Nigam Harsh ; Jain Raveena ; Infertility ; Homoeopathic Heritage ; October, 2017 ; ISSN : 9070-6038

Infertility

Author

Dr. Harsh Nigam, MBBS, MD, MF (Hom), completed MBBS from B.R.D. Medical College. MD (Physiology) from M.L.B. Medical College. MF (Hom) Member of Faculty, The Faculty of Homoeopathy U.K. ; Ex-Member Special Committee of clinical research of CCRH ; Ex-Member Editorial Advisory Board, Indian Journal of research in Homoeopathy. He is currently spearheading multi-speciality outdoor Homoeopathic Centre of Excellence in Medical Homoeopathy at Kanpur.
He is a regular contributor to Homoeopathic Heritage and Author of Principles and Practice of Homoeopathic Case Management; Miasma, A Road Less Travelled both published by B. Jain Publishers. His aim is to establish Homoeopathy on its scientific merit and make it integrated with orthodox medicine in such a way that the Scope and Limitation of Homoeopathy are well defined.

Abstract

Infertility is a global health issue affecting 8-10% of couples. It is a multi dimensional problem with social, economic and cultural implications with strong demographic problems. Infertility is the incapacity to fulfill pregnancy after one year of sexual intercourse with no contraceptive measures taken. Infertility is a common problem affecting one couple in six. 20-30% cases are due to male infertility, 20-35% are due to female infertility, 25-40% cases are due to combined problems. In 10-20% of cases, no cause is found.
Homoeopathy is a cost effective modality for all non surgical cases of infertility, male and female.

Keywords : Infertility, Homoeopathy, Therapeutic Approach, Documented Cases.

Introduction

Infertility is defined as one year of unprotected coitus without conception.
Always remember it takes two to be infertile and it's a problem faced by a couple rather than an individual.

Role of the Homoeopathic physician

In response to the needs of the infertile couple, physicians should have four goals in mind

1. To Investigate i.e. to seek out the causes of infertility.
   This is accomplished thorough investigations.

2. To Educate i.e. to provide accurate information and to dispel the misinformation commonly gained by friends and mass media.

3. To Counsel i.e. to provide emotional support for the couple during a trying period (severe anxieties can interfere with ovulation and frequency of intercourse).
   One neglected goal is to counsel a couple regarding the proper time to

discontinue investigation and treatment.(despite the absence of pathology, couples with three or more years of infertility have a bad prognosis).

4. To Cure i.e. to correct infertility by Homoeopathy, Hormonal treatment, ART(assisted reproductive techniques) or Surgery either alone or in tandem.

Myths Regarding Infertility

Myth 1
Women are infertile because they are too nervous it is not true unless sever anxiety interferes with ovulation or frequency of coital frequency.
Myth 2
Adoption increases a couple's fertility. It does not.
Myth 3
Even a Euthyroid female should be treated by thyroid supplements. This is worthless and harmful.
Myth 4
Dilatation & Curettage is a legitimate part of a routine infertility investigation. No matter what gynecologist may want you to believe it's not true in fact D&C provides minimal information beyond that provided by endometrial biopsy and is both expensive and potentially hazardous. There is also no evidence to support the old belief that a women becomes more fertile following D&C. on the contrary, one study indicates a decreased fertility potential for those woman undergoing D&C.
Myth 5
A retroverted uterus is a cause of infertility. Only when it is associated with pelvic adhesions or endometriosis then it does effect fertility.

Causes Of Infertility

The causes of female infertility are problems in the fallopian tubes, the uterus, disorders of menstruation, sexual disorders and ovarian failure and some of the cases of infertility are causeless. Male factor accounts for almost half of all cases of infertility in couples, sperm analysis is mandatory before any treatment. Male infertility is due to deficiency in the semen and sperm quality
Before getting to the treatment part lets review the Basis, Cause and Mechanisms involved in the causation of infertility.
When assessing infertile couples consider
1 Is she producing healthy ova?
(Anovulation causes 21% infertility)
2 Is he producing enough healthy sperms?
(Male factors cause 24% infertility)
3 Are the ova and sperm meeting?
(Tubal cause 14%, Hostile mucus 3%, Sexual dysfunction 3%)
4 Is the embryo implanting ?
5 Endometriosis is thought to be the cause in 6%
6 unexplained infertility is a cause in 27% of couples.

Management Of Infertility

Initial management is to take a full history (orthodox and homoeopathic)
Ask her about
Menstrual history, previous pregnancies and contraception,
history of pelvic infection or abdominal surgery,

also take note of mentals, generals and striking, singular, uncommon peculiar symptoms.

Ask him about

Puberty, previous surgeries (hernias, orchidopexy, bladder neck surgeries), illnesses(venereal disease, adult mumps),drugs, alcohol, smoking, job(is he home when ovulation occurs) and full homoeopathic history off course.

Ask both about

Technique,
frequency and timing of intercourse,
feelings about infertility and parenthood, interpersonal relationship,
previous tests.

Prescribing For Infertility Esee table 2 C table F

In case of Hormonal imbalance I prefer

1.Constitutional remedy in high (200-1M) potency, given at the right time in relation to the hormonal cycle and not repeated frequently.
2.If constitutional remedy fails in 3 months I try to remove blocks to cure by Anti miasmatic remedies or by nosodes.
3.The time between two pulses of constitutional remedies may be utilized by giving Small remedy in low potency(1X-6C) at frequent interval.

