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HOMOEOPATHIC INSIGHT TO UTERINE FIBROID

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ABSTRACT

Uterine fibroids (leiomyomas) are the most common benign tumors of the uterus in women of reproductive age. They arise from smooth muscle cells of the myometrium and are influenced by hormonal and genetic factors, particularly mutations in the MED12 gene. Common symptoms include heavy menstrual bleeding, anemia, pelvic pain, infertility, recurrent miscarriages, and pressure symptoms. Fibroids are classified according to their anatomical location as submucosal, intramural, and subserosal . Diagnosis is mainly based on pelvic examination and ultrasonography, with MRI and hysteroscopy used when necessary. Management includes medical therapy, surgical procedures such as myomectomy, and minimally invasive approaches. Homoeopathy emphasizes individualized treatment based on the totality of symptoms, using remedies such as Calcarea carbonica, Sepia, Sabina, and Trillium pendulum. This review summarizes the etiology, classification, clinical features, diagnosis, complications, and management of uterine fibroids from both conventional and homoeopathic perspectives.

KEYWORDS

Uterine fibroids; Leiomyoma; Menorrhagia; Infertility; MED12 mutation; Ultrasonography; Myomectomy; Homoeopathy

INTRODUCTION

Uterine fibroids (leiomyomas) are the most common tumors in women and arise from smooth muscle cells of the myometrium. They affect about one-quarter of women of reproductive age and can lead to heavy menstrual bleeding, anemia, pelvic pain or pressure, pregnancy loss, and difficulties during labor.

With each ovulatory cycle, the myometrium responds to ovarian hormones—estradiol and progesterone—by increasing stem cell proliferation in preparation for possible pregnancy. During this repeated process, somatic mutations may occur, triggering tumor development.

Most fibroids harbor mutations in either the **MED12 gene (about 77%)** or the **HMGA2/HMGA1 genes (around 10%)**. MED12 encodes a chromatin-associated protein that is part of the Mediator complex. When one copy of this gene is mutated, it disrupts the associated CDK8 kinase module, leading to changes in gene regulation.

These alterations are linked to genomic instability, changes in chromatin organization, altered enhancer activity, and heightened sensitivity to progesterone. Progesterone, along with a small population of stem-like cells within the fibroid, plays a crucial role in sustaining tumor growth and survival.(1,2,3)

DEFINITION

Benign smooth muscle tumors of the uterus that affect women of reproductive age are known as uterine fibroids, also referred to as uterine leiomyomas or fibroids. Smooth muscle and fibroblast

components are found in fibroids. Heavy menstrual bleeding, which can result in anemia, exhaustion, or painful periods, is the most typical presenting symptom.(4)

Lower back pain, pelvic pressure and pain during sexual activity are other potential symptoms. When fibroids are larger than a particular size, pressure on the bladder or intestines may cause constipation, pain, or an increase in the frequency or retention of micturition. Reproductive issues like infertility, repeated miscarriages, and unfavorable obstetric outcomes may also be linked to uterine fibroids.(5, 6)

Classification of Uterine Fibroids

According to their anatomic locations, there are three different types of leiomyomas:

Subserosal or subperitoneal leiomyomata are the most common and are usually asymptomatic unless very large. They originate in the myometrium and grow out toward the serosal surface of the uterus, lying beneath the peritoneum [7]. They may lie just at the serosal surface of the uterus or may become pedunculated. They become parasitic when they derive their entire blood supply outside of the uterus, from omental vessels. Sometimes, their pedicles may atrophy and resorb. When they arise laterally, subserous tumours may extend between the two peritoneal layers of the broad ligament to become intraligamentary leiomyomas.

The uterine cavity and surface may be distorted by intramural or interstitial myomas, which are found inside the myometrium's uterine wall. Menorrhagia, infertility, and abdominal swelling are symptoms that may occur.(7)

Submucosal fibroids are the most likely to produce symptoms. They arise from the myometrium and grow inward toward the endometrial cavity, often protruding into and compressing the uterine cavity. Because they affect the endometrium and its blood supply, they commonly cause abnormal or heavy uterine bleeding.

