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UTERINE ADENOMYOSIS TREATED WITH HOMOEOPATHY: A CASE REPORT

M Beena Rani [1*], S Jeeja [2], TG Filsidas [3]

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Corresponding Author * email address	drbeenarani74@gmail.com
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[1] *Professor, Department of Obstetrics and Gynecology, Govt. Homoeopathic Medical College and Hospital, Iranimuttom, Thiruvananthapuram, Kerala, India*

[2] *Associate professor, Department of Organon of Medicine and Homoeopathic Philosophy, Govt. Homoeopathic Medical College and Hospital, Iranimuttom, Thiruvananthapuram, Kerala, India*

[3] *PG Scholar, Department of Organon of Medicine and Homoeopathic Philosophy, Govt. Homoeopathic Medical College and Hospital, Iranimuttom, Thiruvananthapuram, Kerala, India*

Corresponding Author* Details:

Dr. Beena Rani M
Professor, Department of Obstetrics and Gynecology
Govt. Homoeopathic Medical College and Hospital
Iranimuttom, Thiruvananthapuram, Kerala, India
Mail. Id: drbeenarani74@gmail.com Ph No. +919446175948

ABSTRACT

Background: "Adenomyosis is a common gynecological condition characterized by the presence of endometrial glands and stroma deep within the myometrium associated with myometrial hypertrophy and hyperplasia". In this case report the patient was suggested to have surgery. She came to us for homeopathic treatment since she did not want to undergo surgery.

Case presentation: A 37-year-old female patient presented with irregular, heavy menstrual bleeding with lower abdominal pain and backache. She was diagnosed with uterine adenomyosis and ovarian endometrioma of the left ovary. Individualized Homoeopathic medicine was selected on the basis of the totality of the symptoms of the patient, and which gave significant improvement to the patient's health. At first *Thuja occidentalis* 30 was given and later the potency was raised to 200. *Sulphur* 0/3 was prescribed as an intercurrent remedy following the emergence of superficial skin eruptions, indicating a favorable directional shift in symptoms. The outcome assessment of the case was done by WaLIDD score and menstrual bleeding questionnaire score.

Conclusion: After a homoeopathic treatment period of 28 months, there was significant improvement in the clinical symptoms, WaLIDD score and menstrual bleeding questionnaire score and also shows changes in the ultrasonographic findings before and after treatment. This case study demonstrates the role of individualized homoeopathic medicine in the treatment of adenomyosis.

Keywords: Uterine adenomyosis, *Thuja occidentalis*, Individualized medicine, Homoeopathy.

1. INTRODUCTION

Adenomyosis is a condition where there is ingrowth of the endometrium, both the glandular and stromal components, directly into the myometrium. It is also defined as endometriosis interna (1). Both diffuse and focal adenomyosis have been identified (2). Although dysmenorrhea and excessive menstrual bleeding are the most typical symptoms of adenomyosis, about one by third patients are asymptomatic (3). As imaging techniques advance, adenomyosis is increasingly being discovered in younger infertile people (4). Other symptoms include chronic pelvic pain and dyspareunia (3).

Carl von Rokitansky, a pathologist, originally described adenomyosis in 1860 (5). Adenomyosis affects about 30 to 60 percent of women undergoing hysterectomy procedures. It affects women in the fourth and fifth decades of life in about 70% to 80% of cases. Patients under the age of 39 account for 5–25% of adenomyosis instances, while women over 60 account for only 5%–10% (6). The clinical phenotype of early-stage adenomyosis differs from that of late-stage illness (7).

The exact aetiology of adenomyosis is not definitely known. According to recent study, tissue damage or injury at the endometrial-myometrial junction results in endometrial cell migration into the myometrium and the development of disease (8).

The risk factors include age, multiparity, early menarche, short menstrual cycles, increased body mass index, oral contraceptive use, prior uterine surgery, smoking, Tamoxifen treatment, ectopic gestation, antidepressants (7).

Transabdominal USG frequently lacks the picture resolution necessary to visualize the myometrium, making it insufficiently accurate for diagnosing adenomyosis. As a result, The first-line investigation is a 2D transvaginal USG (9). Sensitivity and specificity ratings for MR imaging can reach up to 88% and 93%, respectively. Some studies show that two are comparable, while others show that MR imaging is superior (7).

In conventional medicine hysterectomy is the only surefire remedy. The alternatives preserve the uterus while addressing the main causes of severe, painful menstrual flow. These include Nonsteroidal anti-inflammatory drugs (NSAIDs) Various hormonal therapies such as oral contraceptive pills (OCPs), levonorgestrel intrauterine device (IUD), danazol, and aromatase inhibitors.

