

HOMOEOPATHIC MANAGEMENT OF URINARY INCONTINENCE IN GERIATRIC PRACTICE: A CASE REPORT WITH IIQ-7 AND MONARCH ASSESSMENT

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ABSTRACT

Background: Urinary incontinence (UI) is a common condition characterized by the involuntary leakage of urine that adversely affects physical, psychological, and social well-being, particularly among older adults. Despite its high prevalence, many patients do not seek timely medical care because of embarrassment and social stigma. Individualized homoeopathic management may provide a complementary therapeutic option in selected cases. **Case Presentation:** An 81-year-old female presented with sudden onset of painless urinary incontinence associated with urinary urgency, nocturia, disturbed sleep, forgetfulness, irritability, and mental dullness. She had a history of type 2 diabetes mellitus and coronary artery disease. A detailed case analysis and repertorization using the Synthesis Repertory were performed, and the prescription was based on the totality of symptoms. **Intervention:** The patient was treated with individualized

homoeopathic medicines, primarily **Baryta carbonica 200C**, along with **Causticum 30C** and **Equisetum hyemale Q**, followed by prescription modifications according to the patient's clinical response during follow-up. **Outcome:** Progressive improvement was observed in urinary urgency, nocturnal incontinence, sleep quality, mental symptoms, and overall well-being. The Incontinence Impact Questionnaire–Short Form (IIQ-7) score improved markedly from **17** before treatment to **2** after treatment, indicating substantial improvement in quality of life. The Modified Naranjo Criteria for Homoeopathy (MONARCH) score was **+9**, suggesting a strong causal relationship between the homoeopathic intervention and the observed clinical improvement. **Conclusion:** This case suggests that individualized homoeopathic treatment was associated with marked clinical improvement and enhanced quality of life in an elderly patient with urinary incontinence. As this is a single case report, the findings cannot be generalized, and further well-designed clinical studies are warranted to establish the effectiveness of homoeopathic treatment in urinary incontinence.

INTRODUCTION

Urinary incontinence (UI) is a common yet frequently underreported condition characterized by the involuntary leakage of urine. It significantly affects physical health, psychological well-being, and social functioning. Although UI can occur at any age, it is more prevalent among women and older adults. The etiology of UI is multifactorial and includes pelvic floor weakness, hormonal changes, neurological disorders and dysfunction of the lower urinary tract. Many patients delay seeking medical attention due to embarrassment, social stigma, or lack of awareness, which often results in reduced quality of life. Effective management requires accurate diagnosis, identification of reversible causes, and individualized treatment. In recent years, holistic and non-invasive approaches, including lifestyle modification and complementary therapies such as homeopathy, have gained attention for their potential role in managing urinary incontinence.^[1-2-3]

EPIDEMIOLOGY - The true prevalence of urinary incontinence is likely underestimated, as many individuals do not report symptoms to healthcare providers.

- **Global Prevalence:** A meta-analysis involving 518,465 women aged 55–106 years reported a pooled prevalence of 37.1%. The highest prevalence was observed in Asia.^[4]
- **Gender-Based Prevalence:** According to the 4th International Consultation on Incontinence, UI affects 25–45% of women. In men, prevalence increases with age.^[5]

- **Indian Data:** Community studies report prevalence between 16–34% among women, pregnant women, and sportswomen. study in Coimbatore (Tamil Nadu), prevalence among women was 33.8%.^[6] In a study of post-menopausal women in India the prevalence of UI was reported at 26.47%, with stress incontinence 13.9%, mixed UI 7.2%, and urge UI 5.4%.⁷ Among pregnant women in central India (Indore), the prevalence during the current pregnancy was found to be 16.4%.^[8] In a study of nulliparous Indian sportswomen (n=560), UI prevalence was 22.5% for stress UI, 8.8% for mixed UI, 8.4% for urge UI.^[9]

ETIOLOGICAL CLASSIFICATION OF URINARY INCONTINENCE

Urinary incontinence (UI) is a complex condition with multifactorial etiopathogenesis, including anatomical, neurological, hormonal, genetic, and molecular influences. Stress urinary incontinence; urge urinary incontinence, mixed urinary incontinence, overflow incontinence, and functional incontinence. Initial evaluation typically does not require urologic or gynecologic assessment, but reversible causes should be ruled out.^[10]

