Case Report

www.ijrap.net

(ISSN Online: 2229–3566, ISSN Print: 2277–4343)

SUCCESSFUL CONCEPTION FOLLOWING RITUCHAKRA-SYNCHRONIZED AYURVEDIC INTERVENTION IN A 41-YEAR-OLD WOMAN WITH DIMINISHED OVARIAN RESERVE: A CASE REPORT

Shivani Sharma [1]*, Leela Ramakrishnan [2]

[1] PG Student, Department of Prasuti Tantra Evam Striroga, Sri Jayendra Saraswathi Ayurveda College & Hospital, Nazarathpettai, Chennai, Department of Ayurveda, Sri Chandrasekharan Saraswathi Viswa Mahavidyalaya, Kanchipuram, India

[2] Associate Professor, PG Department of Prasuti Tantra Evam Striroga, Sri Jayendra Saraswathi Ayurveda College & Hospital, Nazarathpettai, Chennai, Department of Ayurveda, Sri Chandrasekharan Saraswathi Viswa Mahavidyalaya, Kanchipuram, India

Received on: 30/1/26 Accepted on: 04/10/26

***Corresponding author**
E-mail: Shivani.nikey@gmail.com

DOI: 10.7897/2277-4343.175162

ABSTRACT

Background: Diminished ovarian reserve (DOR), characterized by low anti-Müllerian hormone (AMH), is associated with reduced ovarian follicular reserve and increasing age. In women over 40 years, age is an important determinant of reproductive potential. Ayurveda conceptualizes infertility within the framework of Vandhyatva, with consideration of Vata, Artava, Agni, and Kshetra. Case Presentation: A 41-year-old nulligravid woman presented with 2-year primary infertility, irregular menses (cycle length 35–60 days), dysmenorrhea, leukorrhea, headaches, gastrointestinal dysmotility, and insomnia. Baseline investigations included AMH 0.47 ng/mL, subsequently 0.14 ng/mL; TSH 6.32 µIU/mL; and prolactin 26.47 ng/mL, subsequently 15.39 ng/mL. She had a history of laparoscopic myomectomy in 2022 for an 8 × 4 cm intramural fibroid. Partner semen analysis was reported as normozoospermic. Intervention: A seven-month protocol synchronized with Rituchakra phases included Deepana-Pachana, Vata-samana, Artava-janana, Rasayana, and GarbhaSthapanarth Pumsavana Karma. Results: Menstrual regularity improved to 28–32 days, dysmenorrhea reduced, leukorrhea resolved, and urine pregnancy test became positive on 16 August 2025. Transvaginal ultrasonography confirmed an intrauterine pregnancy, with uneventful first-trimester progression. Conclusion: This case describes conception following a phase-specific Ayurvedic intervention in a woman with diminished ovarian reserve. The observed outcome is hypothesis-generating and should not be interpreted as proof of treatment efficacy.

Keywords: Diminished ovarian reserve, low AMH, Vandhyatva, Rituchakra, Artava-janana, infertility, GarbhaSthapanarth Pumsavana.

INTRODUCTION

Infertility affects approximately one in six people of reproductive age worldwide. Female fertility declines with increasing age, and female age is an important predictor of fecundity.[1,2] In clinical practice, ovarian reserve markers such as AMH and antral follicle count are primarily used to assess ovarian response and follicular quantity; they have limited value as independent predictors of natural reproductive potential.[3-5]

The present case involved a 41-year-old woman with low AMH, irregular cycles, previous myomectomy, and associated endocrine abnormalities. Ayurvedic interpretation considered Vandhyatva in relation to Vata, Artava-dushti, Agnimandya, and Kshetra. The classical Ayurvedic framework of Ritu, Kshetra, Ambu, and Bija describes the factors required for conception.[22-24] The case therefore documents a Rituchakra-synchronised treatment approach and its observed clinical outcome.

