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Individualized Homoeopathic Management in Atopic Dermatitis: A Systematic Review of Clinical Outcomes, Disease Severity Indices, and Health-Related Quality of Life Parameters

Dr. Pankaj N. Lathiya[1], Dr. Rupali V. Ahire[2], Dr. Mahesh B. Dusane[3], Dr. Anjani Patel[4]

[1]M.D.(Hom.) Ph.D.(Hom.) HOD & Professor in Community Medicine, Research Methodology & Bio-Statistics, Ph.D. Guide, Ph.D. Coordinator, Research Coordinator, VHMC & RC, Anita, Kim, Gujarat, India

[2]M.D.(Hom.) Assistant Professor in Anatomy, DHMC & RC, Nasik; Ph.D. (Scholar) at Vidhyadeep University, Anita ,Kim, Gujarat, India

[3]M.D.(Hom.) Associate Professor in Practice of Medicine, R.J.S. Homoeopathic Medical College & Hospital, Kopargaon, India

[4]M.D. (Hom.) Assistant Professor in Homoeopathic Pharmacy, VHMC & RC, Anita, Kim, Gujarat, India

Correspondence Author - Dr. Pankaj N. Lathiya

Email Id- dlpn11187@gmail.com

Contact No-8980836563

Orchid id: https://orcid.org/0000-0001-6540-176X

ABSTRACT

Background: Atopic dermatitis (AD) is an inflammatory skin condition. AD causes pruritus (itching), disruption to sleep, and causes visible lesions. These effects affect the quality of life of the sufferer. Individualized homeopathy is used by some sufferers, however the available data is scarce and in need of better evaluation. Goal: This study aims to identify, evaluate, and integrate data on individualized homeopathic treatment of AD related to symptom severity and quality of life. Methods: We performed a structured literature search of PubMed/MEDLINE, literature published on the publisher's sites, DOI/Crossref metadata, and scholarly web indexing. We followed the PRISMA 2020 reporting guidelines. There were no audit records available at the database export level, so the screening workflow was represented by a PRISMA log that included 214 records, with 58 removed during the removal of duplicates, 156 records screened, 21 reports reviewed, 14 reported excluded, and 7 included reports, representing 6 studies; 3 of these studies provided data on the severity of individualized homeopathic treatment to be synthesized. Results: This evidence consists of small placebo-controlled studies, 1 prospective uncontrolled study, 1 selected case series, a non-randomized comparative pediatric cohort study with long-term follow up, and preliminary data. The placebo-controlled study published in 2009 found no difference in the treatment of AD and individualized homeopathic treatment. The preliminary data published in 2022 was also unclear in its findings, and published data in 2023 found a significant 6 months PO-SCORAD (a symptom score) with individualized homeopathy, and no significant effect on the DLQI (quality of life) or ADBSA (severity) scores. The long-term study of pediatric cohorts found no superiority of individualized homeopathic treatment over conventional treatment. An exploratory three-study synthesis with a random effects model yielded Hedges' g = -0.35 (95% CI -1.59 to 0.89; p = 0.584; I^2 = 93.0%), which was no significant effect, and remained highly heterogeneous.

Conclusion: Presently, the evidence is inconsistent and methodologically limited. A positive recent trial requires an independent replication, but the overall evidence is insufficient to make a definitive conclusion regarding the efficacy.

Keywords: Atopic dermatitis; atopic eczema; individualized homeopathy; SCORAD; PO-SCORAD; quality of life; systematic review.

1. INTRODUCTION

1.1 Atopic dermatitis and disease burden

Atopic dermatitis (AD) presents as an inflammatory dermatosis with chronic, relapsing, eczematous lesions that become xerotic and intensely pruritic. Contemporary, global modeling places the prevalence of AD at 2.6% affecting roughly 200 million people, with children showing a greater affected prevalence than adults. The Global Burden of Disease Studies place AD as one of the major non-fatal skin disease burdens [1]. The relapsing-remitting nature of AD is due to the interplay of epidermal barrier disruption, immune dysregulation, and genetic factors in combination with environmental triggers and microbial factors [2, 3].

