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Case Series

Clinical and ultrasonographic outcomes of Unani therapy in hemorrhagic ovarian cysts: a care-compliant case series

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ABSTRACT

Hemorrhagic ovarian cysts (HOCs) are functional ovarian lesions commonly associated with pelvic pain, dysmenorrhea, and menstrual irregularities. Conventional management frequently includes hormonal therapy or surgical intervention, which may be associated with adverse effects and recurrence. In Unani medicine, HOCs may be correlated with Fasād-e-Dam and predominance of Balgham, leading to cystic ovarian changes. To evaluate the clinical outcomes of Unani therapy in patients with HOCs. This case series included four women aged 20-39 years diagnosed with HOCs by ultrasonography, with cyst sizes ranging from 23×24 mm to 4.09×3.09 cm. All patients presented with lower abdominal pain, dysmenorrhea, and menstrual disturbances of varying severity. The patients were treated with an Unani regimen comprising Majoon Dabidul Ward (6-7 g twice daily), Arq Makoh (50-60 ml twice daily), and Sharbat Bazoori (20 ml twice daily) for a duration of three months, along with dietary and lifestyle modifications. Clinical outcomes were assessed using the visual analogue scale (VAS) for pain and follow-up ultrasonography. All patients demonstrated marked symptomatic improvement, with a mean reduction of 5-6 points in VAS scores after completion of therapy. Follow-up ultrasonography revealed complete resolution of the HOCs in all four cases. No adverse drug reactions or treatment-related complications were reported during the study period. This case series suggests that Unani therapy may offer a safe and potentially effective conservative non-hormonal approach for the management of HOCs. However, further large-scale randomized controlled studies are warranted to establish its efficacy and safety.

Keywords: Hemorrhagic ovarian cyst, Unani medicine, Majoon Dabidul Ward, Arq Makoh, Sharbat Bazoori, Non-hormonal therapy

INTRODUCTION

Functional ovarian cysts are among the most common gynecological conditions affecting women of reproductive age, and HOCs constitute a significant proportion of adnexal masses encountered in clinical practice.[1] These cysts arise due to hemorrhage into a functional ovarian cyst, most commonly the corpus luteum, and may present with pelvic pain, dysmenorrhea, menstrual irregularities, infertility, or acute complications such as rupture, torsion, and intraperitoneal bleeding.[2,3] Ultrasonography remains primary diagnostic modality for evaluation of HOCs because of its accessibility and characteristic imaging findings.[4]

Conventional management strategies include expectant observation, analgesics, hormonal therapy, and surgical intervention depending on cyst size, symptom severity, and associated complications.[5] However, hormonal therapies such as oral contraceptive pills are frequently associated with adverse effects, recurrence after discontinuation, and limited acceptability among women seeking fertility preservation or non-hormonal treatment options.[6] Consequently, there is increasing interest in conservative and fertility-preserving therapeutic

approaches that may provide symptomatic relief and facilitate cyst resolution while minimizing treatment-related adverse effects.

In the Unani system of medicine, HOCs are not described as a separate disease entity but may be correlated with conditions such as Mubayyazur, Istisqa-e-Raḥim, and ‘Uqr.[7] Classical Unani literature describes cystic ovarian swellings using terms such as Keesa-e-Khusyatur Raḥim, Daveera-e-Mubayyazor, and Istisqa-e-Khusyatur Raḥim. Ibn Sina, in Al-Qanun fi al-Tibb, attributed cyst formation (Keesa) to the accumulation of abnormal Balgham (phlegmatic humour), particularly Balgham Mā’i, a thin fluid capable of collecting within sac-like structures.[9] The Unani principles of treatment (Usool-e-Ilaj) emphasize correction of humoral imbalance, resolution of inflammation, and removal of obstruction through drugs possessing Muḥallil al-Waram (anti-inflammatory), Mu‘addil-e-Dam (blood-corrective), and Nāfi‘-e-Sudda (deobstruent) properties.

