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The Utility of the Complete Repertory in the Homoeopathic Management of Chronic Bronchial Asthma: A Case Series Study

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ABSTRACT

Background: Bronchial asthma is a chronic, heterogeneous airway disease, and India carries a heavy and disproportionate share of its burden. Individualised homoeopathic prescribing depends on repertorisation, yet published accounts that document the use of the Complete Repertory in asthma are scarce.

Objectives: To study the utility of the Complete Repertory in the homoeopathic management of chronic bronchial asthma; to explore the effectiveness of individualised homoeopathic medicines in this condition; and to examine whether treatment reduced asthma symptom burden, including the frequency of attacks.

Methods: A case series of 45 patients of any age and either sex with diagnosed bronchial asthma was conducted over 18 months, with patients drawn from a college outpatient department, peripheral outpatient departments and medical camps by simple random sampling. After informed consent, each case was recorded in a standard Case Record Format, analysed, repertorised with the Complete Repertory, and treated with an individualised remedy confirmed against the Homoeopathic Materia Medica. Follow-up was at 7 days and then every 15 days. Outcomes were the Asthma Control Test (ACT) score before and after treatment and a clinical rating of Improved or Not Improved. Scores were compared with a paired t-test.

Results: Of 45 patients (28 male, 17 female; age 2.5 to 75 years), the mean ACT score rose from 13.27 to 21.40, a mean gain of 8.13 points (95% CI 7.24 to 9.02; paired t = 18.44, df = 44, p < 0.001). Forty-four patients gained at least 3 points, the accepted minimally important difference. Before treatment 34 patients were poorly controlled, 11 partly controlled and none well controlled; afterwards none was poorly controlled, 3 were partly controlled and 42 were well controlled. Clinically, 43 patients (95.6%) were rated Improved and 2 (4.4%) Not Improved. Twenty-one different remedies were prescribed; Phosphorus (n = 6) and Pulsatilla (n = 5) were the commonest.

Conclusion: In this small, uncontrolled series, repertory-guided individualised homoeopathic treatment was followed by marked improvement in asthma control, and the Complete Repertory proved a workable tool for individualisation. Because there was no comparison group and follow-up was short, these findings show utility and feasibility, not causal efficacy; larger controlled studies with longer follow-up are warranted.

Keywords: Bronchial asthma; Complete Repertory; Homoeopathy; Asthma Control Test (ACT); Individualised prescribing; Clinical improvement; Frequency of asthmatic attacks

1. Introduction

Asthma is a long-term disease of the airways that affects people of every age [1]. Genetic susceptibility and environmental exposure both contribute, and no single cause explains it [2]. Current international guidance describes it as a heterogeneous condition in which chronic airway inflammation coexists with variable expiratory airflow, and which declares itself through wheeze, breathlessness, chest tightness and cough that fluctuate in timing and intensity [3,4]. The disease is coded as J45 in the ICD-10 classification [5]. The name is old: it derives from a Greek word for panting or laboured breathing [6–8], was used in Greek antiquity before it acquired a medical meaning [9], and the first detailed clinical description is generally credited to Aretaeus of Cappadocia [10].

The public-health weight of asthma is considerable. About 300 million people live with the disease worldwide [2], and its prevalence has been estimated to rise by roughly half every ten years [1]. India accounts for an estimated 34.3 million cases, close to 13% of the global total [11]. The more troubling figure is mortality: India holds about 13% of the world's population but around 42% of asthma deaths, a mismatch that points to gaps in diagnosis, specialist care and long-term control, not simply to how common the disease is [12,13]. Severe uncontrolled attacks can progress to status asthmaticus, which is life-threatening [14], and persistent poor control brings anxiety, depression, missed school and work, and a poorer quality of life [15].

