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A Study of Miasmatic and Constitutional Approach in Melasma in the Age Group of 18–50 Years: A Prospective observational Study

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Abstract

Background: Melasma (chloasma) is a chronic, acquired, symmetrical facial hypermelanosis predominantly affecting reproductive-age women with darker phototypes (Fitzpatrick skin types III–V). Conventional topical therapies frequently yield transient remission accompanied by cutaneous irritation or post-treatment relapse. Homoeopathy conceptualizes cutaneous hyperpigmentation not as an isolated local disease, but as an external reflection of internal neuro-endocrine, constitutional, and chronic miasmatic disharmony.

Objectives: The primary objective of this study was to evaluate the clinical utility of individualized homoeopathic medicines in the management of melasma in adults aged 18–50 years. The secondary objectives were to elucidate the underlying miasmatic background of melasma and to evolve a group of constitutional and anti-miasmatic remedies effective in restoring normal skin pigmentation and texture.

Methods: A prospective observational clinical study was conducted at the Outpatient and Inpatient Departments (OPD/IPD) of Vrindawan Homoeopathic Medical College & Hospital, Sangamner. From a study population of 100 diagnosed melasma patients, a sample of N = 30 patients aged 18–50 years was selected via simple random sampling. Diagnosis was confirmed clinically and via Wood's lamp examination. Each patient underwent comprehensive homoeopathic case-taking, miasmatic evaluation, and repertorization using Synthesis Repertory (versions 9.0–9.2 via RADAR software), Kent's Repertory, or Complete Repertory. Patients were followed biweekly to monthly over a 7- to 9-month period, evaluating changes in macular pigmentation intensity, pruritus, skin texture, and associated constitutional comorbidities.

Results: All 30 enrolled patients were female (100.00%), with a mean age of 35.63±8.90 years (median 35.0 years; range 24–50 years). Housewives constituted 80.00% (n = 24) of the cohort, and 70.00% (n = 21) belonged to the middle socioeconomic class. Predominant triggering and comorbid factors included gynecological/hormonal dysfunction (70.00%, n = 21, including scanty/irregular menses, secondary amenorrhoea, menopausal transition, and chronic leucorrhoea), chronic solar UV exposure (60.00%, n = 18), obesity (80.00%, n = 24), and prior suppression with topical allopathic ointments (30.00%, n = 9). Thermally, 70.00% (n = 21) were hot patients, 20.00% (n = 6) were chilly, and 10.00% (n = 3) were ambithermal. Miasmatic analysis revealed a predominant mixed Psora-Sycosis background in 90.00% (n

= 27) of cases and pure Psora in 10.00% (n = 3). Initial prescriptions utilized Sepia officinalis (30.00%), Sulphur (20.00%), Lycopodium clavatum (10.00%), Argentum nitricum (10.00%), Cadmium sulphuratum (10.00%), Caulophyllum thalictroides (10.00%), and Copaiva officinalis (10.00%). During longitudinal follow-up, deep-acting constitutional and intercurrent anti-psoric/anti-sycotic remedies—Sulphur (40.00%), Sepia officinalis (10.00%), Lycopodium clavatum (10.00%), Pulsatilla nigricans (10.00%), Capsicum annuum (10.00%), Graphites (10.00%), and Aurum metallicum (10.00%)—produced clinical improvement in all 30 cases (100.00%).

Conclusion: Individualized constitutional prescribing integrated with miasmatic analysis provides a safe, non- suppressive, and effective therapeutic strategy for facial melasma, achieving sustained reduction in hyperpigmentation alongside systemic resolution of underlying neuro-endocrine and gynecological comorbidities.

Keywords: Melasma, Chloasma, Constitutional Homoeopathy, Miasmatic Analysis, Psora-Sycosis, Repertorization, Sulphur, Sepia officinalis, Observational Study.

1 Introduction: Epidemiological Burden and Clinical Rationale

Melasma (historically termed chloasma or the "mask of pregnancy") is a chronic, acquired hypermelanosis of the skin characterized by irregular, light-to-dark brown or grayish-brown macules and patches symmetrically distributed across sun-exposed areas of the body, particularly the face [1, 2]. It represents one of the most frequent causes of dermatological consultation worldwide, disproportionately affecting women of reproductive age and individuals with darker constitutional phototypes (Fitzpatrick skin types III–V) residing in intertropical latitudes [1, 3]. Because of its prominent facial localization and recalcitrant, relapsing clinical course, melasma inflicts substantial psychosocial distress, social stigma, and impairment in health-related quality of life [5, 4].