As a holistic medical system, homeopathy offers more potential for managing adenomyosis because it allows for the use of a constitutional approach. Homoeopathy can provide a higher quality of life and preserve the reproductive function of the female with adenomyosis than hysterectomy or hormone therapy, both of which have several negative effects. Prior research on the effectiveness of homoeopathy in treating adenomyosis is also constrained (10).

2. CASE REPORT

PRELIMINARY DATA

Age: 37 years
Sex: Female
Occupation: Home maker
Education: Plus two
Religion: Muslim

PRESENTING COMPLAINT

A 37-year-old female patient consulted on 13 May 2022 in our outpatient department, having complaints of irregular menses, heavy menstrual bleeding with severe lower abdominal pain and backache for the past five months. She was suffering from profuse bleeding, and had to change 8–10 pads daily for the first five to six days. Flow lasting for about ten to twelve days. The complaints are worse by exertion and movement and better by lying down.

HISTORY OF PRESENTING COMPLAINT

The patient has been suffering from these complaints for two years. The complaint began as amenorrhoea for two months two year back followed by severe lower abdominal pain and profuse menstrual bleeding. She took conventional treatment and they advised to take USG and diagnosed as having uterine adenomyosis and ovarian endometrioma of the left ovary. No improvement in symptoms was observed after three months of conventional medication. The patient was therefore recommended to have surgery. She came to us for homeopathic treatment since she did not want to undergo surgery.

HISTORY OF PAST ILLNESS

She had diagnosed with thyroglossal cyst at the age of eight and undergone surgery and completely relieved.

FAMILY HISTORY

Father had diabetes mellitus and hypertension and died due to cerebro-vascular accident 2 years back. Mother had undergone premature menopause at the age of 38. Sister has been diagnosed with uterine fibroid 3 years back and she is under conventional medicine treatment.

PERSONAL HISTORY

She is from a Muslim middle-class household and works as a homemaker. She has been married for 10 years and she is the parent of two kids.

PHYSICAL GENERALS

Appetite: decreased
Thirst: good (2-3L/day)
Sleep: sound
Bowel: difficult, burning pain during stool.
Urination: Nothing particular
Sweat: profuse perspiration
Reaction to:
Desires: fanning, sweets
Averion: covering especially the soles of the foot
Intolerance to: beef (causes itching of the body), mutton (causes breathing difficulty), hot climate

MENTAL GENERALS

She is mild and soft natured, very sensitive , religious, anxiety about her health.

MENSTRUAL HISTORY

At thirteen, she experienced menarche. Her bleeding was severe and lasted for 6–7 days. LMP was on April 15, 2022. The bleeding was dark red in colour and had large clots. Associated with severe lower abdominal pain and backache during menses.

OBSTETRIC HISTORY

P2L2A0 (all were full term normal delivery)

REGIONALS

Warts on the face and skin tag around the neck

PHYSICAL EXAMINATION - GENERAL

Body built and nourishment: moderately built and nourished
Anaemia: no pallor
Jaundice: not icteric
Clubbing: no clubbing
Cyanosis: no cyanosis
Oedema: no oedema
Lymphadenopathy: no palpable lymph nodes
Blood pressure: 130/90 mm of Hg
Respiratory rate: 16 breaths/min
Pulse rate: 74 beats/min
Temperature: 37.2 °C

SYSTEMIC EXAMINATION

Tenderness in the lower abdomen which is mild in nature

ANALYSIS AND EVALUATION OF SYMPTOMS

After detailed case taking the complete symptoms of the patient was obtained and evaluation was done according to Kent's method of evaluation

Table no – 1

Mental generals	Anxiety about health, very sensitive
Physical generals	Profuse bleeding, severe lower abdominal pain during menses. Desire sweets, intolerance to beef and mutton. Desire for fanning and aversion to covering especially of the foot, Thermally hot Appetite decreased difficulty in passing stool, burning pain during defaecation. menses profuse dark red clotted Profuse perspiration
Particulars	Backache worse during exertion Warts on the face and skin tag around the neck
Common	Mild tenderness in the lower abdomen

TOTALITY OF SYMPTOMS

Anxiety about health, very sensitive.
Profuse bleeding with dark red clotted blood
Severe lower abdominal pain during menses
Worse during exertion and better by rest
Appetite decreased, Desire sweets
Desire fanning
Difficulty in passing stool with burning pain during defaecation.
Can't bear to cover the soles of the foot
Profuse Perspiration
Intolerance to beef and mutton
Thermally hot

REPERTORIAL TOTALITY

MIND – ANXIETY – health about
GENERALITIES – FOOD AND DRINKS – meat agg
GENERALITIES -HEAT – sensation of

