



E-ISSN: 2706-9575
P-ISSN: 2706-9567
IJARM 2025; 7(1): 20-26
www.medicinpaper.net
Received: 18-12-2024
Accepted: 23-01-2025

Dr. Jeni Desai
P.G. Scholar, Department of
Organon of Medicine,
Jawaharlal Nehru
Homoeopathic Medical
College, Parul University,
Vadodara, Gujarat, India

Dr. Partha Sarathi Mandal
Professor, P.G Guide, HOD in
Department of Organon of
Medicine, Jawaharlal Nehru
Homoeopathic Medical
College, Parul University,
Vadodara, Gujarat, India

Corresponding Author:
Dr. Jeni Desai
P.G. Scholar, Department of
Organon of Medicine,
Jawaharlal Nehru
Homoeopathic Medical
College, Parul University,
Vadodara, Gujarat, India

Role of individualized homoeopathic medicine in the management of hyperlipidemia

Jeni Desai and Partha Sarathi Mandal

DOI: <https://doi.org/10.22271/27069567.2025.v7.i1a.606>

Abstract

Lipid (fat) levels are the hallmark of hyperlipidemia, a condition that is a major global public health problem. Triglycerides, low-density lipoprotein cholesterol (LDL C), total cholesterol, and/or low levels of high-density lipoprotein cholesterol (HDL-C) are all included in the condition. Establishing an early diagnosis and stopping the disease's course are essential for reducing the morbidity and mortality rates linked to this ailment.

Keywords: Hyperlipidemia, Homoeopathy, Individualized homoeopathic medicine

Introduction

Hyperlipidemia refers to an abnormality in lipid profile, encompassing a variety of disorders relating to elevation in total cholesterol, LDL, TG and conversely lower levels of HDL. By giving a single cut off value it is difficult to define hyperlipidemia [1]. It is defined as total cholesterol lipoprotein level, LDL-C and triglycerides above the 90th percentile or HDL-C level below the 10th percentile for the general population. Excess cholesterol has a tendency to deposit into various tissues especially the adipose tissue. However, circulating cholesterols may also deposit in the arterial walls as fatty streaks and initiate atherosclerosis and then producing IHD [2].

Materials and Methods

Sources of data

Project site:

- Jawaharlal Nehru Homoeopathic Medical College & Hospital, Waghodia, Vadodara.

The material utilized for the study

- Specially Designed Case Performa
- Homoeopathic Software - RADAR

Methods of collection of data

Type of study: Prospective, Interventional Study

Methods of sampling: Non-Random sampling

No of cases: 40 cases

Duration of study: 12 months

Duration of treatment: 6 months

Criteria of selection of cases

Inclusion criteria

- Cases of both genders are included
- Cases of 19-60 age group will be selected
- Cases of all socioeconomic classes
- Pre diagnosed and diagnosed cases will be selected

Exclusion criteria

- Cases on other mode of treatment for the same complain

- Pregnant and breast-feeding women
- Cases with advance pathological changes
- Irregular follow up cases would not be taken into account for the study

- Follow up of the case will be done every 7, 15, 30 days or as per the requirement of the case.
- Response will be analysed according to the investigations with its specifically related to hyperlipidemia.

Methodology

- Case taking will be done according to the guidelines of chronic case taking mentioned by Dr. Hahnemann in Organon of medicine.
- Medicine will be selected by repertorial approach or non- repertorial approach as per need of the case.
- According to the case, proper analysis, evaluation and totality will be formed.
- Medicine will be given in different potencies as per susceptibility of the cases.
- Medicine will be repeated as per the need of the case.

Improvement criteria

Response will be analysed especially using lipid profile test:

Desirable values:

1. **TC (total cholesterol) -<200mg/dl**
2. **LDL (low density lipoprotein)-60-130mg/dl**
3. **HDL (high density lipoprotein)-60mg/dl**
4. **TG (triglycerides)-<150mg/dl**

No improvement	No changes in symptomatology and investigations.	No changes in any variables.
Mild improvement	mild decrease in intensity and frequency of clinical features with mild decrease in lipid profile levels.	Marked changes in one variable.
Moderate improvement	decrease in intensity and frequency of clinical features with moderate decrease in lipid profile levels.	Marked changes in more than one variable.
Significant improvement	Marked decrease in intensity and frequency of clinical features and lipid profile levels with feeling of well-being.	Marked Changes in all the variables.

