Research Article

Clinical Effectiveness Of Individualized Rare and Lesser-Known Homoeopathic Medicines in Lumbosacral Radiculopathy (Sciatica): A Prospective, Single-Blind Interventional Study Based on The Complete Repertory Approach

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Abstract

Background: Lumbosacral radiculopathy (sciatica) is a debilitating neuro-orthopedic syndrome characterized by pain radiating along the sciatic nerve distribution, frequently accompanied by paresthesia, dural tension, and motor weakness. While routine homoeopathic prescribing relies heavily on a handful of well-known polychrests, clinical cases presenting with distinct anatomical laterality and uncommon postural or barometric modalities often require lesser-known ("rare") remedies indexed in comprehensive repertories.

Objectives: To evaluate the clinical effectiveness of individualized rare and lesser-known homoeopathic medicines—selected systematically via the Complete Repertory in CARA software—on radicular pain severity, back-specific functional disability, passive nerve-root mobility, motor strength, local tenderness, and rescue analgesic consumption over a 6-month follow-up period.

Methods: A prospective, single-blind, interventional clinical cohort study was conducted on 100 adult patients (aged 30–60 years; 53 females, 47 males) diagnosed with sciatica at the Outpatient Department of Ram Krishna College of Homoeopathy and Medical Sciences (RKCHMS), Bhopal, India. Prescriptions were individualized based on anatomical side affinity (63 right-sided, 37 left-sided), pain character, and modifying modalities using the Complete Repertory. Eleven remedies were allocated in descending order of clinical frequency: Phytolacca decandra (n = 16), Ruta graveolens (n = 14), Gnaphalium polycephalum (n = 13), Helonias dioica (n = 11), Ammonium muriaticum (n = 10), Kali bichromicum (n = 9), Ranunculus bulbosus (n = 8), Syphilinum (n = 7), Plumbum metallicum (n = 5), Dioscorea villosa (n = 4), and Tellurium metallicum (n = 3). Outcomes were evaluated at baseline and 6 months using the Visual Analogue Scale (VAS, 0–10), Maine–Seattle Back Questionnaire (MSBQ, 0–12), Weekly Rescue Analgesic Intake (pills/week), goniometric Straight Leg Raise (SLR) angle (degrees), Medical Research Council (MRC) Muscle Power (Grade 0–5), and Sciatic Tenderness (Grade 0–3).

Results: Across the entire cohort (N = 100), highly significant improvements ($p < 0.001$) were achieved across all six clinical parameters at 6 months: mean VAS pain dropped from 6.99 ± 1.24 to 3.24 ± 1.37 (Δ = 3.75 ± 1.71, Cohen's d = 2.19), MSBQ functional disability declined from 8.52 ± 1.51 to 4.48 ± 1.58 (Δ = 4.04 ± 2.19, d = 1.84), and rescue analgesic intake fell by 82.2% from 7.77 ± 1.25 to 1.38 ± 1.00 pills/week (Δ = 6.39 ± 1.56, d = 4.10). Objectively, passive SLR excursion increased from 34.86° ± 8.06° to 62.12° ± 10.09° (Δ = +27.26° ± 12.49°, d = 2.18), motor power improved from 2.45 ± 0.96 to 2.97 ± 1.17 (Δ = +0.52 ± 0.67, d = 0.78), and tenderness decreased from 1.97 ± 0.64 to 1.66 ± 0.87 (Δ = 0.31 ± 0.63, d = 0.49). Subgroup analysis confirmed distinct therapeutic affinities: Kali bichromicum achieved the greatest pain reduction (VAS Δ = 4.89 ± 1.69, $p < 0.001$) and SLR gain (+32.89° ± 15.62°, $p < 0.001$); Gnaphalium polycephalum (+32.08°, $p < 0.001$) and Ruta graveolens (+29.93°, $p < 0.001$) markedly restored dural mobility and motor strength; and Dioscorea villosa (Δ = 5.75, $p = 0.046$), Plumbum metallicum (Δ = 5.00, $p = 0.004$), and Phytolacca decandra (Δ = 4.81, $p < 0.001$) produced the largest functional recovery on the MSBQ.

Conclusion: Individualized rare and lesser-known homoeopathic medicines selected via the Complete Repertory substantially reduce radicular pain and disability, restore passive neural mobility, and markedly curtail conventional analgesic dependence in patients with sciatica.

Keywords: Sciatica; Lumbosacral radiculopathy; Complete Repertory; Rare homoeopathic medicines; Straight Leg Raise (SLR); Maine–Seattle Back Questionnaire (MSBQ); CARA software; Homoeopathy.

1. Introduction

Lumbosacral radiculopathy, clinically referred to as sciatica, is a debilitating neuro-orthopedic syndrome characterized by sharp, shooting, or aching pain originating in the lumbosacral spine and radiating along the anatomical course of the sciatic nerve (nerve roots L4–S3) into the gluteal region, posterior thigh, calf, and foot[1,2].

Etymologically derived from the Greek ischiadikos ("pain in the hip"), first described by Hippocrates and differentiated from local hip joint disease by Domenico Cotugno in 1764, the disorder remains a major cause of occupational disability and healthcare utilization worldwide[3]. Epidemiological surveys indicate a lifetime prevalence ranging between 13% and 40% and an annual incidence of 1% to 5% in the general adult population, peaking between the fourth andsixth decades of life[3,4]. According to the Global Burden of Disease (GBD) study, low back pain—with radicular sciatica representing its most severe and costly clinical phenotype—ranks as the single leading cause of years lived with disability (YLDs) globally[4]. In India, hospital-based orthopedic registries report a high burden of lumbosacral radiculopathy among both manual laborers and sedentary office workers, with slightly higher prevalence and chronicity observed among women due to multiparity, domestic postural strain, and osteopenic spinal degeneration[5].

Pathophysiologically, nearly 85–90% of sciatica cases arise from mechanical compression combined with biochemical inflammation of the exiting lumbosacral nerve roots (most frequently L4–L5 and L5–S1) secondary to intervertebral disc herniation, annular tears, facet joint hypertrophy, or foraminal stenosis[1,2]. Extrusion of nucleus pulposus material into the epidural space releases pro-inflammatory mediators—including phospholipase A2, tumor necrosis factor-alpha (TNF-α), interleukin-1β, and nitric oxide—which provoke endoneurial edema, demyelination, and ectopic nociceptive firing within the dorsal root ganglion[2,6]. Clinically, this dual mechano-chemical insult manifests not only as dermatomal lancinating pain, but also as sensory paresthesia (numbness, tingling, formication), dural tension restricting passive Straight Leg Raise (Lasègue's sign), and myotomal motor weakness (such as extensor hallucis longus or ankle dorsiflexor paresis)[1,6].

Conventional conservative management relies primarily on non-steroidal anti-inflammatory drugs (NSAIDs), skeletal muscle relaxants, oral corticosteroids, and neuropathic neuromodulators (Gabapentin or Pregabalin), supplemented by physical therapy or fluoroscopically guided epidural corticosteroid injections[7,8,9]. However, systematic reviews and Cochrane meta-analyses demonstrate that NSAIDs and Gabapentinoids offer modest, short-term pain relief in radicular sciatica while carrying substantial risks of peptic ulceration, nephrotoxicity, cardiovascular events, dizziness, and somnolence[7,8]. Similarly, while epidural steroid injections and lumbar microdiscectomy accelerate acute pain resolution, randomized trials show that their 1- to 2-year functional outcomes converge closely with conservative care, leaving a considerable proportion of patients with recurrent radicular pain and chronic analgesic dependency[8,9].

