RESEARCH PAPER

Rapid Clinical and Radiological Improvement in Bulky Uterus and Haemorrhagic Ovarian Cyst Following Dr. Raju's Proprietary Standardized Treatment Protocol: A Case Report

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ABSTRACT

Background:
Abnormal uterine bleeding associated with a bulky uterus, thickened heterogeneous endometrium, probable endometrial hyperplasia, and haemorrhagic ovarian cysts may significantly affect a patient's quality of life and may require gynecological evaluation, medical management, and, in selected circumstances, procedural or surgical intervention. This case report describes the clinical and radiological course of a 40-year-old woman who received a standardized Neo Ayurveda treatment protocol based on the Dr. Raju Cell Regeneration Principle.

Case Presentation:

A 40-year-old woman, Nirmala, presented with polymenorrhoea, persistent heavy menstrual bleeding, abdominal pain, pelvic heaviness, and increased menstrual flow requiring approximately 4–6 sanitary pads per day. Abdominal ultrasonography performed on 27 May 2026 demonstrated a bulky uterus with thickened heterogeneous endometrium containing cystic spaces and free fluid within the endometrial cavity, considered suggestive of endometrial hyperplasia, together with a left haemorrhagic ovarian cyst.

Therapeutic Intervention:

A standardized Neo Ayurveda treatment protocol was initiated on 13 June 2026. The regimen included proprietary formulations comprising S-1 Anti-Ageing Support, S-3 Cardiovascular Support, S-6 Gastro Support, S-4 Liver Health Support, and Edemax powder, together with a structured predominantly uncooked dietary and nutritional program. The dietary intervention incorporated prebiotic foods, flaxseed-based nutrition, vegetable juices, seeds, fruits, salads, cold-pressed oils, and avoidance of selected processed foods, refined foods, excess salt, and other restricted dietary components.

Reported Clinical Outcomes:

According to the patient's video-recorded statement dated 11 July 2026, the previously continuous and heavy menstrual bleeding reduced noticeably by the afternoon of the first day of treatment. The bleeding subsequently ceased completely within approximately one week. The patient also reported symptomatic improvement during the treatment period. A rise in haemoglobin from approximately 8.0 to 8.8 g/dL was noted in the case documentation.

Measured Radiological Outcomes:

Follow-up ultrasonography performed on 26 August 2026, approximately 74 days after initiation of treatment, reported that both ovaries appeared normal in size and echotexture with no obvious detectable abnormality. The previously documented endometrial thickness decreased from 17 mm to 5.6 mm, representing an approximate 67% reduction in measured endometrial thickness.

Conclusion:
This case documents a marked temporal association between a structured Neo Ayurveda treatment protocol and both rapid symptomatic improvement and substantial radiological change in a patient with heavy menstrual bleeding, a bulky uterus, probable endometrial hyperplasia, and a left haemorrhagic ovarian cyst. Patient-reported heavy bleeding decreased on the first day and reportedly ceased within approximately one week, while follow-up imaging after approximately 70–74 days demonstrated normalization of ovarian appearance and reduction in endometrial thickness from 17 mm to 5.6 mm. However, this single uncontrolled case cannot establish treatment causality, histological reversal of endometrial hyperplasia, complete anatomical regeneration, or the mechanism proposed by the Dr. Raju Cell Regeneration Principle. Further evaluation using gynecological examination, serial ultrasonography, endometrial assessment where clinically indicated, standardized symptom measures, haemoglobin monitoring, and longer-term follow-up is warranted.

Keywords: Abnormal uterine bleeding; Heavy menstrual bleeding; Polymenorrhoea; Bulky uterus; Thickened endometrium; Probable endometrial hyperplasia; Haemorrhagic ovarian cyst; Endometrial thickness; Neo Ayurveda; Dr. Raju Cell Regeneration Principle; Non-surgical management; Radiological improvement; Clinical symptom resolution; Integrative medicine; Clinical case report.

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1. Introduction

Abnormal uterine bleeding associated with a **bulky uterus, thickened heterogeneous endometrium, suspected endometrial hyperplasia, and ovarian cystic changes** can produce substantial clinical symptoms, including heavy or prolonged menstrual bleeding, pelvic or abdominal pain, fatigue, weakness, and reduced quality of life. Clinical evaluation commonly relies on menstrual history, gynecological assessment, ultrasonography, haemoglobin measurement, and, when indicated, further endometrial investigation.

The present case concerns a **40-year-old woman, Nirmala**, who presented with **polymenorrhoea, uncontrollable menstrual bleeding, abdominal pain, and a sensation of pelvic or abdominal heaviness**. The case documentation records that the patient was using approximately **4–6 sanitary pads per day** because of the increased menstrual flow. Ultrasonography of the abdomen performed on **27 May 2026** reported a **bulky uterus with thickened heterogeneous endometrium containing cystic spaces and free fluid within the endometrial cavity, considered likely to represent endometrial hyperplasia**, together with a **left haemorrhagic ovarian cyst**.

The patient subsequently commenced a structured **Neo Ayurveda treatment protocol on 13 June 2026**. The intervention included proprietary herbal formulations together with a defined predominantly uncooked dietary and nutritional program. The documented regimen included **S-1 Anti-Ageing Support, S-3 Cardiovascular Support, S-6 Gastro Support, S-4 Liver Health Support, and Edemax powder**, along with dietary components such as prebiotic foods, flax-based nutrition, raw vegetable juice, seeds, fruits, salads, and cold-pressed oils.

The treatment was administered within the conceptual framework described by the author as the **Dr. Raju Cell Regeneration Principle**. According to the case

documentation, this framework proposes that nutritional support, gut microbial activity, cellular detoxification, mitochondrial function, circulation, and cellular stress-response mechanisms may contribute to recovery in stressed or dysfunctional tissues.

These proposed mechanisms were not directly measured in the present patient. Therefore, they are presented as the theoretical basis of the intervention rather than as biological mechanisms established by this individual case.

The clinical course was considered noteworthy because, according to the patient's video-recorded statement, **heavy menstrual bleeding decreased noticeably on the first day of treatment and stopped completely within approximately one week**. The case documentation also records an improvement in haemoglobin from approximately **8.0 to 8.8 g/dL** during follow-up.

Follow-up ultrasonography performed on **26 August 2026**, approximately 74 days after treatment initiation, reported that **both ovaries appeared normal in size and echo pattern with no obvious detectable abnormality**, while the **endometrial thickness decreased from 17 mm to 5.6 mm**.

This case report therefore documents the **clinical and radiological course of a woman with heavy menstrual bleeding, bulky uterus, suspected endometrial hyperplasia, and a left haemorrhagic ovarian cyst following approximately 70–74 days of a structured Neo Ayurveda treatment protocol**. Particular attention is given to the rapid reported control of heavy menstrual bleeding and the subsequent measurable reduction in endometrial thickness and normalization of ovarian imaging.

Because this is a single uncontrolled case, and because the diagnosis of endometrial hyperplasia was based on imaging rather than documented histopathology, the findings should be interpreted as **hypothesis-generating clinical observations** rather than proof of complete histological reversal, cellular regeneration, or treatment causality.

2. Case Presentation

A **40-year-old woman, Nirmala**, presented with **polymenorrhoea, continuous heavy menstrual bleeding, abdominal pain, and a sensation of abdominal or pelvic heaviness**. According to the case documentation, the severity of menstrual blood loss required the use of approximately **4–6 sanitary pads per day**.

Baseline Clinical and Ultrasonographic Findings

An abdominal ultrasonography examination performed on **27 May 2026** documented:

- **Bulky uterus**
- **Thickened heterogeneous endometrium**
- Cystic spaces within the endometrial cavity
- Free fluid within the endometrial cavity
- Imaging appearance considered suggestive of **endometrial hyperplasia**
- **Left haemorrhagic ovarian cyst**
- Baseline **endometrial thickness: 17 mm**

The baseline endometrial thickness of **17 mm** is documented in the later comparative case record, which states that the thickness subsequently reduced to 5.6 mm.

The patient commenced the structured Neo Ayurveda treatment protocol on **13 June 2026**.

Follow-Up Ultrasonographic Findings

A repeat abdominal ultrasonography examination performed on **26 August 2026**, approximately 74 days after treatment initiation, documented:

- **Endometrial thickness: 5.6 mm**
- Both ovaries appearing **normal in size and echo pattern**
- **No obvious detectable ovarian abnormality**

The previously documented left haemorrhagic ovarian cyst was therefore **not described as detectable on the follow-up scan**.

Quantified Change in Endometrial Thickness

The endometrial thickness changed from:

17 mm at baseline → 5.6 mm at follow-up

This represents an absolute reduction of:

17 − 5.6 = 11.4 mm

and an approximate percentage reduction of:

(17 − 5.6) ÷ 17 × 100 = 67.1%

Thus, the documented imaging comparison demonstrated an approximately **67% reduction in endometrial thickness** over the treatment and follow-up period.

Reported Clinical Outcome

According to the patient's video-recorded statement dated **11 July 2026**, the previously continuous heavy menstrual bleeding decreased noticeably by the afternoon of the **first day of treatment** and reportedly stopped completely within approximately **one week**. The case documentation also records an increase in haemoglobin from approximately **8.0 to 8.8 g/dL**.

Objective Comparison

Parameter	Baseline	Follow-Up
Date	27 May 2026	26 August 2026
Endometrial thickness	**17 mm**	**5.6 mm**
Change in thickness	—	**11.4 mm reduction (~67.1%)**
Uterus	Bulky	Follow-up source provided does not specify uterine size
Endometrium	Thickened, heterogeneous, cystic spaces	Thickness reduced to 5.6 mm
Left ovary	Haemorrhagic ovarian cyst	No obvious detectable abnormality reported
Both ovaries	Abnormality involving left ovary	Normal size and echo pattern

The distinction is important: the available follow-up documentation clearly supports the **reduction in endometrial thickness and normalization of ovarian appearance**, but it does not provide a specific follow-up uterine-size measurement. Therefore, the manuscript should avoid stating that the "bulky uterus completely disappeared" unless the original follow-up ultrasound explicitly says the uterus returned to normal size.

3. Therapeutic Intervention

The patient commenced the structured **Neo Ayurveda treatment protocol on 13 June 2026**. The intervention combined proprietary herbal formulations with a defined predominantly uncooked dietary and nutritional program.