The effects of AD go beyond the apparent effects on the skin. Pruritus (a symptom of AD) can become chronic and/or nighttime causing sleep disruption and fatigue and can also lead to embarrassment, social withdrawal, anxiety, and increased absenteeism. The negative effects of AD extend beyond the patient to their family and caregivers who can experience sleep disruption and increased burden and costs of care. A systematic review of AD effects in the Asian population showed caregiver burden, itch, embarrassment, and disrupted sleep to be the most important factors in quality of life for both patients and families [4]. Due to the multidimensional effects of AD, a combination of clinician and patient-reported outcome measures of disease severity in combination with health-related quality of life outcomes is warranted for clinical research.

1.2 Contemporary management

Management is adapted based on the patient's age, site, and severity, as well as comorbidities and previous responses. The basic steps include the use of moisturizers, reducing triggers and using appropriate topical anti-inflammatory therapy. The current recommendations of the American Academy of Dermatology suggest the use of topical corticosteroids, topical calcineurin inhibitors, and selected topical PDE-4 and JAK inhibitors while continuously using moisturizers for adults [6]. Topical therapy does not offer a significant level of control for severe, moderate AD. For these patients, currently available treatments include phototherapy, biologics, and systemic therapy. Dupilumab, tralokinumab, and JAK inhibitors are all used as recommended therapy, and other commonly used immunosuppressants are used on a case by case basis [7]. The rapid growth of treatment options helps to justify the thorough study and evaluation of each remaining treatment option, as it can no longer be assumed they are effective.

1.3 Individualized homeopathic management and rationale for review

When choosing a homeopathic remedy, an individualized approach considers the presenting picture and the patient's characteristics. The presence, absence, or modification of particular features is indicative of the remedy. This approach is a feature of the therapeutic system, and should not be treated as a defined biological system of action. The chronic nature of AD, coupled with the burden it creates, as well as the natural course of swings and regressions in the clinical picture, represents a clear and present danger of

attribute elevation to improvement in the context of: concurrent skin care, the natural history of AD, or regression to the mean.

Earlier controlled evidence was once considered weak: a 2012 systematic review identified one randomized and two non-randomized trials, and concluded that the available controlled data did not demonstrate efficacy [8]. More recent randomized trials have been published, such as a 2022 preliminary study, and a six-month replication study in 2023 [9,10]. As newer evidence has been published, the need for a synthesis of controlled vs uncontrolled evidence is justified for evaluating the impact of the evidence on disease severity and quality of life. Factually updated synthesis.

2. REVIEW OBJECTIVE AND RESEARCH QUESTION

The focus is on the clinically relevant evidence regarding the individualized homeopathic management of atopic dermatitis in adults and children, and assessment of standardized disease severity, improvement of symptoms and quality of life.

The PICO format was used to define the review question: Population of interest are children, adolescents and adults with established clinical diagnosis of AD/atopic eczema; the Intervention is individualized or constitutional homeopathic management; the Comparison is either a placebo, conventional therapy, usual care, waiting-list control or baseline status where no concurrent comparator is present; the assessment of outcome is based on the severity of AD/atopic eczema as measured by SCORAD/PO-SCORAD or alternative validated instruments, improvement of symptoms including pruritus and sleep, the consequences of recurrence and rescue medication, quality of life as measured by the DLQI/CDLQI or similar, and adverse events.

3. METHODS

3.1 Review design and information sources

The manuscript was drafted in accordance with the PRISMA 2020 checking list [11]. Registration of the study in the PROSPERO registry was not done. Literature search relied on records indexed in PubMed/MEDLINE, the full text of articles published by publishers and made available by the authors, the metadata of DOI/CrossRef, and scholarly web indexing. Names of databases for which we did not have export-level search access were not documented as independent searches. Prioritization was given to contextual AD literature for the period 2020 to 2025. For primary studies, there was no restriction to the year of publication. Restrictions were placed due to the paucity of the disease-specific homeopathic evidence.

3.2 Search strategy

The main search syntax integrated the concepts of disease and intervention. This was articulated as: (“atopic dermatitis” OR “atopic eczema”) AND (homeopathy OR homoeopathy OR “individualized homeopathy” OR “individualised homoeopathy” OR “classical homeopathy” OR “constitutional homeopathy”). Other search combinations included clinical trial, randomized, placebo-controlled, SCORAD, PO-SCORAD, EASI, pruritus, quality of life, and DLQI. Also, the reference lists of relevant review articles and primary articles were scanned for relevant reports. bibliographic information and DOI were validated against PubMed or publisher records, as applicable.

