IJARSCT
International Journal of Advanced Research in Science, Communication and Technology
International Open-Access, Double-Blind, Peer-Reviewed, Refereed, Multidisciplinary Online Journal
ISSN: 2581-9429
Volume 6, Issue 1, November 2026
Impact Factor: 8.2

Role of Homoeopathic Medicine Oophorinumin Treating Ovarian Cyst– An Evidence-Based Case Report

Dr Ruchimehta[1], Dr Bithi Roy[2], Dr Shivani Mishra[3], Dr Kirtika Tyagi[3], Dr Monika Choudhary[3]
[1]Associate Professor, Phd Homoeopathy, Department of Obstetrics & Gynaecology
[2]Sr. Consultant, NCH
[3]PG Scholar, Department of Homoeopathic Materia Medica
Dr. MPK Homoeopathic Medical College, Hospital and Research Centre, Jaipur, Rajasthan

Abstract: ***Background:*** *Ovarian cysts are common benign gynaecological conditions and may coexist with endometrial hyperplasia, leading to heavy menstrual bleeding and hormonal imbalance. Individualised homoeopathic medicine offers a holistic approach in such complex presentations.*
Case summary: *A 40-year-old female presented with heavy, profuse menstrual bleeding. Ultrasonography confirmed a left ovarian cyst with endometrial hyperplasia. An individualised homoeopathic medicine was selected after a detailed case analysis and given as an intercurrent later; however, due to the marked ovarian involvement, Oophorinum 30C was introduced early as an organ-specific remedy, given its recognised affinity for ovarian and hormonal dysfunctions in classical homoeopathic literature.*
Conclusion*: Over a period of 5 months, Oophorinum play a key role, contributing to a marked improvement in complaints and overall hormonal balance. The coordinated use of organ-specific Oophorinum with individualised homoeopathic treatment as an intercurrent remedy resulted in consistent clinical progress and favourable symptomatic outcomes.*

Keywords: Ovarian cyst, Endometrial hyperplasia, homoeopathy, menorrhagia

I. INTRODUCTION

Ovarian cysts are benign growths originating from the ovary. Ovarian cysts are commonly seen in women throughout their lifetime, occurring at any age from menarche to menopause. They are divided into three main groups: functional, benign and malignant. Gradual abdominal distension accompanied by a dull ache may serve as the initial presenting symptom. Menstrual irregularities are generally absent. However, pressure-related symptoms, such as increased urinary frequency and retention, may occasionally be evident; nonetheless, most cases remain asymptomatic. There is only minimal evidence to suggest that benign ovarian cysts may undergo malignant transformation. In the majority of cases, cysts will be benign and can be managed conservatively. However, symptomatic ovarian cysts are likely to require surgical management. In the premenopausal patient, the risk of a symptomatic ovarian cyst being malignant is 1 in 1000 [1][2].

Most ovarian cysts, however, develop during infancy and adolescence—times of hormonal activity. The majority are functional and tend to resolve on their own without treatment [3]

Most ovarian cysts in patients are asymptomatic and are often found incidentally during ultrasonography or routine pelvic exams. However, some cysts can be linked to a variety of symptoms, which can sometimes be severe [4], whereas malignant ovarian cysts often remain symptomless until they become advanced. Lower abdominal pain or anxiety are possible.

IJARSCT
International Journal of Advanced Research in Science, Communication and Technology
International Open-Access, Double-Blind, Peer-Reviewed, Refereed, Multidisciplinary Online Journal
ISSN: 2581-9429 Volume 6, Issue 1, November 2026 Impact Factor: 8.2

More intense pain may result from rupture or torsion (twisting). The hallmark of a cyst rupture is abrupt, unilateral, acute pelvic discomfort. Exercise, coitus, or trauma can all be associated with this. Additionally, peritoneal symptoms, abdominal distention, and bleeding that usually resolve on their own can result from cyst rupture[5] [6].

According to ultrasonographic data, many patients with simple ovarian cysts don't need therapy. Serial ultrasonographic exams may be used to monitor a persistent simple cyst smaller than 10 cm in size in a postmenopausal patient with a normal CA125 value [4]. Premenopausal women who have simple, asymptomatic cysts smaller than 8 cm on sonograms and whose CA125 result falls within the reference range can be followed up with another ultrasound in 8 to 12 weeks [7].

The following is a case of ovarian cyst with Endometrial Hyperplasia in the reproductive age group treated successfully with Homoeopathy. Her informed consent was taken.

