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Type 2 Diabetes Mellitus treated successfully with Individualized Homoeopathy - Case Series

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ABSTRACT:

Diabetes is a multifactorial metabolic disease of major concern throughout the world. It has been observed and well-established fact that beside the conventional medicines, Individualised Homoeopathic Medicines (IHM) can also be effective in control of blood glucose. A cases series consisting of five cases of type-2 Diabetes mellitus (T2DM) treated with IHM with report of before and after treatment has been discussed here, three of which were taken from personal clinic and two from the outpatient department (O.P.D) of Mahesh Bhattacharyya homoeopathic medical college and hospital within a span of one year. All the cases were repertorised using authentic software and medicines prescribed according to the homoeopathic principle, from a good manufacturing practices (GMP) certified company. Modified Naranjo Criteria for Homoeopathy – Causal Attribution Inventory (MONARCH, v.2) was used in all the cases to assess the relation whether the result was really from the homoeopathic medicine or not. Remarkable improvement of the level of blood glucose (one case with HbA1C, 4 cases with report of FBS and PPBS) seen in all the five cases within a suitable time period after administration of the IHM. This case series with IHM is the first pavement towards the evidence that homoeopathy can control type-2 diabetes. As the placebo control studies in T2DM has a great concern about ethical issue, this type of case series may be the key towards evidence-based medicine (EBM) in Homoeopathy.

KEY WORDS: Diabetes, Homoeopathy, Individualised homoeopathic medicine, High blood sugar, HbA1c.

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INTRODUCTION:

Diabetes Mellitus (DM) is defined as a metabolic disorder of multifactorial aetiology, characterized by chronic hyperglycaemia with disturbances in the metabolism of carbohydrates, lipids, and proteins, resulting from defects in insulin secretion, or its action [1]. Type-2 diabetes is a heterogeneous condition characterised by varying degrees of insulin resistance and β-cell dysfunction, commonly associated with obesity. Approximately 40% of overall type-2 diabetes risk is determined by genetic factors, with the rest due to environmental (acquired) factors [2]. Rapid urbanisation and life style changes on the last century facilitates the various lifestyle disorders such as Diabetes, Hypertension,

Hypercholesteremia etc. According to the World Health Organization (WHO), noncommunicable diseases (NCDs) accounted for 74% of deaths globally in 2019, of which, diabetes resulted in 1.6 million deaths, thus becoming the ninth leading cause of death globally [3]. As of 2015, > 415 million adults have diabetes mellitus, and this number is estimated to increase to 642 million by 2040. More than 95% of all adults with DM are the sufferers of T2DM [2]. Diseases like Diabetes Mellitus was considered to be an affluent from the western world but now it is also a major problem for the developing economics like China and India [3]. When talking about India and its subcontinent, we can see the problem is even more alarming. Various studies had shown that India is one of the epicentres for the global Diabetes [4]. According to the International Diabetes Federation (IDF) in 2019, the top three countries with the highest number of individuals with diabetes are China (116.4 million), India (77.0 million), and the United States of America (31.0 million) [4]. However, current research indicates that 10.1 crore Indians are estimated to have diabetes [5]. Currently, the gold standard for evaluating a patient's long-term glycaemic control and response to medical treatment in patients with diabetes is glycated haemoglobin [6]. However, haemoglobin that has been glycated does not compensate for blood glucose variations. Blood glucose variations are referred to as glucose variability (GV) [6]. Modern medicines for DM can only control the glucose level with some major and minor side effects. Long time use of drugs like metformin, Glimiperide, Pioglitazone has well and wide side effects like gastrointestinal complications, chances of renal failure, osteoporosis, hepatic steatosis, heart failure etc [7]. Indigenous therapy, beside the modern conventional therapy can be an answer for the uncontrollable rise of DM in the society and also to avoid adverse effect free diabetes control. IHM was proven to be statistically significant in controlling blood glucose levels in prediabetic patients [8]. Homoeopathy, alongside the allopathic medicine has better glycaemic control compared to conventional medicine alone [9]. Even some studies also claim that in case of longstanding DM, with some complication, Homoeopathy works effectively well [9]. Here, we will discuss the pre-post analysis of the five cases of type-2 Diabetes mellitus treated with individualised homoeopathic medicine.

CASE – 01

A 52 years old female patient visited our clinic complaining of bilateral sciatica which was triggered by change of position and relieved by lying down and rest. Swelling was noted in both ankle joints. She also reported extreme fatigue, loss of weight, eructation, fullness of abdomen and flatulence mostly after eating.

History –

Patient suffered from lumbar spondylosis since the age of 40 years. She also had undergone haemorrhoidectomy at 45 years of age. She was known to be diabetic for last 2 years and was taking active medication for hyperglycaemia without any improvement.

Family history –

Her father was a known diabetic died of cerebrovascular attack and mother suffered from uterine fibroid. All her siblings are suffered from diabetes and systolic hypertension.

Personal history –

She used to take liquor tea thrice daily and of non-vegetarian food habit. She was married and her level of physical activity was moderate. No adverse effects following

immunization (AEFI) was recorded and developmental milestones were not delayed.

Mind symptoms –
Patient got angry on provocation and after least contradiction. Consolation ameliorates. She is very fearful to stay alone.

Physical generals –
Patient's appetite was good but no desire to eat, thirst was adequate. The tongue was moist and white coated in middle. No characteristic craving and aversion for food were noted. Allergy to oysters and sea food were recorded. She also complained involuntary urination mostly at night. Regular morning stool was present. Sleep duration was 5-6 hours daily with frequent waking at night, unrefreshing sleep. Thermally, she was affected by both heat and cold.

General survey –
The patient was conscious, alert, and cooperative. Clinically pallor was detected. Cyanosis, jaundice, or clubbing not detected. Moderate oedema near both ankle joints were seen. Moderate built, dark complexion and anxious facies were noted with regular, rhythmical radial pulse. Blood pressure was 144/90 mm Hg and her height and weight were 5'4" and 51 kg respectively.

Investigation –
Patient approached with reports showing increased level of blood sugar levels both fasting (234 mg/dl) and post prandial (412 mg/dl) in the first visit *(Fig. 1).* But her blood glucose levels were fluctuating and she felt extreme dizziness and fatigue with loss of weight.

Totality of symptoms –
The symptoms considered for the analysis and evaluation of the case were done using Kentian approach.

- Fear of staying alone.
- Anger after least contradiction and provocation.
- Aggravation from oysters and sea food.
- Involuntary urination at night.
- Unrefreshing sleep.
- Swelling of ankle joint.
- Extreme weakness from slight exertion.

Remedy selection and administration –
HOMPATH *Zomeo pro* version was consulted as the case presented with few characteristic mental and physical general symptoms. *Lycopodium* (26/7), *Calcarea carb* (20/6), *Bryonia* (18/7), *Arsenicum album* (18/6), *Sepia* (18/6) were the medicines in the top gradation. *Lycopodium* covered most of the symptoms with highest gradation *(Fig. 2)*. But after consulting Boericke's materia medica, we found *Uranium nitricum*, which was an excellent anti-hyperglycaemic medicine and related closely to *Lycopodium* as the symptom mentioned *'Abdomen bloated, gas second only to Lycopodium.'* [10] Dr. Hahnemann also instructed that *'It is rarely advisable to begin the treatment of chronic disease with Lycopodium.'* [11] So, we considered *Uranium nitricum* based on the following symptoms.

- Frequent urination (4 times at least), cannot hold urge at night.
- Tendency to oedema in lower extremities especially in ankle joint.
- Cachectic patient, sensation of extreme fatigue and loss of weight.
- High blood sugar associated with systemic hypertension.

Initially six medicated globules (globule no – 20) of *Uranium nitricum* 30 CH was administered in 10 ml of distilled water. Ten drops from the solution were advised to be taken twice daily for subsequent five days in empty stomach. This was followed by

(Liquid placebo) LPL once daily, early morning in empty stomach for seven subsequent days.

Follow-up and outcome –
Follow-ups were done at ten days interval for initial 2 visits followed by two weeks interval for subsequent two visits to record any complication or recurrence of old symptoms. Marked changes in symptomatology were elicited at the end of treatment *(Table 1)* and improvement in blood sugar levels were seen *(Fig. 3, 4)*.

CASE – 02
A female patient, aged 56 years, visited our clinic, who was suffering from type-2 Diabetes mellitus since last 9 years. She also had complained cramps of calf muscle with feeling of constriction which was aggravated at night and while beginning to move. Burning in the sole of both legs were present mostly in night. Patient also reports occipital headache occasionally when she was on empty stomach and the headache was relieved by eating. Heartburn and eructation were also reported mostly in the afternoon after eating oily and spicy-rich food. Previously the blood sugar was under control with allopathic treatment, but since last six months the blood glucose was fluctuating. Repeated alteration of medicines was done but no satisfactory results were obtained.

