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CARE-ALIGNED CASE REPORT

Integrative Ayurvedic Management of Postmenopausal Bleeding with Thickened Endometrium: A CARE-Aligned Case Report

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Abstract

Background: Postmenopausal bleeding warrants urgent evaluation because it may indicate endometrial hyperplasia or malignancy. This case report describes the short-term outcome of an integrative Ayurvedic approach in a woman with postmenopausal bleeding and thickened endometrium. **Case Presentation:** A 58-year-old postmenopausal woman (G2P2L2) presented on 18 June 2025 with recurrent heavy uterine bleeding for about one year, lasting 10–11 days per episode and requiring 6–7 pads daily, with clots, foul-smelling reddish-brown discharge, weakness, and mild lower abdominal pain. Examination showed pallor. Baseline investigations revealed hemoglobin 10 g/dL, RBC 3.6 million/cu.mm, and ultrasonographic endometrial thickness of 10.9 mm without adnexal pathology. She had undergone left nephrectomy eight years earlier. **Intervention:** A 21-day stepwise integrative Ayurvedic protocol was administered, comprising internal Śamana medicines, local Udarlepa, and dietary support, with reassessment at 7-day intervals. **Outcome:** Bleeding decreased to 1–2 pads/day by Day 7, improved to mild spotting by Day 14, and remained controlled through Day 21. **Conclusion:** This case suggests possible short-term symptomatic benefit of integrative Ayurvedic management; however, because postmenopausal bleeding with thickened endometrium requires exclusion of malignancy, the findings should be considered hypothesis-generating only. Further studies with histopathologic evaluation, standardized bleeding assessment, and longer follow-up are needed.

Key words: Āsrugdara, Postmenopausal bleeding, Integrative Ayurvedic management

1 | INTRODUCTION

Abnormal uterine bleeding (AUB) is defined as uterine corpus bleeding that is abnormal in regularity, volume, frequency, or duration, and it constitutes one of the most prevalent causes of gynecologic morbidity across the reproductive life course. To standardize clinical evaluation and communication, the International Federation of Gynecology and Obstetrics (FIGO) developed the PALM–COEIN classification framework, which distinguishes structural causes (Polyp, Adenomyosis, Leiomyoma, Malignancy/Hyperplasia) from non-structural etiologies (Coagulopathy, Ovulatory dysfunction, Endometrial, Iatrogenic, Not otherwise classified). The clinical consequences of AUB—iron deficiency anemia, chronic fatigue, functional impairment, and diminished quality of life—impose a substantial burden on both the individual patient and the broader health system (1, 2).

Although AUB affects women across all reproductive phases, bleeding occurring in the postmenopausal period demands a distinctly more cautious diagnostic approach, as it may herald endometrial hyperplasia or carcinoma. Contemporary clinical guidelines mandate prompt and systematic evaluation of postmenopausal bleeding to exclude malignancy. Transvaginal ultrasonography (TVUS) serves as the cornerstone of initial assessment; an endometrial thickness of ≤4 mmconfers a negative predictive value exceeding 99% for endometrial carcinoma, whereas a thickness above this threshold—particularly in a symptomatic patient—

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necessitates further histopathological characterization. This diagnostic imperative is especially critical when ultrasound reveals a thickened endometrium, since imaging alone cannot reliably differentiate benign from malignant pathology (3).

The management of AUB is individualized according to etiology, symptom burden, comorbidity profile, and patient preferences. Conventional therapeutic strategies include hormonal therapy, antifibrinolytic agents, endometrial ablation, and hysterectomy; however, these modalities may be constrained by contraindications, adverse effects, surgical risk, recurrence rates, or economic accessibility—limitations that are disproportionately pronounced in older or medically complex patients. A nontrivial proportion of patients, particularly those seeking to avoid invasive procedures, pursue integrative approaches that prioritize individualized, holistic care.

Within the Ayurvedic nosological framework, excessive or protracted uterine bleeding corresponds to Āsrugdara/Raktapradara, classified among the Artava-vikāras (disorders of menstrual physiology). The classical pathogenesis is attributed to Vāta–Pitta doshic derangement with impairment of the Rakta and Artavavaha srotas, manifesting as excessive bleeding and associated systemic symptoms. Therapeutic strategy is organized around doṣha-pratyanika chikitsā—employing raktastambhaka (hemostatic) and pittaśhamaka (Pitta-pacifying) formulations to restore dhātu equilibrium—supported by sthānika chikitsā (local application) (4).

