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Review Article

Case of Ringworm like eruption with Tinea pedis cured with LM Scale Potency which didn't improve with Centecimal potency

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Abstract

LM potencies, introduced by Dr. Samuel Hahnemann in the sixth edition of the *Organon of Medicine*, were proposed as a modified method of dynamization for the management of diseases. This case report describes the clinical management of a 41-year-old female presenting with severe itching, burning, desquamation, and skin lesions over both feet. The patient had previously obtained only temporary relief with Homeopathic remedy Sulphur 30. Thorough case taking & case processing shows the same remedy as an indicated remedy which was prescribed in LM potency. During follow-up, the patient experienced progressive relief in itching and burning, with marked improvement in the skin lesions and overall comfort. This clinical observation highlights the potential usefulness of appropriate potency selection in homoeopathic prescribing and illustrates the practical application of LM potency in accordance with the principles described in the sixth edition of the *Organon of Medicine*. This clinical study as like others shows the

efficacy of LM scale remedies which the profession should adopt in all types of cases..

Keywords

LM potency; 50 Millecimal potencies; Homoeopathy; Sulphur; Homeopathic prescribing; Chronic skin disease; Case report; Organon of Medicine; Sixth edition.

Introduction

Case presentation

Name:- Mrs. Shagufta
Age:- 41Years **Sex:-** Female
Occupation:- Receptionist
Address:- Aqsa Nagar, Jalgaon City
Date:- 20th May 2026
Referred by:- intern student
Chief complaint:-

- Itching over the dorsal aspect of the last three toes of both feet with irregular skin lesions and desquamation (peeling of skin) over the planter aspect and interdigital spaces, with small ringworm-like eruptions for 2 months. Patient want to scratch all the time. Itching is so severe that it disturbs the sleep. After scratching there is a burning and mild watery discharge. The burning is so intense that the patient is unable to tolerate covering the affected parts. Complaints are relieved temporarily by cold applications.
- Swelling and pain of both legs from knees to the feet

MEDICATION:- Taken Sulphur-30 BD x 3days, with temporary relief. Complaints reappeared & increasing since then.

H/O/C/C:- The patient is under stress as she is a single parent & having a financial crisis. She is the only earning member of the family and worried about managing household expenses.

PAST HISTORY:-

- Hypothyroidism since 4 years, Rx on Tab Thyronorm 50mcg OD

GENERALS:-

Appetite:- Increase
Thirst:- Normal
Aversion:- sweet
Bowel:- constipation, hard stool
Urine:- Normal

CASE PROCESSING:-

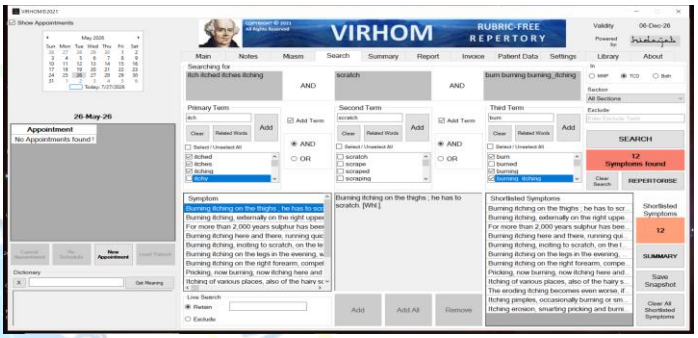
The patient is having two different complaints. One is itching eruptions on foot & another is swelling & pain in the legs. Out of these, skin complaints are giving more trouble. So we considered it first to deal as per Aph. 167-171. Remaining complaint of swelling we will consider in next follow ups.

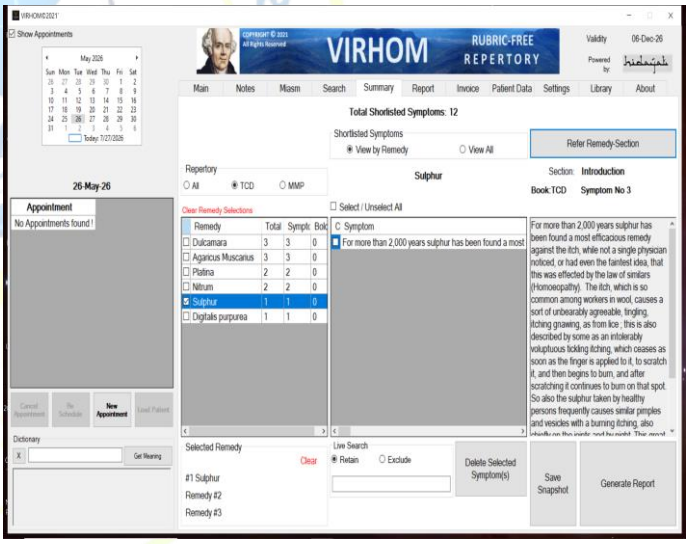
REPERTORIZATION:-

Here used the **VirHom Rubric-free Repertory Software t**o repertorize the case
(This is the unique repertory software developed by Team Virgin Homeopathy, A group of homeopaths teaching & practicing strictly as per Dr. Hahnemann)

