2026 Volume: 02 Issue: 11 www.ijrpa.com ISSN 2456-9995 Case Study

International Journal Research Publication Analysis

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# EFFECTIVENESS OF CONSTITUTIONAL AND TOTALITY-BASED HOMOEOPATHIC PRESCRIBING IN GASTRITIS: A PROSPECTIVE COMPARATIVE CLINICAL STUDY

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**Article Received: 30 September 2026**
**Article Revised: 19 October 2026**
**Published on: 09 November 2026**

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DOI: https://doi-doi.org/101555/ijrpa.8127

## ABSTRACT

**Background:** Gastritis is inflammation of the stomach lining that causes upper abdominal pain, nausea and loss of appetite. In homoeopathy a remedy is either chosen on the constitution or on the totality of symptoms of the clinical condition, but the two approaches have not been compared in gastritis.

**Aim:** To compare constitutional prescribing with totality-based clinical condition prescribing in gastritis.

**Methods:** A prospective comparative study was done at Sarada Krishna Homoeopathic Medical College and Hospital, Kulasekharam. Thirty patients selected by purposive sampling were divided into Group A (constitutional remedy, n = 15) and Group B (totality-based clinical condition remedy, n = 15). Both groups received lifestyle advice. A symptom score (maximum 60, on the Gastrointestinal Symptom Rating Scale) was recorded at baseline and at weeks 4, 8 and 12.

**Results:** All 30 patients completed follow-up. The mean score fell from 30.8 to 12.6 in Group A and from 28.2 to 12.3 in Group B. The mean fall at week 12 was 18.2 points in Group A and 15.9 points in Group B, which was significantly different. Moderate or well improvement occurred in 14 of 15 and 12 of 15 patients respectively.

**Conclusion:** Both approaches produced a significant fall in symptom score, and the difference between the groups was not significant.

**KEYWORDS:** Gastritis; constitutional prescribing; totality of symptoms; homoeopathy; symptom score.

## INTRODUCTION

Gastritis is inflammation of the gastric mucosa. It can start abruptly and settle within days (acute gastritis), or it can develop gradually and last for years (chronic gastritis)[1,2]. The updated Sydney System grades gastritis by its site, cause and degree of inflammation[3], and reported prevalence differs according to the definition adopted[4]. Infection with Helicobacter pylori is the commonest cause[5], and its pooled global prevalence is about 44%[6]. Other causes are aspirin and other non-steroidal anti-inflammatory drugs, heavy alcohol use, bile reflux, stress and autoimmune injury to the mucosa[1,7].

Typical complaints are upper abdominal pain or burning, nausea, vomiting, bloating, belching and poor appetite[1,8]. Conventional management removes the precipitating cause, suppresses acid and, where H. pylori is present, eradicates the organism[1,9]. Because symptoms may recur and repeated courses of drugs are needed, some patients seek complementary treatment such as homoeopathy.

Hahnemann regarded the totality of symptoms as the true guide to the remedy[10], and Kent laid special stress on the patient's constitution[11]. Two styles of prescribing can therefore be distinguished. In constitutional prescribing the remedy is chosen chiefly from the patient's make-up, whereas in totality-based clinical condition prescribing it is chosen chiefly from the totality of the symptoms of the current illness, including the features characteristic of the clinical condition (pathological generals)[12]. Homoeopathic publications on gastritis are few and do not set one approach against the other[13-16]. Symptom change can be quantified with a rating scale such as the Gastrointestinal Symptom Rating Scale (GSRS)[17]. This study compares the two prescribing approaches in patients with gastritis.

To our knowledge, no earlier prospective study has compared constitutional prescribing directly with totality-based clinical condition prescribing in gastritis using a scored outcome. The aim of the study was to compare the effectiveness of the two approaches. The objectives were to assess the change in symptom score with a constitutional remedy and a totality-based

clinical condition remedy and to compare improvement between the groups at weeks 4, 8 and 12.