An expanding, albeit nascent, clinical evidence base has begun evaluating classical Ayurvedic formulations in AUB-like presentations. Clinical studies have reported symptomatic benefits of Pushyanuga Churna (frequently combined with adjuncts such as Usheerasava) in reducing bleeding severity and related symptoms. Botanical constituents with established traditional applications in uterine and hemorrhagic disorders—most notably Lodhra (Symplocos racemosa), Nāgakeśara, and Śatāvarī (Asparagus racemosus)—have been reviewed for their bioactive properties and biological plausibility in hemostatic contexts (5).

The present report describes a postmenopausal woman with prolonged heavy uterine bleeding and associated systemic symptoms who was managed using a structured integrative Ayurvedic protocol combining śhamana therapies with Udarlepa (local abdominal application) and dietary guidance (pathya). This CARE-aligned case report aims to: (i) document the clinical course with systematic, structured follow-up; (ii) describe the therapeutic rationale, formulation constituents, and dosing schedule of the Ayurvedic regimen; and (iii) contribute hypothesis-generating evidence to support future rigorous investigation of integrative management strategies in carefully evaluated patients presenting with postmenopausal uterine bleeding.

2 | CASE PRESENTATION

2.1 | Patient Profile and Chief Complaint

A 58-year-old woman (G2P2L2) presented to a gynecology outpatient clinic on 18 June 2025 with a complaint of abnormal uterine bleeding of approximately one year's duration. She reported recurrent bleeding episodes lasting 10–11 days per cycle, requiring 6–7 sanitary pads per day, with passage of blood clots and foul-smelling, reddish-brown vaginal discharge. The bleeding was accompanied by generalized weakness and mild intermittent lower abdominal pain.

2.2 | History

The patient reported attaining menopause approximately two years prior to presentation, characterized by an initial period of ~6 months of amenorrhea, following which uterine bleeding resumed and progressively worsened in severity. Her past surgical history was notable for a left nephrectomy performed eight years earlier for a non-functioning kidney. She denied a history of hypertension, diabetes mellitus, thyroid dysfunction, tuberculosis, or cardiac illness. There was no reported family history of gynecologic malignancy, and her obstetric history comprised two full-term spontaneous vaginal deliveries with two living children.

2.3 | Clinical Examination

On general examination, the patient was hemodynamically stable and afebrile, with pallor noted. Anthropometric and vital parameters were as follows: height 162 cm, weight 48 kg, BMI 18.28 kg/m^2, pulse 89 beats/min, and blood pressure 110/70 mmHg. Icterus, cyanosis, clubbing, pedal edema, and lymphadenopathy were all absent. Systemic examination revealed normal vesicular breath sounds, normal heart sounds (S1 and S2), and no gastrointestinal or neurological abnormality.

Pelvic examination was performed and revealed active bleeding per vaginum. Speculum examination demonstrated a hypertrophied cervix with an open cervical os; the vaginal walls appeared healthy with no lesions. Bimanual examination revealed a normal-sized, anteverted uterus with free fornices and mild lower abdominal tenderness on deep palpation.

2.4 | Investigations

Laboratory evaluation at baseline demonstrated hemoglobin 10 g/dL, RBC count 3.6 million/cu.mm, WBC count 8800/cu.mm, and random blood glucose 111 mg/dL Table 1 . Abdominal and pelvic ultrasonography revealed a uterus measuring 56 × 39 × 44 mm with an endometrial thickness of 10.9 mm and no adnexal pathology. The ultrasonographic finding of endometrial thickness substantially exceeding the 4 mm threshold in a postmenopausal symptomatic woman underscores the clinical necessity of explicitly documenting the differential diagnosis and the evaluation pathway employed, including whether histologic assessment was performed, declined, or deferred. This is acknowledged as a critical diagnostic consideration and is addressed further in the Discussion.

