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Scope of homoeopathic management in hypothyroidism: A case report

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Abstract
Hypothyroidism is a widely discussed term these days in medical field owing to its affection which involves different organ system and hypo metabolism. Also the cardiac and OBG complications wrapped as an essential prognosis makes its management even more controversial. The adequate clinical examination, intricate investigative measures with proper screening leads to well established diagnosis of the above. The survey report study suggests, around 1.8% of the population is affected by it which positions it almost 2nd to DM in terms of endocrine disorders.

Keywords: Tetraiodothyronine, hypothyroidism, thyroid gland, thyroid stimulating hormone (TSH)

Introduction

To evaluate this intricate and broad subject, we need to understand and unravel the core with its defined layers. So, in order to understand 'Hypothyroidism' we need to grasp the true mechanism and modus operandi involved with the 'Thyroid Gland'.

Thyroid Gland: It is the largest gland of endocrine system which weighs b/w 15-25gms. Measures around 5cms; extends from between C5 to T1 vertebrae. Located anteriorly to the trachea between the cricoid cartilage and suprasternal notch. The two right and left lobes are connected infer medially by 'ISTHMUS'; while the posteromedial sections are attached by lateral thyroid ligaments to the cricoid cartilage. The thyroid follicles are formed by simple low columnar/cuboidal epithelium. There are two biologically active thyroid hormones: -

1. Tetraiodothyronine (T_4) - Thyroxine.
2. Triiodothyronine (T_3) - derived product of modification of tyrosine.

Thyroid Stimulating Hormone (TSH) being the dominant growth/function regulator of thyroid gland is released in pulsatile manner from the anterior pituitary.

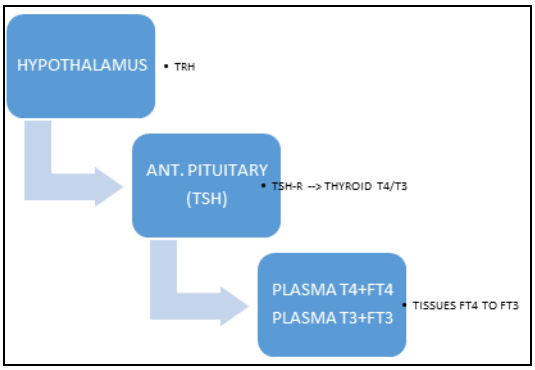


Fig 1: Thyroid Regulation

Composition of TSH: It is composed of two subunits

1. Alpha subunit: LH, FSH, HCG.
2. Beta subunit: Receptor binding.

Action of TSH

1. In increasing the transport of iodide into follicular cells.
2. Increase in production of thyroglobulin.
3. Increase in iodination of thyroglobulin.

