
HOMOEOPATHY IN ACNE VULGARIS: A NARRATIVE REVIEW OF CLINICAL EVIDENCE

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ABSTRACT

Background: Acne vulgaris is a chronic inflammatory disorder affecting the hair follicle and its sebaceous gland. It appears as comedones, papules and pustules and, in severe cases, as nodules, cysts and scars, and it may reduce a patient's quality of life. The homoeopathic literature on acne consists of randomized placebo-controlled trials, observational studies, case series and case reports, which vary considerably in design, sample size, outcome measures and quality.

Objective: To review the published clinical literature on homoeopathic treatment of acne vulgaris in narrative form, to summarize reported outcomes and prescribing approaches, and to point out methodological weaknesses and evidence gaps.

Methods: Records were retrieved via Google Scholar, the only database searched, and examined qualitatively for design, population, intervention, comparator, outcomes, attrition and methodological weaknesses. This is not a formal systematic review: no protocol was registered and no independent duplicate screening took place. Seventeen clinical records were extracted.

Results: Of the records, three were randomized placebo-controlled trials, two were other controlled or placebo run-in studies, four were prospective or observational studies, three were case series and five were case reports. The largest randomized trial (126 participants) tended to favour individualized homoeopathic medicines, though at three months the groups did not differ significantly. A fixed homoeopathic complex performed no better than placebo in its trial.

Significant within-group declines in lesion counts, Global Acne Grading System (GAGS) scores and quality-of-life scores were reported by open-label studies of *Zingiber officinale*, *Arctium lappa* and *Azadirachta indica* and by an individualized single-arm study. Remission was recorded in 81.9% of an 83-patient case series.

Conclusion: Homoeopathy has been investigated as an acne vulgaris treatment, and improvement is described by most uncontrolled studies. The strongest comparative evidence, though, has shown no statistically significant advantage over placebo. Further study is warranted; before firm conclusions on efficacy are possible, adequately powered randomized controlled trials with standard outcome measures and longer follow-up are needed.

KEYWORDS: Homoeopathy; acne vulgaris; individualized treatment; Global Acne Grading System; acne-specific quality of life; randomized controlled trial; narrative review.

INTRODUCTION

Acne vulgaris is a chronic inflammatory disease centred on the pilosebaceous unit. Its lesions span open and closed comedones, red papules and pustules and, in severe forms, deep nodules, cysts and scars. The face is the most common site, while the chest and back are involved less frequently. Four interacting factors are generally held responsible: excess sebum production, abnormal shedding of follicular cells, proliferation of *Cutibacterium acnes* within the follicle, and local inflammation^[19].

The condition usually starts in adolescence and, in many people, persists into adulthood^[19]. Besides visible lesions and scarring, patients may suffer reduced self-confidence, social withdrawal, anxiety and low mood; both lesion severity and quality of life are therefore relevant when a treatment is judged. Conventional treatments, such as topical retinoids, antibiotics, benzoyl peroxide, hormonal agents and isotretinoin, benefit many patients, yet side effects, relapse, difficulty keeping to a regimen or personal preference push some people to seek complementary options^[3].

Homoeopathic literature describes treatment as individualized: the medicine is selected on the totality of the person's symptoms rather than on the look of the acne alone (Organon of Medicine, §§7 and 18). In this review, "individualized" carries that meaning, i.e. the medicine is matched to the individual patient by considering mental and general characteristics, modalities and accompanying symptoms, rather than prescribing one fixed medicine for everybody. Other studies investigate a single named medicine administered to every participant, for example *Zingiber officinale*, *Arctium lappa* or *Azadirachta indica*; because

the medicine was not selected for each patient, these are termed "medicine-specific" here and are not individualized in the sense described above. A third group investigates fixed combination products, which likewise depart from the principle of giving one simple medicine at a time (Organon, §273). These three strategies differ conceptually and are therefore treated separately in this review.

Study strength also differs considerably. Randomized placebo-controlled trials make it possible to compare treatments, while observational studies, case series and case reports only record what happened during treatment. Several factors can distort uncontrolled results: the natural ups and downs of acne, regression to the mean, other topical or conventional treatment, changes in skin care, placebo and contextual effects, adherence and biased reporting. The review therefore examines how reliable the reported results are as well as what they show.

Homoeopathic clinics can treat acne effectively, with an accompanying improvement in patients' quality of life. Greater acne severity was linked to poorer quality of life. Further pragmatic studies using a comparative cohort would be desirable.

