

HOLISTIC HEALING OF ALOPECIA AREATA THROUGH HOMOEOPATHY

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ABSTRACT

Alopecia areata (AA) is a common form of non-scarring hair loss of scalp and/or body. Genetic predisposition, autoimmunity, and environmental factors play a major role in the etiopathogenesis of AA. Patchy AA is the most common form. Treatment is mainly focused to contain the disease symptoms. A case of an 11 year boy with alopecia areata treated successfully with Homoeopathy is reported here. He presented with multiple bald spot on scalp with hairfall and itching without any concomitant organ-specific autoimmune disorder. He was treated with homoeopathic medicines following holistic concepts of homoeopathy. *Sepia Officinalis* was given and the potency was selected and repeated as per the response of the medicine upon patient.

KEYWORDS: Alopecia areata, homoeopathy, *Sepia Officinalis*, Simillimum.

INTRODUCTION

Alopecia areata (AA) is a common type of non-scarring hair loss that can affect the scalp and other parts of the body, typically without visible signs of inflammation. It is one of the most frequently encountered forms of hair loss in dermatology, accounting for about 25% of all

alopecia cases. The condition was first described by Cornelius Celsus, while the term “alopecia areata” was introduced by Sauvages in 1760.^[1]

AA represents approximately 2–3% of new dermatology cases in the UK and USA, 3.8% in China, and around 0.7% in India. In the general population, its prevalence is estimated to be 0.1–0.2%, with a lifetime risk of about 1.7%. Both males and females are affected equally, although some studies suggest a slight male predominance.^[2,3]

The condition can occur at any age, ranging from as early as 4 months to as late as the late seventies. About 20% of cases occur in children, and 60% of patients experience their first episode before the age of 20. The highest prevalence is seen in individuals aged 30–59 years. A family history is present in approximately 8.7–20% of cases, indicating a possible genetic predisposition.^[3,4,5]

Etiopathogenesis

Hair growth and maintenance occur through three phases of the hair cycle: anagen (active growth phase), catagen (involution phase), and telogen (resting phase). The type and length of hair are determined by the duration of the anagen phase. In healthy individuals, hair shedding takes place after the resting phase, coinciding with the beginning of a new anagen phase (exogen). However, in alopecia, hair shedding may occur before the onset of a new anagen phase, leaving the hair follicle temporarily empty (kenogen). Therefore, alopecia areata (AA) is primarily a disorder of hair cycling and is regarded as a state of kenogen.^[6,7]

Alopecia areata (AA) is regarded as an autoimmune disorder. Its association with other autoimmune conditions—such as thyroid disorders, anaemia, diabetes mellitus, vitiligo, and psoriasis—supports this concept. In patients with AA, there is an increased presence of hair follicle-specific antibodies in the peripheral blood, particularly against keratin 16 and trichohyalin.^[8,9]

Normally, the hair follicle is considered an immune-privileged site. In healthy follicles, the epithelium shows minimal expression of major histocompatibility complex (MHC) class I and II molecules, while immunosuppressive factors such as TGF- β , IGF-1, and α -MSH are expressed at higher levels.^[9,10]

In AA, this immune privilege is disrupted. There is increased expression of MHC class I and II molecules, reduced levels of immunosuppressive factors, and enhanced expression of

adhesion molecules like ICAM-2 and ELAM-1 in the perivascular and peribulbar regions of the follicle. This leads to perifollicular inflammation.^[10]

The resulting peribulbar inflammation negatively affects hair follicle function, producing thin, dystrophic, and miniaturized hairs. Therefore, AA is considered a hair follicle-specific autoimmune disease, likely triggered by environmental factors in genetically predisposed individuals.^[10,11,12]

Clinical Features

Alopecia areata (AA) typically presents as localized, well-defined patches of hair loss that are often noticed suddenly and may enlarge circumferentially. It can appear as a single patch or multiple patches, and smaller lesions may coalesce to form larger areas of alopecia. The scalp is the most commonly affected site (about 90%), although any hair-bearing area of the body can be involved.^[13]

