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EFFICACY OF INDIVIDUALISED HOMOEOPATHIC MEDICINE IN TREATMENT OF OVARIAN HAEMORRHAGIC CYST - A CASE REPORT.

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Abstract: **Introduction-**.Ovarian Haemorrhagic cyst also known as functional cyst is fluid filled sac that bleeds.Though minor cyst resolves on its own ,cysts of more than 10mm size may require surgical intervention so as to avoid complications. **Patient's main concerns-**abdominal pain and per vaginal spotting and menta symptoms of deliriums and delusion .**Diagnosis-**Ovarian Haemorrhagic cyst **Intervention-** Based on individualisation Opium 200 single dose was prescribed **Outcomes-** The patient showed marked improvement in the symptoms without experiencing any adverse effects.. The individual curative response of the case was assessed using Modified Naranjo criteria for homoeopathic case reporting, casual attribution (MONARCH) which had a score of 12. **Conclusion-** Homoeopathy has the potential to treat Ovarian Haemorrhagic Cyst. Its further role should be evaluated with more controlled trials.

Index Terms - Individualised Homoeopathy, ovarian haemorrhagic cyst ,A case report.

INTRODUCTION-

Cyst is an enclosed sac within body tissues as a result of proliferation of epithelium, having a membrane and usually containing a liquid matter. Although most of the cysts are benign, several varieties may be malignant or precancerous[1]. Hemorrhagic ovarian cysts (HOCs) are not very commonly seen in clinical practice [2]. Patients with haemorrhagic ovarian cysts can present with no symptoms or a variety of them as a result of cyst rupture, hemorrhage, or torsion [3,4]. With increasing prevalance homoeopathy can be opted as an complementary medicine in treatment and management of haemorrhagic ovarian cyst [5,6]. The case presented here is of 37 years female who started with complains of delirium and delusions after the death of grandmother. Her mental phase had led to development of Haemorrhagic cyst in left ovary causing her sharp abdominal pain.After taking antispasmodics and antipsychotic medications her conditioned remained the same . She was then shifted to homoeopathy. Upon case taking ,considering the causation,the mental and physical symtoms, Opium 200 single dose helped in management of the case

CASE PRESENTATION-

A diagnosed case of haemorrhagic cyst,35 years female presented on 18th of february 2023 with complaints of abdominal sharp severe pain along with vaginal spotting since 15 days . The patient was in delirious state.

HISTORY OF PRESENTING COMPLAIN-

The patients mental state was affected due to the death of her grandmother . She developed delious and delusional mental state.The patient complained of vaginal spotting 15 days ago .Gradually within 3-4 days started with sharp abdominal pain.

MEDICAL HISTORY

Patient had no history of any major illness
Obstetric history-G2P2L2 (normal delivery)
Menstrual history-29 days cycle/5 days of moderate bright red bleeding.

GENETIC AND FAMILY HISTORY-

Mother- Apparently healthy
Father- Type 2 Diabetes mellitus

PAST INTERVENTIONS AND THEIR OUTCOME

Antispasmodics for abdominal pain
Advised-Oopherectomy

Clinical findings

A.Local examination-
Pain in hypogastric and left inguinal region on palpation.

B.Physical generals

- Thirst-small quantity at large intervals
  Stools- once a day/soft stool
- Desire –sweet+
  Urine-Clear urine,4-5 times /day
  Sleep- sound

C.Mental generals

- Delusions of snakes around her
  Dreams of dead grandmother
  Ailments started after death of grandmother.

