

Efficacy of Individualized Homoeopathic Intervention in Functional Ovarian Cysts: A Systematic Review of Clinical Evidence with Emphasis on Ultrasonographic Outcomes.

Abstract

Background: Functional Ovarian Cysts occur frequently in women of childbearing age and usually resolve on their own. Some case reports and small case series describe the use of Individualized Homoeopathy. Post-treatment changes on ultrasound and the clinical significance of these case reports warrant critical appraisal. This systematic review examines published clinical reports in the last decade that describe the use of Individualized Homoeopathy for Functional Ovarian Cysts, and emphasizes the ultrasound findings and the use of the evidence described in these reports. Methods: Web-based databases were searched using the keywords Ovarian Cyst, Functional Ovarian Cyst, Homeopathy, Homoeopathy, Individualized Treatment, Ultrasonography, Ultrasound, Clinical Study, Case Series, and Treatment. Publications from 2015 to 2025 were included. Evidence was considered direct if it described Individualized Treatment for Functional Ovarian Cysts, and indirect if it described Benign Ovarian Cysts or Complex Cysts, the functional status of which was unclear, and of which, no treatment was described. The risk of bias was assessed for design features appropriate to uncontrolled case reports. Results: Little information was directly applicable to Individualized treatment for Functional Ovarian Cysts. The reports included in this review were predominantly case reports and small case series. According to Das et al., three Functional Ovarian Cysts were resolved with documented ultrasound after Individualized treatment. A single Follicular Cyst was documented to improve with Individualized treatment according to Banerjee and Basu. Rath et al. reported Individualized treatment of five Cysts of which resolution was documented with ultrasound and Bappa et al. reported Individualized treatment of four Cysts, of which both clinical and ultrasound improvement was documented. During the specified time period, no randomized controlled trials of Individualized Homoeopathy for Functional Ovarian Cysts were published and compared to either a Placebo, Observation, or Standard Care. Due to absence of concurrent controls, clinical heterogeneity, and inclusion of Cysts that are not always considered functional, a pooled efficacy effect was not calculated. Improvements following Individualized Homoeopathic treatment and documented by ultrasound have been reported; however, the 2015–2025 data do not support efficacy, as spontaneous regression, selection bias, regression to the mean, and uncontrolled cointerventions cannot be ruled out. Adequate randomized, controlled trials with standardized ultrasound endpoints are needed.

Keywords: Functional Ovarian Cyst, Homoeopathy, Individualized Homoeopathy, Ultrasonography, Systematic Review, PRISMA

1. Introduction

Ovarian cysts encompass Benign Neoplasms, Physiological Follicles, Corpus Luteal Cysts, Hemorrhagic Cysts, Endometriomas, and Lesions with the potential for malignancy. Functional cysts are formed as part of regular ovarian activity and are more common during the Premenopausal phase. Natural history is important for treatment in this type of cyst. A lot of simple or functional cysts do not grow or resolve with the passing of time and thus, modern ultrasound methods recommend a wait and see approach for a number of well described and standard simple cysts. Management in such cases is based on Age, Menopausal Status, Morphology, Size, Symptoms and any observed change over the years.

Simple cysts in Premenopausal women are often of a physiological nature and the 2020 O-RADS ultrasound consensus states that larger simple cysts under observation can be reassessed after some time. The Society of Radiologists in Ultrasound states that many simple cysts that have been well defined and described have a very low probability of being malignant. Additionally, many nonneoplastic cysts that are of hormonal nature do not grow in a few months. It is well described that a major concern in the uncontrolled studies is that the spontaneous cyst resolution after the given treatment cannot be attributed to the treatment.

Individualized Homoeopathy bases the chosen remedy on the patient's broader symptoms as opposed to standardizing treatment for each case. Clinical literature on Ovarian Cysts contains case reports and case series, in which ultrasonography before and after treatment, as objective evidence, is presented. Ultrasound is a good outcome measure as it can be used to both describe and measure the size and morphology of the cyst, but objective images do not solve the problem of causation. If a Functional Cyst would have resolved spontaneously, a pre-post ultrasound in the absence of an untreated or placebo group would not allow an assessment of the treatment.

