Pharmacogn. Res., 2026; 18(1):206-212.
https://www.phcogres.com

Case Series

Case Series on the Ayurvedic Management of Pubertal Menorrhagia Using *Ficus racemosa Nasya*

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ABSTRACT

Pubertal menorrhagia is characterized by abnormal uterine bleeding in adolescent girls, primarily due to the immaturity of the Hypothalamic-Pituitary-Ovarian (HPO) axis rather than any identifiable pelvic pathology. In Ayurvedic literature, this condition corresponds to *Asrigdara*, attributed to vitiation of *Pitta* and *Rakta Doshas*. *Nasya Karma* (nasal administration of medicated substances) is traditionally recommended for managing neuroendocrine dysfunctions. Two adolescent females, aged 13 and 15, presented with excessive and prolonged menstrual bleeding, shortened intermenstrual intervals, and dysmenorrhea. Menarche had occurred 1-2 years earlier. Based on Ayurvedic assessment, both were diagnosed with *Asrigdara*. Modern investigations, including pelvic ultrasound, complete blood count, and coagulation profiles, excluding structural or systemic abnormalities. Hormonal profiles revealed elevated or borderline LH/FSH levels, indicating an immature HPO axis. Both patients were administered an aqueous extract of *Udumbara* (*Ficus racemosa*) fruit-4 nasal drops per nostril daily for 7 days post-menstruation-over two menstrual cycles. No oral medications were given, minimizing systemic exposure in this pediatric group. Follow-up and Outcomes: Significant clinical improvement was noted in both cases, with reductions in menstrual blood loss, improved cycle regularity, and relief from dysmenorrhea. Hormonal assays post-treatment showed normalization trends in LH and FSH. No adverse reactions were reported. These findings suggest that *Udumbara Phala Nasya* may exert beneficial effects on the neuroendocrine axis, potentially through olfactory-mediated pathways. The non-invasive and localized nature of the therapy aligns with Ayurvedic practices and is well-suited for adolescent patients. *Udumbara Phala Nasya* demonstrates promise as a safe and effective integrative therapy for managing pubertal menorrhagia. Further large-scale clinical studies are needed to substantiate its efficacy and elucidate its underlying mechanisms.

Keywords: Menorrhagia, Menarche, *Asrigdara, Nasya, Udumbara*, H-P-O Axis.

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Received: 28-07-2025;
Revised: 15-09-2025;
Accepted: 06-11-2025.

INTRODUCTION

Asrigdara is defined as excessive and prolonged menstrual bleeding, or even scanty bleeding occurring between menstrual cycles. It is termed as *Pradara* due to the excessive discharge of *Raja*, and when there is an excessive excretion of *Asrk* (blood), it is specifically referred to as *Asrigdara*.[1] Acharya Charaka has described *Asrigdara* as a distinct disease entity along with its management in the *Yoni Vyapada Chikitsa*.[2,3] He has also classified it under *Raktaja Vikara* and mentioned its pathogenesis as *Pitta Avrita Apana Vayu*.[3,4] Acharya Sushruta has described *Asrigdara* as a separate disease in the *Sharira Sthana*, specifically in the *Shukra Shonita Shuddhi Sharira Adhyaya*.[1,3]

In *Samhitas*, many causative factors like *Atilavana, Amala, Katu rasa sevana, Viruddha Ahara* and *Vihara* like *Chinta, Bhaya, Krodha*, etc., are explained as *Nidana* of *Asrigdara*. Vitiated *Vatadi Doshas* affect the *Artava Vaha Strotasa* and causes *Asrigdara*. If not properly managed, *Asrigdara* can lead to several complications (*Upadrava*) such as *Bhrama, Moorcha, Daha, Angamarda, Pralapa, Pandutva*, and *Tandra*, among others. Acharya Charaka describes four types of *Asrigdara - Vataja, Pittaja, Kaphaja* and *Sannipataja. Madhava Nidana, Bhavaprakasha* and *Yogaratnakara* also mention the same. Acharya Charaka, while describing treatment, mentions management of *Pitta-Vataja Asrigdara*, which implies acceptance of *Dwidoshaja Asrigdara*.[5]

