



Scope of Homoeopathy in the Management of Polycystic Ovary Syndrome (PCOS)

Dr. Jaya Laxman Kharat, M.D. (Homoeopathy)

Professor, Department of Pathology and Microbiology,
Kakasaheb Mhaske Homoeopathic Medical College, Hospital & Post Graduate Institute, Ahmednagar - 414111 (M.S.) INDIA
E-mail: drjaya_meetme@rediffmail.com

ABSTRACT

Polycystic ovary syndrome (PCOS) is a common hormonal disorder that affects women of reproductive age. It usually starts during adolescence, but symptoms can fluctuate over time.

PCOS can cause hormonal imbalances, irregular periods, excess androgen levels, and ovarian cysts. Irregular periods, usually with insufficient ovulation, can make it difficult to get pregnant. PCOS is a leading cause of infertility.

PCOS is a chronic disease and cannot be cured. However, some symptoms can be improved with lifestyle changes, medication and fertility treatments.

The cause of PCOS is unknown, but women with a family history or type 2 diabetes are at higher risk.

PCOS represents a significant public health problem and is one of the most common hormonal disorders affecting women of reproductive age. The disease affects an estimated 8-13% of women of reproductive age, and up to 70% of cases go undiagnosed.

The prevalence of PCOS is higher in some ethnic groups, and these groups often experience more complications, especially related to metabolic problems.

The biological and psychological effects of PCOS, particularly those related to obesity, body image and infertility, can lead to mental health problems and social stigma.

Key facts

- Polycystic ovary syndrome (PCOS) affects an estimated 8-13% of women of reproductive age.
- Up to 70% of affected women remain undiagnosed worldwide.
- PCOS is the most common cause of anovulation and the leading cause of infertility.
- PCOS is associated with a number of long-term health problems that affect physical and emotional well-being.
- PCOS runs in families, but there are ethnic differences in how PCOS manifests and affects people.

KEYWORDS: Polycystic ovary syndrome (PCOS), Polycystic ovary disease (PCOD), Pathology, Homoeopathic Treatment, Homeopathy and Homeopathic Medicine.

INTRODUCTION

The ovaries are a paired organ in the female reproductive system; they are located in the pelvis, one on each side of the uterus, which is a hollow, pear-shaped organ where the baby grows. Each ovary is about the size and shape of an almond. The ovaries produce eggs and female hormones. Hormones are chemicals that control the functioning of certain cells or organs.

Each month during the menstrual cycle, an egg is released from one ovary in a process called ovulation. The egg travels from the ovary through the fallopian tube to the uterus. The ovaries are also the main source of the female hormones estrogen and progesterone. These hormones affect female breast development, body shape and body hair. They also regulate the menstrual cycle and pregnancy.

In 1935, Stein and Leventhal first described a syndrome consisting of symptoms of oligomenorrhea, anovulation, hirsutism, and obesity associated with bilaterally enlarged polycentric ovaries.

Polycystic ovary syndrome comprises a heterogeneous group of patients who may present to a gynecologist with infertility or menstrual problems or an endocrinologist with obesity, hirsutism, or acne/skin problems.

Polycystic ovary disease is the 4th gynecological problem of hospital admission. 90% of all ovarian tumors are benign, although this varies by age. Benign ovarian cysts are asymptomatic and resolve spontaneously.

In their population studies, Hull et al and Adam et al reported the ultrasound appearance of polycystic ovaries in 20% of women with normal menstrual cycles, 26–32% with amenorrhea, 87–90% with oligomenorrhea, and 90–95% with hirsutism.

Regan et al reported that 50% of women with recurrent miscarriage had polycystic ovaries on ultrasound.

Despite many years of research, the etiology of PCOS remains a mystery. It is unclear whether this is a primary ovarian disorder or secondary to a central hypothalamic-pituitary defect.

The initiating events of PCOS are not certain. It has been suggested that excessive androgen production at puberty triggers a chain of events that can lead to polycystic ovaries. It seems likely that there is a familial component to the development of polycystic ovaries.

Whether the genetic mechanism responsible for typical ovarian morphological changes remains uncertain. It is possible that these changes are caused by exposure of the ovary to excess androgen sometime during its development. If androgens are the trigger for the development of polycystic ovaries, the source may be the ovaries or adrenal glands. A central abnormality in PCOS is the abnormal regulation of 17 α -hydroxylase, the enzyme responsible for the conversion of progesterone to 17 α -hydroxyprogesterone and then to androstenedione. P450 C17 α is a key rate-limiting enzyme for androgen synthesis in both the ovaries and adrenal glands. However, it is only one of many possible factors that may be important in the etiology of PCOS.

Benign ovarian cysts that are larger than a few inches across can move away from the abdomen, so women may feel like they are gaining weight or pregnant, although their periods may or may not be affected. Cysts of this kind are likely to cause problems and may need to be surgically removed. If not removed, such cysts can twist, rupture, or bleed into the abdominal cavity.

If the condition is removed surgically, without any attempt being made to correct the constitutional condition which gave rise to them, the changes of recurrence are very great, and the actual condition is worse than better. It is logical to say that surgery does not remove the cause of the disease, it only removes the result. The altered human system that caused the surgical disease continues to function in this altered state even after surgical manipulation. The tendency of the tissue to grow or form cysts remains unchanged.

