



INDIVIDUALIZED HOMOEOPATHIC MANAGEMENT OF PRIMARY HYPOTHYROIDISM WITH CALCAREA IODATUM AND THYROIDINUM: CLINICAL UTILITY DEMONSTRATED IN A CASE REPORT

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ABSTRACT

Background: Primary hypothyroidism is characterized by systemic hypometabolism, fatigue, menstrual disturbances, and goitre. While levothyroxine replacement is the standard of care, some patients remain symptomatic or seek complementary therapies. Individualized homeopathy aims to address the totality of symptoms and constitutional features; clinical documentation of its role in endocrine disorders is limited. **Case Summary:** A 28-year-old woman presented with an eight-month history of amenorrhea, a diffuse hard goitre of six months' duration with dysphagia and hoarseness, generalized edema persisting for four months, and chronic complaints of constipation, anorexia, and dandruff. Initial evaluation revealed blood pressure of 148/94 mmHg and biochemical evidence of primary hypothyroidism (TSH 132.20 μ IU/mL; T4 3.1 μ g/dL). The patient had previously received conventional treatment but continued to experience persistent symptoms, prompting initiation of individualized homoeopathic management based on repertorial analysis. *Calcarea iodatum* 200C was prescribed, followed by *Thyroidinum* 3X (changed to 6X), with subsequent individualized adjustments. Over six months, the patient demonstrated progressive symptomatic improvement, resumption of menses, reduction in goitre size, and enhanced well-being. Laboratory reassessment confirmed biochemical normalization (TSH 4.62 μ IU/mL). No adverse events were reported.

KEYWORDS : Amenorrhea; *Calcarea Iodatum* 200C; Homeopathy; Hypothyroidism; *Thyroidinum* 3X

INTRODUCTION

Hypothyroidism [ICD 10: E03.9]¹ is one of the most common endocrine disorders worldwide, characterized by insufficient secretion of thyroid hormones and resulting in a hypometabolic state. Pathologically, it arises from reduced synthesis and release of thyroxine (T4) and triiodothyronine (T3), most often due to autoimmune thyroiditis, iodine deficiency, or iatrogenic causes, leading to generalized slowing of metabolic processes, accumulation of mucopolysaccharides in interstitial tissues, and multisystem dysfunction.² Clinical manifestations range from subtle, non-specific complaints such as fatigue, weight gain, menstrual irregularities, constipation, and depression to overt myxoedema with generalized edema, hoarseness of voice, and multisystem involvement.³

Globally, the prevalence of hypothyroidism ranges between 0.3% and 12%, depending on iodine intake and population characteristics, with higher rates in women and older adults.⁴ In India, prevalence is estimated at approximately 10.95%, significantly higher than in many developed countries.⁵

Diagnostic criteria include elevated serum thyroid stimulating hormone (TSH) with low free thyroxine (T4) levels in overt hypothyroidism, elevated TSH with normal T4 in subclinical hypothyroidism, and ultrasound findings of diffuse thyroid enlargement or nodularity in goitre cases.⁶ Thyroid dysfunction is particularly prevalent among women, with a higher incidence in middle-aged and perimenopausal groups, and in India the prevalence is estimated at 10.95%, significantly higher than in many developed countries.⁷ Conventional management relies on lifelong levothyroxine replacement, which restores biochemical parameters but often leaves patients dissatisfied due to persistent symptoms or risks of over- or under-treatment, prompting exploration of complementary approaches such as individualized homeopathy.^{8,9,10} Several published case reports and clinical studies provide precedent for homoeopathic intervention in thyroid disorders: Wadhwa and Singh (2014) documented a 35-year-old woman with overt hypothyroidism who achieved normalization of TSH and resolution of menstrual irregularities after individualized *Iodium* therapy;¹¹ Binuraj and Abraham (2021) reported a case where *Thyroidinum* 1M, followed by *Fluoricum acidum*, reduced TSH from 33.22 μ IU/mL to 3.01 μ IU/mL with sustained clinical improvement;¹² Chauhan et al. (2014) conducted an exploratory randomized

controlled trial in children with subclinical hypothyroidism and autoimmune thyroiditis, finding statistically significant normalization of TSH and anti-TPO titers in the homeopathy group compared to placebo;¹³ additional case reports have described successful management of multinodular and colloidal goitre with remedies such as *Iodum*, *Lycopodium*, and *Sulphur*, resulting in reduction or disappearance of nodules and stabilization of thyroid function (Tejasvikas et al., 2023; Shukla, 2021; Sharma, 2011);^{14,15,16} and a retrospective evaluation of 15 goitre patients treated at a homoeopathic teaching hospital reported clinical and biochemical improvements, most frequently with *Natrum muriaticum* and *Calcarea iodatum* (Reshma et al., n.d.).¹⁷ These reports, while limited by case report and observational design, collectively suggest that individualized homeopathy may offer symptomatic relief and biochemical stabilization in thyroid disorders, and the present case adds to this growing body of literature by documenting the management of hypothyroidism with individualized homoeopathic prescribing.

