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AYURVEDA IN ACTION: A CASE STUDY ON SUCCESSFUL CONCEPTION THROUGH COUPLE-BASED INFERTILITY MANAGEMENT

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ABSTRACT

Introduction: Infertility (*Vandhyatva*) is an increasing concern among young couples and is often multifactorial in origin. In this case, the female partner presented with PCOS, hyperprolactinemia, and Toxoplasmosis IgG positivity, contributing to *Ārtava duṣṭi* and *Agnimāndya* as explained in Ayurveda. The male partner exhibited mild oligospermia with reduced progressive motility. Ayurveda attributes *Vandhyatva* to *Doṣa duṣṭi*, impaired Agni, and disturbance in *Garbhasambhava Sāmagrī*, emphasizing a holistic couple-oriented approach. Both partners received individualized Ayurvedic treatment. The male partner showed significant enhancement in sperm count and motility, while the female partner achieved better menstrual regularity and hormonal balance. The combined Ayurvedic intervention led to successful conception, demonstrating the effectiveness of comprehensive management in couple infertility. **Methods**: A 19-year-old married woman with primary infertility, diagnosed with PCOS, borderline hyperprolactinemia and Toxoplasma IgG positivity, was managed through a structured Ayurvedic therapeutic protocol focusing on *Kapha–Vāta śamana, Agnidīpana, Āmapācana* and *Ārtava-janana*. Simultaneously, her 26-year-old husband, who had mild oligospermia with reduced progressive motility, underwent Ayurvedic management aimed at improving *Shukra dhātu* quality through *Vṛṣya, Balya and Rasāyana* interventions. **Results**: Over sequential treatment cycles, the female partner showed progressive normalization of menstrual rhythm, improvement in ovulatory function and betterment of clinical hormonal parameters. Concurrently, the male partner demonstrated notable enhancement in semen quality with improved sperm count and motility following Ayurvedic intervention. Together, these changes culminated in spontaneous conception without the use of ovulation-inducing agents, indicating a favorable therapeutic response to comprehensive Ayurvedic couple-based management. **Discussion:** The case highlights the potential efficacy of Ayurvedic interventions in multifactorial infertility by targeting foundational pathophysiological components such as *Doṣa* imbalance, *Agnimāndya* and *Dhātu duṣṭi*. This supports the relevance of a *saṃprāpti*-based, individualized Ayurvedic approach in reproductive disorders.

KEYWORDS: Vandhyatva; PCOS; Oligospermia; Ayurveda; Couple infertility.

INTRODUCTION

Infertility, defined in modern medicine as the inability to conceive after 12 months of regular, unprotected intercourse, has major medical, psychological, and social impacts. It is classified as primary or secondary. Globally, infertility affects about **8–12% of couples of reproductive age.**[1,2] In India, prevalence ranges from **3.9% to around 16.8%**, with primary infertility forming a significant share.[2,3] Causes include ovulatory disorders, endocrine imbalances, structural defects, infections, and lifestyle factors.[1,4] Male-factor infertility also contributes to nearly **30–50% of infertility cases worldwide**, commonly presenting as oligospermia, asthenozoospermia or teratozoospermia, and is therefore an essential component of a couple-based evaluation.[22,23]

Polycystic Ovary Syndrome (PCOS), affecting roughly **10–20% of Indian women of reproductive age depending on criteria and region**, is a leading cause of anovulatory infertility.[5,6] It is marked by oligo/anovulation, hyperandrogenism, and polycystic ovarian morphology, and is strongly linked to insulin resistance, dyslipidemia, and increased cardiometabolic risk.**[5,6]** Hyperprolactinemia is also frequently reported in women with PCOS and contributes to cycle disturbance and anovulation via hypothalamic–pituitary–ovarian axis suppression.[7,8]

Infections such as *Toxoplasma gondii* can additionally impair fertility. Indian studies report IgG seroprevalence among women of reproductive age and antenatal women in the range of approximately **15–30%**, indicating significant past exposure and potential reproductive impact in a subset of patients.[9]

From an Ayurvedic perspective, infertility (**Vandhyatva**) arises when the **Garbhasambhava Samagri—Ṛtu (fertile period), Kṣetra (healthy uterus and reproductive tract), Ambu (nutritive essence), and Bīja (healthy gametes)**—are disturbed, often due to vitiation of **Apāna Vāta** and associated **Kapha–Medo dhātu duṣṭi.**[12,13] Disturbances in any of these factors, along with vitiation of Vāta doṣa, particularly Apāna Vāta, can result in infertility. Vandhyatva is further classified into **Sahaja (congenital)** and **Kṛtrima (acquired)**, the latter often arising due to **Bīja duṣṭi**, **Ārtavavaha srotas duṣṭi**, and systemic doṣa imbalance.[11,17]

Conditions like PCOS are interpreted through an Ayurvedic lens as **Ārtavakṣaya (diminished or scanty menstruation)** or **Nāṣṭārtava (amenorrhoea)**, and have also been correlated with entities such as **Puṣpaghni Jataharinī**, characterised by anovulatory cycles and hyperandrogenic features, with predominant **Kapha and Meda dhātu duṣṭi** obstructing normal ovulation.[14–16] Hyperprolactinemia and toxoplasmosis, though not described in identical terms, can be understood as factors aggravating doṣa imbalance, reducing **Ārtava śuddhi**, and impairing uterine receptivity.[13,14,17]

Infertility is inherently multifactorial, and in cases where several pathologies coexist—such as PCOS, hyperprolactinemia and infectious exposure—management requires a broad, coordinated approach.**[1,4,17]** In parallel, male-factor infertility—commonly rooted in endocrine disorders, lifestyle factors, infections or idiopathic causes—adds further complexity, reinforcing the need for holistic evaluation of both partners.[22,23]

Modern medicine offers precision diagnostics and evidence-based interventions, including hormonal evaluation (FSH, LH, prolactin, TSH, androgens) and ultrasound imaging to diagnose PCOS and detect ovarian or uterine abnormalities; dopamine agonists for hyperprolactinemia; ovulation-induction agents for anovulation; and antimicrobial therapy for infectious causes, along with lifestyle interventions focusing on weight reduction, diet modification and exercise.[1,4,7–9]

Ayurveda complements this by addressing root imbalances in doṣa and dhātu, and improving systemic and reproductive health through **Śamana therapies**, herbal formulations aimed at restoring hormonal balance, improving **Agnibala**, and enhancing **Ārtava dhātu** quality; **Rasāyana** and **Vājīkaraṇa** therapies to rejuvenate reproductive tissues and optimise fertility; and dietary and lifestyle regimens (**Pathya–Apathya, Dinacharya, Ritucharya**) tailored to the individual's **Prakṛti** and disease profile.[12,13,17]

This combined framework, wherein modern diagnostic tools provide biomedical precision while Ayurvedic interventions work to restore systemic harmony, improve ovulatory function, enhance endometrial receptivity, and strengthen overall health, is increasingly recognized in Indian clinical practice as it allows for personalized care, improved patient compliance, and the potential for better reproductive outcomes.[17]

Rationale for Present Case

The present case of a **19-year-old married woman with Vandhyatva (primary infertility)** associated with **Puṣpaghni Jataharinī–like features** due to **Ārtava duṣṭi from PCOS**, along with **Kapha–Meda–related hormonal imbalance resembling hyperprolactinemia** and **Rakta duṣṭi features resembling chronic infectious states such as toxoplasmosis**, illustrates the multifactorial nature of infertility.[14–17] This report highlights the Ayurvedic diagnostic approach and the use of targeted **Śamana auṣadhi** to address the underlying **Doṣa–Duṣya** imbalance. By selecting formulations aimed at **Kapha–Vāta śāmaka, Ārtava janana, Rasāyana and Agnidīpana**, together with **Āhāra–Vihāra modifications** based on **Dinacharya and Ritucharya**, the treatment strategy focused on restoring **Ārtava pravṛtti**, regulating hormonal balance and strengthening **Garbhasambhava Samagri**, thereby offering a holistic and sustainable pathway towards conception.[12–14]

Simultaneously, the **26-year-old male partner** presented with **mild oligospermia and reduced progressive motility**, constituting a contributory male factor in the couple's infertility. Addressing this through **Vṛṣya, Balya and Rasāyana therapies** for **Shukra dhātu poṣaṇa** helped correct **Shukra duṣṭi** and enhance seminal quality, reinforcing the couple-centered therapeutic rationale essential for optimizing **Garbhasambhava Samagri.**[22-24]

CASE REPORT

A 19-year-old married female, with an obese build and one year of marital life, presented with amenorrhea for 42 days and a negative urine pregnancy test. She reported inability to conceive despite regular, unprotected intercourse for the past year. Her menstrual history revealed irregular cycles occurring every 3–4 months, each lasting 5–6 days. She also noted progressive weight gain over the past six months. At her first OPD visit on 11/10/2024, her last menstrual period (LMP) was recorded as 30/08/2024, corresponding to 42 days of amenorrhea. She additionally complained of generalized weakness and fatigue. Her 26-year-old husband had no addictions or significant medical complaints, though semen analysis revealed mild oligospermia with reduced progressive motility, indicating a contributory male factor in the couple's infertility.

PAST HISTORY

There was no history of diabetes mellitus, hypertension, thyroid dysfunction or any other significant systemic illness in either partner.

PERSONAL HISTORY

Table no.1

Parameter	Female	Male
Diet	mixed	mixed
Appetite	reduced	good
bowel	normal	normal
Micturition	Adequate (6-7 times a day)	Adequate (4-5 times a day)
Sleep	sound	sound

MENSTRUAL HISTORY

Table no. 2

PMP	07/07/2024
LMP	30/08/2024
Cycle	Irregular
Interval	3-4 months
Duration	5-6 days
Amount of bleeding	3-4 pads/ day (fully soaked)
Clots	ABSENT
Dysmenorrhea	ABSENT

Obstetric History- ML- 1 year (Nulligravida)

Contraceptive History-NIL

Coital Frequency -4 to 5 times a week

Clinical Findings

General Examination

Table no. 3

Parameter	Female	Male
Built	Obese	
Height	160 cm	170 cm
Weight	70 kg	65kg
BMI	27.3 kg/m^2	22.5 kg/m^2
BP	120/80 mmHg	130/80 mmHg
PR	92 Bpm	87 bpm
RR	18 / min	20/min
Pallor	Absent	Absent
Icterus	Absent	Absent
Edema	Absent	-
Lymphadenopathy	Absent	-
Acne	present	-
Hirsutism	present	-
Acanthosis nigricans	present	-

ASTHAVIDHA PARIKSHA

Table no. 4

Parameter	Female	Male
Nadi	*Pitta-kapha*	*Vāta-pitta*
Mala	*Samanya*	*Samanya*
Mutra	*Anavila*	*Anavila*
Jivha	*Lipta*	*Alipta*
Shabda	*Spashta*	*Spashta*
Sparsha	*Anushnasheeta*	*Anushnasheeta*
Drik	*Prakrita*	*Prakrita*
Akruti	*Sthoola*	*Madhyama*

DASHAVIDHA PARIKSHA

Table no. 5

Sl. No.	Parameter	Female	Male
1	Doṣa	Kapha-Vāta pradhāna – obesity, irregular cycles, ovulatory delay	Vāta–Pitta
2	Duṣhya	Rasa, Rakta, Meda, Ārtava Dhātu duṣṭi	Shukra Dhātu duṣṭi
3	Mala	Abada; mild Āma suggested by coated tongue	Samyak
4	Agni	Manda Agni → Āma saṃcaya	Sama Agni
5	Sātmya	Madhyama – mixed diet tolerated	Madhyama
6	Sāra	Madhyama – moderate tissue strength	Madhyama
7	Pramāṇa	Sthūla śarīra (BMI 27.3 kg/m²)	Madhyama śarīra
8	Satva	Madhyama – mild anxiety	Madhyama
9	Āhāra śakti	Avara – reduced appetite	Madhyama
10	Vyāyāma śakti	Avara – easy fatigability	Madhyama

SYSTEMIC EXAMINATION

Table no. 6

parameter	Female	Male
RS	AEBE, Clear	AEBE, Clear
CVS	S1S2 normal	S1S2 normal
CNS	Conscious well oriented	Conscious well oriented
P/A	Soft, non-tender	Soft, non-tender

GYNECOLOGICAL EXAMINATION in female

External genitalia: Normal; no lesions, ulcers, or abnormal discharge

Pubic hair: Normal female pattern

Vulva: Normal appearance; no edema or inflammation

Per speculum

Vagina -discharge (mild)

Cervix healthy

Os-nulliparous

Per vaginal

Uterus -anteverted, mobile

Cervix -firm, mobile, nontender

Adnexa: No masses, no cystic swelling, no tenderness

Fornices: Clear; no fullness or tenderness

Pelvic floor: Normal tone

Local Examination – Male

External genitalia: Normal

Penis: Normal size and morphology

Scrotum: Normal, no swelling or lesions

Testes: Bilateral testes present, normal in size, shape, and consistency

Epididymis: No tenderness, no nodules

Spermatic cord: No varicosities palpable; no clinical varicocele

Inguinal region: No hernia, no lymphadenopathy

Secondary sexual characteristics: Normal (normal hair distribution, musculature)

Nidana panchaka

Table no. 7

Nidāna Pañcaka	Female Findings	Male Findings
1. Nidāna	Ati-madhura, guru āhāra; divā-svapna; alpa-vyāyāma; mānasika chintā → Kapha–Meda vṛddhi, Āma saṃcaya	No specific external nidāna; normal routine, diet, and sleep. Possible Bīja-doṣa or mild Dhātu-agni mandya leading to Shukra Dhātu duṣṭi.
2. Pūrvarūpa	Irregular cycles, weight gain, lethargy, acne	No pūrvarūpa; asymptomatic
3. Rūpa	Oligomenorrhoea, hirsutism, acanthosis nigricans, śveta-pradara, sthūlya	Oligospermia with reduced progressive motility (Shukra duṣṭi lakṣaṇa)
4. Upaśaya–Anupaśaya	Relief with Agnidīpana & Ārtava-janana dravyas (Āśokāriṣṭa, Rājapravartinī Vaṭī, Kumāryāsava, Kalonjījādi Cūrṇa)	Improvement with Vṛṣya, Balya, Rasāyana therapies (Śukra-dhātu poshana)
5. Saṃprāpti	Kapha–Meda vṛddhi → Manda Agni → Āma utpatti → Ārtavavaha Srotas āvaraṇa → Ārtava-kṣaya → Vandhyatva	Subtle Doṣa involvement at Shukra dhātu → Dhātu-agni mandya / Bīja-doṣa → Shukra kṣaya & Shukra duṣṭi → Bīja-doṣa → Male factor infertility

Samprapti ghataka

Table no. 8.

