



Infantile uterus and infertility managed with individualised classical homoeopathy, two case reports

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ABSTRACT

Congenital uterine malformations are one of the major causes for female infertility. Müllerian duct anomalies, of which uterine hypoplasia is characterised by stunting of uterine growth and in some cases complete aplasia, pose a challenge in management. Presented below are two cases of uterine hypoplasia where classical homoeopathy was shown to be of benefit in two women with infertility due to uterine hypoplasia. The women also had further complicating comorbidities of hypothyroidism and ovarian cysts. The treatment led to conception and normal full-term deliveries of healthy babies in both cases. Individualised classical homoeopathy may benefit infertility due to uterine hypoplasia but needs further scientific investigation.

KEYWORDS – infertility, uterine hypoplasia, hypothyroid, ovarian cyst, homoeopathy

Introduction

Infertility, diagnosed with inability to establish clinical pregnancy after twelve months of unprotected regular sexual intercourse is on the rise. Affecting nearly 8 to 12% of couples, its global burden is increasing 0.37% per year for females and 0.291% for males^{1,2}. Mainly influenced by the period of preventing pregnancy, age of the female partner and systemic diseases, infertility is attributable to purely male causes in 20–30% cases but overall amounting to an equal share in both the partners³. Hormonal disorders, hypogonadotropic hypogonadism,

disorders of ciliary function, anatomical obstructions and deformities, ovarian insufficiency, polycystic ovarian disease, uterine fibroids, testicular and post testicular deficiency, semen decline, systemic diseases and consanguinity are some of the likely causes for infertility³. Psychological stress, by way of influence on hormones, has been attributed as a cause in infertility¹. Many times no such cause may be detected which is termed unexplained infertility¹.

Congenital uterine malformations, estimated at 7% prevalence in the population, are associated with negative pregnancy outcomes including infertility⁴. The most common of these are Müllerian duct anomalies, of which uterine hypoplasia is relatively rare, with decreased prospects of spontaneous pregnancy^{5,6}. Uterine hypoplasia (Fig 1) is characterised by stunting of uterine growth and in some cases complete

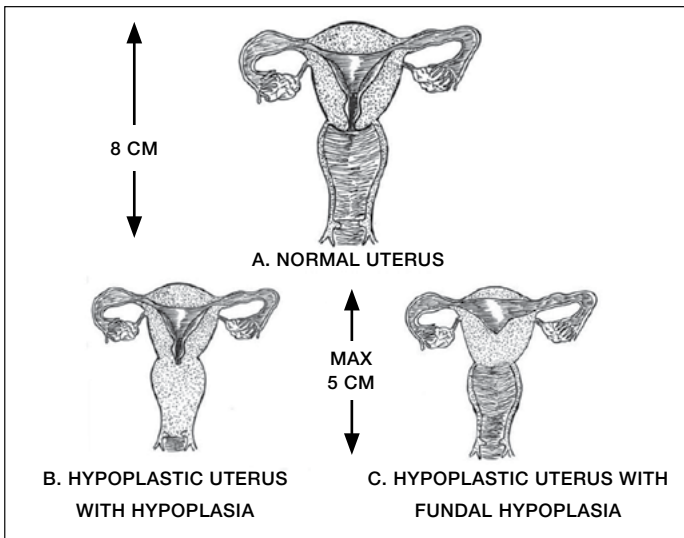


Fig 1: Normal and hypoplastic uterus comparison

aplasia. It is usually detected when couples fail to conceive⁷. Some women, however, complain of metrorrhagia and early abortions as well⁷. In clinical practice, it is often seen that reproductive disorders do not occur in isolation and uterine hypoplasia or infantile uterus existing in combination with disorders such as that of thyroid or PCOD or pelvic inflammatory diseases may further complicate the situation.

The literature regarding management of uterine hypoplasia is scarce. One study reported assisted pregnancy in a woman with infantile uterus (from oophoritis post mumps) after treatment with low dose contraceptives from her 19th to 30th year⁸.

Grey literature presents with a few instances of homoeopathy helping in infantile uterus, while there are many more in general infertility scenarios^{9,10}.