In case of Organic pathology

I always give Medium to high potency of constitutional medicine at long intervals and I always prefer to give small remedy frequently/daily in mother tinctures or low potency.

In case of Tubal blockage

I usually advice the patient of tubal blockage for laparoscopic surgery and only when surgery fails I try Silica, Scirrhinum etc.

In cases of Bad Obstetric History

specially after repeated abortions(induced or spontaneous)
I start with Arnica and follow it up with anti sycotic remedies like Thuja Nat-S Sabina. According to Kent Secale corr is another very important remedy after abortions sprcialy when Ergot has been used as abortificant.If menses are effected I treat the cause as that of hormonal imbalance.

In the cases of unexplained infertility

1. First clear the miasmatic background
2. Follow with the constitutional remedy in ultra low molecular potency(1M-CM).
3. Wait and watch patiently.

"Always remember we are not miracle workers and selecting the right remedy is science first and art/intuition later. Follow these simple rules for success."

1. Take a full History
   (Follow Hahnemann's instructions Para 82-104 The Organon).
2. Repertorise
   On the basis of totality of symptoms.
   (Para 153 The organon, Lesser writings- Kent).
3. Recognize Miasm.
4. Master the art of Layered Prescribing ; The following table1 might help as a guideline

Table 1

LAYERED THERAPEUTIC APPROACH (BURNETTAND EIZAYAGA)						
S. No.	**Constitutional Layer**	**Miasmatic Layer**	**Fundamental Layer No Organic Disease Present**		**Lesion Layer Organic Disease Present**	
Illness			**Chronic miasmatic disease (Stage1): Malaise**	**Chronic miasmatic disease (Stage2): Functional disease**	**Chronic miasmatic disease (Stage3): Organic disease**	**Chronic miasmatic disease (Stage4): End Stage multi-systemic disease**
Strategy	**Prescribe on normal traits:** 1.Physical (typology). 2.General (biological). 3.Psychological (temperament).	**Prescribe on pattern of illness depending on:** Personal history. Past history. Family history.	**Classical Prescribing** based on totality that is ,the sum and the essence of symptoms.	**Prescribing based on** Fundamental shift of symptoms. Followed by Classical prescribing.	**Organ remedies Drainage treatments. Clinical prescribing. Layered prescribing.**	**Local disease. Organ Remedies Drainage treatments.**
Aim	**Prevention**	**Prevention. Remove The Blocks To cure.**	**Cure.**	**Cure.**	**Initiate reversal Of Pathology Then cure.**	**Palliation.**

THERAPEUTIC STRATEGY

For complex cases, best suited strategy is “Layered Prescribing”. Layered prescribing is a method based on the assumption that certain patients have distinct levels of disease, which require separate prescriptions to be given in appropriate sequence in order to bring about a complete and lasting cure

TREATMENT PLAN IN MODERN SETTINGS

The aim is balance between facilitation by Homoeopathy and decompensation caused by Antipathy/Allopathy. That is how Homoeopathic management is integrated with orthodox management. This is not easy and much consideration is required such as:

a. A Heavily medicated patient
    1. Single dose should be avoided and it is better to use
        - Split single dose
        - Multiple doses (LM Potency)
    2. Give small remedies before giving constitutional remedy.
b. If current orthodox medicine is producing side effects:
    1. Consider drainage: Review case after two weeks, if nothing happens then shift to specifics.
    2. Specifics/organ remedies to detoxify and tone up the organ or system before giving a deeper organ remedy given as mother tincture or 1x to 6x.
    3. Therapeutic/Fundamental prescription: Emphasis is placed on clinical diagnosis focusing on a group of remedies with known affinity to a system or a clinical condition (whole person is not taken in account) yet the case is taken completely, considering locality, etiology, modality, sensation and concomitant. The aim is to select a simillimum which corrects the disturbance prevailing in an organ/tissue/system.

    This usually results in the use of a medium or a small remedy.
    4. After the therapeutic fundamental prescription,if no response = Think of blocks to cure,if Response = Think of withdrawal of orthodox medicine if medically justified

HOMOEOPATHIC MEDICINAL MANAGEMENT OF MALE INFERTILITY

Table 2

	Small Remedies	Constitutional Remedies	Nosodes	Miscellaneous
Premature ejaculation	Agnus castus Erigeron/Acid phos Caladium Nuphar luteum Selenium	Graphites Lyc/Calc-carb Sulphur Natrum mur Thuja/Baryta carb	Psorinum Medorrhinum Leuticum Tuberculinum Carcinosin	Counseling
Oligospermia	Acid phos/Kali phos/Nat-phos Calc-phos Caladium China/Selenium Sabal-serr	Calc-carb Lycopodium Sulphur/Graphites Silicia/Staph Conium/Phosphorus Sepia/Lachesis Nat-mur/Nitric acid Kalium's Carboneum's Bromium's	Psorinum Leuticum Medorrhinum Tuberculinum	In case of blockage microsurgery is advisable
Testicular Atrophy	Capsicum Carbo-an/Gelsemium Abrotanum Arnica Picric acid	Aurum Iodium's Baryta carb Argentum's	Tub-testi Lyssinum	
Hormonal Imbalance	Sabal-serr Pareria B Chimaphila	Pulsatilla/Cyclamen Sepia Lachesis	Pituitrinum Folliculinum	

