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Ayurvedic Perspectives on Polyendocrine Metabolic Ovarian Syndrome: A Narrative Review

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Abstract

Polyendocrine Metabolic Ovarian Syndrome (PMOS) is the most common endocrine and metabolic disorder affecting women of reproductive age, characterised by oligo-anovulation, clinical or biochemical hyperandrogenism, and polycystic ovarian morphology. Although PMOS as a distinct clinical entity is not named in classical Ayurvedic texts, its clinical presentation closely parallels several Ayurvedic descriptions of menstrual and reproductive disorders, most notably Artava Kshaya and various forms of Yonivyapada such as Nashtartava, Arajaska, Vandhya Yonivyapada and Pushpaghni Jataharini. This review synthesises the contemporary understanding of PMOS with the Ayurvedic conceptual framework of Nidana (aetiology), Dosha-Dushya Samprapti (pathogenesis) and Lakshana (clinical features), and examines the published clinical and preclinical evidence for Ayurvedic management through Shamana (palliative) and Shodhana (bio-purificatory) approaches, including Virechana, Vamana, Basti, Uttarabasti and single or compound formulations such as Kanchanar Guggulu, Shatavari and Guduchi. A narrative synthesis of the available literature suggests that Kapha-Pitta predominant Tridosha vitiation with involvement of Rasa, Rakta, Meda and Artava Dhatu underlies the Ayurvedic conceptualisation of PMOS, and that integrating Ayurvedic Shodhana and Shamana Chikitsa with contemporary lifestyle and pharmacological management may offer a complementary, low-cost approach with a favourable safety profile. Larger, methodologically rigorous randomised trials remain necessary to establish robust clinical evidence.

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1. Introduction

Polyendocrine Metabolic Ovarian Syndrome (PMOS) is a heterogeneous endocrinopathy affecting an estimated 6% to 20% of women of reproductive age worldwide, with variation depending on the diagnostic criteria and population studied [5]. It is the most common cause of anovulatory infertility and is associated with long-term metabolic sequelae including insulin resistance, type 2 diabetes mellitus, dyslipidaemia and cardiovascular risk [1, 3]. PMOS frequently begins around puberty, and its multisystem impact on reproductive, metabolic, dermatological and psychological health makes it a significant public-health concern [4].

Conventional management largely remains symptom-directed, employing combined oral contraceptives, insulin sensitisers, anti-androgens and ovulation-induction agents; a curative approach addressing the underlying pathophysiology is still lacking [3]. This gap has generated growing interest in traditional and complementary systems of medicine, including Ayurveda, which approaches reproductive disorders through the framework of Dosha-Dushya Samprapti rather than isolated organ pathology.

Because PMOS as a named entity does not exist in classical Ayurvedic literature, it is considered an Anukta Vyadhi (a condition not explicitly described), and its clinical features are correlated with the classical descriptions of Artava Kshaya and related Yonivyapadas on the basis of shared signs and symptoms [7, 9].

This review aims to consolidate the modern clinical understanding of PMOS with its Ayurvedic conceptual correlates, and to critically summarise the published evidence on Ayurvedic therapeutic interventions, with a view to informing an integrative approach applicable in academic and clinical Ayurvedic practice.

2. Aims and Objectives

- To review the modern epidemiology, diagnostic criteria and pathophysiology of PMOS.
- To explore the Ayurvedic conceptual correlation of PMOS with Artava Kshaya and Yonivyapada, including Nidana, Samprapti and Lakshana.
- To compile and critically appraise the published clinical evidence on Ayurvedic Shamana and Shodhana interventions in PMOS.
- To identify gaps in the existing literature and propose directions for future integrative research.