Self-made questionnaire form (SF-36 scoring): It represents the overall health status of the patient; I have evaluated overall health score in reference to SF 36 scoring

method. The scores are weighted sums of the questions in each section.

Improvement	Scoring
Mild improvement	0-40
Moderate improvement	41-60
Significant improvement	61-100

Results

Table 1: Distribution of cases according to age group

Age Group (In Years)	No of Cases	Percentage (%)
<20	0	0
21-30	1	2.5
31-40	15	37.5
41-50	16	40
51-60	8	20
Total	40	100

Table 2: Distribution of cases according to gender

Gender	No of Cases	Percentage
Male	23	57.5
Female	17	42.5
Total	40	100

Table 3: Distribution of cases according to socio economic status

Socio economic Status	No of Cases	Percentage
Lower Class	10	25
Middle Class	22	55
Upper Class	8	20
Total	40	100

Table 4: Distribution of cases according to residence

Residence	No of Cases	Percentage
Rural	23	57.5
Urban	17	42.5
Total	40	100

Table 5: Distribution of cases according to result obtained

Result	No of Cases	Percentage
Significant Improvement	8	20
Moderate Improvement	12	30
Mild Improvement	17	42.5
No Improvement	3	7.5
Total	40	100

Table 6: Distribution of cases according to remedy prescribed

No	Medicine	No of Cases	Percentage
1	Sepia	4	10
2	Kali carb	2	5
3	Lycopodium	5	12.5
4	Natrium Muriaticum	7	17.5
5	Pulsatilla	2	5
6	Calcarea Carbonicum	5	12.5
7	Baryta Carbonicum	3	7.5
8	Nux Vomica	2	5
9	Sulphur	3	7.5
10	Natrium Phosphoricum	2	5
11	Thuja	2	5
12	Phosphorus	3	7.5
	Total	40	100

Table 7: Distribution of cases according to score obtained from self-made questionnaire form

Score	No of Cases	
	Before	After
00-30 (Mild)	1	0
31-60 (Moderate)	32	5
61-100 (Significant)	7	35
Total	40	

Table 8: Distribution of cases according to potency prescribed with result

Potency	No of Cases	Mild Improvement	Moderate Improvement	Significant Improvement	No Improvement	Percentage
30	8	4	3	0	1	20
200	26	13	6	6	1	65
1M	6	0	3	2	1	15
Total	40	17	12	8	3	100
Percentage		42.5	30	20	7.5	

Table 9: Lipid profile values

Case No	Lipid profile values								Results
	Before				After				
	TC	TG	HDL	LDL	TC	TG	HDL	LDL	
1	215	255	33	131.4	200	210	40	118	Significant improvement
2	210	198	33	137.4	180	170	49	97	Significant improvement
3	228	247	51	127.6	208	196	50	118.8	Significant improvement
4	188	369	48	66	200	210	45	113	Moderate improvement
5	259	244	48	162	266	214	48	175	Moderate improvement
6	200	190	31	120	190	160	32	125	Moderate improvement
7	220	200	40	140	222	180	42	138	Mild improvement
8	208	176	40	110	190	174	42	112	Mild improvement
9	220	190	48	130	218	150	46	120	Mild improvement
10	300	230	30	140	250	190	50	130	Significant improvement
11	210	160	45	130	200	162	42	120	Mild improvement
12	250	170	52	120	210	150	50	118	Moderate improvement
13	270	200	30	130	272	210	32	135	No improvement
14	310	200	40	136	280	200	42	134	Mild improvement
15	250	195	30	110	210	170	32	110	Moderate improvement
16	350	230	20	140	280	200	40	120	Significant improvement
17	278	160	32	110	210	145	32	112	Moderate improvement
18	286	190	64	110	200	152	40	130	Significant improvement
19	237	160	30	118	210	162	32	116	Mild improvement
20	230	194	40	124	232	160	42	121	Mild improvement
21	300	210	24	160	296	206	24	158	No improvement

