

Role Of Individualized Homoeopathic Treatment In Improving Quality Of Life In Migraine Patients.

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Abstract

The concept of the “new man” in Colossians 3:12–16 speaks of the transformation of life and character of a person who has been united with Christ. For theology students, this understanding is very important because it not only emphasizes mastery of theology, but also demands the realization of a life that reflects the character of Christ in academic, church, and social environments. In the process of theological education, various challenges such as academic pressure, moral demands, expectations of church service, and the dynamics of social relations often test the maturity of faith and character. Therefore, Paul's advice in Colossians 3:12–16 about mercy, kindness, humility, gentleness, patience, forgiveness, love, peace, and the word of Christ become an important foundation for the formation of the identity of the new man who lives in Christ. This study aims to explain how the character of Christ becomes the basis of the identity of the new man for theology students and analyze its implications for the formation of character and integrity in theological education. The study uses a qualitative theological approach with a literature study method, through a review of the biblical text (Colossians 3:12–16), Pauline theological literature, and contextual reflection on the formation of today's theology students. The research findings show that the character of Christ in this text is not merely a moral code, but rather a new identity that marks a true life in fellowship with Christ. Therefore, the formation of theology students must center on Christ as the primary example to foster a life filled with love, peace, and the truth of the Word, and to become a tangible witness to the Gospel in society. Migraine is a disabling cause of a very common neurological disorder, with an estimated 1.158 billion incidents around the world in the year 2021. The ongoing reality is that despite being one of those diseases contributing to the largest number of years with disability, it generally has limited conventional methods of prophylactics and abortive treatment grounded in tolerability, contraindications, non-take-up, and effectiveness. This has resulted in much impetus among patients exploring complementary alternative medicine, particularly for patient-specific homeopathy, wherein medicines are chosen for each individual based on his complete subjective symptom rather than a fixed disease protocol. In this investigation, secondary data were systematically collated from published randomized controlled trials and observational research aimed at evaluating whether homeopathy treatment individualized by the symptom totality case improved the quality of life and reduced frequency or duration of episodes and disability caused by migraines.

In line with the PRISMA systematic review guidelines, we discovered four double-blind, placebo-controlled RCTs (N = 60-98 per trial) and two prospective sub-cohort studies (N = 168-212) that were incorporated and built up based on existing RCT-only meta-analysis analysis. Herein, different study designs bring discord: namely, the results of all observational cohorts showed large and maintained changes in attacks and quality assurance over between 6-month and 24-month follow-up periods. Studies that pooled evidence from multiple RCTs found that the likelihood favored homeopathy, whereas that significance vanished if the correction for publication bias was taken and expressed with no direct relation to methodological quality and the amount of treatment so reported. Whether benefitting from the QoL outcomes or solely to the treatment consultation process-religious remedy-specific pharmacological action is yet to be confirmed with single-case and small-N methods. However, this cannot exclude the remedy from turning out to be quite worthwhile in complementing low-risk, health-centered adjuncts in an integrative migraine care setting. This paper underscores the absence of standardized, migraine-specific QoL outcome measures (eg, MSQ, MIDAS) in existing homeopathy trials. Clearly powered, consultation-controlled RCTs should seek to disentangle degrees of both that from that of the patient-specific context of individualized homeopathic treatment in relation to QoL among migraine patients.

Keywords: individualized homeopathy, migraine, quality of life, MSQ, MIDAS, systematic review

INTRODUCTION

Migraine still ranks as the most debilitating neurological disorder globally and is among the top disorders for years lost to disability across all age groups. In the 2021 GBDS, migraine cases jumped from 732.56 million in 1990 to 1,158 billion in 2021, thus coming up to 58% per cent increase, with the DALYs supposedly having increased as much over this period (GBD 2021, as cited in Frontiers in Neurology, 2025). The latest 2019 edition

of the same report highlights that migraine is second only to low back pain in case of YLDs on a global scale, hitting women, individuals in the 30–39 age bracket, and high sociodemographic index (SDI) populations the hardest way since GBD 2019 Headache Collaborators, as cited in PubMed, 2023. In 2023, it was estimated that the population would be specifically 2.9 billion people suffering from all kinds of headaches, with the age-standardized YLD rate of 487.5 per 100,000 population for migraine alone (GBD 2023 Headache Collaborators, 2025). In these numbers, it is seen that it is not an incalculable but a chronic, disabling, and, in turn, intense public health and economic concern.

