Indian Journal of Research in Homoeopathy

Volume 18 | Issue 4 Article 4

23-12-2024

Homoeopathy in the treatment of tinea cruris and tinea corporis – A case series

Renu Mittal
Central Council for Research in Homoeopathy, New Delhi, India, renumittal8@gmail.com

Akshaya Kumar Prusty
Central Council for Research in Homoeopathy-Regional Research Institute(H), Puri, Odisha, India, prustyakshayakumar@gmail.com

Ashish Shivadikar
Central Council for Research in Homoeopathy-Clinical Research Unit(H), Goa, India, ashishshivadikar@gmail.com

Divya Taneja
Central Council for Research in Homoeopathy, New Delhi, India, drdivyataneja@gmail.com

Noopur Kumari
Central Council for Research in Homoeopathy, New Delhi, India, noopurgautam91@gmail.com

See next page for additional authors

How to cite this article

Mittal R, Prusty AK, Shivadikar A, Taneja D, Kumari N, Kaushik S. Homoeopathy in the treatment of tinea cruris and tinea corporis – A case series. Indian J Res Homoeopathy 2024;18:245-257.

Homoeopathy in the treatment of tinea cruris and tinea corporis – A case series

Abstract

Background: Dermatophytosis is a fungal infection affecting keratinised tissues such as the epidermis, hairs and nails. It is particularly prevalent in tropical regions due to favourable conditions for fungal growth, such as warmth and humidity. Dermatophytes metabolise keratin leading to various pathological clinical presentations, such as tinea pedis, tinea corporis and tinea cruris. Case reports, case series and studies published on treatment of tinea corporis add to the evidence-based effectiveness of Homoeopathy in treatment of the condition.

Objective: The objective of the study was to assess the therapeutic efficacy of individualised homoeopathic medicines in the clinical management of cases presented with tinea cruris and tinea corporis.

Methods: The present case series includes 26 cases of dermatophytosis. KOH mount test was used as the diagnostic tool for confirming tinea infection. Clinical Cure, Skindex-16 and Global Evaluation Response were the main outcome assessment tools. The causal relationship between intervention and outcome was assessed through MONARCH criteria.

Results: Out of 26 cases, nine cases (34%) experienced complete disappearance of lesions, 14 cases (53.8%) showed symptomatic improvement and progression of lesions was seen in three cases (11.5%). The collated data of these 26 cases showed a significant reduction in mean Clinical Cure Composite Score (pruritus, erythema and scaling) (p = 0.000) and Skindex-16 composite scores (p = 0.00) were observed.

Conclusion: This series provides evidence supporting the usefulness of Homoeopathy treatments for dermatophytosis, particularly tinea cruris and tinea corporis. Employing clinical assessments, standardised evaluation metrics and photographic documentation ensures a thorough and objective evaluation of treatment usefulness and patients' quality of life.

Acknowledgments and Source of Funding

Acknowledgement: The authors are grateful to Dr. Anil Khurana, Former Director General, CCRH, New Delhi for conceptualization of the project, approval, permission, implementation and guidance for the project. The authors are also grateful to Dr. N. Sowbhagya Lalitha, SRF(H); Dr. Preeti Bhandari, JRF(H); Dr. Avinash Kumar, SRF (H) for their assistance for conducting the trial. We sincerely thank the staff, pharmacists and the patients for their sincere participation in the study. Source of Funding: Central Council for Research in Homoeopathy

Authors

Renu Mittal, Akshaya Kumar Prusty, Ashish Shivadikar, Divya Taneja, Noopur Kumari, and Subhash Kaushik

Homoeopathy in the treatment of tinea cruris and tinea corporis – A case series

Renu Mittal[1]*, Akshaya Kumar Prusty[2], Ashish Shivadikar[3], Divya Taneja[1], Noopur Kumari[1], Subhash Kaushik[1]

[1]Central Council for Research in Homoeopathy, New Delhi, India, [2]Central Council for Research in Homoeopathy-Regional Research Institute(H), Puri, Odisha, India, [3]Central Council for Research in Homoeopathy-Clinical Research Unit(H), Goa, India

Abstract

Background: Dermatophytosis is a fungal infection affecting keratinised tissues such as the epidermis, hairs and nails. It is particularly prevalent in tropical regions due to favourable conditions for fungal growth, such as warmth and humidity. Dermatophytes metabolise keratin leading to various pathological clinical presentations, such as tinea pedis, tinea corporis and tinea cruris. Case reports, case series and studies published on treatment of tinea corporis add to the evidence-based effectiveness of Homoeopathy in treatment of the condition. **Objective:** The objective of the study was to assess the therapeutic efficacy of individualised homoeopathic medicines in the clinical management of cases presented with tinea cruris and tinea corporis. **Methods:** The present case series includes 26 cases of dermatophytosis. KOH mount test was used as the diagnostic tool for confirming tinea infection. Clinical Cure, Skindex-16 and Global Evaluation Response were the main outcome assessment tools. The causal relationship between intervention and outcome was assessed through MONARCH criteria. **Results:** Out of 26 cases, nine cases (34%) experienced complete disappearance of lesions, 14 cases (53.8%) showed symptomatic improvement and progression of lesions was seen in three cases (11.5%). The collated data of these 26 cases showed a significant reduction in mean Clinical Cure Composite Score (pruritus, erythema and scaling) (p = 0.000) and Skindex-16 composite scores (p = 0.00) were observed. **Conclusion:** This series provides evidence supporting the usefulness of Homoeopathy treatments for dermatophytosis, particularly tinea cruris and tinea corporis. Employing clinical assessments, standardised evaluation metrics and photographic documentation ensures a thorough and objective evaluation of treatment usefulness and patients' quality of life.

Keywords: Case series, Global evaluation response, Homoeopathy, MONARCH, Skindex-16, Tinea.

Introduction

Dermatophytes are fungi that invade and multiply within keratinised tissues (skin, hairs and nails), causing infection.[1] Based on their genera, dermatophytes can be classified into three groups: *Trichophyton* (which causes infections on skin, hairs and nails), epidermophyton (which causes infections on skin and nails) and *Microsporum* (which causes infections on skin and hairs). Based on the site of infection, it has been classified clinically into tinea capitis (head), tinea faciei (face), tinea barbae (beard), tinea corporis (body), tinea manus (hand), tinea cruris (groin), tinea pedis (foot) and tinea unguium (nail).[2,3]

Superficial fungal infections are highly prevalent worldwide, affecting more than 25% of the global population. In India, the incidence is approximately 4.1%. These infections are more common in communities with lower socioeconomic status and in warm and humid climates, which also contribute to higher recurrence rates. The primary symptom of dermatophytosis is the presence of an erythematous (red) patch on the skin that is typically very itchy. It typically presents as a well-demarcated, sharply circumscribed, oval or circular, mildly erythematous, scaly patch or plaque with a raised leading edge. The lesion starts as a flat, scaly spot that spreads centrifugally and clears centrally to form a characteristic annular lesion, giving rise to the term 'ringworm'.[2] The central area becomes hypopigmented or brown and less scaly as the active border progresses outwards. The border is usually annular and irregular. Occasionally, the border can be papular,

***Address for correspondence:** Renu Mittal, Central Council for Research in Homoeopathy, New Delhi, India. E-mail: renumittal8@gmail.com

Received: 03 October 2023; **Accepted:** 03 December 2024

Access this article online	
Quick Response Code: Available in print version only	**Website:** www.ijrh.org
	DOI: 10.53945/2320-7094.1959

How to cite this article: Mittal R, Prusty AK, Shivadikar A, Taneja D, Kumari N, Kaushik S. Homoeopathy in the treatment of tinea cruris and tinea corporis – A case series. Indian J Res Homoeopathy 2024;18:245-257.

vesicular or pustular. Lesions may assume other shapes such as circinate and arcuate.[4] The incubation period of tinea is 1–3 weeks. Dermatophytosis is rarely confined to one area of the body; instead, it tends to spread gradually to other regions.[5] For a definitive diagnosis, a clinical examination is followed by a microscopic examination of the affected skin. During a mycological examination, the presence of hyphae – long, branching filamentous structures of the fungus – can be observed. The combination of clinical presentation and microscopic examination is crucial for diagnosing and confirming dermatophytosis, leading to appropriate treatment and management of the infection. Tinea, including pedia, unguinum and corporis are most commonly seen in adults.[1,6,7] Tinea cruris is especially seen in adult males. Clinically, tinea corporis is the most common dermatophytosis. The recent prevalence of dermatophytosis in India ranges from 36.6–78.4%.[5] Tinea corporis and tinea cruris have been classified as B35.4 and B35.6, respectively, under the World Health Organisation, International Classification of Diseases, 10th revision.

