



International Journal of Homoeopathic Sciences

E-ISSN: 2616-4493
P-ISSN: 2616-4485
Impact Factor (RJIF): 5.96
www.homoeopathicjournal.com
IJHS 2025; 9(3): 1500-1503
Received: 10-06-2025
Accepted: 12-07-2025

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Role of homoeopathy in the long-term management of varicose ulcer following deep vein thrombosis: A case report

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DOI: <https://www.doi.org/10.33545/26164485.2025.v9.i3.W.1890>

Abstract

A 65-year-old female presented with a history of Deep Vein Thrombosis (DVT) and varicose ulcer since 2015. Initial homeopathic management with Lachesis and Ceanothus Americanus resulted in improvement; however, in 2018, after prolonged travel, a severe ulcer developed requiring allopathic intervention. Subsequently, homeopathic treatment was resumed with Lachesis, Hamamelis, and Ceanothus Americanus, along with the use of varicose stockings. Over 10 years of follow-up, the patient demonstrated significant healing of ulceration, reduction in pain, and progressive improvement in skin discoloration. This case highlights the potential role of individualized homeopathic medicines in chronic venous insufficiency and ulcer management.

Keywords: Varicose ulcer, venous leg ulcer, chronic venous insufficiency, deep vein thrombosis, homeopathy, Lachesis, Ceanothus americanus, hamamelis, compression therapy, wound healing

Introduction

A varicose ulcer, also known as a venous leg ulcer, is a wound that develops in the lower leg due to poor blood circulation in the veins, especially around the medial malleolus^[1, 2]. Most often on the inner side of the leg, and represents the most advanced stage of vein disease^[1, 2]. Venous ulcers are the most common type of leg ulcer, responsible for about 60-80% of all cases^[1, 2].

The condition is more prevalent in elderly populations, with reported prevalence ranging between 0.1-0.3% in the general adult population and rising to 1-2% among those aged over 65 years^[3]. Women are affected more often than men, largely due to pregnancy and hormonal influences. Risk factors include obesity, prolonged standing, immobility, previous Deep Vein Thrombosis (DVT), trauma, and family history of venous disease^[4]. This causes swelling, skin changes, and poor wound healing^[5].

Varicose ulcers can be painful, slow to heal, and often recur. They significantly affect a patient's quality of life and place a heavy burden on healthcare systems, since recurrence rates can reach up to 70% within five years if the underlying vein problem is not treated^[6]. Therefore, they require comprehensive management, including proper wound care, compression therapy, and treatment of the vein disorder.

Varicose ulcers typically present with an irregular shape and sharply demarcated margins, most commonly occurring in the peri-malleolar region^[2]. While the depth of these ulcers is generally confined to the subcutaneous tissue, secondary infection may extend the damage into deeper structures." <http://www.ncbi.nlm.nih.gov/pubmed/26358303>.

Venous leg ulcers account for 60-80% of all lower-limb ulcers, making them the most common cause of chronic ulceration of the leg^[1, 2]. They are typically shallow with irregular margins, often associated with varicose veins, edema, hyperpigmentation, lipodermatosclerosis, and venous eczema^[2].

Etiology

- Primary varicose veins (incompetent valves of long/short saphenous or perforators).
- Secondary to DVT (post-thrombotic syndrome).
- Prolonged standing, pregnancy, obesity (predisposing factors).

Pathophysiology of varicose ulcers

Varicose ulcers, also called venous leg ulcers, develop as a complication of Chronic Venous Insufficiency (CVI). The main underlying mechanism is venous hypertension, which results

from incompetent venous valves, venous obstruction, or calf muscle pump dysfunction.

1. Venous hypertension

Failure of the venous valves causes blood reflux and pooling in superficial and perforator veins, leading to sustained venous hypertension in the lower limbs.

2. Microcirculatory changes

The increased pressure is transmitted to the capillary bed, causing dilation and leakage of plasma proteins, fibrinogen, and red blood cells into the interstitial tissue. This produces fibrin cuffs and pericapillary edema, impairing oxygen and nutrient diffusion.

3. Leukocyte Activation and Inflammation

Leukocyte trapping and activation in the microcirculation release inflammatory mediators (e.g., TNF- α , matrix metalloproteinases), which damage the endothelium and extracellular matrix, further impairing healing.

4. Tissue hypoxia

The combination of fibrin deposition, capillary obstruction, and edema reduces oxygen delivery to tissues, resulting in chronic ischemia.

5. Skin and tissue breakdown

Persistent hypoxia, along with chronic inflammation and poor nutrient delivery, leads to skin atrophy, necrosis, and ultimately ulcer formation, typically around the medial malleolus.

Genetic mutations may predispose individuals to the development of venous ulcers. Factor XIII plays a crucial role in forming the fibrin matrix that covers wounds and initiates fibroblast growth and migration. Mutations in the F13A1 gene, which encodes Factor XIII, have been linked to larger venous leg ulcers and delayed wound healing. Moreover, a recent study by Anwar *et al.* highlighted several genetic mutations associated with impaired healing and progression of venous ulcers.

