Adenomyosis With Infertility: A Case Report

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***Abstract*—Objectives: Adenomyosis is a common yet often under-recognized cause of pelvic pain, menstrual disturbances, and infertility, particularly in women of reproductive age. This report aims to highlight the potential role of individualized homoeopathic treatment in the management of adenomyosis associated with infertility. Material and Methods: A young woman diagnosed with adenomyosis presented with long-standing menstrual irregularities, dysmenorrhoea, and infertility. A classical homoeopathic approach was adopted, with detailed evaluation of physical complaints, associated systemic features, and emotional characteristics. Remedy selection was based on the totality of symptoms, followed by regular clinical follow-up. Results: The patient showed progressive improvement in the complaints and emotional well-being. During the follow-up period, reproductive function was restored, indicating a favourable clinical outcome. Conclusion: This case draws attention to the scope of individualized homoeopathic management as a non-invasive and holistic option in adenomyosis with infertility. By addressing both constitutional and local factors, homoeopathy may offer meaningful clinical benefits, warranting further systematic exploration.**

***Index Terms*—Adenomyosis, Infertility, Menstrual irregularities, Dysmenorrhea, Homoeopathy.**

I. INTRODUCTION

Adenomyosis, also referred to as internal endometriosis, is a histologically benign uterine disorder characterized by the presence of endometrial glands and stroma within the myometrium, extending to a depth of approximately 2.5 mm or more. This ectopic infiltration is accompanied by reactive myometrial hyperplasia, resulting in globular or cystic enlargement of the uterus, which may contain areas of haemolyzed blood. Clinically, the condition commonly manifests as heavy menstrual bleeding, often leading to anaemia and general weakness. Conventional management primarily involves hormonal therapy or surgical interventions aimed at symptom control. However, these approaches are frequently associated with adverse effects, symptom recurrence, or loss of fertility, posing a therapeutic challenge in women desiring conception. Homoeopathy, through its individualized and holistic approach, seeks to address both constitutional susceptibility and local pathology. The objective of this article is to present a case of adenomyosis with infertility managed through individualized homoeopathic treatment and to explore its potential role as a non-invasive, fertility-preserving therapeutic option.

II. CAUSES

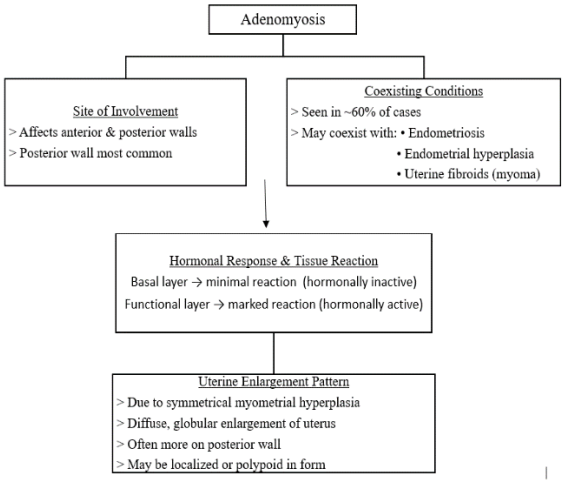
The exact cause of such endometrial ingrowth is not clearly known. It is believed to be associated with factors such as repeated childbirths, vigorous uterine curettage, or an excessive estrogenic effect. Additionally, pelvic endometriosis is found to co-exist in approximately 40% of cases. [1] The condition predominantly occurs in women between 35 and 50 years of age, although it may occasionally be observed in younger women as well.[3]

III. PREVALENCE

Adenomyosis was historically diagnosed primarily through histopathological examination, which has contributed to the imprecise estimation of its actual prevalence. Reported incidence rates vary considerably, ranging from 5% to 70%, with an average prevalence of 20–30% in women undergoing hysterectomy. The condition continues to be underdiagnosed, largely due to the absence of specific or pathognomonic clinical features. Approximately

30% of patients remain asymptomatic, whereas others present with varying degrees of menstrual irregularities and pelvic symptoms. [4]

IV. PATHOLOGY [1,3]



V. SYMPTOMS

The major clinical manifestations include: [1,3]

1. Menorrhagia (≈70%) – Characterized by excessive and prolonged menstrual bleeding, often lasting more than 7 days and frequently associated with passage of clots.
2. Dysmenorrhea (≈30%) – Progressively worsening colicky pain during menstruation due to increased uterine contractions.
3. Dyspareunia – Pain during sexual intercourse, commonly resulting from uterine tenderness and pelvic congestion.
4. Frequency of Urination – Caused by enlargement and tenderness of the uterus, leading to pressure on the urinary bladder.
5. Infertility and Miscarriage – Higher incidence of both due to distortion of the uterine architecture and impaired implantation associated with adenomyosis.
6. Backache – Often accompanies the above symptoms, resulting from pelvic congestion and uterine enlargement.