The conventional treatment for dermatophytosis includes both topical and systemic antifungal therapies, depending on the severity and extent of the infection. For localised lesions, topical treatments such as terbinafine and itraconazole are commonly recommended. In cases where the infection is multiple, extensive, deep, recurrent, chronic or unresponsive to topical treatments, or if the patient has an immunodeficiency, systemic antifungal treatments are suggested.[8,9]

Two randomised controlled trials[9,10] and one observational study[11] reported the use of individualised homoeopathic remedies in the treatment of dermatophytosis. In addition, a pilot feasibility trial specifically investigated the use of *Bacillinum* in all cases.[12] Three case series reported successful use of individualised homoeopathic medicines in tinea treatment.[13-15] Furthermore, case reports, including one with two cases[16] and others with single cases of various types of dermatophytosis such as tinea corporis, tinea cruris, tinea capitis and tinea faciei, reported positive response to individualised Homoeopathy medicines.[17-21] The present case series adds to the existing literature of evidence pool in favour of Homoeopathy in treatment of tinea infections. All cases were confirmed using diagnostic investigations and treatment response recorded on validated scales.

Materials and Methods

Study design

Prospective case series to assess the usefulness of individualised homoeopathic medicines in the clinical management of cases presented with tinea cruris and tinea corporis.

Study settings

The study was carried out in the dermatology outpatient department (OPDs) clinics of CCRH research institutes, namely DDPRCRI (H), Noida, Regional Research Institute (H), Puri, Regional Research Institute (H), Gudivada, India. These clinics provide routine OPD care to all kinds of patients, including those suffering from dermatological disorders using homoeopathic medicines only and are managed by trained homoeopathic practitioners with a postgraduate degree in Homoeopathy and more than 5 years of research and clinical experience.

The cases reported in these dermatology OPDs from February to August 2021 with clinical presentation of tinea were sent for 10–20% potassium hydroxide [KOH] mounting investigation for conforming diagnosis.

Participants' details

A total of 26 cases of dermatophytosis were analysed in this case series. The patients between the age group of 18–70 years of both genders, with mycological confirmation, i.e. KOH-positive cases were assessed. The diagnosis was made by the presence of refractile, long, smooth, undulating, branching and septate hyphal filaments with or without arthroconidiospore in skin scrapings. The patients having evidence of skin conditions other than tinea cruris and tinea corporis, who had received topical/systematic or immune modulating oral treatment up to past 15 days before the initiation of treatment or who were having any systemic diseases were excluded from the study. Voluntary written informed consent was obtained from the patients, and those consenting to participate were further evaluated. The details of the patients were recorded at baseline in the case recording format.

Homoeopathic intervention

Comprehensive symptom profiles were constructed for each patient, detailing the specific clinical manifestations of their fungal infection and a totality was formed. The symptoms were repertorised using Synthesis Repertory version 9.0 with the aid of RADAR[22] software. After repertorisation, the homoeopathic prescription was made by consulting standard materia medica(s) to ensure the selection of the most appropriate remedy.

Each patient was consulted for a period ranging from 15 to 30 min, depending on the complexity and severity of their condition. Homoeopathic medicines were dispensed in pills made of cane sugar, size 30, 4 medicated pills constituted one dose. Homoeopathic medicines in the OPD are sourced from good manufacturing practices (GMP) compliant pharmaceutical firms to ensure quality and compliance. The subsequent change of medicines was done as per the need of the case. Potency and dosage were as per homoeopathic principles of prescribing. Medicines were dispensed from the pharmacy of the respective centres where the patients were reported.

Outcome measures

Clinical Cure scale and global evaluation response used in a previous study[23] were used fortnightly to assess the patient response to treatment on disease parameters. Further quality of life was assessed using Skindex-16 score[24] every 2 weeks.

- Clinical cure scale: This scale is based on the visual scale for the assessment of lesions and resolution of signs and

symptoms such as scaling, erythema and pruritis. The scale ranges from 0-9, where 1-3 is considered as mild; 4-6 as moderate and 7-9 as severe.

- Global evaluation response: This is a scale based on percentages considering the improvements of clinical signs and symptoms. The improvement rate for the case is as follows: 'Cleared - 100% remission of the clinical signs and symptoms except for residual manifestations', 'Excellent - 90–99% improvement of clinical signs and symptom of baselines', 'Good - 50–89% improvements of clinical signs and symptoms of baseline', 'Fair - 25–49% improvements of clinical signs and symptoms of baseline', 'Poor - <25% improvements of clinical signs and symptoms of baseline' and 'Worse- clinical signs deteriorated from baseline.'
- Skindex-16: It is a version of Skindex consisting of 16 items which are assigned into 03 domains (symptoms domain, emotional domain and functional domain). The score of each question ranges from 0–6, where 0 is 'Never bothered' and 6 is 'Always bothered'.
- Causal attribution and evaluation: The Modified Naranjo Criteria for Homoeopathy (MONARCH)[25] criteria was used to assess the causal relationship between clinical outcomes and Homoeopathy interventions. It is a validated tool for assessing the likelihood of causal relationship between Homoeopathy medicines and clinical response.
- Photographic records: The treating physicians maintained photographic records at the baseline and during subsequent visits for ongoing assessment.

Follow-up

Patients were followed up every 15 days to monitor progress and assess treatment. The treatment continued until the patient was cured or chose to discontinue the treatment.

Data analysis

Data of individual cases were compiled to identify individual case responses. Statistical analysis was conducted on the change in the scores of the Clinical Cure Score and Skindex-16 using the Mann–Whitney test. Cases 1–5 are presented in detail, providing insights into the clinical presentation, treatment administered and the response to treatment, as a sample of how the case details were recorded in the OPD. Photographic records were used to document the progression and resolution of the fungal infections from baseline to subsequent visits.

Results

Twenty-six confirmed cases of tinea corporis or cruris with mean age 31.9 ± 9.4 (range: 18–53 years) are presented here. There were 16 males and 10 females [Table 1]. The mean duration of treatment was 5.5 months (1.5–10 months).

Although this was not a specifically designed study, the treatment response of the cases of the same condition was assessed on common scales. As such, the data of the cases has been consolidated, analysed and is presented here to identify treatment response in these cases [Table 2].

Table 1: Age and gender distribution of included cases

Age (years)	Male	Female	Total
18–30	8	5	13
31–45	7	5	12
>45	1	0	1
Total	16	10	26

Table 2: Comparison of changes in the score of patients with respect to clinical cure score and Skindex-16

Character	Mean±SD		*p* value*
	Baseline	After treatment	
Clinical cure score	7.00±2.11	1.84±2.20	0.000
Skindex-16	52.0±22.35	25.0±14.9	0.000

*Mann–Whitney U test: $p \leq 0.05$ considered statistically significant; *p* values are given as exact up to 3 decimal places

At the end of treatment, a decrease in average composite score for Clinical Cure Scale was observed, as compared to baseline. There was a complete remission of the clinical signs and symptoms (100% cleared) in 09 patients; excellent recovery (90–99%) in 06; good (50–89%) in 08 and poor recovery (less than 25%) in 03 cases, as per Global evaluation response. The mean difference in Skindex 16 score before and after treatment was 27 ± 7.45. At the end of treatment and follow-up phase, the mycological assessment of 23 patients reported to be negative.

All the cases were assessed for possible causal relationship between homoeopathic treatment and clinical outcomes as per MONARCH criteria. The observed clinical outcome turned out to be attributable to the homoeopathic treatment established in 23 out of 26 cases [Supplementary Table 1, available in the online version only].