Other associated symptoms include painful menstruation, infertility, and recurrent pregnancy loss. These fibroids may also become pedunculated and extend fully into the uterine cavity. In some cases, they can pass through the cervical canal while still attached to the uterus by a long stalk, where they are at risk of twisting (torsion) or becoming infected.(8)

Cervical leiomyomas are an uncommon form and are sometimes confused with vaginal leiomyomas because they can present with similar symptoms. They tend to produce early pressure effects around the bladder neck and may lead to infections, painful intercourse (dyspareunia), and infertility.(9)

With respect to the location of the fibroids, 89.4% submucous, 10.6% subserous and 74.5% were intramural according to a study done in Cameroon [10].

EPIDEMILOGY

Before puberty, uterine leiomyomata are rare. After that, the incidence significantly increases during the reproductive years and continues to rise when individuals age until menopause. It is estimated that between 20% and 40% of females of reproductive age have leiomyomata, with women in their fifth and sixth decades of life showing the highest occurrence.[36] Because hormones stimulate fibroid growth, premenopausal women have higher incidences of uterine leiomyomata than postmenopausal women (35,36).

Uterine leiomyomata are found in about 5% to 10% of women experiencing infertility. In approximately 2% to 4% of infertile women, these fibroids are considered the sole factor affecting fertility. (37,38)

INCIDENCE

Across four large US registry studies involving between 9,910 and 1,795,473 participants (median sample size: 42,098), the reported incidence of Uterine fibroids showed substantial variation. The California Teachers Study documented 217 cases per 100,000 women-years, whereas the Black Women's Health Study reported a much higher rate of 3,745 cases per 100,000 women-years. The higher incidence observed in the Black Women's Health Study, which exclusively enrolled Black women, contrasted with the lower rates reported in the California Teachers Study and Nurses' Health Study II, where Black participants accounted for only 3% and 1% of the study populations, respectively.(39,40)

Most studies, reporting incidence rates ranging from 845 to 3,745 cases per 100,000 women-years, were based on self-reported diagnoses confirmed by physicians through ultrasound or hysterectomy procedures. Uterine fibroids were found to have a higher reported incidence in studies that included pelvic examination as a diagnostic approach compared with those relying solely on ultrasound or hysterectomy.(41,42)

PREVELANCE

The reported prevalence of Uterine fibroids varied widely across studies, ranging from 4.5% to 68.6%. The differences in prevalence were not consistently associated with factors such as geographic region, participants' health status (healthy women versus women requiring gynecological care), study design (registry-based, single-center, or other observational studies), or duration of follow-up.(43,44)

ETIOLOGY

Uterine fibroids are benign monoclonal tumors originating from smooth muscle cells within the uterus.[19] The exact initiating factor of fibroid formation remains unclear.

Several molecular studies have identified specific gene mutations associated with leiomyomata, the most common of which is the *MED12* gene located on chromosome X at position q13.[20]
About 70% of uterine leiomyomas have a mutation in the MED12 gene, which codes for one of the essential proteins in the mediator complex (subunit 12) that controls RNA polymerase II.[21] High mobility group AT-hook 1 and 2 (HMGA1 and HMGA2) and collagen type IV alpha 4 and 6 (COL4A4 and COL4A6) are both more common mutations associated with leiomyomas.[22][23] Fumarate hydratase mutations increase the risk of hereditary leiomyomatosis and renal cell carcinoma (HLRCC) syndrome, which often manifests as uterine leiomyomata; however, HLRCC-related uterine leiomyomata are far less common than sporadic fibroids linked to MED12 mutations.
Additionally, research has shown that uterine leiomyomata are hormonally sensitive tumors that overexpress specific estrogen and progesterone receptors in comparison to the normal surrounding myometrium.[24]

RISK FACTORS

1. **RACE**

It is clear that African-American women are at greater risk to have uterine fibroids, especially when they are younger.(25)
Among women of African descent living in Europe, a comparable pattern has been reported, characterized by more severe symptoms and the need for surgical treatment at a younger age. In addition, recurrence following myomectomy may reach up to 59% within 4–5 years among women of African origin.(26,27)

