

CLINICAL

Homeopathy for the treatment of menstrual irregularities: a case series

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Objective: A preliminary study to evaluate the usefulness of homeopathic treatment in the care of menstrual irregularities.

Method: Patients were diagnosed at the first appointment according to menstrual cycle over the past year: Amenorrhea (AM), Oligo-amenorrhea (OL-AM), OL, Taking hormone replacement therapy (HRT). All patients were prescribed an individualised, global homeopathic treatment. The main outcomes were: time to resumption of periods, change of clinical diagnosis at the end of follow-up or after 2 years. The secondary outcomes were: menstrual regularity at the end of follow-up, compared to pre-treatment frequency; flow characteristics; clinical course of acute and chronic concomitant symptoms.

Results: 18 consecutive cases of secondary amenorrhea (SA) and oligomenorrhea (OL) met the entry criteria. 8 women had SA, 2 were on HRT, 6 had OL-AM and 2 had OL. The average duration of considered follow-up was 21 months. The average time before the reappearance of menstruation was 58 days (s.d. 20) in the 8 women with SA at the time of the first appointment, for all cases 46 days (s.d. 42). Change of clinical diagnosis: 50% of women, who were diagnosed AM, recovered their ovulatory cycle (OV), whereas 12.5% remained amenorrheic; 33.3% of patients, who were initially OL-AM, showed an OV; 100% of oligomenorrheic and HRT patients recovered an OV. The average frequency of spontaneous cycles per year changes from 4.32 (s.d. 1.97) pre-treatment to 9.6 cycles per year at the end (s.d. 2.92). Four detailed case histories are reported. *Homeopathy* (2009) 98, 97–106.

Keywords: secondary amenorrhea; oligomenorrhea; classical homeopathy; menstrual res time; menstrual frequency

Introduction

Menstrual irregularities have become very frequent. 58% of adolescent girls requesting a gynaecological consultation have secondary amenorrhea (SA) and 42% have oligomenorrhea (OL).¹ The annual prevalence of SA in the general 15–44 year-old population is 4.6%.² The most common forms of SA are Hypogonadotrophic disorders caused by hypothalamic suppression, particularly Functional Hypothalamic Amenorrhea (FHA), and an ovulatory disorders often associated with Polycystic Ovary Syndrome (PCOS).

Less frequently, they are related to Hyperprolactinaemia (HYPER), Hypergonadotrophic conditions caused by Premature Ovarian Failure (POF) and concomitant hormonal disorders (hyper- or hypothyroidism, Cushing's Syndrome). The frequency of the various forms varies with the subject's age.^{3,4} Discontinuation of oral contraception can cause Post-pill Amenorrhea (PPA) in 2% of women or significantly increase the length of the cycle for the first 9 months.⁵ Hormone Replacement or Progesterone Therapy (HRT/PROG) does not appear to restore normal Hypothalamus-Hypophysis-Ovarian axis function and physiological cyclicality and sex hormone pulsatility. On suspending HRT/PROG, after 1 year, only 5 out of 100 women regain a normal OV, 4 become oligomenorrheic, the others remain amenorrheic.³

SA is the interruption of menstrual flow for more than 3 months in women with a history of spontaneous periods.^{3–6} Identifying the cause of SA allows often-successful aetiological treatment. The most frequent specific causes are

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tumours, chronic illnesses, medicines, concomitant endocrinopathies, excessive exercise or drastic weight loss.⁶ However, in many cases, either it is difficult to define a specific cause that can be eliminated³ or the outcome of therapy is an irregular, oligomenorrhic menstrual cycle. Cytogenetic studies on women with SA have shown karyotype chromosome anomalies in 16.33%⁷ and of sexual chromosomes alone in 9.9%,⁸ suggesting that SA sometimes has a genetic aetiology. It has also been observed that situations of severe stress that activate the hypothalamus-hypophysis-adrenal gland axis or suppress the hypothalamus-hypophysis-thyroid axis, can interrupt the HPO axis with consequent FHA.⁹

Classic homeopathy indicates a single homeopathic medicine is given, taking into account the patient's overall symptomatology.¹⁰ Some individual cases of amenorrhea (AM), treated with classical homeopathy have been reported in the literature.^{11,12} No systematic studies on the efficacy of homeopathic treatment in the SA have been published, but the possible efficacy of complex¹³ and unitary¹⁴ homeopathic medicines has been observed in restoring the oestrus cycle in dairy cattle.

I report the results of classical homeopathic treatment in 18 patients with menstrual irregularities and describe 4 successful case histories.

Materials and methods

Patients

My patients' records are filed using Radar and Winchip software. Of the 8022 records available, I selected those with primary diagnosis: SA and OL. 27 patients were identified. Only 18 of these satisfied the following inclusion criteria:

1. Age 16–45, diagnosed by a gynaecologist as having SA.
2. At least 12 months' follow-up with regular check-ups at least once every 3 months.
3. Regular recording of all menstrual cycles.
4. No administration, during homeopathic treatment, of sex hormones or medicines that stimulate or regularise production of the same.
5. No more than 7 menstrual cycles per year, equal to an average cycle length of 52 days or with AM at the time of the first appointment.
6. Absence of a clear aetiological cause, whose elimination might restore a normal menstrual cycle.

