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INDIVIDUALIZED HOMOEOPATHIC MANAGEMENT OF POLYENDOCRINE METABOLIC OVARIAN SYNDROME WITH SECONDARY INFERTILITY: A CASE REPORT

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ABSTRACT

Background: Polyendocrine Metabolic Ovarian Syndrome is an endocrine and reproductive disorder affecting 7 to 15% of women of reproductive age. PMOS is the first cause of anovulatory infertility nowadays and infertility is found in 70 to 80% of affected women. Currently, the most preferred and better serving regimen of PMOS is opting for allopathic medicines; however, considering the side effects, there is a demand for a complementary therapy. Constitutional Homoeopathic medicine acts on psychic, somatic and pathological levels providing holistic approach to cure diseases.

Case Report: A 19-year-old woman presented to the National Institute of Homoeopathy on April 7, 2025, with a clinical history of secondary infertility of two years' duration. Her presentation included associated symptoms of scanty menses, leucorrhea, and headaches. Mentally, she is sensitive to contradiction, fears being alone, and suffers from deep grief regarding her inability to conceive. Ultrasound (USG) showed polycystic ovarian morphology, and blood test indicated a prolactin level of 52.11 ng/ml. This indicates the diagnosis of PMOS with secondary infertility.

Intervention and Outcome: The remedy selected was NATRUM CARBONICUM. The patient was followed up for 12 months. After taking NATRUM CARBONICUM 0/1 to 0/12, her condition improved markedly; USG report showed that the polycystic morphology was resolved and the serum prolactin level came to normal, from 52.11 ng/ml to 19.72 ng/ml. She subsequently became pregnant, confirmed by a positive urine HCG test and a serum beta-HCG level of 95.2 mIU/ml. Modified Naranjo Criteria for Homoeopathy (MONARCH) score was reported as +8.

Conclusion: The case was followed for 12 months with a positive result of pregnancy after individualized homoeopathic treatment. Constitutional homoeopathy was reported to be successful in the treatment of PMOS with secondary infertility.

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INTRODUCTION

Polyendocrine Metabolic Ovarian Syndrome is an endocrine and reproductive disorder affecting 7 to 15% of women of reproductive age. It was first described by Stein and Leventhal in 1935. PMOS etiology is complex, including genetic, environmental and lifestyle factors and remains controversial. PMOS is defined by the presence of at least two of the Rotterdam criteria: oligo-anovulation, clinical or biological hyperandrogenism, and micro polycystic syndrome (ovarian volume >10 ml and/or more than 12 follicles by the ovary). Patients suffering from PMOS will consult for different degrees of hyperandrogenism (hirsutism, seborrhea, acne), dysfunction of the menstrual cycles, overweight and infertility. A delayed diagnosis has

been well documented in the literature, explained in part by the lateness of referral to a specialist, often for infertility. PMOS is the first cause of anovulatory infertility nowadays and infertility is found in 70 to 80% of affected women. Evaluation of infertility or subfertility is recommended after 12 months without pregnancy in couples having regular sexual intercourse (2 or 3 times/week) [1].

Moreover, hyperprolactinemia is a disorder characterized by increased blood levels of prolactin, which may have physiological, pathogenic, or idiopathic causes [2]. Women are more likely to develop prolactin-secreting pituitary adenoma (prolactinoma) and idiopathic hyperprolactinemia. Additional less frequently observed causes include intake of drugs, pituitary and hypothalamic tumors, and primary hypothyroidism that compresses the pituitary stalk. Hyperprolactinemia in females is characterized by amenorrhea, galactorrhea, and infertility. It is also important to note that hyperprolactinemia can be triggered by hypothyroidism in patients having PMOS. However, the exact mechanism is not known [2].

Women with PMOS are potentially at an increased risk of miscarriage and during pregnancy they are at an increased risk of developing gestational diabetes, pregnancy-induced hypertension and pre-eclampsia [3].

