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Individualized Homeopathic Treatment in Hyperthyroidism with Increased Anti-Thyroglobulin Levels: A Case Report

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ABSTRACT:

Hyperthyroidism is an endocrine disorder characterised by excessive secretion of thyroid hormone. Several metabolic disturbances and multiple organ involvement can be occurred due to this condition. Elevated thyroid autoantibody levels, particularly anti-thyroglobulin (Anti-Tg) and anti-thyroid peroxidase (Anti-TPO), are frequently detected in autoimmune hyperthyroidism (e.g., Graves' disease), though they are more prevalent in autoimmune hypothyroidism (Hashimoto's thyroiditis). This case report describes a 40-year-old female presenting with features of hyperthyroidism associated with reduced Thyroid Stimulating Hormone (TSH) levels and increased Anti-Thyroglobulin (Anti-Tg) levels, who had been receiving conventional treatment long-term, was subsequently prescribed individualized homeopathic medicine – *Phosphorus*, based on totality of symptoms and an intercurrent remedy, *Carcinosin,* the patient demonstrated significant clinical and biochemical improvement and the conventional treatment was also stopped in during subsequent follow-up visits. With improvements in the clinical symptoms and biochemical markers, the homeopathic approach, which emphasizes individualized treatment and minimal dosing, proved successful in managing the condition. This case report highlights the potential role of *homeopathy* in the treatment of hyperthyroidism and also in reducing the Anti-Tg levels.

KEYWORDS: Anti-thyroglobulin levels, Autoantibodies, Hyperthyroidism, *Homeopathy*, Thyroid stimulating hormone.

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INTRODUCTION:

Hyperthyroidism is defined as increased thyroid hormone synthesis and secretion from the thyroid gland and thyrotoxicosis is the clinical state of excessive circulating thyroid hormones, regardless of their source. Graves' disease, toxic nodular goiter, toxic adenoma, thyroiditis and iodine intoxication are the most common causes of hyperthyroidism [1]. The prevalence of thyroid disorders in India is approximately 10%. Prevalence and incidence increase with age, and women are affected more frequently than men [2]. Its global prevalence ranges from 0.2% to 1.3% [3]. Overt hyperthyroidism, characterized by suppressed thyrotropin (TSH) and elevated triiodothyronine (T3) and/or free thyroxine (FT4), affects approximately 0.2% to 1.4% of the population worldwide. Low concentration of thyrotropin and normal concentration of T3 and FT4 is called subclinical hyperthyroidism and it affects 0.7 % to 1.45% of people worldwide[4]. Increased levels of thyroid peroxidase (TPO) and thyroglobulin (Tg) antibodies occur in 80% of patients with hyperthyroidism[5,6]. Anxiety, insomnia, palpitations, unintentional weight loss, diarrhoea and heat intolerance are the most common symptoms of thyrotoxicosis. Thyroid function tests, TSH receptor antibodies, thyroid peroxidase and thyroglobulin antibodies, thyroid ultrasonography, and scintigraphy are the common diagnostic tests. In the majority of cases, the standard treatment includes beta blockers, radioactive iodine ablation, antithyroid medications and surgery[7]. Complications can be osteoporosis, heart disease, and increased mortality[4]. High recurrence rates after treatment are the major limitation of antithyroid treatment. The frequent development of permanent hypothyroidism is the major drawback of radioactive iodine ablation and thyroidectomy. Life-long thyroid hormone replacement therapy will be required for most of the patients [8].

Homeopathy is based on the principle of similia similibus curentur, proved effective in treating many endocrine disorders, including thyroid disorders. An individualized homeopathic approach offers a valuable role in the management of hyperthyroidism by addressing the underlying susceptibility, reducing symptom burden, and potentially improving long term outcomes without inducing permanent hypothyroidism. However, robust clinical evidence remains limited. This case report provides additional evidence highlighting the potential role of *homeopathy* in the treatment of hyperthyroidism and will be beneficial to conduct further research on this condition to prove its efficacy.

CASE HISTORY:

A 40-year-old female from Madamon, Pathanamthitta, Kerala, India presented to the Endocrinology OPD on 20/07/2023 with generalized weakness and recurrent headaches localized to the vertex, aggravated by travel and sun exposure. She also reported prominent, painless dilated veins over both legs. She had been diagnosed with hyperthyroidism for 5–6 years and was

on conventional treatment until July 2024. There was a past history of chickenpox in childhood and fibroadenoma in left breast surgically removed in 2016. Family history revealed thyroid disorder in a maternal aunt. Her appetite was low with early satiety, thirst diminished, and her thermal modalities indicated a 'chilly' constitution (preference for warmth, aggravation from cold). Her menstrual cycles were regular with mild lumbar pain, LMP – 26/06/2023 and had leucorrhea before menses. Emotionally, she was cheerful, content, and preferred company. On examination, vital signs were within normal limits. There was no swelling in the anterior part of neck.

