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Ayurvedic Management of Infertility Associated with Anovulatory Cycles: A Case Report Based on *Vandhyatva* and *Artava Dushti*

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Abstract

Background: Infertility is a multifactorial reproductive health condition resulting from abnormalities involving ovulation, tubal patency, uterine factors, male factors or a combination of these conditions. Ovulatory dysfunction is one of the important causes of female infertility, with anovulation resulting in inadequate or absent ovulation and consequently impaired opportunities for conception.

Ayurveda approaches female infertility through the concept of *Vandhyatva* and considers the normal functioning of *Artava*, *Beeja*, *Garbhashaya*, *Apana Vayu* and reproductive tissue nourishment to be essential for conception. Disturbances in *Artava* may be understood under *Artava Dushti*, while impairment of ovulation may be interpreted through dysfunction of *Artava* and *Apana Vayu*, along with abnormalities of *Dosha*, *Agni* and *Dhatu*.

Case Presentation: A 30-year-old married woman presented with inability to conceive for 3 years despite regular unprotected intercourse. Her menstrual cycles were irregular, occurring every 40–60 days, with 3–4 days of moderate menstrual flow. She had progressive weight gain and clinical features suggestive of ovulatory dysfunction. Contemporary evaluation demonstrated irregular ovulation, elevated anti-Müllerian hormone and polycystic ovarian morphology, while thyroid and prolactin levels were within reference ranges. Tubal patency was confirmed and the husband's semen analysis was within the laboratory reference range. From an Ayurvedic perspective, the patient was assessed as having *Vandhyatva* associated with *Artava Dushti*, predominantly involving *Kapha-Vata*, *Agnimandya*, *Medodushti* and *Apana Vayu Vaigunya*.

Intervention: Management was individualized according to Ayurvedic principles of *Agni Deepana*, *Kapha-Meda Shamana*, *Vata Anulomana*, correction of *Artava Dushti*, optimization of reproductive health and conception planning. Dietary modification, exercise, yoga and stress management were incorporated. Ovulation was monitored using follicular ultrasonography. The illustrative follow-up demonstrated improved menstrual regularity and evidence of ovulation.

Outcome: Following treatment, the menstrual cycle became more regular and follicular monitoring demonstrated development and rupture of a dominant follicle. The patient was counselled regarding the fertile window and timed intercourse. The illustrative case subsequently demonstrated a positive urine pregnancy test, followed by biochemical confirmation of pregnancy.

Conclusion: Anovulatory infertility may be interpreted within Ayurveda through the clinical framework of *Vandhyatva*, *Artava Dushti*, *Apana Vayu* dysfunction and impairment of reproductive tissue function. An individualized Ayurvedic approach combined with contemporary evaluation and objective ovulation monitoring may provide a useful integrative model. However, a single case cannot establish therapeutic efficacy, and appropriately designed clinical trials are required to evaluate Ayurvedic interventions for anovulatory infertility.

Keywords: Vandhyatva, Artava Dushti, infertility, anovulation, Ayurveda, ovulation, conception, Apana Vayu, Kapha, Vata, PCOS.

1. Introduction

Infertility is defined as failure to achieve pregnancy after 12 months or more of regular unprotected sexual intercourse. It is a major reproductive health concern affecting individuals and couples worldwide. [1, 2]

Female infertility may result from ovulatory dysfunction, tubal disease, uterine pathology, endometriosis, diminished ovarian reserve, age-related reproductive decline or combinations of these factors. Male factors also contribute substantially to infertility and therefore evaluation of both partners is essential. [1-4]

Ovulatory dysfunction is among the most common causes of female infertility. Polycystic ovary syndrome is an important cause of anovulatory infertility, although other endocrine and

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hypothalamic-pituitary-ovarian disorders may also result in anovulation. [3, 5]

Contemporary evaluation of anovulatory infertility involves menstrual history, ovulation assessment, endocrine evaluation, ovarian reserve assessment where indicated, pelvic imaging and assessment of tubal and male factors. [3,6]

Ayurveda discusses infertility primarily through the concept of *Vandhyatva*. Classical Ayurvedic literature considers successful conception dependent upon appropriate functioning of the reproductive factors including *Ritu*, *Kshetra*, *Ambu* and *Beeja*. [7-10]

Artava has an important role in female reproductive physiology. Abnormalities of *Artava* may be interpreted through the concept of *Artava Dushti*, while *Apana Vayu* is considered essential for normal reproductive and pelvic functions.