II. CASE REPORT

A female of 40 years with 162cm and a weight of 68kg with a complaint of profuse menstrual bleeding for the past 1 year reported at OPD of Dr. Girendra Pal Homoeopathic Medical College, Hospital & Research Centre, Collegiate Hospital of Dr. M.P.K. Homoeopathic Medical College, Hospital & Research Centre, Homoeopathy University, Saipura, Sanganer, Jaipur, Rajasthan on 25 November 2024. Her duration of cycle was 24-25 days with profuse and painful menstrual bleeding for up to 7-8 days using 5-6 pads per day. The patient is a housewife who has consulted several Allopathic Physicians for her menstrual complaints. A month ago, she dropped her allopathic treatment because it failed to provide complete relief. On the advice of the same physician, she had an ultrasound done (22/11/2024), which reported increased endometrial thickness (14.5mm) with a left ovarian cyst (23*25mm). She also had complaints of dyspepsia on and off, especially after heavy meals.

PAST HISTORY: Patient has a history of Jaundice in 2009.

She was anaemic since childhood and has taken lots of Iron Tonics, and is still having them on and off.

FAMILY HISTORY: Her Family history reveals Hypertension in her mother and maternal grandmother, and Diabetes in her father. Her Paternal Grandmother has Osteoarthritis.

III. PHYSICAL GENERALS

The patient was tall and had an ectomorphic build. She is a pure vegetarian. She was equally sensitive to both Heat and cold. She has a good appetite, but fatty foods usually cause indigestion after having dinner at weddings/ functions. She doesn't like warm food or drinks, and usually avoids them. She is thirstless and can hardly drink around a litre of water a day. The stool is normal, soft, and satisfactory, but it can sometimes become constipated. She also has burning after micturition, mostly in the summer. Perspiration was scanty and only on the forehead. Her Sleep was deep and refreshing, but she sometimes had dreams of ghosts.

PERSONAL HISTORY

LMP: 10/11/2024

CYCLE: 24-25 days

DURATION: 7-8 days

FLOW: Profuse, Dark, clots++; 5-6 pads/days,

Severe lower abdominal pain during menses

IV. MENTAL GENERALS

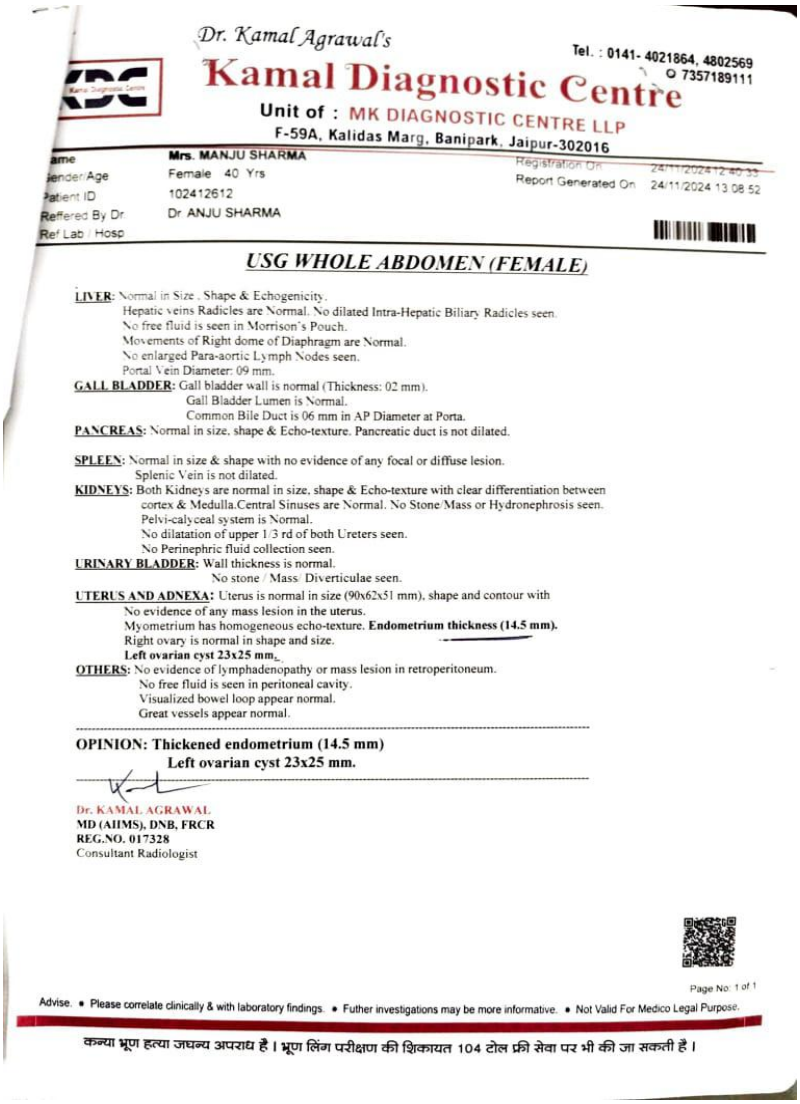
Throughout the case, the patient appears to be very mild in nature and stated that she rarely gets annoyed with people. Even when she becomes so angry, she would start crying. She has a very low threshold for emotional distress and weeps once she gets into it. The patient feels better after the consolation. The patient is afraid of solitude and always wants someone by her side; she doesn't even go out alone, especially after dark.

