# SUCCESSFUL MANAGEMENT OF POLYCYSTIC OVARIAN DISEASE WITH KANCHANAR GUGGULU AND CHANDRAPRABHA VATI: A CASE REPORT

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**Received:**1stOctober,2026; **Revised:**5thOctober,2026; **Accepted:**8thOctober,2026; **Available Online:**20thOctober, 2026

**Abstract**
oligomenorrhoea (cycle interval 45-60 days, flow 1-2days), lower abdominal heaviness, facial acne and 4.5 kg weight gain. Pelvic ultrasonography on 11th October 2023 showed bilaterally enlarged ovaries with numerous peripheral subcentimetric follicles and prominent central stroma, confirming polycystic ovarian disease; She fulfilled two of three Rotterdam criteria in the absence of clinical hyperandrogenism. She declined hormonal therapy and received *Kanchanar Guggulu* 1,000 mg twice daily and Chandraprabha Vati 1,000 mg twice daily with lukewarm water, alongside diet and yoga, for 15 weeks (108 days). Menstrual rhythm normalised progressively (day 35 at week 5, day 31 at week 10, and a 29 -day cycle with 4-5 days of flow at week 15); weight fell from 66.0 to 63.5 kg (BMI 26.4 to 25.4 kg/m$^2$) and repeat ultrasonography on 27 January 2024 showed complete morphological resolution – right ovary 28×15 mm, left ovary 29×15 mm, 5 mm endometrium. No adverse events occurred. This case illustrates that classical Ayurvedic Shamana therapy with lifestyle correction can reverse polycystic ovarian morphology, while highlighting the need for biochemical exclusion of mimics and for controlled studies.

**KEY WORDS:** Polycystic ovarian disease; *Artava Kshaya; Kaphaja Granthi; Kanchanar Guggulu; Chandraprabha Vati;* ultrasonography; case report.
**How to cite this article:** Bera A, Deb B, Mohanta SS, Das A, Nayak A., Successful Management of Polycystic Ovarian Disease with Kanchanar Guggulu and Chandraprabha Vati: A Case Report. Int J Drug Deliv Technol. 2026;16(89s): 1245-1249; DOI: 10.25258/ijddt.16.89s.129

## Introduction

Polycystic ovarian disease, overlapping the polycystic ovary syndrome spectrum, is the commonest endocrine disorder of women of reproduction age and a frequent cause of oligomenorrhoea and anovulatory infertility. Reported prevalence depends on the criteria applied:8-13% by Rotterdam criteria versus 6% by National Institute of Health and 10% by AE-PCOS Society criteria **[1];** 4-8 % under NIH/NICHD definitions, with Rotterdam-based estimates two to three times higher **[2];** and 2.2% to 26% across countries **[3].** In the first community-based study using current Rotterdam criteria, prevalence was 18%, 70% of affected women were undiagnosed, and 28 % of unselected obese versus 5% of lean women were affected **[4].**

Conventional management centres on combined oral contraceptive, progestins, antiandrogens such as

spironolactone and cyproterone acetate, and insulin sensitisers such as metformin, which remains the comparator in current randomised trials of Ayurvedic regimens **[5].** Fear of side effects and adverse effects of allopathic medicines leads some women with PCOS to prefer Ayurvedic treatment **[6].** Ayurvedic aligns the presentation with *Artava Kshaya, Kaphaja Granthi* and *Pushpaghni Jataharini* of *the Kashyapa Samhita;* its *samprapti* proceeds from *jatharagnimandya* and *Aama* through Srotorodha to *Apana Vata* dysfunction, so therapy targets Lekhana, Bhedana, Deepana- Pachana and Vatanulomana. We report a young woman whose polycystic ovarian morphology resolved completely after 15 weeks of oral Kanchanar Guggulu and

Chandraprabha Vati with diet and Yoga, and discuss the diagnostic and therapeutic learning points, in accordance with the care guideline **[7].**

**PATIENT INFORMATION:** A 23-year-old unmarried female graduate student from Bargarh, Odisha, India, presented with an 18-month history of irregular, delayed menstruation (cycle interval 45-60 days) and scanty flow lasting 1-2 days, requiring one lightly stained pad daily. She also reported lower abdominal heaviness and dull premenstrual pelvic aching, involuntary weight gain of approximately 4.5 kg over 12 months, and persistent acne over the chin and jawline. Menarche occurred at 13 years with previously regular 28-30day cycles; deterioration coincide with academic stress and a sedentary lifestyle. She had never used hormonal contraceptives or metformin and preferred a non – hormonal approach. There was no history of diabetes, hypertension, thyroid dysfunction or tuberculosis, no surgery, and no maternal history of PCOS, early menopause or metabolic syndrome. Her diet featured irregular meal timings, refined and deep-fried foods, daytime napping and minimal physical activity.