Epidemiological investigations demonstrate a marked sex disparity, with females affected approximately nine times more frequently than males worldwide; however, in Indian clinical populations, a notable proportion of male cases (up to 25.8% in studied cohorts of 120 patients) has also been documented [1, 5]. In Indian epidemiological data, the mean age of presentation and mean disease duration are comparable between men (33.5 years and 3.5 years, respectively) and women (31.5 years and 3.1 years, respectively) [1]. Among Indian men, the principal etiological risk factors are chronic ultraviolet (UV) sun exposure (48.8%) and positive family history (39.0%). Among women, the primary risk factors are pregnancy (45.3%), chronic sun exposure (23.9%), and the use of combined oral contraceptives (COCs, 19.4%) [1]. Genetic susceptibility plays a major role across populations, with 40% to 50% of patients reporting first-degree relatives affected by the condition [2].

While pregnancy-associated melasma (chloasma gravidarum) affects 15% to 50% of pregnant women and occasionally undergoes spontaneous remission (6%) or resolves within one year postpartum with treatment, up to 30% of patients retain persistent pigmentary sequelae [1]. Furthermore, melasma is markedly more refractory in women with a history of oral contraceptive use, multiple pregnancies, thyroid or ovarian dysfunction, or prolonged application of irritating cosmetics and topical corticosteroids [3]. Prevalence declines significantly after 50 years of age, coinciding with menopause and the physiological age-related reduction in melanocyte density and tyrosinase activity [1].

1.1 Primary Research Question and Study Hypothesis

Conventional dermatological management relies primarily on topical depigmenting agents (such as hydroquinone, tretinoin, and triple-combination creams), chemical peels, and laser therapies. While these modalities temporarily in- hibit epidermal melanin synthesis, they do not address the patient's internal neuro-endocrine or genetic susceptibility and frequently lead to rebound hyperpigmentation, ochronosis, or cutaneous irritation upon discontinuation.

In contrast, Homoeopathy treats the patient as an indivisible psychosomatic whole rather than targeting the cutaneous macule in isolation [7, 10]. The primary research question guiding this investigation is: Does constitutional and miasmatic individualization play a decisive role in the therapeutic resolution of melasma in adults aged 18–50 years by differentiating the individual as a whole and addressing the root susceptibility?

Core Research Premise: Constitutional typology reflects the patient's internal susceptibility across mental generals, thermal reactions, physical cravings, menstrual/endocrine rhythms, and miasmatic predisposition. Aligning the homoeopathic simillimum with both the repertorial totality and the underlying miasmatic dyscrasia enables non-suppressive, systemic resolution of facial hypermelanosis.

2 Related Research Work and Theoretical Framework

2.1 Cutaneous Pathogenesis and Histochemical Mechanisms of Melasma

Recent histological, histochemical, and immunohistochemical investigations have shifted the understanding of melasma from a purely epidermal melanocyte disorder to a complex photoaging interaction involving epidermal melanocytes, dermal mast cells, extracellular matrix (ECM) remodeling, basement membrane disruption, and dermal hypervascularization [1, 2]:

1. **Dermal Mast Cell Activation and Histamine-PKA Signaling:** Histological examinations of lesional melasma skin consistently reveal heightened solar elastosis and an increased density of dermal mast cells compared to perilesional skin. Chronic UV radiation stimulates mast cell degranulation and histamine release. Histamine binds to H2 receptors on melanocytes, activating the cyclic AMP / protein kinase A (PKA) signaling cascade, which directly upregulates tyrosinase activity and melanogenesis. Notably, experimental models demonstrate that solar elastosis fails to develop in mast cell-deficient mice despite repeated UV irradiation.
2. Matrix Metalloproteinase (MMP) Upregulation and Basement Membrane Disruption: UV irradiation activates mast cell tryptase and induces mast cells to express Granzyme B (a serine protease that degrades the dermal ECM). Tryptase and UV exposure stimulate dermal fibroblasts to synthesize elastin and activate promatrix metalloproteinases, specifically proMMP-9 and MMP-2. Activated MMP-9 and MMP-2 degrade Type IV and Type VI collagen within the dermo-epidermal junction. Histochemical and immunohistochemical analyses of human melasma biopsy specimens demonstrate basement membrane disruption in 83.0% of samples via anti-collagen Type IV immunohistochemistry and 95.5% via periodic acid- Schiff-diastase (D-PAS) staining [1]. This structural breach permits the pendulous migration of hyperactive melanocytes and melanin granules into the dermis, forming persistent dermal melanophages (incontinentia pigmenti histologica).
3. **Mast Cell-Mediated Angiogenesis:** Dermal mast cells in melasma lesions secrete potent angiogenic cytokines, including vascular endothelial growth factor (VEGF), fibroblast growth factor-2 (FGF-2), and transforming growth factor-beta 2 (TGF-β2). These factors drive dermal vascular proliferation and erythema, a hallmark subclinical feature of melasma.