HOMOEOPATHIC MEDICINAL MANAGEMENT OF FEMALE INFERTILITY

Table 3

Cause	Small Remedies	Constitutional Remedy	Nosode	Miscellaneous
A. Hormonal Imbalance	Senecio Helonias Kreosote Caulophyllum Sabina Lilium-tig Sabal-serr Apium	A.Menses Supressed/Scanty/ Absent Puls Calc/Graph Nat-mur/Borax Sep/lach/Sil/Aur/Con B.Menses Copius & Irregular Puls/ Cyclamen Nat-mur/Borax Lach/Hyos/Merc/ Nux-v/Phos/Plat/Sulph Calc/Ferr/Caps/Nat-c	Psorinum Folliculinu m Carcinosin	
B. Organic Pathology				
Uterine fibroids	Franixus Am Aur Mur Nat Thalapsi / Phytolacca-d	Conium/Phosphorus Lachesis/Silicia		
Polycystic ovary(PCOD)	Apis/Apium Cenchris Kali brom Aur-iod	Lachesis Platina/Palladium Calcarea/Graphites Iodium	Leuticum Med/Tuber culinum Folliculinu m Carcinosin	
PID	Echinacea Anthracinum Gun powder		Leuticum Med/Tuber culinum Folliculinu m Carcinosin	
Bad Obstetric History	Arnica Sabina/Sec-cor Caul/Cimic	Sepia/Calcarea Lachesis/Staphysagria		
Tubal block	Silicia/Hepar-s		Scirrhinum Tuberculin um	Surgery remains the mainstay of treatment
C. Unexplained Infertility		First clear background, then follow with other Miasmatic Constitutional Remedies		

INFERTILITY CASES

Illustrative Case of Male Infertility
Mr. S, Age 33 Yrs. A Case of Oligospermia(See Fig.2 Case 2 M)

Mr. S presented with oligospermia, erections were incomplete and ejaculation was quick. He also had varicocele. He complained of weakness and the semen was thin and sticky. Semen analysis done on 05/08/14 showed total count which was 60 million, the count per ml was 20 million per ml, which suggested of moderate oligospermia. According to symptom similarity Lycopodium 10 M was given in three doses and Caladium, Acid phos and Agnus castus were given in lower dilutions.

The semen analysis was again done on 02/12/14 which showed total count of 187.5 million and count per ml was 75 per ml and active progressive motility of sperms was 65%.

Documented Cases of Male Infertility

Table 4

MALE INFERTILITY			
CASE	NAME	TOTAL SPERM COUNT (BEFORE)	TOTAL SPERM COUNT (AFTER)
1. M Fig 1	Mr. S, 35 Yrs	26/10/2016 8 million	05/04/2017 65 illlion
2. M Fig 2	Mr. S, 33 Yrs	05/08/2014 60 million	02/12/2014 187.5 million
3. M Fig 3	Mr. F, 28 Yrs	24/10/2010 45.1 million	09/12/2011 120 million
4. M Fig 4	Mr. C, 36 Yrs	14/03/2009 10 million	08/04/2009 78 million
5. M Fig 5	Mr. M, 28 Yrs	24/08/2008 25 million	08/12/2011 116.4 million
6. M Fig 6	Mr. D, 30 Yrs	06/08/2007 84 million	04/03/2008 232 million
7. M Fig 7	Mr. V, 34 Yrs	24/06/2002 2.8 million	26/06/2003 28.8 million
8. M Fig 8	Mr. G, 35 Yrs	02/02/1999 22 million	14/10/1999 72 million

ILLUSTRATIVE CASE OF PRIMARY INFERTILITY

CASE A (See Case 1 F; Fig 9)
Mrs. P S, age 31 years, married for 5 years presented with infertility. She had been investigated and treated by conventional gynaecologist but could not conceive. The cause ascertained was follicular immaturity with bad obstetric history. She had past history of a miscarriage in the year 2002. Her investigations were done which revealed that her Cytomegalovirus (CMV-IGG) was raised, its value was 439.7. Her Hysterosalpingography report was done on 06/02/2017 showed right sided hydrosalpinx. Her histopathologiccal examination done on 08/12/2016 revealed chronic endommetritis with endometrium in non secretory phase.

Particular symptoms
The menses were normal. Additionally she had pityriasis alba. There was no leucorrhea.

General symptoms
1) Mental generals : the patient has great anger and irritability. Consolation aggravates. Weeping from trifles. Fear of being alone and the dark. The patient is timid.
2) Appetite : Normal.
3) Stool : Normal.
4) Urine : Normal.
5) Thirst : Thirstless.
6) Perspiration : Mostly over face.
7) Desire : Spicy and sour food.
8) Taste : Normal.
9) Sleep : Normal, Position on sides
10) Dreams : No.
11) Relation To Heat And Cold : Hot Patient.

Past History
There was no significant severe illness except chickenpox and fungal infection. There was a history of one miscarriage in the year 2012.

Family history
In her family, her father had Chronic Kidney Disease.

Selection Of Medicine
The complete history taking of the patient was done, followed by repertorisation of the case with the help of Radar.
After repertorisation the medicine selected was Medorrhinum 10M was given in three doses,to clear the miasmatic background as indicated by her bad obstretic history. One month later she was prescribed Ovarium 6CH to be taken 4 times a day for seven days.No medicine for next seven days then Folliculinum 6CH 4 times a day for one week.

