



Homoeopathic Treatment of Gout in Patients Aged 25–50 Years: A Clinical Study

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ABSTRACT

Background: Gout is a painful joint disease caused by uric acid crystals building up in the joints. It is now being seen in younger adults, whose work and daily life are disturbed by repeated attacks. Conventional medicines help but can cause side effects, and there is little clinical research on homoeopathic treatment of gout.

Aim: To study the effect of individualised homoeopathic medicines in clinically diagnosed gout in patients aged 25–50 years.

Materials and methods: This single-arm, before-and-after study enrolled 30 patients from the outpatient and inpatient departments and medical camps of the institute. Gout was confirmed with the 2015 ACR/EULAR criteria. A detailed homoeopathic case was taken for each patient, and an individualised medicine was chosen with the help of repertory. Severity was scored from 0 to 24 on a six-item Gout Symptom Severity Score (GSSS) before treatment and at the end of follow-up. Patients were classed as recovered (score 0, no recurrence), improved (score 1–6) or not improved (score unchanged). Scores were compared with the paired t-test.

Results: Most patients were aged 46–50 years (33.3%) and male (56.7%). The first metatarsophalangeal (big toe) joint was the commonest site (33.3%), and *Lycopodium clavatum* was the commonest medicine (13.3%). At the end of follow-up, 16 patients (53.3%) had recovered, 10 (33.3%) had improved and 4 (13.3%) had not improved. The mean score fell from 15.13 ± 3.99 to 4.57 ± 7.06 (mean fall 10.57, 95% CI 8.80–12.33; $t = 12.25$, $df = 29$, $p < 0.001$).

Conclusion: Most patients in this small study improved clearly, and their scores fell significantly after individualised homoeopathic treatment. Because there was no comparison group, this shows an association, not proof that the medicines worked. Larger controlled trials are needed.

Keywords: Gout, Hyperuricaemia, Monosodium urate crystals, Individualised homoeopathy, Gout Symptom Severity Score, ACR/EULAR criteria

INTRODUCTION

Gout is the most common inflammatory arthritis. It happens when a high level of uric acid in the blood forms monosodium urate (MSU) crystals in the joints and nearby tissues ^[1,2]. It typically causes a sudden, very painful, hot, red and swollen joint, most often the big toe joint. If it is not controlled, repeated attacks can lead to chronic gout with lumps (tophi), joint damage, deformity and kidney problems ^[2,3].

Gout is becoming more common in many countries. Obesity, high blood pressure, diabetes, kidney disease, alcohol, purine-rich food and an inactive lifestyle are the main risk factors ^[4,5]. High uric acid alone does not explain the disease, because many people with high levels never get gout; genes, immune response and individual susceptibility also play a part ^[1,3]. The attack itself is caused by the body's immune reaction to MSU crystals, in which interleukin-1 β plays a key role ^[6].

Gout was once thought of as a disease of older people, but it is now often seen in people in their twenties, thirties and forties. These are working-age adults, and repeated attacks disturb their work, daily activities and wellbeing. Standard treatment uses anti-inflammatory drugs, colchicine and steroids for attacks, and allopurinol or febuxostat to lower uric acid in the long term. These drugs work, but they can cause stomach, liver, kidney and allergic problems in some patients ^[3,7], so many patients look for other options.

Homoeopathy is based on the principle that like cures like (*similia similibus curentur*) and on treating each patient as an individual. It sees disease as a disturbance of the vital force, and the medicine is chosen from the whole picture of the patient's mental, general and local symptoms, not from the diagnosis alone ^[8,9]. Medicines such as *Colchicum autumnale*, *Ledum palustre*, *Benzoicum acidum*, *Lycopodium clavatum*, *Urtica urens*, *Bryonia alba*, *Rhus toxicodendron*, *Calcarea carbonica* and *Sulphur* are described for gout in the materia medica when the symptoms match ^[10,11]. The published evidence

is limited to case reports, observational studies and one laboratory study on crystal formation^[12-14]. This study was planned to add clinical data, using a standard diagnostic definition and a scored outcome, for patients aged 25–50 years.

METHODOLOGY

❖ Study design and setting

- This was an 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 our college

❖ Sample, sampling and duration

- At least 30 cases of gout were to be recorded, and 30 patients were enrolled by simple random sampling. The study ran for 18 months. Each patient was followed for up to six months, with visits every 15 days to one month, or sooner if needed.

❖ Eligibility criteria

● Inclusion criteria

- Age 25–50 years, of either sex and any socioeconomic status.
- Clinically diagnosed gout.
- Willingness to take part, with written informed consent.

