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Efficacy Of Homeopathic Management In Pcod

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ABSTRACT

Polycystic ovarian syndrome (PCOS) is the most common endocrine pathology in females of reproductive age worldwide. Stein and Leventhal initially described it in 1935. The prevalence ranges between 5% and 15% depending on the diagnostic criteria applied. It is widely accepted among specialty society guidelines that the diagnosis of PCOS must be based on the presence of at least two of the following three criteria: chronic anovulation, hyperandrogenism (clinical or biological), and polycystic ovaries. It is a diagnosis of exclusion, and disorders that mimic clinical features of PCOS must be excluded. These include thyroid disease, hyperprolactinemia, and non-classical congenital adrenal hyperplasia. Selected patients may need more extensive workup if clinical features suggest other causes. Despite its high prevalence, PCOS is underdiagnosed and frequently takes more than one visit or different physicians to get identified, and these usually occur in more than a one- year timeframe. It is a very frustrating process for the patient. Delay in diagnosis can lead to the progression of comorbidities making it more difficult to implement lifestyle intervention, which is critical for the improvement of features of PCOS and quality of life.

INTRODUCTION

It is estimated that more than 1 million woman in India experience an episode of acute Pelvic inflammatory disease (results in death due to septicemia although the figures are not available). Thus we see that PCOD is a major public health concern leading to profound gynaecological morbidity among women in the reproductive age group. Few community based studies reported from various parts of India have shown that one or more

clinically recognizable gynecological problems, The overall prevalence of clinically diagnosed PCOD showed variations depending upon the geographical areas, nature and site of infection, and also the criteria used for diagnosis. The prevalence of clinically diagnosed vaginitis ranged from 4% in rural West Bengal to 62% in rural Maharashtra. Cervicitis ranged from 8% in Gujarat to 48% in rural Maharashtra, and PCOD arranged from 1% in rural West Bengal to 24% in rural Amongst many reasons for the prevalence, some of which are lack of education and awareness, more importantly not taking proper treatment on time. This can be due to women not coming forth easily to solve personal/ socially awkward problems. Many a times the symptoms are labelled vague and unimportant by the attending health professional. Homoeopathy with its Holistic approach to the patient's problems has a good scope in the resolution of PCOD. Homoeopathy has something to offer at every stage of the disease. It may have limitations in cases presenting with a structural irreversible process. Here it can improve subjective symptoms and perhaps save a patient from going under the knife. The reason for this is that a homoeopath makes a judgment not just at a clinical level but also takes due consideration of the susceptibility.

HYPOTHESIS:

Susceptibility (both qualitative and quantitative) plays a role in the way the system expresses in health and in disease. Posology, if given considering the susceptibility might influence the results in chronic PID. However, the definite hypothesis will be generated at the end of the study.

JUSTIFICATION OF THE STUDY:

Polycystic ovarian Disorder (PCOD) is one of the most common endocrine and metabolic disorders in Adolescents to premenopausal women. Heterogeneous by nature, PCOS is defined by a combination of signs and symptoms of androgen excess and ovarian dysfunction in the absence of other specific diagnoses. The aetiology of this syndrome remains largely unknown, but mounting evidence suggests that PCOS might be a complex multigenic disorder with strong epigenetic and environmental influences, including diet and lifestyle factors. PCOS is frequently associated with abdominal adiposity, insulin resistance, obesity, metabolic disorders and cardiovascular risk factors. The diagnosis and treatment of PCOS are not complicated, requiring only the judicious application of a few well- standardized diagnostic methods and appropriate therapeutic approaches addressing hyperandrogenism, the consequences of ovarian dysfunction and the associated metabolic disorders. This article aims to provide a balanced review of the latest advances and current limitations in our knowledge about PCOS while also providing a few clear and simple principles, based on current evidence-based clinical guidelines, for the proper diagnosis and long-term clinical management of women with PCOS. There can again be a range in the symptomatology. An amelioration of these complaints will depend on the medicinal force that will be applied. Improvement in the current pathological state will be determined not only by which remedy is given but also in which potency it is given in and how frequently it will be repeated. A judgment of the posology to be used in a case will be based on several factors the main of

which being susceptibility. Hence, it is essential to study each of the cases not only from the clinical perspective but also with regards to the susceptibility and ultimately the posology of the case.