Nine patients were excluded for the following reasons: 2 for inadequate follow-up, 3 for imprecise recording of the length of periods, 4 because of hormonal therapy administration. The 18 included patients were divided into 4 groups, according to the clinical diagnosis at the first appointment:

1. AM: absence of menstrual cycle for more than 3 months at the time of the first homeopathic appointment.
2. OL-AM: less than 5 cycles in the last year or at the most 7 cycles per year but with a period of AM exceeding 3 months.
3. OL: 5–7 cycles in the past year.
4. Taking HRT.

Almost all patients have had severe menstrual irregularities in their gynaecological history (Table 1).

Table 2 shows the gonadotrophic diagnosis made by gynaecologist, their hormonal therapy and the reason that led the patients to choose the homeopathic treatment. The reasons were often connected to the fact that hormonal treatment is unable to regulate the menstrual cycle and has undesired and/or non-tolerated effects. Five patients refused hormonal therapy.

Table 1 Gynaecological history

Case no.	Age	Initial clinical diagnosis	Duration of SA (months)	Onset of menstrual irregularity	Hormone treatment duration	Period free of hormonal drugs before homeopathic treatment	Spontaneous cycles in last year
1	19	AM		Menarche	3 years	7 months	0
2	32	AM	6	Menarche	7 years	6 months	0
3	31	AM	5	10 months	1 month	7 months	1
4	20	AM	8	Menarche	5 months	5 months	0
5	26	AM	5	3 years	2 years	6 months	0
6	38	AM	6	Menarche	8 years	10 years	3
			8				
7	40	AM		9 months	2 months	3 months	2
8	45	AM		2 years	no	yes	6
9	27	OL-AM	3	5 years	1 year	2 years	2
			13				
10	32	OL-AM	Primary	Primary AM	13 years	3 years	5
11	22	OL-AM	12	Menarche	no	yes	2
12	28	OL-AM	13	Menarche	2 years	2 years	4
13	41	OL-AM	4	11 months	no	yes	7
14	43	OL-AM	4	3 years	no	yes	7
			3				
15	43	ON-HRT	6	Menarche	18 years	no	0
16	18	ON-HRT	6	Menarche	8 months	no	0
17	24	OL	8	5 years	4 years	1 year	6
18	16	OL	3	Menarche	no	yes	7

Table 2 Diagnosis based on gonadotrophic status, hormonal treatment, reason for choosing homeopathy

Case no.	Clinical diagnosis	Past diagnosis based on gonadotrophic status	Past hormonal treatment	Reason for choosing homeopathy
1	AM	PCOS	Ciproterone acetate + etinylestradiol	Unsatisfactory result: acne did not ameliorate, AM after hormone treatment discontinuation
2	AM	PCOS	Medroxyprogesterone acetate, Ciproterone acetate & etinylestradiol, Spironolactone	Unsatisfactory result: AM after hormone treatment discontinuation. Not tolerated: overweight.
3	AM	HYPERP	HRT	Not tolerated: metrorrhagia.
4	AM	FHA	HRT	Unsatisfactory result: AM, acne did not ameliorate.
5	AM	PPA	HRT	Recurrent PPA, resolved previous year using homeopathy. Wants spontaneous pregnancy.
6	AM	HYPOG	Clomiphene, HRT	Unsatisfactory result: AM persists. Neurological side effects
7	AM	POF	Medroxyprogesterone acetate	Breast cancer, HRT contraindicated Unsatisfactory result with Medroxyprogesterone acetate.
8	AM	POF	No	Refused HRT AM not accepted psychologically
9	OL-AM	PCOS	Ciproterone acetate & etinylestradiol	Side effect: phlebitis.
10	OL-AM	HYPOG	Clomiphene, HRT	Wants spontaneous pregnancy. Unsatisfactory result: OL-AM persists.
11	OL-AM	FHA	No	Refused HRT, OL-AM persists.
12	OL-AM	PPA	HRT	PPA that persists during HRT.
13	OL-AM	POF	No	Refused HRT, family history of POF/EM
14	OL-AM	POF	No	Refused HRT, recurrent AM.
15	ON-HRT	HYPOG	HRT	Gynaecologist advises discontinuing oral contraceptive after 18 years Not tolerated: oedema.
16	ON-HRT	PCOS	HRT	Young age, wanted spontaneous cycles for future pregnancy.
17	OL	PCOS	Ciproterone acetate & etinylestradiol	Not tolerated: tiredness, weight gain.
18	OL	PCOS	No	Young age, acne.

Key: HYPOG = Hypogonadotropic hypogonadism.

