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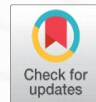
*Interns, Dhanvantari Homoeopathic Medical College and Hospital & Research Centre, Nashik,
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**Role of individualised Homoeopathic Medicine in management of Tinea
Corporis: A Case Series Study**

September-October 2026, Vol 6(05), 381-388

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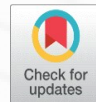
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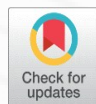
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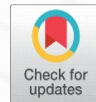
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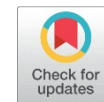
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Role of individualised Homoeopathic Medicine in management of Tinea Corporis: A Case Series Study

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Abstract: Background: Tinea corporis is a superficial dermatophyte infection of glabrous skin, commonly presenting with annular, erythematous and scaly lesions with central clearing and an advancing border. It is common in tropical and subtropical settings and may be complicated by recurrence, incomplete treatment, reinfection and inappropriate use of topical corticosteroid-containing preparations. Individualised homoeopathic treatment is selected according to the totality of symptoms and patient characteristics. Evidence concerning its role in tinea corporis remains limited and heterogeneous. **Objective:** To document the clinical presentation and assess the clinical response observed following individualised homoeopathic treatment in patients with tinea corporis. **Methods:** This was a case series conducted in institutional/peripheral outpatient settings in Nashik. Thirty patients of all age groups diagnosed clinically with tinea corporis were included by convenience sampling. Individualised homoeopathic medicines were prescribed on the basis of case-taking and symptom totality. Clinical response was documented using the study's Clinical Severity Score (CSS), parameter-specific assessment, symptom severity grading, clinical follow-up and before-and-after photographs. Follow-up was performed approximately every six days or as clinically required. Pre-treatment and post-treatment CSS values from the master chart were compared using a paired-samples t-test. **Results:** Thirty cases were included. The largest age-group representation was 21–30 years (9/30, 30.0%), followed by 31–40 years (8/30, 26.7%). Sixteen participants were male (53.3%) and fourteen were female (46.7%). The most frequently prescribed medicines were Calcarea carbonica and Sulphur (7 cases each; 23.3%), followed by Natrum muriaticum (5; 16.7%) and Sepia (3; 10.0%). Twenty-eight cases (93.3%) were recorded as improved and 2 (6.7%) as not improved. Mean CSS decreased from 5.87 ± 0.94 before treatment to 1.47 ± 0.82 after treatment, with a mean reduction of 4.40 points. The paired-samples t-test showed a statistically significant within-participant reduction in CSS, $t(29) = 21.875$, $p < 0.0001$. **Conclusion:** The study demonstrated a statistically significant reduction in CSS and a high proportion of recorded clinical improvement during the observation period. However, the uncontrolled case-series design, small convenience sample, lack of blinding and absence of consistent objective mycological confirmation prevent attribution of the observed change specifically to individualized homoeopathic treatment. Larger controlled studies are required.

Keywords: Tinea corporis; dermatophytosis; individualised homoeopathy; Clinical Severity Score; paired t-test; case series; skin infection.

1. Introduction

Tinea corporis, commonly called ringworm of the body, is a superficial infection of keratinized skin caused by dermatophytes, principally organisms belonging to the genera *Trichophyton*, *Microsporum* and *Epidermophyton*. The infection typically produces a well-demarcated annular or arcuate erythematous and scaly lesion with an active advancing border and relative central clearing. Pruritus is common, and multiple lesions may occur or coalesce. Because annular eruptions have several differential diagnoses, including eczema, psoriasis, pityriasis rosea and granuloma annulare, clinical assessment and, when necessary, laboratory confirmation are important.^{1–4}

Dermatophytes acquire nutrients from keratin and remain predominantly within the superficial keratinized layers. Following exposure to infected humans, animals, fomites or environmental sources, fungal elements adhere to the stratum corneum and produce keratin-degrading enzymes that facilitate growth along keratinized tissue. The interaction between fungal proliferation and host inflammatory responses contributes to erythema, scaling and pruritus.^{5–8}

