Uterine Leiomyoma and its Homoeopathic Treatment: An Integrative Approach

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ABSTRACT

Uterine Leiomyomas, commonly know as Fibroids, are benign smooth muscle tumour of the uterus and represent one of the most prevalent gynaecological conditions in women of reproductive age. Conventional treatments often involve hormonal therapy or surgery, which may not always align with the patient's desire for fertility preservation and non-invasive management. This article explores the Uterine Leiomyoma from an integrative perspective, emphasizing the role of constitutional and Miasmatic homoeopathic treatment as a viable alternative for long- term management and symptomatic relief. This Article comprehensively summarizes the recent research advances on uterine fibroids, focusing on risk factors, development origin, pathogenetic mechanisms, and treatment options. Deeper mechanistic insights into tumour etiology and the complexity of uterine fibroids can contribute to the progress of newer targeted therapies.

Keywords: Uterine fibroids, Uterine Leiomyomas, homoeopathy treatment, Genetics, histopathology, genes 12 and14, Myoma uteri, Benign uterine tumour, Smooth muscle tumour uterus, Fibromyomas.

Abbreviations: HPF: high power fields

PID: Pelvic Inflammatory Diseases

MRI: Magnetic resonance imaging

CT: computed tomography

INTRODUCTION

Uterine Leiomyomas/ Fibromyomas (fibroids) are generally benign uterine neoplasms, commonly encountered in gynaecological practice (5-20% of women in the reproductive age group). They are slow growing tumours and takes 3-5 years to be clinically palpable, unlike ovarian tumours.[1]by age 50, it is estimated that 70% of women will have one or more uterine fibroids, which around 30% of patients symptomatic and requesting treatment. Women of all races are affected, but fibroids are common and develop at an earlier age, in women of African origin.[4] By the age 35 years, 60% of African-American women will have fibroids, compared 40% in Caucasian women of the same age. Other risk factors include age (increasing incidence with age up to the menopause, then usually decreasing in size), nulliparity, genetic factors, early menarche, caffeine, alcohol, obesity and Hypertension.[5]

The etiology is largely unknown, but they are oestrogen- and progesterone-dependent tumours, very rare before menarche, common in reproductive life, and frequently regress in size after menopause.(6) An imbalance in female hormones is the basic cause behind the growth of fibroids. Homeopathy tends to work on resolving the root cause that has caused fibroids to manifest itself and help stop further growth and aid shrinking of fibroids.

Usually, birth control pills are prescribed in conventional mode that only manages the symptoms and does not cure the disease and after discontinuing these hormonal pills the menstrual irregularity worsens. On the other hand, homeopathy in addition to managing symptoms also helps in shrinking fibroids aiding toward cure.

Homeopathy does not support the use of a specific medicine that can be prescribed in every case of uterine fibroids after ascertaining the diagnosis. Rather homeopathic medicines are prescribed by taking into consideration the peculiar characteristic symptoms of the patient. This is the key to finding the most suitable homeopathic medicine for any given case to bring recovery.

DEFINATION:

Uterine leiomyomas (fibroids) are benign monoclonal tumours of smooth muscles, taking origin in the myometrium. They are the commonest benign tumours of the uterus, and are typically round well-circumscribed masses. They are usually multiple, and can range in size from a few millimeters to massive growth of 20cm diameter and more.

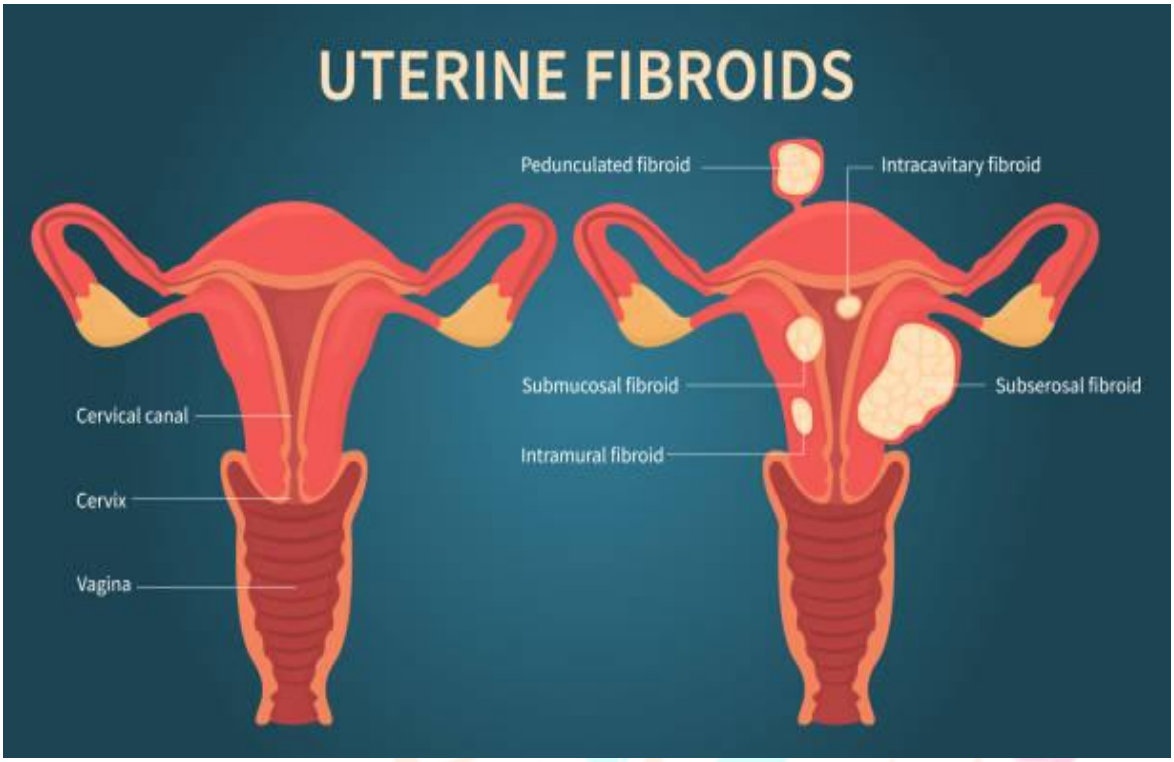
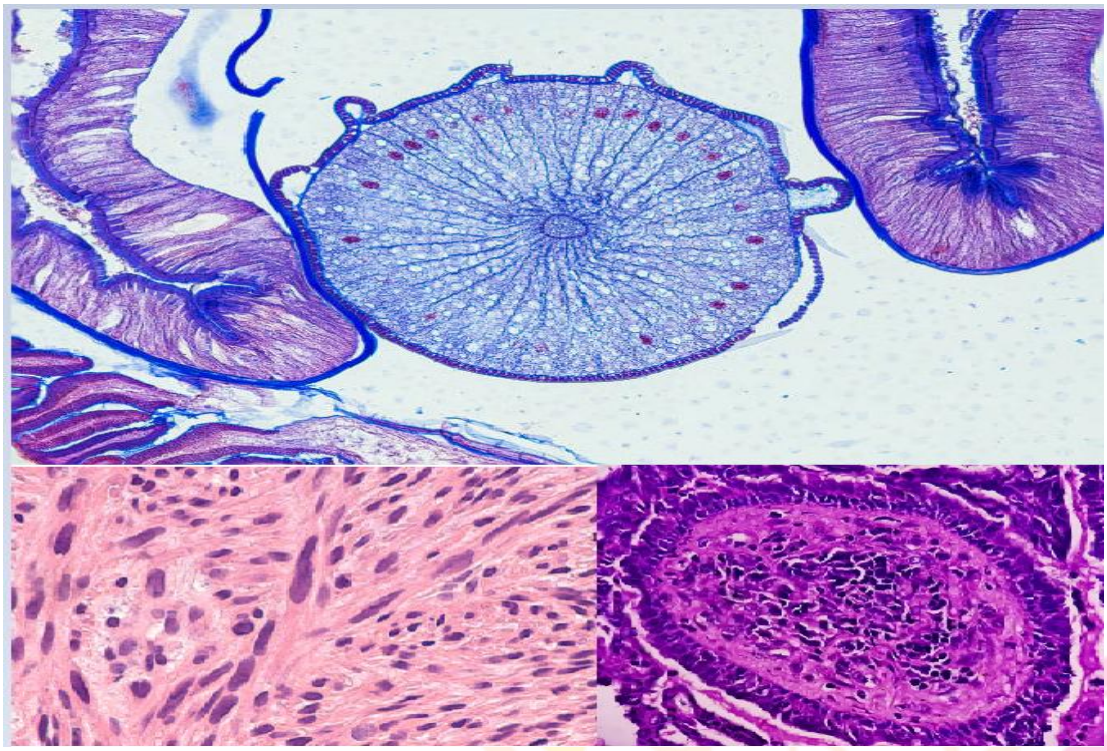


