RESEARCH PAPER

# 6.6-cm Haemorrhagic Ovarian Cyst: Non-Visualization at 98-Day Follow-Up Following the Dr. S. M. Raju-Defined Neo Ayurveda Treatment Protocol

**Dr. S. M. Raju, IAS (Retd.)[1*], Dr. Vallari Poojari[2], Ms. Jasmine[3]**
[1]Author and Corresponding Author, Sri Venkateshwara Manor, No. 490, Third Floor, 80 Feet Road, R.T. Nagar Main Road, Bengaluru, Karnataka – 560032, India
[2]Treating Physician, BAMS, MD, Clinical treatment administered according to the defined Neo Ayurveda treatment protocol developed by Dr. S. M. Raju
[3]Dietician, Dietary Intervention and Monitoring, responsible for implementation, dietary counselling, and monitoring of the prescribed kidney-oriented dietary protocol
A Public-Awareness Report from Dr. S. M. Raju's Neo Ayurveda–Miracle Drinks Clinic, Karnataka, India
***Corresponding Author:** Dr. S. M. Raju, IAS (Retd.), Sri Venkateshwara Manor, No. 490, Third Floor, 80 Feet Road, R.T. Nagar Main Road, Bengaluru, Karnataka – 560032, India
Mobile: +91 91089 92568
Email: smraju777@gmail.com
**Received:** 25th October 2026; **Revised:** 28th October 2026; **Accepted:** 3rd November 2026; **Available Online:** 7th November 2026

***ABSTRACT***

**Background:**
Haemorrhagic ovarian cysts may present with abnormal uterine bleeding, pelvic or abdominal pain, weakness, and other associated symptoms. Management depends on cyst characteristics, persistence, symptom severity, and clinical assessment, with surgical intervention considered in selected cases. Neo Ayurveda is an integrative treatment approach developed by Dr. S. M. Raju based on approximately four decades of observational work and incorporates proprietary herbal formulations, dietary modification, prebiotic and probiotic principles, and nutritional strategies intended to support cellular metabolism, mitochondrial function, gut health, and the body's intrinsic reparative processes.

**Case Presentation:**

A 23-year-old woman presented with polymenorrhoea, irregular bleeding, abdominal pain, weakness, gastritis, and a sensation of heaviness in the chest. Ultrasonography of the abdomen dated 10 April 2026 demonstrated a left ovarian cyst measuring 6.6 × 5.8 × 6.0 cm, showing a thin reticular pattern and internal echoes, reported as being suggestive of a haemorrhagic ovarian cyst. According to the patient's subsequent oral testimony, surgical removal had been advised; however, the patient and her family elected to pursue a non-surgical approach.

**Intervention:**
A structured Neo Ayurveda protocol was initiated on 10 June 2026 under clinical supervision. The protocol included proprietary herbal formulations directed toward systemic, cardiovascular, gastrointestinal, immune, and metabolic support, together with Graviola 500 mg and a defined dietary program. The nutritional regimen incorporated garlic, ginger, soaked fenugreek seeds, a flaxseed–flax oil–yogurt preparation, leached raw vegetable juice, increased intake of vegetables, leafy vegetables, fruits and dry fruits, restricted fried and processed foods, and a predominantly plant-based dietary pattern. The intervention was designed according to the Dr. Raju Cell Regeneration Principle, which proposes that nutritional support, detoxification, gut microbial support, improved microcirculation, mitochondrial activation, and cellular protein-homeostasis mechanisms may contribute to functional recovery in stressed or degenerative tissues. These proposed mechanisms remain hypotheses requiring independent experimental and clinical validation.

**Outcome:**
During the treatment period, the patient reported progressive resolution of abnormal bleeding, abdominal discomfort, weakness, gastritis, and associated physical symptoms. Follow-up ultrasonography performed on 16 September 2026, approximately 98 days after initiation of the protocol, did not demonstrate the previously documented ovarian cyst,

and the study was reported as showing no significant abnormality. A video-recorded patient statement obtained on 19 September 2026 described substantial symptomatic recovery without surgical intervention.

**Conclusion:**
This case documents interval non-visualization of a previously reported 6.6-cm haemorrhagic ovarian cyst, accompanied by resolution of the patient's reported clinical symptoms following approximately 100 days of a structured Neo Ayurveda treatment and dietary protocol. While the temporal association is clinically noteworthy, a single case cannot establish causation, spontaneous resolution cannot be excluded, and the specific contribution of individual components of the multi-modal protocol cannot be determined. The findings support the need for prospective studies with serial imaging, standardized outcome measures, biochemical monitoring, comparator groups, and independent evaluation to investigate the reproducibility and potential biological mechanisms underlying the observed clinical and radiological changes.

**Keywords:** Haemorrhagic ovarian cyst; Ovarian cyst; Polymenorrhoea; Abnormal uterine bleeding; Neo Ayurveda; Dr. Raju Cell Regeneration Principle; Interval non-visualization; Clinical symptom resolution; Integrative medicine; Herbal formulations; Dietary intervention; Mitochondrial support; Gut microbiota; Clinical case report

***How to cite this article:*** *S. M. Raju IAS (Retd.)1* Dr. Vallari Poojari2 Ms. Jasmine3. 6.6-cm Haemorrhagic Ovarian Cyst: Non-Visualization at 98-Day Follow-Up Following the Dr. S. M. Raju-Defined Neo Ayurveda Treatment Protocol. Int J Drug Deliv Technol. 2026;16(90s):1391-1400. DOI: 10.25258/ijddt.16.90s.137.*

*Source of support:* ***Nil.***

***Conflict of interest:*** *None*

## 1. Introduction

Haemorrhagic ovarian cysts are commonly encountered functional ovarian lesions that may develop when bleeding occurs within a follicular or corpus luteum cyst. Their clinical presentation can vary considerably, ranging from an incidental finding on ultrasonography to symptoms such as pelvic or abdominal pain, menstrual irregularity, abnormal uterine bleeding, abdominal discomfort, weakness, and a sensation of pelvic heaviness. Management depends on several factors, including the patient's age, cyst size and morphology, persistence on follow-up imaging, severity of symptoms, haemodynamic stability, and the possibility of complications such as rupture or ovarian torsion. While many functional ovarian cysts may regress spontaneously, persistent, symptomatic, enlarging, or diagnostically uncertain lesions may require closer surveillance or surgical evaluation.

