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A RETROSPECTIVE CASE SERIES OF ALLERGIC RHINITIS TREATED WITH NUX VOMICA

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ABSTRACT

Background: Allergic rhinitis is an IgE-mediated inflammatory disorder of the nasal mucosa that affects an estimated 10–30% of the population worldwide. It causes sneezing, watery discharge, nasal blockage and itching, and disturbs sleep and daily activity. Nux vomica is a commonly prescribed homoeopathic medicine for chilly, irritable, oversensitive patients with sneezing and nasal blockage.

AIM AND OBJECTIVES

Aim: To describe how Nux vomica was prescribed, and what was recorded at follow-up, in patients with allergic rhinitis attending an outpatient department. The study was not designed to test whether Nux vomica works.

Objectives

- To describe the age and sex distribution of the patients.
- To describe the potencies in which Nux vomica was prescribed.
- To describe the frequency with which the medicine was repeated.
- To report the outcome recorded during follow-up.

MATERIALS AND METHODS

A retrospective case series of fifteen outpatient records (study period October 2025 to October 2026) of clinically diagnosed allergic rhinitis treated with Nux vomica, with complete follow-up, at OPD. Data are presented as counts and percentages, and total nasal symptom scores (TNSS) as median (range).

RESULTS

Fifteen patients were included. The largest age group was 31–40 years (6 patients, 40%), and 11 patients (73.3%) were male. The commonest potency was 200C (7 patients, 46.7%). Twelve patients (80%) received the same schedule, four times a week. At follow-up, 11 patients (73.3%) were recorded as improved and 4 (26.7%) as unchanged; none was recorded as worse.

CONCLUSION

Nux vomica was often prescribed as 200C (46.7%) and 12 of 15 patients (80%) had the same four times a week schedule, a routine rather than varied pattern; reasons for dosing were not recorded. Eleven of 15 patients improved and 4 did not change, but with no comparison group, selected records and a very small sample, this does not show that Nux vomica is effective. Controlled prospective studies are needed.

KEYWORDS: Allergic rhinitis; Nux vomica; Homoeopathy; Case series; Potency; Repetition; Case record analysis.

INTRODUCTION

Allergic rhinitis is among the most frequent long-standing complaints of the upper airway, affecting an estimated 10–30% of the population worldwide, with higher figures reported in children ^[14,15]. It arises when an individual who has become sensitised meets an allergen such as dust mite, pollen, mould, animal dander or smoke. Mast cells in the nasal mucosa release histamine and other mediators, producing sneezing, a runny and itchy nose, congestion and sometimes itchy, watering eyes. The pattern may be seasonal or perennial depending on how constant the exposure is. ^[10,11]

Although it does not threaten life, the condition lowers the quality of life through disturbed sleep, tiredness, poor attention and missed school or work. It is also linked with asthma, eczema and conjunctivitis. Management consists of identifying and avoiding triggers, medication, and patient education. ^[10–12]

In homoeopathic practice Nux vomica is considered for persons of a sensitive, impatient and chilly disposition who suffer from fluent nasal discharge by day with blockage at night, repeated violent sneezing, and aggravation in the morning, in dry cold weather and from stimulants or irregular habits ^[1–5]. The choice of potency and the interval of repetition are left to the prescriber ^[6,7], but little is written about how these choices are made in routine outpatient practice.

Aim of the study: to describe the age and sex of patients with allergic rhinitis who were prescribed Nux vomica in one outpatient department, the potencies and repetition schedules used, and the outcome recorded at follow-up. As a case series without a comparison group, the study describes practice; it does not test the effectiveness of the medicine.

MATERIALS AND METHODS

Study Design and Setting

A retrospective, descriptive case series (record review) conducted at the Outpatient Department of Sarada Krishna Homoeopathic Medical College and Hospital, Kanyakumari, Tamil Nadu.

Selection of Records and Study Period

Records of patients treated between 01.10.2025 and 01.10.2026 were screened. Around 25 cases records of allergic rhinitis were identified in a specific OPD; in 15 of these Nux vomica was prescribed, and 10 were excluded for incomplete follow-up or other exclusion criteria, leaving fifteen.

Study Population

Fifteen case records of patients aged 1–50 years, of either sex, with clinically diagnosed allergic rhinitis, treated with Nux vomica and followed up at the OPD, were reviewed.