FIGURE 1: UTERINE FIBROIDS

FIGURE 2: SHOWING UTERINE FIBROIDS

HISTOPATHOLOGY:



As the fibroid grows, the cells differentiate into 4 different cells type that can be reliably characterized: Smooth muscle cells, Vascular smooth muscle cells, and two different subpopulations of Fibroblasts. It has been shown that all 4 cell types derive from a single clonal origin.(7)

Macroscopically, the lesions are usually multiple, pale, firm and rubbery, with a whorled cut surface, well demarcated from adjacent myometrium. There may be areas of mucoid change, hemorrhage, or necrosis and calcification visible on gross inspection. Microscopically, they are composed of spindle cells arranged in fascicles that interweave to form a circumscribed lesion. Mitotic activity may be observed, but there are usually less than 5 mitoses per 10 high power fields (HPF), and no atypical forms. Mitotic activity is significantly higher in the secretory phase of the cycle(8).

an observation that suggests importance of progesterone and its receptor PR in fibroid growth. There is a great degree of variability in the amount of extracellular matrix and collagen in fibroids, leading to considerable heterogeneity in histological patterns. Degenerative changes may be superimposed, including hyaline and myxoid change, hydropic degeneration, necrosis, and calcification.

Cellular leiomyoma is significantly more cellular than the usual type, but shows no nuclear atypia, a low mitotic index (4 or less mitoses per 10 HPF), and no necrosis. ***Leiomyoma with bizarre nuclei*** (previously termed atypical or symplastic leiomyoma) characteristically shows highly pleomorphic extremely bizarre nuclei, often in a background of more typical leiomyoma cells. Mitotic activity is usually low, but karyorrhexis may mimic atypical mitoses, and the histopathologist must be cautious not to diagnose sarcoma, as these are benign lesions. ***Mitotically active leiomyoma*** shows a high mitotic index (>10 mitoses per 10 HPF), but no other concerning features, with an absence of nuclear atypia and necrosis. ***Diffuse leiomyomatosis*** is a rare condition in which multitudes of benign-appearing leiomyomatous nodules blend with uterine smooth muscle,

and may extend beyond the uterus into the peritoneal cavity forming tumour-like nodules, grossly resembling disseminated gynaecological cancers. The process is benign, and surgical removal is curative.

LIFE CYCLE OF FIBROIDS:

A careful morphological review [9] led to the hypothesis that fibroid formation may represent an abnormal response to injury. This proposes that normal myometrium may be subject to repeated injury through vasoconstriction and hypoxia during menstruation, and that development of fibroids may represent a reaction to that injury.

Uterine fibroids have a self-limited life cycle of proliferative growth, synthesis of collagen, increasing deposition of extracellular matrix, decreasing vascularity, and ultimately senescence and involution through ischaemic degeneration and inanition [9].

Four phases in the life cycle of fibroids have been described, defined somewhat arbitrarily and representing a continuous process, progressing through phenotypic transformation of the proliferating contractile myocyte and evolutionary selection of a single clone. There is increasing deposition of collagen, and as the process of fibroid growth and development evolves, the phenotype of the clonally proliferating myocytes changes from contractile to collagen synthesizing, with significant elaboration of extracellular ground substance. Myocytes become separated from vessels by increased amounts of extracellular matrix, and angiogenesis does not keep up with the increasing size of the fibroid. Ischaemia eventually occurs, and there is cessation of myocyte proliferation and cellular atrophy. In the end stage, there is abundant hyaline matrix enclosing islands of atrophic myocytes, and there may be necrosis and calcification. Processes of cell death, resorption and reclamation now occur, termed ‘inanosis’ by the authors. These differ from necrosis and apoptosis in their morphology, in their long, protracted durations, and in the absence of any inflammatory or phagocytic response to cell death.

