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Management of depression in perimenopausal woman using LM potency medicines: A case report

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Abstract
Depression is common among perimenopausal women due to hormonal fluctuations, psychosocial stressors, and emotional vulnerability during the menopausal transition. This phase is often associated with vasomotor symptoms, menstrual irregularities, sleep disturbances, and mood changes that significantly affect quality of life. Homoeopathy, with its holistic and individualized approach, offers a gentle and effective mode of treatment, especially through the use of 50 Millesimal (LM) potencies. Diagnosis of depression was done using the DSM 5 criteria and assessment of severity before and after was assessed using Hamilton depression rating scale.

Keywords: Depression, perimenopausal women, lm potency, homoeopathy, ham d

Introduction

Clinical depression, another name for major depressive disorder (MDD), is a mental illness marked by at least two weeks of persistent low mood, low self-esteem, and loss of interest or pleasure in often rewarding activities. The American Psychiatric Association used the phrase, which was first used by a group of US doctors in the mid-1970s, for this cluster of symptoms under mood disorders in the 1980 edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III). Since then, it has been used extensively. After low back pain, the condition results in the second-highest number of years spent disabled. Females are affected almost three times more frequently than males, with the most common beginning occurring in the 20s. The disorder can progress in a variety of ways, from a single episode that lasts for months to a chronic condition with frequent occurrences [1].

Depression is expected to affect 4% of the population, including 5.7% of adults (4.6% of men and 6.9% of women) and 5.9% of individuals 70 years of age and older. Depression affects about 332 million people worldwide. Women are almost 1.5 times as likely than males to experience depression. Over 10% of pregnant and postpartum women worldwide suffer from depression [2]. Some women may experience a depressive episode as a result of physical and hormonal changes brought on by pregnancy, the postpartum phase, the menstrual cycle, and the perimenopause [3]. Menopause, which marks the end of a woman's reproductive years, is one stage in a continuum of life stages, according to the World Health Organization. Most women between the ages of 45 and 55 naturally go through the menopause due to biological aging. Menstrual cycle changes usually occur before the menopausal transition, which may occur gradually. "Perimenopause" refers to the period of time that starts when these symptoms start and ends a year after the last menstrual cycle. Perimenopause may have long-lasting consequences on a person's mental, emotional, social, and physical health [4].

Menopausal women had a pooled prevalence of 35.6% (95% CI: 32.0-39.2%), perimenopausal women had a prevalence of 33.9% (95% CI: 27.8-40.0%), and postmenopausal women had a prevalence of 34.9% (95% CI: 30.7-39.1%) [5]. In India, the pooled estimate for the prevalence of depression in perimenopausal and postmenopausal women using the random effects model is 42.47% (95% CI: 28.73-57.49, I2 = 97.7%) [6].

Many people have irregular menstrual cycles, fluctuating hormone levels, and sleeplessness during this perimenopausal stage. Hot flashes can be very uncomfortable and are also extremely common. Some ladies may undergo emotional changes in addition to physical ones. Perimenopausal depression is a type of depression that can occasionally result from certain emotional situations. In fact, over 35% of perimenopausal women develop depressive symptoms, according to study [7].

Fatigue and lack of energy, slowed cognitive function, inattentiveness, a lack of interest in once-enjoyable activities, feelings of worthlessness, hopelessness, or helplessness are some of the symptoms of major depressive disorder (MDD), whether it occurs during perimenopause or at any other time in your life. Perimenopausal depression can also manifest as mood swings, anger, unreasonable sobbing or tearfulness, elevated anxiety, deep despair, and sweating.

According to research, a woman's lifetime exposure to estragon may be a predictor of perimenopausal depression. For example, a 2010 review of research revealed that premenopausal women were two to four times less likely than perimenopausal women without a history of depression to have depression. The review also mentioned hot flashes and how they affect sleep habits. People in this stage of life frequently experience stressful life events including divorce, losing their job, or losing a parent. Depression may also be brought on by these occurrences [7].

Perimenopausal depression has also been associated with a number of other factors, such as a family history of depression, obesity, a history of sexual abuse or violence, negative feelings about aging and menopause, severe menopausal symptoms, a sedentary lifestyle, smoking, social isolation, low self-esteem, and disappointment in not being able to have any more children [7].

Hormones and mood

During the menopausal transition, many women experience abrupt mood swings. Hormone fluctuations may be connected to these mood swings. Serotonin and norepinephrine levels in the brain are impacted by changes in estragon levels. Dopamine, norepinephrine, and serotonin are brain chemicals that directly affect your mood. Among other things, they can help you feel happier by lowering anxiety and enhancing sleep. When these mood-power players are in balance, you feel generally at ease and content. Serotonin and norepinephrine's capacity to function as neurotransmitters can be hampered by hormone imbalances, such as an increase in estragon while a decrease in progesterone. Mood swings that may culminate in depression are the outcome [7].

The association between depression and perimenopause is complex. In addition to the effects of perimenopause, depression itself may cause early-onset perimenopause, according to a 2003 study (Trusted Source). The study found that women who experienced "significant symptoms of depression in their late 30s and early 40s" were more likely than those who did not to have perimenopause before turning 45 [7].