Diagnostic Criteria

Allergic rhinitis was diagnosed clinically, from history and ENT examination, on the basis of [10, 13].

- Repeated bouts of sneezing
- Watery nasal discharge
- Blocked nose
- Itching of the nose, eyes, palate or ears
- Symptoms linked to exposure to a trigger

Inclusion Criteria

- Patients aged 1–50 years, of either sex.
- Clinically diagnosed allergic rhinitis.
- Nux vomica prescribed as the medicine.
- Complete records with baseline and follow-up details.

Exclusion Criteria

- Acute infective rhinitis or sinusitis.

- Nasal polyps, deviated septum needing surgery, or nasal tumours.
- Associated chronic respiratory disease such as bronchial asthma.
- Incomplete records.

DATA COLLECTION

Information was entered on a structured proforma covering age, sex, presenting complaints, triggers, potency of Nux vomica, frequency of repetition, follow-up and outcome.

INTERVENTION

Nux vomica was prescribed by the treating physician on the basis of the totality of symptoms [6–9]. The reasons for choosing a particular potency or repetition schedule were not recorded in the case records, so the dosing pattern is described here but cannot be explained.

OUTCOME MEASURES

Primary Outcome

Change in the Total Nasal Symptom Score (TNSS) between baseline (first visit) and the last recorded follow-up. Each of four symptoms (sneezing, rhinorrhoea, nasal obstruction and nasal itching) is scored 0–3 (0 = none, 1 = mild, 2 = moderate, 3 = severe), so the TNSS ranges from 0 to 12; a higher score means worse symptoms. The scoring sheet used is shown below.

Sample TNSS scoring sheet.

Symptom	0 = None	1 = Mild	2 = Moderate	3 = Severe
Sneezing	No sneezing	1–4 sneezes per bout, easily tolerated	5–10 per bout, bothersome	More than 10 per bout, hard to tolerate
Rhinorrhoea (runny nose)	Absent	Slight, wiping occasionally	Frequent wiping	Continuous dripping, disturbs activity
Nasal obstruction	Absent	Mild, breathing mostly clear	Frequent blockage, mouth-breathing at times	Almost constantly blocked, disturbs sleep
Nasal itching	Absent	Mild, easily tolerated	Bothersome, nose often rubs	Hard to tolerate, disturbs daily activity or sleep

Illustrative example (not patient data): sneezing 2 + rhinorrhoea 3 + nasal obstruction 2 + nasal itching 1 = TNSS 8 out of 12.

Definition of Outcome Categories

Improved: TNSS at last follow-up lower than baseline by 3 points or more. Unchanged: change of less than 3 points in either direction. Worse: TNSS higher than baseline by 3 points or more.

Statistical Analysis

Data were tabulated and summarised as counts and percentages, and total nasal symptom scores (TNAA) as median (range). No hypothesis tests were done, because there is no comparison group. The proportion improved is reported with an exact (Clopper-Pearson) 95% confidence interval.

Ethical Considerations

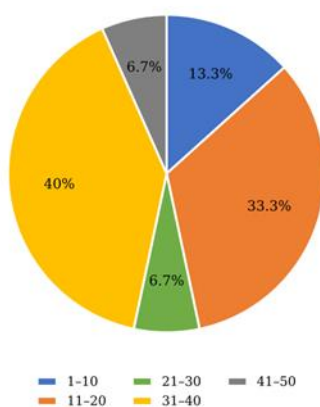
This was a retrospective review of anonymised outpatient records; no patient names or other identifiers were collected.

PATIENT DISTRIBUTION TABLES AND CHARTS

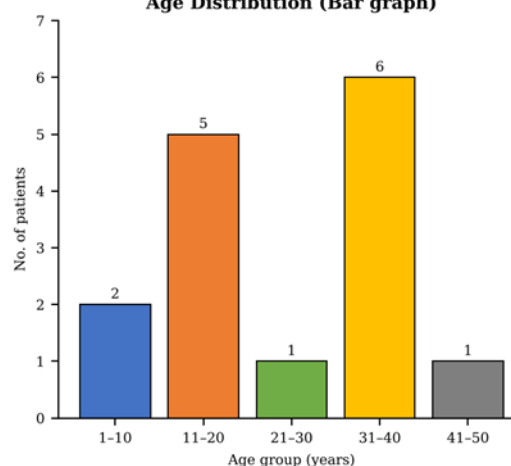
Age Distribution

Age (Years)	No. of Patients
1–10	2
11–20	5
21–30	1
31–40	6
41–50	1
Total	15

Age Distribution (Pie chart)