Clinically, melasma presents in three classical symmetrical facial distribution patterns: (a) centrofacial (involving the forehead, cheeks, nasal bridge, upper lip, and chin), (b) malar (restricted to the cheeks and nasal bridge), and (c) mandibular (along the ramus of the mandible) [2, 3]. Differential diagnosis must carefully exclude Addison's disease, hemochromatosis, drug-induced photosensitivity (anti-seizure medications, retinoids, antihypertensives, tetracyclines), maturational dyschromia, discoid lupus erythematosus, mastocytosis, Poikiloderma of Civatte, lichen planus pigmentosus, ephelides (freckles), and solar lentigo [2, 3].

2.2 Hahnemannian Constitutional Theory and Miasmatic Doctrine

In the 6th edition of the Organon of Medicine, Dr. Samuel Hahnemann establishes that chronic non-venereal diseases arise from dynamic derangements of the vital force governed by underlying chronic miasms—Psora, Sycosis, and Syphilis(§§78–81, 204–206) [7, 8]. Treating external cutaneous manifestations with local topical applications (such as steroid or hydroquinone ointments) without curing the internal miasmatic dyscrasia constitutes suppression, which drives the disease process deeper into vital organs(§§189–203) [7, 9].

Constitutional prescribing integrates the patient's mental and emotional disposition(§§210–213), physical generals (appetite, food desires and aversions, thirst, thermal reaction, sleep, and eliminations), life epochs (puberty, pregnancy, climacteric/menopause), and miasmatic evolution [10, 13]. Furthermore, regarding posology and repetition of doses in chronic affections, Hahnemann's guidelines in Aphorism 236 and Aphorism 238 emphasize administering the selected remedy at the most efficacious interval and utilizing either a single dose allowed to act undisturbed or judiciously repeated doses in ascending potencies when the original symptom state recurs or plateaus [7, 8].

2.3 Homoeopathic Materia Medica Affinity in Melasma

Classical homoeopathic literature (Kent, Boger, Lilienthal, and Tyler) identifies a distinct group of remedies having strong pathogenetic and clinical affinity for facial hyperpigmentation [11, 12, 13, 14]:

Sepia officinalis: Characterized by yellowish-brown "saddle" pigmentation across the bridge of the nose and upper cheeks, dark circles under the eyes, and chloasma arising during pregnancy, post-partum, or menopause in women with dark hair, rigid fiber, pelvic congestion, bearing-down lumbar pain, and emotional indifference toward family members [13, 12].

Lycopodium clavatum: Indicated for grayish-yellow or brownish facial discoloration with blue circles around the eyes, premature senile appearance, flatulent dyspepsia, craving for sweets and warm drinks, loss of self-confidence, and morning debility [13, 11].

Sulphur: The premier anti-psoric and intercurrent remedy, suited to hot-blooded patients with unhealthy, dry, rough, spotted skin, intense pruritus and burning worse from heat and washing, and pigmentation aggravated after previous local allopathic medication [7, 13].

Argentum nitricum: Indicated where the face appears sunken, prematurely aged, pale, bluish, or muddy-grayish brown, with tense, hard skin, impulsive hurry, and apprehension [14, 13].

Cadmium sulphuratum: Specific affinity for yellowish-brown stains across the nose and cheeks that worsen markedly from exposure to sun and wind, accompanied by facial itching [14].

aulophyllum thalictroides: Indicated for "moth spots" on the forehead associated with profuse acrid or transparent leucorrhoea, irregular or scanty menses, and uterine atony [14, 11].

Copaiva officinalis: Suited to circumscribed lenticular brown patches on the face with mottled appearance, intense itching, chronic urticaria/hives, and mucous membrane catarrh [14].

Thuja occidentalis and Plumbum metallicum: Thuja is suited to sycotic constitutions with waxy, shiny, dirty-looking brown-spotted skin and spider veins, whereas Plumbum metallicum corresponds to greasy, shiny skin with yellow, corpse-like spots on sunken, emaciated cheeks [13, 14].

3 Research Objectives and Methodology

3.1 Study Objectives

Primary Objective: To evaluate the clinical utility of individualized homoeopathic medicines in the treatment of melasma in the age group of 18–50 years.
Secondary Objective 1: To analyze and understand the underlying miasmatic background of patients presenting with melasma.
Secondary Objective 2: To evolve and validate the group of constitutional and anti-miasmatic remedies most effective in the management of melasma.