Thyroid function tests on 14/03/2023 showed low TSH (0.01 µIU/ml) with normal Free T4 (0.83 ng/dl), suggestive of hyperthyroidism and the antibody levels which were checked later in the subsequent follow-up showed increased Anti-Tg level and normal Anti-TPO level (checked on 18/04/2024, Anti – Tg – 306 U/ml, Anti – TPO - < 9 U/ml).

THERAPEUTIC INTERVENTION:

After repertorization (figure 1), she was prescribed *Phosphorus* 30CH*,* two doses administered at two-week intervals, 1 dose/ 2 weeks on 20/07/2023, individualized to her mental and physical generals and in her monthly report, *Phosphorus* 30CH was repeated based on symptomatic improvement and later received *Phosphorus* 200CH as the symptom improvement plateaued and *Carcinosin* 200CH was prescribed once as an intercurrent remedy when the Anti-Tg levels were high. Thereafter *Phosphorus* 200CH was repeated on subsequent visits based on the symptomatological improvement and the biochemical markers showed normal levels. As the patient was under conventional treatment for hyperthyroidism, it was stopped within one year of treatment.

Table – 1: Timeline and Follow-up assessment

Date	Follow-Up	Prescription
31/08/2023	Weakness of whole body better Headache – persists < sun exposure Dilated veins on both legs persists as same Menses – regular, LMP – 20/08/2023, Previous LMP – 26/07/2023, flow - moderate for 2 days, Lumbar pain during menses, Generals – good	R_X *Phosphorus* 30CH/ 2D + *Saccharum lactis/* 2D (1-0-0) on alternate weeks
19/10/2023	Weakness of whole body persists Pain in right hip alternating with left hip occasionally Dilated veins on both legs persists as same Menses – regular, LMP – 30/09/2023, flow - moderate for 3 days, Lumbar pain during menses – better	R_X *Phosphorus* 30CH/1D + *Saccharum lactis/* 3D (1-0-0) once a week

	Hairfall present, Generals – good	
30/11/2023	Weakness of whole body better Pain in right hip alternating with left hip - nil Dilated veins on both legs persists as same Menses – regular, LMP – 30/10/2023, flow - moderate for 3 days, mild lumbar pain during menses Hairfall present, Generals – good	R_X *Phosphorus* 30CH/ 1D+ *Saccharum lactis/* 3D (1-0-0) once a week
25/01/2024	Weakness of whole body better Dilated veins on both legs persists Menses – regular, LMP – 30/12/2023, flow - moderate for 3 days. Hairfall present, Generals – good	R_X *Phosphorus* 30CH/ 1D + *Saccharum lactis/* 3D (1-0-0) once a week
18/04/2024	Stitching pain in right heel occasionally Weakness of whole body persists Hairfall – persists, Menses – regular Dilated veins on both legs persists Generals – good	R_X *Phosphorus* 200CH/ 2D + *Saccharum lactis/* 2D (1-0-0) on alternate weeks
11/07/2024	Stitching pain in right heel better Weakness of whole body persists Dilated veins on both legs persists Hairfall – persists, Menses - regular Generals – good Stopped allopathic medication of hyperthyroidism since 1 month	R_X *Carcinosin* 200CH/ 2D + *Saccharum lactis/* 2D (1-0-0) on alternate weeks
22/08/2024	Stitching pain in right heel better Dilated veins on both legs persists Weakness of whole body better Hairfall – persists, Menses - regular Generals – good	R_X *Phosphorus* 200CH/ 2D + *Saccharum lactis/* 2D (1-0-0) on alternate weeks
17/10/2024	Weakness of body better Pain in right heel – relieved Dilated veins on both legs persists Generals – good	R_X *Phosphorus* 200CH/ 2D + *Saccharum lactis/* 2D (1-0-0) on alternate weeks
23/01/2025	Dilated veins on both legs persists Generals – good	R_X *Phosphorus* 200CH/ 4D + *Saccharum lactis/* 4D (1-0-0) on alternate weeks
27/03/2025	Dilated veins on both legs persists Generals – good	R_X *Saccharum lactis/*4D (1-0-0)once a week Adviced to stop medications after 1 month and check for Anti Tg and Anti TPO levels review after 3 months