## MATERIALS AND METHODS

### Study setting and design

A prospective, two-group comparative clinical study was conducted in the out-patient and in-patient departments of Sarada Krishna Homoeopathic Medical College and Hospital, Kulasekharam, Kanniyakumari District, Tamil Nadu. Each patient was followed for 12 weeks. Institutional ethics committee approval number: SKHMC/IEC/792/2026, dated 12/1/2026.

### Sample

Thirty patients with gastritis were selected by purposive sampling and divided into two groups of 15: Group A (constitutional remedy) and Group B (totality-based clinical condition remedy).

### Selection criteria

*Inclusion criteria*: patients of either sex and of any age with a clinical diagnosis of gastritis; a baseline symptom score in the moderate to severe range; and willingness to attend follow-up for 12 weeks.

*Exclusion criteria*: a history of peptic ulcer disease or gastrointestinal bleeding; severe systemic illness such as malignancy, uncontrolled diabetes, liver cirrhosis or renal failure; and pregnancy or lactation.

### Intervention

In Group A, a single remedy was selected mainly on constitutional assessment after detailed case-taking that covered temperament, modalities, mental and emotional characteristics and family history. In Group B, the remedy was selected mainly on the totality of the symptoms of the present illness and the characteristic features of the clinical condition (pathological generals), with less weight on long-standing constitutional features. Both groups received dietary and lifestyle advice for gastritis. The dose was repeated as required.

### Procedure

Patients with symptoms suggestive of gastritis were examined, and those who satisfied the selection criteria and agreed to follow-up were enrolled. A detailed case was taken and the

baseline symptom score was recorded at the first visit (week 1). The 30 patients were divided into the two groups, the remedy was prescribed according to the group, and dietary and lifestyle advice was given. Patients were reviewed at weeks 4, 8 and 12, and the score was recorded at each visit.

### Outcome measure

The outcome was a gastrointestinal symptom score modelled on the GSRS[17], with a maximum of 60; a lower score indicates fewer symptoms. The primary outcome was the fall in score from baseline to week 12, graded as mild (up to 10 points), moderate (11 to 17 points) or well (18 points or more).

### Statistical analysis

Data were entered in Microsoft Excel and analysed with Python (SciPy). Continuous data are expressed as mean ± standard deviation (SD). The paired t-test was used for change within a group, the independent t-test for differences between groups, and Fisher's exact test for improvement categories. A p value below 0.05 was taken as significant.

## RESULTS AND DISCUSSION

### Results

All 30 patients (15 per group) completed the 12-week follow-up, and there were no dropouts.

### Age and sex

The commonest age group was 41–50 years (8 patients) and the least common was up to 20 years (2 patients) (Table 1). Group A was concentrated at 41–60 years (10 of 15), while Group B was spread more widely, with most patients (5) at 21–30 years. The mean age was 46.2 years (range 29–65) in Group A and 38.3 years (range 13–67) in Group B ($p = 0.148$). There were 16 males and 14 females, and each group had 8 males and 7 females.

**Table 1: Distribution of patients by age and sex.**

| Characteristic | Group A (n) | Group B (n) | Total (n) |
|---|---|---|---|
| **Age group (years)** | | | |
| Up to 20 | 0 | 2 | 2 |
| 21–30 | 1 | 5 | 6 |
| 31–40 | 3 | 2 | 5 |
| 41–50 | 5 | 3 | 8 |
| 51–60 | 5 | 0 | 5 |
| Above 60 | 1 | 3 | 4 |
| **Sex** | | | |
| Male | 8 | 8 | 16 |
| Female | 7 | 7 | 14 |
| **Total** | **15** | **15** | **30** |

**Change in symptom score**

The mean score fell steadily at every review in both groups (Table 2, Figure 1). It dropped from 30.8 to 12.6 in Group A and from 28.2 to 12.3 in Group B, and the fall from baseline was significant at weeks 4, 8 and 12 in both groups (paired t-test, $p < 0.001$ for each). The two groups were similar at baseline. Group B had lower raw scores at week 4 and week 8, but this reflects its slightly lower starting score, because the fall from baseline did not differ between groups at week 4, week 8 or week 12. The raw scores were also alike at week 12 (Figure 2).

