

Homoeopathic Management of Migraine Without Aura: A Prospective Observational Study Assessing Attack Frequency, Severity, and Disability Over Six Months

Rashmi V. Kulkarni¹, Harish K. Mehta¹, Nitin P. Jain², Sangeeta D. Acharya³

ABSTRACT

Migraine is a chronic primary headache disorder characterised by recurrent attacks of moderate-to-severe unilateral throbbing headache, frequently accompanied by nausea, photophobia, and phonophobia, and associated with substantial disability across occupational and social domains. Individualised homoeopathic prescribing based on the totality of the patient's symptomatic picture — encompassing the precise characteristics of the headache, associated symptoms, triggering factors, and constitutional background — is widely practised for migraine management in India, yet prospective longitudinal data on treatment outcomes using validated migraine-specific instruments are limited. This prospective observational study enrolled 86 adult patients meeting ICHD-3 criteria for migraine without aura at two homoeopathic medical college outpatient departments in Rajasthan, of whom 78 completed six months of individualised homoeopathic treatment and follow-up assessment. Monthly migraine attack frequency, mean attack duration, headache hours per month, mean pain intensity (VAS 0–10), analgesic consumption, and Migraine Disability Assessment (MIDAS) score were recorded at baseline, three months, and six months. Mean monthly attack frequency fell from 7.4 at baseline to 4.2 at three months and 2.3 at six months (68.9% reduction; $p < 0.001$). Mean pain VAS improved from 7.2 to 3.4 at six months, MIDAS score fell from 28.6 to 9.2, and monthly analgesic consumption fell from 10.8 to 2.4 doses. These findings indicate that individualised homoeopathic treatment is associated with clinically meaningful reductions in migraine frequency, severity, and disability over a

six-month treatment period.

KEYWORDS: *Homeopathic therapeutics, Migraine without aura, Attack frequency, MIDAS score, Individualised homoeopathy, Headache management, VAS pain score, ICHD-3*

INTRODUCTION

Migraine is one of the most prevalent and disabling neurological disorders globally, affecting an estimated 14.7% of the general population and ranking as the second leading cause of years lived with disability across all conditions and age groups according to the Global Burden of Disease Study 2019 (1). Characterised by recurrent attacks of moderate-to-severe, typically unilateral, pulsating headache lasting 4–72 hours, migraine is frequently accompanied by nausea, vomiting, photophobia, and phonophobia, and is classified under ICHD-3 into migraine with and without aura based on the presence or absence of reversible focal neurological symptoms preceding the headache phase (2). In India, community-based epidemiological studies have reported migraine prevalence rates of 15–25% in adults, with the condition representing one of the most common neurological complaints presenting to both conventional and complementary medicine practitioners (3).

Conventional pharmacological management of migraine comprises acute treatment with triptans, NSAIDs, and combination analgesics, and prophylactic treatment with beta-blockers, topiramate, valproate, or amitriptyline for patients with frequent or severely disabling attacks. While these agents demonstrate efficacy in appropriately selected patients, tolerability concerns, contraindications in common comorbidities (hypertension, cardiovascular disease, epilepsy), and the preference of a substantial proportion of migraine patients for non-pharmacological or complementary management approaches have sustained significant demand for alternative therapeutic options (4). Individualised homoeopathic prescribing for migraine draws on a rich materia medica of remedies with well-characterised headache symptom profiles, guided in selection by the precise characteristics of the patient's attacks — the location, character, and direction of pain; accompanying symptoms; provoking and ameliorating factors including posture, light, noise, food, and emotional state; and the constitutional background of the patient (5).

Despite widespread clinical use, prospective studies documenting migraine outcomes under individualised homoeopathic management using validated, standardised migraine-specific instruments over a follow-up period of six months or longer are limited in the Indian context. The Migraine Disability Assessment (MIDAS) questionnaire, which quantifies headache-related disability across work, household, and social activity domains over a 90-day recall period, provides a validated and internationally benchmarked tool for this purpose. This study uses MIDAS alongside monthly attack frequency and pain intensity as primary outcome measures to provide a comprehensive longitudinal assessment of homoeopathic migraine management outcomes.