AIM

To provide a narrative review of the published clinical evidence on homoeopathic management of acne vulgaris.

OBJECTIVES

- To identify published clinical studies and reports on the homoeopathic management of acne vulgaris.
- To summarize each study's design, population, intervention, comparator and reported outcomes.
- To list the homoeopathic medicines and prescribing approaches described in the clinical literature.
- To examine outcomes assessed by the clinician or investigator (lesion counts, GAGS) alongside those reported by patients (CADI, Acne-QoL, DLQI, T-QoL).
- To identify methodological weaknesses and risks of bias using criteria appropriate to each study design.
- To highlight evidence gaps and priorities for future controlled research.

MATERIALS AND METHODS

Review design

This work is a narrative review, not a formal systematic review. Because the acne literature combines randomized, controlled, observational, case-series and case-report designs, the findings are described in words and were not statistically pooled. A protocol was not registered and no second reviewer screened records independently; consequently, compliance with PRISMA 2020 is not claimed.

Data source and search strategy

On 8 August 2026, Google Scholar, the only source searched, was queried with combinations of the terms "acne vulgaris", "acne", "homeopathy", "homoeopathy", "individualized homeopathic treatment", "Arctium lappa", "Lappa", "Zingiber officinale", "Azadirachta indica", "homoeopathic complex", "randomized placebo-controlled", "case series" and "case report". The reference lists of retrieved papers were also checked for further clinical records indexed in Google Scholar. Search results in Google Scholar are ranked by relevance and cannot be reproduced in full, so the search may not be exactly repeatable.

Eligibility criteria

A record was eligible if it satisfied the following conditions:

- Clinical studies, observational studies, case series or case reports involving human participants with acne vulgaris.
- Assessment of homoeopathic medicines, homoeopathic complexes or individualized homoeopathic treatment.
- Presentation of clinical outcomes, such as lesion counts, severity scores, quality-of-life measures or treatment response.
- An abstract or full text available through Google Scholar. Master's dissertations kept in institutional repositories were accepted and are labelled accordingly. One exception was made: the *Azadirachta indica* study [10] was included even though neither its abstract nor its full text could be accessed, with its details drawn from a secondary citing paper. It is flagged as unverified throughout, and none of this review's conclusions rest on it.

Records were excluded in these situations:

- Animal or in-vitro studies, including laboratory studies of microbial sensitivity.
- Studies not concerned with acne vulgaris.
- Narrative reviews, protocols and theoretical papers that lacked patient outcomes.

- Duplicate publications.

Study selection

Relevance was first judged from titles and abstracts, after which whatever details of each article were available were read. Records carrying clinical information on homoeopathy in acne vulgaris were taken into the narrative synthesis. Where only an abstract or a secondary citation was accessible, the tables say so, and no assumption was made beyond the information at hand.

Data extraction

For each record, where available, the following details were noted: author and year, country, design, number of participants, homoeopathic intervention, comparator, duration of treatment, outcome measures, main findings, adverse events, funding and conflicts of interest.

Methodological appraisal

What was examined depended on the study design. Randomized and other controlled studies were assessed for randomization, allocation, blinding, comparator, outcome measurement, attrition and reporting. Observational studies and case series were assessed for patient selection, confounding, concurrent treatment, attrition and outcome measurement. Case reports were assessed for diagnostic clarity, description of the intervention, follow-up, photographs and alternative explanations for improvement.

No formal appraisal instrument (for example RoB 2, ROBINS-I or GRADE) was used, and no numerical quality scores were given. The labels appearing in the appraisal tables are the reviewers' own descriptive judgements, defined as follows. *Some concerns*: a randomized, blinded, placebo-controlled design in which only minor or unresolved questions remain.

Important limitations: a comparator, measured outcomes, or both, but with shortcomings such as no concurrent randomized control, a small sample, short follow-up or substantial loss to follow-up. *High concern*: a very small series, or a single case, with no comparator or with very limited methodological detail. *Unclear*: the available information was insufficient to judge. The descriptions of overall evidence strength (very low, low, moderate) are likewise informal summaries rather than GRADE ratings.

RESULTS

Characteristics of clinical studies

Seventeen clinical records qualified for inclusion. These comprised three randomized placebo-controlled trials (one journal article and two master's dissertations), two other controlled or placebo run-in studies, four prospective or observational studies, three case series and five case reports, and came from India, Romania, South Africa and Ukraine. Every study is described in the data extraction table below, organized by design, and the first column gives the reference number used in the text.