IJARSCT
International Journal of Advanced Research in Science, Communication and Technology
International Open-Access, Double-Blind, Peer-Reviewed, Refereed, Multidisciplinary Online Journal
ISSN: 2581-9429
Volume 6, Issue 1, November 2026
Impact Factor: 8.2

V. PHYSICAL EXAMINATION

Built: Endomorph
Nutrition: undernourished
Pallor: ++
Oral-teeth/tongue/gums: Mouth and lips are dry
Skin/Hair/Nails: Brittle nails
Height: 5'3" (162cm)
Weight: 68kg
BMI: 25.9
Temperature: 98.20F
Pulse: 74/m
Blood Pressure: 109/70mmhg
SPO2: 99%
The Ultrasound of the Whole abdomen is given in Figure 1
Other findings of systemic examination were normal

IJARSCT
International Journal of Advanced Research in Science, Communication and Technology
International Open-Access, Double-Blind, Peer-Reviewed, Refereed, Multidisciplinary Online Journal
ISSN: 2581-9429
Volume 6, Issue 1, November 2026
Impact Factor: 8.2



Dr. Kamal Agrawal's
Kamal Diagnostic Centre
Tel. : 0141- 4021864, 4802569
7357189111
Unit of : MK DIAGNOSTIC CENTRE LLP
F-59A, Kalidas Marg, Banipark, Jaipur-302016

Name: Mrs. MANJU SHARMA
Gender/Age: Female 40 Yrs
Patient ID: 102412612
Reffered By Dr.: Dr. ANJU SHARMA
Ref Lab / Hosp:
Registration On: 24/11/2024 12:40:33
Report Generated On: 24/11/2024 13:08:52

USG WHOLE ABDOMEN (FEMALE)

LIVER: Normal in Size , Shape & Echogenicity.
Hepatic veins Radicles are Normal. No dilated Intra-Hepatic Biliary Radicles seen.
No free fluid is seen in Morrison's Pouch.
Movements of Right dome of Diaphragm are Normal.
No enlarged Para-aortic Lymph Nodes seen.
Portal Vein Diameter: 09 mm.
GALL BLADDER: Gall bladder wall is normal (Thickness: 02 mm).
Gall Bladder Lumen is Normal.
Common Bile Duct is 06 mm in AP Diameter at Porta.
PANCREAS: Normal in size, shape & Echo-texture. Pancreatic duct is not dilated.

SPLEEN: Normal in size & shape with no evidence of any focal or diffuse lesion.
Splenic Vein is not dilated.
KIDNEYS: Both Kidneys are normal in size, shape & Echo-texture with clear differentiation between cortex & Medulla.Central Sinuses are Normal. No Stone/Mass or Hydronephrosis seen.
Pelvi-calyceal system is Normal.
No dilatation of upper 1/3 rd of both Ureters seen.
No Perinephric fluid collection seen.
URINARY BLADDER: Wall thickness is normal.
No stone / Mass/ Diverticulae seen.
UTERUS AND ADNEXA: Uterus is normal in size (90x62x51 mm), shape and contour with
No evidence of any mass lesion in the uterus.
Myometrium has homogeneous echo-texture. **Endometrium thickness (14.5 mm).**
Right ovary is normal in shape and size.
Left ovarian cyst 23x25 mm.
OTHERS: No evidence of lymphadenopathy or mass lesion in retroperitoneum.
No free fluid is seen in peritoneal cavity.
Visualized bowel loop appear normal.
Great vessels appear normal.

