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Effectiveness of miasmatic approach in management of hypothyroidism: An evidence-based case report

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Abstract
Hypothyroidism is a prevalent endocrine disorder and a hypo-metabolic state resulting from inadequate secretion of thyroid hormones, characterised by a general reduction in metabolic function that manifests as slowing of physical and mental activity. It is the second most common endocrine disorder among females and a leading cause of menstrual irregularities in all age groups due to hormonal causes, thereby mostly affecting reproductive functions in females. While conventional treatment offers hormonal regulation, it often does not address the constitutional and psychosomatic dimensions of the disease. Homoeopathy, through its individualised and holistic approach, aims to restore health by considering the totality of symptoms and underlying miasmatic influences. This case report illustrates the role of miasmatic analysis in the successful Homoeopathic management of hypothyroidism. The patient exhibited both physical and psychological symptoms characteristic of chronic miasmatic symptoms. A comprehensive evaluation of mental, physical generals, and characteristic particulars guided the prescription of a constitutional antimiasmatic remedy. The individualised selection was supported by repertorization and Materia Medica consultation, taking into account dominant miasmatic expressions, which were primarily psoric and sycotic in nature. Throughout treatment, the patient demonstrated consistent improvement in general well-being, emotional stability, and normalisation of thyroid function without reliance on conventional hormone therapy. This case highlights the significance of a miasmatic approach in the long-term management of hypothyroidism and underscores the potential of Homoeopathy to offer a deeper, more sustainable healing response. This report supports the need for broader clinical exploration into miasmatic prescribing in endocrine disorders.

Keywords: Hypothyroidism, homoeopathy, miasmatic approach, individualised treatment, case report, constitutional symptoms, menstrual irregularities, endocrine disorders

Introduction

Homoeopathy is a therapeutic system that emphasizes treating the individual based on the principle of similarity between the remedy and the patient. A careful review of the homoeopathic literature highlights the extensive clinical and therapeutic material available for managing thyroid disorders [1]. Research studies reveal that in endocrine disorders, homoeopathic remedies act to stimulate the glands in cases of deficient secretion and to quiet them in cases of excess secretion. Endocrine disorders, such as thyroid disorders, are often hereditary or constitutional defects; homoeopathic medicines have a great role in such conditions. In most cases, remedy selection depends on an individual's totality of symptoms [3]. There is definite evidence that suggests that homoeopathic medicines can effectively stimulate the thyroid gland to regulate and maintain normal hormone levels [4]. Hypothyroidism is a hypometabolic state resulting from inadequate secretion of thyroid hormones for a longer period or rarely from resistance of the peripheral tissues to the effects of thyroid Hormones [5].

Evaluation of Hypothyroidism

Epidemiology: The incidence of hypothyroidism has increased to 5:100 individuals, with a marked predominance among females. It is considered a significant risk factor for infertility and complications during pregnancy. In India, the estimated prevalence of gestational Hypothyroidism is around 13.13% [6]. If left untreated or maltreated, gestational Hypothyroidism results in newborn's brain development leading to impaired intellectual, cognitive and neurological functions. Attention deficit and hyperactive disorders are common in children who were born to a hypothyroid mother [7]. Thyroid hormones play a crucial role in regulating both oestrogen and androgen metabolism. This is evident by the history of delayed puberty, irregular menstrual cycles, anovulation, miscarriage and infertility in hypothyroid individuals [8, 9].

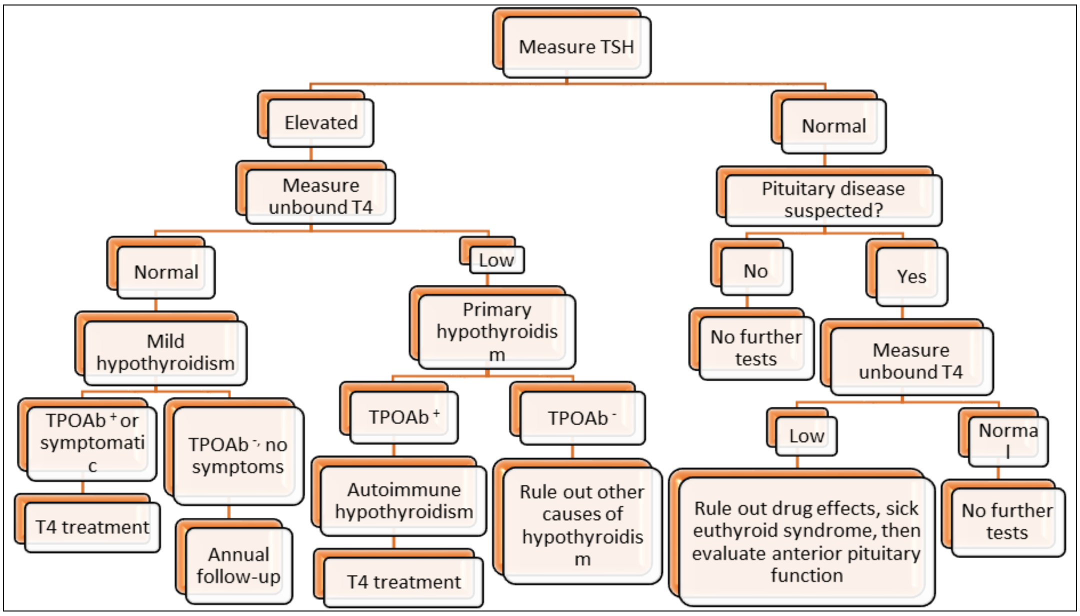


Fig 1: Evaluation of hypothyroidism. TPOAb⁺, thyroid peroxidase antibodies present; TPOAb⁻, thyroid peroxidase antibodies not present; TSH, thyroid-stimulating hormone