FEMALE GENITALIA – MENSES – copious
ABDOMEN -PAIN- menses during -agg
RECTUM -CONSTIPATION – difficult stool
FEMALE GENITALIA – ENLARGED -uterus
FEMALE GENITALIA – TUMORS – Ovaries - cysts– left

REPERTORIAL CHART

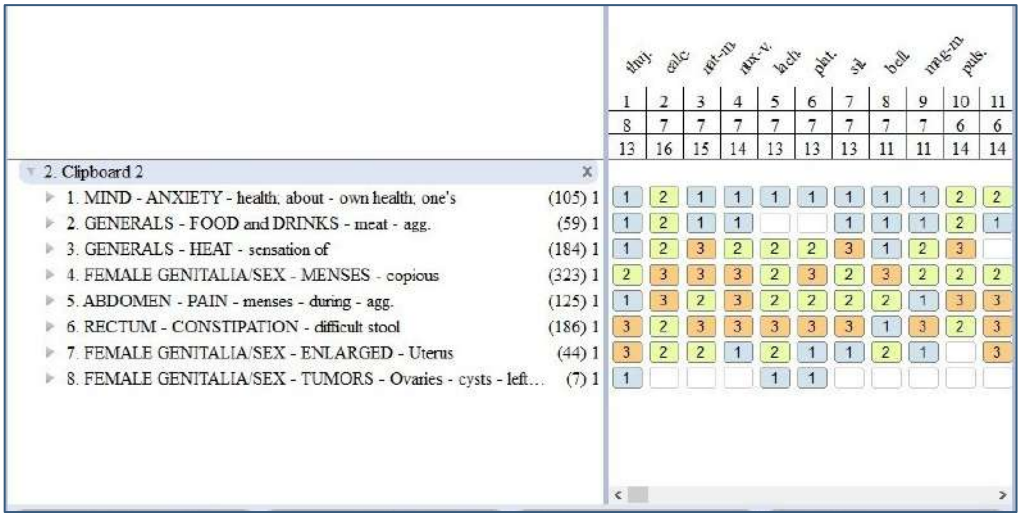


Figure 1

SELECTION OF REMEDY AND POTENCY

On the basis of repertorisation and final consultation with Materia medica, *Thuja occidentalis* was selected and prescribed to the patient as a first remedy. The first potency selected was 30, later the potency raised to 200. After that *Lachesis muta* 200 was prescribed as the patient presented with heavy menstrual bleeding associated with hot flushes. Then the patient again presented with irregular flow and *Thuja* 200 was repeated. Patient had developed itching eruptions in the course of treatment then *Sulphur* 0/3 was prescribed, and now patient feels so much better. The hospital pharmacy distributes medications that are bought from HOMCO and supplied in sugar of milk. ***Thuja occidentalis*** and ***Sulphur*** are included in **Volume I** of Homoeopathic Pharmacopoeia of India (HPI).

FOLLOW UP

Table no: 2- Follow up chart

Date	Symptoms	Prescriptions
13/05/22	Heavy menstrual bleeding	*Thuja* 30 /2doses
18/06/22	LMP- 15/6 22 Patient has relief of symptoms during menstruation	*Thuja* 30 /1 dose
25/07/22	LMP – 15/7/22 Duration of flow 3-4 days.	*Thuja* 30 /2 doses
21/10/22	LMP – 3/9/ 22 Duration of flow 3 days. regular flow	*Thuja* 30 /1 dose
16/12/22	LMP- 29/10/22 left upper abdominal pain	*Thuja* 200/1 dose
20/01/23	LMP – 3/1/23	*Thuja* 30/1 dose
24/02/23	LMP- 16/2/23 Duration – 4 days	*Thuja* 30/1 dose
15/06/23	LMP – 20/ 05/ 23 Duration – 5 days	*Thuja* 200 /1 dose
18/08/23	LMP – 28/07/23 Duration - 4 days	*Thuja* 200 /1 dose

10/05/24	LMP- 10/4/24. Profuse menstrual bleeding for 3-7 day. hot flushes, lower abdominal pain.	*Lachesis* 200 /1 dose
31/07/24	LMP- 20/5/24. Irregular flow. profuse flow with lower abdominal pain	*Thuja* 200/1 dose
28/08/24	itching plaque of eruption in the back. dry skin with exfoliation < warmth	*Sulphur* 0/3 /4 dose
30/10/24	Pain in dorsal aspect of right foot. itching lesion in the inner aspect of left thigh. other eruptions disappeared	*Sulphur* 0/3/4 dose
25/11/24	>of all complaints.	*Saccharum lactis* (placebo)/4 dose