Pubertal menorrhagia refers to excessive and/or prolonged uterine bleeding that occurs during adolescence, especially in the early post-menarche years, in the absence of any organic pelvic pathology. The most common cause is the physiological immaturity of the hypothalamic-pituitary-ovarian (HPO) axis, which results in anovulatory cycles due to lack of a luteal

DOI: 10.5530/pres.20260059

phase and progesterone deficiency.[6] This leads to unopposed estrogenic stimulation of the endometrium, causing endometrial proliferation without regular shedding, and eventually irregular, heavy or prolonged bleeding.[7] Pubertal menorrhagia is typically self-limiting as the HPO axis matures, but if unmanaged, it can result in iron deficiency anemia and negatively impact the adolescent's quality of life.[8] Most cases occur within the first two years of menarche and constitute a significant portion of abnormal uterine bleeding in adolescents.[9] In such cases, reassurance, correction of anemia, and hormonal therapy, if needed, form the basis of treatment.[10]

Among the three *Doshas, Vata* plays a significant role in both the physiology and pathology of the reproductive system, and *Basti* is regarded as the most effective treatment for *Vata*-related disorders.[11,12,13] Along with *Basti, Nasya Karma* (transmucosal nasal administration) is also commonly recommended in the management of *Vandhyatva* (infertility) and various menstrual disorders.[13,14] Acharya Kashyapa explains the use of *Nasya* in *Atyartava* and *Artavakshaya* in the chapter *Shatapuspa Shatavari Kalpa Adhyaya*, which is clinically found effective. According to Acharya Kashyapa, *Nasya Karma* administered just after menstruation can cause *Soshana* of *Yoni* (dryness due to reduced estrogen), suggesting that *Nasya* may potentially modulate estrogen levels-an essential therapeutic approach in the management of menorrhagia caused by hormonal imbalance.[15]

PATIENT INFORMATION AND CLINICAL FINDINGS

All related information with Signs and Symptoms present at the time of enrolment in both the patients are given in Table 1.

DIAGNOSTIC ASSESMENT

Investigations done before enrolment of patients are described

Based on history and clinical investigations patient 1 and patient 2 are diagnosed with Dysfunctional Uterine bleeding, which is abnormal uterine bleeding in absence of any pelvic pathology. This can also be titled as Pubertal Menorrhagia but as per Ayurveda we can correlate with *Asrigdara* based on her *lakshanas (*~symptoms*)* similarity with DUB i.e., *Deergakala anubandhi* (~prolonged menstrual bleeding), *Atiartava pravritti* (~excessive menstrual bleeding), *anrutavamapi* (~intermenstrual bleeding or reduced interval of cycle). Here Pubertal Menorrhagia can be titled under DUB (Table 2).

CASE 1

Her USG was performed on September 05, 2024, and no significant abnormality were detected, the Endometrial thickness was 10.3 mm. This USG was performed on 13th day of her menstrual cycle which can be considered as a normal scan. She already had other blood investigations done priorly on August 16, 2024. Which showed normal Haematocrit levels, normal Thyroid function test, normal bleeding and clotting time. This can be concluded as the patient was having complaint of Menorrhagia in absence of any Pelvic pathology, Thyroid dysfunctions or any coagulopathies. However, her Haemoglobin level was very low i.e. 9.8 gm%. This might be because of excess blood loss through menses. Hormone assessment was done during late follicular phase (on16/08/25) showed high level of LH (Luteinizing Hormone) which was 20.26 with normal level of FSH (Follicle Stimulating Hormone) which was 5.71. Such high levels of LH and presence of complaints despite normalcy of other investigations suggests that ovulation was about to proceed soon after the LH surge but she got her menses in next 7 days (without medication) which clearly suggests Luteal Hase Defect occurring with reduced levels of Progesterone. This normally occurs in early menarche where there is absence of Progesterone with unopposed Estrogen.