History –
Patient was affected with dengue fever in 2016. She also had undergone hysterectomy in 2008. She was diagnosed covid positive in 2021.

Family history –
Her father was diagnosed previously with chronic bronchitis and her mother was known diabetic. Her niece was suffered previously with bone tuberculosis.

Personal history –
Patient was a married housewife; she was of non-vegetarian food habit and level of physical activity was moderate. No adverse effects following immunization (AEFI) were recorded and developmental milestones were not delayed.

Mind symptoms –
Patient was of impatient and irritable temperament, extremely nervous, she had loss of self-confidence and aggravation from contradiction. Anxious; fear of disease was present.

Physical generals –
Patient could not tolerate hunger, felt weakness while fasting. Stool passed without satisfaction twice daily with burning in anus after passing stool. Frequent micturition, could not hold urine, passed involuntarily while coughing and sneezing. Profuse thirst for cold water as mouth became dry very frequently. She had profuse offensive perspiration mostly on scalp. She had desire for sweet, mutton, fried food, cold food, and drinks; aggravation from oily fried food was also noted. Her tongue was dry and clean. Her sleep was very light, easily broken with slight sounds. Thermally she could not tolerate heat in any form.

General survey –
The patient was conscious, alert, and cooperative. Clinically pallor was detected. Cyanosis, jaundice, oedema or clubbing not detected. Built sthenic, fair complexion and anxious facies were noted with regular radial pulse. Blood pressure was 140/82 mm Hg and her height and weight were 5’2” and 59 kg respectively.

Investigation –
Patient was initially sent for HbA1C and *Average blood glucose* (ABG) which were

9.3% of total haemoglobin and 220 mg/dl respectively *(Fig. 5)*.

Totality of symptoms –
Analysis and evaluation of the case were done using Kentian approach. Following symptoms were considered as totality of symptoms.

- Cannot tolerate contradiction.
- Lack of self-confidence.
- Extreme restless, nervous.
- Fear of disease.
- Desire for sweets and cold food.
- Intolerance to oily, spicy, highly seasoned food.
- Burning and smarting in rectum after passing stool.
- Sweating mostly on scalp.
- Frequent and involuntary micturition, cannot hold especially while coughing.
- Burning in soles mostly at night.
- Cramping pain in the legs especially calf < night, first motion.

Repertorization with remedial analysis –
HOMPATH *Zomeo pro* version was consulted as the case presented with characteristic mental and physical general symptoms. *Sulphur* (36/13), *Lycopodium* (29/11), *Phosphorus* (27/11), *Acid nitricum* (26/10) *Pulsatilla* (26/10), *Calcarea carb* (26/9) were the medicines in the top gradation *(Fig. 6)*. *Sulphur* covered most of the symptoms with highest gradation.

Remedy selection and administration –
Initially, one medicated globule (globule no – 20) of *Sulphur* 200 CH potency was dispensed in 10 ml of distilled water, the whole quantity to be taken once in early morning in empty stomach. This single dose was followed by Liquid placebo (LPL) once daily, early morning in empty stomach for 14 subsequent days.

Follow-up and outcome –
Follow-ups were done at 2 weeks interval to record any complication or recurrence of old symptoms. Marked changes in symptomatology were elicited at the end of treatment *(Table 2)* and visible improvement in HbA1C and ABG were seen *(Fig.7)*.

CASE – 03
A 55 years old female visited the Out-patient department (OPD) of Mahesh Bhattacharyya Homoeopathic Medical College and Hospital complaining of acute onset toothache which was aggravated at night and while chewing with bleeding gums on provocation and offensive breath. Multiple carious teeth and ulceration of the left edge of the tongue was noticed with deep vertical crack of tongue. During case interrogation, she was known to be a sufferer of type-2 Diabetes mellitus since last one year eight months. She was under allopathic medication from the beginning but her blood glucose level was fluctuating.

History –
Patient has undergone extraction of teeth previously (2 years earlier) with loss of right and left second molars of upper jaw, left second premolar and first molar of lower jaw.

Family history –
Her father died of cerebrovascular accident with diabetes and dyslipidaemia as co-morbidity. Diabetes and liver cirrhosis were also found in her family (Uncle).

Personal history –
She was married, non-vegetarian by food habit, professionally used to do tailoring and embroidery works and moderate level of activity was mentioned. No adverse effects following immunization (AEFI) was

recorded and developmental milestones were not delayed.

Mind symptoms –

She was of excitable temperament does not communicate with anyone following anger, self-obsessed, intolerant of contradiction. She had anxiety about her health issues with fear of death. A state of indifference was observed as if she was discouraged in everything.

Physical generals –

She had loss of appetite and extremely thirstless. Watery stool passed 2-3 times per day followed by sensation of urging for stool. She also complained of extreme exhaustion after passing stool every time. She had profuse offensive perspiration mostly on scalp. She had desire for sweet; aggravation from milk and spiced food producing gastric irritation and burning in anus after passing stool. Deep vertical crack on tongue was noticed in the midline. Thermally she could not tolerate cold.

General survey –

The patient was conscious, alert, and cooperative. Clinically pallor, cyanosis, jaundice, oedema or clubbing not detected. Asthenic built, brownish complexion and anxious facies were noted with regular radial pulse. Blood pressure was 130/76 mm Hg and her height and weight were 5'3" and 55 kgs respectively.

Investigation –

Patient was initially sent for routine blood test followed by fasting and post-prandial blood sugar level. Increased level of fasting blood glucose (132 mg/dl) and post prandial blood glucose (288 mg/dl) were detected *(Fig. 8, 9)*.

Totality of symptoms –

The case was analysed and evaluated following Kentian method. The symptoms considered for the totality were:

- Violent anger, mostly angry over her own mistakes; Contradiction aggravation.
- Fear of death over her health issues.
- Desire for sweets.
- Burning and smarting in rectum after passing stool.
- Scalp perspires profusely than other part of body.
- Burning in soles mostly at night.
- Pain mostly in decayed teeth, pain < at night and while chewing.
- Ulceration of the left edge of the tongue with extreme offensive odour from mouth.

Repertorization with remedial analysis –

HOMPATH *Zomeo pro* version was consulted as the case presented with characteristic mental and physical general symptoms. *Nitricum acidum* (39/12), *Mercurius* (34/11), *Staphysagria* (33/11), *Sulphur* (33/11), *Bryonia* (32/11) were the medicines in the top gradation *(Fig. 10)*. *Nitricum acidum* covered most of the symptoms with highest gradation.

Remedy selection and administration –

One medicated globule (globule no – 10) of *Nitricum acidum* 0/1 potency was dispensed in 100 ml of distilled water added with 10 drops of rectified spirit, followed by mixing the solution firmly and 14 doses were made by marking, from which each dose was advised to mix in 15 ml of purified water, stirred well and to take one tablespoon full of that solution every day in early morning in empty stomach for 14 days.

Follow-up and outcome –

Weekly follow-ups were done for continuous 4 weeks to record any complication or

recurrence of old symptoms. Changes in symptomatology were mentioned (*Table 3*) and improvement in fasting and post-prandial blood sugar levels were seen *(Fig. 11)*.

CASE – 04

A female, aged 53 years, visited our clinic, who was suffering from teniasis represented by itch eruption in the different parts of the body mostly aggravated at night and relieved by cold water application on the affected parts for a week. Scratching followed by burning with minimal transparent discharge were noted. Bilateral knee pain was present with right sided dominance and while extend the leg. Occasional vertigo was reported while stooping and non-pitting swelling of the limbs were noted. No history of taking anti-diabetic treatment was present.

History –

She was a chronic sufferer of haemorrhoids and her gall bladder was operated in 2011. No co-morbidity was found to be noted.

Family history –

Her father was a known diabetic and a sufferer of liver disease and her mother suffered from rheumatism and uterine fibroid.

Personal history –

Patient was a married housewife, had three children, of non-vegetarian food habit. Moderate to heavy physical activity were mentioned. No delayed developmental milestones were found.

Mind symptoms –

Patient was of an irritable and hurried temperament, extremely anxious and weeping disposition, a deep grief about loss of parents. she did not like much company and aggravated by consolation.