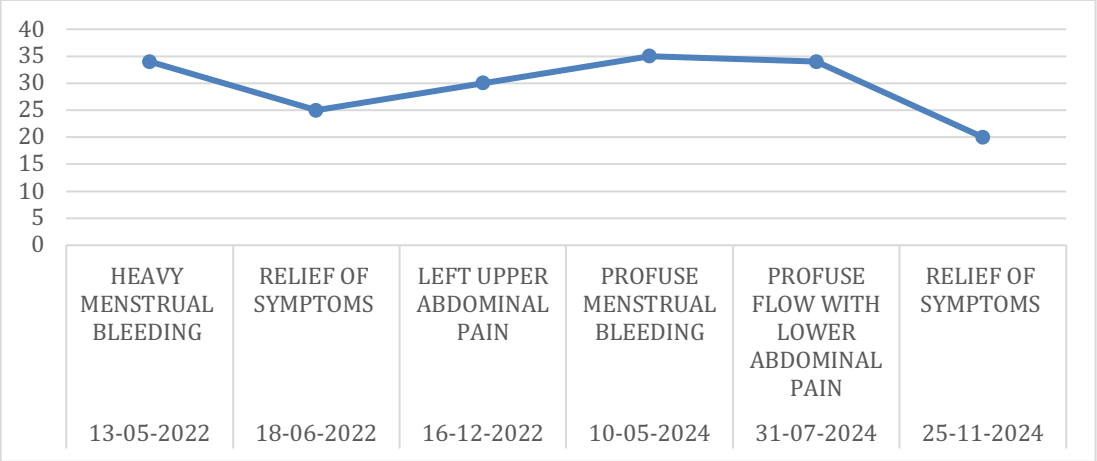
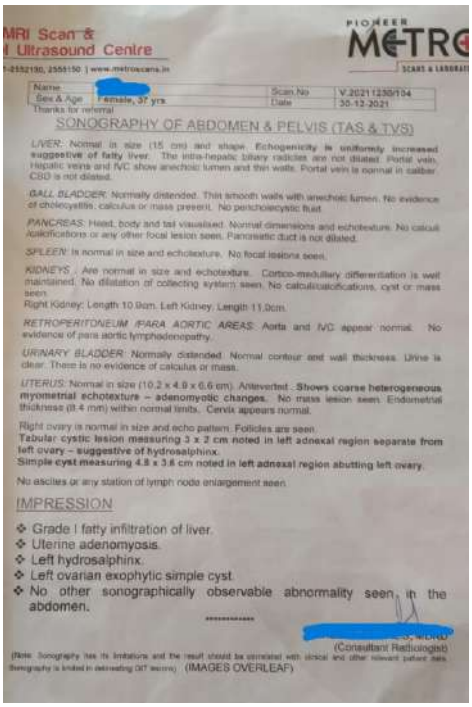


Figure 2

DIAGNOSIS AND CLINICAL ASSESSMENT


MRI Scan & Ultrasound Centre

PIONEER METRO

SONOGRAPHY OF ABDOMEN & PELVIS (TAS & TVS)

LIVER: Normal in size (15 cm) and shape. Echogenicity is uniformly increased suggestive of fatty liver. The intra-hepatic biliary radicles are not dilated. Portal vein, Hepatic veins and IVC show anechoic lumen and thin walls. Portal vein is normal in caliber. CBD is not dilated.

GALL BLADDER: Normally distended. Thin smooth walls with anechoic lumen. No evidence of cholecystitis, calculus or mass present. No pericholecystic fluid.

PANCREAS: Head, body and tail visualised. Normal dimensions and echotexture. No calculi/calcifications or any other focal lesion seen. Pancreatic duct is not dilated.

SPLEEN: is normal in size and echotexture. No focal lesions seen.

KIDNEYS: Are normal in size and echotexture. Cortico-medullary differentiation is well maintained. No dilatation of collecting system seen. No calculi/calcifications, cyst or mass seen.
Right Kidney: Length 10.9cm. Left Kidney: Length 11.0cm.

RETROPERITONEUM /PARA AORTIC AREAS: Aorta and IVC appear normal. No evidence of para aortic lymphadenopathy.

URINARY BLADDER: Normally distended. Normal contour and wall thickness. Urine is clear. There is no evidence of calculus or mass.

UTERUS: Normal in size (10.2 x 4.9 x 6.6 cm). Anteverted. Shows coarse heterogeneous myometrial echotexture – adenomyotic changes. No mass lesion seen. Endometrial thickness (8.4 mm) within normal limits. Cervix appears normal.

Right ovary is normal in size and echo pattern. Follicles are seen.
Tabular cystic lesion measuring 3 x 2 cm noted in left adnexal region separate from left ovary – suggestive of hydrosalphinx.
Simple cyst measuring 4.8 x 3.8 cm noted in left adnexal region abutting left ovary.

No ascites or any station of lymph node enlargement seen.

