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From Itch to Ease: Homoeopathic Resolution of Chronic Atopic Dermatitis - An Evidence-Based Case Report

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ABSTRACT

Background: Atopic dermatitis (AD) (ICD 11 EA80) is a chronic relapsing inflammatory skin disease with severe pruritus and eczematous lesions. Conventional treatments yield temporary relief with potential recurrence. Individualized homoeopathic treatment seeks to re-establish systemic balance by holistic means.
Case Summary: A 10-year-old boy presented with intense itching and offensive sticky secretions over the flexural side of the right elbow for six months. The condition was recurrent, with earlier suppression by allopathic medication. On thorough case analysis, mental, physical, and miasmatic assessment the entirety of symptoms pointed towards Graphites as the similimum. Graphites 200 (two doses) followed by placebo resulted in noteworthy improvement within three weeks. At the second follow-up, lesions had completely cleared, and after that two-month follow-up showed no recurrence of the symptoms with General well-being, regular bowel movements, and sound sleep.
Results: The case was evaluated with the Modified Naranjo Criteria for Homoeopathy (MONARCH) and scored +9, establishing a strong causal connection between the remedy and cure. The improvement was in accordance with Hering's Law of Cure and involved both local and general improvement.
Conclusion: This case illustrates the potential therapeutic usefulness of individualized homoeopathic management with Graphites 200 in the treatment of chronic atopic dermatitis. The chronic and overall improvement attests to the therapeutic applicability of homoeopathy in chronic skin diseases and deserves further systematic investigation.

Keywords: Atopic dermatitis, Homoeopathy, MONARCH, Graphites, Case Report

INTRODUCTION

Atopic dermatitis (ICD 11 EA80) is a recurring and chronic inflammatory skin killed, itchy disorder, which is due to a defect in the skin barrier and a maladjusted immune reaction [1-2]. It is present in two out of ten children and up to ten percent of adults in most parts of the world and in most instances, it starts at early childhood [3]. It may include itches, dry skin, red spots/patches, and in the long-term diseases, thickened skin, which is typically on the flexural areas [4]. Such complications may include secondary infections, eczema herpeticum, sleep

disturbance and correlation of asthma/allergic rhinitis [5]. Among the treatment tools, there are moisturizers, avoidance triggers, topical corticosteroids/ calcineurin and systemic agents or biologic medications in the worst cases [6]. Atopic dermatitis (AD) is a very prevalent chronic skin lesion in the world with geographic and age distributions of up to 1520 percent and 85 percent of the infected patients in the first year of life and 85 percent respectively [3]. Atopic dermatitis (AD) can be found even in adults. It is prevalent in urban and industrialized countries, probably because of the environmental components and the hygiene hypothesis [2]. There is no significant difference in the incidence of this in adults, and there are few cases more in female children [3]. The causes of atopic dermatitis are the combination of environmental factors, immunological dysregulation, epidermal barrier malfunction, and the genetic factors [2-4]. Mutations in filaggrin (FLG) gene influence the integrity of epidermal barrier that permits the influx of allergens and irritants to rise and also the water loss across the epidermal layer to rise [3-4]. The stratum corneum damage happens due to the defecting structural proteins (including filaggrin) and lipid structure (ceramides) alterations, which puts the skin at risk of both being dry and sensitive [3]. Th2 skewed immune response predominates in the acute phase, where eosinophil is recruited, the IgE is up-regulated and the production of cytokines (IL-4, IL-5, IL- 13 and IL-31) is excessive [3-4]. There is Th1/Th17/Th22 activity in chronic lesions that maintains lichenification and inflammation [4]. Reduced microbial diversity can increase the issue of barrier functionality, and the proliferation of Staphylococcus aureus is prevalent and uses superantigens to develop inflammation [3,5]. The activation of the immune system and disruption of the barrier is also intensified by irritants, allergens, infections, and psychological stress, despite the presence of IL-22 in epidermal thickening, increased levels of Th2 cytokines prefer IgE production and itching, and both affected and unaffected skin have a depleted quantity of barrier proteins (filaggrin, loricrin) [2-4]. Histopathological changes in acute and chronic lesion of AD are observed [4]. It is characterized by acute lesions with formation of vesicles, parakeratosis, presence of eosinophils and intercellular oedema in the epidermis are characteristic of spongiotic dermatitis [4]. persistent cases are characterised by the heavy infiltration of lymphocytes, eosinophils and intercellular oedema in the dermis, clinically associated with lichenification, and hyperkeratosis, fibrosis, rete ridge elongation and marked in case of subacute lesions, where the Pruritus, xerosis and chronic relapsing dermatitis are the characteristics of AD that have different distributions with age [3-4]. One of its typical symptoms is pruritus that might be acute and most often worsens during the night disturbing sleep. The lesions on the face, the scalp and surfaces of the extensor of infants at the age below two years are acute, erythematous, oozing, and crusty. Lichenified lesions are more chronic, and are more likely to occur in flexural areas (antecubital, popliteal fossae, neck, wrists and ankles) of children aged 2-12 years. Hit-and-miss xerosis (bacterial acnes) Webs and the crooks in most teenagers and adults who have extensive xerosis, lengthy standing, thicker and itchy plaques are often found on the flexures, face, neck, hands and the bends. They can be having such problems as hyperlinear palms, keratosis pilaris, pityriasis alba, and Dennie-Morgan folds (under the eyes). Atopic dermatitis (AD) is mostly characterized by establishing the diagnosis by clinical evaluation using a list of criteria and additional tests when necessary; there is no definite diagnosis test that can be used to date and identify the disease [3-4]. In the blood tests, peripheral non-discriminatory eosinophilia is observed and in about 80 percent of the patients, the concentration of total IgE is elevated. To identify allergens the serum-specific IgE or skin prick-tests can be applied; however, none of them can confirm the presence of a

