Theft of Womanhood – Polycystic Ovarian Syndrome: Role of Homeopathy

Dr Rekha Thomas, MD (Hom)

Abstract: This article gives an account on the Polycystic Ovarian Syndrome and two cases studies illustrating treatment with individualised homeopathic approach that proved to be beneficial.

Keywords: PCOS, epidemic, homeopathy, hirsuitism, infertility, oligomenorrhoea

Introduction

Polycystic Ovarian Syndrome (PCOS) is a complex metabolic, endocrine, reproductive and psychosocial disorder that impacts quality of life of a female patient. This syndrome has a major impact on the psychosocial health of a woman as it impairs *feminity* due to menstrual abnormalities, infertility, obesity, hirsutism, hair loss, and facial acne. Approximately 5-10% of the female population in developed countries is affected, while the prevalence in India is 9.13%. (2) The global prevalence of PCOS is on the rise and is showing a galloping increase in parallel with the rising prevalence of type 2 diabetes mellitus.

Before the induction of clinical ultrasonography in 1980, PCOS was known as Stein-Leventhal Syndrome after I.F. Stein and M.L. Leventhal-the first researchers to recognise an association between the presence of polycystic ovaries, signs of hirsutism and amenorrhea, in the year 1935. After women diagnosed with Stein-Leventhal syndrome underwent successful wedge resection of the ovaries, their menstrual cycles became regular, and they were able to be pregnant. As a consequence, a primary ovarian defect was thought to be the main culprit, and the disorder came to be known as *Polycystic Ovarian Disease*. Further biochemical, clinical, and endocrinological studies revealed an array of underlying abnormalities. As a result, the condition is now referred to as *Polycystic Ovarian Syndrome*; although it may occur in women without ovarian cysts and in recent times ovarian morphology is no longer an essential requirement for diagnosis.

Aetiopathogenesis

There are multiple underlying pathophysiological mechanisms due to the heterogeneity of this disorder. Several theories have been proposed to explain the pathogenesis of PCOS.

a) An alteration in gonadotropin-releasing hormone secretion results in increased luteinizing hormone (LH) secretion.
b) An alteration in insulin secretion and insulin action results in hyperinsulinemia and insulin resistance.
c) A defect in androgen synthesis that results in increased ovarian androgen production.

Genetic and environmental contributors along with other factors, including obesity complicate the pathogenic cycle. Insulin resistance contributes not only to metabolic features but also to reproductive features through augmenting androgen production and increasing free androgens by reducing Sex Hormone Binding Globulin (SHBG). Obesity increases hyperandrogenism, hirsutism, infertility and pregnancy complications both independently and by exacerbating PCOS.

Clinical Features

The major features of PCOS include menstrual dysfunction, anovulation, and signs of hyperandrogenism. Other signs and symptoms of PCOS are hirsutism, infertility, obesity, metabolic syndrome, diabetes and obstructive sleep apnea. Although the majority of women diagnosed with PCOS are anovulatory, only small percentages are totally amenorrheic. Majority are oligomenorrheic (i.e. infrequent menses), having only six to eight spontaneous episodes of vaginal bleeding per year. Typically, PCOS-associated menstrual dysfunction develops during the perimenarchal period. Hirsutism is the most common manifestation of androgen excess associated with PCOS. It affects approximately 70% of women with PCOS. Increased androgen levels are also associated with the increased sebum production and acne, which are frequently seen in women with PCOS. Acanthosis nigricans, a dermatologic condition in which the skin appears velvety and hyperpigmented, is frequently seen in persons who are in a state of insulin resistance. It is often found on the nape of the neck, the axilla, and the area beneath the breasts. The obesity commonly seen with PCOS is characterised by an increase in the waist circumference (> 35 inches) as opposed to truncal or overall obesity.

Long-Term Health Risks

Women with PCOS are at increased (3–7 times) risk of developing type 2 diabetes, cardiovascular disease. Insulin-resistant states are associated

with greater than normal susceptibility to coronary heart disease and dyslipidaemia and markers of abnormal vascular function. Women with PCOS are also thought to be at increased risk for endometrial cancer through chronic anovulation with unopposed estrogen exposure of the endometrium.

Diagnosis and Differential Diagnosis

The diagnosis of PCOS is one of exclusion. In October 2013, The Endocrine Society recommended the use of Rotterdam criteria for diagnosing PCOS. Presence of two out of the following three criteria is required for diagnosis of PCOS (Rotterdam consensus workshop 2003):

1. Oligomenorrhoea/ amenorrhoea,
2. Hyperandrogenism (clinical and/or biochemical),
3. Polycystic ovary on ultrasound with exclusion of other etiologies.

All other endocrinal disorders responsible for these symptoms must be ruled out. Ultrasound diagnosis by transvaginal sonography is done on the basis of three criterias: presence of 12 or more cysts of 2- 9mm, Ovarian volume equal to or more than 12 cm and bright echogenic stroma.

PCOS has to be differentiated from Pregnancy, Hypothyroidism, Hyperprolactinemia, Ovarian tumour, Adrenal tumour, Cushings syndrome.

Physical Examination and Laboratory Investigations

The physical examination should include an assessment of the body mass index and the blood pressure. An elevated blood pressure may suggest androgen excess related to congenital adrenal hyperplasia. The amount and distribution of excess hair should be noted. The Ferriman-Gallwey scoring system has been used for evaluation of hirsutism but is limited by subjective variability and is thought by many experts to be of little clinical use. Signs of virilization should be evaluated. Skin changes are to be noted, such as acne, acanthosis nigricans, and striae, which may be the clinical features of Cushing's syndrome. A thorough abdominal and pelvic examination should be performed to exclude any masses. It is also important to check for the presence of galact-orrhea by compressing the areola from its outer perimeter toward the nipple.

The Blood tests that should be done are:

1. LH (measured on day 2-3 or any day if amenorrhic
2. FSH (measured on day 2-3 or any day if amenorrhic)
3. TSH
4. Prolactin
5. Lipid Profile
6. Fasting Insulin
7. Glucose tolerance test
8. DHEAS
9. Total and free testosterone

General Management

Lifestyle modification is the first line of treatment and it is known that even 5-10% weight loss has led to significant clinical benefits improving psychological outcomes, reproductive and metabolic features.