22	232	170	35	110	200	172	32	120	Mild improvement
23	240	160	42	120	210	162	44	122	Mild improvement
24	285	197	46	140	210	160	45	138	Moderate improvement
25	320	200	40	135	280	180	42	138	Moderate improvement
26	247	177	42	112	208	172	44	110	Mild improvement
27	400	235	25	158	290	200	40	140	Significant improvement
28	270	165	50	130	220	150	53	142	Moderate improvement
29	292	180	45	130	290	178	43	138	No improvement
30	221	160	30	117	200	164	32	110	Mild improvement
31	265	197	42	124	210	190	40	120	Mild improvement
32	217	175	36	110	190	173	34	114	Mild improvement
33	260	200	50	140	262	165	40	130	Mild improvement
34	279	210	44	136	236	118	40	130	Moderate improvement
35	234	160	50	130	230	157	34	128	Mild improvement
36	350	250	30	157	250	195	48	132	Significant improvement
37	218	172	42	147	192	150	48	136	Moderate improvement
38	400	290	30	154	320	286	32	150	Mild improvement
39	253	169	47	131	246	140	42	135	Mild improvement
40	290	195	30	158	218	150	35	152	Moderate improvement

Table 10: Self-made questionnaire form score (overall health score (out of 100))

	Before	After
1	57	75
2	55	71
3	56	73
4	55	71
5	55	70
6	60	80
7	50	68
8	56	70
9	50	66
10	60	88
11	58	76
12	54	76
13	50	54
14	60	70
15	55	75
16	60	80
17	59	78
18	58	78
19	50	70
20	68	78
21	32	40
22	56	78
23	60	72
24	54	70
25	50	67
26	60	70
27	68	88
28	59	70
29	30	58
30	56	80
31	60	78
32	54	70
33	52	67
34	67	82
35	55	69
36	56	78
37	62	79
38	58	70
39	48	60
40	68	78

Statistical analysis

Statistical test

T test, Wilcoxon signed ranks test were used to find the significance of parameters pre to post test.

Table 11: Paired t test

Paired Samples Statistics					
		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	TCB	262.3000	40	50.68819	8.01451
	TCA	229.6500	40	36.05377	5.70060
Pair 2	TGB	200.7500	40	41.27503	6.52616
	TGA	175.8250	40	28.86919	4.56462
Pair 3	HDLB	39.1250	40	9.38408	1.48375
	HDLA	40.5000	40	6.70247	1.05975
Pair 4	LDLB	129.7850	40	18.43188	2.91434
	LDLA	127.6450	40	15.05767	2.38083
Pair 5	SMQB	55.7750	40	7.61068	1.20335
	SMQA	72.2750	40	8.75591	1.38443

		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
					Lower	Upper			
Pair 1	TCB - TCA	32.65000	31.02071	4.90481	22.72909	42.57091	6.657	39	0.000
Pair 2	TGB - TGA	24.92500	30.18438	4.77257	15.27157	34.57843	5.223	39	0.000
Pair 3	HDLB - HDLA	-1.37500	8.35030	1.32030	-4.04556	1.29556	-1.041	39	0.304
Pair 4	LDLB - LDLA	2.14000	13.35797	2.11208	-2.13209	6.41209	1.013	39	0.317
Pair 5	SMQB - SMQA	-16.50000	5.08895	0.80463	-18.12753	-14.87247	-20.506	39	0.000