In homoeopathic clinical practice, patients with sciatica are frequently prescribed routine polychrest remedies such as Colocynthis, Rhus toxicodendron, or Magnesia phosphorica. While effective when their characteristic symptom picture is present, many chronic radiculopathy cases fail to respond fully to common polychrests because their distinctive neurological concomitants, strict anatomical laterality (right vs. left nerve trunk affinity), and peculiar kinetic or thermal modalities correspond instead to lesser-known or "Rare" remedies documented in classical Materia Medica[10-13]. Roger Van Zandvoort's Complete Repertory—integrating the synthesis of Kent's Repertory, Knerr's Repertory of Hering's Guiding Symptoms, and Boenninghausen's therapeutic pocketbook across more than 2,100 remedies—provides granular sub-rubrics under Extremities – Pain – Sciatic nerve for localizing these lesser-known medicines[14,15]. For instance, Phytolacca decandra, Gnaphalium polycephalum, Helonias dioica, Kali bichromicum, Syphilinum, Dioscorea villosa, and Tellurium metallicum exhibit well-defined clinical affinities for right-sided sciatic radiculopathy with distinct modifying modalities, whereas Ruta graveolens, Ammonium muriaticum, Ranunculus bulbosus, and Plumbum metallicum cover specific pathophysiological presentations of left-sided sciatica[11-14].

Although observational studies and small clinical trials have suggested positive outcomes for homoeopathic therapy in chronic low back pain and sciatica[16,17], rigorous prospective studies evaluating the systematic application of the Complete Repertory to prescribe lesser-known remedies across both subjective disability scales and objective neurological examination parameters remain scarce. The present prospective, single-blind clinical study was therefore conducted to evaluate the clinical effectiveness of eleven individualized rare and lesser-known Homoeopathic medicines in 100 patients with Lumbosacral radiculopathy over a 6-month follow-up period.

2. Materials and Methods

2.1 Study Design and Clinical Setting

This investigation was designed as a prospective, single-blind, interventional clinical cohort study conducted at the Outpatient Department (OPD) of Ram Krishna College of Homoeopathy and Medical Sciences (RKCHMS), Bhopal, Madhya Pradesh, India, under the doctoral research supervision of Janardan Rai Nagar Rajasthan Vidyapeeth (Deemed to be University), Udaipur. Participant screening, enrollment, and longitudinal follow-up took place over an 18-month period from June 2024 to November 2025 (12 months of recruitment followed by 6 months of active clinical follow-up per patient). Study reporting conforms to the REDHOT (Reporting Data on Homeopathic Treatments) extension of the CONSORT statement[18].

2.2 Ethical Clearance and Patient Consent

Prior to initiating recruitment, the study protocol, standardized case recording proforma, and bilingual (Hindi and English) patient information and consent documents were approved by the Institutional Ethical Committee (IEC) of Janardan Rai Nagar Rajasthan Vidyapeeth (Deemed to be University), Udaipur. All clinical procedures adhered to the ethical standards of the Declaration of Helsinki and the Indian Council of Medical Research (ICMR) National Ethical Guidelines. Written informed consent was obtained from every participant before baseline neurological examination.

2.3 Study Population and Eligibility Criteria

Adult patients presenting to the RKCHMS outpatient clinic with radiating lower-back and lower-extremity pain were evaluated through detailed clinical history and physical neurological examination. A final cohort of 100 eligible patients who completed the full 6-month follow-up protocol was analyzed.

Inclusion Criteria: (1) Male and female patients aged 30 to 60 years; (2) clinical diagnosis of unilateral lumbosacral radiculopathy (sciatica) characterized by pain radiating from the lower back or buttock below the knee along the L4, L5, or S1 dermatomal distribution; (3) positive passive Straight Leg Raise (Lasègue's) test reproducing radicular pain between 15° and 60° of hip flexion; and (4) willingness to provide written informed consent and comply with the 6-month follow-up schedule.

Exclusion Criteria: (1) Age < 30 years or > 60 years; (2) acute neurosurgical emergencies, specifically cauda equina syndrome (saddle anesthesia, bladder/bowel incontinence) or rapidly progressive foot drop requiring urgent surgical decompression; (3) sciatica secondary to spinal malignancy, Potts spine (tuberculous spondylitis), acute vertebral fracture, or epidural abscess; (4) pregnant or lactating women; (5) severe uncontrolled systemic comorbidities (decompensated diabetes mellitus with peripheral polyneuropathy, advanced renal/hepatic failure); and (6) concurrent participation in invasive spinal interventions (epidural steroid injections) during the study window.

2.4 Repertorization, Remedy Allocation, and Single-Blind Posology Protocol

Each patient underwent a comprehensive homoeopathic and neurological evaluation recorded on a structured Case Taking Proforma. Following Hahnemannian principles (§ 83–104 and § 153 of the Organon of Medicine)[10], special emphasis was placed on eliciting characteristic particulars: anatomical side (right vs. left lower extremity), exact radiation trajectory, quality of pain (shooting, tearing, stitching, cramping, burning), neurological concomitants (sensory numbness, formication, hamstring shortening sensation, muscular atrophy), and modifying modalities (posture, motion, sitting, bending backward, nocturnal aggravation, barometric change, and Valsalva strain).

Case rubrics were erected following Kentian general-to-particular hierarchy and repertorized using the Complete Repertory module in CARA Professional software[14,15]. Common routine polychrests were excluded when lesser-known or rare remedies covered the characteristic neurological modalities and side affinity with higher specificity, verified against authoritative Materia Medica texts (Hahnemann, Hering, Clarke, and Boericke)[10-13]. Across the 100 patients, this individualized repertorial process yielded a strictly unequal, descending frequency distribution across eleven remedies: seven remedies corresponded to the 63 right-sided sciatica cases—Phytolacca decandra (n = 16), Gnaphalium polycephalum (n = 13), Helonias dioica (n = 11), Kali bichromicum (n = 9), Syphilinum (n = 7), Dioscorea villosa (n = 4), and Tellurium metallicum (n = 3)—while four remedies corresponded to the 37 left-sided sciatica cases—Ruta graveolens (n = 14), Ammonium muriaticum (n = 10), Ranunculus bulbosus (n = 8), and Plumbum metallicum (n = 5).

All medicines were sourced from a GMP-certified homoeopathic pharmaceutical manufacturer in compliance with the Homoeopathic Pharmacopoeia of India (HPI). Therapy commenced in the 30C centesimal potency (four medicated globules of size 30 administered orally twice daily on an empty stomach), with ascending potencies (200C or 1M) utilized when indicated by clinical response plateaus. Under the single-blind design, patients were blinded to the identity of the dispensed remedy and potency. Identical vials containing unmedicated sucrose globules (Rubrum / Sacchrum lactis) were interposed during intervals of steady clinical improvement to avoid dynamic over-stimulation

and control for placebo expectation. Patients were followed weekly for the first two weeks, fortnightly during the first month, and monthly (or fortnightly if symptoms persisted) through the end of Month 6. Basic ergonomic advice (avoiding heavy forward lifting and prolonged slumped sitting) was provided to all participants, while rescue analgesics (Paracetamol/NSAIDs) were permitted only on an as-needed basis with strict weekly pill-count logging.

2.5 Outcome Measures

Six clinical outcome parameters—comprising three patient-reported subjective measures and three clinician-assessed objective physical/neurological measures—were evaluated at baseline and at the 6-month endpoint:

1. Visual Analogue Scale (VAS) for Radicular Pain (0–10 cm): A standard 11-point numerical/visual scale anchored from 0 ("no pain") to 10 ("worst imaginable excruciating radicular pain"), recorded at every follow-up visit.

2. Maine–Seattle Back Questionnaire (MSBQ, 0–12 Scale): A validated 12-item sciatica- and back-specific functional disability instrument derived from the Patrick modified Roland–Morris scale[19,20], assessing daily activity limitations (standing, walking, sleeping, dressing, stair climbing, and sitting tolerance). Each endorsed item scores 1 point (total range: 0–12; higher scores signify greater functional disability).

3. Weekly Rescue Analgesic Consumption (Pills/Week): The total number of rescue analgesic tablets (NSAIDs/Acetaminophen) consumed by the patient per week, verified via patient diary and blister-pack inspection at each consultation.