Post Treatment Evaluation

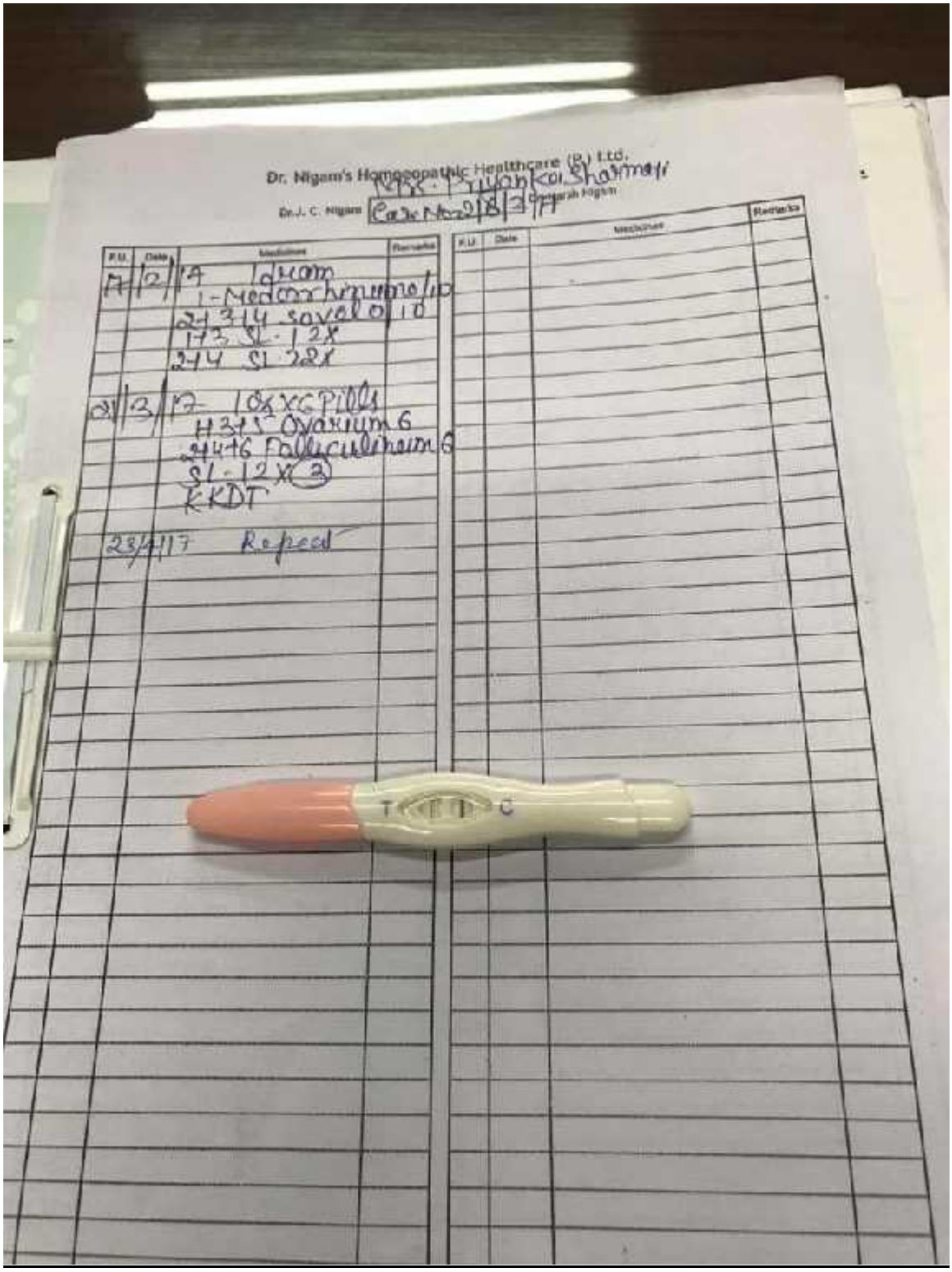
After about four months of prescribing medicines to her, the patient reported of conception. Her UPT was positive.
General symptoms recorded after prescribing medicines are as follows:

Mental generals : The patient significantly normal as regards her anger and irritability. She became calm and there was no weeping tendency.
Thirst : Normal.
Perspiration : Normal.
Desire and aversion : No significant change.
Stool : Normal.
Urine : Normal.
Sleep : Normal.

During treatment no other complaint was reported by the patient.

Laboratory Investigations

USG done on 30/07/2017 showed intrauterine gestation sac of 6 weeks 0 days (Fig 9:Case 1F) Her UPT was positive in May 2017 (Picture below)



Dr. Nigam's Homoeopathic Healthcare (P) Ltd.