From an Ayurvedic perspective, abnormalities of *Dosha*, *Agni*, *Dhatu* and *Srotas* may contribute to impaired reproductive function.

The present case illustrates an Ayurvedic interpretation of anovulatory infertility as *Vandhyatva* associated with *Artava Dushti*, while incorporating contemporary reproductive investigations and objective ovulation monitoring.

2. Aim

To describe an Ayurvedic approach to infertility associated with anovulatory cycles through the classical concepts of *Vandhyatva* and *Artava Dushti*, with objective assessment of ovulation and conception planning.

3. Objectives

i). To document the clinical presentation of anovulatory infertility.
ii). To assess the patient according to Ayurvedic principles.
iii). To interpret the condition through *Vandhyatva* and *Artava Dushti*.
iv). To assess the possible involvement of *Dosha*, *Agni*, *Dhatu* and *Apana Vayu*.
v). To describe an individualized Ayurvedic management strategy.
vi). To monitor ovulation objectively.
vii). To assess menstrual and reproductive outcomes during follow-up.
viii). To integrate classical Ayurvedic concepts with contemporary infertility evaluation.

4. Case Presentation

Table 1: Patient Identification

Parameter	Details
Patient ID	VAND/ANOV/001
Age	30 years
Sex	Female
Marital status	Married
Occupation	Teacher
Residence	Nagpur, Maharashtra
Duration of infertility	3 years
Date of first consultation	15/06/2026
Main complaint	Inability to conceive

5. Chief Complaints

The patient presented with:

i). Inability to conceive despite regular unprotected intercourse – 3 years.
ii). Irregular menstrual cycles – 3 years.
iii). Delayed menstruation – 3 years.
iv). Gradual weight gain – approximately 3 years.
v). Occasional facial acne – approximately 1 year.

6. History of Present Illness

The patient had been married for approximately four years and had been attempting conception for three years through regular unprotected intercourse.

Initially, menstrual cycles occurred approximately every 30–35 days. Over the subsequent three years, the cycle interval gradually increased to 40–60 days.

Menstrual bleeding generally lasted 3–4 days and was moderate in quantity.

The patient reported difficulty predicting her fertile period because of irregular cycles.

She had consulted a gynaecologist and undergone preliminary investigations. Previous ultrasonography demonstrated polycystic ovarian morphology.

There was no history of:

- Previous pregnancy
- Abortion
- Ectopic pregnancy
- Pelvic surgery
- Tuberculosis
- Severe pelvic infection
- Galactorrhoea
- Significant thyroid symptoms

7. Infertility History

- **Duration:** 3 years of infertility.
- **Intercourse:** Regular unprotected intercourse approximately 2–3 times per week.
- **Previous fertility treatment:** No previous assisted reproductive procedure.
- **Previous ovulation-induction treatment:** No prolonged course of ovulation-induction medication.

8. Menstrual History

Table 2:

Parameter	Finding
Age at menarche	13 years
Cycle interval	40–60 days
Duration	3–4 days
Quantity	Moderate
Colour	Dark red
Clots	Absent
Pain	Mild
Intermenstrual bleeding	Absent
LMP	28/05/2026

9. Obstetric History

- Gravida: 0

- Para: 0
- Living: 0
- Abortions: 0
- Ectopic pregnancy: 0

The patient therefore represented a case of primary infertility.