Conventional management is built around inhaled corticosteroids and bronchodilators, stepped up according to control [3,16,17]. These measures control the disease in many patients without curing it, and prolonged or high-dose corticosteroid exposure can affect bone density, growth in children and adrenal function [18]. Such limits are one reason many patients look for complementary options, homoeopathy among them [19]. The underlying pathology is well described: allergen exposure in a susceptible person drives a Th2-dominated immune response with IgE-mediated mast-cell activation, followed by a late-phase eosinophilic reaction and, over years, airway remodelling [1,3,20]. Beyond this immunological core, a psychosomatic and neurological dimension is increasingly recognised. Psychosocial stress can alter autonomic, endocrine and immune function and influence the onset and course of asthma [21–23], and sensory nerves and immune cells in the airway interact in a two-way fashion that can sustain inflammation [24,25]. Autonomic regulation has been discussed in this connection as well [26].

Homoeopathy, founded by Samuel Hahnemann on the principle of similars, directs treatment at the pattern of disturbance shown by the individual patient and not at the disease label [27]. Hahnemann also described chronic miasms as deep-seated predispositions to chronic disease [28], and Kent stressed that general and mental symptoms carry the greatest weight in choosing a remedy, so that two patients with the same diagnosis may need different medicines [29]. The repertory is the working instrument of this method. It is an index of symptoms (rubrics), each listing the remedies associated with that symptom, and it helps the physician narrow a long list of candidates to a few that fit the whole case [30]. Boenninghausen's Therapeutic Pocket Book was an early and influential example [30]; later works include the Synthesis Repertory [31] and Murphy's Homeopathic Medical Repertory [32].

The Complete Repertory, compiled by Roger van Zandvoort, retains Kent's general-to-particular framework while integrating material from Boenninghausen and Boger, with the stated aim of serving as a "super repertory" [33–35]. It was first released in full in 1996 [33,36]. Recent editions contain more than 230,000 rubrics, more than 2,500 remedies and more than 4,000 documented sources, arranged in 44 chapters, and every remedy entry carries a four-level grade [34,37,38]. Despite its wide use, published research on this repertory is thin. The examples we located concern Bayesian validation of rubrics [39] and a comparative study of remedies in suppurative uveitis and panophthalmitis [40], and we found no published case series that evaluates it specifically in bronchial asthma.

The wider evidence on homoeopathy in asthma is mixed. A systematic review of controlled trials judged the support for individualised homoeopathy inconclusive, largely because the individualisation process was reported inconsistently [19]. A Cochrane review reached a similar view of the then-available evidence [41], and a randomised placebo-controlled trial of individualised homoeopathy as an adjunct in childhood asthma found no advantage over placebo [42]. Observational data from the Central Council for Research in Homoeopathy, by contrast, recorded favourable responses to several remedies, including *Arsenicum album*, *Pulsatilla*, *Kali carbonicum*, *Natrum sulphuricum* and *Carbo vegetabilis* [43]. Against this background, a transparently documented series, in which the rubrics, the remedy and the measured outcome of every patient are traceable, can contribute useful groundwork. The present study was designed in that spirit.

2. Aim and Objectives

Aim: To study the utility of the Complete Repertory in the homoeopathic management of chronic bronchial asthma.

- Primary objective: to study the utility of the Complete Repertory in the homoeopathic management of bronchial asthma.
- Secondary objective: to explore the effectiveness of homoeopathic medicine in cases of bronchial asthma.
- Tertiary objective: to study whether homoeopathic medicine decreases the frequency of attacks of bronchial asthma.

3. Materials and Methods

3.1 Study design, setting and duration

This was a case series conducted over 18 months. Patients were recruited from the outpatient department of the parent homoeopathic college, from its peripheral outpatient departments and from medical camps. No comparison or control group was used, and no matching was applicable.

3.2 Participants and sampling

The source population was the general population presenting with breathlessness, wheezing, chest tightness and cough. Forty-five cases were selected by simple random sampling from those who met the criteria below.

Inclusion criteria: patients of any age and either sex who gave consent, had a diagnosis of bronchial asthma, and showed its signs and symptoms.

Exclusion criteria: pathological changes other than bronchial asthma; immunocompromised patients, or patients already taking medicine from another system of medicine; and asthma coexisting with other respiratory conditions.

Withdrawal criteria: withdrawal of consent or irregular follow-up.