**Table 2: Mean symptom score (maximum 60) and fall from baseline.**

| Time point | Group A mean | Group B mean | p value* |
|---|---|---|---|
| Baseline (week 1) | 30.8 | 28.2 | 0.096 |
| Week 4 | 26.3 | 22.8 | 0.015 |
| Week 8 | 20.0 | 17.1 | 0.041 |
| Week 12 | 12.6 | 12.3 | 0.860 |
| **Fall from baseline** | | | |
| At week 4 | 4.5 | 5.4 | 0.268 |
| At week 8 | 10.8 | 11.1 | 0.847 |
| At week 12 | 18.2 | 15.9 | 0.261 |

**Independent t-test between groups. Within-group fall from baseline: $p < 0.001$ at each time point in both groups (paired t-test).*

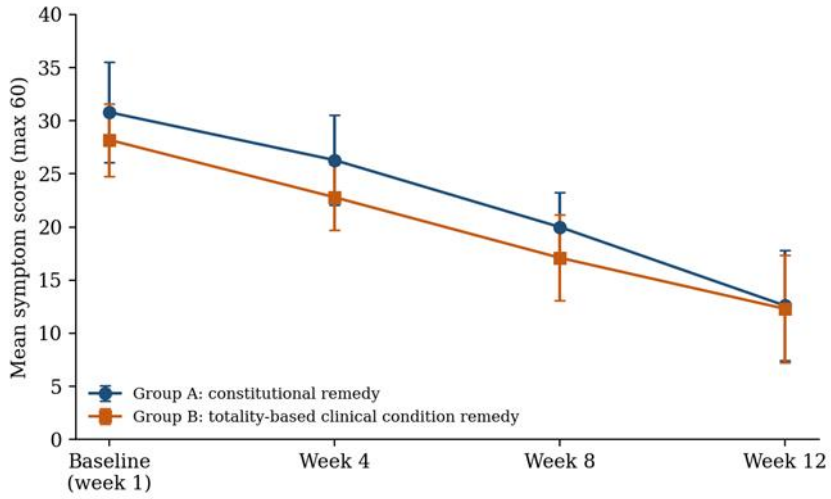



**Figure 1: Mean symptom score (± SD) from baseline to week 12 in the two groups.**

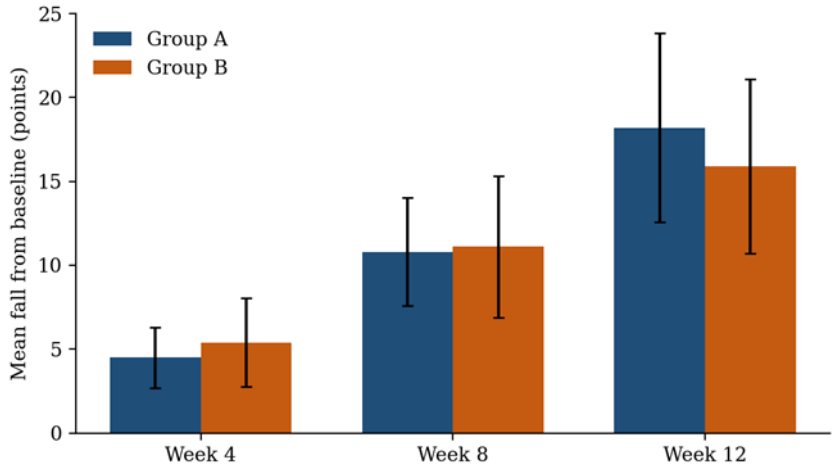



**Figure 2: Mean fall in symptom score from baseline at weeks 4, 8 and 12.**

## Grading of improvement

Moderate improvement was the commonest grade (15 patients) and mild improvement the least common (4 patients) (Table 3, Figure 3). No patient failed to improve; the smallest fall was 7 points (Group B) and the largest 28 points (Group A). Moderate or well improvement was seen in 14 of 15 patients in Group A and 12 of 15 in Group B, and the distribution of grades did not differ significantly (Fisher's exact test, $p = 0.598$).

