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TO EVALUATE THE ROLE OF INDIVIDUALIZED HOMEOPATHIC MEDICINE IN MANAGEMENT OF PRIMARY DYSMENORRHEA IN 14-30 YEARS FEMALE A CASE SERIES STUDY

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ABSTRACT

Background: Primary dysmenorrhoea is recurrent menstrual pain in the absence of identifiable pelvic pathology and is a common cause of functional limitation among adolescents and young women. Individualized homoeopathic treatment is based on the totality of symptoms, but clinical documentation from Indian settings remains limited.

Objective: To evaluate the role of individualized homoeopathic medicine in the management of primary dysmenorrhoea among females aged 14–30 years.

Methods: An observational case-series study was conducted over 18 months. Thirty patients with primary dysmenorrhoea who fulfilled the study criteria were recruited from the institutional OPD/IPD, peripheral OPDs and homoeopathic medical camps. Detailed case taking, clinical examination and symptom assessment were undertaken. Individualized homoeopathic medicines were prescribed according to the totality of symptoms. Menstrual pain was assessed using a 0–10 pain rating scale before and after treatment, and clinical outcome was recorded at follow-up.

Results: Twenty-five of 30 cases (83.33%) were classified as improved and five (16.67%) as not improved. The largest age group was 16–20 years (70.00%). Before treatment, pain scores ranged from 5 to 9, with the largest proportion scoring 8 (36.67%). After treatment, scores were distributed mainly between 3 and 6, with the largest proportion scoring 4 (26.67%). Phosphorus and Silicea were the most frequently prescribed medicines (4 cases each; 13.33%), followed by Ignatia (3 cases; 10.00%).

Conclusion: In this case series, individualized homoeopathic treatment was associated with symptomatic improvement in most participants and a shift toward lower pain scores. Because the study had a small sample, no control group and limited follow-up, the findings should be interpreted as preliminary. Larger controlled studies with standardized outcomes and longer follow-up are warranted.

Keywords: Primary dysmenorrhoea(PD); homoeopathy; individualized treatment; menstrual pain; pain rating scale; case series.

INTRODUCTION

Primary dysmenorrhoea (PD) is painful menstruation occurring in the absence of identifiable pelvic pathology. It commonly begins after establishment of ovulatory cycles and presents with cramping lower abdominal pain around the onset of menstrual flow, often accompanied by backache, nausea, vomiting, fatigue, headache or irritability. Excess endometrial prostaglandin production, particularly PGF2α and PGE2, contributes to increased myometrial contractility, uterine ischaemia and pain.[1,2]

PD is highly prevalent among adolescents and young women and can interfere with school attendance, work, concentration, social activities and quality of life. Epidemiological estimates vary according to population and diagnostic methods; the literature cited in the dissertation reports a substantial burden among student populations and Indian adolescents.[3,6–8] Recurrent symptoms also create a cumulative burden because pain may recur every menstrual cycle.[2,5]

Conventional management commonly includes non-steroidal anti-inflammatory drugs (NSAIDs), hormonal contraceptives and non-pharmacological measures. NSAIDs reduce prostaglandin-mediated pain and are effective for many patients, although treatment response and adherence vary.[1,2] Complementary approaches are therefore used by some patients. The evidence base for individualized homoeopathy in PD is mixed: the dissertation cites randomized and observational studies reporting improvement with individualized treatment, while also noting small samples, methodological heterogeneity and the need for independent replication.[11–13]

Individualized prescribing differs from using a single remedy for a diagnostic label; remedy selection is based on the characteristic symptom totality of the individual patient. In the dissertation, systematic clinical documentation of this approach, including pain assessment and follow-up in an Indian institutional setting, was identified as a gap. The present case series was therefore undertaken to document the clinical response observed in 30 females with PD.

AIM AND OBJECTIVES

Aim: To evaluate the role of individualized homoeopathic medicine in the management of primary dysmenorrhoea in females aged 14–30 years.

Primary objective: To assess the effect of individualized homoeopathic medicine in cases of primary dysmenorrhoea.

Secondary objectives: (1) to identify common presentations on the basis of the totality of symptoms; (2) to identify reported causes/associated factors where documented; and (3) to attempt management of associated complaints when present.

MATERIALS AND METHODS

Study design and setting

An observational case-series study was conducted over 18 months. Participants were selected from the institutional OPD/IPD, peripheral OPDs and homoeopathic medical camps associated with the institution. The dissertation records a total sample of 30 cases.