The condition is translated clinically as to inclusive or exclusive typing under the International Classification of Headache Disorders, 3rd edition (ICHD-3), according to which clinical migraine would manifest as migraine without aura, migraine with aura, and chronic migraine (International Headache Society [IHS], 2018). The migrainous headache without aura is typified by moderate or severe attacks that wax and wane in sundry manners, normally unilateral, lasting 4–72 hours and INCLUDE nausea and photophobia or phonophobia (IHS, 2018). Migraine with aura is distinguished by its headache phase, itself accompanied by transient fully reversible neurological symptoms—visual, sensory, speech, motor, brainstem, or monocular retinal symptoms. These typically precede the headache timeframe such that the headache lasts a considerable time beyond the point those neurological symptoms have disappeared (IHS, 2018). Chronic episodic migraine is defined as their having at least eight migraine days per month without aura in the headache for some definite days and the frequent headache of 15 or more days per month over three months (IHS, 2018). This sort of classification is critical in the diagnosis of cases in clinical practice but also in homeopathic practice with regard to a homeopathic case-taking process because the type, periodicity, and concomitant presentations of the attack dictate the approach with individualized selection of a remedy.

Common pharmacological treatments for migraines include abortive medications for the acute treatment of migraine (triptans, NSAIDs, ergotamines) and prophylaxis agents (CGRP antagonists, anticonvulsants, beta-blockers) with their respective limitations. The treatment of migraines with a selective serotonin-agonist drug, the acute abortive first-line treatment of migraines, is associated with many side effects, including muscle tingling, redness of the skin, and tightening in the chest, ranging from life-threatening cardiovascular events and even contraindicated coronary artery disease, uncontrolled hypertension, or any cerebrovascular phenomenon in the patient's history (StatPearls, 2024). Repeated triptan use over 10 days per month can result in medication-overuse headache because triptan overuse rates vary greatly, ranging from 2.0% to 46.0% (StatPearls, 2024; PMC, 2021). Approximately 53% of patients who use triptans report that they have not been effectively cured by such therapy or cannot tolerate it effectively.

Lesser adherence makes conventional therapy mostly unsatisfactory for migrainers because of the combination of toll gaps that develop between safety and the side effects that can occur and the cost burden. This gap between more than far-from-optimal conventional therapy and effective CAM to complement it has been well reflected in migraine sufferers. Estimates from population studies indicate that 41.3–52.55% of adults faced severe headaches and migraines during the previous year with CAM use, significantly higher compared with the general community. One of the studies from Italy—with a highly-attributable rate of headache patients attending a specialized headache clinic at Camerino open in 1987—found 38.2% had used at least one modality from another CAM, and 89.3% had used CAM specifically for the remedy of their headache rather than wellness in general. Rationales for CAM initiation were consistent complaints about side effects combined with a preference for holistic, individualized efficacy of care and minimization of the use of medications from the long-term (Rossi et al., 2005; PubMed, 2018). Homeopathy is significantly one of the detected CAM modalities commonly sought by migraine patients and has a potential value in terms of clinical utility, even under research, as adjunct treatment or, rather, an alternative to the widely conventional prophylaxis.

Homeopathy is a treatment that is designed to cater for the individual's specific case, as per the definition of Samuel Hahnemann. In this process of treatment, remedies are selected according to *similia similibus curentur* (let like be cured with like) and the theory of symptom-totality, where any remedy prescribed or administered to the sick man will have to be the one which corresponds to the complete, unique symptom picture—physical, mental, and emotional—rather than a mere label of his disease (Hahnemann, 1922 6-7, 17-18). This is called a constitutional approach, which means repertorizing. It entails eliciting the most characteristic and peculiar symptoms-modality and constitutional tendencies in detail with the case-taking prior to arriving at the *simillimum*—the one single remedy, which corresponds the most to the totality of the patient (Homoeopathic Journal, 2023). By contrast with the protocol-based conventional descriptions, this treatment provides individuals with migraines and constitutes every such person as a separate clinical entity, which supporters argue is particularly well-suited with migraine, aesthetic diathesis, for instance, where trigger profiles, aura characteristics, and accompanying emotional states differ significantly among patients.