Increase in iodination of thyroglobulin

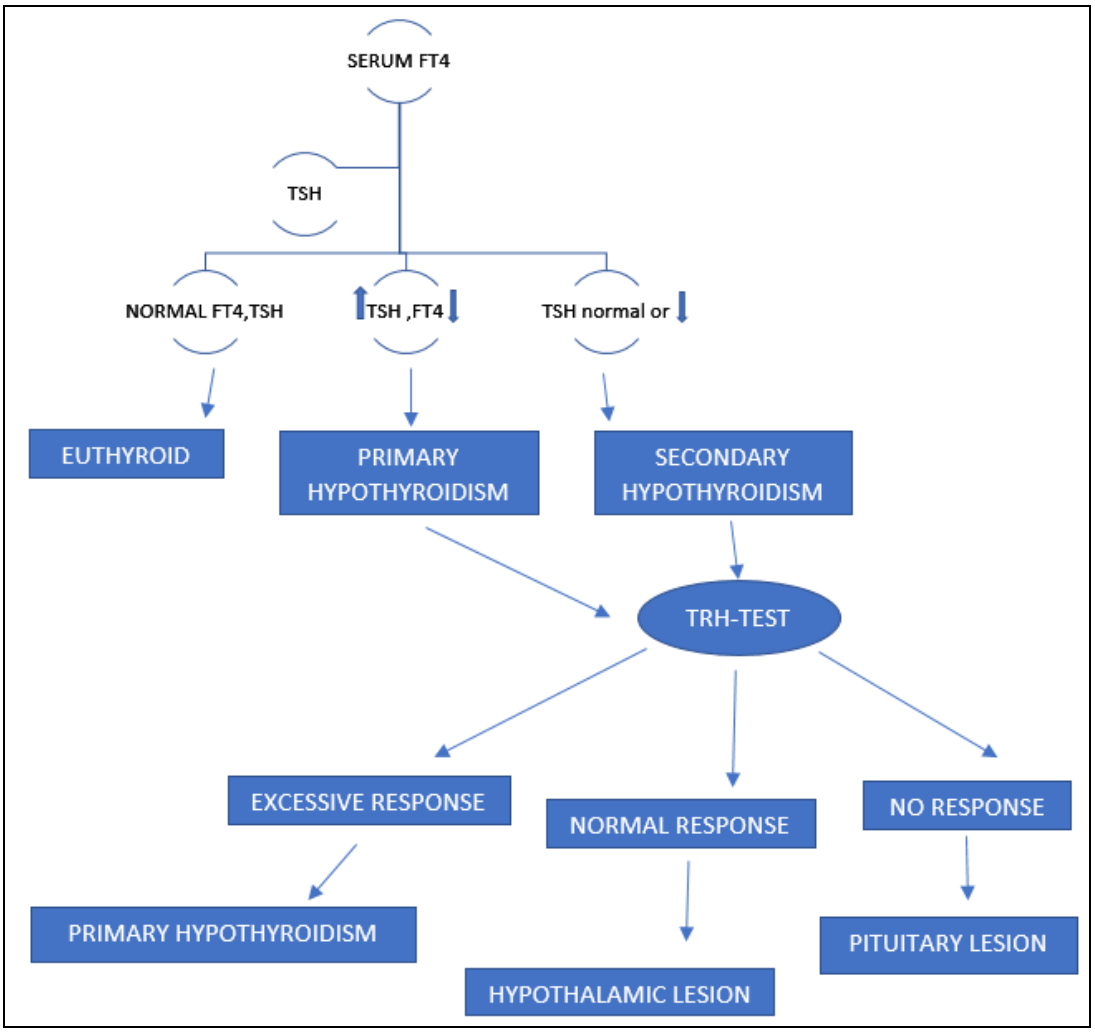


Fig 2: Classification of hypothyroidism (based on thyroid function test)

Table 1: Interpretation of thyroid function test

	Low T4	Normal T4	High T4
Low TSH	Pituitary/hypothalamic hypothyroidism	Subclinical hyperthyroidism	hyperthyroidism
Normal TSH	Severe non thyroidal illness	Normal	----------
High TSH	Primary hypothyroidism	Subclinical hypothyroidism	Pituitary hyperthyroidism

Aetiology

1. Primary

- Autoimmune hypothyroidism: Hashimoto's thyroiditis, atrophic thyroiditis.
- Congenital.
- Drugs.
- Radiation therapy.
- Infiltrative disorders/iodine deficiency.

2. Transient

a) Silent thyroiditis
b) Postpartum disorders.
c) Sub-acute thyroiditis.

3. Secondary

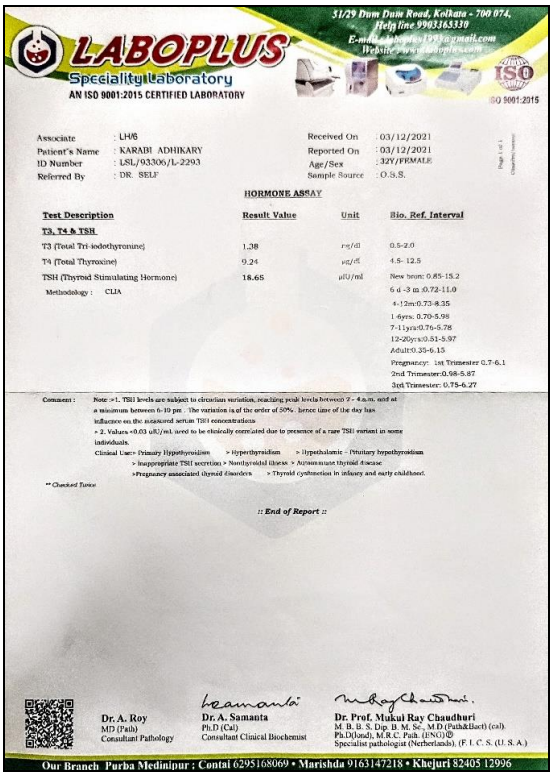
a) Tumors, trauma, infiltrative disorders, idiopathic.
b) TSH Deficiency or inactivity.

