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Homoeopathic Treatment of Tinea Corporis: A Clinical Study

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ABSTRACT

Background: Tinea corporis, or ringworm of the body, is a common fungal infection of the skin. It causes itchy, red, scaly, ring-shaped patches, and it often returns after treatment. Antifungal medicines are widely used, but recurrence and difficult-to-treat cases are a growing problem, and there are few clinical studies of individualised homoeopathic treatment in this condition.

Aim: To study the role of individualised homoeopathic medicines in the management of tinea corporis.

Materials and methods: This single-arm, before-and-after study enrolled 30 patients of all ages with clinically diagnosed tinea corporis from the outpatient and inpatient departments and medical camps of the institute. Patients were chosen by non-randomised sampling. A detailed case was taken for each patient, and an individualised medicine was selected with the help of repertory. Severity was scored from 0 to 12 on the Symptom Severity Score for Tinea Corporis (itching, papular eruptions, redness and scaling) before treatment and at the end of follow-up. Patients were classed as cured (score 0, no recurrence), improved (score 1–4) or not improved (score unchanged). Scores were compared with the paired t-test.

Results: The commonest age group was 21–30 years (20.0%), and two-thirds of the patients were male (66.7%). Rhus toxicodendron and Sulphur were the commonest medicines (13.3% each). At the end of follow-up, 18 patients (60.0%) were cured, 8 (26.7%) had improved and 4 (13.3%) had not improved. The mean score fell from 8.47 ± 1.83 to 2.30 ± 3.63 (mean fall 6.17, 95% CI 5.02–7.31; $t = 11.03$, $df = 29$, $p < 0.001$). All 15 patients with moderate disease at the start responded, while all four non-responders began with severe disease.

Conclusion: Most patients in this small uncontrolled study improved or were cured, and their scores fell significantly after individualised homoeopathic treatment. Because there was no comparison group and no laboratory confirmation, the findings show an association, not proof that the medicines worked. Larger controlled trials are needed.

Keywords: Tinea corporis, Ringworm, Dermatophytosis, Individualised homoeopathy, Symptom Severity Score, Miasm

INTRODUCTION

Tinea corporis, commonly called ringworm, is a fungal infection of the skin of the trunk and limbs, excluding the palms, soles and groin. It is caused by dermatophytes, which are fungi that feed on keratin, the protein in skin, hair and nails [1,2]. The name is misleading, as no worm is involved. The typical lesion is a round or ring-shaped, red, scaly patch with a raised edge and clearer skin in the centre, and it is usually very itchy [1,3]. The most common cause is *Trichophyton rubrum*, and other species of *Trichophyton*, *Microsporum* and *Epidermophyton* are also involved [2,5].

The infection spreads through direct skin contact with an infected person or animal, and through shared towels, clothing and bedding [1,3]. It is most common in hot, humid, crowded settings, where sweating, tight clothing and poor hygiene help the fungus to grow. India has seen a marked rise in recurrent and hard-to-treat dermatophytosis in recent years [4]. Diagnosis is mainly clinical and can be supported by a potassium hydroxide (KOH) smear or fungal culture [3]. Treatment is with topical or oral antifungal medicines, but relapse is common, and not every patient can use or tolerate these drugs for long [3,6].

Homoeopathy looks at the skin as a reflection of the person's overall state of health. In this view, a skin eruption is the body's way of pushing disease outwards, and suppressing it locally without treating the person may lead to recurrence or to deeper disease [10,11]. The medicine is chosen on the totality of the patient's mental, general and local symptoms, and on the underlying miasm, and not on the name of the disease [10–12,15]. Many medicines are described in the materia medica for ringworm, including Sulphur, Tellurium, Graphites, Sepia, Arsenicum album, Natrum muriaticum, Bacillinum and Rhus toxicodendron [12–14].

Clinical evidence for homoeopathy in tinea corporis comes mainly from reviews, case reports and a few clinical studies [16–20]. Documented studies that use a scored outcome are still scarce. This study was therefore planned to record the response of patients with tinea corporis to individualised homoeopathic medicines, using a simple symptom score.

