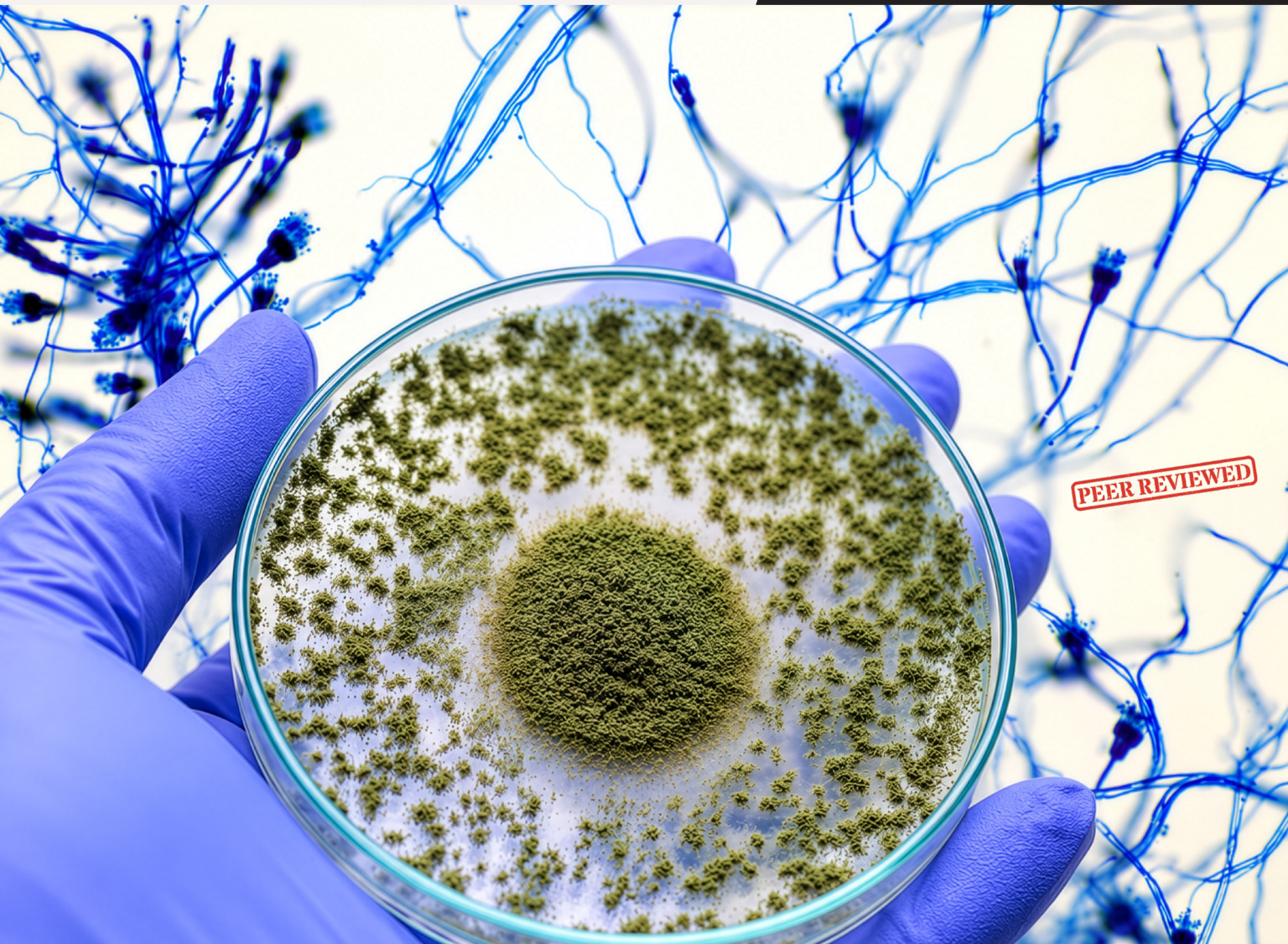


THE HOMOEOPATHIC HERITAGE

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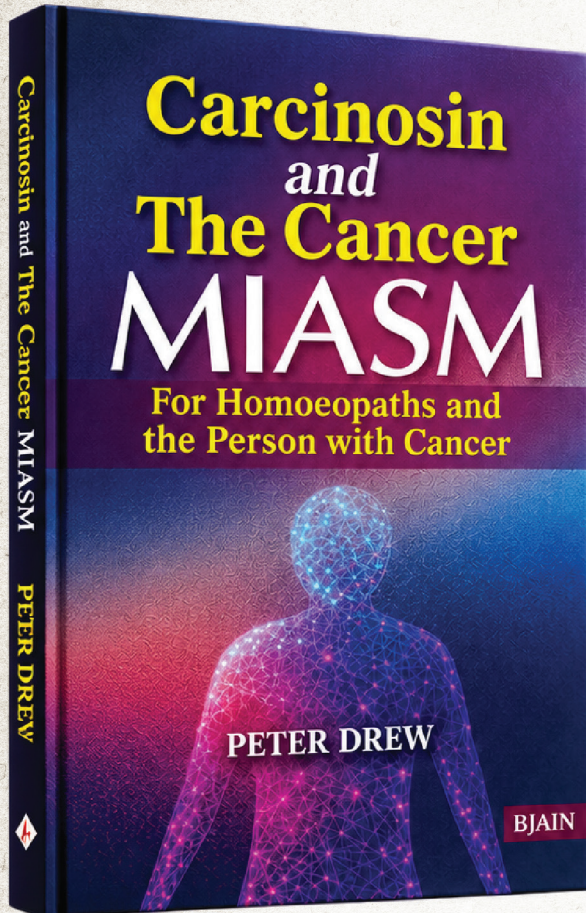
Understanding Fungal Disorders through the Lens of Homeopathy

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CONTENTS

EDITORIAL

Dr Mansi Tyagi 5

FROM THE EDITORS' DESK

The Trinity of Healing Systems: A Rational Taxonomy of Global Medical Traditions—Biomedicine, Vitalistic Medicine and Spiritual Healing

Dr Eswara Das 7

IN ITALICS

Homoeopathy at a Transitional Phase: Reimagining Education, Practice and Research for the Future

Dr. Rajat Chattopadhyay 16

STALWARTS' EXPEDITION

Dr. Ramanlal Prabhudas Patel (1926-2019) The Man, The Vision, The Legacy

Dr. Subhas Singh, Dr. Dodani Riya Rajkumar, Dr. Sudhanshu Kumar, Dr. Gone Mani prasad 23

OPINION PIECE

The Miasmatic Spectrum of Fungal Disease

Dr. Sheetal Beri, Dr. Anil Aggarwal 27

Decoding Fungal Recurrence: Where Contemporary Mycology Meets Homoeopathy

Dr. Rutvi Akash Joshi, Dr. Akash Navinchandra Joshi 32

Antifungal Potential of Medicinal Plants Used in Homoeopathy: A Narrative Review of Experimental and Pharmacological Evidence

Dr. Anand Pal Singh Kushwah, Dr. Komalba Kushwah 50

Mapping Cutaneous Fungal Disorders: A Comprehensive Analysis of Tinea Subtypes, Miasm and Classical Approach Across Classical Repertories and Materia Medica

Dr. Dhruvika Patel, Dr. Annapurna Mistry 58

Understanding Fungal Disorders through the Lens of Homoeopathy: Current Concepts and Homeopathic Perspectives

Dr. Manisha, Dr. Pravin Kumar Singh 64

Understanding Fungal Disorders Through The Lens of Homoeopathy

Dr. Divya Patel, Dr. Aparna Mudaliar 69

Fungal Infections and Homoeopathy: A Comprehensive Review

Dr. Upasana Kumari, Dr. Dewesh Kumar Dewanshu 76

Mucormycosis: A Review of its Clinical and Homoeopathic Aspects

Dr. Tanya Vaish 82

Host Susceptibility in Opportunistic Fungal Infections: An Integrative Review of Modern Mycology and Homoeopathic Perspectives

Dr. Putla Prathyush, Dr. N. Prasanna Gayathri 87

Host Fungus Interaction And Homoeopathic Susceptibility: Interpreting Modern Immunology Through The Lens Of Homoeopathic Philosophy

Keerthana.M.P, Kokila.B, Lakhshaya.K, Laya.R.Raj, Sibin R.A 96

Sporotrichosis: The Rose Gardener's Disease and Homeopathic Management

Dr. Krutika N. Rothe, Dr. Apurva V. Rangari, Dr. Himani A. Kulkarni, Dr. Nikita S. Karale 106

Unveiling miasmatic matrix: A Repertorial exploration in Homoeopathic management of Fungal infections.

Dr Sayali Wandhare, Dr Harshita Khandelwal, Dr Sejal Sawant, Dr Ajay Sutar 113

CASE REPORT

Onychomycosis: From Diagnosis to Individualized Homoeopathic Management : A Case Report

Aakriti Rai, Jalpa Barot 120

Healing Beyond the Lesions: A KOH-Confirmed Case Report on Individualized Homoeopathic Management of Dermatophytosis

Dr U. Rajeev Nair, Dr Aishwarya Shukla, Dr Nancy Singhal, Dr Ayushi Gupta 127

Unmasking the Fungal lesion: Decoding the deeper state in fungal disorders through the Lens of Homoeopathy

Dr. Swati Rani, Dr. Ashwin Dwivedi 134

Tinea: A Case Report Illustrating

Constitutional and Intercurrent Anti-Miasmatic Prescribing.

Dr. Richa Chauhan 139

Tracing Roots of Disease: A Homoeopathic Case Report of Tinea Corporis Highlighting Prenatal and Emotional Influences

Dr Parul Vasava, Dr Annapurna Mistry 144

KOH-Confirmed Tinea Corporis Managed with Chrysarobinum: A Case Report with DLQI Assessment

Dr. Ezekiel E. Warbah 149

Cassia Sophera In Recurrent Tinea Cruris: A Case Report

Dr. Pooja Bhatt, Dr. Namrata Chauhan, Dr. Rahul Makwana 156

Management of Renal Stone With Individualized Homoeopathic Medicine- A Case Report

Dr. Pravin Kumar Singh M.D.(Hom), Dr. Pranjal Kumar, Dr. Sambit Kumar Nayak, Dr. Pradeep Kumar Tiwari 162

RESEARCH

In-Vitro Evaluation Of The Antifungal Activity Of Homoeopathic Azadirachta Indica Against Candida Albicans And Aspergillus Niger Using Disc Diffusion Method

Dinesh M, Ebenshiya Sharon E, Franda Ashi T, Gohila Vadivu S, Sibin R.A 167

Association of Miasmatic and Thermal Patterns with Clinical Characteristics in Patients with Rheumatoid Arthritis: A Descriptive Observational Study from a Homoeopathic Hospital Outpatient Department

Dr. Md. Latif Uddin Ahmed, Dr. Mostafijur Rahaman, Dr. Abdul Karim 171

An In Vitro Study of Antifungal Activity of Homoeopathic Medicine on Malassezia Furfur

Bejashini P, Bhuvaneswari N, Chandana B, Devatharshini G, Dr SIBIN RA 178

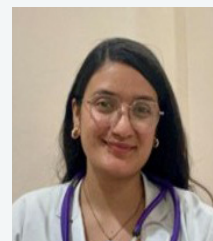
BOOK REVIEW

Book Review on "The Art and Craft of Writing and Publishing Scientific Articles"

Dr. Vishal V Deshpande, Dr. Santhosh Kumar A 182

Dear Readers,

Fungal infections are seldom constructed at initial stages that intensify the severity of infections and complicate the treatment procedures. Viewing fungal disorders through the lens of homeopathy invites a deeper, more ecological understanding of human health. Fungal overgrowth is not merely an external invasion to be aggressively wiped out; it is a vital signal pointing to an altered internal environment. We are honoured to feature *The Editor's Desk*, eloquently written by Dr Eswara Das, MD(Hom), PhD, MBA (Health Care), International Advisors (The Homeopathic Heritage). While the Stalwart section is enriched by Prof. (Dr.) Subhas Singh. The In Italics section features a scholarly contribution by Prof. (Dr.) Rajat Chattopadhyay, PhD(Hom.)(WBUHS); MD (Hom) (NIH, Cal), MBA (Health Care) President, Homoeopathy Education Board, NCH. Further enhancing the academic value of this issue by book review of 'The Art and Craft of Writing and Publishing Scientific Articles': Editor: Prof. (Dr.) Chaturbhuja Nayak



The intense, relentless itching of a fungal infection—especially at night when the rest of the world goes quiet—can feel like a genuine form of slow torture. That unstoppable urge to scratch provides momentary relief, only to trigger a fiercer cycle of burning, inflammation, and skin damage.

Fungal infections are seldom constructed at initial stages that intensify the severity of infections and complicate the treatment procedures. Fungal pathogens employ various mechanisms to evade the host immune system and to progress the severity of infections. For the treatment of diverse superficial and systemic infections, antifungal drugs from the available repertoire are administered. However, well documented evidence of fungal resistance to most of the antifungal drugs hampers disease control and poses challenges in antifungal therapy.

The first symptoms of infection were always produced by the affected “Vital Force” on the surface of the body. In Classical Homeopathy, as outlined by the Master Samuel Hahnemann, the skin is viewed as the body’s primary outward canvas. When the internal balance or Vital Force is deranged, the organism attempts to protect vital internal organs by projecting the disharmony outward onto the non-lethal surface: the skin. There are itching skin eruptions indicated in Psora.

Allen, like Kent, expressed the belief that microbes only began to develop after the moment of infection when a patient's predisposition connected with an infection. Allen associated the etiology

of Psora, as well as the etiology of other miasms, with negative thinking and the violation of a person's conscience.

In aphorism 38, Master Hahnemann provides historical clinical examples to illustrate the behavior of **dissimilar diseases** meeting in the human body. He notes that when a newer, stronger dissimilar disease enters the body, it temporarily **suspends** the weaker, older disease. Once the new disease completes its course or is removed, the old disease returns unchanged.

Hahnemann uses **tinea (ringworm)** as a prime example by citing a case observed by the physician Nicolaes Tulpius:

“Two children affected with a kind of epilepsy remained free from epileptic attacks after infection with ringworm (tinea); but as soon as the eruption on the head was gone, the epilepsy returned just as before...”

In Aph 187- 190: Hahnemann details how local manifestations (such as chronic skin eruptions like tinea) are actually external reflections of an internal, systemic malady (**Psora**) and cautions against suppressing them with topical ointments.

Viewing fungal disorders through the lens of homeopathy invites a deeper, more ecological understanding of human health. Fungal overgrowth is not merely an external invasion to be aggressively wiped out; it is a vital signal pointing to an altered internal environment. With this theme in mind, we invites all the readers to dive into the rich compilation of clinical case studies, research

evidence, disease progression dynamics, and individualized homeopathic approaches to fungal disorders.

The October issue is compiled with the theme of “Understanding Fungal Disorders through the Lens of Homeopathy”. We are honoured to feature *The Editor’s Desk*, eloquently written by **Dr Eswara Das**, MD(Hom), PhD, MBA (Health Care), International Advisors (The Homeopathic Heritage). While the Stalwart section is enriched by **Prof. (Dr.) Subhas Singh**, HOD, Department of Organon of Medicine, NIH, Kolkata, who presents a compelling life sketch of Dr. Ramanlal Prabhudas Patel (1926-2019). The In Italics section features a scholarly contribution by Prof. (Dr.)

Rajat Chattopadhyay, PhD(Hom.)(WBUHS); MD (Hom) (NIH, Cal), MBA (Health Care) President, Homoeopathy Education Board, NCH. Further enhancing the academic value of this issue by book review of ‘The Art and Craft of Writing and Publishing Scientific Articles’: Editor: **Prof. (Dr.) Chaturbhuja Nayak**

Happy Reading!

Dr Mansi Tyagi

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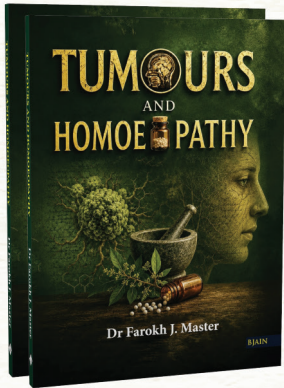
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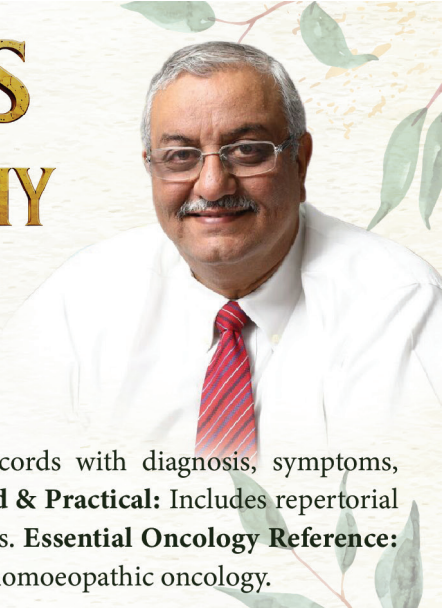
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TUMOURS AND HOMOEOPATHY

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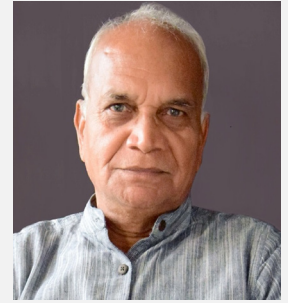


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The Trinity of Healing Systems: A Rational Taxonomy of Global Medical Traditions—Biomedicine, Vitalistic Medicine and Spiritual Healing

Dr Eswara Das

MD(Hom), PhD, MBA (Health Care), International Advisors (The Homeopathic Heritage),
Former Director, National Institute of Homeopathy and Consulting Advisor (Homeopathy) in
the Ministry of Ayush, Government of India.



Abstract

The coexistence of diverse medical traditions across the world has produced classifications such as Conventional Medicine and Traditional, Complementary and Alternative Medicine (TCAM), which are useful administratively but do not always reflect the philosophical and epistemological foundations that distinguish one healing tradition from another. This conceptual article proposes a rational, philosophy-based taxonomy of global healing systems through comparative analysis of their historical evolution, cultural origins, concepts of health and disease, causation, diagnostic reasoning, and therapeutic logic. It first distinguishes medical systems from medical practices and then identifies three broad paradigms—Biomedicine, Vitalistic Medicine, and Spiritual Healing. Biomedicine is grounded predominantly in mind-body duality, reductionist science, objective diagnosis, and targeted intervention; Vitalistic Medicine is rooted in mind-body synergy, life-force concepts, inductive reasoning, constitutional balance, and individualised therapeutics; and Spiritual Healing approaches health through the mind-body-spirit interface, consciousness, belief, meaning, and inner transformation. The proposed trinity is not intended as a hierarchy of medical systems, but as a conceptual framework for understanding their distinct ontologies, epistemologies, strengths, limitations, and possible areas of complementarity. Such a taxonomy may provide greater clarity for medical pluralism, research methodology, health policy, education, culturally competent care, and thoughtful integration while preserving the philosophical

identity of each healing tradition.

Keywords

Medical pluralism, Biomedicine, Vitalistic Medicine, Vitalism, Spiritual Healing, Integrative health care, Traditional medicine, Health systems classification, Homeopathy, Indian Medicine, Chinese Medicine, WHO Classification, Taxonomy

Introduction

Healthcare has never evolved as a single, uniform tradition. Modern biomedicine now occupies the dominant position in organised healthcare, yet Indian Medicine, Chinese medicine, Arabic medicine, Homeopathy, Naturopathy, Tibetan medicine, and several other systems continue to be practised across cultures. Alongside them are non-pharmacological approaches such as Yoga, Acupuncture, Chiropractic, and Reflexology, as well as faith-based and spiritual forms of healing. Each arose within a particular historical, cultural, and philosophical setting and developed its own understanding of health, disease, causation, and therapeutic intervention.

The difficulty lies less in their diversity than in the way they are presently classified. Broad labels such as conventional, traditional, complementary, alternative, and integrative medicine are useful for administrative purposes, but they often group together systems that differ fundamentally in their philosophical premises and therapeutic logic. Without a clearer conceptual framework, meaningful comparison becomes difficult and may limit rational policy, research design,

academic discourse, and appropriate clinical integration. This article therefore examines the historical and philosophical foundations of the major healing traditions and proposes a threefold taxonomy—Biomedicine, Vitalistic Medicine, and Spiritual Healing—as a more coherent basis for understanding their distinctive contributions to healthcare.

Historical Perspective on the Evolution of Medicine

The origin of medicine lies in humanity's early attempts to understand nature and its effects on health, disease, and healing. Ancient people observed the therapeutic properties of herbs, the influence of seasons, and patterns of illness, gradually developing a body of therapeutic knowledge. These insights gave rise to folk medicine, which later evolved into more codified treatment approaches.

As human societies settled in different regions, medical systems developed independently based on cultural preferences, beliefs, and philosophical frameworks. This led to the emergence of diverse medical traditions such as Mesopotamian, Egyptian, Chinese, Greek, and Indian medicine¹. With increasing ease of travel and cross-cultural exchange, these bodies of knowledge began to influence one another, contributing to the evolution of organised medical systems.

- In the West, the foundational contributions of Hippocrates, Galen, and Paracelsus shaped what later became known as Western Medicine.
- The *Vedic* influence laid the foundation of Indian traditional medical systems, while *Taoism* contributed to the fundamental texts of Chinese medicine.
- In the Middle East, the Unani tradition emerged through synthesised Greco-Arabic medical knowledge.

These systems are not arbitrary compilations of belief, but coherent frameworks based on observation, logical reasoning, and time-tested clinical experience. They survived across centuries not merely as relics of the past, but as living traditions that are still actively practised.

Though there are multiple medical approaches, a critical examination shows that:

- Each system has certain unique strengths in managing specific categories of diseases.
- Some illnesses are self-limiting and require minimal intervention, where any system may suffice to manage such cases.
- Certain diseases remain poorly understood or untreatable, where palliative and spiritual care are accepted norms.
- Most health problems are at the primary care level, where many systems—traditional or modern—can offer effective solutions.

These realities call for encouraging coexistence, cross-referral, and respectful integration of various medical practices based on their strengths. It is not only rational but necessary for a responsive and equitable healthcare model.

Fallacies of Nomenclature in Health Care

Across the globe, numerous healthcare systems and technologies are practised, each claiming to cure conditions ranging from ailments like allergies and common colds to complex diseases like asthma and cancer. The process of understanding illness and restoring health involves a complex interplay of pathophysiological mechanisms, pharmaceutical interventions, and supportive therapies. Health itself is a dynamic concept—encompassing promotion of wellbeing, disease prevention, clinical treatment, or even palliation.

A major shift in the modernisation of medical education began with the publication of the Flexner Report in 1910, which evaluated the state of medical schools in the United States and Canada. Abraham Flexner emphasised the importance of scientific rigour in medical training, advocating for a curriculum based on laboratory sciences and teaching on the pathological basis of diseases². The rise of germ theory and the development of vaccination contributed to a new phase that prioritised identifying specific causes for specific diseases. This orientation favoured targeted, interventionist approaches over Hippocratic observational methods, eventually coming to be known as modern medicine.

While this transformation led to undeniable advances in biomedical research and clinical practice, it also contributed to the marginalization of classical diagnostic techniques—such as comprehensive patient history-taking, physical examination, and bedside observation—which had been vital to earlier traditions of medical care. The growing emphasis on laboratory evidence and imaging tended to reduce the patient to a set of biochemical or radiological findings, often distancing the physician from the subjective experience of the patient.

The classical clinical teachings of Chamberlain, Hutchinson, and Harrison, once crucial to medical training, are now largely confined to academic curricula and seldom practised in routine clinical care. The famous statement by Sir William Osler, considered the father of modern medicine, “The good physician treats the disease; the great physician treats the patient who has the disease,” has lost relevance within the highly mechanised and protocol-driven scientific model of modern care³.

This transformation led to a growing divide in healthcare, which in turn prompted a resurgence of traditional, compassionate, and holistic systems of healing. Though there are systemic differences among the traditional systems, they coexist due to conceptual similarities. These similarities deserve delicate analysis rather than indiscriminate grouping, to ensure each system receives the recognition it deserves.

Categories of Medical Approaches

Medical traditions across the world can broadly be categorized into two overarching domains: *medical systems* and *medical practices*.

- **Medical systems** rely primarily on therapeutic interventions involving medicinal substances—whether drugs, remedies, or preparations. These systems are typically governed by pharmacopoeias, which outline standards for the preparation, composition, and usage of therapeutic agents. Examples include Allopathy, Homeopathy, Ayurveda, and Unani.
- **Medical practices**, by contrast, do not primarily use pharmacological substances.

Instead, they rely on techniques, physical modalities, and non-material therapies to manage disease, promote wellness, or prevent illness. These practices are not regulated by pharmacopoeias but are guided by codified scriptures, oral traditions, or experiential philosophies. Examples include Yoga, Acupuncture, Reiki, Reflexology, Pranic Healing, and Chiropractic.

The World Health Organization (WHO) has categorized these diverse approaches as follows:⁴

- **Conventional Medicine:** The evidence-based biomedical approach rooted in biology, physiology, and pathology
- **Traditional Medicine:** Indigenous, culturally rooted health practices.
- **Complementary and Alternative Medicine (CAM):** Practices used alongside or instead of conventional medicine.
- **TCAM (Traditional, Complementary, and Alternative Medicine):** A unified term merging traditional and complementary practices.
- **Integrative Medicine:** An emerging model that combines biomedicine with selected practices from other TCAM approaches, based on evidence and clinical relevance.

Perspectives on Different Health Care Technologies

Modern healthcare is a mosaic of diverse medical systems—each shaped by distinct cultural traditions, historical experiences, and philosophical outlooks. From ancient indigenous knowledge systems to contemporary medicine, health care reflects humanity’s enduring pursuit of healing.

While the WHO categorisation, though beneficial for administrative and research purposes, often lack conceptual clarity. They tend to obscure the underlying philosophical foundations and therapeutic logics fundamental to different systems. For instance, Homeopathy—despite not being traditional in a cultural or historical sense—is included in TCAM, while non-pharmacological practices like Yoga and Reiki are grouped alongside

biologically based therapies. This amalgamation results in arbitrary and overlapping categories that mislead rather than exemplify the true nature and origins of these medical traditions.

Medical systems do not merely differ in their external features—they diverge fundamentally in how they conceptualize health, disease, causation, and healing. Each system is fortified by a distinct set of ontological, epistemological, aetiological, and therapeutic principles. To understand a system's science, one must engage with the foundational view in which it is embedded. For instance:

- Those who understand Indian philosophy often recognize the *Tridosha* theory as a coherent, internally consistent system⁵.
- Believers in the Similia concept accept Homeopathy as a rational, science-based medicine aligned with its own principles.

The debate over whether traditional or non-bio-medical systems are “scientific” often arises from an imperative mismatch between competing understandings of health and healing. Science, in its broadest sense, is not limited to laboratory-based experimentation. It includes systematic observation, internal logic, and empirical validation within the framework of the system itself. Thus, dismissing certain systems as “dogma” merely because they do not conform to a different paradigm is both reductive and ethnocentric. The nature of science itself evolves when new theoretical frameworks replace earlier paradigms⁶. It is also stated that the validity of scientific knowledge depends on consensus amongst the scientific community, rather than solely on objective findings⁷. Many TCAM therapies are rooted in ancient wisdom, validated through centuries of use, and aligned with subjective human experience. Recognising the value and limitations of each healing system is essential for constructing a holistic and patient-centred model of care, as emphasised in integrative frameworks that advocate for combining the best of conventional and traditional approaches^{8,9,10}.

Rational and Practical Categorization of Health Care Technologies

Globally, a wide variety of medical systems and

health practices claim therapeutic efficacy across disease categories. However, the general public often lacks reliable, unbiased information about these systems beyond promotional claims or biased narratives. This highlights the need for a rational, principle-based classification of health care approaches—one that moves beyond historical narratives or institutional convenience.

Current classifications often fall short in this regard. For example:

- The term “Conventional Medicine” is used to describe modern biomedicine, despite the fact that it is an evolving science without much conventional tradition.
- “Alternative medicine” is a misnomer, as no system is inherently an alternative to another—each developed independently with its own logic and strengths.
- The terminology “Complementary medicine” is more neutral, but the fact is that every medical system complements the others and provides an adjunctive role.
- The umbrella term “TCAM” combines vastly different systems—ranging from Homeopathy (a relatively recent system with its own defined methodology) to Yoga and Reiki, which are primarily non-pharmacological and rooted in spiritual or energetic traditions.

Such classifications distort the boundaries and hinder meaningful comparison in developing better educational policies, research methodologies, and policy initiatives. This also unintentionally reinforces the hegemony of biomedicine by grouping all other medical systems as complementary to it.

A rational categorization may be based on core concepts and logical footing, particularly:

- The system's understanding of disease causation
- Its underlying aetiological and epistemological assumptions.
- Its diagnostic logic

- The nature of its therapeutic interventions

An unbiased examination of global medical traditions reveals that each system draws upon a distinct combination of scientific reasoning and logical medical philosophy. These components may vary in proportion across systems, but none are devoid of structure or logic. This calls for a different and more complex research strategy¹¹ and a comprehensive method of categorisation of medical systems.

The contribution of each system to disease prevention and health promotion continues to be relevant even today.

A renewed and principled taxonomy is essential not only for academic clarity, but also for regulatory standards, clinical integration, and cultural respect in pluralistic health systems.

1. Biomedicine: A Reductionist Science

Biomedicine, often referred to as scientific medicine¹², emerged from the rationalist traditions of Greek and Roman thought and underwent a major transformation during the Scientific Revolution in Europe. In the 19th century, Samuel Hahnemann, the founder of Homeopathy, coined the term Allopathy to distinguish his new therapeutic system from the prevailing Western medical practice of treating diseases on the Hippocratic principle *Contraria contrariis curantur*.

The evolution of biomedicine was strongly influenced by Cartesian philosophy, especially René Descartes' theory of mind-body dualism and his mechanistic view of the human body. This perspective laid the groundwork for a reductionist approach to medicine, where complex biological systems were understood by breaking them down into constituent parts. Disease was viewed as a malfunction in the structure or function of specific organs or biochemical processes.

Under this framework, anatomy, physiology, experimental pathology, and clinical evidence became the cornerstones of medical knowledge. Diagnostic tools, laboratory investigations, and surgical interventions advanced rapidly. The germ theory of disease, discoveries in microbiology, and the development of vaccines, antibiotics, and surgical techniques gave biomedicine

a dominant role in global healthcare. The influence of the pharmaceutical industry further consolidated its institutional power, particularly after the establishment of regulatory agencies and standardised treatment protocols.

Biomedicine is based on the premise that diseases arise from identifiable biological causes—such as pathogens, genetic mutations, metabolic imbalances, degenerative changes or organ dysfunctions—which can be studied, quantified, and treated using pharmacologically active drugs or surgically corrective interventions. It relies heavily on deductive reasoning, clinical trials, and epidemiological models to define treatment pathways.

While the system has achieved undeniable success—especially in emergency care, infectious diseases, and acute conditions—its limitations are evident in dealing with long-term chronic diseases of multifactorial causation or psychosomatic illnesses, where its diagnostic tools often fail to capture the complexity of human suffering.

In essence, biomedicine represents the empirical tradition of healing, well suited to certain domains of care. It continues to evolve on the foundational logic of mechanistic, quantitative, evidence-based, and experiential dimensions of health. Therefore, it is termed experimental medicine or scientific medicine.

2. Vitalistic Medicine: The Inductive Science

Historically, diverse healing systems have emerged across civilizations, rooted in the observation of nature, the rhythms of the body, and the belief in a life-sustaining energy. These are presently known as traditional and complementary systems. They share a fundamental view that life is governed by an invisible but all-pervasive life force—referred to as *prana*, *qi*, or *vital force*¹³.

Thus, the term Vitalism entered the field of medicine. Vitalism is a philosophical doctrine that postulates the existence of a vital force or life force, distinct from physical and chemical processes, which is responsible for the unique characteristics of living organisms¹⁴. It asserts that life cannot be fully explained by mechanistic approaches alone. This worldview forms the basis of Holistic Medicine.

Vitalistic systems employ inductive reasoning—drawing conclusions from time-tested, accumulated experience, observation of nature, and individualised response to treatment. Here, health is seen as the balance or harmony of life force, and disease as a disturbance in this equilibrium. Diagnosis often involves understanding patterns of imbalance, expressed by the life force through signs and symptoms at both the mental and physical levels, rather than identifying a single causative agent. Now, most of these systems use variations in pathophysiological and biochemical parameters to understand the pace and depth of disease progression and for prognostic decisions.

These systems were shaped by the intellectual contributions of figures such as:

- Charaka, Sushrut, and Nagarjuna in Indian Medicine, Huang Di in Chinese Medicine
- Hippocrates and Galen in Greek medicine
- Avicenna (Ibn Sina) in Islamic Unani medicine
- Samuel Hahnemann in Homeopathy

Such highly celebrated personalities contributed to the evolution of coherent systems of thought and codified principles, laid down codes of medical practice, and developed effective therapeutics that endure to this day. Their emphasis on the whole person—body, mind, and environment—marks a major holistic perspective, based on strong medical philosophy and a repository of science and art that prevailed at the time of their evolution.

In recent decades, interest in vitalistic systems has grown, particularly for chronic illnesses, lifestyle-related conditions, and functional disorders. Vitalistic systems are increasingly used to enhance immune response, restore constitutional balance, and stimulate self-healing mechanisms¹⁵.

There is a consistent demand amongst the public for such systems, and a new set of wellness concepts is emerging as a holistic approach. On the other hand, there is emerging criticism from detractors, stemming from the inability of these systems to explain some of their core concepts in the language of reductionist science. It is interesting

that vitalistic medicine operates within a different scientific framework—one that recognises the subjective, individualised, and dynamic aspects of healing. It is holistic, not just in its treatment, but in its understanding of the human experience.

3. Spiritual Healing: Faith and Consciousness Experiences

Spiritual healing is neither new nor an unfamiliar term in the history of healing. Rooted in the sacred and ritualistic practices of ancient societies, it predated both organised religion and rational biomedicine. Healing is seen not merely as a technical intervention but as a spiritual realignment—a return to harmony with nature, society, and the divine.

Though medicine and religion diverged after the Hippocratic revolution, spiritual elements never vanished from healing traditions. Across cultures, spiritual practices have addressed suffering, invoked divine aid, and offered meaning in illness and death. In the 21st century, spiritual healing is resurging—not as superstition, but as a vital complement to the increasingly fragmented approach to healthcare.

Spiritual healing is based on the belief that health is the harmonious alignment of body, mind, spirit, and the transcendent. Spiritual healing approaches illness as a manifestation of deeper imbalances—such as emotional repression, moral confusion, or spiritual disconnection. This paradigm holds that the soul—or higher consciousness—is the ultimate agent in healing. Therapeutic approaches range from prayer, chanting, mantra, and ritual to more subtle practices like inner contemplation, energy work, or consciousness elevation. Thus, it may be viewed as a science based on subjective experience or as an experience-based science.

Religious traditions have associated cleanliness with spiritual readiness and moral integrity. Hinduism prescribes ritual bathing, fasting, and dietary laws to sanctify the body; Islam requires ablution as a prerequisite for prayer; Christianity emphasizes both inner and outer purity through sacraments; Judaism codifies bodily purity in the *Torah*; while Buddhism and Jainism regard daily cleanliness as a form of moral discipline. Beyond

hygiene, religion offers a comprehensive model for health and well-being: Buddhism promotes mindfulness and the Eightfold Path; Christianity highlights compassion and prayer; Islamic medicine integrates spiritual practice with natural remedies; and Sikhism combines spirituality with health through remembrance of God, honest living, and selfless service. While not all religious practices equate to spiritual healing, many traditions have either contributed to or directly shaped forms of spiritual healing within their teachings.

Spiritual healing incorporates diverse healing methods: belief, energy healing, consciousness-based practices, and self-healing. Contemporary neuroscience validates the impact of belief and emotional state on immune function and stress¹⁶.

Spiritual traditions share foundational healing principles such as compassion, silence, sacred sound, vital energy, and ritual. They offer a profound contribution to health, especially in areas such as grief, chronic illness, and existential suffering. The results are individualistic and subjective and, therefore, not always quantifiable with prevalent research models.

DISCUSSION

Biomedicine has transformed healthcare through scientific inquiry, diagnostic precision, pharmacology, surgery, emergency and intensive care, vaccination, and public-health interventions. Its greatest strength lies in identifying and acting upon measurable biological mechanisms. At the same time, increasing specialisation and molecular reductionism may narrow attention to organ pathology and biochemical correction, sometimes leaving the psychological, social, and existential dimensions of illness less fully addressed¹⁷.

Health, however, is multidimensional and shaped by the interaction of host, causative factors, environment, behaviour, and experience. This provides an important point of dialogue with vitalistic systems, which traditionally approach the patient as an integrated whole. Although their metaphysical premises and lack of conventional biomarkers attract criticism, emerging fields such as systems theory and psycho-neuro-endocrine-immunology (PNEI) demonstrate that mental states, neural pathways, endocrine responses,

and immune functions are dynamically interconnected^{18,19}. Such parallels do not establish equivalence, but they open a legitimate space for scientific enquiry and methodological dialogue²⁰.

Vitalistic traditions therefore represent not merely alternative treatments but alternative ways of organising clinical knowledge—rooted in observation, individual response, constitutional patterns, and accumulated experience. Their concepts cannot always be translated directly into the language of reductionist science; equally, the absence of such translation should not by itself settle questions of value or validity. What is required is research methodology capable of examining each system according to its therapeutic claims while still maintaining appropriate standards of evidence.

Spiritual healing occupies a different domain. Prayer, ritual, meditation, faith, forgiveness, compassion, and contemplative practices address meaning, hope, belonging, and inner transformation, particularly in chronic illness, grief, palliative care, and existential suffering. Reports of faith-based recovery remain difficult to quantify, yet the influence of belief, emotional state, and spiritual wellbeing on the experience of illness merits scientific and clinical attention^{21,22}. As Deepak Chopra's formulation of 'quantum healing' illustrates, some spiritual interpretations extend healing beyond material pathology to consciousness and meaning²³; such claims require critical enquiry rather than either unqualified acceptance or automatic dismissal.

The purpose of a pluralistic framework is therefore not to erase the boundaries between these paradigms. It is to recognise that they ask different questions, employ different explanatory models, and may contribute at different levels of human suffering and recovery. A mature healthcare system should be able to examine these differences critically while preserving compassion, cultural sensitivity, and the primacy of patient welfare.

Comparative Table of Healing Systems

Concept on causation of diseases	Disease arises from biological or physical causes	Disease results from imbalance in life force	Disease is caused by spiritual disharmony or disconnection from the divine
Ontology	Materialist: body and mind are separate entities	Vitalist: life force permeates all living beings	Spiritualist: consciousness or divine reality is fundamental
Cause of Disease	Pathogens, genetic anomalies, organ dysfunction	Blocked or disturbed vital energy	Spiritual misalignment, karmic burden, sin, or loss of faith
Healing Approach	Pharmaceuticals, surgery, physical interventions	Natural therapies, energetic modulation, support of self-healing	Prayer, meditation, rituals, divine grace, spiritual insight
Examples of Systems	Allopathy, Modern Western Medicine	Indian medicines, Traditional Chinese Medicine, Homeopathy, Naturopathy	Faith healing, Reiki, Shamanic practices, Christian, Yogic or Sufi healing
Evidence Base	Empirical trials, measurable objective outcomes	Observational evidence, traditional clinical outcomes	Faith-based experience, subjective transformation
Mind-Body-Spirit Integration	Weak or indirect	Strong mind-body correlation	Spirit as central, governing both mind and body
Role of Patient	Passive recipient of treatment	Active participant in healing	Seeker of transformation and inner or divine connection
Prevention Emphasis	Moderate, through screening and lifestyle advice	Strong, via behavioural balance and natural living	Strong, through ethical living, mindfulness, prayer
Concept of Health	Absence of disease and physiological normalcy	Dynamic balance of vital energies	Spiritual harmony and inner peace
Knowledge Source	Scientific research, clinical trials	Traditional knowledge, experiential insight, case-study series	Sacred texts, spiritual teachers, mystical experience

Toward an Integrative Paradigm

A truly patient-centred and future-ready model of healthcare must overcome the duality of science and tradition. It must be guided by the following principles:

- No single system can comprehensively address all health challenges.
- Healing surpasses not only biochemical correction but also includes emotional, ethical, and spiritual dimensions.
- Quality of life, psychological well-being, and spiritual fulfilment are integral to health outcomes.

While Biomedicine offers precision in diagnosis, effective emergency, acute and intensive care, and pharmacological intervention, Vitalistic medicine supports long-term health through constitutional balance, immune resilience, and gentle, individualised therapies. Spiritual healing provides emotional support, existential meaning, and psychological integration, particularly valuable in

chronic, autoimmune, and palliative settings. Thus, each of the three medical paradigms contributes uniquely to the spectrum of healing.

Integrative medicine, which consciously synthesises elements from all three domains, presents a more inclusive, compassionate, and context-sensitive model of care. This approach does not abandon scientific rigour but expands the definition of evidence to incorporate patient narratives, cultural relevance, clinical intuition, and spiritual insight.

Ultimately, authentic healing must engage the full spectrum of human experience—physical, emotional, social, and spiritual. It must be ethically anchored, culturally attuned, and epistemologically pluralistic to meet the diverse needs of a global society.

CONCLUSION

The central proposition of this article is that the diversity of healing traditions is better understood through their foundational philosophies

than through labels based merely on chronology, geography, or their relationship to biomedicine. Biomedicine, Vitalistic Medicine, and Spiritual Healing represent three distinguishable ways of understanding disease, the human person, therapeutic action, and the meaning of recovery. Their differences are real and should neither be blurred in the name of integration nor arranged automatically in a hierarchy. The proposed trinity is therefore a taxonomy of perspectives, not a ranking of systems.

Such a framework has practical consequences. It can help research ask questions appropriate to the claims of each paradigm, enable education to present medical pluralism with greater conceptual clarity, and assist policy-makers and clinicians in recognising where different approaches may contribute, coexist, or require clear boundaries. Integration, when appropriate, should arise from evidence, clinical need, safety, cultural context, and respect for the philosophical integrity of the systems involved—not from indiscriminate amalgamation.

The future of healthcare may therefore depend less on choosing one healing tradition over another than on learning to understand their proper domains, limitations, and possibilities. A rationally pluralistic, patient-centred model can preserve the precision of science, the whole-person orientation of vitalistic traditions, and the meaning-centred contribution of spiritual care. In that sense, the ultimate value of this taxonomy lies not in creating three compartments, but in providing a clearer intellectual basis for restoring the whole human being while safeguarding reason, dignity, and responsible care.

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Homoeopathy at a Transitional Phase: Reimagining Education, Practice and Research for the Future

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Abstract

Homoeopathy in India is passing through a defining transitional phase. The transition is not simply a change in curriculum, regulations or institutional structures; it represents a fundamental shift in the way a future homoeopathic physician is educated, trained, assessed and prepared for professional life.

The comprehensive transformation of undergraduate and postgraduate Homoeopathy education through the Competency-Based Dynamic Curriculum (CBDC) places competence at the centre of education, clinical practice and research. Module-based learning, electives, foundation programmes, continuous assessment, early clinical exposure, bedside teaching, structured internship and a progressively strengthened research orientation are redefining the educational journey of the homoeopathic student.

Equally significant is the attempt to create a connected academic ecosystem through student and teacher identification systems and the AYUSH education portal, allowing the professional journey of a student to be viewed as a continuum—from entry into the first year to completion of undergraduate and postgraduate education and beyond.

The emerging scientific landscape also offers an unprecedented opportunity. Concepts such as precision medicine, genomics, multi-omics, big data, polygenic risk scores and systems-level understanding of disease may provide new

frameworks through which the fundamental principles of Homoeopathy can be explored and understood scientifically. The distance between scientific enquiry and Homoeopathic philosophy need not remain static; it can progressively become narrower through rational, structured and scientifically rigorous investigation.

This article discusses the ongoing transition and argues that the future of Homoeopathy will depend not on abandoning its identity, but on strengthening its fundamentals while developing competent, reflective, scientifically oriented and compassionate physicians.

Keywords

Homoeopathy, Competency-Based Dynamic Curriculum, Homoeopathic Education, Clinical Education, Research Methodology, Precision Medicine, Genomics, Medical Education, NEP 2020

Introduction : A Profession at a Turning Point

Every discipline reaches moments when it must pause, look back at its journey and ask a difficult question:

Are we preparing our students for the world they entered yesterday, or for the world in which they will practise tomorrow?

Homoeopathy in India is at such a moment. The transition currently taking place in Homoeopathy education is much larger than a revision of syllabus. It is a transformation in educational philosophy. The objective is no longer merely to ensure

that a student has acquired information before appearing for an examination. The larger objective is to ensure that the graduate can think, observe, communicate, investigate, decide and practise competently. This is the essence of the transition.

The new educational approach seeks to connect the classroom with the patient, knowledge with application, theory with observation, and education with lifelong professional development. At the heart of this transformation lies the Competency-Based Dynamic Curriculum (CBDC).

From Knowledge Acquisition to Competency Development:

Traditional medical education has often been organised around subjects, lectures, examinations and successful completion of prescribed academic requirements. Such an approach has undoubtedly contributed to the growth of healthcare education. Yet the contemporary healthcare environment demands something more. A physician must be able to apply knowledge. A student may know the definition of a disease, its pathology, clinical manifestations and treatment principles. But the real question is whether the student can face a patient, listen carefully, observe systematically, analyse the available information, formulate a clinical understanding and make a rational therapeutic decision. CBDC seeks to bring this transformation into Homoeopathy education.

The focus therefore shifts:

- from syllabus completion to competency attainment;
- from passive learning to active learning;
- from lectures to clinical engagement;
- from examination-oriented preparation to professional preparedness.

This is not a rejection of knowledge. Rather, it is an acknowledgement that knowledge becomes meaningful only when it can be applied appropriately.

A Curriculum That Begins the Homoeopathic Journey Early: One of the important changes is the introduction of Homoeopathy and its foundational understanding from the very beginning of the

undergraduate course. This has considerable educational significance. A student should not have to wait for years before beginning to understand the identity, philosophy and clinical approach of the profession he or she has chosen. Early introduction provides an opportunity to gradually develop an integrated Homoeopathic perspective. The learner can progressively understand the relationship between the individual patient, disease, totality of symptoms, clinical observation, therapeutic reasoning and the principles of Homoeopathy. This is particularly important because professional identity is not created in a single classroom or during the final year. It is developed gradually—one patient, one observation, one discussion and one reflective learning experience at a time.

From the Classroom to the Bedside:

Perhaps one of the most visible changes is the increasing emphasis on clinical exposure from the early stages of education. Observation and clinical learning should not be postponed until the later part of the curriculum. Outdoor Patient Departments and Inpatient Departments provide the living classroom of medicine. A patient is not a textbook case. A patient speaks, hesitates, worries, remembers, forgets, describes symptoms differently and expresses suffering in an individual manner. Learning to understand that individual dimension is fundamental to Homoeopathic practice. Therefore, clinical education must progressively move from the classroom towards the patient. The conventional didactic lecture has its place. But under a competency-based approach, the teacher increasingly becomes a facilitator of clinical learning.

The transition is from:

“Let me tell you what the textbook says”

to

“Let us see what this patient is telling us, and let us understand why.”

This is the human face of competency-based education.

Bedside teaching, case discussion, clinical observation, supervised decision-making and reflective learning can gradually transform the student

from an observer into a confident practitioner.

Module-Based Learning: Structure Without Restriction:

The chapter-wise and subchapter-wise module structure provides an important academic framework. However, module-based learning should never be misunderstood as a mechanism to confine the teacher within rigid boundaries. A curriculum provides the architecture; the teacher provides the life within that architecture.

The modules establish the essential competencies and learning outcomes that every student should acquire. Within that framework, however, the teacher should retain the academic freedom to innovate, contextualise, demonstrate, discuss and inspire.

Every teacher has a distinctive personality, experience and method of communication.

One may teach through a clinical story; another through a demonstration; another through a problem-solving exercise; another through a patient discussion. CBDC should therefore ensure standardisation of essential competencies without standardising the individuality of teachers. The objective is not to make every teacher teach identically.

The objective is to ensure that every student achieves the essential competencies, while allowing teachers to ignite curiosity in their own unique ways.

Electives and the Individuality of Learning:

The introduction of electives is another important step towards recognising that every learner does not have exactly the same academic interests. Electives can allow students to explore areas beyond the core curriculum and develop additional interests and skills. This is particularly relevant in a rapidly changing healthcare environment where interdisciplinary knowledge is becoming increasingly important. The Homoeopathic physician of tomorrow may need familiarity with digital health, research methods, epidemiology, public health, clinical communication, data interpretation, integrative healthcare, artificial intelligence and emerging biomedical sciences.

Education should therefore create opportunities for curiosity. A good curriculum should not only answer questions. It should create better questions.

Foundation Programme: The First Step into Professional Identity:

The Foundation Programme provides an important bridge between admission and professional education. The transition from school education to professional education is substantial. Students enter medical institutions with diverse academic backgrounds, expectations and levels of exposure. An induction or foundation programme can help students understand their chosen profession, institutional responsibilities, ethics, communication, learning methods and the broader healthcare ecosystem. It also sends a powerful message to the learner:

“You are not merely entering a course; you are beginning a professional journey.” That distinction matters.

Research Must Begin Before the Postgraduate Years:

One of the most significant changes is the strengthening of research aptitude from the undergraduate level and the greater emphasis on structured research methodology at the postgraduate level.

Research should not be perceived as something that begins only when a dissertation is assigned. A research mindset begins much earlier—with the ability to ask: Why?

- Why did this patient respond differently?
- Why did two apparently similar patients present differently?
- Why does one observation appear repeatedly?
- What is the evidence?
- How can the observation be measured?
- What could be an alternative explanation?
- How can the finding be tested?

These questions are the seeds of research.

Therefore, the development of research aptitude should be continuous—from undergraduate observation to postgraduate investigation. The increasing emphasis on research methodology will help postgraduate learners understand study design, scientific writing, critical appraisal, data interpretation and responsible research practices. This is not merely an academic requirement. It is an investment in the intellectual future of Homoeopathy.

Continuous Assessment: Making Evaluation Part of Learning:

Assessment is often regarded by students as an event that happens at the end of learning. Competency-based education changes this philosophy. Assessment becomes continuous, formative and developmental. The purpose is not simply to determine whether a student has passed or failed. It is to identify where the student is progressing well and where further guidance is required. A compassionate teacher should ideally discover a learning gap before an examination discovers it. Continuous assessment can therefore become an instrument for mentoring rather than merely grading. This is a significant cultural shift.

Internship: From Student to Budding Physician:

The internship period occupies a special place in medical education. It is the stage when knowledge, skills, behaviour and professional responsibility begin to come together. The redesigned internship should therefore not be treated as a period of waiting between academic education and professional life. It should be a period of professional maturation. The young Homoeopathic physician should gradually acquire confidence in approaching different clinical conditions, communicating with patients and families, recognising situations requiring referral or multidisciplinary care, maintaining records, understanding clinical responsibility and applying Homoeopathic knowledge appropriately.

The goal is simple but profound: A student should complete the course not merely with a degree, but with the confidence and competence to begin professional life responsibly.

Creating a Digital Academic Identity:

The development of an AYUSH education portal and the introduction of unique identification mechanisms for students and teacher codes represent important steps towards creating a connected academic ecosystem. A student's educational journey should increasingly be viewed as a continuum rather than a collection of disconnected years.

From the first year of undergraduate education through completion of the programme, postgraduate education and subsequent professional development, a structured digital identity can help create continuity and accountability.

Similarly, a unique teacher identity can facilitate better recognition and tracking of faculty within the academic system. These initiatives may appear administrative on the surface, but they have a deeper significance. They represent the movement from fragmented records towards an integrated educational ecosystem.

Homoeopathy and the Emerging Scientific Landscape:

Perhaps the most exciting aspect of this transitional phase lies at the intersection of Homoeopathic philosophy and contemporary science. Modern medicine is increasingly moving towards understanding the individual rather than disease in isolation.

Precision medicine, genomics, multi-omics, systems biology, big-data analytics, artificial intelligence and polygenic risk scoring are examples of this changing landscape. These developments invite us to reconsider an important question:

Can contemporary science provide new conceptual and methodological frameworks for investigating some of the individualised principles long emphasised in Homoeopathy?

This question deserves serious scientific investigation.

The objective should neither be to force modern science to validate every Homoeopathic concept nor to dismiss Homoeopathic principles because they do not immediately fit existing scientific

models. The appropriate approach is open, rigorous and hypothesis-driven enquiry. Genomics may help us understand individual biological susceptibility. Omics may provide multidimensional biological signatures. Big-data approaches may identify complex patterns that conventional analysis may overlook. Polygenic risk scoring may help characterise predisposition to disease. Single-cell and molecular approaches may provide increasingly fine resolution of biological processes.

These developments do not automatically prove Homoeopathic principles.

But they create an increasingly sophisticated scientific environment in which questions concerning individuality, susceptibility, biological response and complex systems can be investigated with greater precision. The opportunity before Homoeopathy is therefore not to remain distant from science, but to engage with science without losing its conceptual identity.

Narrowing the Distance Between Philosophy and Science:

For many years, the relationship between Homoeopathic philosophy and contemporary science has been viewed through two extremes—either unquestioning acceptance or complete rejection. The future demands a third approach:

- scientific curiosity with intellectual honesty.

The distance between scientific enquiry and Homoeopathic philosophy can progressively become narrower when questions are translated into testable hypotheses, appropriate methodologies are applied, observations are reproducible and results are critically evaluated. CBDC can contribute to this transformation by creating a generation of students who are not only familiar with Homoeopathic philosophy but are also comfortable with scientific reasoning. This is perhaps one of the most important opportunities of the present transition.

The Teacher of Tomorrow: From Lecturer to Facilitator:

The changing curriculum inevitably changes the

role of the teacher. The teacher will remain indispensable—but the nature of teaching will change. The teacher of tomorrow will increasingly be:

- * a facilitator rather than merely a lecturer;
- * a mentor rather than only an examiner;
- * a clinical guide rather than simply a transmitter of information;
- * a research motivator rather than only a supervisor;
- * and, above all, a role model for professional behaviour.

Technology can provide information. Artificial intelligence can provide explanations. Digital platforms can provide learning resources. But a student still needs a teacher who can look at a confused face and say: “Let us try this again.”

That human connection cannot be replaced by technology.

Education ultimately remains a relationship between people. Preserving the Fundamentals While Embracing the Future, Transformation should never mean losing identity. The purpose of CBDC is not to dilute Homoeopathy or replace its fundamental principles with fashionable terminology.

Rather, the challenge is to create a structured educational environment in which the fundamentals of Homoeopathy remain intact while its learners acquire the competence to understand, apply, investigate and communicate them in the contemporary healthcare environment.

This balance is critical.

Innovation without fundamentals may lead to loss of identity.

Fundamentals without innovation may lead to stagnation. The future lies between the two:

- Rooted in fundamentals.
- Open to evidence.
- Prepared for innovation.
- Committed to the patient.

A Human-Centred Transition:

Amidst all these reforms, it is important not to forget the person at the centre of healthcare—the patient. Curriculum reform, digital platforms, competency frameworks, examinations, research methodology and regulations are ultimately means to an end.

The end is a better-trained physician and, consequently, better care for the patient.

- Behind every case sheet is a human being.
- Behind every symptom is a person.
- Behind every research participant is a life.

And behind every student sitting in a classroom is a young person who has dreams, uncertainty, ambition and responsibility. If our reforms can transform that young student into a physician who is competent and compassionate, scientifically curious and philosophically grounded, confident and humble, then the transition will have achieved its real purpose.

The Road Ahead

The transition currently underway should therefore be viewed as the beginning of a journey rather than the completion of a reform. The coming years will require continuous refinement. Institutions will need to adapt.

- Faculty will require orientation and capacity building.
- Assessment systems will evolve.
- Clinical teaching will become increasingly structured.

Research methodology will become an integral part of professional education.

Digital systems will become more interconnected. And students will increasingly be expected to become active participants in their own learning.

Most importantly, the success of CBDC will not be measured only by how well the curriculum is written. It will be measured by what happens to the student in the classroom, what happens to the learner at the bedside, what happens to the young

researcher in the laboratory and, ultimately, what happens to the patient in front of the physician.

CONCLUSION: A TRANSITION WORTH EMBRACING

Homoeopathy in India stands at an important crossroads.

The transition from a predominantly curriculum-driven model towards a competency-based, clinically oriented, research-aware, digitally connected and scientifically engaged educational system is both necessary and timely.

The Competency-Based Dynamic Curriculum provides a structured pathway for this transformation. Early clinical exposure, module-based learning, electives, foundation programmes, continuous assessment, enhanced research orientation, postgraduate research methodology, redesigned internship and digital academic identity together represent important components of a larger educational vision. Institutions that innovate. Eta coccri And policymakers who have the courage to reform.

The real success of this transition will therefore be seen not in documents, notifications or examinations, but in the emergence of a new generation of Homoeopathic physicians—competent in practice, disciplined in scientific enquiry, grounded in Homoeopathic fundamentals and sensitive to the human being behind every illness.

We should not fear transition.

A living system must evolve.

Homoeopathy has travelled a long way in India. It now stands at a point where its educational foundations are being redesigned for a new generation.

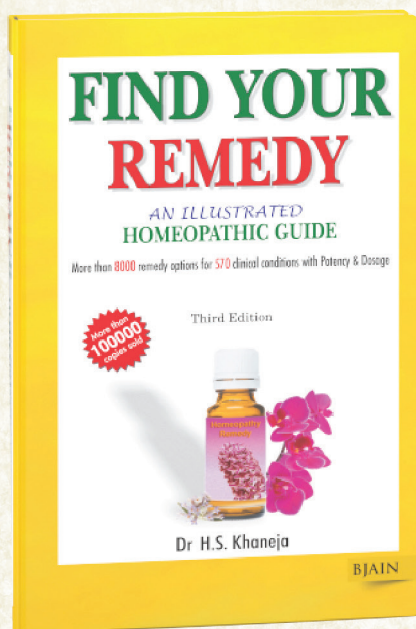
The task before us is not to choose between tradition and modernity.

It is to carry the wisdom of the fundamentals into the possibilities of the future.

And perhaps that is the true meaning of this transitional phase:

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Dr. Ramanlal Prabhudas Patel (1926-2019) The Man, The Vision, The Legacy

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Dr. Ramanlal Prabhudas Patel was a distinguished Indian Homoeopathic physician, teacher, researcher, author, repertorian and innovator who made significant contributions to the development and propagation of Homoeopathy, particularly in the fields of the Organon of Medicine, chronic miasms, repertory and the 50 Millesimal Scale of Potencies. He was also recognized for his extensive clinical work, research on cancer cases, and his efforts to preserve and promote the historical legacy of Dr. Samuel Hahnemann.

A multifaceted personality, Dr. Patel was known for his commitment, dedication, hard work, innovative approach, willingness to share knowledge and ability to motivate others. Above all, he was remembered as a passionate Homoeopath and a great human being.

Early Life

Dr. Ramanlal Prabhudas Patel was born on 1st August 1926 in the small village of Subhanpura, Baroda (Vadodara), Gujarat State, India. Alongside his medical career, he was also associated with India's freedom struggle and actively participated in the Quit India Movement.

From his student days, he demonstrated a strong commitment to the advancement of Homoeopathy. After joining The Calcutta Homoeopathic Medical College in 1947, he took an active part in efforts directed towards the improvement of the college and its hospital.

Education and Postgraduate Training

Dr. Patel completed his D.M.S. from The Calcutta Homoeopathic Medical College in 1951 under the General Council and State Faculty of Homoeopathic Medicine, Calcutta. His academic interests and quest for wider knowledge subsequently took him abroad for advanced studies in Homoeopathy.

In 1952, he attended a postgraduate course at the Royal London Homoeopathic Hospital, London, England, and obtained the D.F. Hom. of London in 1952. He also worked for a period at the Glasgow Homoeopathic Hospital under eminent physicians including Dr. T. D. Ross, Dr. Boyd and Dr. Paterson.

He further attended the Children's Homoeopathic Hospital, where he studied under physicians including Dr. Hector Macwill, Dr. H. E. Boyd and Dr. Thomas Ferguson Stewart.

Then he proceeded to the Robert Bosch Hospital in Stuttgart, Germany, where he undertook a postgraduate course in Homoeopathy and studied under Late Dr. Otto Lesser for approximately nine months. During this period of international exposure, he also visited Homoeopathic institutions in Austria, Italy, France, Belgium, Holland and Denmark. He returned to India in 1954.

Later, he attended postgraduate training conducted by the American Institute of Homoeopathy and the American Foundation of Homoeopathy in the United States of America, in the early 1960s.

Professional Career

In 1954, Dr. Patel was appointed as the Chief Homoeopathic Physician at Father Muller's Homoeopathic Hospital, Mangalore. After a period of service there, he resigned and subsequently established his practice at Baroda.

His major professional contribution in the field of Homoeopathic education, however, was associated with Kerala. In 1958, he was invited by the late Dr. A. R. Menon, then Health Minister of Kerala, to serve the cause of Homoeopathy in the state. He took charge of Athurasramam NSS Homoeopathic Medical College as its Principal and headed the Department of Organon of Medicine for several years.

He was also associated with the administration and examination system of Homoeopathic education in Kerala. He served as Superintendent of Government Examinations in Homoeopathy, Kerala State, from 1960 onwards, and was an Examiner in Organon of Medicine for the Board of Examiners in Homoeopathy, Kerala, from 1960 onwards.

He also served as a Special Technical Assistant to the Kerala Public Service Commission and was associated with the Homoeopathic Education Committee and Research and Technical Sub-Committee.

Professional Distinctions and International Representation

Dr. Patel represented India at several important international Homoeopathic forums. He was a delegate from India to the International Homoeopathic Congress held at Brussels, Belgium in 1952.

He also represented India at the Convention of the American Institute of Homoeopathy in the United States in 1963.

He was a member of the Homoeopathic Research Committee of the International Homoeopathic Congress at Montreux in 1960.

He was also associated with the Panel on Health of the Planning Commission, Government of India, and served as a committee member concerned with pharmaceutical training and drugs.

Dr. Patel served as Chief Editor of the A. H. Medical College Magazine from 1958 and was associated with the Homoeopathic Research Hospital at Sachivothemapuram as its Director.

Contributions to Homoeopathic Education and Literature

Dr. Patel made extensive contributions through teaching, writing and research. His writings covered several important areas of Homoeopathic philosophy and practice, including the Organon of Medicine, chronic miasms, repertory and the 50 Millesimal Scale of Potencies.