Signs and symptoms

Symptoms	Signs
Tiredness/Prostration/Exhaustion	Dry mouth/tongue/skin
Dry skin and cold tendency	Slow movement/ lethargic feeling
Hair loss	Bradycardia
Dyspnea	Periorbital oedema
Constipation	Diastolic hypertension
Myalgia	Slow reflex
Depression	Palpitations
Anxiety	

Case Proper

A female of age ’33 years old’ visited the OPD of NIH on 28/04/22 with complaints of excessive exhaustion and prostration. Accompanied with rise in palpitation, vertigo, loss of appetite, persistent insomnia and emaciation over whole body as stated by the patient (since 1 year). Based on clinical examination and extensive lab investigation reports submitted, other possibilities were excluded and the diagnosis was established to be, ‘Subclinical Hypothyroidism’. The following test reports were submitted of previous investigations done by the patient. TILL FEB 2022, the patient was under allopathic medication but due to excessive derangement of generalities the patient stopped it abruptly in March. After a span of around one month visited OPD with a current thyroid profile investigation indicating TSH to be on higher levels (46.32 Uiu/ml). Whereas with clinical examination no adenoma/swelling was detected, neither the patient complained of Globus hysteric us. The LFT and blood sugar examination which was carried out around 4 months ago also suggested of normal readings.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E-mail : laboplus199@gmail.com
Website : www.laboplus.com

Associate : LH/6
Patient's Name : KARABI ADHIKARY
ID Number : LSL/93306/L-2293
Referred By : DR. SELF

Received On : 03/12/2021
Reported On : 03/12/2021
Age/Sex : 32Y/FEMALE
Sample Source : O.S.S.

HORMONE ASSAY

Test Description	Result Value	Unit	Bio. Ref. Interval
T3, T4 & TSH			
T3 (Total Tri-iodothyronine)	1.28	ng/dl	0.5-2.0
T4 (Total Thyroxine)	9.24	µg/dl	4.5- 12.5
TSH (Thyroid Stimulating Hormone)	18.65	µIU/ml	New born: 0.85-15.2 6 d -3 m :0.72-11.0 4-12m:0.73-8.35 1-6yrs: 0.70-5.98 7-11yrs:0.76-5.78 12-20yrs:0.51-5.97 Adult:0.35-6.15 Pregnancy: 1st Trimester 0.7-6.1 2nd Trimester:0.98-5.87 3rd Trimester: 0.75-6.27

Methodology : CLIA

Comment : Note :>1. TSH levels are subject to circadian variation, reaching peak levels between 2 - 4 a.m. and at a minimum between 6-10 pm . The variation is of the order of 50% . hence time of the day has influence on the measured serum TSH concentrations
> 2. Values <0.03 uIU/ml, need to be clinically correlated due to presence of a rare TSH variant in some individuals.
Clinical Use:> Primary Hypothyroidism > Hyperthyroidism > Hypothalamic - Pituitary hypothyroidism > Inappropriate TSH secretion > Nonthyroidal illness > Autoimmune thyroid disease >Pregnancy associated thyroid disorders > Thyroid dysfunction in infancy and early childhood.