3.1 Proprietary Herbal Formulations

The documented treatment regimen included:

- **S-1 Anti-Ageing Support** – administered in the morning
- **S-3 Cardiovascular Support** – administered in the morning
- **S-6 Gastro Support** – administered in the morning
- **S-4 Liver Health Support** – administered in the afternoon
- **Edemax powder** – one tablespoon in the morning and evening

The case documentation states that these preparations were proprietary formulations developed by the author on the basis of his observational studies and subsequently incorporated into the Neo Ayurveda treatment protocol. The formulations were described as being licensed under the relevant AYUSH framework and also registered as health supplements under the **Food Safety and Standards Authority of India (FSSAI), Ministry of Health and Family Welfare, Government of India**. Detailed phytochemical composition, manufacturing standardization, and pharmacological characterization were not available in the case documentation and are therefore not further specified in this report.

3.2 Predominantly Uncooked Dietary Program

The therapeutic protocol included a defined predominantly uncooked dietary regimen. The patient was advised to avoid or restrict sweets other than fruits and dry fruits, wheat, maize, meat, beef, pork, microwave-heated foods, excess salt, most oils and fats except cold-pressed flaxseed and coconut oil, milk and milk-based products other than fat-free curd or yogurt, processed and baked foods, alcohol, and aerated beverages.

3.3 Prebiotic Component

The patient was advised to consume the following once daily in the morning on an empty stomach:

- **Garlic:** approximately 2–3 small pieces

- **Ginger:** approximately ½ cm sliced
- **Fenugreek seeds:** approximately ½ teaspoon, soaked and sprouted overnight

This component formed part of the protocol's emphasis on supporting gastrointestinal and microbial health.

3.4 Flaxseed-Based Nutritional Support

A defined **flax drink** was prescribed up to three times daily, in the morning, afternoon, and evening, if tolerated. The case documentation describes this preparation as providing omega-3 and omega-6 fatty acids and lignans.

Edemax powder could also be mixed with the flax preparation or taken with other health supplements.

3.5 Additional Nutritional Components

The protocol further included:

- **Banana stem juice** twice daily, approximately 100–150 mL per serving
- **Turmeric powder or tablets**
- **Neem and peepal leaf extract**
- Mixed seeds including sunflower, pumpkin, melon, apricot, and sesame
- **Chia seeds** where flaxseed was not tolerated
- **Raw vegetable juice**, approximately 150–200 mL twice daily
- Coconut milk
- Sprouts such as green gram, chickpeas, and peanuts
- Salads with sprouts and dry fruits
- Fruits and dry fruits
- Cold-pressed coconut oil
- Spice drink
- Dry-fruit smoothies
- Kosambari or green gram salad
- Poppy seed milk
- Sweet corn juice
- Roasted nuts and makhana seeds

3.6 Daily Meal Structure

The documented dietary schedule consisted primarily of uncooked or minimally processed foods.

For **breakfast**, the first course consisted of the flax preparation, followed by mixed fruits, dry-fruit smoothie, grated salad, peanuts, dry fruits, and cold-pressed coconut oil. Banana stem juice was advised approximately 30 minutes later where available.

For **lunch**, the first course consisted of approximately 200 mL of leached raw vegetable juice, followed by grated salads with soaked green gram and sweet corn.

The **evening** regimen included the flax preparation with coconut, dates, peanuts, chickpeas, smoothies, coconut milk, and dry fruits.

For **dinner**, the first course consisted of vegetable juice, followed by grated salads, dry fruits or pulses, mixed fruits, or chia-based preparations, with cold-pressed coconut oil afterward.

3.7 Conceptual Basis of the Intervention

The treatment was administered within the conceptual framework described by the author as the **Dr. Raju Cell Regeneration Principle**. According to the case documentation, the proposed framework emphasizes nutritional support, gut microbial activity, cellular detoxification, mitochondrial function, and cellular stress-response mechanisms, including chaperone or heat-shock protein activity.

These proposed mechanisms were not directly measured in this patient. Accordingly, they are presented as the theoretical basis of the treatment protocol rather than as mechanisms demonstrated by this individual case.

The patient continued the defined Neo Ayurveda intervention during the approximately **70–74-day observation period**, after which follow-up ultrasonography documented reduction in endometrial thickness from **17 mm to 5.6 mm** and normal appearance of both ovaries without an obvious detectable abnormality.

4. Clinical Course

The patient commenced the structured **Neo Ayurveda treatment protocol on 13 June 2026**. At baseline, she had polymenorrhoea, persistent heavy menstrual bleeding, abdominal pain, and pelvic or abdominal heaviness. Baseline ultrasonography dated **27 May 2026** documented a bulky uterus, thickened heterogeneous endometrium with cystic spaces and free fluid within the endometrial cavity, findings considered suggestive of endometrial hyperplasia, and a left haemorrhagic ovarian cyst. The comparative

case documentation recorded a baseline endometrial thickness of **17 mm**.

4.1 Patient-Reported Clinical Outcomes

According to the patient's video-recorded statement dated **11 July 2026**, the previously continuous heavy menstrual bleeding decreased noticeably by the afternoon of the **first day of treatment**. She reported that the bleeding stopped completely within approximately **one week**.

The patient also reported improvement in her general condition during the treatment period. These symptomatic outcomes were based on patient testimony and were not assessed using standardized menstrual blood-loss scores, pain scales, or validated quality-of-life instruments.

The reported clinical outcomes were therefore:

- marked reduction in heavy menstrual bleeding on the first day of treatment;
- complete cessation of the previously continuous bleeding within approximately one week; and
- overall symptomatic improvement during follow-up.

4.2 Objective Laboratory Outcome

The case documentation recorded an increase in haemoglobin from approximately:

8.0 g/dL at baseline → 8.8 g/dL at follow-up

This represents an absolute increase of approximately **0.8 g/dL**.

4.3 Objective Radiological Outcomes

The principal objective imaging outcome was assessed by comparing the baseline and follow-up ultrasonography findings.

Baseline ultrasound — 27 May 2026

The scan documented:

- bulky uterus;
- thickened heterogeneous endometrium;
- cystic spaces within the endometrial cavity;
- free fluid within the endometrial cavity;
- findings considered suggestive of endometrial hyperplasia;
- left haemorrhagic ovarian cyst; and
- documented comparative endometrial thickness of **17 mm**.

Follow-up ultrasound — 26 August 2026

The follow-up scan documented:

- endometrial thickness of **5.6 mm**;
- both ovaries appearing normal in size and echo pattern; and
- no obvious detectable ovarian abnormality.

The measured endometrial thickness therefore changed from:

17 mm → 5.6 mm

This represents:

- an absolute reduction of **11.4 mm**; and
- an approximate **67.1% reduction in endometrial thickness**.

The previously documented left haemorrhagic ovarian cyst was not described as detectable on the follow-up scan.

4.4 Interpretation of the Two Outcome Categories

The case therefore showed two clearly distinguishable categories of improvement:

Patient-reported outcomes: rapid reduction and subsequent cessation of heavy menstrual bleeding and general symptomatic improvement.

Objective outcomes: haemoglobin increase from approximately **8.0 to 8.8 g/dL**, reduction in endometrial thickness from **17 mm to 5.6 mm**, and normalization of ovarian appearance on follow-up ultrasonography.

The available follow-up documentation does **not** provide a numerical uterine-size measurement. Therefore, although the baseline scan described a bulky uterus, the supplied records do not objectively establish complete normalization of uterine size.

5. Outcome and Follow-Up

Following initiation of the structured **Neo Ayurveda treatment protocol on 13 June 2026**, the patient was followed clinically, through laboratory assessment, and by repeat ultrasonography over the subsequent approximately **70–74 days**.

5.1 Patient-Reported Clinical Outcomes

According to the patient's video-recorded statement dated **11 July 2026**, the previously continuous heavy menstrual bleeding reduced markedly by the afternoon of the **first day of treatment**. She further reported that the bleeding stopped completely within approximately **one week**.

The patient also reported general symptomatic improvement during the treatment period. These outcomes were based on patient testimony and were not quantified using standardized menstrual blood-loss scoring systems, pain scales, or quality-of-life instruments.

5.2 Objective Laboratory Outcome

The case documentation recorded an improvement in haemoglobin from approximately:

8.0 g/dL → 8.8 g/dL

This represents an absolute increase of approximately **0.8 g/dL** during follow-up.

5.3 Objective Radiological Outcomes

A repeat abdominal ultrasonography examination was performed on **26 August 2026**.

The baseline study dated **27 May 2026** had documented:

- a bulky uterus;
- thickened heterogeneous endometrium;
- cystic spaces within the endometrial cavity;
- free fluid within the endometrial cavity;
- imaging findings considered suggestive of endometrial hyperplasia;
- a left haemorrhagic ovarian cyst; and
- comparative baseline endometrial thickness of **17 mm**.

The follow-up ultrasonography dated **26 August 2026** documented:

- endometrial thickness reduced to **5.6 mm**;
- both ovaries appearing **normal in size and echo pattern**; and
- **no obvious detectable ovarian abnormality**.

The measured endometrial thickness therefore decreased from:

17 mm → 5.6 mm

This represents an absolute reduction of **11.4 mm**, corresponding to an approximate **67.1% reduction in endometrial thickness**.

The previously documented left haemorrhagic ovarian cyst was not described as detectable on follow-up imaging.

5.4 Overall Outcome

The documented follow-up therefore demonstrated two distinct categories of outcome:

Patient-reported outcome: rapid reduction and subsequent cessation of heavy menstrual bleeding, together with general symptomatic improvement.

Objective outcome: haemoglobin increased from approximately **8.0 to 8.8 g/dL**, endometrial thickness decreased from **17 mm to 5.6 mm**, and follow-up ultrasonography reported normal ovarian size and echo pattern without an obvious detectable abnormality.

The available follow-up documentation does not provide a quantitative measurement of uterine size. Accordingly, although the initial scan described a bulky uterus, the supplied records do not establish objective normalization of uterine dimensions.

Similarly, because the original impression described findings as **likely endometrial hyperplasia** on ultrasonography and no histopathological confirmation is provided in the available case documentation, the follow-up findings should be described as radiological improvement rather than proven histological resolution of endometrial hyperplasia.

At the time of the available follow-up, the case therefore demonstrated **marked symptomatic improvement accompanied by measurable laboratory and radiological changes over approximately 70–74 days**.

Here is a publication-style **Discussion** section, grounded in the case record and keeping reported outcomes separate from objective findings.