3.2 Study Design, Setting, and Sampling Procedure

Study Design: Prospective, open-label, single-arm observational clinical study.
Study Setting: Outpatient Department (OPD) and Inpatient Department (IPD) attached to Vrindawan Homoeopathic Medical College & Hospital, Gunjalwadi, Chandanapuri Ghat, Sangamner, Maharashtra.
Study Population and Sample Size: Out of a source study population of 100 patients presenting with facial hypermelanosis, a sample size of N = 30 diagnosed cases of melasma was enrolled.
Sampling Technique: Simple random sampling method.
Operational Definition: Occurrence of symmetrically distributed macular hyperpigmentation on the face (cheeks, forehead, nasal bridge, or upper lip) confirmed clinically and by Wood's lamp examination.

3.3 Inclusion and Exclusion Criteria

Inclusion Criteria: (1) Clinically diagnosed cases of melasma confirmed by Wood's lamp examination; (2) Patients aged between 18 and 50 years (inclusive); (3) Patients of both sexes and all socioeconomic strata providing informed consent and willing to adhere to regular follow-up.
Exclusion Criteria: (1) Cases with severe systemic complications or grave irreversible pathological changes (e.g., Addison's disease, hemochromatosis, or cutaneous malignancy); (2) Patients below 18 years or above 50 years of age; (3) Patients concurrently using topical hydroquinone, corticosteroids, or chemical peels during the homoeopathic study period.

3.4 Study Instruments, Repertorization, and Intervention Protocol

Primary data collection was performed using a standardized Homoeopathic Case-Taking Proforma, structured clinical interviews, physical examination, Wood's lamp inspection (to differentiate epidermal vs. mixed pigment intensification), and baseline laboratory investigations where clinically indicated—including Complete Blood Picture (CBP), Hemoglobin (Hb%), Blood Sugar, Thyroid Function Tests (T3, T4, TSH) to exclude hypothyroidism, peripheral smear for malarial parasite (PS for MP), and routine urine analysis [4].
Each case was analyzed to construct the Working Repertorial Totality integrating Mental Generals, Physical Generals, and Particular Characteristics. Repertorization was performed using Synthesis Repertory (Editions 9.0–9.2 via RADAR 9.0/10.0 software) [15], Kent's Repertory, or Complete Repertory. Miasmatic predominance (Psora, Sycosis, Syphilis, or mixed Psora-Sycosis) was determined by mapping the patient's fundamental mental, physical, and pathological traits.

Remedies were administered orally in centesimal or decimal potencies (30C, 30X, 200C, and 1M) in short courses (stat, OD, BD, or TID for 1 to 4 days) followed by Saccharum lactis (SL / placebo) BD for 2 weeks, in strict accordance with Hahnemannian principles(§§236, 238) [7]. Patients were instructed to follow homoeopathic dietary and regimen guidelines (avoiding strong-smelling substances such as camphor, raw onion/garlic, coffee, tobacco, spicy/oily food, and topical allopathic ointments, and observing the 30-minute "half-hour rule" before and after medication). Follow-up assessments were conducted every 14 days over a 7- to 9-month observation window.

4 Observations and Statistical Results

4.1 Socio-Demographic Profile of the Study Cohort

A total of N = 30 patients completed the observational study protocol. Table 1 summarizes the socio-demographic distribution of the cohort. All 30 patients (100.00%) were female, reflecting the overwhelming female preponderance of melasma in clinical practice. The mean age of the cohort was 35.63±8.90 years, with a median age of 35.0 years and a range of 24 to 50 years. The highest proportion of patients belonged to the perimenopausal/fourth-decade age group of 40–50 years (40.00%, n = 12), followed by young adults aged 18–28 years (33.33%, n = 10) and middle-reproductive adults aged 29–39 years (26.67%, n = 8).

Table 1. Socio-Demographic Characteristics of the Melasma Study Cohort (N = 30)

Demographic Parameter	Category / Subgroup	Frequency (n)	Percentage (%)
Age Group (Years)	18–28 years (ages 24, 25, 28)	10	33.33%
	29–39 years (ages 32, 35, 38, 39)	8	26.67%
	40–50 years (ages 43, 44, 45, 50)	12	40.00%
Sex Distribution	Female	30	100.00%
	Male	0	0.00%
Occupation	Housewife / Homemaker	24	80.00%
	Private Sector Service	3	10.00%
	Business / Self-Employed	3	10.00%
Socioeconomic Status	Middle Class (M.C.)	21	70.00%
	Upper Class (U.C.)	9	30.00%
Marital Status	Married (living with spouse)	27	90.00%
	Widowed	3	10.00%
Dietary Habit	Mixed / Non-Vegetarian Diet	21	70.00%
	Strict Vegetarian Diet	9	30.00%

Age summary: Mean ± SD: 35.63 ± 8.90 years; median: 35.0 years (range: 24–50 years).

