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RESEARCH ARTICLE

EXPLORING THE CLINICAL EFFICACY OF INDIVIDUALIZED HOMOEOPATHY IN CHRONIC DISEASE MANAGEMENT

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Abstract

Background: The specific efficacy of Individualized Homeopathy for the treatment of Chronic Diseases has not been established. There is ongoing debate about the role of extended consultations, constitutional and miasmatic classifications, and the overall operation of the system in Individualized Homeopathy.

Objective: The objective of this article is to evaluate recent Randomize d Controlled Trials and distinguish condition-specific patient outcomes from the overall claims of therapeutic effectiveness.

Methods: I performed a focused review of trial records and associated abstracts, including methods and recent evidence syntheses. The scope of this article was limited to 8 published Placebo controlled Individuali zed Homeopathy Trials and 453 Randomized patients. The search was not a fully exported and deduplicated database review; thus, overall counts per PRISMA guidelines cannot be reported.

Results: I identified a range of results. One 2021 Individualized Home opathy Trial for Rhinosinusitis reported no between-group differences. A 2022 Individualized Homeopathy preliminary trial for Atopic Dermatitis reported no primary difference at 3 months. A 2023 Individu alized Homeopathy replication trial for Atopic Dermatitis reported a PO-SCORAD of −18.1 (95% CI −24.0 to −12.2) at 6 months. A 2023 Individualized Homeopathy trial for Psoriasis reported a significant difference in the primary PASI. Individualized Homeopathy for post-COVID in 2025 reported a difference of −4.2 (95% CI −4.9 to −3.4) at 3 months. The remaining studies reported adverse effects.

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Conclusion: The published studies report mostly null or positive findings, mainly from small studies. The verified publications do not establish a common effect for Chronic Diseases and do not validate miasmatic constructs. Large independently replicated, well-reported trials with clinical outcomes are necessary.

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Introduction:-

Chronic illness requires repeat assessment, accurate diagnostic classification, adherence to treatment, and assessment of adverse effects and benefits. In some instances, patient reported symptom burden and quality of life are relevant, but may not adequately capture disease activity, risk of complications and functional status. Homoeopathy (Individualized Medicine) is based on an extensive case history and selection of a remedy based on a broad symptom (preference) profile. Individualization may be based on classical (Constitutional) Homoeopathic principles, in which case selection of a remedy is made based on the Totality of the Symptoms of the individual. A placebo effect is always a possibility, and may be confused with true benefit from the medication. Regression to the mean, fluctuations in the natural disease state, and the context of other supportive care and clinical attention must be considered. The benefit observed may not necessarily be due to the medicinal preparation. [2, 11, 12, 13]

Miasmatic Homoeopathic classification is distinct from the principles of Constitutional Homoeopathy and refers to classifying symptoms based on historical and philosophical foundations of Homoeopathic medicine. Case notes may include these symptoms and classifications, but systematic reviews cannot extrapolate these to be validated and biological classifications of disease. Conclusion about “Miasmatic Evolution” should not be drawn unless the reliability and effect on the outcome of the study is measured.Various published studies demonstrate the need for condition specificity. Although some conditions may be chronic or persistent, symptoms and the means to measure function may be different.The wider Homoeopathy literature includes reports addressing Emotional Suppression and Psychosomatic presentations, Cutaneous conditions, Thyroid disorders and broader community health applications. Such reports vary considerably in study design and are not interchangeable with Blinded Placebo-Controlled Trials; their descriptive findings require separate interpretation. [15–19, 21–35]Even a significant positive change in response to one questionnaire is not sufficient to evaluate the impact in another disease condition. Here the aim is to provide a constructive, well-researched evaluation of a defined set of studies, and present contrasting outcomes, keeping in view what an exhaustive systematic review would reveal. [3-10]

Review Questions and Methods:-

The primary review question was to investigate the effect of Individualized Homeopathic medicines on condition-specific validated outcomes as compared to placebo or defined controls, in people with persistent or recurring clinical conditions. Secondary questions were concerned with the effects on durability and quality of life and safety, as well as reporting and testing of Individualization or Miasmatic classification. Population, Intervention, Comparator and Outcome (PICO) definitions were made a priori. Population of interest was adult or mixed-age patients with defined clinical conditions. The intervention was the choice of Individualized Homeopathic medicine by the practitioner. Comparator was defined control and the outcomes of interest were measured at pre-determined clinical time intervals. Comparison of Individual Homeopathic medicines to Botanical Pharmacological Preparations was outside the scope.