** Checked Twice

:: End of Report ::

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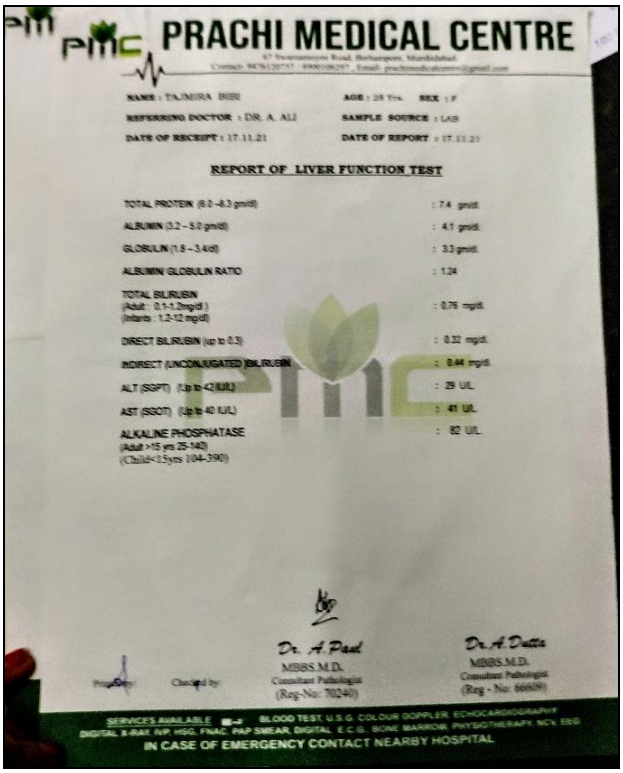
PRACHI MEDICAL CENTRE

NAME : TAJMIRA BIBI AGE : 28 Yrs. SEX : F
REFERRING DOCTOR : DR. A. ALI SAMPLE SOURCE : LAB
DATE OF RECEIPT : 17.11.21 DATE OF REPORT : 17.11.21

REPORT OF LIVER FUNCTION TEST

TOTAL PROTEIN (6.0 -8.3 gm/dl)	: 7.4 gm/dl
ALBUMIN (3.2 – 5.0 gm/dl)	: 4.1 gm/dl
GLOBULIN (1.8 – 3.4 dl)	: 3.3 gm/dl
ALBUMIN GLOBULIN RATIO	: 1.24
TOTAL BILIRUBIN (Adult : 0.1-1.2mg/dl) (Infants : 1.2-12 mg/dl)	: 0.76 mg/dl
DIRECT BILIRUBIN (up to 0.3)	: 0.32 mg/dl
INDIRECT (UNCONJUGATED) BILIRUBIN	: 0.44 mg/dl
ALT (SGPT) (Up to 42 IU/L)	: 29 U/L
AST (SGOT) (Up to 40 IU/L)	: 41 U/L
ALKALINE PHOSPHATASE (Adult >15 yrs 25-140) (Child<15yrs 104-390)	: 82 U/L

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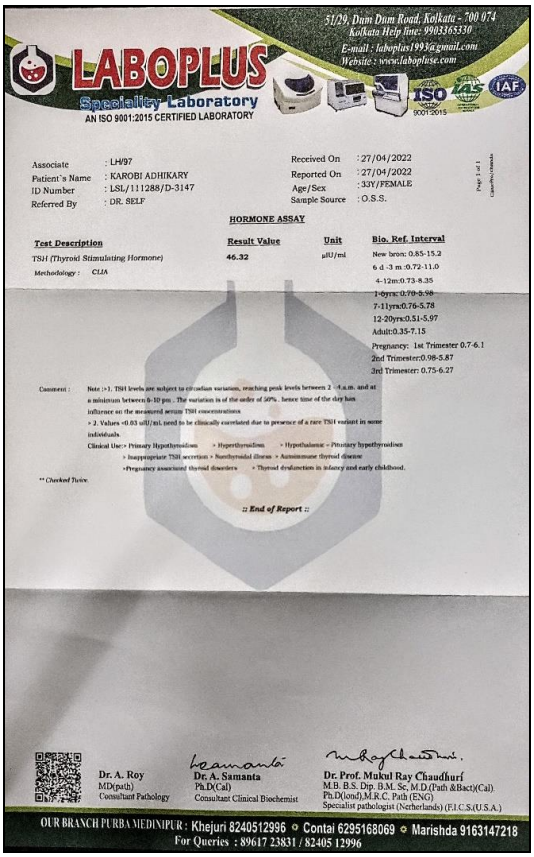
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E-mail : laboplus199@gmail.com
Website : www.laboplus.com

Associate : LH/97
Patient's Name : KAROBI ADHIKARY
ID Number : LSL/111288/D-3147
Referred By : DR. SELF

Received On : 27/04/2022
Reported On : 27/04/2022
Age/Sex : 33Y/FEMALE
Sample Source : O.S.S.