Participants

Females aged 14–30 years with complaints consistent with primary dysmenorrhoea were eligible if they consented to participate and agreed to comply with the study protocol. Patients with secondary dysmenorrhoea, immunocompromised status, severe systemic illness, or inability/unwillingness to participate were excluded. Withdrawal criteria included irregular follow-up, withdrawal of consent and commencement of another treatment during the study period.

Clinical assessment and intervention

Each participant underwent detailed case taking, clinical examination and symptom assessment. The diagnosis of primary dysmenorrhoea was based on the characteristic recurrent menstrual pain and exclusion of secondary causes according to the study criteria. Individualized homoeopathic medicine was selected on the basis of the totality of symptoms and the individual case presentation. The medicines prescribed across the 30 cases included Phosphorus, Silicea, Ignatia, Pulsatilla, Hyoscyamus, Sepia, Lycopodium, Natrum muriaticum, Sulphur, Lilium tigrinum, Calcarea carbonica, Magnesia phosphorica, Kali carbonicum, Nux vomica, Belladonna and Staphysagria.

Outcome assessment

Menstrual pain was recorded on a 0–10 numerical pain rating scale, with 0 representing no pain, 1–3 mild pain, 4–6 moderate pain and 7–10 severe pain. The study compared symptom severity before and after treatment and classified cases according to the clinical outcome documented in the dissertation as improved or not improved.

Ethical and reporting considerations

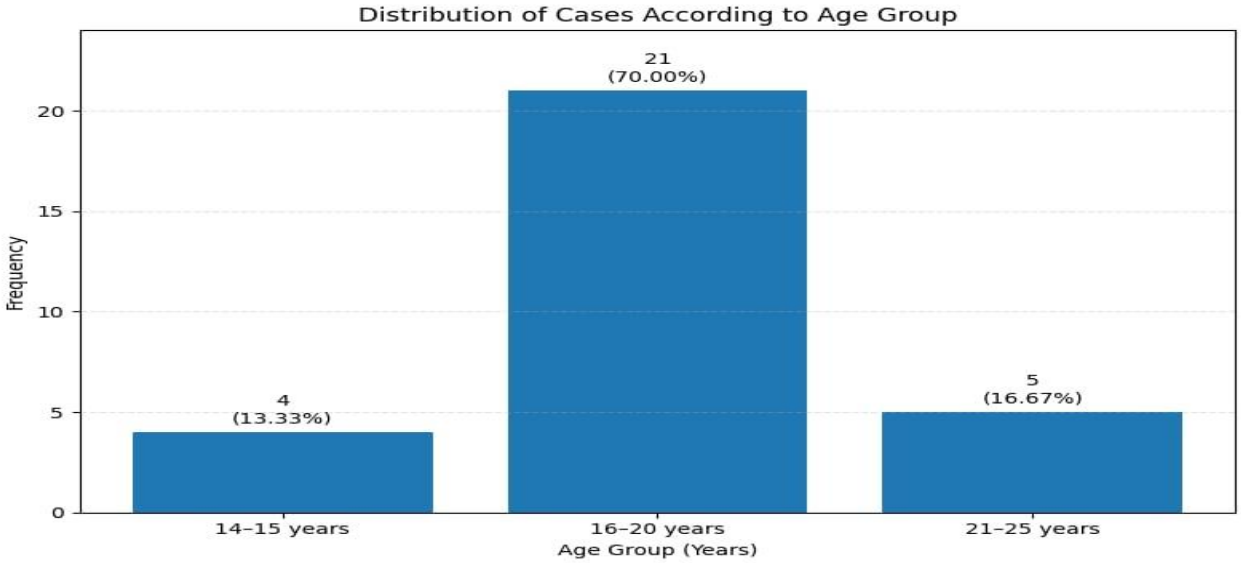
Written consent was included in the dissertation protocol. The article reports aggregate data only and does not identify individual participants. As this manuscript is derived from an undergraduate dissertation, the final manuscript should be checked against the original institutional ethics/approval documentation before submission.

RESULTS

Thirty cases were included. The largest proportion was aged 16–20 years (70.00%), followed by 21–25 years (16.67%) and 14–15 years (13.33%).

Age Group (Years)	Frequency	Percentage (%)
14–15	4	13.33%
16–20	21	70.00%
21–25	5	16.67%
Total	**30**	**100%**

Table 1. Distribution of cases according to age group.