Aetiology: Hypothyroidism may arise from inadequate thyroid hormone production, most often due to thyroid gland dysfunction (primary hypothyroidism) or, less frequently, from disorders of the pituitary or hypothalamus (secondary hypothyroidism). Transient hypothyroidism can also occur in cases of silent or subacute thyroiditis. Subclinical (or mild) hypothyroidism is characterised by mildly elevated TSH levels while free thyroid hormone levels remain within the normal range; despite being termed 'subclinical,' some individuals may exhibit minor symptoms. With higher TSH levels and low free T4 levels, symptoms become more readily apparent in clinical (or overt) hypothyroidism. In areas of iodine sufficiency, autoimmune disease and iatrogenic causes are the most common causes of hypothyroidism [5].

Primary hypothyroidism

- Autoimmune hypothyroidism: Hashimoto's thyroiditis, atrophic thyroiditis
- Iatrogenic: ^{131}I treatment, subtotal or total thyroidectomy, external irradiation of neck for lymphoma or cancer
- Drugs: iodine excess (including iodine-containing contrast media and amiodarone), lithium, antithyroid drugs, p-aminosalicylic acid, interferon α and other cytokines, aminoglutethimide, sunitinib
- Congenital hypothyroidism: absent or ectopic thyroid gland, dyshormonogenesis, TSH-R mutation
- Iodine deficiency
- Infiltrative disorders: amyloidosis, sarcoidosis, hemochromatosis, scleroderma, cystinosis, Riedel's thyroiditis
- Overexpression of type 3 deiodinase in infantile hemangioma

Transient hypothyroidism

- Hypopituitarism: tumors, pituitary surgery or irradiation, infiltrative disorders, Sheehan's syndrome, trauma, genetic forms of combined pituitary hormone deficiencies
- Isolated TSH deficiency or inactivity
- Bexarotene treatment
- Hypothalamic disease: tumors, trauma, infiltrative disorders, idiopathic

Secondary hypothyroidism

- Silent thyroiditis, including postpartum thyroiditis
- Subacute thyroiditis
- Withdrawal of thyroxine treatment in individuals with an intact thyroid
- After ^{131}I treatment or subtotal thyroidectomy for Graves' disease

Fig 2: Causes of hypothyroidism

Clinical Features: Hypothyroidism may result in a myriad of clinical signs and symptoms. Symptoms commonly associated with hypothyroidism are often nonspecific. These include weight gain, fatigue, poor concentration, depression, diffuse muscle pain, and menstrual irregularities. Symptoms with high specificity for hypothyroidism include constipation, cold intolerance, dry skin, proximal muscle weakness, and hair loss [10]. Cardinal features on examination include bradycardia, mild diastolic hypertension, prolongation of the relaxation phase of deep tendon reflexes, and cool peripheral extremities. Goitre may be palpated, or the thyroid may be atrophic and nonpalpable [5].

Diagnosis: Hypothyroidism can be easily detected by assessing TSH levels in the blood. A slight increase in TSH levels with normal T_3 and T_4 indicates subclinical hypothyroidism, whereas high TSH levels accompanied by low T_3 and T_4 levels indicate clinical hypothyroidism [10]. Decreased serum free T_4 is common to all varieties of hypothyroidism. A raised serum TSH level serves as a reliable indicator of primary hypothyroidism, though it is typically absent in secondary hypothyroidism. In autoimmune-related hypothyroidism, thyroid peroxidase (TPO) antibodies are elevated in over 90% of cases. Laboratory findings may also show elevated cholesterol, increased creatine phosphokinase and anaemia. Electrocardiograms (ECGs) may reveal bradycardia, low-amplitude QRS complexes, and flattened or inverted T waves [5].

Complications: If left untreated, hypothyroidism can result in serious cardiovascular and neurological complications. (11) It may also lead to complications such as mental problems, peripheral neuropathy, myxoedema and infertility [12].

Treatment: The gold-standard treatment for primary hypothyroidism is thyroid hormone replacement therapy with Levothyroxine [13]. The treatment dosage of thyroid hormone is gradually titrated upwards until an individual displays normal physiological concentrations of free thyroxine (FT4) and TSH in the serum [14]. When levothyroxine monotherapy is used for a prolonged period, it may produce some harmful effects [19, 20]. The most common side effects include increased appetite, heat sensitivity, excessive sweating, headache, hyperactivity, nervousness, anxiety, and irritability. Research studies also show a potential association between long-term levothyroxine therapy and increased risks of cardiovascular disease, osteoporosis, and fractures.