HORMONE ASSAY

Test Description	Result Value	Unit	Bio. Ref. Interval
TSH (Thyroid Stimulating Hormone)	46.32	µIU/ml	New born: 0.85-15.2 6 d -3 m :0.72-11.0 4-12m:0.73-8.35 1-6yrs: 0.70-5.98 7-11yrs:0.76-5.78 12-20yrs:0.51-5.97 Adult:0.35-7.15 Pregnancy: 1st Trimester 0.7-6.1 2nd Trimester:0.98-5.87 3rd Trimester: 0.75-6.27

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For Queries : 89617 23831 / 82405 12996

Present Complaint

Past History

1) Chicken Pox – 2 Years Ago.
2) Miscarriage - 10 Years Ago.

Menstrual History: Menarche: 12 years of age
LMP – 10/5/22, Duration- 3 Days
Nature And Character - Irregular, profuse, dark reddish in colour, clotted/watery, no offensive, Odour.

Personal history

1. Occupation: Housewife.
2. Accommodation: Pakka house, ventilated with no dampness.
3. Marital status: married since 10 years.
4. Obstetrical history- P1+11 NVD (8 yrs. ago), 1 Clinical Abortion (5 yrs. ago).
5. No. of children – 1 boy (8 years old).
6. Tongue – white coating on tongue, dry, cracked.
7. Appetite- good but feels emaciated even after eating.
8. Socio-economic background-poor.

Physical generals

1. T/R - Hot patient, can't tolerate sun (burning in eyes/vertigo/headache), hot vertex.
2. DESIRE - Raw salt++, spicy food, milk and milk products.
3. Aversion-roti.
4. Intolerance- kocchu patta.
5. Thirst – Profuse, 3-4 l/day, desire to dissolve pinch of salt in water.
6. Stool – Unsatisfactory, regular but constipated no offensive smell.
7. Urine – Can't hold urge, involuntary dribbling.
8. Sleep and dreams – persistent insomnia, disturbed sleep wakes up with jerks preferred decubitus- supine position (on back).
9. Perspiration – profuse on face and neck, leaves no stains, no offensive odour.

Mental generals

1. Timid, shy, polite, doesn't get angry easily, keeps feeling suppressed.
2. Doesn't revolt against injustice/insults but remembers very vividly.
3. Memory power good.
4. Desires solitude, socially awkward, aversion to social gatherings.
5. Grief prolonged along with great anxiety regarding future.

Totality of symptoms

1. Prolonged, persistent grief and despair with great anxiety regarding future.
2. Aversion to social gatherings and desires for solitude.
3. Intolerance to sunlight (headache/burning sensation in eyes and head/fullness/straining)
4. Exhaustion, prostration with excessive palpitation.
5. Perspiration profuse around neck and face.
6. Cracked tongue with dryness in mouth.
7. Constipated stool, great straining, dry and hard.
8. Involuntary dribbling of urine, cannot hold the urge in excitement.
9. Disturbed sleep, waking frequently with jerks.
10. Good appetite with emaciation of whole body.
11. Aversion to roti.
12. Great longing for salt.

Repertorisation

Rubrics	Drug Remedy						
	NAT-M	Calc.	Sulph.	NUX-V	Phos.	Chin.	Sep.
Total Symptoms	20	14	13	12	13	11	11
Total Degree	42	25	23	19	29	21	20
MIND-Ailments From-Grief-silent grief	3						
MIND- Anxiety- future, about	2	3	2	2	3	2	2
MIND-Company-Aversion TO-desire for solitude	3		1	1			1
MIND- Fear- people	2	1	1			1	1
MIND-Indifference-everything	2	1	1	2	2	1	2
MIND-Light-aversion to-sunlight	1	2			1		
MIND-Eyes-evading the look of other persons-spoken to; when	1						
MIND-Palpitation agg.	1	1		1	1		
HEAD-Pain-Forehead-supper-after	1						
EYES-Fullness, sensation of	1		1	1			1
EYE-Looking-pressing pain	3		1		2		
EYE-Photophobia-light; from-sunlight	1	1	3		2	3	
FACE-Eruptions-Lips-perspiration, during	3	1		2			2
Mouth-Cracked-tongue fissured	1	2	2	1	3	2	
Rectum-inactivity of rectum	3	2	2	3	3	2	2
Bladder-Urination-involuntary	3	1	2	2	3	2	3
Sleep-Waking-frequent	2	3	3	1	3	2	3
Generals-Emaciation-appetite; ravenous	3	3	2	2	2	1	
generals-food and drinks-bread-aversion	3	2	2	1	1	3	2
generals-food and drinks-salt-desire	3	2			3	2	1