D.Miasmatic analysis-

- Syco-syphillitic

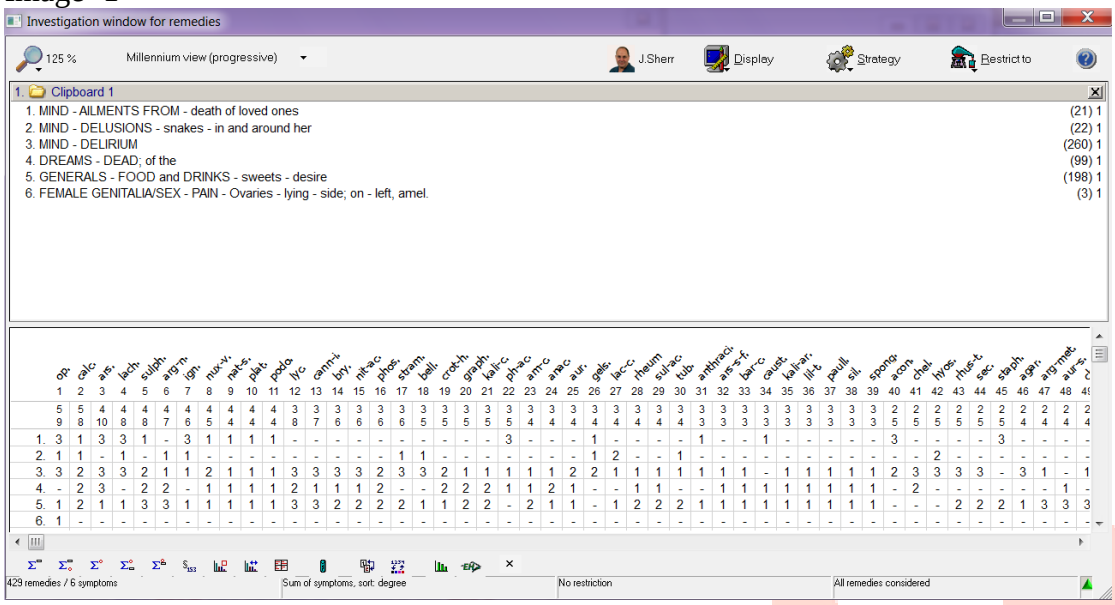
E. USG Reports-13 february 2023
Mild free fluid in Pouch of Douglas and pelvis,suggestive of Pelvic inflammatory disease.
A 20X18X16 mm size dominant follicle in left ovary with haemorrhagic transformation within.

THERAPEUTIC INTERVENTION

Rubrics and Remedial analysis-

MIND - AILMENTS FROM - death of loved ones
MIND - DELUSIONS - snakes - in and around her
MIND - DELIRIUM
DREAMS - DEAD; of the
GENERALS - FOOD and DRINKS - sweets - desire
FEMALE GENITALIA/SEX - PAIN - Ovaries - lying - side; on - left, amel.

Image- 1



Rx,
1.Opium 200,Single doses stat in sacchrum lactis
2.Placebo in 30 number globules,2 drachm bottle to be taken 4 pills BD, 1month