Therapy

All patients were treated with individualized homeopathic medicines diagnosed on the global level. In 4 patients another medicine was also prescribed, mostly on aetiological grounds, (case 6), or local symptoms, (cases 3, 14, 18). These medicines were prescribed in succession rather than at the same time as individualized homeopathic medicines. The dilutions used were Korsakovian (K), from 6 K to 200,000 K manufactured by CEMON. The pharmaceutical forms were single doses of granules or drops of 18% alcohol solution. The posology was as follows: ascending potencies from 6 to 1000 K (6-12-30-200-1000) or single doses alone or followed by drops of alcohol solution for 3 or more days ('plusing' method). The same medicine at higher dilution was usually prescribed in acute diseases or in case of a deteriorating of the clinical picture. The homeopathic medicine was changed only if there was no improvement; it was prescribed at regular intervals (every 21–30 days) until the onset of menstruation and then in the specific oligomenorrhic phase (SOP) (from 15 days after a period until 21 days before the first possible subsequent period), which precedes the probable peri-ovulatory phase.¹⁵ After regularisation of menstruation, the homeopathic medicine was taken by patients immediately before the possible peri-ovulatory phase (11–21 days before the presumed menstruation date). Table 3 shows the homeopathic treatment by patient.

Assessment of clinical progress

The patients were followed from a minimum of 12 months to a maximum of 13 years. Evaluation of the effect of treatment

was limited to the first 2 years or to the whole follow-up period. The symptoms indicating a recovery of hormonal activity were monitored: Cyclical mastodynia, cervical mucus, intermenstrual abdominal pain and non-inflammatory leucorrhoea.

Main clinical gynaecological outcomes were:

1. Menstruation restart time, in cases of AM.
2. Change of clinical diagnosis at the end of follow-up or after 2 years.

Secondary outcomes were:

1. Menstrual regularity: differences compared to pre-treatment spontaneous menstrual frequency.
2. Flow characteristics: duration, quantity and presence of premenstrual or ovulatory spotting.

I consider the spontaneous pre-treatment menstrual frequency, the number of cycles/year before starting homeopathic treatment in cases of OL or OL-AM and before hormone treatment or before SA in cases of AM. I considered the cycle OV when it appeared almost monthly.

The dynamics of all clinically relevant concomitant symptoms were monitored, especially those that were new, old, persistent and keynotes of the patients, according to classic homeopathic methodology.¹⁶

Results

At the start of the homeopathic treatment, 8 women had SA, 2 were on HRT, 6 had OL-AM and 2 had OL. The average duration of AM for the 8 cases of SA was 163 days

Table 3 Characteristics of treatments

Case no.	Homeopathic medicines prescribed	Dilutions
1	<i>Mercurius solubilis</i>	6-1000k, 10,000k, 50,000k
2	<i>Nux vomica</i>	200k, 1000k, 10,000k, 50,000k
3	<i>Pulsatilla pratensis, Chamomilla vulgaris</i>	6-1000k, 10,000k, 50,000k
4	<i>Arsenicum album, Phosphorus flavus, Natrum muriaticum, Sepia officinalis</i>	30k, 200k, 1000k, 10,000k
5	<i>Sepia officinalis</i>	200k, 1000k, 10,000k, 50,000k, 100,000k
6	<i>Gelsemium sempervirens, Calcarea carbonica</i>	200k, 1000k, 10,000k
7	<i>Calcarea carbonica</i>	6-1000k, 1000k, 10,000k, 50,000k, 100,000k
8	<i>Pulsatilla pratensis</i>	200k, 1000k, 10,000k, 50,000k
9	<i>Phosphorus flavus</i>	1000k, 10,000k
10	<i>Pulsatilla pratensis</i>	200, 1000k, 10,000k
11	<i>Natrum muriaticum</i>	1000k, 10,000k
12	<i>Calcarea carbonica</i>	1000k
13	<i>Sepia officinalis</i>	1000k, 10,000k, 50,000k
14	<i>Lycopodium clavatum, Rhus toxicodendron</i>	1000k, 10,000k
15	<i>Pulsatilla pratensis</i>	6-1000k, 10,000k, 50,000k, 100,000k, 200,000k
16	<i>Pulsatilla pratensis, Baryta carbonica, Natrum muriaticum</i>	200k, 1000k, 10,000k
17	<i>Sepia officinalis</i>	200k, 1000k, 10,000k
18	<i>Natrum muriaticum, Kalium bromatum</i>	6-1000k, 10,000k

(s.d. 57). The average time elapsing before the reappearance of menstruation with homeopathic treatment was 58 days (s.d. 20) in the 8 women with SA at the time of the first appointment, for all cases, 46 days (s.d. 42). Initial diagnosis changed after 2 years of homeopathic treatment as follows: 4/8 (50%) of women who were initially with AM recovered their OV, 1/8 (12.5%) remained amenorrhic. 2/6 patients (33.3%) who were initially OL-AM resumed an OV. The women OL and on HRT all regained their monthly cycle. Five women had AM during treatment: for periods ranging from 93 to 269 days.

Taking only the 14 women who had a history of less than 9 cycles/year, and comparing the average menstruation frequency after 2 years or at the end of the treatment, the average frequency of spontaneous cycles per year in the year before treatment was 4.32 (s.d. 1.97), rising to 9.6 cycles per year (s.d. 2.92), after a median follow-up

of 21 months. (Table 4). Most women had normal characteristics of the flow. Significant alterations were seen in 3 patients, concentrated mostly in the 1st year. Cases 16 and 18 had premenstrual spotting and hypomenorrhoea, case 4 metrorrhagia. The clinical outcome for the major sub-diagnoses are summarised in Table 5. There is a good correlation between the clinical and gynaecological outcome in all cases.