Ref.	Author Year	Country	Study design	No. of patients	Intervention / medicine	Main outcomes
Randomized placebo-controlled trials						
5	Rai et al., 2022	India	Double-blind, randomized, placebo-controlled trial	126	Individualized homoeopathic medicines compared with placebo	Primary outcome GAGS, secondary outcomes CADI and DLQI; a trend favouring homoeopathy, with no significant between-group differences
14	McDavid, 1994	South Africa	Randomized, placebo-controlled with before-and-after assessment and a	30 (15 homoeopathic; 15 placebo)	Individualized homoeopathic medication compared with placebo	Clinical features, patient-perception questionnaire and photographs; the
Ref.	Author Year	Country	Study design	No. of patients	Intervention / medicine	Main outcomes
			control group; master's dissertation			indexed abstract gives no numerical results
15	Ally, 2014	South Africa	Randomized placebo-controlled; master's dissertation	37 recruited; 34 analysed	Fixed homoeopathic complex (Kalium bromatum, Natrum muriaticum	Facial lesions counted by the Leeds technique over 6 weeks; no significant difference between groups;

					, Selenium, Sulphur, Thuja; 9CH) compared with placebo	complex judged ineffective
Other controlled or placebo run-in studies						
16	Bekker, 2013	South Africa	Single group, placebo period then treatment; master's dissertation	30 enrolled; 28 completed	Testis compositu m (homoeopa thic complex)	Facial lesion counts over 8 weeks; significant improvement was reported
17	Kolyadenko et al., 2014	Ukraine	Two-group controlled clinical study; add-	60	Routine acne therapy alone or	Clinical improvement in 53.3% vs 20%;
Ref.	Author Year	/Country	Study design	No. of patients	of Intervention medicine	Main outcomes
			on design		combined with the homoeopa thic tablet Lomax Lux Acnemol	remission in 16.6% vs 23.3%; no adverse effects reported
Prospective or observational studies						
1	Miglani & Manchanda, 2014	India	Prospective, open-label, non-randomised	32 enrolled; 31 analysed	Zingiber officinale (medicine-specific), potencies 6C to 1M, administered as needed	Significant improvement in lesion counts, GAGS and Acne-QoL (P<0.001)
2	Miglani & Manchanda, 2014	India	Uncontrolled interventional observational study	34 enrolled; 32 completed	Arctium lappa (Lappa) (medicine-specific), potencies 6C to 1M, administered as needed	Significant improvement in lesion counts, GAGS and Acne-QoL (P<0.001)
10	Miglani & Manchanda, 2014	India	Open-label observational study	31 (figure taken from a later citing	Azadirachta indica (medicine-	Significant improvement in lesion counts,

			(unverified : details from a secondary citation)	paper)	specific)	GAGS and Acne-QoL reported (P<0.001)
3	Sharma & Manchanda	India	Open-label,	84 enrolled and	Individualized	GAGS and CADI
Ref.	Author Year	/Country	Study design	No. of patients	Intervention /medicine	Main outcomes
	, 2020		single-arm, non-comparative	analysed (modified intention-to-treat)	homoeopathy; most often used: Natrum muriaticum, Calcarea sulphurica, Sulphur, Kalium bromatum and Hepar sulphuris	recorded at baseline, 3 months and 6 months; both decreased significantly (P<0.001)
Case series						
4	Nwabudike, 2021	Romania	Clinical case series (record review)	83	One individualized medicine per patient; 17 different medicines	Remission in 81.9%; no response in 2.4%; 15.7% lost to follow-up
11	Rath et al., 2023	India	Single-centre outpatient case series	5	Individualized medicines selected using location, sensation, modalities and concomitant symptoms	GAGS applied; improvement reported in patients who had not responded to prolonged conventional treatment
12	Debnath et al., 2025	India	Case series reported	3 teenagers	Individualized	GAGS and T-QoL
Ref.	Author Year	/Country	Study design	No. of patients	Intervention /medicine	Main outcomes
			per HOM-CASE		homoeopathic treatment	scores decreased; clearance within 2 months; MONARCH supported a causal link
Case reports						
6	Nwabudike, 2018	Romania	Case reports	2	One individualized medicine per patient	Both patients attained remission; photographs

