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Case Report

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SUCCESSFUL AYURVEDIC MANAGEMENT OF SECONDARY INFERTILITY IN A PATIENT WITH LOW AMH AND LARGE UTERINE FIBROID: A CASE REPORT

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ABSTRACT

Low Anti-Müllerian Hormone (AMH) is a well-established marker of diminished ovarian reserve and is associated with reduced reproductive potential. When coupled with structural uterine abnormalities such as fibroids—particularly large fibroids—the likelihood of natural conception is often considered poor, and assisted reproductive technologies (ART) or surgical interventions are commonly advised. This case report describes Ayurvedic management of a 32-year-old female with secondary infertility, diminished ovarian reserve (AMH: 0.3 ng/mL), and a large intramural uterine fibroid measuring 54×66 mm, resulting in successful conception. The male partner exhibited normospermia, indicating no contributory male factor. A structured and individualized Ayurvedic treatment protocol—including *Poshini, Vardhani, Bhedini, and Upaja*—was implemented, focusing on enhancing oocyte quality, improving ovarian function, regulating hormonal balance, optimizing uterine health, and addressing fibroid-related pathology. Following three months of consistent treatment along with appropriate lifestyle modifications, spontaneous natural conception was achieved without the use of assisted reproductive techniques or surgical intervention. This case underscores the potential of Ayurvedic management as a non-invasive, holistic approach capable of addressing both functional (ovarian reserve) and structural (fibroid) factors in infertility. It highlights the importance of improving the internal reproductive environment and suggests a promising complementary role for Ayurveda in the management of complex infertility cases.

KEYWORDS: Low AMH, Diminished Ovarian Reserve, Uterine Fibroid, Secondary Infertility, Ayurvedic Fertility Management, Oocyte Quality, Spontaneous Conception.

INTRODUCTION

Uterine fibroids are benign smooth muscle tumors of the uterus and represent one of the most common gynecological conditions in women of reproductive age. Their impact on fertility is multifactorial and depends on size, number, and location. Larger fibroids, particularly those exceeding 5 cm, may impair fertility by distorting uterine architecture, altering endometrial receptivity, disrupting uterine contractility, and contributing to a state of hormonal imbalance, often characterized by relative estrogen dominance. These changes can adversely affect implantation and early embryo development, thereby reducing the likelihood of successful conception.[1]

Anti-Müllerian Hormone (AMH), secreted by the granulosa cells of pre-antral and small antral follicles, is a well-established biomarker of ovarian reserve. It reflects the quantitative aspect of the ovarian follicular pool and is widely used in fertility assessment. AMH levels below 1 ng/mL are indicative of diminished ovarian reserve, while values around 0.3 ng/mL suggest a markedly reduced follicular pool and significantly compromised reproductive potential. In clinical practice, such patients are often considered poor responders to conventional fertility treatments and are frequently advised to pursue assisted reproductive technologies (ART), including in vitro fertilization (IVF), sometimes with donor oocytes.[2]

The coexistence of diminished ovarian reserve and a large uterine fibroid presents a dual challenge in fertility management. While low AMH reflects a reduced availability of oocytes, fibroids may create a suboptimal uterine environment for implantation. This combination

often leads to a guarded prognosis for natural conception and increases reliance on invasive or technologically intensive interventions.

Ayurveda conceptualizes infertility *(Vandhyatva)* as a result of imbalances in the fundamental physiological processes governing reproduction, including impairment of *Artava Dhatu* (reproductive tissue), vitiation of *Doshas*—particularly *Apana Vata*—and obstruction of bodily channels *(Srotorodha)*. The Ayurvedic approach emphasizes restoration of systemic balance through enhancement of tissue nourishment (*Dhatu Poshana*), correction of metabolic function (*Agni*), detoxification, and regulation of hormonal and neuroendocrine pathways. Additionally, Ayurveda recognizes the role of psychological well-being and stress in reproductive health, advocating a mind-body integrated approach to treatment.[3][4][5]

Unlike conventional management, which often addresses ovarian reserve and fibroids as separate entities, Ayurveda adopts a holistic strategy aimed at improving the internal reproductive milieu. By focusing on enhancing oocyte quality, regulating hormonal balance, and optimizing uterine receptivity, it seeks to overcome both functional and structural barriers to conception.

