

**BAD OBSTETRIC HISTORY: A DUAL LENS APPROACH FROM AYURVED AND MODERN MEDICINE****\*Dr. Sharayu Arun Gaikwad**

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Bad Obstetric History (BOH) comprises repeated pregnancy losses, stillbirths, congenital anomalies, neonatal deaths, and infertility. Modern biomedical science attributes BOH to genetic, endocrine, uterine, infectious, and immunological causes, managed through counselling, screening, and assisted reproductive techniques.<sup>[1]</sup> Ayurved correlates BOH with imbalances in *Garbha Samagri* (Ritu, Kshetra, Ambu, Beeja), *Artava Dushti*, and *Yonivyapad*. Classical texts emphasize *Shodhana*, *Rasayana*, and *Garbhini Paricharya* for prevention and care. This review article synthesizes biomedical and Ayurvedic perspectives, highlighting integrative strategies. Ethical counselling, lifestyle regulation, and Rasayana therapy can complement modern interventions, offering holistic care for women with BOH.<sup>[2-6]</sup>

**KEYWORDS:** Bad Obstetric History, Ayurveda, *Garbha Samagri*, Rasayana, Preconception Care, Antenatal Care.**INTRODUCTION**

Bad Obstetric History (BOH) refers to women with recurrent pregnancy losses or significant adverse pregnancy outcomes such as repeated miscarriages, stillbirths, neonatal deaths, or congenital anomalies. Globally, BOH contributes to approximately 1–2% of pregnancies, with miscarriage rates ranging between 12–15% and recurrent losses affecting 3–5% of women. Nearly half of these cases remain unexplained despite extensive investigations, compounding the emotional distress experienced by couples and increasing the risk of adverse neonatal outcomes such as low birth weight, preterm birth, and neonatal intensive care admissions.

Women experiencing BOH often face profound psychosocial consequences, including anxiety, depression, and feelings of guilt that erode self-confidence. Families, too, endure emotional strain, strained relationships, and social stigma, especially in communities where reproductive success is closely tied to identity and status. These cumulative effects highlight the urgent need for integrative counselling approaches

that address not only medical causes but also the emotional and social dimensions of BOH.<sup>[7-10]</sup>

**Traditional definition: Previously, BOH was applied to couples with  $\geq 3$  consecutive fetal losses.****Current perspective:** Even a single fetal loss (miscarriage, stillbirth, neonatal death) is now considered significant and warrants counselling and evaluation.

BOH is a clinically significant entity covering recurrent pregnancy losses, intrauterine fetal demise, stillbirths, neonatal deaths, and congenital anomalies. Traditional concept has evolved and even a single adverse pregnancy outcome is now considered sufficient to warrant evaluation due to its substantial impact on maternal and perinatal health.

The burden of BOH is multifactorial, arising from genetic abnormalities, endocrine disorders, uterine anomalies, immunological dysfunctions, and infectious aetiologies. Its global significance lies not only in the clinical consequences but also in the psychosocial

impact, making it a priority area for integrative approaches that combine modern biomedical strategies with traditional systems of medicine.<sup>[11-13]</sup>

### Rationale for Integrated Treatment

Despite advances in modern obstetrics, there has been a decline in trust among many women regarding purely biomedical approaches to recurrent pregnancy loss and adverse outcomes. Modern medicine excels at identifying aetiological factors—chromosomal translocations, thyroid autoimmunity, insulin resistance, uterine malformations, TORCH infections, and antiphospholipid antibodies—but often falls short in addressing the psychological, moral, and socio-cultural dimensions of reproductive health.

BOH is not merely a clinical condition; it is a deeply personal and emotional experience. Couples facing repeated losses often suffer from anxiety, guilt, and diminished confidence in medical systems. This highlights the need for integrative counselling, where biomedical diagnosis is complemented by holistic care that addresses emotional resilience, lifestyle, and moral support.

Ayurveda contributes a unique dimension: *Garbha Samagri* (Ritu, Kshetra, Ambu, Beeja) as a systems biology model, Shodhana for purification, Rasayana for rejuvenation, and Satvavajaya Chikitsa for emotional stability. Rasayana herbs such as Guduchi, Ashwagandha, and Shatavari demonstrate immunomodulatory, antioxidant, and phytoestrogenic effects validated in modern pharmacology. Shodhana therapies may influence detoxification pathways and microbiome modulation.

Thus, while modern medicine can diagnose the cause of BOH, effective management requires a biopsychosocial model where Ayurveda plays a vital role in addressing the moral, emotional, and lifestyle factors. This integrative approach not only enhances clinical outcomes but also rebuilds trust in healthcare systems.<sup>[14-16]</sup>

### Objective

This study reviews BOH through Ayurvedic and biomedical lenses to develop an integrative framework for management. By combining modern obstetrics with Ayurvedic paradigms, BOH is established as a biopsychosocial condition requiring counselling, lifestyle modification, and therapeutic integration to enhance pregnancy outcomes and maternal well-being.