Differential diagnosis of primary hypothyroidism based on clinical presentation due to the subtle signs and symptoms includes Euthyroid sick syndrome, Goitre, myxoedema coma, anaemia, subacute thyroiditis, iodine deficiency, Addison's disease, chronic fatigue syndrome, depression, erectile dysfunction, and infertility [15].

In contrast, homoeopathy, grounded in the principles of Similia Similibus Curantur, aims to stimulate the vital force and correct underlying imbalances. Recent homoeopathic perspectives emphasise the importance of identifying the dominant miasm and constitutional type in each case of hypothyroidism to facilitate a deeper and more sustained curative process. Homoeopathy offers a gentle, holistic, and natural pathway to managing hypothyroidism by addressing the individual as a whole body, mind, and emotions. Rather than merely suppressing symptoms, homoeopathic remedies are carefully selected based on the unique physical, mental, and emotional constitution of each person, aiming to correct the underlying imbalance that gives rise to disease. These remedies, prepared from highly diluted natural substances, work by stimulating the body's innate healing ability and restoring energetic harmony. By targeting the root cause rather than the surface manifestations, homoeopathy presents a compassionate and individualised alternative to conventional thyroid treatments, nurturing balance, relieving symptoms, and revitalising overall well-being. Homoeopathy views chronic diseases like hypothyroidism as the result of deep-rooted miasmatic influences. According to Hahnemann's miasmatic theory, chronic diseases stem from inherited or acquired taints Psora, Sycosis, and Syphilis which shape the predisposition to disease and the pattern of symptom evolution [16-18].

Case Reports

Patient information

A 26-year-old female came outpatient department on 27th June 2024 with complaints of irregular and delayed menstrual cycles (occurring every 45-50 days) and severe lower abdominal pain during menstruation. Her last menstrual period was on 11th June 2024, preceded by one on 25th April 2024, with scanty, dark red menstrual flow. She also reported a 4-month history of acne which aggravated before+ and during menses, hair fall, bloated abdomen, constipation, general weakness, and easy fatigability. The acne lesions were painful, papulo-pustular, and left scars. Additionally, she experienced intermittent constipation, especially during menses, and has gained approximately 8 kg in weight over the past 6 months. The patient has a known history of hypothyroidism for the past 3 years. On investigation, her TSH level was elevated to 7.27 µIU/mL, confirming a diagnosis of overt hypothyroidism.

Past History

The patient has a known history of hypothyroidism for the past 3 years and had been on allopathic medication for 2.4 years, maintaining a stable TSH level at 5.42 µIU/mL, but discontinued the medication 6 months ago. Since then, her symptoms have progressively worsened.

Family history

Father has been diagnosed with hypothyroidism and is receiving Homoeopathic treatment for it, while Mother has been diagnosed with varicose veins and is also undergoing Homoeopathic treatment to manage her condition.

Physical generals

She was fatty (obese), flabby and fair-complexioned. Her thermal reaction was hot. She could not bear the hot climate. She prefers to live in an air-conditioned room. On further investigation, she gives a history of irregular food habits, including a good appetite with three meals per day and had desire to eat cheese+ and salty foods. No particular aversion to eating. Tongue was dry & clean. The patient is mostly thirst less. Perspiration is profuse, mostly on the head, nose and back. Bowel movements are irregular, and stools are hard & knotty, occasionally experiencing intermittent constipation, especially during menses. Urine was regular and satisfactory. Sleep was 5-6 hours per night, but disturbed and unsound.

Life space investigation

The patient belongs to a middle-class family and is the second child of her parents. She has one elder brother and one younger sister. She shares a good relationship with her family and friends. Her developmental milestones were normal, and she had a positive experience during her schooling and college years, completing her degree course. At the age of 25, she encountered disturbances at home due to conflicts among family members, which adversely affected her concentration and studies, particularly while preparing for her entrance examination. Despite these challenges, she maintains a generally happy disposition and remains friendly and well-adjusted in her interpersonal relationships.

Mental generals

The woman had a jolly and extroverted nature, emotionally attached to and loving towards her family. Despite her generally sluggish and indolent behaviour due to a sedentary lifestyle, she completes any task she undertakes with diligence. She has a fear of being observed due to her facial acne and body fat, which has affected her confidence. She is indifference to important matters, especially concerning her health.

Menstrual history

There have been irregular menses in the last 3 months, occurring every 45-50 days. The flow is scanty, lasting for 2-3 days, and is accompanied by severe lower abdominal pain and constipation (occasionally) during menstruation. LMP: 11/06/2024 and before that, 25/04/2024.

Clinical findings: General Physical examination

On examination, the patient was of obese build, fair, fatty and flabby with 152 cm height and 72 kg weight. Her blood pressure was 110/70 mmHg, her pulse rate was 79/min & feeble, and her respiratory rate was 16/min. There was no pallor, cyanosis, lymphadenopathy, icterus, oedema or clubbing on examination.

Systemic examination

Thyroid gland: On examination of the neck, the thyroid gland was not palpable and had free upward movement on swallowing. On palpation, the thyroid gland was mobile, firm and non-tender. No visibly dilated veins were detected on the anterior part of the thorax.

Diagnostic assessment

Thyroid profile investigation dated 26th June 2024 revealed TSH level to be 07.27 ulU/mL, with T3**:** 1.13 ng/dL and T4: 6.94 µg/dL.