Parameter	Female	Male
Doṣa	Kapha–Vāta pradhāna, Pitta anubandha	Vāta–Pitta pradhāna (at Shukra dhātu level)
Duṣhya	Rasa, Rakta, Meda, Ārtava Dhātu	Shukra Dhātu
Agni	Manda Agni → Āma utpatti	Mild Dhātu-agni mandya (Shukra level)
Srotas	Ārtavavaha, Medovaha, Rasavaha Srotas	Śukravaha Srotas
Srotoduṣṭi Prakāra	Āvaraṇa (Ārtavavaha Srotas obstructed by Kapha–Meda)	Kṣaya + Duṣṭi of Shukra Dhātu
Udbhava Sthāna	Āmāśaya / Medodhātu	Pittāśaya / Dhātu level (Shukra)
Vyakti Sthāna (Adhiṣṭhāna)	Garbhāśaya and Ārtavavaha Srotas	Shukra-vaha Srotas / Bīja
Saṃprāpti Mārga	Āma saṃcaya → Kapha–Meda vṛddhi → Āvaraṇa of Ārtavavaha Srotas → Ārtava-kṣaya → Vandhyatva	Doṣa involvement at Shukra Dhātu → Dhātu-agni mandya → Shukra kṣaya & Shukra duṣṭi → Bīja-doṣa → Male factor infertility
Roga Mārgā	Madhyama Rogamārga	Madhyama Rogamārga
Roga Avasthā	Chirakāla (Chronic)	Madhyama / Chirakāla (mild chronic Shukra duṣṭi)

INVESTIGATION

BLOOD INVESTIGATIONS OF FEMALE PARTNER – (6/11/2024)

Table no. 9

BLOOD GROUP	B POSITIVE
HB	11.9 gm/dl
RBC	4.32
TC	7,900
DC (N, E, B, L, M) %	49,20,00,26,00
PLATELET	3,14,000
PERIPHERAL SMEAR	NORMOCYTIC NORMOCHROMIC CELLS
ESR	18mm
RBS	125mg%
HIV I & II, HBsAg, VDRL	NEGATIVE
E2	44 pg/ml
TOXO GONDII-IgG	84.48

TOXO GONDII -IgM	<1
FREE TESTOSTERONE	0.88pg/ml
INSULIN-FASTING	23.39 µU/ml
FSH	5.25 mU/ml
LH	10.8 mU/ml
PROLACTIN	28.6 ng/ml
TSH	1.604 µU/ml
T3	93 ng/ml
T4	8.15 ng/ml
TOTAL CHOLESTEROL (mg/dL)	140
TRIGLYCERIDES (mg/dL)	94
TC/HDL CHOLESTEROL RATIO	2.7
LDL/HDL RATIO	1.4
HbA1c-(HPLC)	5.1%

BLOOD INVESTIGATIONS OF MALE PARTNER

Table no. 10

BLOOD GROUP	**AB POSITIVE**
RBS	125mg%
HIV I & II, HBsAg, VDRL	NEGATIVE

SEMEN ANALYSIS (24/10/2024)

Table no. 11

TIME OF LIQUIFICATION	40 min
QUANTITY	2 ml
color	Whitish
Viscosity	thin
reaction	alkaline
Appearance	clear
Actively motile	30%
Sluggishly motile	40%
Non motile	30%
RBC	NIL/HPF
PUS CELLS	2-3/HPF
TOTAL SPERM COUNT	32 million/ml

USG (28/10/2024)

Uterus – Anteverted measuring 6.0x3.5x2.5cms in Size

Endometrial Thickness-4mm

Right Ovary- Measures 3.7 X 3.5 X2.5cm in Size (Volume=17.5 Cc)

Left Ovary-- Measures 3.5 X 2.8 X2.7 Cm in Size (Volume=14.2 Cc)

Both Ovaries Show Multiple Small Poorly Developed Peripherally Placed Follicles with Central Echogenic Stroma

IMPRESSION-SLIGHTLY ENLARGED BOTH OVARIES SHOWING MULTIPLE SMALL POORLY DEVELOPED PERPHERALLY PLACED FOLLICLES WITH CENTRAL ECHOGENIC STROMA - POLYCYSTIC OVARIAN DISEASE

HSG (28/10/2024)

Uterine Cavity -Normal

Uterine Walls Smooth

Both Fallopian Tubes Are Visualized and Appear Normal

Free Peritoneal Spill Seen Bilaterally

THERAPEUTIC INTERVENTIONS FOR FEMALE PARTNER: 11/10/2024–06/06/2025

Table no. 12

Visit Date	Observations	Intervention
11/10/2024	C/o amenorrhea × 42 days; UPT – Negative; Generalized weakness; Irregular cycles 3–4 months	**Tab Rajapravartini Vati** 2–2–2 × 5 days; **Syp Kumaryasava** 15 ml –0–15 ml × 5 days
18/10/2024	Menses resumed; LMP – 18/10/2024; Previous LMP – 30/08/2024; Interval – 49 days; Duration – 4–5 days; Flow – 2–3 pads/day; Wt – 70 kg	**Syp Asokarista** 15 ml –0–15 ml (A/F)
28/10/2024	USG: PCOD; HSG: Normal uterus, bilateral free spill; Vitals stable	**Syp Asokarista** continued 15 ml –0–15 ml (A/F)
06/11/2024	LMP – 05/11/2024; Interval – 18 days; Duration – 5 days; Flow – 2–3 pads/day; Wt – 68.2 kg	Continue same; Advised Blood investigations + Day-2 hormonal assay
10/11/2024	Investigation report: Toxoplasma IgG – 84.48; Insulin fasting – 23.39 µU/ml; Prolactin – 28.6 ng/ml	**Kalounjiadi Choorna** 6 g –0–6 g (B/F); **Varunadi Kashaya** 15 ml –0–15 ml with lukewarm water (B/F); **Tab Eve Care Forte** 1-0-1 (A/F); **Guduchi Vati** 250 mg 1–0–1 (A/F)
04/12/2024	LMP – 03/12/2024; Interval – 28 days; Duration – 5 days; Normal flow; Wt – 67.4 kg; Acne reduced	**Varunadi Kashaya**, **Kalounjiadi Choorna**, **Eve Care Forte**, **Guduchi Vati** continued
05/01/2025	LMP – 04/01/2025; Interval – 32 days; Duration – 5 days; Flow normal; Wt – 66.2 kg	Continued **Kalounjiadi Choorna**, **Varunadi Kashaya**, **Eve Care Forte**, **Guduchi Vati**
07/02/2025	LMP – 06/02/2025; Interval – 33 days; Duration – 5 days; Flow – 3–4 pads/day; Wt – 66.4 kg	**Cap Infinity-F** 1–1–1 (A/F); **Syp Uterojoy 15ml-0-15ml (A/F)**; **Tab Aq Fol** 1–0–0 (B/F)
15/03/2025	LMP – 14/03/2025; Interval – 36 days; Duration – 5 days; Flow – 3–4 pads/day; Wt – 65.1 kg	**Cap Infinity-F, Syp Uterojoy, Tab Aq Fol** continued;
21/04/2025	LMP – 20/04/2025; Interval – 37 days; Duration – 5 days; Flow –3–4 pads/day; Wt – 64.5 kg	**Cap Infinity-F, Syp Uterojoy, Tab Aq Fol** continued;
06/06/2025	Amenorrhea × 47 days; C/o nausea, fatigue; UPT – Positive; Wt – 64.7 kg; Early pregnancy symptoms present	**Tab Aq Fol** 1–0–0 (B/F) continued for early antenatal care

FOR MALE PARTNER (From 24/10/2024 to 24/01/2025)

Cap Spermore 1-0-1 (For 3 months)

PATHYAPATHYA FOR FEMALE PARTNER

Table no. 13

Pathya	***Apathya***
Green leafy vegetables	*Processed foods, fast food*
Vegetable soup, green gram soup	*Soft drinks*
Whole grains (e.g., brown rice)	*Red meat*
Warm, light meals; Agnidīpana spices (jeera, ajwain, methi)	*Excess sweets, bakery items*
Low glycemic fruits	*Sedentary lifestyle*
Moderate exercise, brisk walking	*Excessive stress*
Regular sleep and routine	*Day sleep, late nights*

PATHYAPATHYA FOR MALE PARTNER

Table no.14

Pathya	**Apathya**
Milk, ghee	Excess heat exposure (hot baths, tight underwear)
Almonds, walnuts, sesame	Junk/oily/fried foods
Dates, figs, raisins	Excess tea, coffee, soft drinks
Fresh fruits & vegetables	Alcohol, smoking
Protein-rich foods (moong, paneer)	Heavy workouts, prolonged sitting with heat
Adequate sleep & hydration	Late nights, irregular meals
Moderate exercise	Excess spicy, sour foods

RESULTS

Following the initiation of **Kapha–Vāta śamana**, **Agnidīpana–Āmapācana**, and **Ārtava-janana** therapy, the **female partner** demonstrated progressive improvement in general health and reproductive function. Menstrual cycles, previously occurring once in 3–4 months, gradually regularized to **28–37-day intervals** with normal flow and duration. Weight reduced from **70 kg to 64.7 kg**, appetite improved, acne and lethargy subsided, and there were no further episodes of white discharge. These outcomes reflect effective correction of Kapha–Meda vṛddhi, Agnimāndya and Apāna Vāta āvaraṇa, along with improvement in Ārtava pravṛtti and endometrial receptivity.

The **male partner**, who had mild oligospermia with reduced progressive motility, received **Cap Spermore 1–0–1 for three months** as a Vṛṣya–Rasāyana intervention. Follow-up semen analysis revealed **significant improvement** in seminal parameters:

SEMEN ANALYSIS (27/01/2025)

Table no. 15

TIME OF LIQUIFICATION	40 min
QUANTITY	2 ml
color	Whitish
Viscosity	thin
reaction	alkaline
Appearance	clear
Actively motile	50%
Sluggishly motile	30%
Non motile	20%
RBC	NIL/HPF
PUS CELLS	2-3/HPF
TOTAL SPERM COUNT	56 million/ml

- **Total sperm count:** increased from **32 million/ml to 56 million/ml**
- **Actively motile sperm:** improved from **30% to 50%**
- **Non-motile sperm:** reduced from **30% to 20%**

These findings indicate effective enhancement of **Shukra Dhātu** quality and functional improvement in spermatogenesis.

A missed menstrual period in June 2025 led to urine pregnancy testing, which was **positive on 06/06/2025**, confirming **spontaneous conception without any ovulation-inducing or hormonal therapy**. Subsequent obstetric evaluation showed a normally growing **single live intra-uterine pregnancy**.

Early Pregnancy Ultrasound (06/06/2025)

- CRL 17 mm ≈ 8 weeks 1 day
- FHR 156 bpm
- Cervical length 3.4 cm
- Impression: Healthy single live gestation; EDD 01/02/2026

Anomaly Scan (04/09/2025)

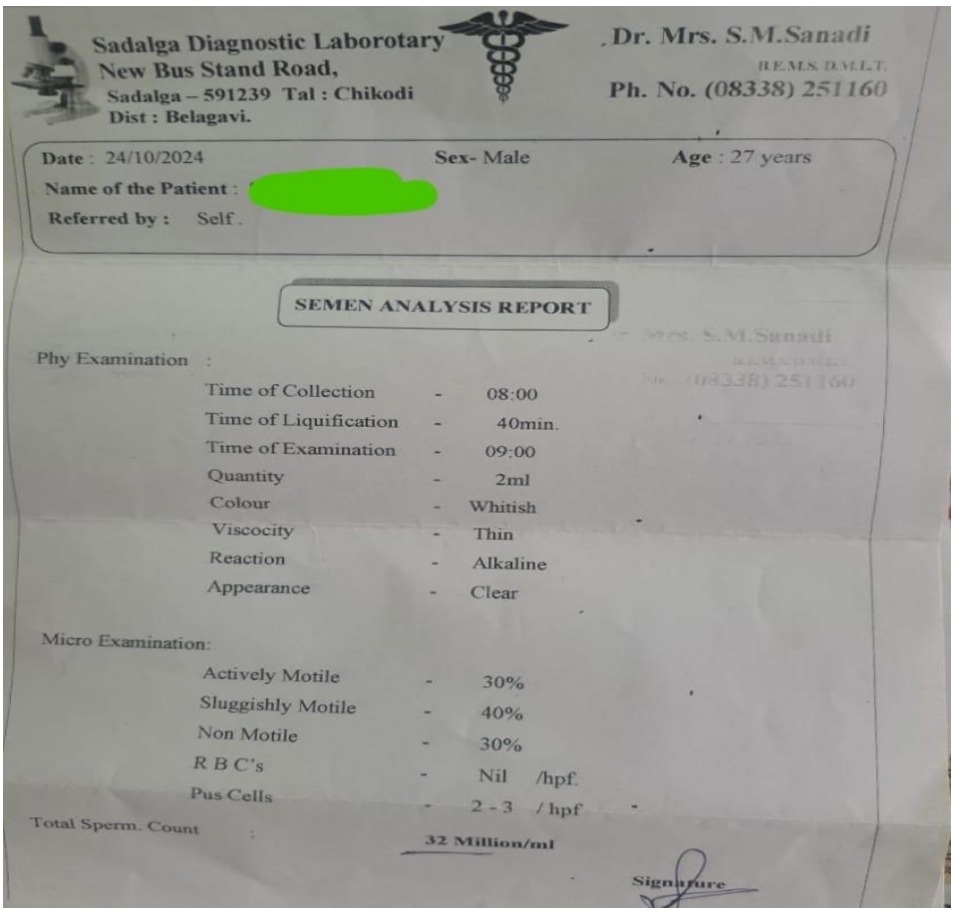
- Single fetus with normal growth parameters
- Normal anatomy; 3-vessel cord

- Placenta fundal-posterior; liquor adequate
- EDD: 31/01/2026

Overall, the treatment resulted in **successful restoration of Garbhasambhava Sāmagrī in both partners**, culminating in spontaneous conception and ongoing normal intra-uterine pregnancy.

