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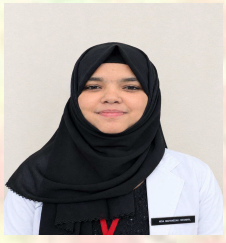


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CASE REPORT ON EFFECTIVENESS OF HOMOEOPATHIC TREATMENT IN IMPROVING THE QUALITY OF LIFE IN PATIENT WITH BRONCHIAL ASTHMA AND ALLERGIC RHINITIS USING INDIVIDUALIZED HOMOEOPATHIC

ABSTRACT: Asthma is a chronic inflammatory disorder of the airways, in which many cells and cellular elements play a role. A 59-year-old male patient presented with symptoms of breathlessness, sneezing and coryza for last 32 years, diagnosed with Bronchial Asthma and Allergic Rhinitis, was treated with Natrum Muriaticum 200, based on constitutional totality. There was gradual improvement observed in the symptoms along with the quality of life of the patient.

KEYWORDS: Bronchial Asthma, Natrum Muriaticum, Quality of Life, case report

INTRODUCTION: Asthma is a disease of airways that is characterized by increased responsiveness of the tracheobronchial tree to a variety of stimuli resulting in widespread spasmodic narrowing of the air passages which may be relieved spontaneously or by therapy. It's a highly prevalent respiratory disease worldwide, driven by both genetic and environmental factors. Its symptoms exhibit significant variability with the degree of airflow limitation. In 2021, the global confirmed cases reached 270 million, with 450,000 deaths. The pathogenesis of asthma is complex, involving multiple factors such as immune imbalance. Poor long-term control leads to progressive decline in lung function, increasing the risk of acute exacerbations and death.

OBJECTIVE: To assess the quality of life in asthmatic patient after constitutional treatment using asthma quality of life questionnaire.

METHODOLOGY: Allergic Rhinitis was diagnosed using SFAR questionnaire and Bronchial Asthma was diagnosed using spirometry. Constitutional totality was framed using Kent's method and Repertorisation done using Synthesis Repertory. Natrum Muriaticum 200 was prescribed in Saccharum Lactis and placebo was given in the form of cane sugar globules medicated with rectified spirit. Patient was advised to continue using inhaler whenever the patient became breathless. Asthma Quality of Life Questionnaire was used, first on 2/12/25 and second on 24/01/26.

PRELIMINARY DATA: Name – Xyz, Age – 59 Yrs, Sex – Male, Religion – Muslim, Education – SSLC, Occupation – Auto Driver (Retired), Marital Status – Married Since 30 Yrs, Address – Belagavi, Date of Case Taking – 2/12/25

LOCATION	SENSATION	MODALITIES	CONCOMITANTS
Respiratory System Chest Since 32 years Sudden onset and progression	Breathlessness Wheezing Cough with whitish Expectoration scanty	< Cold Weather <4 Am – 11 Am < Dust > Summer Season	
Nose Since 30 Years	Sneezing Watery Coryza Itching In Nose	< Dust Exposure < Winter Season	Itching In Eyes

PRESENTING COMPLAINT: Patient came with the complaint of breathlessness, sneezing and coryza in the last 32 years increased in the last 6 months.

HISTORY OF CHIEF COMPLAINT

In the year 1993, patient got shifted near lake. He developed with the complaints of sneezing. It used to aggravate when he went outdoors due to exposure to dust and during winter season. Whenever he sneezed, it used to be 3 – 4 times. It was associated with lachrymation, itching in nose and eyes. He used to take allopathic treatment and used to be temporarily better.

At the same time, he developed with wheeze, breathlessness and cough. It used to aggravate at 11pm or 12 am. It is associated with dry cough. The complaints used to be worse in winter season and when exposed to fog. Whenever he got the attack, he used to consult his physician, he would give him injection, which would suffice for his complaints for 1 month.

Then in 1998, he was prescribed theoasthalin tablet. He used to take 1 or 1/2 tablet whenever he had breathlessness. Since 2002, he started using inhaler. Earlier he used inhaler only once in a day then gradually it increased to once every 2 – 3 hours. In the year 2022, he had severe breathlessness with cough. He was admitted in the hospital for 8 days and was better after treatment.

Currently there is no history of chest pain, haemoptysis or fever. Patient is a known case of tobacco chewing from 1996 – 2014.

PAST HISTORY:

MEDICAL HISTORY-k/c/o hypertension since 1 year, diabetes mellitus since 9 years, Malaria age of 27 years, Childhood-Chicken pox, Epilepsy 2 episodes; TREATMENT HISTORY-Insulin injection – 15u, Metformin 500mg (0 – 0 – 1), Telmisartan 40mg (1/2 – 0 – ½); SURGICAL HISTORY-Nil; FAMILY HISTORY-Mother – diabetes mellitus and hypertension expired 2 years back, Father – stroke, hypertension expired in 2009, Younger sister – rhinitis, Younger brother – bipolar disorder ; ALLERGIC HISTORY-Allergic to medicine, dust

PERSONAL HISTORY: DIET – mixed, APPETITE – good, THIRST – thirsty, CRAVING – spicy, sour, AVERSION – nil, BOWEL HABITS – 1 t/day, no difficulty, BLADDER HABITS – 5 t/day, SLEEP – good, DREAMS – daily events, PERSPIRATION – on exertion, increased on head, THERMALS – hot, ADDICTIONS – tobacco chewing

LIFE SPACE INVESTIGATION: Patient hails from a middle socio-economic status. His father was a mechanic and mother was a housewife. He has 1 younger brother and 1 younger sister.

During his childhood he received adequate love from his parents. He was very intelligent and good in his studies and was very social. But was not active in other co-curricular activities. His mother was very spiritual and strict. She made sure her children strictly followed moral values. Due to this, if anything went wrong, patient used to cry due to guilty feeling.

In the year 1985, after SSLC patient wanted to continue with his studies. His dream was to join the industrial training institute. But his father didn't allow him. He said it was of no use studying and made him join a factory. This had a huge impact on him. After 2 years, he developed with hallucinations. Early morning felt someone was talking to him. There were objects floating in the sky. There were involuntary movement of the limbs. He was taken to a psychiatrist. He was given shock treatment, along with allopathic tablets. This continued till 1994. He had also taken homoeopathic treatment in 1992. He got married in the year 1996. It was an arrange marriage. He has 2 children, 1 son and 1 daughter. His relation with his wife and kids his good. As a person- Prefers solitude, Irritable, Brooding.