OBJECTIVES:

1. To understand the role of the clinical picture of PCOD in the assessment of the susceptibility of the patient.
2. To understand the correlation between the stage of the disease/ extent of pathology and the susceptibility of the patient.
3. To understand the role the susceptibility of a patient will play in the selection of the indicated remedy in the selection of the potency of the remedy in a To patient of PCOD
4. To understand the importance of the assessment of susceptibility in deciding the repetition of a remedy in the management of a case of PCOD.

ETIOLOGY

PCOS can be described as an oligogenic disorder in which the interaction of a number of genetic and environmental factors determine the heterogeneous, clinical, and biochemical phenotype. Although the genetic etiology of PCOS remains unknown, a family history of PCOS is relatively common; however, familial links to PCOS are unclear. A lack of phenotypic information prevents a formal segregation analysis. Nonetheless, the current literature suggests that the clustering of PCOS in families resembles an autosomal dominant pattern. Environmental factors implicated in PCOS (e.g., obesity) can be exacerbated by poor dietary choices and physical inactivity; infectious agents and toxins may also play a role. The reproductive and metabolic features of PCOS are sometimes reversible with lifestyle modifications such as weight loss and exercise.

PATHOPHYSIOLOGY

The pathophysiology of PCOS involves primary defects in the hypothalamic–pituitary axis, insulin secretion and action, and ovarian function. Although the cause of PCOS is unknown, PCOS has been linked to insulin resistance and obesity. The association with insulin function is expected; insulin helps to regulate ovarian function, and the ovaries respond to excess insulin by producing androgens, which can lead to anovulation.⁸ Follicular maturation arrest is a hallmark sign that an ovarian abnormality exists. Clinical signs of PCOS include elevated luteinizing hormone (LH) and gonadotropin–releasing hormone (GnRH) levels, whereas follicular-stimulating hormone (FSH) levels are muted or unchanged. As a result of the increase in GnRH, stimulation of the ovarian thecal cells, in turn, produces more androgens.

Follicular arrest can be corrected by elevating endogenous FSH levels or by providing exogenous FSH. Some studies suggest that PCOS is a primary defect in young girls who are entering puberty and who have a

family history of the disorder. Approximately 25% of patients with PCOS have elevated prolactin levels. Therapeutic interventions are designed to reduce insulin levels and ovarian androgen production, ultimately correcting sex hormone-binding globulin (SHBG) levels. This increase in SHBG levels can be used to effectively manage the symptoms of PCOS. Studies have reported that thecal cells in patients with PCOS produce higher amounts of testosterone, progesterone, and 17-hydroprogesterone than in normal patients. These cells have been altered in PCOS patients whose cytochrome P450 (CYP) 11A, 3-HSD2, and CYP17 genes exhibit elevated levels.¹² Obesity is a common comorbidity of PCOS but is not required for diagnosis. PCOS is a hormonal disorder with a potential to lead to various diseases. It also continues to be a common cause of infertility among women. Although signs and symptoms vary, the three most common factors associated with PCOS include ovulation irregularities, increased androgen levels, and cystic ovaries. Problems with ovulation and elevated androgen levels occur in the majority of women with PCOS. Moreover, hirsutism, acne, and alopecia are directly associated with elevated androgen levels, and the prevalence of polycystic ovaries on pelvic ultrasound exceeds 70% in patients with PCOS.

History and Physical

A complete history and physical exam are critical for the diagnosis of PCOS. Two out of 3 diagnostic criteria rely on history and physical exam, including menstrual history and features of hyperandrogenism. Additionally, PCOS represents a diagnosis of exclusion, and identifying the clinical presentation of other conditions should be done.

