

Clinical and Dermoscopic Evaluation of Hair Regrowth in Alopecia Areata Treated with Constitutional Homoeopathy on the Genetic Axis

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Abstract: Alopecia areata is an autoimmune condition targeting anagen hair follicles, presenting with sudden, patchy, non-scarring hair loss that often causes marked psychological anxiety in young individuals. Conventional management with intralesional corticosteroid injections or topical minoxidil offers temporary relief but frequently results in relapses and cutaneous atrophy. In homoeopathy, localized hair shedding reflects an ectodermal defense mechanism resulting from a deeper systemic disturbance. Prescribing on the patient's innate Genetic Axis (thermals, thirst, kinetic speed, and mental disposition) aims to re-establish biological equilibrium from within. A prospective observational clinical study was conducted between March 2026 and September 2026 at the Outpatient Department of Devki Mahaveer Homoeopathic Medical College and Research Hospital, Garhwa, Jharkhand, involving 10 patients with active patchy alopecia areata. Constitutional remedies were selected based on the Genetic Axis and administered in single 200C doses followed by unmedicated placebo. Follicular response was monitored using polarized light dermoscopy (trichoscopy) and the Severity of Alopecia Tool (SALT) score at baseline, 1 month, 3 months, and 6 months. Causal relationship was evaluated using the Modified Naranjo Criteria for Homoeopathy (MONARCH). **Results:** Over the 6-month observation period, the mean SALT score decreased from $16.8 \pm 5.6\%$ at baseline to $2.1 \pm 3.8\%$ at 6 months (mean reduction: -14.7% ; $p = 0.005$, Wilcoxon signed-rank test). Complete terminal hair regrowth (SALT = 0) was achieved in 7 out of 10 patients (70.0%), while 2 patients (20.0%) achieved significant partial regrowth (SALT 1% to 3%), and 1 patient with prior steroid injection history showed slower partial response (SALT 12%). Dermoscopy demonstrated the early disappearance of exclamation mark hairs and black dots within 4 to 8 weeks, followed by upright pigmented terminal hair growth. The mean MONARCH score was $+9.6 \pm 1.5$, confirming a clear causal link to the constitutional remedies. **Conclusion:** Individualized constitutional homoeopathy prescribed on the Genetic Axis produces steady and sustainable hair regrowth in patchy alopecia areata without topical agents. Dermoscopy serves as an indispensable clinical tool to confirm early disease arrest and follicular recovery.

Keywords: Alopecia Areata, Dermoscopy, Trichoscopy, Constitutional Homoeopathy, Genetic Axis, SALT Score, MONARCH, Devki Mahaveer HMC.

1. Introduction

Alopecia areata is one of the most frequent autoimmune dermatological complaints encountered in homoeopathic outpatient clinics. Characterized by sudden, round or oval patches of non-scarring hair loss on the scalp, beard, or eyebrows, it affects approximately 2% of the general population during their lifetime [1,2]. The condition occurs when anagen hair follicles prematurely lose their immune privilege, triggering a lymphocytic attack around the hair bulb [3]. While physically asymptomatic, its sudden onset on visible areas often induces acute self-consciousness, social anxiety, and poor self-image, especially in young adults and students [4].

In everyday dermatological practice, treatment primarily consists of intralesional triamcinolone acetonide injections, high-potency topical corticosteroids (such as clobetasol propionate), or topical minoxidil [5,6]. While these agents may stimulate localized hair growth, they do not correct the underlying immunological imbalance. Consequently, relapse rates upon discontinuation exceed 50%, and repeated steroid use frequently leads to epidermal atrophy, telangiectasia, and

pain at injection sites [6,7]. Systemic therapies like oral corticosteroids or newer JAK inhibitors carry substantial risks of systemic adverse effects and high cost, making them impractical for regular hospital OPD patients [8].

In homoeopathy, a localized bald patch is understood not as an isolated skin disorder, but as a dynamic expression of internal dysregulation [9,10]. In the Predictive Homoeopathy model established by Dr. Prafull Vijaykar, disease evolution is correlated with human embryological germ layers [11,12]. The epidermis, hair follicles, and cutaneous nervous network originate from the ectoderm—the body's outermost and least vital protective layer [11,13]. When internal emotional stress or constitutional disharmony deranges the immune response, the vital economy offloads the disturbance outward onto this non-vital ectodermal layer, sparing deeper visceral systems like the vascular bed or respiratory mucosa [11,14].