We present two cases of uterine hypoplasia that progressed to normal pregnancy and parturition with individualised classical homoeopathy.

Case reports

Case 1

Case presentation:

On 02/02/2018, a 24-year-old lady consulted the homoeopathic medical doctor for irregular menstruation and failure to conceive despite 3 years of regular sexual intercourse.

Past medical history:

Chronic tonsillitis in childhood, chronic pyelonephritis, cystitis with frequent exacerbations since a few years.

Family history:

Mother is hypertensive, had chronic tonsillitis and chronic pyelonephritis.

Gynaecological history:

She attained menarche at the age of 13 and her menses have been irregular (45 to 55 days) since then, with profuse bleeding. She took antispasmodics for painful menstruation. Sexually active since the age of 17 (2 partners so far). She has been married for 3 years now with regular unprotected sexual intercourse.

Diagnostics:

Clinical examination by a gynaecologist: patient was underweight, with poorly developed secondary sexual characteristics, that is, poor development of the mammary glands. Eumorphic pudendum, female pattern of hair distribution. Speculum investigation showed pink mucous membranes, conical shape cervix. Per vaginum examination revealed a small body of uterus, anteverted, small, painful on displacement and normal adnexa. The discharge is mucoid. The gynaecologist gave a provisional diagnosis of genital infantilism, primary infertility and irregular menstruation.

General clinical examination was normal except thyroid, which appeared enlarged, with no hyperthyroid signs.

Patient was advised to have further hormonal evaluation and ultrasound scan.

Laboratory tests results showed increased Thyroid Stimulating Hormone (TSH), lowered estriol, lowered Luteinizing Hormone (LH) and increased prolactin (Table 1).

Her husband's sperm examination was normal.

Diagnosis:

Diagnostic Test	Result	Reference range
TSH	6.1 mcMU/L	0.4–4 mcMU/L
FSH	16.7 mMU/ml	3.5–12.5 mMU/ml
LH	0.938 mMU/ml	1.59–14.9 mMU/ml
Estriol	10.2 ng/L	15–60 ng/L
Anti-Müllerian Hormone	3.2 ng/ml	1.88–7.29 ng/ml
Prolactin	657 mcMU/ml	102–496 mcMU/ml
Ultrasound scan pelvis	Multifollicular ovaries. Signs of chronic inflammation in the small pelvis.	

Table 1. Diagnostic test results of Case 1 at initial consultation

TSH: thyroid stimulating hormone; FSH: follicle stimulating hormone; LH: luteinizing hormone

Irregular menstruation (ICD 10 – N 92.6). Primary infertility (ICD 10 – N 97.9) and uterine hypoplasia (ICD10 – Q51.811).

The patient is referred for a consultation at a homoeopathic clinic.

Homoeopathic consultation:

Along with the presenting complaints of infertility, irregular and painful menstruation, the psychological attributes of the lady were studied, and the relevant symptoms were repertorised in accordance with the individualising principles of classical homoeopathy. Fig. 2 shows the symptoms considered for repertorisation during the first consultation and the result of this analysis on the Vithoulkas Compass repertorisation software¹¹.

