Concept of Polycystic Ovarian Syndrome: Perspectives of Ayurveda and Modern Science

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Received: 12th Sep, 17; Revised 10th Oct, 17, Accepted: 18th Oct, 17; Available Online: 25th Oct, 17

ABSTRACT

Polycystic ovarian syndrome is a hormonal disorder affecting 12-18% women of reproductive age. Women with PCOS have irregular menstrual cycle, excess of androgens, insulin resistance, serum lipids alteration, anovulation, acne, hirsutism and infertility. According to Ayurveda this type of clinical features are found in Pushpadhni jataharini (disease similar to Polycystic ovarian syndrome mostly having hyperandrogenism and anovulatory cycle) and Nashtarta (no proper growth of follicles and chronic anovulation). It involves the imbalance of dosha, dhatu and upadhatu. Evidence based medical management of PCOS is done by controlling irregular menses, treatment of hirsutism and acne, management of infertility and insulin resistance. The chemical based drugs induce ovulatory cycle in women, instead of allowing it to restore to its original healthy rhythm. The successful treatment of infertility is usually possible in the majority of patients with PCOS by using natural, non-invasive and non-chemical remedies. The present review provides information about some herbal plants, extracts of plants, active constituents from plants and some formulations clinically tested in animal models inducing PCOS and humans suffering from PCOS.

Keywords: Polycystic ovarian syndrome, anovulation, hyperinsulinemia, Ayurveda, dosha.

INTRODUCTION

Polycystic ovarian syndrome (PCOS) may clinically be manifested in young women of reproductive age as oligo-ovulation, biochemical or clinical hyperandrogenism, hirsutism, male pattern baldness, acne, acanthonsis nigracans and polycystic ovaries. But PCOS has a long prodrome with detectable abnormalities that present as the metabolic syndrome like hyperinsulinemia, obesity, dyslipidemia related to decrease high density lipoprotein cholesterol and hypertriglyceridemia, hypertension, atherosclerosis, increased risk of development of type II diabetes and cardiovascular disease throughout the life of affected women¹.

PCOS is a heterogeneous disorder that affects at least 7% of adult women. According to the National Institute of Health Office of Disease Prevention, PCOS affects approximately 5 million women of child bearing age. Research suggests that 5-10% of females at 18 to 44 years of age are affected by PCOS making it the most common endocrine abnormality among women of reproductive age².

As no specific sole cause of PCOS has been determined, the most accepted evidence is a multifactorial model where interactions between environmental cues and factors intrinsic to individual act in consonance towards a common result, which is development of hyperandrogenemia, a biochemical hallmark of this pathology. This alteration is the main culprit behind most clinical manifestations of PCOS. There are no single criteria sufficient for clinical diagnosis because of multiple aetiologies and presentations. Though globally it has an alarming incidence, its diagnosis is difficult as it manifests as a spectrum of symptoms rather than a specific one³.

Pathophysiology

Modern perspective of PCOS

PCOS has a heterogeneous etiology involving a variety of combination of reproductive, metabolic and genetic determinants. No single etiology has so far been found to have particular predictive power in explaining the occurrence of PCOS. Furthermore no single etiological gene or inheritance pattern has been found for occurrence of PCOS. Clearly improvements in our understanding of the developmental process causing PCOS are necessary to clarify the relative importance of the multifactorial components in PCOS development and to focus clinical initiative in prevention, diagnosis and treatment. PCOS is imbalance of female sex hormones. The ovaries are the part of female reproductive system along with uterus, fallopian tubes and vagina. The ovaries contain the lifetime supply of eggs. These eggs are immature and stored in tiny fluid filled follicles.

Pituitary gland located at the base of brain produces hormones which direct the function of ovaries. Each

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month the pituitary gland secretes Follicle Stimulating Hormone (FSH) and Luteinizing Hormone (LH) in blood stream. After these hormones reach the ovaries several hundred immature eggs start maturing expanding the size of follicles which simultaneously secretes estrogen, the main female sex hormone. Once the level of estrogen reaches to certain level, the pituitary gland senses the surge of luteinizing hormone to the ovaries causing the most mature follicle to release the egg called ovulation. The free egg travels the fallopian tube where it awaits fertilization, eventually the remaining follicles and eggs dissolve. If the egg is not fertilized the lining of uterus sheds during the menstruation.