3. Materials and Methods

This is a narrative review. Classical Ayurvedic texts Charaka Samhita, Sushruta Samhita, Ashtanga Hridaya and Kashyapa Samhita were consulted for references pertaining to Artava Kshaya and Yonivyapada. Contemporary literature was retrieved from PubMed/PMC, ScienceDirect, DOAJ and indexed Ayurveda journals such as the Journal of Ayurveda and Integrated Medical Sciences, the International Journal of Ayurvedic Medicine, AYU and the Journal of Clinical and Diagnostic Research, using the search terms “PMOS”, “Polyendocrine Metabolic Ovarian Syndrome”, “Artava Kshaya”, “Yonivyapada”, “Panchakarma”, “Virechana” and related Ayurvedic and biomedical terminology. Case reports, case series, clinical trials, narrative and conceptual reviews published in English were included; sources were synthesised descriptively rather than through formal meta-analysis, in keeping with the scope of a narrative/conceptual review

4. Results of the Literature Review

The selected literature is synthesised below by contemporary diagnostic understanding, Ayurvedic conceptual correlations, and reported interventions. As this is a narrative review, no original patient-level data or pooled effect estimates are presented.

4.1. Modern Understanding of the Condition

4.1. Epidemiology and Prevalence

PMOS affects approximately 4% to 21% of women of reproductive age depending on the diagnostic criteria applied, and is reported to affect around 7% of women in United States-based cohorts using Rotterdam-type criteria [1]. It is recognised as the leading cause of anovulatory infertility globally [6], and up to 70% of affected women are estimated to remain undiagnosed [12].

4.2 Diagnostic Criteria

he diagnostic pathway when both hyperandrogenism and ovulatory dysfunction are already present2The 2003 Rotterdam consensus criteria remain the most widely used diagnostic framework, requiring at least two of the following three features after exclusion of other endocrinopathies: (i) oligo- or anovulation, (ii) clinical and/or biochemical hyperandrogenism, and (iii) polycystic ovarian morphology on ultrasonography [2]. The 2023 International Evidence-based Guideline retained this framework while permitting anti-Müllerian hormone (AMH) levels as an alternative to ultrasound in adults, and simplifying t.

4.3. Pathophysiology

The pathogenesis of PMOS is multifactorial, involving genetic predisposition, disturbed hypothalamic–pituitary–ovarian (HPO) axis signalling with increased LH pulsatility, insulin resistance with compensatory hyperinsulinaemia, and hyperandrogenism arising from ovarian and adrenal sources [4]. Insulin resistance is considered a key contributory factor and is disproportionately common in affected women, predisposing them to metabolic syndrome and type 2 diabetes at rates several-fold higher than the general population [1]. Emerging evidence also implicates chronic low-grade inflammation and oxidative stress as contributors to disease progression [3].

4.4. Clinical Manifestations

Clinical presentation is variable and includes menstrual irregularity (oligomenorrhoea or amenorrhoea), infertility, hirsutism, acne, androgenic alopecia, obesity, and psychological comorbidities such as anxiety and depression [6], [7]. Long-term risks include endometrial hyperplasia, dyslipidaemia, cardiovascular disease and, in a subset of patients, endometrial carcinoma [21].

4.5. Conventional Management

Management is largely symptomatic and individualised to the patient’s presenting concern (infertility, menstrual irregularity, hyperandrogenism or metabolic risk), employing lifestyle modification as first-line therapy, combined oral contraceptives for cycle regulation and hyperandrogenism, metformin or other insulin sensitisers for metabolic features, and ovulation-induction agents or assisted reproduction for infertility [3]. No single conventional therapy addresses the underlying multisystem pathophysiology, which has driven interest in complementary approaches [3].

5. Ayurvedic Perspective on Polyendocrine Metabolic Ovarian Syndrome

5.1. Nomenclature and Conceptual Correlation

No single disease entity corresponding precisely to PMOS is described in classical Ayurvedic literature; it is therefore approached as an Anukta Vyadhi, a condition to be understood through Samprapti (pathogenesis) and Lakshana (signs and symptoms) rather than a fixed nomenclature, in keeping with the principle articulated by Acharya Charaka that an unnamed condition may be diagnosed and managed

on the basis of its manifest features [11, 10]. Most authors correlate PMOS predominantly with Artava Kshaya (diminution or vitiation of Artava, the menstrual/ovarian factor), described classically as delayed, scanty menstruation lasting less than the physiological duration, often with associated pelvic pain [9, 12]. Overlapping correlation is also drawn with several Yonivyapadas (gynaecological disorders) described by Acharya Kashyapa and other classical authors, including Nashtartava/Anartava, Arajaska Yonivyapada, Lohitakshaya Yonivyapada, Vandhya Yonivyapada, Shandi Yonivyapada and Pushpaghni Jataharini, each of which resembles a particular clinical facet of PMOS such as amenorrhoea, subfertility or abnormal uterine bleeding [6, 9].