Among his notable works were:

- *The Art of Case Taking and Practical Repertorisation in Homoeopathy*
- *My Experiments with 50 Millesimal Scale Potencies*
- *Chronic Miasms in Homoeopathy and Their Cure with Classification of Their Rubrics/Symptoms in Kent's Repertory*
- *Word index to Kent's Repertory*
- *Principles and Doctrines in Homoeopathy (Discoveries by Dr. Hahnemann)*
- *What is Tautopathy?*
- *A Treatise on Homoeopathic Surgery*
- *Ailments and Complaints Before, During and After in Homoeopathy*

Through these writings, he promoted the systematic study and practical application of Homoeopathic principles, particularly repertorisation, miasmatic analysis and the use of the 50 Millesimal Scale.

Contribution to Kent's Repertory

One of Dr. Patel's most important areas of contribution was the correction, revision, expansion and practical development of Kent's Repertory.

Word Index to Kent's Repertory

Dr. Patel published the *Word Index to Kent's Repertory* in 1977. It contained approximately 5,302 rubrics and sub-rubrics arranged alphabetically,

providing an organized approach to locating symptoms in Kent's Repertory.

Kent's Repertory – Corrected, Revised and Improved

His work on *Kent's Repertory of Homoeopathic Materia Medica – Corrected, Revised & Improved* was first published in 1977, with the fourth edition appearing in 2003. This work represented his efforts to improve the practical utility and accuracy of the repertory for Homoeopathic practitioners.

Work on Chronic Miasms

Dr. Patel made a significant contribution to the study and classification of chronic miasms through his work entitled *Chronic Miasms in Homoeopathy and Their Cure with Classification of Their Rubrics/Symptoms in Kent's Repertory*, published in 1996.

The work attempted to connect the study of chronic miasms with the practical classification and interpretation of symptoms and rubrics in Kent's Repertory. His writings in this field contributed to the discussion and teaching of miasmatic concepts in Homoeopathic practice.

Revival of the 50 Millesimal Scale

One of Dr. Patel's notable contributions was his work on the 50 Millesimal Scale of Potencies. Through his clinical experience, writings and teaching, he helped resurrect and popularize the use of this potency scale among Homoeopathic practitioners.

His work, *My Experiments with 50 Millesimal Scale Potencies*, documented his experience and observations concerning the practical use of these potencies.

Auto-Visual and Audiovisual Repertory

Dr. Patel was an innovator who sought to introduce technological approaches into repertorisation at a remarkably early stage.

He developed an **Auto-Visual/Audiovisual Homoeopathic Repertory**, described as a mechanically aided repertory. It was published in 1972 and consisted of two major components: the auto-strip and the audiovisual apparatus. The system

incorporated approximately 435 medicines.

His interest in computerization was equally visionary. In the 1950s, he reportedly approached IBM with the idea of computerizing repertories, at a time when such an application of technology to Homoeopathic repertorisation was highly unconventional.

He also patented his audiovisual repertory, making it one of the early patents associated with technological innovation in Homoeopathy.

Kentian Software

Dr. Patel continued his efforts to integrate technology with Homoeopathic repertorisation through the development of **Kentian software**, in collaboration with Dr. G. I. Patel.

The software was developed through Sai Homoeo Book Corporation, Kerala, and was based on *Kent's Repertory of Homoeopathic Materia Medica – Corrected, Revised & Improved*. It also incorporated Dr. Patel's expert system, reflecting his continued interest in applying systematic and technological methods to Homoeopathic case analysis.

Clinical Practice and Research in Cancer

Dr. Patel was particularly known for his clinical work and research involving cancer cases. He reported treating a large number of cancer patients and maintained long-term follow-up of several cases.

The cases and their associated documentation were preserved at the **Kent's Documentation Centre**, established as part of the museum founded by him. These records were intended to preserve clinical experiences and evidence-based documentation for future study and reference.

His interest in cancer was also deeply personal. He himself was diagnosed with spindle cell carcinoma. His subsequent survival became an important personal experience that strengthened his faith in Homoeopathy and influenced his continued commitment to the system.

His work in cancer and his efforts to document clinical cases formed an important part of his professional identity, alongside his contributions to repertory and Homoeopathic education.

Hahnemann House-Meissen and Preservation of Homoeopathic Heritage

Dr. Patel had a deep admiration and affection for Dr. Samuel Hahnemann, the founder of Homoeopathy. His dedication to preserving Hahnemann's historical legacy was reflected in the construction of **Hahnemann House-Meissen** at Baroda (Vadodara).

The three-storey building was designed as a faithful representation inspired by Hahnemann's birthplace in Meissen, Germany. At the age of approximately 90, Dr. Patel undertook this remarkable tribute to Hahnemann.

The building incorporated several features dedicated to Hahnemann. A statue of Hahnemann was placed in the front garden, a bust was installed in the waiting hall, and portraits were displayed on the entrance wall.

The premises housed the **R. P. Patel Homoeopathic Museum**, which preserved a range of historical and personal materials, including manuscripts, medicine boxes, handwritten repertories and other memorabilia associated with Homoeopathy and Dr. Patel's work.

The museum and documentation centre represented his efforts not only to practise Homoeopathy but also to preserve its intellectual, clinical and historical heritage for future generations.

Awards and Recognition

Dr. R. P. Patel received several honours in recognition of his lifelong dedication to Homoeopathy. He was awarded the AYUSH Lifetime Honour in 2019 by the Ministry of AYUSH for his lifelong service as a Homoeopathic practitioner.

In 2018, he received the Dr. Jugal Kishore Memorial Award in Vadodara for his lifetime contributions to Homoeopathy.

He was also honoured with the International Hahnemann Award for the year 2020, presented at the 2nd International Conference held in

Meissen, Germany, on 10 April 2023.

Owing to his remarkable clinical experience, scholarship and teaching spanning several decades, he was fondly regarded as the **"Kent of India"** and a **"Living Hahnemann."**

Personality and Philosophy

Dr. R. P. Patel was regarded as a multifaceted personality whose professional life extended beyond clinical practice. His career reflected a combination of clinical dedication, academic pursuit, teaching, research, writing, innovation and preservation of Homoeopathic heritage.

Among the qualities associated with him were commitment, perseverance, silent and dedicated work, pursuit of excellence through hard work, willingness to share knowledge, motivation of others and an innovative spirit.

His extensive international education demonstrated his lifelong desire to learn, while his writings and teaching reflected his commitment to disseminating knowledge. His attempts to integrate technology with repertorisation demonstrated his forward-looking and avant-garde approach.

Later Life and Legacy

Dr. R. P. Patel continued his Homoeopathic practice and association with research in Vadodara well into his later years. He served as the Director of the R. P. Patel Institute of Homoeopathy for Research and Education in Homoeopathy at Baroda and remained actively engaged in the profession until his final years. He passed away on 25th December 2019 due to cardiac arrest, leaving behind an irreplaceable void in the field of Homoeopathy.

His life was marked by unwavering dedication, intellectual curiosity and profound devotion to Homoeopathy. His passing marked the end of an illustrious era, yet his work, vision and enduring contributions continue to inspire generations of Homoeopathic physicians and students.

The Miasmatic Spectrum of Fungal Disease

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Abstract

Fungal infections are among the most prevalent dermatological disorders worldwide. Although antifungal agents effectively eradicate superficial fungal organisms in many cases, recurrence remains a significant clinical challenge. Classical homeopathy attributes this tendency to recurrence not merely to environmental exposure but to an underlying constitutional susceptibility or miasmatic dyscrasia. According to Hahnemann's Chronic Disease Theory, chronic skin disorders often represent manifestations of deeper miasmatic disturbances. This paper explores the homeopathic miasmatic interpretation of fungal diseases, particularly dermatophytosis (ringworm), discusses their constitutional evaluation, outlines the role of miasmatic diagnosis in remedy selection, and reviews commonly indicated anti-miasmatic medicines.

Materials and Methods

A narrative literature review was undertaken using classical homeopathic texts, including *Organon of Medicine*, *The Chronic Diseases*, Banerjee's *Miasmatic Prescribing*, Kent's philosophical writings, and contemporary peer-reviewed literature indexed in PubMed on fungal infections, dermatophytosis, mycology, host immunity and recurrence. Information was synthesised to compare biomedical concepts of fungal pathogenesis with the homeopathic theory of miasmatic susceptibility.

Results

Modern literature identifies host immunity,

disruption of skin barriers, diabetes, immunosuppression and environmental exposure as major contributors to recurrent fungal infections. Classical homeopathy interprets recurrent dermatophytosis as a manifestation of disturbed susceptibility expressed through different miasmatic states. Psoric, sycotic, syphilitic and tubercular backgrounds demonstrate distinct clinical characteristics that may assist constitutional remedy selection.

Conclusion

An integrated understanding of fungal diseases combining contemporary mycology with constitutional miasmatic assessment may enrich individualised case analysis in homeopathic practice. Further clinical research is required to evaluate the therapeutic role of miasmatic prescribing in recurrent fungal infections.

Keywords

Homeopathy, Miasm, Ringworm, Dermatophytosis, Fungal infections, Chronic diseases, Constitutional prescribing

Abbreviations

IFI – Invasive Fungal Infection, HIV – Human Immunodeficiency Virus, ICU – Intensive Care Unit, IL – Interleukin, TLR – Toll-like Receptor

Introduction

Fungal infections constitute one of the most prevalent infectious diseases affecting humans and remain a significant public health concern worldwide. It is estimated that superficial fungal

infections affect approximately 20–25% of the global population, making dermatophytosis one of the commonest skin disorders encountered in clinical practice. The incidence continues to rise because of urbanisation, humid climates, diabetes mellitus, widespread use of corticosteroids, immunosuppressive therapies, and lifestyle changes that favour fungal transmission.

From a biomedical perspective, fungal diseases are caused by pathogenic fungi that invade keratinised tissues, mucous membranes or internal organs. Dermatophytes including *Trichophyton*, *Microsporum* and *Epidermophyton* produce superficial infections such as tinea corporis, tinea cruris, tinea pedis, tinea capitis and onychomycosis, whereas opportunistic organisms such as *Candida* and *Aspergillus* may cause invasive disease in immunocompromised individuals.

Despite advances in antifungal therapy, recurrence remains a major clinical problem. Modern medicine attributes recurrence to persistent exposure, inadequate treatment, host immune dysfunction, diabetes, obesity and environmental factors. Classical homeopathy, however, interprets recurrent fungal infections differently. Rather than considering them merely as local infections, they are viewed as manifestations of an underlying constitutional susceptibility governed by chronic miasmatic influences described by Samuel Hahnemann.

Understanding fungal diseases from both biomedical and homeopathic perspectives may therefore provide a more comprehensive approach towards recurrent disease.

Objectives of the Study

The present review aims:

- To review the modern understanding of fungal diseases and their pathophysiology.
- To correlate host susceptibility with the homeopathic concept of miasmatic dyscrasia.
- To describe the miasmatic interpretation of recurrent fungal diseases.
- To discuss the role of constitutional anti-miasmatic prescribing in clinical practice.

Why is Knowledge of Miasm Important in Homeopathic Prescribing?

- **To open one-sided or suppressed cases**

Deep-acting anti-miasmatic remedies may bring suppressed symptoms to the surface, allowing the complete symptom picture to emerge.

- **To select the constitutional anti-miasmatic remedy**

When characteristic symptoms are insufficient, understanding the patient's dominant miasm and constitutional nature helps in selecting the appropriate anti-miasmatic remedy.

- **To include the surface miasm in totality**

The miasm forms an essential part of the patient's disease picture and should be considered alongside the presenting symptoms during remedy selection.

- **To know when to continue the same remedy**

If the presenting complaint improves but the same miasmatic state persists, the physician may continue the same remedy rather than changing it unnecessarily.

- **To assess prognosis**

Improvement during anti-miasmatic treatment may be indicated by:

- » Increased sense of well-being
- » Improved energy levels
- » Better appetite
- » Improved quality of sleep
- » Greater emotional balance and tranquility
- » Return of previously suppressed symptoms, consistent with

Hering's Law of Cure

- **To remove layers of suppression**

Anti-miasmatic treatment aims to:

- » Address suppressed symptoms from the

past.

- » Treat present symptoms at their root.
- » Reduce susceptibility to future illnesses by strengthening the patient's constitution.

- **Provides long-term constitutional improvement**

By addressing the underlying miasm, treatment seeks not only symptomatic relief but also restoration of overall health and resistance to disease.

Diseases caused by invasive fungal infections

Disease Type	Causative Agent	Clinical Signs and Symptoms
Candidiasis	<i>Candida</i> spp.	Acute disseminated: fever, chills, polymyalgia, polyarthralgia, non-tender pinkish skin lesions, retinal exudates. Chronic: complaints related to the affected organ.
Aspergillosis	<i>Aspergillus</i> spp.	Unremitting fever with pulmonary infiltrates during antibiotic therapy, chest pain, pleural rub, pleural effusion, haemoptysis, halo sign and air-crescent sign on chest radiograph/CT scan, clinical and radiological sinusitis.
Cryptococcosis	<i>Cryptococcus neoformans</i>	Flu-like symptoms, skin lesions, headache without meningismus.
Zygomycosis (Mucormycosis)	<i>Rhizopus</i> spp. <i>Absidia</i> spp. <i>Mucor</i> spp.	Similar to aspergillosis but with a more pronounced rhino-cerebral presentation and serosanguinous nasal discharge.
Malassezia Infection	<i>Malassezia furfur</i>	Frequently catheter-associated; may cause pneumonia in susceptible individuals.
Trichosporonosis	<i>Trichosporon</i> spp.	Skin and lung lesions.
Fusariosis	<i>Fusarium</i> spp.	Frequently positive blood cultures, skin lesions, severe myalgia.
Pseudallescheriasis	<i>Pseudallescheria</i> spp.	Abscess formation with manifestations depending upon the organ involved.

Endemic Fungal Pathogens Causing Human Disease

Disease Type	Causative Agent	Clinical Signs and Symptoms
Blastomycosis	<i>Blastomyces dermatitidis</i>	Ulcerative lesions involving the skin and urogenital tract; central nervous system involvement.
Histoplasmosis	<i>Histoplasma capsulatum</i>	Pulmonary infiltrates, mucocutaneous ulcers, hepatosplenomegaly.
Coccidioidomycosis	<i>Coccidioides immitis</i>	Pulmonary infection with dissemination causing osteomyelitis, arthritis and meningitis.
Paracoccidioidomycosis	<i>Paracoccidioides brasiliensis</i>	Pulmonary infection with dissemination to the skin, mucosa and lymph nodes.
Penicilliosis	<i>Penicillium marneffei</i>	Skin and subcutaneous lesions, pulmonary involvement, lymphadenitis and splenomegaly.

The Fungal Disease Continuum

Modern Medicine sees

Healthy
↓
Exposure
↓
Infection
↓
Treatment
↓
Recovery

Homeopathy Adds

Healthy Constitution
↓
Susceptibility
↓
Exposure
↓
Disease
↓
Suppression
↓
Recurrence
↓
Chronic Miasmatic State

Miasmatic Understanding of Fungal Diseases

In classical homeopathy, fungal infections (tinea, candidiasis, onychomycosis, etc.) are generally not viewed as purely local diseases. Rather, they are considered expressions of an underlying miasmatic dyscrasia and constitutional susceptibility.

Different schools of homeopathy differ in how they classify fungal diseases:

- Psoric predominance:** Acute, superficial, itchy fungal eruptions.
- Sycotic predominance:** Chronic, recurrent, moist, infiltrated, thickened lesions.
- Syphilitic predominance:** Destructive, ulcerative, fissured, nail-destroying or deep fungal pathology.

- Tubercular influence:** Rapidly changing, recurrent infections with poor immunity and strong family history.

Miasmatic Classification of Common Fungal Disorders

Disease	Predominant Miasm	Secondary Miasm
Tinea corporis (Ring-worm)	Psora	Sycosis
Tinea cruris	Sycosis	Psora
Athlete's foot	Sycosis	Psora
Nail fungus	Sycosis	Syphilis
Chronic candidiasis	Sycosis	Tubercular
Recurrent fungal infections	Sycosis	Tubercular
Extensive dermatophytosis	Psoro-sycotic	Tubercular

Miasmatic Type	Clinical Features	Common Constitutional Remedies
Psoric Ringworm	- Intense itching - Dry scaling - Circular lesions - Red margins - Better from scratching temporarily - Worse from warmth of bed	- Sulphur - Psorinum - Arsenicum album - Lycopodium - Natrum muriaticum
Sycotic Ringworm	- Chronic recurrence - Moist lesions - Thick skin - Hyperpigmentation - Excessive perspiration - Involvement of groins, axillae, and skin folds	- Thuja occidentalis - Medorrhinum - Natrum sulphuricum - Graphites - Tellurium
Syphilitic Fungal Disease	- Nail destruction - Deep fissures - Ulceration - Cracked heels - Long-standing untreated infections	- Mercurius solubilis - Syphilinum - Nitric acid - Hepar sulphuris - Fluoric acid
Tubercular Background	- Ringworm repeatedly changes location - Recurrent infections - Poor immunity - Family history of tuberculosis or allergic disorders	- Tuberculinum - Bacillinum - Calcarea phosphorica - Phosphorus - Silicea

Miasmatic Assessment Matrix

Medicine	Psora	Sycosis	Syphilis	Tubercular
Sulphur	★★★★★	★	—	★
Psorinum	★★★★★	★★	—	★

Tellurium	★★★	★★★★★	★	—
Graphites	★★	★★★★★	★	—
Thuja	★	★★★★★	★	—
Medorrhinum	★	★★★★★	★★	★

Natrum sulphuricum	★★	★★★★	★	★
Mercurius	★	★	★★★★★	—
Syphilinum	—	★	★★★★★	★
Tuberculinum	★★	★	★	★★★★★
Silicea	★★	★★	★	★★★★

General Miasmatic Approach

Many classical homeopaths advocate:

- Determine the dominant miasm from the patient's constitutional picture.
- Prescribe on the totality of symptoms, not solely on the diagnosis.
- Avoid treating fungal lesions as isolated local diseases.
- Follow the patient's response and re-evaluate the constitutional state over time rather than changing remedies based only on the appearance of the skin.

Clinical Approach to Miasmatic Prescribing

The constitutional homeopath generally proceeds through the following stages:

1. Confirm the diagnosis.
2. Assess constitutional characteristics.
3. Determine the dominant miasmatic background.
4. Evaluate previous suppressive treatments.
5. Prescribe the constitutional anti-miasmatic remedy.

6. Monitor changes according to the direction of cure.
7. Avoid unnecessary repetition or premature change of remedy.

Miasmatic Evaluation During Follow-up

Improvement may include:

- Enhanced sense of well-being
- Better sleep
- Improved appetite
- Increased energy
- Reduction in recurrence
- Return of previously suppressed symptoms in accordance with Hering's Law of Cure (as interpreted within homeopathic philosophy)

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Decoding Fungal Recurrence: Where Contemporary Mycology Meets Homoeopathy



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Abstract

Fungal infections are still a problem for doctors to deal with even with new treatments. When people get infections over and over again it is because of how the fungus and the person's body interact in complicated ways. The fungus has things that make it strong and the person's immune system tries to fight it. But the person's genes, the balance of living things inside them and things in their environment can all affect how well they can fight the fungus. Also, the fungus can become resistant to the treatments.

Scientists who study fungi have found out some ways that fungi can keep coming. They can form groups, avoid the immune system, change how they look and use their outer layer to protect themselves. On the hand, Homeopathy thinks that people get sick again because they are more likely to get sick in the first place. This means that some people are more prone to getting diseases because of who they are and what is around them. Even though these two ideas come from ways of thinking about medicine, they both agree that the person's body plays a big role in whether they get sick again with a fungal infection. Fungal infections and their recurrence are closely linked to how the person's body and the fungus interact.

Keywords

Fungal infections; Contemporary mycology;

Homoeopathy; Susceptibility; Biofilm; Fungal cell wall; Host immunity; Chronic disease; Constitutional treatment; Antifungal resistance.

Introduction

Fungal infections are a problem for people's health. They affect more than one billion people around the world every year. Fungal infections can be mild, like skin diseases. They can be life-threatening. Most of the time these infections can be treated with medicine. They often come back. This is a challenge for doctors. People get these infections again and again even after they seem to be cured. This means they are sick for a time, their quality of life is not good and it costs a lot of money to treat them. Also, the fungi can become resistant to the medicines used to treat them.

We need to understand why these infections keep coming. We need to know more about the fungi and the people who get infected. We have learned a lot about fungi. How they make people sick. Fungi have ways to survive and thrive inside the body. They can change their shape, form groups that're hard to kill and even trick the immune system. It is not just the fungi that are the problem. The people who get infected also play a role. If someone's immune system is not working well or if they have health problems, they are more likely to get infected. The cell wall of the fungi is very important. It helps the fungi survive and infect people.

The fungi can change their cell wall to avoid being killed by the system or by medicines. This makes it hard to get rid of the infection. Fungi can also form groups on surfaces, like skin or medical devices that are hard to kill. If we look at this from a Homoeopathic point of view, we see that it is not just about the fungi. Homoeopathy says that people get sick because they are susceptible to things. This means that some people are more likely to get sick than others even if they are exposed to the things.

Samuel Hahnemann, who started Homoeopathy said that the key to understanding disease is to look at the persons susceptibility. Contemporary mycology, which is the study of fungi and Homoeopathy are two ways of looking at the world. They both agree that the person who gets infected plays a big role in whether they get sick or not. Mycology looks at things like the system, genetics and the environment. Homoeopathy looks at the persons susceptibility. How they respond to things.

This article wants to bring what we know about fungal infections from mycology and Homoeopathy. We want to look at the biology of the fungi how the immune system works and how the persons' susceptibility affects their likelihood of getting infected. We hope to find areas where these two ways of looking at the world agree and to propose ways of doing research into fungal infections.

Global Burden Of Recurrent Fungal Infections

Fungal infections are among the most prevalent infectious diseases worldwide, affecting an estimated one billion people annually and causing more than 1.5 million deaths each year, primarily from invasive mycoses ^[1,2]. While invasive fungal infections contribute substantially to mortality in immunocompromised populations, superficial fungal infections—including dermatophytosis, candidiasis, pityriasis versicolor, and onychomycosis—represent the greatest burden in terms of prevalence, healthcare utilization, and recurrence ^[2–4]. The chronic and relapsing nature of these infections significantly affects quality of life, productivity, and healthcare expenditure ^[3,4].

Recurrent fungal infections constitute a major

clinical challenge because complete clinical resolution does not necessarily equate to eradication of the causative organism. Many patients experience repeated episodes despite receiving appropriate antifungal therapy ^[5,6]. Recurrence may arise from persistent fungal reservoirs, reinfection from environmental or household sources, incomplete treatment, antifungal resistance, biofilm-associated persistence, or unresolved host-related risk factors ^[5–8]. Consequently, management often requires repeated treatment courses, increasing the likelihood of treatment failure and the emergence of resistant fungal strains ^[7,8].

Epidemiology Of Superficial Fungal Infections

Fungal infections are really common over the world. In fact, they are among the common infectious diseases. 20 To 25 percent of people have fungal infections at any given time ^[3,9]. This is especially true for dermatophyte infections. These infections are caused by fungi like *Trichophyton*, *Microsporum* and *Epidermophyton* ^[3,9]. They are more common in humid places where people live close together and do not have good access to healthcare. This makes it easier for fungi to spread.

Vulvovaginal candidiasis is another fungal infection. It is also known as VVC. 75 Percent of women get VVC at least once in their lifetime. Many women get it more than once. Some women get it a lot, which is called vulvovaginal candidiasis or RVVC. This happens to about 5 to 8 percent of women who're old enough to have children. RVVC is not just physically uncomfortable it also affects women emotionally and financially ^[10–14].

Onychomycosis is an infection of the nails. It affects about 5 to 10 percent of people. Older adults and people with health problems, like diabetes are more likely to get onychomycosis. Even when people get treatment; the infection can come back. This is because the fungi that cause onychomycosis can stay in the nails, skin, shoes or home ^[15,16].

Emerging Public Health Challenges

The growing prevalence of diabetes mellitus, obesity, HIV infection, malignancies, organ transplantation, and widespread use of immunosuppressive medications has expanded the population

susceptible to fungal disease ^[17–18]. In addition, inappropriate or prolonged use of broad-spectrum antibiotics disrupts the normal bacterial microbiota, facilitating fungal overgrowth, particularly by *Candida* species ^[18].

An emerging concern is the worldwide increase in antifungal resistance. Resistance among dermatophytes to terbinafine and among *Candida* species to azole antifungal agents has been increasingly documented ^[10–12]. The emergence of multidrug-resistant fungi such as *Candida auris* further highlights the urgent need for effective antifungal stewardship, improved diagnostic methods, and novel therapeutic strategies ^[5,10,13]. Biofilm-associated fungal communities are especially problematic because they exhibit markedly reduced susceptibility to both antifungal agents and host immune responses, thereby promoting persistence and recurrence ^[14,15].

Burden Beyond Infection

The effect of repeated infections goes beyond just the germs staying in the body. Lasting itching, pain changes in appearance trouble sleeping, problems with sex and feeling embarrassed often make patients' lives much harder ^[4,13,15]. Going to the doctor times doing lots of tests taking medicine for a long time and missing work or school cost a lot of money, for both people and the health system ^[4,15]. Getting sick again can also make patients less likely to follow their treatment use medicine on their own without help and use creams that mix steroids and antifungals without thinking in places where there is not enough medicine. This can make the treatment not work and make the fungi stronger ^[10,10,11].

Importance Of Host Susceptibility

Fungal infections are a problem. Fungal virulence factors are necessary for the infection to start. It is also clear that the infection coming back is because of how the fungus and the person's body interact with each other ^[14–16].

Environmental exposure alone cannot explain why only certain individuals develop repeated infections despite similar living conditions ^[17,18].

The growing global burden of recurrent fungal

infections therefore necessitates a comprehensive approach that integrates advances in fungal biology, host immunology, public health, and patient-centred management ^[1,5,13,16].

Contemporary Mycology

Structure Of Fungi

Fungi are eukaryotic microorganisms that exist as unicellular yeasts, multicellular moulds, or dimorphic fungi capable of switching between these forms depending on environmental conditions ^[17,18]. Unlike bacteria, fungal cells possess a membrane-bound nucleus, mitochondria, endoplasmic reticulum, Golgi apparatus, and other membrane-bound organelles, making them structurally and metabolically more similar to human cells. This close evolutionary relationship presents a major challenge in antifungal drug development because selective toxicity is more difficult to achieve than with antibacterial agents ^[17,18].

In pathogenic fungi, morphogenesis is a major determinant of disease progression. For example, *Candida albicans* undergoes a reversible transition between yeast and hyphal forms, allowing adhesion, tissue penetration, biofilm formation, and escape from immune surveillance ^[12]. Similarly, dermatophytes produce keratinolytic enzymes that degrade keratinized tissues such as skin, hair, and nails, enabling persistent colonization and recurrent infection ^[13].

Cell Wall Architecture

It provides structural rigidity, maintains cellular morphology, protects against osmotic stress, and mediates interactions with the host immune system ^[15].

Importantly, the fungal cell wall is not a static structure. Continuous remodelling occurs during growth, morphogenesis, environmental stress, and exposure to antifungal agents ^[16,18]. Alterations in cell wall composition may reduce immune recognition, enhance survival under antifungal pressure, and facilitate persistence within host tissues ^[18].

Biofilm Formation

Biofilm formation is one of the most important

mechanisms responsible for chronic and recurrent fungal infections ^[10]. A fungal biofilm is a highly organized three-dimensional community of fungal cells embedded within a self-produced extracellular polymeric matrix consisting of polysaccharides, proteins, lipids, extracellular DNA, and water ^[11].

Biofilm development generally proceeds through four sequential stages: initial adhesion to host tissue or an abiotic surface, cellular proliferation and microcolony formation, maturation into a complex three-dimensional architecture, and eventual dispersal of fungal cells capable of initiating new sites of infection ^[10,12].

Immune Evasion

Successful fungal pathogens have evolved sophisticated mechanisms to evade host immune responses, enabling prolonged survival and recurrent infection ^[14]. Host defence against fungi relies upon both innate and adaptive immunity. Neutrophils, macrophages, dendritic cells, natural killer cells, and epithelial barriers constitute the first line of defence, whereas T-helper (Th1 and Th17) lymphocytes play a crucial role in long-term fungal clearance ^[15,16].

Fungi evade immune surveillance through multiple mechanisms. Cell wall remodelling may conceal immunogenic β -glucans beneath an outer mannoprotein layer, thereby reducing recognition by pattern-recognition receptors such as Dectin-1 and Toll-like receptors ^[7,14]. Certain fungi secrete enzymes capable of degrading complement proteins, neutralizing reactive oxygen species, or interfering with phagocytic killing ^[14,17]. *Candida albicans* can survive intracellularly within macrophages, undergo hyphal transformation, and escape following phagocytosis ^[12,17].

These immune escape strategies allow fungal organisms to remain within host tissues even after apparent clinical improvement, contributing significantly to recurrent disease.

Antifungal Resistance

Antifungal resistance has emerged as a major global health concern, complicating the management of recurrent fungal infections ⁽¹⁸⁾. Resistance

may be intrinsic or acquired through prolonged antifungal exposure, genetic mutation, or adaptive cellular responses ^[18,19].

Azole resistance commonly results from mutations in the ERG11 gene encoding lanosterol 14 α -demethylase, overexpression of ATP-binding cassette (ABC) and major facilitator superfamily (MFS) efflux pumps, and alterations in ergosterol biosynthesis ^[9,10]. Echinocandin resistance is primarily associated with mutations in the FKS1 and FKS2 genes encoding β -(1,3)-glucan synthase ^[9,18]. Resistance to polyenes may occur through modifications in membrane sterol composition that reduce amphotericin B binding ^[19].

In recent years, terbinafine-resistant *Trichophyton indotineae* has emerged as an important cause of chronic and recurrent dermatophytosis, particularly in South Asia ^[11,12].

Reasons For Recurrence

Recurrent fungal infections are now recognised as multifactorial disorders resulting from complex interactions between fungal biology, host susceptibility, environmental exposure, and therapeutic limitations rather than persistence of the microorganism alone.

Major contributors to recurrence include:

- Incomplete eradication of fungal organisms due to inadequate treatment duration or poor adherence.
- Biofilm-associated persistence protecting fungal cells from antifungal agents and immune responses.
- Antifungal resistance mediated by genetic mutations, efflux pumps, and adaptive stress responses.
- Continuous environmental reinfection through contaminated clothing, footwear, bedding, fomites, and infected household contacts.
- Host-related factors such as diabetes mellitus, obesity, immunosuppression, HIV infection, corticosteroid therapy, genetic susceptibility, pregnancy, and advancing age.

- Skin barrier disruption, excessive sweating, poor hygiene, and persistent moisture favouring fungal colonization.
- Alterations in the cutaneous and mucosal microbiome that reduce colonization resistance and facilitate fungal overgrowth.
- Immune dysregulation involving impaired neutrophil function, defective Th17 responses, and abnormalities in innate immune recognition [10-18].

Host Susceptibility

Host susceptibility is a factor in how fungal infections develop, stay around and come back again. Even though fungi have traits that help them cause infections just being around these fungi isn't enough to make every person sick. What happens after someone is exposed to fungi depends on things. These things include how strong the person's immune system is, their genes, how well their skin and mucus layers are working, the mix of bad bacteria they have, their body's energy levels, the environment they live in and their daily habits. Modern research on fungi shows that repeated infections are mostly problems with how the body and the fungi interact, not just because the fungi keep growing in the body.

The skin and the inside of the body like the mouth and nose are the way the body stops fungi, from getting in. When these areas are damaged the body's natural defences and the advanced immune system work together to find the fungi, get rid of them and protect against future infections. If any part of these defence systems is not working properly it makes it more likely for the fungi to stay and cause repeated infections [9-19].

Innate Immunity

Innate immunity provides the immediate, non-specific defence against fungal pathogens and plays a crucial role in preventing initial colonisation and dissemination. The intact epidermis, mucosal epithelium, acidic skin pH, antimicrobial peptides, sebaceous secretions, and the resident microbiota together form an effective physical and chemical barrier against fungal invasion.

Following fungal entry, pattern-recognition

receptors (PRRs) expressed on macrophages, dendritic cells, neutrophils, epithelial cells, and monocytes recognise conserved fungal pathogen-associated molecular patterns (PAMPs), including β -glucans, mannans, and chitin present within the fungal cell wall. Among these receptors, Dectin-1, Dectin-2, Toll-like receptors (TLR-2 and TLR-4), mannose receptors, and C-type lectin receptors are particularly important in initiating antifungal immunity.

Activation of these receptors stimulates intracellular signalling pathways that induce the production of pro-inflammatory cytokines such as interleukin (IL)-1 β , IL-6, tumour necrosis factor- α (TNF- α), and IL-23, thereby recruiting neutrophils and macrophages to the site of infection. Neutrophils eliminate fungal organisms through phagocytosis, oxidative burst, degranulation, and the formation of neutrophil extracellular traps (NETs), whereas macrophages destroy fungal cells through intracellular killing and antigen presentation.

Natural killer (NK) cells also contribute to antifungal defence by producing interferon- γ (IFN- γ), which activates macrophages and enhances fungal killing [12-18].

Adaptive Immunity

Adaptive immune responses involve coordinated activation of antigen-specific T lymphocytes and B lymphocytes following antigen presentation by dendritic cells and macrophages.

Memory T and B lymphocytes provide accelerated immune responses upon subsequent fungal exposure, reducing the likelihood of reinfection in immunocompetent individuals.

Immunocompromised states—including HIV infection, haematological malignancies, organ transplantation, immunosuppressive therapy, uncontrolled diabetes mellitus, and ageing—significantly impair adaptive immune responses, predisposing individuals to recurrent and invasive fungal disease [10-13].

Homeopathic Concept

The idea of susceptibility is really important in Homeopathic philosophy. It is seen as the reason

for getting sick getting better and how people respond to treatment. Homoeopathic philosophy is different from what modern medicine says about susceptibility. Modern medicine says that susceptibility is mainly because of the system genes, the environment and tiny living things like germs. Homoeopathy thinks that susceptibility is about how well the body can deal with things that happen inside and outside of it.

When someone who is susceptible meets something that can make them sick, they will get sick. So, susceptibility decides if someone gets sick how sick they get, if the sickness is term if it comes back and if the treatment works.

From a point of view getting fungal infections over and over is not just because of germs. It is because something is wrong with the persons health. To make these better Homoeopathic doctors give treatment that's just, for that person. This treatment tries to change the persons susceptibility so they do not get sick much ^[20].

Samuel Hahnemann's Concept Of Susceptibility

Although Samuel Hahnemann (1755–1843) did not formulate a separate chapter devoted exclusively to this point, the concept permeates his writings throughout the *Organon of Medicine* and *The Chronic Diseases*. Hahnemann proposed that disease arises only when the vital force (*Lebenskraft*) becomes sufficiently susceptible to the action of morbidic influences. External agents, whether infectious, environmental, emotional, or physical, cannot produce disease unless the organism possesses the corresponding susceptibility ^[20].

In Aphorisms 30–32 of the *Organon*, Hahnemann emphasised that disease-producing influences act only upon susceptible individuals, whereas healthy persons lacking such susceptibility remain unaffected under identical circumstances ^[20]. Similarly, in Aphorism 31, he explained that pathogenic agents require a receptive state of the organism to exert their effects. This principle provides the philosophical basis for understanding why not every individual exposed to fungal pathogens develops recurrent infection.

In *The Chronic Diseases*, Hahnemann further

proposed that chronic recurrent illnesses reflect deeper constitutional disturbances associated with chronic miasms, particularly Psora, which he regarded as the fundamental predisposition underlying many chronic diseases ^[35]. Within this framework, recurrent infections represent repeated expressions of an underlying constitutional susceptibility rather than isolated local disorders ^[35].

James Tyler Kent

James Tyler Kent greatly expanded Hahnemann's concept by defining it as the organism's inherent capacity to receive impressions and react to stimuli ^[22]. He considered susceptibility to be the foundation of both disease and cure, asserting that the same property enabling disease also permits the curative action of the *similimum*. According to him, every individual possesses a unique constitutional susceptibility that determines both vulnerability to illness and responsiveness to Homoeopathic treatment ^[22].

Kent emphasised that chronic diseases arise from disturbances of the dynamic plane of the individual rather than from isolated pathological lesions. Consequently, recurrent local manifestations, including repeated infections, should not be regarded as independent disease entities but as external expressions of deeper constitutional imbalance ^[22].

Constantine Hering

Constantine Hering reinforced the importance of it through his observations on the direction of cure and the relationship between constitutional health and disease manifestations ^[32]. Hering maintained that disease progresses according to definite natural laws and that successful treatment should restore harmony within the organism as a whole rather than simply eliminate local symptoms.

Hering's well-known "Law of Cure" proposes that genuine healing progresses from within outward, from more vital organs to less vital structures, from above downward, and in the reverse order of symptom appearance ^[32]. Although this principle remains a doctrine within Homoeopathy rather than an empirically established biological law, it reflects Hering's belief that constitutional

improvement precedes the disappearance of local disease manifestations, including recurrent infections ^[32].

Stuart Close

Stuart Close provided one of the most comprehensive discussions in his *The Genius of Homoeopathy* ^[27]. He described it as the individual's inherent ability to react to both disease-producing and therapeutic influences, considering it one of the fundamental principles governing Homeopathic practice.

Close emphasised that susceptibility varies according to age, heredity, nutrition, emotional state, environmental conditions, and constitutional vitality ^[27]. He proposed that successful Homeopathic treatment depends upon selecting a medicine capable of matching the patient's characteristic susceptibility according to the law of similars. In recurrent diseases, constitutional prescribing seeks to modify this underlying predisposition rather than repeatedly addressing individual episodes in isolation.

Ortega

Protasio Ortega further elaborated this point by integrating constitutional characteristics, hereditary tendencies, environmental influences, and chronic miasmatic predispositions into a unified interpretation of disease ^[31]. Ortega regarded susceptibility as a dynamic interaction between inherited constitutional tendencies and acquired environmental influences.

According to Ortega, recurrent illnesses indicate persistent constitutional imbalance in which external factors merely serve as exciting causes acting upon an already susceptible individual ^[31]. His interpretation broadened classical Homeopathic thinking by emphasising that susceptibility is continuously modified by lifestyle, nutrition, emotional stress, occupation, and environmental exposure throughout life ^[31].

Modern Interpretation

Contemporary Homoeopathic authors continue to regard susceptibility as a cornerstone of constitutional medicine while attempting to interpret this classical concept within the context of advances

in immunology, genetics, epigenetics, systems biology, and psychoneuroimmunology ^[20-35]. Rather than viewing susceptibility solely through the traditional concept of the vital force, some modern scholars propose that it may represent the organism's overall capacity for physiological adaptation and regulation in response to internal and external stressors ^[20-35].

Current scientific evidence demonstrates that recurrent fungal infections are influenced by measurable factors such as immune competence, genetic polymorphisms, epithelial barrier integrity, microbiome composition, metabolic disorders, and environmental exposure ^[20-35]. Whether the Homoeopathic concept of susceptibility corresponds to, overlaps with, or differs fundamentally from these biological determinants remains uncertain and requires rigorous interdisciplinary investigation ^[20-35].

Consequently, while the Homoeopathic concept of susceptibility provides a coherent philosophical framework for constitutional prescribing, its relationship to contemporary concepts of host susceptibility should presently be regarded as a hypothesis requiring further experimental and clinical validation.

Comparative Analysis

Biomedical Susceptibility Versus Homeopathic Susceptibility

Contemporary biomedical science and Homoeopathy come from different ways of thinking but they both agree that just being around a germ is not enough to make every person sick. When it comes to getting infections over and over both biomedical science and Homoeopathy say that things about the person themselves play a big role in deciding whether they get a little sick really sick or keep getting sick again and again ^[5-18].

From a point of view being susceptible to getting sick means that someone's body is more likely to catch an infection get really sick or not be able to fight it off. This susceptibility is figured out by looking at how their body can fight off germs any genetic problems they might have how healthy their skin and insides are, if they have any other health issues what kinds of germs are living in

and on them what they are exposed to in their environment what they eat and how they behave ^[5-18].

On the hand classical Homoeopathy thinks of susceptibility as how well the whole person can respond to things that might make them sick and to treatments. According to Hahnemann being means that someone's body can be affected by things that might make them sick and Kent said it is the persons natural ability to feel things and react to what is going on inside and outside of them ^[20-38].

The goal of Homoeopathy is to find a treatment that matches all of the persons symptoms and helps their whole body get better rather than just treating the fungal infection.

Homeopathic susceptibility, by comparison, is evaluated through an individualised constitutional assessment incorporating the patient's physical symptoms, mental and emotional characteristics, personal history, family history, environmental influences, and characteristic symptom patterns according to classical Homeopathic principles ^[19-28]. Constitutional prescribing seeks to select a medicine corresponding to the totality of symptoms with the aim of restoring the individual's overall susceptibility rather than treating the fungal pathogen directly ^[19-28].

Thus, while biomedical science attributes recurrent fungal infections to demonstrable abnormalities of host defence and fungal pathogenicity, Homoeopathy interprets recurrence primarily as an expression of altered constitutional susceptibility.

Aspect	Mycology (Contemporary Science)	Homoeopathy (Constitutional Perspective)
Basis of Understanding	Pathogen–host interaction based on biology, microbiology, immunology, and molecular science.	Holistic view of the individual; disease expression reflects altered constitutional susceptibility.
Primary Focus	Eradication of the fungal pathogen and correction of predisposing factors.	Strengthening the vital force and addressing the underlying constitutional predisposition.
Concept of Susceptibility	Determined by genetic, immune, metabolic, hormonal, environmental, and microbiome-related factors.	Based on constitutional weakness, miasmatic background, individual sensitivity, and imbalance of the vital force.
Pathogenic Mechanism	Fungal virulence factors, cell wall components, bio-film formation, immune evasion, and antifungal resistance contribute to disease persistence and recurrence.	Disease develops when imbalance or disharmony of the vital force permits expression of susceptibility and recurrence.
Assessment Parameters	Microscopy, fungal culture, histopathology, molecular diagnostics, immunological markers, imaging, and evaluation of clinical risk factors.	Totality of symptoms (mental, emotional, and physical), constitution, modalities, miasmatic analysis, family history, and general characteristics.
Therapeutic Approach	Topical and systemic antifungal agents, combination therapy, immunotherapy, probiotics, lifestyle modification, hygiene measures, and environmental control.	Individualized constitutional remedy (simillimum) selected according to the totality of symptoms to stimulate self-regulation and restore constitutional balance.
Goal of Treatment	Mycological cure, symptom relief, and prevention of recurrence and complications.	Restoration of the balance of the vital force, correction of susceptibility, and long-term reduction in recurrence.
Evidence Base	Extensive experimental, clinical, epidemiological, and translational research supporting diagnosis and treatment.	Primarily based on clinical experience, observational studies, case reports, and limited clinical trials; requires further high-quality research.

Areas of Convergence

Despite their differing conceptual foundations, several areas of convergence may be identified between contemporary mycology and the Homeopathic concept of susceptibility.

Recognition Of Individual Variation

Both paradigms recognise that individuals

exposed to identical fungal organisms do not experience identical clinical outcomes ^[5,13]. Biomedical science explains this variation through differences in immune competence, genetics, microbiome composition, and environmental factors ^[5,13], whereas Homoeopathy attributes it to constitutional susceptibility and individual responsiveness ^[5,13,32].

Importance Of The Host Rather Than The Pathogen Alone

Modern infectious disease research increasingly emphasises that recurrent fungal infections arise from complex host–pathogen interactions rather than from fungal virulence alone ^[11,18]. Similarly, Homoeopathy has historically regarded the host constitution as more important than the external exciting cause in determining disease manifestation ^[20,32]. This conceptual emphasis on the individual rather than the microorganism represents an important philosophical overlap.

Holistic Patient Assessment

Both approaches increasingly advocate comprehensive patient evaluation. Biomedical management incorporates assessment of immune status, metabolic disease, medications, nutritional deficiencies, environmental exposure, hygiene, and lifestyle factors ^[14–17]. Homoeopathy similarly evaluates constitutional characteristics, mental and emotional symptoms, environmental influences, hereditary tendencies, and general health when selecting an individualized remedy ^[21–33].

Prevention Of Recurrence

A common therapeutic objective in both systems is reducing recurrence rather than merely suppressing acute episodes. Contemporary medicine attempts to achieve this through optimisation of antifungal therapy, correction of underlying risk factors, antifungal stewardship, and preventive strategies ^[8,14,16]. Homoeopathy seeks the same clinical objective through constitutional treatment intended to restore susceptibility according to its theoretical framework ^[20–23]. Whether constitutional Homeopathic treatment reduces recurrence beyond placebo or adjunctive care remains insufficiently established and requires further high-quality clinical research ^[20–23].

Areas Of Divergence

Despite these conceptual similarities, important differences distinguish the biomedical and Homeopathic understanding of susceptibility.

Nature Of Susceptibility

Biomedical science considers susceptibility to be

a measurable biological phenomenon involving immune function, genetics, microbiome composition, epithelial integrity, and environmental risk factors ^[9–15]. Homoeopathy, however, defines susceptibility as a dynamic constitutional property of the living organism that cannot presently be measured directly using established biomedical methods ^[26,30,32].

DISEASE MECHANISM

Contemporary mycology explains recurrent fungal infections through fungal cell wall biology, virulence factors, biofilm formation, immune evasion, antifungal resistance, microbiome dysbiosis, and host immune dysfunction ^[14–18]. Homoeopathy interprets recurrence as the external manifestation of deeper constitutional imbalance, frequently associated with chronic miasmatic predisposition ^[29–33]. These explanations arise from fundamentally different theoretical frameworks.

Therapeutic Strategy

Biomedical treatment aims to eradicate fungal pathogens using evidence-based antifungal drugs while correcting identifiable host risk factors and preventing reinfection ^[8,14]. Homoeopathy emphasises individualized constitutional prescribing according to the law of similars with the objective of restoring the patient's susceptibility rather than directly targeting fungal organisms ^[26,30,32].

Evidence Base

Biomedical concepts of susceptibility are supported by extensive laboratory investigations, molecular biology, immunology, genetics, microbiology, animal models, epidemiological studies, and randomised clinical trials ^[9–15]. In contrast, the Homeopathic concept of susceptibility is derived primarily from classical philosophical writings, clinical observations, and constitutional theory ^[26–33].

Integrative Clinical Perspective

Contemporary evidence suggest that recurrence occurs from a multifactorial interaction among fungal virulence, host immune competence, genetic susceptibility, epithelial barrier integrity, microbiome composition, environmental exposure, behavioural factors, and therapeutic adherence ^[5–18]. Consequently, effective long-term

management needs not only suitable antifungal therapy but also identification and correction of the underlying predisposing factors that favours for recurrence of disease [5-18].

Among Allopathic point of view Antifungal treatment remains the mainstream of evidence-based management. Selection of therapy depends upon the infecting species, anatomical site, severity of infection, antifungal susceptibility, and patient-specific factors [9-16]. Correct treatment duration, patient co-operation, avoidance of irrational topical corticosteroid-antifungal combinations, management of infected household contacts, decontamination of clothing, footwear, bedding, and personal items are equally valuable in preventing reinfection [10,11]. Increasing awareness of antifungal stewardship has become particularly important in response to the emergence of terbinafine-resistant *Trichophyton indotineae* and multidrug-resistant *Candida auris* [11-13].

Advances in immunology and microbiome research have further expanded the understanding of recurrent fungal infections. Restoration of epithelial barrier function, optimisation of metabolic control in diabetes mellitus, maintenance of healthy skin and mucosal microbiota, and correction of nutritional deficiencies may enhance host resistance against fungal pathogens [5-18].

Within Homoeopathy, recurrent fungal infections are interpreted through the concept of altered constitutional susceptibility rather than persistent microbial colonisation alone [20-36]. Classical Homeopathic management therefore focuses on comprehensive individualisation of the patient, considering physical generals, mental and emotional characteristics, constitutional traits, family history, environmental influences, and characteristic symptom patterns before selecting an

individualized remedy according to the law of similars [20-36]. The therapeutic objective is to improve the patient's overall constitutional health and thereby reduce the tendency toward recurrent illness.

From an integrative perspective, constitutional Homoeopathic treatment may be viewed as a complementary patient-centred approach when used alongside standard medical evaluation and evidence-based antifungal therapy, provided that conventional treatment is not delayed or replaced in situations where it is clinically indicated [28]. Such an approach emphasises holistic assessment, patient education, lifestyle modification, optimisation of general health, and long-term follow-up while ensuring appropriate microbiological diagnosis and pharmacological management according to established clinical guidelines [20-36].

It is important to distinguish clinical observations from established scientific evidence. Although Homeopathic practitioners have reported improvements in recurrent fungal disorders following individualized constitutional treatment, the available clinical literature consists predominantly of observational studies, case reports, and small heterogeneous clinical trials with variable methodological quality [26,32].

Traditional Homoeopathic Medicines For Recurrent Fungal Infections: Organ Affinity And Clinical Indications

In classical Homoeopathy, medicine selection is individualized according to the totality of symptoms, constitutional characteristics, and susceptibility rather than the diagnosis alone. Nevertheless, certain remedies have traditionally been associated with recurrent fungal infections involving particular anatomical sites.

Homoeopathic Medicine	Principal Affinity	Traditional Indications in Fungal Disorders [21,24,28,30,32,34]
Sulphur	Skin, mucocutaneous junctions	Chronic recurrent tinea, intense itching aggravated by warmth, burning after scratching, recurrent fungal eruptions with unhealthy skin.
Graphites	Flexures, ears, scalp, nails	Moist eczema with fissures, fungal infections in skin folds, thickened nails, sticky honey-like discharge.
Sepia	Groins, genitalia, vagina	Recurrent vulvovaginal candidiasis, fungal infection associated with hormonal changes, pregnancy or menopause.
Natrum muriaticum	Scalp, lips, skin folds	Dry fissured skin, recurrent herpes and fungal eruptions aggravated by emotional stress.

Calcarea carbonica	Skin, feet, nails	Obese, chilly patients with excessive perspiration, recurrent athlete's foot, chronic nail fungus.
Silicea	Nails, skin, sweat glands	Chronic onychomycosis, slow healing, recurrent suppuration, unhealthy skin.
Tellurium	Entire skin, especially circular lesions	Classical remedy for extensive ringworm with concentric ("ring-within-ring") lesions and offensive perspiration.
Mezereum	Scalp and face	Thick crusts, fungal scalp lesions with intense itching beneath crusts.
Psorinum	General skin	Dirty-looking skin, offensive discharges, recurrent infections in patients with marked constitutional weakness.
Petroleum	Hands, feet, fissures	Deep fissured skin, winter aggravation, chronic fungal infection of palms and soles.
Arsenicum album	Skin, mucosa	Burning pains relieved by warmth, recurrent fungal lesions in debilitated individuals.
Thuja occidentalis	Skin, nails, mucous membranes	Chronic moist skin eruptions, recurrent fungal growths associated with sycotic constitution.
Hepar sulphuris calcareum	Skin folds	Secondary bacterial infection complicating chronic fungal lesions, marked hypersensitivity to touch.
Mercurius solubilis	Mouth, groins, skin folds	Moist fungal lesions with offensive perspiration and profuse sweating.
Kali sulphuricum	Epidermis	Desquamating fungal eruptions with yellow scales and shifting lesions.
Lycopodium clavatum	Epidermis, Dermis	Fungal infections in skin folds with digestive bloating and right-sided complaints.

Medicines Frequently Considered For Dermato-phytosis [21,24,28,30,32,34]

- **Chrysarobinum** – Severe itching with thick crusted skin lesions.
- **Kali arsenicosum** – Chronic itchy, burning skin infections.
- **Antimonium crudum** – Thickened, horny skin with fungal involvement.
- **Hepar sulphuris** – Suppurative, sensitive fungal lesions.
- **Mercurius corrosivus** – Severe ulcerative, burning mucosal fungal infections.
- **Acidum nitricum** – Fissured, painful fungal lesions with sharp splinter-like pain.
- **Rhus toxicodendron** – Itchy vesicular fungal eruptions worse from rest.
- **Croton tiglium** – Vesicular eruptions with intense itching and burning.
- **Dulcamara** – Fungal eruptions aggravated by damp, cold weather.

Medicines Traditionally Used In Recurrent Candidiasis [21,24,28,30,32,34]

- **Sepia** – Vaginal candidiasis with hormonal imbalance and fatigue.
- **Kreosotum** – Offensive, corrosive vaginal discharge with irritation.
- **Borax** – White, sticky vaginal discharge with sensitivity.
- **Helonias dioica** – Uterine weakness with recurrent infections.
- **Pulsatilla** – Mild, changeable vaginal discharge with emotional sensitivity.
- **Natrum muriaticum** – Dry, recurrent mucosal infections with emotional suppression. Medorrhinum – Chronic recurrent genital infections with past gonorrheal mis-asm.
- **Candida albicans nosode** – Recurrent candidiasis with systemic predisposition.
- **Psorinum** – Chronic, offensive, relapsing candidal infections.
- **Sulphur** – Burning, itchy mucosal infections

with recurrence tendency.

- Kali bichromicum – Thick, stringy mucous discharge with fungal involvement.

Rarely Discussed Remedies ^[21,24,28,30,32,34]

Remedy	Organ Affinity	Traditional Clinical Indications
Tellurium	Skin	Extensive dermatophytosis with concentric rings, offensive perspiration.
Bovista	Skin folds	Moist fungal eruptions aggravated by damp weather and tight clothing.
Sanicula aqua	Feet	Offensive sweaty feet with recurrent tinea pedis and fissures.
Fluoric acid	Nails	Brittle, distorted nails with chronic onychomycosis.
Cistus canadensis	Skin	Chronic fissured lesions in cold-sensitive individuals. Recurrent fungal infections with glandular swelling
Juglans cinerea	Scalp	Chronic scalp eruptions with excessive sebaceous secretion. Chronic skin eruptions with hepatic involvement
Bacillinum	Constitution	Occasionally prescribed constitutionally in patients with recurrent infections according to Homeopathic tradition.
Tuberculinum	Constitution	Considered by some homeopaths in recurrent infections with strong family history of chronic respiratory disease.
Medorrhinum	Genitourinary tract	Traditionally considered in recurrent mucocutaneous infections with sycotic features.
Syphilinum	Deep tissues	Occasionally used constitutionally in destructive chronic skin conditions according to miasmatic prescribing.
Fagopyrum	Skin	Itchy skin eruptions with burning and redness.
Juglans regia	Skin	Fungal skin infections with glandular weakness
Oleander	Skin	Dry, scaly eruptions with fragile skin
Myristica sebifera	Skin	Suppurative skin infections with abscess tendency.

Hydrocotyle asiatica	Skin	Skin-Thickened, indurated chronic skin lesions.
Pix liquida	Skin	Fungal infections with intense itching and burning.
Anacardium orientale	Skin	Itchy eruptions with mental irritability.
Carcinosinum	Skin	Long-standing recurrent infections with family history of chronic disease.
Morgan Pure	Skin	Chronic skin infections with intestinal dysbiosis tendency.
Morgan Gaertner	Skin	Offensive, recurrent infections with toxic state.
Dysentery Co.	Skin	Post-infective susceptibility to recurrent mucosal infections.
Proteus nosode	Skin	Recurrent, rapidly changing infections.
Bacillinum Burnett	Skin	Tubercular diathesis with recurrent skin infections.

Homoeopathic Medicines According To Site Of Fungal Infection ^[37]

Sr. No	Site of Infection	Clinical Condition	Commonly Indicated Homoeopathic Medicines
1	Scalp	Tinea capitis	Mezereum, Graphites, Sulphur, Tellurium, Juglans cinerea, Calcarea carbonica
2	Face	Tinea faciei	Graphites, Sulphur, Petroleum, Natrum muriaticum, Arsenicum album
3	Body	Tinea corporis	Tellurium, Sulphur, Sepia, Graphites, Kali sulphuricum, Psorinum
4	Groin	Tinea cruris	Sepia, Graphites, Sulphur, Mercurius, Petroleum
5	Feet	Tinea pedis	Sanicula aqua, Petroleum, Silicea, Calcarea carbonica, Graphites
6	Nails	Tinea unguium	Silicea, Fluoric acid, Graphites, Antimonium crudum, Thuja occidentalis
7	Female Genital Tract	Vulvovaginal Candidiasis	Sepia, Kreosotum, Borax, Natrum muriaticum, Pulsatilla, Calcarea carbonica
8	Oral Cavity	Oral Candidiasis	Borax, Mercurius solubilis, Nitric acid, Kali chloricum, Arsenicum album

Bach Flower Remedies And Their Emotional Indications In Patients With Chronic And Recurrent Fungal Disorders ^[38]

Sr. No	Bach Flower Remedy	Emotional Indication
1	Crab Apple	Feelings of impurity, shame, embarrassment, or dissatisfaction with skin conditions ("cleansing remedy").
2	Walnut	Difficulty adapting to environmental changes, hormonal changes, or life transitions that may trigger recurrence.
3	Elm	Feeling overwhelmed by the burden of prolonged or recurrent illness despite previous competence.
4	Olive	Physical and mental exhaustion following chronic or recurrent fungal infections.
5	Mimulus	Fear of recurrence, medical procedures, investigations, or future infections.
6	White Chestnut	Persistent worrying thoughts, obsessive thinking, and mental preoccupation about relapse.
7	Star of Bethlehem	Emotional trauma, shock, or psychological distress associated with prolonged illness.
8	Rescue Remedy	Acute emotional distress, anxiety, panic, or crisis during symptomatic episodes.
9	Agrimony	Hidden anxiety or emotional suffering masked behind a cheerful appearance; concern about visible skin lesions.
10	Centaury	Over-compliance, inability to refuse others, weak personal boundaries, and emotional vulnerability.
11	Hornbeam	Mental fatigue, lack of motivation, and difficulty initiating treatment or daily activities.
12	Gorse	Hopelessness, pessimism, and loss of confidence after repeated relapses or unsuccessful treatments.
13	Sweet Chestnut	Extreme despair, emotional anguish, and feelings of being unable to cope with chronic illness.

Biochemic (Schüßler) Tissue Salts Traditionally Used In Chronic And Recurrent Fungal Disorders ^[39]

Sr. No	Biochemic (Schüßler) Tissue Salt	Traditional Indication
1	Calc. Sulph	Traditionally indicated for chronic suppurative skin lesions, unhealthy skin, and delayed wound healing.
2	Kali Sulph	Traditionally used for scaling skin disorders, superficial eruptions, and desquamative conditions.
3	Nat. Sulph.	Traditionally indicated for moist skin eruptions, humid-weather aggravation, and chronic skin complaints.
4	Silicea	Traditionally used for brittle or deformed nails, recurrent boils, chronic unhealthy skin, and delayed tissue repair.
5	Calc. Fluor	Traditionally indicated for thickened, brittle nails, fissured skin, and loss of tissue elasticity.
6	Ferr. Phos.	Traditionally used during the early inflammatory stage of superficial infections and mild inflammatory conditions.
7	Nat. Phos	Traditionally indicated for acid-related skin and mucosal disturbances and conditions associated with excess acidity.
8	Nat. Mur.	Traditionally used for dry, cracked skin, mucosal imbalance, and chronic dryness of the skin and mucous membranes.

Clinical Consideration

Classical Homoeopathy emphasises that recurrent fungal infections should not be treated solely on the basis of anatomical location. Constitutional prescribing, incorporating the patient's general symptoms, mental and emotional characteristics, modalities, family history, and overall susceptibility, remains the fundamental principle of remedy selection ^[21,24,28,30,32]. Therefore, the medicines listed above represent traditional clinical affinities rather than fixed prescriptions for specific fungal diseases. These indications are derived from traditional Homeopathic literature and should be interpreted within that context.

Repertorial Correlation For Recurrent Fungal Infections ^[23-33,40,41]

Sr. No.	Repertory	Chapter	Main Rubric	Sub-rubric	Commonly Indicated Remedies
1	Kent	Skin	Eruptions	Ringworm	Sulph., Tell., Sep., Ars., Graph., Calc., Psor.
2	Kent	Skin	Eruptions	Itching; warmth aggravates	Sulph., Ars., Rhus-t., Psor., Mez.
3	Kent	Skin	Eruptions	Moist	Graph., Mez., Petr., Merc., Rhus-t.
4	Kent	Skin	Nails	Deformed	Sil., Graph., Fluor-ac., Ant-c.
5	Kent	Extremities	Feet	Perspiration; offensive	Sil., Calc., Sanic., Graph.
6	Kent	Female Genitalia	Leucorrhoea	Acrid; itching	Sep., Kreos., Bor., Nat-m., Puls.
7	Kent	Mouth	Aphthae	Thrush	Bor., Merc., Nit-ac., Ars.
8	Murphy	Skin	Fungal infection	General	Sulph., Graph., Tell., Ars., Sep.
9	Murphy	Skin	Athlete's foot	—	Sanic., Petr., Calc., Sil.
10	Murphy	Skin	Ringworm	General	Tell., Sulph., Graph.
11	Murphy	Nails	Onychomycosis	—	Sil., Fluor-ac., Graph., Thuja
12	Murphy	Female	Vaginal candidiasis	Recurrent	Sep., Bor., Puls., Kreos.
13	BTPB	Skin	Itching	Scratching aggravates	Sulph., Ars., Rhus-t.
14	BTPB	Skin	Moist eruptions	Flexures	Graph., Petr., Merc.
15	BTPB	Generalities	Recurrence	Periodicity	Sulph., Psor., Tub.
16	Boericke	Skin	Ringworm	Chronic	Tell., Sulph., Graph.
17	BBCR	Skin	Herpetic eruptions	Circular	Tell., Sulph., Graph.
18	BBCR	Skin	Perspiration	Offensive feet	Sil., Calc., Sanic.
19	BBCR	Skin	Ringworm	Chronic	Tell., Sulph., Graph.
20	BBCR	Female	Vaginal itching	Fungal tendency	Sep., Kreos., Bor.
21	Phatak	Skin	Fungal eruptions	Moist	Graph., Sulph., Tell.
22	Phatak	Skin	Nails	Thickened	Sil., Fluor-ac., Graph.
23	Knerr	Skin	Eruptions	Circular	Tell., Sulph., Sep.
24	Knerr	Generalities	Relapsing complaints	—	Psor., Sulph., Tub., Med.
25	Clarke	Skin	Ringworm	Extensive	Tell., Sulph., Graph.
26	Clarke	Skin	Cracked skin	With fungal infection	Petr., Graph., Sil.

Abbreviations:

Sulph. = Sulphur; Tell. = Tellurium; Sep. = Sepia; Ars. = Arsenicum album; Graph. = Graphites; Calc. = Calcareo carbonica; Psor. = Psorinum; Petr. = Petroleum; Sil. = Silicea; Merc. = Mercurius solubilis; Rhus-t. = Rhus toxicodendron; Mez. = Mezereum; Fluor-ac. = Fluoric acid; Ant-c. = Antimonium crudum; Sanic. = Sanicula aqua; Nat-m. = Natrum muriaticum; Kreos. = Kreosotum; Bor. = Borax; Puls. = Pulsatilla; Tub. = Tuberculinum; Med. = Medorrhinum; Thuja = Thuja occidentalis.

