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A CASE DISCUSSION OF AYURVEDIC MANAGEMENT OF "VANDHYATVA" [INFERTILITY]

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ABSTRACT

This one is from a mothers' diary **"No diamond necklace can replace the beauty of hands of my kids around my neck."** Really motherhood is a blessing! But unfortunately, not all are blessed with motherhood. Various hormonal, mental, occupational factors are responsible for infertility. Apart from mental disturbances that a couple goes through, social stigma attached to infertility adds the fuel to the fire. Hereby presenting a case of Primary Infertility with multiple female factors namely advanced maternal age i.e 34, k/c/o Hypothyroidism, h/o endometrial tuberculosis & low AMH managed successfully by Ayurvedic treatment.

Keywords: Infertility, low AMH, *shatavari*

INTRODUCTION

Infertility is defined as inability of the couple to achieve conception after one year of unprotected intercourse [1]. Primary infertility is failure to conceive at least once.

Ayurvedic view –According to Ayurved, menopausal **women and** patients with anovulatory cycles are called as "Vandhya", due to their inability to conceive.There are various opinions cited in different Samhitas which include both male and female factors responsible for Infertility but most relevant reference to this case is from *SushrutSamhita*, *AacharyaSushrut* has explained four essential factors for conception namely *Rutu* (ovulatory phase), *Kshetra* (endometrium), *Ambu* (*matrujaaharras*), *Beej* (ovum & sperm). These factors act simultaneously to produce a healthy progeny. Any abnormality of these factors leads to *vandhyatva*[2]. Because of some *aaharatmak/viharatmakdosha* any one of these/all of the mentioned factors gets vitiated causing infertility. *Prajotpadan* being the prime function of *Aapanvayu,chikitsa* has to be aimed at ***aapanvayushaman & beejprasadan*.** Same principle is followed in the treatment of this present patient.

Modern view –

Main causes of infertility include male factor, decreased ovarian reserve, tubal injury or blockage, paratubal adhesions, advanced maternal age, endocrine abnormalities, etc. and unexplained infertility [3].
Of the various factors mentioned above following points were present in **this** patient.

- Advanced maternal age – An association between the age of the woman and reduced fertility has been well documented. The decline in fecundability begins in the early 30s and accelerates during late 30s and early 40s [4].
- Decreased ovarian reserve – Oocyte reserve refers to the size of the non-growing or resting primordial follicle population which presumably determines the number of growing follicles and the quality or the reproductive potential of their oocyte. Oocyte related decline in fertility is known as "decreased ovarian reserve" [5].
- Genital tuberculosis - Genital tuberculosis is responsible for 5% of all female pelvic infections. It occurs mostly secondary to pulmonary TB by hematogenous route. Endometrium is **the mostly** involved site. Infertility, **pelvic pain**, disorders of menstruation is **a usual** presentation. Infertility is mostly because of the pathology of the endometrium [6].
- Hypothyroidism – This appears to be associated with decreased fertility resulting from ovulatory difficulties and possibly with spontaneous abortion. Severe primary hypothyroidism is associated with amenorrhoea/anovulation [7].
- Low AMH/MIS – Recently MIS has been investigated as a marker of ovarian reserve and for ovarian responsiveness to stimulation. The serum level of MIS in women with normal cycles declines with age and becomes undetectable by the time of menopause. As the ovarian primordial follicle count decreases the serum MIS concentration also decreases making this hormone an ideal candidate for the early detection of ovarian reserve depletion [8].

CASE REPORT–

History – Mrs.X, age-34, married for fourteen years came to O.P.D with chief complaints of inability to conceive.
Past menstrual history – interval- 30 days, duration 4-5 days, regular, painless, moderate.
Present menstrual history - interval- 30 days, duration 2 days, regular, painless, scanty
Obs/history – G0P0
Family history – NAD
History of past illness –
1) H/O Endometrial TB [Before seven years, treatment taken for six months.] Repeat endometrial biopsy before two years revealed no AFB
2) k/c/o Hypothyroidismfor 5-6 years, on tablet eltroxin 50 mg OD.
3) H/O IVF failed four times.
4) H/O IUI failed six times.
History of past surgery –
H/O HLScopy (Hystero-laparoscopy)- – Both tubes patent.
Examination-
P/V –
Uterus – Size – Normal, retroverted, Fornices – Non-tender.
P/S- Pin point cervical os.

INVESTIGATIONS –
Sr.FSH – 7.18.
Sr.LH – 4.94.
Sr.Prolactin – 8.53.
Sr. AMH – 1.61.
TSH – 6.68.
Repeat Endometrial biopsy – Negative for TB.
Karyotyping of patient – 46 XX.
Semen analysis of husband – Normal.

Aahar – Katutiktapradhanya
Vihar-
Patient had shift duty in following manner:
1st ten days – 7 a.m. to 3 a.m.
2nd ten days – 11 p.m to 7 a.m.
3rd ten days – 3.00 p.m. to 11 p.m.
Prakruti – vata-kapha
Agni –Mand
Koshtha – Krura.