6. Discussion

This case describes a **40-year-old woman with polymenorrhoea, persistent heavy menstrual bleeding, abdominal pain, a bulky uterus, thickened heterogeneous endometrium with cystic changes considered suggestive of endometrial hyperplasia, and a left haemorrhagic ovarian cyst**. The patient subsequently underwent a structured Neo Ayurveda treatment protocol beginning on **13 June 2026**.

The clinical course was notable for both rapid patient-reported improvement and measurable follow-up changes. According to the patient's video-recorded statement, heavy menstrual bleeding reduced markedly by the afternoon of the first day of treatment and stopped completely within approximately one week. The case documentation also recorded an increase in haemoglobin from approximately **8.0 to 8.8 g/dL**.

The principal objective radiological change was documented on follow-up ultrasonography dated **26 August 2026**, 74 days after treatment initiation. The endometrial thickness had decreased from **17 mm to 5.6 mm**, representing an absolute reduction of **11.4 mm** and an approximate **67.1% reduction in measured endometrial thickness**. In addition, both ovaries were reported as normal in size and echo pattern, with no obvious detectable abnormality.

6.1 Significance of the Radiological Findings

The reduction in endometrial thickness from 17 mm to 5.6 mm is the strongest objective imaging outcome in this case. The baseline study documented thickened heterogeneous endometrium with cystic spaces and free fluid in the cavity, while the follow-up scan documented a substantially lower endometrial thickness.

The left haemorrhagic ovarian cyst that had been described on the baseline scan was not reported as detectable on the follow-up study, and both ovaries were described as normal in size and echo pattern.

However, the available follow-up report does not provide a quantitative measurement of uterine size. Therefore, although the baseline scan described a bulky uterus, the present case cannot objectively establish complete normalization of uterine dimensions.

Likewise, the baseline report described the endometrial appearance as **likely endometrial hyperplasia** on ultrasonography. No histopathological confirmation is documented in the available case material. Accordingly, the follow-up findings should be interpreted as **radiological improvement in endometrial thickness and morphology**, rather than as proven histological resolution of endometrial hyperplasia.

6.2 Reported Symptomatic Improvement

The patient-reported improvement in heavy menstrual bleeding was rapid. According to the case documentation, bleeding reduced substantially on the first day and reportedly stopped completely within approximately one week. This was accompanied by general symptomatic improvement.

The improvement in haemoglobin from approximately 8.0 to 8.8 g/dL is consistent with an improving clinical course, although the available documentation does not provide the full blood count, timing of each laboratory measurement, iron studies, or information regarding any concurrent iron supplementation or other supportive therapy.

The patient-reported outcomes should therefore be interpreted separately from the objective laboratory and imaging findings. No validated menstrual blood-loss score, standardized pain scale, or quality-of-life instrument was used in the available case documentation.

6.3 Nature of the Intervention

The Neo Ayurveda intervention in this case was multi-component. It included proprietary formulations described as **S-1 Anti-Ageing Support, S-3 Cardiovascular Support, S-6 Gastro Support, S-4 Liver Health Support, and Edemax powder**, together with a predominantly uncooked dietary and nutritional regimen.

The dietary protocol incorporated prebiotic foods, flaxseed-based nutrition, raw vegetable juices, fruits, seeds, sprouts, salads, cold-pressed oils, and multiple other nutritional components.

Because several interventions were introduced simultaneously, the observed clinical and radiological changes cannot be attributed to any single proprietary formulation, dietary component, or nutritional measure.

6.4 Dr. Raju Cell Regeneration Principle

The intervention was administered within the conceptual framework described by the author as the **Dr. Raju Cell Regeneration Principle**. According to the case documentation, this framework proposes that nutritional support, gut microbial activity, cellular detoxification, mitochondrial function, chaperone or heat-shock protein activity, and inter-organ biological communication may contribute to recovery in stressed or dysfunctional tissues.

These mechanisms were not directly measured in the present patient. No mitochondrial assays, heat-shock protein measurements, microbiome analysis, tissue biomarkers, hormonal studies, or histological evidence of cellular regeneration were available.

Accordingly, the Dr. Raju Cell Regeneration Principle should be regarded in this report as the **theoretical framework underlying the intervention**, whereas the documented evidence consists of the reduction in endometrial thickness, normalization of ovarian appearance on follow-up imaging, haemoglobin improvement, and patient-reported reduction in bleeding.

6.5 Interpretation of the Ovarian Cyst Finding

The baseline ultrasonography documented a **left haemorrhagic ovarian cyst**, while the follow-up scan reported that both ovaries appeared normal in size and echo pattern with no obvious detectable abnormality.

This represents interval non-visualization of the previously described ovarian abnormality. However, the available documentation does not establish the exact mechanism responsible for this change. In particular, the case record does not include serial imaging showing the intermediate course of the cyst.

6.6 Strengths of the Case

A major strength of this case is the availability of **baseline and follow-up ultrasonography**, which allows direct comparison of the endometrial thickness and ovarian findings.

A second strength is the presence of both **objective and patient-reported outcomes**. The reduction in endometrial thickness from 17 mm to 5.6 mm and the improvement in haemoglobin provide measurable findings, while the patient's testimony documents the rapid change in heavy menstrual bleeding and general symptoms.

The 74-day interval between initiation of treatment and follow-up imaging also provides a clearly defined short-term observation period.

6.7 Limitations

Several limitations must be acknowledged. This is a **single uncontrolled clinical case**, and no comparison group was available. The baseline diagnosis of endometrial hyperplasia was based on ultrasonographic appearance rather than documented histopathology. The follow-up scan did not provide a quantitative uterine-size measurement, so complete resolution of the bulky uterus cannot be confirmed from the supplied records.

The case documentation also does not provide serial hormonal profiles, endometrial biopsy results, iron studies, complete blood counts, menstrual-cycle phase at the time of each ultrasound, or long-term follow-up beyond the documented period.

The reported reduction in menstrual bleeding was based primarily on patient testimony rather than a validated bleeding assessment tool. In addition, because the treatment was multi-component, the relative contribution of the proprietary formulations, nutritional intervention, and dietary measures cannot be determined.

Finally, the available data do not establish whether the observed changes resulted from the treatment protocol, natural variation, spontaneous resolution of the ovarian cyst, menstrual-cycle-related changes in endometrial thickness, or a combination of factors.

6.8 Implications for Further Research

The combination of rapid improvement in heavy menstrual bleeding, haemoglobin increase, approximately **67.1% reduction in measured**

endometrial thickness, and normalization of ovarian appearance over 74 days is sufficiently notable to justify further systematic investigation.

Future studies should include standardized gynecological examination, serial pelvic ultrasonography performed at comparable phases of the menstrual cycle, complete blood counts, iron studies, hormonal assessment, validated menstrual blood-loss scoring, and histopathological evaluation of the endometrium where clinically indicated.

Further research would also be required to evaluate the proposed biological mechanisms underlying the Dr. Raju Cell Regeneration Principle, including mitochondrial function, cellular stress-response pathways, gut microbial changes, nutritional status, and related biomarkers.

In summary, this case demonstrates **marked short-term clinical and radiological improvement during a 74-day Neo Ayurveda treatment period**, characterized by rapid patient-reported control of heavy menstrual bleeding, improvement in haemoglobin, reduction in endometrial thickness from 17 mm to 5.6 mm, and non-visualization of the previously reported left haemorrhagic ovarian cyst. The findings are hypothesis-generating and warrant further investigation but do not by themselves establish treatment causality, histological reversal of endometrial hyperplasia, or cellular regeneration.

Clarify the treatment timelineReduce repetition across sections

7. Conclusion

This case report documents **marked short-term clinical, laboratory, and radiological improvement over a 74-day treatment period** in a 40-year-old woman who initially presented with polymenorrhoea, persistent heavy menstrual bleeding, abdominal pain, a bulky uterus, thickened heterogeneous endometrium with cystic changes considered suggestive of endometrial hyperplasia, and a left haemorrhagic ovarian cyst.

According to the patient’s testimony, the previously heavy and continuous menstrual bleeding reduced markedly by the afternoon of the **first day of treatment** and stopped completely within approximately **one week**. These symptomatic changes were patient-reported and were not measured using a standardized menstrual blood-loss assessment tool.

Objective follow-up findings demonstrated an increase in haemoglobin from approximately **8.0 to 8.8 g/dL** and a reduction in endometrial thickness from **17 mm to 5.6 mm**, representing an absolute reduction of **11.4 mm** and an approximate **67.1% decrease in measured endometrial thickness**. Follow-up ultrasonography on **26 August 2026** also reported both ovaries as normal in size and echo pattern, with no obvious detectable abnormality, indicating non-visualization of the previously reported left haemorrhagic ovarian cyst.

The patient received a structured **Neo Ayurveda treatment protocol beginning on 13 June 2026**, incorporating proprietary herbal formulations together with a defined predominantly uncooked dietary and nutritional program. The intervention was delivered within the conceptual framework of the **Dr. Raju Cell Regeneration Principle**. However, the available case documentation does not include direct measurements of mitochondrial function, heat-shock protein activity, microbiome changes, histological regeneration, or other biomarkers that could establish the proposed mechanism.

The findings therefore demonstrate a **clear temporal association between the 74-day treatment period and substantial symptomatic, laboratory, and imaging improvement**, but they do not establish treatment causality, histological reversal of endometrial hyperplasia, normalization of uterine size, or proof of cellular regeneration.

The case is best regarded as a **hypothesis-generating clinical observation**. Further investigation should include serial pelvic ultrasonography performed at comparable menstrual-cycle phases, standardized menstrual blood-loss assessment, complete blood counts and iron studies, gynecological evaluation, endometrial sampling where clinically indicated, and longer-term follow-up.

If similar objectively documented outcomes are reproduced in larger and independently evaluated patient groups, further research may help determine whether the standardized Neo Ayurveda protocol and the proposed Dr. Raju Cell Regeneration Principle have a measurable role in supporting recovery in selected gynecological conditions.