IMPRESSION

- Grade I fatty infiltration of liver.
- Uterine adenomyosis.
- Left hydrosalphinx.
- Left ovarian exophytic simple cyst.
- No other sonographically observable abnormality seen in the abdomen.

(Consultant Radiologist)

(IMAGES OVERLEAF)


NATIONAL SCA

Name
Age & Sex
Ref by : AMRITHA HOMEOS
Visit ID : PC20230320/111
Collected on : 20/03/2023 11:50A

ULTRASOUND SCAN

USS OF ABDOMEN AND PELVIS - FEMALE

Liver	Normal size, parenchyma slightly hyperechoic No Focal lesion. IHBR not dilated
Gall Bladder	Well distended. Wall and lumen- Normal. No calculi
Pancreas	Head, body and tail are normal. No mass lesions. No calcification Pancreatic duct - not dilated
Spleen	Normal size , echotexture normal. No focal lesions. Portal vein - Normal.
Kidneys	Both kidneys are normal in size and echotexture. Pelvicalyceal system is normal. CMD is maintained. No Calculi. Both ureters not dilated, No ureteric calculus detected
Urinary Bladder	Well distended, wall and lumen - normal. No calculi/Debris.
No ascites	
Bowel loops	Normal. No bowel mass
Uterus	measures 110 x 65 x 55 mm Myometrium – with slighty inhomogenous texture Endometrium – 7 mm Cavity – Empty
Right ovary	measures 32 x 19 mm
Left ovary	Cyst of 56 x 32 mm with septae and low level echoes , no nodular areas seen
	POD Clear

IMPRESSION: Mild fatty infiltration of liver.
Bulky uterus with diffuse adenomyosis
Chocolate cyst in left ovary.

Consultant Radiologist

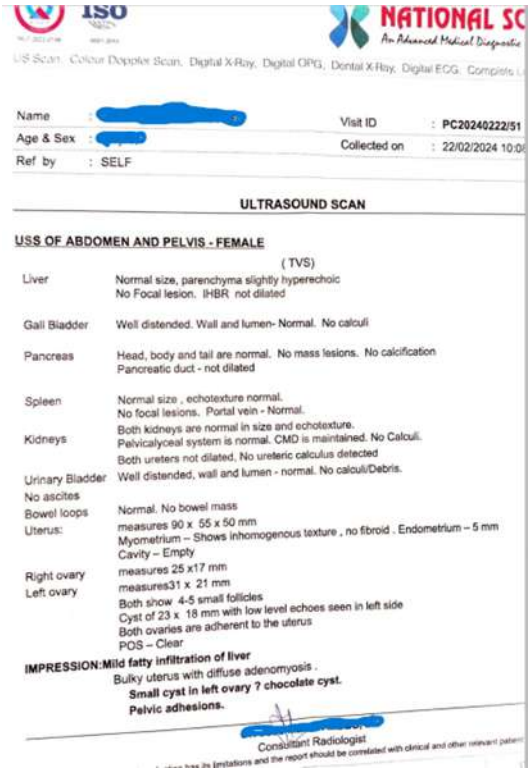
(Note : Sonological evaluation has its limitations and the report should be correlated with clinical and other relevant patient data)

(IMAGE OVERLEAF)

** End of report **

Figure 3 USG before treatment

Figure 4 USG during treatment



NATIONAL SC

An Advanced Medical Diagnostic

US Scan, Colour Doppler Scan, Digital X-Ray, Digital OPG, Dental X-Ray, Digital ECG, Complete

Name : [redacted]
Age & Sex : [redacted]
Ref by : SELF

Visit ID : PC20240222/51
Collected on : 22/02/2024 10:0

ULTRASOUND SCAN

USS OF ABDOMEN AND PELVIS - FEMALE

(TVS)

Liver	Normal size, parenchyma slightly hyperechoic No Focal lesion. IHBR not dilated
Gall Bladder	Well distended. Wall and lumen- Normal. No calculi
Pancreas	Head, body and tail are normal. No mass lesions. No calcification Pancreatic duct - not dilated
Spleen	Normal size , echotexture normal. No focal lesions. Portal vein - Normal.
Kidneys	Both kidneys are normal in size and echotexture. Pelvicalyceal system is normal. CMD is maintained. No Calculi. Both ureters not dilated, No ureteric calculus detected
Urinary Bladder	Well distended, wall and lumen - normal. No calculi/Debris.
No ascites	
Bowel loops	Normal. No bowel mass
Uterus:	measures 90 x 55 x 50 mm Myometrium – Shows inhomogenous texture , no fibroid . Endometrium – 5 mm Cavity – Empty
Right ovary	measures 25 x17 mm
Left ovary	measures31 x 21 mm Both show 4-5 small follicles Cyst of 23 x 18 mm with low level echoes seen in left side Both ovaries are adherent to the uterus POS – Clear

IMPRESSION:Mild fatty infiltration of liver
Bulky uterus with diffuse adenomyosis .
Small cyst in left ovary ? chocolate cyst.
Pelvic adhesions.