OPINION: Thickened endometrium (14.5 mm)
Left ovarian cyst 23x25 mm.

Dr. KAMAL AGRAWAL
MD (AIIMS), DNB, FRCR
REG.NO. 017328
Consultant Radiologist

Page No: 1 of 1
Advise. • Please correlate clinically & with laboratory findings. • Futher investigations may be more informative. • Not Valid For Medico Legal Purpose.
कन्या भ्रूण हत्या जघन्य अपराध है। भ्रूण लिंग परीक्षण की शिकायत 104 टोल फ्री सेवा पर भी की जा सकती है।

Figure 1: USG whole abdomen reports Left endometrium cyst

VI. FIRST PRESCRIPTION

An individualised homoeopathic medicine, PULSATILLA NIGRICANS 200/1 dose, along with adjuvant after 2 days OOPHORINUM 30/TDS, was prescribed for 14 days. This case was followed up to April 21, 2025, as per the follow-up table [Table 1].

BASIS OF PRESCRIPTION

Repertorisation of the case was done on the basis of the following symptoms

Low threshold to emotional distress and weeps easily, consolation ameliorates, afraid of being alone, fear of darkness, avoids warm food and drinks, profuse menstrual bleeding, ovarian cyst, dreams of ghosts, anaemic.

After the repertorisation, Pulsatilla nigricans scores the highest marks.

The repertorisation sheet is given in Figure 2

Report of Ultrasonography after treatment was given in Figure 3

IJARSCT
International Journal of Advanced Research in Science, Communication and Technology
International Open-Access, Double-Blind, Peer-Reviewed, Refereed, Multidisciplinary Online Journal
ISSN: 2581-9429
Volume 6, Issue 1, November 2026
Impact Factor: 8.2