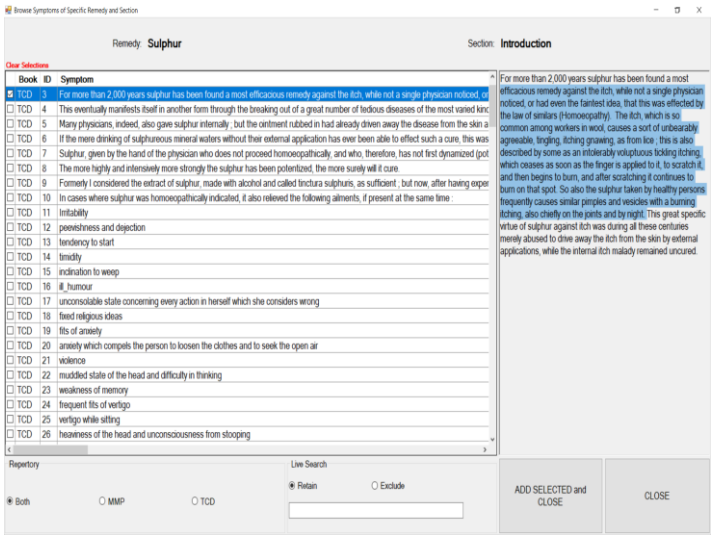
We search the related words & terms directly in to the Materia Medica Pura & The Chronic Diseases in spite of conventional repertorization

We Searched the following words -
Itch, Itching, Itches + scratch + burn, burns, burning





There are 12 symptom states of 6 remedies such as Dulcamara, Agaricus, Platina, Nitrum, Sulphur, Digitalis after searching in VirHom Repertory. Now we will read all the symptom states from all the 6 remedies from the original proving data of *The Chronic Diseases (TCD).*



After reading the skin section of all the above remedies, the most similar remedy found is Sulphur. Now here is the question, should I give the same remedy Sulphur as it was already given a few weeks before with temporary relief.

As experience taught me that, the Sulphur was prescribed & relieved previously is the surest sign to prescribe the same remedy as it is still the similimum. So I need to work on potency, dose & repetition.

REMEDY SELECTION:- Final remedy selection is the Sulphur in LM scale potency & prescribed as follow -

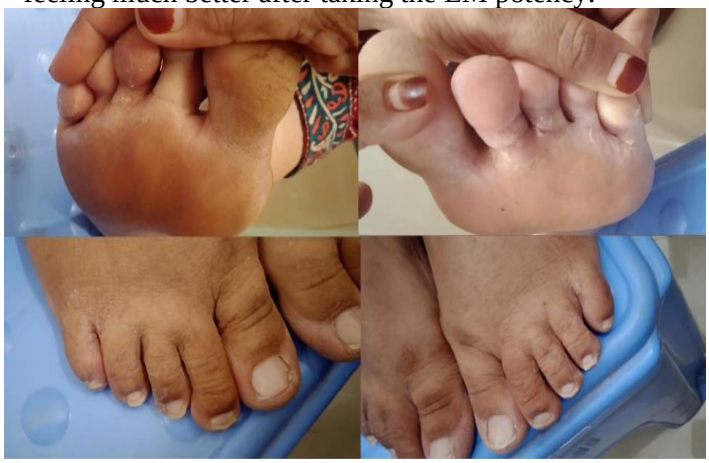
Sulphur-0/1 BD x 2weeks

Asked to give follow up after 3-4 days (As per Aph. 248)

(Give 5 succussions to the medicine bottle. Then add 5 drops in 1 glassful water. Stir it with a spoon & take 5 spoons from the glass. Repeat the process before every repetition of the dose)

Follow up on 04.06.2026:-

Patient reported significant improvement in the intensity of itching within 3-4days. After 15 days of starting Sulphur-0/1, the itching had completely subsided, and there was marked relief in the burning sensation. Mild peeling of the skin was still present, but the overall condition had improved considerably. The patient expressed satisfaction with the treatment and reported feeling much better after taking the LM potency.