8. References

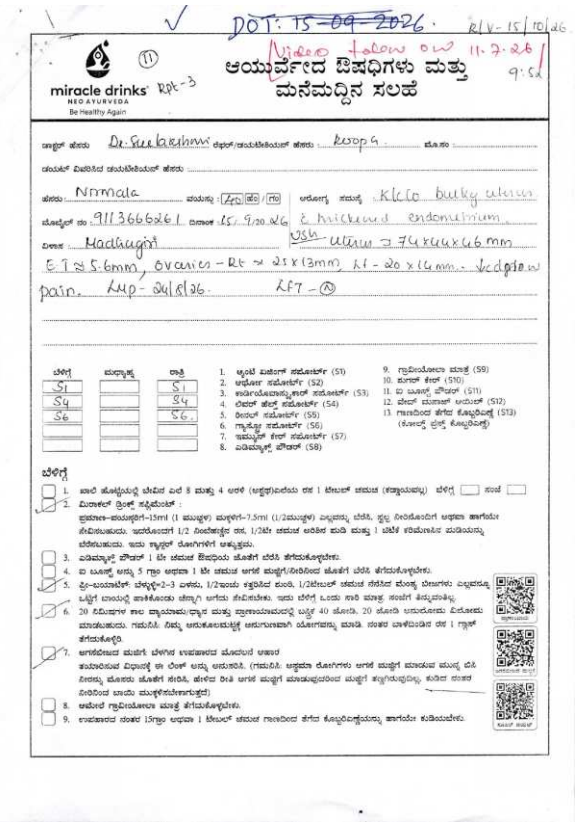
1. American College of Obstetricians and Gynecologists. **Endometrial Hyperplasia.** Washington, DC: ACOG.

ACOG notes that abnormal uterine bleeding is a common presentation of endometrial hyperplasia and that transvaginal ultrasonography may identify increased endometrial thickness, while definitive diagnosis may require endometrial tissue assessment.

2. American College of Obstetricians and Gynecologists. Management of endometrial intraepithelial neoplasia or atypical endometrial hyperplasia. **Obstet Gynecol.** 2023;142:735–744.
   This clinical consensus discusses pathological diagnosis, exclusion of concurrent carcinoma, nonsurgical management, and follow-up of atypical endometrial hyperplasia/endometrial intraepithelial neoplasia.
3. American College of Obstetricians and Gynecologists. **Abnormal Uterine Bleeding: Uterine Evaluation.** Washington, DC: ACOG.
   Evaluation of abnormal uterine bleeding may include imaging, endometrial assessment, hysteroscopy, or biopsy depending on age, symptoms, risk factors, and ultrasound findings.
4. Levine D, Brown DL, Andreotti RF, Benacerraf B, Benson CB, Brewster WR, et al. Management of asymptomatic ovarian and other adnexal cysts imaged at US: Society of Radiologists in Ultrasound Consensus Conference Statement. **Radiology.** 2010;256(3):943–954. doi:10.1148/radiol.10100213.
   This consensus statement provides an established framework for ultrasonographic characterization and follow-up of ovarian and adnexal cystic lesions.
5. Tabibzadeh S, Kong QF, Satyaswaroop PG, Babaknia A. Heat shock proteins in human endometrium throughout the menstrual cycle. **Hum Reprod.** 1996;11(3):633–640.
   This study demonstrates expression of several heat-shock proteins in human endometrium and variation in their expression across the menstrual cycle.
6. **Mitochondrial homeostasis: a key regulator in endometrial physiology and pathology.** 2025.
   This review discusses mitochondrial energy metabolism, mitochondrial quality control, mitophagy, oxidative balance, and their potential relevance to normal and pathological endometrial function.
7. Ciocca DR, Oesterreich S, Chamness GC, McGuire WL, Fuqua SAW. Heat-shock protein 27 and its role in female reproductive organs.
   This literature discusses the relationship between HSP27, steroid hormones, and endometrial and other female reproductive tissues.
8. Raju SM. **Hope to Those Who Lost Hope – A Living Book.** Bengaluru: Miracolo Drinks Group – A Global Health & Wellness Publication; Mallur Flora and Hospitality Pvt Ltd.; 2026. ISBN: **978-81-685825-3-8**.
   This book describes the author's conceptual development of Neo Ayurveda, the "Food as Medicine" philosophy, and the Dr. Raju Cell Regeneration Principle.

Case-Specific Clinical Documentation

9. **Baseline abdominal ultrasonography report dated 27 May 2026.** The examination documented a bulky uterus, thickened heterogeneous endometrium with cystic spaces and free fluid in the endometrial cavity, findings considered suggestive of endometrial hyperplasia, and a left haemorrhagic ovarian cyst. Unpublished clinical record.
10. **Comparative endometrial measurement.** Baseline endometrial thickness was documented as **17 mm**, compared with **5.6 mm** on follow-up ultrasonography. This represents an absolute reduction of **11.4 mm**, or approximately **67.1%**. Unpublished clinical documentation.
11. **Follow-up abdominal ultrasonography report dated 26 August 2026.** The examination documented an endometrial thickness of **5.6 mm** and reported that both ovaries appeared normal in size and echo pattern, with no obvious detectable abnormality. Unpublished clinical record.
12. **Patient video-recorded testimony dated 11 July 2026.** The patient reported substantial reduction in heavy menstrual bleeding by the afternoon of the first treatment day and complete cessation of bleeding within approximately one week. The case documentation also records improvement in haemoglobin from approximately **8.0 to 8.8 g/dL**. Unpublished clinical documentation.



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ಆಯುರ್ವೇದ ಔಷಧಿಗಳು ಮತ್ತು ಮನೆಮದ್ದಿನ ಸಲಹೆ

DOT: 15-09-2026. RLV-15/10/26

Video taken on 11.7.26 9:52

ಡಾಕ್ಟರ್ ಹೆಸರು: Dr. Sreelakshmi ಕ್ಲಿನಿಕ್/ಆಯುರ್ವೇದಿಕ್ ಹೆಸರು: Roopa ಊರು:

ರಾಯಭಾರ ವಿಷಯಿತ ರಾಯಭಾರಿಯವರ ಹೆಸರು:

ಹೆಸರು: Nirmala ವಯಸ್ಸು: 39 ಪುರುಷ / ಸ್ತ್ರೀ

ಮೊಬೈಲ್ ನಂ: 9113666261 ದಿನಾಂಕ: 15/9/20 26

ವಿಳಾಸ: Madhugiri

ಆರೋಗ್ಯ ಸಮಸ್ಯೆ: Klclo bulky uterus & thickened endometrium.

USG uterus = 7cm x 4cm x 6.6mm

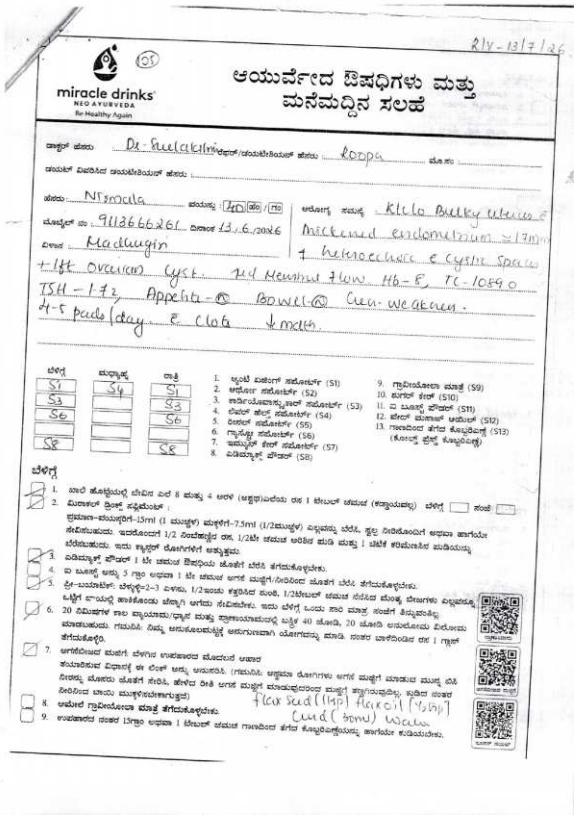
ET = 5.6mm, Ovaries - Rt = 2.1 x 1.3mm, Lt - 2.0 x 1.6mm - Pedpelvic pain. LMP - 26/8/26. LFT - (A)

ಬೆಳಿಗ್ಗೆ	ಮಧ್ಯಾಹ್ನ	ರಾತ್ರಿ
S1		S1
S4		S4
S6		S6

1. ಆ್ಯಂಟಿ ಬಯೋಟಿಕ್ ಸಪೋರ್ಟರ್ (S1)
2. ಆಫೀಸ್ ಸಪೋರ್ಟರ್ (S2)
3. ಕಾರ್ಡಿಯೋವಾಸ್ಕ್ಯುಲರ್ ಸಪೋರ್ಟರ್ (S3)
4. ಲಿವರ್ ಹೆಲ್ತ್ ಸಪೋರ್ಟರ್ (S4)
5. ಡೈಜೆಸ್ಟ್ ಸಪೋರ್ಟರ್ (S5)
6. ಗ್ಯಾಸ್ಟ್ರೋ ಸಪೋರ್ಟರ್ (S6)
7. ಇಮ್ಯೂನ್ ಕೇರ್ ಸಪೋರ್ಟರ್ (S7)
8. ವಿಡಿಮ್ಯಾಕ್ಸ್ ಪ್ಲಸ್ (S8)
9. ಗ್ಲುಮಿಲೋಜಾ ಮಾತ್ರೆ (S9)
10. ಶುಗರ್ ಕೇರ್ (S10)
11. ಐ ಬ್ಯೂಟಿ ಪ್ಲಸ್ (S11)
12. ಪೌಲ್ ಮಾಸ್ಕ್ ಆಯಿಲ್ (S12)
13. ಗಾಲಬಿಂದ ತೆಗೆದ ಕೊಬ್ಬಿನಿಂದ (S13) (ಕೊಬ್ಬಿನ ಫ್ರೀಜ್ ಕೊಬ್ಬಿನಿಂದ)