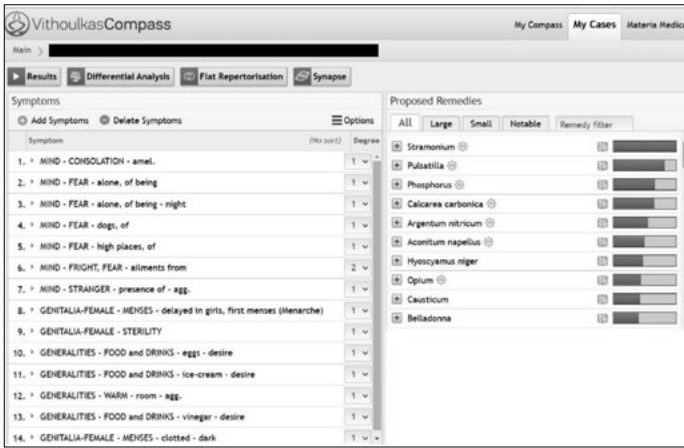


Fig. 2: Repertorisation of symptoms of case 1 at first consultation

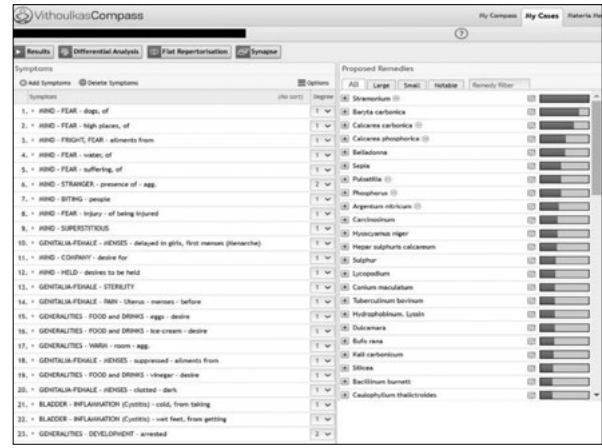


Fig 3: Repertorisation of symptoms of case 1 on 13.02.2019

Date	Consultation	Observations	Investigations	Diagnosis	Medications
2/02/2018 (1st consultation)	Gynaecologist	Irregular, profuse and painful menstruation and failure to conceive. Delayed menses for 45–55 days.	Increased TSH, low estriol, low LH, and increased prolactin.	Irregular menstruation, primary infertility and uterine hypoplasia.	Conventional anti spasmodic and painkillers for painful menses
11/03/2018 (1st consultation)	Homoeopath	Irregular, profuse and painful menstruation and failure to conceive. Patient weeps a lot and wants consolation. She has a lot of fears due to past incidents.			<i>Stramonium 200CH</i> , 3 globules; one dose
18/10/2018	Gynaecologist	Menstrual cycle is from 36–40 days. Dysmenorrhoea has decreased. Exacerbations of cystitis have reduced	Oncocytology smear shows a histogram of inflammation; an increased amount of microflora and leukocytes is detected.	No change	
22/10/2018	Homoeopath	Menstrual cycle decreased from 45 days to 35 days. Dysmenorrhoea persists but the intensity has reduced. Her energy levels much better than before, her memory has improved She used to live with her mother despite being married. Now she is able to move in with her husband. Weeping has reduced.			<i>Stramonium 1M</i> , 3 globules; one dose
13/02/2019	Homoeopath	Generally better and irritability decreased. Menses regular with 35 days cycle. She reported of acute viral respiratory infection with temperature of 37.5°C lasting for 3 days. No medications were taken. Then there was a thrush in the vagina with whitish discharge with slight itching for 5 days, resolved without medication. She did not need medications for her painful menses. UTI has reduced. New symptoms requiring new repertorisation (Fig. 3)			<i>Pulsatilla 200CH</i> , 3 globules once a day, three doses.
12/04/2019	Gynaecologist	Menstrual cycle – 30–35 days. Excessive bleeding and dysmenorrhoea have reduced. No requirement of antispasmodics during menses. No conception.	Ultrasound (U/S) had impressions of proliferative phase of menstrual cycle. Oncocytology smear and microflora were normal.	No change	
22/11/2019	Homoeopath	Better generally. Fears have reduced. Menstrual cycle is regular and painless. Rise in basal body temperature during mid-cycle as patient has started to measure it.			<i>Pulsatilla 200CH</i> , 3 doses 3 globules
04/12.2020	Laboratory		U/S scan of uterine size: A-P: 27 mm (N – 30–45 mm); length: 41 mm (N - 45–50 mm); diagonal: 31mm (N - 35–50mm); ratio of the body of the uterus and cervix: 3: 1 (N – 2: 1); endometrial thickness: 4 mm (N – more than 6 mm).		
12.02/2020	Gynaecologist	Duration of the menstrual cycle is 28–30 days.	Uterus and ovaries ultrasound shows signs of dominant follicle in the right ovary.	No change	
12/06/2020	Gynaecologist	Delayed menstruation.	Pregnancy test positive.	Diagnosed with genital infantilism and short gestation duration.	U/S is recommended in 2 weeks and supervision at antenatal clinic.
24/08/2020	Homoeopath			Pregnancy was diagnosed.	Treatment stopped. Patient is asked to consult in case of any symptoms.