AA is classified based on the extent and pattern of hair loss. It may present as patchy AA or progress to more extensive forms such as alopecia totalis (AT), which involves complete loss of scalp and body hair (including eyebrows, eyelashes, beard, axillary, and pubic hair), and alopecia universalis (AU), where there is total loss of body hair. Approximately 5–10% of patients with patchy AA progress to AT or AU. The risk of progression is higher when the condition begins before puberty (around 50%), compared to about 25% in adults.^[13,14,15,16]

Different patterns of hair loss are also recognized, including reticular, ophiasis, and sisaipho. Ophiasis presents as a band-like pattern of hair loss along the occipital and temporal scalp margins, while sisaipho (ophiasis inversus) affects the frontal, temporal, and parietal regions but spares the peripheral scalp, resembling androgenetic alopecia.^[16,17]

A recently described variant, acute diffuse and total alopecia is characterized by a higher prevalence in females, diffuse hair thinning, rapid progression, tissue eosinophilia, widespread involvement, a short clinical course, and a generally favorable prognosis. Another rare variant, perinevoid alopecia, presents as hair loss surrounding melanocytic nevi. Occasionally, atypical presentations such as linear patterns of hair loss may also be observed.^[17,18,19,20]

CASE REPORT

An 11-year-old boy visited at the Aravali homoeopathic clinic, Alwar, India, with extensive alopecia areata (AA). He had multiple bald patches on his scalp that had been present for more than one year. Apart from this condition, the boy was otherwise healthy and showed no abnormalities of the skin or nails.

His parents were worried about his condition and sought treatment from a homoeopath. The child had previously taken homoeopathic medicines for three months but experienced no improvement. There was no family history of alopecia areata or any autoimmune disorders. During case-taking, his mother reported that he had difficulty in concentration and he does not like company. He had anxiety when he was angry and consolation made him worse. He had a strong preference for sweet foods, and had a chilly thermal constitution. Consent was obtained from the patient for the use of his images and clinical information.

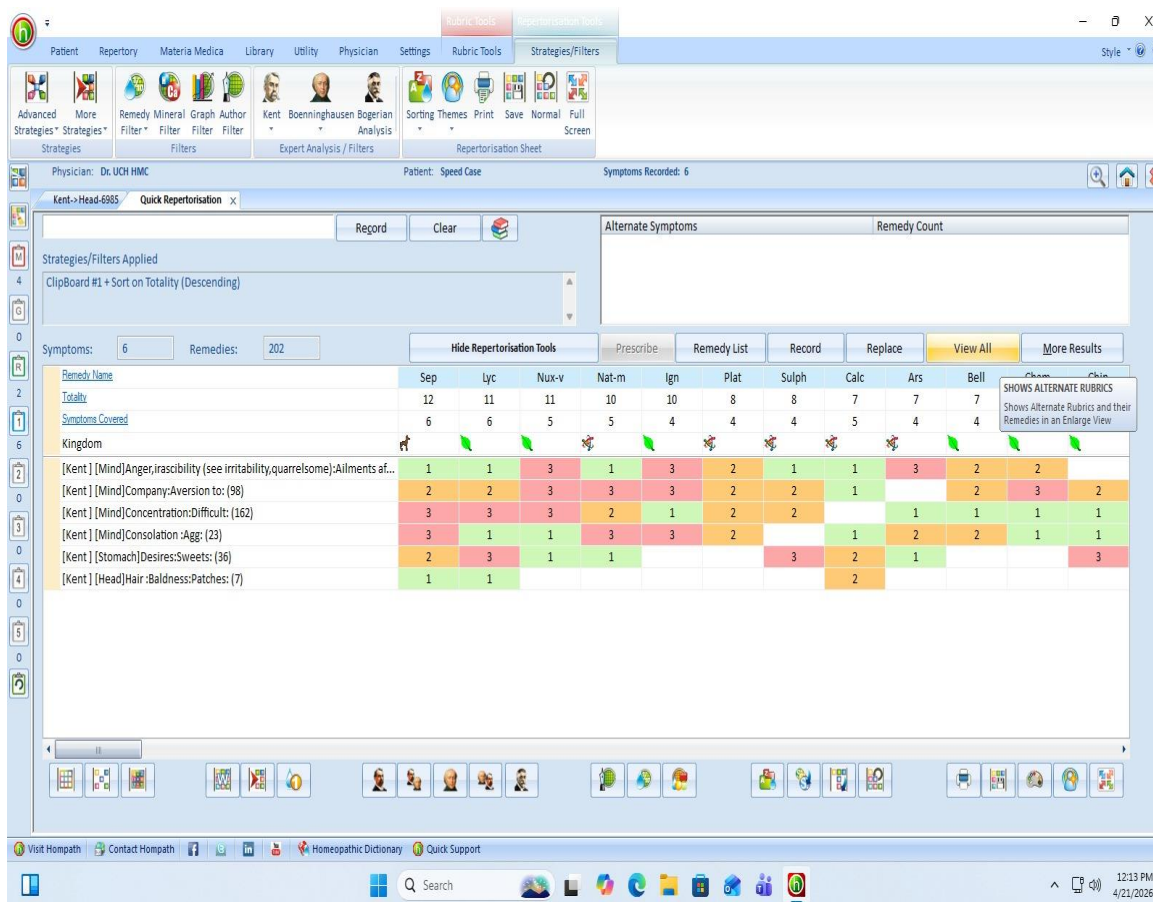
The following characteristic symptoms were selected for repertorisation.