2. AGE

Over a six-month period, the mean tumor growth rate was 9%; however, after controlling for age, growth patterns varied by race. White women < 35 years old showed rapid tumor growth than those over 45, with relatively slower growth. On the other hand, there is no age-related decline in the myoma growth rates among African American women.(28)

3. EARLY MENARCHE

Early menarche raises the risk of fibroids and is considered to be a risk factor for other hormonally related diseases like breast and endometrial malignancies. (29)

4. PARITY

Although the exact process is yet unknown, uterine fibroids have been reported to be prevented by pregnancy. It has been proposed that tiny lesions may undergo selective apoptosis during postpartum uterine remodeling. Additionally, fibroid tissue may be particularly vulnerable to ischemia after parturition and uterine remodeling. (31, 30)

5. CAFFINE, ALCOHOL

A study investigating the health of women of African origin reported a link between alcohol and caffeine consumption and an increased risk of developing uterine fibroids.(32)

6. OTHER FACTOR

The development of leiomyomas may be impacted by general health problems, including obesity and hypertension. Additionally, smoking has been connected to a lower incidence of leiomyomas, while a diet heavy in red meat has been linked to an increased risk, albeit the underlying mechanism is yet unknown.(33, 34)

PATHOPHYSIOLOGY

HISTOPATHOLOGY

Histological Examination Leiomyomata

Uterine fibroids consist of monoclonal smooth muscle cells and fibroblasts that have undergone microscopic changes influenced by sex steroid hormones. These altered cells show increased expression of progesterone receptors (mainly the PR-A isoform) and estrogen receptors (primarily ER-α). (11,12)

Histological examination of uterine leiomyomas reveals a prominent extracellular matrix made up of collagen, proteoglycans, and fibronectin, surrounding disorganized myometrial cells.(13,14) The cells typically exhibit a low rate of mitosis. Additionally, uterine leiomyomas are usually enclosed by a thin layer of areolar tissue along with compressed muscle fibers. (15,16)

Pathologic Classification

There are three types of uterine leiomyomata: submucosal, intramural, and subserosal. Intramural uterine leiomyomata are those which grow completely inside the myometrium. Subserosal leiomyomata are fibroids that

protrude superficially from just below the uterine serosa. The lower abdomen, pelvis, and sometimes the upper abdomen are prone to subserosal leiomyomata. On the other hand, submucosal uterine leiomyomata develop into the uterine cavity after emerging from the myometrium just deep to the endometrium. Pedunculated fibroids can also be subserosal and submucosal.

The International Federation of Gynecology and Obstetrics (FIGO) classifies uterine leiomyomata as follows:

- **Type 0**: Pedunculated intracavitary
- **Type 1**: Submucosal with < 50% intramural
- **Type 2**: Submucosal with ≥ 50% intramural
- **Type 3**: Located 100% intramural, though directly contacts the endometrium
- **Type 4**: Located 100% intramural without direct contact with the endometrium
- **Type 5**: Subserosal with ≥ 50% intramural
- **Type 6**: Subserosal with < 50% intramural
- **Type 7**: Subserosal, pedunculated outside the uterine body
- **Type 8**: Other, including cervical and parasitic [17][18]

CLINICAL FEATURES

During every ovulatory cycle, proliferating smooth muscle stem cells within the myometrium may acquire tumor-promoting somatic mutations that initiate the development of neoplastic changes.(45,46) Additionally, approximately 15–30% of women diagnosed with Uterine fibroids through ultrasound experience symptoms such as heavy menstrual bleeding, anemia, pelvic pain, implantation failure, or recurrent pregnancy loss.