CASE 2

Her USG was performed on January 01, 2025, and no significant abnormality were detected, the Endometrial thickness was 6.8 mm. This USG was performed on 6th day of her menstrual cycle which can be considered as a normal, but the scan shows presence of free fluid in cul-de-sac which is normally seen at the time of Ovulation. Hence this case can be considered of having early ovulation that might causes early bleeding. After that other blood investigations were done priorly on same date. Which showed normal Haematocrit levels except for WBC which suggest presence of some other infections irrespective of menstrual irregularities, normal Thyroid function test, normal bleeding and clotting time. This can be concluded as the patient was having complaint of Menorrhagia in absence of any Pelvic pathology, Thyroid dysfunctions or any coagulopathies. However, her Haemoglobin level was very low i.e. 10.3 gm%. This might be because of excess blood loss through menses. Hormone assessment was done during mid follicular phase showed low level of LH (Luteinizing Hormone) which was 1.63 with normal level of FSH (Follicle Stimulating Hormone) which was 5.54. Here low levels of LH suggest ovulation had already occurred and as here cycle length is 20 days, it can be assumed as reduced follicular phase length with normal length of luteal phase.

Diagnostic Challenges

As few years after attaining menarche there are multiple changes in the female body both physiologically, psychologically and endocrinologically where hormonal imbalances can occur at different level in different adolescent girls. Hence same cause cannot be found in each and every girl. Therefore, same diagnosis in not possible in all adolescent girls with pubertal menorrhagia.

THERAPEUTIC INTERVENTIONS

Both the patients were treated through *Nasya chikitsa* as follows:

Table 1: Patient's information with signs and symptoms in summarized form.

PATIENT	1	2
Date of Visit	05/09/24	09/01/25
Age (Years)	13	16
Sex	Female	Female
BMI	21.5 kg/m^2	18.9 kg/m^2
Symptoms	Excessive menstrual bleeding PV with increased duration Severe pain in abdomen during menses	Prolonged and excess bleeding PV during menses with reduced intermenstrual period
Onset (years)	2 years	1 year
Menarche	Before 2 years (Age-11)	Before 3 years (Age-13)
Pelvic Pathology (ruled out by USG)	Absent	Absent
LMP at 1st visit in OPD	24/08/24	04/01/25
Thyroid Dysfunction	Absent	Absent
Other systemic illness	None	None
Past Tx	Hormone replacement by OC Pills, *Bolabaddha Rasa*	None
Past Tx Duration	OCPs for 2-3 months after 1 year of menarche, *Bollabaddha Rasa* for 2 months after about 4-6 months of previous treatment	-
Current Tx	Udumbara Phala Nasya	Udumbara Phala Nasya
Current Tx duration (follow up)	7 days for 2 consecutive cycles 3 times (every month after cessation of menses)	7 days for 2 consecutive cycles 3 times (every month after cessation of menses)
SIGNS AND SYMPOMS		
LMP	23/08/24	04/01/25
PLMP	31/07/24	16/12/24
Menstrual Cycle		
Duration	8-10 days	10-11 days
Interval	10-20 days	15-25 days
Pain during menses	+++	++
Passage of clots	++	++
Foul Smell	+	-
Pads per cycle	30-35pads/cycle	35-40pads/cycle
Menorrhagia	✓	✓
Metrorrhagia	×	×
Polymenorrhoea	✓	✓
Dysmenorrhoea	✓	✓
Irregular Cycles	✓	✓
Gen. weakness and Lethargy	✓	✓
Dizziness	✓	×
Weight loss	Mild	Severe
PALM-COIEN criteria	×	×
Coagulopathy	×	×
Vitals	Stable	Stable