This case report illustrates the successful application of such an integrative Ayurvedic approach in achieving spontaneous natural conception in a patient with low AMH and a large uterine fibroid, highlighting its potential role as a non-invasive and effective strategy in complex infertility scenarios.

CASE REPORT

Patient Information

A 32-year-old female presented with a history of secondary infertility and inability to conceive despite regular unprotected intercourse. The couple had been attempting conception for a period of six years without success and sought evaluation for planning their second child. The patient was otherwise healthy, with no major systemic illnesses, but reported psychological stress related to delayed conception.

She had been previously diagnosed with diminished ovarian reserve, with an Anti-Müllerian Hormone (AMH) level of 0.3 ng/mL. In addition, ultrasonographic evaluation revealed the presence of a large uterine fibroid measuring 54×66 mm. The male partner, aged 35, had no known medical conditions, and his semen analysis was within normal limits.

Female Patient's General Health Vitals

Table 1: Patient Vital Signs.

Vitals	Values
Pulse	74/min
BP (Blood Pressure)	122/80 mmHg
RR (Respiratory Rate)	18/min
SpO_2 (Oxygen Saturation)	98%

Other Examinations

Table 2: Clinical Examination.

Parameter	Observation
Naadi Pariksha	Pitta-Vata
Appetite	Normal
Bowel	Normal
Sleep	Normal
Energy Levels	Normal

Personal History

Table 3: Personal History of Patient.

Parameter	Observation
Alcohol Consumption	No
Smoking	No
Junk Food	Occasional intake
Non-vegetarian Diet	Occasional intake
Stress	Primarily related to fertility concerns

Table 4: Menstrual History.

Parameter	Observation
Cycle Duration	28–30 days, regular
Menstrual Flow	2–4 days
Pain	Mild body pain
Clots	Absent

Obstetric History

G2 P1 L1 A1 D0 (Previous history of missed abortion), 12 year old living female child.

Sexual History

Table 5: Sexual History.

Parameter	Observation
Vaginal Dryness	No
Dyspareunia	No
Libido	No

Hormonal Profile

AMH: 0.3 ng/mL (indicative of diminished ovarian reserve) TSH, FSH, and prolactin: Within normal limits.

Ultrasound Findings

Large uterine fibroid measuring 54×66 mm Normal uterine size aside from fibroid Endometrial thickness

within normal range Both ovaries visualized.

Male Partner Evaluation
Semen analysis: Normospermia (normal count, motility, and morphology)

Diagnosis
Secondary Infertility
Diminished Ovarian Reserve (Low AMH) Large Uterine Fibroid

Fertility Treatment History
Given the low AMH levels and the presence of a large fibroid, the couple had been counseled regarding the reduced likelihood of natural conception. Assisted reproductive techniques, including in vitro fertilization (IVF), were suggested as potential options. However, the couple opted for a non-invasive approach.

Surgical History
No significant surgical history reported.

Family History
No relevant findings.

Male Partner's General Health
The male partner, aged 35, had no significant medical or surgical history. Semen analysis confirmed normal fertility parameters, and no intervention was required.

Treatment and Management

Table 7: Ayurvedic Proprietary Medicines, Ingredients, and Dosage for Treatment.

Medicine given	Ingredients/Contents	Dosage
1. *Tablet Vardhani (600 mg)*	*Shuddha Hingul, Haritaki, Amalaki, Bibhitak, Shatawari, Shatapushpa, Bala*	2 pills after breakfast and 2 pills after dinner
2. *Tablet Bhedini (600 mg)*	*Sariva, Patol, Shuddha Hingul, Lauha*	2 pills after breakfast and 2 pills after dinner
	Bhasma,Anantmool, Guggulu, Nimba, Kutaja	
3. *Tab. Upaja (300 mg)*	*Kumari, Shuddha Kasis, Gulkand, Sunthi, Dalchini, Elaichi*	2 pills after breakfast and 2 pills after dinner
4. *Tablet Poshini (600 mg)*	*Shuddha Hingul, Bang Bhasma, Shivlingi, Shatavari, Ashwagandha, Jivanti, Putranjivak*	2 pills after breakfast and 2 pills after dinner