1. Anxiety during anger.
2. Aversion to company.
3. Difficulty in concentration.
4. Consolation makes him worse.
5. Desire for sweets
6. Hair baldness in patches.

REPERTORIAL TOTALITY

S.NO.	SYMPTOM	RUBRIC
1.	Anxiety during anger.	MIND- anger, irascibility: Ailments after anger, vexation, etc.: Anxiety, with
2.	Aversion to company.	MIND- company: aversion to
3.	Difficulty in concentration.	MIND- concentration: difficult
4.	Consolation makes him worse.	MIND- consolation: agg
5.	Desire for sweets	STOMACH- desire: sweets
6.	Hair baldness in patches.	HEAD- hair: baldness:patches

REPERTORISATION^[22]



INTERVENTION

First prescription: On 14/4/2025, *Sepia officinalis* 200C was prescribed one dose and sac lac 30/TDS for 14 days.

Basis of prescription: The remedy was selected after careful individualisation of the case, considering the totality of the patient’s symptoms and consulting the Materia Medica. *Sepia officinalis* was chosen because it corresponded closely with the overall symptom picture, including the patient’s chilly thermal constitution. Therefore, *Sepia officinalis* 200C was prescribed one dose and sac lac 30/ TDS for 14 days. During subsequent follow-up visits, the potency was adjusted based on the patient’s response and the progress observed in the bald patches.

FOLLOW UPS

The patient was monitored through monthly follow-up visits, or more frequently when necessary. A detailed record of the follow-ups arranged by date is presented in Table 2.