GENERAL PHYSICAL EXAMINATION: Weight - 69 kg, moderately built and nourished, well oriented with time, place and person, Head – senile greying of hair present, Nose – DNS present towards left side, turbinates in right nostril enlarged, Mouth – cavities present, tongue yellow coating,

VITAL SIGNS: TEMP – afebrile, PULSE – 78 beats/min, BP – 130/70mmhg, RR – 16 breaths/min, SPO2 - 97%

SYSTEMIC EXAMINATION: RESPIRATORY SYSTEM, AUSCULTATION - Added/ adventitious sounds – rhonchi and crepitations heard

INVESTIGATIONS DONE

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Before using inhaler



After using inhaler

DIFFERENTIAL DIAGNOSIS: COPD and VASOMOTOR RHINITIS

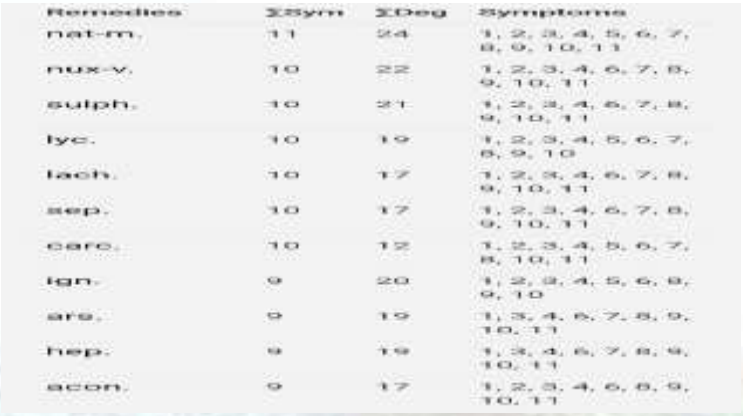
DIAGNOSIS: BRONCHIAL ASTHMA and ALLERGIC RHINITIS

TOTALITY: CONSTITUTIONAL TOTALITY

MENTAL GENERALS- Anger, prefers solitude, hallucinations, Brooding, Guilty, suppressed emotions; PHYSICAL GENERALS- Thirsty, Craving – spicy food, Sleep – 3am – 10am, Dreams – daily events, Perspiration – increased on head on exertion, Thermals – hot; PARTICULARS- breathlessness, wheezing< cold weather, < night (11 pm/ 12 am), < dust exposure, cough, sneezing, watery coryza, itching in nose, Itching in eyes< dust exposure< winter season, Recurrent cold

REPERTORIAL TOTALITY





Remedies	ΣSym	ΣDeg	Symptoms
nat-m.	11	24	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11
nux-v.	10	22	1, 2, 3, 4, 6, 7, 8, 9, 10, 11
sulph.	10	21	1, 2, 3, 4, 6, 7, 8, 9, 10, 11
lyc.	10	19	1, 2, 3, 4, 5, 6, 7, 8, 9, 10
lach.	10	17	1, 2, 3, 4, 6, 7, 8, 9, 10, 11
sep.	10	17	1, 2, 3, 4, 6, 7, 8, 9, 10, 11
carc.	10	12	1, 2, 3, 4, 5, 6, 7, 8, 10, 11
ign.	9	20	1, 2, 3, 4, 5, 6, 8, 9, 10
ars.	9	19	1, 3, 4, 5, 7, 8, 9, 10, 11
hep.	9	19	1, 3, 4, 5, 7, 8, 9, 10, 11
acon.	9	17	1, 2, 3, 4, 6, 8, 9, 10, 11

RESULTS

PRESCRIPTION- RX- 1. NATRUM MUR 200, 1 DOSE; 2. PLACEBO 4 – 4 – 4/ FOR 2 WEEKS

FOLLOW UP

DATE	SYMPTOMS	REMEDY
9/12/25	c/o breathlessness better, c/o cough better, is easily able to expectorate, c/o sneeze better, c/o itching in eyes, nose better, frequency of inhaler reduced, on auscultation rhonchi heard all over the lung fields	Rx 1. PL 1 dose 2. PL 4 – 4 – 4 X for 2 weeks
27/12/25	c/o breathlessness better 70%, cough better by 70%, c/o sneezing better, c/o itching in eyes and nose better, is able to sleep in supine position, BP – 120/60 mmhg, wt – 71 kg, on auscultation rhonchi heard all over the lung fields	Rx 1. PL 1 dose 2. PL 4 – 4 – 4 X for 2 weeks
10/01/26	c/o breathlessness better, inhaler uses 2 – 3 times in 24 hours, c/o cough better, c/o sneezed, itching in eyes and nose better, sleep improved, BP – 134/70 mmhg, on auscultation – rhonchi heard in b/l suprascapular Region and interscapular region	Rx 1. PL 1 dose 2. PL 4 – 4 – 4 X for 2 weeks
24/01/26	c/o breathlessness slightly increased, on auscultation – rhonchi heard in b/l suprascapular and inter scapular region, BP – 150/80 mmhg	Rx 1. NATRUM MUR 200 1 dose 2. PL 4 – 4 – 4 X for 2 weeks
27/01/26	c/o breathlessness better, on auscultation, rhonchi heard in b/l suprascapular and interscapular region, all other physical generals good	Rx 1. PL 1 dose 2. PL 4 – 4 – 4 X for 2 weeks

Asthma Quality of Life Questionnaire Score: Before treatment – 3 After treatment – 6

S. NO.	CRITERIA	YES	NO	NOT SURE
1.	Was there an improvement in the main symptom or condition for which the homeopathic medicine was prescribed?	+2		
2.	Did the clinical improvement occur within a plausible time frame relative to the medicine intake?	+1		
3.	Was there a homeopathic aggravation of symptoms?		0	
4.	Did the effect encompass more than the main symptom or condition (i.e. were other symptoms ultimately improved or changed)?	+1		
5.	Did overall well-being improve? (suggest using a validated scale)	+1		
6A.	Direction of cure: did some symptoms improve in the opposite order of the development of symptoms of the disease?			0
6B.	Direction of cure: did at least one of the following aspects apply to the order of improvement of symptoms: -from organs of more importance to those of less importance? -from deeper to more superficial aspects of the individual? -from the top downwards?			0
7.	Did 'old symptoms' (defined as non-seasonal and non-cyclical symptoms that were previously thought to have resolved) reappear temporarily during the course of improvement?		0	
8.	Are there alternate causes (i.e. other than the medicine) that – with a high probability – could have caused the improvement? (Consider a known course of disease, other forms of treatment and other clinically relevant interventions)		+1	
9.	Was the health improvement confirmed by any objective evidence? (e.g. laboratory test, clinical observation, etc.)	+2		
10.	Did repeat dosing, if conducted, create similar clinical improvement?			0
	TOTAL	+8		