In PCOS the pituitary gland releases abnormally high amount of Luteinizing hormone in blood stream disrupting the normal menstruation cycle. As a result the follicle does not mature and ovulation does not occur which can lead to anovulation. The immature follicle which does not dissolve remains as fluid filled sacs or cysts. These cysts lead to a hormonal imbalance because of an increased amount of testosterone. This can result in acne, an increase in facial and body hair and irregular periods.

In addition there is high level of insulin hormone produced by pancreas. Insulin combines with luteinizing hormone and lead to excess production of male hormone testosterone in ovaries. Abnormally high amount of testosterone in the ovaries prevent ovulation which can lead to infertility. Along with it, PCOS raises the risk of Type II diabetes because of excess of insulin or insulin resistance, heart disease, high blood pressure, cholesterol androstenedione and endometrial cancer4.

Irregular periods
When you have PCOS, the hormone activity becomes irregular as ovulation is not occurring in an expected way. The body gives mixed signals and the menstrual cycle is disrupted. Periods can vary widely from woman to woman. It can change from irregular, infrequent periods (oligomenorrhea) or heavy to absent periods (amenorrhea)3.

Insulin resistance
Insulin resistance accompanied by uncompensating hyperinsulinemia (elevated fasting blood insulin level) is important biochemical feature of PCOS. Hyperinsulinemia increases ovarian androgen production (particularly testosterone and androstenedione) and decreases the sex hormone binding globulin (SHBG) concentration6.

Research at the University of Oxford and The Imperial College London revealed that a gene implicated in the development of obesity is also linked to susceptibility to PCOS. A study revealed that elevated levels of androgen than normal subjects were found in mothers and sisters of patient suffering from PCOS. It is also manifested that PCOS is genetically transferred ovarian syndrome and it is heterogeneous disorder which involves the interaction of the other genes with the environment7.

Histomorphology of ovaries
Polycystic ovaries are six fold larger than normal ovarian size. There is large number of immature follicles (subcortical cysts) which causes the change in the shape of ovary. The ovary becomes whitish in color and there is multiple cystic follicles covered by a dense fibrous capsule. There is luteinization of the theca cells (hyperthecosis) and thickening of tunica albugenia (connective tissue covering the ovaries)3.

Changes in hormonal level
The ovarian and adrenal glands of women with PCOS are usually the sites of production of elevated androgens. It is also proposed that women with PCOS have a hyper production of CYP17 enzyme, which is found to be responsible for forming androgens in the ovaries and adrenals5. Ovaries makes several androgens of which testosterone is the most prominent others include androstenedione and dehydroepiandrosterone (DHEAS). The most typical feature of polycystic ovary is the stroma and theca cells make excessive of testosterone10.

Signs and Symptoms
The major signs and symptoms related to PCOS includes menstrual disturbances ranging from amenorrhea to oligomenorrhagia to episodic menometrorrhagia with anemia, hyperandrogenism, increased muscle mass, androgenic alopecia, deepening of voice, clitoromegaly, hirsutism, acne, insulin resistance, acanthosis nigricans, dyslipidemia, infertility and miscarriage11.

Diagnosis
Women may have cysts in the ovaries for a number of reasons and so it is the characteristics constellation of symptoms, rather than the presence of cysts themselves that is important in establishing the diagnosis of PCOS. The Rotterdam criteria of assessment: presence of two out of the following three criteria: Oligomenorrhea and/or anovulation Hyperandrogenism (clinical and/or biochemical) Polycystic ovaries with exclusion of other etiologies.