**CLINICAL FINDINGS:** General examination: hight 158cm, wight66.o kg, BMI 26.4 kg/m$^2$(overweight by Asia-Pacific WHO criteria), blood pressure 118/76mmHg, pulse 74 beats per minute, respiratory rate 16 per minutes. No pallor, icterus, cyanosis, clubbing, oedema or lymphadenopathy. Grade I facial acne and subtle posterior neck hyperpigmentation suggesting early acanthosis nigricans were present; the modified Ferriman-Gallwey score was 4/36, indicating no frank hirsutism. Systemic examination was normal and pelvic examination was deferred as the patient was unmarried. Ayurvedic assessment showed Manda- *Gambhira Nadi, Saama Jihwa* (circulating *Aama*), *Vibandha* with *krura Koshtha, Madhyam - Sthoola Akruti, and Kapha-Vataja Prakriti with Meda-Sara* constitution.

**TIMELINE:** The sequence of events was as follows. (Table 1)

**Table 1: The sequence of events.**

| Date | Events |
|---|---|
| 11 October 2023 | • Initial Consultation at IPGAE &R AT SVSP HOSPITAL KOL-09<br>• Menstrual cycle: 45-60 days; flow duration: 1-2 days (scanty).<br>• Baseline USG Pelvis: Uterus 7.4 x 3.4 cm; Bilateral polycystic ovaries. |
| 14 October 2023 | • Initiation of Ayurvedic Shamana Therapy<br>• *Kanchanar Guggulu*: 1,000 mg BID with lukewarm water before meals.<br>• Chandraprabha Vati: 1,000 mg BID with lukewarm water before meals.<br>• Lifestyle regimen: Pathya Ahara, 45 min daily brisk walking/*Yogasanas* |
| 18 November 2023 | • 1$^{st}$ Interim Follow-Up (Week 5)<br>• Withdrawal bleeding observed at Day 35 of cycle; flow duration 3 days.<br>• Bowel evacuation normalized; reduction in postprandial heaviness |
| 23 December 2023 | • 2nd Interim Follow-Up (Week 10)<br>• Menstrual cycle occurred at Day 31; flow lasted 4 days (normal red, no clots).<br>• Weight: 64.8 kg (loss of 1.2 kg); facial acne visibly reduced. |
| 27 January 2024 | • Final Follow-Up & Confirmatory USG (Week 15)<br>• Menstrual cycle: 29 days; flow lasted 4-5 days; no pelvic dysmenorrhea. Weight: 63.5 kg (total loss: 2.5 kg; BMI 25.4 kg/m²).<br>• Follow-up USG Pelvis: Uterus 79 x 34 mm, endometrium 5 mm;<br>• Bilateral ovaries completely normal in size (Rt: 28×15 mm, Lt: 29×15 mm); Conclusion: Normal Pelvic scan (Complete resolution of PCOD) |

**DIAGNOSTIC ASSESSMENT:** Diagnosis rested on clinical evaluation and transabdominal ultrasonography at a single accredited unit; biochemical testing was not performed because of financial constraints. Baseline Ultrasonography (11th oct 2023) showed a normal uterus of 7.4×3.4 cm with homogenous myometrium and bilaterally enlarged ovaries with echogenic central stroma and more than 12 sub centimetric peripheral follicles of 2-8 mm in the classical "string-of-pearls" pattern; extra-pelvic and adnexal finding were normal. Two of the three Rotterdam criteria were satisfied- oligo-ovulation and polycystic ovarian morphology-without clinical hyperandrogenism. Sonographic thresholds are method-dependent-ovarian volume of 7cm$^3$ (87% sensitivity, 89% specificity), follicle number per ovary of 26(85%, 94%) and ovarian volume of 10 cm$^3$ (81%, 84%) **[2]-** which is why the qualitative appearance anchored the diagnosis. In *Ayurvedic* terms this was *Artava Kshaya* secondary to *Kaphaja- Medovaha Srotorodha* with *Apana Vata avarodha.* PCOS is a diagnosis of exclusion: non-Classic congenital adrenal hyperplasia can closely mimic the syndrome, and pregnancy,