● Exclusion criteria

- Age below 25 or above 50 years.
- Co-existing conditions such as hypertension, diabetes mellitus, hepatitis, systemic lupus erythematosus or HIV, and other autoimmune or irreversible gross pathological conditions.
- Pregnancy and lactation.
- Severe allergic reaction to any medicine.
- Any condition requiring emergency or surgical intervention.

● Withdrawal criteria: Irregular follow-up, lack of cooperation, or withdrawal of consent.

❖ Diagnosis

- Gout was defined as in ICD-11 (FA25): a joint disease caused by a buildup of MSU crystals in joint tissues, usually linked with high blood uric acid. Every diagnosis was confirmed with the 2015 American College of Rheumatology/European League Against Rheumatism (ACR/EULAR) classification criteria [15], and examination and tests were used whenever needed to confirm or rule out gout.

❖ Case-taking and prescribing

- After written consent, a structured case record was filled in. It covered the main and associated complaints (with location, sensation, modalities and concomitants), past and family history, physical generals (appetite, thirst, desires, aversions, sleep, dreams, stool, urine, sweat and thermal reaction), life space, and general and systemic examination. The symptoms were analysed, the miasmatic background was assessed, and the totality of symptoms was formed. RADAR software was used for repertorisation where needed, and the choice was checked against the materia medica. Potency and repetition depended on the severity of the disease and the patient's susceptibility, and an acute medicine was added when needed.

❖ Outcome assessment

- Severity was scored with a Gout Symptom Severity Score (GSSS) covering six items, each rated 0 to 4: pain (visual analogue scale), joint swelling, tenderness, restricted movement, redness and difficulty in daily activities. The total ranges from 0 to 24 (1–6 mild, 7–12 moderate, 13–18 severe, 19–24 very severe). The score was recorded before treatment and at the end of follow-up. Outcomes were defined as follows:
 - **Recovered:** complete relief of pain, swelling, tenderness, restricted movement and disability, 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 1–6.
 - **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 GSSS is an ordinal score, the Wilcoxon signed-rank test was also run as a check.

RESULTS

Thirty patients completed the study, and none was lost to follow-up.

❖ Characteristics of the participants

Table 1. Age distribution (n = 30)

Age group (years)	Cases	%
25–30	2	6.7
31–35	4	13.3
36–40	6	20.0
41–45	8	26.7
46–50	10	33.3

- The number of cases rose with each age band, and one-third of the patients were aged 46–50 years

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

Variable	Category	Cases	%
Sex	Male	17	56.7
	Female	13	43.3
Socioeconomic status	Lower class	12	40.0
	Middle class	12	40.0
	Upper class	6	20.0

Table 3. Miasmatic background (n = 30)

Miasmatic combination	Cases	%
Psora–sycosis–syphilis	12	40.0
Psora–sycosis	8	26.7
Sycosis–syphilis	6	20.0
Psora–syphilis	4	13.3

Table 4. Joints affected (n = 30)

Site	Cases	%
First metatarsophalangeal joint	10	33.3
Foot and ankle	6	20.0
Fingers and toes (both)	5	16.7
Knee	4	13.3
Wrist and hand	3	10.0
Elbow	2	6.7

❖ **Medicines prescribed****Table 5. Medicines prescribed (n = 30)**

Medicine	Cases	%
Lycopodium clavatum	4	13.3
Colchicum autumnale	3	10.0
Ledum palustre	3	10.0
Pulsatilla nigricans	3	10.0
Sulphur	3	10.0
Benzoicum acidum	2	6.7
Bryonia alba	2	6.7
Rhus toxicodendron	2	6.7
Sepia officinalis	2	6.7
Calcareo carbonica	2	6.7
Kali bichromicum	2	6.7
Nux vomica	1	3.3
Urtica urens	1	3.3

- Thirteen different medicines were used for 30 patients, and no medicine was used in more than four.

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

Outcome	Cases	%
Recovered (score 0)	16	53.3
Improved (score 1–6)	10	33.3
Not improved (score unchanged)	4	13.3

- In all, 26 of 30 patients (86.7%) recovered or improved. The four who did not improve started with some of the highest scores (18, 20, 22 and 24; mean 21.0), while the 26 who recovered or improved started at a mean of 14.2.

❖ **Change in severity score****Table 7. GSSS before and after treatment (n = 30)**

Measure	Before treatment	After treatment
Mean $\pm$ SD	15.13 $\pm$ 3.99	4.57 $\pm$ 7.06
Median	14.5	0
Sum of scores	454	137

- On average, each patient's score fell by 10.57 points (SD 4.72; standard error 0.86; 95% CI 8.80 to 12.33). The paired t-test gave $t = 12.25$ with 29 degrees of freedom ($p < 0.001$), so the null hypothesis was rejected. The Wilcoxon signed-rank test agreed ($p < 0.001$).