Homeopathy, a system of medicine, removes the suffering of the sick by not considering a single disease entity, but by its holistic approach. He is not against surgery. Surgery can bring beneficial results to the organism, but because homeopathy has in its hands the most effective means of eradicating constitutional tendencies. Therefore, it is believed that surgery is not the solution in such cases, but a constitutional and holistic approach to the problem will remove the cause of the surgical disease and remove the pathology process to achieve a permanent cure. The tendency of the tissue to grow is arrested by constitutional homeopathic treatment.

REVIEW OF LITERATURE

Polycystic ovarian Syndrome (PCOS).

Definition:

Accumulation of many incompletely developed follicles in the ovaries. This condition is characterized by scanty or menses (menstruation), multiple ovarian cysts, and infertility. The classic features of the complete symptom complex, originally described by Stein and Leventhal in 1935, were amenorrhea, infertility, obesity, and facial hirsutism. Typical microscopic findings in polycystic ovary syndrome are hyperplasia and luteinization of the theca interna.

Stein and Leventhal recognized that some symptoms were erratic; hirsutism occurred in only about 50% and instead amenorrhea, menstrual irregularities with episodes of menometrorrhagia were not uncommon. Amenorrhea develops gradually over the years. Obesity is not always present.

The typical ovarian appearance, characterized by multiple cysts in the ovarian cortex producing a "pearl" along with endocrinopathy associated with hyperandrogenism and often hyperinsulinism with insulin resistance, is the hormonal basis that produces ovaries with a multicystic appearance. The clinical picture is characterized by chronic anovulation associated with hyperandrogenism in the absence of any specific underlying adrenal or pituitary diseases. For this reason, the syndrome is often called chronic androgenized anovulation or chronic estrogenized anovulation.

Polycystic ovarian disease is the most common ovarian dysfunction and endocrine disorder, affecting approximately 15-20 percent of women of reproductive age. Affected women often have signs and symptoms of elevated androgen levels, menstrual irregularities and weight gain, abnormal facial or body hair growth, and no periods at all (amenorrhea). The syndrome initially appears in the peripubertal years and is progressive.

PCOS is a female hormonal imbalance in which a mature egg fails to be expelled from the ovary and immature follicles form in the ovaries. The cysts then contribute to a hormonal imbalance that causes more cysts and enlarged ovaries. Polycystic ovary syndrome is characterized by anovulation (no egg

production) regardless of period (regular or irregular or absent) and hyperandrogenism (increased serum testosterone and androgen). Also, women with PCOS who become pregnant have a higher rate of early fetal loss than women without PCOS.

Causes, incidence and risk factors:

Polycystic ovary syndrome is an endocrine disorder, meaning that normal hormone cycles are disrupted. An estimated 5 to 10 percent of women of childbearing age have PCOS. Hormones control many functions of the body, for example, hormones regulate reproductive functions, including the normal development of eggs in the ovaries. It is not fully understood why or how hormonal cycles are interrupted, although there are several working theories.

In polycystic ovary syndrome, underdeveloped follicles accumulate in the ovaries. Follicles are sacs in the ovaries that contain eggs. Eggs do not mature in these follicles and therefore cannot be released from the ovaries. Instead, they accumulate as cysts in the ovary. This can contribute to infertility. Lack of follicle maturation and failure to ovulate is likely due to low levels of follicle-stimulating hormone (FSH) and higher-than-normal levels of androgens (male hormones) produced in the ovaries.

Polycystic ovaries are 2 to 5 times larger than normal ovaries and have a white, thick, very rigid outer shell. PCO usually appears shortly after puberty. Women with PCO will stop menstruating (or may never have started) or have irregular periods. She will gain weight, eventually become obese, and may develop excessive facial or body hair (hirsutism). Although the cause of PCO is not fully understood, there are several theories that suggest problems with estrogen production and hypothalamic-ovarian feedback. With reduced pituitary hormones, ovarian function will not normally occur, but increasing the amount of follicle-stimulating hormone (FSH), one of the hormones normally produced by the pituitary gland, is often successful in stimulating underdeveloped eggs. mature and be released from the ovary. Women diagnosed with this disorder often have a mother sister with similar symptoms associated with PCOS. However, currently there is not enough evidence to prove a genetic link to the disease, conception is often possible with proper surgical or medical treatment. After conception, pregnancy is usually uneventful.

PCOS runs in families. Several genes contribute to the pathogenesis of PCOS. Many of these genes are associated with insulin resistance with elevated fasting blood insulin levels of androgen hormones interfering with the pituitary ovarian axis, leading to elevated LH levels, anovulation, amenorrhea, and infertility.

Young diabetics treated with insulin are at particular risk of PCOS. The amount of insulin administered by insulin-dependent or insulin-requiring diabetics far exceeds what the body naturally produces.

Obesity is a common part of PCOS and many of these women are also insulin resistant. When a woman is insulin resistant, her fat cells do not respond normally to insulin in the bloodstream. Weight gain itself may result from high serum insulin levels.

Women with PCOS have less chance of getting pregnant compared to normal women who ovulate every month. Normal women have 12 chances to get pregnant in a year. But women with PCOS hardly get 3-4 chances due to delayed period.

Pathogenesis:

Patients with PCOS almost always have elevated LH tone due to increased secretion of GnRH from the hypothalamic arc. Increased LH tone promotes the secretion of androgens from the ovarian theca and thus increased levels of intraovarian androgens. An increased amount of androgens causes atresia of the developing follicles and forms the interface with the emergence of the dominant follicle. Therefore, normal estrogen secretion patterns are disrupted, there is no mid-cycle LH surge, and progesterone secretion is absent. Because follicles can secrete estrogen, these patients are hyperestrogenic and hyperandrogenic.