FOLLOW UP

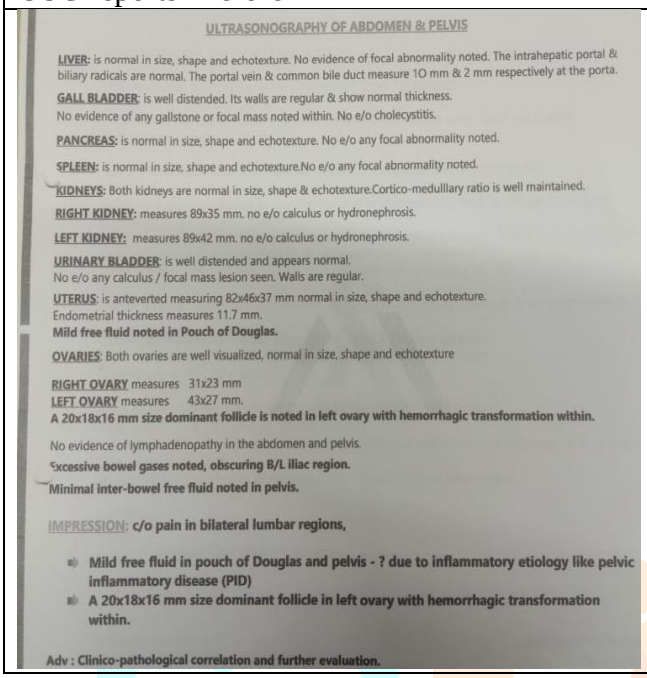
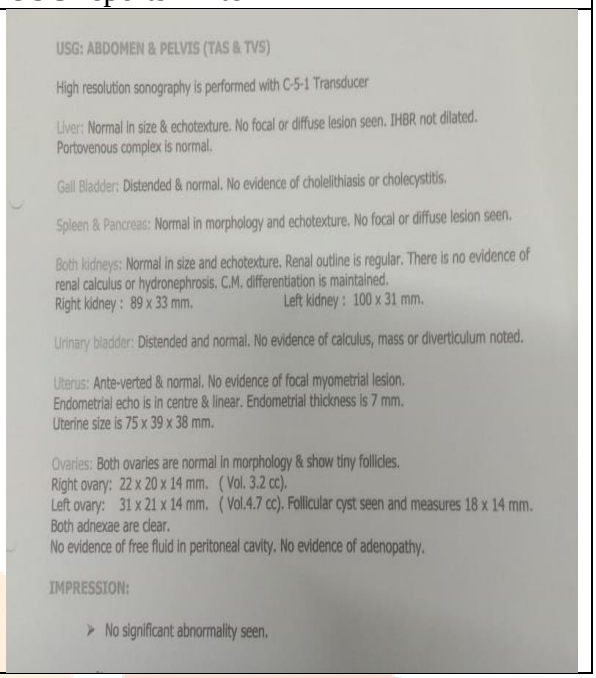
17 March 2023

Vaginal spotting stopped within 24 hours after taking medicine.
The patient was consious and oriented
Abdominal pain better.

Rx,
Placebo in 30 number globules,2 drachm bottle to be taken 4 pills BD, 1month
Advised- USG

2 April 2023

No recurrence of complaints
LMP- 19 march 2023/5 days/moderate flow
Usg – verified no significant abnormality and resolving of Haemorrhagic cyst.

USG reports -Before	USG reports -After
	

ULTRASONOGRAPHY OF ABDOMEN & PELVIS

LIVER: is normal in size, shape and echotexture. No evidence of focal abnormality noted. The intrahepatic portal & biliary radicals are normal. The portal vein & common bile duct measure 10 mm & 2 mm respectively at the porta.

GALL BLADDER: is well distended. Its walls are regular & show normal thickness.
No evidence of any gallstone or focal mass noted within. No e/o cholecystitis.

PANCREAS: is normal in size, shape and echotexture. No e/o any focal abnormality noted.

SPLEEN: is normal in size, shape and echotexture.No e/o any focal abnormality noted.

KIDNEYS: Both kidneys are normal in size, shape & echotexture.Cortico-medullary ratio is well maintained.

RIGHT KIDNEY: measures 89x35 mm. no e/o calculus or hydronephrosis.

LEFT KIDNEY: measures 89x42 mm. no e/o calculus or hydronephrosis.

URINARY BLADDER: is well distended and appears normal.
No e/o any calculus / focal mass lesion seen. Walls are regular.

UTERUS: is anteverted measuring 82x46x37 mm normal in size, shape and echotexture.
Endometrial thickness measures 11.7 mm.
Mild free fluid noted in Pouch of Douglas.

OVARIES: Both ovaries are well visualized, normal in size, shape and echotexture

RIGHT OVARY measures 31x23 mm
LEFT OVARY measures 43x27 mm.
A 20x18x16 mm size dominant follicle is noted in left ovary with hemorrhagic transformation within.

No evidence of lymphadenopathy in the abdomen and pelvis.
Excessive bowel gases noted, obscuring B/L iliac region.
Minimal inter-bowel free fluid noted in pelvis.

IMPRESSION: **c/o pain in bilateral lumbar regions,**

- **Mild free fluid in pouch of Douglas and pelvis - ? due to inflammatory etiology like pelvic inflammatory disease (PID)**
- **A 20x18x16 mm size dominant follicle in left ovary with hemorrhagic transformation within.**

Adv : Clinico-pathological correlation and further evaluation.