5.2. Nidana

Ayurvedic aetiological factors correlated with PMOS causation include Ahara (dietary) factors such as excessive intake of Guru heavy, Snigdha unctuous and Madhura sweet foods, Vihara (lifestyle) factors such as Avyayama sedentary habits and disturbed sleep–wake cycles, and Manasika Nidana (psychological factors) such as chronic stress, all of which are recognised to influence Agni digestive-metabolic fire, Prakriti (constitution) and the site-specific manifestation of disease [8]. These closely mirror the modern recognition of diet, sedentary lifestyle, obesity and chronic stress as contributory factors in PMOS [12].

5.3. *Samprapti* — Dosha-Dushya Vijnana

PMOS is understood in Ayurveda as a disorder of predominantly Kapha and Pitta Dosha, occurring against a background of Vata vitiation that governs ovulatory and menstrual regularity; several authors describe PMOS as arising from Avarana obstruction of Vata by aggravated Kapha, impairing the normal downward movement "Apana Vata" responsible for menstruation and ovulation [9]. Kapha predominance manifests clinically as weight gain, subfertility, hirsutism and a tendency towards insulin resistance/diabetic predisposition, while Pitta predominance manifests as acne, painful or clotted menses and hair loss [9]. The Dushya structural tissue elements implicated include Rasa, Rakta and Meda Dhatu plasma, blood and adipose tissue, with Artava as the principal Upadhatu affected, alongside impaired Agni leading to the formation of Ama (metabolic toxins) that obstruct the Artava Vaha Srotas (reproductive channels) [6, 27].

5.4. *Samprapti* Ghataka (Components of Pathogenesis)

Table 1: Samprapti Ghataka of PMOS correlated with Artava Kshaya/Yonivyapada, adapted from published conceptual reviews.

***Samprapti* Ghataka**	**Ayurvedic Correlate**	**Modern Correlate**
Dosha	Kapha-Pitta predominant *Tridosha* with *Vata Avarana*	Insulin resistance/hyperinsulinaemia *Kapha*; hyperandrogenism *Pitta*; HPO axis dysregulation *Vata*
Dushya	*Rasa, Rakta, Meda, Artava*	Plasma glucose/lipids, blood, adipose tissue, ovarian-follicular function
Agni	*Jatharagni* and *DhatvagniMandya*	Impaired metabolic/insulin signalling
Ama	*Ama* accumulation obstructing *Srotas*	Chronic low-grade inflammation, oxidative stress
Srotas	*Artava Vaha*, *Rasa Vaha*, *Meda VahaSrotas*	Reproductive, circulatory, adipose pathways
Srotodushti	*Sanga*	Anovulation, follicular arrest
Udbhavasthana	*Amashaya*/*Pakvashaya*	Gut, hypothalamic-pituitary-ovarian axis
Adhishthana	*Yoni*/*Garbhashaya*	Ovary and endometrium

5.5. *Lakshana* and Ayurvedic–Modern Symptom Correlation

These symptom correlations form the basis on which authors clinically diagnose and grade PMOS-related presentations along Ayurvedic lines and select an individualised Dosha-specific treatment protocol [9, 12].

Table 2: Correlation of Ayurvedic Lakshana with modern clinical features of PMOS.

Ayurvedic *Lakshana*	**Modern Clinical Feature**
(*Yathochita Kala Artava Adarshana*)	Oligomenorrhoea
Alpata (scanty flow)	Hypomenorrhoea
Anartava/*Nashtartava*	Amenorrhoea
Yoni Vedana (pelvic pain)	Pelvic pain/dysmenorrhoea
Sthoulya	Obesity, central adiposity
Vandhyatva	Anovulatory infertility
Lomasha/*Ati Roma*	Hirsutism
Mukhadushti	Acne

6. Ayurvedic Management of PMOSs

Ayurvedic management of PMOS is individualised according to the patient's Dosha-Dushya predominance, Agni status, body constitution and the presenting complaint (menstrual irregularity, infertility, weight gain or hirsutism), and typically integrates Nidana Parivarjana (avoidance of causative factors), Shamana Chikitsa palliative herbal therapy and Shodhana Chikitsa bio-purificatory Panchakarma procedures [27].