10. Past History

No significant history of:

- Diabetes mellitus
- Hypertension
- Thyroid disease
- Tuberculosis
- Chronic renal disease
- Chronic liver disease
- Major surgery

11. Family History

No significant family history of:

- Premature menopause
- Infertility
- PCOS
- Recurrent pregnancy loss

12. Personal History

Table 3:

Parameter	Finding
Appetite	Moderate
Agni	Manda/Vishama
Bowel	Once daily
Urine	Normal
Sleep	6–7 hours
Exercise	Minimal
Diet	Mixed
Processed food	Frequent
Tea/coffee	2 cups/day
Water intake	Approximately 1.5–2 L/day
Addiction	None
Stress	Moderate
Physical activity	Sedentary

13. Ayurvedic Assessment

- Prakriti
- Kapha-Vata Prakriti
- Vikriti
- Predominantly:
  - Kapha
  - Vata
  - Meda

- Agni
- Manda/Vishama Agni
- Koshtha
- Madhyama.
- Satva
- Madhyama.
- Vyayama Shakti
- Avara.

14. Ashtavidha Pariksha

Table 4:

Examination	Finding
Nadi	Kapha-Vata
Mutra	Prakrita
Mala	Prakrita
Jihva	Mild coating
Shabda	Prakrita
Sparsha	Normal
Drik	Normal
Akriti	Sthula/Madhyama

15. Dashavidha Pariksha

Table 5:

Parameter	Finding
Prakriti	*Kapha-Vata*
Vikriti	*Kapha-Vata*
Sara	*Madhyama*
Samhanana	*Madhyama*
Pramana	*Increased*
Satmya	*Madhyama*
Satva	*Madhyama*
Ahara Shakti	*Madhyama*
Vyayama Shakti	*Avara*
Vaya	*Yuva*

16. General Examination

The patient was conscious, cooperative and oriented.

- **Pallor:** Absent
- **Icterus:** Absent
- **Cyanosis:** Absent
- **Clubbing:** Absent
- **Lymphadenopathy:** Absent
- **Pedal oedema:** Absent

Vital Signs

- **Pulse:** 80/min
- **Blood pressure:** 116/74 mmHg
- **Respiratory rate:** 18/min
- **Temperature:** 98.4°F

17. Anthropometric Assessment

Table 6:

Parameter	Baseline
Height	160 cm
Weight	78 kg
BMI	30.5 kg/m²
Waist circumference	94 cm
Hip circumference	106 cm
Waist-hip ratio	0.89

18. Hyperandrogenic Features

- The patient reported mild acne.
- Mild facial hair growth was noted.
- Illustrative modified Ferriman-Gallwey score: **8**.

19. Systemic Examination

- **Cardiovascular system:** S1 and S2 normal.
- **Respiratory system:** Bilateral air entry normal.
- **Central nervous system:** No significant abnormality.
- **Abdomen:** Soft and non-tender.
- **Pelvic examination:** No significant pelvic abnormality detected.

20. Contemporary Investigations

Table 7: Complete Blood Count

Parameter	Result
Hb	11.8 g/dL
TLC	7,200/µL
Platelets	2.70 lakh/µL

21. Blood Glucose

Table 8:

Test	Result
Fasting blood glucose	96 mg/dL
HbA1c	5.6%

22. Thyroid Profile

Table 9:

Test	Result
TSH	2.6 µIU/mL
Free T4	1.14 ng/dL

23. Prolactin

Serum prolactin: 13.4 ng/mL: The result was within the laboratory reference range.

24. Reproductive Hormonal Profile

Table 10: Illustrative baseline values:

Investigation	Result
FSH	5.9 mIU/mL
LH	10.8 mIU/mL
Estradiol	48 pg/mL
Total testosterone	57 ng/dL
DHEA-S	Within reference range
SHBG	32 nmol/L
AMH	6.4 ng/mL

25. Metabolic Assessment

Table 11:

Parameter	Result
Total cholesterol	198 mg/dL
LDL	124 mg/dL
HDL	43 mg/dL
Triglycerides	158 mg/dL
Fasting insulin	16 µIU/mL

26. Pelvic Ultrasonography

Illustrative baseline USG

Uterus: Anteverted, normal size and morphology.
Endometrium: 6 mm.
Right ovary: Volume approximately 12.5 mL with multiple small follicles.
Left ovary: Volume approximately 11.8 mL with multiple small follicles.
Impression: Bilateral polycystic ovarian morphology.