Medication Period

After cessation of menses from the very next day patient was advised to take *Nasya* (Nasal instillation of medicine) of *Udumbara phala* Extract (which was priorly prepared in GMP certified Parul Ayurved Pharmacy). Patients were advised to instil 4 drops in each nostril once daily (in morning after taking bath and before having breakfast) for 7 days continuously. After that stop the *Nasya*. Wait till commencement of menses in next cycle. Then again patients were called for follow up on the next day of cessation of menses of next cycle and again advised to do *Nasya* for one more cycle with same protocol and once again stop the instillation after 7 days and wait for commencement of next cycle. 2nd follow up after cessation of menses of 3rd cycle.

Table 2: **Investigations done before enrolment of patients.**

	PATIENT 1	PATIENT 2
USG findings		
Uterus	N- 57×28×42 mm	N- 56×26×50 mm
Rt ovary	N - 24×16 mm	N - 22×12 mm
Lt ovary	N - 23×17 mm	N - 20×14 mm
ET	10.3 mm	6.3 mm
Other comments	Not any	Min to mild free fluid in cul-de-sac
CBC: Hb	9.8 g%	10.6 gm%
RBC	4.64 mil/cmm	4.31 mil/cmm
WBC	6900/cmm	12600/cmm
PC	347000/cmm	288000/cmm
BT	1:57 min	2:13 min
CT	4:41 min	5:33 min
RBS	105 mg/dl	119 mg/dl
TSH	2.160 mcIU/mL	2.29 mcIU/mL
T3	1.04 ng/dl	1.567 ng/dl
T4	90 mcg/mL	75 mcg/mL

No medicine period

After 2nd follow up till commencement of next menses. Final (3rd) follow up after cessation of 4th cycle.

Hence total period of treatment given with medicine was for 2 consecutive cycles and one month without medicine.

OUTCOME

The outcome of this case series reveals that the patient feels relieved in signs and symptoms, and it will be described as follows:

Changes in signs and symptoms, before and after treatment are shown as follows (Table 3).

Differences of LH and FSH before and after treatment for both cases are shown in (Table 4).

DISCUSSION

The presented case series involved two adolescent females with features of Pubertal Menorrhagia, correlating with the Ayurvedic diagnosis of *Asrigdara*, which is characterized by excessive or prolonged discharge of *Asrk* (blood) from the vaginal canal. This disorder is listed under *Yonivyapad* and specifically addressed by *Acharya Charaka* and *Acharya Sushruta* as a distinct pathological entity.[1,17] According to Ayurveda, *Asrigdara* is primarily caused by *Pitta* vitiation, obstructing Apana Vayu, thereby disturbing the *Artava Vaha Srotasa* (channels carrying menstrual

Table 3: **These table shows changes in signs and symptoms, before and after treatment.**

Sign and symptoms	Patient 1		Patient 2	
	Before treatment	After treatment	Before treatment	After treatment
Menstrual Cycle				
Duration	8-10 days	5-6 days	10-11 days	6 days
Interval	10-20 days	25 days	15-25 days	30 days
Pain during menses	+++	+	++	+
Passage of clots	++	-	++	-
Foul Smell	+	-	-	-
Pads per cycle	30-35pads/cycle	15-17 pads/day	35-40pads/cycle	18-20 pads/day
Menorrhagia	Present	Absent	Present	Absent
Metrorrhagia	Absent	Absent	Absent	Absent
Polymenorrhoea	Present	Reduced	Present	Absent
Dysmenorrhoea	Severe	Mild	Moderate	Mild
Nature of Cycles	Irregular	Regular	Irregular	Regular
Gen. weakness and Lethargy	Moderate	Absent	Severe	Mild
Dizziness	Moderate	Absent	Mild	Absent
Weight loss	Mild	Absent	Severe	Mild

Table 4: Difference of levels of LH and FSH before and after treatment for both cases.