Dermatophytosis is particularly prevalent in warm and humid environments. India has experienced a substantial burden of chronic, recurrent and treatment-resistant dermatophytosis, with factors such as inappropriate topical corticosteroid use, incomplete treatment, reinfection and household transmission contributing to persistence. A multicentric Indian study reported glabrous dermatophytosis in 17.31% of screened patients and found tinea corporis to constitute a large proportion of chronic and recurrent cases.^{9,10}

Conventional management depends on extent and severity and generally includes topical or systemic antifungal therapy. Recurrence, adherence problems, inappropriate topical combinations and concerns regarding antifungal resistance can complicate management.^{3,4,8}

Within homoeopathic clinical practice, treatment is individualized rather than prescribed solely from the disease label. Remedy selection is based on the totality of characteristic symptoms and individual patient features. The evidence base specific to tinea corporis is still developing. A double-blind randomized placebo-controlled trial of individualized homoeopathic medicines in tinea corporis did not demonstrate a significant difference in its primary endpoint of complete lesion disappearance, although some secondary measures of itching and quality of life favored the intervention.¹¹ Observational studies have reported reductions in symptom and quality-of-life scores, while a recent case series reported clinical improvement using standardized outcome measures.^{12,13} These findings are not sufficient to establish causality and require confirmation through appropriately controlled research.

The present case series was undertaken to document the clinical characteristics of patients with tinea corporis and the changes observed after individualized homoeopathic management using the clinical assessment approach described in the dissertation.

2. Aim & Objectives

Aim: To assess the clinical outcome observed following individualised homoeopathic treatment in patients with tinea corporis.

Primary objective: To assess the therapeutic response observed with individualised homoeopathic medicines in patients of all age groups diagnosed with tinea corporis.

Secondary objective: To document the clinical presentation and symptomatology of tinea corporis in the study participants.

3. Materials & Methods

Study design and setting

A case series study was conducted in institutional and peripheral outpatient settings associated with Dhanvantari Homoeopathic Medical College and Hospital & Research Centre, Nashik, Maharashtra, India. The dissertation reports a sample of 30 cases and convenience sampling. Patients fulfilling the study criteria were enrolled until the intended sample size was achieved. The study was designed to document clinical outcomes in routine practice rather than to provide a randomized controlled comparison.¹⁴

Participants

Patients of all age groups with a clinical diagnosis of tinea corporis were eligible. The dissertation excluded patients with immunocompromised states, lactating women, cancer patients and severe cases, because these conditions could alter disease course, treatment considerations or clinical response. Patients who lost two follow-ups were specified as a withdrawal criterion. The source document contains inconsistent placement of exclusion and withdrawal criteria in different sections; the article reports the criteria according to the consolidated methods section while retaining the original study design.

Intervention

Individualised homoeopathic medicines were selected after case-taking and assessment of the totality of symptoms and individual patient characteristics. The dissertation states that potency was selected according to symptom severity and susceptibility/sensitivity and that 200C was the most commonly selected potency. Repetition was individualized according to the reported clinical response and symptom severity. Hygiene advice included maintaining personal hygiene, avoiding sharing clothes, towels and bedding, wearing loose-fitting cotton clothing, and washing/drying clothes appropriately. These measures were part of the clinical management documented in the thesis and may themselves influence clinical outcomes.

Outcome assessment

Clinical response was assessed using the study's Clinical Severity Score. The score incorporated system-level parameters—erythema, pruritus and scaling—graded from 0 (absent) to 3 (severe), together with extent of lesion based on body-

Role of individualised Homoeopathic Medicine in management of Tinea Corporis: A Case Series Study

surface-area categories. The dissertation describes a maximum composite score of 12. Before-and-after clinical photographs, parameter-specific assessment and symptom severity grading were also used. Follow-up was conducted approximately every six days or as required.

Statistical analysis

The individual pre-treatment and post-treatment CSS values were taken from the master chart of the dissertation. Descriptive statistics were used to summarize participant characteristics, prescribing patterns and clinical outcomes. A paired-samples t-test was used to compare the pre-treatment and post-treatment CSS values for the 30 paired observations. The analysis used a two-sided significance level of 0.05. The mean difference was calculated as pre-treatment CSS minus post-treatment CSS, so a positive value represented reduction in clinical severity.