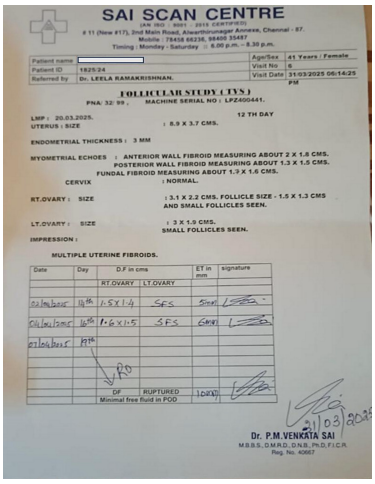
PATIENT DETAILS

The patient was 41 years old with a BMI of 24.5 kg/m². She had primary infertility for 24 months and reported coital frequency of 4–5 times per week. Obstetric history was G0P0, with a history of medical termination related to fibroid disease. She had undergone laparoscopic myomectomy in 2022. The partner's semen analysis was reported as normozoospermic according to the WHO 2021 laboratory manual.[8]

Diagnostic Investigations

Parameter	February 2025	Reference / Comment
AMH	0.14 ng/mL	Laboratory reference: 1.0–4.0 ng/mL
TSH	Not repeated	Previous value 6.32 µIU/mL
Prolactin	15.39 ng/mL	Laboratory reference: 4.8–23.3 ng/mL
Pelvic USG	Endometrial thickness 8.2 mm (proliferative phase)	Serial follicular study documented below

The previous investigations recorded AMH 0.47 ng/mL, later declining to 0.14 ng/mL; TSH 6.32 µIU/mL; and prolactin 26.47 ng/mL, later 15.39 ng/mL. AMH is a marker of the growing follicle pool and is commonly used in ovarian reserve assessment.[3-5] Subclinical thyroid dysfunction was also documented and should be interpreted according to laboratory-specific reference ranges and current infertility guidance.[11]


SAI SCAN CENTRE

FOLLICULAR STUDY (TVS)

Dr. P.M.VENKATA SAI

Figure 1: Follicular study report. The report parameters are also documented in the manuscript text above.

Ultrasonographic Findings

The follicular study report dated 31 March 2025 documented a uterus measuring approximately 8.9 × 3.7 cm, endometrial thickness of 3 mm on cycle day 12, and multiple uterine fibroids measuring approximately 2.0 × 1.8 cm in the anterior wall, 1.5 × 1.5 cm in the posterior wall, and 1.7 × 1.6 cm in the fundal region. The right ovary measured approximately 3.1 × 2.2 cm with a dominant follicle measuring about 1.5 × 1.3 cm and small follicles; the left ovary measured approximately 3.0 × 1.9 cm with small follicles. Serial follow-up documented follicular growth, subsequent follicular rupture, and endometrial thickness reaching approximately 10 mm with minimal free fluid in the pouch of Douglas. The documented follicular progression was used clinically to identify ovulation. Ultrasound monitoring of follicular growth is an established method for documenting follicular development and ovulation.[6]

Ayurvedic Diagnosis

The Ayurvedic diagnosis was Vandhyatva due to Balakshay, with Artava-dushti, Agnimandya, and Kshetra-dushti.

RESULTS

We documented the clinical course using a Rituchakra-synchronised timeline. The Ayurvedic interpretation of Ritu, Kshetra, Ambu, and Bija was based on classical sources, while modern reproductive parameters were recorded alongside the clinical observations.[22-24]