Table no. 16: Outcome of case.

Outcome Domain	Baseline Status	Post-Treatment Outcome
Menstrual Regularity (Female)	Cycles every 3–4 months	Regular 28–37-day cycles
Ovulatory Function (Female)	Anovulatory; PCOD changes	Regular ovulation; conception
Weight / BMI (Female)	70 kg; BMI 27.3	64.7 kg; improved metabolism
Hyperandrogenism (Female)	Acne, hirsutism, acanthosis	Acne ↓; acanthosis ↓; hirsutism mild
Insulin Resistance (Female)	Fasting insulin ↑ (23.39 µU/ml)	Clinical improvement; weight ↓
Prolactin Status (Female)	Borderline high	Improved rhythm; clinically stable
Toxoplasma Status (Female)	IgG positive	No reactivation; supported with Guduchi
General Health (Female)	Fatigue, low appetite	Improved energy and appetite
Endometrial Receptivity	Thin endometrium (4 mm)	Successful implantation
Semen Count (Male)	32 million/ml	56 million/ml
Progressive Motility (Male)	30%	50%
Male-Factor Status	Mild oligospermia	Improved Shukra Dhātu; better seminal quality
Conception	Primary infertility × 1 year	Spontaneous conception (06/06/2025)
Overall Response	Couple infertility (female + male factor)	Saṃprāpti-based management restored fertility in both partners


Sadalga Diagnostic Laborotary
New Bus Stand Road,
Sadalga – 591239 Tal : Chikodi
Dist : Belagavi.

Dr. Mrs. S.M.Sanadi
B.E.M.S. D.M.L.T.
Ph. No. (08338) 251160

Date : 24/10/2024 Sex- Male Age : 27 years
Name of the Patient :
Referred by : Self.

SEMEN ANALYSIS REPORT

Phy Examination :

Time of Collection	-	08:00
Time of Liquification	-	40min.
Time of Examination	-	09:00
Quantity	-	2ml
Colour	-	Whitish
Viscocity	-	Thin
Reaction	-	Alkaline
Appearance	-	Clear

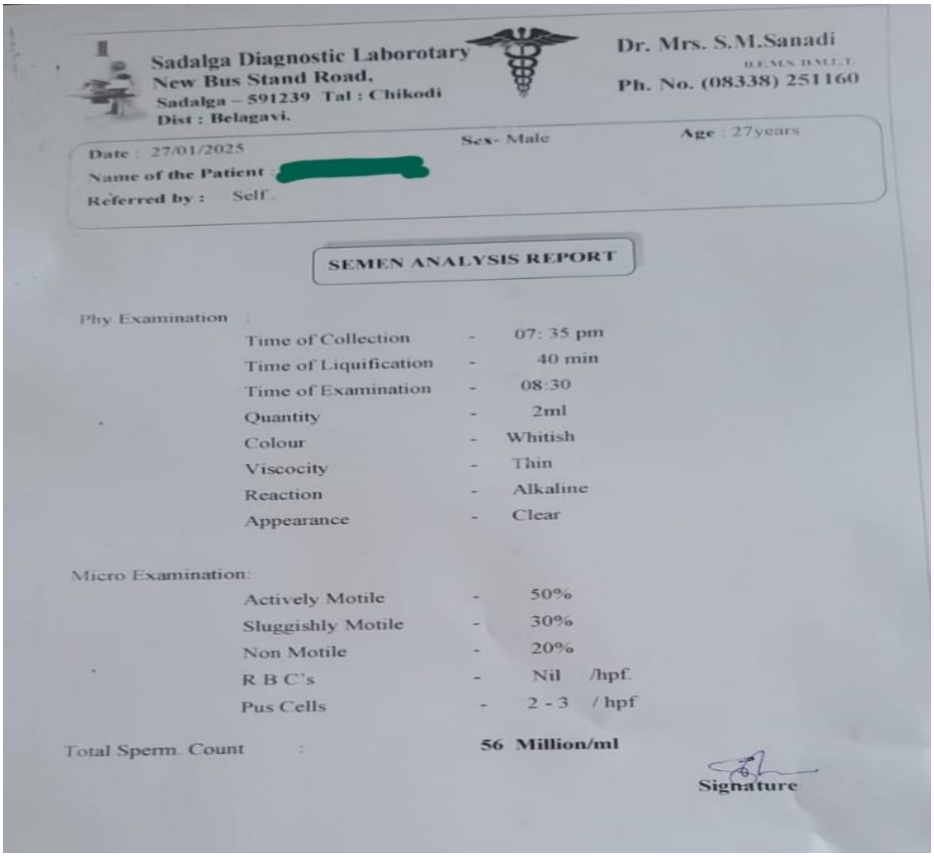
Micro Examination:

Actively Motile	-	30%
Sluggishly Motile	-	40%
Non Motile	-	30%
R B C's	-	Nil /hpf.
Pus Cells	-	2 - 3 / hpf

Total Sperm. Count : 32 Million/ml

Signature

Figure no. 1.



Sadalga Diagnostic Laborotary
New Bus Stand Road,
Sadalga – 591239 Tal : Chikodi
Dist : Belagavi.

Dr. Mrs. S.M.Sanadi
B.E.M.S. D.M.L.T.
Ph. No. (08338) 251160

Date : 27/01/2025 Sex- Male Age : 27years
Name of the Patient :
Referred by : Self

SEMEN ANALYSIS REPORT

Phy Examination :

Time of Collection	-	07: 35 pm
Time of Liquification	-	40 min
Time of Examination	-	08:30
Quantity	-	2ml
Colour	-	Whitish
Viscocity	-	Thin
Reaction	-	Alkaline
Appearance	-	Clear

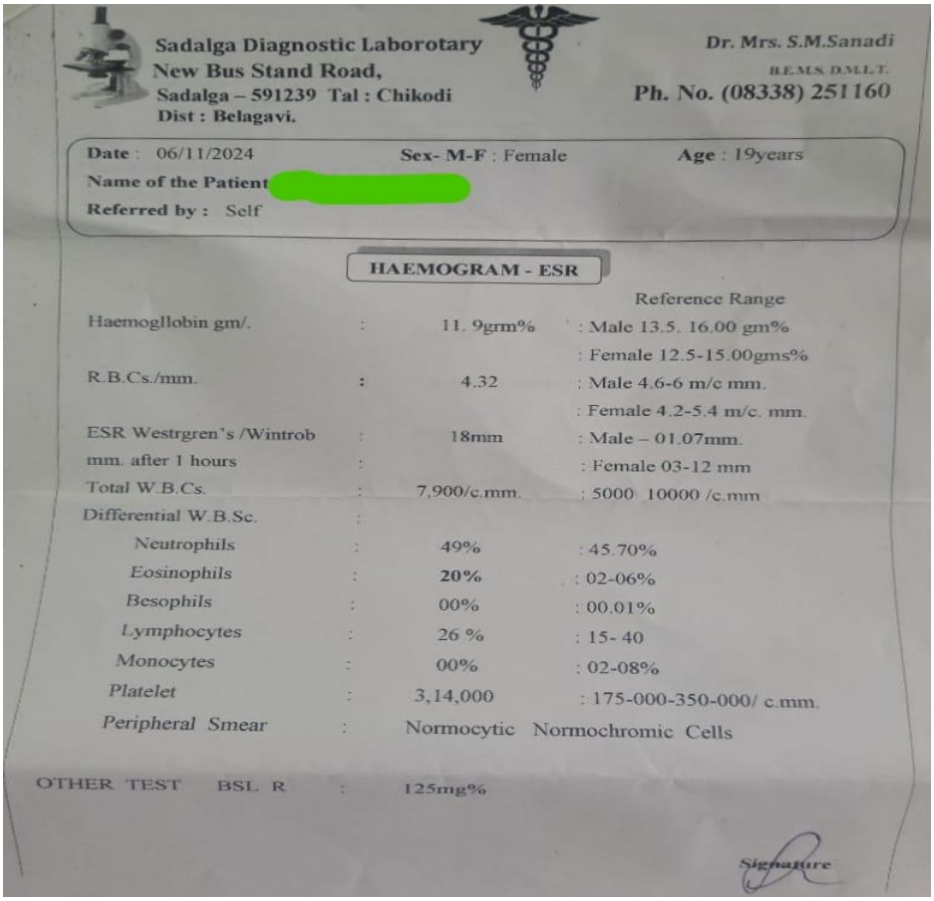
Micro Examination:

Actively Motile	-	50%
Sluggishly Motile	-	30%
Non Motile	-	20%
R B C's	-	Nil /hpf.
Pus Cells	-	2 - 3 / hpf

Total Sperm Count : **56 Million/ml**

Signature

Figure no. 2.



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Sadalga – 591239 Tal : Chikodi
Dist : Belagavi.

Dr. Mrs. S.M.Sanadi
B.E.M.S. D.M.L.T.
Ph. No. (08338) 251160

Date : 06/11/2024 Sex- M-F : Female Age : 19years
Name of the Patient
Referred by : Self

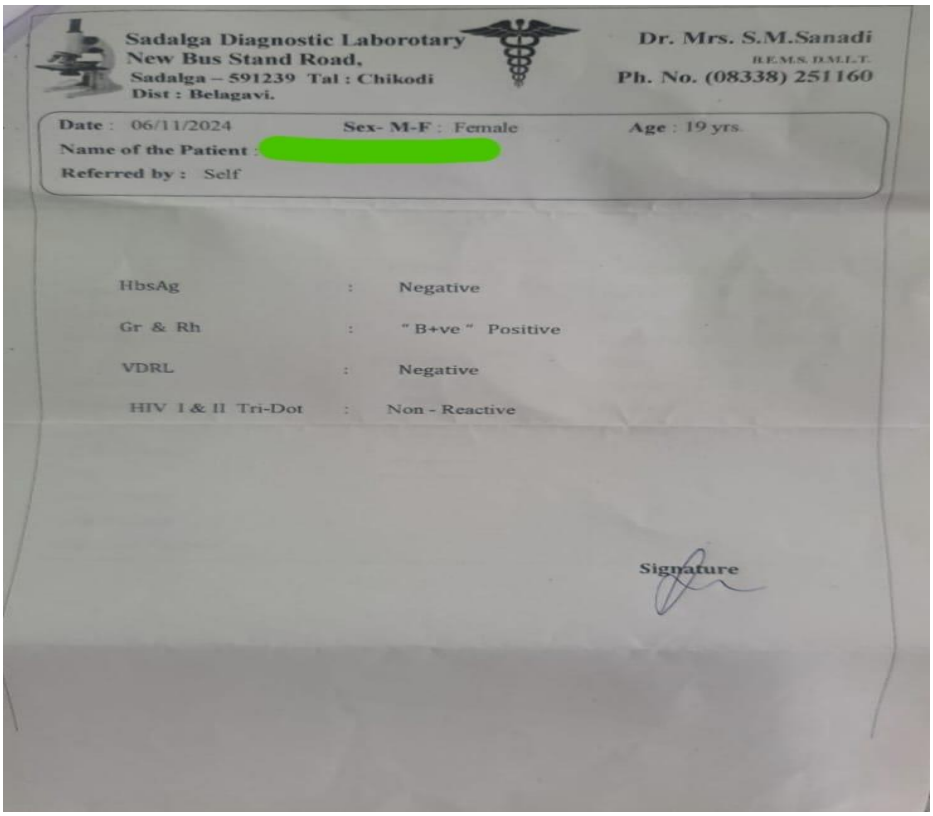
HAEMOGRAM - ESR

			Reference Range
Haemoglobin gm/.	:	11. 9grm%	: Male 13.5. 16.00 gm%
			: Female 12.5-15.00gms%
R.B.Cs./mm.	:	4.32	: Male 4.6-6 m/c mm.
			: Female 4.2-5.4 m/c. mm.
ESR Westrgren's /Wintrob	:	18mm	: Male – 01.07mm.
mm. after 1 hours	:		: Female 03-12 mm
Total W.B.Cs.	:	7,900/c.mm.	: 5000 10000 /c.mm
Differential W.B.Sc.	:		
Neutrophils	:	49%	: 45.70%
Eosinophils	:	20%	: 02-06%
Besophils	:	00%	: 00.01%
Lymphocytes	:	26 %	: 15- 40
Monocytes	:	00%	: 02-08%
Platelet	:	3,14,000	: 175-000-350-000/ c.mm.
Peripheral Smear	:	Normocytic Normochromic Cells	

OTHER TEST BSL R : 125mg%

Signature

Figure no. 3.



Sadalga Diagnostic Laborotary
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Dist : Belagavi.

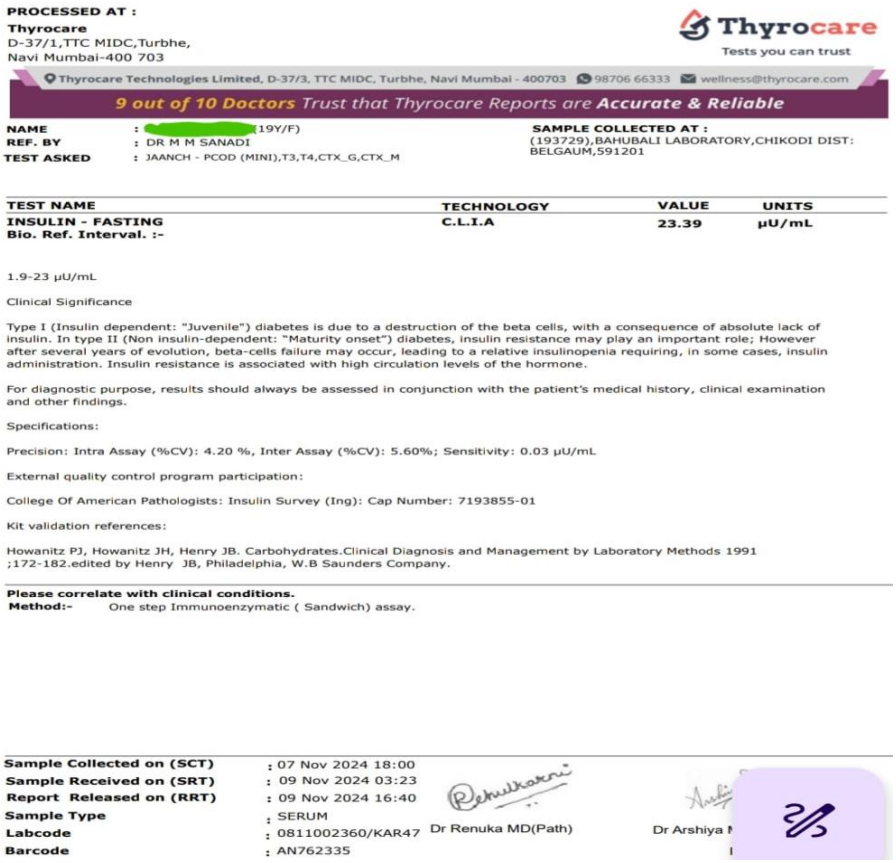
Dr. Mrs. S.M.Sanadi
B.E.M.S. D.M.L.T.
Ph. No. (08338) 251160

Date : 06/11/2024 Sex- M-F : Female Age : 19 yrs.
Name of the Patient :
Referred by : Self

HbsAg	:	Negative
Gr & Rh	:	" B+ve " Positive
VDRL	:	Negative
HIV I & II Tri-Dot	:	Non - Reactive

Signature

Figure no. 4.