More precisely, the syndrome of polycystic ovaries reflects a prolonged, persistent anovulation, the development of a steady state in feedback loops of estrogen on gonadotropin, secretion. FSH levels fall in the low normal range with no mid-cycle peak; LH secretion remained elevated without an appropriate mid-cycle surge. In addition, there is an increased sensitivity of LH to GnRH.

Sustained gonadotropin stimulation initially causes follicles to grow and estradiol and estrone to increase, but eggs are not released. Follicular arrest and cystic or atretic and stromal tissue is increased. The amount of estradiol produced will decrease, but the estrogen precursors (androstenedione and testosterone) will increase significantly. Androstenedione can undergo conversion to testosterone in the ovary and peripherally. It also undergoes conversion to estrone by adipose tissue and this contributes to the circulating pool.

These disorders characteristic of polycystic ovary syndrome are thus self-perpetuating. A sustained surge of LH causes some increase in adrenal and ovarian androgen secretion.

An alternative cause of PCOS may lie primarily in hyperinsulinemia associated with insulin resistance. Insulin induces the secretion of androgens in the ovary and can itself induce the same type of androgen-induced follicular disruption. Insulin resistance is associated with obesity and therefore obese women are observed to be more at risk of PCOS.

Increased androgens generally decrease hepatic production and secretion of sex hormone-binding globulin. When high androgen levels suppress sex hormone levels. The amount of free testosterone can increase dramatically, even if the overall increase in testosterone is mild or small.

Symptoms of PCOS:

The most common symptoms of PCOS are

- Irregular and infrequent menstruation or no menstruation;
- infrequent or no ovulation with elevated levels of male hormones-testosterone in the serum;
- Inability to conceive within one year of unprotected intercourse;
- Weight gain or obesity;
- Diabetes, overproduction of insulin with abnormal lipid levels and high blood pressure;
- Male-type excessive growth of facial, chest, stomach hair (hirsutism) and male-pattern baldness or thinning or baldness; Acne, oily skin or dandruff;
- Patches of thickened and dark brown or black skin on the neck, groin, armpits or skin folds.
- Skin tags or small excess skin flaps in the armpit or neck area;
- Male pattern of fat storage – instead of the standard female pattern on the thighs, hips and waist rather than the standard female pattern; and mid-cycle indicating painful ovulation - due to enlargement and blockage of ovarian surface;

Other rare symptoms:

Fatigue, weakness, lack of energy, excessive cravings for sweets and chocolate, irritability and emotional stress have also been reported in PCOS patients. Some of these symptoms may be due to insulin resistance.

Asymptomatic:

About 20% of women with polycystic ovaries may be asymptomatic, and some of these women may be diagnosed as having polycystic ovaries and an ultrasound scan to rule out any other gynecological pathology. Future weight gain can also cause these patients to develop all the other features of PCOS.

PCOS signs:

- Multiple cysts on the ovaries, sonography may appear as a "string of pearls".
- Enlarged ovaries, generally 1.5 to 3 times larger than normal due to multiple cysts.
- Reinforced smooth pearl with an outer surface of the ovary.
- Chronic pelvic pain, possibly due to pelvic displacement from enlarged ovaries.
- The LH to FSH ratio is 2.1 or more, especially early in the menstrual cycle.
- Increased testosterone levels.
- Decreased level of sex hormones binding globulin.
- Hyperinsulinemia.

Consequences of PCOS:

Hyperinsulinemia in PCOS is also associated with high blood pressure and increased clot formation and appears to be a major risk factor for the development of heart disease, stroke, and type II diabetes.

Women with irregular cycles need to rule out other conditions such as anorexia, stress or exercise-induced menstrual cycle problems, other hormonal problems such as thyroid disease, or medication problems.

Common consequences of PCOS are:

Menstrual Irregularities – The constant production of estrogen stimulates the growth of the uterine lining, which usually causes very heavy episodes of uterine bleeding that can occur over a long period of time (oligomenorrhea) or in some women not at all (amenorrhea). Irregular menstruation is unpleasant and indicates some hormonal disorder or the risk of eudiometric thickening.

Impaired fertility: - Another consequence of incomplete follicle development is the lack of regular ovulation. Irregular ovulation usually means that it is more difficult to get pregnant. Similarly, if there is no ovulation, it is not possible to get pregnant.

Miscarriage: Although miscarriage seems to be an unfortunate accident for most couples, it is clear that women with PCOS may be at increased risk of premature fetal loss. The hormonal environment in PCOS can interfere with the development of the egg in the follicle and disrupt the implantation of the embryo in the uterus.

Hair and skin problems: Androgen (male hormone) is a byproduct of the ovaries. In PCOS, androgen production such as testosterone is excessive, causing abnormally increased hair growth and contributing to acne. Assessing excessive body hair (or hirsutism) can be difficult.

Obesity: About 50 percent of women with PCOS are obese. Obesity in this disorder tends to increase abnormal estrogen and androgen production, which only exacerbates problems with irregular bleeding and excessive hair growth.

Long term sequelae of PCOS:

More importantly, the long-term effects of unopposed estrogen put women with the syndrome at significant risk of endometrial or breast cancer.