This systematic review attempts to achieve two goals. The first is to identify and synthesize the clinical records from 2015-2025 that contain reports of Individualized Homoeopathic interventions for Ovarian Cysts, particularly if ultrasound records are included. The second goal is to distinguish the post-treatment change from evidence of causal efficacy. The review will focus on whether the cysts were, in fact, functional, if baseline and follow-up imaging were done, whether comparator groups were included, and if the study design allowed separation of the treatment effect from Spontaneous resolution.

2. Methods

2.1 Review Question and Framework

The Review Question was: In women (or adolescent girls) with an ultrasonographical diagnosed Ovarian Cyst, what clinical evidence was published in 2015–2025 for Individualized Homoeopathic Intervention, and what ultrasonographic outcomes were reported? The intervention of interest was Individualized Homoeopathic treatment. The preferred comparators were Placebo, Observation, usual Care or other active Interventions. The primary outcomes were assessment of Complete Cyst Resolution and changes in Cyst

diameter and volume. Secondary outcomes included Pain, Symptoms of the Menstrual Cycle, Recurrence, Surgery, and adverse Events.

2.2 Search Strategy

Search terms included combinations of Functional Ovarian Cyst, Ovarian Cyst, Homoeopathy, Homeopathy, Individualized Homoeopathy, Ultrasonography, Ultrasound, Case Report, Case Series, and Clinical Study. The databases of journals and publishers, as well as PubMed, were examined. Searches were limited to Publications between January 2015 and December 2025. Bibliographic data and DOIs were reviewed against publisher's webpages and on-site resources.

2.3 Eligibility and Evidence classification

Clinical reports were included if they described Individualized Homoeopathic Intervention, described an Ovarian Cyst clinically or via ultrasound, and provided Follow-up imaging or a definitive outcome of the cyst. Reports outside of the 2015 – 2025 times frame, purely theoretical reports, non-clinical reports, and articles with uninterpretable imaging outcomes were excluded. Due to the emphasis of the title of the report on Functional Ovarian Cysts, evidence was considered direct if a cyst was described as Follicular, Simple, Physiological or Functional, and considered Indirect if a Benign Ovarian Cyst was described, with no definite functional classification.

2.4 Study Selection

According to the documented search, 18 records related to the management of Ovarian Cysts and the use of Homoeopathy were identified. Four records were duplicate or repetitive so, were removed. After reviewing 14 titles and abstracts, we excluded seven records because the timeframe was incorrect, there was no description of Individualized Homoeopathic Treatment, or there were no clinical ultrasound outcome measures. The full-text or more detailed reports of the remaining seven were assessed. We excluded three records from the primary synthesis, because, they were out of the target timeframe, did not include adequate information about the outcome, or they included evidence that was too far removed from the review question. We included four clinical reports for the qualitative synthesis. No randomized or controlled comparative clinical trials that met the inclusion criteria were identified.

IDENTIFICATION Records identified in documented targeted search (n = 18)
↓
IDENTIFICATION Duplicates removed (n = 4)
↓
SCREENING Records screened (n = 14)