Table 2: Follow-up of case 1 during homoeopathic treatment

Prescription and follow-up:

On 11/3/2018 the patient was prescribed one dose of *Stramonium 200CH*, 3 globules, sublingually. The follow-up is provided in Table 2.

Outcome:

The lady had her last menstrual period on 10/5/2020 before being diagnosed as pregnant two months later. She went on to have a healthy antenatal period and delivered normally at full term, a healthy baby.

Case 2

Case presentation:

A 20-year-old woman complained of failure to conceive despite five years of regular unprotected sexual intercourse with the same partner.

History of presenting complaints:

She had been diagnosed with autoimmune thyroiditis and was on levothyroxine. She was also diagnosed with ovarian cysts but took no treatment for this. No recent thyroid reports were available at the time of consultation.

Past medical history:

The patient had suffered repeated acute respiratory infections with high fever till the age of 15 years.

Family history:

Her father suffered from peptic ulcer, her paternal grandmother had mild uterine prolapsus and her paternal grandfather was diagnosed with Parkinsonism. Her mother had cervical dysplasia and polyps. The maternal grandmother had died at the age of 57 with alcoholic liver cirrhosis and diabetes mellitus; this was followed by the maternal grandfather developing throat cancer, which he died of at the age of 70 years.

Gynaecological history:

She attained menarche at the age of 13 years and her secondary sexual characteristics were well developed. There were problems with the cycles from the very beginning: irregular periods, which could be absent for 2–3 months; painful menstruation with severe pain on the first day (but she did not take pain killers, as she had a negative attitude towards them). The menses were profuse and prolonged.

At the age of 19, she was diagnosed with an ovarian cyst and fluid in the pouch of Douglas.

Diagnostics:

Ultrasound scan of the abdomen and pelvis showed a small uterus of 4.6 x 2.8 x 4.2 cm and pelvic adhesions.

She was advised to undergo screening for sexually transmitted infections and a hormonal profile, but she did not take them. She was advised hormonal therapy and regular gynaecological consultation but chose to take homeopathy instead.

Diagnosis:

Primary infertility (ICD 10 – N 97.9), uterine hypoplasia (ICD10 – Q51.811), autoimmune thyroiditis (ICD 10 – E06.3).

Homeopathic consultation:

In this case, the lady had no other complaints except the infantile uterus. Homeopathic repertory provides the remedies that are indicated in such a condition under the rubric development arrested¹¹. The foremost of the remedies for such a condition is *Baryta carbonica*.

Prescription and follow-up:

Baryta carbonica 200CH was prescribed on 30/06/2014. The follow-up is provided in Table 3.

Outcome:

Eight months from commencing homeopathy, she became pregnant.

An ultrasound scan on 5/08/2015 showed a pregnancy of 25 weeks with all parameters being normal.

An ultrasound scan on 25/10/2015 showed a pregnancy of 33 weeks of a normal female fetus.

The lady delivered a healthy female baby at 40 weeks on 23/11/2015.

The patient had a healthy second pregnancy and delivered a baby boy at 41 weeks on 9/7/2019.

Post the second delivery she had no irregularities in her cycles nor had any pains during menses.

Date	Consultation	Observations	Investigations	Diagnosis	Medications
29/07/2014	Homeopath	Generally well, no new complaints	Nil		<i>Baryta carbonica 200CH</i> one dose
19/09/2014	Homeopath	Generally well, no new complaints	Nil		<i>Baryta carbonica 200CH</i> one dose
04/11/2014	Homeopath		Nil		<i>Baryta carbonica 200CH</i> one dose
26/12/2014	Homeopath	Generally well, no new complaints	Nil		<i>Baryta carbonica 200CH</i> one dose
28/03/2015		Pregnancy confirmed.	Pregnancy test	Pregnancy of 6–7 weeks.	Nil
05.08.2015	Gynaecologist		Ultrasound (U/S) scan of abdomen and pelvis	Pregnancy of 25 weeks; all parameters normal	Nil
25/10/2015	Gynaecologist		(U/S) scan of abdomen and pelvis	Pregnancy of 33 weeks with normal female fetus	Nil