Provisional diagnosis

Hypothyroidism with features suggestive of Polycystic Ovary Syndrome (PCOS)?

Confirmed diagnosis

Overt Hypothyroidism, confirmed by elevated TSH = 7.27 µIU/mL, history of diagnosed hypothyroidism for 3 years, stoppage of medication 6 months ago, return of classical symptoms (fatigue, weight gain, constipation, cold intolerance, menstrual irregularities).

Miasmatic diagnosis

Miasmatic evaluation of all the presenting symptoms was done with the help of “Chronic Miasms in Homoeopathy and their Cure with the Classification of their Rubrics/Symptoms in Dr. Kent's Repertory by Dr. RP Patel, which showed the predominance of the Psoro-sycotic miasm over Syphilitic Miasm.

Table 1: Miasmatic evaluation

S. No.	PSORA	Sycosis	Syphilis
1.	Sluggishness and mental indolence	Irregular menses: Delayed, scanty menses	Acne with scarring
2.	Constipation (intermittent) menses during	Obesity and progressive weight gain	Diffuse hair fall
3.	Fear of being observed (due to acne)	Acne aggravated before/during menstruation	Indifference to important matters (especially her health)
4.	Conscientiousness in work	Desire for cheese and salt	Severe lower abdominal pain during menstruation
5.	Emotional attachment to family	Glandular hypo-function (thyroid involvement)	
6.	Desire for salty food	Profuse perspiration, especially on the head	
7.	Thirstlessness		

Analysis and evaluation of symptoms

Table 2: Evaluation of symptoms

Mental generals	Physical generals	Characteristic particulars
Jolly, extroverted nature	Thirstlessness	Irregular, delayed menses (45-50 days)
Emotionally attached to family	Dry tongue without thirst	Menses: scanty flow, dark red
Sluggish and indolent, but completes tasks well	Profuse perspiration on the head	Severe lower abdominal pain during menses
Fear of being observed (due to acne)	Desire for salty food	Acne before+ and during menses, pustular, with scars
Indifference to health	Desire for cheese	Diffuse hair fall
Conscientious about work	Obesity, weight gain (8 kg in 6 months)	Heaviness after eating
	Hot patient	Constipation (intermittent)

Prescribing the totality of symptoms

Based on the detailed case taking, the totality of symptoms for the case was framed as below:

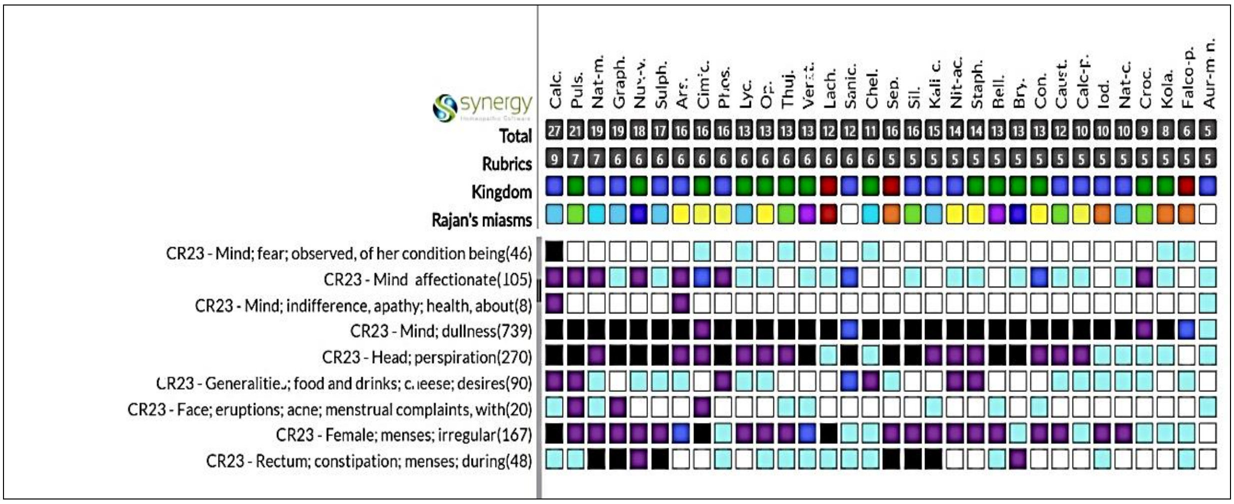
1. Fear of being observed (due to acne)
2. Emotionally attached to family
3. Indifference to health
4. Sluggish yet conscientious
5. Profuse perspiration on the head
6. Desire for cheese
7. Acne before and during menses
8. Irregular menses (45-50 days), scanty, painful
9. Constipation (intermittent) menses during

Conversion of symptoms into rubrics

Table 3: Conversion of symptoms into rubrics

S No.	Symptoms	Rubrics
1.	Fear of being observed	Mind, fear, observed, of her condition being
2.	Emotionally attached to family	Mind affectionate
3.	Indifference to health	Mind; indifference, apathy; health, about
4.	Sluggish	Mind; dullness
5.	Profuse perspiration on the head	Head; perspiration
6.	Desire for cheese	Generalities; food and drinks; cheese; desires
7.	Acne before and during menses	Face; eruptions; acne; menstrual complaints, with
8.	Irregular menses	Female; menses; irregular
9.	Constipation menses during	Rectum; constipation; menses; during

REPERTORIAL analysis



Final selection of medicine based on the concept of materia medica

After repertorization and miasmatic analysis, *Calcarea Carbonica* was selected, which covers general constitution (3F, i.e. Fair, Fatty & Flabby), mental, general, and particular symptoms in depth, strong psoro-sycotic constitution (matches miasmatic diagnosis). Considering all the aspects of the case and consultation with Materia Medica "*Calcarea Carbonica*" was found to be the final selection for a prescription.