Regarding why individualized homeopathy is linked to quality of life outcomes, rather than symptom frequency alone, the rationale for this arises really from the pervasive impact of migraine upon role, emotional functioning and daily productivity - domains captured by the two valid instruments of the Migraine-Specific Quality of Life

Questionnaire (MSQ v2.1) and the Migraine Disability Assessment (MIDAS) scale. This basis for UNION has, among other proofs, already a large, prospective multicenter observational study of 212 migraine patients who were treated homeopathically in primary care and reported a large effect size for symptom-severity reduction (Cohen's $d=1.48$ at 3 months, increasing up to 2.28 at 24 months) together with congruent improvements in SF-36 Mental and Physical Component Scores, while there was also a reduction in conventional treatment and health-care service utilization (Witt et al., 2010). Double-blind, randomized, placebo-controlled evidence from earlier clinical trials, on the other hand, emerged in a rather more cautious tone: the authors showed an advantage for homeopathy in their studies, although there was strong evidence for some of the outcome measures, but by no means for all of them (Whitmarsh et al., 1997). Unfortunately, the subsequent systematic reviews and meta-analyses of RCTs on homeopathy for headache and migraine also fail to give a definitive statement about efficacy because evidence is found to be insufficient (Ernst, 2009, as shown in ScienceDirect; academia.edu meta-analysis, 2013). This is the very empirical puzzle the current study wants to resolve.

Statement of the problem. Though migraine had been of growing interest globally, there was very little existing evidence to show this exacerbation in the rising morbidity of the condition; despite the well appreciable shortcomings of pharmacological prophylaxis in migraine, most of the research on homeopathic management of migraines tends to focus mainly on attack frequency, pain intensity, and outcomes rather than patient-centered, standardized overall quality of life. Scattered evidence in observational studies includes strong effect sizes, but mixed with RCTs that at times fail and sometimes come out with no significant results found so far in studies from the indigenous clinical context in India assessing individualized treatment according to validated QoL questionnaires like the MSQ and MIDAS. This demarcates a void about whether or to what extent customized homeopathic care might truly affect the lived experience of functions in migraine sufferers isolated from an attenuation of individual symptom metrics.

Significance of the study. In measuring an individualized homeopathy's QoL impact, there are very direct clinical and policy clarifications which are in place. Homeopathy would become a viable addition or alternative in integrative migraine treatment for patients who react to or have contraindications to conventional preventive agents, provided solid proof for an improved QoL. This data would also help those within health care systems to identify the most appropriate utilization of homeopathy for migraine while identifying potential methodological changes necessary in future controlled trials. Data collected using standardized, comparable outcome measures would fortify the evidence-now largely anecdotal and poor quality observational data-needed to grow homeopathy for migraine into defensible, patient-centred practice.

3. Review of Literature

Epidemiology and burden of migraine. From what it was over the last three decades, the international presence of migraine appears to be enveloping more and more people now. According to the Global Burden of Disease Study 2021 report, 1.158 billion individuals are known to suffer from prevalent migraines around the world. That growth is a sharp 58% in the division of 732.56 million cases during the year of 1990. The major indicator of the parallel will have appeared in disability-adjusted life years (DALYs) whose increase has been happening in the relatively higher middle-SDI regions (GBD 2021 Headache Collaborators, as cited in Frontiers in Neurology, 2025). The GBD 2019 study has already cited migraine as the second-leading cause of years lived with disability (YLD) worldwide, and the disease has usually been considered an issue heavily concentrated among women and adults 30-39 years of age (GBD 2019 Headache Collaborators, as cited in PubMed, 2023). The most recent GBD 2023 calculation puts the total sum under those conditions at 2.9 billion people with headache disorders and supplemented estimates with one more type of headache disorder-that is, migraine, age-standardized YLD rate of 487.5 per 100,000 (GBD 2023 Headache Collaborators, 2025). Approximately 1.2 million Migraineurs visit an emergency department in the United States every year, and over 4 million patients suffer from chronic migraine with more than 15 headache days a month (Headache, 2017). Such severe disability, as well as high medical costs, incurred directly and indirectly, has been cited time and time again as a reason for reasons looking into something adjunctive, complementary, or alternative to manage migraine in particular.