Searches and cross-checks were conducted using publicly accessible PubMed IDs, original publisher records, and clinical trial registry records. Search strategies combined homeopath* or homoeopath* with individualiz* and terms from the following groups: Randomized, Placebo, Chronic, and relevant condition names. A large focus was on the years 2020-2025. This methodology verified bibliographic records for eight clinical trials. It did not comprise an exhaustive multilingual search of Embase/CENTRAL/Scopus, dual independent screening, registry reconciliation, or a reproducible all-record deduplication log. Therefore, it would not be appropriate to populate a PRISMA 2020 Flow Diagram with contrived identification, screening, and exclusion numbers. Figure 1 shows the numbers and rationales for these fields, when available. [1,2]

Only Randomized Placebo-Controlled Trials (including pilot and feasibility studies) that tested Homeopathic treatments were included. Details for these studies were abstracted from primary, or, if available, publisher’s, abstracts. If available, outcomes for each study were abstracted in their original format, and if quantitative, were retained for subsequent analysis. A full Cochrane’s risk of bias assessment would require primary documentation (including methods, randomization, deviations, and missing data), and an explanation for any post hoc analyses. As abstracts were the only source of information available for many studies, the assessment of risk of bias in this review should be interpreted as provisional. [2]

Supplementary publications supplied for contextual discussion were checked separately, including Observational Reports, Case Studies, Narrative Reviews and recent Evidence Syntheses published through 2026. These sources are discussed narratively as background and methodological comparisons; they were not enrolled as additional randomized studies, were not entered into the eight-trial participant total, and did not contribute to the numerical

displays. Bibliographic identification alone does not establish clinical efficacy. [15–35]Given the heterogeneity of the conditions and outcomes across the included studies, it was not possible to conduct a meta-analysis. Figure 2 provides an evidence display for the included studies and should not be misconstrued as an independent studies' meta-analysis. [2,8,10]

