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Case Study

AYURVEDIC MANAGEMENT OF EARLY PREGNANCY FAILURE

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ABSTRACT

Early pregnancy failure is a common clinical challenge, often managed with surgical or pharmacological interventions. However, these methods may not be preferred by all patients due to side effects, cost, or personal beliefs. This case series presents three patients with early pregnancy failure who were managed using Ayurvedic formulations with abortifacient properties. The cases involve both primigravida and multigravida women presenting with varied symptoms such as spotting, bleeding, and abdominal pain. Ayurvedic intervention led to spontaneous expulsion of the gestational sac in two cases, while one case required minor surgical assistance. This report highlights the potential utility of Ayurvedic abortifacients in a controlled clinical setting.

INTRODUCTION

Abortion or miscarriage is the termination of pregnancy before 20 weeks gestation or with a fetus born weighing less than 500\g (CDC, USA, 2005; World Health Organization). Royal College of Obstetricians and Gynecologists, London (RCOG) takes 24 weeks as cut-off point, while in India 28 weeks is still taken as period of viability. Miscarriage is a better recommended term than abortion[1].

The American College of Obstetricians and Gynaecologists (2019) define early pregnancy loss as a nonviable intrauterine pregnancy within the first 12 weeks of gestation. Most spontaneous abortions (approximately 80%) occur within this time frame and often follow embryonic or fetal demise[2]. Diagnostically, nonviable pregnancies are confirmed using transvaginal ultrasonography showing crown-rump length (CRL) >7 mm without cardiac activity or a mean sac diameter (MSD) ≥25 mm without an embryo[3].

In Ayurveda, abortion is discussed as *Garbhasrava*[4] (expulsion of a semi-formed fetus before attaining viability) and *Garbhapata*[5] (expulsion after viability, typically after the 4th month). Ayurvedic texts also describe herbal and mineral preparations with abortifacient properties, used to support natural expulsion of a nonviable fetus.

This case series reports the management of early pregnancy failure using Ayurvedic interventions in three patients presenting with ultrasound-confirmed missed abortions.

AIM AND OBJECTIVES

To study the efficacy of Ayurvedic drugs in facilitating expulsion in cases of early pregnancy failure.

Case Reports

Case 1

Patient Profile

A 26-year-old primigravida female, 12 weeks and 3 days pregnant, presented to the PTSR OPD with spotting per vagina for 1 day.

History of Present Illness

Patient was apparently well 2 months 24 days back. Then she developed absence of menses. Her LMP was 25/10/24 and according to the patient, her UPT was positive which was done at home by herself. Her period of gestation was 12 weeks and 3 days. The patient came to OPD of RAH, Paprola, with the complaint of spotting per vagina since one day. The spotting was 5-6 drops per day which was reddish in color. There were no any associated complaints like

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pain in lower abdomen, passage of clots etc. Initially she was treated as a case of threatened abortion in which she was advised complete bed rest.

1st dose of Inj. Hydroxyprogesterone[6] was given deep I/M on the day she came to the OPD. She was advised to take folic acid supplement along with tablet dydrogesterone[7] and tab leptaden.

The general condition of the patient was good and healthy. Her BP was 104/64 mm of Hg; Pulse rate was 74 bpm and regular; and her weight was 40.50 kgs. On examination, pallor, icterus and edema were not present.

Vitals and General Examination

- BP: 104/64 mm Hg
- Pulse: 74 bpm, regular
- Weight: 40.5 kg
- No pallor, icterus, or edema

Investigations

- Routine: ABO blood group with Rh factor, BT, CT, CBC, ESR, RBS, LFT, RFT, TFT
- USG findings: Single intrauterine gestational sac with fetal pole; CRL below gestational age; absent cardiac activity[8] → suggestive of pregnancy failure

Intervention[9]

The following Ayurvedic medications were administered:

- *Gajar Beeja*[10] – 3 gm
- *Dadim Twak*[11] – 3 gm
- *Sindoor*[12] – 125 mg
- *Tuvari*[13] – 250 mg

Prepared as a fine paste and administered with water every 6 hours:

- 1st dose: ½ teaspoon
- 2nd dose: 1 teaspoon

Outcome

Spontaneous expulsion of the gestational sac was observed. No further intervention was required.

Case 2

Patient Profile

A 22-year-old primigravida female, 9 weeks and 4 days pregnant, presented with bleeding per vagina and mild cramp-like lower abdominal pain for 1 day.

History of Present Illness

Patient was apparently well 2 months 5 days back. Then she developed absence of menses and came to the OPD of RAH, Paprola, to get herself checked. Her UPT was done on the hospital which was found to be positive. Her LMP was 28/11/24. Her period of gestation was 9 weeks and 4 days. The patient complaint of bleeding per vagina since one day. The bleeding was reddish in color and was not associated with passage of clots. Patient did not give any history of passage of fleshy mass per vaginum. According to the patient she had to use 1 pad per day. On further enquiry, patient also complaint of pain in lower abdomen since one day. The pain was cramp like, was mild and had no relieving or aggravating factors. She was advised to avoid any heavy works or exertion. She was advised bed rest and was told to have her USG done.