The salient features of each case are summarised in Supplementary Table 2 (available in the online version only).

Illustrative cases

Five illustrative cases are described below.

Case 1

Patient information

A 38-year-old male, travel agent by profession, reported in OPD with complaints of circular, patchy eruptions on the left shoulder, back, right wrist, buttock and groins since one year. The eruptions appeared as small papules on left shoulder first, then to back, right wrist, buttocks and lastly over groins. These small papular eruptions gradually increased in size and became circular patchy lesions. There was slight itching in the lesions that ameliorated from warmth. Scaling and burning present in the lesions were aggravated after scratching, with slight watery discharge oozing out from the lesions occasionally.

The patient had taken anti-fungal medicines for 15 days with temporary relief.

The patient reported that he gets irritable at petty issues and does not like the company of anyone. He was religious and had a desire for sour food and drinks, milk and bitter things. He had a sudden urge to pass stools after waking up in the morning. He felt uncomfortable in warm weather and had profuse perspiration all over the body.

He had a history of some non-specific skin ailments during his childhood which was treated allopathically. Two years back, he had hydrocele which was resolved spontaneously.

Clinical findings

Multiple annular eruptions were seen on the left shoulder, back, right wrist, buttock and groins. The margins of these lesions were inflamed, erythematous and well-defined. There was slight scaling in the lesions.

The characteristics symptoms considered for repertorisation are given in Figure 1. The case follow-ups, outcome assessments and prescribed medicines are mentioned in Table 3. The pictorial evidence of Case 1 is presented in Figure 2.

Case 2

Patient information

A 24-year-old male reported in the OPD with circular patchy eruption on legs, buttocks, back, right hand, axilla and face since four months. Initially, the eruptions appeared as small papules on both legs simultaneously and then started spreading upwards from buttocks to back, right hand, axilla and lastly over face. Later, these small papular eruptions slowly increased in size and became circular patchy lesions. Itching was aggravated by scratching and in the evening. Itching was followed by scaling. He took allopathic medicines for three months without any relief. He had not taken any medication for the past 15 days.

Mentally, he was irritable and hated consolation. He had a desire for bitter things, chicken, milk and green chilies. He had an intolerance towards eggs and chicken, consumption of these food products leads to stomach aches and nausea. The sweat is offensive and mainly seen on the palms and soles.

Clinical findings

Multiple annular eruptions were seen on legs, buttocks, back, right hand, axilla and face. There is erythema and scaling in

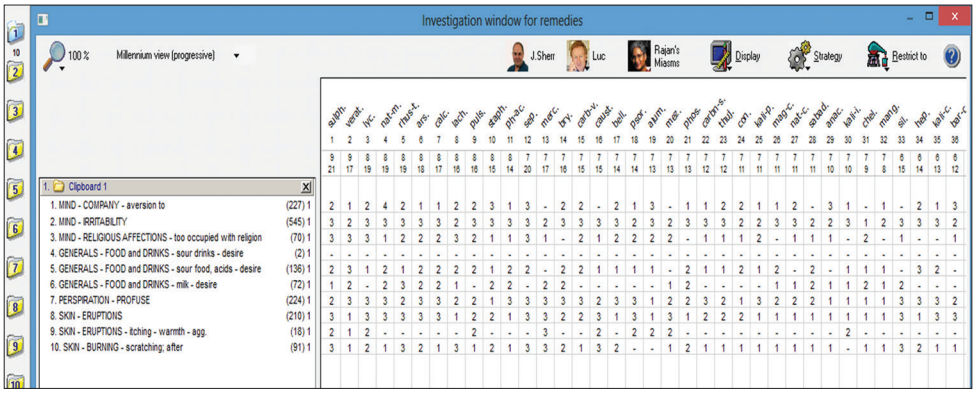

Figure 1: Repertorisation chart of Case 1

Table 3: Timeline of therapeutic intervention of Case 1

Days	Symptoms	Outcome Assessment	Medicine
Day 1	Circular patchy eruptions on the left shoulder, back, right wrist, buttock and groins. Margins inflamed, erythematous and well-defined. Slight scaling in the lesions. Itching ameliorated from warmth. Scaling and burning aggravation from scratching. Watery discharge from the eruptions.	Clinical Cure score=8 Skindex-16 score=52	*Sulphur* 6C/BD/3 days
Day 15	Circular patchy eruptions in the affected areas: Decreased in size. Erythema, scaling and itching: Slightly decreased. Inflammation around margins: Decreased.	Clinical Cure score=7 Skindex-16 score=39 Global evaluation response= Fair: 25–49%	*Sulphur* 6C/BD/3 days
Day 35	Size of the circular patchy eruptions on the affected areas: Decreased. Erythema and scaling: Reduced Itching in the eruptions: Increased.	Clinical Cure score=5 Skindex-16 score=30 Global evaluation response=Good: 50–89%	*Sulphur* 30C/OD/2 doses
Day 69	Eruptions over back: Increased in size. Itching in the lesions: Increased. Eruptions in other affected areas: Decreased in size. Erythema and scaling: Decreased. Margins of the lesions defined but not inflamed.	Clinical Cure score=4 Skindex-16 score=22 Global evaluation response=Good: 50–89%	*Sulphur* 30C/OD/2 doses

Table 4: Timeline of therapeutic intervention of Case 2

Days	Symptoms	Outcome Assessment	Medicine
Day 1	Circular patchy eruption on legs, buttocks, back, right hand, axilla and face. Itching aggravation from scratching, evening. Sticky watery discharge got aggravated from scratching. Erythema and scaling in the lesions. Margins of the lesions were well defined and inflamed.	Clinical Cure score=8 Skindex-16 score=62	*Sulphur* 6C/BD/3 days
Day 21	Circular patchy eruption on legs, buttocks, back, right hand, axilla and face- Increased in size and number. Itching in evening- Increased Bloody discharge from eruptions-aggravation scratching, night. Erythema and scaling- Same as before. Margins of the lesions were well defined and inflamed.	Clinical Cure score=8 Skindex-16 score=68 Global evaluation response=Worse	*Sulphur* 30C/OD/2 doses
Day 35	Circular patchy eruption on legs, buttocks, back, right hand, axilla and face- Decreased in size but again relapsed for 2 days back. Itching, erythema and scaling - Slightly better. The margins of the lesions were well-defined but not inflamed.	Clinical Cure score=5 Skindex-16 score=40 Global evaluation response=Fair: 25–49%	*Sulphur* 30C/OD/two doses
Day 55	Eruptions on the affected parts decreased in size and number. The itching increased for 2 days. Erythema and scaling of the lesions decreased. Margins of the lesions were well-defined but not inflamed.	Clinical Cure score=5 Skindex-16 score=40 Global evaluation response=Fair: 25–49%	*Sulphur* 30C/OD/two doses
Day 76	Eruptions on the affected parts decreased in size and number. Itching decreased. Erythema and scaling of the lesions decreased. The margins of the lesions were ill-defined and not inflamed.	Clinical Cure score=4 Skindex-16 score=29 Global evaluation response=Good: 50–89%	No medicine was given as improvement continued
Day 105	Eruptions on the affected parts - Decreased in size and number. Itching- Increased for 2 days. Erythema and scaling of the lesions - Decreased. Margins of the lesions were well-defined but not inflamed.	Clinical Cure score=5 Skindex-16 score=40 Global evaluation response=Good: 50–89%	No medicine was given as improvement continued

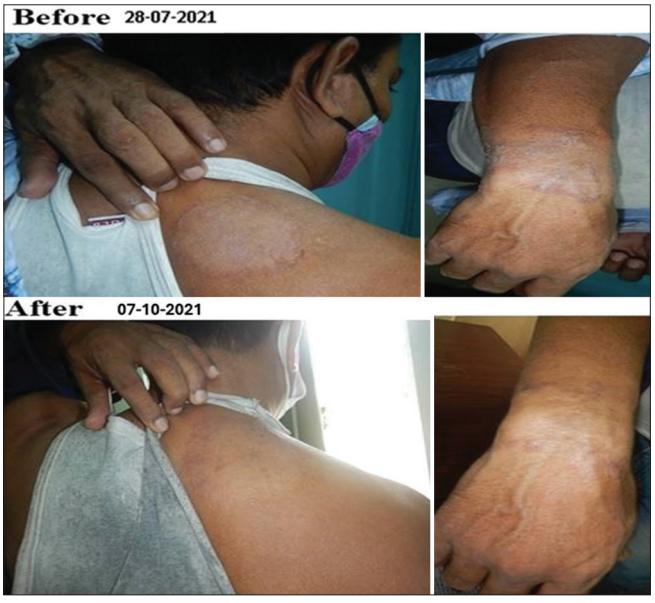

Figure 2: Before (28 July 2021) and after (07 October 2021) photographs of Case 1

the lesions. The margins of the lesions were well defined and inflamed.