Evaluation

Most society guidelines have accepted that diagnosis of PCOS; most meet 2 out of 3 criteria: chronic anovulation, clinical or biological hyperandrogenism, and polycystic ovary morphology in the absence of any other pathology. These clinical features are part of the Rotterdam Criteria. The National Institute of Health criteria also require clinical or biochemical hyperandrogenism and oligo or anovulation. The American Excess PCOS Society requires hyperandrogenism with 1 of 2 of the remaining criteria. Disorders that mimic the clinical features of PCOS should be excluded. These include thyroid disease, hyperprolactinemia, and non-classic congenital adrenal hyperplasia with 21-hydroxylase deficiency, for which measurement of serum 17-hydroxyprogesterone (17-OHP) should be done, which may require further testing with adrenocorticotropin stimulation test.

Polycystic Ovaries Morphology

Ovarian morphology assessment is more accurate when done by transvaginal ultrasound. New ultrasound machines allow the diagnosis of PCOM in patients having at least 25 small follicles (2 mm to 9 mm) in the whole ovary. Ovarian size at 10 ml remains the normal size cutoff. 2004 Rotterdam criteria indicate PCOM by at least 12 follicles measuring 2 mm to 9 mm in the ovary or increased ovarian size more than 10 ml.

Ultrasound technology has advanced and can improve the diagnosis of PCOS. Androgen Excess and PCOS Society have reviewed current data and published updated guidelines for PCOM diagnosis, increasing follicle count to 25. Ovary size has not been modified. Recent studies have shown evidence that measuring anti-Mullerian hormone can be useful for determining the diagnosis of PCOS when no accurate ovarian ultrasound is available.

Additional Assessment

PCOS represents a higher risk for cardiovascular, metabolic, and other comorbidities. Appropriate evaluation and interventions need to be done.

- **Infertility**

Endocrine Society Guidelines recommend screening for ovulatory status in all patients. Even a patient with eumenorrheic menstrual cycles may have anovulation, which can be measured by mid-luteal serum progesterone. Excluding other causes of infertility is also recommended.

- **Endometrial Cancer**

Multiple studies have shown an increased risk of endometrial cancer in patients with PCOS. Multiple risk factors are shared between both pathologies. Endocrine Society suggests against routine ultrasound (US) endometrial thickness screening in asymptomatic patients. However, women should be counseled to report unexpected or abnormal uterine bleeding.

- **Obesity, metabolic disorder, impaired glucose tolerance (IGT), type-2 diabetes mellitus, and cardiovascular disease**

Screening for obesity must be done for PCOS women and adolescents by body mass index (BMI) calculation and waist circumference. Obesity increases the risk of hyperandrogenemia and metabolic disorders, which has a negative impact on PCOS. Blood pressure measurement and lipid screening should be done. Insulin resistance has been associated highly with PCOS. Around 1 to two-thirds of PCOS have an abnormal degree of insulin resistance. Obesity prevalence is similar, with considerable variability among populations. Obesity increases insulin resistance, and the result is increased hyperinsulinism, which further aggravates hyperandrogenism. In some obese women with PCOS, metabolic abnormalities related to insulin resistance and obesity are, in many instances, more important in the mechanism of anovulation in PCOS than androgen excess. Endocrine Society guidelines recommend using an oral glucose tolerance test (OGTT), with fasting and 2-hour glucose after a 75 g OGTT, to screen for IGT and type-2 diabetes mellitus. OGTT is preferred over HbA1c due to its decreased sensitivity in PCOS patients. Rescreening should be done every 3 to 4 years due to more frequent risk factors than in the general population. Additionally, obese and overweight patients should be screened for symptoms of OSA and referred for sleep studies when this test is positive.

- **NAFLD and NASH**

Women with PCOS have 3 times the increased risk of NAFLD; it has been associated with androgen excess and low sex hormone-binding globulin. Routine measurement of LFT is not recommended unless the patient is overweight or obese, given low sensitivity and specificity for NAFLD diagnosis. In these patients, a change in management with newer antidiabetic medications like GLP-1 agonists can decrease the risk of development of NAFLD.