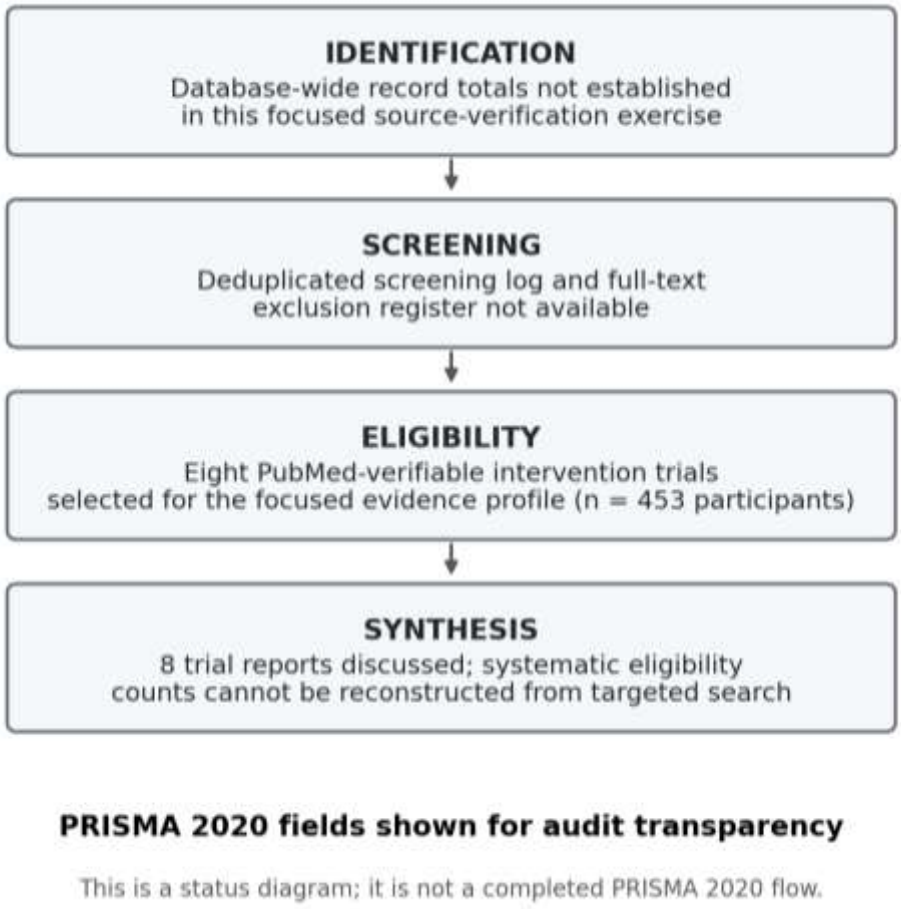


Figure 1. Search-audit status using PRISMA 2020 categories; record-level counts are not reconstructible from the documented targeted checks.

Results:-

The focused corpus is made up of eight published trial reports, with 453 Randomized participants: 62 for Chronic Rhinosinusitis, 60 for Preliminary Atopic Dermatitis, 60 for Vitiligo, 60 for irritable bowel syndrome, 51 for Psoriasis, 60 for Atopic Dermatitis Replication, 40 for Knee Osteoarthritis and 60 for Post-COVID conditions. We report the trial-specific enrollment totals. Follow-up in the selected trial reports was approximately three to six months. It is insufficient to make confident claims regarding disease modification over multi-year timeframes. [3-10]

Chronic Rhinosinusitis: A double-blind study randomly assigned 62 participants to the intervention or control group and measured the SNOT-20 and other quality of life and symptom scales for up to 4 months. Numerically greater improvement was observed for the active treatment group; however, all between-group comparisons for the Primary and Secondary endpoints were statistically nonsignificant. [3]

Atopic Dermatitis: The first double-blind, preliminary trial randomly assigned 60 adults to the intervention or control group and assessed PO-SCORAD at one, two and three months. At each time point, the between-group comparisons for the primary outcome were statistically nonsignificant. A second, 6-month replication trial randomly assigned 60 adults to the intervention or control group and assessed PO-SCORAD at month six. The primary

outcome of the second trial favorably supported the Individualized medicines. These results are not logically inconsistent; they may have differed due to replication, follow-up and other procedures. Secondary DLQI and other comparisons of treatment burden in the second trial were reported as statistically nonsignificant. [4, 8]

Vitiligo: A double-blind, feasibility trial randomly assigned 60 participants to the intervention or control group and assessed VASI, VitiQoL and DLQI at 3 and 6 months.

It states that larger effect size reductions were seen in the Individualized arm and calls for a definitive trial to establish efficacy. The publication's feasibility orientation and omission of a complete extractable comparative effect in the checked abstract, limit their claims regarding established clinical benefit. [5]

Irritable bowel syndrome: A 60-participant trial used the IBS-QOL as the primary outcome measure and the IBS-SSS and EQ-5D-5L as the secondary outcome measures over 3 months. The published report describes group comparisons and effect size calculations. The length of the study, single-center nature and reliance on self-reported measures are some of the most important factors limiting generalizability, particularly when significant effects are noted. Given the short period of the study, a claim of sustained remission would require longer period of follow up than that which was tested. [6]

Psoriasis: A 51-participant study (of which 25 were in the active arm and 26 were in the placebo arm) reported a PASI group difference ($F[1,49]=10.448$, $p=0.002$) after 6 months. The difference in the DLQI daily activity subscale ($p=0.023$) and the total PDI ($p=0.01$) and total DLQI ($p=0.247$) differences were reported as non-significant. The difference between the primary outcome measure of skin-condition and broad life quality is cautioned when stating a broad improvement was noted. [7]

Knee Osteoarthritis: The 2024 feasibility trial included 40 participants in a double-blind parallel comparison. The results of this trial can help plan and improve the operational aspects of a future full-scale trial, but the success of a small trial to demonstrate the reproducibility of clinical effect is uncertain. More independent studies with pain and function endpoints would be necessary to support condition-specific recommendations. [9]