Table 12: Wilcoxon signed ranks test

Descriptive Statistics					
	N	Mean	Std. Deviation	Minimum	Maximum
TCB	40	262.3000	50.68819	188.00	400.00
TGB	40	200.7500	41.27503	160.00	369.00
HDLB	40	39.1250	9.38408	20.00	64.00
LDLB	40	129.7850	18.43188	66.00	162.00
SMQB	40	55.7750	7.61068	30.00	68.00
TCA	40	229.6500	36.05377	180.00	320.00
TGA	40	175.8250	28.86919	118.00	286.00
HDLA	40	40.5000	6.70247	24.00	53.00
LDLA	40	127.6450	15.05767	97.00	175.00
SMQA	40	72.2750	8.75591	40.00	88.00

Test Statistics					
	TCA - TCB	TGA - TGB	HDLA - HDLB	LDLA - LDLB	SMQA - SMQB
Z	-5.023 ^b	-4.889 ^b	-1.054 ^c	-1.456 ^b	-5.517 ^c
Asymp. Sig. (2-tailed)	0.000	0.000	0.292	0.145	0.000

Interpretation of statistical analysis

- This research study had sample size (n) of 40 cases with degree of freedom, DF = (n-1) = 40-1 =39.
- The pair T test analysis showed significant decrease in TCB (M = 262.30, SD=50.688) to TCA (M=229.65, SD=36.053), TGB (M=200.75, SD=41.275) to TGA (M=175.82, SD=28.869), LDLB (M=129.78, SD=18.431) to LDLA (M=127.645, SD=15.057), HDLB (M=39.125, SD=9.384) to HDLA (M=40.50, SD=6.7024), SMQB (M=55.775, SD=7.610) to SMQA (M=72.275, SD=8.755).
- Wilcoxon test showed a significant decrease in TCB (M=262.30, SD=50.688) to TCA (M=229.65, SD=36.053), TGB (M=200.750, SD=41.2750) TGA (M=175.825, SD=28.869), LDLB (M=129.785, SD=18.431) to LDLA (M=127.64, SD=15.057), HDLB (M=39.125, SD=9.384) to HDLA (M=40.50, SD=6.70), SMQB (M=55.775, SD=7.610) to SMQA (M=72.275, SD=8.755).
- As actual difference between means ≠ 0, null hypothesis must be rejected and alternative hypothesis must be accepted which shows that there is

effectiveness of homoeopathic medicines in hyperlipidemia cases.

- T test and Wilcoxon test was applied to assess the significance of medicines selected on the ground of individualization. P value was found <0.001 which suggests that the obtained result is statistically significant. Henceforth, there is significant reduction in lipid profile values and improvement in overall health score.

Discussion

In my research, I address a number of issues that came up when examining the 40 instances that were examined, as listed below:

The data showed that the incidence of hyperlipidemia increased significantly with age. The age group of 41 to 50 years old had the highest prevalence, accounting for 40% of all cases. The age group of 31 to 40 years old comes next, with a frequency of 37.5%. between age of 51 to 60, the prevalence of the disease is 20%, With only 2.5% of instances in the 21-30, there was a noticeable decrease in prevalence in the following age categories. It is noteworthy that there were no cases recorded in the age group under 20. These results are consistent with the recognized hyperlipidemia epidemiological data. Age-related increases in prevalence can be linked to a number of variables, such as hormonal fluctuations, changes in metabolism, and accumulated lifestyle influences. The fact that these risk factors take longer to manifest could explain the somewhat reduced incidence in younger age groups.

In our study population, males had a higher prevalence of hyperlipidemia than females. Out of the forty cases in total, 17 (42.5%) were female and 23 (57.5%) were male. This data suggests the possibility of a gender difference in the prevalence of hyperlipidemia.

The study's findings emphasize the necessity of gender-specific hyperlipidemia management and prevention plans. The particular requirements of both men and women should be taken into account when designing targeted treatments intended to lower risk factors and promote healthy lifestyles. Data that indicates an important difference in the prevalence of instances of hyperlipidemia among various

socioeconomic strata. With 55% of the total cases, the medium socioeconomic class had the highest prevalence. Next in line, accounting for 25% of cases, are the lower socioeconomic class and the upper socioeconomic class. These results point to a complicated link between the risk of hyperlipidemia and socioeconomic position. This observed gap may be caused by a number of factors, such as stress, eating choices, physical activity levels, and access to healthcare. The underlying processes of hyperlipidemia and the precise therapies needed to reduce its disproportionate effect on lower socioeconomic groups should be investigated further.