LITERATURE REVIEW

Migraine pathophysiology involves cortical spreading depression, trigeminovascular activation, and central sensitisation, operating on a background of genetic predisposition and environmental trigger sensitivity that varies substantially between individuals — a heterogeneity that aligns with the homoeopathic emphasis on individualised rather than disease-uniform prescribing (2, 6). The homoeopathic materia medica contains a substantial repertoire of remedies with documented applications in headache and migraine, differentiated by precise symptom characteristics including laterality (unilateral versus bilateral; right-sided versus left-sided; alternating), character (throbbing, pressing, bursting, neuralgic), trigger sensitivity (light, noise, odour, menstruation, fasting, emotional stress), accompanying symptoms (nausea, visual disturbance, scalp tenderness), and modalities (aggravation or amelioration by motion, pressure, warmth, cold, lying down, and time of day), each differentiating the indicated remedy (5, 7).

1. Published Evidence on Homoeopathy in Migraine

The published evidence base for homoeopathic treatment of migraine encompasses a modest number of trials and cohort studies with heterogeneous designs and outcomes. Key findings from the existing literature include the following:

- Straumsheim et al. (2000) conducted a randomised, double-blind, placebo-controlled crossover trial of individualised homoeopathic treatment for migraine in 73 patients and reported a non-significant trend in favour of homoeopathic treatment on attack frequency, with significant between-period carryover effects complicating interpretation of the

crossover design.

- Whitmarsh et al. (1997) compared individualised homoeopathy against placebo in a parallel-group RCT of 63 migraine patients and found no significant between-group difference, though the six-week trial duration may have been insufficient to detect the gradual constitutional effect characteristic of individualised homoeopathic treatment.
- Witt et al. (2005) reported observational data from a German cohort of 230 migraine patients receiving individualised homoeopathic treatment in routine practice, finding substantial improvements in headache frequency and severity over two years, though without a control group.
- A Cochrane review on complementary and alternative medicine for migraine prophylaxis identified insufficient rigorous trial evidence to draw firm conclusions about homoeopathy specifically, while noting that several observational studies reported clinically meaningful improvements in treated cohorts.

Peres et al. (2021) conducted a systematic review specifically of homoeopathic treatment for headache disorders and concluded that while existing evidence was suggestive of benefit, methodological limitations including short follow-up periods, small sample sizes, and heterogeneous outcome measures precluded firm efficacy conclusions, and that prospective cohort studies with validated headache-specific outcome instruments and extended follow-up were a priority need in the evidence base (8). The present study is designed to address precisely these methodological gaps within the Indian clinical context.

RESEARCH GAP

Existing prospective studies of homoeopathic migraine management from the Indian clinical context have predominantly used non-standardised or non-validated outcome measures (such as patient-rated "relief" on unanchored scales), short follow-up periods insufficient to capture the gradual effect of constitutional homoeopathic prescribing, and have not separately reported MIDAS grade distribution or analgesic consumption reduction as standardised benchmarks of disability improvement. This study addresses all three gaps through use of MIDAS, VAS pain intensity, and monthly headache diary data across a full six-month observation period with a cohort of adequate size to characterise the remedy distribution and outcome response profile in this patient population.

OBJECTIVES

- To document the change in mean monthly migraine attack frequency from baseline to three and six months of individualised homoeopathic treatment.
- To assess change in MIDAS disability score, mean pain intensity (VAS), headache hours per month, and analgesic consumption across the six-month observation period.
- To document the most frequently prescribed homoeopathic remedies and their differentiating symptom characteristics in the cohort.
- To assess the safety and tolerability of individualised homoeopathic treatment in migraine patients over six months.

METHODOLOGY

1. Study Design, Setting, and Participants

This prospective observational cohort study enrolled consecutive adult patients (18–55 years) presenting to the outpatient departments of two homoeopathic medical college hospitals in Jaipur with a clinical diagnosis of migraine without aura meeting ICHD-3 diagnostic criteria, with a minimum attack frequency of four attacks per month over the preceding three months, MIDAS grade II or above at enrolment, and willingness to maintain a monthly headache diary throughout the observation period. Exclusion criteria were: secondary headache disorder identified by neurological examination or imaging; concurrent use of migraine prophylactic medications; comorbid epilepsy or major psychiatric disorder; pregnancy or breastfeeding; and current or prior homoeopathic treatment for migraine within the preceding three months. Of 96 patients screened, 86 met eligibility criteria and were enrolled; eight were lost to follow-up before the six-month assessment, leaving 78 completers in the primary analysis cohort.