ಬೆಳಿಗ್ಗೆ

1. ಖಾಲಿ ಹೊಟ್ಟೆಯಲ್ಲಿ ಬೆಳಿಗ್ಗೆ ಎದ್ದ 5 ಮತ್ತು 4 ಆಳ (ಅಡ್ಡ)ವಿರುವ ರಂಧ್ರ 1 ಟೇಬಲ್ ಚಮಚ (ಕಾಲ್ಕುಮಾಪಲ್ಲು) ಬೆಳಿಗ್ಗೆ ☐ ಸಂಜೆ ☐
2. ಮಿಲಾಕಲ್ ಡ್ರಿಂಕ್ಸ್ ಸಪ್ಲಿಮೆಂಟ್ : ಪ್ರಮಾಣ-ಆಯಸ್ಸಿಗೆ-15ml (1 ಮುಚ್ಚಳ) ಮಕ್ಕಳಿಗೆ-7.5ml (1/2ಮುಚ್ಚಳ) ಎಲ್ಲವನ್ನು ಬೆರೆಸಿ, ಕ್ಷಲ್ಲ ನೀರಿನೊಂದಿಗೆ ಅಥವಾ ಹಾಗೆಯೇ ಸೇವಿಸಿಬಹುದು. ಇದರೊಂದಿಗೆ 1/2 ನಿಂಬೆಹಣ್ಣಿನ ರಸ, 1/2ಟೀ ಚಮಚ ಅರಿಶಿನ ಪುಡಿ ಮತ್ತು 1 ಚಿಟಿಕೆ ಕರಿಮೆಣಸನ್ನು ಸೇರಿಸಿಬಹುದು. ಇದು ಲ್ಯಾಕ್ಟೋ ಡೋಸಿಗಳಿಗೆ ಅತ್ಯುತ್ತಮ.
3. ವಿಡಿಮ್ಯಾಕ್ಸ್ ಪ್ಲಸ್ 1 ಟೀ ಚಮಚ ಜೀರಿಗೆಯ ಜೊತೆಗೆ ಬೆರೆಸಿ ತೆಗೆದುಕೊಳ್ಳಬೇಕು.
4. ಐ ಬ್ಯೂಟಿ ಪ್ಲಸ್ 5 ಗ್ರಾಂ ಅಥವಾ 1 ಟೀ ಚಮಚ ಆಗಲಿ ಮಜ್ಜಿಗೆ/ನೀರಿನಿಂದ ಜೊತೆಗೆ ಬೆರೆಸಿ ತೆಗೆದುಕೊಳ್ಳಬೇಕು.
5. ಫ್ರೀ-ಬಯೋಟಿಕ್: ಬೆಳ್ಳಗ್ಗೆ-2-3 ಎಳನೀರು, 1/2ಇಂಚು ಕತ್ತರಿಸಿದ ಶುಂಠಿ, 1/2ಟೀಸ್ಪೂನ್ ಚಮಚದ ಸಕ್ಕರೆಪುಡಿ ಮತ್ತು ಬೇಸಾಗಲು ಎಲ್ಲವನ್ನೂ ಒಟ್ಟಿಗೆ ಬಾಯಲ್ಲಿ ಜಾಕೆಕೊಂಡು ಚೆನ್ನಾಗಿ ಅಗಿದು ಸೇವಿಸಬೇಕು. ಇದು ಬೆಳಿಗ್ಗೆ ಒಂದು ಸಾರಿ ಮಾತ್ರ ಸಂಜೆಗೆ ತೆಗ್ಗುವುದಿಲ್ಲ.
6. 20 ನಿಮಿಷಗಳ ಕಾಲ ವ್ಯಾಯಾಮ/ಧ್ಯಾನ ಮತ್ತು ಪ್ರಾಣಾಯಾಮವನ್ನಲ್ಲಿ ಬಿಡದೆ 40 ಹೋಗಿ. 20 ಹೋಗಿ ಆಗುವುದಿಲ್ಲ ಮೊದಲು ಮಾಡಬೇಕು. ಗಮನಿಸಿ: ನಿಮ್ಮ ಆರೋಗ್ಯಕ್ಕಾಗಿ ಯೋಗಗಳನ್ನು ಮಾಡಿ. ಸಂತರ ಬಾಳಿರುವಿಗೆ ರಂಧ್ರ 1 ಗ್ಲಾಸ್ ತೆಗೆದುಕೊಳ್ಳಿರಿ.
7. ಆಗಾಗೆರೆಯಾದ ಮಹಿಳೆಗೆ ಬೆಳಿಗ್ಗೆ ಉಪಹಾರದ ಮೊದಲಿಗೆ ಆಹಾರ ತಂಪಾಗಿರುವ ವಿದ್ಯಾರ್ಥಿ ಈ ಲೆಂಜ್ ಅನ್ನು ಅನುಸರಿಸಿ. (ಗಮನಿಸಿ: ಅಥವಾ ಯೋಗಗಳು ಆಗದ ಮಹಿಳೆಗೆ ಮಾಡುವ ಮುನ್ನ ಬಿಸಿ ನೀರನ್ನು ಕುಡಿದು ಹೊಟ್ಟೆಗೆ ಸೇರಿಸಿ, ಹೊಳೆದ ರೀತಿ ಆಗದೆ ಮಹಿಳೆಗೆ ಮಾತನಾಡುವುದರಿಂದ ಮಹಿಳೆಗೆ ತಲ್ಲಗೆಯಾಗುವುದು, ಕುಡಿದ ನಂತರ ನೀರಿನಿಂದ ಬಾಯಿ ಮುಕ್ಕಳಿಸಬೇಕಾಗುತ್ತದೆ)
8. ಆಮೇಲೆ ಗ್ಲುಮಿಲೋಜಾ ಮಾತ್ರೆ ತೆಗೆದುಕೊಳ್ಳಬೇಕು.
9. ಉಪಹಾರದ ನಂತರ 15ನಿಮಿಷ ಆದಮೇಲೆ 1 ಟೇಬಲ್ ಚಮಚ ಗಾಲಬಿಂದ ತೆಗೆದ ಕೊಬ್ಬಿನಿಂದ ತೆಗೆದ ಕೊಬ್ಬಿನಿಂದ ಅಥವಾ ಕುಡಿಯಬೇಕು.



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ಆಯುರ್ವೇದ ಔಷಧಿಗಳು ಮತ್ತು ಮನೆಮದ್ದಿನ ಸಲಹೆ

RLV-13/7/26

ಡಾಕ್ಟರ್ ಹೆಸರು: Dr. Sreelakshmi ಕ್ಲಿನಿಕ್/ಆಯುರ್ವೇದಿಕ್ ಹೆಸರು: Roopa ಊರು:

ರಾಯಭಾರ ವಿಷಯಿತ ರಾಯಭಾರಿಯವರ ಹೆಸರು:

ಹೆಸರು: Nirmala ವಯಸ್ಸು: 39 ಪುರುಷ / ಸ್ತ್ರೀ

ಮೊಬೈಲ್ ನಂ: 9113666261 ದಿನಾಂಕ: 13/6/2026

ವಿಳಾಸ: Madhugiri

ಆರೋಗ್ಯ ಸಮಸ್ಯೆ: Klclo Bulky uterus & thickened endometrium = 17mm + heterocchaic & cystic spaces + lft Ovarian Cyst. 1cm Hemmat 7cm Hb-8, TC-10590 TSH-1.72, Appetite - ⊘ Bowel - ⊘ Uen-weakness. 4-5 pads/day. & clots & more.

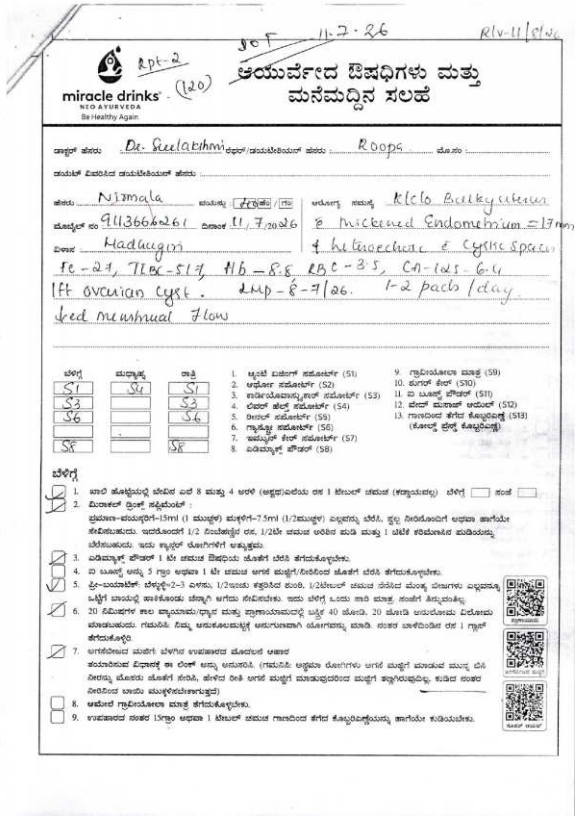
ಬೆಳಿಗ್ಗೆ	ಮಧ್ಯಾಹ್ನ	ರಾತ್ರಿ
S1	S4	S1
S3		S3
S6		S6
S8		S8

1. ಆ್ಯಂಟಿ ಬಯೋಟಿಕ್ ಸಪೋರ್ಟರ್ (S1)
2. ಆಫೀಸ್ ಸಪೋರ್ಟರ್ (S2)
3. ಕಾರ್ಡಿಯೋವಾಸ್ಕ್ಯುಲರ್ ಸಪೋರ್ಟರ್ (S3)
4. ಲಿವರ್ ಹೆಲ್ತ್ ಸಪೋರ್ಟರ್ (S4)
5. ಡೈಜೆಸ್ಟ್ ಸಪೋರ್ಟರ್ (S5)
6. ಗ್ಯಾಸ್ಟ್ರೋ ಸಪೋರ್ಟರ್ (S6)
7. ಇಮ್ಯೂನ್ ಕೇರ್ ಸಪೋರ್ಟರ್ (S7)
8. ವಿಡಿಮ್ಯಾಕ್ಸ್ ಪ್ಲಸ್ (S8)
9. ಗ್ಲುಮಿಲೋಜಾ ಮಾತ್ರೆ (S9)
10. ಶುಗರ್ ಕೇರ್ (S10)
11. ಐ ಬ್ಯೂಟಿ ಪ್ಲಸ್ (S11)
12. ಪೌಲ್ ಮಾಸ್ಕ್ ಆಯಿಲ್ (S12)
13. ಗಾಲಬಿಂದ ತೆಗೆದ ಕೊಬ್ಬಿನಿಂದ (S13) (ಕೊಬ್ಬಿನ ಫ್ರೀಜ್ ಕೊಬ್ಬಿನಿಂದ)