Table 2: Changes in biochemistry values

Date	T3(75–175 ng/dL)	Free T4 (0.7–1.63 ng/dl)	T4 (4–11 µg/dL)	TSH (0.2–4.5 mIU/L)	Anti Tg (<115U/ml or <4.11IU/ml)	Anti –TPO (<34U/ml or <9 IU/ml)
14/03/2023		0.83		0.01		
30/08/2023		0.91		0.86		
18/10/2023		0.94		0.95		
29/11/2023		0.92		1.65		
17/04/2024		0.94		0.45		
18/04/2024					306 U/ml	< 9 U/ml
10/07/2024		0.92		0.21		
22/01/2025	97.62		9.56	1.23	2.2 IU/ml	0.3 IU/ml
26/03/2025	88.33		9.79	1.01		
14/08/2025					2.2 IU/ml	0.4 IU/ml

Table 3: Assessment with Modified Naranjo criteria:

Domains	Score
1. Was there an improvement in the main symptom or condition for which the homeopathic medicine was prescribed?	+2
2. Did the clinical improvement occur within a plausible timeframe relative to the drug intake?	0
3. Was there an initial aggravation of symptoms?	0
4. Did the effect encompass more than the main symptom or condition (i.e., were other symptoms ultimately improved or changed)?	+1
5. Did overall well-being improve? (suggest using validated scale)	+1
6A Direction of cure: did some symptoms improve in the opposite order of the development of symptoms of the disease?	0
6B Direction of cure: did at least two of the following aspects apply to the order of improvement of symptoms: –from organs of more importance to those of less importance? –from deeper to more superficial aspects of the individual? –from the top downwards?	0
7. Did “old symptoms” (defined as non-seasonal and non-cyclical symptoms that were previously thought to have resolved) reappear temporarily during the course of improvement?	0
8. Are there alternate causes (other than the medicine) that—with a high probability— could have caused the improvement? (Consider known course of disease, other forms of treatment, and other clinically relevant interventions)	0
9. Was the health improvement confirmed by any objective evidence? (e.g., laboratory test, clinical observation, etc.)	+2
10. Did repeat dosing, if conducted, create similar clinical improvement?	+1
Total	7

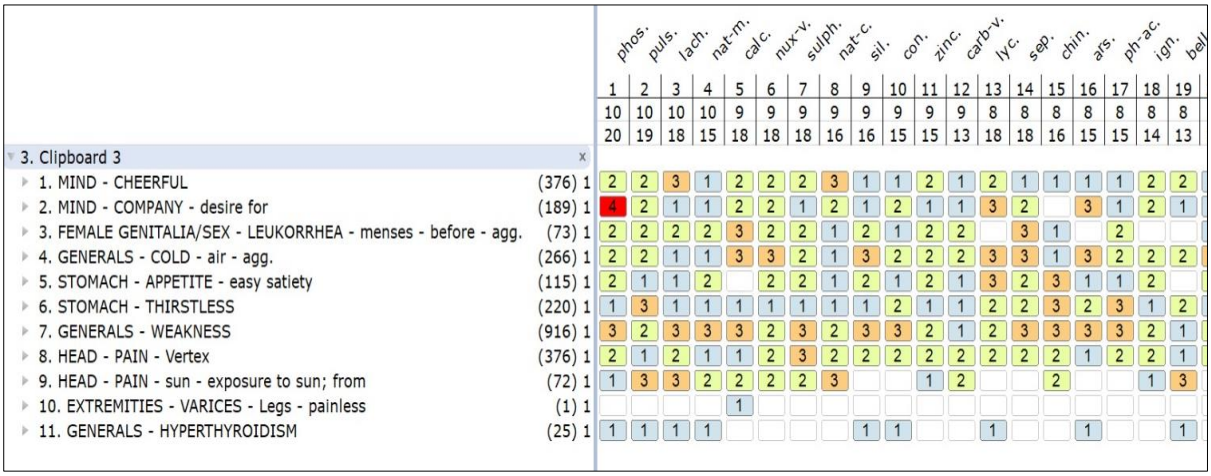
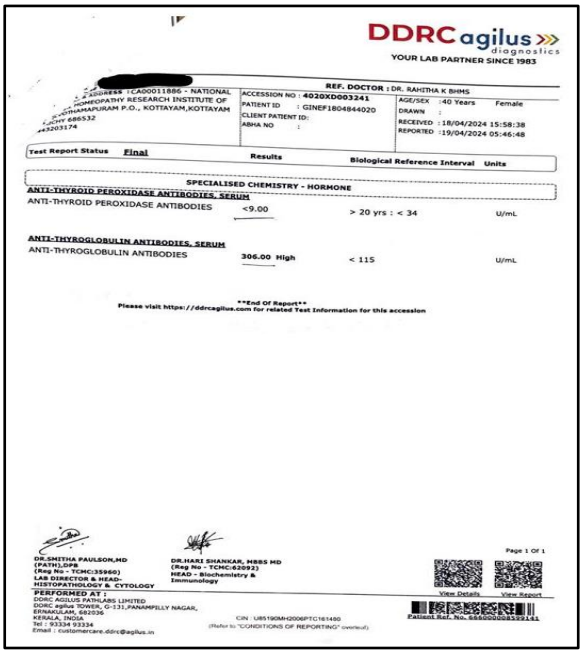