4. Passive Straight Leg Raise (SLR) Angle (Degrees, 0°–90°): Measured objectively in the supine position using a standard universal goniometer centered over the greater trochanter. With the knee held in full extension, the affected lower limb was passively elevated by the examiner until radicular pain or paresthesia was reproduced along the sciatic distribution. Increases in SLR angle reflect reduced lumbosacral nerve-root mechanosensitivity and dural tension.

5. Lower-Limb Motor Muscle Power (MRC Scale, Grade 0–5): Manual muscle testing of the affected myotomes (ankle dorsiflexion [L4], great toe extension [L5], and ankle plantarflexion/hamstring flexion [S1]) graded according to the Medical Research Council (MRC) 0–5 scale (0 = complete paralysis; 3 = active movement against gravity; 5 = normal maximal power against full resistance).

6. Local Paraspinal and Sciatic Notch Tenderness (Grade 0–3): Assessed by standardized digital palpation over the lumbosacral paraspinal musculature, sacroiliac joint, and greater sciatic foramen (Valleix's points), graded on a 4-point ordinal scale (0 = no tenderness; 1 = mild tenderness reported on deep palpation; 2 = moderate tenderness with facial grimacing/winces; 3 = severe tenderness with immediate withdrawal upon light palpation).

2.6 Statistical Analysis

Statistical analyses were conducted using Python (Pandas, NumPy, and SciPy.stats). Continuous and ordinal variables are summarized as mean ± standard deviation (SD), while categorical variables are presented as counts and percentages (n, %). Individual change scores were computed as Δ = Baseline − 6-Month for pain (VAS), disability (MSBQ), analgesic intake, and tenderness (where positive Δ indicates reduction), and as Δ = 6-Month − Baseline for SLR angle and MRC motor power (where positive Δ indicates functional gain). The Shapiro–Wilk test was applied to the paired difference distributions to assess normality ($\alpha = 0.05$). Parametric two-tailed paired Student's t-tests were utilized for normally distributed subgroup differences ($p \geq 0.05$), whereas the non-parametric Wilcoxon signed-rank test was applied where difference scores departed from normality ($p < 0.05$). Standardized effect sizes were calculated using Cohen's d ($d = |\text{Mean_diff}| / \text{SD_diff}$; graded per Cohen[21] as small [0.20–0.49], medium [0.50–0.79], and large [≥ 0.80]). Statistical significance was established at $p < 0.05$.

3. Results

3.1 Baseline Demographic Profile, Anatomical Laterality, and Remedy Distribution

All 100 enrolled patients completed the 6-month clinical follow-up. The baseline demographic characteristics and remedy allocations are detailed in Table 1. The cohort exhibited a slight female predominance, comprising 53 females (53.0%; mean age: 47.7 ± 8.3 years) and 47 males (47.0%; mean age: 45.9 ± 7.8 years), with an overall cohort mean age of 46.8 ± 8.1 years (range: 31–60 years). With respect to anatomical laterality of radicular symptoms, 63 patients (63.0%; mean age: 46.3 ± 7.8 years) presented with right-sided sciatica and 37 patients (37.0%; mean age: 47.6 ± 8.5 years) presented with left-sided sciatica.

Individualized Repertorization via the Complete Repertory distributed the 100 patients across eleven homoeopathic remedies in strictly descending order of frequency (Table 1 and Figure 1). Among the right-sided cases (n = 63),

Phytolacca decandra was the most frequently prescribed medicine (n = 16, 16.0%), followed by Gnaphalium polycephalum (n = 13, 13.0%), Helonias dioica (n = 11, 11.0%), Kali bichromicum (n = 9, 9.0%), Syphilinum (n = 7, 7.0%), Dioscorea villosa (n = 4, 4.0%), and Tellurium metallicum (n = 3, 3.0%). Among the left-sided cases (n = 37), Ruta graveolens was the leading prescription (n = 14, 14.0%), followed by Ammonium muriaticum (n = 10, 10.0%), Ranunculus bulbosus (n = 8, 8.0%), and Plumbum metallicum (n = 5, 5.0%).

Table 1: Baseline Demographic Profile, Anatomical Laterality, and Individualized Homoeopathic Remedy Allocation (N = 100)

Category / Prescribed Remedy	Laterality / Subgroup	n (%)	Age (Years) Mean ± SD	Characteristic Repertorial & Clinical Guiding Modalities
Gender: Female	Demographic	**53 (53.0%)**	47.7 ± 8.3	Predominance of domestic postural strain and multiparous lumbosacral load
Gender: Male	Demographic	**47 (47.0%)**	45.9 ± 7.8	Occupational mechanical axial loading, driving, and manual labor
Laterality: Right Side	Anatomical Side	**63 (63.0%)**	46.3 ± 7.8	Right L4–S1 radicular distribution (allocated across 7 right-sided remedies)
Laterality: Left Side	Anatomical Side	**37 (37.0%)**	47.6 ± 8.5	Left L4–S1 radicular distribution (allocated across 4 left-sided remedies)
1. Phytolacca decandra	Right-Sided	**16 (16.0%)**	43.6 ± 6.0	Shooting, electric-like pain down outer aspect of right thigh; < night, damp cold weather, motion.
2. Ruta graveolens	Left-Sided	**14 (14.0%)**	48.6 ± 8.1	Deep bruised aching along left ischium and posterior thigh; < lying down, cold wet; > gentle walking.
3. Gnaphalium polycephalum	Right-Sided	**13 (13.0%)**	47.7 ± 7.7	Intense darting sciatic neuralgia alternating with numbness/tingling; > sitting in chair, flexing thigh.
4. Helonias dioica	Right-Sided	**11 (11.0%)**	44.2 ± 9.3	Severe lumbosacral dragging, burning

				weariness, and pelvic congestion radiating into right gluteal/thigh.
5. Ammonium muriaticum	Left-Sided	**10 (10.0%)**	43.5 ± 7.1	Tearing left sciatic pain with sensation as if hamstring tendons are too short; < sitting, > lying down.
6. Kali bichromicum	Right-Sided	**9 (9.0%)**	48.6 ± 8.9	Wandering, shifting right radicular pain appearing and disappearing suddenly in small spots; > warmth.
7. Ranunculus bulbosus	Left-Sided	**8 (8.0%)**	47.1 ± 11.1	Sharp stitching, burning neuralgia along left sciatic nerve; < motion, touch, draft of air, wet weather.
8. Syphilinum (Luesinum)	Right-Sided	**7 (7.0%)**	48.6 ± 6.4	Excruciating nocturnal right radicular pain commencing at sunset and ceasing at daylight; > pacing floor.
9. Plumbum metallicum	Left-Sided	**5 (5.0%)**	54.0 ± 3.3	Paroxysmal lightning-like left sciatica with marked distal motor paresis and early muscular atrophy.
10. Dioscorea villosa	Right-Sided	**4 (4.0%)**	43.8 ± 9.2	Drawing, cramping right sacroiliac and sciatic pain; < stooping forward, > standing erect or bending backward.
11. Tellurium metallicum	Right-Sided	**3 (3.0%)**	54.3 ± 4.7	Right radicular pain with vertebral spinal tenderness; sharply < coughing, sneezing, laughing, or straining.