This case concerns a 23-year-old woman who presented with polymenorrhoea, irregular bleeding, abdominal pain, gastritis, weakness, and a sensation of heaviness in the chest. Ultrasonography of the abdomen performed on 10 April 2026 demonstrated a left ovarian cyst measuring **6.6 × 5.8 × 6.0 cm**, with a thin reticular internal pattern and internal echoes, interpreted as being suggestive of a haemorrhagic ovarian cyst. According to the patient's subsequent oral testimony, surgical removal of the cyst had been advised; however, the patient and her family elected to pursue a non-surgical treatment approach.

The patient subsequently commenced a structured **Neo Ayurveda treatment protocol** developed by Dr. S. M. Raju. Neo Ayurveda, as formulated by the author, integrates selected principles of modern physiology with herbal and nutritional approaches derived from Ayurveda and places particular emphasis on the concept of **"Food as Medicine."** The protocol combines proprietary herbal formulations with a defined dietary program incorporating prebiotic foods, flaxseed-based nutritional support, vegetable preparations, plant-based dietary measures, and avoidance of fried and highly processed foods.

The conceptual basis of the protocol is described by the author as the **Dr. Raju Cell Regeneration Principle**. This principle proposes that the human body possesses an intrinsic capacity for biological repair when appropriate nutritional support, cellular detoxification, gut microbial balance, tissue perfusion, and mitochondrial function are adequately supported. The author further hypothesizes that cellular stress responses, including chaperone or heat-shock protein activity, mitochondrial energy metabolism, gut-derived nutritional signaling, and inter-organ biological communication may contribute to the restoration of function in stressed or degenerative

tissues. These proposed mechanisms remain theoretical in the context of the present case and require independent experimental and clinical validation.

The Neo Ayurveda approach was developed from the author's long-term observational work with chronic and degenerative disorders and from his experience documenting patients who sought this approach after receiving conventional or other forms of treatment. The author has therefore undertaken the documentation of individual cases using available pre-treatment and post-treatment investigations, clinical observations, and patient-reported outcomes, with the objective of generating hypotheses for further scientific evaluation rather than establishing therapeutic efficacy from individual cases alone.

In the present case, the patient received the defined Neo Ayurveda protocol for approximately 100 days. Follow-up abdominal ultrasonography performed on 16 September 2026 did not demonstrate the previously documented ovarian cyst and reportedly showed no significant abnormality. The patient also described resolution of the previously reported abnormal bleeding, abdominal discomfort, weakness, and gastrointestinal symptoms.

This case report therefore documents the **interval non-visualization of a previously identified 6.6-cm haemorrhagic ovarian cyst together with complete reported clinical symptom resolution following a structured Neo Ayurveda protocol**. The case is presented to describe the temporal clinical and radiological changes observed during treatment and to support further investigation of the Dr. Raju Cell Regeneration Principle through prospective, independently evaluated clinical studies. Because haemorrhagic ovarian cysts may also resolve spontaneously, the observations in this single case should not be interpreted as proof of causation or regeneration without further controlled evidence.

## 2. Case Presentation

A 23-year-old woman, presented with a history of **polymenorrhoea, irregular uterine bleeding, abdominal pain, generalized weakness, gastritis, and a sensation of heaviness in the chest**. Because of the persistent bleeding and associated symptoms, she underwent abdominal ultrasonography for further evaluation.

An **ultrasonography (USG) examination of the abdomen dated 10 April 2026** demonstrated a cystic lesion involving the left ovary. The cyst measured approximately **6.6 × 5.8 × 6.0 cm** and showed a thin reticular internal pattern with internal echoes. The imaging impression described the lesion as being **possibly consistent with a haemorrhagic ovarian cyst**.

According to the patient's later video-recorded oral statement, she had initially sought medical evaluation because of abnormal bleeding, gastric complaints, weakness, and abdominal discomfort. Following the identification of the ovarian cyst, surgical removal was reportedly advised. The patient and her family, however, did not proceed with the proposed surgical intervention and instead elected to pursue a non-surgical treatment approach.

The patient subsequently attended a Neo Ayurveda clinic and commenced treatment on **10 June 2026**. The treatment was administered under the clinical supervision of **Dr. Rahul Nair, BAMS**, using a protocol developed by **Dr. S. M. Raju**. The therapeutic plan consisted of proprietary herbal formulations together with a structured dietary and nutritional program.

## 3. Therapeutic Intervention

The patient commenced the defined **Neo Ayurveda treatment protocol on 10 June 2026** under the clinical supervision of **Dr. Rahul Nair, BAMS**, using a therapeutic framework developed by **Dr. S. M. Raju**. The intervention combined proprietary herbal formulations with a structured dietary and nutritional program intended to support systemic metabolism, gut health, nutritional status, and overall physiological recovery.

### 3.1 Proprietary Herbal Formulations

The patient received the following formulations twice daily:

- **S-1 Anti-Ageing Support** – 15 mL in the morning and 15 mL in the evening
- **S-3 Cardiovascular Support** – 15 mL in the morning and 15 mL in the evening
- **S-7 Immune Care Support** – 15 mL in the morning and 15 mL in the evening
- **Graviola** – 500 mg in the morning and 500 mg in the evening

These formulations were proprietary preparations developed by the author from his long-term

observational work and subsequently incorporated into the Neo Ayurveda treatment protocol. The preparations were reported as being licensed under the applicable AYUSH framework .

Detailed phytochemical composition, batch-specific standardization data, pharmacokinetic information, and formal pharmacological characterization were not available in the clinical case documentation, these aspects are not further specified in the present report.

### 3.2 Prebiotic Dietary Component

The patient was advised to consume a daily prebiotic combination consisting of:

- approximately two cloves of garlic;
- approximately half an inch of fresh ginger; and
- one teaspoon of soaked fenugreek seeds.

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

### 3.3 Flaxseed-Based Nutritional Preparation

A flaxseed-based preparation was administered twice daily, once as the first course of breakfast and once as an evening snack. Each serving consisted of approximately:

- **15 g raw flaxseeds**;
- **15 g cold-pressed flaxseed oil**; and
- **100 g yogurt**.

The flaxseeds were freshly ground and blended with the flaxseed oil and yogurt before consumption. This preparation was included as a source of dietary fatty acids, lignans, protein, and fermented dairy components.

### 3.4 Leached Raw Vegetable Juice

The patient consumed approximately **200 mL of vegetable-based juice twice daily**. The preparation was made from approximately 250 g of combined ingredients, including beetroot, bottle gourd, betel leaf, carrot, cabbage, coriander leaves, cucumber, and one fruit. The ingredients were generally used in approximately equal proportions, with one betel leaf and about 20 g of coriander leaves.