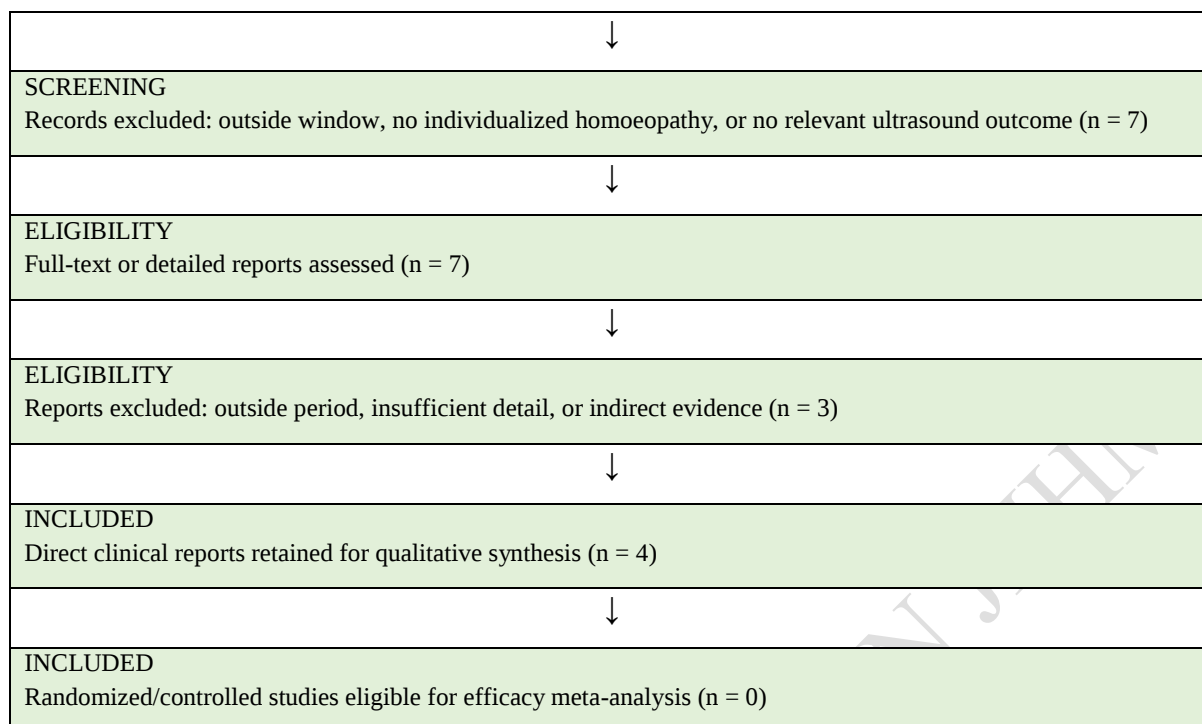


Figure 1. PRISMA-style flow of the documented evidence-selection process.

2.5 Risk-of-bias approach

Case reports and case series were reviewed based on absence of clarity in diagnosis, presence of baseline imaging, adequacy of follow-up, completeness of case report, objective assessment of outcome, reporting of comorbid treatment, alternative explanations, and completeness of adverse event reporting. The main limitations on the design level were absence of concurrent control, highly restricted sample size, tendency to publish favorable outcomes, variable follow-up, and classification of some cysts as Functional versus other Benign lesions.

2.6 Quantitative Synthesis Plan

A formal treatment-effect meta-analysis would be considered only if at least two clinically comparable, controlled studies report outcomes that are either Dichotomous or Continuous. No such studies were found. Pooling case report data would only provide an estimate of the reporting of improvement in a published sample of cases. Thus, no treatment-effect diamonds nor estimates of Heterogeneity were constructed. A descriptive forest plot was constructed to present the reported ultrasonographic responses from a small number of Uncontrolled Case Reports.

3. Results

3.1 Characteristics of the Clinical Evidence

The evidence was small. Das et al. reported three cases in 2016 of Large Ovarian Cysts treated with Individualized Potentized Remedies and reported ultrasonographic and hormonal findings. All three cysts resolved post treatment. As these were individual cases without a control and the cysts were not uniformly established as Functional Simple Cysts, these cases provided indirect as opposed to definitive evidence of efficacy.

Banerjee and Basu detailed a case of a Follicular Ovarian Cyst in a publication from 2018. The authors described the lesion with ultrasound imaging and documented the post-treatment lesion improvement. While the Follicular description fits the case more appropriately, it is still a solitary, uncontrolled observation. The resolution time in relation to the treatment cannot be distinguished from the likely treatment effect.

