures: 29 mm x 24 mm. x 35 mm. volume is 13.1 cc.
Left ovary measures: 29 mm x 26 mm. x 29 mm. volume is 12.1 cc.

No adnexal lesion is seen.

No fluid in cul-de-sac seen.

Screening of bilateral iliac fossa regions show no obvious focal bowel wall thickening, soft tissue lesion, free fluid or lymphnode.

No edema / fat stranding seen in both iliac fossa.

Bilateral subphrenic spaces are clear.

Bilateral pleural spaces reveal no free fluid.

IMPRESSION:

Mild PCOS changes in both ovaries.

[Further investigation suggested, if clinically indicated]

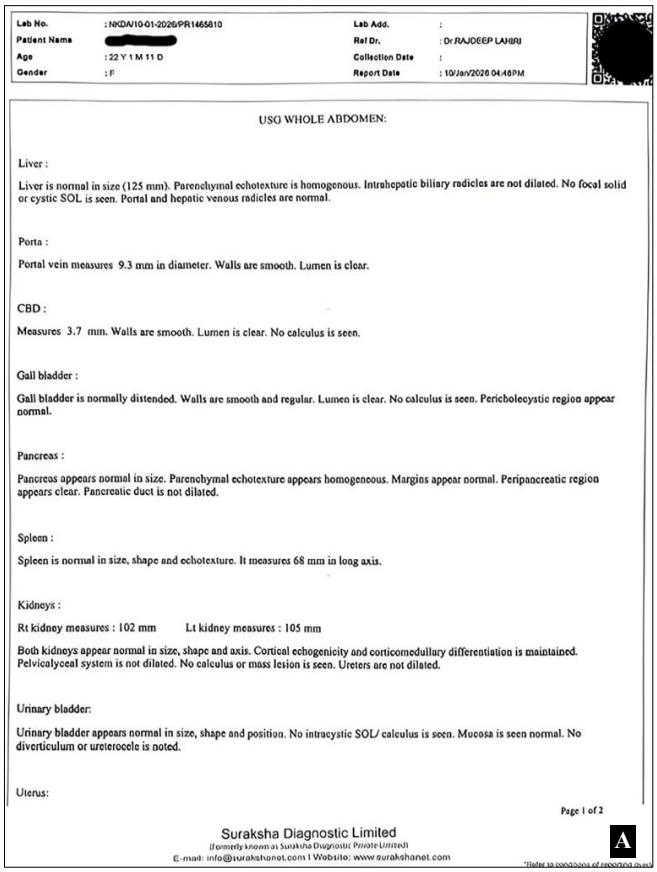
Kindly note

- *Ultrasound is not the modality of choice to rule out subtle bowel lesion.*
- *Ultrasound has low sensitivity for detecting small renal calculi.*
- *Please Intimate us for any typing mistakes and send the report for correction within 7 days.*

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B

Figure 1 (A and B): USG report before treatment.



Lab No.	: NKDA/10-01-2026/PR1465810	Lab Add.	:
Patient Name	[redacted]	Ref Dr.	: Dr.RAJDEEP LAHIRI
Age	: 22 Y 1 M 11 D	Collection Date	:
Gender	: F	Report Date	: 10/Jan/2026 04:48PM

USG WHOLE ABDOMEN:

Liver :

Liver is normal in size (125 mm). Parenchymal echotexture is homogenous. Intrahepatic biliary radicles are not dilated. No focal solid or cystic SOL is seen. Portal and hepatic venous radicles are normal.

Porta :

Portal vein measures 9.3 mm in diameter. Walls are smooth. Lumen is clear.

CBD :

Measures 3.7 mm. Walls are smooth. Lumen is clear. No calculus is seen.

Gall bladder :

Gall bladder is normally distended. Walls are smooth and regular. Lumen is clear. No calculus is seen. Pericholecystic region appear normal.

Pancreas :

Pancreas appears normal in size. Parenchymal echotexture appears homogeneous. Margins appear normal. Peripancreatic region appears clear. Pancreatic duct is not dilated.

Spleen :

Spleen is normal in size, shape and echotexture. It measures 68 mm in long axis.

Kidneys :

Rt kidney measures : 102 mm Lt kidney measures : 105 mm

Both kidneys appear normal in size, shape and axis. Cortical echogenicity and corticomedullary differentiation is maintained. Pelvicalyceal system is not dilated. No calculus or mass lesion is seen. Ureters are not dilated.