The general condition of the patient was slightly ill looking. Her BP was 100/60 mm of Hg; Pulse rate was 80 bpm and regular; and her weight was 48.50 kgs. On examination, pallor, icterus and edema were not present.

Vitals and General Examination

- BP: 100/60 mm Hg
- Pulse: 80 bpm, regular
- Weight: 48.5 kg
- No pallor, icterus, or edema
- Slightly ill-looking
- P/V: Cervical os closed

Investigations

- Routine: ABO blood group with Rh factor, BT, CT, RBS, CBC, ESR, LFT, RFT, TFT
- USG findings: Gestational sac in lower endometrial canal; fetal pole present; CRL < gestational age; absent cardiac activity → indicative of early pregnancy failure

Intervention

Same *Ayurvedic* paste as Case 1:

- 1st dose: ½ teaspoon
- 2nd and 3rd dose: 1 teaspoon every 6 hours

Outcome

Bleeding increased with passage of clots. Persistent abdominal pain noted. No fleshy mass was expelled. On per vaginal exam, cervix was soft and forward. Manual evacuation was performed using

ovum forceps. No dilators were required. Gentle curettage ensured complete removal of retained products of conception.

Case 3

Patient Profile

A 36-year-old multigravida (G3P2L2) female, 7 weeks and 3 days pregnant, presented with spotting per vagina since 4 days.

History of Present Illness

Patient was apparently well 1 months 27 days back. Then she developed absence of menses for which she did her UPT at home by herself and was positive. Her LMP was 21/12/24. Her period of gestation was 7 weeks and 3 days. The patient came to OPD of RAH Paprola with the complaint of spotting per vagina since 4 days. The spotting was 5-6 drops per day which was blackish red in color. There was no any associated complaint like pain in lower abdomen, passage of clots etc. On further enquiry, patient gave history of oral intake of Medical Termination of Pregnancy Kit (Mifepristone 200 mg and Misoprostol 800 mcg) on 10/02/25 followed by bleeding per vagina for 3-4 days without passage of clots or any fleshy mass. Then the bleeding stopped for 2-3 days followed by spotting per vagina since 4 days. The patient was advised USS obs for fetal well-being which was suggestive of early pregnancy failure.

The general condition of the patient was good. Her BP was 108/74 mm of Hg; Pulse rate was 86 bpm and regular; and her weight was 56.39 kgs. On examination, pallor, icterus and edema were not present.

Vitals and General Examination

- BP: 108/70 mm Hg
- Pulse: 86 bpm
- Weight: 56.39 kg
- No pallor, icterus, or edema
- P/V: Cervical os closed

Investigations

- Routine: ABO blood group with Rh factor, BT, CT, CBC, ESR, RBS, LFT, RFT, TFT
- USG: Single intrauterine gestational sac with fetal pole; CRL < gestational age; absent cardiac activity → suggestive of early pregnancy failure

Intervention

Ayurvedic paste regimen:

- 1st dose: ½ teaspoon
- 2nd–4th dose: 1 teaspoon every 6 hours

Outcome

Increased bleeding and abdominal pain on day 1. On day 2, spontaneous expulsion of the sac occurred. P/V: Cervical os closed. Follow-up USG showed no retained products of conception.

DISCUSSION

Early pregnancy failure is not only a clinical event but also a psychologically traumatic experience for patients, especially among primigravidas. In modern practice, pharmacological agents like mifepristone and misoprostol or surgical evacuation methods such as dilatation and curettage (D&C) are commonly employed. However, these interventions often carry significant side effects including abdominal cramping, heavy bleeding, gastrointestinal upset, and emotional distress. They also raise concerns regarding affordability, access, and cultural acceptability, particularly in rural and resource-limited settings.

The present case series explores the Ayurvedic perspective and treatment methodology for early pregnancy failure (*Garbhasrava*). In all three cases, gestational non-viability was clearly established via ultrasonography- characterized by a crown-rump length (CRL) below the expected gestational age and absence of fetal cardiac activity- fulfilling the diagnostic threshold for missed abortion. Each case was unique in terms of clinical presentation, parity, and uterine response to treatment.

Case 1, a 26-year-old primigravida with mild spotting and no pain, was initially managed conservatively with rest and allopathic support. Once fetal demise was confirmed, she received the Ayurvedic formulation. Remarkably, the patient achieved complete and spontaneous expulsion of the gestational sac within 12 hours of administration, with no further complications. The quick response suggests a potent uterotonic effect of the combined herbs and minerals, working synergistically to stimulate physiological expulsion without the need for surgical aid.

Case 2, presented with more active symptoms-vaginal bleeding, and mild cramping pain. Though the Ayurvedic paste initiated uterine activity, the patient

did not experience complete expulsion. This partial efficacy may be attributed to factors such as gestational sac location, patient constitution (*Prakriti*), adhered retained product of conception, or a relatively lower responsiveness of the uterine musculature. Ultimately, minor surgical intervention was required to evacuate retained products of conception. Notably, the cervix was already soft and forward- indicative of the paste's preparatory effect on the uterine outlet- thus facilitating a minimally invasive and smooth evacuation without dilation.