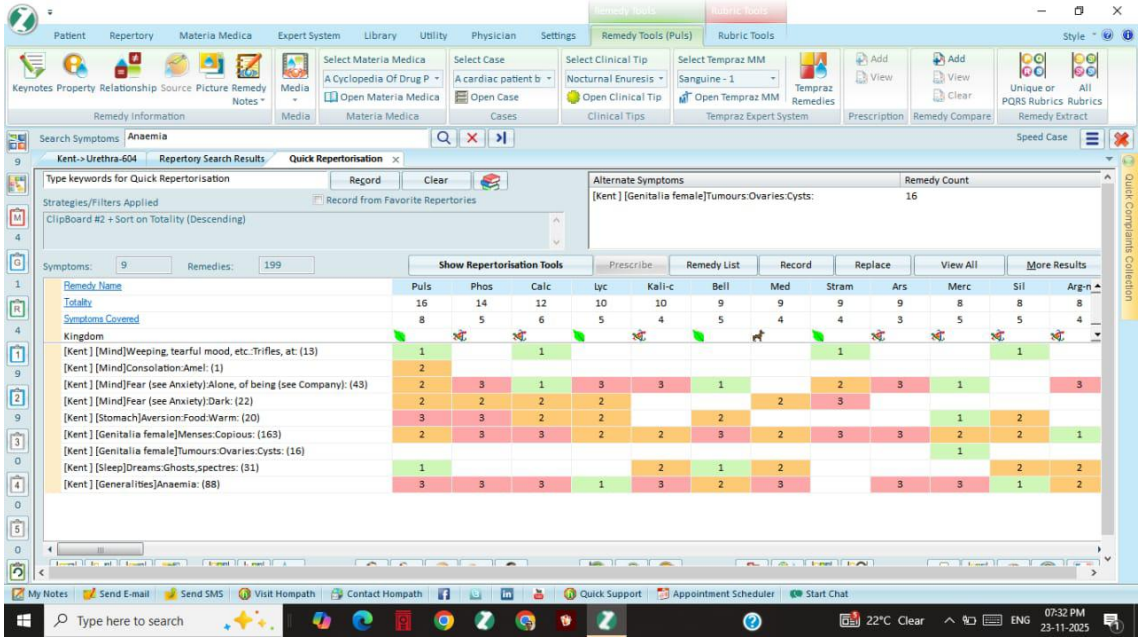
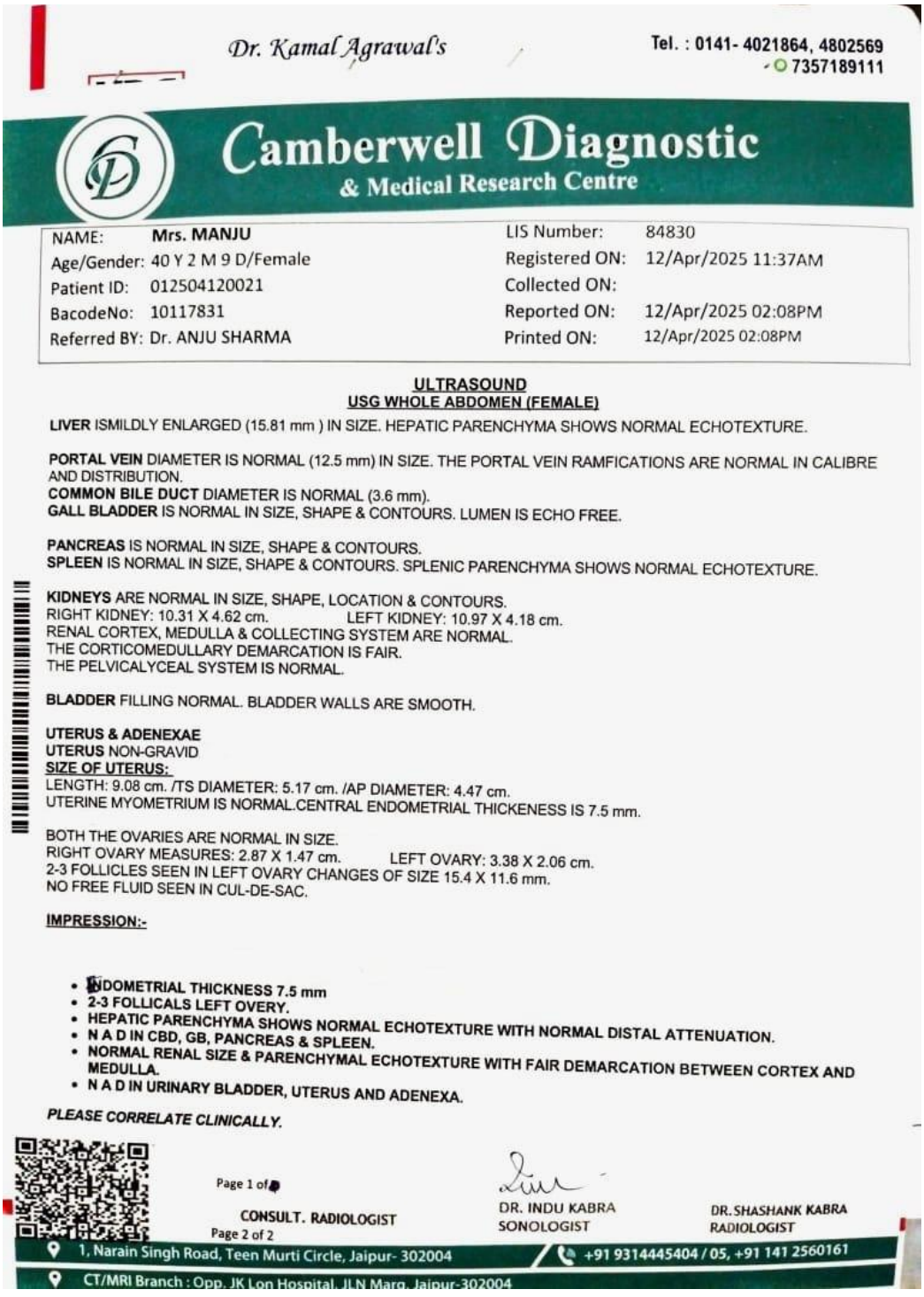


Figure 2: Repertorisation sheet

Table 1: Case Timeline with follow-ups

DATE	FOLLOW-UP	PRESCRIPTION
23/12/2024	The intensity of menstrual flow reduced; only a few clots present, bright red LMP- 6/12/2024, 4pads/day, mild dysmenorrhea	RUBRUM 200/1 dose OOPHORINUM 30/TDS (14 Days)
13/01/2025	LMP- 04/01/2025, flow was increased, 4-5 pads/day, pain during menses Relief in GI Complaints	RUBRUM 200/1 DOSE OOPHORINUM 30/TDS (14 DAYS)
24/02/2025	LMP- 01/02/2025, pain during menses was increased in intensity, flow profuse, no clots present, bright red, 4-5pads/day No dyspepsia	PULSATILLA NIGRICANS 1M/1 DOSE OOPHORINUM 30/TDS (28 DAYS)
21/03/2024	LMP- 02/03/2025, the flow was normal, only mild pain during menses, flow normal 03 pads/day (Advised to repeat USG whole abdomen)	RUBRUM 200/1 DOSE OOPHORINUM 30/TDS (28 DAYS)
20/04/2024	LMP-02/04/2025, flow was normal, mild menstrual pain, no clots, 03 pads/day USG was normal	RUBRUM 200/ 1 DOSE OOPHORINUM 30/TDS (14 Days)