### Literature Review

#### 1. Modern Biomedical Perspective

- 1.1 Definition: BOH =  $\geq 3$  adverse pregnancy outcomes.
- 1.2 Causes: Genetic abnormalities, endocrine disorders (thyroid, diabetes, PMOS), uterine anomalies, infections (TORCH), immunological factors.
- 1.3 Investigations:

- 1.3.1 Genetic: Karyotyping, chromosomal microarray.
- 1.3.2 Endocrine: TSH, HbA1c, AMH, LH/FSH.
- 1.3.3 Uterine: Ultrasound, hysteroscopy, MRI.
- 1.3.4 Infectious: TORCH panel, HIV, syphilis.
- 1.3.5 Immunological: Antiphospholipid antibodies, ANA.
- 1.4 Management: Preconception counselling, folic acid, infection control, hormonal therapy, ART (IVF, ICSI)

#### 2. Ayurvedic Perspective

- 2.1 Conceptual Correlates:
  - 2.1.1 *Garbha Samagri* (Ritu, Kshetra, Ambu, Beeja).
  - 2.1.2 *Artava Dushti* → poor ovulation.
  - 2.1.3 *Yonivyapad* → uterine disorders.

#### 3. Ayurvedic Literature Review

- 3.1 Charaka Samhita, Sharira Sthana – Emphasizes *Rasayana* therapy for strengthening reproductive tissues.
- 3.1 Sushruta Samhita, Sharira Sthana – Discusses *Beeja Dushti* (defective gametes) as a cause of poor pregnancy outcomes.
- 3.2 Kashyapa Samhita, Garbhini Paricharya – Stresses antenatal care and purification therapies before conception.
- 3.3 Ashtanga Hridaya, Sharira Sthana – Highlights the importance of *Satvavajaya Chikitsa* for emotional stability during pregnancy.
- 3.4 Bhavaprakasha, Purva Khanda – Details dietary and lifestyle regimens for women to promote healthy conception and fetal development.

#### 4. Investigations (Ayurvedic)

- 4.1 *Nidana Panchaka* (aetiology, pre-monitory signs, symptoms, therapeutic tests, prognosis).
- 4.2 *Artava Pariksha* (assessment of menstrual blood).
- 4.3 *Sharira Pariksha* (constitution, dosha balance).

#### 5. Ayurvedic Recommendations

- 5.1 Preconception Care: *Shodhana* (Virechana, Uttar Basti),
- 5.2 *Rasayana* (Guduchi, Ashwagandha, Shatavari).
- 5.3 Diet & Lifestyle: Pathya foods (milk, ghee, dates), yoga, meditation.
- 5.4 Antenatal Care: Monthly regimen, emotional stability, family support.

**Integrative Correlation Table.**<sup>[17-18]</sup>

BOH Cause (Modern)	Ayurvedic Correlate	Recommendation	Benefit
Genetic / chromosomal	<i>Beeja Dushti</i>	Preconception <i>Shodhana</i> , Rasayana	Healthier gametes
Endocrine disorders	<i>Artava Dushti</i>	Diet regulation, Shatavari, Yoga	Hormonal balance
Uterine anomalies	<i>Kshetra Dushti</i>	<i>Uttar Basti</i> , Rasayana	Improved uterine health
Infections	<i>Ambu Dushti</i>	Guduchi, Amalaki	Reduced infection risk
Psychological stress	<i>Satva imbalance</i>	Meditation, Satvavajaya	Emotional stability

**Comparative Analysis: Modern vs Ayurved.**<sup>[19]</sup>

Aspect	Allopathic Approach	Ayurvedic Approach	Integrative Benefit
Genetic screening	Karyotyping, IVF with donor gametes	<i>Beeja Shuddhi</i> via <i>Shodhana</i>	Combines precision with purification
Endocrine disorders	Thyroid medicines, insulin, metformin	Shatavari, yoga, diet	Hormonal balance + fewer side effects
Uterine anomalies	Surgery, hysteroscopy	<i>Uttar Basti</i> , Rasayana	Structural correction + tissue rejuvenation
Infections	Antibiotics, antivirals	Immunomodulators (Guduchi, Amalaki)	Reduced recurrence
Psychological stress	Counselling, SSRIs (Selective Serotonin Reuptake Inhibitors)	Meditation, Satvavajaya	Emotional resilience

## DISCUSSION

Bad Obstetric History (BOH) arises from diverse factors—genetic, endocrine, uterine, infectious, and immunological—making it a complex clinical challenge. Modern medicine provides accuracy in diagnostics and targeted interventions, while Ayurveda contributes a holistic dimension through *Shodhana* (purification), *Rasayana* (rejuvenation), and *Satvavajaya Chikitsa* (emotional stability). Together, these systems form a complementary framework that addresses both biological causes and psychosocial consequences.

