



Review Article

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A HOLISTIC PERSPECTIVE: REVIEWING THE ROLE OF HOMOEOPATHY IN TREATING PERIPHERAL NEUROPATHY

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ABSTRACT

Peripheral neuropathy is a common clinical condition that may present with sensory loss, muscle weakness, pain, and functional limitation. Despite advances in diagnostic techniques, many cases remain idiopathic, making management difficult. Homoeopathy offers an individualized and holistic approach to such conditions, focusing on the person as a whole rather than the diseased nerve alone. Guided by the principle of *similia similibus curentur*, homoeopathic treatment aims to relieve neuropathic symptoms, support nerve recovery, and improve overall function. This review outlines the classification, clinical features, causes, diagnostic approach, and management challenges of peripheral neuropathy, followed by a homoeopathic perspective. Miasmatic interpretation, repertorial references, and commonly indicated remedies from Materia Medica are briefly discussed, highlighting the potential role of homoeopathy and the need for further systematic research in this field.

KEYWORDS:

Clinical Diagnosis, Homoeopathy, Individualization, Miasmatic view, Peripheral neuropathy,

INTRODUCTION

Peripheral neuropathy (PN) refers to a peripheral nerve disorder of any cause. About 2.4% of the world population is affected by peripheral nerve disorders; the prevalence increases to 8% in older populations. Diabetic neuropathy occurs in approximately half of individuals with chronic type 1 and type 2 diabetes. Globally, leprosy remains a common cause of peripheral neuropathy, with the highest prevalence in Southeast Asia.

Nerve involvement may be single (mononeuropathy) or multiple (polyneuropathy). Peripheral neuropathies are further classified into those that primarily affect the cell body (e.g., neuronopathy or ganglionopathy), myelin (myelinopathy), and the axon (axonopathy). These different classes of peripheral neuropathies have distinct clinical and electrophysiologic features. Most peripheral nerves are mixed and contain sensory and motor as well as autonomic fibres. Nerves can be subdivided into three major classes: large myelinated, small myelinated, and small unmyelinated. Motor axons are usually large, myelinated fibres that conduct rapidly (~50 m/s). Sensory fibres may be any of the three types. Large-diameter sensory fibres conduct proprioception and vibratory sensation to the brain, while the smaller-diameter myelinated and unmyelinated fibres transmit pain and temperature sensation. Autonomic nerves are also small in diameter. Thus, peripheral neuropathies can impair sensory, motor, or autonomic function, either singly or in combination.

APPROACH TO THE PATIENT WITH NEUROPATHY

In approaching a patient with a neuropathy, the clinician has three main goals: **(1) identify where the lesion is, (2) identify the cause, and (3) determine the proper treatment.** The first goal is accomplished by obtaining a thorough **history, neurologic examination, and electrodiagnostic and other laboratory studies**, despite an extensive evaluation, in approximately half of patients, no aetiology is ever found; these patients typically have a predominately sensory polyneuropathy and have been labelled as having idiopathic or cryptogenic sensory and sensorimotor polyneuropathy (CSPN)

Seven key questions to be asked to approach the suspected case of neuropathy.

1.	What systems are involved? Motor, sensory, autonomic, or combinations
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2.	What is the distribution of weakness? Only distal versus proximal and distal, focal/asymmetric versus symmetric
3	What is the nature of sensory involvement? Temperature loss or burning or stabbing pain (e.g., small fiber), Vibratory or proprioceptive loss (e.g., large fiber)
4.	Is there evidence of upper motor neuron involvement? Without sensory loss, With sensory loss
5.	What is temporal evolution? Acute (days to 4 weeks), Subacute (4–8 weeks), Chronic (>8 weeks), Monophasic, progressive, or relapsing-remitting
6.	Is there evidence for hereditary neuropathy? Family history of neuropathy, Lack of sensory symptoms despite sensory signs
7.	Are there any associated medical conditions? Cancer, diabetes mellitus, connective tissue disease or other autoimmune diseases, infection (e.g., HIV, Lyme disease, leprosy), Medications including over-the-counter drugs that may cause a toxic neuropathy, Preceding events, drugs, toxins