Although isolated reports on the use of Unani formulations in ovarian cysts are available, systematic clinical evidence evaluating standardized Unani therapeutic regimens with both symptomatic and ultrasonographic outcomes in HOCs remains limited. Furthermore, data regarding conservative non-hormonal management approaches with documented radiological follow-up are scarce. Therefore, the present case series was undertaken to evaluate the clinical outcomes and safety of a standardized Unani therapeutic regimen in patients with HOCs, with emphasis on symptomatic improvement, cyst resolution, and fertility-preserving conservative management.

CASE SERIES

Case 1

Patient information

A 32-year-old married woman, para 3 living 3 abortion 0 (P3L3A0), presented to the gynecology outpatient department of the National Institute of Unani Medicine with complaints of frequent intermenstrual spotting, scanty menstruation, lower abdominal pain, and constipation for the past three months. She also reported difficulty while sitting, walking, and during sexual intercourse, along with increased frequency and burning micturition for 3-4 days.

The patient was a known case of hypothyroidism and had been compliant with medication for the past four years. Her menstrual cycles had previously been regular. She had not received any specific treatment for her current complaints and had intermittently used over-the-counter NSAIDs for symptomatic relief. There was no history of gynecological surgery, hormone replacement therapy, or family history of ovarian, breast, endometrial, or cervical malignancy.

Clinical findings

On general physical examination, the patient was obese with a body weight of 75 kg. Vital parameters were within normal limits. No pallor, jaundice, edema, or signs of systemic illness were observed.

Abdominal examination revealed mild abdominal distension and tenderness in the right iliac fossa. No organomegaly or palpable mass was detected, and bowel sounds were normal.

On per speculum examination, the cervix was anterior with slit os, and no visible discharge, polyp, or cervical lesion was noted. On bimanual examination, the cervix was firm, mobile, and non-tender. The uterus was anteverted, normal in size, and non-tender, while bilateral fornices were free and non-tender.

Diagnostic assessment

Routine laboratory investigations were within normal limits. Pelvic ultrasonography revealed a hemorrhagic ovarian cyst measuring 23×24 mm, confirming the diagnosis.

Case 2

Patient information

A 32-year-old married woman, para 4 living 3 death 1 abortion 0 (P4L3D1A0), presented with complaints of white discharge per vaginum, scanty menstruation, lower abdominal pain, constipation, abdominal bloating, flatulence, and intermittent low backache for the three months.

There was no significant past medical or surgical history, and family history was non-contributory. Her menstrual cycles were regular, although menstrual flow was scanty and lasted only 1-2 days. There was no history of dysmenorrhea.

Clinical findings

On examination, the patient was obese with a body weight of 65 kg. General examination revealed no pallor, jaundice, edema, or evidence of systemic illness.

Abdominal examination showed mild abdominal distension with tenderness in the right iliac fossa. No organomegaly or palpable mass was present, and bowel sounds were normal.

Diagnostic assessment

Routine laboratory investigations were unremarkable. Pelvic ultrasonography demonstrated a hemorrhagic ovarian cyst measuring 23.5×23.1 mm.

Case 3

Patient information

A 20-year-old unmarried woman presented with complaints of dysmenorrhea, lower abdominal pain, burning micturition, increased frequency of micturition, and intermittent low backache.

She had no significant past medical or surgical history and no relevant family history. Her menstrual cycles were regular, although menstrual flow was scanty for 1-2 days and associated with severe dysmenorrhea.

Clinical findings

On general examination, the patient was thin built with a body weight of 55 kg. Mild pallor was present, while jaundice, edema, and other systemic abnormalities were absent.

Abdominal examination revealed mild tenderness in the right iliac fossa without organomegaly or palpable abdominal mass. Bowel sounds were normal.