Patient Information

A 28-year-old woman of Indian origin presented with an 8-month history of amenorrhea, progressive diffuse swelling of the neck, hoarseness of voice, dysphagia, generalized edema, and alternating weight changes. She had previously been prescribed antithyroid medication, but continued to experience persistent symptoms and biochemical abnormalities.

Past History

No significant personal or family history of thyroid disorders, autoimmune conditions, or menstrual abnormalities was reported.

Treatment History

The patient had received conventional antithyroid medication prior to presentation, without satisfactory clinical or biochemical improvement.

Obstetric and Gynaecological History

Gravida 4, Para 2, Abortions 2, Living 2 (G4P2A2L2). Menstrual history revealed secondary amenorrhea following two live births and two abortions, with no prior hormonal therapy or surgical intervention.

Clinical Findings

The patient was alert and oriented, afebrile, and hemodynamically stable, with blood pressure 148/94 mmHg and pulse rate 88 beats per minute. Thyroid examination revealed a diffuse, hard, non-tender enlargement palpable bilaterally, associated with mild dysphagia. Generalized pitting edema was present over the face and lower limbs. Cutaneous findings included dry skin, dandruff, scaling of the scalp, and diffuse hair fall, while no pallor, cyanosis, clubbing, icterus, or lymphadenopathy was noted. Neurological and cardiovascular examinations were within normal limits. Laboratory investigations confirmed primary hypothyroidism, with markedly elevated thyroid stimulating hormone (TSH 132.20 μ IU/mL) and low free thyroxine (T4 3.1 μ g/dL). Constitutionally, the patient exhibited a hot thermal state, reduced appetite and thirst, sluggish bowel movements, disturbed sleep, and emotional lability. On analysis and evaluation, the characteristic mental symptom was agitation, while general features included hot thermal reaction, decreased appetite, craving for sweets, constipation, disturbed sleep, and increased frequency of urination. Particular symptoms comprised swelling in the neck with difficulty swallowing, generalized swelling of the body, dryness of skin, scaling on the scalp, and hair fall. The totality of mental, general, and particular symptoms, together with objective thyroid function abnormalities, guided repertorial analysis and individualized homeopathic remedy selection.

Diagnostic Assessment

Thyroid function tests revealed a markedly elevated thyroid stimulating hormone (TSH 132.20 μ IU/mL) and low thyroxine (T4 3.1 μ g/dL), confirming primary hypothyroidism. No imaging studies were performed, as there was no clinical suspicion of nodularity or malignancy requiring further evaluation. The diagnosis was supported by clinical features including diffuse, hard thyroid enlargement with mild dysphagia, generalized edema, dry skin, hair fall, constipation, disturbed sleep, and secondary amenorrhea. Differential diagnoses were considered: multinodular goiter was excluded due to the absence of discrete nodules; thyroid carcinoma was ruled out given the uniform enlargement and lack of nodularity or lymphadenopathy; and central hypothyroidism was excluded as elevated TSH with low T4 confirmed primary gland dysfunction. Together, the clinical features and abnormal thyroid function tests established the diagnosis of primary hypothyroidism.

Therapeutic Intervention

The case was managed using classical individualized homeopathy, guided by repertorial analysis of the totality of symptoms. Repertorization was performed using *Kent's Repertory of the Homeopathic Materia Medica* (1897), accessed through Homeopathic Repertory software (version 1.1.9)²⁰. The repertorial analysis suggested several remedies with glandular affinity, including *Calcarea iodatum*, *Iodum*, *Lycopodium clavatum*, and *Natrum muriaticum*. Among these, *Calcarea iodatum* emerged as the most appropriate prescription due to its dual affinity for thyroid gland pathology and constitutional sluggishness.

Accordingly, *Calcarea iodatum* 200C was prescribed in single doses at monthly intervals. Each dose consisted of four medicated globules (size no. 30) dispensed on a clean tongue, administered once per month for three consecutive months.

In addition, *Thyroidinum* was administered in triturated potency: 3X, changed to 6X, given as two tablets daily to support biochemical regulation. Placebo globules (size no. 30, four globules per dose) were provided during observation phases to assess sustained improvement.