Physical generals –

Her appetite and thirst were good. Stool passed without satisfaction 3-4 times daily. She could not hold the urge of micturition since last 2 years. She had profuse offensive perspiration mostly on back and armpit. She had desire for eggs; aggravation from lentils (masoor), tendency to take extra salt during lunch and dinner were also noted. Her tongue was whitish, moist, and marked with indentation of teeth. Her sleep was very light, easily broken with slight sounds. Thermally she could not tolerate heat, especially sun heat. She had a tendency to catch cold easily followed by paroxysmal sneezing.

General survey –

The patient was conscious, alert, and cooperative. Clinically pallor and non-pitting oedema in both legs were detected. Cyanosis, jaundice or clubbing not detected. Built sthenic, brownish complexion and anxious facies were noted with regular radial pulse. Oily greasy face was also noted. Blood pressure was 126/64 mm Hg and her height and weight were 5’4” and 62 kg respectively.

Investigation –

Patient was initially sent for routine blood test followed by fasting and post-prandial blood sugar level which were 144 mg/dl and 225 mg/dl respectively *(Fig. 12)*.

Totality of symptoms –

The case was analysed and evaluated following Kentian approach. The symptoms considered for the totality were:

- Weeping mood.
- Do not like company and aggravation while getting sympathy.
- Extremely hurried and impatient, restlessness.

- Desire salty food and extra salt while eating.
- Tendency to catch cold easily.
- Unsatisfactory stool – Insufficient in quantity.
- Profuse perspiration of the back with oily face.
- Itching of skin mostly at night.
- Vertigo aggravated by stooping.

Repertorization with remedial analysis –
HOMPATH *Zomeo pro* version was consulted as the case presented with characteristic mental and physical general symptoms. *Natrium muriaticum* (32/11), *Silicea* (32/11), *Sepia* (31/11), *Sulphur* (31/10), *Calcarea carb* (30/12) and *Thuja* (29/11) were the medicines in the top gradation *(Fig. 13)*. *Natrium muriaticum* covered most of the symptoms with highest gradation.

Remedy selection and administration –
After consultation with homoeopathic materia medica, *Natrum muriaticum* was found to fit in this case. Four medicated globule (globule no – 10) of *Natrum muriaticum* 200 CH potency was dispensed in 20 ml of distilled water added with 10 drops of rectified spirit, two doses were given to take once daily in early morning and empty stomach. 10 ml liquid placebo was also administered to take 5 drops, twice a day for consequtive 14 days.

Follow-up and outcome –
Weekly follow-ups were done for continuous 4 weeks to record any complication or recurrence of old symptoms. Changes in symptomatology were discussed *(Table 4.)* and improvement in blood sugar levels were elicited *(Fig. 14, 15)*.

CASE – 05
49-years-old, female private tutor of literature, visited the dental OPD of Mahesh Bhattacharyya homoeopathic medical college and hospital with the suffering from type-2 Diabetes mellitus since last 8 years. She came to consult her dental complaints which was extremely tender to touch and aggravated from cold applications since last 6 months. On examination, she was diagnosed with dental caries of right upper third molar and left lower second molar. She also reported chronic onset lower back pain with burning sensation of the back with no prominent modality.

History –
Patient had suffered previously from fracture of sacral joint 15 years ago. Rehabilitation was done properly.

Family history –
Her father was suffered from respiratory distress and palpitation and mother suffered from osteoarthritis of knee joints.

Personal history –
She was occupationally a private tutor and unmarried, of non-vegetarian food habit, level of physical activity was least. No adverse effects following immunization (AEFI) was recorded and developmental milestones were not delayed.

Mind symptoms –
Patient was of very amused character but on careful interrogation massive depression was found. She was previously a professor of a renowned degree college but after her accident she was unable to do her duty smoothly. She also noticed her colleagues and student made fun of her. She then resigned from her job and ended as private tutor. She also remained bachelor considering that she will not get enough attention and respect from her partner. Deep seated depression and insult were found as most important characteristic symptom.

Physical generals –

Patient had a moderate appetite and thirst. She had desire for cold food. No characteristic intolerance and aversion of food were recorded. Profuse clammy perspiration mostly on face were complained of. She also complained of urethral burning sometimes with increased urinary frequency. Stool passed regularly at morning and she was worried for deficient sleep as she awakened at night without cause. No special dream was found. Her tongue was pointed, clean and moist. Thermally, she felt more warmth than cold.

General survey –

The patient was conscious, alert, and cooperative. Clinically, pallor, cyanosis, jaundice, or clubbing were not detected. Non pitting oedema around knee joint was noted. Previously, she was healthy and fit, but she became obese in last 3 years. Fair complexion and cheerful facies were noted with regular radial pulse. Blood pressure was 140/82 mm Hg and her height and weight were 5'4" and 68 kgs respectively.

Investigation –

Patient was initially sent for routine blood test followed by fasting and post-prandial blood sugar level and digital OPG for dental condition. Fasting and post-prandial blood sugar were 231 mg/dl and 290mg/dl respectively *(Fig. 16)*.

Totality of symptoms – The symptoms considered for the analysis and evaluation of the case were done using Kentian approach.

- Bad effects after insult/indignation.
- Massive depression, lack of realization.
- Desires for cold drinks.
- Profuse clammy perspiration in face.
- Frequent urination with burning in urethra.
- Yellowish discoloration of teeth with dental caries.

Repertorization with remedial analysis and selection –

HOMPATH Zomeo pro version was consulted as the case presented with characteristic mental and physical general symptoms. *Staphysagria* (22/6), *Mercurius* (22/6), *Arsenicum album* (21/6), *Lycopodium* (21/6), *Nux vomica* (20/6) and *Silicea* (20/6) were the medicines in the top gradation *(Fig. 17)*. *Staphysagria* and *Mercurius* covered most of the symptoms with highest gradation. But *Staphysagria* was selected as the medicine of choice in this case due to prominent symptomatology of following symptoms.

- Massive heartbreak due to insults, Silent anger, regrets, and depression.
- Burning in urethra when not micturating with increased frequency of urination.
- Dental caries with yellowish stain of the teeth aggravated by cold application.
- Desire for milk and cold food.

Remedy administration –

Initially two medicated globules (globule no – 20) of *Staphysagria* 10M was administered in 10 ml of distilled water. Staphysagria high potency (10M) has been selected as per S Close's guidelines [12] of choosing high potency in case of more prominent causative factors or events. It was advised to mix in ½ ounce of purified water and taken orally in the next day in empty stomach at early morning. This was followed by (Liquid placebo) LPL once daily, early morning in empty stomach for three subsequent weeks.

Follow-up and outcome –

Follow-ups were done at three weeks interval for initial two visits to record any complication or recurrence of old symptoms *(Table 5)*. Marked changes in symptomatology were elicited at the end of treatment with improved blood sugar levels *(Fig. 18)*.

CASE 1:

Table 1: Follow-up with timeline of Case-1:

Date	Symptomatology	Treatment	Justification
19th August, 2022 (First visit)	First visit. Frequent and involuntary micturition at night (3-4 times). Extreme fatigue and weakness. Loss of weight. B/L pedal oedema Patient was sent for CBC, FBS, PPBS.	*Uranium nitricum* 30 CH. Fractional doses, twice a day for seven days.	Based on symptom similarity.
29th August, 2022 (Follow-up 1)	Frequency improved (2-3times), but incontinence was present. Oedema not improved. Weakness present. Sciatic pain reduced.	Liquid placebo *(LPL)* for ten days once daily, in early morning and in empty stomach.	Patient was better.
9th September, 2022 (Follow-up 2)	Patient could hold urine up to a certain limit. Urination twice per night. No weight loss noticed. Pedal swelling reduced. Sciatic pain occurred occasionally.	*LPL* for ten days once daily, in early morning and in empty stomach.	Patient was improving.
23nd September, 2022 (Follow-up 3)	No complaints of incontinence were present. Used to Pass urine once at 4 am. No fatigue present. Pedal oedema markedly reduced. Sciatic pain slightly reduced.	*LPL* for ten days once daily, in early morning and in empty stomach.	Complaints were better so advised for placebo.
14th October, 2022 (Follow-up 4)	Sour eructation and waterbrash from mouth < eating, contradiction agg. Sciatica – difficulty in lying on right side, > warmth and walking, sweet and hot food desires, palms were hot. Urinary frequency once per night. No pedal oedema present.	*Lycopodium* 1M. Five globules (one dose) in early morning, in empty stomach. *Placebo* (two globules) once daily for next fourteen days.	Based on repertorization and re-case taking.