Post-COVID conditions: A placebo-controlled feasibility study (3 months) published in 2022, randomized 60 participants to one of the two arms. Thirty participants were in each arm. High retention and favorable symptom improvements were reported in this study, but the main limitation of the study was the very short follow-up and patient reported outcomes. The endpoints for this study are correlated observations of the same 60 participants and should not be viewed as two independent studies. [10]

Table 1. Verified Randomized Trials in the focused evidence profile

Indication / Year	Sample	Follow-up	Comparison and Primary Evidence
Rhinosinusitis / 2021	62	4 months	Individualized remedy versus placebo; primary differences nonsignificant [3]
Atopic dermatitis / 2022	60	3 months	PO-SCORAD: no significant between-group difference [4]
Vitiligo / 2022	60	6 months	Pilot; feasibility emphasis, larger numerical changes reported [5]
IBS / 2023	60	3 months	IBS-QOL and IBS-SSS; condition-specific trial [6]
Psoriasis / 2023	51	6 months	PASI $p=0.002$; total DLQI $p=0.247$ [7]
Atopic dermatitis / 2023	60	6 months	PO-SCORAD MD −18.1, 95% CI −24.0 to −12.2 [8]
Knee osteoarthritis / 2024	40	Feasibility	Small randomized feasibility comparison [9]

Post-COVID / 2025	60	3 months	Symptoms MD −4.2, 95% CI −4.9 to −3.4 [10]

Table 2. Outcome-specific Numerical results with transparent Interpretation

Study	Endpoint	Published Result	Interpretation
Dey 2022 [4]	PO-SCORAD	Month 3 p=0.229	Difference not statistically significant
Balamurugan 2023 [7]	PASI	F(1,49)=10.448; p=0.002	Difference favored individualized arm
Balamurugan 2023 [7]	Total DLQI	p=0.247	Difference not statistically significant
Mandal 2023 [8]	PO-SCORAD	MD −18.1 [−24.0,−12.2]	6-month difference favored individualized arm
Rana 2025 [10]	Symptom checklist	MD −4.2 [−4.9,−3.4]	3-month difference, feasibility study
Rana 2025 [10]	MYMOP-2 profile	MD −2.2 [−2.8,−1.7]	Same participants as preceding outcome