IJARSCT
International Journal of Advanced Research in Science, Communication and Technology
International Open-Access, Double-Blind, Peer-Reviewed, Refereed, Multidisciplinary Online Journal
ISSN: 2581-9429
Volume 6, Issue 1, November 2026
Impact Factor: 8.2



Dr. Kamal Agrawal's

Tel. : 0141- 4021864, 4802569
7357189111

Camberwell Diagnostic
& Medical Research Centre

NAME:	Mrs. MANJU	LIS Number:	84830
Age/Gender:	40 Y 2 M 9 D/Female	Registered ON:	12/Apr/2025 11:37AM
Patient ID:	012504120021	Collected ON:	
BacodeNo:	10117831	Reported ON:	12/Apr/2025 02:08PM
Referred BY:	Dr. ANJU SHARMA	Printed ON:	12/Apr/2025 02:08PM

ULTRASOUND
USG WHOLE ABDOMEN (FEMALE)

LIVER ISMILDLY ENLARGED (15.81 mm) IN SIZE. HEPATIC PARENCHYMA SHOWS NORMAL ECHOTEXTURE.

PORTAL VEIN DIAMETER IS NORMAL (12.5 mm) IN SIZE. THE PORTAL VEIN RAMFICATIONS ARE NORMAL IN CALIBRE AND DISTRIBUTION.
COMMON BILE DUCT DIAMETER IS NORMAL (3.6 mm).
GALL BLADDER IS NORMAL IN SIZE, SHAPE & CONTOURS. LUMEN IS ECHO FREE.

PANCREAS IS NORMAL IN SIZE, SHAPE & CONTOURS.
SPLEEN IS NORMAL IN SIZE, SHAPE & CONTOURS. SPLENIC PARENCHYMA SHOWS NORMAL ECHOTEXTURE.

KIDNEYS ARE NORMAL IN SIZE, SHAPE, LOCATION & CONTOURS.
RIGHT KIDNEY: 10.31 X 4.62 cm. LEFT KIDNEY: 10.97 X 4.18 cm.
RENAL CORTEX, MEDULLA & COLLECTING SYSTEM ARE NORMAL.
THE CORTICOMEDULLARY DEMARCATION IS FAIR.
THE PELVICALYCEAL SYSTEM IS NORMAL.

BLADDER FILLING NORMAL. BLADDER WALLS ARE SMOOTH.

UTERUS & ADENEXAE
UTERUS NON-GRAVID
SIZE OF UTERUS:
LENGTH: 9.08 cm. /TS DIAMETER: 5.17 cm. /AP DIAMETER: 4.47 cm.
UTERINE MYOMETRIUM IS NORMAL.CENTRAL ENDOMETRIAL THICKENESS IS 7.5 mm.

BOTH THE OVARIES ARE NORMAL IN SIZE.
RIGHT OVARY MEASURES: 2.87 X 1.47 cm. LEFT OVARY: 3.38 X 2.06 cm.
2-3 FOLLICLES SEEN IN LEFT OVARY CHANGES OF SIZE 15.4 X 11.6 mm.
NO FREE FLUID SEEN IN CUL-DE-SAC.

IMPRESSION:-

- ENDOMETRIAL THICKNESS 7.5 mm
- 2-3 FOLLICALS LEFT OVERY.
- HEPATIC PARENCHYMA SHOWS NORMAL ECHOTEXTURE WITH NORMAL DISTAL ATTENUATION.
- N A D IN CBD, GB, PANCREAS & SPLEEN.
- NORMAL RENAL SIZE & PARENCHYMAL ECHOTEXTURE WITH FAIR DEMARCATION BETWEEN CORTEX AND MEDULLA.
- N A D IN URINARY BLADDER, UTERUS AND ADENEXA.

PLEASE CORRELATE CLINICALLY.