USG: ABDOMEN & PELVIS (TAS & TVS)

High resolution sonography is performed with C-5-1 Transducer

Liver: Normal in size & echotexture. No focal or diffuse lesion seen. IHBR not dilated.
Portovenous complex is normal.

Gall Bladder: Distended & normal. No evidence of cholelithiasis or cholecystitis.

Spleen & Pancreas: Normal in morphology and echotexture. No focal or diffuse lesion seen.

Both kidneys: Normal in size and echotexture. Renal outline is regular. There is no evidence of renal calculus or hydronephrosis. C.M. differentiation is maintained.
Right kidney : 89 x 33 mm. Left kidney : 100 x 31 mm.

Urinary bladder: Distended and normal. No evidence of calculus, mass or diverticulum noted.

Uterus: Ante-verted & normal. No evidence of focal myometrial lesion.
Endometrial echo is in centre & linear. Endometrial thickness is 7 mm.
Uterine size is 75 x 39 x 38 mm.

Ovaries: Both ovaries are normal in morphology & show tiny follicles.
Right ovary: 22 x 20 x 14 mm. (Vol. 3.2 cc).
Left ovary: 31 x 21 x 14 mm. (Vol.4.7 cc). Follicular cyst seen and measures 18 x 14 mm.
Both adnexae are clear.
No evidence of free fluid in peritoneal cavity. No evidence of adenopathy.

IMPRESSION:

- No significant abnormality seen.

DISCUSSION-

Ovarian cysts causing clinical complications are reported of about 4% of women being admitted to hospital with an ovarian cyst by the age of 65. Ovarian cysts are also common in older women, with up to 18% of post-menopausal women having simple ovarian cysts and up to 21% having any type of ovarian mass. Most of the ovarian cysts diagnosed in all age groups are usually benign [7]. An ovarian cyst is a is divided into 2 main subtypes mainly physiological and pathological. Physiological cysts are follicular cysts and luteal cysts [8]. Pathological cysts are considered ovarian tumours, which might be benign, malignant, or borderline. Benign tumours are mostly encountered in young females, but malignant are more frequent seen in elderly females[9] ·Majority of ovarian cysts are usually asymptomatic and disappear on their own. Large ovarian cysts may cause abdominal discomfort [10].The signs and symptoms of ovarian cysts include pelvic pain, dysmenorrheal, and dyspareunia. Other symptoms include nausea, vomiting, breast tenderness, fullness and heaviness in the abdomen and frequency and difficulty in urination. Ovarian hematomas are divided into four subtypes namely the large ovarian cysts with hemorrhagic contents due, the perforating hemorrhagic cysts of the ovary, and the follicular and corpus luteum cysts of the ovary which on their rupture may give rise to severe intraperitoneal haemorrhage [11]. Ovarian cyst rupture and haemorrhage are physiological events during the ovarian cycle, involving the follicle or corpus luteum. The theca interna and the corpus luteum are particularly liable to haemorrhage due to their increased vascularity. The most common cause of lower abdominal pain unilaterally in early pregnancy is a corpus luteal cyst, often seen with haemorrhage within. Other gynaecological events that may have a similar clinical presentation to an ovarian cyst event include ectopic pregnancy, PID and a tubo-ovarian abscess. Non-gynaecological causes include appendicitis or an appendix abscess, diverticulitis, intestinal obstruction or urinary tract pathology such as infection or ureteric calculi [12,13]. The case presented here is of 37-year-old female who started with complaints of delirium and delusions after the death of her grandmother. Her mental phase had led to the development of a Haemorrhagic cyst in her left ovary causing her sharp abdominal pain. She dreamt of her dead grandmother. She was in a delirious state where she would sometimes recognise people around and sometimes not. She was almost in a drowsy state most of the time of the day. After taking antispasmodics and antipsychotic medications her condition remained the same. She was then shifted to homoeopathy. After considering the causation, and the mental and physical symptoms, Opium 200 single dose helped in the management of the case. The symptoms did not relapse in the last 1 year. Modified Naranjo criteria for

homoeopathy, casual attribution(MONARCH)[15] inventory was used to assess the curative response of the case which had a score of 12. Reporting of the case adheres to HOM-CASE-CARE [16] guidelines.