Weight loss: Aim of weight loss of 5-10% and BMI of < 27.

Diet: Diet modifications in the form of consumption of foods of low glycemic index and limiting carbohydrates and foods high in PUFA is advocated.

Exercise: Aerobic exercises like walking, jogging, swimming etc for at least 30 minutes for at least 5 days a week.

Homoeopathic Approach in PCOS

In the past, polycystic ovary syndrome has been looked at primarily as an endocrine disorder. Studies now show that polycystic ovary syndrome is a metabolic, hormonal, and psychosocial disorder that impacts a patient's quality of life. Studies have shown that depression and anxiety are common in patients with PCOS as compared with healthy women due to obesity and metabolic abnormalities. The depression and anxiety did not show a significant change in PCOS after treatment with oral contraceptive pills. Homeopathy approaches such cases with a holistic view point. Homeopathic approach towards management of PCOS is constitutional, taking into account the patient's physical symptoms along with their mental and genetic make-up that individualises the person. In the foot note of aphorism 94 of *Organon of medicine*, Dr Samuel Hahnemann mentions in detail the points to be noted in case taking of chronic diseases of females. Early intervention with homeopathy can assist in preventing further progress and hence deterioration caused by PCOS. Homeopathic constitutional treatment helps to balance hyperactivity of the glands, regulate hormonal balance, dissolve the cysts in the ovaries and enhances the normal functioning of ovaries thereby eliminating the need for hormone therapies and surgery. This can significantly increase the chances of conception. The different expressions of this disease can be managed effectively, safely and gently with homeopathic remedies. Proper case taking, analyses and evaluation of case followed by repertorisation is the ideal

homeopathic approach.

Some Important Rubrics with Medicines for PCOS

Repertory of Hering's Guiding Symptoms of our Materia Medica

Genitalia, female, ovaries, affections (undefined) – (page 1130) ARN, KREOS, **LYC**, Pall, **Plat**

Genitalia, female, ovaries, congestion- (Page 1131) Apis, BELL, Ham, Polyg-h, SEP, Syph, Ust

Genitalia, female, ovaries, swelling (see congested, enlarged, inflammation, tumour)- (page 1136) APIS, bell, BUFO, Con, Ham, IOD, LACH, LIL-T, Ust

Genitalia, female, ovaries, tumours – Page 1136 **APIS**, Apoc, APS, BAR.M, CALC, COLO, Iod, **LYC**, PLAT, Podo

Kent's Repertory of Homeopathic Materia Medica

GENITALIA FEMALE; TUMORS; Ovaries: **Apis., Lach., Lyc.**, *ars., bar-m., calc., coloc., iod., plat., podo.,* apoc., ars- fl-ac., graph., hep., staph., stram., syph., thuj., zinc.

Case Studies

Two case studies of patients suffering from PCOS, who were treated successfully based on individualised homeopathic approach, are described.

Case 1

A 26 year old married lady presented in the OPD of Nehru Homeopathic Medical College & Hospital on 17.7.13 with the diagnosis of PCOS. She was dark complexioned and of heavy built. She complained of irregular and scanty menses since 3 years and pain in right iliac fossa since 7 years. She also complained of weight gain and falling of hair. There was pain in the whole lower abdomen, especially the right iliac fossa after appendicectomy 7 years back. Pain was of pricking nature, relieved by pressure.

Her menstrual history revealed that she had her menarche at the age of 12years, and her cycles had now become irregular and scanty since 3 years. The flow lasted for one to two days and cycle was of 45 to 60 days duration. Discharge was dark brown, scanty and offensive. Pain in iliac region, especially right side during menses. She was taking Oral Contraceptive Pills since 3 years.

LMP: 29.05.13

Past History

She underwent appendicectomy 7years back.

Family History

All family members are healthy and alive.

Personal History

She is married since 4 years, takes vegetarian diet. She is working as a senior manager in a consultancy

Physical generals

Appetite: increased, heaviness after eating with flatulence

Desires: sweets, spicy and warm food

Stools: Tendency for constipation

Perspiration: Profuse and generalised

Sleep: She prefers to sleep on right side

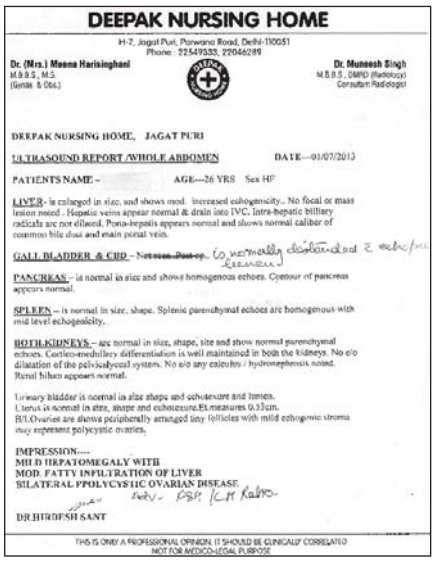
Thermal reaction: Hot

Mental Generals

She appeared to be very domineering.

Investigations

Ultrasound Report of 01/07/13 revealed Bilateral Polycystic Ovarian Disease, mild hepatomegaly with moderate fatty infiltration of liver. *(Figure 1)*



DEEPAK NURSING HOME

H-7, Jagat Puri, Parwana Road, Delhi-110051
Phone : 22549333, 27046289

Dr. (Mrs.) Meena Harisinghani
M.B.B.S., M.S.
(Genito. & Obs.)

Dr. Muneesh Singh
M.B.B.S., DMRD (Radiology)
Consultant Radiologist

DEEPAK NURSING HOME, JAGAT PURI

ULTRASOUND REPORT /WHOLE ABDOMEN DATE—01/07/2013

PATIENTS NAME – AGE---26 YRS Sex HF

LIVER- is enlarged in size, and shows mod. increased echogenicity.. No focal or mass lesion noted . Hepatic veins appear normal & drain into IVC. Intra-hepatic billiary radicals are not dilated. Porta-hepatis appears normal and shows normal caliber of common bile duct and main portal vein.