The term "perimenopause" or "climacteric" also describes the years of decreasing ovarian function that coincide with a woman's diminishing fertility, menopause, and degeneration that follow long-term estrogen shortage. Menopause results from the ovaries' failure to perform their two main functions and their depletion of primordial follicles. These are the production of hormones and the monthly release of an ovum. The pituitary secretes more luteinizing and follicle stimulating hormones in an attempt to encourage ovulation. Menopause is indicated by a high FSH level of more than 20 iU/L [8].

Depending on the aetiology, condition, feeling, and modality of the complaints, a variety of homoeopathic remedies can be selected for perimenopausal symptoms. The following are some crucial homeopathic remedies for perimenopausal symptoms: Capsicum, Anacardium, Pulsatilla, Sepia, Lachesis, Natrum mur, Sanguinaria, Amyl nit, Calcarea carb, Verat alb, and sulphur [8].

Researchers discovered that compared to premenopausal or postmenopausal women, women in perimenopause, which usually lasts three to five years before menopause and may involve mood swings, had a 40% higher risk of depression. According to the study's authors, the results highlight the need of screening women for depression during perimenopause and offering the required support [9].

The DSM-5 diagnostic criteria for major depressive disorder [10]

A. Five or more of the following symptoms have been present during the same 2 weeks period and represent a change from previous functioning; at least one of the symptoms is either depressed mood or loss of interest or pleasure

1. Depressed mood most of the day, nearly every day as indicated by either subjective report (e.g. feels sad, empty, hopeless) or observation made by others (e.g. appears tearful).
2. Markedly diminished interest or pleasure in all, or almost all activities most of the day, nearly every day (as indicated by either subjective account or observation).
3. Significant weight loss when not dieting or weight gain (e.g. a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others, not nearly subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feeling of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
8. Diminished ability to think or concentrate or indecisiveness nearly every day (either by subjective account or as observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without as specific plan, or a suicide attempt, or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the physiological effect of substance or to other medical condition [10]

Homeopathic point of view

For depression, homeopathy provides a very gentle and safe treatment. Homeopathic medications are natural treatments that help treat this illness by acting on the mind at a very deep level. In situations of depression, the primary goal of homeopathy is to effect a cure rather than only provide symptomatic alleviation. When it is used, the complaint's initial severity progressively decreases. A state of wellbeing is then restored. Furthermore, homeopathic treatments in any form are not designed to suppress complaints. Both acute and chronic depression can benefit from homeopathy [11].

Homeopathy uses carefully chosen constitutional remedies that is, medications chosen according to a person's emotional, mental, and physical states that reveal their personality to treat depression. Instead of only treating the symptoms, these medications heal the patient holistically by acting on a deep psychological level. This disruption in a person's mental health can be repaired with appropriate constitution treatment in homoeopathy, providing a sense of comfort and wellbeing as well as mental health restoration. In cases of depression, it results in an effective cure. Ignatia, Natrum Mur, Aurum Met, Kali Phos, Sepia, Cimicifuga Racemosa, Lachesis, and Coffea Cruda are the top eight homeopathic remedies for depression [11].

Concept of LM potency

LM potency, where L stands for 50 and M for Millesimal, is another name for 50 Millesimal potency. In Bangladesh, these potencies are represented as LM/1, LM/2, LM/3, etc. Dr. Hahnemann himself, and it is represented as 0/1, 0/2, 0/3, etc. in India. The drug ratio is 1:50,000, meaning that 50,000 parts of the vehicle and one component of the drug material. The 50 Millesimal Scale was dubbed the "New, Altered but Perfect Method" by Dr. Hahnemann. Because treatment with low potencies cannot stimulate and treatment with larger potencies causes severe aggravation, he was dissatisfied with the centesimal potencies, particularly in weak, sensitive constitutions with chronic Miasmatic cases [12].

The goal of Dr. Hahnemann's treatment was to minimize the patient's disturbances. Dr. Hahnemann only suggests potencies between 0/1 and 0/30, according to aphorism 270 in the sixth edition of Organon. Incredibly helpful for mental illnesses with minimal aggravation. When needed, the medications can be taken intermittently. If a medication is chosen incorrectly, a new, carefully chosen medication can be administered without counteracting the effects of the old medication. It can be used safely without worrying about aggravation because 50 millilitres of potency causes the least amount of aggravation [12].

When a patient is taking homoeopathy for the first time, it is very well tolerated. Additionally, the medication must be administered for seven or fourteen days in a row before calling for another visit [12].

Case Report

Patient Identification

- **Name:** [Withheld for confidentiality]
- **Age/Sex:** 48-year-old female
- **Marital Status:** Married at the age of 20 years, 1 son
- **Occupation:** Teacher
- **Date of First Visit:** 22/08/2025

Chief Complaints

Persistent sadness with weeping tendency

Restlessness out of anxiety, increased weakness

Disturbed sleep marked irritability since

Irregular periods with hot flushes, increased perspiration, increased frequency of urination.