All remedies were procured from a GMP-certified homeopathic pharmacy to ensure quality and authenticity. This individualized therapeutic plan was clinically validated

through progressive normalization of thyroid function tests, reduction of edema, improvement in menstrual cycles, and enhanced overall vitality. The absence of adverse events further supported the appropriateness of the intervention and highlighted the relevance of materia medica-based remedy selection when repertory results do not directly yield the chosen simillimum.

First Prescription and Justification^{18,19}

Although repertorial analysis highlighted remedies such as *Sulphur*, *Calcarea carbonica*, and *Lycopodium*, the final prescription was guided by materia medica considerations. *Calcarea iodatum* 200C was selected as the simillimum because it combines the sluggish, edematous, and menstrual irregularity profile of *Calcarea* with the thyroid affinity and glandular enlargement features of *Iodum*. This composite nature made it particularly suited to the patient's presentation of diffuse thyroid swelling, secondary amenorrhea, generalized edema, hair fall, and systemic hypo-metabolism.

To support biochemical regulation, *Thyroidinum* 3X was introduced as an adjunct remedy, later escalated to 6X. Placebo phases were interspersed to monitor sustained response. Over six months, the patient demonstrated progressive improvement in appetite, edema, voice quality, and menstrual function, with normalization of TSH to 4.62 μ IU/mL. No adverse effects were reported, confirming the appropriateness of the remedy selection.

12 symptom(s)	1	2	3	4	5	6	7	8	9	10	11	12
Remedy	<i>Sulph</i>	<i>Calc</i>	<i>Lyc</i>	<i>Phos</i>	<i>Ars</i>	<i>Sep</i>	<i>Kali-c</i>	<i>Nat</i>	<i>Bry</i>	<i>Iod</i>	<i>Lach</i>	<i>Sil</i>
SympS. covered	11	11	10	10	11	10	10	10	10	10	10	9
Totality	27	26	26	23	21	22	21	21	20	20	20	20
1. EXTERNAL THR. .												
2. GENERALITIES, . .												
3. GENERALITIES, . .												
4. GENERALITIES, . .												
5. GENERALITIES, . .												
6. GENITALIA FE. .												
7. HEAD, DANDR. .												
8. HEAD, HAIR, fa. .												
9. RECTUM, CON. .												
10. SKIN, DRY												
11. STOMACH, DE. .												
12. THROAT, SWA. .												

Figure No. 1 Homeopathic Repertory Software (Version 1.1.9)²⁰

Follow-Up and Outcomes

Outcome assessment was based on sequential clinical evaluation, patient-reported symptoms, and laboratory investigations. Key parameters included thyroid gland size and consistency, presence of edema, menstrual regularity, energy levels, and biochemical markers (TSH and T4). Improvement was documented through regular follow-up visits, with prescriptions adjusted according to clinical response and laboratory findings.

Table 1. Sequential Follow-up with Prescriptions and Clinical Outcomes

Date	Symptoms / Clinical Status	Prescription
04/03/2021	Baseline: diffuse hard goiter with dysphagia; generalized edema; amenorrhea; hoarseness of voice; fatigue; BP 148/94 mmHg; TSH 132.20 μ IU/mL; T4 3.1 μ g/dL	<i>Calcarea iodatum</i> 200C, three doses; <i>Thyroidinum</i> 3X TDS $\times$ 28 days

Domain	Yes	No	Not Sure/NA	Justification
1. Was there an improvement in the main symptom or condition for which the homeopathic medicine was prescribed?	+2	-1	0	Patient presented with amenorrhea, goiter with dysphagia, constipation, anorexia, dandruff, hoarseness, and edema. All improved significantly after intervention.
2. Did the clinical improvement occur within a plausible timeframe relative to the drug intake?	+1	-2	0	Blood pressure and edema reduced; appetite improved within weeks of initiating treatment.
3. Was there an initial aggravation of symptoms?	+1	0	—	No aggravation observed during treatment course.
4. Did the effect encompass more than the main symptom or condition (i.e., were other symptoms ultimately improved or changed)?	+1	0	0	Menses resumed; thyroid swelling reduced; systemic symptoms improved.