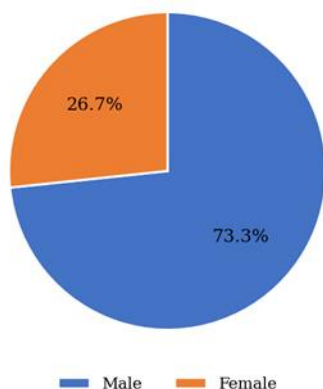
Age Distribution (Bar graph)



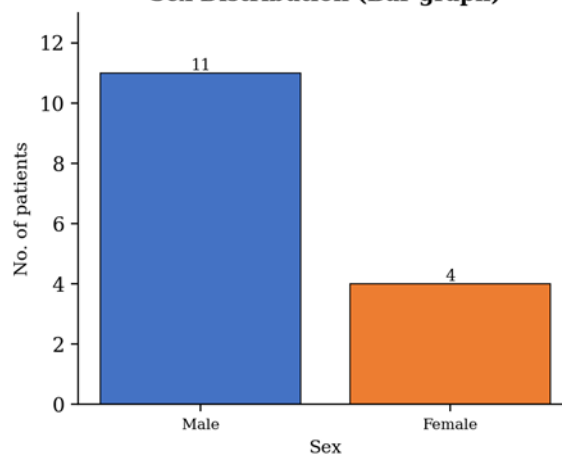
Sex Distribution

Sex	No. of Patients
Male	11
Female	4
Total	15

Sex Distribution (Pie chart)



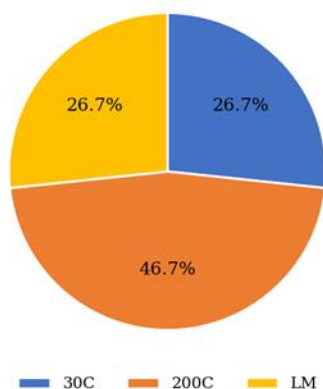
Sex Distribution (Bar graph)



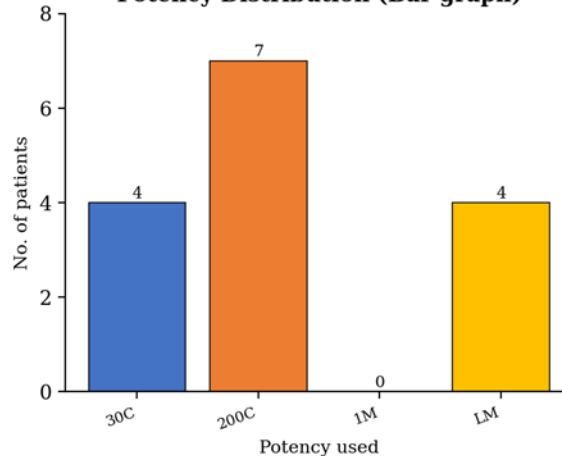
Potency Distribution

Potency Used	No. of Patients
30C	4
200C	7
1M	0
LM	4
Total	15

Potency Distribution (Pie chart)



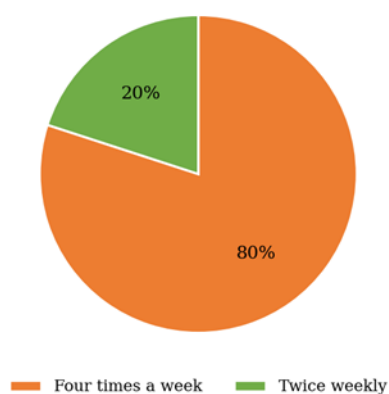
Potency Distribution (Bar graph)



