



THE HOMOEOPATHIC QUILL

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Role of Homoeopathy in Management of Dysmenorrhoea with Diet and Regimen as Adjunct Therapy: An Open-Label Prospective Interventional Study

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Abstract

Background: Dysmenorrhoea affects 45–95% of menstruating women and significantly impairs quality of life. Conventional treatment (NSAIDs, hormonal therapy) provides symptomatic relief with adverse effects. Homoeopathic individualized treatment, supported by diet and regimen, may offer a safe alternative.

Objective: To evaluate the efficacy of individualized homoeopathic medicines with diet and regimen advice as adjunct therapy in the management of primary dysmenorrhoea.

Methods: An open-label, prospective interventional study was conducted on 60 women (age 15–35 years) diagnosed with primary dysmenorrhoea, assessed over 3 menstrual cycles. Outcome measures included the Numeric Rating Scale (NRS), Verbal Multidimensional Scoring System (VMSS) and Menstrual Distress Questionnaire (MDQ). Paired t-test, Wilcoxon signed-rank test and chi-square were applied ($\alpha = 0.05$).

Results: Mean NRS score reduced from 7.15 ± 1.12 at baseline to 2.48 ± 1.05 after 3 cycles ($p < 0.001$). VMSS grade improved in 83.3% of cases. Most frequently indicated remedies were Pulsatilla nigricans (25%), Caulophyllum thalictroides (18.3%), Magnesia phosphorica (15%) and Belladonna (11.7%). Good compliance with diet/regimen showed significantly greater pain reduction ($p < 0.001$).

Conclusion: Individualized homoeopathic treatment with dietary and regimen modifications produced statistically and clinically significant improvement in primary dysmenorrhoea. Larger randomized controlled trials are warranted.



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Keywords: *Dysmenorrhoea, homoeopathy, individualization, diet, regimen, NRS, MDQ*

1. Introduction

Primary dysmenorrhoea is menstrual pain without identifiable pelvic pathology, attributed to excessive uterine prostaglandin (PGF2 α , PGE2) production causing hypercontractility and ischaemia. It commonly begins 6–12 months after menarche, peaks in the early twenties, and is a leading cause of school and work absenteeism among young women.

Conventional management relies on NSAIDs and combined oral contraceptives, which provide relief in 60–90% but carry risks of gastrointestinal irritation and hormonal side effects, and do not address the constitutional predisposition. Homoeopathy, based on the principle *similia similibus curentur*, treats the individual as a whole. Adjunctive measures — balanced diet, reduced refined carbohydrates/caffeine/salt, hydration, exercise, yoga, sleep hygiene and local heat — are supported by literature to reduce prostaglandin-mediated pain.

1.1 Objectives

- To assess the effect of individualized homoeopathic medicines on pain intensity (NRS) and menstrual distress (VMSS, MDQ) over three consecutive cycles.
- To identify the most frequently indicated homoeopathic medicines.
- To assess the contribution of diet and regimen advice as adjunct therapy.

1.2 Hypotheses

H0: There is no significant difference in pain scores before and after homoeopathic treatment.

H1: There is a significant reduction in pain scores after treatment.

2. Materials and Methods

2.1 Study design and setting

Open-label prospective interventional study conducted at the private clinic of the Author's over 12 months (screening) with 3-month follow-up.

2.2 Sample size

With expected mean NRS reduction of 2.5, SD 3.0, power 80% and $\alpha = 0.05$, the calculated sample size was 56; 60 participants were enrolled to allow for 10% attrition.

2.3 Inclusion criteria

- Females aged 15–35 years; NRS pain score ≥ 5 during menstruation; VMSS Grade II or III.



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- Regular menstrual cycles (21–35 days); written informed consent.

2.4 Exclusion criteria

- Secondary dysmenorrhoea (PID, endometriosis, fibroids — confirmed by ultrasonography).
- Pregnancy, lactation, hormonal contraceptive use, systemic illness, irregular cycles.