Urinary bladder:

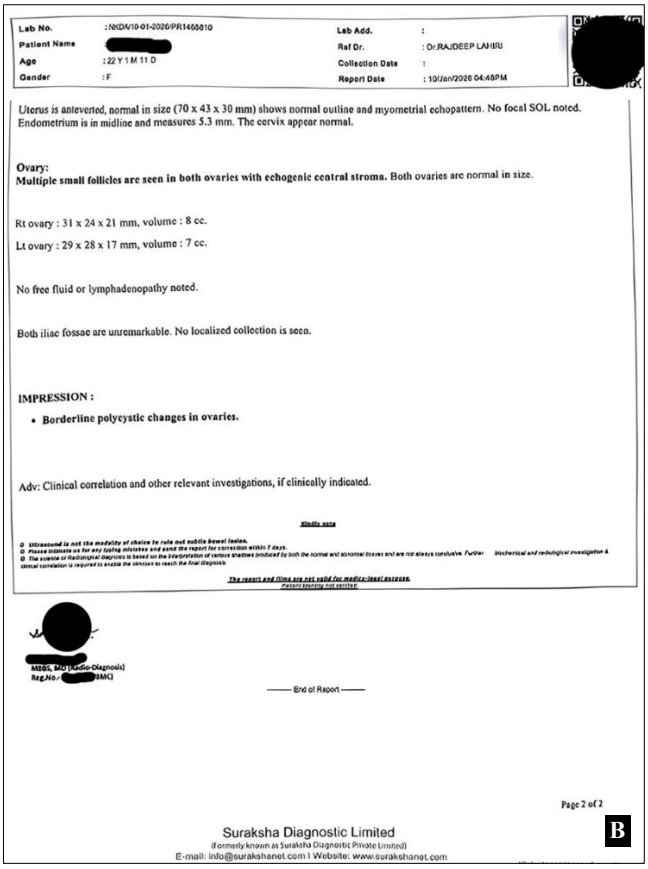
Urinary bladder appears normal in size, shape and position. No intracystic SOL/ calculus is seen. Mucosa is seen normal. No diverticulum or ureterocele is noted.

Uterus:

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A



Lab No.	: NKDA/10-01-2026/PR1465810	Lab Add.	:
Patient Name	[redacted]	Ref Dr.	: Dr.RAJDEEP LAHIRI
Age	: 22 Y 1 M 11 D	Collection Date	:
Gender	: F	Report Date	: 10/Jan/2026 04:48PM

Uterus is anteverted, normal in size (70 x 43 x 30 mm) shows normal outline and myometrial echopattern. No focal SOL noted. Endometrium is in midline and measures 5.3 mm. The cervix appear normal.

Ovary:
Multiple small follicles are seen in both ovaries with echogenic central stroma. Both ovaries are normal in size.

Rt ovary : 31 x 24 x 21 mm, volume : 8 cc.

Lt ovary : 29 x 28 x 17 mm, volume : 7 cc.

No free fluid or lymphadenopathy noted.

Both iliac fossae are unremarkable. No localized collection is seen.

IMPRESSION :

- **Borderline polycystic changes in ovaries.**

Adv: Clinical correlation and other relevant investigations, if clinically indicated.

Kindly note

- Ultrasound is not the modality of choice to rule out subtle bowel lesion.
- Please intimate us for any typing mistakes and send the report for correction within 7 days.
- The science of Radiological diagnosis is based on the interpretation of various shadows produced by both the normal and abnormal tissues and are not always conclusive. Further biochemical and radiological investigation & clinical correlation is required to enable the clinician to reach the final diagnosis.

The report and films are not valid for medico-legal purposes.
Patient identity not verified.

[redacted]
MBBS, MD (Radio-Diagnosis)
Reg.No.:[redacted](MMC)

End of Report

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B

Figure 2 (A and B): USG report after treatment.

Table 1: Analysis of symptoms.

	General symptoms	Particular symptoms
1.	Delayed and irregular menstruation	1. Hair growth on upper lip
2.	Intolerance to warmth	
3.	Cravings for meat, sweet and spicy foods	
4.	Intolerance to spicy and rich foods	
5.	Thirst is less	
6.	Inability to tolerate hunger	
7.	Fears of ghosts and darkness	
8.	Sentimental mind	
9.	Consolation amelioration	
10.	Inability to express grief and anger	

Table 2: Repertorial results obtained from the complete repertory.