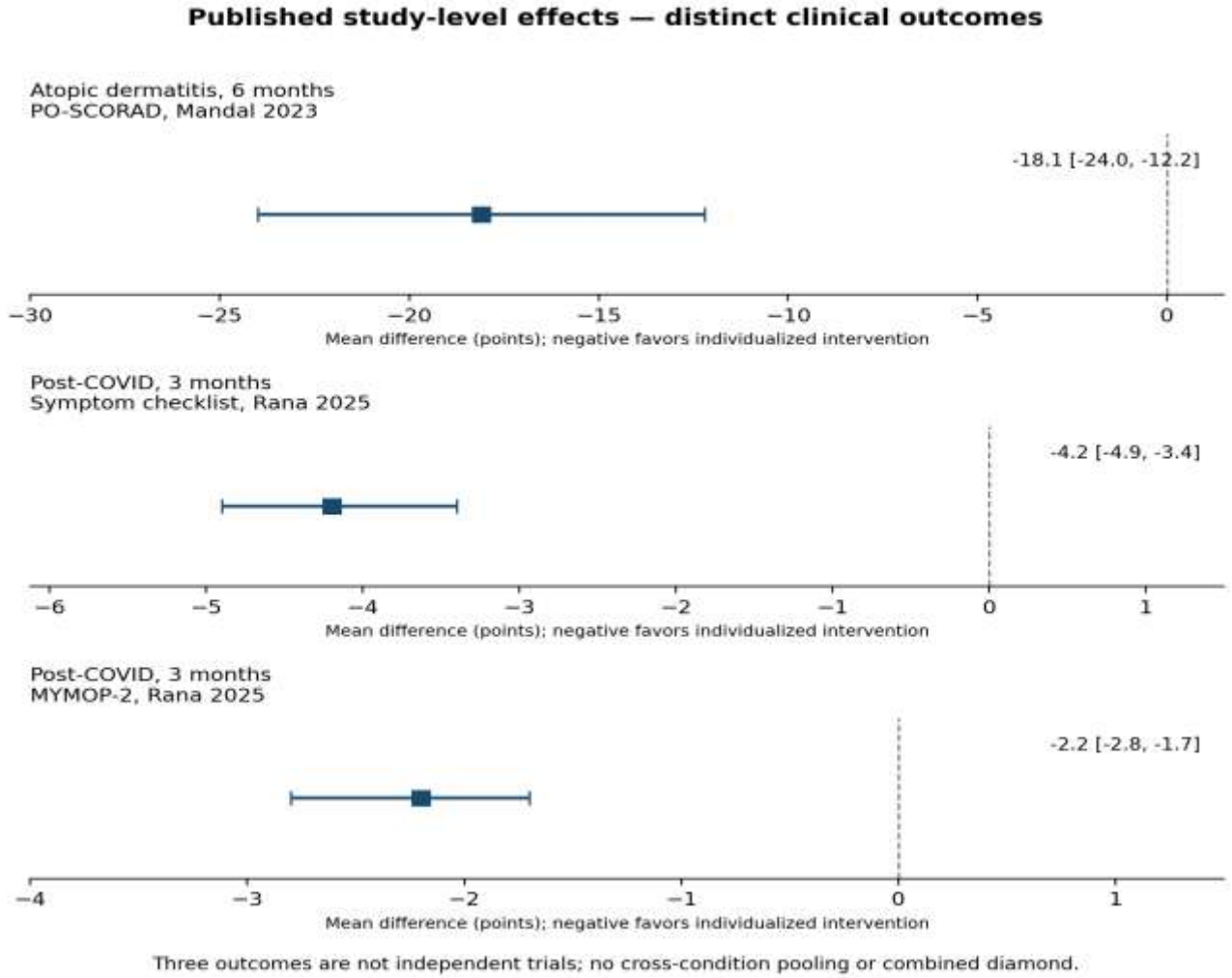


Figure 2. Forest-style displays of three published numerical effect estimate from two studies. Units and conditions differ, and no pooled estimate is asserted.

Constitutional Individualization and Miasmatic Interpretation:-

The focus of these trials is on the prescription, not on the predictive biomarker. Several reports describe the repeated prescription of certain remedies or the use of patient-specific selection procedures. The repetitive prescription of certain remedies can be related to the use of constitutional assessment. However, the fact that a particular category of constitutional assessment is prescribed does not necessarily mean that category caused the outcome. This would require a number of prerequisites. First, the category should be defined in an operational way. Second, there should be validated measures of reliability regarding the definition. Third, the category should be assessed prior to randomization. Finally, there should be sufficiently powered models of effect modification. [3-10]

Miasmatic descriptions serve an important historical function; however, they should not be interpreted as evidence of a mechanism for Chronic Inflammatory Illness, Immunoregulation, Fertility and Post Viral illness. To test the "Miasmatic Evolution" hypothesis, reproducible measures of importance to patients should be employed and associations with prognostic variables should be accounted for. None of the checked trial abstracts offer this evidence. The appropriate conclusion is that this trial set provides no evidence for the validity of this mechanism.

These are complex clinical encounters. Much can be done during the consultation to influence the outcome. The use of traditional remedies may produce similar effects to placebos; however, an uncontrolled before-and-after study may not isolate the effect of the prescription. The outcome of the trial may be affected by a number of confounding factors, including inconsistencies in contact time. This is of particular concern for the assessment of patient reported quality of life. [2, 12]

Table 3. Conceptual claims and the measurements necessary to evaluate them

Construct	What a trial would need	Finding in reviewed evidence
Constitutional match	Prespecified reproducible matching score and treatment interaction	Selection often described; independent predictive validity not shown
Miasmatic classification	Operational definitions, assessor agreement and blinded repeated measures	Not validated as a disease mechanism
Long-term stabilization	Validated disease-specific outcomes after 12–24 months	Predominantly 3–6-month follow-up
Remedy-specific action	Randomized contrast holding consultation constant	Some placebo-controlled contrasts, with mixed findings
Safety	Prospectively elicited adverse events and treatment delay	Insufficient power for uncommon harms