- **Modality:** all complaints < morning on waking up
- **Duration:** - Present continuously since last 6 months.
- **Progression:** Gradually increasing.

History of Present Illness

The patient had persistent sadness for 6 months, gradually progressive, without any apparent exciting cause. Sadness was accompanied by agitation, marked irritability, anger outbursts, and frequent weeping spells, especially in the morning on waking. She felt mentally restless, anxious, and suspicious of family members.

Since the last six months, her menses had become irregular, associated with hot flushes, excessive perspiration, and increased frequency of urination. She complained of generalized body pains and extreme weakness, leading to aversion to routine work.

Emotionally, her complaints started after becoming a mother-in-law one year ago. She expressed intense dissatisfaction with the new family situation, fear that her son would no longer love her, and suspicion that her husband would reject her as she aged. Always check his phone out of suspicion. She feared the end of her womanhood with approaching menopause and was jealous of her daughter-in-law. The patient had a dominant personality with strong emotional reactions.

Past Medical History

- **Age 6 years:** Chickenpox - Treated with homoeopathy - Relieved
- **Age 25 years:** Typhoid - Treated with allopathy- Relieved

Family History

- **Mother:** uterine fibroid,
- **Father:** Diabetes mellitus type II, Hypertension (no more from cardiac arrest, at the age of 70 years)

Personal History

- Education: Masters
- Occupation: Teachers
- Marital status: married at the age of 20 years

Mental Generals

- Delusion of being hated, jealousy, suspicion, restlessness out of anxiety.
- Sadness, anxiety, weeping <morning on waking up.

Physical Generals

- **Thirst:** Excessive, unquenchable
- **Appetite:** Reduced
- **Perspiration:** Profuse with hot flushes all over body.
- **Desire:** Salt
- **Thermal State:** Hot patient
- **Stool:** regular
- **Urine:** frequency increased since last 6 months.
- **Sexual function:** indifference

Menstrual history

- **Menarche:** 13 years
- **Features:** flow was profuse, reddish black, clots with backpain but since last 6 months menses is irregular with increased flow and occurs at irregular interval with backpain weakness, agitation, hot flushes, increased perspiration and increased urination since then.

Gynaecological history and Obstetrical history

1 child, normal vaginal delivery.

Examination

The patient is a well-groomed fair woman with a moderately -built body who was anxious sad and restless. Her attitude toward the examiner is cooperative, without any ingratiating behaviour. Her mood appears sad, though his affect remains appropriate to the situation. Speech is normal. Thought processes are marked by fear of loss of love and affection by family and a fixed idea that everyone hates her. No perceptual disturbances are noted. Cognition is intact, and she demonstrates true emotional insight into her condition.

Diagnosis

- Major Depressive Disorder (DSM-5 criteria fulfilled).
- Hamilton depression rating scale [13] = 18 marks (moderate depression).

The presence of more than five characteristic symptoms, including depressed mood, anhedonia, fatigue, sleep disturbance, psychomotor agitation, and emotional distress causing functional impairment, confirms that this case satisfies DSM-5 criteria for Major Depressive Disorder.

Miasmatic Diagnosis

- **Fundamental miasm:** Psora -Functional hormonal imbalance of perimenopause.
- **Predominant miasm:** sycosis - Suspicion, jealousy, insecurity, fixed ideas, fear of losing relationships.
- **Minor syphilitic touch:** Depth of sadness, melancholia, despair related to loss of womanhood.

Totality of Symptoms

- sadness
- weeping tendency
- anxious restlessness
- fixed idea that others hate her
- unreasonable jealousy towards daughter in low
- suspicious of others
- hot thermally
- hot flushes
- desire for pungent things and cold food
- increased perspiration
- disturbed sleep
- irregular menses

Rubrics- synthesis repertory

- Mind -Delusions-hated; by others
- Mind- Jealousy
- Mind - Restlessness- anxious
- Mind- Sadness
- Mind- Suspicious
- Mind-Weeping
- Female Genitalia/Sex-Menses-irregular
- Sleep- Disturbed
- Generals- Food and drinks-cold food -desire
- Generals- Food and drinks-pungent things -desire
- Generals-Heat- flushes of

Repertorial result

- Lachesis -24/11
- Pulsatilla 22/10
- Sulphur 22/10
- Caust 21/10
- Nux vom 19/10

Remedy Selection

Based on mental and physical totality: Lachesis Mutus - well-suited to women of perimenopausal age group and their complaints, the hot flushes, thermally hot nature, desires in food and the mental picture of depression, from jealousy and unreasonable anxiety of losing love and attention of others at the change of life suggested this medicine only and it was given in series of LM potencies as suggested by Dr Sammuel Hahnemann starting from 0/1,0/2 and 0/3.

Mode of Administration

Aphorisms 246-248 in the sixth edition of the Organon of Medicine describe its style of repetition. One 50 millesimal scale globule of medication is dissolved in seven to eight tablespoons of water and thoroughly succussed eight to ten times in a phial for repetition. One tablespoonful is taken from this, added to a glass with seven or eight tablespoons of water, and thoroughly mixed. The patient is then given a convenient dose. Medication for chronic illnesses is repeated every day or every other day. Medication is repeated every two or six hours for acute illnesses, and every hour or more frequently for really urgent situations. When medication is repeated, its strength is altered and somewhat increased by thoroughly and vigorously succussing the solution of each dose [14].