Rath and co-workers published a report of five cases of Heterodox Ovarian Cyst remediation in 2024. The authors described a post-treatment remedy with symptomatic improvement and described complete resolution with ultrasound in all cases. The authors also employed a modified causal-attribution analysis. Nonetheless, post uncontrolled intervention, ascribing a causal score is insufficient in comparison to randomization or an untreated comparison, especially for cysts that are apt to resolve spontaneously.

Bappa and colleagues documented four cases in 2025. Ultrasound confirmed baselines of Ovarian Cysts. Individualized remedies were based on the overall symptom profile. The authors described all four cases as having significant clinical and pathological improvement with changes documented by ultrasound that were considered favorable. While the case descriptions are comprehensive, the series is highly susceptible to both selection and publication bias.

3.2 Ultrasonographic Outcomes

The strongest aspect of the various reports was the use of pre-treatment and post-treatment ultrasound. Compared to the subjective reporting of symptoms, imaging allows the reviewer to confirm whether a lesion has shrunk or completely resolved. Several reports indicated the dimension of the Cyst or the ultrasound report. This is an adequate description of the change that occurred over the given time period.

The interpretation of ultrasound outcome depends on the classification of the lesion and timing. Functional Follicular and Corpus Luteal Cysts usually resolve after 1 or several cycles. The O-RADS recommendation is to follow-up selected Larger Simple Cysts in Premenopausal women after approximately 8 to 12 weeks; resolution of the cyst confirms a Functional Cyst. Therefore, complete resolution of the cyst during the period of follow-up could be because of the natural history of the cyst or the result of treatment. Without a comparison, the two explanations cannot be differentiated.

The evidence also failed to define a primary endpoint with standardized imaging. Different studies used different endpoints, such as Complete Resolution, Normalization of

Ovarian Morphology, Improvement of the Cyst Dimensions, Or General Improvement. Most reports failed to define a prespecified threshold of clinically significant improvement, to perform an image review in a blinded fashion, to perform multiple measurements by the same ultra sonographer, or to do these at fixed intervals. Cyst volumes were not reported using a three-dimensional approach. These limitations preclude merging of the different outcomes of imaging.