Prescription

Rx,

1. *Calcarea Carbonica* 200°C/one dose stat
2. SAC LAC 30/ 1 drachm, thrice a day for 15 days

General Management Advice

1. Light regular exercise (walk/yoga)
2. Avoid refined sugar, saturated fats, caffeine & alcohol
3. Intake Iodine-rich foods like Seaweed, dairy, bananas, nuts and High fibre foods like whole grains, legumes, etc.
4. Get thyroid function (TSH) rechecked every 2 months
5. Encourage emotional support and awareness about self-care.
6. Maintain a menstrual diary.
7. Maintain a Regular Sleep Cycle-7-8 hours of quality sleep.
8. Drink warm water to improve digestion.

Follow-up

Table 4: The patient was followed up every month

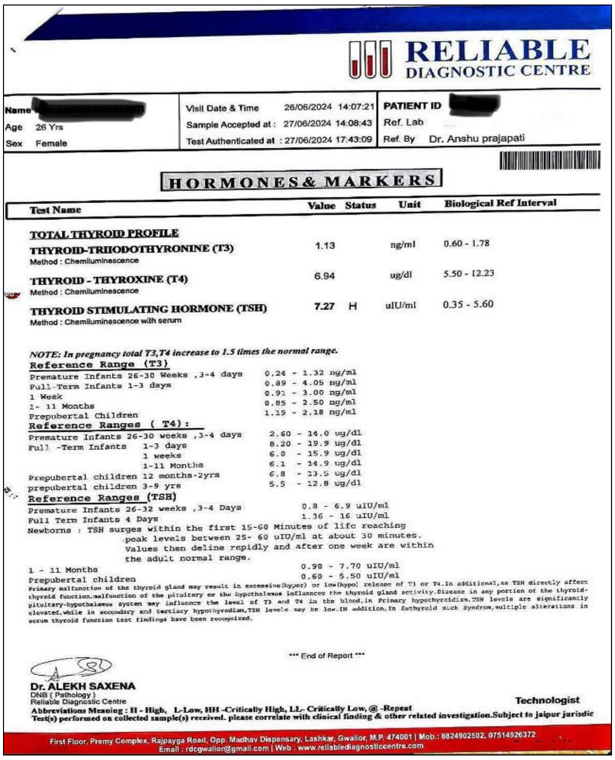
Date	Symptoms Change	Prescription
12-07-2024	The patient reports feeling slightly better overall, with a noticeable increase in both appetite and thirst. However, there has not been a significant observable improvement in the skin eruptions-Acne has reduced by approximately. 10%. Menses have not yet occurred, and energy levels are slightly better.	Rx Saclac 30/od/15 days
29-07-2024	There is a slight improvement in her overall condition. Menses occurred after 45 days and were characterised by dark colored, still scanty flow and were less painful. Acne is slightly improving and better than at the last follow-up. Constipation has also improved. LMP: 27-07-2024	Rx Saclac 30/od/15 days

16-08-2024	The patient shows overall improvement. Skin eruption (acne) is 50% better. Menses occurred after 40 days with reduced bloating. Mentally, she felt significantly better and reported an improved mood. Her appetite, thirst, sleep, and bowel movements are all satisfactory. She has no major complaints. Additionally, she mentioned feeling generally better during her menstrual periods compared to before. *Improvement continues…*	Rx Saclac 30/od/15 days
02-09-2024	The patient reported marked improvement in her overall condition. There was no further weight gain. Menses occurred at 35 days, with a dark-colored flow lasting for four days. The lower abdominal pain during menstruation was noticeably milder compared to the previous cycle. Mentally, she felt significantly better than before, and her skin eruptions continued to show improvement, with approximately 90% in the acne. Lmp: 01-09-2024 *Improvement continues….*	Rx Calc. Carb 200C/1 dose Saclac 30/od/15 days
18-09-2024	The patient reported feeling much better overall. Mentally, she felt significantly more stable and at ease. Her skin eruptions also showed marked improvement. She experienced good energy levels and reported a weight loss of 2 kg. She was advised to undergo a complete blood count and thyroid profile for further evaluation. *Improvement continues….*	Rx Saclac 30/od/10 days
03-10-2024	The patient expressed happiness and relief, noting that her menstrual cycles have become regular, occurring every 30 days, with no associated complaints. Her skin has cleared beautifully, with no visible eruptions. She reported no fatigue, and her appetite and bowel movements are regular. Both her thyroid profile and complete blood count were found to be within normal limits, adding to her sense of well-being. LMP: 01-10-2024 TSH-4.79µIU/mL She reported no other complaints and expressed satisfaction with her recovery.	Rx Saclac 30/od/15 days