In 4 patients a mostly local prescription was also given: *Chamomilla* (case 3) at the end of the treatment for deteriorating hyperthyroidism but without success.

Kalium bromatum (case 18) at the end of treatment for worsening acne, which improved.

Gelsemium (case 6) as a first line therapy for an aetiological cause (fright): SA cured.

Rhus toxicodendron (case 14) for lumbar-sciatic pain without improvement.

Table 4 Clinical outcomes

Case no.	Age	Initial diagnosis and duration	Final diagnosis	Cycles/year*	Menstrual regularity at the end: cycles/year†	Time to resumption of Menstruation (d)‡	Duration of follow-up
1	19	AM, 193d	OL-AM	3	5	87	38 months
2	32	AM, 169d	OV	2.5	10	41	13 years
3	31	AM, 153d	OV	9	12	29	30 months
4	20	AM, 150d	OL-AM	4	4	63	17 months
5	26	AM, 182d	OV	Monthly	12	62	24 months
6	38	AM, 91d	OV	3	12	70	8 years
7	40	AM, 270d	AM	Monthly	SA	38	34 months
8	45	AM, 96d	OL	Monthly	7	71	12 months
9	27	OL/AM	OL	2	8	55	21 months
10	32	OL/AM	OL	5	9	17	9 years
11	22	OL/AM	OV	2	12	26	5 years
12	28	OL/AM	OV	4	13	15	12 months
13	41	OL/AM	OL	7	9	9	13 months
14	43	OL/AM	OL/AM	7	6	12	26 months
15	43	ON/HRT	OV	2	13	12	42 months
16	18	ON/HRT	OV	6	11	185	21 months
17	24	OL	OV	6	10	14	13 months
18	16	OL	OV	7	10	26	28 months

* spontaneous cycles/year in year before starting homeopathic treatment in cases of OL or OL/AM and before hormone treatment or before SA in cases of AM.

† during last year of homeopathic treatment.

‡ days after the first dose of homeopathic medicine.

Clinical case histories

Case 7: P.O., aged 40. Follow-up: 34 months:

Main complaint: 9 months AM.

Secondary complaints: reactive depression for the last 3 years; foot cramps; chronic constipation.

Past history: chickenpox; asthma as child; frequent tooth and skin abscesses. "The last skin abscess, as big as an apricot, burst after 3-4 days. The discharge was white, dense and didn't smell bad".

Family history: Cancer: grandparents and father. Uterine fibroma: mother.

Ongoing treatments: psychotherapy for 4 years.

History: P.O. is unmarried and lives alone. She has been smoking 20 cigarettes a day for 14 years. At the age of 33, she had a mastectomy for breast cancer, "I could feel it, it was as hard as a stone", followed by chemo- and radiotherapy. After 6 years of polymenorrhea, she became amenorrheic with FSH 54.3. As HRT was contraindicated, because of the history of breast cancer, the gynaecologist

Table 5 Clinical outcome of major sub-diagnosis

Case no.	Main clinical diagnosis	Major sub-diagnoses		Clinical result
		Chronic	Acute	
1	AM	Acne		>
2	AM	Somnambulism		U
		Hypertrichosis		U
3	AM	Bulimia		>
		Gastritis		U
		Bipolar syndrome		U
		Hypothyroidism		U
		Hyperthyroidism		U
4	AM	Obesity		U
		Bulimia		U
5	AM	Acne		U
		Obsessive-compulsive disorder		>
6	AM	Allergic rhinoconjunctivitis		U
		Verruca		U
7	AM	Nightmares		U
		Verruca		U
		Phobic neurosis		U
8	AM		Lumbar pain and sciatica	U
		Reactive depression		U
		Foot cramps		U
		Constipation		U
9	OL-AM	Right shoulder pain	Tooth abscess	U
		Cervical pain		>
10	OL-AM	Frontal sinusitis		U
		Dysmenorrhoea		U
		Acne		U
11	OL-AM	PMS		U
		Hypertrichosis		U
12	OL-AM	Allergic rhinoconjunctivitis		U
		Acne		U
13	OL-AM	Chronic lumbar pain		U
		Onychodystrophy		U
		Ulcerous stomatitis		U
14	OL-AM	Hypothyroidism		U
		Leucorrhoea		U
15	ON/HRT	Migraine		U
		Acne		U
16	ON/HRT		Acute lumbar pain and sciatica	U
		Allergic rhinoconjunctivitis		U
		Generalised anxiety syndrome		U
		Food intolerances		U
17	OL	Sinus tachycardia		U
			Acute lumbar pain and sciatica	U
18	OL	Constipation		U
		Acne		U
		Severe aphtha		U
		Angular cheilitis		U
		Sebaceous dermatitis		U
		Acne		U
19	OL	Cyclical mastodynia		U
		Dysmenhorrea		U
20	OL		Acute lumbar pain and sciatica	U
		Acne		U
		Herpes labialis		U

Key: C = cured; U = unchanged; > = improved; < = deteriorated.

made an unsuccessful attempt at restarting her cycle with three administrations of medroxyprogesterone acetate. Three months later she contacted me. She suffered from cyclic mastodynia. She would like to regain her menstruation but is afraid. *"The oncologist told me, in an aggressive tone, that it would be better for the cycle not to come back"*.

