



International Journal of Homoeopathic Sciences

E-ISSN: 2616-4493
P-ISSN: 2616-4485
Impact Factor (RJIF): 5.96
www.homoeopathicjournal.com
IJHS 2025; 9(4): 779-783
Received: 01-08-2025
Accepted: 03-09-2025

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Homoeopathic management of facial verruca with *Thuja occidentalis*: A case study

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DOI: <https://www.doi.org/10.33545/26164485.2025.v9.i4.L.1999>

Abstract

Warts (verrucae) are benign proliferative skin lesions caused by infection of keratinocytes with human papillomavirus (HPV). These lesions present in various morphological types depending on the site and HPV subtype, including common warts, plantar warts, flat warts, anogenital warts, and those seen in rarer conditions such as epidermodysplasia verruciformis. The natural history often involves spontaneous resolution, but many lesions persist or recur. Diagnosis is primarily clinical, based on characteristic appearance, though histopathology or molecular testing may be required in atypical or treatment-resistant cases. Understanding the etiology, modes of transmission, immune response, and diagnostic criteria are essential for effective management. This review synthesizes current knowledge regarding the etiology and diagnosis of warts, drawing from recent guidelines and studies.

Keywords: Warts, verrucae, human papilloma virus, cutaneous warts, diagnosis, etiology, dermatology

Introduction

Warts (also termed verrucae) are common dermatologic lesions that result from infection of the skin by human papillomavirus (HPV). They affect individuals of all ages but are particularly frequent in children and young adults. Although benign, warts can cause discomfort, cosmetic concern, and may spread, recur, or become resistant to therapy. Multiple types exist, differentiated by location, morphology, and HPV subtype. Given the variable clinical courses and therapeutic responses, accurate diagnosis and understanding of causative factors are critical in guiding management.

Etiology

1. Causal agent - Human Papillomavirus

Warts are caused by infection with HPV, a non-enveloped double-stranded DNA virus from the Papillomaviridae family. Over 100 HPV subtypes have been identified, some being more likely to cause specific wart types. PMC+3MSD Manuals+3PubMed+3

2. Transmission and inoculation

- **Autoinoculation:** Self-spread to adjacent skin or via scratching.
- **Person-to-person:** Direct skin-to-skin contact.
- **Indirect contact:** Via fomites (e.g. towels, surfaces).
- **Facilitating factors:** Disruption of skin barrier (minor trauma, maceration). Immunosuppression also increases risk. PubMed+2MSD Manuals+2

3. Host factors and immune response

- The immune response (both cellular, particularly CD8⁺ T cells, and humoral) governs clearance or persistence. MSD Manuals+1
- Immunocompromised individuals (e.g. HIV infection, transplant recipients, other immunosuppressive states) tend to have more widespread, persistent, or treatment-resistant warts. MSD Manuals+1

4. HPV subtype and lesion type correlations

- Different HPV types tend to cause different wart morphologies (common hands, plantar feet, flat warts etc.). High-risk HPV types are usually associated with anogenital lesions and potential carcinogenesis. PubMed+1
- Rare genetic conditions such as epidermodysplasia verruciformis predispose to specific, often chronic warts, and some risk of malignant transformation. PubMed+2PMC+2

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Diagnosis

Diagnosis of warts involves a combination of history, clinical examination, and sometimes laboratory/histologic confirmation. Here are key aspects:

1. History

- Onset: when lesions first appeared, duration, any known preceding trauma.
- Symptoms: pain (especially plantar warts), itching, bleeding, tenderness.
- Previous treatments and response.
- Immunologic status (e.g. HIV, immunosuppressive therapy).
- Risk exposure: contact with someone with warts, communal showers/pools, object exposure, sexual exposure (for genital warts). PubMed+1