Patterns of neuropathic disorders

<p>Pattern 1: Symmetric proximal and distal weakness with sensory loss Consider: inflammatory demyelinating polyneuropathy (GBS and CIDP)</p>
<p>Pattern 2: Symmetric distal sensory loss with or without distal weakness Consider: cryptogenic or idiopathic sensory polyneuropathy (CSPN), diabetes mellitus and other metabolic disorders, drugs, toxins, familial (HSAN), CMT, amyloidosis, and others</p>
<p>Pattern 3: Asymmetric distal weakness with sensory loss with involvement of multiple nerves Consider: multifocal CIDP, vasculitis, cryoglobulinemia, amyloidosis, sarcoid, infectious (leprosy, Lyme, hepatitis B, C, or E, HIV, CMV), HNPP, tumor infiltration</p>
<p>Pattern 4: Asymmetric proximal and distal weakness with sensory loss Consider: polyradiculopathy or plexopathy due to diabetes mellitus, meningeal carcinomatosis or lymphomatosis, sarcoid, amyloid, hereditary plexopathy (HNPP, HNA), idiopathic</p>

Pattern 5: Asymmetric distal weakness without sensory loss with upper motor neuron findings Consider: motor neuron disease Without upper motor neuron findings Consider: progressive muscular atrophy, juvenile monomelic amyotrophy (Hirayama's disease), multifocal motor neuropathy, multifocal acquired motor axonopathy

Pattern 6: Symmetric sensory loss and distal areflexia with upper motor neuron findings Consider: Vitamin B12, vitamin E, and copper deficiency with combined system degeneration with peripheral neuropathy, chronic liver disease, hereditary leukodystrophies (e.g., adrenomyeloneuropathy) **HSP-plus**

Pattern 7: Symmetric weakness without sensory loss with proximal and distal weakness Consider: SMA With distal weakness Consider: hereditary motor neuropathy ("**distal**" **SMA**) or atypical CMT

Pattern 8: Focal midline proximal symmetric weakness Neck extensor weakness Consider: ALS Bulbar weakness Consider: **ALS/PLS**, isolated bulbar ALS (IBALS), Kennedy's syndrome (X-linked, bulbospinal SMA), bulbar presentation GBS Diaphragm weakness (SOB) Consider: ALS

Pattern 9: Asymmetric proprioceptive sensory loss without weakness Consider causes of a sensory neuronopathy (ganglionopathy): Cancer (paraneoplastic) Sjögren's syndrome Idiopathic sensory neuronopathy (possible GBS variant) Cisplatin and other chemotherapeutic agents Vitamin B6 toxicity HIV-related sensory neuronopathy

Pattern 10: Autonomic symptoms and signs Consider neuropathies associated with prominent autonomic dysfunction: Hereditary sensory and autonomic neuropathy Amyloidosis (familial and acquired) Diabetes mellitus Idiopathic pandysautonomia (may be a variant of Guillain-Barré syndrome) Porphyria HIV-related autonomic neuropathy Vincristine and other chemotherapeutic agents

Abbreviations Mentioned above : **ALS**, amyotrophic lateral sclerosis; **CIDP**, chronic inflammatory demyelinating polyneuropathy; **CMT**, Charcot-Marie-Tooth disease; **CMV**, cytomegalovirus; **GBS**, Guillain-Barré syndrome; **HIV**, human immunodeficiency virus; **HNA**, hereditary neuralgic amyotrophy; **HNPP**, hereditary neuropathy with liability to pressure

palsies; **HSAN**, hereditary sensory and autonomic neuropathy; **HSP-plus**, hereditary spastic paraplegia plus neuropathy; **PLS**, primary lateral sclerosis; **SMA**, spinal muscular atrophy; **SOB**, shortness of breath. (1)

ETIOLOGY

Peripheral neuropathies stem from a variety of origins, including metabolic, systemic, and toxic causes. Commons ones are summarising below:

- Diabetes mellitus
- Chronic alcoholism
- Nutritional deficiencies (eg, B1, B6, B12, and vitamin E)
- Inflammatory conditions (eg, vasculitis)
- Hypothyroidism
- Autoimmune disease (eg, Sjögren syndrome, lupus, rheumatoid arthritis)
- Infections (eg, Lyme disease, Epstein-Barr virus, hepatitis C, shingles, leprosy, HIV)
- Guillain-Barre syndrome
- Toxins (heavy metals, chemicals)
- Chemotherapy agents
- Medications (antibiotics, cardiovascular medications)
- Tumors (secondary to compression or associated paraneoplastic syndromes)
- Inherited conditions (eg, Charcot-Marie-Tooth disease, familial amyloidosis)
- Trauma or injury
- Multiple myeloma and its treatments
- Monoclonal gammopathy of undetermined significance (MGUS)(2)

DIAGNOSTIC EVALUATION

Screening laboratory studies in a distal, symmetric polyneuropathy may include:

1. A complete blood count,

2. Basic chemistries including serum electrolytes and tests of renal and hepatic function, fasting blood glucose, HbA1c, urinalysis, thyroid function tests, B12, folate, ESR, rheumatoid factor;
3. Antinuclear antibodies (ANA),
4. Serum protein electrophoresis (SPEP) and immunoelectrophoresis or immunofixation, and urine for Bence Jones protein.
5. An oral glucose tolerance test is indicated in patients with painful sensory neuropathies even if other screens for diabetes are negative.

Tests to further characterize the neuropathy include:

Nerve conduction studies (NCS), electromyography (EMG),

Sural nerve biopsy, muscle biopsy, skin biopsies, and quantitative sensory testing. Diagnostic tests are more likely to be informative in pts with asymmetric, motor-predominant, rapid-onset, or demyelinating neuropathies.

MANAGEMENT OF NEUROPATHIES

Neuropathies are difficult to manage due to their many underlying causes, complex and diverse mechanisms, and the lack of a single, effective treatment. The wide variety of causes, including genetic factors, diabetes, infections, injuries, and certain medications, makes a one-size-fits-all approach impossible. Additionally, current treatments often have limited effectiveness or side effects, and the complexity of the nervous system itself complicates management strategies. (1)

HOMOEOPATHY PERSPECTIVES

As neuropathies are difficult to manage, Homoeopathy which works on the principle of similia and emphasizes individualized treatment based on a patient's specific symptoms, constitution, and temperament can give good results in these conditions.

Miasmatic view

The primary miasms implicated in neuropathy and related symptoms include: The syphilitic miasm is associated with destructive and degenerative processes that lead to the death or loss of tissue. Characteristic symptoms: This miasm can manifest as severe, destructive

neurological issues, such as those found in tertiary syphilis (e.g., tabes dorsalis), which involve muscle weakness, abnormal sensations (including "lightning pains"), and nerve damage. Psora represented as hypersensitivity, restlessness, tingling, burning etc.

Repertorial View

Various homeopathic repertories contain rubrics related to the symptoms of peripheral neuropathies some of them are summarized below.

Boericke's Manual of Homoeopathic Materia Medica with Repertory

Nervous System

NEURITIS (Inflammation) -- *Acon., Arn., Ars., Bell., Bellis., Carbon s., Ced., Cepa, Gels., Hyper., Plumb., Stann., Thall.,*

TYPE (causes of neuropathies in form of various rubrics)

Alcoholic -- *Nux v., Strych.*

Anterior crural -- *Pareira.*

Circumflex-- *Sang.*

Lesser sciatic -- *Aesc.*

Lumbosacral plexus -- *Berb. v. (Lumbosacral plexopathies)*

Upper dorsal roots -- *Ananth.*

Injuries of nerves -- *Bellis, Cepa, Hyper., Phos. ac.*

Multiple -- *Bov., Con., Morph., Thallium.*

Retrobulbar, with sudden loss of sight -- *Chin. s.*

Traumatic -- *Arn., Calend., Cepa, Hyper.*

BERI BERI - *Elat., Lath., Rhus-t*

CEREBRAL SCLEROSIS OR TUMOR- *Plb.*

PARALYSIS

Ascending spinal (See Spine.) -- *Alum., Bar. ac., Con., Gels., Lathyr., Led., Ox. ac., Phos., Picr. ac., Sec. (seen in GBS, West Nile Virus, Tick paralysis and HIV)*