DISCUSSION
This case highlights successful spontaneous conception in the presence of two traditionally adverse reproductive factors: diminished ovarian reserve, as indicated by low Anti-Müllerian Hormone (AMH), and a large uterine fibroid. Individually, both conditions are associated with reduced fertility, and their coexistence is typically considered to confer a poor prognosis for natural conception.[1][2]

AMH is a well-established biomarker of ovarian reserve, reflecting the quantitative follicular pool. Levels below 0.5 ng/mL, such as the 0.3 ng/mL observed in this case, are associated with diminished ovarian reserve and poor response to ovarian stimulation. Consequently, such patients are often directed toward assisted reproductive technologies (ART), including in vitro fertilization, with consideration of donor oocytes. However, AMH does not directly assess oocyte quality, which remains a critical determinant of fertilization and embryo viability.[2]

The presence of a large uterine fibroid (54×66 mm) further complicates the clinical picture. Fibroids of this size are considered clinically significant and may impair fertility through distortion of the uterine cavity, impaired endometrial receptivity, altered uterine contractility, and a hyperestrogenic environment. Accordingly, myomectomy is frequently recommended prior to conception attempts.[1]

The patient also had a prior history of missed abortion, which may further reflect compromised endometrial receptivity and implantation failure. This could plausibly be attributed to the presence of fibroids affecting the uterine environment, thereby interfering with optimal embryo implantation and early pregnancy maintenance.

However, a key clinical insight from this case is that the primary driver of infertility was not the fibroid itself, but underlying endocrine dysfunction manifesting as anovulatory cycles.

The fibroid, in this context, is more plausibly a secondary manifestation of chronic hormonal imbalance, particularly prolonged unopposed estrogen exposure associated with anovulation. Thus, the root cause of infertility appears to be ovulatory dysfunction rather than structural pathology.[3]

Furthermore, markedly low AMH not only reflects reduced follicular quantity but is often associated with compromised oocyte quality. Poor oocyte competence can impair follicular maturation and ovulation, thereby contributing to anovulatory cycles. In this case, infertility

was likely driven by a combination of impaired ovulation, suboptimal oocyte quality, and reduced endometrial receptivity, rather than direct mechanical interference from the fibroid.[1][2]

This distinction has important therapeutic implications. While myomectomy is commonly advocated, it may not address the underlying endocrine pathology in cases where anovulation is the primary issue. In selected patients, particularly when fibroids do not significantly distort the uterine cavity, restoration of ovulation and hormonal balance may be sufficient to achieve conception without surgical intervention.

The present case supports this perspective, as conception was achieved without surgical removal of the fibroid, emphasizing the importance of optimizing the functional reproductive environment.

The Ayurvedic management adopted in this case aimed to address both ovarian and uterine factors through a systemic approach. Infertility *(Vandhyatva)* is conceptualized in Ayurveda as a disorder of *Artava Dhatu, Dosha* imbalance—particularly *Apana Vata*—and *Srotorodha* (channel obstruction). The therapeutic strategy focused on *Artava Dhatu Poshana, Srotoshodhana,* and *Agni* correction, thereby enhancing reproductive capacity.

The administered formulations—*Poshini, Vardhani, Bhedini, and Upaj*a—were selected for their complementary actions in improving reproductive health. *Tablet Vardhani* is designed to enhance oocyte quality, particularly in women with diminished ovarian reserve. The presence of *Triphala* components—*Haritaki, Amalaki, and Bibhitaki*—provides potent antioxidant and detoxifying effects, reducing oxidative stress within the ovarian microenvironment, a key factor in oocyte degeneration. Shatavari contributes phytoestrogenic activity, supporting folliculogenesis and hormonal balance, while *Shatapushpa* aids in regulation of ovulation. Bala offers tissue nourishment *(Dhatu poshan*), improving overall reproductive strength. *Shuddha Hingul* acts as a *Yogavahi*, enhancing bioavailability and facilitating deeper tissue action of the formulation.[6][7]