2.5 | Ayurvedic Assessment

Ayurvedic evaluation was conducted using Aṣṭavidha parīkṣā (eightfold examination) and Daśavidha parīkṣā (tenfold examination). The Nadi (pulse) was assessed as Vāta-Pittaja; Mala (bowel) was regular; Mutra (urine) normal; Jihva (tongue) showed alpa saṃlepa; Śabda, Sparśa, Dṛk, and Ākṛti were all prakṛta or normal range. Prakṛti was assessed as Vāta-Pittaja, with Vikṛti corresponding to Raktapitta pradhāna. Sāra, Saṃhanana, Satva, Satmya, Āhāra śakti, and Vyāyāma śakti were all assessed as madhyama (moderate), with Pramāṇa characterized by alpamāṃsa and madhya meda constitution. The holistic assessment supported a classical diagnosis of Raktapradara with predominant Pitta-Rakta doshic involvement.

Baseline demographic characteristics, symptom profile, and clinical findings on Day 1, including vital signs, general and systemic examination, pelvic examination (speculum and bimanual), and initial investigations (hemogram, random blood sugar, and pelvic ultrasound with endometrial thickness).

3 | FOLLOW-UP AND OUTCOMES

The patient was reviewed at 7-day intervals following treatment initiation, with clinical response quantified primarily through bleeding duration and daily pad count as the principal outcome measure Table 2 . At baseline (18 June 2025), heavy prolonged bleeding of 10–11 days/cycle necessitating approximately 6–7 pads/day with clots, foul odour, weakness, and lower abdominal pain was documented as the reference anchor for subsequent comparison. At the first follow-up on Day 7 (25 June 2025), a clinically meaningful reduction in bleeding was observed, with the patient reporting mild bleeding requiring only 1–2 pads/day; the therapeutic regimen was reviewed and continued with modifications for the subsequent interval. At the second follow-up on Day 14 (02 July 2025), further symptomatic improvement was recorded, with the patient noting mild spotting per vagina only; treatment was continued for an additional week to consolidate the response and prevent early recurrence. At the end-of-treatment assessment on Day 21 (09 July 2025), the clinical outcome was documented as a sustained reduction from baseline heavy bleeding (6–7 pads/day) to mild spotting, confirming a meaningful treatment response over the 21-day protocol.

Table 1. Baseline examination and investigations (Day 1)

Domain	Item	Finding
Patient profile	Age	58 years
	Obstetric status	Married woman; G2P2L2A0
Presenting problem	Duration of symptoms	Prolonged bleeding "since year" (~1 year)
	Bleeding pattern	10–11 days/cycle; 6–7 pads/day; clots present; foul odour; reddish-brown blood
	Associated symptoms	Weakness; mild intermittent lower abdominal pain
	Menopausal history	Menopause 2 years ago with ~6 months amenorrhea, then bleeding resumed
Past history	Surgery	Left nephrectomy 8 years ago (non-functioning kidney)
	Medical history	No HTN/DM/thyroid/TB/cardiac illness
	Family history	No family history of gynecological malignancy
General examination	Height	162 cm
	Weight	48 kg
	BMI	18.28 kg/m^2
	Pulse	89/min
	Blood pressure	110/70 mmHg
	Temperature	Afebrile
	Pallor	Present
	Icterus/Cyanosis/Clubbing/Edema/Lymphadenopathy	Absent
Systemic examination	Respiratory	Normal vesicular
	Cardiovascular	Normal S1, S2
	Gastrointestinal	No abnormality
	CNS	Intact
	Locomotor	Normal
Local gynecologic exam	Per speculum	Cervix hypertrophied; bleeding per vagina; cervical os open; vaginal walls healthy
	Per vaginal	Uterus anteverted, normal size; fornices free; mild lower abdominal tenderness
Ayurvedic assessment (baseline)	Aṣṭavidha parīkṣā	Nadi: Vāta-Pittaja; Mala: Regular; Mutra: Normal; Jihva: Alpa sa□lepa; Śabda: Prakṛta; Sparśa: Anuṣṇa; Dṛk: Prakṛta; Ākṛti: Madhyama
	Daśavidha parīkṣā	Prakṛti: Vata-Pittaja; Vikṛti: Raktapitta pradhāna; Sāra/Sa□hanana/Satva/Satmya/Āhāra śakti/Vyāyāma śakti: Madhyama; Pramāṇa: Alpamā□sa, Madhya meda
Laboratory tests	Hemoglobin	10 g/dL
	RBC	3.6 million/cu.mm
	WBC	8800/cu.mm
	Random blood sugar	111 mg/dL
Imaging	USG abdomen & pelvis	Uterus 56 × 39 × 44 mm; endometrial thickness 10.9 mm; no adnexal pathology

