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A PROSPECTIVE CLINICAL EVALUATION OF HOMOEOPATHIC MANAGEMENT IN PATIENTS WITH HYPOTHYROIDISM

Dr. Nymisha Dokala*[1], Dr. M. Harinath MD (Hom)[2]

[1]MD Scholar, GHMC KADAPA, Andhra Pradesh.

[2]Professor and HOD, Dept. of Hom. Pharmacy GHMC KADAPA, Andhra Pradesh.

***Corresponding Author: Dr. Nymisha Dokala**

MD Scholar, GHMC KADAPA, Andhra Pradesh.

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ABSTRACT

Introduction: In the modern world, Thyroid disease is one of the most common conditions. Globally, Hypothyroidism is the most prevalent Thyroid disorder. India is also seeing an increase in this problem. Thyroid illness is currently the second most prevalent condition in India. Thyroid hormone shortage causes Hypothyroidism, a common endocrine condition. The thyroid gland's inability to produce enough thyroid hormone is typically the main cause. A prospective Clinical study to evaluate the effectiveness of Homoeopathic management was conducted with the assessment of TSH (Thyroid Stimulating hormone) values and improvement in signs and symptoms.

Objective

1. To Study the Types and Clinical presentation of Hypothyroidism.
2. To Study the Effectiveness of Homoeopathic medicines in the management of Hypothyroidism by analysing Thyroid function tests.

Methods: A Prospective clinical study was conducted on 48 patients suffering from Hypothyroidism at the outpatient of Government Homeopathic Medical College and Hospital, Kadapa, Andhra Pradesh, India, and treated with Individualised Homoeopathic medicines. Serum TSH were considered as the treatment outcome, measured at baseline and after 6 to 12 months of treatment. The results were analysed in the end by paired t-tests. **Results:** Total 48 patients were screened, of which 30 patients were enrolled; 6 patients dropped out, 9 patients migrated to other places, 3 patients did not meet with inclusion criteria. Mean age was 36 years (standard deviation: 7.32), and majority of the patients were female (83.33%). Results showed significant difference after comparing pre and post treatment values using Paired t test. The Mean TSH value of 14.42 µIU/mL decreased to 8.56 µIU/mL. Most frequently used medicines were Natrum muriaticum (23.33%), Calc carb (20%), Lycopodium (16.66%), Pulsatilla nigricans(13.33%), and Kali Iod (6.66%). **Conclusion:** This study indicates a significant role of Homoeopathic management in individualised patients with Hypothyroidism.

KEYWORDS: Prospective study, Hypothyroidism, TSH, Homoeopathy, Primary Hypothyroidism, Subclinical Hypothyroidism.

INTRODUCTION

Hypothyroidism (ICD11 Code 5A00.Z).[1] is the condition resulting from insufficient synthesis of thyroid hormones. Hypothyroidism dating from birth is termed cretinism. The term myxoedema indicates severe hypothyroidism in which there is accumulation of hydrophilic mucopolysaccharides in the skin and other tissues.[2] Deficient thyroid hormone secretion can be due to thyroid failure (primary hypothyroidism) or, less commonly, pituitary or hypothalamic disease (secondary hypothyroidism) (Table 181-1). Transient hypothyroidism may occur in silent or subacute thyroiditis. Subclinical (or mild) hypothyroidism is a state of normal free thyroid hormone levels and mild elevation of TSH; despite the name, some pts may have minor symptoms. With higher TSH levels and low free T4 levels, symptoms become more readily apparent in clinical (or overt) hypothyroidism.[3]

The prevalence of hypothyroidism in the developed world is about 4-5% The prevalence of subclinical hypothyroidism in the developed world is about 4-15%.[4] Hypothyroidism occurs at any age but is particularly common among the elderly. It occurs in close to 10% of women and 6% of men > 65. Although typically easy to diagnose in younger adults, it may be subtle and manifest atypically in the elderly.[5]

Symptoms and signs of primary hypothyroidism are usually subtle and insidious, including cold intolerance, constipation, forgetfulness, personality changes, weight gain, and paraesthesia due to carpal or tarsal tunnel syndrome. Women may experience menorrhagia or secondary amenorrhea. Characteristic features include dull facial expression, hoarse voice, slow speech, facial puffiness, periorbital oedema, coarse dry skin, sparse hair, drooping eyelids, and delayed relaxation of deep tendon reflexes. Hypothermia, dementia, or psychosis (myxoedema madness) may also occur. Carotenemia, macroglossia, bradycardia, and cardiac enlargement due to pericardial effusion may be present, along with pleural or abdominal effusions. In elderly patients, symptoms are often vague and may resemble geriatric disorders such as confusion, anorexia, weight loss, falls, incontinence, decreased mobility, dementia, or parkinsonism. Musculoskeletal complaints like arthralgia, muscle aches, weakness, and elevated CK levels are also common.[5]

PATIENT AND METHODS

The study was conducted through theoretical insights and clinical investigation, utilizing literature compiled from academic books, scientific journals, articles, and online databases/websites.