Lead -- *Alumen, Caust., Cupr., Kali iod., Nux v., Op., Plumb., Sul. ac. (toxic cause of neuropathy)*

LOCALIZED

Face (Bell's palsy) -- *Am. phos., Kali chlor., Zinc. picr.*

Motor nerves -- *Cur., Cystisin, Gels., Ox. ac., Phos., Physost., Xanth.*

Sensory nerves -- *Cocaine, Laburn., Plat.*

POST-DIPHTHERITIC -- *Arg. N., Caust., Cocc., Diph., Gels., Lach., v.*

Rheumatic -- *Caust., Rhus t. (RA)*

LOCOMOTOR ATAXIA -- *Alumen., Alum., Am. m., Arg. n., Ars. Atrop., Aur. mur., Bell., Con., Ferr. picr., Fluor. ac., Ign., Kali iod., Mag. p., Nux v., Ox. ac., Phos., Physost., Picr. ac., Plumb. m., Plumb. phos., Sec., Sil., Strych., Zinc. p.*

DEGENERATION (Softening, sclerosis, etc) -- *Aur. mur., Phos., Plumb. iod.,*

Multiple sclerosis -- *Arg. n., Atrop., Aur., Crot., Lathyr., Nux v., Phos., Physost., Plumb., Strych.,*

NEURALGIA -- *Aconitin, Acon. Arg. n., Arn., Ars., Bell., Bry., Can. ind., Cham., Chel., Chin. ars., Chin. s., Ced., Cim., Cinch., Coff., Col., Gels., Gnaph., Ign., Kali bich., Kal., Mag. p., Mez., Morph., Phos., Phyt., Puls., Ran. b., Rhod., Sil, Spig., Stann., Ver. a., Verbasc., Zinc. V.*

LOCATION

Cervico-occipital -- *Bell., Bry., Chin. s., Cinch., Nux v., Puls., Zinc. p.*

Ciliary -- *Cim., Gels., Mez., Nat. m., Spig.*

Crural anterior -- *Am. m., Coff., Col., Gels., Gnaph., Limul., Nat. ars., Œnanthe, Solan. lyc., Spig., Staph., Sul., Xanth.*

Infraorbital - *Arg.n Bell., Mag. p., Mez., Nux v., Pos.*

Intercostal -- *Acon., Aran., Arn., Ars., Ars. iod., Asclep. t., Aster., Bell., Brom., Bry., Chel., Cim., Gaulth., Mag. p., Menthol, Mez., Morph., Nux v., Paris, Phos., Puls., Ran. b., Rhod., Samb., Zinc m.*

Lumbo-abdominal -- *Aran., Bell., Clem., Col., Cupr. ars., Ham., Mag. p., Nux v.*

Phrenic -- *Bell.*

EXTREMITIES

Numbness, tingling, fall asleep -- *Acon., Arg. n., Calc. p., Carbo v., Caust., Cocc., Gels., Kali c., Lonic., Morph., Onosm., Op., Ox. ac., Phos., Picr. ac., Plat., Sec., Sil., Thall., Zinc. m.*

Weakness, debility - *Alum., Am. caust., Ars., Calc. c., Caust., Cinch., Cocc., Con., Gels., Gins., Kali bich., Mur. ac., Onosm., Phos. ac., Phos, Picr. ac., Plat., Sarcol. ac., stann., Thall., Zinc. M.*

Inversion - feet- cic., nux-v., plb., sec. (*present in Charcot Marie Tooth disease, Refsum disease*)

EXTREMITIES (UPPER)

Numbness Fall asleep -- Acon., Cact., Cham., Cim., Cocc., Graph., Latrod., Mag. m., Nux v. Rhus t.,

Left arm -- Acon., Dig., Kal., Puls., Rhus t., Sumb.

Right arm -- Phyt

Sensibility, diminished -- Carbon. s., Phos.