hyperprolactinaemia, hypothyroidism, ovarian failure and hypogonadotropic hypogonadism are recognised causes of oligomenorrhoea and amenorrhoea **[8].** Consensus recommendations specify exclusion of congenital adrenal hyperplasia, androgen-secreting tumours and Cushing syndrome, and assessment of thyroid function alongside exclusion of hyperprolactinaemia and other mimics **[9].** Among 170 women with oligomenorrhoea, two-thirds had abnormal hormone levels-hyperandrogenaemia in 41.8%, hyperprolactinaemia in 25.9%, thyroid dysfunction in 21.7% and hypergonadotropic FSH in 3.5% - with overlap in one third **[10].**

**THERAPUTIC INTERVENTION:** Treatment aimed at *Samprapti Vighatana through Lekhana, Granthi-hara, Deepana- Pachana* and *Artavajana* with *Vatanulomana.* Two classical formulations were given for 15 weeks (108 days): Kachanar Guggulu two 500 mg tablets (1000 mg) twice daily and *Chandraprabha Vati* two 500 mg tablets (1000 mg) twice daily, both 30 minutes before meals with lukewarm water. *Kanchanar Guggulu* contains Bauhinia variegata contains flavonoids, glycosides, alkaloids, tannins and terpenoids with reported antidiabetic and antioxidant activity **[11],** and its aqueous leaf extract lowered plasma glucose in diabetic animal models over 28 days while inhibiting α-glucosidase **[12].** Guggulsterones are farnesoid X receptor antagonists that lower hepatic cholesterol and inhibit nuclear factor-κB activation, the proposed basis of their anti-inflammatory action **[13].** *Chandraprabha Vati* Contains 37 ingredients with *Shilajit* and *Guggulu* in the largest (32-part) proportion; it is *katu* (73.38%) and *tikta* (69.78%) in rasa*, laghu* (76.98%) and *ruksha* (74.10%) in *guna, ushna virya* (70.50%), *katu vipaka* (69.06%) and predominantly Vata-kapha shamaka (91.37% and 84.89%), Classically indicated in PCOD, dysmenorrhoea and female infertility **[14].** Shilajit at 100mg/kg/day produced maximal reductions in blood glucose and improved lipid profile in alloxan-diabetic rats, enhanced by metformin or glibenclamide **[15].** Lifestyle measures comprised avoidance of deep-fried foods, refined flour, sugary confectionary, carbonated drinks, panner, cheese, whole buffalo milk and daytime sleeping; a diet of barely, brown rice, split green gram, bitter ground, bottle ground and fenugreek with warm; dinner by 8:30 PM with a 13-14 hour overnight fast; and daily Surya *Namaskar , Baddha Konasana, Bhujangasana, Paschimottanasana and Kapalabhati.*

**FOLLOW-UP AND OUTCOMES:** At week 5 bleeding occurred on day 35(three days, two pads daily, bright red without clots), and constipation and postprandial lethargy had resolved. At week 10 menstruation began spontaneously on day 31, lasting four days with minimal cramping. By week 15 cycles had settled into a 29-day rhythm with 4-5 days of normal flow and no pelvic pain; weight fell from 66.0 kg to 63.5 kg, a loss of 2.5 kg (BMI 26.4 to 25.4 kg/m$^2$). Adherence was complete, verified by a self-recorded dose log, and no gastrointestinal upset, nausea, headache or skin rash occurred. Repeat ultrasonography on 27 January 2024 showed an anteverted uterus of 79×34 mm with a regular 5 mm endometrium, right ovary 28×15 mm and left ovary 29×15 mm, complete clearance of the peripheral microcyst rim and resolution of stomal hypertrophy, with a final impression of normal pelvic scan. (Table 2).

**Table 2. Comparative clinical and ultrasonographic parameters at baseline and after 15 weeks of Ayurvedic therapy**.

| Parameter | Baseline (11 October 2023) | Post-treatment (27 January 2024) |
|---|---|---|
| Menstrual cycle interval | 45-60 days | 28-30 days (29 days at final review |
| Flow duration / volume | 1-2 days; 1 lightly stained pad per day | 4-5 days; 3 pads per day at peak |
| Dysmenorrhoea /pelvic heaviness | Present (dull ache) | Absent |
| Body weight / BMI | 66.0 kg / 26.4 kg/m² | 63.5 kg/25.4 kg/m² |
| Uterus | 7.4 x 3.4 cm | 79 x 34 mm; endometrium 5 mm |
| Right ovary | Enlarged; >12 peripheral follicles of 2-8 mm; echogenic stroma | 28 x 15 mm; normal morphology |
| Left ovary | Enlarged; >12 peripheral follicles of 2-8 mm; echogenic stroma | 29 x 15 mm; normal morphology |
| Ultrasonographic impression | Polycystic ovaries | Normal pelvic scan |