[redacted]
Consultant Radiologist

Figure 5 USG During treatment

ISO

NATIONAL SCAI

An Advanced Medical Diagnostic Cen

US Scan, Colour Doppler Scan, Digital X-Ray, Digital OPG, Dental X-Ray, Digital ECG, Complete Labor

Name : [redacted]
Age & Sex : [redacted]
Ref by : GOVT HOMEO HOSPITAL

Visit ID : PC2024102 4/48
Collected on : 24/10/2024 10:11AM

ULTRASOUND SCAN

USS OF ABDOMEN AND PELVIS - FEMALE

(TVS)

Liver	Normal size, parenchyma slightly hyperechoic No Focal lesion. IHBR not dilated
Gall Bladder	Well distended. Wall and lumen- Normal. No calculi
Pancreas	Head, body and tail are normal. No mass lesions. No calcification Pancreatic duct - not dilated
Spleen	Normal size , echotexture normal. No focal lesions. Portal vein - Normal.
Kidneys	Both kidneys are normal in size and echotexture. Pelvicalyceal system is normal. CMD is maintained. No Calculi. Both ureters not dilated, No ureteric calculus detected
Urinary Bladder	Well distended, wall and lumen - normal. No calculi/Debris.
No ascites	
Bowel loops	Normal. No bowel mass
Uterus:	measures 75 x 50 x 45mm Myometrium – Normal, Endometrium –5 mm No focal lesions seen, Cavity – Empty
Right ovary	measures 27 x 18 mm
Left ovary	measures 29 x 16 mm Both show 3-4small follicles Cyst of 14 mm with low level echoes seen in left ovary POD Clear

IMPRESSION: Grade 1 fatty infiltraion of liver.
S.mall cyst in left ovary size less compared to previous scan ,

[redacted] Consultant Radiologist

(Note : Sonological evaluation has its limitations and the report should be correlated with clinical and other relevant patient data)
(IMAGE OVERLEAF)

** End of report **

Figure 6 USG after treatment

DIFFERENTIAL DIAGNOSIS

Uterine leiomyomas: Uterine fibroids are common, noncancerous muscular tumors that grow in or on the wall of the uterus. Often asymptomatic, they can cause heavy or painful periods, pelvic pressure, frequent urination, and lower back pain. Uterine fibroids and adenomyosis share overlapping symptoms (heavy bleeding and pelvic pain), but differ structurally. On ultrasound, fibroids appear as well-defined, circular, solid tumors with a clear capsule, while adenomyosis presents as ill-defined, diffuse thickening of the uterine wall with tiny cysts and radiating shadows.

Endometrial carcinoma: is the most common gynecologic malignancy, beginning in the lining of the uterus (the endometrium). Its hallmark symptom is abnormal vaginal bleeding—particularly any bleeding post-menopause or irregular spotting between periods. In ultrasound, carcinoma presents as a focal or irregular, thickened endometrial mass, while adenomyosis causes global uterine enlargement with blurred boundaries and myometrial cysts.

Endometrial polyp: Endometrial polyps are benign growths extending into the uterine cavity, often linked to hormonal imbalances and excess estrogen. While many are asymptomatic, they frequently cause abnormal bleeding (e.g., heavy periods, postmenopausal bleeding) and can impact fertility. On ultrasound, polyps appear as distinct, bright masses within the uterine cavity, while adenomyosis presents as blurred, asymmetrical thickening of the muscular wall.

Endometriosis: is a chronic condition where tissue similar to the lining of the uterus grows outside it, typically on pelvic organs. It causes severe pelvic pain, heavy bleeding, and potential infertility. In endometriosis, tissue grows *outside* the uterus (e.g., ovaries, fallopian tubes, peritoneum). In adenomyosis, it grows *into* the muscular wall of the uterus (myometrium).

Pelvic Inflammatory Disease: an infection of the female reproductive organs. It is frequently caused by untreated sexually transmitted infections (STIs) like chlamydia and gonorrhea spreading from the vagina to the uterus and fallopian tubes. Symptoms include pain in the lower belly or pelvis, unusual or heavy vaginal discharge, sometimes with a foul odor, pain or bleeding during or after sexual intercourse, fever, sometimes accompanied by chills.

3. DISCUSSION

This is a case report which shows the efficacy of individualized homoeopathic medicines in the management of adenomyosis.