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NAME : (19Y/F)
REF. BY : DR M M SANADI
TEST ASKED : JAANCH - PCOD (MINI),T3,T4,CTX_G,CTX_M

SAMPLE COLLECTED AT :
(193729),BAHUBALI LABORATORY,CHIKODI DIST: BELGAUM,591201

TEST NAME	TECHNOLOGY	VALUE	UNITS
INSULIN - FASTING	**C.L.I.A**	**23.39**	**µU/mL**
Bio. Ref. Interval. :-			

1.9-23 µU/mL

Clinical Significance

Type I (Insulin dependent: "Juvenile") diabetes is due to a destruction of the beta cells, with a consequence of absolute lack of insulin. In type II (Non insulin-dependent: "Maturity onset") diabetes, insulin resistance may play an important role; However after several years of evolution, beta-cells failure may occur, leading to a relative insulinopenia requiring, in some cases, insulin administration. Insulin resistance is associated with high circulation levels of the hormone.

For diagnostic purpose, results should always be assessed in conjunction with the patient's medical history, clinical examination and other findings.

Specifications:

Precision: Intra Assay (%CV): 4.20 %, Inter Assay (%CV): 5.60%; Sensitivity: 0.03 µU/mL

External quality control program participation:

College Of American Pathologists: Insulin Survey (Ing): Cap Number: 7193855-01

Kit validation references:

Howanitz PJ, Howanitz JH, Henry JB. Carbohydrates.Clinical Diagnosis and Management by Laboratory Methods 1991 ;172-182.edited by Henry JB, Philadelphia, W.B Saunders Company.

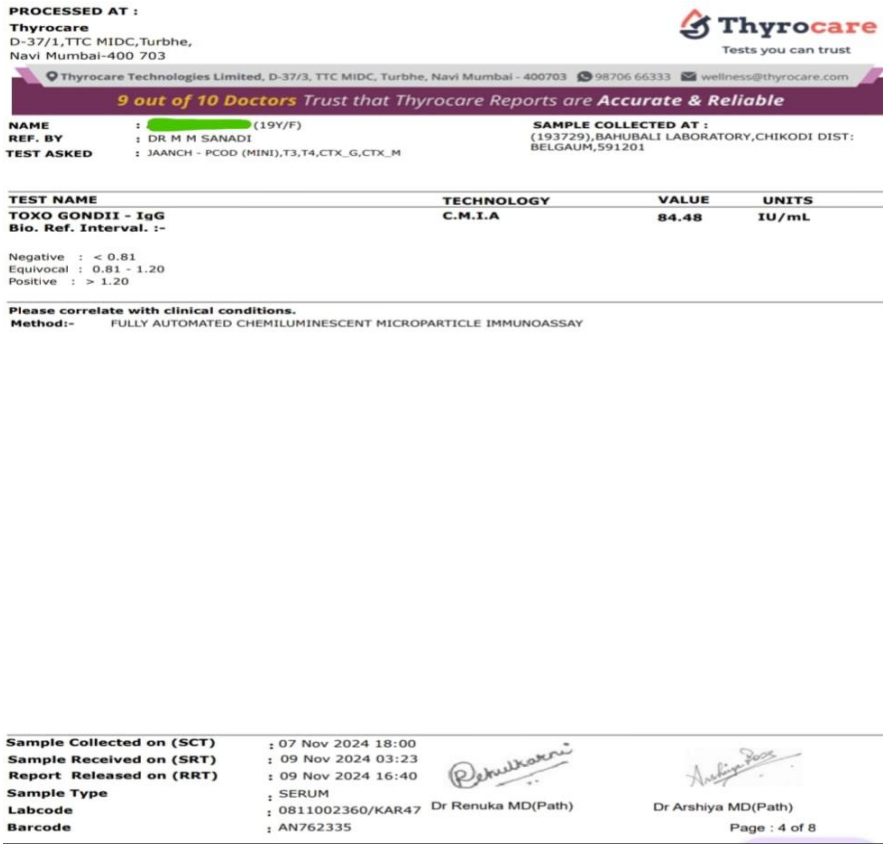
Please correlate with clinical conditions.
Method:- One step Immunoenzymatic (Sandwich) assay.

Sample Collected on (SCT)	: 07 Nov 2024 18:00
Sample Received on (SRT)	: 09 Nov 2024 03:23
Report Released on (RRT)	: 09 Nov 2024 16:40
Sample Type	: SERUM
Labcode	: 0811002360/KAR47
Barcode	: AN762335

Dr Renuka MD(Path)

Dr Arshiya

Figure no. 5.



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NAME : [redacted] (19Y/F)
REF. BY : DR M M SANADI
TEST ASKED : JAANCH - PCOD (MINI),T3,T4,CTX_G,CTX_M

SAMPLE COLLECTED AT :
(193729),BAHUBALI LABORATORY,CHIKODI DIST: BELGAUM,591201

TEST NAME	TECHNOLOGY	VALUE	UNITS
TOXO GONDII - IgG	C.M.I.A	84.48	IU/mL

Bio. Ref. Interval. :-

Negative : < 0.81
Equivocal : 0.81 - 1.20
Positive : > 1.20

Please correlate with clinical conditions.
Method:- FULLY AUTOMATED CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY

Sample Collected on (SCT) : 07 Nov 2024 18:00
Sample Received on (SRT) : 09 Nov 2024 03:23
Report Released on (RRT) : 09 Nov 2024 16:40
Sample Type : SERUM
Labcode : 0811002360/KAR47
Barcode : AN762335

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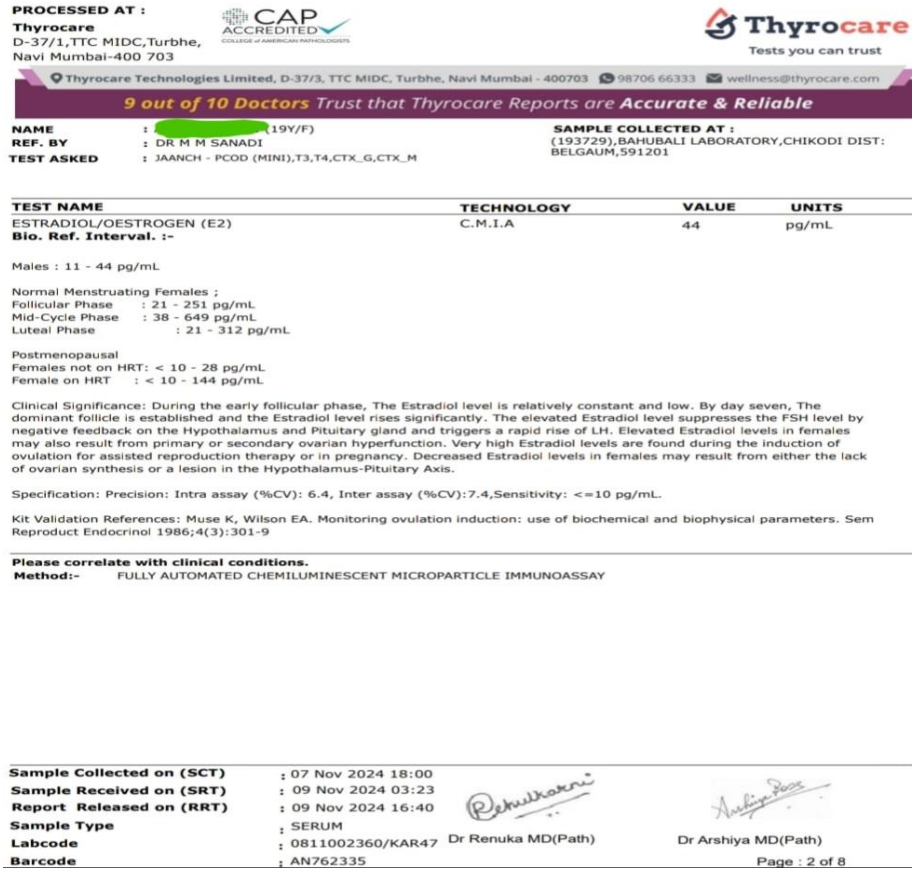
Dr Arshiya MD(Path)

Page : 4 of 8

Figure no. 6.



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NAME : [redacted] (19Y/F)
REF. BY : DR M M SANADI
TEST ASKED : JAANCH - PCOD (MINI),T3,T4,CTX_G,CTX_M

SAMPLE COLLECTED AT :
(193729),BAHUBALI LABORATORY,CHIKODI DIST: BELGAUM,591201

TEST NAME	TECHNOLOGY	VALUE	UNITS
ESTRADIOL/OESTROGEN (E2)	C.M.I.A	44	pg/mL

Bio. Ref. Interval. :-

Males : 11 - 44 pg/mL

Normal Menstruating Females ;
Follicular Phase : 21 - 251 pg/mL
Mid-Cycle Phase : 38 - 649 pg/mL
Luteal Phase : 21 - 312 pg/mL

Postmenopausal
Females not on HRT: < 10 - 28 pg/mL
Female on HRT : < 10 - 144 pg/mL

Clinical Significance: During the early follicular phase, The Estradiol level is relatively constant and low. By day seven, The dominant follicle is established and the Estradiol level rises significantly. The elevated Estradiol level suppresses the FSH level by negative feedback on the Hypothalamus and Pituitary gland and triggers a rapid rise of LH. Elevated Estradiol levels in females may also result from primary or secondary ovarian hyperfunction. Very high Estradiol levels are found during the induction of ovulation for assisted reproduction therapy or in pregnancy. Decreased Estradiol levels in females may result from either the lack of ovarian synthesis or a lesion in the Hypothalamus-Pituitary Axis.

Specification: Precision: Intra assay (%CV): 6.4, Inter assay (%CV):7.4,Sensitivity: <=10 pg/mL.

Kit Validation References: Muse K, Wilson EA. Monitoring ovulation induction: use of biochemical and biophysical parameters. Sem Reproduct Endocrinol 1986;4(3):301-9

Please correlate with clinical conditions.
Method:- FULLY AUTOMATED CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY

Sample Collected on (SCT) : 07 Nov 2024 18:00
Sample Received on (SRT) : 09 Nov 2024 03:23
Report Released on (RRT) : 09 Nov 2024 16:40
Sample Type : SERUM
Labcode : 0811002360/KAR47
Barcode : AN762335

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Dr Arshiya MD(Path)

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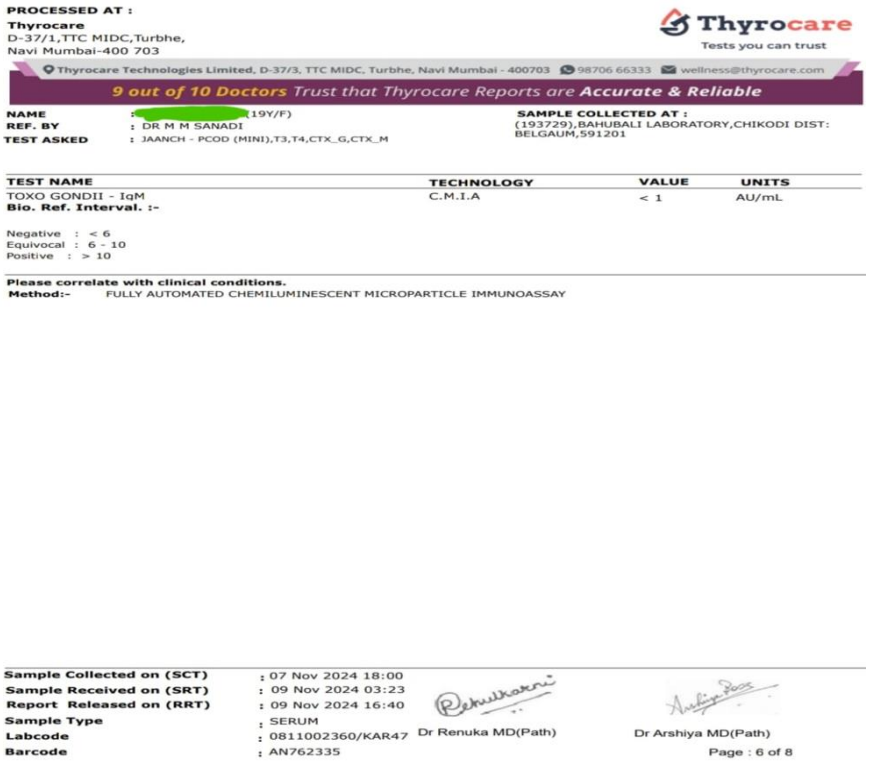
Figure no. 7.