DATE	SYMPTOMS	PRESCRIPTION	JUSTIFICATION
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30/4/2025	No change noted on bald patches	<i>Sepia officinalis</i> 200/1 dose Sac lac 30/tds for one month.	As there were no changes observed, the same medicine was continued.
28/5/2025	New hair growth appeared on bald patches	Sac lac 30/tds for one month.	Considering improvement in complaints, Sac lac was given
23/6/2025	Small hairs observed on bald patches	Sac lac 30/tds for one month.	Considering improvement in complaints, Sac lac was given
27/7/2025	Complaints status quo	<i>Sepia officinalis</i> 1M/ 1 dose Sac lac 30/tds for one month.	In view of no further improvement, potency of the medicine was raised, <i>Sepia</i> was prescribed
24/8/2025	Slow and continuous improvement observed in bald patches	Sac lac 30/tds for one month.	Considering improvement in complaints, Sac lac was given
27/9/2025	Complaints status quo	<i>Sepia officinalis</i> 1M/ 1 dose Sac lac 30/tds for one month	There was distinct improvement in the bald patches, <i>Lycopodium</i> 1M was repeated
26/10/2025	Marked improvement observed in bald patches	Sac lac 30/tds for one month.	Considering improvement in complaints, Sac lac was given
28/11/2025	Significant improvement of hair growth on the head without any recurrence of new bald patches	Sac lac 30/tds for one month.	Complete disappearance of the bald patches on the head without any recurrence of any other new bald patch, Sac lac was continued
26/12/2025	Complete growth of hair on the head	Sac lac 30/tds for one month.	Complete disappearance of bald patches on head, without recurrence of any bald patches, for over a period of 9 MONTHS of homoeopathic treatment, Sac lac was prescribed

RESULT

The bald patches on the patient's scalp gradually began to show signs of new hair growth during the course of treatment. In the initial stages, *Sepia officinalis* 200C produced noticeable improvement. However, a more significant and faster response was observed after the potency was increased to *Sepia officinalis* 1M. With continued homoeopathic treatment and regular follow-up, the bald patches completely resolved, and full hair regrowth was achieved over a period of three years, as documented in Figures.

BEFORE

AFTER



DISCUSSION

The patient presented with bald patch on the scalp, and there was no family history of alopecia areata (AA) or other autoimmune diseases. In this case, treatment with an individualized homoeopathic medicine resulted in complete regrowth of hair, with no recurrence observed during the follow-up period.

Since conventional medicine does not always provide consistently effective treatment for AA, many patients turn to complementary and alternative medicine (CAM) for relief. In the present case, a detailed case history was taken, followed by repertorisation and consultation of the *Materia Medica*. Based on the totality of symptoms *Sepia officinalis* was selected as the most appropriate remedy. The patient initially showed signs of improvement, which indicated that the medicine had been correctly chosen. However, the progress was relatively slow when treated with the lower potency of *Sepia officinalis* 200C. A more noticeable and faster improvement was observed after the potency was increased to 1M.^[22]

Overall, this case highlights the potential effectiveness of homoeopathic treatment in managing alopecia areata when remedies are prescribed according to classical homoeopathic principles and tailored to the individual patient.

CONCLUSION

Homoeopathy is a specialized system of medicine that focuses on treating the patient as a whole rather than addressing only the presenting symptoms. In this case, complete regrowth of hair without any recurrence of bald patches was observed, which is documented in Figures.

This case suggests a positive role of homoeopathic treatment in the management of alopecia areata (AA). However, since this is a single case report and AA is known to have a variable and unpredictable pattern of remission, well-designed and larger studies are required to scientifically validate these findings.