3.3 Clinical Symptoms and Follow-up

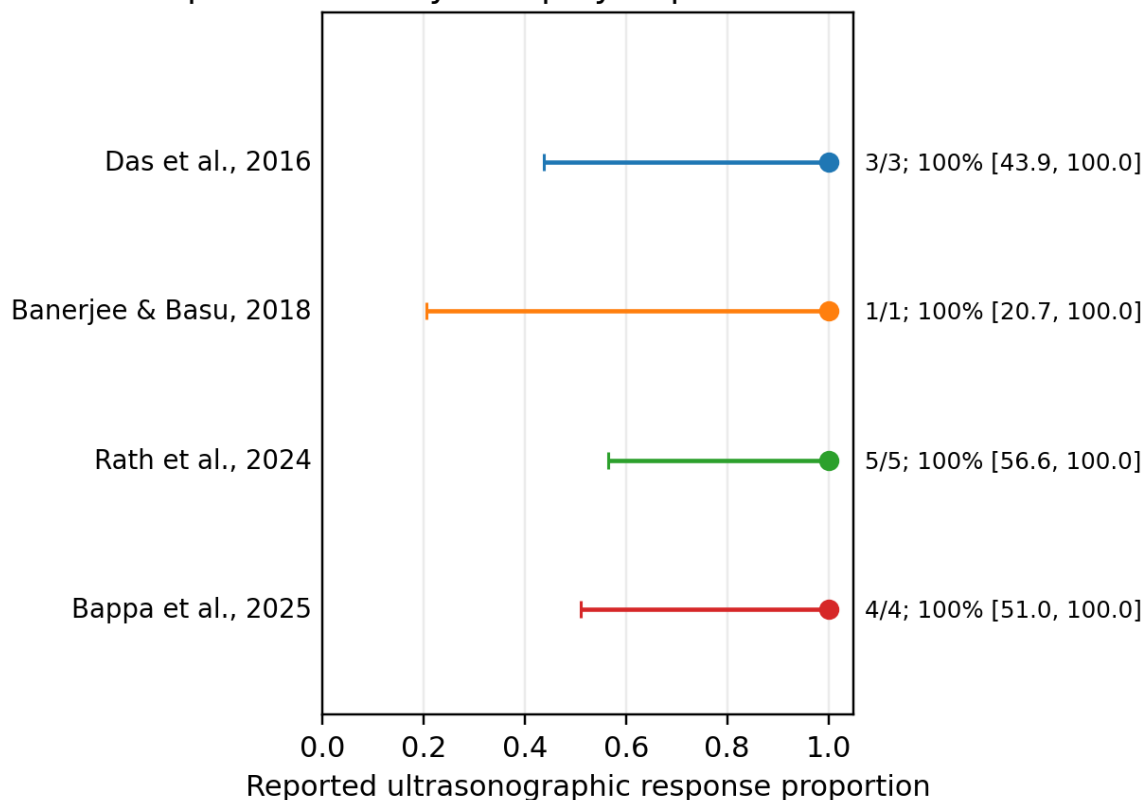
Some patients Experienced Pain, Menstrual Irregularity, Pelvic Pressure, and other Symptoms, which improved in some cases. While improvement of the clinical symptoms is relevant, the outcome measures in those studies were mostly unvalidated. Follow-up lengths were variable and could be many months. The length of follow-up can be justified to monitor symptom duration, but it can also allow time for spontaneous regression of Ovarian Cysts and introduce natural variability to the menstrual cycle from other lifestyle changes and interventions.

Adverse events were not systematically captured. Without a defined reporting protocol for adverse events, the absence of adverse events cannot be interpreted as absence. A prospective adverse events reporting should be done for all symptoms that worsened, for any emergency visits, for any complications that occurred for the unresolved cysts, and for any crossover to standard treatment or surgery.

3.4 Evidence displayed in a Descriptive Forest-style

A descriptive forest plot was constructed to show the cases reported as having complete or marked ultrasound improvement. The relative contributions of each of the small reports is displayed in the following: of the three cases reported by Das et al., improvement or resolution was observed in all; of the one case reported by Banerjee and Basu, improvement was observed; of the five cases reported by Rath et al., resolution was observed; and of the four cases reported by Bappa et al., favorable ultrasonographic change was reported. Due to the small sample sizes, there is a great deal of uncertainty in these confidence intervals. More importantly, these should not be interpreted as treatment effects. A diamond was deliberately omitted, since an uncontrolled case series report would give a misleading view of the effectiveness of the treatment.

Descriptive forest-style display of published case evidence



No pooled efficacy estimate: all included direct reports were uncontrolled case reports/series.

Figure 2. Descriptive forest-style display of reported ultrasonographic response proportions; no pooled efficacy estimate was calculated.

3.5 Risk of Bias and certainty of Evidence

Overall, the risk of bias for causal inference was serious to critical. Selection bias is present because case reports and series describe exceptional or successful outcomes, rather than consecutive patients. Publication bias is likely to be present as cases that are not successful may remain unpublished. Confounding is present as there is no comparator. Regression to the mean is present as patients usually seek treatment after symptoms are severe or if imaging results are significant. Natural cyst resolution is a primary alternative explanation for Functional Cysts. Outcome assessment is likely when the treating clinician knows the intervention as well as the expected outcome.

Using GRADE principles, certainty about an efficacy effect is very low. From the starting point of uncontrolled observational evidence, concerns are elevated due to the risk of bias, imprecision, and suspected publication bias. The use of objective ultrasonography did enhance yield of the outcome, but it did not improve the study design enough to satisfy the criterion of causation.