Quality of life in migraine patients: conceptual framework. One will easily be convinced that migraine is a disease terrible beyond mere pain through its implications on impairments sustained in functional and emotional realms life quality (QoL) dimensions. QoL assessment on migraine is considered to be the most needed and essential outcome for any research that would concern migraine since it has been covered in clinical areas as well. It is accomplished through the use of the MSQ v2.1, besides ensuring that its translation into three domains is realized and construed as the role function-restrictive (limitation for daily activities), role function-preventive (no participation in a certain activity because of anticipation of attacks), and emotional function (in this case, frustration, helplessness) (Giannouli et al., 2024). Supportive of this disease-specific measure is the measurement MIDAS, the Migraine Disability Assessment, which permits the quantification of lost productivity in terms of grades across work to home and other leisure functions within the previous three calendar months with lower grades that correspond to less disability (Shibata & Ashina, 2020). Migraine is the lowest stage of lost functioning

considering attack effect recorded by patients as 90% have been found not able to function properly during the migraine attack, this becomes directly proportional to the measurable decrease in the quality of life that the attack frequency and severity draw. A very logical idea; it calls for treatment, not only for the injuries of the attack but also for measuring the effectiveness of interventions aimed at individualized homeopathy on the disease's experiential or holistic experience as opposed to an isolated phenomenon.

Historical and clinical evidence for homeopathic management of migraine. Clinical interest in homeopathy as a treatment approach for chronic allergic diseases dates back to over three decades and can be assumed to have begun with the first convincing controlled Studies, most likely by Brigo & Serpelloni (1991), whose result was that individualized remedies significantly lowered migraine intensity, duration, and frequency far better than placebo in an enrollment of 60 patients. More recent induction research has now extended the longitudinal evidence up to the present: Witt et. al (2010) followed 212 migraine patients for two years under homeopathic care and reported considerably large effect sizes for severity reduction in symptoms (Cohen's $d = 1.48$ at three months, increasing to 2.28 at 24 months) with parallel improvements noted for SF-36 mental & physical component scores, while the use of conventional medications decreased. In children, Danno et. al. (2013) conducted up to a domestic observational study across multiple centers in children who receive homeopathic treatment for migraines, and did observe a stable reduction in attack frequencies and severity during the follow-up. In sum, all these observational studies are converging across a common narrative of improvement in both symptom burden and in the QoL indicators over extended treatment periods-and perhaps the wishes, yet design depreciation limits the inference of causal links.

Randomized controlled trials: mixed findings. Evidence from randomized, double-blind, placebo-controlled trials presents a considerably more heterogeneous picture. Whitmarsh et al. (1997) conducted a four-month RCT among 63 migraine outpatients receiving individualized homeopathic prophylaxis and found that on most measures of headache severity, the treatment group did not differ significantly from placebo, despite some improvement being observed. Similarly, Straumsheim et al. (2000) enrolled 68 patients in a comparable double-blind design and reported no statistically significant benefit of individualized homeopathy over placebo on primary headache outcomes. Walach et al. (1997) extended this line of inquiry to chronic headache patients more broadly and likewise found no significant advantage for classical homeopathic treatment. These null or mixed RCT findings stand in direct tension with the more favourable observational literature, a pattern repeatedly noted in reviews of the field (Migraine and the Scope of Homeopathy, 2017; EBSCO, 2024).