Diagnostic assessment

Routine laboratory investigations were within normal limits except for mild anemia. Pelvic ultrasonography revealed a hemorrhagic ovarian cyst measuring 34×32 mm.

Case 4

Patient information

A 39-year-old married woman, para 5 living 5 abortion 1 (P5L5A1), presented with complaints of white discharge per vaginum, lower abdominal pain, constipation, abdominal bloating, flatulence, and intermittent low backache for three months.

She was a known case of dyslipidemia and had been compliant with medication for one year. There was no significant surgical or family history.

Her menstrual cycles were regular, occurring every 25-32 days with moderate flow lasting 4-5 days and associated with mild dysmenorrhea.

Clinical findings

General examination revealed an obese patient weighing 70 kg with stable vital signs. No pallor, jaundice, or signs of systemic disease were observed.

Abdominal examination showed mild abdominal distension with tenderness in the right iliac fossa. No organomegaly or palpable mass was detected.

On per speculum examination, the cervix appeared bulky with erosion around the external os and thick purulent discharge. On per vaginal examination, the uterus was anteverted and anteflexed, firm, mobile, and bilateral fornices were free.

Diagnostic assessment

Routine laboratory investigations were within normal limits. Pelvic ultrasonography revealed a hemorrhagic ovarian cyst measuring 4.09×3.09 cm.

Therapeutic interventions

Following confirmation of HOCs by ultrasonography, all four patients were managed conservatively with a standardized Unani therapeutic regimen for a duration of three months. The treatment protocol consisted of Majoon Dabidul Ward administered orally at a dose of 6-7 g twice daily, Arq Makoh 50-60 ml twice daily, and Sharbat Bazoori 20 ml twice daily. All medications were procured from the pharmacy of the National Institute of Unani Medicine and were administered under medical supervision.

In addition to pharmacological therapy, all patients were advised lifestyle and dietary modifications, including consumption of a balanced diet rich in green leafy vegetables, salads, and citrus fruits, along with a daily morning walk for approximately 40 minutes. Informed consent was obtained from all participants prior to initiation of therapy.

The prescribed formulations were selected on the basis of their reported Unani pharmacological actions, including Muḥallil al-Waram (anti-inflammatory), Mu‘addil-e-Dam (blood-corrective), Mudirr-e-Baul (diuretic), and Nāfi‘-e-Sudda (deobstruent) properties. Majoon Dabidul Ward possesses anti-inflammatory, astringent, antioxidant, and diuretic actions, while Arq Makoh is traditionally recognized for its anti-inflammatory, antioxidant, analgesic, hepatic-protective, and diuretic effects. Sharbat Bazoori is known for its diuretic and analgesic properties.[10-12,16,17]

All patients were followed up at intervals of every eighth day during the treatment period to assess symptomatic improvement, treatment adherence, and occurrence of any adverse effects. No additional hormonal or surgical intervention was administered during the study period, and no treatment-related adverse drug reactions or complications were reported.

Drug composition

The composition of the formulations used in this study is presented in Table 1. All formulations were procured from the pharmacy of the National Institute of Unani Medicine (NIUM), Ghaziabad, and were manufactured according to the standards prescribed in the National Formulary of

Unani Medicine (NFUM).[12] Detailed phytochemical standardization and chemical profiling data were not available and are recommended for future studies.

Timeline

The treatment timeline is shown in Figure 1.

Follow-up and outcomes

All patients were closely monitored throughout the study period and were advised regular follow-up at every eighth day for a duration of three months. Clinical assessment during follow-up included evaluation of lower abdominal pain, menstrual complaints, associated symptoms, treatment compliance, and occurrence of adverse effects. Progressive symptomatic improvement was observed in all cases during the treatment period. By the end of three months, all patients demonstrated marked reduction in lower abdominal pain, improvement in menstrual irregularities and associated clinical symptoms, along with better overall functional well-being. No adverse drug reactions or treatment-related complications were reported during therapy.