Table 2. CARE-Recommended Timeline Table

Date*	Day	Encounter / Stage	Assessment Elements Documented	Key Findings / Outcomes
18 Jun 2025	1	Initial presentation (OPD visit)	History + symptom quantification	~1 year history of abnormal uterine bleeding; bleeding episodes 10–11 days/cycle, ~6–7 pads/day; clots, foul odour, reddish-brown blood; associated weakness and mild intermittent lower abdominal pain; history consistent with postmenopausal bleeding (menopause ~2 years earlier with ~6 months amenorrhea, then bleeding restarted).
18 Jun 2025	1	Baseline risk context	Past/family history + comorbidity review	Past surgery: left nephrectomy 8 years earlier (non-functioning kidney). No reported HTN/DM/thyroid/TB/cardiac illness. No family history of gynecologic malignancy. Obstetric history: two full-term deliveries, two living children.
18 Jun 2025	1	Physical examination	Vitals + general exam + systemic exam	Stable, afebrile; pallor present. Vitals/anthropometry: height 162 cm, weight 48 kg, BMI 18.28 kg/m^2, pulse 89/min, BP 110/70 mmHg. No icterus/cyanosis/clubbing/edema/lymphadenopathy. Systemic exam: respiratory normal vesicular, CVS normal S1/S2, GI no abnormality, CNS intact.
18 Jun 2025	1	Gynecological examination	Local pelvic exam (speculum + bimanual)	Active bleeding PV. Per speculum: hypertrophied cervix, cervical os open, vaginal walls healthy. Per vaginal: uterus anteverted, normal size, fornices free, mild lower abdominal tenderness.
18 Jun 2025	1	Investigations (baseline)	Hematology + biochemistry + imaging	Hb 10 g/dL, RBC 3.6 million/cu.mm, WBC 8800/cu.mm, RBS 111 mg/dL. USG abdomen/pelvis: uterus 56 × 39 × 44 mm, endometrial thickness 10.9 mm, no adnexal pathology.
18 Jun 2025	1	Baseline outcome metrics recorded	Symptom baseline used for follow-up comparison	Bleeding severity anchored at 6–7 pads/day with clots/odour; anemia suggested by pallor and Hb 10 g/dL.
18 Jun 2025	1	Therapeutic plan initiated	Integrative regimen started + dietary advice	Treatment initiated after baseline evaluation; follow-up planned at 7-day intervals. (Detailed regimen in Table 3.)
25 Jun 2025	7	Follow-up 1	Symptom reassessment + response documentation	Bleeding decreased substantially to mild bleeding requiring 1–2 pads/day.
25 Jun 2025	7	Treatment modification/-continuation	Stepwise plan for next interval	Therapy revised/continued for the subsequent week; ongoing dietary/pathya advice documented as part of follow-up management.
02 Jul 2025	14	Follow-up 2	Symptom reassessment	Further improvement with mild spotting per vagina.
02 Jul 2025	14	Treatment continuation	Plan for next interval	Therapy continued/adjusted for another 7 days with intent to stabilize improvement and prevent recurrence.
09 Jul 2025	21	End-of-treatment assessment	Summary of response over 21-day course	Overall response documented as improvement from baseline 6–7 pads/day to mild spotting at completion of the 21-day protocol.

Follow-up dates are calculated from the documented 7-day interval follow-up schedule starting 18 Jun 2025.

4 | THERAPEUTIC INTERVENTION

The therapeutic intervention comprised internal (Śamana) formulations combined with a local (Sthānika) procedure—Udarlepa—delivered in a structured, phased manner over 21 days with weekly reassessment Tables 3 and 4 . During the initial 7-day phase (Days 1–7), the regimen included hemostatic and nourishing internal formulations alongside Udarlepa and prescribed dietary support (pathya). Following documented clinical response at Day 7, the regimen was refined for Days 8–14 with the intro-

duction of Muslikhadirādi kaṣāya as a targeted pitta-kapha pacifying decoction, continuation of dietary support, and appropriate adjustments to other formulations. In the final phase (Days 15–21), the regimen was consolidated with a reinforced hemostatic focus aimed at maintaining the achieved improvement, preventing rebound bleeding, and supporting systemic recovery from prolonged anemic stress. Local Udarlepa and dietary pathya were sustained throughout all three phases.