Correlation Of Standard Clinical Outcome Measures With The Homoeopathy ^[42-45]

The success of treatment in fungal infections is currently evaluated using validated clinical and microbiological outcome measures, including Patient Global Assessment (PtGA), Clinical Cure Rate (CCR), Mycological Cure Rate (MCR), and Complete Cure Rate (ComCR). These endpoints are widely accepted in dermatological clinical trials because they provide objective assessment of treatment response and recurrence.

Within classical Homoeopathy, however,

therapeutic success has traditionally been assessed through constitutional improvement, restoration of general health, reduction in disease susceptibility, improvement in mental and emotional well-being, and long-term prevention of recurrence. Integrating these conventional outcome measures with Homoeopathic assessment may provide a comprehensive framework for future integrative clinical research.

Patient Global Assessment (Ptga)

Patient Global Assessment (PtGA) is a patient-reported outcome measure reflecting the individual's overall perception of disease severity, symptom relief, treatment satisfaction, and quality of life following therapy. In fungal infections, PtGA commonly evaluates improvement in itching, burning, erythema, scaling, discomfort, cosmetic appearance, and the patient's overall perception of recovery.

From a Homoeopathic perspective, improvement extends beyond resolution of local skin lesions. Constitutional prescribing aims to improve general well-being, vitality, sleep, appetite, emotional balance, resistance to recurrent illness, and overall quality of life. Consequently, PtGA may provide an important patient-centred outcome capable of capturing broader constitutional changes that are valued in Homeopathic practice.

Mycological Cure Rate (Mcr)

Mycological Cure Rate is defined as the absence of demonstrable fungal organisms by direct microscopy (potassium hydroxide preparation) and/or negative fungal culture following treatment. It represents objective microbiological eradication of the infecting organism and is considered one of the most important endpoints in antifungal clinical trials.

Incorporation of Mycological Cure Rate into Homoeopathic clinical research would strengthen methodological quality by providing objective evidence independent of subjective symptom improvement.

Clinical Cure Rate (Ccr)

Clinical Cure Rate refers to complete or near-complete disappearance of the clinical manifestations

of fungal infection, including erythema, scaling, pruritus, maceration, vesiculation, fissuring, and inflammation, as determined by clinical examination.

Homoeopathic management similarly considers improvement in local manifestations important; however, these findings are interpreted within the broader context of constitutional recovery rather than as isolated therapeutic endpoints. Improvement in skin lesions, reduction in itching, restoration of normal skin texture, improved patient comfort, and prolonged symptom-free intervals may all contribute to assessment of clinical improvement following individualized treatment.

Complete Cure Rate (Comcr)

Complete Cure Rate represents the most rigorous therapeutic endpoint and is generally defined as the simultaneous achievement of both clinical cure and mycological cure. Patients meeting this endpoint demonstrate complete resolution of clinical signs together with negative mycological investigations.

Within an integrative model, Complete Cure Rate provides an objective biomedical endpoint, whereas constitutional improvement reflects the traditional therapeutic goal of Homoeopathy. Simultaneous evaluation of Complete Cure Rate together with constitutional assessment, quality-of-life measures, and long-term recurrence may provide a more comprehensive evaluation of individualized Homeopathic management than either approach alone.

Integrative Outcome Framework

The integration of conventional dermatological outcome measures with constitutional Homeopathic assessment may enhance the methodological quality of future research. Biomedical endpoints objectively evaluate fungal eradication and clinical resolution, whereas Homeopathic assessment emphasises individualized changes in general health, constitutional symptoms, and long-term susceptibility.

Outcome Measure	Biomedical Definition	Homoeopathic Correlation	Suggested Research Endpoint
Patient Global Assessment (PtGA)	Patient's overall perception of improvement	Constitutional well-being, vitality, symptom relief	PtGA score, quality of life, patient satisfaction
Clinical Cure Rate (CCR)	Resolution of clinical signs and symptoms	Improvement in local manifestations within constitutional recovery	Dermatological severity score, blinded clinical assessment
Mycological Cure Rate (MCR)	Negative KOH microscopy and/or fungal culture	Objective confirmation of fungal eradication; not replaced by constitutional assessment	KOH, fungal culture, molecular testing
Complete Cure Rate (ComCR)	Both clinical and mycological cure achieved	Constitutional improvement evaluated alongside objective cure	Combined clinical, microbiological, constitutional, and recurrence outcomes
Long-term Recurrence	Absence of relapse after treatment	Traditional goal of reducing susceptibility to recurrent illness	Recurrence-free survival at 6–12 months

Future Research Priorities

Future clinical research should prioritise adequately powered multicentre randomized controlled trials with concealed allocation, double blinding where feasible, microbiological confirmation of fungal eradication, standardized outcome measures, and long-term follow-up specifically evaluating recurrence rates. Integration of immunological biomarkers, microbiome profiling, genomic analysis, and quality-of-life assessment may help determine whether individualized Homoeopathic treatment exerts measurable effects on host susceptibility or clinical recurrence when used as an adjunct to evidence-based antifungal therapy. Such studies would provide a stronger scientific basis for evaluating the potential role of Homoeopathy in recurrent fungal infections [36].

Overall, the published literature suggests that individualized Homeopathic treatment may be associated with symptomatic improvement in some patients with superficial fungal infections, particularly dermatophytosis.

CONCLUSION

Fungal infections remain a major global health concern because of their chronic course, high relapse rates, increasing antifungal resistance, and substantial impact on quality of life and healthcare resources [1–5,20]. Contemporary mycology has demonstrated that recurrence is a multifactorial phenomenon resulting from the complex interaction between fungal virulence factors—including cell wall architecture, biofilm formation, immune evasion, and antifungal resistance—and

host-related determinants such as innate and adaptive immunity, genetic predisposition, epithelial barrier integrity, microbiome composition, metabolic disorders, and environmental influences [5–17]. These advances have shifted the understanding of recurrent fungal disease from a purely pathogen-centred model to a dynamic host–pathogen interaction.

The Homeopathic concept provides a constitutional interpretation of recurrent disease that has been a central principle of classical Homeopathic philosophy since the writings of Hahnemann and was subsequently elaborated by Kent, Hering, Close, Ortega, and later authors [20–39]. According to this perspective, recurrence reflects an underlying constitutional predisposition rather than the persistence of the pathogen alone, and individualized treatment seeks to address this inherent susceptibility. Although this concept differs fundamentally from the biomedical understanding of host susceptibility, both paradigms recognise that disease expression depends not only on the microorganism but also on characteristics of the individual host [5–15].

Nevertheless, both perspectives converge in emphasising the importance of individual variability in determining disease recurrence and therapeutic outcomes.

The review of published literature indicates that individualized Homeopathic treatment has shown encouraging clinical observations in some studies involving recurrent superficial fungal infections, particularly dermatophytosis. However, the current evidence is limited by small sample sizes, methodological heterogeneity, inadequate

microbiological confirmation, and insufficient long-term follow-up^[36].

From a clinical perspective, the management of recurrent fungal infections should continue to be based upon accurate diagnosis, appropriate antifungal therapy, identification and correction of underlying predisposing factors, patient education, hygiene measures, and antifungal stewardship in accordance with contemporary evidence-based guidelines. Where Homoeopathy is utilised, it should be considered a complementary, patient-centred approach and should not replace conventional antifungal treatment when such treatment is clinically indicated^[36]. This integrated approach prioritises patient safety while allowing objective evaluation of complementary therapeutic strategies.

Future interdisciplinary research should focus on high-quality randomised controlled trials, translational immunological studies, microbiome research, molecular biology, systems medicine, and precision medicine approaches to determine whether constitutional Homeopathic treatment exerts measurable effects on host resilience, immune regulation, or recurrence rates when used as an adjunct to standard care^[42-45]. Such investigations should employ rigorous methodology, transparent reporting, microbiological confirmation, and objective biological outcome measures to ensure scientific validity.

In conclusion, fungal infections represent a complex interaction between fungal pathogenicity and host susceptibility. Contemporary mycology provides robust mechanistic explanations for recurrence, whereas Homoeopathy offers a constitutional framework centred on individual susceptibility. Although these perspectives differ substantially in their conceptual foundations, they share an interest in understanding why certain individuals experience repeated fungal disease despite similar environmental exposure. Bridging these perspectives through rigorous interdisciplinary research, while maintaining a clear distinction between established scientific evidence and Homeopathic theory, may contribute to a more comprehensive understanding of recurrent fungal infections and stimulate the development of innovative, patient-centred strategies for

their long-term prevention and management.

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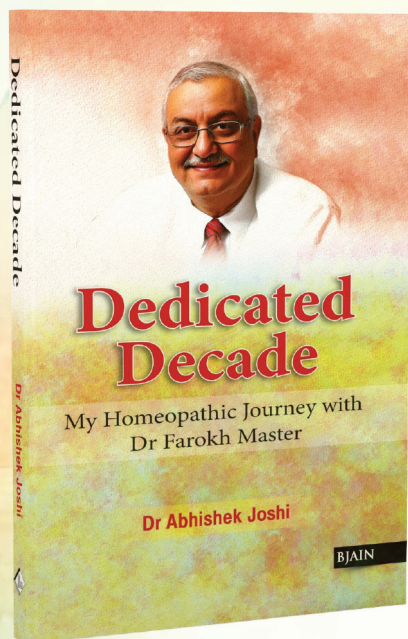
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Antifungal Potential of Medicinal Plants Used in Homoeopathy: A Narrative Review of Experimental and Pharmacological Evidence

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Abstract

Background: Fungal infections constitute a growing global health challenge owing to the increasing prevalence of opportunistic mycoses, emergence of multidrug-resistant fungal pathogens, and the limited efficacy and safety of existing antifungal therapies. These concerns have renewed interest in medicinal plants used in complementary systems of medicine, including Homoeopathy, as potential sources of novel antifungal agents.

Objective: This narrative review examines the antifungal potential of selected medicinal plants that are also represented as plant-derived sources in Homoeopathic materia medica and pharmacopoeial literature, while distinguishing this experimental/pharmacological evidence from a separate clinical case involving the non-plant medicine Tellurium metallicum.

Methods: A narrative literature search was undertaken using Scopus, PubMed, Web of Science, Google Scholar, and Embase, with emphasis on literature published between 2020 and 2025. Experimental in vitro and in vivo studies, mechanistic investigations, phytochemical reports, and relevant review literature concerning antifungal activity of selected medicinal plants represented in Homoeopathy were considered. The clinical case of Tellurium metallicum was treated as a separate clinical observation and was not considered experimental evidence for plant-derived antifungal activity.

Results: Experimental studies have reported

antifungal activity for selected medicinal plants represented in Homoeopathic materia medica, including *Calendula officinalis*, *Azadirachta indica*, *Hydrastis canadensis*, *Terminalia chebula*, *Curcuma longa*, *Ocimum tenuiflorum*, *Piper nigrum*, and other plant sources. Reported activity varies with plant species, plant part, extraction solvent, phytochemical composition, fungal strain, assay methodology, and concentration. Evidence includes activity against *Candida* spp., *Aspergillus* spp., and dermatophytes, with mechanisms reported to include membrane disruption, interference with ergosterol-related pathways, biofilm inhibition, oxidative stress, and effects on fungal virulence. Much of this evidence remains preclinical and should not be interpreted as equivalent to established clinical efficacy. The Tellurium metallicum case is presented separately as a clinical Homoeopathic observation and is not used as experimental evidence for a medicinal plant.

Conclusion: Selected medicinal plants represented in Homoeopathic literature show promising preclinical antifungal activity, but substantial heterogeneity in experimental methods and limited clinical evidence preclude direct extrapolation to therapeutic efficacy of Homoeopathic preparations. Standardized pharmaceutical characterization, mechanistic studies, toxicological assessment, and well-designed clinical research are required. The separate Tellurium metallicum case illustrates a clinical Homoeopathic observation but does not establish antifungal efficacy.

Keywords

Homoeopathy; antifungal activity; medicinal plants; phytopharmacology; *Candida albicans*; dermatophytes; biofilm inhibition; nanotechnology; evidence-based medicine; review.

1. Introduction

Fungal infections have become a significant public health concern worldwide due to their increasing incidence, recurrent nature, and rising resistance to conventional antifungal drugs. Opportunistic fungal pathogens such as ***Candida albicans***, ***Aspergillus fumigatus***, ***Trichophyton rubrum***, ***Microsporum gypseum***, and ***Cryptococcus neoformans*** are responsible for a wide spectrum of superficial and invasive mycoses. Immunocompromised individuals, patients with diabetes mellitus, malignancies, organ transplantation, prolonged corticosteroid therapy, HIV/AIDS, and intensive care unit admissions are particularly susceptible to these infections.

Although azoles, polyenes, echinocandins, and allylamines remain the standard antifungal therapies, their clinical utility is increasingly compromised by toxicity, drug interactions, prolonged treatment duration, biofilm-associated resistance, and the emergence of multidrug-resistant fungal species. Consequently, there is growing interest in plant-derived bioactive compounds and complementary medical systems that may provide safer and effective therapeutic alternatives.

Homoeopathy utilizes medicines prepared from botanical, mineral, and animal sources according to pharmaceutical procedures described in the Homoeopathic Pharmacopoeia. Selected medicinal plants represented in Homoeopathic literature contain phytochemicals—including alkaloids, flavonoids, terpenoids, phenolics, tannins, coumarins, and essential oils—that have been investigated for antifungal activity. Importantly, evidence concerning crude plants, extracts, or isolated phytoconstituents should not be equated with evidence for corresponding Homoeopathic preparations or potencies.

2. Burden of Fungal Diseases

Fungal diseases contribute substantially to global

morbidity and mortality. Recent epidemiological studies estimate that more than one billion individuals suffer from superficial fungal infections annually, while invasive fungal infections account for over 1.5 million deaths worldwide each year.

India bears one of the highest burdens of fungal diseases globally. The widespread prevalence of diabetes mellitus, tuberculosis, prolonged antibiotic usage, corticosteroid therapy, immunosuppressive treatment, and post-COVID-19 mucormycosis has significantly increased fungal infections. Dermatophytosis has become endemic in many parts of India, whereas candidiasis and aspergillosis remain major causes of opportunistic infections among hospitalized patients.

The emergence of antifungal resistance, particularly among *Candida auris*, azole-resistant *Aspergillus fumigatus*, and resistant dermatophytes, poses an additional therapeutic challenge. These limitations have stimulated renewed interest in medicinal plants with validated antifungal properties that may complement conventional therapy.

3. Homoeopathic Concept of Fungal Infections

Homoeopathy does not classify fungal infections as a separate nosological entity; instead, they are understood according to the totality of symptoms, constitutional susceptibility, and chronic miasmatic predisposition.

According to Samuel Hahnemann's Chronic Disease Theory, persistent skin diseases frequently represent manifestations of the psoric miasm, although sycotic and syphilitic influences may contribute in chronic or destructive fungal disorders. The individual's susceptibility plays a central role in disease development, and successful treatment aims not only to eliminate local manifestations but also to correct the underlying constitutional imbalance.

Homoeopathic Materia Medica describes several medicines indicated in ringworm, candidiasis, chronic eczema with fungal superinfection, intertrigo, pruritus, fissures, ulcerations, moist eruptions, and recurrent cutaneous infections. Medicines including Sulphur, Graphites, Sepia, Tellurium, Mezereum, Thuja occidentalis,

Calendula officinalis, *Hydrastis canadensis*, and *Azadirachta indica* are frequently prescribed based on symptom similarity.

Modern phytopharmacological investigations have reported antifungal, anti-inflammatory, wound-healing, antioxidant, and immunomodulatory activities for selected botanical sources. These findings are relevant to pharmacological research but do not by themselves establish the clinical efficacy of Homoeopathic preparations.

4. Medicines Traditionally Indicated in Homoeopathic Materia Medica

The following selected medicinal plants are represented in Homoeopathic materia medica/pharmacopoeial literature and have been investigated experimentally for antifungal activity:

* <i>Calendula officinalis</i>	* <i>Curcuma longa</i>
* <i>Azadirachta indica</i>	* <i>Terminalia chebula</i>
* <i>Hydrastis canadensis</i>	* <i>Piper nigrum</i>
* <i>Berberis vulgaris</i>	* <i>Ocimum tenuiflorum</i>
* <i>Thuja occidentalis</i>	* <i>Syzygium cumini</i>
* <i>Echinacea angustifolia</i>	* <i>Baptisia tinctoria</i>

In Homoeopathic practice, these medicines may be used in different pharmaceutical forms according to the principles of Homoeopathic prescribing. Their traditional indications should not be interpreted as evidence that the corresponding preparations have demonstrated antifungal efficacy in controlled clinical trials.

Traditional indications include:

* Ringworm (Tinea)	* Cracked skin
* Oral candidiasis	* Moist eruptions
* Intertrigo	* Persistent itching
* Chronic eczema with secondary fungal infection	* Diabetic foot infections
* Ulcerative skin lesions	

5. Experimental Evidence of Source Plants

Experimental studies have reported antifungal activity for selected medicinal plants that are also represented as plant-derived sources in Homoeopathic materia medica and pharmacopoeial literature. However, the magnitude of activity

varies according to plant species, plant part, extraction solvent, phytochemical composition, fungal strain, assay methodology, and concentration. Much of the available evidence remains preclinical, particularly in vitro, and therefore should not be interpreted as equivalent to established clinical efficacy.

- ✓ *Calendula officinalis* has been investigated experimentally for antifungal activity, including activity against *Candida* species; reported effects include inhibition of fungal growth and biofilm-related processes. [18]
- ✓ *Azadirachta indica* has been investigated for antifungal effects of its extracts and phytoconstituents. Reported activity varies with preparation and test organism and has included activity against dermatophytes and *Candida* species.
- ✓ *Hydrastis canadensis* and its characteristic alkaloid berberine have been investigated for antimicrobial and antifungal activity; however, the available evidence should be interpreted as preclinical rather than as proof of efficacy of a Homoeopathic preparation.
- ✓ *Terminalia chebula* fruit extracts have demonstrated antifungal activity in experimental studies, including activity against fungal organisms relevant to dermatological disease. [7]
- ✓ *Curcuma longa* has demonstrated in-vitro antifungal activity in experimental screening studies, with activity depending on extract characteristics and the test organism. [12]
- ✓ *Piper nigrum* extract has been experimentally evaluated for effects on *Candida albicans* growth, yeast-hyphal transition, virulence-associated enzymes, and biofilm formation. [3]
- ✓ *Ocimum tenuiflorum* has demonstrated antimicrobial activity, including activity against *Candida albicans*, in experimental studies. [5]

Collectively, these findings support further investigation of selected plant-derived sources represented in Homoeopathic literature. They do not establish that all Homoeopathic medicines derived from these plants possess antifungal

activity, nor do they establish that experimental activity of crude extracts or phytoconstituents is retained at Homoeopathic potencies.

6. Mechanism of Antifungal Action

The antifungal effects reported for medicinal plants and their extracts involve multiple proposed molecular mechanisms. Depending on the plant, extract, constituent, and fungal model, experimental studies have described effects on membrane integrity, ergosterol-related pathways, oxidative stress, biofilm formation, morphogenesis, fungal adhesins, cell-wall processes, and virulence. These mechanisms remain largely pre-clinical and should not be generalized across all medicinal plants or Homoeopathic preparations.

Major mechanisms include:	* Disruption of fungal cell membrane integrity * Inhibition of ergosterol biosynthesis * Increased reactive oxygen species production * Inhibition of fungal biofilm formation * Suppression of yeast-to-hypha transition	* Mitochondrial dysfunction * Inhibition of fungal adhesins * Cell wall damage * DNA fragmentation * Down-regulation of fungal virulence genes * Immunomodulatory effects enhancing host defence.
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The presence of multiple proposed mechanisms is of pharmacological interest, but it should not be interpreted as evidence that plant-derived Homoeopathic preparations have clinically established multimodal antifungal effects.

7. Nanotechnology and Phytopharmaceutical Advances

Recent research has explored green nanotechnology and plant-mediated nanoparticles as potential strategies for improving delivery or antifungal activity. These studies primarily concern plant extracts or phytochemical-associated nanomaterials and should be distinguished from conventional Homoeopathic preparations.

Plant-mediated synthesis of silver nanoparticles (AgNPs), zinc oxide nanoparticles (ZnO-NPs),

cerium oxide nanoparticles (CeO₂-NPs), and copper oxide nanoparticles has demonstrated remarkable activity against resistant fungal pathogens.

These nanoparticles exhibit:	* Improved drug penetration * Enhanced bio-availability * Sustained drug release * Greater biofilm disruption	* Reduced minimum inhibitory concentrations * Lower toxicity * Enhanced wound healing
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Plant-mediated nanotechnology combined with selected medicinal plants represents an emerging research area; however, its relevance to Homoeopathic pharmaceutical preparations requires separate experimental validation.

8. Future Prospects

Despite encouraging experimental findings, high-quality clinical evidence remains limited. Future investigations should distinguish clearly between crude plant/extract studies, isolated phytoconstituents, nanoparticle formulations, and Homoeopathic preparations or potencies.

Future investigations should focus on:	* Standardization of Homoeopathic mother tinctures * Phytochemical fingerprinting * Molecular docking studies * Mechanistic pharmacology * Omics-based investigations	* Nano pharmaceutical formulations * Randomized controlled clinical trials * Toxicological evaluation * Good Manufacturing Practice (GMP)-based standardization * Artificial intelligence-assisted phytochemical screening
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Integrating Homoeopathic pharmaceutical research with modern molecular biology and evidence-based medicine may facilitate the development of novel adjunctive antifungal therapies.

9. CONCLUSION

Experimental evidence indicates that selected

medicinal plants represented in Homoeopathic literature may possess antifungal activity in pre-clinical models. Reported mechanisms include effects on fungal membranes, ergosterol-related pathways, biofilm formation, oxidative stress, and virulence. However, these findings cannot be directly extrapolated to the clinical efficacy of Homoeopathic preparations.

The pharmacological literature therefore supports continued investigation rather than a conclusion of established antifungal efficacy. Future research should include standardized characterization of source materials and Homoeopathic preparations, mechanistic and toxicological studies, and appropriately designed clinical trials. The following

Tellurium metallicum case is presented separately as a clinical Homoeopathic observation; Tellurium is an elemental/non-plant medicine and is not part of the plant-based experimental evidence synthesis.

Evidence-scope note: This case is not presented as experimental evidence for antifungal activity of a medicinal plant. The Homoeopathic Pharmacopoeia of India describes Tellurium as elemental tellurium (Te) and specifies its pharmaceutical preparation. Accordingly, the following clinical observation is included only in the Homoeopathic clinical context and is clearly separated from the plant-based pharmacological evidence.

Clinical Case Presentation: Tellurium metallicum (separate from the plant-based narrative review)

Clinical Case Presentation: Tellurium metallicum		
Patient Information Age / Sex: 62-year-old male Residence: Deen Dayal Nagar, Gwalior, Madhya Pradesh, India Date of First Consultation: 22 January 2026 Occupation: Teacher	Chief Complaint Recurrent pruritic annular skin eruptions over the face, right wrist, and bilateral knees for one year	
History of Present Illness ✓ The patient presented with recurrent erythematous annular eruptions associated with intense itching for one year. ✓ The lesions initially appeared as small papules and gradually enlarged into circular plaques with central clearing and scaling. The itching was worse at night and was followed by burning after scratching. ✓ Symptoms were ameliorated in open air. The eruptions were moist with yellowish discharge and an offensive odour. He had previously been diagnosed with tinea corporis and treated with oral fluconazole and topical clotrimazole-beclomethasone cream, which produced only temporary relief, followed by recurrence.	Past History Diabetes mellitus – present Hypertension – present Eczema in the past History of topical steroid use No history of tuberculosis No previous documented fungal infection before the current episode Family History Diabetes mellitus – present Eczema – present Psoriasis – absent Tuberculosis – absent Cancer – absent	Mental Generals Trait Observation Nature Irritable Fear Snakes Anxiety Marked anxiety before undertaking new work Anger Occasional Memory Sharp Stress According to workload Relationship with family “Tit-for-tat” attitude Aversion Talking with the opposite sex
Physical Generals Appetite Good Thirst Approximately 4 L/day Thermal reaction Chilly	Particular Symptoms Location Face, right wrist, bilateral knees Appearance Circular annular plaques with central clearing Colour Yellowish moist lesions	Clinical Examination Pulse 76/min Blood Pressure 138/84 mmHg Temperature Afebrile Weight 68 kg

Perspiration Profuse on axillae and forehead Odor of sweat Egg-like offensive odour Staining Brown staining Sleep Frequent catnaps Dreams Snakes and accidents Stool Hard, ball-like, offensive Urine Brownish-yellow Sexual satisfaction Unsatisfactory Desire Marked desire for spicy food Addictions Alcohol and smoking	Scaling Present Discharge Offensive Itching Intense; worse at night Amelioration Open air After scratching Burning sensation	Investigations Investigation Result Haemoglobin 14 g/dL Total leukocyte counts 8000/mm³ Random blood sugar 108 mg/dL Serum uric acid 4.14 mg/dL KOH mount Positive for dermatophytes Fungal culture Not performed
Clinical Diagnosis Recurrent Tinea Corporis (Dermatophytosis) Based on annular lesions with central clearing, scaling, intense pruritus, and positive KOH examination.	Totality of Symptoms Recurrent annular fungal eruptions Intense itching, worse at night Burning after scratching Moist yellow offensive lesions Better in open air Offensive perspiration Chilly patient Fear of snakes Anxiety before new work Irritable disposition Hard, ball-like offensive stools Marked desire for spicy food	
Repertorial Analysis Selected rubrics (Kent/Synthesis): Skin – Ringworm Skin – Eruptions – Circular Skin – Itching – Night Skin – Burning after scratching Skin – Moist eruptions Generalities – Chilly patient Mind – Fear – Snakes Mind – Irritability Mind – Anxiety before undertaking new work Rectum – Constipation – Sheep dung stool	Repertorial Result Remedy Score Tellurium 24/10 Sulphur 21/10 Graphites 19/9 Mezereum 17/8 Psorinum 16/8 Remedy Selection Tellurium was selected as the similimum because of the close correspondence between the patient's symptom totality and the characteristic indications of the remedy in Homoeopathic Materia Medica, particularly: Ringworm and circular eruptions Offensive moist skin lesions Intense itching with burning after scratching	Follow-up 22 February 2026 Pruritus markedly reduced Burning after scratching absent Scaling significantly decreased No new lesions developed Existing lesions showed regression Overall clinical improvement Approximately 80%

	Recurrent fungal eruptions Offensive perspiration <u>Prescription</u> Tellurium 200C Date 20 February 2026 Dose: Single oral dose Repetition None Followed by Placebo	
Outcome The patient demonstrated substantial clinical improvement after a single dose of Tellurium 200C, with marked reduction in itching, scaling, erythema, and lesion size. No aggravation or adverse effects were observed, and no repetition of the remedy was required during the initial follow-up period.		

Before Treatment



After Homoeopathic Treatment



Case interpretation: The reported clinical improvement is an individual clinical observation without a control group, blinding, fungal culture confirmation, or other design features that would permit attribution of the outcome to Tellurium 200C or establish antifungal efficacy. It is therefore not used as evidence in the narrative pharmacological synthesis.

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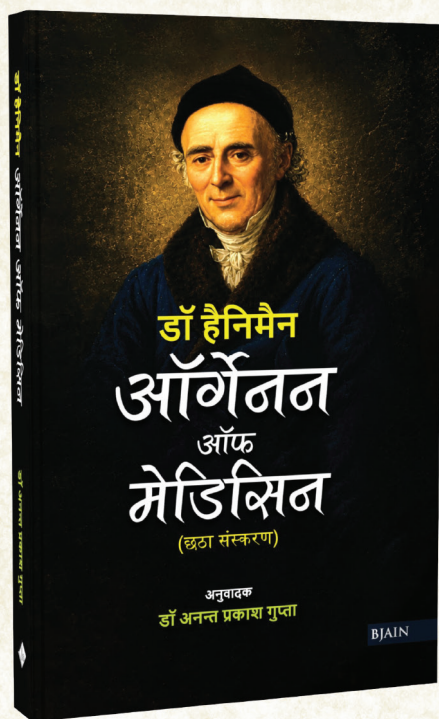
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Dr. Anant P. Gupta

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Mapping Cutaneous Fungal Disorders: A Comprehensive Analysis of Tinea Subtypes, Miasm and Classical Approach Across Classical Repertories and Materia Medica



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Abstract

Cutaneous fungal infections are among the most prevalent dermatological disorders, with increasing recurrence and therapeutic challenges in conventional treatment. Homoeopathic management focuses on individual susceptibility through precise symptom similarity rather than mere pathogen suppression and correlation of these conditions are essential to achieve lasting cure. This article provides a crucial clinical bridge by mapping major tinea subtypes, their characteristic clinical features, miasm, while correlating these conditions with rubrics from classical homoeopathic repertories, some rare remedies from Materia Medica and a stepwise clinical approach to facilitate accurate prescribing.

Keywords

fungal disorder, tinea, homoeopathy, miasm, repertory, materia medica

Introduction

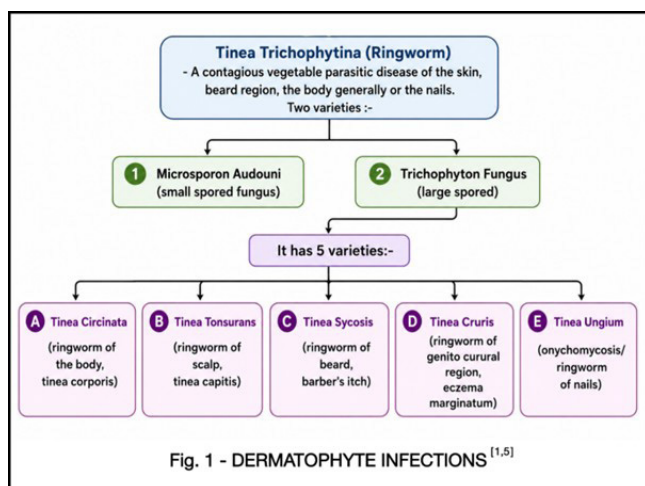
Dermatological diseases involving fungal disorders of the skin are generally caused by microorganisms that live in humid conditions. The emergence of pathological microorganisms is often

caused by negative environmental conditions, skin barrier impairments, and reduced immune function in the host. Superficial cutaneous fungal infections (SFIs) are non invasive and only involve dead keratinized structures (hair, nails, and epidermis).⁽¹⁾

The most widespread infectious skin disease is SFIs, affecting nearly 1.7 billion people worldwide (GBD Study 2021). Up to 10% of all DALYs with skin diseases are associated with these affecting mainly elderly population. Prevalence in India is 36.6%-78.4%.^(2,3,4)

Categorized into two microbiological groups:

Yeast Infection ⁽¹⁾	Dermatophyte Infection ^(1,2)
• Cause- Localised lipophilic yeasts (Malassezia furfur, M. Pachydermatis) • Acts on- Sebum rich area • Species remains in stratum corneum layer, causing folliculitis, seborrheic dermatitis, tinea versicolor without much inflammation (invasive disease is rare)	• Cause- Non resident molds (Trichophyton, Microsporum, Epidermophyton) • Symptoms are result of immune response to fungal pathogen • Pattern- Centrifugal development of lesion results in ringworm • Transmission- Human, animal, soil, fomites • Prevalence- 20-25% of global population (rural>>urban region) • Progesterone inhibit mold growth making it more prevalent in males



DISEASE	LOCATION	SYMPTOM
TINEA FAVOSA 	Scalp and hair follicles >> body and nails	Size: Pin head to pea sized Color: sulphur yellow Odour: characteristic musty/ mouse like Lesion: cup shaped, dry, friable crusts (scutula) around hair follicles, often pierced by hairs, becomes brittle and breaks with chronic disease causing scarring alopecia
TINEA TRICHOPHYTINA (Trichophytosis) ⁽⁷⁾ 	Body, scalp, beard, genito-crural region, nails	Tinea Circinata, Tinea Tonsurans, Tinea Sycosis, Tinea Cruris, Tinea Ungium
TINEA CIRCINATA ⁽⁷⁾ 	Body, especially face, neck, arms Except palms, soles, groins	Size: Pea sized initially, may enlarge to several inches Color: Erythematous Lesion: Round/ irregular hyperaemic spots with fine scales, peripheral extension and central clearing giving ring like lesion, margins slightly elevated and may show vesicles/ vesicopapules and concentric rings.

TINEA TONSURANS ⁽⁸⁾ 	Scalp & hair, mainly in children	Size: variable small lesion to large areas of scalp Color: slightly red-dened/ erythematous Lesion: Circumscribed scaly patches with slight itching, broken, short/ stubby brittle hairs, peripheral extension, broken hair stumps may produce characteristic "goose flesh" appearance, inflammatory forms may develop marginal pustules/ crusts. Ringworm without central clearing.
TINEA SYCOSIS ⁽⁹⁾ 	Bearded region-chin, neck, submaxillary region, hair follicles >> upper lip	Size: Small, rounded patches initially, later nodulations/ tumefactions Color: erythematous initially Lesion: Begins as tinea circinate like scaly patches, deeper follicular involvement forming nodules and pustules, hairs become brittle, break/ fall out and are easily and painlessly removed.
TINEA CRURIS ⁽⁷⁾ 	Genito-crural region, spreading to genitals, thighs, groins and nates	Size: Diffuse/ wide-spread, may spread rapidly Color: brownish-red Lesion: well defined, slightly elevated/ marginated lesions expand centrifugally and center clears with rapid peripheral spread, characteristic intense itching, may develop an eczematous reaction. Chronic lesion may show hyperpigmentation, nodulation, lichenification.
TINEA UNGUIUM ⁽⁸⁾ 	Nails (toe >> finger), may be associated with tinea pedis	Color: white, opaque Lesion: Thickened, soft/ brittle, typically two or more nails affected, asymmetrical, decidedly chronic.

		Begins at free distal edge, causing yellow brown discoloration, crumbling and tunnelling with subungual friable debris (subungual hyperkeratosis) and onycholysis.
TINEA VERSICOLOR (Pityriasis versicolor, Chromophytosis) ^(1,5,10,11) 	Mainly chest, interscapular region>>face and neck	Size: Pin head to pea sized initially, may coalesce into large patches Color: pale yellow to dark brown, sometimes salmon tinted Lesion: Irregular, well defined macular patches with characteristic furfuraceous/mealy scaling more apparent on scraping, lesions are usually not elevated

Miasmatic Perspective

The fungal skin disorder- ringworm, suppressed or history of ringworm belongs to tubercular miasm, while tinea barbae and versicolor to sycotic miasm.⁽¹²⁾ Dr Sankaran introduced Ringworm

miasm, positioned between psora and sycosis, representing alteration between struggling, trying and giving up. He correlates it with the infection which comes up suddenly with intense struggle, not life threatening but at other times is quiet and fixed which is seen in ringworm infection. Patient often have a history of fungal infection, either in groins, between toes, with period of terrible itching, alternating with periods of no itching. The situation of ringworm miasm seems to be one that is on borderline of patient's capacity and while not threatening.⁽¹³⁾ We can correlate it with characteristic peripheral (border) elevation and central clearing respectively. It corresponds to his description of situation that is challenging but not beyond recovery.

Repertorial Aspect

Repertorial rubrics provide an essential structural framework. The repertorial classification of superficial cutaneous fungal infections bridges clinical dermatological conditions with homoeopathy. Given the distinct anatomical predilections ranging from the scalp, beard, and groins to the general body surface, classical repertories utilize specific localized chapters and rubrics to systematize these pathological states.

REPERTORY	CONDITION	CHAPTER	RUBRIC & SUBRUBRIC	MEDICINE
BOERICKE ⁽¹⁴⁾	TINEA FAVUS	Skin	Tinea favosa, favus	Ars-i, Brom, Calc, Dulc, Jug-r, Kali-c, Lyc, Mez, Sep, Sulo-ac, Vinc, Viol-t.
		Head	Eruptions- Favus	Ars, Calc m, Dulc, Ferr-i, Graph, Hep, Jug-r, Sil, Viol-t
	TINEA CIRCINATA	Skin	Trichophytosis, ringworm	Ars, Bac, Chrysar, Graph, Jug-c, Jug-r, Mez, Psor, Sep., Sulph, Tell, Tub, Viol-t
	TINEA TONSURANS	Head	Eruptions- Ringworm (tinea capitis)	Bac, Bar-m, Calc, Chrysar, Graph, Mez, Psor, Sep, Tell
	TINEA SYCOSIS	Skin	Sycosis (Barber's itch)	Ant-t, Calc, Chrysar, Cic, Graph, Kali-bi, Lyc, Nit ac, Plat, Staph, Sul-i, Thuj
	TINEA VERSICOLOR	Skin	Tinea versicolor	Bac, Chrysar, Nat-ar, Sep, Tell
PHATAK ⁽¹⁵⁾	TINEA FAVUS	-	Eruptions- Favus	Ars, Sul
	TINEA CIRCINATA		Eruption- Herpetic (ringworm)	ARS, Calc s, Dul, Grap, Merc, NAT-M, RHUS-T, Sep, Sul
	TINEA TONSURANS		Head- head external (scalp and skull)- scalp- eruption on- ringworm	Dulc
BBCR ⁽¹⁶⁾	TINEA FAVUS	Head- External	Eruption on- favus	Brom, dul, hep, kali c, lyc, merc, pho, sul
	TINEA CIRCINATA	Skin and exterior body	Tetters- ringworm	Calc c, grap, Nat c, nat m, SEP, Sul, tell

KENT ⁽¹⁷⁾	TINEA CIRCINATA	Skin	Eruptions- herpetic- circinate	<i>Bar-c, calc, eup-per, graph, lith, nat-c, Nat-m, Phyt, Sep, Tell, Tub</i>
	TINEA VERSICOLOR	Abdomen Chest	Eruptions- herpes- ringworm Eruptions- Mammae- furfuraceous, between mammae	Nat-m, Tell Aster
COMPLETE ⁽¹⁸⁾	TINEA FAVUS	Head	Eruption- tinea- favosa capitis, scaldhead, porrigo, ringworm	AGAR, ARS, ARUM-T, BAC, CALC, CAUST, DULC, IRIS JUG-R, KALI-CHL, LAPPA, PSOR, RHUS-T, SEP, VIOL-T
	TINEA CIRCINATA	Skin	Trichophytosis	ARS, BAC, CHRYSAR, GRAPH, PSOR, RAN-B, SEP, TELL
	TINEA TONSURANS	Face	Eruptions- herpetic, circinatus, tonsurans	ANAG, BAR-C, CIC, CINNB, LITH-C, NAT-C NAT-M, PSOR, SEP SUL-I, SULPH, TELL, TUB
	TINEA SYCOSIS	Face	Eruptions- sycosis barbae	ANT-C, CALC, GRAPH, KALI-BI, KALI-CHL, LITH-C, NAT-M, NAT-S, NIT-AC, PHYT, SIL, SULPH, TELL
	TINEA VERSICOLOR	Skin	Pityriasis- versicolor	CARB-AC, MEZ, NAT-AR, SEP, SULO-AC, TELL
	TINEA UNGIUM	Head Extremities	Eruptions- tinea- versicolor Fungous growths, nails	NAT-AR, SEP Adam, ant-c, calc-f, falco-p, graph, hep, MED, nat-s, sil, tax
	TINEA CRURIS	Extremities	Eruptions – herpetic - circinate, ringworm – thighs - between	Lappa, morg

Homoeopathic Therapeutics

Remedy confirmation in homoeopathy depends on the individualization of the patient through symptom similarity. Fungal dermatoses exhibit distinct tissue affinities, specific lesion characteristics and modalities. Although we are familiar

with commonly indicated homoeopathic medicines for fungal disorders, particularly ringworm (such as Sepia, Tellurium, Natrum muriaticum, Sulphur, and Bacillinum), the following section highlights some less frequently prescribed but highly useful remedies along with their key clinical indications.

MEDICINE	REGION	CHARACTER/ INDICATIONS	MODALITIES
SULPHUR IODATUM (14,19)	Face, scalp, flexures	- Barber's itch, - Chronic obstinate ringworm - Moist eczema/ fungal tendency - Thick scaling - Unhealthy skin	Agg- warmth of bed, night Amel- cold
JUGLANS REGIA (14,19,20)	Scalp, face, trunk	- Tinea Favosa, especially in scalp behind the ear - Intense itching. - Obstinate Ringworm - Crusted eczema - Fungal eruptions	Agg- warmth, night Amel- open air
VIOLA TRICOLOR (10,14,19)	Scalp, face	- Tinea favosa/ tinea capitis with frequent involuntary urination - Thick crusts on head with unbearable burning - Yellow pus, hair matted - Dry sulphur coloured crusts - Offensive pustular eruptions	Agg- winter Amel- motion, open air
CORNUS ALTERNI-FOLIA (14,19)	Head	- Ringworm on forehead. Circular/ herpetic ringworm like eruptions - Marked itching&scaling - Dry or moist eruptions	Agg- scratching, night, cold, summer heat Amel-open air, coffee

DULCAMARA ^(14,21)	Hands, feet, groins, scalp, face	• Circinate herpetic eruptions brought on by cold • Ringworm/ fungal eruption associated with damp cold exposure • Moist eruption • Itching and pricking in various sites • Scratching gives no relief	Agg- night, damp, rainy weather Amel- warmth
CHRYSAROBINUM ^(14,19)	Groins, body folds, scalp	• Chief remedy for ringworm • Psoriasis like scaling • Dry scaly fungal eruptions	Agg- warmth Amel- open air

Step Wise Clinical Approach ⁽²²⁾

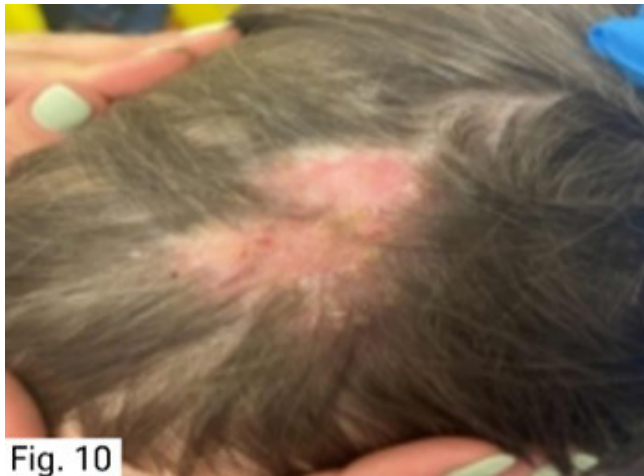


Fig. 10

Anatomical site & lesion- Scalp, Erythematous patch with scaling/ crusting

Tinea subtype- Tinea capitis

Repertory & Rubric- Boericke → Head- Ringworm (tinea capitis)

Group of medicines- Bac, Bar-m, Calc, Chrysar, Graph, Mez, Psor, Sep, Tell

Choice of remedy- final choice of medicine should be based on patient’s individuality after correlating it with materia medica.

CONCLUSION

With the alarming rise in chronic, recurrent and difficult-to-treat dermatophytosis, an effective management is essential to address both the physical and psychosocial burden on patients. Homoeopathy offers a patient-centred, individualized approach based on symptom similarity to restore health at deeper level. Correlating dermatological features with classical repertorial data and materia medica provides an integrated clinical approach and structured framework for precise

remedy selection with greater clarity, confidence and potentially supporting long-term recovery in fungal disorders.

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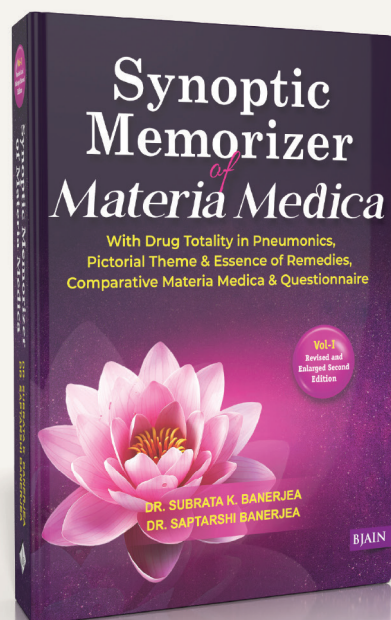
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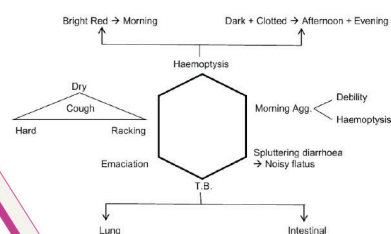


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DRUG TOTALITY

A = Absent minded.
 G = Gonorrhoeal history: its bad effects.
 N = Nervous debility: neurasthenia.
 U = Undue old-age; premature.
 S = Smells: imaginary.
 C = Complete impotency.
 A = Apathy: adapted to lymphatic constitution.
 S = Suppression of milk.
 T = Thirstlessness (Ref. Lippe).
 U = Unmarried persons: old-sinners.
 S = Sadness; says she will die.

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Understanding Fungal Disorders through the Lens of Homeopathy: Current Concepts and Homeopathic Perspectives

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Abstract

Background: Fungal infections range from superficial disease to life-threatening invasive mycoses; recurrent infection and antifungal resistance pose clinical challenges.

Objective: To summarise the classification, diagnosis and management of fungal disorders and critically describe homeopathic perspectives.

Methodology: This narrative review synthesises the medical and classical homeopathic sources listed in the references; no systematic search, study selection or meta-analysis was conducted.

Results: Laboratory confirmation, appropriate antifungal therapy and correction of risk factors remain central to care. Homeopathic indications are described in classical literature, but evidence for efficacy in fungal disease is insufficient to establish clinical benefit.

Conclusion: Individualised homeopathy may be discussed only as an adjunct for selected superficial cases and must not delay evidence-based treatment. Controlled studies with mycological outcomes are needed.

Keywords

Fungal disorders, Dermatophytosis, Homeopathy, Constitutional treatment, Susceptibility, Individualisation, Mycosis

Introduction

Fungal disorders constitute a significant global health problem, affecting millions of individuals each year. Although many fungal infections are superficial and confined to the skin, hair, nails, or mucous membranes, they are often persistent, recurrent, and capable of causing considerable physical discomfort, cosmetic concerns, psychological distress, and impairment in quality of life. In immunocompromised individuals, fungi may invade deeper tissues and produce life-threatening systemic disease. [1, 2, 6]

The increasing incidence of fungal infections has been attributed to multiple factors, including diabetes mellitus, prolonged antibiotic therapy, immunosuppressive drugs, HIV infection, obesity, excessive sweating, ageing, and changing environmental conditions. In tropical countries such as India, warm and humid climates create favourable conditions for fungal proliferation, making superficial mycoses one of the most frequent dermatological complaints encountered in clinical practice. [7, 8]

Classical homeopathy considers individual susceptibility and the totality of symptoms when selecting a remedy. These concepts should be distinguished from established mechanisms of fungal infection and from evidence of clinical efficacy. [9, 10]

This narrative review outlines fungal classification, diagnosis, conventional care and homeopathic perspectives, with attention to the limitations of

current evidence.

Methods

This narrative review draws on the dermatology, microbiology, public health and classical homeopathic sources listed below. Material was organised by clinical topic. No prespecified search strategy, eligibility criteria, duplicate screening or formal risk-of-bias assessment was used; the account cannot estimate treatment effects or claim comprehensive coverage. [1–4, 7, 8, 19, 20]

Epidemiology

Fungal disorders are among the most common

Classification of Fungal Disorders

Classification by depth of involvement is summarised in Table 1. [1, 4]

Table 1 Classification of fungal disorders Sources: [1, 4].

Category	Tissue involved	Examples	Common pathogens
Superficial	Outermost skin and hair shaft	Pityriasis versicolor; piedra	Malassezia; Piedraia; Trichosporon
Cutaneous	Keratinised skin, hair and nails	Tinea corporis, cruris, pedis and capitis; onychomycosis	Trichophyton; Microsporum; Epidermophyton
Subcutaneous	Skin and subcutaneous tissue	Sporotrichosis; chromoblastomycosis; eumycetoma	Sporothrix; Fonsecaea; Madurella
Systemic and opportunistic	Internal organs	Invasive candidiasis; aspergillosis; cryptococcosis; mucormycosis	Candida; Aspergillus; Cryptococcus; Mucorales

Aetiology and Risk Factors

Fungal disorders are caused by a diverse group of pathogenic fungi capable of infecting keratinised tissues, mucous membranes, subcutaneous tissues, or internal organs. The most common causative organisms of superficial mycoses are dermatophytes, particularly species of Trichophyton, Microsporum, and Epidermophyton. Yeasts such as *Candida albicans* are responsible for candidiasis, while *Malassezia furfur* causes pityriasis versicolor. Opportunistic moulds, including *Aspergillus* and *Mucor* species, are important causes of invasive fungal infections in immunocompromised individuals. [1, 4]

The occurrence of fungal infection depends on the interaction between the pathogen, host immunity, and environmental factors. Individuals with diabetes mellitus, HIV infection, malignancy, malnutrition, obesity, excessive perspiration, peripheral vascular disease, or immunosuppressive therapy

infectious diseases worldwide, affecting an estimated 20–25% of the global population at any given time. Superficial fungal infections, particularly dermatophytosis, candidiasis, and pityriasis versicolor, are highly prevalent in tropical and subtropical regions due to warm and humid climatic conditions. The burden is greater among individuals with diabetes, immunosuppression, obesity, poor hygiene, and prolonged use of antibiotics or corticosteroids. In recent years, increasing recurrence and antifungal resistance have emerged as important public health concerns, particularly in countries such as India, where dermatophytosis has reached epidemic proportions. [7, 8]

exhibit increased susceptibility. Pregnancy, advanced age, prolonged administration of broad-spectrum antibiotics, corticosteroids, and cytotoxic drugs further predispose to fungal infections by altering the normal microbial flora or impairing immune function. [1, 2, 4]

Environmental and behavioural factors also play a significant role. Hot and humid climates, overcrowding, poor personal hygiene, occlusive footwear, tight-fitting synthetic clothing, sharing of towels or footwear, repeated trauma to the skin or nails, and occupational exposure to moisture facilitate fungal growth and transmission. In India, the irrational use of topical corticosteroid–antifungal combinations has emerged as a major contributor to chronic, atypical, and recurrent dermatophytosis. [8]

Pathogenesis

Fungal infection begins when viable fungal spores

or hyphae come into contact with a susceptible host. Dermatophytes adhere to keratinised tissues and produce enzymes such as keratinases, lipases, and proteases, enabling them to digest keratin and colonise the stratum corneum, hair shafts, or nail plates. Since these organisms are generally confined to non-living keratinised tissue, superficial infections seldom invade deeper structures in immunocompetent individuals. [3, 4]

The host immune response is crucial in determining disease severity. Physical barriers, normal skin microbiota, neutrophils, macrophages, and cell-mediated immunity collectively restrict fungal proliferation. Defects in these defence mechanisms permit persistent colonisation, recurrent infection, or dissemination. Chronic inflammation induced by fungal antigens results in erythema, scaling, pruritus, fissuring, and occasionally secondary bacterial infection. [3, 4]

In homeopathic theory, recurrent infection is interpreted in relation to constitutional susceptibility; this interpretation does not replace microbiological diagnosis or management of identifiable risk factors. [9, 10]

Clinical Manifestations

Presentation varies by organism, site, immune status and duration. [1, 2]

Tinea corporis presents as annular erythematous plaques with well-defined, scaly, advancing margins and central clearing. Pruritus is usually the predominant symptom. [1, 2]

Tinea cruris commonly affects the groin and adjacent thighs, producing erythematous, itchy lesions with sharply demarcated borders. It is frequently associated with excessive sweating and obesity. [1, 2]

Tinea pedis is characterised by interdigital maceration, fissuring, scaling, burning sensation, and unpleasant odour. Hyperkeratotic and vesicular forms may also occur. [1, 2]

Tinea capitis predominantly affects children and manifests as patchy alopecia, scalp scaling, broken hairs, and, in inflammatory cases, painful kerion formation. [1, 2]

Onychomycosis presents with nail thickening, yellow or brown discolouration, subungual debris, brittleness, and progressive nail plate destruction. [1, 2]

Candidiasis commonly involves the oral cavity, genital mucosa, intertriginous areas, and nail folds, producing erythema, soreness, itching, and characteristic white curd-like deposits in oral lesions. [1, 4]

Invasive fungal infections may present with prolonged fever, cough, dyspnoea, weight loss, neurological manifestations, or multiorgan involvement and require urgent medical intervention. [1, 4, 6] [16]

Diagnosis

The diagnosis of fungal disorders is established through careful clinical evaluation supported by appropriate laboratory investigations. A detailed history should include the duration of illness, recurrence, previous treatment, associated systemic diseases, occupational exposure, personal hygiene practices, family history, and use of corticosteroids or immunosuppressive medication. [1, 2]

Examine lesion morphology and extent, including hair, nails and signs of secondary infection. [1, 2]

Direct microscopy using a potassium hydroxide (KOH) preparation can detect fungal elements, while culture may assist organism identification in recurrent, atypical or treatment-resistant cases. Histopathology, periodic acid–Schiff staining, dermoscopy and Wood's lamp examination can be useful in selected settings. Polymerase chain reaction (PCR)–based molecular assays can provide rapid identification of fungal DNA and, depending on the assay, help distinguish species; availability and performance vary by organism and laboratory. In persistent infection or suspected resistance, species identification and antifungal susceptibility testing should be considered through a laboratory able to perform and interpret these tests; susceptibility testing is not routinely available for dermatophytes. [4, 17, 18]

Recurrent or extensive infection warrants assessment for diabetes, immunodeficiency and other predisposing conditions. [1, 2]

Conventional Management

Treatment depends on infection site, extent and host status, with mycological cure and prevention of recurrence as key goals. [1, 2]

Localised superficial infections are generally treated with topical antifungal agents such as clotrimazole, miconazole, ketoconazole, luliconazole, terbinafine, sertaconazole, ciclopirox, etc. Extensive dermatophytosis, onychomycosis, tinea capitis, and recurrent infections usually require systemic antifungal therapy with terbinafine, itraconazole, fluconazole, or griseofulvin, prescribed according to current treatment guidelines. The duration of therapy depends upon the site of infection, clinical response, and mycological clearance. [1, 2]

Keep affected areas dry, avoid sharing towels or footwear, address diabetes and discourage steroid-containing antifungal combinations. Follow-up should assess adherence, response and the need for laboratory confirmation. [8, 18]

Homeopathic Perspective

Classical homeopathy selects a medicine using physical and mental characteristics, modalities and symptom totality. These are prescribing concepts within homeopathy, not established antifungal mechanisms. [9, 11–14]

Patients with the same diagnosis may receive different remedies. Miasmatic terms such as psora and sycosis belong to classical homeopathic interpretation; they do not identify fungal species or predict mycological cure. [9, 10, 14]

Homeopathy must not delay antifungal therapy, particularly for extensive, rapidly progressive or invasive infection. Any complementary use should be discussed alongside appropriate clinical care. [6, 18]

Homeopathic Therapeutics

Table 2 summarises traditional materia medica indications. These descriptions do not demonstrate antifungal efficacy or replace laboratory confirmation and indicated treatment. [11–13]

Table 2 Traditional homeopathic indications in fungal presentations Sources for traditional indications: [11–13]; clinical efficacy is unproven.

Homoeopathic Medicines	Characteristic Indications in Fungal Disorders	Clinical Application
Sulphur	Intense itching, burning after scratching, dry scaly eruptions, chronic recurrent skin infections	Recurrent dermatophytosis with marked pruritus and scaling
Graphites	Moist fissured eruptions, sticky honey-like discharge, thickened nails, unhealthy skin	Onychomycosis and fungal infections of skin folds
Tellurium	Circular (ring-shaped) lesions, offensive odour, centrifugal spread, severe itching	Tinea corporis and other dermatophyte infections with annular lesions
Sepia	Recurrent candidiasis, itching of genital region, hormonal association	Recurrent vulvovaginal candidiasis and flexural fungal infections
Arsenicum album	Burning pains relieved by warmth, restlessness, weakness, recurrent infections	Chronic fungal infections in debilitated individuals
Petroleum	Dry, cracked, fissured skin with excessive itching, worse in winter	Chronic tinea pedis and fissured fungal lesions
Silicea	Brittle nails, delayed healing, recurrent infections, excessive foot perspiration	Chronic onychomycosis and recurrent fungal infections
Thuja occidentalis	Thickened skin, nail deformity, chronic recurrent infections, sycotic tendency	Long-standing recurrent fungal disorders with hyperkeratosis

Current Evidence and Future Directions

Recurrent dermatophytosis and antifungal resistance strengthen the need for effective diagnosis, appropriate therapy and careful evaluation of additional interventions. [8, 18]

A published review by Murgod and Shah described nine articles on homoeopathic treatment for tinea, including case reports, a case series and an observational study. Such designs cannot establish efficacy, and findings for tinea cannot be generalised to all fungal disorders. Another systematic review of complementary treatments for onychomycosis identified no homeopathy studies among its 17 included articles; it cannot establish whether homeopathy works. [19, 20]

Future controlled trials should specify laboratory-confirmed diagnosis, antifungal co-treatment, mycological cure, adverse events and long-term recurrence.

DISCUSSION

Recurrent fungal infections have become more common in recent years, and increasing resistance to antifungal medicines has made their treatment more difficult. Although conventional antifungal drugs remain the main treatment, many patients experience repeated infections because underlying risk factors such as diabetes, poor hygiene, excessive sweating, or reduced immunity are not adequately addressed. Therefore, a holistic approach that considers both the infection and the patient's overall health may be beneficial. [8, 18]

In classical homeopathic practice, medicines are selected from the individual symptom picture and constitutional characteristics. Claims that this approach improves general health or prevents recurrence of fungal infection require controlled clinical evidence. [9, 11–14]

Dr Pravin Singh reported a 38-year-old woman with clinically described circular eruptions treated with *Apis mellifica* 30C; symptoms improved during follow-up over four weeks [5]. The report did not document mycological confirmation or a comparison group, so symptom improvement cannot establish an antifungal effect or attribute the outcome to homeopathy.

This narrative review lacks a systematic search, prespecified study selection and formal quality appraisal; relevant studies may have been missed. The therapeutic table summarises traditional indications, not proven antifungal effects. Evidence across fungal diseases is too limited and heterogeneous for a pooled conclusion.

Controlled, independently replicated studies with longer follow-up are required before a complementary role can be defined.

CONCLUSION

Fungal disorders may recur and sometimes become invasive. Laboratory confirmation when appropriate, antifungal treatment, risk-factor management and patient education remain essential. [1, 2, 6]

Homeopathic prescribing offers an individualised framework, but efficacy against fungal infection or recurrence is unestablished. It must not replace

or delay indicated care. Well-designed clinical trials are needed to determine whether it offers additional benefit.

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Understanding Fungal Disorders Through The Lens of Homoeopathy



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Keywords

Fungal disorders, Dermatophytes, Yeasts / Molds, Keratinized tissues, Itching, burning, scaling, Recurrence / chronicity, Vital force disturbance, Constitutional susceptibility, Psoric miasm, Totality of symptoms, Modalities (dampness, warmth, scratching), Suppression vs dynamic cure, Holistic treatment, Patient individuality, Balance and harmony

Abstract

Fungal disorders, including ringworm, athlete's foot, and nail infections, are widespread conditions caused by dermatophytes and yeasts that invade keratinized tissues. Conventional medicine explains them as local infections requiring anti-fungal eradication. However, homoeopathy interprets these disorders as manifestations of constitutional imbalance and psoric miasm, reflecting a disturbance of the vital force rather than mere external invasion.

The homoeopathic approach emphasizes the totality of symptoms—itching, burning, odour, recurrence, and modalities such as aggravation in damp weather—over pathogen identification. Remedies like *Sepia*, *Tellurium*, *Sulphur*, *Graphites*, and *Bacillinum* are prescribed based on similarity to the patient's symptom picture. Unlike suppression through topical antifungals, homoeopathy seeks to correct the predisposition, aiming for

long-term balance and prevention of recurrence.

Thus, fungal disorders, when viewed through the Organon's principles, highlight the need to treat the patient as a whole, addressing the dynamic disturbance of the vital force and restoring constitutional harmony.

Introduction

Ringworm (tinea) is a contagious fungal infection of the skin, hair, or nails caused by dermatophyte fungi not worms producing characteristic ring-shaped, scaly, itchy patches. It thrives in warm, moist environments and spreads through contact with infected people, animals, or contaminated surfaces.

Name origin: The rash often forms circular lesions with raised, worm-like edges, hence “ringworm,” though no worms are involved.

• Epidemiology of Ringworm in India⁽⁴⁾

Prevalence

- » Estimated burden: ~170 million Indians suffer from superficial dermatophytosis at any given time.
- » Age groups: All ages affected, but children and young adults show higher prevalence for scalp and body infections.
- » Geographic distribution: More common in

hot, humid regions, with seasonal spikes during the monsoon months (June–September).

• Pathophysiology ⁽⁴⁾

1. Entry & Colonization ⁽⁴⁾

- » Fungi enter via **minor skin trauma** or contact with contaminated surfaces.
- » They adhere to **keratinized tissues** (stratum corneum, hair, nails) using **adhesins** on their cell wall.

2. Keratin Degradation ⁽⁴⁾

- » Dermatophytes secrete **keratinases and proteases** that digest keratin, allowing them to grow and spread.
- » They remain confined to **superficial layers** (do not invade deeper tissue in healthy hosts).

3. Immune Response ⁽⁴⁾

- » **Innate immunity:** Neutrophils and macrophages attempt to clear fungi.
- » **Adaptive immunity:**
 - **Th1 response** → protective, helps limit infection.
 - **Th2 response** → associated with chronicity and recurrence.
- » Inflammation produces **erythema, scaling, and itching**.

4. Lesion Formation ⁽⁴⁾

- » Central clearance with peripheral fungal activity produces the **classic ring-shaped lesion**.
- » In hair infections: fungi invade shafts → **endothrix** (inside hair) or **ectothrix** (outside hair), leading to hair breakage.
- » In nails: fungi invade nail plate → **onychomycosis** (thick, brittle, discoloured nails).

• Variants & Pathophysiological Notes ⁽⁴⁾

Variant	Pathophysiology	Clinical Outcome
Kerion	Intense neutrophilic reaction in scalp follicles	Boggy, painful swelling; risk of scarring alopecia
Majocchi granuloma	Follicular invasion into dermis	Papules/pustules after shaving
Tinea incognito	Steroid misuse suppresses inflammation	Atypical, widespread lesions
Favus	Chronic follicular invasion (<i>T. schoenleinii</i>)	Crusty scutula, scarring alopecia

• Pathology ⁽³⁾

1. Site of Infection ⁽³⁾

- » **Skin (stratum corneum)** – most common, producing annular scaly patches.
- » **Hair shafts (tinea capitis)** – fungi invade hair either:
 - **Endothrix:** grow inside hair shaft.
 - **Ectothrix:** grow on hair surface, degrading cuticle.
- » **Nails (onychomycosis)** – thickened, brittle, discoloured nails with subungual debris.