6.1. *Nidana Parivarjana* and *Pathya-Apathya*

Avoidance of Kapha-aggravating dietary habits (excess Guru, Snigdha and Madhura foods), correction of sedentary habits, regular physical activity and stress management are

recommended as foundational measures, paralleling the modern emphasis on weight management, a low-glycaemic-index diet and exercise as first-line interventions in PMOS [8].

6.2. *Shamana Chikitsa* — Herbal and Compound Formulations

Kanchanar Guggulu, a classical Kapha-Medohara and Lekhaniya (scraping) compound formulation, is among the most widely used preparations for PMOS in published case studies, and has demonstrated symptomatic and sonographic improvement in single-case and small case-series reports over 90-day treatment courses [14, 29]. Network pharmacology and molecular docking studies have proposed plausible mechanistic targets for its phytoconstituents relevant to hormonal and inflammatory pathways in PMOS, though such in-silico findings require clinical validation [16, 17].

Shatavari (Asparagus racemosus), traditionally regarded as a female reproductive tonic ("Rasayana"), has shown benefit in combination regimens for follicular maturity and cycle regularity [15], and a randomised, double-blind, placebo-controlled trial of Shatavari root extract over 12 weeks reported measurable improvement in ovarian and endometrial parameters in women with PMOS [18]. Guduchi (Tinospora cordifolia) is frequently combined with Shatavari and Shatapushpa for its Ojovardhaka (immunomodulatory) action, and preclinical studies support its antihyperglycaemic activity relevant to the insulin-resistant phenotype of PMOS [20]. A prospective clinical study of a combined Ayurvedic regimen (Shatavari, Shatapushpa, Guduchi, Krishna Jeeraka, Atibala and Rasayana Kalpa) in 40 women with subfertility associated with PMOS reported favourable outcomes on menstrual regularity and fertility parameters over a structured multi-stage protocol [15].

6.3. Shodhana Chikitsa — Panchakarma Interventions

Virechana therapeutic purgation is regarded as a principal Shodhana procedure for PMOS, acting to reduce Pitta and normalise Agneyatva metabolic fire of Artava; a retrospective analysis of Virechana with Danti Avaleha and a dedicated doctoral study on Virechana in PMOS reported improvement in menstrual regularisation and reduction in ovarian cyst number/size [21, 25]. A related clinical study using Virechana followed by Triphaladi Kashaya with processed Guggulu in benign ovarian cysts demonstrated statistically significant reduction in cyst size, volume and serum CA-125 over 60 days [22].

Vamana Karma therapeutic emesis is indicated for Kapha-dominant presentations; a quasi-experimental study evaluating Vamana Karma with Shatapushpa Churna reported promising improvement in clinical and metabolic parameters of PMOS [23], consistent with the rationale that Vamana improves metabolism, reduces weight and may thereby improve androgen and glucose handling and ovulatory function [8].

Basti medicated enema therapy, particularly Yoga Basti regimens with Erandamooladi or Triphala-based decoctions, is considered the principal treatment for Vata-dominant reproductive disorders, since no Yonivyapada is described without Vata involvement [8]. An open-label randomised comparative trial of Panchakarma protocols in female infertility (including PMOS-associated cases) compared Virechana followed by Yoga Basti against Yoga Basti followed by Uttarabasti, with both regimens showing clinical benefit [24]. Uttarabasti intrauterine instillation therapy has additionally been reported to improve ovulatory and endometrial parameters in resistant anovulation associated with PMOS in individual case reports [26].