CARE

CARE Checklist of information to include when writing a case report

Topic	Item	Checklist item description	Reported on Line
Title	1	The diagnosis or intervention of primary focus followed by the words "case report"	1
Key Words	2	2 to 5 key words that identify diagnoses or interventions in this case report, including "case report"	1
Abstract (no references)	3a	Introduction: What is unique about this case and what does it add to the scientific literature?	1
	3b	Main symptoms and/or important clinical findings	1, 2, 3
	3c	The main diagnoses, therapeutic interventions, and outcomes	3, 4
	3d	Conclusion—What is the main "take-away" lesson(s) from this case?	4
Introduction	4	One or two paragraphs summarizing why this case is unique (**may include references**)	1
Patient Information	5a	De-identified patient specific information	2
	5b	Primary concerns and symptoms of the patient	1
	5c	Medical, family, and psycho-social history including relevant genetic information	2
	5d	Relevant past interventions with outcomes	2
Clinical Findings	6	Describe significant physical examination (PE) and important clinical findings	2
Timeline	7	Historical and current information from this episode of care organized as a timeline	Not mentioned
Diagnostic Assessment	8a	Diagnostic testing (such as PE, laboratory testing, imaging, surveys)	3
	8b	Diagnostic challenges (such as access to testing, financial, or cultural)	Not mentioned
	8c	Diagnosis (including other diagnoses considered)	3
	8d	Prognosis (such as staging in oncology) where applicable	Not mentioned
Therapeutic Intervention	9a	Types of therapeutic intervention (such as pharmacologic, surgical, preventive, self-care)	3.
	9b	Administration of therapeutic intervention (such as dosage, strength, duration)	3, 4
	9c	Changes in therapeutic intervention (with rationale)	3, 4
Follow-up and Outcomes	10a	Clinician and patient-assessed outcomes (if available)	4, 5
	10b	Important follow-up diagnostic and other test results	Not mentioned
	10c	Intervention adherence and tolerability (How was this assessed?)	Not mentioned
	10d	Adverse and unanticipated events	Not mentioned
Discussion	11a	A scientific discussion of the strengths AND limitations associated with this case report	Not mentioned
	11b	Discussion of the relevant medical literature **with references**	4
	11c	The scientific rationale for any conclusions (including assessment of possible causes)	4
	11d	The primary "take-away" lessons of this case report (without references) in a one paragraph conclusion	4
Patient Perspective	12	The patient should share their perspective in one to two paragraphs on the treatment(s) they received	Not mentioned
Informed Consent	13	Did the patient give informed consent? Please provide if requested	Yes ☑ No ☐

DISCUSSION

A 2026 case report titled 'Homoeopathic Management of Bronchial Asthma with Natrum muriaticum in LM Potency' by Dr Deepa Rathore and Dr Geeta Tiwari published in Indian journal of Homeopathic Sciences for Bronchial Asthma and assessed using Asthma Control Test and Peak Expiratory flow rate showed symptom improvement and increase in Asthma Control test score, hence demonstrating efficacy of Natrum Muriaticum. Another clinical study of adults with bronchial asthma reported that Natrum Muriaticum was one of the commonly prescribed medicines, following Arsenicum Album. The study reported improvement in spirometric parameters and Asthma Quality of Life Questionnaire scores after homoeopathic treatment.

CONCLUSION

The case is classified under dynamic, chronic, fully developed, miasmatic disease. Since the patient had come with previous course of medicine, the symptoms and ailments which he

suffered from before the use of the medicine was taken into consideration as this is what frames the original picture of the disease as per aphorism 91. It was a chronic disease, so the constitution of the patient was taken for treatment as mentioned in aphorism 5 and Natrum Muriaticum 200 was prescribed. This case demonstrates the effectiveness of homoeopathic medicines in improving the quality of life in chronic case of asthmatic patients along with ongoing allopathic treatment.

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EVIDENCE BASED CASE REPORT ON THE EFFECTIVENESS OF INDIVIDUALIZED HOMOEOPATHIC MEDICINE IN ACUTE APPENDICITIS

ABSTRACT: Acute appendicitis is the most common surgical condition of the abdomen presenting as acute abdominal pain. Diagnosis predominantly clinical but heavily assisted by scoring systems and by modern imaging. Approximately 7% population will have appendicitis in their life time, with peak incidence occurring between the ages of 10 and 30 years. Males and females have a lifetime appendicitis risk of 8.6%and 6.7% respectively. Here is a case report of 12 years female child with symptoms of pain in abdomen, nausea and giddiness came in my clinic which was diagnosed as Acute appendicitis with appendicolith by USG and treated with PHOSPHOROUS 30C followed by 200C based on the totality of symptoms. Pre and Post treatment analysis was done on the basis of Ultrasonography of abdomen and pelvis.

KEY WORDS: Acute appendicitis, Appendicolith, Phosphorous, Constitutional medicine, similimum, Ultrasonography.

INTRODUCTION: The appendix is a small worm like diverticulum of the caecum, potentially having a role in regulating intestinal microbiota and immunology. The neonatal appendix averages 4.5cm in length compared with 9.5cm for adults. Inflammation of appendix, acute appendicitis is one of the most common reasons for acute abdominal pain in children and adults. An accurate diagnosis of acute appendicitis is important to avoid severe outcome or unnecessary surgery. Hyperplasia of appendiceal lymphoid follicle frequently causes luminal obstruction. Studies have proved that some of the patients who had a history of abdominal pain with localized abdominal tenderness and hemodynamic stability could be treated non-operatively.

OBJECTIVE: To assess the effectiveness of the constitutional treatment in a 12 years female child diagnosed with Acute appendicitis &appendicolith.

METHODOLOGY: Acute appendicitis was diagnosed based on clinical history, examination &USG(Ultrasonography). Vas Score is used to assess the pain severity. Constitutional totality was framed using Kent's method and repertorization done using Kent's repertory. Phosphorous 30C followed by 200C was given in saccharum lactis and placebo was given in the form of cane

sugar globules with rectified spirit. Monarch assessment was done for assessing improvement in symptoms after the treatment.

PRELIMINARY DATA: Name: ABC, Age: 12 years, Sex: Female, Religion: Muslim, Occupation: Student, Address: Aero Nagar-Coimbatore, Date of case taking: 3-11-25.

PRESENTING COMPLAINTS: Patient came with the- complaints of Pain in right side of lower abdomen since 3 days and complaints of nausea since1 day

LOCATION	SENSATION	MODALITY	CONCOMITANTS
Right side of lower abdomen	Burning pain	<from walking, from touch, coughing >by rest, lying down	Giddiness on and off
Stomach	Nausea	<over eating >by drinking cold water	

VAS (Visual Analogue Scale) Score – 9

HISTORY OF CHIEF COMPLAINTS: Patient came to the clinic with complaints of severe burning pain in right lower abdomen and nausea. Pain started 3 days back and got severe in the day when she came to clinic. Nausea present since1 day. There is a history of similar pain in lower abdomen on and off since1 month. Initially the pain was around umbilicus which gradually shifted to the right lower quadrant of abdomen. There was loss of appetite and slight raise in body temperature. The pain was aggravated by walking, coughing and touch. No history of vomiting.