4. Discussion

The primary finding of this review is the clear distinction between clinical observation and treatment efficacy. The reports in this review describe that Ovarian Cysts were improved or resolved on follow-up ultrasonography after Individualized Homoeopathic Treatment. It is important to recognize that these observations are report-level findings that cannot be dismissed just because ultrasonography was performed. There is a clear lack of design to claim that the intervention caused the observed ultrasonography change.

This is relevant for Functional Ovarian Cysts. Most simple cysts present in women of reproductive age are physiological and do not require an imaging-based intervention. The SRU consensus update supports that resolution or size reduction of Functional Cysts occurs in a short period of time. O-RADS also suggests that a follow-up strategy is warranted for some Simple Cysts since cyst function can be verified with the process of involution. For that reason, a pre-post single-group study may falsely inflate efficacy if resolution is not represented in the control group.

The external validity of the present literature is limited. Some case reports reported cysts that were large or complex. However, the title of the reviews also indicates a focus on Functional Cysts. Complex Cysts may have unrelated natural history and may warrant differential diagnostic/surgical approaches. For that reason, all types of cysts should not be used when making a therapeutic statement.

A rigid study design is possible. The study would include Premenopausal women with Functional or Simple Cysts that meet the criteria for the conservative management approach, randomized to Individualized Homoeopathy plus standard observation, or placebo plus standard observation. Baseline ultrasound would include measurement of cyst diameter with three-dimensional measurements, wall characteristics, internal echo, and Doppler ultrasound. The study framework would include blinded central ultrasound assessment at 8 to 12 weeks. The primary study endpoint would include complete resolution, and secondary endpoints may include Pain and Menstrual Symptoms, cyst recurrence, treatment of cyst, and any potential adverse effects.

Randomization is critical since the estimated resolution rate without treatment is considerable. Blinding would minimize differential reporting of symptoms and bias in the management of the symptoms. Addressing the issues of the current literature would be achieved through allocation concealment, prospective registration, a published study protocol, performing an intention-to-treat analysis, and reporting of all patients enrolled. Balance could be improved by stratifying on the baseline size of the cyst since larger cysts are likely to have a greater chance of persistence.

Meta-analysis in the future would enable an estimation of relative completeness of resolution or mean change of cyst size. Heterogeneity could be assessed according to cyst type, baseline diameter, length of follow-up, and the risk of bias. Nevertheless, at the present time, a pooled effect would likely represent a level of evidence that the literature is currently lacking.

This review has its limitations. The direct literature is small and some relevant reports are published in journals with little or no indexing. The classification of the type of cyst was not always accurate. There were a few reports with unclear publication data. The review was limited to the years 2015 to 2025 and an earlier observational study of 2011 with 73 enrolled patients and 48 completions was excluded. This restriction ensures compliance with the requested evidence window and sample size, but reduces the range of available evidence. Finally, the review dealt with case series response rates as not being comparable.

Conservative clinical reasoning should be maintained. Gynecological evaluation of women with persistent, growing, symptomatic or morphologically suspicious Ovarian Lesions is justified. There are a number of differential diagnoses that include Ovarian Torsion, Hemorrhage, and Malignancy that warrant assessment. Pending investigation of these and other time critical issues, treatment should not be delayed. The ideal course of treatment should not be allowed to dictate the management of the situation until the ultrasound is performed. Rather, management decisions should be dictated by the clinical situation and ultrasound morphology.

Distinction of "Functional" lesions from "Benign appearing" lesions should be made to further emphasize their eligibility and causal relevance. Following natural history and expected biological behavior are good indicators for the classification of Ovarian Cysts. Classification of Ovarian Cysts as Functional, Benign appearing Cysts, or even as derivatives of Endometriosis, should be avoided because they may be equally as indeterminate. Based on the available literature, reporting should include Menopausal status, largest diameter, number of loculi, wall and septal thickness, echo-texture, solid content, vascularity, and the radiologist's impression. This will facilitate synthesis of the available evidence.