2. Mechanism ⁽³⁾

- » **Adhesion:** Fungal cell wall adhesins attach to keratinized tissue.
- » **Keratin digestion:** Fungal proteases break down keratin for nutrition.
- » **Spread:** Confined to superficial layers; rarely invades deeper tissue in healthy individuals.
- » **Immune response:**
 - **Innate:** Neutrophils, macrophages.
 - **Adaptive:** Humoral and cell-mediated immunity.
 - Inflammation varies from mild erythema to pustular reactions (e.g., kerion).

3. Histopathology ⁽³⁾

» Microscopic findings:

- Hyphae and spores (1–2 µm) in stratum corneum or follicles.
- **Sandwich sign:** alternating layers of orthokeratosis/parakeratosis with fungal elements.
- Epidermal spongiosis, lymphocytic/neutrophilic infiltrates.

» Special stains: PAS (Periodic Acid-Schiff), GMS (Grocott-Gomori silver) highlight

fungal organisms

Variant	Pathology	Clinical Note
Kerion	Intense neutrophilic inflammation of scalp follicles	Painful, boggy swelling; risk of scarring alopecia
Majocchi granuloma	Follicular & dermal invasion	Seen after shaving; perifollicular papules/pustules
Tinea incognito	Altered pathology due to steroid misuse	Suppressed inflammation, atypical morphology
Favus (T. schoenleinii)	Crusty scutula with hyphae in follicles	Chronic scarring alopecia, endemic in parts of India

Classification of Ringworm ⁽⁴⁾

Type	Common Name	Location	Key Features
Tinea capitis	Scalp ringworm	Scalp, hair shafts	Scaly patches, hair loss, common in children
Tinea corporis	Body ringworm	Arms, legs, trunk	Classic ring-shaped, itchy rash
Tinea cruris	Jock itch	Groin, inner thighs	Red, itchy, scaly rash, common in men
Tinea pedis	Athlete's foot	Feet, between toes	Scaling, cracking, itching, burning
Tinea unguium (Onychomycosis)	Nail ringworm	Fingernails, toenails	Thick, brittle, discoloured nails
Tinea barbae	Beard ringworm	Beard area in men	Crusted, pustular patches, folliculitis
Tinea faciei	Facial ringworm	Face (non-beard area)	Red, scaly patches, often misdiagnosed
Tinea manuum	Hand ringworm	Palms, fingers	Dry scaling, often with tinea pedis
Tinea versicolor	Pityriasis versicolor	Upper trunk, shoulders	Hypo/hyperpigmented patches, fine scaling

Organon of Medicine Perspective ⁽²⁾

Hahnemann's *Organon of Medicine* emphasizes that diseases are not merely local phenomena but **expressions of internal derangement of the vital force**. Applying this principle to fungal disorders:

- **Vital Force Disturbance:** Fungal eruptions (itching, scaling, burning, recurrence) are outward signs of a deeper imbalance in the vital force.
- **Miasmatic Background:** Chronic fungal infections are often interpreted as **psoric manifestations**—the psora miasm being the root of many chronic skin affections.
- **Totality of Symptoms:** Remedy selection must be based on the *complete symptom picture* (modalities, sensations, recurrence, constitutional traits), not on the fungus itself.
- **Local vs. Whole:** The *Organon* warns against

treating only the local lesion (e.g., with topical antifungals). Suppression of eruptions without addressing the internal imbalance leads to deeper disease manifestations.

- **Dynamic Treatment:** Homoeopathy aims to restore harmony of the vital force through remedies that match the patient's symptom totality, thereby preventing recurrence and promoting long-term cure.

Role of homoeopathic medicines on different types of Ringworm

1. Tinea Capitis ⁽⁴⁾

Tinea capitis (scalp ringworm) is a contagious fungal infection of the scalp and hair, most common in children. Conventional treatment requires oral antifungal medicines, but in homeopathy, remedies are chosen based on symptom patterns such as itching, scaling, hair loss, or kerion formation.

Key Points on Tinea Capitis ⁽⁴⁾

- **Cause:** Dermatophyte fungi (Trichophyton, Microsporum).
- **Symptoms:** Scaly patches, itching, hair breakage, bald spots, sometimes painful kerion with pus.
- **Spread:** Direct contact, shared combs/hats, pets.
- **Homoeopathic Management ⁽¹⁾**

Remedy	Key Indications
Tellurium	Circular, ring-shaped eruptions with itching and offensive odour.
Sepia	Scalp eruptions with itching, worse in damp weather; hair falls easily.
Sulphur	Intense itching, burning scalp, dandruff-like scaling, worse from warmth.
Graphites	Thick, scabby eruptions with sticky discharge; scalp feels moist.
Arsenicum album	Burning, restlessness, scalp eruptions with anxiety.
Calcarea carbonica	Scalp infections in children with profuse sweating of head, slow healing.
Mezereum	Thick crusts on scalp with pus underneath, offensive smell.

2. Tinea Corporis ⁽⁴⁾

Tinea corporis (ringworm of the body) is a superficial fungal infection caused by dermatophytes, producing circular, red, scaly lesions with itching. Conventional treatment requires antifungal creams or oral antifungals, but in homeopathy, remedies are selected based on the characteristic appearance, modalities, and patient constitution.

Key Points on Tinea Corporis ⁽⁴⁾

- **Cause:** Dermatophyte fungi (Trichophyton, Microsporum, Epidermophyton).
- **Symptoms:** Ring-shaped, red, scaly patches with itching; may spread outward with central clearing.
- **Spread:** Skin-to-skin contact, contaminated clothing, bedding, pets.

• Homoeopathic Management ⁽¹⁾

Remedy	Key Indications
Tellurium	Classic ring-shaped eruptions, itching, offensive odor; lesions often coalesce.
Sepia	Dry, scaly patches, worse in damp weather; itching with burning; tendency to recur.
Sulphur	Intense itching, burning, worse from warmth of bed; chronic tendency to fungal eruptions.
Graphites	Thick, scabby eruptions with sticky discharge; moist skin folds affected.
Arsenicum album	Burning, restlessness, eruptions with anxiety; worse at night.
Calcarea carbonica	Ringworm in children with profuse sweating, slow healing, tendency to recurrence.
Mezereum	Thick crusts with pus beneath, offensive smell; eruptions may extend widely.

3. Tinea cruris ⁽⁴⁾

Tinea cruris (commonly called “jock itch”) is a fungal infection of the groin, inner thighs, and buttocks. It thrives in warm, moist areas and causes itching, redness, and ring-shaped rashes. Conventional treatment involves antifungal creams or oral antifungals, but in homeopathy remedies are studied according to symptom modalities and constitutional tendencies.

Key Points on Tinea Cruris ⁽⁴⁾

- **Cause:** Dermatophyte fungi (Trichophyton rubrum most common).
- **Symptoms:** Itching, burning, ring-shaped red patches in groin/thigh folds; worse with sweating.
- **Spread:** Tight clothing, humid climate, contaminated towels, close contact.
- **Homoeopathic management ⁽¹⁾**

Remedy	Key Indications
Tellurium	Ring-shaped eruptions with offensive odour; lesions coalesce; itching worse at night.
Sepia	Dry, scaly patches in groin; itching worse in damp weather; tendency to recur.
Sulphur	Intense itching, burning, worse from warmth of bed; chronic fungal tendency.
Graphites	Moist, sticky eruptions in folds; fissures with discharge; suited for groin eczema/fungus.

Arsenicum album	Burning, restlessness, eruptions worse at night; anxiety with skin complaints.
Calcarea carbonica	Susceptibility in overweight or sweaty individuals; slow healing tendency.
Mezereum	Thick crusts with pus beneath; offensive smell; eruptions may extend widely.

4. Tinea pedis ⁽⁴⁾

Tinea pedis (athlete's foot) is a fungal infection of the feet, especially between the toes and soles. It thrives in warm, moist environments like shoes and locker rooms. Conventional treatment requires antifungal creams or oral antifungals, but in homeopathy remedies are studied according to lesion type, modalities, and constitutional tendencies.

Key Points on Tinea Pedis ⁽⁴⁾

- **Cause:** Dermatophyte fungi (Trichophyton rubrum, T. interdigitale).
- **Symptoms:** Itching, burning, scaling, fissures between toes, foul odor, thickened nails.
- **Spread:** Walking barefoot in damp areas, tight footwear, shared socks/shoes.
- **Homoeopathic management ⁽¹⁾**

Remedy	Key Indications
Graphites	Cracked, fissured skin between toes; moist eruptions with sticky discharge.
Silicea	Offensive foot sweat, recurrent fungal infections; brittle nails.
Sulphur	Burning, itching, redness of soles and toes; worse from heat, bathing.
Thuja occidentalis	Thickened skin, warty growths with fungal tendency; resistant cases.
Antimonium crudum	Thickened, horny skin on soles; painful cracks; worse from cold water.
Sepia	Ring-shaped eruptions on feet; chronic fungal tendency; worse in damp weather.
Tellurium	Circular, offensive-smelling eruptions with scaling; lesions spread rapidly.
Bacillinum	Chronic, relapsing fungal infections; used in resistant dermatophytosis.

5. Tinea unguium (Onychomycosis) ⁽⁴⁾

Tinea unguium (Onychomycosis) is a fungal infection of the nails, leading to thickening, discoloration, brittleness, and deformity. Conventional

treatment requires oral antifungals (terbinafine, itraconazole) and sometimes topical lacquers, but in homeopathy remedies are studied according to nail changes, modalities, and constitutional tendencies.

Key Points on Tinea Unguium ⁽⁴⁾

- **Cause:** Dermatophytes (Trichophyton rubrum most common), sometimes yeasts.
- **Symptoms:** Thickened, brittle, discoloured nails (yellow, brown, white), crumbling edges, slow growth.
- **Risks:** Diabetes, poor circulation, repeated trauma, humid footwear.
- **Homoeopathic Management ⁽¹⁾**

Remedy	Key Indications
Graphites	Thick, deformed nails with cracks; moist eruptions around nail folds.
Silicea	Brittle nails, recurrent fungal infections; offensive foot sweat; nails grow slowly.
Antimonium crudum	Thickened, horny nails; painful cracks; worse from cold water.
Thuja occidentalis	Deformed, brittle nails with fungal tendency; warty growths nearby.
Sulphur	Burning, itching around nails; chronic tendency to fungal eruptions.
Calcarea carbonica	Nails affected in children or sluggish constitutions; profuse sweating, slow healing.
Nitric acid	Splinter-like pains around nails; nails brittle, deformed.
Arsenicum album	Burning pains, restlessness; nails discoloured with surrounding eruptions.

6. Tinea barbae ⁽⁴⁾

Tinea barbae (barber's itch) is a fungal infection of the beard area, usually caused by dermatophytes. It affects men's facial hair regions, producing pustules, crusts, and sometimes painful swelling (kerion-like). Conventional treatment requires antifungal therapy, but in homeopathy remedies are studied according to lesion type, modalities, and constitutional tendencies.

Key Points on Tinea Barbae ⁽⁴⁾

- **Cause:** Dermatophyte fungi (Trichophyton species).
- **Symptoms:** Red, scaly eruptions in beard area,

- pustules, crusts, painful swelling, hair loss.
- **Spread:** Contaminated razors, barber tools, close contact.
 - **Homoeopathic management** ⁽¹⁾

Remedy	Key Indications
Tellurium	Ring-shaped eruptions with offensive odor; lesions coalesce; itching and scaling.
Mezereum	Thick crusts with pus beneath; offensive smell; eruptions on hairy parts.
Graphites	Moist, sticky eruptions with cracks; suited for beard eczema/fungus.
Sulphur	Burning, itching eruptions; worse from warmth; chronic fungal tendency.
Sepia	Dry, scaly patches; worse in damp weather; tendency to recur.
Arsenicum album	Burning pains, restlessness; eruptions worse at night.
Silicea	Suppuration tendency; offensive sweat; recurrent fungal infections.
Calcarea carbonica	Susceptibility in sluggish constitutions; profuse sweating; slow healing.

7. Tinea facies ⁽⁴⁾

Tinea faciei (ringworm of the face) is a superficial fungal infection affecting non-bearded areas of the face. It produces circular, scaly, red patches with itching or burning. Conventional treatment requires antifungal creams or oral antifungals, but in homeopathy remedies are studied according to lesion type, modalities, and constitutional tendencies.

Key Points on Tinea Facies ⁽⁴⁾

- **Cause:** Dermatophyte fungi (Trichophyton, Microsporum).
- **Symptoms:** Ring-shaped, red, scaly patches on cheeks, forehead, or eyelids; itching, burning, sometimes spreading.
- **Spread:** Direct contact, contaminated towels, clothing, pets.

- **Homoeopathic management** ⁽¹⁾

Remedy	Key Indications
Tellurium	Classic ring-shaped eruptions with offensive odor; lesions coalesce; itching worse at night.
Sepia	Dry, scaly patches on face; worse in damp weather; tendency to recur.
Sulphur	Burning, itching eruptions; worse from warmth of bed; chronic fungal tendency.
Graphites	Moist, sticky eruptions with cracks; suited for facial eczema/fungus.
Mezereum	Thick crusts with pus beneath; offensive smell; eruptions on hairy or facial parts.
Arsenicum album	Burning pains, restlessness; eruptions worse at night.
Calcarea carbonica	Susceptibility in children or sluggish constitutions; profuse sweating; slow healing.
Silicea	Suppuration tendency; brittle nails and recurrent fungal infections; slow recovery.

8. Tinea manuum ⁽⁴⁾

Tinea manuum (fungal infection of the hands) is a dermatophyte infection affecting palms, fingers, and interdigital spaces. It often appears as dry scaling, itching, or ring-shaped lesions. Conventional treatment requires antifungal creams or oral antifungals, but in homeopathy remedies are studied according to lesion type, modalities, and constitutional tendencies.

Key Points on Tinea Manuum ⁽⁴⁾

- **Cause:** Dermatophytes (Trichophyton rubrum most common).
- **Symptoms:** Dry scaling of palms, itching, fissures between fingers, ring-shaped patches, sometimes resembling eczema.
- **Spread:** Direct contact, contaminated towels, soil, pets.
- **Homoeopathic Management** ⁽¹⁾

Remedy	Key Indications
Tellurium	Ring-shaped eruptions with offensive odor; lesions coalesce; itching worse at night.
Graphites	Moist, sticky eruptions with cracks between fingers; suited for hand eczema/fungus.

Sulphur	Burning, itching eruptions; worse from warmth; chronic fungal tendency.
Sepia	Dry, scaly patches on hands; worse in damp weather; tendency to recur.
Antimonium crudum	Thickened, horny skin on palms; painful cracks; worse from cold water.
Silicea	Suppuration tendency; brittle nails; recurrent fungal infections.
Arsenicum album	Burning pains, restlessness; eruptions worse at night.
Calcarea carbonica	Susceptibility in sluggish constitutions; profuse sweating; slow healing.

Sepia	Pigmentary changes on skin; brownish patches; worse in damp weather.
Sulphur	Itching, burning eruptions; chronic fungal tendency; worse from warmth.
Graphites	Moist, sticky eruptions with cracks; suited for chronic skin fungus.
Arsenicum album	Burning, restlessness; discoloured patches with itching; worse at night.
Calcarea carbonica	Susceptibility in sluggish constitutions; profuse sweating; slow healing.
Mezereum	Thick crusts with pus beneath; offensive smell; eruptions on trunk.
Thuja occidentalis	Chronic, resistant fungal eruptions; warty growths with discoloration.

9. Tinea versicolor ⁽⁴⁾

Tinea versicolor (Pityriasis versicolor) is a superficial fungal infection of the skin caused by *Malassezia* yeast. It produces hypopigmented or hyperpigmented patches, often on the trunk, neck, or arms. Conventional treatment requires antifungal creams or shampoos, but in homeopathy remedies are studied according to skin changes, modalities, and constitutional tendencies.

Key Points on Tinea Versicolor ⁽⁴⁾

- **Cause:** Overgrowth of *Malassezia* yeast (normally present on skin).
- **Symptoms:** Discoloured patches (lighter or darker than surrounding skin), fine scaling, mild itching.
- **Sites:** Chest, back, neck, upper arms.
- **Homoeopathic management ⁽¹⁾**

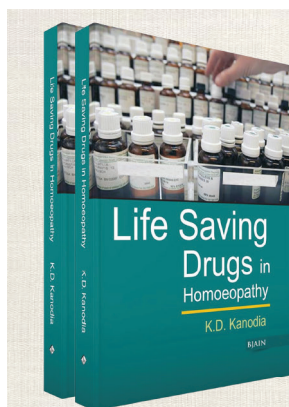
Remedy	Key Indications
Tellurium	Circular, ring-shaped eruptions with scaling; offensive odor; lesions coalesce.

CONCLUSION

Homoeopathy offers a holistic approach in the management of fungal disorders by treating the individual as a whole rather than focusing solely on the infection. By selecting the similimum based on the totality of symptoms, it aims to enhance the body's natural healing response, reduce recurrence, and improve overall health. However, maintaining proper hygiene and addressing predisposing factors remain essential for successful outcomes.

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Dr. K.D. Kanodia



Fungal Infections and Homoeopathy: A Comprehensive Review

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Abstract

Fungal infections, collectively known as mycoses, are important infectious disorders affecting humans worldwide. They range from superficial infections of the skin, hair and nails to mucosal, subcutaneous and invasive systemic diseases. Dermatophytosis, candidiasis and pityriasis versicolor are among the common superficial fungal infections, particularly in warm and humid climates. Predisposing factors include excessive sweating, occlusive clothing, obesity, diabetes mellitus, immunosuppression, antibiotic exposure and inappropriate corticosteroid use. Increasing antifungal resistance has further emphasized the need for accurate diagnosis, rational treatment and continued research. The World Health Organization has identified 19 fungal pathogens or pathogen groups as global priority threats because of their public-health impact and treatment challenges.¹

Homoeopathy traditionally approaches chronic and recurrent skin disorders through individualization and consideration of the totality of symptoms. Classical homoeopathic materia medica describes remedies such as Sulphur, Graphites, Petroleum, Sepia, Arsenicum album, Natrum muriaticum, Tellurium and Thuja in relation to characteristic dermatological symptom patterns. However, traditional materia-medica indications should not be equated with demonstrated antifungal activity. Current clinical evidence is insufficient to establish homoeopathy as a replacement for evidence-based antifungal treatment. This review discusses fungal infections, their diagnosis and management, the traditional homoeopathic

approach, and the need for scientifically rigorous research.

Keywords

Fungal infection, mycosis, dermatophytosis, tinea, candidiasis, homoeopathy, homoeopathic pharmacy, antifungal therapy, materia medica, individualization.

1. Introduction

Fungi are eukaryotic organisms widely distributed in the environment. Although many are harmless, pathogenic fungi can cause diseases ranging from localized superficial infections to severe invasive infections. The global importance of fungal disease has increased because of emerging antifungal resistance, increasing numbers of immunocompromised patients and limitations in diagnosis and treatment.¹

Superficial fungal infections are particularly common in tropical and subtropical environments where heat, humidity and perspiration favour fungal growth. Dermatophytes primarily infect keratinized tissues such as skin, hair and nails, whereas *Candida* species may cause mucosal, cutaneous and systemic disease.

Clinical management depends on the site, causative organism, severity and host factors. Accurate diagnosis is therefore important, particularly in recurrent, extensive or atypical disease. The increasing occurrence of resistant fungal pathogens has also created a need for research into new therapeutic strategies.¹

2. Classification of Fungal Infections

Fungal infections may be classified according to the depth and anatomical site of infection.

2.1 Superficial Mycoses

These are generally restricted to the outermost layers of skin or hair and include:

Pityriasis versicolor

Tinea nigra

Piedra

2.2 Cutaneous Mycoses

These involve the skin, hair or nails and are predominantly caused by dermatophytes. Important clinical forms include:

Tinea corporis – infection of the body

Tinea cruris – infection of the groin

Tinea pedis – athlete's foot

Tinea capitis – scalp infection

Tinea faciei – facial infection

Tinea manuum – infection of the hands

Tinea unguium/onychomycosis – fungal infection of the nails

2.3 Candidiasis

Candidiasis is commonly caused by *Candida albicans*, although other species may also be involved. It may affect the oral cavity, genital tract, skin folds and, in susceptible individuals, internal organs.

2.4 Subcutaneous and Systemic Mycoses

Subcutaneous infections may follow traumatic inoculation of fungi into the skin. Sporotrichosis and eumycetoma are examples. Systemic infections include histoplasmosis, cryptococcosis, aspergillosis, invasive candidiasis and mucormycosis. Some invasive fungal pathogens are classified by WHO as critical or high-priority pathogens.¹

3. Risk Factors

- Important risk factors include:
- Warm and humid climate
- Excessive sweating
- Tight or occlusive clothing
- Poor ventilation of skin folds
- Obesity
- Diabetes mellitus
- Immunosuppression
- HIV infection and other immunodeficiency states
- Prolonged antibiotic use
- Corticosteroid therapy
- Trauma to skin or nails
- Contact with infected people or animals
- Sharing towels, clothing or footwear
- Use of communal bathing facilities
- Poor control of underlying diseases and inappropriate treatment may contribute to persistence and recurrence.

4. Clinical Manifestations

Clinical manifestations depend on the organism and anatomical site.

Skin

Dermatophytosis commonly produces itching, erythema, scaling, burning and annular lesions. A typical ringworm lesion may have a raised, scaly margin and central clearing, although appearances can vary.²

Scalp

Tinea capitis may cause scaling, itching, broken hairs, alopecia and inflammatory swelling. Severe inflammatory disease may produce kerion.

Nails

Onychomycosis may cause nail thickening, discoloration, brittleness, subungual debris and distortion.

Candidiasis

Cutaneous candidiasis commonly affects moist skin folds. Oral candidiasis may produce white or creamy plaques, while genital candidiasis may cause itching, irritation and abnormal discharge.

5. Diagnosis

Clinical examination is important, but several dermatological disorders can resemble fungal infection. Diagnostic confirmation may therefore involve:

Direct microscopic examination using KOH preparation

Fungal culture

PAS staining and histopathology

Molecular tests where indicated

Wood's lamp examination in selected conditions

Testing is particularly useful in recurrent, atypical or treatment-resistant infections. CDC guidance also emphasizes that testing can help distinguish ringworm from other skin and nail disorders.²

6. Conventional Management

Treatment depends upon the site and severity of infection.

Topical antifungal medicines commonly used for uncomplicated superficial infections include clotrimazole, miconazole, terbinafine, ketoconazole and related agents. More extensive infections, tinea capitis and many nail infections may require systemic antifungal treatment.²

Antifungal therapy should be used for the recommended duration even when symptoms improve early. CDC guidance emphasizes that treatment selection depends on the

anatomical site and severity of infection.²

Tinea Incognito

Inappropriate use of topical corticosteroids can suppress inflammation without eliminating the fungus. This may allow infection to spread and alter its clinical appearance, producing tinea incognito. Current CDC guidance specifically advises against using steroid creams for ringworm or undiagnosed rashes that may represent ringworm.²

7. Prevention

Prevention is an important component of fungal disease management. Patients should:

Keep affected areas clean and dry.

Change sweaty clothing regularly.

Wear breathable clothing and footwear.

Avoid sharing towels, clothes, combs and footwear.

Maintain appropriate foot hygiene.

Avoid unnecessary corticosteroid-containing creams.

Control underlying conditions such as diabetes.

Seek medical evaluation for recurrent or extensive disease.

Complete prescribed antifungal treatment.

Obtain evaluation of relevant household contacts or animals when indicated.

8. Homoeopathic Perspective

Homoeopathy traditionally considers the individual patient rather than only the pathological diagnosis. In classical practice, skin disorders are assessed through the totality of symptoms, including local manifestations, general symptoms, constitutional characteristics and modalities.

Case-taking may consider:

Character and intensity of itching

Burning or stinging

Nature of eruption

Scaling and fissuring

Site and distribution

Aggravating and ameliorating factors

Perspiration

Thermal preference

Appetite and thirst

Sleep

General constitutional features

Associated symptoms

Previous treatment

Thus, in traditional homoeopathic prescribing, a patient is not treated merely because the diagnosis is "ringworm." Remedy selection is based on the characteristic symptom picture of the individual.

9. Homoeopathic Materia Medica in Skin Disorders

Several remedies are traditionally described in homoeopathic materia medica in relation to dermatological complaints.

Sulphur

Sulphur occupies an important position in classical descriptions of chronic skin disorders, particularly conditions associated with itching and burning sensations and characteristic modalities.

Graphites

Graphites is traditionally associated with chronic, dry, fissured and eczematous skin conditions, especially when characteristic sticky discharges are present.

Petroleum

Petroleum is traditionally described for dry, rough, cracked and fissured skin, with characteristic modalities.

Sepia

Sepia is described in relation to selected chronic skin and mucocutaneous manifestations accompanied by characteristic constitutional symptoms.

Arsenicum album

Arsenicum album is traditionally associated with burning sensations, restlessness and selected chronic skin manifestations.

Natrum muriaticum

Natrium muriaticum is described for certain chronic skin complaints occurring with characteristic constitutional and general symptoms.

Tellurium

Tellurium has traditionally been associated with certain offensive skin eruptions and characteristic itching and discharge patterns.

Thuja occidentalis

Thuja is traditionally described for various skin manifestations, particularly warty and abnormal epithelial growth patterns.

These descriptions are derived from traditional materia-medica literature. They should not be interpreted as proof of direct antifungal activity or clinical cure of fungal infection.

10. Individualization in Fungal Skin Complaints

Individualization is a central concept in classical homoeopathy. Two patients with apparently similar fungal lesions may present with different constitutional characteristics, sensations and modalities.

For example, one patient may have marked itching and burning with a particular aggravation, while another may have dryness, fissuring and a characteristic discharge. Traditional homoeopathic prescribing may therefore select different remedies for these patients.

This approach illustrates the distinction between diagnosis-based conventional

antifungal therapy and symptom-based individualized homoeopathic prescribing.

11. Evidence and Limitations

The scientific evidence supporting homoeopathy as a specific treatment for fungal infection remains inadequate. Traditional materia-medica descriptions, case reports and uncontrolled observations cannot establish efficacy at the same level as well-designed randomized controlled trials.

A scientifically rigorous study of homoeopathy in fungal disease would require:

Microbiologically confirmed infection

Adequate sample size

Randomization

Appropriate control group

Standardized diagnostic criteria

Objective clinical outcomes

Microbiological assessment

Adequate follow-up

Assessment of recurrence

Appropriate statistical analysis

Laboratory evidence, even when positive, should also be distinguished from clinical efficacy in humans.

Therefore, homoeopathy should not be presented as a substitute for established antifungal therapy, particularly in extensive, recurrent, invasive or systemic fungal infections.

12. Integrative and Patient-Centred Approach

A patient-centred approach should prioritize accurate diagnosis and timely management. Patients who use or wish to use complementary approaches should communicate this to their treating healthcare professional.

Homoeopathic practitioners should recognize situations requiring referral, particularly:

Tinea capitis

Extensive dermatophytosis

Suspected fungal nail infection

Recurrent or treatment-resistant infection

Immunocompromised patients

Diabetes-associated infection

Suspected invasive fungal disease

Delaying effective treatment in serious fungal infections may result in complications.

13. Role of Homoeopathic Pharmacy and Future Research

- Homoeopathic pharmacy can contribute to scientific investigation through:
- Standardization of starting materials
- Quality control of preparations
- Physicochemical characterization
- Controlled microbiological studies
- In-vitro antifungal investigations
- Appropriate experimental models
- Randomized clinical trials
- Pharmacovigilance
- Reproducibility studies

Research should clearly distinguish traditional homoeopathic concepts from experimentally demonstrated biological effects. Given increasing antifungal resistance and limited therapeutic options, scientifically rigorous research into complementary approaches may be valuable. WHO specifically identifies strengthening laboratory capacity, surveillance and research as priorities for fungal disease.¹

14. CONCLUSION

Fungal infections constitute a major group of infectious diseases ranging from superficial dermatophytosis and candidiasis to severe invasive mycoses. Accurate diagnosis, identification of predisposing factors, appropriate antifungal

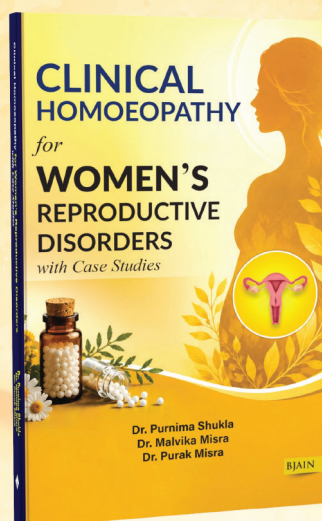
treatment and preventive measures are essential for effective management.

Homoeopathy has a long tradition of individualized assessment of skin complaints, and classical materia medica describes several remedies in relation to characteristic dermatological symptom patterns. However, traditional indications should be distinguished from scientifically demonstrated antifungal activity. At present, there is insufficient clinical evidence to establish homoeopathy as a replacement for evidence-based antifungal therapy.

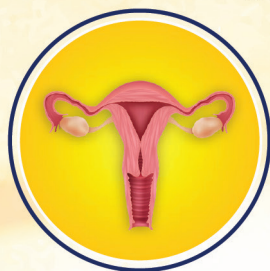
Future research should employ rigorous microbiological methods, appropriate clinical trial designs and reproducible outcome measures. A scientifically responsible approach should preserve the historical and therapeutic framework of homoeopathy while maintaining the principles of accurate diagnosis, patient safety, evidence-based practice and responsible clinical research.

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Mucormycosis: A Review of its Clinical and Homoeopathic Aspects

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Abstract

Mucormycosis is a rapidly progressing fungal infection. People with uncontrolled diabetes, weak immunity, and prolonged corticosteroid use, severe COVID-19, neutropenia, trauma, or burns are affected. The infection involves the nose, sinuses, lungs, skin, and gastrointestinal tract. Early diagnosis and treatment is important because the fungus can spread causes tissue death. This review describes the causes, risk factors, pathophysiology, clinical features, diagnosis, differential diagnosis, and management. It also discusses the homoeopathic approach, including commonly described remedies which are selected according to totality of symptoms. However, there is limited clinical evidence regarding the effectiveness of homoeopathy in mucormycosis. Further research is needed to evaluate more possible supportive role of homoeopathy in these cases.

Keywords

Mucormycosis, fungal infection, mucorales, miasm, homoeopathy

Introduction

Mucormycosis is a serious fungal infection that can affect different parts of the body. It mostly affects immunocompromised persons. It manifests in several clinical forms, including sino-orbital, rhinocerebral, sinopulmonary, gastrointestinal, cutaneous, musculoskeletal, osteoarticular and disseminated mucormycosis and single organ disease. Early intervention reduces the mortality rate. Treatment requires an approach that includes correction of the underlying predisposing factor. In conventional method surgically and

antifungal therapy is given.^[1]

Etiology

It is an infection caused by fungi belongs to order of Mucorales within the class of Mucoromycetes. This comprises more than 300 species out of which 39 species are causing human infections.^[2] Microscopically, Mucorales are filamentous molds and reproduce asexually through the formation of sporangiospores. It grow rapidly, produce broad, ribbonlike hyphae, are typically pauciseptate, and exhibit irregular right-angle branching. These structural features are important for histopathological identification.^[3,4] Rhizopus is the most common genus in human infection; about 70% cases are responsible worldwide.^[5] Generally these fungi are nonpathogenic in immunocompetent hosts, they can only affect immunocompromised hosts^[6]

Epidemiology

Incidence of mucormycosis is 2.7 cases per 100,000 people world widely.^[7] In India incidence rate is high, which is due to poorly controlled diabetes mellitus, high use of corticosteroids and other environmental factors.^[8,9]

Risk Factors

Diabetes mellitus, especially with case of diabetic ketoacidosis, prolonged neutropenia, Severe COVID-19 infection, Iron overload, Glucocorticoid therapy, Trauma and severe burns, Human immunodeficiency virus infection. In India 50% risk factors are seen.^[10] COVID-19-associated cases occurred during the pandemic, in which half cases were in India (57%).^[11]

Pathophysiology

Mucorales are acquired by inhalation. In healthy person, spores are cleared by mucociliary action and alveolar macrophages. But in immunocompromised patient spores can germinate into hyphae. The fungi then enter in blood vessels, which causes thrombosis, ischemia, and tissue necrosis.^[12] In person with diabetes mellitus which is poorly controlled, provides an environment for rapid filamentous growth. Metabolic acidosis exacerbates this process by inhibiting polymorphonuclear cell chemotaxis, reducing phagocytic activity, and dampening the local inflammatory response. Because Mucorales depend on free iron for uptake, iron overload states are a critical predisposing factor for infection.^[5]

Even people with good immune if develop weak immune defenses after severe injuries, and then fungal spores enter into skin directly. This temporary immune weakness allows the fungus to grow and spread quickly in tissue.^[13]

Histopathology

Histology is the main test used to confirm mucormycosis. It typically shows broad, ribbon-like, non septate or few septate hyphae and most importantly, invades blood vessels. Tissue samples are taken from the site of infection. It can occur along with aspergillus infection, so identifying the fungus is important for choosing the right antifungal treatment. Even if hyphae are not seen mucormycosis should not be ruled out when the clinical features and risk strongly suggest it.^[3]

Types And Clinical Presentation

The infection in human occurs in two types

Superficial and Visceral, Localized and Disseminated.^[14]

- **Rhino orbital cerebral mucormycosis:** Common in people with poorly controlled diabetes. It enters through the nose and spread through sinuses, eyes and brain. Symptoms are blocked nose, facial numbness, blurred vision, drooping of eyelids, bulging eyes, loss eye movement. Black dead tissue in nose is a warning sign.^[3,15]

- **Pulmonary mucormycosis:** Common in people with prolonged low white blood cell, especially after stem cell transplantation. It enters through inhalation and infects lungs. Symptoms are fever, cough with blood, and difficulty in breathing and chest pain with cavity in lungs.^[3,14]
- **Cutaneous mucormycosis:** Skin, deeper tissues & bones are affected. It enters through burns, wound or injuries. Area is swollen, painful with brown or black dead tissues. If lesions spread then multiple lesions are seen.^[3]
- **Gastrointestinal mucormycosis:** Stomach and intestines are affected. Common in malnourished people and premature infants. Symptoms are abdominal pain, nausea and vomiting. If severe then bleeding, ulcers, perforations and peritonitis is seen.^[16,17,18]
- **Disseminated mucormycosis:** Here infection spreads through bloodstream to several organs especially in people with low white blood cells. Lung, kidney, brain and other organs are affected. Symptoms are according to part affected.^[3]

Investigation

The diagnosis is done by histo and microbe cultures.^[19] PCR-based molecular test in immunocompromised patients, mucorales are detected even when cultures are negative.^[20] Next-generation sequencing (NGS) is a newer diagnostic method helps in identifying infections quickly. MRI and CT scan. In necrosis a tissue biopsy is done.^[3, 16]

Conventional Management

It includes controlling the underlying problems removing infected tissues and starting antifungal medicines. The chances of recovery are poor if the patient's have poor immune, even when strong medical and surgical treatment is given. The first treatment in most cases is liposomal amphotericin B, usually given through a vein, starting dose of 5 mg/kg once daily. If the infection may have spread to the brain or central nervous system, or if the patient has received a transplant, a higher dose of 10 mg/kg once daily is used. Dose increases up to 10

mg/kg daily should be considered in individuals not responding to treatment after 1 week. Once there are signs of clinical improvement, individuals can be switched to maintenance therapy, with isavuconazole or posaconazole.^[21,22]

Differential Dignosis

Depends on the site of infection: Bacterial orbital cellulites, Cavernous sinus thrombosis, Granulomatosis with polyangiitis. Pulmonary tuberculosis, pulmonary nocardiosis, pulmonary embolism. Ecthyma gangrenosum, Cutaneous anthrax, Cellulitis, Abscess. Abdominal tuberculosis, Bowel obstruction, Ischemic colitis, Mesenteric ischemia, Malignant neoplasm^[3,23]

Homoeopathic Management

Homoeopathy offers a holistic approach and aim is not to treat only mucormycosis symptoms but also remove its underlying cause. Few research studies undertaken on various fungi model showed that Homoeopathy medicine could prevent the growth of the fungus and disease originated due to fungus. As in past studies, it is seen that *Kalium* group remedies, *Silicea*, *Thuja*, *Lycopodium*, and *Nitric acid* acting as alternative or adjunctive treatments.^[24] There are remedies which have antifungal effects.^[25]

Few Homoeopathic medicines details:

- ***Arsenicum Album*:** Burning pain, the parts burn like fire. Gangrenous aphthae. Worse at mid night. Great anguish, restlessness, fear of death. Great thirst for cold water, drinks very often, but takes but little at a time.^[26,27]
- ***Aurum Metelicum*:** From nervous system it acts upon the palatine bones; osseous system, more especially the nasal and palatine bones. Caries of the nasal, palatine, mastoid, and ossicular bones. Swelling of the skull bones. Worse at night and morning; on getting cold; while reposing. Relieved by moving; while walking, and on getting warm.^[26,27]
- ***Condurango*:** Painful cracks in corner of mouth. Chronic gastric catarrh, syphilis, and cancer. Tumors; stricture of oesophagus. Fissures form about the muco-cutaneous outlets. Epithelioma of lips or anus. Ulcerative stage

of carcinoma cutis when fissures form.^[28]

- ***Acidum Fluoricum*:** Caries in consequence of syphilis, or abuse of Mercury, especially of the temporal bone.-RAUE. Digestive Organs.-Rapid caries of the teeth. Dental and lachrymal fistulae. Syphilitic erosions, mucous tubercles, exostoses, and nightly bone-pains. Varicose veins; typhus with decubitus.^[26,27]
- ***Sulphur Iodatum*:** Obstinate skin affections; painless enlargement of glands and infiltration of tissues with thickening. Weakness; as from influenza. Prostration and sensitive to everything. Faint and sick. Raw burning heat internally with external coldness. Acrid discharges. Single parts, fingers etc. turn white and insensible. Suppuration. Breathing asthmatic, irregular, rattling and suffocative. Cough worse a.m.; spasmodic. Expectoration greenish, purulent, copious, viscid and yellow. Chest constricted dropsy of pleura, and eruptions on chest. Itching. Ulcers. Moist eczema. Acne, suppurating. Barbers' itch. Aching soreness below knees. Soles of feet ache, burn and sore, when standing.^[29]
- ***Kalium Bichromicum*:** Acts through the ganglionic system upon the mucous membranes; the glandular system; fibrous tissue and skin. The mucous membranes chiefly affected are the mouth, throat, cardiac portion of the stomach, duodenum, jejunum, and rectum; the whole respiratory membrane, including the conjunctiva and the uterus. Upon the skin it causes papules, pustules, and ulcers. Upon the fibrous tissue, about the joints and the periosteum, it has a marked and powerful influence. It also affects the cartilages, especially that of the nose, which it has entirely destroyed. Cough, with expectoration of tough, stringy mucus, which sticks to the throat, mouth and lips; the cough in choking and croupy; worse in the morning. Discharges from the nose, mouth, throat, stomach, vagina, or any of the mucous membranes, of a tough, stringy mucus, which sticks to the parts, and can be drawn out into strings three feet long.^[26,27,28]
- ***Mercurius Solubilis Hahnemanni* :** Complaints of Syphilitic origin. Aggravation Heat as well as cold, night, warmth of bed. Nostrils

are raw ulcerated. Pain and swelling of the nasal bones and decay with ulceration. Glandular enlargement with easy suppuration. Offensive discharges which are yellow green. Ulcerations spreading superficially with lardaceous base. Great thirst with moist mouth.^[27,30]

- **Secal Cornutum:** Strong tendency to putrescence, discharge of black blood; with tingling in the limbs and great debility. Passive haemorrhages; everything seems open and loose; no action, in thin, scrawny, cachectic women. Dry gangrene of the extremities; the parts are dry, cold, hard, and insensible, of a uniform black color, and free from fetor. The ulcer feels as though it had been burnt; discharges a putrid, bloody fluid, and is sometimes decidedly gangrenous and painless; in thin, scrawny cachectic people.^[26,27]

Few Repertories with Rubrics and Their Remedies:-

- Boericke: Actinomycosis: Hecla, Kali.iod, Nit. ac.; Tumours - Fungoid – Thuja, Skin - Ulcers with Fungus growths - Mur. Acid^[31]
- BBCR: Nose Bleeding Black - Crocus, Crotalus, Kreosote, Nitric acid, Mercsol; Fungus Haematodes - EYES -- BELL, CALC, LYC, SEP, SIL; SKIN- ulcers - Spongy –Fungoid - margins at - CARB-AN, ARS, LACH, SIL, Merc, Sep, Phos, Staph, Thuja^[32]
- Chaudhary: Epithelioma - Fungus - CALC, PHOS, SIL, THUJA^[33]
- Clarke Clinical repertory: Fungus Haematosis - LACH, PHOS Actinomycosis - Kali.Iod, NIT. ACID^[34]
- Kent: EYE- Cancer - Fungus - CALC, PHOS, Lyc, sep, sil.^[35]
- Murphy: Cancer - Fungus Growths - Spongy - Carb.an, Lach, Nit.ac, Thuja
- Ulcers -Generals - Fungal - ARS, SEP, THUJA^[36]
- Synthesis: Mycosis Fungoides - Carbo animalis Mouth thrush Chemotherapy after – LACH Generals - Fungoid Diseases - Kali.Iod Eyes

- Fungus - CALC, PHOS, Lyc, Sep, Sil^[37]

CONCLUSION

Mucormycosis is a invasive fungal infection in which early diagnosis, identification of risk factors, and treatment are essential. Important predisposing factors are Diabetic, immunosuppression, corticosteroid use, severe COVID-19, neutropenia, iron overload, trauma, and burns. Delay in diagnosis and treatment may result death. Homoeopathy have potential as a supportive adjunct in mucormycosis by addressing the patient's individual symptom picture, underlying predispositions, treatment-related complaints, recovery, and post-infection effects, while potentially supporting the body's natural immune response. Its traditional literature includes remedies associated with ulceration, necrosis, burning pain, offensive discharges, mucosal involvement, and fungoid conditions. However, clinical evidence in mucormycosis is currently limited. Therefore, I recommend further clinical and laboratory research with larger patient populations and a wider range of homoeopathic remedies. Such studies may help in identifying more useful remedies and clarify their role as an adjunct to conventional treatment, including whether they can help reduce treatment-related side effects and support recovery. At present, there is less number of clinical evidence but it is an alternative treatment.

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Host Susceptibility in Opportunistic Fungal Infections: An Integrative Review of Modern Mycology and Homoeopathic Perspectives

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Abstract

Opportunistic fungal infections (OFIs) are an important cause of morbidity and mortality among immunocompromised individuals, particularly those with diabetes mellitus, HIV infection, malignancies, organ transplantation, and prolonged immunosuppressive therapy. Advances in medical mycology have improved the understanding of fungal pathogens, diagnostic methods, and antifungal therapy; however, host susceptibility remains a major determinant of disease occurrence and outcome. This review summarizes the major opportunistic fungal pathogens, risk factors, clinical manifestations, diagnostic approaches, and current management strategies, with particular emphasis on host susceptibility. It further discusses the homoeopathic concept of susceptibility, highlighting constitutional assessment and individualized prescribing as fundamental principles of patient care. Current evidence supporting homoeopathy in fungal disorders is critically reviewed, acknowledging its limitations and the need for high-quality clinical research. By integrating contemporary concepts of medical mycology with homoeopathic philosophy, this review provides a balanced perspective on host susceptibility and identifies future directions for interdisciplinary research and patient-centred care.

Keywords

Opportunistic fungal infections; Host susceptibility; Immunocompromised individuals; Medical

mycology; Homoeopathy; Individualization; Antifungal resistance; Patient-centred care.

Introduction

Opportunistic fungal infections (OFIs) have emerged as an important public health concern, particularly among individuals with impaired immune function. The increasing prevalence of diabetes mellitus, HIV infection, malignancies, organ transplantation, prolonged corticosteroid therapy, and other immunosuppressive conditions has expanded the population at risk for invasive and recurrent fungal infections. Once considered relatively uncommon, these infections are now associated with substantial morbidity, mortality, prolonged hospitalization, and increased healthcare costs.^{1–3}

Unlike primary fungal pathogens, opportunistic fungi cause disease predominantly in hosts with compromised immune defenses. Species such as *Candida*, *Aspergillus*, *Cryptococcus*, and members of the order *Mucorales* exploit defects in innate and adaptive immunity, producing infections that range from superficial mucocutaneous disease to life-threatening invasive infections. Despite significant advances in medical mycology, including improved understanding of fungal biology, host-pathogen interactions, diagnostic techniques, and antifungal therapies, delayed diagnosis, emerging antifungal resistance, and recurrent infections continue to pose major clinical challenges.^{2–5}

From a homoeopathic perspective, disease is

understood not merely as the result of pathogen exposure but as an expression of altered susceptibility within the individual. While conventional medicine focuses on identifying the causative organism and correcting immune dysfunction, homoeopathy emphasizes constitutional characteristics, individual susceptibility, and the totality of symptoms in therapeutic decision-making. Although these approaches arise from different theoretical frameworks, both recognize the pivotal role of the host in determining disease occurrence and progression.

Although numerous reviews have addressed fungal infections or their homoeopathic management, few have examined **host susceptibility** as the central theme while integrating contemporary concepts of medical mycology with homoeopathic philosophy. This review therefore aims to provide a balanced overview of opportunistic fungal infections in immunocompromised individuals, highlighting host susceptibility, recent advances in medical mycology, and the homoeopathic perspective on individualized patient care.

Opportunistic Fungal Infections: An Overview

Opportunistic fungal infections (OFIs) are caused by fungi that rarely produce disease in healthy individuals but can result in severe or life-threatening infections when host immune defenses are compromised. The increasing prevalence of diabetes mellitus, HIV infection, malignancies, organ transplantation, prolonged corticosteroid therapy, and other immunosuppressive conditions has contributed to a growing global burden of these infections.^{1–3}

Medical mycology has identified several fungi that account for the majority of opportunistic infections in humans, including *Candida* spp., *Aspergillus* spp., *Cryptococcus neoformans*, members of the order *Mucorales*, and *Pneumocystis jirovecii*. These organisms are ubiquitous in the environment or exist as part of the normal human microbiota, becoming pathogenic only when host immune defenses are impaired. Depending on the infecting organism and the degree of immunosuppression, OFIs may range from superficial mucocutaneous infections to invasive diseases involving the lungs, central nervous system, bloodstream, and other vital organs.^{2–4}

Recent advances in medical mycology have improved the understanding of fungal biology, laboratory diagnostics, and antifungal therapy. However, opportunistic fungal infections continue to pose significant clinical challenges because of delayed diagnosis, increasing antifungal resistance, and the expanding population of immunocompromised individuals. Recognizing their growing public health importance, the World Health Organization (WHO) published the **Fungal Priority Pathogens List (FPPL)** in 2022 to guide research, surveillance, and the development of improved diagnostic and therapeutic strategies.¹

Ultimately, the occurrence of opportunistic fungal infections depends not only on exposure to fungal pathogens but also on the host's ability to mount an effective immune response. Therefore, understanding the factors that influence host susceptibility is fundamental to preventing, diagnosing, and managing these infections in immunocompromised individuals.

Table 1. Major Opportunistic Fungal Pathogens

Fungal pathogen	Common clinical manifestations	Major predisposing conditions
<i>Candida</i> spp.	Candidiasis, candidemia	Diabetes mellitus, ICU admission, prolonged antibiotic therapy
<i>Aspergillus</i> spp.	Pulmonary and invasive aspergillosis	Neutropenia, organ transplantation, corticosteroid therapy
<i>Cryptococcus neoformans</i>	Cryptococcal meningitis	HIV/AIDS, immunosuppressive therapy
<i>Mucorales</i>	Rhinocerebral and pulmonary mucormycosis	Uncontrolled diabetes mellitus, corticosteroid therapy
<i>Pneumocystis jirovecii</i>	Pneumocystis pneumonia (PCP)	HIV/AIDS, chemotherapy, prolonged immunosuppression

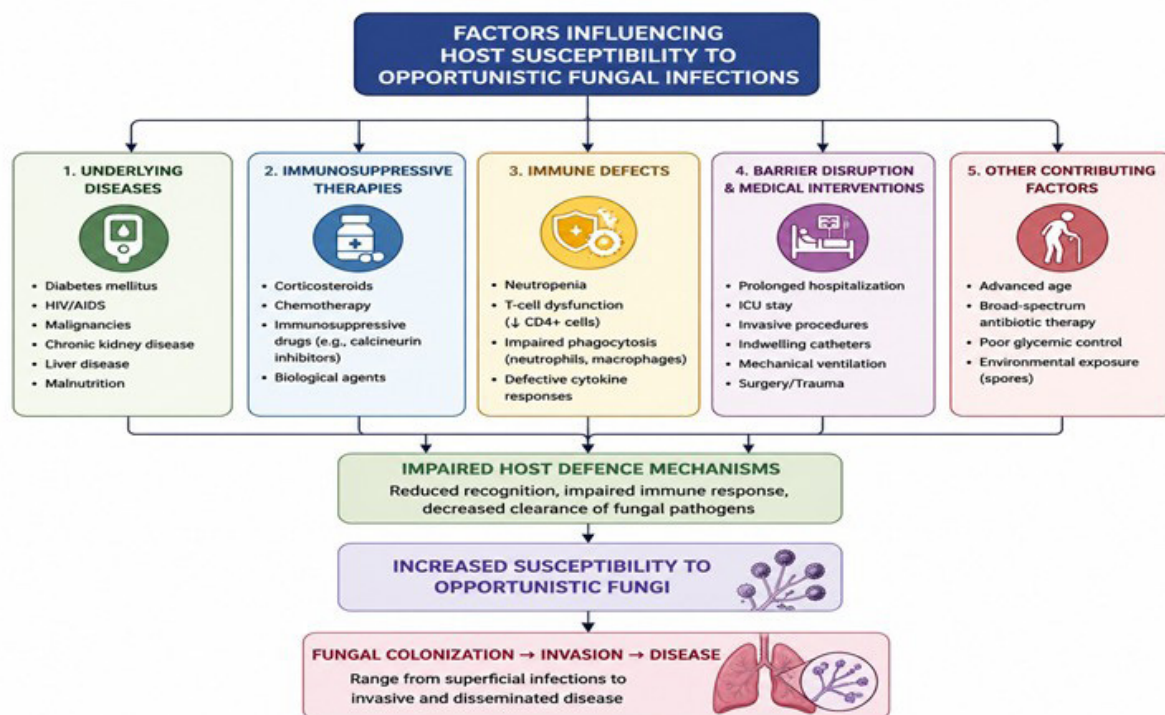
Host Susceptibility in Immunocompromised Individuals

The development of opportunistic fungal infections is influenced not only by the virulence of the infecting organism but also by the host's ability to mount an effective immune response. In healthy individuals, intact skin and mucosal barriers, together with innate and adaptive immune

mechanisms, provide effective protection against fungal invasion. However, impairment of these defense systems due to underlying diseases or immunosuppressive therapies creates a favorable environment for opportunistic fungi to colonize,

invade, and disseminate. Consequently, host susceptibility is regarded as a major determinant of the occurrence, severity, and outcome of opportunistic fungal infections.^{1–3}

Figure 1 : Factors Influencing Host Susceptibility to Opportunistic Fungal Infections



Host defence against fungal pathogens depends on intact epithelial barriers together with coordinated innate and adaptive immune responses. Disruption of these mechanisms predisposes immunocompromised individuals to opportunistic fungal infections. Among the various predisposing conditions, **diabetes mellitus** is one of the most important risk factors. Persistent hyperglycemia impairs neutrophil chemotaxis, phagocytosis, and intracellular killing, while poor vascular supply and delayed wound healing facilitate fungal invasion. Consequently, diabetic patients are particularly susceptible to candidiasis and mucormycosis.^{3,5}

Individuals with **HIV/AIDS** are highly vulnerable because progressive depletion of CD4⁺ T lymphocytes compromises cell-mediated immunity, increasing the risk of infections such as oral candidiasis, cryptococcal meningitis, and *Pneumocystis jirovecii* pneumonia. Likewise, patients

with **hematological malignancies**, those receiving **cytotoxic chemotherapy**, and **organ transplant recipients** experience prolonged immunosuppression or neutropenia, predisposing them to invasive aspergillosis and candidiasis.^{2,5,6}

The widespread use of **corticosteroids** further contributes to host susceptibility by suppressing inflammatory responses and impairing macrophage and T-cell function. This association became particularly evident during the COVID-19 pandemic, when uncontrolled diabetes combined with corticosteroid therapy was linked to a marked increase in mucormycosis. Other contributing factors include prolonged hospitalization, intensive care unit admission, broad-spectrum antibiotic therapy, chronic kidney disease, malnutrition, advanced age, and the use of invasive medical devices, all of which compromise normal host defenses and increase the likelihood of fungal infection.^{2,6,7}

Table 2 : Immunocompromised Conditions, Associated Immune Defects, and Common Opportunistic Fungal Infections

Immunocompromised condition	Immune defect	Common opportunistic fungal infections
Diabetes mellitus	Impaired neutrophil function, hyperglycemia	Candidiasis, mucormycosis
HIV/AIDS	CD4+ T-cell depletion	Cryptococcosis, PCP, candidiasis
Hematological malignancies	Neutropenia	Aspergillosis, candidiasis
Organ transplantation	Immunosuppressive therapy	Aspergillosis, candidiasis
Corticosteroid therapy	Impaired cell-mediated immunity	Aspergillosis, mucormycosis
Chronic kidney disease	Immune dysfunction	Candidiasis
ICU patients	Barrier disruption, invasive devices	Candidemia

Although opportunistic fungi are widely distributed in the environment, disease develops predominantly when host defense mechanisms are compromised. Therefore, identifying individuals at increased risk is essential for early diagnosis, timely intervention, and prevention of invasive fungal disease. Understanding these host-related factors also provides the basis for appreciating the homoeopathic concept of susceptibility, which is discussed in subsequent sections.

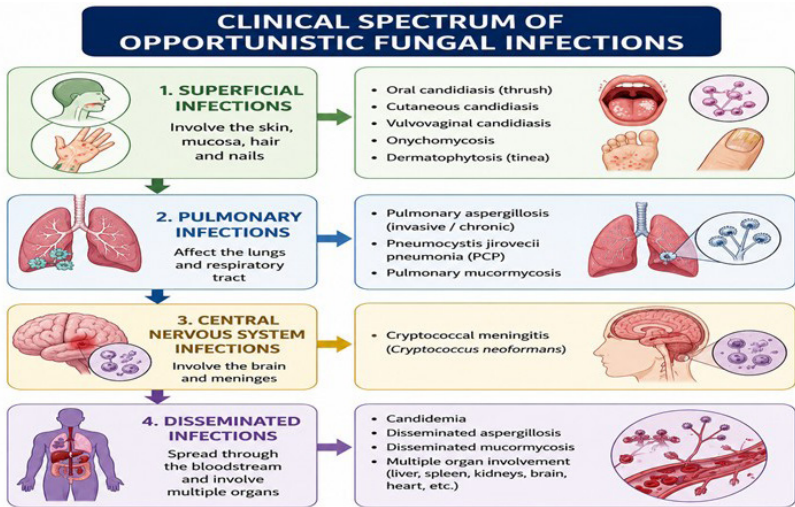
Clinical Presentation and Diagnosis

The clinical presentation of opportunistic fungal

infections varies according to the infecting organism, the site of involvement, and the degree of immunosuppression. While superficial infections are generally localized and less severe, invasive fungal infections may rapidly progress to life-threatening disease, particularly in immunocompromised individuals. Because the clinical manifestations often overlap with bacterial and viral infections, a high index of suspicion is essential for early recognition and timely intervention.¹⁻³

Superficial fungal infections commonly involve the skin, oral cavity, nails, and genital mucosa, with *Candida* species being the predominant pathogens. Oral candidiasis typically presents with white curd-like plaques, whereas vulvovaginal candidiasis is characterized by pruritus, erythema, and thick white discharge. Pulmonary infections, particularly invasive aspergillosis and *Pneumocystis jirovecii* pneumonia, commonly present with fever, cough, dyspnoea, pleuritic chest pain, and hypoxaemia. Central nervous system involvement is most frequently caused by *Cryptococcus neoformans*, resulting in meningitis characterized by headache, fever, neck stiffness, and altered sensorium. Rhinocerebral mucormycosis, commonly associated with uncontrolled diabetes mellitus, presents with facial pain, nasal congestion, black necrotic eschar, ophthalmoplegia, and visual disturbances. Disseminated infections, including candidemia and invasive aspergillosis, may involve multiple organs and are associated with high mortality if diagnosis is delayed.^{2,4-6}

Figure 2: Clinical Spectrum of Opportunistic Fungal Infections



Early diagnosis is critical for improving clinical outcomes but remains challenging because of nonspecific symptoms and the coexistence of multiple comorbidities in immunocompromised patients. Accurate diagnosis relies on a combination of clinical assessment, microbiological investigations, imaging studies, and histopathological examination. Direct microscopy using potassium hydroxide (KOH) preparation provides rapid detection of fungal elements in superficial infections, while fungal culture remains the reference standard for species identification and antifungal susceptibility testing. Histopathology confirms tissue invasion and differentiates colonization from invasive disease. Recent advances in molecular diagnostics, including polymerase chain reaction (PCR), MALDI-TOF mass spectrometry, and fungal biomarker assays such as galactomannan, β -D-glucan, and cryptococcal antigen testing, have significantly enhanced the early diagnosis of invasive fungal infections, particularly in high-risk patients.^{4,6–8}

Table 3 here: Diagnostic Modalities for Opportunistic Fungal Infections

Diagnostic modality	Clinical application
Direct microscopy (KOH mount)	Rapid detection of fungal elements in superficial infections
Fungal culture	Species identification and antifungal susceptibility testing
Histopathology	Confirmation of tissue invasion in invasive fungal infections
Antigen detection (Galactomannan, Cryptococcal antigen)	Early diagnosis of aspergillosis and cryptococcosis
β -D-glucan assay	Supportive diagnosis of invasive fungal infections
PCR and molecular assays	Rapid and sensitive identification of fungal pathogens
CT/MRI imaging	Assessment of pulmonary, cerebral, and disseminated fungal disease

No single diagnostic method is sufficient for all opportunistic fungal infections. Therefore, early recognition depends on integrating clinical findings with microbiological, histopathological, serological, and radiological investigations. Such a multidisciplinary diagnostic approach facilitates timely initiation of appropriate therapy and improves patient outcomes.

Current Management and Challenges

The successful management of opportunistic fungal infections depends on early diagnosis, prompt initiation of appropriate antifungal therapy, correction of underlying predisposing factors, and supportive care. Because invasive fungal infections progress rapidly in immunocompromised individuals, timely intervention is essential to reduce morbidity and mortality. The choice of antifungal therapy is determined by the infecting fungal species, the site and severity of infection, the patient's immune status, and associated comorbidities.^{1–3}

The major classes of antifungal agents used in clinical practice include **polyenes, azoles, echinocandins, and pyrimidine analogues** (Table 4). Amphotericin B remains the preferred treatment for many severe invasive fungal infections, whereas azoles are widely used for candidiasis, aspergillosis, and cryptococcosis. Echinocandins have become first-line agents for invasive candidiasis, particularly in critically ill patients, while flucytosine is commonly used in combination therapy for cryptococcal meningitis. Appropriate antifungal selection should be guided by the causative organism, disease severity, antifungal susceptibility, and patient-specific factors.^{2,4}

Effective management extends beyond antifungal therapy and includes correction of the underlying conditions that predispose patients to infection. Optimal glycaemic control in diabetes mellitus, initiation or optimization of antiretroviral therapy in HIV infection, judicious use of immunosuppressive agents, removal of infected indwelling catheters, and surgical debridement in mucormycosis are important components of comprehensive patient care. A multidisciplinary approach involving infectious disease specialists, microbiologists, surgeons, and intensivists is often required for patients with invasive fungal infections.^{1,3}

Despite advances in antifungal therapy, several challenges continue to compromise treatment outcomes. Increasing antifungal resistance, delayed diagnosis, limited access to advanced diagnostic facilities, drug-related toxicities, and significant drug–drug interactions remain major obstacles. Furthermore, the growing population

of immunocompromised individuals and the emergence of multidrug-resistant fungal pathogens underscore the need for improved antifungal stewardship, enhanced surveillance, and the development of novel therapeutic strategies.^{2,5}

Although modern antifungal therapy has significantly improved patient survival, recurrent infections remain common in individuals with persistent immune dysfunction. Consequently, long-term management should focus not only on eradication of the pathogen but also on reducing host susceptibility and preventing recurrence. This concept provides a meaningful transition to the homoeopathic perspective, where susceptibility and individualized patient assessment constitute the foundation of therapeutic management.

Homoeopathic Perspective on Host Susceptibility

The concept of **susceptibility** is fundamental to homoeopathic philosophy and provides the basis for understanding disease occurrence, progression, and recovery. According to Samuel Hahnemann, disease is not merely the result of exposure to external pathogens but arises from a disturbance of the vital force, rendering the individual susceptible to disease-producing influences. Consequently, not every individual exposed to fungal organisms develops infection; rather, disease occurs when the host's inherent resistance is compromised. Although described using different conceptual frameworks, this principle parallels the modern understanding that opportunistic fungal infections predominantly affect individuals with impaired immunity.⁸⁻¹⁰

From a homoeopathic perspective, susceptibility is influenced by constitutional makeup, hereditary tendencies, lifestyle, environmental factors, and the individual's adaptive capacity. These factors determine not only the likelihood of developing disease but also its severity, recurrence, and response to treatment. Therefore, homoeopathy places greater emphasis on treating the patient as a whole rather than focusing solely on the fungal pathogen or the affected organ. This individualized approach distinguishes homoeopathy from disease-oriented therapeutic models.^{9,10}

A central principle of homoeopathic practice is

individualization, wherein remedy selection is based on the totality of characteristic symptoms, including mental and emotional features, physical generals, modalities, constitutional traits, past medical history, and maintaining causes. Thus, patients presenting with similar fungal infections may require different remedies depending on their individual symptom profiles. The objective is not only to relieve local manifestations but also to reduce the patient's underlying susceptibility and improve overall health.^{9,11}

The **miasmatic concept**, described by Hahnemann in *The Chronic Diseases*, provides an additional framework for interpreting chronic and recurrent fungal disorders. Persistent fungal infections may be considered expressions of underlying chronic miasmatic influences, particularly psoric or sycotic tendencies, depending on the patient's constitutional characteristics and clinical presentation. While this concept represents a philosophical interpretation rather than a biomedical explanation, it continues to guide constitutional prescribing in homoeopathic practice.^{8,9}

Table 4 : Commonly Indicated Homoeopathic Remedies in Fungal Disorders

Remedy	Common clinical indications*
Sulphur	Recurrent itching, burning, dry scaly eruptions
Graphites	Moist, fissured, sticky skin eruptions with oozing
Sepia	Chronic fungal infections in skin folds; recurrent vulvovaginal candidiasis (individualized indication)
Tellurium	Ring-shaped lesions with offensive discharge
Silicea	Chronic nail involvement; recurrent suppurative tendency
Arsenicum album	Burning pains, restlessness, marked weakness
Natrum muriaticum	Chronic recurrent fungal infections in susceptible individuals
Thuja occidentalis	Chronic skin conditions with sycotic features

Homoeopathic therapeutics in fungal disorders is therefore directed toward the individual rather than the disease alone. Remedies such as **Sulphur**, **Graphites**, **Sepia**, **Tellurium**, **Silicea**, **Arsenicum album**, **Natrum muriaticum**, and **Thuja occidentalis** are frequently encountered in homoeopathic

literature; however, their prescription depends entirely on the individual's symptom totality and constitutional state rather than on the diagnosis itself.