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NAME : [redacted] (19Y/F)
REF. BY : DR M M SANADI
TEST ASKED : JAANCH - PCOD (MINI),T3,T4,CTX_G,CTX_M

SAMPLE COLLECTED AT :
(193729),BAHUBALI LABORATORY,CHIKODI DIST: BELGAUM,591201

TEST NAME	TECHNOLOGY	VALUE	UNITS
TOXO GONDII - IgM	C.M.I.A	< 1	AU/mL

Bio. Ref. Interval. :-

Negative : < 6
Equivocal : 6 - 10
Positive : > 10

Please correlate with clinical conditions.
Method:- FULLY AUTOMATED CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY

Sample Collected on (SCT) : 07 Nov 2024 18:00
Sample Received on (SRT) : 09 Nov 2024 03:23
Report Released on (RRT) : 09 Nov 2024 16:40
Sample Type : SERUM
Labcode : 0811002360/KAR47
Barcode : AN762335

Dr Renuka MD(Path) Dr Arshiya MD(Path)

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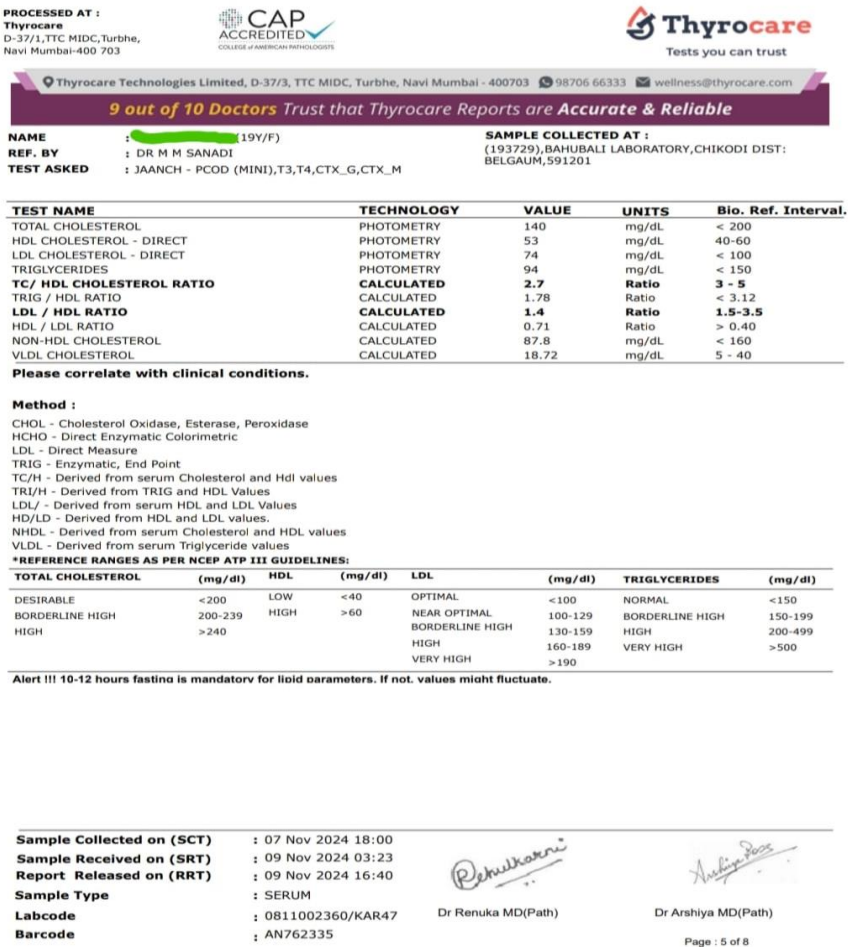
Figure no. 8.



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NAME : [redacted] (19Y/F)
REF. BY : DR M M SANADI
TEST ASKED : JAANCH - PCOD (MINI),T3,T4,CTX_G,CTX_M

SAMPLE COLLECTED AT :
(193729),BAHUBALI LABORATORY,CHIKODI DIST: BELGAUM,591201

TEST NAME	TECHNOLOGY	VALUE	UNITS	Bio. Ref. Interval.
TOTAL CHOLESTEROL	PHOTOMETRY	140	mg/dL	< 200
HDL CHOLESTEROL - DIRECT	PHOTOMETRY	53	mg/dL	40-60
LDL CHOLESTEROL - DIRECT	PHOTOMETRY	74	mg/dL	< 100
TRIGLYCERIDES	PHOTOMETRY	94	mg/dL	< 150
TC/ HDL CHOLESTEROL RATIO	**CALCULATED**	**2.7**	**Ratio**	**3 - 5**
TRIG / HDL RATIO	CALCULATED	1.78	Ratio	< 3.12
LDL / HDL RATIO	**CALCULATED**	**1.4**	**Ratio**	**1.5-3.5**
HDL / LDL RATIO	CALCULATED	0.71	Ratio	> 0.40
NON-HDL CHOLESTEROL	CALCULATED	87.8	mg/dL	< 160
VLDL CHOLESTEROL	CALCULATED	18.72	mg/dL	5 - 40

Please correlate with clinical conditions.

Method :

CHOL - Cholesterol Oxidase, Esterase, Peroxidase
HCHO - Direct Enzymatic Colorimetric
LDL - Direct Measure
TRIG - Enzymatic, End Point
TC/H - Derived from serum Cholesterol and Hdl values
TRI/H - Derived from TRIG and HDL Values
LDL/ - Derived from serum HDL and LDL Values
HD/LD - Derived from HDL and LDL values.
NHDL - Derived from serum Cholesterol and HDL values
VLDL - Derived from serum Triglyceride values

***REFERENCE RANGES AS PER NCEP ATP III GUIDELINES:**

TOTAL CHOLESTEROL	(mg/dl)	HDL	(mg/dl)	LDL	(mg/dl)	TRIGLYCERIDES	(mg/dl)
DESIRABLE	<200	LOW	<40	OPTIMAL	<100	NORMAL	<150
BORDERLINE HIGH	200-239	HIGH	>60	NEAR OPTIMAL	100-129	BORDERLINE HIGH	150-199
HIGH	>240			BORDERLINE HIGH	130-159	HIGH	200-499
				HIGH	160-189	VERY HIGH	>500
				VERY HIGH	>190		

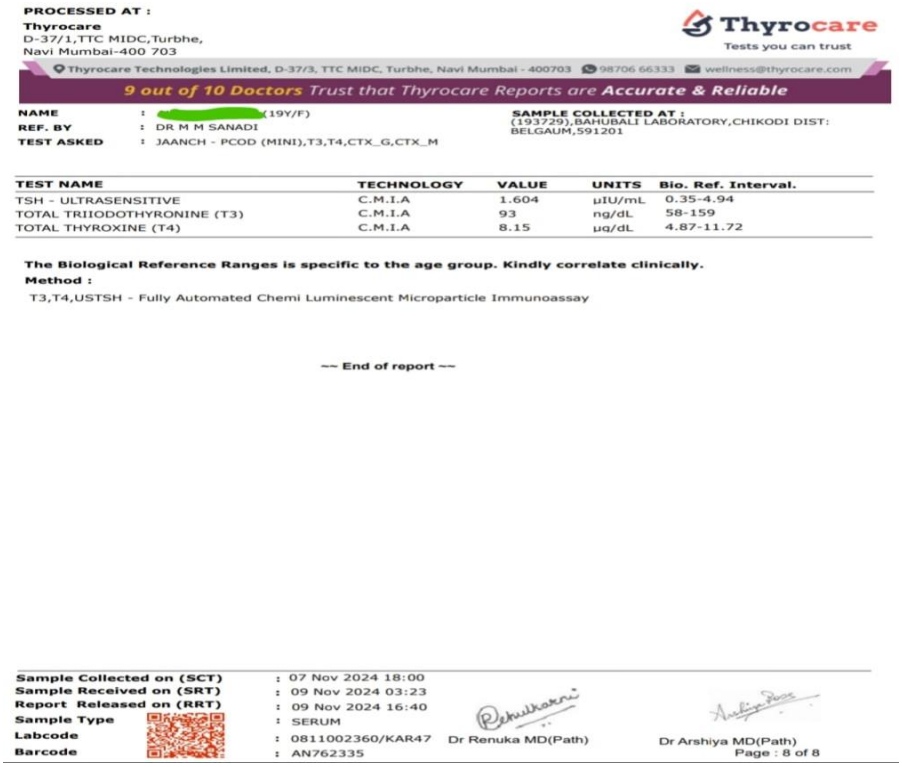
Alert !!! 10-12 hours fasting is mandatory for lipid parameters. If not, values might fluctuate.

Sample Collected on (SCT) : 07 Nov 2024 18:00
Sample Received on (SRT) : 09 Nov 2024 03:23
Report Released on (RRT) : 09 Nov 2024 16:40
Sample Type : SERUM
Labcode : 0811002360/KAR47
Barcode : AN762335

Dr Renuka MD(Path) Dr Arshiya MD(Path)

Page : 5 of 8

Figure no. 9.



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NAME : [redacted] (19Y/F)
REF. BY : DR M M SANADI
TEST ASKED : JAANCH - PCOD (MINI),T3,T4,CTX_G,CTX_M

SAMPLE COLLECTED AT :
(193729),BAHUBALI LABORATORY,CHIKODI DIST: BELGAUM,591201

TEST NAME	TECHNOLOGY	VALUE	UNITS	Bio. Ref. Interval.
TSH - ULTRASENSITIVE	C.M.I.A	1.604	µIU/mL	0.35-4.94
TOTAL TRIIODOTHYRONINE (T3)	C.M.I.A	93	ng/dL	58-159
TOTAL THYROXINE (T4)	C.M.I.A	8.15	µg/dL	4.87-11.72

The Biological Reference Ranges is specific to the age group. Kindly correlate clinically.
Method :
T3,T4,USTSH - Fully Automated Chemi Luminescent Microparticle Immunoassay

~~ End of report ~~

Sample Collected on (SCT) : 07 Nov 2024 18:00
Sample Received on (SRT) : 09 Nov 2024 03:23
Report Released on (RRT) : 09 Nov 2024 16:40
Sample Type : SERUM
Labcode : 0811002360/KAR47
Barcode : AN762335

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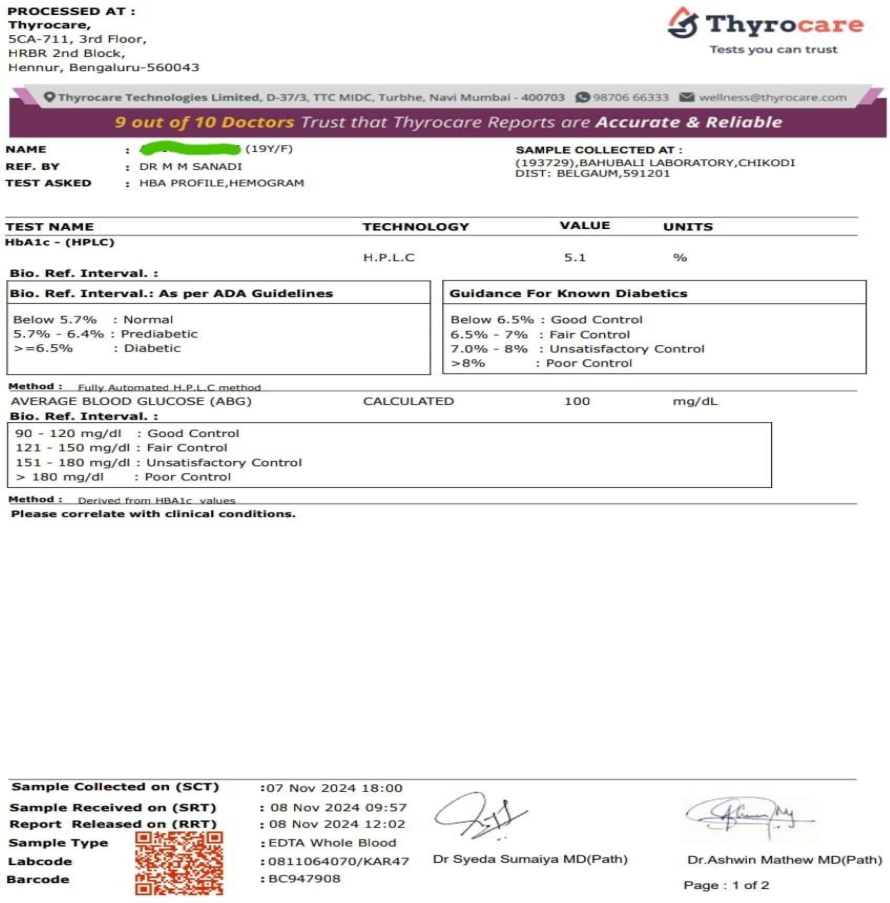
Dr Arshiya MD(Path)
Page : 8 of 8

Figure no. 10.



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NAME : [redacted] (19Y/F)
REF. BY : DR M M SANADI
TEST ASKED : HBA PROFILE,HEMOGRAM

SAMPLE COLLECTED AT :
(193729),BAHUBALI LABORATORY,CHIKODI DIST: BELGAUM,591201

TEST NAME	TECHNOLOGY	VALUE	UNITS
HbA1c - (HPLC)	H.P.L.C	5.1	%

Bio. Ref. Interval. :

Bio. Ref. Interval.: As per ADA Guidelines	Guidance For Known Diabetics
Below 5.7% : Normal 5.7% - 6.4% : Prediabetic >=6.5% : Diabetic	Below 6.5% : Good Control 6.5% - 7% : Fair Control 7.0% - 8% : Unsatisfactory Control >8% : Poor Control

Method : Fully Automated H.P.L.C method

AVERAGE BLOOD GLUCOSE (ABG)	CALCULATED	100	mg/dL

Bio. Ref. Interval. :

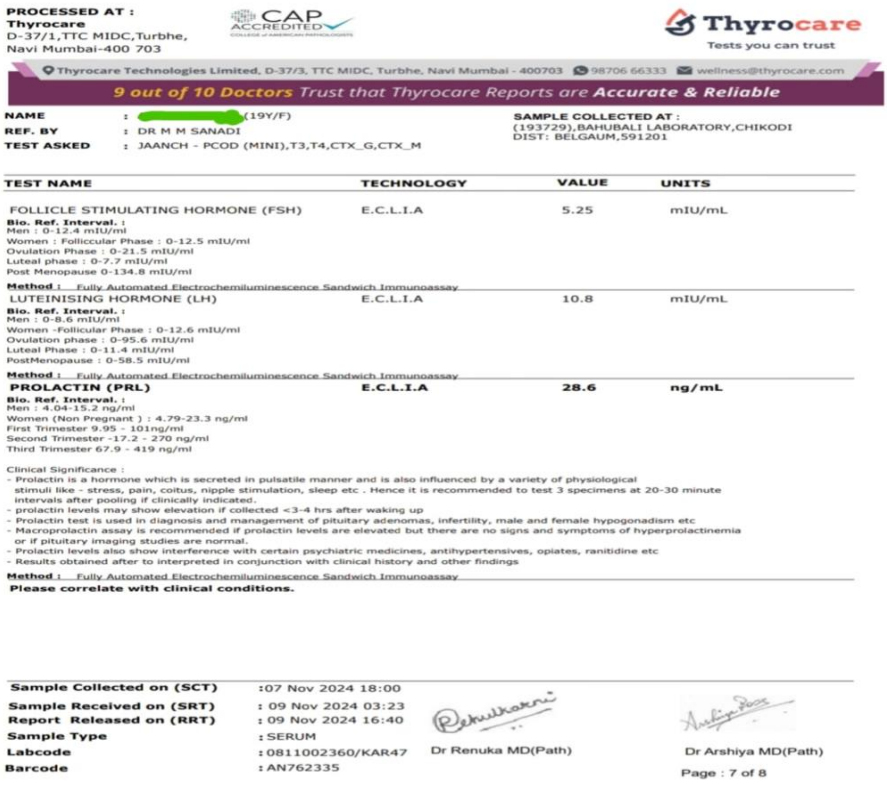
90 - 120 mg/dl : Good Control
121 - 150 mg/dl : Fair Control
151 - 180 mg/dl : Unsatisfactory Control
> 180 mg/dl : Poor Control

Method : Derived from HBA1c values
Please correlate with clinical conditions.