Dr. J. C. Nigam

Case No. 2/8/3

F.U.	Date	Medicines	Remarks
1st	2/	Rx Iquam 1-Medorrhinum/10 2-314 Saval D/10 1+3 SL-12X 2+4 SL 12X	
2nd	3/	Rx 10 X G Pills H 315 Ovarium 6 2+4+6 Folliculinum 6 SL-12X (3) KKDT	
28/4/17		Repeat	

F.U.	Date	Medicines	Remarks

DOCUMENTED CASES OF FEMALE INFERTILITY

Table 5

FEMALE INFERTILITY			
CASE	NAME	CAUSE	RESULT
1. F Fig. 9	Mrs. P, 31 yrs	06/02/2017 Primary infertility with Right Sided Hydrosalpinx	USG (30/07/2017) Intrauterine GS of 6 weeks 0 days
2. F Fig.10	Mrs. A, 22 yrs	09/09/2016 Secondary infertility due to recurrent abortion	USG (22/11/16) Early live intrauterine pregnancy of 7 weeks and 4 days
3. F Fig.11	Mrs. L, 29 yrs	01/07/2015 Irregular menses with primary infertility	USG (30/03/16) Single viable intrauterine GS of 8 weeks and 5 days
4. F Fig.12	Mrs. P, yrs	14/05/2015 Primary infertility with irregular menses	USG (05/10/2015) Single sac seen in uterine cavity approx. 7 weeks and 2 days
5. F Fig.13	Mrs. G, 25 yrs	03/12/2014 Primary infertility with irregular menses with scanty menses	USG (23/02/15) Live fetus of 9 weeks and 0 days±1 week
6. F Fig.14	Mrs. S, 21 yrs	03/09/2014 Recurrent abortions leading to secondary infertility	USG (27/08/15) Enlarged uterus with GS containing live fetal node of approx. 8 wks, 7days±3 days
7. F Fig.15	Mrs. R, 26 yrs	26/07/2012 Primary infertility with leucorrhea and obesity	(23/10/2012) Pregnancy test came positive
8. F Fig.16	Mrs. A, 28 yrs	24/02/2011 Primary infertility	USG (22/06/2011) Pregnancy test came positive
9. F Fig.17	Mrs. J, 31 yrs	10/11/2010 Primary infertility due to scanty menses	USG (18/02/11) Reported on phone that she is one month pregnant
10. F Fig.18	Mrs. J, 29 yrs	04/04/2010 Primary infertility due to bilateral tubo-ovarian complex cyst adenoma with hypothyroidism	USG (30/05/2010) Bulky gravid uterus with well defined GS in fundal region of mean sac diameter approx. 12.1 mm
11. F Fig.19	Mrs. J, 25 yrs	30/03/2010 Primary infertility due to PCOD	USG (28/06/2010) Single live GS of approx. 6-7 weeks
12. Fig.20	Mrs. S, 29 yrs	13/12/2007 Mildly retroverted uterus with mild adhesions	USG (13/05/2008) Bulky uterus with mildly edematous GS of 14.8 mm, 6 weeks and 2 days gestational age
13.	Mrs. G,	08/12/2006	USG (12/03/2008)

Fig.21	34 yrs	Secondary infertility due to recurrent abortions with HSV and rubella positive	Single live intrauterine fetus in changing lie at present breech
14. F Fig.22	Mrs. N, 28 yrs	01/12/2006 Recurrent abortions with delayed menses	UPT RESULT (16/12/06) Positive
15. F Fig.23	Mrs. A, 32 yrs	26/11/2006 Primary infertility due to hormonal imbalance	(28/11/2006) Pregnancy test came positive
16. F Fig.24	Mrs. R, 20 yrs	04/07/2005 Primary infertility with pelvic inflammatory disease	USG (02/08/2005) Bulky single GS of approx 6 weeks size
17. F Fig.25	Mrs. R, 24 yrs	22/06/2006 Multiple fibroid lesion in uterus with infertility	USG (23/07/2006) Enlarged uterus with single live fetus GS approx. 10 weeks and 4 days.
18. F Fig.26	Mrs. M, 23 yrs	22/10/2004 Left ovarian cyst	USG (14/01/2005) Single live fetus of approx. 10 weeks seen in uterus
19. F Fig.27	Mrs. S, 25 yrs	08/10/1998 Primary infertility due to left ovarian cyst	USG (08/08/2000) Early pregnancy of 9.5 weeks in uterus
20. F Fig.28	Mrs. S, 34 yrs	10/12/1998 Uterine fibroids	USG (06/12/2001) Single live fetus of 10 weeks and 1 day gestational age