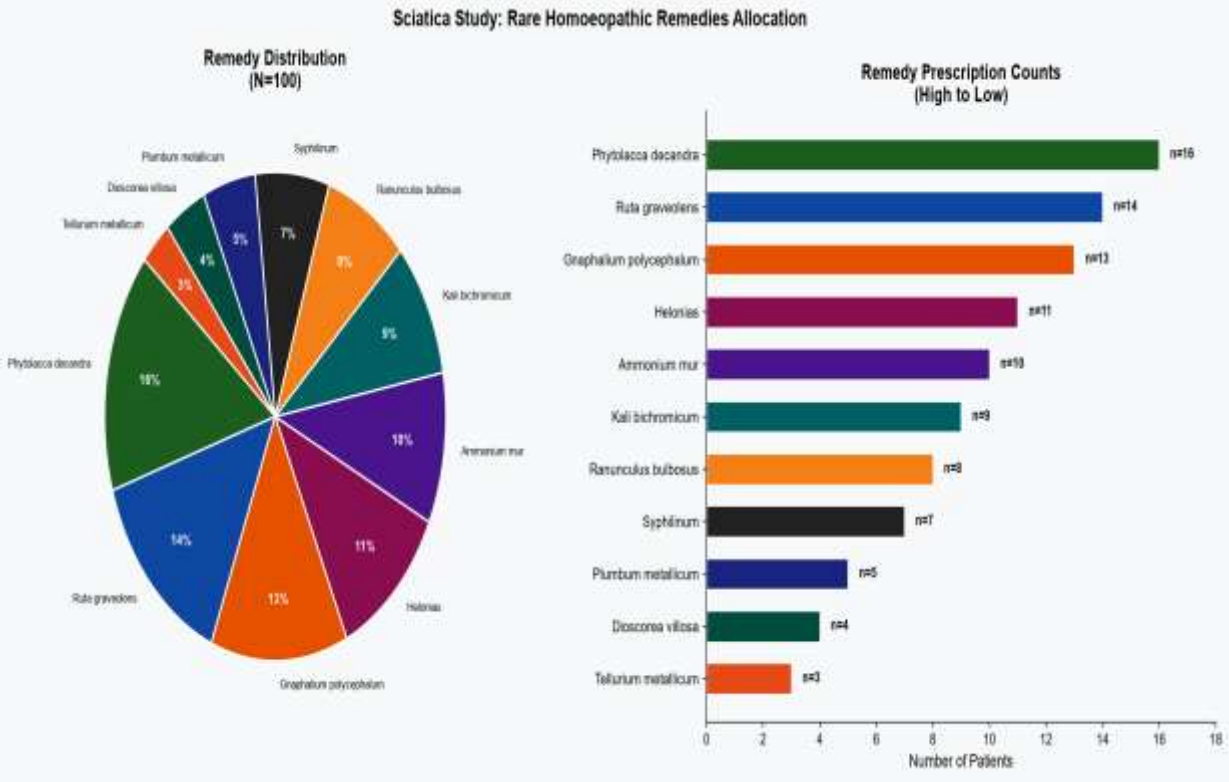


Figure 1: Distribution of individualized homoeopathic medicines across the study cohort (N = 100), arranged in descending order from Phytolacca decandra (n = 16) to Tellurium metallicum (n = 3) and color-coded by anatomical nerve laterality (Right = 63, Left = 37).

3.2 Overall Cohort Clinical Outcomes (N = 100)

At the completion of the 6-month follow-up period, the overall study cohort (N = 100) demonstrated highly statistically significant improvements ($p < 0.001$) across all six subjective and objective outcome parameters (Table 2, Figure 2, and Figure 3).

In the subjective clinical domain (Figure 2), mean radicular pain intensity on the Visual Analogue Scale (VAS) decreased by 53.6%, falling from 6.99 ± 1.24 at baseline to 3.24 ± 1.37 at 6 months (mean reduction: Δ = 3.75 ± 1.71 points; Wilcoxon signed-rank test and paired t-test $p < 0.001$), yielding a very large standardized effect size (Cohen's $d = 2.19$). Concurrently, functional back disability on the Maine–Seattle Back Questionnaire (MSBQ) declined by 47.4%, from a baseline mean of 8.52 ± 1.51 to 4.48 ± 1.58 at 6 months (mean reduction: Δ = 4.04 ± 2.19 points; $p < 0.001$; Cohen's $d = 1.84$). Most notably, weekly rescue analgesic consumption dropped by 82.2%, from 7.77 ± 1.25 pills/week at baseline to 1.38 ± 1.00 pills/week at the 6-month endpoint (mean reduction: Δ = 6.39 ± 1.56 pills/week; $p < 0.001$; Cohen's $d = 4.10$), confirming that symptomatic relief was accompanied by near-complete cessation of conventional analgesic dependency.

Objective neurological and physical examination metrics (Figure 3) corroborated the subjective improvements. Passive Straight Leg Raise (SLR) excursion increased from a severely restricted baseline mean of 34.86° ± 8.06° to 62.12° ± 10.09° at 6 months, representing a mean angular gain of +27.26° ± 12.49° ($p < 0.001$; Cohen's $d = 2.18$, large effect) and restoring limb elevation beyond the 60° threshold of dural nerve-root tension. Lower-extremity motor muscle power on the 0–5 MRC scale improved significantly from 2.45 ± 0.96 to 2.97 ± 1.17 (mean gain: Δ = +0.52 ± 0.67 grades; $p < 0.001$; Cohen's $d = 0.78$, medium-to-large effect), while local paraspinal and sciatic notch tenderness declined significantly from 1.97 ± 0.64 to 1.66 ± 0.87 (mean reduction: Δ = 0.31 ± 0.63 grades; $p < 0.001$; Cohen's $d = 0.49$).

Table 2: Overall Cohort Pre- vs. Post-Intervention Subjective and Objective Clinical Outcomes at 6 Months (N = 100)

Clinical Outcome Parameter	Baseline (Mean ± SD)	6-Month Endpoint (Mean ± SD)	Mean Change (Δ) (Mean ± SD)	Shapiro–Wilk Normality (p)	Statistical Test Applied	p-value	Effect Size (Cohen's d)
Pain Score (VAS, 0–10 cm)	6.99 ± 1.24	3.24 ± 1.37	−3.75 ± 1.71	0.0007	Wilcoxon / Paired t	**< 0.001***	2.19 (Large)
Functional Disability (MSBQ, 0–12)	8.52 ± 1.51	4.48 ± 1.58	−4.04 ± 2.19	0.0004	Wilcoxon / Paired t	**< 0.001***	1.84 (Large)
Analgesic Intake (Pills/Week)	7.77 ± 1.25	1.38 ± 1.00	−6.39 ± 1.56	0.0029	Wilcoxon / Paired t	**< 0.001***	4.10 (Large)
Passive SLR Angle (Degrees, 0°–90°)	34.86° ± 8.06°	62.12° ± 10.09°	+27.26° ± 12.49°	0.0127	Wilcoxon / Paired t	**< 0.001***	2.18 (Large)
Muscle Power (MRC Grade 0–5)	2.45 ± 0.96	2.97 ± 1.17	+0.52 ± 0.67	< 0.0001	Wilcoxon Signed-Rank	**< 0.001***	0.78 (Medium)
Local Tenderness (Grade 0–3)	1.97 ± 0.64	1.66 ± 0.87	−0.31 ± 0.63	< 0.0001	Wilcoxon Signed-Rank	**< 0.001***	0.49 (Small/Med)

*Statistically significant at p < 0.001 (both non-parametric Wilcoxon signed-rank test and parametric paired Student's t-test yielded p < 0.001 across all six overall parameters). VAS: Visual Analogue Scale; MSBQ: Maine–Seattle Back Questionnaire; SLR: Straight Leg Raise; MRC: Medical Research Council.