The information of how hyperlipidemia is distributed throughout different occupational groups. According to our research, those who work in the private sector-which accounts for 37.5% of all cases have a substantially higher risk of hyperlipidemia. Housewives (27.5%), small-scale employees (12.5%), and business owners (7.5%) come next. Teachers, farmers, older people, and computer operators all have hyperlipidemia, albeit at a lesser prevalence.

There are a number of possible reasons for the high incidence of hyperlipidemia among workers in the private sector, such as sedentary lifestyles, stressful work settings, and unhealthful eating habits that are frequently connected to corporate positions. The significant percentage of housewives impacted emphasizes how critical it is to treat hyperlipidemia risk factors in this population. with 57.5% of cases coming from rural areas and 42.5% from urban areas, data shows that hyperlipidemia is more common in rural than in urban settings. This result defies the widely held belief that urban lives, with their sedentary behaviours and poor diets, have a greater causal role in the development of hyperlipidemia.

This unexpected observation may be explained by a number of causes. The results could have been impacted by the underreporting of instances in metropolitan regions where access to diagnostic and healthcare facilities is better. In addition, dietary habits, exercise regimens, and exposure to environmental contaminants in both urban and rural environments may all be significant factors in determining the prevalence of hyperlipidemia.

The information shows that the drug administered to treat hyperlipidemia has a generally good effect. The condition of a significant majority of patients, 92% (37 instances), showed improvement. This is a positive finding, indicating that a sizable segment of the study group responded well to the treatment plan.

Different responder cases have different levels of improvement, according to additional data analysis. Although 42% of patients showed mild improvement, 30% of patients showed moderate improvement. Notably, the hyperlipidemia levels of 20% of the patients showed a considerable improvement. These results highlight the diversity of the patient group and the varying reactions to the therapy.

An overview of the research population's drug prescribing trends for hyperlipidemia is given. With 17.5% of cases, natrium muriaticum was found to be the most commonly prescribed medication. Following closely at 12.5% apiece, Lycopodium and Calcarea Carbonicum demonstrate their frequent use in the treatment of this ailment. 10% of cases had a prescription for sepia, indicating a significant frequency of use.

The usage of Baryta carb, Sulphur and phosphorus were less

common, in 7.5% of instances, a prescription was written for each. The other 5 drugs which are Kali carb, Pulsatilla, Nux vomica, Natrum phosphoricum and Thuja were given to a comparatively lower number of patient-5% of them.

According to these results, there should be several approaches taken in the care of hyperlipidemia, with natrium muriaticum being the recommended option for a considerable proportion of patients. The need for customized treatment strategies and the intricacy of the ailment are highlighted by the use of a broad variety of medicines.

The number of cases compared to the score obtained from self-made questionnaires shows that the Mild score (0-30) is 1 before treatment and 0 afterward. The moderate score (31-60) was 32 before therapy and decreased to 5 after treatment. The significant score (61-70) was 7 before and grew to 35 after therapy. The greatest potency necessary for the therapy of hyperlipidemia is 200C, and 26 (65%) patients received it. A total of eight (20%) and six (15%) patients were prescribed 30C and 1M potency, respectively. Overall, 17 (42.5%) patients showed minor improvement, with 4 from 30C, 13 from 200C, and no instances from 1M potency. Similarly, 12 (30%) patients had Moderate Improvement. These cases are classified into three from 30C, six from 200C, and three from 1M potency. Significant improvement is observed in a total of eight cases, six of which are from 200C potency and two from 1M potency.