Result This case was repertories using synthesis repertory and software radar opus 3.1.5. The provided result was analysed and rationalized, prioritizing equal importance to nearly all the symptoms forming the foundation for totality of the case report. The most well indicated remedy was Natrum muriaticum.

Prescription

Rx

1. Natrium Muriaticum 0/1, 0/2 * 16 Doses.
   BD*16 Days (EACH).
2. Rubrum Met 200/2 Drachms.
   BD*One Month.

Timeline (Course of Treatment)

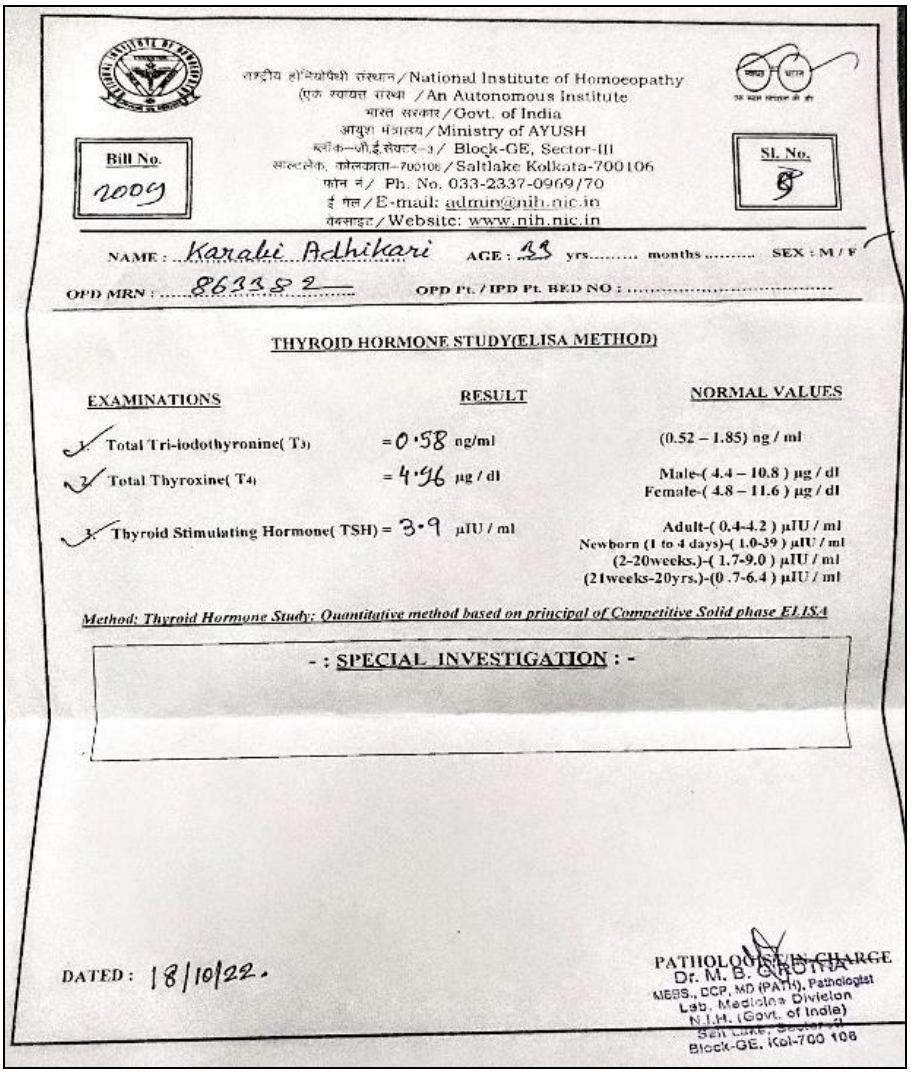
The treatment started from 28th April 2022, followed by a rigorous course of treatment of around 5 months. 'Natrium Muriaticum' was selected as the most indicated constitutional remedy which was being prescribed on 'LM potency' till '0/11 &0/12'till 5 follow-ups (Sep).