27. Ovulation Assessment

Because menstrual irregularity suggested possible anovulation, ovulation monitoring was undertaken.

Baseline cycle

Follicular monitoring demonstrated:

- Multiple small follicles initially.
- No clear dominant follicle during the expected period.
- No sonographic evidence of follicular rupture.

This supported the possibility of anovulatory cycles.

28. Additional Infertility Evaluation

Because infertility is a couple-level condition, the evaluation included assessment of both partners.

Tubal Assessment

Hysterosalpingography demonstrated:

- Bilateral fallopian tube patency.
- Normal uterine cavity.

Male Factor

Semen analysis of the husband was within the laboratory reference range for:

- Volume
- Sperm concentration
- Motility
- Morphology

The exact values should be inserted from the actual report.

29. Contemporary Diagnosis

The clinical findings were consistent with:

Anovulatory infertility associated with PCOS phenotype

The patient had:

- Oligo/anovulatory cycles
- Clinical hyperandrogenic features
- Polycystic ovarian morphology
- Obesity/central adiposity

Other important causes of ovulatory dysfunction, including thyroid dysfunction and hyperprolactinaemia, were not identified in the illustrative evaluation.

30. Ayurvedic Diagnosis

The primary Ayurvedic diagnosis was considered:
Vandhyatva associated with Artava Dushti
With:

- Kapha-Vata Dushti
- Agnimandya
- Medodushti
- Artavavaha Srotodushti
- Apana Vayu Vaigunya

31. Concept of Vandhyatva

Ayurveda places successful conception on the appropriate functioning of essential reproductive factors.
The classical concept of conception emphasizes:

- Ritu
- Kshetra
- Ambu
- Beeja

Appropriate functioning of these factors is essential for conception. [7-10]
The present patient demonstrated an apparently functional reproductive tract and patent tubes, while the principal abnormality was impaired/irregular ovulation.
Thus, the Ayurvedic interpretation emphasized *Artava Dushti* and disturbance of the reproductive process rather than structural obstruction.

32. Artava Dushti

Artava has an important role in female reproductive physiology.
Abnormality in its:

- Quantity
- Quality
- Periodicity
- Timing
- Functional capacity

May be interpreted under *Artava Dushti*.
In the present case, the most relevant features were:

- Delayed menstrual cycles
- Irregular menstruation
- Evidence suggestive of anovulation
- Associated Kapha-Meda phenotype

Therefore, *Artava Dushti* was considered an important component of the Ayurvedic diagnosis.

33. Role of Apana Vayu

Apana Vayu is associated with pelvic and downward-moving physiological functions.
Its normal function is important for:

- Menstruation
- Ovulation-related reproductive physiology
- Conception
- Pregnancy-related pelvic functions
- Parturition

In the present case, *Apana Vayu Vaigunya* was considered a contributing factor in the disturbed reproductive cycle.

34. Role of Kapha

Kapha may be involved in the phenotype characterized by:

- Excess body weight
- Heaviness
- Sluggish metabolism
- Increased adiposity
- Reduced activity

From the contemporary perspective, obesity and insulin resistance are strongly associated with anovulatory PCOS phenotypes. [5, 11]
The Ayurvedic interpretation of Kapha-Meda involvement therefore provided a conceptual framework for addressing weight and metabolic factors.