.Improvement in the affected toes after 15 days of treatment

Complete resolution of skin complaints & normal healthy skin appeared within a month of treatment with the same remedy & same dosing.

DISCUSSION:-

The patient had taken Sulphur-30 BD for 3 days and experienced temporary relief, but the symptoms returned after some time. Here the present totality shows the selection of the remedy was correct. Only potency, dose & repetition need to be improved. Sulphur was then prescribed in First LM potency, in spite of the same remedy taken by the patient in 30 potency before 1 month, after which the patient showed significant improvement. The itching, burning and skin lesions speedily reduced and the symptoms started resolving during follow up. Complete recovery achieved within a month of treatment.

CONCLUSION:-

This case shows that selecting the correct remedy alone is not sufficient (Aph.275); choosing the appropriate potency, smallness of quantity of dose & proper repetition is also important. Sulphur 30 gave only temporary relief, whereas Sulphur 0/1 (LM potency) produced quick and lasting improvement. The patient's symptoms quickly resolved after the administration of first LM potency. Therefore, this case demonstrates the clinical value of LM potencies as described by Dr. Hahnemann in the management of chronic diseases. Also the rapid cure is achieved as per Aph. 2 & 246.

LM scale was called by Dr. Hahnemann as

"……new altered but perfected method of dynamization"

Acknowledgement

I am grateful to the Principal & Medical Superintendent of Shri Chamundamata HMC & Hospital for allowing me to publish the case treated at the hospital. Also thanks to the patient who willfully allowed to present her case with written consent.

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Marma	Surface zone	Plausible modern complex	Clinical concern
Kurpara	Elbow	Cubital fossa; brachial artery and major nerves	Bleeding or motor-sensory deficit
Talahridaya	Central palm	Palmar arches and median-ulnar branches	Grip, sensation, and perfusion
Kshipra	First web space	Digital nerves and radial arterial branches	Bleeding, pain, or thumb dysfunction
Lohitaksha	Groin	Femoral neurovascular bundle	Major hemorrhage or limb ischemia
Urvi	Middle thigh	Adductor canal and femoral vessels	Vascular or sensory injury
Shankha	Temple	Pterion and middle meningeal artery	Intracranial hemorrhage
Manya	Lateral neck	Carotid sheath and adjacent nerves	Hemorrhage or cerebral ischemia
Apanga	Lateral canthus	Orbital neurovascular and fascial structures	Visual or ocular-motor impairment

Table 2. Selected location-based correlations. The entries represent anatomical zones, not exact equivalences.

10. Trauma and Emergency Care

Trauma care gives the comparison its clearest practical relevance. Modern trauma texts emphasize rapid recognition of vascular injury, occult hemorrhage, ischemia, and combined nerve damage [25]. Surgical principles likewise depend on exposure that controls bleeding while preserving viable tissue and critical neural pathways [26].

The classical warning attached to a *Marma* can be read as an early danger signal: do not judge an injury only by its surface appearance. A wound near the groin, axilla, side of the neck, temple, or cubital fossa deserves careful neurovascular examination. This observation does not alter current trauma protocols, but it offers a historically grounded way to teach why certain sites demand urgency.

11. Hand Surgery and Reconstruction

The hand illustrates how a small anatomical field can contain a large functional burden. Operative hand surgery depends on precise preservation or repair of digital nerves, arteries, tendon systems, pulleys, and fascial spaces [27]. This helps explain why trauma near *Talahridaya* or *Kshipra* may produce a combination of bleeding, sensory change, pain, and impaired movement.

Microsurgical reconstruction applies the same principle elsewhere. Free flaps and limb-salvage procedures require reliable recipient vessels, intact motor and sensory pathways, and careful handling of the surrounding soft tissue. A *Marma*-based surface map might supplement teaching, but it cannot replace imaging, Doppler assessment, magnification, or standard operative anatomy.

12. Peripheral Nerve Injury and Rehabilitation

Peripheral nerve injury may cause weakness, sensory loss, neuropathic pain, and long-term disability even when circulation remains intact. Outcome depends on the nerve involved, level and mechanism of injury, delay before repair, and distance to the target tissue [28]. This pattern is relevant to the *Vaikalyakara* and *Rujakara* categories, which foreground lasting functional loss and pain.

Rehabilitation must therefore address more than wound closure. Motor retraining, sensory re-education, protection of denervated skin, pain management, splinting, and psychological support may all be needed. *Marma Chikitsa* is sometimes discussed in this setting, but its techniques, dose, indications, and safety require clinical evaluation before they can be integrated into nerve-rehabilitation pathways.

