

Individualized Homoeopathic Approach to Diabetic Foot Ulcer: A Case Report of Clinical Progression and Outcome

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Abstract—Introduction

Diabetic foot ulceration is a serious complication of diabetes mellitus resulting from the interaction of peripheral neuropathy, vascular impairment, mechanical stress, impaired tissue repair and infection. Severe ulcers require systematic assessment and multidisciplinary management because progression to deep infection, osteomyelitis and amputation may occur. This simulated case describes the clinical course of a severe diabetic foot ulcer managed with individualized homoeopathic treatment alongside appropriate standard wound care.

Case Presentation

A 54-year-old male with a 12-year history of type 2 diabetes mellitus presented with a non-healing ulceration over the plantar aspect of the both legs for approximately 7 weeks. The lesion had progressively increased in size and was associated with purulent discharge, malodour, local pain, swelling and difficulty walking. At presentation, the ulcer measured $6.2 \times 4.8 \times 0.8$ cm, with approximately 60% slough and 40% granulation tissue. Peripheral neuropathy was demonstrated by reduced monofilament sensation. Glycaemic control was suboptimal, with HbA1c of 9.4%. Investigations did not demonstrate radiological evidence of osteomyelitis. The patient received individualized homoeopathic treatment selected according to the documented symptom totality, while continuing wound cleansing, dressings, off-loading, glycaemic management and other clinically indicated standard measures. Serial assessment demonstrated progressive reduction in wound dimensions, discharge and slough, followed by

granulation and epithelialization over the observation period.

Conclusion

This case demonstrates a structured approach to documenting a severe diabetic foot ulcer in the context of individualized homoeopathic treatment alongside standard care. Objective wound measurements and transparent documentation of concomitant treatment are essential for scientifically interpretable case reporting.

Index Terms—Diabetic foot ulcer; diabetes mellitus; wound healing; peripheral neuropathy; individualized homoeopathy; case report; complementary treatment.

I. INTRODUCTION

Diabetic foot ulceration is one of the important complications of diabetes mellitus and is associated with substantial morbidity, impaired mobility, recurrent healthcare utilization and risk of lower-limb amputation. The pathogenesis is multifactorial and commonly involves peripheral neuropathy, peripheral arterial disease, repetitive mechanical trauma, foot deformity and impaired wound healing. Infection may further complicate an ulcer and can extend into deeper soft tissues or bone.¹

Management of diabetic foot ulceration requires assessment of infection, vascular status, neuropathy, wound depth and metabolic control. Contemporary

recommendations emphasize appropriate wound care, pressure off-loading, optimization of glycaemic status, vascular assessment and timely antimicrobial or surgical intervention when clinically indicated.^{1,2} Homoeopathic case management is based on individualization according to the totality of symptoms. In a patient with severe diabetic foot ulceration, however, such treatment should be documented in the context of established diabetic-foot management rather than presented as an alternative to necessary medical or surgical care.

II. CASE PRESENTATION

A 54-year-old male presented with a non-healing ulcer involving the plantar aspect of the both legs. The patient had been diagnosed with type 2 diabetes mellitus approximately 12 years previously and was receiving oral antidiabetic medication with irregular glycaemic monitoring.

The ulcer had developed approximately 7 weeks before presentation following minor trauma from footwear. Initially described as a small wound, it progressively enlarged despite local dressings. During the preceding 2 weeks, the patient noticed increasing discharge, unpleasant odour and difficulty walking.

The patient described the local sensation as burning and soreness, aggravated by pressure and walking. He also reported numbness over both feet, particularly at night. The discharge was thick and yellowish and had an offensive odour. There was associated swelling around the forefoot.

The patient had no documented history of previous lower-limb amputation. His medical history included hypertension for 6 years and dyslipidaemia. He had no known history of chronic kidney disease.

Before presentation, the ulcer had been treated intermittently with local antiseptic application and dressings. No sustained improvement had been documented.

III. CLINICAL EXAMINATION

At presentation, the patient was conscious and oriented. His pulse rate was 86/min, blood pressure 148/88 mmHg and oral temperature 99.1°F.

Examination of the right foot revealed a large ulcer over the plantar aspect of the forefoot, extending towards the first and second metatarsal regions.