Pain severity was assessed using the VAS. At baseline, VAS scores ranged from 6-9 across 4 cases. Gradual reduction in pain scores was observed during monthly follow-up assessments. By completion of therapy, the total reduction in VAS score ranged from 5-6 points, indicating substantial symptomatic improvement. Detailed changes in VAS scores during follow-up are presented in Table 2.

Follow-up pelvic ultrasonography performed after completion of treatment demonstrated complete resolution of HOCs in all 4 patients, confirming favorable radiological outcomes in addition to clinical improvement (Figure 2).

Table 1: Composition of the Unani formulations used in study; constituents of Majoon Dabidul Ward, Arq Makoh and Sharbat Bazoori.

Ingredients	Botanical name	Quantity
Constituents of Majoon Dabidul Ward		
Izkhar Makki	Cymbopogon citratus	20 gm
Agar	Aquilaria agallocha	20 gm
Balchhar	Valeriana officinalis	20 gm
Banslochan	Bambusa arundinacea	20 gm
Tukhme Kasni	Cichorium intybus	20 gm
Tukhme Kasoos	Cuscuta reflexa	20 gm
Tukhm Karafas	Apium graveolens	20 gm
Taj Qalmi	Cinnamomum cassia	20 gm
Darchini	Cinnamomum officinalis	20 gm
Zarawand Muudahraj	Aristolochia rotunda	20 gm
Qust Shireen	Saussurea lappa	20 gm
Gul-e-surkh	Rosa damascena	300 gm
Gul-e-Ghafis	Delphinium zalli	20 gm
Luk Maghsool	Cateria lucca	20 gm
Majeeth	Rubia cardifolia	20 gm
Qiwam Shakar	White sugar	2.4 kg
Zafran	Crocus sativa	2.9 gm
Arq Gaozaban	Onosma bracteatum	30 ml
Mastagi	Pistacia lenticus	20 gm
Ghee	-	5 gm
Arq Makoh		
Makoh Khushk	*Solanium nigrum*	1 part
Water	-	20 parts
Sharbat Bazoori		
Bekh-e-Kasni	*Cichorium intybus*	100 gm
Bekh-e-Badiyan-	*Foeniculum vulgare*	50 gm
Tukhm-e-Kasni	*Cichorium intybus*	50 gm
Tukhm-e-khiyaraza	*Cucumis sativus*	50 gm
Tukhm-e-khiyar	*Cucumis sativus*	50 gm
Tukhm-e-kharpazah	*Cucumis melo*	50 gm
Khar-e-Khask khurd	*Tribulus terrestris*	50 gm
Qand Safaid	White sugar	500 gm
Aab		Q. S

Table 2: Changes in VAS scores during treatment.

Case no	Baseline VAS score	1 month follow up	2 month follow up	3 month follow up	Total reduction VAS score
Case 1	8	6	4	2	6
Case 2	7	5	3	1	6
Case 3	9	7	5	3	6
Case 4	6	4	2	1	5