Rituchakra-Synchronised Timeline

Date/Rituchakra Phase	Clinical Status	Dosa Status	Medicines Prescribed	Ayurvedic Therapeutic Rationale	Reproductive / Modern Parameters
31-01-2025 / Rajasrava Kala	Painful menses, clots, leukorrhea	Vata + Rakta dushti	Sukumara Kasayam; Trayantyadi Kasayam; Kanchanara Guggulu; Chandraprabha Vati	Apana Vatanulomana; Kshetra sodhana; Lekhana	Artava shuddhi; improved Yoni-marga; improved endometrial shedding
11-02-2025 / Rtu Kala (Follicular)	Very low AMH 0.4 ng/mL; TSH elevated	Kapha kshaya + Vata prakopa	Sukumara Kasayam; Trayantyadi; Satapushpa Churna; Abhraka Bhasma; Pancakolasava; Kumaryasava	Artava-janana and Bija-vriddhi oriented regimen	Follicular recruitment monitored by serial study
27-02-2025 / Rajasrava Kala	Clots persisted but pain decreased	Apana Vata + Rakta dushti	Phala Sarpis; Mahadhanvantaram Gulika; Jiraka Kasaya	Rakta prasadana; Artava sodhana; Vatanulomana	Improved clinical symptoms
29-03-2025 / Rtu Kala → Ovulatory	PMS reduced; endometrium improved	Vata-Kapha equilibrium	Sukumara Ghrita; Phala Sarpis; Pushpadhanva Rasa	Ovarian Rasayana; Artava upacaya	Mature follicle development monitored
22-04-2025 / Ovulatory peak	Flow improved; pain decreased	Balanced Kapha and Pitta	Triphala Guggulu; Arogyavardhini; Phala Ghrita; Satapushpa Churna	Deepana-Pachana; Ambu poshana	Fertile timing established by follicular monitoring
20-05-2025 / Rtuvyatitkrama Kala (Luteal)	Cycle stable	Pitta + Apana Vata stabilization	Arogyavardhini; Phala Ghrita; Satapushpa Churna	Garbhasthapana; Garbhasaya poshana	Luteal support / implantation-ready environment
14-07-2025 / Follicular-Luteal	Discharge reduced; mild pain only	Dosha status regulated	Hingvastaka; Arogyavardhini; Sukumara Ghrita; Phala Ghrita	Maintenance of phase-specific regimen	Conception environment clinically favorable
16-08-2025 / Post-ovulatory	UPT positive	Apana Vata stable	Pregnancy support	Garbhasthapana	Intrauterine pregnancy subsequently confirmed
18-08-2025 to 15-10-2025 / Pregnancy	Pregnancy stable; no spotting	Garbhasthapana	Yastimadhu; Mahadhanvantaram Gulika; Phala Sarpis; Dadimadi Ghrita; GarbhaSthapanarth Pumsavana Karma	Placental/Rasa-Dhatu nourishment and pregnancy support	Healthy ongoing pregnancy documented

Garbha Sambhav Samagri

Factor	Baseline	Post-Intervention
Ritu	Anovulatory / irregular cycles	28–32-day cycles; ovulation documented through follicular study
Kshetra	History of scarring and clots	Endometrial thickness reached approximately 10 mm during the documented ovulatory cycle
Ambu	Agnimandya	Garbha poshanartha approach documented
Bija	AMH 0.14 ng/mL	Conception achieved

RESULTS

After approximately six months of treatment, cycle length was 28–32 days, dysmenorrhea had improved, leukorrhea had resolved, and sleep quality had improved. A urine pregnancy test was positive on 16 August 2025. Transvaginal ultrasonography subsequently confirmed a viable intrauterine gestation, with a gestational sac measuring 5.2 mm and a yolk sac present. Trimester progression was reported as uneventful, with three sessions of Pumsavana Karma described for Garbha Sthapana. No adverse events were reported.

DISCUSSION

This case describes a single patient and therefore cannot establish that the Ayurvedic intervention caused conception. Current evidence indicates that AMH and AFC are useful markers of ovarian reserve and ovarian response but are not independent measures of natural reproductive potential.[3-5] The patient's age, previous uterine surgery, cycle irregularity, endocrine findings, and timing of intercourse are all relevant contextual factors in interpreting the outcome. [2,7-11]

The Ayurvedic rationale is organised around Rituchakra and the classical framework of Ritu, Kshetra, Ambu, and Bija. Sushruta describes these four factors as necessary for conception, while Charaka and Vagbhata discuss conception, fetal development, and pregnancy-related care within their respective Sharira and related sections. [22-24] Pumsavana Karma is also described in Ayurvedic literature as a prenatal procedure, although its historical descriptions should not be equated with modern genetic or reproductive mechanisms.[25] The Rituchakra-synchronised approach used in this case should therefore be presented as a clinical application of an Ayurvedic framework rather than as an established biomedical mechanism.