Figrue 1. Distribution of cases according to age group.

The most frequent baseline score was 8 (36.67%), followed by 9 (23.33%), 7 (20.00%), 6 (13.33%) and 5 (2/30; 6.67%). After treatment, the most frequent score was 4 (26.67%), followed by 6 (23.33%), 5 (20.00%), 7 (10.00%), 8 (10.00%), 3 (6.67%) and 9 (3.33%). Thus, the distribution shifted toward lower scores, although not all participants improved.

Pain Rating Scale (Before Treatment)	**Frequency**	**Percentage (%)**
5	2	6.67 %
6	4	13.33 %
7	6	20.00 %
8	11	36.67 %
9	7	23.33 %
TOTAL	30	100.00 %

Table 2. Distribution of pain scores before treatment

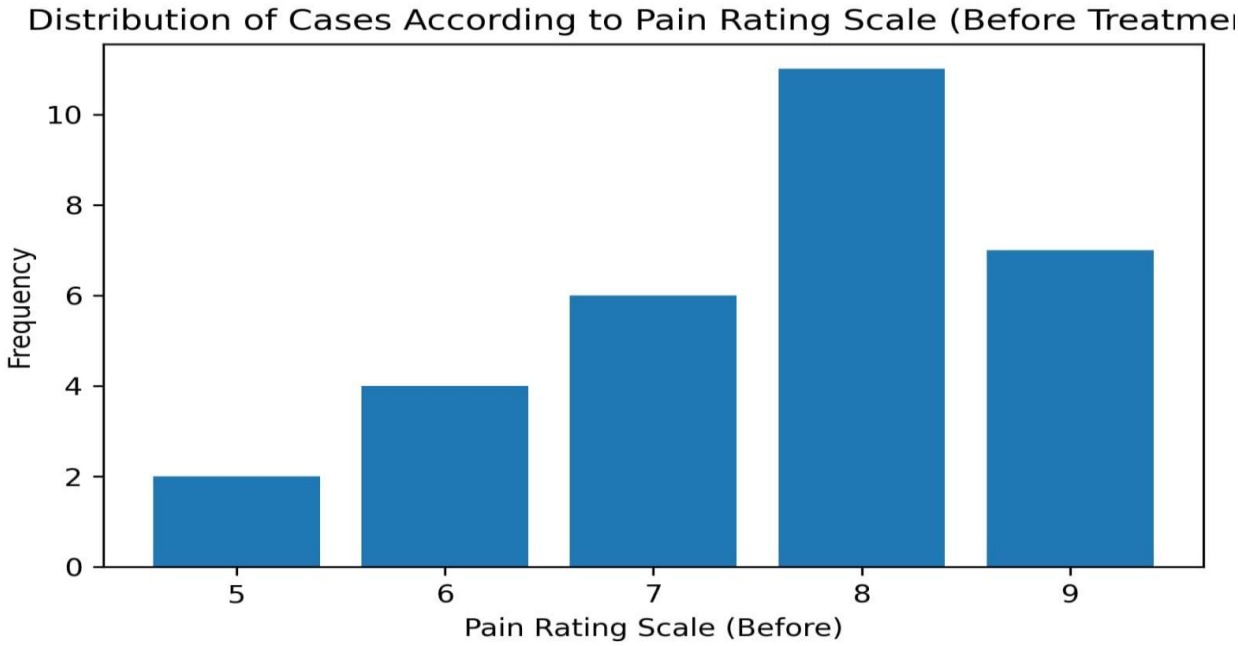


Figure 2. Distribution of pain scores before treatment

Pain Rating **Scale (**After Treatment)	Frequency	Percentage (%)
3	2	6.67 %
4	8	26.67 %
5	6	20.00 %
6	7	23.33 %
7	3	10.00 %
8	3	10.00 %
9	1	3.33 %
TOTAL	30	100.00 %

Table 3. Distribution of pain scores after treatment.