Consequently, individualized prescribing remains the cornerstone of homoeopathic management.

Although homoeopathy and conventional medicine explain disease through different theoretical models, both acknowledge that the host plays a decisive role in determining disease occurrence and outcome. This shared emphasis on host susceptibility provides a conceptual bridge between modern immunology and homoeopathic philosophy and forms the basis for future interdisciplinary research.

Current Evidence and Future Directions

The current evidence supporting homoeopathy in the management of fungal disorders remains limited when compared with conventional antifungal research. Most published studies consist of case reports, case series, observational studies, and a small number of experimental investigations. Although several reports describe favourable outcomes following individualized homoeopathic treatment in patients with recurrent fungal infections, the available evidence is insufficient to establish definitive conclusions because of methodological limitations, small sample sizes, and the lack of adequately controlled clinical trials.^{13–15}

Experimental studies have investigated the antifungal activity of selected homoeopathic preparations against organisms such as *Candida albicans* and certain dermatophytes. While some in vitro studies have demonstrated inhibitory effects, their findings remain inconsistent and their clinical applicability has yet to be established. Likewise, published case reports and observational studies provide valuable clinical observations but do not offer the level of evidence required to confirm therapeutic efficacy. Therefore, these findings should be interpreted with appropriate scientific caution.^{14–16}

From a contemporary medical perspective, invasive opportunistic fungal infections require prompt diagnosis, evidence-based antifungal

therapy, and correction of the underlying immunocompromised state. Within this context, homoeopathy may be considered an individualized complementary approach in selected clinical situations, particularly for patients with recurrent superficial fungal infections where constitutional management is appropriate. However, it should not be regarded as a replacement for established conventional treatment in severe or life-threatening invasive fungal diseases.

Future research should prioritize well-designed randomized controlled trials, multicentre observational studies, and standardized reporting of individualized homoeopathic interventions. Collaborative research involving clinicians, microbiologists, immunologists, and homoeopathic researchers may further explore the relationship between host susceptibility, constitutional characteristics, and recurrent fungal infections. Strengthening the quality of evidence will be essential to better define the potential role of homoeopathy within the broader context of patient-centred care.

Integrative Perspective

The increasing burden of opportunistic fungal infections among immunocompromised individuals underscores the importance of adopting a comprehensive understanding of disease that considers both pathogen-related and host-related factors. Modern medical mycology has significantly advanced the understanding of fungal pathogens, host–pathogen interactions, diagnostic methods, and antifungal therapy, leading to improved survival in many high-risk patients. Nevertheless, recurrent infections, antifungal resistance, and the expanding population of immunocompromised individuals continue to present important clinical challenges.^{1–3}

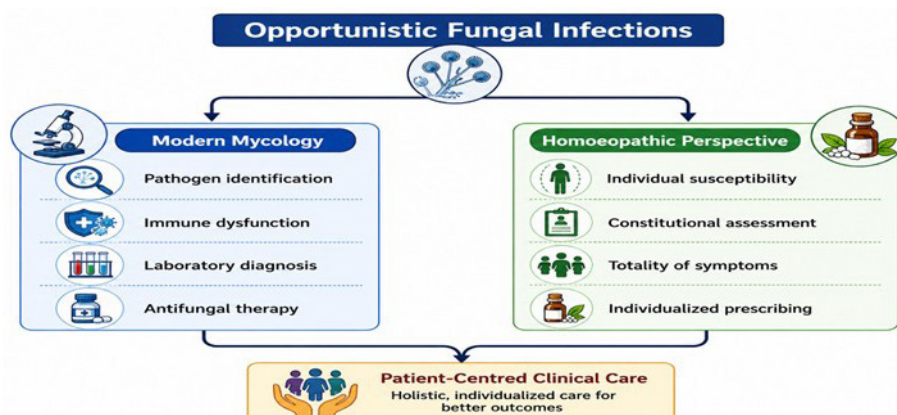
Homoeopathy approaches the same clinical problem from a different philosophical perspective by emphasizing the individual's susceptibility, constitutional characteristics, and symptom totality. While these concepts differ from the immunological framework of conventional medicine, both systems acknowledge that the host plays a central role in determining disease occurrence and outcome. Modern medicine explains susceptibility through measurable alterations in immune function, whereas homoeopathy interprets

susceptibility as an individual's constitutional responsiveness to disease.^{5–7}

Rather than viewing these perspectives as competing, they may be regarded as complementary in understanding different dimensions of patient care. Modern medicine provides evidence-based diagnosis and treatment that are indispensable

for the management of acute and invasive opportunistic fungal infections. Homoeopathy, within its own philosophical framework, emphasizes individualized patient assessment and long-term constitutional management. Integrating these perspectives encourages a broader appreciation of host-centred care while recognizing the distinct principles and scope of each system.

Figure 3: Integrating Modern Mycology and Homoeopathic Perspective



Future interdisciplinary research should explore host susceptibility using rigorous scientific methodologies while encouraging dialogue between medical mycology, immunology, and homoeopathy. Such an approach may contribute to a more comprehensive understanding of recurrent fungal disorders and support the development of holistic, patient-centred healthcare strategies.

CONCLUSION

Opportunistic fungal infections remain a significant cause of morbidity and mortality among immunocompromised individuals, with their increasing incidence driven by the growing prevalence of diabetes mellitus, HIV infection, malignancies, organ transplantation, and immunosuppressive therapies. Although substantial advances in medical mycology have improved the understanding of fungal pathogens, diagnostic techniques, and antifungal treatment, early diagnosis and effective management continue to be challenged by antifungal resistance, recurrent infections, and persistent host susceptibility.^{1–3}

This review highlights that host susceptibility is a critical determinant in the development and progression of opportunistic fungal infections.

Modern medicine explains this susceptibility through alterations in immune function, whereas homoeopathy emphasizes the constitutional state and individual susceptibility as the basis for disease occurrence and therapeutic decision-making. Although these perspectives arise from different theoretical frameworks, both recognize the importance of the host in influencing disease expression and clinical outcomes.

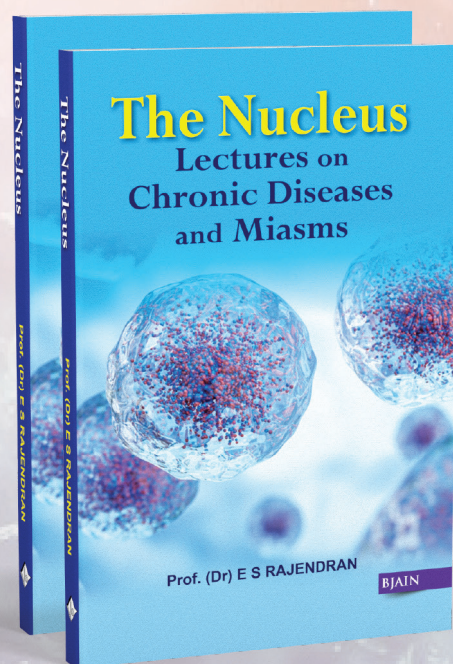
Current evidence supporting homoeopathy in fungal disorders remains limited and is largely based on case reports, observational studies, and experimental investigations. Therefore, individualized homoeopathic management should be interpreted within its own philosophical framework, while acknowledging that invasive opportunistic fungal infections require prompt diagnosis and evidence-based conventional antifungal therapy.

Future research should focus on high-quality clinical studies, standardized reporting, and interdisciplinary collaboration to further explore host susceptibility and individualized approaches to patient care. By integrating contemporary advances in medical mycology with a host-centred perspective, this review aims to encourage further research and contribute to a more comprehensive

understanding of opportunistic fungal infections.

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Host Fungus Interaction And Homoeopathic Susceptibility: Interpreting Modern Immunology Through The Lens Of Homoeopathic Philosophy

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Abstract

Fungal infections range from superficial dermatophytosis to life-threatening invasive disease, and their global concern is rising with antifungal resistance and increasing numbers of immunocompromised patients. Although many are exposed to environmental and commensal fungi, only a small group develop disease, suggesting that host factors play a crucial role rather than exposure alone. Modern immunology explains this through innate defences, adaptive Th1/Th17 responses, host genetics, skin barrier integrity, and gut microbiome composition. Homoeopathy has long been recognised the same as susceptibility - the individual's capacity to respond to disease, governed by vital force, constitution, and miasmatic predisposition. This review examines host-fungus interactions through both lenses, with clinical relevance in recurrent candidiasis, dermatophytosis, onychomycosis, tinea corporis, and tinea versicolor. However, any integrative link between host-fungus interactions and homoeopathic susceptibility must be approached carefully, requiring sustained experimental and clinical investigation before it can be considered scientifically sound.

1. Introduction

Fungal infections rank among today's major and still-underappreciated health concerns, ranging from highly prevalent superficial conditions that affect the skin, hair, and nails to invasive disease capable of spreading through the body and causing death. Worldwide, more than 600 million

people currently live with superficial fungal infections at any given time, and an estimated 1.7 billion new cases are thought to arise every single year, a scale of disease burden that rivals many far more widely discussed infectious conditions.^[1]

The incidence of systemic fungal disease has climbed steadily alongside the growing numbers of immunocompromised patients worldwide, the expanded use of intensive-care interventions, the increasing frequency of organ transplantation, and the ongoing prevalence of HIV infection and diabetes. An estimated 6.5 million people develop invasive fungal infections each year around the globe, and nearly 3.8 million of them ultimately die as a result, a devastating toll that nonetheless leaves fungal disease an under-recognized and comparatively understudied contributor to infectious mortality worldwide.^[2] Figures of this magnitude point unmistakably to a pressing need for better diagnostic tools, more robust surveillance systems, and more effective treatment strategies than are currently available.

Antifungal resistance has also emerged as a growing threat, eroding the effectiveness of the drug classes most commonly relied upon, azoles, echinocandins, and polyenes. Widespread use of antifungal agents in both medicine and agriculture, together with prolonged courses of treatment, has driven the emergence of drug-resistant organisms, among them *Candida auris*, azole-resistant *Aspergillus fumigatus*, and resistant *Candida* species more broadly. The consequences include more frequent treatment failure, longer hospital

stays, and higher mortality.^{[3][4]}

People are exposed almost continually to fungal spores and commensal fungi present throughout their everyday surroundings, yet illness follows in only a small minority of these encounters, a pattern that strongly suggests host immunity, rather than the exposure itself, largely determines whether disease ultimately develops. A fully functioning innate and adaptive immune system generally protects the individual against fungal disease, whereas immunosuppression, diabetes mellitus, HIV infection, malignancy, corticosteroid therapy, and organ transplantation all substantially raise the risk of both superficial and invasive fungal infection.^{[5][6]}

Homoeopathy captures this very same idea, though from an entirely different conceptual starting point, under the term susceptibility: the patient's inherent predisposition to both disease-causing influences and to therapeutic agents alike. Hahnemann held that disease arises only because the host is susceptible to the morbid agent in question, a stance that makes susceptibility the central determinant of disease development within the homoeopathic framework. Treatment therefore aims not merely to relieve the presenting symptoms but, more fundamentally, to raise the patient's overall vitality while simultaneously reducing that underlying susceptibility.^[7]

2. Biology of Host – Fungus Interaction

2.1 Human Mycobiome

The term human mycobiome refers collectively to the fungal communities that reside on the skin and within the oral, gastrointestinal, respiratory, and genitourinary tracts, forming an often-overlooked component of the body's broader microbial ecosystem. Fungi make up only a small fraction of the overall human microbiome by sheer numbers, yet they nonetheless contribute substantially to maintaining microbial balance and to shaping the behavior of host immunity in ways researchers are only beginning to appreciate fully. *Candida*, *Malassezia*, *Saccharomyces*, *Cladosporium*, and *Aspergillus* number among the most common commensal fungi found across these body sites.^[8] Shifts in mycobiome composition, a state generally referred to as fungal dysbiosis, have been

associated with inflammatory bowel disease, allergic conditions, chronic respiratory illness, and invasive fungal infection.^[9] Health, in other words, depends in no small part on the ongoing three-way interaction among fungi, bacteria, and host immunity, rather than on any single one of these components acting alone.

2.2 Opportunistic Fungi

Opportunistic fungi normally live as harmless commensals or environmental saprophytes, turning pathogenic only once host defenses falter. *Candida albicans*, *Aspergillus fumigatus*, *Cryptococcus neoformans*, *Pneumocystis jirovecii*, and the emerging pathogen *Candida auris* count among the principal organisms in this category.^[10] Opportunistic fungal infections have become considerably more common in immunocompromised patients.^[11]

2.3 Colonization versus Infection

Colonization describes fungi that persist and multiply on body surfaces without invading tissue or producing symptoms, and many individuals carry *Candida* species in this way without ever developing disease.^[12]

Infection, by contrast, occurs once fungi breach host tissue and overwhelm host defenses, triggering inflammation and clinical symptoms. Whether colonization progresses to infection depends less on exposure than on the fungus's virulence factors, disruption of the resident microbiota, breakdown of epithelial barrier function, and suppression of host immunity.^[13] Distinguishing colonization from true infection matters clinically, because inappropriate antifungal use in colonized but asymptomatic individuals can itself promote the development of drug resistance.

2.4 Virulence Factors of Fungi

Virulence factors are the traits that let fungi adhere to host tissue, invade cells, withstand host immunity, and survive within the host. Adhesins, the morphogenetic switch from yeast to hyphal form, secretion of hydrolytic enzymes (proteases, phospholipases, and lipases), toxin production, thermotolerance, iron acquisition, and antioxidant enzymes that neutralize oxidative stress all fall into this category.^[14] These properties both promote fungal survival and drive disease severity.

2.5 Biofilm Formation

Biofilms are organized microbial communities encased in an extracellular polymeric matrix that attach readily to living tissue and to medical devices. Once established, biofilms confer resistance to antifungal drugs, shield fungal cells from host defenses, and promote chronic infection; fungal cells embedded within a biofilm also display altered metabolism and reduced susceptibility to both drugs and phagocytic attack.^[15]

2.6 Immune Evasion

Pathogenic fungi employ a range of strategies to escape host immunity: masking immunogenic cell-wall components such as β -glucans, building a protective capsule as *Cryptococcus neoformans* does, blocking phagocytosis, neutralizing reactive oxygen species, surviving inside macrophages, and secreting factors that dampen inflammatory cytokine production.^[16] Understanding these evasion mechanisms is important for designing new antifungal agents and for developing therapeutic strategies aimed at host-directed targets.

3. Modern Immunology Of Fungal Susceptibility

3.1 Innate Immunity

Innate immunity is the body's first and most immediate defence against fungal pathogens, preventing their colonization, tissue invasion, and systemic dissemination.^[17] It relies on pattern-recognition receptors (PRRs) to identify fungal pathogen-associated molecular patterns (PAMPs). Among the key PRRs involved in antifungal defence are Dectin-1, Dectin-2, Dectin-3, Mincle, Toll-like receptors (TLR2 and TLR4), the mannose receptor, and complement receptors. Activation of these receptors initiates intracellular signalling through the SYK–CARD9–BCL10–MALT1 pathway, leading to NF- κ B activation and the production of pro-inflammatory cytokines such as TNF- α , IL-1 β , and IL-6, which coordinate the early antifungal response.^[18]

Macrophages are the first resident immune cells to recognize and phagocytose fungal pathogens, whereas neutrophils eliminate fungal hyphae through phagocytosis, oxidative burst, degranulation, antimicrobial peptide release, and

neutrophil extracellular traps (NETs). Dendritic cells serve as a crucial link between innate and adaptive immunity by processing fungal antigens and presenting them to T lymphocytes.^{[17][18]}

3.2 Adaptive Immunity

Adaptive immunity provides a highly specific and long-lasting immune response against fungal pathogens following antigen presentation by dendritic cells and macrophages.^[19] Naive CD4⁺ T cells differentiate into Th1, Th17, Th2, or regulatory T (Treg) cells, depending on the surrounding cytokine environment. Th1 cells produce interferon- γ (IFN- γ) and TNF- α , enhancing macrophage-mediated fungal killing, whereas Th17 cells secrete IL-17 and IL-22, promoting neutrophil recruitment, antimicrobial peptide production, and maintenance of mucosal barrier integrity.^[19]

In addition, CD8⁺ T cells destroy infected cells, while B cells and antibodies facilitate fungal clearance through opsonization and complement activation. Impairment of adaptive immunity, such as CD4⁺ T-cell depletion in HIV infection or defects in IL-17 signalling, markedly increases the risk of superficial and invasive fungal infections, highlighting the indispensable role of adaptive immune responses in antifungal defence.^[6]

3.3 Genetic Susceptibility to Fungal Infections

Host genetic factors play a significant role in determining susceptibility to fungal infections by influencing fungal recognition and immune responses. Mutations in genes such as CARD9, CLEC7A (Dectin-1), STAT1, STAT3, IL17RA, ACT1, and AIRE impair antifungal immunity, increasing the risk of mucocutaneous candidiasis, invasive candidiasis, aspergillosis, cryptococcosis, and deep dermatophytosis. In addition, polymorphisms in PTX3, Toll-like receptors (TLRs), and CXCR1 have been associated with an increased risk of invasive fungal diseases, particularly in immunocompromised individuals. Understanding these genetic factors has improved knowledge of antifungal host defence and supports the development of personalized approaches to diagnosis, risk assessment, and immunotherapy.^{[6][20]}

3.4 Skin Barrier Dysfunction

The skin is an important physical and immunological barrier against fungal pathogens. Its protective function depends on an intact stratum corneum, acidic surface pH, antimicrobial peptides such as β -defensins and LL-37, and the resident skin microbiota, all of which help prevent fungal colonization and invasion. Disruption of this barrier due to trauma, burns, surgery, chronic wounds, diabetes mellitus, prolonged steroid therapy, excessive moisture, or genetic defects such as filaggrin (FLG) mutations increases susceptibility to fungal infections.^[17] Keratinocytes actively participate in antifungal defence by recognizing fungal pathogens through Dectin-1, Toll-like receptors, and other pattern-recognition receptors, leading to the release of cytokines and chemokines that recruit immune cells to the site of infection. Defects in these protective mechanisms facilitate both superficial and invasive fungal infections, highlighting the importance of maintaining skin barrier integrity.^{[17][18]}

3.5 Gut Microbiome

The gut microbiome plays a vital role in maintaining immune homeostasis and protecting against fungal infections. A healthy and diverse intestinal microbiota limits fungal growth by competing for nutrients, producing antimicrobial metabolites such as short-chain fatty acids, strengthening the intestinal barrier, and stimulating the production of antimicrobial peptides. It also regulates innate and adaptive immunity by promoting the activity of dendritic cells, macrophages, regulatory T cells, and Th17 cells, while enhancing the production of IL-17 and IL-22, which are essential for mucosal defence.^[19] Disruption of the gut microbiome (dysbiosis), often caused by antibiotics or underlying illness, promotes fungal overgrowth and increases susceptibility to opportunistic fungal infections.^[6] Therefore, maintaining a balanced gut microbiome is increasingly recognized as an important strategy for supporting antifungal immunity and preventing fungal disease.^[17]

3.6 Why Does Everyone Exposed to Fungi Not Develop Infection?

People inhale, ingest, and come into skin contact with fungal spores and yeasts on a near-continuous,

almost daily basis over the course of their lives, yet infection rarely follows any single one of these encounters, because effective host defenses generally clear the organisms before they ever have the chance to establish themselves. Intact skin, mucous membranes, mucus, and tight junctions prevent fungal attachment and invasion in the first place, together with the resident skin microbiome, restrains fungal growth through colonization resistance.^{[17][18]}

Two distinct defense strategies provide a host with survival to infectious diseases: resistance and tolerance. Resistance is dependent on the ability of the host to kill pathogens. Tolerance promotes host health while having a neutral to positive impact of pathogen fitness.^[21] Resistance is meant to reduce pathogen burden during infection through innate and adaptive immune mechanisms, whereas tolerance mitigates the substantial cost of resistance to host fitness through a multitude of anti-inflammatory mechanisms, including immunological tolerance.^[22] Immune mechanisms of disease tolerance function independently of pathogen killing. Studying tolerance to pathogens could reveal novel immune mechanisms. Tolerance requires collaboration between host metabolism and immunity. Environmental factors (eg microbiota) influence immunity and tolerance to disease.

4. Homoeopathic Concept Of Susceptibility

Homoeopathic susceptibility reveals itself either as a response to some external force acting upon the organism or as a shift in internal energy that disturbs the individual from within, quietly, before any overt symptom appears. In broad terms, it denotes the organism's overall capacity to be affected by disease-causing influences and to react, in its own particular way, to irritants of every kind. Because a living organism exists in a continual state of renewal and repair, it is also inevitably subject to small cellular-level errors that arise from ongoing degeneration and from genetic mutation over the course of a lifetime. Susceptibility to disease is shaped by numerous contributing factors working together, among them the microbiome, inoculum, sex, temperature, environment, age, chance, personal history, immunity, nutrition, and genetics. This multifactorial picture

aligns closely with homoeopathic thinking on the subject and helps explain why a broad, integrative approach is required if one hopes to understand the pathogenesis of susceptibility in any given patient.^[23]

Homoeopathic principles hold that two people exposed to an identical pathogen or environmental stressor can respond in entirely different ways, a divergence attributed not to genetic differences alone but to differing inner vital susceptibility. The genome sets out a fixed range of possibilities, while the epigenome determines which of those possibilities is actually expressed, in which tissues, to what degree, and in response to which stimuli.^[24]

Hahnemann's vital force is not some mysterious abstraction but a dynamic, self-regulating, hierarchically organized principle that keeps the organism in optimal condition and responds adaptively to disturbances of any kind, whether disease itself or therapeutic intervention. One of the most demanding and defining features of homoeopathic practice is its insistence on individualization: choosing a remedy not on the strength of diagnosis alone but according to the unique totality of physical, mental, and emotional symptoms that mark a given patient's experience of illness. In carrying out a thorough case-taking, the homoeopath therefore builds a comprehensive picture of the patient's constitution and of how that patient reacts to environmental stimuli at the physical, emotional, and mental levels alike. The constitution arrived at in this way mirrors the patient's underlying susceptibility pattern. The parallel between susceptibility and epigenetic vulnerability reflects a broader understanding that disease expression is individual, dynamic, and environmentally responsive, while the regulatory concept of vital force echoes Hahnemann's original view of the organism as a complex biological network.^[24]

Chronic disease cannot be attributed to the causative pathogen alone; it depends heavily on the individual's susceptibility to that particular agent, which drives the disease process forward and reflects the body's capacity to register and respond to both external and internal cellular injury.

Homoeopathy regards the origin of disease and the patient's susceptibility as inseparably linked,

both being central to how chronic disease develops. For this reason, factors such as gestational state, family history, causation, modalities, diet, and emotional stress all carry weight in homoeopathic practice.^[23]

In Aphorism 77, Hahnemann proposes that chronic disease can arise not only through miasms, the inherited pathway of transmission, but also through drugs or treatments that alter the organism, modifying its vital force by way of susceptibility. Aphorism 31 adds that disease-producing agents can act only on an organism that is susceptible to their influence in the first place.

5. Bridging Two Concepts

The concept of susceptibility occupies an important place in both modern immunology and homoeopathic philosophy, although the two disciplines interpret it from different perspectives. In modern immunology, susceptibility refers to the host's likelihood of developing disease based on factors such as immune competence, genetic makeup, environmental influences, and immune regulation.^{[18][5]} In homoeopathy, susceptibility is viewed as the dynamic state of the individual that is governed by the vital force, constitutional characteristics, and miasmatic predisposition.^[7] Although these explanations arise from different scientific and philosophical frameworks, both recognize that the host's internal condition plays a decisive role in determining whether exposure to a pathogen ultimately leads to disease.^{[5][25]}

A comparable philosophical principle is described by Samuel Hahnemann in the *Organon of Medicine*.

In Aphorism 9, he states:

"In the healthy condition of man, the spiritual vital force (autocracy), the dynamis that animates the material body (organism), rules with unbounded sway, and retains all the parts of the organism in admirable, harmonious, vital operation, as regards both sensations and functions, so that our indwelling, reason-gifted mind can freely employ this living, healthy instrument for the higher purpose of our existence."^[7]

This aphorism explains that health is maintained by the harmonious action of the vital force.

According to Aphorisms 10 and 11, disease begins when this dynamic vital force becomes disturbed by a morbid influence, resulting in altered sensations and functions before structural changes become evident.^[7] Thus, while immunology explains resistance through immune competence, homeopathy attributes health to the harmonious functioning of the vital force. The importance of host susceptibility represents one of the strongest conceptual similarities between the two disciplines. Modern immunology recognizes that exposure to the same fungal organism does not produce identical outcomes in every individual. Differences in immune competence, age, nutritional status, microbiome composition, genetic polymorphisms, and associated medical conditions determine whether infection develops and how severe it becomes.^{[5][26]}

Hahnemann expressed a similar concept in the *Organon*. Aphorism 31 states:

“The inimical forces, partly psychical, partly physical, to which our terrestrial existence is exposed, which are termed morbid noxious agents, do not possess the power of morbidly deranging the health of man unconditionally; but we are made ill by them only when our organism is sufficiently disposed and susceptible to attack of the morbid cause that may be present, and to be altered in its health, deranged and made to undergo abnormal sensations and functions – hence they do not produce disease in every one nor at all times.”^[7]

This statement reflects the principle that disease depends not merely on exposure to a pathogenic agent but also on the susceptibility of the individual. Although expressed within different conceptual systems, this idea resembles the modern understanding that host immunity frequently has a greater influence on disease development than exposure to fungi alone.

Modern biomedical research also demonstrates that genetic predisposition contributes significantly to susceptibility.

Homeopathy approaches this concept through the doctrine of the constitution. Constitutional characteristics include inherited and acquired physical, mental, and emotional traits that

influence an individual's susceptibility to disease and form the basis of individualized remedy selection.^{[7][27]} Although constitutional theory is not equivalent to genetic susceptibility, both perspectives acknowledge that inherent characteristics of the individual influence disease expression and clinical outcome.

Another important point of comparison is the relationship between immune dysregulation and miasmatic predisposition. Modern immunology has shown that defective immune regulation and persistent inflammatory responses contribute to recurrent fungal infections, chronic inflammation, and progressive tissue injury.^[5] Homeopathy explains recurrent and chronic diseases through the doctrine of chronic miasms. In Aphorism 78, Hahnemann wrote:

“The true natural chronic diseases are those that arise from a chronic miasm.”^[7]

According to homeopathic philosophy, Psora, Sycosis, and Syphilis represent chronic miasmatic influences that modify susceptibility and contribute to the persistence and recurrence of disease. While these concepts are philosophical rather than experimentally established immunological mechanisms, both systems emphasize that long-standing internal disturbances play an important role in chronic disease.

Overall, modern immunology and homeopathic philosophy converge in recognizing that host-related factors are central to disease development, even though they explain these factors differently. Modern immunology interprets susceptibility through measurable biological processes, including immune competence, genetic influences, inflammatory regulation, and host–pathogen interactions.^{[18][5]} Homeopathy explains susceptibility through the concepts of the vital force, constitution, and miasmatic predisposition.^[7] These concepts should not be regarded as direct scientific equivalents; however, both frameworks emphasize that disease depends not only on the presence of a pathogen but also on the characteristics of the host. This conceptual parallel provides a useful basis for discussing host–fungus interactions and may encourage future interdisciplinary research exploring individualized approaches to infectious diseases.^[25]

6. Clinical Relevance Of Host – Fungus Interaction

6.1 Candidiasis

Candidiasis, and vulvovaginal candidiasis in particular, offers a textbook illustration of how host susceptibility shapes fungal disease. Roughly 5–8% of women of reproductive age experience recurrent episodes, defined as at least three symptomatic flares within a single year, and although *Candida albicans* remains the predominant causative organism, recurrence is driven mainly by defects in host immunity rather than by any special virulence of the fungus.

Immune dysregulation underlying recurrent disease includes disturbances in innate immunity, impaired Th17 responses, deficient IL-17 and IL-22 production, and predisposing conditions together with genetic polymorphisms affecting pattern-recognition receptors. Biofilm formation by *Candida* compounds the problem, heightening antifungal resistance and persistence and making eradication difficult. Recurrent candidiasis therefore demonstrates that disease severity hinges largely on host immunity and susceptibility rather than on fungal exposure alone. ^{[28][15]}

6.2 Dermatophytosis

Dermatophytosis, caused by dermatophyte fungi, ranks among the most common superficial infections. It begins when the pathogen's arthroconidia adhere to keratinized tissue, after which secreted keratinases and proteases facilitate invasion. In chronic or recurrent disease tends to arise from defective cell-mediated immunity, diabetes, malnutrition, excessive sweating, tight clothing, or corticosteroid misuse. Recent trends point to a rising frequency of chronic dermatophytosis alongside the emergence of antifungal-resistant *Trichophyton* strains. ^[29]

6.3 Onychomycosis

Onychomycosis, a chronic infection of the nail apparatus, is caused predominantly by dermatophytes, *Trichophyton rubrum* foremost among them, though yeasts and non-dermatophyte moulds can also be responsible. The nail plate's poor vascularity makes it a relatively protected site, one that immune cells and antifungal drugs

alike struggle to penetrate. Advanced age, diabetes mellitus, peripheral vascular disease, immunosuppression, nail trauma, and individual susceptibility all raise the risk of infection, and fungal biofilm formation adds a further mechanism sustaining chronicity. Onychomycosis thus exemplifies a disease in which insufficient local host defense allows chronic colonization and recurrent infection to take hold. ^[30]

6.4 Tinea Corporis

Tinea corporis, commonly known as ringworm of the body, is a superficial dermatophyte infection of the hairless skin that develops following direct contact with an infected person, animal, or object.

An effective response confines the infection to localized foci that generally respond well to topical treatment, whereas patients with impaired immunity may develop disseminated, atypical, chronic, or recurrent disease requiring systemic antifungal therapy. Misuse of topical corticosteroids can suppress local immunity further, giving rise to the altered clinical presentation known as tinea incognito. ^[31]

6.5 Tinea Versicolor

Tinea versicolor, also known as pityriasis versicolor, results from infection by *Malassezia*, a lipophilic fungus that ordinarily lives as a natural constituent of the skin flora. Disease emerges when the fungus converts from its commensal to its pathogenic form under favorable host conditions, excessive sweating, a humid environment, heightened sebaceous gland activity, pregnancy, malnutrition, diabetes mellitus, corticosteroid use, or immunosuppression among them. Patients typically present with recurring hypopigmented or hyperpigmented scaly macules, mainly on the trunk and upper limbs. Because *Malassezia* persists within the skin flora, relapses are frequent, and host predisposition matters far more to recurrence than fresh reinfection does; some patients require long-term prophylactic antifungal therapy. ^[32]

7. Homoeopathic Perspective

7.1 Individualisation in Homoeopathy

Individualisation refers to the practice of selecting

a remedy on the basis of a patient's total symptom picture, taken as a whole, rather than on the basis of the diagnosed disease category alone. Hahnemann held that every individual responds to illness in his or her own distinctive way, according to physical constitution, mental and emotional disposition, inherited predisposition, environmental influence, and susceptibility. Homoeopathic treatment accordingly attends to a patient's characteristic symptoms, modalities, causation, temperament, and constitution in order to identify the *simillimum*, the remedy that best corresponds to that person. ^{[7][27]} In contemporary practice, individualisation is increasingly understood as a patient-centered approach that combines clinical diagnosis with the totality of symptoms to achieve the best possible outcome. ^{[33][34]} Even so, while individualisation remains a foundational principle of homoeopathy, the scientific evidence supporting its clinical efficacy is still debated. ^[34]

7.2 Constitutional Prescription

Constitutional prescribing, a core principle of homoeopathy, bases remedy selection not on diagnostic data but on the patient's overall constitution, physical structure, physiology, mental and emotional disposition, temperament, hereditary predisposition, susceptibility, lifestyle, and total symptom picture. ^[33] Hahnemann viewed every patient as unique in his or her response to disease and held that the physician's task was to prescribe the *simillimum* matching that individual's full symptom totality in order to restore health. ^[7] In practice, constitutional prescribing weighs thermal preferences, food cravings and aversions, sleep patterns, sweating, reactions to various influences, miasmatic background, family history, and other patient-specific data, directing treatment at the whole organism rather than at isolated symptoms. ^[27] It finds frequent use in chronic disease, where the goal is to strengthen the organism's self-regulation, lower susceptibility, and prevent recurrence. ^[33]

Contemporary practitioners continue to treat constitutional prescribing as the cornerstone of individualized care, even as its clinical effectiveness remains an open question under ongoing scientific scrutiny. ^[34]

7.3 Role of Susceptibility in Remedy Selection

Susceptibility, the individual's inherent capacity to respond to disease, environmental influence, and homoeopathic medicine, functions as the central principle guiding remedy selection in classical homoeopathy. ^{[7][34]} Hahnemann considered susceptibility the basis both for how disease develops and for how the *simillimum* exerts its curative effect. ^[7] During case-taking, the physician assesses constitutional features, mental and emotional state, physical generals, characteristic symptoms, hereditary and miasmatic background, vitality, and other environmental factors in order to gauge susceptibility and select the appropriate remedy. ^{[7][27]} Susceptibility also informs decisions about potency, dose, and repetition frequency, since highly susceptible patients generally require fewer repetitions, while those with diminished vitality or advanced pathology call for greater caution. ^[33] Kent argued that attending to susceptibility enabled truly individualised prescribing, minimized unnecessary aggravations, and achieved a gentler cure. ^[35] Susceptibility therefore remains one of the principles binding together individualisation, constitutional prescribing, and remedy selection in classical homoeopathy. ^{[7][34][35]}

7.4 Importance of Addressing the Patient's Overall State

Classical homoeopathy treats the patient as a whole person rather than focusing on a disease entity or a single affected organ. Since every individual has a distinct constitution, susceptibility, and way of reacting to illness, treatment requires evaluating the totality of symptoms, mental and emotional state, physical generals, constitutional features, particular symptoms, modalities, exciting and maintaining causes, hereditary predisposition, occupation, habits, lifestyle, and environmental influences included. ^{[7][27]} Hahnemann maintained that this totality of symptoms is the only reliable guide to selecting the *simillimum*, since it reflects disturbance of the vital force rather than a diagnostic label. ^[7] Constitutional prescribing seeks to restore harmony to the vital force, improve general health, strengthen resistance to disease, and lower susceptibility to recurrence by addressing the underlying constitutional disturbance rather than suppressing individual

symptoms. [27][33] Kent emphasized that shifts in mental and emotional state, energy level, appetite, sleep, thermal reactions, and overall well-being should all be read as indicators of cure. [35] Attending to the patient's general state therefore remains the foundation on which both individualisation and constitutional prescribing rest. [7][34] [35]

7.5 Limitations

This review is based on published literature and does not include original experimental or clinical data. The proposed relationship between host–fungus interactions and homoeopathic susceptibility remains theoretical, as direct scientific evidence is currently limited. Further interdisciplinary and well-designed clinical studies are needed to validate these concepts.

8. Future Research Directions

Future work in this area should aim, above all, to translate the philosophical construct of homoeopathic susceptibility into a hypothesis that can actually be tested rigorously in the clinic, a task considerably complicated by the current lack of any validated, universally accepted biomarkers for susceptibility. One useful direction would be to determine whether patients with recurrent fungal infections show measurable changes in IL-17 and IL-22 levels, TNF- α and IFN- γ responses, antimicrobial peptide expression, or serum immunoglobulin profiles; existing reviews have already established the pivotal role of Th17-mediated immunity in mucosal defense against fungal pathogens. [36]

Prospective cohort studies could further examine recurrence frequency alongside constitutional factors, stress and lifestyle variables, microbiome changes, and immune responses. Recent work in fungal immunology has identified CARD9 deficiency in humans as a key factor underlying recurrent and severe fungal infection, since the CARD9 protein is essential to antifungal immune surveillance through its role in signaling pathways downstream of fungal pattern-recognition receptors. [37] On the homoeopathy side, recent methodological efforts have attempted to build structured tools for measuring susceptibility and responsiveness to homoeopathic potencies, and

mixed-methods studies have produced preliminary instruments that could improve the reliability and reproducibility of clinical research in this area. [38] Continued development of such susceptibility scales could eventually yield criteria for grading degree of susceptibility, remedy sensitivity, potency selection, and prognosis. [39]

Rigorous experimental and clinical research remains essential if any proposed integrative framework linking host–fungus interaction with homoeopathic susceptibility is to be placed on scientifically credible footing.

9. CONCLUSION

Taken together, the evidence reviewed throughout this paper points to a single idea running through both approaches, however differently each one expresses it: fungal exposure is common, almost universal in fact, but disease is not, and that gap between exposure and illness is explained chiefly by differences among hosts rather than by any special property of the fungi themselves. Immunology and homoeopathy arrive at this same underlying conclusion from very different starting points and by very different routes, one working through pattern-recognition receptors, cytokines, and intracellular signaling pathways, the other through the language of vital force and constitutional susceptibility, and yet both ultimately place the host, rather than the fungus, at the center of the infectious process.

Recurrent vulvovaginal candidiasis, dermatophytosis, and onychomycosis all illustrate the point: some patients develop these conditions despite fungal exposure comparable to that of people who never fall ill. None of this implies that the two frameworks are interchangeable. The concepts of vital force and miasmatic theory still lack direct scientific support, whereas immunological susceptibility rests on a well-established foundation of receptors, cytokines, and genetic markers.

Even so, both traditions converge on the view that host individuality matters as much as pathogen behavior, an insight modern immunology is only now confirming through genetic and immune profiling of patients. Moving this conversation forward will require developing genuine measurement tools for susceptibility, tools that could

eventually put to the test what homoeopathy has long observed in clinical practice and, where appropriate, integrate it with host-directed strategies in the broader management of fungal disease.

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Sporotrichosis: The Rose Gardener's Disease and Homeopathic Management

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Abstract

Background- Sporotrichosis is a chronic subcutaneous fungal infection caused by members of the *Sporothrix* species complex, predominantly *Sporothrix schenckii*. The fungus is commonly found in soil, decaying vegetation, wood, hay, and sphagnum moss. Infection generally occurs following traumatic inoculation of the organism into the skin. Clinically, sporotrichosis commonly presents as a papule or nodule at the site of inoculation, which may ulcerate and subsequently spread along the lymphatic channels. Osteoarticular, pulmonary, and disseminated forms may occur, particularly in immunocompromised individuals. Fungal culture remains the gold standard for laboratory confirmation, and timely antifungal treatment is important to prevent progression and complications.

Objective- To describe the clinical features, diagnosis, and potential complementary role of individualized homeopathic treatment in patients presenting with chronic suppurative skin lesions and lymphatic involvement resembling sporotrichosis.

Methodology- A descriptive approach was used to review the clinical presentation and conventional diagnostic considerations of sporotrichosis, along with homeopathic remedies traditionally described for chronic suppurative skin lesions, ulcers, and lymphatic involvement. Remedies including *Silicea*, *Hepar sulphuris calcareum*, *Graphites*, *Arsenicum album*, *Mercurius solubilis*, *Calcar-
ea sulphurica*, *Myristica sebifera*, and *Sulphur* were

considered based on the individual symptom profile and totality of symptoms. Fungal culture was considered the standard method for confirmation of sporotrichosis.

Results- Sporotrichosis typically develops after traumatic inoculation, with lesions appearing after an incubation period of several days to weeks. The infection may remain localized or progress through lymphatic channels. In homeopathic practice, the selection of a remedy is individualized according to the patient's presenting symptoms and overall clinical characteristics. The above-mentioned remedies have been traditionally described in relation to chronic suppuration, ulceration, induration, and lymphatic involvement. However, there is currently insufficient clinical evidence to establish the effectiveness of these remedies as a treatment for confirmed sporotrichosis.

Conclusion- Sporotrichosis is an important chronic fungal infection that requires appropriate clinical recognition and laboratory confirmation, particularly by fungal culture. Early conventional antifungal therapy is essential for confirmed infection and for preventing complications. Individualized homeopathic treatment may be explored as a complementary approach to patient care, but it should not replace established antifungal therapy. Further well-designed clinical research is required to determine whether homeopathic interventions have any demonstrable benefit in the management of sporotrichosis.

Keywords

Sporotrichosis, *Sporothrix schenckii*, Immuno-compromised, verrucous lesions, Homoeopathy.

Introduction

Sporotrichosis, commonly known as "Rose Gardener's Disease," is a subacute or chronic subcutaneous fungal infection caused by the dimorphic saprophytic fungus *Sporothrix schenckii* and other members of the *Sporothrix* species complex. The fungus is widely distributed in soil, decaying vegetation, sphagnum moss, hay, and wood. Infection usually occurs following traumatic inoculation of the fungus into the skin through thorns, splinters, or other contaminated plant materials. The disease primarily affects the skin and lymphatic system but may involve bones, joints, lungs, or other organs, particularly in immunocompromised individuals.

Subcutaneous mycoses are fungal infections involving the skin, subcutaneous tissue, fascia, and occasionally deeper structures such as bones and internal organs. They account for a small proportion of all fungal infections and are most commonly acquired through traumatic implantation of environmental fungi present in soil, decaying vegetation, and plant materials. Although these infections have traditionally been associated with tropical and subtropical regions, their incidence has increased globally due to travel, occupational exposure, and changing environmental conditions. The growing number of immunocompromised individuals, including those with HIV/AIDS, malignancies, organ transplants, or receiving immunosuppressive therapy, has further contributed to their rising prevalence.

Among the various subcutaneous mycoses, sporotrichosis is one of the most common and widely distributed infections worldwide. It is caused by fungi belonging to the *Sporothrix schenckii* species complex and typically presents with a wide range of cutaneous manifestations, including nodules, plaques, ulcers, verrucous lesions, cystic swellings, and lymphatic involvement. This diverse clinical presentation often resembles other infectious or non-infectious skin disorders, making diagnosis challenging, particularly in non-endemic regions. Delayed diagnosis may result in

prolonged disease, increased morbidity, and, in immunocompromised patients, dissemination to extracutaneous sites. Therefore, prompt recognition and appropriate treatment are essential for favorable clinical outcomes.

Epidemiology:

Sporotrichosis can affect individuals of any age, sex, or ethnic background because the likelihood of infection depends primarily on exposure to the fungus in the environment and the route through which it enters the body. Although many studies report a higher incidence among males, this is generally explained by greater occupational and environmental exposure rather than an inherent biological susceptibility.

The infection is most commonly acquired through traumatic implantation of the fungus into the skin. As a result, exposed body sites, particularly the extremities, are affected most frequently, with the upper limbs involved nearly twice as often as the lower limbs, while involvement of other body regions is relatively uncommon.

Aetiology:

Sporotrichosis is particularly prevalent in rural settings, where occupations involving frequent contact with plants, soil, or organic matter increase the risk of infection. Farmers, gardeners, florists, forestry workers, and nursery employees are among the groups most commonly affected. Most patients are between 20 and 50 years of age, representing the period of greatest occupational activity and increased likelihood of sustaining minor skin injuries. Infection occurs when *Sporothrix schenckii* is introduced into the skin through punctures or abrasions caused by contaminated thorns, splinters, hay, barbed wire, soil, or other environmental materials. However, only about 10–62% of affected individuals recall a preceding injury, as the trauma is often minor, occurs several weeks before symptom onset, and is easily overlooked.

Although animals are not considered the primary source of human infection, zoonotic transmission has been documented following insect bites, handling of fish, and bites or scratches from cats, birds, dogs, rats, reptiles, and horses. Cats have

emerged as a particularly important reservoir during the prolonged sporotrichosis outbreak in Brazil, where *S. brasiliensis* was identified in the majority of isolates obtained from both humans and felines. This has highlighted veterinary professionals, animal handlers, and cat owners as additional at-risk populations. Human-to-human transmission is uncommon but has been reported, mainly through contamination of wounds by infected dressings or the use of contaminated traditional or herbal topical preparations, suggesting that this mode of transmission may be underrecognized.

Pathogenesis:

The incubation period of sporotrichosis has not been clearly established and may vary from several days to a few months, with an average duration of approximately three weeks. The infection initially involves the skin and adjacent lymphatic vessels, where a small, firm papule or nodule develops at the site of fungal inoculation. This lesion gradually enlarges and may ulcerate, forming a characteristic sporotrichotic chancre, typically in the absence of systemic manifestations. In some patients, the lesion remains localized, whereas in others, additional lesions develop over time.

Clinical Classification:

Clinically, sporotrichosis is classified into three principal cutaneous forms: lymphocutaneous, fixed cutaneous, and multifocal or disseminated cutaneous disease. In certain cases, the infection may extend beyond the skin, resulting in extracutaneous or systemic sporotrichosis. Such dissemination usually occurs through hematogenous spread from the primary inoculation site, regional lymph nodes or more commonly, from a pulmonary focus, particularly in immunocompromised individuals.

In children, the overall clinical presentation resembles that seen in adults; however, facial lesions are encountered more frequently, accounting for approximately 40–60% of cases and reaching as high as 97% in some reported series.

A. Lymphocutaneous Sporotrichosis:

Lymphocutaneous sporotrichosis is the most

frequently encountered clinical form, representing approximately 70–80% of all cases of cutaneous sporotrichosis. The infection predominantly involves the upper and lower extremities. It typically begins with the development of a nodular or ulcerative lesion, known as a sporotrichotic chancre, at the site of fungal inoculation. Over time, additional lesions appear along the course of the draining lymphatic vessels, often accompanied by transient enlargement of the regional lymph nodes.

The secondary lesions may present as erythematous papules, nodules, or plaques with either smooth or verrucous surfaces. As the disease progresses, these lesions can become fluctuant, ulcerate, and produce serous or purulent discharge. Although they are generally painless and asymptomatic, some patients may experience mild itching or tenderness. Similar to the primary lesion, the secondary lesions usually follow a slow, chronic, and indolent clinical course.

Figure 1 – Showing Lymphocutaneous spread of sporotrichosis



B. Fixed Cutaneous Sporotrichosis:

Fixed cutaneous sporotrichosis is a less common clinical presentation in which the infection remains confined to the site of fungal inoculation without spread through the lymphatic channels. Compared with the lymphocutaneous form, involvement of the face is observed more frequently in this variant. The lesions are generally asymptomatic and may appear as erythematous papules,

papulopustules, nodules, verrucous plaques, non-healing ulcers, or small abscesses.

Because of its variable clinical appearance, fixed cutaneous sporotrichosis can mimic several dermatological conditions, including keratoacanthoma, facial cellulitis, pyoderma gangrenosum, prurigo nodularis, soft tissue sarcoma, basal cell carcinoma, erysipeloid, and rosacea. This form is thought to occur predominantly in individuals with relatively strong host immunity, resulting in localized disease. In some cases, the lesions may resolve spontaneously, although they can persist if left untreated. Overall, fixed cutaneous sporotrichosis generally demonstrates a favorable response to appropriate antifungal therapy.

Figure 2- Showing Fixed Cutaneous Sporotrichosis



C. Multifocal or Disseminated Cutaneous Sporotrichosis:

Multifocal or disseminated cutaneous sporotrichosis is an uncommon clinical variant characterized by the presence of three or more lesions distributed across at least two separate anatomical sites. Cutaneous dissemination is believed to result primarily from multiple traumatic inoculations of the fungus into the skin. In rare instances, however, widespread skin involvement may occur through hematogenous dissemination, even in individuals without identifiable risk factors or underlying immunosuppression.

D. Extracutaneous Sporotrichosis:

Extracutaneous sporotrichosis is an

uncommon but severe form of the disease that occurs predominantly in individuals with impaired immunity, including those with diabetes mellitus, chronic alcoholism, HIV/AIDS, malignancies, or those receiving corticosteroids or other immunosuppressive therapies. The infection spreads beyond the skin through hematogenous dissemination, affecting various organ systems.

Osteoarticular involvement is the most frequent systemic manifestation and can occur in both immunocompetent and immunocompromised individuals. It typically presents as chronic monoarthritis involving large joints such as the knee, wrist, elbow, or ankle. Early manifestations include tenosynovitis, bursitis, and joint effusion, while delayed diagnosis may result in progressive joint destruction and functional impairment.

Pulmonary sporotrichosis is a rare form acquired through inhalation of fungal conidia. It commonly presents with chronic cough, low-grade fever, weight loss, and cavitary lung lesions that may resemble pulmonary tuberculosis, particularly in patients with underlying chronic lung disease.

Less commonly, the infection may involve the eyes, paranasal sinuses, or central nervous system. Central nervous system involvement is seen mainly in immunocompromised patients and may present with subtle neurological symptoms, including altered mental status or meningitis.

Diagnosis:-

Early diagnosis of sporotrichosis relies primarily on a high index of clinical suspicion, particularly in patients with a history of environmental exposure or traumatic inoculation. The disease should be differentiated from other conditions with similar clinical presentations, including cutaneous tuberculosis, cutaneous leishmaniasis, nocardiosis, chromoblastomycosis, blastomycosis, paracoccidioidomycosis, atypical mycobacterial infections, and pyoderma gangrenosum.

Direct microscopic examination of pus or tissue specimens has limited diagnostic value because

fungal elements are usually sparse.

Histopathological examination or fine-needle aspiration cytology may occasionally demonstrate granulomatous inflammation, asteroid bodies, or the characteristic cigar-shaped yeast forms when special stains such as Periodic Acid–Schiff (PAS) and Gomori methenamine silver (GMS) are used. However, these findings are inconsistent and cannot reliably establish the diagnosis.

Isolation of *Sporothrix schenckii* by fungal culture remains the gold standard for confirming sporotrichosis.

Animal inoculation studies are rarely required in routine clinical practice.

Miasmatic Analysis of Sporotrichosis:- (According to the 6th Edition of Organon of Medicine)

According to Hahnemann's doctrine of chronic diseases and the principles outlined in the 6th edition of the Organon of Medicine, sporotrichosis may be interpreted as a disease expressing a mixed miasmatic background. Although it is an infectious fungal disease with a definite external cause, the nature, chronicity, tissue changes, and response of the host suggest the predominance of different miasms at various stages of the disease.

Psoric Miasm:

The early stage of sporotrichosis, characterized by localized papules, mild inflammation, itching, and initial skin involvement following inoculation, reflects psoric activity. This stage represents the primary functional disturbance with limited tissue destruction.

Sycotic Miasm:

As the disease progresses, nodular lesions, induration, verrucous plaques, chronic inflammation, lymphatic spread, and persistent subcutaneous swellings indicate a predominance of the sycotic miasm. The proliferative and infiltrative nature of the lesions is consistent with sycotic pathology.

Syphilitic Miasm:

Advanced cases with ulceration, tissue destruction, chronic non-healing ulcers, sinus formation, osteoarticular involvement, or dissemination to

internal organs demonstrate syphilitic characteristics. Bone destruction, necrosis, and severe structural damage are classical manifestations of the destructive syphilitic miasm.

Tubercular Miasm:

In cases showing rapid progression, recurrent lesions, pulmonary involvement, marked debility, emaciation, and a tendency toward dissemination, especially in immunocompromised individuals, a tubercular miasmatic influence may be considered. This miasm represents a combination of psoric and syphilitic tendencies with increased susceptibility and reduced vitality.

Miasmatic Conclusion-

Sporotrichosis is best understood as a mixed miasmatic disease. The disease commonly begins with psoric manifestations, progresses predominantly through the sycotic miasm due to chronic nodular and proliferative changes, and may eventually exhibit syphilitic features when ulceration, tissue destruction, or systemic dissemination occurs. In rapidly progressive or disseminated cases associated with profound constitutional weakness, a tubercular miasmatic background may also be present.

Therefore, from the standpoint of the 6th edition of the Organon of Medicine, successful homeopathic management requires individualization of the patient and selection of the similimum based on the totality of symptoms, constitutional characteristics, and the predominant miasmatic state rather than on the pathological diagnosis alone.

Repertorial Analysis:

- Skin – Ulcers
- Skin – Eruptions
- Skin – Boils
- Skin – Abscess
- Skin – Suppuration
- Glands – Swelling
- Extremities – Ulcers
- Skin – Nodules

- Skin – Granulomatous eruptions
- Skin – Ulcers – edges undermined
- Skin – Suppuration – chronic
- Skin – Fistula
- Skin – Cellulitis

Homeopathic Approach and Commonly Indicated Medicines:-

Homeopathic management is based on the totality of symptoms, constitutional characteristics, and individual susceptibility. Remedy selection depends on the patient's physical, mental, and local symptoms rather than the diagnosis alone. Some commonly indicated remedies include:

1. *Silicea* – Frequently considered for chronic suppurative conditions, recurrent abscesses, non-healing ulcers, and delayed wound healing. It is often indicated when pus formation is persistent and recovery is slow.
2. *Hepar sulphuris calcareum* – Commonly used in painful, highly sensitive suppurative lesions with marked tenderness and offensive purulent discharge. It is often considered when abscesses are progressing toward suppuration.
3. *Graphites* – Indicated for chronic skin disorders with thickened, fissured skin and sticky, honey-like discharge. It may be considered in slow-healing ulcers with unhealthy granulation tissue.
4. *Arsenicum album* – Used in ulcerative skin lesions associated with burning pain, restlessness, weakness, and offensive discharges. Symptoms are often relieved by warmth.
5. *Mercurius solubilis* – Considered in ulcerative lesions with profuse offensive discharge, swollen lymph nodes, excessive perspiration, and symptoms that worsen at night.
6. *Calcarea sulphurica* – Traditionally used for persistent suppuration, chronic abscesses, and wounds that continue to discharge yellow pus despite slow healing.
7. *Myristica sebifera* – Often referred to as the "homeopathic knife" because it is used for

abscesses, boils, and deep-seated suppurative infections where drainage is delayed.

8. *Sulphur* – Frequently prescribed in chronic skin diseases with itching, burning, unhealthy skin, and recurrent eruptions, particularly when healing is prolonged or other remedies have failed to produce lasting improvement.
9. *Calendula officinalis* – Primarily used as a local or internal remedy to promote healthy wound healing, reduce inflammation, and support tissue repair in ulcerative lesions.
10. *Lachesis mutus* – May be considered for bluish or purplish inflamed lesions with marked sensitivity to touch and a tendency toward septic or destructive processes.

The final remedy is selected after individualized case-taking according to classical homeopathic principles.

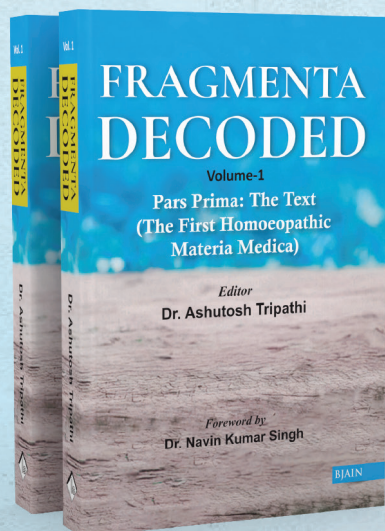
CONCLUSION

Sporotrichosis is a chronic subcutaneous fungal infection that should be considered in patients presenting with persistent nodular, ulcerative, or suppurative skin lesions, particularly when there is lymphatic spread following a history of traumatic inoculation. Accurate diagnosis, with fungal culture serving as an important confirmatory investigation, is essential for appropriate management and prevention of complications. Conventional antifungal therapy remains the established treatment for confirmed sporotrichosis.

Individualized homeopathic remedies traditionally indicated for chronic suppuration, ulceration, induration, and lymphatic involvement may be considered as a complementary component of patient care; however, there is currently insufficient clinical evidence to establish their efficacy in treating sporotrichosis or eradicating the causative fungus. Well-designed clinical studies with confirmed microbiological diagnoses and clinically meaningful outcomes are needed to determine whether individualized homeopathic interventions provide any additional benefit when used alongside standard antifungal treatment.

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Unveiling miasmatic matrix: A Repertorial exploration in Homoeopathic management of Fungal infections.

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Abstract

Background: Fungal dermatoses present a major clinical challenge in dermatology due to high recurrence rates, therapeutic resistance, and chronic host susceptibility. While conventional management focuses primarily on localized antifungal therapy, homoeopathy addresses underlying systemic susceptibility through miasmatic philosophy and repertorial individualization.

Objective: To synthesize classical homoeopathic miasmatic concepts with contemporary immunological insights and repertorial methodology, establishing an integrated conceptual framework for managing fungal dermatoses.

Methodology: Literature from Dr. Samuel Hahnemann's *Organon of Medicine*, classical miasmatic treatises, and modern repertories (such as the Synthesis Repertory) was cross-analysed alongside contemporary dermatological concepts and cutaneous microbiome dynamics.^[4]

Results: Fungal pathologies were mapped across five core miasmatic dynamics: Psoric (functional hypersensitivity), Sycotic (hyperkeratosis and chronicity), Ringworm (alternating struggle and remission), Tubercular (changeable and rapid spread), and Syphilitic (destructive and ulcerative changes).^[9]

Conclusion: Integrating miasmatic dynamics with

repertorial individualization offers a comprehensive homoeopathic framework for addressing systemic host susceptibility, mitigating recurrence, and managing chronic fungal infections.

Keywords

Fungal infection, Homoeopathic Perspective, Miasmatic understanding, Organon of Medicine, Repertory.

Introduction

Fungal infections are caused by non-photosynthetic vegetable parasites called fungi, which can be broadly divided into two basic forms, moulds and yeasts. Fungi are capable of colonizing almost any environment, and generally play an invaluable role in the decomposition and recycling of organic matter. They tend to produce harmful effects by producing mycotoxins, by evoking allergic reactions or by direct tissue invasion.

Some skin lesions can be diagnosed on sight with confidence but even in such cases a detailed history is indispensable for effectively planned management. Even when morphological diagnosis is rapidly established, a well-planned history is essential to allow the evaluation of other factors of the disease conditions.^[2]

The physician will have to assess the patient's emotional state, domestic and business conflicts.

The possible role of psychological factors should be thoroughly explored. They are of the greatest importance in initiating, aggravating or perpetuating a wide variety of dermatoses.^[6]

Methodology

This review utilizes a qualitative narrative synthesis and cross-analytical methodology to establish an integrated homoeopathic and dermatological framework for fungal infections. The methodology comprises three structured phases:

A. Literature Identification and Search Strategy:

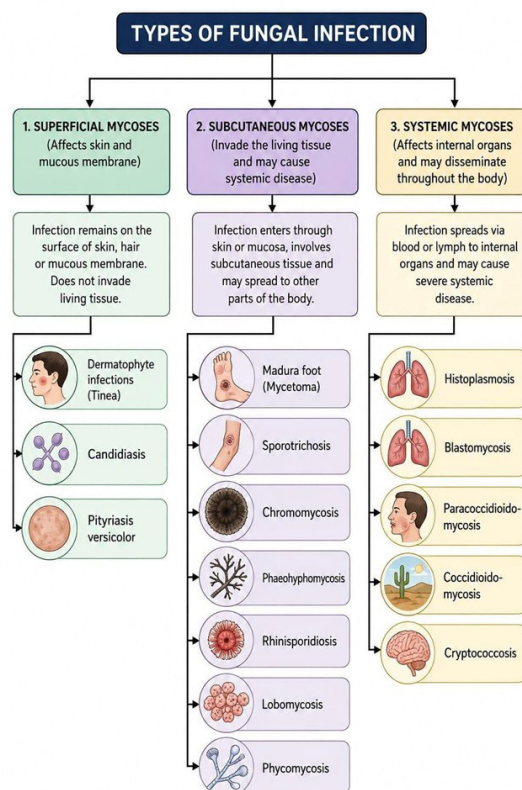
A comprehensive search was conducted across both classical homoeopathic literature and modern scientific databases (including PubMed/MEDLINE, Google Scholar, and standard textbooks of dermatology and internal medicine). The search focused on foundational homoeopathic texts—including Dr. Samuel Hahnemann's *Organon of Medicine* and *The Chronic Diseases*, J.H. Allen's *The Chronic Miasms*, and Rajan Sankaran's miasmatic works—alongside standard medical references such as the *API Textbook of Medicine* and *Manual of Skin Diseases*. Keywords included *fungal infections*, *dermatophytosis*, *miasmatic dynamics*, *Organon of Medicine*, *Synthesis Repertory*, and *host susceptibility*.

B. Categorization and Synthesis:

- **Dermatological Classification:** Fungal pathologies were categorized into superficial, subcutaneous, and systemic mycoses, mapping their etiology, transmission modes, and clinical progression.
- **Miasmatic Mapping:** Pathological expressions and host responses were mapped across five miasmatic spectrums: Psoric (functional/itching phase), Sycotic (hyperkeratotic/proliferative phase), Ringworm (struggle and remission phase), Tubercular (changeable/rapid spread phase), and Syphilitic (destructive/ulcerative phase).^[7]
- **Repertorial Integration:** Using Frederick Schroyens' *Synthesis Repertory* (9th Edition), specific rubrics corresponding to dermatophytic and fungal manifestations

(e.g., *SKIN, RINGWORM; SKIN, PITYRIASIS; HEAD, TINEA CAPITIS*) were selected, analysed, and correlated with their respective miasmatic dominance to facilitate systematic homoeopathic case analysis and individualization.^[11]

Types -



A. Superficial mycoses:

1. **Superficial mycoses: Dermatophyte Infections (Tinea)** - These infections are caused by multicellular filamentous fungi, the dermatophytes, which invade the dead keratinized tissues i.e. the stratum corneum of skin, hair and nail. The dermatophytes are classified into three genera - microsporum, trichophyton and epidermophyton. Microsporum species (*M. audouinii*) produce disease in skin and hair and nails.

Dermatophyte infections are classified according to the anatomical sites of involvement, are as follows:

1. Tinea capitis (Scalp)

2. Tinea barbae (Beard)
3. Tinea corporis (Body)
4. Tinea cruris (Groin)
5. Tinea manuum (Hand)
6. Tinea pedis (Foot)
7. Tinea unguium (Nail)

2. **Candidiasis** - Candidiasis is an infection of skin, mucous membrane and viscera, caused by *Candida albicans*. *Candida albicans* is a normal inhabitant of oral cavity, gastrointestinal tract and vaginal mucosa. Mucosal candidiasis produces soft white plaques on the tongue and buccal surfaces which can be scrapped off to leave a bright red moist base. Similar lesions may occur on the mucosa of the vagina (Vulvo-vaginitis) and usually associated with creamy discharge and marked local pruritis.