2. Clinical examination

Table 1: Key morphological features depending on type

Wart Type	Typical Appearance	Common Sites
Common verruca (verruca vulgaris)	Rough, hyperkeratotic papules, often with black dots (thrombosed capillaries) when pared	Hands, fingers, knees
Plantar warts	Hard, thick lesions on soles; pain on pressure; black flecks; disruption of skin lines	Soles of feet
Flat warts (verruca plana)	Smooth, flat-topped papules, often multiple; may coalesce	Face, forearms, shins
Filiform/flat variants near eyes or face	Thread-like, spiky projections	Face, near eyelids
Genital warts (condylomata acuminata)	Soft, papillomatous growths; may be sessile or pedunculated	External genitalia, perianal region
Epidermodysplasia verruciformis	Widespread flat wart-like or pityriasis-versicolor-like lesions, risk of malignant change	Sun-exposed skin, generalized

Other signs: disruption of skin lines (plantar/callus distinction), pain on lateral vs direct pressure, presence of koebnerization (new lesions at sites of trauma). PubMed

3. Differential Diagnosis

Conditions that may mimic warts include:

- Calluses, corns
- Molluscum contagiosum
- Seborrheic keratosis
- Lichen planus, cutaneous horns
- In genital region: HPV-induced low risk warts vs possible premalignant conditions (e.g. Bowenoid papulosis) PubMed+1

4. Laboratory / Histology

Usually not required unless:

- Lesions are atypical in appearance.
- Treatment-resistant or extensive.
- Suspicion of malignancy (especially in genital or sun-exposed areas).

Histologic features include

- Hyperkeratosis, papillomatosis, acanthosis.
- Elongated rete ridges.
- Parakeratosis.
- Thrombosed capillaries (black dots).

Laboratory/molecular testing for HPV type may be done in research or in special cases. PubMed+1

5. Clinical Guidelines & Diagnostic Standards

According to the 2022 “Clinical guideline for the diagnosis and treatment of cutaneous warts,” cutaneous warts are benign proliferative lesions caused by HPV infection of keratinocytes. Diagnostic “gold standard” is typically clinical examination; laboratory tests reserved for special circumstances. PMC

Conclusion (Diagnosis & Etiology Summary)

- Warts are caused by HPV infection of skin or mucosa; their occurrence depends on viral subtype, host immune status, and skin integrity.
- Most warts can be diagnosed clinically. Histology and molecular tests are reserved for atypical or treatment-resistant lesions.
- Understanding which HPV type, the wart origin, and patient immune function helps in prognostication and planning therapy.

Epidemiology

- The overall population prevalence of non-genital warts is estimated at 7-12% in the general population. Medscape+1
- Among school-aged children, prevalence is higher, about 10-20%. Medscape+2NCBI+2
- Peak incidence for non-genital warts tends to be in children and adolescents, particularly ages 12-16 years. Medscape+1
- Sex distribution is roughly equal (male: female $\approx$ 1:1) for non-genital warts. Medscape+1
- Differences by race: White populations have about twice the frequency of common warts compared to Black or Asian populations. Medscape+1
- Among special occupational groups, e.g. meat handlers, poultry/fish handlers, higher prevalence is seen. Medscape+2NCBI+2

Genital warts (anogenital warts, AGWs):

- Annual incidence (new + recurrent) ranges from ~160 to 289 per 100,000 (both sexes combined). BioMed Central
- Among males median ~137/100,000; among females ~120.5/100,000. BioMed Central
- Prevalence estimates vary depending on data source; for example, from medical chart reviews or genital examinations the prevalence is from 0.13% to ~5% depending on study methods. BioMed Central
- Highest rates occur in younger age groups: females <24 years; males in mid 20s to 30s. BioMed Central
- Natural history: a significant proportion of warts resolve spontaneously. For non-genital warts, about 65% may disappear within 2 years without treatment. Medscape

Treatment Modalities

Table 2: Treatment strategies depend on the type of wart (common, plantar, flat, genital), size, location, number of lesions, patient age, immune status, and patient preference. Here are the main modalities:

Modality	Indications / Notes	Advantages	Disadvantages / Risks
Topical Keratolytics (e.g. salicylic acid)	First line for many common warts; useful for plantar warts; home use possible. MSD Manuals+1	Non-invasive, inexpensive, minimal risk; can be used by patient.	Requires long duration (weeks to months); adherence; skin irritation; variable effectiveness.
Cryotherapy (Liquid nitrogen)	Common warts, plantar warts, lesions not responsive to simpler topical therapy; office procedure. Medscape+2MSD Manuals+2	Rapid destruction; widely available.	Pain, blistering, risk of scarring, pigment changes; may require multiple sessions; recurrence.
Chemical destruction (e.g. trichloroacetic acid, podophyllin/podofilox)	Especially for genital warts; small or superficial lesions. Medscape+2AAFP+2	Outpatient; can be effective; sometimes easier for patients than physical removal.	Irritation, risk of damage to adjacent tissue; toxicity in some agents (e.g. podophyllin); contraindications (e.g. pregnancy for some agents).
Surgical removal / Destructive methods (curettage, electrodesiccation, excision, laser)	Large, stubborn, or numerous warts; cosmetically sensitive areas; lesions resistant to simpler therapies. MSD Manuals+2American Academy of Dermatology+2	Can achieve rapid removal; useful for refractory lesions; possible immediate cosmetic results.	More risk of scarring; require anesthesia; cost; possible recurrence.
Immunotherapy / Immune modulators (e.g. imiquimod, antigen injections, interferons)	For warts not responding to destructive methods; genital warts; for patients preferring less invasive options. Medscape+2American Academy of Dermatology+2	Can address underlying viral persistence; sometimes better for areas where destructive methods are risky; less scarring.	Local irritation; takes longer; possible systemic side effects in some; cost; patient compliance.
Combination therapies	Using more than one therapy (e.g. salicylic acid + cryotherapy) often gives better results. AAFP+1	Potential synergistic effect; improvement in cure rates.	More complex treatment; more side effects; requires careful follow-up.

Some details

- A 2011 AAFP review found that topical salicylic acid, cryotherapy, and topical 5-fluorouracil are effective for non-genital warts. AAFP
- Bleomycin and interferons are reserved for difficult / treatment-resistant cases. American Academy of Dermatology+1
- For genital warts, agents like imiquimod 5% cream, podofilox, trichloroacetic acid, and sometimes interferon, are used. Medscape+1
- Podophyllin: effective but has toxicity risk. It must be carefully applied, limited in area, and avoided in pregnancy. AAFP

Prevention

Reducing risk of HPV infection and spread of warts involves behavioral, environmental, and immunologic strategies. Key preventive measures include:

1. Hygiene and skin care

- Wash hands regularly; avoid touching others' warts, and wash hands after touching own warts. American Academy of Dermatology
- Keep skin clean, moisturized; avoid cracks, dryness, or skin trauma which facilitate HPV entry. American Academy of Dermatology+1
- Avoid sharing personal items (towels, socks, shoes, nail clippers etc.) with someone who has warts. American Academy of Dermatology

2. Environmental precautions

- Wear protective footwear (flip-flops or sandals) in communal moist areas (showers, pool decks, locker rooms) to reduce risk of plantar warts. American Academy of Dermatology+1
- Cover cuts or abrasions to avoid sites of entry. American Academy of Dermatology

3. Behavioral strategies

- Avoid nail-biting or cuticle picking, which may permit inoculation. American Academy of Dermatology
- For genital warts safer sex practices, condom use helps reduce (but may not completely eliminate) transmission. SAGE Journals+2Medscape+2
- Limit number of sexual partners; early vaccination against HPV (especially including types which cause genital warts) is very important. SAGE Journals+1

4. Vaccination

- HPV vaccines that include low-risk types (e.g. HPV-6 and HPV-11) substantially reduce incidence of genital warts. SAGE Journals+1
- Public health vaccination programmes have shown reductions in new genital warts diagnoses among vaccinated cohorts. PubMed

5. Early treatment to limit spread

- Prompt treatment of existing warts may reduce spreading to other sites or other persons.
- Keep warts covered; avoid shaving over them; avoid trauma.