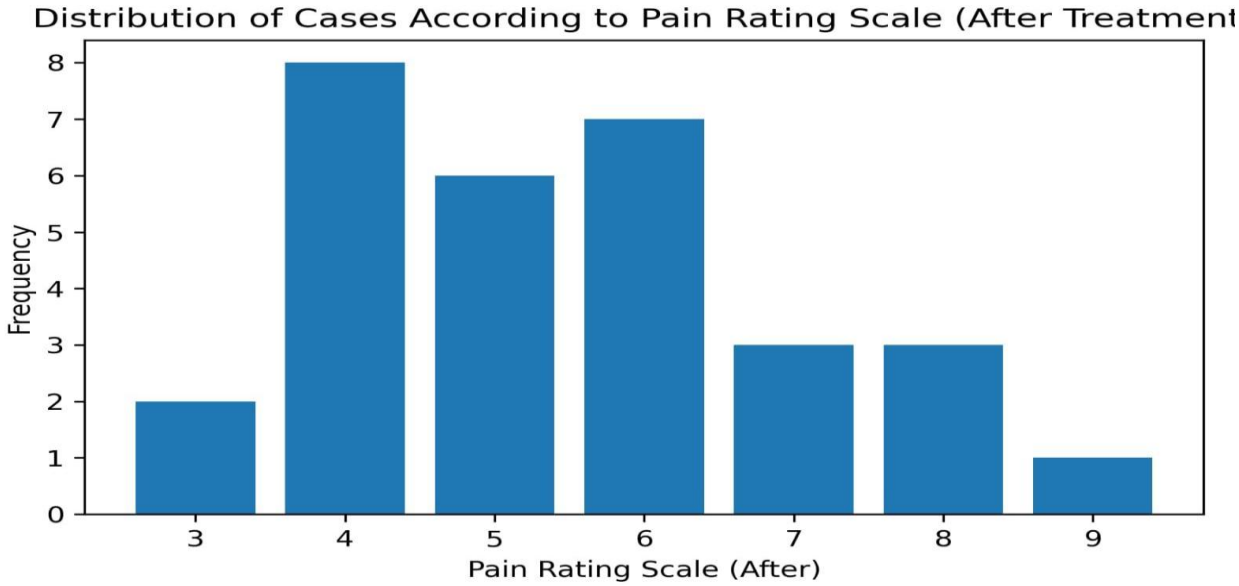


Figure 3. Distribution of pain scores after treatment.

Phosphorus and Silicea were the most frequently prescribed medicines, with four cases each (13.33%). Ignatia was prescribed in three cases (10.00%). Pulsatilla, Hyoscyamus, Sepia, Lycopodium, Natrum muriaticum and Sulphur were each prescribed in two cases (6.67%). Six other medicines were each prescribed in one case (3.33%).

Medicine	**Frequency**	**Percentage (%)**
Phosphorus	4	13.33%
Silicea	4	13.33%
Ignatia	3	10.0%
Pulsatilla	2	6.67%
Hyoscyamus	2	6.67%
Sepia	2	6.67%
Lycopodium	2	6.67%
Natrum Mur	2	6.67%
Sulphur	2	6.67%
Lilium Tigrinum	1	3.33%
Calcarea Carb	1	3.33%
Magnesia Phos	1	3.33%
Kali Carb	1	3.33%

Nux Vomica	1	3.33%
Belladonna	1	3.33%
Staphysagria	1	3.33%
Total	30	100%

Table 4. Distribution of prescribed medicines.