**Table 3: Grading of improvement at week 12.**

| Improvement (fall in score) | Group A (n) | Group B (n) | Total n (%) |
|---|---|---|---|
| Mild (up to 10 points) | 1 | 3 | 4 (13.3) |
| Moderate (11–17 points) | 8 | 7 | 15 (50.0) |
| Well (18 points or more) | 6 | 5 | 11 (36.7) |
| **Total** | **15** | **15** | **30 (100)** |

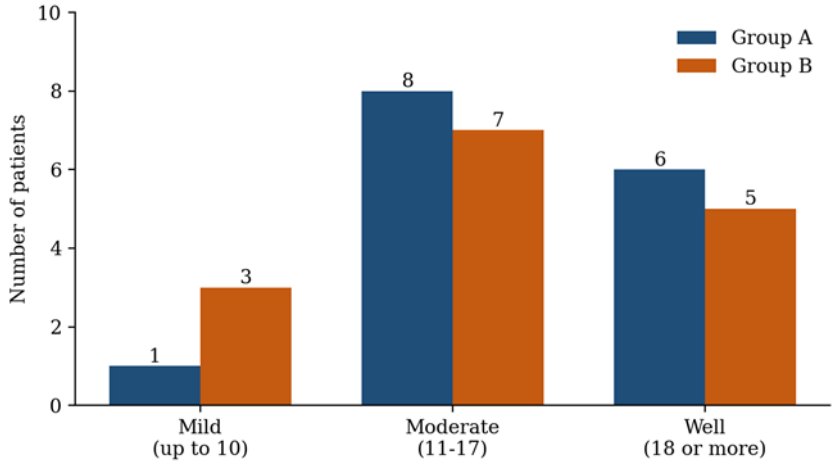



**Figure 3: Grading of improvement at week 12 in Group A and Group B.**

**Medicines and potencies**

Group A received 10 different medicines. Lycopodium was the commonest (3 patients), followed by Sulphur, Natrum muriaticum and Nux vomica (2 each); the other six medicines were each used once. In Group B, Hydrastis, Sulphuricum acidum and Robinia were each used in 2 patients and the remaining nine medicines once each (Table 4, Figure 4). In Group A the commonest potency was 200C (7 patients), followed by 1M (4 patients), whereas in Group B it was 30C (9 patients), followed by 200C and the mother tincture (2 each) (Figure 5). Thus 200C and 1M made up 73.3% of Group A prescriptions, while 30C, mother tincture and 6X made up 80.0% of Group B prescriptions.

**Table 4: Most frequently prescribed medicines and potencies.**

| | Group A (n = 15) | Group B (n = 15) |
|---|---|---|
| Medicines used (n) | 10 | 12 |
| Commonest medicines | Lycopodium (3); Sulphur, Natrum muriaticum, Nux vomica (2 each) | Hydrastis, Sulphuricum acidum, Robinia (2 each) |
| Commonest potency | 200C (7), 1M (4), LM 0/1 (2) | 30C (9), 200C (2), Q (2) |