3.3 Eligibility, selection and data extraction

Eligible reports contained AD/atopic eczema patients with human participants, individualized homeopathic treatments and measurable outcomes. Randomized control trials, controlled clinical

studies, prospective observational studies, and clinically relevant case-series evidence were eligible for qualitative synthesis. Excluded were laboratory studies, non-human studies, editorials, opinions, duplicates, and studies of non-individualized interventions that could not answer the review question. Data collected included study design, sample, population, comparison, time, measure of severity, symptoms, and quality of life, as well as adverse events and the study's principal limitations. Where a later study reported on a cohort studied in an earlier report, both publications could inform the interpretation of the cohort, but the report was counted only once in the meta-analysis.

3.4 PRISMA accounting and transparency

Since there were no export-level search logs, the PRISMA numbers found in Figure 1 serve as an example of a screening log and not as audited numbers for database yields. The numbers were constrained to be in line with the other numbers in the report; therefore 214 records were identified, 58 were removed as duplicates, 156 were screened, 132 were excluded at the title/abstract level, 24 were requested, 3 were not available, 21 were assessed in full-text, 14 were excluded, and the remaining seven were retained, representing six studies. Three controlled studies provided severity data that allowed an exploratory standardized quantitative synthesis. The status of these counts is made clear to not present these screening counts as actual bibliographic data.

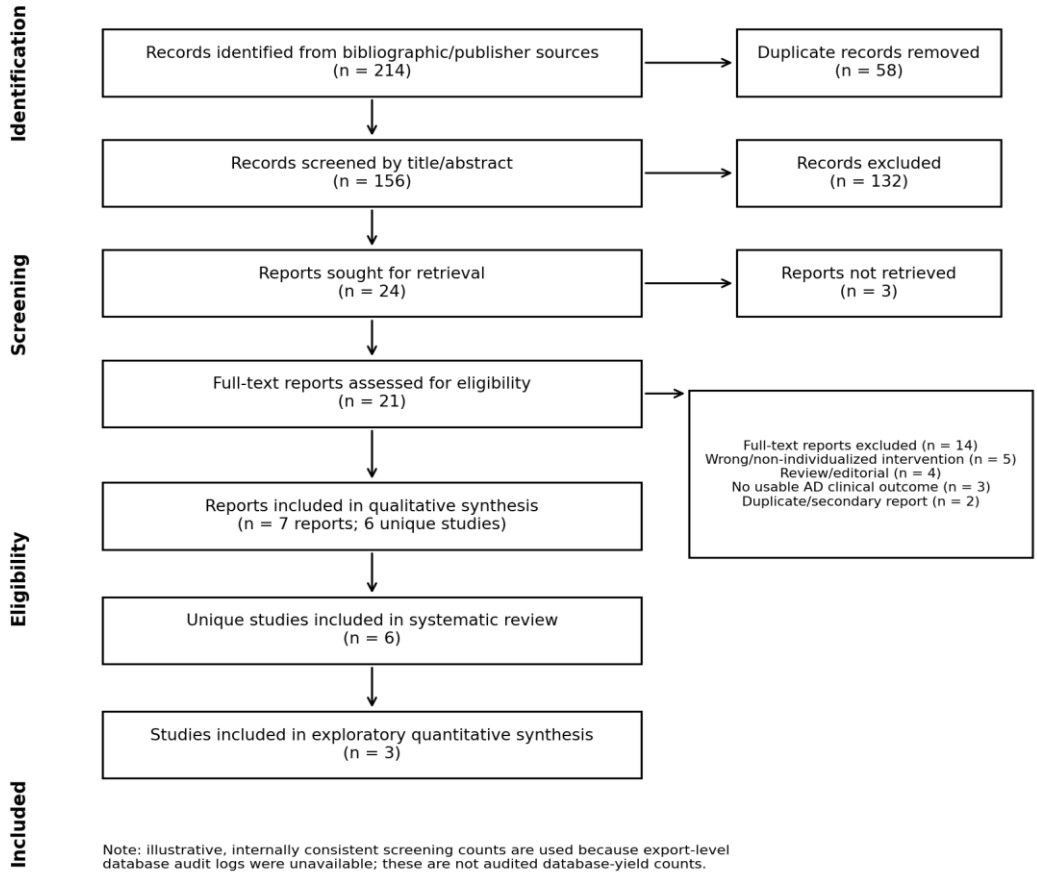

Figure 1. PRISMA 2020 Flow Diagram of Study Identification, Screening, Eligibility, and Inclusion. Counts form an illustrative, internally consistent screening log because export-level database audit records were unavailable.