GALL BLADDER & CBD – Not seen. Post op. (o/w normally distended & echo free)

PANCREAS – is normal in size and shows homogenous echoes. Contour of pancreas appears normal.

SPLEEN – is normal in size, shape. Splenic parenchymal echoes are homogenous with mid level echogenicity.

BOTH KIDNEYS – are normal in size, shape, site and show normal parenchymal echoes. Cortico-medullary differentiation is well maintained in both the kidneys. No e/o dilatation of the pelvicalyceal system. No e/o any calculus / hydronephrosis noted. Renal hilum appears normal.

Urinary bladder is normal in size shape and echotexture and lumen.
Uterus is normal in size, shape and echotexture.Et measures 9.33cm.
B/L Ovaries are shown peripherally arranged tiny follicles with mild echogenic stroma may represent polycystic ovaries.

IMPRESSION----
MILD HEPATOMEGALY WITH
MOD. FATTY INFILTRATION OF LIVER
BILATERAL PPOLYCYSTIC OVARIAN DISEASE

DR HITADESH SANT

THIS IS ONLY A PROFESSIONAL OPINION. IT SHOULD BE CLINICALLY CORRELATED NOT FOR MEDICO-LEGAL PURPOSE

Figure 1

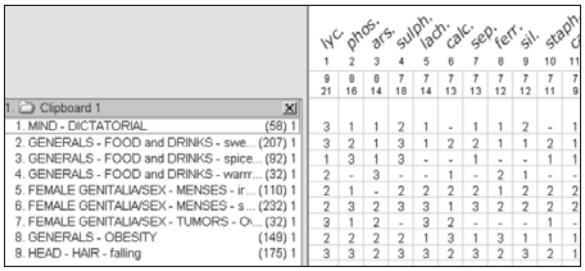
Prescription and Follow-up

After repertorisation *(Figure 2)* and consulting Materia Medica, *Lycopodium* was selected. Patient was told to follow a strict regimen of regular exercise and healthy food with low glycemic index. She was told to report every month after her periods.

17.7.13: Prescription -*Lycopodium* 200/1dose

14.08.13: Menses appeared on 31.07.13. Flow was scanty. Pain present Prescription -*Lycopodium* 200/1dose and placebo for 4 weeks.

04.09.13: LMP: 27.08.13. Menses



Clipboard 1	lyc.	phos.	ars.	sulph.	lach.	calc.	sep.	ferr.	sil.	staph.
	1	2	3	4	5	6	7	8	9	10	11
	9 21	8 16	8 14	7 18	7 14	7 13	7 13	7 12	7 12	7 11	7 9
1. MIND - DICTATORIAL (58) 1	3	1	1	2	1	-	1	1	2	-	1
2. GENERALS - FOOD and DRINKS - swe... (207) 1	3	2	1	3	1	2	2	1	1	2	1
3. GENERALS - FOOD and DRINKS - spice... (92) 1	1	3	1	3	-	-	1	-	-	1	1
4. GENERALS - FOOD and DRINKS - warm... (32) 1	2	-	3	-	-	1	-	2	1	-	-
5. FEMALE GENITALIA/SEX - MENSES - ir... (110) 1	2	1	-	2	2	2	2	1	2	2	2
6. FEMALE GENITALIA/SEX - MENSES - s... (232) 1	2	3	2	3	3	1	3	2	2	2	2
7. FEMALE GENITALIA/SEX - TUMORS - O... (32) 1	3	1	2	-	3	2	-	-	-	1	-
8. GENERALS - OBESITY (149) 1	2	2	2	2	1	3	1	3	1	1	1
9. HEAD - HAIR - falling (175) 1	3	3	2	3	3	2	3	2	3	2	1

Figure 2: Case 1 Repertorisation

appeared on time. Quantity of flow slightly better. Pain during menses better. Prescription - Placebo/4weeks

05.10.13: Menses is coming regularly. Flow has improved. Prescription - Placebo/4weeks

As there was relief in her menstrual and general symptoms the medicine was not repeated.

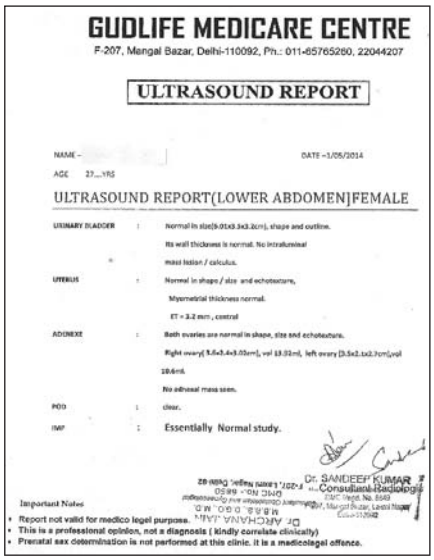
Moreover she had managed to reduce her weight also.

15.01.14: Patient came with the complaint of delayed menses. Her gastric symptoms were also aggravated. Prescription-*Lycopodium* 1M/1dose, Placebo/4weeks

12.03.14: Menses was coming regularly. Now she had flow for 3 days. Hair fall has reduced. Prescription - Placebo/4weeks

16.4.14: Menses has become regular with moderate flow. General complaints were better. There was reduction of 7kg of body weight. Prescription - Placebo/4weeks.

USG dated 01/05/14 showed 'essentially normal study'. *(Figure 3)*



GUDLIFE MEDICARE CENTRE

F-207, Mangal Bazar, Delhi-110092, Ph.: 011-65765260, 22044207

ULTRASOUND REPORT

NAME -

DATE -1/05/2014

AGE 27...YRS

ULTRASOUND REPORT(LOWER ABDOMEN]FEMALE

URINARY BLADDER : Normal in size(9.01x3.3x3.2cm), shape and outline.
Its wall thickness is normal. No intraluminal
mass lesion / calculus.

UTERUS : Normal in shape / size and echotexture.
Myometrial thickness normal.
ET = 3.2 mm , central

ADNEXE : Both ovaries are normal in shape, size and echotexture.
Right ovary(3.6x3.4x3.0cm), vol 19.92ml, left ovary [3.5x2.1x2.7cm],vol
10.6ml.
No adnexal mass seen.