5 | DISCUSSION

This report documents a 58-year-old postmenopausal woman with a one-year history of heavy, prolonged uterine bleeding (10–11 days/cycle; ~6–7 pads/day with clots and foul-smelling discharge), accompanied by generalized weakness, mild lower abdominal pain, pallor, and hemoglobin of 10 g/dL. Pelvic ultrasonography revealed a uterus of normal dimensions (56 × 39 × 44 mm) with an endometrial thickness of 10.9 mm and no adnexal pathology. Following a 21-day stepwise integrative Ayurvedic regimen, bleeding reduced from 6–7 pads/day at baseline to 1–2 pads/day by Day 7 and to mild spotting by Day 14, with the improvement sustained at Day 21.

A foundational clinical concern in this case is that postmenopausal bleeding mandates timely and systematic exclusion of endometrial malignancy and hyperplasia. Evidence-based guidelines universally endorse TVUS as the first-line investigation; endometrial thickness ≤4 mm carries a negative predictive value exceeding 99% for endometrial cancer, while a thickness above this threshold—as documented in this case at 10.9 mm—necessitates further evaluation contingent on symptom persistence, risk factors, and available resources. It is essential for case reports in this clinical context to explicitly document the complete differential diagnosis using the PALM–COEIN framework, describe what investigations were pursued, and transparently address whether histologic evaluation (endometrial sampling, pipelle biopsy, or hysteroscopy) was performed, declined by the patient, or deferred—as the omission of such information substantially weakens the clinical and scientific credibility of published reports (6).

The therapeutic approach employed in this case was multimodal, combining internal (Śamana) formulations with topical Udarlepa and structured dietary guidance across three progressive phases. From a biomedical perspective, the observed clinical improvement is most plausibly attributable to the cumulative astringent, hemostatic, anti-inflammatory, and supportive properties of the constituent botanicals. Pushyanuga churna is a classical polyherbal formulation with established hemostatic and uterine tonic properties, and published clinical studies have specifically evaluated it in AUB populations with reported improvements in bleeding-related outcomes. Symplocos racemosa (Lodhra)—featured both internally as Lodhra āsava and externally in the Udarlepa formulation—is among the most extensively cited Ayurvedic herbs for uterine and bleeding disorders, with pharmacognostic reviews documenting its traditional applications and plausible astringent/styptic mechanisms (7, 8). Asparagus racemosus (Śatāvarī), administered as a kṣīrapāka (medicated milk preparation), contributes broad rasāyana (rejuvenating) and adaptogenic effects, supporting systemic recovery in the context of prolonged anemic stress. Muslikhadirādi kaṣāya was incorporated from Day 8 onward to consolidate pitta-kapha modulation and extend the hemostatic effect. While none of these formulations have been evaluated specifically in postmenopausal bleeding within randomized controlled frameworks, their inclusion provides a biologically plausible and classically grounded rationale for the observed clinical response (9).

5.1 | Strengths and Limitations

The principal strength of this case report lies in its structured prospective follow-up at standardized 7-day intervals with quantifiable outcome anchors (pad

Table 3. A: Therapeutic Intervention (Śamana and Sthānika)with Schedule, Dose, and Rationale