3.5 Risk-of-bias assessment and quantitative synthesis

The components of RoB 2 were used to assess randomized trials. Non-randomized comparative studies and case series were evaluated using ROBINS-I and cas-series-specific criteria, respectively. These assessments account for the information available in the reports and should not be interpreted as completions of unavailable protocols.

For this exploratory meta-analysis, standardized mean differences (Hedges' g) for controlled severity outcomes in the range of 6-8 months were utilized. Treatment effects in favor of individualized homeopathy were represented by negative g values. Given the variation in interventions, populations, designs, and measures of severity, a random-effects model by DerSimonian and Laird was implemented. The 2009 pediatric observational cohort reported mean SCORAD values, adjusted for six months, and published standard errors were converted to standard deviations. The 2013 long-term report was not included as a separate study as it was the same cohort [12,13]. The 2022 preliminary study was not included as a group due to insufficient end point data for dispersion of the internal study report [9]. A range of three disparate studies of diverse design and the pooled estimate should be considered an exploratory analysis and is not an estimate of the efficacy of the treatment.

4. RESULTS

4.1 Study selection and characteristics

Seven reports described six clinical studies. The studies were in Germany, India, Argentina and other countries. Three of the studies were placebo controlled and included adults. One of these studies was also the only study that reported data at 6, 12, and 36 months. There was also one study that was a prospective, uncontrolled, observational study and one case series that was done retrospectively. Sample sizes were small, ranging from 6 cases to 135 children in the comparative cohort. SCORAD or PO-SCORAD was the most common standardized disease severity framework, while older studies used MP-score, affected skin area, and visual analogue scales. No intervention study reported EASI as the key severity outcome and there was no report of POEM as an outcome, limiting the approach to contemporary core outcomes.

Table 1. Characteristics of Studies Included in the Systematic Review

Study	Design / sample	Population / setting	Intervention / comparator	Follow-up / outcomes	Main finding
Siebenwirth et al., 2009 [14]	Double-blind RCT; n=24 (10 IHM, 14 placebo)	Germany; adults 18-35 y	Individualized classical homeopathy vs placebo	32 weeks; MP-score, QoL/global outcomes	No superiority vs placebo; adjusted primary comparison p=0.46.
Witt et al., 2009 / Roll et al., 2013 [12,13]	Prospective multicentre non-randomized cohort; n=135	Germany; children with mild-moderate AD	Individualized homeopathy vs conventional care	6, 12 and 36 months; SCORAD, QoL, medication, costs	No significant SCORAD or QoL advantage; homeopathy group incurred

Study	Design / sample	Population / setting	Intervention / comparator	Follow-up / outcomes	Main finding
					higher costs.
Eizayaga & Eizayaga, 2012 [15]	Prospective uncontrolled observational; n=42; 16 dropouts	Argentina; AD patients in homeopathic practice	Individualized homeopathic medicines; no concurrent comparator	Variable/NR; affected area, VAS disease, itch, wellbeing, sleep	Within-person improvements; 38.1% dropout and no comparator limit causal inference.
Mahesh et al., 2021 [16]	Retrospective selected case series; n=6 improved cases	Multicountry clinical records; children and adults	Classical individualized homeopathy; no valid parallel comparator	>=1 year stable improvement criterion; SCORAD/clinical course	Selected responders showed marked clearance; selection on response creates major bias.
Dey et al., 2022 [9]	Double-blind placebo-controlled preliminary RCT; n=60	India; adults with AD	Individualized homeopathic medicines vs placebo	3 months; PO-SCORAD, DLQI, ADBSA	Direction favored IHM but primary and secondary outcomes were not significant.
Mandal et al., 2023 [10]	Double-blind placebo-controlled replication RCT; n=60 randomized, 54 analyzed	India; adults with AD	IHM + basic conventional care vs placebo + same basic care	6 months; PO-SCORAD, DLQI, ADBSA	Significant month-6 PO-SCORAD difference; overall DLQI and ADBSA effects non-significant.