case of atopic dermatitis (AD). Not very much required is the skin biopsy which may indicate spongiotic dermatitis as already mentioned in the histological description. Recurrent infections are to be cultured on Staphylococcus aureus. The medical research and measuring the severity of the condition is conducted using scoring systems, which are SCORAD or EASI [3]. AD subjects the patients to a number of local and systemic effects as a result of persistent inflammation and obstruction of barriers [3-5]. The most widespread superinfection is caused by Staphylococcus aureus; eczema herpeticum (HSV infection) may be life threatening. Eye problems like cataracts, keratoconjunctivitis and keratoconus are especially frequent with the severe chronic cases. Neuropsychological effects involve sleep difficulties persistence because of constant itching leading to sadness, anxiety, and low living standard. Also, AD may predispose to develop allergies to foods, asthma and allergic rhinitis [5]. In acute cases of chronic AD, it may lead to erythroderma, hand dermatitis and higher cardiovascular and metabolism risks [5]. AD multidimensional, systematic management is aimed at excluding inflammation, revitalizing the work of the barrier, and preventing outcomes [2-6]. To reduce the exacerbation, the barrier is supposed to be replenished with emollients and moisturizers on a daily basis. The irritants the patient should avoid are allergies, severe soaps, wool garments, stress, and infections. Topical corticosteroids are the initial mode of therapy of inflammation. Topical PDE-4 (unless unavailable) and topical calcineurin (tacrolimus, pimecrolimus) can be applied to sensitive sites (face, folds). Dupilumab (anti-IL-4R alpha monoclonal antibody) is effective in moderate-to-severe AD; newer biologics (IL-13 based tralokinumab, lebrikizumab) are IL-13 based [3-4]. Despite their efficiency, JAK inhibitors need careful monitoring as far as side effects are concerned.

CASE HISTORY

A male child patient aged about 10 years came to the OPD of Burdwan Homoeopathic Medical College and Hospital, Bardhaman, West Bengal, on 7th April 2025 with the complaint of severe itching with offensive sticky discharges at the ventral aspect of the elbow joint of the right hand since the last 6 months. On the next visit on 28th April, itching and discharges were much reduced, and on 7th July, the skin became almost normal.

History of present complaint:

The above-said skin complaint appeared at the age of 3 years, then with the help of allopathic treatment it got suppressed. Now recently, since 6 months ago, there was a slight itching eruption, and after scratching, there was oozing of sticky moisture, and gradually it became more serious with severe itching with discharges.

Past history:

This same kind of eruption appeared at the age of 3 years.
Typhoid at the age of 7 years of age.
Family history: nothing significant

Physical general:

Thermal relation chilly patient. Appetite was good; cannot tolerate hunger. Desire for fish, egg, sour, milk. Tongue white-coated with moderate thirst. Sweat profuse, whole body, offensive. Stool was constipated with hard, knotty, offensive stool, not complete with occasional diarrhoea with offensive, watery, undigested food particles. Urine clear but offensive. Sleep soundly with occasional horror dreams.
Mental general: very shy in nature, does not want to meet new people, fearful, irritable, obstinate, weeps easily

Systemic and local examinations:

The patient was alert, conscious, and cooperative. Moderately nourished. The itching eruption was situated at the ventral aspect of the elbow joint of the right hand, covering the lower part of the arm and the

upper part of the forearm. The margin was not well demarcated; there was a reddish and blackish, uneven, and ugly-looking eruption with offensive sticky discharge.