Diagnosis of PCOS:

There is no single test to diagnose PCOS. History, physical examination, possibly including ultrasound, checks hormone levels and measures glucose or blood sugar. If you are producing too much male hormones, your doctor will confirm that it is PCOS. During a pelvic exam, the ovaries may be enlarged or swollen with an increased number of small cysts. This can be more easily seen with a vaginal ultrasound or screening to examine the ovaries for cysts and endoderm. The endometrium is the lining of the uterus. The lining of the uterus can thicken if you don't have regular periods.

Clinical manifestations including menstrual irregularities, usually oligomenorrhea but occasionally menometrorrhagia, may begin in adolescence or early twenties, predating the development of secondary amenorrhea by several years. Infertility is caused by anovulation. Obesity and hirsutism may or may not be linked. Ovarian enlargement is a common but not essential feature. The size is within normal limits in about a third of the cases. A smooth, gray, sclerotic capsule is characteristic of persistent anovulation.

Core body temperature is monophasic, cervical mucus shows arborization without significant changes during the cycle, and the endometrium is proliferative or hyperplastic. Estrogen secretion is within normal limits, but without progesterone resistance.

Gonadotropin secretion assumes a relatively steady state, although actual values vary. FSH is usually in the normal range and LH is elevated. The LH:FSH ratio is usually greater than 3:1. the level of 17-ketosteroids in the urine is normal or slightly elevated. Serum DHEAS is normal or slightly elevated. Plasma testosterone is usually elevated when hirsutism is associated, but is usually less than 200 ng/dL.

Laboratory examination:

- Increased testosterone levels
- Decreased sex hormone-binding globulin.
- Increased LH levels.
- Selected LH: FSH levels.
- Increased fasting insulin levels.

It is important to note that total testosterone levels may be only marginally elevated in women with PCOS. Free testosterone is higher than normal because SHBG levels are low. Testosterone levels > 5 nmol/l should prompt a search for an androgen-secreting tumor.

Symptoms of PCOS are slightly enlarged ovaries and may contain 10 or smaller cysts located on the periphery of the ovary that have led to polycystic ovaries. These cysts are generally less than 8 mm in size and can usually be detected by ultrasound.

Height and weight will be recorded along with any increase in facial or body hair or loss of hair on the head, acne and discoloration of the skin under the arms, breasts and groin. An increased level of androgens or testosterone confirms the diagnosis.

"The National Institute of Health-National Institute of Child Health and Human Development (NH-NICHHD) Conference on PCOS in April 1990 reached a consensus regarding the diagnosis of PCOS based on certain defined major and minor criteria:

1. Main criteria:

- Chronic anovulation
- Hyperandrogenism
- Clinical features of hyper androgenism
- Exclusion of other etiology.

2. Secondary criteria

- Insulin resistance (acanthosis nigricans and biochemical).
- Perimenarcheal onset of hirsutism and obesity
- Increased LH:FSH ratio.
- Ultrasonographic evidence of PCOS.
- Intermittent and associated with hyperandrogenism (free testosterone and androstenedione.)

Differential diagnosis:

Other causes of irregular/absent menstruation and hirsutism such as congenital adrenal hyperplasia, Cushing's syndrome, hyperprolactinemia, and other pituitary or adrenal disorders should be investigated.

MANGEMENT:

The decision to treat PCOS depends on symptoms, age, whether or not the patient wants to become pregnant, and the degree of ovarian and adrenal androgen excess. First-line management includes dietary modification, weight loss, and stress reduction, as obesity and stress can contribute to androgen excess. Other management and treatment approaches are aimed at addressing specific symptoms (ie, acne, excessive hair growth, menstrual problems, infertility) and preventing long-term complications, given that PCOS may be present in adolescence or earlier.

Traditional method of treatment:

Watchful waiting: - the patient waits and is examined again in one to three months to see if the size of the cyst has changed. This is a common treatment option for women who are of childbearing age, have no symptoms, and have a fluid-filled cyst. It may also be an option for postmenopausal women.

Surgery: If the cyst does not go away for several menstrual periods, has grown in size, looks unusual on ultrasound, causes pain, or the patient is postmenopausal, the cyst can be removed. There are two main surgical procedures.

(a) **Laparoscopy:** if the cyst is small and looks benign on ultrasound, the doctor will perform a laparoscopy. This procedure is performed under general anesthesia. A small incision is made above or below the navel and a small instrument that acts like a telescope is inserted into the abdomen. If the cyst is small and looks benign, it can be removed.

(b) **Laparotomy:** If the cyst is large and looks suspicious, the doctor may perform a procedure called laparotomy. This procedure involves making larger incisions in the cyst to see if the tissue is cancerous. For cancer, the doctor may need to remove the ovary and other tissue that may be affected, such as uterine lymph nodes.

Birth control pills: If you have frequent cysts, your doctor may prescribe birth control pills to prevent you from ovulating. This will reduce the chances of new cysts forming. For patients who wish to become pregnant, ovulation induction is initiated. If the patient does not become pregnant after six ovulatory cycles, an anatomical examination including hysterosalpingography, ultrasonography or even laparoscopy should be strongly considered. Patients who do not wish to become pregnant are treated with periodic discontinuation of progesterone. However, this method is usually effective in treating hirsutism.