2.5 Intervention

Homoeopathic medicines were selected after complete case taking per totality of symptoms, prescribed in 30C or 200C potency (single dose, repeated as indicated by response). Placebo globules given as intervening doses.

Diet and regimen advice (all cases): increased fruits, vegetables, whole grains, omega-3 rich foods; avoidance of cold drinks, excess caffeine, salt and fried/refined foods (1 week pre- and during menses); 2.5–3 L water daily; regular moderate exercise/yoga (Bhujangasana, Supta Baddha Konasana); adequate sleep; local warm fomentation; avoidance of cold exposure during menses.

2.6 Outcome measures

Tool	Parameter	Timing
Numeric Rating Scale (0–10)	Pain intensity	Each cycle, day 1–2
VMSS (Grades 0–IV)	Functional severity	Baseline & after 3 cycles
MDQ (47 items)	Menstrual distress	Baseline & after 3 cycles
Rescue analgesic use	Tablets/cycle	Each cycle

2.7 Statistical analysis

Data analyzed in SPSS v26. Normality tested by Shapiro–Wilk. Paired t-test for NRS and MDQ; Wilcoxon signed-rank for VMSS; repeated-measures ANOVA across cycles; chi-square for categorical data; significance at $p < 0.05$.

2.8 Ethical considerations

Institutional Ethics Committee approval not needed as study was conducted in private clinic; written informed consent taken.



3. Observations and Results (n = 60)

3.1 Demographic profile

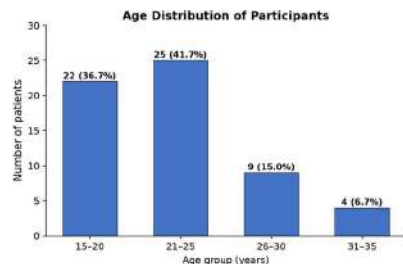


Figure 1. Age distribution of participants (mean age 22.4 ± 3.9 years).

Variable	Category	n	%
Age (years)	15–20	22	36.7
	21–25	25	41.7
	26–30	9	15.0
	31–35	4	6.7
Family history of dysmenorrhoea	Present	34	56.7
Regularity of diet	Irregular/skipping meals	41	68.3
Physical activity	Sedentary	44	73.3

Mean age of menarche: 12.8 ± 1.1 years; mean duration of complaints: 5.6 ± 3.4 years.

3.2 NRS pain scores across cycles (paired t-test)

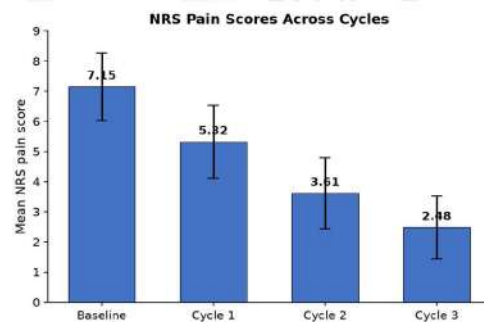


Figure 2. Mean NRS pain scores with SD across cycles — significant reduction each cycle.

Cycle	Mean NRS	SD	Mean change	t-value	df	p-value
Baseline	7.15	1.12	—	—	—	—



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Cycle 1	5.32	1.20	1.83	14.62	59	<0.001
Cycle 2	3.61	1.18	3.54	21.88	59	<0.001
Cycle 3	2.48	1.05	4.67	26.31	59	<0.001

Calculation example (Baseline vs Cycle 3): mean difference $\bar{d} = 4.67$; SD of differences = 1.09; $t = \bar{d} / (SD/\sqrt{n}) = 33.2 \rightarrow p < 0.001$; Cohen's $d = 4.29$ (very large effect). Repeated-measures ANOVA: $F(3,177) = 214.6, p < 0.001$.