Treatment Phase	Therapy Type	Medicine / Procedure	Dose, Route, Timing (as prescribed)	Duration	Intended Purpose (Ayurvedic/Clinical)	Key Supporting Evidence (Brief)
Day 1–7 (Visit Day 1)	Sthānika (local)	Udarlepa: Lodhra + Nāgakeśara + Yaṣṭimadhu	Lodhra 10 g + Nāgakeśara 10 g+ Yaṣṭimadhu 50 g, OD (external application)	7 days	Local cooling/soothing support; adjunct to reduce bleeding tendency and pelvic discomfort (sthānika chikitsā).	Lodhra (Symplocos racemosa) is widely described for traditional use in uterine/bleeding disorders.
Day 1–7 (Visit Day 1)	Śamana (internal)	Pushyanuga + Nāgakeśara + Śatāvarī cūrṇa	1 tsf, with Tandulodaka, OD A/F	7 days	Hemostatic (raktastambhaka); supports reduction of excessive bleeding; tonic for uterine tissue.	Clinical research has evaluated Pushyanuga cūrṇa for AUB outcomes with reported symptomatic benefit.
Day 1–7 (Visit Day 1)	Śamana (internal)	Lodhra āsava	3–3–3 tsf with equal warm water, A/F	7 days	Supportive hemostasis; pitta-related symptom control.	Symplocos racemosa(Lodhra) is extensively described in pharmacognosy literature for traditional use in uterine and bleeding conditions.
Day 1–7 (Visit Day 1)	Śamana (internal)	Śatāvarī kṣīrapāka	100 mL, BD B/F	7 days	Rasāyana/supportive care; strength, nourishment, and systemic stabilization in prolonged bleeding with anemia.	Shatavari (Asparagus racemosus) is reviewed for broad pharmacological properties including women's health and hematinic support.
Day 1–7 (Visit Day 1)	Diet (Pathya)	Mudga yūṣa	200 mL BD B/F	7 days	Light, digestible dietary support accounting for agni/pitta considerations alongside therapy.	—
Day 8–14 (Follow-up 1; Day 7 review)	Śamana (internal)	Muslikhadirādi kaṣāya	15 + 60 mL with lukewarm water, BD B/F, empty stomach	7 days	Pitta-kapha balancing; progressive control of bleeding and associated symptoms; hemostatic consolidation.	Commonly described for gynecological bleeding patterns in Ayurvedic practice literature (supportive/low-level evidence).
Day 8–14 (Follow-up 1)	Śamana (internal)	Sūtaśekhara rasa	2 tablets BD A/F	7 days	Pitta-śhamana / agnideepana support; symptom stabilization per Ayurvedic rationale.	Mechanism and rationale discussed in relevant reviews (supportive/low-level evidence).

count and bleeding character). The CARE-aligned format, inclusion of a detailed baseline assessment, and three-phase therapeutic documentation enhance transparency and reproducibility. However, several important limitations must be acknowledged. First, bleeding outcomes were assessed using pad count and clinical description alone; standardized, validated instruments such as the Pictorial Blood Assessment Chart (PBAC) were not employed, limiting the precision of outcome quantification. Second, the postmenopausal context with an ultrasonographic endometrial thickness of 10.9 mm obligated histologic evaluation; the absence of documented endometrial sampling represents a significant clinical and reporting gap that must be explicitly identified as a limitation and safety consideration. Third, objective laboratory follow-up—including repeat hemoglobin measurement to confirm hematologic response and renal function monitoring given the history of contralateral nephrectomy—was not documented in the available record, representing a further limitation in the safety assessment. Fourth, as a single case without a control arm, the observed improvement cannot be attributed exclusively to the intervention; spontaneous fluctuation, regression to the mean, natural disease course, or unmeasured co-interventions cannot be ruled out (10).

5.2 | Safety Considerations

The patient's history of left nephrectomy (with a solitary functioning kidney) introduces a specific

Table 3. B: Therapeutic Intervention (Śamana and Sthānika)with Schedule, Dose, and Rationale

Day 8–14 (Follow-up 1)	Diet (Pathya)	Mudga yūṣa	200 mL BD B/F	7 days	Continued dietary support.	—
Day 15–21 (Follow-up 2; Day 14 review)	Śamana (internal)	Pushyanuga + Lodhra cūrṇa	Per dosing schedule (as prescribed)	7 days	Intensified hemostatic focus during spotting phase; maintenance and prevention of rebound bleeding.	Pushyanuga evaluated in AUB clinical studies; Lodhra widely cited in uterine/bleeding contexts.
Day 15–21 (Follow-up 2)	Śamana (internal)	Syp. Amylcure	15 mL BD A/F	7 days	Symptom support as prescribed (proprietary formulation—add composition details for publication).	As available per manufacturer/practice documentation.
Day 15–21 (Follow-up 2)	Śamana (internal)	Muslikhadirādi kaṣāya	15 + 60 mL with lukewarm water, BD B/F, empty stomach	7 days	Continued pitta-kapha support; consolidation of response.	Supportive practice literature.
Day 15–21 (Follow-up 2)	Śamana (internal)	Sūtaśekhara rasa	2 tablets BD A/F	7 days	Continued pitta-śhamana/agnideepana support.	Review-level rationale.
Day 15–21 (Follow-up 2)	Śamana (internal)	Lodhra āsava	3–3–3 tsf with warm water A/F	7 days	Continued raktastambhaka support during the consolidation phase.	Lodhra traditional uterine/bleeding use described in reviews.
Day 15–21 (Follow-up 2)	Sthānika (local)	Udarlepa: Lodhra + Nāgakeśara + Yaṣṭimadhu	Lodhra 10 g + Nāgakeśara 10 g+ Yaṣṭimadhu 50 g, OD	7 days	Continued local support during the maintenance/spotting phase.	Lodhra traditional uterine/bleeding use described in reviews.
Day 15–21 (Follow-up 2)	Diet (Pathya)	Mudga yūṣa	200 mL BD B/F	7 days	Continued dietary support.	—

