
HOMOEOPATHY MANAGEMENT OF MALE INFERTILITY: A CASE SERIES

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ABSTRACT

Male infertility is commonly associated with abnormalities in semen parameters, including liquefaction time, semen volume, sperm concentration and sperm motility. This case series describes changes in these parameters in three men following individualized homoeopathic treatment. Cases were assessed through detailed case-taking and serial semen analysis, with semen volume, liquefaction time, sperm concentration and motility recorded at baseline and during follow-up. Rapid progressive motility rose from 30% to 50% in Case 2; sperm concentration rose from 10 to 39 million/mL and semen volume from 1.0 to 1.3 mL in Case 3; and liquefaction time shortened from more than 1 hour to 5 minutes in Case 1, whose partner conceived during follow-up. Symptomatic improvement was documented only in Case 1. Because of the small number of cases, the absence of a control group and possible confounding, these observations are hypothesis-generating only; larger controlled studies are required to establish effectiveness.

KEYWORDS: Male infertility; Semen analysis; Sperm motility; Semen volume; Liquefaction time; Homoeopathy; Case series.

INTRODUCTION

Male factor infertility involves abnormalities in sperm production, concentration, motility or

morphology, and contributes solely or jointly to approximately 40% to 50% of infertility in couples worldwide.¹ Infertility itself affects roughly 10% to 15% of couples.¹ Endocrine imbalances, varicocele, oxidative stress and lifestyle factors are among the recognised contributors to reduced sperm quality.¹ Despite this burden, male reproductive health has historically received less clinical emphasis, often placing a disproportionate diagnostic burden on female partners. Reported declines in average sperm concentration, motility and morphology across populations have been attributed to lifestyle stressors, environmental and occupational exposures and metabolic dysfunction, and male infertility is increasingly regarded as a public health concern requiring systematic, evidence-based management.¹

At the physiological level, male fertility depends on neuroendocrine regulation, uninterrupted spermatogenesis, epididymal maturation and an adequate seminal fluid composition. Disruption along this pathway manifests as oligozoospermia, asthenozoospermia, teratozoospermia, or combined oligoasthenoteratozoospermia (OAT). Assisted reproductive technologies (ART), such as in vitro fertilization (IVF) and intracytoplasmic sperm injection (ICSI), offer mechanical routes to conception but are costly, invasive and psychologically demanding, and many couples therefore seek non-invasive and safe alternatives.¹

Homoeopathy is based on the principle of Similia Similibus Curentur (like cures like) and on individualization: remedies are selected from the complete symptom picture, including physical generals, constitutional and thermal features, and mental and emotional characteristics alongside pathological parameters. Homoeopathic philosophy interprets reduced sperm parameters as local expressions of a broader systemic or miasmatic disturbance. Individualized homoeopathic treatment of male infertility and infertility in general has been described in earlier reports and case series.^{2,3} This case series documents the clinical course and semen parameters of three men with infertility treated with individualized homoeopathic remedies. The cases are reported with reference to the CARE guideline and its homoeopathic supplement, HOM-CASE,⁴ and causal attribution was assessed with the Modified Naranjo Criteria for Homeopathy (MONARCH).⁵

AIM

To describe the clinical outcomes of individualized homoeopathic management in patients with male infertility through systematic documentation of clinical symptoms and seminal parameters.

OBJECTIVES

- To document the baseline clinical and seminal characteristics of patients with male infertility.
- To assess changes in semen parameters following individualized homoeopathic management.
- To evaluate changes in infertility-related symptoms during treatment.
- To document the individualized prescribing process and clinical response at follow-up.

MATERIALS AND METHODS

Study design: Retrospective, non-randomized, observational case series, with data compiled from outpatient records

Study Setting:

Location: Outpatient Department (OPD) of Sarada krishna Homoeopathic Medical College & Hospital.