❖ **Illustrative cases**

Table 8. Selected cases

Case	Presentation (summary)	Medicine	Score before → after
37-year-old man	Right first metatarsophalangeal joint; hot, red, swollen; worse from the slightest movement and better for complete rest; irritable during pain; marked thirst; constipation	Bryonia alba 200C	14 → 0
48-year-old woman	Right wrist and small joints of the hand; tearing, stitching pain with stiffness; mild, tearful, seeks consolation; thirstless; better in open air	Pulsatilla nigricans 200C	12 → 0
42-year-old woman	Left great toe, dorsum of foot and ankle; bruised soreness; indifferent to loved ones, wants solitude; thirstless; desires sour and salty food	Sepia officinalis 200C	16 → 0
50-year-old man	Violent tearing pain, intolerable to touch or movement; anxiety about business, fear of failure; desires sweets; constipation	Lycopodium clavatum 200C	10 → 0

DISCUSSION

This study followed 30 patients aged 25–50 years with gout who were treated with individualised homeopathic medicines. The main finding is a large and statistically significant fall in the severity score: 16 patients recovered completely and 10 improved. An average fall of more than 10 points on a 24-point scale is clinically meaningful, and the narrow confidence interval shows the change was not trivial in this sample.

The patient profile matches what is known about gout. Cases increased with age, which fits the idea that years of high uric acid, metabolic problems and reduced kidney excretion raise the risk ^[2,4]. Men were in the majority (56.7%), as usually expected, though the share of women (43.3%) is fairly high; with a small sample from one institution, this should be read with caution. Four-fifths of the patients were from the lower and middle classes, which may reflect the people the hospital and its camps serve, differences in diet and late treatment-seeking, rather than a true difference in risk. The big toe joint was the commonest site, and the foot, ankle and toes together made up most cases, as described in standard rheumatology texts ^[2,3].

Most patients had a mixed miasmatic background, most often psora–sycosis–syphilis. This fits the classical view that long-standing, recurring conditions rarely rest on a single miasm ^[8,9]. The finding depends on the prescriber's assessment and does not show cause.

The wide range of medicines is the most typical feature of the prescribing: 13 medicines were needed for 30 patients, with *Lycopodium clavatum* used most often, followed by *Colchicum*, *Ledum*, *Pulsatilla* and *Sulphur*. This is expected in individualised prescribing, where the medicine follows the whole symptom picture rather than the diagnosis. The sample cases show this: the patient who was hot, red and could not bear movement received *Bryonia*; the mild, tearful patient who wanted consolation and open air received *Pulsatilla*; and the indifferent patient who wanted solitude and craved sour food received *Sepia*. A laboratory study has reported that *Lycopodium clavatum* reduces MSU crystal formation ^[14]. This is interesting for further research but does not by itself explain the clinical results seen here.

Observational studies and case series in homeopathic practice have also reported improvement in pain, swelling and function in gout and high uric acid ^[12,13,16]. Together with the present results, they suggest the question deserves testing under controlled conditions, but they do not settle it.

The four patients who did not improve deserve a comment. Their starting scores were among the highest, so very severe or long-standing gout may respond less well, or may need extra measures. With so few patients no firm conclusion is possible, but a larger study could look at starting severity, how long the disease has been present, and the effect of diet and lifestyle.

LIMITATIONS

The design limits what can be concluded. There was no control group, so the improvement cannot be credited to the medicines alone: acute gout attacks often settle on their own, scores can drift back towards the average, and the consultation, expectation and any diet or lifestyle advice may all have helped. The sample was small and came from one institution. The GSSS mixes doctor-rated and patient-rated items, and its reliability and validity have not been reported. Serum uric acid was not analysed as an outcome, and no data on how often attacks recurred are given. Follow-up was short for a disease that relapses. Patients with common conditions such as high blood pressure and diabetes were excluded, so the results may not apply to all patients seen in practice.

CONCLUSION

In 30 patients aged 25–50 years with gout, 53.3% recovered and 33.3% improved after individualised homoeopathic treatment, and the average severity score fell significantly ($p < 0.001$). The results are encouraging, but because the study was small and had no control group, they cannot prove that the treatment works. Randomised, controlled, multicentre trials with a validated scale, serum uric acid and attack-frequency data, and longer follow-up are needed.

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