SOURCES OF DATA: The subjects included in the study were chosen from the OPD in Government Homoeopathic Hospital, Kadapa.

METHODS OF COLLECTION OF DATA

- A Prospective study was conducted in the OPD of Government Homoeopathic Hospital, Kadapa.
- A minimum of 30 Subjects were selected based on the predefined inclusion and exclusion criteria.
- Duration of Study: 12 Months from the onset of Research.
- Detailed case history was taken through Interview method as per Structured case proforma formulated for the purpose of the study.
- All the cases were treated according to the Principles of Homoeopathy.
- Administration of remedy was done as per the case requisites in consideration with patient susceptibility & changes in the symptoms.
- Repetition, change of remedy and potency were done according to the Principles of Homoeopathy.
- Repertorisation was done using RADAR software.
- All the cases were followed for a minimum period of 6 months and follow up was conducted at two – three weeks interval.
- No control group has been kept for this study purpose.

TYPE OF RESEARCH: Prospective Clinical Study.
SAMPLE DESIGN: Simple Random Sampling.
SELECTION CRITERIA: Based on the Inclusion and Exclusion Criteria.

INCLUSION CRITERIA

➢ Subjects aged 25–50 years, both male and female, were included in the study population.
➢ Confirmed cases of Hypothyroidism, as evidenced by thyroid function tests, were considered.

EXCLUSION CRITERIA

➢ Diseases with advanced pathological changes
➢ Cases of any malignancies or tumours.

ASSESSMENT OF TREATMENT OUTCOME

The result of the treatment of Hypothyroidism was assessed based on the following criteria.

- MARKED IMPROVMENT: Complete relief of signs and symptoms indicating successful treatment with TSH within the normal range.
- MODERATE IMPROVMENT: Noticeable improvement of signs and symptoms with significant reduction of TSH towards the normal range.
- MILD IMPROVMENT: Mild relief of signs and symptoms with slight decrease of TSH level but still be elevated and fails to be within the normal range.
- NO IMPROVMENT: Persistence or worsening of signs and symptoms with no change or elevated TSH levels.

STATISTICAL METHOD EMPLOYED: Paired Students "t" Test was used to find Statistical Significance. The method of study is Clinical without use of Control.

RESULTS

Total 48 patients were screened, of which 30 patients were enrolled; 6 patients dropped out, 9 patients migrated to other places, 3 patients did not meet with inclusion criteria. 7 cases (23.33%) are under the age group of 25 –30 years, 12 cases (40%) are under the age group of 31 – 35 years, 2 cases (6.66%) are under the age group of 36 – 40 years, 5 cases (16.66%) are under the age group of 41 – 45 years and 4 cases (13.33%) are under the age group of 46 – 50 years. (Table 1).

Table 1: Distribution of cases according to age (in years).

S.NO	AGE (in years)	NO. OF PATIENTS	PERCENTAGE
1	25 - 30	07	23.33%
2	31 – 35	12	40%
3	36 - 40	02	6.66%

5 cases (16.66%) were Males and 25 cases (83.33%) were Females.

19 cases (63%) were Homemaker's, 2 cases (7%) were students, 1 case (3%) was Business people, 2 cases (7%) were College Professor, 1 case (3%) was Housemaid, 2 cases (7%) were Clerk and 3 cases (10%) were related to Software Employees.

20 cases (67%) have Family History of Hypothyroidism and 10 cases (33%) had no Family history of Hypothyroidism. (Table 2)

Table 2: Distribution of cases according to Family history of Hypothyroidism.

S.NO	FAMILY HISTORY	NO. OF PATIENTS	PERCENTAGE
1	With Family history	20	67%
2	Without Family history	10	10 33%

6 Patients (36.67%) have normal BMI i.e.18.5 – 24.9 Kg/m^2, 14 Patients (46%) are overweight i.e. 25 – 29.9 Kg/m^2, 8 Patients (27%) belong to Class I Obese category i.e., 30.0 – 34.9 Kg/m^2 and 2 Patients (7%) belong to Class II Obese category i.e. 35.0 – 39.9 Kg/m^2.

8 cases (26.67%) diagnosed as Primary Hypothyroidism, 22 cases (73.33%) diagnosed as Subclinical Hypothyroidism.