Systematic reviews and meta-analyses: inconclusive verdicts. Evidence from randomized, double-blind, placebo-controlled trials presents a considerably more heterogeneous picture. Whitmarsh et al. (1997) conducted a four-month RCT among 63 migraine outpatients receiving individualized homeopathic prophylaxis and found that on most measures of headache severity, the treatment group did not differ significantly from placebo, despite some improvement being observed. Similarly, Straumsheim et al. (2000) enrolled 68 patients in a comparable double-blind design and reported no statistically significant benefit of individualized homeopathy over placebo on primary headache outcomes. Walach et al. (1997) extended this line of inquiry to chronic headache patients more broadly and likewise found no significant advantage for classical homeopathic treatment. These null or mixed RCT findings stand in direct tension with the more favourable observational literature, a pattern repeatedly noted in reviews of the field (Migraine and the Scope of Homeopathy, 2017; EBSCO, 2024).

Common homeopathic remedies and individualization rationale. Across the clinical literature, a recurring set of constitutional remedies is prescribed for migraine based on characteristic symptom pictures rather than diagnostic labels. Belladonna is typically indicated for throbbing pain aggravated by light, motion, and noise, accompanied by a flushed, hot face; Lachesis for left-sided, congested, pulsating pain worse after sleep; Natrum muriaticum for migraines linked to emotional stress, grief, or hormonal triggers; and Silicea for right-sided pain originating occipitally and extending frontally, often triggered by mental exertion or menstruation (EBSCO, 2024). Other remedies noted across trials and reviews include Gelsemium, Cyclamen, Ignatia, Sulphur, Bryonia, Glonoinum, and Rhus toxicodendron, with Spigelia and Iris versicolor additionally cited for left-sided and right-sided ocular-associated migraines respectively in individualization literature (Brainritual, 2024). This remedy diversity itself illustrates the core methodological challenge in homeopathy research: because prescriptions are matched to individual totality-of-symptoms profiles rather than a single protocol, trial designs must accommodate multiple simultaneously active remedies, complicating standard RCT blinding and pooling procedures.

Research gap identification. The recap, taken together, suggests that there is a gaping void left in research resources available for assessing homeopathy in the management of migraine. Firstly, there exists a very jarring contrast between the positive results shown by prolonged observational data such as (Witt et al., 2010, Danno et al., 2013) with largely insignificant results in short-term RCTs (Whitmarsh et al., 1997; Straumsheim et al., 2000; Walach et al., 1997), and no available resolution to this issue. With only a few select cases coming in for comparison, the primary effectsizes of the existing randomized trials on homeopathy use include attack frequency, duration, and intensity, which limits the comparison with studies in standard remission without any kind of quantity in migraine outcomes research-MSQ v2.1 or MIDAS, some of which are still awaiting standards of

development for their use as endpoints in mainstream migraine outcomes research. Still, there was a less adequate set of views geographically on the evidence. It studied Europe mainly, including Germany, UK, Norway, and Italy, with almost nothing from India or among other clinical settings in South Asia even when homeopathy is significantly used in India's integrated health sector. This study addresses what this one actually did and take care of these gaps: the effect of individualized homeopathic treatments focusing on the valid QoL measures within a rare clinical setting.

4. Aim and Objectives

This study is intended to evaluate the effectiveness of individualised homeopathic treatment for the treatment of various aspects of health in patients with migraine. The purpose of the study is to assess change in MSQ v2.1 scores, which is measured from the baseline to the post-study survey (Shibata, A., et al., 2020; Giannouli, H. 2024). Secondary evaluations were made at the following parameters: attack frequencies, durations, pain VAS scores, and MIDAS disability scores (Savikalpa, 2026; migraine.com, 2020).

H₀: Individualized homeopathic therapy results in no significant change in scores on MSQ, MIDAS, or VAS. H₁: Individualized homeopathic treatment induces a significant effect in an improvement in these scores.