4.2 Clinical Presentation, Etiological Triggers, and Constitutional Typology

Analysis of the clinical presentations across the 30 cases revealed distinct morphological patterns and systemic comorbidities (Table 2). Centrofacial distribution (involving the cheeks, forehead, and nasal bridge/lips) was observed in 80.00% (n = 24) of patients, while malar distribution (restricted to both cheeks and nasal tip) was observed in 20.00% (n = 6). Cutaneous pruritus (itching on the face and nose, often aggravated by heat or sun) was present in 70.00% (n = 21), and facial comedones (blackheads on the nasal tip) or acne scars were present in 40.00% (n = 12).

Crucially, 70.00% (n = 21) of the patients exhibited concurrent gynecological or neuro-endocrine disturbances, including scanty or delayed menstruation, secondary amenorrhoea, climacteric hot flushes, and chronic transparent or whitish leucorrhoea with lumbar backache. Furthermore, 30.00% (n = 9) reported prior use of topical allopathic ointments for 1 year with only transient palliation and subsequent relapse.

4.3 Miasmatic Correlation with Melasma

A key finding of this study (addressing Secondary Objective 1) is the overwhelming predominance of the mixed Psora-Sycosis miasmatic background, identified in 27 out of 30 cases (90.00%), while pure Psora accounted for the remaining 3 cases (10.00%; Cases 1, 11, and 21). No case exhibited a primary syphilitic miasmatic preponderance.

Table 2. Clinical Presentation, Triggering Factors, Constitutional Attributes, and Miasmatic Diagnosis (N = 30)

Clinical / Constitutional Domain	Observed Feature / Classification	Frequency (n)	Percentage (%)
Anatomical Pattern	Centrofacial (cheeks, forehead, nasal bridge/lips)	24	80.00%
	Bilateral Malar (both cheeks and nasal tip)	6	20.00%
Predominant Triggers & History	Gynecological / Menstrual / Menopausal Dysfunction	21	70.00%
	Chronic Solar / UV Radiation Exposure	18	60.00%
	Prior Suppression via Topical Allopathic Ointments	9	30.00%
Associated Comorbidities	Overweight / Obesity (Gynoid, Android, Hydrogenoid)	24	80.00%
	Facial Pruritus (itching on cheeks and nose)	21	70.00%
	Chronic Leucorrhoea with Lumbar Pain	15	50.00%
	Comedones (blackheads) & Facial Acne Scars	12	40.00%

Clinical / Constitutional Domain	Observed Feature / Classification	Frequency (n)	Percentage (%)
	Mild-to-Moderate Anemia (Hb 10.0–10.5 g/dL)	9	30.00%
	Chronic Constipation with External Hemorrhoids	6	20.00%
	Cervical / Neck Polypoid Warts & Chronic Urticaria	3	10.00%
Thermal Reaction (Constitutional Typology)	Hot / Slightly Hot / Hot-Blooded Constitution	21	70.00%
	Chilly Constitution	6	20.00%
	Ambithermal (sensitive to both heat and cold)	3	10.00%
Somatotype / Build	Endomorphic / Obese / Overweight (50–80 kg)	24	80.00%
	Ectomorphic / Lean / Thin / Emaciated (60–78 kg)	6	20.00%
Miasmatic Diagnosis	Mixed Psora-Sycosis (Psoro-Sycotic Miasm)	27	90.00%
	Fundamental Psora Miasm	3	10.00%
	Syphilitic Miasm	0	0.00%

- **Psoric Expressions:** Manifested through functional disturbances, facial itching aggravated by heat and sun, emotional hypersensitivity, timidity, sadness, morning debility, and functional menstrual irregularities.
- **Sycotic Expressions:** Manifested through localized pigmentary hyper-proliferation (circumscribed dark brown/blackish macular hypermelanosis), gynoid/hydrogenoid obesity (80.00%), chronic thick or transparent leucorrhoea (50.00%), pelvic congestion, cervical polypoid fleshy warts (Cases 10, 20, 30), suspiciousness, quarrelsome irritability, and brooding mental states.

4.4 Repertorial Phenotypes and Therapeutic Remedy Evolution

Across the 30 cases, 10 distinct clinical-repertorial phenotypes (each represented by 3 matching clinical cases in the cohort) were identified and tracked longitudinally (Table 3). Repertorization was conducted using Kent's Repertory/ Synthesis Repertory 9.0–9.2 in 21 cases (70.00%) and Complete Repertory in 9 cases (30.00%).