13. Brachial Plexus, Axilla, and Regional Anaesthesia

The brachial plexus and axillary vessels change their relations as they pass from the neck into the upper limb. Their arrangement explains why traction, penetrating trauma, dislocation, or surgery may injure several functions at once [29]. *Kakshadhara* and nearby upper-limb *Marma* are therefore more plausibly interpreted as regional complexes than as isolated nerve points.

Regional anaesthesia deliberately approaches nerves near companion vessels. Ultrasound, aspiration, dose control, sterile technique, and continuous monitoring remain the basis of safe practice. Awareness of classical surface landmarks may be educational, but it should never be used as a substitute for validated block anatomy or real-time imaging.

14. Surface Anatomy and Clinical Education

Surface anatomy connects the visible body with structures that cannot be seen during routine examination. Contemporary teaching uses palpable bones, pulses, skin creases, muscle borders, and projected lines to locate clinically important structures [30]. Classical *Marma* descriptions rely on a related observational skill, often using regional landmarks and proportional measurements.

Teaching the two maps side by side could make anatomy more memorable if the boundaries remain explicit. Students can identify a proposed *Marma* zone, predict the tissues beneath it, trace the likely deficit from injury, and then verify the relation with an atlas, ultrasound, or dissection. The exercise encourages clinical reasoning without requiring that every traditional description be forced into a modern label.

15. Additional Clinical Applications

Potential applications extend to orthopaedic surgery, vascular access, pain medicine, and rehabilitation. Joint surgery around the shoulder, elbow, hip, and knee routinely requires protection of adjacent nerves and vessels. Vascular procedures use some of the same surface

territories for cannulation or surgical exposure. In pain practice, selected *Marma* lie near nerve entrapment sites, tendon insertions, or fascial intersections.

Similarity of location does not establish similarity of mechanism. *Marma Chikitsa*, trigger-point therapy, peripheral nerve stimulation, and acupuncture arise from different theories and use different procedures. Comparative trials would need clearly defined interventions, credible controls, adverse-event monitoring, and outcomes relevant to pain and function.

16. Critical Appraisal

The strongest correlations are those in which location, underlying anatomy, and consequences of injury all agree. *Shankha* and the pterion, *Lohitaksha* and the femoral triangle, *Kurpara* and the cubital fossa, and *Manya* and the carotid region meet this standard reasonably well. Even here, a *Marma* should be treated as a region with variable depth and extent rather than as a precisely measured modern structure.

Several limitations remain. Classical measurements may vary with body size and interpretation. Surface landmarks shift with posture, age, adiposity, and sex. Neurovascular branching patterns differ among individuals. Much of the present literature is narrative, and some proposed correlations repeat earlier opinions without independent anatomical testing.

There is also a risk of selective confirmation. A fatal classical description may appear to fit whichever important vessel lies nearby, while alternative structures are ignored. A rigorous study must specify the proposed location before dissection or imaging, record every structure within the defined volume, include independent observers, and report negative as well as positive findings.

17. Research Priorities

The first priority is a reproducible atlas of all 107 *Marma*. Classical landmarks and dimensions should be translated into a transparent surface-mapping protocol and tested for agreement among trained assessors. Cadaveric studies could then document nerves, vessels, fascia, muscles, bones, and joints at each site, including anatomical variation.

High-resolution ultrasound is well suited to superficial, living anatomy and could assess whether a proposed zone consistently overlies a neurovascular complex. Magnetic resonance imaging and three-dimensional reconstruction may be more useful for deeper regions. Researchers should define their hypotheses in advance and avoid altering a boundary after viewing the anatomy.

Clinical work could compare the pattern and severity of real injuries within and outside prespecified *Marma* zones. Educational studies could test whether an integrated map improves anatomical recall or recognition of surgical danger zones. Therapeutic research should remain separate from mapping research so that evidence for anatomical correspondence is not mistaken for evidence of treatment efficacy.

18. Conclusion

Marma Sharir is an early and clinically oriented account of anatomical vulnerability. Its distinctive contribution is to combine a surface location, dominant tissue, expected consequence of injury, and practical warning to the surgeon. Modern neurovascular anatomy uses different concepts and methods, yet it confirms the central observation that compact regions containing several essential structures can carry disproportionate risk.

Selected correlations are persuasive enough to merit careful teaching and investigation, particularly in the temporal region, neck, axilla, cubital fossa, palm, groin, and thigh. The comparison is most credible when *Marma* are treated as functional anatomical zones rather than as exact synonyms for nerves or vessels. Standardized mapping, cadaveric verification, imaging, and prospective clinical evidence are now needed to move the field beyond plausible interpretation.

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