Figure 1: Repertorization chart using synthesis repertory

Figure - 2 Investigation on 30/8/2023

Figure – 3 Investigation on 17/04/2024



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REF. DOCTOR : DR. RAHITHA K BHMS
ACCESSION NO : 4020XD003241
PATIENT ID : GINEF1804844020
AGE/SEX : 40 Years Female
DRAWN :
RECEIVED : 18/04/2024 15:58:38
REPORTED : 19/04/2024 05:46:48

Test Report Status Final

Test	Results	Biological Reference Interval	Units
SPECIALISED CHEMISTRY - HORMONE			
ANTI-THYROID PEROXIDASE ANTIBODIES, SERUM			
ANTI-THYROID PEROXIDASE ANTIBODIES	<9.00	> 20 yrs : < 34	U/mL
ANTI-THYROGLOBULIN ANTIBODIES, SERUM			
ANTI-THYROGLOBULIN ANTIBODIES	306.00 High	< 115	U/mL

End Of Report
Please visit https://ddrcagilus.com for related Test Information for this accession

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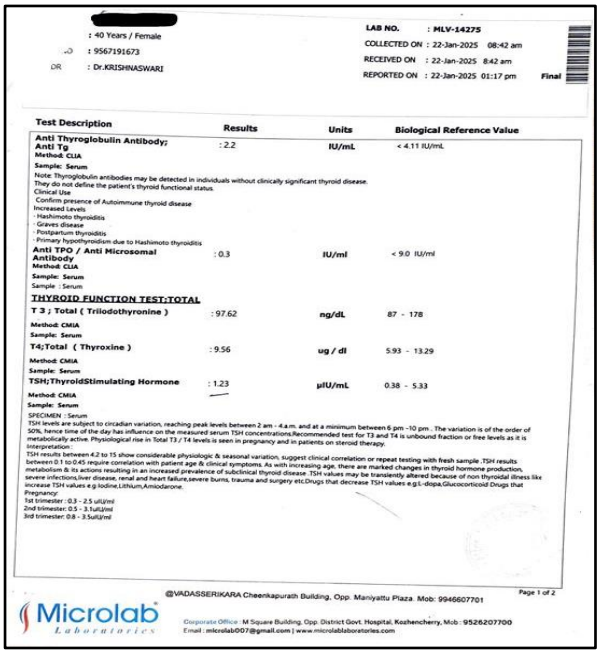
Figure – 4 Investigation on 18/04/2024



: 40 Years / Female
: 9567191673
DR : Dr.KRISHNASWARI

LAB NO. : MLV-14275
COLLECTED ON : 22-Jan-2025 08:42 am
RECEIVED ON : 22-Jan-2025 8:42 am
REPORTED ON : 22-Jan-2025 01:17 pm Final

Test Description	Results	Units	Biological Reference Value
Anti Thyroglobulin Antibody; Anti Tg	: 2.2	IU/mL	< 4.11 IU/mL
Method: CLIA			
Sample: Serum			
Note: Thyroglobulin antibodies may be detected in individuals without clinically significant thyroid disease. They do not define the patient's thyroid functional status.			
Clinical Use			
- Confirm presence of Autoimmune thyroid disease			
Increased Levels			
- Hashimoto thyroiditis			
- Graves disease			
- Postpartum thyroiditis			
- Primary hypothyroidism due to Hashimoto thyroiditis			
Anti TPO / Anti Microsomal Antibody	: 0.3	IU/ml	< 9.0 IU/ml
Method: CLIA			
Sample: Serum			
Sample : Serum			
THYROID FUNCTION TEST;TOTAL			
T 3 ; Total (Triiodothyronine)	: 97.62	ng/dL	87 - 178
Method: CMIA			
Sample: Serum			
T4;Total (Thyroxine)	: 9.56	ug / dl	5.93 - 13.29
Method: CMIA			
Sample: Serum			
TSH;ThyroidStimulating Hormone	: 1.23	µIU/mL	0.38 - 5.33
Method: CMIA			
Sample: Serum			