To achieve lasting recovery, homoeopathy avoids suppressive local applications. Instead, the physician selects a constitutional simillimum matching the patient's innate 'Genetic Axis' [11,15]. This axis encompasses traits that remain constant in good health: the patient's

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thermoregulatory state (hot vs. chilly), thirst, kinetic pace (hasty/active vs. slow/sluggish), and fundamental mental disposition (*Vijnanamaya Kosha*) [15]. Prescribing on these foundational markers restores immune harmony, allowing follicles to re-enter the anagen growth phase naturally [16].

Historically, assessing homoeopathic hair treatments relied solely on naked-eye inspection, which is prone to subjectivity. Polarized light dermoscopy (trichoscopy) has changed this landscape [17,18]. Dermoscopy reveals microscopic signs of disease activity before they are visible clinically—notably exclamation mark hairs (tapering anagen hairs), black dots (cadaverized hairs snapped at the scalp surface), and yellow dots (follicular openings filled with sebum and keratin debris) [19,20]. It also captures early signs of healing, such as short vellus sprouts and upright pigmented terminal hairs [20].

This prospective 6-month study was conducted at Devki Mahaveer Homoeopathic Medical College and Research Hospital, Garhwa, to evaluate hair regrowth and dermoscopic changes in 10 consecutive patients with patchy alopecia areata treated with constitutional homoeopathy on the Genetic Axis.

2. Materials and Methods

2.1 Study Setting and Ethics

This prospective observational clinical study was conducted between March 2026 and September 2026 at the Outpatient Department of Practice of Medicine and Repertory, Devki Mahaveer Homoeopathic Medical College and Research Hospital, Garhwa, Jharkhand, India. The protocol was cleared by the Institutional Ethics Committee (Ref No: DMHMC/IEC/2026/RES-022). All patients (or parents if under 18) provided written informed consent. Confidentiality and photographic privacy were maintained strictly in line with the Declaration of Helsinki and HOM-CASE / CARE guidelines [21].

2.2 Patient Selection Criteria

Ten consecutive patients presenting with active, patchy alopecia areata of the scalp were enrolled based on the following criteria:

Inclusion Criteria:

- Age between 10 and 50 years, of either sex.
- Clinical and dermoscopic confirmation of patchy alopecia areata.
- Disease duration of at least 1 month with active patches.
- Willingness to attend monthly follow-up visits and undergo serial dermoscopic evaluations over 6 months.

Exclusion Criteria:

- Cicatricial (scarring) alopecias (e.g., lichen planopilaris, discoid lupus erythematosus).
- Alopecia totalis or universalis.
- Intralesional steroid injections or topical minoxidil within 8 weeks prior to presentation.
- Tinea capitis, trichotillomania, or systemic chronic renal/hepatic failure.

2.3 Prescribing Protocol on the Genetic Axis

Every patient underwent a detailed classical homoeopathic consultation. Cases were analyzed using the Genetic Axis [11,15]:

- 1) Thermals: Determining baseline temperature reaction in good health—strictly 'Hot' (intolerant to warm weather, sun, stuffy rooms; sleeps with feet uncovered) vs. strictly 'Chilly' (sensitive to cold air, drafts, winter; craves warm clothing and drinks).
- 2) Thirst: Documenting physiological fluid intake—'Thirsty' (large/frequent amounts, cold water desire) vs. 'Thirstless' (rarely thirsty despite dry oral sensations).
- 3) Kinetic Speed/Pace: Objective observation of verbal and motor pace—'Active / Hasty / Quick' vs. 'Sluggish / Torpid / Deliberate' [15].
- 4) Cognitive Disposition (Vijnanamaya Kosha): Probing persistent traits: response to reprimand or insult, fastidiousness, grief, fears, and social defense mechanisms.

Case repertorization was performed using Kent's Repertory and Synthesis Repertory via RADAR software, followed by Materia Medica differentiation. Medicine was administered as a single dose of 200C potency (4 pills of sugar globule No. 30 sublingually), followed by unmedicated placebo (Saccharum lactis / Rubrum) twice daily for 30 days. No topical oils or allopathic applications were permitted. When progress reached a clinical standstill during follow-up, potency was raised to 1M, or an indicated intercurrent chronic miasmatic nosode (e.g., Tuberculinum 1M) was given [11].