Hahnemann in Organon of medicine aphorisms states that we produce the following solution for any prescribed medication: We take one little globule (which is rarely more than one globule) of (0/1 or 0/2 or any other stated potency in 50 millesimal scale, of which 100 weigh one that is required to use more grain, i.e., 10 number globules (foot note to aphorism 270).Next, we use some milk sugar to crush it (aphorism 272). It is better to smash the globule of high potency in a few grains of milk sugar. Since one tablespoon is equal to fifteen milliliters, we put this crushed powder in a glass vial with seven or eight tablespoons of water, or 105 to 120 milliliters. (If necessary, we can also produce the solution in 0, 30, 20, 15, or 8 tablespoonfuls of water, or 600 ml, 450 ml, 300 ml, 225 ml, or 120 ml of water, respectively.) Next, we add 15-20 drops of alcohol to preserve it. If not, the water can deteriorate in a matter

Of days. According to aphorism 248, which states, "For this purpose, we potentize anew the medicinal solution with perhaps 8, 10, 12 succussions," we apply thorough succussions (8, 10, 12 successions) to the preceding solution. One tablespoonful of this solution is added to a glass of water, thoroughly stirred, and then administered to the patient [15].

Management & Advice

a) Maintain a regular daily routine and adequate sleep.
b) Avoid mental stress and emotional strain.
c) Practice mindfulness exercises daily to improve emotional awareness.

d) Perform box breathing (4-4-4-4 technique) during anxiety or restlessness.
e) Practice meditation.
f) Follow a light, balanced diet and ensure proper hydration.
g) Engage in gentle physical activity like walking.
h) Stay in a cool, well-ventilated environment.
i) Reassurance and emotional support regarding perimenopausal changes.
j) Regular follow-ups for assessment and guidance.

Prognosis

Favourable - based on constitutional improvement and return of emotional balance Outcome

- Marked improvement in sad melancholic mood
- Improvement in hot flushes, restlessness out of anxiety and sleep.
- Mental and emotional well-being restored
- Patient satisfied with treatment

Tables Charts Pictures

Image of rubrics from synthesis repertory

1 MIND - DELUSIONS - hated; by others
2 MIND - JEALOUSY
3 MIND - RESTLESSNESS - anxious
4 MIND - SADNESS
5 MIND - SUSPICIOUS
6 MIND - WEEPING
FEMALE GENITALIA/SEX
7 FEMALE GENITALIA/SEX - MENS irregular
SLEEP
8 SLEEP - DISTURBED
GENERALS
9 GENERALS - FOOD and DRINKS - desire
10 GENERALS - FOOD and DRINKS desire
11 GENERALS - HEAT - flushes of

Remedies	∑Sym	∑Deg	Symptoms
lach.	11	24	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11
puls.	10	22	2, 3, 4, 5, 6, 7, 8, 9, 10, 11
sulph.	10	22	2, 3, 4, 5, 6, 7, 8, 9, 10, 11
caust.	10	21	2, 3, 4, 5, 6, 7, 8, 9, 10, 11
nux-v.	10	19	2, 3, 4, 5, 6, 7, 8, 9, 10, 11
phos.	10	19	2, 3, 4, 5, 6, 7, 8, 9, 10, 11
verat.	10	18	2, 3, 4, 5, 6, 7, 8, 9, 10, 11
nat-m.	10	15	2, 3, 4, 5, 6, 7, 8, 9, 10, 11
lyc.	9	23	2, 3, 4, 5, 6, 7, 8, 9, 11
ars.	9	19	2, 3, 4, 5, 6, 8, 9, 10, 11

HAM D assessment before (20/8/25)

20/8/25.

Hamilton Depression Rating Scale (HDRS)

Reference: **Hamilton M. A rating scale for depression. J Neurol Neurosurg Psychiatry 1960; 23:56–62**

Rating Clinician-rated

Administration time 20–30 minutes

Main purpose To assess severity of, and change in, depressive symptoms

Population Adults

Commentary

The HDRS (also known as the Ham-D) is the most widely used clinician-administered depression assessment scale. The original version contains 17 items ($HDRS_{17}$) pertaining to symptoms of depression experienced over the past week. Although the scale was designed for completion after an unstructured clinical interview, there are now semi-structured interview guides available. The HDRS was originally developed for hospital inpatients, thus the emphasis on melancholic and physical symptoms of depression. A later 21-item version ($HDRS_{21}$) included 4 items intended to subtype the depression, but which are sometimes, incorrectly, used to rate severity. A limitation of the HDRS is that atypical symptoms of depression (e.g., hypersomnia, hyperphagia) are not assessed (see SIGH-SAD, page 55).

Scoring

Method for scoring varies by version. For the $HDRS_{17}$, a score of 0–7 is generally accepted to be within the normal range (or in clinical remission), while a score of 20 or higher (indicating at least moderate severity) is usually required for entry into a clinical trial.