The severity of symptoms associated with Uterine fibroids generally increases with the size of the fibroid and the extent to which it projects into the uterine cavity. Most symptomatic fibroids measure 3 cm or larger unless they directly involve the uterine cavity. While intracavitary fibroids affect the uterine cavity itself, intramural fibroids are primarily located within the myometrial wall and do not directly involve the endometrium. Nevertheless, they may still modify endometrial function and contribute to heavy menstrual bleeding through the release of bioactive substances or changes in uterine mechanotransduction properties.(47,48,49)

Subserosal fibroids are less likely to affect the endometrium or cause heavy menstrual bleeding because they develop toward the abdominal cavity. However, based on their size and location, these fibroids can exert pressure on nearby organs such as the bladder or rectum, leading to urinary or bowel symptoms, including constipation. In some cases, they may also mimic or obscure the presence of a malignant tumor.(50,51)

DIAGNOSIS

Pelvic examination

An enlarged uterus or tumor may be visible upon pelvic examination. A hemoglobin test can identify iron deficiency anemia if a woman reports heavy menstrual flow and fibroids are suspected.(52)

Ultrasonography

Ultrasound is considered the most dependable diagnostic method for detecting Uterine fibroids. Its broad availability allows for a simple and cost-effective confirmation of the condition in most cases. Ultrasonography is also useful for identifying submucosal myomas and assessing the proximity of intramural myomas to the endometrial cavity after saline infusion into the uterus. With advancements in three-dimensional imaging technology, 3D ultrasound has become an important modality for evaluating myometrial abnormalities, as it enables reconstruction of the uterine coronal plane.(53)

Hysteroscopy

Hysteroscopy may be required to differentiate large endometrial polyps from intracavitary Uterine fibroids. It is commonly performed on an outpatient basis and typically does not require anesthesia. When hysteroscopic myomectomy is planned, diagnostic hysteroscopy and saline infusion ultrasonography are generally considered complementary investigations rather than standalone tests. In addition, hysteroscopy can be combined with an endometrial biopsy in patients who present with abnormal uterine bleeding or have risk factors for endometrial hyperplasia, such as obesity or chronic anovulation.(52)

Magnetic Resonance Imaging

The number, size, vascularization, relationship to the endometrial cavity and serosal surface, and boundaries with normal myometrium of fibroids can all be assessed using magnetic resonance imaging (MRI). However, it should be emphasized that, similar to ultrasonography, MRI cannot definitively identify cancer. Although sarcoma may be suspected based on MRI findings, there is currently no preoperative test that can completely exclude it. The accuracy of detecting sarcoma, which remains a relatively rare condition (1/1,500 in women under 40 and 1/1,100 in women aged 40 to 44), may be improved in the future with the development of new imaging techniques.(56,57)

Laboratory Studies

For patients of reproductive age presenting with heavy menstrual bleeding (HMB) or abnormal uterine bleeding (AUB), the initial evaluation should include a beta-human chorionic gonadotropin (hCG) test to exclude pregnancy, a complete blood count (CBC) to assess for anemia, and measurements of thyroid-stimulating hormone (TSH) and prolactin levels to identify possible non-structural causes of AUB. In addition, patients with risk factors for endometrial cancer—such as obesity, chronic anovulation, or older age—should undergo an endometrial biopsy. [53, 54]

Complications

Non-obstetric Complications

Uterine fibroids can lead to any of the following complications:

- Chronic pelvic pain
- Heavy menstrual bleeding
- Anemia
- Infertility
- Sexual dysfunction
- Constipation
- Urinary tract infections or urinary incontinence

- Torsion of a pedunculated fibroid
- Degeneration with or without infection

Obstetric Complications

Although the evidence on obstetric complications related to uterine fibroids is mixed, studies indicate that fibroids may increase the risk of adverse outcomes such as preterm labor and birth, placental abruption, placenta previa, fetal malpresentation, preterm prelabor rupture of membranes, dysfunctional labor, cesarean delivery, and postpartum hemorrhage. [53,55][56][57]

Some studies suggest that an increased risk of preterm labor is most apparent when there are multiple fibroids, a fibroid is >5 cm in size, or the placenta is located near the fibroid. The exact reason for this association is unclear