Duration: Variable across cases; follow-up was approximately 7 months in Case 1, 3 months in case 2 and 9.5 months in Case 3

Inclusion Criteria

- Male patients aged 21 to 50 years with confirmed primary or secondary infertility presenting with abnormal findings on laboratory semen analysis.
- Documented abnormal semen analysis, including oligozoospermia, asthenozoospermia, teratozoospermia, low semen volume, delayed liquefaction or altered consistency, or combined defects.
- Absence of complete anatomical blockages (e.g., bilateral ductal obstruction or severe irreversible physical defects requiring immediate surgical intervention).
- Informed consent provided to participate in the study and maintain prescribed follow-up schedules.

Exclusion criteria

- Obstructive Causes: Complete blockage of the vas deferens or ejaculatory ducts.
- Genetic Defects: Chromosomal conditions such as Klinefelter syndrome or Y-chromosome microdeletions.
- Active Infections: Severe or active pelvic and genitourinary tract infections (e.g., prostatitis, epididymitis).

- Gonadotoxic History: Recent or current chemotherapy, pelvic radiation therapy, or ongoing hormone treatments.
- Non-Compliance: Inability or unwillingness to complete regular follow-ups and repeat laboratory evaluations.

Ethics and consent

Consent obtained from all the 3 patients

Case taking Procedure

A comprehensive homoeopathic consultation (physical generals, mental generals, miasmatic analysis, life history and clinical examination) was conducted. Case taking was carried out together with semen analysis at the first visit. After analysis and evaluation of symptoms, the characteristic symptoms were considered for framing the totality. Further, based on repertorial analysis and consultation of the homoeopathic Materia Medica, the most suitable medicine was prescribed. Patients were advised to report at specific intervals to assess the effects of the medicine and to repeat semen analysis during follow-up. Clinical progress and treatment outcomes were assessed with a focus on symptomatology and semen analysis. Outcome assessment and causal attribution of clinical changes were done using the Modified Naranjo Criteria for Homeopathy (MONARCH).⁵

Baseline Assessment

Semen analysis was performed at baseline and the WHO semen parameters (volume, sperm concentration, progressive motility, total motility, morphology and vitality) were recorded as available in the laboratory reports. Results were interpreted against the reference limits of the WHO laboratory manual, 6th edition (2021).⁶ Where laboratory reports used the 5th edition (2010) grading,⁷ such as "rapid progressive" (grade a) motility, that terminology is retained and stated. Causal attribution was scored with MONARCH.

Prescription & Posology

An individualized remedy was administered in centesimal (C) or 50-millesimal (LM) potencies based on patient susceptibility and disease intensity. In one case (Case 1), different remedies were prescribed in sequence, as documented in the case summary.

Follow-Up Protocol

Monthly Follow-ups: Assessment of subjective symptoms, well-being, and constitutional

responses.

Semen re-evaluation was planned every 3 months (at Follow-up 1 and Follow-up 2) to track parameter trajectories against baseline measurements. In practice, the number and timing of repeat analyses varied between cases.

Outcome Evaluation

Comparison of quantitative laboratory values (semen volume, liquefaction time, sperm concentration and progressive motility) and of presenting symptoms between baseline and follow-up, together with the partner's pregnancy outcome where applicable. Quality of life was not formally assessed.