Currently, the most preferred and better serving regimen of PMOS is opting for allopathic medicines like clomiphene citrate, metformin, tamoxifen, and troglitazone [4]. Considering the side effects associated with conventional treatment and the patients who fail to respond to these measures, there is a demand for a complementary therapy that would alleviate symptoms of PMOS without side effects. Homoeopathy is a complementary system of medicine that has been used in different disease conditions, including PMOS [5]. Homoeopathy has been used in the management of a broad spectrum of diseases. Constitutional Homoeopathic medicine acts on psychic, somatic and pathological levels providing holistic approach to cure diseases. However, in gynaecology, its use remains limited when it comes to the context of evidence and publication [6].

A case is presented here where constitutional homoeopathy was used in the treatment of PMOS with infertility.

PATIENT INFORMATION

A 19-year-old woman presented to the National Institute of Homoeopathy on April 7, 2025, with a clinical history of secondary infertility of two years' duration, despite regular unprotected intercourse. Her presentation included associated symptoms of scanty menses, leucorrhea persisting for one year, and headaches lasting two years.

Her menstrual cycle was regular, characterized by a scanty flow of dark blood without clots, using 1 pad per day, with a 3/30-day cycle. The leucorrhea consisted of a thick, white, offensive discharge after menses. She described a headache localized to the left temple that radiated to the right, aggravated by sun exposure and ameliorated by sleep.

Her medical history was significant for childhood chickenpox and two spontaneous abortions in 2023, while her family history revealed that her mother suffered from heart disease. Married at age 17, the patient reported sexual intercourse 5–6 times per month without associated complaints.

Regarding physical generals, she had a craving for salt and spicy food, an aversion to milk, and experienced profuse perspiration that generally made her feel better. Mentally, she was sensitive to contradiction, feared being alone, and suffered from deep grief regarding her inability to conceive, often leading to a weeping tendency when she was by herself.

DIAGNOSTIC ASSESSMENT

Based on the reports from December 2, 2025, the ultrasound (USG W/A) showed polycystic ovarian morphology, and the blood test indicated a prolactin level of 52.11 ng/ml. This was reported as the diagnosis of PMOS with secondary infertility.

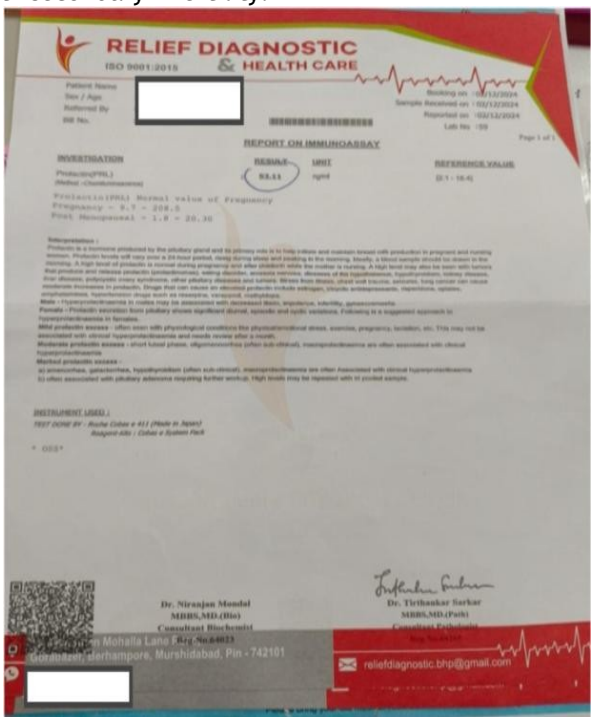


Figure 01: Diagnostic investigation/report.