MANAGEMENT

Fibroids can be treated with medicine, surgery, and interventional radiology. By shrinking the fibroids, reducing abnormal uterine flow, or possibly curing the fibroids, the treatment reduces discomfort [51]. Surgery is necessary to remove intramural fibroids, but it causes the uterus wall scarred, which may have an impact on future pregnancies. Therefore, the indications for surgery should be carefully considered.
Abnormal uterine bleeding can be treated with medication, although this method only has a temporary impact on fibroids. Gonadotropin-releasing hormone (GnRH) agonists or antagonists,
anti-progestins, progesterone-only therapies, combined hormonal contraceptives, selective progesterone receptor modulators (SPRMs), anti-fibrinolytic agents, and non-steroidal anti-inflammatory drugs (NSAIDs) are among the available medical treatments. GnRH agonists may occasionally be given prior to surgery to reduce fibroids and raise hemoglobin levels in patients who are experiencing symptoms. However, GnRH agonists cannot be administered for an extended period of time due to their adverse consequences [57]

Currently, hysteroscopic myomectomy is the gold standard for surgical treatment of submucosal fibroids (FIGO 0 and 1 fibroids) [58,59]. FIGO 2 fibroids are more difficult to resect and may require a two-stage treatment, especially if they are larger than 3 cm in size [60].

Laparoscopy or laparotomy are the most effective ways to remove intramural and subserosal fibroids (FIGO 3 fibroids and higher). When there are no contraindications, laparoscopic surgery is the primary option. Many gynecological surgeons view laparoscopic myomectomy as more challenging, but it has some advantages, including reduced postoperative pain, shorter hospital stays, reduced blood loss, and quicker recovery. Regarding reproductive outcomes, there was no discernible difference between the laparoscopic and abdominal approaches [52].

Contraindications to laparoscopic myomectomy include multiple fibroids (>4) at different sites of the uterus, requiring numerous incisions, and the presence of an intramural fibroid >10–12 cm in size or suspected of being a leiomyosarcoma [60].

Complex cases may include associated conditions such as adenomyosis or adenomyoma, as well as the excision of large intramural fibroids. The use of anti-adhesion agents may decrease postoperative adhesions. Pregnancy-related complications following myomectomy are primarily linked to myometrial weakness caused by extensive coagulation, inadequate suturing, or poor tissue healing, with uterine rupture occurring in approximately 1% of subsequent pregnancies.[61] Although leiomyosarcoma is uncommon in fibroids (<0.3%), concerns about tissue dissemination during morcellation continue to be widely debated.[60]

CONCLUSION

Uterine fibroids are the most frequent benign uterine tumours in females of reproductive age. Although benign in character they are associated with adverse outcomes such as miscarriages, aseptic necrobiosis, foetal mal-presentation, obstructed labour, premature births, caesarean sections, postpartum haemorrhage in pregnancy, and

an altered menstrual cycle, heavy menstrual bleeding, infertility, constipation, urinary incontinence, and malignant transformation in non-pregnant women. Through this chapter the authors sought to contribute to the scarce evidence on its idiopathic pathophysiology and present all its available management options.

Our master Dr. Hahnemann has said, there is no disease, but sick individual. Homoeopathy is a holistic approach of medicine, in which we treat patient as a whole, not a particular organ or disease. It is the individual who is sick. In aphorism 1 of Organon of medicine 5th and 6th edition written by Dr. Hahnemann, it is mentioned that, 'THE PHYSICIANS HIGH AND ONLY MISSION IS TO RESTORE THE SICK, TO HEALTH, TO CURE AS IT IS TERMED'. So depending on every individual case, the Homoeopathic medicine selected will be different. When a patient comes to homoeopathic physician, peculiar characteristic rare symptoms representing the patient as a whole is chosen and an individualized homoeopathic medicine is prescribed. (62)