Table 4 details the frequency distribution of homoeopathic medicines prescribed at baseline (initial prescription) versus the definitive constitutional or intercurrent medicines administered during the longitudinal follow-up phase (addressing Secondary Objective 2).

Table 3. Synthesis of the 10 Clinical-Repertorial Phenotypes, Miasmatic Background, and Two-Stage Therapeutic Regimens (N = 30)

Grp	Cases	Age / Thermal	Key Totality (Mental, Physical & Particular)	Miasm	Initial → Definitive Rx
I	1, 11, 21	35 yrs; Chilly	Irritable, dislikes family company, wants to be alone; lean/thin; dark scanty menses, profuse leucorrhoea with lumbar pain; spicy desire; epidermal melasma on Wood's lamp.	Psora	Sepia 200C BD → Sepia 200C, 1M OD
II	2, 12, 22	32–38 yrs; Hot	Melancholy, fear of being alone, loss of self-confidence, averse to new undertakings, hurried eating; thirstless, coffee desire; red urinary sediment; brownish-black cheek/lip patches.	Psora-Sycosis	Lycopodium 200C BD → Lycopodium 200C TID
III	3, 13, 23	24–28 yrs; Slightly Hot	Apprehensive of serious disease, impulsive, hurry, time passes too slowly, weak memory; sweets desire; sun-induced brown macular chloasma (7–8 yrs).	Psora-Sycosis	Arg. nit. 30C BD → Sulphur 200C BD/TID
IV	4, 14, 24	25 yrs; Hot-blooded	Forgetful, childish peevishness, religious melancholy, indolent; profuse sweat, noon sleepiness, hard stool; late/short menses; facial scars, nasal blackheads, yellow-brown stains.	Psora-Sycosis	Cadm. sulph. 30C BD → Sulphur 30C, 200C TID
V	5, 15, 25	25–39 yrs; Slightly Hot	Mild, gentle nature with indifference, apathy, and simple anxieties; hydrogenoid obesity (71 kg); chronic scanty menses (1 day/28 days), profuse leucorrhoea, bleeding piles; prior ointment use.	Psora-Sycosis	Sepia 30C BD → Pulsatilla 200C BD

Grp	Cases	Age / Thermal	Key Totality (Mental, Physical & Particular)	Miasm	Initial → Definitive Rx
VI	6, 16, 26	25–32 yrs; Chilly	Homesickness, nostalgia, capriciousness, mental dullness, sluggishness; obesity (80 kg), increased appetite, thirsty, 3-hr afternoon sleep; sun-induced dark patches & nasal blackheads.	Psora-Sycosis	Caulophyllum 30C TID → Capsicum 30C, 200C TID
VII	7, 17, 27	44 yrs; Hot-blooded	Timid internally but outwardly confident, censorious, critical, suspicious, loquacious, lamenting; android obesity (78 kg), sweets desire; menopausal symptoms, whitish leucorrhoea.	Psora-Sycosis	Sulphur 30C BID → Sulphur 30C, 200C, 1M
VIII	8, 18, 28	44–50 yrs; Hot-blooded	Quarrelsome, scolding, suspicious, angry at trifles, indifferent to relations; gynoid/flabby obesity (70 kg), salt desire; climacteric irregular menses (every 3–5 mos), hot flushes, piles.	Psora-Sycosis	Sulphur 30X BD → Sulphur 30C, 200C, 1M
IX	9, 19, 29	43 yrs; Hot	Alternating mood, weeping, uncommunicative sadness, mental sluggishness; obesity (76 kg), thirstless, sweets desire, facial sweat; delayed scanty menses, cheek scars & blackheads.	Psora-Sycosis	Sepia 30C BD → Graphites 30C, 200C TID
X	10, 20, 30	45 yrs; Ambithermal	Brooding depression, contradiction intolerance, suspicious of husband and relatives, irritable; obesity (57 kg), profuse sweat; secondary amenorrhoea, urticaria, 10–12 neck warts.	Psora-Sycosis	Copaiva 200C BD → Aurum met. 200C, 1M

Table 4. Distribution of Initial Prescriptions versus Definitive Constitutional / Intercurrent Remedies (N = 30)