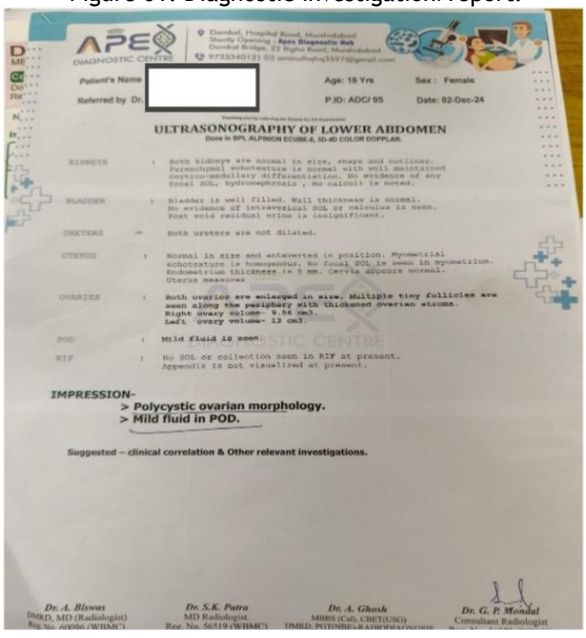


Figure 02: Relevant clinical/laboratory investigation reports.

DIFFERENTIAL DIAGNOSIS

Hypogonadotropic hypogonadism, hyperprolactinemia, hypothyroidism, and hyperadrenalism [7].

REPERTORIAL SELECTION

For repertory selection and remedy selection, SYNTHESIS 9.0 English repertory was chosen, utilizing RADAR 10 software.[8] The decision to use the SYNTHESIS repertory was based on the presence of many general symptoms in the case. This repertory was deemed suitable for analyzing and evaluating the case's symptoms and characteristics. Ten rubrics were selected based on Kent's method of evaluation.

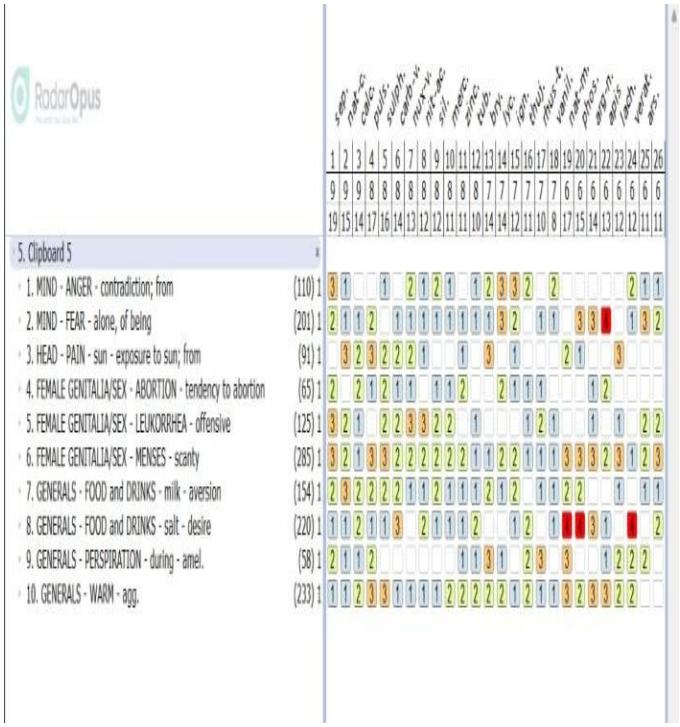


Figure 03: Repertorial analysis.

REPERTORIAL ANALYSIS

The repertorial analysis indicated:

- SEPIA OFFICINALIS – 19/9
- NATRUM CARBONICUM – 15/9
- CALCAREA CARBONICUM – 14/9
- PULSATILLA NIG – 17/8
- SULPHUR – 16/8

The remedy selected was NATRUM CARBONICUM. The final selected remedy was made after referring to Boericke Materia Medica[9] and H. C. Allen's Keynotes.[10]

THERAPEUTIC INTERVENTION

NATRUM CARBONICUM in millesimal potency, sourced from Hahnemann Publishing Co. Pvt. Ltd. (HAPCO), was prescribed from NATRUM CARBONICUM 0/1 up to 0/12. The medicine was taken on an empty stomach in the morning daily.