**DISCUSSION:** This case documents complete clinical and sonographic reversal of PCOD after 15 weeks of oral *shamana* therapy with *Kanchanar Guggulu* and *Chandraprabha Vati* supported by diet and *Yoga.* The mechanism is biological Plausible: intra-ovarian hyperandrogenism promotes early follicular growth, producing an excess of 2-5 mm follicles, while hyperinsulinemia acts as a second hit that worsens follicular arrest **[16];** women with PCOS show marked insulin resistance independent of obesity, and insulin acts as a co-gonadotropin modulating ovarian steroidogenesis **[17],** with theca cells overexpressing steroidogenic enzymes, particularly P450c17 **[18].** Reducing this insulin

drive addresses both the metabolic and reproductive limbs of the disorder, precisely where *Deepana-Pachana* and *Srotovishodhana* operate.

Lifestyle change must also be credited: a modest 2-5% weight loss improves ovulation and menstrual regularity, and losses above 5% are associated with reduced ovarian volume and follicle number **[19];** responders to a six-month diet-and exercise programme showed an 11% reduction in central fat, a 71% improvements in insulin sensitive index, a 33% fall in fasting insulin and a 39% reduction in luteinising hormone **[20];** and two-thirds of overweight women with PCOS resumed regular mensuration after four months of diet and/or exercise **[21].** The 2.5 kg loss here, 3.8 % of body weight, probably contributed.

Three learning points emerge. First, oligo-ovulation plus polycystic morphology alone satisfies the Rotterdam criteria when hyperandrogenism is absent, yet PCOS remains a diagnosis of exclusion: thyroid function and prolactin should be assessed **[9],**17-hydroxyprogesterone below 200 ng/dL rules out 21-hydroxylase deficiency **[8],** and marked hyperandrogenaemia or rapid virilisation requires exclusion of androgen-secreting tumours **[8],**Second, complete morphological normalisation is achievable without hormonal therapy, but the open-label design means drug effect, lifestyle change and regression to the mean cannot be separated. Third, such complete reversal is rarely reported: the *Ayurvedic* PCOS literature is dominated by case studies in which *kanchnara guggulu* 750 mg is among the most used formulations **[22];** a comparable case using *Kanchnara guggulu* 750 mg with *Kanya lohadi vati* and *Kanchnar kasaya* for 90 days also improved symptoms and ultrasonographic findings **[23];** and a randomised trial of an *Ayurveda* regimen versus metformin in 180 women, with normal cycle length of 21-35 days as the primary outcome, is under way **[5].** Limitations are the absent LH, FSH, AMH, fasting insulin and free testosterone measurements, single-centre assessment, sonographic surrogate endpoints and follow-up limited to 15 weeks.

**CONCLUSION:** In these young women with oligo-ovulation and polycystic ovarian morphology but no clinical hyperandrogenism, 15 weeks *of Kanchanar Guggulu* and *Chandraprabha Vati* with diet and *yoga* restored weight from 66.0 to 63.5 kg and normalised ovarian morphology on ultrasonography. The case illustrates that *Ayurvedic Shamana* therapy with lifestyle correction can achieve complete sonographic reversal, while underscoring two caveats: PCOS remains a diagnosis of exclusion requiring biochemical screening [8], and lifestyle change contributes independently to ovulatory recovery [19]. Controlled trials with hormonal endpoints are needed before wider adoption.

**PATIENT PROSPECTIVE:** "For more than a year my periods came only every second month and lasted barely a day, and I was anxious after being told my ultrasound showed polycystic ovaries. I did not want hormonal tablets and wanted to treat the cause. Within two months of the prescribe medicines and lifestyle changes my periods returned on time, and the final scan showed normal ovaries."

**ACKNOWLEDGEMENTS:** None

**AUTHORS'CONTRIBUTION:** Each author took an equal part in both the design and execution of the study.

**FUNDING:** None

**ETHICAL APPROVALS:** No Ethical clearance was needed for this case study because it simply involves the recording of one patient's clinical case.

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