35. Role of Agni

The patient demonstrated features interpreted as *Manda/Vishama Agni*.
The proposed sequence was:

Manda Agni
↓
Improper metabolic processing
↓
Meda accumulation
↓
Kapha aggravation
↓
Artavavaha Srotas dysfunction
↓
Artava Dushti
↓
Anovulatory cycles

This is an Ayurvedic explanatory model rather than a demonstrated molecular pathway.

36. Nidana

Possible causative factors included:

Ahara

- Excessive calorie-dense food
- Madhura/Guru Ahara predominance
- Processed food
- Irregular meals

Vihara

- Sedentary lifestyle
- Inadequate exercise
- Prolonged sitting
- Irregular sleep

Manasika factors

- Stress
- Chinta
- Psychological pressure associated with infertility

37. Samprapti Ghataka

Table 12:

Factor	Finding
Dosha	Kapha-Vata
Dushya	Rasa, Meda, Artava
Agni	Manda/Vishama
Ama	Possible
Srotas	Rasavaha, Medovaha, Artavavaha
Srotodushti	Sanga
Sthana	Pelvic/reproductive region
Adhisthana	Artavavaha system
Rogamarga	Abhyantara
Vyadhi	Vandhyatva with Artava Dushti

The management was planned according to the following principles:
i). Agni Deepana

ii). Ama Pachana, where clinically indicated
iii). Kapha-Meda Shamana
iv). Vata Anulomana
v). Apana Vayu correction
vi). Artava Dushti correction

38. Illustrative Ayurvedic Treatment Protocol

Table 13: The exact medicines must be replaced by the actual prescription used.

Intervention	Dose	Anupana	Frequency	Duration
Ayurvedic formulation 1	Actual prescribed dose	As prescribed	BD	8–12 weeks
Ayurvedic formulation 2	Actual prescribed dose	As prescribed	BD	8–12 weeks
Medohara/Agni-supportive intervention	Actual prescribed dose	As prescribed	OD/BD	8 weeks
Yoga	Individualized	—	Daily	12 weeks
Dietary modification	Individualized	—	Daily	12 weeks
Exercise	Individualized	—	5 days/week	12 weeks
Fertile-window counselling	—	—	Each cycle	Throughout

39. Dietary Management

The patient was advised to adopt an individualized calorie-controlled diet.

Recommended

- Adequate protein
- Whole grains
- Green vegetables
- Fibre-rich foods
- Appropriate fruits
- Legumes
- Adequate hydration

Restricted

- Excess refined carbohydrates
- Sugary beverages
- Excess fried foods
- Ultra-processed foods
- Excess calorie-dense snacks

The objective was gradual and sustainable improvement in body composition and metabolic health rather than rapid weight loss.

40. Lifestyle Modification

The patient was advised:

- Brisk walking
- Resistance exercise
- Yoga
- Pranayama
- Regular sleep
- Reduction of prolonged sitting
- Stress management

Contemporary PCOS guidance considers lifestyle intervention a core component of management. [5]

41. Ovulation Monitoring

Objective monitoring was incorporated to assess treatment response.
Follicular ultrasonography was performed during subsequent cycles.

Illustrative Cycle 1

- **Day 10:** Multiple follicles, largest 11 mm.
- **Day 13:** Dominant follicle 15 mm.
- **Day 16:** Dominant follicle 18 mm.
- **Day 18:** Follicle approximately 21 mm.
- **Day 20:** Evidence of follicular rupture and free fluid in the pouch of Douglas.

This was interpreted as evidence of ovulation.

42. Fertile Window and Conception Planning

The patient and her husband were counselled regarding the fertile period.
Timed intercourse was advised around the predicted fertile window based on follicular monitoring.
The patient was also counselled regarding:

- Adequate sleep
- Avoidance of tobacco/alcohol exposure
- Folic acid supplementation according to standard preconception care
- Healthy body weight
- Avoidance of unnecessary medications
- Appropriate antenatal care after conception

Preconception counselling should follow contemporary reproductive-care recommendations.

43. Follow-up

Table 14: The patient was followed over three months.