HOMOEOPATHIC APPROACH

Homoeopathy is a system of Medicine Founded on a definitive Law "Similia Similibus Curantur" which means like cures like. The fundamental principles of Homoeopathy are embodied in a system of doctrines, laws, and rules of practice.
When pain alerts the brain to damage, it acts as a defense mechanism and a signal for disorder. Informing us about the internal health of the human body and guiding us towards the most appropriate treatment plan, it also functions as an instrument of Providence. Knowledge of lesser-known drugs is required for the homoeopathic clinical approach. Both main and minor types of drugs apply to its extensive range of therapies. A certain amount of strategic flexibility is required when applying homoeopathic concepts.
Polycrest and uncommon drugs are known to be listed in the rubrics of the repertory. Thus, it becomes imperative to take into account these lesser-known drugs. Prior to becoming a massive polycrest medication, each medicine in our Materia Medica must pass through a lower stage. These less well-known drugs are included in our Materia Medica because there isn't much information available about their ability to treat particular geographic conditions. (63).

HOMOEOPATHIC MANAGEMENT

1. **Calcarea Carbonica**

- Large, slow-growing fibroids
- Profuse, prolonged menses; obesity; chilliness
- Heavy, prolonged, and/or painful menstrual bleeding, which may include the passage of blood clots. This heavy bleeding can lead to weakness and anemia.
- Menstruation- Premature, profuse and protracted. Suppressed menses after working in water. Suppression of the menses in persons of full habit. Membranous dysmenorrhea. The least excitement causes the menses to return. Menstrual discharge light-colored or bright-red.[65]

2. **Sepia Officinalis**

- Bearing-down sensation in pelvis
- Hormonal imbalance, pelvic congestion
- Menstruation. Generally too early and too profuse and flowing only in the morning. Menses too early and too scanty and lasting only one day. Delaying menses which are too scanty when they do appear. Menses too scanty or suppressed. Menstruation regular but scanty and the flow dark. Menstrual discharge usually dark.

- Before Menstruation. Sadness and weeping. Violent colic with fainting. Goose-flesh over the whole body with shuddering. Painful sense of emptiness in the stomach.
- Melancholy mood in the morning.Great depression of spirits. Mania, with profuse menstruation. Lassitude. Great exhaustion in the morning. Great restlessness. Sleeplessness at night on account of tearing pain in the back, with shivering and heat, thirst and painful contractions in the chest.[65,66]

3. **Sabina**

- Bright red bleeding + dark clots
- Pain from sacrum to pubes. Menses too early and too profuse.
- Menstruation continuing too long. Debilitating menses with abdominal spasms. Menses superceded or followed by fetid leucorrhea. The menstrual discharge is partly fluid, partly clotted, and offensive, it may be either bright-red, or dark and coagulated. Flows mostly in paroxysms, which are brought on by the slightest motion, or it ceases when walking about. Profuse hemorrhage, consisting of thin, watery blood mixed with blackish clots. heavy or painful periods, bleeding between periods, pelvic pain, bloating, and frequent urination. [67]

4. **Belladonna**

- Sudden, violent pelvic pain
- Congested, hot uterus, acute attacks
- **ntense, sudden pain:** Acute, spasmodic, or cramping pain in the abdominal region during periods.
- **Bearing-down sensation:** A feeling as though the pelvic organs are being forced downwards, as if all viscera would protrude through the genitals.
- **Characteristic bleeding:** Menses that are profuse, bright red, and potentially have a foul odor. The blood flow may also feel hot.
- **Pain radiating:** Pains described as shooting or cutting, potentially moving from one hip to the other.[68]

5. **Phosphorus**

- Bright red bleeding, frequent metrorrhagia
- Bleeding tendency, anemia
- **Heavy menstrual bleeding** (menorrhagia), which can lead to anemia, fatigue, and weakness.
- **Prolonged periods**, lasting more than a week.
- **Pelvic pain or pressure**, and a feeling of fullness in the lower abdomen.
- **Frequent urination** or difficulty emptying the bladder, due to fibroids pressing on the bladder.
- **Constipation** or difficulty with bowel movements if fibroids press on the rectum.
- **Backache or leg pain** if fibroids press on nerves or blood vessels.
- **Pain during sexual intercourse**.