Ovarian cysts cannot be prevented. Fortunately, most cysts do not even cause symptoms, are not related to cancer, and go away on their own. Pelvic examination. Alternatively, an ultrasound can help determine if a cyst is causing the problem. Functional ovarian cysts are common during childbearing years. Most often, cysts in women of this age group are cancerous. Women who are postmenopausal (age 50-70) with ovarian cysts have a higher risk of ovarian cancer.

Getting back to normal can be tiring:

- 1) Eating a balanced, low-carb diet and maintaining a healthy weight can help alleviate PCOS symptoms.
- 2) Regular exercise aids in weight loss and also helps the body in lowering blood glucose levels. Aerobic activities such as walking, jogging or swimming are recommended. With weight reduction and reduction of insulin resistance, regular menstruation usually resumes. Women who have reached their ideal body weight and continue to exercise cannot always be promised that they can ovulate regularly.
- 3) Depigmentation with wax or depilatory cream can be used to reduce excess hair on the body and face. Electrolysis is used to permanently remove facial hair.

Researchers are looking at how hormone levels change as women with PCOS age. They think that when women reach menopause, ovarian function changes and the menstrual cycle can become more normal. But even as male hormone levels decline, excessive hair growth continues and male pattern baldness, or thinning hair, worsens after menopause.

HOMOEOPATHIC THERAPEUTICS:

1. **ACTEA RACEMOSA:** Especially useful in rheumatic, nervous subjects with ovarian irritation. Chubby, delicate, sensitive, nervous, cold women who complain of back pain. Many complaints depend on irritation of the uterus and ovaries. Symptoms are irregular, variable and alternating. She suffers from nervous symptoms such as insomnia, great changes in mental mood, mental excitement and hysteromaniacal states due to depressed ovarian function. amenorrhea; Pain in the region of the ovaries shoots up and down the front of the thighs. Pain immediately before menstruation. Ovarian neuralgia; with other reflex left-sided pains, pains across the pelvis, from ovary to ovary, or goes up or down along thighs. Menses suppressed from emotion. Menstruation profuse, dark, coagulated, offensive with pain in the back, nervousness always irregular. Ovarian pains are very pronounced. Infrared chest pain. Pain in the left ovary, utero-ovarian disorders.

2. **APIS MEL:** Used for pains occurring in the region of the right ovary and thought to be caused by ovarian disease. Amenorrhea of puberty, ovaries; numbness or congestion due to suppression of menstruation. Dysmenorrhoea with scanty discharge of mucous blood or ovarian pain. Ovarian dropsy,

even cystic ovarian degeneration was cured. Ovarian neuralgia, inflammation of the ovaries and uterus may require this medicine. The right ovary is most affected. The most characteristic symptoms are burning stabbing pains and great soreness in the region of the right ovary.

3. BOVISTA: Adapted to old maidens with visible palpitation of the heart and trembling of the hands - nervous and weak joints. Tetter patients. A cure for cysts. Diarrhea before and during menstruation. Menses too early and copious, discharge every two weeks, worse at night, less on motion. Occasional performances between periods. Sensual sensation. Leucorrhoea acrid, thick, hard, greenish, leaving green spots on linen when walking; follows menstruation. He can't stand tight clothes around the waist. Traces of menstruation between periods. Pubic pain during menstruation. Metrorrhagia. Parovarian cysts.

4. COLOCYNTIS: Suitable for easily angered, irritable persons with a tendency to corpulence, for sedentary women, with profuse menstruation. Many cases of cystic tumors of the ovaries and broad ligaments have been cured by this remedy, especially when the tumors are round and small, associated with pain and general discomfort > hard pressure, the patient always wants the abdomen covered with a strong bandage. Ovarian inflammations with great soreness, ovarian colic, etc. Dull and constricting pain in ovarian region, must increase double, with great restlessness. Spasm like pain in region of left ovary, as if squeezed

In a vise. Ovarian cyst with pain > flexing thigh on pelvis. Suppression of menses or lochia from exasperation. Dysmenorrhoea < eating and drinking. Menstruation is abundant in women with sedentary habits. Suppressed menstruation with characteristic colic. Dysmenorrhoea with violent pain > strong pressure.

5 GRAPHITES: Specially adapted to women prone to obesity who suffer from the habit

constipation and delayed menstruation. Prone to unhealthy fat; chubby, anemic, fair. He cured ovarian cysts. Scanty and delayed menses, especially in scrofulous individuals who tend to obesity, often with profuse thin leucorrhoea of white mucus, occurring in torrents, often replacing the menses. Nausea and weakness during menses. Membranous dysmenorrhea. Enlargement and induration of left ovary, very hard and tender.

6. IODINE: Persons with scrofulous diathesis with dark or black eyes and hair. Loss of flesh and great appetite. Great emaciation. Induration and swelling of the uterus and ovaries. Pain beginning in the right ovary passing through the broad ligament into the uterus. Great sensitiveness of right ovary before or during menses. Pain in ovaries and back during menstruation. Dull, pressive, wedge-shaped pain, as if a dull plug had been forced from the right ovary into the uterus. Pain in lower abdomen < region of left ovary comes on about 3 a.m., > by motion and food, like sour things; area of left ovary sensitive to pressure; pain before and after stool; leucorrhoea thick yellow burning. Menstruation too early, chronic ovaritis. Pain and tenderness in region of right ovary. Ovarian cyst. Ovarian dropsy. Menstruation sometimes too early, sometimes too late, prematurely violent and profuse. Chronic menorrhagia in thin, delicate women. Irregular period delayed by eight days. Long-term chronic amenorrhea. Flashes of heat with palpitations before menses. During menses pain in back and ovaries, malaise, great weakness and loss of breath. After throbbing menstruation. Chronic inflammation of the ovaries with thick burning leucorrhoea. This medicine has cured many cases of ovarian cysts.