POD : clear.

IMP : Essentially Normal study.

Dr. SANDEEP KUMAR
Consultant Radiologist

Important Notes
- Report not valid for medico legal purpose.
- This is a professional opinion, not a diagnosis (kindly correlate clinically)
- Prenatal sex determination is not performed at this clinic. it is a medicolegal offence.

Figure 3

Patient was advised to continue a strict regimen of regular exercise and healthy food with low glycemic index. She was also advised to plan for pregnancy. Counselling was given at every visit to boost the morale of the patient and motivate her to maintain a healthy lifestyle.

Case 2

A 19 year old unmarried girl presented in the OPD of Nehru Homeopathic Medical College & Hospital on 29.5.13 with the diagnosis of PCOS. She complained of irregular and scanty menses since 3 months and also complained of heaviness of whole body as if swollen. Along with heaviness there was sensation of heat and shifting pains in head. Premature graying of hair was present

Her menstrual history revealed that she had her menarche at the age of 14years, now irregular and scanty since 3 months. Cycle: 2-3/45day's. Bright red discharge. LMP: 12.05.13.

She was dark complexioned and had a short stature.

Past History

Chicken pox at 15years of age.

Family History

Mother suffers from Diabetes Mellitus

Physical Generals

Appetite: Decreased, Feels nauseated

Desires: Spicy food

Thirst: Decreased, likes cold water

Stools: Tendency for constipation, passes hard stool once in 2 to 3 days.

Sleep: Unrefreshing sleep. Feels tired and wants to sleep all the time.

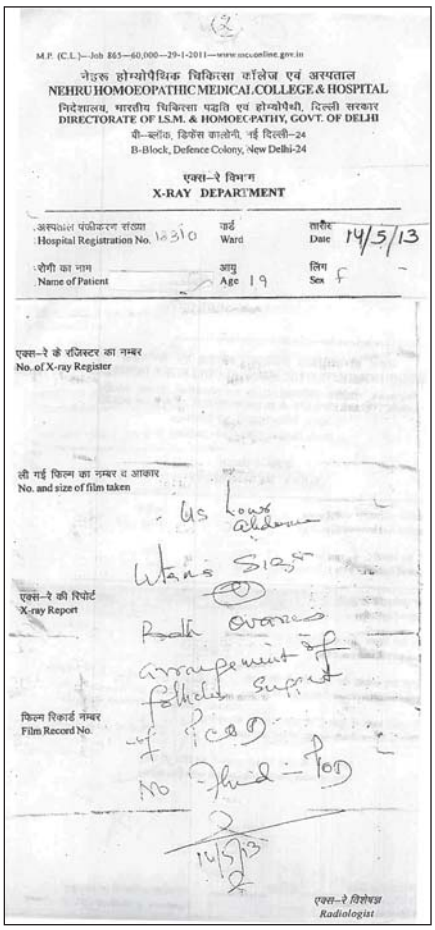
Thermal reaction: Hot

Mental Generals

Patient was tensed about the poor financial condition at home. She was very sensitive and was crying while telling about her symptoms.

Investigation

Ultrasound Report of 14/05/13 Revealed Bilateral Polycystic Ovarian Disease. *(Figure 4)*



NEHRU HOMOEOPATHIC MEDICAL COLLEGE & HOSPITAL
DIRECTORATE OF I.S.M. & HOMOEOPATHY, GOVT. OF DELHI
B-Block, Defence Colony, New Delhi-24

X-RAY DEPARTMENT

Hospital Registration No. 13310 Ward Date 14/5/13

Name of Patient Age 19 Sex F

No. of X-ray Register

No. and size of film taken

X-ray Report

Film Record No.

Radiologist

Figure 4

Prescription and Followup

After repertorisation *(Figure 5)* and consulting materia medica *Apis Mellifica* was selected.

Patient was told to follow a strict regimen of regular exercise and healthy food with low glycemic index. She was told to report every month after her periods.

	lyc.	phos.	sulph.	sep.	puls.	ars.	nux-v.	apis	arg-n.	calc.	cocc.	caust
	1	2	3	4	5	6	7	8	9	10	11	12
	11/26	10/23	10/23	10/22	10/21	10/20	10/19	9/20	9/18	9/18	9/17	8/1
1. MIND - WEEPING tearful mood,etc (167)	1	3	2	3	3	3	1	2	3	2	3	2	3	2
2. HEAD - HAIR, - gray,becomes (11)	1	3	-	-	-	-	2	-	-	-	-	-	-	-
3. STOMACH - DESIRES - cold drinks (95)	1	2	3	1	2	1	3	1	-	2	2	2	2	-
4. STOMACH - DESIRES - highly seasoned ... (11)	1	-	3	3	1	1	-	2	-	-	-	-	-	-
5. STOMACH - THIRSTLESS (87)	1	2	1	1	2	3	2	1	3	2	-	1	1	2
6. RECTUM - CONSTIPATION (213)	1	3	3	3	3	2	3	3	3	2	3	3	3	3
7. STOOL - HARD (164)	1	3	3	3	3	2	2	3	2	2	3	2	2	1
8. FEMALE GENITALIA - MENSES, - irregular (61)	1	2	1	2	2	1	-	2	2	2	2	2	2	2
9. FEMALE GENITALIA - MENSES, - scanty (101)	1	2	3	3	3	3	2	2	2	2	1	2	2	2
10. FEMALE GENITALIA - TUMORS - Ovaries (20)	1	3	-	-	-	-	2	-	3	-	2	-	-	1
11. SLEEP - UNREFRESHING (111)	1	2	3	2	2	2	2	1	2	1	2	1	1	1
12. GENERALS - SWOLLEN sensation (112)	1	1	1	2	1	3	1	1	1	2	1	2	1	1