PAST HISTORY WITH MEDICAL TREATMENT HISTORY: The patient was normal vaginal delivered baby with a birth weight of 2.9 kg. Vaccination was appropriate for the age. History of similar episodes of pain in right lower abdomen on and off since1 month. No treatment done for the same. There is no significant history of previous medical illness, hospitalization or surgery.

FAMILY HISTORY: There is no significant family history of similar abdominal complaints or any major hereditary illness among the family members.

PERSONAL HISTORY: Appetite: reduced intake due to nausea, Thirst: reduced (approximately 500ml-800ml per day), Diet: mixed, Cravings: Bread, paneer, Aversion: non-veg, Bowel habits: 2 days once, normal stool since childhood, Bladder habits: Normal (3-4 times per day), Sleep: Disturbed due to abdominal pain (11 pm -5am), Perspiration: generalized, Thermal reaction: Hot (likes to drink cold water), Physical activity: present, Built and nourishment: Moderately built and nourished.

MENTAL GENEREALS: The patient has fear of ghosts, fear of darkness, and fear of scolding from father.

LIFESPACE INVESTIGATION: The patient born and brought up in a middle-class family. Lining in a joint family with grandmother, father, mother and younger sister. Developmental milestones were normal. There is a good relationship with friends and family members. She seeks attraction and affection from family members and enjoys being noticed and appreciated by others. Likes drawing and very good in academic performance too. She fears a lot in darkness and being alone. She does all her works with great enthusiasm.

GENERAL PHYSICAL EXAMINATION:

Respiratory System: Bilaterally symmetrical air entry present. Normal vesicular breath sounds heard. No added sounds.

Cardiovascular system: S1S2 heard. No murmurs.

Nervous system: Conscious and alert. Normal movements of the extremities present.

No pallor, No jaundice, Cyanosis not present, No clubbing, No lymphadenopathy, No pedal oedema

VITAL SIGNS:

Height: 148 cm Weight: 38 Kg BMI: 17.3 Kg/m2 Temperature: 100 F

Pulse: 96 beats/min Respiratory rate: 20 breaths/min Blood Pressure: 110/70 mmHg SpO2: 98%on room air

SYSTEMIC EXAMINATION: Gastrointestinal system:

Inspection: Mildly distended in right lower quadrant, No visible scars or peristalsis

Palpation: Localized tenderness present in right iliac fossa, rebound tenderness was present, no palpable mass. Rovsing's sign, Psoas sign and obturator sign was Positive. No rigidity over muscles.

Percussion: Localized tenderness present in right iliac fossa on percussion, Slight dullness and distension present.

Auscultation: Bowel sounds heard as normal.

DIFFERENTIAL DIAGNOSIS: Mesenteric lymphadenitis, Meckel's Diverticulitis, Intussusception, Ovarian torsion and Acute Gastroenteritis.

INVESTIGATIONS: USG abdomen and pelvis shows Acute appendicitis with an Appendicolith of 17 mm.

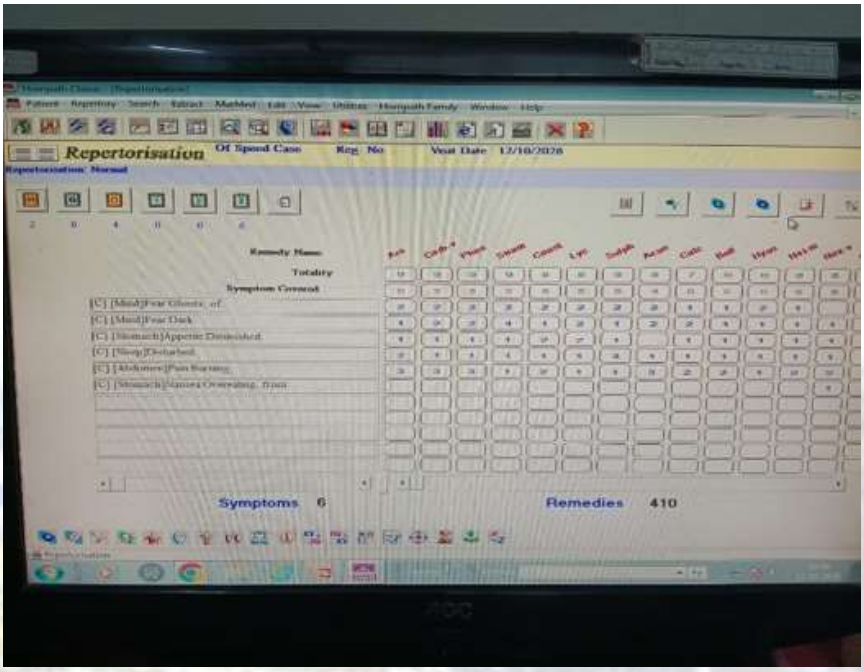
DIAGNOSIS: Acute appendicitis?

TOTALITY OF SYMPTOMS: constitutional totality

MENTAL GENERALS	**PHYSICAL GENERALS**
Fear of ghosts	Appetite reduced
Fear of darkness	Thirst for cold water
Fear of scolding from father	Reduced sleep
	Burning pain in abdomen
	Nausea worse from overeating
	Abdomen pain worse by touch, walking

Miasmatic Totality: Most of the symptoms in this case as Fear, burning pain and nausea (functional disturbances) comes under PSORA as it major Miasm in the background.

REPERTORIAL TOTALITY



PRESCRIPTION: Phosphorous 30C/ 1 Dose (4 pills STAT), Placebo/ 1 dram (2 pills TDS)

FOLLOW-UP and OUTCOME ASSESSMENT:

DATE	COMPLAINTS	PRESCRIPTION
14/11/2025	Pain in abdomen better than before No fever. Nausea or vomiting Sleep disturbed Vas score: 2	Phosphorous 200C/1 dose (4 pills) Placebo/1 dram (2 pills TDS)
27/11/2025	Slight pain in abdomen present No nausea, vomiting or fever USG shows improvement Vas Score: 1	Placebo/1 dose (4 pills)
3/12/2025	No pain or tenderness in abdomen Vas Score:0	Placebo/1 dose (4 pills)

MONARCH (Modified Naranjo Criteria for Homoeopathy) assessment table

Serial no.	Monarch assessment domain	Findings in the case	Marks
1.	Improvement after intervention	Present	+2
2.	Time relationship between intervention and improvement	Improvement within one week of treatment	+1
3.	Improvement in other symptoms	Improvement present in Pain in abdomen and nausea	+1