Versions

The scale has been translated into a number of languages including French, German, Italian, Thai, and Turkish. As well, there is an Interactive Voice Response version (IVR), a Seasonal Affective Disorder version (SIGH-SAD, see page 55), and a Structured Interview Version (HDS-SIV). Numerous versions with varying lengths include the HDRS17, HDRS21, HDRS29, HDRS8, HDRS6, HDRS24, and HDRS7 (see page 30).

Additional references

Hamilton M. Development of a rating scale for primary depressive illness. Br J Soc Clin Psychol 1967; 6(4):278–96.

Williams JB. A structured interview guide for the Hamilton Depression Rating Scale. Arch Gen Psychiatry 1988; 45(8):742–7.

Address for correspondence

The HDRS is in the public domain.

Hamilton Depression Rating Scale (HDRS)

PLEASE COMPLETE THE SCALE BASED ON A STRUCTURED INTERVIEW

Instructions: for each item select the one "cue" which best characterizes the patient. Be sure to record the answers in the appropriate spaces (positions 0 through 4).

1 **DEPRESSED MOOD** (sadness, hopeless, helpless, worthless)
- 0 ☐ Absent.
- 1 ☐ These feeling states indicated only on questioning.
- 2 ☐ These feeling states spontaneously reported verbally.
- 3 ☑ Communicates feeling states non-verbally, i.e. through facial expression, posture, voice and tendency to weep.
- 4 ☐ Patient reports virtually only these feeling states in his/her spontaneous verbal and non-verbal communication.

2 **FEELINGS OF GUILT**
- 0 ☑ Absent.
- 1 ☐ Self reproach, feels he/she has let people down.
- 2 ☐ Ideas of guilt or rumination over past errors or sinful deeds.
- 3 ☐ Present illness is a punishment. Delusions of guilt.
- 4 ☐ Hears accusatory or denunciatory voices and/or experiences threatening visual hallucinations.

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20/4/25

3 SUICIDE
0 ☑ Absent.
1 ☐ Feels life is not worth living.
2 ☐ Wishes he/she were dead or any thoughts of possible death to self.
3 ☐ Ideas or gestures of suicide.
4 ☐ Attempts at suicide (any serious attempt rates 4).

4 INSOMNIA: EARLY IN THE NIGHT
0 ☐ No difficulty falling asleep.
1 ☐ Complains of occasional difficulty falling asleep, i.e. more than ½ hour.
2 ☑ Complains of nightly difficulty falling asleep.

5 INSOMNIA: MIDDLE OF THE NIGHT
0 ☐ No difficulty.
1 ☑ Patient complains of being restless and disturbed during the night.
2 ☐ Waking during the night – any getting out of bed rates 2 (except for purposes of voiding).

6 INSOMNIA: EARLY HOURS OF THE MORNING
0 ☑ No difficulty.
1 ☐ Waking in early hours of the morning but goes back to sleep.
2 ☐ Unable to fall asleep again if he/she gets out of bed.

7 WORK AND ACTIVITIES
0 ☐ No difficulty.
1 ☑ Thoughts and feelings of incapacity, fatigue or weakness related to activities, work or hobbies.
2 ☐ Loss of interest in activity, hobbies or work – either directly reported by the patient or indirect in listlessness, indecision and vacillation (feels he/she has to push self to work or activities).
3 ☐ Decrease in actual time spent in activities or decrease in productivity. Rate 3 if the patient does not spend at least three hours a day in activities (job or hobbies) excluding routine chores.
4 ☐ Stopped working because of present illness. Rate 4 if patient engages in no activities except routine chores, or if patient fails to perform routine chores unassisted.

8 RETARDATION (slowness of thought and speech, impaired ability to concentrate, decreased motor activity)
0 ☐ Normal speech and thought.
1 ☑ Slight retardation during the interview.
2 ☐ Obvious retardation during the interview.
3 ☐ Interview difficult.
4 ☐ Complete stupor.

9 AGITATION
0 ☐ None.
1 ☑ Fidgetiness.
2 ☐ Playing with hands, hair, etc.
3 ☐ Moving about, can't sit still.
4 ☐ Hand wringing, nail biting, hair-pulling, biting of lips.

10 ANXIETY PSYCHIC
0 ☐ No difficulty.
1 ☐ Subjective tension and irritability.
2 ☑ Worrying about minor matters.
3 ☐ Apprehensive attitude apparent in face or speech.
4 ☐ Fears expressed without questioning.

11 ANXIETY SOMATIC (physiological concomitants of anxiety) such as:
gastro-intestinal – dry mouth, wind, indigestion, diarrhea, cramps, belching
cardio-vascular – palpitations, headaches
respiratory – hyperventilation, sighing
✓ Urinary frequency
✓ Sweating
0 ☐ Absent.
1 ☐ Mild.
2 ☑ Moderate.
3 ☐ Severe.
4 ☐ Incapacitating.