Homoeopathic perspective

There are several homoeopathic medicines which act miraculously in condition of warts. They either given after individualization (after thorough case taking), or therapeutically acts wonderfully in warts and recovery or cure occurs. Below mentioned the indications from Boericke's Repertory useful in cases of warts. These indications with their homoeopathic medicines are taken from Boericke's Homoeopathic Materia Medica. The rubric for warts is mentioned in Boericke's Repertory as VERRUCA and it is mentioned below.

- **VERUCCA (warts)** -- Acet. ac., Am. c., Anac. oc., Anag., Ant. c., Ant. t., Ars. br., Aur. m. n., Bar. c., Calc.

c., Castorea, Cast. eq., *Caust.*, Chrom. oxy., Cinnab., *Dulc.*, *Ferr. picr.*, Kali m., Kali perm., Lyc., *Mag. s.*, *Nat. c.*, *Nat. m.*, *Nat. s.*, *Nit. ac.*, Ran. b., Semperv. t., Sep., *Sil.*, Staph., Sul., Sul. ac., *Thuja*, X-ray.

- **Bleed easily** -- Cinnab.
- **Jagged, large** -- *Caust.*, *Nit. ac.*
- **Condylomata, fig warts** -- Calc. c., Cinnab., Euphras., Kali iod., Lyc., Med., Merc. c., Merc. s., *Nat. s.*, *Nit. ac.*, Phos. ac., Sab., Sep., *Sil.*, Staph., *Thuja*.
- **Cracked, ragged, with furfureaceous areola** -- Lyc.
- **Flat, smooth, sore** -- Ruta.
- **Horny, broad** -- Rhus t.
- **Large**
- **Seedy** -- *Thuja*.
- **Smooth, fleshy, on back of hands** -- *Dulc.*
- **Lupoid** -- *Ferr. picr.*
- **Moist**
- **Itching, flat, broad** -- *Thuja*.
- **Oozing** -- *Nit. ac.*
- **Painful**
- **Hard, stiff, shining** -- *Sil.*
- **Sticking** -- *Nit. ac.*, Staph., *Thuja*.
- **Pedunculated** -- *Caust.*, Lyc., *Nit. ac.*, Sab., Staph., *Thuja*.
- **Location**
- **Body, in general** -- *Nat. s.*, Sep.
- **Breast** -- Castor.
- **Face, hands** -- Calc. c., *Caust.*, Carbo an., *Dulc.*, Kali c.
- **Forehead** -- Castorea.
- **Genito-anal surface** -- *Nit. ac.*, *Thuja*.
- **Hands** -- Anac., *Bufo*, *Ferr. magnet.*, Kali m., Lach., *Nat. c.*, *Nat. m.*, Rhus t., Ruta.
- **Neck, arms, hands, soft, smooth** -- Ant. c.
- **Nose, finger tips, eye brows** -- *Caust.*
- **Prepuce** -- Cinnab., Phos. ac., Sab.
- **Small, all over body** -- *Caust.*
- **Smooth** -- Calc. c., Ruta.
- **Sycotic, syphilitic** -- *Nit. ac.*
- **Homoeopathic Medicines**