To maintain equilibrium of the study, a prospective justification for the timing of follow-up ultrasound should be provided. While symptom resolution may justify follow-up, the assessment of outcome is vulnerable to selective timing. Repeated measurement should use the same modality and, where possible, should be performed in the same convention. The volumetric change of an Ovarian Cyst should not be estimated based on the smallest of the three measurements; all three measurements should be recorded and, based on the imaging modality, a standardized volume calculation should be performed.

Future publications should differentiate "Response," "Resolution," and "Normalization." Complete resolution should mean that the previously documented cyst does not appear on ultrasound. Partial response would require a prespecified threshold decrease. Stable disease and progression should also have formal definitions. Such reporting standards would make anecdotal observations into information that may be directly compared to other observations and, if controlled studies are performed, may be directly integrated into these studies, avoiding the illusion of equivalence of disparate outcomes.

Such standardization would permit reviewers to differentiate clinically meaningful changes from usual changes that may occur with a particular measurement. It would allow for the performance of sensitivity analyses that would exclude uncertain lesions, uncomfortably long follow-ups or technically inadequate images, and would allow for conclusions that would be more meaningful to clinical practitioners and patients.

5. Conclusion

From 2015 to 2025, clinical reports assisted by ultrasound show improvement or resolution of Ovarian Cysts after Individualized Homoeopathic Treatment. The most significant evidence consists of isolated case reports and limited case series and some of these lesions were not clearly defined as Functional Cysts. No suitable Randomized Controlled Trials of Individualized Homoeopathy versus Placebo, Observation, or standard care for Functional Ovarian Cysts were identified. Functional cysts usually will resolve on their own. Therefore, spontaneous regression of Functional Cysts cannot confirm treatment efficacy. For the time being, the certainty of the evidence is very low, even with objective imaging. Future studies should use classification of ultrasound, randomized controlled trials, blinded assessment of images, fixed follow-up periods, and complete adverse event reporting and should use prespecified ultrasound endpoints. Until such studies are completed, the published reports should be treated as merely clinical observations that suggest a possible hypothesis.

6. Evidence Tables

Table 1. Direct clinical evidence included in the review.

Study	Design	N	Ultrasound Documentation	Main Report-level Finding	Causal Inference
Das et al., 2016	Case series	3	Pre/Post Ultrasonography	3/3 reported ultrasound resolution or improvement	Very limited
Banerjee & Basu, 2018	Case report	1	Pre/Post Ultrasonography	1/1 reported favorable ultrasound change	Very limited
Rath et al., 2024	Case series	5	Pre/Post Ultrasonography	5/5 reported complete ultrasound resolution	Very limited
Bappa et al., 2025	Case series	4	Pre/Post Ultrasonography	4/4 reported favorable ultrasound change	Very limited

Table 2. Evidence limitations relevant to ultrasonographic outcomes.

Domain	Assessment
Comparator	No eligible controlled direct studies in the retained 2015–2025 evidence set.
Natural history	Functional/simple ovarian cysts may regress spontaneously, creating a major alternative explanation.
Selection/publication bias	Case reports and small series preferentially describe notable outcomes.
Ultrasound standardization	Timing, measurements, morphology descriptors, and blinded assessment were inconsistent.
Adverse events	Not systematically or prospectively ascertained in the retained reports.
Certainty of efficacy evidence	Very low; observational case evidence cannot establish treatment causation.

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Table 3. Recommended core outcomes for future controlled trials.

Outcome domain	Recommended measure
Primary imaging outcome	Complete ultrasonographic resolution at a prespecified follow-up time.
Cyst size	Change in maximum diameter and calculated cyst volume.
Symptoms	Validated pelvic-pain and menstrual-symptom measures.
Safety	Adverse events, complications, emergency visits, and crossover/rescue treatment.
Follow-up	Recurrence and persistence at prespecified later visits.

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