The characteristic symptoms considered for repertorisation are given in Figure 3. The follow-ups of the case, along with outcome assessment and medicines, are mentioned in Table 4.

The pictorial evidence of Case 1 is presented in Figure 4.

Case 3

Patient information

A 45-year-old male, tailor by profession, reported in OPD with complaints of circular patchy eruptions on the left side of the abdomen since two months. There was a single lesion of small size which increased gradually, then another lesion appeared. There was slight itching and scaling which were aggravated by sweating and night. One year back, he had the same lesions on the groins for which he took homoeopathic medicines for about 6 months (*Mezereum, Mercurius solubilis*) with substantial relief. In the past four months, however, he had not been under any treatment. He complained of non-specific pain occasionally in the left side of the chest for 5–6 years which was worse in the evening and better by passing flatus.

He stated that he had palpitations when hearing good news and gets anxious when hearing bad news, with trembling in the extremities. He had a fear that something would happen to him. He had a desire for company, especially in the evening, as he anticipated bad things would happen during that time. He got angry when contradicted. He had a fear of death.

He had thirst for small quantity of water at frequent intervals. His tongue was moist, coated white with imprints of teeth. The patient felt comfortable in cold weather and open air and covering was required less often.

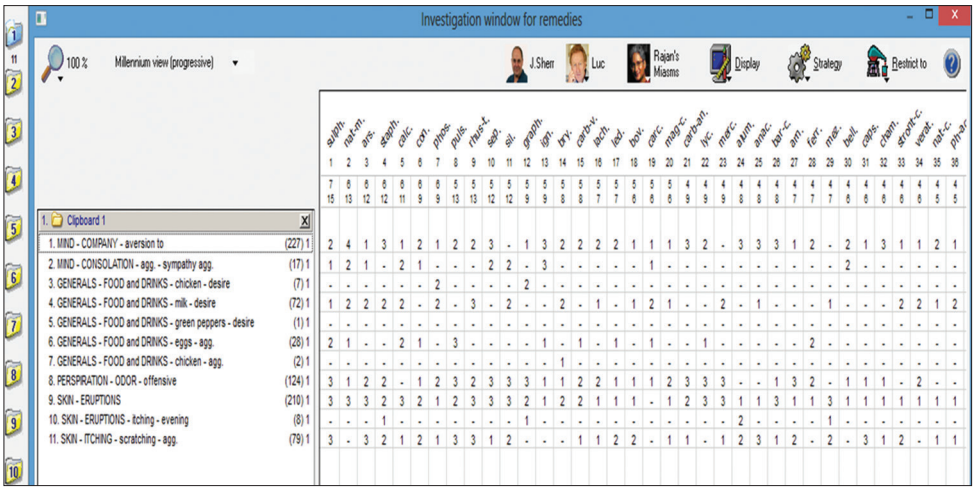

Figure 3: Repertorisation chart of Case 2

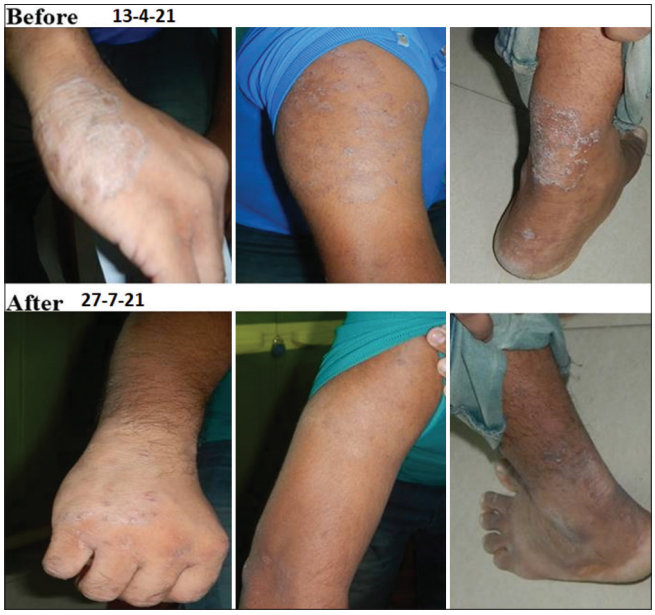

Figure 4: Before (13 April 2021) and after (27 July 2021) photographs of Case 2

Clinical findings

Two annular eruptions were present on the left side of the abdomen. The margins were ill-defined, and erythema was present on the margins of the lesions. There was slight scaling in the lesions which fell off after scratching.

The characteristic symptoms considered for repertorisation are given in Figure 5. The pictorial evidence of Case 3 is presented in Figure 6. The case follow-ups, outcome assessment and medicines are mentioned in Table 5.

Case 4

Patient information

An 18-year-old female reported in the OPD with complaints of circular patchy eruptions on her right thigh, both arms, abdomen and back since the past two months. It began as a small papular eruption, first seen over the right thigh, then to the right arm, left arm, abdomen and lastly over the back. Gradually, the lesions increased in size and became circular and patchy. There was intense itching and burning in the eruptions, worse after scratching. One month back, she took allopathic treatment for 15 days, without any relief.

She loved making new friends and felt comfortable in their company. She was soft-spoken, jovial and fond of cleaning her surroundings and belongings. The patient had a desire for sour food and drinks. She used to drink large quantities of water in one go but her tongue was dry. The patient was chilly but had a desire to be in the open air.

She had past history of pneumonia and urticaria, for which she took homoeopathic medicines with good relief.

Clinical findings

Multiple annular eruptions were seen on both arms, right thigh, abdomen and back. There was slight erythema and scaling in the lesions. The margins of lesions were well-defined, but not inflamed.

The characteristic symptoms considered for repertorisation are given in Figure 7. The pictorial evidence of Case 4 is presented in Figure 8. The follow-ups of the case, along with outcome assessment and medicines, are mentioned in Table 6.

Case 5

Patient information

A 40-year-old businessman reported in the OPD with complaints of circular, patchy eruptions on thighs and hands for two years. There was a small, papular eruption, first seen over the right thigh followed by the left thigh and lastly to both hands simultaneously. Gradually, the lesions increased in size and became circular patchy eruptions. There was itching in affected areas, aggravated by heat and sun exposure.

The patient had a desire for salt and spinach and had an intolerance to meat and eggs, which caused abdominal pains and bloating after eating.

Table 5: Timeline for therapeutic intervention of Case 3

Days	Symptoms	Outcome assessment	Medicines
Day 1	Circular patchy eruptions on the left side of the abdomen for 2 months. Itching and burning got worse at night and from sweating. The margins of the lesions were erythematous, ill-defined and inflamed. Scaling was present in the lesions	Clinical Cure score=2 Skindex-16 score=5	*Arsenic album* 6C/ BD/ 3 days
Day 37	Itching reduced slightly in the old lesions. New circular patchy eruptions were seen in the gluteal region. Margins of lesions were defined and inflamed.	Clinical Cure score=3 Skindex-16 score=5 Global evaluation response=Worse	*Arsenic album* 6C/ BD/ 3 days
Day 150	Itching, erythema and scaling - Reduced Burning in the lesions - Slightly increased Margins of lesions were defined and inflamed.	Clinical Cure score=2 Skindex-16 score=2 Global evaluation response=Good: 50–89%	*Arsenic album* 30C/ OD/ 3 days
Day 200	Eruptions - Reduced in size. Itching - Decreased. There were no scaling and burning in the lesions.	Clinical Cure score=2 Skindex-16 score=1 Global evaluation response=Excellent: 90–99%	No medicine was given as improvement continued.
Day 207	No eruptions were seen, there was no itching and burning.	Clinical Cure score=1 Skindex-16 score=1 Global evaluation response=Cleared: 100%	No medicine was given as improvement continued.