EPIDEMIOLOGY & RISK FACTORS:

The prevalence of uterine fibroids is increasing in some populations, such as in African American women.[10] They are slow growing tumours and takes 3-5 years to be clinically palpable, unlike ovarian tumours.[1]by age 50, it is estimated that 70% of women will have one or more uterine fibroids, which around 30% of patients symptomatic and requesting treatment. Women of all races are affected, but fibroids are common and develop at an earlier age, in women of African origin.[4] By the age 35 years, 60% of African-American women will have fibroids, compared 40% in Caucasian women of the same age. Other risk factors include age (increasing incidence with age up to the menopause, then usually decreasing in size), nulliparity, genetic factors, early menarche, caffeine, alcohol, obesity and Hypertension.[5]

1. AGE- Increasing age is a significant risk factor for uterine fibroids, especially among women at the premenopausal stage and those ≥ 40 years of age.[11,12,13] In several cases, adolescent patients had a translocation between chromosomes 12 and 14, which is a confirmed risk factor for uterine fibroid.[14,15] Women at the menopausal stage have shrunk uterine fibroid lesions and decreased sex hormones. Notably,

the use of hormonal replacement therapy may cause these lesions to regrow and may induce the 1st clinical symptoms of uterine fibroids.(16)

2. RACE & ETHNICITY: they are more common in white African and American women due to deficiency of vitamin D

3. OBESITY: Obesity is directly related to increased energy consumption and reduced physical activity.(17) Currently, obesity is the fifth leading cause of *death*(18). Several studies have found obesity as a significant risk factor for uterine fibroids development, which has been attributed to the metabolic functions of adipose tissues. Adipose tissues produce and release various cytokines and growth factors involved in regulating diverse physiological and pathological processes, including immunity and inflammation. Adrenal androgens are mostly metabolized by aromatase in adipose tissues to estrogens.

4. HYPERTENSION: There is a direct correlation between arterial hypertension and uterine fibroids. Increased diastolic blood pressure is associated with a higher risk of uterine fibroids, regardless of use of antihypertensive drugs .(19)

5. VITAMIN D DEFICIENCY: Vitamin D is a collective term for fat-soluble steroid compounds with pleiotropic solid influence in the human body Vitamin D is synthesized in the human skin from 7-dehydrocholesterol upon exposure to sunlight. Then, it is transported by the vitamin D-binding protein to the liver and kidneys, where it is converted to 25-hydroxyvitamin D [25(OH)D] and 1,25-dihydroxyvitamin D [1,25(OH)D], respectively, and ultimately carried to the target tissues.

6. DIET: diet rich in meet red, ham, beef have increased risk of fibroid.

7. SMOKING AND TISSUE INJURY.

AETIOLOGY OF LEIOMYOMA:

Each myoma is derived from the smooth muscle cell rests, either from vessel wall or uterine musculature. Although Oestrogen, Progesterone growth hormones and possibly Human Placental Lactogen have been implicated in the growth of myomas, the evidence in support of Oestrogen and Progesterone dependence for their growth is impressive.(1)

- Precise cause of fibroids is unknown (idiopathic).
- Genetics: fibroids are monoclonal and 40% have chromosome abnormalities that include-

❖ Translocation between chromosome no 10 and 14.

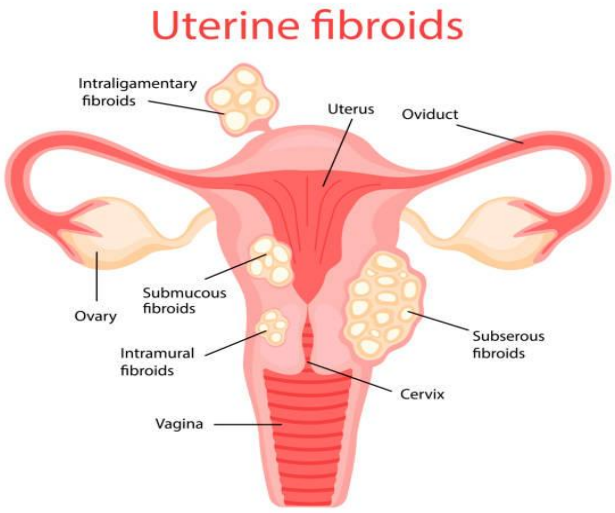
❖ Deletions of chromosomes 7

❖ Trisomy of chromosome no 12

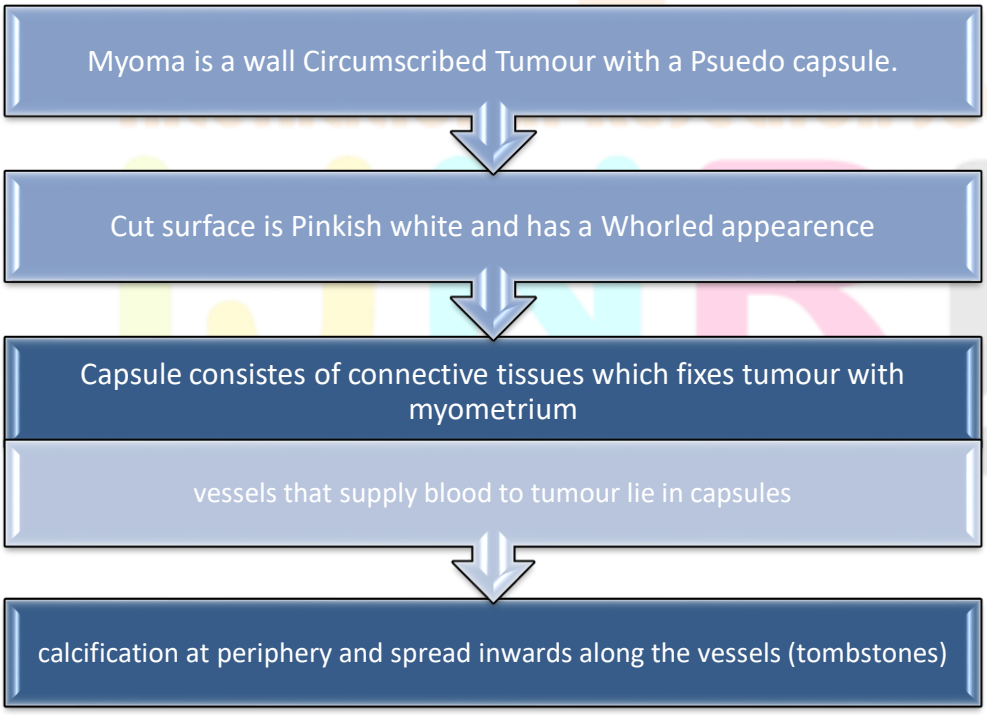
- Hormones: both increase in number and responsiveness of receptors for Oestrogen and Progesterone appear to promote fibroid growth.
- Growth Factor: Proteins Polypeptides produces locally by smooth muscles cells and fibroblasts appear to promote growth of fibroid.