- **Reproductive issues**, such as difficulty getting pregnant, recurrent miscarriages, or complications during pregnancy and labor.[68]

6. **Trillium Pendulum**

- Severe hemorrhage with pelvic weakness
- Sensation as if hips are falling apart
- Menstruation. Premature and profuse. Gushing of bright-red blood from the uterus on the least movement. Profuse flow of dark, thick and clotted blood, continuing at intervals for several days.
- Profuse flow during the climacteric period, discharge dark, thick or clotted blood. Menses returning every fourteen days, in the intervening time, profuse leucorrhea of a yellowish color and creamy consistence. Menses often return after over-exertion, after riding, after too long a walk, etc. The menstrual discharge is at first bright, but later becomes pale from anæmia.
- **Excessive Bleeding:** It is primarily recommended for abnormal uterine bleeding (menorrhagia) that is profuse, bright red, and may occur frequently or between periods (metrorrhagia). The bleeding may gush with the slightest movement.

- **Pain and Discomfort:** It is used when bleeding is accompanied by severe menstrual cramps, low back pain, or a sensation that the hips and back are "falling to pieces".

- **Associated Symptoms:** Other symptoms that might indicate this remedy in homeopathy include weakness, dizziness, fainting spells, and a sensation of heat and burning in the stomach.

- **Uterine Prolapse:** It is also traditionally used in cases of uterine prolapse with a bearing-down sensation in the pelvic region. [65]

7. **China Officinalis**

- Anemia from chronic blood loss
- Weakness after heavy menses (supportive)
- **Profuse menstrual bleeding:** Characterized by heavy flow and the presence of clots.

- **Anemia:** Due to excessive blood loss, which can lead to fatigue and weakness.

- **Exhaustion and fainting spells:** Associated with the depletion from heavy bleeding.

- **Dark menstrual blood**. [68]

8. **Aurum Muriaticum Natronatum**

- Chronic uterine indurations
- Depression, heaviness in pelvis
- **Heavy menstrual bleeding** and prolonged periods.

- **Excessive pain** in the uterus during menstruation.

- **Bleeding between periods**.

- **Pelvic pressure** and a feeling of heaviness or discomfort.

- **Low back pain** and pain in the legs.

- **Pain during intercourse**.
- **Frequent urination** or trouble urinating due to pressure on the bladder.
- **Constipation**.
- **Glandular swellings[67,68]**

9. **Ustilago Maydis**

- Dark, stringy uterine bleeding
- Fibroid-associated metrorrhagia
- Menstruation. -Too frequent, too profuse and of too long dura-
- tion. Discharge of dark, fluid blood, intermixed with small, black coagule. Profuse gushes of bright-red blood. Persistent oozing of a dark, mahogany-colored, semi-fluid blood slightly coagulable, though occasionally forming long, black, stringy clots, similar to those indi-cating Crocus. Irregular menstruation. Scanty menstruation with ovarian irritation. Menses every three weeks, with dark coagulæ; profuse, with gushes of bright-red blood when rising from a seat or after having been startled or frightened. Active and constant flood-ing, with frequent clots of bright-red blood. Passive hæmorrhage, blood dark-colored, and continuing for a long time. Hæmatemesis in place of the menses. Vicarious menstruation.
- Before Menstruation. Heavy backache, with sharp pains across the abdomen, from hip to hip, followed by expulsive pains. The pain diminishes as the flow commences and stops with it. Al-buminous leucorrhea.[66]

10. Murex Purpurea

- Pelvic congestion with strong sexual excitement
- Fibroids causing pressure sensations.
- MUREX PURPUREA. (PURPLE SHELL-FISH.)
- Menstruation. Too early and too profuse, amounting to hæmorrhage. Menses profuse with soreness in the uterus. Patient lively and in good spirits. Menses intermit.
- During Menstruation. Sensation of uterine constriction.
- Sore pain in the uterus, as if cut with a sharp instrument, or violent pain in the right side of the uterus extending to the chest. Feeling of great heaviness in the vagina during menstrual colic. During profuse menstruation, there is a sensation of constriction in the uterus.
- **Heavy and irregular periods** with large clots and significant pain.
- **A sensation of bearing down** or uterine prolapse (a feeling that the womb is protruding or pushing out), sometimes relieved by crossing the legs or pressure.
- **Mental and emotional symptoms** such as great sadness, anxiety, or depression, which may alternate with physical symptoms.[66]