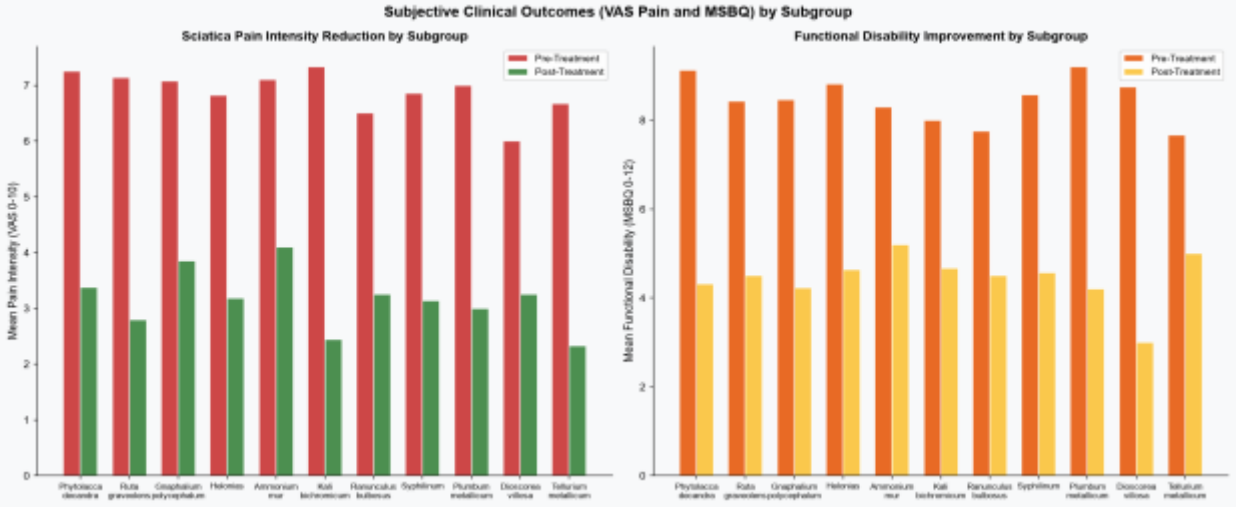


Figure 2: Pre- vs. post-treatment comparison of overall cohort subjective clinical outcomes (N = 100): Pain Intensity (VAS 0–10), Functional Back Disability (MSBQ 0–12), and Weekly Rescue Analgesic Consumption (pills/week). All comparisons p < 0.001.

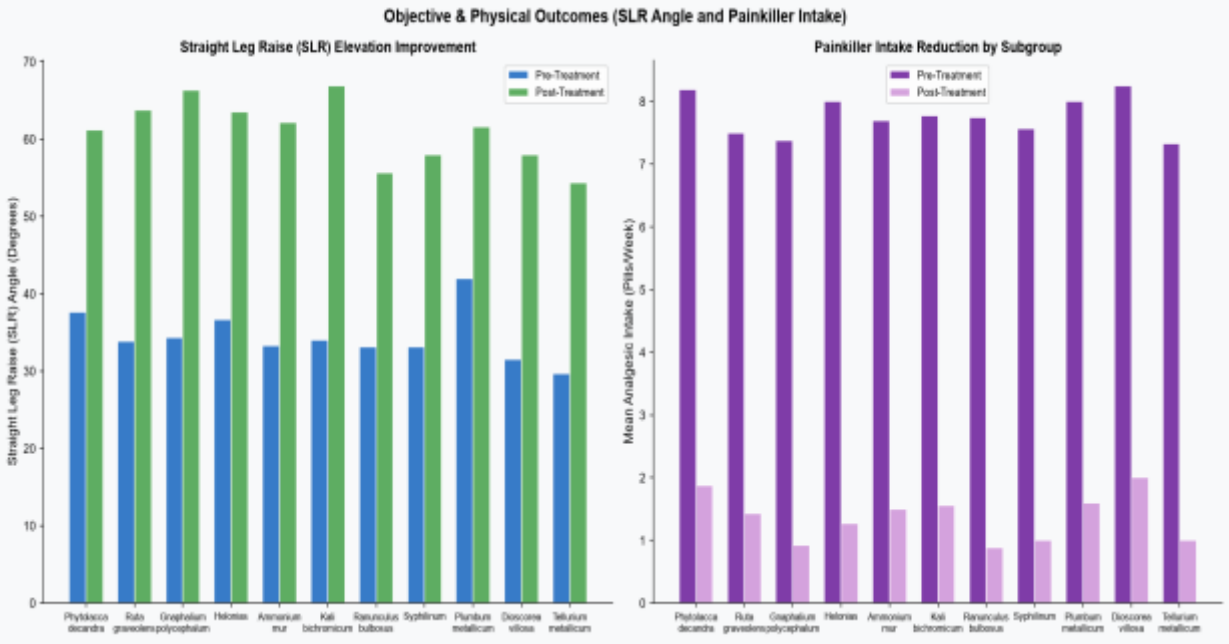


Figure 3: Pre- vs. post-treatment comparison of overall cohort objective physical and neurological parameters (N = 100): (A) Passive Straight Leg Raise (SLR) angle in degrees, and (B) Lower-limb MRC Muscle Power (0–5) and Palpatory Tenderness (0–3). All comparisons $p < 0.001$.

3.3 Subgroup Analysis Across the Eleven Homoeopathic Remedies

Subgroup analyses evaluating the therapeutic response of each of the eleven prescribed homoeopathic medicines are presented in Table 3 (subjective pain, functional disability, and analgesic intake; illustrated in Figure 4) and Table 4 (objective SLR angle, motor muscle power, and local tenderness).

Remarkably, every single one of the eleven remedy subgroups achieved a statistically significant reduction in VAS radicular pain (all $p < 0.05$; Table 3), with large standardized effect sizes ranging from $d = 1.55$ (Ammonium muriaticum) to $d = 2.96$ (Gnaphalium polycephalum). The largest absolute mean reduction in VAS pain occurred in the Kali bichromicum subgroup ($n = 9$; baseline: 7.33 ± 1.22 to 2.44 ± 1.42; $\Delta = 4.89 \pm 1.69$; $p < 0.001$; $d = 2.89$), followed by Ruta graveolens ($n = 14$; $\Delta = 4.36 \pm 1.82$; $p < 0.001$; $d = 2.40$), Tellurium metallicum ($n = 3$; $\Delta = 4.33 \pm 1.53$; $p = 0.039$; $d = 2.83$), Plumbum metallicum ($n = 5$; $\Delta = 4.00 \pm 2.35$; $p = 0.019$; $d = 1.70$), and the largest subgroup, Phytolacca decandra ($n = 16$; baseline: 7.25 ± 1.29 to 3.38 ± 1.31; $\Delta = 3.88 \pm 1.78$; $p < 0.001$; $d = 2.18$).

Similarly, ten of the eleven subgroups recorded statistically significant improvements in MSBQ functional disability ($p < 0.05$; Table 3), led by Dioscorea villosa ($n = 4$; $\Delta = 5.75 \pm 3.50$; $p = 0.046$; $d = 1.64$), Plumbum metallicum ($n = 5$; $\Delta = 5.00 \pm 1.87$; $p = 0.004$; $d = 2.67$), Phytolacca decandra ($n = 16$; $\Delta = 4.81 \pm 2.23$; $p < 0.001$; $d = 2.16$), Gnaphalium polycephalum ($n = 13$; $\Delta = 4.23 \pm 2.39$; $p < 0.001$; $d = 1.77$), and Helonias dioica ($n = 11$; $\Delta = 4.18 \pm 2.56$; $p < 0.001$; $d = 1.63$). Weekly rescue analgesic intake dropped significantly in ten of the eleven groups (all $p \leq 0.011$; Table 3), with Ranunculus bulbosus ($\Delta = 6.88 \pm 1.25$ pills/week, $p < 0.001$) and Helonias dioica ($\Delta = 6.73 \pm 1.79$ pills/week, $p < 0.001$) showing the steepest reductions.