Followed by 'Variolinum 200'; 2 Doses, as an Intercurrent in the 4th follow up i.e., in the month of August.

Since the generalities were being improved to a much higher extent, the pt. was advised for "Thyroid profile test'' again. Which was carried out in the diagnostic lab of the hospital itself on '18th Oct 2022".

Date	Follow-Ups
27/05/22	PT. Feels better than before, sleep cycle improved, darkish pigmentation decreased 20%, excessive palpitation decreased
28/06/22	Appetite increased with gain in body weight of 1.5Kgs, nausea relieved, relief from excessive palpitation, darkish pigmentation decreased 40%
30/07/22	Stool-regular, satisfactory, rarely constipated sleep cycle-balanced relief from excessive exhaustion and prostration mind-cheerful new acute complaint- allergic rhinitis
28/08/22	Intercurrent was introduced. Was advised to include fresh fruits and vegetables in diet/morning walks.
25/09/22	All generalities were improved. Pt. was advised for 'Thyroid profile test' to correlate the condition with investigative reports

Result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Bill No. 10059

Sl. No. 8

NAME : Karabi Adhikari AGE : 33 yrs..... months..... SEX : M / F

OPD MRN : 8633882 OPD Pt. / IPD Pt. BED NO : .....

THYROID HORMONE STUDY(ELISA METHOD)

EXAMINATIONS	RESULT	NORMAL VALUES
1. Total Tri-iodothyronine(T_3)	= 0·58 ng/ml	(0.52 – 1.85) ng / ml
2. Total Thyroxine(T_4)	= 4·96 µg / dl	Male-(4.4 – 10.8) µg / dl Female-(4.8 – 11.6) µg / dl
3. Thyroid Stimulating Hormone(TSH)	= 3·9 µIU / ml	Adult-(0.4-4.2) µIU / ml Newborn (1 to 4 days)-(1.0-39) µIU / ml (2-20weeks.)-(1.7-9.0) µIU / ml (21weeks-20yrs.)-(0 .7-6.4) µIU / ml

Method: Thyroid Hormone Study: Quantitative method based on principal of Competitive Solid phase ELISA

- : SPECIAL INVESTIGATION : -

DATED : 18/10/22.

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Salt Lake, Sector-III
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Fig 3: The TSH Levels indicate a lowering up to 3.9Uiu/ml.

Discussion

A 33 yr. old female, from Kolkata, west Bengal visited; 'National Institute of Homoeopathy' on 28th April 2022 (OPD Reg No 8863382) with numerous general complaints along with test reports suggesting elevation in TSH levels since Last Nov 2021 (based on the speculation of

investigative reports). Excluding all other probabilities with thorough clinical examinations and investigations the case was diagnosed to be 'subliminal hypothyroidism'. Based on brief detailed clinical study and comprehensive analysis of patient's history. The most well indicated constitutional remedy was introduced as 'Natrium Muriaticum' In 'LM potency' which led to positive evidential result in approx. 5 months.

Coming from a homoeopathic background, the main point of concern was not only to lower the TSH levels but also to treat patient as a whole and individually. The improvement of physical and mental treatment and also lowered down her anxiety levels.

Conclusion

With the positive outcome, this case report can be considered as an exemplary therapeutics for another possible certified branch of medication. Suggestive homoeopathic intervention in these cases of hormonal misbalance emphasizes on reliability of another parallel mode of treatment. It might be slightly time taking in some cases; although, as the aim is not to palliate but to bring cure and restore the sick to health in every possible dimension it is relatively cost effective, simple, repeatable and easily acceptable for nearly all gradations and creed of patient.

Financial support and sponsorship: Nil.

Conflicts of interest: None declared.