4.	Improvement in overall being	Improvement present in sleep, appetite and activity	+1
5.	Direction of cure	Relief in nausea followed by relief in Pain present	+2
6.	Homoeopathic remedy's specific relationship to the outcome	Yes (based on the repertorisation and Materia medica symptomatology)	+1
7.	Previous similar clinical experience	No	0
8.	Dose- Response relationship	30C followed by 200C based on the symptom relief response	+1
9.	Objective evidence supporting improvement	Present (VAS Score-0after treatment, USG report)	+2
10.	Other interventions or explanations for improvement	No intervention of conventional or surgical treatment	0

Assessment Score: 11 (Total possible range: -6 to +13)

DISCUSSION: The present case concerns about a patient presenting with pain in lower abdomen with nausea. The case was evaluated in homoeopathic approach by taking the constitutional totality including the mental generals, physical generals, particulars with the help of detailed history taking and clinical examination. Phosphorous was considered as the similimum by correlating the patient's symptoms with the Homoeopathic Materia medica with the help of repertorization. Miasmatic assessment was made based on the symptomatic miasmatic presentation. Acute appendicitis is an acute condition that may progress to perforation, abscess formation or peritonitis. Clinical examination, appropriate investigations and timely treatment are essential. The patient's response should be assessed using objective clinical findings and appropriate follow-up.

CONCLUSION: The case highlights the importance of systematic case-taking, individual symptom analysis, repertorial analysis and Materia medica correlation in homoeopathic prescription. This case demonstrates the effectiveness of individualized homoeopathic medicines in the treatment of acute appendicitis. Even though the above case shows Homoeopathic individualized medicine can treat such surgical emergencies, the patient requires urgent assessment, homoeopathic medicines must not delay investigations or references when indicated for emergency surgery.

PATIENT CARE GUIDELINES

CARE Checklist of information to include when writing a case report

Topic	Item	Checklist item description	Reported on Line
Title	1	The diagnosis or intervention of primary focus followed by the words "case report"	1
Key Words	2	2 to 5 key words that identify diagnoses or interventions in this case report, including "case report"	1
Abstract (no references)	3a	Introduction: What is unique about this case and what does it add to the scientific literature?	1
	3b	Main symptoms and/or important clinical findings	2
	3c	The main diagnoses, therapeutic interventions, and outcomes	4
	3d	Conclusion—What is the main "take-away" lesson(s) from this case?	8
Introduction	4	One or two paragraphs summarizing why this case is unique (**may include references**)	7
Patient Information	5a	De-identified patient specific information	2
	5b	Primary concerns and symptoms of the patient	2
	5c	Medical, family, and psycho-social history including relevant genetic information	2
	5d	Relevant past interventions with outcomes	2
Clinical Findings	6	Describe significant physical examination (PE) and important clinical findings	4
Timeline	7	Historical and current information from this episode of care organized as a timeline	3
Diagnostic Assessment	8a	Diagnostic testing (such as PE, laboratory testing, imaging, surveys)	8
	8b	Diagnostic challenges (such as access to testing, financial, or cultural)	6
	8c	Diagnosis (including other diagnoses considered)	4
	8d	Prognosis (such as staging in oncology) where applicable	2
Therapeutic Intervention	9a	Types of therapeutic intervention (such as pharmacologic, surgical, preventive, self-care)	2
	9b	Administration of therapeutic intervention (such as dosage, strength, duration)	2
	9c	Changes in therapeutic intervention (with rationale)	8
Follow-up and Outcomes	10a	Clinician and patient-assessed outcomes (if available)	7
	10b	Important follow-up diagnostic and other test results	9
	10c	Intervention adherence and tolerability (How was this assessed?)	7
	10d	Adverse and unanticipated events	Not mentioned
Discussion	11a	A scientific discussion of the strengths AND limitations associated with this case report	7
	11b	Discussion of the relevant medical literature **with references**	10
	11c	The scientific rationale for any conclusions (including assessment of possible causes)	10
	11d	The primary "take-away" lessons of this case report (without references) in a one paragraph conclusion	8
Patient Perspective	12	The patient should share their perspective in one to two paragraphs on the treatment(s) they received	Not mentioned
Informed Consent	13	Did the patient give informed consent? Please provide if requested	Yes ☑ No ☒

PRE AND POST USG REPORTS





ULTRASOUND SCAN OF ABDOMEN

RIF: CT correlation done.

LIVER - Normal in size and echotexture. No evidence of focal lesions.

BILIARY RADICLES - No dilatation.

CBD - Normal in size. No evidence of calculi.

GALL BLADDER - Normal in echotexture. No stone, sludge or polyp seen. Wall thickness is normal. No pericholecystic collections.

PORTAL VEIN - Normal in calibre.

PANCREAS – Head and body of pancreas show normal echotexture. Tail of pancreas is

Clinical Diagnosis:

Appendix is mildly thickened measuring approximately 8 mm in maximum calibre; no significant periappendiceal soft tissue inflammation/ fluid collections. No evidence of appendicolith. Mild probe tenderness is present in the corresponding region.

IMPRESSION:

- Mildly thickened appendix without significant periappendiceal inflammation. No evidence of appendicolith. Mild probe tenderness is present in the corresponding region. Features likely represent early acute appendicitis. Suggested clinical correlation/follow up.

ULTRASOUND REPORT

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INDIVIDUALIZED HOMOEOPATHIC MANAGEMENT OF MENSTRUAL MIGRAINE WITHOUT AURA USING *CIMICIFUGA RACEMOSA*: A CASE REPORT

ABSTRACT

Introduction: Menstrual migraine without aura is a migraine phenotype in which migraine attacks occur in close temporal relationship with menstruation.

Case Presentation: A 34-year-old married woman, a secondary school teacher, presented with recurrent throbbing headache for four years. Attacks occurred 1–2 days before menstruation, predominantly in the occipital region extending towards the vertex, lasted 8–10 hours and were associated with nausea, photophobia and phonophobia. The headache was aggravated by mental exertion and before menstruation and relieved by rest and after onset of menstruation. No aura or intermenstrual headache was reported. Baseline VAS was 8/10 and MIDAS score was 19.

Homoeopathic assessment and intervention: The totality included mental exertion aggravation, premenstrual sensitivity, mental fatigue, chilly thermal state, disturbed sleep before attacks and the characteristic occiput-to-vertex throbbing headache. Repertorization using the Hompath classic software repertory yielded Sepia and Cimicifuga racemosa as leading remedies. Comparative materia medica analysis favored Cimicifuga racemosa, prescribed in 200C potency as one dose followed by placebo.

Outcome: During four months of follow-up, attack frequency remained one attack per cycle. Headache duration decreased from 8–10 to 3–4 hours and VAS from 8/10 to 4/10. Nausea, photophobia, phonophobia and sleep disturbance progressively improved. Analgesic use decreased from 2 tablets/month to nil. MIDAS decreased from 19 at baseline to 12 at the third month.

Conclusion: This case documents individualized homoeopathic management with longitudinal outcome assessment. Because it is a single uncontrolled case without prospective headache-diary documentation, the observed temporal association cannot establish treatment efficacy.