Figure 5: Case 2 Repertorisation

29.5.13: Prescription -*Apis mel* 30/9doses (TDS for 3 days); Placebo/4weeks

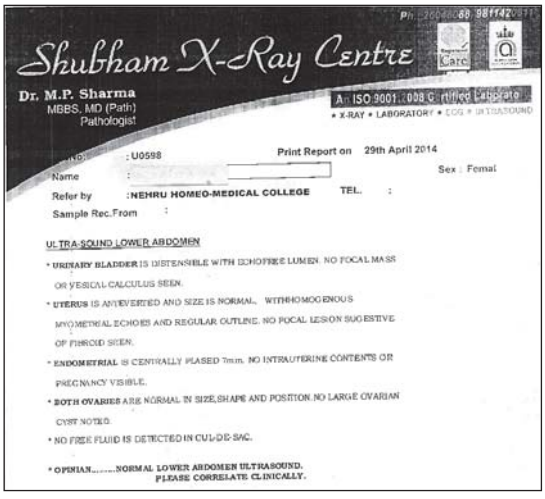
24.07.13: Menses appeared on time. Nausea and flatulence better. Prescription - Placebo /4weeks

21.08.13: Menses is coming regularly. Quantity of flow slightly better. Sensation of heaviness of whole body: same. Prescription– *Apis mel* 30/9doses (TDS for 3 days); Placebo /4weeks

23.10.13: Menses is coming regularly. Flow scanty. Prescription – *Apis Mel* 200/1 dose. Placebo/4weeks

11.12.13: There was relief in her menstrual and general symptoms. She had reduced weight also. Prescription-Placebo /4weeks

12.03.14: Return of old complaints. Prescription - Apis 1M/1dose; Placebo/4weeks


Shubham X-Ray Centre

Dr. M.P. Sharma
MBBS, MD (Path)
Pathologist

An ISO 9001 : 2008 Certified Laboratory
• X-RAY • LABORATORY • ECG • ULTRASOUND

: U0598 Print Report on 29th April 2014
Name : Sex : Femal
Refer by :NEHRU HOMEO-MEDICAL COLLEGE TEL. :
Sample Rec.From :

ULTRA-SOUND LOWER ABDOMEN

* URINARY BLADDER IS DISTENSIBLE WITH ECHOFREE LUMEN. NO FOCAL MASS OR VESICAL CALCULUS SEEN.
* UTERUS IS ANTEVERTED AND SIZE IS NORMAL. WITHHOMOGENOUS MYOMETRIAL ECHOES AND REGULAR OUTLINE. NO FOCAL LESION SUGESTIVE OF FIBROID SEEN.
* ENDOMETRIAL IS CENTRALLY PLASED 7mm. NO INTRAUTERINE CONTENTS OR PREGNANCY VISIBLE.
* BOTH OVARIES ARE NORMAL IN SIZE,SHAPE AND POSITION.NO LARGE OVARIAN CYST NOTED.
* NO FREE FLUID IS DETECTED IN CUL-DE-SAC.

* OPINION.....NORMAL LOWER ABDOMEN ULTRASOUND.
PLEASE CORRELATE CLINICALLY.

Figure 6

30.04.14: Menses coming regularly. Now she had flow for 3 days. Sensation of heaviness was also better. Prescription: Placebo/4weeks.

Ultrasound Report of 29.04.14 revealed 'Essentially normal study' Prescription - Placebo/4weeks. *(Figure 6)*

The patient was advised to continue a strict regimen of regular exercise and healthy food with low glycemic index. The patient who was in her teenage years was very much worried about her appearance, hence she was also counseled periodically to boost her morale and motivate her to maintain a healthy lifestyle

Discussion

The two patients of PCOS presented with irregular and scanty menses with obesity. Both the patients were young and very much concerned about their appearance and future childbearing capacity. Hormonal assay and USG pelvis in both the cases indicates Polycystic Ovarian Syndrome. After case taking and analysing the cases, repertorisation was done and the final selection of the medicine was made with the help of Materia Medica. The patients were reviewed monthly after every menses. The pelvic ultrasound and hormonal assay were repeated regularly. Both cases have shown improvement symptomatically as well as shown disappearance of the ovarian pathology in cases of PCOS after homeopathic treatment. Information on various studies indicates a positive role of homeopathy in PCOS but more rigorous studies with well documented cases with investigation reports is a need of the hour and shall help in achieving the goal of evidence-based medicine for homeopathy in such conditions.

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About the Authors

Dr Rekha Thomas, studied homeopathy from 'Government Homeopathic Medical College', Calicut, Kerala and is working as Reader, Department of Gynaecology & Obstretics Nehru Homoeopathic Medical College, New Delhi.

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The Change of Life in Women: Role of Homeopathy

Dr Rekha Thomas, MD (Hom.)

Abstract: Menopause or the 'change of life' is the permanent cessation of menstruation resulting from the loss of ovarian follicular activity. It involves biological and psychosocial changes that may significantly impair quality of life in a woman. With increase in life expectancy, on an average a woman spends one- third of her life in a state of oestrogen deprivation with long term symptomatic and metabolic complications. Homeopathy is the safest treatment for menopausal complaints because it stimulates the natural hormonal balance without the use of harmful drugs. Moreover since the treatment modality of Hormone Replacement Therapy has many adverse effects, homoeopathy has the potential to develop as the first line of treatment for the management of menopausal complaints.

Keywords: menopause, homeopathy, hormone replacement therapy

Introduction

The term natural menopause is defined as the permanent cessation of menstruation resulting from the loss of ovarian follicular activity. Natural menopause is recognised to have occurred after twelve consecutive months of amenorrhea, for which there is no other obvious pathological or physiological cause. Menopause occurs with the final menstrual period (FMP) which is known with certainty only in retrospect a year or more after the event. An adequate biological marker for the event does not exist. [Source: WHO][1]. The word menopause is derived from two Greek words *mens* meaning 'month' and *pausis* meaning 'stop'.