METHODOLOGY

- ❖ **Study design and setting:** This was an experimental, uncontrolled, single-arm study in which each patient's score was compared before and after treatment. Patients came from the outpatient department (OPD), inpatient department (IPD) and medical camps of college.
- ❖ **Sample, sampling and duration:** At least 30 cases of tinea corporis were to be recorded, and 30 patients were enrolled by non-randomised sampling. The study ran for 18 months. Each case was treated for one to two months, and follow-up continued as the case needed.
- ❖ **Eligibility criteria**
 - **Inclusion criteria**
 - Clinically diagnosed tinea corporis.
 - Patients of all ages, either sex and any socioeconomic class.
 - **Exclusion criteria**
 - Irreversible or severe pathology.
 - Immunocompromised patients.
 - Any condition needing emergency or surgical care.
 - **Withdrawal criteria:** Irregular follow-up, lack of cooperation or withdrawal of consent.
- ❖ **Diagnosis**
 - Tinea corporis was defined as in ICD-11 (1F28.Y): a superficial fungal infection of the hairless skin that appears on the trunk and limbs and can occur at any age and in either sex. The diagnosis was made on clinical grounds, and investigations were done when needed to confirm or rule it out.
- ❖ **Case-taking and prescribing**
 - After written consent, a structured record was filled in with the patient's name, age, sex, detailed history of the complaints, family and past history and associated complaints. A general, physical, local and systemic examination followed. The symptoms were analysed, the totality was formed, and RADAR software was used for repertorisation. The final medicine was chosen from the totality and checked against the materia medica. Potency and dose depended on the severity of the disease and the patient's susceptibility, and an acute prescription was given when needed. In the case records, the potency prescribed was 200C.
- ❖ **Outcome assessment**
 - Severity was scored with the Symptom Severity Score for Tinea Corporis. It rates four features, each from 0 (absent) to 3 (severe): itching, papular eruptions, redness and scaling. The total therefore ranges from 0 to 12 (1–4 mild, 5–8 moderate, 9–12 severe). The score was recorded before treatment and at the end of follow-up. Outcomes were defined as follows:
 - **Cured:** complete relief of itching, redness and scaling with no recurrence and a post-treatment score of 0.
 - **Improved:** improvement in these complaints, with or without recurrence, and a post-treatment score of 1–4.
 - **Not improved:** no improvement, with the score unchanged.
- ❖ **Statistical analysis**
 - Patient characteristics are given as numbers and percentages, and scores as mean and standard deviation. Scores before and after treatment were compared with the paired t-test (null hypothesis: no change in score) at a significance level of 0.05. Because the score is ordinal, the Wilcoxon signed-rank test was also run as a check.
- ❖ **Ethical considerations**
 - All participants gave written informed consent after the study was explained to them. Taking part was voluntary, and patients could withdraw at any time without giving a reason. Records were kept confidential.

RESULTS

All 30 patients completed the study.

❖ Characteristics of the patients

Table 1. Age distribution (n = 30)

Age group (years)	Cases	%
1–10	1	3.3
11–20	4	13.3
21–30	6	20.0
31–40	4	13.3
41–50	5	16.7
51–60	3	10.0
61–70	4	13.3
71–80	3	10.0

- The disease occurred in every age band, and the commonest group was 21–30 years.

Table 2. Sex and socioeconomic class (n = 30)

Variable	Category	Cases	%
Sex	Male	20	66.7
	Female	10	33.3
Socioeconomic class	Lower	10	33.3
	Middle	14	46.7
	Upper	6	20.0

Table 3. Predominant miasm (n = 30)

Miasm	Cases	%
Psora	12	40.0
Sycosis	8	26.7
Tubercular	8	26.7
Syphilis	2	6.7

- Percentages are rounded and may not add up to exactly 100.

Table 4. Baseline severity (n = 30)

Baseline score	Cases	%
Mild (1–4)	0	0.0
Moderate (5–8)	15	50.0
Severe (9–12)	15	50.0

❖ Medicines prescribed

Table 5. Medicines prescribed (n = 30)

Medicine	Cases	%
Rhus toxicodendron	4	13.3
Sulphur	4	13.3
Lycopodium clavatum	3	10.0
Arsenicum album	2	6.7
Graphites	2	6.7
Natrum muriaticum	2	6.7
Hepar sulphuris	2	6.7
Pulsatilla nigricans	2	6.7
Sepia officinalis	2	6.7
Bacillinum	2	6.7
Petroleum	2	6.7
Calcarea carbonica	1	3.3
Benzoicum acidum	1	3.3
Tellurium	1	3.3

- Fourteen different medicines were used for 30 patients, and none was used in more than four.

❖ Clinical outcome

Table 6. Outcome at the end of follow-up (n = 30)

Outcome	Cases	%
Cured (score 0)	18	60.0
Improved (score 1–4)	8	26.7
Not improved (score unchanged)	4	13.3

- In all, 26 of 30 patients (86.7%) were cured or improved. All 15 patients with moderate disease at the start responded (cured or improved). Of the 15 with severe disease, 11 responded and 4 did not. The four patients who did not improve began with scores of 12, 10, 11 and 9 (mean 10.5), against a mean of 8.2 in the other 26.