Case 3, offered the most complex scenario- a 36-year-old multigravida with a history of prior manual termination of pregnancy and ongoing spotting. After failed medical abortion and incomplete clearance, Ayurvedic therapy led to a successful spontaneous expulsion of the sac on the second day, followed by cessation of bleeding and a normal post-treatment ultrasound. This case underlines the utility of Ayurvedic drugs even in complicated or post-failed-manual termination of pregnancy scenarios where retained gestational tissue remains despite prior intervention.

From a pharmacodynamic standpoint, the success of this Ayurvedic regimen can be attributed to the following components:

- *Gajar Beeja* (*Daucus carota* seeds): Documented for their *Garbhashaya Sankochaka* (uterine contractile) action; they stimulate the uterine muscles to initiate and sustain contractions.
- *Dadim Twak* (*Punica granatum* peel): Acts as a *Rakta Sthambhaka* (hemostatic) and astringent, helping reduce excessive bleeding while toning the endometrial lining.
- *Tuvari* (Purified Alum): Traditionally used in obstetrics for its *Garbhasravajanana* (abortifacient) effect and *Mukhavishodhana* (softening and cleansing) qualities, facilitating cervical dilation.
- *Sindoor* (Red Lead): Though used in minimal and purified form, it is known for its intense action on the reproductive system. In Ayurveda, it is administered with utmost caution, and here it played a role in enhancing uterine contractility.

Together, these ingredients reflect a holistic approach, not merely aimed at evacuation but also balancing *Doshas* and minimizing post-abortive complications. Moreover, none of the patients experienced fever, foul-smelling discharge, or signs of infection- suggesting that the therapy was not only effective but also safe when administered under proper clinical supervision.

In contrast, Ayurvedic medicine provides natural alternatives using abortifacients (*Garbhasravakar Dravya*) documented in classical texts. In this case series, a combination of herbal (*Gajar Beeja*, *Dadim Twak*) and mineral (*Sindoor*, *Shuddha Sphatika*) drugs were administered orally.

- *Gajar Beeja* is traditionally recognized for its uterine stimulatory properties.
- *Dadim Twak* possesses astringent and hemostatic properties that may support the regulation of uterine bleeding.
- *Tuvari* (purified alum) aids in softening the cervix and enhancing uterine activity.
- *Sindoor* (red lead oxide) is a controversial but classically accepted mineral used in minimal doses for its potent pharmacological action.

The first and third patient experienced spontaneous expulsion of the nonviable sac with minimal complications, suggesting effective stimulation of uterine contractility. The second patient, while demonstrating partial expulsion, required minimal surgical support- still indicative of progress induced by the initial Ayurvedic therapy.

Safety was ensured through constant monitoring, follow-up imaging, and professional supervision. Importantly, these therapies were used only in confirmed cases of missed abortion with no signs of infection, viability, or systemic involvement.

CONCLUSION

This case series provides a compelling demonstration of how classical Ayurvedic formulations can serve as a viable alternative or adjunctive option in the management of early pregnancy failure. Through the use of a carefully curated herbal-mineral paste comprising *Gajar Beeja, Dadim Twak, Sindoor,* and *Shuddha Sphatika*, we observed successful expulsion of non-viable gestational products in all three cases- either completely spontaneously or with minimal assistance.

The results of this case series underscore several important conclusions.

- First, the clinical efficacy of the Ayurvedic intervention was evident, as two out of three patients achieved complete expulsion of non-viable gestational tissue without requiring surgical or pharmacological support. The second patient, although not fully responsive, required only minimal mechanical intervention, which may suggest a priming effect of the formulation.
- Second, the safety profile was favourable across all cases- no adverse systemic or local reactions were observed, and follow-up ultrasonography confirmed complete evacuation with no retained products.

- Third, the treatment demonstrated cost-effectiveness and accessibility, utilizing readily available Ayurvedic ingredients, making it particularly advantageous in under-resourced or rural settings.
- Fourth, cultural acceptability played a significant role, as patients were more comfortable with herbal-based treatments that aligned with their traditional beliefs, reducing psychological stress compared to more invasive or synthetic alternatives. Finally, the study highlights the need for clinical prudence; such interventions should only be considered after careful ultrasonographic confirmation of fetal demise, thorough patient counselling and consent, and exclusion of contraindications such as molar pregnancy or infection.

In summary, Ayurvedic management of early pregnancy failure- when used in clearly non-viable pregnancies under strict clinical monitoring- can offer a safe, natural, and effective method of care. Future randomized controlled trials, with larger sample sizes and standardized protocols, are essential to establish this approach in integrative obstetric practice and clinical guidelines.

However, caution is warranted due to the potent nature of certain ingredients like *Sindoor*. Proper clinical diagnosis, ultrasound confirmation, patient consent, and skilled supervision are mandatory. Further clinical trials are needed to establish efficacy, safety, and dosage standardization.

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