LMP: Last menstrual period; TSH: Thyroid-stimulating hormone

Treatment reports

Thyroid profile reports: Before and after treatment



RELIABLE DIAGNOSTIC CENTRE

Name [redacted]
Age 26 Yrs
Sex Female

Visit Date & Time 26/06/2024 14:07:21
Sample Accepted at : 27/06/2024 14:08:43
Test Authenticated at : 27/06/2024 17:43:09

PATIENT ID [redacted]
Ref. Lab
Ref. By Dr. Anshu prajapati

HORMONES& MARKERS

Test Name	Value	Status	Unit	Biological Ref Interval
TOTAL THYROID PROFILE				
THYROID-TRIIODOTHYRONINE (T3) Method : Chemiluminescence	1.13		ng/ml	0.60 - 1.78
THYROID - THYROXINE (T4) Method : Chemiluminescence	6.94		ug/dl	5.50 - 12.23
THYROID STIMULATING HORMONE (TSH) Method : Chemiluminescence with serum	7.27	H	uIU/ml	0.35 - 5.60

NOTE: In pregnancy total T3,T4 increase to 1.5 times the normal range.

Reference Range (T3)

Premature Infants 26-30 Weeks ,3-4 days	0.24 - 1.32 ng/ml
Full-Term Infants 1-3 days	0.89 - 4.05 ng/ml
1 Week	0.91 - 3.00 ng/ml
1- 11 Months	0.85 - 2.50 ng/ml
Prepubertal Children	1.19 - 2.18 ng/ml

Reference Ranges (T4):

Premature Infants 26-30 weeks ,3-4 days	2.60 - 14.0 ug/dl
Full -Term Infants 1-3 days	8.20 - 19.9 ug/dl
1 weeks	6.0 - 15.9 ug/dl
1-11 Months	6.1 - 14.9 ug/dl
Prepubertal children 12 months-2yrs	6.8 - 13.5 ug/dl
prepubertal children 3-9 yrs	5.5 - 12.8 ug/dl

Reference Ranges (TSH)

Premature Infants 26-32 weeks ,3-4 Days	0.8 - 6.9 uIU/ml
Full Term Infants 4 Days	1.36 - 16 uIU/ml

Newborns : TSH surges within the first 15-60 Minutes of life reaching peak levels between 25- 60 uIU/ml at about 30 minutes. Values then deline repidly and after one week are within the adult normal range.

1 - 11 Months	0.90 - 7.70 uIU/ml
Prepubertal children	0.60 - 5.50 uIU/ml

Primary malfunction of the thyroid gland may result in excessive(hyper) or low(hypo) release of T3 or T4.In additional,as TSH directly affect thyroid function,malfunction of the pituitary or the hypothalamus influences the thyroid gland activity.Disease in any portion of the thyroid-pituitary-hypothalamus system may influence the level of T3 and T4 in the blood,in Primary hypothyroidism,TSH levels are significantly elevated,while in secondary and tertiary hypothyrodism,TSH levels may be low.IN addition,In Euthyroid sick Syndrom,multiple alterations in serum thyroid function test findings have been recognized.

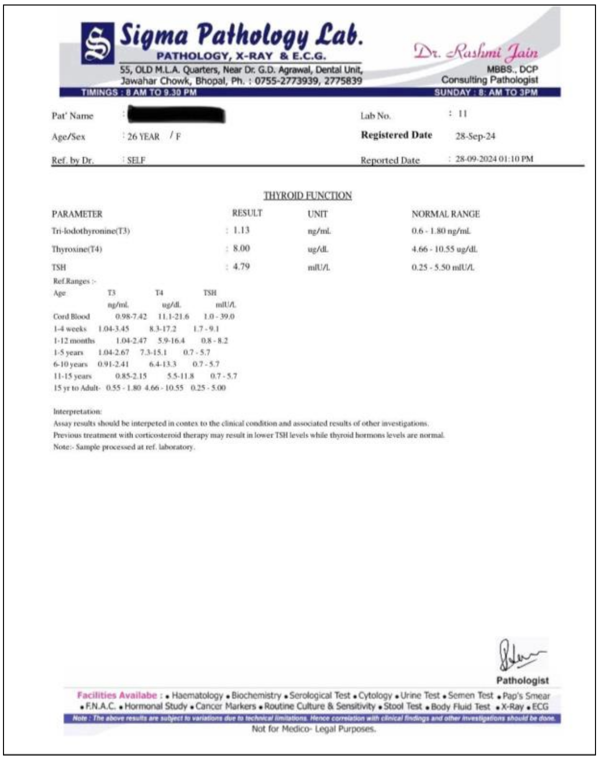
*** End of Report ***

Dr. ALEKH SAXENA
DNB (Pathology)
Reliable Diagnostic Centre

Technologist

Abbreviations Meaning : H - High, L-Low, HH -Critically High, LL- Critically Low, @ -Repeat
Test(s) performed on collected sample(s) received. please correlate with clinical finding & other related investigation.Subject to jaipur jurisdic