The other methods of diagnosis are gynecological ultrasonography, laparoscopic examination which reveals a thickened, smooth, pearl white outer surface of the ovary, serum (blood) elevated levels of androgens (male hormones), including androstenedione, testosterone and dehydroepiandrosterone sulphate, the ratio of Luteinising hormone and Follicle stimulating hormone being greater than 1:1 as on the day 3 of menstrual cycle, reduced levels of sex hormone binding globulin (SHBG), fasting biochemical and lipid profile, prolactin to rule out hyperprolactinemia, TSH to rule out hyperthyroidism12.

Ayurvedic perspective of PCOS
Ayurveda describes PCOS to have an equal involvement of the Dosha, Dhatu and Upadhatu. It does not correlate the condition to a single disease or syndrome but the symptoms bears a resemblance to the terminologies defined as Anartava- Amenorrhea, Yonivapad-anatomical and physiological disorder of the reproductive system like Arjaska- oligomenorrhoea due to vitiation of vata dosha, Lohitakshaya- oligomenorrhoea due to vitiation of vata-pitta dosha, Vandhya-Infertility, Pushpaganhi- Revati- Idiosyncratic anovulatory menstruation, Abeejata- anovulation, Rajodushti and Ashartava Dushhti- Menstrual flow disorder due to vitiation of Doshka, Shandhi Yonivapad- Vitation of vata.
due to genetic factors causes menstrual irregularities which may or may not be associated with anovulation\textsuperscript{13}. Vishama ahara and vihara (improper diet and activities) which causes reduced digestion and metabolism leading to immaturity of digestive extract and formation of immature rasa which vitiates menstrual blood and leads to increase in meda dhatu and kapha which causes

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Part/extract used</th>
<th>Dosage</th>
<th>Animal Model</th>
<th>Parameters used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thuja occidentalis\textsuperscript{20}</td>
<td>Oil</td>
<td>500 mg/kg</td>
<td>Letrozole induced PCOS model</td>
<td>Serum gonadotropins, steroids, blood lipid, leptin and glucose. Histopathology of ovaries</td>
</tr>
<tr>
<td>Tephrosia purpura\textsuperscript{21}</td>
<td>Seed powder</td>
<td>0.2 gm/kg</td>
<td>Letrozole induced PCOS model</td>
<td>Ovary weight, Hormonal assay, Testosterone, Luteinizing Hormone, Follicle stimulating hormone, Estrogen</td>
</tr>
<tr>
<td>Camellia sinensis\textsuperscript{22}</td>
<td>Seed powder</td>
<td>0.2 gm/kg</td>
<td>Letrozole induced PCOS model</td>
<td>Examination of Estrous cycle</td>
</tr>
<tr>
<td>Labisia pumila\textsuperscript{23}</td>
<td>Entire herb</td>
<td>50 mg/kg</td>
<td>Estradiol valerate induced PCOS model</td>
<td>Hormonal assay, histological study of ovary</td>
</tr>
<tr>
<td>Nardostachys jatamansi\textsuperscript{24}</td>
<td>-</td>
<td>-</td>
<td>Estradiol valerate induced PCOS in rat</td>
<td>Antiandrogenic activity, estrous cyclicity, steroidal hormone levels</td>
</tr>
<tr>
<td>Tribulus terrestris\textsuperscript{24}</td>
<td>-</td>
<td>-</td>
<td>Estradiol valerate induced PCOS in rat</td>
<td>Antiandrogenic activity, estrous cyclicity, steroidal hormone levels</td>
</tr>
<tr>
<td>Symplocos racemosa\textsuperscript{25}</td>
<td>Aqueous extract of stem bark</td>
<td>250-1000 mg/kg</td>
<td>Letrozole induced PCOS rat model</td>
<td>Ovarian and uterine weight, hormonal assay, histology of ovaries</td>
</tr>
<tr>
<td>Aloe barbadensis\textsuperscript{26}</td>
<td>Gel from leaves</td>
<td>10 mg/day</td>
<td>Letrozole induced PCOS rat model</td>
<td>Insulin sensitivity by OGTT, steroidogenic enzyme assay. Histological examination of ovaries</td>
</tr>
<tr>
<td>Commiphora makul\textsuperscript{27}</td>
<td>Gum-guggulu</td>
<td>40 mg/100 gm body weight</td>
<td>Letrozole induced PCOS rat model</td>
<td>Estrous cycle is monitored by daily examination of vaginal smear, body weight, histomorphometry of ovary, western blot analysis of IL-6 in ovarian tissue. Determination of C- protein, testosterone, superoxide dismutase, catalase, LPO, etc.</td>
</tr>
<tr>
<td>Commiphora wightii\textsuperscript{28}</td>
<td>Ethanoic extract</td>
<td>100 mg in sesame oil</td>
<td>Dehydroepiandrosterone (DHEA) induced PCOS in rats</td>
<td>Measurement of body weight, ovary weight, liver weight. Serum analysis T3, T4, TSH, FSH, LH, Testosterone, estradiol, progesterone, histology of ovaries</td>
</tr>
<tr>
<td>Saraca asoca\textsuperscript{29}</td>
<td>Bark extract</td>
<td>500 mg/kg body weight</td>
<td>Estrogenicity in adult female ovarietomised mice</td>
<td>Induction of estrous cycle, detrimination of size and weight of uterus</td>
</tr>
<tr>
<td>Mentha piperita\textsuperscript{30}</td>
<td>Herbal tea</td>
<td>40 gm/l</td>
<td>Letrozole induced PCOS rat model</td>
<td>Hormonal analysis, histomorphometry of ovary and uterus, immunohistochemical investigations in ovary.</td>
</tr>
<tr>
<td>Pergularia daemia\textsuperscript{31}</td>
<td>Fresh juice</td>
<td>-</td>
<td>Testosterone propionate induced PCOS rat model</td>
<td>Study of vaginal smears.</td>
</tr>
<tr>
<td>Corylus avellana\textsuperscript{32}</td>
<td>Seed oil</td>
<td>2 ml/day</td>
<td>Letrozole induced PCOS rat model</td>
<td>Determination of serum gonadotropins, serum lipids, leptin, glucose levels, histology of ovary.</td>
</tr>
<tr>
<td>Mimosa pudica Linn.\textsuperscript{33}</td>
<td>Aqueous extract</td>
<td>250,500 and 1000 mg/kg</td>
<td>Letrozole induced PCOS rat model</td>
<td>Determination of testosterone, estrogen, progesterone, cholesterol levels, weight of ovary and uterus was determined, histology of ovary was done.</td>
</tr>
</tbody>
</table>