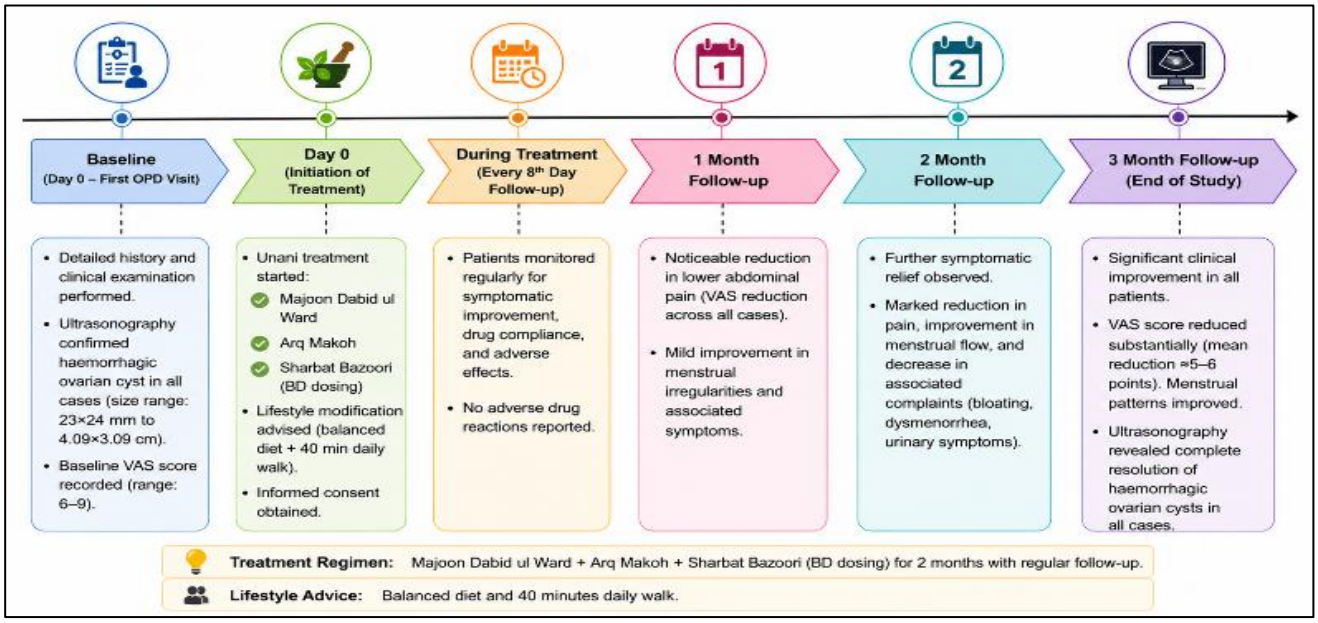


Figure 1: Treatment timeline.