Sample Collected on (SCT) :07 Nov 2024 18:00
Sample Received on (SRT) : 08 Nov 2024 09:57
Report Released on (RRT) : 08 Nov 2024 12:02
Sample Type : EDTA Whole Blood
Labcode : 0811064070/KAR47
Barcode : BC947908

Dr Syeda Sumaiya MD(Path)
Dr.Ashwin Mathew MD(Path)
Page : 1 of 2

Figure no. 11.



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NAME : [redacted] (19Y/F)
REF. BY : DR M M SANADI
TEST ASKED : JAANCH - PCOD (MINI),T3,T4,CTX_G,CTX_M

SAMPLE COLLECTED AT :
(193729),BAHUBALI LABORATORY,CHIKODI
DIST: BELGAUM,591201

TEST NAME	TECHNOLOGY	VALUE	UNITS
FOLLICLE STIMULATING HORMONE (FSH)	E.C.L.I.A	5.25	mIU/mL
Bio. Ref. Interval. : Men : 0-12.4 mIU/ml Women : Follicular Phase : 0-12.5 mIU/ml Ovulation Phase : 0-21.5 mIU/ml Luteal phase : 0-7.7 mIU/ml Post Menopause 0-134.8 mIU/ml			
Method : Fully Automated Electrochemiluminescence Sandwich Immunoassay			
LUTEINISING HORMONE (LH)	E.C.L.I.A	10.8	mIU/mL
Bio. Ref. Interval. : Men : 0-8.6 mIU/ml Women -Follicular Phase : 0-12.6 mIU/ml Ovulation phase : 0-95.6 mIU/ml Luteal Phase : 0-11.4 mIU/ml PostMenopause : 0-58.5 mIU/ml			
Method : Fully Automated Electrochemiluminescence Sandwich Immunoassay			
PROLACTIN (PRL)	**E.C.L.I.A**	**28.6**	**ng/mL**
Bio. Ref. Interval. : Men : 4.04-15.2 ng/ml Women (Non Pregnant) : 4.79-23.3 ng/ml First Trimester 9.95 - 101ng/ml Second Trimester -17.2 - 270 ng/ml Third Trimester 67.9 - 419 ng/ml			

Clinical Significance :
- Prolactin is a hormone which is secreted in pulsatile manner and is also influenced by a variety of physiological stimuli like - stress, pain, coitus, nipple stimulation, sleep etc . Hence it is recommended to test 3 specimens at 20-30 minute intervals after pooling if clinically indicated.
- prolactin levels may show elevation if collected <3-4 hrs after waking up
- Prolactin test is used in diagnosis and management of pituitary adenomas, infertility, male and female hypogonadism etc
- Macroprolactin assay is recommended if prolactin levels are elevated but there are no signs and symptoms of hyperprolactinemia or if pituitary imaging studies are normal.
- Prolactin levels also show interference with certain psychiatric medicines, antihypertensives, opiates, ranitidine etc
- Results obtained after to interpreted in conjunction with clinical history and other findings

Method : Fully Automated Electrochemiluminescence Sandwich Immunoassay
Please correlate with clinical conditions.

Sample Collected on (SCT) :07 Nov 2024 18:00
Sample Received on (SRT) : 09 Nov 2024 03:23
Report Released on (RRT) : 09 Nov 2024 16:40
Sample Type : SERUM
Labcode : 0811002360/KAR47
Barcode : AN762335

Dr Renuka MD(Path)

Dr Arshiya MD(Path)

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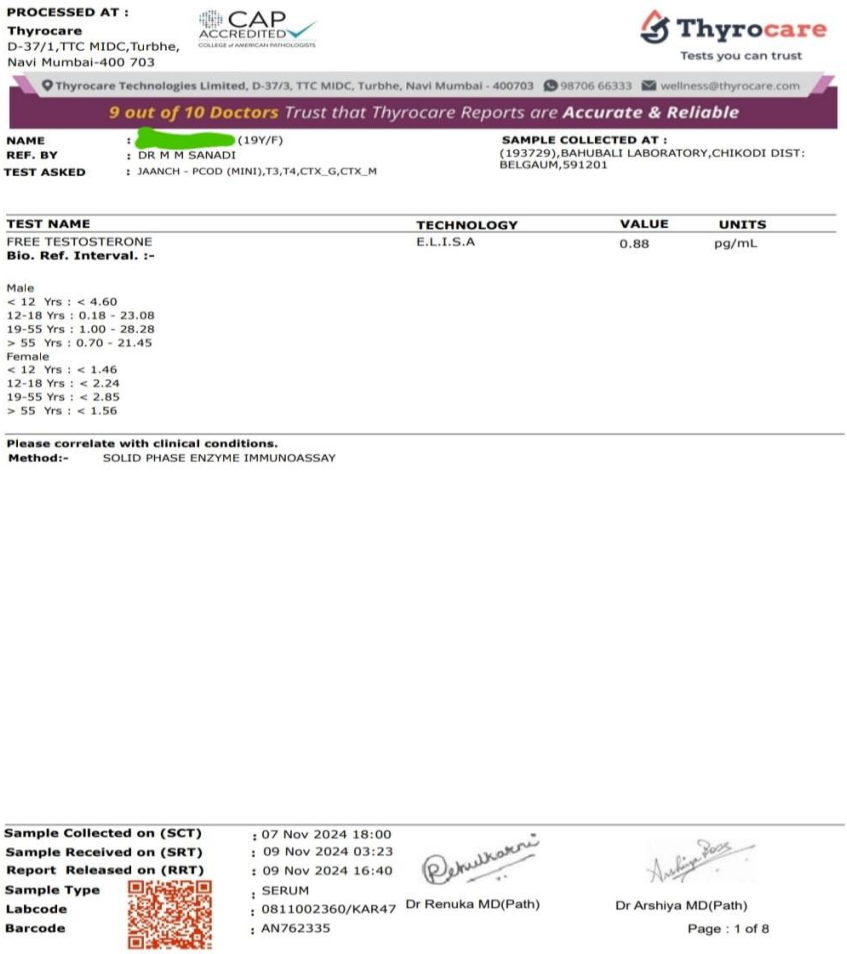
Figure no. 12.



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9 out of 10 Doctors Trust that Thyrocare Reports are ***Accurate & Reliable***

NAME : [redacted] (19Y/F)
REF. BY : DR M M SANADI
TEST ASKED : JAANCH - PCOD (MINI),T3,T4,CTX_G,CTX_M

SAMPLE COLLECTED AT :
(193729),BAHUBALI LABORATORY,CHIKODI DIST:
BELGAUM,591201

TEST NAME	TECHNOLOGY	VALUE	UNITS
FREE TESTOSTERONE	E.L.I.S.A	0.88	pg/mL
Bio. Ref. Interval. :-			

Male
< 12 Yrs : < 4.60
12-18 Yrs : 0.18 - 23.08
19-55 Yrs : 1.00 - 28.28
> 55 Yrs : 0.70 - 21.45
Female
< 12 Yrs : < 1.46
12-18 Yrs : < 2.24
19-55 Yrs : < 2.85
> 55 Yrs : < 1.56

Please correlate with clinical conditions.
Method:- SOLID PHASE ENZYME IMMUNOASSAY

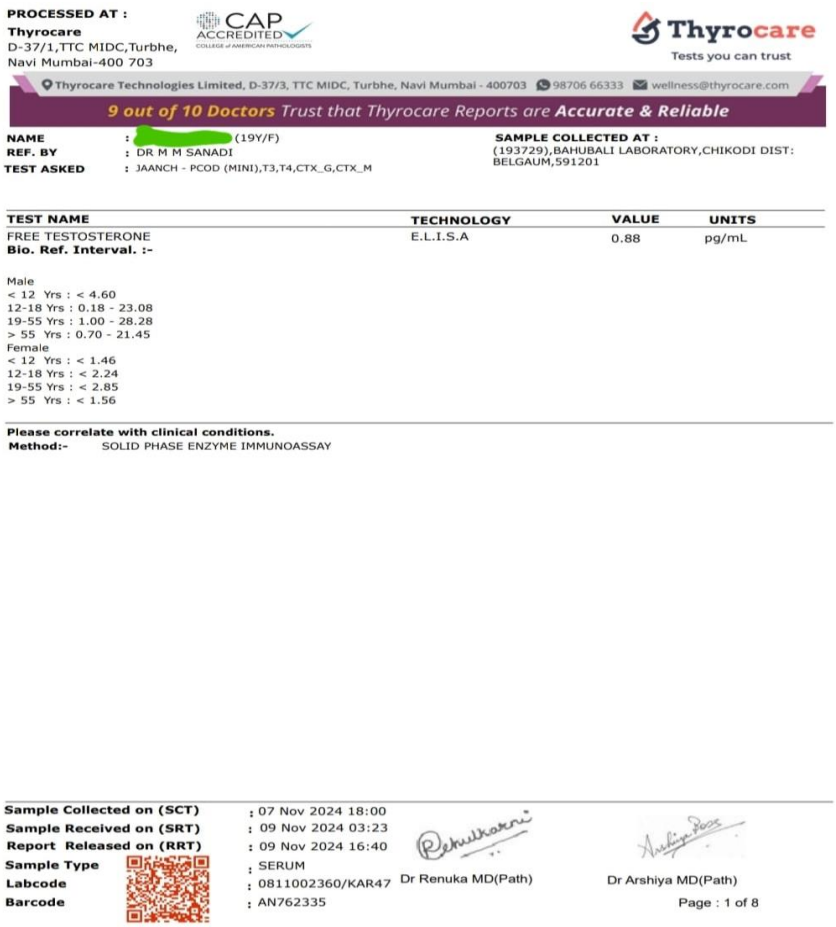
Sample Collected on (SCT) : 07 Nov 2024 18:00
Sample Received on (SRT) : 09 Nov 2024 03:23
Report Released on (RRT) : 09 Nov 2024 16:40
Sample Type : SERUM
Labcode : 0811002360/KAR47
Barcode : AN762335

Dr Renuka MD(Path)

Dr Arshiya MD(Path)

Page : 1 of 8

Figure no. 13.



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Navi Mumbai-400 703

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REF. BY : DR M M SANADI
TEST ASKED : JAANCH - PCOD (MINI),T3,T4,CTX_G,CTX_M

SAMPLE COLLECTED AT :
(193729),BAHUBALI LABORATORY,CHIKODI DIST: BELGAUM,591201

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Please correlate with clinical conditions.
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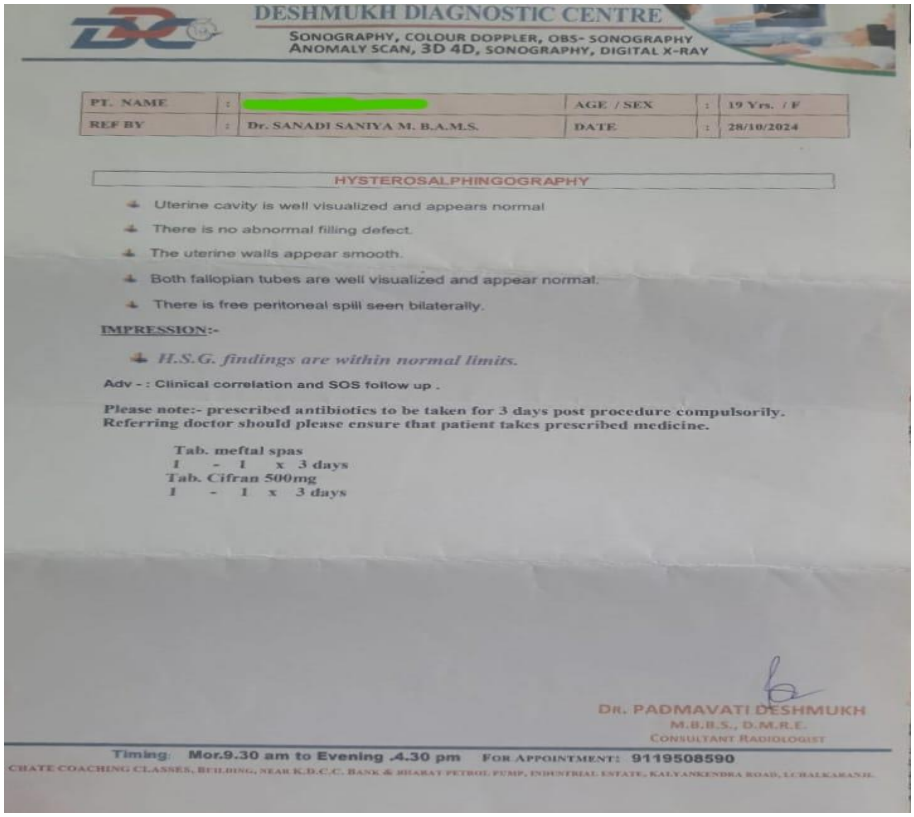
Sample Type : SERUM
Labcode : 0811002360/KAR47
Barcode : AN762335

Dr Renuka MD(Path)
Dr Arshiya MD(Path)

Page : 1 of 8

Figure no. 14.