This dietary component was incorporated into the protocol as a concentrated source of plant-derived nutrients.

### 3.5 Predominantly Plant-Based Dietary Regimen

For approximately two months, the patient was advised to follow a predominantly uncooked or minimally processed plant-based dietary pattern, referred to within the protocol as a **"monkey diet."** Cereals such as wheat, jowar, and rice were restricted to approximately **25–30% of total dietary intake**, while vegetables, leafy vegetables, pulses, and salads constituted more than 50% of the diet.

Greater consumption of fresh fruits, dry fruits, and fresh fruit juices was encouraged. Fried foods, highly processed foods, and junk foods were avoided.

### 3.6 Cold-Pressed Coconut Oil

The patient was advised to consume **15 mL of cold-pressed raw coconut oil after breakfast and 15 mL after dinner**, for a total intake of approximately 30 mL per day.

### 3.7 Therapeutic Rationale

The intervention was based on the author's **Dr. Raju Cell Regeneration Principle**, which proposes that appropriate nutrition, gut microbial support, cellular detoxification, mitochondrial metabolic support, microcirculatory improvement, and restoration of cellular homeostasis may support the body's intrinsic reparative mechanisms.

Within this conceptual framework, the combined herbal and dietary intervention was intended to support the physiological environment of stressed tissues rather than to target the ovarian cyst through a single isolated pharmacological mechanism. The proposed roles of mitochondrial activation, chaperone or heat-shock protein function, gut-derived metabolic signaling, and inter-organ communication remain theoretical in the context of this individual case and require independent experimental and clinical validation.

The patient continued the structured protocol for approximately **98–100 days**, after which follow-up ultrasonography documented non-visualization of the previously reported ovarian cyst together with complete reported resolution of the associated clinical symptoms.

**4. Clinical Course**

The patient entered the Neo Ayurveda treatment program on **10 June 2026** after a previously documented left ovarian cyst measuring **6.6 × 5.8 × 6.0 cm** had been identified on ultrasonography dated **10 April 2026**. At presentation, the patient reported polymenorrhoea, irregular uterine bleeding, abdominal pain, generalized weakness, gastritis, and a sensation of heaviness in the chest. According to the patient's later oral testimony, surgical removal of the cyst had been advised before she elected to pursue the Neo Ayurveda protocol.

The therapeutic program consisted of **S-1 Anti-Ageing Support, S-3 Cardiovascular Support, S-7 Immune Care Support, Graviola 500 mg**, and a structured dietary and nutritional regimen. The patient continued the intervention under clinical supervision.

During the treatment period, the patient reported gradual improvement in her previously documented symptoms. Abnormal bleeding progressively subsided, abdominal discomfort diminished, gastric complaints improved, and generalized weakness resolved. By the end of the treatment period, the patient reported complete clinical resolution of the symptoms that had prompted the original medical evaluation.

A follow-up **ultrasonography of the abdomen performed on 16 September 2026**, approximately **98 days after initiation of the treatment protocol**, did not demonstrate the previously reported left ovarian cyst. The imaging report reportedly stated that **no significant abnormality was seen on the study**.

A video-recorded oral statement obtained on **19 September 2026** documented the patient's account of the clinical course. She stated that she had initially undergone evaluation because of abnormal bleeding, weakness, gastric symptoms, and abdominal complaints, which led to the detection of the ovarian cyst. She further reported that surgical removal had been advised but was not undertaken, and that she instead completed approximately four months of Neo Ayurveda treatment.

At follow-up, the patient reported absence of the previously experienced abnormal bleeding, abdominal symptoms, weakness, and gastric complaints. The radiological finding of interval non-visualization of the ovarian cyst occurred concurrently with this reported clinical recovery.

The chronological sequence of the case may therefore be summarized as follows:

- **10 April 2026:** Initial USG documented a **6.6 × 5.8 × 6.0 cm left ovarian cyst**, possibly haemorrhagic in nature.
- **10 June 2026:** Neo Ayurveda therapeutic and dietary protocol initiated.
- **June–September 2026:** Progressive patient-reported improvement in bleeding, abdominal discomfort, weakness, and gastric symptoms.
- **16 September 2026:** Follow-up USG did not visualize the previously documented ovarian cyst and reported no significant abnormality.
- **19 September 2026:** Video-recorded patient testimony documented complete reported symptomatic recovery and avoidance of the previously proposed surgical intervention.

No surgical procedure was performed during the documented treatment interval. The clinical course therefore demonstrated both **symptomatic resolution and interval radiological non-visualization** of the previously documented ovarian cyst during the period of the Neo Ayurveda intervention.

**5. Outcome and Follow-Up**

Following initiation of the Neo Ayurveda treatment protocol on **10 June 2026**, the patient reported progressive improvement in the symptoms that had been present at the time of initial evaluation. These included polymenorrhoea, irregular uterine bleeding, abdominal pain, generalized weakness, gastritis, and a sensation of heaviness in the chest.

By the completion of approximately **98 days of treatment**, the patient reported complete resolution of the previously experienced clinical symptoms. In particular, the abnormal bleeding had ceased, abdominal discomfort had resolved, weakness had improved, and the associated gastric complaints were no longer present according to the patient's follow-up account.

A repeat **ultrasonography of the abdomen performed on 16 September 2026** did not demonstrate the previously documented left ovarian cyst measuring **6.6 × 5.8 × 6.0 cm**. The follow-up imaging report reportedly concluded that **no significant abnormality was seen on the study**. Thus, the previously visualized ovarian cyst was not identified on follow-up imaging.

A video-recorded patient statement obtained on **19 September 2026** further documented the patient's subjective clinical recovery. She reported that the symptoms that had initially prompted medical evaluation had resolved and that she had not undergone the previously advised surgical intervention during the treatment period.

The principal documented outcomes in this case were therefore:

- complete patient-reported resolution of abnormal uterine bleeding and associated physical symptoms;
- absence of the previously documented ovarian cyst on follow-up ultrasonography;
- no significant abnormality reported on the follow-up USG study; and
- avoidance of surgical intervention during the documented follow-up period.

At the time of the available follow-up documentation, the patient remained clinically improved and no recurrence of the previously reported symptoms was documented.

Because haemorrhagic ovarian cysts can undergo spontaneous resolution, the observed radiological and symptomatic improvement cannot, on the basis of this single case, be attributed definitively to the treatment protocol. Longer-term follow-up with repeat pelvic ultrasonography, menstrual history, clinical examination, and laboratory assessment would be valuable to document sustained resolution and exclude recurrence.