Conclusion

- The research focuses on the role of individualized homeopathic medicine in cases of hyperlipidemia. It found that hyperlipidemia incidence increased significantly with age, with the highest prevalence in the age group of 41 to 50 years old. Males had a higher prevalence than females, suggesting the need for gender-specific hyperlipidemia management and prevention plans.
- The study also revealed a significant difference in hyperlipidemia prevalence among various socioeconomic strata, with the medium socioeconomic class having the highest prevalence. This gap may be caused by factors such as stress, eating choices, physical activity levels, and access to healthcare.
- The research also showed that hyperlipidemia is distributed throughout different occupational groups, with the private sector having a higher risk. Housewives (27.5%), small-scale employees (12.5%), and business owners (7.5%) are the most affected.
- The study also found that hyperlipidemia is more common in rural areas than urban areas, defying the belief that urban lives have a greater causal role in hyperlipidemia development. Factors such as dietary habits, exercise regimens, and exposure to environmental contaminants may also contribute to the prevalence of hyperlipidemia.
- The majority of patients showed improvement, with 92% showing improvement. However, different levels of improvement were observed, with 42% showing mild improvement and 30% showing moderate improvement. The study recommends using a broad variety of medications, with natrium muriaticum being the recommended option for a significant proportion of patients.
- T test and Wilcoxon test were applied to assess the

significance of medicines selected on the ground of individualization. P value was found <0.001 which suggests that the obtained results is statistically significant. So, null hypothesis is rejected and alternative hypothesis is accepted. Henceforth, there is reduction in cholesterol level, improvement in overall health score and whole improvement in lifestyle of the patients.

- The study also highlighted the importance of personalized treatment strategies and the complexity of hyperlipidemia. I humbly present this work to homoeopathic fraternity and hope that it helps to brief a new thinking for the management of hyperlipidemia cases with homoeopathic medicines. and provide motivation to new aspirants to explore further utility for practicing homoeopathy.

Acknowledgement

I would like to express my sincere and heartfelt thanks to my respected teacher and guide, Dr. Partha Sarathi Mandal, Dr. Poorav Desai, Principal, Jawaharlal Nehru Homoeopathic Medical College, Vadodara. I am thankful to Dr. Kirtida Desai, P.G. Coordinator of Jawaharlal Nehru Homoeopathic Medical College for kind cooperation, valuable hints and guidance.

Funding statement

This work is self-funded, and the authors received no external financial support.

Conflict of interest

The author declares no conflict of interest

References

1. Davidson S. *Davidson's Principles & Practice of Medicine*. 21st ed. Edinburgh: Churchill Livingstone Elsevier; c2010.
2. Agrawal P, Mathew KG. *Medicine Prep Manual for Undergraduate*. 6th ed. New Delhi: India; c2019.
3. Sembulingam K. *Essentials of Medical Physiology*. 5th ed. New Delhi: Jaypee Brothers Medical Publishers (P) Ltd.; c2010.
4. Harrison TR. *Harrison's Principles of Internal Medicine*. 19th ed. Vol. 2. New York: McGraw Hill Companies; c2015.
5. Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults. Third Report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III); c2001.
6. Hahnemann S. *Organon of Medicine*. 6th ed. New Delhi: LPE Publisher Limited; c2010.
7. Gralia M, Martinez. Efficacy of Lycopodium in Hyperlipidemia Patients: A Double Blind, Placebo-Controlled Trial. *Homoeopathic Medicine*. 2019;15(04):211-218.
8. Boericke W. *Pocket Manual of Homoeopathic Materia Medica and Repertory*. 11th ed. New Delhi: B. Jain Publisher (P) Ltd.; c2012.

Creative Commons (CC) License

This is an open-access journal, and articles are distributed under the terms of the Creative Commons Attribution-Non Commercial-Share Alike 4.0 International (CC BY-NC-SA 4.0) License, which allows others to remix, tweak, and build upon the work non-commercially, as long as appropriate credit is given and the new creations are licensed under the identical terms.

How to Cite This Article

Desai J, Mandal PS. Role of individualized homoeopathic medicine in the management of hyperlipidemia. *International Journal of Advanced Research in Medicine*. 2025;7(1):20-26.