12 SOMATIC SYMPTOMS GASTRO-INTESTINAL
0 ☐ None.
1 ☑ Loss of appetite but eating without staff encouragement. Heavy feelings in abdomen.
2 ☐ Difficulty eating without staff urging. Requests or requires laxatives or medication for bowels or medication for gastro-intestinal symptoms.

13 GENERAL SOMATIC SYMPTOMS
0 ☐ None.
1 ☑ Heaviness in limbs, back or head. Backaches, headaches, muscle aches. Loss of energy and fatigability.
2 ☐ Any clear-cut symptom rates 2.

14 GENITAL SYMPTOMS (symptoms such as loss of libido, menstrual disturbances)
0 ☐ Absent.
1 ☐ Mild.
2 ☑ Severe.

15 HYPOCHONDRIASIS
0 ☐ Not present.
1 ☑ Self-absorption (bodily).
2 ☐ Preoccupation with health.
3 ☐ Frequent complains, requests for help, etc.
4 ☐ Hypochondriacal delusions.

16 LOSS OF WEIGHT (RATE EITHER a OR b)

a) According to the patient:	b) According to weekly measurements:
0 ☑ No weight loss.	0 ☐ Less than 1 lb weight loss in week.
1 ☐ Probable weight loss associated with present illness.	1 ☐ Greater than 1 lb weight loss in week.
2 ☐ Definite (according to patient) weight loss.	2 ☐ Greater than 2 lb weight loss in week.
3 ☐ Not assessed.	3 ☐ Not assessed.

17 INSIGHT
0 ☑ Acknowledges being depressed and ill.
1 ☐ Acknowledges illness but attributes cause to bad food, climate, overwork, virus, need for rest, etc.
2 ☐ Denies being ill at all.

Total score: 18

This scale is in the public domain.

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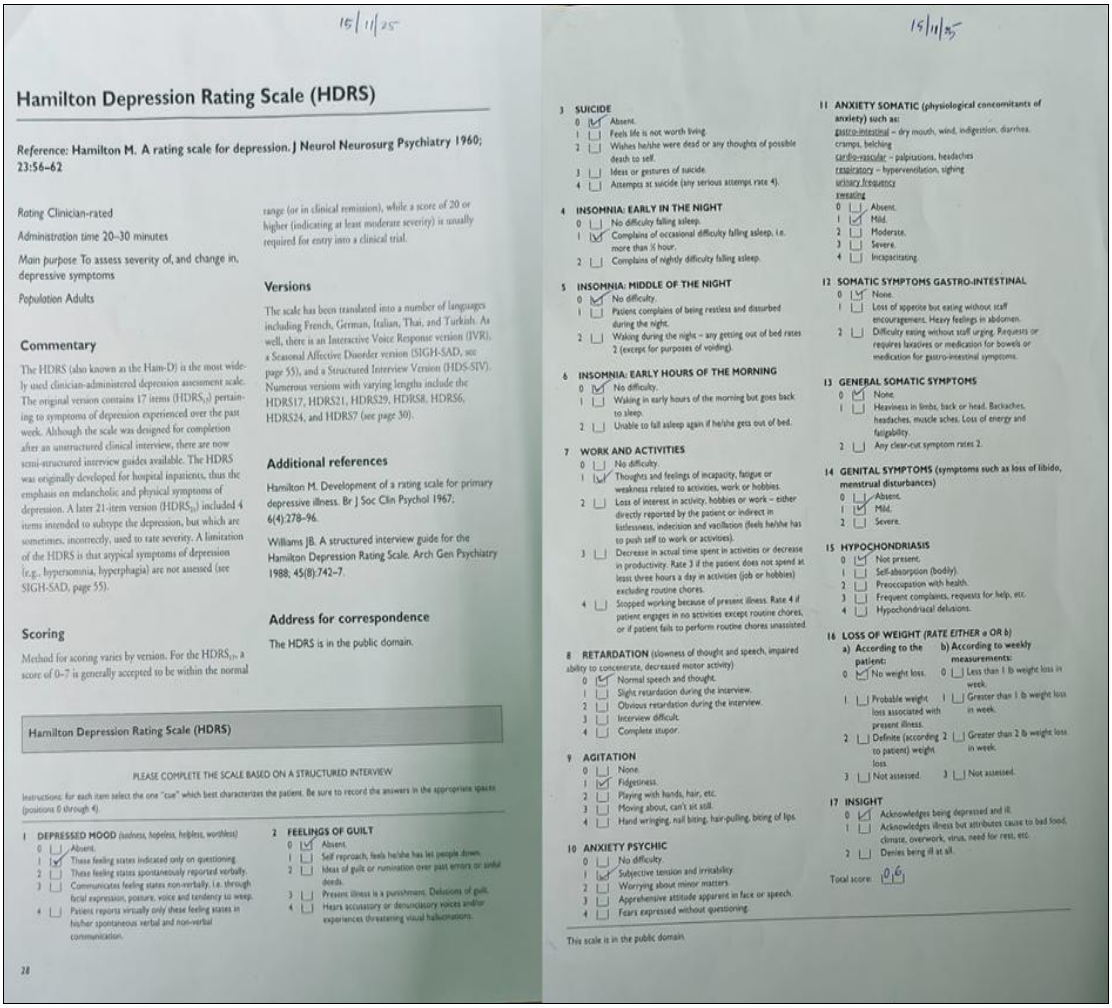
HAM D assessment -after (15/11/25)



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Method for scoring varies by version. For the $HDRS_{17}$, a score of 0–7 is generally accepted to be within the normal range (or in clinical remission), while a score of 20 or higher (indicating at least moderate severity) is usually required for entry into a clinical trial.