SPECIMEN : Serum
TSH levels are subject to circadian variation, reaching peak levels between 2 am - 4 a.m. and at a minimum between 6 pm -10 pm . The variation is of the order of 50%, hence time of the day has influence on the measured serum TSH concentrations.Recommended test for T3 and T4 is unbound fraction or free levels as it is metabolically active. Physiological rise in Total T3 / T4 levels is seen in pregnancy and in patients on steroid therapy.
Interpretation :
TSH results between 4.2 to 15 show considerable physiologic & seasonal variation, suggest clinical correlation or repeat testing with fresh sample .TSH results between 0.1 to 0.45 require correlation with patient age & clinical symptoms. As with increasing age, there are marked changes in thyroid hormone production, metabolism & its actions resulting in an increased prevalence of subclinical thyroid disease .TSH values may be transiently altered because of non thyroidal illness like severe infections,liver disease, renal and heart failure,severe burns, trauma and surgery etc.Drugs that decrease TSH values e.g:L-dopa,Glucocorticoid Drugs that increase TSH values e.g Iodine,Lithium,Amiodarone.
Pregnancy:
1st trimester : 0.3 - 2.5 uIU/ml
2nd trimester: 0.5 - 3.1uIU/ml
3rd trimester: 0.8 - 3.5uIU/ml

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Figure – 5 Investigation on 22/01/2025

: 40 Years / Female
: 9567191673

LAB NO. : MLV-16960
COLLECTED ON : 26-Mar-2025 08:49 am
RECEIVED ON : 26-Mar-2025 8:49 am
REPORTED ON : 26-Mar-2025 01:41 pm Final

Test Description	Results	Units	Biological Reference Value
THYROID FUNCTION TEST;TOTAL			
T 3 ; Total (Triiodothyronine)	: 88.33	ng/dL	87 - 178
Method: CMIA			
Sample: Serum			
T4;Total (Thyroxine)	: 9.79	ug / dl	5.93 - 13.29
Method: CMIA			
Sample: Serum			
TSH;ThyroidStimulating Hormone	: 1.01	µIU/mL	0.38 - 5.33
Method: CMIA			
Sample: Serum			

SPECIMEN : Serum
TSH levels are subject to circadian variation, reaching peak levels between 2 am - 4 a.m. and at a minimum between 6 pm -10 pm . The variation is of the order of 50%, hence time of the day has influence on the measured serum TSH concentrations.Recommended test for T3 and T4 is unbound fraction or free levels as it is metabolically active. Physiological rise in Total T3 / T4 levels is seen in pregnancy and in patients on steroid therapy.
Interpretation :
TSH results between 4.2 to 15 show considerable physiologic & seasonal variation, suggest clinical correlation or repeat testing with fresh sample .TSH results between 0.1 to 0.45 require correlation with patient age & clinical symptoms. As with increasing age, there are marked changes in thyroid hormone production, metabolism & its actions resulting in an increased prevalence of subclinical thyroid disease .TSH values may be transiently altered because of non thyroidal illness like severe infections,liver disease, renal and heart failure,severe burns, trauma and surgery etc.Drugs that decrease TSH values e.g:L-dopa,Glucocorticoid Drugs that increase TSH values e.g Iodine,Lithium,Amiodarone.
Pregnancy:
1st trimester : 0.3 - 2.5 uIU/ml
2nd trimester: 0.5 - 3.1uIU/ml
3rd trimester: 0.8 - 3.5uIU/ml

Verified by:
Leeba Saji
Senior Technologist, MSc. MLT

Authorized by:
Dr. Jiby Soosen Ninan
MD (pathology)

Kindly correlate clinically
Biological reference interval pertains to the age and sex of the patient
Given reference interval values pertain to Human samples only.

