



ADJUNCTIVE INDIVIDUALISED HOMOEOPATHY IN PULMONARY TUBERCULOSIS AND POST-TUBERCULOSIS LUNG DISEASE: A CRITICAL NARRATIVE REVIEW

Homeopathy

Dr. Gouri Devi Ningthoujam*	Assistant Professor, Department of Practice of Medicine, College of Homoeopathy, North Eastern Institute of Ayurveda and Homoeopathy (NEIAH), Mawdiangdiang, Shillong – 793018, Meghalaya, India*Corresponding Author
Dr. Bianghunlang Nongsiej	Assistant Professor, Department of Practice of Medicine, College of Homoeopathy, North Eastern Institute of Ayurveda and Homoeopathy (NEIAH), Mawdiangdiang, Shillong – 793018, Meghalaya, India
Dr. Khursida Nongjai	3rd-year postgraduate scholar, Department of Practice of Medicine, College of Homoeopathy, North Eastern Institute of Ayurveda and Homoeopathy (NEIAH), Mawdiangdiang, Shillong – 793018, Meghalaya, India

ABSTRACT

Background: Tuberculosis (TB) remains a major global health problem, and some people experience persistent respiratory impairment after treatment. This review critically examines published reports on homoeopathy used alongside standard TB care and their relevance to post-TB lung disease. **Methods:** A focused narrative appraisal was undertaken of a randomised controlled trial in multidrug-resistant TB, a retrospective case series in tubercular lymphadenitis, a conference abstract on post-treatment pulmonary impairment, and a clinical study describing post-TB sequelae. Results: In the randomised trial, sputum culture conversion was 23/60 (38.3%) in each group in the intention-to-treat analysis; the difference was not statistically significant. The lymphadenitis report was an uncontrolled retrospective series, while the post-treatment pulmonary findings were reported in a conference abstract rather than a full trial paper. **Conclusion:** These reports do not establish that homoeopathy treats active TB or post-TB lung disease. It must never replace, delay, or interfere with guideline-based care. Independent, adequately designed research would be required to determine whether any adjunctive benefit exists.

KEYWORDS

Tuberculosis; Homoeopathy; Multidrug-resistant Tuberculosis; Post-tuberculosis Lung Disease; Narrative Review

INTRODUCTION

Tuberculosis (TB), caused by *Mycobacterium tuberculosis*, remains a major public-health concern. The World Health Organisation (WHO) estimated that 10.7 million people developed TB and 1.23 million died from it in 2024. India continues to account for a substantial proportion of the global burden (World Health Organisation [WHO], 2025a). These figures reinforce the importance of early diagnosis, appropriate multidrug treatment, treatment support, and follow-up. Successful completion of TB treatment does not guarantee full respiratory recovery. Post-tuberculosis lung disease (PTLD) may include persistent respiratory symptoms, airflow limitation, bronchiectasis, fibrosis, reduced exercise tolerance, and impaired quality of life. An Indian tertiary-care study described morbidity and quality-of-life impairment among people presenting with post-pulmonary-TB sequelae (Thoker et al., 2023). Homoeopathic literature contains historical descriptions of respiratory symptoms and concepts such as individualised prescribing and the “tubercular miasm.” These concepts belong to homoeopathic doctrine and should not be presented as established biomedical explanations of TB. This review distinguishes historical theory from clinical evidence and assesses what the published reports can—and cannot—support.

METHODS

This is a critical narrative review, not a systematic review. It appraises the principal clinical reports cited in the source manuscripts: a randomised placebo-controlled trial in multidrug-resistant pulmonary TB, a retrospective case series involving tubercular lymphadenitis, a conference abstract concerning pulmonary impairment after TB treatment, and a clinical study describing post-TB sequelae. WHO publications were consulted for current epidemiological context and treatment guidance.

The source material did not document a reproducible systematic search: complete search strings, search dates, predefined eligibility criteria, duplicate screening, or a formal risk-of-bias assessment were not available. The review is therefore not exhaustive, and the included reports should not be treated as a complete evidence base. We did not attempt a meta-analysis because the designs, populations, interventions, and outcomes differ.

Clinical evidence on homoeopathy in tuberculosis

Multidrug-resistant pulmonary TB. Chand et al. (2014) reported a randomised, double-blind, placebo-controlled study of 120 patients

who received standard treatment plus individualised homoeopathy or an identical placebo. In the intention-to-treat analysis, sputum culture conversion was reported in 23 patients (38.3%) in each group; the between-group difference was not statistically significant ($p = .269$). Some secondary outcomes, including radiographic change, favoured the homoeopathy group, but the primary bacteriological result did not establish an added effect. The authors called for larger studies. These findings should not be described as proof that homoeopathy improves TB cure or sputum conversion.

Tubercular lymphadenitis. Chand et al. (2011) described a retrospective exploratory series of 25 diagnosed cases. The reported approach combined an individualised constitutional medicine with *Tuberculinum* and *Silicea 6X*. Because the report was small, retrospective, and lacked a control group, it cannot determine whether homoeopathy caused the reported outcomes. It does not support replacing or modifying standard anti-tuberculosis treatment.

Post-treatment pulmonary impairment. Sharma and Sharma (2012) reported a placebo-controlled study in a conference-supplement abstract. The abstract described 118 participants who had completed anti-TB treatment within the previous five years, with 61 receiving individualised homoeopathy and 57 receiving placebo. It reported improvements in several pulmonary-function, symptom, weight, and quality-of-life measures. However, a conference abstract provides less information than a complete peer-reviewed trial report; the methods, outcome definitions, analysis, completeness of reporting, and risk of bias cannot be fully evaluated from the abstract alone. These results are hypothesis-generating and require independent replication.