ಬೆಳಿಗ್ಗೆ

1. ಖಾಲಿ ಹೊಟ್ಟೆಯಲ್ಲಿ ಬೆಳಿಗ್ಗೆ ಎದ್ದ 5 ಮತ್ತು 4 ಆಳ (ಅಡ್ಡ)ವಿರುವ ರಂಧ್ರ 1 ಟೇಬಲ್ ಚಮಚ (ಕಾಲ್ಕುಮಾಪಲ್ಲು) ಬೆಳಿಗ್ಗೆ ☐ ಸಂಜೆ ☐
2. ಮಿಲಾಕಲ್ ಡ್ರಿಂಕ್ಸ್ ಸಪ್ಲಿಮೆಂಟ್ : ಪ್ರಮಾಣ-ಆಯಸ್ಸಿಗೆ-15ml (1 ಮುಚ್ಚಳ) ಮಕ್ಕಳಿಗೆ-7.5ml (1/2ಮುಚ್ಚಳ) ಎಲ್ಲವನ್ನು ಬೆರೆಸಿ, ಕ್ಷಲ್ಲ ನೀರಿನೊಂದಿಗೆ ಅಥವಾ ಹಾಗೆಯೇ ಸೇವಿಸಿಬಹುದು. ಇದರೊಂದಿಗೆ 1/2 ನಿಂಬೆಹಣ್ಣಿನ ರಸ, 1/2ಟೀ ಚಮಚ ಅರಿಶಿನ ಪುಡಿ ಮತ್ತು 1 ಚಿಟಿಕೆ ಕರಿಮೆಣಸನ್ನು ಸೇರಿಸಿಬಹುದು. ಇದು ಲ್ಯಾಕ್ಟೋ ಡೋಸಿಗಳಿಗೆ ಅತ್ಯುತ್ತಮ.
3. ವಿಡಿಮ್ಯಾಕ್ಸ್ ಪ್ಲಸ್ 1 ಟೀ ಚಮಚ ಜೀರಿಗೆಯ ಜೊತೆಗೆ ಬೆರೆಸಿ ತೆಗೆದುಕೊಳ್ಳಬೇಕು.
4. ಐ ಬ್ಯೂಟಿ ಪ್ಲಸ್ 5 ಗ್ರಾಂ ಅಥವಾ 1 ಟೀ ಚಮಚ ಆಗಲಿ ಮಜ್ಜಿಗೆ/ನೀರಿನಿಂದ ಜೊತೆಗೆ ಬೆರೆಸಿ ತೆಗೆದುಕೊಳ್ಳಬೇಕು.
5. ಫ್ರೀ-ಬಯೋಟಿಕ್: ಬೆಳ್ಳಗ್ಗೆ-2-3 ಎಳನೀರು, 1/2ಇಂಚು ಕತ್ತರಿಸಿದ ಶುಂಠಿ, 1/2ಟೀಸ್ಪೂನ್ ಚಮಚದ ಸಕ್ಕರೆಪುಡಿ ಮತ್ತು ಬೇಸಾಗಲು ಎಲ್ಲವನ್ನೂ ಒಟ್ಟಿಗೆ ಬಾಯಲ್ಲಿ ಜಾಕೆಕೊಂಡು ಚೆನ್ನಾಗಿ ಅಗಿದು ಸೇವಿಸಬೇಕು. ಇದು ಬೆಳಿಗ್ಗೆ ಒಂದು ಸಾರಿ ಮಾತ್ರ ಸಂಜೆಗೆ ತೆಗ್ಗುವುದಿಲ್ಲ.
6. 20 ನಿಮಿಷಗಳ ಕಾಲ ವ್ಯಾಯಾಮ/ಧ್ಯಾನ ಮತ್ತು ಪ್ರಾಣಾಯಾಮವನ್ನಲ್ಲಿ ಬಿಡದೆ 40 ಹೋಗಿ. 20 ಹೋಗಿ ಆಗುವುದಿಲ್ಲ ಮೊದಲು ಮಾಡಬೇಕು. ಗಮನಿಸಿ: ನಿಮ್ಮ ಆರೋಗ್ಯಕ್ಕಾಗಿ ಯೋಗಗಳನ್ನು ಮಾಡಿ. ಸಂತರ ಬಾಳಿರುವಿಗೆ ರಂಧ್ರ 1 ಗ್ಲಾಸ್ ತೆಗೆದುಕೊಳ್ಳಿರಿ.
7. ಆಗಾಗೆರೆಯಾದ ಮಹಿಳೆಗೆ ಬೆಳಿಗ್ಗೆ ಉಪಹಾರದ ಮೊದಲಿಗೆ ಆಹಾರ ತಂಪಾಗಿರುವ ವಿದ್ಯಾರ್ಥಿ ಈ ಲೆಂಜ್ ಅನ್ನು ಅನುಸರಿಸಿ. (ಗಮನಿಸಿ: ಅಥವಾ ಯೋಗಗಳು ಆಗದ ಮಹಿಳೆಗೆ ಮಾಡುವ ಮುನ್ನ ಬಿಸಿ ನೀರನ್ನು ಕುಡಿದು ಹೊಟ್ಟೆಗೆ ಸೇರಿಸಿ, ಹೊಳೆದ ರೀತಿ ಆಗದೆ ಮಹಿಳೆಗೆ ಮಾತನಾಡುವುದರಿಂದ ಮಹಿಳೆಗೆ ತಲ್ಲಗೆಯಾಗುವುದು, ಕುಡಿದ ನಂತರ ನೀರಿನಿಂದ ಬಾಯಿ ಮುಕ್ಕಳಿಸಬೇಕಾಗುತ್ತದೆ)
8. ಆಮೇಲೆ ಗ್ಲುಮಿಲೋಜಾ ಮಾತ್ರೆ ತೆಗೆದುಕೊಳ್ಳಬೇಕು.
9. ಉಪಹಾರದ ನಂತರ 15ನಿಮಿಷ ಆದಮೇಲೆ 1 ಟೇಬಲ್ ಚಮಚ ಗಾಲಬಿಂದ ತೆಗೆದ ಕೊಬ್ಬಿನಿಂದ ತೆಗೆದ ಕೊಬ್ಬಿನಿಂದ ಅಥವಾ ಕುಡಿಯಬೇಕು.

flax seed (1tsp) flaxoil (1tsp) Curd (50ml) Water



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ಆಯುರ್ವೇದ ಔಷಧಿಗಳು ಮತ್ತು ಮನೆಮದ್ದಿನ ಸಲಹೆ

DOT: 11.7.26 RLV-11/9/26

Rpt-2 (120)

ಡಾಕ್ಟರ್ ಹೆಸರು: Dr. Sreelakshmi ಕ್ಲಿನಿಕ್/ಆಯುರ್ವೇದಿಕ್ ಹೆಸರು: Roops ಊರು:

ರಾಯಭಾರ ವಿಷಯಿತ ರಾಯಭಾರಿಯವರ ಹೆಸರು:

ಹೆಸರು: Nirmala ವಯಸ್ಸು: 39 ಪುರುಷ / ಸ್ತ್ರೀ

ಮೊಬೈಲ್ ನಂ: 9113666261 ದಿನಾಂಕ: 11/7/2026

ವಿಳಾಸ: Madhugiri

ಆರೋಗ್ಯ ಸಮಸ್ಯೆ: Klclo Bulky uterus & thickened Endometrium = 17mm + heterocchaic & cystic spaces

Fe-21, TIBC-517, Hb-8.8, RBC-3.5, CA-12.5-6.4

lft ovarian cyst. LMP-8-7/26. 1-2 pads/day

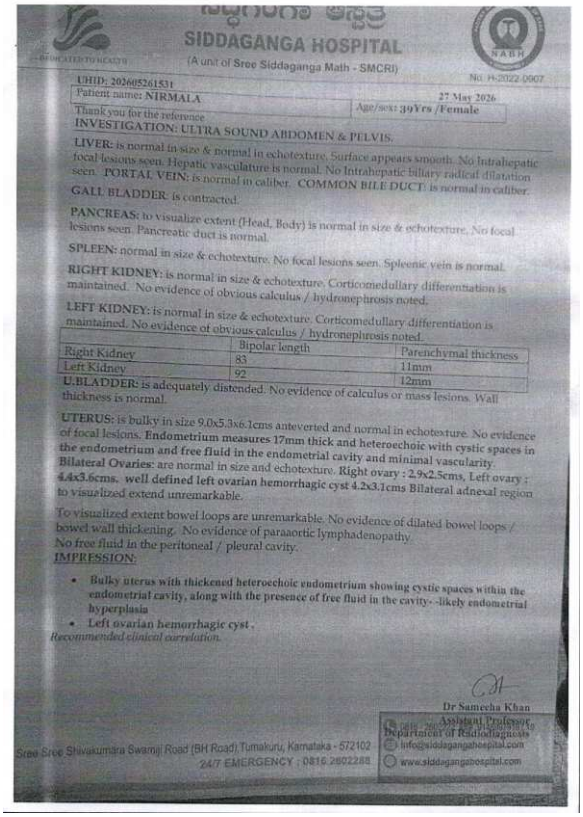
Med menstrual flow

ಬೆಳಿಗ್ಗೆ	ಮಧ್ಯಾಹ್ನ	ರಾತ್ರಿ
S1	S4	S1
S3		S3
S6		S6
S8		S8

1. ಆ್ಯಂಟಿ ಬಯೋಟಿಕ್ ಸಪೋರ್ಟರ್ (S1)
2. ಆಫೀಸ್ ಸಪೋರ್ಟರ್ (S2)
3. ಕಾರ್ಡಿಯೋವಾಸ್ಕ್ಯುಲರ್ ಸಪೋರ್ಟರ್ (S3)
4. ಲಿವರ್ ಹೆಲ್ತ್ ಸಪೋರ್ಟರ್ (S4)
5. ಡೈಜೆಸ್ಟ್ ಸಪೋರ್ಟರ್ (S5)
6. ಗ್ಯಾಸ್ಟ್ರೋ ಸಪೋರ್ಟರ್ (S6)
7. ಇಮ್ಯೂನ್ ಕೇರ್ ಸಪೋರ್ಟರ್ (S7)
8. ವಿಡಿಮ್ಯಾಕ್ಸ್ ಪ್ಲಸ್ (S8)
9. ಗ್ಲುಮಿಲೋಜಾ ಮಾತ್ರೆ (S9)
10. ಶುಗರ್ ಕೇರ್ (S10)
11. ಐ ಬ್ಯೂಟಿ ಪ್ಲಸ್ (S11)
12. ಪೌಲ್ ಮಾಸ್ಕ್ ಆಯಿಲ್ (S12)
13. ಗಾಲಬಿಂದ ತೆಗೆದ ಕೊಬ್ಬಿನಿಂದ (S13) (ಕೊಬ್ಬಿನ ಫ್ರೀಜ್ ಕೊಬ್ಬಿನಿಂದ)