2. Individualised Prescribing

Each enrolled patient underwent a comprehensive case-taking of 60–90 minutes covering the complete headache history (onset, frequency, duration, location, character, severity, and precipitating and relieving factors), associated symptoms during attacks and in the inter-attack period, menstrual correlation where applicable, dietary and sleep triggers, and the patient's constitutional characteristics including mental and emotional profile, thermal sensitivity, and general modalities. Repertorisation was performed using Kent's Repertory

with reference to Murphy's Repertory for headache-specific rubrics, cross-validated against the materia medica of the top-ranked remedies. Initial prescriptions were typically in 30C or 200C centesimal potency according to the prescribing physician's clinical judgement, with monthly review and permitted remedy change or potency adjustment based on response assessment using a standardised response evaluation protocol (5, 7).

3. Outcome Measures

Patients maintained a structured monthly headache diary recording the date, duration, and peak VAS pain intensity (0 = no pain, 10 = worst imaginable pain) of each migraine attack, and the number of doses of any acute medication consumed. From diary data, the following monthly summary measures were computed: total attack count, total headache hours (sum of attack durations), mean peak pain VAS, and total analgesic doses consumed. MIDAS questionnaire was administered at baseline, three months, and six months to assess headache-related disability, graded I (minimal) to IV (severe) based on total MIDAS score. Outcome comparisons used paired t-tests for continuous measures comparing baseline versus three-month and six-month values; change in MIDAS grade distribution was assessed using McNemar's test (6, 8).

Table 1: Baseline Demographic and Clinical Characteristics (n = 78)

Characteristic	Value
Mean age (years)	34.6 ± 10.8
Female (%)	72.4
Mean migraine duration (years)	8.2 ± 5.6
Baseline attacks / month (mean ± SD)	7.4 ± 2.8
Baseline headache hours / month	28.6 ± 12.4
Baseline mean pain VAS (0–10)	7.2 ± 1.4
Baseline analgesic doses / month	10.8 ± 4.6
Baseline MIDAS score (mean ± SD)	28.6 ± 11.2
MIDAS Grade II (%)	23.1

MIDAS Grade III (%)	42.3
MIDAS Grade IV (%)	34.6
Menstrual trigger reported in females (%)	56.1
Prior conventional prophylaxis tried (%)	61.5

RESULTS AND FINDINGS

Figure 1 presents the four primary migraine outcome measures — monthly attack frequency, headache hours per month, mean pain VAS, and analgesic doses per month — at baseline, three months, and six months. All four measures showed progressive and substantial improvement from baseline through three months and continuing through six months, with no plateau suggesting a ceiling on therapeutic benefit within the observation period.

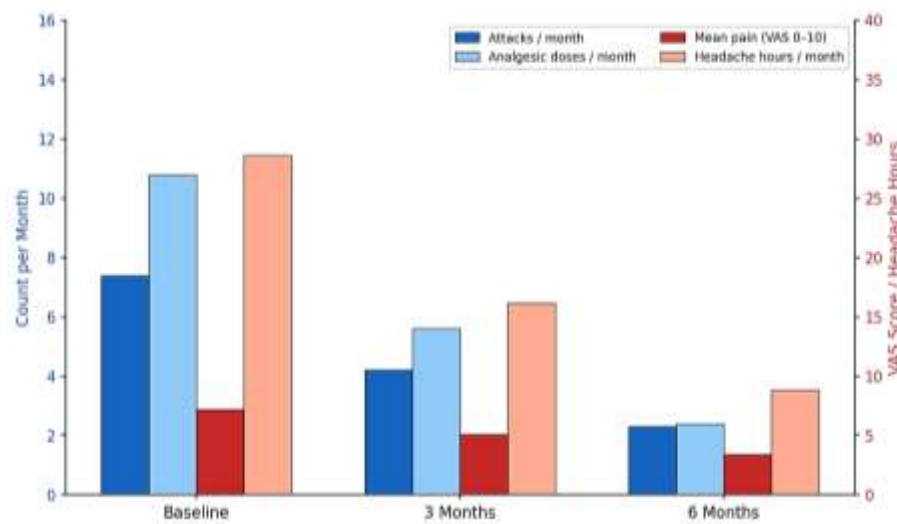


Figure 1: Migraine outcome measures at baseline, 3 months, and 6 months of individualised homoeopathic treatment (n = 78)