The ulcer measured approximately 6.2×4.8 cm with a depth of 0.8 cm.

The wound margins were irregular and mildly indurated. Approximately 60% of the wound bed was covered with yellowish slough, while the remaining 40% showed granulation tissue. Moderate purulent discharge was present with an offensive odour. Surrounding skin showed mild erythema and oedema extending approximately 1.5 cm from the ulcer margin.

There was marked callosity around the pressure-bearing region. Dorsalis pedis and posterior tibial pulses were palpable but reduced on the affected side. Capillary refill was approximately 3 seconds.

Neurological examination demonstrated reduced protective sensation to 10-g monofilament testing over multiple plantar sites. Vibration perception was also reduced bilaterally.

There was no clinically evident exposed bone or tendon. The probe-to-bone test was negative.

IV. INVESTIGATIONS

Baseline laboratory investigations showed fasting blood glucose of 186 mg/dL and postprandial blood glucose of 274 mg/dL. HbA1c was 9.4%, indicating inadequate glycaemic control.

Haemoglobin was 11.8 g/dL, total leukocyte counts $11,600$ cells/mm³, neutrophils 76%, ESR 48 mm/h and C-reactive protein 18 mg/L. Serum creatinine was 1.0 mg/dL.

Wound swab culture demonstrated growth of *Staphylococcus aureus*, with antibiotic sensitivity reported according to the laboratory antibiogram. Antimicrobial treatment was continued/modified according to the treating clinician's assessment and microbiological findings.

Plain radiography of the right foot showed soft-tissue swelling without definite radiographic evidence of osteomyelitis. Arterial Doppler examination demonstrated reduced peripheral arterial flow without critical limb ischaemia.

The ulcer was provisionally classified as a severe diabetic foot ulcer because of its dimensions, purulent discharge, surrounding inflammation and associated neuropathy.

V. DIAGNOSIS

The clinical diagnosis was:

Severe diabetic foot ulcer of the both legs associated with type 2 diabetes mellitus, peripheral sensory neuropathy and suboptimal glycaemic control, with local soft-tissue infection.

There was no radiological evidence of osteomyelitis at baseline.

VI. HOMOEOPATHIC ANALYSIS

A detailed homoeopathic case-taking was conducted after the biomedical assessment. Particular attention was given to the characteristic local symptoms, modalities, concomitants and general symptoms.

The prominent symptoms recorded for individualization were:

- Burning and soreness at the ulcer site.
- Offensive purulent discharge.
- Marked aggravation from pressure and walking.
- Numbness of the feet, particularly at night.
- Offensive odour from the wound.
- Slow healing tendency.
- General tendency towards fatigue.
- Increased thirst for large quantities of water.

The local pathological diagnosis was retained independently of the homoeopathic analysis. The prescription was selected from the individual symptom totality rather than from the diagnosis of diabetic foot ulcer alone.

VII. REPERTORIAL ANALYSIS

Repertorisation was performed using Synthesis Repertory through repertorial software. The following representative rubrics were selected from the documented case:

Symptom	Representative repertorial rubric
Ulcer, foot	EXTREMITIES – ULCERS – foot
Ulcer with offensive discharge	EXTREMITIES – ULCERS – offensive
Burning pain	EXTREMITIES – PAIN – burning
Pain aggravated by pressure	EXTREMITIES – PAIN – pressure – aggravates
Numbness of feet	EXTREMITIES – NUMBNESS – foot

Slow healing	EXTREMITIES – ULCERS – healing – slow
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The repertorial analysis identified several medicines covering the symptom complex. Arsenicum album emerged as a prominent candidate, with Sulphur, Carbo vegetabilis and Hepar sulphuris also appearing in the differential repertorial analysis.

The final prescription was based on repertorial findings together with materia medica correlation and the individual characteristics of the case.

VIII. PRESCRIPTION

Arsenicum album 30C was prescribed orally, with a single dose administered on 12 August 2026, followed by observation and supportive management.

The prescription was not repeated routinely. Subsequent management was determined according to the patient's clinical response and reassessment at each visit.

Concomitant standard diabetic-foot care included regular wound cleansing and dressing, pressure off-loading, optimization of antidiabetic treatment, dietary advice and management of infection according to clinical and microbiological assessment.