MANAGEMAENT –

Table-1

Drug/Procedure	Dose	Duration
Shatavarichurna with *Goghrut*	5 gm OD (early morning before breakfast).	Throughout cycle
Ashwagandhaksheerpak with *Goghrut*	30 ml OD (after breakfast)	till 16th day of menses.
Tankan bhasma	125 mg OD (Before lunch)	Throughout cycle
Hingwashtak churna	1 gm BD(Before food)	Throughout cycle
Sthanik snehan with *til tail* and ***shtanik swedan*** with *Dashamool kwath*	As required **(*Poorvakarma* before *uttar basti*)**	For 5 days after cessation of menses.
Uttarbasti with *Phalghrit*	5 ml	For 5 days after cessation of menses.

Taking into consideration shift duty i.e ***viharatmakdosha,*** a request letter was written to the organisation where patient was working, asking them to allocate her only morning shift, which was accepted.

Patient was advised to give follow up after every 15 days.
Remarkable changes observed in subsequent follow-up

Table-2

No. of follow up	Before	After
1st follow up	feeling of hunger - No, (used to have food just by looking at standard lunch and dinner time)	feeling of hunger +.
3rd follow up	Daily *Mala pravrutti* – No (**alternate days**.occasionally straining.)	Daily *Mala pravrutti* + (Majority of times had regular *malapravrutti*without straining)
5thfollow up	Scanty menses +++ (lasting only for two days)	Scanty menses- Nil (By the end of third month menstrual flow increased from two days to four days)

OBSERVATIONS AND RESULTS

1) Patient conceived on 3 rd month of starting the treatment.
2) She didn't have any complications in 1st Trimester.
3) Anomaly scan at 20 weeks was Normal.
4) Patient had full term LSCS, Indication- Elderly primi and CPD (Cephalo-pelvic disproportion).
5) Both mother & baby had no complications.

DISCUSSIONS

1) *Shatavarichurna* – ***Shatavari*** **has** got "*Pushpaprajakari*" effect i.e it helps in ovulation and thereby attaining pregnancy. The 5 gm dose and *pratahkal* was chosen as per reference of *kashyapsamhita*.[9]
2) *Ashwagandhaksheerpak[10]* - As the follicular recruitment for next cycle starts from D1 of menses & follicular maturation is completed by D14 [in a regular 28 days cycle], starting of "*Ashwagandhaksheerpak* with *Goghrut"* immediately after menses helps in effective follicular development. Mode of action slightly resembles to ovulation induction which is done in cases of infertility. Besides this *ashwagandha* is a ***vrushya dravya*** **and** ***ksheer*** *and goghrut* are *rasayandravyas*. Taking into consideration advanced maternal age and low AMH status of the patient both of these qualities were expected and ***Ashwagandhaksheerpak*** **mentioned** in *Bhavprakashn* was a perfect choice for it.
3) *Tankan bhasma*–As the patient had history of endometrial tuberculosis **a** ***dravya*** which would throw out leftover toxins in endometrium, would heal the deranged and scarred endometrium, lead to formation of new lining of endometrium and help in ***sthanik doshapachan*** was needed. *Tankan bhasma*[11] achieved all of these and much more by its *sthavaradivishapaha, , vrananashak, ushna,teekshna* attributes. As the patient presented with scanty menses ***Streepushpajanan*** **activity** of tankan bhasma helped in both ways i.e it caused ovulation and increased menstrual flow of patient.
4) *Hingwashtakchurna* – Hingu possess *streepushpajanan*[12] activity. Besides this, as *Annavahastrotas* is called as ***mahastrotas*** **i.e** starting point of any disease, *agneedeepan* will lead to formation of wholesome *aaharras* as a result *rasa dhatu* will be of optimum quality leading to formation of superior *raja* and ***stanya upadhatus.***
5) *Uttarbasti* with *Phalghrit* – *Uttarbasti* is considered to be a superior basti because of its route of administration and its action on vitiated *vatadosha*[13]. It prepares the endometrial bed for healthy implantation. Its *sneha*content makes endometrium favourable for adhesion, apposition etc. of the fertilized ovum.***Phalghrit*** **has** been cited in many samhitas for its role in infertility [14]. ***Uttarbasti*** **was** preceded by ***sthanik snehan*** with *til tail* and ***sthaniksweda*** with *dashamool kwath.*

CONCLUSION

- *Shatavari, Hingu, Tankan bhasma* assisted in follicular recruitment, maturation and ovulation.
- *Tankanbhasma* caused *garbhashayashodhan* and helped in producing healthy *Garbhashayya* by its *ush-*

na,teekshna,vishapaha and vrananashakactivity.

- ***Uttarbasti* with *phalghrit*** caused *apan-vayu shaman* which helped in conception.
- As patient started to work from 7.00 a.m. to 3.00 p.m. her *viharatmak dosha* was eliminated which is one of the most important factor in delayed conception as cited in ***charak samhita***.

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