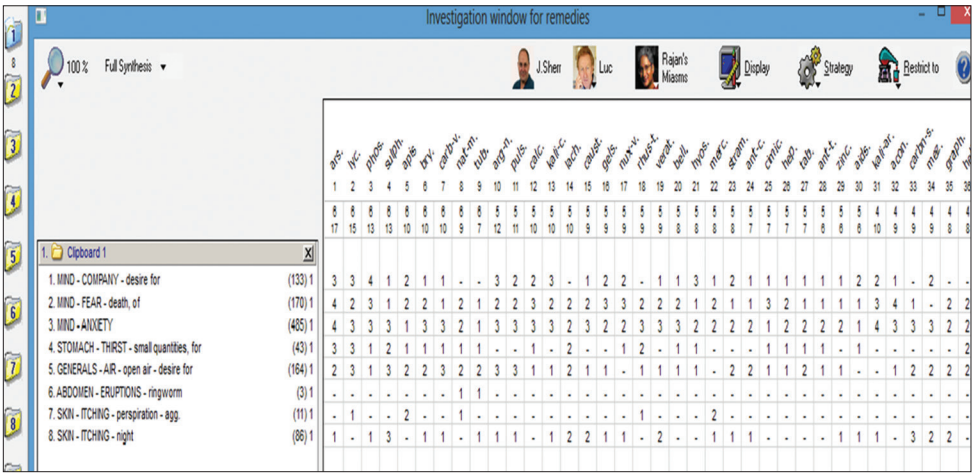

Figure 5: Repertorisation chart of case 3

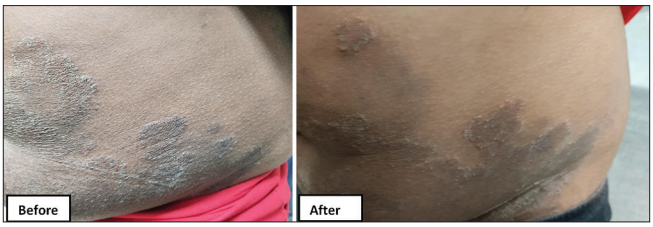

Figure 6: Before (18 February 2021) and after (13 September 2021) photographs of Case 3

Clinical findings

Multiple annular eruptions were seen on the thighs and hands. There was mild erythema and scaling in the eruptions. The margins of the lesions are irregular and inflammed.

The characteristic symptoms considered for repertorisation are given in Figure 9. The pictorial evidence of Case 5 is presented as Figure 10. The follow-ups of the case along with outcome assessment and medicines are mentioned in Table 7.

Discussion

Dermatophytosis infections are one of the most common fungal infections of the skin. They are known as fungal infections and affect the quality of life of patients due to the concomitant inflammatory symptoms involving pruritus. The findings confirm that dermatophytosis, particularly tinea cruris and tinea corporis, is more prevalent in the age group of 21–30 years (46%), followed by 31–40 years (30.7%). These results are

Table 6: Timeline of therapeutic intervention of Case 4

Days	Symptoms	Outcome assessment	Medicines
Day 1	Circular patchy eruption on right thigh, both arms, abdomen and back. Itching and burning got worse from scratching. There was slight erythema and scaling present in the lesions. Margins of lesions were well defined but not inflamed	Clinical Cure score=4 Skindex-16 score=8	*Sepia* 6C/ BD/ 3 days
Day 30	Eruptions on the affected parts - Increased in size. Scaling and erythema - Absent. Margins of lesions were well defined but not inflamed.	Clinical Cure score=3 Skindex-16 score=3 Global Evaluation Response=Fair: 25–49%	*Sepia* 6C/ BD/ 3 days
Day 68	Eruptions on the affected parts - Same in size. Itching in the eruptions - Slightly decreased. Itching - Present. Scales were present in the eruptions. Margins of the lesions were ill defined, not inflammed.	Clinical Cure score=2 Skindex-16 score=3 Global evaluation response=Fair: 25–49%	*Sepia* 6C/ BD/ 3 days
Day 82	Eruptions on the affected parts - Decreased in size and number. Itching - Decreased. Erythema and scaling in the lesions - Absent Margins of the lesions were disappearing.	Clinical Cure score=1 Skindex-16 score=2 Global evaluation response= Good: 50–89%	No medicine was given as improvement continued.
Day 153	Eruptions on the affected parts disappeared	Clinical Cure score=0 Skindex-16 score=0 Global evaluation response=Cleared: 100%	No medicine was given as improvement continued.

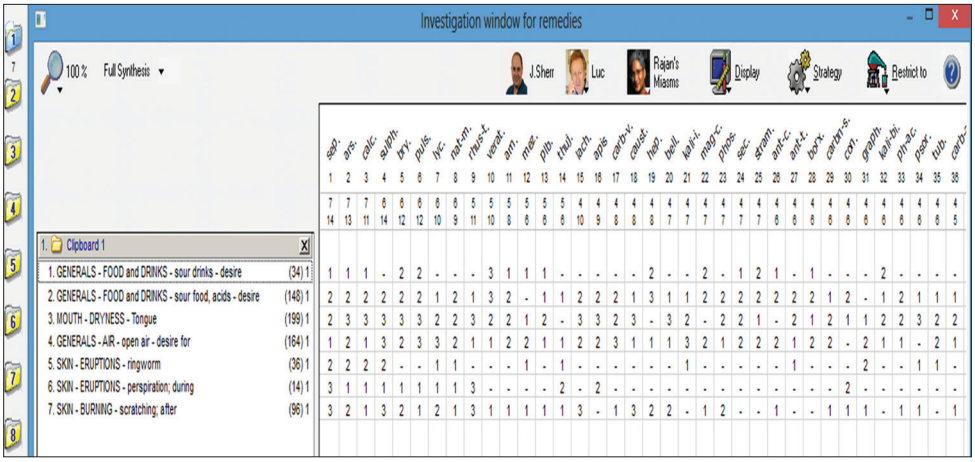

Figure 7: Repertorisation chart of Case 4

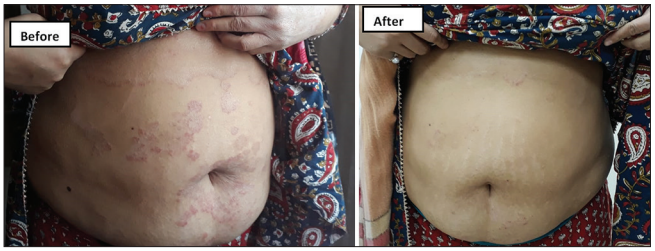

Figure 8: Before (23 February 2021) and after (24 July 2021) photographs of Case 4

consistent with previous research studies,[12,13] underscoring the need for targeted interventions and awareness programmes to effectively manage and prevent these infections in the identified high-risk groups. 57.7% of cases had a mixed presentation of tinea corporis with male predominance underscoring the complexity of dermatophytosis and the need for comprehensive diagnostic and treatment approaches. This finding is consistent with some previous studies.[26-28]

Homoeopathy is based on the principle of "like cures like," where a substance causing symptoms in a healthy person is used to treat similar symptoms in a sick person. The selection of remedies is highly individualised and based on a comprehensive understanding of the patient's constitution, mental, emotional and physical characteristics. Conventional treatments such as topical creams and oral medications are effective in eliminating the fungus from skin. These treatments can sometimes lead to suppression. In Homoeopathy, suppressing external symptoms, without addressing the underlying imbalance, can drive the disease deeper into the body, leading to recurrence or chronic conditions. The cases in this series were treated with a single,