Ethical and reporting considerations

This manuscript is a condensed report of the submitted dissertation and does not add participants or outcomes beyond those documented in the source thesis. Institutional ethical approval/registration details should be inserted in the final manuscript after verification from the institutional records or dissertation documentation. The manuscript should be submitted only after verification and approval by the respective guide, as required by the publication instructions.

4. Results

Thirty cases of tinea corporis were included. The age distribution showed the highest representation in the 21–30-year group (30.0%), followed by 31–40 years (26.7%). Participants were slightly more often male than female. Ten different individualized medicines were documented, with *Calcarea carbonica* and *Sulphur* being the most frequently prescribed. Overall, 28 participants (93.3%) were classified as improved and 2 (6.7%) as not improved.

Age group (years)	n	%
0–10	2	6.7
11–20	4	13.3
21–30	9	30.0
31–40	8	26.7
41–50	4	13.3
51–60	1	3.3
61–70	2	6.7
Total	30	100.0

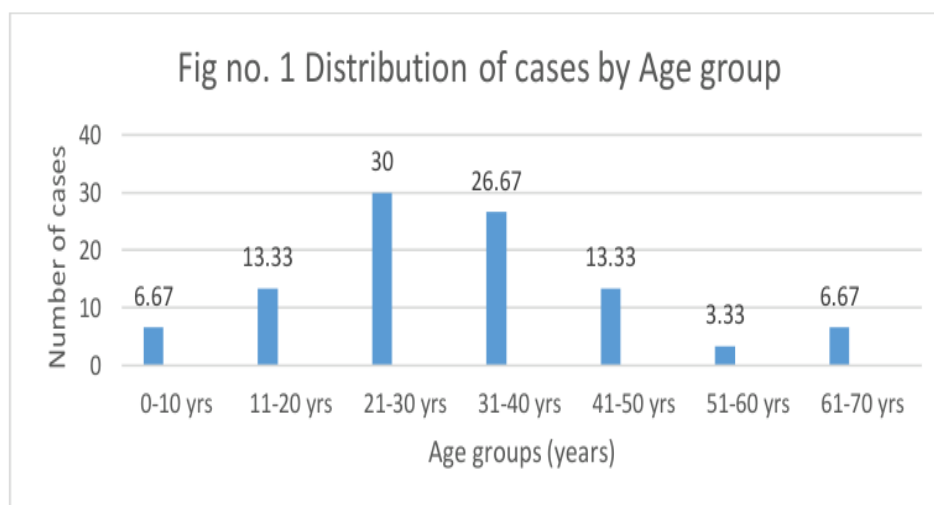


Figure 1. Age distribution of study participants.

Gender	n	%
Male	16	53.3
Female	14	46.7
Total	30	100.0

Table 1. Age distribution of study participants.

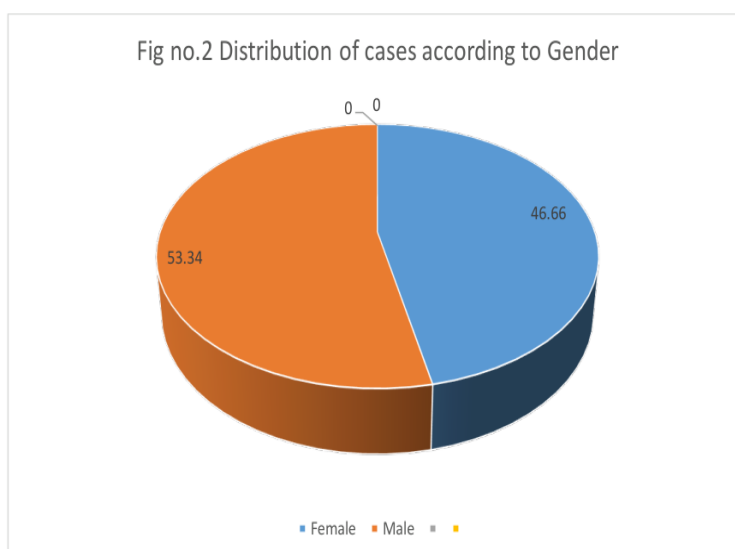


Figure 2. Gender distribution of study participants.