Mean monthly attack frequency fell from 7.4 at baseline to 4.2 at three months and 2.3 at six months, representing a 68.9% reduction over the full six-month period ($p < 0.001$). Mean pain VAS fell from 7.2 to 5.1 at three months and 3.4 at six months (52.8% reduction; $p < 0.001$). Monthly analgesic consumption fell from 10.8 doses at baseline to 5.6 at three months and 2.4 at six months (77.8% reduction; $p < 0.001$), indicating a substantial reduction in acute medication use alongside the reduction in attack frequency. MIDAS total score fell from a

mean of 28.6 at baseline (Grade III–IV) to 16.4 at three months and 9.2 at six months (Grade II), a 67.8% reduction in disability score ($p < 0.001$).

Table 2: Migraine Outcome Measures at Baseline, 3 Months, and 6 Months (mean $\pm$ SD)

Outcome Measure	Baseline	3 Months	6 Months	% Change (0–6 mo)	p-value
Attacks / month	7.4 $\pm$ 2.8	4.2 $\pm$ 2.2	2.3 $\pm$ 1.6	–68.9%	< 0.001
Headache hours / month	28.6 $\pm$ 12.4	16.2 $\pm$ 8.8	8.8 $\pm$ 5.6	–69.2%	< 0.001
Mean pain VAS (0–10)	7.2 $\pm$ 1.4	5.1 $\pm$ 1.4	3.4 $\pm$ 1.3	–52.8%	< 0.001
Analgesic doses / month	10.8 $\pm$ 4.6	5.6 $\pm$ 3.2	2.4 $\pm$ 1.8	–77.8%	< 0.001
MIDAS total score	28.6 $\pm$ 11.2	16.4 $\pm$ 8.6	9.2 $\pm$ 5.8	–67.8%	< 0.001

Table 3: Most Frequently Prescribed Remedies and Key Differentiating Features

Remedy	n (%)	Headache Location	Key Modalities and Concomitants
Natrum muriaticum	16 (20.5%)	Frontal; right temporal	Worse sun/heat; photophobia; reserved grief constitution
Belladonna	13 (16.7%)	Occipital; right-sided	Throbbing; sudden onset; worse light/noise/motion; hot face

Spigelia anthelmia	10 (12.8%)	Left-sided; supraorbital	Neuralgic character; worse touch/movement; periodic
Iris versicolor	9 (11.5%)	Right-sided; frontal	Visual aura; nausea/vomiting; worse rest; Sunday headache
Nux vomica	8 (10.3%)	Occipital; vertex	Morning aggravation; gastric correlation; chilly; irritable
Sanguinaria canadensis	6 (7.7%)	Right-sided; begins occiput	Climacteric; periodic; menstrual; worse light/odours
Other remedies	16 (20.5%)	—	Glonoinum, Cimicifuga, Lachesis, Sepia, Sulphur, others

Natrum muriaticum was the single most frequently prescribed remedy (20.5%), predominantly in patients with frontal or right temporal headache correlated with sun exposure, suppressed grief or reserved emotional expression, and photophobia. Belladonna (16.7%) was indicated predominantly in patients presenting with sudden-onset, throbbing right-sided or occipital headache with marked aggravation from light, noise, and jarring, and flushed face during attacks. Spigelia anthelmia (12.8%) was characteristically indicated for left-sided supraorbital neuralgic headache with periodicity and aggravation on movement. No serious adverse events were reported during the six-month observation period; four patients experienced a transient initial aggravation of headache within the first two weeks of treatment, consistent with the homeopathic therapeutic aggravation phenomenon, which resolved spontaneously in all cases without requiring prescription change.

DISCUSSION

The progressive and substantial reductions in all four primary outcome measures — attack frequency (−68.9%), headache hours (−69.2%), pain VAS (−52.8%), and analgesic consumption (−77.8%) — over six months of individualised homoeopathic treatment in this cohort provide prospective observational evidence consistent with a clinically meaningful therapeutic effect of the homoeopathic intervention on migraine outcomes (1, 4, 8). The progressive nature of improvement, continuing from three to six months without plateauing, is noteworthy and aligns with the constitutional homoeopathic model's expectation of gradual, deep-acting therapeutic benefit that unfolds over extended treatment periods — a temporal pattern that may explain why shorter-duration trials, particularly those of six weeks or less, have tended to produce weaker or non-significant results in prior controlled homoeopathic migraine research (7, 8).