## 6. Discussion

This case describes a 23-year-old woman with a previously documented **6.6 × 5.8 × 6.0 cm left ovarian cyst**, radiologically considered possibly haemorrhagic, who subsequently demonstrated **interval non-visualization of the cyst on follow-up ultrasonography approximately 98 days after initiation of a structured Neo Ayurveda protocol**. The radiological finding was accompanied by patient-reported resolution of abnormal uterine bleeding, abdominal pain, weakness, gastritis, and other associated symptoms. No surgical intervention was undertaken during the documented treatment period.

The simultaneous improvement in clinical symptoms and follow-up imaging findings is notable. However, interpretation of the outcome requires caution because functional and haemorrhagic ovarian cysts may resolve spontaneously over time. Accordingly, the disappearance of the cyst on follow-up imaging cannot, from a single uncontrolled case, be attributed definitively to the therapeutic intervention. The principal value of the present report lies in documenting the temporal sequence of the clinical and radiological observations and in generating hypotheses for further investigation.

The therapeutic intervention used in this case differed from a single-agent pharmacological approach. It combined proprietary herbal formulations with prebiotic foods, a flaxseed-based dietary preparation, plant-derived foods and juices, cold-pressed oils, increased consumption of fruits and vegetables, and avoidance of fried and highly processed foods. The overall approach was intended to modify the patient's nutritional and metabolic environment rather than target the ovarian cyst through one isolated mechanism.

The intervention was developed within the conceptual framework described by the author as the **Dr. Raju Cell Regeneration Principle**. According to this hypothesis, the human body possesses an intrinsic capacity for biological repair and functional correction when cells receive appropriate nutrients, metabolic support, adequate microcirculation, and an environment favorable to mitochondrial and cellular function. The author further proposes that restoration of gut microbial balance, improved nutrient availability, cellular detoxification, and support of mitochondrial activity may collectively contribute to tissue recovery.

A particular component of this proposed mechanism concerns **cellular chaperones and heat-shock proteins (HSPs)**. Molecular chaperones are involved in maintaining protein homeostasis by assisting protein folding and limiting the accumulation of damaged or misfolded proteins during cellular stress. Mitochondrial function is also closely related to cellular energy production, oxidative balance, and stress responses. These established biological processes provide plausible areas for mechanistic investigation; however, the present case did not directly measure heat-shock protein activity, mitochondrial function, oxidative stress, or cellular regeneration. Consequently, any relationship between these mechanisms and the observed ovarian findings remains hypothetical.

The Neo Ayurveda concept also emphasizes the **gut as an important regulator of systemic health**. The

protocol incorporates prebiotic and probiotic nutritional principles on the premise that beneficial intestinal microorganisms may contribute to digestion, nutrient release, metabolic signaling, and systemic homeostasis. Modern research increasingly recognizes interactions between the gut microbiome, metabolism, immunity, and endocrine signaling. Nevertheless, no microbiome testing was performed in this patient, and the extent to which changes in gut microbial composition contributed to the observed clinical course cannot be determined.

Another proposed aspect of the author's model is the concept of **inter-organ biological communication**. Human organs function through interconnected endocrine, metabolic, vascular, immune, and neural pathways. The author hypothesizes that dysfunction in one or more supporting systems may contribute to impaired recovery of another organ and that broader nutritional and metabolic support could therefore facilitate physiological correction. While inter-organ communication is an established biological concept, the specific pathways proposed within the Dr. Raju Cell Regeneration Principle require targeted experimental validation.

The dietary component may also be relevant when considering the patient's overall improvement. The regimen emphasized vegetables, leafy vegetables, fruits, seeds, fermented dairy, and minimally processed foods while restricting fried and highly processed foods. Such changes may influence nutritional status, bowel function, metabolic parameters, inflammatory signaling, and general well-being. However, because the protocol consisted of multiple simultaneous components, the contribution of any individual food, formulation, or dietary practice cannot be separated from the overall intervention.

An important feature of the present case is that the patient's outcome was documented through both **before-and-after ultrasonography and patient-reported clinical recovery**. The initial scan documented a sizeable ovarian cyst with features interpreted as possibly haemorrhagic, whereas the follow-up examination did not identify the lesion and reportedly showed no significant abnormality. This combination of objective imaging and subjective clinical improvement strengthens the documentation of change over time, although it does not establish treatment causality.

The case also illustrates the importance of documenting patients who choose complementary or integrative approaches after conventional medical evaluation. Such observations can contribute to hypothesis generation when they are presented transparently, with clear distinction between documented outcomes, patient testimony, therapeutic hypotheses, and established scientific knowledge. Individual case reports should not be used to generalize therapeutic effectiveness but can identify clinical observations worthy of systematic evaluation.

Several limitations must therefore be acknowledged. This report concerns a **single patient**, there was no untreated or conventionally treated comparison group, and no serial imaging was available to determine exactly when the cyst began to regress. Detailed hormonal studies, inflammatory markers, ovarian reserve measures, mitochondrial biomarkers, microbiome analysis, and histopathological confirmation were not available. In addition, haemorrhagic ovarian cysts may resolve naturally, creating an important alternative explanation for the imaging outcome. Patient-reported symptom resolution may also be influenced by factors independent of the intervention.

Despite these limitations, the observation of complete reported symptomatic recovery together with interval non-visualization of a previously documented **6.6-cm ovarian cyst** after approximately 98 days warrants further investigation. Future studies should include prospective enrollment, standardized pelvic ultrasonography at predefined intervals, gynecological assessment, menstrual-cycle documentation, relevant hormonal and biochemical parameters, safety monitoring, and clearly defined outcome measures. Controlled or comparative study designs would be necessary to determine whether the observed rate or pattern of resolution differs from the expected natural history of haemorrhagic ovarian cysts.

Further mechanistic work could also evaluate whether components of the protocol influence mitochondrial function, cellular stress responses, heat-shock protein expression, inflammatory pathways, gut microbial composition, endocrine signaling, or tissue perfusion. Such investigations would allow the proposed **Dr. Raju Cell Regeneration Principle** to be tested through measurable biological endpoints rather than inferred from clinical outcomes alone.

In summary, this case documents a clinically meaningful temporal association between a structured Neo Ayurveda intervention, complete reported symptom resolution, and follow-up non-visualization of a previously documented haemorrhagic ovarian cyst. The findings are hypothesis-generating and

support further systematic evaluation, while spontaneous resolution and other alternative explanations must remain part of the scientific interpretation.