This symptom complex varies in severity, and the degree of discomfort often correlates with the extent of myometrial involvement.

VI. PHYSICAL EXAMINATION

In patients presenting with menorrhagia and progressive dysmenorrhea, the possibility of adenomyosis should always be considered. [3]

- Abdominal Examination:
  - A hypogastric mass may be palpable, arising from the pelvis and occupying the midline.
  - The uterine enlargement is typically smooth, firm, and uniform, and the size rarely exceeds that of a 14-week gravid uterus.

- Pelvic Examination:
  - Reveals a symmetrical, uniformly enlarged, and tender uterus, characteristic of adenomyosis.
  - The consistency may be firm or cystic, depending on the degree of myometrial involvement.
  - Findings may be modified or obscured in the presence of coexisting lesions, such as uterine fibroids or pelvic endometriosis.

VII. INVESTIGATIONS

1. Ultrasonography (USG) and Transvaginal Sonography (TVS) with Color Doppler
   - Useful in assessing the location, size, and extent of adenomyotic changes.
   - Typical findings include:
- Heterogeneous myometrial echotexture
- Asymmetrical thickening of the uterine walls (commonly posterior)
- Presence of small myometrial cysts
- Poorly defined Endo myometrial junction

2. Magnetic Resonance Imaging (MRI)
   - Considered the most specific and sensitive diagnostic tool for adenomyosis.
   - Demonstrates a thickened junctional zone (JZ) and low-signal intensity areas on T2-weighted images.
   - A junctional zone thickness ≤ 8 mm generally rules out adenomyosis, whereas a thickness ≥ 12 mm is highly suggestive of the disease.

VIII. CASE REPORT

Presenting complaint

A 27-year-old married woman, married for three years, presented to the outpatient department with

complaints of long-standing menstrual irregularities and progressively worsening dysmenorrhoea.

History of Presenting Complaint

The patient reported irregular menstrual cycles accompanied by severe lower abdominal pain during menses. The menstrual flow was markedly scanty, frequently limited to spotting lasting one to two days. She also complained of recurrent painful ulcerations affecting the tongue and throat occurring predominantly in the premenstrual period, leading to difficulty in swallowing and reduced food intake. Additionally, she experienced frequent eructation's, especially after consuming vegetables such as cabbage and cauliflower.

Past history & its treatment history

The patient had been diagnosed with adenomyosis based on prior gynaecological evaluation. She had received allopathic treatment for approximately three months, after which the medications were discontinued. Six months following cessation of conventional therapy, she sought homoeopathic treatment for symptom control and overall well-being. There was no history of major surgeries, systemic illnesses, or long-term medication use. Obstetric history was non-contributory.

Family history

No relevant family history.

Life space investigation

The patient presents as a markedly anxious individual who expresses her worries impulsively, yet withdraws emotionally when faced with personal hurt. Information corroborated by her husband reveals a deeply ingrained pattern of emotional deprivation originating in childhood. She was raised in an atmosphere devoid of maternal affection due to early parental separation. Growing up without her mother's presence instilled in her a persistent inner sense of abandonment and forsakenness. Although her relationship with her father remains cordial, she never experienced consistent emotional security. Being predominantly brought up by a domineering grandmother, she was subjected to constant control over her behaviour and decisions. Over time, this prolonged dominance shaped her into a submissive and compliant personality, accustomed to suppressing her own desires to maintain peace. She exhibits a profound sensitivity to rejection and emotional neglect. Despite extending wholehearted support to others particularly her elder sister, for whom she assumes significant financial responsibility she repeatedly encounters a lack of acknowledgment and appreciation. Even when she bore the entire expense of a recent family function, she received neither gratitude nor basic respect. When questioned about such incidents, she avoids confrontation and responds with passive resignation, often saying, "Leave it." There is a striking pattern in her life: she gives unconditionally yet feels emotionally untouched, unvalued, and inwardly alone. She harbours silent hurt but does not openly express resentment. Instead, she internalizes disappointment, gradually developing feelings of self-loathing and aversion toward emotional closeness. Episodes of quarrelling or perceived betrayal in friendships deeply affect her, reinforcing her belief that affection and belonging are uncertain and unreliable.