7. KALIBROMATUM: Adapted to large fleshy persons with a tendency to OBESITY, nervous women. Pain swelling and tenderness of left ovary. Epilepsy from ovarian irritation. Ovarian cystic tumor. Menorrhagia, metrorrhagia, nymphomania and epilepsy from ovarian irritation. Headaches before menstruation. During menses epileptic convulsions, nymphomania and itching, after menses headaches, insomnia and heat in the genitals. Weak menstruation in fleshy women. Sensual itching, tingling and irritation of external organs. Removed ovarian cysts.

8. KALI CARBONICUM: Weakness, characteristic of all potassium salts, is manifested especially by a soft pulse, coldness, general depression, and very characteristic stitches, which may be felt in any part of the body or in connection with any affection. Tends to obesity, prone to swelling. Delayed first period. Amenorrhea. Menstruation too late acrid. Violent colicky pains before menses that are irritating and have a pungent smell. Leucorrhoea with labor pains causing itching and burning in the pudendum; better washing.

Complaints after childbirth and abortion. Bleeding after curettage and all kinds of other treatments. Uterine tumors and cysts. Menorrhagia better bath. Menses early, with copious discharge; late with weak and pale discharge. Severe uterine cramps without menstruation, with a feeling of heat and restlessness.

9. LACHESIS: Suitable for emaciated persons, especially women with choleric temperament, freckles and red-spotted purple skin, and who are of a more melancholy nature with dark eyes and low spirits. Axle on the left side. Complaints from left to right. < lying on left side. Warm-blooded, < hot > Open air. < Sleeps during or after sleep until worse. Membranous dysmenorrhea < alcoholic stimulants. Great pain in left ovary shooting up. Valuable remedy for inflammation of ovaries, < left, with violent pain and sensitiveness to weight of clothing, especially if menstrual flow is offensive, sometimes general relief from free occurrence of menses. Left ovary very painful and swollen, indurated. Menstrual colic starting in left ovary. Ovarian neuralgia, especially on the left side, intense, pressing, burning or stitching pains. Frequent severe, drawing pain in region of right ovary, from hip joint to os pubis, sometimes burning. Swelling of the right ovary. The pain in the region of the right ovary increases more and more until it is relieved by the discharge of blood. Induration and suppuration of the ovaries. Right ovary size of fist; 1 plus ½ inch thick, painful when pressed, attached to the uterus by a string as thick as a finger. Ovaritis. Menses irregular dark dirty looking and offensive.

10. LILIUM TIGRINUM: Women exhausted by sexual excesses. Reflection of complaints about some pathological state of the uterus and ovaries. Lil.tig pains are wandering, flying, shooting, squeezing and relaxing, opening and closing burning and radiating. They radiate from the ovary to the heart to the left breast, the lower limb especially the left, across to the opposite ovary through the left breast to the back, from the hip bone to the hip bone, through

the sacrum. Ovary swollen almost to the size of a child's head. Pain in left ovary and left mother. Menstruation disappears only when moving. Tenderness over the region of the left ovary, with downward pressure, as if everything came from the vulva, and a sensation as if it had to be held up in that region.

11. MUREX PURPUREUS: Nervous, lively and affectionate women are most adapted to this remedy. Great depression of spirits. Deep hypochondriacal state. Who are sexually violently excited by the slightest contact of parts, excessive desire for embrace; from suppressed menstruation. Sinking sensation in epigastrium. Menses profuse. Sensation as if something were pressing on the pelvis. Sharp pain from right side of uterus to left mother, leucorrhoea green or bloody. Womb Consciousness. The patient keeps the legs firmly crossed to ease the position. A large cyst from the left ovary, located in the fossa Douglasi, after the secretion of a very clear fluid by the vagina. The pains are diagonal, from the ovary to the opposite breast.

12. PLATINUM:

Primarily a woman's remedy, especially primitive old maidens; women with dark hair, dark skin, having stiff muscle fibers. Hysterical, sanguine nervous temperament. ovariitis; the pain in the region of the ovaries is of a burning nature, increasing into paroxysmal ailments, with stitches in the forehead and excessive sexual desire, usually followed by a copious flow of coagulated blood; with sterility. There is a high risk that menstruation will come. The right ovary is more liable to be affected, and inflammation there may be the cause of nymphomania; relieved ovaritis even after suppuration had occurred. Aponia, cough, palpitations, numbness, convulsions and insomnia are associated with ovarian problems. Ovaries tender with burning pains in them.

13. PULSATILLA:

Adapted to a person of indecisive, slow, phlegmatic temperament, with sandy hair, blue eyes, pale face, plethoric, feminine remedy. Symptoms are constantly changing, never fixed since puberty. Ovarian pain, inflammation of the ovaries.

14. STAPHYSAGRIA:

It is suitable for persons who are pale and sunken, worn and exhausted from sexual excesses and self-torture with sunken eyes and a guilty, ashamed look, refusing to look up during conversation. Sexual fantasy. Good for ovarian disease. Inflammation of the ovaries, with burning, stinging, and pressing. Very sharp shooting pains in the ovary, which is extremely sensitive to pressure, pains extending into the iliac region and thighs. Menses irregular, late and profuse and sometimes unwanted, first pale blood, then dark and clotted.