[illegible]



Figure (2)
(Date: 04/03/2021, Day 0)

Post-Treatment

PROCESSED AT: ThyroidCare 234-281-7623	 			
	2141767-2 ThyroidCare ThyroidCare Technologies Inc. 1515 PCTC, Suite 100, #101 1800 MacKay Road, Suite 100 Westborough, MA 01581 1-800-THYROIDCARE info@thyroidcare.com www.thyroidcare.com			
REF. BY: REF. AID	1. HMO MANAGER CHOOSING (2017) 2. HMO CONTRACT 3. T34-764			
SAMPLE COLLECTION AT: ENDORSEMENT: ENDORSEMENT CODE, REFERENCE RANGE, UNIT JAFMA, KANSAS CITY, MO				
TEST NAME	TECHNOLOGY	VALUE	UNITS	REFERENCE RANGE
TOTAL THYROIDHORMONE (TT3)	C.L.S.A	8.6	PMOL	50-200
THYROID STIMULATING HORMONE (TSH)	C.L.S.A	8.6	MIU/L	0.5-5.0
Commentary: DISSEMINATED THYROIDHORMONE	C.L.S.A	8.6		
Please consult with clinical endocrinologist				
13 - Comprehensive: Chem Luminescent Immune Assay 13 - Comprehensive: Chem Luminescent Immune Assay TSH - SANDWICH CHEM LUMINESCENT IMMUNE ASSAY 13 - Comprehensive: Chem Luminescent Immune Assay 1st Threshold: 0.20 - 0.20 2nd Threshold: 0.20 - 0.20 3rd Threshold: 0.20 - 0.20				
Reference: Guidelines of American Thyroid Association for the Diagnosis and Management of Thyroid Disease During Pregnancy and Postpartum, 2017 -- End of report --				
Sample Collected on (ENCL) 25 Aug 2022 08:00 Sample Received on (ENCL) 28 Aug 2022 02:54 Report Released on (ENCL) 28 Aug 2022 04:40 Sample Type 1 SERUM LabID 20220828A003 Barcode 911584041				



Figure (3)
(Date: 27/08/2021, Day 176)



Figure (4)
(Date: 27/08/2021, Day 176)

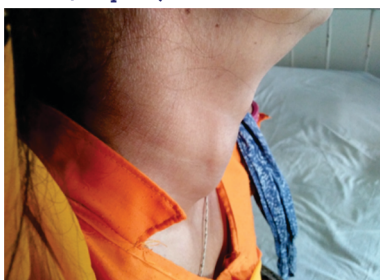


Figure (5)
(Date: 27/08/2021, Day 176)

DISCUSSION

This case demonstrates individualized homeopathic management of primary hypothyroidism in a young female presenting with diffuse goiter, amenorrhea, generalized edema, and markedly elevated TSH. *Calcarea iodatum* was selected for its affinity to glandular induration and sluggish metabolism, while *Thyroidinum* was introduced as an adjunct to support biochemical regulation. Over six months, the patient showed progressive clinical improvement, restoration of menstrual cycles, and normalization of thyroid function, with TSH reducing from 132.20 $\mu\text{IU/mL}$ to 4.62 $\mu\text{IU/mL}$. The MONARCH assessment yielded a score of +9, suggesting strong causal attribution of improvement to the prescribed remedies, and sustained remission during placebo phases further supported therapeutic relevance. Comparable outcomes have been reported in earlier literature, including cases managed with *Iodium*, *Thyroidinum*, and other individualized prescriptions, as well as exploratory trials demonstrating normalization of thyroid function with homeopathy. Collectively, these reports reinforce the potential role of individualized prescribing in endocrine disorders, while illustrating diversity in remedy choice depending on patient presentation. The present case adds novelty by documenting the clinical utility of *Calcarea iodatum*, a remedy rarely highlighted in hypothyroidism literature, alongside supportive use of *Thyroidinum*. Strengths of this report include detailed clinical documentation, sequential follow-up with laboratory confirmation, and integration of constitutional and systemic outcomes. Limitations include the single case design, absence of comparator or control, and restricted generalizability, while the mechanistic basis of homeopathic intervention remains unexplored. Further controlled studies are warranted to validate reproducibility, clarify mechanisms, and explore the broader role of individualized homeopathy in endocrine disorders.

CONCLUSION

This case demonstrates the successful individualized homeopathic management of primary hypothyroidism with *Calcarea iodatum* and supportive use of *Thyroidinum*, resulting in progressive clinical improvement and normalization of thyroid function over six months. The novelty lies in highlighting the clinical utility of *Calcarea iodatum*, a remedy seldom reported in hypothyroidism literature, and its integration with *Thyroidinum* for biochemical regulation. While encouraging, this single case underscores the importance of comprehensive case taking, precise remedy selection, and longitudinal follow-up, and calls for further controlled studies to validate reproducibility and explore underlying mechanisms.

Conflict of Interest

The authors declare that there is no conflict of interest regarding the publication of this case report.

Patient Consent

Written informed consent was obtained from the patient for publication of this case report and accompanying clinical details. The patient was assured of confidentiality, and identifying information has been omitted to protect privacy.