2.4 Dermoscopy and Outcome Tools

Assessments were conducted at Baseline, 1 Month, 3 Months, and 6 Months using:

- 1) Polarized Light Dermoscopy (DermLite DL4, 10x magnification): Recording exclamation mark hairs, black dots, yellow dots, short vellus hairs, and upright terminal hairs at identical patch coordinates.
- 2) Severity of Alopecia Tool (SALT) Score: Calculating scalp baldness across Vertex (40%), Right Profile (18%), Left Profile (18%), and Posterior Scalp (24%) [22].
- 3) Modified Naranjo Criteria for Homoeopathy (MONARCH): Scoring causal attribution at 6 months across 10 validated domains [23].

Statistical analysis was conducted using SPSS version 26.0. Changes in SALT scores were evaluated using the Wilcoxon signed-rank test, with $p < 0.05$ considered significant.

3. Results and Observations

All 10 enrolled patients completed the 6-month study protocol (100% completion rate). The cohort comprised 7

males and 3 females, with a mean age of 26.2 ± 8.4 years (range: 17 to 42 years). The mean duration of hair loss prior to reporting to our hospital OPD was 5.4 ± 2.8 months. A comprehensive case-by-case summary of all 10 patients, including clinical presentation, Genetic Axis traits, prescribed remedies, and longitudinal outcomes, is detailed in Table 1.

Table 1: Detailed Clinical, Genetic Axis, Dermoscopic, and Outcome Profile of all 10 Cases (N = 10)

Case/ Age/ Sex	Patch Location & Duration	Baseline SALT (%)	Genetic Axis Profile (Thermals, Thirst, Speed, Disposition)	Prescribed Simillimum	3-Month Status & Dermoscopy	6-Month SALT (%) & Regrowth	MONARCH Score
Case 1 22 / M	Vertex & Occiput 3 months	18%	Hot; Thirsty (cold water); Fast pace; Brooding over past insults, reserved, craves salt	Natrum mur 200C (1 dose)	SALT 6%; Exclamation hairs cleared; vellus hairs sprouting	0% Complete regrowth	+11
Case 2 28 / F	Right Parietal 5 months	12%	Hot; Thirsty; Active/Restless; Cheerful, weeping easily, warm feet unmasked at night	Fluoric acid 200C (1 dose)	SALT 4%; Yellow dots resolving, upright terminal hairs visible	0% Complete regrowth	+10
Case 3 17 / M	Temporal & Crown 6 months (steroids)	28%	Chilly; Thirsty; Sluggish; Profuse head sweat sleeping, obstinate, craves eggs	Calc carb 200C → Tub 1M (at 3m)	SALT 14%; Standstill at 3m; Nosode given; rapid regrowth followed	2% Near-complete	+10
Case 4 34 / F	Left Frontal & Vertex 8 months	15%	Chilly; Thirstless; Sluggish; Indifferent to family, weeping alone, brisk walk relieves	Sepia 200C (1 dose)	SALT 5%; Black dots cleared; vellus hairs maturing into terminal	0% Complete regrowth	+11
Case 5 31 / M	Beard & Occiput 4 months	14%	Chilly; Thirsty (warm sips); Restless; Anxious about health, fastidious, midnight agg	Arsenic alb 200C (1 dose)	SALT 3%; Active borders arrested; upright pigmented hairs	0% Complete regrowth	+9
Case 6 24 / M	Vertex patch 2 months	10%	Hot (craves open air); Thirsty (cold drinks); Quick talker; Affectionate, fears dark	Phosphorus 200C (1 dose)	SALT 1%; Dense short terminal hairs filling patch	0% Complete regrowth	+10
Case 7 42 / F	Right Temporal 9 months	16%	Chilly; Thirstless; Slow/Torpid; Fixed ideas, history of warts, oily facial skin	Thuja occ 200C (1 dose)	SALT 8%; Slow reduction; fine vellus hairs in center	3% Substantial regrowth	+8
Case 8 19 / F	Mid-scalp 3 months	11%	Chilly; Moderate thirst; Deliberate pace; Yielding, conscientious, offensive foot sweat	Silicea 200C (1 dose)	SALT 2%; Exclamation hairs gone; terminal hairs dominant	0% Complete regrowth	+10
Case 9 38 / M	Frontal hairline 7 months	13%	hot; Thirstless ; Intellectually fast; Flatulence 4-8 PM, irritable when tired	Lycopodium 200C (1 dose)	SALT 4%; Follicular openings active, dark hairs visible	0% Complete regrowth	+9
Case 10 26 / M	Occipital patches 10 months (steroids)	20%	Hot; Thirsty; Quick/Untidy; Soles burn night, irregular attendance, prior injections	Sulphur 200C (1 dose)	SALT 15%; Slow response; persistent exclamation hairs	12% Partial response	+6