Parameter	Baseline	4 Weeks	8 Weeks	12 Weeks
Weight	78 kg	76.8	75.2	73.9
BMI	30.5	30.0	29.4	28.9
Cycle interval	45–60 d	42	36	32
Menstrual duration	4 d	4	4	4
Ovulation	Absent/uncertain	Uncertain	Present	Present
Acne	Mild	Mild	Reduced	Minimal
Waist circumference	94 cm	92	90	88 cm

Values are illustrative.

44. Hormonal Follow-up

Where clinically justified, selected hormonal parameters may be reassessed.

Table 15: Illustrative values:

Parameter	Baseline	12 weeks
LH	10.8 mIU/mL	7.4
FSH	5.9 mIU/mL	6.1
Total testosterone	57 ng/dL	43 ng/dL
AMH	6.4 ng/mL	5.8 ng/mL

45. Outcome

At the end of the illustrative treatment period:

- Menstrual cycles became more regular.
- Weight and waist circumference decreased.
- Follicular monitoring demonstrated ovulation.
- The patient was able to identify the fertile window.
- Timed intercourse was undertaken.

In the illustrative case, a urine pregnancy test performed after a missed period was positive.
Serum β-hCG was subsequently positive and appropriately increased on repeat testing.

Illustrative pregnancy outcome
Clinical pregnancy was confirmed at approximately 5 weeks of gestation by ultrasound.
Important: This pregnancy outcome must be removed if it did not actually occur in the real patient.

46. Contemporary Interpretation

The patient's presentation was consistent with anovulatory infertility in the context of a PCOS phenotype.
PCOS is one of the most common causes of anovulatory infertility. [5, 11]
The contemporary diagnostic framework emphasizes:

- Ovulatory dysfunction
- Hyperandrogenism
- Polycystic ovarian morphology

While excluding alternative diagnoses.
For infertility, assessment should also include tubal patency and semen analysis because infertility may be multifactorial. [3, 6]
In the present illustrative case, tubal patency and semen parameters were normal, making ovulatory dysfunction the principal identified factor.

47. Ayurvedic Interpretation

From the Ayurvedic perspective, the reproductive problem was interpreted as:

Vandhyatva
Associated with: Artava Dushti
And:

- Kapha-Vata Dushti
- Medodushti
- Agnimandya
- Apana Vayu Vaigunya
- Artavavaha Srotodushti

The therapeutic strategy therefore focused on improving systemic metabolic health, restoring appropriate *Artava* function and supporting normal *Apana Vayu*.

48. Classical and Contemporary Correlation

Table 16:

Ayurvedic Concept	Clinical Manifestation	Contemporary Perspective
Vandhyatva	Failure to conceive	Infertility
Artava Dushti	Irregular/abnormal menstruation	Ovulatory dysfunction
Kapha Dushti	Heaviness/obesity	Adiposity/metabolic risk
Medodushti	Excess adiposity	Obesity/insulin resistance
Agnimandya	Impaired metabolic function	Metabolic dysfunction
Apana Vayu Vaigunya	Disturbed reproductive function	No direct biomedical equivalent
Artavavaha Srotas Dushti	Reproductive dysfunction	Ovarian/reproductive dysfunction
Nidana Parivarjana	Diet/lifestyle correction	Lifestyle intervention

49. Discussion

Infertility is a complex condition involving both male and female reproductive factors. Ovulatory dysfunction is a major cause of female infertility, and PCOS is among the most important causes of chronic anovulation. [3, 5, 11]
The illustrative patient presented with three years of infertility and menstrual cycles occurring every 40–60 days. Follicular monitoring demonstrated absence of clear ovulation during the baseline cycle, while subsequent monitoring demonstrated follicular maturation and rupture.
The contemporary assessment therefore identified anovulation as the major reproductive abnormality.
From an Ayurvedic perspective, the condition was interpreted as *Vandhyatva* associated with *Artava Dushti*. The patient's obesity, sedentary lifestyle and menstrual irregularity were considered compatible with *Kapha-Meda* involvement, while *Vata* and *Apana Vayu* were considered relevant to reproductive function.
The classical Ayurvedic conception of reproductive health emphasizes the coordinated functioning of *Ritu*, *Kshetra*, *Ambu* and *Beeja*. [7-10]. In the present case, the principal identifiable abnormality was related to ovulation, while tubal and male factors were not identified.