3. **Pityriasis Versicolor** - Pityriasis versicolor is a mild, chronic, asymptomatic infection of the most superficial layers of the skin caused by *Pityrosporum orbiculare*. It is characterized by fine, scaly, hyper or hypo pigmented macules of varying sizes and shape and macules may become confluent to form polycyclic patches.^[3]

B. Subcutaneous mycoses:

1. **Madura Foot (Mycetoma)** - Mycetoma is a chronic granulomatous condition which affects skin, subcutaneous tissue and bones. It may be Eumycetoma, caused by variety of fungi, actinomycetoma, caused by aerobic actinomycetes. Clinically, it is characterized by presence of firm to hard subcutaneous nodules and swellings. These nodules break open and discharge pus containing grains.

2. **Sporotrichosis** - It is a chronic infection of skin, subcutaneous tissue and lymph node caused by *Sporothrix schenckii*. Clinically, it is characterized by presence of nodulo-ulcerative lesions in a linear fashion along the lymphatics. Regional lymph nodes may be enlarged. Rarely, sporotrichosis may disseminate via the blood stream.

3. **Chromomycosis** - It is a cutaneous and subcutaneous mycosis caused by species of *Phialophora* and *Cladosporium*. Clinically, it is characterized by the development of multiple, indurated papular nodules on the foot or leg which slowly increase and take verrucous cauliflower like appearance. In deep Mycoses the organism's inoculation in subcutaneous tissue after trauma. Candidiasis and aspergillosis represent two most common fungal infections that occur in patients who are undergoing cytotoxic chemotherapy or stem cell transplantation or who have acute myeloproliferative disorders.

4. **Phaeohyphomycosis** - Mycotic infection caused by dematiaceous fungi, which form pigmented hyphae in tissue resulting in cyst and abscess formation. Caused by fungi *Exophiala jeikei*, dermatitis. Initial lesions consist of a firm, sometimes tender nodule, which may develop into large cyst.

5. **Lobomycosis** - Caused by *Loboa loboi* fungus present in water, soil and forest vegetation. Characterized by keloidal skin lesions occurring on any part of body, in long standing cases, there is involvement of regional lymph nodes.

6. **Rhinisporidiosis** - Caused by *Rhinosporidium seberi*, where there is development of polyps of the mucous membrane of nose, nasopharynx, soft palate etc.

7. **Phycomycosis** - Localised subcutaneous and predominantly tropical mycosis characterized by chronic hard swelling of subcutaneous tissue. Slowly growing painless lesions, disc shaped swelling. It may be single or multiple.^[4]

C. Systemic mycosis:

1. **Histoplasmosis** - A highly infectious mycosis caused by *Histoplasma capsulatum* and affecting primarily the lungs, where it is generally asymptomatic. The fungus is intracellular, parasitizing the reticuloendothelial system and involving the spleen, liver, kidney, central nervous system and other organs.

2. **Blastomycosis** - It is a chronic granulomatous

and suppurative mycosis caused by *Blastomyces dermatitidis*, affecting primarily the lungs but with disseminating forms affecting skin, bones, central nervous system and other sites.

3. **Paracoccidioidomycosis** - It is a chronic granulomatous fungal infection caused by *Paracoccidioides brasiliensis*, affecting the skin, mucous membranes, lymph nodes and internal organs.
4. **Coccidioidomycosis** - It is a Primary respiratory fungal infection caused by *Coccidioides immitis*, which may become progressive and disseminated, with severe or fatal forms.
5. **Cryptococcosis** - It is an acute, subacute or chronic infection caused by the encapsulated yeast *Cryptococcus neoformans*. There is a marked predilection for the brain and meninges, although the lungs and occasionally the skin and other parts of the body may be involved.^[1]

Spread of infection - They may spread from human to human (anthropophilic) animal to Human (zoophilic) or soil to human (geophilic).

- Infected animals or humans, via fomites.
- Contaminated combs and hairbrushes.
- Having direct, skin-to-skin contact with affected areas of an infected person's body.
- While playing with pets.
- Clothing, towels and bed linen.^[2]

Pathogenesis - It is known that the pathogenesis of dermatophytosis includes several stages (i.e. fungal adhesion, germination, invasion, penetration) associated with the secretion of enzymes to degrade skin components and development of host response. Adults, young and middle aged, are typically affected. Obesity, diabetes mellitus, sweating tendency, high temperatures at work place (e.g. near boilers, furnaces), wearing damp or non- absorbent or thick clothing or footwear in a humid atmosphere, sharing personal articles like towels, all predispose to these infections.^{[3][13]}

Prevention -

- Avoid sharing personal items such as clothing, towels, hairbrushes, and sports gear.
- Shower right after playing sports and keep your uniform and gear clean.
- Change your clothes, including your underwear and socks, every day, and wash them before wearing them again.
- Wear waterproof shoes in locker rooms, public or shared showers, and pool areas.^[3]

Miasmatic approach -

The Miasmatic theory of chronic diseases explained by Dr. Samuel Hahnemann is an important part of homeopathy. They predominantly reflect the interplay of psoric and sycotic miasms, with occasional syphilitic involvement in advanced stages.^[5]

Sr.No.	Miasm	Intro	Clinical Features	Miasmatic interpretation
1.	Psoric Miasm- (Functional / Itching Stage) ^{[10][14]}	The initial phase of fungal infection corresponds to psora, characterized by functional disturbances and hypersensitivity of the skin.	• Intense itching, often worse at night or from warmth. • Dry, scaly eruptions Mild inflammation with redness but minimal infiltration. • Hypersensitive skin • Represents early or superficial fungal infection. • Mental traits: Anxiety about health, overthinking worry, restlessness as in patient constant attention to itching.	Psora signifies a state of reaction and irritation. In fungal infections, this stage correlates with initial colonization of fungi, producing itching and mild inflammatory response. Example: Tinea corporis (early), Pityriasis versicular, etc.

2.	Sycotic Miasm - (Infiltration/ Proliferative Stage) ^[5]	As the disease progresses, sycosis predominates, marked by tissue overgrowth, infiltration, and chronicity. Sycosis is characterized by overproduction and infiltration. In fungal infections, this reflects fungal persistence, proliferation, and chronicity, leading to thickened tissues and deeper involvement.	- Moist eruptions, especially in skin folds (groin, axilla) - Thickened skin and nails - Hyperkeratosis - Nail involvement (onychomycosis) - Greenish or yellowish discharge (commonly in candidiasis) - Recurrent and persistent infections - Mental traits: Secretive, fear of being exposed as in patient suffering from recurrent fungal infection. (specially in groin)	Recurrent fungal infections with thickened skin and nail changes strongly indicate sycotic dominance, requiring anti-sycotic remedies and attention to maintaining causes. Example: tinea cruris, tinea pedis, candidiasis(recurrent) etc.
3.	Ringworm Miasm - (struggle & resigned acceptance) ^[8]	Most characteristic miasm of fungal infection. It lies between psora & sycosis miasm. It is characterized by an element of struggle & resigned acceptance.	- Recurrent fungal infections - Lesions in groin, between toes - Non-destructive but persistent circular spreading Lesions - This intermediate state is Characterized alteration between active effort and passive acceptance, where the individual the repeatedly attempts to overcome the condition but eventually resigns to its Persistence.	Clinically this is reflected in recurrent fungal infections with periodic exacerbations and remission, particularly affecting moist spaces. This condition typically lacks destructive pathology, groin and interdigital indicating predominantly psoro-sycotic miasmatic background. Example: tinea corporis.
4.	Tubercular miasms – (Changeable stage & recurrence) ^[5]	It is also called as pseudo-psora. It is the combination of psora & syphilis.	- Recurrent fungal infection - Rapid spread - Change of location (e.g. tinea shifting) - weak immunity - Restlessness. - Seen in chronic tinea recurrence & immuno-compromised patient.	Fungal skin or nail infections that continuously return or shift locations are considered as tubercular miasm (pseudopsora). Example: Athlete's foot, Jock itch, etc.
5.	Syphilitic miasm – (Destructive stage) ^[6]	It is the later stage in fungal infections corresponds to tissue destruction, structural changes & ulceration. It represents the ultimate stage of chronic disease progression involving deep-seated, irreversible structural changes.	- Ulceration - Tissue destruction - cracks bleeding lesions only in complicated or neglected fungal infection - Mental traits: hopelessness despair as in patient suffering from chronic recurrent complicated destructive fungal infection.	Chronic & systemic fungal infections that cause destructive skin lesions, deep-seated granulomas or tissue necrosis are viewed through the miasms, as they are considered as mixed miasmatic diseases with predominance of syphilis. Example: chronic fungal ulcers untreated case.

Repertorial approach -

Repertorisation is a scientific and systematic process of analyzing the totality of symptoms to identify the most appropriate homoeopathic remedy (similimum). In fungal diseases, the diagnosis (e.g., dermatophytosis, candidiasis, pityriasis versicolor, or onychomycosis) provides the pathological basis, but remedy selection is based on the

patient's individual symptomatology. The repertory serves as an indispensable tool for converting clinical observations into repertorial language and narrowing the choice of remedies through logical analysis.

Unlike many disease-specific conditions, fungal infections are not represented under a single chapter or rubric in most classical homoeopathic

repertories. The symptoms of fungal infections are scattered across different sections of the repertory according to the affected organ, location, sensation, pathology, modalities, and concomitant symptoms. So, successful Repertorisation depends on case analysis and appropriate selection of characteristic rubrics instead of searching for a single disease rubric.^[11]

Rubric from Synthesis repertory -

SKIN, ERUPTION, Itching, night- Psora

SKIN ERUPTION, Bend of joints-Psora

SKIN, ERUPTION, burning – Psora

SKIN, ERUPTION, itching – Psora

SKIN, ERUPTION, winter, agg – Psora

SKIN, ERUPTION, patches – Psora

SKIN, ERUPTION, scaly – Psora

SKIN, ERUPTION, scratching agg, after – Psora

SKIN, PITYRIASIS – Psora

SKIN, ERUPTION, desquamating, scales, white-Psora

SKIN, RINGWORM - Sycosis

SKIN ERUPTIONS, Covered parts; on- Sycosis

SKIN ERUPTIONS, Hairy parts, on- Sycosis

HEAD, TINEA CAPITIS – Sycosis

SKIN, ERUPTION, ringworm- Sycosis

SKIN, ERUPTION, discharging amel, -Sycosis

MOUTH, CANDIDA ALBICANS – Sycosis

EXTREMITIES, ERUPTION, Toes, Between – Sycosis

ABDOMEN, ERUPTION, ringworm- Sycosis

SKIN, ERUPTION, offensive – Syphilis

SKIN, ERUPTION, bleeding – Syphilis

SKIN, ERUPTION, ulcerating- Syphilis

SKIN, TRICHOPHYTOSIS - Psora-Sycosis

SKIN, ERUPTION, chronic – Psora- Sycotic

SKIN, TINEA VERSICOLOR- Psora /psora-sycotic

SKIN, ERUPTION, pityriasis versicolor – Psora-Sycotic

SKIN, ERUPTION, oozing – Psora/ Sycosis

SKIN, ERUPTION, recurrent – Psora- Sycotic

SKIN, ERUPTION, red – Psora/syphilis

SKIN, ERUPTION, symmetrical – Psora-sycotic

SKIN, ERUPTION, dermatomycosis – Psora- Sycotic

MOUTH, ERUPTION, ringworm, Tongue, right side -tubercular (psora-sycotic/psora- syphilitic/psora- tubercular)^[11]

DISCUSSION

The management of fungal dermatoses presents a complex clinical challenge in modern dermatology, largely driven by rising therapeutic resistance, frequent relapses, and persistent host susceptibility. While conventional dermatological paradigms primarily center on microbial eradication via topical or systemic antifungals, homoeopathy posits that persistent or recurrent fungal colonization reflects an underlying constitutional imbalance and altered host susceptibility (*dynamis*). This review synthesizes classical Hahnemannian miasmatic philosophy with modern immunological and microbiomic insights, offering an integrated framework for clinical application.^[12]

CONCLUSION

Integrating miasmatic analysis with systematic repertorisation enhances individualization, helps identify maintaining causes, and reduces recurrence. This review demonstrates how classical homoeopathic principles align with modern host-susceptibility models to optimize clinical outcomes in dermatological practice.

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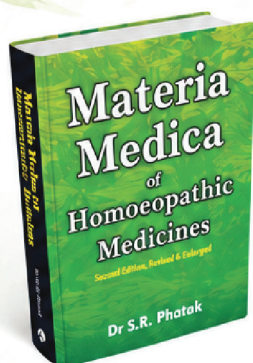
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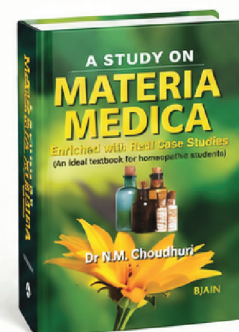
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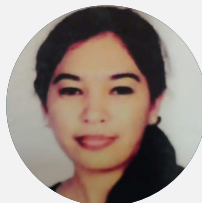


Onychomycosis: From Diagnosis to Individualized Homoeopathic Management : A Case Report



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“Looking Beyond the Lesion, Treating the Individual”.

Abstract

A patient presented with onychomycosis, a chronic fungal infection of the nail causing discoloration, dystrophy, and progressive nail involvement. Detailed case taking revealed characteristic physical and mental symptoms, forming the basis for an individualized homoeopathic prescription. Gradual restoration of healthy nail growth with sustained clinical improvement during follow-up highlighted the importance of constitutional treatment based on the totality of symptoms rather than the diagnosis alone. This case illustrates the homoeopathic approach to fungal diseases through individualization and supports the need for further clinical research in the management of chronic fungal infections.

Keywords

Onychomycosis, fungal disease, individualized homoeopathy, constitutional prescribing, sepia, case report.

Introduction

Onychomycosis is a chronic fungal infection of the nail, accounting for nearly half of all

nail disorders and presenting with discoloration, thickening, dystrophy, and nail plate destruction. In India, its prevalence ranges from 0.5% to 12% in the general population, with higher rates reported among high-risk groups. Despite the availability of antifungal therapy, treatment is often prolonged and associated with recurrence and variable therapeutic outcomes. Homoeopathy adopts an individualized, holistic approach based on the totality of symptoms, aiming to address the underlying susceptibility rather than the local pathology alone. This article highlights the homoeopathic perspective on fungal diseases through a case of onychomycosis managed with individualized homoeopathic treatment.

What is Onychomycosis?

Onychomycosis is **fungal infection** of nails.

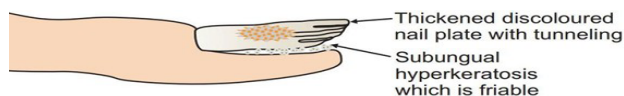
Aetiology:

Dermatophytes: Caused by one of the following three dermatophytes:

- **Trichophyton rubrum:** (commonest and most resistant to treatment).
- **Trichophyton mentagrophytes:** var interdigital.
- **Epidermophyton floccosum:**

Other fungi: Like candida

Clinical features:



Three distinct clinical patterns are seen:

- **Distal and lateral subungual onychomycosis (DLSO):** is the most common form of infection, which usually presents itself as a white or yellow streak or patch at the free edge of the nail plate, often near the lateral nail fold.
- **Superficial White Onychomycosis (SWO):** is where the dorsal surface of the nail plate is eroded in well-circumscribed, powdery white patches, often away from the free edge. It is distinguishable from other causes of leukonychia by the powdery nature of the white material, which can easily be scraped away.
- **Proximal subungual onychomycosis:** is a form seen especially in AIDS patients. Here there is rapid invasion of the nail plate from the posterior nail fold, producing a white nail with only marginal increase in thickness.

Morphology:

- Nail plate is yellow and thick and crumbles easily (so is tunnelled). There is subungual hyperkeratosis, which is friable.
- Involvement starts at the distal edge and Spreads proximally.
- **Sites of involvement:** Toe nails more frequently Involved than finger nails and only a few nails
- Are asymmetrically affected.
- **Associations:**

Finger nail involvement: with tinea cruris.

Toe nail involvement: with tinea pedis.

Diagnosis: Onychomycosis should be differentiated from: ¹

<i>Psoriasis of nails</i>	<i>Onychomycosis</i>
<i>Symmetry:</i> symmetrical involvement of several nails	Asymmetrical involvement of few nails
<i>Site:</i> begins proximally	Usually begins distally
<i>Pitting:</i> very frequent	Not seen
<i>Nail plate:</i> thickened and discolored	Thickened, discolored and tunneled
<i>Subungual debris:</i> does not crumble because it is firm	Friable

- In cases of **eczema**, there is an irregular buckling of the nail.
- **Lichen planus** causes a ridge or dysplastic changes of the nail.
- **Paronychia**, due either to bacteria or to Candida, usually affects the nail plate proximally and laterally, while the free edge is often spared, at least initially. Also, there is no swelling of the nail fold seen in dermatophyte infections, with a purulent discharge, which is never seen tinea unguium.
- Nail dystrophies can be distinguished from this condition by checking out the scrapings and also since they are usually symmetric affections, whereas fungal infections are usually asymmetric².

Onychomycosis: refers to infection of nails by any fungus. **Tinea unguium**, on the other hand, is one type of onychomycosis which is caused by dermatophytes.

Investigations: Potassium hydroxide preparation of nail clip-pings shows fungal hyphae. Culture for fungus.

Treatment: Therapy with systemic terbinafine (if dermatophytes on culture) or itraconazole (if no culture available or non-dermatophytes on culture) is necessary, if disease is symptomatic or cosmetically disfiguring.

Topical therapy (amorolfine/ciclopirox) useful if a single nail is involved in distal half¹.

Importance of Making The Right Diagnosis And Role Of Homoeopathy

The point of making a diagnosis is to improve our predictive ability about the course of a disease in a particular patient and its likely response to treatment. Three important steps in dermatological diagnosis are:

Morphological Diagnosis

Based on morphological study, localization and distribution.

Clinical Diagnosis

Establishment of the disease entity based on history and signs.

Etiological Diagnosis

Establishment of cause or causes in the individual patient. The ultimate aim of the treating homeopath should be to establish the etiological diagnosis. Having established the diagnosis, information regarding activity, severity and acuity of the disease process (prognostic criteria) should be elicited and collected before treatment is prescribed.

History

The full history consists first of a pertinent 'screening' history which includes questions of Special significance in disorders of the skin, as well as a succinct enquiry concerning Major systematic symptoms, and second, of a series of questions orientated by the Patient's presenting complaint in the light of the physician's experience. It is by asking the Right questions that the good physician obtains the answers that assist his or her Diagnosis.

GENERAL HISTORY

Category	Details
Race	Record the patient's race as it may indicate genetic predisposition.
Family History	Similar diseases in relatives; significance of positive/negative family history.
Geographical Factors	Present & past residence, duration of stay, environmental exposure.

Occupation	Present & past occupation; exposure to carcinogens, metals, etc.
Leisure Activities	Sports, hobbies, excessive sunlight, trauma, irritants, chemicals.
Social Factors	Living conditions, economic status, nutrition.
Ethnic Traditions	Dietary habits, religious beliefs, attitudes toward disease & treatment.
Personal History	Hobbies, special habits, etc.
Past Illnesses	Previous illnesses, infections, medications, self-medication.
General Health	Any systemic disorder and its relation to skin disease.

SPECIAL HISTORY (History of Presenting Complaint)

Category	Details
Onset of Skin Lesions	Exact time of onset, exacerbations, recurrences.
Duration of Complaints	Duration, periodicity, evolution of lesions.
Site of Onset	First site where lesions appeared.
Primary Lesions	Original lesion and subsequent changes.
Manner of Spread / Extension	Enlargement, spread, dissemination.
Provoking Factors	Heat, cold, sunlight, etc.; aggravating or relieving factors.
Eruption - Active or Quiescent	Whether disease is active or inactive.
Subjective Symptoms	Itching, pain, periodicity, whether symptoms preceded or followed eruption.
Topical Therapy	Previous local applications and self-treatment.
Illness Preceding /Accompanying Skin Disorder	Associated systemic illness.
Environmental Factors	Drugs, light, parasites, irritants, sensitizing chemicals.
Psychological Factors	Emotional state, domestic/business conflicts, stress.

EXAMINATION

Category	Details
Local Inspection	Primary, secondary or special lesions.
Shape & Pattern	Shape and pattern of lesions.
Distribution	Regional, generalized, localized, grouped, polymorphous.
Colour	Colour of lesion.
Particular Examination	Scalp, mouth, nails, genitalia, feet.
Palpation	Effect of rubbing, lichenification, broken hair, dystrophic nails.
Special Signs	Koebner phenomenon, Isomorphic phenomenon, diascopy, etc.
General Physical Examination	Ill, toxic, conscious, cyanotic, febrile, anaemic, debilitated; mental make-up, bearing, clothes, mannerisms.
Laboratory Aids	Relevant laboratory investigations.

Case History:**Preliminary data:**

Name	Age & Sex	Religion	Occupation	Education	Marital Status
XYZ	43/F	Hindu	Housewife	B.Com	Married

Chief Complain (OPD):

Patient came with a complaint of blackish yellowish nail discoloration with crippled, nail growth started 2 years before from index finger of right hand and gradually thumb was also affected, also pus formation along nail bed of middle finger of same hand. Aggravation from washing vessel or working in water (fig 3,4)

History of present illness:

Discoloration started 2 years back no treatment taken before

Associated complain: Migraine with aura since last 20 years

Physical generals:

Physical General	Details
Appetite	3 times/day, satisfactory.
Thirst	2-3 L approx., normal water.
Desires	N.S.
Aversions	N.S.
Bowel	Once a day; passes stool soon after first tea in morning.
Urine	Very offensive urine, 3-4 times/day, as if something has stale.
Perspiration	N.S.
Thermals	Covering needed; slight wind can affect; winter aggravates; very chilly; can't tolerate cold.
Sleep	Satisfactory.
Dreams	N.S.
Addiction	Tea.

Menstrual and obstetric history:

Menses started at age of 13 years, 3 -4 days, 3 pads per day, no any complain

No. Of pregnancy: 4

No. Of abortions: 1 (2 months)

Nature of delivery: caesarean section

1 ectopic pregnancy

Family History:

Family Member	Details
Mother	Hepatitis B death.
Father	Healthy, alive.
Brother	Healthy, alive.
Sister	Endometriosis, Alive.
Grandfather	Natural death.
Grandmother	Natural death (both healthy).
Maternal Grandfather	Healthy, natural death.
Maternal Grandmother	Healthy, natural death.

Mental symptoms:

Her husband cheated on her, and she cried a lot during that period. Despite being mistreated by him, she never opposed him and continued fulfilling her responsibilities towards her family.

She feels that she has to do everything for her children, even though she suffers internally.

She feels physically and mentally exhausted and does not want to do anything, yet she continues to manage all the household work and take care of her in-laws.

During case taking, she talked extensively about her family and children.

She keeps working throughout the day and does not take any rest, even though she feels tired.

Diagnosis:

ONYCOMYCOSIS (B35.1) with CHRONIC PARONYCHIA (B37.2)

TOTALITY OF SYMPTOMS:

Ailments from grief, disappointment and prolonged emotional suffering.

Weeping; feels relieved after crying.

Mild, yielding disposition; does not oppose despite ill-treatment.

Affectionate and cares excessively for family and children.

Indifference to everything and everyone in home except children

Physical and mental exhaustion.

Chilly patient; < cold air, < winter; desires covering.

Urine very offensive.

Addiction of tea

Blackish, yellowish, brittle, deformed nails.

Pus formation along nail bed.

Nail complaints < working in water.

Nail complaints < cold air.

REPERTORIAL JUSTIFICATION: Complete repertory from Zomeo Ultimate Software [4] was selected because the case had more general symptoms, and Complete has more remedies than Kent Repertory.

REPERTORIAL TOTALITY :-

1. Mind; disappointment, deception agg., ailments from
2. Mind; indifference, apathy; family, towards ones
3. Mind; weeping, tearful mood; amel.
4. Mind; yielding disposition
5. Generalities; food and drinks; tea; desires
6. Generalities; washing; agg.; clothing, laundry
7. Urine; offensive
8. Extremities; distortion; nails
9. Extremities; felon, onychia, paronychia

REPERTORY SHEET :- attached below

REPERTORIAL RESULT:-

S R . NO.	MEDICINES	SYMPTOMS COVERED	MARKS OBTAINED
1.	SEPIA OFFICINALIS	9	26
2.	PHOSPHORUS	7	21
3.	PULSATILLA PRATENSIS	6	21
4.	LYCOPodium CLAVATUM	7	20
5.	THUJA OCCIDENTALIS	5	15
6.	GRAPHITES	4	15
7.	NITRIC ACID	6	14
8.	NUX VOMICA	6	14
9.	CAUSTICUM	5	14
10.	NATRIUM MURIATICUM	6	13

Zomeo Ultimate

Patient Repertory Books Remedy Words Utility Academics Acute Seigel Scholten Tempaz Physician Preferences Help Edit Window

Repertory Repertory Search Repertisation

Speed Case

Repertisation Strategy Filters Remedy Filters Expert Filter

Symptoms 9 Remedies 473 Filters : Normal

Remedy	Sep	Phos	Puls	Lyc	Thu	Graph	Nit-ac	Nux-v	Caust	Nat-m	Alum	Sulph	Phac	Merc	Lach	Sil	Apis	Ans	Ign	Hell	Carb-v	Hep	Phac	Rhus-t	Sac-sh	Art-c	Can	Bar
Totally	26	21	21	20	15	15	14	14	14	13	13	13	12	11	11	11	10	10	10	9	9	9	9	9	9	9	9	8
Symptoms Covered	9	7	6	7	5	4	6	6	5	6	4	4	4	5	4	4	4	4	4	5	4	4	4	4	4	3	3	4
Kindom																												
[Complete] [Mind]DISAPPOINTMENT, DECEPTION AGG.																												
[Complete] [Mind]INDIFFERENCE, APATHY:Family, toward																												
[Complete] [Mind]WEEPING, TEARFUL MOOD:Amel: (69)																												
[Complete] [Mind]YIELDING DISPOSITION: (110)																												
[Complete] [Urine]OFFENSIVE: (185)																												
[Complete] [Extremities]DISTORTION:Nails: (21)																												
[Complete] [Extremities]FELON, ONYCHIA, PARONYCHIA:																												
[Complete] [Generalities]FOOD AND DRINKS:Tea:Desires:																												
[Complete] [Generalities]WASHING:Agg.:Clothing, laundr																												

REMEDY SELECTION: SEPIA OFFICINALIS

REMEDY JUSTIFICATION: in this case not only mentals but physical generals such as very offensive urine, desire for tea, and the most specific which lead me to select SEPIA OFFICINALIS was **washerwomen's remedy**, as patients complain was aggravating while working in water

As well as mentals such as while case taking during her narration, she seemed indifferent to her in laws which was very prominent.

FIRST VISIT: 5th November 2024 [Fig no. (1)]



Fig. No. (1) : 5 NOVEMBER 2024

Prescription:

Rx

SEPIA OFFICINALIS 200 – 4 globules – Stat dose

SAC-LAC 30 – 4 globules – BD for 15 days

(Date :- 5th November, 2024)



Fig. No. (2) : 30 NOVEMBER 2024

First Follow Up: 30th November' 2024 [Fig no. (2)]

She was feeling better as in daily household work she could easily conduct less weakness and exhaust feeling, but there was no significant change in nails, but physical generals were better.

Rx

SAC-LAC 30C – 4 globules – BD for 15 days

(Date :- 30th November, 2024)

Second Follow Up: 12th September' 2024 [Fig no. (3)]



Fig. No. (3) : 12 SEPTEMBER 2024

Pus from middle finger got expelled and also there were changes in nail texture of thumb Also, the state of indifference got better and she was in general feeling good mood vise.

Strong odour of urine was also better but still present.

But nail of ring finger also started affecting.

So, another dose of SEPIA OFFICINALIS in the same potency was given.

Rx

SEPIA OFFICINALIS 200 – 4 globules – Repeated
SAC-LAC 30 – 4 globules – BD for 15 days

(Date :- 12th September, 2024)

Third Follow Up: 2nd January 2025 [Fig no. (4)]



Fig. No. (4) : 2 JANUARY 2025

Patients complaint was way better

Nail of thumb and ring finger was improved and also no pus formation in any other or same finger.

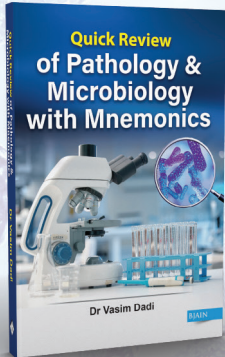
No further medication was given.

CONCLUSION

This case highlights the effectiveness of individualized homoeopathic treatment in the management of onychomycosis with chronic paronychia. By prescribing on the totality of symptoms rather than the local pathology alone, sustained clinical improvement and healthy nail regeneration were achieved. The case emphasizes the importance of constitutional prescribing and supports the need for further well-designed clinical studies to strengthen the evidence for homoeopathic management of chronic fungal diseases

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Healing Beyond the Lesions: A KOH-Confirmed Case Report on Individualized Homoeopathic Management of Dermatophytosis



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Abstract

Background - Dermatophytosis is a superficial fungal infection of keratinized tissues caused by dermatophytes and characterized by erythematous, scaly, pruritic lesions with central clearing (1). It is highly prevalent in India, with reported prevalence ranging from 6.09% to 61.5%, attributed to favorable climatic conditions and increasing chronic and recurrent cases (2). Although antifungal therapy remains the standard treatment, homoeopathy offers an individualized therapeutic approach that may aid symptom resolution and reduce recurrence.

Case Summary- This case report describes a 52-year-old male with chronic dermatophytosis involving the bilateral axillae and right inner thigh. Following individualized homoeopathic case analysis, a single dose of *Sulphur* 30 was prescribed. After three months of treatment, the patient demonstrated complete clinical and mycological improvement, confirmed by serial photographs and a negative KOH wet mount. The Peak Pruritus Numeric Rating Scale (PP-NRS) improved from +8 to 0, while a modified Naranjo score of +8 indicated a probable association

between the observed clinical outcome and the homoeopathic intervention.

Conclusion- The observed clinical and mycological improvement suggests that individualized homoeopathic treatment may have potential as a therapeutic option for dermatophytosis. Further well-designed studies are warranted to evaluate its efficacy and reproducibility in larger patient populations.

Objective - To demonstrate the clinical and mycological outcomes of Individualized homoeopathic treatment in a patient with dermatophytosis, with treatment response documented through serial clinical assessment and KOH microscopy.

Keywords

Dermatophytosis, Homoeopathy, Individualized, KOH, PP-NRS

Introduction

Superficial dermatophytosis is among the most prevalent fungal infections worldwide, affecting an estimated 20–25% of the global population⁽³⁾. In recent years, India has witnessed a notable

increase in the incidence of dermatophytosis, particularly recalcitrant, recurrent, and chronic cases that pose significant therapeutic challenges⁽⁴⁾. The warm and humid climatic conditions prevalent in tropical and subtropical regions, including India, create an environment favorable for the growth and transmission of dermatophytes⁽⁵⁾. Dermatophytes are classified into three anamorphic genera based on the morphology of their conidia. *Trichophyton* species commonly infect the skin, hair, and nails; *Microsporum* species primarily involve the skin and hair; whereas *Epidermophyton* species predominantly affect the skin and nails⁽⁶⁾

Table 1 : Classification of Dermatophytosis

S.NO	TYPES	FEATURES
1.	Tinea Corporis	Appears on the body's arms, legs, and trunk, usually presenting as circular, red patches with active border and central clearing.
2.	Tinea Pedis (Athlete's Foot)	Affects the feet, often between the toes, leading to itching, burning, and cracked skin. Predisposing factors- moist weather, tight footwear, hyperhidrosis of soles, presence of tinea unguium.
3.	Tinea Cruris (Jock's Itch)	Occurs in the groin area, perianal and perineal areas, usually bilateral and often asymmetric, extending down the sides of the inner thigh, causing intense itching and red, scaly lesions.
4.	Tinea Capitis (Scalp Ringworm)	Common in children, usually caused by members of the genera Microsporum and Trichophyton. This type results in scaly patches on the scalp, which can lead to hair loss.
5.	Tinea Unguium (Onychomycosis):	Involves the nails, causing thickening of nail plate, yellow brown discolouration, increased friability due to collection of debris under nail plate.
6.	Tinea Mannum (Ringworm of Hands)	Occurs on the dorsal aspect of hands with erythema of palm and accumulation of fine scales on creases.

Diagnosis is based on clinical evaluation supported by laboratory methods: Wood's lamp examination (365 nm) may reveal fluorescence in certain species; direct microscopy with potassium hydroxide (KOH) preparation of skin scrapings, nail clippings, or hair samples dissolves keratin to expose fungal elements; and fungal culture on Sabouraud dextrose agar provides confirmatory identification through colony morphology and growth characteristics after incubation⁽¹⁾.

Case Report

Patient Details

A 52-year-old male reported at the Out Patient Department (OPD) of Dr. B.R. Sur Homoeopathic Medical College, Hospital and Research Centre, New Delhi on 14th May 2025 with complaints of severe itchy circular erythematous lesions on bilateral axilla and right inner thigh region for the past six months. (Fig.2)

History Of Presenting Complaint

The patient developed skin lesions about 6 months ago, beginning with severe itching in the axilla followed by circular erythematous lesions that gradually enlarged with raised edges, itching, and burning. Despite 4 months of topical antifungal treatment, there was little relief, and a new lesion appeared on the right inner thigh. The lesions progressively increased in size, showing erythematous margins with central clearing. Itching worsened after bathing, often accompanied by burning pain, and excessive scratching occasionally led to bleeding, though without discharge.

Patient History

The patient underwent cholecystectomy in 2011. His father passed away in the same year due to throat cancer, his mother is currently suffering from osteoarthritis, and his sister has hypothyroidism. He is employed in the government sector, belongs to an upper-class family, and has two sons who are pursuing their studies. He leads a sedentary lifestyle.

Physical Generals

Appetite- 3 meals/day, 3 chapatti/meal

Thirst- 2-3 litres in a day

Desires- Alcohol, Meat

Aversion- Nothing specific

Thermal- towards Hot

Perspiration- Profuse perspiration especially on scalp, non-offensive and non- staining.

Sleep- 6-7 hrs, Refreshed in the morning, Position- on back

Dreams- Nothing specific

Bowel habit- D1N0, satisfactory.

Urination- D5-6N1, pale yellow colour, slightly offensive.

Mental Generals

He is talkative and sociable, yet his temperament reflects marked irritability and dissatisfaction. During case taking, he spoke casually and at length about his government position, his car, and the comfortable lifestyle he maintains, subtly projecting a sense of pride in his status. He appeared haughty in his demeanor, often conveying a feeling of superiority and emphasizing how he prefers to order others around and have things done according to his directions. He becomes easily irritated over minor issues, especially when circumstances do not meet his expectations. Despite having a stable professional and family life, he remains inwardly discontented and frequently expresses dissatisfaction with treatments and situations around him. The repeated failure of previous therapies has further intensified his frustration, making him impatient and critical. Overall, he presents as outwardly confident and expressive, but internally restless, dissatisfied, and prone to irritability.

General Physical Examination

On general examination, the patient measured 5 feet 1 inch in height and weighed 105 kg. There was no evidence of pallor, icterus, cyanosis, or edema. Vital signs revealed a blood pressure of

140/90 mmHg, pulse rate of 70 beats per minute, and respiratory rate of 16 breaths per minute. The patient's built was endomorphic with adequate nutrition.

Clinical Findings

On local examination, multiple ring-shaped hyperpigmented lesions were noted, characterized by erythematous borders and central clearing. These lesions were present on the right inner thigh and on the bilateral axillae. The margins appeared well-defined, with surrounding skin showing mild erythema and scaling. No discharge, induration, or tenderness was observed.

Diagnostic Assessment

A provisional diagnosis of dermatophytosis was made on clinical examination, as the lesions showed annular plaques with raised, scaly, erythematous borders and central clearing. Skin scrapings from both sites were examined by potassium hydroxide (KOH) wet mount, revealing branching fungal hyphae and confirming the diagnosis. **Fig.5&6** illustrates KOH findings with fungal hyphae before treatment (**Fig.5**) and absence after treatment (**Fig.6**), confirming the effectiveness of the intervention..

Totality of Case

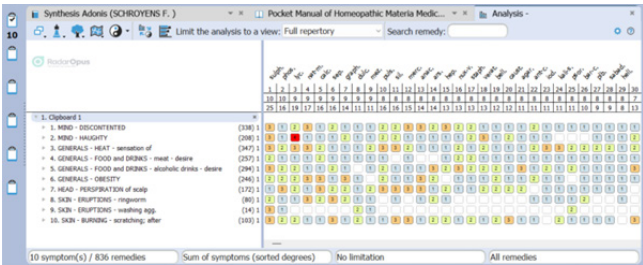
Discontented, Haughty nature, Hot patient, Desire for meat and alcoholic drinks, Obese patient, Perspiration on scalp, Ring-like erythematous lesions over skin of inner thigh and axilla, Burning pain in lesion after scratching. Itching aggravated after bathing/washing.

Repertorial Totality- Synthesis Repertory In The Radaropus 3.3.24⁽⁷⁾

1. MIND- DISCONTENTED
2. MIND- HAUGHTY
3. GENERALS- HEAT, SENSATION OF
4. GENERALS- FOOD AND DRINKS, MEAT DESIRE
5. GENERALS- FOOD AND DRINKS, ALCOHOLIC DRINKS

- 6. GENERALS- OBESITY
- 7. HEAD- PERSPIRATION OF SCALP
- 8. SKIN ERUPTION- RINGWORM
- 9. SKIN- ERUPTION- WASHING AGG
- 10. SKIN- BURNING- SCRATCHING AFTER

Fig 1: Repertorization chart



Therapeutic Intervention

This case was repertorized using *Synthesis Repertory* in RadarOpus 3.3.24 (Fig.1), with Sulphur, Lycopodium, and Phosphorus emerging as leading remedies⁽⁷⁾. On consulting *Materia Medica*, the patient’s hot thermal state, desire for alcohol and meat, burning pain after scratching, aggravation after bathing, and skin complaints worse at night

Table 2 : Timeline of treatment and Follow ups

DATE	PRESCRIPTION	JUSTIFICATION	PP-NRS SCORE
14/5/25 (Baseline visit)	Sulphur 30/1 dose stat, Sac Lac 30/TDS/ 15 days	Axillae and groin lesions: Severe pruritic erythematous lesions with well-defined active peripheral margins, accompanied by intense itching aggravated after bathing and a burning sensation following scratching (Fig. 2). KOH Wet mount- Fungal hyphae with branching and spores seen on microscopic examination (Fig. 5).	8
28/5/25	Sac Lac 30/TDS/ 15 days	Groin region - Redness and inflammation in the right inner thigh region showed marked reduction with slight improvement in itching intensity. Axillae Region - The lesions of axillae remained unchanged. Burning pain in lesions after scratching present. No new lesions.	7
11/6/25	Sac Lac 30/TDS/ 15 days	Axillae and groin lesions: Increased pigmentation in the axillae and mild residual pigmentation in the groin. Pruritus persisted with slight improvement, burning after scratching decreased by 45%, and no new lesions developed (Fig. 3).	8
25/06/25	Sac lac 30/TDS/ 15 days	Axillae and groin lesions: Pruritus remained unchanged, hyperpigmentation decreased, burning after scratching persisted, and no new lesions were observed.	6
11/07/25	Sulphur 200/ 1 dose/ stat Sac lac 30/TDS/ 15 days	Axillae and groin lesions: Pruritus and burning after scratching remained unchanged, with slight reduction in pigmentation.	6

supported Sulphur. Lycopodium was ruled out as, despite being talkative and sociable, the patient’s haughty demeanor, irritability, and dissatisfaction reflected egotism rather than Lycopodium’s insecurity, lack of confidence, and dependence on others. Moreover, Lycopodium shows predominance of gastrointestinal complaints such as flatulence, bloating, and craving sweets, along with skin eruptions that are dry, cracked, or suppurative—features absent here. Phosphorus was also excluded, as it corresponds to patients who are affectionate, sympathetic, emotionally sensitive, fearful, crave cold drinks, show bleeding tendencies, and whose complaints improve by washing with cold water, none of which matched this case^(8,9,10). Hence, Sulphur was prescribed, beginning with a single dose of 30C on 14th May 2025 followed by *Sac Lac* for 15 days; with standstill improvement, potency was raised to 200C, leading to gradual resolution of dermatophytosis lesions and restoration of normal skin color (Fig 4).

The patient was counseled regarding the importance of maintaining good personal hygiene and adopting a healthy lifestyle. He was instructed to refrain from consuming alcohol and from applying any topical antifungal ointments during the course of treatment.

25/07/25	Sac lac 30/TDS/ 15 days	Axillae and groin lesions: Marked reduction in pruritus, noticeable decrease in hyperpigmentation, burning after scratching reduced by 85%, and no new lesions were observed.	3
06/08/25	Sac lac 30/TDS/15 days	Axillae and groin lesions: Pruritus and burning after scratching resolved, pigmentation nearly returned to normal, and no new lesions were observed (Fig.4). KOH Wet mount- No fungal element with only few spores were seen on microscopic examination. (Fig.6)	0

Follow-up and Outcomes (Table 2)

Clinical improvement was monitored through serial clinical examinations of the lesions, supported by photographic documentation and assessment using the PP-NRS⁽¹¹⁾ throughout the treatment period. At the completion of treatment, a repeat KOH wet mount examination was performed to objectively evaluate the treatment outcome. Microscopic examination revealed no fungal hyphae, indicating successful resolution of the fungal infection.

FIG 2. Baseline Visit (on 14th May 2025)

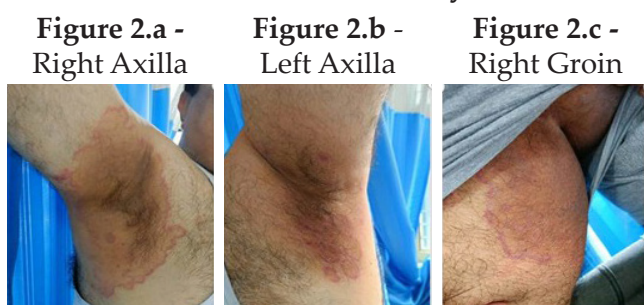


FIG 3. During Treatment (on 11th June 2025)

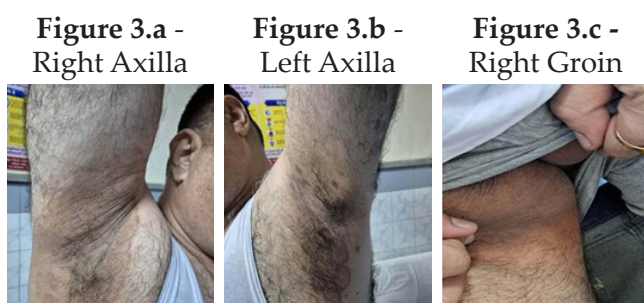
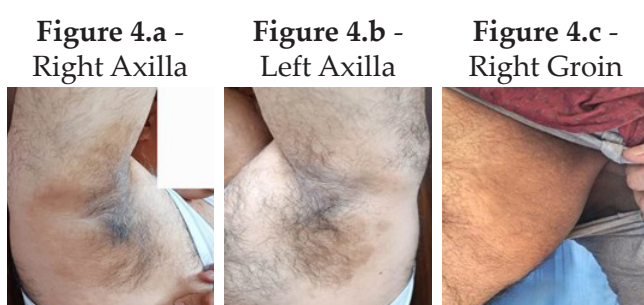


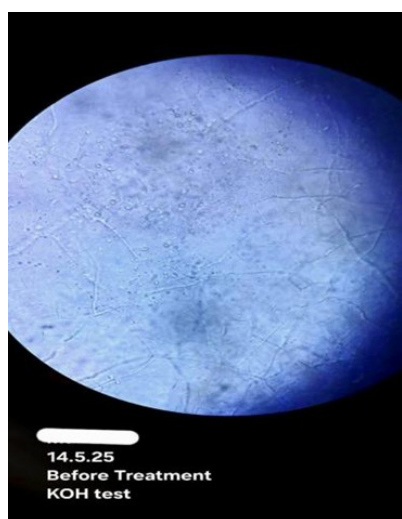
FIG 4. After Treatment (on 6th August 2025)



DISCUSSION

Dermatophytosis is a common superficial fungal infection with an increasing incidence of recurrent and chronic and poorly responsive cases, highlighting the need for alternative therapeutic approaches. This case report describes the management of persistent dermatophytosis using individualized constitutional homoeopathic treatment. Based on the totality of symptoms, *Sulphur* was prescribed, beginning with 30C and subsequently increased to 200C in accordance with the patient's clinical response and established homoeopathic principles, resulting in marked improvement of the skin lesions. Progressive improvement was documented clinically, with the **Peak Pruritus Numeric Rating Scale (PP-NRS)** score decreasing from 8 at baseline to 0 at the final follow-up. Mycological assessment by KOH mount changed from positive to negative following treatment, providing objective evidence alongside clinical improvement. **The Modified Naranjo Criteria for Homoeopathy (MONARCH)**⁽¹²⁾ (Table 3) yielded a score of +8, indicating a positive causal association between the individualized homoeopathic intervention and the observed therapeutic outcome. This case suggests that individualized constitutional homoeopathic treatment may have a potential role in the management of dermatophytosis and highlights the need for further well-designed clinical studies to evaluate its efficacy. However, the interpretation of this case is limited by its single-case design, absence of a control or comparator group, and the potential influence of factors that cannot be fully excluded in an individual case. Therefore, the findings cannot be generalized or used to establish treatment efficacy. This case suggests that individualized constitutional homoeopathic treatment may have a potential role in the management of dermatophytosis and highlights the need for further well-designed, controlled clinical studies to evaluate its efficacy and reproducibility.

FIG 5.(a&b) Before Treatment -Koh Wet Mount Image & Report



DR. B.R. SUR HOMOEOPATHIC MEDICAL COLLEGE, HOSPITAL AND RESEARCH CENTRE
KOH Wet Mount Microscopic Examination Form
(For Fungal Element Detection)

Patient Information

- Name: _____
- Age / Gender: 52 / M
- OPD Number: 2025003462
- Date of Sample Collection: 14.5.25
- Site of Lesion: Grain and crumb lesion
- Clinical Diagnosis: T. Capitis & aurea
- Visit Type: ☒ Baseline ☐ Follow-up (Month: _____) ☐ Final Visit

Sample Details

- Specimen Type: ☒ Skin scrapings ☐ Nail clippings ☐ Hair sample ☐ Other: _____
- Preparation Used: ☐ 10% KOH ☒ 20% KOH ☐ 40% KOH ☐ Other: _____

Microscopic Examination

- Examined By: Dr. Piyali Dhas
- Date of Examination: 14.5.25

Findings:

- ☒ Fungal hyphae observed
- ☐ Spores observed
- ☐ No fungal elements seen
- ☐ Artifacts present
- ☐ Repeat sample advised

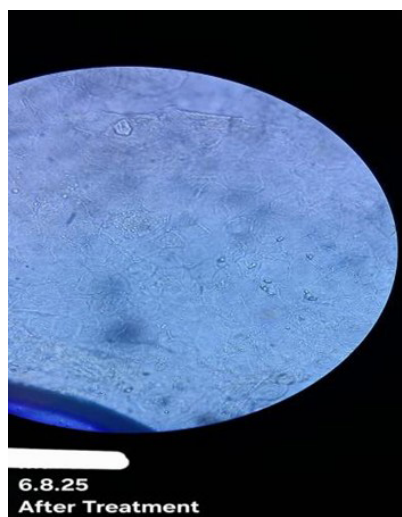
Description (if positive):
Fungal hyphae 2+ with branching seen spores not.

Remarks by Microbiologist
Signature: Dr. Piyali Dhas
Date: 14.5.25
Stamp: Dr. Piyali Dhas MBBS, DCP Regd-14349 (AMCI)

KOH Wet Mount Microscopic Examination Form
(For Fungal Element Detection)

34

FIG 6.(a&b) After Treatment - Koh Wet Mount Image & Report



KOH Wet Mount Microscopic Examination
(Follow-up test)

Name: _____
Age / Gender: 52 / M
OPD Number: 2025003462
Follow-up (Month: _____)

- Examined By: Dr. Piyali Dhas
- Date: 06.08.25

- ☐ Fungal hyphae observed
- ☐ Spores observed
- ☒ No fungal elements seen
- ☐ Artifacts present
- ☐ Repeat sample advised

Description (if positive):
No active fungal elements seen on microscopic examination.

Comparative Analysis / Remarks
Post-treatment examination shows complete resolution of previously detected fungal element, with no fungal hyphae or spores identified on wet mount microscopy.

Dr. Piyali Dhas
Pathologist / Microbiologist's Name & Signature

Name: Dr. Piyali Dhas Date: 06.08.25
Stamp: Dr. Piyali Dhas MBBS, DCP Regd-14349 (AMCI)

35

CONCLUSION

This case report documents the management of a persistent case of dermatophytosis with individualized constitutional homoeopathic treatment. Clinical improvement was objectively demonstrated through serial assessment of lesion morphology, photographic documentation, and reduction in PP-NRS scores, while repeat KOH wet mount examination showed the absence of fungal hyphae following treatment.

The concordance between clinical findings and laboratory evidence supports the observed treatment response in this case. Although conclusions cannot be generalized from a single case, these findings highlight the need for further evaluation of individualized homoeopathic treatment in well-designed controlled clinical studies.

Declaration Of Patient Consent

The author has obtained informed consent from the patient to use his images and other clinical information for the publication of his case report, ensuring his identity remained confidential.

Financial Support And Sponsorship- Nil

Conflicts of Interest- None declared.

Table 3 : Modified Naranjo Criteria

Domains	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 drug intake?	+1		
3. Was there an initial 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)?		0	
5. Did overall well-being improve? (suggest using validated scale)	+1		
6A Direction of cure: did some symptoms improve in the opposite order of the development of symptoms of the disease?	1+		
6B Direction of cure: did at least two 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 (other than the medicine) that—with a high probability— could have caused the improvement? (Consider 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 Score = 8			

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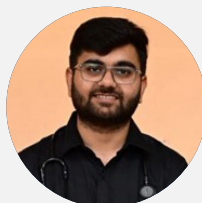
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Unmasking the Fungal lesion: Decoding the deeper state in fungal disorders through the Lens of Homoeopathy



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Abstract

Fungal diseases represent a growing health concern, from superficial infections such as dermatophytosis and candidiasis to severe invasive and systemic mycosis associated with substantial morbidity and mortality. Although conventional antifungal agents remain the established standard of care, their use may be complicated by drug toxicity, therapeutic limitations, recurrence, drug interactions, and the antifungal resistance. These challenges have stimulated interest in complementary and integrative approaches to fungal disease management. This article explores usefulness of homoeopathy, beyond the local cutaneous lesion, to consider the deeper state of the patient. It discusses the clinical significance of fungal infection, antifungal resistance and relevant demographic considerations followed by homoeopathic concept of skin disease, suppression, and Burnett's view of cutaneous manifestations as expression of internal disorder. A framework for miasmatic analysis, the role of intercurrent remedies, and therapeutic and repertorial approaches are also discussed.

Keywords

Dermatophytosis, Respiratory disease, anti-fungal, drug resistance, miasmatic analysis, suppression, concept of deeper state

Introduction

Fungal infections are some of the major health concerns for humankind. Fungal infections encompass a broad spectrum of diseases, ranging from superficial and cutaneous infections to subcutaneous, mucosal, and systemic infections, with varying degrees of severity.^[1]

Mucocutaneous infections have lower severity than systemic infections, which are more severe and generally associated with immunodeficient diseases. In addition to opportunistic and systemic infections, fungal pathogens such as *Candida*, *Aspergillus*, *Fusarium*, *Mucorales*, and other moulds are recognised as important causes of healthcare-associated infections (HAIs).^[2] In 2021, fungal skin diseases had a substantial global burden, with an age-standardised incidence rate (ASIR) of 21,668.4 per 100,000 population, showing a slight increase since 1990. The burden was disproportionately higher in low-SDI countries, particularly among children aged 5–14 years, with males being slightly more affected than females. Low-SDI regions recorded an ASIR of 31,124.75 per 100,000, nearly twice that of high-SDI regions (16,147.92 per 100,000).^[3] Global estimates from more than 120 countries indicate that approximately 6.5 million invasive fungal infections occur annually, causing 3.8 million deaths, of which nearly 2.5 million are directly attributable to fungal infections. Invasive

aspergillosis, candidiasis, cryptococcal meningitis, and Pneumocystis pneumonia constitute major contributors to this burden, highlighting the substantial global impact of fungal diseases and the need for improved diagnosis and management.^[4]

Fungal exposure is associated with a substantial global burden of allergic respiratory diseases, including ABPA, SAFS, and AFRS, affecting an estimated 4.8 million, 6 million, and 12 million individuals, respectively.^[5,6]

Systemic fungal infections commonly originate in the **lungs**, particularly through inhalation of fungal spores, as seen in aspergillosis and other mould infections. They may also arise from **endogenous fungal flora**, as in candidemia, which can develop from infected intravascular lines or leakage from the gastrointestinal tract. Once established, these infections can disseminate through the bloodstream and **involve multiple organs**.^[7,8]

Antifungal resistance is an increasingly important challenge in clinical practice, largely due to the rising burden of fungal infections and the limited availability of effective antifungal agents. Fungi can exhibit **intrinsic resistance** through mechanisms such as reduced drug–target affinity, enhanced efflux pump activity, and distinctive cell wall and membrane structures. **Acquired resistance** may develop through genetic alterations, including mutations, gene duplication, transposon insertion, aneuploidy, and loss of heterozygosity. In addition, **antifungal tolerance**, in which subsets of fungal cells survive and continue to grow despite exposure to otherwise inhibitory drug concentrations, can further hinder successful treatment.^[9,10]

Homoeopathy can play a crucial role in improving the general health of the population suffering from fungal diseases. Research conducted by Saha et al^[11] at the National Institute of Homoeopathy shows that Homoeopathic medicine in different potencies shows antimicrobial properties, where Kreosotum and Sepia show significant results.

Many of the studies have shown significant improvement in dermatophytosis, where individualised homoeopathic treatment has given satisfactory results in pre- and post-observations.^[12,13]

Homoeopathic Understanding Of Fungal Disorder

1. The Skin Disease Beyond The Local Lesion: The Concept Of Deeper State^[14]

A cutaneous eruption is viewed not merely as a local skin lesion but as an external manifestation of an underlying internal disease state. The original eruption is related to the deeper state of the individual, deeper patterns and deeper miasm, and focuses on the mind state and healing of skin disease; its premature removal may be followed by the appearance of secondary internal symptoms. Conversely, the reappearance of the cutaneous eruption is described as associated with the temporary reduction or disappearance of such internal complaints. Thus, the skin manifestation is considered in relation to the deeper state of the organism rather than as an isolated local condition.

2. Dr. Burnett's Concept Of The Skin As A Reflection Of Constitutional Disease:^[15]

Burnett regarded the skin as an important organ closely connected with the internal organs and the overall constitution. He considered most skin diseases to arise from within and viewed cutaneous lesions as external expressions of an underlying internal disorder. Hence, he regarded treatment directed solely at removing the skin lesion as inadequate, emphasising the need to address the underlying disease state.

3. The Homoeopathic Concept Of Suppression In Cutaneous Disease:^[14]

Hahnemann described suppression as the disappearance of a cutaneous eruption or itching following local treatment, without addressing the underlying internal disorder. According to his concept, when an external skin manifestation is forcibly removed, the internal disease may persist and subsequently express itself through other organs or systems. In *The Chronic Diseases*, he cited observations in which suppression of itching was followed by various complaints, including asthma, pulmonary disorders, ulcers, menstrual disturbances, joint problems, epilepsy, visual

disturbances, paralysis and other systemic manifestations. He therefore emphasised that removing the skin eruption alone should not be considered a true cure. Instead, treatment should be directed towards the underlying internal disease through appropriate internal therapy. Thus, within Hahnemann's homoeopathic concept, suppression represents the removal of the external manifestation while the presumed internal disease remains active and

may reappear in a different form.

4. A Homoeopathic Framework For Miasmatic Interpretation Of Fungal Presentation:^[16]

Skin is described as a mirror of reflection of internal stress and internal dynamics of the organism. Chronic miasms are considered as the fundamental cause of true natural chronic disease, classified as psora, syphilis, sycosis and tubercular.

Psora	Syphilitic	Sycosis	Tubercular
Dryness, roughness of skin	Ulcer - Open ulcer with puss & blood	Soft tissue affection	Recurrence & alteration, periodicity of symptom
Dirty unhealthy-looking skin	Deep cracks & Fissure	Recurrent sexual organ pathology – itchy eruption around the genitals	Thick yellow crust
Recurrent skin disease	Copper coloured eruption	Repeated vaccination leads to skin complain	Recurrence abscess
Scratching causes dryness	Thick crust	Slowness of disease	Ringworm infection
Voluptuous itching aggravated by rubbing & scratching, warmth	Aggravation night, summer, warm	Aggravation humid condition, rainy weather, meat	Aggravation thunderstorm, night, thinking of complaint
Amelioration natural discharge	Amelioration from abnormal discharge, daytime, cold	Amelioration dry weather, pressure, discharge	Amelioration dry weather, open air
Redness & congestion in skin	Putrid offensive discharge	Yellow greenish discharge	
Reappearance of suppressed skin disease	Eruption around joint & flexure	Nail – ridges, corrugated, thick	
Itching with desire to run		Vesicular eruption	
Sensation like burning		Alopecia Aerata, Warts, moles, skin tag, scar, Keloid	
Crust is thin, light & fine			

5. Intercurrent Remedy Prescription:^[14,16]

An intercurrent remedy plays an important role in homoeopathic case management when the action of a well-selected constitutional remedy becomes interrupted or fails to produce further improvement. It is prescribed with the aim of removing obstacles to cure, which are often considered *miasmatic blocks*, and thereby restoring the patient's responsiveness to the constitutional remedy. The selection of an intercurrent remedy is based on the overall clinical presentation and, particularly in chronic cases, the prevailing miasmatic picture. Commonly described intercurrent remedies include constitutional remedies, complementary remedies, and nosodes.

6. Homoeopathic Therapeutics Why Modalities Matter^[17,18]:

- **Natrum Muriaticum-** Eczema with white, scaly, thick scales, itching, with rawness and soreness, pricking and stinging sensation in skin; itching worse in forenoon, from exercise or warmth, (**Warmth Aggravation**) better when lying down.
- **Rhus Toxicodendron-** Moist eruptions with offensive oozing, beginning with small yellow vesicles with red areola, turning into thick, hard crusts; intense itching, worse at night, surface raw, excoriated, hardness of skin with thickening; worse at change of weather, wet weather, winter.

- **Sulphur-** Dry, offensive, scabby, easily bleeding, burning eruption, with sore pain and cracks, better from scratching; often humid, thick pus, yellow crusts, itching and burning; itching aggravated by any form of heat, from getting warm at work, in bed; hates to be washed, better in fresh air. Scratching with burning. (**Warm Aggravation**)
- **Fagopyrum Esculentum:** Marked action on skin producing pruritic, itching better by bathing in cold water. (**Cold Amelioration**)
- **Arsenic Album:** Dry, scaly, itchy, marked exfoliation of skin in the form of large scales. Worse cold and scratching and ameliorated from heat. (**Warm Amelioration**)
- **Clematis Erecta:** Red, burning, vesicular, scaly, scabby. Itches terribly; worse washing in cold water, worse face, hands and scalp. (**Cold Aggravation**)
- **Oleander:** Violent itching eruption, bleeding oozing eczema pruritic especially of scalp worse undressing, friction of clothes.
- **Mezerum:** Eczema, intolerable itching: chilliness with pruritic. Eruptions ulcerate and form thick scabs under which purulent matter exudes. worse cold air, night, touch, motion; better open air.

7. Repertorial Approach

Rubrics from Kent's Repertory^[19]:-

HEAD, FUNGUS: *Apis., calc-p., phos.*

EYE, Cancer, Fungus: *Bell., Calc., lyc., Phos., sep., sil., thuj*

SKIN, ERUPTIONS, herpetic, crusty: *ars., aur-m., aur., Calc., clem., Con., cupr., dulc., Graph., led., Lyc., Merc., mez., Rhus-t., sep., sil., Sulph., viol-t.,*

SKIN, EXCRESCENCES, fungus, cauliflower: *Ant-c., ars., con., kreos., Lach., nit-ac., Sil., staph., Thuj.*

SKIN, EXCRESCENCES, fungus, haematodes: *Ars., carb-v., kreos., lach., lyc., merc., nat-m., nit-ac., Phos., rhus-t., Sil., sulph., Thuj.*

SKIN, EXCRESCENCES, fungus, syphilitic: *Ars-i., ars., aur-m-n., aur-m., aur., iod., Lach., manc., Merc-c., Merc., Nit-ac., Sil., staph., thuj.*

Rubrics from BBCR^[21]:

EYES, Fungus haematods: *BELL., Calc., Lyc., Sep., Sil.*

EAR, Fungus in: *Merc*

Skin and exterior body, Fungus, Haematodes: *Ant-t., Ars., Bell., Calc., Carb-an., Carb-v., Clem., Kreos., Lach., Lyc., Merc., Nit-ac., Nux-v., PHOS., Rhus-t., Sep., Sil., Staph., Sulph., Thuj.*

Rubrics from Boerricke's Repertory:

Skin, ERUPTIONS, Dry, scaly: *Alumen, Anag., Ant. c., Ars., Ars. iod., Berb. aq., Bov., Cadm. s., Canth., Cory., Euphorb. d., Graph., Hydr., Iod., Kali ars., Kali m., Kali s., Lith. c., Lyc., Malandr., Merc. s., Nat. m., Nit. ac., Petrol., Phos., Phyt., Pip. m., Pix l., Psor., Sars., Selen., Sep., Sul., Tub., Xero.*

Skin, ERUPTIONS, Humid, moist -- *Ant. c., Ant. t., Bar. c., Bov., Caust., Chrysarob., Clem., Crot. t., Dulc., Graph., Hep., Lyc., Manc., Merc. s., Mez., Nat. m., Oleand., Petrol., Psor., Rhus t., Sep., Staph., Stront-c., Variol., Viola tr.*

Skin, FUNGUS HEMATODES: *Ars., Lach., Lyc., Mancin., Phos., Thuja.*

8. Evidence From Homoeopathic Literature And Clinical Studies

Published studies on dermatophytosis and tinea corporis have explored the individualised homoeopathic approach based on the totality of symptoms. Observational findings have reported improvement in clinical symptoms and quality of life.