## 7. Conclusion

This clinical case documents the **interval non-visualization of a previously identified 6.6 × 5.8 × 6.0 cm haemorrhagic left ovarian cyst**, accompanied by complete patient-reported resolution of abnormal uterine bleeding, abdominal pain, weakness, gastritis, and associated symptoms following approximately **98 days of a structured Neo Ayurveda treatment protocol**. The patient did not undergo the previously advised surgical intervention during the documented treatment period.

The intervention combined proprietary herbal formulations with a defined nutritional and dietary program developed within the conceptual framework of the **Dr. Raju Cell Regeneration Principle**. The observed improvement in both clinical symptoms and follow-up ultrasonography represents a noteworthy temporal association.

However, because haemorrhagic ovarian cysts may resolve spontaneously, this single case cannot establish that the treatment protocol caused the disappearance of the cyst or prove cellular regeneration. The findings should therefore be regarded as **hypothesis-generating evidence** rather than confirmation of therapeutic efficacy or mechanism.

The case supports the need for further prospective and controlled clinical investigation using serial imaging, standardized gynecological assessment, biochemical and hormonal measurements, safety monitoring, and mechanistic studies evaluating mitochondrial function, cellular stress responses, gut microbiota, and related biological pathways.

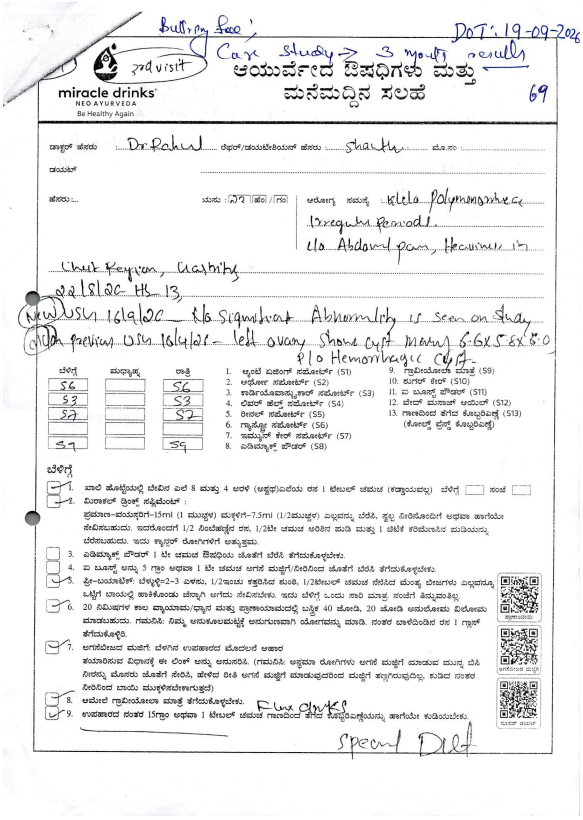
If similar outcomes are reproducibly demonstrated in larger and independently evaluated patient populations, such studies may help clarify whether the Neo Ayurveda protocol and the proposed Dr. Raju Cell Regeneration Principle have a measurable role in supporting physiological recovery in selected clinical conditions.