Vishama ahara and vihara (improper diet and activities) which causes reduced digestion and metabolism leading to immaturity of digestive extract and formation of immature rasa which vitiates menstrual blood and leads to increase in meda dhatu and kapha which causes
obstruction of body channels and vata prakopa causing obesity and amenorrhoea. Vata and Kapha doshas as well as vishama aahar and vihara leads to reduced digestive fire and causes production of Ama (undigested food). This ama production causes improper enzymatic reactions leading to incomplete metabolism and hormonal imbalance. This hormonal imbalance causes hyperinsulinaemia and hyperandrogenism ultimately leading to anovulation and amenorrhoea/oligomenorrhoea and ovarian abnormalities like polycystic ovaries43.

Ayurveda does not speak in the terms of “hormones”. It has its own unique language and terms. Hormones are considered as fire elements in the tissue. The action of hormones expresses the nature of pitta, the energy responsible for transformation. All stages of the female reproductive process are a result of the interplay of hormones. The fact behind the alteration of each stage is due to pitta replicated in the effect of the hormones on the various stages of the ovarian and menstrual cycles. If pitta predominates it manifests as hair loss, acne, painful menses, clots and heart problems. Kapha’s heavy cool qualities nourish the development of vata which is manifested as increased weight, subfertility, hirsutism, diabetic tendencies and coldness. Vata is reliable for affecting the movement of the follicle during the ovarian cycle, the breakdown of the ovary wall for releasing the matured ovum, the movement of the fimbriae - directs the ovum into the fallopian tubes and the movements of the ovum near the uterus. The predominance of vata is manifested as painful menses, scanty or less menstrual blood and severe menstrual irregularity15.