Versions

The scale has been translated into a number of languages including French, German, Italian, Thai, and Turkish. As well, there is an Interactive Voice Response version (IVR), a Seasonal Affective Disorder version (SIGH-SAD, see page 55), and a Structured Interview Version (HDS-SIV). Numerous versions with varying lengths include the HDRS17, HDRS21, HDRS29, HDRS8, HDRS6, HDRS24, and HDRS7 (see page 30).

Additional references

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Address for correspondence

The HDRS is in the public domain.

Hamilton Depression Rating Scale (HDRS)

PLEASE COMPLETE THE SCALE BASED ON A STRUCTURED INTERVIEW

Instructions: for each item select the one "cue" which best characterizes the patient. Be sure to record the answers in the appropriate spaces (positions 0 through 4).

1 DEPRESSED MOOD (sadness, hopeless, helpless, worthless)
0 [ ] Absent.
1 [✓] These feeling states indicated only on questioning.
2 [ ] These feeling states spontaneously reported verbally.
3 [ ] Communicates feeling states non-verbally, i.e. through facial expression, posture, voice and tendency to weep.
4 [ ] Patient reports virtually only these feeling states in his/her spontaneous verbal and non-verbal communication.

2 FEELINGS OF GUILT
0 [✓] Absent.
1 [ ] Self reproach, feels he/she has let people down.
2 [ ] Ideas of guilt or rumination over past errors or sinful deeds.
3 [ ] Present illness is a punishment. Delusions of guilt.
4 [ ] Hears accusatory or denunciatory voices and/or experiences threatening visual hallucinations.

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3 SUICIDE
0 [✓] Absent.
1 [ ] Feels life is not worth living.
2 [ ] Wishes he/she were dead or any thoughts of possible death to self.
3 [ ] Ideas or gestures of suicide.
4 [ ] Attempts at suicide (any serious attempt rate 4).

4 INSOMNIA: EARLY IN THE NIGHT
0 [ ] No difficulty falling asleep.
1 [✓] Complains of occasional difficulty falling asleep, i.e. more than ½ hour.
2 [ ] Complains of nightly difficulty falling asleep.

5 INSOMNIA: MIDDLE OF THE NIGHT
0 [✓] No difficulty.
1 [ ] Patient complains of being restless and disturbed during the night.
2 [ ] Waking during the night – any getting out of bed rates 2 (except for purposes of voiding).

6 INSOMNIA: EARLY HOURS OF THE MORNING
0 [✓] No difficulty.
1 [ ] Waking in early hours of the morning but goes back to sleep.
2 [ ] Unable to fall asleep again if he/she gets out of bed.

7 WORK AND ACTIVITIES
0 [ ] No difficulty.
1 [✓] Thoughts and feelings of incapacity, fatigue or weakness related to activities, work or hobbies.
2 [ ] Loss of interest in activity, hobbies or work – either directly reported by the patient or indirect in listlessness, indecision and vacillation (feels he/she has to push self to work or activities).
3 [ ] Decrease in actual time spent in activities or decrease in productivity. Rate 3 if the patient does not spend at least three hours a day in activities (job or hobbies) excluding routine chores.
4 [ ] Stopped working because of present illness. Rate 4 if patient engages in no activities except routine chores, or if patient fails to perform routine chores unassisted.

8 RETARDATION (slowness of thought and speech, impaired ability to concentrate, decreased motor activity)
0 [✓] Normal speech and thought.
1 [ ] Slight retardation during the interview.
2 [ ] Obvious retardation during the interview.
3 [ ] Interview difficult.
4 [ ] Complete stupor.

9 AGITATION
0 [ ] None.
1 [✓] Fidgetiness.
2 [ ] Playing with hands, hair, etc.
3 [ ] Moving about, can't sit still.
4 [ ] Hand wringing, nail biting, hair-pulling, biting of lips.

10 ANXIETY PSYCHIC
0 [ ] No difficulty.
1 [✓] Subjective tension and irritability.
2 [ ] Worrying about minor matters.
3 [ ] Apprehensive attitude apparent in face or speech.
4 [ ] Fears expressed without questioning.

11 ANXIETY SOMATIC (physiological concomitants of anxiety) such as:
gastro-intestinal – dry mouth, wind, indigestion, diarrhea, cramps, belching
cardio-vascular – palpitations, headaches
respiratory – hyperventilation, sighing
urinary frequency
sweating
0 [ ] Absent.
1 [✓] Mild.
2 [ ] Moderate.
3 [ ] Severe.
4 [ ] Incapacitating.