LOCATION OF LEIOMYOMA:

1. Uterine Body: intramural or interstitial (75%).
2. Cervical: <5%.
3. Ligamentary: True/false broad ligament fibroid.
4. Extrauterine
5. Submucous (15%)
6. Subserous (10%)



PATHOLOGY OF FIBROID:



TYPES OF FIBROIDS:

Fibroids are classified based on their **location** in relation to the uterine wall:

1. Intramural Fibroid[1,2]

- **Location**: Within the muscular wall (myometrium) of the uterus.
- **Most common type**
- **Symptoms**: Menorrhagia, pressure symptoms.

2. Subserosal Fibroid[1]

- **Location**: Beneath the outer serosa surface of the uterus.
- May become **pedunculated** (on a stalk).
- **Symptoms**: Pressure effects (e.g., on bladder, rectum), less menstrual disturbance.

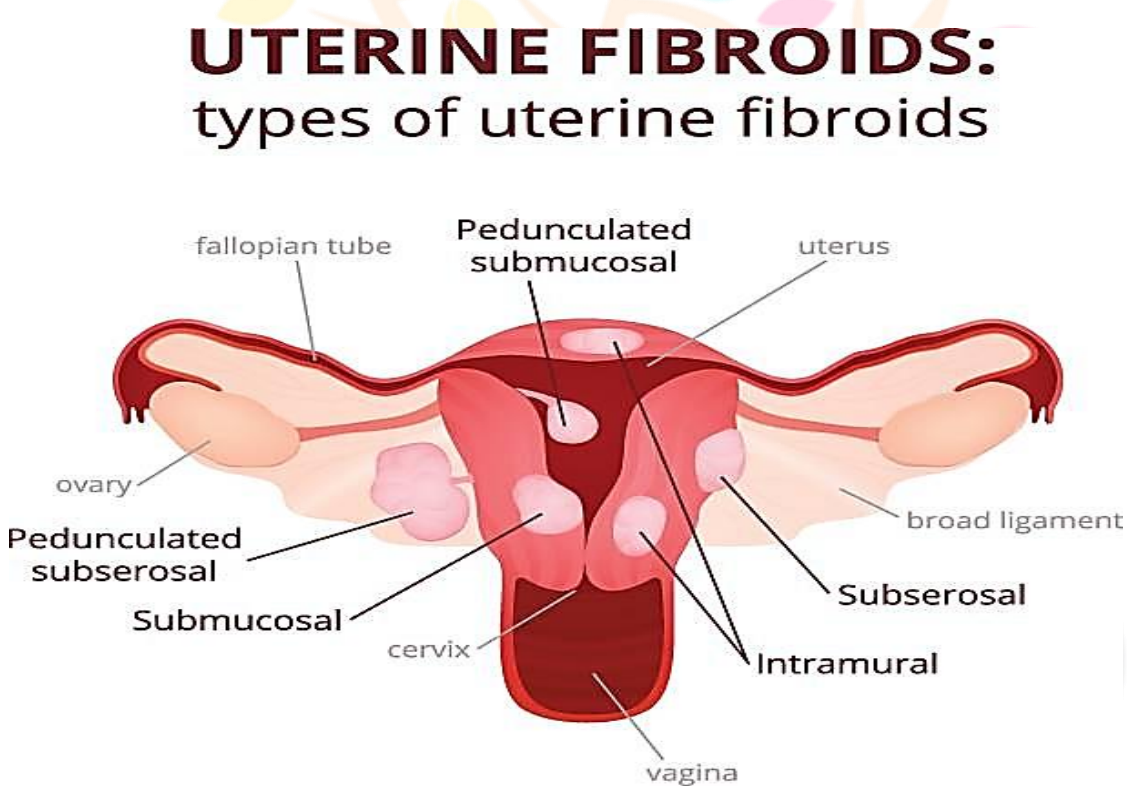


FIGURE 4: TYPES OF FIBROIDS

3. Submucosal Fibroid[2]

- **Location**: Just beneath the endometrium, protruding into the uterine cavity.
- May cause **heavy menstrual bleeding**, infertility, and recurrent miscarriage.

4. Cervical Fibroid[1]

- **Location**: Arises from the cervix rather than the body of the uterus.

- May cause **dyspareunia**, urinary symptoms, or obstructed labour.

5. Pedunculated Fibroid[2]

- A subtype of subserosal or submucosal fibroids **attached by a stalk**.
- Can undergo **torsion**, leading to acute pain.

6. Interfilamentous Fibroid[1]

- Grows **between the layers of the broad ligament**.
- May mimic an ovarian mass.

CLINICAL FEATURES OF LEIOMYOMAS:[1]

Symptoms depend on the size, number, and location of the fibroid, Fibroids are seen in childbearing age, 30-40years, nulliparous pr low parity, delay menopause in postmenopausal women

50% women are Asymptomatic most of the times.

- PROGRESSIVE MENORRHAGIA: seen in Intramural and sub-mucous myoma is due to increased vascularity. Endometrial hyperplasia and enlarged uterine cavity. Further away from the cavity. Lesser is the possibility of menopause. For this reason, subserous and Pedunculated fibroids do not cause menorrhagia.

- METORRHAGIA: is common with the Submucous fibroids. An infected polyp will also cause purulent discharge. Metrorrhagia in a woman over 40 requires D&C to rule out endometrial cancer, which is associated with fibroids in 3% cases.

- POLYMENORRHOEA: occurs when cystic ovaries and pelvic inflammatory diseases (PID) coexist with fibromyomas.

- INFERTILITY: Fibroids do not necessarily cause infertility. Infertility is either due to associated PID, endometriosis or anovulatory cycles or due to distortion of the uterine cavity causing obstruction to sperm ascent, poor nidation or cornual tubal block. A fibroid bigger than 4cm in size can cause infertility.

FIGURE 5 image shows a surgically removed large uterine fibroid about 22 cm

- PAIN: most women complaints of heaviness in the lower abdomen congestive and spasmodic dysmenorrhoea are often symptoms of fibroids or associated pelvic diseases. A submucous fibroid often causes spasmodic dysmenorrhoea. Acute pain is seen when a fibroid is complicated by torsion, haemorrhage, and red degeneration.