Table 3: Remedy-Specific Subgroup Analysis of Subjective Outcomes: Radicular Pain (VAS), Functional Disability (MSBQ), and Weekly Analgesic Intake Across Eleven Homoeopathic Medicines (N = 100)

Remedy (Side)	n	VAS Pre→Post (Mean±SD)	VAS Δ (Mean±SD)	VAS p (d)	MSBQ Pre→Post (Mean±SD)	MSBQ Δ (Mean±SD)	MSBQ p (d)	Pills/Wk Pre→Post (Mean±SD)	Pills Δ (Mean±SD)	Pills p (d)
Phytolacca decandra (R)	**16**	7.25±1.29 →	3.88±1.78	< 0.001	9.12±1.26 →	4.81±2.23	< 0.001	8.19±1.28 →	6.31±1.82	< 0.001

		3.38±1.31		(2.18)	4.31±1.62		(2.16)	1.88±1.26		(3.47)
Ruta graveolens (L)	**14**	7.14±1.03 → 2.79±1.31	4.36±1.82	< 0.001 (2.40)	8.43±1.65 → 4.50±1.45	3.93±1.90	< 0.001 (2.07)	7.50±1.29 → 1.43±0.65	6.07±1.54	< 0.001 (3.94)
Gnaphalium polycephalum (R)	**13**	7.08±1.19 → 3.85±1.34	3.23±1.09	< 0.001 (2.96)	8.46±1.33 → 4.23±1.92	4.23±2.39	< 0.001 (1.77)	7.38±1.33 → 0.92±0.86	6.46±1.61	< 0.001 (4.01)
Helonias dioica (R)	**11**	6.82±1.60 → 3.18±1.25	3.64±1.75	< 0.001 (2.08)	8.82±1.83 → 4.64±1.86	4.18±2.56	< 0.001 (1.63)	8.00±1.10 → 1.27±1.19	6.73±1.79	< 0.001 (3.76)
Ammonium muriaticum (L)	**10**	7.10±1.10 → 4.10±1.10	3.00±1.94	< 0.001 (1.55)	8.30±1.06 → 5.20±1.48	3.10±1.91	< 0.001 (1.62)	7.70±1.06 → 1.50±0.97	6.20±1.40	< 0.001 (4.43)
Kali bichromicum (R)	**9**	7.33±1.22 → 2.44±1.42	4.89±1.69	< 0.001 (2.89)	8.00±1.87 → 4.67±1.00	3.33±1.66	< 0.001 (2.01)	7.78±1.30 → 1.56±1.24	6.22±1.72	0.004 (3.62)
Ranunculus bulbosus (L)	**8**	6.50±1.20 → 3.25±1.39	3.25±1.28	< 0.001 (2.54)	7.75±1.67 → 4.50±1.41	3.25±1.98	0.002 (1.64)	7.75±1.16 → 0.88±0.83	6.88±1.25	< 0.001 (5.50)
Syphilinum (Luesinum) (R)	**7**	6.86±1.21 → 3.14±2.04	3.71±1.70	0.001 (2.18)	8.57±1.27 → 4.57±2.23	4.00±2.31	0.004 (1.73)	7.57±1.72 → 1.00±0.58	6.57±2.15	< 0.001 (3.06)
Plumbum metallicum (L)	**5**	7.00±2.12 → 3.00±1.00	4.00±2.35	0.019 (1.70)	9.20±1.64 → 4.20±1.10	5.00±1.87	0.004 (2.67)	8.00±1.00 → 1.60±0.55	6.40±0.89	0.062 (7.19)
Dioscorea villosa (R)	**4**	6.00±0.82 → 3.25±0.96	2.75±1.71	0.049 (1.61)	8.75±2.22 → 3.00±1.41	5.75±3.50	0.046 (1.64)	8.25±1.71 → 2.00±1.41	6.25±1.26	0.002 (4.96)
Tellurium metallicum (R)	**3**	6.67±0.58 → 2.33±1.53	4.33±1.53	0.039 (2.83)	7.67±0.58 → 5.00±1.00	2.67±1.53	0.094 (1.75)	7.33±1.15 → 1.00±0.00	6.33±1.15	0.011 (5.50)

Note: R = Right-sided affinity; L = Left-sided affinity. Δ = Baseline minus 6-month score. Values in parentheses next to p-values denote standardized effect size (Cohen's d).

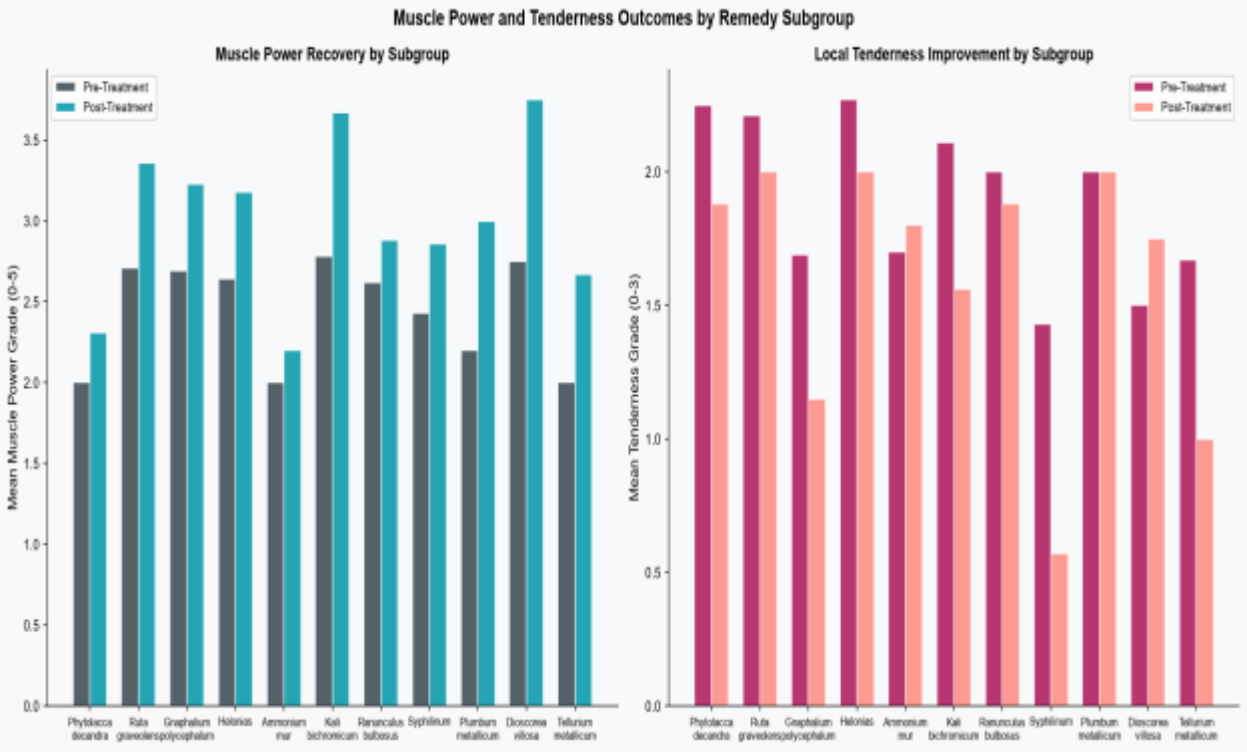


Figure 4: Subgroup comparison of baseline and 6-month mean scores across all eleven homoeopathic remedies for (A) Radicular Pain Intensity (VAS 0–10) and (B) Functional Disability on the Maine–Seattle Back Questionnaire (MSBQ 0–12).

On objective physical and neurological examination (Table 4), passive Straight Leg Raise (SLR) angle improved significantly across all eleven remedy subgroups (all $p \leq 0.020$), confirming consistent resolution of lumbosacral nerve-root irritation across both right- and left-sided remedies. The largest goniometric SLR gains were recorded in Kali bichromicum (n = 9; 34.00° ± 6.82° to 66.89° ± 11.81°; Δ = +32.89° ± 15.62°; $p < 0.001$; d = 2.11) and Gnaphalium polycephalum (n = 13; 34.31° ± 8.68° to 66.38° ± 9.93°; Δ = +32.08° ± 13.79°; $p < 0.001$; d = 2.33), followed among left-sided remedies by Ruta graveolens (n = 14; Δ = +29.93° ± 11.65°; $p < 0.001$; d = 2.57) and Ammonium muriaticum (n = 10; Δ = +28.90° ± 11.54°; Wilcoxon p = 0.002; d = 2.50).