						recorded; benefit reportedly sustained at long-term follow-up
7	Vishwakarma, 2022	India	Case report	1	Individualized prescription; Natrum muriaticum 200C reported	Pustular acne improved
8	Ravi et al., 2024	India	Evidence-based case report	1	Kalium bromatum 30C	Acne reportedly cleared in about 2 months
9	Tiwari et	India	Clinical	1	Individualized	Inflammatory facial
Ref.	Author /Year	/Country	Study design	No. of patients	Intervention /medicine	Main outcomes
	al., 2025		case report		homoeopathic prescription	acne reported to improve
13	Gupta, 2025	India	Clinical image / single case	1	Individualized medicine selected after repertorization (Synthesis repertory)	Photographs show resolution of erythematous brown spots on the cheeks

Randomized and controlled studies

In the double-blind, randomized, placebo-controlled trial of Rai et al. [5], 126 patients were allocated 1:1 to individualized homoeopathic medicine or placebo. Small to medium effect sizes pointed to greater overall improvement in the treated group; nonetheless, the primary between-group comparison (GAGS) and the secondary measures (CADI and DLQI) were not statistically significant at three months. Prescribed most often were Sulphur (17.5%), Natrum muriaticum (15.1%), Calcarea phosphorica (14.3%), Pulsatilla nigricans (10.3%) and Antimonium crudum (7.1%); no serious adverse event was recorded.

Ally [15], in a randomized placebo-controlled dissertation, tested a fixed homoeopathic complex (Kalium bromatum, Natrum muriaticum, Selenium, Sulphur and Thuja occidentalis, each at 9CH) for six weeks, with 34 participants aged 18 to 31 years analysed. No significant between-group difference emerged for non-inflamed, inflamed or total lesion counts. In females, the placebo group showed a significantly larger fall in total lesions ($p = 0.034$), but this post hoc subgroup result is probably due to chance given the multiple comparisons and should not be given weight. The author judged the complex ineffective. As a negative

controlled result the study has value, even though it examined a fixed combination and not individualized prescribing.

McDavid [14] randomly allocated 30 patients to homoeopathic treatment or placebo (15 per group) and reviewed them every four weeks using questionnaires and photographs. The indexed abstract outlines the design and outcome measures but provides no numerical results, so no further findings can be reported.

Bekker [16] gave Testis compositum to 30 participants (28 completed) for eight weeks, as a two-week placebo phase followed by six weeks of active treatment in the same people, and reported a

significant fall in facial lesion counts, though the lack of parallel controls restricts interpretation. In the study by Kolyadenko et al. [17], 60 patients with mild to moderate acne received six weeks of either routine acne therapy alone or the same therapy together with the homoeopathic tablet Loma Lux Acnemol. Clinical improvement was 53.3% against 20%, clinical remission was 16.6% against 23.3%, and no adverse effects were noted.

Observational and pilot studies

Three open-label studies by Miglani and Manchanda each centred on one medicine administered to every participant, so they are medicine-specific rather than individualized. In the Zingiber officinale study [1], 32 participants were enrolled and 31 analysed across six months, with potencies spanning 6C to 1M; lesion counts, GAGS and Acne-QoL all changed significantly ($P < 0.001$). For Arctium lappa [2], 34 participants were enrolled and 32 finished follow-up, and the same measures changed significantly ($P < 0.001$). The primary article on Azadirachta indica

[10] was inaccessible; secondary literature cites it as showing significant improvement on these measures in 31 participants, but that report is unverified. In all three reports the authors asked for larger randomized controlled trials.

Sharma and Manchanda [3] carried out an open, single-arm study in which 84 patients at a rural clinic in India received individualized homoeopathy. The most commonly prescribed medicines were Natrum muriaticum ($n=14$), Calcarea sulphurica ($n=14$), Sulphur ($n=13$), Kalium bromatum ($n=10$) and Hepar sulphuris ($n=9$). From baseline to six months, the mean fall in GAGS was

15.47 points (95% CI 13.79 to 17.16) and in CADI 6.94 points (95% CI 6.12 to 7.75), both $p < 0.001$. A positive correlation between GAGS and CADI ($r = 0.585$) meant that worse acne went with a poorer quality of life.

Case series

Nwabudike [4] conducted a record review of 83 patients managed with individualized homoeopathic medicine alone; most had already tried conventional treatment with little success. Women made up 55 (66.3%) of the group, acne had been present for an average of 5.5 years, and severity was mild in 7 (8.4%), moderate in 37 (44.6%) and severe in 39 (47%). A total of 17 medicines were prescribed, with Lycopodium, Palladium and Platinum used most often.