Page 1 of 2
Page 2 of 2

CONSULT. RADIOLOGIST
DR. INDU KABRA
SONOLOGIST
DR. SHASHANK KABRA
RADIOLOGIST

1, Narain Singh Road, Teen Murti Circle, Jaipur- 302004 +91 9314445404 / 05, +91 141 2560161
CT/MRI Branch : Opp. JK Lon Hospital, JLN Marg, Jaipur-302004

Figure 3: USG report after treatment

IJARSCT
International Journal of Advanced Research in Science, Communication and Technology
International Open-Access, Double-Blind, Peer-Reviewed, Refereed, Multidisciplinary Online Journal
ISSN: 2581-9429
Volume 6, Issue 1, November 2026
Impact Factor: 8.2

VII. DISCUSSION

Ovarian cysts are a highly frequent benign gynaecological tumour that affects 20–50% of women nowadays, particularly during their reproductive years. Numerous symptoms, including irregular and painful menstruation, infertility, anaemia, pressure in the bladder, abortions, recurrent pregnancy loss, lower abdomen or pelvic pain, and abdominal enlargement, are associated with this disease; nevertheless, 75% of cases are asymptomatic [8]. The incidence is twice as common in white women as in black women. The prevalence rate is approximately 1 in 20 or 13.6 million women globally.

While ovarian cysts are commonly encountered and well-documented in gynaecological practice, they may also appear in association with other reproductive system pathologies. In the present case, the simultaneous finding of endometrial hyperplasia adds a significant dimension to the clinical picture. Therefore, it is relevant to discuss the nature and implications of endometrial hyperplasia in conjunction with ovarian cysts.

Endometrial hyperplasia (EH) is a pre-cancerous, non-physiological, and non-invasive proliferation of the endometrium that results in an increased volume of endometrial tissue, with alterations in glandular architecture (shape and size) and an endometrial gland-to-stroma ratio greater than 1:1. Currently, the incidence of EH is indistinctly reported to bear around 200,000 new EH cases per year in Western countries [9]. The commonest type is simple EH. The hallmark of endometrial hyperplasia is excessive endometrial gland proliferation brought on by estrogenic stimulation that is not inhibited by progesterone. It may coexist with other ovarian or uterine disorders and frequently manifests as abnormal uterine haemorrhage [10]. Endometrial thickness is a key indicator for endometrial hyperplasia, with a thickness over 11 mm in premenopausal women and over 4–5 mm in postmenopausal women often indicating a potential problem that requires further investigation.

Endometrial hyperplasia generally occurs as a response to estrogen stimulation that is not adequately balanced by progesterone. Considering its association with hormonal imbalances, it is unsurprising that endometrial hyperplasia is predominantly observed around or following menopause. Nevertheless, premenopausal women experiencing sclerocystic ovaries or obesity are also at an elevated risk. In the perimenopausal period, excess estrogen may result from either exogenous hormone replacement therapy or endogenous factors, such as anovulation. Additionally, obesity contributes to estrogen excess through the process of conversion [11].

The occurrence of EH varies significantly based on age and symptoms. In asymptomatic premenopausal women, the incidence of EH without atypia is less than 5%, and with atypia is less than 1%. For premenopausal women experiencing abnormal uterine bleeding, the incidence can be as high as 10%. Among women with PCOS and oligomenorrhea, the reported incidence exceeds 20% [12].

Although there is no bona fide treatment for EH, most current guidelines recommend hormone therapies (including the use of progestin, gonadotropin-releasing hormone (GnRH) or its analogues or their combination) or surgical treatment. The selection criteria

treatment options are based on patient age, health, the presence of cytologic atypia and fertility status [9].

Homoeopathic treatment has no side effects and holistically treats individuals. Homoeopathic medicines can modify general tendencies, thus causing the cure of conditions. Homoeopathic literature mentions many medicines for these conditions, of which a similimum can help a patient keep the disease at bay for a longer period, as evidenced in this case.

In the present case, a 40-year-old female presented with profuse menstrual bleeding and severe lower abdominal pain; ultrasonography revealed a left ovarian cyst associated with endometrial hyperplasia. After detailed case analysis and repertorisation, PULSATILLA NIGRICANS 200C was selected as the first prescription based on the totality of symptoms. Pulsatilla matched the emotional and physical modalities expressed by the patient.