Table 3: Follow-up of case 2 during homeopathic treatment

Discussion:

Classical homoeopathy views the human organism as an integral being, consisting of the physical, emotional and mental faculties, in that hierarchy. The organism is usually affected as a whole, even when the obvious pathology is focused on any one of these levels¹². There is ample evidence in immunology showing the systemic involvement in chronic inflammatory diseases and the alteration in mental emotional attributes during such illnesses^{13,14}. Homoeopathy tailors the treatment to this integral picture of sickness, boosting the body's own immune strategy to overcome the disease¹². Therefore, different *strategies of prescription* are applied, as dictated by the individual case in question.

In the first case, there was a systemic involvement with a mildly hypoplastic uterus, hormonal irregularities, painful menstruation and emotional disturbances. A deeper and prolonged treatment based on the totality of symptoms was required. The second case did not exhibit any systemic involvement and required only a pathology-based prescription and resulted in a favorable outcome within a short period.

The mainstay of conventional treatment in infertility cases with uterine hypoplasia is hormonal and, even then, the results are not assured. Further complicating presence of thyroid and ovarian hormonal imbalance in this case would have been a challenge indeed. We see that despite these, the lady's ultrasound scan showed a progression from having a multi-follicular appearance to one with a dominant follicle, followed by a successful pregnancy (Table 2). In the second case, the hypoplasia was remarkable (2.8 cm in one dimension) and the chance of successful pregnancy seemed limited without hormonal therapy⁸. She successfully carried two children post treatment. Even though infertility treatment has made great progress in the last decade^{15,16}, a less invasive method and with least side effects is desirable. With scientific investigation to establish the efficacy, classical homoeopathy may be one such option.

Criteria	Y	N	Not sure/NA	Case 1	Case 2
1. Was there an improvement in the main symptom or condition for which the homoeopathic medicine was prescribed?	2	-1	0	2	2
2. Did the clinical improvement occur within a plausible time frame relative to the drug intake?	1	-2	0	1	1
3. Was there an initial aggravation of symptoms?	1	0	0	0	0
4. Did the effect encompass more than the main symptom or condition, that is, were other symptoms ultimately improved or changed?	1	0	0	1	0
5. Did overall well-being improve?	1	0	0	1	1
6 (A) <i>Direction of cure</i> : did some symptoms improve in the opposite order of the development of symptoms of the disease?	1	0	0	0	0
6 (B) <i>Direction of cure</i> : did at least two of the following aspects apply to the order of improvement of symptoms:: – from organs of more importance to those of less importance; – from deeper to more superficial aspects of the individual; – from the top downwards?	1	0	0	0	0
7. Did 'old symptoms' (defined as non-seasonal and non-cyclical symptoms that were previously thought to have resolved) reappear temporarily during the course of improvement?	1	0	0	0	0
8. Are there alternative causes (other than the medicine) that with a high probability could have caused the improvement (consider known course of disease, other forms of treatment and other clinically relevant interventions)?	-3	1	0	1	1
9. Was the health improvement confirmed by any objective evidence (in this case by conception)?	2	0	0	2	2
10. Did repeat dosing, if conducted, create similar clinical improvement?	1	0	0	1	1
Total				+9	+8