Homeopathic history

Appearance: Quiet, hook nose, tall and strong build. Dresses ostentatiously, not elegant, doesn't match colours.

Observed symptoms: Jumps on hearing the doorbell; handshake weak and sweaty.

Temperature: Sensitive to cold, never goes to the mountains; chilblains on feet when working in cold temperatures.

Food desire: Eggs cooked in butter, sweets, hot beverages.

Food aversion: Fruit and vegetables.

Thirst: Very little.

Sleep: Good.

Physical: Foot cramps when swimming or walking for long. Chronic constipation that improved during her period.

Mental: Reserved, accurate, determined and practical in her personal choices: owns a flower shop that she runs with great commitment: at the same time she attends evening classes to obtain her secondary school certificate. For the past 3 years, she has been suffering from depression caused by a relationship with a man who hesitates about declaring himself openly. They see each other occasionally and he often does not show up for their appointments or does not call her. She does not have the courage to leave him and is patiently waiting for him to make his mind up. P.O.'s shop is in a small village and she is afraid that other people might say nasty things about her, since he's younger than her. She feels that everyone is observing what she does and that negative rumours circulate about her. When she is alone, she often bursts into tears.

She cannot stand the sight of violence, as she is easily affected: *"Once I saw a dead rat on a road, and since then, every time I walk by that place, the image comes back into my mind"*.

Repertorization

Generals – abscesses – pus – whitish.

Generals – food and drinks – eggs – desire.

Generals – food and drinks – sweets – desire.

Extremities – cramps – foot – motion, on.

Chest – cancer – mammae.

Mind – starting, startled – noise, from

Mind – fear – observed; of her condition being.

Mind – delusions – watched, she is being.

Mind – horrible things, sad stories affect her profoundly.

Prescription

Calcium carbonicum 1000 K: a single dose; from the following day 3 drops 3 times daily for 3 days; repeat this regime every 30 days until the period starts; then repeat on the 15th day of the period.

Follow-up

The FSH dropped to 21.7 after 18 days and the cycle started again 38 days after taking *Calc*. The first cycle was followed by 15 cycles: 8 almost-normal cycles, then 7 hypomenorrhic cycles: 3 at increasing intervals, 92–122–209 days, followed by 4, closer together. Finally, she went into premature menopause with FSH 78.5. I interpret the cycle structure trend as an expression of the definitive exhaustion of her residual ovarian activity.

When the alternation between hypomenorrhic cycles and AM started, I prescribed *Calc* in increasing dilutions, from 6 K to 100,000 K, the latter maintained for the past year: one dose every 21 days. Even when there was no menstruation, there were symptoms of hormonal activity, in particular: mastodynia and white vaginal discharge lasting 2–3 days.

Bowel activity progressively became regular and from the 2nd year of therapy there were no more complaints of foot cramps during physical activity. Her depression improved only during the 3rd year of therapy when, after yet another missed appointment by her boyfriend, she finally found the strength to leave him; 3 months later she started a relationship with another man. Two intercurrent acute events were treated successfully with *Calc* 10,000 K: a tooth abscess and peri-arthritis of the left shoulder.

Case 9: M.L., aged 27. Follow-up: 21 months:

Main complaint: OL-AM

Secondary complaints: acne, dysmenorrhoea and premenstrual syndrome.

Past history: measles, tooth abscesses.

Family history: Liver cancer: grandfather; uterine fibroma, psoriasis: mother.

Ongoing treatments: none.

History: M.L. is a kindergarten teacher. At the age of 22 her gynaecologist diagnosed her with PCOS, accompanied by acne and severe OL. After a 4-year treatment with ciproterone acetate and ethinylestradiol, at the age of 25, she had to suspend the treatment due to phlebitis in the right leg. Since her menstruation had not restarted, she asked a homeopathic doctor for advice; he prescribed Pulsatilla but to no avail. During 8 months of homeopathic treatment, her AM continued. The AM lasted for another 3 months. She started homeopathic treatment with me after menstruating twice in the last 12 months.

Homeopathic history

Appearance: black hair with very low hairline; spontaneous, slightly embarrassed; talks little, reserved.

Observed symptoms: sweaty hands.

Temperature: not too sensitive to cold but likes staying near the stove.

Food desire: salty foods and sweets at the same time, fatty foods, vegetables, ice cream.

Food aversion: spicy food, hot soups.

Thirst: little, drinks cold beverages.

Appetite: very good.

Sleep: she likes sleeping very close to her partner; erotic dreams. Sleeps well. *"Even if I only sleep for 10 min, I dream and wake up rested"*.

Physical: Acne on face and neck. Hypertrichosis, especially on the chin, worse before menstruation. Painful dysmenorrhoea, pain increases when flow is copious and clotty. PMS: menstrual flow is always preceded by severe tension in the breasts and depression, with a strong need to cry.

Mental: She has been working in a kindergarten for 6 months, at the same time trying to complete her university degree. She loves working with children, but has problems in her relationship with the parents, "I find it hard to make them respect me and be authoritative with them," and with other colleagues, "I'm shy, I take a long time to familiarize myself with new people". As a child she was so shy that she could not walk into a shop to buy groceries alone. Today she still feels very nervous if she has to speak in front of an audience. She lives with her mother, who is separated, and is very happy about it. However, "After separation, my father had another child and I felt that I wasn't receiving enough love". She is very reserved, talks very little about herself, sensitive, "When I meet new people, I immediately sense if they have a negative attitude towards me". Sudden mood changes, from laughter into tears. Since childhood, she has sometimes experienced a strong fear of death when she goes to bed at night or wakes up in the morning.