3.3 Ethical considerations

Informed consent, with a patient information sheet in the local language and English, was obtained from every participant, and identities were kept confidential. Ethical approval for the study was obtained from the Ethical committee of Motiwala homoeopathic medical college and hospital, Nashik before start of the study.

3.4 Data collection and case analysis

Each patient was interviewed and examined using a standard Case Record Format that captured presenting complaints, history, family and past history, personal and mental generals, thermal state, physical and systemic examination. The symptoms were then analysed and classified into mental, physical general and particular symptoms, with characteristic symptoms identified. Evaluation of the symptoms gave a totality, and the miasmatic background was also considered.

3.5 Repertorisation and prescription

Selected rubrics were repertorised with the Complete Repertory, following Kent's method of choosing a rubric for each characteristic symptom, building a repertorial grid, and totalling the grades each remedy receives [33]. Rubrics were drawn mainly from the Mind, Stomach, Respiration, Chest and Generalities chapters. The leading remedies were then compared against the Homoeopathic Materia Medica [44,45] and the principles of homoeopathy [27,29], and one individualised remedy was prescribed on the basis of symptom similarity. The remedy was given mainly in the 200C potency, as a single dose, and was followed by placebo; a lower potency was used in a few cases, and a dose was repeated when the clinical response called for it.

3.6 Follow-up and outcome assessment

The first follow-up was at 7 days and later follow-ups at 15-day intervals. Asthma control was measured with the Asthma Control Test (ACT), a five-item self-administered questionnaire with a four-week recall period and a score range of 5 to 25 [46,47]. In line with GINA-linked usage [48,49], scores of 15 or less were taken as poorly controlled, 16 to 19 as partly controlled and 20 or more as well controlled. A change of 3 points is regarded as the minimally important difference [50]. The ACT was recorded before treatment and again at the final follow-up. Because the ACT asks directly about breathlessness, night-time waking and rescue-inhaler use, the frequency of attacks was assessed through this instrument and not as a separate measure.

Each case was also given an overall clinical rating by the treating physician. **Improved** meant improvement on the scale together with relief of clinical signs and symptoms; **Not Improved** meant neither.

3.7 Statistical analysis

Before and after ACT scores were compared with a paired t-test (two-sided, significance at $p < 0.05$), and the mean paired difference is reported with its 95% confidence interval. As a sensitivity check, a Wilcoxon signed-rank test was also applied. Categorical data are given as counts and percentages.

4. Results

4.1 Patient characteristics

All 45 planned cases were recruited and have complete records. Twenty-eight patients (62.2%) were male and 17 (37.8%) female. Ages ranged from 2.5 to 75 years, covering children, adults and the elderly (Table 1). Working-age adults between 18 and 59 years formed the largest share (33 of 45).

Table 1. Age and sex distribution of the patients (n = 45)

Characteristic	Number	Percentage
Male	28	62.2
Female	17	37.8
Age 0–17 years	6	13.3
Age 18–29 years	7	15.6
Age 30–44 years	16	35.6

Characteristic	Number	Percentage
Age 45–59 years	10	22.2
Age 60 years and above	6	13.3

4.2 Change in Asthma Control Test scores

The mean ACT score was 13.27 (SD 2.90; range 6–18) before treatment and 21.40 (SD 1.27; range 17–24) after treatment. The mean paired gain was 8.13 points (SD 2.96; standard error 0.44; 95% CI 7.24 to 9.02), corresponding to a mean rise of 61.3% over the baseline mean. The paired t-test gave $t = 18.44$ with 44 degrees of freedom ($p < 0.001$), and the Wilcoxon signed-rank test agreed ($p < 0.001$). Every patient's score rose. Forty-four of 45 patients (97.8%) improved by 3 points or more, the accepted minimally important difference [50]; the median gain was 8 points (range 1 to 15). The change in the mean score is shown in Figure 1.