- PRESSURE SYMPTOMS: Anterior and Posterior fibroids lodged in the pouch of Douglas cause increase in frequency and retention of urine, more often premenstrually because of premenstrual gestion and enlargement of the tumour. Broad ligament fibroids can cause hydroureter and hydronephrosis which is reversible following surgery.

- ABDOMINAL LUMP: A large fibroid may be observed as an abdominal tumour which grows slowly or not at all over a long period. a rapid growth only occurs during pregnancy due to oral contraceptives hormones and malignancy. A pedunculated fibroid
  Feels separate from the uterus and gives the impression of an ovarian tumour.

- VAGINAL DISCHARGES: are rare symptoms and often is blood stained in a pedunculated submucous fibroid. Acute clinical conditions associated with uterine fibroid are:
  - Acute retention of urine and acute abdominal pain with red degenerative fibroids during pregnancy.
  - Rare case of thrombo-embolism.

- PHYSICAL SIGNS: Anaemia may be noted. An abdominal examination lump may be felt arising from the pelvis.
- Bimanual examination will reveal an enlarged uterus, regular or bossy depending upon the number of the tumours. The cervix moves with the swelling which is not felt separate from the uterus unless its pedunculated.

- In a Cervical fibroid, normal uterus is perched on top of the tumour. A broad ligament fibroid displaces the uterus to the opposite side.
- DEGENRATIVE CHANGES (SECONDARY CHANGES):

➢ Subserosal fluid.
➢ Atrophy
➢ Hyaline Degeneration
➢ Fatty Degeneration
➢ Red degeneration (aseptic necrobiosis)
➢ Saponification
➢ Cystic degeneration
➢ Calcification
➢ Haemorrhagic changes, torsion
➢ Sarcomatous changes
➢ Infection
➢ Endometrial cancer
➢ Inversion of uterus
➢ Follicular enlargement of ovaries
➢ Pedunculate fibroid

DIFFERENTIAL DIAGNOSIS OF LEIOMYOMAS:[1]

- Hematometra.
- Adenomyosis
- Bicornuate uterus
- Endometriosis, Chocolate cyst.
- Ectopic Pregnancy
- Chronic PID
- Benign ovarian tumour
- Endometrial cancer
- Pelvic kidney
- Pregnancy
- Malignant ovarian tumour
- Myxomatous polyps

INVESTIGATIONS OF LEIOMYOMAS:[1]

Uterine fibroids often are found by chance during a routine pelvic exam. Your doctor may feel irregular changes in the shape of your uterus, suggesting the presence of fibroids. f you have symptoms of uterine fibroids; you may need these tests:

1) **Haemoglobin and cbc.**
2) **ULTRASONOGRAPHY (USG):** well, defined rounded tumour, hypoechoic with cystic spaces.

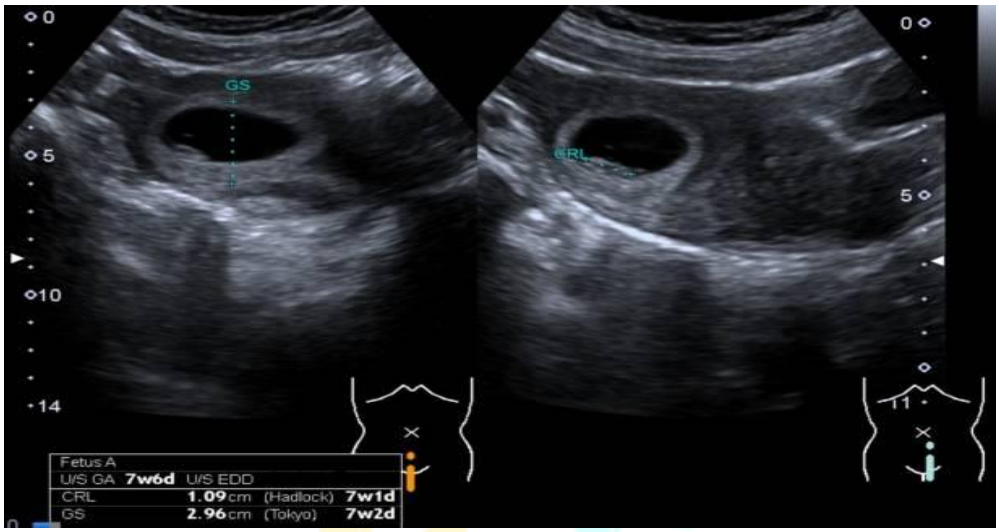


FIGURE 6: PICTURE SHOWS FIBROID SIZE IN **ULTRASONOGRAPHY**

3) **PA EXAMINATION:** fibroid within uterus larger than 12-14wks. Surfaces irregular, nodular, firm, no FHS.
4) **PELVIC EXAMINATION:** Enlarged uterus due to variable size, irregular surfaces. Cystic enlargement of ovary. Enlarged uterus and cervix more together.

5) HYSTERO-SALPHINGOGRAPHY & SONOSALPINOGRAPHY: IDENTIFIES A SUBMUCOUS MYOMA AND CHECKS THE PATENCY OF FALLOPIAN TUBES IN INFERTILITY.