DESHMUKH DIAGNOSTIC CENTRE
SONOGRAPHY, COLOUR DOPPLER, OBS- SONOGRAPHY
ANOMALY SCAN, 3D 4D, SONOGRAPHY, DIGITAL X-RAY

PT. NAME	:	[redacted]	AGE / SEX	:	19 Yrs. / F
REF BY	:	Dr. SANADI SANIYA M. B.A.M.S.	DATE	:	28/10/2024

HYSTEROSALPHINGOGRAPHY

- Uterine cavity is well visualized and appears normal
- There is no abnormal filling defect.
- The uterine walls appear smooth.
- Both fallopian tubes are well visualized and appear normal.
- There is free peritoneal spill seen bilaterally.

IMPRESSION:-

- *H.S.G. findings are within normal limits.*

Adv - : Clinical correlation and SOS follow up .

Please note:- prescribed antibiotics to be taken for 3 days post procedure compulsorily.
Referring doctor should please ensure that patient takes prescribed medicine.

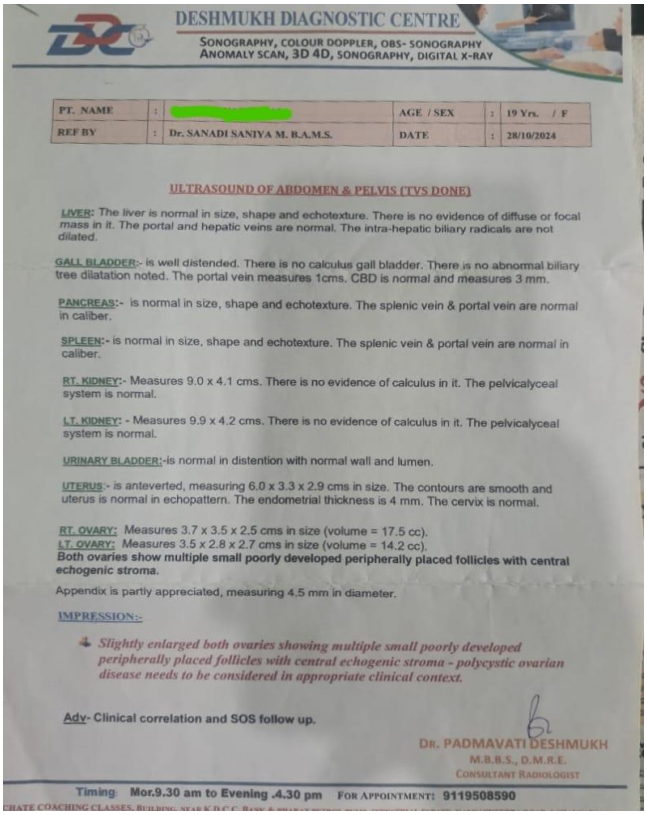
Tab. meftal spas
1 - 1 x 3 days
Tab. Cifran 500mg
1 - 1 x 3 days

DR. PADMAVATI DESHMUKH
M.B.B.S., D.M.R.E.
CONSULTANT RADIOLOGIST

Timing: Mor.9.30 am to Evening .4.30 pm FOR APPOINTMENT: 9119508590

CHATE COACHING CLASSES, BUILDING, NEAR K.D.C.C. BANK & BHARAT PETROL PUMP, INDUSTRIAL ESTATE, KALYANKENDRA ROAD, ICHALKARANJI.

Figure no. 15.



DESHMUKH DIAGNOSTIC CENTRE

SONOGRAPHY, COLOUR DOPPLER, OBS- SONOGRAPHY
ANOMALY SCAN, 3D 4D, SONOGRAPHY, DIGITAL X-RAY

PT. NAME	:	[redacted]	AGE / SEX	:	19 Yrs. / F
REF BY	:	Dr. SANADI SANIYA M. B.A.M.S.	DATE	:	28/10/2024

ULTRASOUND OF ABDOMEN & PELVIS (TVS DONE)

LIVER: The liver is normal in size, shape and echotexture. There is no evidence of diffuse or focal mass in it. The portal and hepatic veins are normal. The intra-hepatic biliary radicals are not dilated.

GALL BLADDER:- is well distended. There is no calculus gall bladder. There is no abnormal biliary tree dilatation noted. The portal vein measures 1cms. CBD is normal and measures 3 mm.

PANCREAS:- is normal in size, shape and echotexture. The splenic vein & portal vein are normal in caliber.

SPLEEN:- is normal in size, shape and echotexture. The splenic vein & portal vein are normal in caliber.

RT. KIDNEY:- Measures 9.0 x 4.1 cms. There is no evidence of calculus in it. The pelvicalyceal system is normal.

LT. KIDNEY: - Measures 9.9 x 4.2 cms. There is no evidence of calculus in it. The pelvicalyceal system is normal.

URINARY BLADDER:-is normal in distention with normal wall and lumen.

UTERUS:- is anteverted, measuring 6.0 x 3.3 x 2.9 cms in size. The contours are smooth and uterus is normal in echopattern. The endometrial thickness is 4 mm. The cervix is normal.

RT. OVARY: Measures 3.7 x 3.5 x 2.5 cms in size (volume = 17.5 cc).
LT. OVARY: Measures 3.5 x 2.8 x 2.7 cms in size (volume = 14.2 cc).
Both ovaries show multiple small poorly developed peripherally placed follicles with central echogenic stroma.

Appendix is partly appreciated, measuring 4.5 mm in diameter.

IMPRESSION:-

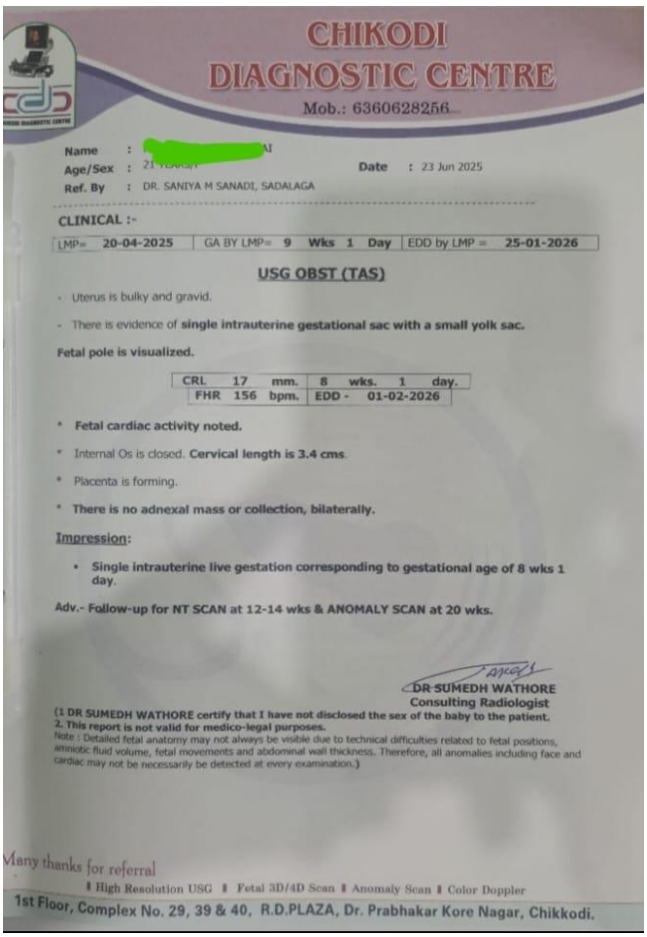
- *Slightly enlarged both ovaries showing multiple small poorly developed peripherally placed follicles with central echogenic stroma - polycystic ovarian disease needs to be considered in appropriate clinical context.*

Adv- Clinical correlation and SOS follow up.

DR. PADMAVATI DESHMUKH
M.B.B.S., D.M.R.E.
CONSULTANT RADIOLOGIST

Timing Mor.9.30 am to Evening .4.30 pm FOR APPOINTMENT: 9119508590

Figure no. 16.



CHIKODI
DIAGNOSTIC CENTRE
Mob.: 6360628256

Name : [redacted]
Age/Sex : 21 YEARS/F
Ref. By : DR. SANIYA M SANADI, SADALAGA
Date : 23 Jun 2025

CLINICAL :-

LMP=	20-04-2025	GA BY LMP=	9 Wks 1 Day	EDD by LMP =	25-01-2026

USG OBST (TAS)

- Uterus is bulky and gravid.
- There is evidence of **single intrauterine gestational sac with a small yolk sac.**

Fetal pole is visualized.

CRL	17	mm.	8	wks.	1 day.
FHR	156	bpm.	EDD -	01-02-2026	

- **Fetal cardiac activity noted.**
- Internal Os is closed. **Cervical length is 3.4 cms.**
- Placenta is forming.
- **There is no adnexal mass or collection, bilaterally.**

Impression:

- **Single intrauterine live gestation corresponding to gestational age of 8 wks 1 day.**

Adv.- Follow-up for NT SCAN at 12-14 wks & ANOMALY SCAN at 20 wks.

DR SUMEDH WATHORE
Consulting Radiologist

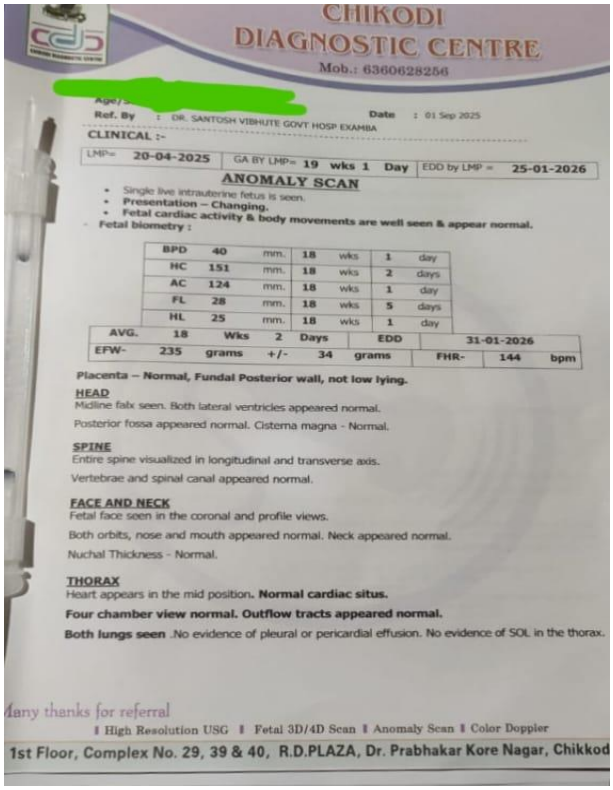
(1 DR SUMEDH WATHORE certify that I have not disclosed the sex of the baby to the patient.
2. This report is not valid for medico-legal purposes.
Note : Detailed fetal anatomy may not always be visible due to technical difficulties related to fetal positions, amniotic fluid volume, fetal movements and abdominal wall thickness. Therefore, all anomalies including face and cardiac may not be necessarily be detected at every examination.)

Many thanks for referral

High Resolution USG | Fetal 3D/4D Scan | Anomaly Scan | Color Doppler

1st Floor, Complex No. 29, 39 & 40, R.D.PLAZA, Dr. Prabhakar Kore Nagar, Chikkodi.

Figure no. 17.



CHIKODI
DIAGNOSTIC CENTRE
Mob.: 6360628256

Ref. By : DR. SANTOSH VIBHUTE GOVT HOSP EXAMBA
Date : 01 Sep 2025

CLINICAL :-

LMP= 20-04-2025 | GA BY LMP= 19 wks 1 Day | EDD by LMP = 25-01-2026

ANOMALY SCAN

- Single live intrauterine fetus is seen.
- Presentation – Changing.
- Fetal cardiac activity & body movements are well seen & appear normal.

Fetal biometry :

BPD	40	mm.	18	wks	1 day
HC	151	mm.	18	wks	2 days
AC	124	mm.	18	wks	1 day
FL	28	mm.	18	wks	5 days
HL	25	mm.	18	wks	1 day

AVG.	18	Wks	2	Days	EDD	31-01-2026	
EFW-	235	grams	+/-	34	grams	FHR-	144 bpm

Placenta – Normal, Fundal Posterior wall, not low lying.

HEAD
Midline falx seen. Both lateral ventricles appeared normal.
Posterior fossa appeared normal. Cisterna magna - Normal.

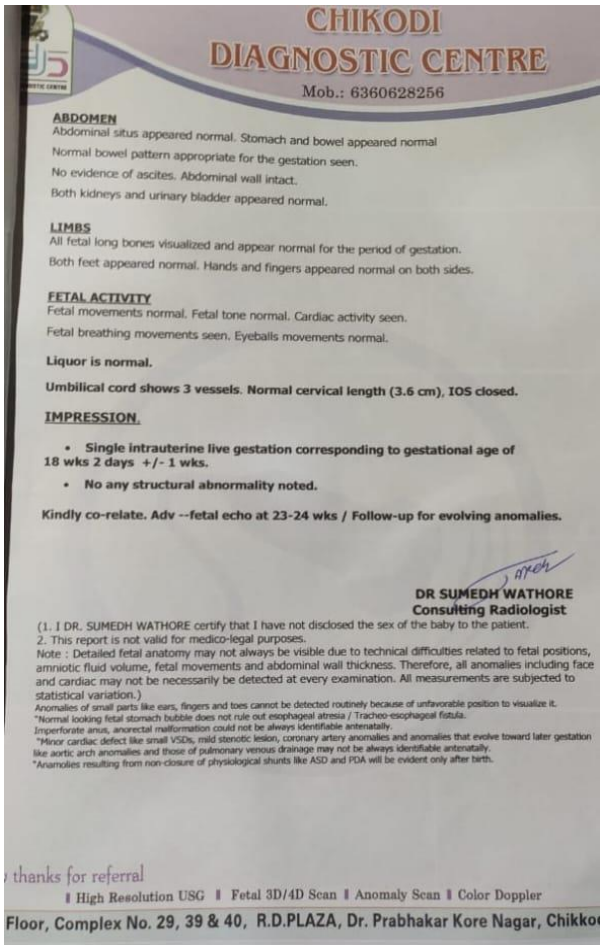
SPINE
Entire spine visualized in longitudinal and transverse axis.
Vertebrae and spinal canal appeared normal.

FACE AND NECK
Fetal face seen in the coronal and profile views.
Both orbits, nose and mouth appeared normal. Neck appeared normal.
Nuchal Thickness - Normal.

THORAX
Heart appears in the mid position. **Normal cardiac situs.**
Four chamber view normal. Outflow tracts appeared normal.
Both lungs seen .No evidence of pleural or pericardial effusion. No evidence of SOL in the thorax.