CASE 2:

Table -2: Follow-up with timeline of Case – 2:

Date	Symptomatology	Treatment	Justification
12nd December, 2022 (First visit)	First visit. Involuntary micturition on coughing. Burning soles; Burning of rectum after stool. Leg cramps < night, first motion Patient was sent for HbA1C and ABG profile.	*Sulphur* 30 CH. Five globules once daily for two days, in empty stomach. *Placebo* (two globules) once daily for next fourteen days.	Based on symptom similarity.
9th January, 2023 (Follow-up 1)	Incontinence was still present. Burnings were reduced. Intensity of leg cramp slightly reduced. HbA1C profile suggests high titre.	*LPL* (Liquid placebo) for fifteen days to be taken once daily, in early morning and in empty stomach.	Patient was slightly better.
24th January, 2023 (Follow-up 2)	Incontinence of urine not markedly reduced. Intermittently burnings were present. Leg cramp persisted.	*Insulinum* 200 CH. Five globules (one dose) in morning. *Placebo* (two globules) once daily for next fourteen days.	Progressive amelioration stopped, Insulinum used as intercurrent medicine as patient was fatty and history of diarrhoea and liver disease were present.
8th February, 2023 (Follow-up 3)	Urinary incontinence reduced. No burning of sole was present. Rectal burning was still present occasionally. Leg cramps occasionally.	*LPL* for fourteen days once daily, in early morning and in empty stomach.	Complaints were better so advised for placebo.
21st February, 2023 (Follow-up 4)	Patient could hold urine after last medicine. No burning was present. Leg cramps mostly after extreme exertion. Quality of overall health was improved.	*LPL* for fourteen days once daily, in early morning and in empty stomach.	Marked improvements were seen.

CASE 3:

Table- 3: Follow-up with timeline of Case – 3:

Date	Symptomatology	Treatment	Justification
28th September 2022 (First visit)	Patient came up with multiple carious teeth and toothache < at night, while chewing. Offensive mouth breath. Ulceration of tongue. Frequent and very offensive micturition. Advised for FBS, PPBS and Lipid profile.	*Placebo* (two globules) once daily for next fourteen days.	Patient was under a lot of medication.
21st October, 2022 (Follow-up 1)	Complaints same as before. Ofensiveness in urine and from mouth was very marked. Gum bleeding was present. FBS and PPBS shows high blood sugar level.	*Nitricum acidum* 0/1 14 doses. One dose mixed with 30 ml of water and two tsf to be taken every morning.	Based on symptom similarity.
4th November, 2022 (Follow-up 2)	Ulcerated area became little healthy. Intensity of toothache reduced slightly. Gum bleeding was checked.	*Nitricum acidum* 0/2 14 doses. One dose mixed with 30 ml of water and two tsf to be taken every morning.	Patient was better.
18th November, 2022 (Follow-up 3)	Toothache only while chewing. Gum bled thrice in last 2 weeks. Urinary frequency reduced.	Liquid placebo, once daily, in morning and empty stomach for one month.	Patient was improving.
16 December, 2022 (Follow-up 4)	No episodes of gum bleeding was present. Offensiveness of urine vanished, but offesnsive halitosis was still present. Tongue ulcer totally healed.	Liquid placebo, once daily, in morning and empty stomach for one month.	Complaints were better so advised for placebo.
20th January, 2023 (Follow-up 5)	Toothache intolerable at night with offensive mouth breath > warm drinks. Marked thirst was present with flabby tongue. Salivation at night. Urinay frequency same.	*Mercurius* 200 CH. Five globules (one dose) in early morning.	Based on re-case taking.
03th February, 2023 (Follow-up 6)	Toothache markedly reduced. No gum bleeding was present. Offensiveness of breath reduced. Urine frequency reduced to normal. Patient was overall improved.	*LPL* for fourteen days once daily, in early morning and in empty stomach.	Patient was markedly better.

CASE 4:

Table 4: Follow-up with timeline of Case – 4:

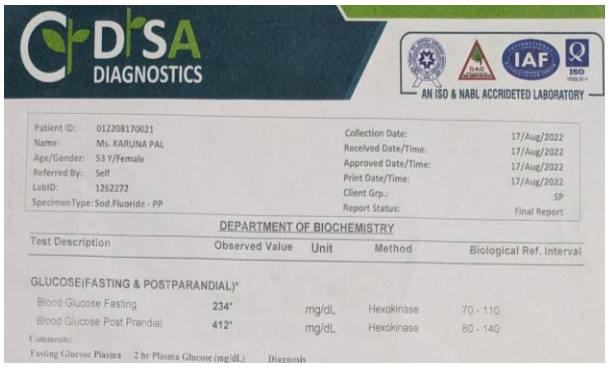
Date	Symptomatology	Treatment	Justification
23rd November, 2022 (First visit)	Frequent urination, cannot hold urge, consipation with rectal burning, itching eruption on skin < night > cold application, right knee joint pain and vertigo.	*Natrum muriaticum* 200 CH. One dose (five globules) in early morning followed by placebo once daily for two weeks.	Based on case taking and symptom similarity.
7th December, 2022 (Follow-up 1)	Frequency of micturition was little reduced, skin eruption were same as earlier, burning of the rectum still present. No vertigo.	Liquid placebo (*LPL*) for four weeks once daily.	Patient was better than before.
4th January, 2023 (Follow-up 2)	Patient was able to hold the urge, Frequency of micturition was reduced. Rectal burning was present and right knee pain slightly improved.	*Natrum muriaticum* 1M. One dose (five globules) in early morning followed by *LPL* for next four weeks once daily.	Higher potency was administered as no marked improvement of symptoms.
2nd February, 2023 (Follow-up 3)	Frequency and urgency of urination were improved but burning in rectum and itching on skin were still present.	*Sulphur* 200 CH. Five globules once daily for two days, in empty stomach, followed by *Placebo* for next four weeks, once daily.	New medicine was selected after reconsideration.
1st March, 2023 (Follow-up 4)	Itching improved, no rectal burning, hold urge of urine.	*LPL* for twenty-one days once daily.	Patient was improving.
29th March, 2023 (Follow-up 5)	Burning in rectum improved, Skin eruption was no more, no itching present. No complaints of incontinence. Intensity of right knee joint pain was improved.	*LPL* for twenty-one days once daily.	Complaints were better so advised for placebo.

CASE 5:

Table 5: Follow-up with timeline of Case – 5:

Date	Symptomatology	Treatment	Justification
18th April, 2023 (First visit)	First visit. Frequent micturition with burning at urethra. Massive depression from insults, silent anger. Dental caries, toothache < cold. Yellowish sordes. Desire for milk, cold food.	*Staphysagria* 10M. One dose (five globules) in early morning, in very next day. Diabetic diet was suggested.	Based on symptom similarity.
30th April, 2023 (Follow-up 1)	Frequency improved and sometimes burning was present. Extraction of tooth was suggested after blood glucose level shows massive improvement.	Liquid placebo *(LPL)* for fourteen days once daily, in early morning and in empty stomach.	Patient was doing better.
21st May, 2023 (Follow-up 2)	Urination twice per night. No incident of burning in past three weeks. Low back pain was also started improving. Extraction of upper molar done.	*LPL* for fourteen days once daily, in early morning and in empty stomach.	Patient was improving. She was suggested post-operative managements.
11st June, 2023 (Follow-up 3)	Passed urine once only at midnight. Low back pain improved greatly. Dental complaints resolved. No toothache was present.	*LPL* for fourteen days once daily, in early morning and in empty stomach.	Complaints were better so advised for placebo.