Nasya nasal instillation therapy is proposed to act via stimulation of the olfactory and limbic pathways, influencing hypothalamic GnRH pulsatility and thereby the hypothalamic–pituitary–ovarian axis, and is used as an adjunct for cycle regularisation [9]. Viddha Karma therapeutic puncture/bloodletting-based intervention has also been reported to improve menstrual regularity and reduce cyst size after a course of sessions in small clinical observations, though evidence remains preliminary [28]. Snehabasti as a Poorvakarma preparatory procedure preceding Virechana has been validated as an effective alternative to oral Snehapana in overweight individuals, a population that overlaps considerably with the PMOS phenotype [19].

6.4. Lifestyle, Diet and Yoga

Both systems converge on the centrality of weight management and lifestyle correction. Ayurvedic texts emphasise Vyayama (exercise) and a Kapha-Pitta pacifying diet, aligning with the modern evidence base supporting structured exercise, low-glycaemic-index diets and weight reduction as first-line, evidence-backed interventions in PMOS management [3, 8].

7. Current Evidence and Research Gaps

The majority of available Ayurvedic evidence for PMOS consists of single case reports, case series and small open-label or quasi-experimental studies [14, 22, 23], with only a limited number of randomised controlled trials, such as the placebo-controlled Shatavari trial [18] and comparative Panchakarma trials in infertility [24]. Sample sizes are generally small, outcome measures are heterogeneous across studies (symptom scores, ultrasonographic parameters, hormonal assays), and long-term follow-up data are scarce. Mechanistic (in-silico) studies on formulations such as Kanchanar Guggulu offer plausible pharmacological rationale but require corroboration through in-vivo and clinical studies [16, 17]. Standardisation of Dosha-based diagnostic criteria for patient selection, and adherence to CONSORT-type reporting standards, would substantially strengthen the evidence base for integrative management of PMOS.

Overall, the integrative model is most useful when the strengths of both systems are retained. Contemporary medicine provides established diagnostic criteria, metabolic risk assessment and evidence-based pharmacological options, while Ayurveda offers an individualised framework emphasising diet, lifestyle, constitution and symptom patterns. Rather than replacing one framework with another, future clinical research can examine whether carefully defined Ayurvedic interventions add measurable benefit to standard care. This approach may clarify which components are clinically useful, for whom they are useful, and which outcomes are most consistently affected.

Future research should also move beyond menstrual regularity and ovarian morphology as isolated outcomes. Studies could evaluate a combination of reproductive, metabolic and patient-centred endpoints, including ovulatory function, androgen measures, glucose regulation, lipid profile, quality of life and longer-term follow-up. Stratification according to phenotype, metabolic status and Ayurvedic Dosha-Dushya assessment may help determine

whether individualised treatment produces different outcomes from standardised protocols. Randomised controlled trials with transparent reporting, appropriate control groups and predefined outcomes would provide stronger evidence for the role of Ayurveda as an adjunct to contemporary PMOS management.

Safety and standardisation are essential components of future integrative care. Herbal formulations and Panchakarma procedures should be administered by appropriately trained practitioners, with attention to contraindications, drug interactions, treatment quality and monitoring. In patients receiving conventional medicines, coordinated clinical supervision is important so that established therapies are not discontinued without appropriate medical advice. Research should report adverse events as carefully as therapeutic outcomes. Standardisation of formulations, dosage, treatment duration and diagnostic criteria would improve reproducibility and allow meaningful comparison between studies.

Ayurvedic Shamana and Shodhana therapies have been investigated in PMOS, but the evidence remains heterogeneous. Reports involving Kanchanar Guggulu, Shatavari, Guduchi and compound regimens describe improvements in selected menstrual, sonographic or fertility outcomes, while studies of Virechana, Vamana and Basti have reported changes in clinical and reproductive parameters. However, differences in sample size, diagnostic criteria, treatment duration, co-interventions and outcome measures make direct comparison difficult. Small studies and case reports can generate hypotheses, but they cannot establish effectiveness or safety with the same confidence as adequately powered controlled trials. The existing literature therefore supports further investigation rather than definitive claims of efficacy.

The reproductive manifestations of PMOS also require individual assessment. Menstrual irregularity may result from anovulation, and the presence of polycystic ovarian morphology alone does not establish the diagnosis. The modern diagnostic approach requires assessment of the recognised diagnostic domains after exclusion of other relevant conditions. From an Ayurvedic perspective, the menstrual pattern, associated pain, quantity of flow, digestive status, bowel habits, sleep, stress and other constitutional features may be documented as part of the broader clinical picture. Such documentation may help researchers determine whether particular Ayurvedic phenotypes are associated with different treatment responses.