PTLD context. Thoker et al. (2023) described clinical features and quality-of-life impairment among patients with post-pulmonary-TB sequelae. This study did not test homoeopathy. Evidence that PTLD is a clinically important condition is not evidence that a particular intervention is effective. Persistent or worsening symptoms require clinical assessment, including evaluation for active or recurrent TB when indicated, and appropriate respiratory care.

Homoeopathic theory and clinical interpretation

Traditional homoeopathic texts describe individualised remedy selection according to a person's reported symptoms and overall presentation (Hahnemann, 2005). The “tubercular miasm,” discussed in later homoeopathic writing, is a historical explanatory construct

within that tradition (Allen, 2003). Materia medica descriptions of remedies for cough or other respiratory symptoms document historical practice; they are not evidence of antimicrobial activity, eradication of *M. tuberculosis*, prevention of transmission, or prevention of lung damage. Remedy descriptions should therefore not be framed as validated TB treatment recommendations.

A distinction must be maintained between symptom reports and disease-modifying outcomes. TB requires prompt diagnosis and completion of a regimen selected according to current national guidance, drug susceptibility, clinical factors, and treatment response. WHO guidance describes evidence-based treatment and care for drug-susceptible and drug-resistant TB (WHO, 2025b). Homoeopathy must not delay diagnosis, interrupt prescribed medicines, or be represented as a substitute for anti-tuberculosis treatment.

Relevance to Northeast India and research priorities

Northeast India, including Meghalaya, is a relevant setting for locally grounded TB-service research. Geography, access to services, language, socioeconomic circumstances, and continuity of care may affect the patient journey. However, specific claims about district-level adolescent TB prevalence, treatment default, or the number of patients covered by state initiatives should only be included when supported by a directly relevant, independently verifiable official dataset or peer-reviewed source. Each statistic should specify its year, denominator, definition, and source. Claims from a preprint or news report should be labelled accordingly and should not be presented as settled findings.

Future research on any proposed adjunct should be conducted with TB-programme and respiratory-care teams, receive appropriate ethics approval, and be prospectively registered where applicable. Standard treatment must not be withheld or modified. Protocols should prespecify clinically meaningful outcomes, including microbiological results for active TB, adverse events, validated symptom measures, spirometry, functional capacity, and quality of life for PTLT. Adequate sample size, transparent allocation methods, blinded outcome assessment where feasible, complete reporting, and independent replication are important. Active TB and post-treatment impairment should be studied as distinct clinical populations.

Limitations

This review is limited by its narrative approach, the small number of clinical reports identified in the source manuscripts, reliance on a conference abstract for post-treatment pulmonary impairment, and the absence of a formal risk-of-bias assessment. The reports differ in design, population, intervention, and outcome measures, so their results cannot be pooled or regarded as a consistent body of evidence. Selection, measurement, and reporting biases are possible. This review cannot establish efficacy, safety, cost-effectiveness, or suitability for inclusion in a public TB programme.

CONCLUSION

Published clinical evidence on homoeopathy used alongside standard TB care is limited and inconclusive. In the principal randomised trial identified, the intention-to-treat analysis found no statistically significant difference between groups in sputum culture conversion. The tubercular lymphadenitis series and the post-treatment conference abstract are insufficient to establish a reliable treatment effect. On the basis of these reports, homoeopathy should not be recommended as a treatment for active TB or PTLT and must never replace, delay, or interfere with guideline-based care. Further independent, well-designed research could examine specific adjunctive questions, but the evidence reviewed here does not support routine adoption within TB programmes.

REFERENCES

- Allen, J. H. (2003). *The chronic miasms: Psora and pseudo-psora*. B. Jain Publishers.
- Chand, K. S., Manchanda, R. K., Mittal, R., Batra, S., Banavaliker, J. N., & De, I. (2014). Homeopathic treatment in addition to standard care in multidrug-resistant pulmonary tuberculosis: A randomized, double-blind, placebo-controlled clinical trial. *Homeopathy*, 103(2), 97–107. DOI: [10.1016/j.homp.2013.12.003](https://doi.org/10.1016/j.homp.2013.12.003)
- Chand, K. S., Manchanda, R. K., Batra, S., & Mittal, R. (2011). Homeopathy in the treatment of tubercular lymphadenitis (TBLN)—An Indian experience. *Homeopathy*, 100(3), 157–167. DOI: [10.1016/j.homp.2010.11.006](https://doi.org/10.1016/j.homp.2010.11.006)
- Hahnemann, S. (2005). *Organon of medicine* (6th ed.). B. Jain Publishers. (Original work published 1842)
- Sharma, S., & Sharma, N. (2012). P02.167. Long term evaluation of homeopathy on post treatment impairment of pulmonary tuberculosis. *BMC Complementary and Alternative Medicine*, 12(Suppl. 1), P223. doi: [10.1186/1472-6882-12-S1-P223](https://doi.org/10.1186/1472-6882-12-S1-P223)
- Thoker, Z. A., Madan, K., Mittal, S., Tiwari, P., Shah, T. H., Mohan, A., Hadda, V., & Guleria, R. (2023). Clinical profile and quality of life of patients with post-pulmonary tuberculosis sequelae presenting to a tertiary care hospital. *Cureus*, 15(3), Article

e36354. DOI: [10.7759/cureus.36354](https://doi.org/10.7759/cureus.36354)

- World Health Organization. (2025a). Global tuberculosis report 2025. <https://www.who.int/publications/i/item/9789240116924>
- World Health Organization. (2025b). WHO consolidated guidelines on tuberculosis: Module 4: Treatment and care. <https://www.who.int/publications/i/item/9789240107243>