CASE 1:


DISA DIAGNOSTICS
AN ISO & NABL ACCRIDETED LABORATORY

Patient ID: 012208170021
Name: Ms. KARUNA PAL
Age/Gender: 53 Y/Female
Referred By: Self
LabID: 1262272
SpecimenType: Sod.Fluoride - PP

Collection Date: 17/Aug/2022
Received Date/Time: 17/Aug/2022
Approved Date/Time: 17/Aug/2022
Print Date/Time: 17/Aug/2022
Client Grp.: SP
Report Status: Final Report

DEPARTMENT OF BIOCHEMISTRY

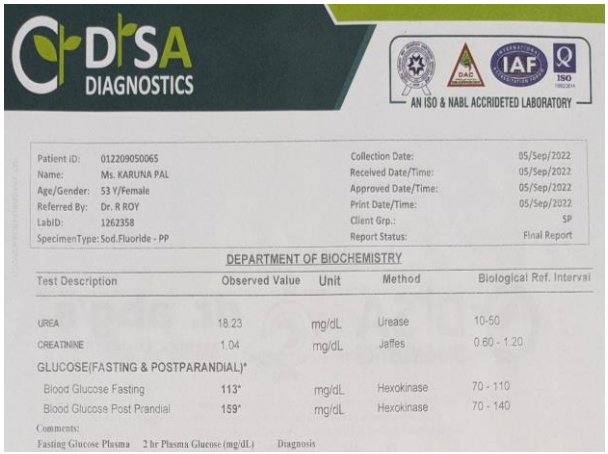
Test Description	Observed Value	Unit	Method	Biological Ref. Interval
GLUCOSE(FASTING & POSTPARANDIAL)*				
Blood Glucose Fasting	234*	mg/dL	Hexokinase	70 - 110
Blood Glucose Post Prandial	412*	mg/dL	Hexokinase	80 - 140

Comments:
Fasting Glucose Plasma 2 hr Plasma Glucose (mg/dL) Diagnosis

Figure 1: Pre-treatment Blood glucose level

Remedy	Lyc	Calc	Bry	Ars	Sep	Phos	Puls	Sulph	Merc	Bell	Rhus-t	Ferr	Carb-v	Nat-m	Con
Totality	26	20	18	18	18	17	17	17	16	15	15	15	14	14	14
Symptoms Covered	7	6	7	6	6	5	5	5	6	6	6	5	6	6	5
[Complete] [Mind]Fear:Alone, being:	4	3	1	4	3	4	3	0	3	3	1	0	1	1	3
[Complete] [Mind]Anger:Contradiction, from:	4	0	3	1	4	0	0	3	1	1	0	4	0	1	1
[Complete] [Generalities]Food and drinks:Oysters:Agg.:	4	2	3	0	0	0	4	0	0	3	1	0	3	0	0
[Complete] [Bladder]Involuntary urination:Night, incontinence in bed:	4	4	3	4	4	3	4	4	3	4	4	4	4	4	3
[Complete] [Sleep]Unrefreshing:	4	4	4	3	4	4	3	4	3	3	3	2	3	3	4
[Complete] [Extremities]Swelling:Ankles:	4	4	1	3	1	3	3	4	4	1	3	3	1	3	0
[Kent] [Generalities]Weakness,enervation (see lassitude,weariness):Exertion,from slight:Agg:	2	3	3	3	2	3	0	2	2	0	3	2	2	2	3

Figure 2: Repertorial analysis (Case -1)


DISA DIAGNOSTICS
AN ISO & NABL ACCRIDETED LABORATORY

Patient ID: 012209050065
Name: Ms. KARUNA PAL
Age/Gender: 53 Y/Female
Referred By: Dr. R ROY
LabID: 1262358
SpecimenType: Sod.Fluoride - PP

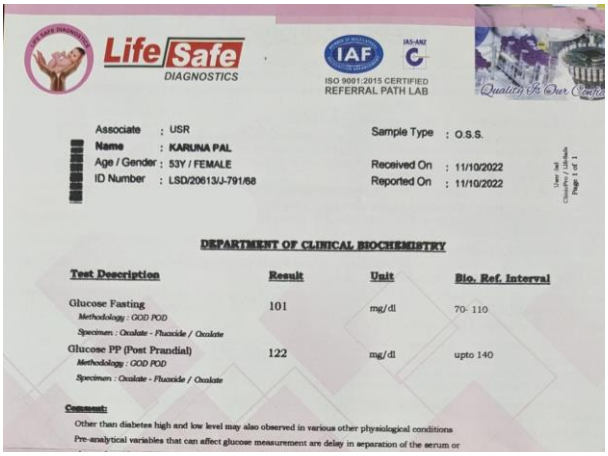
Collection Date: 05/Sep/2022
Received Date/Time: 05/Sep/2022
Approved Date/Time: 05/Sep/2022
Print Date/Time: 05/Sep/2022
Client Grp.: SP
Report Status: Final Report

DEPARTMENT OF BIOCHEMISTRY

Test Description	Observed Value	Unit	Method	Biological Ref. Interval
UREA	18.23	mg/dL	Urease	10-50
CREATININE	1.04	mg/dL	Jaffes	0.60 - 1.20
GLUCOSE(FASTING & POSTPARANDIAL)*				
Blood Glucose Fasting	113*	mg/dL	Hexokinase	70 - 110
Blood Glucose Post Prandial	159*	mg/dL	Hexokinase	70 - 140

Comments:
Fasting Glucose Plasma 2 hr Plasma Glucose (mg/dL) Diagnosis

Figure 3: Blood glucose level status after one month of treatment


LifeSafe DIAGNOSTICS
ISO 9001:2015 CERTIFIED REFERRAL PATH LAB
Quality Is Our Clarity

Associate : USR
Name : KARUNA PAL
Age / Gender : 53Y / FEMALE
ID Number : LSD/20613/J-791/68

Sample Type : O.S.S.
Received On : 11/10/2022
Reported On : 11/10/2022

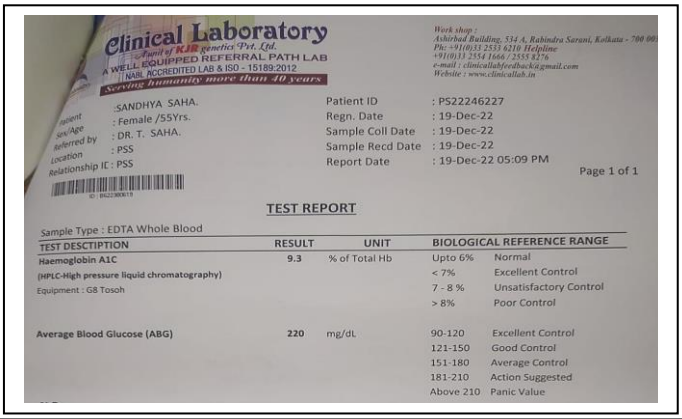
DEPARTMENT OF CLINICAL BIOCHEMISTRY

Test Description	Result	Unit	Bio. Ref. Interval
Glucose Fasting Methodology : GOD POD Specimen : Oxalate - Fluoride / Oxalate	101	mg/dl	70- 110
Glucose PP (Post Prandial) Methodology : GOD POD Specimen : Oxalate - Fluoride / Oxalate	122	mg/dl	upto 140

Comment:
Other than diabetes high and low level may also observed in various other physiological conditions
Pre-analytical variables that can affect glucose measurement are delay in separation of the serum or

Figure 4: Blood glucose level status after two months of treatment

CASE 2:



Clinical Laboratory
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NABL ACCREDITED LAB & ISO - 15189:2012
Serving humanity more than 40 years

Work shop : Ashirbad Building, 534 A, Rabindra Sarani, Kolkata - 700 006
Ph: +91(0)33 2553 6210 Helpline +91(0)33 2554 1666 / 2555 8276
e-mail : clinicallabfeedback@gmail.com
Website : www.clinicallab.in

Patient :SANDHYA SAHA.
Sex/Age : Female /55Yrs.
Referred by : DR. T. SAHA.
Location : PSS
Relationship IC : PSS

Patient ID : PS22246227
Regn. Date : 19-Dec-22
Sample Coll Date : 19-Dec-22
Sample Recd Date : 19-Dec-22
Report Date : 19-Dec-22 05:09 PM

Page 1 of 1

TEST REPORT

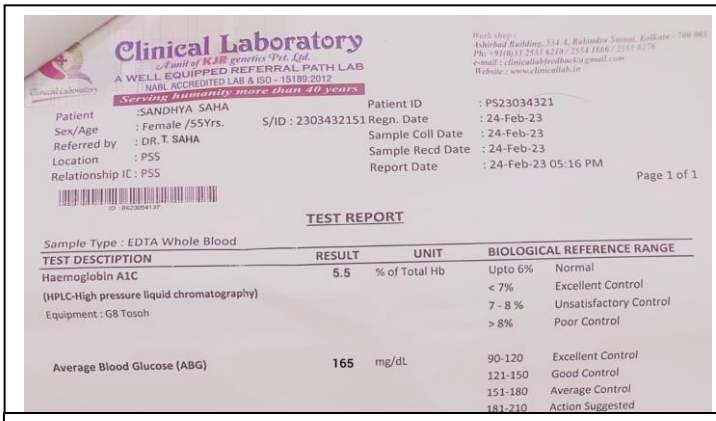
Sample Type : EDTA Whole Blood

TEST DESCTIPTION	RESULT	UNIT	BIOLOGICAL REFERENCE RANGE	
Haemoglobin A1C	9.3	% of Total Hb	Upto 6%	Normal
(HPLC-High pressure liquid chromatography)			< 7%	Excellent Control
Equipment : G8 Tosoh			7 - 8 %	Unsatisfactory Control
			> 8%	Poor Control
Average Blood Glucose (ABG)	220	mg/dL	90-120	Excellent Control
			121-150	Good Control
			151-180	Average Control
			181-210	Action Suggested
			Above 210	Panic Value