REFERENCES

1. McMichael AJ, Pearce DJ, Wasserman D, Camacho FT, Fleischer Jr AB, Feldman SR, *et al.* Alopecia in the United States: Outpatient utilization and common prescribing patterns. *J Am Acad. Dermatol*, 2007; 57: 49-51. [Google Scholar]
2. Sharma VK, Dawn G, Kumar B. Profile of alopecia areata in Northern India. *Int. J Dermatol*, 1996; 35: 22-7. [Google Scholar]
3. Safavi KH, Muller SA, Suman VJ, Moshell AN, Melton LJ 3rd. Incidence of alopecia areata in Olmsted County, Minnesota, 1975 through 1989. *Mayo Clin. Proc.*, 1995; 70: 628-33. [Google Scholar]
4. Tan E, Tay YK, Goh CL, Chin Giam Y. The pattern of alopecia areata in Singapore - A study of 219 Asians. *Int. J Dermatol*, 2002; 41: 748-53. [Google Scholar]
5. Wasserman D, Guzman-Sanchez DA, Scott K, McMichael A. Alopecia areata. *Int. J Dermatol*, 2007; 46: 121-31. [Google Scholar]
6. Al-Mutairi N, Eldin ON. Clinical profile and impact on quality of life: Seven years experience with patients of alopecia areata. *Indian J Dermatol Venereol Leprol*, 2011; 77: 489-93. [Google Scholar]
7. Bhat YJ, Manzoor S, Khan AR, Qayoom S. Trace element levels in alopecia areata. *Indian J Dermatol Venereol Leprol*, 2009; 75: 29-31. [Google Scholar]
8. Muller SA, Winkelmann RK. Alopecia areata - An evaluation of 736 patients. *Arch Dermatol*, 1963; 88: 290-7. [Google Scholar]
9. Wang E, McElwee KJ. Etiopathogenesis of alopecia areata: Why do our patients get it? *Dermatol Ther.*, 2011; 24: 337-47. [Google Scholar]
10. Tosti A, La Placa M, Placucci F, Gentilomi G, Venturoli S, Zerbini M, *et al.* No correlation between CMV and alopecia areata. *J Invest Dermatol*, 1996; 107: 443. [Google Scholar]
11. Barahmani N, Schabath MB, Duvic M. History of atopy or autoimmunity increases risk of alopecia areata. *J Am Acad Dermatol*, 2009; 61: 581-91. [Google Scholar]

12. Xiao FL, Yang S, Liu JB, He PP, Yang J, Cui Y, *et al.* The epidemiology of childhood alopecia areata in China: A study of 226 patients. *Pediatr Dermatol*, 2006; 23: 13-8. [Google Scholar]
13. Leung MC, Sutton CW, Fenton DA, Tobin DJ. Trichohyalin a potential major autoantigen in human alopecia areata. *J Proteome Res.*, 2010; 9: 5153-63. [Google Scholar]
14. Kang H, Wu WY, Lo BK, Yu M, Leung G, Shapiro J, *et al.* Hair follicles from alopecia areata patients exhibit alterations in immune privilege associated gene expression in advance of hair loss. *J Invest Dermatol*, 2010; 130: 2677-80. [Google Scholar]
15. Gilhar A. Collapse of immune privilege in alopecia areata: Coincidental or substantial? *J Invest Dermatol*, 2010; 130: 2535-7. [Google Scholar]
16. Madani S, Shapiro J. Alopecia areata update. *J Am Acad Dermatol*, 2000; 42: 549-66. [Google Scholar]
17. Finner AM. Alopecia areata: Clinical presentation, diagnosis, and unusual cases. *Dermatol Ther.*, 2011; 24: 348-54. [Google Scholar]
18. Sato-Kawamura M, Aiba S, Tagami H. Acute diffuse and total alopecia of the female scalp. A new subtype of diffuse alopecia areata that has a favorable prognosis. *Dermatology*, 2002; 205: 367-73. [Google Scholar]
19. Lew BL, Shin MK, Sim WY. Acute diffuse and total alopecia: A new subtype of alopecia areata with a favorable prognosis. *J Am Acad. Dermatol*, 2009; 60: 85-93. [Google Scholar]
20. Yesudian P, Thambiah AS. Perinevoid alopecia. An unusual variety of alopecia areata. *Arch. Dermatol*, 1976; 112: 1432-4. [Google Scholar]
21. Evidence- based homoeopathy: Case report of alopecia areata in an 11 year old boy Ashish Pandurang Shivadikar. n.d.
22. Hompath. Neometal [Internet]. India: Hompath; [cited 2026 Apr 21].
23. Boericke W, Boericke O. Pocket Manual of Homoeopathic Materia Medica Comprising of the Characteristic and Guiding Symptoms of all Remedies (Clinical and Pathogenetic) (3rd ed). New Delhi: B; New Delhi: Jain Publishers Private Ltd; 2012.