Critical Appraisal and Certainty:-

Reports typically use a double-blind, randomized design, which is a strength compared to descriptions of uncontrolled practice. However, assessing internal validity also requires examination of sequence generation, concealment and allocation, treatment fidelity, mechanisms for missing data, and planned versus reported analyses. The information retrieved for this review does not support a complete RoB 2 assessment for each outcome. The table, therefore, indicates the review-level appraisal issues, rather than state adjudicated, low-risk judgments. [2]

Precision is limited by the small numbers of studies and the small number of participants in each study. A final analysis may be based on a small number of participants; in several studies, only approximately 20 to 30 participants were randomized. Many studies explicitly stated that their work was preliminary. In multi-arm trials, especially in rare disease groups, a statistically significant outcome may be unstable based on different assumptions about missing data, multiplicity, case mix of the disease, or independent replication. Publication bias may exist in this body of work, but may not substantially affect any of the conclusions. This body of work examines broad chronic conditions, and there are no firm conclusions that can be generalized to "Homoeopathy for Chronic Conditions." Positive and negative results need to be reported. [2, 11-14]

Table 4. Methodological Limitations in the selected trial profile

Domain	Practical appraisal	Impact on interpretation
Random sequence and concealment	Reported randomization does not alone document all RoB 2 signaling questions	Requires full protocol and trial report
Small studies	Trial N range 40–62	Wide uncertainty and fragile effect sizes
Outcome multiplicity	Many scales and subscales per trial	Potential selective emphasis
Comparators	Placebo-controlled, mostly with individualized visits	Contextual effect needs explicit separation
Follow-up	Three to six months in the profiled trials	Long-term disease modification unproven
External validity	Many single-center Indian settings	Independent multicenter replication needed

Table 5. Provisional GRADE-oriented conclusion by evidence question

Question	Synthesis	Certainty judgment
Chronic disease efficacy as one class	Outcomes and diagnoses not directly poolable	Not estimable as a single effect
Atopic Dermatitis	One nonsignificant 3-month trial; one positive 6-month primary result	Limited and uncertain
Psoriasis	Positive PASI; broad QoL totals nonsignificant	Limited, single-trial
Rhinosinusitis	Nonsignificant between-group differences	Limited, single-trial
Post-COVID symptoms	Positive patient-reported scores in feasibility RCT	Limited, short-term
Miasmatic theory as mediator	No direct operationalized randomized test verified	Not established

Discussion:-

An adequate synthesis relies on the need to group similar conditions based on specific questions, not the convenience of grouping different conditions based on a single classification of symptoms and treatment. The verified trial set includes a favorable result for Psoriasis, an Atopic Dermatitis Replication Trial, and null results in a previous Dermatitis Trial and Chronic Rhinosinusitis. There are substantial differences between the conditions, and these are not a problem to be addressed by a pooled cross-condition statistic. Similarity in intervention philosophy does not make PASI, PO-SCORAD, IBS-QOL, SNOT-20, and post COVID symptoms, measurements of the same thing, or interchangeable. [3-10]

Contextual Literature (Observational Evidence, Reports and Reviews):-

Psychosomatic and Emotional themes. A retrospective clinical report discussing Psychosomatic illness and Emotional Suppression [15], a Natrum-focused report [17], and discussions of Mental well-being and Emotional Suppression [19, 22] describe Individualized Homoeopathic case-taking and reported outcomes. A subsequent analytical review [28] revisits the mind–body context.

Cutaneous Warts and related Skin lesions: The Causticum publication describes a 50-patient clinical series [16], whereas a 2024 conference report and a 2025 publication describe 100 wart cases from a private clinic [18, 23]. A Thuja intercurrent-remedy analysis addresses a subset of 62 of 100 cases [26]; these reports must not be treated as

four independent cohorts without participant-level reconciliation. A 2026 synthesis on Cutaneous Warts [32] reports very low certainty overall and emphasizes limitations of uncontrolled observational evidence. Spontaneous wart regression, concurrent procedures, selective follow-up and lack of blinded comparators preclude assigning observed clearance to homoeopathic preparations.