Physical generals

The patient has reduced appetite due to painful ulcerations before menses, thirstless, itching of scalp in damp wet weather conditions, desires fruits, frequent eructation's after eating cabbage mainly and cauliflower, drinks coffee twice daily, sleep is refreshing at times disturbed too due to overthinking, dreams of floods, thermally patient is towards chilly side.

Examination

On general examination, the patient appeared anxious but cooperative. No significant abnormalities were detected on systemic examination. Gynaecological findings were consistent with the previously diagnosed adenomyosis.

Diagnostic Assessment

Based on the clinical history, presenting gynaecological complaints, associated somatic symptoms, and emotional profile, the case was assessed as adenomyosis with prominent psychosomatic and emotional components contributing to disease expression.

Repertorial analysis

Following a thorough case taking and analysis, the symptoms were evaluated to form the totality.

Based on this assessment, repertorization was carried out.

The following characteristic symptoms were identified after detailed case analysis and were selected for repertorization. Repertorization was carried out using Synthesis Mobile Repertory software [5], which facilitated systematic evaluation and ranking of remedies based on the constructed totality.

Figure 1 Repertorial analysis

Therapeutic Intervention

First Prescription

Date: 12/06/2025

Remedy: *Magnesium carbonicum* 200C

Dose: Single dose

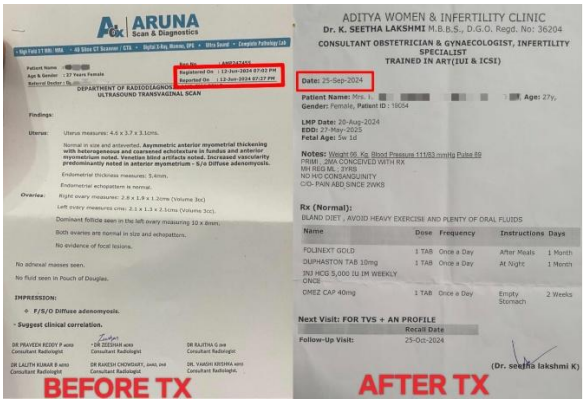
Basis of Prescription

The prescription was made after a comprehensive evaluation of the case, including analysis of the repertorial totality, miasmatic background, and Materia medica [6,7] correlation. The remedy selection emphasized the patient's characteristic gynaecological symptoms, gastrointestinal sensitivity, recurrent premenstrual ulcerations, and her distinctive emotional profile marked by anxiety, emotional deprivation, submission, and avoidance of confrontation. Based on this individualization, *Magnesium carbonicum*[8]200C was administered as a single dose on 12/06/2025.

Follow-Up and Outcomes

Date	Symptomatology	Prescription
10/07/2025	Dysmenorrhoea significantly reduced; eructation is decreased; oral ulcers less painful; noticeable improvement in anxiety levels.	*Rubrum* BD × 6 pills
08/08/2025	Menstrual complaints markedly improved; general physical condition better; emotional well-being improved with reduced anxiety and increased stability.	*Rubrum* BD × 6 pills
25/09/2025	Amenorrhoea present; mild nausea without vomiting; no abdominal pain or vaginal bleeding; general condition stable. **Ultrasonography revealed a single intrauterine pregnancy of 5 weeks and 1 day.**	*Rubrum* BD × 6 pills
25/10/2025	Pregnancy progressing normally; mild nausea persists; appetite and sleep satisfactory; no abdominal pain or bleeding; emotionally calm and reassured.	*Rubrum* BD × 6 pills
25/11/2025	Second month of antenatal follow-up: no new complaints; no signs of threatened abortion; general health good; mental and emotional state balanced.	*Rubrum* BD × 6 pills

Evidence based reports



IX. CONCLUSION

This case highlights the individualized homoeopathic management of adenomyosis in a young woman presenting with significant gynaecological, gastrointestinal, and psychosomatic symptoms. Following a detailed case analysis and individualized remedy selection, the patient demonstrated marked improvement in dysmenorrhoea, menstrual irregularities, emotional well-being, and general health. Subsequent conception and normal progression of early pregnancy further indicate a favourable clinical outcome. Although adenomyosis is often managed surgically or hormonally in conventional medicine, this case suggests that individualized homoeopathic treatment may offer a holistic therapeutic approach by addressing both physical pathology and underlying emotional factors. Further systematic studies and controlled clinical trials are warranted to substantiate these observations.

INFORMED CONSENT

Written informed consent was obtained from the patient for publication of this case report and accompanying clinical data, ensuring anonymity and confidentiality.

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CONFLICT OF INTEREST:

The authors declare no conflict of interest related to this case report.

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