The manifestation of physiological changes of menopause can be very variable among women as to the age of onset, symptoms produced, duration, intensity etc. At menopausal age, the health status of a woman is influenced by factors such as her career, changes in family life, diet and physical activity, the economy, society and the environment. These changes, together with the natural process of ageing and the hormonal changes in the reproductive system, affect the wellbeing of women. It was only in the last decade that the menopausal syndrome was identified and acknowledged as an issue that affected some women and become a matter of concern to health care providers. Sixty million women in India are above the age of 55 years. An average Indian woman now lives up to 65 years of age, whereas in developed countries a lifespan up to 80 years is possible, with the consequence that a woman spends one-third of her life in a state of oestrogen deprivation with long term symptomatic and metabolic complications.[2] It is important therefore to address all these menopause related diseases and apply prophylactic measures so that these women can lead an enjoyable and healthy life.

Age of menopause is genetically predetermined. It ranges from 45 to 50 years, average being 47 years. Hormonal changes and clinical symptoms occur over a period leading up to and immediately following menopause. This period is frequently termed the climacteric or peri-menopause but is increasingly referred to by a more recently coined term, the Menopausal Transition (MT). The MT characteristically begins years before menopause.[3, 4] Delayed menopause is seen in women suffering from uterine fibroids and those at high risk of endometrial cancer. If menopause occurs below 40 years it is called premature menopause. Smoking induces premature menopause.[2]

During climacteric, the ovarian activity declines. Initially, ovulation fails, no corpus luteum forms and no progesterone is secreted by the ovary. Therefore, the pre-menopausal menstrual cycles are often anovulatory and irregular. Later, graffian follicles also fail to develop, oestrogenic activity is reduced and endometrium atrophies leading to amenorrhoea. Cessation of ovarian activity and a fall in the oestrogen and inhibin levels cause a rebound increase in the secretion of Follicle Stimulating Hormone (FSH) and Luteinizing Hormone (LH) by the anterior pituitary gland. With advancing years, gonadotrophin activity of the pituitary gland also ceases, and a fall in the FSH level eventually occurs.

Table 1: Hormone levels in a menopausal woman[2]

E2	5-25pg/ml
Oestrone	20-70pg/ml-more in obese woman
FSH	>40mIU/ml
Androgen	0. 3-0. 1ng/ml

Testosterone	0. 1-0. 5ng/ml
LH	50-100mIU/ml
Androstenedione	800pg/ml

Menopause is characterised by a myriad of symptoms. The three classical ways in which the menstrual period ceases are sudden cessation, gradual diminution in the amount of blood loss with each regular period until menstruation stops, and gradual increase in the spacing of the periods until they cease for at least a period of one year. Although by definition, menopause is said to have set in if amenorrhoea lasts for a year, a woman who bleeds after a gap of six months is considered to have post-menopausal bleeding and should be thoroughly investigated.

Table 2: Most frequently observed afflictions in menopause[5]

Hot flushes/perspiration	60-80%
Insomnia	50-70%
Loss of drive / tiredness	50-80%
Nervousness/irritability	70%
Forgetfulness	65-70%
Depression	20-80%
Headaches	40-80%
Loss of libido	20-80%
Arthralgia/myalgia	40-55%
Palpitation	20-50%
Weeping spasms	40%
Paresthesia	25%
Dizziness	20%

Menopausal women with chronic oestrogen deficiency are liable to develop arthritis, osteoporosis and fracture, cardiovascular accidents such as ischaemic heart disease, myocardial infarction, atherosclerosis, and hypertension, stroke, skin changes, Alzheimer disease, ano-colonic cancer, tooth decay, prolapse genital tract, stress incontinence of urine, faecal incontinence, cataract, glaucoma and macular degeneration, locomotor system disorders – menopausal arthropathy, osteoarthritis

Investigations

- General examination includes blood pressure recording, palpation of the breasts, weight and hirsutism.
- Blood sugar, lipid profile, ECG
- Mammography, pelvic ultrasound
- Pelvic examination such as pap smear
- Vaginal cytology – showing maturation index of at least 10/85/5 (features of low oestrogen)
- Endometrial biopsy can show a range of endometrial appearances, from mildly proliferated to atrophic. Endometrial hyperplasia can be suggested by ultrasonographic findings (i.e. endometrial thickness >5 mm), which are useful for excluding hyperplasia and cancer of the endometrium in postmenopausal women. Endometrial biopsy is indicated in women on Hormone Replacement Therapy (HRT) and tamoxifen.
- Serum estradiol (Normal value <20pg/ml)
- Serum FSH and LH. Normal value: >40mIu/ml (three values at weeks interval required) FSH is the diagnostic marker for ovarian failure.
- Assessment of Anti-Müllerian hormone (AMH) and Müllerian-inhibiting substance (MIS), which are produced by granulosa cells of follicles may be the earliest and most effective way of measuring progress toward menopause. [3,4]
- Bone density study. DEXA is a quick test with less radiation
- Hysteroscopy allows visually guided biopsies and the identification and removal of focal lesions, including endometrial polyps or submucous fibroids in the uterine cavity
- The European Menopause and Andropause Society (EMAS) recommendation on endometrial assessment in perimenopausal and postmenopausal women says that no single method is perfect, and a combination of methods may be necessary for the diagnosis.

Management

Modern medicine employs Hormone replacement therapy (HRT) to treat the symptoms of menopausal transition (MT) and actual menopause. The American College of Obstetricians and Gynaecologists recommends treatment of vasomotor symptoms of menopause and vaginal atrophy, by systemic hormone therapy with oestrogen or oestrogen plus progestin. They recommend low-dose oestrogen and ultra-low systemic doses of oestrogen as they have a better adverse effect profile than standard doses. Alternatives to hormone therapy for vasomotor symptoms include selective serotonin reuptake inhibitors, selective serotonin and norepinephrine reuptake inhibitors, clonidine, and gabapentin[6]. Paroxetine mesylate (Brisdelle) is the first non-hormonal therapy for vasomotor symptoms (VMS) (hot flashes) associated with menopause. But labeling for paroxetine will include a boxed

warning about the increased risk for suicidality and a warning that paroxetine mesylate can reduce the effectiveness of the breast cancer drug tamoxifen, increase bleeding risk, and increase the risk for serotonin syndrome[7,8].