Supplementary table 1: MONARCH score



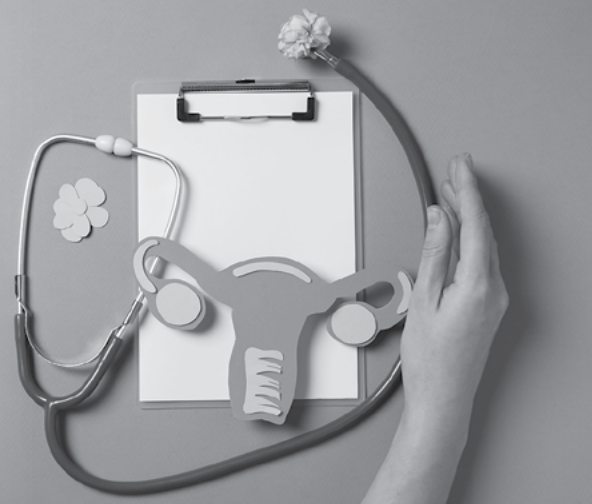
Conclusions

Individualised classical homoeopathy was beneficial in two women with uterine hypoplasia and primary infertility. There is a need to scientifically investigate the relevance of classical homoeopathy in this pathology.

Topic	Content	Case 1 page no	Case 1 page no
Title	The word 'case report' should be in the title along with what is of greatest interest in this case.	1	1
Keywords	The key elements of this case in 2 to 5 keywords.	1	1
Abstract	Introduction — what is unique about this case? What does it add to the medical literature? The main symptoms of the patient and the important clinical findings. The main diagnoses, therapeutic interventions and outcomes. Conclusion — what are the main 'take-away' lessons from this case?	1	1
Introduction	Brief background summary of this case, referencing the relevant medical literature.	2	2
Patient information	Demographic information (such as age, gender, ethnicity, occupation). Main symptoms of the patient (his or her chief complaints). Medical, family and psychosocial history, including comorbidities and relevant genetic information. Relevant past interventions and their outcomes.	3	5, 6
Clinical findings	Describe the relevant physical examination (PE) findings and clinical history details (homoeopathic symptoms used for decision, etc.).	3, 4	6
Timeline	Depicts important milestones related to your diagnoses and interventions (table or figure).	Table 2	Table 3
Diagnostic assessment	Diagnostic methods (such as PE, laboratory testing, imaging, questionnaires). Diagnostic challenges (such as financial, language or cultural). Diagnostic reasoning including other diagnoses considered. Prognostic characteristics (such as staging in oncology) where applicable.	4, Table 1	5
Therapeutic intervention	Types of interventions (such as pharmacological, surgical, preventive, self-care). Type of homoeopathy: individualised. Medication(s): nomenclature (list individual prescriptions or constituents or trade names), manufacture, potency, scale and galenic form. Administration of interventions (such as dosage, strength, duration). Changes in intervention (with rationale).	4	6
Follow-up and outcomes	Clinician-and-patient-assessed outcomes. Important follow-up test results. Intervention adherence and tolerability (how was this assessed?) Adverse and unanticipated events. Objective evidence (if applicable). Occurrence of homoeopathic aggravation. Possible causal attribution of changes explicitly assessed/discussed.	Table 2	Table 3
Discussion	Discussion of the strengths and limitations in the management of this case. Discussion of the relevant medical literature. The rationale for conclusions (including assessment of possible causes). The main 'take-away' lessons of this case report.	6, 7	6, 7
Patient perspective	Did the patient share his or her perspective or experience?	Yes	Yes
Informed consent	Did the patient give informed consent? Please provide if requested.	Yes	Yes

Supplementary table 2: The HOM-CASE guideline items

Classical homoeopathy views the human organism as an integral being, consisting of the physical, emotional and mental faculties.



Highlights:

- Infertility affects nearly 8–12% of couples, with its global burden on the rise.
- Anatomical causes for infertility pose a challenge to treatment.
- We present two cases of uterine hypoplasia, diagnosed with primary infertility that progressed to normal pregnancy and parturition with individualised classical homeopathic treatment.
- Even though infertility treatment has made great progress in the last decade, a less invasive method with least side effects is desirable, and classical homeopathy may be one such option.

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Conflict of interest: the authors declare that there are no conflicts of interest.

Consent for publication: the patients have provided informed written consent for publication of the case and reports.

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She was awarded the Certificate of Excellence for her research poster at the 'Movement – Brain – Body – Cognition' conference at Harvard Medical School, USA.

Known for her teaching, she has taught homeopathy and research on global platforms held at USA, Mexico, Greece, Brazil, Turkey, Thailand, Malaysia, Israel, Egypt and India with audiences from across the world.