The patient first presented with symptoms of heavy menstrual bleeding and lower abdominal pain during menses. The first USG scan took on 30/12/2021 showed coarse heterogeneous myometrial echotexture suggestive of adenomyosis and a simple cyst of left ovary measuring 4.8×3.8 cm. *Thuja* was prescribed in 30 potency after repertorisation using RADAR OPUS software (version 3.3.24). *Thuja occidentalis* was selected not only for its repertorial totality but because it covers the underlying sycotic miasm evident in the patient's pathology (adenomyosis representing tissue hyperplasia) and physical generals (facial warts, skin tags, and intolerance to meat). and final consultation with the materia medica. *Thuja* 30 was repeated according to the principles of repetition.

Another scan taken on 20/ 03/2023 showed bulky uterus with features of adenomyosis, ovarian endometrioma of the left ovary measuring 5.6×3.2 cm. The potency raised to 200 and repeated accordingly.

In the USG scan took on 20/02/2024, the size of the uterus is reduced and the cyst in the left ovary measured 2.3 ×1.8 cm. Lachesis 200 was prescribed to the patient once when she presented with heavy menstrual bleeding and hot flushes. Then again *Thuja* 200 repeated when irregular flow reappeared. Patient symptomatically very much improved after that. During treatment itching eruptions appeared over the extremities and then *Sulphur* 0/3 was prescribed. According to Hering's Law of Cure, the emergence of superficial skin eruptions while deeper visceral pathologies (adenomyosis and endometrioma) were resolving suggests a favorable outward directional shift of the disease force, rather than an unrelated adverse event or suppression.

Final USG took on 24/10/2024 showed a normal sized uterus with no features of adenomyosis and the cyst in the left ovary was significantly reduced to a size of 1.4 cm. WaLIDD score (11) before treatment was 12 and after treatment it was decreased to 4. Initially the menstrual bleeding questionnaire score (12) was 25 and after treatment it was reduced to 15.

Table 3: Modified Naranjo Criteria for Homeopathy (MONARCH) assessment

MONARCH Criteria	Answer	Score
1. Was there an improvement in the main symptom or condition for which the homeopathic medicine was prescribed?	Yes	+2
2. Did the clinical improvement occur within a plausible timeframe relative to the drug intake?	Yes	+1
3. Was there a homeopathic aggravation of symptoms?	No	0
4. Did the effect encompass more than the main symptom or condition? (i.e., were other symptoms improved or changed?)	Yes	+1
5. Did overall well-being improve? (Suggests an improvement in vitality)	Yes	+1
6A. Direction of cure: Did some symptoms improve in the opposite order of their development, from inside-out, top-down, or more important to less important organs?	Yes	+1
6B. Old symptoms: Did old symptoms reappear?	No	0
7. Are there alternative causes (other than the medicine) that—with a high probability—could have caused the improvement?	No	+1

MONARCH Criteria	Answer	Score
8. Was the effect confirmed by objective evidence?	Yes	+2
9. Did repeat dosing, if conducted, create similar clinical improvement?	Yes	+1
10. Did the patient have a similar favorable response to this homeopathic medicine in the past?	No	0
Total Score		10

The causal attribution of the clinical outcome to the homoeopathic intervention was assessed using the Modified Naranjo Criteria for Homeopathy (MONARCH) inventory. The total score was 10 out of 13, indicating a highly probable causal relationship between the individualized homoeopathic treatment and the resolution of the patient's adenomyosis and ovarian endometrioma.

Adenomyosis has long been thought of being a histological diagnosis obtained following abnormal uterine bleeding (AUB) or pelvic pain. Adenomyosis was an undertreated clinical disease until recently. Today's imaging developments allow for the diagnosis of adenomyosis using non-invasive methods as well. Both transvaginal ultrasonography (TVUS) and magnetic resonance imaging (MRI) are increasingly utilized to detect the existence of adenomyotic lesions and to determine the best course of treatment. It has been observed that both technologies have equal sensitivities and specificities in the diagnosis of adenomyosis (2).

Homoeopathic remedies are effective in managing and curing surgical diseases like adenomyosis. Avoidance of surgery and preservation of the uterus especially in reproductive age group is possible through the homoeopathic mode of treatment (10).

There are many medicines in homoeopathy which we can prescribe in case of adenomyosis. Some of the important medicines are - *Nux vomica, Secale cor, Apis mel, Lachesis, Medorrhinum, Pulsatilla, Sepia, Thuja, Pyrogen, Ars alb, Belladonna* (10).

The case study in this article illustrated the effectiveness of homeopathic remedies in treating uterine adenomyosis, as well as the need of obtaining a thorough medical history and administering constitutional medicine. The prescription was given following a final consultation with the Homoeopathic materia medica with the aid of repertory, it also helps to validate the symptoms listed in these sources.

This case study also shows that by choosing the appropriate individualized remedy, pathological alterations (Uterine Adenomyosis) can be reversed and health can be restored.