Keywords: Menstrual migraine; Migraine without aura; Cimicifuga racemosa; Individualized homoeopathy; MIDAS; Menstruation; Case report.

INTRODUCTION:

Migraine is a recurrent neurological disorder characterized by attacks of headache and associated symptoms such as nausea, photophobia and phonophobia. Menstrual migraine is a clinically important phenotype in women in whom attacks show a temporal relationship with menstruation.

The International Classification of Headache Disorders, 3rd edition (ICHD-3), distinguishes menstrual migraine without aura from other migraine phenotypes. In the present case, the headache was consistently reported 1–2 days before menstruation and resolved after onset of menstrual flow, with no intermenstrual headache reported.

The case presentation records the use of ICHD-3 for diagnosis and a differential consideration of migraine with aura, tension-type headache and chronic migraine. The clinical picture was considered consistent with menstrual migraine without aura.

In individualized homoeopathy, remedy selection is based on the totality of characteristic symptoms rather than diagnosis alone. This case therefore focuses on the clinical presentation, individualized symptom analysis, repertorial evaluation, differential remedial diagnosis and longitudinal follow-up.

OBJECTIVE:

To evaluate improvement in the patient's migraine-related disability and clinical symptom burden following individualized homoeopathic management of menstrual migraine without aura, using the MIDAS score together with VAS and clinical follow-up parameters.

CASE DETAILS:

34 yr female patient married, Bed graduate working as a teacher residing in Belagavi came on 17/02/2026

Presenting complaint:

Recurrent throbbing headache for 4 years. The pain was predominantly occipital, extending towards the vertex, lasting 8–10 hours. It was aggravated 1–2 days before menstruation and by mental exertion, and relieved after onset of menstruation and by rest. Nausea, photophobia and phonophobia were associated.

History of chief complaint:

The patient was apparently healthy four years previously. Headaches developed gradually, initially occurring once every 2–3 months, mild in intensity and relieved by rest. Over the years, frequency, severity and duration progressively increased. The headache began in the occipital region, extended towards the vertex, remained throbbing and lasted 8–10 hours; it subsided after onset of menstrual flow. Nausea, photophobia and phonophobia were associated.

Disturbed sleep before headache episodes, mental fatigue and reduced concentration had been present for the preceding two years. With increasing severity, the patient required repeated doses of over-the-counter analgesics during menstrual episodes, with temporary relief. During severe attacks she became emotionally disturbed, preferred to remain alone and sought a quiet environment. The complaints interfered with professional responsibilities, household activities, social interactions and overall quality of life.

Past, treatment and family history:

Initially, attacks were managed with rest. With progression, analgesics were used approximately 2–3 times per month with temporary relief. The father had hypertension; the mother was healthy.

Personal, menstrual and obstetric history:

Appetite was normal; diet mixed; thirst 3–4 L/day; no specific craving or aversion; bowel regular; urination 3–4 times/day and 0–1 time/night; perspiration moderate and non-offensive.

Thermal state was chilly. Sleep was disturbed during migraine episodes but otherwise satisfactory; dreams were not remembered.

No significant menstrual history and obstetric history

LIFE-SPACE INVESTIGATION:

The patient described a disciplined and supportive childhood environment. Since childhood she preferred maintaining harmony and avoiding conflicts, was obedient and responsible, and tended to become quiet during stressful situations. She was sincere in professional duties; prolonged teaching hours and sustained mental work produced mental fatigue. She was emotionally attached to her family and often avoided sharing her discomfort so as not to worry others. Premenstrualy she experienced increased emotional sensitivity, nervousness and disturbed sleep. During severe headaches she became quiet and withdrawn and preferred silence and solitude. She preferred a small circle of close relationships, listened more than she spoke, and valued responsibility, family harmony and sincerity.

CLINICAL EXAMINATION:

Nothing abnormal detected.

DIAGNOSTIC ASSESSMENT:

Using ICHD-3, the provisional and final diagnosis in the case presentation was menstrual migraine without aura. The case was characterized by recurrent throbbing headache, attacks 1–2 days before menstruation, occiput-to-vertex extension, nausea, photophobia and phonophobia, absence of visual or sensory aura, headache frequency below 15 days per month, and improvement after onset of menstruation.

Differential diagnoses considered were migraine with aura, tension-type headache and chronic migraine. Migraine with aura was considered less likely because aura symptoms were absent. Tension-type headache was considered less likely because the pain was throbbing and accompanied by nausea, photophobia and phonophobia. Chronic migraine was considered less likely because headache frequency remained well below 15 days per month.

HOMOEOPATHIC CASE ANALYSIS:

The case was analyzed according to the totality of characteristic symptoms. Mental generals included mental exertion, sensitivity before menses, responsible/conscientious disposition and mental fatigue. Physical generals included chilly thermal state and disturbed sleep before attacks. Particulars included occipital headache extending to vertex, throbbing pain, aggravation before menses and from mental exertion, and amelioration after onset of menses and with rest.

REPERTORIAL ANALYSIS:

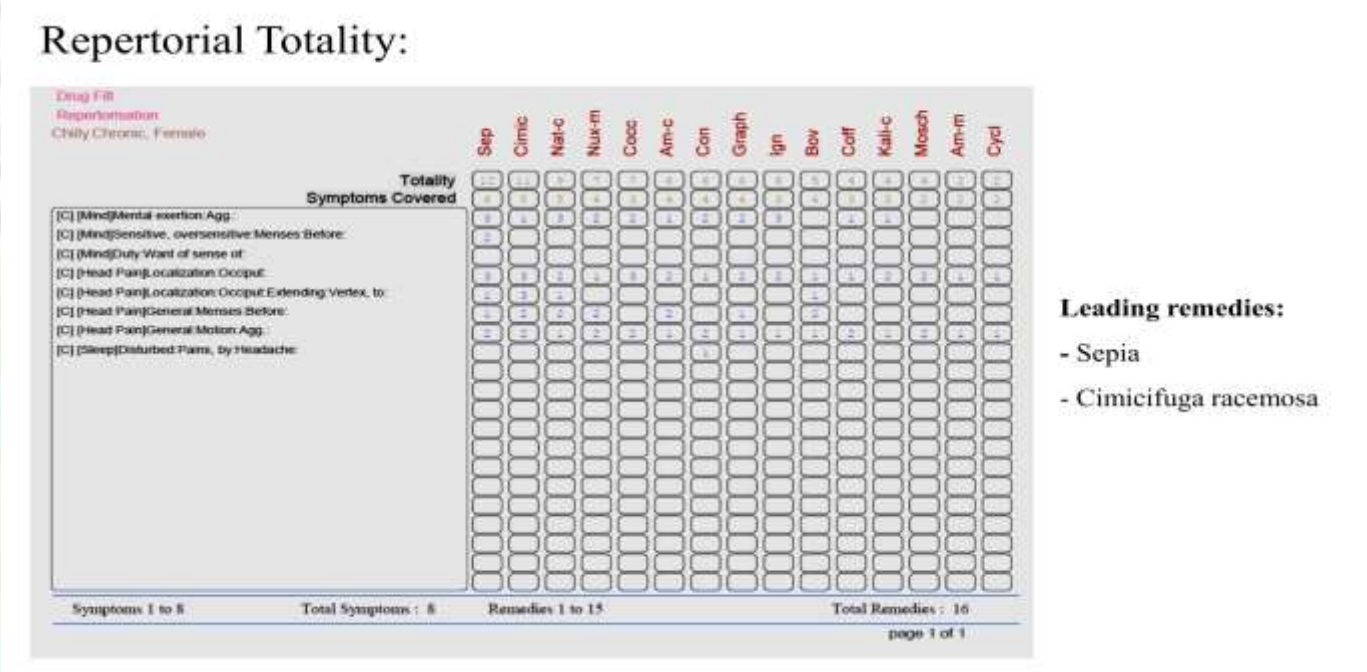


Figure 1. Repertorial totality and leading remedies.

HAHNEMANNIAN CLASSIFICATION AND DIFFERENTIAL REMEDIAL DIAGNOSIS:

The disease was classified as a dynamic, chronic, periodic, miasmatic disease with predominantly psoric and sycotic manifestations. Differential remedial diagnosis was performed between Sepia and Cimicifuga racemosa. Sepia was considered on the basis of its marked menstrual relationship and female symptomatology, whereas Cimicifuga racemosa was considered more closely corresponding to the nervous manifestations, menstrual

periodicity, occiput-to-vertex headache, emotional withdrawal and sleep disturbance described in this case.

HOMOEOPATHIC INTERVENTION:

Prescription: Cimicifuga racemosa 200C, one dose, followed by placebo TID for one month. Subsequent follow-ups continued with placebo as documented in the case presentation. The assessment tools used were MIDAS (Migraine Disability Assessment Scale) for migraine-related disability affecting work, household activities and social life over the previous three months, and VAS for headache severity.

FOLLOW-UP AND OUTCOME:

Table 3. Follow-up over four months

Parameter	**Baseline 17-2-26**	**1st month 17-3-26**	**2nd month 18-4-26**	**3rd month 19-5-26**	**4th month 19-6-26**
Prescription	Cimicifuga R 200C	Placebo	Placebo	Placebo	Placebo
Frequency of attacks	1 attack/cycle	1 attack/cycle	1 attack/cycle	1 attack/cycle	1 attack/cycle
Duration of headache	8–10 h	7–8 h	6–7 h	4–6 h	3–4 h
Severity (VAS)	8/10	7/10	7/10	5/10	4/10
Nausea	Present	Reduced	Mild	Mild	Minimal
Photophobia	Present	Reduced	Mild	Mild	Minimal
Phonophobia	Present	Reduced	Mild	Mild	Minimal
Sleep disturbance	Present	Improved	Improved	Markedly improved	Normal
Analgesic use	2 tablets/month	2 tablets/month	1 tablet/month	Nil	Nil
MIDAS score	19	—	—	12	—

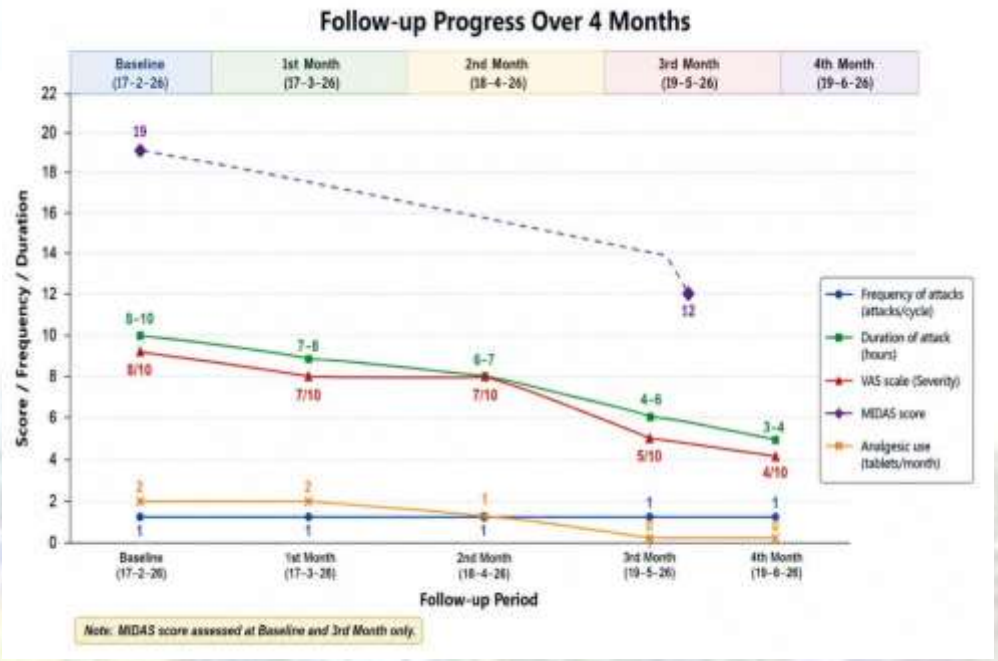
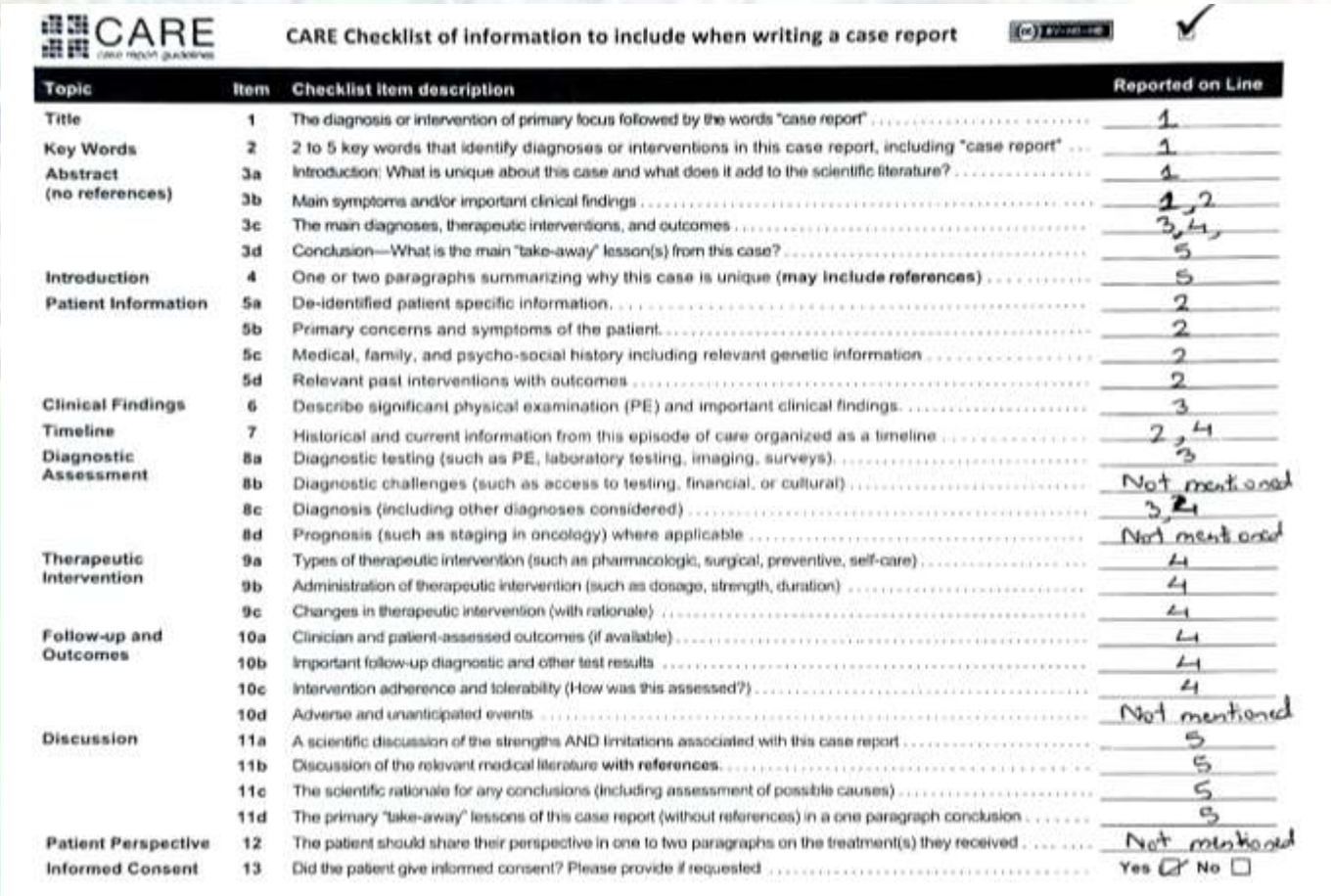