Hair fall was the most common presenting complaint, 19 (63.33%); followed by weight gain in 18 (60%) cases; joint pain in 15 (50%) cases; Generalized weakness in 13(43.33%) cases; Diminished appetite in 9 (30%) cases; Irregular menses in 7 (23.33%) cases; Headache in 6 (20%) cases; Menorrhagia in 5 (16.66%) cases; Distension of abdomen in 4 (13.33%) cases; Stiffness of calf muscles, Dryness of skin and constipation in 3 (10%) cases each; Lethargy and muscle cramps in 2 (6.66%) cases each; Numbness, tingling, scanty menses and Breathlessness in 1 (3.33%) case each. (Table 3)

Table 3: Distribution of cases according to presenting complaint.

S.NO	PRESENTING COMPLAINT	NO. OF CASES	PERCENTAGE
1	HEADACHE	6	20%
2	WEIGHT GAIN	18	60%
3	JOINT PAIN	15	50%
4	HAIR FALL	19	63.33%
5	CONSTIPATION	3	50%
6	BREATHLESSNESS	1	10%
7	GENERALIZED WEAKNESS	13	26.67%
8	IRREGULAR MENSES	7	83.33%
9.	DRYNESS OF SKIN	3	10%
10.	MUSCLE CRAMPS	2	6.66%
11.	DIMINISHED APPETITE	9	30%
12.	LETHARGY	2	6.66%
13	STIFFNESS OF CALF MUSCLES	3	10%
14.	NUMBNESS	1	3.33%
15.	TINGLING	1	3.33%
16.	DISTENSION OF ABDOMEN	4	13.33%
17.	MENORRHAGIA	5	16.66%
18.	SCANTY MENSES	1	3.33%

MEASUREMENT OF OUTCOME

Among 30 patients, 21 cases (70%) got marked improvement, 3 cases (10%) got moderate improvement, 2 cases (7%) got mild improvement and 4 cases (13%) had no improvement. Patients with mild improvement and no improvement have been referred to Endocrinologist for further reference. Mean TSH values Pretreatment was 14.42 µIU/mL and Post treatment was 8.56 µIU/mL. Therefore, Mean TSH value of 14.42 µIU/mL decreased to 8.56 µIU/mL.

DISCUSSION

A Prospective Clinical study was conducted in the OPD of Government Homoeopathic Hospital, Kadapa, to evaluate the efficacy of Homoeopathic medicines in the management of Hypothyroidism. The Goal of the current study was to assess the therapeutic response and clinical

profile of Homoeopathic intervention in Hypothyroidism patients.

Based on inclusion/exclusion criteria, history, and clinical presentation, a total of thirty individuals were chosen. Clinical examination, bystander information, and patient feedback were used in a thorough case-taking process. The selection, potency, dosage, and repetition of remedies were customized based on patient susceptibility, symptom changes, and case demands. For six to twelve months, cases were monitored. The paired t-test was used for statistical analysis of the thyroid profiles taken before and after therapy (at the first and sixth month).

The discussion below interprets the findings in relation to age, gender, occupation, familial predisposition, BMI, type of hypothyroidism, presenting complaints, Miasmatic predominance, homoeopathic medicines prescribed, and therapeutic outcomes, followed by statistical interpretation.

In this study of 30 subjects, the highest number of hypothyroidism cases (12) occurred in the 31–35 years age group, indicating that the condition most commonly affects individuals in early to mid-adulthood. This aligns with previous epidemiological findings showing increased prevalence among adults aged 30–40 years, possibly due to heightened autoimmune activity, hormonal changes, and stress factors typical of this age range. Among the 30 study subjects, 25 (83%) were female and 5 (17%) were male, indicating a marked female preponderance. This finding aligns with established literature, which consistently reports a higher incidence of hypothyroidism among females. The hormonal variations, particularly during pregnancy and menopause, as well as autoimmune predisposition, may account for this gender difference. Occupational analysis showed that homemakers made up the majority of subjects (63%), followed by software employees (10%), students (7%), college professors (7%), clerks (7%), businesspersons (3%), and housemaids (3%). The predominance of homemakers may relate to lifestyle factors such as low physical activity, dietary irregularities, and psychosocial stress, which can affect thyroid function. However, as occupation may also reflect broader social demographics rather than a direct causal factor, further studies with larger and more diverse groups are needed.

A significant proportion of patients (20 out of 30, i.e., 67%) reported a positive family history of Hypothyroidism highlighting the role of hereditary factors in the disease's development. This observation supports the established understanding that genetic predisposition contributes to autoimmune thyroid disorders. Familial clustering of Hypothyroidism has been previously documented, suggesting a heritable component influencing thyroid autoimmunity 36.67% of research participants had a normal BMI, 46% were overweight, and 34% were obese (Class I and II). These results show a substantial link between hypothyroidism and weight gain. The increased incidence of overweight and obesity among hypothyroid patients may be explained by decreased basal metabolic rate and water retention brought on by thyroid hormone deficiency. This pattern emphasizes how crucial weight control is as a supplement to therapeutic intervention.