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Figure – 6 Investigation on 26/03/2025

RESULTS AND DISCUSSION:

This case report describes a patient diagnosed with Hyperthyroidism with increased anti-Tg levels who was managed with individualized homeopathic treatment over a period of 2 years and it demonstrated clinical improvement, including reduction in fatigue, no recurrent attacks of headache and decline in anti-Tg. Thyroid function tests (TSH, free T3, free T4) normalized during follow-up and the use of conventional thyroid hormone replacement therapy had been stopped within the period of one year of treatment. The remedies used- *Phosphorus*, was selected based on the totality of physical, emotional, and

constitutional symptoms and *Carcinosin,* given as an intercurrent remedy, in accordance with homeopathic principles of individualization.

Our observations are consistent with previous case report by Goem M et al., suggesting potential symptomatic relief and improvement in biochemical markers with individualized *homeopathy* treatment[9]. A case study by Divya Padmakumar et al, showing clinical and biochemical improvement in a case of hyperthyroidism treated with Calcarea carbonicum 10M provides an added evidence for our consistent results[10]. Another case reported by Ansar et al, illustrates the potential efficacy of individualized homeopathic treatment in autoimmune thyrotoxicosis, including Graves' disease. The observed resolution of clinical symptoms concomitant with the progressive normalization of thyroid function tests underscores the possibility of achieving biochemical and symptomatic remission through individualized *homeopathy* [11].

While robust randomized controlled trials remain limited, emerging evidence from observational studies supports the feasibility of homeopathic interventions in this condition. The observed reduction in thyroid antibody levels aligns with preclinical data indicating that homeopathic remedies may influence immune regulation.[12] One of the studies related to hyperthyroidism included in a comprehensive systematic review -Unveiling the Potential of Ultra-High Dilutions in Thyroid Disorder Management by Parth Aphale et al., suggested Phosphorus has a potential role in managing hyperthyroidism symptoms [13].

Phosphorus has been investigated in models of oxidative stress. Siqueira et al. found that *Phosphorus* 30C reduced oxidative stress markers in rat brain tissue, suggesting a potential role in mitigating tissue damage associated with autoimmune inflammation.[14] Rajan et al. demonstrated that *Carcinosin* 200CH modulated gene expression in human lymphoid cell lines, affecting pathways involved in immune response and apoptosis, suggesting a plausible mechanism for its role in autoimmune regulation. [15,16]

In this case report, individualized homeopathic remedies in potencies of 30CH, 200CH were administered. Clinical improvements were observed in thyroid function, symptom burden, and quality of life. The selection of higher potencies was guided by classical homeopathic principles, which suggest that chronic, systemic conditions may require deeper-acting remedies in higher dilutions.[17] These findings resonate with the theoretical premise that high potencies may exert more profound effects on chronic disease processes, though this remains a subject of debate.[18] However, some studies have achieved favorable outcomes with lower potencies. Walach et al. conducted a randomized controlled trial in thyroid disorders using predominantly 30CH potencies and reported significant improvement in fatigue and well-being scores, although no significant change in antibody levels was observed.[19] This suggests that lower potencies may alleviate subjective

symptoms, while higher potencies could potentially influence immunological parameters, a hypothesis supported by basic research on ultra-high dilutions showing bioactive effects.[20] The variability in potency selection across studies underscores the absence of standardized protocols in homeopathic research.

CONCLUSION:

This case report provides preliminary clinical evidence on the potential role of individualized homeopathic treatment in patients with hyperthyroidism with increased anti-Tg level. The patient demonstrated sustained symptomatic improvement and favourable changes in thyroid function and autoantibody profiles over 2 years. While these findings are encouraging, they must be interpreted with caution due to the inherent limitations of the case report. The observed outcomes may reflect a convergence of treatment effects, natural history, and contextual factors.

Further research particularly prospective cohort studies and randomized controlled trials with standardized outcome measures is necessary to evaluate the efficacy, safety, and mechanisms of *homeopathy* in Hyperthyroidism. Such studies should incorporate both patient-reported outcomes and biomarker-based assessments to build a robust evidence base for integrative approaches in this condition.

Limitations of the study:

This single case report limits statistical power and generalizability, therefore, further clinical trials and studies are required.

Acknowledgement

The authors are thankful to Dr. Debadatta Nayak, Officer-in-charge, Dr.Sitharthan.R, Principal, National Homoeopathy Research Institute in Mental Health, Kerala. They are also obliged to the patient for the valuable inputs.

Consent of the patient

Written informed consent was obtained from the patient for publication of results of the treatment.

Conflict of interest: The author declares that there is no conflict of interest.

Guarantor*:* The corresponding author is the guarantor of this article and its contents.

Source of support: None

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