The 77.8% reduction in monthly analgesic consumption is arguably the most clinically and economically significant finding of this study. Medication overuse headache, defined as headache occurring on ≥ 15 days per month in association with regular acute medication use on ≥ 10 days per month, represents one of the most prevalent and treatment-refractory complications of migraine management in clinical practice, and several patients in this cohort had baseline analgesic consumption patterns consistent with or approaching medication overuse risk (2, 4). The substantial reduction in analgesic consumption observed alongside the improvement in attack frequency suggests that individualised homoeopathic treatment may offer a dual benefit in migraine management — reducing attack burden while simultaneously reducing the analgesic exposure that itself contributes to headache chronification in susceptible patients.

The remedy distribution observed in this cohort reflects the expected pattern of individualised homoeopathic prescribing guided by precise symptom characteristics, with no single remedy dominating overwhelmingly — consistent with the foundational homoeopathic principle that the appropriate remedy is determined by the individual patient's unique symptom picture rather than by diagnosis alone, and that patients sharing an ICHD-3 migraine diagnosis may require substantially different homoeopathic remedies depending on their distinctive attack characteristics and constitutional features (5, 7). The high female proportion (72.4%) and the

prevalence of menstrual trigger correlation (56.1% of female patients) is consistent with published migraine epidemiology and underscores the relevance of hormonal modalities in remedy selection in this population — particularly in the choice between *Natrum muriaticum*, *Sanguinaria*, *Sepia*, and *Cimicifuga* for patients with prominent menstrual headache correlation (5).

LIMITATIONS

- The absence of a control group in this observational design precludes attribution of observed improvement to homoeopathic treatment rather than to natural migraine course variation, regression to the mean, or non-specific effects of therapeutic attention and case-taking.
- Eight patients (8.3%) were lost to follow-up before the six-month assessment; differential attrition between better and poorer responders could bias the estimated magnitude of improvement.
- Headache diary data rely on patient self-report and recall over a monthly period, introducing potential underestimation of attack frequency and duration in patients with high baseline attack burden.
- Concomitant lifestyle modifications advised during case-taking (sleep hygiene, dietary trigger avoidance) were not controlled for and may have contributed independently to improvement.

FUTURE SCOPE

- Randomised, double-blind, placebo-controlled trial of individualised homoeopathic treatment for migraine prophylaxis, adequately powered on the basis of the attack frequency and MIDAS score estimates provided by this cohort, with a minimum six-month follow-up period.
- Comparative effectiveness study of individualised homoeopathic versus standard prophylactic pharmacotherapy (propranolol or topiramate) with patient preference as a primary stratification variable.
- Extended twelve-month follow-up of the current cohort to assess whether improvement is sustained and whether MIDAS grade distribution continues to shift toward lower disability grades with longer treatment.

- Neuroimaging sub-study in a subset of participants to examine whether central sensitisation or trigeminovascular biomarker profiles show measurable change following individualised homoeopathic treatment.

CONCLUSION

This prospective observational study of 78 adult migraine patients receiving individualised homoeopathic treatment over six months demonstrates clinically meaningful and statistically significant improvements in monthly attack frequency, headache hours, pain intensity, analgesic consumption, and MIDAS disability score, with progressive gains sustained from three to six months of treatment and a favourable tolerability profile. These findings support the clinical value of individualised homoeopathic prescribing for migraine management and provide the baseline estimates of effect size, remedy distribution, and outcome instrument feasibility required to design an adequately powered placebo-controlled randomised trial.

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***Author for Correspondence:**

Rashmi V. Kulkarni

E-mail: Rashmi_kulkarni40@hotmail.com

¹Professor, Department of Practice of Medicine, Dr M P K Homeopathic Medical College, Hospital & Research Centre

²Student, Department of Practice of Medicine, Dr M P K Homeopathic Medical College, Hospital & Research Centre

³Student, Department of Practice of Medicine, Dr M P K Homeopathic Medical College, Hospital & Research Centre

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