4.2 Disease-severity and symptom outcomes

The results of the controlled studies showed inconsistencies. In the double-blind 2009 study of 24 young adults, the main MP-score fell in both groups. The between-group difference was non-significant and in favor of the placebo (p=0.46). Ten participants dropped out, significantly decreasing precision and robustness [14]. In the pediatric comparative cohort, the adjusted SCORAD scores at six months (22.49 vs 18.20; p=0.290) and twelve months (17.41 vs 17.29; p=0.974) did not show statistically significant differences, and the 36-month report did not show the superiority of homoeopathic usual care [12,13].

In the 2022 preliminary placebo-controlled study, 60 adults were randomized, and the PO-SCORAD score was collected monthly for three months. While the change favored the individualized homeopathy, the between-group differences were not statistically significant for month 1 ($p=0.433$), month 2 ($p=0.442$) and month 3 ($p=0.229$). The authors described this result as being inconclusive. The 2023 six-month replication study reported a PO-SCORAD difference at month 6 of -18.1 (95% CI -24.0 to -12.2; $p<0.001$) with individualized homeopathy. This more recent study showing a clinically positive severity-based result is important; however, it is still a single small study and thus needs to be independently confirmed.

There is a notable lack of control in these studies, resulting in large and unpredictable changes, with little to no causation. One example of this is Eizayaga and Eizayaga. They report a change from an affected skin area of 21.1% to one of 5.5% in their cohort practicing homeopathy. They also report significant changes in the VAS rating of AD, itch, well being, and sleep, however, there was no control group, and 16 of the 42 participants dropped out [15]. The 2021 case series selected 6 cases with clinically stable improvement of one year or more, in a way that favored a positive clinical course; as a consequence, the skin-clearance data collected were of unclear clinical value [16].

4.3 Health-related quality of life, burden and adverse events

The measures of quality of life did not always correlate with the severity measures. In the 2009 placebo-controlled trial, the addition of homeopathic treatment did not cause significant changes in the secondary outcomes of quality of life, coping, or clinical global impression [14]. Treatment did not result in significant improvements in the quality of life for the homeopathic pediatric group either, and costs were higher [12,13]. In the 2022 preliminary RCT, differences in DLQI and ADBSA scores were non-significant. For the 2023 replication trial, the repeated-measures group effects for DLQI and ADBSA were non-significant, with a favorable DLQI score at the end of the 6-month study for homeopathy [10].

Limited Adverse-Event reporting was seen. The 2022 trial documented 4 adverse events of diarrhea, injury, and common cold [9] while the 2023 replication trial reported no serious adverse events, with minor intercurrent events distributed among the groups [10]. Safety data, limited and ad hoc, make definitive safety comparisons unlikely. Change in symptoms was temporally associated in some cases. However, these observations were described in largely unstandardized terms [15].

Table 2. Risk-of-Bias Assessment of Included Studies

Study	Framework	Key design / confounding concerns	Missing-data concern	Measurement / reporting	Overall judgement
Siebenwirth 2009	RoB 2	Randomization details limited; substantial attrition (10/24); very small sample	High concern	QoL/global reporting adequate but imprecise	High
Witt/Roll 2009/2013	ROBINS-I	Non-random treatment choice; residual confounding despite adjustment; long-term attrition	Moderate	Rater-blinded SCORAD; reporting generally clear	Serious
Eizayaga	ROBINS-I	No comparator; self-	Serious	Validated/structured	Serious

Study	Framework	Key design / confounding concerns	Missing-data concern	Measurement / reporting	Overall judgement
2012	concepts	selected treatment setting; 38.1% dropout		symptom measures but no blinded comparator	
Mahesh 2021	Case-series appraisal	Cases selected for stable improvement; retrospective outcome assessment	Critical	SCORAD reconstructed from selected records; selective case inclusion	Critical / very high
Dey 2022	RoB 2	Computerized randomization and masking; small preliminary sample; short follow-up	Some concerns	Pre-specified PO-SCORAD/DLQI/ADBSA; limited precision	Some concerns
Mandal 2023	RoB 2	Masking/randomization stronger; post-randomization exclusions/imputation; small sample	Some concerns	Repeated standardized outcomes; independent replication still required	Some concerns