Analysis of the case:

After analyzing the case, characteristic mental and physical symptoms were taken into account; the following symptoms guided the formation of the totality of symptoms, which are as follows: very shy in nature, fears meeting new strangers, thermal relation chilly, moist itching eruption with sticky discharges, past history of this kind of eruption, appetite was good, cannot tolerate hunger, desires milk, had profuse offensive sweat over the whole body, stool was hard, knotty, offensive, and incomplete, also had occasional offensive watery stool with undigested food particles, and had occasional dreams of horror things.

Repertorial analysis

Considering the above-mentioned symptoms repertorization was done using Hompath ZOMEO software. [figure 1].

Rubrics:

1. Mind- fear- people, of
2. Generalities- heat- lack of vital heat
3. Skin- eruptions- moist
4. Skin- eruptions- itching
5. Skin- eruptions- discharge- moist
6. Generalities- eruptions- suppressed
7. Stomach- desires- milk
8. Stool- hard
9. Stool- knotty
10. Stool- offensive

Symptoms: 9 Remedies: 267 | Applied Filter

Remedy Name	Graph	Sulph	Sil	Ars	Calc	Lyc	Rhus-t
Totality / Symptom Covered	22 / 8	21 / 9	21 / 8	20 / 9	20 / 9	20 / 8	20 / 8
[Kent] [Mind]Fear (see anxiety):People,of: (55)	1	1		1	1	3	3
[Kent] [Generalities]Heat:Vital,lack of: (108)	3	2	3	3	3	2	3
[Kent] [Skin]Eruptions:Crusty:Moist: (26)	3	3	2	3	3	3	3
[Kent] [Skin]Eruptions:Itching: (109)	3	3	2	3	2	2	3
[Kent] [Skin]Eruptions:Discharging:Moist: (83)	3	2	3	2	2	3	3
[Kent] [Stomach]Desires:Milk: (27)		1	2	2	2		3
[Kent] [Stool]Hard: (164)	3	3	3	2	3	3	1
[Kent] [Stool]Knotty,nodular,lumpy: (85)	3	3	3	1	2	3	
[Kent] [Stool]Odour:Offensive: (135)	3	3	3	3	2	1	1

Figure 1: Repertorial analysis

Miasmatic analysis: After analysing the case and going through the miasmatic analysis the predominant miasm came out to be is Psora with influence of Syphilis and Sycosis. [Table 1]

Table -1: Miasmatic analysis of the case

Symptoms	Miasmatic analysis
Fear to meet new stranger	Psora
Thermal relation chilly	Sycosis
Moist itching eruption with sticky discharges	Sycosis
Past history of moist skin affection with sticky discharges	Psora+ Sycosis
Appetite good, cannot tolerate hunger	Psora
Stool hard, knotty, offensive, incomplete	sycosis
Offensive watery stool	syphilis

Treatment given: After forming the totality of symptoms, repertorization and analyzing of miasmatic background and consulting with Materia Medica choice of medicine come to Graphites. Graphites 200, 2 doses were given and She was advised to take the medicine on an empty stomach once in the morning for two consecutive days. Followed by placebo for 21 days. She was asked to come for follow-up after 2 months. The follow-up is given below.

Table 2: Treatment timeline and follow up of the case:

date	symptoms	Prescribed treatment
07/04/2025	Severe itching with offensive sticky discharges at the ventral aspect of the elbow joint of the right hand. [figure 2]	Graphites 200, 2 doses were given. To be taken once daily in empty stomach for two consecutive days. Followed by Placebo for 21 days, once in morning.
28/04/2025	Itching and discharges much reduced. [Figure 3]	Placebo was given.
07/07/2025	There were no itching and no discharge. [Figure 4]	Placebo was given.
08/09/2025	Follow-up after 2 months showed no complaints at present. There was no recurrence of the complaint. Overall, well-being was observed. Bowel habits become normal, and stool becomes regular, semisolid, clear, and non-offensive.	Placebo was given.

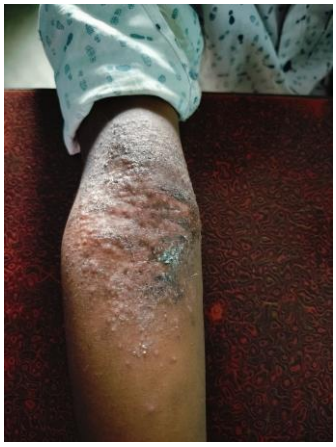

Figure 2: Severe itchy eruption with sticky discharge in ventral aspect of right elbow