ಬೆಳಿಗ್ಗೆ

1. ಖಾಲಿ ಹೊಟ್ಟೆಯಲ್ಲಿ ಬೆಳಿಗ್ಗೆ ಎದ್ದ 5 ಮತ್ತು 4 ಆಳ (ಅಡ್ಡ)ವಿರುವ ರಂಧ್ರ 1 ಟೇಬಲ್ ಚಮಚ (ಕಾಲ್ಕುಮಾಪಲ್ಲು) ಬೆಳಿಗ್ಗೆ ☐ ಸಂಜೆ ☐
2. ಮಿಲಾಕಲ್ ಡ್ರಿಂಕ್ಸ್ ಸಪ್ಲಿಮೆಂಟ್ : ಪ್ರಮಾಣ-ಆಯಸ್ಸಿಗೆ-15ml (1 ಮುಚ್ಚಳ) ಮಕ್ಕಳಿಗೆ-7.5ml (1/2ಮುಚ್ಚಳ) ಎಲ್ಲವನ್ನು ಬೆರೆಸಿ, ಕ್ಷಲ್ಲ ನೀರಿನೊಂದಿಗೆ ಅಥವಾ ಹಾಗೆಯೇ ಸೇವಿಸಿಬಹುದು. ಇದರೊಂದಿಗೆ 1/2 ನಿಂಬೆಹಣ್ಣಿನ ರಸ, 1/2ಟೀ ಚಮಚ ಅರಿಶಿನ ಪುಡಿ ಮತ್ತು 1 ಚಿಟಿಕೆ ಕರಿಮೆಣಸನ್ನು ಸೇರಿಸಿಬಹುದು. ಇದು ಲ್ಯಾಕ್ಟೋ ಡೋಸಿಗಳಿಗೆ ಅತ್ಯುತ್ತಮ.
3. ವಿಡಿಮ್ಯಾಕ್ಸ್ ಪ್ಲಸ್ 1 ಟೀ ಚಮಚ ಜೀರಿಗೆಯ ಜೊತೆಗೆ ಬೆರೆಸಿ ತೆಗೆದುಕೊಳ್ಳಬೇಕು.
4. ಐ ಬ್ಯೂಟಿ ಪ್ಲಸ್ 5 ಗ್ರಾಂ ಅಥವಾ 1 ಟೀ ಚಮಚ ಆಗಲಿ ಮಜ್ಜಿಗೆ/ನೀರಿನಿಂದ ಜೊತೆಗೆ ಬೆರೆಸಿ ತೆಗೆದುಕೊಳ್ಳಬೇಕು.
5. ಫ್ರೀ-ಬಯೋಟಿಕ್: ಬೆಳ್ಳಗ್ಗೆ-2-3 ಎಳನೀರು, 1/2ಇಂಚು ಕತ್ತರಿಸಿದ ಶುಂಠಿ, 1/2ಟೀಸ್ಪೂನ್ ಚಮಚದ ಸಕ್ಕರೆಪುಡಿ ಮತ್ತು ಬೇಸಾಗಲು ಎಲ್ಲವನ್ನೂ ಒಟ್ಟಿಗೆ ಬಾಯಲ್ಲಿ ಜಾಕೆಕೊಂಡು ಚೆನ್ನಾಗಿ ಅಗಿದು ಸೇವಿಸಬೇಕು. ಇದು ಬೆಳಿಗ್ಗೆ ಒಂದು ಸಾರಿ ಮಾತ್ರ ಸಂಜೆಗೆ ತೆಗ್ಗುವುದಿಲ್ಲ.
6. 20 ನಿಮಿಷಗಳ ಕಾಲ ವ್ಯಾಯಾಮ/ಧ್ಯಾನ ಮತ್ತು ಪ್ರಾಣಾಯಾಮವನ್ನಲ್ಲಿ ಬಿಡದೆ 40 ಹೋಗಿ. 20 ಹೋಗಿ ಆಗುವುದಿಲ್ಲ ಮೊದಲು ಮಾಡಬೇಕು. ಗಮನಿಸಿ: ನಿಮ್ಮ ಆರೋಗ್ಯಕ್ಕಾಗಿ ಯೋಗಗಳನ್ನು ಮಾಡಿ. ಸಂತರ ಬಾಳಿರುವಿಗೆ ರಂಧ್ರ 1 ಗ್ಲಾಸ್ ತೆಗೆದುಕೊಳ್ಳಿರಿ.
7. ಆಗಾಗೆರೆಯಾದ ಮಹಿಳೆಗೆ ಬೆಳಿಗ್ಗೆ ಉಪಹಾರದ ಮೊದಲಿಗೆ ಆಹಾರ ತಂಪಾಗಿರುವ ವಿದ್ಯಾರ್ಥಿ ಈ ಲೆಂಜ್ ಅನ್ನು ಅನುಸರಿಸಿ. (ಗಮನಿಸಿ: ಅಥವಾ ಯೋಗಗಳು ಆಗದ ಮಹಿಳೆಗೆ ಮಾಡುವ ಮುನ್ನ ಬಿಸಿ ನೀರನ್ನು ಕುಡಿದು ಹೊಟ್ಟೆಗೆ ಸೇರಿಸಿ, ಹೊಳೆದ ರೀತಿ ಆಗದೆ ಮಹಿಳೆಗೆ ಮಾತನಾಡುವುದರಿಂದ ಮಹಿಳೆಗೆ ತಲ್ಲಗೆಯಾಗುವುದು, ಕುಡಿದ ನಂತರ ನೀರಿನಿಂದ ಬಾಯಿ ಮುಕ್ಕಳಿಸಬೇಕಾಗುತ್ತದೆ)
8. ಆಮೇಲೆ ಗ್ಲುಮಿಲೋಜಾ ಮಾತ್ರೆ ತೆಗೆದುಕೊಳ್ಳಬೇಕು.
9. ಉಪಹಾರದ ನಂತರ 15ನಿಮಿಷ ಆದಮೇಲೆ 1 ಟೇಬಲ್ ಚಮಚ ಗಾಲಬಿಂದ ತೆಗೆದ ಕೊಬ್ಬಿನಿಂದ ತೆಗೆದ ಕೊಬ್ಬಿನಿಂದ ಅಥವಾ ಕುಡಿಯಬೇಕು.



ಸಿದ್ಧಗಂಗಾ ಆಸ್ಪತ್ರೆ

SIDDAGANGA HOSPITAL

(A unit of Sree Siddaganga Math - SMCRI)

EDUCATION TO HEALTH

NABH

No. H-2022-0007

UHID: 20260526153 1

Patient name: NIRMALA 27 May 2026

Age/sex: 39Yrs /Female

Thank you for the reference

INVESTIGATION: ULTRA SOUND ABDOMEN & PELVIS.

LIVER: is normal in size & normal in echotexture. Surface appears smooth. No Intrahepatic focal lesions seen. Hepatic vasculature is normal. No Intrahepatic biliary radical dilatation seen. **PORTAL VEIN:** is normal in caliber. **COMMON BILE DUCT:** is normal in caliber.

GALL BLADDER: is contracted.

PANCREAS: to visualize extent (Head, Body) is normal in size & echotexture. No focal lesions seen. Pancreatic duct is normal.

SPLEEN: normal in size & echotexture. No focal lesions seen. Splenic vein is normal.

RIGHT KIDNEY: is normal in size & echotexture. Corticomedullary differentiation is maintained. No evidence of obvious calculus / hydronephrosis noted.

LEFT KIDNEY: is normal in size & echotexture. Corticomedullary differentiation is maintained. No evidence of obvious calculus / hydronephrosis noted.

	Bipolar length	Parenchymal thickness
Right Kidney	83	11mm
Left Kidney	92	12mm

U.BLADDER: is adequately distended. No evidence of calculus or mass lesions. Wall thickness is normal.

UTERUS: is bulky in size 9.0x5.3x6.1cms anteverted and normal in echotexture. No evidence of focal lesions. **Endometrium measures 17mm thick and heterochoic with cystic spaces in the endometrium and free fluid in the endometrial cavity and minimal vascularity. Bilateral Ovaries:** are normal in size and echotexture. **Right ovary : 2.9x2.5cms, Left ovary : 4.4x3.6cms. well defined left ovarian hemorrhagic cyst 4.2x3.1cms** Bilateral adnexal region to visualized extend unremarkable.

To visualized extent bowel loops are unremarkable. No evidence of dilated bowel loops / bowel wall thickening. No evidence of paraaortic lymphadenopathy.

No free fluid in the peritoneal / pleural cavity.

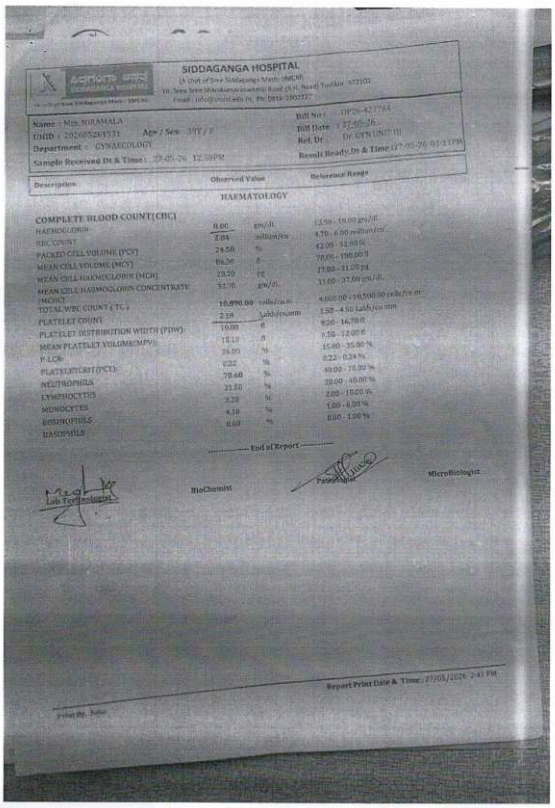
IMPRESSION:

- **Bulky uterus with thickened heterochoic endometrium showing cystic spaces within the endometrial cavity, along with the presence of free fluid in the cavity - likely endometrial hyperplasia**
- **Left ovarian hemorrhagic cyst .**

Recommended clinical correlation.