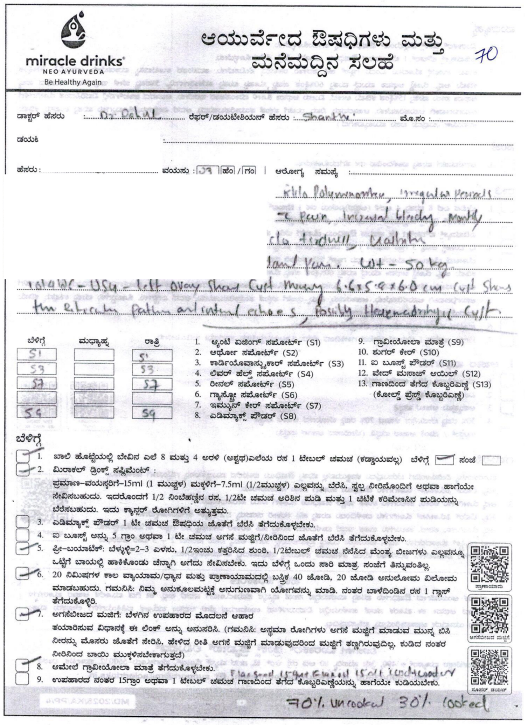
## 8. References

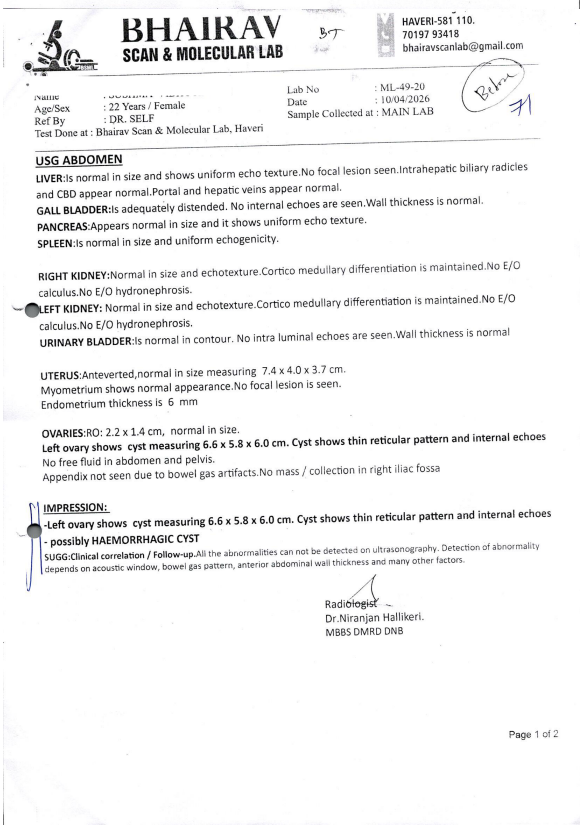

1. Levine D, Brown DL, Andreotti RF, Benacerraf B, Benson CB, Brewster WR, et al. Management of asymptomatic ovarian and other adnexal cysts imaged at US: Society of Radiologists in Ultrasound Consensus Conference Statement. **Radiology.** 2010;256(3):943–954. doi:10.1148/radiol.10100213.
2. American College of Radiology. **O-RADS Ultrasound v2022: Updates to Management Recommendations for Classic Benign Lesions.** American College of Radiology; 2022. The O-RADS framework includes management guidance for haemorrhagic cysts and follow-up imaging.
3. Saibil H. Chaperone machines for protein folding, unfolding and disaggregation. **Nat Rev Mol Cell Biol.** 2013;14:630–642. doi:10.1038/nrm3658.
4. Rosenzweig R, Nillegoda NB, Mayer MP, Bukau B. The Hsp70 chaperone network. **Nat Rev Mol Cell Biol.** 2019;20:665–680. doi:10.1038/s41580-019-0133-3.
5. Schopf FH, Biebl MM, Buchner J. The HSP90 chaperone machinery. **Nat Rev Mol Cell Biol.** 2017;18:345–360. doi:10.1038/nrm.2017.20.
6. Zong Y, Li H, Liao P, Chen L, Pan Y, Zheng Y, et al. Mitochondrial dysfunction: mechanisms and advances in therapy. **Signal Transduct Target Ther.** 2024;9:124. doi:10.1038/s41392-024-01839-8.
7. Noecker C, Turnbaugh PJ. Emerging tools and best practices for studying gut microbial community metabolism. **Nat Metab.** 2024;6:1225–1236. doi:10.1038/s42255-024-01074-z.
8. Mann ER, Lam YK, Uhlig HH. Short-chain fatty acids: linking diet, the microbiome and immunity. **Nat Rev Immunol.** 2024;24:577–595. doi:10.1038/s41577-024-01014-8.
9. Tan S, Santolaya JL, Wright TF, et al. Interaction between the gut microbiota and colonic enteroendocrine cells regulates host metabolism. **Nat Metab.** 2024;6:1076–1091. doi:10.1038/s42255-024-01044-5.
10. 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.

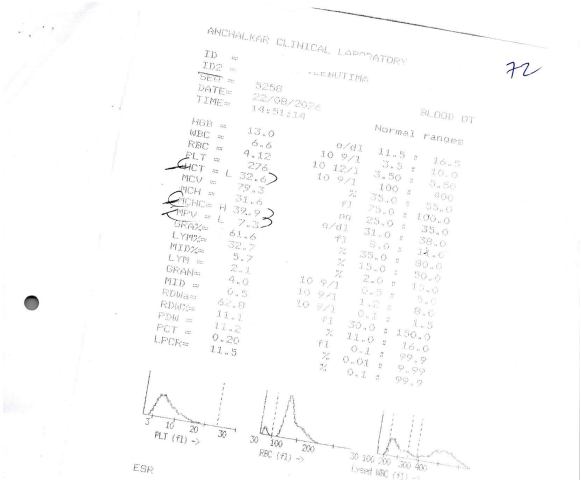

**Case-Specific Source Documentation**

11. Patient abdominal ultrasonography report dated **10 April 2026**, documenting a left ovarian cyst measuring **6.6 × 5.8 × 6.0 cm** with a thin reticular pattern and internal echoes, interpreted as possibly haemorrhagic. Unpublished clinical record.
12. Follow-up abdominal ultrasonography report dated **16 September 2026**, documenting non-visualization of the previously reported ovarian cyst and reporting no significant abnormality. Unpublished clinical record.
13. Patient video-recorded oral testimony dated **19 September 2026**, describing the presenting symptoms, prior recommendation for surgical removal, Neo Ayurveda treatment course, and subsequent symptomatic improvement. Unpublished clinical documentation.





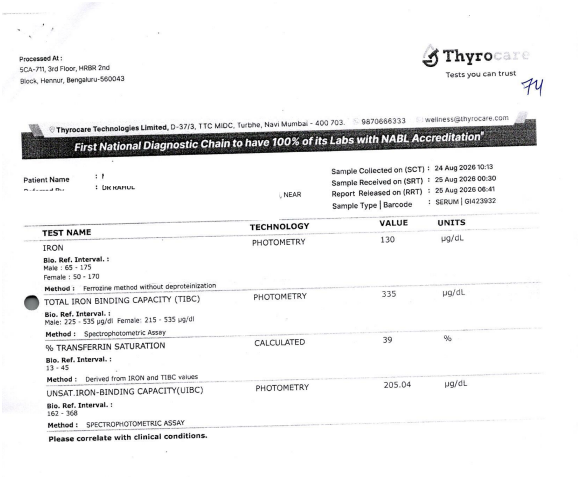
ANCHALKAR CLINICAL LABORATORY

72

| | | | Normal ranges |
|---|---|---|---|
| HGB | 13.0 | g/dl | 11.5 - 16.5 |
| WBC | 6.6 | 10 9/l | 3.5 - 10.0 |
| RBC | 4.12 | 10 12/l | 3.50 - 5.50 |
| PLT | 276 | 10 9/l | 100 - 400 |
| HCT | L 32.6 | % | 35.0 - 55.0 |
| MCV | 79.3 | fl | 75.0 - 100.0 |
| MCH | 31.6 | pg | 25.0 - 35.0 |
| MCHC | H 39.9 | g/dl | 31.0 - 35.0 |
| NEU% | L 7.33 | fl | 8.0 - 15.0 |
| GRA% | 61.6 | % | 35.0 - 80.0 |
| LYM% | 32.7 | % | 15.0 - 50.0 |
| LYM | 3.7 | 10 9/l | 1.0 - 4.8 |
| GRA## | 2.1 | 10 9/l | 0.5 - 8.0 |
| MID | 4.0 | % | 2.0 - 10.0 |
| MID## | 0.5 | 10 9/l | 0.2 - 1.5 |
| RDW | 54.8 | % | 11.5 - 14.5 |
| RDW | 11.1 | fl | 35.0 - 56.0 |
| PDW | 11.2 | % | 13.0 - 130.0 |
| PCT | 0.20 | fl | 6.0 - 16.0 |
| LPCR | 11.5 | % | 0.01 - 99.9 |
| | | % | 0.1 - 99.9 |

PLT (fl) → RBC (fl) → Used WBC (fl) →

ESR



Processed At :
SCA-711, 3rd Floor, HRBR 2nd Block, Hennur, Bengaluru-560043

Thyrocare
Tests you can trust

74

Thyrocare Technologies Limited, D-37/3, TTC MIDC, Turbhe, Navi Mumbai - 400 703. 9870666333 wellness@thyrocare.com

First National Diagnostic Chain to have 100% of its Labs with NABL Accreditation*