First Floor, Premy Complex, Rajpayga Road, Opp. Madhav Dispensary, Lashkar, Gwalior, M.P. 474001 | Mob.: 8824902502, 07514926372
Email : rdcgwalior@gmail.com | Web : www.reliablediagnosticcentre.com



Sigma Pathology Lab.
PATHOLOGY, X-RAY & E.C.G.
55, OLD M.L.A. Quarters, Near Dr. G.D. Agrawal, Dental Unit, Jawahar Chowk, Bhopal, Ph. : 0755-2773939, 2775839
TIMINGS : 8 AM TO 9.30 PM

Dr. Rashmi Jain
MBBS., DCP
Consulting Pathologist
SUNDAY : 8: AM TO 3PM

Pat' Name : [redacted]
Age/Sex : 26 YEAR / F
Ref. by Dr. : SELF

Lab No. : 11
Registered Date 28-Sep-24
Reported Date : 28-09-2024 01:10 PM

THYROID FUNCTION

PARAMETER	RESULT	UNIT	NORMAL RANGE
Tri-Iodothyronine(T3)	: 1.13	ng/mL	0.6 - 1.80 ng/mL
Thyroxine(T4)	: 8.00	ug/dL	4.66 - 10.55 ug/dL
TSH	: 4.79	mIU/L	0.25 - 5.50 mIU/L

Ref.Ranges :-

Age	T3 ng/mL	T4 ug/dL	TSH mIU/L
Cord Blood	0.98-7.42	11.1-21.6	1.0 - 39.0
1-4 weeks	1.04-3.45	8.3-17.2	1.7 - 9.1
1-12 months	1.04-2.47	5.9-16.4	0.8 - 8.2
1-5 years	1.04-2.67	7.3-15.1	0.7 - 5.7
6-10 years	0.91-2.41	6.4-13.3	0.7 - 5.7
11-15 years	0.85-2.15	5.5-11.8	0.7 - 5.7
15 yr to Adult-	0.55 - 1.80	4.66 - 10.55	0.25 - 5.00

Interpretation:
Assay results should be interpeted in contex to the clinical condition and associated results of other investigations.
Previous treatment with corticosteroid therapy may result in lower TSH levels while thyroid hormons levels are normal.
Note:- Sample processed at ref. laboratory.

Pathologist

Facilities Availabe : • Haematology • Biochemistry • Serological Test • Cytology • Urine Test • Semen Test • Pap's Smear • F.N.A.C. • Hormonal Study • Cancer Markers • Routine Culture & Sensitivity • Stool Test • Body Fluid Test • X-Ray • ECG
Note : The above results are subject to variations due to technical limitations. Hence correlation with clinical findings and other investigations should be done.
Not for Medico- Legal Purposes.

Results and Discussion

In Homoeopathy, we treat the patient (individual) as a whole, not the disease by its name and diagnosis. Our approach to every individual case is to stimulate the patient's own vital force and immunity by removing the underlying miasmatic blockages responsible for disease manifestation with our antimiasmatic medicines so that the patient can get back to normalcy without any adverse and unwanted complications. This differs greatly from conventional treatments that primarily focus on suppressing symptoms and replacing hormones. This approach aims at permanent restoration of health rather than temporary relief.

In this particular case, the patient presented with a history of hypothyroidism for the past 3 years and had been on medication for 2.4 years, during which her TSH remained sub-clinically elevated. She discontinued the medication 6 months before the consultation and started experiencing a resurgence of symptoms like irregular and painful menses, acne with scarring, hair fall, fatigue, constipation, bloating, obesity, and mental symptoms like fear of being observed, indifference, and sluggishness. On her first visit (27.06.2024), the female presented with elevated TSH level, which was 7.27 µIU/mL and her symptom totality indicated a mixed miasmatic background, predominantly deep-rooted psoro-sycotic miasmatic with minor syphilitic elements. This evaluation was done using Dr. RP Patel's classification of miasms through Kent's Repertory (Table 1). Based on individualised case taking, totality and miasmatic analysis, repertorial report, and confirmation through Materia Medica, *Calcarea Carbonic*a was prescribed in 200°C potency, selected as the simillimum. This prescription covers both the psoric and sycotic layers and was based on her mental generals, physical generals and characteristic particulars (Table 2). The patient was followed monthly. Gradually, her complaints improved, like acne and skin eruptions reduced significantly, menses became regular and painless, constipation, bloating, and fatigue subsided, weight stabilised, appetite normalised and most importantly, her mental well-being was restored she became emotionally more stable, confident, and proactive. TSH level reduced from 7.27 µIU/mL to 4.790 µIU/mL in a short period of 3 months with individualised homoeopathic medicine without any conventional supplement, with non-recurrence of complaints and with constitutional and miasmatic individualised homoeopathic medicine without any conventional supplement, is documentary evidence in favour of homoeopathy. Homoeopathy not only regulated her thyroid function but also brought harmony to her menstrual and emotional life. Various research studies have shown the efficacy of homoeopathy in the successful treatment of Hypothyroidism.