5. Materials and Methods

This study will use a prospective, single-arm, pre-post observational design (Witt et al., 2010; Danno et al., 2013), conducted at an outpatient homeopathic clinic over 6 months, with sample size calculated using standard pre-post comparison formulae (80% power, $\alpha = 0.05$). Participants will be recruited via consecutive sampling. Inclusion criteria: adults aged 18–65 with migraine (with/without aura, episodic/chronic) diagnosed per ICHD-3 criteria (IHS, 2018), history ≥ 1 year, willing to give informed consent. Exclusion criteria: secondary headache, pregnancy, major psychiatric/neurological comorbidity, or inability to complete questionnaires.

Each patient will undergo individualized homeopathic case-taking based on Hahnemannian totality of symptoms, followed by repertorization to select the simillimum, with follow-up and remedy adjustment at 2–4-week intervals (Hahnemann, 1842/1922).

Outcome measures: MSQ v2.1 (role function-restrictive, role function-preventive, emotional function domains; Shibata et al., 2020), MIDAS score (disability grades I–IV; Savikalpa, 2026), and VAS for pain intensity, recorded at baseline and follow-up visits, supplemented by a patient migraine diary for attack frequency/duration.

Analysis: Paired t-test or Wilcoxon signed-rank test (based on normality) for pre-post comparisons; repeated-measures ANOVA across follow-up points; correlation analysis between QoL and attack-frequency change; significance at $p < 0.05$ (SPSS).

Ethics: Informed consent, Institutional Ethics Committee approval, and CTRI registration (if interventional), with participant confidentiality and right to withdraw ensured.

7. Discussion

Interpretation of findings in relation to QoL improvement. The evidence synthesized in this summary implies significance for an actual but methodologically fragile association between individualization homeopathic treatment and an improvement in quality of life in patients with migraine. Quality of life improvements including reduced disability, better emotive functioning, and less role restriction were documented most clearly in studies with long-term, real-world follow-up rather than short, tightl windows of controlled trial, suggesting that benefits from individualized homeopathy maybe realized more slowly through more and better remedy from operations, rather than just onswift pharmacological effect.

Comparison with observational evidence. As stated by Witt et al. (2010) is perhaps symptomatic in his principal-care,-validity of the first use could be adequate; however, as the strength of the study grew from a population of 212 migraine patients to be much large and impressive, with the outcome that the primary-quality care-cohort demonstrated improved migraine with a very large effect size (Cohen's $d = 1.48$ after 3 months, increasing to 2.28 after 24 months). This has an immediate association on both Mental and Physical Component Scores for SF-36 and a decline in the use of conventional medications and thus highlights, over two years, evidence of an ongoing, cumulative benefit under these circumstances. Population scores 1 and 2 thus provide a high evidence level for the persistent, self-amplifying benefit of individualized homeopathy in the real world, namely, under unblinded conditions.

Comparison with RCT evidence. This particular photograph is quite different when compared to the placebo-controlled trial literature. For example, Whitmarsh et al. (1997) had managed to prove that homeopathy could not demonstrate any significant requirement on migraine, but could prove it was better than a placebo. The combined meta-analysis on four randomized controlled clinical trials (Saha and Koley, 2013) produced a risk ratio of 1.58 with a 95% CI of 0.8-3.1 that was later pulled down to a non-significant level of 0.98, after adjustment for publication bias — so that there was nothing left that would suggest any benefit. The study showed that the methodological quality across the trials is inversely proportional to the magnitude of the effect; the best trial, the

most positive, scored less on quality scores (Brigo and Serpelloni, 1991) and most of all even the most high-quality trial (Walach et al., 1997) directed to placebo. Given that one study created the most significant known variability in the literature, what would TP27 look like? It is important that publication and quality bias are demonstrated so well in CAM research (Saha and Koley, 2013): They are known to seriously soften any rigid causal assertion about remedy-specific efficacy.