In this study, Subclinical Hypothyroidism was found in 73.33% of subjects, whereas 26.67% had Primary Hypothyroidism. This predominance of subclinical cases corresponds with trends observed in general population studies, suggesting early detection and increasing awareness of thyroid disorders. Subclinical Hypothyroidism, if left untreated, can progress to overt Hypothyroidism; therefore, timely diagnosis and intervention are crucial. Hair fall (63.33%) was the most common presenting symptom, followed by weight gain (60%), joint pain (50%), generalized weakness (43.33%), and reduced appetite (30%). Other symptoms included menstrual irregularities, headache, abdominal distension, dry skin, constipation, and lethargy. These findings align with the classical multisystemic presentation of hypothyroidism and supported the individualization of Homoeopathic prescriptions.

Analysis of Miasmatic background showed that 93% of patients had a Psoro-Sycotic predominance, while 7% exhibited a Tri-Miasmatic constitution. This indicates that chronic Miasmatic influences may contribute to the development and persistence of Hypothyroidism according to Homoeopathic theory. Identifying Miasmatic predominance helped in guiding the selection of appropriate constitutional remedies. The most frequently prescribed medicines were Natrum muriaticum (23.33%) and Calcarea carbonica (20%), followed by Lycopodium clavatum (16.66%), Pulsatilla nigricans (13.33%), and Kali iodatum (6.66%). Other remedies—such as Calcarea phosphoricum, Causticum, Conium, Lachesis, Nux vomica, and Phosphorus—were used in isolated cases. Remedy selection was based on totality of symptoms, Miasmatic background, and individualization. The frequent use of Natrum muriaticum and Calcarea carbonica reflects their relevance in hypothyroid cases marked by sluggish metabolism, weight gain, and emotional sensitivity. Therapeutic assessment revealed that 70% of patients showed marked improvement, 10% moderate improvement, 7% mild improvement, and 13% no improvement. This indicates a favourable clinical response to homoeopathic management.

The high rate of marked improvement demonstrates the potential effectiveness of individualized homoeopathic treatment in reducing symptoms and normalizing thyroid function. Before treatment, the mean TSH level was 14.42 µIU/mL; after treatment, it was 8.56 µIU/mL, showing a considerable biochemical improvement. The clinically noted improvement in symptoms is supported

by this quantifiable decrease. These results imply that customized homoeopathic remedies may have a regulatory effect on thyroid function. Statistical evaluation was conducted to test the null and alternate hypotheses.

The null hypothesis (H_0), which stated that Homoeopathic medicines have no significant effect in the management of Hypothyroidism, was rejected. The alternate hypothesis (H_1), stating that Homoeopathic medicines significantly improve Hypothyroid conditions was accepted. Hence, the findings of this study provide statistical evidence supporting the efficacy of Homoeopathic intervention in the management of Hypothyroidism. Since the sample size was less than 30, the Z-test was not suitable, hence the paired t-test was employed to analyse the data.

The paired "t" test at the 5% and 1% level of significance for n-1 degrees of freedom is the statistical instrument used to assess the effectiveness of homoeopathic medications in the treatment of hypothyroidism. 't' critical value for 29 degrees of freedom at 5% level of significance is 1.699 & at 1% level of significance is 2.462. The observed 't' value is 5.42. Here, if 't' calculated value is < 't' critical value then, we accept the null hypothesis (H0), otherwise if 't' calculated value ≥ 't' critical value then we reject the null hypothesis (H0). Hence, we reject the null hypothesis and accept the alternate hypothesis in both 5% & 1% level of significance as the critical value is less than the calculated value. 'p' value at 5% and 1% level of significance is 0.00001; so, $p < 0.05$ and $p < 0.01$. Hence, there is a significance in the efficacy of Homoeopathic medicines in the management of Hypothyroidism.

CONCLUSION

A sample of 30 subjects were considered for this study and each case was studied in detail including Past history, Family History and Physical Examination. Thus, this study indicates that there is Statistical significance in the Effectiveness of Homoeopathic medicines in the Management of Hypothyroidism.

ETHICAL APPRPOVAL

The study protocol was approved by the IEC dated 14th December 2023.

FINANCIAL SUPPORT

Nil.

CONFLICT OF INTEREST

There is no conflict of interest. The study was conducted as Postgraduate thesis of the corresponding author.

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