Remission occurred in 68 patients (81.9%), two (2.4%) did not respond, and 13 (15.7%) were lost to follow-up; the mean time to remission was reported as 1.9 months, with no relapse or side effects.

Rath et al. [11] presented five patients from a dermatology outpatient department, none of whom had gained benefit from long conventional treatment. Their medicines were individualized according to location, sensation, modalities and concomitants, and severity was graded with GAGS. Debnath et al. [12] described three teenagers, written up following the HOM-CASE guideline and evaluated with GAGS and the Teenager's Quality of Life (T-QoL) scale; all three reportedly cleared within two months, scores on both scales dropped, and the Modified Naranjo Criteria for Homeopathy (MONARCH) gave a positive causal attribution.

Case reports

The case reports describe improvement following individualized prescribing. Nwabudike [6] documented two patients with severe acne who achieved remission, supported by photographs, long follow-up and no significant side effects. Vishwakarma [7] reported improved pustular acne with Natrum muriaticum 200C; Ravi et al. [8] reported acne clearing in about two months with Kalium bromatum 30C; Tiwari et al. [9] reported improvement in inflammatory facial acne; and Gupta [13] used photographs to show that red-brown marks on the cheeks resolved after a medicine selected by repertorization. These reports demonstrate that individualized prescribing is feasible in practice, but they cannot establish that it works better than other approaches.

Medicines and prescribing approaches reported

No single fixed acne protocol emerges from the literature; it describes individualized prescribing. Sulphur, Natrum muriaticum, Calcarea sulphurica, Calcarea phosphorica, Kalium bromatum, Pulsatilla nigricans, Hepar sulphuris and Antimonium crudum are named

most frequently, while Lycopodium, Palladium and Platinum were the leading medicines in the 83-patient series [4].

Zingiber officinale, Arctium lappa and Azadirachta indica were each tested as a single medicine given to all participants; two studies [15,16] tested combination preparations and one [17] a proprietary tablet. A medicine's being reported often does not by itself show that it works for acne.

Outcome measures used

Investigator-assessed measures were lesion counts (including the Leeds technique) and acne severity by GAGS, whereas patient-completed measures of disability and quality of life were CADI, Acne-QoL, DLQI and T-QoL. Photographs were also used, and MONARCH was applied for causal attribution in case reports. GAGS and CADI recur across several Indian studies, which would ease future comparisons.

METHODOLOGICAL APPRAISAL

Appraisal by study design

Studies varied greatly in methodological strength. Randomized, blinded and placebo-controlled, the trial by Rai et al. [5] is the most reliable, although its main between-group comparisons did not reach statistical significance. Open-label and observational studies relied on measurable outcomes, which strengthens outcome assessment, but with no concurrent control group they cannot support conclusions about cause. The labels below are the reviewers' own descriptive judgements, defined in the Methods, and not RoB 2 or GRADE ratings.

Study design	No. identified	Main appraisal	Overall evidence strength (descriptive)
Randomized placebo-controlled trials	3 [5,14,15]	Randomized with a placebo comparison; the largest trial [5]	Moderate for [5]; low to moderate for
Study design	No. identified	Main appraisal	Overall evidence strength (descriptive)
		and the complex trial [15] showed no significant between-group difference; the abstract of the 1994 dissertation [14] reports no numerical results	[14,15]
Other controlled or	2 [16,17]	A comparator or placebo period existed,	Low to moderate

placebo run-in studies		but randomization, blinding or concealment is unclear; one study tested a proprietary combination product	
Prospective or observational studies	4 [1,2,3,10]	Outcomes were measured (lesion counts, GAGS, CADI, Acne-QoL) but there was no concurrent comparison group	Low to moderate
Clinical case series	3 [4,11,12]	Larger or well-described clinical datasets lacking controls; open to selection bias and loss to follow-up	Low
Case reports	5 [6,7,8,9,13]	Detailed single-patient accounts, some with photographs; no control	Very low