APPENDIX

1.MALE INFERTILITY

Fig 1: Case 1 M

Before After

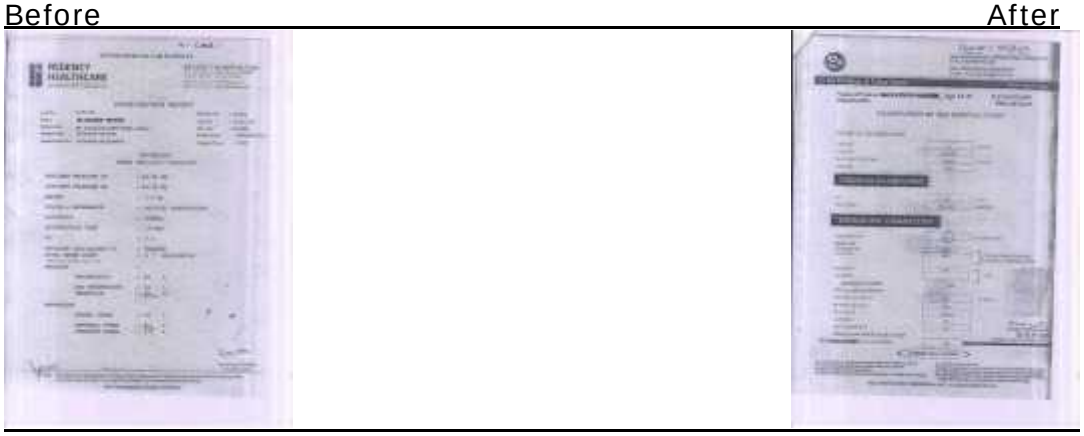


Fig 2: Case 2 M

Before After

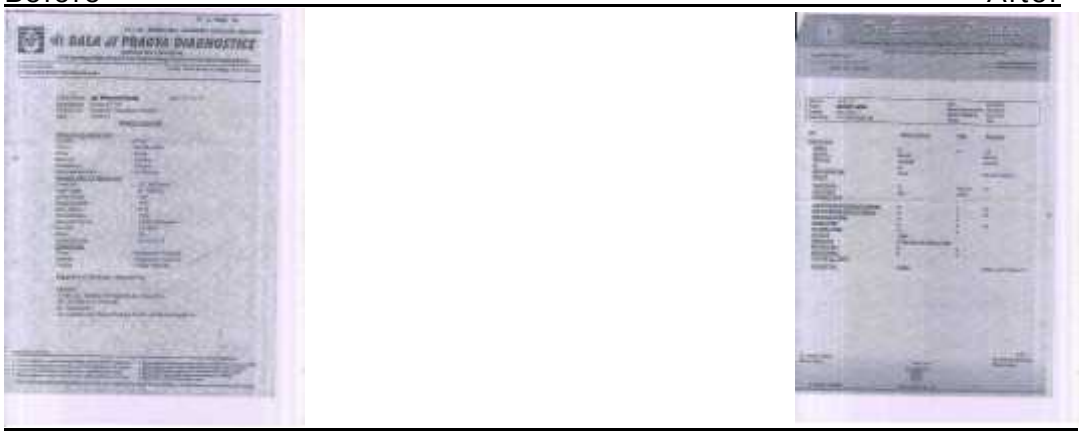


Fig.3 Case 3 M

Before After

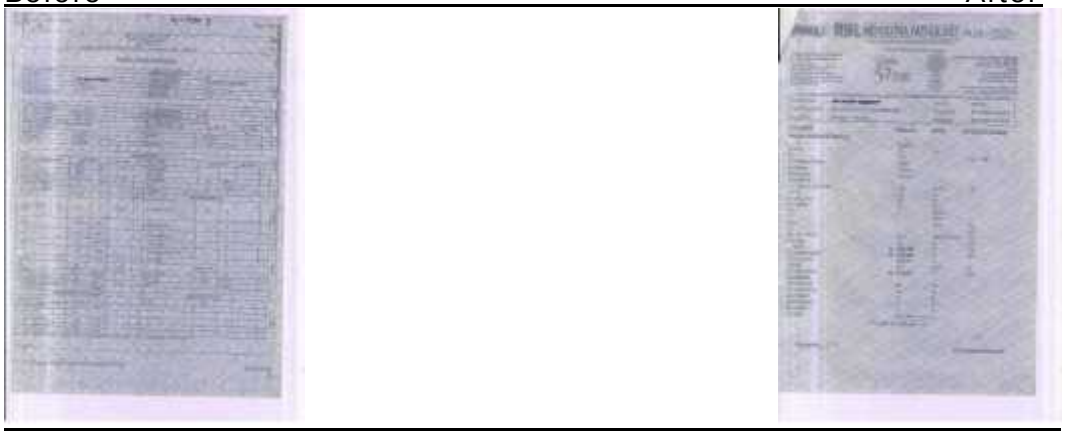


Fig.4: Case 4 M

Before After

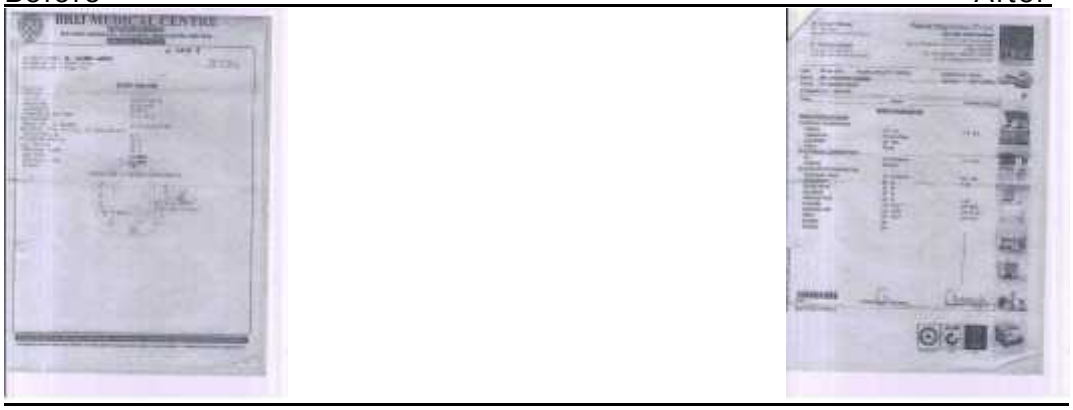


Fig.5: Case 5 M