Tablet Bhedini is aimed at reducing and resolving fibroid mass through a combination of anti-inflammatory, detoxifying, and scraping (*Lekhana*) actions. *Guggulu* and *Nimba* exhibit strong anti-inflammatory and anti-proliferative properties, potentially inhibiting abnormal tissue growth. *Kutaja* and *Patol* contribute to metabolic correction and detoxification, helping reduce pathological accumulation. *Sariva and Anantmool* act as blood purifiers (*Rakta shodhaka*), improving uterine circulation and reducing congestion. *Lauha Bhasma* supports hematological health, addressing associated anemia. *Shuddha Hingul* enhances drug delivery and metabolic activity, supporting deeper action on fibroid tissue.[6][7]

Tablet Upaja primarily supports ovulation and menstrual regulation, addressing anovulatory cycles often associated with fibroids. *Kumari* (Aloe vera) has a well-documented role in stimulating uterine function and regulating cycles. *Shuddha Kasis* aids in correcting iron deficiency and improving endometrial health. *Sunthi* (dry ginger) and *Dalchini* (cinnamon) enhance insulin sensitivity and metabolic function, which are crucial in restoring ovulation, especially in hormonally imbalanced states. *Elaichi* supports digestive and metabolic balance, while *Gulkand* provides a mild cooling and pitta-balancing effect, supporting reproductive harmony.[6][7]

Tablet Poshini acts as a comprehensive fertility promoter, focusing on reproductive tissue nourishment and hormonal stability. *Shivlingi* and *Putranjivaka* are traditionally known for their role in enhancing fertility and supporting conception. *Shatavari* and *Ashwagandha* provide adaptogenic and phytoestrogenic effects, helping regulate the hypothalamic–pituitary–ovarian axis and reduce stress-induced hormonal disruption. Jivanti contributes to tissue vitality and endometrial receptivity. *Bang Bhasma* supports reproductive tissue metabolism, while *Shuddha Hingul* enhances the overall bioavailability and efficacy of the formulation.[6][7]

A notable feature of this case is the relatively short time to conception (three months), suggesting rapid improvement in ovulatory function and endometrial receptivity. This indicates that functional reproductive impairments may be reversible when systemic balance is restored.

Adjunctive lifestyle modifications, including stress reduction, dietary regulation, and ovulation tracking, likely contributed to improved hypothalamic–pituitary–ovarian axis function and overall reproductive outcomes.

Overall, this case challenges the conventional paradigm that low AMH and large fibroids necessitate invasive or ART-based interventions. Instead, it underscores the importance of identifying and addressing underlying functional disturbances—particularly anovulation, hormonal imbalance, and impaired endometrial receptivity—even in the presence of structural abnormalities.

CONCLUSION

This case demonstrates that successful spontaneous conception is achievable even in the presence of markedly diminished ovarian reserve and a large uterine fibroid when underlying functional disturbances are effectively addressed. The findings suggest that infertility in this patient was primarily driven by anovulatory cycles—likely contributing to fibroid development—as well as compromised oocyte quality associated with low AMH and suboptimal endometrial receptivity, rather than the fibroid itself.

The Ayurvedic treatment protocol—comprising *Poshini, Vardhani, Bhedini, and Upaja*—played a pivotal role in restoring reproductive function by improving oocyte quality, inducing ovulation, regulating hormonal balance, enhancing endometrial receptivity, and addressing fibroid-related pathology. Conception within three months underscores the effectiveness of this systemic, non-invasive approach.

This case supports Ayurvedic management as a viable mainstream approach in selected infertility cases, particularly those driven by functional and hormonal imbalances. By targeting root causes rather than isolated structural abnormalities, it may reduce reliance on invasive procedures and assisted reproductive techniques.

However, larger, well-designed clinical studies are essential to validate efficacy, safety, and reproducibility, and to establish its role in evidence-based fertility care.

CONFLICT OF INTEREST

The authors declare no conflicts of interest.

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