	LH		FSH	
	B/T	A/T	B/T	A/T
Case 1	20.26	7.89	5.71	6.21
Case 2	1.63	8.56	5.54	6.35

blood).[4] In modern gynecology, Pubertal Menorrhagia is defined as abnormal uterine bleeding (AUB) in adolescents, occurring within the first 2-3 years after menarche, commonly due to anovulatory cycles resulting from the immaturity of the hypothalamic-pituitary-ovarian (HPO) axis.[6] In both patients presented, no organic pathology, endocrine disorders, or coagulation defects were found, supporting a diagnosis of DUB.[9,10]

Case 1 demonstrated high LH (20.26 mIU/mL) in the late follicular phase with normal FSH, which suggests an upcoming LH surge but there is inadequate luteal support. This is reflective of a luteal phase defect, a common manifestation in early adolescence due to incomplete maturation of the HPO axis. This aligns with the modern understanding that unopposed estrogen leads to excessive endometrial proliferation and erratic shedding due to absence of progesterone, resulting in menorrhagia.[7,8] Case 2, in contrast, showed low LH (1.63 mIU/mL) with evidence of presence of free fluid in POD assuming occurrence of ovulation, causing shortened follicular phase. It is a rare condition in adolescent girls. The clear cause behind the presenting symptoms can't be ruled out but post medication results were promising. Despite differing hormonal patterns, both patients presented clinically with prolonged cycles, reduced interval between cycles (polymenorrhea), dysmenorrhea, and general fatigue-hallmark features of both Pubertal Menorrhagia and *Pitta-Vataja Asrigdara*.

The Ayurvedic diagnosis of *Pitta-Vataja Asrigdara* is supported by the clinical features: excessive bleeding (*Pitta*), painful menses and irregularity (*Vata*), presence of clots, and systemic fatigue. *Acharya Charaka* clearly states that when *Pitta* is predominant and blocks the course of *Apana Vayu*, it leads to *Raktapravritti* beyond physiological limits.[17] He classifies four types of *Asrigdara-Vataja, Pittaja, Kaphaja,* and *Sannipataja*, but emphasizes dual *Dosha* involvement, particularly *Pitta* and *Vata*, in prolonged and irregular menstruation.[5] The choice of *Udumbara Phala* (*Ficus racemosa*) is justified by its *Kashaya rasa, Sheeta veerya*, and *Raktastambhaka* and *Pittahara* properties, which suit the management of *Pitta-Rakta dushti* in *Asrigdara*.[18] Ayurvedic text named *Sahastrayogam* clearly states direct use of *Udumbara* (*Ficus Racemosa*) *apakwa phala* (Unripe fruit) in management of *Asrigdra*.[19] In various Ayurvedic texts use of *Udumbara apakwa phala, pakwa phala, patra, twaka and kshira* in various formulations has been described in different *Stri Roga Vikaras*.[20] Moreover, *Ficus Racemosa* fruits contain Tannins and Flavonoids which helps in increasing the concentration of PGE_2 and supressing endothelial prostaglandins.[21,22] *Nasya Karma*, a *Shirovirechana* procedure, is indicated in various gynecological disorders involving hormonal imbalances. *Acharya Kashyapa* has advocated *Nasya Karma* in both *Artavakshaya* and *Atyartava*, indicating its dual action on insufficient and excessive bleeding, likely due to its systemic effect on neuroendocrine pathways.[13] The nasal mucosa's proximity to the brain's limbic and hypothalamic systems makes it a possible route for systemic effect through transmucosal absorption. This can have a direct impact on Hypothalamus and Anterior Pituitary gland which releases hormones like GnRH, LH and FSH, and thus regulating their normal levels. The timing of *Nasya*-immediately post-menstruation-was based on *Kashyapa's* recommendation, which aims to influence post-menstrual hormonal reset.