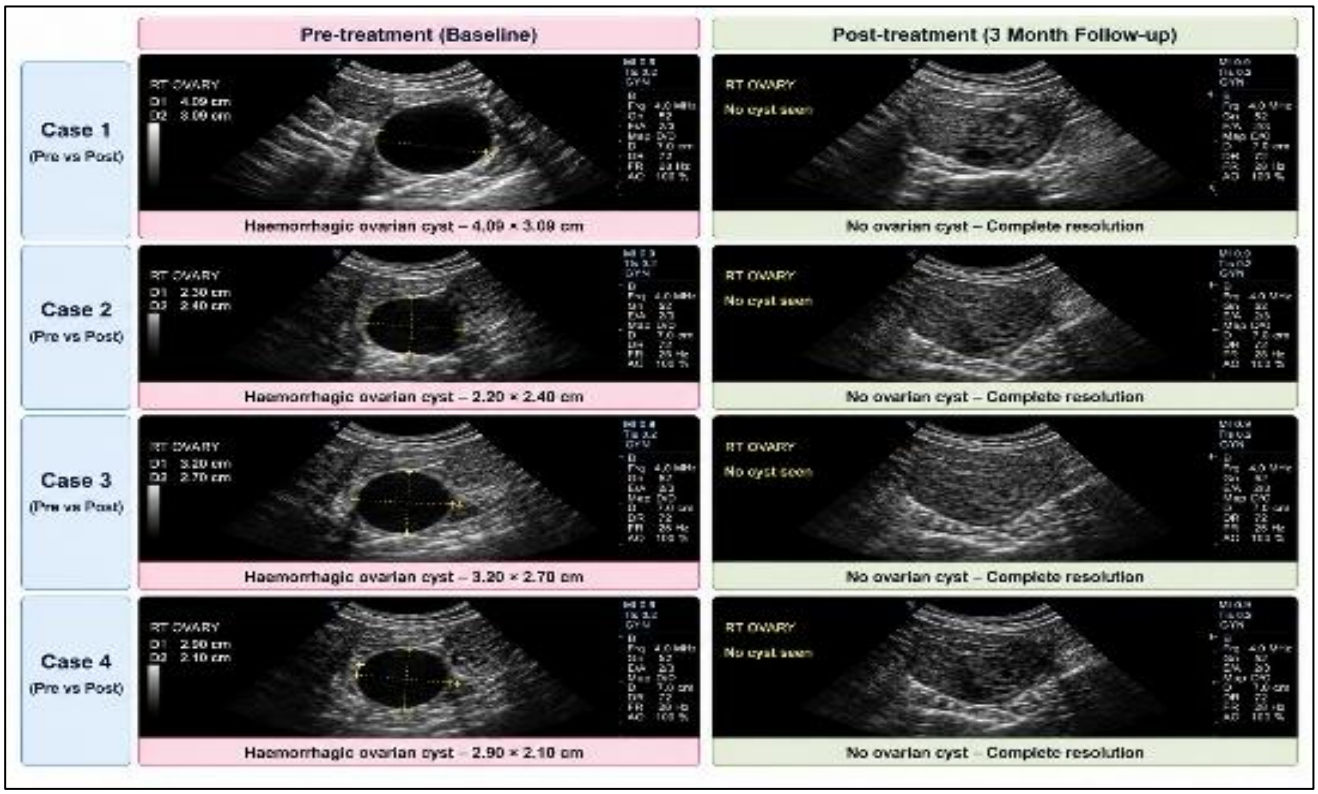


Figure 2: Ultrasonography images (Pre and post treatments).

DISCUSSION

HOCs are common functional ovarian lesions encountered during the reproductive years and are usually managed conservatively because many resolve spontaneously within a few menstrual cycles. However, persistent pelvic pain, dysmenorrhea, menstrual irregularities, and anxiety related to adnexal masses frequently necessitate active clinical management and serial ultrasonographic monitoring. Contemporary literature supports conservative follow-up in uncomplicated haemorrhagic cysts, particularly in reproductive-age women, with repeat ultrasonography generally recommended within 6-12 weeks.[12]

In the Unani system of medicine, conditions resembling haemorrhagic ovarian cysts may be correlated with Ehtebas-e-Tams, Mubayyazur, and cystic swellings described as Kisa-e-Khusyatur Raḥim. Classical Unani scholars, particularly Ibn Sina in Al-Qanun fi al-Tibb, attributed cyst formation (Keesa) to derangement of humors, especially Fasād-e-Dam and abnormal predominance of Balgham, resulting in accumulation of morbid material within sac-like structures. The principles of treatment (Usool-e-Ilaj) therefore emphasize correction of humoral imbalance, resolution of inflammation (Muḥallil-e-Awram), evacuation of morbid material, and removal of obstruction (Nāfi'-e-Sudad).[5,6] In the present case series, all patients treated with the standardized Unani regimen comprising Majoon Dabidul Ward, Arq Makoh, and Sharbat Bazoori for three months demonstrated marked symptomatic improvement along with complete ultrasonographic resolution of haemorrhagic ovarian cysts. Mean reduction in VAS scores was approximately 5-6 points, indicating substantial relief in pelvic pain and dysmenorrhea. Improvement was also observed in menstrual irregularities, bloating, and associated urinary symptoms.

The therapeutic response observed in this study may be explained by the pharmacological properties traditionally attributed to the prescribed formulations. Majoon Dabidul Ward is described in Unani literature as possessing Mu'addil-e-Dam, anti-inflammatory, and deobstruent actions that may help reduce pelvic congestion and local inflammation. Arq Makoh is traditionally used for its anti-inflammatory and Nāfi'-e-Sudda properties, whereas Sharbat Bazoori is considered useful in promoting elimination of morbid matter and reducing inflammatory symptoms. Collectively, these formulations may contribute toward restoration of humoral balance and regression of cystic pathology.