Patient Name : ?
: DR RAHUL
, NEAR

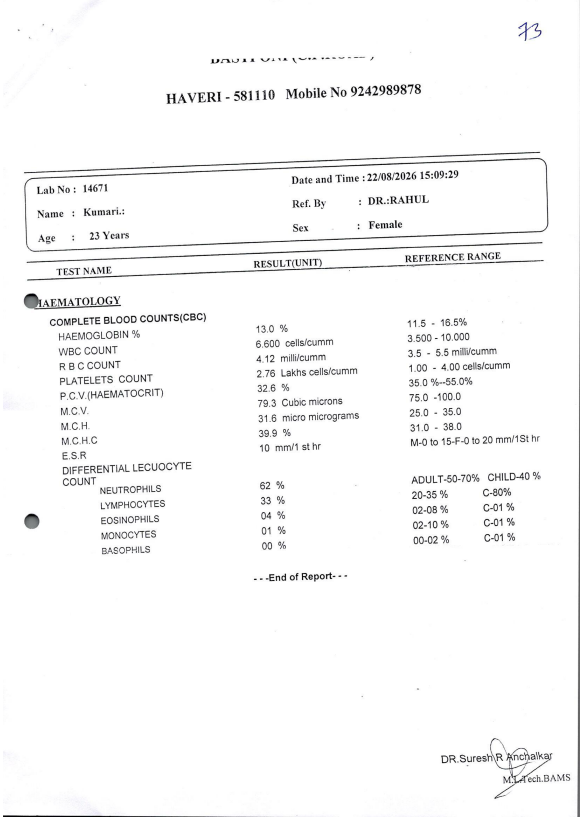
Sample Collected on (SCT) : 24 Aug 2026 10:13
Sample Received on (SRT) : 25 Aug 2026 00:30
Report Released on (RRT) : 25 Aug 2026 06:41
Sample Type | Barcode : SERUM | GI423932

| TEST NAME | TECHNOLOGY | VALUE | UNITS |
|---|---|---|---|
| IRON | PHOTOMETRY | 130 | µg/dL |
| Bio. Ref. Interval. : Male : 65 - 175 Female : 50 - 170 | | | |
| Method : Ferrozine method without deproteinization | | | |
| TOTAL IRON BINDING CAPACITY (TIBC) | PHOTOMETRY | 335 | µg/dL |
| Bio. Ref. Interval. : Male: 225 - 535 µg/dl Female: 215 - 535 µg/dl | | | |
| Method : Spectrophotometric Assay | | | |
| % TRANSFERRIN SATURATION | CALCULATED | 39 | % |
| Bio. Ref. Interval. : 13 - 45 | | | |
| Method : Derived from IRON and TIBC values | | | |
| UNSAT.IRON-BINDING CAPACITY(UIBC) | PHOTOMETRY | 205.04 | µg/dL |
| Bio. Ref. Interval. : 162 - 368 | | | |
| Method : SPECTROPHOTOMETRIC ASSAY | | | |

Please correlate with clinical conditions.

Tests Done : IRON DEFICIENCY PROFILE,T3-T4-USTSH

M. Ankuwath



73

HAVERI - 581110 Mobile No 9242989878

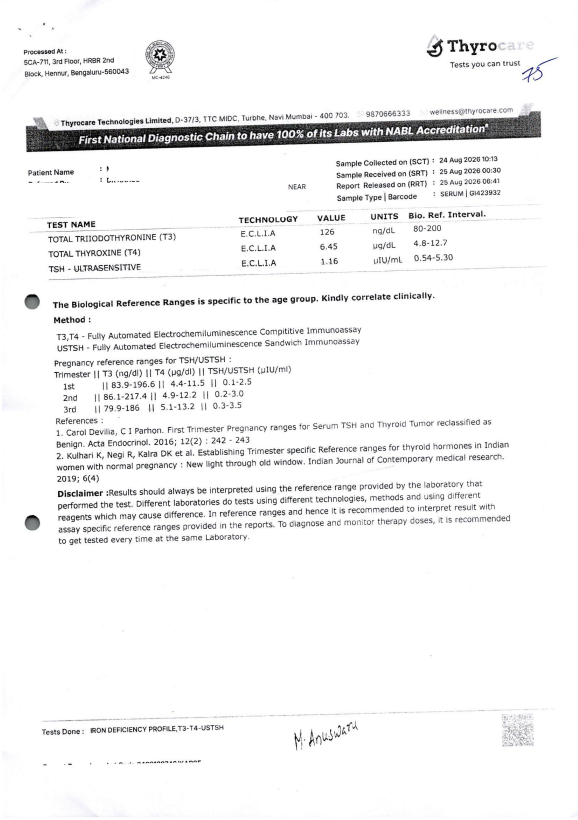
Lab No : 14671
Name : Kumari.:
Age : 23 Years

Date and Time : 22/08/2026 15:09:29
Ref. By : DR.:RAHUL
Sex : Female

| TEST NAME | RESULT(UNIT) | REFERENCE RANGE |
|---|---|---|
| **HAEMATOLOGY** | | |
| **COMPLETE BLOOD COUNTS(CBC)** | | |
| HAEMOGLOBIN % | 13.0 % | 11.5 - 16.5% |
| WBC COUNT | 6,600 cells/cumm | 3,500 - 10,000 |
| R B C COUNT | 4.12 milli/cumm | 3.5 - 5.5 milli/cumm |
| PLATELETS COUNT | 2.76 Lakhs cells/cumm | 1.00 - 4.00 cells/cumm |
| P.C.V.(HAEMATOCRIT) | 32.6 % | 35.0 %--55.0% |
| M.C.V. | 79.3 Cubic microns | 75.0 -100.0 |
| M.C.H. | 31.6 micro micrograms | 25.0 - 35.0 |
| M.C.H.C | 39.9 % | 31.0 - 38.0 |
| E.S.R | 10 mm/1 st hr | M-0 to 15-F-0 to 20 mm/1St hr |
| DIFFERENTIAL LECUOCYTE COUNT | | |
| NEUTROPHILS | 62 % | ADULT-50-70% CHILD-40 % |
| LYMPHOCYTES | 33 % | 20-35 % C-80% |
| EOSINOPHILS | 04 % | 02-08 % C-01 % |
| MONOCYTES | 01 % | 02-10 % C-01 % |
| BASOPHILS | 00 % | 00-02 % C-01 % |

- - -End of Report- - -

DR.Suresh R Anchalkar
M.D.Tech.BAMS



Processed At :
SCA-711, 3rd Floor, HRBR 2nd Block, Hennur, Bengaluru-560043

Thyrocare
Tests you can trust

75

Thyrocare Technologies Limited, D-37/3, TTC MIDC, Turbhe, Navi Mumbai - 400 703. 9870666333 wellness@thyrocare.com