Remedy	Puls	Phos	Caust	Sulph	Lyc	Ars	Calc	Nat-m	Sep	Tub
Totality	31	27	27	27	26	24	24	23	22	20
Symptoms Covered	9	9	8	8	8	9	8	9	8	7
Kingdom	Plants	Minerals	Minerals	Minerals	Plants	Minerals	Minerals	Minerals	Animals, sarcodes	Nosodes, Micro-organisms
[Complete] [Mind] CONSOLATION, SYMPATHY: Amel.: (49)	4	3				1		1		
[Complete] [Mind]SENTIMENTAL: (114)	3	3	3	3	3	1	1	3	3	3
[Complete] [Mind]FEAR:Ghosts, spectres, of: (81)	4	3	3	4	3	4	3	1	3	
[Complete] [Mind]FEAR:Dark,of: (146)	4	3	3	1	3	2	3	3	1	1
[Complete] [Stomach] THIRSTLESSNESS: (407)	4	4	4	4	4	4	3	3	4	4
[Complete] [Generalities]WARMTH:Agg.: (655)	4	4	4	4	4	4	4	4	4	4
[Complete] [Generalities]FOOD AND DRINKS:Meat:Desires: (193)	1	3	4	4	3	3	3	1	1	4
[Complete] [Generalities]FOOD AND DRINKS:Fat and rich food:Agg.: (171)	4	3	3	4	3	3	3	4	3	1
[Complete] [Female Genitilia]MENSES:Irregular: (167)	3	1	3	3	3	2	4	3	3	3

Table 3: Follow-up and outcome.

Date	Patient's status	Prescription
26th August 2025	1st visit	Pulsatilla Nigricans 0/1, 14 doses Placebo, 14 doses
16th December 2025 (1st follow up)	Delay in menstruation reduced than before with reduction in pain which was radiating much down to thighs	Pulsatilla Nigricans 0/2, 14 doses Placebo, 14 doses
16th January 2026 (2nd follow up)	Reduction is the delay dates than before with almost timely periods and pain down the thighs reduced further with reduction of upper lip hair growth	Placebo, 28 doses
31st March 2026 (3rd follow up)	Menstruation is almost on normal time with pain in lower abdomen persisted only for 2 days	Placebo, 28 doses
5th June 2026 (4th follow up)	Menstruation delayed by 5days with re-occurrence radiation of pain to thigh	Pulsatilla Nigricans 0/3, 14 doses Placebo, 14 doses
31st July 2026 (5th follow up)	No irregularities in menses noted with no radiation of pain down to thighs. Lower abdominal pain noted slightly on 1st day of onset of menses only. Upper lip hair growth reduced much than before	Placebo, 28 doses

Table 4: Modified Naranjo criteria for homoeopathy (MONARCH), assessment of causal attribution and total score.

	Domains	Yes	No	Not sure or N/A
1.	Was there an improvement in the main symptom or condition for which the homoeopathic medicine was prescribed?	+2 ✓	–1	0
2.	Did the clinical improvement occur within a plausible time frame relative to the drug intake?	+1 ✓	–2	0
3.	Was there an initial aggravation of symptoms?	+1	0 ✓	0
4.	Did the effect encompass more than the main symptom or condition (i.e., were other symptoms ultimately improved or changed)?	+1 ✓	0	0
5.	Did overall well-being improve? (suggest using a validated scale)	+1	0 ✓	0
6A	Direction of cure: did some symptoms improve in the opposite order of the development of symptoms of the disease?	+1 ✓	0	0
6B	Direction of cure: did at least two of the following aspects apply to the order of improvement of symptoms: –from organs of more importance to those of less importance? –from deeper to more superficial aspects of the individual? –from the top downwards?	+1	0 ✓	0
7.	Did "old symptoms" (defined as non-seasonal and non-cyclical symptoms that were previously thought to have resolved) reappear temporarily during improvement?	+1 ✓	0	0
8.	Are there alternate causes (other than the medicine) that-with a high probability—could have caused the improvement? (Consider known course of disease, other forms of treatment, and other clinically relevant interventions)	–3	+1 ✓	0
9.	Was the health improvement confirmed by any objective evidence? (e.g., laboratory test, clinical observation, etc.)	+2 ✓	0	0
10.	Did repeat dosing, if conducted, create similar clinical improvement?	+1 ✓	0	0
	Total score	**+10**		

After repertorisation by complete repertory, it was found out that "*Pulsatilla Nigricans*" covered most of the symptoms and scored highest among all followed by other remedies like Phosphorus, Causticum, Sulphur and so on.[25] *Pulsatilla Nigricans* was selected on the basis of totality of symptoms and has covered the characteristic symptoms. During her 1st visit on 26th august 2025, after repertorisation and with consultation from materia medica, *Pulsatilla Nigricans 0/1* was prescribed followed by placebo. On her 2nd visit, her irregularities in menstruation have reduced marked by reducing the date delayed on every previous menstruation as per her LMP with reduction in lower abdominal pain. She was prescribed *Pulsatilla Nigricans 0/2* on her 2nd visit. The patient was advised to follow up on a regular period as she started showing improvements. The improvements noted was remarkable and progressive and now she is free from all her complaints as stated above.