The medicines used in the case included classical formulations such as Sukumara preparations, Phala Ghrita/Sarpis, Kanchanara Guggulu, Arogyavardhini, Satapushpa, and other formulations. Published Ayurvedic literature includes case reports and systematic reviews describing multimodal Ayurvedic approaches to infertility, but the evidence base remains heterogeneous and includes many case reports. [17-19,26,27] Recent controlled studies of Shatavari in women have examined outcomes such as sexual wellness and PCOS-related parameters; these findings should not be extrapolated to diminished ovarian reserve. [27,28] The present observation adds to the descriptive literature but requires confirmation in controlled clinical studies.

The documented follicular study and endometrial measurements provide objective reproductive parameters alongside the Ayurvedic assessment. Endometrial receptivity and implantation depend on coordinated embryo–endometrium interactions during a limited window of receptivity. [12-15] The case therefore supports the value of documenting serial ultrasound findings rather than relying only on clinical impressions.

Ethical Statement

This case report should be reported in accordance with the Indian Council of Medical Research National Ethical Guidelines for Biomedical and Health Research Involving Human Participants.[21] Case-report reporting should also follow the CARE guideline framework.[20] Written informed consent for publication of anonymised clinical information and the accompanying clinical image should be documented by the authors before submission. The authors should also state the name of the Institutional Ethics Committee and approval/waiver status, if applicable.

Patient Consent

The authors should confirm written informed consent for publication of anonymised clinical information and the clinical image and retain it with the study records.

CONCLUSION

A seven-month Rituchakra-synchronised Ayurvedic intervention was followed by improved menstrual regularity and spontaneous conception in this 41-year-old woman with diminished ovarian reserve. Because this is a single case, the observed association is hypothesis-generating and does not establish treatment efficacy. Further prospective, controlled research with standardised outcomes is required.

REFERENCES

1. World Health Organization. Infertility. Geneva: World Health Organization; 2023.
2. American Society for Reproductive Medicine. Fertility evaluation of infertile women: a committee opinion. Fertil Steril. 2021;116:1255-1265.
3. American Society for Reproductive Medicine. Testing and interpreting measures of ovarian reserve: a committee opinion. Fertil Steril. 2020;114:1151-1157.
4. Broekmans FJ, Kwee J, Hendriks DJ, Mol BWJ, Lambalk CB. A systematic review of tests predicting ovarian reserve and IVF outcome. Hum Reprod Update. 2006;12(6):685-718.
5. Moolhuijsen LME, Visser JA. Anti-Müllerian hormone and ovarian reserve: update on assessing ovarian function. J Clin Endocrinol Metab. 2020;105(11):3361-3373.
6. van Rooij IAJ, Broekmans FJM, te Velde ER, Fauser BCJM, Bancsi LFJM, de Jong FH, *et al*. Serum anti-Müllerian hormone levels: a novel measure of ovarian reserve. Hum Reprod. 2002;17(12):3065-3071.
7. Wilcox AJ, Weinberg CR, Baird DD. Timing of sexual intercourse in relation to ovulation—effects on the probability of conception, survival of the pregnancy, and sex of the baby. N Engl J Med. 1995;333(23):1517-1521.
8. World Health Organization. WHO laboratory manual for the examination and processing of human semen. 6th ed. Geneva: World Health Organization; 2021.
9. Pritts EA, Parker WH, Olive DL. Fibroids and infertility: an updated systematic review of the evidence. Fertil Steril. 2009;91(4):1215-1223.
10. Orlando M, Kollikonda S, Hackett L, Kho R. Non-hysteroscopic myomectomy and fertility outcomes: a systematic review. J Minim Invasive Gynecol. 2021;28(3):598-618.e1.
11. American Society for Reproductive Medicine. Subclinical hypothyroidism in the infertile female population: a guideline. Fertil Steril. 2024;121:765-782.
12. Lessey BA, Young SL. What exactly is endometrial receptivity? Fertil Steril. 2019;111(4):611-617.
13. Achache H, Revel A. Endometrial receptivity markers, the journey to successful embryo implantation. Hum Reprod Update. 2006;12(6):731-746.
14. Craciunas L, Gallos I, Chu J, Bourne T, Quenby S, Brosens JJ, *et al*. Conventional and modern markers of endometrial receptivity: a systematic review and meta-analysis. Hum Reprod Update. 2019;25(2):202-223.
15. Diedrich K, Fauser BCJM, Devroey P, Griesinger G; Evian Annual Reproduction Workshop Group. The role of the endometrium and embryo in human implantation. Hum Reprod Update. 2007;13(4):365-377.
16. Conforti A, Carbone L, Di Girolamo R, Iorio GG, Guida M, Campitiello MR, *et al.* Therapeutic management in women with a diminished ovarian reserve: a systematic review and