Other Dermatological observations: A published Alopecia Areata case study [21], a Retrospective Pediatric Molluscum Contagiosum series [30], and a September 2026 National Journal of Homoeopathy item on Pediatric Alopecia Areata [34] expand the descriptive range of reported practice. Case reports are useful for documenting care pathways and generating research questions but do not establish comparative efficacy, long-term prevention of relapse or treatment safety. Article-level author and pagination details of the cited journal-magazine item [34] could not be independently resolved from the available flipbook metadata.

Thyroid and Endocrine care: A 2024 Thyroidinum report [25], a 2026 critical review of Hypothyroidism [29], and a PubMed-indexed 2026 narrative review [33] describe Individualized prescribing approaches and methodological limitations. The 2026 narrative review expressly distinguishes reported symptoms and laboratory changes from specific treatment effects and states that indicated Thyroid Hormone treatment should not be replaced or delayed. Improvements in Thyroid-stimulating Hormone or symptoms in uncontrolled cases may reflect fluctuation, concomitant medication and confounding, rather than a remedy-specific effect.
Scope outside Chronic-Disease Randomized Trials. A discussion of Acute Surgical mimics [20], a historical prophylaxis-oriented article [24], a Community/Preventive-Care Integration Study [27] and a Non-Severe Dengue Adjunctive-Care Analysis [31] address markedly different indications and endpoints. These publications provide research context, not evidence that the chronic-disease trial profile demonstrates prevention of infection, dengue recovery or the safety of deferring indicated surgery or other treatment. Such claims require independent diagnosis-specific controlled evaluation.

Atopic Dermatitis evidence in newer reviews. A 2026 systematic review focusing on Individualized Homoeopathy in Atopic Dermatitis [35] reports inconsistent and heterogeneous evidence, including the positive and null placebo-controlled results already discussed here. This context supports retaining the original trial-level distinctions, without importing that review's separate study selection or pooled estimates into the present fixed eight-trial profile. None of the added publications modifies the original results tables, participant total, or the PRISMA audit limitations.

The 2023 review of Placebo-Controlled Homoeopathy Trials meta-analyses reported positive overall results in several previous meta-analyses. It acknowledged variation in how trialists set their quality standards and interpret their results. Another 2023 publication on methodological analysis of trial effects investigated positive results in a field used for methodological research. Neither publication provides evidence for a high-certainty effect estimate for a new population. The evidence debate should address whether there is a bias in the research protocols, how subjects are assigned to interventions, which outcomes are missing, small study effects, and reproducibility. [11, 12]

In the absence of long-term outcome data, the effect of the intervention in the short or medium term can be evaluated. A symptom may resolve in the short-term, but this does not mean the disease has been cured. Improvements may occur spontaneously, even with chronic conditions. It is possible to recommend the use of an intervention for the long-term, to mitigate the need for other treatments, but improvements should be documented to show the intervention was effective.Comprehensive safety surveillance should also address the possible delay in the effective standard treatments.The best next step is to adequately perform, and statistically power, clinical trials in specifically defined conditions. The elements of randomization should include a prespecified primary endpoint, a clinically relevant difference, usual (standardized) care, a credible placebo, double (blind) assessment, individualized (prescribing) algorithms, capturing adverse events, a detailed analysis plan, and long-term follow-up. This assessment has a deliberate boundary: it is an evidence-based manuscript formatted from primary research and other credible sources; however, it is not a complete, and exhaustive, systematic review.The details provided are insufficient to perform a final PRISMA-compliant analysis and submit the manuscript to the journal. The flow diagrams illustrate what is missing rather than providing unverified totals.

Conclusion:-

There are verified randomized studies of Individualized Homoeopathy for various Chronic conditions that demonstrate favorable or null results, typically from small sample sizes and/or short-term (up to 6 months) follow-up. Replication is warranted for the differences reported, but these do not prove a general treatment effect for all conditions or modification of the conditions over the long-term, nor the biological validity of the miasmatic

classification. Diagnosis-specific considerations must be taken, including the risks of bias, endpoints, multiplicity, consultation and/or expectation effects as well as patient-important outcomes. This review provides a sourced starting point; a fully audited search and study-level appraisal are essential to complete a systematic review.

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