Figure 2. Follow-up progress over four months: frequency, headache duration, VAS severity, MIDAS score and analgesic use.

S. NO.	MONARCH ASSESSMENT CRITERIA	YES	NO	NOT SURE
1.	Was there an improvement in the main symptom or condition for which the homeopathic medicine was prescribed?	+2		
2.	Did the clinical improvement occur within a plausible time frame relative to the medicine intake?	+1		
3.	Was there a homeopathic aggravation of symptoms?		0	
4.	Did the effect encompass more than the main symptom or condition (i.e. were other symptoms ultimately improved or changed)?	+1		
5.	Did overall well-being improve? (suggest using a validated scale)	+1		
6A.	Direction of cure: did some symptoms improve in the opposite order of the development of symptoms of the disease?			0
6B.	Direction of cure: did at least one of the following aspects apply to the order of improvement of symptoms: -from organs of more importance to those of less importance? -from deeper to more superficial aspects of the individual? -from the top downwards?			0
7.	Did ‘old symptoms’ (defined as non-seasonal and non-cyclical symptoms that were previously thought to have resolved) reappear temporarily during the course of improvement?		0	

8.	Are there alternate causes (i.e. other than the medicine) that – with a high probability – could have caused the improvement? (Consider a known course of disease, other forms of treatment and other clinically relevant interventions)		+1	
9.	Was the health improvement confirmed by any objective evidence? (e.g. laboratory test, clinical observation, etc.)	+2		
10.	Did repeat dosing, if conducted, create similar clinical improvement?		0	
	TOTAL	+8		



CARE

CARE Checklist of information to include when writing a case report ✓

Topic	Item	Checklist item description	Reported on Line
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Key Words	2	2 to 5 key words that identify diagnoses or interventions in this case report, including "case report"	1
Abstract (no references)	3a	Introduction: What is unique about this case and what does it add to the scientific literature?	1
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	3d	Conclusion—What is the main "take-away" lesson(s) from this case?	5
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	10b	Important follow-up diagnostic and other test results	4
	10c	Intervention adherence and tolerability (How was this assessed?)	4
	10d	Adverse and unanticipated events	Not mentioned
Discussion	11a	A scientific discussion of the strengths AND limitations associated with this case report	5
	11b	Discussion of the relevant medical literature with references.	5
	11c	The scientific rationale for any conclusions (including assessment of possible causes)	5
	11d	The primary "take-away" lessons of this case report (without references) in a one paragraph conclusion	5
Patient Perspective	12	The patient should share their perspective in one to two paragraphs on the treatment(s) they received	Not mentioned
Informed Consent	13	Did the patient give informed consent? Please provide if requested	Yes ☑ No ☐

DISCUSSION:

The present case demonstrates a clear temporal relationship between headache and menstruation. The combination of throbbing pain, nausea, photophobia and phonophobia, absence of aura and consistent premenstrual onset supported the diagnosis recorded in the case report.

From a homoeopathic perspective, the prescription was based on individualization. The repertorial analysis produced Sepia and Cimicifuga racemosa as leading remedies, after which

comparative materia medica was used for remedy selection. The characteristic correspondence emphasized the menstrual periodicity and nervous manifestations together with the occipital-to-vertex headache and mental-emotional features.

The longitudinal outcome showed improvement in headache duration, VAS severity, associated symptoms, sleep disturbance and analgesic requirement, while attack frequency remained unchanged at one attack per cycle. This distinction is important because the observed benefit was principally a reduction in attack burden rather than attack frequency.

MIDAS was used to assess migraine-related disability. The score decreased from 19 to 12 between baseline and the third month. MIDAS was originally developed to quantify disability associated with headache across work/school, household and social/leisure activities.

The result should be interpreted cautiously because this was an individual case without a control group or blinding, and prospective headache-diary documentation was not available. The temporal association between the intervention and improvement therefore cannot establish efficacy. Natural fluctuation in headache severity and other nonspecific influences cannot be excluded.

CONCLUSION:

This case report describes individualized homoeopathic management of a 34-year-old woman with menstrual migraine without aura as documented in the case report. Following Cimicifuga racemosa 200C as a single dose followed by placebo, progressive improvement was observed in headache duration, VAS severity, associated symptoms, sleep disturbance, analgesic requirement and the numerical MIDAS score, while attack frequency remained one attack per menstrual cycle.

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