Table 01: Details of follow-up visits

Date	Follow-up	Prescription	Adverse effects
19/05/2025	White discharge per vagina reduced. Pain in head reduced. Menses regular, scanty, 1 pad/day, dark-coloured blood. No new complaints.	NATRUM CARBONICUM 0/1, 16 doses OD/AC × 16 days, followed by NATRUM CARBONICUM 0/2, 16 doses OD/AC × 16 days.	None reported
26/06/2025	White discharge per vagina reduced markedly. Pain in head reduced. Menses regular, moderate flow, 2 pads/day, dark-coloured blood. No new complaints.	NATRUM CARBONICUM 0/3, 16 doses OD/AC × 16 days, followed by NATRUM CARBONICUM 0/4, 16 doses OD/AC × 16 days.	None reported
28/07/2025	White discharge previously reduced markedly but increased for 3 days. Pain in head increased. Menses regular, moderate flow, 2 pads/day, dark-coloured blood. No new complaints.	NATRUM CARBONICUM 0/5, 16 doses OD/AC × 16 days, followed by NATRUM CARBONICUM 0/6, 16 doses OD/AC × 16 days.	None reported
06/10/2025	White discharge reduced completely. Pain in head increased. Menses regular, moderate flow, 2 pads/day,	NATRUM CARBONICUM 0/7, 16 doses OD/AC × 16 days, followed by NATRUM CARBONICUM 0/8, 16 doses OD/AC × 16 days.	None reported

	bright red blood. No new complaints.		
10/11/2025	Pain in head reduced. Menses regular, moderate flow, 2 pads/day, bright red blood, 3-4/30-day cycle. No new complaints. Patient advised USG whole abdomen and serum prolactin level.	NATRUM CARBONICUM 0/9, 16 doses OD/AC × 16 days, followed by NATRUM CARBONICUM 0/10, 16 doses OD/AC × 16 days.	None reported
22/12/2025	Pain in head reduced completely. Menses regular, moderate flow, 2 pads/day, bright red blood, 3-4/30-day cycle. No new complaints. USG reported normal limits; polycystic morphology resolved. Serum prolactin decreased from 52.11 ng/ml to 19.72 ng/ml.	NATRUM CARBONICUM 0/11, 16 doses OD/AC × 16 days, followed by NATRUM CARBONICUM 0/12, 16 doses OD/AC × 16 days.	None reported
09/03/2026	Menses regular. No new complaints.	RUBRUM 30 doses OD/AC × 30 days.	None reported
30/03/2026	LMP: 24/02/2026. No menses appeared that month. Urine HCG test advised.	Consulted through phone; no medication prescribed.	None reported
03/04/2026	Urine HCG test returned positive. Serum beta-HCG was 95.2 mIU/ml (reference range <0.5 mIU/ml), consistent with conception.	—	—

Abbreviations: OD = once a day; AC = after food; AD = alternate days.

RESPONSE TO TREATMENT

The patient was followed up for 12 months. After taking NATRUM CARBONICUM 0/1 to 0/12, her condition improved markedly. The USG report showed normal limits, with resolution of polycystic ovarian morphology, and the serum prolactin level decreased from 52.11 ng/ml to 19.72 ng/ml.

She subsequently became pregnant. The urine HCG test returned positive and the serum beta-HCG level was 95.2 mIU/ml (reference range <0.5 mIU/ml). USG report showed a single live intrauterine pregnancy of 7 weeks and 5 days as of May 4, 2026. These results indicated conception after two years of infertility.

The authors continued to contact her by telephone to monitor her progress, and she was referred for appropriate antenatal care. No adverse reactions or homoeopathic aggravation were reported during the treatment.

OBJECTIVE EVIDENCE

Photographs and investigation reports before and after treatment are presented as Figures 1–8.