Dr Samecha Khan
Assistant Professor
Department of Radiodiagnosis

Sree Sree Shivakumara Swamiji Road (BH Road) Tumakuru, Karnataka - 572102
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SIDDAGANGA HOSPITAL

(A Unit of Sree Siddaganga Math - SMCRI)

Dr. Sree Sree Shivakumar swamiji Road (B.H. Road) Tumkur - 572102

Email : info@smcri.edu.in, Ph: 0816-2002222

Name : Mrs. NIRAMALA
UHID : 202605261531 Age / Sex : 39Y / F
Department : GYNAECOLOGY
Sample Received Dt & Time : 27-05-26 12:58PM

Bill No : OP26-427764
Bill Date : 27-05-26
Ref. Dr : Dr. GYN UNIT III
Result Ready Dt & Time 27-05-26 01:37PM

Description	Observed Value	Reference Range

HAEMATOLOGY

COMPLETE BLOOD COUNT(CBC)

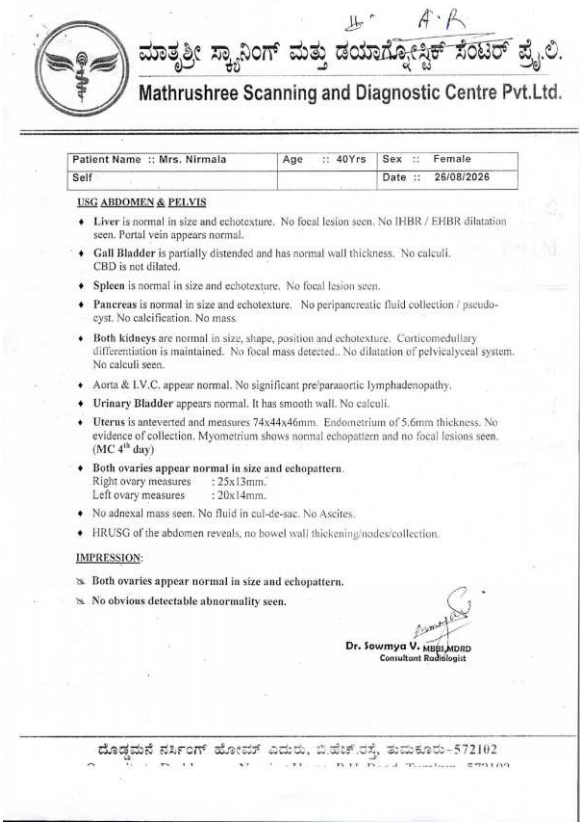
HAEMOGLOBIN	8.00	gm/dl	12.00 - 16.00 gm/dl
RBC COUNT	3.04	million/cu	4.70 - 6.00 million/cu
PACKED CELL VOLUME (PCV)	28.50	%	42.00 - 52.00 %
MEAN CELL VOLUME (MCV)	93.70	fl	70.00 - 100.00 fl
MEAN CELL HAEMOGLOBIN (MCH)	23.20	pg	27.00 - 31.20 pg
MEAN CELL HAEMOGLOBIN CONCENTRATE (MCHC)	32.70	gm/dl	31.00 - 37.00 gm/dl
TOTAL WBC COUNT (TC)	10,890.00	cells/cu.m	4,000.00 - 10,500.00 cells/cu.m
PLATELET COUNT	2.16	Lakh/cumm	1.50 - 4.50 Lakh/cu.mm
PLATELET DISTRIBUTION WIDTH (PDW)	10.00	fl	9.00 - 16.70 fl
MEAN PLATELET VOLUME(MPV)	12.10	fl	7.50 - 12.00 fl
P-LCR	26.00	%	15.00 - 35.00 %
PLATELETCRIT (PCT)	0.22	%	0.22 - 0.24 %
NEUTROPHILS	70.60	%	40.00 - 70.00 %
LYMPHOCYTES	21.50	%	20.00 - 40.00 %
MONOCYTES	3.20	%	2.00 - 10.00 %
EOSINOPHILS	4.10	%	1.00 - 6.00 %
BASOPHILS	0.60	%	0.00 - 1.00 %

End of Report

Lab Technologist | BioChemist | Pathologist | MicroBiologist

Report Print Date & Time : 27/05/2026 2:41 PM

Print By : Nalini



ಮಾತೃಶ್ರೀ ಸ್ಕ್ಯಾನಿಂಗ್ ಮತ್ತು ಡಯಾಗ್ನೋಸ್ಟಿಕ್ ಸೆಂಟರ್ ಪ್ರೈ.ಲಿ.

Mathrushree Scanning and Diagnostic Centre Pvt.Ltd.

Patient Name :: Mrs. Nirmala	Age :: 40Yrs	Sex :: Female
Self		Date :: 26/08/2026

USG ABDOMEN & PELVIS

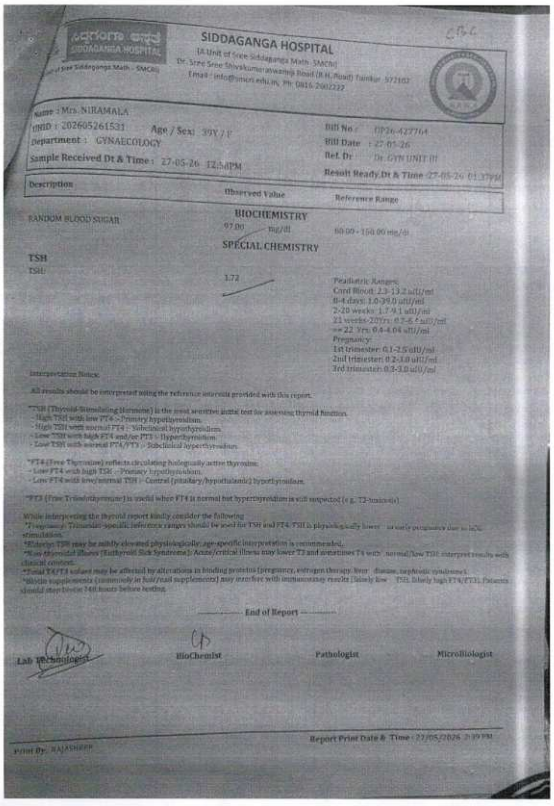
- **Liver** is normal in size and echotexture. No focal lesion seen. No IHBR / EHBR dilatation seen. Portal vein appears normal.
- **Gall Bladder** is partially distended and has normal wall thickness. No calculi. CBD is not dilated.
- **Spleen** is normal in size and echotexture. No focal lesion seen.
- **Pancreas** is normal in size and echotexture. No peripancreatic fluid collection / pseudo-cyst. No calcification. No mass.
- **Both kidneys** are normal in size, shape, position and echotexture. Corticomedullary differentiation is maintained. No focal mass detected.. No dilatation of pelvicalyceal system. No calculi seen.
- Aorta & I.V.C. appear normal. No significant pre/paraaortic lymphadenopathy.
- **Urinary Bladder** appears normal. It has smooth wall. No calculi.
- **Uterus** is anteverted and measures 74x44x46mm. Endometrium of 5.6mm thickness. No evidence of collection. Myometrium shows normal echopattern and no focal lesions seen. **(MC 4th day)**
- **Both ovaries appear normal in size and echopattern.**
  Right ovary measures : 25x13mm.
  Left ovary measures : 20x14mm.
- No adnexal mass seen. No fluid in cul-de-sac. No Ascites.
- HRUSG of the abdomen reveals, no bowel wall thickening/nodes/collection.

IMPRESSION:

- **Both ovaries appear normal in size and echopattern.**
- **No obvious detectable abnormality seen.**

Dr. Sowmya V. MBBS,MDRD
Consultant Radiologist

ದೊಡ್ಡಮನೆ ಸರ್ಕಾಂಗ್ ಜೋಯ್ ಎದುರು, ಬಿ.ಹೆಚ್.ರಸ್ತೆ, ತುಮಕೂರು-572102



SIDDAGANGA HOSPITAL

(A Unit of Sree Siddaganga Math - SMCRI)

Dr. Sree Sree Shivakumar swamiji Road (B.H. Road) Tumkur - 572102

Email : info@smcri.edu.in, Ph: 0816-2002222

Name : Mrs. NIRAMALA
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Result Ready Dt & Time 27-05-26 01:37PM

Description	Observed Value	Reference Range
RANDOM BLOOD SUGAR	97.00 mg/dl	60.00 - 150.00 mg/dl

BIOCHEMISTRY

SPECIAL CHEMISTRY

TSH

TSH: 3.72

Paediatric Ranges:
Cord Blood: 2.3 - 13.2 uIU/ml
0-4 days: 1.0-39.0 uIU/ml
2-20 weeks: 1.7-9.1 uIU/ml
21 weeks-20Yrs: 0.7-6.4 uIU/ml
>= 22 Yrs: 0.4-4.04 uIU/ml
Pregnancy:
1st trimester: 0.1-2.5 uIU/ml
2nd trimester: 0.2-3.0 uIU/ml
3rd trimester: 0.3-3.0 uIU/ml

Interpretative Notes:

All results should be interpreted using the reference intervals provided with this report.

*TSH (Thyroid-Stimulating Hormone) is the most sensitive initial test for assessing thyroid function.
- High TSH with low FT4 → Primary hypothyroidism.
- High TSH with normal FT4 → Subclinical hypothyroidism.
- Low TSH with high FT4 and/or FT3 → Hyperthyroidism.
- Low TSH with normal FT4/FT3 → Subclinical hyperthyroidism.

*FT4 (Free Thyroxine) reflects circulating biologically active thyroxine.
- Low FT4 with high TSH → Primary hypothyroidism.
- Low FT4 with low/normal TSH → Central (pituitary/hypothalamic) hypothyroidism.

*FT3 (Free Triiodothyronine) is useful when FT4 is normal but hyperthyroidism is still suspected (e.g. T3-toxicosis).

While interpreting the thyroid report kindly consider the following:
*Pregnancy: Trimester-specific reference ranges should be used for TSH and FT4. TSH is physiologically lower in early pregnancy due to hCG stimulation.
*Elderly: TSH may be mildly elevated physiologically; age-specific interpretation is recommended.
*Acute Abdominal Illness (Euthyroid Sick Syndrome): Acute/critical illness may lower T3 and sometimes T4 with normal/low TSH; interpret results with clinical context.
*Total FT3/FT4 values may be affected by alterations in binding proteins (pregnancy, estrogen therapy, liver disease, nephrotic syndrome).
*Biotin supplements (commonly in hair/nail supplements) may interfere with immunoassay results (falsely low TSH, falsely high FT4/FT3). Patients should stop biotin 7-10 hours before testing.

End of Report

Lab Technologist | BioChemist | Pathologist | MicroBiologist

Report Print Date & Time : 27/05/2026 2:39 PM

Print By : RAJASHREE