During her 1st visit, on 26th august 2025, on taking the case and on repertorisation with consulting materia medica, *Pulsatilla Nigricans 0/1* was prescribed followed by placebo. On her 2nd visit on 16th December 2025, her complaints of menstruation delay with extension from thirty-five to fifty days duration got reduced slightly with reduction of pain down to thighs than before. She was prescribed *Pulsatilla Nigricans 0/2* on her 2nd visit followed by placebo. On her 3rd visit, her complaints got reduced even further than before and was prescribed placebo only. On her 4th visit, she was again prescribed placebo. On her 5th visit, with slight recurrence of her previous complaints, she was prescribed *Pulsatilla Nigricans 0/3* followed by placebo. Lastly on her 6th visit, she was prescribed placebo and no medicines needed till now and she is completely free from her presenting complaints with no recurrence noted any further. The conclusive outcome was with the help of USG reports and by using Modified Naranjo Criteria for Homoeopathy (MONARCH).[26]

Following the last date of prescription, no further medicine was needed till now.

DISCUSSION

This is the presentation of a case of PCOS who presented with gradual delay and irregular menstruation for 6 months and pain of lower abdomen which radiates to thigh during menstrual cycle. Her menstrual cycle is of thirty-five to fifty days interval. Duration of her cycle was three to six days and colour of her menstrual blood is deep red, sometimes brownish. She has slight development of abnormal hair growth on her upper lip. Her changes in ovaries were evidenced by the USG reports (as presented in Figure 1 and 2). She was suffering for whole 6 months with gradual development of the presenting complaints. Homoeopathic medicines in this case have shown great potential in treating symptoms of PCOS with gradual reduction of extended duration of menstruation every month and now the cycle became regular every month with reduction of pain that radiates to thighs and lower abdomen that occasionally persists up to second days and reduction in abnormal hair growth on upper lip. Various available case reports and case series have shown potential benefits in treating PCOS symptoms.[26,27,28-33]

Considering the patient's presenting complaint, past history, family history with consultation from authentic materia medica and using complete repertory for repertorisation, *Pulsatilla Nigricans 0/1* was prescribed. The doctrine of doses in homoeopathy requires sex, age, constitution, environment, habit and seat of the disease and medicines have been applied entirely based on the totality of symptoms.

By figuring out the individuality of the case and by giving the treatment accordingly, homoeopathy has proved as a valuable approach in treatment of presenting symptoms of PCOS as well as the size of the ovaries reduced to normal. The positive outcome in this case like gradual reduction of irregular menses back to normalcy with reduction of abnormal upper lip hair growth with reduction of size of ovaries back to normal (as shown in Figure 1 and 2) which she was suffering from 6 months which she wasn't getting relief by use of conventional medicine reflects the benefits of individual homoeopathic medicine in a case of vitiligo.

The application of Modified Naranjo Criteria for Homoeopathy (MONARCH) was done to ascertain the causal attribution between individualized homoeopathic medicine administered and the changes observed in the patient's signs and symptoms (Table 4).[34] As per the Modified Naranjo Criteria, the following observations are made and scored [+10]. This indicates a favourable response and suggests a relationship between homoeopathic medicine administration and improvement in patient's condition.

Limitations

Though this is a single case presented on PCOS but a large number of cases in series in a well-planned manner is required to establish the effectiveness and potential of homoeopathic in effectiveness and potentiality of homoeopathic medicines in treating such cases.

CONCLUSION

In cases of PCOS, conventional treatment approaches focusses on Combined Oral Contraceptive (COC) which is a hormonal treatment along with anti-androgenic and anti-diabetic medications but homoeopathic treatment focusses on individualization that is a whole new light on treatment such diseases which is evident by USG reports as shown above along with MONARCH criteria that gave a valuable outcome in the treatment of PCOS, reflecting the effectiveness of individualized homoeopathic medicinal approaches. The constitutional approach includes thorough and holistic evaluation of the patient's overall constitution, individual symptoms, marking characteristic

symptoms, is demonstrated to be a most potent method in homoeopathy. The approach considers the entirety of the patient's both physical and mental aspects. While other approaches have their merits, this case report emphasizes on the enduring value of the constitutional approach in the homoeopathic treatment in PCOS along with lifestyle managements and food habits. The evidenced based outcome of this study along with previous research contributes to a more comprehensive understanding of the diverse treatment approach available in homoeopathy.

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