Table 2. Asthma Control Test scores before and after treatment (n = 45)

Measure	Before	After	Difference
Mean score	13.27	21.40	8.13
Standard deviation	2.90	1.27	2.96
Range	6–18	17–24	1–15
Paired t-test			$t = 18.44$, $df = 44$, $p < 0.001$

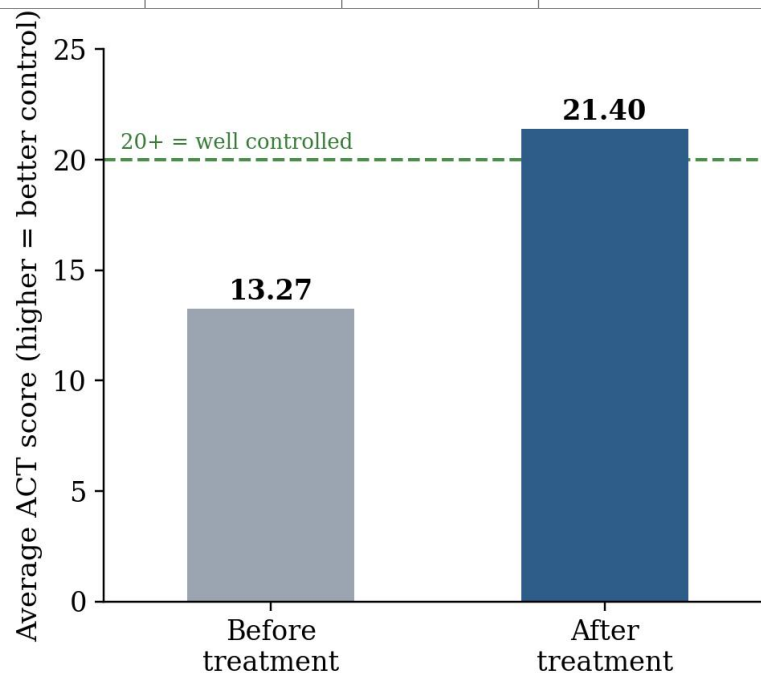


Figure 1. Average Asthma Control Test (ACT) score of the 45 patients before and after treatment. The dashed line at 20 marks the score from which asthma is considered well controlled.

4.3 Shift in asthma control category

At baseline no patient was well controlled, 11 were partly controlled and 34 (75.6%) were poorly controlled. After treatment none remained poorly controlled, 3 were partly controlled and 42 (93.3%) were well controlled (Table 3, Figure 2).

Table 3. Distribution of patients by asthma control category (n = 45)

Control category (ACT score)	Before treatment	After treatment
Poorly controlled (≤ 15)	34	0
Partly controlled (16–19)	11	3
Well controlled (≥ 20)	0	42

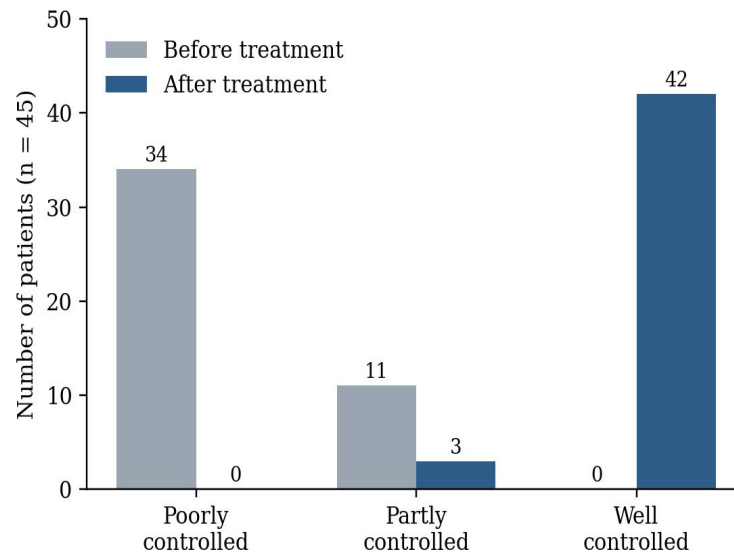


Figure 2. Number of patients in each GINA-linked control category before and after treatment.