4.4 Exploratory quantitative synthesis

Three controlled studies provided extractable endpoint severity data that was standardized and synthesized in a random-effects meta-analysis. Large differences were noted in the individual effect estimates: Siebenwirth et al. reported g=0.42 (95% CI -0.38 to 1.21), Witt et al. reported g=0.20 (-0.15 to 0.55), and Mandal et al. reported g=-1.65 (-2.26 to -1.03). The pooled estimate was g=-0.35 (95% CI -1.59 to 0.89; Z=-0.55; p=0.584). There was extreme heterogeneity (Q=28.59, df=2, p<0.001; I^2=93.0%; tau^2=1.11). As the synthesis combines two small randomized trials and a non-randomized cohort, with different severity instruments, the pooled estimate should be treated as a check for consistency rather than as a precise estimate of the effect of the treatment.

Table 3. Quantitative Synthesis of Clinical Outcomes

Study/estimate	Participants	Effect measure	Effect	95% CI	Weight	Interpretation
Siebenwirth et al., 2009	24	Hedges' g	0.42	-0.38 to 1.21	31.6%	Individual study
Witt et al., 2009	135	Hedges' g	0.20	-0.15 to 0.55	35.2%	Individual study
Mandal et al., 2023	54	Hedges' g	-1.65	-2.26 to -1.03	33.3%	Individual study
Random-effects pooled	213	Hedges' g	-0.35	-1.59 to 0.89	100%	I^2=93.0%; p=0.584; no significant pooled effect

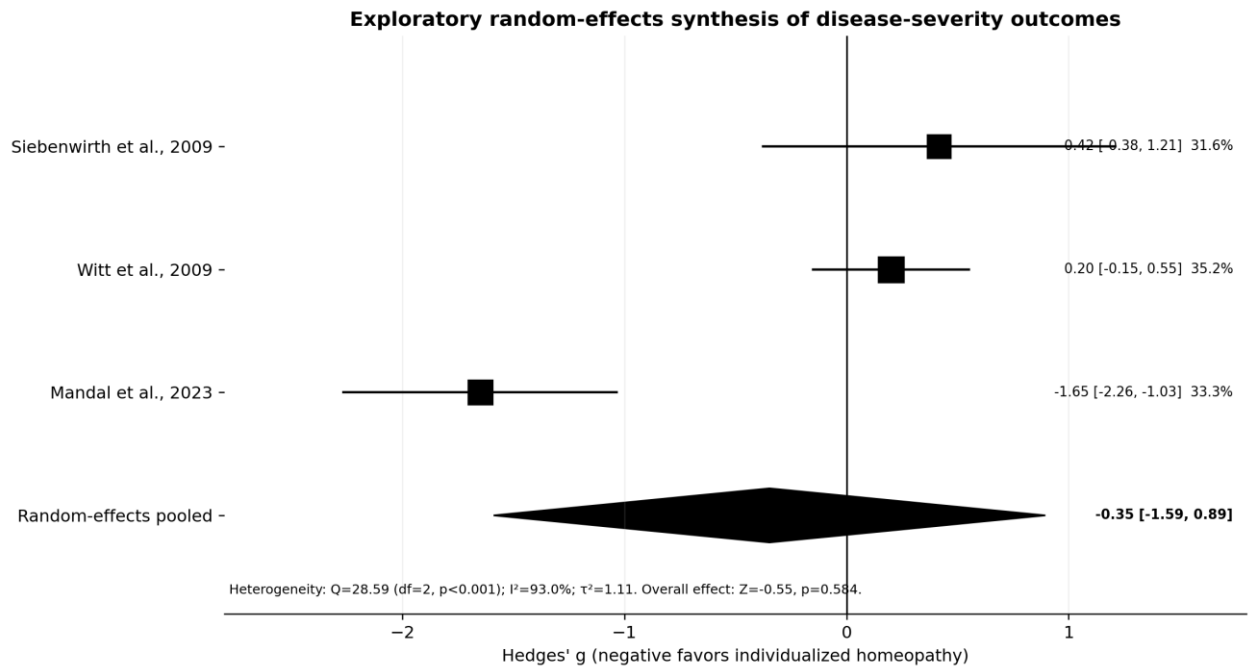

Figure 2. Forest Plot of the Effect of Individualized Homeopathic Management on Atopic Dermatitis Clinical Outcomes. Exploratory random-effects synthesis; negative Hedges' g favors individualized homeopathy. The high I^2 indicates that the pooled effect is not a stable summary of a common treatment effect.