Many thanks for referral
High Resolution USG | Fetal 3D/4D Scan | Anomaly Scan | Color Doppler
1st Floor, Complex No. 29, 39 & 40, R.D.PLAZA, Dr. Prabhakar Kore Nagar, Chikkod

Figure no. 18.



CHIKODI
DIAGNOSTIC CENTRE
Mob.: 6360628256

ABDOMEN
Abdominal situs appeared normal. Stomach and bowel appeared normal
Normal bowel pattern appropriate for the gestation seen.
No evidence of ascites. Abdominal wall intact.
Both kidneys and urinary bladder appeared normal.

LIMBS
All fetal long bones visualized and appear normal for the period of gestation.
Both feet appeared normal. Hands and fingers appeared normal on both sides.

FETAL ACTIVITY
Fetal movements normal. Fetal tone normal. Cardiac activity seen.
Fetal breathing movements seen. Eyeballs movements normal.

Liquor is normal.

Umbilical cord shows 3 vessels. Normal cervical length (3.6 cm), IOS closed.

IMPRESSION.

- **Single intrauterine live gestation corresponding to gestational age of 18 wks 2 days +/- 1 wks.**
- **No any structural abnormality noted.**

Kindly co-relate. Adv --fetal echo at 23-24 wks / Follow-up for evolving anomalies.

DR SUMEDH WATHORE
Consulting Radiologist

(1. I DR. SUMEDH WATHORE certify that I have not disclosed the sex of the baby to the patient.
2. This report is not valid for medico-legal purposes.
Note : Detailed fetal anatomy may not always be visible due to technical difficulties related to fetal positions, amniotic fluid volume, fetal movements and abdominal wall thickness. Therefore, all anomalies including face and cardiac may not be necessarily be detected at every examination. All measurements are subjected to statistical variation.)
Anomalies of small parts like ears, fingers and toes cannot be detected routinely because of unfavorable position to visualize it.
*Normal looking fetal stomach bubble does not rule out esophageal atresia / Trachoo-esophageal fistula.
Imperforate anus, anorectal malformation could not be always identifiable antenatally.
*Minor cardiac defect like small VSDs, mild stenotic lesion, coronary artery anomalies and anomalies that evolve toward later gestation like aortic arch anomalies and those of pulmonary venous drainage may not be always identifiable antenatally.
*Anamolies resulting from non-closure of physiological shunts like ASD and PDA will be evident only after birth.

thanks for referral
High Resolution USG | Fetal 3D/4D Scan | Anomaly Scan | Color Doppler
Floor, Complex No. 29, 39 & 40, R.D.PLAZA, Dr. Prabhakar Kore Nagar, Chikko

Figure no. 19.

DISCUSSION

Overview of Couple Pathophysiology

Infertility in this couple was multifactorial and involved significant contributions from both partners. In the female partner, chronic anovulation due to PCOS with insulin resistance,[5–8] borderline hyperprolactinemia[7,8] and latent *Toxoplasma gondii* exposure[9] were the principal biomedical factors. Oligomenorrhoea (3–4-monthly cycles), acne, hirsutism, acanthosis nigricans and polycystic ovarian morphology on ultrasound were consistent with PCOS.[5–8] Elevated fasting insulin indicated insulin resistance, which is known to disturb folliculogenesis, androgen balance and ovulation.[5–8]

Toxoplasma IgG positivity with IgM negativity suggested past exposure; however, latent toxoplasmosis has been associated with a chronic low-grade inflammatory state that may impair implantation and endometrial receptivity in susceptible patients.[9,17] Mildly raised prolactin (28.6 ng/ml) further contributed to hypothalamic–pituitary–ovarian axis disturbance and menstrual irregularity.[7,8]

The male partner, although systemically healthy and free from addictions, showed mild oligospermia with reduced progressive motility, constituting a clear male-factor component. Male-factor infertility accounts for around 30–50% of infertility cases worldwide,[22,23] with many cases being idiopathic, reflecting subtle spermatogenic dysfunction and oxidative stress despite normal general examination.[22–24] This case therefore underscores the necessity of couple-based evaluation and management, rather than a predominantly female-centred approach.

Ayurvedic Correlation and Saṃprāpti

From an Ayurvedic perspective, the female presentation resembles Ārtava-kṣaya / Nāṣṭārtava and Bīja–Garbhāśaya duṣṭi on a Kapha–Vāta-dominant background.[10–13] Excessive guru–madhura āhāra, divā-svapna and alpa-vyāyāma led to Kapha–Meda vṛddhi and Agnimāndya, resulting in Āma sañcaya in Rasavaha, Medovaha and Ārtavavaha srotas. This produced srotorodha and Ārtava duṣṭi, with Apāna Vāta becoming āvṛta (obstructed), thereby disturbing Garbhasambhava Sāmagrī (Ṛtu, Kṣetra, Ambu, Bīja).[10–13] Latent infectious status (Toxoplasma IgG positivity) can be interpreted as Rakta duṣṭi, further compromising Kṣetra-śuddhi and uterine receptivity.[9,11,17] The overall picture is comparable to PCOS-related Vandhyatva with Puṣpaghni Jataharinī–like features described in contemporary Ayurvedic literature.[12–16]

In the male partner, absence of overt Nidāna with isolated semen abnormality is best understood as Shukra Dhātu duṣṭi / kṣaya with involvement of Śukravaha srotas and subtle Bīja-doṣa.[11,24] Dhātu-agni mandya at Shukra level leads to qualitative and quantitative impairment of Shukra Dhātu, manifesting clinically as reduced sperm count and motility. Thus, Vandhyatva here arises from female Ārtava duṣṭi and Kṣetra aśuddhi together with male Shukra duṣṭi, justifying a Saṃprāpti-based, couple-oriented management plan.[10–13,22–24]

Therapeutic Rationale – Female Partner

The Cikitsā-sūtra for the female partner was framed as:

- Agnidīpana–Āmapācana – correction of Agnimāndya and clearance of Āma,[10–13]
- Kapha–Meda-hara – to address obesity, insulin resistance and srotorodha,[10–13,17]
- Vātānulomana & Ārtava-janana – to relieve Apāna Vāta āvaraṇa and restore ovulation,[12–16]
- Rakta-śodhana & Rasāyana – to correct Rakta/Ārtava duṣṭi and optimise Kṣetra.[10–13,17]

Rājapravartinī Vaṭi (Kanyā/Aloe vera, Kāsīsa, Tankana, Hiṅgu, processed with Kumārī svarasa) is described in Bhaiṣajya Ratnāvali as an Ārtava-pravartaka and Agnidīpaka yoga.[16,18] Kāsīsa and Tankana provide Lekhana and Srotoshodhana, while Hiṅgu and Kumārī support Agni and Apāna Vāta regulation, helping to break the initial Saṃprāpti of delayed and scanty menstruation.[16,18]

Kumaryāsava, with Kumārī rasa as base, jaggery and honey for fermentation, Loha bhasma, Trikatu (Śuṇṭhi, Maricha, Pippalī), Triphalā (Harītakī, Vibhitakī, Āmalakī), Vidanga, Chitraka, Gokṣura, Kapikacchu, Punarnavā, Lodhra, Rasna, Devadāru, Musta and other Deepana–Pācana–Rasāyana drugs,[16–18] acts on Rasavaha–Medovaha srotas, improves Agni, supports hematinic function and enhances Ārtava dhātu quality. In PCOS with obesity and mild anemia/insulin derangement, this aligns with reports of successful PCOS management using similar Deepana–Pācana–Ārtava-janana protocols.[12–15]

Āśokāriṣṭa is based on Aśoka (Saraca asoka) bark decoction and contains Dhatakī, Triphalā, Musta, Utpala, Amrasthi, Jeeraka, Vasa and Chandana.[16–20] Aśoka is a well-known Yoni-balya and Raktaprasādana herb, indicated in kṛcchrārtava and asrugdara.[16–18] In this case, Āśokāriṣṭa provided uterine toning, stambhana where needed, and support to endometrial receptivity.

For metabolic correction and insulin resistance, **Varuṇādi Kaṣāya** and **Kalounjīādi Cūrṇa** were selected. Varuṇādi Kaṣāya includes Varuṇa (Crataeva religiosa), Śatāvarī (Asparagus racemosus), Plumbago (Dahana), Bilva, Triphalā group, Punarnavā, Karanja and other Deepana–Pācana–Lekhana dravyas that act as Kapha–Meda-hara and Srotoshodhaka.[16–18] Kalounjīādi Cūrṇa with Kalounjī (Nigella sativa), Methi, Ajwain, Dhanyaka and Jeeraka offers strong Agnidīpana, Vātānulomana and metabolic benefits; Nigella has been shown to improve glycaemic control and oxidative stress in clinical settings,[19] supporting its use in insulin-resistant PCOS.

Guduchi Ghan Vaṭi, prepared from Tinospora cordifolia extract, was justified by the Toxoplasma IgG positivity. Guḍūcī possesses Rasāyana and immunomodulatory actions and is reported to contain compounds with significant immunomodulatory activity [20], which is desirable in cases with latent infectious diathesis and possible inflammatory background.

Eve Care Forte (Aloe vera, Jatāmāṃsī, Lodhra, Methi, Mundi) provided Rasāyana, Yoni-balya, Medhya–stress-modulating and mild Pittāśāmaka support. Lodhra and Aloe contribute to pelvic toning and Raktaprasādana, while Jatāmāṃsī and Methi may help in stress and metabolic balance, aligning with data on adaptogenic and reproductive benefits of Śatāvarī and similar dravyas.[21]

In the later phase, **Infinity F**—containing Jiyapota (Putranjiva roxburghii) seeds, Garbhadhārak Yog, Garbhapāla Rasa, Pushpadhanwa Ras, Madhumalini Vasant and Praval Piṣṭi—was introduced as a Vṛṣya–Rasāyana–Garbha-sthāpana support.[16–18,24] Jiyapota and Pushpadhanwa Ras are classically mentioned for Bīja-bala and infertility,[16–18] while Garbhadhārak Yog and Garbhapāla Rasa support implantation and early gestational stability. Praval Piṣṭi provides dhātu-poṣaṇa and cooling Raktaprasādana, supporting uterine environment.[16–18]

Uterojoy syrup adds another layer of Yoni-balya and Raktaprasādana through a mixture of Ashoka, Lodhra, Dhatakī, Triphalā, Mustaka, Amra, Rakta Chandana, Jeeraka, Daruharidrā, Adusa, Pippalī and Kumud (with honey as yogavāhi).

Overall, the female regimen targeted the key Saṃprāpti components—Kapha–Meda vṛddhi, Āma sañcaya, Agnimāndya, Ārtavavaha srotorodha, Rakta/Ārtava duṣṭi and Kṣetra aśuddhi—consistent with classical guidance and recent Ayurvedic case literature on PCOS-related Vandhyatva.[10–17]

Therapeutic Rationale – Male Partner

Management of the male partner focused on Shukra Dhātu poṣaṇa, Vṛṣyatva and Rasāyana, in accordance with Ayurvedic principles for Klāibya and Shukra kṣaya.[16-18,24]

Cap Spermore contains Śilājit, Lata Kasturi, Śatāvarī, Aśvagandhā, Safed Musli, Akarkara, Gokhru, Kauch beej, Vang bhasma and Lauh bhasma. Śilājit acts as a potent Rasāyana and Yogavāhi.[16-18] Śatāvarī and Safed Musli are established Vṛṣya and Balya Rasāyanas, improving Shukra Dhātu formation and dhātu-bala,[21,23,24] while Aśvagandhā is Medhya, Balya and Rasāyana with documented benefits on stress and male reproductive parameters.[24] Gokhru and Kapikacchu (Kauch beej) are classical Vṛṣya drugs for Shukra-kṣaya and male infertility,[18,24] and Akarkara supports Vātānulomana and neuro-reproductive stimulation. Vang and Lauh bhasma provide dhātu-poṣaṇa and Rasāyana support.[16–18,24]

Thus, Spermore is rationally designed to enhance spermatogenesis, sperm motility and overall Shukra quality, addressing the diagnosed mild oligospermia and asthenozoospermia in line with Ayurvedic male-infertility management concepts.[22–24]

Clinical Response and Couple-Based Outcome

In the female partner, menstrual cycles normalized from 3–4-monthly to 28–37-day intervals with consistent flow, weight reduced from 70 kg to 64.7 kg and acne and lethargy improved. These changes reflect effective Kapha–Meda-hara, Agnidīpana–Āmapācana, Vātānulomana and Ārtava-janana, suggesting restoration of Ārtava pravṛtti, improved metabolic profile and better Kṣetra-śuddhi.[12–17]

In the male partner, semen analysis after three months of therapy showed an increase in total sperm count from 32 million/ml to 56 million/ml, with actively motile sperm improving from 30% to 50% and non-motile forms decreasing from 30% to 20%. This indicates successful Shukra Dhātu poṣaṇa and correction of Shukra duṣṭi/kṣaya, aligning with the documented potential of Vṛṣya–Rasāyana regimens in male-factor infertility.[22–24]

Spontaneous conception in June 2025, without any hormonal or ovulation-inducing therapy, and a normally progressing intra-uterine pregnancy on follow-up ultrasonography, indicate that the core components of Garbhasambhava Sāmagrī were restored in both partners.[10–13,17]

Overall, this case suggests that a classically grounded, Saṃprāpti-vighātana–based, couple-centred Ayurvedic protocol can meaningfully address complex infertility involving PCOS, endocrine disturbance, latent infection and mild male-factor infertility.

CONCLUSION

This case illustrates that a structured, Saṃprāpti-oriented Ayurvedic protocol can effectively address multifactorial couple infertility when both partners are evaluated and managed together. In the female partner, Agnidīpana, Āmapācana, Kapha–Meda-hara, Vātānulomana and Ārtava-janana therapies successfully restored metabolic balance,

hormonal rhythm, ovulatory function and endometrial receptivity. Simultaneously, the male partner's mild oligospermia and reduced motility improved with Vṛṣya–Rasāyana interventions, resulting in significant enhancement of Shukra Dhātu quality.

The coordinated correction of Ārtava duṣṭi and Shukra duṣṭi re-established the essential components of Garbhasambhava Sāmagrī for both partners. The achievement of spontaneous conception without hormonal or ovulation-inducing agents highlights the therapeutic potential of holistic, couple-focused Ayurvedic management in complex infertility. Further controlled clinical studies are warranted to validate these encouraging outcomes and to support evidence-based standardisation of Ayurvedic protocols in reproductive health.

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