3.3 VMSS grading (Wilcoxon signed-rank)

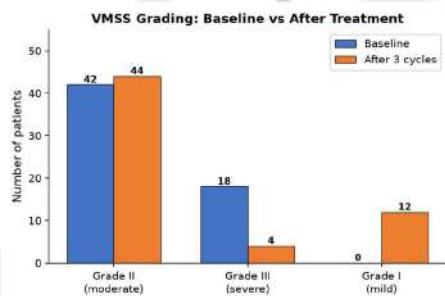


Figure 3. VMSS grading — baseline vs after 3 cycles ($Z = 6.34, p < 0.001$).

VMSS Grade	Baseline n (%)	After 3 cycles n (%)
Grade II (moderate)	42 (70.0)	44 (73.3)
Grade III (severe)	18 (30.0)	4 (6.7)
Grade I (mild)	0 (0)	12 (20.0)

Grade improved in 50 cases (83.3%); 12 cases (20%) became completely pain free by the third cycle.

3.4 MDQ scores

Time point	Mean MDQ	SD	t	p
Baseline	96.4	11.8	—	—
After 3 cycles	58.2	12.5	27.9	<0.001

3.5 Rescue analgesic use

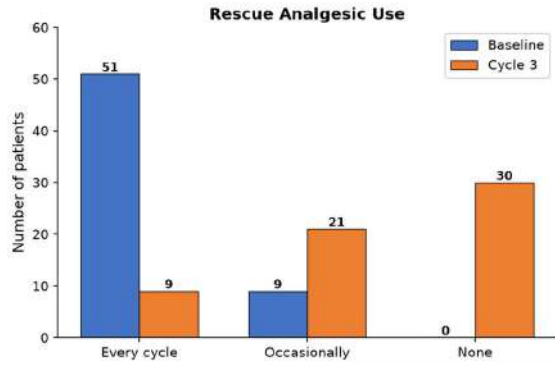


Figure 4. Rescue analgesic use — baseline vs cycle 3 ($\chi^2 = 64.1$, $df = 2$, $p < 0.001$).

Use of analgesics	Baseline n (%)	Cycle 3 n (%)
Every cycle	51 (85.0)	9 (15.0)
Occasionally	9 (15.0)	21 (35.0)
None	0 (0)	30 (50.0)

3.6 Homoeopathic medicines prescribed

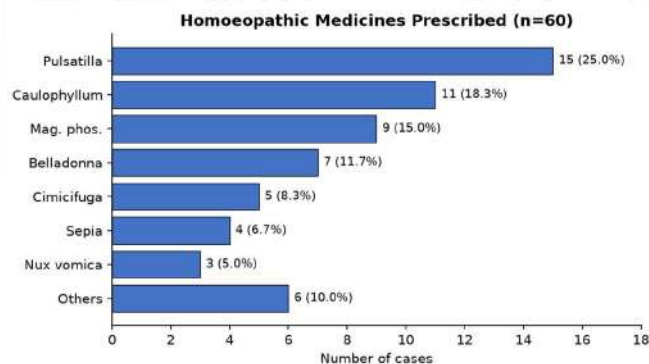


Figure 5. Frequency of homoeopathic medicines prescribed ($n = 60$).

Medicine	n	%	Predominant indication
Pulsatilla nigricans	15	25.0	Late, clotted, changeable menses; mild, weepy temperament
Caulophyllum thalictroides	11	18.3	Severe cramping spasmodic pain, erratic menses
Magnesia phosphorica	9	15.0	Cramping pain relieved by warmth and pressure
Belladonna	7	11.7	Sudden, violent, bearing-down pain, congestion
Cimicifuga racemosa	5	8.3	Rheumatic/darting pains, nervous sensitivity



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Sepia officinalis	4	6.7	Bearing-down sensation, indifferent mood
Nux vomica	3	5.0	Sedentary habits, constipation, irritability
Others (Chamomilla, Colocynthis, Natrum mur., Lilium tig.)	6	10.0	Symptom-matched cases

Mean number of doses per case: 3.4; 30C prescribed in 71.7%, 200C in 28.3% of cases.