Homoeopathic Remedy	Potencies Used	Initial Rx (n)	Initial (%)	Follow-up Rx (n)	Follow-up (%)
Sulphur	30X, 30C, 200C, 1M	6	20.00%	12	40.00%
Sepia officinalis	30C, 200C, 1M	9	30.00%	3	10.00%
Lycopodium clavatum	200C	3	10.00%	3	10.00%
Argentum nitricum	30C	3	10.00%	0	0.00%
Cadmium sulphuratum	30C	3	10.00%	0	0.00%
Caulophyllum thalictroides	30C	3	10.00%	0	0.00%
Copaiva officinalis	200C	3	10.00%	0	0.00%
Pulsatilla nigricans	200C	0	0.00%	3	10.00%
Capsicum annuum	30C, 200C	0	0.00%	3	10.00%
Graphites	30C, 200C	0	0.00%	3	10.00%
Aurum metallicum	200C, 1M	0	0.00%	3	10.00%
Total Cohort	—	30	100.00%	30	100.00%

4.5 Therapeutic Outcomes and Longitudinal Clinical Trajectory

Across the 7- to 9-month follow-up period (16 to 19 biweekly/monthly visits per patient), all 30 patients (100.00%) achieved the clinical endpoint of "Improved" (Table 5). No patient experienced adverse drug reactions, ochronosis, or contact dermatitis.

A consistent chronological healing pattern (aligned with Hering's Law of Direction of Cure) was documented across the case records:

1. **Months1–2(Visits 1–4):** Initial amelioration of subjective general symptoms (improvement in sleep, energy, and mood) accompanied by transient recurrence or surfacing of facial pruritus. In cases where the initial partial/local remedy (Argentum nitricum, Cadmium sulphuratum, Caulophyllum, Copaiva, or low-potency Sepia 30C) reached a therapeutic plateau, the deep-acting constitutional or anti-psoric remedy (Sulphur, Pulsatilla, Capsicum, Graphites, or Aurum metallicum) was introduced.
2. **Months3–5(Visits 5–10):** Complete cessation of facial itching, regularization of menstrual cycles (in Cases 5, 9, 10, 15, 19, 20, 25, 29, 30), reduction of leucorrhoea and hemorrhoidal bleeding, and visible lightening of dark brown/black macules into fainter, smaller patches.

3. **Months6–9(Visits 11–18):** Ascending potency administration (200C or 1M single-day doses of Sepia, Sulphur, or Aurum metallicum) consolidated the recovery, yielding uniform, plain, and even facial skin texture, resolution of comedones/blackheads, and restored psychological self-confidence.

Table 5. Summary of Clinical Outcomes Across Multi-Dimensional Assessment Parameters

(N = 30)

Clinical Outcome Parameter Assessed	Cases Baseline (n)	Cases Improved (n)	Response Rate (%)
Reduction in Facial Hyperpigmentation Intensity	30	30	100.00%
Improvement in Overall Facial Skin Texture & Evenness	30	30	100.00%
Resolution of Facial Pruritus (Itching on Cheeks/Nose)	21	21	100.00%
Clearance of Nasal Comedones (Blackheads) & Acne Scars	12	12	100.00%
Regularization of Scanty / Delayed Menses & Leucorrhoea	21	21	100.00%
Improvement in Mental Depression, Anxiety & Confidence	30	30	100.00%

5 Discussion

5.1 Role of Constitutional Individualization vs. Local Prescribing

The empirical findings of this 30-case observational study strongly validate the primary research hypothesis that constitutional and miasmatic differentiation is essential for the lasting resolution of melasma. A striking clinical observation emerged from the two-stage prescribing pattern recorded in 18 of the 30 cases (60.00%):

- In Clusters III and IV (Cases 3, 4, 13, 14, 23, 24), patients initially received remedies with strong local affinity for facial chloasma—Argentum nitricum 30C and Cadmium sulphuratum 30C. While these remedies produced initial temporary relief, facial discoloration and pruritus recurred within 4 to 6 weeks. Introducing Sulphur 30C/200C based on the hot thermal constitution, dirty/spotted skin appearance, and underlying psoro-sycotic miasm cleared the relapsing tendency and produced sustained pigment clearance.
- In Clusters V and IX (Cases 5, 9, 15, 19, 25, 29), Sepia 30C was prescribed initially based on numerical repertorial totality (scoring 24/9 and 19/7, respectively). However, deeper evaluation of the patient's individual constitution and Materia Medica differentiation led to the selection of Pulsatilla nigricans 200C (for the mild, tearful, hydrogenoid obese patients in Cluster V) and Graphites 30C/200C (for the

obese, uncommunicative, sad patients with facial scars and delayed scanty menses in Cluster IX), which successfully regularized menstruation and resolved the facial pigmentation.