Significant gains in lower-limb MRC motor muscle power were achieved in Ruta graveolens (n = 14; 2.71 ± 0.99 to 3.36 ± 1.34; Δ = +0.64 ± 0.63; p = 0.007; d = 1.02), Gnaphalium polycephalum (n = 13; Δ = +0.54 ± 0.52; p = 0.016; d = 1.04), and Kali bichromicum (n = 9; Δ = +0.89 ± 0.60; p = 0.016; d = 1.48), while notable clinically positive motor gains (+0.80 to +1.00 MRC grade) were also observed in Plumbum metallicum (n = 5, p = 0.099) and Dioscorea villosa (n = 4, p = 0.092). For local paraspinal and sciatic tenderness, statistically significant reductions were concentrated in Syphilinum (n = 7; Δ = 0.86 ± 0.38; p = 0.031; d = 2.26), Gnaphalium polycephalum (n = 13; Δ = 0.54 ± 0.52; p = 0.016; d = 1.04), and Phytolacca decandra (n = 16; Δ = 0.38 ± 0.62; p = 0.034; d = 0.61).

Table 4: Remedy-Specific Subgroup Analysis of Objective Physical and Neurological Outcomes: Passive SLR Angle, MRC Muscle Power, and Local Tenderness Across Eleven Homoeopathic Medicines (N = 100)

Remedy (Side)	n	SLR (°) Pre→Post (Mean±SD)	SLR Gain Δ (Mean±SD)	SLR p (d)	Muscle Pre→Post (Mean±SD)	Muscle Δ (Mean±SD)	Muscle p (d)	Tender Pre→Post (Mean±SD)	Tender Δ (Mean±SD)	Tender p (d)
Phytolacca decandra (R)	**16**	37.6°±9.5° →	+23.56°±13.93°	< 0.001	2.00±0.89 →	+0.31±0.70	0.096 (0.44)	2.25±0.58 →	0.38±0.62	0.034 (0.61)

		61.2°±13.0°		(1.69)	2.31±1.08			1.88±0.72		
Ruta graveolens (L)	**14**	33.9°±10.4° → 63.8°±8.0°	+29.93°±11.65°	< 0.001 (2.57)	2.71±0.99 → 3.36±1.34	+0.64±0.63	0.007 (1.02)	2.21±0.70 → 2.00±0.78	0.21±0.43	0.083 (0.49)
Gnaphalium polycephalum (R)	**13**	34.3°±8.7° → 66.4°±9.9°	+32.08°±13.79°	< 0.001 (2.33)	2.69±1.03 → 3.23±0.83	+0.54±0.52	0.016 (1.04)	1.69±0.63 → 1.15±0.69	0.54±0.52	0.016 (1.04)
Helonias dioica (R)	**11**	36.6°±5.9° → 63.5°±5.4°	+26.91°±8.92°	< 0.001 (3.02)	2.64±1.21 → 3.18±1.54	+0.55±0.69	0.062 (0.80)	2.27±0.47 → 2.00±0.45	0.27±0.47	0.250 (0.57)
Ammonium muriaticum (L)	**10**	33.3°±8.1° → 62.2°±11.0°	+28.90°±11.54°	0.002 (2.50)	2.00±1.05 → 2.20±0.92	+0.20±0.63	0.625 (0.32)	1.70±0.48 → 1.80±0.92	-0.10±0.74	1.000 (0.14)
Kali bichromicum (R)	**9**	34.0°±6.8° → 66.9°±11.8°	+32.89°±15.62°	< 0.001 (2.11)	2.78±0.97 → 3.67±1.32	+0.89±0.60	0.016 (1.48)	2.11±0.60 → 1.56±1.13	0.56±0.88	0.095 (0.64)
Ranunculus bulbosus (L)	**8**	33.1°±3.6° → 55.6°±9.1°	+22.50°±10.27°	< 0.001 (2.19)	2.62±0.92 → 2.88±0.99	+0.25±0.71	0.351 (0.35)	2.00±0.76 → 1.88±0.99	0.12±0.83	0.685 (0.14)
Syphilinum (Luesinum) (R)	**7**	33.1°±9.2° → 58.0°±10.7°	+24.86°±15.86°	0.006 (1.57)	2.43±0.79 → 2.86±0.90	+0.43±0.79	0.500 (0.54)	1.43±0.53 → 0.57±0.53	0.86±0.38	0.031 (2.26)
Plumbum metallicum (L)	**5**	42.0°±4.8° → 61.6°±10.7°	+19.60°±11.61°	0.020 (1.69)	2.20±0.45 → 3.00±1.00	+0.80±0.84	0.099 (0.95)	2.00±0.71 → 2.00±0.71	0.00±0.00	1.000 (0.00)
Dioscorea villosa (R)	**4**	31.5°±6.5° → 58.0°±5.0°	+26.50°±9.33°	0.011 (2.84)	2.75±0.50 → 3.75±0.50	+1.00±0.82	0.092 (1.22)	1.50±0.58 → 1.75±0.96	-0.25±0.50	0.391 (0.50)
Tellurium metallicum (R)	**3**	29.7°±2.1° → 54.3°±1.5°	+24.67°±3.21°	0.006 (7.69)	2.00±0.00 → 2.67±0.58	+0.67±0.58	0.184 (1.16)	1.67±0.58 → 1.00±1.00	0.67±0.58	0.184 (1.16)

Note: For Passive SLR Angle and MRC Muscle Power, positive Δ values represent functional improvement (increase in angle/strength); for Local Tenderness, positive Δ values represent reduction in palpatory tenderness. Values in parentheses denote Cohen's d.

4. Discussion

This prospective, single-blind clinical investigation evaluated the therapeutic utility of eleven individualized rare and lesser-known homoeopathic medicines selected via Roger van Zandvoort's Complete Repertory in 100 patients with lumbosacral radiculopathy (sciatica). Over the 6-month observation period, individualized homoeopathic management produced highly significant improvements across both patient-reported disability scales and clinician-measured neurological parameters: radicular pain severity (VAS) fell by 53.6% ($\Delta = 3.75 \pm 1.71$, $p < 0.001$, $d = 2.19$) and back-specific functional disability (MSBQ) decreased by 47.4% ($\Delta = 4.04 \pm 2.19$, $p < 0.001$, $d = 1.84$). Crucially, these symptomatic gains were accompanied by an 82.2% reduction in weekly rescue analgesic consumption (dropping from 7.77 ± 1.25 to 1.38 ± 1.00 pills/week, $p < 0.001$, $d = 4.10$). In clinical trials of radicular pain, analgesic-sparing effect is a vital internal validity indicator: it demonstrates that the observed reductions in VAS and MSBQ scores were not artifacts of concurrent NSAIDs or Gabapentinoid escalation, but reflected genuine resolution of radicular inflammation[16,22].

Equally important from a neuro-orthopedic standpoint is the substantial recovery of passive Straight Leg Raise (SLR) excursion, which rose by +27.26° ± 12.49° from a baseline mean of 34.86° ± 8.06° to 62.12° ± 10.09° at 6 months ($p < 0.001$, $d = 2.18$). Biomechanically, passive hip flexion with the knee extended places progressive tensile load on the L4, L5, and S1 nerve roots as they traverse the intervertebral neural foramina; pain reproduction below 40° (a strongly positive Lasègue's sign) indicates acute perineural edema and dural sleeve mechanosensitivity [1,6]. Crossing the 60° threshold at 6 months—accompanied by a statistically significant gain in myotomal motor strength (MRC grade rising from 2.45 to 2.97, $p < 0.001$) and reduced Valleix-point tenderness ($p < 0.001$)—provides objective physical evidence of nerve-root decompression and restored axoplasmic conduction.