Medicine prescribed	n	%
Calcarea carbonica	7	23.3
Sulphur	7	23.3
Natrum muriaticum	5	16.7
Sepia	3	10.0
Dulcamara	2	6.7
Lycopodium	2	6.7
Phosphorus	1	3.3
Arsenicum album	1	3.3
Thuja	1	3.3
Staphysagria	1	3.3
Total	30	100.0

Table 2. Gender distribution of study participants.

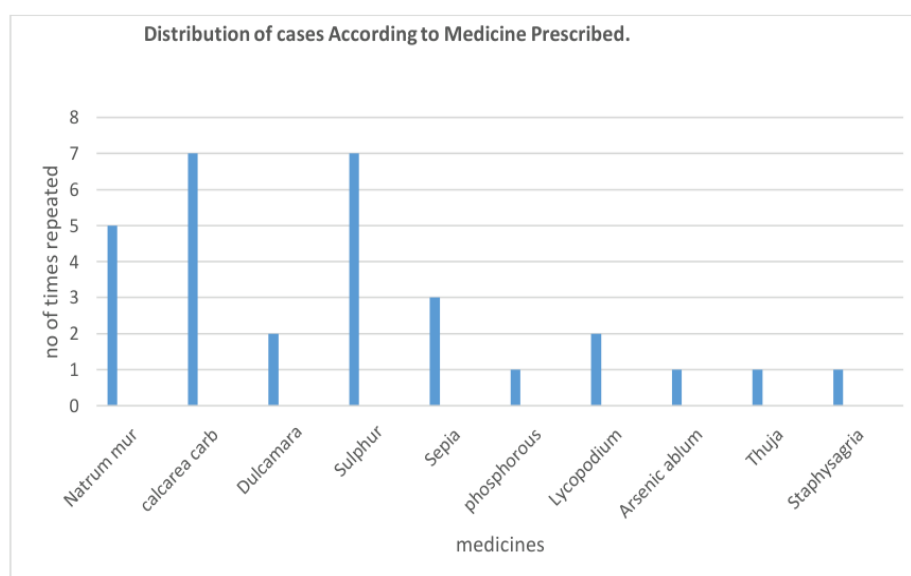


Figure 3. Distribution of individualized homoeopathic medicines prescribed.

Outcome	n	%
Improved	28	93.3
Not improved	2	6.7
Total	30	100.0

Table 3. Distribution of individualized homoeopathic medicines prescribed.

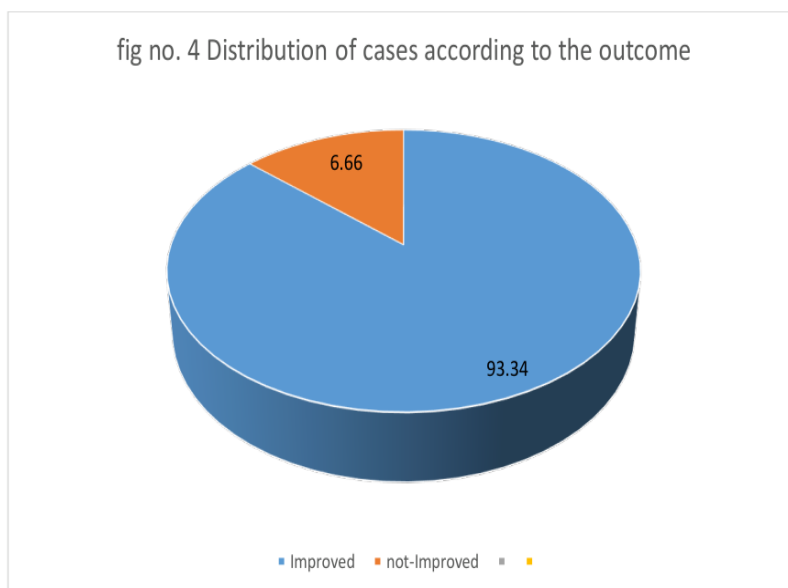


Figure 4. Overall clinical outcome recorded in the case series.