Study-level appraisal

Study	Design	Assessment	Overall concern	Main limitation
Rai 2022 [5]	RCT	Randomized, double-blind, placebo-controlled; registered trial	Some concerns	No significant between-group difference at 3 months
McDavid 1994 [14]	Randomized placebo-controlled dissertation	Comparator present; abstract reports no results	Unclear	Small sample; unpublished thesis
Ally 2014 [15]	RCT (dissertation)	Placebo-controlled; Leeds lesion counting; 3 dropouts	Important limitations	Small sample; 6-week treatment only; fixed complex, not individualized
Bekker 2013 [16]	Single group with placebo period	Two-week placebo period then treatment; photographs	Important limitations	No parallel control; short follow-up; fixed complex
Kolyadenko 2014 [17]	Controlled add-on study	Two equal groups; efficacy and tolerability assessed	Important limitations	Randomization and blinding unclear; proprietary product; non-English article
Miglani 2014 (Zingiber) [1]	Prospective open-label	Outcomes measured; no comparator; 31 of 32 analysed	Important limitations	Non-randomised; no control group
Miglani 2014 (Arctium) [2]	Observational	Outcomes measured; no comparator; 32 of 34 completed	Important limitations	Uncontrolled; small sample
Miglani 2014 (Azadirachta) [10]	Open-label Study	Outcomes measured; data taken from a secondary citation	Important limitations / unclear	Uncontrolled; primary article not accessed or verified
Sharma 2020 [3]	Open single-arm	GAGS and CADI at three time points;	Important limitations	No comparator; one rural clinic

		modified intention-to-treat		
Nwabudike 2021 [4]	Case series	Large series; remission defined by lesion number, duration and intensity	Important limitations	Selection bias and losses to follow-up; no comparator
Rath 2023 [11]	Case series	Standard case format; GAGS used; small series	High concern	Five patients; no comparator
Debnath 2025 [12]	Case series	HOM-CASE reporting; GAGS, T-QoL and MONARCH	High concern	Three patients; no comparator
Nwabudike 2018 [6]	Case reports	Photographs and long-term follow-up	High concern	Two patients; no comparator
Vishwakarma 2022 [7]	Case report	No concurrent comparator	High concern	Single patient
Ravi 2024 [8]	Case report	No comparator; other explanations not excluded	High concern	Single patient
Tiwari 2025 [9]	Case report	No comparator; limited methodological detail	High concern	Single patient
Gupta 2025 [13]	Clinical image	Photographic record only	High concern	Single patient; limited outcome
Study	Design	Assessment	Overall concern	Main limitation
				data

DISCUSSION

Several distinct homoeopathic strategies have been applied to acne vulgaris: individualized prescribing, single named medicines given to all participants, and fixed combination products. The individualized strategy is the most prominent, since the randomized trial [5], the 83-patient series [4], the single-arm study [3] and most case-based reports chose medicines from the totality of symptoms (Organon, §§7 and 18). The difference is important. A fixed combination given to everyone departs from the principle of one simple medicine chosen for the individual patient (Organon, §273), so a negative result for a fixed complex [15] settles nothing about individualized prescribing. In the same way, a favourable uncontrolled result for one medicine cannot be extended to all patients with acne, and the single-medicine studies [1,2,10], which gave every participant the same medicine, are not tests of individualized homoeopathy.

The central point of this synthesis is that improvement within a group, or in an uncontrolled study, is no proof that the treatment works. The best comparative evidence located is the double-blind randomized placebo-controlled trial [5]: its effect leaned toward treatment, with

small to medium effect sizes, but at three months the between-group difference was not significant. A randomized placebo-controlled trial of a fixed complex [15] was negative as well. On the whole, current evidence has not established that homoeopathic treatment beats placebo in acne vulgaris. Conversely, one moderately sized trial with a non-significant result cannot prove that no effect exists, since its confidence intervals can span both a small benefit and no benefit.

Many of the studies used outcomes that matter to patients. GAGS provides a structured severity grade assessed by the investigator; CADI, Acne-QoL, DLQI and T-QoL, by contrast, capture patients' own perception of disability and quality of life. The association between GAGS and CADI in the single-arm study [3] implies that fewer lesions accompany better quality of life, a clinically sensible finding that favours using both kinds of scale in later trials. Significant reductions in lesion counts, GAGS and Acne-QoL were reported by all three single-medicine studies [1,2,10], a repeated pattern of within-group improvement under open-label conditions, though the report on [10] could not be verified.