Management of PCOS

Allopathic management of PCOS

The medical management of PCOS can be divided in to four components: three of them are acute issues which include control of irregular menses, treatment of hirsutism and management of infertility. One that is more chronic is the management of insulin resistance syndrome46. To regulate menstrual cycle, combination of birth control pills containing both estrogens and progestin are used. The birth control pills decrease androgen production and give body a break from the effects of continuous estrogen, lowering the risk of endometrial cancer and correcting abnormal bleeding. To treat the hirsutism Co-cyprinol and Eflorithine can be used. Efloriznithine is a topical cream that has been

Table 2: Formulations screened for PCOS.

<table>
<thead>
<tr>
<th>Name of formulation</th>
<th>Dosage</th>
<th>Animal Model/ Clinical Trail</th>
<th>Parameters used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stanyas Sadhana Gana</td>
<td>10 gm bd in empty stomach with luke warm water</td>
<td>30 year old women with PCOD</td>
<td>Changes in menstrual cycle, changes in ovarian volume with USG, ovulation etc.</td>
</tr>
<tr>
<td>Gynocare355</td>
<td>1 capsule per day</td>
<td>Women with PCOS</td>
<td></td>
</tr>
<tr>
<td>Ugyanotone forte capsules</td>
<td>Open labeled non comparative study for female patients aged between 12-55 and fulfilling ESHRE/ ASRM Rotterdam criteria for PCOD, 2003</td>
<td></td>
<td>Chronicity of menstrual regulation (CIM), Ovarian size, Obesity, Acne, Hairloss and Hirsutism. Hb %, TLC, DLC, ESR, USG.</td>
</tr>
<tr>
<td>Evecare syrup37</td>
<td>2-3 tablespoon twice daily</td>
<td>Double blind placebo controlled study in women aged above 18 years suffering from infertility due to PCOS presenting with symptoms such as hirsutism, acne and obesity</td>
<td>BMI, duration of infertility, acne, hirsutism, obesity, oligomenorrhea</td>
</tr>
<tr>
<td>Kanchnar guggulu</td>
<td>750 mg bd</td>
<td>28 years aged women with PCOS</td>
<td>Pelvic pain, irregular menstruation cycle, USG of uterus and ovaries. Regularity or irregularity of menstrual cycle, hirsutism, ovulation, no. of cysts, size of ovary, serum insulin level, BMI</td>
</tr>
<tr>
<td>Ovaryl tablet39</td>
<td>Tablet twice a day</td>
<td>Open observational trail in women with PCOS</td>
<td>Determination of ovarian cycle, ovarian histomorphology, hormonal assay for plasma testosterone, progesterone and estrogen.</td>
</tr>
<tr>
<td>Shilajatu rasayana-herbomineral formulation</td>
<td>25.31 mg rasayana/200 gm body weight</td>
<td>Letrozole induced PCOS model</td>
<td>Determination of androgens.</td>
</tr>
<tr>
<td>Mehani41</td>
<td>50 mg/100 gm body weight</td>
<td>Testosterone propionate induced PCOS model</td>
<td></td>
</tr>
</tbody>
</table>
approved by the US Food and Drug Administration for removal of unwanted facial hair in females. Eflornithine inhibits the enzyme ornithine decarboxylase in the skin, which inhibits cell division and synthetic functions, thus reducing the rate of hair growth. It should be used twice daily, at least 8 hours apart, on the affected areas of the face and chin. The management of infertility can be done using non-pharmacological and pharmacological approach. The first line non-pharmacological management of PCOS can be done by life style management which targets weight loss and prevention of weight gain and includes both reduced dietary energy intake and exercise. While the first line pharmacological treatment is clomiphene citrate which improves fertility. It is partially selective estrogen receptor modulator. Its antiestrogenic activity at the hypothalamus induces a change in gonadotropin releasing hormone (GnRH) pulse frequency leading to increased release of follicle stimulating hormone (FSH) from the pituitary gland.