Repertorization

Female genitalia/sex – menses – painful – flow – more the flow, greater the pain.

Mind – weeping – menses – before.

Face – eruptions – pimples – red.

Generals – sleep – after sleep – amel.

Generals – food and drinks – fat – desire.

Generals – food and drinks – salt – desire – and – sweets.

Mind – fear – death, of – alone, when – evening in bed.

Mind – timidity – public; about appearing in.

Mind – reserved.

Prescription

Phosphorus 1000 K: single dose. From the following day: 3 drops three times daily, for 3 days. Repeat this regimen every 30 days until the menstruation appears: then repeat on the 15th day of the period.

Follow-up

First menstruation appeared after 55 days. The number of cycles per year has gone from 2 to 8 by the end of treatment. The menstrual cycle is regular: 40–45 days. Her acne progressively improved and after 7 months of treatment, face and neck are clear of acne. However, after 12 months new pimples appear on her buttocks, a symptom she has never experienced before. With no changes to the treatment, they disappear 2 months afterwards and did not recur. Dysmenorrhoea disappears and the flow becomes less abundant. The PMS has improved, even though some depression remains. The tension in her breasts is pleasant, "Too bad it goes away!".

Hypertrichosis improved but it is still evident, especially on the chin. Echography, carried out during the 15th month of treatment, shows left ovarian polycystosis, no cysts on

the right. From the mental point of view, she says she feels better. She is less emotional, her hands do not sweat any more; she is calmer in the workplace and she is able to talk to colleagues; she has found a husband.

Case 15 B.M. aged 43. Follow-up: 42 months:

Main complaint: Discontinuation of 18 years HRT.

Secondary complaints: Allergic rhinoconjunctivitis, Generalised anxiety syndrome, Sinus tachycardia, Food intolerances.

Past history: SA, infertility, appendectomy, kidney stones.

Family history: Aneurism; father. SA, Early menopause; mother.

Ongoing treatments: Diazepam 2 mg three times daily; Atenolol 50 mg; Antihistamine.

History: Hairdresser. She had an oligomenorrhoeic cycle since menarche, which subsequently dwindled to just 2 cycles a year. This was extensively investigated but no cause identified, she therefore started HRT at the age of 23, which was interrupted by a pregnancy following a pharmacologically induced ovulation. Discontinuation of HRT was always associated with AM. The gynaecologist has advised her to stop HRT but she's afraid of having no further menstruation.

Homeopathic history

Appearance: She cares very much about her physical appearance: dyed blond hair, low-neck dress. Warm, spontaneous and very willing to answer questions.

Observed symptoms: She cries speaking about her father's death.

Temperature: Sensitive to cold, loves heat; does not like to stay indoors.

Food desire: milk.

Food aversion: water.

Food aggravation: Tomatoes (even touch), legumes, spinach, cabbage, fruit with the exception of apples.

Thirst: little.

Sleep: On the left side.

Physical She has suffered from allergic rhinoconjunctivitis for 7 years: seasonal from April to August. "I have to go out with a mask on and I cannot wear contact lenses. I often put antibiotic drops in my eyes". She has a swollen throat and eyes. Paroxysms of sneezing outdoors.

If she eats food to which she is sensitive, she has swelling in her abdomen, ankles, eyes, itchy skin and sometimes urticaria. She cannot even touch a tomato with her hands otherwise they become red. She can only eat two vegetables: potatoes and courgettes; and one fruit: apples. Violent palpitations when she is nervous or anxious, when she lies and especially at night in bed.

Mental: B.M. is divorced and lives with a partner and a child of 18 years old. "I live in an impossible relationship with my partner, we are opposite characters. He leaves me in my world and does not seek my company". She needs to feel important to others.

B.M. has an accommodating nature and seeks harmony in the family. She suffers in silence but ultimately explodes with anger. "I say bad and offensive words to my family and

throw dishes on the floor". On the death of her father, she felt anger and a sense of being abandoned. She has sudden panic attacks: she wakes up at night or in the morning sweating with palpitations. She cannot stand closed narrow places and has a fear of swimming, "*I never put my head underwater*".

Repertorization

Chest – palpitation of heart – night – bed aggravated (agg); in.

Generals – pain – appear suddenly – disappear; and – gradually.

Generals – food and drinks – fruit – agg.

Generals – food and drinks – tomatoes – agg.

Generals – food and drinks – water – aversion.

Mind – forsaken feeling – beloved by his parents, wife, friends; feeling of not being.

Mind – fear – narrow place, in.

Mind – weeping – cannot weep, though sad.

Prescription

Pulsatilla ascending potencies, single dose, at night, according to the following scheme: 6 K 1st and 3rd days, 12 K 6th and 9th days, 30 K 12th and 15th, 200 K 20th, 1000 K 30th day. If the menstruation reappears, she must phone me and stop the treatment.