Conclusion

This case provides strong clinical evidence of the effectiveness of individualised, miasmatic-based homoeopathic treatment in managing such endocrine conditions like hypothyroidism. As it is evident that, particularly with this patient, even after taking conventional medication for over 2 years, with no substantial improvement. Whereas on proper and detailed history taking based on Dr Hahnemann's homoeopathic Principles, we could provide her complete relief from not only physical Symptoms but also her mental symptoms within 3 months through constitutional prescribing. This case study highlights the effectiveness of individualised Homoeopathic medicine *Calcarea Carbonic*a for managing hypothyroidism. The deep acting antipsoric and antisycotic remedy was selected based on a thorough assessment of the patient's total symptom picture, comprehensive miasmatic analysis aligned with the teachings of Dr. Samuel Hahnemann and Dr. RP Patel and also corroborated through repertorization. As this case shows how understanding the miasmatic background helps in selecting the right remedy, guiding the direction of cure, and avoiding superficial prescribing. This approach not only resolved the physical complaints but also addressed her emotional stagnation and psychological distress, offering a complete mind-body cure. While this is a single case study, it underscores the power of miasmatic homoeopathy in chronic hormonal and metabolic disorders. More clinical research and documentation of similar cases can further validate Homoeopathy as a safe, effective, and holistic alternative for managing endocrine pathologies.

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References

1. Manchanda RK, Archana N, Saurav A, Latika N. Homoeopathic perspective of thyroid disorders. Hpathy, 2010.
2. Alam S. Endocrine disorder and their homoeopathic management. Int J Homoeopath Sci. 2020;4:33-37.
3. Singh A, Ram H, Bagdi N, Choudhary P. Management of primary hypothyroidism through homoeopathic medicine: A case report. World J Pharm Res. 2020;9:1559-1574.
4. Harrison's. Principles of internal medicine. 16th Ed. USA: McGraw-Hill Companies, Inc., 2004.
5. Sahay RK, Nagesh VS. Hypothyroidism in pregnancy. Indian J Endocrinol Metab. 2012;16(3):364-370.
6. Ghassabian A, Bongers-Schokking JJ, de Rijke YB, *et al*. Maternal thyroid autoimmunity during pregnancy and the risk of attention deficit/hyperactivity problems in children; The generation R study. Thyroid. 2012;22(2):178-186.
7. Unisa S. Childishness in Andhra Pradesh. Reprod Health Matters. 1999;7:54-64.
8. Zargar AH, Wani AI, Masoodi SR, *et al*. Epidemiologic and etiologic aspects of primary infertility in the Kashmir region of India. Fertil Steril. 1997;68(4):637-643.
9. Verma I, Sood R, Juneja S, Kaur S. Prevalence of hypothyroidism in infertile women and evaluation of response of treatment for hypothyroidism on infertility. Int J Appl Basic Med Res. 2012;2(1):17-19.
10. Der EM, Quayson SE, Lamptey CJN, Wiredu EK, Ephraim RK, Gyasi RK. Thyroid disorders in Accra, Ghana: A retrospective histopathological study at the Korle-Bu teaching hospital. J Med Biol Sci. 2013;2(1).
11. Dutta D, Garg A, Khandelwal D, Kalra S, Mittal S, Chittawar S. Thyroid symptomatology across the spectrum of hypothyroidism and impact of levothyroxine supplementation in patients with severe primary hypothyroidism. Indian J Endocrinol Metab. 2019;23:373-378.
12. De Carvalho GA, Filho PG, Junior CM, Graf H. Management of endocrine disease: Pitfalls in the replacement therapy for primary and central hypothyroidism in adults. Eur J Endocrinol. 2018;178(6):R231-2344.
13. Brown BT, Graham PL, Bonello R, Pollard H. A biopsychosocial approach to primary hypothyroidism: Treatment and harms data from a randomised controlled trial. Chiropr Man Therap. 2015;23(1):24.
14. Patil N, Rehman A, Jialal I. Hypothyroidism.

In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing, 2020.
15. Hahnemann S. The chronic diseases: Their peculiar nature and their homoeopathic cure. New Delhi: B Jain Publishers, 2002.
16. Hahnemann S Organon of medicine. Dudgeon RE, translator. New Delhi: B Jain Publishers, 2002.
17. Allen JH. The chronic miasm, psora and pseudo-psora. Vol. I & II. New Delhi: B Jain Publishers, 2004.
18. Flynn RWV, Bonellie SR, Jung RT, MacDonald TM, Morris AD, Leese GP, *et al*. Serum thyroid-stimulating hormone concentration and morbidity from cardiovascular disease and fractures in patients on long-term thyroxine therapy. J Clin Endocrinol Metab, 2010 Jan;95(1):186-193. Available from: https://academic.oup.com/jcem/articleabstract/95/1/186/2835226
19. Feller M, Snel M, Moutzouri E, Bauer DC, de Montmollin M, Aujesky D, *et al*. Association of thyroid hormone therapy with quality of life and thyroid-related symptoms in patients with subclinical hypothyroidism: A systematic review and meta-analysis. JAMA. 2018 Apr 3;319(14):1388-139.
20. Patil N, Rehman A, Jialal I. Hypothyroidism. In: Stat Pearls [Internet]. Treasure Island (FL): Stat Pearls Publishing, 2020.

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