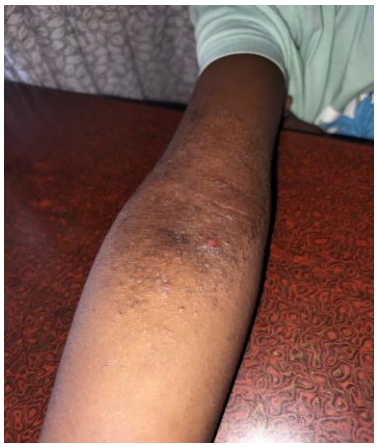

Figure 3: Itching and discharge much reduced

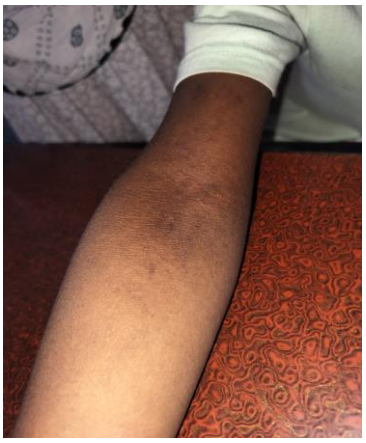

Figure 4: No itching eruption or discharge

Assessment of the case:

Assessment of the case is done according to MONARCH [7] criteria [Table 3]

Table 3: assessment of case by MONARCH

Domains	yes	no	Not sure
1. Was there an improvement in the main symptom or condition for which the homeopathic medicine was prescribed?	+2		
2. Did the clinical improvement occur within a plausible timeframe relative to the drug intake?	+1		
3. Was there an initial aggravation of symptoms?		0	
4. Did the effect encompass more than the main symptom or condition (i.e., were other symptoms ultimately improved or changed)?	+1		
5. Did overall well-being improve? *(*Suggest using validated scale*)*	+1		
6A. *Direction of cure:* did some symptoms improve in the opposite order of the development of symptoms of the disease?	+1		

6B. *Direction of cure:* did at least two of the following aspects apply to the order of improvement of symptoms: □ from organs of more importance to those of less importance? □ from deeper to more superficial aspects of the individual? □ from the top downwards?			0
7. Did "old symptoms" (defined as non-seasonal and non-cyclical symptoms that were previously thought to have resolved) reappear temporarily during the course of improvement?			0
8. Are there alternate causes (other than the medicine) that—with a high probability—could have caused the improvement? (Consider known course of disease, other forms of treatment, and other clinically relevant interventions)		+1	
9. Was the health improvement confirmed by any objective evidence? (e.g., laboratory test, clinical observation, etc.)	+2		
10. Did repeat dosing, if conducted, create similar clinical improvement?			0
TOTAL SCORE =+9			

RESULT AND DISCUSSION

In this given case medicine is prescribed on the basis of individualisation. After repertorization, miasmatic analysis and reviewing Materia medica Graphites 200 was administered. after administration of Graphites 200 in two doses separated by a five days interval, the patient showed a dramatic clinical improvement in three weeks. The acute itchiness and sticky greenish exudate at the flexural aspect of the right elbow decreased significantly on the initial follow-up on 28th April 2025. On the 2nd follow-up, 7th July 2025, the affected skin was nearly normal, and itching, discharge, and discoloration have disappeared. No reappearance of the lesion was seen on the last follow-up visit, 8th September 2025 and the patient showed a general sense of well-being. His bowel functions became normal, offensive perspiration stopped, and the quality of his sleep enhanced as he stopped having horror dreams. No additional dosage was necessary following the initial prescription and the placebo period was a confirmation of the delayed effect of the remedy. The healing process was guided by Hering Law of Cure that proclaimed the healing process was profound and comprehensive. Where tropical external treatment may result in many recurrences as seen in many previous cases also where homoeopathy showed improvement [8-10]. A scientific framework for evaluating the dependability of the relationship between the intervention and the result is provided by the MONARCH causal attribution criterion [7]. The observed result has scientific validity because the case received a favourable score of +9 on important factors like improvement in general health, therapeutic relevance, temporal association, and non-recurrence. [Table 3]

CONCLUSION

This case provides evidence of the effective management of chronic atopic dermatitis with a personalized homoeopathic prescription of Graphites 200, which is done according to the totality of the symptoms and miasmatic assessment. The full and long-lasting improvement, which is confirmed by the subjective and objective parameters, points to the therapeutic significance of homoeopathy in the case of chronic inflammatory skin diseases. The positive clinical effect, which is also supported by a high MONARCH score, indicates the clear causal relationship between the remedy and the cure. This fact highlights the necessity of additional systematic literature and controlled trials that would support the role of individualized homoeopathy in the dermatological practice. Therefore, when based on sound principles of totality and miasmatic cognizance, homoeopathy has the potential of providing a safe, holistic, and sustainable solution when dealing with chronic diseases such as atopic dermatitis.

Declaration by Authors

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Conflict of Interest: The authors declare no conflict of interest.

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