Follow-up

Menstruation reappeared after 12 days and remains monthly for the entire follow-up. The patient is still being treating.

After the reappearance of the menstruation, I prescribed *Puls* single doses, from 30 K up to 100,000 K, every month on the twelfth night, sometimes with 'plussing' for 3–5 days. She described a re-emergence of old symptoms, which disappeared spontaneously after a few days. After the second dose of 12 K, she had flushing with a lot of sweating followed by chills, after the second dose of 30 K, a headache, "*Like a brick in the brain, which did not disappear with analgesics*". Within 2 months the food intolerances had settled. "*I eat all foods including tomatoes*". Since then, she no longer has swelling and accompanying itching. The 1st year has now been better with allergic rhinoconjunctivitis, which has been very mild requiring only 3–4 days of antihistamine and she can easily wear contact lenses. In subsequent years, it did not recur. The sinus tachycardia improved significantly in the third month, enough to enable her to stop Atenolol. Sleep has returned and is calm.

Mentally, after the 12 K, she improved gradually leading to a reduction of the diazepam to 1 mg in the morning. After 8 months of treatment, the relationship with her partner deteriorated and panic attacks and anxiety recur. I can keep her in a psycho-physical balance for almost 2 years, rising as far as the 100,000 K dilution and limiting diazepam to 1–2 mg daily. Then her partner suddenly left her without offering an explanation.

B.M. became depressed, which was seemingly unmotivated, given that she had hoped to end relationship anyway. She wants to be alone, does not feel in harmony with herself, cannot bear the presence of men,

has a knot in her throat and is unable to drink water, "*I must spit it out*". After taking *Puls* 100,000 K for 5 days, I prescribed 200,000 K. This unblocked the situation: it has liberated tears, as at the beginning of the treatment, she can now understand why she felt so bad after the abandonment by her partner, whom she no longer loved. She revived the violent abandonment 'without explanation' of her father (death). She also recalled that her mother, "*Told me that what I was doing was wrong and I was like a prostitute*". Currently, she is not taking diazepam and continues treatment with *Puls* 100,000 K, one dose the twelfth night of a period.

Case 17: G.F., aged 24. Follow-up: 13 months;

Main complaint: OL.

Secondary complaints: Cyclical mastodynia. Severe aphthae. Angular chelitis, Sebaceous dermatitis, Acne, Dysmenhorrea.

Past history: Styes as a child; leucorrhoea before menarche; at age 22 diagnosed with a 3-cm ovarian cyst; recurrent vaginitis.

Family history: Cancer, heart problems: grandparents. Melanoma: mother.

Ongoing treatments: none.

History: at 22 she was diagnosed with SA and PCOS with a 3-cm cyst in the right ovary. The cyst was painless and coincided with an 8-month period of AM. She was treated with ciproterone acetate and etinylestradiol for 4 years, the cyst resolved and the acne improved. She stopped the treatment because it made her gain weight and feel tired. She has not taken any drugs in the past year: she has had 6 cycles and the acne has worsened.

Homeopathic history

Appearance: Dark hair, square jaw, direct gaze.

Observed symptoms: Closes her left eye while speaking.

Temperature: Loves warm weather, likes staying in the sun but has to keep moving.

Food desire: Sweets.

Thirst: Needs to drink often.

Sleep: Only sleeps on her front; dreams in colour.

Physical: Acne, especially on the face, accompanied by localized erythema; angular chelitis on both corners of mouth; Sebaceous dermatitis on frontal hairline; oral aphthae recurring 3–4 times every year; dysmenorrhoea, pain extending to lower limbs, her thighs hurt so much she cannot cross her legs. She complains of a painful cyclic mastodynia, which starts 20 days before each menstruation. Yellow leucorrhoea before the flow, which becomes abundant and prolonged if the flow does not start. Menstrual flow only during the day.

Mental: Office worker, lives alone. Has an impetuous, impatient personality; wants to finish what she started as soon as possible; she is always busy; loves dancing, even for 2–3 consecutive hours, especially latin dance. She is upset by violent images. She likes energetic people. In order to learn how to sail, she signed on a course with 'military-school-like' timetables and physical training programs. Answers with malice to criticisms, "*I've been told that I have a forked tongue*".

Repertorization

Female genitalia/sex – leukorrhoea – girls, in little.
 Female genitalia/sex – leukorrhoea – menses – instead of.
 Female genitalia/sex – menses – daytime only.
 Abdomen – pain – extending to – thighs.
 Generals – food and drinks – sweets – desire.
 Sleep – position – abdomen, on.
 Head – eruptions – margin of hair.
 Face – cracked – mouth; corners of.
 Mind – impetuous.

Prescription

Sepia: 200 K, one dose on the first evening; 1000 K, one dose on the second evening; then one dose 1000 K on the 12th day of the period.