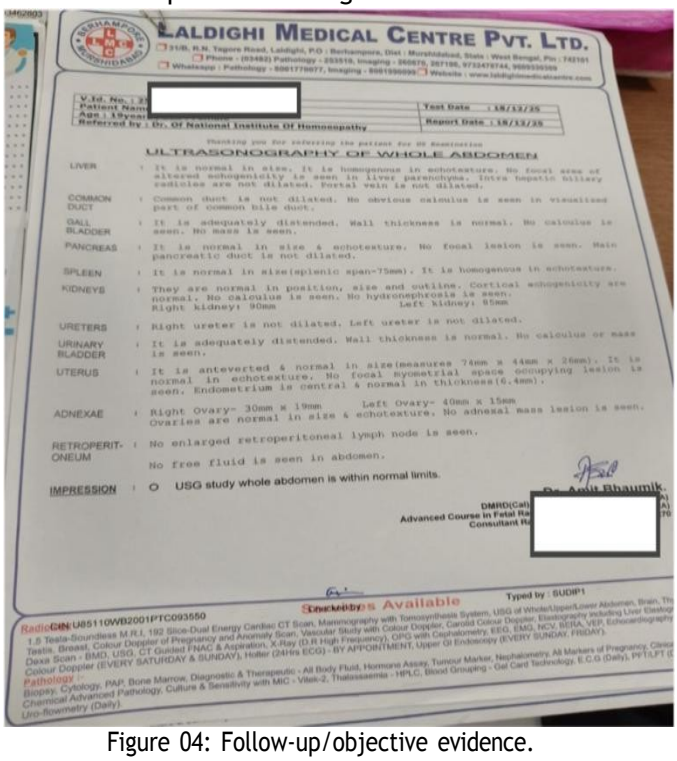
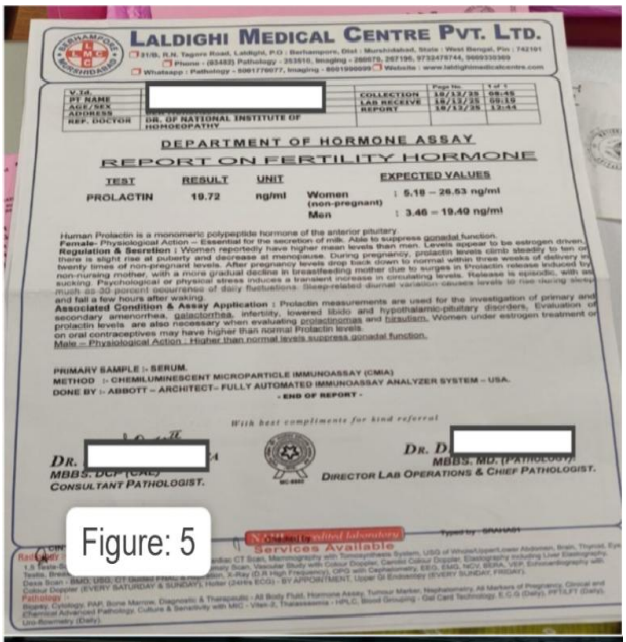
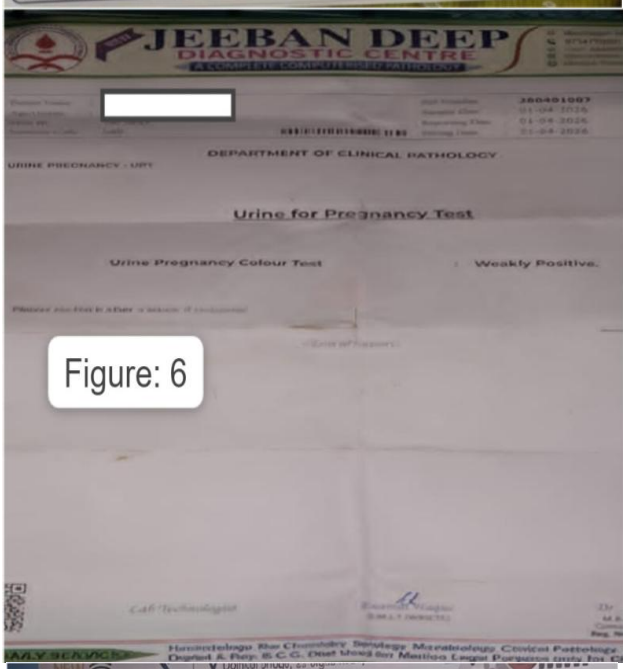