50. Role of Artava

Artava occupies an important position in Ayurvedic gynaecology.
Normal *Artava* is considered essential for reproductive function.
In this case, irregular and delayed menstruation was interpreted as evidence of disturbed *Artava* function.
It is important, however, to distinguish the classical concept of *Artava* from the modern ovarian follicle/ovum/endocrine system. The concepts overlap only partially and should not be treated as synonyms.

51. Role of Apana Vayu in Conception

Apana Vayu has a central role in the Ayurvedic interpretation of reproductive function.
Its physiological activity includes:

- Menstrual flow
- Pelvic functions
- Expulsion
- Parturition

- Reproductive processes

Therefore, *Apana Vayu Vaigunya* was considered a potential contributor to the patient's reproductive dysfunction.
The management therefore included *Vata Anulomana* and measures directed toward restoring pelvic physiological function.

52. PCOS and Metabolic Dysfunction

Contemporary evidence recognizes PCOS as a reproductive-metabolic disorder.
Insulin resistance may contribute to hyperinsulinaemia, ovarian androgen excess and impaired follicular development. [11, 12]
Obesity can further aggravate metabolic and reproductive dysfunction.
Therefore, the Ayurvedic focus on diet, physical activity, *Kapha-Meda* management and sustainable weight reduction may be conceptually complementary to contemporary lifestyle management.
However, Ayurvedic concepts such as *Meda Dushti* and *Kapha* should not be presented as direct equivalents of adipose tissue or insulin resistance.

53. Role of Lifestyle Modification

Lifestyle intervention is a core component of contemporary PCOS management. [5]
The objectives include:

- Improved body composition
- Improved metabolic health
- Prevention of further weight gain
- Improved quality of life
- Support of reproductive function

In the present illustrative case, lifestyle modification was combined with Ayurvedic management rather than used as a separate intervention.
This is an important limitation because the individual contribution of each component cannot be determined in a single case.

54. Ovulation Monitoring as an Outcome Measure

One of the strengths of the present case design is objective follicular monitoring.
Menstrual regularity alone does not necessarily prove ovulation.
Therefore, follicular ultrasonography provides stronger evidence of treatment response than simply reporting a shorter menstrual cycle.
For an actual publication, serial follicular measurements should be accompanied by:

- Cycle day
- Follicular diameter
- Endometrial thickness
- Evidence of follicular rupture
- Corpus luteum formation where visualized
- Relevant hormonal confirmation where performed

55. Conclusion

Anovulatory infertility represents an important and potentially treatable cause of female infertility. The present illustrative case demonstrates how anovulatory infertility may be interpreted through the Ayurvedic concepts of *Vandhyatva*, *Artava Dushti*, *Kapha-Meda Dushti*, *Agnimandya* and *Apana Vayu Vaigunya*.
The Ayurvedic approach emphasizes correction of causative factors, optimization of metabolic health, regulation of *Dosha*, improvement of *Artava* function, restoration of physiological *Apana Vayu* and appropriate conception planning.
Contemporary evaluation remains essential to identify PCOS, thyroid disorders, hyperprolactinaemia, tubal disease, male-factor infertility and other causes. Objective ovulation monitoring provides a more reliable assessment of treatment response than menstrual regularity alone.
An integrative model combining individualized Ayurvedic management, lifestyle modification, objective ovulation assessment and evidence-based fertility care may be useful in selected patients.
Nevertheless, a single case cannot demonstrate efficacy or causality. Prospective controlled studies are required to determine the effectiveness, safety and reproducibility of specific Ayurvedic interventions in anovulatory infertility.

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