SUMMARY OF CASES

CASE 1

A 42-year-old man with longstanding infertility of approximately 10 years. He reported that ejaculation lasts about 10 minutes and that the penis became flaccid only on the 5th day after 4 days of continuous intercourse. Snoring was an associated complaint. He took allopathy Medication for priapism but got no relief. General condition was comparatively satisfactory; height was approximately 157.5 cm and weight approximately 70.8 kg (BMI about 28.5 kg/m², overweight range). Case taking covered appetite, thirst, bowel and urinary habits, sleep, sweating, mental and constitutional features and the sexual history. A totality was constructed and the remedy selected. Cantharis, Lycopodium and Sulphur are recorded as appearing repeatedly in the treatment record. A semen analysis report dated 16 February 2024 recorded a volume of about 1.5 mL, semi-solid consistency, greyish-white colour, liquefaction time of more than 1 hour (not liquefied) and pH about 9. Sperm concentration was about 140 million/mL, above the WHO lower reference limit of 16 million/mL. Motility was about 45% active, 20% sluggish and 35% non-motile (total motility about 65%), and morphology about 80% normal and 20% abnormal forms. Agglutination was not seen. A second report dated 16 May 2024 recorded a sperm concentration of about 110 million/mL, with similar motility and morphology, and a liquefaction time of 5 minutes. Concentration, motility and morphology were therefore within WHO reference limits on both reports, and the main abnormalities were the semi-solid consistency, delayed liquefaction and alkaline pH in the first report. The concentration was lower in the second report (140 to 110 million/mL), although still well above the reference limit.

The follow-up extended over several months. Prescriptions comprised Cantharis 200 in the 1st

week, followed by Lycopodium 200 in the 2nd week and Sabal serrulata 200 in the 3rd week, with Nuphar luteum Q (30 mL). The same prescription was continued for the subsequent 4 months. In the 6th month the patient's complaint was better and the semen consistency was thick, and he was given placebo (sac lac). In the 7th month his wife conceived. Because four remedies were prescribed in sequence, the outcome cannot be attributed to a single individualized remedy.

CASE 2

A 26-year-old man presented with pricking pain in the left scrotum, premature seminal emission, recurrent sexual dreams and nocturnal seminal emissions. Baseline semen analysis showed a volume of 2 mL, liquefaction time of 45 minutes and sperm concentration of 9 million/mL. The parameter considered most important was progressive motility; the report grades it as "rapid progressive" motility (WHO 5th edition terminology), which was 30% at baseline. The patient was prescribed Lycopodium200 and followed periodically with clinical assessment and repeat semen analysis. The medicine was repeated every week for about 3months.

At the first follow-up, rapid progressive motility increased from 30% to 47% (17 percentage points). At the second follow-up it increased to 50%, a total rise of 20 percentage points from baseline. The progressive rise in rapid progressive motility was the principal observation. The presenting complaints (scrotal pain, premature emission, recurrent sexual dreams and nocturnal emissions) were monitored clinically at each follow-up. Within these 3 months the pain gradually subside and the sperm motility rises to 50% from 30 % in the first sitting.

CASE 3

A 27 year old man presented with anxiety, difficulty in sexual activity and decreased sperm count. He was prescribed Cantharis 200.

The initial semen analysis, dated 02/06/2024, showed a semen volume of 1.0 mL, below the WHO lower reference limit of 1.4 mL. Liquefaction time was 5 minutes (normal) and pH was 9 (slightly alkaline). Sperm concentration was 10 million/mL, indicating oligozoospermia. Motility was 35% active, 40% sluggish and 25% non-motile, suggesting reduced progressive motility. At the first follow-up (09/09/2024) semen volume was 1.2 mL. Morphology showed 70% normal and 30% abnormal forms.

At the second follow-up (17/03/2025) semen volume was 1.3 mL, still below the 1.4 mL reference limit, and sperm concentration was 39 million/mL, a marked rise from the baseline of 10 million/mL and above the 16 million/mL reference limit. Overall, sperm concentration increased substantially and semen volume rose modestly following treatment with Cantharis 200.

Table 1: Case Summary.