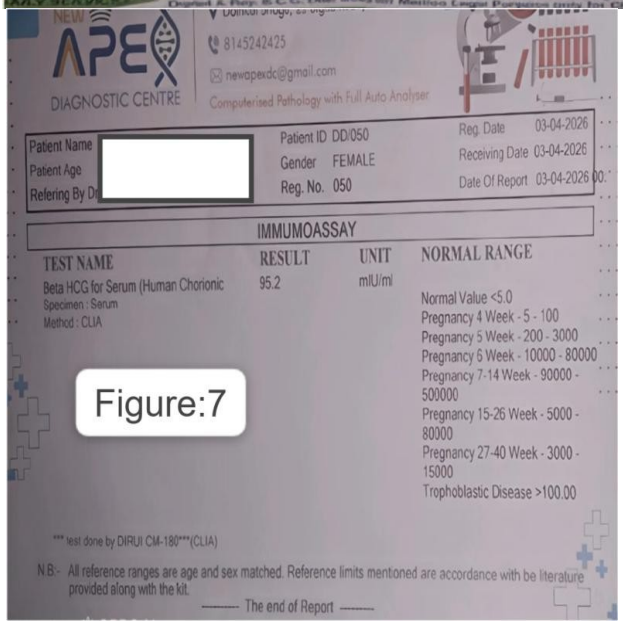
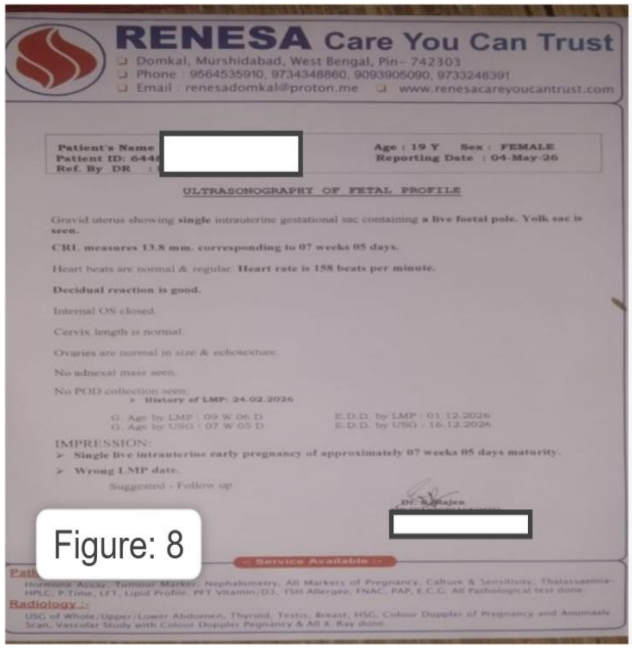