Conclusion-Ovarian Haemorrhagic cyst was effectively managed in a pre-diagnosed case with homoeopathic Intervention. While there is limited trial evidence regarding the efficacy of complementary medicine for Ovarian Haemorrhagic cysts, case reports like these can be base for further standardised randomised control trials to evaluate the role of homoeopathic medicines in the management of Ovarian Haemorrhagic cysts.

Declaration of Patient Consent -

The authors certify that they have obtained appropriate patient written format from the patient.

Conflicts of Interest: Authors declare no conflict of interest

Reference

1. Pal PP, Mahato J. Homoeopathic treatment of combined pathology of kidney and ovarian cyst with bulky uterus. World J Pharm Res. 2019 Jan 28;8:897-904.
2. Patel MD, Feldstein VA, Filly RA. The likelihood ratio of sonographic findings for the diagnosis of hemorrhagic ovarian cysts. Journal of ultrasound in medicine. 2005 May;24(5):607-14.
3. Abbas AM, Amin MT, Tolba SM, Ali MK. Hemorrhagic ovarian cysts: Clinical and sonographic correlation with the management options. Middle East fertility society journal. 2016 Mar 1;21(1):41-5.
4. Bottomley C, Bourne T. Diagnosis and management of ovarian cyst accidents. Best practice & research Clinical obstetrics & gynaecology. 2009 Oct 1;23(5):711-24.
5. Nath A, Palit DK, Kundu N. Homoeopathic management of ovarian cyst–a case report. Int J Res Ayush Allied Syst. 2019;6:2393-9.
6. Chakma A, Ranjan Sarangi M. Homoeopathic treatment of hepatic haemangioma with ovarian cyst.
7. Abduljabbar HS, Bukhari YA, Al Hachim EG, Ashour GS, Amer AA, Shaikhoon MM, Khojah MI. Review of 244 cases of ovarian cysts. Saudi medical journal. 2015 Jul;36(7):834.
8. Grimes DA, Jones LB, Lopez LM, Schulz KF. Oral contraceptives for functional ovarian cysts. Cochrane Database SystRev. 2014;4:CD006134.
9. Hongqian L, Xiangao W, Donghao L, Zhihong L, Gang S. Ovarian masses in children and adolescents in China: analysis of 203 cases. J Ovarian Res. 2013;6:47.
10. Rofe G, Auslend R, Dirnfeld M. Benign ovarian cysts in reproductive-age women undergoing assisted reproductive technology treatment. Open J Obstet Gynecol. 2013;3:17–22.
11. Farghaly SA. Current diagnosis and management of ovarian cysts. Clin Exp Obstet Gynecol. 2014;41:609–612.
12. Medeiros L, Rosa D, Bozzetti M, Fachel J, Furness S, Garry R, Rosa M, et al. Laparoscopy versus laparotomy for benign ovarian tumour. Cochrane Database Syst Rev. 2009;2:CD004751.
13. Bottomley C, Bourne T. Diagnosis and management of ovarian cyst accidents. Best Pract Res Clin Obstet Gynaecol. 2009;23:711–724.

14. Lamba CD, Gupta VK, van Haselen R, Rutten L, Mahajan N, Molla AM, Singhal R. Evaluation of the Modified Naranjo Criteria for assessing causal attribution of clinical outcome to homeopathic intervention as presented in case reports. Homeopathy. 2020 Nov;109(04):191-7.
15. Van Haselen RA. Homeopathic clinical case reports: Development of a supplement (HOM-CASE) to the CARE clinical case reporting guideline. Complement Ther Med 2016; 25:78-85.