1. Stress Urinary Incontinence (SUI) - Stress urinary incontinence is the involuntary leakage of urine that occurs with increased intra-abdominal pressure during activities such as exertion, straining, Valsalva, sneezing, or coughing. Young women active in sports may experience this type of incontinence pregnant women and women who have experienced childbirth may be prone to stress urinary incontinence. Stress incontinence in men is typically a complication of prostate surgery, resulting in sphincteric insufficiency.^[11]

2. Urge Incontinence - Urge incontinence is also known as (OAB) over active bladder defined as the involuntary leakage of urine that is typically associated with a sudden and compelling urge to void.^[12] the development of urge incontinence at the cellular and neurophysiological level is a multifactorial process, primarily related to detrusor overactivity.^[13] This overactivity may result from irritation or increased sensitivity of the bladder urothelium and interstitial (myofibroblast) cells, leading to excessive afferent signaling and a reduction in central inhibitory neurological control over bladder contractions.^[12-13] Urge incontinence may occur due to detrusor instability, overactive bladder syndrome, or neurological conditions such as stroke, Parkinson's disease, or multiple sclerosis.^[14-15]

3. Mixed Urinary Incontinence (MUI) - (MUI) is characterized by the involuntary leakage of urine associated with both physical exertion (stress incontinence) and urgency (urge

incontinence). It results from a combination of urethral sphincter weakness and detrusor overactivity, commonly seen in women, particularly after childbirth or menopause. Factors such as pelvic floor dysfunction, hormonal changes, aging, and neurological impairment contribute to its development. Diagnosis involves clinical evaluation and urodynamic studies, while management includes behavioral therapy, pelvic floor exercises, pharmacotherapy, and surgical interventions based on the predominant component.^[16]

4. Overflow urinary incontinence (OAB) - (OAB) is the involuntary leakage of urine from an over distended bladder due to impaired detrusor contractility and bladder outlet obstruction. Neurologic diseases such as spinal cord injuries, multiple sclerosis, and diabetes can impair detrusor function, resulting in a hypotonic neurogenic bladder. Bladder outlet obstruction can be caused by external compression by abdominal or pelvic masses, urethral strictures, and pelvic organ prolapse, among other causes. A common etiology in men is benign prostatic hyperplasia. Overflow urinary incontinence is the only type of urinary incontinence considered directly physically dangerous, as it can lead to renal failure and permanent bladder damage.^[10]

Common Factors Responsible for Urinary Incontinence

Urinary incontinence develops due to multiple anatomical, neurological, hormonal, and functional abnormalities that impair normal bladder storage and voiding mechanisms. The major contributing factors include:

- **Pelvic floor muscle weakness and urethral hypermobility** (childbirth, aging, menopause, pelvic surgery, obesity, chronic cough, constipation)^[12]
- **Intrinsic urethral sphincter deficiency (ISD)** resulting in reduced urethral closure pressure due to aging, estrogen deficiency, trauma, or previous pelvic surgery.^[13]
- **Detrusor overactivity** (idiopathic or secondary to neurological diseases, urinary tract infection, bladder stones, tumors, or bladder irritation)
- **Detrusor underactivity** caused by aging, prolonged bladder over distension, diabetic cystopathy, chronic alcoholism, or medications reducing bladder contractility.^[14]
- **Neurological disorders** including stroke, spinal cord injury, diabetic neuropathy, Parkinson's disease, multiple sclerosis, and other central or peripheral nervous system diseases

- **Bladder outlet obstruction** such as benign prostatic hyperplasia (BPH), urethral stricture, pelvic organ prolapse, bladder neck obstruction, pelvic masses, tumors, or severe constipation
- **Age-related structural and functional changes**, including reduced bladder capacity and compliance, diminished connective tissue elasticity, impaired urethral closure, vascular insufficiency, and increased afferent nerve activity
- **Hormonal changes**, particularly estrogen deficiency after menopause causing atrophy of the urethral mucosa and pelvic tissues
- **Urothelial dysfunction and abnormal afferent nerve signaling**, leading to increased bladder sensation and involuntary detrusor contractions
- **Local bladder pathology**, including urinary tract infections, bladder stones, tumors, radiation injury, and chronic inflammation
- **Medication-induced factors**, such as diuretics, cholinergic agents, alpha-blockers, anticholinergics, antihistamines, tricyclic antidepressants, calcium channel blockers, opioids, muscle relaxants, and central nervous system depressants
- **Functional and lifestyle factors**, including obesity, smoking, excessive caffeine or alcohol intake, sedentary lifestyle, anxiety, psychological stress, cognitive impairment, dementia, reduced mobility, and environmental triggers (e.g., cold exposure or running water sounds)^[17-18-19-20-21]

ICD-11 Classification of Urinary Incontinence^[22]

(ICD-11 uses a new structure under “GB20 – Incontinence of Urine” group.)