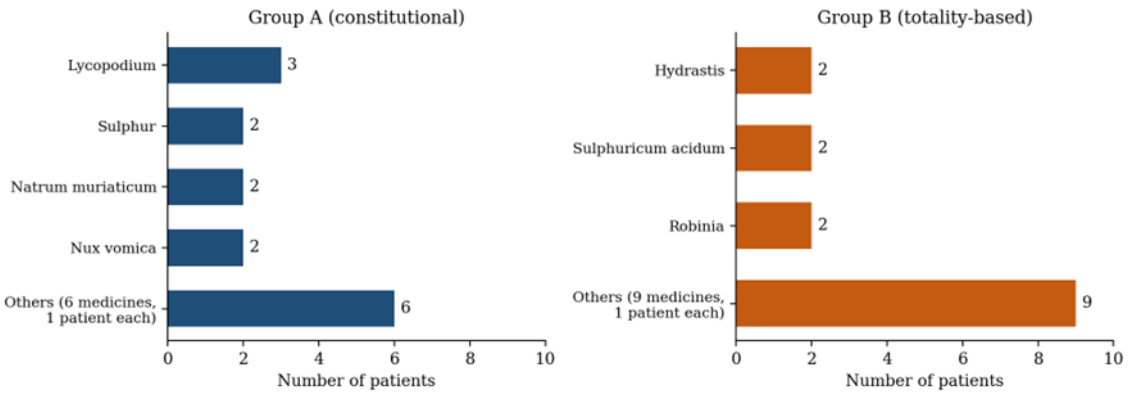



**Figure 4: Medicines prescribed in Group A and Group B. (number of patients)**

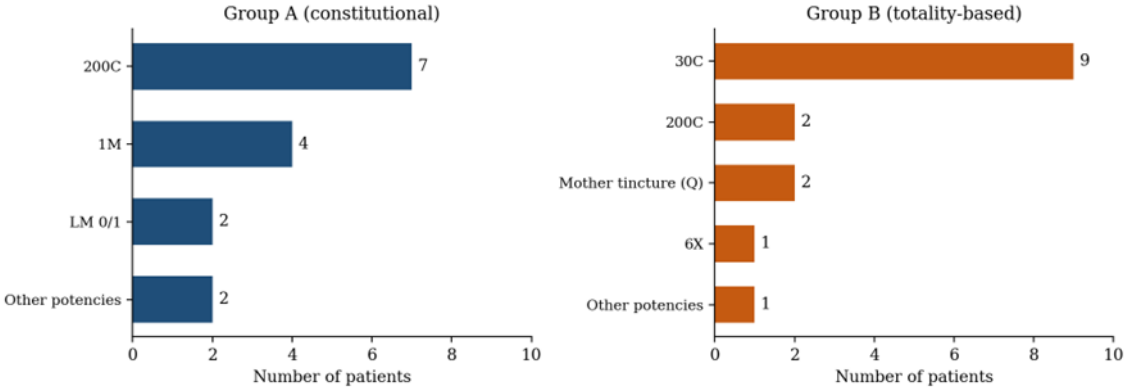



**Figure 5: Potencies prescribed in Group A and Group B. (number of patients)**

## DISCUSSION

Earlier homoeopathic work on gastritis has been largely descriptive. A retrospective case series of 40 patients found Lycopodium, Nux vomica, Pulsatilla and Sulphur to be the most frequently used medicines[18], and a case series of 30 patients with acid-peptic disorders found Robinia and Natrum sulphuricum to be the most frequent[15]. Other reports examined modalities and triggering factors in choosing the remedy[14], evaluated homoeopathic treatment of gastritis with anxiety before and after treatment[19], reviewed interventions in acute gastritis[20] and described a single treated case[21]. To our knowledge none of them compared one prescribing method with another.

The medicines in the present series agree with these reports: Lycopodium, Nux vomica, Pulsatilla and Sulphur were all used in Group A, and Robinia was used in Group B[15,18]. The present study differs in being prospective, in following two groups for 12 weeks, and in measuring symptoms at four time points, so it adds scored outcomes to the remedies and

rubrics described earlier. Its strengths are the direct comparison of the two methods in one setting, complete follow-up of all 30 patients and a steady fall in scores with both approaches.

## CONCLUSION

Both constitutional prescribing and totality-based clinical condition prescribing were followed by a significant fall in the gastritis symptom score over 12 weeks ($p < 0.001$ in each group), and every patient improved. The difference in improvement between the two groups was not statistically significant at weeks 4, 8 or 12, so no clear advantage of either approach was seen in this study. Either approach may therefore be used in the homoeopathic management of gastritis, according to what suits the individual patient.

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