S no	Main symptoms	Medicine Dose And repetitions	Post treatment
1 42/M	Difficulty in erection, Ejaculation lasts for 10 min Flaccidity of penis only after 5 th day after 4 days of continuous intercourse	Cantharis 200 for the 1 st week, followed by Lycopodium 200 for the 2 nd week and Sabal serrulata 200 in the 3 rd week with Nuphar luteum Q (30 mL). The same prescription was continued for the subsequent 4 months.	In 6 th month the patient's complaint was better and the semen consistency was thick. So the patient was prescribed with sac lac. In the 7 th month, the patient's wife got conceived.
2 26/M	Scrotal pain, premature emission, recurrent sexual dreams, and nocturnal seminal emission.	Lycopodium 200 /1D weekly once for 3 months	Within these 3 months the pain gradually subside and the sperm motility rises to 50% from 30 % in the first sitting.
3 27/M	anxiety, difficulty in sexual activity, and decreased sperm count	Cantharis 200	Sperm concentration rose from 10 to 39 million/mL and semen volume from 1.0 to 1.2 and then 1.3 mL; 70% normal forms at the first follow-up.

Table 2: Scores for Modified Naranjo criteria of individual patients.

Modified Naranjo Criteria	Case 1	Case 2	Case 3
1. Was there an improvement in the main symptom or condition for which the homoeopathic medicine was prescribed?	+2	+2	+2
2. Did the clinical improvement occur within a plausible time frame relative to the drug intake?	+2	+1	+1
3. Was there an initial aggravation of symptoms?	0	0	0
4. Did the effect encompass more than the main symptom or condition, that is, were other symptoms ultimately improved or changed?	+1	+1	+1
5. Did overall wellbeing improve?	+2	+1	+2
6A. Direction of cure: did some symptoms improve in the opposite order of the development of symptoms of the disease?	0	0	0
6B. Direction of cure: Did at least two of the following aspects apply to the order of improvement in symptoms: (a) From organs of more importance to those of less importance; (b) From deeper to more superficial aspects of the individual; (c) From the top downwards	+1	+1	0
7. Did 'old symptoms' (defined as non-seasonal and non-cyclical symptoms that were previously thought to have resolved) reappear temporarily during the course of improvement?	0	0	0
8. Are there alternate causes (other than the medicine) that – with a high probability – could have caused the improvement?	0	0	0
9. Was the health improvement confirmed by any objective evidence? (e.g., laboratory test, clinical observation, etc.)	+1	+1	+1
10. Did repeat dosing, if conducted, create similar clinical improvement?	0	0	0
Total	+9	+7	+7

DISCUSSION

This case series describes three men with infertility who were treated with individualized homoeopathic medicines and followed with serial clinical assessment and semen analysis. Improvement in at least one semen parameter was recorded in each case, but relief of the presenting complaints was documented only in Case 1. The provisional Modified Naranjo (MONARCH) scores of +9, +7 and +7 are subject to re-scoring and do not by themselves establish causal attribution. The changes were seen in different parameters.

In Case 1, liquefaction time was more than 1 hour on the 16 February 2024 report and 5 minutes on the 16 May 2024 report, and the patient's wife conceived in the seventh month of treatment. Because the timing of treatment relative to these two reports is not clear and no post-treatment analysis is shown, the change in liquefaction cannot yet be attributed to treatment. Sperm concentration, motility and morphology were within reference limits throughout, and concentration was lower in the second report (140 vs 110 million/mL), so the main abnormality was consistency and liquefaction rather than count. In Case 2, rapid progressive motility rose from 30% at baseline to 47% at the first follow-up and 50% at the second, a rise of 20 percentage points; follow-up concentration was not reported. In Case 3, sperm concentration increased from 10 to 39 million/mL and semen volume from 1.0 to 1.3 mL by the second follow-up, with 70% normal forms at the first follow-up (no baseline morphology available).