Figure 5: HbA1C and ABG profile prior to treatment

Remedy	Sulph	Lyc	Phos	Nit-ac	Puls	Calc	Thuj	Nux-v	Merc	Sil	Sep	Rhus-t	Bry	Kali-c	Nat-m
Totality	36	29	27	26	26	26	25	25	24	24	23	23	23	23	22
Symptoms Covered	13	11	11	10	10	9	11	10	9	9	11	9	8	8	10
[Complete] [Mind]Contradiction:Ailments from, agg.:	3	4	1	3	1	1	3	3	3	3	4	1	3	0	3
[Complete] [Mind]Confidence:Want of self:	1	4	1	1	3	3	4	1	1	4	1	2	3	3	3
[Complete] [Mind]Restlessness, nervousness:	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
[Complete] [Mind]Fear:Disease, of:	4	1	4	3	3	4	1	4	1	1	3	1	1	4	1
[Complete] [Generalities]Food and drinks:Sweets:Desires:	4	4	3	3	3	4	3	1	3	1	3	3	3	4	1
[Complete] [Generalities]Food and drinks:Cold:Drinks:Desires:	3	3	4	1	3	3	3	3	4	3	3	4	4	1	3
[Complete] [Generalities]Food and drinks:Spices, condiments, piquant, highly seasoned food:Agg.:	3	1	2	0	0	0	1	4	0	0	1	0	0	0	0
[Murphy] [Food]Oily, foods:Agg.:	1	0	0	0	3	0	0	0	0	0	0	0	1	0	2
[Allen] [S]Scalp:Sweat:	1	0	1	2	2	0	0	1	1	3	1	0	0	1	1
[Gentry] [Urine and Urinary Organs]Involuntary:Discharge of urine:When coughing:	1	0	1	0	1	0	1	0	0	0	1	0	0	0	1
[Complete] [Rectum]Pain:Burning, smarting:Stool:After:	4	3	3	4	3	3	3	3	3	4	1	1	4	3	3
[Complete] [Extremities]Pain:Legs:Night:Agg.:	3	1	3	4	0	0	1	1	4	0	1	4	0	3	0
[Murphy] [Legs]Pain, legs:Move, beginning to:	0	3	0	1	0	1	1	0	0	0	0	3	0	0	0
[Complete] [Extremities]Pain:Burning, smarting:Feet:Soles:Night:	4	1	0	0	0	3	0	0	0	1	0	0	0	0	0

Figure 6: Repertorial analysis (Case – 2)



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Work shop : Ashirbad Building, 534 A, Rabindra Sarani, Kolkata - 700 006
Ph: +91(0)33 2553 6210 / 2554 1666 / 2555 8276
e-mail : clinicallabfeedback@gmail.com
Website : www.clinicallab.in

Patient :SANDHYA SAHA
Sex/Age : Female /55Yrs.
Referred by : DR. T. SAHA
Location : PSS
Relationship IC : PSS

S/ID : 2303432151

Patient ID : PS23034321
Regn. Date : 24-Feb-23
Sample Coll Date : 24-Feb-23
Sample Recd Date : 24-Feb-23
Report Date : 24-Feb-23 05:16 PM

Page 1 of 1

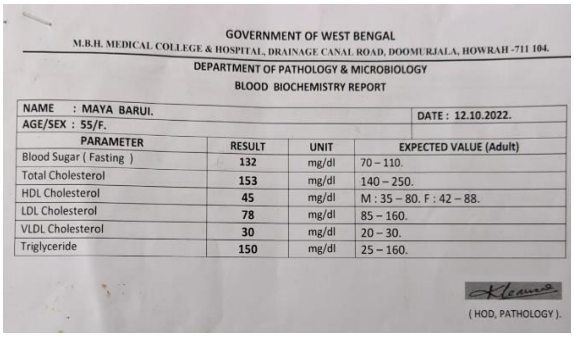
TEST REPORT

Sample Type : EDTA Whole Blood

TEST DESCTIPTION	RESULT	UNIT	BIOLOGICAL REFERENCE RANGE	
Haemoglobin A1C	5.5	% of Total Hb	Upto 6%	Normal
(HPLC-High pressure liquid chromatography)			< 7%	Excellent Control
Equipment : G8 Tosoh			7 - 8 %	Unsatisfactory Control
			> 8%	Poor Control
Average Blood Glucose (ABG)	165	mg/dL	90-120	Excellent Control
			121-150	Good Control
			151-180	Average Control
			181-210	Action Suggested

Figure 7*:* HbA1C and ABG profile after treatment

CASE 3:

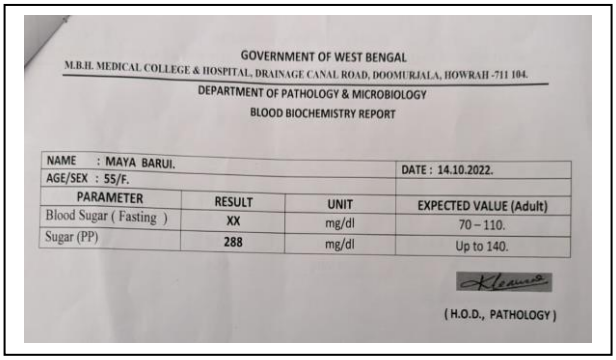


GOVERNMENT OF WEST BENGAL
M.B.H. MEDICAL COLLEGE & HOSPITAL, DRAINAGE CANAL ROAD, DOOMURJALA, HOWRAH -711 104.
DEPARTMENT OF PATHOLOGY & MICROBIOLOGY
BLOOD BIOCHEMISTRY REPORT

NAME : MAYA BARUI. DATE : 12.10.2022.
AGE/SEX : 55/F.

PARAMETER	RESULT	UNIT	EXPECTED VALUE (Adult)
Blood Sugar (Fasting)	132	mg/dl	70 – 110.
Total Cholesterol	153	mg/dl	140 – 250.
HDL Cholesterol	45	mg/dl	M : 35 – 80. F : 42 – 88.
LDL Cholesterol	78	mg/dl	85 – 160.
VLDL Cholesterol	30	mg/dl	20 – 30.
Triglyceride	150	mg/dl	25 – 160.

(HOD, PATHOLOGY).



GOVERNMENT OF WEST BENGAL
M.B.H. MEDICAL COLLEGE & HOSPITAL, DRAINAGE CANAL ROAD, DOOMURJALA, HOWRAH -711 104.
DEPARTMENT OF PATHOLOGY & MICROBIOLOGY
BLOOD BIOCHEMISTRY REPORT

NAME : MAYA BARUI. DATE : 14.10.2022.
AGE/SEX : 55/F.

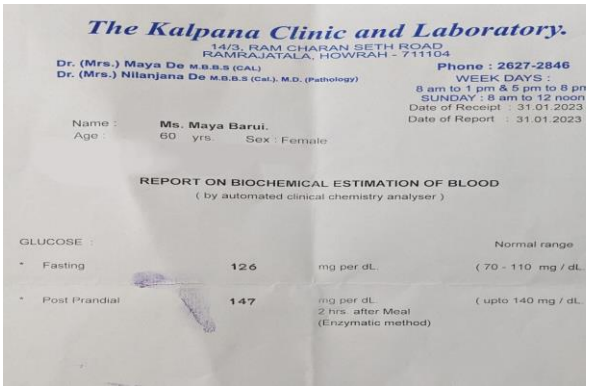
PARAMETER	RESULT	UNIT	EXPECTED VALUE (Adult)
Blood Sugar (Fasting)	XX	mg/dl	70 – 110.
Sugar (PP)	288	mg/dl	Up to 140.