Examples of 4 Cases' Photographs before and After Treatment

Representative clinical photographs from four cases documented in the dissertation are presented below to illustrate the clinical changes observed between the pre-treatment and final assessment photographs.

Case	Before treatment	After treatment
Case 1		
Case 2		
Case 3		

Case	Before treatment	After treatment
Case 4		

Table 4. Overall clinical outcome recorded in the case series.

The demographic, medicine-distribution, and clinical-outcome graphs below are reproduced from the dissertation observations and correspond to Tables 1–4.

Paired comparison of Clinical Severity Score

The master chart contained paired CSS observations for all 30 cases. The pre-treatment CSS values ranged from 4 to 7, while post-treatment values ranged from 0 to 4. The mean CSS before treatment was 5.87 ± 0.94 and after treatment was 1.47 ± 0.82 . The mean reduction was 4.40 points (95% CI 3.99–4.81).

Measure	Before treatment	After treatment / comparison
n	30	30
Mean CSS $\pm$ SD	5.87 ± 0.94	1.47 ± 0.82
Mean reduction in CSS	—	4.40
95% CI for mean reduction	—	3.99–4.81
Paired t-value	—	21.875
df	—	29
p-value (two-sided)	—	<0.0001*

*Exact two-sided p-value = 1.43×10^{-19} .

Thus, there was a highly statistically significant within-participant reduction in the recorded CSS from baseline to the final assessment.

Interpretation of findings

The CSS showed a marked reduction during the observation period, with the mean score decreasing from 5.87 before treatment to 1.47 after treatment, representing a mean reduction of 4.40 points. The paired-samples t-test demonstrated a statistically significant within-participant difference, $t(29) = 21.875$, $p < 0.0001$. This indicates that the observed mean pre-treatment/post-treatment difference was statistically distinguishable from zero under the assumptions of the paired t-test.

Twenty-eight of the 30 cases (93.3%) were also classified as improved and 2 (6.7%) as not improved. These categorical outcomes and the continuous CSS analysis both describe changes observed during the study period. They should not, however, be interpreted as proof that the individualized homoeopathic medicine itself caused the improvement.

5. Discussion

The present case series documented 30 patients with tinea corporis managed with individualized homoeopathic medicines, of whom 28 (93.3%) were recorded as improved during the study period. The largest proportion of participants was in the 21–30-year age group, and males represented 53.3% of the sample. *Calcarea carbonica* and *Sulphur* were each prescribed in seven cases, followed by *Natrum muriaticum* in five cases. These findings describe the characteristics of this clinical sample and the prescribing pattern observed in the study; they should not be interpreted as evidence that any particular medicine was superior.

The observed clinical improvement is broadly comparable in direction with some published observational homoeopathic literature, although direct comparison is limited by differences in study design, diagnostic confirmation, outcome measures and follow-up. Dixit et al. reported significant reductions in numeric symptom and Dermatology Life Quality Index scores in an open-label pre-post observational study of 103 patients with dermatophytosis; tinea cruris was most common and tinea corporis accounted for 13.6% of infections.¹² The authors nevertheless called for larger and more diverse studies. A 2024 case series of 26 patients with tinea cruris and tinea corporis reported complete disappearance of lesions in 34% and symptomatic improvement in 53.8%, with significant reductions in Clinical Cure Composite Score and Skindex-16 scores.¹³ The present study similarly used clinical assessment and photographic documentation, but did not employ the same validated quality-of-life instruments or consistent mycological confirmation.

The evidence from controlled research is more cautious. Laskar et al. conducted a double-blind randomized placebo-controlled trial in 62 participants with tinea corporis. The primary outcome of complete disappearance of lesions did not differ between groups, although several secondary measures, including itching and some quality-of-life domains, favored

Role of individualised Homoeopathic Medicine in management of Tinea Corporis: A Case Series Study

individualized homoeopathic medicines.¹¹ this finding is important when interpreting the 93.3% improvement observed in the present uncontrolled series: improvement over time cannot by itself establish that the intervention caused the change.