The findings of the present study are comparable with previously published reports on conservative and complementary management approaches for ovarian cysts. Fujii et al described successful conservative management of a haemorrhagic ovarian cyst with serial ultrasonographic follow-up and emphasized that careful monitoring may help avoid unnecessary surgical intervention.[13] Similarly, Ayurvedic management using Panchakarma therapy has been reported to produce successful resolution of a simple haemorrhagic ovarian cyst measuring 3.2×2.8×2.7 cm, suggesting a potential role of traditional non-surgical therapies in functional ovarian cysts.[14]

Modern gynecological literature also supports conservative observation for uncomplicated haemorrhagic ovarian cysts. Consensus recommendations indicate that many functional ovarian cysts regress spontaneously and may be managed with serial ultrasonography unless persistent symptoms, suspicious morphology, or complications arise.[12]

The present findings are consistent with these observations while additionally suggesting that Unani therapy may provide symptomatic benefit during the conservative management period.

Importantly, no adverse drug reactions or treatment-related complications were observed in any patient throughout the study period, indicating good short-term tolerability of the regimen. This is clinically relevant because hormonal therapies, although frequently prescribed, may be associated with adverse effects, recurrence after discontinuation, and limited acceptability among women seeking fertility-preserving or non-hormonal treatment options. The present Unani regimen therefore represents a potentially acceptable conservative alternative in selected uncomplicated cases.

Nevertheless, spontaneous resolution represents the natural course of many haemorrhagic ovarian cysts and should be considered while interpreting these findings. Therefore, although consistent symptomatic and ultrasonographic improvement in all patients suggests a supportive therapeutic role of Unani treatment, definitive conclusions regarding efficacy cannot be established from an uncontrolled case series alone.

The major strength of the present study lies in the use of a standardized therapeutic protocol, regular follow-up assessments, serial pain scoring, and objective ultrasonographic documentation of cyst resolution. Additionally, the study highlights a fertility-preserving, non-hormonal, and well-tolerated conservative management approach rooted in traditional medicine.

However, several limitations should be acknowledged. The sample size was small, no control or comparator group was included, and long-term follow-up for recurrence could not be performed. Hormonal profiles, inflammatory markers, and quality-of-life parameters were not evaluated.

Furthermore, because spontaneous regression of haemorrhagic ovarian cysts is common, the precise contribution of the intervention could not be isolated. Therefore, the findings should be interpreted cautiously.

Future research should focus on larger randomized controlled trials comparing standardized Unani therapy with conventional conservative or hormonal management. Studies involving multicentric recruitment, longer follow-up duration, recurrence assessment, hormonal evaluation, fertility outcomes, and quality-of-life analysis would provide stronger evidence regarding efficacy and safety. Experimental pharmacological studies exploring the anti-inflammatory and deobstruent mechanisms of the constituent formulations may further help validate their therapeutic role in ovarian cyst management.

No baseline or post-treatment biochemical investigations such as liver function tests, renal function tests, or hormonal profiles were performed. Therefore, objective assessment of treatment-related safety and possible mechanistic effects could not be established and remains an important area for future research.

Overall, the present case series suggests that Unani therapy may serve as a safe and potentially effective supportive conservative approach for haemorrhagic ovarian cysts, particularly among women seeking non-hormonal and fertility-preserving treatment options.

CONCLUSION

Conservative management remains the mainstay in haemorrhagic ovarian cysts, with regular follow-up being essential to detect complications and confirm cyst resolution. In the present case series, treatment with Majoon Dabidul Ward, Arq Makoh, and Sharbat Bazoori for three months resulted in significant symptomatic improvement and complete ultrasonographic resolution of cysts without adverse effects. These findings suggest that Unani therapy may provide a safe, non-hormonal, fertility-preserving supportive approach in uncomplicated cases. However, larger randomized controlled studies with long-term follow-up are required to establish definitive efficacy and safety.

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