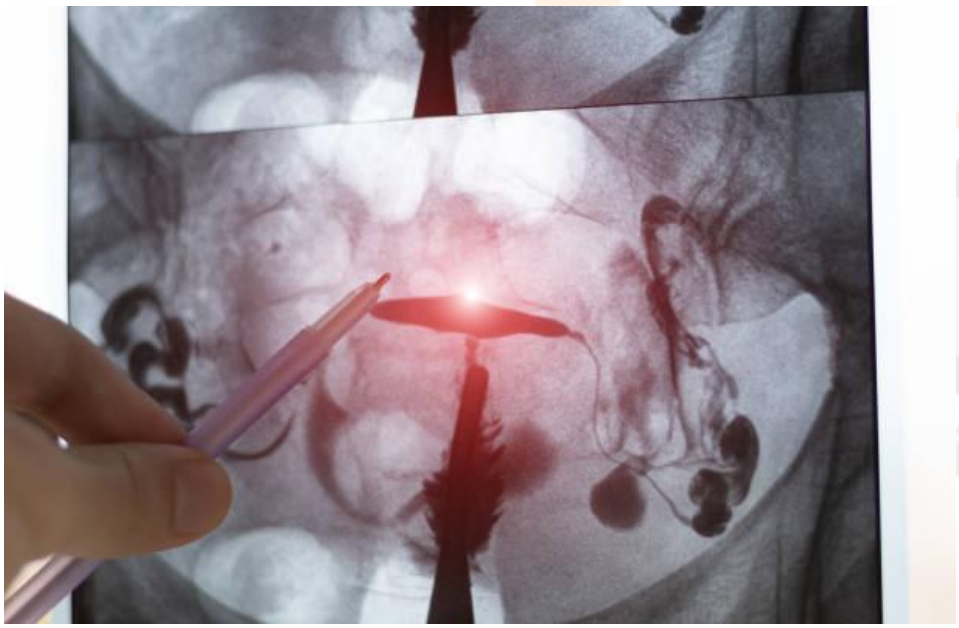


FIGURE 7: PICTURE SHOWING **HYSTERO-SALPHINGOGRAPHY**

6) **HYSTEROSCOPY: it not only recognizes** SUBMUCOUS polyp but also allow to rule out its excision under direct vision.

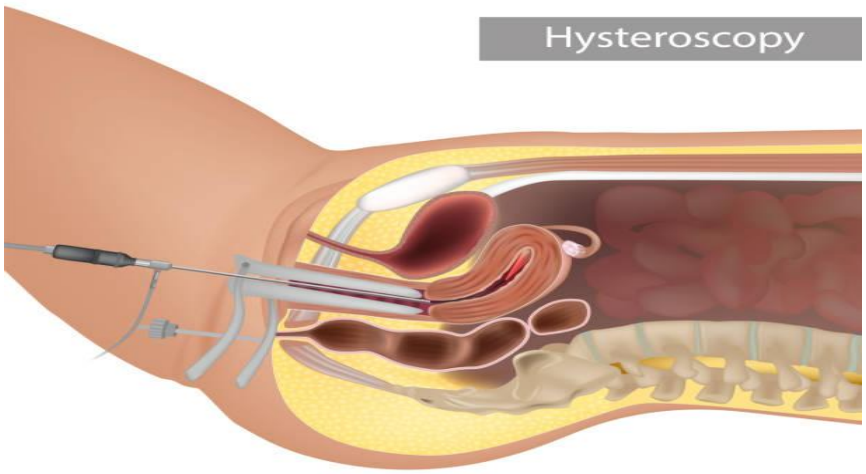
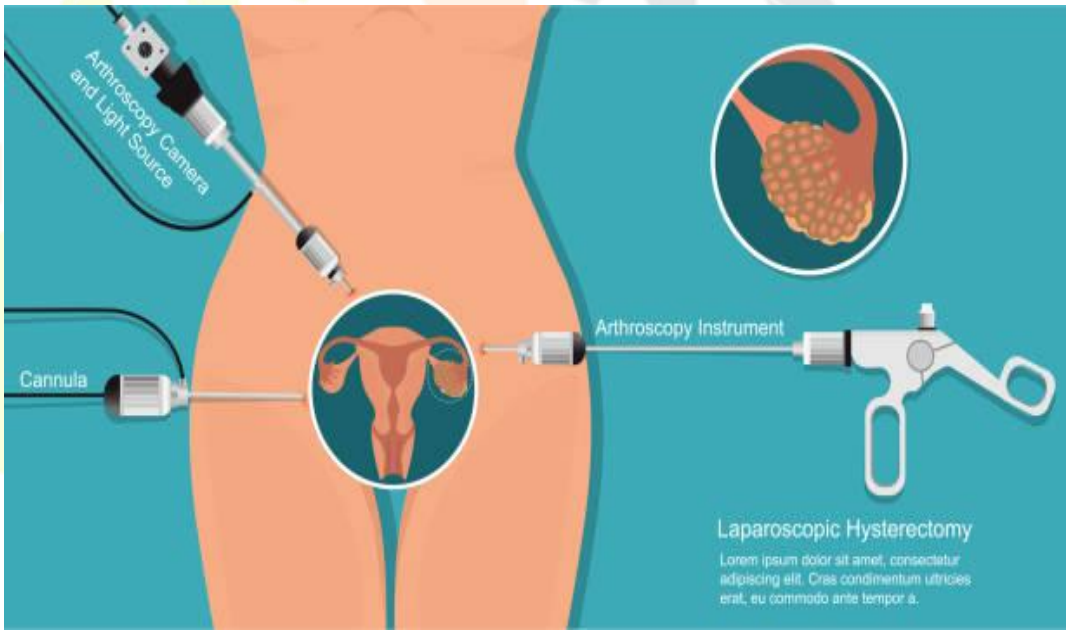


FIGURE 8: PICTURE SHOWING HYSTEROSCOPY

7) **D&C:** is required to rule out endometrial cancer.

8) **LEPRASCOPY:** is required in inversion of uterus while excising a myomatous polyp an to detect associated PID and endometriosis.



9) **CT SACN & MRI:** CT scan is not very useful but MRI is accurate in identifying adenomyosis and sarcoma

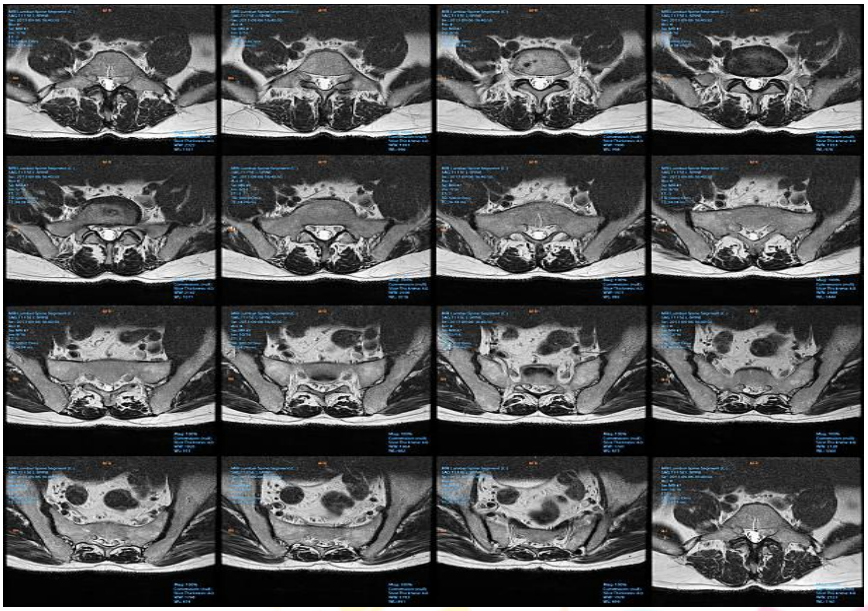


FIGURE 9: PICTURE SHOWING FIBROIDS IN MRI

10) **RADIOGRAPHY:** has been superseded by ultrasound. Calcification seen as peripheral calcified area is also seen in certain ovarian tumour, TB mass, calcified mucocele of appendix and bone tumour.