Table 7: Timeline of the therapeutic intervention of Case 5

Days	Symptoms	Outcome Assessment	Medicine
Day 1	Circular patchy eruptions on thighs and hands. Itching aggravation from heat and sun exposure. Margins of the eruptions were inflammed and well-defined	Clinical Cure score=9 Skindex-16 score=52	*Psorinum* 6C/ BD/ 3 days
Day 30	Eruptions on the affected parts - Decreased in size. Erythema and itching - Decreased. Scaling- Same. Margins of the eruptions were inflammed and well-defined.	Clinical Cure score=6 Skindex-16 score=39 Global evaluation response=Fair: 25–49%	No medicine was given as improvement continued.
Day 76	Eruptions on the affected parts - Same in size. Itching in the eruptions - Slightly increased. Scales in the eruptions - Increased. Margins of the eruptions were inflammed and well-defined	Clinical Cure score=2 Skindex-16 score=45 Global evaluation response=Poor: <25%	*Psorinum* 30C/ BD/ 3 days
Day 91	Eruptions on the affected parts - Increased in size and number. Itching - Increased. Erythema and scaling - Increased in the lesions. Margins of the lesions were irregular and inflammed.	Clinical Cure score=5 Skindex-16 score=50 Global evaluation response=Poor: <25%	*Psorinum* 200C/ OD/ 3 days
Day 120	Eruptions on the affected parts decreased in size and number. Itching, erythema and scaling decreased. Margins of the lesions were irregular and inflammed.	Clinical Cure score=4 Skindex-16 score=37 Global evaluation response=Good: 50–89%	No medicine was given as improvement continued.
Day 150	Eruptions on the affected parts - Decreased in size and number. Itching, erythema and scaling - Much decreased. Margins of the lesions were irregular but not inflamed.	Clinical Cure score=3 Skindex-16 score=3 Global evaluation response=Good: 50–89%	No medicine was given as improvement continued.

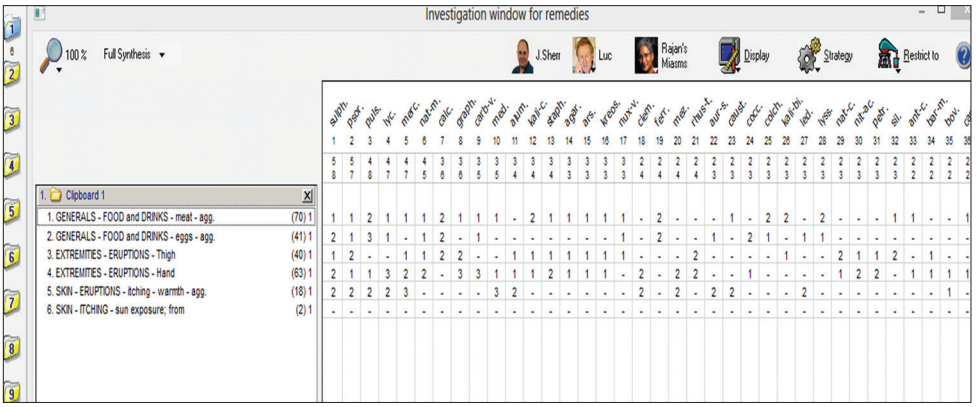

Figure 9: Repertorisation chart of Case 5

individualised homoeopathic remedy. The effectiveness of this approach was successfully evaluated using Clinical Cure assessed for resolution of symptoms, Global Evaluation Response for overall assessment of the patient's health and response to treatment and Skindex-16 for measurement of impact on the patient's quality of life.

All cases exhibited clinical symptoms of erythema, scaling and itching in the affected areas. 88% of patients showed improvement in their symptoms with homoeopathic treatment. A comparison of baseline and end-of-treatment data showed a statistically significant decrease in the Clinical Cure score. A complete clearance of symptoms was seen in 34% of patients, while 90-99% improvement in the skin lesions was seen in 23% of patients. The use of Skindex-16 allowed for the quantitative measurement of the impact of dermatophytosis and its treatment on patients' quality of life. Statistically significant improvement in Skindex-16 composite scores ($P = 0.00$) reflects the positive effect of homoeopathic treatment on patients' overall well-being.

None of these cases had undertaken any conventional topical treatments and had reported directly for the study. During the course of the treatment, none developed extensive, deep, recurrent, complaints requiring referral for systemic antifungal treatments.

The series demonstrated the usefulness of homoeopathic medicines in curing tinea cruris and tinea corporis. *Sulphur* was prescribed in 23% of cases, showing maximum improvement. Other medicines found effective were *Natrum muriaticum*, *Sepia* and *Psorinum*. The clinical outcomes were assessed using the MONARCH criteria which is an objective evidence of the

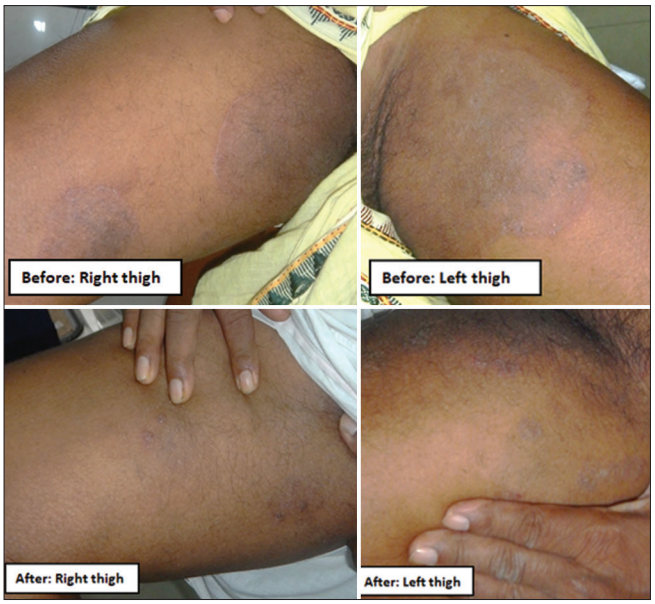

Figure 10: Before (2 March 2021) and after (1 September 2021) photographs of Case 5

causal relationship between the homoeopathic intervention and the observed clinical outcomes. The scores of 8 or 7 in 22 cases indicate a possible causal attribution of individualised Homoeopathy in treating tinea corporis and cruris.

This case series provides insight into disease patterns, evolution, signs and symptoms, probable causes, response to treatment modalities and aid in generating hypotheses based on group similarities. The homoeopathic practitioners are known to treat dermatological conditions successfully, where diagnosis is based on clinical presentations. Adding requisite investigations not only confirms the diagnosis and prevents misdiagnosis, but also adds objectivity to the response measurement, when clinical improvement corroborates with the cessation of pathology. This case series advocates a structured and consistent approach to the homoeopathic treatment of dermatophytosis, thus allowing for standardised assessment and documentation of effective treatment across all cases in the series. There are some limitations due to the non-availability of the comparator group, and the double-blind studies with longer follow-up periods may yield more meaningful data.

Conclusion

This case series provides preliminary evidence for the usefulness of homoeopathic treatment for dermatophytosis, particularly tinea cruris and tinea corporis. Employing clinical assessment, standardised evaluation metrics and photographic documentation methods ensures an unbiased, objective evaluation of treatment and patient's quality of life. A continued research using rigorous criteria, like MONARCH, can further substantiate the role of homoeopathy in managing dermatophytosis and other chronic conditions.