- **GB20.00 – Stress Urinary Incontinence:** Involuntary leakage on effort, coughing, or sneezing.
- **GB20.01 – Urgency Urinary Incontinence:** Leakage preceded by sudden strong urge.
- **GB20.02 – Mixed Urinary Incontinence:** both stress and urgency components present.
- **GB20.03 – Overflow Urinary Incontinence:** Leakage due to chronic retention and over distension.
- **GB20.04 – Continuous Urinary Incontinence:** Persistent, uninterrupted leakage.
- **GB20.0Y – Other Specified Urinary Incontinence:** used for less common forms.
- **GB20.0Z – Urinary Incontinence, Unspecified.**

Case Profile – Patient is an 81-year-old female who developed sudden urinary incontinence as an acute emergency at night. He experienced involuntary dribbling of urine with sudden

urgency and complete loss of bladder control. There was no pain or discomfort associated with the incontinence. Due to this complaint, the patient has faced extreme embarrassment in front of family members and has become self-conscious about attending public gatherings.

Past History of Presenting Complaint – In history patient facing similar kind of complaint such as nocturnal urinary incontinence with diagnosed diabetes mellitus (DM) – Type 2 and atherosclerotic changes detected of coronary artery disease (CAD) in CT Angiography which is managed by conventional modern medicine treatment and management after that there is no such kind of complaint patient facing after treatment.

Family History

Father – Expired

Mother – Expired

Siblings – Brothers -2, Sister - 2

One elder brother died 10 years ago due accident at construction site and another younger brother have copd due to smoking and prostomegaly and an another both 2 sister healthy alive.

(Physical Generals and Particulars)

S. No.	Parameter	Findings
1	Built & Appearance	Endomorphic built; fair, bright and flabby complexion
2	Thermal Reaction	Chilly patient; extremely sensitive to cold
3	Appetite	D2–N1; takes 3–4 chapattis at a time
4	Thirst	Decreased; drinks medium to large quantities at long intervals (approximately 350–500 ml at a time)
5	Desire	Marked craving for sweets (+++); mild desire for salt (+)
6	Aversion	Nothing specific
7	Aggravation	Nothing specific reported
8	Stool	Once daily (D1); satisfactory
9	Urine	Urination 5–6 times during the day and 5–7 times at night; associated with sudden urgency and episodes of urinary incontinence with pungent odor
10	Perspiration	General perspiration over the body, more on face, head, chest and axilla; fishy odor noticed on clothes after undressing
11	Sleep	Disturbed and unrefreshing
12	Skin	Dry and cold to touch

(Mental Generals)

S. No.	Parameter	Findings
1	Dullness	Mental dullness present
2	Memory	Forgetfulness, especially common in old age
3	Temperament	Gets angry at little trifles
4	Disposition	Disposition to contradiction

Totality of symptoms

S. No.	Symptom Category	Totality
1	Mind	Dullness in old people
2	Mind	Angry at little trifles
3	Mind	Disposition to contradiction
4	Mind	Forgetfulness in old people
5	General	Chilly thermal state
6	General	Craving for sweets (+++)
7	General	Profuse perspiration with fetid odor
8	Particular	Urinary bladder – involuntary urination

Repertorial Result

The screenshot shows the Zomeo Elite Repertorial software interface. The main window displays a repertorial analysis with the following data:

Symptoms	Remedies	Filters
8	226	Normal

The table below shows the repertorial analysis results for the symptoms listed in the screenshot:

Remedy	Lyc	Hep	Bar-c	Sep	Merc	Ars	Bry	Nat-m	Psor	Sulph	Nux-v	Carb-v	Caust	Chin	Ph-ac	Rhus-t	Nat-c	Arg-n	Calc
Totality	17	14	11	11	10	10	10	10	10	10	9	9	9	9	9	9	8	8	8
Symptoms Covered	7	5	6	4	6	4	4	4	4	4	5	4	4	4	4	4	5	4	4
Kingdom																			
[Kent] [Mind]ANGER, IRASCIBILITY (SEE IRRITABILITY, QUARREL...	3	3	1	3	1	3	3	3	2	3	3	2	2	1	2	2	1	1	2
[Kent] [Mind]CONTRADICT, DISPOSITION TO: (21)	2	3			1						1		2				1		
[Kent] [Mind]FORGETFUL (SEE MEMORY):Old people, of: (4)	2		2												2				
[Kent] [Stomach]DESIRE:Sweets: (36)	3		1	2	1	1	2	1		3	1	2		3		2	2	3	2
[Kent] [Perspiration]PROFUSE: (133)	3	3	2	3	3	3	3	3	3	2	2	3	2	3	3	2	2	1	3
[Kent] [Perspiration]ODOUR:Fetid: (20)	1	3			2				2										
[Kent] [Bladder]URINATION:Involuntary: (129)	3	2	2	3	2	3	2	3	3	2	2	2	3	2	2	3	2	3	1
[Kent] [Mind]DULLNESS, SLUGGISHNESS, DIFFICULTY OF THIN...			3																

Table 1: Repertorial Analysis.

S.NO	Remedies	Relative Score
1	Lycopodium Clavatum	7/17
2	Hepar Sulph	5/14
3	Baryta Carbonica	6/11
4	Sepia officinalis	4/11
5	Mercurius Solublis	6/10

Prescription and Justification

1. Baryta Carbonica 200 CH OD for 7 Days
2. Equisetum Hyemale Q Mother Tincture 10 Drops TDS in half cup of water
3. Causticum 30 CH TDS for 7 Days

Table 3: FOLLOW – UPS.^[25]

S. No.	Date	Symptoms / Findings	Treatment
1	05/01/2026	Painless involuntary urination occasionally without urging; extreme general prostration; sleeplessness with dullness; highly irritable; marked weakness of memory; indifference to thoughts.	Equisetum hyemale Q – 10 Drops TDS for 7 days. Causticum 30 – TDS for 7 days. Baryta carbonica 200 – OD for 7 days.
2	12/01/2026	Urinary urgency and incontinence reduced; dullness and sleeplessness improved compared to before; irritability decreased; weakness slightly improved.	Sac Lac 200 – OD for 7 days. Causticum 30 – BD for 7 days. Equisetum hyemale Q – 10 drops BD for 7 days.
3	19/01/2026	General condition improved; dullness and sleeplessness markedly better; only very mild episodes of urinary incontinence remain.	Sac Lac 200 – OD for 15 days. Causticum 30 – OD for 15 days. Equisetum hyemale Q – 15 drops OD for 15 days.
4	04/02/2026	No new symptoms appeared; previous complaints improved completely; patient generally feels better.	Phytum 200 – Single dose. Sac Lac 30 – BD for 15 days.

The Modified Naranjo Criteria for Homeopathy (MONARCH) is a structured tool used to assess the causal relationship between a homeopathic medicine and clinical improvement. It evaluates factors such as improvement in the main complaint, appropriate timing of response, homeopathic aggravation, improvement in overall well-being, direction of cure, reappearance of old symptoms, objective clinical evidence, and exclusion of alternative causes. Each criterion is assigned a score to estimate the likelihood that the remedy contributed to the patient's recovery. In this case, the patient showed marked improvement in the presenting complaint along with better general well-being and the total MONARCH score of +9 indicates a strong causal attribution to the homeopathic intervention.^[23]

Table 2: Modified Naranjo Criteria.

S.NO	Criteria	Yes	No	Not sure
1.	Was there an improvement in the main symptom or condition for which the homeopathic medicine was prescribed?	+2	-1	0
2.	Did the clinical improvement occur within a plausible timeframe relative to the drug intake?	+2	-2	0
3.	Was there a homeopathic aggravation* of symptoms?	+1	0	0
4.	Did the effect encompass more than the main symptom or condition (i.e., were other symptoms, not related to the main presenting complaint, improved or changed)?	+1	0	0
5.	Did overall well-being improve? (Suggest using a validated scale or mention about changes in physical, emotional, and behavioral elements)	+1	0	0
6.	(A) Direction of cure: did some symptoms improve in the opposite order of the development of symptoms of the disease?	+1	0	0
7.	(B) Direction of cure: did at least one of the following aspects apply to the order of improvement of symptoms: +1 0 0 0 - from organs of more importance to those of less importance - from deeper to more superficial aspects of the individual - from the top downwards	+1	0	0
8.	Did “old symptoms” (defined as non-seasonal and non-cyclical symptoms that were previously thought to have resolved) reappear temporarily during the course of improvement?	+1	0	0
9.	Are there alternative causes (other than the medicine) that –with a high probability- could have produced the improvement? (Consider known course of disease, other forms of treatment, and other clinically relevant interventions)	-3	+1	0
10.	Was the health improvement confirmed by any objective evidence*? (e.g., investigations, clinical examination, etc.)	+2	0	0
11	Did repeat dosing, if conducted, create similar clinical improvement?	+1	0	0
Total Score	+9			