4. PATIENT PERSPECTIVE

"I had been suffering from severe menstrual pain and heavy bleeding for several years. Every month, my periods were extremely painful, and I often had to miss work and avoid my daily activities because of the discomfort. I consulted several doctors and was treated with painkillers and hormonal medicines, but the relief was only temporary. My symptoms kept returning, and eventually I was advised to undergo surgery.

The thought of surgery made me anxious, so I decided to try homoeopathic treatment before making that decision. During my first consultation, I felt that my concerns were listened to carefully, and my treatment was planned according to my individual symptoms.

With regular homoeopathic treatment and follow-up, I gradually noticed positive changes. The intensity of my menstrual pain reduced, the bleeding became more manageable, and I started feeling healthier overall. Month by month, I was able to carry out my normal daily activities without the fear of severe pain. My quality of life improved significantly, and I felt relieved that I had found a treatment that helped me without having to undergo surgery.

Today, I feel much more confident and grateful for the improvement I have experienced through homoeopathic treatment."

5. CONCLUSION

This case study demonstrates the efficacy of homeopathic therapy in the treatment of adenomyosis and other ailments. It also indicates that in surgical cases like these, homeopathy may be the preferred course of treatment.

6. CONSENT OF THE PATIENT

Was obtained for writing the manuscript

7. CONFLICT OF INTEREST

None

8. REFERENCES

1. Konar H. *DC Dutta's Textbook of Gynecology*. 8th ed. New Delhi: Jaypee Brothers Medical Publishers; 2020

2. Moawad G, Fruscalzo A, Youssef Y, Kheil M, Tawil T, Nehme J, et al. Adenomyosis: An Updated Review on Diagnosis and Classification. J Clin Med. 2023 Jul 21;12(14):4828. doi: 10.3390/jcm12144828

3. Struble J, Reid S, Bedaiwy MA. Adenomyosis: A Clinical Review of a Challenging Gynecologic Condition. J Minim Invasive Gynecol. 2016 Feb 1;23(2):164–85. DOI: 10.1016/j.jmig.2015.09.018

4. Schrager S, Yogendran L, Marquez CM, Sadowski EA. Adenomyosis: Diagnosis and Management. Am Fam Physician. 2022 Jan 1;105(1):33–38. Available form: https://www.aafp.org/afp/2022/0100/p33

5. Gunther R, Walker C. Adenomyosis. In: StatPearls [Internet] [Internet]. StatPearls Publishing; 2023 [cited 2023 Aug 22]. Available from: https://www.ncbi.nlm.nih.gov/books/NBK539868/

6. Nagandla K, Idris N, Nalliah S, Sreeramareddy CT, George SR, Kanagasabai S. Hormonal treatment for uterine adenomyosis. Cochrane Gynaecology and Fertility Group, editor. Cochrane Database Syst Rev [Internet]. 2014 Nov 11 [cited 2023 Aug 11]; Available from: https://doi.wiley.com/10.1002/14651858.CD011372

7. Taran FA, Stewart EA, Brucker S. Adenomyosis: Epidemiology, Risk Factors, Clinical Phenotype and Surgical and Interventional Alternatives to Hysterectomy. Geburtshilfe Frauenheilkd. 2013 Sep;73(9):924–31. DOI: 10.1055/s-0033-1350840

8. Upson K, Missmer SA. Epidemiology of Adenomyosis. Semin Reprod Med. 2020 May;38(2–03):89–107. doi: 10.1055/s-0040-1718920

9. Li JJ, Chung JPW, Wang S, Li TC, Duan H. The Investigation and Management of Adenomyosis in Women Who Wish to Improve or Preserve Fertility. BioMed Res Int. 2018 Mar 15;2018:e6832685. https://doi.org/10.1155/2018/6832685

10. Js DrS, Reddy DrTA, Madhumitha K, Laharika K. Adenomyosis and homoeopathy. Int J Homoeopath Sci. 2023 Jan 1;7(1):89–91. https://doi.org/10.33545/26164485.2023.v7.i1b.735

11. Teherán AA, Piñeros LG, Pulido F, Mejía Guatibonza MC. WaLIDD score, a new tool to diagnose dysmenorrhea and predict medical leave in university students. Int J Womens Health. 2018 Jan 17;10:35–45. doi: 10.2147/IJWH.S143510

12. Rodpetch T, Manonai J, Angchaisuksiri P, Boonyawat K. A quality-of-life questionnaire for heavy menstrual bleeding in Thai women receiving oral antithrombotics: Assessment of the translated Menstrual Bleeding Questionnaire. Res Pract Thromb Haemost. 2021 Oct 1;5(7):e12617. DOI: 10.1185/03007995.2010.532200