References

1. Weitzman I, Summerbell RC. The dermatophytes. Clin Microbiol Rev 1995;8:240-59.
2. Sahoo AK, Mahajan R. Management of tinea corporis, tinea cruris, and tinea pedis: A comprehensive review. Indian Dermatol Online J 2016;7:77-86.
3. Lakshmanan A, Ganeshkumar P, Mohan SR, Hemamalini M, Madhavan R. Epidemiological and clinical pattern of dermatomycoses in rural India. Indian J Med Microbiol 2015;33:S134-36.
4. Longo DL, Fauci AS, Kasper DL, Hauser SL, Jameson JL, Loscalzo J. Harrison's Principles of Internal Medicine. 18th ed. New York: Mc Graw-Hill; 2012. p. 350.
5. Weinstein A, Berman B. Topical treatment of common superficial tinea infections. Am Fam Physician 2002;65:2095-102.
6. Rajagopalan M, Inamadar A, Mittal A, Miskeen AK, Srinivas CR, Sardana K, *et al*. Expert consensus on the management of dermatophytosis in India (ECTODERM India). BMC Dermatol 2018;18:6.
7. Leung AK, Lam JM, Leong KF, Hon KL. Tinea corporis: An updated review. Drugs Context 2020;9:2020-5-6.
8. Kaul S, Yadav S, Dogra S. Treatment of dermatophytosis in elderly, children, and pregnant women. Indian Dermatol Online J 2017;8:310-18.
9. Laskar B, Paul S, Chattopadhyay A, Karuppusamy A, Balamurugan D, Bhakta P, *et al*. Individualized homeopathic medicines in the treatment of tinea corporis: Double-blind, randomized, placebo-controlled trial. Homeopathy 2023;112:74-84.
10. Hazra P, Mukherjee SK, Ganguly S, Roy AS, Dutta S, Sadhukhan S, *et al*. A comparative study of 50-millesimal potencies and centesimal potencies in the treatment of tinea corporis: An open, randomised, pilot trial. Homœopathic Links 2021;34:267-77.
11. Dixit AK, Javed D, Srivastava A, Bala R, Giri N. Homeopathic medicines in the management of dermatophytosis (tinea infections): A clinico-epidemiological study with pre-post comparison design. Homeopathy 2024;113:149-57.
12. Sherr J, Davy J, Saghai Z, Quirk T, Fibert P. The comparative effectiveness of the homeopathic medicine Bacillinum for ringworm (tinea): A pilot feasibility study. Eur J Integr Med 2022;53:102142.
13. Singh AK, Singh R, Bishnoi SK, Choudhary H, Kuntal RS. Different types of dermatophytic infection on the basis of site homoeopathic approach: Case series. Int J Homoeopath Sci 2020;4:67-73.
14. Nagar N, Poswal RK, Kumar A, Singhal K. Usefulness of homeopathic treatment in tinea faciei: A case series. Int J Homoeopath Sci 2023;7:492-8.
15. Roy PS, Tabassum SN, Das S, Fouzdar V, Hazra A, Goswami P. Efficacy of individualized homeopathic treatment in the management of dermatophytosis-a case series. Int J Ayush Case Rep 2021;5:321-32.
16. Shukla I. Tinea faciei treated with constitutional homoeopathic medicine using vithoulkas compass: Two evidence-based case reports. Indian J Res Homoeopathy 2022;16:171-7.
17. Choudhary H, Singh U. Tinea faciei successfully treated with individualised homoeopathic medicine: A case report. Homœopath Links 2023;36:34-41.
18. Kareliya AJ, Harde M, Desai P, Desai K, Awati S. Treatment of tinea cruris with individualized homoeopathic medicine by using synthesis repertory: A case study. Int J Homoeopath Sci 2023;7:620-4.
19. Garg K, Bansal D, Mittal A. Tinea capitis treated with homoeopathic medicine *Pulsatilla* nigricans: A case report. Indian J Res Homoeopathy 2023;17:241-8.
20. Gupta Y, Sharma A, Sharma S. Tinea cruris treated with individualised homoeopathic medicine: An evidence-based case report. Indian J Res Homoeopathy 2023;17:181-6.
21. Manimegalai S, Murugan M, Mon RS. Personalized approach to persistent and recurrent tinea corporis: A case report. Int J Homoeopath Sci 2022;6:428-9.
22. Archibel Homoeopathic Software. RADAR 10. Belgium: Archibel; 2009.
23. Thaker SJ, Mehta DS, Shah HA, Dave JN, Mundhava SG. A comparative randomized open label study to evaluate efficacy, safety

and cost effectiveness between topical 2% sertaconazole and topical 1% butenafine in tinea infections of skin. Indian J Dermatol 2013;58:451-6.
24. Chren MM, Lasek RJ, Sahay AP, Sands LP. Measurement properties of skindex-16: A brief quality-of-life measure for patients with skin diseases. J Cutan Med Surg 2001;5:105-10.
25. Lamba CD, Gupta VK, Van Haselen R, Rutten L, Mahajan N, Molla AM, *et al*. Evaluation of the modified naranjo criteria for assessing causal attribution of clinical outcome to homeopathic intervention as presented in case reports. Homeopathy 2020;109:191-7.
26. Itamura R. Effect of homeopathic treatment of 60 Japanese patients with chronic skin disease. Complement Ther Med 2007;15:115-20.
27. Bindu V, Pavithran K. Clinico-mycological study of dermatophytosis in calicut. Indian J Dermatol Venereol Leprol 2002;68:259-61.
28. Surendran K, Bhat RM, Boloor R, Nandakishore B, Sukumar D. A clinical and mycological study of dermatophytic infections. Indian J Dermatol 2014;59:262-7.

L'homéopathie dans le traitement de la teigne crurale et de la teigne corporelle - Une série de cas

Contexte: La dermatophytose est une infection fongique affectant les tissus kératinisés tels que l'épiderme, les cheveux et les ongles. Elle est particulièrement répandue dans les régions tropicales en raison des conditions favorables à la croissance fongique, telles que la chaleur et l'humidité. Les dermatophytes métabolisent la kératine, ce qui conduit à diverses présentations cliniques pathologiques, telles que la teigne des pieds, la teigne du corps et la teigne crurale. Les rapports de cas, les séries de cas et les études publiées sur le traitement de la teigne du corps ajoutent à l'efficacité fondée sur des preuves de l'homéopathie dans le traitement de la maladie. **Objectif:** L'objectif de l'étude était d'évaluer l'efficacité thérapeutique de médicaments homéopathiques individualisés dans la prise en charge clinique des cas présentés avec la teigne crurale et la teigne du corps. **Méthodes:** La présente série de cas comprend 26 cas de dermatophytose. Le test de montage KOH a été utilisé comme outil de diagnostic pour confirmer l'infection par la teigne. La guérison clinique, le Skindex - 16 et la réponse d'évaluation globale étaient les principaux outils d'évaluation des résultats. La relation de cause à effet entre l'intervention et le résultat a été évaluée selon les critères MONARCH. **Résultats:** Sur 26 cas, neuf cas (34 %) ont connu une disparition complète des lésions, 14 cas (53,8 %) ont montré une amélioration symptomatique et une progression des lésions a été observée dans trois cas (11,5 %). Les données recueillies sur ces 26 cas ont montré une réduction significative du score composite moyen de guérison clinique (prurit, érythème et desquamation) (p = 0,000) et des scores composites Skindex - 16 (p = 0,00). **Conclusion:** Cette série fournit des preuves à l'appui de l'utilité des traitements homéopathiques pour les dermatophytoses, en particulier la teigne crurale et la teigne corporelle. L'utilisation d'évaluations cliniques, de mesures d'évaluation standardisées et de documentation photographique garantit une évaluation approfondie et objective de l'utilité du traitement et de la qualité de vie des patients.