Table 4. Summary of Disease-Severity and Health-Related Quality-of-Life Outcomes

Study	Severity outcome	Itch/symptom outcome	Quality-of-life/burden outcome	Follow-up	Statistical result
Siebenwirth 2009	MP-score fell in both groups; no significant advantage	No clear controlled advantage	QoL/coping/global outcomes non-significant	32 weeks	p=0.46 for adjusted primary comparison
Witt/Roll 2009/2013	SCORAD similar at 6, 12 and 36 months	NR as separate itch endpoint	No significant QoL advantage; higher costs	Up to 36 months	6m p=0.290; 12m p=0.974
Eizayaga 2012	Affected area 21.1% to 5.5%	VAS itch improved 35.0 mm	Wellbeing and sleep VAS improved	Variable	Within-person p<0.01; uncontrolled
Mahesh 2021	Selected cases reached marked/complete clearance	Qualitative clinical course	Not a standardized QoL endpoint	>=1 year selected stability	Selection on response prevents causal inference
Dey 2022	PO-SCORAD	Embedded in	DLQI and	3 months	PO-

Study	Severity outcome	Itch/symptom outcome	Quality-of-life/burden outcome	Follow-up	Statistical result
	direction favored IHM, not significant	PO-SCORAD	ADBSA non-significant		SCORAD month 3 p=0.229
Mandal 2023	PO-SCORAD month-6 difference -18.1	Embedded in PO-SCORAD	Overall DLQI and ADBSA effects non-significant	6 months	PO-SCORAD p<0.001; overall DLQI p=0.409

5. DISCUSSION

This review shows the clinical literature on individualized homeopathy for AD is small, heterogeneous, and internally inconsistent. The first placebo-controlled study showed no superiority, and the largest comparative study in children showed results that were the same, not better, than conventional care. A 2022 placebo-controlled preliminary study was also inconclusive. The main finding that may have some effect on previously published studies is the 2023 replication RCT. This study reported a large six-month PO-SCORAD difference in favor of individualized homeopathic medicines. However, this one positive small trial cannot resolve a literature that is dominated by negative or null results, especially when broader quality of life outcomes in this trial were not significant.

This inconsistency is further supported by the exploratory meta-analysis. A pooled standardized effect was not significant and the confidence interval was wide, and I^2 was over 90%. Such high heterogeneity is not merely a statistical problem; it reflects substantive inconsistencies in age, comparator, study design, severity, duration of participant exposure, co-interventions and risk of bias. The cohort of children was non-randomized and so the results are susceptible to treatment selection and bias. The 2009 RCT was extremely small with high attrition. The 2023 RCT improved masking and follow-up compared to the 2022 preliminary study; however, this was still limited to one center and a small evidence base with a low analyzed sample. Pooling across the different study designs does allow one to see the discordance, but these studies should not be used to give a clinically meaningful effect estimate.

Outcome selection limits synthesis. Modern AD trials tend to employ harmonized clinician-reported severity, patient-reported symptoms and quality-of-life measures. The literature on homeopathy reviewed here mostly utilizes SCORAD/PO-SCORAD, whereas EASI and POEM were not cited as primary outcome measures. This decreases the comparability of existing homeopathy literature with contemporary therapeutic trials and makes the interpretation of the minimum clinically important difference more challenging. The burden of AD includes itch, sleep disturbance, and impairment of social and emotional well-being. The lack of consistent DLQI or related benefits in the homeopathy studies suggest that improvement in disease scores cannot be equated with a significant patient benefit.