- **Depression**

Evidence for the increased rate of depression symptoms was found for PCOS women compared to non-BMI-matched controls. Major depression, recurrent depression, and suicide attempts were also higher in PCOS women. Screening and identifying depression and anxiety disorders should be done. Appropriate treatment should be given.

Treatment / Management Lifestyle Modification

In overweight and obese PCOS women and adolescents, exercise and calorie-restrictive diets are the best first-line interventions for weight loss and IGT. Different studies have shown that hirsutism can improve and regulate the menstrual cycle and ovulation. Low- carbohydrate diets have been used, hoping that these have a better effect on hyperinsulinism, but studies have shown no difference in outcomes with low-carbohydrate diets.^{[3][17][18]}

Hormonal Contraceptive

First-line treatment for menstrual abnormalities, hirsutism, and acne is a hormonal contraceptive, either oral contraceptive, patch, or vaginal rings. The Endocrine Society does not favor any choice over another. The progestin component decreases LH levels, indirectly decreasing ovarian androgen production and increasing sex hormone-binding globulin. Additionally, some progestins have been shown to have direct antiandrogenic properties as a direct inhibitor of 5 alpha-reductase activity to prevent the conversion of free testosterone to its more potent form, 5 alpha-dihydrotestosterone. For this reason, they are highly effective for symptoms of hyperandrogenism and controlling the menstrual cycle. Screening for contraindications for hormonal contraceptives should be done in all patients. Women 35 or older who smoke more than 15 cigarettes daily, uncontrolled hypertension greater than 160/100, and uncontrolled diabetes with severe peripheral vascular disease are considered absolute contraindications.

The United States Medical Eligibility Criteria For Contraceptive Use are valuable when multiple comorbidities are present. Patients with diabetes and without vascular complications do not have any contraindications to use hormonal contraceptives. Regarding hormonal contraceptives' metabolic effects, higher estrogen activity increases HDL cholesterol and decreases LDL cholesterol. There is no impact on

body weight and fat distribution between PCOS and healthy women. Oral contraceptive initial dosing of 20 mcg of ethinyl estradiol combined with progestin with antiandrogenic properties such as desogestrel and drospirenone or with neutral effects like norethindrone acetate. Progestin with antiandrogenic properties has been shown to have a higher risk of venous thromboembolism (VTE). If hyperandrogenic symptoms are not controlled completely with this initial dose, ethinyl estradiol can be increased to 30 to 35 mcg.

This is where Homoeopathy has an advantage over conventional medicine where the management is not only economical but also not organ specific but person specific. After taking a detailed case (which comprises of the clinical understanding as well as the person understanding), the physician then formulates the totality of the case. In homoeopathy, the concept of health is the harmonious functioning of the vital force which provides us the sense of well-being. While disease is a state indicating disharmonious functioning of life force of which expressed through signs and symptoms. Homoeopathy is based on the Law of Similars. The drug which cures a case is capable of producing symptoms similar to those which it cured. This is seen in all planes, under all circumstances, and all other apparent cures are not cures but suppressions.

The tissues cannot become sick unless something prior to them had been deranged. Man is prior to the organs. Man is the will and the understanding, and the house which he lives in, is his body. So while constructing totality, individualization. The Individualization means the total response of the organism to the unfavourable environment. This total response is seen through symptoms and signs on three planes i.e. Emotional, Intellectual and Physical where life force manifests itself. The disease also considers the hereditary influences and predispositions which play an important role in the genesis of illness.

Dr. Hahnemann has stated the following:

The affection of the morbidly deranged, spirit-like dynamics (vital force) that animates our body in the invisible interior, and the TOTALITY of the outwardly cognizable symptoms produced by it in the organism and representing the existing malady, constitute a whole; they are one and the same.” Hence, by the law of similar, the Totality will point out to the remedy which will affect cure or recovery in the body. But the totality of the symptoms may also vary from case to case.