(H.O.D., PATHOLOGY)

Figure 8 & 9: Fasting and post-prandial blood glucose level prior to treatment

Remedy	Nit-ac	Merc	Staph	Sulph	Bry	Lyc	Nux-v	Calc	Sil	Puls	Phos	Ars	Lach	Nat-m	Carb-v
Totality	39	34	33	33	32	31	28	28	27	27	27	26	26	26	26
Symptoms Covered	12	11	11	11	11	9	11	10	11	10	9	11	10	10	9
[Complete] [Mind]Anger:Violent:	4	1	4	3	3	3	4	3	1	1	3	3	1	3	4
[Complete] [Mind]Anger:Mistakes, about one's:	3	0	3	3	1	0	1	0	0	0	0	1	0	0	0
[Complete] [Mind]Fear:Death, of:	4	4	3	3	4	3	4	4	1	4	4	4	4	3	3
[Complete] [Mind]Contradiction:Ailments from, agg.:	3	3	3	3	3	4	3	1	3	1	1	1	3	3	1
[Complete] [Generalities]Food and drinks:Sweets:Desires:	3	3	3	4	3	4	1	4	1	3	3	1	1	1	3
[Complete] [Rectum]Pain:Burning, smarting:Stool:After:	4	3	3	4	4	3	3	3	4	3	3	4	3	3	3
[Murphy] [Head]Perspiration, scalp:	2	3	1	1	3	2	1	3	3	3	3	1	1	1	2
[Complete] [Mouth]Ulcers:Tongue:Edges:	4	4	0	0	0	0	0	3	2	0	0	3	3	0	0
[Complete] [Teeth]Pain, toothache:Night:Agg.:	3	4	4	4	3	4	3	3	4	4	4	3	3	3	3
[Complete] [Teeth]Pain, toothache:Chewing:Agg.:	4	4	4	3	4	4	3	1	3	3	3	1	3	4	3
[Complete] [Mouth]Offensive odor:	4	4	4	4	3	4	4	3	4	4	3	4	4	4	4
[Gentry] [Mouth]Pain:In decayed hollow teeth:	1	1	1	1	1	0	1	0	1	1	0	0	0	1	0

Figure 10: Repertorial analysis (Case – 3)



The Kalpana Clinic and Laboratory.
14/3, RAM CHARAN SETH ROAD
RAMRAJATALA, HOWRAH - 711104
Dr. (Mrs.) Maya De M.B.B.S (Cal.)
Dr. (Mrs.) Nilanjana De M.B.B.S (Cal.), M.D. (Pathology)
Phone : 2627-2846
WEEK DAYS :
8 am to 1 pm & 5 pm to 8 pm
SUNDAY : 8 am to 12 noon
Date of Receipt : 31.01.2023
Date of Report : 31.01.2023

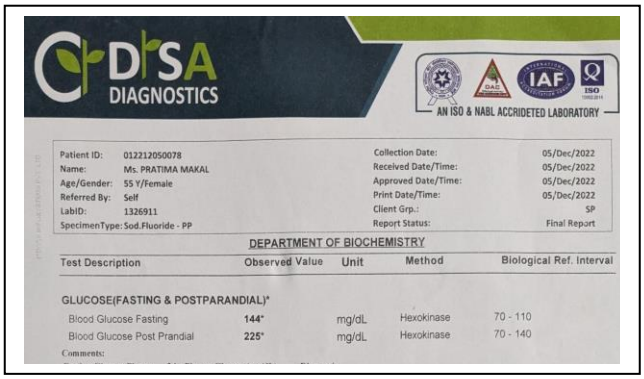
Name : Ms. Maya Barui.
Age : 60 yrs. Sex : Female

REPORT ON BIOCHEMICAL ESTIMATION OF BLOOD
(by automated clinical chemistry analyser)

GLUCOSE :			Normal range
* Fasting	126	mg per dL	(70 - 110 mg / dL
* Post Prandial	147	mg per dL 2 hrs. after Meal (Enzymatic method)	(upto 140 mg / dL

Figure 11: Fasting and post-prandial blood glucose level after treatment

CASE 4:


DISA DIAGNOSTICS
AN ISO & NABL ACCRIDETED LABORATORY

Patient ID: 012212050078
Name: Ms. PRATIMA MAKAL
Age/Gender: 55 Y/Female
Referred By: Self
LabID: 1326911
SpecimenType: Sod.Fluoride - PP

Collection Date: 05/Dec/2022
Received Date/Time: 05/Dec/2022
Approved Date/Time: 05/Dec/2022
Print Date/Time: 05/Dec/2022
Client Grp.: SP
Report Status: Final Report

DEPARTMENT OF BIOCHEMISTRY

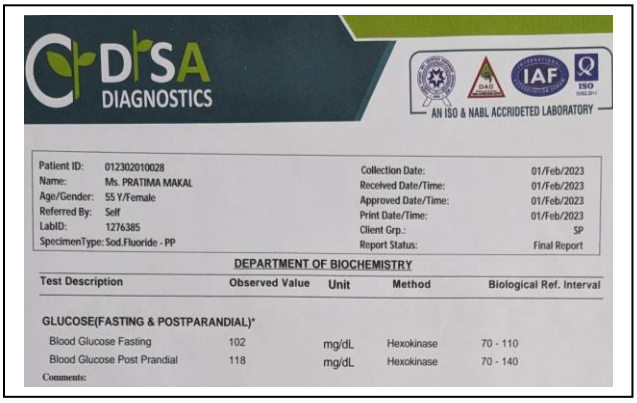
Test Description	Observed Value	Unit	Method	Biological Ref. Interval
GLUCOSE(FASTING & POSTPARANDIAL)*				
Blood Glucose Fasting	144*	mg/dL	Hexokinase	70 - 110
Blood Glucose Post Prandial	225*	mg/dL	Hexokinase	70 - 140

Comments:

Figure 12: Blood glucose level before treatment

Remedy	Nat-m	Sil	Sep	Sulph	Calc	Thuj	Ars	Merc	Rhus-t	Lyc	Phos	Ign	Nit-ac	Nux-v	Cham
Totality	32	32	31	31	30	29	29	29	29	27	27	27	27	26	26
Symptoms Covered	11	11	11	10	12	11	10	10	10	11	10	9	9	9	8
[Complete] [Mind]Weeping, tearful mood:	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
[Complete] [Mind]Company:Aversion to:	4	3	4	3	3	3	4	3	4	4	3	4	0	4	4
[Complete] [Mind]Consolation, sympathy:Ailments from, agg.:	4	4	4	3	3	3	3	1	1	1	3	4	3	1	4
[Murphy] [Mind]Restlessness, mental, (see Hurried, Impatient):	2	3	3	3	3	2	4	4	4	3	2	2	2	2	2
[Complete] [Generalities]Food and drinks:Salt or salty food:Desires:	4	1	3	3	3	3	0	1	0	1	4	0	4	0	0
[Murphy] [Clinical]Colds, tendency to catch:	3	3	3	2	3	3	2	3	2	3	3	1	3	3	3
[Complete] [Mouth]Indented:Tongue:	1	0	3	0	1	1	4	4	4	1	0	3	1	1	0
[Complete] [Rectum]Constipation:Insufficient, incomplete, unsatisfactory stools:	4	4	4	4	1	3	1	0	3	3	1	3	4	4	3
[Complete] [Back]Perspiration:Profuse:	0	3	0	0	2	0	0	0	0	0	0	0	0	0	0
[Murphy] [Face]GREASY, face, (see Oily):	2	1	1	1	1	3	1	2	2	1	1	0	0	0	0
[Complete] [Skin]Itching:Night:	3	3	1	4	3	3	3	4	4	3	3	3	3	3	3
[Complete] [Vertigo]Stooping:Agg.:	1	3	1	4	3	1	3	3	1	3	3	3	3	4	3

Figure 13: Repertorial analysis (Case - 4)


DISA DIAGNOSTICS
AN ISO & NABL ACCRIDETED LABORATORY

Patient ID: 012302010028
Name: Ms. PRATIMA MAKAL
Age/Gender: 55 Y/Female
Referred By: Self
LabID: 1276385
SpecimenType: Sod.Fluoride - PP

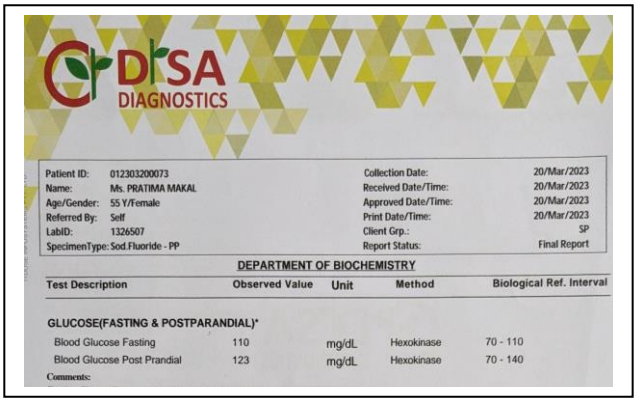
Collection Date: 01/Feb/2023
Received Date/Time: 01/Feb/2023
Approved Date/Time: 01/Feb/2023
Print Date/Time: 01/Feb/2023
Client Grp.: SP
Report Status: Final Report