Incontinence Impact Questionnaire, Short Form (IIQ-7)^[24]

The Incontinence Impact Questionnaire–Short Form (IIQ-7) was used to assess the impact of urinary incontinence on the patient’s quality of life before and after treatment. The **pre-treatment score was 17**, indicating a considerable negative impact on daily activities, emotional health, and social participation. After treatment, the **post-treatment score reduced to 2**, suggesting a marked improvement in symptoms and minimal interference with routine activities. This substantial reduction in the IIQ-7 score demonstrates significant

clinical improvement and indicates that the intervention was effective in improving the patient's quality of life. Behind those numbers lies something simple and human: less embarrassment, more freedom to move through daily life.

Pre (IIQ-7) Score = 17



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Urology

Patient Name: [REDACTED]

Date of Birth: 2-July-1995

MRN: _____

Date of Service: 5 January 2026

Physician: Dr. Anur Nishad

Incontinence Impact Questionnaire, Short Form (IIQ-7)

Some people find that accidental urine loss may affect their activities, relationships, and feelings. For each question, circle the response that best describes how much your activities, relationships, and feelings are being affected by urine leakage over the past month.

Has urine leakage (incontinence) affected your:

	Not at All	Slightly	Moderately	Greatly
Ability to do household chores (cooking, housecleaning, laundry)?	0	1	(2)	3
Physical recreation such as walking, swimming, or other exercise?	0	1	(2)	3
Entertaining activities (movies, concerts, etc.)?	0	1	(2)	3
Ability to travel by car or bus more than 30 minutes from home?	0	1	(2)	3
Participation in social activities outside your home?	0	1	2	(3)
Emotional health (nervousness, depression, etc.)?	0	1	2	(3)
Feeling frustrated?	0	1	2	(3)

Total Score = 17.

Adapted from Uebersax JS, Wyman FF, Shumaker SA, et al. Short forms to assess life quality and symptom distress for urinary incontinence in women: the incontinence impact questionnaire and urogenital distress inventory. *Neurourol Urodyn* 1995; 14: 131.

Post IIQ-7 Score = 2



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Urology

Patient Name: [REDACTED]

Date of Birth: 2 July 1975

MRN: [REDACTED]

Date of Service: 7 February 2026

Physician: Dr. Anand Nishad

Incontinence Impact Questionnaire, Short Form (IIQ-7)

Some people find that accidental urine loss may affect their activities, relationships, and feelings. For each question, circle the response that best describes how much your activities, relationships, and feelings are being affected by urine leakage over the past month.

Has urine leakage (incontinence) affected your:

	Not at All	Slightly	Moderately	Greatly
Ability to do household chores (cooking, housecleaning, laundry)?	(0)	1	2	3
Physical recreation such as walking, swimming, or other exercise?	(0)	1	2	3
Entertaining activities (movies, concerts, etc.)?	(0)	1	2	3
Ability to travel by car or bus more than 30 minutes from home?	(0)	1	2	3
Participation in social activities outside your home?	0	(1)	2	3
Emotional health (nervousness, depression, etc.)?	0	(1)	2	3
Feeling frustrated?	(0)	1	2	3

Total Score = 2.

Adapted from Uebersax JS, Wyman FF, Shumaker SA, et al. Short forms to assess life quality and symptom distress for urinary incontinence in women: the incontinence impact questionnaire and urogenital distress inventory. NeuroUrol Urodyn 1995; 14: 131.

RESULT AND CONCLUSION

Homoeopathy is a system of medicine that takes a holistic approach to patient care to explicate the constitutionally of the patient, detailed case taking is required and series of medicines is chosen based on constitutional and clinical presentation of patient complaint of disease according to principle given by Dr. CFS Hahnemann. Patients become well-being and his complaints get better and overall quality of life gets improved.

REPERTORY SELECTION - Synthesis Repertory.

CONFLICT OF INTEREST – Nil.

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