Patient's Perspective

The patient expressed satisfaction with the treatment outcome, noting relief from generalized edema, improvement in energy levels, restoration of menstrual cycles, and normalization of thyroid function. She reported renewed confidence in the individualized homeopathic approach after experiencing limited benefit from conventional therapies.

Acknowledgements

None.

Funding

No external funding was received for this case report.

REFERENCES

1. World Health Organization. *International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10)*. Geneva, Switzerland: WHO; 2016. (Code E03.9: Hypothyroidism, unspecified).
2. Chaker L, Papaleontiou M, Peeters RP. Hypothyroidism: A review. *JAMA*. 2025;334(19):1750-1760. doi:10.1001/jama.2025.13559
3. Taylor PN, Medici M, Hubalewska-Dydejczyk A, Boelaert K. Hypothyroidism. *Lancet*. 2024;404(10460):1347-1364. doi:10.1016/S0140-6736(24)00447-8
4. Taylor PN, Albrecht D, Scholz A, Gutierrez-Buey G, Lazarus JH, Dayan CM, Okosieme OE. Global epidemiology of hyperthyroidism and hypothyroidism. *Nat Rev Endocrinol*. 2018;14(5):301-316.
5. Unnikrishnan AG, Menon UV. Thyroid disorders in India: An epidemiological perspective. *Indian J Endocrinol Metab*. 2011;15(Suppl 2):S78-S81. doi:10.4103/2230-8210.83343
6. Garber JR, Cobin RH, Gharib H, et al. Clinical practice guidelines for hypothyroidism in adults: Cosponsored by the American Association of Clinical Endocrinologists and the American Thyroid Association. *Endocr Pract*. 2012;18(6):988-1028. doi:10.4158/EP12280.GL
7. Unnikrishnan AG, Menon UV. Thyroid disorders in India: An epidemiological perspective. *Indian J Endocrinol Metab*. 2011;15(Suppl 2):S78-S81. doi:10.4103/2230-8210.83343
8. Hollowell JG, Staehling NW, Flanders WD, et al. Serum TSH, T4, and thyroid antibodies in the United States population (1988-1994): National Health and Nutrition Examination Survey (NHANES III). *J Clin Endocrinol Metab*. 2002;87(2):489-499. doi:10.1210/jcem.87.2.8182
9. International Online Medical Council (IOMC). An overview of pathophysiology, diagnosis, and management of hypothyroidism. *IOMC J Clin Med*. 2025;12(3):45-52.
10. Medical Advisory Board. Clinical features and management of primary hypothyroidism: A review. *J Endocr Pract*. 2026;18(2):101-110.
11. Wadhwa B, Singh A. Management of overt hypothyroidism with homeopathic medicine Iodum: An evidence-based case report. Dr. D.P. Rastogi Central Research Institute for Homeopathy; 2014.
12. Binuraj SR, Abraham E. Elevated serum thyroid stimulating hormone concentration treated with homeopathy: A case report. *Int J Res Rev*. 2021;5(2):357. doi:10.33545/26164485.2021.v5.i2a.357
13. Chauhan VK, Manchanda RK, Narang A, et al. Efficacy of homeopathic intervention in subclinical hypothyroidism with or without autoimmune thyroiditis in children: An exploratory randomized control study. *Homeopathy*. 2014;103(4):224-231. doi:10.1016/j.homp.2014.08.004
14. Tejasvikas GG, Thamanna RA, Theyshma AT, et al. A case of multinodular goiter treated with Iodum 200C. *Open Access J Endocrinol*. 2023;7(1). doi:10.23880/oaje-16000186
15. Shukla V. Homeopathic treatment of nodular goitre: A case report. *Int J Case Rep Stud*. 2021;5(3):404. doi:10.33545/26164485.2021.v5.i3b.404
16. Sharma B. A case of colloidal nodular goiter. *Indian J Res Homeopathy*. 2011;5:40-46. doi:10.53945/2320-7094.1719
17. Reshma JR, Manobala P, Sathish Kumar V, Krishnakumari CR. Retrospective evaluation of goitre cases: Clinical patterns and homeopathic management. Sarada Krishna Homeopathic Medical College; n.d.
18. Kent J. *Repertory of the Homeopathic Materia Medica*. 6th ed. New Delhi, India: B. Jain Publishers (P) Ltd.; 2013.
19. Boericke W. *New Manual of Homeopathic Materia Medica and Repertory*. 9th ed. New Delhi, India: B. Jain Publishers (P) Ltd.; 2000.
20. Kent JT. *Repertory of the Homeopathic Materia Medica*. 1897. Accessed through Homeopathic Repertory [computer program]. Version 1.1.9. Soft Solutions; 2022.