4.4 Overall clinical outcome

By the physician's overall rating, 43 patients (95.6%) were Improved and 2 (4.4%) were Not Improved. The rating usually coincided with reaching the well-controlled band but not always. One patient whose score moved from 13 to 19 stayed just below the well-controlled threshold yet was rated Improved on the strength of observed symptomatic relief. Both Not Improved patients showed a numerical rise (16 to 17, and 12 to 18) that the physician did not judge to be a genuine clinical improvement.

4.5 Remedies prescribed

Twenty-one different remedies were used across the 45 cases (Table 4), and no single remedy accounted for more than one case in eight. Phosphorus was prescribed most often (6 cases), followed by Pulsatilla (5), and Kali carbonicum, Nux vomica and Natrum muriaticum (4 each). Arsenicum album, Calcarea carbonica, Sulphur, Lycopodium and Lachesis were each used twice. Eleven further remedies, namely Thuja occidentalis, Ignatia amara, Calcarea silicata, Silicea, Natrum sulphuricum, Sepia, Stramonium, Tuberculinum, Bacillinum, Argentum nitricum and Carcinosin, were each used once.

Table 4. Remedies prescribed in the series

Remedy	Number of cases	Share of series
Phosphorus	6	13.3%
Pulsatilla	5	11.1%
Kali carbonicum	4	8.9%
Nux vomica	4	8.9%

Remedy	Number of cases	Share of series
Natrum muriaticum	4	8.9%
Arsenicum album	2	4.4%
Calcarea carbonica	2	4.4%
Sulphur	2	4.4%
Lycopodium	2	4.4%
Lachesis	2	4.4%
Eleven other remedies (one case each)	11	24.4%

4.6 Illustrative case

A 42-year-old woman had suffered breathlessness, wheezing, chest tightness and a dry cough with scanty white expectoration for eight years. Attacks began after a move to a new house, were worst between 1 and 3 a.m., forced her to sit up and lean forward, and were aggravated by the rainy season, cold and dust. She became intensely fearful of dying during attacks, was restless, worried constantly about her health, changed doctors often, was fastidious about neatness, was chilly, sipped small quantities of water and preferred warm drinks. Her father had asthma, and she had a history of suppressed skin eruptions in youth. The repertorial totality combined rubrics for anxiety about health, fear of suffocation with asthmatic complaints, restlessness with asthmatic complaints, fastidiousness, thirst for small quantities, aggravation from cold, difficult respiration after midnight, and the need to sit up. Arsenicum album emerged as the leading remedy, with Kali carbonicum and Cuprum metallicum as the alternatives, and it was preferred because its picture matched her mental and general state as well as the particulars. A single dose of Arsenicum album 200C was given, followed by placebo, with a second dose at one follow-up when mild wheezing persisted. Over about three months her attacks stopped, fear and irritability settled, sleep normalised, an old skin eruption that had resurfaced cleared, and her ACT score rose from 17 to 22.

5. Discussion

In this series of 45 patients, asthma control improved substantially after individualised, repertory-guided homoeopathic treatment. The mean ACT score rose by 8.13 points, well beyond the 3-point threshold regarded as clinically important [50], and 44 of 45 patients crossed that threshold. The distribution of patients moved from predominantly poorly controlled to predominantly well controlled, and 95.6% were rated clinically improved. Because the ACT contains items on night waking, breathlessness and rescue-inhaler use, the gain also bears on the tertiary objective, a lower burden of attacks, although attack frequency was not recorded as a separate measure.

These results need cautious reading. A case series without a comparison group cannot separate the effect of the remedies from the natural fluctuation of asthma, regression towards the mean in patients who were recruited when symptomatic (34 were poorly controlled at entry), the non-specific effects of a long and attentive consultation, or the influence of prior conventional treatment. The randomised evidence is not uniformly favourable: a placebo-controlled trial of individualised homoeopathy as an adjunct in childhood asthma found no benefit over placebo [42], and systematic reviews describe the overall evidence as inconclusive or limited by quality [19,41]. Our findings therefore speak to the feasibility and utility of the repertorial method in practice, not to efficacy.