First National Diagnostic Chain to have 100% of its Labs with NABL Accreditation*

Patient Name : ?
NEAR

Sample Collected on (SCT) : 24 Aug 2026 10:13
Sample Received on (SRT) : 25 Aug 2026 00:30
Report Released on (RRT) : 25 Aug 2026 06:41
Sample Type | Barcode : SERUM | GI423932

| TEST NAME | TECHNOLOGY | VALUE | UNITS | Bio. Ref. Interval. |
|---|---|---|---|---|
| TOTAL TRIIODOTHYRONINE (T3) | E.C.L.I.A | 126 | ng/dL | 80-200 |
| TOTAL THYROXINE (T4) | E.C.L.I.A | 6.45 | µg/dL | 4.8-12.7 |
| TSH - ULTRASENSITIVE | E.C.L.I.A | 1.16 | µIU/mL | 0.54-5.30 |

**The Biological Reference Ranges is specific to the age group. Kindly correlate clinically.**

**Method :**

T3,T4 - Fully Automated Electrochemiluminescence Compititive Immunoassay
USTSH - Fully Automated Electrochemiluminescence Sandwich Immunoassay

Pregnancy reference ranges for TSH/USTSH :

| Trimester | T3 (ng/dl) | T4 (µg/dl) | TSH/USTSH (µIU/ml) |
|---|---|---|---|
| 1st | 83.9-196.6 | 4.4-11.5 | 0.1-2.5 |
| 2nd | 86.1-217.4 | 4.9-12.2 | 0.2-3.0 |
| 3rd | 79.9-186 | 5.1-13.2 | 0.3-3.5 |

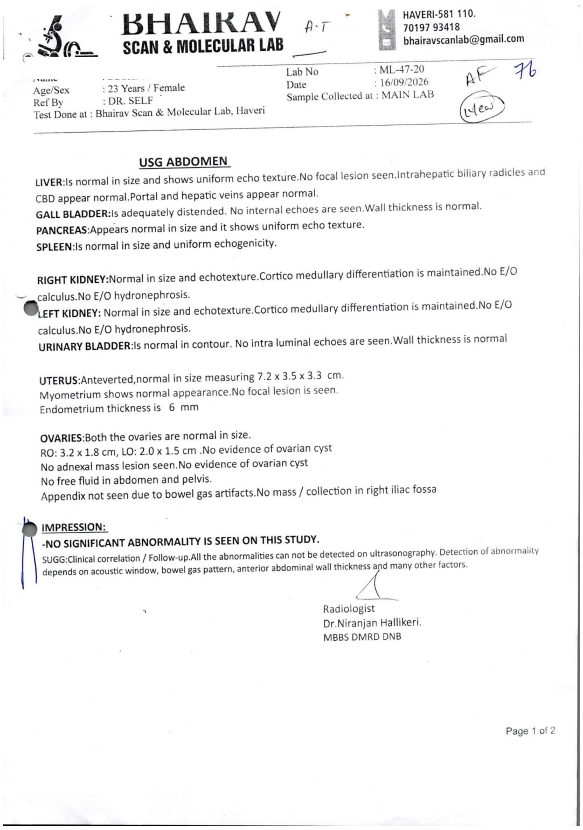
References :

1. Carol Devilla, C 1 Parhon. First Trimester Pregnancy ranges for Serum TSH and Thyroid Tumor reclassified as Benign. Acta Endocrinol. 2016; 12(2) : 242 - 243
2. Kulhari K, Negi R, Kalra DK et al. Establishing Trimester specific Reference ranges for thyroid hormones in Indian women with normal pregnancy : New light through old window. Indian Journal of Contemporary medical research. 2019; 6(4)

**Disclaimer :**Results should always be interpreted using the reference range provided by the laboratory that performed the test. Different laboratories do tests using different technologies, methods and using different reagents which may cause difference. In reference ranges and hence it is recommended to interpret result with assay specific reference ranges provided in the reports. To diagnose and monitor therapy doses, it is recommended to get tested every time at the same Laboratory.

Tests Done : IRON DEFICIENCY PROFILE,T3-T4-USTSH

M. Ankuwath



**BHAIRAV**
**SCAN & MOLECULAR LAB**

A·T

HAVERI-581 110.
70197 93418
bhairavscanlab@gmail.com

Age/Sex : 23 Years / Female
Ref By : DR. SELF
Test Done at : Bhairav Scan & Molecular Lab, Haveri

Lab No : ML-47-20
Date : 16/09/2026
Sample Collected at : MAIN LAB

AF 76

**USG ABDOMEN**

**LIVER:**Is normal in size and shows uniform echo texture.No focal lesion seen.Intrahepatic biliary radicles and CBD appear normal.Portal and hepatic veins appear normal.
**GALL BLADDER:**Is adequately distended. No internal echoes are seen.Wall thickness is normal.
**PANCREAS:**Appears normal in size and it shows uniform echo texture.
**SPLEEN:**Is normal in size and uniform echogenicity.

**RIGHT KIDNEY:**Normal in size and echotexture.Cortico medullary differentiation is maintained.No E/O calculus.No E/O hydronephrosis.
**LEFT KIDNEY:** Normal in size and echotexture.Cortico medullary differentiation is maintained.No E/O calculus.No E/O hydronephrosis.
**URINARY BLADDER:**Is normal in contour. No intra luminal echoes are seen.Wall thickness is normal

**UTERUS:**Anteverted,normal in size measuring 7.2 x 3.5 x 3.3 cm.
Myometrium shows normal appearance.No focal lesion is seen.
Endometrium thickness is 6 mm

**OVARIES:**Both the ovaries are normal in size.
RO: 3.2 x 1.8 cm, LO: 2.0 x 1.5 cm .No evidence of ovarian cyst
No adnexal mass lesion seen.No evidence of ovarian cyst
No free fluid in abdomen and pelvis.
Appendix not seen due to bowel gas artifacts.No mass / collection in right iliac fossa

**IMPRESSION:**
**-NO SIGNIFICANT ABNORMALITY IS SEEN ON THIS STUDY.**
SUGG:Clinical correlation / Follow-up.All the abnormalities can not be detected on ultrasonography. Detection of abnormality depends on acoustic window, bowel gas pattern, anterior abdominal wall thickness and many other factors.

Radiologist
Dr.Niranjan Hallikeri.
MBBS DMRD DNB

Page 1 of 2