Clinically, both cases showed substantial improvement. Menstrual bleeding duration and quantity reduced, pain subsided, and cycle regularity improved. Notably, the hormonal assessment showed significant modulation. In Case 1, LH reduced from 20.26 mIU/mL to 7.89 mIU/mL post-treatment, and in Case 2, LH increased from 1.63 to 8.56 mIU/mL, suggesting movement toward physiological balance based on individual baseline deviations. FSH levels showed mild upward correction in both, aligning with hormonal axis maturation. These changes indicate that *Nasya* might be influencing central hormonal feedback mechanisms, potentially stabilizing the HPO axis. Moreover, here *Nasya* is given by the aqueous extract of *Ficus Racemosa* fruit. This means no *Taila* (oil) or *Ghrita* (ghee) has been processed with it hence it contains pure form of phytoconstituents that works on controlling bleeding. Plus, the colourless, odourless and tasteless effect of extract ensures easy and convenient administration of a *Panchakarma* procedure like *Nasya* in adolescent girls. Importantly, the therapy was administered without any oral medication, ensuring that the observed effects could be attributed primarily to the *Udumbara Phala Extract Nasya*. No adverse effects were noted, reinforcing the safety and tolerability of this method in adolescents.

These results suggest that *Nasya Karma* may exert a regulating effect on HPO axis function, leading to normalization of ovulatory cycles. It appears neither suppressive (like OCPs) nor merely symptomatic, but rather homeostatic in action. This is consistent with Ayurveda's aim of restoring equilibrium rather than substituting physiological functions.[13,14]

The heterogeneity of hormonal patterns in adolescent menorrhagia-as seen in our two cases-indicates that uniform treatment approaches may be insufficient. Ayurvedic

categorization based on *Dosha* dominance and symptom expression provides a useful framework for individualized therapy. Further, the intervention was well tolerated, had no side effects, and required no systemic hormone use-making it suitable for adolescent management. This also raises the possibility that Ayurveda's *Shamana* therapies (like *Nasya*) may offer a more natural path to HPO axis maturation in early adolescence, especially in conditions that are self-limiting but symptomatic, such as pubertal Menorrhagia. While modern medicine acknowledges the transient nature of such dysfunctions, it lacks a clear non-hormonal management protocol, particularly for girls reluctant to use hormonal medications.

Strength and Limitations

This study was done on only 2 adolescent girls if this could be done with larger sample size it might show exact effect on all pubertal menorrhagia cases. While it had shown promising effects in many cases of DUB in patients aged from 18 to 50 years.

CONCLUSION

Udumbara Phala (*Ficus racemosa*) *Nasya* demonstrates therapeutic efficacy in the management of pubertal Menorrhagia, clinically correlating with *Pitta-Vataja Asrigdara*. Its pharmacodynamic properties-specifically astringent tannins, flavonoids, and anti-inflammatory constituents-support hemostasis by promoting vasoconstriction, reducing capillary permeability, and modulating prostaglandin synthesis (notably inhibiting excess PGI_2 while enhancing PGE_2). The transmucosal nasal administration facilitates rapid systemic absorption and may act via the olfactory-limbic-hypothalamic axis, thereby influencing gonadotropin-releasing hormone (GnRH) pulsatility and subsequent pituitary secretion of LH and FSH. This aligns with Ayurvedic principles where *Nasya Karma* is said to influence *Shirastha marma* and regulate *Apana Vayu* function. Unlike exogenous hormonal therapies, *Udumbara Phala Nasya* appears to promote endogenous neuroendocrine equilibrium without disrupting hypothalamic-pituitary-ovarian (HPO) axis maturation, offering a non-hormonal, bio-regulatory approach for adolescent menstrual dysfunctions.

ACKNOWLEDGEMENT

The authors gratefully acknowledge Parul Institute of Ayurveda, Parul University, and the CR4D Department, Parul University, for their valuable help and guidance in this work.