Homöopathie bei der Behandlung von Tinea cruris und Tinea corporis – eine Fallserie

Hintergrund: Dermatophytose ist eine Pilzinfektion, die keratinisierte Gewebe wie Epidermis, Haare und Nägel befällt. Sie tritt besonders in tropischen Regionen auf, da dort die Bedingungen für das Pilzwachstum günstig sind, wie Wärme und Feuchtigkeit. Dermatophyten verstoffwechseln Keratin, was zu verschiedenen pathologischen klinischen Erscheinungen führt, wie Tinea pedis, Tinea corporis und Tinea cruris. Veröffentlichte Fallberichte, Fallserien und Studien zur Behandlung von Tinea corporis untermauern die evidenzbasierte Wirksamkeit der Homöopathie bei der Behandlung dieser Erkrankung. **Ziel:** Die Ziele der Studie bestanden darin, die therapeutische Wirksamkeit individueller homöopathischer Arzneimittel bei der klinischen Behandlung von Fällen von Tinea cruris und Tinea corporis zu beurteilen. **Methoden:** Die vorliegende Fallserie umfasst 26 Fälle von Dermatophytose. Der KOH-Präparattest wurde als diagnostisches Instrument zur Bestätigung einer Tinea-Infektion verwendet. Clinical Cure, Skindex - 16 und Global Evaluation Response waren die wichtigsten Instrumente zur Ergebnisbewertung. Der kausale Zusammenhang zwischen Intervention und Ergebnis wurde anhand der MONARCH-Kriterien bewertet. **Ergebnisse:** In neun von 26 Fällen (34 %) verschwanden die Läsionen vollständig, in 14 Fällen (53,8 %) kam es zu einer symptomatischen Besserung und in drei Fällen (11,5 %) kam es zu einem Fortschreiten der Läsionen. Die gesammelten Daten dieser 26 Fälle zeigten eine signifikante Verringerung des mittleren Clinical Cure Composite Score (Jucken, Erythem und Schuppung) (p = 0,000) und der Skindex-16-Composite-Scores (p = 0,00). Schlussfolgerung: Diese Serie liefert Belege für die Nützlichkeit homöopathischer Behandlungen bei Dermatophytose, insbesondere Tinea cruris und Tinea corporis. Der Einsatz klinischer Bewertungen, standardisierter Bewertungsmaßstäbe und fotografischer Dokumentation gewährleistet eine gründliche und objektive Bewertung der Nützlichkeit der Behandlung und der Lebensqualität der Patienten.

टिनिया क्रूरिस और टिनिया कॉर्पोरिस के उपचार में होम्योपैथी - एक केस सीरीज़

पृष्ठभूमि: डर्मेटोफाइटोसिस एक फंगल संक्रमण है जो एपिडर्मिस, बाल और नाखून जैसे केराटिनाइज्ड ऊतकों को प्रभावित करता है। यह विशेष रूप से उष्णकटिबंधीय क्षेत्रों में कवक के विकास के लिए अनुकूल परिस्थितियों, जैसे गर्मी और आर्द्रता के कारण प्रचलित है। डर्मेटोफाइट्स केराटिन को मेटाबॉलाइज करते हैं जिससे विभिन्न रोग संबंधी नैदानिक प्रस्तुतियाँ होती हैं, जैसे टिनिया पेडिस, टिनिया कॉर्पोरिस और टिनिया क्रूरिस। टिनिया कॉर्पोरिस के उपचार पर प्रकाशित केस रिपोर्ट, केस सीरीज और अध्ययन इस स्थिति के उपचार में होम्योपैथी की साक्ष्य-आधारित प्रभावशीलता में इजाफा करते हैं। **उद्देश्य:** अध्ययन का उद्देश्य टिनिया क्रूरिस और टिनिया कॉर्पोरिस से पीड़ित मामलों के नैदानिक प्रबंधन में व्यक्तिगत होम्योपैथिक दवाओं की चिकित्सीय प्रभावकारिता का आकलन करना था। **तरीके:** वर्तमान केस सीरीज में डर्मेटोफाइटिस के 26 मामले शामिल किए गए । टिनिया संक्रमण की पुष्टि के लिए नैदानिक उपकरण के रूप में KOH माउंट परीक्षण का उपयोग किया गया । **परिणाम:** 26 मामलों में से, नौ मामलों (34%) में घावों का पूरी तरह से गायब होना देखा गया, 14 मामलों (53.8%) में लक्षणों में सुधार देखा गया और तीन मामलों (11.5%) में घावों की प्रगति देखी गई । इन 26 मामलों के एकत्रित आंकड़ों ने औसत क्लिनिकल क्योर कम्पोजिट स्कोर (प्रूरिटस, एरिथेमा और स्केलिंग) (पी = 0.000) और स्किनडेक्स - 16 कम्पोजिट स्कोर (पी = 0.00) में महत्वपूर्ण कमी देखी गई । **निष्कर्ष:** यह केस सीरीज़ डर्मेटोफाइटिस, विशेष रूप से टिनिया क्रूरिस और टिनिया कॉर्पोरिस के लिए होम्योपैथीक उपचार की उपयोगिता का समर्थन करने वाले साक्ष्य प्रदान करती है। नैदानिक मूल्यांकन, मानकीकृत मूल्यांकन मेट्रिक्स और फोटोग्राफिक दस्तावेज़ीकरण का उपयोग उपचार की उपयोगिता और रोगियों के जीवन की गुणवत्ता का गहन और वस्तुनिष्ठ मूल्यांकन सुनिश्चित करता है।

Homeopatía en el tratamiento de la tiña crural y la tiña corporal: una serie de casos

Antecedentes: La dermatofitosis es una infección fúngica que afecta a los tejidos queratinizados, como la epidermis, el cabello y las uñas. Es particularmente frecuente en las regiones tropicales debido a las condiciones favorables para el crecimiento de los hongos, como el calor y la humedad. Los dermatofitos metabolizan la queratina, lo que da lugar a diversas presentaciones clínicas patológicas, como tinea pedis, tinea corporis y tinea cruris. Los informes de casos, las series de casos y los estudios publicados sobre el tratamiento de la tinea corporis se suman a la eficacia basada en la evidencia de la homeopatía en el tratamiento de la afección. **Objetivo:** Los objetivos del estudio fueron evaluar la eficacia terapéutica de los medicamentos homeopáticos individualizados en el manejo clínico de los casos presentados con tinea cruris y tinea corporis. Métodos: La presente serie de casos incluye 26 casos de dermatofitosis. La prueba de montaje de KOH se utilizó como herramienta de diagnóstico para confirmar la infección de tiña. Clinical Cure, Skindex - 16 y Global Evaluation Response fueron las principales herramientas de evaluación de resultados. La relación causal entre la intervención y el resultado se evaluó a través de los criterios MONARCH. **Resultados:** De 26 casos, nueve casos (34%) experimentaron la desaparición completa de las lesiones, 14 casos (53,8%) mostraron una mejoría sintomática y se observó progresión de las lesiones en tres casos (11,5%). Los datos recopilados de estos 26 casos mostraron una reducción significativa en la puntuación compuesta de curación clínica media (prurito, eritema y descamación) (p = 0,000) y se observaron puntuaciones compuestas de Skindex - 16 (p = 0,00). **Conclusión:** Esta serie proporciona evidencia que respalda la utilidad de los tratamientos homeopáticos para la dermatofitosis, en particular la tiña crural y la tiña corporal. El uso de evaluaciones clínicas, métricas de evaluación estandarizadas y documentación fotográfica garantiza una evaluación exhaustiva y objetiva de la utilidad del tratamiento y la calidad de vida de los pacientes.

順勢療法治療股癬和體癬 - 病例係列

背景：皮癬菌症是一種影響角質化組織（如表皮、毛髮和指甲）的真菌感染。由於溫暖和潮濕等有利於真菌生長的條件，這種情況在熱帶地區尤其普遍。皮癬菌代謝角質蛋白，導致各種病理臨床表現，如足癬、體癬和股癬。已發表的有關體癬治療的病例報告、病例係列和研究進一步證實了順勢療法治療體癬的有效性。目的：本研究的目的是評估個人化順勢療法藥物在股癬和體癬病例臨床治療的治療效果。方法：本病例係列包括 26 例皮癬菌症病例。 KOH安裝測試被用作確認癬感染的診斷工具。臨床治癒、Skindex - 16 和整體評估反應是主要的結果評估工具。介入與結果之間的因果關係透過 MONARCH 標準進行評估。結果：26例中，9例（34%）皮損完全消失，14例（53.8%）症狀改善，3例（11.5%）皮損進展。這 26 例病例的整理數據顯示，觀察到平均臨床治癒綜合評分（搔癢、紅斑和鱗屑）（p = 0.000）和 Skindex-16 綜合評分（p = 0.00）顯著降低。結論：本系列提供的證據支持順勢療法治療皮癬菌病，特別是股癬和體癬的有效性。採用臨床評估、標準化評估指標和照片記錄可確保對治療有效性和患者生活品質進行徹底、客觀的評估。