Possible explanatory mechanisms. The discrepancy between observational and RCT evidence is best accounted for by the very significant contribution of unspecific contextual therapeutic effects inherent in individualized homeopathic consultation. The extensive, empathetic, and highly individualized case-taking process inherent in classical homeopathy creates very high expectations on the part of drugs and results in a particular relationship between practitioner and patient, well-known drivers in placebo response: they act on the endogenous opioid and dopaminergic pathways (Colagiuri & Benedetti, 2010; see the literature on placebo homeopathy). Very similar research on rheumatoid arthritis has shown that most of the clinical benefits attributed to homeopathic therapy are actually due to the patient's overall relief, rather than the specific remedies used (Brien et al., 2011). In addition, natural fluctuation in severity of migraines, regression to the mean, Hawthorne effect by being observed in a study, and diminished reliance on conventional side effect-laden medicine can all contribute to the improvement in QoL evidenced by uncontrolled cohorts without needing a specific pharmacological action of the remedy.

Clinical implications. Despite this mechanistic uncertainty, the evidence has practical relevance for migraine management. Clinical practice guidelines already recognise homeopathy among the complementary approaches used alongside conventional pharmacotherapy for headache disorders (Herman et al., 2021, as reviewed in headache CPG literature), and given the individualized, holistic consultation model's demonstrated association with improved patient-reported wellbeing, it may reasonably be offered as a low-risk adjunct — particularly for patients dissatisfied with or intolerant of pharmacological prophylaxis — provided it does not replace evidence-based acute or preventive medical care.

Strengths of the study. One of the noticeable strengths of this review is its triangulation strategy in terms of study designs by pooling controlled and uncontrolled evidence to identify 'between-consultation/reperfusion' differences that a single-method review could miss and its formal publication-bias adjustment approach to the meta-analysis of RCT in place of simply taking an unadjusted pooled estimate at face value.

8. Limitations and Future Scope

The evidence base is constrained by small sample sizes across all four RCTs (60–98 participants each), limiting statistical power and generalizability; the two supportive observational studies, while larger, lacked control groups, precluding causal attribution of improvement to the homeopathic remedy rather than to consultation effects, regression to the mean, or concurrent conventional treatment. Follow-up duration varied widely, from 3–4 months in the RCTs to 24 months in Witt et al. (2010), making direct comparison of "sustained" benefit difficult, and none of the RCTs employed migraine-specific QoL instruments (MSQ) as primary endpoints, restricting this review's ability to draw firm QoL-specific conclusions from controlled data.

Future research should prioritise adequately powered, double-blind, placebo-controlled trials that retain individualized remedy selection while incorporating a parallel non-treatment (no-consultation) control arm, enabling separation of remedy-specific and consultation-specific effects (Brien et al., 2011). Such trials should adopt standardized, validated migraine-specific QoL and disability instruments (MSQ v2.1, MIDAS) as primary outcomes, alongside pre-registered protocols and longer follow-up (minimum 6–12 months), to reduce publication bias and enable meaningful synthesis across future systematic reviews.

9. Conclusion

The review indicates that individualized homeopathic treatment provides uniform quality-of-life improvement with a reduction in the burden of migraines in observational, real-world iterations; but rigorously pooled, bias-corrected randomized controlled trials fail yet to provide evidence for a particular effect beyond placebo attributed to the use of homeopathic remedies. The most reasonable explanation of this inconsistency in the data is that the pharmacological pertinence of the cure to the interactive case-taking process bestows the lion's share of the effect noted in the interim, rather than from the action of the remedy itself.

This highlights that individualized homeopathy can definitely be part of a low-risk, patient-centered, adjunct approach for those with migraines who are more inclined to seek holistic treatment or are unsatisfied with existing conventional prophylaxis. But such a utilization of homeopathy should not be substituted for the evidence-based action of pharmacological management, especially in moderate-to-severe or chronic migraine cases.

From the patient perspective, the identified and consistent real-world quality of life gains across observational cohorts indicate an available basis for making a choice — be it rightly or wrongly, given its offset in real-world problems with more empirical, controlled-trial levels of evidence.

Basically, while confirmed as true in clinical daily reality taken as a given, the rest of appearing as sources of evidence of a remedy-specific intervention of homeopathy for migraine-related quality of life remain as a

conundrum-unresolved, that is how these questions will best be resolved. A well-designed trial, hence, may help to figure out any existing or nonexistent gap that is verifiable there between the two phenomena of individually-derived therapy and manual consultation in the context of quality of life...

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