Dixit et al. (2024) studied individualised

homoeopathic medicines in 103 patients with dermatophytosis. Treatment was selected according to symptom totality and repertorization. After three months, significant improvement was reported in symptom severity and quality of life.^[12]

Laskar et al. (2023) conducted a double-blind, randomised, placebo-controlled trial involving 62 patients with tinea corporis. Although no significant difference was found in the primary outcome of complete disappearance of lesions, some secondary outcomes, including itching and quality-of-life measures, favoured individualised homoeopathic medicines. The authors concluded that further robust trials are required.^[21]

CONCLUSION

Fungal disorders are an increasing clinical concern due to their diverse manifestations, recurrence, emerging antifungal resistance, and limited therapeutic options. The present review highlights the potential role of homoeopathy through its individualised approach, totality of symptoms, repertorial analysis, Materia medica, and philosophical concepts such as susceptibility and suppression. The reviewed literature suggests that homoeopathy has been used in various fungal conditions; however, current scientific evidence remains limited and heterogeneous. Fungal disorder, though clinically expressed through the skin, may be understood in homoeopathy within the broader context of individual constitution and deeper state of disease, miasm and focus on mind and state of healing.. Future research should emphasise well-designed clinical trials, objective microbiological outcomes, standardised protocols, and long-term follow-up.

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Tinea: A Case Report Illustrating Constitutional and Intercurrent Anti-Miasmatic Prescribing.

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Abstract

Background: Dermatophytosis, commonly known as ringworm, is a highly prevalent superficial fungal infection. Conventional treatments rely heavily on topical and systemic antifungals, which frequently lead to suppression or recurrence. Homoeopathy offers a holistic approach by treating the individual's underlying miasmatic susceptibility.

Case Summary: A 42-year-old female presented with severe, itching, ring-shaped lesions over her thighs, hips, and lower legs and then chest for three months, accompanied by exertional breathlessness. She had a strong family history of metabolic and chronic dermatological conditions. Based on the totality of symptoms particularly her profound sympathetic nature, intolerance to injustice, and physical generals *Causticum* 1M was prescribed constitutionally. *Bacillinum* 1M was later utilized as an intercurrent anti-miasmatic remedy when progress plateaued, leading to complete clinical clearance.

Conclusion: This case illustrates the efficacy of individualized homoeopathic treatment, highlighting the critical role of intercurrent miasmatic prescribing in chronic dermatological affections.

Keywords

Homoeopathy, *Tinea corporis*, *Tinea cruris*, Dermatophytosis, *Causticum*, *Bacillinum*, Anti Miasmatic prescribing.

Introduction

Dermatophytosis is a superficial fungal infection of the keratinized tissues (skin, hair, and nails) caused by dermatophytes.⁽¹⁾ *Tinea corporis* and *tinea cruris* are characterized by pruritic, annular, scaly plaques with raised active margins.⁽²⁾ In contemporary clinical practice, widespread use of over the counter topical corticosteroids and antifungals frequently alters the clinical presentation (*tinea incognito*) and increases chronicity and recurrence.⁽³⁾

From a Hahnemannian perspective, local skin manifestations are merely the outward expression of internal systemic derangement. Suppressing these local symptoms with topical applications inevitably deepens the internal miasmatic load.⁽⁴⁾ This case report illustrates the successful management of recurrent tinea utilizing a combination of constitutional and intercurrent anti-miasmatic homoeopathic remedies.

Patient Information

A 42-year-old female patient presented with a primary complaint of severely itchy, skin lesions.

Chief Complaints and History of Present Illness:

The patient reported annular lesions over both thighs, hips, and lower legs (below the knees) and then chest that had been present for 2–3 months. The eruptions were characterized by severe itching +++ that worsened with perspiration and scratching. Scratching followed by marked redness.

Initially, the lesions were moist, exuding a sticky, watery discharge. Over time, they evolved into dry, scaly plaques with distinctly elevated edges. She had applied various over the counter topical allopathic ointments and coconut oil, which provided only transient relief. Additionally, she complained of exertional breathlessness while climbing stairs and on exertion.

Past History:

- Malaria 10 years ago, conventionally treated.
- Hypertension diagnosed 2–3 years ago; taking medication occasionally.

Family History:

- Father: Type 2 Diabetes Mellitus.
- Mother: Hypertension and chronic pruritus.
- Brother: History of tinea infection (recovered).
- Elder Sister: Hypertension, Diabetes Mellitus, and recurrent tinea.
- Son: Psoriasis.
- Husband: Apparently healthy.

Physical Generals:

- Thermal state: Hot patient, prefers warm bathing.
- Appetite: Adequate.
- Thirst: Approx. 2 liters/day; has to consciously remember to drink.
- Desires: Sour foods++, green chillies++.
- Aversions: Brinjal.
- Perspiration: Moderate and generalized, predominantly on the back and legs.
- Urine: Normal 4-5 times/day.
- Bowel: Regular twice a day.
- Sleep: Sound.

Obstetric & Gynaecological History:

- Menstrual cycle: Regular, 28-day cycle; moderate flow lasting 5 days.
- Obstetric history: G1P1A0 (FTND).

Mental Generals:

The patient is highly sympathetic and cannot bear to see others in pain. She is profoundly intolerant of injustice. She is very active. She is very much helpful to others, punctual, talkative, and religious. She has a tendency toward overthinking. When angered, she speaks in a loud voice but easily pacifies herself by reciting God's name. It remains in her mind but still she will talk and doesn't make others feel that they had hurt her. She is family-oriented and possesses moderate self-confidence (approximately 70%).

Physical Examination:

- Weight: 63 kg.
- Local Examination: Multiple annular, erythematous plaques with central clearing and scaly borders distributed over the bilateral anterior thighs, gluteal region, and calves.

Diagnostic Assessment

Clinical Diagnosis: Dermatophytosis, clinically consistent with tinea corporis with involvement of the groin region suggestive of tinea cruris.

Investigations: No laboratory investigations, including potassium hydroxide (KOH) microscopy or fungal culture, were performed in this case.

ICD-10 Codes:

- B35.4 (Tinea corporis)
- B35.6 (Tinea cruris)

Case Analysis and Miasmatic Evaluation

Miasmatic Diagnosis:

The primary phase of the lesion combined with the annular morphology indicates a strong Sycotic component. The patient's breathlessness, coupled with a dense family history of metabolic diseases

and chronic skin conditions (psoriasis, recurrent tinea), strongly highlights an underlying Tubercular diathesis.⁽⁵⁾

Repertorial Sheet:

Repertorization Sheet - ZOMEIO													
Physician Name : Dr. Dhami, Patient Name : , Reg. No. : , Date : 14/05/2024													
Remedy	Act	Phos	Sulph	Puls	Sep	Calc	Bell	Nat m	Ign	Magph	Caust	Hep	
Totally	36	33	33	33	33	33	33	33	33	33	33	33	33
Symptoms Covered	13	13	13	13	13	13	13	13	13	13	13	13	13
[Complete] [Mind] [Sympathetic, compassionate, sensitive]	3	4	1	4	3	1	1	3	3	3	4	3	
[Complete] [Mind] [Sympathetic, cannot support]	1	1	1	2	2	1	1	2	2	2	3	0	
[Complete] [Mind] [Sympathetic, affectionate]	4	1	4	4	4	3	4	1	3	4	1	0	
[Complete] [Mind] [Sympathetic]	3	3	3	3	0	3	4	1	3	2	2	3	
[Complete] [Mind] [Sympathetic, phlegmatic]	3	4	4	3	3	3	3	4	4	3	4	4	
[Complete] [Mind] [Sympathetic]	4	4	4	4	4	4	4	4	4	4	4	4	
[Exact] [Stomach] [Thirstless]	2	1	1	3	2	0	2	1	1	2	1	1	
[Exact] [Stomach] [Desires Pungent things]	2	0	0	0	0	0	0	0	0	0	0	2	
[Exact] [Stomach] [Desires Sweet acids, etc.]	2	2	2	2	2	2	1	2	2	0	0	3	
[Complete] [Respiratory] [Difficult]	4	4	4	4	4	4	4	4	4	4	4	4	
[Exact] [Respiratory] [Difficult Walking Asper]	3	2	3	2	2	3	1	1	2	0	2	0	
[Exact] [Skin] [Eruptions Herpetic]	3	2	3	1	3	3	1	3	0	2	2	2	
[Exact]	0	0	0	0	0	0	0	0	0	0	0	0	
[Exact] [Eruptions Itching, itching, scratching, after]	0	1	0	0	0	0	0	0	0	0	0	0	
[Exact] [Skin] [Eruptions Itching, itching, Red]	3	3	2	0	3	2	3	2	0	1	0	1	
[Exact] [Skin] [Eruptions Scaly]	3	3	2	0	3	2	3	2	0	1	0	1	

Totality of Symptoms

Symptoms Covered													
[Complete] [Mind] [Sympathetic, compassionate, sensitive]	3	4	1	4	3	1	1	3	3	3	4	3	
[Complete] [Mind] [Sympathetic, cannot support]	1	1	1	2	2	1	1	2	2	2	3	0	
[Complete] [Mind] [Sympathetic, affectionate]	4	1	4	4	4	3	4	1	3	4	1	0	
[Complete] [Mind] [Sympathetic]	3	3	3	3	0	3	4	1	3	2	2	3	
[Complete] [Mind] [Sympathetic, phlegmatic]	3	4	4	3	3	3	3	4	4	3	4	4	
[Complete] [Mind] [Sympathetic]	4	4	4	4	4	4	4	4	4	4	4	4	
[Exact] [Stomach] [Thirstless]	2	1	1	3	2	0	2	1	1	2	1	1	
[Exact] [Stomach] [Desires Pungent things]	2	0	0	0	0	0	0	0	0	0	0	2	
[Exact] [Stomach] [Desires Sweet acids, etc.]	2	2	2	2	2	2	1	2	2	0	0	3	
[Complete] [Respiratory] [Difficult]	4	4	4	4	4	4	4	4	4	4	4	4	
[Exact] [Respiratory] [Difficult Walking Asper]	3	2	3	2	2	3	1	1	2	0	2	0	
[Exact] [Skin] [Eruptions Herpetic]	3	2	3	1	3	3	1	3	0	2	2	2	
[Exact]	0	0	0	0	0	0	0	0	0	0	0	0	
[Exact] [Eruptions Itching, itching, scratching, after]	0	1	0	0	0	0	0	0	0	0	0	0	
[Exact] [Skin] [Eruptions Itching, itching, Red]	3	3	2	0	3	2	3	2	0	1	0	1	
[Exact] [Skin] [Eruptions Scaly]	3	3	2	0	3	2	3	2	0	1	0	1	

Elimination Method

Repertorial Analysis:

Repertorization was carried out using ZOMEIO PRO Software with cross repertorization on the basis of characteristic mental generals, physical generals and particular symptoms. The marked sympathy and profound intolerance of injustice were the most characteristic mental symptoms which were also used as an eliminating symptoms which strongly indicated Causticum, and after confirming with Materia Medica it was selected as the constitutional remedy.

Intervention

The mental profile sympathetic, intolerant of injustice, strongly pointed toward Causticum. While Causticum is traditionally a chilly remedy, the profound mental picture took precedence over the thermal state, as guided by classical homeopathic principles.⁽⁶⁾

First Prescription: Date:18/05/25.

Rx,

Causticum 1M single oral dose.

Phytum 30C TDS for 15 days.

The patient was advised to maintain local hygiene, avoid sharing towels or clothing, keep the affected areas dry, and discontinue topical corticosteroids or other medicated ointments during treatment.

Follow-Up and Outcomes

Date	Clinical Status & Symptom Evaluation	Prescription
02/06/25 	Itching+++ as it is more on chest area. < sour things, curd?. The redness, raised margins and are still active and got spread. The area is dry and scaly.	Rx: Bacillinum 1M, 1 dose. Phytum 30C TDS for 30 days.
03/07/25 	Eruptions are stationary; the spread has stopped. Itching is moderate but still present. The affected area has dried up. Mild change in exertional breathlessness.	Rx: Phytum 30C TDS for 30 days.
04/08/25 	Remarkable improvement upto 50%. The raised active margins of the lesions have flattened and blackish discoloration is seen. Itching is there but moderate. Breathlessness has reduced significantly. Energy levels improved.	Rx: Causticum 1M, 1 dose. Phytum 30C TDS for 30 days.
04/09/25 	Complete clearance of the ring-shaped lesions. Only mild post-inflammatory hyperpigmentation remains. Very mild itching, no new lesions. Breathlessness is entirely resolved.	Rx: Phytum 30C TDS for 30 days.

Clinical Pictures:

Figure 1: Before Treatment



Figure 2: After Treatment



DISCUSSION

Treating chronic dermatophytosis requires a multifaceted approach. Conventional topical treatments often lead to the suppression of the disease, pushing the pathology to deeper organs, which Hahnemann warned against in his theory of Chronic Diseases.⁽⁴⁾ In the present case, the concurrent history of exertional breathlessness was considered during case analysis; however, a causal relationship between the cutaneous disease and respiratory symptom was not established.

Causticum was selected as the foundational constitutional remedy. Its pathogenesis deeply covers the patient's striking mental characteristics extreme sympathy and intolerance of injustice.

The turning point of the case occurred during the second follow-up when the pathology became stationary. According to H.A. Roberts and J.H. Allen, when well-indicated remedies fail to progress a case, an intercurrent nosode corresponding to the underlying miasm is required.⁽⁵⁾

The patient's symptom of breathlessness, combined with a family history of psoriasis and recurrent tinea, clearly indicated the Tubercular miasm. Following the administration of a single dose of Bacillinum 1M, subsequent follow-up demonstrated cessation of lesion spread, progressive reduction in itching and flattening of the active margins, accompanied by improvement in exertional breathlessness.

CONCLUSION

This case illustrates the profound efficacy of individualized homeopathic treatment in managing chronic dermatophytosis. It highlights the importance of matching the patient's mental totality for constitutional prescribing, and firmly validates

the clinical necessity of miasmatic evaluation and the use of intercurrent nosode like Bacillinum when healing reaches a plateau.

Declaration of Patient Consent

Consent was obtained from the patient for the use of clinical information and images for academic and scientific publication purposes and was informed that her name and initials will not be published and due efforts will be made to conceal the identity, but anonymity cannot be guaranteed.

Conflict of Interest

None.

Remedy Profile:

Bacillinum

- Dr. Burnett has shown that ringworm of the scalp and pityriasis versicolor on the body are indications of tubercular diathesis, and they respond to this remedy.
- Also they are leading indications for it when present in combination with other affections.⁽⁸⁾
- *Ringworm; pityriasis.*^(7,9)
- Useful as an intercurrent remedy.⁽⁹⁾

Causticum

- Causticum is portrayed in homeopathic literature as a serious, sincere, and justice-driven personality who is deeply affected by the suffering of others.
- They strongly oppose injustice and often take responsibility for helping people, making them loyal, empathetic, and willing to sacrifice for a cause.
- When excessive, their sense of sacrifice may turn into martyrdom, emotional manipulation, resentment, or a need to control others.
- Causticum personalities may also become morally rigid, judgmental, and convinced that they are always right.

- Their strong identification with being the “helper” can make it difficult to recognize their own contradictions or contribution to conflicts.
- Physically, homeopathic sources associate Causticum with symptoms such as
 - » ill effects of burns and scalds, fright, grief, worry, sorrow, night watching;
 - » hoarseness or loss of voice,
 - » paralysis,
 - » urinary problems,
 - » joint stiffness,
 - » warts,
 - » chronic cough, particularly when linked to grief or prolonged emotional stress.
- Itching and humid tetter.
- Ulcerative vesicles.
- Burning ulcers, with yellowish-looking skin; ulcers burning, with corroding pus, with thin or watery pus, suppurating; jerking pains running through the ulcers.
- Excoriation in children.
- Painful corns in the feet.
- Warts, also with pain and inflammation.
- Panaris.
- Painful varices.

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Skin⁽⁸⁾

- Violent itching, esp. in the back, and in the calves of the legs.
- Itching of the whole body at night (Itch).
- Injuries of the skin, which had been healed, become sore again.
- Itch suppressed by mercury or sulphur; burning itch.
- Tingling (or stinging) swelling (sometimes called "buzzing" swelling) (Guernsey).
- Eruptions resembling scabies.
- Miliary eruptions and nettle-rash.

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Tracing Roots of Disease: A Homoeopathic Case Report of Tinea Corporis Highlighting Prenatal and Emotional Influences

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Abstract

Background:

Ringworm (Tinea Corporis) is a superficial fungal infection of keratinised tissue which is caused by dermatophytes, affecting skin, hair and nails. Its increasing prevalence, recurrence and antifungal resistance have become major challenges. Homoeopathy offers an individualised holistic approach by considering the patient's constitutional characteristic factor rather than treating fungal infection alone.

Case Presentation:

A 9-year-old female child presented with recurrent tinea infection for 6 months, characterised by annular pruritic lesions over the chin and clavicular region without any discharge. Detailed case taking revealed characteristic mental and physical generals, including indifference, reserved nature, aversion to play, thirstlessness, constipation, and dry skin, along with significant maternal History.

Conclusion:

This case highlights the role of individualised constitutional Homeopathic treatment in the management of recurrent tinea infection. Improvement was achieved through totality-based remedy selection, suggesting that Homoeopathy

may help to reduce susceptibility and recurrence while improving the overall well-being.

Keywords:

Tinea Corporis, Homoeopathy, Maternal History, Constitutional Prescribing, Case Report.

Introduction:

Dermatophytosis, commonly referred to as tinea or ringworm, is a superficial fungal infection of keratinised tissues, including skin, hair, and nails, caused by keratinophilic dermatophytes^(1,5). The three principal genera responsible for dermatophytosis are Trichophyton, Microsporum, and Epidermophyton^(1,4,5). Tinea infection is found to be prevalent in tropical and geographical areas where higher humidity, overpopulation and poor hygienic living conditions are present. According to WHO, the prevalence rate of superficial mycotic infections worldwide is 20-25%. Tinea Corporis was the commonest clinical presentation, followed by tinea cruris (10%), Tinea Manuum (2.5%), Tinea Facitis (1.8%), Tinea pedis (0.7%)^(5,7). In India, the prevalence rate of tinea is about 36.6–78.4%⁽³⁾. Clinical manifestation includes intense itching, annular plaques with peripheral scaling, central healing and gradual centrifugal spread.

Table 1: Repertorial Mapping of Sepia in Diverse Clinical Manifestations of Tinea

REPERTORY	RUBRICS	CLINICAL PRESENTATION
BOERICKE	1. [skin] Tinea Favosa, Favus 2. [skin] Herpes (tetter): Circinatus: Transurans 3. [skin] Trichophytosis, ringworm 4. [skin] Trichophytosis, Ringworm: isolated spots on upper part 5. [Skin] Herpes (tetter): circinatus: isolated spots in 6. [Head] Scalp: Eruption: Favus (prurigo, scald head)	 Fig.1 Tinea favosa (Favus)
BBCR	1. [Head External]: Crust (scurf), tinea 2. [Head] Eruption on: Favus 3. [Skin and exterior body] Tetter (including herpes and eczema): Ringworm Eruption (tendency to) Herpetic Ringworm	 Fig.2 Tinea Capitis
COMPLETE	1. Skin, Trichophytosis 2. Skin, Trichophytosis isolated spots on upper part of body, in	 Fig.3 Tinea Corporis
SYNTHESIS	1. (skin), eruption, Ringworm 2. (Skin), eruption, herpetic circinate 3. (Skin), eruption, herpetic, circinate, spots in isolated 4. (Skin) eruption, herpetic, circinate, spring every 5. (skin), eruption, ringworm, spots, in upper parts of body 6. Head, Eruption, Herpes, circinate	 Fig.4 Tinea Corporis
MURPHY	1. Skin, Ringworm, general 2. Abdomen, Ringworm 3. Diseases, Ringworm, general beard 4. Diseases, Ringworm, general face 5. Diseases, Ringworm, general head 6. Face, Barber's itch, ringworm of beard 7. Head, Dandruff herpetic circles like ringworm, in	 Fig.5 Tinea Barbae

Homeopathic Management:

In Homeopathy, cure is based on the law of similia and selection of the remedy is based on the constitutional approach in the management in disease. According to homeopathic principles, the removal of local symptoms by external application may suppress the disease and drive it internally^(1,4). The remedy selected on the specific symptoms and characterised of the infection, as well as the individual's unique constitution.

Homeopathic medicine focuses on stimulating the body's natural healing mechanism to combat the infection from within. (Homeopathic Medicine has ability to target the root cause at problem rather than suppressing symptoms and also prevent disease recurrence⁽¹⁾).

Case Report:

A 9-year-old female child presented with the complaint of ringworm. The patient was apparently well until 6 months ago, when she first

developed a ringworm lesion on the right side of her chin. Subsequently, a similar lesion developed near the clavicular region. The lesions were associated with severe itching but there was no discharge. The patient had also taken allopathic treatment, which provided only temporary relief, and the condition recurred frequently.

Associated complaint: Dry Hard Stool Occasionally.

Physical General:

- Appetite: Take meals twice daily
- Desire: sour food

- Aversion: Ns
- Bowel: Once/day but occasionally constipated
- Thirst: Decreases
- Urine: Pale yellow, occasionally Burning.
- Perspiration: Scanty (only in summer) no stain, no odour.
- Thermal: Chilly
- Allergy/Habit/Addiction: none.
- Skin: Dryness ++
- Past History: Nothing Specific

Table 2: Family History

Family Member	Age	Complaints
Father	40	HTN (On Allopathic Rx)
Mother	35	Ringworm on Neck (Rx Ayurvedic)
Sister	15	Healthy
Paternal Grandfather	Not Known	HTN (On allopathic Rx)
Paternal Grandmother	Not Known	DM (On allopathic Rx)
Maternal Grandfather	Not Known	Died
Maternal Grandmother	Not Known	Died

Mental Generals:

- Reserved by Nature
- Became silent and withdrawn when reprimanded by family member.
- Became irritable when consoled by her family members.
- Prefer to play alone rather than play with other children.
- Does not express her emotions easily and talks very little with family members.

Pregnancy History OF Mother:

The patient's mother reported that she was under emotional stress throughout pregnancy. She already had one daughter while her mother-in-law strongly desires a male child. As a result, she was repeatedly taunted and criticized for not giving birth to a son, even minor mistakes in household work were met with frequent criticism and

emotional humiliation. The husband was unemployed and had alcohol dependence, leaving entire responsibility of supporting the family to the mother. Whenever she shared her feelings with her husband, he became irritable and did not provide emotional support. Gradually, she became emotionally withdrawn, remained silent, lost interest in social interaction and spoke very little with family members, which leads to indifference.

First Prescription: (05/07/2025): *Sepia 200 OD 1 dose for 3 days, SL 4 pills TDS for 7 days.*

Auxiliary Measures:

- Wash clothes in hot water
- Avoid Scratching
- Keep fingernails short & clean.
- Don't share Personal items like towels, clothes, comb, etc.

Repertorial Sheet:

Fig.6: Reperterisation chart from Cara ©1997 Miccant Ltd

	Sep	Hell	Lyc	Nat-m	Nit-ac	Phos	Bell	Calc	Chin	Ign	Nat-c	Nux-v	Plat	Staph	Sulph	Thuja	Am-c	Ambr	Arg-n
Weighted	18	11	11	13	10	14	9	10	10	9	8	7	10	10	9	8	6	5	6
Indifference, apathy family, to his	8	7	6	6	6	5	5	5	5	5	5	5	5	5	5	5	4	4	4
Irritability, consolation agg	18	11	11	13	10	14	9	10	10	9	8	7	10	10	9	8	6	5	6
Reserved	3	1			1	3													
Thirstless	3	1	1	3	2		2	1	1	3		1	2	1					
Constipation,	1	2	1	1	1	3	1	2	1	2	1	1	2	2	1	1	1	1	1
Dry, skin,	2	3	2	1	1	1	1		3	1	1	1	1	1	1	1	1	1	2
Ringworm, general ringworm, face	3	2	3	3	3	3	1	3	2	2	2	3	3	3	3	3	2	2	2
Ringworm, general spots, in isolated	2	1	3	3	2	3	3	3	3	1	2	1	2	2	3	1	2	1	1
	3	1	1	2		1		1			2				1	2			
	1																		

Reason for Selection: The remedy was selected on the basis of the totality of symptoms. The characteristic mental symptoms included reserved nature, indifference towards family interactions, aversion to play with other children, preference for solitude, and becoming silent and withdrawn after reprimand. The physical generals comprised thirstlessness, occasional constipation, dry skin,

and desire for sour food. The particular symptoms included recurrent annular pruritic lesions over the face and clavicular region, with ringworm affecting an isolated spot in the upper part of the body. Considering the totality of the characteristic mental symptoms, physical generals, particulars, and the significant maternal history, *Sepia officinalis* was selected as the constitutional remedy.

Table 3: Follow-up

Date	Follow Up	Treatment
12/07/2025	No Change Observed in lesion. The patient condition remained stable.	SL 4 pills TDS For 15 days.
27/07/2025	Itching slightly reduced, No New lesion appears. Irritability reduced. Constipation Released.	SL 4 Pills TDS For 15 days
11/08/2025	Itching slight increasing in scapular Region, sleep disturb due to itching.	Sepia 200 (1) dose. SL 4 pills TDS For 15 days.
26/08/2025	Lesion disappear but Itching remains same. Generals Better	SL 4 Pills TDS For 15 days.
10/09/2025	Complaints 70 % Better. Itching Better. Sleep Better. Lesion almost Disappear but marks remain.	SL 4 Pills TDS For 15 days.
25/09/2025	Lesion Further Healed in size. No itching. No Lesion. Sleep Better. Better in Mood. Child now plays with other Children. Communicating with Family. No Constipation. Generals are Better.	SL 4 Pills TDS For 15 days.
10/10/2025	No Significant complaints. No itching. Lesion Completely Healed. No marks. Child is turned from indifference to joyful state.	RX Stopped. Complete Cure.

Fig 7: Before treatment and after treatment evidence



DISCUSSION:

Dermatophytosis (tinea/ringworm) is a common superficial fungal infection of the skin, hair, and nails caused by *Trichophyton*, *Microsporum*, and *Epidermophyton* species. It affects approximately 20–25% of the global population and is particularly prevalent in tropical regions. In India, tinea corporis is the most common presentation, with a prevalence of 36.6–78.4%. This case was selected because of its chronic recurrent nature, significant psychological background, and favourable response to individualised homoeopathic treatment. Previous studies have identified dermatophytosis as a major global health problem, particularly among children, adolescents, older adults, individuals with diabetes, poor hygiene, topical corticosteroid use, poor circulation, and impaired immunity. Among 89 Indian studies published in the past five years, only 30 were freely available in full text, and few evaluated homoeopathic management. Alam et al. (2020) reported that tinea corporis constituted 35% of cases, predominantly among males aged 21–40 years. Studies by Sharma et al. (2022), Singh et al. (2020), Uttam Chandani et al. (2019), Acharya et al. (2021), and Roy et al. (2021) demonstrated encouraging outcomes with individualised homoeopathic treatment for various forms of dermatophytosis.^[2]

Experimental studies suggest that certain homoeopathic medicines possess antifungal and immunomodulatory properties, with efficacy comparable to ketoconazole in some studies^[3]. A previous case report using *Psorinum* 200C reported complete recovery, no recurrence during six months of follow-up, marked improvement in DLQI score (22 to 2), and a MONARCH Inventory score of +9. The report also cited evidence from randomised controlled trials, observational studies, and a systematic review supporting homoeopathy in different forms of tinea^[5]. In the present case, itching gradually subsided, lesions resolved completely, sleep and constipation improved, and emotional well-being improved significantly. No new lesions appeared, and complete healing was maintained without recurrence during follow-up. Although these findings suggest a potential role for constitutional homoeopathic treatment in tinea corporis, larger well-designed clinical trials with longer follow-up are needed to confirm

these findings objectively.

CONCLUSION:

This case report highlights the successful homoeopathic management of recurrent tinea corporis through a holistic and individualised constitutional approach. Selection of the constitutional remedy was based on the patient's characteristic mental and physical generals, along with the significant prenatal emotional history of the mother, reflecting the concept of individual susceptibility. Progressive reduction in itching, complete resolution of lesions, absence of recurrence during follow-up, and improvement in the patient's emotional well-being support the effectiveness of individualised homoeopathic treatment. This case also emphasises the importance of considering prenatal emotional influences while evaluating paediatric cases

Declaration of patient consent:

Written informed consent was obtained from the parent(s)/legal guardian(s) of the female child for publication of her clinical information and images. The child's identity has been protected, and no identifying information has been disclosed.

FINANCIAL SUPPORT AND SPONSORSHIP: Nil.

CONFLICTS OF INTEREST: None declared

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KOH-Confirmed Tinea Corporis Managed with Chrysarobinum: A Case Report with DLQI Assessment

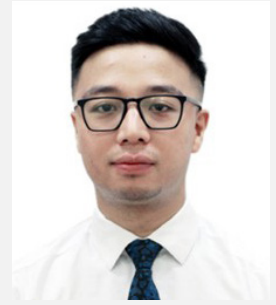
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Research conducted during postgraduate training



PEER REVIEWED

Abstract

Background

Tinea corporis is a common superficial dermatophyte infection characterised by annular erythematous lesions, pruritus, and an advancing raised border. Although diagnosis is primarily clinical, potassium hydroxide (KOH) examination can provide mycological support. The Dermatology Life Quality Index (DLQI) is a validated tool for assessing the impact of dermatological conditions on quality of life.

Case Presentation

A 49-year-old male presented with a one-month history of itching, burning, and reddish annular eruptions involving the bilateral axillae and lower abdomen, aggravated at night and during perspiration. Clinical examination revealed well-defined raised margins with central clearing, and KOH examination of skin scrapings was positive for fungal elements, supporting the diagnosis of tinea corporis. Based on the characteristic local symptoms and their modalities, *Chrysarobinum* 30C was prescribed. The patient was followed up over two subsequent visits, with clinical findings and DLQI documented.

Outcome

At the first follow-up, improvement in the documented symptoms was noted, although reddish eruptions persisted. At the final documented follow-up, the active eruptions were no longer

observed, with residual blackish discoloration over the previously affected areas. The DLQI score decreased from 8 at baseline to 6 at the final follow-up. Post-treatment KOH examination was not performed; therefore, microbiological clearance could not be confirmed.

Conclusion

This case documents clinical improvement in a KOH-confirmed case of tinea corporis following individualised homoeopathic management with *Chrysarobinum* 30C, accompanied by an improvement in the patient's reported quality of life. As this is a single case without post-treatment mycological confirmation, the findings cannot establish treatment efficacy or fungal eradication. Further systematic studies with objective mycological assessment and longer follow-up are warranted.

Keywords

Tinea corporis; Dermatophytosis; *Chrysarobinum*; Homoeopathy; KOH examination; Dermatology Life Quality Index; DLQI; Case report

Introduction

Tinea corporis, commonly known as ringworm of the body, is a superficial dermatophyte infection affecting the glabrous skin. It is predominantly caused by species belonging to the genera *Trichophyton*, *Microsporum*, and *Epidermophyton*. Dermatophytes invade the keratinised tissues of the skin and are favoured by warm and humid environmental conditions. Factors such as excessive perspiration, occlusive or tight clothing, close contact

with infected individuals or animals, and compromised skin integrity may facilitate transmission and persistence of infection. [1-3]

Clinically, tinea corporis typically presents as an annular, erythematous and scaly plaque with an advancing raised border and central clearing. Pruritus is a common symptom and may be accompanied by burning or irritation. Lesions may occur singly or at multiple sites and may enlarge or coalesce as the infection progresses. Although the diagnosis is frequently made clinically, mycological examination can provide supportive evidence, particularly when the clinical presentation is atypical or when confirmation is required. Potassium hydroxide (KOH) preparation of skin scrapings is a simple direct microscopic method for demonstrating fungal elements and supporting the diagnosis of dermatophytosis. [4-6]

Management of tinea corporis generally involves topical antifungal therapy for localised disease, while systemic antifungal treatment may be required in extensive, recurrent, or difficult-to-treat infections. In addition to treatment, measures such as maintaining the affected areas clean and dry, avoiding sharing personal articles, regular laundering of clothing and bedding, and reducing occlusion and friction are important in limiting transmission and recurrence.

Dermatological disorders may also affect a patient's quality of life in addition to producing physical symptoms. The **Dermatology Life Quality Index (DLQI)**, developed by Finlay and Khan, is a validated ten-item questionnaire used to assess the impact of skin disease on various aspects of daily life, including symptoms, daily activities, leisure, work or study, personal relationships, and treatment. The instrument is widely used in dermatological practice and research to quantify the patient's perceived burden of skin disease and to monitor changes over time. [7]

Homoeopathic management is based on individualised assessment of the patient's characteristic symptoms, including the presenting local manifestations together with relevant general and mental symptoms. *Chrysarobinum* has traditionally been described in homoeopathic literature in relation to various chronic and inflammatory skin conditions, including ringworm and intensely

itching eruptions. [8,9] The present case describes the management of a KOH-confirmed case of tinea corporis with *Chrysarobinum*, with clinical follow-up and assessment of dermatology-related quality of life using the DLQI.

CASE PRESENTATION

Preliminary Data

Name: Mr RHS
Age: 49 years
Sex: Male
Religion: Islam
Education: Diploma in
Occupation: Manager
Marital Status: Married
Address: Kankanaddy, Mangalore
Date: 13/08/2025
SCR no: 68938

Chief Complaint: The patient presented with a complaint of itching of the skin on both axillae and lower abdomen for the past month.

LOCATION	SENSATION	MODALITIES	ACCOMPANIMENTS
INTUGEMARY SYSTEM	Itching++	< Night++	-
B/L Axilla, & Lower Abdomen Since 1 Month	Burning++ Eruption: Reddish with raised edges and central clearing++	< Perspiration++	
Gradual onset and progression.			

History Of Chief Complaint:

The patient was apparently well one month back and gradually started with itching and eruptions over the bilateral axilla and lower abdomen. The complaint is more at night and during perspiration. The eruptions are reddish in colour and have raised edges with central clearing. There is no discharge or bleeding from the region

Past History:

Medical History: Nothing Significant

Family History: Nothing Significant

Treatment History: For the presenting complaint.

Surgical History: Nothing Significant

Allergic History: Not allergic to Dust, Diet or Drug.

Personal History:

- **Diet:** Mixed
- **Appetite:** Good
- **Thirst:** 2-3 litres/day
- **Craving:** Sweets++
- **Aversion:** Sour+
- **Perspiration:** Generalised
- **Bowel:** 1 time/day
- **Bladder:** 8-10 times/day; 1 time/ night
- **Sleep:** Good
- **Dreams:** Unremembered
- **Thermal:** Likes Monsoon, winter season, likes fan, likes open air, uncovers while sleeping, prefers light and loose clothing, baths in tepid water- HOT PATIENT
- **Addictions:** Nil

General Physical Examination:

Appearance: Moderately-built & Nourished, Light complexion. Lean individual.

No signs of Pallor, Cyanosis, Clubbing, Icterus, Oedema and Lymphadenopathy.

Vital Signs: **Temperature-** Afebrile at the time of examination; BP:110/80 mmHg **Pulse:** 66 bpm **Weight-** 80 kg **Height:** 178cm

Local Examination- Skin

Axilla (b/L) & Lower Abdomen: Reddish eruptions, well-defined raised margins with central

clearing, KOH Test: +ve

Systemic Examination:

Respiratory System: Normal Vesicular Breath Sounds heard, No Added Sounds.

Cardio-vascular System: S1 & S2 heard, No Murmurs.

Provisional Diagnosis

Tinea Corporis

- Annular, erythematous eruptions.
- Scaly plaques with central clearing and an active advancing border.
- Itching, sometimes a burning sensation.
- Lesions are often circular or polycyclic and may coalesce into larger patches.
- Worse while perspiring.
- KOH Mount: +ve (presence of fungal hyphae).

Sector Totality:

- Eruptions over B/L Axilla & Abdomen.
- Reddish eruptions, well-defined raised margins with central clearing.
- Itching.
- Burning Sensation.
- Aggravation during perspiration & night.

General Management:

Diet and Regimen	Ancillary Measures	Education and Orientation
Recommended: - Vitamin C & Zinc-rich foods such as Citrus fruits, nuts, which promote skin healing. - Anti-inflammatory foods such as garlic, turmeric and ginger have natural antifungal effects. - Hydration: To drink plenty of water and eat hydrating foods. To Avoid: - Sugary & refined carbs: Promote fungal growth. - Excess dairy & yeast-rich foods: May aggravate symptoms in some. - Processed & oily foods: Can impair immunity and slow healing.	- Keep the affected area clean and dry. - To not share towels or clothes. - Wash towels, sheets and clothes frequently - Avoid wearing tight clothing to avoid causing friction. - Try not to scratch the rash as this may spread the fungus to other areas of the body.[17]	- Educating the patient in detail about personal hygiene. - Assuring the patient that symptoms are manageable. - To be regular in follow-ups.

Remedy Selection- Acute Totality

PROVISIONAL REMEDY	DIFFERENTIAL REMEDY
CHRYSAROBINUM - Skin diseases with intense itching and burning. - Ringworm (Tinea corporis, Tinea capitis) – crusted, scaly, itching lesions. - Violent itching is worse at night, leading to scratching until skin bleeds. - Erythematous, oozing, and crust-forming eruptions. - Skin appears dry, shrivelled, and dirty-looking.	TELLURIUM - Circular lesions with “double ring” or overlapping rings. - Severe itching with burning; lesions often offensive. - Moist, offensive-smelling eruptions, often raw underneath. - Moist, scaly, reddish patches with a distinct ring form. Ruled out: As a double ring is absent or no overlapping rings, moist and offensive-smelling eruptions, Tellurium is ruled out.

Prescription

Date: 13 August 2025

Medicine	Potency	Dosage and schedule	Duration
<i>Chrysarobinum</i>	30C	4 globules, three times daily	2 weeks
2-grain tablets	—	2 tablets, three times daily	2 weeks
SL packet	—	1 packet at bedtime on alternate nights	2 weeks

Follow-up Criteria:

- Itching
- Burning sensation
- Aggravation at Night
- Aggravation during Perspiration

5. Eruptions

Follow-up

27 August 2025: The same prescription was continued for a further 2 weeks.

11 September 2025: The same prescription was continued for a further 2 weeks.

Table 1 — Follow-up clinical response

Follow-up	Itching	Burning	Aggravation at night	Aggravation during perspiration	Eruptions	Clinical examination
27 Aug 2025	Decreased	Decreased	Decreased	Increased	Present	Reddish eruptions over bilateral axillae and lower abdomen
11 Sep 2025	Decreased	Decreased	Decreased	Present	Absent	Blackish discoloration over bilateral axillae and lower abdomen

Table 2 — DLQI assessment

Time point	DLQI score
Baseline – 13 Aug 2025	8
Final documented follow-up – 11 Sep 2025	6

Outcome and Clinical Response

Following initiation of *Chrysarobinum* 30C, the patient was followed up on 27 August 2025 and 11 September 2025.

At the **first follow-up (27 August 2025)**, the patient reported improvement in the presenting symptoms, although reddish eruptions were still observed over the bilateral axillae and lower abdomen. The patient's general condition remained

good, and the prescribed treatment was continued.

At the **second and final documented follow-up (11 September 2025)**, further clinical improvement was noted. The previously documented eruptions were no longer present, while **blackish discoloration remained over the bilateral axillae and lower abdomen**. The patient's general condition remained good. The same prescription was continued.

The **Dermatology Life Quality Index (DLQI)** score decreased from **8 at baseline to 6 at the final documented follow-up**, representing a two-point reduction in the patient's reported dermatology-related quality-of-life impact.

Table: Clinical progression

Assessment	Clinical findings	DLQI
Baseline – 13 Aug 2025	Reddish annular eruptions with raised margins and central clearing over bilateral axillae and lower abdomen; itching and burning	8
Follow-up 1 – 27 Aug 2025	Reddish eruptions persisted; improvement in documented symptoms	—
Follow-up 2 – 11 Sep 2025	Active eruptions no longer observed; residual blackish discoloration over affected areas	6

Note: Post-treatment KOH examination was not performed; therefore, microbiological clearance could not be assessed.

DISCUSSION

Tinea corporis is a common superficial dermatophyte infection characterised by annular erythematous lesions with an advancing raised border and central clearing, often accompanied by pruritus and, in some cases, burning sensations. In the present case, the clinical presentation was consistent with tinea corporis, with reddish annular eruptions involving the bilateral axillae and lower abdomen, associated with itching and burning. The symptoms were aggravated at night and during perspiration. The clinical diagnosis was further supported by a positive potassium hydroxide (KOH) preparation from the affected skin.

The selection of *Chrysarobinum* was based on the characteristic features of the acute skin presentation. The patient presented with itching and burning associated with reddish eruptions, with aggravation at night and during perspiration. *Chrysarobinum* has been described in homoeopathic literature in relation to intensely itching and burning skin eruptions and ringworm-like conditions. The remedy was therefore selected based on the characteristic local manifestations and their modalities. *Tellurium* was considered as a differential remedy because of its association with circular or ring-shaped eruptions. However, the absence of characteristic features such as double or

overlapping rings and offensive, moist eruptions supported the selection of *Chrysarobinum*.

A change in the clinical appearance of the lesions was documented over the follow-up period. At the first follow-up, reddish eruptions were still observed over the bilateral axillae and lower abdomen. At the second and final documented follow-up, the active eruptions were no longer observed, although blackish discoloration remained over the previously affected areas. This residual discoloration may represent a post-inflammatory pigmentary change; however, its exact nature cannot be established from the available clinical documentation alone.

The patient's **DLQI score decreased from 8 at baseline to 6 at the final documented follow-up**, representing a two-point reduction. According to the standard DLQI interpretation, both scores fall within the category indicating a moderate effect of the skin condition on quality of life. The reduction in score suggests an improvement in the patient's reported dermatology-related quality of life during the documented follow-up period. However, as this was a single case, the change should be interpreted descriptively rather than as evidence of statistical significance.

An important limitation of the present case is the absence of a post-treatment KOH examination. Although the initial diagnosis was supported by a positive KOH preparation, microbiological clearance could not be assessed at the final follow-up. Therefore, the observed clinical improvement should not be interpreted as confirmed fungal eradication. Additional limitations include the single-patient nature of the report and the relatively short documented follow-up period, which does not permit assessment of long-term recurrence.

Despite these limitations, the case provides a documented clinical course of a KOH-confirmed tinea corporis case managed with an individualised homoeopathic prescription of *Chrysarobinum*, with clinical follow-up and assessment using the DLQI. The case may provide a basis for further systematic investigation of individualised homoeopathic approaches in dermatophytosis.

Limitations

- Single-patient case; therefore, the findings cannot be generalised.
- Post-treatment KOH was not performed, so microbiological clearance could not be confirmed.
- The short follow-up period did not allow assessment of long-term recurrence.

Recommendations

- Larger studies with longer follow-up are recommended to evaluate the reproducibility of the observed clinical response.
- Future cases should include **serial KOH examination and standardised clinical photographs** to correlate clinical and mycological outcomes.

CONCLUSION

This case describes the clinical improvement of a KOH-confirmed tinea corporis following individualised homoeopathic management with *Chrysarobinum* 30C. Improvement in the clinical features was accompanied by a reduction in DLQI score from 8 to 6. Although the findings are limited to a single case and microbiological clearance was not assessed at follow-up, the case highlights the potential value of documenting individualised homoeopathic management alongside objective clinical and patient-reported outcome measures. Further systematic studies are required to evaluate this approach.

Patient Consent

Written informed consent was obtained from the patient for publication of the case details and accompanying clinical photographs.

FIGURE 1— BASELINE CLINICAL AND KOH FINDINGS 13 AUGUST 2025

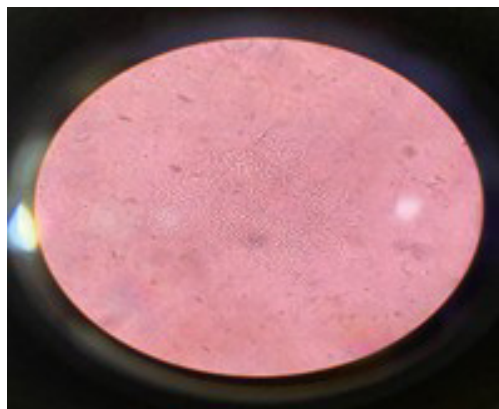
(A) —Clinical photograph



(B) —Clinical photograph



(C) —KOH image



(D) —KOH image

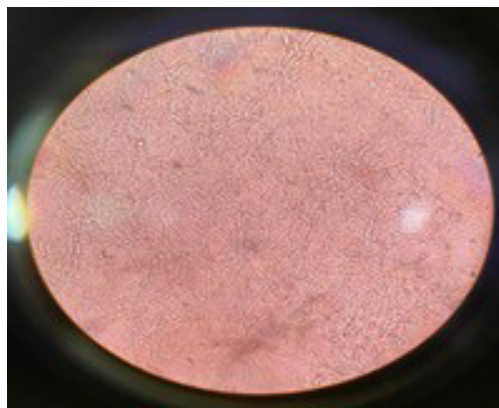


Figure 1. Baseline clinical and mycological findings in tinea corporis. (A, B) Clinical photographs showing the characteristic erythematous annular eruptions over the affected areas. (C, D) KOH preparations of skin scrapings demonstrating positive fungal elements.

AFTER

Figure 2 — Final follow-up

(A)



(B)



Figure 2. Clinical appearance at the final documented follow-up (11 September 2025). (A, B) Clinical photographs showing disappearance of the active eruptions with residual blackish discoloration over the previously affected areas.

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Cassia Sophera In Recurrent Tinea Cruris: A Case Report



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Abstract

Recurrent dermatophytosis is a common clinical problem and may significantly affect quality of life. A 16-year-old male presented with recurrent tinea cruris involving the bilateral inner thighs and gluteal region for 3–4 months. He had a previous episode three years earlier with temporary relief following topical antifungal treatment. The present lesions were associated with intense itching, aggravated at night and by thinking of the complaint, burning aggravated after bathing, particularly with cold water, and stinging after scratching. Profuse perspiration of palms and soles, desire for salty food and a hot thermal state were also noted. Based on the totality of characteristic symptoms, the case was repertorised using Synthesis Repertory. *Cassia sophera* was selected after repertorial analysis and *Materia Medica* verification. Following treatment with *Cassia sophera* 30, progressive improvement was observed, with complete resolution of active lesions and reduction of DLQI from 21 to 0 over three months. No recurrence was observed during follow-up.

Keywords

Tinea cruris, *Cassia sophera*, Homoeopathy, Repertorisation, DLQI.

Introduction

Ringworm, scientifically known as tinea or dermatophytosis, is a widespread fungal infection that affects the skin, nails, and scalp. Its name derives from the characteristic circular rash it forms, although the condition is caused by fungi such as *Trichophyton*, *Microsporum*, and *Epidermophyton*. This infection can manifest in various forms depending upon the body area affected, including athlete's foot (*Tinea Pedis*), jock itch (*Tinea Cruris*), scalp ringworm (*Tinea Capitis*), and body ringworm (*Tinea Corporis*)^[1]. Superficial dermatophytosis affects 20–25% of the world population and is a common infective dermatosis in clinical practice. What was once considered an innocuous, easy-to-treat infection of tropical and subtropical countries mainly seen during the summer and rainy seasons has now become a perennial and difficult to treat entity in India. According to recent studies there has been an increase in the incidence of dermatophytosis across the country in the past decade and especially so over the past 5–6 years. This increase has been at an alarming rate and has resulted in an epidemic-like situation in the country. The current reported prevalence in India falls in a very wide range (6.09%– 61.5%). A prevalence of 6.09% to 27.6% has been reported in studies from south India, while a high prevalence of 61.5% has been recorded in north India. Most of this data comes from hospital-based studies over

periods ranging from 1-2 years. Further, there appears to be a steady increase in the incidence of chronic, relapsing and recurrent dermatophytosis it is not uncommon to encounter disease durations running into months or years [2].

Tinea Cruris also known as jock itch, is an infection involving the genital, pubic, perineal, and perianal skin caused by pathogenic fungi known as dermatophytes. These dermatophytes affect keratinized structures such as hair and the epidermis stratum corneum resulting in a characteristic rash. Intertriginous areas are hospitable environments for fungus with sweating, maceration, and alkaline pH being responsible for the groin's predilection for infection. While tinea infections are often classified by the location of the body affected they are also organized according to the responsible organism's primary source and mode of transmission. Geophilic, zoophilic and anthropophilic fungi are found in and transmitted by soil, animals, and humans respectively. Autoinfection of dermatophytes is also possible and especially crucial in tinea cruris as foot-to-groin spread can occur[3].

Patient Information

A 16-year-old male student from Dhandhuka, Gujarat, pursuing a diploma in Agriculture, presented to the outpatient department on **10 April 2026** with complaints of recurrent ringworm involving the bilateral inner thighs and gluteal region for the past 3–4 months. The patient was apparently well until **3 years ago**, when he first noticed a small brownish, discoloured, circular patch over the bilateral groin region associated with mild itching. Over the following weeks the lesion gradually increased in size became erythematous with well-defined raised margins and central clearing and was accompanied by itching and burning sensation. He consulted a dermatologist and was treated with topical antifungal ointments following which the lesions subsided completely.

After remaining symptom free for nearly **3 years** similar lesions reappeared approximately **3–4 months** before his visit to our outpatient department. Initially the lesions appeared as small brownish discoloured patches over the bilateral inner thighs which gradually enlarged and became erythematous with raised active margins

and subsequently spread to involve the gluteal region. The lesions were associated with intense itching (3+), predominantly aggravated at night and on thinking about the affected areas. The patient also complained of marked burning sensation (3+), which was aggravated after bathing, particularly with cold water. Scratching was followed by a stinging sensation, and repeated scratching occasionally resulted in dry scaling and superficial bleeding over the affected areas. During this recurrence, he again applied topical allopathic antifungal ointments, which produced only temporary relief, following which the lesions gradually increased in extent, prompting him to seek homeopathic treatment.

The patient had a past history of urticaria at the age of 13–14 years, suggestive of a recurrent tendency towards cutaneous disorders. His appetite was satisfactory, taking three regular meals daily. He had a marked desire for salty food. Thirst was normal, approximately 2–3 litres of water daily. Urination occurred three to four times daily without any associated urinary complaints. Bowel habits were regular, with one satisfactory stool daily. Perspiration was profuse, particularly over both palms and soles. The patient was thermally hot and preferred a cooler environment. Sleep was sound and refreshing, with no significant dreams.

A strong family history of dermatophytic infection was present. His mother had extensive ringworm involving multiple parts of the body with associated skin eruptions, while his father was affected with ringworm over the neck. The positive family history, previous episode of ringworm, recurrence following topical treatment, and persistent nature of the lesions suggested a recurrent dermatophytic infection with probable familial transmission.

Clinical findings

The patient was well-nourished, moderately built, conscious, cooperative, and well-oriented to time, place, and person. On general examination, he was afebrile, with a pulse rate of 76/min, blood pressure of 118/80 mmHg, and respiratory rate of 16/min. There was no pallor, icterus, cyanosis, clubbing, lymphadenopathy, or pedal oedema.

Dermatological examination revealed multiple

well-defined annular erythematous plaques involving the bilateral inner thighs and gluteal region. The lesions exhibited raised, dry, scaly active margins with central clearing, characteristic of dermatophytosis. Excoriation marks were present due to repeated scratching, with occasional superficial bleeding. The patient complained of intense pruritus (3+), predominantly aggravated at night and on thinking about the lesions. A marked burning sensation (3+), aggravated after bathing, particularly with cold water, was also reported. Scratching was followed by a stinging sensation, and intermittent dry scaling was observed over the affected areas. There was no evidence of vesiculation, pustulation, secondary bacterial infection, mucosal involvement, nail involvement, regional lymphadenopathy, or systemic manifestations.

Based on the patient's history and the characteristic morphology and distribution of the lesions, the clinical diagnosis was recurrent tinea cruris with extension to the gluteal region (tinea corporis involving the buttocks).

Case analysis

All symptoms obtained during case taking were analysed according to homoeopathic principles. The characteristic mental and physical generals together with the peculiar particulars were considered while constructing the totality of the case. The following symptoms formed the basis for repertorisation:

- Recurrent tinea cruris involving bilateral inner thighs and buttocks
- Itching aggravated at night
- Burning after itching.
- Stinging sensation after scratching
- Profuse perspiration of palms and soles
- Desire for salty food
- Hot patient

Repertorial totality :

Ringworm

Back

EXTREMITIES			
1 EXTREMITIES - ERUPTIONS - Thigh			
ringworm			
2 EXTREMITIES - PERSPIRATION - Fo			
profuse			
3 EXTREMITIES - PERSPIRATION - H			
profuse			
SKIN			
4 SKIN - ITCHING - burning			
5 SKIN - ITCHING - stinging			
GENERALS			
6 GENERALS - FOOD and DRINKS - sa			
desire			
Remedies	ΣSym	ΣDeg	Symptoms
cassia-s.	5	5	1, 2, 3, 4, 6
sulph.	4	7	3, 4, 5, 6
nat-m.	3	7	4, 5, 6
phos.	3	7	4, 5, 6
caust	3	6	4, 5, 6

Therapeutic intervention

The case was repertorised using the Synthesis Repertory, which yielded Sulphur and **Cassia sophora** as the most closely indicated remedies. Although Sulphur covered several general characteristics of the patient, it failed to cover certain peculiar and individualising symptoms observed in this case. The rubrics "Ringworm – thighs" and "Perspiration – hands – profuse" are specifically represented by Cassia sophora in the Synthesis Repertory, whereas Sulphur does not adequately cover these characteristic features. Considering the recurrent nature of the disease, the localisation of the lesions over the inner thighs and gluteal region, profuse perspiration of both palms and soles, the patient's hot thermal reaction, desire for salty food, and confirmation from the Materia Medica, Cassia sophora was selected as the similimum.

The patient was prescribed Cassia sophora 30, one dose twice daily for 7 days. The case was reviewed at weekly intervals, and the prescription was repeated or modified according to the patient's response and homoeopathic principles.

Follow-up :

Date	Symptoms presented	Intervention	Justification
10/04/2026 (1st Visit)	• Recurrent annular erythematous lesions over bilateral inner thighs and gluteal region. • Severe itching (3+) aggravated at night and by thinking about the lesions. • Burning (3+) • Stinging sensation after scratching. • Profuse perspiration of palms and soles.	Cassia sophera 30 BD for 7 days.	Prescription selected after reperi- torisation based on the individ- ualising symptoms, particularly the localisation of ringworm over the thighs, profuse perspiration of palms and soles, thermal reaction, and characteristic modalities. DLQI: 21
17/04/2026 (2nd Visit)	• Itching reduced by approximately 25%; still aggravat- ed at night but less intense. • Burning sensation slightly reduced. • Stinging after scratching less frequent. • No fresh lesions developed. • Perspiration unchanged.	Cassia sophera 30 BD for 7 days.	Improvement in the chief com- plaints without appearance of new lesions indicated favourable reme- dy action; same medicine contin- ued. DLQI: 17
24/04/2026 (3rd Visit)	• Further reduction in itching (about 50%). • Burning markedly decreased. • Night aggravation less frequent. • Stinging sensation occasional. • Lesions becoming lighter in colour with reduced ery- thematous margins. • Perspiration remained unchanged.	Cassia sophera 30 BD for 7 days.	Continued improvement in both subjective and objective symptoms confirmed that the selected remedy remained indicated. DLQI: 13
01/05/2026 (4th Visit)	• Itching present only occasionally. • Burning almost absent. • No stinging after scratching. • Lesions reduced considerably in size with healing from the centre. • Residual hyperpigmentation beginning to appear. • No new eruptions.	Cassia sophera 30 BD for 7 days.	Sustained improvement without any aggravation suggested contin- uation of the same prescription. DLQI: 9
15/05/2026 (5th Visit)	• Marked reduction in lesions. • Itching only occasionally after excessive sweating. • Burning completely absent. • Active margins disappeared. • Lesions showed residual post-inflammatory pigmen- tation only.	Cassia sophera 30 BD for 7 days.	Progressive healing of lesions with disappearance of characteristic symptoms indicated continued cu- rative action of the remedy. DLQI: 5
05/06/2026 (6th Visit)	• No itching, burning and stinging sensation. • Complete healing of lesions except faint residual pig- mentation. • No recurrence or development of new lesions.	Cassia sophera 30 BD for 7 days.	Complete disappearance of active disease with only residual pigmen- tation suggested that no further me- dicinal intervention was required. DLQI: 1
10/07/2026 (7th Visit)	• Complete resolution of all cutaneous lesions. • Residual pigmentation further reduced. • No itching, burning and stinging. • No recurrence during the three-month follow-up pe- riod. • Patient resumed normal daily activities without dis- comfort.	SL BD for 7 days.	Sustained clinical improvement without recurrence confirmed a fa- vourable long-term outcome fol- lowing individualized homoeo- pathic treatment. DLQI: 0

Follow-up and outcomes :

The patient was reviewed at weekly intervals and subsequently followed up for **3 months**. The detailed clinical progress and therapeutic interventions are summarised in **Table**. No adverse effects were observed throughout the treatment period. The **Dermatology Life Quality Index (DLQI)** was used to assess the impact of the disease on the patient's quality of life before and during treatment.

Following the initiation of **Cassia sophera 30** administered twice daily, the patient experienced a gradual reduction in itching and burning without any significant aggravation. During subsequent follow-ups, itching progressively decreased in intensity, night aggravation subsided, and the burning sensation disappeared completely. The stinging sensation following scratching also diminished, The lesions gradually regressed in size, erythema subsided, and healing occurred with residual post-inflammatory hyperpigmentation.

By the end of **three months**, all active lesions over the bilateral inner thighs and gluteal region had completely resolved. No itching, burning or new lesions were observed. The patient resumed normal daily activities without discomfort and no recurrence was noted during the follow-up period. Serial clinical photographs documented the progressive improvement.

Cassia sophera Linn :

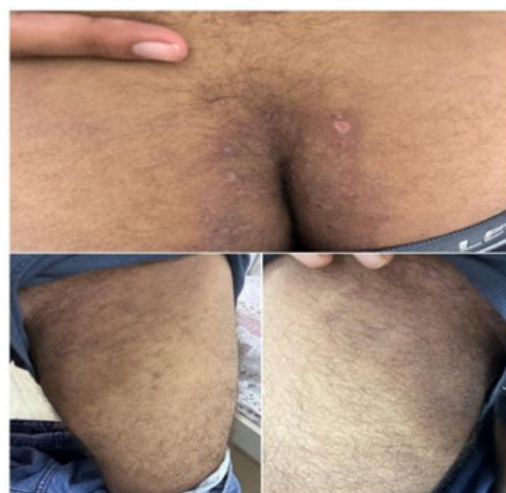
It is the plant found throughout India and in most tropical countries. It is common in wastelands, on roadsides and in the forest. It belongs to Cassalpiniaceae family. The part used for medicine is root bark of the plant[4].It mainly affects respiratory system in which, it acts as an expectorant and bronchodilators.On GIT it works as anthelmintic and as cathartic. And on skin as antiseptic. In ayurvedic its leaves are used as anthelmintic and antiseptic[5].Especially in skin there is symptomatology observed such as Itching all over the body;agg. night, amel. Scratching; more on lower extremities with small vesicles and pustules;agg. uncovering, scratching, heat. Intense itching with eruptions in hypogastric region, burning pain after scratching, sticky discharge, agg after scratching, night, warmth, uncovering, amel. open air, while scratching.Ringworm like eruptions on

thighs. Macular eruptions on the bridge of the nose, turning into painful vesicles, with pricking pain, amel. cold application. Macular eruptions about the left corner of mouth, appearing in a crop, with itching. Rash; over thighs with intense itching, agg. washing with cold water, amel. rubbing gently. Painful pimple like eruption in the middle of the upper lip. Small boil like painful eruptions with itching; discharging yellowish pus; agg. scratching after. Urticarial eruptions over forearms^{[4][6]}.

Before treatment (10/04/26)



After treatment (10/07/26)



DISCUSSION

Tinea cruris is one of the most common superficial dermatophytic infections and frequently presents with recurrence, particularly in warm and humid climates. The increasing prevalence of recurrent

dermatophytosis has been attributed to factors such as excessive perspiration, close household contact, poor hygiene practices, and the widespread use of topical antifungal–corticosteroid combinations, which often provide temporary symptomatic relief without preventing relapse. In the present case, the patient had experienced a previous episode of ringworm that responded temporarily to topical antifungal treatment but recurred after approximately three years. A positive family history of dermatophytosis in both parents further suggested continuous exposure and a predisposition to recurrence.

Although potassium hydroxide (KOH) examination is considered a useful investigation for confirming dermatophytosis, the diagnosis in this case was established clinically based on the patient's history and the characteristic morphology and distribution of the lesions, as laboratory confirmation was not available.

The homoeopathic prescription was based on the totality of characteristic symptoms rather than the pathological diagnosis alone. Repertorisation using the **Synthesis Repertory** indicated Sulphur and *Cassia sophera* among the leading remedies. However, the final selection of *Cassia sophera* was guided by the patient's individualising symptoms, particularly the localisation of ringworm over the inner thighs, profuse perspiration of both palms and soles, aggravation of itching at night and by thinking about the lesions, burning aggravated after bathing, hot thermal reaction, and desire for salty food. These peculiar characteristics corresponded more closely with *Cassia sophera*

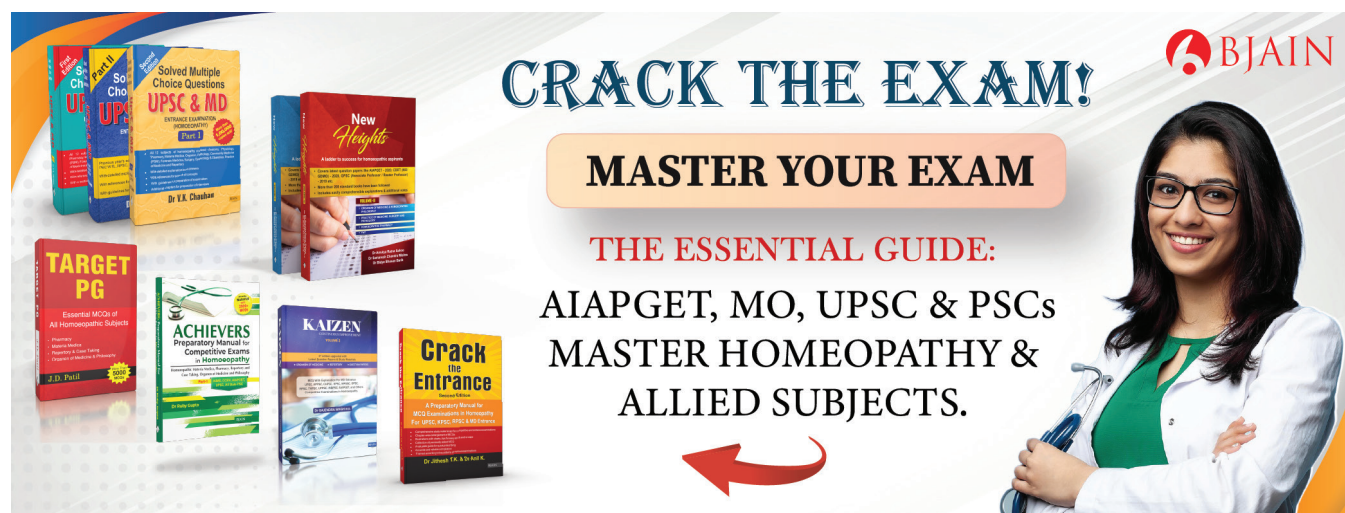
than with Sulphur, and *Materia Medica* verification further supported the prescription.