The second line pharmacological management includes Metformin combined with clomiphene citrate to improve fertility outcome rather than persisting clomiphene citrate alone in women with PCOS who are resistant to clomiphene citrate. Metformin if BMI < 30 Kg/m² can be used alone to improve ovulation rate and pregnancy rate in women with PCOS who are anovulatory and are infertile with no other infertility factors.

Gonadotropins can be used as second line pharmacological therapy in women with PCOS who have clomiphene citrate resistance or failure, and are anovulatory and infertile. Aromatase inhibitors- Letrozole under caution can be offered as a pharmacological treatment for ovulation induction indicated for infertile anovulatory woman with PCOS. Laproscopic ovarian surgery and Bariatric surgery are also the options available. PCOS has a complex ateiopathogenesis involving mostly a combination of reproductive, metabolic and genetic elements. No single prognostic element has been able to strongly explain the pathophysiology and occurrence of PCOS. Furthermore, no single etiological gene or inheritance pattern has been found for occurrence of PCOS. Obvious enhancement in our understanding of the various progressions causing PCOS are required to simplify the relative importance of the multifactorial components in PCOS development and to focus clinical initiative in prevention, diagnosis and treatment. Chemical based medications prescribed by allopathic medicines can be harmful to our body and have side effects including vaginal bleeding, blurred vision, nausea, ovarian hyper stimulation (ovarian enlargement), vomiting, flushing, breast tenderness, increased likelihood to multiple births, strokes, seizures, shortness of breath, etc.

These drugs chemically induce a women ovulatory cycle, instead of allowing it to be restored to its original healthy rhythm. The successful treatment of infertility is usually possible in the majority of patients with PCOS by using natural, non-invasive and non-chemical remedies. The herbal therapies are found to restore the normal rhythm of the menstrual cycle by balancing the hormones and also they are found to restore the imbalance of doshas occurring due to anovulation. Moreover there are herbs having phytoestrogens are available which can also be helpful in the treatment of disease. The plants maintaining the level of insulin and lipid lowering herbs can also be incorporated in the therapy for PCOS. The following tables provide the information about the drugs which were screened in animals as well as those who were clinically tested in the human volunteers. It also

Table 3: Active constituents screened for PCOS.

<table>
<thead>
<tr>
<th>Name of Active constituent</th>
<th>Dosage</th>
<th>Animal Model/ Clinical trail</th>
<th>Parameters used</th>
</tr>
</thead>
<tbody>
<tr>
<td>α-Thujone&lt;sup&gt;42&lt;/sup&gt;</td>
<td>-</td>
<td>Letrozole induced PCOS model</td>
<td>Serum gonadotropins, steroids, blood lipid, leptin and glucose. Histopathology of ovaries.</td>
</tr>
<tr>
<td>Berberine&lt;sup&gt;43,44,45&lt;/sup&gt;</td>
<td>1.5 gm/day</td>
<td>Women with PCOS undergoing IVF treatment Multicenter randomized double blind trail</td>
<td>Clinical, metabolic and endocrine effects of berberine. Ovulation, effect on corpus luteum, implantation and obstetrics complications.</td>
</tr>
<tr>
<td></td>
<td>500 mg three times a day</td>
<td>100 subjects with PCOS and insulin resistance</td>
<td>Antropometric measurements, serum concentration of TT, SHBG, insulin, glucose, TC, TG, HDTC, LDLC.</td>
</tr>
<tr>
<td>Curcumin&lt;sup&gt;46&lt;/sup&gt;</td>
<td>100-200 mg/kg</td>
<td>Letrozole induced PCOS in female wistar rats</td>
<td>Hormonal assay, measurement of fasting blood glucose, glycosylated hemoglobin level, assessment of lipid profil, antioxidant assay for superoxide dismutase, catalase, reduced glutathione, ovarian histomorphology.</td>
</tr>
</tbody>
</table>
Table 4: Clinical trials of Herbs performed for PCOS