Before After

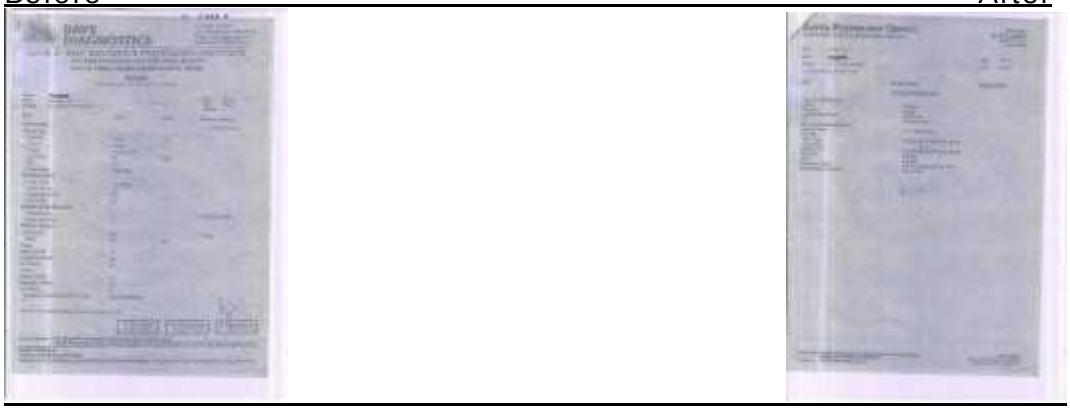


Fig.6: Case 6 M

Before After

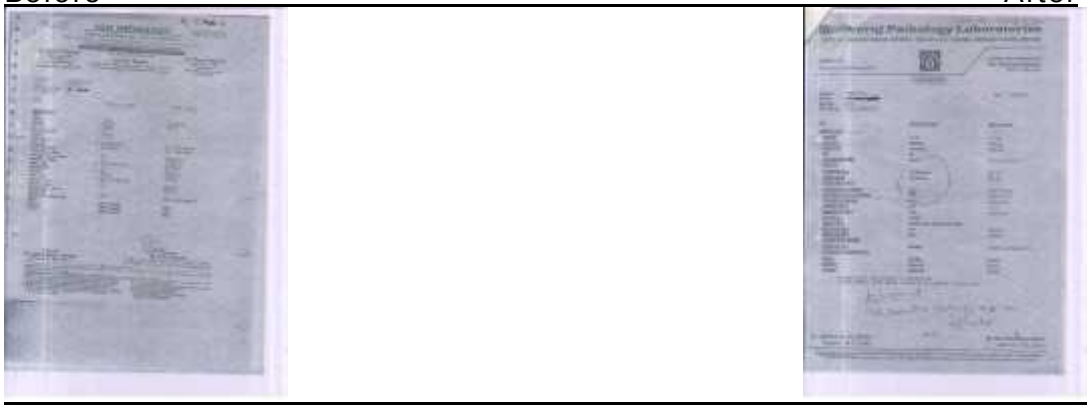


Fig.7: Case 7 M

Before After

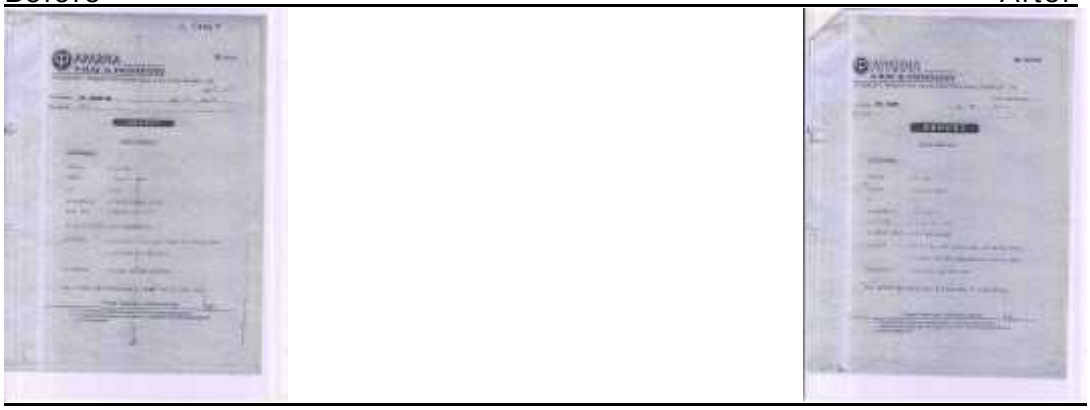
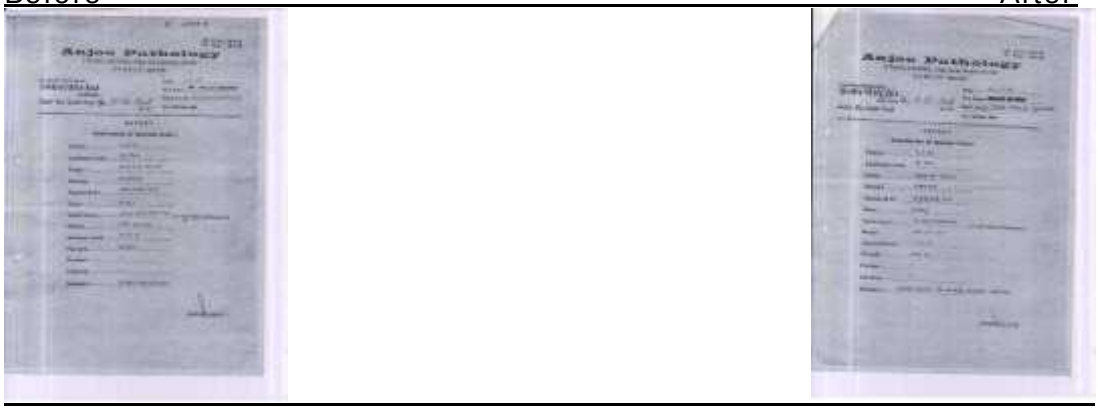


Fig.8: Case 8 M

Before After



2.FEMALE INFERTILITY

Fig 9: Case 1 F Fig.10: Case 2 F Fig.11: Case 3 F .