But the use of HRT is associated with several adverse effects like bloating, mastodynia, vaginal bleeding, and headaches. Selective oestrogen receptor modulators (SERMs) and oestrogen increase the risk of thromboembolic events [9]. Some studies show an increased risk of breast cancer with postmenopausal oestrogen use. The use of hormone replacement therapy (HRT) also appears to be associated with an increased risk of acute pancreatitis. [10,11]

Homeopathic Approach in Menopausal Complaints

Menopause is a transitional phase during which a lady undergoes lot of hormonal, metabolic and psychic changes which manifest as symptoms unique to each woman. According to the symptomatology and the unique symptoms, a suitable homeopathic constitutional remedy can be chosen to manage both, the physical and the emotional aspect of menopause. Dr Hahnemann in §153 of *Organon of Medicine*[12] says that it is the peculiar, characteristic and individualizing symptoms and not the common symptoms that denote the similimum; further he says in § 210 that, '*In all cases of disease to be cured, the patient's emotional state should be noted as one of the most preeminent symptoms, along with the symptom complex, if one wants to record a true image of the disease in order to be able to successfully cure it homeopathically'*. Dr Elizabeth Wright Hubbard reported such good results in treating women with homeopathic medicines that she proclaimed, '*under Homeopathy life can begin at 60'*.

A review of homeopathic literature showed that both, the materia medica and the repertory are rich in medicines for menopausal complaints. A study of the *Synthesis Repertory* 8.0[13], shows that the following rubrics cover various menopausal complaints:

MIND - ANXIETY - fear; with - menopause; during

MIND - ANXIETY - health; about - own health; his - menopause; during

MIND - ANGER - delusions during menopause; with

MIND - COMPLAINING - menopause; during

MIND - DOUBTFUL - recovery, of - menopause; during

MIND - EXCITEMENT - menopause; during

MIND - FEAR - insanity - menopause; during

MIND - FEAR - open spaces; fear of - menopause; during

MIND - FEAR - recover, he will not - menopause; during

MIND - FORGETFUL - menopause; during

MIND - HYSTERIA - menopause; at

MIND - INDIFFERENCE, apathy - menopause; in

MIND - INSANITY, madness - menopause, during

MIND - IRRITABILITY - menopause; during

MIND - LAUGHING - menopause; during

MIND - LAUGHING - weeping - same time; weeping and laughing at the - menopause; during

MIND - LOQUACITY - menopause; during

MIND - MENOPAUSE agg.

MIND - MOROSE - menopause; at

MIND - NYMPHOMANIA - menopause; at

MIND - RESTLESSNESS - menopause; at

MIND - SADNESS - menopause, during

MIND - SIGHING - menopause; during

MIND - SUSPICIOUS - menopause; during

MIND - WEEPING - menopause; at

VERTIGO - MENOPAUSE

HEAD - HAIR - falling - menopause

HEAD - HEAT - flushes of - menopause; during

HEAD - HEAT - menopause, at

HEAD - HEAT - Vertex - menopause, during

HEAD - PAIN - violent pains - menopause; during

HEAD - PAIN - burning - menopause; during

HEAD - PAIN - burning - Vertex - menopause, during

STOMACH - APPETITE - ravenous - menopause, at

STOMACH - NAUSEA - menopause, during

ABDOMEN - PAIN - menopause, with sadness; during

RECTUM - HEMORRHAGE from

anus - menopause; at

URETHRA - PAIN - menopause, during

URINE - ODOR - putrid - menopause, during

FEMALE GENITALIA/SEX - COITION - aversion to - menopause, during: con

FEMALE GENITALIA/SEX - LEUKORRHEA - acrid, excoriating - menopause, during

FEMALE GENITALIA/SEX - LEUKORRHEA - itching - menopause, in

FEMALE GENITALIA/SEX - LEUKORRHEA - menopause, at

FEMALE GENITALIA/SEX - LEUKORRHEA - offensive - menopause, in

FEMALE GENITALIA/SEX - LEUKORRHEA - yellow - menopause, at

FEMALE GENITALIA/SEX - MENOPAUSE

FEMALE GENITALIA/SEX - MENSES - copious - menopause, during

FEMALE GENITALIA/SEX - MENSES - frequent, too - fourteen days, every - menopause, at

FEMALE GENITALIA/SEX - MENSES - frequent, too - menopause, in

FEMALE GENITALIA/SEX - MENSES - painful, dysmenorrhea - menopause, near the

FEMALE GENITALIA/SEX - MENSES - return - menopause, after

FEMALE GENITALIA/SEX - METRORRHAGIA - menopause

FEMALE GENITALIA/SEX - SEXUAL DESIRE - increased - menopause, at

FEMALE GENITALIA/SEX - Atrophy of - Uterus

FEMALE GENITALIA/SEX - Atrophy of - Ovaries

FEMALE GENITALIA/SEX - Inflammation of - ovaries, Uterus, Vagina

CHEST - PALPITATION of heart - menopause

SLEEP - SLEEPLESSNESS - menopause; during

PERSPIRATION - CLAMMY - menopause; during

GENERALS - CHOREA - menopause; during

GENERALS - CONVULSIONS - menopause; during

GENERALS - FAINTNESS - menopause; during

GENERALS - FOOD and DRINKS - coffee - agg. - smell of coffee - sensitive to the - menopause; during

GENERALS - HEAT - flushes of - menopause, during:

GENERALS - HEAT - Flushes of - perspiration with

GENERALS - HEAT - Flushes of - perspiration without

GENERALS - HEAT - lack of vital heat - menopause; during

GENERALS - HEMORRHAGE - menopause; in

GENERALS - NUMBNESS - externally - menopause; during

GENERALS - OBESITY - menopause; during

GENERALS - REACTION - lack of - menopause; during

GENERALS - SEXUAL - desire; suppression of sexual - menopause; during

GENERALS - TREMBLING - externally - menopause; during

GENERALS - TREMBLING - internally - menopause, during

GENERALS - WEAKNESS - menopause; during

GENERALS - WEARINESS - menopause; during

GENERALS - Osteoporosis

Dr William Boericke's *Pocket manual of Materia Medica and Repertory* [15] mentions the followings remedies for menopause.