11. **Viburnum Opulus**

- Cramping pelvic pain
- Spasmodic dysmenorrhea from fibroids
- Menstruation. Too early, too profuse and offensive in odor.
- Discharge looks like jelly. Flow stains the napkins permanently. Menstruation retarded. Menses scanty, thin, light-colored and con-tinuing but a few days.
- Pain in the back gradually extending to the hypogastric region and down the thighs. Headache, nausea and uneasiness. Cramps and bearing-down pains before the discharge appears (J. C. King).

Spasmodic and membranous dysmenorrhœa. Excrutiating colicky pains through the womb and lower part of the abdomen, coming on suddenly just preceding the menstrual flow and sometimes lasting ten or twelve hours (Lilienthal). Backache as if it would break. Bearing-down sensation, as if the menses would appear. Congested feeling, as if the menses would soon come on. Pains in the ovaries.[67]

12. **Pulsatilla Nigricans**

- Delayed periods, changeable flow
- Better in open air; emotional sensitivity
- Pressure in the abdomen and small of the back as from a stone, with disposition of the lower limbs to go to sleep when sitting, attended with ineffectual desire for stool. Menstrual colic, with great restlessness, tossing about in every di-rection. The discharge flows by fits and starts. She feels worse in a close, warm room.

- The menstrual discharge is thick, viscous, black and coagu-lated, or pale and watery, or changeable. The discharge is very changeable in its appearance and is apt to flow intermittently. The menses flow only in the daytime, or more in the daytime and while she walks about, very little or none at all at night.

- Contractive pain in the left side of the uterus, obliging her to bend double. Pulling and pressure in the lower part of the uterus in the morning, with drowsiness. Uterine cramps, like labor-pains. Cut-ting pain in the os tince. Burning stitches in the vagina and labia.

- **General Modalities:**
    - Symptoms that are **changeable** in nature.
    - Feeling **better in fresh air** and an aversion to a stuffy room.
    - Thirstlessness despite a dry tongue.
- **Emotional and Mental State:**
    - A mild, gentle, and yielding disposition.
    - A strong tendency to **weep easily**, especially when telling her symptoms.
    - Desire for company and sympathy; symptoms may be aggravated by consolation.
    - May feel irritable, helpless, wearisome, or offended easily.

13. **Fraxinus Americana**

- Classic remedy for fibrous tumors of the uterus
- Enlarged uterus, bearing-down sensation, painfulness and heaviness of uterus.
- Fibroid with bearing-down sensations. [67]

14. **Thlaspi Bursa Pastoris**

- Profuse bleeding with clots, menses too frequent and copious.
- Haemorrhages dark bleeding and clotting with violent uterine colic and cramps, every alternate period very profuse.
- Sexual excitement.-Metrorrhagia; with uterine colic; in haemorrhagic chlorosis; in sequelae of abortion or labour.-Premature menstruation; first day she hardly had a show, second day a haemorrhage with severe colic and expulsion of clots, flow lasted eight to fifteen days, left a state of exhaustion which was not recovered from before the next period came on; this proved very profuse, next less so.
- Haemorrhages: with violent uterine colic and cramps; consequent on abortion; at critical age; with cancer of cervix; or fibroids.-Too frequent and copious menstruation, esp. in persons of a relaxed constitution.-Haemorrhages dark, with clots.[68]

15. Lachesis Mutus

- Left-sided fibroids or left-sided pain
- Menopausal bleeding; dark, clotted blood
- Menstruation suppressed.-Menstruation too scanty (blood black). Abdominal spasms during catamenia.
- Before menses: pains and throbbing in the head, vertigo, epistaxis, aching in stomach, risings, cuttings in hypogastrium, flow of mucus from urethra, and cramps in chest.
- Before and after menses, diarrhoea with violent colic.-Menstrual colic, beginning in l. ovary.-Swelling, induration, pain and other anomalies.[68]

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