11) **INTRAVENOUS PYELOGRAHY:** is required for broad ligament fibroids to check the anatomy and pathology of ureter an to identify a pelvic kidney.

PREDOMINANT MIASM

SYCOSIS[20,21,22,23]

Reason why sycosis:

GENERAL

Feature in Uterine Fibroid	Sycotic Miasm Expression
Benign tumor of smooth muscle origin	Sycosis promotes abnormal cell proliferation and tissue hyperplasia
Fibrous induration and enlargement of uterus	Sycosis tends to produce indurations, nodular growths, and fibrosis
Chronicity and slow-growing nature	Sycotic miasm shows slow, insidious development of disease
Suppressed discharges or history of suppressed gonorrhea	Sycosis is often a result of suppressed infections
Hormonal imbalance (excess estrogen effect)	Sycosis reflects dysregulation of metabolic and hormonal processes

MANGEMENT

1. Watchful Waiting (Expectant Management)[2]

- Indicated for **asymptomatic fibroids**, especially small and slow-growing.
- Regular follow-up with **pelvic ultrasound** to monitor size and symptoms.

2. Medical Management[3]

Hormonal Treatments:

- **GnRH analogues**: Temporarily reduce fibroid size by inducing hypoestrogenism.
- **Progestins**, **combined oral contraceptives**: Control bleeding.
- **Tranexamic acid**, **NSAIDs**: For symptomatic relief of menorrhagia.

PROGNOSIS

- **Uterine fibroids are benign tumours** and rarely become malignant.
- Most fibroids **grow slowly** and may even shrink after menopause due to declining estrogen levels.
- Many women with fibroids remain **asymptomatic** and do not require treatment

HOMOEOPATHIC MANAGEMENT[24,25]

here is a highly impressive treatment in homeopathy for uterine fibroids. Initially homeopathic medicines aim to offer symptomatic relief in uterine fibroids. Symptoms such as heavy menstrual bleeding, prolonged periods, frequent periods, painful periods, and pelvic pain are wonderfully allayed with these medicines. Later, these medicines dissolve the fibroids gradually. homeopathic medicines through individualized approach work marvelously to the extent that they can even do away with the need for surgery in fibroids of mild to moderate size. Besides the above, infertility due to uterine fibroids can be treated with regular homeopathic treatment under the guidance of a homeopath with proper follow-ups.

Homeopathy fixes root cause

It is very necessary that to cure any disease the underlying cause be addressed. An imbalance in female hormones is the basic cause behind the growth of fibroids. Homeopathy tends to work on resolving the root cause that has caused fibroids to manifest itself and help stop further growth and aid shrinking of fibroids. Usually, birth control pills are prescribed in conventional mode that only manages the symptoms and does not cure the disease and after discontinuing these hormonal pills the menstrual irregularity worsens. On the other hand, homeopathy in addition to managing symptoms also helps in shrinking fibroids aiding toward cure.

Prescription as per characteristic symptoms

Homeopathy does not support the use of a specific medicine that can be prescribed in every case of uterine fibroids after ascertaining the diagnosis. Rather homeopathic medicines are prescribed by taking into consideration the peculiar characteristic symptoms of the patient. This is the key to finding the most suitable homeopathic medicine for any given case to bring recovery.

The top-ranked homeopathic medicines to treat leiomyoma include:

1. Erigeron Canadensis – For Frequent Urination in case of Uterine Fibroids

Erigeron Canadensis is a beneficial medicine for treating frequent urination in case of uterine fibroids. In some cases, painful urination may also arise. The attending features are excessive menstrual bleeding which is bright red in colour. Erigeron Canadensis is also used for inter-menstrual bleeding from slight exertion.

2. Calcarea Carb – For Heavy Periods from Uterine Fibroids

Calcarea Carb is a very useful medicine for treating heavy periods from uterine fibroids. Menses continue for long and may even appear early. Vertigo during menses may arise. Leucorrhea of thick, milky or yellow color is another complaint that may attend.

3. Sabina Officinalis – For Uterine Fibroids where Clots Pass with Menstrual Blood

In the case of menstrual bleeding with clots in uterine fibroid cases, Sabina Officinalis is a significant medicine. The slightest motion increases menstrual bleeding. Pain from sacrum to pubis is another attending feature. During menses, pain in the uterus may be present that gets better by lying on the back. Uterine pain may extend to the thighs. Other symptoms include foul, acrid, corrosive, yellow leucorrhea.

4. Sepia Officinalis – For Uterine Fibroids where Menses are Painful

Sepia Officinalis is well-indicated medicine for uterine fibroids where the menses are painful. Use of Sepia Officinalis is recommended in case of griping, burning or bearing down pains during menses. Menses start early and are quite copious. Fainting and chilliness during menses may attend. Sepia Officinalis is also indicated for treating painful intercourse in uterine fibroids cases.

5. Ustilago Maydis – For Uterine Fibroids with Dark Menstrual Bleeding

Ustilago Maydis is a highly suitable medicine for uterine fibroids where menstrual bleeding is dark. Clots may also be present in menstrual blood. Uterine bleeding may be stringy in nature.

6. Fraxinus Americana – Excellent Homeopathic medicine for uterine fibroids with bearing down sensation

Fraxinus Americana is a top grade medicine for uterine fibroids which is mostly recommended when the major indicating feature is a bearing down sensation in the pelvis from uterine fibroid.

7. Trillium Pendulum – For Uterine Fibroids with Back Pain during Menses

In uterine fibroid cases with back pain during the menstrual cycle, Trillium Pendulum comes highly recommended. The pain may radiate to the hips from the back during menses. Tight binding of the back and hips provides relief. Menstrual bleeding is bright red and gushing. The slightest movement worsens uterine bleeding. Trillium Pendulum is also indicated for inter-menstrual bleeding every two weeks.