Fig.12: Case 4 F Fig.13: Case 5 F Fig.14: Case 6 F .

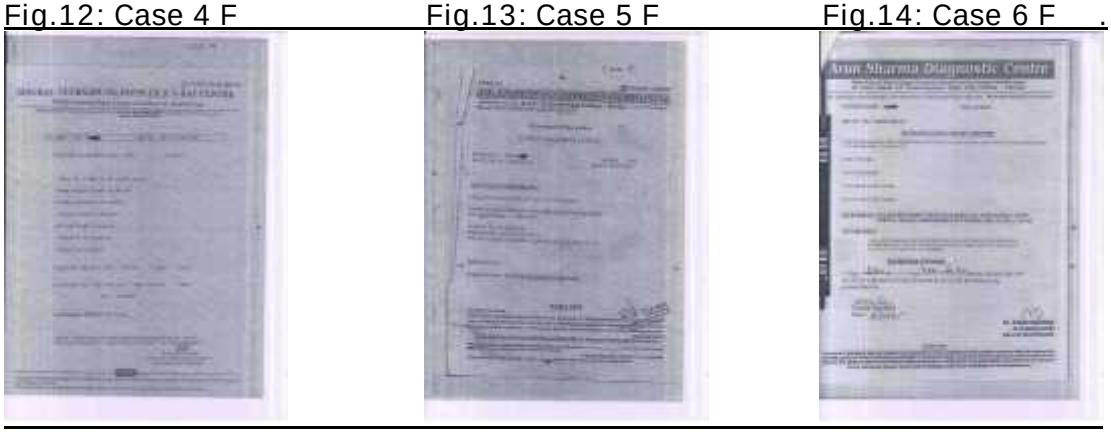


Fig.15: Case 7 F Fig.16: Case 8F Fig.17: Case 9 F .

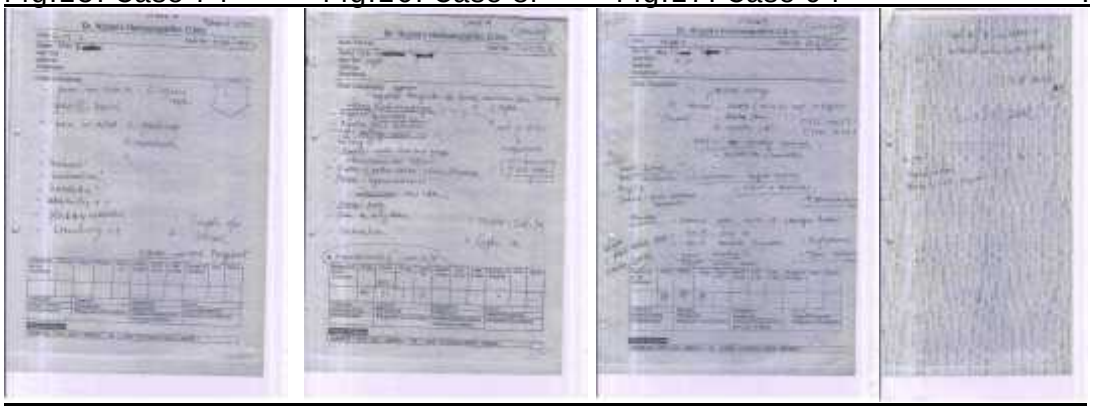


Fig.18: Case 10F

Fig.19: Case 11 F

Fig.20: Case 12F .

Fig.21: Case 13F

Fig. 22: Case 14 F

Fig.23: Case 15 F .

Fig.24: Case 16 F

Fig.25: Case 17 F

Fig.26: Case 18 F .

Fig.27: Case 19F

Fig.28: Case 20 F

References

1. Hahnemann's Organon of Medicine, fifth and sixth editions.
2. Nigam Harsh; Principles and Practice Of Homoeopathic Case Management; Second Edition ; B. Jain Publishers; New Delhi.
3. Gunavante S.M.; Introduction to Homoeopathic Prescribing.
4. Mathur K.N.; Principles of Precribing.
5. Ortega p.s.; Notes on Miasms.
6. William Boericke; New Manual of Homoeopathic Materia Medica and Repertory; Augmented Edition based on Ninth Edition; B Jain Publisher; New Delhi.
7. Lilienthal, Samuel Thrapeutic Index; Published 1879; Publisher, Boericke & Tafel; New York.
8. Roberts H.A. Principles and Art of Cure B. Jain Publishers, New Delhi.
9. Clarke J.H.; A Dictionary of Practical Materia Medica; Reprint Edition: 1993; B Jain Publishers; New Delhi.
10. Kent J.T.; Repertory of Homoeopathic Materia Medica; Reprint Edition: 1993; B. Jain Publishers; New Delhi.
11. Kent J.T.; Lectures on Homoeopathic Materia Medica; B Jain Publishers; New Delhi.
12. Nigam Harsh; Miasma, The Road Less Travelled; First Edition; B. Jain Publishers; New Delhi.
13. A.C. Cowperthwaite; A Textbook of Materia Medica and Therapeutics, 13th Edition; B. Jain Publishers, New Delhi.