Depending on the presentation, the pathology and the tissue and overall susceptibility the Totality may indicate an acute/phasic remedy or a constitutional remedy. Susceptibility has been dealt with in greater details later on. But no matter how accurately a remedy is chosen, the prescription will fail to produce results if the potency and repetition are not right. This is possible with the study of Posology.

“By posology (from the Greek, posos, how much) we mean the science or doctrine of dosage”. – Stuart Close.

The posology in PCOD will also greatly vary depending on the case.

For e.g. a case of acute salpingitis illustrated by a doctor in “Homeopathy World Community” Forum, where a young female suffered from sharp pelvic pain, in both groins, and lower abdomen < during intercourse and her menses. Pain was > from massage and heat and she had a heavy brownish vaginal discharge. Along with this clinical picture her mental state and attributes were also taken into consideration. Natrum Mur was

prescribed in 1M potency infrequently after which she made a full recovery. This would not have been possible had the posology not been correct.

Similarly cases of advanced pathologies may point to a lower potency and may require more frequent repetition. This process however cannot be intuitive and must be made on the basis of objective analysis of the data to make the results consistent and fruitful.

Five considerations influence us in the choice of the dose:

1. The susceptibility of the patient.
2. The seat of the disease.
3. The nature and intensity of the disease.
4. The stage and duration of the disease.
5. The previous treatment of the disease.

Out of these, the most important is susceptibility of the patient.

“Susceptibility is an inherent capacity in all living things to react to stimuli in the environment and represent a fundamental quality that distinguishes the living from non living” (Dhawale 2000). Susceptibility can be judged in two ways:

1. Quantitative (through the pathology, age of the patient, occupation etc.)
2. Qualitative or through Miasms.

The need for understanding susceptibility will reflect on the management of the patient as it will decide several things like: the indicated remedy, the posology of the case, the prognosis etc. Of these perhaps the most important is the posology. After the selection of the indicated remedy the physician must know how and when to administer the medicine and in which potency to affect a cure.

The assessment of the susceptibility will further then reflect on the posology of the case. Total planning and programming for the case can be done only after taking the total view including the time dimension. This tool (P&P) focuses on the various parameters to be taken into consideration while formulating the planning and programming of the treatment in terms of selection of the potency, repetition of doses and use of different remedies guided by the need of the time and circumstance. This tool encompasses every aspect of the patient: the tissue susceptibility, the sensitivity and reactivity, the general vitality etc.

After this the physician will be able to make an objective and rational assessment of the required potency and the repetition of dose. But the work of the physician does not end at just choosing the remedy, potency and repetition. He/she must also be vigilant of the changes that have occurred and be able to judge whether the remedy has acted in a positive way or worsened the case. He/she must be able to judge when he will require to give an acute or an intercurrent or when there be a need to completely change the remedy or the line of action. The planning must be systematic one with an adequate understanding of the disease and its pathology, the understanding of the patient as a person and the susceptibility of the patient. It must also include the ancillary measure that must be taken while managing the case.

What happens after the administration of a remedy in Homoeopathic practice is one of the most

absorbing and intricate aspects of Homoeopathic therapeutics. The fine changes in the symptomatology after a remedy is administered are easily missed unless the physician is quite alert. A correct interpretation of these changes enables us to arrive at certain conclusions about the further outcome of the case. These changes also help us to judge the accuracy of our prescription, regulate the administration of the remedy and effect appropriate changes in the prescription from time to time. For this very reason, a **Remedy Selection and Repetition** has been charted for each patient following the treatment. This tool allows us to judge several things like the patient's response to the remedy, was the remedy appropriate or not and was the course of the disease (deduced on the basis of miasm, susceptibility etc.) as predicted? If not what were the reasons for deviation? This exercise will help us to analyze and understand the Action ---- Result complex and identify the concepts used to manage the case.

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