DEPARTMENT OF BIOCHEMISTRY

Test Description	Observed Value	Unit	Method	Biological Ref. Interval
GLUCOSE(FASTING & POSTPARANDIAL)*				
Blood Glucose Fasting	102	mg/dL	Hexokinase	70 - 110
Blood Glucose Post Prandial	118	mg/dL	Hexokinase	70 - 140

Comments:

Figure 14: FBS and PPBS level at the end of two months of treatment


DISA DIAGNOSTICS

Patient ID: 012303200073
Name: Ms. PRATIMA MAKAL
Age/Gender: 55 Y/Female
Referred By: Self
LabID: 1326507
SpecimenType: Sod.Fluoride - PP

Collection Date: 20/Mar/2023
Received Date/Time: 20/Mar/2023
Approved Date/Time: 20/Mar/2023
Print Date/Time: 20/Mar/2023
Client Grp.: SP
Report Status: Final Report

DEPARTMENT OF BIOCHEMISTRY

Test Description	Observed Value	Unit	Method	Biological Ref. Interval
GLUCOSE(FASTING & POSTPARANDIAL)*				
Blood Glucose Fasting	110	mg/dL	Hexokinase	70 - 110
Blood Glucose Post Prandial	123	mg/dL	Hexokinase	70 - 140

Comments:

Figure 15: FBS and PPBS level at the end of four months of treatment

CASE 5:

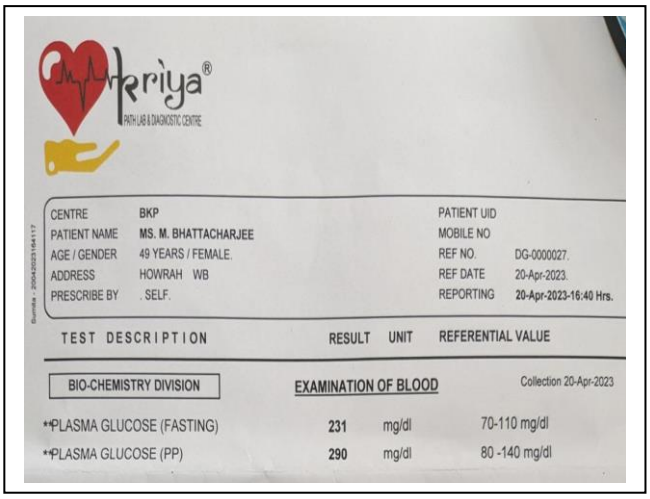


Figure 16: Blood glucose level prior to treatment

Remedy	Merc	Staph	Ars	Lyc	Nux-v	Sil	Thuj	Phos	Rhus-t	Bell	Calc	Cann-i	Nat-m	Puls	Sep
Totality	22	22	21	21	20	20	20	20	20	19	19	19	19	19	19
Symptoms Covered	6	6	6	6	6	6	6	5	5	5	5	5	5	5	5
[Kent] [Mind]Indignation:Bad effects following:	0	3	0	0	1	0	0	0	0	0	0	0	0	0	0
[Complete] [Mind]Psychological themes:Rationalizing, lack of feelings, depression:	4	4	4	4	4	3	4	4	4	4	4	4	4	4	4
[Complete] [Generalities]Food and drinks:Cold:Drinks:Desires:	4	3	4	3	3	3	3	4	4	3	3	4	3	3	3
[Complete] [Face]Perspiration:	4	4	4	4	4	4	3	4	4	4	4	4	4	4	4
[Complete] [Bladder]Urination:Frequent:	4	4	4	4	4	4	4	4	4	4	4	3	4	4	4
[Complete] [Urethra]Pain:Burning, smarting:	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
[Murphy] [Teeth]DISCOLORATION, teeth:Yellow:	2	0	1	2	0	2	2	0	0	0	0	0	0	0	0

Figure 17: Repertorial analysis (Case - 5)

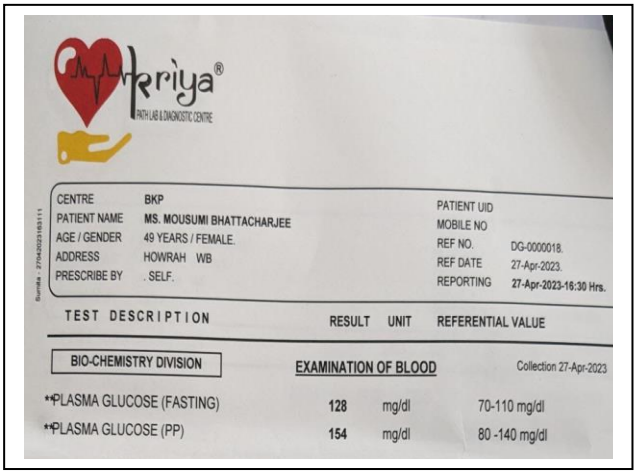


Figure 18: Blood glucose level after one week of treatment

Assessment of cases according to MONARCH: MODIFIED NARANJO CRITERIA (Fig. 19)

Q1 – Was there an improvement in the main symptom or condition for which the homeopathic medicine was prescribed?
Q2 – Did the clinical improvement occur within a plausible timeframe relative to the drug intake?
Q3 – Was there an initial aggravation of symptoms?
Q4 – Did the effect encompass more than the main symptom or condition ?
Q5 – Did overall well-being improve?
Q6 – Direction of cure: did some symptoms improve in the opposite order of the development of symptoms of the disease?
Q7 – Direction of cure: did at least two of the following aspects apply to the order of improvement of symptoms:

–from organs of more importance to those of less importance?
–from deeper to more superficial aspects of the individual?
–from the top downwards?

Q8 – Did "old symptoms" (defined as non-seasonal and non-cyclical symptoms that were previously thought to have resolved) reappear temporarily during improvement?
Q9 – Are there alternate causes (other than the medicine) that—with a high probability— could have caused the improvement?
Q10 – Was the health improvement confirmed by any objective evidence?
Q11 – Did repeat dosing, if conducted, create similar clinical improvement?

Evaluation of cases as per Modified Naranjio criteria

	1st case			2nd case			3rd case			4th case			5th case		
Domain	Yes	No	Not sure	Yes	No	Not sure	Yes	No	Not sure	Yes	No	Not sure	Yes	No	Not sure
Q1	2			2			2			2			2		
Q2	1			1			1			1			1		
Q3		0			0		1			1				0	
Q4	1			1			1			1			1		
Q5	1			1			1			1			1		
Q6			0		0			0			0				0
Q7		0		1			1			1				0	
Q8	1			1			1			1			1		
Q9		1			1			1			1			1	
Q10	2			2			2			2			2		
Q11		0			0			0			0			0	
Total	9			10			11			11			9		

Figure 19: Assessment of cases according to MONARCH: MODIFIED NARANJO CRITERIA

DISCUSSION:

Homoeopathy is an individualistic system of medicine. Here we treat patient with symptom similarity. Diabetes is a lifestyle disorder, where some maintaining causes are responsible for aetiology as well as carrying the disease through put the life. Homoeopathy, since the beginning proved itself as effective system of answer to this disease. When we found the aetiology of the

blood glucose increase in blood, we can see that various allopathic medications are responsible for the destruction of the Beta cell of pancreas. Homoeopathic medicines have no record of such. Replacement of those medicines with homoeopathy can save the destruction of Beta cell. More and more such cases will establish the claim of the glycaemic control of homoeopathy more profoundly and strongly. The use of individualized homoeopathic medicines, chosen based on homoeopathic principles, demonstrated exceptional therapeutic outcomes in these instances of hyperglycaemia. In accordance with the homoeopathic philosophy and the homoeopathic Materia Medica, different medicines were chosen applying Kentian approach (mental generals, particulars, and physical generals etc.). Medication was administered in minimum possible dosages, and it seemed to be highly successful in treating the patient as noticeable and quick recovery was observed. Potencies were selected as per theory of susceptibility [12] by Dr. S Close. This case series validated the efficacy of individualized homoeopathic medicines and supported the homoeopathic concept and principles. It may be shown how homoeopathy manage this kind of condition with very little dosage in a short amount of time without aggravating the condition or having any adverse side effects. Few limitations like inappropriate knowledge of disease, unawareness (not performing regular blood sugar tests), lethargy to continuing treatment, improper health facilities in the rural areas, too much medicine intake etc. can be considered.

CONCLUSION:

Although the above case series is a well-documented proof of controlling blood glucose level by individualised homoeopathic medicine, but more such strong cases or higher studies is needed to improve the concept. As we know placebo control studies in diabetes with IHM is a concern of ethical issue, so this type of case series will establish the pavement towards the EBM for diabetes cases in Homoeopathy.

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