12 SOMATIC SYMPTOMS GASTRO-INTESTINAL
0 [✓] None.
1 [ ] Loss of appetite but eating without staff encouragement. Heavy feelings in abdomen.
2 [ ] Difficulty eating without staff urging. Requests or requires laxatives or medication for bowels or medication for gastro-intestinal symptoms.

13 GENERAL SOMATIC SYMPTOMS
0 [✓] None.
1 [ ] Heaviness in limbs, back or head. Backaches, headaches, muscle aches. Loss of energy and fatigability.
2 [ ] Any clear-cut symptom rates 2.

14 GENITAL SYMPTOMS (symptoms such as loss of libido, menstrual disturbances)
0 [ ] Absent.
1 [✓] Mild.
2 [ ] Severe.

15 HYPOCHONDRIASIS
0 [✓] Not present.
1 [ ] Self-absorption (bodily).
2 [ ] Preoccupation with health.
3 [ ] Frequent complaints, requests for help, etc.
4 [ ] Hypochondriacal delusions.

16 LOSS OF WEIGHT (RATE EITHER a OR b)
a) According to the patient:
0 [✓] No weight loss.
1 [ ] Probable weight loss associated with present illness.
2 [ ] Definite (according to patient) weight loss.
3 [ ] Not assessed.
b) According to weekly measurements:
0 [ ] Less than 1 lb weight loss in week.
1 [ ] Greater than 1 lb weight loss in week.
2 [ ] Greater than 2 lb weight loss in week.
3 [ ] Not assessed.

17 INSIGHT
0 [✓] Acknowledges being depressed and ill.
1 [ ] Acknowledges illness but attributes cause to bad food, climate, overwork, virus, need for rest, etc.
2 [ ] Denies being ill at all.

Total score: 06

This scale is in the public domain.

Table 1: Prescription of first visit and Follow-Up

Date	Symptoms	Prescription
20/08/25	Persistant sadness, weeping, loss of intrest in day to day activities, restlessness out of activities,Anger bouts, hot flushes, hot perspitation, increased freequency of micturition HAM D score = 18 (moderate depression)	LACHESIS MUTUS 0/1 Medicine in the form of water solution -OD - early morning empty stomach for 15 days
5/09/25	Mild relief in the symptoms of sadness and weeping .Improvement in sleep Ham D score =16	LACHESIS MUTUS 0/1 Medicine in the form of water solution -OD - early morning empty stomach for 15 days(continue the same)
19/09/25	Mild relief in the sadness and weeping was present, but remains stand still since a few days .All other symptoms persist. HAM D score= 15 (moderate)	LACHESIS MUTUS 0/2 Medicine in the form of water solution - once in a day- early morning empty stomach for 15 days
3/10/25	Improvement present in the symptoms of sadness, weeping and sleep. HAM D score =13(mild depression)	LACHESIS MUTUS 0/2 Medicine in the form of water solution - once in a day- early morning empty stomach for 15 days(continue the same)
17/10/25	Relief in symptoms was noticed but stands still since a few days HAMD score = 13(mild depression)	LACHESIS MUTUS 0/3 Medicine in the form of water solution - OD?- early morning empty stomach for 15 days.
1/11/25	Persistant sadness and weeping reduced in intensity, relief in frequent urination. Restlessness out of anxiety reduced in intensity.Sleep improved.All other symptoms persist HAM D score =10 (mild)	LACHESIS MUTUS 0/3 Medicine in the form of water solution - OD- early morning empty stomach for 15 days. (continue the same)
15/11/25	No sadness and weeping tendancy. Patient feels better herself.Sleep improved.restlessness and anxiety reduced. Hot flushes reduced in intensity, perspiartion reduced. HAM D score = 6 (normal)	Sac Lac /1 dose

Discussion

This case shows the effectiveness of LM potency medicines in the management of depression among perimenopausal women. The patient's emotional issues developed with the irregularity in menses when she was approaching her menopause, demonstrated clear improvement following the administration of a carefully selected simillimum Lachesis mutus in series of LM potencies based on a well-defined totality of symptoms, especially the mental and emotional landscape.

The hallmark signs of major depressive disorder persistent and pervasive sadness, weeping, restless out of anxiety, anger issues out of any reasons, disturbed sleep were accompanied by irregularities in her menses, hot flushes, increased perspiration, increased frequency of urination . patient was very much anxious from the change of life with the concept that she is losing her women hood and nobody is going to love her anymore.

Lachesis mutus, a snake remedy well-known for ailments during perimenopausal complaints, matched the patient's thermal state, thirst, personality traits, and emotional reserve. The selected potency schedule and gradual potency elevation from 0/1 to 0/3 helped to improve the patient's emotional and physical sufferings gradually which was successfully assessed using HAM D scale in every follow up.

Conclusion

This case illustrates the marked effectiveness of *Lachesis* administered in LM potency in the management of Major Depressive Disorder, Demonstrating the clinical value of LM potencies, and underscoring the need for greater attention to the often-neglected complaints of perimenopausal women, particularly depression developing during this transitional phase, which frequently remains inadequately addressed.

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