The medicines from Boericke's *Materia Medica* are as follows

1. **Antimonium Crudum: Skin:** Dry skin. Warts (*Thuja*; *Sabina*; *Caust.*). Dry gangrene. Scaly, pustular eruption with burning and itching, worse at night.
2. **Calcareo Carbonica:** Skin-Unhealthy; readily ulcerating; flaccid. Small wounds do not heal readily. Glands swollen. Nettle rash; better in cold air. Warts on face and hands. Petechial eruptions.
3. **Causticum:** Skin-Warts large, jagged, bleeding easily, on tips of fingers and nose.
4. **Dulcamara:** Skin-Warts, large, smooth, on face and palmar surface of hands. Anasarca. Thick, brown-yellow crusts, bleeding when scratched.
5. **Magnesium Sulphuricum:** The skin, urinary, and female symptoms are most marked. Small pimples over the whole body, that itch violently. Suppressed itch (*Sulph.*). Crawling in the tips of the fingers of the left hand; better on rubbing. Warts.
6. **Nitric Acid:** Warts, large jagged; bleed on washing. Ulcers bleed easily, sensitive; splinter-like pains;

zigzag, irregular edges; base looks like raw flesh. Exuberant granulations.

7. ***Thuja occidentalis:*** Acts on skin, blood, gastrointestinal tract, kidneys, and brain. Its relation to the production of pathological vegetations condylomate, warty excrescences, spongy tumors is very important. Polypi, tubercles, warts epithelioma, naevi, carbuncles; ulcers, especially in ano-genital region.

Introduction

- **Reg no:** 56583
- **Name:** PQR
- **Age:** 20 yrs
- **Sex:** Female
- **Religion:** Hindu
- **Address:** Vishesh Khand Gomti Nagar, Lucknow
- **Occupation:** Student
- **Present Complaint:** Multiple small warts on face since 2 years.
- **Location:** Both the cheeks.
- **Sensation:** Itching and burning (sometimes).
- **Modalities:** Aggravation-Afternoon, sun heat,
- **Amelioration:** After washing the face with cold water.
- **History of Present Complaint:** A patient of age 20 years visited to OPD due to complaint of facial warts since 2 years. Actual cause was unknown to the patient. The eruptions sometimes itches and bleeds after scratching. treatment taken was some external application but got no relief.
- **Past History:** Nothing specific found.
- **Family History:** Paternal side-NAD
- **Maternal side:** NAD
- **Own side:** NAD

Personal History

- **Food habits:** Vegetarian
- **Socio economic status:** Lower middle class
- **Menstrual History:** Character -Pain-for 1-2 days
- **Colour:** Bright red
- **Duration:** 4-5/30-32 days

Generalities

Physical Generals

- **Appetite:** Good
- **Thirst:** Large quantities at a time.
- **Desire:** Sweets, raw onion
- **Sleep:** Good 7-8 hours.
- **Stool:** 1/2 times daily, soft stool, non offensive
- **Perspiration:** Profuse, more on face

Mental Generals

Cheerful, happy go lucky personality, Tensed only about her career.

Homoeopathic Treatment Plan 17/05/2025

- *Thuja occidentalis* 200/3 doses
- Nihilinum 30/TDS

15/07/2025

- Nihilinum 30/TDS
- R. Met 200/3 Doses

2/08/2025

- R. Met 200/3 Doses
- Thuja 200/0/3 Doses

Before**After****Prevention and Patient Education**

- Avoid direct contact with warts
- Use footwear in communal areas
- Do not share personal items (towels, razors)
- Practice safe sex to prevent genital warts
- HPV vaccination (e.g., Gardasil) for prevention of genital and cervical lesions.

Conclusion: Warts, though benign, can significantly impact quality of life due to discomfort, cosmetic disfigurement, and social stigma. Understanding the diverse clinical presentations and available treatment modalities allows for individualized patient care. While many cases resolve spontaneously, a variety of topical, procedural, and immunotherapeutic options exist for resistant cases. Advances in HPV vaccination and immunomodulation offer promising avenues for both prevention and management.

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How to Cite This Article

Rupali Verma and Dileep Kumar Sonkar. Homoeopathic management of facial verruca with *Thuja occidentalis*: A case study. International Journal of Homoeopathic Sciences. 2025;9(4):779-783.

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