Menopause – Climacteric period; change of life; Remedies in general: Acon; Agar ; Alet ; *Amyl* ; Aquil ; Arg. N.; *Bell.; Bellis*.; Bor.ac.; *Cact.;* Calc.ars.; Calc.c.; Carbo.v.; *Caul.*; *Cim.*; Cocc.; Coff.; *Con.*; Cycl.; err.; *Gels.*; *Glon.*; Graph.; Helon.; *Ign.; Jabor.*; Kahbr.; *Kali c.*; *Kreos.* ; Lach.; Mag.c.; *Mancin.; Murex.*; *Nux m.; Nux.v.*; *Oophor.*; Plumb.; *Puls.*; *Sang.*; Semperv.T.; *Sep.*; *Sul.*; Sul.ac.; Ther.; *Ustil.*; Val.; Vipera.; Viscum.; *Zinc.v*.

For hypertension at climacteric, following homeopathic medicines can be considered[16]:

Glonoinum, Sanguinaria canadensis, Lachesis mutus, Sepia officinalis, Cactus grandiflorus, Amylenum nitrosum Sulphuricum acidum, Conium maculatum.

Apart from the above mentioned drugs, sarcodes are well indicated in menopausal complaints. *Oophorinum* (*Ovininum*) can be given for the sufferings following the excision of ovaries. It is indicated for the climacteric disturbances especially nervous sufferings, cutaneous

disorders, acne, prurigo etc., ovarian cyst and complaints ameliorate during menses. Clarke had good results in such cases in the lower triturations. *Orchitinum* has been used with success, in the triturations, in climacteric sufferings; in the sequelae of ovariotomy, in cases of debility, sexual weakness, and premature senile decay. *Folliculinum* is indicated in dullness and slowness of mind at climacteric in ladies who from birth onwards face restrictions of various kinds imposed by the behaviour of others. There is also a history of marked aggravation during ovulation.

Banerjea Subrata Kumar,[17] puts forth his views of miasmatic diagnosis of menopausal syndrome, wherein he says various disturbances from imbalance of the hormonal system, particularly around puberty and the menopause are due to a sycotic base.

Previous Studies

Various clinical studies conducted worldwide show that homeopathy is efficacious for menopausal complaints[18,19]. In a study by Central Council for Research in Homoeopathy (CCRH), homeopathic therapy was found to be useful in relieving menopausal distressing symptoms such as hot flushes, night sweats, anxiety, palpitation, depression, insomnia, and so on[20]. Influence on serum levels of FSH, high-density lipoprotein, and low-density lipoprotein was not significant but serum levels of cholesterol, triglycerides, and very-low-density lipoprotein decreased significantly. The medicines found to be most frequently indicated and useful were *Sepia, Lachesis, Calcarea carbonica, Lycopodium,* and *Sulphur*. In another study, ninety-nine physicians in 8 countries took part and included 438 patients with an average age of 55.[21] *Lachesis, Belladonna, Sepia officinalis, Sulphur* and *Sanguinaria canadensis* were the most prescribed. This observational study revealed a significant reduction ($p<0.001$) in the frequency of hot flushes by day and night and a significant reduction in the daily discomfort they caused (mean fall of 3.6 and 3.8 points respectively, on a 10cm visual analogue scale; $p<0.001$). Ninety percent of the women reported disappearance or lessening of their symptoms, these changes mostly took place within 15 days of starting homeopathic treatment. In an uncontrolled, pilot outcome study, conducted at the Tunbridge Wells Homeopathic Hospital (TWHH) in 1998-1999, thirty-one patients with menopausal flushes were assessed in three groups – Hot flushes: No history of carcinoma of the breast; Hot flushes: Treatment for breast carcinoma, not receiving Tamoxifen; and, Hot flushes: Treatment for breast cancer including Tamoxifen. The results indicated useful symptomatic benefit for all the three groups of patients.[22]

Lifestyle Measures

Several randomised controlled trials of middle-aged/menopausal-age women have found that aerobic exercise can result in significant improvements in several common menopause-related symptoms (relative to non-exercise comparison groups)[23]. Low intensity exercise such as *yoga* may be beneficial in reducing vasomotor symptoms and improving psychological wellbeing in menopausal women. Not all types of activity lead to an improvement in symptoms. Infrequent high-impact exercise can actually make symptoms worse. The best activity appears to be regular sustained aerobic exercise such as swimming or running. Avoidance or reduction of alcohol and caffeine intake can reduce the severity and frequency of vasomotor symptoms.[24] Populations consuming a diet high in phytoestrogens (plant substances that have similar effects to oestrogens) such as the Japanese, appear to have lower rates of menopausal vasomotor symptoms, cardiovascular disease, osteoporosis and breast, colon, endometrial and ovarian cancers.[25] The most important groups of phytoestrogens are called isoflavones and lignans. Isoflavones are found in soybeans, chickpeas and red clover, and probably in other legumes (beans and peas). Oilseeds such as flaxseed are rich in lignans, which are also found in cereal bran, whole cereals, vegetables, legumes and fruit. As phytoestrogens have oestrogenic actions, there are concerns about safety in hormone-sensitive tissues such as the breast and uterus and interactions with selective oestrogen receptor modulators such as tamoxifen and aromatase inhibitors (e.g. letrozole). In a relatively large study of red clover isoflavone users, no effect on breast cancer risk was found in women with a significant family history.[26]

Conclusion

The myriad dramatic disturbances of menopausal period play havoc on the physical and emotional health of a woman. Proper understanding and correct management of 'change of life in women' is important. The increasing evidence regarding beneficial effects of homeopathy as shown by data from case histories, observational studies and randomized trials are encouraging. The fact that homeopathy is helpful in an area such as menopause where conventional treatment appear to hold some risks should make homeopathic treatment a first option for treatment. But more research is

needed.

Moreover, in a developing country like India, homeopathy offers a cost effective [26] and effective method to treat menopausal complaints.

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About the Author

Dr Rekha Thomas, is working as Reader and Incharge, Department of Gynaecology & Obstetrics, Nehru Homoeopathic Medical College & Hospital, New Delhi. She completed BHMS from 'Government Homeopathic Medical College & Hospital', Calicut, Kerala.

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