❖ Change in severity score

Table 7. Symptom severity score before and after treatment (n = 30)

Measure	Before treatment	After treatment
Mean $\pm$ SD	8.47 $\pm$ 1.83	2.30 $\pm$ 3.63
Median	8.5	0
Sum of scores	254	69

- On average, each patient's score fell by 6.17 points (SD 3.06; standard error 0.56; 95% CI 5.02 to 7.31). The paired t-test gave $t = 11.03$ with 29 degrees of freedom ($p < 0.001$), so the null hypothesis was rejected. The Wilcoxon signed-rank test agreed ($p < 0.001$).

❖ Selected cases

Table 8. Selected cases

Case	Presentation (summary)	Medicine	Score before → after
27-year-old man	Round, moist, scaly eruptions on both shins for 4–5 months; severe itching, worse in the evening and from sweating; better from cold applications and fanning	Tellurium 200C	9 → 0 (cured)
56-year-old man	Dry, scabby eruptions on the chin for 1 year, with sticky watery discharge on scratching	Lycopodium clavatum 200C	6 → 0 (cured)
16-year-old girl	Annular, red, finely scaly lesions on forearms and neck for 4 months; itching worse from sweating and hot weather	Pulsatilla nigricans 200C	8 → 3 (improved)
20-year-old woman	Intensely itchy annular lesions on trunk and arms for 12 months; worse in hot, humid weather	Pulsatilla nigricans 200C	12 → 12 (not improved)

DISCUSSION

This study followed 30 patients with tinea corporis who were treated with individualised homeopathic medicines. The main finding is a large and statistically significant fall in the symptom score, with 18 patients cured and 8 improved. An average fall of more than six points on a 12-point scale is clinically meaningful, and the confidence interval shows that the change was not trivial in this sample.

The patient profile fits what is known about dermatophyte infection. The disease was seen at every age, but most often in adolescents and adults, who are more exposed to sweating, outdoor activity, close contact and occupational factors. Men made up two-thirds of the group, and male predominance has been described in several Indian series, where it is linked to sweating, occlusive clothing and outdoor work [4]; this sample is too small to confirm that. Four-fifths of the patients were from the middle and lower classes, which may reflect the population served by the hospital and its camps, as well as crowding, humid housing and late treatment-seeking, and no firm conclusion about risk can be drawn from it.

In homeopathic terms, psora was the commonest miasm (40.0%), followed by sycosis and the tubercular miasm (26.7% each). This agrees with the classical view that skin disease has a psoric basis and that chronic or recurrent eruptions often carry other miasmatic influences too [10,11,15]. The finding depends on the prescriber's assessment and does not show cause.

The wide range of medicines is typical of individualised prescribing: 14 medicines were needed for 30 patients, with Rhus toxicodendron and Sulphur used most often, followed by Lycopodium. The medicine followed the whole symptom picture, including modalities, thermal state and miasmatic background, and not the diagnosis. Several of the medicines used, such as Sulphur, Graphites, Sepia, Tellurium and Bacillinum, are the ones described for ringworm in the classical materia medica [12–14]. The cases in Table 8 show how the same remedy can give different results: Pulsatilla was followed by improvement in one patient and no change in another.

Similar encouraging findings have been reported in a prospective observational study of tinea corporis and tinea cruris [19], and other work has looked at the question with a randomised, placebo-controlled design [20]. Case reports describe complete resolution with single well-chosen medicines [17]. Taken together with the present results, these reports suggest the question deserves further testing under controlled conditions, but they do not settle it.

The four patients who did not improve all began with severe disease, and none of the 15 patients with moderate disease failed to respond. This suggests that more severe, extensive or long-standing disease may respond less well or may need extra measures such as treatment of the source of infection, hygiene advice or a change of medicine. Poor compliance and reinfection are other possible reasons, but neither was measured here, and the numbers are too small for firm conclusions.

LIMITATIONS

The design limits what can be concluded. There was no control group, so the improvement cannot be credited to the medicines alone: lesions may clear over time, scores can drift back towards the average, and the consultation, expectation and any hygiene advice may all have helped. The sample was small, non-randomised and drawn from one institution. The diagnosis was clinical, with no routine KOH smear or culture, so some lesions may have been other conditions that look like ringworm. The symptom score is a clinician-rated scale whose reliability and validity are not reported here. Each case

was treated for only one to two months, and recurrence, which is one of the stated objectives, was not followed in a systematic way. Whether patients used other antifungal or steroid creams during the study is not reported.

CONCLUSION

In 30 patients with tinea corporis, 60.0% were cured and 26.7% improved after individualised homoeopathic treatment, and the average symptom score fell significantly ($p < 0.001$). The results are encouraging, but because the study was small and uncontrolled, they cannot prove that the treatment works. Randomised, controlled, multicentre trials with laboratory confirmation of the diagnosis, a validated outcome scale and longer follow-up for recurrence are needed to test these observations.

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