The pattern of prescribing supports the point of individualisation. Twenty-one different remedies were needed for 45 patients, and the commonest remedy covered only 6 of them. This is the picture expected when each patient's totality, and not the diagnostic label, drives selection [27,29]. Many of the remedies used are familiar from the classical asthma literature [44,45], and several of those most frequently prescribed here, such as Pulsatilla, Kali carbonicum and Arsenicum album, also appear among the remedies reported as beneficial in the Council's observational data [43]. Hughes, writing in 1902, likewise listed Nux vomica, Arsenicum album, Blatta orientalis, Grindelia, Naja tripudians and Natrum sulphuricum among his usual first choices in asthma [51].

The Complete Repertory supplied several features that suited this task: broad coverage of the Respiration, Chest and Generalities chapters, specific rubrics for the time, modality and concomitants of attacks, the four-level grading that allows a long rubric to be filtered to its best-confirmed remedies, and source documentation behind its entries [33,34,37]. Its size also brings a practical difficulty. A rubric can return a very long remedy list, grading is not perfectly uniform across contributors, and the repertory can only narrow the field, so that the final choice must always be confirmed against the Materia Medica [34]. In our experience, careful selection of narrow and characteristic rubrics, and not broad ones, produced more usable remedy lists. The scarcity of published work on this repertory [39,40] means that the present series adds descriptive data in a setting where little exists.

Our case-taking was shaped by the psychosomatic and neuro-immune literature on asthma. Stress and emotional state can influence the occurrence and severity of attacks [21–25], and anxiety and depression are common in people with asthma, especially children, and can worsen control [15]. Asking systematically about fears, stress and temperament, as in the illustrative case, widened the totality available for repertorisation. This is a plausible rationale for a whole-person approach, but our design does not test whether it contributed to the outcomes.

5.1 Strengths and limitations

The strengths of the study are the complete data set, the use of a validated outcome measure with a recognised minimal important difference, the broad age and sex range, and the traceable record of the rubrics, remedy and score for every patient, which addresses the poor documentation of individualisation noted by earlier reviewers [19]. The limitations are considerable. The sample was small and drawn from one college and its camps. There was no control group. Follow-up was short and the durability of benefit is unknown. The physician who prescribed also assigned the clinical rating, so assessment was not blinded. The ACT is subjective and was not supplemented by spirometry or peak flow, and attack frequency was not captured separately. The standard ACT is validated for people aged 12 years and older, so scores in the three children under 12 should be interpreted with caution. Many patients had used inhalers or steroids for long periods before enrolment, which may have blurred their natural symptom picture and complicates attribution of change. Finally, patients who felt better sometimes dropped out of follow-up and had to be contacted by telephone, which may bias the series.

5.2 Directions for future research

Larger, multicentre studies would test whether these findings hold across more varied patients. A controlled design comparing Complete Repertory-guided treatment with placebo or usual care, ideally with blinded outcome assessment and objective lung-function measures, is the logical next step. Longer follow-up would show whether improvement persists or relapses once remedies are stopped, attack frequency should be recorded as its own outcome, and further work could examine whether miasmatic background or psychosomatic pattern predicts the remedy a patient needs.

6. Conclusion

In this case series of 45 patients with chronic bronchial asthma, individualised homeopathic treatment guided by the Complete Repertory was followed by a statistically significant and clinically meaningful rise in ACT scores, a shift from poor to good control in most patients, and clinical improvement in 95.6%. The wide range of remedies used shows how the repertory supports individualisation, and the study provides documented data on a repertory that has little published evaluation in asthma. Given the small sample, lack of a control group and short follow-up, the study establishes utility and feasibility and generates a hypothesis; confirmation requires larger, controlled and longer-term studies.

Declarations

Ethics approval and consent: Ethical committee of Motiwala homeopathic medical college and hospital, Nashik; informed consent obtained from all participants or their guardians.

Funding: [None / specify].

Conflict of interest: None

Data availability: The anonymised master chart of ACT scores and remedies is available from the corresponding author on reasonable request.

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