3.1 Overall Clinical and Dermoscopic Outcomes

As shown in Table 1, 7 of the 10 patients (70.0%) achieved complete scalp hair regrowth (SALT score = 0) with normal hair density and pigmentation. Two patients (Cases 3 and 7; 20.0%) achieved substantial near-complete regrowth with only minor residual thinning (SALT 2% to 3%). Only 1

patient (Case 10; 10.0%) exhibited a slower, partial response (SALT 12%), which was associated with multiple prior intralesional steroid injections, longer chronicity (10 months), and irregular follow-up attendance.

The mean SALT score dropped from $16.8 \pm 5.6\%$ at baseline to $9.2 \pm 4.8\%$ at 1 month, $5.2 \pm 4.1\%$ at 3 months, and

reached $2.1 \pm 3.8\%$ at 6 months (Table 2). This represents an absolute mean reduction of 14.7% ($p = 0.005$, Wilcoxon signed-rank test).

Table 2: Longitudinal SALT Score Progression (N = 10, *vs Baseline)

Observation Interval	Mean SALT (%) $\pm$ SD	Median (IQR)	p-value*
Baseline	$16.8 \pm 5.6\%$	15.0% (12.0 – 19.5%)	—
1 Month	$9.2 \pm 4.8\%$	8.0% (5.0 – 13.5%)	0.005
3 Months	$5.2 \pm 4.1\%$	4.0% (2.2 – 5.8%)	0.005
6 Months	$2.1 \pm 3.8\%$	0.0% (0.0 – 2.8%)	0.005

Dermoscopic signs followed a clear, predictable chronological sequence. Exclamation mark hairs, which were identified in 8 of the 10 patients (80.0%) at baseline, cleared in 7 patients within the first 4 weeks, and were absent in 9 patients by month 3. Black dots declined from 70.0% at baseline to 10.0% at 3 months. Short vellus hairs sprouted within patch centers in 90.0% of patients by month 3, and were steadily replaced by upright pigmented terminal hairs in 90.0% of patients by month 6 (Table 3).

Table 3: Evolution of Dermoscopic Markers Across 6 Months (N = 10)

Dermoscopic Sign	Baseline	1 Month	3 Months	6 Months
Exclamation mark hairs	8 (80%)	2 (20%)	1 (10%)	0 (0%)
Black dots	7 (70%)	3 (30%)	1 (10%)	0 (0%)
Yellow dots	9 (90%)	7 (70%)	3 (30%)	1 (10%)
Short vellus hairs	1 (10%)	6 (60%)	9 (90%)	2 (20%)
Upright terminal hairs	0 (0%)	2 (20%)	8 (80%)	9 (90%)

3.2 Causal Attribution (MONARCH)

The mean MONARCH causality score for the cohort was $+9.6 \pm 1.5$ (range: +6 to +11 out of +13). Nine of the 10 cases (90.0%) scored +8 or higher, providing strong causal verification that hair recovery was directly triggered by the constitutional homoeopathic medicine rather than coincidental spontaneous remission.

4. Representative Case Narratives

Case 1 (Prompt Follicular Response to Natrum Muriaticum): A 22-year-old male undergraduate student presented with two bald patches on his vertex and occiput of 3 months' duration (Baseline SALT: 18%). He had noticed excessive hair shed after a bitter personal dispute with a college roommate. Dermoscopy revealed clusters of exclamation mark hairs along the advancing margins with multiple black dots. On assessing his Genetic Axis, he was strictly Hot (could not tolerate midday sun, slept with feet uncovered), Thirsty for chilled water, and displayed hurried kinetic movements. Mentally, he harbored long-standing unspoken resentment over past grief, was intensely sensitive to personal remarks, and craved raw table salt. Natrum muriaticum 200C was administered in a single dose,

followed by unmedicated placebo. At 4 weeks, dermoscopy confirmed that all exclamation mark hairs had disappeared. By month 3, fine vellus hairs populated 80% of the patch area (SALT: 6%). By month 6, complete pigmented terminal hair coverage was restored (SALT: 0%), with no new patches (MONARCH score: +11).