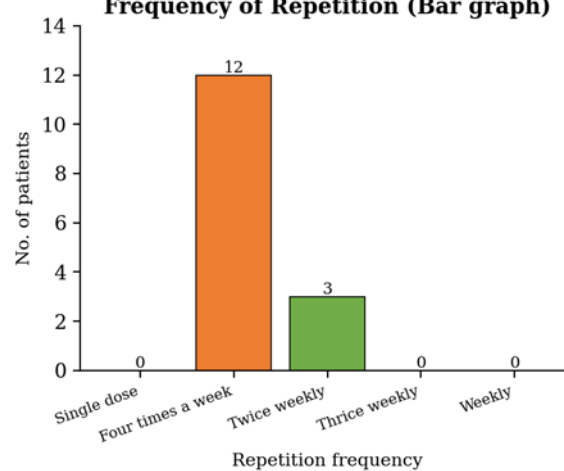
Frequency of Repetition

Repetition Frequency	No. of Patients
Single dose	0
Four times a week	12
Twice weekly	3
Thrice weekly	0
Weekly	0
Total	15

Frequency of Repetition (Pie chart)



Frequency of Repetition (Bar graph)



Outcome at Follow-up

Outcome	No. of Patients (%)
Improved	11(73.3%)
Unchanged	4(26.7%)
Worse	0 (0%)
Total	15 (100%)

Symptom Scores (TNSS) of Individual Patients

Case no.	Baseline TNSS	Follow-up TNSS	Change	Category
1	10	5	5	Improved
2	8	3	5	Improved
3	6	6	0	Unchanged
4	9	4	5	Improved
5	7	2	5	Improved

Case no.	Baseline TNSS	Follow-up TNSS	Change	Category
6	11	7	4	Improved
7	5	2	3	Improved
8	8	8	0	Unchanged
9	10	3	7	Improved
10	6	4	2	No change
11	9	5	4	Improved
12	7	7	0	Unchanged
13	12	6	6	Improved
14	5	1	4	Improved
15	8	2	6	Improved

RESULT

Fifteen records were analysed; the full age, sex, potency and repetition distributions are in the tables and charts above. The commonest potency was 200C (7 patients, 46.7%), and 12 patients (80%) received the same schedule, four times a week.

At follow-up, 11 of 15 patients (73.3%; exact 95% CI 44.9-92.2%) were recorded as improved and 4(26.7%) as unchanged; none was worse. Median (range)TNSS was 8 (5-12) at baseline and 4(1-8) at the last followup; the median reduction was 4 points 9range0-7)

DISCUSSION

This case series describes fifteen patients with allergic rhinitis who were prescribed Nux vomica at one outpatient department. The 31–40 year group was the largest and most patients were male; with so few patients, this may reflect who attends the clinic rather than who has the disease, and nothing can be inferred about occurrence.

The dosing pattern was uniform. Twelve of 15 patients (80%) received the same four-times-a-week schedule, and 200C was the commonest potency (46.7%). Such uniformity suggests a routine habit of the clinic rather than doses fitted to each patient. The reasons for each potency and repetition choice were not recorded, so this series cannot show whether dose and interval were matched to the patient's sensitivity or response.

Eleven patients improved and four did not change. These figures cannot be attributed to Nux vomica. Allergic rhinitis fluctuates with exposure and season; symptoms tend to return towards their usual level after a bad spell; non-specific and placebo effects occur; and patients may have been advised to avoid triggers or may have used other treatment. With no

comparison group, none of these can be separated from any effect of the medicine. The meaning of “improved” also depends on how it was defined (see Methods).

Limitations

- Selection: only patients who received Nux vomica and had complete follow-up were included. Patients who dropped out, or who did badly and stopped attending, are missing, so the proportion improved is probably overstated.
- Very small sample from a single centre, with no comparison group.
- Retrospective use of case records: data quality depends on what was written down, and reasons for dosing decisions were not recorded.
- Diagnosis was clinical; sensitisation was not confirmed by skin-prick or serum IgE testing.
- Follow-up length and timing.

A prospective controlled study with a pre-defined dosing protocol, standardised symptom scoring and a stated definition of improvement would be needed to test whether Nux vomica has any effect in allergic rhinitis.

CONCLUSION

In fifteen selected case records of allergic rhinitis, Nux vomica was prescribed often as 200C (46.7%) ad 80% If patients received the same four times a week schedule, which suggests a routine rather than an individualised regimen, and the reasons for dosing choices were not recorded. At follow-up 11 patients (73.3%) improved and 4 (26.7%) were unchanged. Because the series is small, has no comparison group and included only patients with complete follow-up, it cannot show that Nux vomica is effective, and the improvement seen should not be credited to the medicine. Controlled prospective studies are needed.

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