8 Conium maculatum: - For uterine fibroid with irregular menses, too late and scanty.

Conium maculatum is a beneficial medicine for treating irregular menses in case of uterine fibroids. Uterine pain extending to thighs. Thermal chilly, food desires- coffee and aversion to bread.

9 Aurum Muriaticum Natronatum: - For uterine fibroid with indurations.

Pressure in right hypochondrium. Thermal-chilly, food desires- meat, salt, sweets. < from sitting and > from the motion.

10 Silicea: - For uterine fibroid with early and scanty menses.

Cutting pains around navel. Thermal-chilly, very thirsty, food desires- indigestible things and food aversion- meat.

CONCLUSION

Uterine fibroids, though benign, can significantly impact a woman's physical, emotional, and reproductive health. While modern medicine offers surgical and hormonal options for management, homeopathy provides a **gentle, holistic, and individualized approach** that addresses both the **local pathology** and the **underlying miasmatic state**. Homeopathy not only aims to reduce the size and impact of fibroids but also to restore **hormonal balance**, **regulate the menstrual cycle**, and **enhance overall well-being** without invasive procedures. Constitutional homeopathic remedies such as **Calcarea Carbonica**, **Sepia**, **Thlaspi bursa pastoris**, and **Fraxinus americana** have shown favorable outcomes in relieving symptoms like menorrhagia, pelvic pain, and pressure effects, and in preventing recurrence. Early intervention with proper remedy selection based on the totality of symptoms and miasmatic background can lead to lasting relief and improved quality of life.

REFERENCES

1 Padubidri VG, Daftary SN. *Shaw's Textbook of Gynaecology*. 16th ed. New Delhi: Elsevier; 2019.

2 Berek JS. *Berek & Novak's Gynaecology*. 16th ed. Philadelphia: Wolters Kluwer; 2022.

3 Stewart EA. Uterine fibroids. *Lancet*. 2001;357(9252):293–298.

4 Baird DD, Dunson DB, Hill MC, et al. : High cumulative incidence of uterine leiomyoma in black and white women: ultrasound evidence. *Am J Obstet Gynecol.* 2003;188(1):100–7. 10.1067/mob.2003.99

5 Donnez J, Dolmans M: Uterine fibroid management: from the present to the future. *Hum Reprod Update.* 2016;22(6):665–86. 10.1093/humupd/dmw023 [

6 Cramer SF, Patel A: The frequency of uterine leiomyomas. *Am J Clin Pathol.* 1990;94(4):435–8. 10.1093/ajcp/94.4.435

7 Holdsworth-Carson SJ, Zaitseva M, Vollenhoven BJ, et al. : Clonality of smooth muscle and fibroblast cell populations isolated from human fibroid and myometrial tissues. *Mol Hum Reprod.* 2014;20(3):250–9. 10.1093/molehr/gat083

8 Kawaguchi K, Fujii S, Konishi I, et al. : Mitotic activity in uterine leiomyomas during the menstrual cycle. *Am J Obstet Gynecol.* 1989;160(3):637–41. 10.1016/S0002-9378(89)80046-

9 Flake GP, Moore AB, Sutton D, et al. : The natural history of uterine leiomyomas: light and electron microscopic studies of fibroid phases, interstitial ischemia, inanosis, and reclamation. *Obstet Gynecol Int*. 2013;2013:528376. 10.1155/2013/528376

10 Lee M, Chung YJ, Kim HK, et al. Estimated prevalence and incidence of uterine leiomyoma, and its treatment trend in South Korean women for 12 years: a national population-based study. J Womens Health (Larchmt). 2021;30(7):1038-1046.

11 Faerstein E, Szklo M, Rosenshein N. Risk factors for uterine leiomyoma: a practice-based case-control study. I. African-American heritage, reproductive history, body size, and smoking. Am J Epidemiol. 2001;153(1):1-10

12 Marshall LM, Spiegelman D, Barbieri RL, et al. Variation in the incidence of uterine leiomyoma among premenopausal women by age and race. Obstet Gynecol. 1997;90(6):967-973.

13 Wise LA, Palmer JR, Stewart EA, Rosenberg L. Age-specific incidence rates for self-reported uterine leiomyomata in the Black Women's Health Study. Obstet Gynecol. 2005;105(3):563-568

14 Wright KN, Laufer MR. Leiomyomas in adolescents. Fertil Steril. 2011;95(7):2434.e15-2434.e17.

15 Moroni RM, Vieira CS, Ferriani RA, Reis RM, Nogueira AA, Brito LG. Presentation and treatment of uterine leiomyoma in adolescence: a systematic review. BMC Womens Health. 2015;15:4.

16 Yang CH, Lee JN, Hsu SC, Kuo CH, Tsai EM. Effect of hormone replacement therapy on uterine fibroids in postmenopausal women–a 3-year study. Maturitas. 2002;43(1):35-39.

17 Romieu I, Dossus L, Barquera S, et al. ; IARC working group on Energy Balance and Obesity. Energy balance and obesity: what are the main drivers? Cancer Causes Control. 2017;28(3):247-258.

18 Afzal S, Brøndum-Jacobsen P, Bojesen SE, Nordestgaard BG. Vitamin D concentration, obesity, and risk of diabetes: a Mendelian randomisation study. Lancet Diabetes Endocrinol. 2014;2(4):298-306.

19 Boynton-Jarrett R, Rich-Edwards J, Malspeis S, Missmer SA, Wright R. A prospective study of hypertension and risk of uterine leiomyomata. Am J Epidemiol. 2005;161(7):628-638

20 Allen JH. *The Chronic Miasms: Psora and Pseudo-Psora*. New Delhi: B. Jain Publishers; 2002.

21 Ortega P. *Notes on the Miasms*. New Delhi: National Homoeopathic Pharmacy; 1980.

22 Roberts HA. *The Principles and Art of Cure by Homoeopathy*. New Delhi: B. Jain Publishers; 2003.

23 Kent JT. *Lectures on Homoeopathic Philosophy*. New Delhi: B. Jain Publishers; 2004.

24 Boericke's W. *Pocket Manual of Homoeopathic Materia Medica and Repertory*. Revised edition. New Delhi: B. Jain Publishers; 2021.

25 Lilienthal S. *Homeopathic Therapeutics*. Reprint edition. New Delhi: B. Jain Publishers; 2006.