Figure 04: Follow-up/objective evidence.









Figures 05-08: Relevant investigation reports and follow-up evidence.

IMPORTANT FOLLOW-UP AND RESULT

The case was followed for 12 months with a positive pregnancy outcome following individualized homoeopathic treatment. The patient remained in contact.

INTERVENTION ADHERENCE AND TOLERABILITY

Intervention adherence and tolerability were assessed through periodic telephonic conversations with the patient twice a month.

ADVERSE OR UNANTICIPATED EVENTS

No exacerbation of complaints occurred during the treatment period. No adverse reactions or unanticipated events were reported during the consultations.

POSSIBLE CAUSAL ATTRIBUTION

The Modified Naranjo Criteria for Homoeopathy (MONARCH) was performed after resolution of the chief complaints for qualitative assessment of a possible causal relationship between clinical improvement and homoeopathic intervention.

The MONARCH score contains 10 items, with a minimum score of −6 and a maximum score of +13. The case was reported to have a score of +9 in the tabulated assessment.

Table 02: Causality assessment by Modified Naranjo Criteria for Homoeopathy (MONARCH) after treatment

Item	Assessment	Score
1. Was there an improvement in the main symptom or condition for which the homoeopathic medicine was prescribed?	Yes	+2
2. Did the clinical improvement occur within a plausible time frame relative to the drug intake?	Yes	+1

3. Was there an initial aggravation of symptoms?	No	0
4. Did the effect encompass more than the main symptom or condition, i.e. were other symptoms ultimately improved or changed?	Yes	+1
5. Did overall wellbeing improve?	Yes	+1
6(A). Direction of cure: did some symptoms improve in the opposite order of the development of symptoms of the disease?	Not sure/N/A	—
6(B). Direction of cure: did at least two aspects apply to the order of improvement of symptoms?	Yes	+1
7. Did old symptoms reappear temporarily during the course of improvement?	No	0
8. Are there alternate causes, other than the medicine, that with a high probability could have caused the improvement?	Not sure/N/A	—
9. Was the health improvement confirmed by any objective evidence?	Yes	+2
10. Did repeat dosing, if conducted, create similar clinical improvement?	Not sure/N/A	0

Total Score = +8
Note: Maximum Score = 13; Minimum Score = −6.

DISCUSSION

The primary strength of this case report lies in the objective evidence used to track the patient's progress over 12 months. This includes pre- and post-intervention ultrasonography showing resolution of polycystic ovarian morphology and laboratory assays demonstrating normalization of serum prolactin levels from 52.11 ng/ml to 19.72 ng/ml. Furthermore, the application of the Modified Naranjo Criteria for Homoeopathy (MONARCH) resulted in a score of +8, providing a systematic framework for assessing the possible causal relationship between the individualized homoeopathic prescription and the clinical improvement.

Infertility is associated with suffering of individuals and affects the socio-demographic structure of the population. It results from immunological and metabolic abnormalities that initiate endocrine disorders. The main factors causing infertility among women with PMOS are impaired ovulation, implantation, and low-grade inflammation [11].

PMOS and hyperprolactinemia are common causes of infertility in reproductive-age women. PMOS patients with a PRL level of ≥52.9 ng/mL may need to undergo sella MRI for detecting pituitary adenomas. To help ensure a favorable clinical course for these patients, systematic diagnosis, treatment, and follow-up plans should be established [12].

Modern medicine mainly treats infertile patients with PMOS by improving lifestyle, ovulation induction therapy, and assisted reproductive technology (ART). Complementary and alternative medicine has also been discussed in relation to PMOS infertility [13].

However, the case-report approach is inherently limited by the nature of a single-case study, as the successful outcome of one patient cannot be generalized to the broader population of women suffering from PMOS. Additionally, despite the positive outcome, the broader clinical literature regarding homoeopathic evidence in gynaecology remains limited, necessitating more rigorous, large-scale studies.

CONCLUSION

The case was followed for 12 months with a positive pregnancy outcome following individualized homoeopathic treatment. Constitutional homoeopathy was used in the management of PMOS with secondary infertility, with resolution of polycystic ovarian morphology on ultrasound and normalization of serum prolactin levels from 52.11 ng/ml to 19.72 ng/ml. The individualized homoeopathic prescription of NATRUM CARBONICUM in 50 millesimal potency was followed by successful conception, confirmed by a serum beta-HCG level of 95.2 mIU/ml. The findings of this single case warrant further systematic investigation rather than generalization to a wider population.

DECLARATION OF PATIENTS' CONSENT

The authors confirm that they have secured the necessary consent forms from the patient. The consent forms explicitly grant permission for clinical information to be included in the journal publication, with the understanding that the patient's identity will be protected and her name and initials will not be disclosed. While every effort will be made to ensure anonymity, it cannot be guaranteed.

CONFLICT OF INTEREST

Nil

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AUTHOR CONTRIBUTION

All are contributed equally

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Not Declared

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