Follow-up

Menstruation appeared 14 days after starting *Sepia*. Period was regular (35–40 days) for the whole year of treatment. Oral aphthae appeared during the 4th month, for which I prescribed *Sep* 10,000 K, single dose. As a reaction, after menstruation, she had leucorrhoea and burning/itchiness of the labia, for which I prescribed a placebo. The next menstruation appeared after 65 days, preceded by 20 days of mastodynia. I went back to the prescription of one dose of *Sepia* 10,000 K on the 12th evening, and the period normalized again. There were no more aphthae. The angular chelitis disappeared and acne improved progressively, though it was still present at the last examination. Erythema improved as early as the 2nd month and disappeared completely during the 9th month. Sebaceous dermatitis improved by 60%, both in intensity and extent. Premenstrual leucorrhoea and dysmenorrhoea finally disappeared, after the first assumption of *Sepia* 10,000 K.

Discussion

The outcomes of my cases, both positive and negative, follow a similar clinical course in their menstrual irregularities and symptoms of the sub-diagnosis. There is not unilateral improvement or worsening, which confirms that the individualized homeopathic medicine has a global, systemic action.

In my experience, the homeopathic symptoms specific to the menstrual irregularities are not very useful for the diagnosis of the medicine. The rubrics of the Repertory are not characteristic, furthermore or they are very large eg, Female-menses- absent, 204 medicines, or too small, eg, Female – menses – late, too – 21 days, only *Puls*. The choice of homeopathic medicines is based on the totality of the symptoms with the unique exception of case number 6. For this patient, I prescribed *Gels* on the basis of aetiological and mental symptoms, because the AM had been caused by a fright. Once the cycle restarted, I prescribed *Calc carb*, based on the totality of the symptoms, to maintain the period regular. I prescribed more than one medicine diagnosed on the global level, to treat the menstrual irregularity, only in two cases. Case 4 did not respond to four

different medicines; the AM resolved but the cycle never regularised: there were alternating periods of AM and menometrorrhagia and the psychological state and the physical symptoms that accompanied it have worsened.

The patient number 16, on HRT, has shown the longest latency before the cycle reappeared: 185 days. It was a defective case and the first prescription of *Puls* and then of *Bar-c* made the symptoms emerge that clearly indicated *Nat-m*: Chest – palpitation of heart – evening – bed agg.– in, Face – Cracked – Lips – Lower – Middle of and Mouth – aphthae – Tongue. With *Nat-m* the periods reappeared and became monthly.

The medicines most frequently prescribed were *Puls*, *Nat-m*, *Sep*, *Calc* and *Phos*. Certainly *Puls* has a great organotropism for the female endocrine system, but if it not well indicated, it will not make the menstruation reappear. In fact it was prescribed, by other homeopathic doctors before me, in case number 4 for 5 months and in case number 9 for 8 months without attaining the reappearance of the menstruation.

In my experience the appearance of symptoms in the breast is a very reliable parameter to follow the progress of the treatment. The presence of tension, swelling or pain to the breast in a woman in AM, indicates the return of ovarian activity with the production of estrogens and progesterone. When these appear I suspend the therapy because, nearly always within 20 days, the cycle reappears. Of the 8 women in AM, only 2 did not have it: case number 4, it did not respond positively to the therapy, and case number 8 a peri-menopausal woman. In my case notes the medicine to which the patients respond with stronger symptoms to the breast is *Sep*: strong tension, itching and pain specifically to the nipple.

I have found taking of the medicine during the SOP phase, in the oligomenorrhoeic women and before the periovulatory phase, in the women who recovered a regular cycle, to be very effective. The aim was to restore the physiological cyclicity and sex hormone pulsatility and favour ovulation. I use this with good results, even for disturbances to the cycle regarding the characteristics of the flow: menorrhagia and metrorrhagia.

Conventional therapy, if not bringing about undesirable adverse effects, can resolve the AM but is not able to return the regular OV. In this, the homeopathic treatment can be useful and perform a role of therapeutic integration. Excluding the women who have entered menopause (cases 7 and 8), my case notes confirm that the menstrual cycle structure of 14 out of the 16 women improved. To stabilise the menstruation, it is necessary to continue the treatment for at least 8–10 months. Afterwards, to maintain regularity, it is not necessary to continue the homeopathic medicine. The 5 cases that I have been able to follow for over 8 years, show that the menstrual cycle is kept regular both when the homeopathic medicine is discontinued, cases 5, 6, 11, and when it is continued, case numbers 2–10.

If SA is untreated for over 1 year, bone density can be compromised, with a greater risk of osteoporosis after menopause,^{17,18} and heart disease¹⁹ These considerations, combined with the psychological unease that AM causes

women, make it advisable to recover a normal menstrual cycle as quickly as possible and in any case within 1 year. This requirement is respected in my case load. In my experience homeopathic therapy is particularly successful in PPA and POF, in particular in this syndrome if the woman refuses HRT which would exclude the possibility of both spontaneous menstrual cycle and pregnancy. Conversely to premature menopause, POF has been shown to be reversible.²⁰

Menstrual irregularities are very widespread. When the causal pathogenetic approach to menstrual irregularities cannot be applied, we should use the modern concept of chronic multifactorial diseases as an expression of a complex alteration of the system of networks that ensure that the body is kept balanced and therefore in good health. The loss of self-regulation ability generates a pathological trend, namely a chronic illness.²¹ The rationale of non-suppressive treatment is to re-establish the capacity of self-regulation of the mind-body system through general, systemic treatment, such as individualized homeopathic therapy.²² In this light classical homeopathy could be a valid alternative to HRT.

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