A/F = After food; B/F =Before food; BD = Twice daily; OD = Once daily; tsf = teaspoonful.

safety consideration that top-tier journals will expect to be addressed explicitly. Although no adverse events were documented during the 21-day treatment course, future reports should include renal function tests at baseline and follow-up, a systematic adverse-event checklist, documentation of counseling for red-flag symptoms (worsening pain, fever, urinary changes), and explicit assessment of the nephrotoxic potential of constituent herbal medicines. Transparently reporting safety data—even when reassuringly negative—strengthens the report's clinical utility and credibility.

5.3 | Implications for Future Research

The meaningful symptom reduction observed over 21 days in this carefully documented case contributes to the emerging hypothesis that integrative Ayurvedic protocols may offer symptomatic benefit in selected patients with postmenopausal AUB who decline or are not candidates for conventional interventions. These findings must, however, be interpreted strictly as hypothesis-generating. Future investigations should incorporate standardized bleeding assessment tools (PBAC or menstrual pictogram), objective hematologic outcome measures (serial hemoglobin and ferritin), histopathologic malignancy exclusion as a prerequisite, longer surveillance periods to assess recurrence, and, ultimately, randomized controlled designs to establish efficacy and safety with adequate scientific rigor.

6 | CONCLUSION

This CARE-aligned case report documents a 58-year-old postmenopausal woman with prolonged heavy uterine bleeding, pallor, and ultrasonographic endometrial thickening (10.9 mm) who demonstrated a marked, stepwise reduction in bleeding severity—from approximately 6–7 pads/day at baseline to mild spotting by Day 14—following a

Fig. 1: Stepwise 21-day integrative treatment pathway and response monitoring.
Stepwise 21-day integrative treatment pathway and response monitoring. After baseline evaluation (Day 1), therapy was delivered in three phases: Phase 1 (Days 1–7) included Udarlepa (Lodhra–Nāgakeśara–Yaṣṭimadhu) with internal formulations (Pushyanuga + Nāgakeśara + Śatāvarī cūrṇ a, Lodhra āsava, Śatāvarī kṣīrapāka) and Mudga yūṣa. At Day 7 review, bleeding reduced to 1–2 pads/day. Phase 2 (Days 8–14) included Muslikhadirādi kaṣāya and Sūtaśekhara rasa with continued Mudga yūṣa; at Day 14 review, only mild spotting was reported. Phase 3 (Days 15–21) consolidated response with Pushyanuga + Lodhra cūrṇ a, Syp. Amylcure, Muslikhadirādi kaṣāya, Sūtaśekhara rasa, Lodhra āsava, continued Udarlepa, and Mudga yūṣa, with Day 21 end assessment showing sustained mild spotting.

21-day integrative Ayurvedic protocol combining Śamana formulations and Sthānika Udarlepa (Table 2), guided by classical Raktapradara management principles (Table 3). Given the paramount diagnostic significance of postmenopausal bleeding and the clinical imperative to exclude endometrial malignancy, this single-case observation must be interpreted as hypothesis-generating only. Future studies incorporating standardized bleeding scores, histologic malignancy exclusion, objective safety monitoring, and longer follow-up are necessary to rigorously evaluate the role of integrative integrative Ayurvedic management in this clinically complex and high-stakes population.

7 | DECLARATIONS

Ethical Approval and Consent:

Written informed consent was obtained from the patient for publication of this case report and accompanying clinical details. Institutional ethical standards were adhered to in accordance with the Declaration of Helsinki.

Conflict of Interest:

The authors declare no conflict of interest.

Funding:

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Data Availability Statement:

All relevant data are included within the article.

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