Lifestyle modification forms a common foundation for management in both approaches. Regular physical activity, appropriate dietary practices, adequate sleep and stress management are relevant because PMOS is influenced by metabolic and behavioural factors as well as reproductive physiology. Ayurvedic recommendations such as Nidana Parivarjana, Vyayama and a Kapha-Pitta-pacifying dietary pattern can therefore be considered alongside contemporary lifestyle interventions. The objective should be sustainable improvement in metabolic health and reproductive function rather than reliance on a short course of treatment alone. Individual dietary tolerance, nutritional adequacy, activity level and the patient's clinical goals should be considered when developing a plan.

The metabolic dimension of PMOS is particularly important. Insulin resistance and compensatory hyperinsulinaemia may contribute to ovarian androgen excess, altered follicular development and anovulation, while obesity and dyslipidaemia can further increase long-term metabolic risk. Within the Ayurvedic model, Meda Dushti, Kapha aggravation and impaired Agni are used to explain tendencies toward excess adiposity and metabolic dysfunction. The concept of Ama and Srotorodha provides an additional explanatory model for impaired physiological pathways. Although these concepts arise from different medical traditions and should not be treated as direct biochemical equivalents, their parallel emphasis on metabolic imbalance, obstruction and systemic effects creates an area suitable for integrative research.

PMOS should be understood as a heterogeneous endocrine-metabolic disorder rather than as an isolated ovarian condition. The clinical expression varies considerably between individuals, with some patients presenting predominantly with menstrual irregularity, others with hyperandrogenic manifestations, and others with metabolic abnormalities. The Ayurvedic framework similarly allows the clinical picture to be interpreted according to the dominant Dosha, affected Dhatu, Agni status and site of Srotodushti. This provides a rationale for individualised assessment rather than applying a single treatment protocol to every patient. In this context, the correlation with Artava Kshaya and Yonivyapada is best regarded as a clinical and conceptual framework rather than as a claim that the classical texts described modern PMOS as a named disease.

8. Expanded Integrative Considerations

8.1. Discussion

The Ayurvedic and biomedical models of PMOS, though framed in different conceptual languages, show substantial convergence. The Ayurvedic emphasis on Kapha-Medo Dushti parallels the biomedical recognition of insulin resistance and obesity as central drivers; Pitta vitiation parallels hyperandrogenic and inflammatory features; and Vata Avarana affecting Artava Vaha Srotas parallels HPO-axis dysregulation and anovulation [9, 4]. This conceptual overlap supports a biologically plausible rationale for integrating Ayurvedic Shodhana and Shamana Chikitsa with conventional lifestyle and pharmacological management, particularly for patients seeking non-hormonal or adjunctive options, or those intolerant of conventional therapy. However, the correlation of PMOS with Artava Kshaya and allied Yonivyapadas remains an interpretive one rather than a textually explicit equivalence, and clinicians should apply this framework as a diagnostic and therapeutic heuristic rather than a literal historical description [7, 10].

9. Conclusion

PMOS is best correlated in Ayurveda with Artava Kshaya and overlapping Yonivyapada syndromes, arising from Kapha-Pitta predominant Tridosha vitiation with Vata-mediated obstruction of the Artava Vaha Srotas, and impaired Agni leading to Ama accumulation. Published clinical literature, although still predominantly of low-to-moderate methodological quality, indicates that individualised Shamana therapy Kanchanar Guggulu, Shatavari, Guduchi and allied formulations and Shodhana procedures Virechana, Vamana, Basti, Uttarabasti and Nasya may improve menstrual regularity, ovulatory and sonographic parameters, and metabolic features in women with PMOS. Given its favourable safety profile and low cost, Ayurvedic management merits consideration as an adjunct within an

integrative care pathway for PMOS, pending confirmation through larger, well-designed randomised controlled trials with standardised outcome measures.

Conflict of Interest

The author declares no conflict of interest.

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