Numbness, go asleep -- Acon., Caust., Cocc., Colch., Hyper., Phos.,

Numbness, tingling of fingers -- Acon., Cocaine, Dig., Ox. ac., Paris, Sec., Sil., Thall., (3)

Synthesis Repertory

Generals- Diabetes Mellitus- accompanied by - Nervous system; complaints of the polyneuropathy- Brass-n-o.

Generals- Diabetes Mellitus- accompanied by- feet; numbness of - Helon.

Generals- Lyme disease- anac., aur-ar, calc-p., chin-su, gaul., lyc., tarent.

Generals- Paralysis-Toxic-arsenic- chin., hep., nux-v

Extremities- Carpal Tunnel syndrome- arn., bell-p., med., guaj., nat-m., nux-v., puls., Viol-o.

Boger's Synoptic key

Back, spine and cord, numbness: Aco., Agar., Berb., Bry., Kali-bi., Ox-ac., Plat., Sep.

Lower limbs, foot, numb, right: Alum., Ant-c., Ars., Cam., Kali-bi., Mang., Rhus-t.

Lower limbs, foot, numb, left: Grap., Kali-c., Med., Nat-m., Pho., Psor., Thu. (5)

A Concise Repertory of Homoeopathic Medicines by Dr. S.R. Pathak

Neuritis, injury, after: Numbness and tingling, with: Bov.

Numbness- Radical nerve along: Pho-ac.

Ulnar nerve along-Aran (*CUBITAL TUNNEL SYNDROME*) (6)

Homoeopathic Medical Repertory by Robin Murphy

Amyotrophic Lateral Sclerosis- arg-n, ars., lach., lath., phos., PLB.

Brachial neuralgia—Bry., HYPER., kalm., rhus-t. (present in HNA—hereditary neuralgic amyotrophy) Gullian- barre syndrome- carc., con., lath.,

Paralysis- infectious disease after- caust.

Mercury from- HEP., (7)

INDICATIONS OF SOME COMMON REMEDIES FROM MATERIA MEDICA

ALUMINA SILICATE—A deep-acting remedy for chronic complaints of the brain, spine and nerves. Constriction is a marked general symptom. Weakness, especially spinal. Aching and burning in the spine. Formication, numbness, and pain in all limbs.

AVENA SATIVA—It is the best tonic for debility after exhausting diseases, nervous exhaustion numbness of limbs, as if paralyzed. Strength of hand diminished. Post-diphtheritic paralysis.

ARGENTUM NITRICUM—In this drug the neurotic effects are very marked, symptoms of incoordination, loss of control and want of balance everywhere, mentally and physically; Numbness of arms. Post-diphtheritic paralysis disseminated sclerosis of brain and cord.

CAUSTICUM- Manifests its action mainly in chronic rheumatic, arthritic and paralytic affections. Left-sided sciatica, with numbness. Paralysis of single parts. Numbness; loss of sensation in hands.

COCCULUS- Sphere of action of Cocculus are spasmodic and paretic affections, notably those affecting one-half of the body Lameness; worse by bending, Arms go to sleep. Hands are alternately hot and cold; numbness and cold sweat now of one, now of the other hand. Numb and unsteady.

CONIUM MACULATUM- The *ascending paralysis* it produces, ending in death by failure of respiration, shows the ultimate tendency of many symptoms produced in the provings, for which Conium is an excellent remedy, such as difficult gait, trembling, sudden loss of strength while walking, painful stiffness of legs. *Muscular weakness*, especially of lower extremities.

COCAINUM HYDROCHLORICUM- It has specific homeopathic uses Sensation as if small foreign bodies or worms were under the skin. Local sensory paralysis. Formication and numbness in hands and forearms.

DUBOISIA MYOPOROIDES- It acts chiefly on the nervous system locomotor ataxia, Loss of power in limbs, staggers; feels as if he stepped on empty space. Trembling, numbness and weakness.

GELSEMIUM SEMPERVIRENS- Centres its action upon the nervous system, causing various degrees of *motor paralysis*. General prostration. *Dizziness, drowsiness, dullness, and trembling*. Loss of power of muscular control. Cramp in muscles of forearm. Professional neuroses. Writer's cramp.