Reference

1. Kent JT. Lectures on homoeopathic Materia medica: Together with Kent's "new remedies incorporated" and arranged in one alphabetical order. New Delhi, India. B Jain; c2022.
2. Phatak SR. Material Medical of Homoeopathic Medicines: Revised edition. New Delhi. India: B Jain; c2022.
3. Schroyens F, Editor. Textbook of repertory language: For essential synthesis, Aberdeen, Scotland: Homoeopathic Book; c2007.
4. Boericke W, Boericke OE. Homoeopathic Material medical with repertory comprising the characteristics and guiding symptoms of the remedies.2nd ed. Savage RB, editor. Sittingbourne, England: homoeopathic book service; c1990.
5. Biondi B, Cooper DS. The clinical significance of subclinical thyroid dysfunction. Endocr Rev. 2008;29:76-131.
6. Cooper DS, Biondi B. Subclinical thyroid disease. Lancet. 2012;379:1142-54.
7. Stockigt Assessment of thyroid function: towards an integrated laboratory-clinical approach. Clin Biochem Rev. 2003 Nov;24(4):109-22.
8. Surks MI, Ortiz E, Daniels GH, Sawin CT, Col NF, Cobin RH, *et al.* Subclinical thyroid disease: scientific review and guidelines for diagnosis and management. JAMA. 2004 Jan 14;291(2):228-38.
9. Zulewski H, Muller B, Exer P, Miserez AR, Staub JJ. Estimation of tissue hypothyroidism by a new clinical score: evaluation of patients with various grades of hypothyroidism and controls. J Clin Endocrinol Metab. 1997 Mar 1;82(3):771-6.
10. Billewicz WZ, Chapman RS, Crooks J, Day ME, Gossage J, Wayne E, *et al.* Statistical methods applied to the diagnosis of hypothyroidism. QJ Med. 1969 Apr 1;38(2):255-66.
11. Dittmar M, Kahaly GJ. Polyglandular autoimmune syndromes: immunogenetics and long-term follow-up. J Clin Endocrinol Metab. 2003 Jul 1;88(7):2983-92.
12. Perros P, McCrimmon RJ, Shaw G, Frier BM. Frequency of thyroid dysfunction in diabetic patients: value of annual screening. Diabet Med. 1995 Jul;12(7):622-7.
13. Kordonouri O, Maguire AM, Knip M, Schober E, Lorini R, Holl RW, *et al.* Other complications and associated conditions with diabetes in children and adolescents. Paediatric Diabetes. 2009 Sep;10(Suppl 12):204-10.
14. Gerstein HC. Incidence of postpartum thyroid dysfunction in patients with type me diabetes mellitus. Ann Intern Med. 1993 Mar 15;118(6):419- 23.
15. Gussekloo J, van Exel E, de Craen AJ, Meinders AE, Frolich M, Westendorp RG. Thyroid status, disability and cognitive function, and survival in old age. JAMA. 2004 Dec 1;292(21):2591-9.
16. Van de Ven AC, Muntjewerff JW, Netea-Maier RT, De Vegt F, Ross HA, Sweep FC, *et al.* Association between thyroid function, thyroid autoimmunity, and state and trait factors of depression. Acta Psychiatry Scand. 2012 Nov;126(5):377-84.
17. Biondi B. Mechanisms in endocrinology: Heart failure and thyroid dysfunction. Eur J Endocrinol. 2012;167:609-18.
18. Gencer B, Collet TH, Virgini V, Bauer DC, Gussekloo J, Cappola AR, *et al.* Subclinical thyroid dysfunction and the risk of heart failure events: an individual participant data analysis from 6 prospective cohorts. Circulation. 2012 Aug 28;126(9):1040-9.
19. Andersen S, Pedersen KM, Bruun NH, Laurberg P. Narrow individual variations in serum T(4) and T(3) in normal subjects: A clue to the understanding of subclinical thyroid disease. J Clin Endocrinol Metab. 2002 Mar 1;87(3):1068-72.
20. Baskin HJ, Cobin RH, Duick DS, Gharib H, Guttler RB, Kaplan MM, *et al.* American Association of Clinical Endocrinologists medical guidelines for clinical practice for the evaluation and treatment of hyperthyroidism and hypothyroidism. Endocr Pract. 2002;8:457-69.

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