Counselling remains central to BOH management, as it enhances treatment adherence, alleviates anxiety, and restores confidence in healthcare. When counselling integrates ethical sensitivity with biomedical and Ayurvedic perspectives, women and families receive support that is medical, emotional, and social.

In community health settings, an integrative approach is particularly valuable. By combining biomedical precision with culturally accepted Ayurvedic practices, health camps can deliver accessible, affordable, and comprehensive care. This model not only improves outcomes but also empowers women to actively engage in their reproductive health journey.

## CONCLUSION

BOH management demands responsibility, compassion, and integrative care. Modern medicine provides accurate diagnostics, advanced screening, and evidence-based interventions, while Ayurveda emphasizes purification, rejuvenation, lifestyle regulation, and emotional stability. By merging biomedical precision with Ayurvedic wisdom, a balanced model of care emerges—one that advances maternal health and restores faith in treatment pathways.

This integrative vision has the potential to rebuild trust, reduce psychosocial distress, and empower women and families facing BOH. By uniting biomedical science with Ayurvedic principles, healthcare providers can move beyond treating pathology alone, towards nurturing resilience, dignity, and holistic well-being.

## REFERENCES

- Gupta M, Gupta P, Gajaria K. Maternal and perinatal outcome in patients with bad obstetric history. *IOSR J Dent Med Sci*. 2018 Apr; 17(4): 12-15.
- Bhadre D, Mundhe M, Bansode N. BOH (Bad Obstetric History) – an Ayurvedic perspective. *AYUSHDHARA*. 2021 May-Jun; 8(3): 3354.
- Sharma PV. *Charaka Samhita*. Chaukhambha Orientalia, Varanasi; 1981.
- Vagbhata. *Ashtanga Hridaya*. Chaukhambha Sanskrit Series, Varanasi; 1995.
- Bhishagratna KK. *Sushruta Samhita*. Chowkhamba Sanskrit Series Office, Varanasi; 1963.
- Patwardhan B. Ayurveda and integrative medicine: global perspective. *J Ayurveda Integr Med*. 2010; 1(1): 3–9.
- Rai P, et al. Genetic factors in recurrent pregnancy loss. *Human Reproduction Update*. 2021; 27(3): 400–415.
- American College of Obstetricians and Gynecologists. *Practice Bulletin on Recurrent Pregnancy Loss*. *Obstet Gynecol*. 2020; 135(5): e197–e207.
- WHO. *Ethics and Health*. Geneva: World Health Organization; 2015.
- Ramya S, Poornima P, Jananisri A, Geofferina IP, Bavyataa V, et al. Role of hormones and the potential impact of multiple stresses on infertility. *Stresses*. 2023; 3: 454-474. doi:10.3390/stresses3020033.

11. Gillon R. Medical ethics: four principles plus attention to scope. *BMJ*. 1994; 309(6948): 184–188.
12. Turlapati VS, Kate MA. Bad obstetric history managed by Ayurvedic line of treatment – a case study. *World J Pharm Med Res*. 2024; 10(2): 242-247.
13. Kumari M, Panda JK, Tanwar S. An Ayurvedic approach on bad obstetric history w.s.r. to Putraghni Yonivyapad – a case. 2023.
14. Mane P, Anupama V. Ayurvedic management of Vandhyatva associated with bad obstetric history – a case report. *World J Pharm Life Sci*. 2026; 12(1): 159-163.
15. Case-control studies. Recurrent pregnancy loss and bad obstetric history: role of TORCH infections, endocrine disorders, and immunological factors. Summarized in integrative reviews (Ayushdhara, *WJPMR*). 2022-2023.
16. Rajini P. Ayurvedic perspective of recurrent pregnancy loss. *AYUSHDHARA*. 2023; 9(3). doi:10.47070/ayushdhara.v9i3.986.
17. Agarwal A, Aponte-Mellado A, Premkumar BJ, Shaman A, Gupta S. The effects of oxidative stress on female reproduction: a review. *Reprod Biol Endocrinol*. 2012 Jun 29; 10: 49. doi:10.1186/1477-7827-10-49. PMID:22748101; PMCID: PMC3399070
18. Editorial. Recurrent pregnancy loss and endocrine dysfunction. *Front Endocrinol (Lausanne)*. 2024 Jul 9; 15. doi:10.3389/fendo.2024.1453336.
19. Zhang L, Du Y, Zhou J, Li J, Shen H, Liu Y, Liu C, Qiao C. Diagnostic workup of endocrine dysfunction in recurrent pregnancy loss: a cross-sectional study in Northeast China. *Front Endocrinol (Lausanne)*. 2023 Sep 18; 14: 1215469. doi:10.3389/fendo.2023.1215469. PMCID: PMC10545878.