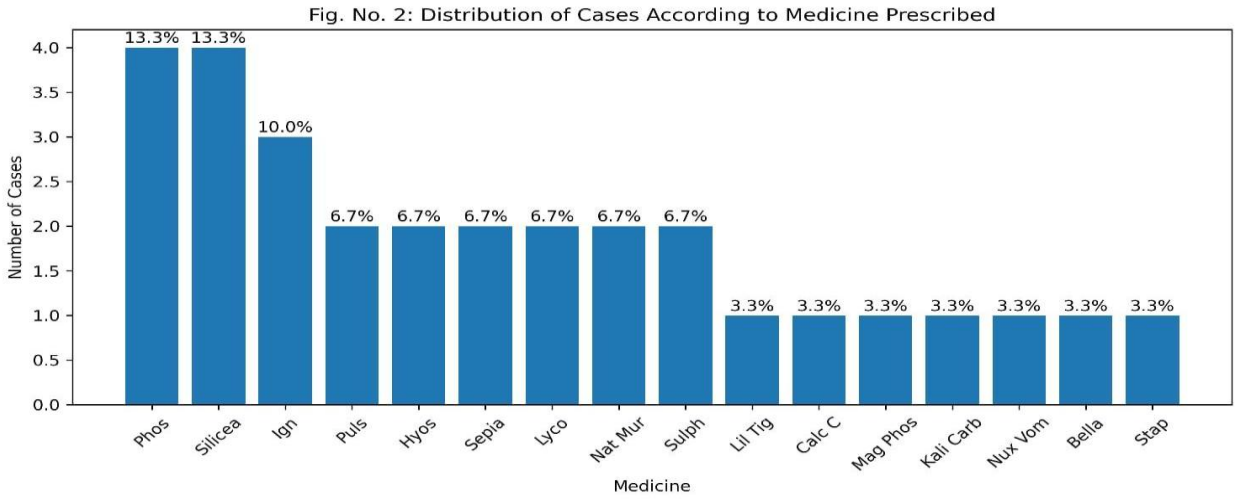


Figure 4. Distribution of prescribed medicines.

Overall, 25 cases (83.33%) were documented as improved and 5 cases (16.67%) as not improved. The dissertation describes associated improvement in symptom severity, general well-being and daily activities among many participants.

Clinical outcome	Frequency	Percentage
Improved	25	83.33%
Not improved	5	16.67%
Total	30	100%

Table 5. Overall clinical outcome.

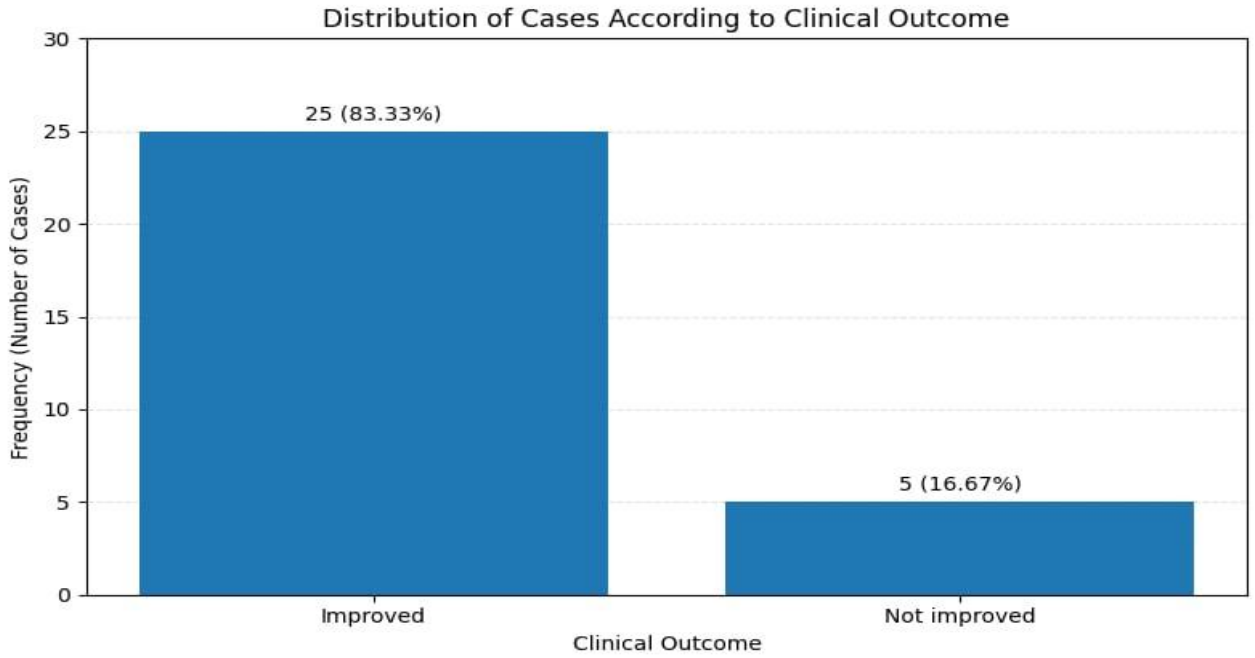


Figure 5. Overall clinical outcome.

Interpretation

Statistical analysis: The mean pain score decreased from 7.53 before treatment to 5.37 after treatment, giving a mean reduction of 2.17 points. A paired-samples t-test demonstrated a statistically significant within-participant reduction in pain score, $t(29) = 6.385$, $p < 0.0001$.

Measure	Before treatment	After treatment / comparison
n	30	30
Mean pain score	7.53	5.37
Mean reduction in pain score	—	2.17
95% CI for mean reduction	—	Approximately 1.48–2.86
Paired t-value	—	6.385
df	—	29
p-value (two-sided)	—	<0.0001*

Exact two-sided p-value = 5.57×10^{-7}.