The present analysis adds a quantitative pre-post comparison to the descriptive findings. The mean CSS decreased from 5.87 ± 0.94 to 1.47 ± 0.82 , with a mean within-participant reduction of 4.40 points. The paired-samples t-test yielded $t(29) = 21.875$, $p < 0.0001$. This statistically significant result supports the presence of a substantial change in CSS between the two assessments. However, the p-value addresses the statistical evidence for a non-zero within-participant change; it does not establish treatment efficacy or causality in an uncontrolled case series.

The clinical course of tinea corporis is also influenced by factors outside the prescribed medicine. Hygiene practices, avoidance of shared fomites, clothing practices, natural evolution of lesions, adherence to follow-up and changes in previous treatment can affect clinical appearance. In addition, the present study did not consistently document post-treatment KOH microscopy or culture. Therefore, clinical improvement should not be equated with microbiological eradication. Contemporary literature emphasizes the importance of appropriate diagnosis and objective mycological assessment where clinically indicated, particularly in recurrent or atypical disease.^{3,4,8}

The case-series design provides useful practice-based descriptive information, including the range of individualized medicines used and the clinical outcome observed in routine settings. However, the sample size was small and selected by convenience sampling, there was no untreated, placebo or conventional-treatment control group, and neither participants nor assessors were blinded. The duration of follow-up was not sufficient to establish long-term recurrence outcomes. Subjective components of clinical assessment may introduce observer or reporting bias.

The master chart also shows that two cases were classified as not improved even though their CSS values decreased numerically: case 19 decreased from 7 to 2 and case 30 from 5 to 2. Therefore, categorical outcome classification and numerical CSS change should be considered as separate outcome measures. The article does not reinterpret these classifications beyond what was recorded in the thesis.

The findings therefore support the feasibility of systematically documenting individualized homoeopathic management of tinea corporis but should be regarded as preliminary clinical observations rather than proof of efficacy. Future studies should use larger samples, clearly defined diagnostic criteria, standardized severity instruments, KOH microscopy and/or culture at baseline and outcome assessment, blinded outcome assessment where feasible, predefined treatment and follow-up schedules, and appropriate comparator groups. Long-term follow-up would also help determine whether apparent clinical improvement is sustained and whether recurrence occurs.

6. Conclusion

In this case series of 30 patients with tinea corporis, 28 cases (93.3%) were recorded as improved and 2 (6.7%) as not improved following individualized homoeopathic management during the observation period.

The Clinical Severity Score showed a marked reduction, with the mean CSS decreasing from 5.87 ± 0.94 before treatment to 1.47 ± 0.82 after treatment, giving a mean reduction of 4.40 points (95% CI 3.99–4.81). The paired-samples t-test demonstrated a statistically significant within-participant reduction in CSS, $t(29) = 21.875$, $p < 0.0001$ (exact $p = 1.43 \times 10^{-19}$).

These findings indicate a statistically significant reduction in the recorded clinical severity of tinea corporis between the baseline and final assessments. However, because the study was an uncontrolled case series, the statistical significance of the pre-post change cannot establish a causal treatment effect attributable specifically to individualized homoeopathic medicine.

The findings should therefore be regarded as preliminary clinical observations. Larger, well-designed controlled studies with standardized clinical and mycological outcomes, appropriate comparator groups, blinding where feasible and longer follow-up are required to determine the effectiveness and sustainability of individualized homoeopathic treatment in tinea corporis.

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Role of individualised Homoeopathic Medicine in management of Tinea Corporis: A Case Series Study

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Author Contributions

Dhanashree Ganesh Patekar and Arti Ganesh Solanki contributed to the conduct and documentation of the research work and preparation of the manuscript. The respective guide contributed to supervision, scientific review and manuscript guidance. The exact contribution statement should be finalized and approved by all authors before submission.

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Conflict of Interest

To be confirmed by all authors before submission.

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