Caution is needed in reading these observational results. When there is no randomization and no control group, the apparent improvement could simply be acne's natural course, regression to the mean (patients tend to seek help when their acne is at its worst), parallel changes in topical care or diet, expectation, or biased reporting. Acne is also notable for a strong placebo response: both groups improved to a similar degree in the complex trial [15], and in the add-on study [17] clinical remission was numerically commoner in the control group. The 83-patient series [4] reports a high remission rate that is clinically interesting, yet causal conclusions are ruled out by loss to follow-up, the inclusion of many patients for whom conventional treatment had failed, and the lack of a comparison group.

Case-based reports add clinical detail about how a medicine is picked from location, sensation, modalities, concomitants and the patient's overall presentation, often with photographs as support [6,11,12,13]. Reporting guidelines such as HOM-CASE and causal attribution tools such as MONARCH [12] are a helpful advance because they make the reasoning behind each prescription visible. Even so, selection and publication bias affect case reports and small series, and they cannot demonstrate comparative efficacy.

The variety of medicines reported deserves comment. In the larger studies [3,5], Sulphur, Natrum muriaticum, Calcarea phosphorica, Pulsatilla nigricans, Calcarea sulphurica and Kalium bromatum come up repeatedly, whereas Lycopodium, Palladium and Platinum were the leading medicines in the 83-patient series [4]. Such variety suits an individualized approach, where one diagnosis may be matched with different prescriptions, but it also means

that this evidence cannot support recommending one acne protocol. The *Zingiber officinale*, *Arctium lappa* and *Azadirachta indica* studies [1,2,10], each using a single medicine, serve to generate hypotheses and would be considerably stronger if tested against placebo in randomized designs.

Acne is clinically a chronic and relapsing condition; managing it means controlling inflammatory lesions, preventing scars and dealing with the psychological burden. Studies that report an improved quality of life along with lower lesion counts are therefore of clinical relevance. Some studies reported adverse events as absent or non-serious, among them the randomized trial [5], which recorded no serious adverse events, but most studies did not record them systematically, so this literature does not allow a firm conclusion about safety. Moderate to severe or scarring acne can leave permanent damage, and the present evidence therefore does not justify substituting homoeopathy for established effective treatment; any use alongside conventional care should be agreed with the patient and a qualified dermatological opinion.

To sum up, the literature supports further study of individualized homoeopathy in acne vulgaris but not a firm claim of efficacy. Future trials ought to feature proper randomization with concealed allocation, blinded assessment of outcomes, standard severity scales such as GAGS, validated quality-of-life tools, prospective registration, explicit documentation of every prescription and potency, sample sizes based on a clinically meaningful difference, standardized or recorded background skin care, and follow-up long enough to detect relapse.

CONFLICT OF INTEREST, FUNDING AND ADVERSE EVENTS

The records reviewed did not consistently provide information on conflicts of interest and funding; missing information is treated as not reported, not as absent. Several studies [4,5,6,17] described adverse events as absent or non-serious, whereas most observational and case-based records did not report them systematically. The authors declare that this review involved no conflict of interest and no external funding.

LIMITATIONS

- This is a narrative review and does not claim to follow the procedures of a formal systematic review.
- A protocol was not registered, no independent duplicate screening was performed, and only Google Scholar was searched, so relevant records indexed elsewhere may have been missed. Searches in Google Scholar are also not fully reproducible.

- No formal risk-of-bias or certainty-of-evidence instrument was used; the appraisal labels are the reviewers' descriptive judgements.
- The literature is heterogeneous in design, intervention, comparator, treatment duration and outcome measurement.
- Several studies are uncontrolled or non-randomized and provide less certain evidence than randomized comparative trials.
- Three records are unpublished master's dissertations and one is an article not in English; abstracts or summary information alone were accessible for some.
- Some studies are small, have short follow-up or lost many participants; the Azadirachta indica study's details came from a secondary citation, an exception to the eligibility rule.
- Case reports and case series are susceptible to selection, reporting and publication bias.
- A meta-analysis was not attempted owing to clinical and methodological differences among the studies.

CONCLUSION

Published clinical work indicates that homoeopathy has been examined in acne vulgaris both through individualized treatment and through medicine-specific treatment, and many studies describe better lesion counts, acne severity and quality of life. Still, the evidence is mixed and made up mostly of observational studies, case series and case reports. A double-blind randomized placebo-controlled trial, the best comparative study, found a non-significant trend favouring individualized homoeopathy over placebo, and a controlled trial of a fixed complex gave a negative result.

Homoeopathy therefore merits further clinical study, particularly of individualized prescribing and patient-centred outcomes, but firm conclusions on efficacy must await adequately powered, well-designed randomized controlled trials.

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