Clinical manifestations of varicose (Venous) ulcers

1. Site

Typically located in the gaiter area, especially around the medial malleolus; less commonly over the lateral malleolus or dorsum of the foot (Valencia *et al.*, 2001) ^[2].

2. Appearance of the ulcer

- Shallow, with irregular margins.
- Base contains granulation tissue, slough, or exudate.
- Surrounding skin shows brownish pigmentation, eczema, and lipodermatosclerosis (Eberhardt & Raffetto, 2014) ^[8].

3. Pain

- Usually mild, dull, or aching.
- Pain worsens with prolonged standing and is relieved by limb elevation (Raffetto & Mannello, 2014) ^[7].

4. Associated skin changes

- Hyperpigmentation from hemosiderin deposition.
- Varicose eczema with itching, redness, and scaling.
- Atrophie blanche (white atrophic patches).

Lipodermatosclerosis causing induration and an “inverted champagne bottle” appearance of the leg (Browse *et al.*, 2000) ^[10].

5. Venous signs

- Visible varicose veins in the limb.
- Edema that worsens after standing.
- Perimalleolar telangiectasia or venous flare (Eberhardt & Raffetto, 2014) ^[8].

6. Chronicity

- Ulcers are recurrent, slow to heal, and prone to secondary infection.
- Healing leaves an atrophic scar that is fragile and easily breaks down (Coleridge Smith, 1997) ^[4].

Case of venous ulcer treated with homoeopathy





Patient information

Patient: Female, age ~65 (in 2015).

History: DVT in 2015, presenting with pain, swelling, skin

darkening, and varicose ulceration.

Treatment history

Hahnemann instruction given in aphorisms 185-203 for treatment of local maladies is followed.

Hahnemann's Instructions in Local Maladies (Varicose Ulcers)

Hahnemann explained that local maladies, such as varicose ulcers, should not be treated by mere local applications alone, but by addressing the internal dynamic cause with the indicated remedy. Local applications may be used only as palliative or supportive when absolutely necessary, but the main cure depends on internal constitutional treatment.

Relevant Aphorism (Organon of Medicine)

Aphorism 186-203: Hahnemann discusses local maladies. He emphasizes that these are not isolated diseases but expressions of internal disorder, hence require internal treatment along with cautious external management.

2015-2017: Lachesis 30C, 200C, (When ever required) Ceanothus Americanus Q. Gradual improvement noted.

2018: After long tour, severe ulceration developed. Allopathic treatment (wound care + medications) given → ulcer healed.

2019-2023: Homeopathy restarted due to residual pain, pigmentation, and varicosity. Remedies included Lachesis 200C (When ever required), Ceanothus Americanus Q, with advice for compression stockings. Gradual improvement in pain and discoloration.

2024: Lachesis 200C, Hamamelis Q, and Ceanothus Americanus Q prescribed. Notable improvement in skin color, reduction of pain, and no recurrence of ulceration.

Current status (April 2025)

- No active ulcer.
- Minimal pigmentation.
- Pain negligible.
- Patient ambulatory without difficulty.

Discussion

Chronic venous ulcer is difficult to manage, often with high recurrence.

Homeopathic remedies

Lachesis: Venous congestion, left-sided complaints, bluish discoloration ^[9].

Ceanothus Americanus: Acts on spleen and venous system, reduces congestion ^[10].

Hamamelis: Well-known for venous stasis, varicose veins, and hemorrhagic tendency, Painful,hard,knotty,varicoses ^[11].

Calcarea flour: This remedy has proved curative in hard swelling on the bones, varicosis, varicose veins,whitlow,induration of testicles ^[12]. The synergistic use of these remedies along with mechanical support (stockings) may have contributed to long-term healing. Importance of individualized remedy selection and long-term follow-up is emphasized.

Limitations: Single case report, occasional allopathic intervention (2018 episode), not a controlled trial.

Conclusion

This case demonstrates successful long-term management of a varicose ulcer following DVT with predominantly homeopathic remedies. The progressive healing and change in the skin colour over 10 years highlights the potential role of homeopathy in chronic venous insufficiency and warrants further clinical research.

Acknowledgement

I am deeply thankful to my respected guide, Dr. Rudresh Koppal, Professor & HOD Department of Homoeopathic Repertory & Case taking BVVS Homoeopathic Medical College Bagalkote, for generously allowing me to publish his treated case. His encouragement, insightful suggestions, and academic guidance have been a constant source of inspiration in preparing this article

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How to Cite This Article

Deshpande T, Koppal R, Hooli A. Role of homeopathy in the long-term management of varicose ulcer following deep vein thrombosis: a case report. *International Journal of Homoeopathic Sciences.* 2025;9(3):1500-1503.