ABBREVIATIONS

HPO Axis: Hypothalamo-Pituitary-Ovarian Axis; **BMI:** Body Mass Index; **USG:** Ultrasonography; **Tx:** Treatment; **LMP:** Last Menstrual Period; **PLMP:** Previous Last Menstrual Period; **ET:** Endometrial Thickness; **Hb:** Hemoglobin; **RBC:** Red Blood Cells; **WBC:** White Blood Cells; **PC:** Platelet Count; **RBS:** Random Blood Sugar; **BT:** Bleeding Time; **CT:** Clotting Time; **TSH:** Thyroid-Stimulating Hormone; **LH:** Luteinizing Hormone; **FSH:** Follicle-Stimulating Hormone; **B/T:** Before Treatment; **A/T:** After Treatment; **DUB:** Dysfunctional Uterine Bleeding; **AUB:** Abnormal Uterine Bleeding; **GMP:** Good Manufacturing Practice; **POD:** Pouch of Douglas; **OCP:** Oral Contraceptive Pills.

CONFLICT OF INTEREST

The authors declare that there is no conflict of interest.

PATIENT'S PERSPECTIVE

Patient 1: "When I came to hospital, I had complaint of heavy and prolonged menstrual bleeding since menarche. I had taken allopathic as well and Ayurvedic treatment but only had relief till I continue medication then again, the symptoms appear. After getting this treatment with Nasal drops I got relief from the symptoms even after the stoppage of medication."

Patient 2: "When I came to hospital, I had complaint of prolonged menstrual bleeding since long. I was afraid of taking allopathic medicine, so I chose to have Ayurved medicine. After the treatment I really got relief from the symptoms and now I can do my daily work without any discomfort.

INFORMED CONSENT

Written permission for the publication of this case study was obtained from the patient.

DECLARATION OF PATIENT CONSENT

The authors certify that they have obtained all appropriate patient consent forms. In the form, the patients have given their consent for other clinical information to be reported in the journal. The patients understand that their names and initials will not be published, and due efforts will be made to conceal their identity.

AUTHOR CONTRIBUTIONS

Dr. Keya: Conceptualization, Methodology, Formal analysis, Investigation, Resources, Data curation, Visualization, Writing – original draft, Review & editing, Supervision.
Dr. Anitha: Conceptualization, Methodology, Formal analysis, Investigation, Visualization, Review & editing, Supervision.
Dr. Shriniwas: Conceptualization, Methodology, Formal analysis, Investigation, Visualization, Review & editing, Supervision.

CLINICAL TRIAL NUMBER

CTRI/2024/04/066545.

SUMMARY

This case series explores the Ayurvedic management of pubertal menorrhagia-characterized by excessive or prolonged menstrual bleeding in adolescent girls-through *Nasya Karma*

(nasal administration) using *Ficus racemosa* (*Udumbara*) fruit extract. Two adolescent females, aged 13 and 15, diagnosed with *Asrigdara* (as per Ayurvedic diagnosis) and Dysfunctional Uterine Bleeding (DUB) (as per modern medicine), were treated with 4 nasal drops of *Udumbara* extract per nostril daily for 7 days after menstruation, across two cycles. No oral medications were given.

Both patients showed significant clinical improvement: reduced blood loss, better cycle regularity, and relief from dysmenorrhea. Hormonal assessments post-treatment indicated normalization of LH and FSH levels, suggesting a stabilizing effect on the hypothalamic-pituitary-ovarian (HPO) axis. No adverse effects were observed.

The treatment's effectiveness is attributed to the *Pitta-Rakta* pacifying and *Raktastambhaka* (hemostatic) properties of *Udumbara*, and the neuroendocrine modulation potential of *Nasya*. This non-hormonal, localized, and well-tolerated therapy presents a promising alternative in adolescent menstrual disorders, supporting the integration of Ayurvedic practices into pediatric gynecology.

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Cite this article: Patel K, Hossur A, Jadhav S. Case Series on the Ayurvedic Management of Pubertal Menorrhagia Using *Ficus racemosa Nasya*. Pharmacog Res. 2026;18(1):206-12.