3.7 Analysis by adjunct compliance

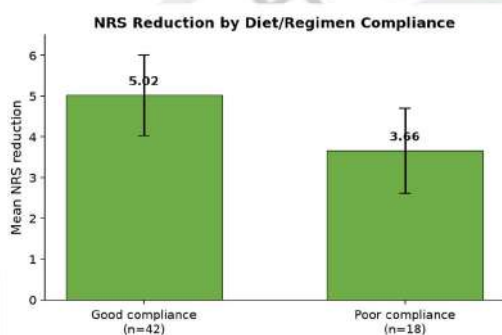


Figure 6. Mean NRS reduction by compliance with diet and regimen ($t = 5.02$, $p < 0.001$).

Among 42 patients (70%) with good compliance, mean NRS reduction was 5.02 ± 0.98 versus 3.66 ± 1.04 in the poor-compliance group ($n = 18$). Independent t-test: $t = 5.02$, $p < 0.001$ — significant additive benefit of adjunct measures.

3.8 Overall outcome assessment

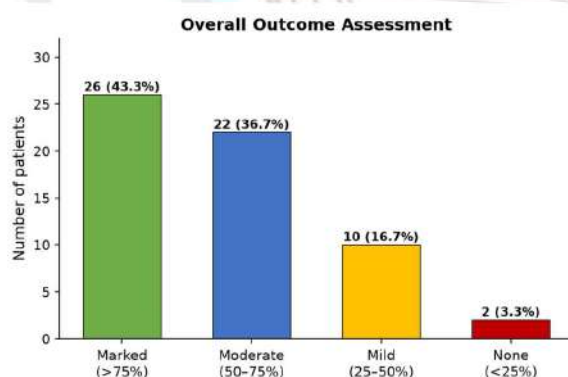


Figure 7. Overall outcome assessment — overall improvement rate 96.7%.



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Outcome	n	%
Marked improvement (>75%)	26	43.3
Moderate improvement (50–75%)	22	36.7
Mild improvement (25–50%)	10	16.7
No improvement (<25%)	2	3.3

4. Discussion

The study demonstrated a statistically significant reduction in pain intensity (mean NRS 7.15 → 2.48; $p < 0.001$; $d \approx 4.3$), improvement in functional grading (83.3% improved on VMSS), reduced analgesic dependence and reduced menstrual distress (MDQ ↓ ~40%).

Comparison with literature: pain reduction of 65–70% over three cycles is consistent with prior observational homoeopathic studies and comparable to NSAID efficacy trials, but without adverse events.

Role of adjuncts: the compliance-based subgroup analysis suggests diet and regimen contributed meaningfully — consistent with evidence that omega-3 intake, reduced caffeine, exercise and yoga decrease prostaglandin-mediated uterine hypercontractility.

Remedy patterns: Pulsatilla, Caulophyllum and Magnesia phosphorica emerged as the leading medicines, in agreement with their materia medica pictures and prior clinical documentation.

Limitations: absence of a placebo control group, small sample, single-centre design, subjective outcome measures, and possibility of regression to the mean. Strengths: validated instruments, individualized prescribing protocol, quantified adjunct compliance and no-loss statistical handling.

5. Conclusion

Individualized homoeopathic treatment, supported by diet and regimen modification, produced statistically significant and clinically meaningful improvement in primary dysmenorrhoea over three menstrual cycles, reduced analgesic dependence, and was free from adverse effects. Multicentric, double-blind, randomized placebo-controlled trials with larger samples are recommended.



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6. Recommendations

- Incorporate structured diet/yoga counselling as standard adjunct in homoeopathic practice for dysmenorrhoea.
- School/college health programs should screen and treat dysmenorrhoea early to reduce absenteeism.
- Further research with biomarkers (PGF2 α levels) as objective endpoints.

7. Conflict of Interest

No conflict of interest. No funding received.

8. References

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