A central contribution of our study is the demonstration that moving beyond routine polychrests via the Complete Repertory yields a natural, unequal clinical distribution across eleven specialized remedies, partitioned cleanly between right-sided (n = 63) and left-sided (n = 37) radiculopathy. Among the right-sided remedies, Phytolacca decandra (n = 16, 16.0%) was the most frequently indicated prescription, achieving highly significant reductions in VAS pain ($\Delta = 3.88 \pm 1.78$, $p < 0.001$), MSBQ disability ($\Delta = 4.81 \pm 2.23$, $p < 0.001$), analgesic intake ($\Delta = 6.31$ pills/week, $p < 0.001$), and local tenderness ($p = 0.034$), alongside a +23.56° gain in SLR. Pathogenetically, Phytolacca exhibits a marked affinity for fibrous sheaths, periosteum, and the fascia lata, matching right-sided sciatica where electric-like lancinating pains shoot rapidly down the outer aspect of the thigh and worsen in damp weather and at night[11,13].

Gnaphalium polycephalum (n = 13, 13.0%) and Helonias dioica (n = 11, 11.0%) formed the next major right-sided subgroups. Gnaphalium is classically distinguished by intense darting pain along the sciatic nerve alternating with—or succeeded by—distressing sensory numbness and formication, relieved by flexing the thigh on the abdomen or sitting in a chair[12,13]. In our cohort, Gnaphalium produced significant improvements across every single outcome domain, including a +32.08° ± 13.79° gain in passive SLR ($p < 0.001$), a +0.54-grade improvement in motor power ($p = 0.016$), and a 0.54-grade reduction in tenderness ($p = 0.016$). Helonias dioica proved highly effective in multiparous female patients and debilitated workers presenting with right-sided sciatica secondary to chronic lumbosacral-pelvic congestion and burning lumbar weariness (VAS $\Delta = 3.64$, MSBQ $\Delta = 4.18$, SLR +26.91°, all $p < 0.001$)[12].

Among the specialized right-sided remedies with smaller subgroup sizes, each validated its classical keynote indications. Kali bichromicum (n = 9) achieved the highest mean pain reduction (VAS $\Delta = 4.89 \pm 1.69$, $p < 0.001$), the greatest SLR restoration (+32.89° ± 15.62°, $p < 0.001$), and a +0.89-grade motor strength gain ($p = 0.016$) in patients whose radicular pains shifted abruptly between the hip, knee, and heel. Syphilinum (n = 7), prescribed when excruciating right sciatic pain exhibited a strict sunset-to-sunrise nocturnal periodicity, produced the largest reduction in deep paraspinal tenderness ($\Delta = 0.86 \pm 0.38$, $p = 0.031$) alongside a 3.71-point drop in VAS ($p = 0.001$). Dioscorea villosa (n = 4) achieved the highest functional MSBQ improvement ($\Delta = 5.75 \pm 3.50$, $p = 0.046$) in patients whose pain was uniquely relieved by standing erect or hyperextending the spine backward (a posture that biomechanically unloads anterior disc protrusion), while Tellurium metallicum (n = 3; VAS $\Delta = 4.33$, $p = 0.039$; SLR +24.67°, $p = 0.006$) resolved radiculopathy characterized by exquisite sensitivity to dural pressure surges during coughing, sneezing, or Valsalva strain.[11-13,19]

In the Left-sided Sciatica cohort (n = 37), Ruta graveolens (n = 14, 14.0%) and Ammonium muriaticum (n = 10, 10.0%) accounted for nearly two-thirds of prescriptions. Ruta graveolens—indicated for deep-seated bruised aching along the left ischial tuberosity and hamstring insertion aggravated by cold dampness and lying down—produced a 4.36-point drop in VAS ($p < 0.001$), a +29.93° increase in SLR ($p < 0.001$), and a statistically significant +0.64-grade recovery in lower-limb motor power ($p = 0.007$). Ammonium muriaticum, selected via the classic Complete Repertory rubric of left sciatic pain worse while sitting, relieved while walking, and entirely ameliorated on lying down with a

sensation of hamstring tendon shortening[11,14], yielded a +28.90° ± 11.54° SLR gain ($p = 0.002$) and a 6.20-pill/week drop in analgesic use ($p < 0.001$). Finally, Ranunculus bulbosus (n = 8) effectively controlled stitching, weather-sensitive left radiculitis (VAS Δ = 3.25, analgesic drop 6.88 pills/week, both $p < 0.001$), while Plumbum metallicum (n = 5), indicated for chronic left radiculopathy with lightning-like pains and incipient motor paresis, achieved a 5.00-point reduction in MSBQ disability ($p = 0.004$) and a +0.80-grade gain in motor strength.

4.1 Study Strengths and Methodological Limitations

Notable strengths of this study include its prospective 6-month longitudinal follow-up, 100% completion rate among enrolled subjects, Computerized Repertorization using the Complete Repertory in CARA software, single-blinding with interspersed Sacchrum lactis control periods, and the integration of subjective questionnaires (VAS, MSBQ) with objective physical examination endpoints (goniometric SLR, MRC muscle grading, and weekly analgesic logs). Certain limitations nevertheless merit consideration. First, the absence of an untreated or parallel placebo-only control arm limits our ability to partition the specific therapeutic effect of the homoeopathic remedies from natural spontaneous regression of acute disc herniation over 6 months. Second, MRI neuroimaging was not repeated at the 6-month endpoint to correlate clinical SLR and motor recovery with anatomical disc resorption. Third, because remedies were allocated naturally according to individualized symptom totality, sample sizes in the rarer tail subgroups (Plumbum metallicum n = 5, Dioscorea villosa n = 4, and Tellurium metallicum n = 3) were small, limiting statistical power for secondary ordinal endpoints such as tenderness. Future multi-center, double-blind, randomized controlled trials incorporating serial MRI neuroimaging and electrodiagnostic nerve conduction studies are recommended.

5. Conclusion

This prospective, single-blind clinical study demonstrates that individualized rare and lesser-known homoeopathic medicines selected systematically via the Complete Repertory approach are highly effective in the clinical management of Lumbosacral Radiculopathy (Sciatica). Over 6 months of treatment, individualized prescriptions across eleven remedies—Phytolacca decandra, Ruta graveolens, Gnaphalium polycephalum, Helonias dioica, Ammonium muriaticum, Kali bichromicum, Ranunculus bulbosus, Syphilinum, Plumbum metallicum, Dioscorea villosa, and Tellurium metallicum—significantly reduced radicular pain severity and functional back disability, restored passive Straight Leg Raise mobility and myotomal motor strength, and eliminated 82.2% of rescue analgesic intake. Respecting anatomical laterality and characteristic kinetic modalities enables homoeopathic physicians to achieve durable neuro-functional recovery in sciatica without the adverse effects of chronic analgesic pharmacotherapy.

Declarations

Ethics Approval and Consent to Participate: The study protocol was approved by the Institutional Ethical Committee of Janardan Rai Nagar Rajasthan Vidyapeeth (Deemed to be University), Udaipur, Rajasthan, India. Written informed consent (in Hindi and English) was obtained from all 100 participants prior to enrollment.

Consent for Publication: Not applicable, as no individual patient-identifiable data or images are included.

Availability of Data and Materials: The master chart and complete statistical datasets generated and analyzed during the present study are available from the corresponding author upon reasonable request.

Competing Interests: The authors declare no competing financial or non-financial interests.

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Author Contributions: MC conceived the study protocol, performed clinical case-taking, neurological examinations, CARA repertorization, and 6-month patient follow-ups at the RKCHMS Bhopal OPD, and drafted the manuscript. LJ supervised the doctoral research, verified repertorial rubrics and remedy selections, and critically reviewed the manuscript. JNS contributed to homoeopathic posology, quality control, and statistical analysis. AA provided methodological supervision and clinical appraisal. PT and AC assisted in data curation, statistical verification, and manuscript preparation. All authors read and approved the final manuscript.

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