meta-analysis of randomized controlled trials. Fertil Steril. 2025;123(3):457-476.
17. Rathi I, Mavi A, Shannawaz M, Saeed S, Yadav A, Hasan S. Effectiveness of Ayurveda intervention in the management of infertility: a systematic review. Cureus. 2024;16(4):e57730.
18. Asmabi MA, Jithesh MK. Ayurveda management of infertility associated with polycystic ovarian syndrome: a case report. J Ayurveda Integr Med. 2022;13(2):100513.
19. Otta SP, Reddy RG, Sangvikar S, Tripathy R. Ayurvedic management of female infertility due to tubal blockage. J Complement Integr Med. 2021;19(1):155-160.
20. Gagnier JJ, Kienle G, Altman DG, Moher D, Sox H, Riley D; CARE Group. The CARE guidelines: consensus-based clinical case reporting guideline development. BMJ Case Rep. 2013;2013:bcr2013201554.
21. Indian Council of Medical Research. National Ethical Guidelines for Biomedical and Health Research Involving Human Participants. New Delhi: ICMR; 2017.
22. Sushruta. Sushruta Samhita of Maharshi Sushruta. Part I. Edited with Ayurveda Tattva Sandipika Hindi commentary by Ambikadatta Shastri. Sharira Sthana, Shukrashonita Shuddhi Sharira, 2/33. Varanasi: Chaukhamba Sanskrit Sansthan; 2021. p.132.
23. Agnivesha, Charaka, Dridhabala. Charaka Samhita. In: Acharya YT, editor. Sharira Sthana, Atulyagotriya Sharira, 2/17; Mahati Garbhavakranti Sharira, 4/18. Varanasi: Chaukhamba Bharati Academy; 2011. p.303, 320.
24. Vagbhata. Ashtanga Hridaya. Sharira Sthana, Garbhavakranti-related sections. Varanasi: Chaukhamba Orientalia; 2019.
25. Vardhan KP. Pumsavana Karma. Ancient Sci Life. 1990;9(3):134-139.
26. Muraleedharan A, Pillai A, Nair BG, Shivapura Krishnarajabhatt H, Ramachandran C, Aji A, *et al*. An exploratory single arm study to evaluate the role of an Ayurvedic treatment protocol as a prerequisite for *in vitro* fertilization in women with diminished ovarian reserve incorporating multi-omics approaches: study protocol. Front Med (Lausanne). 2025;12:1666888.
27. Mhatre Y, Jadhav P, Malik A, Srivathsan M, Langade D. Efficacy and safety of Shatavari root extract in women with polycystic ovarian syndrome: a randomized, double-blind, placebo-controlled trial. Front Endocrinol (Lausanne). 2026;17:1769773.
28. Ademola J, Mahajan S, Srivathsan M, Langade D. Effects of Shatavari (*Asparagus racemosus*) root extract on sexual wellness in women: findings from a prospective, randomized, double-blind, three-arm, parallel-group, placebo-controlled study. Int J Womens Health. 2026;18:561213.

Cite this article as:

Shivani Sharma and Leela Ramakrishnan. Successful conception following Rituchakra-synchronized Ayurvedic intervention in a 41-year-old woman with diminished ovarian reserve: A Case Report. Int. J. Res. Ayurveda Pharm. 2026;17(5):1-4
doi: http://dx.doi.org/10.7897/2277-4343.175162

Source of support: Nil, Conflict of interest: None declared

Disclaimer: IJRAP is solely owned by Moksha Publishing House, a non-profit publishing house dedicated to publishing quality research. We have made every effort to verify the accuracy of the content published in our journal. IJRAP cannot accept any responsibility or liability for the site content and articles published. The views expressed in articles by our contributing authors are not necessarily those of the IJRAP editor or editorial board members.