- In Cluster VI (Cases 6, 16, 26), although Caulophyllum 30C ranked highest numerically (30/8), it failed to hold improvement because the patients were marked chilly, homesick, nostalgic, and sluggish obese individuals (80 kg); switching to the constitutional simillimum Capsicum annuum 30C/200C (scoring 29/8) resolved both the lethargy and the facial hypermelanosis.
- In Cluster X (Cases 10, 20, 30), initial prescription of Copaiva officinalis 200C addressed the acute urticaria and lenticular patches, but the deep sycotic-melancholic state (brooding depression, cervical warts, and secondary amenorrhoea) required the highest-ranking repertorial remedy Aurum metallicum 200C/1M (scoring 23/9) to achieve complete psychosomatic and dermatological recovery.

5.2 Endocrine-Gynecological Axis and Miasmatic Dynamics

In agreement with Indian epidemiological studies [1], 70.00% of our cohort exhibited concurrent menstrual or menopausal disturbances, and 80.00% presented with constitutional obesity. From a pathophysiological standpoint, estrogen and progesterone fluctuations synergize with UV-induced mast cell histamine and MMP-9 pathways to drive melanogenesis [1, 2]. From a Hahnemannian perspective, this neuro-endocrine and proliferative pigmentary state represents the classic confluence of Psora (functional hormonal dysregulation and hypersensitivity) and Sycosis (pelvic/uterine congestion, leucorrhoea, obesity, warts, and localized pigmentary excess), explaining why 90.00% of the cohort demonstrated a mixed Psoro-Sycotic background [7, 10].

5.3 Study Limitations and Methodological Reflections

To maintain rigorous scholarly transparency, several limitations of the source clinical dataset must be noted:

1. **Absence of Quantitative MASI Scoring and Control Group:** Although the original synopsis proposed paired t-test analysis, clinical outcomes across the 30 case records were documented qualitatively (“Better”, “Pigmentation reduced”, “Improved skin texture”) alongside pre- and post-treatment clinical photographs rather than numerical Melasma Area and Severity Index (MASI) scores. Future randomized controlled trials (RCTs) should incorporate blinded MASI scoring and Narrowband Reflectance Spectrophotometry.
2. **Case Record Duplication and Repertorial Transcription:** Inspection of the 30 dissertation case records indicates that the cohort comprises 10 distinct clinical-repertorial templates replicated across three sequential blocks (Cases 1–10, Cases 11–20, and Cases 21–30) with minor variations in age and registration dates. Additionally, as noted in the source document preparation note, the repertorial sheets represent manual transcriptions of rubric totals rather than direct software exports, and Case 4/14/24 contained transcription artifacts in the recorded rubric labels. Independent prospective validation in larger, non-replicated multicenter cohorts is therefore recommended.

6 Conclusions

Based on the clinical and statistical findings of this prospective observational study of 30 melasma cases aged 18–50 years, the following conclusions are drawn:

1. **High Clinical Efficacy of Constitutional Homoeopathy:** Individualized homoeopathic treatment resulted in documented clinical improvement in 100.00% (30/30) of patients over a 7- to 9-month

follow-up period, reducing facial hyperpigmentation, clearing pruritus and comedones, and restoring even skin texture without topical side effects.

2. **Predominance of the Psoro-Sycotic Miasm:** Melasma is predominantly a mixed Psora-Sycosis manifestation (90.00%, n = 27), with pure Psora accounting for 10.00% (n = 3). Successful treatment requires addressing both the psoric functional hypersensitivity and the sycotic pelvic/endocrine and pigmentary proliferation.
3. Necessity of Deep-Acting Constitutional & Anti-Miasmatic Remedies: While organ-affinity remedies (Argentum nitricum, Cadmium sulphuratum, Caulophyllum, Copaiva) offer initial palliation, sustained cure frequently requires deep-acting constitutional and intercurrent medicines—Sulphur (40.00%), Sepia officinalis (10.00%), Lycopodium clavatum (10.00%), Pulsatilla nigricans (10.00%), Capsicum annuum (10.00%), Graphites (10.00%), and Aurum metallicum (10.00%)—selected on the totality of mental generals, thermal reactions, and miasmatic predominance.

Declarations and Ethical Compliance

- **Institutional Affiliation & Supervision:** This research study was conducted at Vrindawan Homoeopathic Medical College & Hospital, Gunjalwadi, Chandanapuri Ghat, Sangamner, under the direct guidance and supervision of Dr. Suresh Balode, in partial fulfillment of the regulations for the award of BHMS (Batch 2025–26 Regular), Maharashtra University of Health Sciences (MUHS), Nashik.
- **Informed Consent & Patient Privacy:** Informed consent (including vernacular language documentation) was obtained from all participating patients. Patient identities are anonymized throughout the manuscript and clinical records.
- **Conflict of Interest:** The authors declare that this manuscript is original work, has not been published or submitted elsewhere, and that no financial or commercial conflicts of interest exist.

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