CONCLUSION

This chapter presents the study summary, limitations, recommendations and conclusions.

This study was conducted on 30 randomly selected patients suffering from PCOS. The objectives of the study were

1. To illustrate the importance of constitutional medicine in the treatment of PCOS.
2. To determine the pre-interventional clinical profile of the patient with PCOS.
3. To determine the post-interventional clinical profile of a patient with PCOS after the administration of a constitutional medicine.

Polycystic ovary disease is the 4th gynecological cause of hospitalization. 90% of all ovarian tumors are benign, although this changes with age. Benign ovarian cysts that are larger than a few inches across can enlarge the abdomen, so women may feel like they are gaining weight or pregnant, although their periods may or may not be affected. Cysts of this kind are likely to cause problems.

This work includes a detailed case study of PCOS and its homeopathic solution. The total number of cases included in this study is 30. These include cured cases without relapses, cases with considerable improvement, cases without any improvement. One case was elaborated in detail.

The survey conducted shows that the age group of 20-25 years is most often affected, i.e. about 36.67% fall into this category and the age of onset is between 20-25 years. (9 cases). Married and unmarried were affected equally, each in 15 cases, a ratio of 1:1. According to the distribution of occupations, students are more affected, 18 cases 60%, 9 cases housewives (30%). No family history was traced.

In most cases, the predisposing factor of psychological stress was traced, most of the married patients came with the despair of not being able to get pregnant.

When the cases were evaluated after the study, a significant improvement was shown. 20 cases (66.67%) showed improvement, 9 (30%) cases were cured and 1 showed no improvement. A disease intensity score was performed to assess improvement, with symptoms taken as pre- and post-treatment parameters. Most of the patients experienced a significant relief from the present problems and even the USG reports showed a significant reduction in the size of the cysts after the administration of the constitutional medicine. Since the patient showed an improvement in his general health, there was relief from accompanying problems. Emotional adjustment and coping also improved.

A "t" test was applied after statistical analysis. The calculated value of 't' was 14.801 and found to be higher than the table value of $t = 2.045$ at 29 degrees of freedom at 5% level of significance. The study provided evidence that there was a significant reduction in disease intensity scores after constitutional-based medication. It was therefore concluded that the treatment of PCOS with homeopathic medicines was effective.

This study shows that PCOS can be managed and brought under control with an appropriate institutional remedy. In some cases, an acute remedy was prescribed according to the seriousness of the complaints made, followed by a constitutional remedy selected on the basis of a summary of the reports.

In cases where there was a miasmatic blockage, an appropriate antimiasmatic drug was given with respect to the dominant miasma. After the filing of the constitutional remedy, intercourse was also filed, which helped to improve the cases quickly.

In this study, the most commonly used constitutional remedies were Pulastialla and Natrum mur, intercurrent Thuja and Medorrhium, and Millefolium tincture.

From this study of 30 cases, it was observed that 9 cases were cured, 20 cases improved and only 1 case showed no improvement. These results help us to conclude about the effectiveness of homeopathy in case of PCOS.

REFERENCES:

1. Marrinan Greg, M.D.Stein Marjorie, M.D, www.emedicine.com
2. Dutta, D.C, Textbook of Gynecology, 2nd edition 1994, New Central Agency Pvt. Ltd.
3. Howkin's & Bourne, Shaw's Textbook of Gynecology, 13th edition, Reed Elsevier India Pvt.Ltd.
4. Hacker, Neville, F.& Moore, George,J. Essentials of Obstetrics & Gynecology, 3rd edition,W.B.Saunders Company Pvt.Ltd.
5. Hart, McKay David, Norman Jane, Genecology Illustrated, 5th edition, Churchill Livingstone Publication.
6. Ratnam S.S, Rao K. Bhaskar, Kumar Arul, Obstetrics & Gynecology for Postgraduates, Vol.2 , 2nd edition, Orient Longman Publications.
7. Arulkumaran Sabaratnam, Sivanesaratnam. V, Chatterjee Alokendra, Kumar Pratap, Essentials of Gynecology, 1st edition, Jaypee Brothers Medical Publishers Pvt. Ltd.
8. Ledger William. J. Obstetrics & Gynecology, 8th edition, Golgotia Publications Pvt. Ltd.
9. Gynecology by ten teachers edited by Morga Ash, 18th edition, Bookpower Publishers.
10. Edmonds Kaith D, Dew Hurt's Textbook of Obstetrics & Gynecology for Postgraduates, 6th edition, Blacked Science Publishers.
11. The National Women's Heath Information Center, U.S. Department of Heath and Human Services, www.4women.com
12. S.Hahnemann, The Chronic Disease Their Nature & Their Homoeopathic Cure, 1998 edition, B.Jain Publishers Pvt. Ltd.
13. S. Hahnemann, The Organon of Medicine, 6th edition, Reprint edition 1990, B. Jain Publishers Pvt. Ltd.
14. S.Hahnemann, Lesser Writings, Reprint edition 1990, B.Jain Publishers Pvt. Ltd.
15. Close Stuart, The Genius of Homoeopathy, Reprint edition 1999, B. Jain Publishers Pvt. Ltd.
16. Speight Phyllis, A comparison of The Chronic Miasms.
17. Roberts H.A. The Principles and Art of Cure by Homoeopathy, Reprint edition 1999, B. Jain Publishers Pvt. Ltd.
18. Kent, J.T. Lectures on Homoeopathic Philosophy, Reprint edition 1999, B. Jain Publishers Pvt. Ltd.
19. Allen J.H. The Chronic Miasms, 1999 edition, B.Jain Publisher Pvt. Ltd.
20. Huges Richard, The Principles and Practice of Homoeopathy, Reprint edition 1999, B. Jain Publishers Pvt. Ltd.
21. Sarkar B.K. Introduction and Commentary, Reprint edition 1987, B. Jain Publishers Pvt. Ltd.
22. Vithoukas George, The Science of Homoeopathy, Indian edition B.Jain Publishers Pvt. Ltd.
23. Chaudhury Harimohan, Introduction of Miasms, 2nd edition, B.Jain Publishers Pvt. Ltd.
24. Boericke , W.Pocket Manual of Homoeopathic Materia Medica & Repertory, Reprint edition B. Jain Publishers Pvt. Ltd.
25. Clarke J.H. a Clinical Repertory to the Dictionary of Materia Medica, Reprint edition 1988, B. Jain Publishers Pvt. .Ltd.
26. Complete Repertory, Homopath Classic Version .8
27. Gentry, Willam. D, The Concordance Repertory of the Materia Medica, Volume 1-6, Reprint edition 1987, B. Jain Publishers Pvt. Ltd.
28. Lippe Constantine ,Repertory to the More Characteristic Symptoms of the Materia Medica, Reprint edition 2001, B. Jain Publishers Pvt. Ltd.
29. Kent J.T. Repertory of the Homoeopathic Materia Medica And Word Index, Reprint edition 1998, B. Jain Publishers Pvt. Ltd.
30. Schroyens Frederick, Synthesis, Repertorium Homoeopathic Syntheticum, 7.1, Reprint edition 2001, B. Jain Publishers Pvt. Ltd.
31. Allen H.C. Keynotes with Nosodes, 8th edition,B.Jain Publishers Pvt. Ltd.
32. Allen T.F. Encyclopedia of Pure Materia Medica Vol I-XII, Reprint edition, B. Jain Publishers Pvt. Ltd.

33. Boericke & Dewey, The Twelve Tissue Remedies of Schussler, 6th edition, B. Jain Publishers Pvt. Ltd.
34. Burt. H. William, Physiological Materia Medica, Reprint 2002, B. Jain Publishers Pvt. Ltd.
35. Clarke J.H. Dictionary of Practical Materia Medica, 3 volumes, Reprint edition 1997, B. Jain Publishers Pvt. Ltd.
36. Clarke J.H. Condensed Materia Medica & Repertory, 2001 Reprint edition, B. Jain Publishers Pvt. Ltd.
37. Hering C, Guiding Symptoms of our Materia Medica, 10 volumes, 1997 Reprint edition, B. Jain Publishers Pvt. Ltd.
38. E. Neatby, A Manual of Homoeopathic Therapeutics, 198 edition, B. Jain Publishers Pvt. Ltd.
39. Kent J.T. Lectures on Homoeopathic Therapeutics, 1998 edition, B. Jain Publishers Pvt. Ltd.
40. Coperthwaite A.W, Textbook of Materia Medica an Therapeutics, Reprint edition 2004, B. Jain Publishers Pvt. Ltd.
41. Nash E.B. Leaders in Homoeopathic Therapeutics, Reprint edition 2000, B. Jain Publishers Pvt. Ltd.
42. Phatak S.R. Concise Materia Medica of Homoeopathic Remedies, 2nd revised and enlarged edition 1999, B. Jain Publishers Pvt. Ltd.
43. Tyler M.L. Homoeopathic Drug Pictures, Reprint edition 2000, B. Jain Publishers Pvt. Ltd.
44. T.F. Allen, Handbook of Materia Medica & Homoeopathic Therapeutics, Reprint edition 2001, B. Jain Publishers Pvt. Ltd.
45. P. Tarkas & Kulkarni Ajit, A Select Homoeopathic Materia Medica, Part I & II, Revised and Augmented edition 2002, B. Jain Publishers Pvt. Ltd.
46. Lilientha Samuel, Homoeopathic Therapeutics, Reprint edition 2003, 2004, B. Jain Publishers Pvt. Ltd.
47. Raue. C.G. Special Pathology and Diagnostic Hints with Homoeopathic Therapeutics, Reprint edition 2002, B. Jain Publishers Pvt. Ltd.
48. Hoyne, Temple, S. Clinical Therapeutics in Homoeopathic Vol. I & II, Reprint edition 2002, B. Jain Publishers Pvt. Ltd.
49. Hahnemann's Materia Medica, Vol. I, II & III, 1st edition 2002 July, B. Jain Publishers Pvt. Ltd.
50. Chaudhuri N.M. A study on Materia Medica, Reprint edition 2002, 2003, B. Jain Publishers Pvt. Ltd.
51. Farrington E.A. Clinical Materia Medica, Reprint edition 1996, B. Jain Publishers Pvt. Ltd.
52. Dunham C, Homoeopathic the Science and Therapeutics, Reprint edition 2005, B. Jain Publishers Pvt. Ltd.
53. Minton's Uterine Therapeutics, 1999 Reprint edition, B. Jain Publishers Pvt. Ltd.