The 95% CI is an approximate interval derived from the reported mean reduction and paired t-statistic; the underlying paired observations should be used for final journal submission

The present case series documented improvement in 25 of 30 cases (83.33%) following individualized homoeopathic treatment, together with a shift in the distribution of pain scores toward lower values. The mean pain score decreased from 7.53 before treatment to 5.37 after treatment, and this within-participant reduction was statistically significant on paired analysis ($t = 6.385$, $df = 29$, $p < 0.0001$). The finding is clinically encouraging but should not be interpreted as definitive evidence of treatment efficacy in the absence of a comparator, because a case series cannot adequately separate treatment effects from natural fluctuation, regression to the mean, placebo/contextual effects or other influences.

DISCUSSION

The present case series documented improvement in 25 of 30 cases (83.33%) following individualized homoeopathic treatment, together with a shift in the distribution of pain scores toward lower values. The finding is clinically encouraging but should not be interpreted as evidence of treatment efficacy in the absence of a comparator, because a case series cannot adequately separate treatment effects from natural fluctuation, regression to the mean, placebo/contextual effects or other influences.

The age distribution, with 70% of participants aged 16–20 years, is consistent with the recognized concentration of PD among adolescents and young women.[1–3] The symptom burden observed at baseline was substantial: 90% of participants had pain scores of 7 or higher. This is important because PD is not merely a menstrual discomfort; severe pain can affect daily activities, concentration and participation in school or work.[2,5,6]

The reduction in the proportion of participants with the highest pain scores is consistent with findings reported in several homoeopathic studies cited in the dissertation. The dissertation describes randomized trials in which individualized homoeopathic treatment was associated with reductions in pain intensity and menstrual symptom scores compared with placebo, as well as observational evidence of improved quality of life and reduced dysmenorrhoea severity.[11–13] However, the evidence is not uniform, and the methodological limitations of earlier studies make cautious interpretation necessary. The present study adds clinical documentation from an Indian institutional setting, but its design does not provide a stronger level of causal inference than the existing controlled literature.

The remedy distribution illustrates the individualized nature of prescribing in this series. Phosphorus and Silicea were each prescribed in four cases, followed by Ignatia in three cases; several other medicines were used less frequently. The diversity of remedies supports the study's stated approach of selecting treatment according to the totality of symptoms rather than using one fixed remedy for PD. At the same time, the

frequency of prescription cannot be interpreted as evidence that any particular medicine is superior, because remedy selection was not randomized and the sample was small.

From a clinical research perspective, the study has useful strengths. It documented individual cases in a defined age range, used a simple numerical pain scale that is easy to reproduce, recorded the prescribed remedies, and included follow-up assessment. The study also excluded secondary dysmenorrhoea and severe systemic illness according to the protocol, thereby creating a more clinically coherent case series.

Important limitations are the small sample size, absence of a control group, lack of blinding, heterogeneous individualized interventions, limited follow-up and reliance mainly on pain severity and clinical outcome. The dissertation itself advises caution in generalizing the results and recommends larger randomized controlled studies with longer follow-up. Future studies should predefine a primary outcome, document the number and timing of menstrual cycles, record rescue analgesic use and absenteeism, include quality-of-life measures, report adverse events, and use an appropriate comparator.

CONCLUSION

In this 30-case series of females aged 14–30 years with primary dysmenorrhoea, individualized homoeopathic treatment was associated with improvement in 25 cases (83.33%) and a shift toward lower pain scores in the aggregate distribution. Phosphorus and Silicea were the most frequently prescribed medicines. These observations suggest a potentially beneficial clinical role but do not establish efficacy because of the uncontrolled case-series design. Well-designed randomized controlled studies with larger samples, longer follow-up and standardized patient-centred outcomes are required before firm conclusions can be drawn.

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AUTHOR CONTRIBUTIONS

RRT and SSM: study conception, case collection, clinical documentation, data compilation and manuscript preparation. SN: supervision, scientific guidance and critical review. All authors should approve the final manuscript before submission.

CONFLICT OF INTEREST

The authors should complete the journal's required conflict-of-interest declaration before submission.

FUNDING

No external funding was reported in the dissertation.

DATA AVAILABILITY

The aggregate data presented in this manuscript are derived from the dissertation. Any request for additional data should be considered subject to institutional and participant confidentiality requirements.

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