CONCLUSION

This case demonstrates the successful management of **recurrent tinea cruris** with individualized homoeopathic treatment. *Cassia sophera* was selected on the basis of characteristic symptoms, repertorial analysis, and *Materia Medica* confirmation, resulting in complete resolution of the lesions within three months without recurrence during follow-up. The improvement in clinical symptoms, quality of life support the potential role of individualized homoeopathy in recurrent dermatophytosis. Nevertheless, larger clinical studies are required to establish the effectiveness of *Cassia sophera* in the management of recurrent tinea infections.

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Management of Renal Stone With Individualized Homoeopathic Medicine- A Case Report

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Abstract

Background:

Renal lithiasis (kidney stone) is a common urological condition that may cause severe pain, burning during micturition and urinary disturbances. This case report describes the management of renal stone with individualized homoeopathic medicine.

Objective:

To describe the clinical management of renal stone using individualized homoeopathic medicine based on the totality of symptoms and to assess the outcome using the Modified Naranjo Criteria for Homoeopathy (MONARCH).

Methodology:

A 32-year-old male presented with burning pain in the urethra before and after micturition for five months, severe pain and dribbling of urine after urination. After detailed case taking, symptom analysis and repertorization, Cantharis 30 was prescribed based on the totality of symptoms. The clinical response was assessed using the Modified Naranjo Criteria for Homoeopathy.

Results:

The patient showed progressive improvement, with relief of pain and burning urination and no further marked episodes of pain during follow-up. The MONARCH score was +9, indicating a possible causal relationship between the treatment and the observed improvement.

Conclusion:

The case showed favourable clinical improvement following individualized homoeopathic treatment with Cantharis. Further controlled studies with larger sample sizes and long-term follow-up are required to evaluate its role in renal stone management.

Keywords

Nephrolithiasis, Individualised Homoeopathy, Modified Naranjo criteria, Cantharis

Introduction

Nephrolithiasis stands third among urinary tract disorders, following prostatic hyperplasia and urinary tract infections. The prevalence of urolithiasis is approximately 12% worldwide.

People at some point in their lives all ages, sexes, and races are affected, but men are more likely than women to experience it between the ages of 20 and 49. Nephrolithiasis is regarded as a risk factor for chronic renal disease in addition to the typical possible side effects linked to kidney stones, including discomfort, infection, and blockage. The frequency and recurrence rates of kidney stone disease are rising globally, and there are few effective medication choices available. Kidney stones are quite common and recurrent, which adds to the significant financial burden that stone disease places on society.

Crystal formation is typically influenced by a number of factors, including heredity, food, and specific medical conditions. Kidney stones can be categorized. According to their chemical makeup. Every kind of stone has distinct qualities and may call for various therapeutic modalities. There are four types of kidney stones. These are Calcium Oxalate stones, Uric Acid stones, Struvite stones & Cystine stones. In conventional medicine, ureteroscopy, percutaneous nephrolithotomy, and laparoscopy are some common approaches to deal with renal stone, and at present, extracorporeal shock wave lithotripsy (ESWL) is the first-line treatment modality. Some drawbacks of ESWL are: early haematuria, perinephric/nephric hematomas, use of general anaesthesia during several sessions of ESWL, increased susceptibility to radiation exposure in paediatric patients and long-term increase in serum creatinine and total homocysteine due to renal injury such as ischaemia/reperfusion injury after first-time ESWL.

Homoeopathy has a holistic approach toward surgical diseases like renal stone. They are considered to be an affection of the constitution rather than a local problem. Homoeopathic treatment is based on same constitutional approach for management of any disease. Recurrence of kidney stone is seen in maximum patients but recurrent surgery may not be the apt solution. A case report on nephrolithiasis successfully treated with homoeopathic medicine Cantharis is presented here. This case highlights the effectiveness of Homoeopathy for the treatment of nephrolithiasis and its associated conditions, following the basic principles of Homoeopathy.

CASE REPORT

Patient Information

A 32-year-old man reported to the outpatient department (OPD) of R.B.T.S. Govt. Homoeopathic Medical College & Hospital Muzaffarpur with Reg. no A44790/47978 on 15 Nov 2024 with burning pain in urethra after and before micturition in the last 5 month. He was shrieking and crying with pain. He was saying help me to get rid of this pain

Past History- N/S

Family History- Grandfather- Joint pain

Physical General-

Thirst- thirsty

Thermal- chilly

Appetite- good

Tongue- clear

Desire- Spicy things

Perspiration- Profuse

Stool- sometime constipation

Urine- Dribbling of urine after urination

Sleep- Normal

Dream- n/s

General physical examination-

- Built: Well, built
- Nourishment: Moderately nourished
- Pallor: Absent

Vital signs

- Pulse rate: 74 beats/minute
- Respiratory rate: 17 breath /min
- Temperature: Afebrile
- Blood pressure: 120/80 mmHg
- Height: 167 cm

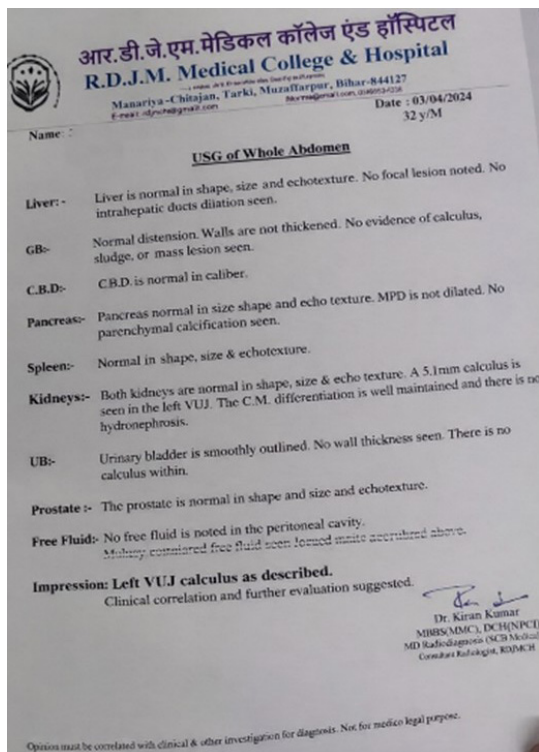
Case Report

- Weight: 61kg

Mental General:

- Crying with pain
- Irritable
- Propensity to broke the things
- Anger upon contradiction
- Desire company

Laboratory investigation:



Confirmed diagnosis: Renal stone

Totality of symptoms

- Anger upon contradiction
- Contradict every matter
- Crying for help due to pain
- Dribbling of urine after urination
- Burning pain in urethra after and before micturition
- Renal stone

Analysis And Evaluation of Symptoms with Miasmatic Analysis

S. NO	SYMPTOMS	ANALYSIS	EVALUATION	MIASMATIC ANALYSIS
1.	Contradicts every matter	Mental general	++	Psora
2.	Irritable	Mental general	+++	Psora
3.	Crying for help due to pain	Mental general	++++	sycosis
4.	Dribbling of urine after urination	Particular general	++	Psora
5.	Renal stone	Particular general	+	Sycosis
6.	Burning pain in urethra after and before micturition	Particular general	+++	Psoro syco syphitic

Symptoms Converted into Rubrics

SYMPTOMS	RUBRICS
1. Contradicts every matter	MIND- CONTRADICTION- Disposition to contradict
2. Irritable	MIND- Irritability
3. Crying for help due to pain	MIND-Delirium-Crying help for
4. Dribbling of urine after urination	BLADDER-URINATION-Dribbling
5. Renal stone	KIDNEY-Stone
6. Burning pain in urethra after and before micturition	URETHRA-PAIN-burning

Repertorization sheet

Remedy Name	Canth	Lyc	Nux-v	Sulph	Lach	Sep	Med	Bell	Calc	Caust	Sars
Canth	17	15	15	15	13	13	12	12	12	12	12
Lyc	6	5	5	5	5	5	5	4	4	4	4
Nux-v	2	2	1	2	3	2	3			3	
Sulph	2	3	4	4	4	3	4	3	3	3	2
Lach	3	2	3	3	1	1	1	2	1	2	2
Sep	3	4	3	2	1	3	1	3	4	4	4
Med	4	4	4	4	4	4	3	4	4	4	4
Bell	3										
Calc											
Caust											
Sars											

Repertorial analysis: -

- Canth – 17/6
- Lyc- 15/5
- Nux-v- 15/5
- Sulph -15/5
- Lach -13/6

Therapeutic intervention: -

After proper case taking, the totality of symptoms were made based on mental generals, physical generals, constitution, miasmatic background, past history etc. according to homoeopathic principles.

After carefully analysing the mental and physical generals of patient and considering the repertorial result, referring back to homoeopathic MM, a similimum was prescribed. Potency is selected as per the susceptibility of the patient Individualised homoeopathic treatment was started with

Prescription –

1. Cantharis 30/ 6dose / 5 globule b d
2. Rubrum 200/ 1 drm/ Bd

Follow Ups

DATE OF VISIT	CHANGE OF SYMPTOMS	MEDICINE/ DOSE/ POTENCY
16.11.24	The pain had relieved and the patient is feeling better.	Phytum 200 / 1 dramch/ 5 glbs BD
2.12.24	Pain persists but is slightly reduced in intensity than before. Frequent urging of urination but burning is not there	Phytum 200 / 1 dramch/ 5 glbs BD
19.12.24	No marked episodes of pain, burning urination were also relieved.	Phytum 200 / 1 dramch/ 5 glbs BD
17.1.25	No more episodes of pain. No more burning urination since the last visit. The patient is feeling better overall.	Phytum 200 / 1 dramch/ 5 glbs BD

After Treatment-

APOLLO ULTRASOUND CENTRE
(Behind of Kamaldeep-Jeebh Chaur)
AMGOLA ROAD, MUZAFFARPUR
Dr. N. Thakur
M.B.B.S.
Reg. No. - 16182

Name: - Ravin Kumar Age: 32y/M Date: 29/12/25
Ref by: - Dr. R.R.T.S.
Part Scanned: - Whole Abdomen

Liver shows uniform echopattern having no evidence of focal or diffuse pathology.
Gallbladder appears normal having no evidence of calculus or mass within it.
Common bile duct dilatation is 0.39cm, having no evidence of calculus.
Pancreas and spleen appears normal.
Both kidneys show normal echopattern having no evidence of calyceal dilatation or calculus.
Size of Lt. Kid 9.90cm, and Rt. Kid 10.20cm.
There is no evidence of ascitis pleural effusion or lymphadenopathy.
Urinary Bladder is normal in contour having no evidence of calculus or mass within it.
Prostate is normal in shape, size (3.28cm x 3.20cm x 2.90cm) and echotexture.
There is no other mass lesion seen in pelvis.

IMPRESSION: SONOGRAPHICALLY NORMAL STUDY

Dr. N. Thakur
MBBS(MC), DNB(DC)
MD (Radio) - Apollo (Dr. N. Thakur)
Consultant Radiologist, MBBS(DC)

Assessment of The Case According To Modified NARANJO Criteria For Homeopathy Inventory

The Modified Naranjo Criteria for Homeopathy Inventory consists of 10 Domains	Yes	No	Not sure or N/A
1. Was there an improvement in the main symptom or condition for which the homoeopathic medicine was prescribed?	+2		
2. Did the clinical improvement occur within a plausible timeframe relative to the drug intake?	+1		
3. Was there an initial 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 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 two 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?	+1		
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?	+1		
8. Are there alternate causes (other than the medicine) that—with a high probability—could have caused the improvement? (Consider 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.)			0
10. Did repeat dosing, if conducted, create similar clinical improvement?	+1		

DISCUSSION

Homoeopathy is a system of medicine which embraces a holistic approach in the treatment of sick. In Homoeopathy, detailed case taking is done to elucidate the constitutional makeup of the patient and a single remedy is selected on the basis of totality of symptoms. After considering the totality

of symptoms, homoeopathic medicine *Cantharis* was selected as similimum.

Cantharis, which was chosen based on the picture produced by the entirety of the symptoms after consulting with materia medica, entirely cured the case. The homoeopathic principles such as the individual's susceptibility and the criteria for the second prescription in Kent's philosophy were followed in the potency selection and dosage repetition.

Homoeopathy treatment is very commonly sought when patients see no hope in the conventional system of medicine, which is generally towards the terminal stages of incurable diseases. This case report as evidence in preclinical condition highlights the use of Homoeopathy right from the beginning of disease.

In the present case, possibility of spontaneous expulsion of stone due to its accuracy of peculiar uncommon symptoms which helps in to reach similimum. Although homoeopathic treatment has shown favourable results in this case and undoubtedly thrown some light on scope of Homoeopathy and possible answer in this unexplored area, controlled studies with long-term follow-up and large sample size are required for validation of the effects of the homoeopathic treatment in such cases.

The MONARCH was used for the assessment of the causal relationship, which yielded a score of '+9', which shows there is a possible causal relationship between the result observed and the prescribed medication

CONCLUSION

From this case, I concluded the efficacy of individualized homoeopathic medicine as a holistic treatment in case of renal stone. The conventional therapeutics for renal stone are the Surgical extraction which may be related to various side effects and hard painful procedures .so it is necessary to promote homoeopathy in the treatment of such cases and further research should be needed

to emphasize the efficacy of homoeopathic medicine in renal stone complains.

ACKNOWLEDGEMENT

The authors gratefully acknowledge the patient for his active cooperation and participation.

DECLARATION OF PATIENTS' CONSENT

Written, informed consent was obtained from the patient for publication of the case report, while he enjoyed free will to quit the consultation in case of any disappointment or adverse events during treatment. The patient was made to understand that her name and initials will not be included in the manuscript and due efforts will be made to conceal her identity, but anonymity cannot be guaranteed.

FINANCIAL SUPPORT AND SPONSORSHIP

Nil.

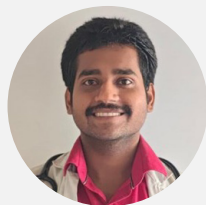
CONFLICTS OF INTEREST

None declared

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In-Vitro Evaluation Of The Antifungal Activity Of Homoeopathic *Azadirachta Indica* Against *Candida Albicans* And *Aspergillus Niger* Using Disc Diffusion Method



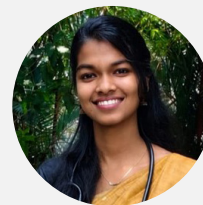
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Abstract

Introduction : The Antifungal activity may vary according to the plant part, method of extraction method, concentration and fungal species tested. These findings provide a scientific basis for further investigation of *Azadirachta indica* as a potential antifungal agent. *Candida albicans* is a common opportunistic yeast responsible for infections such as oral and vaginal candidiasis, while *Aspergillus niger* is a filamentous fungus associated with several superficial and opportunistic infections.

Background: Fungal infections caused by *Candida*

albicans and *Aspergillus niger* pose significant clinical challenges. *Azadirachta indica* (neem) contains bioactive constituents such as azadirachtin, nimbin, nimbidin and gedunin. While crude preparations have documented bioactivity, scientific evaluation of homoeopathic preparations including mother tincture (MT)/(Q) and centesimal potencies (30CH and 200CH) against fungal pathogens requires systematic laboratory investigation.

Objective: To evaluate and compare the *in vitro* antifungal activity of homoeopathic *Azadirachta indica* mother tincture (Q), 30CH and 200CH

potencies against *Candida albicans* and *Aspergillus niger* using the disc diffusion method.

Methods: Standardized suspensions of *Candida albicans* and *Aspergillus niger* were inoculated onto Sabouraud Dextrose Agar (SDA) plates to create uniform lawn cultures. Filter paper discs impregnated with *Azadirachta indica* mother tincture (Q), 30CH and 200CH along with a standard antifungal positive control and negative vehicle control, were placed on the agar surface. After incubation under controlled conditions, the diameters of the zone of inhibition were measured in millimeters.

Results: Disc diffusion testing demonstrated measurable antifungal inhibition across the tested preparations:

- **Against *Candida albicans*:** The 200CH potency produced an 18mm zone of inhibition, mother tincture (Q) produced a 16mm zone, 30CH exhibited a 12mm zone and the control yielded an 8mm zone.
- **Against *Aspergillus niger*:** The 200CH potency produced an 14mm zone of inhibition, mother tincture (Q) produced a 12mm zone, 30CH exhibited a 11mm zone and the control yielded an 10mm zone.

Conclusions: Homoeopathic preparations of *Azadirachta indica* (Q), 200CH and 30CH demonstrate *invitro* inhibitory activity against both *Candida albicans* and *Aspergillus niger* in agar disc diffusion assays. The observed zones of inhibition indicate susceptibility of the test fungi to these preparations.

Keywords

Azadirachta indica, Neem, Homoeopathy, Mother tincture (Q), 200CH, 30CH, *Candida albicans*, *Aspergillus niger*, Disc diffusion method, Zone of inhibition.

1. Introduction

Fungal infections caused by *Candida* and *Aspergillus* species represent significant clinical concerns ranging from superficial mucocutaneous lesions to life threatening systemic opportunistic infections^[1]. Limitations associated with standard antifungal activity therapies including drug

resistance and adverse effects have spurred research into alternative and complementary therapeutic agents^[2].

Azadirachta indica A. Juss., commonly known as Neem (Meliaceae family) is widely distributed across tropical and subtropical regions. The plant possesses a rich phytochemical profile including tetranortriterpenoids (azadirachtin, nimbin, nimbidin, gedunin, nimbolide, salanin) and flavonoids (quercetin). These chemical compounds have demonstrated a wide range of unusual effects against a wide spectrum of pests (insect, fungi and viruses). Crude neem extracts exert antifungal action by disrupting cell membrane integrity, suppressing spore germination and inhibiting fungal enzymes^{[3][4][5]}.

In Homoeopathy, *Azadirachta indica* is utilized both as a mother tincture (Q) containing primary ethanolic botanical extracts and in serial centesimal potencies (200CH and 30CH) prepared through standardized potentization. In vitro methods such as the disc diffusion technique provide a preliminary means of assessing fungal growth inhibition by measuring the zone of inhibition produced by a test preparation^{[6][7][8]}. This study evaluates the relative *in vitro* antifungal efficacy of *Azadirachta indica* (Q), 200CH and 30CH against *Candida albicans* and *Aspergillus niger* using the disc diffusion technique^{[9][10]}.

2. Materials And Methods

2.1 Study Design And Culture Medium

This was an *in vitro* experimental study conducted using the standard Kirby-Bauer diffusion method. Sabouraud Dextrose Agar (SDA) was prepared, sterilized by autoclaving and aseptically poured into sterile Petri dishes to solidify.

2.2 Test Pathogens And Inoculum Preparation

Fresh cultures of the following strains were used:

- *Candida albicans*
- *Aspergillus niger*

Standardized fungal suspensions were prepared in sterile saline or broth, adjusted to

a 0.5 standard turbidity. Using a sterile cotton swab, the inoculum was spread evenly over the surface of the SDA plates to establish uniform lawn cultures.

2.3 Test Preparation And Controls

1. **Test Remedies:** Homoeopathic *Azadirachta indica* in mother tincture (Q), 200CH and 30CH potencies.
2. **Positive Control:** Standard antifungal agent.
3. **Negative Control:** Sterile solvent/dispersing medium/alcohol.

2.4 Disc Diffusion Assay Procedure

1. Sterile filter paper discs were impregnated with the respective potencies mother tincture (Q), 200CH, 30CH and controls.
2. Using sterile forceps, prepared discs were positioned on the inoculated agar surfaces with gentle pressure to ensure full contact.
3. Plates were incubated under fungal-specific conditions:
 - *Candida albicans*: Incubated at 35°C for molds or 37°C for yeast for 24-48 hours (or longer if required for slow growing fungi).
 - *Aspergillus niger*: Incubated at 28°C for molds or 30°C for yeast for 48-72 hours (or longer if required for slow growing fungi).
4. Following incubation, zones of inhibition surrounding each disc were measured in millimeters using a calibrated ruler/caliper.

3. Results:

Quantitative evaluation revealed varying degrees of growth inhibition produced by the test preparations against both target fungal species.

TABLE 1: COMPARATIVE ZONES OF INHIBITION (mm)

TEST GROUP/POTENCY	CANDIDA ALBICANS (mm)	ASPERGILLUS NIGER (mm)
Azadirachta indica 200CH	18mm	14mm
Azadirachta indica (Q)	16mm	12mm
Azadirachta indica 30CH	12mm	11mm
Control (vehicle/solvent)	8mm	10mm

Interpretation: A large zone of inhibition indicates greater fungal sensitivity to the tested agent, whereas smaller zones reflect reduced susceptibility.

Experimental Culture Plates

The photographic records document the sterile tubes of various potencies of *Azadirachta indica* preparations (figure.1), experimental plates and zones of inhibition observed during disc diffusion testing (figure.2).

Fig.1 STERILE TUBES OF VARIOUS POTENCIES OF AZADIRACHTA INDICA PREPARATIONS

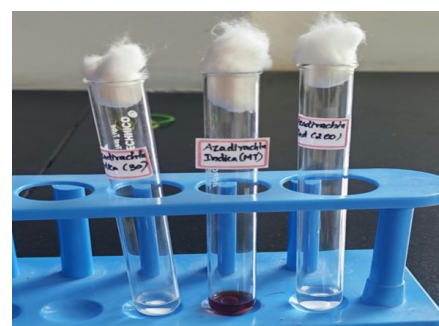
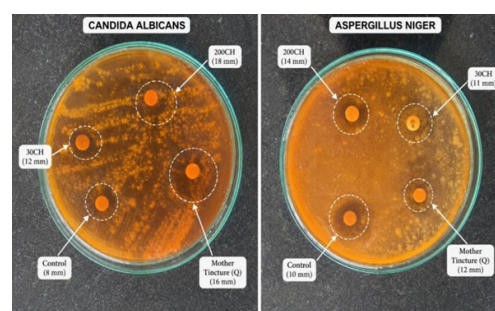


Fig.2 DISC DIFFUSION ASSAY SHOWING ZONES OF INHIBITION PRODUCED BY CANDIDA ALBICANS AND ASPERGILLUS NIGER ON VARIOUS POTENCIES (Q, 200CH, 30CH)



4. DISCUSSION

The experimental findings demonstrate that homoeopathic preparations of *Azadirachta indica* exert measurable *in vitro* inhibitory activity against *Candida albicans* and *Aspergillus niger*.

- **Activity Against *Candida Albicans*:** The 200CH potency produced the largest zone of inhibition (18mm), followed by mother tincture (16mm) and 30CH (12mm), all exceeding the baseline vehicle control (8mm).
- **Activity Against *Aspergillus Niger*:** A similar trend was observed, with the 200CH potency producing a 14mm zone, mother tincture yielding 12mm and 30CH producing 11mm, compared to 10mm for the control.

The antifungal efficacy of the mother tincture aligns with the known chemical constituents of raw *A. indica* leaves, where tetranortriterpenoids and flavonoids directly alter fungal membrane fluidity and chitin structure. The inhibition recorded for higher centesimal potencies (30CH and 200CH) suggests that ultra-diluted homoeopathic remedies retain biological activity *in vitro*, warranting further investigation into their physicochemical properties and non-molecular mechanism of action.

5. CONCLUSION

Homoeopathic *Azadirachta indica* mother tincture (Q), 200CH and 30CH display distinct antifungal activity against *Candida albicans* and *Aspergillus niger* in disc diffusion assays. Among the tested preparations, 200CH and mother tincture showed prominent zones of inhibition. These preliminary findings support further research using microdilution assays and expanded clinical trials to assess the efficacy of homoeopathic Neem preparations.

Limitations

The study is limited by the *in vitro* design, the selected fungal organisms and the limited number of potencies. Photographic results without calibrated measurement cannot substitute for direct zone measurement. Additional limitations include the need for adequate biological replicates, standardized inoculum preparation, appropriate controls and validated susceptibility-testing procedures. *In vitro* observations cannot be directly extrapolated to clinical effectiveness.

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Association of Miasmatic and Thermal Patterns with Clinical Characteristics in Patients with Rheumatoid Arthritis: A Descriptive Observational Study from a Homoeopathic Hospital Outpatient Department

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Abstract

Background: Rheumatoid arthritis (RA) is a chronic inflammatory autoimmune disease in which clinical heterogeneity makes careful characterization important for observational research and future trials. In homoeopathic practice, individualized case analysis may include constitutional, thermal and miasmatic assessments. This study explores the distribution and interrelationship of these recorded variables in patients attending a homoeopathic hospital outpatient department.

Methods: A descriptive observational study analyzed 34 outpatient records labelled as RA from Sagarpara Primary Health Centre, Murshidabad, West Bengal. Demographic variables, recorded thermal preference, food desires and aversions, and practitioner-assigned miasmatic categories were extracted. Six predefined miasmatic categories were used: Psora, Sycosis, Syphilis, Psoro-sycotic, Psoro-syphilitic and Syco-syphilitic. Frequencies, percentages and cross-tabulations of miasm and thermal preference were calculated. No causal or treatment-effect inference was attempted.

Results: Females comprised 28/34 (82.4%). Mean age was 45.9 ± 14.4 years. Hot thermal preference was recorded in 19 (55.9%) and chilly preference in 12 (35.3%). Sycosis was the most frequent

predefined miasmatic category (22; 64.7%), followed by Psora (5; 14.7%). No record was classified as pure Syphilis. Within Sycosis, 50.0% were hot and 36.4% chilly; Psora was 60.0% chilly and 40.0% hot.

Conclusion: The dataset demonstrates a measurable distribution of recorded miasmatic and thermal characteristics and provides preliminary information for future hypothesis-driven research. The observed patterns should not be interpreted as validated disease biomarkers or evidence that a particular miasm causes RA.

Keywords: Rheumatoid arthritis; homoeopathy; miasm; Psora; Sycosis; Syphilis; thermal preference; individualized homoeopathy; observational study.

Introduction

Rheumatoid arthritis (RA) is a chronic, systemic autoimmune inflammatory disease characterized predominantly by persistent synovial inflammation, progressive joint destruction, and a range of extra-articular manifestations. It commonly affects the small joints of the hands and feet in a relatively symmetrical pattern and may subsequently involve larger joints. Persistent inflammation of the synovium can result in cartilage loss, marginal bone erosion, deformity, functional disability, and impaired quality of life. RA is now understood as

a heterogeneous disease arising from complex interactions between genetic susceptibility, environmental exposures, and dysregulated immune responses. Autoimmune abnormalities may precede the development of clinically apparent arthritis by several years, indicating the existence of a preclinical phase of disease. [1] It affects approximately 0.5–1% of the population and occurs more frequently in women, with incidence increasing with age. [2]. RA is considered a multifactorial disease resulting from interactions between genetic susceptibility and environmental factors. Genetic factors, particularly HLA-DRB1 alleles, together with smoking, obesity and other environmental or mucosal exposures, contribute to disease development. [3] Clinically, RA commonly presents with symmetrical inflammatory pain, swelling and prolonged morning stiffness, particularly involving the small joints of the hands and feet; systemic and extra-articular manifestations may include fatigue, rheumatoid nodules, pulmonary, ocular and vascular involvement. [4] Diagnosis is based on clinical assessment supported by laboratory and imaging findings. Rheumatoid factor and anti-citrullinated protein antibodies (ACPA), elevated inflammatory markers, and radiographic or ultrasonographic evidence of synovitis or structural damage aid diagnosis. The 2010 ACR/EULAR classification criteria classify definite RA using a scoring system incorporating joint involvement, serology, acute-phase reactants and symptom duration, with a score of $\geq 6/10$ supporting classification as RA. [5]

Treatment follows a treat-to-target approach aimed at achieving sustained remission or low disease activity. Current EULAR recommendations advise initiating disease-modifying antirheumatic drug (DMARD) therapy promptly, with methotrexate (MTX) as the preferred initial DMARD; leflunomide or sulfasalazine may be alternatives. Short-term glucocorticoids may be used during treatment initiation, while biological or targeted synthetic DMARDs, including Janus kinase (JAK) inhibitors, are considered when the initial strategy is inadequate. [6] However, conventional and targeted therapies may cause adverse effects including gastrointestinal and hepatic toxicity, cytopenias and infections with MTX and other DMARDs, while prolonged glucocorticoid therapy increases risks of osteoporosis, infection and

metabolic complications; JAK inhibitors require consideration of cardiovascular, thromboembolic and malignancy risks. [7]

Within classical homoeopathic literature, chronic disease was historically conceptualized through the theory of chronic miasms. Hahnemann introduced this concept in *The Chronic Diseases, their Specific Nature and their Homoeopathic Treatment* (1828), in which he proposed Psora, Syphilis and Syphilis as the three chronic miasms underlying chronic disease. Hahnemann considered the changing manifestations of chronic illness to represent expressions of a deeper underlying disorder rather than isolated conditions. [8] Subsequent homoeopathic authors, including Kent and J.H. Allen, expanded and modified the concept, introducing broader notions of miasmatic predisposition and miasmatic diathesis. [9, 10]

The present study therefore aims to provide a descriptive foundation for future prospective RA research by examining whether routinely recorded miasmatic categories show identifiable patterns with thermal preference and other individualized case characteristics.

• A miasmatic view of Rheumatoid arthritis [11]

Psora:

- » Neuralgic pains are usually relieved by quiet, rest and warmth, worse by motion.
- » Cramps in the lower extremities in the calves of the legs, in the feet toes, ankles.
- » Numbness of the extremities with tingling in the fingers.

Sycosis:

- » Shooting and tearing pains in the muscles and the joints, pain in fingers or small joints.
- » The sycotic pains are relieved by rest and the patient is relieved by moving, by rubbing, stretching, and better in dry, fair, weather.
- » Pain worse at the approach of a storm or a damp, humid atmosphere and becoming

cold.

- » Stiffness and soreness, especially lameness, is very characteristic of sycosis
- » Infiltration of inflammatory deposits, but it readily absorbs and never formative.
- » It produces violent palpitation with beating of the whole body from reflex rheumatic trouble.

Syphilis:

- » Stitching, shooting or lancinating pains in the periosteum or long bones of the upper or lower extremities.
- » Pains worse at night, or at the approach of the night. They are also worse by change of weather, by cold and damp atmosphere.
- » Nodular growth.
- » Infiltration of inflammatory deposits which are permanent.

• Previous research on homoeopathy in rheumatoid arthritis

Homoeopathic research in rheumatoid arthritis (RA) remains limited and heterogeneous, comprising clinical trials, observational studies, qualitative research, experimental animal studies and narrative reviews. In an exploratory double-blind, randomized, placebo-controlled trial involving 83 patients with active but relatively stable RA receiving conventional treatment, Brien et al. found no significant difference in the co-primary outcomes of ACR20 response and patient global assessment, and no clear effect attributable specifically to the homeopathic remedy. However, patients receiving a homeopathic consultation demonstrated significant improvements in DAS-28, swollen joint count, pain, patient global assessment and negative mood, suggesting that consultation-related effects may have contributed to the observed clinical benefits. [12] A nested qualitative study involving 16 participants further reported that patients perceived the homeopathic consultation as helpful in coping with RA through emotional support, exploration of illness and self, and individualized advice. [13]

An open observational study conducted at the National Institute of Homoeopathy, Kolkata, evaluated 50 patients with RA over four months using individualized homoeopathic treatment. Although six patients discontinued treatment, intention-to-treat analysis demonstrated statistically significant reductions in DAS-28 and RADAI scores, indicating potential clinical benefit; however, the absence of a control group limits causal interpretation. [14] At the experimental level, Singh et al. investigated six homoeopathic mother tinctures in animal models of inflammation, analgesia and adjuvant-induced arthritis. *Curcuma longa* and *Tribulus terrestris* mother tinctures demonstrated reductions in inflammatory paw oedema, while all tested preparations showed peripheral analgesic activity, providing preliminary preclinical evidence requiring further investigation. [15] A recent comprehensive review identified a broader body of RA-related homoeopathic literature encompassing randomized, observational, interventional and experimental studies, but also highlighted the heterogeneous nature of the available evidence. [16]

Overall, previous research suggests possible clinical, symptomatic and consultation-related benefits associated with homoeopathic care in RA; however, the evidence remains insufficient and methodologically heterogeneous. In particular, controlled clinical evidence regarding individualized homoeopathic treatment and the relationship between patients' clinical characteristics and classical homoeopathic concepts remains limited. This provides a rationale for further systematically designed clinical and observational research in RA.

• Thermal preference as a candidate individualized variable

Thermal preference is commonly recorded in homoeopathic case-taking and may influence individualized prescribing. However, its relationship with biomedical RA phenotypes has not been adequately established. The present study therefore examines thermal preference descriptively across miasmatic categories without assuming a predetermined relationship.

• Objectives

Primary objective: To describe the distribution of six predefined miasmatic categories among RA-labelled patients attending the homoeopathic OPD.

Secondary objectives: To describe thermal preference; explore the descriptive relationship between miasmatic category and thermal preference; describe selected food desires, aversions and recorded medicines; and identify variables suitable for future prospective RA research and RCTs.

• Methods

- » **Study design and setting:** This descriptive observational study used routinely recorded clinical information from patients attending the outpatient department of Sagarpara Primary Health Centre, Murshidabad, West Bengal, India.
- » **Data collection period-** January 2025 to June 2026
- » **Participants:** The study included 34 patients attending the Outpatient Department (OPD) of Sagarpara Primary Health Centre, Murshidabad, West Bengal, who were recorded as having rheumatoid arthritis. Participants included both male and female patients of different age groups. All patients had a clinical diagnosis by ACR criteria of rheumatoid arthritis (ICD 11 code- FA20) and were positive for RA factor and few patients have positive anti-cyclic citrullinated peptide (anti-CCP) antibodies.
- » **Miasmatic classification:** The six predefined categories were Psora, Sycosis, Syphilis, Psoro-sycotic, Psoro-syphilitic and Syco-syphilitic.
- » **Thermal classification:** Recorded thermal preference was standardized into Hot, Chilly, Ambithermal and Oversensitive categories.
- » **Other variables:** Food desires, food aversions and medicine labels were counted as non-mutually-exclusive mentions.

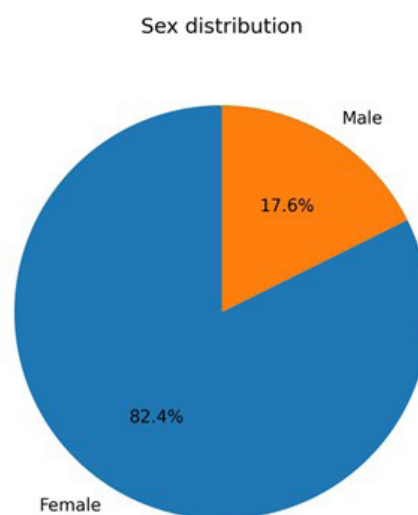
They were not treated as biomedical diagnostic criteria.

- » **Consent and conflicts:** The investigators report that verbal consent was obtained from patients for use of clinical information for research/publication. No conflict of interest.
- » **Statistical analysis:** Age was summarized using mean, standard deviation, median and range. Categorical variables were summarized using frequencies and percentages. A cross-tabulation of miasmatic category and thermal preference was performed. Because of the small sample and sparse cells, the miasm-thermal analysis was treated as exploratory and descriptive; no confirmatory inferential test was used. Excell is used for statistical analysis.

• Results

Thirty-four records were analysed. Females accounted for 28 (82.4%) and males for 6 (17.6%). Age ranged from 14 to 70 years; mean 45.9 ± 14.4 , median 47.5.

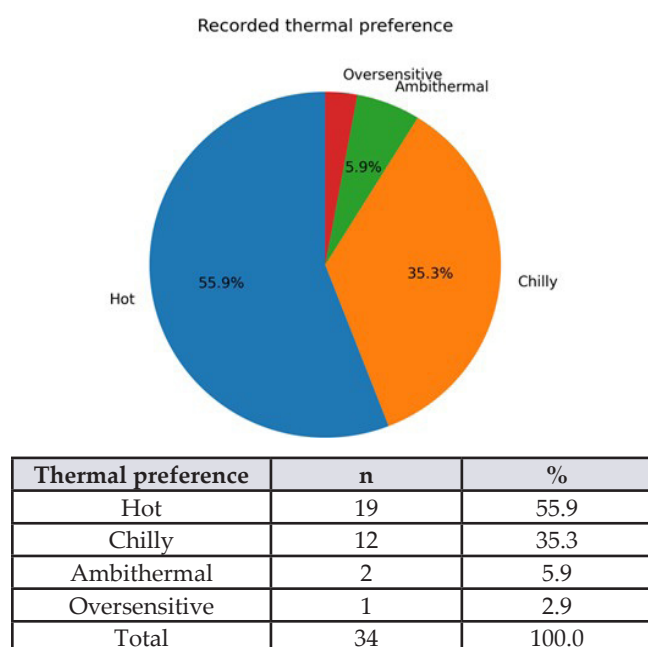
Figure 1. Sex distribution of the 34 RA-labelled outpatient records.



Sex	n	%
Female	28	82.4
Male	6	17.6
Total	34	100.0

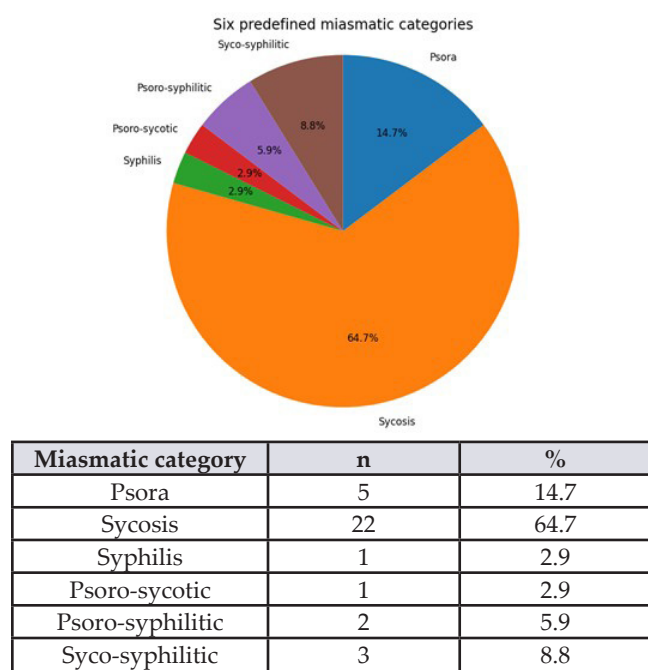
Hot thermal preference was the most frequent category, followed by chilly preference.

Figure 2. Recorded thermal preference among the 34 RA-labelled outpatient records.



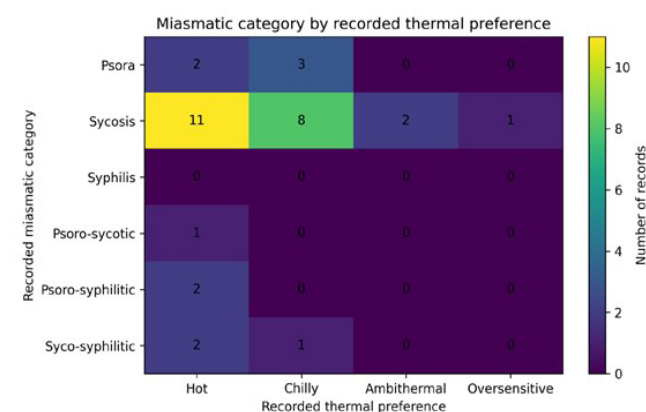
Among the six predefined miasmatic categories, Sycosis was most frequent, followed by Psora. No record was classified as pure Syphilis. This describes the present sample only and should not be interpreted as evidence that pure Syphilis is absent in RA generally.

Figure 3. Distribution of the six predefined miasmatic categories.



The exploratory miasm-thermal cross-tabulation showed 11 hot, 8 chilly, 2 ambithermal and 1 oversensitive record within Sycosis. Psora had 2 hot and 3 chilly records. Psoro-sycotic and Psoro-syphilitic records were all hot. Syco-syphilitic contained 2 hot and 1 chilly record. Pure Syphilis had no observations.

Figure 4. Descriptive cross-tabulation of miasmatic category and thermal preference. Cell values represent number of records.



Miasm	Hot	Chilly	Ambithermal	Oversensitive	Total
Psora	2	3	0	0	5
Sycosis	11	8	2	1	22
Syphilis	0	0	0	0	0
Psoro-sycotic	1	0	0	0	1
Psoro-syphilitic	2	0	0	0	2
Syco-syphilitic	2	1	0	0	3

Within-category percentages were: Psora, 40.0% hot and 60.0% chilly; Sycosis, 50.0% hot, 36.4% chilly, 9.1% ambithermal and 4.5% oversensitive; Syco-syphilitic, 66.7% hot and 33.3% chilly; Psoro-sycotic, 100% hot; and Psoro-syphilitic, 100% hot. The small denominators of the mixed-miasm groups make these percentages unstable.

Meat was the most frequent recorded food desire (16 mentions; 47.1%), and sweet was the most frequent food aversion (10; 29.4%). Medorrhinum was the most frequent medicine label (9; 26.5%).

Food desire	Mentions	% of records
Meat	16	47.1
Salt	9	26.5
Sweet	8	23.5
Milk	7	20.6
Sour	6	17.6
Egg	3	8.8
Chilly	2	5.9
Fast Food	1	2.9
Fish	1	2.9
Chicken	1	2.9
Biryani	1	2.9
Fruits	1	2.9
Cold Food	1	2.9
Food aversion	Mentions	% of records
Sweet	10	29.4
Meat	6	17.6
Salt	1	2.9
Milk	1	2.9
Egg	1	2.9
Bath	1	2.9
Medicine label	Mentions	% of records
Medorrhinum	9	26.5
Ignatia	4	11.8
Thuja	4	11.8
Sarcocollacid	3	8.8
Lachesis	3	8.8
Lycopodium	2	5.9
Sulphur	2	5.9
Staphysagria	2	5.9
Sang Can	1	2.9
Calcarea carb	1	2.9
Natrum sulph	1	2.9
Pulsatilla	1	2.9
Antim Crude	1	2.9
Influenjinum	1	2.9
Calcarea Phos	1	2.9
Natrum carb	1	2.9
Calcarea flour	1	2.9
Nitric acid	1	2.9
Tuberculinum	1	2.9

DISCUSSION

This study provides an initial descriptive map of miasmatic and thermal characteristics recorded in RA-labelled patients attending a homoeopathic hospital OPD. Sycosis was the most frequent recorded category and hot thermal preference was common overall. The cross-tabulation suggests that thermal preference was not identical across miasmatic categories, but the dataset is too small to establish a reliable statistical association.

The finding of frequent Sycosis should be interpreted as a pattern of practitioner-assigned

classification, not as a biological subtype of RA. Similarly, the concentration of hot records among the small Psoro-sycotic and Psoro-syphilitic groups is hypothesis-generating only. Replication with a larger sample and predefined assessment rules is essential.

The absence of pure Syphilis in this dataset is a useful descriptive observation for planning a larger study, but zero observations in a small single-centre series cannot establish that the category is uncommon in RA. Future multicentre recruitment would be needed to estimate the distribution more reliably.

The main research value of this work is methodological: it demonstrates how traditionally qualitative homoeopathic variables can be converted into analyzable categories. A future prospective study should define each miasmatic category before data collection, use a standardized checklist, assess inter-rater reliability, and record thermal preference using a standardized question set.

The current RA homoeopathy literature is largely concerned with treatment efficacy and consultation effects. Controlled trials have produced mixed findings, and a recent systematic review identified a limited and heterogeneous evidence base. [5-8] There is therefore a distinct opportunity to study individualized case characteristics separately from treatment efficacy. This study can serve as a pilot for identifying candidate variables, but it should not be presented as evidence that a miasmatic pattern predicts response to homoeopathic treatment.

For a future observational cohort, miasmatic and thermal categories could be examined against RF, anti-CCP, ESR, CRP, disease duration, joint distribution and validated disease activity measures such as DAS28, CDAI or SDAI. For a later RCT, the most reproducible variables could be pre-specified as exploratory effect modifiers or stratification factors. This would create a logical progression from descriptive clinical observation to analytical epidemiology and finally to randomized hypothesis testing.

• Strengths and Limitations

Strengths include real-world OPD data, explicit

predefined miasmatic categories, direct exploration of miasm-thermal patterns, and a research framework that can be reproduced prospectively.

Limitations include small sample size, single-centre sampling, possible selection bias, incomplete biomedical diagnostic documentation, lack of validated disease-activity outcomes, lack of standardized inter-rater miasmatic assessment, and sparse mixed-miasm categories. Therefore, the study cannot establish diagnostic, prognostic or treatment-response associations.

• Implications for Future Research

The next prospective study should include: ACR/EULAR classification variables; RF and anti-CCP; ESR and CRP; disease duration; tender and swollen joint counts; morning stiffness; functional status; DAS28/CDAI/SDAI; conventional medicines; standardized thermal questions; a predefined miasmatic assessment rubric; food desires and aversions; repertorial totality; remedy, potency and dosing; and predefined follow-up outcomes.

Once these variables are prospectively collected, an adequately powered observational study can examine whether miasmatic categories are associated with clinical phenotype. A subsequent RCT can then test whether prespecified miasmatic or thermal characteristics modify response to individualized homeopathic treatment.

CONCLUSION

In 34 RA-labelled OPD records, Sycosis was the most frequent recorded miasmatic category, followed by Psora, while hot thermal preference was the most frequent thermal characteristic. Psora was more frequently recorded as chilly than hot, whereas the small Psoro-sycotic and Psoro-syphilitic groups were entirely hot. These observations are preliminary and hypothesis-generating. They provide a useful foundation for standardized prospective research and future RCT design but do not establish a specific miasmatic-thermal phenotype or treatment effect in RA.

• Declarations

Consent: Verbal consent was reportedly obtained from patients for research/publication use of clinical information. Confirm journal and institutional

requirements for documenting consent, particularly for minors.

Conflict of interest: No conflict of interest.

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An In Vitro Study of Antifungal Activity of Homoeopathic Medicine on *Malassezia Furfur*

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Abstract:

Background: *Malassezia furfur* is a fungus associated with skin conditions such as dandruff, seborrhoeic dermatitis and pityriasis versicolor. This study was done to evaluate the antifungal activity of selected homoeopathic medicines.

Objectives: To study the antifungal activity of selected homoeopathic medicines against *M. furfur*. To compare their activity at Q, 30C and 200C potencies.

Methodology: An in-vitro agar disc diffusion method was used. Badiaga, Mezereum, Staphysagria and Vinca minor in Q, 30C and 200C were tested against *M. furfur*. The zone of inhibition was measured after incubation at 28°C for 48 hours.

Results: All tested medicines showed antifungal activity. Mezereum Q and Mezereum 200C showed the highest zone of inhibition (14 mm).

Conclusion: The selected homoeopathic medicines showed in-vitro antifungal activity against *Malassezia furfur*, with Mezereum Q and 200C showing the maximum activity. Further studies are needed to confirm these findings.

Keywords: Antifungal activity, Fungal infections, *Malassezia furfur*.

Introduction:

Malassezia furfur is a member of a monophyletic genus of fungi normally found on human and animal skin. These lipid-dependent, commensal

yeasts normally constitute greater than 80% of the total fungal population of human skin and are frequently isolated in both healthy and diseased hosts. *Malassezia furfur* formerly known as *Pityrosporum ovale*. It is associated with a variety of dermatological conditions caused by fungal infections, notably seborrhoeic dermatitis and tinea versicolor. As an opportunistic pathogen, it has further been associated with dandruff, *malassezia* folliculitis, pityriasis versicolor (alba),

and *malassezia* intertrigo, as well as catheter-related fungemia and pneumonia in patients receiving hematopoietic transplants and patients receiving parenteral nutrition.

It affects 1 to 3% of the general population, and this rate would be even higher with the inclusion of milder cases of dandruff. Immunocompromised patients have the highest incidence of up to 33%. It has a seasonal pattern as it occurs more commonly in the winter months. There is a slight male predominance and a bimodal incidence peaking in adolescence and again after age 50.

Homoeopathy as an individualised dynamic medicine treats wide range of diseases at low cost. Up to the minute many researches were conducted proving the efficacy of Homoeopathic medicines in various diseases with scientific documentation. The Homoeopathic medicines Badiaga, Mezereum, Staphysagria, Vinca minor has marked action upon skin conditions, the invitro activity of these medicines has been done in this study to prove their anti-fungal activities in various potencies (Q, 30C, 200C). Badiaga which is prepared from

fresh water sponge, Mezereum commonly called Spurge olive which is used in skin conditions like Eczema, dermatitis and neuralgic conditions, Staphysagria commonly called Stavesacre which is used in skin conditions like Eczema, Warts and genitourinary conditions, Vinca minor commonly called Lesser periwinkle, a remedy for skin affection like Eczema, plica polonica and dandruff.

Materials And Methods

Study Design: An experimental study was adopted to investigate the antifungal effects of Homoeopathic Medicines against a specific strain in *Malassezia* species, *Malassezia furfur*.

MICROORGANISMS: *Malassezia furfur*

HOMOEOPATHIC MEDICINES: Badiaga Q, 30C, 200C, Mezereum Q, 30C, 200C, Staphysagria Q, 30C, 200C, Vinca minor Q, 30C, 200C has been procured from SBL through Online Order.

ANTIFUNGAL ACTIVITY:

Agar Disc Diffusion Test -The Antifungal screening of Staphysagria – 30, 200 and Ø; Mezereum – 30, 200 and Ø; Badiaga- 30, 200 and Ø; Vincaminor- 30, 200 and Ø samples were carried out by determining the Zone of inhibition using the agar disc diffusion method against the *Malassezia furfur*.

Inoculum Preparation- Inoculum of *Malassezia furfur* was prepared in a respective broth and kept for incubation at 28° C for 48-72 hrs.

Blinding: Zone measurements were not blinded which may introduce observer bias

Antifungal assay by disc diffusion method (Bauer et al., 1966)

Antibiotic susceptibility tests were determined by agar disc diffusion method. The medium was prepared by dissolving 65g of SDA (Sabouraud Dextrose Agar) (Hi Media) in 1000 ml of distilled water. The dissolved medium was autoclaved at 15 lbs pressure at 121 °C for 15min. The autoclaved medium was cooled and poured to the petriplates (20 ml/plate) for solidification. Using a sterile cotton swab, spread the plate with *Malassezia furfur* culture uniformly over the surface

of the agar plate to create a lawn culture. Finally, sample Staphysagria – 30, 200 and Ø; Mezereum – 30, 200 and Ø; Badiaga- 30, 200 and Ø; Vincaminor- 30, 200 and Ø with 100 µl concentration in each sample including a positive control (Fluconazole-10µl/25µg) and a negative control (Succussed Ethanol-25µl). The plates were incubate at 28°C for 48 hours. After the incubation, inhibition zones were examined and measured with transparent ruler in millimetres (including disc). The absence of zone inhibition was interpreted as the absence of activity (Kohner et al., 1994; Mathabe Et al., 2006). The activities are expressed as resistant, if the zone of inhibition was less than 7 mm, intermediate 8-10 mm and sensitive if more than 11 mm (Assam et al., 2010).

Conflicts of interest:

The authors declares no conflict of interest

Funding : No external funding was received (self funding)

Ethical approval : Not applicable. This was an In-vitro Study with no human participation, human samples or animals

Statistical analysis:

Zones of inhibition were recorded in mm and compare descriptively with the controls no inferential tests were applied.

Potency selection rationale:

“Mother tincture (Q) was included as the material-dose reference. The 30C and 200C potencies were selected as commonly used low and high potencies in homoeopathic practice, and have been used in earlier in-vitro antifungal studies of homoeopathic medicines. Comparing Q, 30C and 200C allowed the effect of the crude preparation to be compared with potentised preparations.^{(5) (6)}

Medicine selection rationale :

Badiaga : Dandruff; scalp sore dry tetter like.

Mezereum : Scaly eruptions, white scab. Head covered with thick leathery crusts under which pus collects.

Staphysagria: Eczema of head, thick scabs, dry

and itch violently

Vinca minor: A remedy for skin affections spots on scalp ,oozing moisture, corrosive itching of

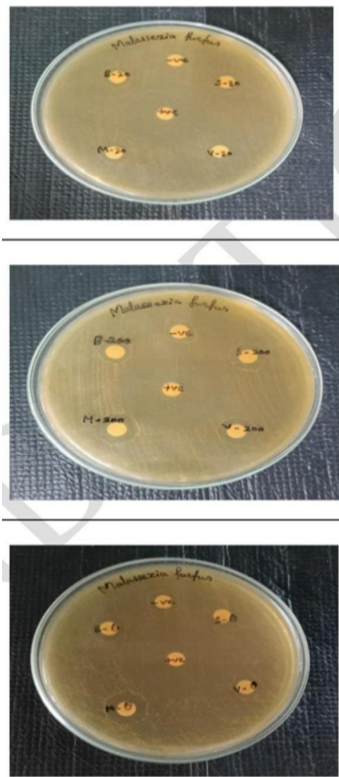
scalp(7)

These medines are selected due to their sphere of action on dandruff and skin complaints

Table 1: Anti-fungal potential of Staphysagria– 30, 200 and Ø ; Mezereum – 30, 200 and Ø; Badiaga- 30, 200 and Ø; Vinca minor- 30, 200 and Ø against Malasseiza furfur

Name of the Sample	Sample code and concentration of sample Zone of inhibition (mm in diameter)		
	PC	NC	100 µl
Staphysagria - 30	34	11	11
Mezerium - 30			11
Badiaga - 30			11
Vincaminor - 30			10
Staphysagria - 200	34	11	12
Mezerium - 200			14
Badiaga - 200			11
Vincaminor - 200			12
Staphysagria - Ø	34	11	13
Mezerium - Ø			14
Badiaga - Ø			12
Vincaminor - Ø			12

Keywords: PC (Positive control) (Fluconazole),NC (Negative control) (Ethanol), mm (Millimetre).



Results:

In this study the antifungal activity of Four homoeopathic mother tinctures were evaluated against the species Malassezia furfur. Four

homoeopathic medicines Badiaga, Mezereum Staphysagria, Vinca minor in Q,30C ,200C as intervention control and compared with negative control (Succussed Ethanol) and positive control (Fluconazole)

From the observation of the zone of inhibition (Table 1) it is evident that Homoeopathic medicines have some antifungal activity against Malassezia furfur. Comparison with negative control and positive control. When looking into the negative control (Ethanol)and other intervention groups, there was visible inhibitory zone in intervention groups. Negative control has zone of inhibition 11mm less than Homoeopathic medicines Mezereum 14mm.

Comparison Of Intervention Group:

In this study, under the positive control (fluconazole),a zone of inhibition is 34mm. Under the negative control(Succussed ethanol), a zone of inhibition is 11mm. Group treated with Badiaga Q has inhibitory zone of 12mm ,Badiaga 30 has inhibitory zone of 11mm ,Badiaga 200 has inhibitory zone of 11mm. Mezereum Q has inhibitory zone of 14mm, Mezereum 30 has an inhibitory zone of 11mm , Mezereum 200 has inhibitory

zone of 14mm. Staphysagria Q has inhibitory zone of 13mm, Staphysagria 30 has inhibitory zone of 11mm, Staphysagria 200 has inhibitory zone of 12mm. Vinca minor Q has inhibitory zone of 12mm, Vinca minor 30 has inhibitory zone of 10mm, Vinca minor 200 has inhibitory zone of 12mm. Among these intervention groups Mezereum Q and 200C showed highest inhibitory zone.

DISCUSSION:

The present study was conducted to assess the antifungal activity of Homoeopathic Medicines against *Malassezia furfur* a common organism, either directly or indirectly involved in the skin manifestations like seborrheic dermatitis, dandruff, pityriasis versicolor. As being the most common organism involved in causes of seborrheic dermatitis and dandruff studies have been conducted to survey the prevalence of different species of *Malassezia* fungi among rural and urban population with results of *M.globosa* (36.2%), *M.restricta* (31.3%), *M.furfur* (15.7%), a mixture of *M.globosa* and *M.restricta* (12%) being more severe disease amidst rural population. Homoeopathy as second commonly used medicine in the world has wide scope in treating fungal infections. Nowadays many researches were conducted (both clinical and invitro) to evaluate the antifungal activity of different homoeopathic medicines including mother tincture and various potencies. In-vitro study has been conducted with Homoeopathic Medicines

Acidum Sulphuricum, Acidum Benzoicum, Azadirachta indica, Cinchona officinalis, Iodium, Phosphorus, Selenium, Sulphur, Zincum Metallicum and Zingiber officinale in 6C, 12C, 30C, 200C, 1M liquid potencies on *Pityrosporum ovale* responsible for dandruff. In this most remedies have good inhibitory zone in their 6C and 200C potency. Other studies also conducted with different homoeopathic medicines against diverse fungal organisms to prove the efficacy both invitro and invivo.

In this study the four homoeopathic medicines Badiaga Q, 30C, 200C, Mezereum Q, 30C, 200C, Staphysagria Q, 30C, 200C, Vinca minor Q, 30C, 200C were selected randomly to know the efficacy of these medicines against *Malassezia furfur*.

Mezereum and Staphysagria are widely used by homoeopathic physician to treat major skin diseases like Eczema, dandruff which is caused by *Malassezia furfur*. In the current study to prove the action of selected Homoeopathic medicines agar disc diffusion method was used. In that after allowing the fungi to grow for 48hrs, zone of inhibition was measured. Negative control (Ethanol) was showing zone of inhibition of 11mm, but Homoeopathic medicines Mezereum, Staphysagria shows inhibition more than that. Considering result of the present study selected Homoeopathic medicines have considerable results in antifungal activity. Which can be further taken into clinical research for proving its efficiency. Curing or giving relief to these skin conditions prevents many psychological affections among teenagers.

CONCLUSION:

Homeopathic medicine for the treatment of *Malassezia furfur* infection as an antifungal agent have shown significant results. And clinically it serves with cost effective and safe administration with no any side effects or adverse event. Current study showed considerable results in antifungal activity, Mezereum Q and 200C with highest zone of inhibition when compared to other medicines Staphysagria, Badiaga, Vinca minor. These medicines has marked inhibitory effect than negative control.

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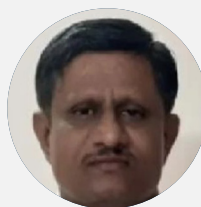
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Book Review on "The Art and Craft of Writing and Publishing Scientific Articles"



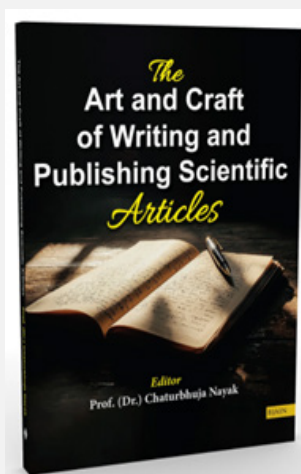
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The Art and Craft of Writing and Publishing Scientific Articles

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ABOUT THE EDITOR

Prof. (Dr.) Chaturbhuja Nayak has spent 50 years working in Homoeopathy, 42 years of them as a teacher, 30 years in research, and 26 years in administration. During this time, he led the Central Council for Research in Homoeopathy (CCRH) as Director General, chaired its Special Committee on Fundamental Research, and headed the Government of India's Homoeopathic Pharmacopoeia Committee. He has also been a member of the Central Council of Homoeopathy and its Education and PG Education Committees,

served as President of Homoeopathy University, Jaipur, and worked as Principal-cum-Superintendent at Dr. A. C. Homoeopathic Medical College and Hospital, Bhubaneswar. He received the Best Teacher Award from the Government of India and the Lifetime Achievement Award from the Government of Odisha, and he once served as Honorary Physician to the Governor of Odisha.

ABOUT THE BOOK

This book is aimed at explaining the rigorous process of scientific documentation for researchers, teachers, and clinicians in Homoeopathy, transforming manuscript writing from a difficult task into a structured, learnable skill. It offers a step-by-step roadmap from formulating a precise research question through to handling the ethical issues in peer review, and while its principles are broadly applicable across medical science, it applies a specialized lens to Homoeopathy, addressing the field's particular need to build a credible, interdisciplinary evidence base. Its key themes include structured scientific writing built around the IMRAD (Introduction, Methods, Results, and Discussion) format, how the publishing system works, including journal metrics, open access, and the peer-review cycle; honest and open research reporting; and clear language skills for reporting research findings accurately.

OUTLINE AND CONTENT

The book runs to 220 pages across 34 chapters, drawing on contributions from more than 40 clinicians, teachers, and researchers. The opening chapters cover the basics of planning a manuscript, including how to structure a research manuscript, plan the writing journey, and design data tables and graphical representations. These are followed by a series of chapters that follow the IMRAD structure step by step - introduction, materials and methods, results, and discussion - before moving into conclusions, acknowledgements, references, and annexures. A large part of the book looks beyond submission, with chapters on paper processing, what editors and reviewers expect, post-acceptance affairs, and how to maintain a paper's value after publication. Research integrity gets special focus through chapters on conflict of interest, publication ethics, and plagiarism. Homoeopathy-specific chapters address indexed and peer-reviewed publications in the field and the specific practice of case reporting in Homoeopathy. The book concludes with practical guidance on identifying high-impact and credible journals, converting a dissertation into a journal article, and recognizing the common mistakes and structural barriers that keep manuscripts from publication.

EVALUATION

The book's main strength is its dual focus: it works both as a general guide to scientific writing and as a guide to the evidence-related challenges specific to Homoeopathy. Chapters on indexed publications and case reporting in Homoeopathy directly address the field's need to turn clinical experience into reliable, evidence-based data, rather than just relabeling general writing advice as homoeopathic. The coverage is truly thorough, extending to practical details that many writing guides miss, such as annexures, author checklists,

and looking after a paper after publication, and the special focus on plagiarism and conflict of interest reflects a welcome seriousness about publication ethics.

The multi-author, chapter-based format, however, has both advantages and disadvantages. It allows readers to consult individual chapters directly without going through unrelated material, but it also produces some repetition, as several chapters revisit IMRAD basics or ethical publishing principles from slightly different angles. Overall, the book reads as if it were put together piece by piece rather than carefully planned, with topical chapters on data tables, grammar, and journal selection mixed in between the step-by-step IMRAD chapters rather than grouped separately. The book is best judged as a practical, teaching guide rather than a research book, it does not present new research data or a deep philosophical review of Homoeopathy's evidence, but within that limit, its guidance is reliable, up to date, and based on the practical experience of its many contributors.

RECOMMENDATION

This book can be recommended to postgraduate students and early-career researchers in Homoeopathy preparing their first manuscript, to faculty supervising dissertations and guiding students toward publication, and to editorial and ethics committees within homoeopathic institutions seeking a shared reference for authorship standards. It is best used not as a linear read but as a guide consulted chapter by chapter throughout the research and writing process - before drafting, during revision, and when responding to reviewers. Its contribution to the field is practical rather than theoretical, it will not settle debates about Homoeopathy's evidentiary status, but it can clearly improve the quality, ethical soundness, and publishability of the manuscripts that Homoeopathy's practitioners produce.

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