GNAPHALIUM POLYCEPHALUM- A remedy of unquestioned benefit in sciatica, when pain is associated with *numbness* of the part affected. Anterior crural neuralgia.

HYPERICUM PERFORATUM- The great remedy for injuries to nerves, especially of fingers, toes and nails. Excessive painfulness is a guiding symptom Neuritis, tingling, burning and numbness.

LATHYRUS SATIVUS- Affects the lateral and anterior columns of the cord. *Reflexes always increased. Lateral sclerosis; Beri-Beri*. Weakness and heaviness, slow recovery of nerve power. Tips of fingers numb.

MAGNESIUM PHOSPHORICUM- The great anti-spasmodic remedy. Cramping of muscles with radiating pains. Neuralgic pains *relieved by warmth*. *Weakness in arms and hands, fingertips stiff and numb*.

MORPHINUM-Multiple neuritis. Sore feeling all over. Bed feels too hard. Aggravation after sleep (Lach). Neuralgia after zoster Extremely susceptible to pain. Neuralgias intensely painful, left supraorbital; right intercostal, better from heat.

OXALICUM ACIDUM- Numb, weak, tingling. Pains start from spine and extend through extremities. numb, weak, Myelitis. Wrist painful, Lower extremities blue, cold, insensible. Sensation of numbness. Multiple cerebral and posterior spinal sclerosis.

PICRICUM ACIDUM - Causes degeneration of the spinal cord, pins and needle sensation in extremities. -Burning along spine. *Great weakness. Tired, heavy feeling all over body, especially limbs; worse, exertion*. Feet cold. Cannot get warm. Acute descending paralysis.

PLUMBUM METALLICUM- The great drug for general sclerotic conditions. Lead paralysis is chiefly of extensors, forearm, or upper limb, from centre to periphery with partial anaesthesia or excessive hyperesthesia, preceded by pain. Localized neuralgic pains, neuritis.

STANNUM METALLICUM- Chief action is centred upon the nervous Paralytic weakness; drops things. Limbs suddenly give out when attempting to sit down. Dizziness and weakness when descending. Neuritis. Typewriters' paralysis

THALLIUM METALLICUM-Chronic myelitis. Numbness in fingers and toes, with extension up the lower extremities, involving the lower abdomen and perineum. *Paralysis of lower limbs*. Formication, beginning in fingers and extending through the pelvis, perineum and inner thighs to the feet. [3]

DISCUSSION

Management of peripheral neuropathy remains challenging, as conventional therapies primarily provide symptomatic relief and often yield partial benefit, particularly in chronic or idiopathic cases, with potential adverse effects. This has prompted interest in complementary and individualized treatment approaches. Homoeopathy adopts a holistic and individualized clinical model, interpreting neuropathic manifestations as expressions of systemic imbalance rather than isolated nerve pathology. The miasmatic concept offers an interpretative framework wherein functional disturbances are linked to psoric influences, while chronic degenerative changes correspond to syphilitic tendencies.

Classical homoeopathic repertories extensively document neuropathic symptoms such as numbness, tingling, neuralgic pain, and paralysis, supporting repertorial analysis in peripheral neuropathy. [3-7] Materia medica descriptions further reinforce this scope, with remedies like *Hypericum perforatum*, *Plumbum metallicum*, *Lathyrus sativus*, *Oxalic acid*, *Picric acid*, and *Gelsemium sempervirens* corresponding to commonly observed neuropathic symptom patterns. These remedies emphasize functional and qualitative nerve disturbances rather than disease-specific pathology.

CONCLUSION

Peripheral neuropathy remains a challenging condition, particularly in chronic and idiopathic cases where treatment options are limited. Homoeopathy offers a holistic and individualized approach that considers the totality of symptoms and underlying miasmatic influences, rather than focusing solely on nerve pathology. Classical homoeopathic literature provides valuable guidance for remedy selection in neuropathic conditions. While clinical observations indicate a potential role for homoeopathy in improving symptoms and quality

of life, further systematic and well-designed clinical studies are essential to establish its efficacy and strengthen evidence-based practice.

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