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Part/ extract used</th>
<th>Dosage</th>
<th>Clinical trail</th>
<th>Parameters used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asparagus racemosus (Shatavari)</td>
<td>Powder of root</td>
<td>5 gm twice a day</td>
<td>25-40 aged subfertility women</td>
<td>Ultrasonography for changes in ovary, LH/FSH ratio</td>
</tr>
<tr>
<td>Anethum graveolens (Shatapushpa)</td>
<td>Seed powder of churna with Cow ghee</td>
<td>5 gm thrice daily with 2.5 ml of cow ghee</td>
<td>15-35 years women with oligomenorrhea</td>
<td>Hemoglobin %, weight of patient, amount of blood flow, subjective parameters like interval of menstruation, duration and pain throughout menstruation period</td>
</tr>
<tr>
<td>Anethum graveolens (Shatapushpa)</td>
<td>Powder</td>
<td>5 gm twice a day</td>
<td>25-40 aged subfertility women</td>
<td>Ultrasonography for changes in ovary, LH/FSH ratio</td>
</tr>
<tr>
<td>Tinospora cordifolia (Guduchi)</td>
<td>Powder</td>
<td>5 gm twice a day</td>
<td>25-40 aged subfertility women</td>
<td>Ultrasonography for changes in ovary, LH/FSH ratio</td>
</tr>
<tr>
<td>Mentha spicata (Spearmint)</td>
<td>Herbal tea</td>
<td>Cup of tea twice a day</td>
<td>Female hirsute patients with PCOS</td>
<td>Levels of androgens</td>
</tr>
<tr>
<td>Mentha spicata (Spearmint)</td>
<td>Herbal tea</td>
<td>-</td>
<td>Randomized control trial</td>
<td>Hormonal assay, hirsutism</td>
</tr>
<tr>
<td>Glycyrrhiza glabra (Liquorice)</td>
<td>Powder</td>
<td>3.5 gm/day</td>
<td>Clinical study in 32 women with PCOS</td>
<td>Blood pressure, BMI, Serum electrolytes, Plasma renin, Plasma aldosterone and cortisol, serum testosterone, urinary tetrahydrocortisol/cortisone ratio.</td>
</tr>
<tr>
<td>Trigonella foenum graceum (Fenugreek)</td>
<td>Seed extract enriched with 40% furostanolic saponins (Furocyst)</td>
<td>2 capsules per day</td>
<td>Multicentric, open labeled, single arm, non randomized study in female (18-45 years) suffering from PCOS.</td>
<td>Effect on leutenising hormone (LH), Follicle stimulating hormone (FSH), change in ovary volume, effect on cyst, menstrual cycle and pregnancy, effect on hemoglobin level and total leucocyte count, plasma glucose, serum triglyceride, serum HDL cholesterol levels etc.</td>
</tr>
<tr>
<td>Cinnamomum cassia</td>
<td>Bark extract</td>
<td>1 gm per day</td>
<td>Clinical study in women with PCOS aged 20-35 years whose chief complaints were menstrual disturbances and infertility and/or clinical signs of hyperandrogenism</td>
<td>Blood samples were assayed for glucose, insulin, FSH, LH, prolactin, TSH, testosterone, estradiol, and SHBG by chemoilluminescence.</td>
</tr>
<tr>
<td>Cimicifuga racemosa</td>
<td>Extract</td>
<td>40 mg/ day</td>
<td>Women with PCOS</td>
<td>Blood tests included follicle-stimulating hormone (FSH), luteinizing hormone (LH) and progesterone. Transvaginal ultrasound was performed to document follicular size and growth as well as endometrial thickness. If a follicle achieved a size of 18 mm or greater, human chorionic gonadotropin (HCG) was given and then intercourse was recommended.</td>
</tr>
</tbody>
</table>
provides information about some herbal formulations which give combined effect in the treatment of PCOS.

**CONCLUSION**
Polycystic ovary syndrome is a complex disorder with multiple etiologies for which multiple treatment approaches are required depending on the reason a patient seeks treatment. To treat PCOS one needs controlled and balanced diet and exercise for weight reduction along with medication and lifestyle management. Modern and traditional management together can have better results. Thus adopting a holistic treatment, good life style with
appropriate diet, yoga, pranayamas and stress free living can prove to be effective in the management of PCOS.

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