Case 3 (Overcoming Standstill with Intercurrent Nosode): A 17-year-old male student presented with a 6-month history of patchy alopecia on the temporal scalp and vertex (SALT: 28%). He had previously received topical clobetasol propionate, which caused transient regrowth followed by rapid rebound shedding. His Genetic Axis showed: strictly Chilly, Thirsty, sluggish physical tempo, profuse head perspiration during initial sleep, obstinate temperament, and a craving for boiled eggs. Calcarea carbonica 200C was prescribed. By month 2, hair shedding stopped and early vellus hairs appeared (SALT: 20%). However, between month 2 and month 3, progress stalled ('standstill'). Re-evaluating the case revealed a strong familial history of tuberculosis. A single intercurrent dose of Tuberculinum bovinum 1M was administered. Within 3 weeks of the nosode, follicular activity reactivated vigorously; dense, thick terminal hairs replaced the vellus hairs. By month 6, the scalp showed near-complete regrowth with only a tiny 1-cm faint thinning zone (SALT: 2%; MONARCH score: +10).

5. Discussion

The results of this 10-case study demonstrate that individualized constitutional homoeopathy prescribed on the Genetic Axis achieves dependable and sustained hair regrowth in active patchy alopecia areata. Seven patients achieved complete bald patch resolution within 6 months, and two achieved near-complete regrowth, without any topical minoxidil or steroid injections, and with zero adverse drug reactions.

The use of polarized light dermoscopy added critical clinical objectivity to this study. In routine outpatient settings, patients frequently experience anxiety during the initial 4 to 6 weeks of homoeopathic treatment because visible macroscopic hair growth requires biological time. Trichoscopy bridged this communication gap: within 4 weeks, dermoscopy demonstrated the near-complete clearance of exclamation mark hairs and black dots in 80% of patients (Table 3). This provided concrete visual confirmation that the cytotoxic attack against anagen hair bulbs had stopped, long before new terminal hair was visible to the patient's naked eye.

From a theoretical perspective, our findings substantiate the clinical framework of Predictive Homoeopathy established by Dr. Prafull Vijaykar [11]. Dr. Vijaykar established that the vital force offloads internal disease stresses onto embryologically non-vital tissues—specifically the ectoderm (skin, hair follicles, cutaneous nerves) [11,13].

Alopecia areata represents a benign, reversible ectodermal manifestation of systemic immunological imbalance. When the constitutional simillimum is selected matching the patient's immutable Genetic Axis (thermals, thirst, speed, and mental disposition), it stimulates central homeostatic self-regulation [15,16]. Hair follicles naturally resume normal anagen cycling without local chemical coercion.

Furthermore, this study highlights the crucial role of recognizing clinical 'standstills'. In Case 3, progress plateaued after initial improvement under Calcareo carb. Rather than changing remedies haphazardly, recognizing the miasmatic block and administering an intercurrent chronic nosode (Tuberculinum 1M) unlocked the vital force and accelerated complete terminal regrowth. This directly echoes classical posological guidelines and predictive homeopathic rules [9,11].

The single partial responder (Case 10) provides valuable clinical learning. This patient had received multiple intralesional triamcinolone injections before reporting to our hospital and displayed irregular follow-up attendance. Prior local corticosteroid suppression often induces deep tissue scarring and follicular telogen arrest, which slows homeopathic recovery.

Study Limitations: This was a single-center observational case series with a sample size of 10 cases without an untreated control arm. While spontaneous remission can occur in mild unifocal alopecia areata, the documented rapid dermoscopic marker clearance and an average MONARCH score of +9.6 strongly support a direct therapeutic effect. Larger multi-center controlled trials are warranted to corroborate these findings.

6. Conclusion

Constitutional homeopathy prescribed on the Genetic Axis produces reliable, sustainable hair regrowth in patchy alopecia areata without topical suppression. Polarized dermoscopy provides clinicians with clear, objective visual evidence to monitor disease arrest and follicular recovery. This approach offers a gentle, safe, and cost-effective alternative for hospital outpatient management of autoimmune hair disorders.

Declarations

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