Alongside this constitutional prescription, OOPHORINUM 30C was introduced as an organ-specific remedy owing to its affinity for ovarian and hormonal disturbances. During the five-month follow-up, Oophorinum consistently supported the case, demonstrating a favourable influence on the ovarian pathology and menstrual symptoms. On the

IJARSCT
International Journal of Advanced Research in Science, Communication and Technology
International Open-Access, Double-Blind, Peer-Reviewed, Refereed, Multidisciplinary Online Journal
ISSN: 2581-9429
Volume 6, Issue 1, November 2026
Impact Factor: 8.2

third visit, Pulsatilla Nigricans was repeated in 1M potency as an intercurrent, following the patient's improvement curve and Kent's guidance on raising potency when vital reaction improves.

After the relief in symptoms, the patient was advised to repeat USG in her 4th visit, which revealed no cyst in the ovary and marked reduction in endometrial thickness along with much improvement in symptoms.

This case clearly shows that an ovarian cyst with endometrial hyperplasia, a surgical case, was recovered by the treatment of Homoeopathic remedies without complications & side effects.

VIII. CONCLUSION

The progressive reduction of symptoms and improvement in clinical parameters point towards the effectiveness of OOPHORINUM as a remedy with marked ovarian sphere action, while the individualised prescription of PULSATILLA NIGRICANS acted constitutionally to complete the cure. This case illustrates the value of combining organ-specific remedies with individualised constitutional treatment.

IX. DECLARATION OF CONSENT

The author certifies that she has obtained the appropriate patient consent forms. In the form, the patient has given her consent for clinical information to be reported in the journal. The patient understands that her name and initials will not be published.

REFERENCES

1. Crayford TJ, Campbell S, Bourne TH, Rawson HJ, Collins WP. Benign ovarian cysts and ovarian cancer: a cohort study with implications for screening. The Lancet. 2000 Mar 25;355(9209):1060-3.
2. Farahani L, Datta S. Benign ovarian cysts. Obstetrics Gynaecology & Reproductive Medicine [Internet]. 2016 Jul 2;26(9):271–5. Available from: https://doi.org/10.1016/j.ogrm.2016.06.003
3. Zahidy ZAA. Causes and management of ovarian cysts. The Egyptian Journal of Hospital Medicine [Internet]. 2018 Jan 1;70(10):1818–22. Available from: https://doi.org/10.12816/0044759
4. Bottomley C, Bourne T(2009): Diagnosis and management of ovarian cyst accidents. Best PractRes Clin ObstetGynaecol. , 23(5):711-24.
5. Bottomley C, Bourne T. Diagnosis and management of ovarian cyst accidents. Best practice & research Clinical obstetrics & gynaecology. 2009 Oct 1;23(5):711-24.
6. Eskander R, Berman M, Keder L. Evaluation and management of adnexal masses. Obstetrics and Gynaecology. 2016 Nov 1;128(5):e210-26.
7. Grimes DA, Jones LB, Lopez LM, Schulz KF. Oral contraceptives for functional ovarian cysts. Cochrane Database of Systematic Reviews. 2011(9).
8. Iqbal Jahan Quadri, MD Shahid Ali, Vatsalya B, Hima Bindu Ponnam, Nikhat Parveen S. Role of homoeopathic medicines in treating Ovarian Cyst: A prospective observational study. Indian Journal of Research in Homoeopathy. 2012 Jan-Jun;6(1-2):8-14.
9. Chandra V, Kim JJ, Benbrook DM, Dwivedi A, Rai R. Therapeutic Options for Management of Endometrial Hyperplasia: An Update. Journal of Gynecologic Oncology [Internet]. 2015 Jan 1; Available from: https://www.ejgo.org/Synapse/Data/PDFData/1114JGO/jgo-26-e32.pdf
10. Individualised homoeopathic approach for simple endometrial hyperplasia presenting with post-menopausal bleeding –A case report. Indian Journal of Research in Homoeopathy. 2022 Sep 23;16(1).
11. Mills AM, Longacre TA. Endometrial hyperplasia. Seminars in Diagnostic Pathology [Internet]. 2010 Nov 1;27(4):199–214. Available from: https://doi.org/10.1053/j.semdp.2010.09.002
12. Armstrong AJ, Hurd WW, Elguero S, Barker NM, Zanotti KM. Diagnosis and Management of Endometrial Hyperplasia. Journal of Minimally Invasive Gynaecology [Internet]. 2012 Aug 3;19(5):562–71. Available from: https://doi.org/10.1016/j.jmig.2012.05.009.