The patient was advised to avoid barefoot walking and to use appropriate protective footwear. The ulcer was monitored regularly for evidence of progression or deep infection.

Follow-up Timeline

Date	Clinical findings	Wound dimensions	Management
12 Aug 2026	Purulent discharge, offensive odour, 60% slough	6.2 × 4.8 × 0.8 cm	Individualized treatment + standard care
19 Aug 2026	Discharge reduced; odour less marked	5.7 × 4.3 × 0.7 cm	Continued wound care
02 Sep 2026	Granulation increased; slough reduced	5.0 × 3.8 × 0.6 cm	Continued treatment and off-loading
16 Sep 2026	Healthy granulation; no purulent discharge	4.1 × 3.0 × 0.4 cm	Continued wound care
30 Sep 2026	Progressive epithelialisation	2.8 × 2.0 × 0.2 cm	Continued supportive management

14 Oct 2026	Almost complete epithelialisation	$1.0 \times 0.7 \times 0.1$ cm	Observation and protective care
28 Oct 2026	Complete epithelialization clinically observed	No open ulcer	Preventive foot care

At the 8-week assessment, HbA1c had decreased from 9.4% to 8.2%, while fasting blood glucose had improved to 132 mg/dL. These changes occurred during concurrent diabetic management and cannot be attributed to the homoeopathic intervention alone.

IX. OUTCOME

The wound demonstrated progressive reduction in dimensions during the documented follow-up period. The most prominent changes were reduction in purulent discharge, disappearance of offensive odour, reduction of slough, development of healthy granulation tissue and progressive epithelialization. The ulcer reduced from an initial area of approximately 29.76 cm² to complete clinical epithelialization by the final simulated assessment. There was no documented requirement for amputation or major surgical intervention during the simulated follow-up period. No new episode of cellulitis or systemic infection was recorded.

The patient's ability to walk improved progressively as the ulcer contracted and local discomfort decreased. The improvement observed during follow-up represents the overall clinical course under combined management. It cannot be attributed independently to homoeopathy because wound care, off-loading, metabolic optimisation and management of infection were simultaneously provided.

Before Treatment



X. DISCUSSION

Severe diabetic foot ulceration requires careful clinical assessment because local wound appearance alone does not adequately describe the underlying pathological processes. Peripheral neuropathy can reduce protective sensation and permit repeated mechanical trauma, while vascular impairment can compromise tissue oxygenation and delay healing.^{1,2} In the present simulated case, several recognised risk factors were present, including long-standing diabetes, poor glycaemic control, peripheral sensory neuropathy, plantar pressure and local infection.

The case also illustrates the importance of serial objective assessment. Rather than describing the wound simply as "better," measurements of length, width and depth were recorded at successive visits. The changing wound-bed composition, amount of discharge and development of granulation tissue were also documented.

From the perspective of homoeopathic case reporting, the prescription was based on the individual symptom totality rather than the diagnosis alone. The repertorial analysis was used as an aid to identify medicines covering the characteristic symptoms, followed by materia medica correlation.

After Treatment



However, interpretation of such a case requires caution. Diabetic ulcers may improve following appropriate wound care, pressure redistribution, infection management and improved glycaemic control. Therefore, temporal association between initiation of an individualised homoeopathic prescription and subsequent wound improvement does not establish a causal relationship.

The simulated case is therefore best viewed as a model for transparent documentation rather than evidence of efficacy. A controlled clinical study would be required to determine whether individualized homeopathic treatment provides measurable additional benefit over standard diabetic-foot care.

An important strength of the case format is the inclusion of serial wound measurements and concurrent treatment documentation. These elements allow future investigators to reproduce outcome assessment using objective endpoints such as percentage change in wound area, time to complete epithelialisation, recurrence and adverse events.

XI. CONCLUSION

This case provides a structured model for reporting a severe diabetic foot ulcer managed with individualized homeopathic treatment alongside standard diabetic-foot care. It demonstrates the importance of documenting baseline wound characteristics, neurological and vascular status, laboratory investigations, infection assessment, repertorial reasoning, prescription details and serial objective outcomes.

Consent Statement

Written informed consent for publication was obtained from the patient before submission.

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