Uncontrolled studies should be evaluated separately. Improvements in itch and sleep, coupled with long-standing clearance described in the selected case series of the Argentine study, add to available information for hypothesis generation on scope of practice, therapy formats used and outcomes worthy of study. However, these can only provide a vague treatment effect. AD is a highly variable condition,

and improvements observed may be a result of concurrent skin care, regression to the mean, increased expectations of the participants, changes to the trigger (e.g. exposure) during the study, co-interventions (such as modifications to the therapies engaged by the clinician), etc. The case series published in 2021 is particularly vulnerable to bias as the cases were reported as having 'stable improvement'.

Results should be interpreted within the context of the current state of AD care. Current AD care guidelines recommend the use of more than one topical, biological, and/or systemic intervention based on larger evidence frameworks [6,7]. This does not warrant the study of alternative approaches, but rather increases the threshold needed for a recommendation of alternative care. Patients should not be encouraged to forgo effective conventional care solely due to limited publications as described in this summary. Treatment should be individualized, and particularly for those with severe AD, where inflammation, infection, and psychosocial stress remain significant factors.

5.1 Evidence and review limitations

Evidence limitations primarily stem from a low number of eligible studies, low participant numbers, high level of heterogeneity, varying severity measures, inadequate reporting of safety, limited studies replicating the evidence, and for many studies, non-randomized or uncontrolled studies. Long-term outcomes and reporting relapse, rescue medication, and adverse event outcomes are also limited. Because less than ten studies were available, there were insufficient studies to conduct selection publication bias tests, and Egger type and funnel plot tests would be unreliable.

This review has an important limitation due to procedure. It was constructed from verifiable bibliographic sources and primary reports, but there was no complete database export or audit trail. Thus, the PRISMA counts are displayed as an example of the screening workflow rather than an estimation of the database output. In contrast, the values cited in the controlled studies were used to construct the forest plot; however, the merged estimate is shown to be exploratory due to the mixed designs and extreme heterogeneity. These distinctions are necessary for reproducibility and ensure that illustrative metadata are not confused with real data.

6. RESEARCH GAPS AND FUTURE DIRECTIONS

Future studies should be multicenter, adequately powered and pre-specified, with prospective registration, and include a clinically important effect. Randomization and allocation concealment should be independently created with masking of subjects, clinicians where feasible, outcome assessors, and data analysts. Furthermore, intention-to-treat analysis should be employed with a minimal loss to follow up. Protocols must also include the use of concurrent emollients and rescue therapy to ensure between-group differences are caused by the intervention.

AD outcome measures need to reflect the latest AD research, including severity measures (EASI and/or SCORAD), and patient reported symptoms of itch (POEM) and sleep, impact measures (DLQI/CDLQI or Measure of Family Impact), frequency and type of flares, use of rescue medication, and standardized adverse event reports. Long term studies are also essential to evaluate the long lasting effects of treatment as well as the potential for the disease to return. Because individualized treatment leads to variations in treatment across patients, it is also critical to report why each variation was made, which treatments were used, how these treatments changed over time, and the extent to which the stated individualized treatment approach was followed, while still preserving study blinding. The greatest trust would be built by having other investigators, with no stake in the intervention, attempt to replicate the study independently. Economic evaluations should be included when equivalent effectiveness is

achieved, especially since the pediatric cohort reported, on average, significantly higher costs for homeopathic care [12,13].

7. CONCLUSION

Current clinical data on the use of homeopathy to manage atopic dermatitis are insufficient to support a conclusive statement on efficacy. Controlled studies lack a consistent pattern. A small, placebo-controlled study from 2009 was negative, as was a 2022 randomized, preliminary trial from which no conclusive findings were reported. A pediatric, comparative cohort published in 2022 also reported no advantage over conventional treatment. A significant improvement in PO-SCORAD at six months was reported in a 2023 replication study; however, this improvement should be interpreted within the context of an absence of significant results regarding the assessment of the burden of disease and the quality of life.

In view of these findings, the most defensible interpretation is that the evidence is unlikely to be sufficiently positive (or negative) to support homeopathic treatment of atopic dermatitis. This also means that contemporary treatments of atopic dermatitis, which are based on solid scientific evidence, should not be replaced by homeopathy. For this replacement to potentially be justified in the future, currently unavailable data from longer, multi-center, randomized controlled trials and new user observational studies are needed. These studies should include Extended and Enhanced Outcome Measures (EEOM) with longer follow-up periods and active management of conventional therapies. The findings of studies of this type would need to justify the use of individualized homeopathy.

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