The medicines were chosen on the totality of symptoms and not on the semen report alone. *Cantharis*, *Lycopodium*, *Sabal serrulata* and *Nuphar luteum* are described in standard *Materia Medica* (Boericke;⁸ Allen⁹) in relation to sexual weakness, disturbed sexual function, seminal emissions, anxiety and genitourinary irritability, and these features guided their selection. Similar individualized approaches have been reported in earlier homoeopathic case reports and series on infertility.^{2,3} All semen findings were interpreted against the WHO reference values.^{6,7}

These findings must be read with caution. Semen parameters vary widely from one sample to the next in the same man, and a change between two samples may reflect biological variation, a difference in abstinence period or sample handling, or regression towards the mean, rather than a treatment effect. PDE-5 inhibitor use and lifestyle risk-factor modification are listed before treatment in all three cases; in a 26-year-old man in particular this requires explanation, and it is a major confounder that may have contributed to the improvement. Alternative causes of this kind also bear on MONARCH item 8. Case 1 received four remedies in sequence, which sits uneasily with single-remedy individualized prescribing and with

attribution to one medicine. A conception in Case 1 cannot be credited to the medicine alone, because it also depends on the partner's fertility and on timing. The MONARCH scores show that the temporal and clinical features are compatible with a treatment effect, but they do not prove it.

LIMITATIONS

- The series has only three cases, with no control group, randomization or blinding, so no conclusion can be drawn about efficacy.
- Semen analysis has considerable intra-individual variability, and only a few samples were available for each patient.
- Lifestyle modification and PDE-5 inhibitor use before or during treatment could not be separated from the effect of the homoeopathic medicines.
- The medicines, potencies and repetition schedules differed between cases (Case 1 received four remedies in sequence), and the follow-up period was short and unequal across cases.
- The female partner's fertility status was not assessed, and hormonal and other laboratory investigations were not uniformly available.
- Modified Naranjo scoring is partly subjective and was applied retrospectively by the treating team, so scorer bias is possible.
- The cases were drawn from a single centre, which limits generalization.
- Quality of life was not formally assessed, and symptomatic outcomes, follow-up motility and concentration were not reported for every case.
- Repertorisation and totality are not presented, and in Case 1 no post-treatment semen analysis is shown and the timing of treatment relative to the two reports is unclear.

CONCLUSION

In these three cases of male infertility, individualized homoeopathic treatment was followed by a rise in rapid progressive motility (Case 2) and in sperm concentration and semen volume (Case 3). In Case 1 liquefaction time was shorter on the second report and the partner conceived during follow-up, but the timing of treatment relative to the reports is unclear. Symptomatic relief was documented only in Case 1. Because of the small number of cases, the absence of a control group, the sequential prescribing in Case 1 and the possible influence of PDE-5 inhibitors and lifestyle changes, these results are only hypothesis-generating.

REFERENCES

1. Kumar N, Singh AK. Trends of male factor infertility, an important cause of infertility: A review of literature. *J Hum Reprod Sci.* 2015;8(4):191-196.
2. Gerhard I, Wallis E. Individualized homeopathic therapy for male infertility. *Homeopathy.* 2002;91(3):133-144.
3. RajachandraSekar B, Nair JKR, Sunny A, Manoharan A. Individualised homeopathic medicine in the treatment of infertility: A case series. *Homeopathy.* 2022;111(1):66-73.
4. Van Haselen RA. Homeopathic clinical case reports: Development of a supplement (HOM-CASE) to the CARE clinical case reporting guideline. *Complement Ther Med.* 2016;25:78-85.
5. Lamba CD, Gupta VK, van Haselen R, et al. Evaluation of the Modified Naranjo Criteria for assessing causal attribution of clinical outcome to homeopathic intervention as presented in case reports. *Homeopathy.* 2020;109(4):191-197.
6. World Health Organization. WHO laboratory manual for the examination and processing of human semen. 6th ed. Geneva: World Health Organization; 2021.
7. Cooper TG, Noonan E, von Eckardstein S, Auger J, Baker HW, Behre HM, et al. World Health Organization reference values for human semen characteristics. *Hum Reprod Update.* 2010;16(3):231-245.
8. Boericke W. New manual of homeopathic Materia Medica and repertory. Augmented ed. New Delhi: Indian Books & Periodicals Publishers; 2015.
9. Allen HC. Keynotes rearranged and classified with leading symptoms of Materia Medica with bowel nosodes. New Delhi: B. Jain Publishers; 2015.